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# Leveraging Key Informant Interviews to Inform Intervention Development: The Greater Lawndale Healthy Work Project

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## Abstract

**Background:** The Greater Lawndale Healthy Work project is a sequential mixed methods community based participatory research project that examines work as a structural determinant of health and builds community capacity for healthy work in a predominantly Black and Latinx community in Chicago known as Greater Lawndale (GL).
**Objectives:** We interviewed community leaders in GL as key informants to understand the barriers to healthy work and inform intervention development.
**Methods:** We conducted a directed content analysis of transcripts from 20 key informants and coded the social ecology and type of intervention.
**Results:** Every key informant mentioned at least one asset in GL, showing an opportunity to employ a capacity-oriented approach to intervention development. Key informants suggested a variety of interventions to address precarious work across levels of the social ecology, with individual and community level interventions being the most salient.
**Conclusion:** Through this approach, we were able to navigate tensions and challenges in conducting research for community-wide change. Key informant stakeholder interviews can be leveraged to meaningfully inform intervention development and support the development of multi-level, sustainable, and culturally acceptable interventions that advance health equity.

## Keywords

community based participatory research, key informant, intervention planning, qualitative

## Introduction

Work is a complex, overlooked social determinant of health that interacts with social, physical, and mental health.[1–5] While the role of work as a social determinant of health is increasingly recognized, the inequitably structured nature of work opportunities shaped by socio-political context and social position are not.[6] Precarious work is work that by nature is unhealthy, unsafe, unstable, low paying and without sufficient benefits such as health insurance, sick time, and parental leave.[7] This exposes employees to exploitation, discrimination, and limited work-life balance. Precarious work impacts many other domains of health such as housing and healthcare access, and can ultimately widen health disparities.[8] Benach and colleagues (2014) synthesized main research findings about the evidence linking precarious employment and health and saw that precarious employment had positive associations with poor health status, cardiovascular risk factors and events, poor psychological health, sleep disorders, musculoskeletal complaints, and more. Furthermore, the root cause of precarious work is complex and multi-layered, influenced by systems of classism, sexism, ableism, and white supremacy, requiring an approach that addresses multiple parts of the problem simultaneously.[9,10] In an effort to promote sustainable community health improvements and advance health equity, the Greater Lawndale Healthy Work project (GLHW) aims to establish interventions that disrupt these pathways of precarious work and

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establish a culture of healthy work through community-level interventions.

## The Greater Lawndale Healthy Work Project

GLHW is a community based participatory research (CBPR) project of the University of Illinois Chicago School of Public Health Center for Healthy Work (a National Institute of Occupational Safety and Health Center of Excellence in Total WorkerHealth®) situated in two adjacent neighborhoods in Chicago, Illinois. Greater Lawndale (GL) is the broader area that is comprised of these two community areas (i.e., neighborhoods): North Lawndale (NL) and South Lawndale (known as Little Village, LV to residents). The GLHW Project began out of the Little Village Participatory Community Health Assessment, where work and occupation emerged as a salient factor that impacts community health in LV through worker exploitation, traditional work-related gender roles, and intergenerational strain.[11] Of the 34,817 NL residents, 86% are African American, while 82.4% of the 71,402 LV residents identify as Hispanic or Latino.[12] The median income of NL and LV is $32,051 and $37,293 respectively, compared to the Chicago median income of $65,564. About 14% of NL residents and 9% of LV residents are unemployed compared to 8% across Chicago. In a community health assessment, researchers found that 85% of the 727 GL employers had <20 employees, where employer size could be documented.[13] The assessment also found that over half of the employers in GL in 2019 were in retail, service, and food sectors. In addition, 46% of GL employers fall into manufacturing and healthcare.[13]

As a CBPR project, GLHW places primacy on the community's issue of interest and builds on existing assets of the community, and emphasizes shared visioning, learning, and reciprocity.[14–16] Meaningful participation is maintained in this project through our academic-community research team, where residents and neighborhood leaders are trained in applicable methodologies and are compensated as members of the research team along with researchers at the academic institution. This academic-community research team collaborates in every step of the research process and has an established history of translating research findings into community-driven action.[17–19]

GLHW uses an iterative, sequential mixed methods design with several research components[20] to determine the context of, and barriers and pathways to, healthy work in GL in order to identify evidenced-based, community informed intervention strategies that promote healthy work at the neighborhood level. We conducted concept mapping to create a community-driven conceptual framework for the study, which informed subsequent design of the project.[10,21,22] A foundational part of the GLHW project was a community health assessment (see Table 1) including focus groups with residents to explore how they experience work and perceive work impacting the health of residents in their neighborhood, a community survey to understand how residents experience precarious work, and semi-structured key informant interviews with community leaders to identify community resources, assets, and gaps.[23] The focus of this paper is on the key informant

**Table 1.** Community Health Assessment Methods Overview.

| Research Method | Dates | Procedures | Setting | Duration | Eligibility | Number of participants |
|---|---|---|---|---|---|---|
| Concept mapping | Jan-May 2017 | Brainstorming events<br>Sorting and rating concepts<br>Spanish and English responses | Community settings including laundromats, community centers, CBOs | Any | Live or work in GL | 292 |
| Individual interviews with key informants | February 2017-February 2018 | Identified by community research team (CRT) Conducted in NL/SL | Community organization host | 60 min | Live or work in GL; knowledgeable about precarious work in the community; fluent in English or Spanish | 20 (10 in NL; 10 in SL) |
| Focus groups | April-May 2017 | Identified by CRT Conducted in NL/SL | Community organization host | 60-90 min | Live or work in GL; at least 18 years old; fluent in English or Spanish | 144; 12 groups (6 in NL;6 in SL) of 10-12 participants per group |
| Community health survey | August 2018-August 2019 | Identified by community partners | Any | Any | Live in GL; at least 18 years old; fluent in English or Spanish | 489; including 20 pretests |

Notes: GL= Greater Lawndale; NL= North Lawndale; SL= South Lawndale.

interviews that were conducted to identify needs and assets with respect to working in GL.

## Methods

### Design and Procedure

We conducted face-to-face semi-structured key informant interviews ($n = 20$; Table 2) with individuals identified by the academic-community research team. Inclusion criteria for participating in an interview were that the key informant (1) live or work in either NL or LV; (2) was at least 18 years old; (3) was perceived by the community partner as knowledgeable about precarious work in the community; (4) worked or volunteered for a community-based organization that serves NL or LV; and (5) fluent in English or Spanish.

**Table 2.** Key Informant Characteristics.

| | Total | Percent (%) |
|---|---|---|
| Gender | | |
| Male | 7 | 35 |
| Female | 11 | 55 |
| Missing | 2 | 10 |
| Community area (residence) | | |
| North lawndale | 5 | 25 |
| Little village | 8 | 40 |
| Other | 5 | 25 |
| Missing | 2 | 10 |
| Community area (Work) | | |
| North lawndale | 6 | 30 |
| Little village | 8 | 40 |
| Other | 4 | 20 |
| Missing | 2 | 10 |
| Country of birth | | |
| US | 14 | 70 |
| Mexico | 3 | 15 |
| Other | 1 | 5 |
| Missing | 2 | 10 |
| Education | | |
| Less than high school | 0 | 0.00 |
| High school | 2 | 10 |
| Some college | 2 | 10 |
| College degree | 14 | 70 |
| Missing | 2 | 10 |
| Languages spoken at home | | |
| Spanish only | 2 | 10 |
| Mostly Spanish | 1 | 5 |
| Both Spanish and English | 3 | 15 |
| Mostly English | 4 | 20 |
| English only | 8 | 40 |
| Missing | 2 | 10 |
| Employment status | | |
| Employed for wages | 17 | 85 |
| Self employed | 2 | 10 |
| Missing | 2 | 10 |

The semi-structured interview guide had 15 questions and was developed by the academic-community research team and structured around our research goals to identify community resources, assets, and gaps. At the beginning of the interview, interviewers described GLHW and defined health, work, and community as follows: "Work is defined as labor that is done to support oneself and one's family financially. Health includes not just the absence of disease, but also encompasses wellness, safety, mental and social health, and other factors."[24] Interview questions focused on domains of health assets and work in GL, health and work needs, work situation and structure, barriers to healthy work, and future needs and assets.

Interviews were conducted by nine members of the academic-community research team between February 2017 and February 2018 in locations convenient to the participants in GL. Potential interviewees were emailed a recruitment script asking them to participate in a 60-min voice-recorded interview. After interviewees provided written and verbal consent, interviewers collected brief sociodemographic information. Ten interviews were conducted in each community area. Key informants were compensated for their time with a $25 gift card. All interviews in NL were conducted in English and professionally transcribed. Of the ten interviews in LV, four were conducted in Spanish by bilingual interviewers. Of the four Spanish-language interviews, two were transcribed and the other two had detailed paraphrased notes in English created by bilingual research team members. This process was needed due to poor quality of recordings. Interview length ranged from 40 to 90 min, but on average lasted 60 min. Prior to analysis, transcribed interviews were cleaned by members of the academic-community research team. Ethics approval was received from the University of Illinois Chicago Institutional Review Board.

### Analysis

Our analysis leveraged a social constructionist analytic lens, recognizing the ways in which people socially construct their realities.[15] Initially, we thematically analyzed the semi-structured individual interviews through participatory coding using the same codebook developed for our focus group data for understanding the context and root causes of precarious work; however, we found that the codebook was not as useful for our aims related to analyzing the key informant interviews and the interviews did not result in unique insights about the needs of the community with respect to precarious work. We repurposed the key informant interviews with a secondary analysis using a directed content analysis (DCA) approach examining the research participants' perceptions of community-level interventions on work and health, using the

conceptual framework of the ecological model.[25] Specifically, we wanted to examine the solutions to precarious work and health that key informants identified. DCA is a deductive approach to coding that starts with a conceptual framework and explores the textual data for directed insight.[26,27] DCA is useful with research where current theory or existing evidence needs advanced elucidation, such as with GLHW.

We developed and applied codes to capture solutions to the issue of precarious work that were suggested by interviewees according to various levels across the social ecology and type of intervention. Data were coded for solutions to healthy work first by the action level, using framework coding[28] to indicate at which level of the ecological model the suggested intervention would occur: individual, interpersonal, employer, community, and society/policy level.[25] Data were also coded for each suggested intervention by intervention type, to broadly describe what kind of intervention the informant suggested: building community capacity, behavior change, knowledge, skill, or structural change. These categories were formed based on our concept map generated from formative research in GL, which includes norms, community capacity, individuals' knowledge and skill, and policy.[22] Each suggested intervention could be coded as occurring on multiple levels and multiple intervention types. Lastly, we created an inductive code for community assets and capacity whenever an asset was mentioned during an interview that could be built on for potential intervention efforts (e.g. a characteristic of the community, a place, a resource, or program). All data were managed and coded in Dedoose, a web-based computer-assisted qualitative analysis software, by the first author, with co-authors involved in developing the codes and reconciling coding challenges through discussion.[29,30] Key findings were identified by examining the coded data for code repetition, code/thematic co-occurrence, and via community-academic research team group dialogue.[31] Following this analysis, the findings were shared with the GLHW academic-community research team, and the findings have informed subsequent action planning (manuscript in preparation) and intervention planning.

## Results

We had a diverse pool of key informants (Table 2). All either lived or worked in GL and most had a college degree. About half were female and about a third spoke at least some Spanish at home. Key informants represented/worked for churches, health care organizations, local government, and other community-based organizations (Table 3).

### *Community Assets*

Every key informant mentioned a community asset, and suggestions for five types of interventions (building community capacity, behavior change, knowledge, skill, or structural change) were similar across the two neighborhoods. Community assets were broad, ranging from specific programs to social and economic assets. For example, key informants shared places and organizations that provided employment opportunities or employment

**Table 3.** Interview Characteristics.

| Interview ID | Community area | Language | Length (mins) | Organization type |
|---|---|---|---|---|
| 1 | NL | English | 35 | Church |
| 2 | NL | English | 41 | Church |
| 3 | LV | Spanish | 71 | Church |
| 4 | NL | English | 85 | CBO |
| 5 | LV | English | 73 | CBO |
| 6 | LV | English | 60 | CBO |
| 7 | LV | English | 72 | CBO |
| 8 | LV | English | 45 | Healthcare |
| 9 | LV | English | 65 | Church |
| 10 | LV | English | 70 | Worker center |
| 11 | NL | English | 90 | CBO |
| 12 | LV | Spanish | 40 | CBO |
| 13 | NL | English | 73 | Healthcare |
| 14 | NL | English | 46 | Other |
| 15 | NL | English | 40 | Healthcare |
| 16 | NL | English | 40 | Government |
| 17 | LV | Spanish | 45 | CBO |
| 18 | LV | Spanish | 43 | CBO |
| 19 | NL | English | 54 | Healthcare |
| 20 | NL | English | 50 | CBO |

assistance, such as two key healthcare organizations in the community, a mentoring program a key informant was involved in, youth employment networks, and ongoing workforce development partnerships that key informants knew about or were involved in. Key informants also mentioned organizations in the community that had more varied resources, like churches, the community newspaper, or community centers. Key informants also referenced assets related to the diversity of the community and community norms such as "the younger generation is being encouraged [to finish school, get a degree, build skills]"; "our community is real diverse"; "word of mouth" as a strength and a "family feel" demonstrated by having shared carpools, for example. Key informants suggested an array of potential interventions to address precarious work (Table 4). Examples of interventions include interview preparation at the individual level, mentoring youth at the interpersonal level, changing hiring practices at the employer level, knowledge-sharing at the community level, and addressing vacant housing at the policy level. Examining results qualitatively, there were no noticeable differences in the types of inventions suggested, when looking across the characteristics of key informants. The most frequently cited action levels were at the individual, community, and employer level.

### *Individual Level Interventions*

All but two key informants suggested individual-level interventions delivered as a service for community members looking for employment ($n$ = 18; see Table 4). The most suggested intervention types at the individual level were skill building ($n$ = 13) and increasing knowledge, particularly job training ($n$ = 14). Key informants emphasized that individuals in the communities have skills that are untapped and have the potential to contribute to the local economy:

> […] We should embrace that there are people with skillsets that are maybe doing things out of their homes and we need to bring them out and showcase it and figure out how to make that into some type of model where they do become counted as an actual business or entity that can provide a tax base even.

To continue, the informant discussed the need to teach entrepreneurial individuals how to formalize their businesses.

**Table 4.** Interventions Suggested by Key Informants.

| SEM level | Suggested solutions |
|---|---|
| Society and policy ($n$=13, 65%) | - Equitable, quality education (STRUCTURAL)<br>- Require employers to provide sick time and vacation time (STRUCTURAL)<br>- Expand transportation access (STRUCTURAL)<br>- Address vacant housing (STRUCTURAL)<br>- Provide housing assistance and affordable housing (STRUCTURAL)<br>- Increase wages (STRUCTURAL)<br>- Criminal justice reform (STRUCTURAL) |
| Community ($n$ =17, 85%) | - Local campaigns to raise awareness (KNOWLEDGE)<br>- Community organizing (BUILD CAPACITY)<br>- Resources for supporting entrepreneurs (SKILL; BUILD CAPACITY)<br>- Community-wide job training/skill building (SKILL)<br>- Community engagement and knowledge sharing initiatives (KNOWLEDGE; BUILD CAPACITY)<br>- Community development (BUILD CAPACITY; STRUCTURAL)<br>- Improve community safety infrastructure to reduce violence and increase physical activity (STRUCTURAL; CHANGE BEHAVIOR) |
| Employers ($n$ =11, 55%) | - Change hiring practices (STRUCTURAL; BEHAVIOR CHANGE)<br>- Offering career paths to people in the neighborhood (SKILL; BEHAVIOR CHANGE)<br>- Internal policy changes: Childcare, wellness programs (STRUCTURAL)<br>- Addressing misconceptions and fears about immigrant workers (KNOWLEDGE) |
| Interpersonal ($n$= 4, 20%) | - Mentoring youth (BEHAVIOR CHANGE)<br>- Family structure support (BEHAVIOR CHANGE) |
| Individual ($n$=18, 90%) | - Interview preparation (SKILL)<br>- Resume building (SKILL)<br>- Job search assistance (SKILL; KNOWLEDGE)<br>- Learning professional behavior (SKILL; KNOWLEDGE)<br>- Job skills training (SKILL; KNOWLEDGE)<br>- Second chance or reintegration programs (KNOWLEDGE)<br>- Worker rights training (KNOWLEDGE)<br>- Budgeting and banking training (SKILL)<br>- Small business incubator (BUILD CAPACITY; SKILL)<br>- Trade program (SKILL) |

Several key informants also suggested that people need to be taught their workers' rights:

> These are things that show that we don't know our full rights and that people in the community need to be educated. Has anyone ever done a training in Little Village about workers' rights? […] This is something as a community we need to do to educate our people.

Key informants also mentioned that individuals need to be taught general professional etiquette in order to obtain healthy work: "[…] so often we'll get someone – it's just like the young lady who thinks she can wear spandex to work, right? Teaching her along the way."

### Interpersonal Interventions

Four key informants suggested interpersonal interventions, all focused on behavior change. Youth programming was suggested by multiple key informants as a potential intervention to model stable employment as an adult and increase pursuit of safe and healthy work. One key informant who worked at a healthcare organization shared:

> I [mentor] five young ladies from different communities. I spend two hours each with them per week, and then you bring them together. And we're allowed to take them around our families to see – a lot of the children don't know what – and I'm not saying my family is so normal. But a lot of children don't know what it is to see a family sit down and eat a meal together.

Several key informants also emphasized the need to build interpersonal relationships to unite the communities across racial and physical divisions in order to bridge opportunities for work across GL:

> The issue and clarity in Little Village and North Lawndale is how [society has] pit us against each other. How they have created physical barriers for us to not be able to communicate. So, there's physical barriers, but there also comes language barriers and cultural barriers that we have to overcome.

### Employer Interventions

Employer-level interventions were suggested by about half of key informants ($n$ = 11). Examples of employer interventions included encouraging employers to alter internal policies and practices and valuing employees more, particularly seeing value in the community and increasing the number of healthy jobs. The most common intervention types on the employer level were changing behavior ($n$ = 7), particularly to encourage employers to hire more GL residents: "We need workplaces that are supportive and understand the complexities of […] the people that come from our neighborhoods."

Key informants also suggested employer-level policy changes ($n$ = 4), such as changing policies to be able to hire individuals with a criminal record and have practices that encourage healthy work such as providing sick time and childcare support, and investing in wellness programs: "People with backgrounds, unfortunately, society sees them something that life is over and that's not necessarily the case. And, we have people over here that are great, great, great workers."

### Community Level Interventions

Community level interventions were suggested by most key informants ($n$ = 17). The most commonly suggested intervention types at the community level were interventions to build capacity ($n$ = 12). One solution was to collect more data about who applies to jobs in the community, in order to identify gaps and areas for growth:

> You put this [job fair announcement] out, how many people come [to the fair]? Out of those, how many apply? Out of those, how many land a job? Out of those who land a job, how long do they stay at work? And sometimes, there's no such data to support anything like that. […] To me, that means nothing unless you kept concrete numbers.

Several key informants also mentioned a need for greater community engagement and knowledge sharing across the community ($n$ = 11) and the need for residents to know about services to help them get healthy jobs and how to access them: "I just think there's a lot of assets in the community, but there's this challenge of community engagement and outreach […] I think getting those services to flow at the community level and people to realize and recognize and be able to utilize those services…"

### Societal Level Interventions

Societal level interventions to address drivers of precarious work were recommended by over half of key informants ($n$ = 13). Suggestions included policy changes ranging from addressing inequities in education, expanding sick time and vacation time, investing in transportation, pursuing urban planning efforts to address vacant buildings, increasing the availability of affordable housing, and increasing wages. These kinds of interventions are complex, but could be transformative for the community, as one key informant suggested:

> We have so many abandoned buildings around here, so many abandoned properties that could be clean. So, this was our idea. If you want to get that – food stamps or checks, we could take a grid, like from Kedzie to Ogden, Cermak to Central Park. And every person that's in this area that's getting subsidized rent or whatever, do so many hours a week to keep this clean. That, to

me, will be honest, healthy work. […] You're making your community safe because if you are out there doing this work, you could see where things are not going right, and you could report that.

This is one example of a transformative practice because it is conceived from the community perspective and is given importance during the collaborative research process, as these results were shared to inform potential interventions. This particular intervention suggestion is one that addresses a community problem (abandoned buildings) with a culturally acceptable solution (community ownership for maintenance and cleaning) that would address the needs of the community and ultimately increase the capacity of the community.

## Discussion

Key informant interviews were part of our community health assessment to understand the broad needs and assets at the neighborhood level with respect to work. Key informant participation in community health assessments may be another mechanism for greater accountability and integrity in research and public health practice, fostering partnerships and reflexive praxis.[32] Because of their expertise and experience, these key informants were able to reflect on neighborhood- and community-level factors that influence getting and keeping work in the area, allowing us to bridge a gap between research and institutional practice. Key informants were also able to discuss work in the context of local culture and diversity, and identify assets, gaps, and resources at the neighborhood- and community-level.[33]

A preliminary thematic analysis of the data did not deepen our understanding of the phenomenon of work at the neighborhood level. Instead, we found the nature of the interview data well-suited to contribute to a broader understanding of emic stakeholder perceptions about multi-level community interventions. Compared with the other GLHW community health assessment data, we had unique insights from the key informant interviews that can be leveraged to inform intervention planning and development. This secondary analysis allowed us to understand how community stakeholders, including service providers, conceptualize precarious work and the solutions to overcoming it. Precarious employment is a complex, adaptive issue, and gaining perspective from stakeholders who work in this complex environment allows further consideration of a systems approach. Systems approaches are increasingly popular because they can address the complexities of health behavior and outcomes and they complement ecological models.[10,21,34] A systems approach both acknowledges multi-level influences on outcomes and understands health outcomes as occurring within an interconnected system; that changing one element in the system may impact another, rather than (or in addition to) the outcome itself.[10]

The key informant interviews allowed us to better define what a systems approach could look like in GL and what kinds of interventions are feasible and sustainable.

These key informant interviews are the only GLHW Project data from service providers and decision-makers, whose perspective is important for designing an intervention that is acceptable and sustainable. Attention to the perspectives of various types of stakeholders and the community context is key to developing a feasible, sustainable, and effective interventions.[35,36] The findings suggest that we should not focus strictly on policy or employer-level action, but also consider ways that we can address both individual skills and knowledge and community-level knowledge and capacity in our interventions, so that service providers champion and support continuing efforts to address precarious work. By considering diverse intervention approaches while leveraging key stakeholders' perspectives, practitioners can better consider potential interventions' perceived feasibility, acceptability, and sustainability by those who we will be asking to implement these interventions.[34,36,37]

These findings also point to the need to shift knowledge around drivers of precarious employment among service providers and community leaders. More often than not, key informants recommended individual or community level interventions, rather than employer or society-level interventions. The more frequent suggestion of individual-level interventions may show that despite recognition of structural determinants of health, service providers believe that individuals can overcome the structural barriers of healthy work with more skills or social support. However, the main drivers of precarious work include systematic marginalization from the pathways to healthy work, contextual and structural hostility to sustain healthy work; and violations in the rights, agency, and autonomy of resident workers—all issues that are driven by employers and policies.[23]

Through this analysis, we were also able to create an inventory of the assets in the community that were valued by key informants. By documenting assets mentioned by key informants, we generated a list of what resources already exist and can be leveraged to achieve the goal of expanding opportunities for healthy work in GL. Furthermore, through this analysis we also noted that several organizations were doing related but separate work, indicating an opportunity for capacity building. The documentation of community assets allows us to employ a comprehensive approach to action planning that builds on the existing strengths and resources of the community rather than starting from scratch.[38] We have already begun to see the benefit of this approach and have used some of the information gleaned from these interviews. For example, some key informants were invited to speak at our GLHW Council meetings, which is a group of community members who are engaged to plan community-level interventions as the next phase of this project. Our approach is unique in that these key informant interviews allowed

stakeholders' perspectives to inform the identification and development of interventions.

Lastly, this process demonstrates the flexibility that is necessary for CBPR. The results were different than what we expected and we had to interpret and navigate these tensions. We expected that key informants would have similar attitudes to those of the community, identifying policy and employer determinants of precarious work. Instead, we saw that interviewees generally lacked a systems perspective on the issues related to precarious employment. While it is easier to set aside data that is not necessarily "helpful" to an overall goal of developing a neighborhood-level intervention for healthy work, we saw that this data could still be useful. With flexibility and creativity that are a key components of CBPR, this secondary analysis allowed us to gain a deeper understanding of the context surrounding our work and the path to sustainable change.

### Limitations

A limitation of this analysis is that although the focus is on solutions to work, key informants were only asked one explicit question specific to solutions to precarious work. Since we analyzed entire interviews and not the single question, there was some level of interpretation necessary to flag that key informants were talking about their suggestions for action. Having had multiple analysts and consensus between authors, this is not a major limitation that impacts the trustworthiness of the data. A second limitation to this analysis is that key informants were identified by research partners, so this study may be impacted by selection bias and the views of our key informants may not be representative to those of other service providers in the community.[39] For example, key informants may have been invited to participate in an interview because of their orientation towards more upstream solutions to work, or due to their familiarity or social connections to some of the academic-community research team members. We may have recruited differently by having more input from community researchers and conducting targeted interviews based on who has the power to influence these issues in the community. A third limitation is that given our commitment to collaborative research, we had nine interviewers. We addressed this potential limitation by having regular debriefing sessions throughout the data collection and analysis process and listening to each other's interviews to share data collection responsibility, which can strengthen confirmability of the findings.[29,30] A fourth limitation is that two of the Spanish-language interviews were not transcribed verbatim, so there may be additional information that was not captured in the English-language notes. A fifth limitation could be the timing of the interviews in the context of the GLHW project. Conducting the interviews after the survey and during the intervention development could have given us a very different perspective, or a second round of interviews could have given us more intervention specific insights. Despite these limitations, the findings are useful for applying in the later phases of this project, as well as for its contributions to the broader fields of community health planning and implementation science.

### Conclusion

Through this analysis of key informant interviews, we identified community resources to leverage and generated insights for implementing a multi-level intervention that is supported by community leaders. This approach demonstrates how CBPR methodologies can support the development of pragmatic, culturally acceptable, and sustainable interventions that advance health equity as well as the production of research that dismantles harmful, deficit-focused narratives about low-income communities. We interviewed stakeholders to gain insight on the issue of precarious work at community level and this focused analysis adds richness to each stage of our research and maximizes the resources that were required to plan and conduct the interviews. Leveraging key informant interviews for purposes beyond concept mapping can facilitate greater impact of our CBPR efforts, and ultimately improve the process of developing a sustainable, culturally appropriate intervention.

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