A Strategy to Address Systemic Racism and Violence as Public Health Priorities: Training and Supporting Community Health Workers to Advance Equity and Violence Prevention

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Abstract

An ongoing barrier to achieving health equity is the persistence of structural racism and violence, which are root causes of adverse social determinants of health, especially among historically oppressed and other peoples experiencing inequities. APHA has recognized racism and violence as public health priorities in its policies. Amid the widespread failure of our society to adequately respond to systemic racism and prevent interpersonal violence, training and supporting community health workers (CHWs) to play a full range of roles offers a vital opportunity to address racism and violence at their core. To leverage this opportunity, deliberate efforts to mitigate the harms of institutional racism and classism that affect the CHW workforce will be essential. CHWs have been highlighted in the Patient Protection and Affordable Care Act of 2010 and recognized by the U.S. Department of Homeland Security as essential critical infrastructure workers in all states, territories, and tribal nations during the COVID-19 pandemic. Despite this recognition, significant challenges prevent optimization of the expertise CHWs possess and the critical support they provide to public health and health care infrastructure. This workforce requires support in order to realize its full potential to address racism and violence as critical public health priorities. This policy calls for providing training, support, and programming for CHWs so that they can build health equity by responding to racial inequities and preventing violence within historically oppressed populations.

Relationship to Existing APHA Policy Statements

The following APHA policy statements relate directly to racism, violence, and CHWs.

- APHA Policy Statement 20189: Achieving Health Equity in the United States
- APHA Policy Statement 20185: Violence is a Public Health Issue: Public Health is Essential to Understanding and Treating Violence in the U.S.
- APHA Policy Statement 201414: Support for Community Health Worker Leadership in Determining Workforce Standards for Training and Credentialing

- APHA Policy Statement 20091: Support for Community Health Workers to Increase Health Access and to Reduce Health Inequities
- APHA Policy Statement 200115: Recognition and Support for Community Health Workers' Contribution to Meeting our Nation's Health Care Needs

Problem Statement

The social determinants of health (SDoH) are understood to be conditioned by larger structural forces that include societal and cultural norms such as systemic racism and structural violence.[1–4] Furthermore, these structural forms of oppression can be identified as key drivers of inequities that lead to interpersonal violence. Interpersonal violence has been identified as one of the primary social determinants compromising the health of historically oppressed communities in America.[1,5–8] This section identifies two central problems and discusses how these problems create additional barriers for historically disparaged communities. The subsequent section explains how these problems can be substantially ameliorated through training, support, and program development for community health workers (CHWs) to address racial inequities and prevent interpersonal violence.

Problem 1—Systemic racism and violence are public health emergencies, and we lack interventions that address the underlying causes of these problems: Systemic racism is one form of structural violence. Structural violence is defined as a form of oppression in which a given social structure harms people by preventing them from meeting their basic needs and being valued.[1–3,5,6] In America, the "legacy of racial oppression has resulted in pervasive social inequalities and health inequities across the life course," creating public health crises.[2–5,9,10] This is the case when racism is a motivator for systemic oppression. Structural violence leads to disproportionate exposure to adverse structural and social determinants of health (SSDoH). SSDoH are defined as both the social factors promoting and undermining the health of individuals and populations and the social processes underlying the unequal distribution of these factors among groups.[2–4] Structural determinants exacerbate insecurities within existing unfavorable social conditions among historically oppressed populations such as increased exposure to interpersonal violence. Interpersonal violence and other adverse social determinants, including poor housing, poverty, and overincarceration, are the principal drivers of chronic disease, inadequate mental health, poor quality of life, and high morbidity rates.[1–4] In an article exploring strategies related to trauma as a root cause of violence, Dicker et al.[7] make the connection between structural and social inequities and the causes of interpersonal violence. According to the authors, "Low neighborhood life expectancy and endemic inequity lead to a sense of hopelessness." They argue that

factors related to mental health, “including sociodemographic and economic characteristics[, exhibit] similarities in the underpinnings of suicide and interpersonal violence.”[7] This article is consistent with the adverse community experience framework, which connects trauma (i.e., historical and persistent) to overexposure to interpersonal violence.[11] This phenomenon can be linked to structural determinants of poor economic conditions, a lack of educational investment, overpolicing, and other risk factors that contribute to already-existing social insecurity and crisis among historically oppressed people.[2,3,5–8,10,11]

Interpersonal violence is both an endemic problem and a health inequity.[1,2,5–7,12,13] It is reported that between 2010 and 2018, more than 300,000 people in the United States died from firearm-related injuries.[7] In 2019, interpersonal violence was responsible for 19,141 deaths and more than 1.4 million injuries.[7] African American men are 14 times more likely than European American men to die as a result of gun-related homicides.[7] In the 20- to 29-year-old age group, firearm homicide rates among African American men are five times higher than among Latino men and 20 times higher than among European men living in the United States.[7]

The United States has a history of creating and implementing racially discriminatory public policies affecting historically oppressed and other peoples experiencing inequities (HOPEIs). This policy defines HOPIEs as historically oppressed people who were brought from Africa and enslaved in America and members of indigenous First Nations groups (including descendants of those groups who trace their genealogy back to indigenous Mexicans, Aztecs, Mayans, Incas, etc.) whose land was colonized by Europeans.[14] In addition, HOPEIs include other populations experiencing inequities (e.g., women; Muslims; immigrants; lesbian, gay, bisexual, transgender, queer, 2-spirit, and intersex [LGBTQ2I] individuals; people with disabilities). The term HOPEI is designed to shift efforts to define diverse ethnicities within racial groupings that often do not reflect how these communities consistently define themselves.[14–17]

Inequitable distribution of resources and social status has been justified as resulting from unintentional policies and ideologies. This suggests that HOPEIs and European Americans have naturally separated themselves rather than correctly identifying the cause as policies that have intentionally created inequities.[10]

Public health legislation has not prioritized advancing equitable policies that fund interventions to mitigate adverse SSDoH experienced among HOPEIs.[2,3,5,6,18,19] The lack of these policies will continue to contribute to structural violence (also leading to interpersonal violence at the community and individual levels) if we disregard the history of public policy and how it continues to manifest [17]. Considering this, it is important to acknowledge that "what was done by public policy can be undone by public policy."[11,20,21]

Failure to address systemic racism and violence at the policy level can result in the following problems at the institutional and organizational levels:

- Lack of equitable partnerships between health care institutions and community-based organizations (CBOs), leading to mistrust and poor health care delivery for HOPEIs.[18,19,22]
- Overemphasis on addressing the health issues of HOPEIs through medical care rather than preventive care and health promotion that address SSDoH as rooted in structural racism and disproportionate exposures to multiple forms of violence.[1,2,5,6,23–25]
- Inequitable access to health care and upstream SSDoH interventions.[2,3,18,19]
- Racial inequities in research and upstream evidence-based practices. Inequitable research results in a lack of funding opportunities, authorship, and intellectual property rights and tokenizes CHWs and CBOs. These inequitable research practices then perpetuate racial biases and inequities.[2,24,26,27]

Problem 2—CHWs have demonstrated the ability to address the underlying causes of systemic racism and interpersonal violence but lack resources and support as a result of their own marginalization in the health care system: CHWs are uniquely suited to support existing efforts to mitigate the harms of systemic racism and prevent interpersonal violence.[5,6,9,28,29] According to APHA, a CHW is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison, link, or intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.[23] CHWs build capacity across all levels of the social ecological model (SEM; i.e., individual, community, organizational, system/policy level),[1,12,23,24,30] as exhibited in the range of roles identified in the nationally recognized C3 Project: (1) providing cultural mediation among individuals, communities, and health and social service systems; (2) offering culturally

appropriate health education and information; (3) offering care coordination, case management, and system navigation; (4) providing coaching and social support; (5) advocating for individuals and communities; (6) building individual and community capacity; (7) providing direct service; (8) implementing individual and community assessments; (9) conducting outreach; and (10) participating in evaluation and research.[1,23,26,31–34]

There is more than 60 years of research documenting the effectiveness of CHW interventions for HOPIEs.[4,7,12,18–20,27,30,32,35,36] Not only are CHWs predominantly members of HOPIEs, but literature reflects that the profession emerged in direct response to the needs of historically oppressed people experiencing health inequities.[12,17,18,31–33,35–38] Dating back to the 15th century during slavery and European colonization of the Americas, the roles that CHWs now play emerged as a natural response to failures of systems to provide equitable distribution of resources needed for health.[17] HOPIEs' ability to naturally respond to inequities began to be understood in the United States in the 1960s, when academic and health professionals began to observe initiatives such as the Black Panther Party's free clinic and breakfast programs in addition to other social movements during this era.[35] Over the course of the next three decades, community health representatives and promotores/as (in addition to others) laid the foundation for the CHW workforce.[34,39,40]

Although CHWs have exhibited capacity to improve health equity, institutional racism and classism experienced by the workforce has resulted in a widespread lack of power, voice, agency, and funding. CHWs are themselves affected by racism and other forms of oppression because they are primarily from historically oppressed communities, which are also usually low-resource communities with minimal opportunities for education and living wage employment.[18,41] These barriers to economic stability are frequently not ameliorated when community members gain jobs as CHWs, because these positions are notoriously unstable and insufficiently paid.[41] CHWs also represent the intersectionality of marginalized social identities (e.g., women, LGBTQ2I individuals, immigrants) and social statuses affected by classism4,19] (e.g., low income, lack of formal education, former incarceration, substance use, immigrant status). Their intersectional social identities and statuses (particularly their lack of formal education) result in unjust treatment within the hierarchical systems of health and social services. Marginalization within the health system decreases CHWs' ability to produce optimal outcomes and ultimately results in poor quality of life and early mortality among HOPEIs, as shown during COVID-19.[18,37]

Further causes and outcomes of marginalization of CHWs within the health system include the following:

- Lack of recognition of the essential role CHWs play in addressing racial inequities and preventing violence.[1,16,22]
- Overly medicalized CHW training rather than training based on grassroots models that emphasize community knowledge such as popular education.[34]
- Evaluations of CHW interventions focusing on return on investment (ROI) and clinical measures rather than on process and outcome measures that protect the integrity of the profession, such as those developed collaboratively with CHW leaders by the CHW Common Indicators Project.[18,34,41]
- Unsustainable and inequitable pay with an overdependency on cyclical grant funding or fee for service.[34,41]

Community-level issues: Adverse SSDoH are most threatening among HOPEIs living in residential areas where there are high levels of poverty, socioeconomic and political disenfranchisement, and marginalization.22,36] Because of the belief that CHWs and CBOs lack the knowledge and skills to lead racial equity and violence prevention interventions for HOPEIs, minimal resources and funding have been dedicated to CHW programs in CBOs. However, evidence demonstrates that CHW programs within CBOs are best placed to understand and address racism and the disproportionate effects of multiple forms of violence.[1,5,6,12,13,38,39] CHWs within organizations emerging from the community who serve HOPEIs are often situated as liaisons between systems and communities.[23,39,40] Vital services designed to be delivered to those most in need are circumvented away from CHW programs within CBOs and placed in the trust of CHW programs within institutions and non-CBOs that lack proximity to the challenges faced by HOPEIs.[39] This produces competition for scarce resources and therefore maintains a perverse power structure wherein support for CBO interventions is needed but support instead is provided to larger institutions that already have funding for CHWs. This imbalanced dynamic breaks down the social cohesion of HOPEIs, rendering them vulnerable to racial inequities and disproportionate effects of multiple forms of violence.[1,5,6,12,13,26,38] The lack of social cohesion of CHWs placed within CBOs reduces community resiliency and the capacity to thrive in the face of racial inequities and structural violence.[1,2] Scarcity of resources within ethnic and demographic boundaries creates unhealthy competition that leads to distrust and a lack of organizational reciprocity and collaboration between CHW programs within health care systems/institutions and programs within CBOs.[22,39] This

lack of collaboration with community-based CHWs fosters adverse power dynamics through which HOPEIs continue to be marginalized.

Research shows that systematic racism inhibits the process of achieving solutions on behalf of HOPEIs in the areas below.

- Adverse SSDoH: Adverse SSDoH in HOPEIs include mass incarceration, residential segregation, food apartheid, underdevelopment of the built environment (e.g., parks, recreation, transportation), poor quality of education, scarcity of health providers, and disproportionate effects of multiple forms of violence, including police violence.[1–3,5,6,24,25]
- Intentional marginalization of CBOs: As noted, services designed for those most in need are often circumvented away from CBOs,[42,43] producing competition for scarce resources, inducing CBOs to limit their full capacity, and thereby maintaining a perverse power structure.
- Compromised social cohesion: As mentioned, lack of social cohesion reduces community resiliency and capacity to thrive.[1–3,5,6,24,25] Scarcity of resources creates unhealthy competition that leads to a lack of organizational reciprocity and collaboration.[11,22,42]

Individual-level issues: Intrapersonal and interpersonal factors are deeply rooted in individualistic attitudes and behaviors. These factors directly govern the formal and informal social networks and support systems where CHWs work and serve. Internalized and interpersonal racism and violence are expressed in a variety of attitudes and behaviors.[2–5] Interpersonal racism includes stereotyped and direct threats, overt discrimination, harassment, microaggressions, implicit bias, exclusion, social distancing, and stigmatization. These behaviors negatively affect the ability of CHWs to serve as liaisons among health care systems, social services, and the community to promote health and deliver quality and culturally competent care in HOPEI households.

When CHWs are inhibited by interpersonal racism, their ability to mitigate the harm of adverse SSDoH and prevent interpersonal violence is hindered.[1–6,12,13,24] Interpersonal violence, including gang violence, sexual violence, domestic violence, and self-abuse, exacerbates existing adverse social conditions that are caused by inequitable distribution of resources and other forms of systemic racism.

Significant challenges exist across all levels of the SEM to realize the full potential of CHWs in terms of the expertise and critical support they provide to the public health and health care infrastructure. This

workforce requires even more support to effectively address racism and violence as critical public health priorities.

Evidence-Based Strategies to Address the Problem

CHWs have been recognized by the U.S. Department of Homeland Security as essential critical infrastructure workers in all states, territories, and tribal nations during the COVID-19 pandemic.[37] During COVID-19, "$250 million has been allocated to aid CBOs and public health departments in hiring CHWs for COVID-19 vaccination efforts, as well as $3 billion for health departments to hire and retain CHWs [by the American Rescue Plan]. This financial commitment reflects mainstream acknowledgment that incorporating CHWs into the fabric of [the] social, medical, and public health care system is essential for strengthening national public health infrastructure."[37] Below evidence-based programs are described that exhibit various ways in which CHWs have demonstrated the capacity to address systemic racism and prevent interpersonal violence.[1,5,6,9,12,13,26,28,29,38,42–53].

CHW programs addressing systemic racism: During the years 2007–2012, the Centers for Disease Control and Prevention (CDC) funded 40 Racial and Ethnic Approaches to Community Health (REACH) programs around the country; the examples below demonstrate evidence of CHW contributions in supporting racial equity interventions in REACH programs.[33]

- Policy level: REACH CHWs developed, advocated for, and implemented diabetes-specific chronic disease guidelines in South Carolina for members of racial and ethnic groups with health care system providers. As a result of this initiative, diabetes-related hospitalizations and emergency department visits decreased by 50%.[33] Other CHW interventions were associated with improved access to medications and immunizations.
- Organizational and community level: CHWs helped to integrate social determinants into health services, developing and disseminating resources to families and providers focused on access to and navigation of housing resources. This program resulted in an ROI of $1.46 for each $1.00 invested.[33]
- Individual level: REACH CHWs provided interventions at an after-school program called Kids with a Positive Attitude where students used photovoice to demonstrate their perspectives of the needs and barriers in their communities. Another REACH program in Arizona included an after-school program addressing health disparities and cervical cancer prevention interventions for youth leaders.[33]

Additional evidence-based programs and strategies in which CHWs have addressed racial equity are described below:

- The Children's Partnership in California "promote[s] equity and anti-racist values."[54] CHWs enrolled 75% of historically oppressed families in Medi-Cal during the course of the program.
- The Northern Manhattan Community Voices Collaborative hired CHWs as a "central strategy to reduce health disparities."[45] CHWs were able to help 40,654 people improve their health and assisted 29,732 adults and children in obtaining health insurance. CHWs also closed the gap in immunization enrollment by 80% relative compared to the national immunization rate.[45]
- Rhode Island General Law 23-64 focuses on health workforce diversity and development through a health in all policies approach.[46,47] The Rhode Island Commission made recommendations for the coordination of state, local, and private sector efforts to develop a more racially and ethnically diverse health care system workforce, highlighting CHWs. The law makes recommendations for the recruitment, assignment, training, and employment of CHWs by "community-based health and wellness organizations, community-based health agencies, and other appropriate organizations."[46,47]

CHW programs addressing violence: Striving To Reduce Youth Violence Everywhere (STRYVE) was a CDC-funded national initiative that supported four demonstration sites in Boston, Massachusetts; Salinas Valley, California; Houston, Texas; and Portland, Oregon. In Portland, from 2011–2016, the Multnomah County Health Department (MCHD) integrated CHWs as co-designers and co-leaders of the development and implementation of the department's comprehensive strategy, which included five nationally recognized evidence-based programs. The initiative's primary objective was to prevent youth violence and promote public health professionals as essential partners in existing efforts to prevent multiple forms of violence.[1,24] The MCHD STRYVE is one of 20 CHW violence prevention programs identified in a comprehensive CDC-led literature review titled "Community Health Worker Activities in Public Health Programs to Prevent Violence: Coding Roles and Scope."[1] This project analyzed "recent examples of CHW activities in violence prevention public health programs with a goal of informing future programs and research."[1] The literature review "collected more than 300 documents published between 2010 and 2020 to identify public health programs to prevent violence including CHW activities."[1] Below examples from the MCHD STRYVE are used to describe various ways CHWs can address violence across the SEM when they are appropriately trained and supported.

- Policy level: CHW "contributions included CHW involvement in countywide strategic planning for comprehensive gang assessment, and policy review and modification, the Local Public Safety

Coordinating Council Youth and Gang Violence Sub-Committee, and the City of Portland's Office of Equity and Human Rights Black Male Achievement Steering Committee."[1,24] CHWs' involvement in these high-level planning and organizing sessions contributed important community insights and introduced upstream public health thinking to county and city initiatives designed to prevent violence.

- Organizational level: CHWs led the adaptation and implementation of a 90-hour CHW certification curriculum approved by the Oregon Health Authority. This adaptation integrated violence prevention within the existing curriculum. Training participants included 27 community professionals selected from across Multnomah County.[24] The training was designed to build capacity within existing organizations and lead to enhanced violence prevention efforts. Results showed that "92% of participants increased their health knowledge from baseline to follow-up" and revealed "substantial increases in confidence in ability to promote health and share health information."[24] The training also introduced violence prevention professionals to public health thinking and methodology. These CHWs were integrated into an existing network of community health professionals whose scope of work included SSDoH. The bringing together of various professionals and organizations increased opportunities for collaboration, coordination, and building of community cohesion and collective efficacy.
- Community and individual level: Youth Empowerment Solutions (YES) was one of the five evidence-based programs used in the MCHD STRYVE. CHWs led the recruitment and training of facilitators and youth participants. CHWs and the STRYVE team also created a report on adaptations of the YES curriculum in partnership with the CDC. These adaptations made the YES curriculum specific to diverse populations in Multnomah County, ensuring that the curriculum content engaged participants in a meaningful way. YES pre-post surveys and other instruments showed that "awareness on most variables increased to 100%."[24] Via advocacy with local public officials, youth in the YES program were able to shut down a strip club operating in their neighborhood that attracted strangers, drugs, violence, and other forms of social risk.[24] After a school shooting at one of the YES sites, CHWs led the development and facilitation of a yearlong training program focused on building resiliency through relationships in educational settings[24]; the program was designed to support staff, students, and administrators in healing and restoring cohesion after the traumatic events.

An adaptation of the MCHD STRYVE model, Community-Based Public Health Response to Violence, is currently being piloted in Wilmington, North Carolina.[1,13,45]

Additional CHW programs that have addressed violence include the following:

- In Acción para la Salud, five health agencies and academic-community partners provided training and technical assistance to CHWs in order to leverage change in the social environment and improve health systems. During this program, "CHWs documented community advocacy activities through encounter forms in which they identified problems, formulated solutions, and described systems and policy change efforts."[49] In addition, "CHWs used local associations to strengthen practices of participation," and 70% of engagement with their clients included "conversations about the wellbeing of their community and what might improve it."[49] Acción para la Salud engaged CHWs, who in turn sought to empower the communities they served to improve social conditions (i.e., social determinants). CHWs encouraged their communities to think holistically and to identify problems and develop solutions. "In three organizations, Acción CHWs initiated activities in the political stream, in several cases directly involving community members."[49]
- The Southcentral Foundation's Family Wellness Warriors Initiative (FWWI), a program created by Alaska Native people, "addresses traumatic experiences as the root cause of family violence…and builds on cultural strengths."[40] An FWWI-associated study sought to build a conceptual model for the program and had more than 11,000 participants. During focus groups, respondents stated that activities in the training consisted of "receiving affirming responses, connecting to others with similar experiences, and actively practicing interpersonal skills, goal setting, and observing and accepting emotions."[40] In addition, respondents noted that participating in a strengths-based Alaska Native–led process was healing and increased self-esteem.[40] This initiative shows how, based on their unique relationships, CHWs are able to support communities they serve to heal trauma, empower each other, and build cohesion, which is key to preventing violence.
- Cure Violence Global trains and activates credible messengers who exhibit the roles of CHWs primarily because they are community professionals who have experienced violence and have close relations to the communities they serve. A South Baltimore Cure Violence program was associated with a 56% reduction in homicides, a 34% reduction in nonfatal shootings, and a 48% reduction in homicides in nearby communities.[13]
- The Health Alliance for Violence Intervention integrates CHW roles into hospital-based programs, resulting in an estimated ROI of $69 million in national savings to the Medicaid program.[12]

This policy emphasizes the importance of organized CHWs being in control of policy creation regarding their profession, which can lead to experientially informed strategies to prevent violence and disrupt the persistence of racial inequities.[20,33–35] In addition, CHWs, CBOs, and dedicated allies within health care systems can train, support, certify, and reimburse CHWs in such a way that skilled and experienced professionals are not barred from contributing to building health equity in our society.[20,32] We have highlighted the above evidence-based strategies as a way forward.

Opposing Arguments/Evidence

The authors of this policy proposal believe that we need all effective strategies to reduce racism and violence and increase equity. No one profession or intervention alone can succeed in the massive task of redressing and undoing centuries of systemic racism and other structural inequities in order to eliminate health inequities. However, the structure of this policy proposal requires that we explicate and counter potential opposing arguments. We undertake this task below.

First argument in opposition—Other public health, health care, and social service professionals are better suited than CHWs to address health inequities: It is sometimes argued that professionals such as physicians, nurses, and social workers, who are currently more recognized within institutions, are well suited to address health and racial inequities. Unquestionably, these professionals provide a significant contribution to addressing entrenched inequities and improving health equity. However, we also need the unique skills, perspectives, and level of community trust that CHWs bring on the basis of their lived experience within communities most affected by inequities (i.e., HOPEI communities). Other health care, social services, and public health professionals are not as frequently in close proximity to social, economic, and political conditions. Furthermore, these professionals have exhibited practices influenced by institutional policies that perpetuate inequities and oppression.[1,13,9,28,29,33,55]

Physicians, who can often wield power based on their position within the medical hierarchy, are well placed to work at both the individual level, where they interact with their patients, and the structural level, where they can influence policies and systems. Groups such as Physicians for Social Responsibility[56] and Physicians for a National Health Program[57] have effectively harnessed physicians' power to bring about meaningful change. However, at least two factors limit physicians' ability to, alone and without others, create health equity. One is their proximity to power. Physicians' power is based, to some degree, on the exact structures that maintain inequities. A desire to maintain their place within the hierarchy can

discourage them from working to promote change. Another factor limiting physicians' ability is the growing power of health care administrators, who curtail physicians' interactions with patients in order to protect and increase the economic bottom line. CHWs, who are less tied to systems and who do not benefit from the current structure of the medical hierarchy, are often more able to oppose it. They also generally have more time than physicians to work with individuals and communities to identify and address underlying causes.

Community health nurses (also referred to as public health nurses) work in the community to promote and maintain the health of all residents. They may provide direct medical care or work with other professionals to ensure that residents have access to needed services. The goal of community health nursing is to promote and protect the health of vulnerable populations. Community health nurses develop and implement prevention and wellness educational programs and advocate for equitable access to health care.[58] An important characteristic that sets CHWs apart from community health nurses is that they are known and trusted members of the community they serve. While this is also true for some community health nurses, it is not an essential characteristic of the profession as it is for CHWs. By uniting the unique skills and characteristics of each profession, CHWs and community health nurses are able to work together to promote equity in communities.

Social workers who focus on community practice also may be well equipped to address inequities based on their work in "social, economic, and environmental justice, and [their eagerness] to collaborate and create solutions on a community level."[59] Social work literature and policy emphasize community engagement and working in partnership. However, it is common knowledge that communities are at risk of being harmed by practices within the profession and the institutions that govern it. These dynamics foster distrust and inhibit social workers from implementing the goals and principles referenced in the literature.[59,60] CHWs, conversely, have historically maintained trusted relationships with their communities based on their lived experience and have historically exhibited capacity to navigate with an efficient level of cultural awareness. These qualities give CHWs an added advantage relative to social workers in addressing the root causes of inequities and multiple forms of violence.

As another frontline workforce, community organizers can also effectively address health inequities; however, this is a role within the CHW profession, and CHWs often work as organizers. As community organizers and capacity builders, CHWs can promote community action and garner support and resources

from community organizations to implement new activities.[61] CHWs can also use techniques to motivate individuals and communities to seek specific policy and social changes. In effect, CHWs encompass a range of roles that can comprehensively address health inequities and multiple forms of violence affecting HOPEIs.

Although the aforementioned public health, health care, and social service workers cannot, alone, address health inequities, CHWs should collaborate with them to more holistically and comprehensively address inequities and multiple forms of violence. CHWs have a unique positionality that sets them apart from other professionals because they have been able to navigate the harms of oppressive systems from their inception. The public narrative needs to be shifted as to who needs to be part of the solution for social change and transformation. CHWs have historically struggled with these issues, are in closest proximity to their communities, and were birthed from their communities. Therefore, CHWs are naturally equipped to address health inequities and multiple forms of violence.

Second argument in opposition—CHWs are, at best, stopgaps to structural barriers to achieving health equity. The only viable way to truly address racism and other structural inequities is through policy and system change. There can be no doubt that conditions that were brought about through structural, systemic oppression need structural, systemic solutions to be reversed. However, two important facts can be noted as counterpoints: first, CHWs have historically been deeply involved in working at the community and policy levels to bring about system change, and, second, only recently have CHWs been mischaracterized as working primarily at the individual level.

This policy statement proposes that CHWs have historically played and should play a wide variety of roles across the SEM. According to a view that has become increasingly widespread since the passage of the Affordable Care Act and increasing integration of CHWs into health care systems, CHWs work primarily at the individual level, rather than the community level, to address the SSDoH by connecting people to predominantly medical and social services. While this is an important role for CHWs, it is far from being the only role. Nonetheless, because it is perhaps the easiest role to monetize, it has become pervasive in many systems and locations. This characterization is extremely deleterious to the potential of the CHW profession and runs counter to the historic role of CHWs, who as shown here have historically been engaged in creating health equity by addressing underlying causes of inequities. As trusted community members, CHWs are uniquely placed to bring communities together to identify pressing

health issues, identify the underlying causes of those issues, and organize communities to bring about change through a variety of mechanisms. Thus, it can be seen that, far from being stopgaps, CHWs are in fact crucial players in creating systemic solutions to address health inequities.

Action Steps

APHA encourages external constituencies to take the comprehensive actions described below to train, support, and measure the impact of CHWs as a means of addressing systemic racism and preventing interpersonal violence among HOPIE communities most affected by inequities.

1) APHA calls on Congress to pass and the president to sign legislation that allocates funding to federal agencies including the Health Resources and Services Administration, Office of Rural Health, Office of Minority Health, Area Health Education Center, and CDC to do the following:
    - Make funding available to community-based organizations (especially those led by HOPEI communities) and selected public agencies (e.g., local health departments) with experience in training CHWs through effective strategies such as popular education to provide training that builds CHWs' skills to address systemic racism and violence as public health priorities.
    - Make funding available to community-based organizations (especially those led HOPEI communities) and selected public agencies (e.g., local health departments) with experience in recruiting, hiring, and retaining CHWs to create programs that support CHWs in playing a wide range of roles, including roles focused on addressing violence and promoting health equity across all levels of the SEM.
    - Make funding available to researchers and evaluators with experience working as or with CHWs and using community-based and community-engaged strategies (especially those led by HOPEI communities) to develop and conduct studies that incorporate consistent measures to assess the impact of CHWs (in concert with other strategies) on reductions in interpersonal violence and health inequities.
    - Provide funding that allows sufficient time for program and evaluation planning and that is sustainable over the long term. Historically, CHW programs have depended almost exclusively on short-term grants, and average federal grant duration has actually decreased during the COVID-19 pandemic.
    - Collect consistent data about both the process and outcomes of CHW programs, such as those developed by the CHW Common Indicators Project with funding from the CDC. Programs should also collect comprehensive and disaggregated sociodemographic data about both CHWs

and the communities they serve using standards such as those developed in the 2015 National Content Test Report produced by the U.S. Census Bureau. Such data increase knowledge about the exact nature and extent of health inequities and the effectiveness of CHW efforts (in concert with other efforts) to address inequities.

2) APHA calls on state legislatures to pass legislation providing funding to state health departments to take actions consistent with the above priorities.
3) APHA calls on national and local CHW associations and CHW employers to endorse training of CHWs in interpersonal violence and systemic racism as stated in this policy proposal. External endorsements to date include CommUnity Healing through, Activism + Strategic Mobilization, North Carolina Area Health Education Center, North Carolina Community Health Worker Association, The University of Wisconsin Population Health Institute, Partners in Health, and CHW Common Indicators Project.
4) APHA calls on foundations and other funders to take actions consistent with the above priorities and provide funding for organizations (especially those led HOPEI communities) with experience in training, hiring, and retaining and conducting research and evaluations involving CHWs. This funding should strengthen the ability of the CHW workforce to address structural racism and violence as root causes of health inequity.
5) APHA calls on colleges and universities that train other public health professionals (e.g., physicians, nurses, public health educators, social workers, psychologists) to include in their curricula information about the historic role and potential of CHWs to contribute to eliminating health inequities by addressing structural racism and violence. These schools should build the capacity of their graduates to understand and address racism and violence as public health priorities, working in partnership with CHWs.

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