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Evaluating the impact of a community health worker training program

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Abstract

Background The Atlanta Region Community Health Workforce Advancement (ARCHWAy) program is designed to train and empower Community Health Workers (CHWs) by centering marginalized voices and integrating theoretical knowledge with hands-on experience. Through a combination of online and in person didactic training, and experiential learning, the program prepares CHWs to address social determinants of health (SDOH) and advocate for health equity.

Methods This program evaluation examined the program's impact on participants' knowledge skills, and competencies. Feedback from course evaluations and encounter logs highlighted the program's effectiveness in equipping CHWs with practical tools to support individuals facing mental health crises, chronic disease management challenges, and barriers to healthcare access.

Results Participants rated the in-person and online didactic curriculum 4.5 or higher on a scale of 1–5. Experiential learning had a positive impact on their abilities to provide services such as individual and community assessment and education, and care coordination and to address the SDOH. Participants reported that they learned how to navigate systems, build trust, and empower individuals to advocate for their own health and well-being.

Discussion Findings suggested that ARCHWAy successfully fostered critical skills and strengthened the CHW workforce, reinforcing the importance of experiential learning and community-centered training. Participants expressed a strong sense of preparedness and commitment to their roles, emphasizing the need for sustained investment in CHW development, including long-term support and recognition. While challenges remain in securing sustainable funding and measuring long-term community health outcomes, the evaluation demonstrated the impact of one CHW training program.

Keywords Community health workers, Program evaluation, Health equity

Community health workers (CHWs) serve economically and socially marginalized communities whose primary languages range globally [9]. Marginalized populations include groups that are often excluded from opportunities due to race, gender identity, sexual orientation, age, physical ability, or language. This intersection between marginalization and health outcomes becomes further evident in the discussion of social determinants of health (SDOH), which emphasizes the importance of considering "upstream" factors typically unrelated to healthcare delivery that affect health outcomes (*Healthy* [4], 2025),

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including, but not limited to conditions in which people are born, live, learn, work, play, worship, and age.

Background

CHWs typically live in and share the language and culture of the communities they serve [8], placing them in an ideal position to make positive and meaningful contributions to the communities in which they live and work. For example, CHWs living and working in Latinx and Vietnamese communities bridge linguistics and translation barriers to support access to care and cultural relevance [5, 6]. However, many CHWs are volunteers receiving little or no compensation for their work in and for their communities [2]. Despite that, CHWs are a much-needed resource for medically underserved communities and historically underrepresented groups. While the demand for CHWs increases, full-time CHWs fall far beneath the requisite number to address existing health disparities and create a lasting impact in marginalized communities [1]. CHWs are often unpaid, and there are growing efforts to support and strengthen this vital frontline workforce by providing certificate training programs and formal paid positions [2].

Training programs for CHWs vary widely depending on who developed and provided the training, the curriculum content and competencies, the training program delivery mode, the length of the training, and the participants. There are formal CHW programs led by subject matter experts or peer-to- peer conducted programs, provided by governments, public–private collaborations, and non-profit organizations [11]. Some curricula provide a generalist approach, while others offer a specialist approach, for example, HIV-focused, disease-specific focused (e.g. diabetes, cardiovascular, surveillance only), some guided by recognized CHW competencies and some not [10]. Programs are delivered in person, online, or some combination and range from less than one week in length to one to six months duration most frequently with traditional classroom instruction [11]. Participants have little or no formal education to participants with master's and doctoral degrees [7, 12]

One program, the Atlanta Region Community Health Workforce Advancement (ARCHWAy) fills the gaps by being competency based and developed and provided by community subject matter experts, lay community members, researchers, and CHWs. The 12-week training program, offered in English and Spanish, provides a competency-based curriculum for public health delivered with online and in-person sessions, hands-on skills demonstration and return demonstration, simulation-based learning with standardized patients, and experiential learning through field placements with both generalist and specialist opportunities [12]. The program reduces barriers to enrollment and retention by providing stipends and wrap-around services. The purpose of this paper is to describe the program evaluation of ARCHWAy,

Methods

Demographic data were collected on the ARCHWAy participants, and ID numbers were assigned to each participant to de-identify data stored in REDCap and Qualtrics. Participants were recruited to the program through in-person information sessions offered at community events, local libraries, and community-based organizations. Individuals interested in the CHW program apply online at the ARCHWAy website georgiachw.org and must be 18 years or older and high school graduates or completed general educational development (GED) equivalent. The 12-week program consisted of weekly online asynchronous modules and four in-person sessions (8AM to 5PM/36 h) for a total of 155 didactic hours. The in-person sessions were comprised of didactic education, simulation-based learning, and hands-on skills. Participants also completed 80 h of experiential learning through field placements. A detailed description of the ARCHWAy program may be found in a previously published paper [12]. The program's structure and evaluation are illustrated in Fig. 1.

Each week, participants were required to complete online modules with a follow-up evaluation that asked about their experience with the online module. Evaluations were required as participants could not progress to next week's course materials without completing the survey. Three Likert-scale questions focused on the navigability of the online material and the instructional design with a rating of 5 = very effective, easy, visually appealing; 4 = quite effective, easy, visually appealing; 3 = mediocre; 2 = somewhat; and 1 = not at all. The survey questions were:

- How effective was the course at helping you reach the learning objectives?
- How easy was the course to use?
- How visually appealing did you find the course?

A fourth question asked participants to rank how many stars they would give the course where one star is the least and five stars is the greatest score.

Participants were required to attend four in-person days with a follow-up evaluation that asked about their experience with the in-person sessions. Three Likert-scale questions were asked with a rating of 5 = excellent; 4 = good; 3 = neutral; 2 = fair; and 1 = poor. The survey items were:

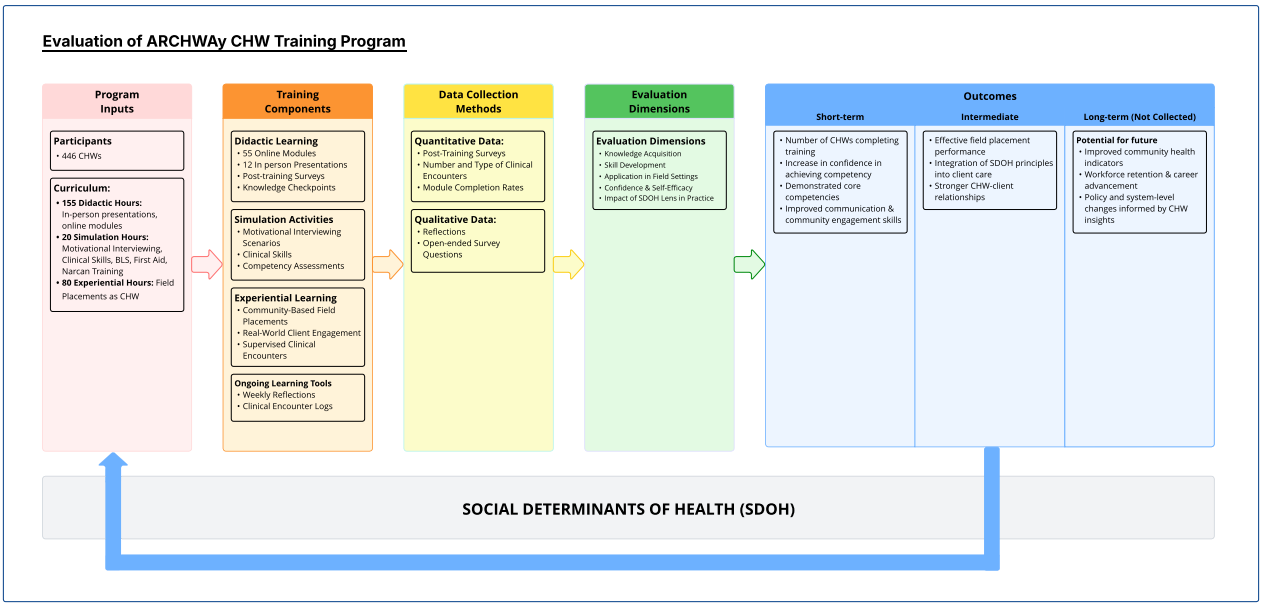

Fig. 1 Program structure and evaluation

- Presenter's knowledge of the subject
- Presenter's organization and clarity of content
- Presenter's effectiveness of teaching methods

A fourth question asked participants to evaluate the entire day with the question: On a scale of 1–5, how many stars would they give the course where one star is the least and five stars is the greatest score.

All participants were required to complete community health work encounter logs as part of their 80 h of experiential learning. The log recorded the participants' individual and community encounters during their field placements, and they completed one log for each individual visit or community activity. The log identified the setting of the encounter, the encounter date, whether the encounter was in-person or virtual, length of the encounter, gender, race/ethnicity, age of the individual, and key services provided. Services were categorized as advocacy, education, emergency response and recovery, health services, navigation, outreach and enrollment, and social-emotional support. Eighteen activities were itemized along with a list of 23 SDOH and the CHW selected the option that most accurately represented their participation in the encounter with the following categories: (1) observation only (trainee watched a healthcare professional perform the activity only), (2) collaboratively (trainee completed the service in partnership with other healthcare professionals), or (3) independently (trainee completed the service autonomously, unaided/unassisted). The log was built in Qualtrics and accessible on handheld devices. Frequencies were calculated for each of the activities and SDOH that the CHWs observed, provided collaboratively, or delivered independently.

Each week participants were asked to reflect on the impact of the CHW role from a personal and professional perspective and how they are applying their didactic learning in their field placements. The reflections were submitted in writing electronically. A rapid thematic analysis approach was used with qualitative reflections. An initial codebook was created using deductive a priori codes derived from the reflection prompts to ensure the validity of the findings. One reflection was selected to pilot the codebook, and three coders independently coded that reflection. After coding the document, the coders discussed areas of convergence and divergence. Next, all reflections were assigned to two individual coders. Coders then coded all the remaining reflections they had been assigned. The team then reviewed codes during debriefing to identify themes.

Due to the program evaluation nature of this work, the Emory University Institutional Review Board deemed that these activities were not human subjects research (#00003023).

Results

CHW participant characteristics

Of the 349 participants, participants were female (82%), 16% held high school diplomas, 26% had some college, 10% held associate degrees, 30% held a bachelor's degree, 16% held master's degrees, and 2% held doctoral degrees. The mean age was 47.27 years (SD ± 16.26; range 19–88). Over 75% of participants identified as Black or African

American, 13% as White, 6% as Asian, 4% as multiracial, 1% as Native Hawaiian or Pacific Islander, and 1% as American Indian or Alaskan Native. Ten percent identified as Hispanic/Latino. Over 80% of participants were new to the CHW role, with 19% reporting that they were currently either working or volunteering as CHWs.

Online module results

Throughout the program, 349 participants (100% response) rated the 55 ARCHWAy online modules as 4.5 or better on a scale of 1 to 5 as helping participants reach their learning objectives, ease of use of online modules, and visual appeal as shown in Table 1. The in-person sessions received positive evaluations as listed in Table 2, underscoring the program's ability to deliver content effectively through various instructional modes. The selected trainings presented in Tables 1 and 2 are representative of the entire curriculum.

Experiential learning encounter logs

The CHW trainees were asked to complete encounter logs for their individual and group encounters as described above. This was a required activity for their experiential field placements. The top 10 services provided based on encounters, in order, were: (1) resource and referral education, (2) individual assessment, (3) education, (4) care coordination, (5) community assessment, (6) community education, (7) mental health first aid, (8) service coordination, (9) SDOH, and (10) chronic disease management. CHWs were most likely to report independently providing resource or referral education and collaboratively with other providers coordinating care. Activities that CHWs most often reported observation only included individual assessments and mental health first aid.

The top 10 SDOH discussed by CHWs based on encounters, in order, were: (1) access to care, (2) access to nutritious food, (3) health literacy, (4) access to primary care provider, (5) housing situation, (6) utilities, (7) language barriers, (8) level of education, (9) occupation, and (10) immigration status.

Reflections

Fifty percent of ARCHWAy participants submitted reflections. Four themes were identified: (1) personal impact and application of training, (2) bridging communities and accessing resources, (3) overcoming challenges and cultivating strengths, and (4) expanding role of CHWs on engaging communities.

Personal impact and application of training: Participants shared that "The CHW training is a reminder of the techniques that I am required to exercise. I am required to use open-ended questions to provoke discussion or clarity of the client's situation. Open-ended questions can

Table 1 Selected modules delivered online

Topic	Overall Rating ± SD (Range)	Met Learning Objectives Rating ± SD (Range)	Ease of Use Rating ± SD (Range)	Visual Appeal Rating ± SD (Range)
Community Capacity Building	4.731 ± 0.52 (3–5)	4.75 ± 0.58 (1–5)	4.70 ± 0.66 (1–5)	4.69 ± 0.68 (1–5)
Advocacy	4.76 ± 0.54 (1–5)	4.70 ± 0.70 (1–5)	4.71 ± 0.66 (1–5)	4.65 ± 0.73 (1–5)
Emergency Preparedness	4.77 ± 0.49 (2–5)	4.69 ± 0.69 (1–5)	4.69 ± 0.68 (1–5)	4.62 ± 0.81 (1–5)
Care Coordination	4.74 ± 0.55 (2–5)	4.69 ± 0.71 (1–5)	4.67 ± 0.72 (1–5)	4.61 ± 0.77 (1–5)
Stigma	4.75 ± 0.59 (1–5)	4.71 ± 0.67 (1–5)	4.73 ± 0.68 (1–5)	4.69 ± 0.70 (1–5)
Cultural Humility and Congruence	4.69 ± 0.60 (1–5)	4.67 ± 0.68 (1–5)	4.62 ± 0.75 (1–5)	4.59 ± 0.78 (1–5)
Introduction to Health Insurance Basics	4.72 ± 0.60 (1–5)	4.64 ± 0.76 (1–5)	4.58 ± 0.82 (1–5)	4.55 ± 0.86 (1–5)
Social and Literacy Support	4.74 ± 0.59 (1–5)	4.70 ± 0.69 (1–5)	4.60 ± 0.83 (1–5)	4.64 ± 0.79 (1–5)
Environmental Health and Justice	4.76 ± 0.55 (1–5)	4.74 ± 0.61 (1–5)	4.66 ± 0.7 (1–5)	4.69 ± 0.66 (1–5)
Models of Treatment for Addiction	4.64 ± 0.69 (1–5)	4.68 ± 0.73 (1–5)	4.56 ± 0.85 (1–5)	4.61 ± 0.78 (1–5)
Talk with Me Baby	4.8 ± 0.48 (3–5)	4.77 ± 0.59 (1–5)	4.75 ± 0.61 (1–5)	4.73 ± 0.63 (1–5)

All cells show weighted mean ± SD (SD-Standard Deviation) (n-weighted)

Table 2 Selected in-person delivered training

Course	Overall Rating ± SD (Range)	Knowledge of Subject Matter Rating ± SD (Range)	Organization and Clarity of Content Rating ± SD (Range)	Effectiveness of Teaching Methods Rating ± SD (Range)
In-Person Session 1	4.83 ± 0.45 (1–5)	–	–	–
Mental Health First Aid	–	4.81 ± 0.50 (1–5)	4.78 ± 0.55 (1–5)	4.80 ± 0.50 (1–5)
In-Person Session 2	4.78 ± 0.47 (3–5)	–	–	–
Community Resources	–	4.80 ± 0.50 (1–5)	4.77 ± 0.49 (1–5)	4.78 ± 0.50 (1–5)
Professional Conduct and Interpersonal Skills	–	4.80 ± 0.54 (1–5)	4.75 ± 0.54 (1–5)	4.74 ± 0.54 (1–5)
Spirituality	–	4.71 ± 0.60 (1–5)	4.71 ± 0.60 (1–5)	4.69 ± 0.64 (1–5)
Violence Prevention	–	4.73 ± 0.58 (1–5)	4.72 ± 0.55 (1–5)	4.71 ± 0.62 (1–5)
In-Person Session 3	4.76 ± 0.57 (1–5)	–	–	–
Storytelling	–	4.71 ± 0.63 (1–5)	4.71 ± 0.57 (1–5)	4.70 ± 0.58 (1–5)
Motivational Interviewing	–	4.72 ± 0.54 (1–5)	4.70 ± 0.59 (1–5)	4.68 ± 0.62 (1–5)
Heartsaver and First Aid	–	4.75 ± 0.53 (1–5)	4.72 ± 0.58 (1–5)	4.71 ± 0.61 (1–5)

All cells show weighted mean ± SD (SD-Standard Deviation) (n-weighted)

sometimes be challenging to present, but maintaining focus on the intended outcome is helpful. The exercises have provided good narratives to enhance this skill." One participant reflected that "The most recent study about HIV/AIDS has profoundly awakened my sensitivity to victims of sexual assault. Heretofore, I focused on victims of drug/alcohol addiction or persons infected through blood transfusions. The course expanded my awareness to sexually abused individuals whose lives are forever changed." While some reflections focused on applying specific topics in the field, one commented on the impact of the CHW role that "I have a better understanding of what it means to be a CHW. I have a family member that is dealing with mental health, for example. Now I can see myself using a different approach when suggesting resources for him." "I can see myself using this content I have learned each day as a healthcare worker and in my everyday life, especially communicating with patients and understanding their needs and reasoning."

Bridging communities and accessing resources: Participants revealed the impact of CHWs on removing barriers to support access to care in when one stated that "Having worked in underserved communities that lacked access to quality healthcare, I am now more empowered to work with faith-based institutions and churches, helping them create health initiatives and bridge the gap between residents and health professionals." A participant remarked that "The module on Caring for the LGBTQI + Community was very informative and raised my level of sensitivity regarding the needs and lack of access to healthcare due to discriminatory practices in this population." Another participant recognized the importance of coordinating community resources to access culturally appropriate care "One key area where I am already using this training is navigating community resources and systems to assist families with state benefit applications, food assistance, and healthcare access. Understanding how to build trust, engage diverse populations, and bridge language and cultural barriers has been invaluable in serving non-native English speakers and individuals with disabilities."

Overcoming challenges and cultivating strengths: CHWs encounter many challenges when trying to provide services and some are able to change those to strengths. One participant stated that "A success that stands out is how this training has strengthened my ability to collaborate with healthcare providers, such as Two Rivers Health Clinic, to provide culturally competent health education. At the same time, a challenge I continue to navigate is ensuring sustainable access to care and resources, particularly in communities with limited transportation and financial barriers." A second participant reflected that "By

using the content that I have learned, I have become better at serving the people I come in contact with facing the challenges that come with helping people." Another participant shared that "I see myself as a connector by bridging the gap between individuals in need and the resources that can support their well-being. My lived experiences have given me a deep understanding of the challenges people face, especially in areas like mental health, addiction recovery, and disability services."

Expanding role of CHWs on engaging communities
The role of CHWs continue to grow as unmet individual and community needs increase, and CHWs are seen as trusted members of healthcare teams. For example, one participant shared that "I've learned a lot about being a Community Health Worker, but the most important thing to me is learning how to go out into the community and be a listening ear—building trust among the people so I can advocate, inform, persuade, build relationships, and provide them with the resources they need." Another stated that "This training has ignited the energy within me to be an advocate for socioeconomic justice, human rights, and just plainly caring for people." This participant said it best that "One of the most important things I have learned is the power of culturally responsive care and advocacy. Many individuals in underserved communities, especially non-native English speakers and those with disabilities, struggle to access the resources they need due to language, financial, or systemic barriers. Through my training and experience, I have learned how to navigate these systems, build trust, and empower individuals to advocate for their own health and well-being."

Discussion

The curriculum and program evaluation were guided by a four-pillar interconnected SDOH framework [3]. The four pillars include (1) social factors resulting from systemic racism and imbalances in power, resources, education, and occupation, (2) cultural factors such as customary beliefs, social norms, attitudes, values, and practices shared by groups, (3) environmental factors, both physical (natural resources, climate change, toxic exposures) and social (faith-based institutions, housing, family compositions), and (4) policy factors such as guidelines, principles, legislation, and activities affecting living conditions and quality of life [3]. The ARCHWAy program was highly effective in participants gaining essential knowledge, skills, and competencies. This analysis found the ARCHWAy program had a broad reach across social, cultural, environmental, and policy influences following successful implementation, with engagement in training activities associated with applying trainings in field placements, facilitating access to resources and connections with communities, cultivating strengths, and expanding the role of CHWs in engaging communities.

Evaluation data was reported for selected modules (not all modules) delivered online and selected in-person trainings as there were over 55 online modules and over 155 h of didactic programming and all ratings were consistently scored 4.5 of better on a scale of 1 to 5. The positive evaluations from participants on the learning objectives, ease of use, and visual appeal of both online and in-person modules underscore the program's effectiveness in delivering content. The high ratings across various topics suggested that the ARCHWAy curriculum is well-designed to meet CHWs' diverse learning needs and leverage their strengths. This is crucial for CHWs who often work in challenging environments where they must navigate complex health and social issues. The ARCHWAy program also contributed to fostering a deeper understanding of SDOH. Participants described how training modules on topics such as cultural humility and stigma reduction increased their ability to address barriers to health equity in their communities. ARCHWAy's dual emphasis on theoretical and practical learning allowed participants to navigate these complex issues effectively.

Strengths of the process included the collaborative nature of building the quantitative and qualitative aspects of the evaluation and the ongoing monitoring of results in the event adjustments to the training were needed. The project team were able to review feedback and had the opportunity to make changes if needed. One improvement for this process is a more thorough analysis of results at each monitoring timepoint. Based on its program components and strengths, this model could be replicated in regions where both English and Spanish are spoken, in regions with simulation centers, and in the context of both CHW generalist and specialist practice.

While challenges remain in securing sustainable funding and measuring long-term community health outcomes, the program demonstrates a promising model for expanding CHW training initiatives. For example, the online modules are built and could be sustained in the short term without funding. However, key in person components – mental health first aid certification, simulation-based motivational interviewing, and skills lab require funding to continue.

In three years, the ARCHWAy program trained both new and current CHWs across multiple community-based organizations and health systems. The scope and scale of the ARCHWAy program expanded upon previous programming. Compared to other CHW training programs offering training over four weeks or less, predominantly traditional classroom instruction, with some offering a combination of classroom and online

instruction, some trainings were competency-based, and stipends between $5 and $250 [11], ARCHWAy provides competency-based training over 12 weeks including in-person and online instruction, 20 simulation hours, and 80 experiential field placement hours with a stipend of $3,500 [12]. Similarities include having CHWs partnering in developing the training, training assessment, linking CHW education and training to the needs of the communities served, and providing a certificate at the completion of training [11]. Compared to a specialty-focus program that offered 80 h of in person and virtual training over 1.5 years [10], ARCHWAy provides 155 h over 12 weeks. Both programs are competency-based with the specialty-focus program guided by the C3 Project competencies while ARCHWAy is guided by the U.S. Department of Labor competencies. Both sets of competencies are similar and include cultural mediation, culturally appropriate health education and information, care coordination, coaching and support, advocacy for individuals and communities, individual and community capacity building, direct health and social service assistance, individual and community assessments, outreach to individuals, communities, service providers, and groups, and participation in evaluation and research.

Unlike other training programs that are often offered in a single language and not competency-based, and either a generalist or specialist approach [10, 11], the ARCHWAy program is unique in that it broadly scaled and made training opportunities accessible in English and Spanish, was competency-based, and offered both generalist and specialist training and experiential learning field placements. The program's success metrics translate into real-world CHW performance and community health outcomes. The ARCHWAy program has trained over 349 competent CHWs to best serve underserved communities and address SDOH. CHW performance included increased knowledge acquisition, skill development, core competencies, and application in field, improved communication and community engagement skills, stronger CHW individual and community relationships, and expanded integration of SDOH principles into care. ARCHWAy has advanced the CHW workforce capacity by offering standardized learning and skill-enriching training with a goal of improving care access, improving community health indicators, and potential impact on policy and system-level changes informed by CHW insights.

Limitations

While designed to assess the impact of processes and activities, program evaluations are limited in their generalizability and cannot ascertain causal effects of interventions. Therefore, improvements in outcomes following training are associative in nature and may not be generalizable to other CHW training programs without further validation. While two of the components of the evaluation were optional, surveys of the modules and weekly reflections, 100% of participants completed the surveys and 50% of participants submitted reflections raising the possibility of response bias. The optional nature of surveys and reflections introduces potential response bias, as only a subset of participants provided feedback. Additional limitations include biases in self-reported data (e.g., social desirability bias in evaluations) and the lack of a control group for comparison. These limitations result in a bias sample that does not accurately represent the group and affects the interpretation of results because those who choose to participate may differ in some systematic way, results may be interpreted more favorably (or less favorable). Strategies to mitigate these biases include verifying self-reported information with other objective data sources, using validated tools, and emphasizing anonymity.

There was overrepresentation of certain demographics in the ARCHWAy program, such as 82% female and 75% Black/African American, that can introduce biases and limit the generalizability of findings. The findings might not accurately reflect the broader population, especially if the overrepresented group's experiences, perspectives, or behaviors are not typical of the general population.

The clinical encounter logs were a required component and representative of all trainees. Additionally, only some respondents chose to elaborate on their answers in an open response. While the results for those questions were overwhelmingly positive, additional feedback could have better illustrated trainee experiences. The evaluation focuses on short-term outcomes (e.g., participant satisfaction, immediate skill application). Longitudinal impact is unknown as there is the lack of long-term data (e.g., CHW retention, community health outcomes). Despite these limitations, the program evaluation was successfully developed and implemented in a longitudinal training program over 12 weeks.

Conclusion

The findings from this evaluation indicate the broad reach, scalability, and sustained impact ARCHWAy had on trainees and subsequently their field placement sites at community organizations and health systems. One health system established the role of the maternal health CHW at one of their hospitals and hired an individual who completed the ARCHWAy program. In addition, a CHW manager was hired and they are in the process of hiring three CHWs, they will heavily consider individuals that have completed the ARCHWAy program. Next, the health system is creating both

generalist and specialist CHW roles across some of their 11 hospitals. For example, the health system plans to hire specialist CHWs as internal patient navigators, service line specific (e.g. maternal health, nephrology) and unit-based (e.g. emergency department and primary care). Generalist CHWs will be hired as external CHWs to lead community-based events and health fairs and provide health education, care coordination, and navigation.

Future longitudinal efforts are needed to track overall community engagement and long-term health outcomes of individuals and communities, such as CHW retention rates, community health outcomes, reduced disparities, improved access, reduced ER visits, and improved chronic disease management. To accomplish this, along with future research directions, a sustainable data-capturing infrastructure and validated long-term outcome measures are required. For example, the ARCHWAy team is exploring utilizing validated measures delivered digitally and automatically prior to and repeatedly after participating in the training to enable continuous program evaluation. These longitudinal data are essential to understanding how best to enhance the delivery and timing of training opportunities. These data also make it possible for the team to discern changes in CHW retention rates, community health outcomes, reduced disparities, and improved access over time. In addition, the team is examining preidentified interim points of analyses to conduct tailored focus groups with trainees to elucidate themes to inform potential opportunities to enhance the program to ensure that the content and delivery methods are representative and relevant to the individuals participating in the ARCHWAy training.

Research directions may be informed by the didactic training on community-based participatory research, and CHWs actively engaging in the research process and ensuring that research is relevant to the community's needs and priorities. Another opportunity informed by SDOH is investigating how experiential field placements guide CHW-led interventions targeted at obtaining stable housing, achieving education, finding employment, and accessing transportation to impact health outcomes. This research should emphasize the importance of culturally appropriate approaches to health interventions ensuring that they are effective and respectful of diverse populations. Studies to evaluate the effectiveness of various CHW-led interventions, such as programs for chronic disease management, mental health support, or substance abuse prevention are essential. Research exploring the role and effectiveness of CHWs in connecting communities with healthcare and social services, addressing health inequities, and improving health outcomes is critical. This capacity-building work requires an initial investment in planning and ongoing evaluation to ensure the sustainability of programming.

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Author contributions
Authors' contributions BAS led conceptualization, funding acquisition, investigation, methodology, project administration, resources, supervision, writing original draft, writing, review and editing. KC carried out investigation, methodology, writing, review and editing. QP carried out investigation, methodology, writing, review and editing. LS participated in project administration, writing, review and editing. SFC, LK, RC, SB, AS participated in writing, review and editing. All authors read and approved the final manuscript.

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Availability of data and materials
No datasets were generated or analysed during the current study.

Declarations

Ethics approval and consent to participate
Not applicable; Emory IRB determined the project was non-human subject research, deemed program evaluation.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

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