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Voices, Images, And Experiences Of Community Health Workers: Advancing Antiracist Policy And Practice

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ABSTRACT Community health workers (CHWs) are front-line public health personnel who share common attributes with or have a nuanced understanding of the communities they serve. Their membership in marginalized communities gives them expertise in delivering contextualized interventions that mitigate their clients' social risk factors, but it also places them at greater risk for exposure to various harms. We employed the photovoice method to illuminate how the lived experiences of CHWs working, residing, or both in Baltimore City, Maryland, dovetail with facets of their jobs. In partnership with our sixteen predominantly racial and ethnic minoritized study participants, we surfaced the ways in which CHWs negotiated and subsequently leveraged experiences with social risk factors rooted in structural racism to shape their approach to intervention delivery for structurally vulnerable communities. We also uncovered several occupational hazards that participants faced as a function of their identities. Our findings underscore the need to embed antiracist principles in the fabric of policies and practices that directly affect the CHW workforce.

Social determinants of health (SDOH) comprise the social, physical, and economic circumstances that affect health.[1,2] They exert their influence through interlocking causal pathways that link structural, upstream determinants, including sociopolitical, economic, and cultural factors such as racism, classism, and other forms of oppression,[3–5] to downstream determinants, such as medical care, health education, and behavioral risk factors.[5] Their convergence profoundly shapes the systems and policies that influence neighborhood conditions, education, income, and psychosocial well-being. As such, adverse exposures to SDOH experienced on the individual level—or social risk factors—are excessive in systematically marginalized communities. These risk factors generate pressing health-related social needs.[6] The confluence of these factors is responsible for producing and reinforcing health disparities.[4]

One proven strategy in disrupting the underlying mechanisms connecting health disparities with SDOH, social risk factors, and social needs is the implementation of community health worker (CHW)-led interventions. CHWs are front-line public health workers who are trusted members of or possess a deep understanding of (or both) the communities that they support.[7] They have long been recognized as critical to linking structurally marginalized communities to health and social service resources that alleviate the impact of social risk factors and attendant social needs.[8–10] Their personal characteristics, intrapersonal qualities, and interpersonal skills uniquely position them at the interface of community empowerment and health care to build individual and collective capacity. They do so

through advocacy, care coordination and navigation, resource linkage, outreach, and social support.[8]

A strong body of evidence demonstrates that CHW-led interventions are cost-effective and reduce intransigent disparities in health, utilization, and process-of-care outcomes.[11–17] CHWs' effectiveness is often attributed to a combination of shared racial or ethnic, linguistic, socioeconomic, and experiential connections. Yet these same qualities situate CHWs within socially disadvantaged groups, which is confirmed by the reality that the majority of CHWs in the US identify their gender as women, identify their race or ethnicity as Black or Latine, and navigate racism-infused social and economic precarity.[17,18] Because CHWs are members of disenfranchised communities, the constellation of activities associated with their roles may increase their exposure to psychosocial and physical risks. Elucidating how CHWs' social risk factor profiles and marginalized identities conjointly affect their professional experiences is critical. Such inquiry may advance antiracist policies and practices that are contextually rooted in recognizing who CHWs are and what they do, as well as their distinct impact on health equity interventions.[17] Thus, to elevate CHWs' voices and experiences, we conducted a community-engaged study—Amplifying the Lived Experiences of Community Health Workers (ALEC)—using photovoice methodology to reveal how CHWs' lived experiences influence their professional activities, with the goal of clarifying policies and practices that are cognizant of the social milieu shaping CHWs' lives.

Study Data And Methods

PHOTOVOICE APPROACH Photovoice is a participatory visual qualitative research method that uses photography to engage participants in reflection and dialogue regarding their communities' strengths, needs, and capacity for social change.[19] Photovoice is a well-established participatory method, but few studies have employed this tool to explore issues relevant to CHWs' lived experiences.[20] We used Caroline Wang's SHOWeD Framework[19] to conduct a series of photovoice discussions with CHWs about their personal and professional experiences navigating social risk factors and social needs. Participants took photos of the environments where they lived, worked, or both, which served as the foundation for each facilitated discussion. All participants provided oral informed consent. Study procedures were approved by the Johns Hopkins University School of Medicine Institutional Review Board. Details of our approach are summarized in online appendix exhibits 1 and 2.[21]

RECRUITMENT We partnered with the Maryland Community Health Worker Association to recruit CHWs via email and virtual information sessions. We also targeted outreach to local organizations based in Baltimore, Maryland, that employed Latine CHWs by sharing recruitment information through their organizations' email distribution lists. Those interested in participating completed an online survey to confirm their eligibility: age eighteen or older, a practicing CHW for at least two years, a resident or worker in Baltimore City, and an English or bilingual English-Spanish speaker. Participants received a $25 gift card for each photovoice session attended.

DATA COLLECTION Participants were divided into four cohorts on the basis of availability and scheduling preferences. One cohort was dedicated to bilingual Spanish-language CHWs to explore their experiences working with clients whose preferred or home language was Spanish. We translated all relevant materials, and a trained, bilingual staff member led the Spanish-language discussions. During March–July 2022, we held twenty virtual photovoice sessions (five for each of the four cohorts), each lasting 90–120 minutes. Sessions were recorded and professionally transcribed. We also collected participants' sociodemographic information and self-reported past and recent social needs through a brief online survey.

ANALYSIS We used MAXQDA2022, a qualitative analysis software program, to facilitate a template analysis of the photovoice discussions based on techniques described by Joanna Brooks and colleagues.[22] The method creates a structured approach to thematic analysis and enables identification of patterns and outliers.[23] The study team met to develop the coding framework based on a priori domains related to the study's research questions, KFF's delineation of SDOH,[24] and themes that emerged through the photovoice sessions. The coding template included personal and professional experiences navigating social risk factors and social needs; perceived barriers and facilitators of CHWs' integration into health care and public health systems; factors shaping CHWs' approach to, and the perceived utility of, the interventions they delivered; and the underlying drivers of prevalent social risk factors in the communities where CHWs worked. Two authors (Chidinma Ibe and Nico Dominguez Carrero) used the template to code and summarize the photovoice transcripts. Three authors (Anika Hines, Shannon Fuller, and Alison Trainor) conducted a secondary review of the transcripts and analytic documents.

The research team met regularly to discuss interpretation and refine themes.

Finally, we invited our study participants to review preliminary findings through virtual member check meetings, where we presented themes and exemplary quotes. Thirteen participants attended these sessions and provided feedback to ensure accurate characterization of the photovoice discussions, for which they received a $25 gift card.

LIMITATIONS Although this study represented a novel approach to situating CHWs' work in the context of their identities and social risk factors, there were some limitations. First, this was an exploratory study based in a single US city. Second, by restricting the study to those who had been a CHW for at least two years, we missed the perspectives of those who were new to the profession or who left the workforce because of some of the very issues our study sought to uncover. Finally, the photovoice sessions occurred during the COVID-19 pandemic. It is likely that some CHWs who would have participated were otherwise encumbered with various obligations that precluded their involvement in this study.

Study Results

PARTICIPANTS' CHARACTERISTICS We recruited and obtained consent from nineteen CHWs to participate, sixteen of whom attended at least three of the five photovoice sessions for their cohort and three of whom withdrew because of competing demands. Participants' mean age was forty-six years (standard deviation: 11); 81 percent ($n = 13$) were women, and 19 percent ($n = 3$) were men. Most reported their race as Black or African American ($n = 10$; 63 percent), followed by other ($n = 4$; 25 percent), American Indian or Alaska Native ($n = 1$), and White ($n = 1$). Approximately 31 percent ($n = 5$) reported their ethnicity as Hispanic or Latine. Most participants ($n = 10$; 63 percent) reported having been a CHW for two to five years. These and other demographic characteristics are summarized in appendix exhibits 3 and 4.[21]

Regarding the social risk factors they experienced, most CHWs reported current stable housing and transportation, but about 56 percent ($n = 9$) reported having experienced housing instability at various points throughout their lives, and 44 percent ($n = 7$) reported the same regarding transportation. Approximately 31 percent ($n = 5$) and 38 percent ($n = 6$) of participants indicated that they either worried about food or were unable to purchase it once it ran out, respectively, within the past year. More than half of the participants had encountered these dimensions of food insecurity at any point in their lives. Similarly, approximately 31 percent ($n = 5$) of participants reported facing issues with their utilities in the past twelve months, and 56 percent ($n = 9$) had experienced these difficulties at any point in their lives.

CHWs' lived experiences confer a unique understanding of structural determinants of health.

THEMATIC FINDINGS The impact of structural and interpersonal racism emerged as an overarching theme across the photovoice sessions. CHWs spoke about the ways in which racism shaped their experiences, the communities they served, and the nature of their work. The following sections present four interconnected themes that illuminate how CHWs attempted to circumvent structural and interpersonal manifestations of racism. Illustrative quotes from two key themes—structural racism as a contributor to CHWs' experiences with social risk factors and social needs, and occupational hazards associated with the CHW role—are in exhibit 1. (See appendix exhibit 5 for a full list of themes, subthemes, and illustrative quotes.)[21]

▶ **THEME 1:** The first theme that emerged was the role of structural racism as a contributor to CHWs' experiences with social risk factors and social needs. Study participants mentioned two interwoven subthemes: their own past and ongoing experiences with health-related social needs and the predominant social risk factors that their clients faced (exhibit 1). Structural racism manifests through the enduring impact of Baltimore City's history of discriminatory housing practices and was cited as a cause of concentrated deprivation within the city's Black and African American communities. This was exemplified by a discussion that ensued when a CHW compared the picture they had taken of a public housing development with a photograph they took of a picture of their relatives: "This photo is from 1918. …I really don't see that much difference than from 2022. My mother, she was saying that it was a lot of White people that lived in the neighborhood, but they kept them separated. …It seems like we're in the same

EXHIBIT 1

Selected quotes from participants that illustrate two study themes from a photovoice study of community health workers (CHWs) working or residing in Baltimore City, Maryland, 2022

Themes	Subthemes	Illustrative quotes
Structural racism as a contributor to CHWs' experiences with social risk factors and social needs	Past and ongoing experiences with social risk factors	I know when I lived in West Baltimore, …I never took my kids to the playground by the neighborhood school because just to go over there, it was too much drug activity around the school. Not to mention when, as adults, my husband and I would just walk over there going for a neighborhood walk and stop in the schoolyard, there was drug paraphernalia on the ground, so I would definitely never take my children to the playground there.
	Predominant social risk factors addressed as a CHW	And so in those cases, I actually help them set up an [Electronic Benefits Transfer] account. And then I would call them. I would set a reminder on my calendar to call them because my question [is]: What time of the month do you normally find that just you're running low? Not when you are out of food, but when do you find yourself running low? And I will set a reminder for myself to call them around that time, get their lists, then we together order their groceries online because I already—they trust me enough to create their account, so clearly they trust me enough to go into their account right there and then they know how to do that. …That's how I'm able to…alleviate the food desert, the food insecurity barrier, and the transportation barrier.
Occupational hazards associated with the CHW role	Psychosocial	I remember this [corner store] every time I go by there. They said that they found a band of people who were bringing women from Central America. Once they came here, they would take their passports and hold them on that same street upstairs. [The police] found them there. What I remember is that we would test those [women] for HIV, but I never thought that the girls I was testing were the same. I heard it on the news, and when they said what street it was, I said, 'Wow, how many times was I there?' Probably close to those people, and I wasn't able to help them because the people that were holding them did not allow it.
	Physical	Safety is something I think about constantly—for example, today I walked to a community meeting, in an area where I usually walk, but in Baltimore City many people have died being shot. So now when I walk in the street I am wondering if I will [be] hit from somewhere, because you never know, and I feel afraid.
	Institutional	That is a concern that all CHWs share, not only with funds for direct services, such as food, but also for our jobs, which are paid with specific funds and are not permanent. When funds are low, they make cuts, which, unfortunately, may be what is needed the most.

SOURCE Transcripts of photovoice focus-group sessions from sessions 2–5 from cohorts 1–4. **NOTES** The two other study themes are presented in the text, with more complete details in appendix exhibit 5 (see note 21 in text). Transcript data are available on reasonable request.

conditions. We think we are not separated anymore, but we are. They house us in different communities where we don't have access to resources or can't pull ourselves up out of these places."

Most of the CHWs discussed social risk factors to which they were exposed in the past, but a few drew attention to their ongoing food insecurity, residence in neighborhoods with dilapidated housing, and limited access to transportation. For example, one participant took a photo of the city bus to symbolize the transportation in their community, noting that those who can't walk or take the bus are stranded (see the interactive gallery of photos and personal reflections—the lived experiences of CHWs in Baltimore City—that accompanies this article online).[25] Another photo shows the site of a local market that shut down earlier in the COVID-19 pandemic and will not reopen, leaving community members without access to healthy and fresh food (exhibit 2). "Most of us in Baltimore live in food deserts," the participant noted. "We are getting our foods from corner stores, delivery, or maybe a food pantry. It's hard if you don't drive and have a vehicle. With taking the bus or hacking a ride [an informal form of ridesharing], you can't carry more than a few bags to feed your whole house."

Study participants also highlighted how they sought to mitigate the impact of food insecurity and poor transportation on the health and well-being of their clients—for instance, by helping them sign up for an Electronic Benefits Transfer account (exhibit 1). They contrasted the availability of resources in comparatively affluent neighborhoods with the distribution of adverse SDOH in the communities they worked in. "In a Black neighborhood, a poor neighborhood, you don't really have the money to buy healthy for your family," one participant said. "It doesn't happen in white-collar neighborhoods because they are financially stable and they have transportation and means to get to good markets. …Your options are better in a different neighborhood rather than a Black community." Several photographs taken by participants allude to the ramifications of racially patterned neighbor-

EXHIBIT 2

The construction site: "This was our local market. It had good prices, an ATM, and a money sending/check cashing inside. During COVID it shut down. We are not getting a new market."

SOURCE Photovoice participant's photo and quote. A more complete narrative is in the interactive gallery of photos and personal reflections that accompanies this article online (see note 25 in text).

hood disinvestment, featuring images of townhouses with roofs fallen in and entire blocks of abandoned and boarded-up houses (see the interactive gallery of photos and reflections that accompanies this article online).[25] The Latine participants emphasized the interactions among poverty, immigration status, and their clients' abilities to access needed resources. For instance, food drives and food delivery initiatives were described as necessary to alleviate the precarious circumstances confronting newly arrived immigrants. "I think it's a combination of factors—the stratospheric increase in prices and the people who cannot receive any other benefits, such as food stamps," one participant stated. "There are people who don't want to apply for food stamps because they don't want to become a public charge."

▶ **THEME 2:** The second theme that emerged was that participants' approaches to intervention delivery were grounded in a socioemotional connection to their clients. Two connected subthemes emerged: CHWs' leveraging their own experiences to discern strategies for intervention delivery, and CHWs' allegiance to their clients and communities, which we conceptualized as a sense of perpetual belongingness. Study participants spoke at length about how personal or familial navigation of social risk factors fundamentally affected the strategies deployed to address clients' social needs. For example, one participant photographed a syringe disposal box, noting that Baltimore's needle exchange was the reason they took the job as a CHW (exhibit 3). "I lost five uncles who shared one needle twenty years ago, and in this picture, I see hope for those who wish to stop using drugs," the participant said. Another CHW stated that their ability to help clients navigate the Section 8 housing application resulted from having done so for their mother. "It was always me involved in the paperwork," the participant stated. "I've helped other people in the same way. They know that I have experience and know how to do it."

CHWs conveyed a sense of allegiance to the individuals and communities they supported, due to an amalgamation of racial and ethnic, socioeconomic, cultural, and experiential concordance between themselves and their clients. CHWs had an implicit understanding of the ways in which institutional and structural racism conspired to perpetuate practices that they deemed harmful to the communities they supported and that warranted their protective oversight. One CHW, who no longer resided in the neighborhoods they worked in, spoke indignantly about their involvement in a local food committee that provided what they regarded as low-quality food: "And when they start sending bad stuff that looked like it was too ripe," they said, "I was like, 'I'm not serving this to the community. You wouldn't serve it to yours. Unh-uh.'"

▶ **THEME 3:** The third theme was the perceived limits and weaknesses of prevailing social risk factor interventions. Study participants highlighted the conceptual failures of interventions marked by a focus on individual-level issues rather than their structural antecedents, and the inadequate provision of context-appropriate supports for the intended beneficiaries of service delivery programs. They emphasized that the health-related social needs they addressed originated in systemic factors outside their control that hindered the impact of their work. One CHW ascribed this phenomenon to a "lack of redevelopment. Lack of grocery stores in minority communities. Lack of employment." They continued: "So as a CHW, I'm trying to connect clients to services, and some days there are good days—I can connect a person. Some days it's a struggle. But when you have to turn away a pregnant mother with a young child because there are no shelter beds, it's a lot, and that

EXHIBIT 3

Hope: "This picture shows the urgency of the drug epidemic in Baltimore City and that there is help available for those who want it. It shows how we can use the needle exchange program to prevent the spread of HIV and other diseases."

SOURCE Photovoice participant's photo and quote. A more complete narrative is in the interactive gallery of photos and personal reflections that accompanies this article online (see note 25 in text).

happened to me today."

Participants viewed the lack of sustainable funding for specific resources, including their own roles, as having potentially dire consequences for their clients and communities. "The concern is that when they run out of funds for CHWs, what are we going to provide? Where can we send them?" one CHW remarked. "The concern is that these direct services for the community are going to run out. Needs keep increasing, and we are not receiving any support."

CHWs frequently expressed frustration with local politicians and organizational leaders for decisions regarded as fundamentally misaligned with community context and antithetical to the stated goals of their initiatives. One CHW photographed a trio of bilingual COVID-19 prevention signs, noting that they had to ask for these signs to be bilingual and fight to get such resources in the community (see the interactive gallery of photos and reflections that accompanies this article online).[25] Another participant described the challenges they encountered when trying to help their clients access a utilities assistance program. They argued that the organization's decision to use ZIP codes as the basis for determining resource allocation did not account for the recent migration of Latine residents to other neighborhoods as a result of gentrification and rising rent costs. Indeed, CHWs provided several examples of organizations failing to provide Spanish interpreters when appropriate, enforcing restrictive inclusion criteria for program participation that rendered the most vulnerable ineligible to receive needed services, and distributing information and services during hours of the day that were at odds with their clients' availability (see appendix exhibit 5).[21]

▶ **THEME 4:** The fourth theme was that CHWs faced unique occupational hazards. Study participants discussed the pervasive hazards that they experienced as a direct result of their work, which they categorized as being psychosocial, physical, and institutional (exhibit 1). Despite the sense of gratification that they derived from their work, CHWs reported feelings of burnout and hopelessness, noting the toll their work took on their mental health and overall well-being. Their characterizations of the conditions they worked in suggested near-constant exposure to direct and vicarious forms of trauma. For instance, some Latine participants described

learning of a group of Central American women who were victims of sex trafficking and were found captive near a community outreach site they had worked at. Given that these women were likely previous clients of theirs, they asked themselves: "How many times was I there? Probably close to those people, and I wasn't able to help them."

Hazards were also physical in nature. Every participant identified safety as a major concern as a result of their being victims of crimes while working or helping clients navigate threats of violence. The experience of interpersonal racism also contributed to CHWs' fears about their own safety while working. One Latina CHW shared an image of American and Maryland flags with a xenophobic sign in a neighborhood where she was distributing resources (exhibit 4), stating, "If you zoom in, it says, 'Close the border.' We didn't even knock at the door there. We skipped it and we moved on." When discussing an image of boarded-up homes in the West Point area of Baltimore, another participant noted that "we're Hispanic, and sometimes, we knock at the door of an American, and they've even threatened us that they will call Immigration. I can tell you countless stories" (see the interactive gallery of photos and reflections that accompanies this article online).[25]

CHWs also reported experiencing discriminatory attitudes, beliefs, and statements within their organizations, particularly expressed by other health care professionals, related to the perceived utility of their roles within those organizations. This was discussed at length within the Latine cohort. When asked whether they had experienced any moments of tension with their care teams, one participant admitted perceiving that her coworkers sometimes behaved in ways that conveyed that "they felt like, 'Well, this girl is not a doctor, so what is she doing here next to me?'" Another CHW shared a similar experience conducting outreach work with other colleagues, explaining that her coworkers expressly dismissed her bilingual language and culture skills as a CHW. According to the CHW, the staff said, "'What are these Latinas doing here? Why didn't they send us to learn Spanish?' Can you imagine that? They thought that it was so simple; a course in Spanish, and they were going to give the same service to Latino people."

EXHIBIT 4

Discrimination: "I have been discriminated against on several occasions because of my way of speaking, my physical appearance, by the native people of this country. Sometimes they see us as immigrants, as nuisances, as people who come to steal their jobs…Even at work, doctors and interpreters can discriminate against you. As much as you want to help, they can see you as a hindrance."

SOURCE Photovoice participant's photo and quote. A more complete narrative is in the interactive gallery of photos and personal reflections that accompanies this article online (see note 25 in text).

Discussion

In our study, CHWs articulated a dynamic relationship between their own personal experiences navigating social risk factors and their professional experiences addressing clients' and communities' social needs. These experiences, as well as their allegiance to the communities they worked in and their nuanced understanding of the compounding, interactive nature of SDOH, served as the foundation on which they conceptualized, appraised, and executed intervention delivery strategies. Study participants also attributed a mosaic of interpersonal, institutional, and structural contributors to the distinctive occupational hazards they faced as CHWs. Overlaying these findings was the influence of structural and interpersonal racism.

This study joins a burgeoning evidence base exploring US-based CHWs' lived experiences through photovoice.[26–29] It also highlights the promise of this methodology as a vehicle for converting participatory qualitative research into actions that advance health equity. One of the primary objectives of Wang's photovoice method is to translate findings into policy by engaging policy makers and key stakeholders.[19] Accordingly, we are partnering with ALEC study

Sustainable financing is an antiracist strategy to buttress a structurally marginalized and minoritized workforce.

participants to organize a stakeholder meeting with policy makers, to display the CHWs' photos, disseminate key findings, and cultivate a CHW-centered policy agenda based on our results.

Our approach was rooted in interrogating the notion of CHWs as members of systematically disadvantaged communities, whose compelling attributes occur alongside their proximity to adverse SDOH that generate and sustain lifetime exposures to numerous economic, psychosocial, and physical threats to their well-being. The Biden administration aims to fortify the nation's public health infrastructure by, among other strategies, increasing the CHW workforce.[30] Our study findings have significant policy and practice implications that warrant consideration, particularly regarding CHWs' experiences with social risk factors and occupational risks. These are predominantly rooted in interpersonal, institutional, and structural racism. We therefore provide the following recommendations to advance an antiracist paradigm of integration of CHWs into community-based organizations, public health agencies, and health care delivery organizations.

RECOMMENDATION 1 Our first recommendation is to uplift CHWs' leadership in intervention development. Study participants' comments indicate the mental calculations that CHWs undertake to identify clients' and patients' needs, determine the proper course of action, and spearhead appropriate service provision. At an institutional level, CHWs should be included as key partners and content experts in interventions and in the development of policy that focuses on addressing social risk factors and social needs. CHWs' expertise in discerning the specific mechanisms that cause interventions to succeed or fail emerges from the knowledge they acquire through supporting their clients in navigating barriers and accessing resources. Further, their lived experiences confer a unique understanding of structural determinants of health, which allows them to conceptualize multifaceted, transdisciplinary interventions across the spectrum of ecosocial levels.

RECOMMENDATION 2 Our second recommendation is to provide culturally responsive, trauma-informed support and supervision to CHWs. Our study illuminated the contextualized occupational hazards that CHWs face because of their intersecting identities. Chief among them was consistent exposure to traumatic events. We also captured concerning instances of interpersonal racism directed at CHWs from their colleagues and the recipients of their services alike. Providing trauma-informed support and antiracism training for staff within organizations may alleviate CHWs' personal and professional stressors. This has ramifications for reducing turnover and improving job satisfaction, thereby ensuring continuity of care for those receiving CHW-facilitated supports.[31]

RECOMMENDATION 3 Our third recommendation is to establish rigorous safety protocols to protect CHWs. CHWs identified numerous safety issues as they described their work. They mentioned being trained to use their discretion and gut feeling to discern whether to enter a space. The burden of determining appropriate safety measures should not fall on people facing potentially dangerous situations. Organizations must institute robust policies and procedures that are spearheaded by CHWs to support CHWs' safety as they work in communities.

RECOMMENDATION 4 Our fourth recommendation is to alleviate CHWs' financial precarity through sustainable financing and appropriate compensation models. Patchwork funding is one of the unfortunate hallmarks of the financing arrangements underpinning CHW programs in the US. Our study underlines its potential role in perpetuating financial instability and fostering periodic occurrences of food, transportation, and housing insecurity or a combination of the three. Expanding the portfolio of sustainable financing arrangements for CHW programs, such as through Medicaid reimbursement of CHW services that accounts for the full complement of supports they provide; long-term, disease-agnostic grant mechanisms; and strategies that incentivize payers and health care providers to fund CHW positions,[32] is a health equity and public health imperative. Sustainable financing is an antiracist strategy to buttress a structurally marginalized and minoritized workforce. Our definition of what constitutes fair compensation of CHWs should be grounded in an appreciation for the intrinsic complexity of their roles and the potential for sustained exposure to assorted occupational hazards to lead to long-term physical and mental health effects. Beyond higher sala-

ries, employers should offer CHWs full health benefits and access to mental health services. Such provisions are critical for ameliorating the deleterious impacts of structural and interpersonal racism on CHWs' overall health.

Conclusion

CHWs are from the same marginalized backgrounds as the people they support, which suggests that inadequate institutional support may reinforce racial and ethnic health inequities by placing an already-vulnerable population in further harm's way. Efforts to embed CHW-delivered resources within health care delivery and public health organizations must be accompanied by CHW-centered policies and practices anchored in the centrality of these workers' unique, intersectional backgrounds. This has ethical implications for the workforce and repercussions for delivering effective health equity interventions that tackle the social risk factors and needs of systematically marginalized communities. ■

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NOTES

1 Braveman P, Gottlieb L. The social determinants of health: it's time to consider the causes of the causes. Public Health Rep. 2014; 129 Suppl 2(Suppl 2):19–31.
2 Marmot M. Social determinants of health inequalities. Lancet. 2005; 365(9464):1099–104.
3 Paradies Y, Ben J, Denson N, Elias A, Priest N, Pieterse A, et al. Racism as a determinant of health: a systematic review and meta-analysis. PLoS One. 2015;10(9):e0138511.
4 Crear-Perry J, Correa-de-Araujo R, Lewis Johnson T, McLemore MR, Neilson E, Wallace M. Social and structural determinants of health inequities in maternal health. J Womens Health (Larchmt). 2021; 30(2):230–5.
5 Braveman P, Egerter S, Williams DR. The social determinants of health: coming of age. Annu Rev Public Health. 2011;32:381–98.
6 Alderwick H, Gottlieb LM. Meanings and misunderstandings: a social determinants of health lexicon for health care systems. Milbank Q. 2019;97(2):407–19.
7 American Public Health Association. Support for community health workers to increase health access and to reduce health inequities [Internet]. Washington (DC): APHA; 2009 Nov 10 [cited 2023 Aug 24]. Available from: https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/09/14/19/support-for-community-health-workers-to-increase-health-access-and-to-reduce-health-inequities
8 Rosenthal EL, Brownstein JN, Rush CH, Hirsch GR, Willaert AM, Scott JR, et al. Community health workers: part of the solution. Health Aff (Millwood). 2010;29(7):1338–42.
9 Smedley BD, Stith AY, Nelson AR, editors. Unequal treatment: confronting racial and ethnic disparities in health care. Washington (DC): National Academies Press; 2003.
10 Freeman J. Community health workers: an important method for addressing the social determinants of health. Fam Med. 2016;48(4): 257–9.
11 Kangovi S, Mitra N, Grande D, Long JA, Asch DA. Evidence-based community health worker program addresses unmet social needs and generates positive return on investment. Health Aff (Millwood). 2020; 39(2):207–13.
12 Palmas W, March D, Darakjy S, Findley SE, Teresi J, Carrasquillo O, et al. Community health worker interventions to improve glycemic control in people with diabetes: a systematic review and meta-analysis. J Gen Intern Med. 2015;30(7): 1004–12.
13 Kim K, Choi JS, Choi E, Nieman CL, Joo JH, Lin FR, et al. Effects of community-based health worker interventions to improve chronic disease management and care among vulnerable populations: a systematic review. Am J Public Health. 2016; 106(4):e3–28.
14 Ibe C, Bowie J, Roter D, Carson KA, Lee B, Monroe D, et al. Intensity of exposure to a patient activation intervention and patient engagement in medical visit communication. Patient Educ Couns. 2017;100(7): 1258–67.
15 Kangovi S, Mitra N, Grande D, Huo H, Smith RA, Long JA. Community health worker support for disadvantaged patients with multiple chronic diseases: a randomized clinical trial. Am J Public Health. 2017;107(10):1660–7.
16 Islam NS, Wyatt LC, Ali SH, Zanowiak JM, Mohaimin S, Goldfeld K, et al. Integrating community health workers into community-based primary care practice settings to improve blood pressure control among South Asian immigrants in New York City: results from a randomized control trial. Circ Cardiovasc Qual Outcomes. 2023;16(3): e009321.
17 Ibe CA, Hickman D, Cooper LA. To advance health equity during COVID-19 and beyond, elevate and support community health workers. JAMA Health Forum. 2021;2(7): e212724.
18 Smith DO. COVID-19 front lines need community health workers, yet they're not getting needed support. USA Today [serial on the Internet]. 2021 May 4 [2023 Aug 24]. Available from: https://www.usatoday.com/story/opinion/voices/2021/05/04/covid-front-lines-need-community-health-workers-column/

4920088001/
19 Wang CC. Photovoice: a participatory action research strategy applied to women's health. J Womens Health. 1999;8(2):185–92.
20 O'Donovan J, Thompson A, Onyilofor C, Hand T, Rosseau N, O'Neil E. The use of participatory visual methods with community health workers: a systematic scoping review of the literature. Glob Public Health. 2019;14(5):722–36.
21 To access the appendix, click on the Details tab of the article online.
22 Brooks J, McCluskey S, Turley E, King N. The utility of template analysis in qualitative psychology research. Qual Res Psychol. 2015; 12(2):202–22.
23 Abraham TH, Finley EP, Drummond KL, Haro EK, Hamilton AB, Townsend JC, et al. A method for developing trustworthiness and preserving richness of qualitative data during team-based analysis of large data sets. Am J Eval. 2021; 42(1):139–56.
24 Artiga S, Hinton E. Beyond health care: the role of social determinants in promoting health and health equity [Internet]. San Francisco (CA): KFF; 2018 May 10 [cited 2023 Aug 24]. Available from: https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/
25 To access the interactive gallery of photos and reflections, "Baltimore Voices: Community Health Workers, Struggling Neighborhoods, and Delivering Effective Health Equity Interventions," by Chidinma Ibe and colleagues, visit "Racism And Health" on the Health Affairs website, https://www.healthaffairs.org/racism-and-health.
26 Mayfield-Johnson S, Rachal JR, Butler J 3rd. "When we learn better, we do better": describing changes in empowerment through photovoice among community health advisors in a breast and cervical cancer health promotion program in Mississippi and Alabama. Adult Educ Q (Am Assoc Adult Contin Educ). 2014; 64(2):91–109.
27 Baquero B, Goldman S, Simán F, Muqueeth S, Villa-Torres L, Eng E, et al. Mi cuerpo, nuestra responsabilidad: using Photovoice to describe the assets and barriers to sexual and reproductive health among Latinos in North Carolina. J Health Dispar Res Pract. 2014;7(1):65–83.
28 Logan RI. Not a duty but an opportunity: exploring the lived experiences of community health workers in Indiana through photovoice. Qual Res Med Healthc. 2018;2(3):132–44.
29 Logan RI. "A poverty in understanding": assessing the structural challenges experienced by community health workers and their clients. Glob Public Health. 2020;15(1): 137–50.
30 White House. Fact sheet: Biden-Harris administration announces American Rescue Plan's historic investments in community health workforce [Internet]. Washington (DC): White House; 2022 Sep 30 [cited 2023 Aug 24]. Available from: https://www.whitehouse.gov/briefing-room/statements-releases/2022/09/30/fact-sheet-biden-harris-administration-announces-american-rescue-plans-historic-investments-in-community-health-workforce/
31 Brown O, Kangovi S, Wiggins N, Alvarado CS. Supervision strategies and community health worker effectiveness in health care settings. NAM Perspect. 2020 Mar 9. [Epub ahead of print].
32 Ibe CA, McNair OS. Advancing and sustaining the community health worker workforce in Baltimore City: a call to action for key stakeholders [Internet]. Baltimore (MD): Abell Foundation; 2021 Oct [cited 2023 Aug 24]. Available from: https://abell.org/wp-content/uploads/2022/02/2021_Abell_CHW20report_FINAL-web.pdf