

Partnering With Community Health Workers to Address COVID-19 Health Inequities: Experiences of the California Alliance Against COVID-19

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With funding from the National Institutes of Health's Community Engagement Alliance, starting in fall 2020, 11 academic medical centers and 75 community partners came together as the California Alliance Against COVID-19 to address COVID-19 inequities in California. Using data from focus groups, statewide meetings, and a statewide partner survey, we describe how *promotoras* and community health workers (P/CHWs; n = 540) helped to promote access to COVID-19 information, testing, and vaccination. We highlight opportunities to promote health equity among other public health collaborators with a P/CHW model. (*Am J Public Health*. 2024;114(S1):S45–S49. <https://doi.org/10.2105/AJPH.2023.307471>)

The COVID-19 pandemic has brought to the forefront existing structural inequities and resulting challenges faced by historically marginalized communities.^{1–3} A partnership between *promotoras* and community health workers (P/CHWs) emerged as a promising culturally informed community-centered participatory approach that can support long-term collaborations of health care and public health systems with the communities most affected by public health crises.

INTERVENTION AND IMPLEMENTATION

P/CHWs (both those with and those without formal certification) share similar life experiences and backgrounds with the communities they serve, allowing them to act as trusted messengers and community leaders and to play a central role in health promotion and

service delivery and coordination and to guide health care and public health systems in providing culturally and linguistically appropriate support.^{4,5} We used P/CHWs' expertise and leadership in their communities to (1) design and implement structurally (e.g., addressing barriers such as documentation or lack of health insurance), culturally, and linguistically relevant outreach and engagement efforts aimed at promoting access to evidence-based information; and (2) promote COVID-19 testing and vaccination across California. We discuss cross-cutting challenges, lessons learned, and opportunities for using this model to inform other large-scale public health collaborations to promote health equity.

Box 1 highlights our structurally, culturally, and linguistically centered strategies, which engaged 540 P/CHWs. P/CHWs in the California Alliance Against COVID-19 (also called STOP

COVID-19 CA; hereafter "Alliance") and quickly mobilized to address inequities through a variety of strategies. Many teams (in the California cities of, e.g., Los Angeles, Stanford, and Irvine) disseminated trusted information through door-to-door canvassing,⁶ and the Merced team developed a multilingual (i.e., Spanish, Punjabi, Hmong, and English) hotline for vaccine appointments. P/CHWs in the Central Valley and in Inland Southern California helped create *pláticas de salud* (health talks) via Facebook Live in which community members (largely farmworkers) could ask Spanish-speaking physicians questions. The Merced team also created the I Test campaign, which featured local celebrities who promoted testing and vaccination and distributed personal protective equipment. In partnership with the Arizona Community Engagement Alliance Against COVID-19 Disparities team, the Merced team

BOX 1— Selected Exemplary Activities and Strategies Used by *Promotoras* and Community Health Workers (P/CHWs) Across Sites: California Alliance Against COVID-19, Fall 2020–Fall 2022

	Activities	Structurally, Culturally, and Linguistically Centered Strategies
Information gathering and dissemination	<ul style="list-style-type: none"> • Focus groups, town halls, and listening sessions with P/CHWs to better understand community needs, set priorities, strategize on solutions, and design outreach activities led by P/CHWs • Community talks/<i>pláticas de salud</i> event hosted by P/CHWs for dissemination 	<ul style="list-style-type: none"> • Focus groups (or similar) facilitated by P/CHWs in participants' preferred language • Development of materials in the form of art and short videos with culturally relevant messaging • P/CHWs were involved, as research partners, in data collection, analysis, and dissemination
Testing	<ul style="list-style-type: none"> • Door-to-door and other outreach (e.g., at schools, markets) in zip codes most affected by COVID-19^a • Partnering with community organizations to connect those testing positive to social needs resources to encourage testing 	<ul style="list-style-type: none"> • Shared own stories to develop rapport and use as educational tool • Relied on shared experiences to develop trust • Provision of information in multiple languages (e.g., Spanish, Vietnamese, Samoan, Mixtec, Tagalog) • Rapid and polymerase chain reaction testing available from local community-based organizations and other convenient community locations
Vaccination <ul style="list-style-type: none"> • Health education and promotion • Identification and removal of barriers • Appointment support and direct delivery 	<ul style="list-style-type: none"> • Development of educational and outreach materials (e.g., Web pages, flyers, social media content, minidocumentaries, public service announcements) 	<ul style="list-style-type: none"> • Materials available in multiple languages and codeveloped with P/CHWs and community organizations^a <ul style="list-style-type: none"> ○ Materials reflect cultural sayings and community values ○ Include graphics and culturally relevant art ○ Use humor and colloquial sayings
	<ul style="list-style-type: none"> • Disseminating information via local networks^a 	<ul style="list-style-type: none"> • P/CHWs disseminated information using channels familiar to the community (e.g., WhatsApp, Facebook groups)
	<ul style="list-style-type: none"> • Hosting community events for outreach and education^a 	<ul style="list-style-type: none"> • Events incorporated cultural celebrations, celebrities, and community leaders • Events featured distribution of other resources (e.g., food box and food voucher distribution, rent assistance) • Partnering with local Mexican consulate to increase trust
	<ul style="list-style-type: none"> • Promotion of vaccine appointments and navigation of the process for community members 	<ul style="list-style-type: none"> • P/CHWs set appointments for those with less access or comfort with technology • P/CHWs assured many that appointments did not involve tracking social security numbers or documentation status
	<ul style="list-style-type: none"> • Mobile or pop-up vaccine clinics 	<ul style="list-style-type: none"> • Reduced access and transportation barriers • P/CHWs assisted with registration and translation support, added a sense of community, and promoted this resource

^aStrategy used across efforts, e.g., information gathering and dissemination, testing, vaccination.

developed short animations (in Spanish and Zapotec) countering common COVID-19 mis- and disinformation.

As testing and vaccines became available, P/CHWs addressed barriers by assisting with making appointments, resources for transportation, childcare, and advocacy for paid time off. P/CHWs provided support and connections through in-person events (e.g., pop-up or mobile community testing) and social media and helped residents make appointments for PCR (polymerase chain reaction) testing. P/CHWs also used door-to-door outreach, phone trees, and other strategies (Box 1) to

share COVID-19 vaccination information. For instance, Irvine P/CHWs worked with schools and transportation assistance organizations to bring mobile vaccination clinics to underserved communities after hours and on weekends. To promote vaccine confidence, P/CHWs used their reputation as trusted messengers to discuss fears and hesitations during outreach, using factual and accessible information to address myths and mis- and disinformation.

Another effective strategy was partnering with clinics and social service organizations to address basic needs.

Inland Southern California P/CHWs partnered with federally qualified health centers and community food banks to engage Latinx immigrants in COVID-19 testing. Northern California P/CHWs worked with urban farms to assist with food distribution while discussing updated COVID-19 guidance, distributing antigen tests, and teaching families how to sign up for PCR test appointments. Central Valley P/CHWs encouraged testing among farmers by connecting them to mutual aid funds, farmworker grants, and resources for self-quarantine. P/CHWs also delivered food boxes and distributed information

on both COVID-19 and available social services (e.g., food banks, free health services).

PLACE, TIME, AND PERSONS

The Alliance⁷ started in September 2020 and included 11 academic sites and more than 75 community partners representing 14 counties and almost 75% of the state population (nearly 30 million residents). The P/CHWs (n = 540) represented diverse communities and languages (e.g., Spanish, Purépecha, Marshallese, Vietnamese).

PURPOSE

One of the key Alliance strategies involved partnering with P/CHWs to work with local communities; this promising culturally informed community-centered participatory approach can support long-term collaborations between health systems and the communities most affected by COVID-19. Many of our sites were in rural communities or in or near communities with large percentages of racial/ethnic minorities, individuals born outside the United States, or medically underserved populations. This was an opportunity for partnering with P/CHWs to address COVID-19 inequities in areas hardest hit by the pandemic.

EVALUATION AND ADVERSE EFFECTS

Several of the Alliance teams engaged in data collection efforts (e.g., focus groups, interviews, community town halls) to assess community needs and existing capacity and to prioritize and guide efforts.⁸ P/CHWs participated both as community leaders bringing

forward information and as meeting facilitators. The data we collected were supplemented by a statewide survey of partners⁷ and notes from bimonthly statewide leadership meetings and monthly workgroup calls regarding ongoing challenges, strategies, and resources.

The number and types of activities conducted by the Alliance were previously published.^{7,8} We focus on the role of P/CHWs in these strategies. Community members often mentioned that they participated in these activities because of the lack of culturally or linguistically tailored resources, whether it was information about COVID-19, access to the vaccines, or other needed resources (e.g., food, rent assistance). Without P/CHWs and these tailored approaches informed by their community expertise, there would likely have remained unmet needs in these diverse communities. P/CHWs greatly contributed to information dissemination: more than 127 000 community members were reached via health fairs or educational outreach, 432 712 accounts were reached via messaging (e.g., WhatsApp), and more than 4 000 000 individuals were reached via culturally and linguistically adapted materials informed by the P/CHWs' community knowledge.⁷

Door-to-door outreach by P/CHWs was also associated with an increase in Latinx individuals receiving testing compared with neighborhood testing sites alone.⁶ Notably, because of the urgent nature of the COVID-19 pandemic, our evaluation efforts were mostly centered on reach metrics and implementation challenges. Future studies should design evaluation efforts to compare the effectiveness of involving P/CHWs with more traditional approaches.

SUSTAINABILITY

Continuous support and capacity-building strategies were crucial for the Alliance's success (Box 2). Across sites, training included a 40-hour certificate program, a four-stage research training series, quarterly community forums hosted by faculty, monthly trainings, and town halls. Another important strategy was the ongoing support for self-care and space to discuss burnout and the mental health effects on P/CHWs of exposure to COVID-19-related trauma. This included weekly or biweekly meetings to debrief P/CHWs on the previous week's activities, facilitate peer support and healing circles to offer space for mental health discussions, and offer tools and coping strategies.⁹ Moving forward, systemic changes to funding practices¹⁰ and sustainable financial investments are needed to support P/CHWs and ensure that they are well integrated into government, public health, and health care agencies. Addressing these structural barriers (e.g., administrative burdens for community partners, financial and bureaucratic structures that hinder timely compensation) can promote trustworthiness in academic and medical institutions and encourage additional partnerships.¹⁰⁻¹²

PUBLIC HEALTH SIGNIFICANCE

As our health systems struggle to meet the needs of an increasingly diverse country, public health systems could partner with P/CHWs to bolster their ability to link health and social systems, support communities with culturally and linguistically responsive team members and resources, foster a more rapid and continuous response to

BOX 2— Summary of Challenges and Recommendations: California Alliance Against COVID-19, Fall 2020–Fall 2022

Stages of the Process	Challenges	Recommendations
Before and after award	<ul style="list-style-type: none"> Fast turnaround of funding announcements, limiting partners' input on proposal development and planning efforts Subcontracting challenges, leading to delays in disseminating funds to community partners 	<ul style="list-style-type: none"> Increase time for applications to encourage codevelopment of proposals and budgets Use existing partnerships with flexibility to add partners as projects are implemented Reduce administrative burden of subcontracting documents <ul style="list-style-type: none"> Allow budget cost for funding administrative grant activities (crucial for small organizations)
Project implementation	<ul style="list-style-type: none"> Lack of training resources for P/CHWs in languages other than English, adapted for communities with lower levels of literacy, or with lack of access to technology Mental health and stress burden placed on P/CHWs Geographic challenges for those in rural areas 	<ul style="list-style-type: none"> Ensure that training and outreach materials are centered in community cultural and language preferences Invest in reducing technological and educational inequities Develop and support infrastructure for ongoing training, capacity development, and adaptation as new information needs develop Incorporate healing circles and other spaces to offer ongoing support and coping strategies
Overarching	<ul style="list-style-type: none"> Having P/CHWs (and their respective organizations) seen as equal research partners Lack of institutional recognition of the value and expertise brought by P/CHWs Stigma associated with working with undocumented/marginalized communities <ul style="list-style-type: none"> Reliance on social security documentation Power inequities in budget and resource sharing Lack of job stability because of project-based funding 	<ul style="list-style-type: none"> Increase education for institutional leaders and administrators on community-based participatory research and the value of community engagement Establish rates for fair and equitable compensation for P/CHWs and their organizations Pay/compensate P/CHW and their respective organizations on time (includes executing subcontracts and consultation agreements in a timely fashion) Dismantle structural barriers (e.g., reliance on social security numbers) for compensating partners with diverse documentation status Increase capacity for community engagement in academic sites Invest in the P/CHW workforce and further incorporate them into governmental (e.g., public health departments) and health care agencies

Note. P/CHW = *promotoras*/community health worker.

emergencies and community concerns, and promote evidence-based efforts to address health inequities. Greater partnership and systemic involvement of P/CHWs as a crucial workforce with community expertise and trust can accelerate efforts to address inequities during public emergencies such as the COVID-19 pandemic and future crises. *AJPH*

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CONTRIBUTORS

P. Rodriguez Espinosa developed the software. P. Rodriguez Espinosa and E. Vázquez performed the visualization. P. Rodriguez Espinosa,

E. Vázquez, and M. AuYoung performed the formal analysis. P. Rodriguez Espinosa, E. Vázquez, M. AuYoung, and F. Zaldivar prepared the first draft of the article. P. Rodriguez Espinosa, M. AuYoung, F. Zaldivar, A. M. Cheney, D. Sorkin, and N.J. Burke acquired the funding. P. Rodriguez Espinosa, M. AuYoung, F. Zaldivar, A. M. Cheney, D. Sorkin, and N.J. Burke administered the project. P. Rodriguez Espinosa, F. Zaldivar, A. M. Cheney, D. Sorkin, and N.J. Burke supervised the project. All authors conceptualized the project, performed the investigation, developed the methodology, procured the resources, curated the data, reviewed and edited the article, and agreed to the published version of the article.

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CONFLICTS OF INTEREST

The authors have no conflicts of interest to declare.

HUMAN PARTICIPANT PROTECTION

Project activities were approved by each site's institutional review board.

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