1 **Advancing Community-Based Participatory Practice in Public Health**

2 **Policy Date:** October 29, 2024

3 **Policy Number:** 20243

4 Abstract

5 This policy statement fills a gap identified by the Joint Policy Committee to address persistent and

6 widening health inequities in the United States by advancing community-based participatory practice.

7 Despite high health care expenditures, the United States continues to underperform in health outcomes

8 relative to other high-income nations, with recent alarming drops in life expectancy. The systems and

9 structures that perpetuate these widening health inequities necessitate comprehensive public health

10 strategies that encompass meaningful collaborative engagement between communities and public health

11 practitioners. This policy statement advocates for widespread adoption of community-based participatory

12 practices throughout the public health field, emphasizing the inclusion of community members in every

13 stage of the public health process. This includes incorporating the lived experiences of community

14 members as a valuable form of expertise, developing action-focused feedback loops to refine

15 interventions, and ensuring data equity to address systemic biases. The statement also underscores the

16 importance of community-based participatory research as a mechanism to meaningfully engage

17 communities in addressing critical gaps in information about public health challenges. In addition, it urges

18 the field to move toward power sharing and collective control in decision-making processes, including the

19 formation of community research review boards to ensure ethical and community-aligned research

20 practices. The overall aim is to foster a more inclusive, equitable, and effective public health system that

21 genuinely addresses the needs and priorities of all communities, particularly those historically

22 marginalized and disproportionately affected by health inequities.

23

24 **Keywords:** health equity; community participation; community health planning; community-based

25 participatory research; health services administration

26

27 Relationship to Existing APHA Policy Statements

28 • APHA Policy Statement 200412: Support for Community-Based Participatory Research in Public
29   Health

30 • APHA Policy Statement 202210: Reimagining Public Health Leadership for Health Equity:
31   Moving Toward Collective and Community-Centered Applied Practice

32 • APHA Policy Statement 20224: Advancing Environmental Health and Justice: A Call for
33   Assessment and Oversight of Health Care Waste

34 • APHA Policy Statement 202115: Noise as a Public Health Hazard

35   • APHA Policy Statement 20218: Call for Urgent Actions to Address Health Inequities in the U.S.
36   Coronavirus Disease 2019 Pandemic and Response
37   • APHA Policy Statement LB20-04: Structural Racism is a Public Health Crisis: Impact on the
38   Black Community
39   • APHA Policy Statement LB20-02: Health Inequities in the U.S. Coronavirus Disease 2019
40   Pandemic and Response
41   • APHA Policy Statement 20197: Addressing Environmental Justice to Achieve Health Equity
42   • APHA Policy Statement 20182: The Environmental and Occupational Health Impacts of
43   Unconventional Oil and Gas Industry
44   • APHA Policy Statement 20171: Supporting Research and Evidence-Based Public Health Practice
45   in State and Local Health Agencies
46
47 I.   Problem Statement
48 Social determinants, systems, and structures are associated with long-standing health inequities.[1,2]
49 Despite decades of attention to health inequities in the United States, widening gaps in health-related
50 outcomes persist.[1] Prior to the COVID-19 pandemic, life expectancy in the United States lagged behind
51 peer nations; the additional drop following the pandemic is staggering, with available data showing the
52 greatest losses experienced by American Indian and Alaska Native, Black, and Latine populations.[3]
53 Beyond COVID-19, health disparities across structurally marginalized groups such as the LGBTQ+
54 (lesbian, gay, bisexual, transgender, and queer) community, immigrants and refugees, people
55 experiencing homelessness, and communities of low socioeconomic status have persisted and, in many
56 cases, worsened, because of intersecting mechanisms based in sociopolitical power and privilege.[4]
57 Maintaining this inequitable system is costly: In addition to unmeasured human capital losses due to
58 preventable illnesses, the United States consistently ranks among the lowest of high-income countries for
59 health-related outcomes, despite reporting the greatest per capita expenditure.[5] Also, recent studies
60 demonstrate diminishing trust in public health and the scientific community.[6,7]
61
62 Communities unjustly impacted by health inequities possess unique skills, strengths, and resources that
63 have allowed them to survive while being structurally marginalized. Often bucketed under the umbrella
64 term "resiliency," public health has embraced the idea of incorporating community assets as a public
65 health strategy for more than a decade.[8] Substantial evidence indicates that structural determinants of
66 social, economic, and political marginalization contribute to persistent health inequities.[9] Shared public
67 health ethics and morality require that we address social determinants, systems, and structures that
68 perpetuate poor health. Active and meaningful participation by structurally marginalized communities is

69   essential to this process. Meaningful community participation is effective in reducing health disparities

70   and fosters community development. [10–12]

71

72   In 2004, APHA recognized the importance of community-based participatory research (CBPR).[13]

73   APHA's policy, building from Barbara Israel's foundational work and the evidence base that has

74   emerged since, supports the effectiveness of CBPR approaches linking participatory research to

75   effective practice.[11,14] There is a growing need to adopt participatory practices developed for CBPR

76   outside of the research context and more broadly throughout public health practice. Here this is

77   referred to as community-based participatory practice (CBPP). However, CBPP can be difficult to

78   honor, in part due to structural, institutional, and systemic barriers. These barriers can contribute to

79   misunderstandings or misalignments of goals, benefits, or processes that strain relationships among

80   communities, researchers, and practitioners.[11] As a result, relationships must be carefully established,

81   nurtured, and maintained over time, in an atmosphere of mutual dialogue and respect, to maintain (or

82   regain) mutual trust.[11] Real ethical concerns about privacy and confidentiality create complexity, while

83   conflicts of interest between a community and researchers or practitioners can halt progress and lead to

84   harm.[11]

85

86   Despite these challenges, recent and ongoing efforts to address systemic drivers of health inequities have

87   resulted in new mandates for the public health community.[1] There is growing recognition that CBPP

88   offers critical insights for improving public health practice as well as research.[14–16] Structurally

89   marginalized communities have generations of experience navigating the systems that perpetuate harm.

90   This lived experience, paired with the increasing inclusion of people from structurally marginalized

91   communities in public health systems and leadership, creates opportunities to improve public health

92   practice toward achieving health equity.

93

94   Evidence-Based Strategies to Address the Problem

95   While CBPR primarily focuses on research processes, CBPP encompasses a broader range of

96   participatory activities that include, but are not limited to, research.[17] While some community-based

97   approaches, notably community health needs assessments, are widely accepted in the field, they are often

98   completed with limited or no meaningful community engagement.[18] To truly build toward CBPP,

99   institutions can incorporate increasing levels of shared leadership and participation progressively over

100   time to build trust and the capacity for CBPP.[12] This policy statement does not intend to curate an

101   exhaustive list of evidence-based strategies but, rather provides feasible examples of different depths of

102   CBPP. Engagement with the public in pursuit of health equity requires a tailored approach with each

103   community to earn trust and build partnerships.[2,19–21] For the purposes of advancing health equity,

104   this statement focuses on evidence-based strategies that involve active multidirectional participation in

105   public health practice.

106

107   Recognize that lived experience is expertise: Ample evidence affirms the value of community input to

108   public health. Community members have unique knowledge about the social and environmental factors

109   contributing to their community's health, first-hand experience navigating health-determining systems,

110   knowledge of what interventions and policies have and have not worked for them, and experiential insight

111   into why.[12,20,22] Given the history of unethical practices and outright discrimination based on income,

112   insurance status, race, and other factors, trustworthiness must be demonstrated by public health

113   practitioners.[23,24] Building trust is required for any longer term investment, particularly in

114   communities accustomed to extractive, short-term engagements.[21] Community members and

115   community-based organizations often serve crucial public health roles as primary responders to local

116   needs left unmet due to systemic failures, gaining unmatched wisdom that can greatly inform and improve

117   public health actions.[19,25]

118

119   Acknowledging lived experience as expertise akin to educational or professional qualifications requires

120   the public health field to challenge elitist notions of "expertise."[26] This may engender resistance from

121   public health teams, their supervisors, and others whose expertise is recognized by dominant groups (e.g..

122   those with academic credentials and other privileged groups) but who lack lived experience.[27] It is the

123   responsibility of the public health community to ensure that community expertise is meaningfully and

124   sustainably integrated into public health activities.[20,27] This responsibility includes acknowledgment of

125   the role public health institutions have played in eroding the trust of structurally marginalized groups and

126   active restitution for those trust-destroying practices.[24,27,28]

127

128   Evidence supports the advantages of integrating lived experience within public health systems (e.g., peer

129   services, promotores), including clinically significant benefits such as reduced need for costly

130   hospitalizations.[20,22,29] Services provided by people with lived experience must not be used to offset

131   labor or budget shortages with lower cost services but be integrated as complementary services that

132   improve quality throughout the system. Lived experience must be valued: Financial compensation should

133   be comparable for services typically requiring academic and professional credentials.[30] Investing a

134   portion of the resources currently used to fund management consultants to support community-based

135   expertise can result in more appropriate and sustainable public health solutions centered on community

136   benefits.[31] In addition to financial compensation, there are opportunities to continue engaging

137   communities that have provided expertise and information, such as using institutional ties and influence

138   to support community action and advocacy related to health challenges.[20,27,30]

139

140   Incorporate place-based and environmental justice approaches: "Place" is a long-established social

141   determinant of health, with widespread development of place-based approaches to achieving health

142   equity.[32,33] In the United States, racist practices and policies have segregated urban and rural

143   geographies, shaping determinants of health and creating geographic health disparities. Public health

144   practitioners using placed-based approaches should consider the interaction of community diversity and

145   geography in the public health process.[29] Communities may self-define according to geographic

146   boundaries that differ from administrative boundaries tied to funding streams, health data aggregation

147   boundaries, or government catchment areas that control upstream policies.[12,32,34]

148

149   Geographically defined communities include members with intersecting identities. There is no single set

150   of best practices that applies to all different community makeups; however, a few universal strategies

151   have emerged.[1,32] Public health practitioners must honor differential relationships and power dynamics

152   at play within participating communities and with the public health community; this requires reflexive

153   self-examination by the public health team and the development of multilevel participatory

154   strategies.[1,32,35]

155

156   CBPP activities are often designed with a geographic component to advance environmental justice, a

157   social movement based on the principle that environmental risks, protections, and benefits should be

158   distributed equally to all people, with the recognition that "dominant political and economic structures

159   disproportionately locate environmental pollution and other sources of health risk with communities in

160   poverty and communities of color."[35] Because environment is a critical determinant of health, public

161   health practitioners must address and acknowledge "environmental justice communities," which are

162   usually geographically defined.[2,27]

163

164   Develop action-focused community feedback loops: Feedback mechanisms that result in corrective action

165   and improved interventions have long been used to identify and address implementation challenges;

166   instituted globally in resource-limited and emergency settings, their feasibility is well established.[36]

167   Tools that highlight the value of integrating action-focused community feedback loops, such as health

168   equity and/or racial equity impact assessments, are recommended in the United States given pervasive

169   health inequities according to race and ethnicity.[20,21] Feedback mechanisms should be context and

170 community specific, taking into account both community acceptability of and familiarity with the
171 mechanism; a variety of feedback mechanisms may be required. Expectations for community members
172 and public health practitioners should be jointly established up front, with predetermined check-ins to
173 evaluate performance and implement necessary changes. Feedback mechanisms must necessitate
174 responsive action, including acknowledgment of received feedback and appropriate communication of
175 actions taken.[32]
176
177 From an intervention perspective, evidence-based practices (EBPs) are recommended by funding
178 institutions due to scientifically backed results; to align with the evidence, such programs are
179 implemented as is to ensure fidelity to the model. However, studies supporting EBPs often have small
180 sample sizes from culturally, linguistically, and/or socioeconomically diverse communities, limiting the
181 generalizability of the evidence base.[20] If the evidence base supporting EBPs has not been fully
182 established for the populations being served, more information is needed to ensure effectiveness beyond
183 acceptability and feasibility.[37] Given the high costs of EBPs, the potential for inefficient investments in
184 programs that are not well evidenced for the communities experiencing health inequities must be
185 considered. Action-focused community feedback loops can detect potential inefficiencies of EBPs within
186 service communities and redirect resources more effectively for greater impact.[20]
187
188 Address gaps in knowledge through CBPR: Participatory research approaches such as CBPR and youth
189 participatory action research are built on an understanding that more traditional, researcher-driven
190 approaches to building knowledge often exclude the critical knowledge and insights of those most
191 adversely impacted by social, economic, and political inequities.[14,38] Systemic inequities affect the
192 information generated, knowledge gained, and ways in which data are collected and used. The resulting
193 understanding of public health challenges is partial and distorted. This directly impacts resource
194 allocation, community trust in public health systems, and uptake of public health activities. If systemic
195 inequities are to be meaningfully addressed, members of disproportionately affected communities should
196 be engaged in identification of research questions, decisions about data needed to understand public
197 health phenomena, interpretation of findings, and decisions about actions based on study findings.[27]
198
199 CBPR is a partnership approach to research that equitably involves community members, organizational
200 representatives, and researchers in all aspects of the research process, including leadership and decision
201 making about how to apply research findings in public health practice and to support relevant policy
202 changes.[10,14] All partners contribute their expertise and share responsibilities and ownership of
203 projects designed to enhance understanding of a given phenomenon as well as integrate the knowledge

204 gained with action to improve the health and well-being of community members. With roots in

205 emancipatory movements for equity in both the Global South and Global North, CBPR is a feasible and

206 powerful approach that leverages multiple methods.[10,14,27] These include quantitative methods (e.g.,

207 traditional, short-response surveys; validated scales; and use of administrative data sets) and qualitative

208 methods (e.g., in-depth interviews with numerous opportunities for substantive, personal, and other

209 insights; focus groups; and visual and narrative methods such as photovoice and storytelling) that can fill

210 gaps in public health knowledge, focus research on community priorities, identify barriers to community

211 wellness, create community-specific solutions to health challenges, and offer benefits to the participants

212 themselves.[14,27,39,40]

213

214 To advance and improve CBPR efforts, public health investments that amplify the capacity of structurally

215 marginalized communities to initiate and lead formal research activities on issues that directly impact

216 them are critical. Building career ladders for the workforce by investing in training and capacity building

217 for people with lived experiences of inequities to lead research activities is one approach.[20,41] This will

218 not only benefit the expansion of knowledge required to advance health equity but sustain and strengthen

219 the field of public health over time.[42] For example, the National Institutes of Health Community

220 Engagement Alliance (CEAL) program built rapid new partnerships between researchers and members of

221 hard-hit communities facing the COVID-19 pandemic to improve access to care.[43]

222

223 Participatory approaches to research can have substantial cost benefits. Not the least of these benefits is

224 the additional effectiveness of interventions when the knowledge, insights, values, and priorities of

225 disproportionately impacted communities are understood and built into intervention efforts. Although this

226 aspect is rarely assessed in published literature, a 2020 study described the hundreds of billions of dollars

227 wasted in medical research, with a key contributor being limited relevance to the communities served.[44]

228 Population health surveys are expensive to conduct, and cost-saving strategies often limit the inclusion of

229 populations that are considered small, such as American Indian and Alaska Native and multiracial

230 populations. Many studies incorporate census data, which are known to have significant flaws with

231 respect to counting certain structurally marginalized populations, to develop sampling plans.[10,45,46]

232 The systemic nature of racism requires us to acknowledge such limitations and consider alternative

233 strategies to adjust for these deficiencies in the near term. Integrating participatory processes within these

234 heavily funded studies can improve the focus of research to result in clinically and community-

235 meaningful activities while also reducing waste.[44,47]

236

237   Operationalize data equity in public health: The COVID-19 pandemic demonstrated the limits of the

238   Health Insurance Portability and Accountability Act when emergency exceptions waiving the Privacy

239   Rule resulted in unprecedented disclosures of protected health information. The pandemic also brought to

240   light deficiencies in an antiquated data infrastructure, resulting in large investments in modernization

241   efforts and cross-sectoral data-sharing partnerships. Data equity refers to examination and improvement

242   of the ways in which data are collected, analyzed, interpreted, and distributed in the context of health

243   equity; data equity is inherently participatory.[48] Failing to honor data equity in public health practice is

244   counterproductive to meaningful social change and can mask existing or emerging inequities. The Urban

245   Indian Health Institute identifies the catastrophic impact of systemic "data genocide and data terrorism

246   that is evident by being eliminated in the data and what scarce data is available being used to harm tribal

247   nations and their citizens."[45] Similarly, inequitable data practices result in inaccurate interpretation of

248   available information, leading to harmful practices, inadequate solutions, and worsening health

249   inequities.[49,50]

250

251   As health inequities are often connected to historical trauma and prolonged oppression, data equity,

252   including indigenous data governance and data sovereignty, is a critical concept for the public health

253   community to adopt.[51,52] The intersectionality framework developed by American civil rights advocate

254   and contributing scholar of critical race theory Kimberlé Crenshaw is a theoretical framework for

255   understanding how multiple social identities intersect at the micro level of individual experience to reflect

256   interlocking systems of privilege and oppression at the macro social-structural level.[26] Intersectionality

257   is critical to operationalize in any data plan because people experiencing the greatest risk for inequities

258   often have multiple social identities that place them at a risk for oppression. Racial justice is a vision and

259   transformation of society to eliminate racial hierarchies and advance collective liberation.[53] A racial

260   justice framework is foundational in all data practices because it is impossible to advance health equity

261   and social change without it. Successfully implementing these or similar frameworks for data equity

262   requires a participatory approach inclusive of structurally marginalized communities: Communities

263   determine when the goals have been achieved.

264

265   Formalize power sharing and collective control: Power sharing and collective control have positive

266   impacts on health.[54,55] Public health programs that focus on "empowerment" through unidirectional

267   knowledge sharing are limited by their reliance on a deficit-focused understanding of health inequities

268   that overemphasizes individual responsibility and fails to acknowledge or address systemic and structural

269   barriers that result in disempowerment and ongoing health inequities.[56,57] A deficit-focused approach

270 neglects the existence and intersection of resources that are already present in the community.[58] This

271 approach is paternalistic and does not reflect a truly participatory approach to engagement.[55]

272

273 Public health institutions can work effectively with other sectors and communities as partners for

274 advancing health and well-being.[33] Public health can recruit people with lived experiences of being

275 marginalized into leadership positions, including executive-level and other roles that involve decision

276 making and oversight of activities such as boards of directors.[42] Public health practitioners can also

277 seek opportunities to partner with and support social movements for equity as foundational to promotion

278 of health equity.[59] Such efforts are cost efficient in supporting and sustaining self-determined

279 objectives and priorities of structurally marginalized communities.[59]

280

281 Public health research activities involving human participants are normally overseen by institutional

282 review boards (IRBs) with responsibility for ensuring ethical and regulatory compliance. In many public

283 health departments, IRBs also review proposed interventions and evaluation activities. IRBs are an

284 essential part of the public health ecosystem, yet they often have requirements inconsistent with

285 CBPR/CBPP and lack the ability to identify and assess community-specific concerns around research and

286 data, monitoring and evaluation activities, or interventions, unintentionally placing communities at

287 risk.[60,61] American Indian and Alaska Native communities responded to the inadequacy of many IRBs

288 by establishing tribal institutional review boards.[62] This approach can be adapted to any community

289 context by establishing community research review boards (CRRBs), an approach that includes training

290 community members to conduct formal review processes associated with research, monitoring and

291 evaluation activities, and public health interventions.[63,64] Similar to IRBs, CRRBs establish guidelines

292 for activities within their community and have decision-making power on how activities proceed. CRRBs

293 are made up of individuals with lived experience who represent the community to be studied, including

294 community priorities and concerns relating to research. The successful implementation of CRRBs

295 demonstrates feasibility, ethical alignment of research activities, and promotion of community benefits;

296 such boards are an important step toward addressing systemic inequities and long-standing ethical

297 dilemmas in research.[52,63]

298

299 Action Steps to Implement Evidence-Based Strategies

Evidence-Based Strategy		Action Steps

1	Recognize that lived experience is expertise.	1a	Integrate community expertise in the public health process.
		1b	Compensate community experts: Integrate within budgets, prioritize lived experience consultancies, and identify opportunities to integrate lived expertise into systems.
		1c	Integrate a variety of participatory methods to capture unique aspects of lived expertise.
		1d	Expand training, credentialing, and career ladders for the lived expertise workforce.
2	Incorporate place-based approaches and environmental justice.	2a	Prioritize community-defined geographies in place-based public health practice.
		2b	Ensure accessibility of place-based activities.
		2c	Incorporate environmental justice into the public health process.
3	Develop action-focused community-feedback loops.	3a	Identify, acknowledge, and address power dynamics within a community and historical oppression/injustice.
		3b	Co-develop a collaborative decision-making and discussion plan.
		3c	Ensure inclusion of intersectional identities, with specific attention to accessibility.
		3d	Use structured assessments that include feedback loops, such as health equity/racial equity impact assessments.
4	Address knowledge gaps through CBPR approaches.	4a	Cultivate public and private support for CBPR that includes planning grants, training, and resources for documentation and evaluation.
		4b	Establish CBPR as the gold standard for research that advances health equity.
		4c	Integrate community expertise via multiple modalities throughout

			the research process; ensure that research aims meet community priorities.
		4d	Be reflexive about the identities of the research team and account for power dynamics in leadership planning and research design.
		4e	Document a collaborative plan for achievement of consensus and conflict resolution.
		4f	Include the community in data collection and analysis, interpretation of results, and dissemination of findings.
5	Operationalize data equity in public health.	5a	Build capacity around intersectionality and racial justice; integrate within data management and analysis plans.
		5b	Critically review existing data systems to identify knowledge gaps and populations routinely underrepresented/excluded.
		5c	Develop partnerships with identified communities to co-develop novel data streams.
		5d	Ensure that tools, methods, and approaches are community responsive.
		5e	Ensure inclusion of communities in leadership and decision making when interpreting data to mitigate biases, identify potential knowledge gaps, and center community strengths.
6	Formalize power sharing and collective control	6a	Ensure that policymakers engage community–public health partnerships in the process of policy-making and evaluation.
		6b	Formalize power sharing and shared leadership between institutional public health staff and community experts.
		6c	Facilitate the development of CRRBs and incorporate them into IRB workflows.

300

301   Opposing Arguments

302   Opposing arguments against CBPP in public health exist and are likely to evolve. They include those

303   outlined below.

304

305   Lack of perceived interest in engagement from communities: Communities that continue to experience

306   health inequities have both historical and present-day lived experiences that result in mistrust of public

307   health systems.[65] It is important to consider that although there is no one "right" way to engage the

308   communities we serve, there is potential for missteps: Community engagement has historically been

309   deployed to tokenize or exploit communities. Failure to correct missteps can lead to devaluation of

310   community input, further disenfranchisement, and spread of misinformation. Preventing potential

311   missteps requires addressing the varied opinions that challenge the integration of CBPP approaches;

312   acknowledging the history and current realities of underresourced communities, political tensions, and

313   socioeconomic inequities that hamper engagement; and being trustworthy, holding central the tenet that

314   authentic community engagement is vital for public health.[19,66,67] In addition, funders, such as the

315   National Institutes of Health, are now requiring or strongly encouraging authentic community

316   engagement.[68]

317

318   Definition of "community": Although evidence is clear that there is immense value in community-level

319   strategies and partnerships, debate on the definition of "community" can delay, impede, or even restrict

320   engagement efforts.[19,32,33] While institutions regularly define community based on historic,

321   administrative, or operational boundaries, communities often define themselves according to solidarity or

322   common perspectives that can be difficult to quantify, locate, and even describe.[11,12,25] Public health

323   practitioners must work in partnership with communities to consider community definitions that may

324   challenge historic institutionally led definitions, which will often require negotiation with and acceptance

325   of ambiguity by institutional leaders.[32,33] Use of fluid and community-driven definitions and

326   recognition that communities may be geographic, identity based, or some combination are essential to

327   effect partnerships.[14]

328

329   Lack of an evidence base: Leaders and community members may reject interventions that have not yet

330   been proven by randomized controlled trials (RCTs), despite the known limitations of RCTs and the costs

331   associated with certifying a practice as "evidence based."[69,70] Limitations in the evidence base for this

332   type of work are plentiful, particularly because of the absence of representation of communities

333   experiencing health inequities.[71] Too often studies focus on demonstrating the feasibility or

334   acceptability of evidence derived from RCTs while ignoring the critical need for evaluation of success,

335   barriers, and consequences to communities. In addition, such approaches may ignore the reality that

336 evidence-based programs are organically adapted to be more suitable to the service population, resulting
337 in poor fidelity to the model. As with defining community, negotiation with institutional leadership may
338 be required to implement CBPP, especially when working to implement community-led and community-
339 derived programs that may not yet have a robust evidence base.[68]
340
341 Insufficient resources: Public health practitioners work within the confines of modest and dwindling
342 resource environments.[72,73] CBPP is thought to be time and resource intensive, and health departments
343 and community-based organizations may not have staff to support such projects.[72] At a time when
344 public health funding is under threat, many health departments, elected officials, and leaders of
345 community-based organizations may be hesitant to invest resources in work not seen as mission critical or
346 whose gains may not be achieved within a fiscal period or political term.[73,74] While it may be widely
347 understood that there is demonstrable cost benefit in direct investment in public health, health equity
348 strategies, and communities, cities and states facing fiscal constraints will inevitably direct resources
349 toward low-resource solutions with shorter-term gains.[73,74] Increased engagement in CBPP may, over
350 time, lead to innovations that reduce resource intensity.[25,74] However, institutional leaders must be
351 careful to avoid quick-win solutions that lack long-term sustainability and results; the long-term costs of
352 growing health inequities, ineffective interventions, and increasing mistrust outweigh the relatively small
353 upfront investment often required by participatory approaches.[73–75] In fact, with the increasing
354 adoption of online and virtual participatory strategies, resource limitations are becoming less of a concern.
355
356 Although truly participatory community engagement requires resources, time, effort, and forethought on
357 the part of all parties involved, it is never too late to initiate such efforts.[16] Public health is ultimately
358 about people, not necessarily credentialed scientists, politicians, or academic institutions. We cannot
359 afford to leave people and their communities out of the equation.[25]
360
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