

1 I. **Title:** Advancing Community-Based Participatory Practice in Public Health

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39

40 **VI. Summary**

41 The policy statement fills a gap identified by the Joint Policy Committee to address persistent and
42 widening health inequities in the United States (U.S.) by advancing community-based participatory
43 practice (CBPP). Despite high healthcare expenditures, the U.S. continues to underperform in health
44 outcomes compared to other high-income nations, with recent alarming drops in life expectancy. The
45 systems and structures that perpetuate these widening health inequities necessitate comprehensive public
46 health strategies that encompass meaningful collaborative engagement between communities and public
47 health practitioners. This policy statement advocates for widespread adoption of community-based
48 participatory practices throughout the public health field, emphasizing the inclusion of community
49 members in every stage of the public health process. This includes incorporating the lived experiences of
50 community members as valuable expertise, developing action-focused feedback loops to refine
51 interventions, and ensuring data equity to address systemic biases. The statement also underscores the
52 importance of community-based participatory research (CBPR) as a mechanism to meaningfully engage
53 communities in addressing critical gaps in information about public health challenges. This statement
54 urges the field to move towards power-sharing and collective control in decision-making processes,
55 including the formation of Community Research Review Boards to ensure ethical and community-aligned
56 research practices. The overall aim is to foster a more inclusive, equitable, and effective public health
57 system that genuinely addresses the needs and priorities of all communities, particularly those historically
58 marginalized and disproportionately affected by health inequities.

59

60 **Keywords:** health equity; community participation; community health planning; community-based
61 participatory research; health services administration

62

63 **VII. Relationship to Existing APHA Policy Statements**

- 64 • 200412: Support for Community-Based Participatory Research in Public Health
- 65 • 202210: Reimagining Public Health Leadership for Health Equity: Moving Toward Collective
66 and Community-Centered Applied Practice
- 67 • 20224: Advancing Environmental Health and Justice: A Call for Assessment and Oversight of
68 Health Care Waste

- 69 • 202115: Noise as a Public Health Hazard
- 70 • 20218: Call for Urgent Actions to Address Health Inequities in the U.S. Coronavirus Disease
- 71 2019 Pandemic and Response
- 72 • LB20-04: Structural Racism is a Public Health Crisis: Impact on the Black Community
- 73 • LB20-02: Health Inequities in the U.S. Coronavirus Disease 2019 Pandemic and Response
- 74 • 20197: Addressing Environmental Justice to Achieve Health Equity
- 75 • 20182: The Environmental and Occupational Health Impacts of Unconventional Oil and Gas
- 76 Industry
- 77 • 20171: Supporting Research and Evidence-Based Public Health Practice in State and Local
- 78 Health Agencies

79

80 **VIII. Rationale for Consideration**

81 Since the adoption of 200412, Community-Based Participatory Research and Practice have
82 increasingly become part of everyday public health work. APHA has adopted several policy statements
83 that cite 200412, many of which account for some aspects of health equity. However, the adoption of
84 truly participatory approaches within public health confronts structural, institutional, and systemic
85 barriers. These barriers can contribute to superficial or performative participatory community engagement
86 which impede the development of meaningful relationships between public health practitioners and
87 community residents, undermining trust and impeding effective participatory practice. Despite over a
88 century of awareness of health inequities, the United States continues to experience growing health
89 disparities. The systemic nature of racism requires a radical shift in the status quo, and more intentional
90 and action-oriented public health practice that is led by the community. This statement addresses a policy
91 gap identified by APHA, re-affirms the need for 200412 as a policy statement, and builds upon the
92 foundation of 200412 to embrace the need to adopt participatory approaches in all aspects of public health
93 practice.

94

95 **I. Problem Statement**

96 Social determinants, systems, and structures are associated with long-standing health
97 inequities.[1,2] Despite decades of attention to health inequities in the United States (U.S.), widening
98 gaps in health-related outcomes persist.[1] Prior to the COVID-19 pandemic, life expectancy in the U.S.
99 lagged behind peer nations; the additional drop following the pandemic is staggering, with available data
100 showing the greatest losses experienced by American Indian and Alaska Native, Black, and Latine
101 populations.[3] Beyond COVID-19, health disparities across structurally marginalized groups such as the
102 LGBTQ+ community, immigrants and refugees, people experiencing homelessness, and low

103 socioeconomic status communities have persisted and, in many cases, worsened, due to intersecting
104 mechanisms based in sociopolitical power and privilege.[4] Maintaining this inequitable system is costly:
105 in addition to unmeasured human capital losses due to preventable illness, the U.S. consistently ranks
106 among the lowest of high-income countries for health-related outcomes, despite reporting the greatest per
107 capita expenditure.[5] Additionally, recent studies demonstrate diminishing trust in public health and the
108 scientific community.[6,7]

109 Communities unjustly impacted by health inequities possess unique skills, strengths, and
110 resources that have allowed them to survive while being structurally marginalized. Often bucketed under
111 the umbrella term “resiliency,” public health has embraced the idea of incorporating community assets as
112 a public health strategy for over a decade.[8] Substantial evidence indicates that structural determinants of
113 social, economic, and political marginalization contribute to persistent health inequities.[9] Shared public
114 health ethics and morality require that we address social determinants, systems, and structures that
115 perpetuate poor health. Active and meaningful participation by structurally marginalized communities is
116 essential to this process. Meaningful community participation is effective in reducing health disparities
117 and fosters community development.[10-12]

118 In 2004, APHA recognized the importance of community-based participatory research
119 (CBPR).[13]¹³ That policy, building from Barbara Israel’s foundational work and the evidence base that
120 has emerged since, support the effectiveness of CBPR approaches linking participatory research to
121 effective practice.[11,14] Critically, there is a growing need to adopt participatory practices developed for
122 CBPR outside of the research context and more broadly throughout public health practice. In this
123 statement, we refer to this as Community-Based Participatory Practice (CBPP). Yet, CBPP can be
124 difficult to honor, in part due to structural, institutional, and systemic barriers. These barriers can
125 contribute to misunderstandings or misalignments of goals, benefits, or processes that strain relationships
126 between communities, researchers, and practitioners.[11] As a result, relationships must be carefully
127 established, nurtured, and maintained over time, in an atmosphere of mutual dialogue and respect, in
128 order to maintain (or regain) mutual trust.[11] Real ethical concerns about privacy and confidentiality
129 create complexity while conflicts of interest between a community and researchers or practitioners can
130 halt progress and result in harm.[11]

131 Despite these challenges, recent and ongoing efforts to address systemic drivers of health
132 inequities have resulted in new mandates for the public health community.[1] There is growing
133 recognition that CBPP offers critical insights for improving public health practice as well as
134 research.[14,15] Structurally marginalized communities have generations of experience navigating the
135 systems that perpetuate harm. This lived experience, paired with the increasing inclusion of people from

136 structurally marginalized communities in public health systems and leadership, creates opportunities to
137 improve public health practice toward achieving health equity.

138

139 **II. Evidence-based Strategies to Address the Problem**

140 While CBPR primarily focuses on research processes CBPP encompasses a broader range of
141 participatory activities that include, but are not limited to, research. [17] While some community-based
142 approaches, notably community health needs assessments (CHNA), are widely accepted in the field, they
143 are often completed with limited to no meaningful community engagement.[18] To truly build towards
144 CBPP, institutions can incorporate increasing levels of shared leadership and participation progressively
145 over time to build trust and the capacity for CBPP.[12] This policy statement does not intend to curate an
146 exhaustive list of evidence-based strategies, but provides feasible examples of different depths of CBPP.
147 Engagement with the public in pursuit of health equity requires a tailored approach with each community
148 in order to earn trust and build partnerships.[2,19-21] For the purposes of advancing health equity, this
149 statement focuses on evidence-based strategies that involve active multi-directional participation in public
150 health practice.

151 ***1. Recognize that lived experience is expertise***

152 Ample evidence affirms the value of community input to public health: community members
153 have unique knowledge about the social and environmental factors contributing to their community's
154 health, first-hand experience navigating health-determining systems, knowledge of what interventions and
155 policies have and have not worked for them, and experiential insight into why.[12,20,22] Given the
156 history of unethical practices and outright discrimination based on income, insurance status, race, and
157 other factors, trustworthiness must be demonstrated by public health practitioners.[23,24] Building trust
158 is required for any longer term investment, particularly in communities accustomed to extractive, short-
159 term engagements.[21] Community members and community-based organizations (CBOs) often serve
160 crucial public health roles as primary responders to local needs left unmet due to systemic failures,
161 gaining unmatched wisdom that can greatly inform and improve public health actions.[19,25]

162 Acknowledging lived experience as expertise akin to educational or professional qualifications
163 requires the public health field to challenge elitist notions of "expertise." [26] This may engender
164 resistance from the public health team, their supervisors, and others whose expertise is recognized by
165 dominant groups (e.g. those with academic credentials, other privileged groups), yet lack lived
166 experience.[27] It is the responsibility of the public health community to ensure that community expertise
167 is meaningfully and sustainably integrated into public health activities.[20,27] This responsibility includes

168 acknowledgment of the role public health institutions have played in eroding the trust of structurally
169 marginalized groups, and active restitution for those trust-destroying practices.[24,27,28]

170 Evidence supports the advantages of integrating lived experience within public health systems
171 (e.g. Peer Services, Promotores), demonstrating clinically significant benefits, including reduced need for
172 costly hospitalization.[20,22,29] Services provided by people with lived experience must not be used to
173 offset labor or budget shortages with lower cost services, but integrated as complementary services that
174 improve quality throughout the system. Lived experience must be valued: financial compensation should
175 be comparable for services typically requiring academic and professional credentials.[30] Investing a
176 portion of the resources currently used to fund management consultants to support community-based
177 expertise can result in more appropriate and sustainable public health solutions centered on community-
178 benefit.[31] In addition to financial compensation, there are opportunities to continue engaging
179 communities who have provided expertise and information, such as using institutional ties and influence
180 to support community action and advocacy related to the health challenge.[20,27,30]

181 **2. *Incorporate place-based and environmental justice approaches***

182 “Place” is a long-established social determinant of health, with widespread development of place-
183 based approaches to achieve health equity.[32,33] In the U.S., racist practices and policies have
184 segregated urban and rural geographies which shapes determinants of health, creating geographic health
185 disparities. Public health practitioners using place based approaches should consider the interaction of
186 community diversity and geography in the public health process.[29] Communities may self-define based
187 on geographic boundaries that differ from administrative boundaries tied to funding streams, health data
188 aggregation boundaries, or government catchment area that control upstream policies.[12,32,34]

189 Geographically defined communities include members with intersecting identities. There is no
190 single set of best practices that applies to all different community makeups; however, a few universal
191 strategies have emerged.[1,32] Public health practitioners must honor differential relationships and power
192 dynamics at play within participating communities and with the public health community: this requires
193 reflexive self-examination by the public health team, and the development of multi-level participatory
194 strategies.[1,32,35]

195 CBPP activities are often designed with a geographic component to advance environmental
196 justice (EJ), a social movement based on the principle that environmental risks, protections, and benefits
197 should be distributed equally to all people, recognizing that “dominant political and economic structures
198 disproportionately locate environmental pollution and other sources of health risk with communities in
199 poverty and communities of color.”[35] Since environment is a critical determinant of health, public

200 health practitioners must address and acknowledge “EJ communities,” which are usually geographically
201 defined.[2,27]

202

203 **3. *Develop action-focused community-feedback loops***

204 Feedback mechanisms that result in corrective action and improved interventions have long been
205 used to identify and address implementation challenges; instituted globally in resource-limited and
206 emergency settings, their feasibility is well established.[36] Tools that highlight the value of integrating
207 action-focused community-feedback loops, such as Health Equity and/or Racial Equity Impact
208 Assessments, are recommended in the U.S. given pervasive health inequities by race and ethnicity.[20,21]
209 Feedback mechanisms should be context- and community-specific, taking into account both community
210 acceptability of and familiarity with the mechanism; a variety of feedback mechanisms may be required.
211 Expectations for community members and public health practitioners should be jointly established up
212 front, with pre-determined check-ins to evaluate performance and implement necessary changes.
213 Feedback mechanisms must necessitate responsive action, including the acknowledgment of received
214 feedback and appropriate communication of actions taken.[32]

215 From an intervention perspective, Evidence-Based Practices (EBP) are recommended by funding
216 institutions due to scientifically backed results; to align with the evidence, such programs are
217 implemented as-is to ensure fidelity to the model. However, studies supporting EBPs often have small
218 sample sizes from culturally, linguistically, and/or socioeconomically diverse communities, limiting the
219 generalizability of the evidence base.[20] If the evidence base supporting EBPs has not been fully
220 established for the populations being served, more information is needed to ensure effectiveness beyond
221 acceptability and feasibility.[37] Given the high costs of EBPs, the potential for inefficient investments in
222 programs that are not well-evidenced for the communities experiencing health inequities must be
223 considered. Action-focused community feedback loops can detect potential inefficiencies of EBPs within
224 service communities and redirect resources more effectively for greater impact.[20]

225

226 **4. *Address gaps in knowledge through Community-Based Participatory Research***

227 Participatory research approaches such as CBPR and youth participatory action research (YPAR)
228 are built on an understanding that more traditional, researcher-driven approaches to building knowledge
229 often exclude the critical knowledge and insights of those most adversely impacted by social, economic,
230 and political inequities.[14,38] Systemic inequities impact the information generated, knowledge gained,
231 and ways in which data are collected and used. The resulting understanding of public health challenges is
232 partial and distorted. This directly impacts resource allocation, community trust in public health systems,
233 and uptake of public health activities. In order to meaningfully address systemic inequities, members of

234 disproportionately affected communities should be engaged in identification of research questions,
235 decisions about data needed to understand public health phenomena, the interpretation of findings, and
236 decisions about actions based on study findings.[27]

237 CBPR is a partnership approach to research that equitably involves community members,
238 organizational representatives, and researchers in all aspects of the research process, including leadership
239 and decision-making about how to apply research findings in public health practice and to support
240 relevant policy change.[10,14] All partners contribute their expertise and share responsibilities and
241 ownership of projects designed to enhance understanding of a given phenomenon as well as integrate the
242 knowledge gained with action to improve the health and well-being of community members. With roots
243 in emancipatory movements for equity in both the global South and North, CBPR is a feasible and
244 powerful approach that leverages multiple methods.[10,14,27] These include quantitative methods (e.g.,
245 traditional, short-response surveys, validated scales, and the use of administrative data sets) and
246 qualitative methods (e.g., in-depth interviews with numerous opportunities for substantive, personal, and
247 other insights; focus groups; and visual and narrative methods such as photovoice and storytelling) that
248 can fill gaps in public health knowledge, focus research on community priorities, identify barriers to
249 community wellness, create community-specific solutions to health challenges, and offer benefits to the
250 participants themselves.[14,27,39,40]

251 To advance and improve CBPR efforts, public health investments that amplify the capacity of
252 structurally marginalized communities to initiate and lead formal research activities on issues that directly
253 impact them are critical. Building career ladders for the workforce by investing in training and capacity
254 building for people with lived experience of inequities to lead research activities is one approach.[20,41]
255 This will not only benefit the expansion of knowledge required to advance health equity, but will sustain
256 and strengthen the field of public health over time.[42] For example, the National Institutes of Health
257 Community Engagement Alliance (CEAL) program built rapid new partnerships between researchers and
258 members of hard hit communities facing the COVID-19 pandemic to improve access to care.[43]

259 Participatory approaches to research can have substantial cost benefits. Not the least of these is
260 the additional effectiveness of interventions when the knowledge, insights, values, and priorities of
261 disproportionately impacted communities are understood and built into intervention efforts. Although this
262 aspect is rarely assessed in published literature, a 2020 study describes the hundreds of billions of dollars
263 wasted in medical research with a key contributor being limited relevance to communities served.[44]
264 Population health surveys are expensive to conduct and cost-saving strategies often limit the inclusion of
265 populations that are considered small, such as American Indian and Alaska Native (AI/AN) and
266 Multiracial populations. Many studies utilize census data, which are known to have significant flaws with
267 counting some structurally marginalized populations, to develop sampling plans.[10,45,46] The systemic

268 nature of racism requires us to acknowledge these limitations and consider alternative strategies to adjust
269 for these deficiencies in the near term. Integrating participatory processes within these heavily funded
270 research studies can improve the focus of research to result in clinically- and community-meaningful
271 activities, while also reducing waste.[44,47]

272

273 **5. Operationalize data equity in Public Health**

274 The COVID-19 pandemic demonstrated the limits of the Health Insurance Portability and
275 Accountability Act when emergency exceptions waiving the Privacy Rule resulted in unprecedented
276 disclosure of Protected Health Information. The pandemic also brought to light deficiencies in an
277 antiquated data infrastructure, resulting in large investments in modernization efforts and cross-sectoral
278 data-sharing partnerships. *Data equity* refers to examination and improvement of the ways in which data
279 are collected, analyzed, interpreted, and distributed in the context of health equity; data equity is
280 inherently participatory.[48] Failing to honor data equity in public health practice is counterproductive to
281 meaningful social change and can mask existing or emerging inequities. The Urban Indian Health
282 Institute identifies the catastrophic impact of systemic “data genocide and data terrorism that is evident by
283 being eliminated in the data and what scarce data is available being used to harm tribal nations and their
284 citizens.”[45] Similarly, inequitable data practices result in inaccurate interpretation of available
285 information, resulting in harmful practices, inadequate solutions, and worsening health inequities.[49,50]

286 As health inequities are often connected to historical trauma and prolonged oppression, data
287 equity, including indigenous data governance and data sovereignty, are critical concepts for the public
288 health community to adopt.[51,52] The Intersectionality Framework developed by American Civil Rights
289 advocate and contributing scholar of Critical Race Theory (CRT) Kimberlé Crenshaw is a theoretical
290 framework for understanding how multiple social identities intersect at the micro level of individual
291 experience to reflect interlocking systems of privilege and oppression at the macro social-structural
292 level.[26] Intersectionality is critical to operationalize in any data plan because people experiencing the
293 greatest risk for inequities often have multiple social identities that place them at a risk for oppression.
294 Racial Justice is a vision and transformation of society to eliminate racial hierarchies and advance
295 collective liberation.[53] A Racial Justice Framework is foundational in all data practices because it is
296 impossible to advance health equity and social change without it. Successfully implementing these or
297 similar frameworks for data equity requires a participatory approach inclusive of structurally marginalized
298 communities: communities determine when the goals have been achieved.

299

300 **6. Formalize power-sharing and collective control**

301 Power-sharing and collective control have positive impacts on health.[54,55] Public health
302 programs that focus on “empowerment” through unidirectional knowledge sharing are limited by reliance
303 on a deficit-focused understanding of health inequities that overemphasizes individual responsibility and
304 fails to acknowledge or address systemic and structural barriers that result in disempowerment and
305 ongoing health inequities.[56,57] A deficit-focused approach neglects the existence and intersection of
306 resources that are already present in the community.[58] This approach is paternalistic and does not
307 reflect a truly participatory approach to engagement.[55]

308 Public health institutions can work effectively with other sectors and communities as partners for
309 advancing health and wellbeing.[33] Public health can recruit people with lived experience of being
310 marginalized into leadership positions, including executive-level and other roles that involve decision-
311 making and oversight of activities, such as Boards of Directors.[42] Public health practitioners can also
312 seek opportunities to partner with, and support, social movements for equity as foundational to promotion
313 of health equity.[59] Such efforts are cost efficient in supporting and sustaining self-determined
314 objectives and priorities of structurally marginalized communities.[59]

315 Public health research activities involving human subjects are normally overseen by Institutional
316 Review Boards (IRB), with responsibility for ensuring ethical and regulatory compliance. In many public
317 health departments, IRBs also review proposed interventions and evaluation activities. IRBs are an
318 essential part of the public health ecosystem, yet they often have requirements inconsistent with
319 CBPR/CBPP, and lack the ability to identify and assess community-specific concerns around research
320 and data, monitoring and evaluation activities, or interventions, unintentionally placing communities at
321 risk.[60,61] AI/AN communities responded to the inadequacy of many IRBs by establishing Tribal
322 Institutional Review Boards.[62] This approach can be adapted to any community context by establishing
323 Community Research Review Boards (CRRB), an approach that includes training community members to
324 conduct the formal review process of research, monitoring and evaluation activities, and public health
325 interventions.[63,64] Similar to IRBs, CRRBs establish guidelines for activities within their community
326 and have decision-making power on how activities proceed. These CRRBs are made up of individuals
327 with lived experience who represent the community to be studied, including community priorities and
328 concerns when it comes to research. The successful implementation of CRRBs demonstrates feasibility,
329 ethical alignment of research activities, and promotion of community benefit; Community Research
330 Review Boards are an important step towards addressing systemic inequities and long-standing ethical
331 dilemmas in research.[52,63]

332

333 **III. Action Steps to Implement Evidence-Based Strategies**

A5: Advancing Community-Based Participatory Practice in Public Health

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

		3	Integrate community expertise through multiple modalities throughout the research process; ensure research aims meet community priorities.
		4	Be reflexive about the identities of the research team and account for power dynamics in leadership plan and research design.
		5	Document a collaborative plan for achievement of consensus and conflict resolution.
		6	Include community in data collection and analysis, interpretation of results, and dissemination of findings.
5	Operationalize data equity in public health	1	Build capacity around intersectionality and racial justice; integrate within data management and analysis plans.
		2	Critically review existing data systems for knowledge gaps and to identify populations routinely underrepresented/excluded.
		3	Develop partnerships with identified communities to co-develop novel data streams.
		4	Ensure tools, methods, and approaches are community responsive.
		5	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	1	Policymakers to engage community-public health partnerships in the process of policymaking and evaluation.
		2	Formalize power-sharing and shared leadership between institutional public health staff and community experts.
		3	Facilitate the development of CRRBs; incorporate into IRB workflows.

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IV. Opposing Arguments

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

- 338 1) *The lack of perceived interest in engagement from communities.* Communities that continue to
339 experience health inequities have both historical and present-day lived experience that result in
340 mistrust of public health systems.[65] It is important to consider that although there is no one “right”
341 way to engage the communities we serve, there is potential for missteps: community engagement has
342 historically been deployed to tokenize or exploit communities. Failure to correct missteps can lead to
343 the devaluation of community input, further disenfranchisement, and spread of misinformation.
344 Preventing potential missteps requires addressing the varied opinions that challenge the integration of
345 CBPP approaches, acknowledging the history and current realities of under-resourced communities,
346 political tensions, and socioeconomic inequities that hamper engagement, and being trustworthy,
347 holding central the tenet that authentic community engagement is vital for public health.[19,66,67]
348 Additionally, funders, such as the National Institutes of Health, are now requiring or strongly
349 encouraging authentic community engagement.[68]
350
- 351 2) *Definition of “community.”* While evidence is clear that there is immense value in community-level
352 strategies and partnerships, debate on the definition of ‘community’ can delay, impede, or even
353 restrict engagement efforts.[19,32,33] While institutions regularly define “community” based on
354 historic, administrative, or operational boundaries, communities often define themselves based on
355 solidarity or common perspectives which can be difficult to quantify, locate, and even
356 describe.[11,12,25] Public health practitioners must work in partnership with communities to consider
357 community definitions that may challenge historic institutionally-led definitions, which will often
358 require negotiation with and acceptance of ambiguity by institutional leadership.[32,33] Use of fluid
359 and community-driven definitions, and recognizing that communities may be geographic, identity-
360 based, or some combination of these. is essential to effect partnerships.[14]
361
- 362 3) *Not “evidence-based.”* Leaders and community members may reject interventions that have not yet
363 been proven by a randomized controlled trial (RCT), despite known limitations of RCTs and costs
364 associated with certifying a practice as “evidence based.”[69,70] Limitations in the evidence base for
365 this type of work are plentiful, particularly due to the absence of representation of communities
366 experiencing health inequities.[71] Too often studies focus on demonstrating the feasibility or
367 acceptability of evidence derived from RCTs, while ignoring the critical need for evaluation of
368 success, barriers, and consequences to communities. In addition, such approaches may ignore the
369 reality that evidence-based programs are organically adapted to be more suitable to the service
370 population, resulting in poor fidelity to the model. As with defining “community,” negotiation with

371 institutional leadership may be required to implement CBPP, especially when working to implement
372 community-led and community-derived programs that may not yet have a robust evidence base.[68]
373

374 4) *Insufficient resources*. Public health practitioners work within the confines of modest and dwindling
375 resource environments.[72,73] CBPP is thought to be time and resource-intensive, and health
376 departments and CBOs may not have staff to support such projects.[72] At a time when public health
377 funding is under threat, many health departments, elected officials, and CBO leaders may be hesitant
378 to resources in work not seen as mission-critical, or whose gains may not be achieved within a fiscal
379 period or political term.[73,74] While it may be widely understood that there is demonstrable cost
380 benefit in direct investment in in public health, health equity strategies, and in communities, cities and
381 states facing fiscal constraints will inevitably direct resources towards low-resource solutions with
382 shorter-term gains.[73,74] Increased engagement in CBPP may, over time, lead to innovations that
383 reduce resource intensity.[25,74] However, institutional leadership must be careful to avoid quick-
384 win solutions that lack long-term sustainability and results; the long-term costs of growing health
385 inequities, ineffective interventions, and increasing mistrust outweigh the relatively small upfront
386 investment often required by participatory approaches.[73-75] In fact, with the increasing adoption of
387 online and virtual participatory strategies, resource limitations are becoming less of a concern.
388

389 Although truly participatory community engagement takes resources, time, effort and forethought on
390 the part of all parties involved, it is never too late to initiate.[16] Public health is ultimately about people,
391 not necessarily credentialed scientists, politicians, or academic institutions. We cannot afford to leave
392 people and their communities out of the equation.[25]
393

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