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Journal of Health Communication
International Perspectives

ISSN: 1081-0730 (Print) 1087-0415 (Online) Journal homepage: www.tandfonline.com/journals/uhcm20

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To cite this article: Carina Zelaya , Cynthia Baur , Anita Atwell Seate , David Liendo Uriona , Christina Getrich , Lahne Mattas-Curry & Brooke Fisher Liu (24 Jul 2026): Connecting Communication Competencies to Public Health Practice: Community Health Workers as Non-Traditional Risk Communicators, Journal of Health Communication, DOI: 10.1080/10810730.2026.2697429

To link to this article: https://doi.org/10.1080/10810730.2026.2697429

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Published online: 24 Jul 2026.

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Journal of Health Communication, 00: 1–10, 2026
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ISSN: 1081-0730 print/1087-0415 online
DOI: https://doi.org/10.1080/10810730.2026.2697429

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Connecting Communication Competencies to Public Health Practice: Community Health Workers as Non-Traditional Risk Communicators

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Public health crises depend on trusted community-based workers who interpret guidance, address local concerns, and help residents act under uncertainty. Existing crisis communication frameworks, including Crisis and Emergency Risk Communication (CERC) and Risk Communication and Community Engagement (RCCE), recognize the importance of community-centered approaches but offer limited guidance on what this work requires in practice. This study examined how community health workers (CHWs) serving Latine communities developed and applied communication competencies during and after the COVID-19 pandemic. We conducted two rounds of in-depth interviews with 41 CHWs in a large U.S. metropolitan area, capturing experiences across response and recovery contexts. Using thematic analysis with a hybrid deductive–inductive approach, we identified six communication competencies: (1) information seeking, sensemaking, and verification; (2) strategic communication and message design; (3) conversational and cultural interaction; (4) digital and media communication; (5) collaborative and team-based communication; and (6) system navigation and resource linkage. CHWs combined these competencies as coordinated practice rather than discrete skills. Findings extend CERC and RCCE by translating broad principles into teachable practices and provide a foundation for strengthening CHW training, supervision, and integration into emergency communication preparedness, particularly for linguistically and culturally diverse communities.

KEYWORDS

Community-based public health, public health workforce, risk communication, communication competencies, Latine health

Public health crises require more than just institutional messaging. They also depend on trusted community-based workers who interpret guidance, address local concerns, and help residents make decisions under uncertainty. Since the early 2000s, the Crisis and Emergency Risk Communication (CERC) has guided public health organizations in preparing for and responding to emergencies (Miller et al., 2021; Reynolds & Seeger, 2005). CERC emphasizes the importance of timely, accurate, and empathetic communication to alleviate uncertainty and promote protective action (Centers for Disease Control and Prevention [CDC], 2018). While CERC has shaped how institutions and spokespersons communicate during crises, it offers less guidance for community-based workers who carry out this work through everyday conversations, trusted relationships, informal networks, and culturally grounded communication.

The COVID-19 pandemic made this gap especially visible. Prolonged uncertainty, rapidly changing guidance, misinformation, and uneven trust in public institutions required more relational, adaptive, and locally grounded communication (Diers-Lawson, 2025; Hannes et al., 2024). Research showed that top-down communication often failed to reach linguistically and culturally diverse communities. As a result, there was an increased reliance on trusted intermediaries and community-based networks to interpret and disseminate crucial information (Krystallidou & Braun, 2022) (Leslie et al., 2025). In response, scholars have called for updates to CERC that better account for culture, community engagement, and non-traditional communicators who

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work outside traditional institutional communication roles (Diers-Lawson, 2025; Sellnow & Seeger, 2025).

The World Health Organization's (WHO) Risk Communication and Community Engagement (RCCE) framework responds to similar concerns by centering community participation in public health communication. RCCE emphasizes two-way communication, listening, community engagement, and adaptation to local contexts across preparedness, response, and recovery (WHO, 2024, 2026). Unlike traditional approaches that focus solely on disseminating messages, the RCCE framework emphasizes the skills and practices that public health workers need to engage communities effectively and inclusively. It also treats communication as a workforce competency rather than only a messaging function, making it especially relevant for training and preparedness across public health roles (WHO, 2024, p. 2).

Community health workers (CHWs) played a vital role in public health before and during the COVID-19 pandemic, particularly in Latine communities across the United States (Hernandez-Salinas et al., 2023; Ingram et al., 2012; Oliver et al., 2024). Positioned between public health systems and community networks, CHWs translated guidance, responded to misinformation, and addressed residents' concerns in real time (Marquez et al., 2023; Petruzzi et al., 2025; Salve et al., 2023). Their work offers a useful case for examining how broad crisis communication and community engagement principles translate into specific communication competencies in community-based public health practice.

These shifts in crisis communication point to a key gap: frameworks increasingly recognize the importance of community-centered approaches but offer limited guidance on what this work requires in practice. This study addresses that gap by examining CHWs' accounts to identify the competencies they rely on across crisis and recovery contexts. By specifying these competencies, we show how community-based communication capacity can be better defined, taught, and supported through crisis communication frameworks and public health workforce development.

Literature Review

CHWs as Community-Based Communicators

Globally, CHWs are widely described as lay or paraprofessional workers who provide culturally grounded health and social support within their communities (Logan, 2022; Olaniran et al., 2017). They work under many titles, including community health advisors, patient navigators, outreach specialists, and *promotores de salud*, a term commonly used for CHWs serving Latine communities (Kowalczyk et al., 2024; Oliver et al., 2024). Although their roles vary across geographic and organizational settings, CHWs share a common purpose: building trust, sharing information, and helping residents navigate health and social systems (Knowles et al., 2023; Salve et al., 2023).

Communication is central to this work, but existing research often treats it as part of CHWs' general role rather than as a set of competencies that can be named, taught, and supported. In this study, we define communication competencies as the knowledge, skills, and context-specific practices that enable CHWs to gather, interpret, adapt, deliver, and coordinate health information across community and organizational settings (Spitzberg & Cupach, 1984; WHO, 2024). CHWs explain institutional guidance, address misinformation, and use lived experience to strengthen credibility with community members (Logan, 2022; Logan & Castañeda, 2020). They also adapt messages to reflect community values, beliefs, and family-centered communication norms (Hernandez-Salinas et al., 2023; Palmer-Wackerly et al., 2020). Yet the literature gives less attention to how CHWs learn to tailor messages, respond to uncertainty, manage sensitive conversations, and communicate across community and institutional settings in both routine and high-stakes situations.

Latine communities are an important context for examining these competencies because communication often occurs across linguistic, cultural, and structural boundaries. Many Latine communities navigate language barriers, immigration-related concerns, uneven access to health information and services, and information flows from both local and transnational sources (Hernandez-Salinas et al., 2023; Marquez et al., 2023). This makes CHWs who serve Latine communities particularly helpful in identifying the communication skills needed for effective community-based public health practice.

Limits of Existing Communication Competency Frameworks

Current CHW training and competency frameworks often acknowledge communication but do not define it as a distinct, multidimensional competency. For example, New York's scope of practice links communication to "outreach" and "health coaching," while Minnesota's curriculum frames it within "advocacy" and "relationship-building" (Findley et al., 2012; Rosenthal et al., 2016). CERC and RCCE also offer useful guidance, but they leave community-based practice underspecified. CERC focuses on credible institutional communication and actionable guidance during emergencies, while RCCE broadens the focus toward participatory, locally responsive engagement and workforce preparation (CDC, 2018; WHO, 2024). These frameworks align with CHW work, but they provide less detail on how community-based workers apply communication principles in everyday outreach, education, and service encounters. Without clearer specifications, communication can be assumed rather than intentionally developed, trained, and supported. This limits how public health systems prepare CHWs to navigate misinformation, uncertainty, diverse literacy levels, institutional constraints, and structural barriers in real time (Ingram et al., 2012; Kowalczyk et al., 2024; Logan & Castañeda, 2020; Owens-Young & Leider, 2026; Perry et al., 2021).

Communication Demands in Public Health Emergencies

Public health emergencies intensify CHWs' communication work because information changes quickly, community concerns shift, and misunderstandings can have immediate consequences. Evidence from earlier crises, including the Ebola outbreak and the 2015 Nepal earthquake, shows that CHWs helped communities interpret risk messages, contextualize

prevention guidance, and cooperate with public health authorities in culturally grounded ways (Fredricks et al., 2017; Springgate et al., 2011).

COVID-19 expanded these responsibilities. CHWs responded to changing guidance, misinformation, digital outreach demands, and heightened fear and uncertainty within communities (Hernandez-Salinas et al., 2023; Marquez et al., 2023; Oliver et al., 2024). This work required more than delivering messages. CHWs had to interpret incomplete information, verify guidance before sharing it, adapt messages to local concerns, manage sensitive conversations, coordinate with colleagues, and help residents connect to services. To strengthen training and workforce development, we need a clearer account of the competencies that enable this work. This study, therefore, examines how CHWs serving Latine communities developed and applied communication competencies during crisis and recovery periods.

Method

Study Design

After Institutional Review Board (IRB) approval, we conducted two rounds of in-depth interviews with CHWs. The first round focused on communication during the federal public health emergency from January 2020 to May 2023. The second round examined communication after the emergency ended on May 11, 2023, as organizations shifted toward long-term recovery and non-COVID-19 concerns. We captured CHW experiences across response and recovery rather than comparing the two periods.

Recruitment and Eligibility

We recruited CHWs serving Latine communities in a large U.S. metropolitan area through four local organizations that employed or partnered with CHWs during the pandemic. These organizations distributed a Qualtrics eligibility survey. Eligibility criteria varied by interview round: the first required CHW experience at any point between January 2020 and May 2023, and the second required current CHW employment or CHW experience through at least December 2024. Participants did not need to have worked continuously across the full emergency period.

Participants

A total of 41 CHWs completed in-depth interviews, with 20 conducted in the first interview round and 21 in the second. Participants ranged in age from 25 to 65. The sample was predominantly female (94%), consistent with the broader CHW workforce (Scott et al., 2018). All but two participants identified as Hispanic, Latino, or Latine, and 38 held CHW certification at the time of the interview. Participants represented a mix of employment roles, including volunteers (37.5%), part-time workers (35.0%), and full-time workers (27.5%), with experience levels ranging from early career to over 20 years in CHW roles.

Interview Guide

We used semi-structured interview guides to explore CHWs' communication practices, challenges, and experiences. In the first round, we asked open-ended questions about CHW roles, outreach and education strategies, misinformation, trust, community concerns, and organizational support for communication (see Appendix A). In the second round, we retained these topics but revised the wording and probes to focus on post-emergency communication, including relationship maintenance, communication adaptation, and ongoing community needs (see Appendix B). Rather than asking participants to summarize the pandemic, we asked for specific examples from different periods, including early response, testing and vaccination, and later shifts in community needs. We pilot tested each interview guide with two CHWs before data collection; because no substantive changes were needed, we included these interviews in the final dataset.

Data Collection

We conducted all interviews via Zoom. We obtained verbal consent before each interview. Bilingual team members (C. Z. and D.L.U.) conducted all interviews, which lasted 37 minutes to 2.5 hours. Participants received a $50 Tango gift card. Most interviews were conducted in Spanish ($n = 37$). The same bilingual team members reviewed and verified translations before importing transcripts into NVivo 15.3.1.

Data Analysis

We analyzed transcripts using thematic analysis (Braun & Clarke, 2006) with a hybrid deductive–inductive coding approach (Tracy, 2024). Two authors (C.Z. & C.B.) independently reviewed the transcripts to familiarize themselves with participants' accounts and identify initial patterns related to CHW communication practices and challenges. An initial codebook was developed and applied to a subset of transcripts, followed by discussions to clarify definitions and reconcile coding differences. The codebook was refined throughout this process. After finalizing the codebook, both authors coded the remaining transcripts and regularly discussed themes and interpretations. The final list of themes was reviewed and approved by the other authors.

Results

Our analysis identified six communication competencies CHWs used across community, organizational, and digital settings during and after the COVID-19 pandemic: 1) information seeking, sensemaking, and verification; 2) strategic communication and message design; 3) conversational and cultural interaction; 4) digital and media communication; 5) collaborative and team-based communication; and 6) system navigation and resource linkage. Together, these competencies show CHW communication as coordinated practice across settings.

Competency 1: Information Seeking, Sensemaking, and Verification

Before deciding what to communicate, CHWs first assessed, interpreted, and verified information. Information seeking involved learning what residents needed, what questions they had, and what information organizations required. Sensemaking involved interpreting that information in context, especially when it was incomplete, sensitive, or tied to trust. Verification involved checking information before sharing it to avoid passing along inaccurate or unsupported guidance.

CHWs described this judgment as especially important when collecting information through organizational intake and exit surveys during outreach and service encounters. Some questions, particularly those about immigration status, discouraged participation. Teresa explained, "People shut down at that question [immigration status] … They think, 'They are going to investigate us,' so we fought to remove it." CHWs had to consider how residents might interpret these questions and whether they could damage trust.

Even basic contact information could raise concerns. As Gloria noted, "They trust us, they listen to us … but they still do not want to share that." CHWs used these reactions to understand which questions made residents uneasy, explain why information was needed, and avoid questions that could make residents feel uncomfortable or unsafe.

CHWs also described verifying information before sharing it. Maria explained, "I don't always have all the answers, but I'll say, 'I don't have that information right now, but I'll follow up with you once I have it,' because I don't want to risk spreading false information." Veronica similarly described waiting to share updates until she confirmed them through official sources: "That's why I sometimes take longer to share something, because I want to verify it. Unless it's posted directly by the county … I check their Facebook page and see what's really happening."

After CHWs determined what information was trustworthy and relevant, the next competency involved turning that information into messages residents could use.

Competency 2: Strategic Communication and Message Design

This competency shows that CHWs acted as message designers, not just information messengers. Strategic communication and message design involved deciding what to share, how much to include, when to share it, and which format would make information most useful for residents. CHWs described shaping information so residents could focus on what mattered and avoid being overwhelmed. Brenda described how she filtered dense institutional materials: "I take out what doesn't apply and just explain the part they need … I'm not going to send 20 flyers … They'll just glance at it and move on."

Community questions also shaped what CHWs communicated. Lorena described using residents' recurring questions to guide her posts: "I listen to what they're asking about … then that's what I choose to post. I'd rather post what's needed than general things." This helped CHWs prioritize timely, relevant information over broad updates.

CHWs also adapted messages when residents encountered confusing or inaccurate information, including information from outside the United States. Gloria described clarifying vaccine guidance by focusing on what was locally available: "Giving them concrete information about the vaccines available here was very useful because it helped them understand exactly what we were talking about." In these situations, CHWs made guidance more specific and easier to apply.

Across these examples, CHWs described strategic communication as shaping information before sharing it. They selected, simplified, timed, and localized messages so residents received relevant, manageable information. After designing messages, CHWs then had to manage how those messages were received in conversation. These message-design decisions set up the next competency: managing how residents received and responded to information in conversation.

Competency 3: Conversational and Cultural Interaction

Conversational and cultural interaction involved adjusting tone, pacing, examples, and guidance in response to residents' questions, emotions, beliefs, and cues. Unlike message design, which focused on preparing information in advance, conversational and cultural interaction centered on real-time responsiveness.

Catalina described this process as "dancing with the community." She explained, "When I say 'dance,' I mean trying to give people confidence … We made it clear that it was their decision to get vaccinated … But still, we can guide them." CHWs described this balance as important: they offered information and encouragement without pressuring residents or taking away their sense of choice.

Cultural beliefs also shaped how CHWs managed conversations. Bianca described responding to traditional practices such as "egg cleansing" by acknowledging the practice and then encouraging clinical care: "You have to respect that because it's part of the culture. But then I'll say, 'Okay, along with the egg cleansing, how about going to a clinic for a check-up?'" Across CHWs' accounts, cultural responsiveness meant working with residents' beliefs rather than simply correcting them. CHWs kept conversations open by avoiding judgment and responding in ways that felt respectful.

CHWs also created dialogue through listening and concrete examples. Rocio described using simple demonstrations instead of scripted presentations: "People understand if you show them an apple, show them a bottle, show them something, and listen to them … It opens up more dialogue." This reflects another common approach: CHWs used conversation, simple examples, and listening to help residents engage with health information.

Across these examples, CHWs described conversational and cultural interaction as the ability to read the room, respond with respect, and adjust their approach in real time. While this competency centered on interpersonal exchanges, CHWs also had to adapt communication through digital and media channels when outreach moved online or required technology support.

Competency 4: Digital and Media Communication

During the pandemic, CHWs relied more heavily on phones, QR codes, video platforms, social media, and messaging apps to share information and connect residents to services. Many said they had to learn these formats without formal training while also helping residents use them.

Digital communication depended on residents' access to devices and comfort with technology. CHWs did not assume residents could easily open a camera, scan a QR code, join a video call, or use an online platform. Teresa described walking residents through basic phone functions: "Some people don't know how to turn on their phone … I'll say, 'Okay, let's go to the little camera icon' … And they get surprised when they see themselves on screen." Lorena described helping residents use QR codes: "I'd say, 'Look, I've never done it before, but I can try.' I'd test it out, and we'd figure it out together … I explain each step … and I leave it installed on their phone."

When communicating with larger groups, CHWs chose platforms that residents already used and could access. Gloria described using Facebook Live to provide updates, answer questions, and communicate across languages: "We had a -health hour on Facebook … We made them interactive, answered questions, and provided updates … We did it trilingual." CHWs described social media as useful when it allowed residents to receive updates, ask questions, and participate in familiar digital spaces.

Digital and media communication, therefore, involved assessing access, teaching basic digital steps, choosing familiar platforms, and keeping communication interactive. Digital tools also supported internal coordination, which became central to how CHWs kept information current and responded to residents' needs.

Competency 5: Collaborative and Team-Based Communication

CHWs described collaborative and team-based communication as necessary to manage the volume and variability of community needs. No single CHW could track every available resource, policy change, or referral option. Instead, CHWs relied on coworkers, peer groups, and partner organizations to keep information current and coordinate responses.

Group messaging served as a real-time coordination tool. Carolina described using WhatsApp to monitor community concerns and verify resource availability: "We have a WhatsApp group where we share and ask each other, 'What is the community saying?' or 'Are they still giving away diapers at that location?' … We don't keep it to ourselves." These exchanges helped CHWs confirm details quickly before directing residents to specific services.

CHWs also turned to colleagues when they needed help identifying the right referral or next step. Bianca described posting questions to a WhatsApp group when she did not know where to refer someone: "If we have a case and we do not know where to turn, we post it [in the WhatsApp group] … and everyone chimes in: 'Check out this place,' 'Refer her to this one.'"

Resource information often varied by area, so CHWs joined multiple local groups. Natalia explained, "We needed to belong to all of them because they were from different localities … Sometimes a person asks us for something, and we know we will find it there." These connections helped CHWs respond to needs that extended beyond their own organization or service area.

Across these accounts, collaborative and team-based communication helped CHWs keep information current, draw on collective expertise, and coordinate referrals. Once CHWs identified resources through team communication, they still had to help residents understand and move through the systems where those resources were located.

Competency 6: System Navigation and Resource Linkage

As we have reported elsewhere Liu et al. (2026), system navigation and resource linkage involved helping residents understand how to access health and social services. CHWs explained eligibility rules, appointment procedures, costs, and service limits, especially when outcomes depended on clinics or agencies.

One part of this competency involved explaining institutional requirements without overpromising. Valentina described how she set boundaries around what she could guarantee: "I always try to explain that each clinic has its own rules. I don't say, 'It'll be free,' or 'You'll definitely qualify,' because that's not up to me." CHWs described being careful not to promise free care, eligibility, or service availability unless they could confirm it.

CHWs also clarified administrative language that could be confusing for residents. Isabel described how even common terms required explanation: "When the flyer said 'first come, first served,' it was difficult to explain to the community … I had to clarify what that meant." In these cases, CHWs turned institutional language into practical steps residents could follow.

System navigation also required assisting residents in completing the steps that followed a referral. Melisa described how this looked in practice: "Part of helping was taking down information, helping them make appointments. We compiled a list of names and phone numbers, and we noted the type of case they had." CHWs used this information to track residents' needs and help them stay connected to services.

Although we present the competencies separately for analytic clarity, CHWs often used them together in practice. Information seeking shaped message design; conversational and cultural interaction shaped how CHWs delivered messages; and collaboration helped them verify information and coordinate referrals. Together, these patterns show that CHW communication competence operated as a coordinated set of practices across community, organizational, and digital settings.

Discussion

This study identifies practice-based communication competencies CHWs used across crisis and recovery contexts. Prior research has documented CHWs' roles in sharing information, supporting testing and vaccination, addressing misinformation,

and connecting residents to services (Knowles et al., 2023; Salve et al., 2023). Our findings extend this work by showing that these activities depend on coordinated competencies, not message delivery, rapport building, or trust alone. CHWs helped residents understand guidance, weigh information, ask questions, access services, and complete next steps across community, organizational, and digital settings. The typology makes visible the specific communication work behind CHWs' broader roles as community-based risk communicators.

Extending CERC and RCCE Through Practice-Based Competencies

The findings extend CERC and RCCE by showing what their core principles look like in CHWs' day-to-day communication with residents. CERC emphasizes accuracy, empathy, credibility, and action guidance, while RCCE emphasizes listening, two-way communication, community engagement, and local adaptation (CDC, 2018; WHO, 2024). In CHWs' accounts, these principles became practical decisions about what information to trust, how to respond to residents' concerns, and how to help people act on guidance.

For example, accuracy required CHWs to seek, interpret, and verify information before sharing it. Empathy required adjusting tone, pacing, and guidance in response to residents' fears, cultural beliefs, and concerns. Action guidance required explaining eligibility rules, appointment procedures, costs, service limits, and referral steps. By naming these practices, the study makes broad concepts such as trust, empathy, accuracy, and engagement easier to teach, support, and evaluate. This level of detail can help training programs move from general advice to concrete skills CHWs can practice, receive feedback on, and use in the field.

Communication Competence as Coordinated Practice

Communication competence in CHW practice was not one broad skill or a set of isolated abilities. CHWs combined related practices as they talked with residents, coordinated with teams, used digital tools, and helped people access services. Information seeking shaped message design, collaboration supported verification and referrals, and conversational skills influenced how residents engaged with guidance. No single "communication skill" captures this range of work. Training and support systems should reflect this reality by preparing CHWs for situations where assessment, adaptation, coordination, and follow-up happen together.

Implications for CHW Training and Workforce Support

The findings provide a concrete basis for communication-informed CHW training. Rather than offering general advice about trust or rapport, training should prepare CHWs for the situations they actually encounter: making decisions with incomplete information, adapting messages to different literacy and access needs, coordinating with colleagues, and helping residents navigate service systems with changing rules or availability. Three areas stood out as especially important for training and workforce support: digital communication, information uncertainty, and service navigation.

Digital communication is one clear example. CHWs used online platforms for outreach. However, many residents needed help using the technology before they could access information or services. CHWs often had to provide that help while learning the tools themselves. Many learned these tools informally rather than through structured training. Future training should therefore cover both how CHWs use digital tools and how they teach residents to use them.

CHWs also need clearer preparation for communicating in uncertain situations. This is especially important when guidance changes quickly, or residents ask questions that CHWs cannot answer immediately. In these situations, CHWs need practical strategies for checking sources, explaining uncertainty, following up when they do not have an answer, and deciding which questions are appropriate to ask residents.

Service navigation created another communication challenge for CHWs. CHWs frequently had to explain institutional limits they could not control, such as eligibility, costs, appointment procedures, and service availability. Training should help CHWs communicate these limits clearly, set realistic expectations, and guide residents through the steps after a referral.

Training alone, however, cannot support this work. CHWs also need organizational conditions that allow them to use these competencies, including clear guidance, current referral information, supportive supervision, access to digital tools, language support, and time for follow-up. Stable funding, fair compensation, and manageable caseloads are also essential because they determine whether CHWs have the time, resources, and stability to carry out this communication work effectively (Kirkland et al., 2024; Schmit et al., 2022).

Implications for Public Health Communication Preparedness

These findings have implications for how public health systems prepare for emergency communication. During the pandemic, public health agencies relied on CHWs as trusted intermediaries in communities facing linguistic, cultural, and structural barriers (Hernandez-Salinas et al., 2023; Marquez et al., 2023; Michelen et al., 2025). CHWs' value came from more than message delivery. They adapted messages to residents' questions, concerns, and access needs.

For future emergencies, this means CHWs should be involved earlier in communication planning. They can help shape message content, language, tone, channel selection, and cultural relevance. They can also support rumor monitoring and feedback loops because they often hear community concerns before those concerns reach formal institutions. Treating CHWs as communication partners, rather than downstream messengers, can make emergency communication more responsive, relevant, and effective.

This implication also aligns with calls to broaden how public health and health care workers support communities in today's information environment. Southwell et al. (2020) argue that addressing misinformation requires roles beyond fact correction, including listening, relationship-building, and helping people make sense of information. Our findings extend this argument to community-based public health work by showing how CHWs help residents interpret guidance, weigh concerns, and connect information to concrete next steps.

Limitations and Future Directions

This study has several limitations. The findings reflect CHWs serving Latine communities in one large U.S. metropolitan area and may not fully transfer to other regions, populations, or employment models. The study also relies on retrospective interviews, so participants' accounts reflect how they remembered and interpreted their experiences after the most acute stages of the pandemic.

Future research should test and refine this typology across different communities, geographic settings, public health systems, and CHW employment models. Studies should also examine how communication competencies vary by training background, certification status, employer type, and organizational support. Additional work could translate the typology into training and assessment tools and identify which competencies receive the least support. Finally, research that includes community members' perspectives would help assess residents' experiences of CHW communication and which competencies matter most to them.

Conclusion

This study identifies the competencies that allow CHWs to translate public health guidance into community-centered communication across crisis and recovery contexts. These competencies offer a practical foundation for strengthening CHW training, supervision, and integration into public health communication systems. Preparing CHWs to be effective risk communicators requires more than simply asking them to relay information. Public health systems must provide the training, resources, and organizational support CHWs need to verify information, explain uncertainty, communicate across cultural and linguistic contexts, and connect residents to services. Strengthening these capacities can improve emergency preparedness and help build more responsive, accessible, and equitable public health communication systems.

Acknowledgments

We thank the organizations and the community health workers who participated in this study for sharing their time and expertise.

Author contributions

CRediT: **Carina Zelaya:** Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Project administration, Writing – original draft, Writing – review & editing; **Cynthia Baur:** Conceptualization, Formal analysis, Funding acquisition, Investigation, Methodology, Writing – original draft, Writing – review & editing; **Anita Atwell Seate:** Conceptualization, Methodology, Writing – review & editing; **David Liendo Uriona:** Data curation, Investigation, Project administration, Writing – review & editing; **Christina Getrich:** Conceptualization, Methodology, Writing – review & editing; **Lahne Mattas-Curry:** Data curation, Writing – review & editing; **Brooke Fisher Liu:** Conceptualization, Funding acquisition, Methodology, Project administration, Writing – review & editing.

Disclosure Statement

No potential conflict of interest was reported by the author(s).

During the preparation of this work, the authors used an enterprise version of ChatGPT to assist in translating Spanish-language transcripts into English. After using this tool/service, bilingual team members reviewed and edited the content as needed and took full responsibility for the content of the published article.

Funding

This work was supported by the Pandemic Readiness Initiative through the University of Maryland Grand Challenges Awards.

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Appendices

Appendix A. Interview guide for phase 1

1. How would you describe your role as a CHW during the COVID-19 pandemic?
2. What challenges do CHWs face in doing their jobs?
   Probes: Infrastructure; funding; organizational support; restricted patient access; medical mistrust.
3. Which social groups were most vulnerable to COVID-19 in your community?
4. How much do you share about your own experiences and identity in your interactions?
   Probes: What is helpful to share; how identity and experience help or hinder service delivery.
5. How did your everyday work life change during the pandemic?
   Probes: Workload; recognition by coworkers; organizational support; funding; job security.
6. What motivates you to work as a CHW?
7. Can you describe activities you were involved in to share health information during the pandemic?
   Probes: Use of social media (e.g., Facebook, Instagram, TikTok, Twitter) or messaging apps (e.g., WhatsApp); most effective platforms; message development strategies; use of toolkits or guidelines; sources of information; priority topics.
8. How did you communicate with community members to engage and educate them about COVID-19?
   Probes: What worked well and why.
9. What communication challenges did you face during the pandemic, and how did you address them?
10. How did you adapt your communication for different people or groups?
11. Can you share a time when your communication helped someone better understand COVID-19?
12. Can you share a time when your communication led someone to take a positive health action?
13. How did you use communication to build trust with community members?
14. How did misinformation about COVID-19 impact your work, and what did you do about it?
    Probes: Effective approaches; addressing vaccine misinformation.
15. What does it mean for community members to trust you as a CHW?
16. Did you or other CHWs experience mistrust from community members? Why?
    Probes: Historical experiences; cultural factors; societal factors.
17. Can you describe a situation involving mistrust and how it was addressed?
18. How did you build and sustain trust during the pandemic?
    Probes: Honesty; fairness; timeliness; confidence; preexisting relationships; responding to feedback; communication channels.
19. Tell us about a time you built relationships with community members during the pandemic.
    Probes: Challenges; hard-to-reach groups; strategies (e.g., listening, sharing identity, transparency, providing relevant information, creating safe spaces).
20. How did you know whether your relationship-building efforts were effective?
    Probes: Indicators such as trust, vaccine confidence, or engagement.
21. How did you use community events to promote health and wellness?
    Probes: Key messages; community response.
22. What did community members need your help with the most during the pandemic?
23. How did you gather feedback from community members?
    Probes: How feedback was used; whether it improved engagement or relationships.

Appendix B. Interview guide for phase 2

1. Since the end of the federal public health emergency (May 2023), what is something important you've learned about your work as a CHW? (For returning participants: This interview focuses on your work since the COVID-19 pandemic.)
2. How are you building and maintaining relationships with community members now?
   Probes: Changes since the pandemic; examples; frequency of interactions; sustained vs. one-time contact.
3. What is your proudest accomplishment in building community relationships?
4. What are your biggest challenges in building relationships?
5. How is the current political climate affecting your relationships with community members?
   Probes: Specific examples.
6. How are you building and maintaining trust in your work now?
   Probes: Whether trust from the pandemic persists; strategies to sustain long-term trust; communication messages and channels.
7. How important is trust in the organizations you represent?

Probes: Use of logos, credentials, institutional affiliation; perceived alignment with community needs.
8. What are your biggest challenges in building trust today?
   Probes: Impact of political environment; changes in community trust over time.
9. How has the way you communicate with community members changed in recent years?
   Probes: Increased skepticism; changes in engagement.
10. How do you access and share information with community members?
    Probes: Organizational vs. self-sourced information; language accessibility; effective messages; communication channels (social media, flyers, events, etc.); support networks; information overload.
11. What steps are you taking to address misinformation or rumors?
    Probes: Barriers and facilitators; verification practices; trusted sources.
12. What should public health authorities understand about your work as a CHW?
    Probes: Overlooked aspects; needed support.
13. How does your Latino/a/e identity influence your communication?
    Probes: Language, cultural references, challenges.
14. How does your understanding of local culture support your work?
    Probes: Traditions, community spaces.
15. What other aspects of your identity influence your effectiveness?
    Probes: Immigration status, gender, age, family roles, religion.
16. How does your identity help build relationships and trust?
    Probes: Examples of connection or trust-building.
17. Describe a time your identity helped bridge gaps with healthcare systems.Probes: Power dynamics; strategies used.
18. (If applicable) How does language (e.g., Spanish) influence your interactions?
    Probes: Language variation; literacy challenges.
19. What support do you provide for digital services (e.g., finding information, registering for services)?
    Probes: Training in digital literacy.
20. How has your emotional well-being been impacted since the pandemic?
    Probes: Stressors; comfort-seeking care; stigma; coping strategies.
21. What support helps you maintain your well-being?
    Probes: Organizational and community resources; unmet needs; comfort accessing support.