Involving Community Health Workers as Evaluation Leaders in a National Community Health Worker Initiative

Victoria Adewumi, Sahlea Tubbeh, Nury Stemple, Floribella Redondo, Durrell Fox, Keara Rodela, and Noelle Wiggins

The community health workers (CHWs) for COVID Response and Resilient Communities initiative further established CHWs as a critical public health workforce through substantial investment in CHW-led activities. The initiative supported CHWs at 67 sites nationwide to mitigate the most severe consequences of COVID-19 among vulnerable populations while strengthening community capacity to address future public health threats in the United States. It also created opportunities for CHWs to serve as leaders in evaluating their own profession.

Based on a review of the literature regarding CHW involvement in research and evaluation and using autoethnography, we—predominantly CHWs—describe the process of including CHWs as evaluation leaders in the initiative. We illuminate successes, such as positioning CHWs in paid team roles, and challenges, such as time constraints.

We conclude that involving CHWs as evaluation leaders helped ensure that findings more accurately reflected the strengths and needs of communities, particularly those that have been historically marginalized. Future public health efforts involving CHWs should engage CHWs in all evaluation activities, from study design through final dissemination to produce findings that are more valid and usable and contribute to CHW self-determination and CHW workforce sustainability. (*Am J Public Health*. 2026; 116(S4):S353–S357. https://doi.org/10.2105/AJPH.2026.308605)

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At the height of the COVID-19 pandemic, communities across the United States were working together to prevent disease spread and protect themselves from COVID-19's worst outcomes while attempting to address the larger systemic and generational inequities the pandemic brought into focus.[1] To accomplish both goals, communities turned to community health workers (CHWs). CHWs are frontline public health professionals who serve as cultural brokers, organizers, advocates, and liaisons between health and social service systems and the community.[2]

CHWs are unique in that they possess a trusted relationship with the communities they serve based on shared language, lived experience, culture, and background. Their intimate knowledge of local resources can be used to meet acute community needs, and their organizing and advocacy functions help communities identify the root causes of health disparities and mobilize community-led solutions. With their focus on social and structural determinants and health-related factors, CHWs are uniquely skilled at navigating systems, connecting communities to resources, identifying underlying causes, and building capacity to address future public health threats. As CHWs are often from historically marginalized backgrounds themselves and CHW programs are often explicitly designed to promote health equity, their work can be understood as part of the movement toward a more just and equitable society.[3]

The CHWs for COVID Response and Resilient Communities (CCR) initiative funded by the Centers for Disease Control and Prevention (CDC) further established CHWs as a critical public health workforce. This $340 million investment in 67 local, state, tribal, and US territorial health recipients was

among the largest investments in the CHW workforce to date. During the most acute phases of the pandemic, CCR-funded CHWs were trained and deployed and engaged in the critical and often dangerous role of supporting COVID-19 response efforts through a variety of activities.[4–6] A more detailed overview of the purpose and structure of the program and the activities in which CHWs were engaged can be found in a preceding article.[7] In addition to supporting CHWs to mitigate the worst effects of the pandemic, CCR also created opportunities for CHWs to act as leaders equipped to evaluate their profession.

This essay, authored predominantly by CHWs, focuses on the successes, challenges, and lessons learned from attempts to involve CHWs in the CCR national evaluation and highlights future opportunities to center CHW leadership in the evaluation of their own profession.

The Centers for Disease Control and Prevention funded Arizona State University and the Washington State Evaluation Partnership to serve as the evaluation providers for the CCR initiative, and each assembled diverse teams of researchers, evaluators, and CHWs to collaborate on key CCR evaluation deliverables. On each team, CHWs functioned as subject matter experts, thought partners, and coleaders of committees to support the CCR evaluation efforts. In line with the American Public Health Association community health worker Section's recommendation that CHW initiatives include at least 51% CHW leadership,[8] CHW leadership of evaluation activities increased over time through advocacy from both CHWs and their allies involved in the initiative.

EVIDENCE ON EVALUATION ROLES

CHW involvement in and leadership of research and evaluation about their own profession has reached significant milestones over the past 3 decades. This is partially because of the growing acceptance of community-based participatory research, which highlights the need for communities to be actively involved in research that directly affects them.

The literature on CHW participation in research and evaluation indicates the need for opportunities for CHWs to build practical skills in conducting research and evaluation, as historically CHWs have had few opportunities to build these skills (Stalker K, Wiggins N, Marsiglia F, Wilkinson-Lee A, Brown ME, unpublished). This may include training in research methods and design, terminology, implementation, ethics, and analysis, among other topics.[9] Training helps CHWs learn to "speak the same language" as researchers. Once trained, CHWs on research teams can help non-CHW researchers build a contextualized understanding of the issues community members face.[10,11]

In studies that prioritize CHW involvement early[12] and in all phases of the research process,[11–15] CHWs are better able to take a critical interpretation role between communities and research teams. This leads to increased community trust in institutions (e.g., health care and academia), facilitates the successful implementation of proposed interventions, and increases involvement from community members who are often not reached by traditional engagement methods.[13,14,16] Without this needed context, researchers may lose critical insights and produce information that is less accurate or relevant to the population of interest.[11,14,15] Participation can also help CHWs become more effective in other roles (e.g., advocacy) and increase the valuation of health data among community members, which may lead to greater community-wide participation in and ownership of related health initiatives.[17]

However, significant barriers prevent CHWs from being fully engaged in the research and evaluation that affect their profession and the communities where they work and live. Researchers working with CHWs often limit them solely to tool development, data collection, participant recruitment, and intervention implementation.[15,16] A relatively small number of studies provide opportunities for CHWs to be involved in forming the research questions and conducting data analysis, interpretation, and dissemination.[15,16,18] Time for CHWs to build skills and confidence in research methods and related topics is not always provided.[16,19] Additionally, some studies do not provide any compensation to CHWs for their participation on the research team.[16,18,19]

ROLES AND SUCCESSES IN THE INITIATIVE EVALUATION

CHW leadership was evident at multiple levels throughout the CCR evaluation structure from the earliest days of the program. In the CDC, an experienced CHW served as the CCR evaluation leader, and another acted as a subject matter expert. Along with members of the 2 evaluation teams, which also included CHWs, they proposed strategies related to individual site support, 2 overall national surveys (CHW and CHW

Employers), and all public-facing dissemination activities.

Individual evaluation teams operationalized CHW leadership in specific ways. At the Washington State Evaluation Partnership, 1 of the 2 principal investigators was a long-serving CHW with deep experience in the national movement of CHW capacity building and self-determination. Four CHWs affiliated with and trained by the CHW Center for Research and Evaluation (CHW-CRE) served on the Washington State Evaluation Partnership Leadership Team. One of these CHWs served as an evaluation technical adviser and liaison and worked directly with sites to support their internal evaluations. Three members of the CHW-CRE Council served on the Washington State Evaluation Partnership CHW Council along with 2 CHWs from CCR programmatic sites. These council members provided real-time feedback on emergent project needs and directives. CHWs participated in development, data collection, and data analysis for a CHW employer survey. Additionally, CHWs codesigned and cofacilitated three 5-session "Communities of Practice," in which evaluators and CHWs came together to learn participatory evaluation methods.

In addition to supporting program evaluation at approximately half of the 67 funded sites, the Washington State Evaluation Partnership conducted 2 special studies. In both, CHWs were actively involved in conducting interviews, leading focus groups, and performing data analysis and coding.

Arizona State University, the evaluation team responsible for overseeing evaluation activities for the other half of funded sites and for conducting the national survey of CHWs, also took a distinct approach to CHW leadership. On this team, 2 CHWs with extensive experience in Latino/a/x/e and farmworker communities were integrated as technical advisers. CHWs on this team were enabled to use their context-specific insights and cultural competencies to enhance the evaluation process. Additionally, Arizona State University contracted with CHW-CRE to include CHW-developed common indicators in this survey and in other evaluation activities and to involve CHWs affiliated with CHW-CRE in their ongoing evaluation efforts.

Arizona State University also championed CHW involvement in implementing digital storytelling as a qualitative research methodology for the special studies they led. This method allowed CHW participants to describe their unique contributions during the most acute phases of the COVID-19 pandemic by creating short, personal, 2- to 5-minute videos about their experiences that could later be thematically analyzed.[20] CHWs on the Arizona State University team were trained in the method and helped lead digital storytelling workshops for more than 30 CHWs across funded sites. These CHW trainers described these trainings and workshops as "empowering" both for themselves and for the CHWs who participated.

The CHWs who authored this essay noted the willingness of leaders both on evaluation teams and at the CDC to intentionally slow down an often fast-moving process with multiple components and attempt to move in ways that allowed true feedback from CHWs to be solicited and acted on. In both teams, CHWs were provided funding to attend national conferences to develop networks with other CHWs and CHW allies and researchers around the country and to disseminate initial lessons learned from the CCR program. They are also authoring and coauthoring journal publications about the initiative.

CHALLENGES TO INVOLVEMENT IN THE EVALUATION

Although there was broad consensus that CHW evaluation leadership and involvement was increasingly prioritized over time in CCR, not all CHWs felt it was actualized in the early phases of the initiative. CHW orientation to evaluation roles took time and required champions to continue to advocate on behalf of and with CHWs to promote their full inclusion. The complex and sometimes technical nature of the work required to build a research and evaluation apparatus to support many recipients, combined with the fast pace, resulted in some CHWs feeling unsupported in their attempts to understand various aspects of the work. Despite clear attempts to slow the pace of the work to ensure maximum CHW involvement, some still felt that the pace did not allow them to always contribute meaningfully to all evaluation activities. This was especially true for CHWs who were participating in evaluation activities in addition to their full-time CHW job.

Barriers related to compensation were also present. Some CHWs who were participating in national evaluation activities as representatives of their programmatic recipient organization were precluded from receiving additional compensation, even though they were performing work that went above and beyond their regular job responsibilities. CHWs often found it hard to access essential resources and information, such as documents stored on shared drives. All these factors led to some CHWs feeling undervalued for

their important contributions. However, CHWs and allies advocated more CHW involvement in and leadership of evaluation efforts, and thus involvement and leadership increased over time.

LESSONS LEARNED FROM EVALUATION INVOLVEMENT

The CCR experience holds many lessons for future CHW involvement in the evaluation of large-scale and national CHW-focused programs. Previous studies affirm that CHWs' community knowledge positions them as experts on the factors that make communities unwell.[14,16] Opportunities for CHWs to develop contextually appropriate solutions to these problems through research and evaluation lead to healthier, more empowered communities.[9,10,17,21,22] CHW involvement in the research and evaluation of their own profession is essential because the insights of people with lived experience and cultural congruence with the communities they serve create and validate the data needed to inform effective public health and health equity interventions.[1,10,23]

Our experiences concur with previous findings while also demonstrating that authentic CHW involvement requires both commitment from the onset and constant recentering throughout the project period. Although research and evaluation are core CHW roles, historically they are the least frequently enacted (Pendas G, Smart J, Manley C, Rodela K, English T, Wiggins N., unpublished).[24,25] Therefore, equitable compensation for CHWs who participate in these activities must be prioritized, especially if employers consider it auxiliary to their main direct service role. This commitment allows CHWs to play a full range of roles, with emphasis on the roles that address the root causes of health inequities, including structural, political, and economic drivers of health. At the same time, it produces the accurate and rigorous CHW-informed and -led findings that can help create conditions that promote the health and well-being of communities.[26,27] Although imperfect, the CCR program's inclusion of CHWs in leadership roles provides a template for future projects, emphasizing the importance of involving CHWs at all levels, slowing the pace of the work as needed, and providing adequate orientation, information, and training upfront to ensure meaningful participation.[10–14]

Future research should further explore the facilitators and barriers to meaningful CHW involvement in evaluation. Partnerships between CHWs and non-CHW researchers are essential to close this knowledge gap.[28] Organizations such as CHW-CRE offer valuable support through training, capacity building, and tools such as the CHW common indicators, a set of process and outcome indicators that can be used across CHW programs to collect data that can be aggregated to make a stronger scientific case for CHWs.[27,29] These resources enable programs to measure success consistently, share lessons across contexts, and cultivate a new generation of CHW research and evaluation leaders. Such efforts are critical for fostering more effective CHW programs and thriving communities nationwide.[9,27]

CONCLUSIONS

In the most recent large-scale investment in the health and well-being of communities by means of the CHW model, evaluation teams helped cultivate CHW research and evaluation leaders by integrating CHWs into leadership roles across all phases of evaluation. Obtaining the full benefit of CHW involvement required intentional efforts from non-CHW leaders, such as slowing project timelines to allow meaningful participation and supporting CHWs with resources and capacity-building opportunities. Future projects should embrace these key elements of successful integration and ensure that CHWs are able to lead the evidence creation that will scale and sustain the workforce, furthering their vital work of uprooting health inequities and saving lives. AJPH

ABOUT THE AUTHORS

All authors were community health workers when this work was completed. Victoria Adewumi and Keara Rodela are with the Center for Research and Evaluation, Boston, MA. Sahlea Tubbeh was with Lane County Public Health, Eugene, OR. Nury Stemple and Floribella Redondo were with the Office of Community Health, Engagement, and Resiliency, Arizona State University, Tempe. Durrell Fox is with JSI Research & Training Institute, Inc., Boston, MA.

CORRESPONDENCE

Correspondence should be sent to Victoria Adewumi, Health Resources in Action, 2 Boylston St 4th floor, Boston, MA 02116 (e-mail: vadewumi@chwcre.org). Reprints can be ordered at https://www.ajph.org by clicking the "Reprints" link.

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ORCID iDs:
Victoria Adewumi https://orcid.org/0009-0002-8444-1788

Sahlea Tubbeh https://orcid.org/0009-0001-7267-5424

Durrell Fox https://orcid.org/0009-0002-3953-7369

Keara Rodela https://orcid.org/0000-0002-3344-4164

Noelle Wiggins https://orcid.org/0000-0002-8986-6657

CONTRIBUTORS

V. Adewumi led the writing and was responsible for all drafts of the essay and incorporation of

author revisions. V. Adewumi, S. Tubbeh, and N. Wiggins made substantial contributions to the conceptualization and design of the work, including data acquisition, analysis, and interpretation. S. Tubbeh supported initial conceptualization of the work and revised the essay critically for important intellectual content. N. Semple and F. Redondo provided significant contributions to the draft and added content. D. Fox and K. Rodela revised the work critically for important intellectual content. N. Wiggins provided expert guidance, analysis, and data interpretation and revised the essay critically for important intellectual content. All authors approved the version to be published.

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CONFLICTS OF INTEREST

We have no conflicts of interest to disclose

HUMAN PARTICIPANT PROTECTION

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