Key Elements of a Community-Engaged Approach to Evaluating a Nationwide Community Health Worker Program

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A recent multisite, nationwide community health worker (CHW) program in the United States made it possible to conduct a comprehensive evaluation (2021–2024) designed to address existing gaps in the evaluation of CHW interventions.

We describe key elements of our approach: using evidence-based frameworks, including community-based participatory research and popular education; centering CHW leadership; using a mixed-methods design; integrating standardized process and outcome measures from the CHW Common Indicators; and using equity-focused principles.

When used to guide the evaluation of existing and future multisite, long-term CHW programs, this approach can be expected to increase understanding of how CHWs achieve expected outcomes, how CHW programs can be evaluated consistently with standardized measures, and how evaluation can be designed to help scale up and sustain CHW programs. (*Am J Public Health*. 2026;116(S4):S341–S352. https://doi.org/10.2105/AJPH.2026.308659)

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Community health workers (CHWs), also known as *promotores/as de salud* and community health representatives, have worked in a variety of settings in the United States for more than 70 years addressing health and social needs and building capacity in the communities they serve.[1] CHWs are increasingly recognized for their essential contribution to promoting holistic health and implementing evidence-based strategies to prevent and manage chronic diseases among populations at increased risk and, recently, for responding to the disproportionate impact of the COVID-19 pandemic on communities that have experienced long-standing health inequities.[1–2]

Historically, a variety of significant systemic issues have hindered the evaluation of CHW programs in the United States. First among these is the lack of funding for national, multisite, long-term CHW programs, such as those that exist in many low- and middle-income countries.[3–5] Programs like these make it possible to conduct the kinds of longitudinal evaluations that have increased public support for interventions by other health professionals; Olds and colleagues' studies of the Nurse–Family Partnership are a notable example.[6] Other shortcomings, until recently, have included a lack of consistent measures (which can facilitate aggregation of data across programs), lack of attention to the processes and roles by which CHWs achieve outcomes,[7] and, perhaps most significantly, the systematic exclusion of CHWs from knowledge production about their own profession.[8] This exclusion is at least partly rooted in CHWs' social location as predominantly Black people, Indigenous people, other people of color, and people sharing other (and often multiple) marginalized identities.[9]

Despite these limitations, there have been several notable attempts to create evaluation frameworks for CHW initiatives. These include the 1998 National Community Health Advisor Study, funded by the Annie E. Casey Foundation, which included a chapter

on CHW program evaluation.[10] Many of the same CHWs and allies who were involved in that study were involved in subsequent initiatives, including the creation of an evaluation toolkit[11] and a research agenda for CHW programs.[12]

A recent important investment in a federal CHW program, Community Health Workers for COVID Response and Resilient Communities (CCR), made possible a large-scale evaluation of the program. The Centers for Disease Control and Prevention (CDC) funded 67 sites (subsequently, "recipients") around the country to train more than 2000 CHWs and integrate them into more than 1000 health care and community-based organizations to tackle COVID-19 and other health and social issues that increase the risk of severe COVID-19 outcomes. An equally important objective was to build the resilience that can help communities cope with the day-to-day stressors of racism and discrimination[13] as well as natural and human-made disasters.[14] De Jesus et al. published a more detailed description of the program.[15]

The CDC partnered with Arizona State University and the Washington State Evaluation Partnership (subsequently, "evaluation partners") to conceptualize, lead, and conduct a national evaluation of the program. The recipients conducted site-specific evaluations. The Community Health Worker Center for Research and Evaluation (CHW-CRE), a CHW-led organization created to address gaps in CHW program evaluation and promote CHW leadership in research and evaluation concerning their profession, served as a subcontractor to Arizona State University and the Washington State Evaluation Partnership. Together with the CDC, we undertook numerous evaluation activities, including the following:

- providing technical assistance to recipients on their program-specific evaluation plans and activities,
- providing general evaluation training,
- reviewing and providing input on the collection and reporting of program performance measure data,
- developing and administering 2 surveys for the national evaluation,
- conducting 5 in-depth case studies to explore special topics with a subset of recipient organizations,
- analyzing and interpreting data, and
- reporting national evaluation findings in academic and community-oriented formats.

Results of many of these evaluation activities are provided elsewhere in this issue of *AJPH*.

Guided by the expected outcomes in a logic model that predated the evaluation (Figure 1), best practices in CHW evaluation,[16] and 2 theoretical frameworks, we designed a structured and replicable community-engaged evaluation that centered CHW leadership and used recently created and CHW-influenced metrics. The purpose of this essay is to share key elements and lessons learned from that approach and to advocate the use of a modified form of the approach in future multisite, long-term CHW programs.

ROADMAP TO DESIGNING THE NATIONAL EVALUATION PLAN

To design the CCR national evaluation plan (NEP), we used evidence-based frameworks, including community-based participatory research and popular education; centered CHW leadership; used a mixed-methods design; integrated standardized process and outcome measures from the CHW Common Indicators; and used equity-focused principles.

Use of Evidence-Based Evaluation Frameworks

Using evidence-based frameworks to guide the design and implementation of a program's evaluation ensures that the evaluation approach reflects and aligns with the scope, principles, and context of the program examined.[17] In addition to the CDC's Framework for Program Evaluation,[18] 2 other frameworks strongly influenced the NEP and provided concrete strategies for conducting effective evaluation: community-based participatory research (CBPR) and popular education.

CBPR is a collaborative approach to research that combines the knowledge of people and communities most affected by an issue with the knowledge of academics and other interested parties to solve concrete problems in communities and increase equity.[19] First introduced as a cohesive framework in the 1990s, CBPR has since been endorsed by major research funders including the National Institutes of Health and the W. K. Kellogg Foundation.[20]

Some of the hallmarks of authentic CBPR, which can be used to measure fidelity to the model, are (1) people and communities most affected should be involved at all stages of the research process, including identification of the problem and dissemination of the findings; (2) the research process should value and build on the unique capacity that all partners bring; (3) equitable and long-term partnerships require careful maintenance and should not depend on funding; and (4) research should result in new knowledge and action for the benefit of all partners.[21]

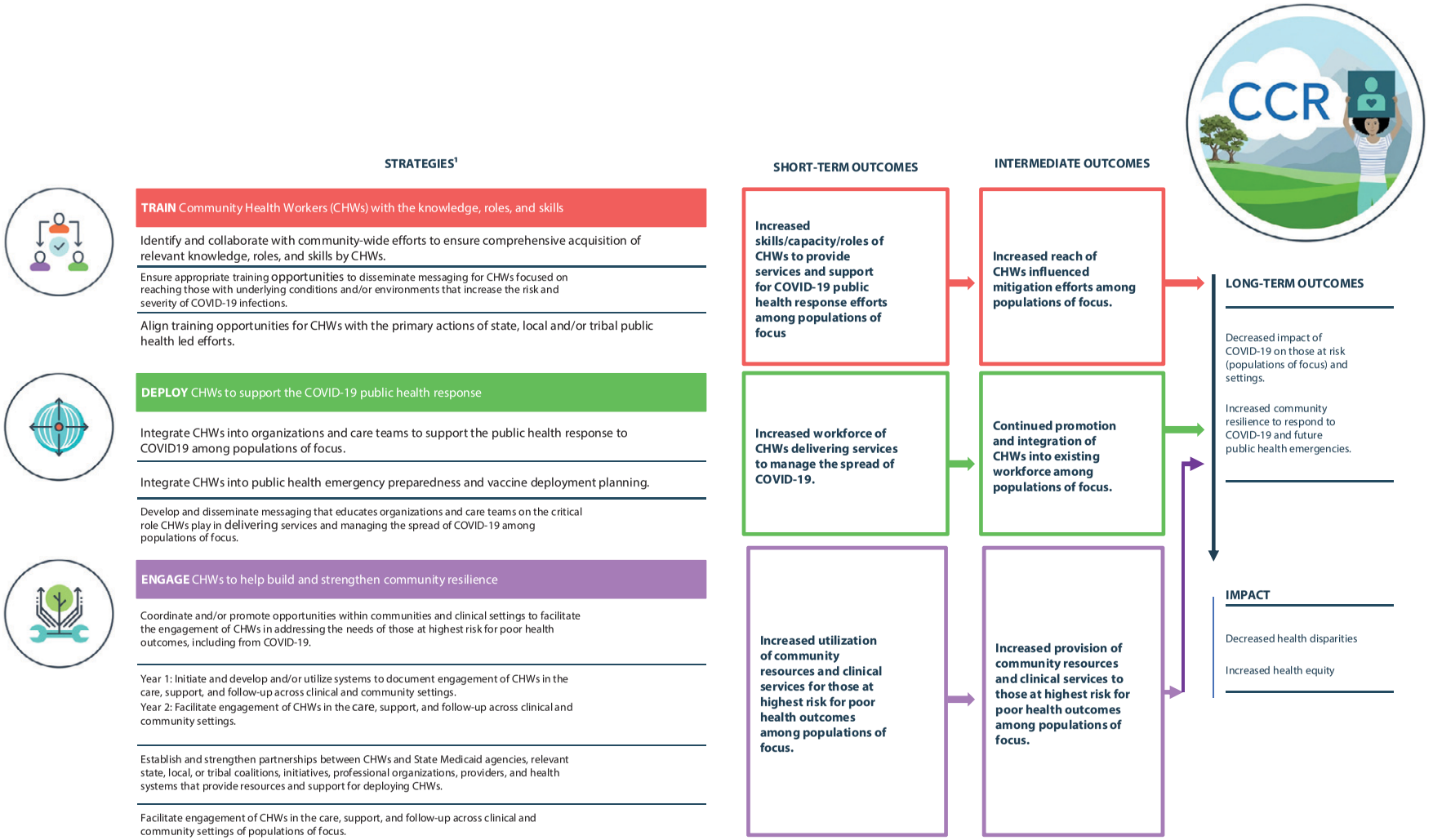


FIGURE 1— Logic Model Guiding the National Evaluation of the Community Health Workers for COVID Response and Resilient Communities Program: United States, 2021–2024

Note. CCR = Community Health Workers for COVID Response and Resilient Communities; CHW = community health worker. The logic model illustrates the 3 program strategies—train, deploy, and engage CHWs—and their expected progression from short-term outcomes to intermediate outcomes, long-term outcomes, and overall public health impact. Colored boxes correspond to the 3 program strategies.

CBPR is part of a continuum of approaches to participatory and action research developed around the world since the 1960s. Wallerstein and Duran[22] categorized these approaches into 2 traditions. The "Northern tradition," represented by the work of German American social psychologist and action research pioneer Kurt Lewin, focuses on efficiency. The "Southern tradition" draws on the anticolonial work of Brazilian educator and political theorist Paulo Freire and emphasizes personal and social liberation. They located CBPR firmly within the Southern tradition.

An analogous, emancipatory approach to evaluation combines roots in South Asia and Latin America with the decolonizing approaches to research and evaluation articulated by Indigenous scholars such as Linda Tuhiwai Smith.[23] Key insights from this approach are that evaluation should not just involve but be conducted from within the worldview of those most affected by a program or intervention and that, when this occurs, evaluation can contribute to empowerment.[24]

Popular education is a philosophy and methodology for education and organizing that seeks to create situations in which people most affected by inequities can reclaim the validity of their knowledge systems, develop their ability to critically assess their reality, and use their knowledge to create a more just and equitable society.[25] Most closely associated with Paulo Freire's work in Latin America, popular education has roots that predate European conquest of the Americas and extend around the world. It has been used successfully for community development, labor organizing, and the promotion of health, literacy, and occupational safety.[26] In a public health context, the use of popular education has been associated with improvements in both health and empowerment.[25]

Like CBPR, popular education is based on principles that guide its application and provide criteria for assessing whether it has been implemented authentically. These principles include the following:

1. The current distribution of power and resources in the world is inequitable, but change is possible.
2. We learn with our heads, our hearts, and our bodies.
3. It is important to create an atmosphere of trust so people feel free to share their wisdom and experience.
4. We all know a lot as a result of our life experience; therefore, educators should start with what people already know and do.
5. The purpose of developing critical consciousness is to be able to take action to change the world.[20]

Popular education is also grounded in particular values (e.g., compassion, discipline, love for the cause of the people) and offers a set of methods that embody the principles and prefigure the type of society popular educators aim to create. These methods include but are not limited to *dinámicas* (social learning games), sociodramas (social skits), brainstorming, simulations, and problem posing.[20] In line with both the principles and values of popular education, popular educators follow certain practices, such as making space for quieter voices, valuing all contributions, negotiating and consistently using group agreements, preparing agendas with clear objectives that are vetted with the group, and dedicating time to relationship building. When popular education and CBPR are used together, these methods and practices can actualize CBPR principles and promote and sustain participation.[20,25]

These 2 frameworks are particularly appropriate for evaluating CHW initiatives, because both have been identified as best practices in the CHW field. They also share historical roots, progenitors, and philosophical principles with the CHW model, including 2 key ideas: the knowledge gained through life experience can be as valuable as the knowledge gained through formal education, and people, especially people most affected by inequities, are the experts about their own lives.[25] A recently developed tool highlights the value of CBPR and popular education for CHW-led research.[16] Having identified these synergistic frameworks, our next step was to use them to create an actionable NEP.

Centering Community Health Worker Leadership

The NEP was the strategic document that outlined the evaluation frameworks; evaluation questions; evaluation design; measures or indicators; data collection, analysis, and interpretation methods; and data management plan. The National Evaluation Plan Action Team—which included members from the CDC and the evaluation partners Arizona State University and the Washington State Evaluation Partnership—developed the NEP. As a way of recognizing the "authoritative knowledge"[27] of CHW leaders and longtime allies, both the evaluation partners and the CDC included among their paid leadership CHWs and allies from national CHW organizations such as the National Council on CHW Core Consensus Standards and the CHW-CRE along with other experts from community-based organizations, public agencies, and academia.

Both evaluation partners established ongoing CHW councils and offered

their members compensation and other types of support (e.g., support to attend conferences) to participate in the development and implementation of the NEP and other evaluation efforts. The NEP also benefited from input from an ad hoc NEP advisers group, a diverse group of experts in the CHW field, who met twice to vet the evaluation frameworks, the evaluation questions, the approaches for answering these questions, and the overall NEP. The NEP advisers group included CHW leaders from the evaluation partners' CHW councils along with representatives from recipient organizations and 2 major health systems. All the advisers had long-term relationships with the evaluation partners and were strategically selected to represent those who would be affected by and use the findings of the evaluation. Together, the CDC, the evaluation partners, the CHW councils, and the NEP advisers group developed the evaluation approach for CCR, which was outlined in the comprehensive NEP.

Using the program logic model that the CDC developed and included in the notice of funding opportunity (Figure 1), we formulated a comprehensive list of evaluation questions to assess processes (i.e., activities) and outcomes (i.e., impact) of the 3 program implementation strategies: train, deploy, and engage CHWs in the care, support, and follow-up of individuals across clinical and community settings.[15]

A major component of the NEP was a questions-to-measures grid, which mapped each evaluation question onto indicators that were built into our data sources. Box 1 provides examples of questions included in the questions-to-measures grid and their corresponding measures and data sources. We shared the final version of the NEP in a webinar with recipients, collaborators, and staff.

Use of a Mixed-Methods Evaluation Design

We employed a concurrent mixed-methods design for the national evaluation (conducted 2021–2024) and combined existing data that recipients were required to report with data collected specifically for the evaluation. We collected data from all sources, analyzed them separately, and triangulated them during the interpretation phase. For example, we interpreted quantitative data about the number of CHW referrals to social and health services in light of qualitative data about barriers and facilitators of CHW referrals collected in case study interviews.

The primary data sources for the NEP were 2 quantitative cross-sectional surveys: 1 for CCR recipients and 1 for CHWs implementing CCR activities. We designed the surveys to complement standardized performance measure data (e.g., number of CHW referrals and number of organizations integrating CHWs) that recipients were required to report biannually. We also collected primary data using qualitative methods (e.g., in-depth interviews, focus groups, and digital storytelling) from a subset of recipient organizations across 5 case studies on specialized topics. Box 2 provides descriptions, strengths, and limitations of each of the methods used in the national evaluation. Again, findings from all major data sources are provided in additional articles in this issue of *AJPH*.

Integration of the Common Indicators

Consistent with the aim of using standardized, CHW-influenced measures to address important gaps in CHW program evaluations,[8] we integrated the national CHW Common Indicators into the data collection efforts of the NEP. The CHW Common Indicators are a set of 12 process and outcome measures designed to systematically and consistently assess the outcomes CHWs are uniquely suited to achieve and the workplace and workforce conditions necessary to achieve these outcomes.[9] The CHW-CRE developed the CHW Common Indicators to address the lack of common process and outcome measures for CHW programs, which hindered data aggregation across programs and regions.[8]

The CHW Common Indicators were specifically designed for use in all CHW programs, regardless of setting, community characteristics, or health issues addressed. Taking into account both the diversity of CHW programs and the emphasis on community and cultural context in CBPR, the CHW-CRE recommends that the indicators be used along with qualitative methods that are specific to the culture, community, and setting. As explained at more length in Wiggins et al. (p. xxx) in this issue, the CHW Common Indicators had previously been collected in local and statewide settings and in 1 regional research study. These efforts established the face validity of the novel scales that the CHW-CRE developed and provided evidence of the internal consistency reliability of 1 scale.[28] CCR made it possible to collect the indicators on a much larger scale and to conduct initial validation using exploratory factor analysis.

Box 2 shows the subset of the CHW Common Indicators that we included in the 2 surveys used in the national evaluation. We prioritized the inclusion of the CHW Common Indicators that assess CHW working conditions, including compensation, benefits, and opportunities for advancement; frequency of

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BOX 1— Example of the Questions-to-Measures Grid Used in the Community Health Workers (CHWs) for COVID Response and Resilient Communities (CCR) National Evaluation: United States, 2021–2024

Evaluation Question	Measures	Data Sources
CCR train CHWs strategy		
What training/certifications addressing health conditions or social service needs of the population of focus were provided to CHWs?	Number and types of training and certifications provided to CHWs	Performance measures reported semiannually by CCR recipients
How many CHWs completed CHW core competency training during CCR implementation?	Number and percentage of CHWs who completed CHW core competency training during CCR implementation	CCR recipient survey[a]
CCR deploy CHWs strategy		
What compensation, benefits, and opportunities for advancement did CHWs receive during the grant period?	CHW • Hourly rate or annual salary • Number of hours of work per week • Number and type of benefits • Number and percentage reporting eligibility for promotions with pay increases at their place of employment • Number and percentage satisfied with payment and benefits	CHW survey[a]: CHWs' compensation, benefits, and opportunities for advancement (CHW Common Indicators.)[b]
• To what extent did organizations integrate CHWs into community and care teams to support public health responses to COVID-19 among populations of focus? • How were CHWs integrated into response teams, and what were the barriers and facilitators for CHW integration in clinical and community settings?	• Number and types of community and health care organizations that integrated CHWs to support state, local, and Tribal public health COVID-19 response efforts • Characteristics of CHW integration into community and health care organizations • Barriers and facilitators of CHW integration in community and health care settings	• Performance measures reported semiannually by CCR recipients • Case study of a subset of CCR recipients: in-depth interviews and document review
CCR engage CHWs strategy		
What populations of focus were served by CCR?	• Geographic areas (e.g., counties) where CCR activities were implemented • Descriptive statistics about the populations of focus served by recipients	• CCR recipient survey[a]
• How many and what type of referrals were made by CHWs to clinical or social services? • What percentage of referrals were completed or used by the individuals referred, and what types of referrals were they? • What were the characteristics, barriers, and facilitators of CHW referrals?	• Number and type of referrals made by CHWs • Number and type of referrals deemed complete (e.g., the participant received the needed service or activity) • Description of the referral loop and its barriers and facilitators	• Performance measures reported semiannually by CCR recipients • Case study of a subset of CCR recipients: in-depth interviews, focus groups, and referral data collected by CCR recipient organization

[a]Office of Management and Budget control no. 0920-1411.
[b]CHW Common Indicators.

enactment of the 10 CHW core roles; involvement in policy and decision-making; authentic integration into teams; and supportive and reflective supervision.[9]

Understanding that CHWs are effective not only because of what they do but also because of who they are and that any erosion of community membership and trust as an essential quality for CHWs could undermine that effectiveness, we also collected data to assess CHWs' sociodemographic characteristics and the extent to which they identified with the populations they served. The results of this assessment are provided in Brown et al. (p. xxx) in this *AJPH* issue.

Incorporation of Equity-Focused Principles

A key aspect of the evaluation design was the identification and refinement of a set of 10 equity-focused principles for evaluation to ensure a community-engaged and strengths-based approach. We drew these principles from several evaluation approaches and from basic principles of popular education, empowerment theory, and the CHW movement.[29–31] The principles included the following:

1. nothing about us without us;
2. participant ownership of data;
3. the importance of context[32];
4. the value of multiple perspectives, especially of those most affected[21,33];

BOX 2— Community Health Workers (CHWs) for COVID Response and Resilient Communities (CCR) Evaluation Data Collection Mixed-Methods Description, Strengths, Limitations, and Lessons Learned: United States, 2021–2024

Data Collection Type (Method and Data Type)	Respondent Description (Sample Size) and Collection Timeframe	Description and Use in the National Evaluation	Strengths	Limitations and Lessons Learned
CCR recipient performance measures (Quantitative, program data)	• 67 CCR recipient organizations (required evaluation deliverable) • Time series semiannually; years 1–3 (2021–2024)	10 performance measures or indicators aligned with the CCR high-level strategies (train, deploy, and engage) to assess • Activities conducted (process) • The direct products and services delivered by the program (outputs) • The results of those products and services (outcomes)	• Before submitting performance measures, we shared a comprehensive guidance document and held webinars and office hours and provided individualized technical assistance to support recipients in their reporting and improve consistency of reporting. • A comprehensive quality control process, including clarification with recipients, was implemented for each round of performance measures. • We incorporated improvements to the performance measure reporting tool on an ongoing basis to improve reporting accuracy.	• The performance measures were provided in the notice of funding opportunity and were not subject to modifications for this evaluation. • Program implementation varied significantly across recipients, program data collection activities were not standardized, and recipient capacity for data reporting varied. • Staff turnover and recipient capacity affected quality and timeliness of data reporting for some recipients.
CCR recipient survey[a] (Quantitative, program data, primarily process related)	• Program directors for 63 out of 67 recipients completed the survey. • Cross-sectional; year 3	A web-based survey available in English and Spanish completed by program directors from CCR recipient sites to assess • Program management, funding used, and program implementation challenges • Populations of focus and geographic areas served • COVID-19 response activities implemented • CHW training, certification, retention, and funding plans for sustainability • CHW CIs ○ CI 1: CHWs' compensation, benefits, and opportunities for advancement ○ CI 2: CHW frequency of enactment of the 10 core roles ○ CI 12: CHW access to supportive and reflective supervision	• High response rate of 94%, indicating strong representation across the CCR recipients. • Cultural and linguistic sensitivity: The survey was developed in both English and Spanish and validated with cognitive testing to ensure questions were culturally relevant and comprehensible. • Quality assurance in data collection: The use of validation checks, skip patterns, follow-up for unclear responses, and a detailed data management protocol for robust data cleaning, coding, and management processes ensured high data quality, accuracy, consistency, and transparency. • Focus on organizational context: The evaluation examined organizational characteristics and capacities, recognizing the importance of context in program success.	• The cross-sectional nature of this survey does not allow for comparison across time points. If feasible, future evaluations could administer multiple surveys (e.g., pre–post program implementation) to allow for evaluation of changes over time. • Program directors from the funded recipient organization responded to this survey; however, CCR programs were often implemented by partner organizations that were not surveyed. To the extent possible, future evaluations can collect data from partner organizations to provide more insight into how the program operated on the ground.

Continued

BOX 2— Continued

Data Collection Type (Method and Data Type)	Respondent Description (Sample Size) and Collection Timeframe	Description and Use in the National Evaluation	Strengths	Limitations and Lessons Learned

CCR CHW survey[a]
 	
(Quantitative, program data, primarily process data)
	• CHWs funded by CCR or implementing the CCR program (n = 689)
	• Cross-sectional; year 3
		A web-based survey available in English and Spanish completed by CHWs supported through CCR funding or CHWs directly involved with the implementation of the program to assess
		
		• Employer organization characteristics
		• CHW training in core competency areas
		• COVID-19 response activities implemented
		• Barriers and facilitators of CHW referrals to health and social services
		• CHW CIs
		  ○ CI 1: CHWs' compensation, benefits, and opportunities for advancement
		  ○ CI 2: CHW frequency of enactment of the 10 core roles
		  ○ CI 4: CHWs' involvement in decision- and policymaking
		  ○ CI 5: CHW integration into teams
		  ○ CI 12: CHW access to supportive and reflective supervision
		• Populations of focus served
		• CHW race/ethnicity and membership in communities defined in other ways
			• Cultural and linguistic sensitivity: The survey was developed in both English and Spanish, with cognitive testing to ensure questions were culturally relevant and comprehensible.
			• Inclusion of CHW CIs, which move the field forward by providing standard measurement of key indicators for CHW workforce sustainability.
			• The sample of n = 689 CHWs implemented CCR across the United States.
				• The cross-sectional nature of this survey does not allow for comparison across time points. If feasible, future evaluations can administer multiple surveys (such as pre–post program implementation) to allow for evaluation of changes over time.
				• The time frame for CHWs to complete the survey was condensed, so many CHWs involved in CCR may not have been able to complete the survey within the data collection time period.
				• Data were collected 6 months before the end of the final fiscal year of the program, so many CCR CHWs had transitioned to new roles or organizations and therefore were not reachable for participation.

Case studies
 	
(Mixed methods; primarily qualitative)
	• Study scope, participants, and inclusion criteria varied based on evaluation question.
	• Participants included
	  ○ CCR recipient program staff, evaluators, CHWs, CHW supervisors, community members, and community leaders.
		• Five case studies conducted with a subset of CCR recipients (n = 3–12 recipient organizations represented per study).
		• Each study had a unique design and inclusion criteria.
		• The studies allowed evaluators to explore certain high-priority evaluation questions in more depth.
		• The 5 studies included
		  ○ CHW referrals to health and social services
		  ○ CHW integration into organizations and care teams
		  ○ CHWs' role in building equitable access to COVID-19 prevention and care in communities experiencing health disparities
		  ○ CHW sustainability capacity
		  ○ CCR community resilience
			• Focusing on specific topic areas afforded the evaluators the ability to delve into nuanced topics that could not be captured within survey data.
			• The inclusion of these studies provided richer contextual data to further support the findings from the CCR recipient performance measures and the CCR recipient and CHW surveys.
				• Findings are specific to participating recipients and not generalizable. However, if supplemented with survey data, case studies can provide opportunities to dive deeper into specific aspects where program records or qualitative data can provide further insight.
				• Short data collection time frame.

Note. CI = CHW Common Indicator.
[a]Office of Management and Budget control no. 0920–1411.

5. empowerment as a goal and aim of participatory research[24];
6. the importance of applying evaluation findings in ways that improve program effectiveness and increase societal well-being[34];
7. data disaggregation to the lowest possible level without compromising confidentiality and privacy[35];
8. self-reflexiveness to explore how our life experiences influence the questions we ask, the methods we use, and our interpretation of findings[36];
9. application of popular education to create and sustain an environment hospitable to participatory evaluation[22]; and
10. the role and ubiquity of power.[37]

We were committed to enacting the principles to the greatest extent possible throughout the implementation of the NEP. In Box 3, we describe how we incorporated select evaluation principles into our evaluation practice.

LESSONS LEARNED FROM THE IMPLEMENTATION OF THE PLAN

In this section, we describe both the strengths and limitations we identified during implementation of the CCR national evaluation plan.

Strengths of Our Equity-Focused Approach

Our approach to the design and implementation of the CCR national evaluation—which was characterized by a focus on equity, strong CHW involvement and leadership, and use of CBPR and popular education as evaluation frameworks—produced key benefits that would not have been achieved with a conventional evaluation approach. Having CHWs who used popular education methods and practices in visible leadership positions meant, among other things, that other CHWs were more willing to speak up in groups; therefore, the team as a whole was able to benefit from their unique insights.

For example, as described further in Adewumi et al. (p. xxx) in this *AJPH* issue, several times during the development of the national evaluation, CHWs expressed to other CHWs and allies on the team that the process was moving too fast for them to be meaningfully engaged. These CHWs and allies were able to intervene with CDC colleagues and ask them to slow down. Because the CDC leadership also included people with experience as CHWs, they were open to these requests and responded positively by providing more time. Additionally, given that the CHW Common Indicators are being developed incrementally based on experience in the field, they could not have been applied correctly or with integrity without the partnership with the CHW-CRE.

Having CHWs in positions of leadership affected both the types of data we collected and how the data were interpreted. An example of the impact of CHW involvement in data collection and interpretation comes from 1 of the special studies. A CHW on the Washington State Evaluation Partnership leadership team facilitated interviews for the case study on how CHWs make referrals and assisted with data analysis. While reviewing the data, she noticed that providing transportation was being coded as a referral, rather than as an additional activity conducted by CHWs. She also pointed out that CHWs do not just make referrals; they also receive them, a fact that had previously gone unreported. Because of her experience as a CHW, she was able to bring a real-world perspective and help ensure that the data accurately reflected what CHWs do from day to day.

Challenges and Limitations

We faced important challenges in designing and implementing the evaluation. First, some programmatic factors, such as a preexisting and unchangeable logic model and a constrained time line (which was further constrained by the time required to gain Office of Management and Budget approval), created limitations for the design of the NEP. They precluded both the collection of data at 2 time points and the assessment of intermediate and long-term outcomes, including outcomes at the participant (e.g., populations of focus) level. The program was rapidly introduced at the national level amid a pandemic and received funding for a single 3-year period. These factors affected recipients' capacity to fully staff and operationalize the program, the data they were able to collect and report, and the capacity of CHWs and program staff to participate in data collection and capacity-building efforts. Had CHWs and advisers been engaged in developing the performance measures, the measures could have been more meaningful. Because the CDC did not require recipients to use specific approaches or to evaluate their programs in standardized ways, it was impossible for us to evaluate specific programmatic strategies or their effects.

Additionally, the full application of some of the equity-focused evaluation principles was limited because of feasibility or ethical considerations. For

BOX 3— Application of Selected Equity-Focused Principles Throughout the Community Health Workers (CHWs) for COVID Response and Resilient Communities (CCR) National Evaluation: United States, 2021–2024

Principle and Meaning	How the Principle Was Applied to the CCR National Evaluation
Principle: Intentional involvement of CHWs in all aspects of evaluation: "Nothing about us without us" Meaning: Just as CHWs should be involved in all aspects of CHW program planning and implementation, to produce valid and actionable findings, CHWs need to be involved in all aspects of CCR evaluation planning, data collection, analysis, interpretation, and application of findings.	Current and former CHWs were paid members and leaders in teams at the CDC and the evaluation partner organizations and, along with other CHWs, participated in all stages of the development and execution of the CCR national evaluation: • Evaluation design: CHWs were members of the national evaluation team and provided input as data collection protocols and instruments were developed, piloted, and implemented. • Data collection: CHWs supported participant recruitment, co-led focus groups, conducted interviews, and facilitated digital storytelling workshops. • Data analysis: CHWs participated in data analysis and interpretation of results. • Dissemination: CHWs were involved in reporting findings to recipients, coauthored publications and co-presented conference presentations.
Principle: The value of multiple perspectives, especially the perspectives of those most affected Meaning: Evaluation conducted in genuine partnership with community members most affected by the problem under study will produce findings that are of higher quality and greater applicability than those produced in evaluations that do not involve community members.[3,19]	For the CCR national evaluation, a critical community of focus was the CHW workforce. Thus, the CDC and the evaluation partners convened the national evaluation plan advisers group, a diverse group of volunteers composed of CHW leaders and representatives of CCR recipients, who provided feedback about the evaluation questions and the approaches being considered to answer these questions.
Principle: The importance of context Meaning: Evaluators pay close attention to the cultural and linguistic context in which they are working.	We prioritized assessing CHW identity and working conditions as fundamental contributors to CHWs' effectiveness. Subsequently, we developed survey questions for both the CCR CHW and recipient surveys to assess (1) CHWs' sociodemographic characteristics, (2) the extent to which they identified with the populations they served, and (3) CHW CIs that assess working conditions, including wages, benefits, and opportunities for advancement; involvement in policy and decision-making; authentic integration into teams; and supportive and reflective supervision.
Principle: Empowerment as a goal and aim of participatory research Meaning: By using their work to build the evaluation skills and capacity of CHWs and community-based groups, evaluators can support them to take more control over their lives and their health.[22,24]	To increase CHWs' capacity to be decision-makers in programs, evaluations, and policies that affect their profession, we developed and facilitated webinars and communities of practice that built CHW capacity to be meaningfully involved in evaluation, addressing topics such as • Digital storytelling, an evaluation methodology that can be used to elevate the voices of CHWs to cause positive change for the workforce. • Sharing data with policymakers and community groups. • Culturally adapted communication of evaluation findings. • Using popular education to operationalize participatory research.
Principle: Application of evaluation findings in ways that improve program effectiveness and increase societal well-being Meaning: Evaluators need to think, from the outset, about how the answers to the questions they are asking can be used to achieve greater societal well-being.[34]	Evaluation findings to improve program effectiveness: We facilitated recipients' use of performance measures for program improvement by developing an interactive dashboard and creating 1-page infographics for each recipient organization that revealed change over time and helped identify strengths and opportunities.
	Evaluation findings to increase societal equity: By integrating the CHW CIs into the CCR national evaluation, the resulting data can be compared and aggregated with data collected from other CHW programs and then used to inform policy strategies that may support the CHW workforce.

Note. CI = CHW Common Indicator.

example, in partial contravention of the principle of participant ownership of data, we chose to provide results of the CHW survey only at the national and regional levels to protect the identity of the respondents, because in some states there was only 1 program with just a few CHWs. Instead, we developed fact sheets with aggregate results for survey and case study data and recipient-specific infographics with their performance measure data. We shared national findings from all data collection efforts with CHWs and recipients via webinars, in-person and virtual presentations, and display tables at conferences.

We encountered several challenges that were specific to our approach. Beliefs about how knowledge is created and acquired in popular education run counter to what most of us have been

taught—both implicitly and explicitly—through years of formal education.[20,25,26] Pushing against the predominant epistemological current almost always produces opposition, which can be overcome only with patience and goodwill. Furthermore, learning to use popular education is a lifelong practice. Members of our large and shifting evaluation team had varying levels of familiarity and comfort with popular education, so it was not applied with fidelity across all contexts and activities. Practicing authentic popular education requires extensive and thoughtful preparation and follow-up; these standards were difficult to achieve in the context of a fast-moving project. Finally, conducting CBPR, practicing popular education, and centering CHW leadership all require making visible, communicating openly about, and redistributing power and recognition, which, although ultimately fruitful, can be both painful and time-consuming.[37]

Recommendations for Future Evaluations

Despite considerable obstacles, incorporating equity-focused guiding principles and best practices for CHW evaluation, using common indicators developed with and by CHWs, and centering CHW leadership at every stage resulted in a strong national evaluation tailored to the conditions experienced by CHWs and their communities. The evaluation approach effectively assessed the initiative's impact while honoring the work of CHWs and the people they serve. This approach can serve as a model for future evaluations of CHW programs.

Although we measured many short-term outcomes as part of this national evaluation, we recommend that future CHW programs with longer implementation periods incorporate intermediate outcome measures at the participant level, such as social support, empowerment, and self-reported health status.[9,10] Requiring and measuring the use of certain CHW best practices, such as supportive and reflective supervision and popular education, can help program leaders and the field better understand how these conditions affect CHWs' ability to remain and advance in their roles and how the conditions are associated with the health improvements that program participants report. Finally, we recommend that programs with longer implementation periods assess the program's impact on expected intermediate and long-term health and economic outcomes. Given that the implementation of these recommendations depends entirely on the existence of long-term, multisite, public health-focused CHW programs, we advocate the creation and maintenance of such programs, which will facilitate better evaluation and improve the health and well-being of the communities most affected by health inequities.[1] AJPH

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CONFLICTS OF INTEREST

The authors have no potential conflicts of interest with respect to the research, authorship, or publication of this article. No copyrighted material, surveys, instruments, or tools were used in the research described in this essay.

HUMAN PARTICIPANT PROTECTION

Both surveys were approved by the evaluation partners' institutional review boards and the Office of Management and Budget (control no. 0920-1411).

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