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Design, implementation, and evaluation of community health worker training programs in Latinx communities: A scoping review

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Abstract

This review examines the current reporting trends of program design, implementation, and evaluation of training programs for Latinx community health workers. Five scholarly databases were searched using a scoping review methodology to identify articles describing training programs for Latinx community health workers. The timeframe was 2009 to 2021. We identified 273 articles, with 59 meeting inclusion criteria. Researchers thematically coded the articles to identify reporting strategies related to program design, implementation, and evaluation. Findings suggest a lack of consensus in reporting elements critical to program resources, instructor qualifications, frequency and length of training implementation, theoretical background, and pedagogical tools associated with the training program. We offer detailed reporting recommendations of community health worker training programs to support the consistent dissemination of promising practices and facilitate the initiation of new programs for Latinx community health workers.

KEYWORDS

community health workers, curriculum, evaluation, Latino, reporting, scoping review, training

1 | INTRODUCTION

Community health workers (CHWs) are critical actors in bridging the gap between communities and healthcare, particularly for those facing significant barriers to accessing quality and culturally responsive health and social services (Adams et al., 2021; American Public Health Association, 2021; Rosenthal et al., 2016). Globally and in the United States, CHW roles within the health system continue to grow. CHW programs aim to improve health and reduce disparities among various populations. Frequently, they are part of a community-based participatory research (CBPR) approach that works directly with the community of interest to identify challenges and solutions through investigative and intervention research methodologies to better the community (Israel et al., 1998; Stanley et al., 2015).

CHWs and CHW programming with a CBPR framework are increasingly popular as a branch of healthcare and human services for their ability to support racially and culturally diverse communities and provide disease-specific prevention, treatment, or support. CHWs improve access to services, lead community interventions for disease prevention, provide social and case management support, and assess community health conditions and needs (Rosenthal et al., 2016; Schleiff et al., 2021; World Health Organization [WHO], 2021). As community leaders, CHWs—also known as lay health advisors, promotores de salud, or patient navigators—are gaining recognition for their positive impact on the healthcare system and communities (Alvarez-Hernandez et al., 2021; Javanparast et al., 2018; WHO, 2007, 2021).

The diversity of education and training programs for CHWs reflects the variety of environments, cultures, needs, and possibilities for CHWs in the United States and globally. In a systematic review, WHO (2021) reported on the diversity of CHW programming globally, finding that programs in low- to middle-income countries focused mainly on primary care, child health, and maternal health, whereas programs in high-income countries often focused on noncommunicable diseases. WHO (2021) also grouped CHWs into six prominent care roles as follows: (1) delivering clinical care, (2) encouraging the use of health services, (3) providing health education, (4) managing data collection, (5) improving relationships between health systems and communities, and (6) offering support.

CBPR, and particularly in the context of CHW programs, can help solve the challenge of translating research findings into real-world neighborhoods, surpassing the difficulties of sharing scientific knowledge and health and human service information with individuals living in marginalized communities. CHWs incorporate indigenous culture, knowledge, and language while maintaining trust with community members (Wallerstein & Duran, 2010). Thus, CHWs can help overcome many of the challenges of implementation science (Glasgow et al., 2012; Rapport et al., 2018). Although the value of CHWs is indisputable, the best strategies for a successful training program for CHWs remain unclear.

1.1 | CHW programming for Latinx communities in the United States

Latinx communities in the United States experience an array of social disparities and barriers to the healthcare and social service systems that CHW programs help to bridge. Economic and linguistic barriers to accessing care (Perez-Escamilla et al., 2010), poor information translation across minority populations and languages (Wilkin & Ball-Rokeach, 2011), structural racism in immigrant-focused policies (Philbin et al., 2018), and high burdens of chronic disease (Centers for Disease Control and Prevention, 2015; Perez-Escamilla et al., 2010) all contribute to the experience of Latinx communities in the US healthcare system. To diminish these disparities, CHWs have participated in diverse initiatives, such as preventing and managing chronic diseases (Ayala et al., 2017; Goebel et al., 2021; Haughton et al., 2015; Kunz et al., 2017; Kutcher et al., 2015; Taverno Ross et al., 2021) and increasing access to local healthcare and social services (Carter-Pokras et al., 2011; Cupertino et al., 2013; Documet et al., 2016; Macia et al., 2016; Matthew et al., 2020; Webber et al., 2016). Although drastically different in setting, focus, and medium of training, CHW programs are becoming critical to the health and wellness of local Latinx communities.

1.2 | Reporting of CHW training programs

The CHW literature has highlighted critical advancements in health promotion, advocacy, and health equity (Rush, 2019). However, a lack of studies examining the efficacy and characteristics of CHW training programs and poor consensus in reporting program methods make the interpretation and replication of programming difficult (Javanparast et al., 2018; Schleiff et al., 2021). Some advancements in the CHW literature prove promising for standardizing the field of CHW training programs. For example, Rosenthal et al.'s (2016) report addresses the scope and competencies of CHW workers in the United States. They accomplished this valuable compilation through consensus building with state-level CHW benchmark documents and national-level advisory committees to identify 10 CHW roles, 11 CHW skills, and various CHW qualities to represent the range of CHW programming in the United States.

Over a decade ago, O'Brien et al. (2009) suggested that consistency in "reporting CHW selection and training is necessary so that other researchers, practitioners, and governmental agencies can best learn from the published CHW experience" (p. S276). Adams et al. (2021) also suggested a need for better reporting of CHW training programs. In fact, in their rationale as the purpose and need for a review of CHW training programs, Adams et al. (2021) stated that "Despite the rapid integration of CHWs in health care delivery models, little is known about best practices for training this workforce to deliver optimal care" (p. 517).

1.3 | Purpose of the present study

Currently, researchers and health advocates interested in starting new programs in the United States have few guidelines for best practices regarding training, particularly for CHWs in Latinx communities. Although Latinx communities in the United States are linguistically and culturally diverse, we approach the US Latinx population broadly here with an understanding that facilitators and scholars may need to tailor the CHW program to the characteristics of the community (Escoffery et al., 2018).

The aim of the current study, using a scoping review methodology, is to summarize and identify trends and gaps in the current reporting practices within peer-reviewed literature on the design, implementation, and evaluation of training programs for Latinx CHWs. Our assessment of the trends and gaps in reporting literature is informed by past (O'Brien et al., 2009) and present (Schleiff et al., 2021) recommendations to enhance the standardized reporting of CHW training programs.

2 | METHOD

The current study employs the scoping review methodology to identify the characteristics of CHW training programs specific to Latinx communities, focusing on the development, implementation, and evaluation of such training programs. Scholars have used scoping reviews since the late 1990s to "map" a range of literature to identify the depth and breadth of a research field, synthesize findings, and identify gaps (Arksey & O'Malley, 2005; Levac et al., 2010; Tricco et al., 2016). Scoping reviews are particularly beneficial when the breadth of research in a field is too sparse or diverse because of the characteristics of the discipline, theory, or method (Arksey & O'Malley, 2005). This study uses the scoping review method, given both the sparse nature of the Latinx-specific CHW literature and the breadth of disciplinary influence in the CHW literature. The current review followed the five-stage methodological guidelines set forth by Arksey and O'Malley (2005), with additional considerations and clarifications from Levac et al. (2010): (1) identify the scope of inquiry, purpose, and research question; (2) set the data search strategy; (3) apply inclusion and exclusion criteria; (4) develop an iterative charting strategy for data analysis; and (5) analyze, report, and discuss the results of the review.

The following research question guided this review: How are the development, implementation, and evaluation of CHW training programs for Latinx populations reported in the peer-reviewed literature? Our scope of inquiry was peer-reviewed articles describing a CHW training program for Latinx communities. We narrowed the search to articles published in English between 2009 and 2021, excluding the gray literature (Figure 1). The search range reflects the time and process of our scoping review. An initial review was performed in 2019 using a 10-year timeline, followed by subsequent updates to the data sets through 2020 and 2021 during analysis, thus expanding our date range to 2009–2021. To cast a wide net, we selected five social and medical science databases that contain relevant, multidisciplinary research about CHW programs: CINAHL, PsychInfo, PubMed, Social Service Abstract, and Web of Science. These databases offer a comprehensive search of journals covering a range of health and social science disciplines from 1315 journal sources through CINAHL (EBSCO, 2022) to 35,000 journal sources through Web of Science (Clarivate, 2021). We searched these databases using the following terms: (["community health worker" OR "patient navigator" OR "health coach" OR promotor*] AND [Latin*] AND [training OR development]). After removing duplicates, 273 studies remained for further review.

We reviewed the 273 articles to assess their accordance with additional inclusion criteria, namely the following: the study discussed the CHW training program design, implementation, and/or evaluation. Articles were excluded if they discussed CHW programming but not CHW training, they did not review CHW training in a Latinx community, or they were significantly unrelated to the topic despite being identified in the electronic search. After removing studies that did not meet the inclusion criteria, 59 articles remained for complete content analysis. Table 1 lists the 59 studies by the first author's last name, year, and selected relevant characteristics.

We analyzed the studies with an iterative charting process using a grounded theory approach (Bernard, 2007). This approach uses inductive reasoning to develop a corpus of thematic codes by identifying trends in the topics and categories within and across articles (Bernard, 2007). This corpus remained flexible in the coding process as

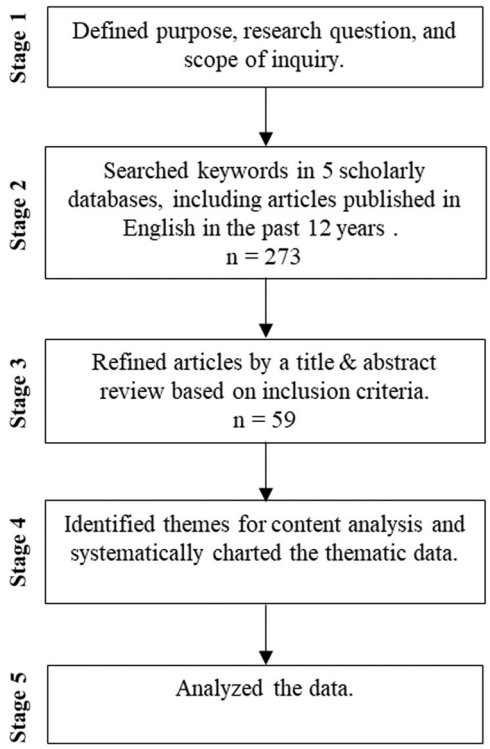

FIGURE 1 Methodological framework applied to the Latinx CHW training program scoping review

TABLE 1 Selected characteristics of the studies included in the review

First author	Years	Structure	Topic	Training schedule
Almeida	2021	Healthcare	Breast cancer	8 h
Alolod	2020	Partnership	Organ donation	>1 h
Alvarez-Hernandez	2021	Community	Boundary setting	4 sessions of 1 h over 3 months
Arrendondo	2021	Partnership	Colorectal cancer screening	80 h
Arvey	2012	Community	Colorectal cancer	3 sessions of 4 h
Askari	2018	Partnership	Alzheimer's disease, dementia	3 sessions of 2 h
Ayala	2017	Partnership	Exercise	48 h total, plus monthly 3 h boosters
Bonilla	2012	Partnership	Women's health	[a]
Briant	2016	Partnership	Cancer	3 days
Carter-Pokras	2011	Community	Access to services	12–44 h, plus 3 h boosters monthly
Coulter	2021	Partnership	Mental health	Monthly sessions
Cupertino	2013	Community	Community health evaluation	15 sessions of 2 h
De La Torre	2021	Partnership	Colorectal cancer	>80 h
DeLiema	2012	Partnership	Abuse and neglect	[a]
Documet	2020	[a]	Research ethics	[a]
Documet	2016	Community	Roles, responsibilities	36 h
Dumbauld	2014	Partnership	Research	3 sessions of 3 h weekly, evening sessions
Fernández	2020	Community	Overweight, obesity	[a]
Fleming	2018	Partnership	HPV, cervical cancer	[a]
Ford	2014	Community	Breast, cervical cancer	2 sessions of 2 h
Ford-Paz	2015	Community	Depression	3 h workshop
Garcia	2012	Partnership	Mental health	1 day
Garza	2020	Community	Neurocognitive disorders	[a]
Goebel	2021	Community	Palliative care, chronic disease	4 workshops over 9 months
Green	2012	Community	Anxiety, depression	10 sessions
Hagwood	2019	Community	Cancer disparities	3 sessions of 2.5–3 h weekly, over 4 weeks
Haughton	2015	Community	Physical activity	2 h sessions, 2 per week for 6 weeks, then less
Hoeft	2015	Partnership	Oral health	Intermittent training over 5 months

TABLE 1 (Continued)

First author	Years	Structure	Topic	Training schedule
Jimenez	2018	Healthcare	Mental disorders	34 h
Kunz	2017	Healthcare	Diabetes	[a]
Kutcher	2015	Partnership	Overweight, obesity	[a]
Lechuga	2015	Partnership	Sexual, reproductive health	20 h per week for 8 weeks
Luque	2011	Partnership	Cervical cancer	6 h; 2 sessions over 2 weeks
Macia	2016	Community	Depression, alcohol	20 h
Marshall	2018	Partnership	Cancer survivors	3 h
Matthew	2020	Community	Connect to services	4 h sessions for 6 months; 70 h first year
Messias	2013	Partnership	Physical activity	32 h
Minkler	2010	Partnership	Toxic-free neighborhoods	[a]
Mojica	2021	Partnership	Cancer	2-week training plus yearly boosters
Moon	2021	Healthcare	Mental health	[a]
Moore-Monroy	2013	Community	Cervical cancer	2-day training
Nebeker	2015	[a]	Human research ethics	[a]
Nebeker	2016	[a]	Research, literacy	Self-paced
Nelson	2011	Partnership	Intimate partner violence	[a]
Otiniano	2012	[a]	Research	3 days
Payán	2020	[a]	Breast cancer	2 sessions per week
Rivera	2018	Community	Cancer	2 days, 5 h each day
Rodriguez	2020	Partnership	Breast cancer	3 h
Sánchez	2012	Partnership	HIV prevention	[a]
Serrano	2018	Community	Alcohol use	2 days
Suarez	2012	Partnership	Smoking	7 sessions of 2 h
TavernoRoss	2021	[a]	Obesity	25 h over 5 days
Tran	2014	[a]	Mental health	6 sessions of 2–3h plus boosters
Vadaparampil	2022	Partnership	Genetic counseling	1.5 days in-person plus 8 online sessions
Vaughan	2021	[a]	Type II diabetes	Weekly Zoom calls
Vaughan	2020	[a]	Type II diabetes	4 h per month for 6 months
Villalta	2019	Partnership	Oral health	4 weekly 2 h sessions; 4–5h homework
Webber	2016	Partnership	Community survey	1 day
Woodruff	2010	Community	Tobacco	9 lessons across 5 weeks for 25 h of training

[a]Article did not present information relevant to this analysis code.

TABLE 2 Code names and code definitions

Code names	Code definitions
Training program design	
Theoretical background	Basis of the learning design/approach of the training program—sets an understanding of how the learning should occur
Training topic	Topics of training (e.g., advocacy, health topic)
CHW skills trained	Skills trained, as aligned with definitions provided by Rosenthal et al. (2016)
Training program implementation	
Instructor qualifications	Title or characteristics of the person leading the training(s) (e.g., program coordinator, nurse, bilingual)
Training schedule	Times, days, scheduling sequence of training
Training program evaluation	
CHWs' evaluation of training	CHW evaluation of the training program
CHWs' accomplishment of training objectives	Evaluation of training program based on the CHWs' performance in the training program

Abbreviation: CHW, community health worker.

themes were added and grouped to identify the scope of reporting trends. We ended our analysis with seven thematic codes: theoretical background, training topic, CHW skills trained, instructor qualification, training schedule, CHWs' evaluation of training, and CHWs' accomplishment of training objectives. Table 2 summarizes the final coding scheme and code definitions used in the analysis organized into three sections: training program design, training program implementation, and training program evaluation. We also describe the characteristics of the studies reviewed by their relationship to the local community and program structure. These categories provide insight into the internal and external program frameworks related to the community and their position in or with other programs and organizations.

To ensure a cohesive reporting and analysis of the training skills, we matched the CHW training curriculum information provided in the articles to the CHW skills outlined in the Community Health Worker Core Consensus (C3) Project (Rosenthal et al., 2016). Based on a consensus-building process, the C3 Project describes the roles, skills, and qualities that CHWs need to meet the needs of their community and the current healthcare system.

3 | RESULTS

The results are organized into four sections as follows: description of the studies reviewed, training program design, training program implementation, and training program evaluation. Table 1 provides excerpts from the full analysis to illustrate both the analysis charting process and the range of studies captured in this review.

3.1 | Description of the studies reviewed

This study consisted of 59 peer-reviewed articles that examined the training of Latinx CHWs. Of note, a few studies reviewed the same CHW programs, specifically: (a) *De la Mano con la Salud* (Documet et al., 2016; Macia et al., 2016); (b) *ALMA—Amigas Latinas Motivando el Alma* (Green et al., 2012; Tran et al., 2014); (c) *LINKS* (Fernández et al., 2020;

De La Torre, 2021; Arredondo et al., 2021); and (d) [program name omitted for double-blind review] (Alvarez-Hernandez et al., 2021; Matthew et al., 2020). We also included a review of several CHW programs in Maryland (Carter-Pokras et al., 2011), which provided valuable information from interviews with program coordinators. Aside from those noted, each article offered unique insights into a Latinx CHW program.

3.1.1 | Relation between the program and the local community

Many programs reported how their CHW programming related to the local community; several programs instituted a CBPR framework as their organizing model ($n = 16$). CBPR is an actionable model of research that intentionally integrates the community with the development, implementation, and evaluation of the program, not just as participants in the intervention (Israel et al., 1998). For example, Documet et al. (2016) described how they integrated community voices through all levels of their organization and invited the community to be active members of the supervising coalition of their CHW program. This supervising coalition consisted of community members, researchers, health and social service providers, and CHWs. Together, the coalition worked to understand and serve the community according to identified needs through their participatory model, which included a participatory health assessment in the county that led to the establishment of the CHW program. With CHWs on the supervising coalition, the coalition received regular feedback on the program's progress, leadership, challenges, and ongoing community needs. As such, the CBPR model proved valuable to understand and develop programming attuned to the unique needs *and* strengths of the local community.

3.1.2 | Program structure

Program structure refers to where and how the CHW program is "housed." We identified three structures as follows: partnership (programs within or between more than one overseeing organization), community (programs in a nongovernmental or academic organization), and healthcare (programs in healthcare-specific organizations such as research institutes, healthcare institutes, or healthcare-based government organizations; Table 1). The structure of CHW training programs may significantly influence, for example, the funding and resources available for a training program, its leadership structure, training topics, and program duration.

Most CHW programs relied on a partnership between more than one program or organization ($n = 27$). This partnership combined academic or research organizations, healthcare institutions, and nongovernmental agencies. For example, Garza et al. (2020) reported that the Hispanic Autism Research Center developed the CHW training program on neurocognitive disorders and partnered with several local organizations that house CHWs to review and pilot the training curriculum. Meanwhile, local universities facilitated the training to meet the standards of CHW certification for the state. This partnership model provided excellent program management and training specialization, while ensuring they met the necessary CHW certification requirements.

Community programs ($n = 19$), the next most common program or organization structure, were often founded by an academic or nongovernmental entity within a single community. For example, Matthew et al. (2020) developed (Lazos Hispanos) separately from other healthcare organizations through an interdisciplinary team of academic researchers and nine community members who trained to become CHWs within the program. Although this program held Memoranda of Understanding with several local health and social service organizations, it was organizationally separate in its training, funding, and leadership. Serrano et al. (2018) and Ford-Paz et al. (2015) also presented their programs as academic-community partnerships that aim to work within a CBPR model to serve the local community. This community-based program structure lends itself well to the CBPR model, because it emphasizes working with local community members to identify needs and solutions.

Healthcare programs (n = 4) were the least common and were often housed within a single research, healthcare, or government organization. Captured in this review, Almeida et al. (2021) provided an example of a healthcare-based program through a cancer institute and Kunz et al. (2017) provided an example of a healthcare-based program through a health center. In their roles, CHWs work with health center patients and call upon tools and programs available through the health center (Kunz et al., 2017). Healthcare-based programs often have the advantage of having in-house services, funding, or opportunities in which CHW programs and community members can share. These program structures offer insight into how CHW training may be developed, organized, and managed within broader program frameworks.

3.2 | Training program design

3.2.1 | Theoretical background

The theoretical background underpins the training framework and, by extension, the pedagogical tools used for CHWs to develop knowledge and skills. Theory, therefore, should guide the development of the training curriculum and the pedagogical tools used in training sessions. However, less than half (n = 20) of the studies discussed the theoretical background of their training or program. Further, several studies included theories that appeared to impact only their community interventions through their CHW program rather than theories that affect CHW training. Arvey et al. (2012) and Marshall et al. (2018) reported the importance of theory in training programs and suggested that the theory should fit well with the local community contexts but did not provide the theoretical background used in their program.

When mentioned, researchers most frequently noted social cognitive theory (Alvarez-Hernandez et al., 2021; Fleming et al., 2018; Hoeft et al., 2015; Rivera et al., 2018; Taverno Ross et al., 2021) and Freirean pedagogy (Bonilla et al., 2012; Kutcher et al., 2015; Moore-Monroy et al., 2013; Sánchez et al., 2012). Cupertino et al. (2013) used both social cognitive theory and Freirean pedagogy in their CHW training framework to situate the CHW program within the larger community social network and implement the training with participatory and interactive pedagogical tools such as open discussions and roleplaying. We include Freirean pedagogy as a theory in this section, because it reflects a comprehensive theoretical and paradigm shift in the training of adults and particularly underserved populations (Freire, 1968). Freirean pedagogy is rooted in critical theory challenging individuals to identify power structures and social inequalities. This view provides insight into appropriate pedagogical tools and strategies for Latinx CHW training.

Researchers also used andragogy, the theoretical framing for teaching adults, in several training programs. For example, the *ALMA* program (Green et al., 2012; Tran et al., 2014), ÁRBOLES Familiares (Vadaparampil et al., 2022), Almeida et al.'s (2021) program, and Nebeker and colleagues' training programs (Nebeker & Lopez-Arenas, 2016; Nebeker et al., 2015) used this framework to guide their training pedagogy for Latinx CHWs. Nebeker et al. summarized the theory of andragogy as "Instruction that engages the learner in defining goals, connects the material to professional interest, and uses problem-based strategies…" (p. 21). In their program design, Nebeker et al. connected this theory to the pedagogical tools they employed in their training. In particular, the authors mentioned defining the purpose of the training, depicting authentic scenarios of best practices to communicate performance expectations, and using case study scenarios to relate possible challenges CHWs may face, while implementing their training. These pedagogical tools are posited to motivate adults in learning, as they engage directly with their life experiences.

Several studies offer more than one theoretical background for their programs (n = 8). For example, Alolod et al. (2020) provided two theories and one model underpinning their program training: vested interest theory, the theory of reasoned action, and the organ donation model. As the program aimed to improve organ donation rates among Latinx communities, these theories worked together within the training to elicit the desired behavior change in both

CHWs and community participants by addressing CHW knowledge of the organ donation process and pathways that lead to behavior change. Bonilla et al. (2012) used multiple theories to guide their workshop practices. In their study, the facilitator of their CHW training workshops used an ecological instructional framework to emphasize "the interplay of factors defining health, illness, and risk" (p. 180), whereas Freirean pedagogy guided the pedagogical practices and materials within the workshop. As evidenced by these and other studies within the review, multiple theories can be employed together for varying program purposes and be responsive to local needs and contexts.

Two studies offered a unique theoretical framing worth exploring in greater detail: Alvarez-Hernandez et al., 2021 used Chicana feminism alongside social cognitive theory and Fernández et al. (2020) used a Community Cultural Wealth framework. Alvarez-Hernandez et al., 2021 used Chicana feminism to address the role of boundary setting among Latina CHWs. As stated by the authors,

> traditional Latinx cultural values embrace these norms, such as *familismo*, *personalismo*, and gendered scripts for women, such as *marianismo* (e.g., Comas-Biaz & Greene, 1994; Falicov, 2014). In the traditional Latinx cultures, these cultural and gendered related values intersect with boundary setting, as Latinas are often socialized to be self-sacrificing, yielding, and accommodating, which centralizes their roles as caretakers. (p. 317)

This theory was the foundation of the training. It brought to light personal and societal expectations Latina CHWs experience in their daily lives, making the practice of boundary setting particularly difficult. This study was one of two that used a Latinx-specific theory in the programs reviewed. The second study by Fernández et al. (2020) used a Cultural Community Wealth framework to understand how female CHWs used their political power from their positions in the Latinx community. The authors explain, citing Yosso (2005), that this framework:

> purports that communities of color, specifically Latinx, hold a wealth of cultural resources, assets, and abilities that allow them to differentially navigate and work through conditions of oppression to build resilience and resistance in the struggle for justice, equality, and equity. (p. 317)

This framework also sheds light on the cultural importance of women in the Latinx community as gatekeepers of culture and tradition. As such, Fernández et al. (2020) suggested that researchers should ensure the inclusivity of their CHW programs for Latinas, given their positions of power in their families and communities.

Both studies present critical insight into the use of Latinx-driven theories in CHW program development. Although social-ecological models and Freirean pedagogy can be advantageous to pedagogical development, the theories presented in Alvarez-Hernandez et al. (2021) and in Fernández et al. (2020) observed the importance of developing theoretically informed and culturally appropriate programming and training. As evidenced by Alvarez-Hernandez et al. (2021), the use of multiple theories in program development can strengthen training programs by ensuring they both model effective structures of change and are situated within the cultural belief systems of local communities.

3.2.2 | Training topic

The training topics covered in CHW programs varied widely. The majority focused on a specific disease or preventative areas ($n = 46$). As depicted in Table 1, cancer, mental health, and overweight/obesity were common in Latinx CHW training programs, whether focused on building social support, developing preventative practices, or managing a disease. Briant et al. (2016) offered an example of a social support training program using digital storytelling to provide a voice to often underheard members of a community. Community members had the opportunity to share their experiences with cancer or other diseases, strengthening their sense of community

support. As an example of preventative care, Ford-Paz et al. (2015) discussed the development of a program to prevent depression and anxiety among Latinx adolescents and their success with CHW training as CHWs gained knowledge, learned about resources, and decreased their stigmatized attitudes toward mental health problems in youth.

Fewer studies focused on the general functioning of a CHW program and the development of CHW skills, like professional education or community needs assessment ($n = 12$). Training programs that did focus on CHW professional skill-building often focused on promoting access to healthcare and social services, enhancing community wellbeing, and engaging the community in empirical research to assess health needs. For example, Nebeker et al. (2015) focused on building CHW professional skills through increasing research capacity with ethics training to understand how to engage research participation in Latinx communities.

3.2.3 | CHW training skills

The studies captured in this review cited all 11 training skills defined by Rosenthal et al. (2016). Rosenthal et al. (2016) offer a set of recommendations for the scope of CHW roles and core competencies to professionalize the field. In these recommendations, the authors identified 11 training skills with related subskills to represent a range of CHW program aims in the United States, which help to standardize CHW training skills and ensure that trained skills relate to CHW roles. These skills are something a person can learn or develop while learning to perform a specified task.

Two skills stood out as being the most reported. First was developing a knowledge base ($n = 31$; e.g., knowledge about social determinants of health, healthy lifestyles, social service systems, health issues, and so on); CHW training programs consider knowledge foundational because it is built and developed in conjunction with other skills. This knowledge base was particularly noted in programs focused on specific topical interventions, such as a disease or preventative practice. Second, communication skills ($n = 17$; e.g., ability to use language to motivate and engage, communicate with empathy and plain language, written communication, listen actively, and so on) were indicated in programs focused on community interventions with various goals, like improving access to healthcare (Matthew et al., 2020) or improving indicators for a particular disease or preventative practice such as reducing smoking (Suarez et al., 2012).

Less commonly trained skills noted in this review were individual and community assessment ($n = 4$) and advocacy ($n = 5$), mainly contributing to policy development and advocating for policy change. One program focused entirely on advocacy as part of a "Toxic-Free Neighborhoods Campaign." CHWs received training to engage politically at board meetings and local media for policy change (Minkler et al., 2010). CHWs in this study worked with partnering organizations to achieve policy objectives for the health and safety of their community.

The skill to assess individuals and communities was often trained in preliminary program projects to identify community needs ($n = 4$). For example, Cupertino et al. (2013) trained CHWs to conduct a community health needs assessment. Through the community survey, CHWs determined that one-third of those who participated in the community survey had at least one smoker in their household, which led to the training of CHWs on smoking cessation skills.

3.2.4 | Gaps in training program design reporting

Based on this review, we noted three apparent gaps in program design reporting: (a) few studies noted details relevant to their curriculum development or attainment from a third party, such as cost or intended availability; (b) few studies presented information on the theoretical underpinning of their training and of those that did present the theoretical background, even fewer expressed how the theory informed their training pedagogies; and (c) few

studies reported on funding sources for their CHW program or training development. These elements are widely under-reported but are likely critical for new CHW programs or training development in Latinx communities.

3.3 | Training program implementation

3.3.1 | Instructor qualifications

Many studies reported that one (or more) individuals served as the CHW training instructor or facilitator and included some information related to the instructor's qualifications. The training facilitators largely depended on the organization or program creating and organizing the training. Some organizations and programs provided their own "in-house" trainers and project members (n = 12), whereas others relied on local physicians, nurses, and other content experts (n= 9). For example, the training reported by Carter-Pokras et al. (2011) on expanding access to health and human service in the Latinx community used both in-house project coordinators and guest speakers as facilitators. In a study on breast cancer education, the facilitator was a bilingual expert researcher in breast cancer genetics, providing training directly to CHWs (Almeida et al., 2021). Meanwhile, in programs like that described by De La Torre et al. (2021), which were built as a partnership of several organizations, the organization housing, the CHWs, provided two training facilitators: the Community Health Educator and Clinic Patient Engagement Specialist.

Two training workshops were facilitated by CHWs who had undergone a train-the-trainer program to expand the reach of health programming. Moore-Monroy et al. (2013) reported on their cancer prevention program training and their multiple program facilitators, including a gynecologist and cervical cancer expert, nurse practitioners, university staff, organization staff, and CHWs. Goebel et al. (2021) used two in-house trainers with *Familias en Acción* to lead their training on palliative care and chronic disease management.

A common theme in facilitator characteristics throughout many of these studies was the importance of bilingual and bicultural facilitators for Latinx training programs (Almeida et al., 2021; Alvarez-Hernandez et al., 2021; Askari et al., 2018; Documet et al., 2020; Matthew et al., 2020; Moon et al., 2021; Serrano et al., 2018; Tran et al., 2014). Askari et al. (2018) reported that bilingual and bicultural staff were essential to building trust between program staff, CHWs, and community members. Bilingual and bicultural facilitators likely improve training outcomes among CHWs by establishing trust and being responsive to cultural expectations of teaching, learning, and sensitive topics.

3.3.2 | Training schedule

Training schedules varied greatly from program to program, as shown in Table 1. Training captured within this scoping review for single programs ranged from one h for a single health topic (Alolod et al., 2020) to 70 h over the course of a year (Matthew et al., 2020). Many training programs reported on some aspect of their training schedule, whether in total hours or total calendar time (n = 46).

Training expectations vary greatly by state regulations for CHWs and CHW certifications. For example, in Texas, CHWs are expected to be certified through programs that are at least 160 h with education courses required every two years to maintain certification (Garza et al., 2020). Not all states require certification, although, so some CHWs could be trained for single health or disease-driven projects. For example, Hoeft et al. (2015) offered intermittent training that increased in frequency and intensity over five months, building to several full-day, back-to-back workshops to train four new CHWs on oral health education. However, training hours varied across programs, even with a similar topic. Villalta et al. (2019) also developed a program for oral health, but their training occurred across two h sessions, once a week, for four weeks, plus several hours of reading that CHWs completed on their own time.

Arvey et al. (2012) noted that introducing new technologies with a training program required more time than initially planned because CHWs had a limited background in computer technologies and often needed extra time

and practice to adapt to the new skillset. Meanwhile, several research groups found that integrating technology for remote CHW training sessions was extremely useful in increasing CHWs' attendance. Using these technologies for training and support positively impacted CHW learning outcomes (Vadaparampil et al., 2022; Vaughan et al., 2020, 2021).

Documet et al. (2020) also noted the importance of considering CHWs' time and outside responsibilities when scheduling their training program. In the pilot testing, the CHWs requested not to hold meetings over lunchtime and include more breaks. Alvarez-Hernandez et al. (2021) also emphasized the importance of understanding CHW roles within their communities beyond their CHW expectations. When considering scheduling, project staff should consider home, family, and other work responsibilities that would impact CHWs' ability to participate or focus on training and remain responsive to CHWs' unique needs.

3.3.3 | Gaps in training program implementation reporting

As noted by Documet et al. (2020) and Alvarez-Hernandez et al. (2021), training schedules are best developed with intention and understanding of CHWs' responsibilities external to the CHW program, although this process was infrequently reported. As Latinx women hold many roles in their family and community (Alvarez-Hernandez et al., 2021), researchers, in consultation with CHWs, are encouraged to identify successful practices for scheduling training, which in turn increases engagement and demonstrates understanding of the familial and social commitments of the Latinx CHWs.

Further, the compensation of actors in the CHW program was rarely reported yet is critical to program development and implementation. Reporting of funding and compensation of program participants and employees is vital information to allow new programs to estimate program costs and appropriate compensation for CHWs for funding applications.

3.4 | Training program evaluation

We present training evaluation from two perspectives: (1) CHWs' evaluation of training and (2) CHWs' accomplishment of training objectives as assessed by the research team or instructors.

3.4.1 | CHWs' evaluation of training

CHWs' evaluation of their training included Likert scale surveys, focus groups, and interviews. Documet et al. (2020) solicited feedback from CHWs in focus groups on training materials and training implementation to improve future CHW activities. In the focus groups, CHWs mainly reported positive feedback on the materials. Still, they recommended adding more breaks during the workshop and not holding the sessions during lunchtime. Green et al. (2012) also reported that CHWs provided feedback on their experiences in each session. Although they immensely enjoyed the content, they recommended longer sessions and additional learning materials.

3.4.2 | CHWs' accomplishment of training objectives

Investigators' evaluation methods of CHWs' accomplishment of training objectives varied greatly. The most common strategies were behavioral observations and surveys. Facilitators observed training skills through CHW-led workshops (Arvey et al., 2012; Carter-Pokras et al., 2011; De La Torre et al., 2021; Hagwood & Larson, 2019;

Haughton et al., 2015; Taverno Ross et al., 2021) or roleplay scenarios (Carter-Pokras et al., 2011) ($n = 7$). Researchers used pre- and post-test surveys of knowledge ($n = 13$) and efficacy of CHWs targeting specific goals of the training program. In the study by Ford-Paz et al. (2015), CHW trainees needed to pass a post-test with 90% accuracy. Documet et al. (2016) reported that CHWs surpassed the initial program goal of recruiting 125 participants in 10 months. In this study, CHWs also established an informal mentorship structure for themselves, which helped the program succeed, as shared by one of the trainees in the program:

> During the first stretch of one or two months [...] it became clear that there were some *promotores* who were very successful. They had fifteen or twenty [participants], and some *promotores* had three or four. So... the general comment was that they didn't have the skills to hook [participants] directly. That's when [*Promotor* 1] said, well, I do it this way. And the other who was quite successful back then was [*Promotor* 8]. And the other who was very successful was [*Promotor* 5]. So they started to offer themselves as mentors for the others. (p. 339)

As evidenced by this quote, analysis of program efficacy through qualitative inquiry provided critical insight into CHW experiences in training programs and their role in program success.

3.4.3 | Gaps in training program evaluation reporting

One type of evaluation rarely noted in this review was fidelity of implementation, which refers to whether the facilitators delivered the CHW training following the program's original design and intent. Fidelity may also refer to how CHWs communicate with the community, which acts as a form of assessment for how CHWs achieved the training objectives. In total, seven studies mentioned fidelity (Ford et al., 2014; Marshall et al., 2018; Matthew et al., 2020; Mojica et al., 2021; Moore-Monroy et al., 2013; Nebeker & Lopez-Arenas, 2016; Serrano et al., 2018). As an example, fidelity is noted in Ford et al. (2014); researchers evaluated how trained participants provided community education according to the original design and intent of the training. Due to the need to culturally tailor curriculums to each CHW program and community, this fidelity measure is not always appropriate to assess or report in CHW training programs. Still, it may be helpful as a tool to evaluate CHWs' accomplishment of training objectives.

4 | DISCUSSION

This scoping review analyzed 59 CHW training programs in Latinx communities for reporting on program design, implementation, and evaluation. This study complements the work of Adams et al. (2021), Rosenthal et al. (2016), O'Brien et al. (2009), and Viswanathan et al. (2010) by providing the current scope of reporting trends of the characteristics of training programs specifically for Latinx CHWs. In accordance with previous literature reviews on CHW programming (Adams et al., 2021; O'Brien et al., 2009; Rosenthal et al., 2016; Viswanathan et al., 2010), it remains vital to ensure adequate reporting of how researchers and practitioners conduct training programs. This information will allow new programs to access promising training recommendations to develop their own culturally and locally responsive training practices (O'Brien et al., 2009; Schleiff et al., 2021). In the results section, we reported the trends in the reporting of training for Latinx CHWs, and from the identified trends, we elaborated on the gaps in the literature.

The reporting of the training program design, implementation, and evaluation for Latinx CHWs varied significantly in the peer-reviewed literature. Acknowledging the diversity of programs reviewed, some variety in training reporting is expected. However, the articles' lack of consistency in training reporting extends beyond those

of various training topics and purposes by revealing little agreement on how to report the training or which training elements are most beneficial for peer-reviewed reporting. This lack of consistency continues in the field despite attempts to provide models to ensure adequate reporting (O'Brien et al., 2009; Rosenthal et al., 2016; Schleiff et al., 2021). The lack of information in current reporting trends decreases the replicability of programs and interventions, potentially distorts, and often simplifies the process of creating and sustaining these programs, thus leading to a lack of scientific reliability and potentially harming program success, growth, and sustainability.

O'Brien et al. (2009) described a conceptual model to illustrate the pathway from selecting CHWs for the training followed by role enactment and program outcome. Their training section highlights four reporting categories: instructional program, instructor qualifications, curriculum source, and evaluation. Our scoping review substantiated these categories with further valuable subcategories. This expansion aims to evaluate with greater specificity the reporting of training programs. We also considered Schleiff et al.'s (2021) suggestions for the continued growth and professionalization of CHW programming, particularly their recommendations that the training should be locally situated, ongoing, and continually evaluated for quality. Based on prior reporting models and this literature review, we organized the discussion into six reporting recommendations: program or organizational structure, program resources and funding, instructional program, curriculum, instructor qualifications, and evaluation (Table 3). Although these recommendations are developed from this review of Latinx CHW training programs, we believe they hold broader implications for CHW program reporting beyond the Latinx community.

4.1 | Program or organizational structure

As evidenced in our findings, it is critical to understand not just the training program but the larger program or organizational structure that houses, facilitates, and designs CHW training. This macro-level influence can significantly impact the enactment of CHW training through access to resources and relationships with community members and organizations. We suggest reporting on established and envisioned community and organizational partners and the assets these relationships provide. This information would offer a detailed outline of the program's resources for CHW training (e.g., meeting space, food, childcare, or transportation) and the program's position in the local professional and social communities.

Information regarding the local community may also clarify how CHWs relate to other professional services and community members. Organizational relationships with local health and social services through formalized Memoranda of Understanding agreements can, for example, strengthen CHWs' confidence and efficacy in supporting the health of the local Latinx community (Matthew et al., 2020). In addition, providing information on whether the CBPR approach was used clarifies the extent to which CHWs and community members were involved in the multiple phases of training development, implementation, and evaluation.

4.2 | Program resources and funding

Disclosing funding sources or the estimated cost of the CHW training program can be valuable for those planning new CWH programs, as funding is critical to program sustainability and efficiency. Although CHW programs are often low-cost solutions to gaps in healthcare services (Javanparast et al., 2018), costs are still associated with these programs. Regrettably, researchers rarely discuss funds for facilitators, externally developed curricula, translation services, CHWs, meeting space, food, or childcare. However, such resources are often necessary to implement effectively in-person and online CHW training sessions.

Reporting funding from grants, donations, or the institutional budget can be particularly relevant to new programs as they develop realistic financial expectations. Further, new programs may need information on how funding is allocated, particularly compensation for CHWs and other personnel. This information may be critical to program sustainability.

TABLE 3 Recommendations for reporting Latinx CHW training programs

Training categories	Suggested elements to report
Program or organizational structure	• Established or envisioned partners with an active role in supporting the program for the Latinx community (e.g., health center, academic partner) • Level of engagement of the Latinx community in the development, implementation, and evaluation of the CHW program
Program resources and funding	• Funding sources for the program's ongoing work and training (e.g., grants, donations, organizational funds) • Additional training resources (e.g., meeting space, food, childcare, transportation) • Compensation and incentives for program personnel (e.g., full-time project managers, volunteer or paid CHWs, university-employed researchers)
Instructional program	• Purpose of the CHW training program (e.g., decrease stigma around seeking mental health services, increase access to health and social services) • Training program topics (e.g., cancer screening, advocacy)
Curriculum	• Source and cost of the training curriculum: who developed it (e.g., in-house, external organization, adapted from a different training) and how might others access it • Methods used to assess training implementation fidelity • Intended population for the CHW training (e.g., Latinx, Afro-Caribbean, rural, urban) • Theoretical framework of the program design (e.g., andragogy, social cognitive framework), noting if the theoretical framework is informed by Latinx culture (e.g., Chicana Feminist Thought) • Pedagogical tools for training with detailed examples (e.g., lectures, discussion, roleplay, case studies) informed by the Latinx culture • Details on the connection between theory, training content, and training pedagogy • Trained CHW skills, as aligned with Rosenthal et al. (2016) • Scheduled training hours and meeting times with the rationale for the designated meetings (e.g., 30 h total, five h every Wednesday morning with a 30 min break after two and a half h, every week for six weeks, to accommodate the needs of caregivers in the group)
Instructor qualifications	• Relationship of the instructor to the CHW and Latinx community (e.g., member of the community, culturally identifies with the community, external to the community) • Language skills that enhance the CHWs' training experience (e.g., Spanish and English if working with Latinx CHWs, indigenous language if working with indigenous CHWs) • Role of the instructor within the organization or program (e.g., co-researcher, project manager, health clinic nurse) • Topical expertise relevant to the training and Latinx community (e.g., specialized knowledge, skills, or experience)
Evaluation	• CHWs' evaluation of the training content and delivery (e.g., focus groups, short answer surveys, interviews, Likert scale surveys) • CHWs' accomplishment of the training objectives (e.g., roleplay, pre- and post-training survey, observations)

Abbreviation: CHW, community health worker.

A few articles in our review presented information on funding for training implementation, although we did not systematically assess it in our data analysis. For example, Fernández et al. (2020) noted that their association with a university was a valuable resource. They worked with student assistants and held meetings in a classroom at a local school; these resources allowed for a smaller budget for program training. Minkler et al. (2010) reported providing small stipends to CHWs, meals, and childcare for training sessions. Although often overlooked in training reporting, such elements are critical to implementing CHW training sessions and assessing training costs. Although CHWs may be satisfied with volunteering to serve their communities, the lack of financial support can cause feelings of being undervalued and lead to difficulties as CHWs attempt to fulfill their expected CHW roles and familial and social responsibilities (Flores et al., 2021).

4.3 | Instructional program

Researchers recommend reporting the training purpose and topics in describing the instructional program—as also recommended by O'Brien et al. (2009). The purpose of the training refers to the problem the CHW training aims to resolve either within the CHW program or the local community. For example, Documet et al. (2016) reported that their training topic of research ethics specific to Latinx cultural expectations and social exchanges was critical to ensuring ethical research participation and engagement by CHWs in the local Latinx community. This reporting provides the necessary background to understand the training's curriculum.

4.4 | Curriculum

Our study expands on previous descriptions of the CHW curriculum development and implementation by providing five recommendations. First, report who developed the curriculum, the cost, and how (if at all) other researchers can obtain it. As evidenced in our results, some training programs were developed by organizations or programs external to those implementing the training (Briant et al., 2016; Garza et al., 2020; Kunz et al., 2017). Information regarding whether a curriculum is free or available for a fee would benefit organizations wishing to implement existing curricula. Further, in-house programs may not have their training manualized and they may not be open to sharing it with other CHW initiatives. If implementing a manualized curriculum, it is likewise recommended that researchers provide information regarding the assessment of implementation fidelity.

Second, clarify whether the curriculum was developed for the Latinx CHWs or adapted for this population. If modified, describe the adaptation process. For example, Bonilla et al. (2012) present their adaptation of the book *Our Bodies, Ourselves* on female health into a Spanish-language training manual for CHWs and describe both the manual's initial development and pilot testing with Latina CHWs.

Third, explain the theoretical framework of the training and the pedagogical tools used. This information not only supports the scientific rigor of CHW training programs but also may provide insight into how the curriculum is designed for specific communities, as suggested by the Latinx-specific theories found in two of the papers reviewed (Alvarez-Hernandez et al., 2021; Fernández et al., 2020). The theoretical background should also extend to the program's pedagogy to exemplify the curriculum in action. Nebeker and Lopez-Arenas (2016) documented this process using their theoretical model to inform their selection of pedagogical training tools. Reporting on the theoretical background and pedagogical tools could help guide those planning to develop new curriculums for CHWs. The connection between theory, content, and pedagogy should be explicit. Further, detail regarding how the Latinx culture informs the selection and application of the theoretical framework would be of great benefit.

Fourth, state the CHW skills covered in the training curriculum and link them to the guidelines set out by Rosenthal et al. (2016). These guidelines provide a cohesive and comprehensive starting point to develop CHW training and programming attuned to national core competencies. These guidelines also help standardize the peer-reviewed reporting of CHW training programs, supporting calls to professionalize the field further.

Fifth, share practical information about the training, particularly the total number of hours of the curriculum and the schedule of meetings. Provide this information in the context of the participants' demographic characteristics and skill levels. For example, some communities may prioritize training schedules attuned to family, social, and community responsibilities of the Latinx CHWs (e.g., picking up children from school, work schedules, or community activity times). Alvarez-Hernandez et al. (2021) underscore this point in their boundary-setting training.

4.5 | Instructor qualifications

To better address program implementation, we recommend reporting three aspects of the instructor qualifications. First, indicate the instructor's relationship to the CHW community (e.g., internal or external to the CHWs' community and the community served); receiving information from members of one's own community increases trust (Balasuriya et al., 2021). Second, note the language skills of the instructor and the language used to conduct the training when working with populations whose first language is not the reporting language. In Latinx communities, CHW training may vary between English, Spanish, or an indigenous language, and is, therefore, essential to report in peer-reviewed literature. Third, describe the topical expertise of the instructors and their roles within the CHW program or partnering organizations—if they hold, for example, positions in project management, research, or healthcare. This information helps to identify the knowledge and skill qualifications of the instructor related to the training topic. For example, Moore-Monroy et al. (2013) reported that their instructors came from various professional backgrounds, including cervical cancer experts, nurse practitioners, university professors, program staff, and CHWs. Each instructor provided unique and specialized knowledge to the CHW training on cervical cancer prevention.

4.6 | Evaluation

Lastly, in line with O'Brien et al. (2009), we recommend reporting on the evaluation of the training program. Adams et al. (2021) emphasized the lack of information in the peer-reviewed literature on the efficacy of pedagogical tools used in CHW training. Meanwhile, Schleiff et al. (2021) suggested that professionalizing CHW training requires constant assessment of the quality of the training. We recommend two different outcome evaluations to address the gap between what is and what should be reported. First, we recommend that CHWs be involved in assessing the training program. Beyond program satisfaction and practical suggestions for conducting future sessions, researchers are encouraged to evaluate CHWs' perceptions of knowledge and self-efficacy gains. Second, researchers recommend reporting CHWs' accomplishment of the training objectives based on professional standards. Examples of strategies to conduct this evaluation are assessing performance in role plays, observing interactions in the community, or completing written surveys before and after the training, all of which were represented in this literature review. Such information would aid others in developing and implementing training curricula and pedagogical tools to enhance training and programmatic outcomes. Each type of evaluation has merit and importance. These evaluations would aid in identifying the best (or most promising) practices that may help develop future Latinx CHW training programs.

4.7 | Limitations

Potential limitations are the scope of the search and the researchers' positionality in the review topic. Although we aimed to be inclusive of the interdisciplinary nature of CHW programming in the databases searched, the choice of five databases and the exclusion of gray literature may have resulted in missing potentially relevant studies.

However, as reported earlier, these five databases are extensive; thus, we expect to have missed few, if any, studies. The authors of this study were involved in one program included in this review (Alvarez-Hernandez et al., 2021; Matthew et al., 2020); however, this is just one of many programs, and we strived to remain unbiased in the data analysis and reporting of results.

4.8 | Contributions to the field

This study offers several contributions to the field. CHW programs remain a promising addition to our current healthcare environment, particularly within underserved communities. Ensuring that researchers and practitioners share the program and training information in the peer-reviewed literature will significantly benefit the field's growth and scientific presence. Developing CHW training programs is an enormous task that would be aided by detailed, peer-reviewed literature describing CHW training programs, particularly for various cultural groups. However, the field continues to be limited by the underreporting of critical components of CHW training in the peer-reviewed literature (Adams et al., 2021; Javanparast et al., 2018; O'Brien et al., 2009; Schleiff et al., 2021). The field of CHW literature in general and Latinx literature specifically would benefit from a systematic and rigorous approach to reporting CHW training programs to enhance their replicability and further contribute to the growth of this field.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request. An appendix detailing the data extracted for review in the analysis process is available upon request.

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