The Ongoing Pursuit of Health Equity in Oregon:

A Case Study of Health Communication and Community Partnerships During the COVID-19 Pandemic

by

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DISSERTATION ABSTRACT

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Doctor of Philosophy in Communication & Media Studies

Title: The Ongoing Pursuit of Health Equity in Oregon: A Case Study of Health Communication and Community Partnerships During the COVID-19 Pandemic

In the U.S. and Oregon, Latinx communities have experienced some of the most disparate health, social, and economic consequences during the COVID-19 pandemic due to existing structural and environmental inequities. In the state of Oregon, many Latinx-serving community-based organizations (CBOs), local public health authorities (LPHAs), and the Oregon Health Authority (OHA) have worked to respond creating culturally appropriate messages to disproportionately impacted Latinx communities during the pandemic and to advocate for critical resources and support. Since LPHAs serve as a direct communication source to local communities and CBOs in addition to acting as intermediaries between state and national health officials, their unique and critical position in public health work warrants distinctive consideration. Drawing from traditional health communication theory, critical and cultural health communication theory, and theorization of structural violence and vulnerability, this dissertation focuses on Oregon's LPHAs as a case study to respond to questions that examine health communication and community partnerships work during the COVID-19 pandemic. Furthermore, it explores how lessons from the pandemic are informing their ongoing work to improve health equity in the state. The study utilizes a mixed-method approach including critical discourse analysis of health communication materials (i.e. videos, posters, social media posts) from Latinx serving CBOs, LPHAs and OHA during the pandemic, semi-structured participant

interviews with LPHA leaders from across the state, and focused insights from participatory observation with one LPHA.

The dissertations' critical discourse analysis reveals that the OHA, LPHAs and CBOs recognized the significant role of various health communication strategies to reach Latinx communities during the pandemic and significant efforts were made to communicate effectively on a wide range of issues. While traditional, individualistic health communication theories were reflected in many health behavior-focused messaging, culture-centered approaches were also widely incorporated to reach highly marginalized community members. Health communication from CBOs suggested the most explicit health activism motivations, especially in the initial stages of the pandemic. Participatory interviews with state LPHA leaders and staff confirmed the importance of effective and clear communication and strong relationships with community partners, including an increase in staffing positions dedicated to this work. Longstanding gaps in public health infrastructure and funding of LPHAs continues to cause challenges and highlights the need for more sustainable funding and improved collaboration with the OHA. Participant observation of Lane County Public Health's innovative Community Partnership Program and a collaborative multi-phase survey project of Latinx community members serve as key examples of community-driven local public health equity work. The findings of this case study provide recommendations for future public health communication and health equity efforts. It suggests ways in which the public health modernization model should be further fulfilled, community engagement may be improved, the establishment of long-term and sustainable support, more focus on policy and systems, and health communication that enables a cultural shift in our understanding of public health and health equity.

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TABLE OF CONTENTS

Chapter | Page

LIST OF TABLES ... *9*

LIST OF FIGURES ... *10*

LIST OF ACRONYMS ... *11*

CHAPTER 1 ... *13*

INTRODUCTION ... *13*

Public Health in the United States- An Overview ... **18**

Local Health Authorities in Public Health ... 23

The Oregon Health Authority (OHA) and Oregon's Local Public Health Authorities (LPHAs) ... 26

Public Health Modernization for Health Equity ... **29**

Latinx History and Inequities in Oregon ... 33

Reflection on My Positionality ... **36**

Structure of Dissertation ... **38**

CHAPTER 2 THEORETICAL FRAMEWORK AND LITERATURE REVIEW ... *40*

A Brief History of Development and Social Change Communication ... **41**

Health Communication ... **46**

Dominant Health Communication Theories ... 47

Critical Cultural Health Communication and Health Activism ... 54

Social Determinants of Health, Structural Violence, and Vulnerability ... **58**

Structural Violence and Vulnerability within Latinx Communities ... 63

Health Communication and Health Equity during COVID-19 Pandemic ... **65**

CHAPTER 3 METHODOLOGY ... *69*

Critical Discourse Analysis ... **69**

Semi-Structured Qualitative Interviews ... **72**

Participatory Observation ... **74**

Sample ... **75**

Dissertation Mixed-Method Case Study Overview ... **78**

Limitations ... **79**

Methodological Reasoning ... **80**

CHAPTER 4 ... *82*

MESSAGING TO REACH THE MOST IMPACTED BY COVID-19: ... *82*

RESULTS OF CRITICAL DISCOURSE ANALYSIS OF LATINX-FOCUSED HEALTH COMMUNICATION FROM CBOS, LPHAS, AND OHA DURING THE COVID-19 PANDEMIC ... *82*

Period 1. Spring 2020: Early Pandemic ... **84**

Period 2. Late Spring- Summer 2020: Pandemic recedes, state reopening ... **96**

Period 3. Winter 2020: Pre-vaccination and pandemic surge..101

Period 4. Late Winter- Spring 2021: Vaccination begins and mass vaccination clinics...............105

Period 5. Summer 2021: Vaccination subgroups and boosters, addressing vaccination inequities 111

Period 6. Fall 2021: Response to Delta variant surge, Continued vaccination efforts..................114

Summary 119

CHAPTER 5 123

LOCAL PUBLIC HEALTH COVID REFLECTIONS, CHALLENGES, AND LESSONS:. 123

RESULTS OF A SURVEY OF OREGON'S LOCAL PUBLIC HEALTH AUTHORITIES (LPHAS), PARTICIPATORY INTERVIEWS WITH LPHA PARTICIPANTS ON STAFFING, COMMUNICATION, PARTNERSHIPS, AND LESSONS LEARNED DURING THE COVID-19 PANDEMIC AND BEYOND 123

LPHA Communication and Community Partnership/ Health Equity- Specific Staffing............125

Overview of Communication Staffing 125

Overview of Community Partnership/ Health Equity LPHA Staffing: 127

LPHA Communication Strategies during the pandemic...129

LPHA Health Equity Concerns and Community Partnerships..133

LPHA Community Partnerships.. 135
Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP) at Oregon's LPHAs 138

Most Significant Lessons from the Pandemic...140

1. The importance of effective and clear communication. 141
2. The importance of having strong relationships with community partners. 145
3. Existing and longstanding gaps in public health infrastructure hindered LPHAs pandemic response and more funding is needed for future work. 149
4. The need for better communication and collaboration between the state (OHA) and local health authorities (LPHAs). 151
5. The importance of work balance and healthy work culture to address the challenge of burnout. 154
6. Public health units benefit from having diverse teams in their staff. 155
7. The importance of transparency, explaining why decisions were made, including the importance of having and sharing local data. 157

Summary 158

CHAPTER 6 BUILDING BEYOND COVID- COMMUNITY PARTNERSHIPS IN LANE COUNTY PUBLIC HEALTH: RESULTS OF PARTICIPANT OBSERVATION AND INTERVIEWS WITH LCPH COMMUNICATION & COMMUNITY PARTNERSHIP PROGRAM TEAMS 161

Lane County Context: Local Health Disparities Pre-Pandemic...162

LCPH Covid-19 Response- Communication and Community Partnership 166

LCPH Latinx Community Survey Research Project...170

Method.. 171
Participant Demographic Background.. 172
Information and Communication Sources for Participants 174

Motivations for Testing 175
Barriers to Testing 176
Motivations for Vaccination 177
Barriers to Vaccination 177
Impacts of the Pandemic 178
Other Insights and Observations from the Survey 179

LCPH's Community Partnerships Program (CPP) 181
CPP Team Background and Early Work 181
CPP's Ongoing Partnership Work After End of Official COVID-19 Emergency 185
CPP's CBO Newsletters 187
CPP's Data Focus 193
CPP's Work on Participatory Grant-Making 197
CPP's Work on Racism as a Public Health Crisis 199
2024 Community Health Assessment Using MAPP 2.0. 201

Summary 202

CHAPTER 7 205

DISCUSSION & CONCLUSION 205

Key Findings and Recommendations 206
Improve Community Engagement 206
Establishment of Long-term and Sustainable Support for Public Health 212
Improved Capacity Building of CBOs 214
More Focus on Policy and Systems 217
Cultural Shift through Health Communication 221

Limitations and Future Research 224

Conclusion 226

APPENDIX A: LATINX COVID-19 MESSAGING IN OREGON 231

APPENDIX B: LIST OF EXAMPLES DISCUSSED IN CHAPTER 4 CRITICAL DISCOURSE ANALYSIS 232

APPENDIX C: INTERVIEW GUIDE FOR SEMI-STRUCTURED LPHA PARTICIPANT INTERVIEWS 235

APPENDIX D: EXAMPLE OF LCPH LATINX COMMUNITY SURVEY PHASE II QUESTIONAIRE 236

REFERNCE LIST 240

LIST OF TABLES

Table Page

1. 3.1 DISSERTATION MIXED-METHOD CASE STUDY OVERVIEW 78-79
2. 5.1 COMMUNICATION SPECIFIC STAFFING AT LPHAS DURING THE PANDEMIC... 126
3. 5.2 COMMUNICATION SPECIFIC STAFFING AT LPHAS AS OF LATE 2023 126-127
4. 5.3 COMMUNITY PARTNERSHIP/ HEALTH EQUITY SPECIFIC STAFFING DURING THE PANDEMIC...127-128
5. 5.4 COMMUNITY PARTNERSHIP/ HEALTH EQUITY SPECIFIC STAFFING AS OF LATE 2023 128
6. 5.5 COMMUNITIES MOST OFTEN LISTED BY LPHAS FOR SPECIFIC HEALTH EQUITY CONCERNS DURING THE PANDEMIC 134
7. 5.6 LPHAS CHA PUBLICATION RANGE... 139
8. 5.7 LPHAS CHIP PUBLICATION RANGE 139
9. 6.1 EMPLOYMENT TYPES.. 173
10. 6.2 PERSONAL EXPERIENCES WITH COVID-19 INFECTION..................... 174
11. 6.3 MOTIVATIONS FOR TESTING 175
10. 6.4 BARRIERS TO TESTING.. 176
11. 6.5 MOTIVATIONS FOR VACCINATION 177
12. 6.6 BARRIERS TO VACCINATION...177-178
13. 6.7 IMPACTS OF THE PANDEMIC 178

LIST OF FIGURES

Figure Page

1. 1.1- IMAGE OF OREGON'S PUBLIC HEALTH MODERNIZATION FRAMEWORK PUBLISHES ON OHA WEBSITE. 31
2. 4.1 APRIL 2, 2020 FACEBOOK POST FROM CBO CASA LATINOS SHARING VIDEO ON HANDWASHING IN MAM 85
3. 4. .2 MARCH 23, 2020 CLA FACEBOOK POST SHARING LINK TO ICE PETITION 90
4. 4.3 MARCH 31, 2020 CASE LATINOS UNIDOS FACEBOOK POST SHARING LINK TO COMMUNITY PETITION TO STATE LEGISLATOR TO ADOPT OWR FUND 93
5. 4.4 SCREENSHOT OF WELCOME SCREEN OF COVID-19 PUBLIC AWARENESS CAMPAIGN SAFE + STRONG LAUNCHED BY GOVERNOR BROWN AND OHA IN APRIL 2020 96
6. 4.5 2020 INFOGRAPHIC ON PROPER FACEMASK PRODUCED BY CDC AND SHARED BY OHA 97
7 AUGUST 19, 2020 LCPH FACEBOOK PROMOTION OF AN EVENT IN COTTAGE GROVE... 101
8. 4.7 EXAMPLE OF EVENT FLYER SHARED BY MULTNOMAH COUNTY LPHA TO FARMWORKERS.. 110
9. 4.8 EXAMPLE OF OWR INFOGRAPHIC SHARED BY CLA'S FACEBOOK PAGE IN MAY 2021 111
10. 4.9 OHA INFOGRAPHIC SHARED AS FACEBOOK POST ON AUGUST 22, 2021 112
11. 4.10 EXAMPLE OF A FACEBOOK POST FROM CENTRO LATINO AMERICANO PROMOTING COMMUNITY VACCINE EVENTS.. 115
12. 6.1 INFORMATION AND COMMUNICATION SOURCES FOR PARTICIPANTS 174
13. 6.2 EXAMPLE OF CBO NEWSLETTER IN SPANISH PUBLISHED ON APRIL 25, 2021 191
14. 6.3 PHOTO OF A COMMUNITY MEMBER PARTICIPANT AT CPP'S BIRTH DATA RELEASE PARTY ON SEPTEMBER 26, 2023, IN EUGENE, OR 196

LIST OF ACRONYMS

Acronym	Meaning
APHA	American Public Health Association
ASTHO	Association of State and Territorial Health Officials
BIPOC	Black, Indigenous, People of Colors
CBO	Community-based organization
CBOAN	Community-based Organization Action Network (of Lane County Public Health's Community Partnerships Program)
CCA	Culture-centered approach, health communication model of Mohan Dutta
CCO	Coordinated care organization
CCP	Community Partnerships Program (of Lane County Public Health)
CDA	Critical Discourse Analysis
CDC	Centers for Disease Control and Prevention
CERC	Crisis and Emergency Risk Communication
CHA	Community Health Assessment
CHADT	Community Health Assessment Design Team
CHIP	Community Health Improvement Plan
CHW	Community Health Worker
CLA	Centro Latino Americano, Latinx-serving CBO in Lane County, now called Plaza de Nuestra Comunidad
CLOH	Oregon Coalition of Local Health Officials
COVID-19	Novel coronavirus disease
CPOP	Community Partner Outreach Program
devcom	Development Communication
EPPM	Extended Parallel Process Model
HB	House Bill
HBM	Health Belief Model
HRSN	Health-Related Social Needs
HTO	Healthier Together Oregon
LCPH	Lane County Public Health
ICE	Immigration and Customs Enforcement
IRCA	Immigration Reform and Control Act
LHD	Local health department
LPHA	Local public health authority

MAPP	Mobilizing for Action Through Planning and Partnerships
NACCHO	National Association of County Health Officials
OHA	Oregon Health Authority
OHP	Oregon Health Plan
OPHA	Oregon Public Health Association
OWR	Oregon Worker Relief Fund
PCUN	Pineros y Campesinos Unidos Noroeste
PHA	Public Health Administrator
PHAB	Public Health Accreditation Board
PHEP	Public Health Emergency Preparedness
PHD	Public Health Division
PIO	Public Information Officer
RFP	Request for proposal
SDH	Social determinants of health
SHA	State Health Assessment
SHIP	State Health Improvement Plan
TFAH	Trust for America's Health
TPB	Theory of Planned Behavior
TRA	Theory of Reasoned Action
WIC	Women, Infants & Children
WVIP	Willamette Valley Immigration Project

CHAPTER 1

INTRODUCTION

The right to health is "perhaps the least contested social right, and thus focusing on health serves to remind us that those who are sick and poor bear the brunt of human rights violations" and deserves more focus in efforts of social change and development. -Paul Farmer, 2003

At the time of my writing this introduction in March 2024, four years after Oregon's first confirmed COVID-19 case in March 2020, the U.S. has had an estimated 1.18 million COVID-19 related deaths and the state of Oregon has had nearly 1 million confirmed COVID-19 cases and over 9,000 deaths to COVID-19 (Our World in Data, 2024; John Hopkins University, 2023). Between March 2020 and July 2022 as the pandemic progressed through multiple waves of surging and declining cases, Oregon Governor Kate Brown issued 39 executive orders aimed at protecting public health by limiting the spread of the novel coronavirus including stay-at-home orders, gathering bans, various business closures, mask and vaccine mandates all the while federal and state emergency response funding was allocated to support the unprecedented public health system pandemic response (Rede Group, 2022). Health communication and outreach has played a significant and necessary role in saving lives during the COVID-19 pandemic. As Fincet et al., (2020) explain, "accurate and well-developed health communication can facilitate how societies handle uncertainty and fear, promote and accomplish adherence to necessary behavior change, and meet individuals' fear and foster hope in the face of a crisis" (p. 873).

However, as the realities of the pandemic have revealed, public health promotion is complex and difficult, and many communities have suffered disproportionately as a result. In the U.S., Latinx [1] communities have experienced some of the most disparate health, social, and

[1] I utilize the term Latinx as opposed to Latino/a or Latinoamericano as a gender-inclusive, pan-ethnic alternative to refer to immigrants, migrants, and communities of Latin American origin or descent.

economic consequences. These disparities have been exacerbated by existing structural and environmental inequities, coexisting chronic medical conditions, limited access to healthcare, high-risk working conditions, precarious housing arrangements, low financial resources, and language barriers (Baquero et al., 2020; Berkowitz et al., 2020; Gil et al., 2020; Page & Flores-Miller, 2020; Selden& Berdahl, 2020). Anti-immigrant policies and rhetoric have discouraged immigrant community members from coming forward to receive COVID-19 related health services (Magaña Lopez & Holmes, 2020). This rhetoric has also contributed to the "parallel pandemic" of misinformation about the coronavirus, especially misinformation spread via social media channels (WHO, 2020). The detrimental impact of the pandemic on Latinx communities has been made clear through analysis of 2020 COVID-19 mortality rates which showed that Latinx people lost 3.03 years in life expectancy compared to white people who lost 0.94 years and Black people who lost 1.90 years (Andrasfay & Goldman, 2021).

In the state of Oregon, many community-based organizations (CBOs), local public health authorities (LPHAs), and the Oregon Health Authority (OHA) have worked to create culturally appropriate messages to disproportionately impacted Latinx communities during the pandemic and to advocate for critical resources and support. These organizations and individuals have been working for years under chronic underfunding, inadequate workforces, and outdated infrastructures with limited flexibility following up to one of the greatest public health crises in which state and local health departments have endured overwork, public outrage, widespread staff defections, burnouts and unpredictable funding and erosion in their authority (Baker & Ivory, 2021; DeSalvo et al., 2021). Local health departments were the first line of response when the outbreak began, working to control the spread in communities across the country and putting into action their own emergency operations and response plans (DeSalvo et al., 2021). The goal

of this dissertation case study is to examine health communication and community partnerships work of LPHAs in the state of Oregon during the COVID-19 pandemic, focusing on health communication for Latinx communities, to better understand the efforts, strategies, and challenges in addressing health inequities. This dissertation seeks to answer two key research questions: how was public health communication during the pandemic approached in Oregon and how have state LPHA staff worked to address health equity concerns in their community during the pandemic and in their ongoing work? As LPHAs serve as a direct communication source for local communities and CBOs in addition to acting as intermediaries between state and national health officials, their unique and critical position in public health work warrants distinctive consideration.

Brief Context and Significance of Issue:

Oregon has a significant Latinx immigrant population with over 760,000 Hispanic ethnicity identifying residents (U.S. Census, 2020). One out of ten state residents are foreign-born and the top country of origin for immigrants is Mexico. In 2016, 26 percent of the immigrant population were undocumented immigrants and comprised 3 percent of the total state population (American Immigration Council, 2020). The situation in Oregon reflects the disparate impact of COVID-19 on Latinx communities around the country. Latinx coronavirus infection rates accounted for in OHA data show 38% of total infections in December 2020, 34% in February 2021 and 24% in June 2021 even as Latinx people comprise 18.7% of Oregon’s population (OHA, 2021; U.S. Census Bureau, 2020). The COVID Tracking Project estimated that Latinx Oregonians are 3.7 times more likely to have contracted COVID-19 compared to white Oregonians (Goldfarb, 2021). Several factors contributed to Latinx community members’ increased risk of COVID-19 including larger household sizes and higher representation in front-

line occupations with higher risk of infection, many with inadequate workplace safety protocols. Because Latinx households are more likely to have a lower socioeconomic status, more adults per Latinx household left their homes to go to work, and with jobs that lacked sick leave, Latinx community members opted to not get tested (Pedraza et al., 2022). In June 2021, Latinx Oregonians also made up 18.7% of total COVID-19 hospitalizations and 8.5% of total COVID-19 deaths in the state. Inequity has been apparent in the state's vaccine distribution as well. In June 2021, only 8% of the of COVID-19 vaccinations had gone to Hispanic community members (OHA, 2021).

At the start of the pandemic, a network of established community-based Latinx organizations quickly organized to both determine and respond to community needs during the public health crisis which ranged from a need for clear public health information, food, housing, and educational resources, as well as legal and health access concerns (Yarris & Schmidt-Murillo, 2020). One of the largest and successful initiatives has been the Oregon Worker Relief Fund (OWR), a public-private partnership, which provided financial assistance to Oregonians excluded from the federal unemployment insurance program due to their immigration status as well as a Quarantine Fund to support farmworkers exposed to COVID-19. In the program's first year, the fund helped over 37,000 individuals and distributed over $60 million to Latinx community members in 34 of the state's 36 counties (Causa, 2021). CBOs in the state like Causa and Pineros y Campesinos Unidos Noroeste (PCUN) also collaborated with state legislators and advocated for bills which addressed the impact of racism, expanded healthcare access, and addressed vulnerabilities in the workplaces, many of which became state policies.

The Oregon Health Authority (OHA) also quickly realized the need for more support for Latinx communities in the state, including Spanish language resources and created an OHA en

Español Facebook page on April 14, 2020. OHA has also funded more than 170 community-based organizations (CBOs) to support culturally and linguistically responsive services as a part of the state's response to the coronavirus, including several Latinx CBOs that have played a crucial role in supporting and communicating with their communities during COVID-19 (OHA, 2021). Additionally in September 2021, OHA's Healthier Together (HTO) state health improvement plan, developed by a range of community partners, added immigrants and refugees to its priority populations (OHA, 2021). These organizations have played a critical role in health communication to Latinx communities in Oregon throughout the pandemic. As health authorities like the CDC and OHA continue to recognize the crucial role of community partners and rely on these groups more to achieve its goals, reflected in OHA's Healthier People Goals and Public Health Modernization policies, it is important to understand how this impacts local health authorities, community partners, and this type of collaborative public health work.

Past research indicates that effective health communication strategies with Latinx and other marginalized communities must be based on a comprehensive understanding of cultural and social realities impacting the needs of those community members. Community-based communication models and interventions are critical in health equity in addition to health communication efforts that seek to address the social determinants of health that have put people of racial and ethnic and minority groups at increased risk of morbidity and mortality during COVID-19 (CDC, 2021; Dutta & Kreps, 2013; Glanz et al., 2015; Brennan Ramirez et al., 2008). Research that seeks to understand health communication efforts that recognize and address social structures impacting marginalized communities is needed, as the COVID-19 pandemic has tragically confirmed. A scoping review of emerging COVID-19 health communication research including 206 articles published in communication journals between January 2020 to April 2021

found that scholars had interrogated issues in COVID-19 communication at the individual, group, organizational, and societal levels but identified an important gap of studies that evaluate communication interventions in under-served populations (Tong & Nan, 2023). This dissertation case study of health communication during the COVID-19 pandemic specifically focused on communication for disproportionally impacted Latinx communities. It adds to this understanding through the examination of health communication practices in Oregon while drawing on theory from three major perspectives: theorization of structural violence and vulnerability, health promotion and traditional health communication theory, and critical cultural health communication and health activism literature. Before a review of literature, this introductory chapter provides pertinent background information about public health systems in the U.S. and Oregon, including funding structures, local public health agencies and policies, defines health equity and public health modernization, and gives a more detailed historical context of the significant inequities for Latinx communities in Oregon. I will also give a brief reflection on my positionality and an overview of the structure of this dissertation.

Public Health in the United States- An Overview

The history of public health stems back to the 19th century when infectious diseases like typhoid and cholera led to the creation of municipal public health infrastructures and an array of public health achievements overall that have led to a dramatic improvement in the average lifespan of people living in the U.S. (CDC, 1999). In the centuries of public health development in the U.S., public health has remained primarily a state rather than a federal matter. States give substantial authority over county, city, town, or other local health departments and deploy most of the resources to deal with a public health emergency at the local level (IOM, 2003). The daily governance and administration of public health is allocated across the 59 recognized state and

territorial health departments and approximately 2,500 local health agencies (NACCHO, 2019; ASTHO, 2016). This federalist approach to public health establishes state flexibility in health policymaking which has meant that certain communities have prioritized public health equity more than others. The U.S. Centers for Disease Control and Prevention (CDC) is the national public health agency housed under the Department of Health and Human Services. The CDC serves the primary source of funding for state, local, tribal, and territorial health departments. Funding for public health specifically has been inadequate for decades, especially leading up to the COVID-19 pandemic.

There is no national public health accreditation process through the CDC or federal government. In 2007, the CDC and the Robert Wood Johnson Foundation launched the Public Health Accreditation Board, a nonprofit organization that articulates common standards for public health departments and accredits those that meet them voluntarily. Accreditation serves to promote coordination across the public health and medical care systems. However, uptake has been slow, with 41 states, 325 of about 3,400 localities, and six of 325 tribal public health departments having been accredited or re-accredited to date (PHB, 2023).

Public Health Funding

"While health departments have faced numerous challenges during COVID-19, the roots of these problems—institutional siloes, rigid funding streams, ambiguities over authority, and neglected infrastructure and workforce development—long predate the pandemic" (DeSalvo et al., 2021). Investment in national public health structures has been inconsistent in recent decades. Data from the Association of State and Territorial Health Officials (ASTHO) (2020) reveals that between fiscal years 2010 and 2018, overall expenditures by public health agencies declined by 10.3% as funding levels from both federal (from $14,309.1M to $12,222.7M) and state (from

$8,854.4M to $6,850.9M) sources fell. Many state and local governments are still feeling sweeping effects from the financial losses stemming from this decline following the 2007-2009 recession deemed the “lost decade” (Pew Charitable Trusts, 2019). ASTHO asserts that this decrease in funding “may not have provided the necessary funding and stability to support routine public health activities alongside planning for public health crises.” In 2020, Americans spent $4.1 trillion on health, but only 5.4 percent of that spending was targeted to public health and prevention, double the amount spent in 2019, due to short term COVID-19 response funding. Federal agencies received several infusions of discrete funding to fight the COVID-19 pandemic, much of it redistributed to states (and their localities) and territories. However, this funding was still largely inadequate as parameters set around the crisis money meant that it could not be used to address long standing deficits in the public health system, including ensuring the provision of basic public health services, replacing antiquated data systems, and growing the public health workforce. (TFAH, 2022).

The CDC’s annual funding for Public Health Emergency Preparedness (PHEP) programs increased slightly between 2021 and 2022, from $840 million to $862 million, but has been reduced by just over one-fifth since 2002, or approximately in half when adjusted for inflation (TFAH, 2022). Following a $22.6 million increase in FY 2022, PHEP received an additional $21 million in FY 2023; however, TFAH and other public health groups recommended $824 million for PHEP in FY 2023 to build readiness for health emergencies nationwide. CDC’s fiscal year 2023 budget, which does not account for one-time infusions of money from pandemic- relief laws, is $9.2 billion, reflecting a $760 million year-over-year increase. However, CDC’s budget rose by just 6 percent over the past decade (FY 2014– 2023), after adjusting for inflation, and this increase was not evenly distributed across the agency and its programs (TFAH, 2023).

At the state level, most states (at least 34 states and the District of Columbia) maintained or increased their funding for public health during FY 2022, while at least 13 reduced that funding. This is an improvement over 15 states reducing funding in FY 2021 (TFAH, 2022 and 2023). Prior to the pandemic, the steady decrease in funding meant that staffing was low in 2019 as state health agencies were down almost 10% in staffing: there were 91,540 full-time equivalents (FTE) working in state health agencies, down from 101,619 FTEs in 2012 (ASTHO, 2020).

An article examining historical US public health spending at local, state, and federal levels summarized the exceptional challenges inherent in the complexity of the current funding system:

> "First, public health is internally siloed owing to the nature of its funding structures, with specific tranches of funding from a variety of sources contributing to specific areas of focus, reducing flexibility and adaptability. This is compounded by the variety of actors involved in the public health system. Second, the relationship between largely privately funded health care and largely publicly funded public health work has been historically difficult to coordinate, reflecting the complexity and variability of the organizations involved. Third, the United States lacks a coherent system for governmental funding of public health, reflecting the independent development over time of different aspects of the public health system, and the persistent lack of meaningful intergovernmental planning to address this deficit" (Leider et al., 2018).

To be effective, coordination and communication within public health must be both horizontal among local health departments in a region, across state lines, and vertical between local public health departments, the CDC, health care providers, and other agencies. Although the communications role varies among public health agencies, all have faced significant challenges in ensuring that accurate and timely information is conveyed to their community members (Stoto et al., 2005). Lack of a formal national system of local health authorities is significant considering that informal networks to share information and advice about community health practices, programs, and policies are also limited in the U.S. A network study of 329 local health

departments (LHDs) nationally found that during the early stages of the COVID-19 pandemic, only 11 LHDs served as peers as sources of advice or examples and 24 acted as relational bridges to hold these emergent networks together (Chung et al., 2021).

Because of the decentralized nature of public health in the U.S., an inconsistent response to the spread of COVID-19 was intensified by a longstanding inequitable distribution of power and resources. This combined with increased risk of exposure and lack of reliable health coverage exacerbated the severity of COVID-19 for BIPOC communities in the U.S. A study in 2020 found that more than half of all Black, Native American, and Hispanic/Latinx workers had essential or nonessential jobs that must be done in person and close to others, compared with 41 percent of white workers. Additionally, these same groups of workers were less likely to have health insurance coverage than white workers. Sixteen percent of Black workers and 28% of Native American workers and Hispanic/Latinx workers are uninsured, compared with 10% of white workers (Dubay, et al., 2020). As Gordon et al. (2020) asserted, “our public health federalism is questionably adequate under the best of circumstances—divided governance and policymaking result in predictably disparate health outcomes that vary by zip code.” In sum the U.S. public health system in 2020 was expensive, fragmented, individualistic, and largely designed for the wealthy and profoundly ill-prepared to manage COVID-19 with many communities hampered by logistical issues (Otenyo & Hardy, 2022). Furthermore, many local departments are concerned that a return to pre-pandemic funding levels and a historic pattern of big increases in funding for public health during an emergency and neglecting it at all other times will continue to impede public health equity progress.

Local Health Authorities in Public Health

Local health departments (LHDs) and Local Public Health Authorities (LPHAs) in Oregon have a fundamental and complex role of serving as the front line for delivery of basic public health services to most of the communities in this country. LHDs in the United States vary widely in geographic size, population, urban or rural settings, economic conditions, and governmental structures. Most LHDs provide a wide variety of services to very diverse communities with limited resources and too few staff (Institute of Medicine Committee on Educating Public Health Professionals, 2003; NACCHO, 2020). The majority of LHDs are classified as small serving fewer than 50,000 people and thus the majority of LHDs employ less than 50 full-time equivalents (FTEs), 37% employing less than 10 FTEs and 40% employing between 10 and 50 FTEs (NACCHO, 2024). Like state public health workforces, LHDs saw a decrease in staffing in the lead up to the pandemic decreasing by 17% between 2008-2019 (NACCHO, 2020). The LHD workforce grew by approximately 19% from 2019 to 2022 likely explained by the supplemental funding from the COVID-19 pandemic. As the 2022 National Association of County Health Officials (NACCHO) National Profile of LHDs explained, at the time this 2022 data was collected, nearly $60 billion in short-term federal emergency supplemental funding was available to state, tribal, local, and territorial jurisdictions for the COVID-19 pandemic response. This large influx in federal funding expires in 2024, and no further federal resources are expected meaning LHDs will likely have to make decisions to accommodate reduced spending in services, programs, or staffing.

LHDs receive funding from a variety of sources, including local, state, federal, and clinical sources, and the general funding structure of LPHAs breaks into pre-service and post-service funds. Half of LHD revenues in 2022 came from federal sources (26% pass through and 25%

direct), 21% come from state sources, 14% from local sources, and only 6% of revenues were payments for clinical services (NACCHO, 2024). In previous years, a smaller portion of revenues came directly from direct federal sources. For example, in the 2019 national profile, 25% of LHD revenues came from local sources and 21% came from state sources, 11% of federal direct, and 16% federal pass-through, and 13% of revenues were payments for clinical services (NACCHO, 2020). Federal dollars normally make up most of the general funds that come to local public health authorities through state contracts or via competitive grants. Counties invest general fund resources into existing public health programs where federal or state funding does not meet community needs and to provide additional prevention interventions (CLOH, 2023). LHDs often need to be creative with their funding to cover their bases. In fact, more than half of all LHDs share resources, like funding, staff, or equipment, with other LHDs on a continuous, recurring, non-emergency basis and more than one-third of LHDs received functions or services from another LHD (NACCHO, 2024).

More than three fourths (76%) of local health departments reported that inadequate staffing levels hindered the effectiveness, scale, or quality of their COVID-19 response (NACCHO, 2022). Some LHDs were able to add staff during the pandemic, but this increase in support was limited. Nationally, LHD's added an average of 22 positions specifically to respond to COVID-19. Contract tracers and public information professionals were the most common occupations hired to address the pandemic. Despite the extra demand, most LHD's hired fewer than five new staff members to specifically respond to the pandemic. 34% of LHD's hired between one and four new employees and 29% did not hire any additional staff (NACCHO, 2022). An October 2021 analysis found that state and local health departments needed an 80% increase in the size of their workforce

to be able to provide comprehensive public health services to their communities (De Beaumont Foundation and Public Health National Center for Innovation, 2021).

LHDs and LPHAs engage in important partnerships with state and other local agencies as well as local community partnerships including with CBOs. Nearly all LHDs work with partners, including emergency responders, hospitals, K-12 schools, community-based organizations, and the media. Almost all (97%) reported that they work with community-based nonprofits in some way and 64% have regularly scheduled meetings, written agreements, or shared resources with CBOs (NACCHO, 2024). This is up from 92% and down from 72% respectively in the same 2019 NACCHO survey (2020). Collaborations with other partners like tribal government, local transportation departments, and health insurers are less universal. Most of the collaboration for LHDs does not extend beyond exchanging information and a greater proportion of LHDs sent data than received data when sharing information in the past year (NACCHO, 2024).

The COVID-19 pandemic necessarily made more people aware of their LHD/LPHA. A 2023 poll conducted by the de Beaumont Foundation found that 60% of Americans are familiar with their health department, compared to 53% in 2022. Of those familiar with their health department, 70% said they had a favorable opinion of that official (Late, 2023). This poll doesn't capture the immense challenges and abuse many local health authorities faced at the start of the pandemic working in difficult conditions following decades of under-resourcing. In fact, a 2021 *New York Times* nationwide review found a staggering exodus from public health agencies and identified more than 500 top health officials who left their jobs in the first 19 months of the pandemic, many of whom faced threats of personal violence (Baker & Ivory, 2021). In a 2022 national survey of LHDs, seventy percent reported that workers were harassed because of

pandemic response measures. A majority of those LHDs also said they had no protections from local, state, or federal governments to respond to threats and harassment (Ediriweera, 2024).

The Oregon Health Authority (OHA) and Oregon's Local Public Health Authorities (LPHAs)

Oregon's public health system consists of the state's Oregon Health Authority (OHA) Public Health Division (PHD) and local health departments known as local public health authorities (LPHAs). Like the national system, Oregon has a decentralized public health system where local governments hold responsibility for public health functions in their communities and operate as separate, autonomous entities. There are 32 LPHAs in Oregon including 26 county-based public health departments, one district health authority, and five public-private partnerships that provide subcontracted services for the Local Public Health Authority. Oregon's 32 LPHAs represent most of Oregon's 36 counties while two counties, Wallowa County and Curry County relinquished their authority to OHA in 2018 and 2021, respectively, and two counties (Wasco and Sherman) are represented by a district health authority (CLOH, 2023). According to Oregon's Coalition of Local Health Officials (2023), in FY 2015, over half of the federal and state funding to local public health authorities in the state goes to support Women, Infants, and Children (WIC) (34%) and school-based health centers (17%). Only 9% of funding was allocated to communicable disease and 8% to preparedness.

Prior to the COVID-19 pandemic, it was clear to state health officials that improvements to public health needed to be made. The leading cause of death in the state— chronic health issues— was costing Oregonians more than $8 billion a year in medical costs (Hass, 2017). The 2013 Oregon Legislature recognized the need for significant changes to the state public health system and created the Task Force on the Future of Public Health Services in House Bill 2348 (2013). The bill developed a set of recommendations to modernize Oregon's governmental public

health system to meet the future needs of the population through equitable, community-centered, and accountable services. The HB 2348 task force studied the regionalization and consolidation of public health services and made recommendations for the future of public health services in Oregon to enhance effectiveness, consider cultural and historical appropriateness, and be supported by best practices (OHA, 2014). The task force was created in response to the growing recognition of the significance of community environment of health and the need to address SDH. As the HB 2348 task force report explained, "While it is clear that addressing the social determinants of health is not the sole responsibility of governmental public health, it is critical that public health departments embrace new tools and train or retrain a workforce with appropriate skills in order to achieve measurable goals that improve population health" (2014, p.3).

One of the key recommendations of the task force was identifying the foundational capabilities and programs to be adopted for Oregon's public health system along with "significant and sustained funding." LPHAs had the flexibility to operationalize the Foundational Capabilities and Programs through a single county structure, a single county with shared services, or a multi-county jurisdiction. (2014, p.5). The task force decided on implementation of the modernization plan in waves to be determined in the assessment and also decided that "improvements and changes in the governmental public health system be structured around state and local metrics, and that these metrics are established and evaluated by an enhanced PHAB 2.0, which will report to the Oregon Health Policy Board." The report also outlined both a statewide community health assessment (CHA) and accompanying community health improvement plan (CHIP), which must include prioritization of health improvement outcomes arising from the CHA. Based on the CHA, LPHAs and community partners develop their CHIP, a long-term, systematic effort to address public health problems. CHIPs are typically updated every three to five years (CDC, 2023). In the

structure, LPHAs should engage community members to develop public health priorities and monitor their plan while drawing from CHA data. The core capability of community partnership development is described in the task force report:

> "Foster a culture of listening and an environment that honors the wisdom and multiple intelligences of communities with the greatest health disparities. Communities of diverse geographic, income and ethnic background often have the most practical, insightful and responsive strategies to improve health outcomes. The health of our state can only improve from listening and engaging these communities as assets and resources" (2014, p. 25).

Following this report in June 2015, the Oregon Legislature passed the Public Health Modernization Act (HB 3100), requiring the OHA to outline a 10-year plan for implementing newly established foundational elements for governmental public health. HB 3100 required all local public health authorities and the OHA Public Health Division to assess their current capacity and expertise to better identify gaps. It also established the seven foundational capabilities for a modernized public health agency including assessment and epidemiology, emergency preparedness and response, communications, policy and planning, leadership and organizational competencies, health equity and cultural responsiveness, and community partnership development. Foundational programs outlined include communicable disease control, environmental public health, prevention and health promotion, clinical preventive services (OHA, 2022).

In 2016, the OHA-PHD and every local public health authority in the state completed an assessment of their ability to provide critical governmental public health functions. The assessment included identifying the funds needed to achieve a sustainable, accountable, and equity-focused public health system. The assessment found many existing gaps including in more than one third of Oregon communities; foundational public health programs like emergency preparedness and response were minimal or limited. The assessment also found system-wide barriers and challenges as LPHAs frequently cited lack of access to timely, accurate and relevant data as a barrier to

running effective programs. In all geographic regions of Oregon, the largest gaps were in fulfilling responsibilities necessary to achieve health equity and cultural responsiveness (OHA, 2016). In 2017, the Oregon Legislature passed HB 2310 which describes how public health modernization will be implemented including establishing metrics for tracking progress toward population health goals and a phased-in approach that allows LPHAs to build up their capacity over time. Since the passage of HB 3100, OHA has also begun funding the federally recognized tribes in Oregon beginning in 2019 and community-based organizations beginning in 2021. State funding for LPHAs has increased in each biennium since 2017 and for federally recognized Tribes since 2019. In 2021, the Oregon Legislature allocated an additional $45 million in funding. The additional investment brought the total investment in public health modernization to $60.6 million (OHA, 2022). Through COVID-19 emergency funding specifically, over $700 million was distributed through contracts and grants to LPHAs, Tribal Nations and the Urban Indian Program (NARA), CBOs, and other state agencies and organizations. OHA funded more than 170 CBOs to support culturally and linguistically responsive services as a part of the state's response to the virus within the first two years. OHA's Public Health Division reported funding allocations of over $220 million to LPHAs, over $29 million to Tribal Nations and NARA, and over $89 million to CBOs (OHA, 2021, Rede Group, 2022).

Public Health Modernization for Health Equity

Health Equity is defined by the National Academies of Sciences, Engineering, and Medicine as "the state in which everyone has the opportunity to attain full health potential and no one is disadvantaged from achieving this potential because of social position or any other socially defined circumstance" (Weinstein et al., 2017). According to the American Public Health Association (APHA), health equity is a framework within which public health practitioners from

all disciplines can and should work (APHA, 2023). In October 2019, the Oregon Health Policy Board and Oregon Health Authority adopted a definition of health equity that acknowledges health equity as both a long- term goal and a daily practice (Rede Group, 2022). Conversely health inequities are "preventable differences in the distribution of disease and death that are systematic, patterned, unjust, and associated with imbalances in power and systems of oppression" (Whitehead, 1992).

A key component of Public Health Modernization is health equity. The Oregon Coalition of Local Health Officials (CLHO) defines Public Health Modernization as ensuring "basic public protections critical to the health of all people in Oregon and future generations - no matter where they live in Oregon. These protections include clean air, safe food and water, health promotion and prevention of diseases, and strong systems to respond to new health threats." The final component of the Public Health Modernization framework is "advancing health equity by lifting up the voices of people who are harmed the most by the health issues we face and intentionally undoing systems that treat people differently because of their race, ethnicity, language, class, disability, gender identity, sexuality, or any intersections of these identities" (CLOH, 2023).

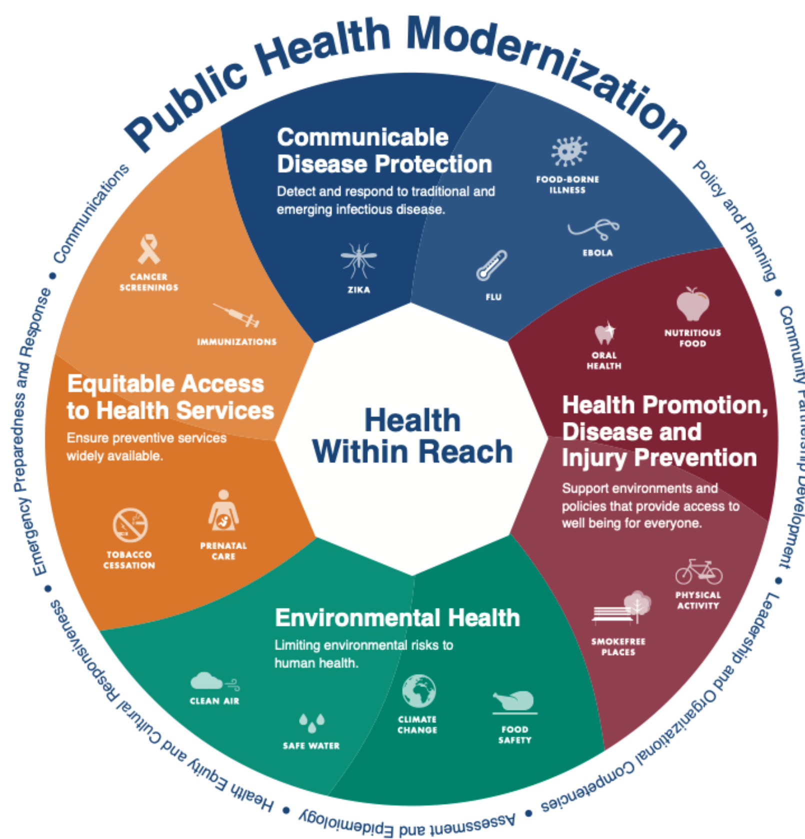


Figure 1.1- Image of Oregon's Public Health Modernization framework publishes on OHA website.

Because of existing relationships, local public health agencies often act as the natural conveners of certain health equity stakeholders, including health care systems, community organizations, and health insurance companies. LPHAs are also often partners with or conveners of community development organizations, faith-based organizations, businesses, and other governmental agencies, like transportation, housing, and education, because public health agencies have the data needed to link nontraditional partners' work and interests to health and to share with them evidence-based approaches (National Academies of Sciences, Engineering, and Medicine, 2017; CDC Foundation, 2024). The National Association of County & City Health Officials'(NACCHO) Mobilizing for Action Through Planning and Partnerships (MAPP) 2.0 is

the current national framework meant to help agencies like LPHAs achieve heath equity by identifying health issues and resources with community through a Community Health Improvement infrastructure and the creation of their local CHA and CHIP. The MAPP 2.0 handbook encourages agencies like LPHAs with historical role in both helping and harming community trust to find ways to transfer power over processes and outcomes to community (NACCHO, 2024).

The statewide public health modernization plan had a goal for all LPHAs to submit a comprehensive modernization plan including a CHIP by 2023 (OHA, 2021). At the state level, OHA's Healthier Together Oregon (HTO) State Health Assessment (SHA) is published by the Oregon Health Authority every five years. OHA's corresponding State Health Improvement Plan (SHIP) functions to identify priorities and strategies for health equity utilizing the Oregon PartnerSHIP community-based steering committee of community representatives and advocates from priority populations (OHA, 2021). Past SHA reveal significant health equity concerns for the state. Oregon "lags far behind many other states in measures of the social determinants of health, which are social factors that influence health." It also highlights health disparities among people in Oregonians for people of color, people with disabilities, people with low incomes, people who identify as LGBTQ+, and people living in rural and frontier areas of the state (OHA, 2018). The current 2020-2024 SHA noted the impacts of structural racism on BIPOC Oregonians during the pandemic and presented a HTO plan that aims to be grounded in data and community voice to advance equity and prioritize people who are BIPOC, have low incomes, people who identify as LGBTQ+, have disabilities, and live in rural areas (OHA, 2020). A handful of local legislative bodies in Oregon have taken part in a national movement of declaring "Racism a Public Health Crisis" that began in 2020 in the wake of Breonna Taylor and George Floyd's murders by police

(Mendez et al., 2020). The foundation of this movement was established by Dr. Camara Jones who launched the National Campaign Against Racism during her 2015-2016 presidency of the APHA. In the summer of 2020, the Oregon Public Health Association (OPHA) convened a group of leaders to form the Oregon Health Equity Task Force that asked the state of Oregon to declare racism a public health crisis through the 2021 HB 2337 which included strategies and public health investments but did not make it to the floor for a vote; instead, a House Resolution simply declaring the crisis was passed. In the 2022 short legislative session, HB 4502 which outlines strategic action by OHA to support the declaration was passed into law; however, subsequent 2023 session bills (HB 2918 and 2925) to subsequent funds to implement these strategies were left in committee with plans for future research and discussion (OPHA, 2023). Current national and state-wide health advocacy efforts reflect the root causes of these health issues and inequities including racism, classism, and other systems of oppression which negatively affect people's health. The impact of Oregon's racist history and the multiple forms of institutional and structural racism remains starkly evident and a powerful force, especially during the COVID-19 pandemic. To better understand how Oregon's racist history has shaped the state's Latinx community specifically, the next section gives a brief history of Latinx peoples in Oregon.

Latinx History and Inequities in Oregon

Latinx community members have been in the region now called Oregon for centuries. The arrival of Latinx immigrants in Oregon began with Spanish explorations in the 16th century (Garcia, 2019). When Mexico gained independence from Spain in 1821, it bordered Oregon territory until 1846 (Stephen, 2012). Between 1910 and 1920 during the Mexican revolution, a million Mexicans came to the United States, some settling in Oregon. Mexicans were exempted from the racist 1917 Immigration Act so they could fill work demands in agriculture, railroads,

mines, and canneries in the United States; however, at the start of the Great Depression employer policies shifted to hiring only white workers and eventually led to the Repatriation Program that removed hundreds of thousands of Mexican American and Mexican nationals from the United States in the 1930s. Some Mexicans remained to perform extremely difficult "stoop labor" as this had been racialized as Mexican slave labor too lowly for white workers (Garcia, 2019). In 1942 the bracero program, a bilateral agreement to bring temporary guest workers from Mexico to the U.S. to help address labor shortages during World War II, brought Mexican laborers to Oregon (Sifuentez, 2016).

Bracero workers faced dehumanizing and slave like working conditions and were blocked from unionizing to ensure that the farmworkers had no recourse. Nonetheless, these Latinx workers still took collective action to resist these oppressive conditions and laid the foundations for future labor organizing and political opposition development by Latinx community members in Oregon. The braceros program officially came to an end in Oregon in 1947 but many braceros found ways to remain working undocumented or returned as season migratory workers. An estimated 40,000 migrants came to Oregon every year by the 1950s, including many Tejanos migrants (Sifuentez, 2016). The use of the label "illegal" to describe Latinx workers and increased racialized discourse to differentiate Latinxs as a lesser class also increased during this period. "Operation Wetback" was a 1954 program focused on preventing undocumented people from entering the United States, rounding up and deporting Latinx-appearing folks (Stephen, 2012). In addition to farming, the logging industry in Oregon has relied on Mexican immigrants to complete strenuous and dangerous labor, especially during the winter months (Sifuentez, 2016).

Oregon Latinx communities also have a rich history of community activism and organizing. In 1972, Centro Latino Americano was founded in Eugene, Oregon by a group of

Chicano student activists to help empower Latinx families (Centro Latino Americano, 2022). In May 1977, the Willamette Valley Immigration Project (WVIP) opened in Portland, Oregon to provide legal advice to and representation for undocumented farmworkers facing immigration concerns. The creation of WVIP was a foundational organizational accomplishment of Latino resistance. In the early 1980s, WVIP focused their efforts on working with reforestation workers who were still being exploited with lower wages and increased INS arrests. By building essential trust among farm and forest workers, WVIP laid the groundwork for a unifying Latinx union and was followed by the foundation of Pineros y Campesinos Unidos Noroeste (PCUN) in 1985 and the official unionization of Latinx laborers in Oregon (Stephen, 2012). The radical benefits of PCUN were apparent in 1986 with the passage of the Immigration Reform and Control Act (IRCA) which allowed undocumented workers in the United States to apply for amnesty and legal permanent residency. PCUN successfully informed Latino workers how to apply for residency under the law while also warning them of embedded white supremacy logic in the legislation through discriminatory actions from employers due to sanctions in the IRCA legislation. PCUN went on to challenge persistent exploitative working conditions for farmworkers including use of dangerous pesticides, successful wage claims, and improved housing (Stephen, 2012; PCUN, 2020).

Despite this progress, labor and immigration policies in Oregon and the U.S. reflect settler colonialism and white supremacy including exemptions of labor laws to farmworkers, demonization of Latinx immigrants in political rhetoric, and arming of U.S. Immigration and Customs Enforcement (ICE) to increase deportations and maintain system of privately owned, for-profit detention centers that hold mostly detained Latinx migrants (Stephen, 2012; Altschuler, 2019). This historical and political context is necessary to understand the long-standing structural

violence and barriers impacting Oregon Latinx community members before and during the COVID-19 pandemic and the relevant context of systemic inequities in which local and state public health authorities have both contributed to and are working to address. I also believe that understanding the personal context in which I am engaging in this research is relevant and important. Thus, the final sections of this introductory chapter give a brief context into my positionality as it relates to this project and an overview of the dissertation's structure.

Reflection on My Positionality

It is imperative in qualitative research, especially critical cultural approaches, that the researcher address and account for their own positionality as it relates to their project. Reflexivity necessarily requires thoughtfulness by the researcher regarding their cultural, political, and social context (Bryman, 2016). As a white, non-Hispanic, middle class, cis woman, academically trained in multiple U.S. universities, an intermediate-level non-native Spanish speaker, and active labor union member, my identity and experiences significantly shape my perspective and motivation to understand health inequities in the U.S. and the role of health communication in public health interventions. Previous research projects on health advocacy strategies, personal connections with healthcare workers, and my growing consciousness of the depth of social inequities and its connection to health outcomes led me to concentrate on health communication and health advocacy as the focus of my doctoral studies at the University of Oregon. During the winter and spring terms of 2020, I was fortunate to take part in the exceptional Latino Roots Project course sequence at UO. In the course, I produced a short documentary film about Representative Teresa Alonso Leon, Oregon's first immigrant Latina state legislator who moved to Oregon as a child with her migrant farmer parents from San Jeronimo, Michoacán, México. She served as the Representative for District 22, one of the most diverse districts and home to the largest Latinx

community in the state where she worked to pass progressive state policies that impact the lived experiences of the Latinx community. This experience gave me a deeper and more nuanced understanding of the role of colonialism, racism, and migration in Oregon and its impact on the Latinx community. It also gave me a great appreciation for the decades of resistance and important community organizing and activism by immigrant and Latinx community members and organizations like PCUN to empower Latinx community members and challenge institutional and structural barriers.

As I finished my film on Rep. Alonso Leon at the start of the pandemic, it was clear that all health communication efforts would be shifting to address this global emergency and my original dissertation plan to compare the health communication approaches of various CBOs would also need to shift. I quickly recognized that the impressive health activism work of Latinx serving CBOs in response to the disproportionate impact of COVID-19 of Latinx communities was a historic and important public health story to better understand and be told. My dissertation proposal sought to study the experiences of Latinx-serving CBOs specifically; however, the reality of barriers to building relationships with potential research partners during the high emergency response demands on organizations and local advocates made that plan unattainable. In January 2021 I learned of Dr. Kristin Yarris's Latinx community survey project. I was fortunate for the opportunity to contribute to this research responding to the impact of systemic inequities and which was informing Lane County Public Health's (LCPH) communication and outreach with Latinx community members. When Dr. Yarris joined the recently formed LCPH Community Partnerships Program (CPP) in August 2022, I was quickly interested in the program's community-focused health equity work and thankful to join the team as an intern. Working with LCPH and CPP gave me important insight into the unique work of LPHAs, especially in its crucial engagement with

community partners. This experience inspired me to shift the focus of this dissertation to LPHAs from CBOs.

Working within public health and engaging in this research has made me more aware of the lack of structural barriers and violence I have faced. I have always had adequate access to health insurance and healthcare either through my parents' insurance, my own employer, or employee labor union in addition to stable housing, food, and other necessities. Because English is my first language, I have not personally faced challenges understanding health information or messages. Because I am white, I have not experienced the impact of systematic racism or white supremist hate. My privilege acts as a guiding force to gain better awareness and understanding of how health inequities and social vulnerabilities and violence impact community members during the COVID-19 pandemic and beyond.

Structure of Dissertation

To help tell the story and better understand the public health response to the COVID-19 pandemic in Oregon and the future of health equity efforts in local public health, this case study dissertation seeks to examine health communication and outreach to Latinx and other marginalized communities. It also seeks to analyze the experience of state LPHAs especially in relation to communication and community partnership work. In Chapter 2, I review the theoretical framework and body of literature informing this research including development communication, health communication, the social determinants of health, structural violence and vulnerability, and recent research related to the COVID-19 pandemic. Chapter 3 outlines the research methodologies utilized within this case study. Chapters 4 through 6 present this dissertations results beginning with a critical discourse analysis of Latinx-focused health communication from CBOs, LPHAs, and OHA during the COVID-19 pandemic. Chapter 5 covers results of a survey of Oregon's Local

Public Health Authorities through participatory interviews with LPHA leaders on staffing, communication, partnerships, and lessons learned during the COVID-19 pandemic and beyond. Chapter 6 details a case study within the larger case study of one LPHA through participant's interviews, and my participant observation and experience working with Lane County Public Health and their Community Partnership Program Team. Finally, chapter 7 concludes the dissertation with a broad discussion of the implications of the dissertations' key findings, interpretations of the results, limitations and challenges, and provide some recommendations for public health communication and health equity efforts including areas of future research.

CHAPTER 2

THEORETICAL FRAMEWORK AND LITERATURE REVIEW

Since 1980, the Department of Health and Human Service's Healthy People initiative has set measurable objectives to improve the health and well-being of the U.S. population. At the beginning of every decade, a new iteration of the initiative is released to set the latest public health priorities and objectives. The most recent Healthy People iteration of 2030 has one key focus- social determinants of health (SDH) or "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks" highlight the importance of upstream factors in health disparities. And a key goal of this decade is to "eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all" (ODPHP, 2020). This strong consideration of non-medial health factors that influence health reflect one of the most important advancements in health equity efforts and had a clear impact in the public health response during the COVID-19 pandemic. Recent efforts to prioritize examination of SDHs, improve public health modernization, community engagement, and health communication has been shaped by decades of debates, especially in development and social change communication and cultural anthropology. Thus, the theoretical framework engaged in this dissertation covers several areas within the fields of communication, anthropology, and public health.

First, I give a brief history of development communication as the precursor to health communication theory. Second, I give an overview of the health communication theory beginning with the dominant health communication theory followed by a review of critical health communication and health activism theory. Third, the chapter covers relevant literature on social determinants of health, structural violence, and vulnerability with a particular focus on

literature related to structural violence and vulnerability within Latinx communities in the United States. Fourth, recent literature related to research around health communication and health equity issues during the COVID-19 pandemic is reviewed. Finally, the chapter ends with the dissertation research questions based on this theoretical framework and literature.

A Brief History of Development and Social Change Communication

The establishment of Development Communication (devcom) as an academic discipline occurred in World War II, beginning in Southeast Asia with a focus on the task of communicating rural and agricultural agendas and quickly becoming more involved in socio-economic and information and communication technology discourse (Amoyan & Custodio, 2019). In the 1960s, extension services took on the task of creating persuasive communication to convince people to change their “primitive” ways of life. These programs were based on Everett Rogers’ (1962) seminal diffusion of innovation model that drew on early mass media research to designate an effective combination of mass-mediated and interpersonal communication strategies to move individuals from a process of awareness, interest, evaluation, trail, and then adoption of a new technology. The theoretical assumption of this model is that innovations are always good. If innovations are rejected, the problems lie in the users and not the innovations or agencies. Users are labeled as passive, incompetent, or less innovative. These early forms of development communication occurred through a top-down persuasive communication approaches via extension service (Rogers, 1962, 1983).

Development communication was shaped largely by the modernization paradigm based on neoclassical and neoliberal political and economic theories, scientific rationality, and individualism. As Melkote & Steeves (2015) explain, “the modernization paradigm presumes a set of interrelated processes: capitalism, industrialization, surveillance of society, and control of

the means of violence" (p.79-80). Daniel Lerner (1958) Wilbur Schramm (1964) were early scholars to connect communication and development through promotion of mass media as the means to establish a climate of acceptance to innovation and modernity. They suggested that the traditional values of underdeveloped nations were the key obstacles to political participation and economic activity. Their proposed solution was mass media use to promote a necessary rejection of traditional values and modification of unproductive attitudes. Schramm asserted that the media, "by brining what is distant near and making what is strange understandable, can help to bridge the transition between traditional and modern society" (1964, p.129). Development scholars like Lerner (1958), Rogers (1969), and McClelland (1966) highlighted the individual, including individual values and attitudes, as necessary factors to achieve modernization.

As development projects quickly discovered that most Third World recipients were indeed non-adopters of innovations and modernity, scholars drew on this theory to develop sociopsychological explanations as to why undeveloped populations would be so resistant to change. Rogers (1969) proposed a "subculture of peasantry" which described ten sociopsychological factors that explained why peasants in nations like Colombia were constrained to adopt innovations. The major implication of this research was that these in-the-head psychological constraints and maladies had to be addressed before development of "peasants" could begin. Thus, modernization theories argued for individual-level change as necessary for macro-level change. In the 1970s, response to the inadequacy of the diffusion of innovation model as a guide for devcom also led to the incorporation of social marketing techniques which emphasized changing individual receivers' values, knowledge, and behaviors (Melkote & Steeves, 2015). This framework has extended to include the application of commercial marketing technologies in social marketing analysis, planning, execution, and

evaluation of programs promoting or influencing socially beneficial behaviors to a targeted audience (Kotler & Lee, 2008).

Criticisms of these early dominant theories and modernization models were quick and vast including its pro-innovation, pro-persuasion, top-down nature, pro-literacy, and pro-mass media biases (Melkote & Steeves, 2015). Others built on critiques of cultural imperialism and recognition of the reinforcement of dependency in these development solutions, especially in global economic structures that relied on legacies of colonialism (Gunder-Frank, 1964). A large body of critique of dominant development theory centers around the active discounting of political, economic, and social structural constraints that are fundamental factors in development in its framework, especially US-trained Third World communication scholars whose direct experiences recognized the social and economic constraints on development (Ascroft et al., 1973; Rahim, 1976). Modernity at an individual level led to victim blaming and ineffective macro-level changes. Critical scholars also noted how these approaches ignored significant issues of power and hegemony by defining social problems as natural (Moore, 1995). Notably, the public health modernization framework described in the introduction chapter is a much different framing of the term modernization and contradicts these traditional top-down modernization models that largely neglected community voices and culture by specifically focusing on the social determinants of health, structural factors, and incorporating community partners. In this manner the traditional modernization paradigm is being challenged, reappropriated, and shifted towards a new and improved version of modernization.

The proliferation of new information and communication technologies (ICT)s and process of globalization beginning in the 1980s created a wave of changes to understandings and approaches to development and social change communication. Political economists contributed

greatly to the critique of global-level partnerships between the US government and media corporations which favor commercial interests and reinforce problematic capitalist values and cultural commodification and homogenization (Schiller, 1970; Herman & McChesney, 1997). The negative impacts that stemmed from the biases of the dominant paradigm and removal of marginalized communities from conversations around change led to another key of critique of the dominant paradigm and its glaring lack of participatory and social justice approaches to social change and communication interventions. As Melkote & Steeves (2015) succinctly explain, "Empowerment and social justice require more than just information delivery and diffusion of innovations. An important focus of development communication should be to help in the process of giving agency to marginalized individuals, groups, and organizations" (p.22). The centers of global power that direct and disseminate development communication continue to be founded on neoliberal logics of privatization of public spaces and resources requiring a shift in social change to center empowerment of local communities (Dutta, 2019).

Contemporary scholars argue that devcom's basic goal is to empower individuals and communities to realize their full potentials (Quebral, 2012). Missing in much of development research and practice has been research at the micro level and acknowledgement that individuals and communities require different strategies for development. Development Support Communication (DSC) was conceptualized by some of the early students of devcom who realized that many earlier development projects did not give enough attention to communication constraints and worked to help bridge gaps between other technical experts and communities by situating projects in relation to local, historical, political, cultural, and geographical contexts (Melkote & Steeves, 2015). Recognition of the realities and challenges brough on by neoliberal policy has directed DSC actions to empowerment and public participation.

Paulo Freire's (1970) seminal theorizing of development as a form of liberation has also greatly shaped emancipatory approaches to social change communication and alternative operationalizing of devcom. Drawing from Christian liberation theology and the actions of other liberation leaders like Gandhi, he proposed radically different assumptions about modernization models asserting that liberation from oppression should be the fundamental purpose of development (Melkote & Steeves, 2015). Freire's conceptualization of conscientization as "learning to perceive social, political, and economic contradictions and to take action against the oppressive elements of reality" was the center of his argument for a pedagogy of liberation (p.19). Freire believed that true dialogue and reflection would lead to praxis; however, "it is necessary to trust the oppressed and in their ability to reason" (p.53). Furthermore, participants in this dialogue should include not only the oppressed but everyone involved in the systems of oppression. Therefore, central to Freire's conscientization and liberation theory is participatory communication. Unlike the diffusion of innovation approach, participation-based communication approaches are two-way and interactive. The appreciation of a participatory communication approach also came about through critique of linear approaches by various agencies for its alienation of indigenous communities from the ideas of development and change undermining important indigenous wisdom and having limited impact on community empowerment (Cahyono, 2019).

Liberation theory also critically highlights how neoliberalist systems and competition-driven market models do not benefit individuals and result in the suppression of political and social life as well as poverty as a form of oppression. He believed that growing gaps between extreme wealth and poverty would impede social stability and result in exploitation and violence of the oppressed. As medical anthropologist Paul Farmer (2003) explains, "within this doctrine,

individuals in a society are viewed, if viewed at all, as autonomous, rational producers and consumers whose decision are motivated by economic of material concerns. But this ideology has little to say about the social and economic inequalities that distort real economics" (p.5). The hegemony of the neoliberal formulation is the depletion of the positive role of the state as responsible for essential resources of human life and wellbeing, accompanied with the rise of private foundations as sites of employing social change communication solutions (Dutta, 2019). These critical expansions of theorizing that emphasize structures, empowerment, power, and participation have also played an important role within the development of health communication theory and practice.

Health Communication

Health is an important and distinctive area within devcom and communication for social change. The development of the field of health communication and promotion theory occurred within and alongside devcom theory including pro-persuasion and other psychosocial theories and approaches, many of which continue to be dominate theoretical utilization. The field of health communication is broadly defined as "the study of the impact of communication on health and health care delivery, with attention to the role that communication plays in the definition of health and wellness, illness and disease, as well as in developing strategies for addressing ways to deal with those health issues" (Lederman, 2010, p. 236).

Health communication plays a major role in impacting changes and improvements in health. Past research indicates that all adults, regardless of their health literacy skills, were more likely to get health information from radio/television, friends/family, and health professionals than from print media (Department of Health and Human Services, 2008). The federal government has recognized the critical function of health communication. The Centers for

Disease Control and Prevention (CDC) developed an office of communication in 1996 with the purpose of diffusing the science of health communication throughout the agency. Health communication has also been a part of the Healthy People objectives since 2010 (Freimuth & Quinn, 2011). Communication is also one of the foundational capabilities of Oregon's Public Health Modernization framework (OHA, 2017). And as demonstrated in the introduction chapter, health communication has been crucial in public health work during the COVID-19 response. Health communication theory encompasses a range of psychological, social, and critical perspectives that have all informed communication strategies during the pandemic. The following subsections provide an overview of dominant health communication theories and critical health communication theory and health activism frameworks.

Dominant Health Communication Theories

Atkin & Silk's (2009) historical overview of the development of health communication theory demonstrates the prevalence of psychosocial, pro-persuasion, top-down theories and approaches that largely ignore political, economic, and structural factors of health. The predominant health communication theories concentrate and apply information-transmission and behavior change models. One of the oldest and most extensively utilized theories in public health interventions and communication is the Health Belief Model (HBM) (Rosenstock (1974), Janz & Becker (1984). HBM grew out of applied research in the Public Health Service in the 1950 and 1960s and thus was developed simultaneously with the solution of practical problems (Rosenstock, 1974). HBM provides seven theoretical constructs to predict health related behaviors: perceived severity, perceived susceptibility, perceived benefits, perceived barriers, modifying variables, cues to action, and self-efficacy.

The model's ability to explain and predict a variety of behaviors associated with positive health outcomes has been widely and successfully replicated (Janz & Becker, 1984). Many successful health communication interventions have been developed utilizing the model by targeting messages at the HBM variables to change health behaviors (Sohl & Moyer, 2007). HBM has also been adapted in successful health campaigns to reach diverse groups and cultural backgrounds in various health contexts (Griffin, 2012), including cervical cancer prevention among Latina immigrants (Scarinci et al., 2012). Nonetheless, the model has many limitations, like its failure to specify variable ordering (Champion et al., 2008), its inability to consider the full reality of the context and broader culture that surrounds an individual, and its failure to include socio-economic factors that create the origins of a behavior (Dutta, 2008). In fact, one of the model's developers Becker even recognized that this theoretical approach creates a bias in seeing health as an individual virtue and form of morality and thus result in people not adopting the so-called health recommendations as being perceived as lacking important individual virtues (Guttman, 2000). Early criticisms of these constructs included its contribution to victim blaming by locating the causes of social problems within the individual, rather than social and environmental factors (Ryan, 1976).

Developed by Icek Ajzen in 1985, the Theory of Planned Behavior (TPB) is another seminal theory in health promotion and communication research. This psychological theory asserts that individuals' intentions to perform behaviors of different kinds can be predicted with high accuracy from attitudes toward the behavior, subjective norms, and perceived behavioral control. These intentions, together with perceptions of behavioral control, account for considerable variance in actual behavior. The theory has been applied to a wide range of health behaviors and found to be well supported by empirical evidence (Godin & Kok, 1996). TPB

developed from Ajzen and Fishbein's (1974, 1980) Theory of Reasoned Action (TRA) which asserts that a person's intention to perform a behavior correlates with both that person's attitude toward the behavior and their perception of the evaluation of the behavior by others. Thus, TPB and TRA approaches to health communication deploy information to add a new belief, increase or decrease the favorability of an existing belief, and increase or decrease a belief strength so the rationally acting receiver can evaluate possible outcomes and make an information-based decision. Relevant to this study, the incorporation of subjective norms in TPB as an important cultural factor is useful in analysis of the health communication strategies of specific communities like Oregon's Latinx population.

Psychologist Bandura's (1977) widely applied social learning theory directs attention to the modeling of healthy behaviors and positive consequences and has emphasized the role self-efficacy, or an individual's belief in their capacity to execute specific behaviors, in health interventions, suggests that individuals are better able to achieve health goals with a high level of self-efficacy for them and vice versa for goals with low self-efficacy. Bandura's (1986) social cognitive theory assets that self-efficacy influences an individual's choices, aspirations, effort asserted, and response to setbacks. When Bandura (1999) applied the perspective of social cognitive theory to health promotion and disease prevention he recognized transformations in such approaches to address the interaction between self-regulatory and environmental determinants of health behavior as well as the socio structural determinants of health and social systems that impact health.

Another model that has been widely adapted to apply to health promotion design is diffusion of innovation (Rogers, 1983). The health attitude or behavior is considered to be the innovation and in the diffusion model, an innovation is adopted if it is perceived to be new,

compatible and advantageous to the members of the social group targeted for intervention. According to Rogers (1983), communication is critical to diffusion, especially interpersonal channels and thus opinion leaders are key players in shaping health attitudes and beliefs in a community. Entertainment-education models were built from early diffusion of innovation work and applied to a range of social issues (Singhal & Rogers, 1999). Entertainment-education strategies utilize on the popular appeal of entertainment media to design messages that target specific populations to achieve changes in knowledge, attitude, and behavior. Entertainment formats can include popular music, films, talk shows, cartoon, comics, or theater and most often involve a one-way flow of communication.

Witte's (1992) Extended Parallel Process Model (EPPM) is a predominant message design theory in the social science fear appeal literature that provides a framework for effective communication of health-related information. The model asserts that the perceived threat and perceived efficacy related to a specific intervention determine the pathway taken by the target audience after exposure to the message. Thus, EPPM operates largely on fear appeals with the notion that prevention campaigns that combine increased perceived threat producing messages with increased self-efficacy messages will have successful health outcomes. Like other dominant theories, the model focuses on individual behavior and individual choice while also incorporating the role of emotions. According the EPPM, identification of appropriate cultural cues for effective fear appeals within a specific population or community can help in message development (Dutta, 2008).

In the 1980s and 1990s, public health communication at local and national levels increasingly adopted social-marketing strategies (Manoff, 1985; Guttman, 2000). Kotler, Roberto & Lee's (2002) application of social marketing techniques from commercial marketing

is often utilized in health communication to position desirable health practices as attractive and minimize potential poor health outcome costs. Social marketing techniques tend to target individual behavior and thus risk reducing structural public health issues to "individual-level problems and defined solutions within so-called information-deficit models" (Guttman, 2000, p.20). Social marketing approaches have also proven effective in incorporating context and cultural sensitive factors including some health promotion efforts of Latinx immigrants for its incorporation of realistic material factors involved in community changes, including costs and institutional partnerships (Smith et al., 2019). Social marketing approaches are especially useful when asking an audience to engage in one key behavior or task (Lee & Kolter, 2016). For example, HIV risk awareness and testing promotion among Latinx communities at the U.S.-Mexico border has successfully been achieved through social marketing campaigns (Olshefsky, et al., 2007).

Risk and crisis communication are other fields within communication that overlaps often with health communication and has especially become more relevant as recent pandemic and crisis responses including the first outbreak of H5N1 in Hong Kong in 1997, anthrax scares in 2001, the September 11th attacks, and Hurricane Katrina illustrated that public health has an extensive role including crisis first responder (Veil et al., 2008). Risk communication, as defined by the World Health Organization (WHO), is "the exchange of real-time information, advice and opinions between experts and people facing threats to their health, economic or social well-being" (2023). The U.S. Centers for Disease Control (CDC) and Prevention's Crisis and Emergency Risk Communication (CERC) model is designed to assist public health authorities, government officials, and other stakeholders in using risk communication during an emergency. The CERC manual integrates elements from risk, crisis, and health communication theories and

outlines six core communication principles: (1) be first, (2) be right, (3) be credible, (4) express empathy, (5) promote action, and (6) show respect (2018). Many public health agencies utilized this model as they made communication decisions during the pandemic, especially at the start of the global emergency. Review of studies on risk communication has found that CERC messengers play an essential role in shaping the public's risk perception about disease severity, information-seeking behavior, and willingness to comply with government interventions (Balog-Way et al., 2020). Lessons in risk communication from previous emergency responses, especially the 2003 SARS epidemic, were highlighted including use of social media channels and including key stakeholders in public health messaging (Abrams & Greenhawt, 2020). The World Health Organization also developed a multilevel global risk communication and community engagement (RCCE) response strategy in response to the COVID-19 outbreak for health care workers, the wider public, and national governments to promote uniform messaging which similarly highlights (WHO, 2020).

While these dominant health communication theories and models continue to be widely and successfully used in health promotion and communication, these theories have also been extensively criticized for their focus on individuals and individual behavior. These theories largely do not consider the interaction of social, cultural, and environmental factors as occurring independently of individual behavior variables (Airhihenbuwa & Dutta, 2012). Furthermore, the predominant health interventions focus on how to make interventions more effective without consideration to the cultural values associated. As Guttman (2000) explains, values in public health communication "tend to be treated as independent variables that may serve as barriers to interventions' behavior-change goals or as dependent variables that can be manipulated to achieve these goals" (p. xv).

Health communication largely continues to be viewed as a top-down and paternalistic exercise in which those with the medical or public health knowledge have the power to disseminate the “correct” message to the masses for their own good (Lupton, 1994). Meta-analyses confirm the continued dominance of traditional health communication theory in the field of research. A 2010 content analysis examined 642 articles published in the journal *Health Communication* since its inception. The analysis found slightly more than half of the articles had no theoretical frames and of the articles that utilized theory, the theory of planned behavior and narrative theory were used most often, followed by social norm theory, framing theory, and extended parallel processing model (Kim et al., 2010). In a more recent content analysis of over 2,000 articles of original research articles published in *Health Communication* and *Journal of Health Communication* between 2010 to 2019, the most common theoretical framework applied was Bandura’s Social Cognitive Theory followed by Theory of Planned Behavior, Framing, Extended Parallel Process Model, and the Health Belief Model. Only 11 studies applied a culture-centered approach (McCullock et. al, 2021). In terms of research paradigms, a post-positivistic approach continues to dominate the paradigm with only nine articles utilizing the critical paradigm in all of *Health Communication*’s articles reviewed (Kim et al, 2010). The prevalence of traditional theories has also maintained in initial COVID-19 health communication research. In a recent review of health communication articles related to COVID-19, the top guiding theories were EPPM, TPB, conceptual metaphor theory, HBM, and TRA (Lin & Nan, 2023).

Because most traditional health behavior theories emphasize the role of the individual thought process, they are less applicable to Latinx traditional social values that prioritize the group and family. Furthermore, Latinx target audiences are often not well defined in health

communication and do not identify significant variations among Latinx members with respect to national background, experience with immigration, past and current socioeconomic status, and community characteristics (Elder et al., 2009). Therefore, this research project also draws extensively from critical health communication and health activism theory.

Critical Cultural Health Communication and Health Activism

McKnight (1988) argues that because the key to improving health is empowering the disenfranchised and improving social determinants of health, this ought to be the goal health communication scholars work toward. As he postulates, "It could be that instructing powerless people to engage in impossible behavior through institutional loudspeakers controlled by the powerful is actually counterproductive…. It may be reasonable to hypothesize that those in greatest need of improved health are the victims of health communication" (p.43). Airhihenbuwa (1999) explains the traditional preventive health behaviorist sees the "tree" as more important than the "forest." Conversely a cultural approach recognizes that "the forest is more important than the individual tree" (p. 269). Critical and cultural health communication scholars have revealed that by focusing on individual health beliefs and behaviors, health communicators have played a role in obscuring significant structural factors and worse yet have perpetuated victim blaming that is deeply embedded through individualistic and psychological bias of the dominant health communication theories. These scholars have developed advanced communicative capacities and theories that further expand beyond Western hegemonic health communication theories.

One of the first models that built on cultural criticism of dominant health communication and health promotion models was Collins Airhihenbuwa's PEN-3 model which was a direct response to the omission of culture in explaining health outcomes in existing models (1989). The

PEN-3 cultural model centralizes culture in the study of health beliefs, behaviors, and health outcomes by placing culture at the core of the development, implementation, and evaluation of successful public health interventions (Airhihenbuwa 1995, 2007). The PEN-3 cultural model consists of three primary domains: cultural identity, relationships and expectations, and cultural empowerment. Each domain includes three factors that form the acronym PEN; person, extended family, neighborhood (cultural identity domain); perceptions, enablers, and nurturers (relationship and expectation domain); positive, existential and negative (cultural empowerment domain) (Airhihenbuwa, 2020). By offering a culture-centered approach, PEN-3 critically extends analysis to all social and cultural contexts that impact health beliefs and behaviors. Review of PEN-3 cultural model use in health promotion reveals the model's use to understand and address problems associated with HIV, cancer, hypertension, diabetes, malaria, nutrition, smoking, and other issues dependent on related cultural contexts to understand (Iwelunmor et al., 2014).The PEN-3 cultural model emphasizes the role of the collective in defining the health experiences of individuals and underscores the importance of family and community in influencing health-related decisions. Another important theme revealed by application of the PEN-3 model is the need to explore the positive aspects of culture on health behaviors (Iwelunmor et al., 2014).

Mohan Dutta's (2005) culture-centered approach (CCA) to health communication is a pivotal community-based approach that builds on a participatory strand of communication scholarship to decenter the dominant framework in mainstream health communication theories through questioning the constructions and application of culture and focusing on understanding health meanings and experiences in marginalized settings (Dutta, 2008). The CCA achieves this critical approach through the intersection of structure, culture, and agency. It considers the co-

construction of alternative rationalities from the margins and development of community-based health solutions through the participation of community members in problem identification and solution development (Dutta, 2008; Dutta & Dutta, 2013). CCA draws upon two important critical theory concepts- ideology and hegemony. Ideology references the naturally accepted ideas and assumptions that help maintain power structures. Cultural hegemony is the concept developed by Antonio Gramsci to explain the how seemingly natural social structures benefit the ruling class and allow them to maintain dominance and control, usually via the active consent of citizens (Gramsci, 2006). Unlike dominant health theory and models, culture is treated as a static set of values, beliefs, and practices with a focus is on adapting health communication concepts to the fixed culture, CCA treats culture as a dynamic entity that is “contextually constituted, continuously contested, and communicatively negotiated” emphasizing the voices of cultural communities (Dutta, 2008, p.41). Key concepts that encapsulate the CCA include power, marginalization, context, stories, and resistance. These concepts are necessary to understand the experience of marginalized communities in Oregon during the pandemic.

McKnight’s (1997) advocacy of resource mobilization strategy at the community level to promote health helps further reflects some of the important critiques of missing local participatory approaches in traditional health communication. McKnight’s social action model stems from the emancipatory approaches of Freire (1970) who advocated for the necessity of education for a critical consciousness so that the oppressed can define the problem, evaluate their options, and mobilize themselves to achieve the desired solution. Also fundamental to Freire’s conscientization and liberation theory is participatory communication, a key component to critical health communication theory.

Health communication theory that seeks to practically advance health advocacy and activism is also limited in the field. For example, the *Handbook of Health Communication* (2003) does not contain a chapter explicitly addressing activism. Health activism scholar Heather Zoller (2005) believes this oversight is due to a greater emphasis on traditional health campaigns and provider–patient interaction in the field. Zoller (2017) defines health activism as implying "at some level, a challenge to the existing order and power relationships that are perceived to influence some aspects of health negatively or to impede health promotion" (p. 219). Health activism's emphasis on research that addresses major structural and economic changes instead of individual level changes is valuable, especially in critical research which seeks to draw attention to the role of agency in defying dominant power relations. As Zoller further explains, "Initially defined in terms of efforts, often grassroots, to change norms, social structures, policies, and power relationships in the health arena, health activism includes actions related to patient activism, health care reform, disease prevention, illness advocacy, physical disability, environmental justice, public safety, and health disparities in populations such as women, minorities, gays, and lesbians, among others" (Zoller, 2005, p. 341). Thus, the term health activism is more encompassing to identify important commonalities and differences among activist efforts that focus on a range of issues related to health which otherwise maybe overlooked (Zoller, 2005).

Like Freire's liberation theory, health activism approaches highlight how neoliberal systems and competition-driven market models do not benefit individuals and result in the suppression of social life and poverty as a form of oppression. As Zoller (2005) asserts, "without attention to issues of power, self-reliance risks reinforcing the logic of neoliberal global economic policies that undercuts the notion of health as a public good and support for social

safety nets" (p.359). Similarly, Dutta's CCA draws from Marxist theory, which centers the role of social structures and the unequal distribution of power in constraining the life experiences of poor and working-class people.

Like Zoller's work, Lam and Mattson's (2016, 2019) foregrounding of the Health Communication Advocacy Tool as a tool of praxis by focusing on communication processes and structured procedures in the context of addressing health inequity, is necessary to understand how social change happens. Mattson & Lam's (2016) comprehensive conceptualization of health advocacy centers the multiple communication processes involved in advocacy including interactions within community organizations, communication theories behind campaign and media strategies, and interpersonal relationships forged in communication networks. These approaches that center the voices of activists, community organizers, and participants from the margins create special entry points for the conversations on social change and to connect theories of change processes to challenges in the practices of communication for social change (Dutta, 2019). Critical health communication and health equity theory is largely interdisciplinary and influenced by several fields. Chief among them is research in cultural and medical anthropology and public health which thus serves as another key framework for this dissertation.

Social Determinants of Health, Structural Violence, and Vulnerability

Extensive research from within fields of anthropology and public health provides seminal insights into social determinants of health and structural vulnerabilities impacting marginalized communities around the world, including Latinx communities in Oregon, and thus constitute another key framework in this dissertation research. The World Health Organization's Commission on the Social Determinants of Health (SDH) was created on the grounds of a "moral obligation" declared after a series of groundbreaking studies by a group that including its

chair, Michael Marmot, which was some of the first to describe a “social gradient in mortality” and changed the framework for explaining inequities in health within societies, among countries, and determined that such inequities are not inevitable (Marmot, 2005). Nationally, the CDC also published a report in partnership with the SDH Work Group at the CDC and the U.S. Department of Health and Human Services. This report led to important development of the Healthy People 2020 national guidelines through the Office of Disease Prevention and Health Promotion by adding SDH one of 42 key topic areas for the first time since the Healthy People initiative was established (CDC, 2020). SDH are grouped into 5 domains by the Office of Disease & Health Promotion to include economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context (ODPHP, 2020).

Although society and public discourse continues to emphasize healthcare access and the medical sector as the major source and answer to health-related issues, a substantial and compelling body of evidence has accumulated over the last few decades to empirically demonstrate the powerful role for social factors—apart from medical care—in shaping health across a wide range of health indicators, settings, and populations (Braveman & Gottlieb, 2014). As Director-General Dr. Margaret Chan asserted in relation to WHO’s final report of the Commission on SDH in 2008, "This ends the debate decisively. Health care is an important determinant of health. Lifestyles are important determinants of health. But... it is factors in the social environment that determine access to health services and influence lifestyle choices in the first place” (Friel et al., 2008). While social determinants of health identify necessary conditions for health, health equity must also consider the systems of inequity that create specific conditions and contexts for social determinants of health. Dr. Camara Jones (2016) differentiates between

social determinants of equity to identify systems of power like racism, sexism, heterosexism, and economic systems like capitalism. Social determinants of equity as a concept helps to acknowledge the systems that create the range of existing contexts that differentially distribute different groups to different contexts and different social determinants of health for different groups.

Structural violence as a term was created by Johan Galtung (1969) and other liberation theologians of the 1960s to describe social structures, economic, political, legal, religious, and cultural, that stop individuals, groups, and societies from reaching their full potential. Galtung (1975) defined structural violence as ‘‘the indirect violence built into repressive social orders creating enormous differences between potential and actual human self-realization’’ (p.173). Anthropologists expanded upon the concept of structural violence to help provide insight into the "causes of the causes" social determinants of health and health inequities (Braveman & Gootlieb, 2014). Paul Farmer's seminal work on endemic power and oppressive regimes as structural forms of violence shapes much of recent theorizing around the concepts of structural violence and vulnerabilities. Paul Farmer (1999, 2003) argues that the social determinants of health outcomes are also often the social determinants of the distribution of structural violence and assaults on human dignity. Through years of clinical and anthropological work around the world, his examination of global and public health interventions in infectious diseases, Farmer highlights how historical, political, and economic violence is overlooked. Farmer's *Infections and Inequalities* (1999), describes a practice of "immodest claims of causality" in sociomedical sciences that cite cultural and other individual and group level explanations for inequities actually shaped by structural violence (p.257). Farmer utilizes the term structural violence "as a broad rubric that includes a host of offensives against human dignity: extreme and relative

poverty, social inequities ranging from racism to gender inequality, and the more spectacular forms of violence that are uncontestably human rights abuses, some of them punishment for efforts to escape structural violence" (2003, p.8).

Some critical anthropologists have proposed that structural violence is too dichotomous of a view, potentially isolating or alienating to sympathetic practitioners and thus limited in its application in spaces like public health (Slack & Whiteford, 2011; Horton, 2016). This has led to the introduction of structural vulnerability as an accompanying conceptualization. Slack and Whiteford (2011) used the term post-structural to violence in their research of border violence to "imply the actions undertaken to mitigate the effects of a particular individual's precarious situation [vulnerability]… not as separate from structural violence, rather an overlapping situation that can be used to expand and specify the multiple layers that make up the continuum of violence" (p. 13). Quesada et al. (2011) argue that the term structural vulnerability is more neutral and inclusive than structural violence and thus more useful to "extend the economic, material, and political insights of structural violence to encompass more explicitly (and to project to a wider audience) not only political-economic but also cultural and idiosyncratic sources of physical and psychodynamic distress" (p. 341). Thus, vulnerability as a concept incorporates positionality and refers to hierarchies of social order and diverse networks of power relations. Structural vulnerability also importantly implies a critique of the concept of individual agency "because it requires an analysis of the forces that constrain decision making, frame choices, and limit life options" (p. 342).

Historically, anthropologists like Geertz and Rhodes have framed biomedicine as a type of cultural system and thus emphasize the cultural beliefs and models of immigrants in understanding medical care (Chavez, 2003). However, many anthropologists studying migrant

health, like Farmer, have challenged this notion and focus on "culture," not only as a heuristic device but because of its routine application in medical and public health settings. Jennifer Hirsch (2003) argues that exaggerating the importance of culture as a determinant of health conceals the pathogenic role of racial, ethnic, economic, and social inequalities shaping immigrant health. For example, cultural competence is often based on static and oversimplified notions of culture and leads to Latinx communities being viewed as a homogeneous group, instead of accounting for different histories and contexts of migration and class (Hirsch, 2003; Castañeda, 2010). As Stephanie Larchanche's (2020) research importantly asserts on the limitation of cultural competency, culturally competent health professionals cannot overcome broader cultural and social anxieties endemic within the violent neoliberal, transnational economy that is a "self-destructive system" (p. 187).

Structure vulnerability as a concept is significant in that it helps respond to the problematic essentialist notions of culture in health by "pointing to the sources and effects of social inequality that can be ameliorated with political will and appropriate allocations of resources, technology, and legislative oversight" (Quesada et al., 2011, p. 350). Within medical anthropology and larger public and clinical health discourse, there is a call for redefining cultural competency in structural terms. Metzl & Hansen (2014) have pushed a framework of structural competency arguing that, "if stigmas are not primarily produced in individual encounters but are enacted there due to structural causes, it then follows that clinical training must shift its gaze from an exclusive focus on the individual encounter to include the organization of institutions and policies, as well as of neighborhoods and cities" in order to impact health inequalities (p. 127). The identified role of structural violence and vulnerability on health within Latinx and

migrant communities specifically demonstrates the significance and necessity of these concepts and theoretical frameworks in broader health equity research.

Structural Violence and Vulnerability within Latinx Communities

Movement and migration have implications for the physical and mental health of both migrants and the people around whom they settle (Chavez, 2003). The concepts of structural vulnerability and violence account for the upstream forces that have historically excluded migrants from healthcare, housing, employment, and social resources. Because Latinx communities in the U.S. face ongoing structural vulnerabilities created by distinctive historical, political and economic factors, much anthropological work has focused on this group. Castañeda (2010) has framed immigration as having conceptual, methodological, and theoretical propositions for anthropologists studying health.

Quesada et al. (2011) maintain that Latinx immigrants in the US constitute a paradigmatic case of a population group subject to structural vulnerability and violence as their subordinated position in the global economy and their culturally disparaged status are worsened by legal persecution. They define structural vulnerability as "a positionality that imposes physical/emotional suffering on specific population groups and individuals in patterned ways" and the product of two complementary forces: "class-based economic exploitation and cultural, gender/sexual, and racialized discrimination" and "processes of depreciated subjectivity formation" increasingly legitimized by "punitive neoliberal policies and discourses of individual unworthiness" (p. 340). Holmes (2011) also proposed the concept of structural vulnerability as "as an important counterpoint to the common individualistic focus on risk behavior in medicine and public health… [and] trains the gaze onto the social structures that produce and organize suffering into what public health denotes as health disparities" (p. 426). Green (2011) has added

to the discussion of structural vulnerability by placing the concept within the global neoliberal economic policies and practices and capitalist systems that produce and commodify "nobodies" as undocumented workers who pass the border "as a cheap yet expendable source of labor and profit" (p. 367). Castañeda et al. (2015) argue that although immigration and immigrant groups have become a focus of public health research, application of structural factors including political and economic structures, policies and institutions that are the cause of inequities are rarely applied. They thus call for the addition of immigration as a primary social determinant of health to bring about necessary future research and policy to better understand and respond appropriately to immigrant health needs.

The impact of this structural vulnerability has been clear in economic-related impacts during the COVID-19 pandemic as Latinos were more likely to have experienced a pay cut (40%) or job loss (29%) compared to the national average of 27% and 20%, respectively (Krogstad et al., 2020). Research indicates that Oregon Latinx immigrants, especially unauthorized, face structural vulnerabilities and violence including more exploitative workplace conditions and exposure to accident and injury, violations of wage and hour laws, and a lack of health insurance coverage. Oregon immigrants are also less able to obtain compensation for employer violations of labor law, especially with the rise of nonstandard work arrangements like temporary and contracted work (Bussel et al., 2008). A climate of anti-immigrant rhetoric continues to be a form of structural vulnerability for Latinx communities. In a December 2019 survey, about half (48%) of Hispanics in the U.S. reported serious concerns about their place in the country and about four-in-ten Latinos (38%) said they experienced discrimination (Gonzales-Barrera & Lopez, 2020). Reports of hate crimes and bias incidents spiked 366% in Oregon at the start of the coronavirus pandemic (Wilson, 2020). The structural and cultural context in which

Latinx communities were situated before and during the pandemic are essential to consider in this case study and any examination of health equity efforts.

Health Communication and Health Equity during COVID-19 Pandemic

Review of health communication literature on research specifically related to the COVID-19 pandemic reveal a range of theoretical considerations and approaches. A scoping review of emerging research on COVID-19 health communication in 206 articles published between January 2020 to April 2021 concluded that health communication scholars have largely "risen to the challenges and interrogated important issues in COVID-19 communication at the individual, group, organizational, and societal levels" (Lin & Nan, 2023, p.2570). Gaps identified in the review include experimental research that tests causal effects of communication, studies that evaluate communication interventions in under-served populations, research on mental health challenges, and investigations on the promise of emerging communication technologies (Lin & Nan, 2023). Review of early COVID-19 communication messages revealed a tendency to focus more on individual risks than community risks (Airhihenbuwa et al., 2020; Munodawafa, D. et al., 2020).

The reliable HBM was used to assess predictors of intent to receive the COVID-19 vaccine and willingness to pay (Wong et al., 2020), and HBM was promoted as a tool to improve effectiveness of public health messaging during the pandemic (Maunder, 2021). Bavel et al., (2020) made an early case for the use of social and behavioral sciences to help in COVID response communication emphasizing factors covered in TPB, TRA, social learning theory, diffusion of innovation, EPPM, as well as culture and factors like misinformation. Other research focused on public health communication from the perspectives of health professionals and community members (Dubé et al., 2022) and use of state government homepages (Yang et al.,

2023). Critical cultural approaches were also incorporated in pandemic communication research. In the Summer of 2020, Airhihenbuwa and other scholars made an appeal for the utilization of PEN-3 as a cultural framework to improve communications around collective risks and structural inequities of the pandemic (Airhihenbuwa et al., 2020). Other early pandemic research applied a specific health equity framework to better understand key factors contributing to COVID-19 inequities including among Latinx populations in Washington State (Baquero et al., 2020), and in Oregon (Garcia et al., 2021), and explored issues of trust impacting perceptions around COVID-19 among these communities (Chee, 2021, Ojikutu et al., 2021). Within Latinx populations specifically, studies measured the value of community health workers to reach this population and promote COVID-19 testing and vaccination (Palmer-Wackerly et al., 2020, DeGarmo et al., 2022). Another group of studies focused specifically on understanding COVID-19 misinformation and narratives especially on social media (Mheidly & Fares, 2020, Roozenbeek et al., 2020, Jennings et al., 2021, Smith et al., 2020) and within specific communities including Black communities (Dodson et al., 2021) and Latinx communities (Longoria et al., 2021).

Several governmental and non-governmental organizations commissioned post-pandemic assessment reports on public health impacts and lessons learned including a comprehensive report titled "Public Health Response to the COVID-19 Pandemic in Oregon" produced by a third-party contractor Rede Group for the OHA (2022), the National Association of County and City Health Officials' (NACCHO) Forces of Change COVID-19 edition report, and the National Academy of Medicine (DeSalvo et al., 2021). Other non-profits like Trust for America's Health (TFAH) published a number of reports around insights and issues during the pandemic (2022, 2023). This dissertation case study of communication targeting Oregon Latinx communities and communication and community partnership work of LPHAs seeks to add to this knowledge and

understanding of health communication and health equity efforts during the COVID-19 pandemic through the following research questions.

Research Questions

SDH like race, ethnicity, language, and social class are also strongly connected to individual health communication behaviors (Viswanath & Ackerson, 2011). A OWR of literature about communication inequalities during the H1N1 pandemic revealed a consistent association between social determinants and inequalities in individual and group-specific exposure to public health messages and emergency preparedness outcomes (Lin et al., 2014). The structural vulnerabilities that impact health also impact communication structures and create similar barriers to effectively communicating SDH, which is evident in the established inaccurate public belief that access to health care and personal health behaviors are the strongest determinant of health (Clarke et al., 2012). Effectively communicating to Latinx and other minority ethnic communities facing language barriers, including health literacy difficulties, has posed additional challenges to state and local health departments and increased risk to Spanish-speaking populations during the COVID-19 pandemic (Macias Gil et al., 2020). Developing health communication and activism approaches that effectively consider structural vulnerabilities and reveal the significance of these vulnerabilities and SDH is crucial for health equity and the future health communication research. This context shapes the focus of this dissertation research and helps frame the following research questions:

1. A. How did CBOs serving Latinx communities, local public health authorities (LPHA), and the state public health authority (OHA) approach health communication for Latinx communities throughout the COVID-19 pandemic (March 2020- December 2021)?

B. Which theories (traditional, individualistic theories or critical-cultural theories) drove health communication and health equity interventions by CBOs, LPHAs, and OHA for Latinx communities in Oregon during COVID-19?

2. A. What was staffing for communication and community partnership-related work at Oregon's LPHAs like during the pandemic? How did LPHAs work to address health equity concerns in their community during the pandemic?

B. What is this staffing post-pandemic (2023)? How are LPHAs incorporating lessons from the pandemic to improve health equity efforts at a community level moving forward?

The next chapter provides an overview of the research methodologies and samples utilized to answer these dissertation questions including critical discourse analysis, semi-structured participatory interviews, and participant observation.

CHAPTER 3

METHODOLOGY

To address this dissertation's research questions, I employed a qualitative mixed methods case study (see Table 3.1). The aim of case study research is to increase knowledge about contemporary communication processes in the context and perspectives of the people involved (Daymon & Holloway, 2011). Case studies are particularly relevant in research that seeks to tell a story, providing a history of a defined place and presenting in-depth descriptions and analyses of how organizations or individuals respond to an event or problem and the social forces that produce our social and cultural worlds (Treadwell, 2011; Bartlett & Vavrus, 2019; Mason, 2002). This dissertation research inherently functions as a case study by closely examining health communication and experiences of LPHAs in Oregon during the COVID-19 pandemic, particularly for Latinx communities. To tell this story I examined health communication from Latinx serving CBOs, LPHAs and OHA during the COVID-19 pandemic (Chapter 4), participant interviews and written questionnaires with LPHA leaders from across the state on staffing and lessons learned (Chapter 5), and focused insights from participatory observation with one LPHA, including two key examples of a local survey of Latinx community members and its Community Partnership Program (Chapter 6).

Critical Discourse Analysis

The first methodological approach of this dissertation is a critical discourse analysis of Latinx serving CBOs, LPHAs and OHA health communication for Latinx communities during the COVID-19 pandemic. Critical Discourse Analysis (CDA) is a distinctive approach to study human discourse in its many forms written, spoken, and visual and the intertextuality between various discourses. The first research question seeking to understand how CBOs serving Latinx

communities, local public health authorities (LPHA), and the state public health authority (OHA) have approached health communication throughout the COVID-19 pandemic operationalized through CDA of examples of health messaging from each organizational level. For example, Chapter 4 includes analysis of several Facebook posts from the CBO Centro Latino Americano, Lane County's LPHA, and OHA around various emergency resources available during the pandemic.

Norman Fairclough argues that CDA as a practice does not only represent the world, but also constructs meaning and is a tool of power and social change (Locke, 2004). Much of Fairclough's work expanded on theorization by Michel Foucault on discursive formation of knowledge that exists in disciplines and institutions while enlisting the concept of ideology to theorize power relations and the subjugation of some social groups (Jorgensen & Phillips, 2002). As Walton and Lazzaro-Salazar (2016) explain, discourses both create and reproduce social realities. "They are structures of knowledge that influence systems of practices" (Chambon, 1999; p. 57). The goal of CDA is to investigate systematically "often opaque relationships of causality and determination between (a) discursive practices, events and texts, and (b) wider social and cultural structures, relations and processes; to investigate how such practices, events and texts arise out of and are ideologically shaped by relations of power and struggles over power…how the opacity of these relationships between discourse and society is itself a factor securing power and hegemony (Foucault cited in Jorgensen & Phillips, 2002, p. 63).

Fairclough's framework combines three levels of interpretation: macro, micro, and meso, an intermediary level between macro and micro (Locke, 2004). This three-dimensional model for CDA includes 1) the text, 2) discursive practice- processes relating to the production and consumption of the text; 3) the social practice- wider context to which the communicative event

belongs (Jorgensen & Phillips, 2002, p. 63). Modern discourse is highly visual, thus CDA is most appropriate as it enables the incorporation of critical visual analysis. As Rose (2016) explains, a critical visual methodology does three things: "takes images seriously, thinks about the social conditions and effects of images and their modes of distribution," and the researcher employing this method "considers [their] own way of looking at images" (p. 22). CDA is also particularly well suited for research of health communication. Critical theorists examining health-related discourse often use discourse analysis to understand the ways in which such discourses reflect the dominant positions of power and imbedded hegemonic ideological configurations and allowing the identification of taken-for-granted assumption in discourse (Dutta & Zoller, 2008).

For this case study, discourse under analysis included all forms of media— text, visuals and audio— in external communication of Latinx serving CBOs, LPHAs and OHA. External communication was gathered from CBO, LPHAs, OHA's public websites, social media sites, predominantly Facebook pages which was the one of the most widely utilized communication channels by all three organizational groups, YouTube channels, and other communication materials and examples with various target populations and beneficiaries within Latinx communities. (A list of specific discourse examples discussed in the chapter analysis is attached in Appendix B). A strength of critical discourse analysis is its ability to combine other theoretical approaches and frameworks within the analysis (Fairclough, 2003). A key goal of this analysis will be to identify the underlying theories driving and shaping health communication and discourse in this case study- including traditional, individual- level psychological health and behavior models as well as cultural and social- structural frameworks and theories of health communication, health disparities, and health activism.

Semi-Structured Qualitative Interviews

The second methodological approach of this dissertation is qualitative, participatory interviews. Research Question 2 seeking to understand what staffing for communication and community partnership-related work at Oregon's LPHAs both during and after the pandemic and related health equity efforts at these LPHAs is operationalized through participatory interviews with LPHA staff members from across the state. The results presented in Chapter 4 include a breakdown of staffing levels and position types identified over a series of interviews in addition to the principal lessons learned by participants during the pandemic and beyond.

Semi-structured qualitative interviews provide a researcher with both structure and flexibility during the process through employment of an interview guide (attached in Appendix C). The guide ensures that a researcher collects similar insights from various participants while reatining the "dross rate" or material of less relevance to the study than for unstructured interviews (Daymon & Holloway, 2011, p.225). This research method also engaged in a postmodern active interview approach. Developed by Holstein & Gubrium (2003), this approach seeks to better understand the lived experience of a participant by explicitly acknowledging that both parties contribute to the interview process. Respondents are viewed as "constructors of knowledge in collaboration" with the interviewer and the interview process (Holstein & Gubrium, 2003, p. 68). Thus, as LPHA participants brought up different topics and challenges particular to their specific location or experience, these stories were pursued in the interview. Unlike other less-flexible structured interview approaches, meaning and knowledge is not created through the "right" question or answer, but through a collaborative process in which interviewer and interviewee "communicatively assemble" meaning (Holstein & Gubrium, 2003, p. 68).

The goal of these interviews was to better understand the staffing, communicative processes, practices, and experiences of local public health workers and advocates. Interview questions covered organizational practices, perspectives, structures, goals, and relationships related to the health and structural vulnerabilities of community members and corresponding communication strategies including staffing, mediums, messages, and audiences, as well as challenges faced and responses to those challenges. As interviews with LPHA participants took place in late 2023 after the official end of the federal COVID-19 health emergency, another key goal of these interviews was to get insight into the staffing and strategies of local health authorities near the start of the "post-pandemic" era and how pandemic lessons are impacting ongoing local public health work. IRB approval for interviews with LPHA staff participants was obtained. To help accommodate limitations of participants and ensure widest participation possible, participants were given the option to participate in an alternate open-ended written questionnaire form (which as shown in the following sample section, only a handful of participants selected).

After the interview process was completed, interviews were transcribed and analyzed using an analytical process of open and axial coding to make connections between the identified communication, partnership, and public health topic categories and relevant theory (Lindlof & Taylor, 2011). As part of this coding process, follow up discussion with interviewee participants as needed helped ensure that analysis and interpretation were accurate and authentic representations of their experiences and perspective. The qualitative interview should not be used in isolation as the realities of an interview are not the only realities with which the social scientist must contend (McCracken, 1988). Utilizing critical discourse analysis and participatory observation as other tools of qualitative investigation helped triangulate insights from these

interviews. The final methodological portion of this case study of participant observation drawn on my experiences working within one of Oregon's 32 LPHAs.

Participatory Observation

Observational methods help acknowledge the depth, complexity, roundness and multidimensionality in social explanations and data (Mason, 2002). As I pursued this case study research, I occupied a participant-observer role in a few ways: first, as a Lane County, Oregon resident attending virtual public health press conferences and community meetings; second, as a research assistant in a local qualitative survey research project involving Latinx community members; and third, as a participant of a local public health team by joining Lane County Public Health's (LCPH) Community Partnership Program (CPP) as an intern and extra help. My participant observation acts as a mini-case study within the larger case study of this dissertation and helps operationalize both research questions by closely examining the health communication and community partnership work at one LPHA. The results of a relevant qualitative survey research project in addition to my direct experience and insight into the work of LCPH's CPP are the focus of the individual county portion of this case study discussed in Chapter 6.

In late January 2021, I joined a small team of researchers, led by P.I. Dr. Kristin Yarris which surveyed 168 Latinx community members through three phases at local outreach and testing events in Lane County between October 2020 and October 2021. The goal of the survey was to obtain community insights to assess motivations, barriers, and main impacts of the pandemic and to help LCPH tailor effective communications campaigns to this community. As a project research assistant, I assisted with back-end questionnaire and survey development as well as data analysis. More specific methodological details of this survey work and its results will be

covered in detail in the results of Chapter 6 as an example of local community-driven efforts to better understand and respond to an acute health equity need.

In June 2022, I reached out to LCPH to propose a voluntary health communication internship and in September 2022 started an official volunteer internship position under the supervision of CPP Supervisor Mo Young which entailed research and report writing related to health communication strategies and planning with LCPH's communication team and CPP. In January 2023, I was hired as an Extra Help position within the Lane County Department of Health and Human Services to continue this internship work with pay. In this position, I have taken photos at public health and CPP events, attended weekly CPP CBO newsletter planning meetings, attended monthly CBO Action Network (CBOAN) meetings, written content related to local public health issues and community conversations, and designed monthly CBO newsletters. These newsletters serve as a key community and participatory-level communication strategy at a local public health agency. To highlight and understand how LPHAs are working to achieve the public health modernization foundational capability of community partnerships, Chapter 6 tells the story of CPP, its mission, and work including the CBO newsletters, data parties, and participatory grant-making work.

Sample

Health communication samples for critical discourse analysis were purposefully selected to examine communication sequentially over the first twenty-two months of the pandemic (March 2020- December 2021) through six distinct time periods including:

- Spring 2020: Early Pandemic
- Late Spring- Summer 2020: Pandemic recedes, state reopening
- Winter 2020: Pre-vaccination pandemic surge
- Late Winter- Spring 2021: Vaccination begins and mass vaccination clinics
- Summer 2021: Vaccination subgroups and boosters, addressing vaccination inequities
- Fall 2021: Delta variant surge, continued vaccination efforts

These six time periods were selected to highlight the different stages during the height of the pandemic including changing information around the novel coronavirus and developing demands in the public health response. (See Appendix A for visual overview timeline of phases and messaging.)

Latinx-serving CBOs in the state were identified utilizing recipients of OHA's COVID-19 specific grants to "support culturally and linguistically responsive services as a part of the state's COVID-19 response" (OHA, 2020). CBOs were given funding to work in one or more of the following three areas: community engagement, education and outreach; contact tracing; and social services and wraparound supports to serve Latino, Latina, Latinx community with the OHA grant funding. Three CBOs served as the main source of discourse examples from Latinx serving CBOs in this CDA. They were Centro Latino Americano (OHA Region 3, Lane County), Consejo Hispano (OHA Region 1, Clatsop County), and Casa Latinos Unidos (OHA Region 2, Benton County). Additionally, one LPHA, Lane County Public Health (LCPH), and one CBO within that county- Centro Latino Americano (CLA), were of primary focus in the messaging examples of this CDA. For each period, approximately five to ten examples of public facing discourse, including social media, websites, video, and audio, were selected from each of the three levels of organizational communication under analysis: the OHA, LPHAs, and Latinx-serving CBOs for a total of ~130 discourse samples in the analysis to address the first set of research questions.

To examine important insights into the lived experiences of LPHAs during the pandemic, lessons learned during this period, and the outlook of continuing health equity efforts at the local public health level, all of Oregon's 32 LPHAs were included in the recruitment of participant interviews. Thus, a full survey of the state was the pursued sample to operationalize research

questions 2a and 2b. To recruit participants, each LPHA Public Health Administrator (PHA) was contacted via email and asked to participate in a 30 to 45-minute interview on Zoom. For LPHAs in which communication or community partnership/ health equity specific staff were identified, these individuals were also contacted for interviews. Participants who were unable to participate in an interview were given an alternative option to respond to the interview questions in an open-ended written questionnaire form. Of the 32 PHAs contacted, nine did not respond or did not follow through with submission of their written questionnaire. Seventeen local health administrators and nine communication, health equity, or community partnership staff members took part in interviews. For one county, a senior program coordinator participated in an interview. Five PHAs who could not take part in an interview submitted written responses to an open-ended questionnaire. Consequently, a total of 24 LPHAs participated in the interview-based survey of LPHAs through a total of 32 individual participants representing the participating LPHAs. Interviews with LPHA participants took place between November 2023 and February 2024.

The individual LPHA selected for a deeper analysis of communication and community partnership work was a convenient sample based on my location and participation as a research assistant in the Lane County Latinx survey research project led by Dr. Kristin Yarris and as an Intern and Extra Help employee in Lane County Health and Human Services Public Health unit. Full sample details for the Latinx survey project are covered in this section of the chapter. Insights from working with CPP including attending weekly CBO newsletter meetings, CPP events like a birth outcomes data party, and a CPP team retreat were the relevant sample for discussion and analysis of CPP’s community engagement work. Participatory interviews with members of the CPP team, Communications team, and LCPH leadership also inform Chapter 6.

Other documents in this CPP-specific sample are the archive of CBO newsletters since the publication's initiation in late August 2021 through the beginning of 2024 (~66 newsletters), CBO Action Network (CBOAN) meeting notes, CPP team presentations, reports, and internal team discussions.

Table 3.1

Dissertation Mixed-Method Case Study Overview

Research Method	Data Gathered	Associated RQ
Critical Discourse Analysis	Examples of public facing discourse/ health messaging, including social media, websites, video, and audio, were selected from each of the three levels of organizational communication under analysis: the OHA, LPHAs, and Latinx-serving CBOs for a total of ~130 discourse samples.	1 A. How did CBOs serving Latinx communities, local public health authorities (LPHA), and the state public health authority (OHA) approach health communication throughout the COVID-19 pandemic (March 2020- December 2021)? B. Which theories drove health communication and health equity interventions by CBOs, LPHAs, and OHA for Latinx communities in Oregon during COVID-19?
Local Public Health Authority (LPHA) Participatory Interviews	-17 participatory interviews with LPHA administrators -5 of open-ended written surveys with LPHA administrators unavailable for interviews -9 participatory interviews with communication and community partnership/ health equity LPHA staff members -1 participatory interview with a senior program coordinator	2 A. What was staffing for communication and community partnership-related work at Oregon's LPHAs like during the pandemic? How did LPHAs work to address health equity concerns in their community during the pandemic? B. What is this staffing like post-pandemic (2023)? How are LPHAs incorporating lessons from the pandemic to improve health equity efforts at a community level moving forward?

Participant Observation in one LPHA- including work on a local Latinx survey project and with LCPH's CPP	-Qualitative Survey of 168 Latinx community members across 22 community events between October 2020 and October 2021 -Experience working as intern/extra help with LCPH's CPP between September 2022-April 2024 and associated team materials, meeting notes, reports, and interviews with CPP team members	Contributes to operationalization of both RQ 1 and 2

Limitations

As discussed in the introduction, the COVID-19 pandemic put massive strains on all components of the public health system and added limitations to this research. Chief among those limitations was constraints on relationship building with local CBOs who were key to health equity and communication efforts. By not having meaningful participation from state CBO advocates and their direct insights, important knowledge is missing from this research. This dissertation purposefully focuses on local public health and excludes the state public health authority. As the state public health authority, OHA directly impacts local public health and community organizations, and certainly had a significant role during the pandemic response. Although OHA's perspective is certainly a relevant and important component of this research, it is not a part of this dissertation. Finally, the response and perspective of community members receiving public health messages and outreach is also missing from this research, outside of the

example Latinx community survey research project discussed in Chapter 6's case study of Lane County.

Methodological Reasoning

As with other subfields of communication, health communication is largely dominated by post-positivist approaches, which are concerned with explaining, controlling, and predicting certain health outcomes by testing the roles of communicative, social and psychological variables. However, many health communication scholars have taken a critical turn in their research methods, noting the importance of attending to the structural and cultural contexts and differing power structures of communication around health (Airhihenbuwa, 1995; Dutta, 2008; Lupton, 1994). Critical health communication approaches are methodologically significant as they offer alternatives for evaluating the effectiveness of social change communications and move away from the largely quantitative focus of field-based experiments with experimental pre-post comparisons of communities. Instead, critical qualitative methods consider "articulations of effectiveness of social change communication from the global margins grounded in narratives that describe the social change process, its effects on the lives of community members, and the effects on societal and cultural processes" (Dutta & Zapta, 2019, p. 5).

Meta-reviews of health communication research literature reveal a consistent reliance on post-positivist, quantitative research methods (Kim et al., 2010; McCullock et al., 2021). Unlike previous reviews, a recent review of articles related to COVID-19 related health communication research found a balanced use of quantitative and qualitative methods in emerging COVID-19 health communication scholarship. Because of the novel and developing nature of the COVID-19 pandemic, qualitative studies are well suited to understand how individuals and organizations communicate about the disease and prevention methods (Lin & Nan, 2023). Another relevant

review of the field of health communication by Hinojosa Hernandez & Martinez (2019) of the field of health communication revealed that Latinx communities and populations have been largely underrepresented and that the predominant methodological approach to this research is quantitative, including surveys and experiments. They recommend future work "embrace more diverse methodological approaches" to provide more nuance, greater analysis integration of self-reflexivity and more "equitable, culturally sensitive, and participatory research that thoroughly centers and respects Latinidad in its myriad nuances and health experiences" (p. 113).

Consequently, this dissertation responds to this need through a case study employing several forms of qualitative research methods: semi-structured participatory interviews and open-ended surveys with LPHA leaders, participatory observation, and critical discourse analysis focused on communication for Latinx communities at the state, local, and community level during the COVID-19 pandemic. The next chapter commences the results of this dissertation research beginning with the critical discourse analysis of Latinx-focused health communication from CBOs, LPHAs, and OHA during the COVID-19 pandemic.

CHAPTER 4

MESSAGING TO REACH THE MOST IMPACTED BY COVID-19: RESULTS OF CRITICAL DISCOURSE ANALYSIS OF LATINX-FOCUSED HEALTH COMMUNICATION FROM CBOS, LPHAS, AND OHA DURING THE COVID-19 PANDEMIC

Initial analysis of communication messages early in the COVID-19 pandemic revealed that messages tended to focus more on individual risks than community risks resulting from existing inequities. In response, some public health experts implored that COVID-19 communication and messaging address cultural factors and community risks at least as much as individual risks (Airhihenbuwa et al., 2020). Many public health leaders in Oregon were quick to respond to this call and need for culturally appropriate and diverse messaging for minority communities in the state. As the government agency overseeing most of Oregon's health-related programs, including public health, and the enforcer of state health policies, the OHA was the chief authority in the state's response to the pandemic, including public health messaging. In addition to the OHA, the state's 32 LPHAs played a crucial role in public health communication, relaying state messages and policies to local communities. LPHAs also contributed greatly to local health communication, directly coordinating with CBOs who were key partners in community outreach and messaging for non-English speaking and structurally marginalized communities most disproportionately impacted during the pandemic, especially Latinx communities. The critical discourse analysis of this chapter highlights specific examples of important public health communication aimed at health education, outreach, and addressing significant inequities among Latinx communities in the state.

The following results address the first set of research questions of this dissertation: 1A. How did CBOs serving Latinx communities, local public health authorities (LPHA), and the state public health authority (OHA) approach health communication throughout the COVID-19 pandemic (March 2020- December 2021)? And 1B. Which theories (traditional, individualistic theories or critical-cultural theories) drove health communication and health equity interventions by CBOs, LPHAs, and OHA for Latinx communities in Oregon during COVID-19? This longitudinal analysis of communication over 22 months from the three institutional levels, OHA, LPHAs, and CBO provides insight into state efforts to improve health equity through public health communication. The health communication samples in this analysis were purposefully selected to examine communication sequentially over the first year and a half of the pandemic through six distinct time periods that serve as the subsections of this chapter: Spring 2020: Early Pandemic; Late Spring- Summer 2020: Pandemic recedes, state reopening; Winter 2020: Pre-vaccination pandemic surge; Late Winter- Spring 2021: Vaccination begins and mass vaccination clinics; Summer 2021: Vaccination subgroups and boosters, addressing vaccination inequities; Fall 2021: Delta variant surge, continued vaccination efforts. For each period, approximately five to ten samples of public facing discourse, including social media, websites, video, and audio, were selected from the key state agencies under analysis: the OHA, LPHAs, and Latinx-serving CBOs (~130 discourse samples total). Unless otherwise noted, all messaging discussed in this chapter was delivered in the Spanish language. The full list of specific messaging examples highlighted in this chapter can be found in Appendix B. (Also see Appendix A for an overview timeline of time periods and messaging.)

Period 1. Spring 2020: Early Pandemic

On March 7, 2020, one day before the official declaration of emergency due to COVID-19 outbreak in Oregon, OHA posted a video in English entitled "Help Us Fight COVID-19 Stigma" which warned against the dangers of health consequences as the result of negative stereotypes. The video stressed the fact that COVID-19 does not discriminate by race, ethnicity, or nationality and that "in order to successfully fight diseases like COVID-19, we need everyone to feel welcome, heard and safe when seeking medical care" (OHA, 2020). This messaging previews many of the challenges faced by public health officials and reflects an early acknowledgment of the political nature of the pandemic, early spread of misinformation and stigma, and the need to consider structural and cultural factors and vulnerabilities related to the emerging pandemic. The relevance of this message is revealed in the increase in anti-Asian hate and bias fueled by political rhetoric blaming China for its role in the COVID-19 pandemic. A 2021 Pew Research Center survey of English-speaking Asian adults showed that one-third of participants feared someone might threaten or physically attack them (Ruiz et al., 2023). And a 2022 study by the Oregon Values and Beliefs Center showed about half (49%) of Oregon's Asian American residents reports having racial slurs or racist language used against them (OVBC, 2022).

Still, in the earliest days of the pandemic, most communication was expectedly focused on basic personal health behavior information and informing the public about new mandates and closures. As public health officials were only beginning to understand the specifics around the novel coronavirus, much of this health communication focused on promotion of basic preventive health behaviors. A very common early public health message centered on hand washing to protect against spreading COVID-19. In late March and early April 2020, Latinx-serving CBOs

shared videos on proper hand washing techniques, including in indigenous languages on their websites and social media pages like the example in the figure below of a hand washing video in the indigenous Mam language with Spanish subtitles that was shared on a CBO's Facebook page. As migrant workers who speak Mam are sometime monolingual, audio-visual messaging like this is an important example of a culture-centered approach (CCA) which considers the specific needs within a group of highly marginalized community members.

Figure 4.1- Screenshot of April 2, 2020 Facebook post from CBO Casa Latinos sharing video on handwashing in the indigenous language Mam.

In April, OHA shared a post stressing the importance of teaching kids how to handwash properly with a link to more detailed CDC education material on handwashing, including details of the five steps of handwashing and a list of key moments to wash your hands. This largely

informative-heavy messaging reflects application of social learning and cognitive theories with a goal to improve audience member's: self-efficacy in practicing proper handwash behavior, ability to correctly chose when to enact this behavior, and increase in behavioral intention. The running header of the page "El lavado de las manos en la comunidad: Las manos limpias salvan vidas" reflects an early application of the Theory of Planned Behavior (TPB) subjective norm with a cultural appeal to community solidarity. This handwashing-specific communication also reflects theoretical connections to Health Belief Model (HBM) perceived benefits of regular handwashing by connecting handwashing to decreased risk of catching COVID-19.

LPHAs and CBOs also shared information around basic personal safety information and health behaviors. A good example of this messaging is an informational video created by Clatsop County Public Health in late April on cleaning and disinfecting that was also shared by local CBO Consejo Hispano. The video includes demonstrations on how to make a disinfectant safely with bleach and water and lists areas in the house that should be cleaned, similarly applying social psychological health behavior change models of improved individual self-efficacy. The video ends with a strong warning in text to never ingest chemical products or disinfectants, responding to misinformation spreading that encouraged drinking of cleaning products as a cure for the virus, including by President Trump who suggested that disinfectants were possible treatments for the virus (Coleman, 2020; Frenkel & Alba, 2020). While COVID-19 mitigation efforts that focus on individual behaviors like handwashing and proper disinfecting techniques were valuable, self-efficacy in these behaviors is also significantly dependent on structural factors like access to housing and clean water.

LPHAs played an important role in giving regular updates on the number of cases in the county and answering the many questions about this novel disease, updating community

members about local policy changes and closures, and providing continuous updates in available resources. Many LPHAs set up daily press conferences with local media and on social media platforms to give these updates. As misinformation around COVID-19 was widely and quickly spread, especially through social media (Mheidly & Fares, 2020, WHO, 2020), LPHAs utilized recognizable, breaking news crisis response messaging. Daily press conferences are a clear example of LPHA's application of the Crisis and Emergency Risk Communication (CERC) CERC model. Several LPHAs also recognized the importance of getting this direct messaging to Latinx community members early on. On March 20, Benton County's LPHA shared a first official COVID-19 update completely in Spanish. The update discussed the importance of getting tested and resources available for any costs associated. Lane County Public Health (LCPH) also quickly recognized the need to have information in their regular updates in Spanish. They began by providing Spanish subtitles in their then daily press briefings beginning on April 7 and incorporating interviews in Spanish with Dr. Guzman in collaboration with Centro Latino Americano (CLA). LCPH later moved to having separate press conferences completely in Spanish with CLA (described further in Chapter 6), like this example on May 21, realizing that translation was not enough to capture cultural context and other community specific topics (J. Davis, personal conversation, 2024).

On March 22, LCPH shared its Non-Emergency COVID-19 Call Center information. About a month later, Lane County announced the inclusion of Spanish speakers at the call center. Many LPHAs around the state were also setting up call centers at this time, moving county FTE to staff them and utilizing early COVID-19 crisis funding to staff the call centers (LPHA leaders, personal communication, 2023). These call centers are a significant example of community level

participatory approaches to communication and mobilizing local resources as critical scholars like McKnight (1997) promote.

CBOs also acted as important messengers to translate new state policies to community members both to the Spanish language and in basic, easy to understand formats. On March 24, CLA shared an infographic with a simple 4-section explanatory table to help community members easily understand the latest executive order by Governor Kate Brown. The upper sections outlined acceptable behaviors including staying at home, maintaining six feet distance from others, leaving only for essential reasons, communicating via video chat, and discouraging non-acceptable behaviors like holding group meetings, going out to meet friends, or unnecessary trips. The lower sections outlined which community businesses and events were open or closed. Based on the information they were receiving from conversations with community members and organization clients, CLA also began working on translating more information about COVID to Spanish and other indigenous languages like Mam, K'iche', and Purepecha to reach many migrant farmworkers working in rural areas of the community. For this messaging, CLA used an audio-visual format. They also worked to create audio-visual communication for community members who are illiterate and physical handouts for community members without computer technology or access to the internet (M. Paz, personal communication, March 19, 2021). These examples reveal how CLA was applying several components of CCA in action by considering the many complex structural, cultural, and agency factors of Latinx community members who were otherwise not receiving any COVID information.

Most notable in CBO communication in this first period of the pandemic was their prompt and critical health activism work in bringing recognition to several concerning structural and systemic inequities. Fear of Immigration and Customs Enforcement (ICE) arrests, and

detentions was an existing structural vulnerability impacting many Latinx members at the start of the pandemic, intensified by the broad anti-immigrant political climate. On March 14, CLA, along with dozens of other state organizations, signed on to an open letter to Portland's Immigration Court and to Oregon's ICE offices demanding that all ICE enforcement activities cease, the release of detainees, closure of the Portland Immigration Court, and development of transparent plans to protect public health in coordination with state health authorities. This a great example of collective health activism action by community partners bringing important and specific policy change demands to address a cause of structural violence against immigrants. CLA extended this health activism communication by sharing a related petition to suspend ICE in Oregon during the COVID-19 Pandemic. By calling on community members to take an action which would lead to a specific policy change to defy a dominant and unequal power relationship, CLA exemplified the type of health promotion through activism that Zoller (2005) calls for and is also a direct acknowledgment of racism as an impacting social determinant of equity (Jones, 2016) for Latinx community members.

Figure 4.2- Screenshot of March 23, 2020 CLA Facebook post sharing link to ICE Petition.

A similar structural vulnerability with potential negative consequences for Latinx community members was the Carga Publica or Public Charge rule used to decide whether a person can enter the U.S. or qualify for U.S. lawful permanent resident status; it considers a noncitizen a "public charge" if they are likely to rely on the government for resources and thus likely discourage noncitizens from utilizing any public resources (OHA, 2023). On March 16, CLA shared an important update that the USCIS (United State Citizenship and Immigration Services), would not restrict access to testing, screening, or treatment of communicable diseases,

including COVID-19. OHA took note of this issue from these community partners sharing an infographic on the public charge on April 29, stressing that obtaining medical attention for COVID-19 does not count under the federal charge and included a link to learn more from the Oregon Health Plan website. This messaging is an especially important example given that pandemic-related research nationally has revealed that the Public Charge Rule specifically caused fear and confusion for mixed-status families during the COVID-19 pandemic, resulting in individuals not receiving public benefits they urgently needed, and increased mental health problems due to inadequate income, housing, and food insecurity (Iraheta & Morey, 2023). By addressing this specific structural vulnerability, CLA and OHA recognized how immigration status can act as a primary SDOH as Castañeda et al. (2015) emphasize.

On March 30, CLA shared a Department of Labor information sheet on the Families First Coronavirus Response Act (FFCRA), an early federal COVID response policy that required certain employers to provide their employees with paid sick leave or expanded family and medical leave for specified reasons related to COVID-19, encouraging employees to know their rights. Undocumented workers were excluded from the leave. As other COVID stimulus funds were established many undocumented Latinx community members continued to be excluded. On March 31, Claudia Torres, the Director of Casa Latinos, utilized Facebook Live to explain to community members how the economic stimulus package, the Coronavirus, Aid, Relief, and Economic Security (CARES) Act, would apply to some mixed-status families and how members could check their recent tax filings to understand their qualification status.

This communication from CBOs shows significant recognition of structural violence created by existing structures and policies like those of ICE, the public charge rule, and limitations to federal resources already creating significant social anxieties and economic

inequities for Latinx community members. With the knowledge that Latinx community members more often work in service and labor industries that were being shut down in statewide closures, these leaders also started making a plan to address the inevitable significant SDH needs. In March and April, a coalition of Latinx community leaders, including state CBO leaders from Causa, Latino Network, PCUN, Innovation Law Lab, APANO, MRG Foundation, and Consejo Hispano, convened to develop a new relief system that was a human-centered, community-led design. They developed the innovative Oregon Worker Relief (OWR) fund and economic assistance system distributed directly to eligible immigrant Oregonians with trusted CBOs acting as navigators to assist community members applying for relief. The coalition secured enough initial support in April to establish an online platform to process applications and distribute funds and organized over 100 nonprofit supporters before the Oregon Legislature's Emergency Board allocated them an initial $10 million for the fund. OWR went live on May 10, 2020 and by April 2021, the fund had distributed over $46 million to over 26,000 community members (Manning & Powers, 2021). CBOs also played an important communication role in bringing awareness to OWR efforts to bring critical financial support to Latinx community members by helping lobby the Oregon Legislature's Emergency Board and garner public support. The next figure from March 31, shows an example from CBO Casa Latinos Unidos promoting a petition to community members and asking them to take action to tell Oregon legislator to adopt the OWR fund.

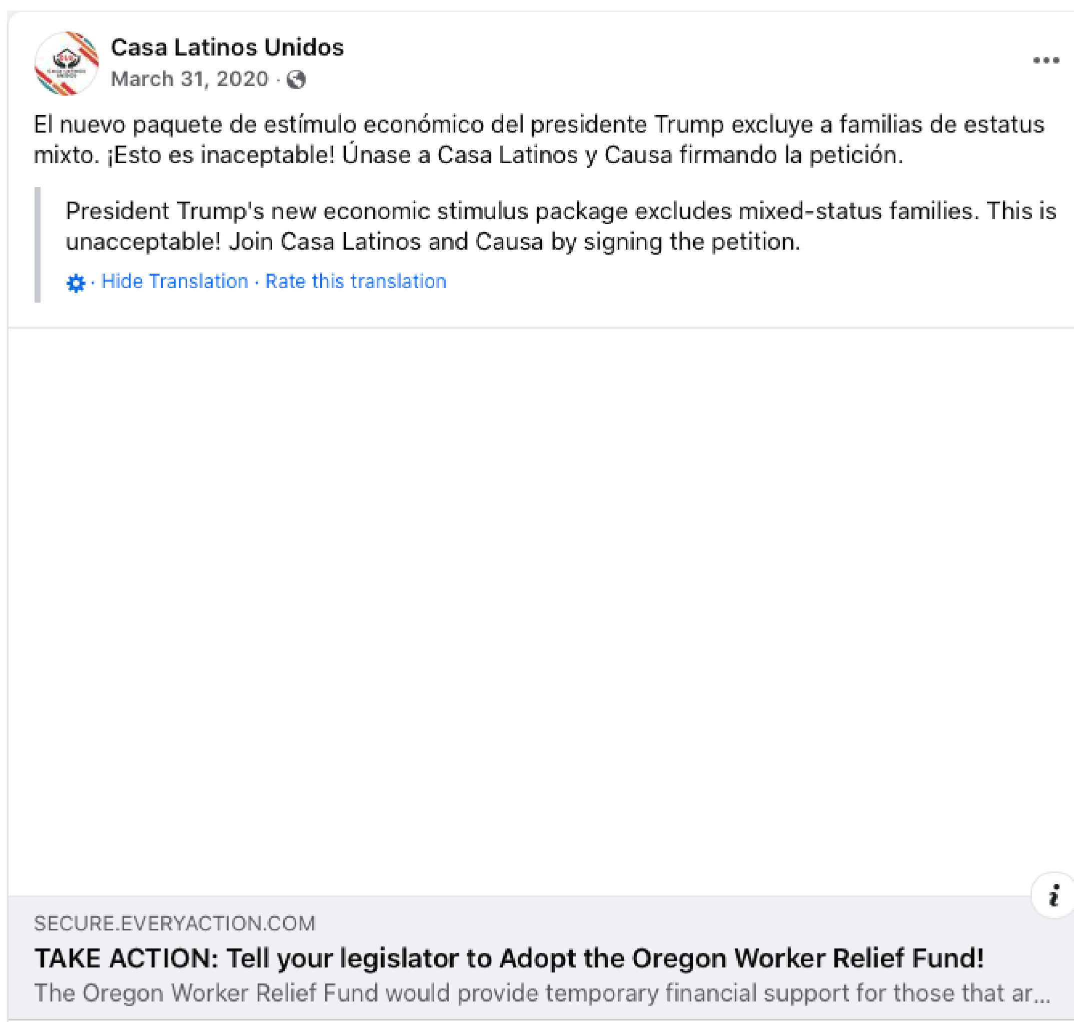


Figure 4.3- Screenshot of March 31, 2020 Casa Latinos Unidos Facebook post sharing link to community petition to state legislator to adopt OWR Fund,

CBOs also successfully directed their health activism communication at the local public health level. On April 15, CLA published a report titled "Impact of COVID-19 on Immigrant & Latino Community in Lane County" based on the survey responses of 43 community member participants who worked for non-profits, in local schools, and a handful in local government. This early in the pandemic, CLA recognized important concerns around uncertainty about their eligibility for public benefits due to mixed or undocumented status, lack of reliable information about COVID-19 in Spanish and indigenous languages, worries about ICE activity, and concern

for community members' ability to meet basic needs. Soon after this report on April 28, LCPH held a press conference to explicitly discuss SDH and health inequities. The discussion included Mo Young, then Equity and Access Coordinator for the county, who first defined SDH and explained how marginalized groups are differentially exposed to SDH, citing a health disparities study conducted by LCPH in 2017 that demonstrated existing health disparities in Lane County with all groups of people of color experiencing greater risk for poor health and poorer health outcomes compared to white residents. Mo explained how these disparities are already revealing themselves in the more severe and disproportionate impact of the COVID-19 pandemic on people of color.

David Ciaz, then Executive Director of CLA, spoke next during the press conference and gave a further overview of the county COVID case numbers and the disproportionate amount among Latinx community members as a "significant and deeply concerning problem". At the time, Latinx community members made up 22% of the positive cases even though they make up less than 10% of the overall county population. Ciaz then discussed the findings CLA and two other Latinx-serving CBOs had made after making phone calls to around 200 community members who participated in their programs. Ciaz's portion further outlined structural vulnerabilities and acted as strong health activism communication by calling for awareness and changes to the local COVID public health response. After speaking, each press conference participant took a moment to sanitize the lectern holding the mics in use. This intentional action acting as a nonverbal application of HBM cue to action by demonstrating desired health behavior.

Early OHA communication also included important information for Latinx community members around state policy and resources. OHA collaborated with TV Jam, a Spanish network, to start messaging information about the Oregon Health Plan, including updates on who may

qualify for the plan with a recent pandemic-related change to their monthly income. A March 18 PSA specified that viewers could get free help in their language from a trusted OHP certified community partner and encourages audience members to share with others who might benefit. Communicating about potential new access to healthcare demonstrates proactive addressing of SDH. Additionally on April 23, OHA launched its Safe + Strong educational campaign, a "community-centered outreach in 12 languages to connect people who are most at-risk of experiencing health disparities with the information, tools and resources they need to stay safe, healthy, and strong during the COVID-19 pandemic." The campaign, which included digital, radio, and print material was developed by the external communications firm Brink Communications and aimed to target BIPOC communities, immigrants and refugees, older Oregonians, and migrant and seasonal farmworkers (KTZ News, 2020). The next figure shows a screenshot of the language options available on the Safe + Strong website. While Spanish is a language option, other indigenous languages commonly spoken in Latinx communities were not included in the webpage, demonstrating the value of translation and interpretation work completed by several CBOs in many Latinx communities around the state.

Figure 4.4- Screenshot of welcome screen of COVID-19 public awareness campaign Safe + Strong website launched by Governor Brown and OHA in April 2020.

Period 2. Late Spring- Summer 2020: Pandemic recedes, state reopening

By late spring, much of public health information was focused on individual behavioral information for people as state stay at home mandates were rescinded and more people were reentering public spaces through state reopening phases beginning in May 2020. Several examples from OHA demonstrates this clearly with reminders to wear masks, physical distance, wash hands, avoid groups, and stay at home when sick. A good example of this communication includes a CDC post shared by OHA in August 2020 with an infographic on how to wear a facemask correctly (Figure 4.2). This post came after an OHA translated update from Governor Kate Brown announcing the requirement of face coverings in indoor spaces on June 29, 2020. This straight-forward, informative messaging drew on social cognitive theory by aiming to improve self-efficacy of audience members to execute this specific health intervention. As many of these health behavior messages were repeated messages, they acted as further HBM cues to action.

Figure 4.5- August 22, 2020 Infographic on proper facemask produced by CDC and shared by OHA.

By June 2020, Oregon was also resuming in-person education in K-12 and higher education institutions with added safety measures. Health communication reflected collaboration with schools to get messaging to these specific audiences. During summer 2020, OHA collaborated with local Latinx media to get out messages to the community. For example, through CBO Acción Rural Hispana or Oregon Rural Action, OHA's Mónica Juárez had a discussion with Hermiston School District official Maria Durón aimed at parents with children in the school district to discuss plans for the upcoming 2020-2021 academic year and recommendations on COVID-19 prevention measures. The conversation was part of a series of episodes produced by Acción Rural Hispana and transmitted on Eastern Oregon Radio station La Ley 100.1FM. Radio is a particularly important and well-established communication channel for many Latinx communities, and surveys indicating that radio listening increased for Latinx people during the pandemic (Flores, 2020). Several LPHAs also collaborated with local Spanish radio stations to get health messages out during the pandemic including Hood River LPHA

collaborating with Radio Tierra. Umatilla County, Lincoln County, and Benton County also utilized local Spanish radio stations for pandemic outreach.

On June 30, OHA shared TV JAM's video of a discussion with Maria Elena of Oregon Law Center about financial support for families to cover the cost of food while schools were closed. The benefit was provided to all families whose children receive free, reduced-priced school meals in Oregon regardless of immigration status. This is an important example of a pandemic-era policy and corresponding health communication recognizing the significant SDH demands with newly created support for families that was not previously available. The conversation in the video explains that if audience members' children or children's school were not receiving free or reduced-price meals, they could still apply for Pandemic EBT support to buy food, including the application link and deadline.

On June 5, the OWR fund was extended and a new quarantine specific fund was created (Manning & Powers, 2021). CBOs continued to spread crucial Information about OWR relief funds through direct communication and by sharing OWR communications through their social networks. CBOs also shared information about other local funds distributed through other non-profits and local governments. For example on June 2, Consejo Hispano shared a post about rent assistance for Tillamook County residents through the non-profit Community Action Resources Enterprises, Inc. On August 15, Casa Latinos Unidos shared information from the Corvallis-Benton Economic Development Office on small business grants available. LPHA's did similar outreach on available assistance. In July, Lane County shared information about both a second round of rent assistance funds and a second round of energy assistance funds, both offered directly through the county. OHA also shared resources from the Oregon Department of Employment about pandemic unemployment benefits and messaging which assuring members of

the Oregon Health Plan that coverage would not end during the national health emergency. At all three organizational levels, prioritizing health communication aimed at addressing SDH, including housing as one of the most critical determinants, reveals a concerted and increased effort to help address pandemic related health inequities. The impact of these resources is significant given the intense need during the pandemic. The Oregon Housing and Community Services state office assisted over 51,000 Oregon households and distributed $426 million in emergency rental assistance during the pandemic (Shumway, 2024). And OWR's Home Fund distributed $12 million in direct relief to nearly 5,000 immigrant Oregonians who experience or are at risk of experiencing eviction or homelessness (OWR, 2024).

OHA collaborated with CBOs to strategically increase the cultural and political power of some of its messaging during this period of the pandemic. On Aug. 26, OHA shared a video of the farmworkers union Piñeros y Campesinos Unidos del Noroeste’s (PCUN) Executive Director Reyna Lopez Osuna, demonstrating how to wear a mask properly with the accompanying text, "This pandemic is affecting people of color disproportionately: Latinos in Oregon have contracted coronavirus at a rate 6 times higher than whites. Thanks to Reyna for sharing the reason she uses mouth covers and why she's asking you guys to use one too. Let's take care and protect each other. United we are stronger!" This is a clear example of OHA incorporating a diffusion of innovation concept by engaging with a well-known, trusted opinion leader in the Latinx community to improve the efficacy of their message.

As the widening and negative impacts of the pandemic continued, Latinx serving CBOs utilized their communication platforms for community-led support. For example, CLA held a Facebook Live event, “Hablemos en Confianza,” a space to talk about what psychological therapy is and how it can help. CBOs also held virtual sessions with updated information about

COVID with opportunities to ask questions. As community-centered, participatory health communication strategy, CLA made use of resources to provide a safe, trusted space for support and understanding and to practically address needs. LPHAs like LCPH continued to hold news conferences in Spanish in collaboration with CLA to cover number of COVID-19 cases, hospitalizations and deaths in the county while also giving updates about workplace outbreaks like the early September 2020 Evergreen memory care outbreak of six employees and stressing the importance of continuing to wear masks. Citing an example of a specific outbreak within a vulnerable group shows application of HBM's perceived seriousness.

By August, more wide-spread testing was available and specific Latinx community testing events were an important area of communication for LPHAs and CBOs. LCPH promoted community testing events in several county locations on Facebook, including the event promoted in the next figure that took place in more rural Cottage Grove where significantly both Mam and Spanish would be spoken and emphasized that all are welcome no matter your immigration status or if you have medical insurance. Promotion of these events deployed both classic HBM theory and structural vulnerabilities by addressing perceived barriers specific to undocumented and uninsured Latinx community members.

PRUEBA COVID-19
GRATUITA PARA LA COMUNIDAD LATINA
LA PRUEBA ES PARA PERSONAS LATINAS CON O SIN SÍNTOMAS DE COVID-19
JUEVES 20 DE AGOSTO, 4:00-7:00 PM
COTTAGE GROVE COMMUNITY CENTER
AND LIBRARY PARKING LOT
700 E GIBBS AVE.
SE HABLA MAM Y ESPAÑOL
LA PRUEBA ES GRATIS. SI TIENE SEGURO MÉDICO, TRAIGA SU TARJETA
TODOS SON BIENVENIDOS A TOMAR LA PRUEBA, SIN IMPORTAR SU ESTATUS MIGRATORIO O SI TIENE SEGURO MÉDICO.
SALUD PÚBLICA
PARA MÁS INFORMACIÓN SOBRE COVID-19, VISITE WWW.LANECOUNTYOR.GOV/SOBRECOVID-19

Figure 4.6- August 19, 2020 LCPH Facebook promotion of a testing event in Cottage Grove.

Period 3. Winter 2020: Pre-vaccination and pandemic surge

Coronavirus infection rates among Latinx community members in the state accounted for 38% of COVID-19 infections in December 2020 (OHA, 2020). As vaccines were on the horizon of availability, messaging continued promotion of Latinx specific mass testing events while emphasizing continued risk and encouraging individual health promotion behaviors. Messaging strategies revealed more specific audience subgroups within Latinx communities. For example, on October 4, OHA's shared Washington County's Facebook post specifically targeting young people between 19 and 24 years old, who at the time had the highest incidence rate of coronavirus, with an image of a little boy with a grandma and a young adult with older grandma wearing masks and the phrase "*Me cuidó cuando era niño, ahora NO VOY A LA FIESTA para protegerla.*"[2] The post's caption, it further explained that while young people are less likely to require hospitalization or die, they can expose parents, grandparent, co-workers and people with

[2] Translated to English: "She took care of me when I was a child, now I DON'T GO TO THE PARTY to protect her."

underlying illnesses whose risk of dying is greater. This is a good example of OHA utilizing strategic messaging developed by LPHAs. This message applies a couple theoretical approaches. First, it applies EPPM by appealing to young community members fear of harming an older family member. It also applies a PEN-3 model and the cultural motivation to keep families healthy among Latinx people, a reported successful technique in other Latinx specific health promotion efforts (Garcés, Scarinci, and Harrison, 2006).

Focus on individual behaviors and concerns of increased disease spread going into winter 2020 holiday gatherings was apparent in health communication at this time. First, increased communication about COVID-19 testing and where to get testing occurred across the levels. On December 7, Benton County Public Health shared a video update in collaboration with Casa Latinos Unidos on both organizations' Facebook platforms which in addition to giving an update on Governor Brown's new community gathering restrictions based on case levels, promoted an upcoming community testing event in Monroe, Oregon. CBOs like Casa Latinos Unidos continued to share relevant updates from TV Jam's Facebook live videos, including a December 14 video in which TV Jam's Antonio Martinez discussed where to get a free COVID-19 test emphasizing the ability of anyone to receive a test without an ID, health insurance, or of any immigrations status. He gave information about four events occurring in cities like Salem and Hillsboro and more rural communities like Rickreall, emphasizing that all these events have people who speak Spanish. In the video, Antonio recommended the Hillsboro location specifically based on his personal experience with the advice to arrive early to beat the line. Antonio also thanked viewers for sharing TV Jam videos with other community members to help keep folks informed, explained the reason for delays in responding to questions left in comments to confirm correct information, and shared his own experience in recently having COVID-19 and

how he had no symptoms emphasizing the importance of getting tested. He concluded with a reminder to continue to “sacrifice” by wearing masks, washing hands, and avoiding large gatherings and staying strong even when it was difficult during the period of the holidays.

There were several infographics with various guidelines on how to protect yourself during the holiday season. A November 18 OHA post encouraged Oregonians to stay home and avoid travel to other states and countries to reduce transmission. The post description recognized a perceived health-related barrier that visiting friends and loved ones may seem necessary or essential after so much time apart, “but this year it’s safer to stay home and avoid someone traveling to visit you.” The post also defined essential trips as only work and study, critical infrastructure support, economic services and supply chains, health and immediate medical care, and safety and protection. On Dec. 24, LCPH made a post with specific recommendations to stay safe during holiday meals with tips like enjoying a meal with the immediate household, gathering outside, preparing individual plates, washing hands thoroughly, and only removing the face mask to eat. Messages that provided specific, concrete, and accessible suggestions and resources to help people stay home or modify behavior reflects further effort to reduce perceived barriers to staying home and following current behavioral guidelines. Consejo Hispano shared a video created by the Tillamook County Community Health Centers on their Facebook page in late November that covered the basics of individual health behaviors including getting a COVID-19 test before a gathering, hand washing, and self-quarantining if you travel. Unlike the December TV Jam video with Antonio, these examples were largely simple translations of English materials and do not reflect culturally specific messaging around winter holidays.

SDH challenges and financial pressures continued for Latinx community members several months into the pandemic, and health communication continued to reflect efforts

addressing these factors. In November 2020, CLA further promoted additional resources available through the Fondo de Cuarentena as part of Oregon Worker Relief Fund, expanding information to include several indigenous languages outside of Spanish. They posted YouTube videos with information about the fund in K'iche, Mam, Mixteco-Alto and Bajo, Purepecha, and Q'anjubal. This is a clear example of a CBO responding to a recognized need to reach the most marginalized communities within the Latinx population. OHA also continued to share information about the two economic funds- work relief and quarantine- available through OWR in by sharing a TV JAM Facebook live video on their page. November 10, LCPH shared updated information about round 4 of rent assistance from the county including when applications would be available and who was eligible. OHA also addressed housing in its communication including a December 30 infographic with information about new rent moratorium program and resources approved by Gov. Kate Brown and the Oregon Legislature. The post also shared a related newsletter from the Oregon Law Center with more information for Multnomah County residents specifically through the Oregon Renter's Rights webpage, reflecting continued recognition of SDH needs related to housing.

Near the end of 2020 community inoculation messages around forthcoming COVID-19 vaccinations began in earnest. On December 16, OHA shared an infographic with facts about vaccine development, including their careful evaluation through extensive clinical trials which included larger trial groups than normal with 30,000-60,000 volunteers; and information that vaccines are only approved if they comply with safety and efficiency standards. Also, in December LCPH shared a series of Facebook posts of different Myths and Facts about the COVID-19 vaccine including the myth that the side effects of the vaccine are worse than contracting COVID as well as the truth that the vaccines were rigorously tested. This

communication clearly aimed at addressing perceived fears as barriers and increase perceived efficacy around vaccines. LCPH was indeed responding to direct insight from a local community survey project (discussed in Chapter 6) which revealed that some Latinx community members lacked confidence in the vaccine, its efficacy, or had fear around the vaccines safety (Yarris & Hansberger, 2020-2021).

Period 4. Late Winter- Spring 2021: Vaccination begins and mass vaccination clinics

As mass COVID-19 vaccinations began and the state made more adjustments to its guidelines, OHA led messaging around these policy updates. OHA gave guidance around the timeline of group eligibility for the vaccine including individuals older than 80 years, healthcare workers, K-12 educators, and other essential workers as explained in detail via a video posted on January 29. Another OHA post in late January explained the state's new public health framework utilizing bi-weekly risk levels which began January 29-February 11 with 25 counties at the extreme risk level, two at high risk, two at moderate risk, and seven at low risk. The post also included a link to a complete list of counties and their risk levels. It also explained modifications in extreme risk counties under this framework, allowing some individuals to gather in an attempt to help both businesses and Oregonians while continuing to stop the spread of COVID-19.

By March 1, 2021, only seven percent of single doses of the COVID-19 vaccinations in Oregon had gone to Hispanic/ Latinx community members (OHA, 2021). Of all the racial and ethnic groups tracked by state officials, the Latinx population was getting vaccinated the least (Zarkhin, 2021). It was clear that more needed to be done to effectively reach Latinx community members and CBOs once again acted as leaders in health activism communication to bring awareness to disparities among Latinx communities in vaccination efforts. On April 15, a group of Latinx community leaders led by the CBO Latino Network held a news conference during

which they expressed frustration with state authorities and its failures in effectively funding and working with Latinx community groups around vaccination. The CBOs presented some key solutions to the issue including providing community groups with more money to staff vaccination clinics themselves, the creation of a Spanish-language vaccine registration hotline and holding future vaccination clinics in more accessible places for Latinx community members (Zarkhin, 2021).

CBOs simultaneously stepped up to work on health communication addressing specific community concerns around vaccination. Some of these concerns included fear of the test or pain associated with it, fear of being exposed to COVID at a testing event, concern that the testing location would require insurance, fees, or official personal information, concern for testing positive and missing work and income, worries about the side effects and the efficacy of the new vaccine, often fueled by misinformation, and lack of personal concern (Yarris & Hansberger, 2020- 2021). CBOs increased efforts to host their own vaccine clinics to better target local Latinx community members in a safe, trusted space. CLA hosted several vaccine clinics which they promoted heavily. One of several strategies to promote vaccination among community members included posting images of community members getting their COVID-19 vaccination cards. A Facebook post on January 27 showed six staff members of CLA staff with their vaccination cards. A post in April of an older community member encouraged others to get vaccinated with the reminder "*Juntos/as podemos detener esta pademia y seguir adelante.*[3]" Another PSA video which featured video clips from previous successful vaccination events with community members explaining why they came to get vaccinated, how it didn't hurt, how it's not dangerous, how they were thankful to be vaccinated, why it is important for community

[3] "Together we can stop this pandemic and move forward."

members to get vaccinated, and inviting others to get vaccinated to help protect their family and community members. Some members explained how they had fears and doubts about the vaccine but came and felt glad they had. Utilizing testimonials in communication helped CBOs apply a range of social psychological theoretical approaches especially cultural appeal to community solidarity.

Benton County LPHA, for example, utilized information from a CBO community assessment that identified an important cultural value around gendered decision-making to create specific community messaging. As Rocío Muñoz, Health Equity, Engagement, and Communications Manager for Benton County Public Health summarizes:

> "We learned that we needed to target messaging to the male of the household. Even though the woman or the mom would make appointments, it was really the male the father figure that would make the ultimate decision. And if one of them got vaccinated, or if he got vaccinated, and then it's likely that the rest of the household would get vaccinated. And so, we learned that the messaging had to be very, very specific. And so that's when the communications team members came up came in and said, we can do that. So we had our amazing bilingual communications coordinator extraordinaire on the phone call, who said, absolutely I can put something together a script of two friends talking to each other and talking about the vaccine. And then our partner was able to secure a contract with a radio, we had already been doing a lot of radio,… and changed the ways that we were reaching them to make sure that the message was getting there."

By having a communications team that could respond quickly and directly to community insight and create culture-centered messaging and air that message on identified reliable communication channels utilized by that community, in this case local radio stations, Benton County's LPHA successfully supported community-driven vaccine education and promotion.

LPHAs also played a role in promoting of specific vaccination group eligibility updates, especially those aimed at addressing growing inequities. In April, LCPH shared a post promoting vaccination for people living in multigenerational homes. This group eligibility was of great significance of many multigenerational Latinx community member homes. According to Pew

Research, 26% of Hispanic Americans lived in multigenerational households in 2021, compared with 13% of those who are White (Cohn et al., 2022). Other pandemic era research has found that Latinx families with larger, multigenerational households were more vulnerable to COVID-19, especially in households with family members working as frontline essential workers in the food industry, factories, construction, and other essential services more likely to be exposed to the virus (Baquero et al., 2020; Dooling et al., 2021)

Consejo Hispano continued to share content from Clatsop County Public Health including a video to address misinformation around vaccine hesitancy by addressing the myth that the vaccine changes a person's DNA. Some LPHAs participated in community events to help address misinformation around the COVID-19 vaccine. For example, Multnomah County's Health Officer attended around 10 Latinx community-organized events to provide information about vaccines and answer questions to actively address vaccine confidence in the community (personal conversation, December 2023). In May 2021, CLA shared a post explaining the risk of blood clots with the Johnson & Johnson vaccine compared to other risks like oral contraceptives or smoking, an appropriate application of both HBMs perceived severity of the risk and perceived barrier. A month earlier, CLA dedicated an entire episode of its podcast "Céntrate" on the Johnson & Johnson vaccine to specifically address and refute concerns around the use of fetal tissue in the vaccine. Clatsop County Public Health also produced a video to dispel myths of fetal tissue material in COVID vaccines. Addressing this particular misinformation is especially culturally relevant to predominantly Catholic Latinx community members who would otherwise refuse such a vaccination on religious grounds, reflected by some efforts at the time by some U.S. Catholic leaders and antiabortion groups who raised ethical objections to some COVID-19 vaccine candidates that utilizing cells derived from aborted human fetuses (Wadman,

2020). Other pro-life research institutes published charts to emphasize the use of "aborted-derived cell lines" in vaccine development, production, and lab testing to help individuals and families "make vaccine decisions in line with their conscience" (Prentice & Sander, 2021). Identifying this important contextual and culturally compelling factor for a likely large Catholic Latinx community members is a good example of applying the PEN-3 model to provide cultural empowerment by addressing cultural forces that affected the health behavior around vaccination.

Some LPHAs targeted their outreach during this period based on information they were gathering from Latinx community members. Multnomah County LPHA also utilized agricultural employer survey results in vaccine efforts for Latinx farmworkers to partner with several large food processing sites to provide educators and interpreters for on-site vaccination, including offering vaccinations for household members at the same time. As part of the strategy Multnomah's LPHA also provided vaccination education a few days before the mobile team arrived, including all day, swing, and night shifts (Multnomah, 2021). In collaboration with the cities of Fairview and Wood Village, Multnomah County LPHA also published an extensive COVID-19 handbook for migrant and seasonal farmworkers with additional resources.

Figure 4.7- Example of event flyer shared by Multnomah County LPHA to farmworkers published in *Multnomah County Vaccine Equity Plan: May 21, 2021*.

Spring 2021 included continued outreach efforts to promote resources from the OWR, county, and other state funds, with CBOs maintaining an important role as navigators to this assistance, as highlighted in the next infographic (Figure 4.5) from OWR details shared by CLA in May. CLA also shared information around monthly child benefit payments between $250-300 depending on each children's age available through the American Rescue Plan beginning in July. And LCPH continued to share information about rent assistance for residents of Lane County. This outreach reflects information gathered from a Latinx community members surveying project (discussed in detail in Chapter 6) in which revealed difficulty paying rent and other bills as a significant impact of the pandemic.

Figure 4.8- OWR infographic shared by CLA's Facebook page on May 27, 2021.

Period 5. Summer 2021: Vaccination subgroups and boosters, addressing vaccination inequities

Almost two thirds of Oregon adults were vaccinated in the weeks following the first end of the indoor masking mandate in June 2021. At this time, Oregon's state pandemic response shifted from acute emergency response to long-term management and recovery and Governor Kate Brown rescinded many of the previously imposed COVID-19 safety measures including the state's mask mandate and social distancing restrictions (Ross, 2021). Communication throughout all three levels at the start of this period was focused on getting messaging to community members yet to be vaccinated. Latinx community leaders continued their direct and successful advocating of OHA and LPHAs to prioritize the vaccination of Latinx community members who were continuing to lag in rate to other racial groups across the state despite increased health

activism efforts. Common topics focused on sustained education around case rates, vaccination rates, and continual sharing information about upcoming vaccine and testing events. For example, OHA shared the following infographic on its Facebook page (Figure 4.7) on August 22. This intervention utilizes HBM to increase the perceived seriousness, i.e. hospitalizations and deaths among unvaccinated people, and perceived susceptibility, i.e. the rate of COVID-19 infections being six times higher among those unvaccinated compared to people who are vaccinated.

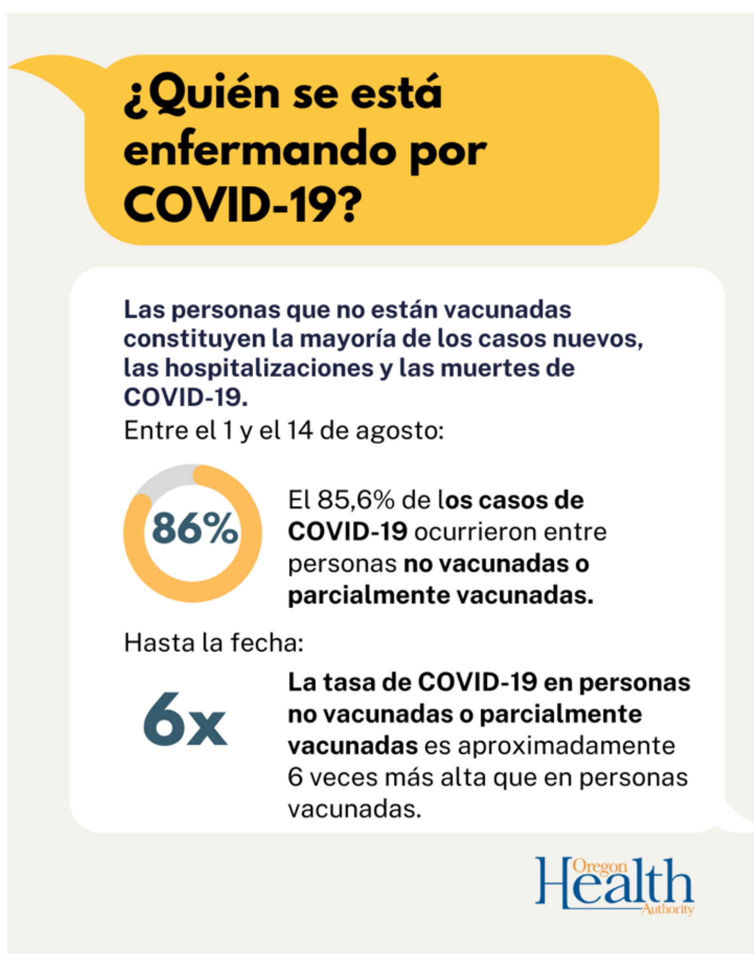


Figure 4.9- OHA infographic shared as Facebook post on August 22, 2021.

Other vaccine promotion took various forms. OHA shared personal stories of Latinx community members through its COVID Blog. For example, in August a blog post told the story of Nancy Vera, a resident of McMinnville who is a Mexican immigrant and nurse at a nursing home. In the post, Nancy described how she got the vaccine as soon as she was eligible in February to help protect her family, the people she works with, and because she knew she wanted to start a family. Nancy describes getting angry when hearing her family and friends both in the U.S. and Mexico talking about the myth that the vaccine caused fertility issues, noting that she was now five months pregnant and both she and the baby were healthy. This reflects targeted messaging to address specific cultural concerns around fertility while also addressing extensive misinformation that the vaccine negatively impacted fertility that was prevalent among some Latinx communities. CBO Casa Latinos Unidos produced a series of videos with a couple dozen Latinx community members called ¿Por qué la vacuna? In each video, a community member is asked to share their reason for receiving the COVID-19 vaccine. Common themes expressed by community members included appeal to community solidarity, protection of family members, and the ability to gather safely with family together without masking. The use of a fun music video reflects positive application of social marketing techniques and the positioning of the desirable health practice of vaccination as attractive to viewers.

Vaccine education messaging also included how to complete vaccination to become fully vaccinated. For example, on July 28, CLA shared a chart outlining when and if a booster is necessary for Pfizer, Moderna, or Johnson & Johnson. OHA promoted several of its "Conversación comunitarias" with Dr. Debess, a Zoom call in which community members could ask questions with an OHA health specialist on Facebook, especially around vaccine rollout and safety, including this conversation around vaccines for children under 12 years old. By having

an opportunity to communicate directly with an OHA Senior Health Advisor, OHA sought to incorporate participatory communication channels and additional CCA approaches. As a regular expert and participant on OHA's Facebook page and community partner calls, Dr. Debess acted as a known, trusted representative for the organization.

Near the end of summer 2021, the more contagious delta variant of COVID-19 created a surge of cases and corresponding policy changes. The policy change updates continued in messaging like LCPH's notice of a new mandatory use of masks indoors on August 13 followed shortly on August 26 by a mandatory mask mandate outdoors when in public areas where 6 feet distance could not be maintained. Other communication promoted the FDA authorization of the Pfizer vaccine for children between 12-15 years old during this time. This messaging largely reflects continued efforts of improved self-efficacy around the new vaccines and continually updating changing vaccine policies.

Period 6. Fall 2021: Response to Delta variant surge, Continued vaccination efforts

By late September 2021, Oregon hospitals remained under severe strain from the surge of Delta COVID-10 cases and were projected to remain at high levels well into late fall (Robinson, 2021). LPHA's communication centered largely around promotion of the vaccination clinics they were helping to facilitate, often in coordination with partner CBOs in an effort to reach community members yet to be vaccinated. CBO vaccination events incorporated culturally appropriate incentives with free foods like tamales and tacos, coordinating with local pantries to provide free food boxes, and free gift cards to local grocery stores for those who came to get vaccinated. While these sorts of strategies deployed traditional psychological theories of TRA and TPB, CBOs were also recognizing the continued SDH inequities and significant food security needs during the pandemic by having food box distribution as a consistent component to

vaccine and testing events. The food insecurity rate in Oregon for 2019-2021 was 10.3% and national data on food insecurity in 2021 revealed that 32% of Latinx households experienced food insecurity, compared to 18% of white and 36% of Black households (Edwards & LeBlanc, 2022; George & Tomer, 2021). These culturally specific additions to the event reflect a PEN-3 model strategy to identify and encourage positive aspects of culture to promote healthy behaviors (Airhihenbuwa & Webster, 2004).

Centro Latino Americano
October 26, 2021 ·

💉 Estas serán nuestras próximas clínicas de vacuna contra COVID-19 en colaboración con Lane County Health & Human Services! 💉

📍Viernes, 29 de octubre de 4PM a 7PM en Willamette High School (1801 Echo Hollow Rd. Eugene, OR 97402)

📍Sábado, 6 de noviembre de 12AM a 1PM en The Arc Lane County (4181 E St. Springfield, OR 97478)

📍V... See more

Figure 4.10- October 26, 2021 Facebook post from Centro Latino Americano promoting community vaccine events.

OHA and LPHAs also used their communication platforms to promote CBO-sponsored vaccination events, including LCPH sharing information on all CLA vaccination events. Other examples include OHA promoting the Mano A Mano Family Center in Salem on September 29

and another vaccine event sponsored by TV Jam and Vive Northwest in Portland on October 29. CBOs continued to share additional testimonial videos from a wide range of Latinx community members and their motivations to get the vaccine, appealing to TPB subjective norms and additional peer group acceptance. Consejo Hispano shared a fun music video of the song “Yo Me Pongo La Vacuna” by Alex Llumiquinga Perez. The song begins with the phrase “Today I bring you a message of hope, it has arrived.” The song appeals to the shared difficulties and changes experienced and frames the vaccine as the solution to a better future and makes appeals to community solidary and shared happiness. This music video is a great example of an entertainment-education strategy to promote positive attitudes toward vaccination and increased vaccine acceptance.

LPHAs continued to educate community members around COVID-19 vaccine developments and updates. In late October, LCPH shared an infographic that explained the difference between a booster shot and an additional dose. A few weeks later they shared information around where children aged 5-11 could receive their vaccines either through their pediatrician or family doctor, pharmacies, and LCPH clinics. Around this time LCPH shared an infographic addressing the question: "Could getting a flu vaccine affect my immigration status?” as a way to bring awareness to HIPPA privacy protections for anyone seeking medical attention which restrict healthcare workers and organizations from disclosing the immigration status of a patient to authorities or anyone else. A similar infographic confirmed one’s ability to get a flu vaccine and COVID-19 vaccine during the same visit. These posts exemplify addressing doubts around vaccination and HBM of perceived barriers. LPHAs and CBOs continued to play an important role in getting information to non-Spanish speaking indigenous Latinx community members during this period of the pandemic. For example, Benton County’s LPHA shared a

COVID-19 video update in Mam on YouTube and social media on November 1, 2021 which shared information about the Moderna and Johnson & Johnson COVID-19 booster vaccine, the new requirement for immigration benefits, and vaccination related events. This is a good example of messaging that importantly recognizes the diversity in local Latinx communities and differences in countries of origin and primary languages that can often be overlooked (Ortiz, 2022).

As schools reopened, communication at all levels targeted parents and concerns around sending their kids to school. On September 22, CLA shared Oregon Department of Education's 30 second video of Latina Troutdale parent Maggie discussing feeling safe sending her kids to school. The English subtitle explained "Oregon schools are getting ready for students to return to the classroom this fall for full-time and in-person instruction. For kids and families, this can be a mix of stress, excitement and opportunity. This may be especially true for families and students who have personally experienced the deep impact of COVID-19, including those who are Black, Latinx, Indigenous, LGBTQ2SIA+, living with a disability, or living in a rural community. It’s important we all show up with care and connection for each other as we begin the new school year together.” Later in October, CLA shared an infographic communicating information from OHA and ODA about what to do if your student tests positive for COVID.

Over a year into the pandemic with the Delta variant spreading, many classic health behavior promotion messaging was repeated with some updates. For example, LCPH Halloween Safety Tips that included vaccination recommendations for anyone 12 years or older, such as selecting a costume that permit the use of a facemask, keeping groups small, and maintaining distance. LPHAs and CBOs collaborated to share local statistics related to COVID. For example, LCPH and CLA shared a post noting 28,275 positive cases since the start of the pandemic, 61

hospitalizations, 479 infectious cases, and the current rate of total population completely vaccinated at 62.15%. The post included information about an upcoming Latinx-specific vaccine clinics and the number to call or website to make an appointment. The post ended with the message: "*¡Sigamos trabajando en solidaridad para mantener a nuestra comunidad saludable y segura!*" [4] This message demonstrates sustained use of TPB's subjective norm strategy with a cultural appeal to continued community solidarity throughout every period of the pandemic.

In September 2021, LCPH began publishing a weekly CBO newsletter with local CBOs. This weekly communication with updates on case numbers, vaccines, clinic, educational opportunities, changes in guidance from local, state, and federal partners and importantly acted as a platform for questions from previous weeks by serving as a communication channel to and from the COVID Emergency Operations Center. The newsletter was published in both English and Spanish. By incorporating a clear, interactive communication tool with CBOs and with the goal to center questions and voices of community advocates, this LPHA incorporated a social action model and health communication advocacy approach to its communication. This newsletter continued through the newly formed Community Partnership Program which is discussed in more detail in Chapter 6.

On November 2, OHA shared a celebratory infographic with the update that 80% of Oregonians 18 years and older in the state had received at least one dose of vaccine "*Lo logramos! Pero nuestra lucha continua*![5]" The accompanying text of the post, a note from the OHA public health director, included a recognition that while the state had made significant progress in closing the vaccination gap, people of color and rural communities were still below

[4] "Let's continue working in solidarity to keep our community healthy and safe!"
[5] We did it! But our fight continues!"

the 80% vaccinated threshold, and that to date 56.1% of the state's Latinx had been vaccinated. Banks explicitly acknowledged that vaccines in Oregon had not been administered as equitably as they should have. This is an important example of public health officials publicly taking responsibility for their actions and how this did not contribute to health equity. By taking accountability and recognizing how systemic inequities impact marginalized communities like the Latinx community, LPHAs and OHA can not only make important changes in their work but can also demonstrate their ability to learn from mistakes and help create better trust and continued engagement with these communities.

Summary

It is clear the OHA, LPHAs and CBOs recognized the significant role of various health communication strategies to reach Latinx communities during the pandemic and significant efforts were made to communicate effectively on a wide range of issues to Latinx communities in Oregon. The messaging in this sample also reflects a range of underlying health communication theoretical approaches. Individualistic theories like the Health Belief Model and Theory of Planned Behavior were evident in many health behaviors focused messaging on handwashing and mask wearing. However, this analysis also shows how the culture-centered approach (CCA) and PEN-3 models considered the specific needs within a group of highly marginalized Latinx community members including indigenous language speakers and migrant farmworker, were also present. Messaging centered relevant cultural factors over the first 22 months of the pandemic from information on targeting increased testing to vaccine promotion in the later pandemic periods. This analysis demonstrates that cultural factors were also incorporated in some individual-focused messaging, especially health behavior messaging to mitigate the spread of COVID-19 among Latinx communities by appealing to social solidarity

and community. Furthermore, communication from the three organizational levels of CBOs, LPHAs, and the OHA also reveal many instances of collaboration and coordination of shared messaging and education.

As this chapter's analysis reflects, health communication from CBOs suggested the most explicit health activism motivations, especially in the initial stages of the pandemic. CBOs called out the structural violence facing Latinx immigrants by calling for the end of ICE detentions and bringing awareness to the impact of Public Charge concerns demonstrate the value of health activism's theoretical emphasis on structural and economic changes (Zoller, 2005). CBOs communication and advocacy around Latinx immigrants' exclusion from emergency relief programs is especially notable. The health activism, informative communication, and promotion of the Oregon Worker Relief (OWR) Fund is one of the clearest examples of the successful community-driven efforts to address SDOH impacting Latinx community members. Indeed, OWR continues to provide relief to Oregon Latinx community members struggling to pay rent through its current Home Fund (OWR, 2023). The significant impact of structural vulnerabilities and SDH on Latinx community members during the pandemic is reflected in the consistent messaging around resources like OWR, rental assistance, and inclusion of food resources at community events.

Because this dissertation research does not measure direct response or reach of this messaging targeting Latinx community members, discussion related to reception and impact is limited. Survey results of Latinx community member in Lane County (discussed in detail in Chapter 6) reveal that social media was the predominant channel for COVID information, reflecting the importance of the messaging in this analysis (Yarris & Hansberger, 2020-2021). LPHA participant interviews reported in the following chapter further note the importance of

social media messaging as a predominant communication channel. The use of video messaging for outreach is also significant. Participants from Benton County LPHA noted almost double the amount of viewership of their Spanish video COVID updates on YouTube than their English videos. In fact, Benton County's videos in Mam got the most views and around 50 times more than the Spanish videos reaching people not only in the Corvallis and Albany area but also the Bay area of California and Central America. As Rocío Muñoz, Health Equity, Engagement, and Communications Manager for Benton County Public Health explained in an interview on that data, "we knew it was the right way to reach the community not just because of the information, it was because of the person delivering the message in Mam and it was because of the environment the culturally specific and relevant information."

Coordination between all three levels— state, local and community— are evident in this CDA and reflect necessary updates on changing information and policies during this period of the pandemic. As insights from LPHA participants in the following chapter will further reveal, there were still areas of improvement in the flow of information and communication from state officials and LPHAs. The communication strategies that combined theoretical approaches by delivering messages employing HBM and TBP to promote important individual health behaviors and delivered from trusted, culturally tailored partners like CBOs and CHWs and promotores demonstrate the value of CCA and PEN-3 model considerations are for outreach and messaging to marginalized groups like many Latinx community members. OHA and LPHAs realized that necessity of not only having translation of messages but also having connections with community partners to get health education information to marginalized communities who otherwise would not have that information because of access restrictions. The importance of

community partner engagement in health equity communication efforts is further addressed through LPHA participant interviews of the next chapter.

CHAPTER 5

LOCAL PUBLIC HEALTH COVID REFLECTIONS, CHALLENGES, AND LESSONS: RESULTS OF A SURVEY OF OREGON'S LOCAL PUBLIC HEALTH AUTHORITIES (LPHAS), PARTICIPATORY INTERVIEWS WITH LPHA PARTICIPANTS ON STAFFING, COMMUNICATION, PARTNERSHIPS, AND LESSONS LEARNED DURING THE COVID-19 PANDEMIC AND BEYOND

"While the federal government may be declaring an end to the COVID-19 public health emergency, there are still significant, longstanding gaps in the public health infrastructure in the U.S. Investing in the resilience of the public health system can help promote health equity, maintain the health and well-being of communities, and ensure better preparedness for future health emergencies."- Kelly Singhose, Harney County LPHA Director

As the frontlines of the public health response to the COVID-19 pandemic, Local Public Health Authorities (LPHAs) working most directly with community members and community-based organizations (CBOs) led much of the health communication and community partnership engagement work. My survey of the entire state, with 24 of the 32 state LPHAs contributing to the results of this chapter, revealing common strategies and barriers in communication, community partnership, and health equity efforts during the pandemic. The group of participants included in these results include perspectives from 22 local Public Health Administrators (PHA) and nine communication, health equity, or community partnership staff members, and one senior program coordinator. The following results of participatory interviews with LPHA staff members in Oregon address the second set of research questions of this dissertation: 2A. What was staffing for communication and community partnership-related work at Oregon's LPHAs like during the pandemic? How did LPHAs work to address health equity concerns in their community during the pandemic? And 2B. What is this staffing post-pandemic (2023)? How are LPHAs incorporating lessons from the pandemic to improve health equity efforts at a community level

moving forward? The full participant interview question guide can be found in Appendix C. These results provide important insights into how these experiences are shaping current public health in the state.

Since the start of the COVID-19 pandemic many of the 24 LPHAs participating had experienced significant staffing changes, including administrative positions. Ten LPHAs had had changes in administration since Fall 2020, limiting some county's direct experience and responses to some of the questions for the full period of the pandemic. One LPHA that declined to participate was Gilliam County due to the fact that all of the county's administration had left in Spring 2023 and the public health services had been taken over by the South Gilliam County Health District organization in July 2022. OHA has noted similar high turnover in LPHA leadership including 18 changes at the local health administrator level across 14 LPHAs and four LPHAs with multiple leaders turning over (OHA, 2023). The impact of this turnover and its contribution to staff burnout was noted by several LPHA participants and discussed more in the chapter's last section.

The themes presented in this chapter were determined through a combination of direct reporting of LPHA participants' responses to questions around staffing levels and types and priority communities for health equity concerns. Theme identification for LPHA's most significant lessons from the pandemic was determined by frequency of responses and intensity of responses. For example, if an LPHA participant gave only one key lesson, this theme was noted. Because some participants wished to participate in this research confidentially, a full list of participating LPHA units is not included. Specific examples from LPHAs in this chapter are only from participants who gave consent to disclose their information.

To get a sense of LPHA staffing and communication and community-partnership work both during the pandemic and after the official end of the pandemic, this chapter begins with a breakdown of LPHA communication and community partnership/ health equity- specific staffing, followed by a description of communication strategies utilized by LPHAs during the pandemic. The next sections cover health equity concerns and community partnerships work among the participating LPHAs, including a survey of published Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP) for each unit. The chapter ends with a discussion of participating LPHA's most significant lessons from the pandemic.

LPHA Communication and Community Partnership/ Health Equity- Specific Staffing

Overview of Communication Staffing

Participants were first asked about staffing in their unit for communication-specific and community partnership/ health equity-specific positions both during the pandemic and as of late 2023. Communication staff work refers to unit staff members whose tasks are related directly to external communication including Public Information Officers (PIO) responsible for giving press updates, writing press releases, email updates, creating social media posts, designing pamphlets, video and/ or audio production, and coordination of external messaging across various platforms. Community Partnership/ Health Equity specific staff refers to unit members responsible for coordinating with community partners and local CBOs and supporting their work which support local public health efforts. The following tables (Tables 5.1-5.4) demonstrate the range of staffing for both these position types among all LPHA participants.

Table 5.1- Communication Specific Staffing at LPHAs During the Pandemic:

Number of Participating LPHAs	Staffing Description
12	Zero communication specific staff members. Of these 12, 4 identified staff members who fully or partially shifted their position to take over communications work.
1	Hired a PIO for a 6-month period of the pandemic
1	Had a PIO/ Comms Coordinator staff member for the entire Health & Human Services unit
1	Shifted part time PIO to full time during pandemic
1	Had a PIO for the entire Health & Human Services Agency and hired a temporary partial FTE for the department
1	Had a Communication Coordinator
1	Hired a PIO and Public Modernization staff member at the start of the pandemic
2	Hired a PIO/ Communication coordinator at the start of the pandemic
2	PIO and hired a Communication Coordinator and/or additional comms staff during pandemic
2	Communication team of 3 or more staff members

Table 5.2- Communication Specific Staffing at LPHAs as of Late 2023:

Number of Participating LPHAs	Staffing Description
6	Zero communication specific staff members (one was trying to fill a communication position, another was setting up a .50 FTE Communication Coordinator, a 3rd had 2 staff members informally taking on communication role). Those who have no staff in this position cited lack of funding as a factor.
4	Rural Communication Coordinator who is staffed by CLOH to serve a small group of

	rural county LPHAs-Baker, Malheur, Grant, and Harney. Staff member works remotely, meeting once a week with each LPHA administrator to create more local, community-focused communication. The position was created in early 2023.
1	Partial FTE communication staff member
2	Staff member who filled both a PIO/Communication Coordinator role and partnership/ public health modernization role
7	Single Communication Coordinator or PIO position within the department
4	3 or more staff members as part of a communication team (one team is shared within Health & Human Services unit)

Overview of Community Partnership/ Health Equity LPHA Staffing:

While LPHA staffing for community partnership and health equity specific work did not see as widespread increases across participant LPHAs, results of this survey still reveal clear efforts to increase this work within the last three years particularly to better meet public health modernization foundational capabilities.

Table 5.3- Community Partnership/ Health Equity Specific Staffing During the Pandemic:

Number of Participating LPHAs	Staffing Description
14	Zero community partnerships/ health equity specific staff members
1	Hired a temporary wraparound activities and Community Partnership Coordinator during pandemic
1	Hired a temporary Community Health Worker during the pandemic to do community partnership work
1	Hired a public health modernization position who is also responsible for PIO work at start of pandemic
1	Hired a Health Equity and Reproductive Health Coordinator
1	Hired a Health Equity Coordinator during the pandemic

1	Health Equity Coordinator who was made into a temporary Partnerships Coordinator
1	Created a Community Partnerships Program and hired 4 staff members during the pandemic
3	3 or more staff members as part of a community partnerships/ health equity team

Table 5.4- Community Partnership/ Health Equity Specific Staffing as of Late 2023:

Number of Participating LPHAs	Staffing Description
10	Zero community partnerships/ health equity specific staff members
1	Community Health Worker doing community partnership work, position will end in October 2024
3	One staff member responsible for both communication and partnership coordinator/ modernization work
1	Emergency Preparedness & COVID-19 Recovery Manager staff member going partnership work with plans to create 2 Community Liaison positions
1	Health Equity and Reproductive Health Coordinator
5	1-2 staff members in a Health Equity Coordinator or Modernization/Community Partnerships coordinator position
3	3 or more staff members as part of a community partnerships/ health equity team

LPHAs saw extensive expansion with the number of LPHAs with no communication staff members improving two-fold and leaving only one quarter of participating LPHAs with no communication specific staff members, Community partnerships/ health equity staffing did not expand as greatly as communication but still saw improvements with a 16.7% increase in participating LPHAs with some community/partnership-health equity specific staffing. In participant interviews, the need for extra communication staff during the pandemic was a common theme. Several LPHAs utilized pandemic-related funds to help hire temporary staff or

to contract with outside media agencies to help produce communication. The most common use of pandemic-specific funding was around extra staffing, especially temporary staffing to support new COVID-19 contract tracing, case investigation, call centers, and testing events. The next section expands on communication how LPHAs approached communication work during the pandemic.

LPHA Communication Strategies during the pandemic

The foundational public health capability of communications was demonstrated as a true foundation and necessary function during the pandemic for the state's LPHAs. LPHAs were tasked with communicating new information and updated policies from national, state, and local agencies, often balancing conflicting information and competing misinformation in their communities. Participants were asked about their unit's communication strategies during the pandemic and discussed a variety of communication tools used by their LPHAs to get messages out ranging from traditional press releases, newspaper, radio, TV, and billboards to new media tools like social media and video production. As demonstrated in the staffing survey (Tables 5.1-5.4), many LPHAs dedicated funding to communication-related staffing. Additionally, at least half a dozen of participating LPHA's noted using pandemic funds to contract outside media producers to help with their health communication including social media and video production.

Every participant LPHA has a website to share information with the public. Several participants citied their website as one of the most important tools to share information during the pandemic. Several LPHAs including in Baker, Benton, Coos, Columbia, Douglas, Lincoln, Malheur, and Umatilla also utilized COVID resources to make improvements to their website in an effort to expand pandemic related communications. Facebook is by far the most utilized social media tool by the state's LPHAs with all but one participating LPHA having a Facebook page at

either the Public Health department or Health and Human Services level (one LPHA utilized a county-wide Facebook page). Several participants noted using new resources and staff to work on Facebook communication specifically. Margarita Park, communication team member at Lane County LPHA said Facebook messaging reached the biggest audience for the unit. One LPHA administrator described Facebook as "stupid," noting the ease with which community members could leave nasty comments on the platform. Nevertheless, this administrator described trying to answer every unscientific question and concern posted to the unit's Facebook page. They eventually blocked the comment section on posts about a year and a half into the pandemic but still got information out seven days a week. Several LPHAs specifically utilized the Facebook Live feature to share live updates. Douglas County's LPHA tallied 149 Facebook live events in total, including twice weekly during the peak of the pandemic (Becker, 2023). Seven participating LPHAs also had an Instagram page and five LPHAs had an account on X (formally known as Twitter) for social media communication.

Call centers were another key communication tool for LPHAs, especially during the early months of the pandemic when community members were inundating LPHAs with questions and concerns about the novel virus. The majority of LPHAs noted making use of emergency pandemic funding to hire temporary staffing for their call center and hotlines. Some LPHAs offered multiple information lines to include access for non-English speaking community members, especially Spanish callers. Utilizing phone calls was also helpful for many LPHAs during vaccination efforts including vaccine clinic scheduling. The November 2021 CLOH newsletter highlighted the work of Yamhill county's LPHA which developed a new discreet system for community members to schedule an appointment to receive a call from a local doctor to ask questions and get accurate information about the COVID-19 vaccines. As Lindsey

Manfrin, PHA at Yamhill County explained, residents had many questions revealing unfortunate local stigmas around both getting vaccinated or not getting vaccinated; therefore, there was a need for a confidential way to have a conversation around those questions. Hotlines generally ended with the end of pandemic emergency funding. For example, Lane County Public Health discontinued its COVID-19 Call Center on June 14, 2023, due to the end of federal funding support.

Physical flyers were an important tool for several LPHAs, especially to reach marginalized communities and as a reliable tool in more rural communities. As Jefferson County PHA Michael Baker explained, "getting information to the local diner spread that message way further than any press release would." Hood River County's LPHA PIO Daron Ryan also noted that physical fliers were important to reach community members who are not connected to the internet, are not smartphone users, or cannot read small print, including many older adults. Through work with CBO partner Age +, Hood River sent mailers to community members. Several LPHAs cited flyers as important tools to reach non-English speakers including many migrant farmworkers. Umatilla County worked with a Latinx serving CBO and farmworker staffing agency to distribute small "goody bags" that included informative handouts as well as facemasks and hand sanitizer. As Umatilla PHA Joseph Fiumara explained this was especially important for this group of folks who often are not using social media or watching the local news to get information. Hood River similarly helped get printed out information as stuffer in pay stubs of seasonal farmworkers. As mentioned in Chapter 4, radio was as a useful communication strategy for several LPHAs, particularly to reach Latinx community members through local Spanish radio stations. Umatilla and Lincoln Counties LPHA utilized area billboards to get out

public health messages during the pandemic. In fact, the running joke was that all billboards in Umatilla County were for public health.

Several LPHAs created extensive email lists to send updates to community members and a handful of counties found newsletters to be an effective method to get out information to relevant audiences. For Hood River County, having a newsletter to update all local medical providers was a useful tool during the pandemic and one they are continuing to share every quarter. Hood River County LPHA PIO Daron Ryan explained that it is very important that providers know what medical information they should be telling their patients and that by including all community providers— especially medical specialists who often get left out of medial updates like acupuncturists and physical therapists— the unit was able to build good rapport with these important community members. Deschutes County is capitalizing on the extensive email listserv they developed during the pandemic to now send out a monthly newsletter with seasonal risk communication messaging. Multnomah County's LPHA published a regular culturally specific newsletter for all partnered CBOs in addition to regular sector specific newsletters (Multnomah, 2021). Lane County Public Health's Community Partnership Program similarly utilized newsletters to send updates to community partners and continues to send these newsletters monthly. This newsletter is discussed further in next chapters' case study of Lane County. Many of the communication strategies utilized by LPHAs involved specific outreach to targeted priority communities of focus for health equity concerns. The next section covers participating LPHA's health equity concerns and interrelated community partnership work.

LPHA Health Equity Concerns and Community Partnerships

Of the 24 participating LPHAs, all but two, which participated via more limited written surveys, noted focusing on certain communities to specifically address health equity concerns during the COVID-19 pandemic. Unsurprisingly based on the established disproportionate impact of COVID-19 on Latinx communities in Oregon, 18 LPHAs (75%) listed Latinx communities as a focus for health equity concerns, many of whom listed this as the top priority for local health equity concerns. The remaining four participants listed migrant farmworkers (largely consisting of Latinx community members) or English as a second language community members; thus, Latinx community members were incorporated in all participating LPHA's health equity efforts in some way. A total of 10 LPHAs listed agriculture/migrant farmworkers specifically. This group of LPHAs noted translating all or a portion of their COVID-19 information to Spanish, and at least three of these LPHAs worked on translations and interpretations to reach Latinx community members who spoke other languages than Spanish, especially the indigenous language Mam.

Other communities most often listed for specific health equity concerns during the pandemic were elderly/older adults/senior citizens, including community members living in nursing home facilities, were a focus for nine participating LPHAs. Eight participating LPHAs focused on tribal members. Rural communities were also often listed for specific health equity concerns for eight participant LPHAs. Houseless community members were listed by six LPHAs for specific health equity concerns and low-income people noted by another two participants. Other minority ethnic communities of concern for health equity are listed in the full table below (Table 5.5).

Table 5.5- Communities most often listed by LPHAs for specific health equity concerns during the pandemic:

Number of Participating LPHAs	Community in focus for health equity concerns
18	Latinx/ Spanish-speaking
10	Agriculture/ migrant farmworkers
9	Elderly/ older adults/ senior citizens, including community members living nursing home facilities
8	Tribal members
8	Rural communities
6	Houseless community members
4	Pacific Islander community
4	Asian communities (including Chinese and Vietnamese)
3	Russian and Ukrainian communities
3	African American/Black community members
2	African migrants (including Somalia)
2	People with disabilities or transportation needs

This survey reveals that LPHAs were highly aware of the impact of systemic inequities on particular community members during the pandemic, especially BIPOC communities. In participant discussions around the unit's use for pandemic emergency funding, many discussed utilizing the resources to help with wraparound services for vulnerable community members including support and resources for those in isolation and quarantine. This support came in the form of grocery deliveries and in other counties in the form of quarantine space. Several LPHAs

paid for hotel rooms. For example, Marion County's LPHA leased an entire hotel in Woodburn to enable identified vulnerable community members in multifamily homes sick with COVID to effectively isolate. Another county set up beds at the local Expo Center.

Four participating LPHA's used funds to purchase vans or trucks for mobile clinics, especially LPHAs with critical need to reach more rural community members for COVID-19 related outreach. In Lincoln County the mobile unit were especially useful to reach people without cars for vaccinations. The county was still doing this sort of mobile outreach in Fall 2023. Later in the pandemic, LPHAs' COVID-specific funds largely helped support vaccine clinics to reach specific community groups, including several Latinx-serving CBOs throughout the state. Several LPHAs used funding for vaccine incentives, including local gift cards to be given away at vaccine clinics. A few participants discussed the strong impact of the vaccine incentives, especially among low-income community members. Perhaps most crucial to health equity related work was increased coordination and support of local CBOs.

LPHA Community Partnerships

Critical Discourse Analysis (reviewed in Chapter 3) highlighted some of the coordinated communication work between LPHAs and CBO partners. Participant interviews confirmed the prevalence and significance of community partnership work among state LPHAs during the pandemic. In fact, 16 of the participating LPHAs, well over half of the group (67%), held regular community partnership and community coalition group meetings during the pandemic. OHA's 2021-2023 Biennium Public Health Modernization Evaluation Report also found significant partnership work among LPHAs with 84% (n=27) of them reporting new or significantly expanded partnerships with CBOs in the past year (OHA, 2023). For several LPHAs, these meetings convened local CBOs to coordinate outreach efforts including wraparound service

delivery and messaging. These meetings were frequent during the height of the pandemic, occurring weekly or bi-weekly for most. There were slight variations in the structure of community partner meetings. Some LPHAs broke up their meetings with specific liaison groups for example a meeting with care provider partners.

In Klamath County, the LPHA utilized "community action teams" established in several of the small towns of this rural Southern County, after learning about the pre-established groups associated largely with the sheriff's office. These teams were especially helpful to deal with some of the challenges of reaching communities in the large geographic area the size of Connecticut. Several LPHAs used pandemic funding to hire community health workers. Deschutes County's LPHA had at one point a ten person Health Equity Team including many temporary community health workers including *promotores de salud* for necessary Latinx community outreach. Washington County's LPHA worked with the Oregon Public Health Institute (OPHI), a non-profit based at the Public Health Institute (PHI) which works to support public health and equity efforts in the state, and who coordinated the hiring and training of a multilingual team. This team was compromised of dedicated Washington County residents from a variety of communities including Somali, Russian, Ukrainian, Latinx, and Pacific Islander; they worked doing community outreach and contact tracing work. As Washington County LPHA Senior Program Coordinator Alex Coleman explained, "Whereas we could have hired somebody who maybe wasn't known in that community and wasn't a trusted entity, and we would not have gotten as far as we did."

Most participants discussed working with community partners to hold vaccination events and several created specific vaccine-provider or vaccine confidence coalition groups and meetings to coordinate dedicated community vaccination efforts. LPHAs that had existing community

partnership programs were especially successful in holding community vaccine event. For example, in Multnomah County, the most populous county and home to the largest city, Portland, the LPHA had held 120 community vaccination events by May 14, 2021, of which about half were BIPOC-specific or focused on other culturally specific communities, and vaccinated more than 20,000 community members, about 75 percent of whom identified as BIPOC (Multnomah County, 2021). Another success story of working with community partners for vaccine outreach events occurred in Washington County whose LPHA was able to reach priority Pacific Islander community members by listening to the community and learning of the importance of drive-through events and having culturally specific meal boxes at community partner events.

While most LPHAs had discontinued regular community partner meetings since the end of the official COVID-19 emergency, some are maintaining them. Yamhill County's LPHA organized a vaccine equity advisory group during the pandemic and has kept the group going to help address larger, continuing health inequities in the community. Yamhill County's Health Equity Coordinator Caitlin Nemeth, a newer position in the LPHA established in 2022, is now organizing the group of community partners and facilitating monthly collaborative meetings as a space for the community to come and talk to the LPHA about what they needed and to contribute to continued efforts to address community health inequities. Nemeth and the LPHA listened to community feedback and shifted the structure of the meetings to have a specific focus as one of the CHIP strategies. At the January 2024 community partnership kickoff meeting, there were 29 participants from the community who now makeup an External Equity Advisory Group for the LPHA.

Lane County's LPHA expanded its community partnership work by establishing a Community Partnerships Program (CPP) in October 2021 largely utilizing available modernization

funds. The core team is made up of a supervisor, an outreach coordinator, and an epidemiologist. CPP Supervisor Mo Young believes that the pandemic brought greater awareness to the critical need to listen to community who know what is needed. As she explained, “the relationships that were started during COVID, or picked back up during COVID, or continued, I feel like that's important across the division and I think anyone would agree with that. I don't I don't think that was true before 2020.” Chapter 6’s case study of Lane County will give an extensive description of the CPP’s community partnership work, including its important work leading the next community health assessment.

Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP) at Oregon’s LPHAs

As discussed in the introductory chapter, the importance and necessity of communication and community partnership work for LPHAs was systemized around a decade ago in state policy with the 2013 House Bill (HB) 2348 public health modernization plan. CHA and CHIP processes act as a key for community engagement and a public health approach to achieving health equity. As part of this dissertation’s state LPHA survey research, each participating LPHA’s most recent Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP) were located at the LPHA or County government website to get more insight into the recency of this form of community engagement and health equity work.

In August 2016, CLOH published a Public Health Modernization Assessment Supplemental Report with key recommendations of needs to support a successful transition to the modernization framework. Among them was improved communication to the LPHAs about the modernization framework, timeline, and expectations and more time and opportunity to explore and embrace the framework, as many LPHAs needed to build their foundational capabilities. The

CLOH report also recommended more time and opportunity for LPHAs to engage with local community partners and build on existing cross-jurisdictional partnerships, reflecting an acute need of many LPHAs for community partnership development (CLOH, 2016). Since that time, LPHAs have been incorporating regular CHA and CHIP processes but some LPHAs seem to continue to struggle with updated CHA and CHIP more than others. All but one participating LPHA had a published CHA and CHIP on their LPHA or county website. The following table (Table 5.6) illustrates the range in time periods in which the remaining 23 participating LPHAs have completed their most recent CHA and CHIP:

Table 5.6- LPHAs CHA publication range

Number of Participating LPHAs	CHA Publication Period
6	Within the last two years, 2022 or 2023
2	Between 2020-2021
13	Between 2018-2019
2	Before 2018 (both in 2015)

Table 5.7- LPHAs CHIP publication range:

Number of Participating LPHAs	CHIP Ending Period
7	In 2024 or beyond
7	2022 or 2023
1	2020 or 2021
6	2018 or 2019
1	Prior to 2018 (published in 2016)
1	No CHIP published (only a CHA)

As LPHAs continue to work to modernize their units, incorporating meaningful community partnerships in their work will be increasingly important, especially for updated

CHA and CHIP that are truly community driven. As this survey demonstrates, the majority (70%) of LPHAs are seemingly working from CHIP for outdated periods. Additionally, the majority (65%) of LPHAs have not completed an updated CHA since prior to the pandemic. Future CHA and CHIP collaboratively produced by LPHAs and community members will incorporate many important lessons from the COVID-19 health emergency and the significant health inequities it exposed. The final section of this chapter previews some of these lessons by discussing the most significant pandemic lessons from the 24 participating LPHAs.

Most Significant Lessons from the Pandemic

At the end of each interview or written survey, LPHA participants were asked to summarize the most significant lessons learned from the pandemic that continue to impact their unit's current work. Seven key, common lessons emerged from these discussions including:

1. The importance of effective and clear communication;
2. The importance of having strong relationships with community partners;
3. Existing and longstanding gaps in public health infrastructure hindered LPHAs pandemic response and more funding is needed for future work;
4. The need for better communication and collaboration between state (OHA) and local health authorities (LPHAs);
5. The importance of work balance and healthy work culture to address the challenge of burnout;
6. Public health units benefit from having diverse teams in their staff;
7. The importance of transparency, explaining why decisions were made, including the importance of having and sharing local data.

The following sections expand upon each of the above key lessons.

1. The importance of effective and clear communication.

The most cited lesson, noted by over half of the participating LPHAs, was the crucial role of effective communication for the public health unit. LPHAs cited a range of communication-related lessons that they are working to improve upon and continue in their future work. Having communication that reaches marginalized populations, including better understanding of the various methods people receive their information was a goal for several LPHAs, as well as translating more information to other languages in the community outside of English, especially Spanish. Yamhill County's LPHA communication staff worked to ensure that all their information was available in Spanish at the same time as it was released in English. Yamhill County's team also prioritized having their communication at a sixth grade reading level to ensure wider access to community members. The American Medical Association recommends medical material be at the sixth-grade level while the Centers for Disease Control and Prevention (CDC) recommend that medical information for the public be written at no higher than an eighth grade reading level (Weis, 2003; Mishra & Dexter, 2020). A study that compared the readability of official public health information about COVID-19 on websites of international agencies and the governments of 15 countries found that all websites evaluated exceeded the recommended reading levels of grades six to eight, suggesting that this was a challenging goal to reach (Mishra & Dexter, 2020).

For several LPHAs, having staff members with formal communication training and skills was an important lesson learned, especially in counties that did not have this sort of staffing during the pandemic. Baker County's LPHA expressed gratitude for the new CLOH staffed Rural Communication Coordinator who is working with four rural LPHAs, noting the challenges faced during the pandemic to get information out. For Jefferson County's LPHA which did not

have a trained PIO in unit, requiring the WIC Coordinator to do this work during the pandemic, sees the value in communication training, and this staff member has since gotten their formal NIMS (National Incident Management System) training.

For those LPHAs who did have communication trained staff, the benefit of their role during the pandemic was outstanding. As Bob Dannenhofffer, Douglas County PHA explained, "Information professionals are just that, and that they have a tremendous experience and knowledge that the rest of us don't. And my best advice for people, is that in this situation, hire! Hire some people who are experts in that field and can help you navigate." For example, Bob said he never would have been able to figure out how to put on a twice weekly Facebook Live without the support of this staff which helped get timely updates to community members. Deschutes County's LPHA noted having a direct communication line with community members as an especially important lesson from the pandemic and a strategy they are continuing, including an LPHA phone line during more recent winter storm emergency events. Umatilla County PHA Joseph Fiumara described how the communication coordinator position his unit created allows them to actually design a website with thought and maintain it with updated information. The position was also crucial to stay up to date with social media by having a dedicated person who could try to track questions and comments and respond to inquiries. He believes this also improved engagement with these communication channels because community members knew there was going to be regular information coming out.

LPHAs found improved communication through the inclusion of community voices in their official LPHA communication. Coordination with partners was essential in these communication efforts. As one LPHA PIO explained, "getting out of the way and letting those voices be heard" was an important communication strategy, especially for non-English and

cultural-specific community outreach. In the comprehensive report titled "Public Health Response to the COVID-19 Pandemic in Oregon" produced by a third-party contractor for OHA, Rede Group, the first recommendation in the report related to health outcomes was improved communication, especially in other languages.

> "Improve equitable communication by ensuring information is timely and accessible for all Oregonians. OHA should do everything possible, including conducting translation in-house, to eliminate the lag in the translation of critical health information into non-English languages. OHA should be hiring, recruiting, and retaining bilingual, and preferably bicultural, staff into various departments- as opposed to hiring that is done solely in response to a critical need" (2022).

The importance of community partners in LPHA outreach is evident in the significant role and increased connections of LPHAs and community partners, discussed more in relation to the next key lesson. OHA's 2021-2023 Biennium Public Health Modernization Evaluation Report also sheds light on the crucial role of community partners in culturally responsive communication efforts. In OHA's survey, fewer than half of LPHAs reported implementing culturally responsive communication systems and facilitating those communications among priority populations in ways that elevate community priorities and health equity considerations into long-term planning and policy making while 94% of modernization-funded CBOs planned or implemented culturally specific communications and collaborated with one or more LPHAs in the development or dissemination of those materials (OHA, 2023).

Several LPHAs, especially in rural settings, could not simply share information directly from national and state sources like the CDC and OHA without adapting the information from for the local community, often needing to conceal the source of the information to avoid pushback and increase acceptance of the message. A few rural county LPHAs got backlash for sharing information from the OHA that wasn't 100% relevant to the county but many also struggled to create their own communication without their own communication staff. For one

rural county, Linn County, CBOs played an exceptionally important role in the LPHA's pandemic health communication and outreach due to lack of funding for communication specific staffing and local political limitations. As Linn County PHA Shane Sanderson explained, the unit had to navigate pressures from commissioners representing constituents that didn't believe COVID was real and viewed the county as the "flagship conservative county of Oregon." So Linn County's LPHA used grant funding to support CBOs get out COVID-related messages which strategically did not include the LPHA logo. "That was definitely a key strategy because we couldn't even really put information saying this is a real thing, and you should get a vaccine [without support from certain county commissioners] So, we relied heavily on partners to do that type of messaging." This was especially true to reach Latinx communities. As Shane Sanderson further explains:

> "I think that that also allowed the kind of government to stop saying, you know, we're, we know everything and we know how to reach the Hispanic community. And instead for me to say, the Casa Latinos Unidos is one of our largest Spanish speaking CBOs here to say, you guys know everything, I have resources, and I can give you support it, I mean, right down to if you say, hey, print this, I will, with no questions asked. And if you do the outreach to reach your community, tell me what you need and I will, you know, scratch claw and do whatever I have to do to get it to you. And that basically was our process. And I would say it actually worked pretty well."

Klamath County's LPHA felt similar limitations around utilizing outside communication sources. The county office hired an outside communication consultant who was not based in the community. The LPHA had access to the consultant but did not utilize them as a resource because they were not from the community, didn't know their partners, and thus could not create effective messages for their needs. This experience highlights the importance of having local communication staff who are familiar with the community to create suitable messaging that is hyper-local. As Klamath County PHA Jennifer Little explained, "particularly for people in these smaller towns that are very proud of where they live and identify very strongly with that

community like, I am from Crescent, I am not from Klamath Falls. I am from Bonanza, I am not from Sprague River, we need to be very intentional of fostering that community pride and be very intentional with our words."

Some LPHAs noted the need for better internal communication. For one PHA, this lesson included the need for quicker communication with County Commissioners as specific stakeholders to aid in better decision making. Another PHA noted a need for improved communication and coordination among all the Health & Human Services programs. For two participants, the need for a better and clearer translation process among the LPHA was strikingly apparent, especially for the related health equity concerns.

2. The importance of having strong relationships with community partners.

The second most cited lesson was clearly the importance of community partners for public health agencies with several LPHAs describing establishing and strengthening relationships with CBOs as one of the positive outcomes of the pandemic, and many LPHAs are working to maintain those partnerships moving forward. As Interim Public Health Director of Benton County Sara Harstein explained CBOs are "really an arm of public health and can reach populations in a way that we may not be able to do because they build trust, they may or may have diverse staff, that that in a way that we don't have." While community partners have long been an important part of the work of many public health units, the COVID-19 pandemic revealed the necessity of community partnership for LPHAs in an unprecedented way.

LPHAs that had established partners prior to the pandemic noted how helpful those connections were during the pandemic. Klamath County PHA Jennifer Little said they felt uniquely fortunate to not have to build new relationships and that because of that their collaborative response "really was a beautiful team effort." Hood River PHA Trish Elliot was

also thankful for the partnerships her LPHA had and believes they have stronger partnerships and more agencies "in the community and beyond" that they consider partners. Multnomah County's LPHA utilized existing community partnerships to apply "a leading-with-race" approach early in its COVID-19 response both due to the obvious disproportionate impacts among Black, Indigenous, and other People of Color (BIPOC) and the County's preexisting commitment to redressing systemic racism. The LPHA developed a COVID-19 BIPOC Reopening Priorities and Strategies for Support Plan in June 2020 to serve as a community response guide. Out of this document, Multnomah County developed BIPOC Plan commitments and goals to ensure racial equity was centered across the unit's areas of work from community testing and contract tracing to data, communication and economic vitality.

> "The role of the County in this outreach will be less about directly interfacing with community members and more about equipping trusted community voices to answer questions and provide the information people need to make decisions around vaccination. These trusted community voices include but are not limited to faith leaders, BIPOC elders, local business owners, certified lactation counselors and community health workers (CHWs)" (Multnomah County, 2021).

The importance of community partners was especially evident for LPHAs to address health equity concerns among marginalized communities. Community partners also crucially helped with translation needs for targeted outreach of non-English speaking community members, especially among LPHAs with limited staffs. Community partners also informed LPHAs when they were failing to reach their communities. For example, one of the state's first massive COVID outbreaks occurred in June 2020 when around 125 cases were linked to an outbreak at Newport's Pacific Seafood processing facility in Lincoln County (Crombie, 2020). The group of workers impacted was comprised largely of Latinx community members who were not being reached by the LPHA. Latinx serving community groups quickly gathered and created a collaborative group with the OHSI extension called "Juntos en colaboracion" to help with

outreach. Lincoln County PHA Florence Pourtal explains that the group called out the LPHA and helped move the unit's approach to be more responsive to non-English speaking population moving forward. Lane County LPHA PIO and Communication Director Jason Davis described a similar lesson around the importance of "making sure that when we're modifying our tactics or our messages to reach a specific community, that we have members of that community as part of the generation process, you know, that we're actually generating the messages and the tactics with them in tandem."

Building trust with community partners was an important lesson and outcome for several participant LPHAs. Shane Sanderson, Linn County PHA explained, "I think the most important part was after doing that [working with partners during the pandemic], for two or three years, we emerged with a lot of healed relationships and a list of regular partners that we talked to monthly that went from two to about 20. And I think that we've been able to build on that and keep some of that going, even after the pandemic." Because so many LPHAs were taking the time to regularly meet with and collaboratively engage and support community partners, relationships and trust were strengthened.

The importance of community partners was also revealed through LPHA's challenges to reach communities lacking CBO representation, especially noted by LPHAs serving more rural communities of the state. For example, while there were some regional CBOs that serve Deschutes, Crook and Jefferson Counties, Jefferson County felt that much of these CBOs works went to population centers and left out rural areas. Deschutes County's LPHA noted the challenge in reaching Asian community members who lacked a specific organization or hub in the community. To manage this gap, LPHA staff took a "grassroots type-level" approach and had a temporary employee who had done direct outreach and personal community link go into

businesses owned by and employing Asian community members including several nail shops to get out information.

Significantly, LPHAs who had limited staff expressed challenges in keeping up with local partnerships. One PHA who was largely managing all community partnerships on their own said, “I think there were moments when, you know, I tried to attend meetings, but it was pretty difficult because it was all hands-on deck, and I already have had limited staff.” Several LPHAs are taking an approach to divide partnership work among staff members, including partner meetings and outreach by relevant topic areas. Columbia County’s LPHA hired one limited duration community health worker during the pandemic but still felt understaffed. Moving forward, building partnerships is a key goal for the unit. Colombia County PHA Jaime Aanensen explained that the LPHA is “focused on building the infrastructure and capabilities along with developing community partnerships to be able to respond to future events in a coordinated and efficient manner.”

Outside of CBOs and non-profit organization community partners, most LPHAs noted working closely with local school districts to get out information to community members. For example, Rocío Muñoz, Health Equity, Engagement, and Communications Manager for Benton County Public Health worked closely with the Corvallis School District Family Liaison to get out updates to parents in Spanish. Other LPHAs shared weekly updates with school district leaders and included school district representatives in community partner meetings. A handful of LPHAs noted the business community as a specific useful partnership during the pandemic. Jefferson and Deschutes Counties’ LPHAs noted working closely with the Chamber of Commerce and other business organizations for communication work and to make sure local businesses had up-to-date information on policies. Jefferson County PHA Michael Baker

participated in regular "Chamber Chat" discussions on Facebook live-, a one-hour broadcasted conversation during which Michael would answer questions on everything and work to get science explained. Another example of collaboration with a local business was of Lane County's LPHA holding a vaccine clinic at a community-trusted Black barber shop. Benton County's LPHA and partner CBOs also shared some outreach in different businesses in target neighborhoods with lower vaccination rates.

3. Existing and longstanding gaps in public health infrastructure hindered LPHAs pandemic response and more funding is needed for future work.

Another frequently cited important lesson for participating LPHAs was clearly related to challenges around public health infrastructure and funding. Indeed, the severity of this lesson is highlighted by the fact that one participating LPHA cited only one lesson, "We are understaffed and underfunded." Another PHA summarized this lesson well saying, "The public health department was understaffed and unprepared for the magnitude of the pandemic response." As Hood River County PHA Trish Elliot explained, with past emergency responses over the years, emergency preparedness money continues to fall off and LPHAs have to wait until the next big emergency and a lot new money comes but it must be used be a certain date. She asks, "why can't we save that money for a rainy day?"

Many LPHAs noted how important recent public health modernization efforts have been for their units, especially in relation to health equity efforts. Several of the communication and community partnership/health equity staff positions listed in the previous section were created and funded only through recent public health modernization investments by the state. However, several participating LPHAs feel that modernization funds are not keeping up with unit demands and are too reliant on each state legislative session for support. One LPHA noted that low staff wages also

made it difficult to hire and retain a full staff. A couple rural LPHAs noted the difficulty in filling open positions with a lack of applications including one PHA that has had five failed attempts to fill a local emergency & response coordinator role for various reasons.

In addition to more funding, having increased flexibility with the funding received was another cited lesson for LPHAs. Administrators noted how useful some of the emergency funding that did not have normal restrictions were in their functioning and vice versa how funds that had strict limitations often went unused because that need was already met or no longer relevant. For example, Klamath County's LPHA received a large amount of limited vaccine specific funds that is now sitting there when it could be used to help with necessary items like food or staffing for vaccine clinics. Similarly, Deschutes County's LPHA noted that their unit had left over funding earmarked for contract tracing which is no longer happening, yet the LPHA needs more funding for vaccines. Another participant expressed frustration with general limitations in the structure of most LPHA work:

> "Most of the requirements that we operate under are not helping people get and retain information they aren't. They're helping make a grant possible for next year. They're helping a politician win reelection, they're helping, you know, people who feel guilty in society about past injustices go forward and wake up tomorrow, those should not be goals. Our goal should be information retention, and comprehension, and inclusion."

Conversely, LPHAs that received funding that was more flexible under the emergency provisions noted the great benefit in their ability to fund whatever was needed for testing, clinics, or partner support and significantly to invest in the LPHA infrastructure. Florence Pourtal, PHA of Lincoln County, cited flexibility in funding as specifically useful to allow her to better cover two of the foundational programs still not covered at her LPHA. Washington County LPHA Sr. Program Coordinator Alex Cleman also noted the benefit of flexibility as a key lesson from the pandemic, especially related to work with community partners and something they're hoping to

keep in future work as it puts less burden on these partners. She explained, “it's a lot simpler for partners to be able to say like, we really want to like host this event, but we don't necessarily have the capacity to do a lot of the planning or the prep, here's what we can do. And we're like, great, we'll work with you to fill in the gaps- we can provide the translation and interpretation services, and just being able to be really responsive to like what partners are saying they can do at any given time.”

As some COVID-19 specific funding has ended, some LPHAs are finding added financial strains on their budgets. For example, Harney County’s LPHA noted that as of September 2023, the LPHA must purchase all COVID vaccines upfront at a difficult high rate and noted a frustrating lack of communication from Medicaid about this cost and the lack of reimbursement for COVID vaccines. Another LPHA administrator said, “I have massive concern of this huge cliff coming for us the fiscal year after this because the ARPA [American Rescue Plan Act] funds are drying up and all of these fed dollars are drying up. And I think the feds are even talking about taking back with what's been unspent.” A few other LPHAs noted difficulties or fear around likely budget constraints and needed cuts. In April 2024, Lane County’s LPHA announced reductions in the Mobile Public Health (MPH) program and staff reassignments, because of ongoing budget deficits (J. Warren, internal division email, April 9, 2024).

4. The need for better communication and collaboration between the state (OHA) and local health authorities (LPHAs).

Several LPHAs noted frustration around gaps in communication between state and local health authorities, especially when it came to getting timely updates. Multiple PHA’s felt that communication from OHA was unpredictable and lacking. Bob Dannenhofffer, Douglas County PHA, said that OHA wasn’t telling locals anything and so he would be blindsided when the state

announced big policy changes saying, “that hurt.” One PHA even described being afraid to hear state updates. “We lived in fear of the governor’s next press conference because we had no idea what she was going to say or what the new policy was going to be until that moment. We were never given a heads up which created challenges at a local level,” they said. Umatilla County PHA Joseph Fiumara shared similar frustrations. “I'm a local health administrator and I had zero idea what the state was going to do day to day. I got to find out about it through the through the newspapers just like everybody else. But the difference was, I had people calling me expecting explanations and expecting understanding for why certain decisions were being made. And sometimes I could provide that. And sometimes I could not.” He added that this challenge added to the massive amount of already existing misinformation and is something the LPHA is still struggling with presently.

Another PHA expressed uncertainty around chain of command at the state level which left their LPHA feeling unsupported. “I don't know, at the state level, I just felt like they didn't know who was on first and what was on second, it just really depends on who you talk to. That's a pretty unwieldy system, but they're the ones that should have that dialed in so that we have our backup to be able to call and instead it was, well call this person, well call this person, you know... it would have been nice, like right out of the gate to not be sent kind of running around to try to figure those pieces out.” In OHA’s state-level post-pandemic public health response assessment, the report also recognized some of the issues LPHA staff members voiced around lack of clarity:

> “Throughout the pandemic, some state-level primary response agencies in Oregon struggled to collaborate in coordinating the response and defining leadership roles and authorities. The lack of role clarity between the Oregon Health Authority and the Oregon Department of Emergency Management likely led to confusion early on in the pandemic. Issues arising from this confusion affected the overall response but directly impacted

> Local Public Health Authorities and City and County Emergency Management" (Rede Group, 2022).

Rapid changing and conflicting information from Portland and Salem based OHA leaders in addition to the CDC meant that many community members in some LPHA communities would not listen to information coming from state or national sources. For example, community members in Jefferson County were upset about a state announcement of restaurant closures due to spreading cases at a time when Jefferson County still had zero cases, and therefore lost trust early on. This lack of community confidence in any sources outside the community resulted in tremendous challenges for some locals, especially in more rural parts of the state.

An interrelated frustration shared among several LPHA participants related to state funding of CBOs and the lack of clear guidance or required coordination with local authorities. One LPHA noted frustration when they realized community members in quarantine were getting the same food resources at the same time from the LPHA and a CBO simply because the LPHA didn't know the CBO had gotten the funding to do that local outreach work. Eventually this LPHA established ongoing meetings with CBOs to help with coordination but noted that some people were better about coming to those meetings than others and felt that having clearer initial expectations for CBOs would have been beneficial. Another shared an example of a local CBO that received state COVID funding and was sharing misinformation with community members including telling people to not get vaccinated because it would hurt their fertility and especially that pregnant women and small children should not be vaccinated. One participant also felt frustration in not having any input around which local CBOs were selected for state funding as Hood River PHA Trish Elliot summarized, it felt like local health was disappointingly just "hopped over" at times.

Similar frustrations around state funding of CBOs in continued modernization also exist. As one participant explained, "Nobody has actually said what CBOs are doing. So it's not as if

like, we know in the modernization manual, those are not all laid out. Nobody has ever said, Oh, this is over here, we're funding this CBO to do this work. When CBOs put in their proposals, they said what they wanted to do, and they're funded for that, it doesn’t change what public health has to do. It’s been curious.” The categorical funding provided by state and federal partners, albeit important, limits the ability of local health authorities to comprehensively assess community health needs and their flexibility to address those community needs (CLOH, 2023).

5. The importance of work balance and healthy work culture to address the challenge of burnout.

A clear challenge for LPHAs during the pandemic was the elevated stress, increased demands and hours, and correlated burnout experienced by staff during the unprecedented public health emergency. The biggest lesson for Coos County PHA Anthony Arton was work-life balance. He described reminding his unit members to remember to “do what you can in a day and the leave work behind” noting the importance of not putting one’s well-bring at risk. This is a significant reminder when also taking into account the many participants who mentioned stress and burnout as a challenge for their units during the pandemic. This stress and burnout is reflected in the high LPHA administrative turnover noted in the introduction of this chapter. Klamath County PHA Jennifer Little wished that she would have hired more staff earlier to help with stress in her unit that was “working itself to the bone.” One interviewee who was a communication staff member of an LPHA described many occasions of working overtime until 9pm to get messages out during the pandemic.

Hood River County PHA Trish Elliott explained that while it may be cliché, considering her staff like family and maintaining a supportive work culture where everyone felt appreciated was a key lesson for her. Grant County PHA Jessica Winegar said, “We lived on such high alert for so long, that trying to just catch up on the basic clinic and public health functions seems like

we will never get caught up." She noted that she makes an effort to encourage staff to take their lunches, breaks, evenings, and weekends off in order to recuperate. LCPH administrator Jocelyn Warren also noted the necessity of considering workforce health as a key lesson. As she described, "you cannot work people that hard that long and expect there not to be any consequences… there are some really serious carryovers from the trauma of, responding to that event that we're still dealing with. We could have done much better in at the time, too, and been more thoughtful about people's work."

The intensity of work during the pandemic for LPHAs was also heightened by the larger political and violent environment. One participant who had worked in public health for over two decades described the impacts of the pandemic as extreme and even suffered death threats for their work during the pandemic. Malheur County's LPHA also noted experiencing death threats and experienced around a 30% staff turnover. Another participant described being surprised at the level of hate that came from some community members, citing an example of a threatening phone call from an influential community member who was upset about resources being spent on vaccine events specific to rural Latinx communities. Enduring racism and widespread misinformation were clear challenges for many LPHAs during the pandemic. The significant amount of staff turnover noted in the beginning of this chapter further reflects the issue of burnout during the pandemic. During periods of turnover and transition, existing staff members had to take on additional roles and manage hiring processes in addition to the already compounded demands of the pandemic response.

6. Public health units benefit from having diverse teams in their staff.

LPHAs recognized the importance of having a staff that reflected the community they are providing services to, especially during a health emergency like the COVID-19 pandemic. For

example, Jefferson County PHA Michael Baker described benefiting from having a PH staff that was already a good representation of the community including staff members who are bilingual and bicultural in Spanish and Latinx communities as well as having important tribal connections with Warm Springs and other area tribes. Similarly, Malheur County's LPHA benefits from having a young, Latinx community member working as the current Immunization Coordinator. As Malheur County PHA Sarah Poe put it, "there is nobody better to go talk to people. And it's not because she's a nurse. Right?" Vanessa Becker, PIO & Public Health Modernization for the Douglas Public Health Network explained how their multidisciplinary team of medical and public health educators and communication specialists was essential in approaching the multi-channel approach to Douglas County LPHA Covid communication strategy (Becker, 2023). Deschutes County LPHA's Program Manager for Emergency Preparedness and COVID-19 Emily Horton expressed feeling lucky to have resources to get a big group of people in their response team and that by having a team of diverse backgrounds, not all public health career people, was beneficial in their ability to use that varied experience to communicate in different and more effective ways.

Other LPHAs also noted the value of multiple team members in improving the quality of work of their units. Hood River PIO Daron Ryan said that having another staff member working on social media with crisis communication training to be able to get feedback on potential messaging with was super valuable. In describing Lane County's Community Partnerships Program (CPP) team, program supervisor Mo Young emphasized the importance of having multiple people within the organization doing this work, not only because they can support each other, "but also knowing that, like, there's no one person is in charge of all the things, we have this brain trust, we have different skills, and we have each other's backs." Additionally, having a team means that when someone needs time off, the team's work is going to happen. As she summarizes,

"even if the work that we're doing is like literally life and death, like with the vaccines, you still can take time to rest and recuperate from whatever you're dealing with, because there are more people." The ability of LPHAs to build teams is directly dependent on their ability to add staff members which is dependent on significant resources which are often not available to LPHAs.

7. The importance of transparency, explaining why decisions were made, including the importance of having and sharing local data.

In the setting of the coinciding "infodemic" during the pandemic and widespread misinformation and large mistrust of health authorities among many communities, lessons around transparency and decision making were also common among Oregon's LPHAs (WHO, 2020). Many participants expressed important lessons around how they made decisions and the important impact of how those decisions were communicated to their communities. Jefferson County PHA Michael Baker described needing to take necessary time to explain what data means, including the basics around scientific research and what COVID-19 is, to answer questions and confront some of the misinformation spread in his community. Deschutes County's LPHA created a local flu surveillance weekly report during the pandemic in response to our local providers who wanted local data and not available data often limited to the Portland area or statewide.

Data including information by race and ethnicity was particularly significant for LPHAs in their health equity efforts. Marion County's PHA Ryan Matthews explained how data on spread of disease by race and ethnicity was important to identify high priority areas for focused outreach. When the county saw a high spread of disease in Woodburn communities, they coordinated outreach with local CBOs to increase testing and resources as well as targeted communication outreach. Similarly, Benton County's LPHA looked at vaccine data broken down by age, race and ethnicity, and detailed geographic areas with its Vaccine Confidence Coalition to help inform CBO

outreach efforts. During coalition meetings, the LPHA had an epidemiologist present to share census data and help identify the neighborhoods to focus outreach efforts. CBO partners on the team would then take that information and do their community engagement work. For some Oregon border communities, making an extra effort to explain why case numbers being released by the LPHA including only county residents may look different than area hospital case numbers that are serving California and other outside residents proofed to be important.

A related lesson for one PHA was to make time for decisions and transparency, especially in moments in which information is changing rapidly and tensions are high. They said that taking the time to communicate with others before making a decision and instead of making a hasty decision that hurt trust with important partners was a mistake they are learning from to this day. This lesson was also felt by communication specialists at LPHAs who noted the competing need to both get information out as quickly as possible and ensuring information is accurate. Margarita Park, communication staff at Lane County LPHA explained that making sure messages are accurate should take more precedence because of the consequential potential impact on the organization's credibility, and "people notice a change in message even when you don't think they will." For two LPHAs, Marion and Douglas Counties, incorporating a debrief process to determine what went well and where future improvements could be made after an event was an important lesson in improving future decision making.

Summary

The experiences of Oregon's LPHAs during the pandemic varied but there were clear shared lessons and challenges. The importance of effective communication and collaboration with community partners and local CBOs is undisputed among this study's participants. One of the clearest indicators of the significance of communication and community partnership-related

work is in the increase in staffing positions dedicated to these tasks. In late 2023, communication specific staffing in state LPHAs had increased by 25% and community partnership/ health equity specific staffing increased by 16.7% compared to staffing levels during the pandemic. As the full results on staffing indicate, some LPHAs are finding creative solutions with often limited funding by sharing staff resources among the entire Health & Human Services unit, combining roles, or sharing across LPHA units as in the case of the CLOH Rural Communication Coordinator.

With whatever staffing was available, all participating LPHAs performed crucial communication and community partnership work during the pandemic. Chief communication channels utilized by LPHAs ranged from traditional communication channels like newspaper, radio, television, and billboards to social media messaging, especially on Facebook. Call centers and hotlines were important for direct community member engagement and specific questions. A smaller group of LPHAs utilized newsletters to reach general community members and specific community partners. Through all communication channels, a key communication strategy was working with community partners to develop and reach priority community members for health equity concerns.

Virtually all participant LPHAs focused on certain communities to address significant health equity concerns during the pandemic. Expectedly, specific outreach to Latinx communities was the most noted by Oregon LPHAs. The majority of LPHAs held regular meetings with local CBOs, including several Latinx-serving CBOs, during the pandemic to coordinate outreach efforts. LPHAs who have incorporated community partnership/ health equity specific staff positions are more likely to be continuing with regular CBO and community partner engagement, including in important upcoming CHA and CHIP processes. This is

significant when considering only 25% of the participant LPHAs had CHAs published within the last two years and less than 30% had a published CHIP for a period ending this year or beyond. As LPHAs continue public health modernization efforts, prioritizing the foundational capability of community partnerships.

Participatory interviews with state LPHA leaders and staff months after the official end of the COVID-19 public health emergency provided important reflections on the significant lessons learned by each unit. The definite importance of effective and clear communication and strong relationships with community partners is shaping current goals around future public health work in the state's LPHAs. Longstanding gaps in public health infrastructure and funding impacted the pandemic response of LPHAs, and more sustainable funding and better communication and collaboration between the OHA and LPHAs is needed. Many LPHAs hope that improved resources and processes can positively impact work culture, diversify their teams, and help avoid future significant burnout experienced by many during the pandemic. Finally, the importance of transparency and sharing local data with community partners and members is a lesson shaping the current and future work of LPHAs. To further examine LPHA communication and community partnership work during the pandemic and beyond, the next chapter takes a closer look at one Oregon County LPHA in Lane County by specifically reviewing a local survey of Latinx community members to help address health equity concerns and innovative community engagement work by the LCPH's Community Partnership Program.

CHAPTER 6

BUILDING BEYOND COVID- COMMUNITY PARTNERSHIPS IN LANE COUNTY PUBLIC HEALTH: RESULTS OF PARTICIPANT OBSERVATION AND INTERVIEWS WITH LCPH COMMUNICATION & COMMUNITY PARTNERSHIP PROGRAM TEAMS

At Lane County Public Health (LCPH), monthly Community-based Organization Action Network (CBOAN) meetings organized and facilitated by the Community Partnership Program (CPP) are still attended regularly by six to seven community partners who began convening to address the local COVID-19 emergency. Today, the group is building beyond the pandemic to discuss ongoing health equity challenges. During a CBOAN meeting at the start of 2024, I could see nearly all the meeting attendees tearing up in our small Zoom squares as a community advocate and network member told an amazing story during the group's sharing of moments of joy, a common meeting practice with extra time beyond the agenda. This CBOAN member told us about a community member and client who had previously lived unhoused in Eugene and struggled with substance abuse. She explained that she hadn't heard from this former client in a while, but she was very happy as this person had reached out to apologize for the gap in communication, and also to share that they just finished their first year of veterinary school and saw a future for themselves for the first time. Another CBOAN member and advocate in a smaller, rural community used her moment of joy to thank the CPP team and CBOAN group. "Having this safe space to share my frustrations and get support from fellow organizers in the community means so much," she explained. As this short story reveals, in its first two years of existence, LCPH's CPP has established meaningful connections with and between local CBOs and the LPHA which is leading community-driven health equity efforts.

By creating a specific community for local public health community partners, LCPH's CPP serves as a great example and case study of how LPHAs in the state are specifically working to achieve the public health modernization foundational capability of community partnerships. Joining the CPP team as an intern in September 2022, I have had direct experience with what this innovative work looks like. By closely examining one Oregon LPHA and two specific examples of local-level work to improve health equity, this chapter will expand on both of this dissertation's main research questions. It will give further insight about how LPHAs and CBOs serving Latinx communities approached health communication, as well as what staffing for communication and community partnership-related work looked like during and post-pandemic. After a summary of background contextual information about Lane County and its LPHA, this chapter will cover specific pandemic-related responses and strategies to improve health communication and community partnerships and LCPH's ongoing work to achieve health equity. The first key example of this local work is an overview of a multi-phase Latinx-community surveying project in Lane County during the pandemic, including the project's research methodology and results. The second key example is the story of LCPH's CPP program, including the program's team background and a description of its varied community partnership and engagement strategies.

Lane County Context: Local Health Disparities Pre-Pandemic

Lane County is in West Central Oregon and is the fourth largest county by population with ~383,000 residents and the sixth largest county in the state by total area (U.S. Census Bureau, 2024). The area of the Willamette valley is the original home of the Kalapuya Ilihi people. White settlers of the region in the 19th century passed several white supremist and settler-colonial exclusion laws and treaties. The county's namesake is Joseph Lane, Oregon's

first territorial governor and an outspoken defender of slavery (Lane County, 2020). The majority of the county's population is white and roughly one in six residents are people of color. People who are Hispanic/Latinx are the second largest racial/ethnic group after people identifying as white and make up approximately half of the non-white population. The county's population is increasingly becoming more diverse with other racial and ethnic populations growing at rates that are ten to twenty times as rapidly as whites (Lane County, 2017). Lane County is considered a metropolitan area connected to the cities of Eugene and Springfield where roughly half of the total county population resides and approximately 17.5% of the population lives in a low population density area (Lane County, 2017; County Health Rankings & Roadmaps, 2023). According to County Health Rankings & Roadmaps, Lane County ranks 18 out of the 35 included state counties in the dataset, placing it in the higher middle range of Oregon Counties (2023).

LCPH was granted its initial accreditation status from the Public Health Accreditation Board (PHAB) in June 2019 (Lane County, 2019). LCPH provides a range of services including Communicable Disease (which now handles all COVID-19 questions), Environmental Health, Women, Infants & Children (WIC), Vital Records, Family & Child Health, and houses PreventionLane, a Prevention section of the unit The unit also houses the Community Partnerships Program (CPP) and the Mobile Public Health Program, both of which were significant unit modernization tools that grew out of and played a part in later pandemic response work. The Mobile Public Health Program utilizes community relationships to hold public health and medical clinic events at cities around the county, libraries, churches, businesses, schools and others to broaden the reach of Public Health programs. They also have had two recurring events

in the rural communities of Florence and Oakridge for scheduled WIC appointments. The MPH was created during the COVID-19 pandemic response via pandemic-specific funding.

LCPH published its first health equity report in 2017 as an initial effort to document health disparities among different racial and ethnic communities and bring attention to disproportionate disparities facing people of color. The report concludes health disparities exist in Lane County, at times in even greater proportion than national and state levels.

> "Among people of color, health disparities often persist even after taking into account other socio-economic factors such as income, employment and level of education. This intersection of marginalization by race and class compounds the magnitude of health inequity for people of color. In Lane County people who are African American, Hispanic/Latino, Asian American, American Indian/Native Alaskan, Native Hawaiian/Pacific Islander, of multiple races or of another race/ethnicity all experience greater risk factors for poor health and poorer health outcomes compared to people who are White" (Lane County, 2017, p. 3).

The report is a primary example of an LPHA directly addressing SDH and health equity concerns in the community. A key goal of the report was to inform and guide community prevention and health intervention efforts. LCPH's most recently published Community Health Assessment (CHA) covering 2018-2020, compiled by the formal partnership organization Live Healthy Lane and other key stakeholders, extended on the findings of the health equity report. While the CHA found that the county was moderately healthy, several SDH varied dramatically including by race, ethnicity, and geography, creating significant inequities in health. Chief among the forces of change identified in the assessment were many tied to SDH threats including housing challenges, federal and state policies cutting social safety nets, vulnerabilities related to immigration, technology, and public discourse threats like deep racism and misinformation (Live Healthy Lane, 2020). The CHA also identified the following key areas of focus for continuing the work of improving the community's health: effective and appropriate data sharing and communications, communication about the broad and integral nature of public health;

engagement with community partners, especially the business community, to better integrate and understand each other's contributions to community well-being; communication and engagement with the community to increase understanding of housing as a public health issue; addressing mental health needs as for improving access to housing; and continuing to focus on health promotion and health education (Live Healthy Lane, 2020).

Thus, prior to the COVID-19 pandemic, LCPH had made concerted efforts to better address health equity issues in the community and identified both communication and community partnerships as key areas of work and improvement for the LPHA. In October 2020, LCPH published an updated health equity report which also informed Lane County's 2021-2025 Community Health Improvement Plan (CHIP). This report further highlighted the deep and pervasive health inequities that are the result of the systematic oppression of Black, Indigenous, People of Colors (BIPOC) communities. The data from the report suggest several significant inequities in health outcomes, among them, cancer deaths impacting Black and Pacific Islander populations at higher rates than any other race/ ethnicity and higher rates of chronic conditions especially within Native American, Black, and Latinx populations. Additionally, self-reported health outcomes show people who identify as white or Asian were more likely to report their general health as good or excellent while people who identify as Native American or Latinx were more likely to report their general health as fair or poor (Lane County, 2020). These enduring health inequities also led to disproportionate impacts on local BIPOC community members during the COVID-19 pandemic. The two major examples highlighted in this chapter demonstrate how work to address some of these key areas of improvement in public health recently identified by local officials have been approached during the pandemic through Latinx community surveying and the work of the CPP. Before diving into those examples, the next

section gives additional context into LCPH's communication and community partnership work in its COVID-19 response.

LCPH Covid-19 Response- Communication and Community Partnership

Like many state LPHAs, LCPH quickly realized the importance of clear communication with community members about the novel coronavirus and ever-changing pandemic response. As part of the county's incident command center, Lane County Health and Human Services PIO and Communications Director Jason Davis became the primary local COVID spokesperson. Jason and the team quickly developed a daily press conference, noting a realization that many community members were turning to the local government and health authority for information as a trusted source and to ensure consistent messaging and information sharing across all local news outlets. My critical discourse analysis showed that LCPH and advocates from local Latinx-serving CBO Centro Latino Americano (CLA), recognized the disproportionate impact of the COVID-19 pandemic within weeks of the first COVID cases in the community, as demonstrated in the April 28, 2020 LCPH press conference. In this discussion, health equity was centered in how the county was approaching its response to the pandemic. The then Equity and Access Coordinator for Lane County Mo Young explained health equity concerns of the county:

> "Although our number of positive tests is small, this is a trend that we must pay attention to and address through making sure that the safety nets that are created are available to everyone in our community, regardless of documentation status, consulting of members of effected communities to determine the best channels of communication, and providing information about COVID-19 in the language that people speak that is heavy on graphics and light on words." She further explains that this matters "because people are dying, and death should not affect one group more than others. It matters because the system hasn't worked for people of color ever, and we're seeing how much this effects our neighbors, our kids' classmates, and our friends. And it matters because if we don't take this time to change the way we do our work, we will cause harm to the people we are meant to serve."

This excerpt from the press conference demonstrates the clear culture-centered approach (CCA) to health communication and advocacy for health equity promoted by LCPH which helped push the unit to incorporate culturally appropriate and innovative outreach strategies to marginalized community members who are often overlooked. LCPH's Ola Adeniji was another advocate reminding the LCPH health team to keep a health-equity perspective. As she described, "messaging needed to resonate with the community. Public health folks get stuck in echo chambers, but especially in moments of crisis, we needed to be sure communication was effective."

Reflecting on LCPH's pandemic response during an interview in March 2024, PIO and Communications Director Jason Davis recognized that almost everything Lane County did for health equity-related outreach and community-based work was the result of questions from equity-minded local government leaders like CPP's Mo Young and Ola Adeniji and from outside community advocates. These questions led to important pandemic interventions, especially for the Latinx community. An early effort to expand Latinx outreach was to also get LCPH's daily press conference updates out in Spanish. The process to expanding this communication effectively included lessons and adjustments. The first attempt was to add Spanish closed captioning subtitles to the English press conferences. To do this, the videos were being sent to a translator in Texas and was quickly ditched due to the excessive delay in delivery. Next, they brought a Spanish translator to translate the English press conference in real time, which they felt also didn't effectively get the message to the target audience. A staff member who is now a member of the LCPH communications team brought up the idea of collaborative content creation with CLA advocates in Spanish instead of direct translation which would cover the same key points but allow the Spanish presenter to add cultural context and necessary explanations for the

specific Latinx audience, including more specific community members like seasonal and migrant farmworkers. Ultimately this approach which gave trusted community members the official LCPH platform to share comprehensible updates from trusted community leaders was most effective and utilized in remaining pandemic press conferences. By taking this approach, LCPH used a culture-centered approach that engaged community members to participate in community-based solutions and communication (Dutta, 2008).

Another great example of a culture-centered approach to health communication is specific outreach to Latinx community members in the rural community of Cottage Grove. Cottage Grove has a significant Latinx community, having the second greatest proportion of the county's Latinx population with 10% of residents reporting Hispanic/ Latinx ethnicity (Lane County, 2017), including many Mam speaking immigrants largely from Guatemala. In fact, South Lane County is home to more than 350 indigenous Guatemalan refugees, the largest population in Oregon (and likely an undercount) (PeaceHealth, 2022). The Family Resource Center, a program of South Lane School District, connects families to basic resources like food, clothing, and diapers and helps families navigate the public school system, especially Latinx community members. One of the longtime leaders of Cottage Grove at the outset of the pandemic and the Family Resource Center, Anna Marie Dudley, was quick to let LCPH know about the Mam-speaking residents in Cottage Grove and the urgent need to get tailored COVID-19 outreach to this group. She came up with the effective strategy of employing young trilingual community members who speak English, Spanish, and Mam who are also digitally proficient to use digital tablets and go door-to-door to show community members informative images and do COVID-19 education and outreach. In our interview, LCPH PIO Jason Davis recalled being happily surprised by the tactic's effectiveness as those community members got needed services

and support that they otherwise wouldn't have known about "purely because of Anna Maria" and her collaborative brainstorming.

LCPH's Communication team members described how while the early pandemic response felt like a war zone and the initial focus was simply getting information out to as many people as possible, when there was a realization that the pandemic was going to last for a while, they had space and resources to listen and respond to community needs and health equity concerns. As Jason Davis explained, "we realized we had specific communications needs that were being unmet within public health, especially around vulnerable communities, and that a few staff members can really make a difference on that. And so that's where that modernization money was sort of repurposed and reimagined, and reimagined to hire those folks." The LCPH communication team added 3 new team members including promoting an intern staff member who began her internship right before the pandemic and worked closely with PIO Jason Davis throughout the pandemic to create content and graphics to a full time Communications Specialist as well as a new Communications Lead position in 2022 and an additional Communications Specialist.

LCPH's communication team and collaboration with equity focused LCPH staff and community partners had direct impact on the type of health communication happening in the county, allowing it to incorporate more community voices (as discussed in Chapter 5) and CCA theoretical and responsive actions. Jason Davis explained further, "We always have had a focus on vulnerable community members as part of our mission, but we always kind of get lost in communicating to the entire community. So, before the pandemic we never really had that focus on the vulnerable communities. For the first time, during COVID, we had the time, the resources, I mean, money was just flowing." With this money, LCPH hired ASL interpreters for every press

conference, and then when CLA reached out about adding Spanish subtitles, the team quickly moved to incorporate those. And later when direct vaccine outreach was needed for rural Latinx farmworkers, LCPH got a mobile unit and interpreters there. LCPH communication for Latinx communities was also informed by a multi-phase survey research project led by local University of Oregon professor Dr. Kristin Yarris and completed through collaboration with LCPH staff and research assistants (including myself). Next, I provide a detailed description of the survey's research method and results as a case study example of how local health authorities approached better understanding and improving health communication for Latinx communities and to address health equity concerns for Latinx community members in Lane County during the COVID-19 pandemic.

LCPH Latinx Community Survey Research Project

At the start of the pandemic in March 2020, only two bilingual, Spanish-speaking case investigators were staffed in the LCPH unit. With the quick awareness of the disproportionate impacts of COVID-19 on the Latinx community, it was also clear to some LCPH staff and local community advocates that there was a need to understand how to better reach Latinx community members beyond the scope of the limited staff (personal conversation Carolina Arredondo Sanchez-Lira, 2021). University of Oregon (UO) professor Dr. Kristin Yarris (Global Studies, P.I.) teamed up with LCPH staff including then-Disease Intervention Specialist Carolina Arredondo Sanchez-Lira to create a collaborative, community-based rapid assessment survey at Latinx testing and vaccine events over numerous phases between 2020-2021. The project team received authorization from the University of Oregon Office of Research Compliance Services (IRB Protocol Number: 07032020.004) for this study and in July 2020 the team began surveying at community events with a central aim to better understand how members of the Latinx

community in Lane County obtained information about COVID- 19 to tailor community LPHA communications more effectively. Dayna Hansberger (Global Studies MA 2020) served as an early research assistant; when I joined the team in January 2021, I took over in research assistance including contributing to back-end survey and questionnaire development while Dr. Yarris and LCPH staff conducted the surveys at the outreach events.

The following summary of the survey research methods and findings over the three phases of research gives insight into the type of local community outreach and research being done in response to the COVID-19 pandemic to improve health equity efforts. The results of this survey project also provide insight into Latinx community member experiences, motivations, barriers, and impacts during the pandemic in Oregon. These results cover participant demographic information, informational channels, motivations for testing, barriers to testing, motivations for vaccination, barriers to vaccination, and impacts of the pandemic.

Method

An initial questionnaire was developed to identify key information channels, assess motivations, barriers, and the main impacts of the pandemic. The survey was implemented with participants in Spanish using Epicollect software on team members' phones who read and recorded questions and responses. (An example of Phase II survey questions is included as Appendix D). Surveys were conducted while community members were at community outreach events waiting to be tested or vaccinated, after being tested or receiving a vaccine dose, or while receiving food or other community services. Participation in the survey was voluntary and no identifying information was collected. Participants were informed that their responses would remain anonymous and proper COVID-19 safety precautions were taken by team members during survey collection. The initial phase survey questionnaire consisted of 10 questions. In

later phases, additional demographic questions were added and as the pandemic progressed the questionnaire was adjusted to assess community perceptions and motivations related to the COVID-19 vaccine. Thus, versions of the questionnaire in the second and third phases of the project ranged from 18 to 23 questions.

The first phase of the survey took place at COVID-19 testing sites between July 2020- October 2020. In this initial phase, 67 community members participated in the survey at nine separate testing events. This phase focused on Latinx community members motivations to pursue COVID-19 testing and sources of information related to the coronavirus. A second phase took place between November 2020- February 2021 involving 52 community members across six testing events. The survey added questions to assess perceptions around vaccination and the impacts of the pandemic on community members. A third and final phase took place between June- October 2021 including 49 community members across seven testing events and continued to assess community members' perceptions and motivations related to the COVID-19 vaccine. Thus, a total of 168 Latinx community members were surveyed at 22 testing events over the three phases.

Participant Demographic Background

The survey gathered basic demographic information from each participant including health insurance, employment, employment types (Table 6.1) and experience with COVID 19 (Table 6.2).

Health Insurance: A significant finding about survey participants included the fact that the majority of participants, 98 (58.3%) were uninsured. The 70 participants who had insurance most often listed the Oregon Health Plan as their source of health coverage. This data point reveals that like other Latinx people in the U.S., Lane County Latinx community members face

challenges in accessing health insurance. In fact, a 2021 Pew Research Center survey found that Hispanic Americans are less likely than people of other racial and ethnic backgrounds to have health insurance (Tyson & Lopez, 2023). This specific systemic inequity and structural vulnerability is a standing issue for the Latinx community but particularly problematic during a global health emergency.

Employment of Participants :119 participants (70.8%) were employed. Of this group, 49 participants (41.2%) indicated that they felt at risk of COVID-19 exposure at their workplace.

Table 6. 1

Employment types:

Industry	Number	Percentage (of participant respondents who indicated industry n=101)
Timber/ Mills	15	14.9%
Domestic workers	17	16.8%
Construction	16	15.8%
Healthcare/ Caregiving	13	12.9%
Restaurants	14	13.9%
Agriculture/ Landscaping	11	11.0%
Education	3	3.0%
Retail/ Sales	2	2.0%
Factory/ Manufacturing	3	3.0%
Others	7	6.9%

Gender (data not collected during Phase 1): Of the 101 survey participants in the second and third survey phases, 59 participants identified as women (58.4%) and 42 participants identified as men (41.6%).

Personal Experience with COVID-19 Infection: During phase three, participants were surveyed about whether they had ever been sick with COVID-19. At the final five events in phase three of the research, participants were also asked about whether they had family members who had been sick w/ COVID-19.

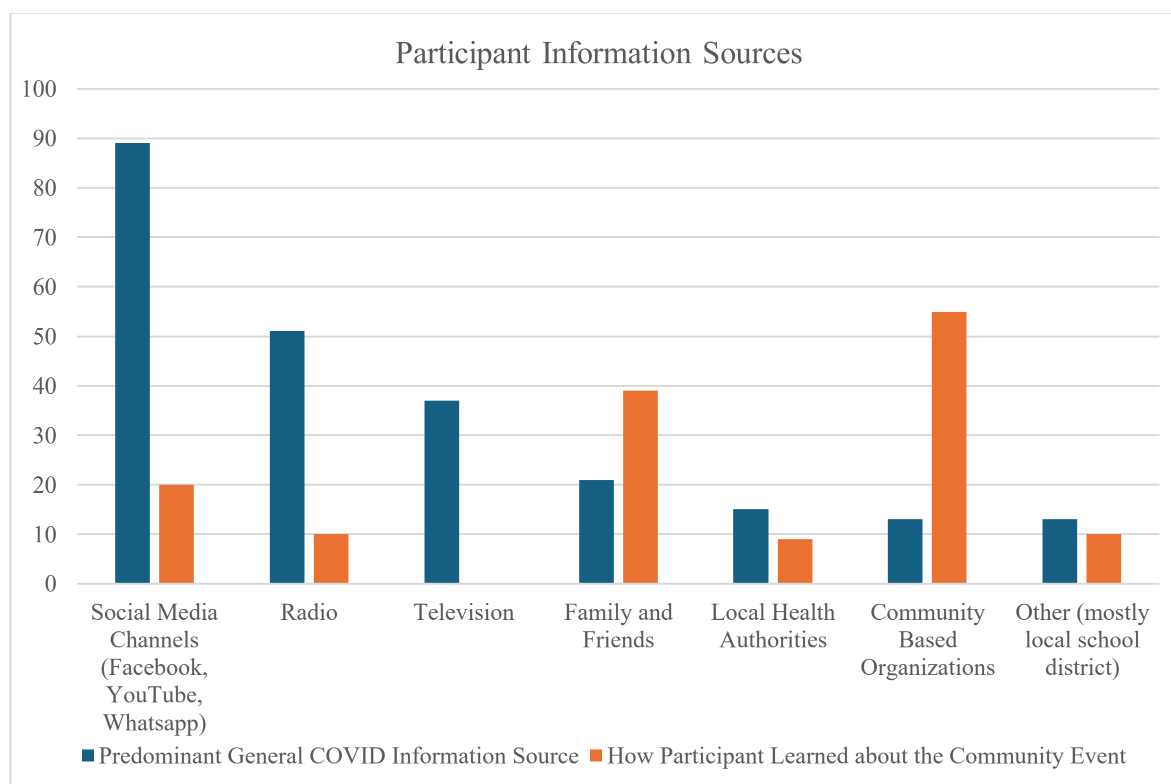
Table 6.2

Personal Experiences with COVID-19 Infection:

Type of Experience	Number	Percentage (of the survey participants in group)
Participant had been sick with COVID-19	21	42.9% (n=49)
Had a family member who had been sick with COVID-19	24	72.7% (n=33)

Figure 6.1

Information and Communication Sources for Participants



While mass media channels like social media, radio, and TV served as the predominant informational sources for participants, Figure 6.1 reveals how CBOs played a much more

important role in motivating people to attend testing and vaccine community events. During the first phase of the survey (July- October 2020), Facebook was serving as a major channel for spreading non-official, misinformation about COVID-19. As demonstrated in Chapter 4 report of my critical discourse analysis, LCPH increased its health education and outreach through its Health and Human Services Facebook page, including information translated to Spanish and promotion of Latinx-specific community events during later months of the pandemic.

Motivations for Testing

During the first and second phases of the survey (July-October 2020 and November 2020-February 2021, surveying mostly took place at community testing events. Thus, the questionnaire asked about motivations for obtaining a COVID-19 test (Table 6.3).

Table 6.3

Response	**Count**	**Percentage (of phase 1 and 2 participants, n=119)**
Prevent the spread	44*	40%
Protect family or loved ones	35	29.4%
Wanted to get free testing	10	8.4%
Been in contact with someone who had COVID symptoms (total):	28	23.5%
Exposed at work	9	7.6% (32% of those exposed)
Exposed outside of work	19	16.0% (68% of those exposed)
Have COVID-like symptoms	12	10.1%
Employer-required testing	3	2.5%
Personal knowledge	21	17.6%
Other (Had shopped at store that had publicized outbreak, travel)	14	11.8%

The finding that 42 of the 44 “prevent the spread” responses were given by participants in phase one of the survey (July-October 2020) suggests that early public health messaging around the importance of testing as a tool to prevent virus spread, including for asymptomatic individuals,

was reaching the Latinx community. In a report on major findings from phase I of the survey prepared by Dr. Kristin Yarris and Dayna Hansberger in October 2020, specific feedback and suggestions based on these findings was provided to inform future local health communication. In reference to testing motivations they explained, “the range of additional responses given as motivations for testing may demonstrate that public health communications need to provide more specific guidance to community members about when testing is appropriate as a prevention strategy” (Yarris & Hasberger, 2020).

Barriers to Testing

Also, during the first two phases of the survey participants were asked about why they thought people in your community are reluctant to get the coronavirus/COVID-19 test and what were their reasons for not getting tested (Table 6.4).

Table 6.4

Response	**Count**	**Percentage (of phase 1 and 2 participants, n=119**
Fear of Test (including fear of mechanism of test, fear of exposure, and fear of obtaining positive test)	64	53.8%
Lack of personal concern/ no need	19	16.0%
Lack of money/ cost associated	18	15.1%
Lack of insurance or ID	15	12.6%
Lack of access to testing	10	8.4%
Lack of social solidarity	2	1.7%
Other: Negligence, religious beliefs, political information	14	11.8%

Motivations for Vaccination

During phase 3 (June - October 2021) the COVID vaccine was recently available, and surveying mostly took place at community testing and vaccine clinic events. Thus, the questionnaire shifted to ask about motivations for obtaining the COVID-19 vaccine (Table 6.5).

Table 6.5

Response	**Count**	**Percentage (n= 49)**
To protect myself	19	38.8%
To protect my family	25	51.0%
Required by work	3	6.1%
Social solidarity	2	4.1%
To be able to travel/ take part in social activities	2	4.1%
Had family members who had been very ill	3	6.1%
Had been very ill with COVID	2	4.1%
Other	4	8.2%

In a summary report prepared by Dr. Yarris for LCPH on survey findings from the first three events of Phase III in early October 2021, discussion of vaccine motivations noted that these responses "demonstrate the influence of personal / family relations as motivating people to obtain the vaccine, even against their own fears and the pervasiveness of misinformation" (Yarris, 2021).

Barriers to Vaccination

Also, during phases II and III a minority group of participants who had not yet been vaccinated and/or had not yet made plans to get vaccinated were asked a follow up question about their reasons for not getting the COVID-19 vaccine (Table 6.6).

Table 6.6

Response	**Count**	**Percentage (n= 101)**
Side effects	13	12.9%

Lack of confidence in the vaccine/ uncertainty about vaccine efficacy	8	7.9%
Fear of vaccine (including pain and safety)	5	5.0%
Indecision/ not thinking about vaccine	11	10.9%
Cost of vaccine/ lack of insurance	5	5.0%
Believe they will get sick from vaccine	3	3.0%
Not necessary	3	3.0%
Don't know where to get vaccine	3	3.0%

Impacts of the Pandemic

Throughout all phases of the survey, participants were asked about other ways the pandemic had impacted them and their families. Participants often indicated multiple impacts (Table 6.7).

Table 6.7

Response	**Count**	**Percentage (of total participants)**
Lost job(s)	64	38.1%
Difficulty with mental or emotional health	66	39.3%
Difficulty with remote schooling or childcare	63	37.5%
Isolating from friends and family	44	26.2%
Difficulty paying rent and/or other bills like electricity, telephone, and food	67	39.9%
Other family concerns including death of family members, divorce, childcare uncertainty, political concerns, and community tension	8	4.8%

Other Insights and Observations from the Survey

During the second phase of the survey (November 2020- February 2021), participants listed fewer concerns around the COVID-19 test, indicating greater testing frequency and increased familiarity with the procedure than during phase one. However, as part of the second phase survey, a follow up question about concerns about testing positive revealed that participants worried about how they would be able to take time off work, noting that many homes relied on income from work for survival and especially when the participant was the sole income-earner in household. Other concerns about testing positive related to infecting other family members and uncertainty around harm reduction strategies like social distancing with family members in case they test positive. This likely reflects concerns of Latinx community members who more often live in multi-generational homes.

Several participants during the second phase of the survey had come for COVID-19 testing due to concerns about exposure at work. In a follow up question, this group of participants explained that although their workplace had COVID-related protection provisions in place (social distancing and mask wearing, or one-way traffic patterns), these provisions were often not enforced by management. Several participants continued reporting feeling that they were exposed to COVID risk at their workplace during the third phase of the survey (June-October 2021). As one participant explained, “We are supposed to wear masks but sometimes people don’t wear masks and we are crowded together without social distancing.” Another participant working in retail noted that many customers were not wearing masks in their workplace.

Common community impacts included loss of employment, difficulty with mental or emotional health, difficulty with remote schooling and childcare, difficulty paying bills, isolation

from friends and family. The impacts reported by Latinx community members throughout the phases of the project also further reflect the longstanding structural violence and inequitable SDH experienced by this group. Each survey included a final open-ended question to give participants an opportunity for any other concerns, questions, or comments they'd like to share. Common responses to this question included a desire for more information about testing and vaccine events and in general. Other community members praised the community-specific outreach events reflecting appreciation for the outreach and resources provided by CBOs like CLA. One community member discussed the public charge rule and the additional stress of not having access to the Oregon Health Plan for five years. These responses indicate that local Latinx community members experienced compounded challenges as a result of the previously outlined structural violence and subsequent structural vulnerability of this community group.

The project had an additional aim beyond accessing community views and that was to share relevant information on COVID-19 prevention and other resources with community members. This included sharing upcoming LCPH health resources like testing and community clinic information, signing people up for COVID vaccine appointments after vaccines were available, and important information about related support services like the Oregon Worker Relief Fund. Thus, health activism was also a central goal of the health communication in this project. This is extra significant when considering that all participants in the first phase were asked if they knew about the Oregon Worker Relief Fund, and 76% of the respondents (n=50) were unaware of the Fund. These participants were provided more information including how to contract OWR and participating CBOs. By surveying at Latinx community events hosted by local Latinx serving CBOs, the research team and LCPH both gained important insights to inform communication and outreach support. It also helped LCPH and further built relationships

with vital community partners during the pandemic. To solidify and structure LCPH's community partnership engagement, the unit created a specific team dedicated to community partnerships- the Community Partnerships Program and is the second key example in this chapter's case study.

LCPH's Community Partnerships Program (CPP)

As established in the previous chapter, LPHAs relied heavily on community partners to reach community members during the pandemic. In a March 2024 interview LCPH epidemiologist Jennifer Webster explained this context and how it helped solidify the formation of LCPH's CPP:

> "I think there's been a recognition more recently, prior to the pandemic, that we need to address health inequities, and the way to do that is to listen to the community and elevate the community voice, that in an academic way, has been known for a long time. And I think the pandemic really just gave us an opportunity to demonstrate in real time that this is how we address inequities, right, we partner with our community, and we let them tell us how to do it. And, you know, we really listen and follow their lead. I think that's one of the really exciting things about our programs that we've really embraced that anti-racist approach to how we address inequity is to really elevate the community and partner in a relational way."

The following sections will begin with some background context of the CPP team and its early work. In addition, it will address the CPP's Ongoing Partnership Work After End of Official COVID-19 Emergency; the group's communication strategy through CBO Newsletters; the team's data focus; the team's work on new participatory grant-making; racism as a public health crisis; and conclude with the LPHA's current CHA development team.

<u>CPP Team Background and Early Work</u>

Efforts to create a program like CPP began at LCPH soon after the passing of House Bill 2310 in 2017 which established public health modernization implementation and metric guidelines. The LPHA recognized a need to improve the modernization foundational capability

of community partnerships. LCPH administrator Jocelyn Warren talked to a consultant who worked with Multnomah County Public Health's team and its extensive Community Partnerships & Capacity Building program that worked to better address their public health priorities in effort to undo systemic inequities (Multnomah County, 2024). The COVID-19 pandemic solidified these efforts to establish a community partnership program at LCPH. Before a program was officially established, LCPH began with the creation of limited duration pandemic community and culturally specific outreach liaisons, a structure utilized in Multnomah County. LCPH also contracted with public health consultant Amy Fellows of Fellows Health Connect, LLC in spring 2020 to quickly organize bi-weekly Community Engagement, Education & Outreach meetings with local CBOs. The local CBOs were receiving grants from the OHA for wraparound service support to help coordinate collaboration among community partners and LCPH and OHA public health authorities in the pandemic response. These meetings were largely focused on technical assistance for the CBOs around how to use the OHA funding but gradually moved into mutual aid sharing, community networking, building community resources, and some messaging development.

CPP was officially established at LCPH in October 2021 and Mo Young began her role as the CPP team Supervisor. Mo had already been actively involved in health equity and COVID-19 conversations and other work happening within LCPH. Ola Adeniji joined soon after as the Outreach Coordinator for CPP. Ola had been working within LCPH in its early response to the pandemic beginning as a member of the county's COVID-19 testing team during which she got involved in conversations around a lack of health equity perspective in the COVID response. She later moved to a short-term COVID response role as a community liaison for the African American community, working on a community elders outreach campaign and collaborating

with NAACP on community information systems. In this role she coordinates with CBOs and facilitates the CBOAN (CBO Action Network) meetings. The team's epidemiologist Jennifer Webster joined the team by moving from LCPH's Prevention unit in spring 2022. Jennifer worked on LCPH's 2020 Health Equity report. As an established LCPH collaborator through her work in the LCPH Latinx surveying project discussed earlier in this chapter, Dr. Kristin Yarris officially joined the CPP team as the Resident Anthropologist in April 2022. And I joined the team as an intern in September 2022. CPP's stated mission is to transform the practice of public health in Lane County so that it: 1. Centers the needs of communities that have experienced the most harm from systemic oppression; 2. Is accountable to communities; 3. Takes responsibility for past harms; and 4. Shares power and resources with communities as partners (CPP Overview Presentation, 2023). Mo Young likes to describe CPP "as a stool with three legs." Those legs are public health modernization, anti-racism, and abolitionist theory; "without any of these legs the stool wouldn't stand, and the program wouldn't exist." CPP draws from the APHA (2022) definition of abolition as a shifting of public resources away from carceral systems (jails, policing, prisons) and towards social care (mental health, harm reduction, health promotion). CPP team members led a recent optional internal Learning Lab course for Lane County Public Health employees entitled "Abolition and Public Health: From Principles to Action." In this training, abolition at a broader level was described by abolitionist scholar and activist Ruth Wilson Gilmore. She explains, "abolition is about presence. Not absence. It is about building life-affirming institutions" (2019). Thus, CPP is rather radically working to show how abolition can be foundational to public health modernization, to the ways in which public health practitioners work with community partners and engage with communities around principles like health promotion, harm reduction, health equity, and health justice.

A key example of early CPP work occurred before its official establishment during community vaccination events supported by LCPH beginning in 2021. The county's main vaccination approach consisted of mass vaccination events which assumed that community members would show up simply because they wanted to have what the public health institution was providing. But as CPP members witnessed, that was simply not the case for many historically marginalized communities, especially communities of color. This group realized that to reach these community members, LCPH had to partner with long-standing trusted community partners and organizations to tailor its outreach events to meet specific community needs. For example, vaccine events held on off hours and the weekends, outside of the normal weekly 9am-5pm mass vaccination events were set up for working people unable to make many mass vaccination events occurring during those times.

The team also helped recognize important factors in event settings that were discouraging for some structurally vulnerable community members. For example, some early vaccine clinics were held at the Lane County Ice Skating arena with a large sign that said ICE, also the abbreviation for Immigration Customs and Enforcement, and included staff help from area law enforcement in uniform. The event did not have translation available and provided minimal health education information. Latinx community members gave feedback about how unwelcoming and intimidating this setting was for their community members. So, CPP listened to local community partners, including insights from the Latinx Survey project led by Dr. Kristin Yarris and CBOs like CLA, to better support community partners in future community-led vaccine events. "If it meant childcare, if it meant food, if it meant more information, if it meant dancing and joy and celebration, we make it happen. We really worked hard with our partners to make sure that events were community-led," explained Ola Adeniji. By listening to community

and considering important cultural and social contexts, CPP was able to help enact community-based solutions and improve outreach.

CPP team members helped develop the CBO Newsletter publication beginning in August 2021 as an innovative communication tool with community partners about COVID-19 related updates. And when the contract with the outside public health consultant holding pandemic response community partner meetings ended, CPP took them over and created the CBO Action Network (CBOAN) which is comprised of approximately 10 to 15 CBOs in the county. As Ola Adeniji explained in a February 2024 interview, "Folks just wanted to stay together to continue the conversation for a little bit." The group talked about unrelenting pandemic health concerns like Long COVID, ongoing immunization efforts, and other community interests. OHA's regional outreach coordinators and representatives continued to attend the CBOAN meetings for a while, but there was regular turnover and changes in these positions, and eventually OHA's participation in the meetings ended. CPP's ongoing community engagement work has taken several forms, some involving continuing strategies like the CBO newsletter and new strategies like participatory grant-making processes discussed in the next sections.

CPP's Ongoing Partnership Work After End of Official COVID-19 Emergency

CPP remains committed toward a vision of Lane County "as a place where we have eliminated inequities that were created by our history of colonialism, slavery, and genocide, and we have co-created, with our partners, a community where everyone can achieve their fullest potential" (Lane County, 2023). Since the COVID-19 emergency officially ended at a national and state level, CPP has continued to provide information, educational opportunities, and technical support to community partners to help them more effectively participate in and guide public health priorities. Through the ongoing CBOAN network, the team helps maintain a space

of collaboration and facilitate a group of community advocates who actively want to stay together to talk about and confront a range of public health issues. For the CPP, maintaining these connections is key to their work. As Ola Adeniji explains, “being able to build that trust we all worked so hard to try and get to where we are now, it just makes sense to maintain the relationships and bolster them as much as we can so that we can get through it together a little easier the next time, because there will inevitably be a next time.”

During each monthly CBOAN meeting, there is a standing agenda item for CBOAN partner members to give updates and discuss recent successes, new projects or events, issues, or struggles, and importantly make requests for support or input from the CPP or other partners. There is also an agenda item for LCPH to share updates; however, the vast majority of the CBOAN meeting time is taken up by community partners and guest presenters, not CPP team members. CPP uses the space to listen and based on what they hear, the CPP team helps facilitate conversations and resources about relevant issues and resources that are directly requested by community partners. Some topics presented at recent CBOAN meetings include a discussion of the impact of the advanced child tax credit stimulus on food insufficiency in the state and the fallout of its ending in 2022 and epidemiologist Jennifer Webster’s presentation on communicable disease data in the county which she prepared per request of partners. In February 2024, Alexander LaVake of LCPH’s Prevention unit gave a presentation on the local fentanyl crisis, and resources available to CBOs. One of the community partner organizations that helped make the request for this fentanyl-related presentation had at one point reported reviving at least one person per week on their site, reflecting the high community impact of the public health crisis. The “moment of joy” portion of CBOAN meetings referenced in the introductory story of this chapter show CPP’s important focus on the positive aspects of culture, a significant

component that the PEN-3 cultural model. As Airhihenbuwa et al. (2020) explain, "the importance of the positive aspects of a community and people, their collective resilience, and their cultural logic must not be overshadowed by the presence of diseases, as we have learned from the work on HIV and Ebola and now COVID-19."

CPP staff also attend other community meetings including the NAACP Health Committee, the South Lane County "SOUP" community coordination group, the Florence Area Community Coalition, and the Regional Health Equity Coalition. This is significant not only to help the CPP team keep up with what is happening in the community, but to also build on relationships outside of LCPH spaces and expand crucial trust with community partners. The impact of this work is notable. In response to the question, "What has this group been effective at in the past year?" at a group visioning discussion in June 2023, participating partners noted COVID resource and information sharing and sharing updates, but the other main theme was connection. One participant even responded, "creating trust between government and communities of color." CPP works to build trust through multiple platforms of engagement, chief among them is its regular CBO newsletter.

CPP's CBO Newsletters

One of the key engagement strategies of the CPP is its regular CBO Newsletter publication. The newsletter helps CPP achieve its major goal to create multiple and consistent feedback loops with community partners to help close any loops, something CPP Supervisor Mo Young has found that government agencies tend to be bad at. As previously noted, the CBO Newsletters began during the pandemic to directly communicate important updates with community partners. The newsletters continue today to follow up and expand on public health conversations within CBOAN and the community. The newsletter is distributed to around 200

contacts around the county and community members can sign up to receive the newsletter on the CPP website. By incorporating community voices and extending analysis of social and cultural contexts, with a focus on the systemic inequities that impact the health of communities, the newsletter incorporates a more critical cultural approach to health communication.

The first LCPH CBO Weekly Update newsletter was published on August 30, 2021. As the newsletter header explains, the intent of this communication was to send "weekly updates on vaccines, clinic, educational opportunities, change in guidance from local, state, and federal partners, as well as a platform for question from previous weeks and to serve as a communication channel to and from the COVID Operations Center." The earliest newsletters were largely composed of COVID-related updates including current statistics on cases, hospitalizations and hospital capacity, vaccines, general updates on vaccine eligibility and approvals, upcoming local vaccine clinics, and COVID-related Questions and Answers. Still, the first newsletter also established the CPPs' health equity centered values and framework for public health. Under the newsletter section titled "What's changed" is the subpoint "Public Health isn't a government organization; it is a concept." In explaining this framing the authors write, "Sound Public Health is based on science and its goal is to improve the health of large groups of people. The people that do Public Health are your friends, neighbors, and family. Most importantly, they love Lane County and want everyone in the community to be as healthy as possible." This newsletter further acknowledges the significant role of community advocates in the pandemic response and health outreach efforts while providing resources stating:

> "We want to send our gratitude and thanks to you for being community stakeholders that care about the health of the community. No messaging campaign or data set is going to change anyone's mind about getting the vaccine. Heartfelt conversations between friends and family will. If you have researched the vaccine and care about your friends and family, have a conversation with them. Our website has suggestions on how to have those tough but necessary conversations."

This messaging incorporates a diffusion of innovations framework by emphasizing the importance of interpersonal channels and trusted community opinion leaders in shaping health attitudes. Early newsletters published prior to the end of the official pandemic health emergency largely reflected other health communication focus at the time in the pandemic including regular COVID updates around vaccine mandates and availability, how to use a cloth mask, isolation and quarantine information, and current case, hospitalizations and death counts, reflecting many of the prevailing Crisis and Emergency Risk Communication (CERC) and dominant health communication theories to communicate updated risk level and promote preventative behaviors. Like other communication shared by LCPH communication channels, the newsletter also included updated information around available community resources like a December 10, 2021 newsletter update on available rental assistance and OHA funding. Each newsletter has included links to current information and resources related to testing or vaccines and regularly includes updates on other opportunities and events, demonstrating an effort to keep partners aware of any potential county or state level resources.

Soon after the CPP team's official establishment, the newsletters were also translated and published as a separate publication in Spanish beginning with the October 22, 2021 newsletter, reflecting a recognition of the importance of outreach and collaboration of Latinx-serving CBOs and community members. In June 2023 the team shifted to a single newsletter published in both English and Spanish. The newsletter continued to run weekly for its first year until September 2022 when it shifted to a bi-weekly publication and then again in October 2022 to its current monthly publication. In February 2022, the newsletter included the publication's first public health calendar piece that seeks to highlight the contributions of associated significant individuals to public health and/or to raise awareness to other public health issues including celebrating Black

History Month, Women's History Month, Autism awareness month, STI awareness week, AANHPI heritage and Jewish American heritage month, Pride month, and Juneteenth. There are a few other regular features in the CBO newsletter including a What's New update, Community Conversation, Demystifying Data, and occasional CBO Spotlights. In the months of September and October 2021, the weekly newsletter included CBO Spotlight pieces that profile specific organizations within CBOAN including the communities served by the CBO, under-utilized resources or services, the organization's vision for a healthy community, and promotion of upcoming events for the organization. CBO Spotlight pieces continue as a semi-regular feature and reflect the important connections and networking facilitated by CBOAN and the CPP.

LANE COUNTY OREGON

ACTUALIZACIÓN SEMANAL CBO

Layout Design by: Margarita Olivas

04.25.2022

Nuestra intención es enviar esta comunicación semanalmente con actualizaciones sobre vacunas y oportunidades de prueba, oportunidades educativas, cambios y actualizaciones en nuestros socios locales, estatales y federales; así como proporcionar una plataforma para preguntas de semanas anteriores y servir como canal de comunicación hacia y desde el Centro de Operaciones de Emergencia COVID.

Este contenido está lo más actualizado posible, pero las cosas cambian rápidamente. Continúe yendo a los sitios web de Salud Pública del Condado de Lane y de la Autoridad de Salud de Oregón para obtener la información más reciente y actualizada entre publicaciones de boletines.

¿Qué hay de nuevo?

¿Sabía que el 21 de abril de 2021, la Junta de Comisionados del Condado de Lane aprobó una resolución declarando el racismo una crisis de salud pública para nuestro condado? Al hacerlo, el condado de Lane se unió a cientos de municipios y cuerpos legislativos de todo el país que aprobaron las declaraciones El racismo es una crisis de salud pública. El impulso de estas declaraciones surgió en 2020 en respuesta tanto a la actual crisis de violencia policial contra los afroamericanos, Black Lives Matter y otros movimientos sociales por la justicia racial, como a las innegables desigualdades raciales y étnicas en la salud que se hicieron evidentes durante la pandemia de COVID-19. pandemia. Nuestra declaración del condado de Lane menciona seis pasos de acción específicos para avanzar hacia el logro de la equidad en la salud; consulte la resolución de la Junta aquí. El Equipo de Comunicaciones de Salud Pública del Condado de Lane está trabajando en una campaña educativa sobre esto y compartiremos más información sobre nuestra campaña en los próximos meses. Abordar las desigualdades raciales en la salud requiere una respuesta de todo el gobierno que aborde los determinantes sociales de la salud y se base en los socios comunitarios. Esperamos que muchos de ustedes se involucren en este importante trabajo.

EL RACISMO ES UNA CRISIS DE SALUD PÚBLICA.

Figure 6.2- Screenshot of CPP CBO Newsletter in Spanish published on April 25, 2022.

Similar to CBOAN meeting presentations, the topics covered in each CBO newsletter (Figure 6.2) are determined and generated by listening to CBOAN partner conversations and identification of the prevailing public health topics and concerns of partners. This meant, for example, the August 2023 CBO newsletter provided resources on air quality monitoring, a community conversation on the disproportionate impact of extreme heat and wildfire smoke on historically-marginalized communities, and a demystifying data piece further highlighting

systemic inequities and disparities in air-quality related illnesses. Houselessness is another pervasive community public health issue and top concern for almost every CBO. In January 2024, the CPP team published a CBO newsletter dedicated to the topic including an update on funding coordination and plans for the $18 million in state emergency funds to address the local housing crisis, a community conversation piece around root causes and misconceptions around houselessness, and a demystifying data piece discussing the challenges and dilemmas of data limitations related to houselessness and the housing crisis impact on community health. As these examples reflect, CBO Newsletter content deliberately seeks to discuss the root causes to health inequities and the upstream social determinants of health at factor in the community.

During our CBO Newsletter team meetings, we also incorporate our own community experiences and connect them to the issues and themes we're hearing in community and the CBOAN space. For examples, in the October 2023 CBO Newsletter, I wrote a Community Conversation piece about the Egan Warming Centers which operate at locations in Eugene and Springfield during the cold weather months. I have volunteered with Egan since 2021 and I knew that the lead agency for the Warming Centers, St. Vincent de Paul had upcoming volunteer trainings. From my attendance in CBOAN meetings, I was also aware that recruiting volunteers was a normal challenge and that getting the call out among the network of readers would be beneficial. In the May 2023 newsletter, the team notified readers of the discontinuing of LCPH's COVID vaccination events because of reductions in federal funding, but also gave assurances of the continued efforts of public health. Based on our team discussion, for this publication, I wrote a piece on community solidarity reflecting on the solidarity of CBOAN advocates still working to provide mutual support to the most vulnerable community members. To further illustrate the continued concerns around COVID-19 after the end of the official national emergency, our team

epidemiologist created a corresponding data story, another important component of the newsletter.

CPP added the regular feature to the newsletter called “Demystifying Data” in June 2022. The goal of these pieces is to help make public health data more accessible to the community and explicitly explore data that demonstrate inequities. The Demystifying Data section description reveals its critical and cultural theoretical grounding explaining, “it is important to recognize that the inequities we see today are the result of centuries of racist and settler colonial policies that systematically provide advantages to white people and deny access to resources for people who are not white. The inequities we see are the result of white supremacy, both in our history and in the systems and structures that govern our society.” The Demystifying Data series has covered a range of public health topics including how mask requirements in school impacted COVID spread, the effect of Child Credit Stimulus Checks on Food Insufficiency in families with children in the state of Oregon, understanding Long COVID and relaying information from a presentation by LCPH epidemiologists to the Board of Health on inequities in health and the SDH in June 2023, and the benefits of volunteering and voting. Incorporating local data in community public health work and community engagement is a focus of the CPP in a few ways.

CPP’s Data Focus

Intentional work with public health data is another key component to CPP’s work and tied directly to the COVID-19 pandemic response. As CPP team member Dr. Kristin Yarris explained in a March 2024 team interview, “during the early months of the COVID 19 pandemic, Oregon as elsewhere in the United States, didn't even have a means of tracking disparities in COVID by race ethnicity.” It wasn’t until summer 2020 that data related to race and ethnicity started getting collected more systematically. When this happened, “not

surprisingly, we saw that COVID wasn't in fact a blind disease or a colorblind disease, but was desperately impacting communities of color, namely, African American, Latinx, immigrant, and communities that were overrepresented in service-sector jobs and working-class jobs in crowded in substandard housing conditions." Once public health data science caught up to the need, it was clear that intentional partnership with communities like that happening with CPP was necessary.

Building on the lessons from the importance of equity-focused public health data during the pandemic, a core commitment of the CPP is to make public health data more accessible and relevant to community partners and the community at large. One way the group is achieving this is through the inclusion of the Demystifying Data series in the CBO Newsletter. Another major strategy is through an innovative method of participatory data analysis called "data parties." Spearheaded by CPP's epidemiologist Jennifer Webster, a data party is "an opportunity to bring folks together who are interested in a specific set of data (e.g., birth outcomes) to review the data and collaborate on developing conclusions, it's a form of participatory data analysis" (CPP, 2022). Through data parties, CBOs and community members are asked to determine what the data is telling, what is still unclear, and which findings are relevant to communicate to a larger audience. Data parties are one tool for LCPH to move from community engagement to community ownership of public health priorities.

The team's first set of data parties centered around birth inequities in Lane County in December 2022 and May 2023. Community members representing three CBOs initially convened to help prioritize data points from data collected from singleton birth (single baby birth) certificates in the county. This same group then reviewed a draft of the data party report in May 2023 to provide feedback. By engaging with partners multiple times in the data party process, the CPP helps ensure that the data and subsequent reports is truly community-driven,

and the knowledge building of the data parties are participatory. Key findings from the birth outcomes data party report include the profound impact of structural inequalities on risk factors like access to care or tobacco use that have negative impacts on birth outcomes. For example, people in Lane County who identify as Black, Indigenous, or Latinx on the Oregon Health Plan, and people whose highest level of education is less than a bachelor's degree had the highest rates of preterm birth. Significantly, the final report includes anecdotal data from community partners not reflected in available birth-record data including the urgent need to address homelessness, substance abuse, and mental health to improve overall health and birth outcomes. As the birth inequities data party report conclusion emphasizes, this project is only meant to be the start of a community conversation around the structural barriers created by white supremacy to assist in future health equity efforts. "Through ongoing collaboration with our community partners, we will continue to develop and support policies, programs, and services that undo the historical harms of racism and address the structural drivers of community health inequities, including birth outcomes" (CPP, 2023). In September 2023, CPP held a Data Release Party to share the results of the collaborative report with community partners and to solicit recommendations for action.

Community members can request a data party on any topic of relevant interest through the CPP website, and the team's strategic plan is to continue to identify data sets that demonstrate racism is a public health crisis and invite CBO partners and community stakeholders to review that data for further context (see Figure 6.3). For LCPH Administrator Jocelyn Warren the data piece of CPP is central to the team's work and modernization efforts. As she explains, public health historically has used data in limited ways, often missing the wider context. CPP's work with data is really bringing that context by taking it to the groups of people for which the

data are meant to be descriptive and asking them about it, what resonates, what is accurate, what is missing, and most crucially, asking what partners need with this data in mind. “That's the piece that we're really working on now. And I think that that that is just such amazing, amazing work, you know, and that really is the foundation of all public health services.”

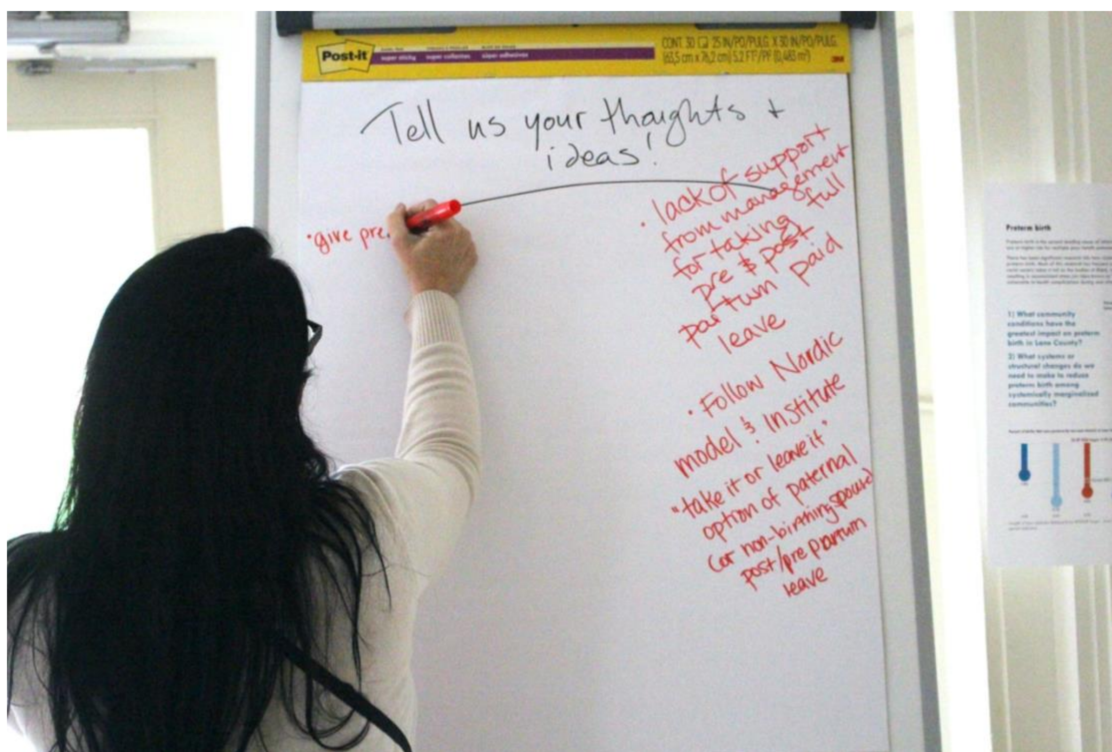


Figure 6.3- Photo of a community member participant at CPP’s Birth Data Release Party on September 26, 2023, in Eugene, OR. Photo by Kisa Clark.

The importance of data in LPHA and CBO partnerships is increasingly recognized in public health. The CDC Foundation’s recent “Recommendation for Strengthening Partnerships Between Health Departments and CBOs” report that one of the key recommendations was for LPHAs to strengthen data dissemination efforts through engagement with CBO partners and to identify gaps in data with CBOs (Day et al., 2024). Incorporating data is important given the significant role of data in public health systems including outcome reports needed for program and unit reviews, CHA and CHIP processes, grant-making, funding processes like RFPs, and more. In fact, a handful of LPHA participants discussed in Chapter 5 noted specific

epidemiologic needs and a few have utilized modernization funding to hire epidemiologists for their unit. Indeed OHA's 2021-2023 Biennium Public Health Modernization Report found that 73% of participants (16 LPHAs) had hired for their Assessment and Epidemiology foundational capability (OHA, 2023). By directly engaging community members with data, CPP is notably helping local community partners build on this essential public health work capacity.

CPP's Work on Participatory Grant-Making

CPP is also working with other LCPH sections and programs to better engage community partners and facilitate improved community-driven processes, especially those that directly involve community partners. To achieve this goal, CPP has piloted a novel participatory grant-making process with the LCPH Prevention section for funding allocated to help address the youth mental health crisis identified in the county's 2020 CHA. The goal of this LCPH collaboration was to help to ensure a robust, community-driven process to allocate the funding aligned with CHIP priorities.

To begin the process, CPP helped recruit a diverse group of community partners to create a Youth Wellness Advisory Committee utilizing the relationships established through the CBOAN network including representation from youth advocacy and service organizations, mental health service providers, and members of systemically marginalized communities. CPP also developed a stipend policy to compensate participating community members for their time and labor on the project. The advisory group met monthly over a 4-month period to develop the priorities for the grant's request for proposal (RFP) and a grant charter with scope, expectations, and ground rules. They also reviewed data to identify gaps in services and resources, set priorities, and develop a project scoring criteria. Once the priorities and scoring criteria were finalized, the committee members were notably invited to participate on the RFP scoring

committee. The RFP was released in Fall 2023 and six organizations were awarded contracts that began at the start of 2024. Funded projects include a creation of a one-on-one mentorship program for youth of color, development of a Family Literacy program in Spanish, training and implementation of a Neurofeedback program, and expanded school and community-based mental health services (CPP, 2024).

The CPP's assessment of this collaborative grant-making process noted important lessons and found promising results. In fact, this participatory RFP resulted in the highest volume of responses to an RFP and the selection process was more competitive than any RFP in recent LCPH history. There were also some challenges associated with changing the normal RFP process and some LCPH staff were nervous about the changes and whether they would result in responses. Likewise, engaging community required more overall time for the process. However, the extra time made an impact and feedback from participants was positive with several community participants noting that it was the most engaging and meaningful RFP review they had participated in.

CPP is now collaborating with the Preparedness section of LCPH to issue a Health Equity & Community Resilience RFP and plans to work to expand community-driven grant-making in other units to further empower the communities most impacted by inequities. In recent CBOAN meetings, the enthusiasm around additional participatory RFPs from core community partners is apparent. As the CPP team explains, "letting community set the priorities means funding what the community needs—and in this case, demonstrating use of an equity lens, trauma-informed practices, and prioritization of our target populations." By leading the establishment of these participatory grant-making processes, CPP is not only helping spread resources to community partners to provide essential services to community members, but also encouraging structural

changes to the LPHA RFP process, which can often be complex, unclear and a barrier to CBOs accessing crucial funds. Changes to this process also reflects CPP's abolitionist framework by incorporating more anti-bureaucratic and community-driven processes to foster better collaboration with partners. This sort of collaborative work and community engagement also solidifies important community relationships for consistent and ongoing community-driven public health work.

CPP's Work on Racism as a Public Health Crisis

On April 21, 2021, a significant resolution passed by the Lane County Board of Commissioners and Board of Health officially declared racism as a public health crisis. The resolution cites the systemic and prolific nature of racism in Oregon particularly and the impact it has on health outcomes, including the disproportionate impact of COVID-19 on Lane County BIPOC communities as a present-day demonstration of the systemic racism in institutions and systems. The resolution also orders the Lane County Board of Health to:

> "1. Promote active and authentic engagement with BIPOC communities on issues of race ethnicity and health.
> 2. Use an equity lens to form policy recommendations that will demonstrably improve health outcomes in Lane County related to race and ethnicity.
> 3. Obtain and use more meaningful data in order to better tell the story of Lane County's BIPOC communities."
> Lane County's declaration of racism as a public health crisis

CPP has been working actively to engage in the efforts set forth in Lane County's resolution declaring racism as a public health crisis in 2021 and views its creation as part of the work to operationalize the ways that racism constitutes a public health crisis in the county. In our CPP team meetings, we are regularly considering how systemic racism is a factor in the issues facing our community whether it is the housing crisis or how experiences of racial discrimination

are associated with substance misuse in discussion of Alcohol Awareness month. CPP is doing this by regularly framing health equity and anti-racism perspectives in its CBOAN conversations and CBO Newsletter publications, including the March 13, 2023 newsletter's Community Conversation piece on anti-Asian hate as an example of racism is a public health crisis. The newsletter also included an update on the Oregon Public Health Association's (OPHA) Oregon Health Equity Task Force's 2023 legislative work to expand on a statewide declaration of racism as a public health crisis by securing funding to implement public health programs to address the emergency. Furthermore, multiple CBO Newsletter Demystifying Data pieces have focused on white supremacy and structural violence including on how racism creates health disparities in cancer mortality and heart disease rates, drives the syphilis epidemic, how structural barriers impact sleep, and how age-adjusted rates for COVID-19 deaths in the US reveal high rates of death for Black and Indigenous people than white people.

CPP also developed an educational webpage titled "Addressing Health Inequities" that can act as an important community resource to discuss the root causes of inequities which are "our national and local history of exclusion based on the values of white supremacy." This includes a link to the detailed Lane County Timeline and Map first published in 2020 which spans from 19th century colonialization to racist language being removed from the Oregon Constitution in 2002 and beyond. It also connects community members to a video from Lane County History's Museum special exhibit titled "Racing to Change: A History of Intolerance" which gives a brief history of Black exclusion. Additional conversations around indicators in the Lane County 2021-25 Community Health Improvement Plan (CHIP) and actions in this CHIP meant to address the causes of these inequities are included.

CPP's engagement with abolitionist theory fundamentally influences its work on redressing the health harms of structural racism. It is significant that CPP is directly taking on the issue of systemic racism in Lane County because it is a way to candidly engage in discussions of social determinants of equity, not only SDH. As Camara Jones (2016) explains the mechanisms of the social determinants of equity are in our decision-making processes, including our structures, policies, practices, norms, and values. During my time with CPP, I have witnessed internal struggles with other Health & Human Services staff members and bureaucratic hurdles and delays related to CPP's work on this project. Nonetheless, the team is steadfast and determined to make action around this declaration a reality. CPP is actively working to normalize anti-racist conversations in public health so that structures and policies in local systems can be changed. Another great example of this current work is the team's advocacy and help establishing anti-racist and health equity values to guide future CHA and CHIP processes.

2024 Community Health Assessment Using MAPP 2.0.

CPP is taking a lead role in the current community CHA process with CPP team members Ola Adeniji serving as a coordinator and facilitator and Jennifer Webster working as part of a team of county epidemiologists overseeing collection and review of assessment data related to causes of health inequities and health outcomes. Once again, CPP helped recruit participant community partners utilizing its establishing community relationships with a goal to create a CHA Design Team (CHADT) that is representative of the community to collectively define a vision for a healthy future Lane County. The group will also complete community status, community partner, and community context assessments, which will culminate with a telling of the community story with local voices to communicate their findings. The current CHA process is in the early stages, but the identified group of community partners is large and diverse with sixteen active partners from a

range of local organizations. Compared to the last CHA team which was developed by local government officials and healthcare providers like the PeaceHealth Oregon Network and the Coordinated Care Organizations (CCO) Trillium Community Health Plan.

The CHADT is very engaged and meeting bi-weekly over an eight-month period. Health equity is a key principle for the CHADT, and the purpose of the assessment is to identify system inequities and barriers that contribute to health disparities as well as the subsets of people who are not currently being served, thus consistent with liberation and critical approaches to development that advocate foregrounding issues of power and access. As part of the CHADT, CPP helped establish working ground rules among the members to help establish an open, respectful, safe, caring, and joyful space for the team to complete its work. This CHA will be used to complete the next shared Community Health Improvement Plan (CHIP) which, following the National Association of County & City Health Officials' (NACCHO) Mobilizing for Action Through Planning and Partnerships (MAPP) 2.0, will include developing shared goals and long-term measures and a continuous quality improvement action planning cycle. As Ola Adeniji explains, its "important that we bring people in at every stage of the process, so they feel more invested and more likely to be engaged in the CHIP planning and implementation." CPP's active and positive role in the current CHA process further demonstrates the significant value of having a team dedicated to community partnerships and community-driven public health work in a LPHA.

Summary

While Lane County's public health response and experiences do not reflect the experiences of all the state's LPHAs, its experience provides important insight into how LPHAs responded to the pandemic through its communication and community partnership work. The importance of clear and effective communication as a crucial part of LCPH response was certain, especially the

need to listen to concerns around health equity and reaching marginalized communities in the LPHA's outreach. With the help of community advocates and health-equity minded local health staff, in addition to increased resources and communication staffing, LCPH incorporated innovative and culturally appropriate updates and outreach to Latinx community members around the county.

Collaborative research like the multi-phase Latinx survey project helped LCPH better understand the community challenges and needs, and which communication channels to best reach community members. By having multiple phases of the survey and listening to community members as the pandemic developed, the research team was able to get updated and relevant insights needed to adapt to changes in the pandemic response, especially related to understanding barriers and motivations to testing and vaccines, helping enable improvements to local vaccine outreach and equity. This survey also reveals the impact of structural violence and vulnerabilities on Latinx community members in Lane County during the COVID-19 pandemic.

LCPH can continue to have the distinct local CBOAN network space because of the continued existence of the CPP staff who are dedicated to this important work. Likewise, the possibility of the CBO newsletter to evolve into its current publication and local public health conversation and community partners engagement tool is because the CPP team is able to regularly listen to partners and then research and locate relevant resources, keep conversations going, and work to implement significant process changes, for instance, through participatory grant-making processes and improved CHA and CHIP practices. As Mo Young explains, "Creating a program that is solely focused on building those relationships, and amplifying the voice of community is a way to show our field, not just our colleagues here, but our field nationally, that this is how we're actually going to take care of our communities. It's not us knowing the answers, it's listening to the

folks who are closest to experiencing the disparities that we see." Because CPP has ongoing relationships and consistently collaborated with community partners and maintained regular engagement through regular CBOAN meetings and CBO Newsletters since the pandemic, it has been able to expand crucial community participation through CPP Data Parties, participatory grant-making processes, and an improved CHA utilizing MAPP 2.0. CPP's incorporation of abolitionist thinking and commitment to addressing racism and systemic inequities serves as an example of public health engaging in emancipatory and participatory work that centers community voice and the cultural and social contexts that determine the lived experiences and health outcomes of community members.

Health equity is not short-term work that finished with the official end of the COVID-19 pandemic. Public health continues to face major challenges tied to an unprecedented housing crisis, fentanyl crisis, major economic inequities, inadequate healthcare systems, increasing environmental risks, and chronic disease. Unfortunately, many LPHAs must determine how to address these challenges with restricted resources. Indeed, recent limitations in LCPH funding have impacted communication work in the unit and in November 2023, members of the LCPH communication team transitioned to become the communications team for the entire Health & Humans Services County department in part so that the funding contribution of LCPH for these staff positions could be reduced. The Mobile Public Health unit has also faced reductions due to budget restraints that will limit outreach and engagement in rural Lane County communities. What the future of public health might look like, including expanded insights and interpretations of the results of this dissertation's case study and recommendations for future public health communication and community partnership work will be covered in the next concluding discussion and final chapter.

CHAPTER 7

DISCUSSION & CONCLUSION

A shared principal goal of both LPHAs and CBOs is improving the lives and wellbeing of their communities. Helping their communities survive a global health pandemic was not an experience LPHAs or CBOs had prior to March 2020 and health communication around COVID-19 was not clear or simple for anyone, let alone when those messages needed to be translated and interpreted for marginalized communities to effectively comprehend. While LPHAs have more expertise and experience with health promotion and communication, many LPHAs were also not prepared to handle the demands of the pandemic. OHA and LPHAs quickly recognized the essential role CBOs would play in reaching the most marginalized community members with prominent health equity concerns. The findings from this dissertation case study confirm a decades-long and well established mandate for social change communication scholars "to bring communication theories closer to the people and involve them in the process of social change" (Amoyan & Cusodio, 2019, p.63). Many policies and funding models from national and state public health agencies including the Public Health Modernization model and continued funding allocated to CBOs for public health work further reflect this understanding of the importance of community engagement and improved culturally appropriate health communication. The lessons from the COVID-19 pandemic and this case study confirm the value of Oregon's Public Health Modernization model and calls for a continued shift in our theoretical understanding of modernization away from the traditional modernization top-down and individual focused framework to one that incorporates the participation, engagement, and decision-making power of community members most impacted by health inequities. These

lessons also suggest important next steps to identify and pursue progressive policies to achieve health equity and corresponding communication to support this work.

In this final chapter, I will first highlight key findings from the results of the case study on heath equity efforts in Oregon during COVID-19 through a discussion of my recommendations for improved public health equity and communication efforts. Next, I will touch on some limitations and areas of beneficial future research. Finally, I conclude with a review of the key-takeaways from this dissertation. The areas of recommendations to improve public health communication and health equity efforts including improved community engagement, the establishment of long-term and sustainable support for public health, improved capacity building of CBOs, more focus on policy and systems, and health communication that enables a cultural shift in our understanding of public health and health equity.

Key Findings and Recommendations

Improve Community Engagement

The definition of community outreach is “temporary, unidirectional, and focused on limited goals.” By contrast, community engagement is “the longer-term process of working collaboratively with groups of people to address issues affecting the well-being of those people” (Bisola, et al., 2021). Public health research and practice have increasingly employed community engagement to build trust and improve overall health outcomes, especially during the pandemic. Community engagement should be ongoing and meaningful by empowering communities with decision-making authority. However, the limited, fragmented, and privatized nature of public health work results in community outreach not community engagement. To reach the public health modernization model’s foundational capability of health equity and cultural responsiveness, OHA and LPHA’s must work in a framework of genuine community

engagement with community partners and members. This case study reveals that much of the community partnership work during the pandemic in Oregon was limited to temporary outreach because of staffing and funding restrictions. Furthermore, LPHA participants made clear the value of communication, community partnership, and health equity-specific staff positions for crucial community engagement work.

An example of positive community outreach during the pandemic is the Oregon Saludable-Juntos Podemos, a National Institutes of Health (NIH) funded research project led by a team at the University of Oregon's Prevention Science Institute that aimed to increase COVID-19 testing and understand other health behaviors to prevent COVID-19 transmission among state Latinx community members. Utilizing the university's laboratory facilities and technical support, the project worked with LCPH and CPP and overall spanned 11 participating counties, involved 16 CBOs, and covered 464 testing events at 61 testing sites across the state by August 2021 (Oregon Saludable, 2021). As part of the project, a culturally informed outreach program was developed utilizing promotores de salud, and Spanish-speaking, local bicultural and bilingual community health workers (CHW). The impact of the promotores was measured through a Clustered Randomized Trial compare testing sites that utilized "outreach as usual" (existing CBO promotion approaches). The outcome of the study demonstrated clear efficacy of outreach from promotores de salud, resulting in more than twice the number of Latinx individuals tested for every Latinx tested at a control site event (DeGarmo, D. et al., 2021; DeGarmo, D. et al, 2022).

The Oregon Saludable team concluded that "simply partnering with CBOs and other community agencies for outreach efforts may not provide sufficient access to key underserved populations to overcome the rate of disproportionality," thus suggesting the need for more

tailored outreach like that provided by promotores and CHWs (DeGarmo, D. et al., 2021; Mauricio, A. et al., 2021). Increased staffing and utilization of CHWs as an outreach and communication strategy was notably utilized by several LPHAs in Oregon during the pandemic, including several of this dissertation's LPHA participants. Nationwide CHWs were an important outreach strategy. In fact, at the height of the pandemic, federal officials allotted more than $500 million to hire and train CHWs (Barna, 2023). The empirical evidence of the value of CHWs during the pandemic is clear and the role of CHWs as frontline agents in reducing health disparities is well documented outside the pandemic response, including better understanding between community members and the health and social system, improved access and use to health services, reduced need for emergency services, and overall enhanced quality of life for people in poor, underserved, and diverse communities (Furino, 2007; Rosenthal et al., 2010).

While the positive impact of the Oregon Saludable project on Oregon's Latinx communities is undeniable, it still reflects major issues with our current fragmented and limited public health system. When the COVID-19 emergency officially ended, and COVID-19 funding likewise was reduced, grant-funding projects like Oregon Saludable also had to end its training and funding of promotores de salud in Oregon communities. Though there are still a range of health education topics and services that CHWs could be providing to Latinx community members including assistance with transportation to medical appointments, grocery deliveries, or help managing their chronic illnesses, these CHWs who have made valuable community connections will have to find a new grant or organization to continue their work which is often unsustainable. A siloed public health finance structure that distributes funding through limited programs, like this example of pandemic response funding disseminated through a short-term university research institute project, doesn't lead to systems of change necessary to bring about

health equity. Bisola et al. (2021) assert, “neither short-term community outreach nor post facto community engagement will contribute to building a foundation of trust. Conversely, these approaches may further exacerbate mistrust and raise questions regarding the motivations of researchers, industry, and policymakers.” Participant interviews with Oregon’s LPHA leaders revealed that LPHAs who had pre-established, trusted relationships and partnership programs had more success in supporting community-driven testing and vaccine events. To build this sort of trust and collaboration, community engagement must be incorporated into everyday public health unit practices, not only when there are emergencies. As CCP’s Ola Adeniji explains, having regular engagement “helps to build the trust that folks are being brought along in an honest, transparent way throughout the entire process, rather than just when we feel we need to swoop in and do a saviorism.”

OHA’s statewide Community Partner Outreach Program (CPOP) is a promising example of a permanent, community engagement strategy and organization. The program team of Regional Outreach Coordinators develop and maintain partnerships to assist the most vulnerable populations. This work includes training, supporting and certifying community partners in 10 regions who assist in Oregon Health Plan enrollment. Additionally, CPOP coordinators help “facilitate on-going partner collaboration and provide technical assistance” acting as a “critical bridge between the public and the state, collecting and sharing feedback to improve the health coverage system for all” (CPOP, 2024). Having a dedicated, ongoing unit to community partnership development and support is the type of sustained support CBOs need to effectively serve their priority community members. As mentioned in the Chapter 6 case study of Lane County, while OHA representatives had been attending early pandemic response community partner meetings, the person in this regional position and OHA representative attending CBOAN

meetings had changed several times since 2020. CPP had not been given updates about who would be the new OHA local representative, reflecting the gap in communication between LPHAs and OHA. This gap was noted by several LPHA staff participants of this study as a significant frustration during the pandemic, as explained in Chapter 5. The CBOAN and its collaborative meeting space undoubtedly benefits from the presence of OHA representatives in their ability to share information, updates, and resources from the state and everyone in the group clearly appreciates when OHA representatives are present. And arguably more important, by being in that community space, OHA representatives hear essential direct feedback from community partners and can take those direct insights and community recommendations to state leaders to enable improvements. Evidence of limits to CPOP's engagement is also suggested by the ending of its Protecting Farmworker Program in June 2023, a type of program that especially benefits many Latinx workers who continue to face an array of structural vulnerabilities already established in this dissertation. In OHA's 2021-2023 Biennium Public Health Modernization Evaluation Report, only six participating CBOs reported having done coalition work with both an LPHA and OHA. Eleven participating CBOs reported partnering with only an LPHA and the other 11 participating CBOs reported partnering only with OHA (OHA, 2023). Clearly CPOP and OHA community partner liaisons to help keep healthy partnerships and improved institutional relationships between all three organizational levels of OHA, LPHAs and CBOs should be expanded, not cut back or limited.

Part of improved community engagement means LPHAs should strive for institutional relationships rather than relying on individual relationships. CPP's Mo Young explains that community partnership work at LCPH prior to CPP was happening through individuals. "And then when they move, or if they move to another organization or another part of the county, they

take their relationships with them." Programs like the CPP are important because community partners get to know and trust an entire team of LPHA staff. Creating multiple trusted relationships over an extended period of community engagement is necessary to build institutional relationships. However, as Mo Young further explains, this is tricky because "nobody wants to have a relationship with an institution. And people also want to be able to trust the institutions. So, we're still working on it, but if we can figure out a way to create and foster and have these relationships across the whole program, and with multiple people in organizations, then it means that we're not we're not starting from scratch every time." As the Chapter 6 case study demonstrated, CPP's multi-pronged approach to community engagement purposively extends beyond limited community outreach. CPP is notably working to close the loop with partners and evaluate whether the team is doing the community engagement needed through a CBO newsletter reader survey and planned series of qualitative interviews with CBOAN members to understand community partners' experiences with the program and respond to any suggestions for improved engagement. As CPP Outreach Coordinator Ola Adeniji explains,

> "CPP is making sure that we still keep it accessible for our community members to join and speak fully with their voice, despite the fact that funding is going away. And despite the fact that a lot of the accessibility that made it possible for folks to attend and participate is going away. So making sure to build that into budgets with translation services, all of the things that we knew worked before to get folks at community gatherings, we're still bringing them into our processes now in non-urgent events, so that folks know we're serious about wanting to make it comfortable for you guys to be able to participate with us."

Centering participatory communication opportunities and genuine community engagement reflects Freire's conscientization and liberation theories by striving for changes in systems of oppression. As Freire explains, conscientization "is not a magical charm for revolutionaries, but

a basic dimension of their reflective action… To be authentic, revolution must be a continuous event. Otherwise, it will cease to be revolution and will become sclerotic bureaucracy" (p. 89, 1985). While public health and government organizations are not positioned to take the radical cultural action proposed by Freire, and indeed have historically often been part of the oppressive regime, by actively bringing in community and the perspective of the oppressed, public health practitioners can help further shift the public health paradigm to one which supports the denouncing of the oppressions of society and help proclaim the advent of a just society to support cultural action. To scale up the existence and capabilities of the engagement work like CPP and meet the foundational capabilities of the public health modernization model throughout more of Health & Human Services units, the OHA, and local community partners, public health agencies and CBOs need more long-term sustainable funding.

Establishment of Long-term and Sustainable Support for Public Health

Throughout the research process for this dissertation, the need for better, more sustainable support for LPHAs and CBOs was unmistakable. During a January 18, 2024, Conference of Local Health Officials (CLOH) Meeting on Zoom, which I attended as a member of the public, there was a conversation about the use of modernization funding formula for specific funds. Near the end of the conversation, Clatsop County's Director of Public Health Jiancheng Huang brought up strong concerns around LPHAs not having consistent funding. He explained that while modernization funding is important, what is more important is consistent funding for long term LPHA work planning. He stressed that while LPHAs had been incorporating public health modernization for close to 10 years, to carry modernization efforts forward, more sustainable, long-term funding from the state that doesn't rely on the county to cover the costs necessary to build up staff and remain stable. He suggested the group of LPHAs

work together to figure out a different approach to the legislature to secure this sort of funding. Adequate, sustained funding would support the issues raised by many of this study's participating LPHAs who noted difficulties in hiring and retaining staff at competitive pay scales. With adequate staffing, the issues of overextended and burnt-out staff and administrators that LPHAs described would also be addressed.

It's not surprising that Oregon LPHA leaders, including several other LPHA participants in this study, are calling for better support. Public health experts estimate an annual shortfall of $4.5 billion in necessary funding for state and local health departments to provide comprehensive public health services in their communities (TFAH, 2023). As discussed in the introduction, National public health funding had faced decreases in the years leading up to the pandemic. And while emergency pandemic funding helped bolster many local health departments, the ending of those funds has left many with shortfalls. On February 29, 2024, House Resolution 7481, the Improving Social Determinants of Health Act of 2024 was introduced in the U.S. House of Representatives. The act would codify and expand the CDC's Social Determinants of Health (SDH) Program and through grants to public health departments and CBOs the program would "help build multisector collaborations to address non-medical drivers of health" including grants for institutions of higher education to conduct research on "SDOH best practices, provide technical training, evaluation assistance, and/or disseminate those best practices" (TFAH, 2024). This act is promising and reflects important acknowledgment of the need to improve SDH, but its success is not guaranteed in the current dysfunctional national legislature and reflects a continued approach to public health funding distribution through limited and often privatized grants. Public health should not function within a supply and demand economic model that the

larger healthcare system follows, but unfortunately the type of support public health needs seems to only come during a global health emergency. As one LPHA participant described:

> "We inched closer to socialism during the pandemic. And by socialism, I mean, truly sharing resources and trying to look out for everybody, for a brief second, we were close to that, and it works. But then we kind of knew in the back of our heads, this is going to shrink, like ARPA [American Rescue Plan Act] is going to go away, all this funding is going to go away. And it did. And now it's even shrinking even more. And now modernization is potentially losing funding. So, everything is kind of in jeopardy that we could lose sort of that those gains."

As the results of this study demonstrate, with the extra pandemic funding, many LPHAs were able to think about vulnerable communities and specific communication needs in a way they hadn't previously been able to. With adequate funding which allows LPHAs to fully reach the foundational capabilities outlined in the public health modernization model, LPHAs and community partners can move beyond standard, individual health messaging and initial necessary CERC emergency response messaging to do work that addresses the causes of ongoing inequities. Reliance on privatized public health approaches can indeed be more damaging to the process of social change, especially in the realm of health which then cannot conceptualize health care as a human right (Wilkins, 1999).

Improved Capacity Building of CBOs

The need for sustainable funding is even more dire for many CBOs. CBOs and non-profits depend on government funding through an established structure that largely distributes support in the form of limited grants. While many CBOs had access to increased funding through the influx of government resources during the pandemic, as these national and state pandemic-related resources have ended, some organizations are facing funding shortfalls. At a 2023 Nonprofit Summit, the most cited challenge by participating leaders was predicting future funding and in a separate 2023 nonprofits study 76 percent of respondents said that their

organizations have experienced either stagnant funding or decreased funding over the last year (Ray, 2023; NonProfitPRO, 2023). Limited state and local budgets are always at risk to changes and complex bureaucratic systems which often lead to delayed and incomplete payments. For example, according to the National Academy of State Health Policy, only around half of states allow CHW Medicaid reimbursement, an important solution to improved CHW outreach. Additionally progress around the Medicaid solution has been hindered by lack of data on the CHW workforce and there is evidence that CBOs often struggle to navigate the Medicaid reimbursement process (Barna, 2023). Indeed, in recent CBOAN meetings, a community partner brought up a concern about their inability to get Medicaid payments for their CHW billing and a networking conversation around figuring out which billing codes are currently working for payments followed. Grant funding most often supports direct delivery of specific services or programs leaving limited room for organizations to invest in critical infrastructure or to build necessary financial reserves to improve their resiliency through tough times.

Grant funding also typically requires strict reporting and documentation that increases administrative work and can demand specific skills and knowledge that some organizations may lack. Other organizations struggle in maintaining the modern technology and software systems necessary for collaborative work, data analytics, and project management. The most recent Salesforce Global Nonprofit Trends Report (2022) found that the strategic use of technology directly linked to improved organizational efficiency and performance across operations in nonprofits. However, in the same 2019 Salesforce survey report, 81% of participating organizations cited budgetary constraints as a factor that posed a challenge to the adoption of new technology (Salesforce, 2019). CBOs that have not been able to update their infrastructure are often at a significant disadvantage and miss future funding opportunities. These concerns

have also been brought up among CBOAN partners who have trouble finding volunteers and cite a lack of digital skills in the organization as a challenge. A couple LPHA interview participants further noted that a lack of administrative capability among some CBO partners had limited their ability to provide services efficiently or to track their data which in turn hurt their chance of winning future grants.

In addition to increased funding, funding structures for both LPHAs and CBOs should be more flexible. As discussed in Chapter 5, restrictions in funding usages have limited LPHAs ability to respond to health equity concerns. Both LPHAs and CBOs need flexibility to utilize funds to better meet the changing needs that community partners understand best. For example, in May 2023, the Oregon Worker Relief coalition is continuing to utilize its coalition of CBOs that helped in specific pandemic relief fund work and launched a new Home Fund[6] to provide short-term rental assistance to households facing eviction or housing instability (Sollitt, 2023). This fund follows a Climate Change Fund established in September 2022 which was aimed at filling the gaps for agricultural workers who lost wages due to extreme heat or smoke (OWR, 2023). The community has the knowledge of community needs and the solutions needed to address those needs. Funding structures must give local health authorities and community organizations the ability to utilize their resources as needed.

In Oregon, evidence of continued support of CBOs beyond emergency pandemic support is promising. In March 2024, OHA's Public Health Division awarded funding to 44 new community-based organizations (CBOs) to support public health equity-based work in their communities. This group of CBOs are joining and existing 150 organizations currently funded by

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[6] As of April 2024, the OWR was still accepting new applications to provide up to two months' rent to immigrant Oregonians who have lost housing or are at risk of eviction.

OHA Public Health Equity grants totaling $16.95 million approved by the Oregon Legislature in 2023. According to OHA, "the new funding opportunity aims to keep health equity and community priorities at the forefront of public health work" (OHA, 2024). Community partnership development as a foundational capability in the Oregon public health modernization framework is needed and verifies that helping CBOs maintain their ability to do their work with communities should be a high priority for their significant role in health communication, especially for marginalized, non-English speakers. CBOs and CHWs are uniquely positioned to get messaging out that is culturally appropriate. In situations in which LPHAs can only reach communities through the communication work of CBOs, as was the case for political restrictions faced by Linn County's LPHA during the pandemic, having healthy CBOs and capacity to effectively engage with these partners is crucial. My hope is that these grants for CBOs are continually renewed. Furthermore, increased funding for CBOs while limiting funding of LPHAs and their capacity to support CBOs does not help build their capacity. This is especially the case in the important role that LPHAs can play in needed policy and systemic changes.

More Focus on Policy and Systems

To gain the sustainable resources and support public health agencies and CBOs need, significant and systemic policy changes are required. In addition to policy changes that increase support of public health work, policy changes that help undo current social and economic policies that harm health is needed. As Fleming et al. powerfully explain public health funding is currently a paradox where "the government and taxpayers are subsidizing both policies that cause health inequities and the work by public health agencies to address them" (2021, p. 10). Over the last few decades, spending on criminalization, policing, and mass incarceration has dramatical increased while simultaneously investment in social safety net programs is slowing

(Hamaji et al., 2017). Projections forecast that spending on low-income health programs will grow over the coming decade, but this increase will be almost entirely offset by the decline in other low-income mandatory programs that help address SDH through 2029 (Kogan & Huang, 2019). U.S. history is filled with policies that have fueled current racial and ethnic health inequities (KFF, 2024). Policing, sentencing, and incarceration disproportionately target poor people and communities of color and have detrimental effects on physical and mental health. Similarly, there is clear evidence that immigration law enforcement causes harm to the health of immigrants and their communities (Hamaji, et al., 2017; Fleming et al., 2021). The current housing crisis has been fueled by racist zoning and land use regulations and outdated financial regulations that have prevented millions of homebuyers, especially Black, Hispanic, and Indigenous people, and those in rural communities, from obtaining financing and mortgages, pushing many borrowers into riskier and more costly alternative financing arrangements (Pew Charitable Trusts, 2024). The lack of healthy and affordable food, largely in communities of color, is not accidental but is the result of decades of racially discriminatory zoning policies, systematic disinvestment, and lack of support for Black farmers, and income inequality (APHA, 2022). Because the fundamental causes of health are based on these social determinants, public health work must focus more on policies that address these causes. Recognition of the value of incorporating ideas from abolitionist thinking in public health, like LCPH's CPP is doing, is necessary to connect public health to the systemic harm of racism and imagining alternative forms of community support, transformative justice, and other anti-carceral and anti-bureaucratic efforts to achieve community well-being. LCPH's CPP is the direct result of an LPHA utilizing public health modernization funds to meet these foundational capabilities.

There are promising examples of frameworks like Oregon's public health modernization model that bring focus to a broad range of policies and planning, including policy and planning is one of the seven foundational capabilities. The National Association of County and City Health Officials' (NACCHO) Health in All Policies (HiAP) is an approach to "determine how decisions are made and implemented by local, state, and federal governments to ensure that policy decisions have neutral or beneficial impacts on the determinants of health" (2024). HiAP recommends incorporating health considerations into decision-making throughout sectors and policy areas. This is the wide range focus public health officials should take in considering all social and economic policies that impact health from criminal justice reforms and a range of public benefits. There are also examples of positive policy changes to help address social determinants of health like Oregon's 1115 Medicaid Waiver Health-Related Social Needs (HRSN) Services program that allows for community members on the state Oregon Health Plan to access services related to social and economic needs affecting health like housing, nutrition, and climate supports as a covered benefit. Oregon's most recent 1115 Waiver was approved for October 2022 through September 2027. HRSN's services is an early phase of implementation with the first just beginning this year. CPP is helping Lane County CBOs connect with the Coordinated Care Organizations tapped by OHA to collaborate on distributing HRSN funds. In addition to assisting the implementation of policy like HRSN, LPHAs should actively connect policy to their work. For example, CPP is also sharing policy briefs that highlight policy options laid out in the CHIP for each priority area. By supporting community-led, equity-focused data collection and sharing, CPP is also helping community-driven policy development. While the

widespread passage of declarations of Racism is a Public Health Crisis is promising, more policy work to take action in response is needed. A study that reviewed 125 resolutions and declarations across the US related to Racism as a Public Health Crisis through the end of September 2020 found that while the majority of policies name racism as critical in addressing racial inequities in health, they provide limited details about specific actions, funding, or resources. As the authors explain, "actions must go further to support communities negatively impacted by institutions with historical and contemporary practices that reinforce racism" (Mendez et al., 2021).

The need for improved social and economic policy in Oregon is striking. As of 2024, there are at least 18,000 people who are houseless in Oregon (Shumway, 2024). Since extra pandemic-related food benefits through SNAP have ended, CBOs that address food insecurity have seen increased demands in their services. The Oregon Food Bank saw an 11% increase in its food distribution between July 2022 and June 2023 and partners at the organization noted that the ending of expanded Supplemental Nutritional Assistance Program (SNAP) support put people "in a dire situation" (Botkin, 2023). Addressing health equity requires thoughtful investment of resources and support in the communities and populations with the greatest need. This approach is well known to public health agencies accustomed to using data to guide their investments in prevention and treatment measures to the highest risk individuals and communities (Weinstein et al., 2017). LPHAs are well positioned to advocate for policies that advance community health equity by improving the social, economic, and environmental causes of health like policies that impacted by policing, housing, and food access. By collaborating with communities in CHA and CHIP processes, the experiences of people who are most severely impacted by harmful policies can and should be prioritized. In OHA's 2021-23 Biennium report, only half of the LPHAs reported working with, or planning to work with, new partners on policy

development or implementation related to their modernization priorities. And only 41% of LPHAs reported working with community partners to better understand and interpret public health data from communities' perspective and the same amount reported working with community partners to provide public health data that is culturally and linguistically relevant (OHA, 2023). Moving forward, the public health modernization model needs to be further operationalized and foundational capabilities better met among all LPHAs so that working with community partners on priorities and policies is a standard operation. LPHAs should have adequate staff and resources to work with community partners to develop and implement health equity focused policy changes. The sorts of systemic policy changes needed to address health equity will require a significant cultural shift in our understanding of public health and health equity, which entails meaningful health communication.

Cultural Shift through Health Communication

The central role of SDH in determining health outcomes has been well understood by public health researchers and practitioners long before the COVID-19 pandemic. While the knowledge of the need to better address SDH to improve health is not new, the pandemic has solidified this knowledge and brought an expanded awareness. As Jocelyn Warren, LPHA Administrator for LCPH describes:

> "Public health has always been about thinking about people in context, and their neighborhoods and their work environment and their families, so that's not new. I would say the focus on the structural determinants, when you talk about racism, or just white supremacy, some of those pieces that have shaped the structures that shaped the housing opportunities that shaped the job opportunities, I think we've gone up a level and haven't had a sense of that… I think that that really is different and exciting to be able to unpack, and it's harder to talk about. So, it takes take some work, I think, for people to kind of wrap their heads around something, some people maybe understand it intimately and immediately, and maybe they live it… then there are other folks for whom it's just is it's different way of thinking about health outcomes. And it just takes a little more kind of background information, teaching, and learning."

The stark understanding of the need for improved health equity in Oregon and the nation following the shared experience of the many health equity failures of the COVID-19 pandemic is well documented. It is important that public health authorities and health communicators promptly capitalize on the lessons from the pandemic to help more people understand the systemic root causes of health inequities to bring about a necessary cultural shift in our understanding and approach to public health work. This understanding of public health must include a shift towards health activism and active identification of the structural conditions that reproduce injustices and then advocate for interventions into these marginalizing practices through communicative acts (Frey & Carragee, 2007). Many LPHAs demonstrated this type of health activism during the pandemic. For example, many LPHAs recognized that much of the root cause of inequities in COVID-19 vaccine distribution among Black and Latinx people in the U.S. was tied to lack of access, not vaccine hesitancy (Murphey, 2021). Like the case of LCPH, they responded by connecting with community partners and getting the vaccine into trusted, culturally appropriate community spaces and vaccine inequities lessened.

Another important component of this cultural shift is the active inclusion of community voice in decision making. Amoyan and Custodio's (2019) work on dialogic space in devcom is timely and important in ongoing public health communication advancements. They posit that the question of communication for social change should not be how to give voice to the voiceless because the real struggle is not for a voice itself but lack of access to a venue or space to speak this voice. As Amoyan and Custodio (2019) eloquently explain, "essentially, the task of every communication practitioner and researcher who desires for social change is to become the provider of this dialogic space, and simultaneously bridge the oppressed-oppressor gap. This dialogic space could possibly be the missing space in development communication to thrive for

social change" (p. 82). There are many examples of LPHA leaders making this sort of dialogic space for community voice during the pandemic but there is still much room for improvement. In OHA's 2021-2023 Biennium Public Health Modernization Evaluation Report, fewer than half of participating LPHAs reported implementing culturally responsive communication systems and facilitating those communications among priority populations in ways that elevate community priorities and health equity considerations into long-term planning and policy making (OHA, 2023). Prioritizing the development and use of culturally responsive, two-way communication systems between LPHAs and community partners is crucial moving forward. The many examples of collaborative and culturally responsive communication that happened during the pandemic, like LCPH's collaboration with community advocates in Cottage Grove to employ trilingual youth to reach marginalized Mam speaking immigrants, demonstrate the value of this collaborative labor and the necessity of resources to employ this community work. The pressing need to address health disparities calls on public health professionals to use the most effective communication tools possible. Creating effective messaging on social media and video production, two key strategies utilized by LPHAs during the pandemic, requires specific communication skills and staffing or resources for contracting outside organizations. Having long-term, sustainable support for LPHA's foundational capability of communication is especially important to enable the ongoing, effective health communication needed for this health equity focused cultural shift.

There are major challenges to this cultural shift to communication that raises public awareness around SDH and health inequities including mismatches between the target audience for raising awareness SDH (i.e. upper class policymakers, opinion leaders and voters) and those disproportionately influenced by SDH and health disparities, human attribution biases which

overemphasize individual factors and underemphasize contextual factors, the prominent ideology of individual responsibility, public health research priorities which emphasize individual behaviors and medical care, and journalistic norms and practices which concentrate on individual rather than broader social factors (Clarke et al., 2012). As this case study confirms, marshalling the public health modernization model in public health communication, especially the horizontal inclusion of community voices that enable participants to identify and explore public health issues and solutions, is needed to help meet these challenges. “Marginalized communities that have been perpetually excluded from economic resources have also been excluded from the very conversations that determine how collective resources are allocated. And without their vital input throughout the design process, well-meaning leaders risk missing key pieces of the puzzle and unintentionally perpetuating the exclusion of the very communities they sought to serve” (Manning & Powers, 2021). Without movement toward more community and culture-centered models of community engagement to identify and address the social and economic roots of health needs in Oregon and investment in our marginalized communities, inequities will only expand. Health communication must largely go beyond traditional, individual psychological theory and focus as individual behavior change is fundamentally not what is needed to improve public health. Policies that inherently challenge the systems meant to benefit the groups of people who maintain enormous power over the current economic and policy systems is needed. As with any shifting of culture and power, communication will play an important role in facilitating those changes.

Limitations and Future Research

As noted in Chapter 3’s methodological overview, this dissertation is largely limited to the experience and perspective of Oregon. Because this research did not directly engage Latinx

community members or any Oregonian recipients of health communication and outreach during the COVID-19 pandemic, the actual reception and impact of the messaging was not measured. Because this study also does not include the perspective of CBOs and community partners who created much of the health messaging in analysis, relevant insight around the motivations and decision-making process behind this communication is also not present. The critical discourse analysis of this case study is based solely on the analysis and interpretation of the messages. While my sample was expansive, it is also a fraction of the health communication happening around the state during the pandemic. It is also important to note that the results of this case study are limited to the participating LPHAs and the self-reported data of LPHA participants cannot capture the full experiences and work of those LPHAs.

Future research should continue to identify strategic approaches to effectively communicate SDH and to build political will and support to address social inequities in health. This will include "initiatives to raise awareness levels of the pervasiveness of inequities in health, build empathy and support for addressing inequities, enhance the capacity of individuals and communities to actively participate in intervention efforts and implement large scale efforts to reduce racial prejudice, ideologies, and stereotypes in the larger culture that undergird policy preferences that initiate and sustain inequities" (Williams & Cooper, 2019, p.606). As critical and cultural theories and models like CCA, PEN-3 model, and health activism have all confirmed, an essential component of identifying these future communication strategies will be inclusion of community voices. Research is rarely focused on the voices of CHWs considering how to increase the sustainability and effectiveness of their important health equity promoting work, including Latinx promotores (Palmer-Wackerly et al., 2020). Research has highlighted issues with the treatment of the Latinx community as a monolithic population when there are

important nuances among the members of individual "Latinx" communities like country of origin, immigration status, generational status, primary language, race, age, sex, gender, or rural residence (Ortiz et al., 2022). It is important for public health officials and communicators to consider and do research to better understand how intersectional complexities affect a range of differences in cultural beliefs and social positions among many different community groups that should be taken into consideration in health messaging and access. This sort of research is especially important for improved response to future pandemics that scholars warn the U.S. especially is not prepared for but could be if we end our collective amnesia about public health disasters and act collaboratively to strengthen services and pursue better health equity (Cipriano et al., 2024).

Conclusion

The story of Oregon's local public health response to the COVID-19 pandemic, especially to address health inequities among systemically marginalized Latinx community members, holds important lessons for health communication and community engagement strategies and challenges. CBOs serving Latinx communities, local public health authorities (LPHA), and the state public health authority (OHA) approached health communication during COVID-19 pandemic utilizing a range of communication strategies with a clear focus to address health inequities. Community outreach and collaboration with CBOs was an essential component to these health equity efforts. This case study confirms the value of Oregon's public health modernization model as one that effectively emphasizes communication and engagement to further shift and improve our understanding of modernization as ground-up and aimed at liberatory changes identified and informed by the communities most impacted by inequities.

The Critical Discourse Analysis reported in Chapter 4 reveals that while traditional, individualistic theories like the Health Belief Model and Theory of Planned Behavior were evident in many health behaviors focused messaging, the culture-centered approach (CCA) and PEN-3 models that considered the specific needs within a group of highly marginalized Latinx community members and messaging and centered relevant cultural factors were also present over the first 22 months of the pandemic. Furthermore, individual health behavior messaging revealed cultural and structural considerations, especially in messaging engaging EPPM and social marketing techniques to make a cultural appeal to community solidarity. Health communication among the three organizational levels of CBOs, LPHAs, and the OHA reveal instances of collaboration. Most notably, health activism messaging by CBOs brought critical awareness to the early disproportionate impact of COVID-19 on Latinx community members and forced OHA and LPHAs to address inequities in health messaging, expand translation and community engagement, and policies around vaccination rollout. Community partners also brought important awareness to structural vulnerabilities and violence (Galtung, 1975; Farmer, 1995) impacting Latinx community members, including harmful immigration policy and exclusion of immigrants from crucial emergency resources brought a broader awareness, which led to important community-based support like the Oregon Worker Relief Fund. CBO communication during the pandemic confirms the value of health activism's theoretical emphasis on structural and economic changes (Zoller, 2005), as well as the importance of CCA's theoretical focus on agency and the importance of communities to be an active participant in formulating solutions to health challenges (Dutta, 2008).

The experience and insight from Oregon's LPHAs narrated in Chapter 5 reveal the clear importance of effective communication and strong relationships with community partners. All

the participating LPHAs in this study worked to address health equity concerns in their community during the pandemic and staffing and community partnership relationships supported their ability to do this work. LPHA collaboration with CBOs partners in communication and outreach further reveal the value of Dutta-Bergman (2005) CCA and effectiveness of active participation of community members in constructing shared meanings and values in messaging around a range of issues during the pandemic.

Staffing for communication and community partnership specific positions during the pandemic was mixed and often limited, especially for rural counties. Jefferson County PHA Michael Baker explained, “rural public health has always had to be more self-sufficient; this was the case during the pandemic too.” Post-pandemic staffing at Oregon’s LPHAs in late 2023 reveal staffing improvements with communication specific staffing in state LPHAs increasing by 25% and community partnership/ health equity specific staffing increasing by 16.7%. LPHAs learned many important lessons from the pandemic that are informing their ongoing efforts to improve health equity, chief among them the importance of communication and community partner engagement. Longstanding gaps in public health infrastructure and funding of LPHAs continues to cause challenges and highlights the need for more sustainable funding and improved collaboration with the OHA. The chapter’s review of participating LPHA’s currently published CHA and CHIP reveals an opportunity for updated community-driven processes around community health priorities and planning and further demonstrates the importance of improving the public health modernization model’s foundational capabilities to improve this community engagement and support ongoing health equity efforts.

The communication and community partnership work of Lane County’s Public Health division discussed in Chapter 6 provide positive examples of how local public health responded

to the COVID-19 health emergency by incorporating community voice and engaging with partners in decision-making and communication including Spanish language press conferences led by the CBO Centro Latino Americano. The collaborative multi-phase Latinx community survey provided important insight that helped LCPH understand the community's challenges, needs, and communication channels. The survey results confirmed the important role of CBOs in outreach and motivating community members to attend COVID-19 testing and vaccine events and helped LCPH better address community barriers and motivations in their communication and outreach efforts.

LCPH's CPP section and team helped enable crucial community engagement during the pandemic and because of its continued existence, is building on these partnerships to continue health equity focused changes like its participatory data parties and grant-making processes, improved CHA and CHIP practices, and incorporating abolitionist theory to operationalize racism as a public health crisis work. As Freire (1970) argued, individuals need relationships to recognize their own internal capacity to develop on their own terms and to act on that capacity. These relationships require a process of communication to meet an essential shared meaning between all participants. Public health modernization efforts like the CPP demonstrate how modernization through 21st century public health is helping shift the field and larger social change paradigm to be more ground-up and participatory.

The discussion of the case study's findings demonstrates how Oregon's public health modernization model should be further pursued so that crucial public health foundational capabilities like communication, community partnership development, health equity and cultural responsiveness, and policy and planning are better fulfilled in LPHAs throughout the state. It also demonstrates how the traditional modernization paradigm is being significantly shifted

towards a new and improved version of modernization by promoting health equity, community participation, and challenges to current systems of power. Overall, this dissertation case study, like other SDH research, shows that health inequity is not inevitable (Marmot, 2006). Inequity can be remedied with the right combination of social and economic policy changes and effective communication which helps to shift cultural understanding of health and well-being to tackle these upstream causes.

APPENDIX A: LATINX COVID-19 MESSAGING IN OREGON

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	Period 1. Spring 2020: Early Pandemic	Period 2. Late Spring- Summer 2020: Pandemic recedes, state reopening	Period 3. Winter 2020: Pre-vaccination and pandemic surge	Period 4. Late Winter- Spring 2021: Vaccination begins and mass vaccination clinics	Period 5. Summer 2021: Vaccination subgroups, addressing vaccination inequities	Period 6. Fall 2021: Response to Delta, Continued vaccination efforts
CONTEXT: CASES/ MEASURES	March- Declaration of state of emergency; stay at home orders, closures; immigrant communities omitted from support/ lack of non-English communication	May-June-Reopening Oregon's economy; in person school resumes July- Latinx make up 35% of infections	Oct- Reopening Oregon's economy phases Dec- Latinx make up 38% of infections	Mass Vaccination Feb- Latinx make up 31% infections; immediate vaccination gap	Mandates and restrictions rescinded June- Latinx make up 24% infections, only 8% vaccinations Delta surge	Late Sept- Hospitals remain under severe strain Dec- start of Omicron spread
OHA MESSAGING	-Fight stigma video -CDC hand washing tips -Spanish Facebook page -Launch of Safe + Strong campaign	-Safety: Face masks, physical distancing -Collaboration w/ Latinx media and leaders for messaging	-Info on rent moratorium program -Innoculation for coming COVID-19 vaccines	- Video explaining vaccine eligibility timelines -Info on new risk level reopening policy	-Community Conversation Zoom calls -Personal vaccine stories on blog -Case rates of vaccinated vs. unvaccianted	-Promote community vaccine events -Celebrate vaccination progress and recognize gaps
LPHA MESSAGING	-Spanish speakers added to local call centers and daily updates -Videos on cleaning & disinfecting	-Promotion of testing events -Rent and energy assitance resource info	-How to stay safe during the holidays -Targeting young community members -Local rent assistance	-Updated mandates -Vaccination and event promotion -Addressing vaccine misinformation	-Updated mask mandates -Vaccination promotion and vaccine event information	-Promote community vaccine events -Updated vaccine education -LCPH begins CBO newsletter
CBO MESSAGING	-Hand washing videos in indigenous languages -Open letter to ICE -Inforgraphics to explain new mandates; updates on Public Charge -Establish Oregon Worker Relief (ORW) Fund -CLA report on COVID impact	-OWR promotion including new quarantine fund -Assistant funds through local government for rent and energy costs -Community-led support spaces	-Continued promotion of support resources, OWR info in indigenous languages -Community-led support spaces	-Press conference to demand improved Latinx vaccination efforts to address gap -Address community vaccine concerns -Outreach promoting community vaccination	-Vaccine and booster education -Video testimony on vaccination -Advocate for more community vaccination events	-Culturally appropriate vaccine events -Music video promoting vaccine -Back-to-school resources

APPENDIX B: LIST OF EXAMPLES DISCUSSED IN CHAPTER 4 CRITICAL DISCOURSE ANALYSIS

The following list of specific communication examples cited in the critical discourse analysis of Chapter 3 includes (when applicable) the date of publication of the messaging, the message publisher (organization), a title or description of the message, and a hyperlink to the message online. These links may have changed or taken down since it was collected for this research and may not function.

Period 1:
1. 3/7/20, OHA video "Help Us Fight COVID-19 Stigma
2. 4/20, OHA shared CDC education material on handwashing
3. 4/20, Clatsop County Public Health informational video on disinfection and cleaning
4. 3/20/20- Benton County LPHA official COVID-19 video update in Spanish
5. 5/21/20- LCPH press conference
6. 3/24/20- CLA infographic shared on Facebook explaining COVID executive order
7. 3/14/23- open letter from Latinx and other state organizations to Portland's Immigration Court and to Oregon's ICE offices demanding that all ICE enforcement activities cease
8. 3/23/20- petition to ICE in Oregon shared on CLA's Facebook page
9. 3/16/20- CLA Facebook post sharing USCIS update
10. 4/29/20- OHA Facebook post sharing infographic update on public charge
11. 3/20/20- CLA Facebook post sharing a Department of Labor info sheet on FFRCA
12. 3/21/20- Casa Latinos- Facebook Live to explain CARES Act
13. 4/15/20- CLA published a report titled "Impact of COVID-19 on Immigrant & Latino Community in Lane County"
14. 4/28/20- LCPH held a press conference to explicitly discuss SDH and health inequities
15. 3/18/20- OHA shared TV Jam PSA on OHP partnership
16. 4/23/20- OHA launches Safe + Strong website

Period 2:
1. 8/22/20- OHA Facebook post sharing CDC facemask guidance infographic
2. 6/30/20- OHA shared TV JAM's discussion with Oregon Law Center on financial support to Facebook page
3. 6/2/20- Consejo Hispano shared a Facebook post about rent assistance
4. 8/15/20- Casa Latinos Unidos shared information from the Corvallis-Benton Economic Development Office on small business grants available
5. 7/13/20- LCPH shared information on rent assistance funds to Facebook
6. 7/29/20- LCPH shared information on energy assistance funds to Facebook
7. 5/29/20- OHA shared resource from the Oregon Department of Employment about pandemic unemployment benefits and OHP plans to Facebook
8. 8/26/20- OHA shared a video of the farmworkers union PCUN Executive Director Reyna Lopez Osuna demonstrating correct mask wearing
9. 8/25/20- CLA held a Facebook Live event, "Hablemos en Confianza," a space to talk about therapy
10. 8/19/20- LCPH Facebook promotion of a testing event in Cottage Grove

Period 3:

1. 10/4/20- OHA's shared Washington County's Facebook post specifically targeting young people between 19 and 24 years old to stay home
2. 12/7/20- Benton County Public Health shared a video update in collaboration with Casa Latinos Unidos on both organizations' Facebook pages
3. 12/14/20- Casa Latinos Unidos shared TV Jam's Facebook live video on where to get a free COVID-19 test to Facebook page
4. 11/18/20- OHA Facebook post on holiday season safety
5. 12/24/20- LCHP Facebook post on safety during holiday meals
6. 11/25/20- Consejo Hispano shared a video created by the Tillamook County Community Health Centers on their Facebook page covering the basics of health safety behaviors
7. 11/14/20- TV JAM live video on OWR funds shared on OHA Facebook page
8. 11/10/20- LCPH Facebook post about round 4 of rent assistance from the county
9. 12/30/20- OHA infographic on new rent moratorium program and resources
10. 12/16/20- OHA infographic on vaccine development

Period 4:

1. 1/29/21- OHA shared video on vaccine group eligibility timeline
2. 1/27//21- OHA Facebook post on new public health risk-levels framework
3. 4/15/21- CBO Latino Network news conference on vaccine inequities
4. 1/27/21-CLA Facebook post of staff masking
5. 4/16/21-CLA video of older community members on vaccination
6. 4/1/21- LCPH promotion of vaccination for people living in multigenerational homes
7. 1/28/21- Consejo Hispano shared Clatsop County video addressing myths of vaccine changing DNA
8. 5/14/21- CLA shared Facebook post explaining the risk of blood clots with the Johnson & Johnson vaccine compared to other risks
9. 4/12/21- CLA podcast "Céntrate" on the Johnson & Johnson vaccine to specifically address and refute concerns around the use of fetal tissue
10. 1/29/21- Clatsop County video to dispel myths of fetal tissue material in COVID vaccines
11. 6/7/21- Multnomah County COVID-19 handbook for migrant and seasonal farmworkers
12. 5/17/21- CLA Facebook post on monthly child benefit payments
13. 5/27/21- CLA shared infographic on accessing OWR funds

Period 5:

1. 8/22/21- OHA infographic on COVID-19 rates
2. 8/30/21- OHA Blog post of Nancy Vera vaccination story
3. 7/2021- Casa Latinos Unidos video series called ¿Por qué la vacuna? shared to Facebook
4. 7/2821- CLA shared a chart outlining when and if a vaccine booster is necessary
5. 7/15/21- OHA Facebook Live "Conversación comunitarias" with Dr. Debess, on vaccine for children under 12 years old
6. 8/13/21- LCPH Facebook infographic on mandatory use of masks indoors
7. 8/276/21- LCPH Facebook infographic on mandatory mask mandate outdoors

Period 6:

1. 10/26/21- CLA Facebook post promoting community vaccine events
2. 9/29/21- OHA Facebook promotion of vaccine event at Mano A Mano Family Center in Salem
3. 10/29/21- OHA Facebook post promoting vaccine event sponsored by TV Jam and Vive Northwest in Portland
4. 9/5/21- Consejo Hispano shared music video of the song "Yo Me Pongo La Vacuna"
5. 10/22/21-LCPH shared infographic on difference between a booster shot and an additional dose to Facebook
6. 11/3/21- LCPH Facebook post on where children aged 5-11 could receive their vaccines
7. 10/21/21- LCPH Facebook infographic on flu vaccine and migration status
8. 11/1/21- Benton County COVID-19 vaccine information video in Mam
9. 9/22/21- CLA shared Oregon Department of Education's video on returning to school
10. 10/15/21- CLA shared an infographic with information from OHA and ODA about what to do if your student tests positive for COVID
11. 10/28/21- LCPH Facebook post on Halloween Safety Tips
12. 10/28/21- CLA and LCPH Facebook post on current COVID-19 cases in county
13. 11/2/21- OHA Facebook infographic on 80% of state vaccinated

APPENDIX C: INTERVIEW GUIDE FOR SEMI-STRUCTURED LPHA PARTICIPANT INTERVIEWS

1. Does your Public Health unit have any designated information officer and/or communication specific employee(s)?
    1a. If yes, how many and what are the names of their positions?
    1b. If no, is there any particular reason your unit is lacking this sort of employee?
2. Has your unit hired communication specific employee(s) since the start of the pandemic?
    2a. If so, how many and when?
    2b. If so, is your unit retaining any staff hired during the pandemic/response?
3. Does your unit have any employee(s) designated to assist with community partnerships and/or health modernization efforts?
    3a. If yes, how many and what are the names of their positions?
    3b. 1b. If no, is there any particular reason your unit is lacking this sort of employee?
4. Has your unit hired community partnership specific employees since the start of the pandemic?
    4a. If so, how many and when?
    4b. If so, is your unit retaining any staff hired during the pandemic/response?
5. Did your public health unit receive any pandemic-specific funding/ grants?
    5a. If so, please briefly describe how those resources were utilized.
6. Has your unit's resources or staffing changed in any other ways not already reflected in your responses since the end of the federal COVID-19 public health emergency?
    6a. If so, please briefly describe those changes and their impact.
7. During the COVID-19 pandemic, were there any specific communities your unit focused on specifically to address health equity concerns?
    7a. If so, please briefly describe which communities and efforts to directly assist them.
8. Briefly summarize the most significant lessons learned from the pandemic that is impacting your unit's current work.

APPENDIX D: EXAMPLE OF LCPH LATINX COMMUNITY SURVEY PHASE II QUESTIONAIRE

Fecha_________________ Lugar _____________________
ENCUESTA SOBRE CORONAVIRUS
DEPARTAMENTO DE SALUD, CONDADO DE LANE
Fase 2b (Junio 2021 -)

Con ésta encuesta, queremos saber más sobre las percepciones y las necesidades de la comunidad Latinx en cuanto al coronavirus / Covid-19. Somos investigadores de la Universidad de Oregón colaborando con el Condado de Lane, Departamento de Salud Pública con éste estudio de investigación. Utilizaremos la información que recopilamos para mejorar los servicios de salud dirigidos a la comunidad hispano-hablante. Si usted decide participar o no, no afectaría su acceso a los servicios de salud de ninguna manera. Además, todas sus respuestas serán anónimas; es decir, no le pediremos ni su nombre ni otra información de identidad personal. Esta encuesta consiste en una seria de preguntas sobre su conocimiento del coronavirus – no hay repuesta "buena" ni "mala" – solo queremos saber sus opiniones y creencias. La encuesta consiste en 10 preguntas y tardará cómo 10 minutos para completar. Si tiene una pregunta o un comentario sobre ésta encuesta, puede comunicarse con la Profesora Kristin Yarris, Programa de Salud Mundial, en la Universidad de Oregón, en keyarris@uoregon.edu *o por telefono en 541.346.1363.*

¿Puede usted contestar algunas preguntas?
Si lo es un evento de LCPH (si no es evento organizado por LCPH, SKIP Q1:
1. ¿Como supo usted de este evento? [Escoge solamente una respuesta]
    a. De un familiar/miembro de mi familia
    b. De una organización comunitaria
    c. De Facebook
    d. De la Radio
    e. De la TV
    f. Otro medio social
    g. Del Condado de Lane, Salud Pública
    h. Autoridad de Salud de Oregon
    i. Otro

2. ¿Cúal es su fuente principal de información sobre coronavirus, incluyendo información sobre la vacuna de COVID-19? [Escoge una]
    a. Amigos
    b. Familiares
    c. Organizaciones comunitarias
    d. Facebook
    e. Radio
    f. TV
    g. Otros medios sociales
    h. Condado de Lane, Salud Pública

i. OHA
j. CDC
k. Otra

Ahora le vamos a hacer algunas preguntas acerca de sus opiniones sobre las vacunas.

3. ¿Usted se ha puesto la vacuna de influenza este año?
   a. Si
   b. No

4. ¿Tiene planes de ponerse la vacuna de influenza este año?
   a. Si
   b. No
   c. Talvez

5. ¿Por cuáles razones no se pondría una vacuna de influenza? (Seleccione todas que apliquen)
   a. Los efectos secundarios
   b. El infectarme por la vacuna
   c. El dolor de ponerme la vacuna
   d. No saber dónde obtener la vacuna
   e. El costo de la vacuna
   f. Falta de confianza en la vacuna
   g. Falta de confianza en las autoridades de salud
   h. Falta de confianza en el gobierno
   i. Aún no me he decidido (indecisión)
   j. No la necesito porque ya tuve la flu
   k. Otro, especifique:

6. ¿Se ha puesto la vacuna de COVID-19?
   a. Si
   b. No

7. *Si la respuesta a Q6 es "sí," pregunte*: ¿Porqué decidió vacunarse?
   a. Para protegerme a mi
   b. Para proteger a mi familia
   c. Por solidaridad social
   d. Porque mi trabajo me lo requirió
   e. Para poder viajar o hacer actividades sociales
   f. Me motivó por la loteria
   g. Otro, especifique: ____________________________

8. *Si la respuesta a Q7 es "no" o "talvez", pregunte*: ¿Tiene planes de ponerse la vacuna de COVID-19?
   a. Si
   b. No
   c. Talvez

9. ¿Sabe dónde puede ir para ponerse la vacuna de COVID-19?
   a. Si
   b. No
   **Si no, tomamos tiempo para informarles y si quieren les hacemos cita para vacunarse*

10. ¿Por cuáles razones usted no se pondría una vacuna de COVID-19? (Seleccione todas que apliquen)
    a. Los efectos secundarios de la vacuna
    b. El infectarme por la vacuna
    c. No la necesito porque ya tuve COVID
    d. No saber dónde obtener la vacuna
    e. El costo de la vacuna
    f. No tengo tiempo disponible del trabajo para ponerme la vacuna
    g. Falta de confianza en la vacuna (p.e. quieren que pase más tiempo antes de ponersela)
    h. Falta de confianza en las autoridades de salud
    i. Falta de confianza en el gobierno
    j. Aún no me he decidido (indecisión)
    k. Otro, especifique:

11. Según cómo usted ve a su comunidad, ¿cuáles son las razones por las que la comunidad hispana/latina/latinx no se quiere vacunar?
    ____

<u>Preguntas Demográficas</u>*: éstas últimas preguntas nos ayudarán aprender un poco más sobre usted para que podemos mejorar nuestros servicios y programas.*

13a. ¿Usted tiene empleo?
   a. Si
   b. No

13b. ¿en qué industria trabaja usted?
   a. Agricultura
   b. Construcción
   c. Restaurantes
   d. Procesamiento de alimentos
   e. Servicio doméstico (limpieza de casas)
   f. Servicios de salud
   g. Jardineria (landscaping)
   h. Mollinos
   i. Ventas
   j. Otro, especifique:

13c. ¿Siente que su empleo le ha expuesto al coronavirus/COVID?
   a. Si
   b. No

13d. Explique su repuesta en #13c:

14. ¿De qué forma ha impactado la situación de coronavirus y la pandemia a usted y su familia? (anote todos que apliquen)
    a. Hemos perdido empleo
    b. Hemos tenido dificultad en pagar la renta (la casa)
    c. Hemos tenido dificultad en pagar los billes (luz, telefono, alimentos, etc)
    d. Hemos tenido dificultad relacionada con la educacción de los niños (e.g. en casa)
    e. Hemos tenido dificultad con la salud mental o emocional
    f. Aislamiento de mis amigos y familiares ha sido dificil
    g. Otro

15. ¿Usted tiene seguro de salud?
    a. Si
    b. No

16. ¿Cuál es su género?
    a. Mujer
    b. Hombre
    c. Trans
    d. No-binario

17. ¿Cuántos años tiene usted?

18. ¿Tiene alguna preocupación, duda, o comentario más que quisiera compartir?

Al concluir, comparte información de recursos y información de salud.
Muchas gracias por su tiempo. Si usted quiere más información sobre servicios de salud en el Condado de Lane, puede llamar a ese número: 541.682.1380

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