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Developing Community-Centred Public Health Communication Frameworks Through Ethnographic Insights and Participatory Research Approaches

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ABSTRACT :

Public health communication depends on how people encounter, interpret and discuss information within their everyday lives. Differences in language, literacy, trust and access to communication channels can limit the relevance and reach of institutional messages. This proposed study will develop a community-centred communication framework by integrating ethnographic inquiry with participatory research. Observation, interviews and communication mapping will explore information practices, local priorities and experiences of existing public health messages. Residents, community organisations and practitioners will jointly interpret findings, prioritise problems and establish design requirements. Co-design activities will produce communication prototypes, which will undergo comprehension and usability testing before pilot implementation. Evaluation will examine reach, understanding, accessibility, participant influence and the feasibility of maintaining the framework. Outcomes will be compared across relevant groups to identify unequal participation or unintended exclusion. A documented decision trail will connect field evidence with design choices and revisions. The study will clarify how contextual understanding and shared decision-making can inform responsive communication while identifying institutional barriers requiring wider action. Findings will guide local adaptation and establish priorities for further evaluation before broader use across public health settings.

Keywords: Community-centred communication, ethnographic research, participatory research, public health, community co-design, health equity.

1. INTRODUCTION

1.1 Public Health Communication in Everyday Community Life

Public health communication helps people understand health issues, assess information and make decisions relevant to their circumstances. Effective communication requires attention to accessibility, relevance and opportunities for action [1]. Messages circulate through households, social networks, community organisations, healthcare encounters and digital platforms. Their meanings can change as people discuss them, compare them with experience and seek clarification.

Language, literacy, disability access and the availability of communication channels influence whose questions are answered and whose needs remain overlooked [2]. Culturally and linguistically appropriate communication also considers beliefs, preferences and the circumstances in which information is used [3]. Communities contain varied experiences and competing perspectives, so shared language or location does not establish uniform understanding [4].

Communication quality therefore shapes opportunities for informed participation in vaccination, screening and other public health activities. Examining everyday information practices helps identify how messages become understandable, credible and practically usable, alongside the barriers that limit participation.

1.2 The Problem of Limited Community Influence

Communication programmes can invite community comment after messages, objectives and delivery arrangements are already fixed. In these circumstances, consultation may leave little opportunity to influence the assumptions guiding the intervention. Participation requires scrutiny of who holds decision-making power, rather than relying on attendance as evidence of influence [5].

Overlooking local priorities can produce information that is accurate but difficult to act upon. Everyday constraints, established sources of advice and previous institutional encounters shape how people receive messages. Ethnographic inquiry examines these relationships through attention to practices, interactions and contextual meanings [6].

Participatory research adds arrangements through which residents and practitioners share interpretation, identify priorities and contribute to decisions [7].

Co-design involves participants in developing alternatives and shaping content, format and delivery [8]. A framework connecting these approaches needs to show how field evidence informs communication choices, who approves those choices and how disagreement is handled. This provides a basis for examining whether community involvement changes the resulting communication in practice.

1.3 Aim, Research Questions and Contribution

This article develops a proposed community-centred public health communication framework informed by ethnographic evidence and participatory research. It asks how communities interpret health information, how participants influence framework development and how its usefulness can be evaluated. Intended users include public health teams, community organisations, researchers and service providers.

The contribution is a documented development process linking experiences with shared interpretation, design requirements and communication decisions. Explicit responsibilities identify who contributes evidence, makes design choices, approves technical content and maintains materials. Participatory principles inform these arrangements [7], while evaluation examines implementation and the assumptions connecting communication with outcomes [9]. Effectiveness requires application in a defined setting, with outcomes appropriate to the communication task and population. Framework development alone establishes neither improved participation nor health benefit. The next section defines community-centred communication and explains the complementary contributions of ethnographic and participatory approaches.

2. CONCEPTUAL FOUNDATIONS AND FRAMEWORK DEVELOPMENT LOGIC

2.1 Defining Community-Centred Public Health Communication

Community-centred public health communication responds to locally identified priorities, enables accessible participation and gives residents meaningful influence over decisions. Community membership can arise through place, shared experience, identity or collective activity. These connections overlap, and participation arrangements need to recognise differences in interests and authority within any group [10].

Information provision, dialogue and collaborative decision-making represent different relationships. Information provision communicates content, dialogue creates opportunities for questions and interpretation, and collaboration shares responsibility for choices. A programme's description of participation should therefore specify what people can influence and how their contributions affect decisions [12].

Representation requires attention to who participates and whose perspectives remain absent. Established organisations can offer connections while overlooking people outside their networks. Recruitment and facilitation consequently need routes for less visible perspectives [7]. Accessibility includes language, format, disability access and practical participation support. Digital materials require attention to accessible interaction [13]. Accuracy and accountability complement these principles through clear approval responsibilities, documented decisions and routes for correction. Together, these commitments make community influence open to examination.

2.2 Complementary Roles of Ethnography and Participatory Research

Ethnography examines everyday practices, relationships, communication encounters and contextual meanings through observation, interviews and sustained engagement [6]. Comparing what people say with what occurs during encounters can reveal differences between official expectations and practical routines. Fieldnotes preserve circumstances that help explain these differences, including interruptions, informal assistance and institutional constraints.

Participatory research shares decisions about research questions, interpretation, intervention development and evaluation [7]. Participants can challenge researchers' explanations, identify overlooked concerns and propose alternatives. Co-design then connects shared interpretation with decisions about content, format and delivery [8]. Disagreement remains relevant evidence rather than an obstacle requiring consensus.

These approaches also introduce tensions. Sustained involvement requires time, accessible arrangements and resources. Representation is contested when community members hold different priorities, while confidentiality can constrain sharing of detailed accounts. Ethical practice requires explicit agreements about consent, disclosure and responsibilities [11]. Decision authority therefore needs clarification. Participants shape relevance and preferred communication approaches, while qualified professionals review clinical accuracy and designated organisations retain statutory responsibilities. Co-production guidance supports transparent discussion of these boundaries and the power relationships affecting their application in practice [12].

2.3 Proposed Development Logic and Assumptions

The proposed development logic connects contextual understanding with shared interpretation, design requirements, communication tools and evaluation. A decision record links each requirement to supporting evidence, identifies who approves it and explains revisions. This makes it possible to examine how participation changes the communication [8].

The framework assumes that partners have sufficient capacity, resources and authority to act on feedback. These assumptions require scrutiny during implementation, particularly when staff turnover, competing priorities or inaccessible participation arrangements interrupt delivery. Process evaluation examines implementation, mechanisms and context together [14].

Communication outcomes include reach, comprehension, perceived relevance and successful completion of information tasks. Behavioural changes and population health outcomes involve additional influences and require corresponding measures and suitable designs [9]. Framework use therefore includes periodic review of assumptions, unexpected consequences and unequal participation. The next section translates these principles into partnership arrangements and fieldwork that capture varied experiences while supporting accountable decisions about communication.

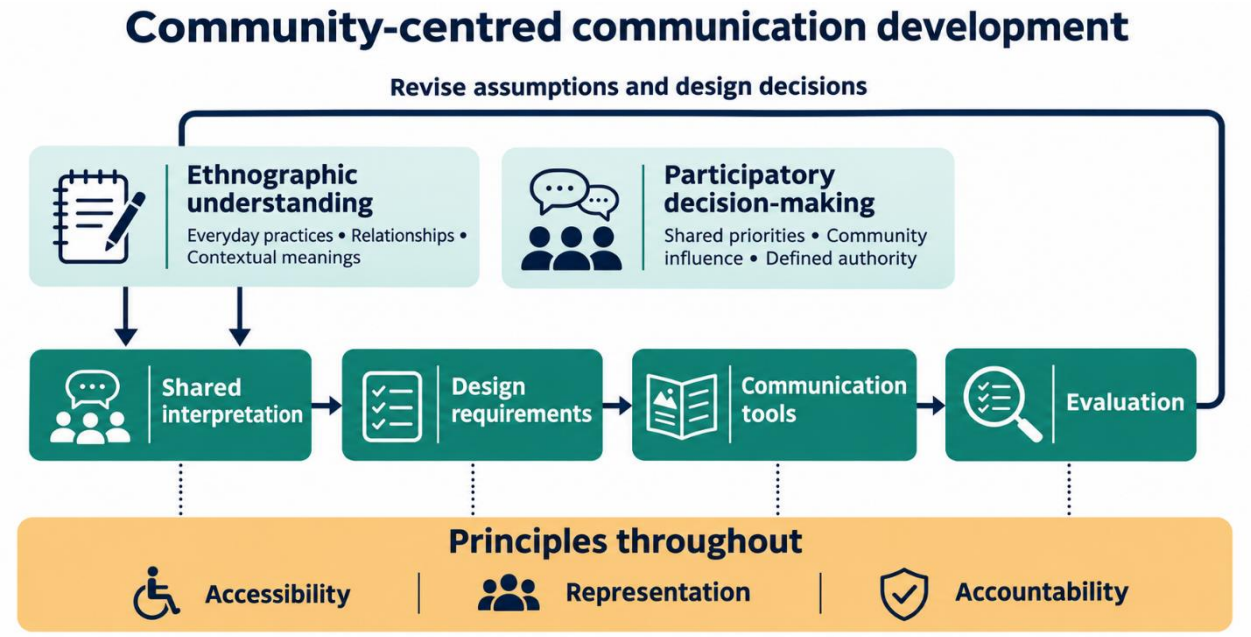


Figure 1. Conceptual foundations of community-centred communication development.

3. COMMUNITY PARTNERSHIPS AND ETHNOGRAPHIC INQUIRY

3.1 Setting, Public Health Issue and Community Boundaries

Framework development takes place within a defined locality and focuses on a public health issue selected with community and service partners. The protocol identifies the locality, population, issue and fieldwork dates before recruitment. Selection considers the importance of communication to the issue and the opportunities for community participation. A setting profile describes existing services, community organisations, outreach activities and relevant printed and digital information.

The inquiry examines how residents encounter, interpret and discuss messages associated with the selected issue. Its initial boundaries include service users, residents outside established networks and people who provide informal communication support. Purposive sampling allows these boundaries to develop as fieldwork identifies overlooked experiences [15].

Researchers review recruitment coverage and communication spaces during fieldwork. Newly identified venues or participant groups enter the inquiry through documented protocol amendments where required. Digital spaces receive consideration alongside physical settings, with attention to accessibility and the groups they exclude [13].

3.2 Partnership Formation and Shared Governance

A working partnership brings residents, community organisations, public health practitioners and researchers into decisions about the inquiry. Terms of reference define responsibilities, approval routes and the scope of shared authority. Residents contribute experiential knowledge, while practitioners review technical accuracy and researchers coordinate fieldwork and analysis. Decisions about communication design remain open to discussion throughout development [16].

The partnership agrees payment for public involvement, reimbursement of expenses and practical support before activities begin. These arrangements are explained separately from research participation. Members declare organisational interests, and facilitators address differences in confidence, professional status and access to information. Smaller discussions and accessible summaries support participation beyond meetings.

Minutes record decisions, disagreements, assigned actions and reasons for unresolved issues. Participants receive accessible accounts of how their contributions affect the project. Periodic reviews examine whose suggestions influence priorities and whether decision authority remains shared. Delivery records also identify participation interruptions or resource constraints that reduce meaningful involvement, supporting examination of implementation and context [14].

3.3 Inclusive Recruitment and Relationship Building

Recruitment combines community invitations, service contacts, outreach and opportunities for residents to approach researchers directly. The sampling strategy seeks varied experiences of trust, literacy, digital access and previous service engagement [15]. Community leaders offer connections while remaining one source of perspective among others.

Researchers identify requirements for interpretation, accessible venues, communication support and flexible scheduling. Cross-language encounters document interpreter roles and choices that affect meaning [17]. Information describes participation, confidentiality and withdrawal in understandable terms. Time to ask questions supports informed decisions.

Relationships develop through repeated contact and reliable follow-up, including acknowledgement of concerns raised during recruitment. Researchers avoid allowing access through an organisation to determine who can participate. Recruitment reviews identify absent perspectives and adjust routes where possible, while respecting decisions to decline or discontinue contact with the team.

3.4 Observation, Interviews and Communication Mapping

Observation covers relevant community meetings, outreach events and service encounters where appropriate permissions and consent are established. Researchers examine how messages enter conversations, who explains them and what practical questions arise. Fieldnotes distinguish observed interactions, contextual details and emerging interpretations. Reflexive entries consider how researcher presence shapes participation and disclosure [18]. Interviews with residents, community workers and public health staff explore communication encounters. Questions address where information originates, why it is trusted or ignored and how people discuss uncertainties. Participants describe experiences of interpreting messages for others and obtaining clarification. Where interpretation is needed, language decisions and ambiguities are recorded [17].

Communication mapping identifies formal channels, informal networks and individuals who relay or explain information. Participants can revise maps, identify missing routes and explain differences between intended and observed circulation. Existing leaflets, websites, notices and digital content are examined for their audience assumptions, clarity and practical instructions [20]. Comparison across sources identifies contradictions between institutional messages and everyday understanding. Iterative analysis retains these differences and traces interpretations back to accounts, materials and observations rather than forcing agreement across sources [19].

3.5 Ethics, Reflexivity and Data Stewardship

Ongoing consent and confidentiality agreements guide collection and sharing. Secure storage and role-based access protect recordings, transcripts and fieldnotes. Reports consider whether contextual details identify individuals or small groups. Sensitive disclosures follow agreed safeguarding and escalation procedures. Reflexive records examine how researcher position and relationships influence interpretation [18]. The partnership agrees accessible reporting formats and checks disclosure risks before dissemination. These arrangements support accountable collaboration, with clear responsibilities for data access, correction and communication of findings throughout framework development [16].

Table 1. Ethnographic evidence sources and communication questions

Evidence source	Communication question	Context captured	Participant contribution	Main limitation
Participant observation	How is information encountered and discussed?	Everyday interactions and practical constraints	Explaining observed routines and meanings	Researcher presence may affect behaviour
Individual interviews	Why is a message trusted, ignored or misunderstood?	Personal experiences and interpretations	Accounts of specific communication encounters	Recall and reporting limitations
Communication mapping	Who carries information between people and organisations?	Channels, relationships and gaps	Identifying trusted contacts and missing routes	Less connected people may remain overlooked
Material review	What assumptions do existing messages make?	Language, format and service instructions	Identifying confusing or irrelevant content	Materials alone do not show actual use

4. PARTICIPATORY INTERPRETATION AND FRAMEWORK CONSTRUCTION

4. Participatory Interpretation and Framework Construction

4.1 Joint Interpretation of Ethnographic Findings

Joint interpretation begins with presentations of field evidence, including anonymised accounts, journey maps and observation summaries. Researchers explain the context of each example and distinguish observed events from analytical interpretations. Participants can confirm, challenge or extend the account, including identifying experiences absent from the initial analysis. Reflexive discussion examines how researcher assumptions shape the material selected for presentation [18].

Comparison across groups and communication settings identifies shared concerns and differences. A disagreement about a message's meaning can reveal different service experiences or information needs. Researchers retain such differences and examine their implications during theme development [19]. Consensus is sought only where it supports a justified decision.

An interpretation record identifies the sources supporting each finding, contradictory evidence and unresolved questions. Findings supported across several encounters remain bounded by the study's coverage. Participant feedback can change an explanation, introduce a new concern or narrow a claim. The record documents these changes and identifies whose contributions influence the revised account, maintaining a visible connection between field evidence and the framework's emerging priorities.

4.2 Prioritising Communication Problems

Findings become problem statements specifying who encounters a difficulty, where it occurs and what happens as a consequence. Statements distinguish a confusing message from an instruction that is understood but impossible to follow. Review of existing materials helps identify unclear actions, unfamiliar terms or missing practical information [20].

Participants and practitioners prioritise problems using their importance to affected residents, potential harm, reach and feasibility of response. Each priority retains the evidence and uncertainty established during interpretation. A recurrent concern in the sample is considered alongside serious problems affecting fewer participants.

A decision log records why priorities are selected, combined or deferred. Issues involving appointment shortages, restrictive procedures or unaffordable access enter a parallel institutional action route. A named partner receives each issue, records the response and reports progress. Researchers examine whether institutional preferences displace community concerns and document unresolved differences rather than treating silence as agreement during design decisions [18].

4.3 Defining Framework Components and Decision Rules

The framework specifies audience understanding, message purpose, language, format, delivery channel, feedback and review. Each component includes a question, a design requirement and an accountable decision-maker. For example, evidence that users cannot identify the next step in a referral generates a requirement for an explicit action and contact route [20].

Community relevance and factual accuracy are reviewed together. Participants assess meaning, relevance and practical usability, while qualified practitioners check health claims and service staff confirm procedural information. The approval record identifies the version reviewed and any conditions attached to release.

Decision rules specify when adaptation is appropriate. Examples, language and delivery arrangements can change according to local needs, while essential technical content receives renewed professional review if its meaning changes. Adaptations are documented with their rationale, timing and responsible contributors [25].

A named content owner maintains approved materials and coordinates updates. The framework guide records supporting evidence, delivery responsibilities and revision procedures in sufficient detail to support replication [23]. Outstanding uncertainties remain visible so implementation teams can identify what requires testing, further consultation or institutional clarification before wider use proceeds.

4.4 Co-Designing Communication Prototypes

Co-design develops alternatives through workshops, paired activities or individual sessions, according to participant preferences. Residents and practitioners work with concepts before finished materials are selected. This creates opportunities to shape the communication itself, including the sequence of information and the type of support accompanying it [21].

Prototypes include printed guides, audio messages, visual explanations, facilitated discussions and digital content. Selection considers literacy, language, disability access and opportunities to ask questions. Participants examine realistic tasks, such as identifying an appointment preparation step or deciding whom to contact for clarification. Discussion explores the reasoning behind their choices and any unexpected interpretations [22].

Facilitators offer quieter participants private feedback routes, supported discussion and options that do not depend on public speaking. Alternative designs and reasons for selection enter the design log. Each prototype remains linked to a prioritised fieldwork finding. When participants propose a new feature, the team examines its purpose, evidence and resource implications. Disagreements return to joint interpretation or the relevant approval process, preserving accountability throughout development and avoiding unexplained departures.

4.5 Refinement and Development Documentation

Refinement tests comprehension, relevance and usability with intended users. Participants explain key messages in their own words and attempt realistic communication tasks, allowing the team to identify unclear instructions and missing information [24]. Testing also explores emotional responses and unintended interpretations.

Feedback informs revisions to content and delivery. Changes undergo checks against current public health guidance and service procedures. The record identifies what changed, why, who authorised it and whether further testing is required [25].

The framework guide consolidates components, responsibilities and adaptation procedures [23]. Pilot readiness requires accurate content, accessible participation arrangements and satisfactory completion of essential tasks under predefined criteria. Unresolved safety or procedural concerns delay release. The resulting specification supports evaluation in a defined activity, linking implementation evidence with outcomes and the distribution of benefits across users.

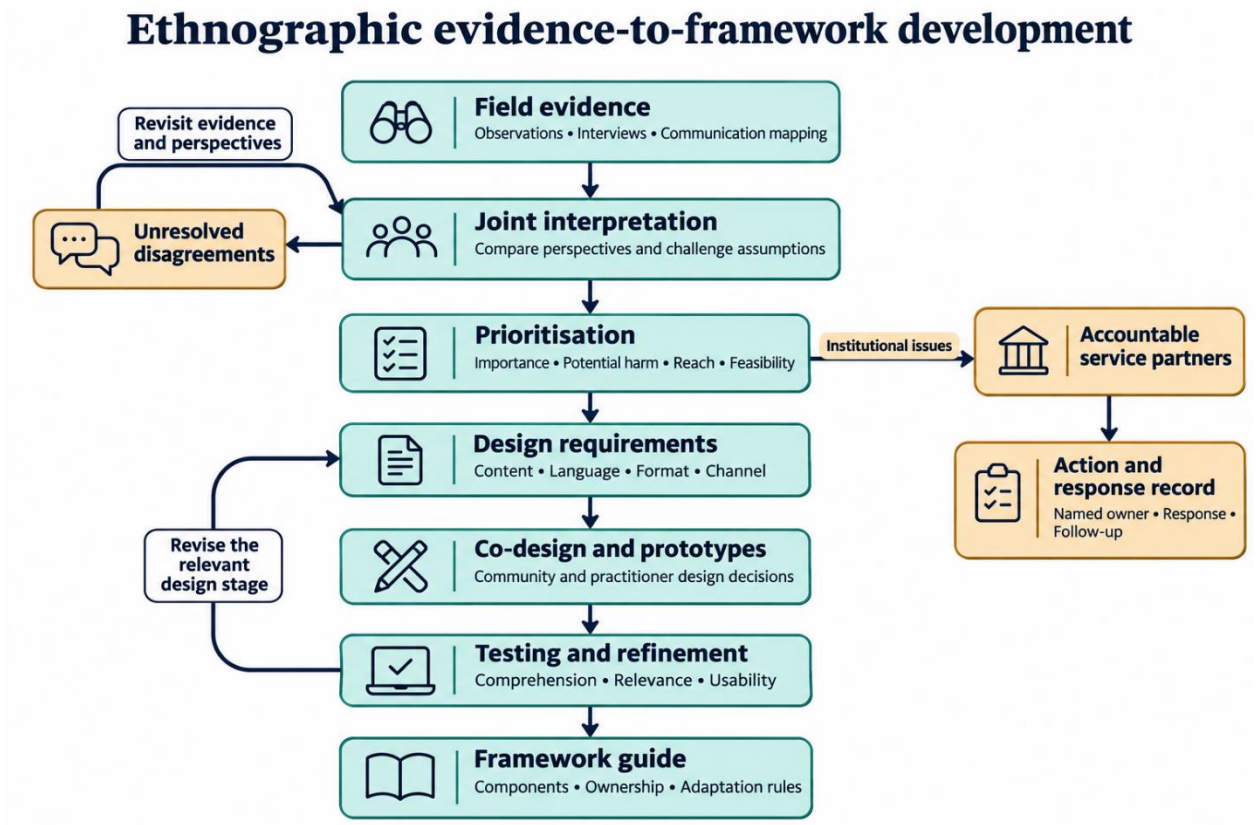


Figure 2. Ethnographic evidence-to-framework development pathway.

Field evidence informs joint interpretation, prioritisation and design requirements. Co-design produces prototypes that undergo testing and refinement. Feedback returns to the relevant design stage, unresolved disagreements return to shared interpretation, and institutional issues follow a parallel route to accountable service partners.

5. PILOT APPLICATION AND EVALUATION

5.1 Establishing the Evaluation Questions and Decision Criteria

Evaluation begins by defining the decisions the pilot needs to inform. These include whether partners can apply the framework, whether intended users understand the resulting communication and whether delivery is manageable within existing resources. The protocol identifies one primary outcome, the evidence required for each decision and the conditions supporting progression to a larger evaluation [27].

Baseline assessment documents usual communication, participant needs and relevant service arrangements. Follow-up examines comparable tasks after implementation. A controlled pilot uses a comparison setting with similar users, procedures and capacity, while recording differences that could affect interpretation.

The analysis plan specifies observation periods, eligible participants, outcome denominators and treatment of missing records before results are examined [28]. Findings are interpreted against these prespecified questions, including inconclusive and unfavourable results. Pilot conclusions address feasibility and preliminary outcome patterns, with stronger effectiveness claims dependent on an evaluation design capable of supporting them and its underlying assumptions [29].

5.2 Examining Whose Experiences Shape the Pilot

The pilot population follows the communication priorities identified during ethnographic fieldwork. Recruitment records distinguish people eligible for the activity, those approached, those offered materials and those participating in evaluation. This allows reach to be examined beyond a simple count of recipients [26].

The partnership reviews coverage across language, disability, digital access and previous service engagement. Community partners identify routes beyond their established memberships, while accessible information, interpretation and flexible arrangements support participation. People who decline evaluation retain access to routine communication and services.

Community influence is assessed through decision records showing proposals, disagreements, responses and resulting changes. Interviews explore whether participants recognise their contributions in the materials and delivery arrangements. Analysis examines whose views remain absent or receive less attention. These findings inform interpretation of the framework's community-centred character, alongside its practical usability. Representation and influence therefore remain evaluation questions throughout the pilot, with documented opportunities to revise recruitment and decision-making arrangements.

5.3 Following Delivery and the Resources It Requires

Implementation records show how the framework operates during one defined communication activity. A named lead coordinates preparation, distribution and support. Community partners introduce materials and facilitate clarification, while practitioners approve technical content and service staff confirm procedural information. The intervention description records responsibilities, channels, materials and delivery frequency [23].

Logs capture training, interruptions, assistance requests and adaptations. Each adaptation identifies what changes, why it changes and who authorises it [25]. Concurrent campaigns, staffing changes and altered service procedures are recorded because they may affect both delivery and outcomes.

Resource assessment includes preparation time, translation, interpretation, distribution and technical support. Staff record clarification work, while participants describe inconvenience, effort and assistance required. Interviews investigate why delivery departs from the approved specification and whether these departures improve local fit or weaken essential components. Process evaluation connects these observations with participants' responses and contextual conditions, providing an account of how the intervention is received [29].

5.4 Connecting Communication Outcomes with Equity

Outcome assessment follows the communication pathway from receipt to understanding, practical use and the intended action. Receipt is recorded separately from opening, reading or listening. Comprehension tasks ask users to explain essential messages, while usability tasks examine whether they can locate information and complete relevant steps.

Relevance and confidence are assessed alongside observed performance. Where feasible, authorised service records or follow-up reports establish completion of the action associated with the selected public health issue. Each measure uses a denominator restricted to eligible participants and a defined observation period.

Analysis compares outcomes across prespecified groups where sample sizes support interpretation. It examines whether delivery disproportionately reaches people already connected to services and whether formats, language or scheduling exclude others [26]. Missing observations and differential follow-up remain visible, with assumptions and sensitivity checks documented [28].

Qualitative accounts explain unexpected patterns, including confusion, stigma or reliance on informal assistance. Improved comprehension supports a communication finding. Behavioural or population health claims require corresponding measures and stronger evidence. Interpretation therefore considers both average outcomes and how benefits, burdens and uncertainties are distributed across intended users during delivery [29].

Table 2. Evidence required for pilot decisions

Evaluation question	Indicator or evidence	Timing	Responsible partner	Interpretation limitation
Can partners apply the framework?	Completion of framework steps, assistance required and implementation difficulties	Preparation and pilot review	Implementation lead and evaluation team	Familiarity may influence perceived ease of use
Who shapes the intervention?	Participant proposals, recorded responses, disagreements and design changes	Throughout development and delivery	Partnership coordinator	Accepted suggestion counts alone do not establish influence
Who receives the communication?	Eligible population, people approached, materials offered and confirmed receipt	Throughout delivery	Community partners and service staff	Unconnected residents may be absent from available population records
Is the communication understood?	Accurate explanation of essential messages	Baseline and after exposure	Trained assessors	Immediate comprehension may differ from later use
Can users complete the task?	Observed navigation or information-task completion, including assistance	Testing and follow-up	Evaluation team	Supported performance may differ from independent use
Does the intended action occur?	Action completion among eligible participants	Within the specified follow-up window	Service data team	Availability and circumstances beyond communication affect completion
Are benefits and burdens distributed equitably?	Group differences, missingness, exclusion accounts and unintended effects	Throughout delivery and follow-up	Evaluators and community partners	Small groups limit precision
Is continued delivery feasible?	Staff time, costs, maintenance capacity and partner commitments	Pilot review	Content owner and service lead	Research support may conceal routine resource constraints

5.5 Turning Findings into Revision and Continuation Decisions

The partnership reviews findings against the criteria established at the outset. Continuation requires workable delivery, acceptable burden and evidence that intended users can understand and use the communication. Unresolved misunderstandings, unequal reach or implementation failures prompt revision. A named content owner maintains materials, and the service lead coordinates procedural changes. Community partners contribute feedback through accessible routes and scheduled review. Changes in guidance, service arrangements or user needs trigger reassessment.

Expansion also depends on sustainable resources and organisational ownership beyond temporary funding or individual champions [30]. Application elsewhere begins with local inquiry. The development record identifies transferable components and context-dependent arrangements. Decisions explain

what continues, what changes and what requires further evaluation before wider application, with responsible partners and review dates.

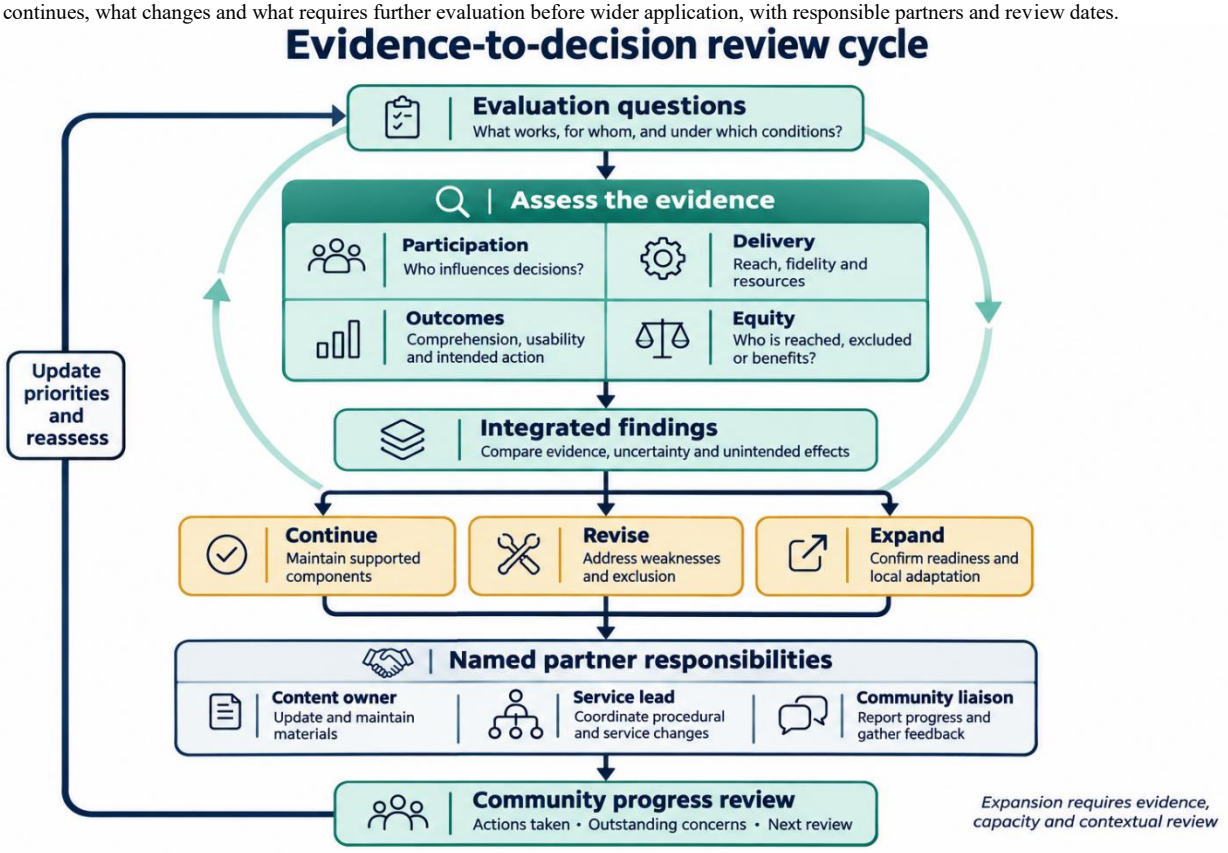


Figure 3. Evidence-to-decision review cycle.

6. DISCUSSION, LIMITATIONS AND FUTURE DEVELOPMENT

6.1 Contribution of Integrating Ethnography and Participation

The framework's contribution is assessed by tracing ethnographic findings into design components. Evidence of difficulty identifying the next action, for example, supports examining whether the framework prompts clearer instructions and contact routes. The decision record shows how observations, participant interpretations and review shape these choices. Process evaluation connects design intentions with delivery and participants' responses [29].

Participant influence is examined through changes to explanations, priorities and prototypes. Attendance or positive feedback alone provides limited evidence of shared decision-making. Analysis compares intended involvement with documented authority over decisions, including instances where community proposals are rejected or altered [31].

Observed practices may challenge institutional assumptions about preferred channels, prior knowledge or available support. Discrepancies help explain why communication operates differently from its specification. Outcomes are interpreted alongside implementation evidence, resource constraints and contextual changes [33]. Contradictory findings remain visible. Materials can be welcomed yet misunderstood, or understood without supporting the intended action. Pilot conclusions therefore distinguish feasibility, outcome patterns and questions requiring evaluation rather than assuming effectiveness from framework development [27].

6.2 Power, Representation and Institutional Responsiveness

Representation is assessed by comparing participants with the groups the framework seeks to involve. Underrepresentation may limit which problems receive attention and which formats appear acceptable. The analysis examines whether meeting arrangements, recruitment channels or professional language privilege participants already comfortable engaging with institutions [31].

Tensions between community priorities and institutional requirements require explicit discussion. Technical approval may constrain content, while organisational timetables can restrict opportunities to revise proposals. The assessment considers whether these limits are explained and whether participants retain meaningful alternatives.

Responsiveness also involves action on concerns beyond message design. Records identify referrals to responsible organisations, their responses and unresolved issues. Involvement is examined for demands on time, emotional effort and support. Sustainable participation requires resources and continuing organisational commitment [30]. Accountability arrangements support responsiveness when responsibilities, decisions and review routes remain visible. They constrain it when authority is unclear or feedback produces no documented consideration or action.

6.3 Methodological and Practical Limitations

Recruitment through partner organisations can favour people with stronger service connections, while limited fieldwork may miss informal conversations and unsuccessful communication encounters. Researcher identity and relationships influence disclosure and interpretation, making reflexive records important for evaluating the account [32].

Interpretation across languages introduces uncertainty about meanings and emphasis. Group dynamics may also discourage disagreement or amplify confident speakers. Self-reported comprehension and intended action can differ from observed understanding and subsequent behaviour. Conclusions therefore depend on the measures actually collected.

Attribution remains limited where comparison groups differ, concurrent campaigns operate or services change during follow-up. Missing observations can further distort comparisons if they concentrate among participants facing greater barriers [28]. Short follow-up limits assessment of sustained use. Transferability depends on local relationships, resources and institutional arrangements [34]. Reporting these conditions helps others assess relevance without assuming that trusted channels or participation structures transfer unchanged. Assumptions about community ownership require evidence of continuing authority, resources and maintenance beyond the pilot period [30].

6.4 Research and Practice Priorities

Comparative applications across communities and public health issues can examine which framework components remain useful under different conditions. Evaluations should compare framework-informed planning with existing practice, using outcomes that reflect both communication quality and participant influence. Larger studies require feasibility evidence and an appropriate comparison strategy [27].

Longer follow-up can assess maintenance, costs and whether benefits persist after research support ends [30]. Measures of influence should capture whose proposals alter decisions, how disagreements are handled and whether less connected residents gain authority.

Research also needs recruitment approaches that extend beyond networks. Wider adoption depends on evidence of delivery, equitable reach and organisational capacity. Continued examination of implementation and context informs adaptation while preserving opportunities for communities to challenge priorities [29].

7. CONCLUSION

7.1 Framework Contribution and Principal Conclusions

Public health communication gains relevance when its development reflects how people encounter, interpret and discuss information in everyday life. Ethnographic inquiry provides contextual understanding, while shared interpretation allows residents and practitioners to challenge assumptions and shape priorities. Participatory design connects these insights with decisions about content, format and delivery. The framework's contribution rests on a documented link between evidence, community influence and practical communication choices. Completed evaluation determines whether partners can apply the framework and whether intended users understand and use the resulting materials. Conclusions remain proportionate to those findings. Successful development establishes a workable process, while sustained behavioural or public health benefits require corresponding outcomes and longer evaluation periods.

7.2 Conditions for Responsible Application

Responsible application requires accessible participation, transparent decisions and accurate content. Named partners need continuing responsibility for maintaining materials, reviewing delivery channels and responding to community feedback. Adequate resources support interpretation, participation and implementation beyond the initial research period. Differences between communities require local inquiry and adaptation, with decisions grounded in the experiences of intended users. Review arrangements examine whose views influence changes and whether participation remains feasible for less connected residents. Sustained partnerships can make public health communication more responsive, accessible and accountable when community influence continues throughout development and use.

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