



COMMUNITY ENGAGEMENT

A health promotion guide for universal health coverage in the hands of the people



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Preface



“A strong primary health care platform with integrated community engagement within the health system is the backbone of universal health coverage.”^a

Health promotion – recast and reinterpreted to augment revitalization of primary health care toward universal health coverage (UHC) – can improve the health of at least a billion people as envisioned in the 13th General Programme of Work 2019–2023 of the World Health Organization (WHO).

WHO was created to uphold better health for *all people*. Through the years, driving forces for health such as globalization, rapid and unplanned urbanization, environmental degradation, demographic ageing, infectious disease outbreaks, the growing epidemic of noncommunicable diseases and climate change have increased disparities, making the mandate for health equity more relevant than ever before.

The Sustainable Development Goals (SDGs) articulate UHC as one of its outcomes and provides a unique opportunity to place health promotion at the centre of the social development. The SDGs have also created new political space for health promotion. While multisectoral action for health has been pursued for decades, there is unprecedented opportunity to work with other sectors through the SDGs to secure the requisites for health. However, global advocacy for the SDGs and UHC needs to be supported by action on the ground.

How can UHC be placed in the hands of the people?

Community engagement is the key.

Using the five health promotion actions described in the Ottawa Charter – namely: (i) developing personal skills, (ii) strengthening community action, (iii) creating supportive environments, (iv) building healthy public policy, and (v) reorienting health systems – a platform for community engagement can be constructed in any setting.

All or any of these health promotion actions can be used in a setting or locality to create the “glue” – community engagement – that ties communities to the UHC agenda and the SDGs.

Member States have used ‘healthy settings’ (i.e. places where people live, work, learn and play – whether they are cities, islands, schools, marketplaces or even hospitals) to be the interface between communities and the health system.

A renewed engagement with communities and healthy settings with a sharper focus on equity, inclusion and social coherence will place UHC into the hands of the people.

It is always tempting to seek complex solutions to complex problems. However, revisiting health promotion actions provides simple and practical reference points for fresh initiatives for participation.

It is my earnest hope that this guide will inspire local leaders around the world to unleash the power of communities to achieve irreversible change in UHC.

Let us use “work with communities” to promote health and achieve health for all, everywhere.

^a Ghebreyesus TA. All roads lead to universal health coverage. *Lancet Glob Health*. 2017;5(9):e839–e840.

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Acronyms

CCHE	Communities Creating Healthy Environments Initiative
CDSMP	Chronic Disease Self-Management Program
PAR	participatory action research
SDG	Sustainable Development Goals
SES	socioeconomic status
UN	United Nations
UHC	universal health coverage
WHO	World Health Organization

Executive summary

Background

The United Nations in 2015 adopted the 2030 Agenda for Sustainable Development – a global blueprint to address the needs of people now, without depriving future generations of the resources they need, to live dignified, healthy and meaningful lives (1,2). Universal health coverage (UHC) is part of the Sustainable Development Goals (SDGs). However, three years into implementation in some areas – particularly, in disadvantaged and marginalized groups – uncertainty of meeting the targets by 2030 has been brought to focus in The Sustainable Development Goals Report 2018 (2).

Limited progress in the achievement of health-related SDG goals have been reported, calling for bold political action, innovative resource mobilization and adaptive leadership models to drive progress in reaching the health-related targets of the SDGs by 2030 (3).

The WHO's 13th General Programme of Work (2019–2023) set the goal of one billion more people enjoying better health and well-being, which can be achieved only by strengthening community engagement efforts. Community and civil society engagements are fundamental components of any strategy to achieve all health goals and targets of the SDGs. Action on UHC and the SDGs can be expedited if strategies for community engagement are put in place in existing 'healthy settings' initiatives and localities that have SDG projects.

WHO has defined community engagement as "a process of developing relationships that enable stakeholders to work together to address health-related issues and promote well-being to achieve positive health impact and outcomes" (4).

There are undeniable benefits to engaging communities in promoting health and well-being (5–7). At its core, community engagement enables changes in behaviour, environments, policies, programmes and practices within communities. There are different levels, depths and breadths of community engagement which determine the type and degree of involvement of the people (8–10).

This guide is intended for change agents involved in community work at the level of communities and healthy settings.

The review of evidence

The guide is based on a literature review that documented a variety of definitions and terminologies used in scientific and grey literature. The review explored theory and practice on community engagement, community organization and community participation including models, conceptual frameworks, influencing factors, lessons learnt, implementation, scalability and sustainability. Unlike previous reviews that were focused on public health emergencies or clinical research, this review focused on community engagement in the context of health and well-being (11–13). The review studied results from 97 articles that were converted into a simple user-friendly reference targeted to change agents at the local level, particularly in low-resource settings.

Building on the Ottawa Charter (14), the guide highlights the importance of five health promotion actions in the context of community engagement: (i) developing personal skills, (ii) strengthening

community action, (iii) creating supportive environments, (iv) building healthy public policy, and (v) reorienting health systems.

The five different levels of community engagement – inform, consult, involve, collaborate and empower – are often referred to as levels of participation (5,8,15–18).

The work of Paulo Friere on 'empowerment'^b (18), as well as the work of Sherry Arstein on a 'ladder of citizen participation' (9) is revisited for understanding people's participation in the development of an effective community engagement strategy.

Theoretical models for community engagement include: (i) self-determination theory; (ii) behaviour change balls; (iii) community-based system dynamics; and (iv) participatory action research. These models articulate reference points that are consistent with health promotion, i.e. identification of stakeholders, social networks, community involvement using visualization techniques as well as people-centred and participatory research.

Community engagement principles, enabling factors and problems to be addressed

Community engagement principles include trust, accessibility, contextualization, equity, transparency and autonomy.

Enabling factors for successful community engagement include governance, leadership, decision-making, communication, collaboration and partnership, and resources.

Community engagement is envisioned to address a range of problems and issues, and include: (i) behavioural, cultural and social conditions; (ii) health system determinants (iii) prerequisites for health; and (iv) upstream driving forces of health.

Four approaches to community engagement

The four approaches to community engagement are introduced and juxtaposed to levels of involvement, problems to be addressed and health promotion actions.

Level 1. **Community-oriented:** the community is **informed** and mobilized to participate in addressing immediate short-term concerns with strong external support.

Level 2. **Community-based:** the community is **consulted and involved** to improve access to health services and programmes by locating interventions inside the community with some external support.

Level 3. **Community-managed:** there is **collaboration** with leaders of the community to enable priority settings and decisions from the people themselves with or without external support of partners.

Level 4. **Community-owned:** community assets are fully mobilized and the community is **empowered** to develop systems for self-governance, establish and set priorities, implement interventions and develop sustainable mechanisms for health promotion with partners and external support groups as part of a network.

^b The idea of empowerment originated in the works of Paulo Freire and has been identified as fundamental to successful community engagement.

Conclusions

- (i) Community engagement using health promotion actions of the Ottawa Charter acts as a 'glue' that links UHC to the people.
- (ii) An effective community engagement strategy should consider:
 - The people themselves, i.e. change agents, stakeholders and social networks.
 - Health promotion capability, i.e. previous health promotion actions used in the community, types of existing healthy settings (such as healthy cities, healthy islands, health-promoting schools, health-promoting hospitals, healthy villages, among others). Experiences in people's participation at the community level, i.e. levels of people's participation in the past, conditions that create trust and mistrust, relevant community engagement principles to overcome barriers to engagement. Infrastructure for community engagement, i.e. enabling factors, how problems will be prioritized, addressed, implemented and evaluated.
- (iii) Community engagement is a process and an outcome. The approaches, i.e. community-oriented, community-based, community-managed and community-owned, are not mutually exclusive, and one type is not better than the other. The appropriateness of the approach will depend on the objectives of community engagement.
- (iv) A renewed engagement with communities and healthy settings is required, using health promotion actions as the main reference points for interventions, with a sharper focus on equity, inclusion and social coherence that places UHC into the hands of the people.





PART I.

Background

Where are we?

- At least half of the world's population still does not have full coverage of essential health services.
- About 100 million people are still being pushed into extreme poverty (defined as living on US\$ 1.90 or less a day) because they have to pay for health care.
- Over 800 million people (almost 12% of the world's population) spent at least 10% of their household budget to pay for health care.
- All United Nations (UN) Member States have agreed to try to achieve universal health coverage (UHC) by 2030, as part of the Sustainable Development Goals (SDGs).
- UHC is not only about individual treatment services, but also includes population-based services such as public health campaigns, adding fluoride to water, controlling mosquito breeding grounds, among others.
- UHC also includes taking steps towards equity, development priorities, as well as social inclusion and cohesion (19).

The United Nations in 2015 adopted the 2030 Agenda for Sustainable Development – a global blueprint to address the needs of people now, without depriving future generations of the resources they need to live dignified, healthy and meaningful lives (1,2). UHC is one of the outcomes of the SDGs, however three years into implementation there is uncertainty of meeting the targets by 2030 (2), particularly for disadvantaged and marginalized groups.

Limited progress in achieving the health-related SDG goals has been reported, calling for bold political action, innovative resource mobilization and adaptive leadership models to drive progress in attaining the health-related targets of the SDGs by 2030 (3).

This guide seeks to expound on a missing piece of UHC: the participation of people in their respective communities.

Towards a Global Action Plan for Healthy Lives and Well-being for All (20) calls for three strategic approaches – align, accelerate and account, for which seven accelerators have been identified:

- (i) Sustainable financing
- (ii) Frontline health systems
- (iii) Community and civil society engagement**
- (iv) Determinants of health
- (v) Research and development, innovation and access
- (vi) Data and digital health
- (vii) Innovative programming in fragile and vulnerable states and for disease outbreak response.

Building on the work on 'healthy settings' and recognizing the power of communities is the key to achieving better health for all.

This guide seeks to expound on a missing piece of the UHC: the participation of people in their respective communities. This guide also explores how community engagement can contribute to UHC in the hands of the people through health promotion actions.

Why must we act?

The WHO's strategic directions as set out in the 13th General Programme of Work highlight the increased need for community participation and participation of the people themselves in achieving the SDGs.

Community and civil society engagement are fundamental components of any strategy to achieve all health goals and targets of SDGs. Action on UHC and the SDGs can be swifter if strategies for community engagement are put in place in existing healthy settings initiatives and localities that have SDG projects.

WHO defines communities as "groups of people that may or may not be spatially connected, but who share common interests, concerns or identities. These communities could be local, national or international, with specific or broad interests" (21).

The role of the community and civil society is essential to public health and health promotion as outlined in the Ottawa Charter for Health Promotion (14), and reiterated in the recent Shanghai Declaration on promoting health in the 2030 Agenda for Sustainable Development (22,23).

Building on the work on 'healthy settings' and recognizing the power of communities is the key to achieving better health for all.

Without community and civil society engagement, advocacy for UHC and the SDGs run the risk of more theoretical discussions with less practical action that impacts on the lives of people.

The perceived emphasis on the financing component of UHC needs to be complemented with broader and bolder efforts for: prevention of disease, population-based interventions, equity, cohesion and social inclusion. These can be addressed through health promotion actions such as (i) developing personal skills, (ii) strengthening community action, (iii) creating supportive environments, (iv) building healthy public policy, and (v) reorienting health services.

These five actions can be reapplied to places where people live, work, learn and play. The more popular healthy settings – healthy islands, healthy cities, health-promoting schools, health-promoting hospitals, healthy marketplaces – are natural starting points for community engagement.

Mindful that communities are not always characterized by solidarity and unity, a good strategy for community engagement considers the problems of polarization, marginalization and distrust. Hence, community engagement must focus on inclusion, social cohesion and building trust.

Why should we focus on community engagement?

WHO has defined community engagement as “a process of developing relationships that enable stakeholders to work together to address health-related issues and promote well-being to achieve positive health impact and outcomes” (4).

Community engagement is both an outcome and a dynamic process (24) which should result in trust, mobilized resources, and facilitation of sustainable collaborations to achieve better health and well-being outcomes (5,15,25,26).

There are undeniable benefits of engaging the community in promoting health and well-being (5–7). At its core, community engagement enables changes in behaviour, environments, policies, programmes and practices within communities. There are different levels, depths and breadths of community engagement which determine the type and degree of involvement of the people (8–10).

At the political level, community engagement works towards building sustainability, efficiency, and resilience of national health systems, by meeting the financial needs of health programmes and services, and supporting initiatives of local communities. Community engagement also facilitates the strengthening of local knowledge, skills and competencies, and can help promote involvement in public health programmes (6).

Who is this document for?

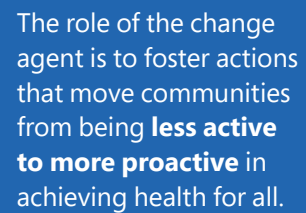
This guide is intended for **change agents** involved in development work at the level of communities and healthy settings.

Change agents are individuals who influence others to embark on change. They may be health workers, social workers, teachers, volunteers, political leaders. Just about anyone who promotes health can be a change agent.

The role of the change agent is to foster actions that move communities from being less active to more proactive in achieving health for all.

This guide can be used with or without technical assistance and training. It provides principles and approaches to community engagement as applied to public health and encourages the users to be intuitive and sensitive to context, culture and current concerns of the community.

The guide does not prescribe any one approach as a combination of approaches to different types of problems and situations is needed.



The role of the change agent is to foster actions that move communities from being **less active** to **more proactive** in achieving health for all.



PART II.

Health promotion for community ownership of universal health coverage and the Sustainable Development Goals

Health promotion actions, universal health coverage and the Sustainable Development Goals

The five actions for health promotion as articulated in the Ottawa Charter (14) are of paramount importance to achieving UHC. In the development of community engagement strategies it is useful to revisit health promotion actions, identify how each action can be used to address community health priorities, and link these to the relevant SDGs (3).

Developing personal skills

To achieve UHC, personal and social skills are needed through information and education. Improving health literacy is a cross-cutting need throughout the life-course and in all communities. Personal skills change and evolve throughout the life-course. Schools and the educational system play a critical role in enabling people to develop knowledge, skills and capability to lead healthier lives. Personal skills increase the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to good health. Without personal skills, health-seeking behaviour, compliance with medications and self-care will remain unchanged and the goals of the UHC will be difficult to meet. This is consistent with SDGs on quality education (SDG 4) and good health and well-being (SDG 3).

Improved health literacy is a cross-cutting need throughout the life-course and in all communities.

Strengthening community action

Community action involves participation of the people themselves in setting priorities, making decisions, planning strategies, as well as implementing and evaluating them to achieve better health. At the heart of this process is the empowerment of communities – their ownership

At the heart of this process is the empowerment of communities – their ownership and control of their own endeavours and intentions.

and control of their own endeavours and intentions. Community action may be as simple as an information campaign, or as complex as participatory budgeting. It is important that the leaders who promote health are able to change the circumstances of their communities or their settings. This is consistent with SDGs on sustainable cities and communities (SDG 11), reduced inequalities (SDG 10), and gender equality (SDG 5).

Creating supportive environments

A socioecological perspective on health is needed to achieve UHC. Changing patterns of life, work and leisure affect the health of a population. The impact of the environment on health has multiple dimensions: physical, social, economic, political, cultural. Healthy settings provide a platform for creating supportive environments, such as in schools, workplaces, islands, cities, marketplaces, villages. The SDGs emphasize the importance of meeting the needs of the current

The impact of the environment on health has multiple dimensions: physical, social, economic, political, cultural.

generation without compromising future generations. This includes actions to maintain and sustain the viability of the environment as a source of food, clean air and water. This is consistent with SDGs related to: no poverty (SDG 1), zero hunger (SDG 2), quality education (SDG 4), clean water and sanitation (SDG 6), decent work and economic growth (SDG 8), life below water (SDG 14), life on land (SDG 15) and peace, justice and strong institutions (SDG 16).

Building healthy public policy

UHC in the SDGs goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health outcomes.

The aim must be to make the healthier choice the easier choice for local leaders, decision-makers and policy makers as well.

Policies can include local ordinances, regulations, legislation, fiscal measures, taxation and organizational change. How financial resources are allocated is a significant indicator of a policy.

Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them. The aim must be to make the healthier choice and the easier choice for local leaders, decision-makers and

policy makers as well. This is consistent with SDGs on affordable and clean energy (SDG 7), industry, innovation and infrastructure (SDG 9), responsible consumption and production (SDG 12), climate action (SDG 13), and partnerships for the goals (SDG 17).

If health financing schemes move increasingly in the direction of health promotion and disease prevention, beyond its responsibility for providing clinical and curative services – people will be healthier and there will be less expenditures for facility-based care.

Reorienting health services

In the context of UHC, the responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. If health financing schemes move increasingly in the direction of health promotion and disease prevention, i.e. beyond its responsibility for providing clinical and curative services, people would be healthier and there would be less expenditure for facility-based care. This is consistent with SDGs on good health and well-being (SDG 3), gender equality (SDG 5), clean water and sanitation (SDG 6), reduced inequalities (SDG 10), and sustainable cities and communities (SDG 11).

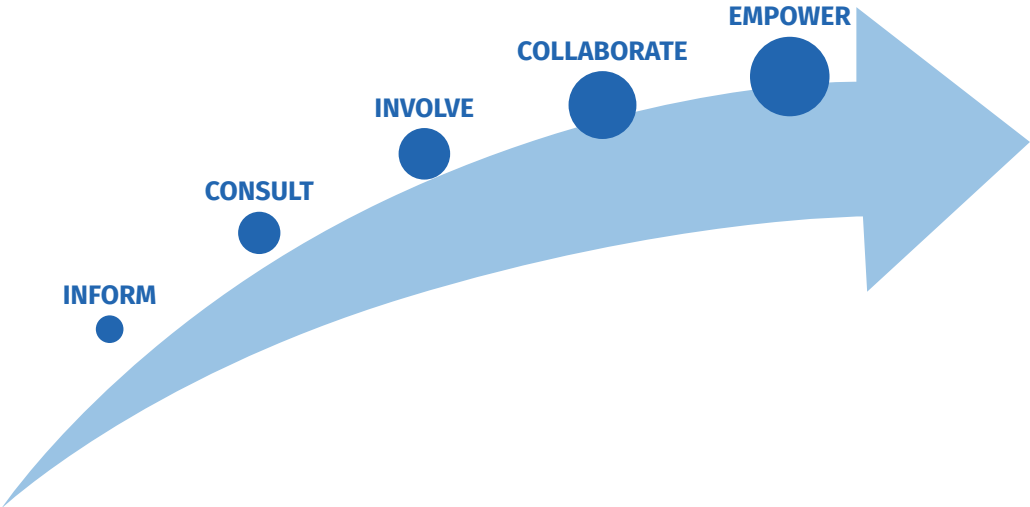
Community engagement and people’s participation

Community engagement has been described as both ‘art and science’ to develop relationships and direct collective actions towards the common good (6,15,27).

Empirical results, known theories, interventions and participatory actions to promote health community engagement show **five levels of community engagement** from involvement to community empowerment^c (5,8,15–18).

These five different levels are often referred to as the levels of participation – inform, consult, involve, collaborate and empower.

Figure 1 Levels of community engagement



Empowerment is considered a level with the highest degree of participation (16,18,28,29).

Empowerment refers to “a process by which people gain greater control over decisions and actions affecting their lives; community empowerment specifically involves people acting collectively to gain greater control over their community, including their health and the quality of life” (20). Inherently, empowerment processes involve changes in power dynamics whereby communities or individuals take control of their health and well-being, facilitated by policy: it cannot be forced upon them (16,28,29).

Sherry Arnstein’s “ladder of degrees of citizen participation” (9) showed community participation ranging from high to low.

This “ladder” model continues to be relevant and useful for knowing who has the power when important decisions are being made. In many settings, nonparticipation and tokenism are still predominant.

Thus, understanding the level of people’s participation is an important consideration in developing a community engagement strategy.

^c The idea of empowerment originated in the works of Paolo Freire and has been identified as fundamental to successful community engagement.

Theoretical models of community engagement

There are several theoretical models for community engagement, such as: (i) self-determination theory; (ii) behaviour change ball; (iii) community-based system dynamics; and (iv) participatory action research (see Annex 1 for details).

These models articulate reference points that are consistent with health promotion as listed below:

- For self-determination theory: stakeholders – their competence, autonomy and relatedness.
- For behaviour change ball: social networks – and how these build or destroy social capital.
- For community-based system dynamics: community involvement using visualization techniques and appreciative inquiry.
- For participatory action research: research and evaluation that are people-centred.



**Figure 2 Arnstein's Ladder (1909)
Degrees of Citizen Participation**





PART III.

Community engagement principles, enabling factors and applications

Community engagement principles

Principles of community engagement provide the value base for common and shared appreciation of purpose. A combination of principles is important for a community engagement strategy.

Trust

A key component to collective work (30) is trust and respect throughout the collaboration process. Building trust should commence early in the engagement. Trust can be strengthened through face-to-face interactions (31), co-planning of agendas and actions, and co-decision-making.

To build trust there needs to be an understanding regarding the importance of transparency and accountability for promoting health and well-being across society (31).

Accessibility

Lack of accessibility is a negative determinant of engagement especially as it is related to geographic, linguistic, cultural and socioeconomic access. Marginalized groups are less likely to engage, hence the need for specific strategies to reduce equity gaps.

The 2018 Global Conference on Primary Health Care in Astana, reiterated the importance and complexity of ensuring access to primary health care services (32,33). Similarly, the equity in accessibility to community engagement initiatives must be considered and should be as universal as possible, eliminating any form of barrier to participation.

Contextualization

The perspective of the people themselves in relation to community engagement is crucial. One identified barrier to effective engagement is the perception that participation is ineffective or time-consuming (34). Change agents play an important role in finding effective ways to engage with the community and to use models of engagement that create impact (35).

An initiative is of higher value (36,37) when there is local understanding and engagement, and is done consistent with language, culture and context (38,39). Understanding what is of value to the community and working on the community's perception of value leads to stronger engagement.



Equity

To effectively address the social determinants of health, equity must be placed at the centre of any public health initiative. Given that the social determinants of health often lie outside the health sector, collaboration with communities, health and non-health partners is essential to achieve health equity (40). Equity is a key principle to drive effective community engagement processes, and initiatives that successfully address the health equity agenda are closely linked to cogent engagement practices.

Transparency

Transparency is key to successful engagement of the community and considered crucial for participatory processes and decision-making. Transparency is essential for trust and can promote other enabling factors required for effective community engagement.

Autonomy

Community engagement develops autonomous and empowered individuals and communities at all levels. It can be utilized as a powerful approach to influence policy and advocate for change.

Community engagement should be integrated at all levels of governance. Opportunities for participation at the local, regional and national levels should be created through participatory governance structures and processes, legal frameworks and the scaling-up of smaller initiatives. It is essential that best practice examples of participatory national governance systems are shared at the international level too.

Enabling factors

There are a range of factors that influence success or failure of community engagement. Based on the literature, the following are the most important enabling factors that contribute to successful community engagement approaches.

Governance

Good governance, strong leadership and clear roles and responsibilities are essential when building meaningful engagement (38,41,42). Developing roles and responsibilities within the community and building on existing capacities enhances community ownership of a programme and buy-in of the community, and should be supported by participatory governance structures and processes.

Leadership

In regards to leadership, two different categories of leadership have been described: (i) the classic conception of leadership that has a top-down character and uses "position power" (43); and (ii) leadership that emerges from the community, which is more collaborative in nature and harnesses the power of a common vision and relationships instead of "position power" (34,42,44). The type of leadership considered within a programme will depend on the context and the aims of the initiative itself. Often top-down approaches can be complemented by bottom-up models and the two can work to support each other in building a holistic and sustainable engagement model.

Decision-making

Sustainability is achieved when there are joint decision-making processes that involve the community in facilitating engagement. The governance of community engagement may facilitate a handover of power and decision-making control to the community, which highlights a shift away from the utilitarian perspective of community engagement (38,39,45,46).

Communication, collaboration and partnerships

Mutual understanding and strong communication practices among the various actors at all levels is important. By creating partnerships, building networks and establishing long-term relationships, community engagement initiatives can profit from sustainability and effectiveness. Incorporating these factors at an early stage of implementation will ensure maximum impact (39,47–51). Local intersectoral coalitions can have a direct impact on the sustainability of engagement initiatives based on established collaborative partnerships (52).

Resources

In the literature, much importance has been given to the availability of resources to sustain community engagement efforts. Particularly, resources in the form of organizing capacity can greatly influence engagement. Furthermore, these empowering approaches are seen as building capacity and increasing assets in the community, thereby increasing the sustainability of community engagement (34,37–42).

Applications: Types of problems addressed by community engagement

The fundamental question in developing an effective community strategy is: What problem do we want to address using community engagement? Or stated another way, 'How can community engagement serve as part of a larger solution to a problem?

A community engagement strategy can address a wide range of concerns, issues, problems and challenges, such as:

- **behavioural, cultural and social conditions** (such as vaccination during outbreak response, awareness on harmful products, exclusion, gender-bias, drunk-driving).
- **health system determinants** (such as access to appropriate and acceptable primary health care services, information and programs for communicable and non-communicable disease, new outlets for mental health services).
- **prerequisites for health** (such as unemployment, lack of housing, lack of water and sanitation projects, lack of access of girls to education, food security).
- **upstream driving forces** (such as poverty, poor working conditions, climate change, environmental degradation, demographic change, rapid and unplanned urbanization).

Wherever there is a need to inform, consult, involve, collaborate or empower people to improve health and its determinants, community engagement principles and approaches are useful.

It is important to underscore the importance of equity in community engagement. Many efforts that engage communities result in working with people who are more likely to participate because they have advantages, resources and support groups.

It is of paramount importance that community engagement efforts strive toward inclusiveness and try to involve as many people as possible, especially those who are marginalized, vulnerable and excluded.

It is worthwhile to note that improvements in health and reduction in health inequity is more likely to occur where social initiatives address upstream determinants of health.

Interventions that are based in health facilities that provide services are less likely to reduce inequity, and instead can further marginalize vulnerable groups. As interventions shift toward public health, intersectoral coordination and social determinants of health, improvements in population health outcomes and decrease in disparities are more likely.



PART IV.

Approaches to community engagement and a checklist for developing a community engagement strategy



Approaches to community engagement for UHC

Four approaches are presented to guide the discussion on the type of community engagement that is most appropriate to a specific context or setting. There are a range of methods and tools that can be used for every approach. These approaches are not discrete, nor mutually exclusive, and a combination of features of these approaches can be used. The approaches have been linked to previously cited levels of participation, i.e. inform, consult, involve, collaborate and empower.

Community-oriented approach: the community is **informed** and mobilized to participate in addressing immediate short-term concerns with strong external support.

Community-based approach: the community is **consulted and involved** to improve access to health services and programmes by locating interventions inside the community with some external support.

Community-managed approach: there is **collaboration** with leaders of the community to enable priority settings and decisions from the people themselves with or without external support of partners.

Community-owned approach: community assets are fully mobilized and the community is **empowered** to develop systems for self-governance, establish and set priorities, implement interventions and develop sustainable mechanisms for health promotion with partners and external support groups as part of a network.

Figure 3 Approaches to community engagement



Each approach is distinct and one is not of a higher order than the other. In selecting an approach, the desired outcome should be the primary consideration. For example, in a measles outbreak, a community-oriented approach is perhaps most appropriate as the objective would be to mobilize parents to have their children vaccinated. On the other hand, in the event of a drought that requires changing of types of crops, a community-owned cooperative for seeds would be more appropriate.

It is important to determine ahead of time, the extent to which engagement and participation can benefit a health promotion intervention toward achieving UHC.

Community engagement as the ‘glue’

The matrix below provides guidance on the types of community engagement approaches that would form the ‘glue’ that links problems to health promotion actions.

Community engagement approach	Examples of types of problems to be addressed	Related health promotion actions
Community-oriented	Behavioural, cultural and social conditions (such as vaccination during outbreak response, awareness on harmful products, exclusion, gender-bias, drunk-driving)	<ul style="list-style-type: none"> • Developing personal skills • Strengthening community action • Creating supportive environments
Community-based	Health system determinants (such as access to appropriate and acceptable primary health care services, information and programs for communicable and noncommunicable disease, new outlets for mental health services)	<ul style="list-style-type: none"> • Developing personal skills • Strengthening community action • Reorienting health systems

Community engagement approach	Examples of types of problems to be addressed	Related health promotion actions
Community-managed	Prerequisites for health (such as unemployment, lack of housing, lack of water and sanitation projects, lack of access of girls to education, food security)	<ul style="list-style-type: none"> • Developing personal skills • Strengthening community action • Creating supportive environments • Building healthy public policy
Community-owned	Upstream driving forces (such as poverty, poor working conditions, climate change, environmental degradation, demographic change, rapid and unplanned urbanization)	<ul style="list-style-type: none"> • Developing personal skills • Strengthening community action • Creating supportive environments • Building healthy public policy • Reorienting health services

A checklist for the development of a community engagement strategy

The checklist tool assesses different aspects of a community engagement strategy that incorporates components discussed in the previous section. A set of questions are also provided to guide the assessment for selecting the appropriate approach.

Assessment points	Checklist	Key questions for a community engagement strategy
Types of change agents	<input type="checkbox"/> Health workers <input type="checkbox"/> Political leaders <input type="checkbox"/> Social workers <input type="checkbox"/> Teachers <input type="checkbox"/> Community leaders <input type="checkbox"/> Volunteers <input type="checkbox"/> Researchers <input type="checkbox"/> Others	<p>Who are the change agents who can make a difference?</p> <p>What is the best way to work with them to lead a community engagement effort?</p> <p>What type of social networks and influence can they leverage for community engagement?</p>
Previous health promotion actions used in the community	<input type="checkbox"/> Developing personal skills <input type="checkbox"/> Strengthening community action <input type="checkbox"/> Creating supportive environments <input type="checkbox"/> Building healthy public policy <input type="checkbox"/> Reorienting health systems <input type="checkbox"/> Others	<p>What health promotion actions are the change agents most familiar with?</p> <p><i>Note: Starting with previous experiences helps build confidence to try other actions</i></p>

Assessment points	Checklist	Key questions for a community engagement strategy
Types of existing healthy settings in the community	<input type="checkbox"/> Healthy cities <input type="checkbox"/> Healthy islands <input type="checkbox"/> Health-promoting schools <input type="checkbox"/> Health-promoting hospitals <input type="checkbox"/> Healthy villages <input type="checkbox"/> Healthy marketplaces <input type="checkbox"/> Others	<p>What types of settings exist?</p> <p>If some healthy settings exist would it make sense to start with these settings and build on them?</p>
Levels of people's participation seen in the past	<input type="checkbox"/> Inform <input type="checkbox"/> Consult <input type="checkbox"/> Involve <input type="checkbox"/> Collaborate <input type="checkbox"/> Empower <input type="checkbox"/> Others	<p>What levels of people's participation has been seen in the past? If higher levels of participation (such as collaboration and empowerment) did not occur; why not?</p>
Relevant community engagement principles for the community/ setting	<input type="checkbox"/> Trust <input type="checkbox"/> Accessibility <input type="checkbox"/> Contextualization <input type="checkbox"/> Equity <input type="checkbox"/> Transparency <input type="checkbox"/> Autonomy	<p>What do people in the community value the most?</p> <p>What values need to be underscored in the strategy to overcome barriers to engagement?</p>
Presence of enabling factors	<input type="checkbox"/> Governance <input type="checkbox"/> Leadership <input type="checkbox"/> Decision-making <input type="checkbox"/> Communication, collaboration and partnerships <input type="checkbox"/> Resources	<p>Describe the enabling factors that are present in the community.</p> <p>What are the current strengths that will ensure engagement?</p>
Priority problems identified by the community	<input type="checkbox"/> Behavioural, cultural and social conditions <input type="checkbox"/> Health systems determinants <input type="checkbox"/> Prerequisites for health <input type="checkbox"/> Upstream driving forces <input type="checkbox"/> Others	<p>What are the perceived problems in the community that are likely to result in strong community engagement?</p> <p>Make a list of the problems, and using participatory methods ask the participants to rank these based on people's perspective.</p>
Approach being considered	<input type="checkbox"/> Community-oriented <input type="checkbox"/> Community-based <input type="checkbox"/> Community-managed <input type="checkbox"/> Community-owned	<p>Choose two of the approaches that approximate the type of engagement best suited to the existing capability of the community and the perceived problems.</p> <p>Review the health promotion actions that are relevant to each approach and develop an action plan based on this.</p>





PART V.

Examples of community engagement approaches and how health promotion actions are applied

Case studies to illustrate the four approaches

The following case studies illustrate how the different approaches use health promotion actions to achieve a health outcome that emphasizes equity, inclusion and social cohesion.

Case Study 1 (53) – A community-managed approach demonstrating community action and reorienting health services

‘Casas Maternas’ in the Rural Highlands of Guatemala

‘Casas Maternas’ (birthing facilities) operate in three municipalities in the isolated north-western highlands of the Huehuetenango Department in Guatemala, where the maternal mortality ratio is high (338 maternal deaths per 100 000 live births). Casas Maternas provide trained staff, facilitate access to referral care and encourage traditional birth attendants to bring patients to deliver in these facilities.

A nongovernmental organization, Curamericas, developed and implemented the initiative in collaboration with local communities. This resulted in the provision of a simple physical facility, a small number of trained staff, some basic supplies and equipment, and a management and financial support structure embedded in the community. As of 2016, four Casas Maternas were providing services to an area with 100 000 inhabitants.

Importantly, traditional birth attendants in the communities supported the use of Casa Maternas and influenced the decision of where the births should take place. Key factors to the success of this initiative include the geographical proximity of the centres to patient’s homes, the use of culturally and linguistically adapted care, the use of staff who either lived in or were from the local community, and a sense of community ownership and accountability. In Casas Maternas, it is made sure that all staff members speak the local dialect and respect local traditional cultural practices.



Case Study 2 (54) – A community-based approach demonstrating developing personal skills, supportive environments and reorienting health services

Project RIU¹ to harness community leaders to spread healthy messages

Project RIU developed at the Alzira Centre of Public Health (Valencia, Spain), aimed to promote accessibility and utilization of health care services in vulnerable settings, in collaboration with local primary health care and social services.

Working in specific neighborhoods, it included and empowered multicultural women with leadership characteristics, to train them as community health agents (*agentes de salud*) who would spread positive health messages in the community.

Positive results of the intervention included increased social recognition and leadership ability of the '*agentes de salud*', as well as improved access and use of health services by the community, with women acquiring information about health, contraception, pregnancy and health services.

The work was facilitated by: the fact that the '*agentes en salud*' valued the project, the identification and facilitation of community-based leadership, and the municipality providing ongoing financial and technical support and working spaces.

¹ *Replica, Innova y Une – replicate, innovate and unite*

Case Study 3 (55) – A community-based approach demonstrating developing personal skills, strengthened community action and creating supportive environments.

A trading shop in the municipality of Vaals, The Netherlands

Vaals, a small town of about 10 000 residents, is located in the southernmost part of the Netherlands, near its borders with Germany and Belgium. The municipality of Vaals is regarded as a region with a moderate to low socioeconomic status when compared with the entire Dutch population. Its residents experience poorer health status, shorter life expectancy, higher rate of mental health issues, poorer health behaviours and higher chronic disease prevalence.

A 'trading shop' was founded in collaboration with citizens of low socioeconomic status, the municipality, the local health service and Maastricht University. It evolved out of the needs of the citizens, as a result of participatory action research which used Photovoice¹. The citizens stayed involved and 'in the lead' throughout the whole process to make the shop a success.

The trading shop in Vaals is a place where citizens can trade goods and services without money, meet each other, learn about their own talents and work together. It is a physical centre that has the ability to activate, motivate and connect volunteers, visitors and professionals. Its aim is to improve health and well-being among the general population in Vaals.

About 900 citizens became members of the trading shop within the first months of opening. There are 34 volunteers (from vulnerable backgrounds) who together with a trained coordinator and board, run the shop with the ambition for it to become one of the major central meeting places in the municipality.

¹ *Photovoice is a qualitative method used in community-based participatory research to document and reflect reality*

Case Study 4 (56) – A community-oriented approach demonstrating developing personal skills, strengthening community action and creating supportive environments

Intergenerational Olympic Games in the La Sidra county of Asturias, Spain

The work of the La Sidra county has long been based on the ideas of leadership and participatory governance for health (also presented in the Health 2020 policy). As part of a strategy to promote social cohesion and healthy habits in their community, children and adolescent representatives of the *Consejo Comarcal de Infancia* (County Council of Childhood), came up with the idea to hold an Intergenerational Olympics. They were later joined by elderly people groups with experience in intergenerational activities.

The objectives of the project were to promote a healthy and active lifestyle through physical activity and sport, increase the sense of identity and belonging in the municipality, improve the intersectoral coordination of community policies and resources, and develop intergenerational social cohesion. The project began after a situational analysis of health was performed in the county, using participatory action research. The project proposal was analysed in the *Mesas Intersectoriales de Salud* (Intersectoral Health Boards) of each municipality.

Once the Intergenerational Games were designed, the project coordinators presented it to the relevant politicians to gain their support and commitment. Importantly, a wide range of financial and in-kind support was received from local councils, mayors, nongovernmental organizations, schools and businesses. A further key component of the project was the use of interdisciplinary work of professionals from areas of health, social services and education. Innovative methods were used to empower those involved in the project, using public ceremonies and performances. Polls were used to evaluate the participation and learning of young members of the community, while discussion groups, including a range of politicians, staff and participants, were formed by the regional health department staff.

Case Study 5 (38) – A community-owned approach demonstrating developing personal skills, strengthening community action, creating supportive environments and building healthy public policy

The Communities Creating Healthy Environments Initiative (CCHIE) in the USA

The aim of the CCHIE was to activate communities of colour through a community-organizing approach, so that they could combat multiple social risk factors that cause childhood obesity. Through the initiative, two key risk factors were addressed: food insecurity and physical inactivity.

This initiative was born from a growing interest among community groups in linking community health with human and civil rights. From there, with the support of a national-level nonprofit organization, a national advisory committee was formed which included academics, community organizers, and experts in food, public health and policy development. This leadership team developed a call for community-owned project applications, especially from multilingual and nontraditional applicants, and provided them with technical support, such as grant-writing help. This resulted in the funding of 22 projects led by grassroots organizations or tribal nations, which received three-year grants to facilitate their communities' capacity to advocate for changes to childhood-obesity related policy, systems and environments.

These projects together were able to use comprehensive knowledge of their communities' socio-environmental conditions, political history, power dynamics, and their organizing abilities to: (i) identify priority issues, (ii) design and initiate policy-related health promotion, (iii) develop community leaders and relationships, (iv) mobilize residents for advocacy activities, and (v) achieve legislative changes.

Over 70 policies were successfully changed across 21 communities of colour, highlighting the importance of basing action within the culture, history and political context of the community. One such best practice project from Albuquerque, New Mexico undertook food justice-oriented health promotion work to improve children's access to affordable, locally grown, healthy foods. Along with the community, the project restored cultural gardening practices, converted vacant properties into urban community gardens and also integrated healthy foods into school meals in the area. These changes resulted in the inclusion of a US\$ 1.44 million bill into the state budget which allowed public schools to use locally grown produce.

Case Study 6 (45) – A community-oriented approach demonstrating developing personal skills, creating supportive environments and reorienting health services

Using dynamic systems mapping to improve childhood asthma care

Researchers and intersectoral practitioners came together to understand caregiver and provider behaviour on adherence to childhood asthma plans. They aimed to use dynamic systems mapping to produce diagrams that would allow translation of evidence and theory into practice, thereby improving the co-creation of asthma action plans.

The first step in the process involved bringing together a group of actors with expertise in systems dynamics, health services, health behaviour and asthma. It was recommended that patients and their parents or caregivers should also be incorporated in this process. Team model building was then used to achieve a common understanding of the relevant health and behaviour change theories. The group then co-defined the issue and its determinants. They decided to focus on understanding the system forces that determine the effectiveness of asthma management interventions. The system boundary was later defined, and the group specifically focused on the objectives of an asthma action plan and the target population of young children.

Key variables were then identified through group discussions, resulting in a list of 55 factors which are potentially relevant to chronic disease management in the context of childhood asthma. The most relevant factors were then mapped using causal loop diagrams, to understand the different forces which determine the management of asthma by the carer. The group also discussed how these variables can change, what can influence the change and what the consequences of the variables are. Finally, the group generated potential explanations for the system forces which led to successful or unsuccessful care being given, thereby identifying key leverage points for future interventions. Overall, this process led to a deeper understanding of the complex factors which determine caregiver behaviour and helped to identify key 'leverage points' to target through interventions.

Case Study 7 (44) – A community-oriented approach demonstrating developing personal skills and reorienting health services

Implementing the Stanford Chronic Disease Self-Management Program with Aboriginal communities

The Stanford Chronic Disease Self-Management Program (CDSMP) aims to increase the capacity of people to self-manage their chronic disease and health. The CDSMP involves participatory and peer support activities and can be delivered by trained peer leaders or health professionals. This programme had been implemented in the Australian state of Queensland, but with very low voluntary participation of the local Murri (Aboriginal) people. Researchers thought that the programme may need to be made more accessible for it to be adapted to the local people and their context; for which the indigenous researchers involved in the programme explained that it would be necessary to allow the indigenous people to voice their experiences and opinions. Culturally appropriate interviews and focus groups were then developed, which respected indigenous ways of understanding the world, incorporated opportunities for participation and enabled them contribute to the health policy design.

From the research it was found that self-management programmes needed to: (i) be more responsive to local systems and structures, (ii) incorporate local cultural traditions and knowledge bases such as 'bush medicine', (iii) use locally accepted forms of cultural communication such as collective gatherings, and (iv) facilitate the development of the local Murri leadership networks to drive health promotion in the community. These factors determined the experience of the programme within each community, ultimately influencing its acceptability, effectiveness and sustainability. This study showed that unless health interventions are based on local cultural knowledge and processes, they are likely to fail.

Case Study 8 (47) – A community-owned approach demonstrating developing personal skills, strengthening community action, creating supportive environments and building healthy public policy

Cwmni Bro Ffestiniog – supporting the communication of community enterprises

Blaenau Ffestiniog was the second largest town in northern Wales in the year 1990. However, the decline of the slate industry meant that the population was reduced to half in 2000, which resulted in Blaenau Ffestiniog becoming one of the areas of the United Kingdom of Great Britain and Northern Ireland with the least economic resources.

Twelve of the town's social enterprises together formed Cwmni Bro Ffestiniog, a community company which operates in Blaenau Ffestiniog and neighbouring towns and villages. The aims of the company are to promote cooperation between the enterprises, support the creation of new enterprises and to work with small businesses in the community.

Cwmni Bro Ffestiniog has the highest per head community-led social enterprise ratio in Wales including ventures such as, hotels, cafes, tourist information centres, leisure centres, mountain biking centres, retail, horticulture, energy saving projects, arts and crafts workshops as well as educational and cultural activities.

The company believes in effective communication methods to facilitate community engagement and focuses their efforts towards these. BROcast Ffestiniog, a digital community service, has been broadcasting since July 2018. This has created a communication platform for the social enterprises. Since its launch, the company has been able to further strengthen the engagement between the enterprises, allowing them to have a long-term sustainable impact.

Conclusions

- Community engagement using health promotion actions of the Ottawa Charter acts as a 'glue' that links UHC to the people.
- An effective community engagement strategy should consider:
 - The people themselves, i.e. change agents, stakeholders and social networks.
 - Health promotion capability, i.e. previous health promotion actions used in the community, types of existing healthy settings.
 - Experiences in people's participation at the community level, i.e. levels of people's participation in the past, levels of trust and mistrust, relevant community engagement principles to overcome barriers to engagement.
 - Infrastructure for community engagement, i.e. enabling factors, how problems will be prioritized, addressed, implemented and evaluated.
- Community engagement is a process and an outcome. The approaches, i.e. community-oriented, community-based, community-managed and community-owned, are not mutually exclusive, and one type is not better than the other. The appropriateness of the approach will depend on the objectives of the community engagement.
- A renewed engagement with communities and healthy settings is required, using health promotion actions as the main reference point for interventions, and with a sharper focus on equity, inclusion and social coherence that places UHC into the hands of the people.





Annex 1.

Theoretical models for community engagement



Behaviour change theories

Self-determination theory

Self-determination theory describes how the satisfaction of basic human needs and goals is a key determinant of human motivation, as is the process of achieving such goals (57). The theory highlights the importance for health and well-being of satisfying the needs for competency, autonomy and connectedness. The theory also states that leadership and communication styles influence whether or not people's needs are being met.

Successful community engagement approaches therefore should address the competence, autonomy and relatedness of key stakeholders.

Behaviour change ball

Behaviour change ball incorporates capability, opportunity and motivation to reflect behaviours of intermediaries to induce processes that lead to intersectoral collaboration. Such ideologies can help organizations and groups to assess their position in a broad and typically 'wicked' health system (the so-called "attractor landscape"), and identify elements that can bring about change (58,59). Behaviour change ball identifies key organizational behaviours of intermediaries, including leadership, agenda setting, policy formulation, adaptive management, network formulation, innovation, teamwork and implementation, across strategic, tactical and operational levels.

Behaviour change ball incorporates the importance of identifying social networks of relevant stakeholders in relation to health (60–62).

Community-based system dynamics

System dynamics emerge from our ability to create mental models representing our thinking, and combine them with computer-simulated formal models to help us “uncover and understand endogenous sources of system behavior” (63).

The basic idea of system dynamics has been applied (15) in various settings to involve communities to create informal causal maps and use formal models to make explicit mental models. Possible explanations about their underlying logic and assumptions about system behaviour can then be tested. Additionally, causal loop diagrams are used to display feedback loops which exist within a system, allowing for causal relationships between variables to be assessed.

This model incorporates concepts such as the Group Model Building by facilitating teamwork, using visual representations and scripts, and identifying participants through gatekeepers, to truly engage the community in solving problems using participatory actions (15,64–66).

Participatory action research

Participatory action research (PAR) aims to put communities and participants, and their needs and desires at the centre of research. It apposes research, planning and intervention in a reflective process, to create transformative social change (67). It brings together communities to jointly analyse and reflect on issues that affect them, after which they can co-design and co-create projects to reduce health inequities, also incorporating participatory monitoring and evaluation. PAR can facilitate the self-organization of communities and contributes to the development of more democratically active citizens (68–70).

Based on the same premises as PAR, community-based participatory research has been described to address many of the health related challenges (68). This provides evidence of PAR being an effective model to facilitate engagement processes in health settings where the desirable engagement levels are involve, collaborate and empower.

Annex 2.

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