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## Perspectives

# An evidence-based framework on community-centred approaches for health: England, UK

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## Summary

Community participation is a central concept for health promotion, covering a breadth of approaches, purposes and activities. This paper reports on a national knowledge translation project in England, UK, which resulted in a conceptual framework and typology of community-based approaches, published as national guidance. A key objective was to develop a conceptual framework linked to sources of evidence that could be used to support increased uptake of participatory methods across the health system. It was recognized that legitimacy of community participation was being undermined by a scattered evidence base, absence of a common terminology and low visibility of community practice. A scoping review, combined with stakeholder consultation, was undertaken and 168 review and conceptual publications were identified and a map produced. A ‘family of community-centred approaches for health and wellbeing’ was then produced as way of organizing the evidence and visually representing the range of intervention types. There are four main groups, with sub-categories: (i) strengthening communities, (ii) volunteer and peer roles, (iii) collaborations and partnerships and (iv) access to community resources. Each group is differentiated using key concepts and theoretical justifications around increasing equity, control and social connectedness. An open access bibliography is available to accompany the framework. The paper discusses the application of the family of community-centred approaches as a flexible planning tool for health promotion practice and its potential to be used as a framework for organizing and synthesizing evidence from a range of participatory methods.

**Key words:** community participation, typology, evidence-based practice, empowerment, public health

## INTRODUCTION

Building on an international tradition that places community participation and empowerment central to health promotion, recent international statements have

reaffirmed the role of civil society in delivering improvements in population health and tackling health inequity (World Health Organization Regional Office for Europe, 2012; World Health Organization, 2016).

The perennial challenge for health planners and practitioners is to translate aspirational statements into meaningful, effective programmes that involve and empower communities, whether those communities are geographic or linked by shared interests (Laverack, 2006). Community participation is a multi-dimensional and somewhat nebulous concept covering a breadth of approaches, purposes and types of actions that denote an active role for citizens in shaping their health and the conditions that create good health (Bracht and Tsouros, 1990). Attention to process and context is key and therefore standardized approaches implemented at scale are the exception not the rule (Rifkin, 2014). This creates difficulties for those wishing to synthesize evidence of what works or to select practical methods from an extensive range of community-based interventions. Moreover, despite a rich and methodologically varied evidence base, participatory approaches have not received the same degree of recognition as more traditional prevention programmes within the field of public health. This paper presents a flexible framework for understanding, mapping and planning participatory approaches for health and wellbeing developed in England, UK. It discusses how this framework addresses legitimization challenges around evidence that form barriers to wider adoption of participatory methods. Challenges are grouped into three themes: epistemological, definitional and socio-political.

The contested nature of evidence for population health (Raphael and Bryant, 2002) is key to understanding the first set of legitimization challenges (*epistemology*). The continued dominance of professionally-derived knowledge built on epidemiological and experimental studies means that experiential and lay evidence, often core to the evaluation of community participation, is less valued (Springett *et al.*, 2007). In public health research, the balance is more often towards measurement of disease not health, and individual-level risk factors not community-level outcomes (Morgan and Ziglio, 2007). Overall, this creates conflicting expectations of what is required for ‘proof of effect’ and what is useful for health promotion practice, as context, culture and capacity are all deemed critical for understanding community processes and impacts (Trickett *et al.*, 2011). Rifkin (2014) argues that the contextual nature of community participation results in a lack of generalizable evidence, which in turn undermines the wider acceptance of these approaches.

The second challenge (*definitional*) is how a body of knowledge characterized by complexity (Cornwall, 2008; Preston *et al.*, 2010) can be synthesized and models differentiated. There is a lack of consistent

terminology around core concepts with a whole plethora of variant terms found within international literature, such as citizen participation, co-production, public involvement and social action (Sarrami-Foroushani *et al.*, 2014). Terms such as ‘empowerment’ may be used with little precision (Woodall *et al.*, 2012) and ‘community’ is itself a contested term subject to interpretation (Yerbury, 2012). A recent systematic review on community engagement and inequalities (O’Mara-Eves *et al.*, 2013) reported that only 8 of the 361 included papers used terms relating to ‘community’ in their title or abstract. Reflecting a similar definitional issue, a scoping review on lay health workers by two of the authors found 70 plus descriptors in international academic literature and these mostly differed from terms used in UK health programmes (South *et al.*, 2013).

The third legitimization challenge (*socio-political*) arises because the generation of evidence is shaped by the socio-political context in which participation occurs (Raphael and Bryant, 2002; Slutsky *et al.*, 2017). In the UK, as in other countries, community participation initiatives can be at the mercy of policy and funding cycles. Evidence is often assessed early in programme implementation and all too frequently programmes are replaced by newer initiatives (Judge and Bauld, 2006). Threats to sustainability make it difficult to synthesize evidence across models. Additionally, there is a publication bias in international literature towards reporting professionally-led interventions with formal evaluations (South *et al.*, 2013), while evidence from community-led activity often remains hidden (Preston *et al.*, 2010).

In summary, the net result of these three legitimization challenges is a dispersed evidence base for participatory approaches in health (O’Mara-Eves *et al.*, 2013; Sarrami-Foroushani *et al.*, 2014). Overall the lack of a shared language of participation, combined with the importance of contextual knowledge (Trickett *et al.*, 2011), impedes knowledge exchange about potentially transferable models.

Having briefly described the challenges, this paper now reports on a knowledge translation project, which was jointly funded and steered by two national health agencies -NHS England and Public Health England (PHE). The project rationale was the need for better knowledge translation to underpin wider adoption of participatory approaches. Notwithstanding a long tradition of community development in the UK (Fisher, 2011), the health system in England had been slow to recognize the contribution of participatory methods in comparison with individual-level lifestyle interventions. A key objective was therefore to develop a conceptual framework linked to sources of evidence that

could be used to support application in practice. In 2015, 'A guide to community-centred approaches for health and wellbeing' (PHE and NHS England, 2015) was published and this introduced a new typology—the family of community-centred approaches for health and wellbeing—as a means of organizing knowledge and understanding the diversity of intervention types. This paper briefly explains how the family was developed prior to presenting the main features.

## METHODS

The 'family of community-centred approaches for health and wellbeing' was developed within a broader conceptual framework that summarizes evidence-based justifications for community participation and the determinants of community health (PHE and NHS England, 2015). An iterative process of identifying concepts and grouping interventions, refined through stakeholder consultation and further mapping of literature, produced an explanatory framework (family tree) that represented the range of approaches. The first stage of this process involved a systematic scoping review of reviews with the aim to map evidence in relation to key concepts, main intervention types, outcomes and any potential frameworks to organize evidence on community participation. Systematic scoping reviews are particularly informative in topic areas that cross traditional disciplinary boundaries (Centre for Reviews and Dissemination, 2009) and can be used to clarify key concepts and report on the types of evidence that inform practice in a topic area (The Joanna Briggs Institute, 2015). They involve a comprehensive and systematic search of published and 'grey' literature, with attempts to locate unpublished studies, but here is no attempt to synthesize the evidence beyond a thematic narrative summary or 'map' (Arksey and O'Malley, 2005).

Due to the breadth of this topic, the systematic scoping review was limited to secondary research (systematic reviews and other research overviews) as this was considered to be the best approach to identify major intervention types and models. Five electronic databases were searched, from January 2004 to April 2014: MEDLINE, IDOX Information Service; CINAHL, Social Policy and Practice and Academic Search Complete. Search terms included synonyms for community/public; concept/review; approaches/interventions; health/wellbeing; inequalities. The full search strategy can be found in the open access bibliography (Bagnall *et al.*, 2015). In addition, 67 websites were searched for published and unpublished literature. Other sources

were experts' libraries; stakeholder input and reference lists of key publications. Titles and abstracts were screened by two reviewers against exclusion and inclusion criteria, with disagreements resolved by discussion within the academic team.

The electronic searches found 4129 titles and abstracts, plus 63 documents obtained from websites and personal libraries of experts (Figure 1). After screening, 168 sources were included to produce a map of relevant secondary and conceptual research (Arksey and O'Malley, 2005). Coding using Microsoft Excel then SPSS statistical software was carried out by one reviewer with a random selection checked by a second reviewer. Coding categories included: study type; population; intervention approach; source and whether health and wellbeing outcomes were reported. Relevant review publications encompassed a range of study types (Figure 1). Of these studies, 84 were carried out in and/or were directly relevant to the UK.

The next stage involved designing an initial 'family tree' structure to help map interventions. Three groups of approaches were informed by the theories of change articulated by O'Mara-Eves *et al.* (2013): (i) empowerment, (ii) lay/peer involvement in delivery and (iii) patient/consumer involvement in development. A fourth group was added on connections with community resources. The family was then broadened to reflect the scope of UK and international practice and the importance of interventions that increase social participation (Piskur *et al.*, 2014). The initial family typology was tested for relevance, clarity and fit with practice through discussions with a number of stakeholders working at a national level, two workshops with public health practitioners and a presentation to voluntary sector representatives attending a national strategic network.

The final stage of development involved mapping the scoping review results back to the emerging typology and expanding sub-categories. Some reviews ( $n=21$ ) listed multiple types of interventions (e.g. Coulter, 2010; Elliott, 2012) and these were mapped against the family, leading to additional interventions being included. Theoretical papers were not mapped to the family unless they presented categories of interventions. A final narrative account including definitions was produced to accompany a visual representation of the typology (Figure 2).

## RESULTS

The family of community-centred approaches is presented within national guidance for working with communities,

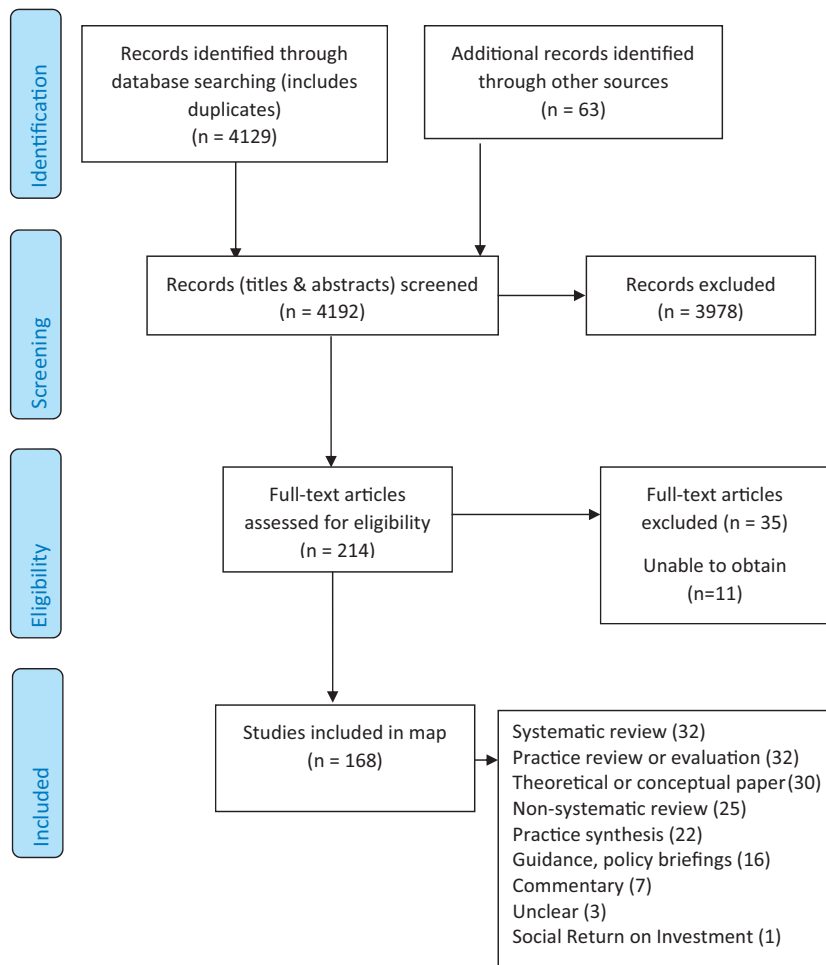
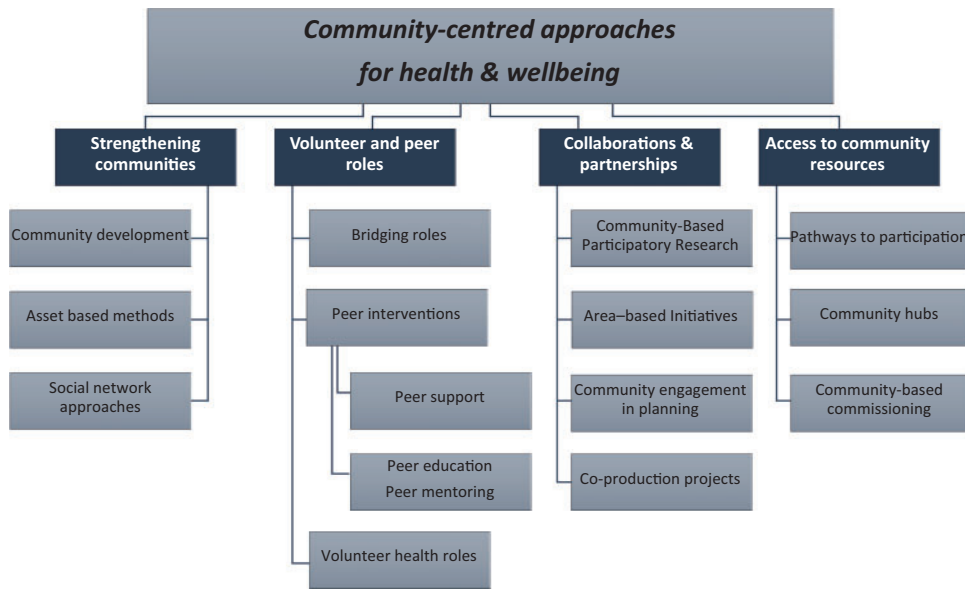


Fig. 1: Study selection flow chart.

including communities of identity as well as those linked geographically (PHE and NHS England, 2015). There is an accompanying open access bibliography, listing the 168 publications from the scoping review (Bagnall *et al.*, 2015). The family is situated within a social model of health where community capital is deemed a major determinant (The Marmot Review, 2010) and the lay contribution is valued (Morgan and Ziglio, 2007). Participatory approaches are acknowledged as a mechanism for addressing power imbalances and for changing social conditions, particularly where populations experience marginalization (Wallerstein, 2002). Based on the review of conceptual literature, three central concepts underpin the justifications for, and definitions of, community-centred approaches: empowerment, equity and social connectedness. This distinguishes community-centredness

from community-based interventions that merely engage ‘target’ populations as recipients of professionally-led activities. Community-centred approaches:

- i. recognize and seek to mobilize assets within communities, including the skills, knowledge and time of individuals and the resources of community organizations and groups
- ii. focus on promoting health and wellbeing in community settings, rather than service settings, using non-clinical methods
- iii. promote equity in health and healthcare by working in partnership with individuals and groups that face barriers to good health
- iv. seek to increase people’s control over their health and lives



**Fig. 2:** The family of community-centred approaches for health and wellbeing (source: PHE and NHS England 2015: 17). This image is made available through the Open Government Licence (<http://www.nationalarchives.gov.uk/doc/open-government-licence/> (last accessed 14 November 2017)) which is a non-exclusive licence.

- v. use participatory methods to facilitate the active involvement of community members (PHE and NHS England, 2015: 15).

The ‘family of community-centred approaches for health and wellbeing’ covers four major groups: (1) strengthening communities, (2) volunteer and peer roles, (3) collaborations and partnerships and (4) access to community resources. A range of interventions, models and methods are mapped to each group, illustrating the heterogeneity of community practice. Sub-groups are identified where approaches share common characteristics; however, it is recognized that there are shared features between groups and sub-groups. [Figure 2](#) shows the visual map of approaches as a family tree and [Table 1](#) provides a summary of the four groups and sub-groups, mapped against examples and outcomes identified through the scoping review. In the guide, a mechanism of change is provided for each group in order to articulate an explanatory account of how these approaches work, including a hypothetical causal pathway between participation, intermediate outcomes and the goals of promoting empowerment, equity and social connectedness. The four groups are therefore distinguished by their focus and means to achieve outcomes, as summarized below:

- i. *Strengthening communities*—where approaches involve building on community capacities to take collective action on health and the social determinants

of health. There are three sub-groups: community development ([Minkler, 2012](#); [Durie and Wyatt, 2013](#)); asset-based approaches ([Foot and Hopkins, 2010](#)) and social network approaches ([Heaney and Israel, 2008](#)). The key processes are community organizing and capacity building, social action and mutual aid focused on social networks within communities ([Laverack, 2006](#); [Minkler, 2012](#)). These approaches tend to be developmental in nature and individual- and community-level outcomes occur as involvement deepens and community members build social action independent of professional services.

- ii. *Volunteer/peer roles*—where approaches focus on enhancing individuals’ capabilities to provide health advice, information and support or organize activities in their or other communities ([Lewin et al., 2005](#)). The purpose of roles and peer identity define the sub-groups: bridging roles, such as community navigators; peer-based interventions and volunteer (non-peer) health roles ([South et al., 2013](#)). There is a wide range of lay health worker interventions in the public health field, in the UK and internationally ([World Health Organization, 2007](#)). In general, these approaches work through utilizing and enhancing the skills, knowledge and commitment of individuals, thereby building community capacity. Whilst the focus is often on the delivery of community-based programmes, a key mechanism is

**Table 1:** Community-centred approaches for health and wellbeing—map of intervention types

Group	Main intervention types	Examples of approaches used in UK	Number of studies—All (UK studies)	Key processes	Example outcomes
Strengthening communities	a. Community development	Community development and health projects; community organizing; Asset Based Community Development; asset mapping; C2—Connecting Communities; time banking; men's sheds.	57 (UK = 27)	Community organizing; community capacity building Critical awareness raising and advocacy Strengthening social networks; mutual aid	Increased self-esteem, confidence and sense of control Increased civic engagement; community influence Improved social networks and social support Improvements in physical environment, local services and community infrastructure
	b. Asset-based methods				
	c. Social network approaches				
Volunteer and peer roles	a. Bridging roles	Community health educators; community navigators; health champions; community food workers; breastfeeding peer support; volunteer-led health walks; befriending schemes.	35 (UK = 19)	Lay health worker recruitment, training and support Strengthening social networks; community capacity building Outreach with cultural connectors	Increased knowledge, confidence and skills Health behaviour change; improved mental health Education and employment opportunities (for LHWs) Increased service uptake and reach
	b. Peer-based interventions				
	c. Volunteer health roles (non-peer)				
	d. (empty)				
Collaborations and partnerships	a. Community-Based Participatory Research	Area forums; open space events; citizens' juries, rapid participatory appraisal; participatory budgeting; co-production projects; neighbourhood renewal; Health Action Zones.	56 (UK = 25)	Community leadership and capacity building Organizational and professional development Coalition building Service redesign	Increased knowledge, skills and confidence Increased community representation and influence Improvements in neighbourhoods and local services Improved access to and uptake of services
	b. Area-based initiatives				
	c. Community engagement in planning				
	d. Co-production projects				
Access to community resources	a. Pathways to participation (community referral)	Social prescribing; Arts on prescription; green gyms community hubs in faith settings; healthy living centres; community-based commissioning frameworks	14 (UK = 11)	Widening access and participation; reducing barriers Community capacity building Partnership working between VCS and primary health care; development of referral pathways	Reduced social isolation; increased social support Increased opportunities for volunteering, education and social participation Strengthened community infrastructure Increased service capacity
	b. Community hubs				
	c. Community-based commissioning				

- the utilization of natural, or in some instances created, social networks to reach underserved communities (Rhodes *et al.*, 2007).
- iii. *Collaborations and partnerships*—where approaches involve professionals/public bodies working in partnership with communities at any stage across the planning cycle from deciding needs and priorities, to service design, delivery or evaluation. This is a broad strand ranging from consultation methods where there might be minimal shifts in power, through to interventions that place priority setting and resource allocation into the hands of communities. The four sub groups are: Community-Based Participatory Research (Minkler, 2010); area-based initiatives where community participation is integral to action on the wider determinants in a neighbourhood or city (Burton *et al.*, 2004); co-production approaches based on equal and reciprocal relationships between professionals and service users (Realising the Value, 2016) and community engagement in planning (Coulter, 2010) and priority setting (SQW Consulting, 2011). Collaborative approaches require community leadership and capacity building combined with organizational and professional development (Harden *et al.*, 2015), with the goal of creating more equitable, needs-based services and area improvements.
  - iv. *Access to community resources*—where approaches focus on connecting people to community resources and opening up opportunities for social participation and social inclusion. Based on an understanding of the breadth of the voluntary and community (non-governmental) sector (VCS) and its key role in addressing unmet health needs and marginalization (NHS Future Forum, 2011), these approaches establish referral routes, reduce barriers to social participation and volunteering, and commission and coordinate community-based group activities. Reflecting different levels through which participation is supported, the three sub-groups are: Pathways to participation, including social prescribing and other types of non-medical referral systems (Scottish Community Development Centre, 2013); community hubs (Hunter, 2007) and holistic models of community-based commissioning (Cabinet Office Social Exclusion Task Force, 2010).

## DISCUSSION

The family of community-centred approaches for health and wellbeing is broader in scope and more upstream in emphasis compared with other identified typologies, many of which focus on consumer and community involvement

in health care (e.g. Oliver *et al.*, 2008; Mittler *et al.*, 2013; Sarrami-Foroushani *et al.*, 2014). Clarity over purpose and attention to process are recurring themes in community participation literature (Cornwall, 2008; Draper *et al.*, 2010). Like Rosato's recent framework for community interventions in global health (Rosato, 2015), the family reflects these themes in differentiating how approaches work, with reference to available theoretical literature. The theories of change developed by O'Mara-Eves *et al.* (2013) proved a good starting point, but these were identified from a systematic review drawing mostly on randomized controlled trials from outside the UK. Our approach was more pluralist and whilst the first legitimization challenge of 'what counts as evidence' remains contested territory, a more rounded picture was gained because some practice-based evidence was included (Figure 1). Nonetheless, there were limitations with the desk-based review, which included only secondary level evidence and could not map the richness of community practice. As this was a broad topic, we applied a study design filter to increase specificity, thereby reducing the number of irrelevant hits, and included only English language publications. This may have resulted in some relevant review-level evidence being missed, including non-UK sources.

The development process involved stakeholder consultation and, although limited in scope, this was of value in testing the relevance and practical significance of the overall framework. It was not possible to involve communities in this process, except through voluntary sector representatives and this is a major limitation. The family of community-centred approaches was deemed to have good face validity as a typology according to feedback from those in policy, practice and academia. A consistent theme was stakeholders' preference for the term 'approaches' rather than 'interventions', as this was considered to encompass ways of working as well as more formal interventions (Preston *et al.*, 2010). Also that while the 'family' brought clarity around types of approaches, comprehensive health promotion interventions in practice might operate across more than one category. The family is therefore situated within a body of literature that acknowledges the primacy of process in understanding community participation practice (Laverack, 2006; Draper *et al.*, 2010).

The project aimed to address the lack of shared terminology and a fragmented knowledge base (the second legitimization challenge). The family tree structure was adopted as a visual representation of the range of, and interrelationships between, participatory approaches. This could be viewed as an over simplistic representation, reducing the complexity of participation processes to a 'menu of interventions'. This was not the intention,



although there is a tension between making evidence more accessible by highlighting practical models and ensuring complexity is represented. Our approach has been to create a flexible and inter-linked framework that acknowledges the wealth of UK and international evidence in this field. In other words, attempts to map and define are there to aid the end user navigate and apply evidence, not to impose rigid categorizations. Variations can occur across a number of dimensions, for example, whether the intervention is focused on wider determinants or on individual health behaviours. The scoping review identified a range of international literature covering different populations and types of inequality; however, there is scope to explore the fit of the family when working with specific communities of interest or identity and in socio-cultural contexts outside the UK. A key conclusion is one of pluralism, recognizing the diversity of participatory methods used in health promotion.

Analysis of power is central to many conceptual frameworks on participation (Jolley *et al.*, 2008; Oliver *et al.*, 2008; O'Mara-Eves *et al.*, 2013). We chose not to assess which are or are not 'empowerment' approaches because the term is not applied consistently in published literature (Woodall *et al.*, 2012) and empowerment should be core to all community-centred practice. Other aspects of community participation also have significance (Cornwall, 2008) and the decision to use social connectedness as an organizing concept influenced the range of intervention types included, for example befriending and social network approaches. This reflects two sets of arguments: strong evidence on social relations as a major determinant of health (Holt-Lunstad *et al.*, 2010) and recent debates that social participation should be seen as part of a spectrum of involvement (Piskur *et al.*, 2014).

One major limitation of the family is the exclusion of citizen advocacy and protest (Wallerstein *et al.*, 2011), although the importance of these forms of social action are acknowledged in the guide. Laverack (2012) argues that contemporary health promotion practice needs to engage with health activism. Community-centred approaches should be seen as complementing community-led action and moreover can be used to build alliances around issues of social justice. A critical perspective should be maintained, recognizing that social-political context influences patterns of public participation at the macro-level (Slutsky *et al.*, 2017) and through exclusionary processes driven by inequalities between and within communities.

### Application to practice

The project aimed to improve knowledge translation of community participation evidence thereby supporting

wider uptake within public health. The publication of the guide was followed by wide dissemination by the two national agencies, NHS England and PHE. Subsequently the UK National Institute for Health and Care Excellence (NICE) (2016) recommended that health planners, commissioners and practitioners use the family alongside NICE guidance on community engagement. The guide has also informed and influenced policy direction and delivery within the two national agencies. Endorsement of community-centred approaches within national strategy and guidance has helped gain greater recognition of community participation as core to public health. Perhaps more critically, and despite definitional issues, legitimacy has been enhanced through acknowledgement of existing research and identification of practical models. Building transferable learning can help counter the threat of short-term policy cycles to the sustainability of community practice.

The family of community-centred approaches has value as a planning tool to identify evidence-based options for working with communities and addressing community-level determinants of health and wellbeing. The flexible structure, highlighting alternative methods and mechanisms, means it can be applied to a range of health improvement programmes and work with different population groups. In England, we have seen some districts, and also individual community-led organizations, adopting the family as a framework for whole system approaches to working with their local populations. This requires action across all four groups and is consistent with a top-down, bottom-up parallel tracking approach to community empowerment (Laverack, 2011).

There is a potential application to research, primarily as a tool for organizing evidence, which may help in the construction of an evidence base for community participation (Sarrami-Foroushani *et al.*, 2014; Rifkin, 2014). Notwithstanding the UK orientation, particularly in identification of exemplar interventions, the family provides an inter-linked typology that is rooted in an international literature. Transferability would need to be tested, including with communities, but we believe that the family of community-centred approaches does have wider relevance and offers a flexible framework to guide identification of alternative approaches.

### CONCLUDING REMARKS

This paper has reported on a UK project that sought to draw together and disseminate evidence on community participation to support a shift to a more community-oriented public health system. The development of national guidance led to the introduction of a conceptual

framework mapping participatory intervention types, which has helped shape national strategy and local practice. The family of community-centred approaches for health and wellbeing comprises four major groups: strengthening communities; volunteer and peer roles; collaborations and partnerships and access to community resources. Whilst there are inherent difficulties applying a retrospective categorization on a field characterized by diversity, we believe that the family provides a flexible framework to help navigate the evidence base and identify potential approaches for working with communities to achieve health goals. Further evaluation is needed to assess the application and impact of this conceptual framework as a planning tool. Its transferability outside the UK needs testing, but hopefully the 'family tree' can evolve when applied in other contexts. Acknowledging the breadth and variety of participatory approaches, aligning evidence and providing definitions help address legitimization challenges that undermine wider adoption in health systems. At a community level, taking a pluralist perspective on interventions support the developmental nature of health promotion practice where the best programmes are ones designed with people not for them.

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