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REVIEW

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Community engagement to promote health and reduce inequalities in Spain: a narrative systematic review

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Abstract

Objectives Over the past decade, increasing attention has been paid to community engagement in health (CEH) across Europe. This study aimed to identify and review CEH interventions to promote health and reduce inequalities within the Spanish context and the key facilitators for these community processes.

Methods A systematic search in six databases, followed by a forward citation search, was conducted to identify implementation literature on CEH in Spain. Articles were included when engagement occurred in at least two stages of the interventions and was not limited to information or consultation of stakeholders.

Results A total of 2023 results were identified; 50 articles were reviewed full text. Five articles were finally selected for inclusion. Data were extracted on various factors including details of the interventions, results achieved, stakeholders involved and their relationships. A narrative synthesis was performed to present results and support the discussion.

Conclusions Three main points are discussed: the role of professionals and citizens in CEH interventions, providing training to enable a reorientation towards a CEH practice and the relevance of contexts as enablers for community engagement processes to thrive.

Keywords Community engagement · Review · Health inequalities · Public health planning

Introduction

Over the past decade, in Spain, there has been a growing interest in the role of community engagement in health (CEH) among both professionals working in public health and primary health care, as well as among community members and policy-makers. Different publications have brought CEH to the core of public health debates in the Spanish context, ranging from reflections on key theoretical aspects of participation in health (Segura 2010), on the

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different ways of understanding it (Escartín Lasierra et al. 2015) or implementing it (Ruiz-Azarola et al. 2012), or on how to enhance community participation from primary health care and public health services (March et al. 2014; MSSSI 2013). Nonetheless, 40 years after the Alma Ata Declaration, which posed participation as a right and a duty of individuals and families in the community (International Conference on Primary Health Care 1979), and 30 years after the Ottawa Charter which considered it essential in interventions to promote health (WHO 1986), we continue to debate on how to improve people's engagement in taking decisions about the health of their communities and in the planning of community interventions.

To support such processes of implementing community engagement, over the past 2 years, the AdaptA GPS Project (from its Spanish acronym: Adapt and Apply Health Promotion Guidelines) has been carried out to translate and adapt the NICE Guideline NG44 on community engagement to improve health and well-being and reduce inequalities (NICE 2016) to the Spanish context. This resulted in the publication of a guideline in Spanish with recommendations based on the evidence in relation to the CEH and the reduction in inequalities (Cassetti et al. 2018b) within the Spanish context.

As part of the AdaptA GPS Project, a review was carried out to explore evidence related to CEH in Spain. In fact, there has been increasing evidence about the importance of engaging people and communities in the decisions concerning their health as a way to enhance their control over health and its determinants and reduce inequalities (NICE 2016), which reflects the basis of the health promotion paradigm as proposed in the Ottawa Charter. However, this is the first time that a systematic review of existing publications on CEH interventions within the Spanish context has been carried out.

We define CEH as the process of "involving […] communities in decision-making, and/or in the planning, design, coordination or implementation of services, using methods of […] collaboration and/or empowerment" (adapted from O'Mara-Eves et al. 2013). This review focussed on publications related to implementation research (actions, projects or programmes) carried out in Spain, where the local population has been engaged in the design and/or implementation, with the aim of generating evidence on what has worked in CEH and could guide and strengthen future CEH interventions.

More specifically, this study aimed to review the evidence available with the following objectives: (1) to identify community engagement interventions to promote health and reduce inequalities within the Spanish context and (2) to describe the key elements which can facilitate community engagement processes in health.

Methods

A search strategy was developed using the "population", "intervention" and "outcome" of the PICO strategy (Booth et al. 2012). The population referred to groups of people living in a defined area, using keywords such as "community" or "neighbourhood" or "local group". As for interventions, the search strategy aimed to identify interventions implemented in local areas where community engagement was used as a core approach, using keywords such as "engage*" or "participation" or "involve" or "collective action". The outcomes searched for included improvements in health or well-being, or reduction in health inequalities, using keywords such as "health" or "inequalit*" or "disadvantage". Finally, to identify studies relevant to the Spanish context, an extended version of the Spanish filter developed by Valderas et al. (2006) was included in the search strategy. The complete search strategy is available in Cassetti et al. (2018b).

Six databases (MEDLINE, PsycINFO, CINAHL, ASSIA, Web of Science and SciELO) were searched between September and November 2017. A forward citation search of the included studies was performed but did not retrieve any additional relevant articles.

Studies were included when they referred to an intervention targeting people or groups of people living in a community, where engagement had occurred at least at the level of "co-creating decisions and actions" (Cassetti et al. (2018a) (Fig. 1). In this review, informing and consulting the population were not considered real forms of community engagement.

Additionally, interventions should have ensured that the community had taken part in at least two of the five main intervention phases (Observatorio de Salud de Asturias 2016; Conselleria de Sanitat Universal i Salut Pública 2018), divided as follows: 1. creating the core working group; 2. health needs and assets assessment; 3. design and planning; 4. implementation; and 5. evaluation. Moreover, as the second review objective aimed to understand facilitators to community engagement processes, articles which provided limited or no details of the design, planning and implementation of the intervention were excluded from this review.

The publication of the first NICE community engagement guideline in 2008 was used as the initial date for searches, and studies were included if published in English, Spanish or Catalan.

Data extraction and synthesis

The review team included five researchers, from different backgrounds within public health and working in four

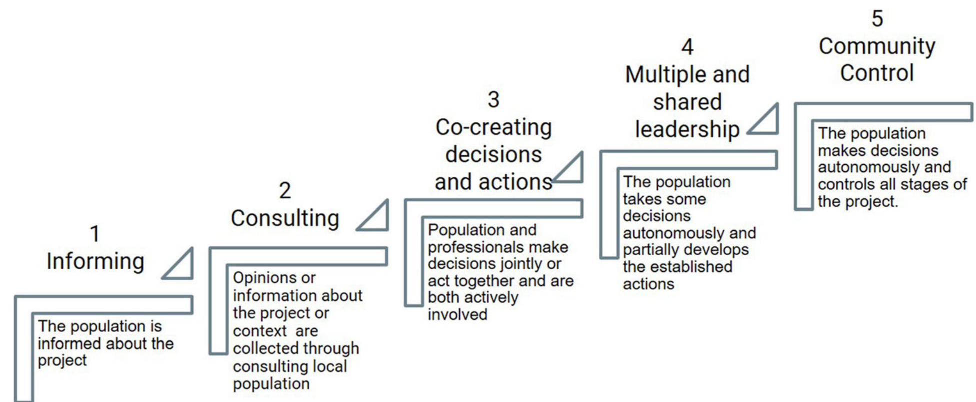

Fig. 1 Levels of community engagement in health used for the Adapt and Apply Health Promotion Guidelines project (AdaptA GPS) carried out in Spain, 2016–2018. Translated and Adapted from Cassetti et al. (2018a)

different regions of Spain. Two reviewers sifted through titles and abstracts and screened the full-text of the initially selected articles. In case of doubt and in order to reach consensus, all reviewers read the full-text articles to check whether inclusion and exclusion criteria were met. To strengthen the data extraction process, each article was assigned to two reviewers from the team, who independently carried out the data extraction process and then compared it to check for potential contrasts.

Data were extracted, using a predefined extraction form, distinguishing between the objectives and results of the published article and those of the empirical intervention. Detailed description of how the intervention was initiated, designed, planned, implemented and evaluated was extracted from each study including how community engagement was defined in each context, whether community engagement was used as a *mean* to achieve other health outcomes or whether community engagement was the *outcome* of the intervention (Oakley 1989), and the conceptual models or theoretical framework underpinning the intervention when available. To explore facilitators of community engagement, information was extracted regarding how the community engagement process had been initiated, by whom, whether it has been on a voluntary basis or not, whether it included intersectoral or multidisciplinary partnerships, whether funding had been allocated specifically for it, whether and how sustainability was ensured, and whether training was provided to the stakeholders involved. Those elements were chosen following the implementation guidelines available in the Spanish context (Departamento de Salud del Gobierno Vasco and Osakidetza 2016; Observatorio de salud en Asturias 2012; OIDP et al. 2015) and taking into account the five principles highlighted in the NICE NG44 guideline (NICE 2016) in relation to successful strategies to ensure engagement.

Given the variety of methodologies and outcomes of community engagement, and the aim to explore the factors which could enhance the implementation of community engagement interventions, this review adopted a narrative approach to synthesise the extracted information (Popay et al. 2006). The information was summarised in a tabulated format and analysed to explore the relationships between the studies and identify emerging patterns in relation to barriers and enablers of community engagement.

Results

The search strategy identified 2023 records, and 50 articles were reviewed full text after screening titles and abstracts. Finally, five articles met the inclusion criteria and were included in this review, as the PRISMA diagram shows (Fig. 2) (Moher et al. 2009).

The results of the review and analysis are presented in Table 1 and in the electronic supplementary tables. Table 1 provides a description of the intervention presented in the selected studies. The electronic supplement provides two additional tables, and Supplementary Table 1 presents information regarding the studies' objectives, evaluation and main results. Supplementary Table 2 provides a detailed description of each intervention: who carries it out, the strategies and theoretical frameworks underpinning it, institutional support, its long-term sustainability, the social determinants of health and the inequalities which it aimed to tackle, the phases of implementation and the stakeholders initiating the participatory process.

Description of the interventions

All the studies specify the objective of the intervention, its justification and the theoretical models on which they are based. Of the five interventions discussed in the included articles: three had been developed in local communities, one aimed to promote physical activity targeting the general population (Cabeza et al. 2016), one targeted elderly people to reduce loneliness (Coll-Planas et al. 2017), and the latter presents a strategy to promote health in the school environment (Ramos et al. 2013). The other two articles

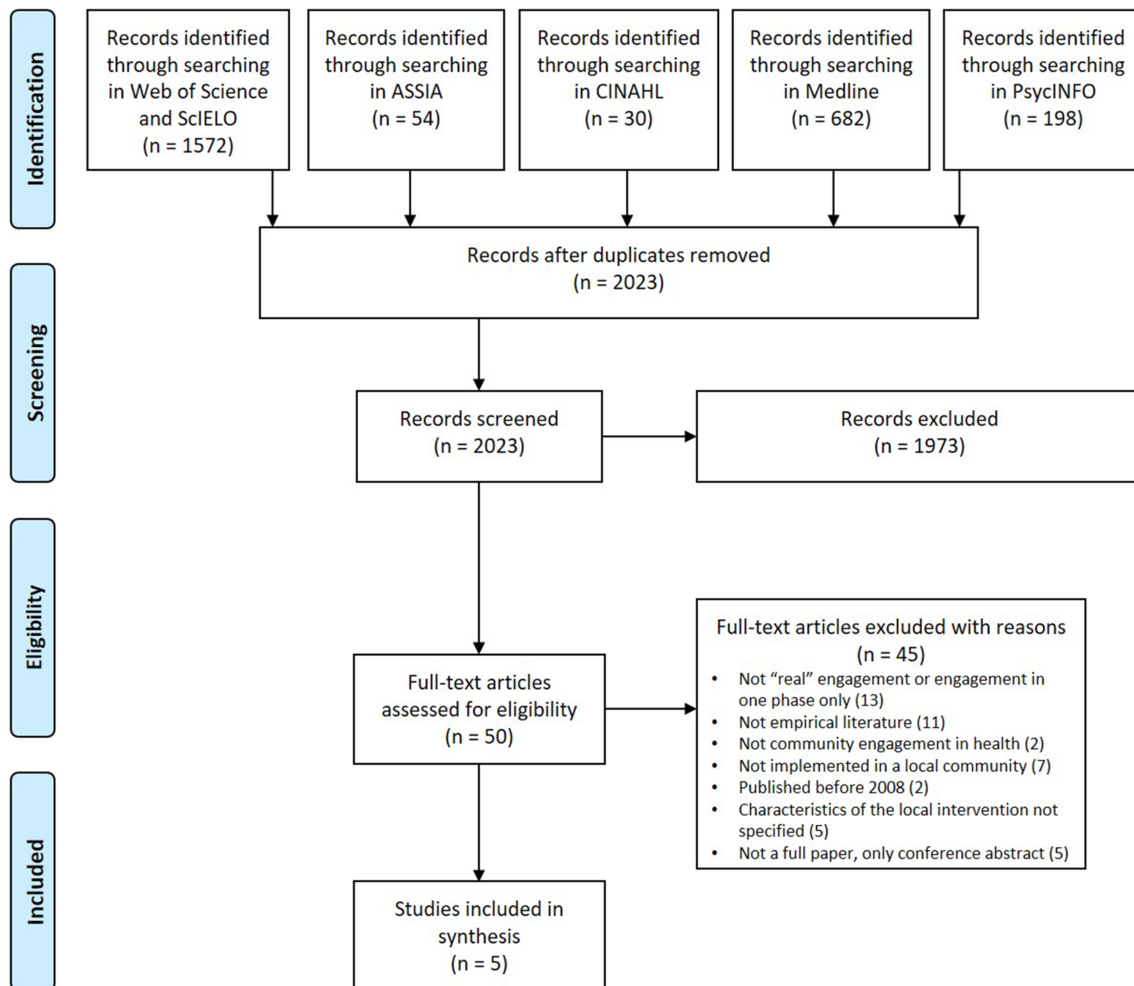

Fig. 2 PRISMA flow diagram of the searches, reasons for exclusions and selection of studies included in the review (2020)

focussed on promoting health in less advantaged neighbourhoods (Avino et al. 2014; Fuertes et al. 2012). Four of these were promoted from public health agencies, from local (Avino et al. 2014) or autonomic institutions (Cabeza et al. 2016; Fuertes et al. 2012), and three were co-designed with primary health care professionals (Cabeza et al. 2016; Avino et al. 2014; Coll-Planas et al. 2017). All of them have institutional support for their implementation, and two of them are presented as part of a long-term strategy and reported the institutional policy framework of which they were part, one being the Neighbourhood Law of Catalonia (Law 2/2004) (Fuertes et al. 2012) and the second being the Strategy of Healthy Eating and Active Life of the Balearic Government (Cabeza et al. 2016).

Social determinants and inequalities tackled

All five interventions embed the social determinants of health framework in their development, targeting disadvantaged population applying "proportionate universalism" (Marmot 2013) with the aim of reducing health inequalities. However, the results were reported for the target population as a whole, making it difficult to appraise whether inequalities were in fact reduced. Nonetheless, all five studies tackled one or more of the health determinants and adopted a community engagement approach to develop the intervention, thus suggesting that these approaches could support reduction in inequalities. More specifically, four of the publications addressed the intermediate determinants such as urbanism and housing (Fuertes et al. 2012), education (Ramos et al. 2013), access to health services (Avino et al. 2014; Cabeza et al. 2016) and social and community networks (Avino et al. 2014; Cabeza et al. 2016; Coll-Planas et al. 2017). Only one intervention considers also the influence of the wider structural determinants, such as the influence of social, economical and political context (Fuertes et al. 2012).

Table 1 Description of the studies included in the narrative review

Article information (Authorship, Title, Journal and Year)	Description
Fuertes, C., Pasarín, M. I., Borrell, C., Artazcoz, L. L., Díez, E., & the Group of Health in the Neighbourhoods Feasibility of a community action model oriented to reduce inequalities in health Health Policy (2012)	Health in the Neighbourhoods is a community health intervention based on a community action model that tackle social inequalities in health. It promotes community participation in taking health-related decisions. The intervention began in 2007 and was carried out in two of the most deprived neighbourhoods in Barcelona. The intervention followed three phases: (i) creating alliances with stakeholders, ranging from formal organisations to local associations, groups and individuals, related to the neighbourhood; (ii) carrying out a health needs assessment; and (iii) planning, implementation and evaluating the interventions, including indicators to measure: mental health, self-autonomy among the elderly, prevention of drug consumption, improved healthy diet habits, increased physical activity
Ramos, P., Pasarin, M., Artazcoz, L., Diez, E., Juarez, O., & Gonzalez, I. Healthy and participative schools: evaluation of a public health strategy Gaceta Sanitaria (2013)	Let's foster health! is a health intervention that was carried out in 37 schools during 2010–2011 in Barcelona. This programme proposed a process that aimed to develop health-promoting school environments. The intervention was based on the participation of families, students and teachers to develop a collective analysis of the centre and plan actions to promote health in schools
Avino, D., Paredes-Carbonell, J. J., Peiro-Perez, R., La Parra Casado, D., & Alvarez-Dardet, C. RIU project: perceived changes by health agents and professionals after a health intervention in an urban an urban area of socioeconomic disadvantage Atencion Primaria (2014)	The RIU project is a community health promotion intervention, developed by the public health service, in collaboration with primary health and social care services. The aim is to train local community members to become peer health promoters in their neighbourhood. The 6-month training combines theoretical classes where local members learn about health, its determinants and available health services, with health promotion actions that local members deliver in their community
Cabeza, E., March, S., Cabezas, C., & Segura, A Health care promotion in primary care: if Hippocrates were alive today… Gaceta Sanitaria (2016)	The Healthy Eating and Active Life Strategy of the Balearic Government launched an intervention, in collaboration with primary health care, with the aim to design healthy environments (healthy walking paths around the neighbourhoods) and promote physical activity. This was a community-based and intersectoral intervention, since it involved the primary health care teams, representatives of the non-health sector and local residents. A core group led the design process, implementation and evaluation of the intervention. It designed a walking path through the neighbourhood, which was validated on site through a questionnaire to be filled out by local stakeholders to check whether the path met the urban and environmental criteria to promote physical activity (luminosity, distance, slopes, obstacles, traffic, etc.). Once the walking path had been established, the health centre started organising walking groups accompanied by a health care professional or an expert patient
Coll-Planas, L., Del Valle Gomez, G., Bonilla, P., Masat, T., Puig, T., & Monteserin, R. Promoting social capital to alleviate loneliness and improve health among older people in Spain Health & Social Care in the Community (2017)	The intervention focused on developing different activities to tackle loneliness. The overall intervention framework was based on the social cohesion approach of social capital theory emphasising the interaction between the older persons and their social environment. The intervention consisted of a coordinated action and group-based programmes. The coordinated action was aimed at building and strengthening the network between primary health care centres, senior centres and other community assets in the neighbourhood where older people could participate in activities. The group-based programmes were conducted from January to June 2012, where the group met for 1.5 h a week for 15 weeks

Community engagement

Definition

All the studies defined engagement as a mean and not as an end, adopting it as a strategy for the intervention to be successful. However, the understanding of engagement varies among the studies: in three of the studies (Coll-Planas et al. 2017; Fuertes et al. 2012; Ramos et al. 2013), engagement refers to the interaction of stakeholders to develop specific actions at local level; in the remaining two (Avino et al. 2014; Cabeza et al. 2016), it refers to stakeholders engaging in the wider process of designing and developing the intervention as a community process. Only

one study (Coll-Planas et al. 2017) specifies that engagement goes beyond the simple participation of a few people during the implementation phase, as it considers participation as an essential element in strengthening local networks and contributing to the growth of social capital.

Processes

These interventions are developed following a similar set of stages.

Prior to the beginning of the intervention process, a core group is formed, who will be in charge of leading the intervention process. In all but one study, the core group is intersectoral and coordinated by health professionals and/or professionals in the area in which the intervention is implemented. For instance, in the case of the health-promoting schools (Ramos et al. 2013), the teaching staff started the core group together with students and parents. To enhance the participatory process, in two of the studies (Cabeza et al. 2016; Fuertes et al. 2012), staff received training regarding the theoretical and policy framework on which the intervention should be based on.

The second stage in all the studies is the health needs and assets assessment: in four of the studies, a description of the area and its population profile is provided, and in two studies (Avino et al. 2014; Cabeza et al. 2016), key social actors with potential interest in the intervention were also identified. All studies targeted population with some degree of vulnerability, thus reflecting the incorporation of an equity perspective in the intervention's overall approach. The third stage is the design of the intervention, where in all articles, the design of the intervention is co-developed between the technical staff and the community members involved, although no training is reported except in one study (Avino et al. 2014). The fourth stage is the implementation of the intervention, whereby greater engagement is described. In all the studies, stakeholders from the three main levels of the decision-making process (managerial, professional and local population) participated. The last stage is the evaluation of the intervention, which in all the studies has been carried out only by front-line and professional workers, who chose the evaluation approach and methods to respond to predetermined indicators.

Outcomes

All studies reported the interventions' evaluation, although different approaches were used: two studies evaluated the overall community action model implemented (Ramos et al. 2013; Fuertes et al. 2012), one study evaluated the perceived changes of the stakeholders (Avino et al. 2014), one the effects of the intervention (Coll-Planas et al. 2017), and the latter provides a descriptive account of both the intervention and the evaluation (Cabeza et al. 2016).

The included interventions adopted different evaluation designs and included a diversity of health-related outcomes. In the school intervention (Ramos et al. 2013), the educational centres involved in the programme increased the number of health education actions and increased the participation of different stakeholders in the decision/organisation structures; the interventions in the neighbourhoods achieved most of the predefined indicators: community groups felt actively involved in establishing health needs and priorities for action, in mobilising local assets, as well as showing improvements in their perceived health (Fuertes et al. 2012). In addition, new partnerships were created, allowing a better use of local resources, and most of the core working groups felt that through the developed intersectoral interventions, they were able to reach the most vulnerable population. In the RIU Project (Avino et al. 2014), the community lay health volunteers perceived that the intervention increased their skills and knowledge in health and health care and felt empowered by their role as peer educators in their own community. Such changes were also recognised by the health professionals involved in the project. In the study related to increasing physical activity (Cabeza et al. 2016), both the role of the nursing and social work professionals, as well as that of the cultural mediators, were identified as key elements for the success of the intervention when implemented in areas with higher migrants and ethnic minorities. This study also provides a descriptive quantitative evaluation, reporting the numbers of health centres (32 out of 58) and the different social actors involved in the core groups and implementation teams: a total of 159 entities engaged (68 from the health sector, 35 from non-health sectors and 56 charities) together with 97 citizens. Finally, the project addressing loneliness in the elderly (Coll-Planas et al. 2017) has reported a reduction in loneliness, better social skills, more social participation and more opportunities for the elderly to engage in their neighbourhood. Information on the level of community engagement is reported in one study: Coll-Planas et al. (2017) surveyed participant using a subjective index of social participation.

Facilitators to engagement

To respond to the second objective of this review, data were extracted on the tools and strategies which could facilitate community engagement processes in health.

Two of the studies (Cabeza et al. 2016; Fuertes et al. 2012) reported that having a protocol that included a theoretical framework on what community engagement was, facilitated the participation of the front-line workers in the initial stages of the intervention process. Another facilitator

reported in two studies (Avino et al. 2014; Ramos et al. 2013) has been the participatory structure and development of the meetings: these meetings were carefully planned and developed in an interactive way, or in the format of discussion workshops, which facilitated stakeholders' engagement. A third strategy reported in the studies is that decision-making process was both interdisciplinary and intersectoral, carried out by different social actors together, coming from a variety of disciplines and including people with an expertise on the local context (Coll-Planas et al. 2017; Fuertes et al. 2012; Ramos et al. 2013). Finally, in one of the studies, co-education in the form of training of local people or professionals was provided throughout the process, thus enhancing stakeholders' capacities to engage or facilitate local processes (Fuertes et al. 2012). Working through an interdisciplinary network (four studies), being underpinned by a policy framework (two studies) and the availability of appropriate resources (three studies) were all factors identified as facilitating community engagement in the long term.

Discussion

This review has presented a description of common elements in community engagement processes within interventions carried out in Spain and has identified key factors which can facilitate engagement. Based on this synthesis, three points are discussed, namely the role of professionals and individuals in community engagement interventions, the importance of training to enable a reorientation towards a CEH practice and finally the relevance of contexts as enablers for community engagement processes to thrive.

First, these studies have shown a tendency of predominance of front-line staff or professional workers in all stages, while community members' engagement is mostly limited to the implementation stage. This may reflect the challenges that adopting a full engagement approach can entail. On one side, it would mean to embrace the complexity of community interventions, and their behaviour as complex systems following nonlinear pathways which clashes with the traditional detailed planning approaches in interventions (Trickett et al. 2011). On the other side, it would mean to see engagement as an end in itself and not just as a mean to carry out programmes designed by experts only (Bhatia and Rifkin 2010). In this sense, our findings share similarities to those of Lapalme et al. (2014) who reviewed interventions to promote positive development in young people. The authors found that despite evidence supporting involvement of young people in decision-making processes, youth are rarely engaged in the planning of interventions related to their own development or to the improvement of their neighbourhoods as these are still predominantly adults-led. In fact, although recently co-production of research and intervention has been increasing, there is still certain resistance on behalf of health professionals to share control over the research process or a programme implementation, resulting in the development of research and interventions where engagement is only in the form of consultation and can risk generating frustration in community members (Sastre Paz et al. 2018). However, it should also be noted that there may be different factors influencing this lack of shared control, such as lack of capacities and training on how to work collaboratively with communities.

To counter this tendency and foster more horizontal approaches to community engagement, the role of the professionals as creators of participatory structures and facilitators of processes enhancing community control is fundamental, provided that professionals are willing to adopt new concepts, attitudes and skills to engage and promote engagement of other stakeholders. In order to achieve this, the training of front-line professionals is key, as highlighted in two of the reviewed studies (Cabeza et al. 2016; Ramos et al. 2013), and as reflected in evidence from other countries (Coulter 2009; National Collaborating Centre for Determinants of Health 2013; O'Mara-Eves et al. 2015). Moreover, the NICE NG44 guidelines recommend to offer training also to the local population, which may suggest that a lack of participatory culture is common also in other parts of the world. Even within academia, where participatory research has been developed since various decades, ethics guidelines have only recently being developed (ICPHR - International Collaboration for Participatory Health Research 2013). Promoting a participatory culture could also enhance the sustainability in those kinds of interventions. Indeed, four of the five interventions are still ongoing. This reflects emerging findings from other participatory programmes such as creating healthy neighbourhoods in the USA (Miller and Scofield 2009; Semenza et al. 2007) or the Big Local initiative in the UK (Orton et al. 2017). It can be argued that having participatory policies in place, while at the same time, ensuring professionals are supporting the development and continuity of community engagement processes and their work is recognised, are all important factors contributing to the sustainability of the interventions. In fact, recently, attention is being paid to the risks of relying on the voluntary work of health professionals, which can lead to staff burnout as well as turn into a potential barrier to engaging in community activities (Sastre Paz et al. 2018). As also evidenced in other studies, participation requires time and resources, both human and financial ones (NICE 2016; Delany et al. 2016; Lapalme et al. 2014).

Finally, it is important to shed light on the fact that engagement is an ongoing process, and as such, it needs an

enabling context to thrive. For this, the central role of repeated meetings, carefully organised, with clear objectives and well-facilitated are keys to nurturing the process as a whole. As well, other common elements of these five studies considered as pivotal to the intervention's functioning were identified in: ensuring institutional support, having an initiating intersectoral core group fostering the development of partnerships, using participatory methodologies and incorporating the perspective of research linked to action and evaluation. These facilitators reflect those suggested by other authors and guides (Cofiño et al. 2016; March et al. 2014; Ruiz-Azarola et al. 2012; Woodall et al. 2018).

A last comment relates to the small number of articles that have been included in the review. This could be partly attributed to the inclusion criteria established, which have meant excluding papers where community engagement occurred only at one stage of the intervention process, articles where participation was reduced to provision of information and/or consultation or articles on CEH but not related to a specific intervention. In addition, our search strategy was restricted to community-based interventions aimed at promoting health, thus leaving out those interventions tackling other social and community processes which could still have impact on health and well-being. Nonetheless, we do believe that such exclusion was important to reflect on what should be considered as engagement, how community engagement is discussed in health interventions and therefore contribute to the body of evidence on community engagement framework in our context. Another element that can explain the few publications found is the young age of the Spanish health system, 40 years, the limited experience in promoting a participatory culture within the Spanish society in comparison with other countries, and the lack of policies that encourage community participation, not only in the health sector. For example, the studies included in the reviews to develop the NICE NG44 guidelines show that participatory strategies have long been implemented in other areas of the world (Brunton et al. 2015; O'Mara-Eves et al. 2013; Stokes et al. 2015). As well, the interdisciplinary nature of community engagement processes suggests there may be publications from other research areas which may have not emerged in those databases. Finally, even when community interventions are carried out in participatory ways, evaluating and publishing these experiences in the scientific literature is an additional challenge which can represent a major barrier for those working outside academia, who in some cases may lack the time and skills needed to publish and disseminate their experience. In this sense, we do believe that more examples of successful practices in CEH exist, beyond the few included in this systematic review, many of which can be found in the grey literature (Cassetti et al. 2018a).

Conclusions

This study has reviewed the evidence available on community engagement in Spain and identified factors which can facilitate these processes in local communities. To our knowledge, this is the first review carried out on this topic in this geographical area. It is hoped that the findings presented here can set up the basis for discussion when planning community engagement interventions. Despite the limited number of studies included, definitions of community engagement were heterogeneous, thus suggesting the importance of further the discussion on what can be understood as community engagement in health. Moreover, attention needs to be paid to how different disciplines and different stakeholders should contribute to both research and practice in this area. Furthermore, it is recommended to ensure participation in all the stages of the intervention. This could encourage an increase in the development and evaluation of community engagement interventions to promote health and reduce inequalities and thus contribute to expand its evidence-based practice and its potential for replicability and transferability to other contexts.

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Compliance with ethical standards

Conflict of interest The authors declare that they have no conflict of interest.

Ethical approval This article complies with ethical standards. As this research did not involve human participants and used secondary data (published available paper), neither ethical approval nor informed consents were required.

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