Community Engagement in Support of Moving Toward Universal Health Coverage

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Abstract—Community engagement describes a complex political process with dynamic negotiation and renegotiation of power and authority between providers and recipients of health care in order to achieve a shared goal of universal health care coverage. Though examples exist of community engagement projects, there is very little guidance on how to implement and embed community engagement as a concerted, integrated, strategic, and sustained component of health systems. Through a series of case studies, this article explores the factors that enable community engagement particularly with a direct impact on health systems.

INTRODUCTION

Universal health coverage (UHC) has its foundations in the Alma Ata Declaration of 1978 when in one of only a few unanimous votes, member states agreed on a call to action to protect and promote the health of all people through primary health care. Primary health care was “based on practical, scientifically sound and socially acceptable methods and technology made universally accessible through people’s full participation and at a cost that the community and country can afford.” The Alma Ata Declaration recognized inequalities in health status as socially, politically, and economically unacceptable; affirmed the importance of economic and social development as a prerequisite to the attainment of health as a human right; and emphasized the critical role of participation of individuals and communities in the planning and implementation of their health care.

Despite significant challenges, and 40 years on, the underlying principles and values of the Alma Ata Declaration continue to drive an agenda for equitable and accessible health systems. Building on lessons over the 40 years, UHC is being promoted to ensure access to the right health services, at the right time, for all, without exposure to financial hardship. UHC requires the establishment...
of financing models that enable the provision of services and ensure that those for whom the services are provided do not incur catastrophic expenditure. UHC aims to strengthen health systems; reduce inefficiencies; develop strategies to enhance the reach of quality, affordable services to even the most marginalized; and revitalize the structures that enable the enjoyment of the right of all to the highest attainable standard of health.\(^2\) UHC thus proposes a framework through which health and well-being, as defined in the Sustainable Development Goals can be addressed. Financing is the key component of UHC, to balance the cost of quality care against limited resources.\(^3\)–\(^7\) In addition to the financing of coverage, it is important to understand what services might be needed as well as how they might be delivered. To that end, there have also been a wide range of innovations and technologies that have focused on quality essential services and service models to ensure that care provided can be patient centered. However, there is also a demand side to the financing and provision of health care, the behaviour of individuals, families, and communities that make up the population must be considered.\(^8\) The evidence on how to implement UHC to deliver on reaching even the most marginalized is limited, particularly in the mechanisms to support participation in the design and implementation of strategies and programs to achieve UHC.\(^8\),\(^9\) The outcomes of poor engagement of consumers of health care services include, among others, poor uptake of services, inappropriate overuse of services, low health literacy, and poor understanding of health and health care.\(^10\),\(^11\)

The need for engagement is normative and recognized not only as inextricably linked to democratic principles but also as integral to the right to health.\(^12\) The Sustainable Development Goals call for integrated, intersectoral approaches that are underpinned by social justice, equity, and human rights. These necessarily require strategies that enable inclusiveness and opportunities to give voice to communities. It has also been argued that grounding the case for UHC in human rights, legal and ethical arguments, and the promotion of community engagement provides a compelling case to strengthen the economic case for UHC.\(^9\) Global politics highlight a strengthening of democratic processes, and citizens are increasingly vocal. Access to health care is often a significant part of election manifestos, and increasing access to information means that people are generally better informed about issues that affect their health.\(^13\) Health systems have had to be responsive to changing health priorities, such as the types of services that need to be covered, the needs of different population groups as population demographic profiles change,\(^14\),\(^15\) and the types of treatments that may be considered essential and/or optional.\(^13\)

In this article, we explore how the process of engagement with communities can be implemented to inform and enhance health systems and support progress toward UHC. We begin with the assumption that as a constitutional right in most countries,\(^10\) community engagement in the design of health policy and health care is desirable and an important intervention. We provide a brief overview of the concept of community engagement and the challenges of undertaking community engagement. We then outline the findings of a scoping review that compiles a series of case studies on community engagement in health systems in the Western Pacific region. These provide the basis for a discussion of factors that enable community engagement within health systems. We highlight the gaps in current policy dialogue and research on community engagement and conclude with recommendations for future directions for engaging communities toward the achievement of UHC.

### Community Engagement—An Overview

Community engagement describes a complex political process with dynamic negotiation and renegotiation of power and authority between providers and recipients of a service or between political authorities and citizens. The purpose of community engagement is to establish a collaborative relationship toward the achievement of a common goal. Ideally, in the process, communities become increasingly empowered, gain a shared sense of ownership of the agenda, and assume joint accountability. Within the context of UHC, effective community engagement would enable communities to be integral to decision making about the sorts of services that are provided and how they are delivered. Communities could hold providers accountable for the quality and outcomes, invest time and effort to ensure sustainability, and be active participants in their health care.\(^16\)

In practice, community engagement covers multiple levels of negotiating power, described here and summarized in Table 1. Examples of specific activities that have included communities at some level are not uncommon. Authorities may engage communities through consultations with community leaders or key stakeholders to gather information; they may seek collaborative cooperation with communities for improved service delivery, by sensitizing communities through surveys and town meetings or actively soliciting partnerships with civil society groups and mobilization of community volunteers; and they may reach beyond collaboration, inviting co-creation of health solutions through shared decision making.
Community engagement also includes horizontal engagement. Horizontal engagement describes internal processes of participation within communities with limited involvement from state authorities or external political processes. Communities respond to their needs independent of the health system that they perceive as unwilling or unable to provide the support required to protect their health. Through grassroots actions, they mobilize and are self-directed to address a need in the absence of state support.

These different types of community engagement achieve different outcomes. Arnstein, a seminal scholar in participation, suggests a “ladder” of participation, with the highest level describing community engagement efforts where health and health care are co-created, where decisions for conceptualization, planning, implementation, and evaluation of services and systems are shared. Communities, in this form of engagement, are “makers and shapers” of the health system and not merely passive “users and choosers” (p. S14). Arnstein argued that other forms of participation that involve consultation but do not place communities in an equal decision-making role are at best tokenistic. However, more recent scholars suggest that the implied hierarchy in Arnstein’s ladder analogy is not particularly constructive; the rungs in the ladder may serve different purposes and therefore more involvement (higher up the ladder) is not always appropriate and may not necessarily result in the most desirable participatory outcome. The International Association of Public Participation refers to a spectrum of public participation that recognizes the more nuanced forms of participation, which we outline below (see Table 1).

### Community Engagement for UHC—The Challenge

Embedding community engagement as a concerted, integrated, strategic, and sustained component of health systems has been and remains a challenge. Policy makers argue that there is limited robust evidence that directly links participation with health outcomes. Others contend that community engagement has had to take a backseat to those activities that are considered easier to address and measure. For funding agencies and governments, addressing the supply side of health service delivery still provides a less complex, structured, and measurable process and outcome than the demand (community) side. Some studies have argued that though individuals and communities may like the idea of engagement, they would be reluctant to be involved in broader policy-level discussions beyond those decisions that might have a direct impact on them. Others suggest that participation from communities is unwarranted and tokenistic and can be seen as an attack on the medical establishment.

Further reasons for the lack of prioritizing of community engagement include that health has traditionally been viewed as owned by experts and delivered to people through various government mechanisms. For instance, relatively successful models of UHC, such as the National Health Service in the UK and social insurance models in South Korea and China, were initially implemented without any significant community engagement.

With the increasing recognition that communities need to be an integral part of health system design as well as implementation, there is a major gap in the evidence on the implementation of community engagement; that is, how health systems can embed community engagement in moving toward achieving UHC. The boundaries of what constitutes community engagement in health systems are poorly defined and descriptions of how to engage, and analyses of what works, are not often described in detail. In this review, therefore, we sought to identify, through case studies, the factors that have enabled community engagement, particularly with a direct impact on health systems.

### METHODS

We focused primarily on case studies that provide some data on the process of community engagement as well as the
The brief for this commissioned article restricted case studies to those reported in English and situated in countries within the WHO Western Pacific Regional Office region and addressed the following questions:

1. In what ways have health systems engaged communities in strategies to achieve universal health coverage—what are the types of engagement?
2. What factors enable or hinder engagement and effectiveness of engagement?
3. What are the key considerations for effective community engagement to achieve universal health coverage?

Cases were identified through the Proquest, Wiley, Sage, and NCBI databases, as well as through the grey literature, to identify project and program reports from government, civil society and nongovernmental organizations (NGOs). The search strategy targeted publications from 2000. The search yielded 137 articles; 18 provided some description of a level of engagement with or participation from communities. Cases that described no link to health systems were excluded.

We included in our search projects that involve population groups, patient groups, and stakeholders in health systems. In broad terms, we were interested in evidence of the efforts of health systems’ work with individuals and communities aimed at improving health and health care at one end and in community-directed projects that informed health care systems at the other. We explored the broader contexts that enabled or hindered community engagement and programs that attempted to give voice, particularly to marginalized and vulnerable groups. Health systems were broadly defined to include activities of NGOs and other multilateral agencies.

The selected cases were chosen because of their particular relevance to enhancing health systems. The results are presented to reflect the different types of participation, according to the framework of engagement types shown in Table 1. We then discuss the factors that enable the integration of community engagement in UHC. It is important to note that the results are restricted to the English-language literature and limited by the lack of detailed implementation descriptions in most projects and studies about the specific aspects of participation or engagement that yielded success or failure.

Findings: Case Examples

Case examples are presented below, highlighting the implementation of community engagement approaches and raising discussion points on the attributes of different methods of engagement. Seven key case studies are summarized in Table 2. Although the examples outlined below provide some insights into community engagement, they are, for the most part, reports of time-limited research studies and therefore it is difficult to determine their sustainability beyond the duration of the project.

Case Study of Consultative Engagement: Listening to the Voices of Children

Part of a larger research study in Vanuatu and Papua New Guinea, “Voices of Pacific Children with Disability,” was a consultative and collaborative project introduced to respond to the neglected needs of children with disabilities. The project elicited the voices of children with disabilities, enabling them to engage with the process of identifying the complex intersectionality of lack of power as a child, discrimination faced both in their homes and schools, and the lack of resources that would enhance their capability to function despite the disability. The responses from the children were used to inform the development of health and welfare policy and services for a group that is often neglected in health service provision. This is an example of the use of a consultative approach toward engagement. The children’s perspectives were important even though they were not in a position to participate actively in the implementation of interventions for their welfare.

Though consultative and collaborative engagement have distinct features, engagement efforts can often shift, with initial consultation developing into collaboration. Alternatively, the same engagement program may be carried out in different ways, taking on the features of consultation or collaboration. In a resource produced by the World Health Organization (WHO) on strategies for health systems strengthening, population consultations are described as a mechanism to elicit information from interested or affected parts of the population, in order to gauge expectations and opinions about health system-related decisions. The results can be used to anticipate any unforeseen consequences and to refine decision making. The process is designed to be inclusive and can influence the outcome; however, it does begin with an a priori determined direction. For this reason, consultations are of value for monitoring the effectiveness, from the perspective of the users, of health system interventions.

Consultations and deliberations also aim to achieve fairness and transparency. They are particularly effective, for instance, in seeking feedback and assessing the differential benefits of particular programs and identifying potential harms or challenges for subgroups of the population. Consultations do not generally seek whole-of-population representativeness; by design, they focus on special interest
| Engagement Type | Engagement Approach                                                                 | Purpose                                                                                                                                  | Factors Affecting Integration with UHC                                                                 | Outcome                                                                 |
|-----------------|---------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|
| Consultative    | Listening to the Voices of Children using creative/play methods to facilitate communication of children's perspectives | Provide avenue for perspectives of a “voiceless” group, disabled children, to be heard                                                   | Engaging with children with disabilities provided an entry point for engaging with parents and families who for reasons of stigmatization would not otherwise engage with the health system. This opened up the opportunity for patient-centered care | Informing of policy and services for neglected group                   |
| Consultative/  | AHWs in diabetes monitoring programs Increased involvement of AHWs for breaking down communication barriers with community patients | Support health service delivery planning and action at the local and regional levels                                                       | Extent to which AHWs were integrated with registered nurses and general practitioners. Institutional affirmation and support for AHWs’ role | Improved communication with patients, better recall of patients with diabetes who had missed diabetic reviews | collaborative |
| Malaria elimination in Laos Recruitment of community volunteers to engage community, report on and address villager concerns | Promote uptake and adherence to program, overcome language barriers                                                                        | Leveraging existing partnership with community. Flexibility to respond to broader health needs identified by community. Time-limited intervention. Lack of long-term integration into local health systems | Increased adherence to the intervention, development of volunteers      |                                                                                        |
| Collaborative   | Reducing malaria transmission in Vanuatu Identify and enact social mechanisms for long-term embedding of malaria prevention practices | Distribution of bed nets and management of the environment                                                                               | Strength of existing social mechanisms for eventual community ownership. Time-limited intervention. Scalability of project to contexts with more complex social–cultural and environmental conditions. Limited scope of intervention | Successful intervention, but scale-up was less effective in other apparently similar islands |
| Partners in Leprosy Action Establishing community clinics and conducting local capacity building for skin health care | CSO initiative to build capacity, reduce stigma, and improve the quality of and access to care for patients with leprosy | Implementation grounded in creation of networks through partnerships with local executive, health, and education government offices | Covers 91% of the target population compared to 72% in the best area of coverage from the public sector |
| Sea ambulances Community-devised solutions to improve access to childbirth care | Financial model for sustainable maintenance of sea ambulances                                                                             | Community empowerment via connecting employment opportunities with PhilHealth framework                                                                 | Coverage for women on remote islands to health facilities for childbirth increased from 20% to 90% |
| Horizontal engagement mDengue mobile application Enabling community to effectively bring dengue breeding sites to authorities’ attention | Address delays in authorities’ response to reports of exposed drains and puddles in public sites                                           | Community empowerment to address pressing health concerns                                                                                           | The intervention is in the beta testing phase and evaluation is ongoing |

**TABLE 2.** Summary of Key Case Studies in Scoping Review
groups or sections of the wider population. Consultations can take the form of surveys, group discussions, or even referenda.

This level of engagement is often undervalued under an Arnstein model of participation because though communities might contribute to an understanding of the problem, they are not necessarily an active part of the solution. Though it does provide valuable information to inform policy and services, communities can often feel let down if there is no perceived short- to medium-term direct benefit in response to their inputs. White describes the purpose of this engagement as nominal; to provide a level of legitimacy, communities are informed or sensitized as part of the process, which may be important, but are not expected to be a part of a change process.

Case Study of Consultative/Collaborative Engagement: Aboriginal Health Workers in Diabetes Monitoring Programs

A common example of contractual consultation/collaboration is the employment of community health workers or provision of incentives for community volunteers. There is an extensive body of literature on the role and effectiveness of community health workers and community health volunteers in community-based programs and in temporarily addressing the shortfall in human resources for health, but very few examples exist of sustaining community health worker programs. A notable exception is in Indigenous health care programs that integrate a community workforce, including family, and formal and informal carers into the health system. Indigenous communities in more remote areas, particularly ones that are marginalized by poverty and geography and are historically disenfranchised, run a major risk of being left behind.

The Aboriginal health workers (AHWs) diabetes monitoring program, for example, uses self-management support. Aboriginal health workers are a trained, credentialed cadre of the health workforce operating in all states and territories in Australia. In an audit of the monitoring program of chronic disease management care in Aboriginal Community Controlled Health Services, AHWs in one of the services had an integral role in diabetes care, working in collaboration with the patient, nurse, and general practitioner (collaborative engagement). In the remaining three services, the AHWs’ role was limited to observing patients and providing information (consultative engagement). The collaborative engagement resulted in higher service delivery rates and better clinical outcomes. Indeed, the involvement of an AHW was found to be an important facilitator for reaching patients who had missed diabetes reviews, and AHWs were also credited with breaking down communication and cultural barriers.

Similar AHW programs have demonstrated good coverage and health outcomes. These programs have provided good models for community-based care and management of chronic conditions like type 2 diabetes.

Case Study of Consultative/Collaborative Engagement: Malaria Elimination in Laos

A malaria elimination project combined elements of consultative and collaborative engagement. Here, a predesigned package of interventions was presented to the community through existing community partners, but the engagement was required to promote uptake and adherence—primarily a consultative form of engagement. Ongoing discussions with the residents informed adaptations in the intervention to be responsive to the needs of the community—even beyond the focus on malaria elimination—a strategy that generated buy-in and enhanced the coverage of the treatment. Additionally, community volunteers were required to overcome the language barrier as the target community was a small linguistic minority in Laos. Though beginning as interpreters, the volunteers took on additional responsibilities and ownership as the project progressed (collaborative elements). It is noteworthy, however, that this was part of a time-limited study and was not integrated into local health systems.

Case Study of Collaborative Engagement: Reducing Malaria Transmission in Vanuatu

A government-led program in Vanuatu solicited community support toward interventions to reduce malaria transmission. The project involved active collaboration of community members in the distribution of bed nets and in the management of the environment to reduce potential breeding sites for the vector. The intervention was considered a success, resulting in a significant reduction in breeding sites and elimination of malaria transmission in sites like the island of Aneityum. However, this outcome has been hard to replicate and scale up across other islands. A research project was therefore undertaken to explicitly explore aspects of community participation that may have contributed to the success in Aneityum. The existence of strong social mechanisms within the Aneityum communities was perceived to be an important factor in maintenance of the program, especially after outside actors and funding were withdrawn when the time-limited intervention ended. In the outer islands,
however, community participation was more difficult because of the increasing complexity and diversity of social and environmental contexts. Indeed, unique histories shaped what was possible, acceptable, and considered successful in community engagement, and locally successful methods may not be easily replicable elsewhere.\textsuperscript{21–23} Finally, the intervention in Aneityum was highly targeted, and the social mechanisms that enabled success could have been leveraged for broader and longer-term health accomplishments.

**Case Study of Collaborative Engagement: Partners in Leprosy Action**

Partners in Leprosy Action (PILA) in the Philippines is an example of a horizontal, socially innovative, community engagement initiative led initially by a civil society organization, the Philippine Leprosy Mission.\textsuperscript{37} The Philippines records the highest number of new leprosy cases in the region and has challenges with case detection and accessing the new cases to provide treatment and manage the spread. The Philippine Leprosy Mission mobilizes patients, their carers, and district health staff for training and development of resources to help to build capacity, reduce stigma, and improve the quality of and access to care for patients with leprosy. The initiative works with the Department of Education to access schools and screen for skin health, to avoid the stigma of leprosy. The development of partnerships and engagement with local stakeholders through workshops and training events have led to co-creation of solutions that have helped to strengthen the district-level health systems. PILA was possible because of the devolution of authority to local government, providing the context for active engagement with civil society organizations (CSOs) working at the grassroots level. The PILA initiative covers 91% of the target population compared to 72% in the best area of coverage from the health department.\textsuperscript{37}

**Case Study of Collaborative Engagement: Sea Ambulances**

Another CSO initiative, also in the Philippines, brings together the private sector, community, and health services.\textsuperscript{38} Described as a social entrepreneurship program, the program was conceptualized to address poor access for women on remote islands to facilities for deliveries. Although there are sea ambulances, the numbers are not enough to service the need. There were some boats that could be used for transportation, but these had high fuel and maintenance costs. The community co-created a financial model that first helped to upgrade a local health facility, which was then accredited by the Health Department. The accreditation enabled eligibility for raising funds through reimbursements, which could, in turn, subsidize the maintenance of the boats. The joint initiative increased utilization of facility-based deliveries from 20% to 90% and has remained sustainable.\textsuperscript{38}

The collaborative engagement cases outlined above illustrate transformative participation that involves shared ownership at all levels and therefore has the potential to change existing institutions and structures.\textsuperscript{34} The advantages of co-creation include increased trust and therefore value and effective utilization of services. Additionally, CSOs are an increasingly important and growing sector that introduce a further partner and stakeholder in the community engagement process. Though they usually act as representatives of sectors in the community, they may also play an almost independent role as a stakeholder with interests related to but separate from that of communities and government. This is usually the case if the CSO is also a private-sector entity.

**Case Study of Horizontal Engagement: Dengue Mobile Application**

The mDengue mobile application was developed in 2016 as a community initiative fueled by dissatisfaction with the public health response to potential mosquito breeding sites.\textsuperscript{39} Raised initially during a community meeting, the community highlighted their frustration with the persistent delays of environmental health officers to deal with reports of exposed drains and puddles in public sites. The mobile application, which is openly accessible and verifiable, enables the upload of photographs and Global Positioning System coordinates to an open-access site that displays the time to response by the public health officer.\textsuperscript{39} Contrary to concerns, the development and trial process has strengthened the relationship between the various stakeholders in the community and district health services, and further mobile applications are under development to enhance opportunities for joint projects.

**DISCUSSION**

Progress toward UHC requires not only technical knowledge but also political know-how.\textsuperscript{55} A critical part of developing political know-how is community engagement, especially to advance health in marginalized groups that are underserved by the mainstream health system.\textsuperscript{56–58} Indeed, it is important to note that all of the case studies on engagement were in the context of those who are not well served by the existing mainstream health care system. This may reflect the unusual nature of the cases and therefore a publication bias, so it cannot be assumed that engagement is or should be limited to these contexts. Nonetheless, the application of engagement in these cases shows how community participation
Such systems enable devolved or decentralized health system models in mainstream health care, which can enhance the quality and sustainability of UHC in the face of growing demands on health systems worldwide. Such systems generally provide smaller population groups with greater homogeneity of interests and ease of diverse representation. In Australia, decentralization has resulted in the development of primary health networks with greater accountability to the target populations. The primary health networks have had contractual obligations to commission appropriate health care services. Community engagement, in this instance, has been through statutory bodies like the Consumers Health Forum and community advisory groups. A major advantage is in the ability to tailor health services to the needs of local communities, given the variation in geography, demography, socioeconomic status, and health needs of the various populations across Australia.

The selected cases demonstrate the importance of the political, social, and environmental contexts in enabling the success of community engagement as a mechanism to make progress toward UHC. Three interrelated elements in particular stand out: time frame, scope, and community embeddedness of interventions. It is interesting to note that, except for the AHW case study, the top-down engagement examples examined herein came with end dates, whereas the bottom-up engagement examples aimed to provide an ongoing service/meet an ongoing need. The time limitations of top-down engagement may be in part due to grant funding cycles but also reflect top-down tendencies in community engagement: that engagement is often instrumental—a tool to solve a particular problem—rather than an integral part of the broader health system. Applications of community engagement limited in scope and duration can generate lasting success in solving particular problems, such as eradication of malaria on the island of Aneityum, when successfully embedded in target communities. However, ongoing engagement provided entry points for the malaria intervention in Laos, and the flexibility of that intervention enabled issues of drinking water and other basic health care to be addressed. Such integration goes beyond using local knowledge and perspectives of problems unavailable to high-level decision makers to improve information flows and delivery mechanisms for particular issues and provides the necessary platform for working toward UHC.

Other studies have also highlighted the need for a systemwide approach to community engagement rather than processes that are often ad hoc. An analysis of World Bank health-sector reforms, for instance, highlighted the constraints that the approach to community engagement imposed on program management and service delivery. The engagement was on the basis of a nonparticipatory process, curtailing the overall effectiveness of the health-sector reform process, especially with regard to ensuring accountability and rights. In contrast, a sectorwide approach, not only to health but also to education and welfare, was introduced in New Zealand because of community consultation and political lobby. The result was the Whānau Ora approach, which has led to a significant extension and utilization of and satisfaction with health services. Like the Australian AHW program, Whānau Ora recognizes the health disparities across the Indigenous population and aims to support communities rather than individuals as the primary locus for health care. This is an approach that was developed with the Maori community and takes into account cultural and acceptable practices for the target communities.

CONCLUSION

The above discussion on decentralization, contextual understandings, and need for systemwide approaches highlight the need for a better understanding of the role of power in UHC. As the compilation of evidence for the value of community engagement for health grows, it is also important to identify the methods, from a health system perspective, for engaging communities effectively in efforts to achieve UHC.

Power Balance

There are two separate challenges of power balance in community engagement: the power balance between community engagement systems and existing governing structures and the power balance within the community itself under engagement. These involve control of resources, control of participation and debate, and the capacity to shape interests.

The reason Arnstein and many other advocates of community engagement have focused on the issue of power and citizen control is that without decision-making ability, community engagement can easily become a sham. This is especially important because most community engagement projects are driven by external groups. In the long term, when community engagement mechanisms do not promote the ability to make and implement decisions, this creates frustration that undermines participation; paradoxically, the ability of community engagement to hold existing government structures to account requires the support from those very same structures.

The second power balance issue lies within communities and societies. Although participatory mechanisms are supposed to provide a voice for marginalized groups, success in achieving equitable outcomes depends on power distribution, level of participant motivation, and presence of facilitating...
Indeed, bottom-up processes may amplify local power asymmetries relative to status quo. Addressing power balance in community engagement requires good design—and new knowledge to enable design. Though standardizing participatory approaches is counterproductive, there needs to be a clear interface between representative and participatory government structures to clarify decision making and implementation responsibilities and ensure clear channels of communication and action. Understanding how these interfaces influence outcomes remains a major research need.

Methods for Effective Engagement
Community engagement is an important process in the implementation of health interventions, but there is a general dearth in the documentation of process-related evidence. Several studies have attempted to assess the evidence for the effectiveness of community engagement in the development of health policy. Though there are clear benefits such as increased health literacy, the outcomes are often poorly specified and it is often difficult to draw out the elements of participation that are effective and why. It is interesting to note that where benefits of community engagement are explicitly addressed, the outcomes listed focus on values and social goods and not on quantitatively measurable cost or program effectiveness indicators. Research from Australia, for instance, describes the benefits as recognition of rights to equitable health care, perception of public value, and robust and enduring relationships. Measurable outcomes include increased compliance to treatment regimes, increased health literacy, and value for money.

Community engagement is also an important means of identifying mechanisms to move toward UHC as well as an end in itself. In order to support and promote community engagement as normative within the context of health systems, the evidence base needs to be strengthened in four areas identified in the case studies as enablers:

1. Useful indicators for demonstrating the health impact of engaging communities, such as:
   • Coverage by community health workers, particularly where services are expanded and integrated.
   • Monitoring costs of community participation as an additional intervention in facilities designed to enhance UHC. This could provide the evidence to begin to reflect the value of engaging community against health indicators such as reduction in morbidity and mortality, as well as systems-related indicators such as quality of care, patient satisfaction, and health service utilization.
2. Evidence of community partnership activities that are sustained beyond or end with funding cycles and the factors that affect these outcomes.
3. Lessons from implementation of interventions that fail.
4. How to scale up successful community engagement interventions to other localities.

Engaging communities in decisions that affect their lives is key to strong and robust societies. Universal health coverage recognizes the core contribution of health and well-being to sustainable development and the provision of health care as a public good, a fundamental right, and a shared responsibility. When community engagement goes beyond instrumentalism and recognizes this right and responsibility, it can be effective in ensuring that health services are available to all—especially marginalized groups.

DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST
No potential conflict of interest was reported by the authors.

FUNDING
This work was supported by the WHO Western Pacific Regional Office Manila.

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REFERENCES
1. WHO. Declaration of Alma-Ata. Alma-Ata USSR; 1978 [accessed 2013 Dec 12]. http://www.who.int/publications/almaata_declaration_en.pdf.
2. World Health Organization (WHO). Ten years in public health 2007–2017. WHO; 2017 [accessed 2017 Dec 11]. http://www.who.int/publications/10-year-review/en/.
3. Boerma T, Eozenou P, Evans D, Evans T, Kieny M-P, Wagstaff A. Monitoring progress toward universal health coverage at country and global levels. PLoS Med. 2014;11:e1001731. doi:10.1371/journal.pmed.1001731.
4. Kutzin J. Health financing for universal coverage and health system performance: concepts and implications for policy. Bull World Health Organ. 2013;91:602–611. doi:10.2471/BLT.12.113985.
5. Global Burden of Disease Health Financing Collaborator Network. Trends in future health financing and coverage:
future health spending and universal health coverage in 188
countries, 2016–40. Lancet Lond Engl. 2018;391:1783–1798.
doi:10.1016/S0140-6736(18)30697-4.
6. Saksena P, Hsu J, Evans DB. Financial risk protection and universal
health coverage: evidence and measurement challenges. PLoS
Med. 2014;11:e1001701. doi:10.1371/journal.pmed.1001701.
7. Stenberg K, Hansson O, Edjejer-T-T-T, Bertram M, Brindley C,
Moshreky A, Rosen JE, Stover J, Verboorn P, Sanders R, et al.
Financing transformative health systems toward achievement of the
health Sustainable Development Goals: a model for projected resource needs in 67 low-income and
middle-income countries. Lancet Glob Health. 2017;5:e875–87.
doi:10.1016/S2214-109X(17)30262-2.
8. Lauer JA, Rajan D, Bertram MY. Priority setting for universal
health coverage: we need to focus both on substance and on
process. Int J Health Policy Manag. 2017;6:601–603.
doi:10.15171/ijhpm.2017.06.
9. Bump I, Cashin C, Chalkidou K, Evans D, González-Pier E, Guo Y,
Holtz J, Hay DT, Levin C, Marten R, et al. Implementing pro-poor universal health coverage. Lancet Glob Health. 2016;4:
e14–6. doi:10.1016/S2214-109X(16)30211-X.
10. Black RE, Taylor CE, Arole S, Bang A, Bhutta ZA, Chowdhury AMR, Kirkwood BR, Kureshy N, Lanata CF,
Phillips JF, et al. Comprehensive review of the evidence regarding the effectiveness of community-based primary
health care in improving maternal, neonatal and child health: 8. summary and recommendations of the Expert Panel. J Glob
Health. 2017;7:010908. doi:10.7189/jogh.07.010908.
11. Perry HB, Sacks E, Schleiff M, Kumapley R, Gupta S, Rassekh BM, Freeman PA. Comprehensive review of the evidence
regarding the effectiveness of community-based primary
primary health care in improving maternal, neonatal and child health: 6. strategies used by effective projects. J Glob Health.
2017;7. doi:10.7189/jogh.07.010906.
12. Potts H, Hunt PH Participation and the right to the highest
attainable standard of health; 2008 [accessed 2018 Aug 31].
http://repository.essex.ac.uk/9714/.
13. Van Minh H, Pocock NS, Chaiyakunapruk N, Chhorvann C,
Duc HA, Hanvorachangpi P, Lim J, Lecero-Prisno, DE, Ng N,
Phaholyothin N. Progress toward universal health coverage in
ASEAN. Glob Health Action. 2014;7:25856. doi:10.3402/gha.
v7.25484.
14. Allotey P, Reidpath DD, Yasin S, Chan CK, de-Graft Aikins A.
Rethinking health-care systems: a focus on chronicity. Lancet.
2011;377:450–451. doi:10.1016/S0140-6736(10)61856-9.
15. Jahan N, Allotey P, Arunachalam D, Yasin S, Soyiri IN,
Davey TM, Reidpath DD. The rural bite in population pyra-
mid: what are the implications for responsiveness of health
systems in middle income countries? BMC Public Health.
2014;14(Suppl 2):S8. doi:10.1186/1471-2458-14-S2-S8.
16. Potts H, Hunt PH Accountability and the right to the highest
attainable standard of health; 2004 [accessed 2017 Nov 5]
http://www.comminit.com/democracy-governance/content/
accountability-and-right-highest-attainable-standard-health.
17. Stuart G. What are vertical and horizontal community
engagement? Sustain Community. 2012. published online
May 24. [accessed 2017 Dec 10]. https://sustainingcommu
nity.wordpress.com/2012/05/24/vertical-and-horizontal-
community-engagement/.
18. Arnstein SR. A ladder of citizen participation. J Am Inst
Plann. 1969;35:216–224. doi:10.1080/01944366908977225.
19. Randall R. Consumer co-creation in health: innovating in Primary Health Networks. Consum Health Forum Aust.
2016. [accessed 2017 Dec 9]. http://ahha.asn.au/system/files/
docs/publications/evidence_brief_14_consumer_co-creation
_in_health_innovating_in_primary_health_networks_0.pdf.
20. Janamian T, Crossland L, Wells L. On the road to value
co-creation in health care: the role of consumers in defining
the destination, planning the journey and sharing the drive.
Med J Aust. 2016;204:S12–14. doi:10.5694/mja16.00123.
21. Reed MS, Vella S, Challies E, de Vente J, Frewer L,
Hohenwallner-Ries D, Huber T, Neumann RK, Oughton EA,
Sidoli del Cenzo J. A theory of participation: what makes
stakeholder and public engagement in environmental
management work? Restor Ecol. 2017;26:S7–17.
22. Stuart G. What is the spectrum of public participation?Sustain
Community. 2017. published online Feb 13 [accessed 2017
Dec 10]. https://sustainingcommunity.wordpress.com/2017/02/
14/spectrum-of-public-participation/.
23. Rifkin SB. Examining the links between community participation and health outcomes: a review of the literature. Health Policy
Plan. 2014;29(Suppl 2):i98–i106. doi:10.1093/heapol/czu076.
24. Rifkin SB, Walt G. Why health improves: defining the issues concerning [’comprehensive primary health care’ and [’selective
primary health care’. Soc Sci Med. 1998;23:559–566. doi:10.1016/
S0794-579X(97)72526-1.
25. Joarder T, Uddin A, Islam A. Achieving universal health
coverage: state of community empowerment in Bangladesh.
Glob Health Gov. 2013;6:129–131.
26. Daveson BA, Bausewein C, Murtagh FEM, Calanzani N,
Higginson JJ, Harding R, Cohen J, Simon ST, Deliens L,
Bechinger-English D, et al. To be involved or not to be involved: a survey of public preferences for self-involvement in
decision-making involving mental capacity (competency)
within Europe. Palliat Med. 2013;27:418–427. doi:10.1177/
0269216312471883.
27. Fredriksson M, Eriksson M, Titter J. Who wants to be involved
in health care decisions? Comparing preferences for individual
and collective involvement in England and Sweden. BMC Public
Health. 2017;18:18. doi:10.1186/s12889-017-4534-y.
28. Oh J, Ko Y, Alley AB, Kwon S. Participation of the lay public
in decision-making for benefit coverage of national health
insurance in South Korea. Health Syst Reform. 2015;1:62–71.
doi:10.4161/23288604.2014.991218.
29. WHO. Healthy China 2030 (from vision to action). WHO.
[accessed 2017 Dec 11]. http://www.who.int/healthpromotion/
conferences/9gchp/healthy-china/en/.
30. Colquhoun HL, Levac D, O’Brien KK, Strauss S, Tricco AC,
Perrier L, Kastner M, Moher D. Scoping reviews: time for clarity in definition, methods, and reporting. J Clin Epidemiol.
2014;67:1291–1294. doi:10.1016/j.jclinepi.2013.09.012.
31. Levac D, Colquhoun H, O’Brien KK. Scoping studies: advancing
the methodology. Implement Sci. 2010;5:69.
doi:10.1186/1748-9098-5-69.
32. Yin RK. Case study research. Design and methods. 4th ed. Los Angeles (London, New York): Sage Publications; 2009.

33. Jenkin E, Wilson E, Clarke M, Campain R, Mufitt K. Listening to the voices of children: understanding the human rights priorities of children with disability in Vanuatu and Papua New Guinea. Disabil Soc. 2017;32:358–380. doi:10.1080/09687599.2017.1296348.

34. Stoneman A, Atkinson D, Davey M, Marley JV. Quality improvement in practice: improving diabetes care and patient outcomes in Aboriginal Community Controlled Health Services. BMC Health Serv Res. 2014;14. doi:10.1186/1472-6963-14-481.

35. Adhikari B, Pell C, Phommasone K, Stevens JG, Page A, Hasnat MA, Dibley MJ, Raynes-Greenow C. Elements of effective community engagement: lessons from a targeted malaria elimination study in Lao PDR (Laos). Glob Health Action. 2017;10:663164. doi:10.1080/16549716.2017.1400048.

36. Atkinson J-AM, Fitzgerald L, Toalui G, Taleo G, Tynan A, Whittaker M, Riley I, Vallely A. Community participation for malaria elimination in Tafea Province, Vanuatu: part I. Maintaining motivation for prevention practices in the context of disappearing disease. Malar J. 2010;9:93. doi:10.1186/1475-2875-9-93.

37. Chater R, van Niekerk L Partners in leprosy action, philippines social innovation in health initiative. 2016 https://www.sociaiinnovationinhealth.org/downloads/Case_Studies/Partners_in_Leprosy_Action_SIIH_Case_Collection.pdf.

38. University of the Philippines Manila. 2017 [accessed 2018 Jan 3]. https://www.upm.edu.ph/node/2285.

39. SEACO (Southeast Asia Community Observatory). mDENGUE mobile application was awarded gold at ITEX 2017; 2017 [accessed 2018 Jan 3]. http://www.seaco.asia/seaco-was-awarded-with-a-gold-medal-in-itex-2017/.

40. WHO. Strategizing national health in the 21st century: a handbook. 2016 [accessed 2017 Nov 8]. http://www.who.int/healthsystems/publications/nhsp-handbook/en/.

41. Rohrer K, Rajan D WHO. Population consultation on needs and expectations. WHO; 2016 [accessed 2017 Nov 8]. http://www.who.int/healthsystems/publications/nhsp-handbook-ch2/en/.

42. Blacksheer E. Participatory and deliberative practices in health: meanings, distinctions, and implications for health equity. J Public Deliberation. 2013;9. https://www.publicdeliberation.net/jpd/vol9/iss1/art6.

43. Brackertz N, Meredith D. Community consultation and the ‘Hard to Reach’. Melbourne: Swinburne Institute for Social Research; 2005. p. 79.

44. White JH, Miller B, Magin P, Attia J, Sturm J, Pollack M. Access and participation in the community: a prospective qualitative study of driving post-stroke. Disabil Rehabil. 2012;34:831–838. doi:10.3109/09638288.2011.623754.

45. Ballard M, Montgomery P. Systematic review of interventions for improving the performance of community health workers in low-income and middle-income countries. BMJ Open. 2017;7:e014216. doi:10.1136/bmjopen-2016-014216.

46. Pallas SW, Minhas D, Pérez-Escamilla R, Taylor L, Curry L, Bradley EH. Community health workers in low- and middle-income countries: what do we know about scaling up and sustainability? Am J Public Health. 2013;103:e74–82. doi:10.2105/AJPH.2012.301102.

47. Anderson I, Robson B, Connolly M, Al-Yaman F, Bjertness E, King A, Tynan M, Madden R, Bang A, Coimbra CEA, et al. Indigenous and tribal peoples’ health (The Lancet-Lowitja Institute Global Collaboration): a population study. Lancet Lond Engl. 2016;388:131–157.

48. Mitchell M, Hussey LM. The Aboriginal health worker. Med J Aust. 2006;184:529–530.

49. Freeman T, Baum F, Lawless A, Labonté R, Sanders D, Boffa J, Edwards T, Javanparast S. Case study of an aboriginal community-controlled health service in Australia: universal, rights-based, publicly funded comprehensive primary health care in action. Health Hum Rights. 2016;18:93–108.

50. Si D, Bailie RS, Togni SI, d’Abbs PHN, Robinson GW. Aboriginal health workers and diabetes care in remote community health centres: a mixed method analysis. Med J Aust. 2006;185:40–45.

51. Franklin A, Krane D, Ebdon C. Multilevel governance processes – citizens & local budgeting: comparing Brazil, China, & The United States. Int Rev Public Adm. 2013;18:121–144.

52. Mahmood Q, Muntaner C. Politics, class actors, and health sector reform in Brazil and Venezuela. Glob Health Promot. 2013;20:59–67. doi:10.1186/17579591-2013-3476902.

53. Reed MS. Stakeholder participation for environmental management: A literature review. Biol Conserv. 2008;141:2417–2431. doi:10.1016/j.biocon.2008.07.014.

54. Institute of Development Studies. Levels of participation participatory methods. [accessed 2017 Dec 10]. http://www.participatorymethods.org/method/levels-participation.

55. Reich MR, Harris J, Ikegami N, Maeda A, Cashin C, Araujo EC, Takemi K, Evans TG. Moving toward universal health coverage: lessons from 11 country studies. Lancet Lond Engl. 2016;387:811–816. doi:10.1016/S0140-6736(15)60002-2.

56. O’Keefe E, Hogg C. Public participation and marginalized groups: the community development model. Health Expect Int J Public Particip Health Care Health Policy. 1999;2:245–254.

57. Cyril S, Smith BJ, Possamai-Inesedy A, Renzaho AMN. Exploring the role of community engagement in improving the health of disadvantaged populations: a systematic review. Glob Health Action. 2015;8:29842. doi:10.3402/gha.v8.29034.

58. Ingram M, Schachter KA, Guernsey de Zapien J, Herman PM, Carvajal SC. Using participatory methods to enhance patient-centered mental health care in a federally qualified community health center serving a Mexican American farm-worker community. Health Expect Int J Public Particip Health Care Health Policy. 2015;18:3007–3018.

59. Odugbile-Kolev A, Parrish-Sprawl J. Universal health coverage and community engagement. Bull World Health Organ. 2018;96:660–661. doi:10.2471/BLT.17.202382.

60. Department AIE. Effectiveness of participatory approaches: do the new approaches offer an effective solution to the conventional problems in rural development projects? ADB independent evaluation department; 2004 [accessed 2018 Aug 8]. https://www.adb.org/documents/effectiveness-participatory-approaches-do-new-approaches-offer-effective-solution.

61. Murthy RK, Klugman B. Service accountability and community participation in the context of health sector reforms in Asia: implications for sexual and reproductive health
services. Health Policy Plan. 2004;19(Suppl 1):i78–86. doi:10.1093/heapol/czh048.

62. Whānau Ora program. Ministry Health NZ. [accessed 2017 Dec 11]. http://www.health.govt.nz/our-work/populations/maori-health/whanau-ora-program.

63. Barten F, Santana VS, Rongo L, Varillas W, Pakasi TA. Contextualising workers’ health and safety in urban settings: the need for a global perspective and an integrated approach. Habitat Int. 2008;32:223–236. doi:10.1016/j.habitatint.2007.08.017.

64. Kohler JC, Martinez MG. Participatory health councils and good governance: healthy democracy in Brazil? Int J Equity Health. 2015;14:21. doi:10.1186/s12939-015-0151-5.

65. Turner BL, Fischer-Kowalski M. Ester Boserup: an interdisciplinary visionary relevant for sustainability. Proc Natl Acad Sci. 2010;107:21963–21965. doi:10.1073/pnas.0910097107.

66. Fischer F Participatory Governance: From Theory To Practice. 2012; published online March 29. doi:10.1093/oxfordhb/9780199560530.013.0032.

67. Conklin A, Morris Z, Nolte E. What is the evidence base for public involvement in health-care policy?: results of a systematic scoping review. Health Expect Int J Public Particip Healthcare Health Policy. 2015;18:153–165.

68. Batalden M, Batalden P, Margolis P, Seid M, Armstrong G, Opipari-Arrigan L, Hartung H. Coproduction of health care service. BMJ Qual Saf. 2015; bmjqs-2015-004315.