

Community Engagement:

A summary of theoretical concepts

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Executive Summary

At the request of Cancer Screening Programs within Alberta Health Services, a high-level review of the literature was conducted to summarize community engagement approaches that target community-based organizations, for the purpose of improving health. Based on a review of an identified sample of articles, there were no engagement approaches that solely targeted community-based organizations. Rather, involving community-based organizations was lauded as an important part of any approach to engage a community (Carlisle, 2010; Jabbar & Abelson, 201; Lane & Tribe, 2010; Pasick, Oliva, Goldstein, & Nguyen, 2010). The method through which community-based organizations are involved depends upon the answer to the question: what level of engagement is required and for what purpose.

One literature review suggested that the effectiveness of any community engagement approach stipulated on the population and the health behavior (Swainston & Summerbell, 2008). Another review reported on the adverse impact an engagement initiative can have on its participants (Attree, French, Milton, Povall, Whitehead, & Popay, 2011), such as causing physical, psychological, and financial stress. Findings from primary studies and position papers suggested that while different approaches and models exist for community engagement, the evaluation of these have been sparse or undocumented. Concepts such as diversity of stakeholders, deliberative methods for consensus building, and equitable representation were identified as points for reflection when designing and implementing a community engagement initiative. Based on the findings of this report, it is recommended that:

- 1) A community engagement approach should be tailored to the population of interest and the target health behavior
- 2) Potential adverse effects of a community engagement initiative must be considered and mitigated
- 3) Community-based organizations must be involved in any engagement initiative
- 4) The inclusion of diverse stakeholders should not be at the expense of consensus building
- 5) Community engagement approaches should be evaluated

Taken together, the results of the summary may inform an engagement strategy to meet the specific needs of Cancer Screening Programs.

Background

In the spring of 2011, Cancer Screening Programs within Alberta Health Services articulated a need to increase rates of breast, cervical, and colorectal screening among ethnically and culturally diverse Albertan populations. As part of an approved 3-year project funded by the Alberta Cancer Prevention Legacy Fund to increase and sustain rates of screening, the project recognized that communities must first be sufficiently engaged. To this end, the project team requested a high-level review of the literature to identify effective approaches to engage with community-based organizations that serve ethnically and culturally diverse populations.

The goal of this report was to summarize engagement approaches with community-based organizations that have resulted in improved health outcomes.

The decision to not limit the outcome of interest only to rates of cancer screening was purposeful. In the case that there was little or no community engagement approach that specifically targeted cancer screening, this wider search would capture literature relevant to the ethnocultural engagement context.

Specifically, literature was gathered to answer the question: what approaches have been used to engage community-based organizations serving ethnically and culturally diverse communities, for the purpose of improving health outcomes?

Methods

To identify academic articles, a search strategy was developed in consultation with an information scientist. The Academic Search Complete database¹ was searched using the following terms: public participation, community engagement, community participation, ethnocultural, ethnic group, and culture group. The search was limited to articles published between January 2001 and May 2011 with the major subject headings of “community-based programs” and “participation.” To identify pertinent grey literature, the same search was performed in Google, where the first 100 results were screened for relevance².

¹ The database includes several electronic databases: CINAHL Plus with Full Text, Family Studies Abstracts, Health Business Elite, Health Source – Consumer Edition, Health Source – Nursing/Academic Edition, MEDLINE, Psychology and Behavioral Sciences Collection, Regional Business News, Social Work Abstracts, SocINDEX with Full Text, and Urban Studies Abstracts.

² At the recommendation of the information scientist, the inclusion of the first 100 hits was meant to keep the results within manageable limits

Articles were screened at title, abstract, and full text for relevance to community engagement. Articles were included if community engagement was discussed for the purpose of improving health or health care services. Articles were excluded if discussion of community engagement was absent or if community engagement was not for the purpose of addressing health outcomes. Results from relevant studies were synthesized narratively.

Results

While literature on the topic of community engagement is expansive, only articles relevant to understanding community engagement for the purpose of improving health were included. Excluded literature discussed community engagement for the purpose of addressing environmental issues (e.g. cleaning up of oil spills, developing safe water strategy, mining, cultural planning, and urban planning). While these issues are also intricately linked to health of the community, the focus was on the concept of advocacy, situated within politically charged settings where the relationship between the statutory agency and the community has been tenuous. For this reason, these articles were excluded because of their limited ability to inform a community engagement approach within the context of the ethnocultural engagement project.

The search for academic literature resulted in 109 hits with the aforementioned limits applied. Eleven articles were retained at full text. The Google-based search resulted in 10 600 hits, of which the first 100 were screened, contributing 5 articles for this review. The total number of articles included for reporting was 16. Two were rapid reviews of evidence, while the rest were primary studies or position papers.

Findings

Evidence from two review-level studies is summarized first, followed by findings from primary studies and position papers.

Review Articles

Swainston and Summerbell (2008) conducted a rapid review of the evidence on the effectiveness of community engagement approaches for health promotion interventions. The two research questions were: What community engagement approaches are effective for the planning, design, or delivery of health promotion interventions? What are barriers to using community engagement and what interventions have successfully overcome these barriers? Studies were excluded if they described secondary prevention interventions (e.g. screening programs), and if they targeted individuals (as opposed to communities).

The following community engagement approaches were identified in the studies included in Swainston and Summerbell's review (2008): community coalitions, neighborhood committees, peer educators, school health promotion council, peer leadership groups, community champions, and community workshops. These approaches were used to address several health domains, including cardiovascular health, childhood immunization, injury prevention, sexual health, smoking, alcohol, nutrition, and physical activity.

The effectiveness of the community engagement approach depended both on the target health behavior as well as the community of interest (Swainston & Summerbell, 2007). For example, peer educators may be effective in improving vaccination uptake among parents, but ineffective in preventing injury prevention in high risk youth (Swainston & Summerbell, 2007). Of particular relevance to the ethnocultural engagement team, community workshops used in the design and delivery of an intervention may facilitate sustained participation (Swainston & Summerbell, 2007).

Barriers to community engagement included: centralized power in statutory sector organizations, short-term funding, lack of infrastructure (e.g. no facilities for meetings), lack of trust from community/voluntary sector organization, and propensity for some organizations to monopolize coalition groups (Swainston & Summerbell, 2008). Included studies did not identify strategies to mitigate these barriers.

The authors' cautioned that the included articles focused on evaluating the effectiveness of the health promotion intervention rather than community engagement. This limited the usability of findings as it was difficult to ascertain whether identified improvements in health were due to the intervention, the community engagement approach, or both (Swainston & Summerbell, 2008).

A second literature review addressed the impact of community engagement on participants of initiatives focused on social determinants of health (Attree et al, 2011). As such, articles in that review were drawn from multiple disciplines such as urban renewal, service planning, and civic participation.

Three main types of community engagement initiatives were found, with some initiatives overlapping between categories (Attree et al, 2011):

- 1) *Area-based initiatives targeting social and economic disparities*
- 2) *Person-based initiatives that aimed to engage marginalized populations*
- 3) *Coalition-based initiatives aimed at harnessing power from interest groups*

The initiatives ranged in their level of engagement, from consultation, to delegated power in planning and design, to co-governance or co-production. Interestingly, none of the initiatives were controlled solely by community members (Attree et al, 2011).

'Engaged' individuals reported positive changes in their physical health, psychological health, self-confidence, self-esteem, sense of personal empowerment, and social relationships (Attree et al, 2011). However, some adverse outcomes were also reported, such as exhaustion, stress, financial burden, consultation fatigue, and disappointment (Attree et al, 2011).

Primary studies/position papers

Three primary themes were identified from the findings from primary studies and position papers, they are summarized accordingly:

- 1) *Approaches/models for community engagement*
- 2) *Principles of community engagement*
- 3) *Cautionary considerations in community engagement*

It should be noted that there is some degree of overlap between these three categories, such that principles of engagement were also reflected in the articles that described approaches/models for engagement. Generally, articles that described principles of engagement without suggestion of an approach or a model were summarized in the principles' section.

Approaches and models for community engagement

The articles discussed here span from theoretical discussions, to considerations for practice, to those that encapsulate both. The inclusion of the theoretical documents was purposeful, because they described approaches/models that were developed from extensive field work. As such, there is confidence in the ability of these approaches/models to inform a community engagement initiative.

I. *National Institute for Health and Clinical Excellence (NICE) recommendations & Community engagement with Black and Minority Ethnic (BME) communities*

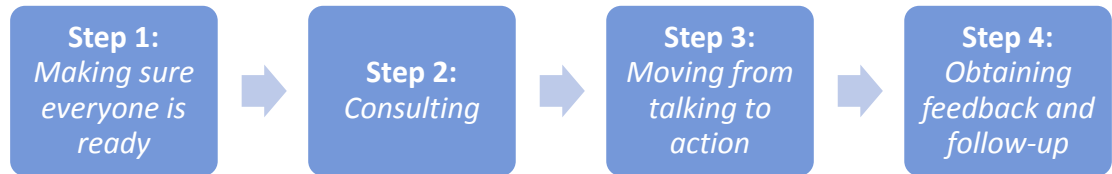
The National Institute for Health and Clinical Excellence in the United Kingdom (U.K) developed a set of 12 recommendations to guide effective community engagement (2008). These recommendations were based on the analysis of various types of data: reviewing government policies; systematically reviewing literature on community engagement approaches and the experience of community engagement; modeling the economic cost of community engagement; and incorporating program theory and evaluation principles (NICE, 2008).

Together, the recommendations cover four major components: prerequisites for success, infrastructure to support implementation, approaches to support and increase levels of community engagement, and evaluation. They are summarized in the table below.

Table 1: NICE Recommendations for Community Engagement

Recommendations	Component addressed by recommendation(s)
Coordinate implementation of relevant policy initiatives	Pre-requisites for success
Commit to long-term investment	
Be open to organizational and cultural change	
Be willing to share power, as appropriate, between statutory and community organizations	
Develop trust and respect among all those involved	
Support training and development of those working with the community (including members of that community)	Infrastructure to support implementation
Establish formal mechanisms that endorse working in partnership	
Support implementation of area-based initiatives	
Utilize community members as agents of change	Supporting/increasing level of engagement
Facilitate workshops in the community	
Consult with residents of the community	
Evaluate how community engagement approaches impact health and social outcomes	Evaluation

Using the NICE recommendations, Lane and Tribe (2010) offered a four-step practical guide based on their work with BME communities:



One of the major tasks in Step 1 is finding a local organization that is willing and able to partner (Lane & Tribe, 2010). To avoid selecting an organization whose views may not reflect that of the greater community, the authors suggested spending sufficient time within the community in order to decide which organization to engage with. While it is important to develop a meaningful partnership with a community, this process can be challenging for health agencies. Indeed, barriers in access to and acceptance by communities may hinder the early establishment of common goals. Other factors to consider during this stage of the engagement include recognizing culture-specific beliefs about health, ethical concerns, timing and commitment of consultation events, and interpretative services (if applicable).

During the consultation phase, Lane and Tribe (2010) highlighted two essential elements: 1) practical considerations – informing participants of what is required of them, and 2) frequency of consultation events. The authors advocated for one-to-one sessions with participants, wherever possible, over group sessions in order to decrease domination of the outcome by community members who may be opinionated (Lane & Tribe, 2010).

II. Centre for Ethnicity and Health (CEH) Community Engagement Model

The Centre for Ethnicity & Health in the United Kingdom, now known as the International School for Communities, Rights, and Inclusion (ISCRI), developed a community engagement model from their work with Black and minority ethnic communities (**Figure 1**).

Figure 1: Centre for Ethnicity and Health Community Engagement Model



Source: Fountain et al, 2007, pg. 5

The aim of the model was to create an equitable environment in which individuals, organizations, and agencies can work together to address an issue of mutual concern. There are several key ingredients to ensure the successful implementation of the model, including:

- A *facilitator* who will advertise, recruit, and select the community organizations to participate; provide and support a team of staff; and encourage inter and intra-community participation
- A *host community organization* that has good links to the target community
- A *task* that is meaningful, time-limited and manageable. It can be any or all of the circles in the model diagram, linking communities and agencies in an equitable working relationship
- *Training* of community organization members as co-coordinators of the project
- *Project support worker(s)* who provide support to the communities, as directed by the facilitator

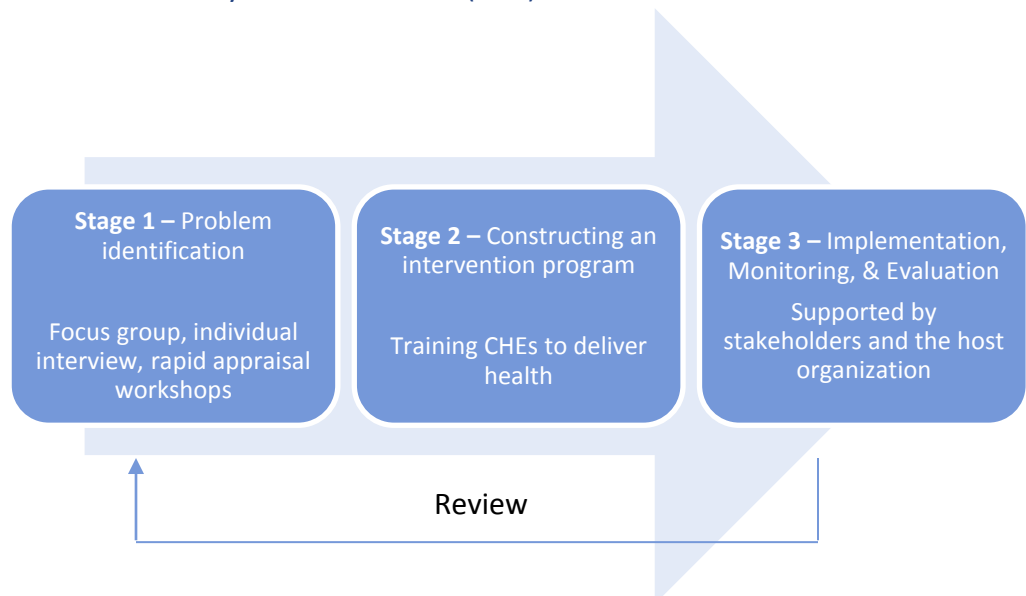
- *Funding* support for project activities and personnel
- A *steering group* that should include local health service planners and providers

This model has been used by the Center for Ethnicity and Health in more than 170 projects, with varying degrees of success (Fountain et al, 2007). However, it was developed in the context of community based research and the communities were financially compensated for participation. The extent to which compensation impacts the success of this model is unclear.

III. Community Health Educator model

Chiu (2008) described the use of a Community Health Educator (CHE) model (**Figure 2**) for engaging ethnic women from the United Kingdom in breast cancer prevention. Adapted from an action research framework, the model was developed on the principles of empowerment and capacity building.

Figure 2: The Community Health Educator (CHE) model



Source: Chiu, 2008, pg 152.

IV. The CLEAN checklist

Meade, Menard, Thervil, and Rivera (2009) used the CLEAN (Culture, Literacy, Education, Assessment, Networking) checklist to guide the engagement of Haitian women in Florida, USA, for the improvement of breast health. Although the checklist was intended to inform the process of health education, it also guided authors during the planning stage of the engagement process. As such,

these may be conceptualized as ‘prerequisites’ for success in community engagement, within the context of the ethnocultural engagement project. Each of the letters in the mnemonic tool is outlined below –

- *Culture*: what are some cultural beliefs within the community that would influence collaborative efforts to improve health?
- *Literacy*: How might language use, include low English proficiency, affect the engagement process? What would be the most appropriate medium to mitigate potential community barrier(s)?
- *Education*: what educational materials and resources are available?
- *Assessment*: What culturally competent health initiatives currently exist? How may these be adapted to fit the current engagement process?
- *Networking*: What additional community services or resources exist that may augment the current engagement process?

V. *Deliberation*

Scutchfield, Hall, and Ireson (2006) defined deliberation as a process that reveals underlying values among similar and different points of view for consensus based decisions. The process includes naming and framing the problem, deliberating about the problem, and determining the best solution to the problem (Scutchfield et al, 2006). To better understand the applicability of the model, investigators interviewed Chief Executive Officers of eight national public health constituent organizations in the US to ascertain whether deliberation was being implemented and what barriers, if any, exist.

Overall, the respondents felt that deliberation was carried out to varying degrees within their organizations. Interestingly, most respondents equated deliberation to community engagement (Scutchfield et al, 2006), based on its ability to instill community ownership over the issue and solution. A major barrier to deliberation included the concern that the deliberative process can further marginalize certain groups within the community if selection of participants was not thoughtful (Scutchfield et al, 2006). Another barrier was the potential tension that can arise when the community identifies a problem different from the one the health agency would like to or is able to address (Scutchfield et al, 2006). One major limitation of this study was the lack of information on the response rate, making it difficult to ascertain selection bias.

Abelson, Eyles, McLeod, Collins, McMullan, and Forest (2003) evaluated the effectiveness of deliberative processes on prioritizing health goals. Deliberative processes encourage dialogue between the community and the health agency, rather than a relay of information. Examples of deliberation methods include citizens' juries and focus groups (Abelson et al, 2003). Citizens' juries are usually comprised of 12-16 people. The purpose of the jury is to examine an issue and make a decision on how best to proceed after hearing from a range of speakers (Fountain et al, 2007). Focus groups are comparably smaller in size, ranging from six to 12 participants. The purpose of a focus group is to understand the perceptions, beliefs, and attitudes on a certain topic. A moderator facilitates the discussion, and there is usually a set of pre-determined questions (Fountain et al, 2007).

According to Abelson et al (2003), deliberative methods are characterized by the following attributes:

- The formation of a small group that is representative of the community of interest
- Single or multiple opportunities for face-to-face meetings
- Communication of relevant background information on the issue
- Involvement of experts to answer participants' questions
- Co-production of a set of recommendations from the group's deliberation

The authors compared rankings of health priorities using three methods: mail survey, telephone survey, and a face-to-face meeting. They found that with increased deliberation, participant views were more amenable to change (Abelson et al, 2003), illustrating the potential for deliberation to encourage consensus building.

VI. The LHIN framework

Jabbar and Abelson (2011) provided the lone community engagement framework developed within the Canadian context. Staff members from Local Health Integration Networks (LHIN³) in Ontario, Canada were recruited to develop a community engagement framework.

³ LHINs are the Ontario-equivalents of the former regional health authorities in the province of Alberta

Using a concept mapping approach, the participants identified six major components of a community engagement framework:

- Collaboration – working together to improve health
- Accessibility – ensuring people have a voice
- Accountability – health agency’s responsibilities to the community
- Education – supporting transparency and information
- Principles – making engagement meaningful
- Organizational capacity – prioritizing community engagement within the health agency

Because the study was explorative in nature, it lacked recommendations on how to operationalize the model.

VII. The CTSI guide to community-engaged research

In 2010, the Clinical Translational Science Institute (CTSI) at the University of California San Francisco (UCSF) produced a manual for researchers to inform collaborations with community-based organizations (Pasick et al, 2010). Although it was meant to guide community engagement for the purpose of conducting research, parts of the guide may be transferrable to community engagement for the purpose of health services. In preparation for the initial conversation with community-based organizations, the authors suggested considering the following questions:

- What interests do you have about the populations we serve?
- What do you want to accomplish?
- What makes your organization a good match for this project? What kind of help do you need?
- How will this project impact our work?
- Have you ever working with organizations similar to us before?
- What resources are available to support our participation?
- What kind of day-to-day and long-range decisions have to be made?
- What will the products of the research of our agency and for our community?

Principles of community engagement

The two papers summarized here include: 1) a theoretical discussion of principles essential to meaningful participation, and 2) an evaluation of a teen pregnancy prevention program with implications for practice.

Webler and Tuler (2002) suggested that there are two levels of enhanced public participation: sustained deliberation and power sharing. At the first level, there is the opportunity for sustained deliberation, which has already been described in a previous section. At the second level is the concept of power sharing, wherein a sense of joint ownership over the issue and its solution is instilled. In order to achieve either level in practice, the principles of *fairness* and *competence* must be adhered to (Webler and Tuler, 2002).

Fairness refers to what participants are entitled to, which includes the opportunity to be present, to make statements, to challenge/answer/argue, and to participate in decision making (Webler and Tuler, 2002). Competence refers to having access to information, and using the best available procedures for knowledge selection. Types of knowledge may include scientific facts, norms, or subjective claims (Webler and Tuler, 2002). If consensus guides the decision making process, communities are more meaningfully engaged and invested in the outcomes (Webler and Tuler, 2002). In other words, consensus is not necessarily required to make all decisions, but there must be mutual agreement on how disputes will be resolved (Webler and Tuler, 2002).

In their evaluation of a teen pregnancy prevention program for African-American communities in North Chicago, informality, flexibility, inclusion, and equity were identified as principles of community engagement that supported the success of the programming (Goldberg et al, 2011).

The authors suggested that community partnerships, for the purpose of reducing health disparities, should be established at the conception of the project, involving diverse groups, and engaging health workers, as they often act as referral sources, advocates, recruiters, connectors, navigators, coaches, or data collectors (Goldberg et al, 2011). The authors further asserted that the engagement process should be cognizant of formal (e.g. executive director) and informal (e.g. case worker) leaders within the context of the organization. The consideration of both types of leaders is imperative to sustainability of partnership beyond engagement (Goldberg et al, 2011).

Cautionary considerations in community engagement

Three case studies offered descriptions of practical challenges in community engagement. Together, the findings can be categorized as cautionary insights that should be considered in the planning, design, and implementation of a community engagement initiative.

In their case study of the Community Partnership Network (CPN) in Greater Victoria, British Columbia, Schmidtke et al (2010) emphasized the critical role of the sociopolitical context. The CPN consisted of community groups and stakeholders, aiming to develop Victoria's capacity to welcome and integrate newcomers into communities, workplaces, and organizations (Schmidtke et al, 2010).

The recruitment of organizations into the network was based on previously established relationships, which included two settlement agencies representing the immigrant community. Authors suggested that this strategy perpetuated an existing unequal distribution of power (Schmidtke et al, 2010). It may also have prevented the successful inclusion of smaller ethnocultural community groups, thus limiting the reach of the network (Schmidtke et al, 2010).

Using the example of public participation in decision-making about health care, Dyer (2004) asserted that without clearly defining *how* community members should be involved and for *what purpose*, their potential contribution is diluted. Highlighting two types of knowledge needed to inform decision making: technical knowledge by scientists and phenomenological knowledge by the community, Dyer (2004) articulated that clarity of roles may facilitate meaningful participation of community members.

Carlisle (2010) offered similar insights from the Social Inclusion Partnerships (SIPs) in Scotland. With representation from community groups as well as local health authorities, SIPs were meant to address health inequalities using a partnership and community-led approach. Recruitment of community representation proved to be a complex and contestable process, as some community organizations felt that only an interested minority would seek involvement, and certain groups, such as youth, will remain unrepresented. Furthermore, the health authorities' emphasis on health promotion initiatives, like decreasing rates of smoking, was in disagreement with the community groups' priorities of creating more affordable housing (Carlisle, 2010). This suggests that depending on the project goal and scope, involving too diverse of partners may divert focus and impede consensus building. Finally, some community representatives exhibited hostile attitudes to others within their own communities, suggested that there is diversity and division by other demographics – age, sex, religion. While true community representation remains elusive, these are critical points of reflection in any community engagement initiative (Carlisle, 2010).



Discussion

An important distinction must be made between community engagement approaches and consultation methods. A community engagement approach is a series of steps to actively involve the community in addressing an issue (Swainston & Summerbell, 2008), such as forming a coalition, or facilitating community workshops. A consultation method is the way in which a community is involved in conversation, such as focus groups or in-person interviews.

The identified articles were broader in scope than the primary research question in that none of the studies discussed engagement approaches with community-based organizations. Rather, the focus of the studies was to engage the entire community of interest, of which involving community-based organizations was one component. To this end, building on existing relationships with community organizations is well documented in the literature as one of the strategies to engage the greater community (Carlisle, 2010; Jabbar & Abelson, 2011; Lane & Tribe, 2010; Pasick et al, 2010), which provides justification for the way the ethnocultural engagement team has chosen to proceed thus far.

Several scholars acknowledged the paucity of research in the evaluation of community engagement approaches (Abelson et al, 2003; Scutchfield et al, 2006; Swainston & Summerbell, 2007). In their narrative review of community engagement approaches and their impact on people and communities, Attree et al (2011) found that even *descriptions* of the approaches/methods were not generally available in the manuscripts.

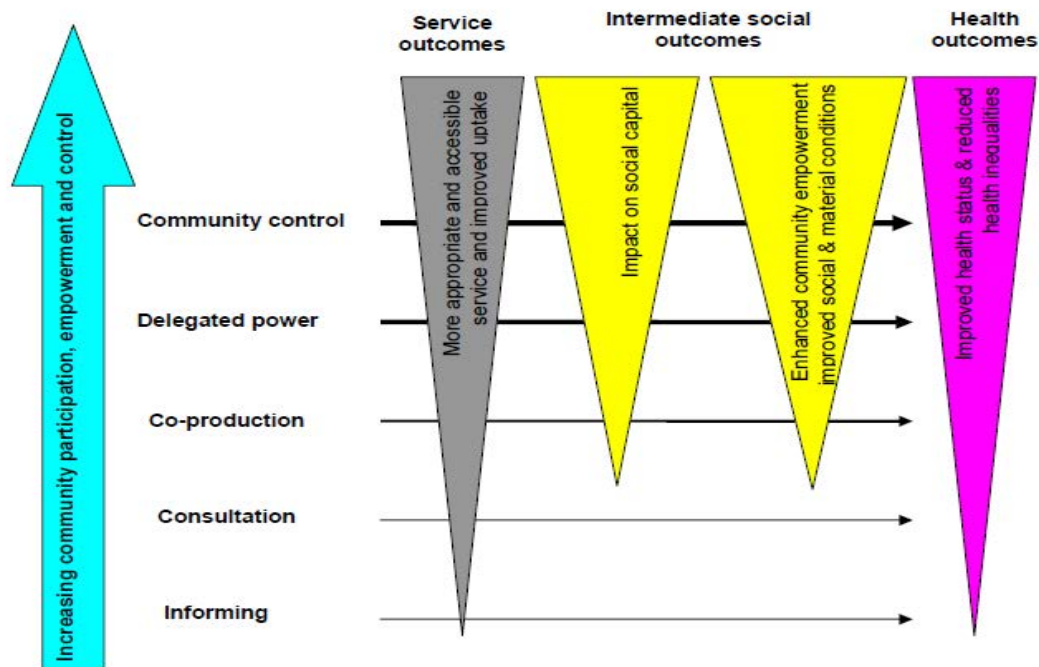
There was limited information how the choice of consultation method was chosen. Investigators used surveys (Abelson et al, 2003), focus groups (Abelson et al, 2003; Chiu, 2008), semi-structured interviews (Chiu, 2008; Lane & Tribe, 2010; Schmidtke et al, 2010), and community workshops (NICE, 2008). Some advocated for informative, discussion based forums (Goldberg et al, 2011). Although a variety of methods were implemented, the effectiveness of these methods is unknown in the absence of evaluation.

Of particular note to the ethnocultural engagement project team, Chiu (2008) elected the use of focus groups, interviews, and workshops within the problem identification stage of the CHE model. These dialogues may provide the project team with a better understanding of how to engage in conversation with the community. Furthermore, these engagement methods are consistent with the supported use of deliberative methods in health intervention planning, which was discussed in a previous section

(page 10). Again, neither the model nor its consultation methods have been evaluated. Its effectiveness, therefore, is unclear.

Taken together, it may be postulated that a prerequisite to choosing an engagement approach or consultation method is to ask the question: what level of engagement is expected from the community and for what purpose? To articulate the relationship between levels of engagement and desired outcomes, Popay’s (2010) illustration is included here (**Figure 3**). Popay (2010) differentiates between these levels of engagement: provision of information to communities, consultation, co-production, delegated power, and full community control. She further asserts that level of engagement is dependent on the desired outcome of the engagement (Popay, 2010). For example, for the service outcome of increasing uptake of services (grey inverted triangle), engagement at the level of informing may be sufficient. There is some evidence to suggest that deliberative methods may be helpful in priority setting, if the intention of the engagement is at the level of co-production or higher (Abelson et al, 2003).

Figure 3: Levels of engagement and desired outcomes



Source: Popay, 2010, pg. 186

Limitations

There are some limitations to this review. First, the literature search was not comprehensive as it was conducted in one academic database (e.g. Academic Search Complete). Although this database was a repository of multiple academic databases, searching in this alone cannot replace searching in each of the databases individually (personal communication, M. Vaska, June. 13th, 2011). Therefore, relevant manuscripts may not have been captured in the initial search. Second, the inclusion and exclusion of articles was at the discretion of a single reviewer. However, there is some confidence that the studies selected were consistent with the purpose of the review, as the reviewer and the project team communicated regularly about the progress of the project. Lastly, the evidence was not systematically reviewed for certainty of effect or scientific rigor. It should be mentioned that the intent of this review, as requested by the project team, was to provide a summary of the evidence. Therefore, although the evidence was not systematically reviewed, the methods and approach aligned with the purpose of the review.

Conclusion

From a review of a select sample of the literature on community engagement, no community engagement approaches that target community-based organizations in isolation were identified. Rather, strategies suggest that involving community-based organization is part of an effective community engagement approach (Carlisle, 2010; Jabbar & Abelson, 2011; Lane & Tribe, 2010; Pasick et al, 2010). In the absence of evidence, the selection of engagement approaches and consultation method will need to be guided by considering the purpose of the engagement. Specifically, what level of engagement is desired from the community and for what purpose.

The lack of comparison between engagement approaches may point to the greater importance of tailoring each approach to the community, rather than adopting one that has been demonstrated to be effective. Indeed, the effectiveness of an approach may depend on the target population and the health behavior (Swainston et al, 2007). The current review identified community engagement approaches that have been developed as a result of extensive field work (NICE, 2008; Fountain et al, 2007; Jabbar & Abelson, 2011; Pasick et al, 2010), principles of engagement that should be incorporated (Goldberg, 2011; Webler, 2002), and cautionary considerations to reflect upon (Dyer, 2004; Schmidtke et al, 2010; Carlisle, 2010). Based on the findings, the following recommendations were developed to provide some guidance in the planning, design, implementation and evaluation of a community engagement initiative specific to the ethnocultural engagement project.

Recommendations

1. A community engagement approach should be tailored to the population of interest as well as the target health behavior, as there is no evidence to suggest one approach is generalizable across these two domains.
2. Consideration must be given to anticipate and mitigate potential adverse effects a community engagement initiative may have on its participants, such as burden on physical, mental, and/or financial health.
3. Engaging with community-based organizations should be included as part of an effective community engagement initiative. The method through which the organization is consulted stipulates on what level of engagement is desired and for what purpose.
4. In selecting relevant stakeholders, consideration should be given in creating a balance between equitable representation of community groups and the impact of diversity on consensus building.
5. Community engagement approaches should be evaluated and their evaluations documented, in order to build upon an existing sparse body of literature. Practitioners and researchers should strive to articulate the community engagement component of a health promoting intervention.



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