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Community engagement and empowerment to address health inequalities: A rapid evidence review

Huw MacDonald [a,*], Martha Martin [b], Adnaan Ghanchi [c], Emily Clark [d], Amy Dehn Lunn [e], Anna Gkiouleka [e], Sashika Harasgama [e], Danielle Lamb [f], John Ford [e]

[a] Royal Free NHS Foundation Trust, UK
[b] GP and Honorary Clinical Research Fellow, Imperial College London, UK
[c] Department of Public Health and Primary Care, University of Cambridge, UK
[d] Norwich Medical School, University of East Anglia, UK
[e] Wolfson Institute for Population Health, Queen Mary University of London, UK
[f] NIHR Applied Research Collaboration, UCL, UK

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ABSTRACT

The policy challenge: Health inequalities in high income countries persist despite decades of policy intervention, with traditional approaches often reinforcing rather than reducing disparities. Community-led strategies offer a more effective alternative, yet they remain underused in public health policy. Here we explore evidence on what works to empower communities and reduce health inequalities.

Key evidence to inform policy: This rapid evidence review explores the effectiveness of community engagement approaches. There is strong evidence supporting the use of community health workers (CHWs) to reduce health inequalities in cardiovascular disease prevention and cancer screening and care, particularly when roles and training are tailored to specific needs. There is also good evidence for partnerships with faith-based organisations, which yield modest but significant improvements in cardiovascular health, healthy weight, and cancer screening outcomes. However, evidence remains mixed or limited for partnerships with other community venues and peer support programmes. The specific health effects of co-design and empowerment approaches remain inconclusive due to few studies in this area. Cross-cutting themes highlight the importance of cultural tailoring and alignment in community engagement strategies.

Further considerations and implications: Community-centred approaches, especially those targeting upstream determinants of health, remain critically understudied with most studies focusing on the US context. This review highlights an urgent need for further research to strengthen the evidence base and refine community engagement strategies for advancing health equity. Policy makers should consider CHW programmes, partnership with faith-based organisations, and cultural tailoring and congruence in advancing health equity.

1. Current policy challenge

Despite being an international policy priority for decades, health inequalities have persisted [1]. Socioeconomic gradients in life expectancy continue; for example, in England there is a 7 and 12-year gap between men and women living in the most and least deprived areas respectively [2]. Similar patterns play out for other outcomes including childhood obesity, hospital admissions for children, and self-harm. Minority groups are also affected, including certain ethnic groups, people who live with disability, asylum seekers and refugees, and people who are LGBTQ+.

Many traditional public health interventions have the potential to exacerbate rather than alleviate health inequalities [3,4]. These 'intervention-generated inequalities' can result from a tendency for the already most advantaged to better access, understand, and comply with health interventions [3,4]. Interventions targeting upstream determinants, including increases to the national minimum wage, funding for housing, and the introduction of children's centres, as in England's

* Corresponding author.
E-mail addresses: huw.macdonald1@nhs.net (H. MacDonald), martha.martin@nhs.net (M. Martin), ag2479@cam.ac.uk (A. Ghanchi), emily.clark2@nhs.net (E. Clark), amy.dehnlunn@nhs.net (A.D. Lunn), a.gkiouleka@qmul.ac.uk (A. Gkiouleka), s.harasgama@qmul.ac.uk (S. Harasgama), d.lamb@ucl.ac.uk (D. Lamb), j.a.ford@qmul.ac.uk (J. Ford).

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health inequalities strategy (1999 to 2010) have been effective [5,6], but are often constrained by economic pressures. Community-centred approaches are an alternative which, through increasing social capital and empowerment, have the potential to deliver significant benefits to the most disadvantaged communities at relatively low cost [4].

Community engagement approaches in public health have previously been mapped and categorised [7,8]. However, it is less clear which approaches are effective in improving health, in which contexts, and the components most crucial for their success. Here, we undertake a rapid evidence review of what works to improve community engagement and empowerment to address health and care inequalities.

2. Approach to collating evidence

We undertook a rapid evidence review to inform policy on community engagement and empowerment. This was a high-level review covering the whole spectrum of community engagement and empowerment approaches. It was not intended to by systematic.

Our inclusion criteria were review articles, published since 2014, reporting on community-centred interventions for disadvantaged groups and including health-related outcomes.

Several search strategies were combined to identify relevant articles. The Health Equity Evidence Centre's Living Evidence Maps, a machine learning powered aggregator of relevant research, was used to identify core papers (as described in Torres et al. [9]). A supplementary manual search was also carried out in Medline, Healthstar, Embase and Emcare for quality assurance purposes, followed by a snowball search using an AI tool (LitMaps). Search terms used combinations of concepts relating to community engagement, disadvantaged or marginalised groups, and health-related outcomes.

We used a prioritisation approach to navigate and effectively synthesise a large evidence base which involved focusing on the most relevant and highest-quality articles. Factors for prioritisation included recency, strength of quantitative findings, volume and breadth of research appraised, direct relevance to community engagement, and translatability to the UK context. In total, after prioritisation, 32 research articles were reviewed. See Table 1 for list of included studies.

3. Key evidence to inform policy

Adapted from a review by O'Mara and colleagues examining community engagement to reduce inequalities [4], a typology was generated to categorise the research articles according to the focus of interventions reviewed [8]. As shown in Fig. 1, this included interventions involved in; (1) co-designing with communities, (2) delivering with communities, or (3) empowering communities (see Fig. 1). Cross-cutting themes were also explored.

Table 1
List of papers reviewed in this evidence review.

First author	Date	Interventions	Study type	Population	Geographical focus of findings
Adeagdo [10]	2022	Co-designing with communities	Systematic review	Black population	Global
Seale [11]	2023	Co-designing with communities	Scoping review	Ethnic minorities	Australia
Yip [12]	2024	Co-designing with communities	Umbrella review	Ethnic minorities	UK
Anderson [13]	2015	Co-designing with communities	Systematic review	Ethnic minorities	USA (mostly)
Kim [14]	2016	Community health workers	Systematic review	Range of marginalised communities	USA (mostly)
Sharma [15]	2019	Community health workers	Scoping review	Range of marginalised communities	USA (mostly)
Rees [16]	2018	Community health workers	Systematic review	Lower socioeconomic groups	Global
Okasako-Schmucker [17]	2023	Community health workers	Systematic review	Adults eligible for cancer screening	USA (mostly)
Tian [18]	2021	Community health workers	Systematic review & meta-analysis	Adult women	USA (mostly)
Chan [19]	2023	Community health workers	Overview of systematic reviews and emerging literature	Adults at risk of or diagnosed with cancer	Global
Mistry [20]	2021	Community health workers	Systematic review	Adults using primary care navigation	USA
Mosquera [21]	2023	Community health workers	Systematic review	Adults eligible for cancer screening	USA
Rana [22]	2024	Community health workers	Systematic review & meta-analysis	Ethnic minorities	USA
Kim [23]	2022	Community health workers	Systematic review & meta-analysis	Asian population	USA
Patil [24]	2024	Community health workers	Systematic review, meta-analysis & RE-AIM evaluation	Socially disadvantaged populations	Global
Rawal [25]	2021	Community health workers	Systematic review & meta-analysis	Migrant populations and ethnic minorities	USA & UK
Evans [26]	2023	Community health workers	Systematic review & meta-analysis	Ethnic minorities; Low-income populations	USA & Australia
Baskin [27]	2021	Community health workers; Peer-led community engagement	Scoping review	Ethnic minorities	UK
Sanusi [28]	2023	Partnering with faith-based organisations	Systematic review	Adult faith communities	USA (mostly)
Chan [29]	2023	Partnering with faith-based organisations	Systematic review & meta-analysis	Hard-to-reach, socio-economically marginalised communities	USA (mostly)
Hou [30]	2018	Partnering with faith-based organisations	Systematic review	Ethnic minorities	USA
Abu-Ras [31]	2024	Partnering with faith-based organisations	Scoping review	Muslim communities	Global
Harris [32]	2015	Peer-led community engagement	Realist review	Disadvantaged communities	Global
Sokol [33]	2016	Peer-led community engagement	Systematic review	“Hardly reached” communities	Global
Huang [34]	2020	Peer-led community engagement	Systematic review & meta-analysis	Mothers and pregnant women	Global
Cooper [35]	2018	Peer-led community engagement	Umbrella review	People with a mental health condition	Global
Cabassa [36]	2017	Peer-led community engagement	Systematic review	People with severe mental illness	USA & Australia
Spencer [37]	2023	Peer-led community engagement	Rapid review	Ethnic minority groups with diabetes	USA, UK & Mexico
Thompson [38]	2022	Peer-led community engagement	Umbrella review	People with long-term conditions	Global
Lim [39]	2024	Peer-led community engagement	Systematic review	Adults at risk of cardiovascular disease	UK
Khosla [40]	2024	Partnering with barbershops	Narrative review	Black population	USA
Joo [41]	2021	Culturally tailored interventions	Umbrella review	Ethnic minorities	Global

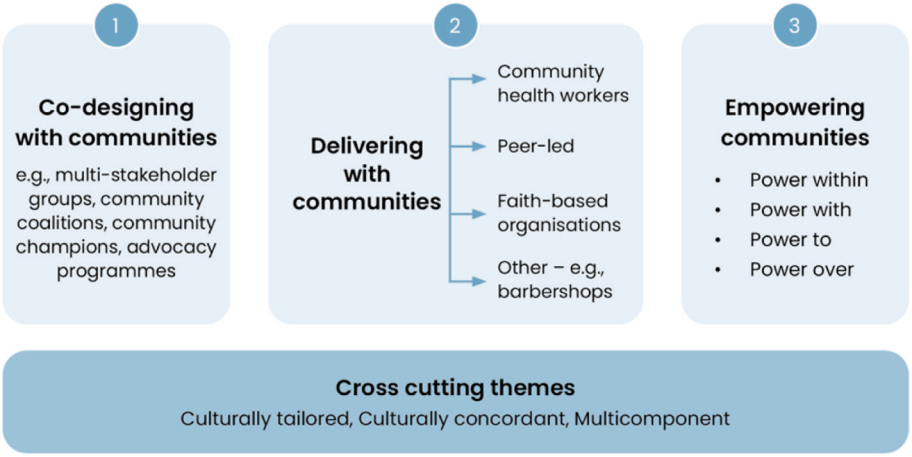

Fig. 1. Summary of action areas and evidence-based examples to support community engagement and empowerment.

3.1. Co-designing with communities

Four reviews examined the effectiveness of community participation in designing health services and interventions, consistently finding improvements in health outcomes for ethnic minority populations [10–13]. Two reviews focused on health inequalities during the COVID-19 pandemic [10,11]. Adeagbo and colleagues (2022) found interventions incorporating communication, community engagement, and culturally-tailored information significantly improved vaccine uptake in black populations, with less effective interventions being incentive or mandate-based [10]. Seale and colleagues (2023) reported similar findings across 38 studies in Australia, showing that community engagement effectively addressed mistrust and the lack of culturally-tailored information [11]. Yip and colleagues (2024) analysed 29 studies aiming to reduce ethnic disparities in UK healthcare, finding that active community involvement promoted culturally appropriate care in palliative service planning [12]. Anderson and colleagues' (2015) review of 58 studies on 'community coalitions'—partnerships between healthcare or social organisations and ethnic minority communities—indicated both individual and health-system level improvements, though they noted power imbalances and poor sustainability may undermine empowerment [13].

None of these reviews conclusively demonstrated the added benefit of community co-design beyond the health interventions alone, although this was mostly not the primary aim of the studies. Only one study within Anderson and colleagues' review tested this specifically. This study of depression care in African American people by Wells and colleagues (2013) found a co-led community engagement programme was more effective at improving health-related quality of life, physical activity, risk factors for homelessness and hospitalisations than a train-the-trainer health care model without community engagement [42].

3.2. Community health workers

Fourteen reviews assessed the effectiveness of community health workers (CHWs) in improving health. In this model, originally developed in Brazil in the 1990s, community members are trained to act as bridges between the community and health systems. Evidence from Brazil shows significantly improved cardiovascular disease outcomes [43], reduced hospitalisation rates [43] and reductions in infant mortality [44]. This is after 20 years of implementation however, and variations implemented outside of Brazil may not be directly comparable or as successful. The strongest evidence reviewed here highlights the potential of CHWs for cardiovascular disease prevention and cancer screening. Kim and colleagues (2016) observed that the majority of 30 studies on cancer screening uptake reported positive outcomes, while 26 studies on reducing cardiovascular disease risks showed improvements in blood pressure, blood glucose, lipid levels, and physical activity [14]. The success of CHWs appears to depend on their specific role, and a behaviour change model can be crucial to ensure roles align with the targeted health outcomes [15,16].

Nine reviews examined cancer screening and care, with most indicating improved outcomes [14–23]. Okasako-Schumucker and colleagues (2022) reported 10 to 13 percentage point increases in breast, cervical, and colorectal cancer screening uptake across 76 studies, primarily in the USA, particularly benefiting Asian Americans and low-income groups [17]. Rees and colleagues (2018), however, found mixed results for cervical cancer [16]. Cancer care outcomes may increase most when CHWs act as 'patient navigators'. Five reviews focusing on patient navigators noted substantial increases in screening uptake, though effects varied by race and education. Tian and colleagues' (2022) meta-analysis of 15 US trials showed that patient navigation doubled the likelihood of breast cancer screening and diagnosis in ethnic minority and low-income populations [18]. Chan and colleagues' (2023) umbrella review revealed that patient navigation also reduced hospitalisations during treatment, increased adherence to surveillance appointments, and improved patient knowledge and satisfaction in cancer survivors [19]. Conversely, Mistry and colleagues (2021) found CHW-led navigation had no effect on treatment outcomes [20]. Mosquera and colleagues' (2023) further demonstrated a risk that patient navigation could widen cancer inequalities if not appropriately targeted towards less advantaged groups [21].

In a large meta-analysis of 41 studies, Patil and colleagues (2024) found that CHW-led interventions achieved declines of 3.7 mmHg in systolic and 1.7 mmHg in diastolic blood pressure in hypertensive adults from disadvantaged populations [24]. In contrast to cancer care, optimal cardiovascular outcomes are linked to CHWs in 'patient educator' roles, focusing on health literacy and culturally relevant education. Two meta-analyses found significant reductions in blood glucose (HbA1c) levels in diabetic patients when CHWs offer basic medical education. In one of these, Rawal and colleagues (2021) found a modest 0.18% decline in blood glucose from CHW-led lifestyle programmes in the USA and UK [25]. Meanwhile, Evans and colleagues' (2023) analysis of 7 trials found a more substantial 0.5% reduction in disadvantaged groups in the USA and Australia, including ethnic minorities and low-income populations [26].

There is limited evidence for the benefits of CHWs in other health areas, possibly due to fewer studies. Mistry and colleagues (2021) found that CHW-led navigation contributed to primary care use optimisation [20]. Baskin and colleagues' (2021) review, meanwhile, found that only one of two CHW-led programmes targeting mental health in ethnic minorities demonstrated significant improvements [27].

Several factors may influence the success of CHW interventions. In two reviews, effectiveness varied with the degree and quality of training provided [14,19]. Several reviews further noted that longer study durations and more visits were associated with better outcomes [15,17,19], albeit at a risk of contact fatigue where some members of the community may become disengaged or less responsive to repeated interactions [15]. Another predictor of sustained outcomes is ensuring integration of CHWs within the wider health system [19].

3.3. Faith-based organisations

Four reviews examined partnership with faith-based organisations in health intervention delivery [28–31]. Most research was from the USA and predominantly focused on churches. There was good evidence for modest improvements in blood pressure, weight and cancer screening intentions.

Two reviews demonstrate that partnering with faith-based organisations delivers cardiovascular health improvements [28,29]. Sanusi and colleagues (2023) analysed 24 studies primarily in US churches, incorporating health education, coaching, diet advice, and blood pressure checks. Results showed a reduction in systolic blood pressure by 3.0 mmHg at three months and 0.7 mmHg at twelve months, with a significant mean weight loss of 0.83 kg at these intervals, though diastolic pressure remained unchanged [28]. Chan and colleagues' (2023) meta-analysis of 11 studies, mostly in US churches and one in a Thai Buddhist temple, noted an average systolic decrease of 6.2 mmHg in hypertensive individuals through interventions like physical activity sessions, healthy food provision, and walking groups, but there was no statistically significant change [29].

Abud-Ras and colleagues (2024) found generally beneficial health outcomes from 14 studies involving mosques [31]. Most were before-and-after studies with interventions including religiously tailored education programmes, peer-to-peer healthcare training, exercise programmes, psychotherapy, smoking cessation and methadone maintenance. Improvements were noted in mental health, engagement with addiction services, cancer screening and smoking cessation.

Hou and Cao's (2017) review found that interventions incorporating individual, group education and written materials in churches improve cancer knowledge and screening uptake in African American, Latino and Hispanic groups [30].

3.4. Peer-led community engagement

Nine reviews exploring community-based peer-led interventions for disadvantaged groups found mixed evidence for improvements in health equity, mental health, and chronic disease management [25,27,32–39].

Two reviews focused on reducing health inequalities [32,33]. Harris and colleagues (2015) found community-based peer support was likely to improve health literacy in disadvantaged communities when incorporating needs assessment, co-design and co-delivery, empowering education, ongoing support, and autonomy for peer supporters [32]. Sokol and Fisher (2016), meanwhile, found that peer support programmes near-universally improved engagement and retention of people from "hardly reached" communities in health programmes, especially when prioritising respect, trust and the involvement of people from disadvantaged backgrounds [33].

Reviews looking at mental health show mixed results [27,35,36]. Two reviews found that peer support is effective in perinatal depression. Huang and colleagues (2020) found a 0.36 mean reduction in depression scores [34]. Cooper and colleagues (2020) also found a positive effect for perinatal depression across 25 studies, and economic analyses featured in three studies found peer support to be both cost-effective and cost-saving [35]. However, there were mixed results for people with severe mental illness. Cabassa and colleagues (2017) shared this latter finding in their review of 18 studies [33]. The most promising interventions focused on self-management and peer-navigation. Two studies on peer support groups for British Pakistani women with depression were analysed by Baskin and colleagues' (2021) review [27]. These showed evidence of improvements in social functioning but mixed effects on depression symptoms. Key success factors for peer support were found to be adequate training and supervision, recovery-orientated culture in workplace interventions, strong leadership and a trusting workplace [35].

Four reviews found mixed results for peer support interventions in chronic disease management [25,37–39]. Spencer and colleagues (2024) found that peer support and self-management education improved diabetes control in a Mayan community in Mexico and in Korean-, African-, and Latino American communities in the USA [37]. Rawal and colleagues (2020) further found that peer-led interventions across 7 studies yielded larger HbA1c reductions than CHW interventions, though this was not statistically significant [25]. Thompson and colleagues (2022) found that peer support for chronic conditions was associated with positive, but usually non-significant effects in quality of life and self-efficacy across 31 studies [38]. Based on two UK feasibility studies of peer support workers in CVD, Lim and colleagues (2024) reported challenges in recruitment and retention, especially in disadvantaged groups [39].

3.5. Barbershops

One mini-review by Khosla and colleagues (2024) focused on barbershop interventions to improve health, particularly in the black community [40]. Of two RCTs included both were from the USA and targeted hypertension reduction in black men. The BARBER-1 trial of 1297 customers across 17 shops found that hypertension education, blood pressure monitoring and healthcare navigation led to an 8.8% higher hypertension control rate after 10 months, and a 21 mmHg reduction in systolic blood pressure for those referred to a hypertension specialist [45]. The Los Angeles Barbershop Blood Pressure Study of 319 black men across 52 barbershops similarly found a reduction of 22 mmHg in systolic blood pressure following referral to a specialist pharmacist at 6 months [46].

3.6. Community empowerment

No reviews were found investigating the effectiveness of community empowerment, defined as giving the community more control over their lives, for improving health.

3.7. Cross-cutting themes

Interventions culturally tailored to ethnic minority groups tend to have the best outcomes. Joo and colleagues' (2020) found that benefits include improved disease-related knowledge, clinical outcomes, satisfaction, and access to healthcare [41]. Ensuring cultural sensitivity and specificity was also a predictor of success in a review of cervical cancer screening interventions employing lay health workers [16]. Chan and colleagues (2023), however, found cultural tailoring of patient navigation in cancer care can have differential impacts by ethnic group, being effective for Hispanic, Latino and Asian populations but less so for African Americans [29].

Similarly, involving community members with high cultural concordance with the target population is generally most effective. Sharma and colleagues (2019), for example, found that, cultural and linguistic congruence between CHWs and the community underlay successful rapport [15]. Similarly, Chan and colleagues (2023) found that patient navigators from the same community and speaking the same language as the target population improved trust and increased the success of cancer care outcomes [19].

4. Further considerations and implications

With the potential of community-centred approaches to shift persistent health inequalities worldwide, this review has consolidated evidence on what works in using community engagement to improve health.

The strongest evidence supports the effectiveness of CHWs, especially in CVD prevention and cancer screening, especially when the role is well suited to the need and comprehensive training is provided. Good evidence is also found for small improvements in blood pressure, cancer screening and weight through partnership with faith-based organisations, but there is limited evidence for partnership with other community venues, and mixed results for peer support programmes.

There is insufficient evidence on the effectiveness of co-design with communities or community empowerment approaches. Studies have generally not compared health interventions led by or co-designed with the community against those same health interventions delivered without community leadership making it impossible to assess what value community involvement adds.

Given that professional-led public health interventions have been associated with 'intervention-generated inequalities', the fact that these community-delivered and community-based interventions have evidenced reducing health inequalities highlights them as a promising future delivery model for a wide range of public health programmes. While the alternative of investing more public spending into public services including education, social support, housing and public infrastructure has also previously shown long-term and wide-scale impact on reducing inequalities [5,6], it is expensive and subject to the volatility of political and economic contexts. Community-centred models are generally lower cost and could, within the right environment, be sustained.

While studies have been broadly categorised into types of community engagement approach, in reality nearly all studies combine multiple elements into a single programme. It is neither possible nor beneficial to dissect these programmes into their individual elements since the resulting health outcomes are likely due to synergistic effects. Future work should therefore consider how alternate combinations of approach could account for variability in the success of individual studies.

5. Limitations

The rapid nature of this evidence review means that relevant literature may have been missed, especially considering the inconsistent framing and the cross-disciplinary nature of community-centred research. Much of the research base is also qualitative in nature, which was not considered here and may have led to missed findings. There are further limitations in the representativeness of existing literature. A clear majority of studies, for example, were based in the USA and may not be generalisable to international contexts. Community-centred approaches, especially those targeting upstream determinants of health, remain critically understudied, limiting their potential to drive meaningful change. This review highlights an urgent need for further research to strengthen the evidence base and refine community engagement strategies for advancing health equity. Without targeted investment in this area, the full potential of community-led approaches will remain unknown.

6. Implications for policy

The evidence summarised here reinforces the need for integration of community-centred models within wider public health strategies. Many health systems, including the UK, are now experimenting with a shift towards community health interventions such as multidisciplinary community-based health teams, and community health and wellbeing workers. This evidence review supports the expansion of CHW programmes to boost preventive service uptake and improve chronic disease management - especially when locally recruited, culturally congruent with the target population, and where full integration into the wider health and care system can be sustained. Policymakers should also consider programmes which promote faith-based interventions, including screening, immunisation, health promotion and chronic disease management.

7. Ethics statement and consent to participate

Not applicable, as this study is based on a literature review and does not involve human participants.

Availability of data and materials

The data supporting this article's conclusions are available in the referenced studies.

Authors' contributions

HM and JF conceptualised the study. HM, AG, and SH conducted the literature review and data extraction. HM, MM, EC, ADL, SH, DL and JF synthesised findings. HM, AGh and JF led manuscript writing. All authors contributed to and approved the final manuscript.

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