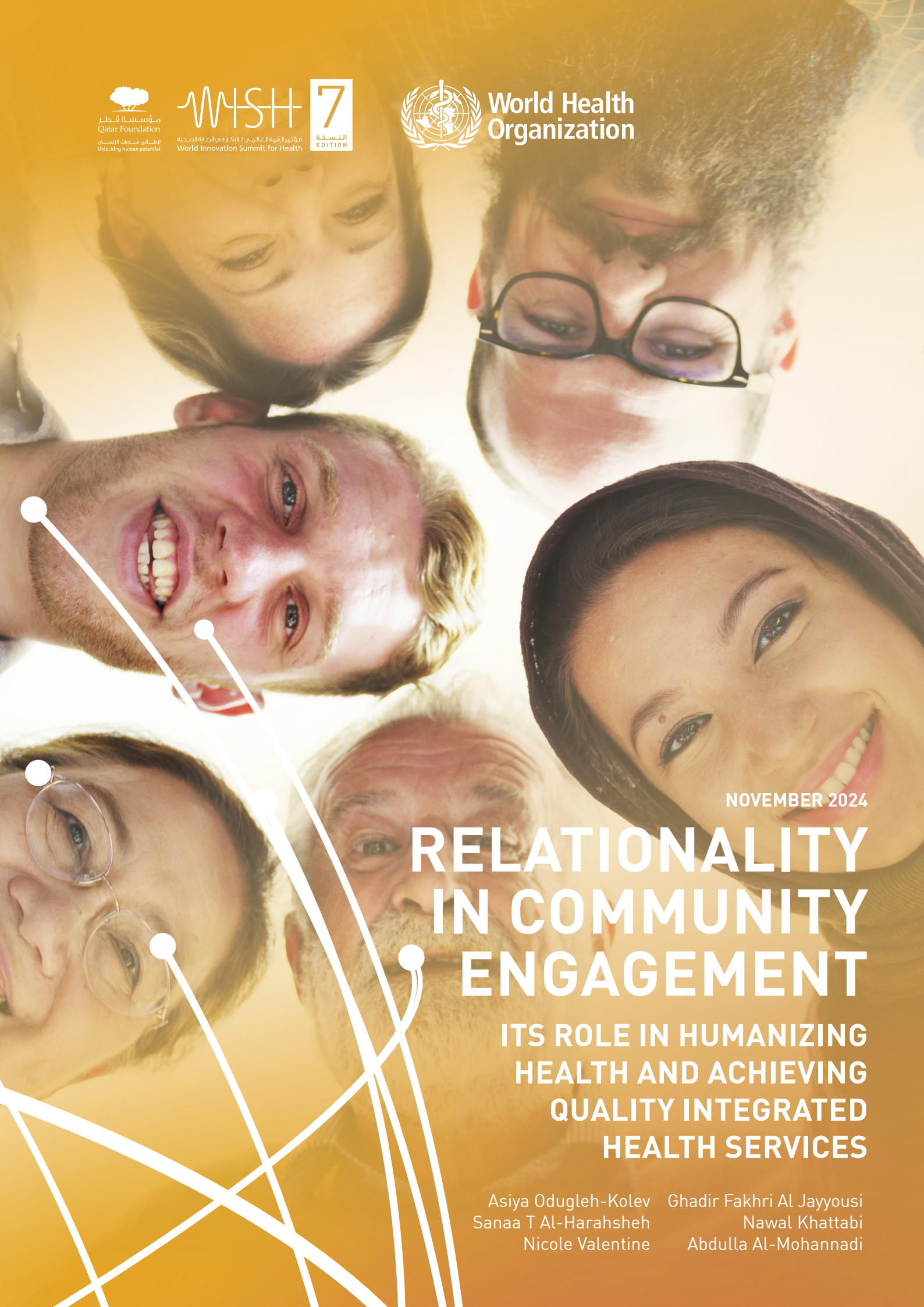

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RELATIONALITY IN COMMUNITY ENGAGEMENT

ITS ROLE IN HUMANIZING HEALTH AND ACHIEVING QUALITY INTEGRATED HEALTH SERVICES

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FOREWORD

Community engagement in health is informed by multiple and diverse disciplines and professions that address the continuum of social connection. This includes attachment in early childhood, as well as the ongoing processes of social interaction during adolescence and throughout adulthood. Our communities and social connections define who we are as much as we define the many communities that we belong to – many concurrent – in our lifetime.

Since the Alma-Ata Declaration in 1978,[1] many terms have been used by the health sector to describe the relationship between government and people – these include 'community empowerment', 'community participation', 'social mobilization' and (more recently) 'social participation'.[2] Within the World Health Organization the term 'community engagement' emerged as a direct legacy of the 2013–2016 Ebola virus epidemic in West Africa, following calls for more meaningful, authentic engagement with affected populations, and better recognition and integration of the social sciences in response to infectious disease outbreaks and other emergencies.

In 2020, the COVID-19 pandemic raised the importance of broad, widescale and meaningful engagement with diverse communities. It was during this time that multidisciplinary research teams collaborated with national and local stakeholders in Cambodia, Lao People's Democratic Republic and Malaysia, to conduct primary community engagement research that took a relational perspective. A relational perspective does not view community engagement as an isolated point of consultation solely for information-sharing but as a dynamic process of continuous relationship-building with a goal of co-production. Multidisciplinary research teams sought to generate empirical evidence for how this form of community engagement could be embedded and sustained in the mindsets and ways of working for primary healthcare, HIV/AIDS, and mental health programming.[3]

WISH has consistently prioritized community engagement in healthcare, emphasizing patient-centered care and fostering global community collaboration for health innovation. The development of this report has provided an opportunity to reflect on the journey so far, revisiting basic concepts and tenets of 'community' as well as the purpose and scope of 'community engagement' and its ability to address quality of care and health system performance on the journey toward achieving universal health coverage. The approach taken has been inductive and deductive, aligning scientific research and community engagement practice anchored in country experiences across diverse contexts and at different scales of application.

Overall, the key message from the report is this – **people change systems**.

We hope that this policy briefing will contribute to the 'cultural shift' needed in communities and health authorities to build and sustain meaningful, trustful, and impactful co-production relationships.

EXECUTIVE SUMMARY

In the aftermath of the COVID-19 pandemic, community engagement has resurfaced as a necessary condition for emergency preparedness, response and recovery efforts in global public health. Yet there is ambiguity and a lack of consensus on definitions and scope, and significant gaps in evidence on how community engagement can be successfully achieved.

In traditional community engagement approaches, 'community' is often treated as a geographical location, or a group of people with lived experience of an issue; while the process of engagement is defined as an exchange of information. However, developments in scientific knowledge suggest that the concept of 'community' should be expanded to encompass the entire range of social connections – from early childhood attachment to ongoing social interactions throughout adolescence and into adulthood. This broader perspective acknowledges that people are inherently part of multiple, interconnected communities throughout their lives – each influencing their identities, emotions, decisions, behaviors and health. The health and care workers' community is also part of this larger context.

This renewed focus on community engagement is central to a primary healthcare (PHC) approach, and it aligns with the Ottawa Charter for Health Promotion which calls for health systems to address individuals' total needs.[4] 'Relational community engagement' emphasizes improving relationships among health and care workers, and between them and the people they care for. Governments are recommended to:

1. **Promote relational leadership, management, and governance**
    - Invest in adaptive transformative leadership models to drive whole-system learning.
    - Develop political commitment to adopt a relationship-focused approach to community engagement as an inherent way of working in health systems and across sectors.
    - Engage the health and care workforce and civil service across sectors to develop a renewed vision for public sector values and ways of working.
2. **Strengthen relationship-building capabilities in health systems**
    - Strengthen communication and collaboration in health systems, setting relational competency benchmarks, and invest in local capacities of communities to address power imbalances.
    - Develop participatory skills in multi-disciplinary teams and interprofessional practice.
    - Integrate social and contextual data in health service design and delivery.
3. **Invest in transdisciplinary research and practice development**
    - Fund research using the Integrated Change Framework (ICF) to foster collaboration across the sciences, technology, and the arts.

SECTION 1. INTRODUCTION

PURPOSE

This report has been developed for policymakers and health service and program managers who are responsible for designing and delivering health services across the life-course at varying levels of national and local health systems.

This report introduces a relational approach to community engagement and outlines investments needed to ready health systems to engage with patients, families and communities.* Section 1 introduces the background and current policy context for community engagement across World Health Organization (WHO) regions. Section 2 introduces an Integrated Change Framework (ICF) to embed and strengthen community engagement processes in health system functions and activities. Section 3 explores eight selected country case studies highlighting common success elements that have been incorporated into the ICF. Section 4 concludes with recommendations on applying the ICF to improve health system performance.

METHODS

WHO's approach to relationality in community engagement has evolved through a collaborative and iterative process involving countries, stakeholders, and partners. This report draws on reviews of existing community engagement frameworks, primary research, desk reviews of the scientific literature, focus group discussions, key informant interviews, community workshops, and WHO-commissioned studies. It also incorporates an analysis of relevant WHO global and regional resolutions, technical and strategic documents.

BACKGROUND AND CONTEXT

Community engagement is defined by WHO as: "the continuous and intentional process of relationship building between stakeholders who need to collaborate, share resources, and work together to achieved shared health goals."[5] This approach emphasizes the quality of relationships and dynamics of interactions between stakeholders, and is critical to enhance the effectiveness of health systems, to address the needs of populations who are living in vulnerable circumstances or otherwise marginalized, and to move closer to achieving universal health coverage (UHC). For the purpose of this report, the term *relational community engagement* is used to differentiate from traditional transactional approaches.

As the world faces environmental degradation, commercialization and societal polarization, these changes, alongside aging populations and shifting disease patterns, underscore the urgent need for health systems to meet these challenges.[6–8] Without this evolution, UHC remains out of reach.[9–11] Health systems must

* "Community engagement is a process of developing and maintaining relationships that enable people to work together to address health-related issues and promote well-being to achieve positive and sustainable health impact and outcomes." See Appendix 2 for the full definition.

prioritize comprehensive quality integrated services that respond to people's needs throughout their lives, particularly focusing on social cohesion, and addressing the needs of marginalized and disadvantaged populations who face systemic barriers to accessing quality care.[12,13]

Relational community engagement supports ongoing efforts of health promotion, health literacy approaches, and recognition of the social determinants of health to improve solidarity for health.[14] Health inequities are often perpetuated through unequal power and resource dynamics between stakeholders. Many health systems operate in a fragmented model, where services are often disconnected from the population's social and cultural contexts. This inconsistency within health systems contributes to inequities in access to care, poor quality of services and poor health outcomes.[15–17]

Relationality recognizes that community engagement is a shared responsibility across the health system. There are multiple interfaces between providers and users of healthcare at various levels of the health system, each contributing to the relationship between communities and the health system, and influencing service responsiveness and the quality of the user experience. Relationality incorporated into the way staff in health systems engage together and outward with communities is vital in settings marked by deep-rooted historical trauma and social injustice, helping to rebuild trust, foster reconciliation and enhance community resilience. Without proactive engagement, preventable health issues can escalate, healthcare costs soar, chronic diseases remain unaddressed, and inequalities widen.[18] For example, medical errors have been reported as the third-leading cause of death in the US, costing the health system $20 billion.[19]

Relational community engagement is not merely a strategic choice but a necessity for achieving the Sustainable Development Goals.

The importance of connection and belonging is well supported by both modern science and Indigenous knowledge, which view relationality as a fundamental aspect of care systems and wellbeing. These systems offer valuable insights as they view relationality as experiencing oneself as part of others, and vice versa. Integrating these insights can "profoundly influence service performance, satisfaction, and health outcomes by centering relational existence over time", benefiting the health and care workforce and the communities they serve.[20–22] Community membership fundamentally shapes how health and care workers carry out their professional duties and responsibilities. Relational community engagement is not merely a strategic choice but a necessity for achieving the Sustainable Development Goals (SDGs), particularly those related to health equality, and engaging stakeholders and inclusive institutions (SDG 3 and SDG 16).[23]

The COVID-19 pandemic further exacerbated gaps in healthcare, and exposed the erosion of trust in science and in the health and care workforce. High turnover rates, burnout and social isolation have alienated health and care workers from each other and the communities they serve, deepening feelings of marginalization, and reducing patient engagement.[24,25] WHO's Global Health and Care Workers Compact offers a framework for improving working conditions and safeguarding worker rights.

It highlights the importance of strengthening relationships in health and social care, and implementing relevant policies effectively.[26] Consequently, a well-defined and comprehensive approach to relational community engagement is essential.

The ICF compiled for this report offers a valuable schema for understanding and taking steps to strengthen the capacity of health systems for relational community engagement. By focusing on relationships within the health system, ICF provides a structured and technically sound approach to creating the conditions that bridge the gap between policy and practice. It helps to facilitate the creation of inclusive, responsive, and resilient health systems and communities.

SECTION 2. RELATIONALITY IN COMMUNITY ENGAGEMENT FOR HEALTH SYSTEMS

THE POLICY CONTEXT FOR COMMUNITY ENGAGEMENT

According to WHO regional resolutions and strategies, community engagement is universally recognized as a necessary condition to address a broad range of public health challenges.[27–33] While each region faces unique public health challenges, common priorities include:

- integrating community engagement into health systems.
- building trust and empowering communities through capacity building and social prescribing.
- ensuring inclusive participation, particularly of marginalized groups, in decision-making.
- fostering cross-sector collaboration.
- enhancing community resilience.
- using data-driven approaches to inform actions.
- securing long-term sustainability through adequate funding and governance.

WHO regional resolutions and strategies emphasize the integration of community engagement with PHC, and Essential Public Health Functions. Community engagement also has an essential role in risk communication, health promotion, disease prevention, and in achieving universal health coverage.

USING THE ICF TO STRENGTHEN RELATIONALITY IN COMMUNITY ENGAGEMENT PROCESSES FOR HEALTH SYSTEMS

The ICF introduced in this report reveals aspects of how health systems function by combining important elements that are common in different approaches: the cause-and-effect analysis of a theory of change; the step-by-step plan of a logic model; and the broader guidance of a framework. It creates a more cohesive approach and provides a unified and holistic guide to embed relational community engagement concepts and processes in health systems.

Many national health systems can be improved by addressing fragmentation, inefficiency, safety, and consistent quality of care but remedies do not usually consider relationality.[34] By specifying inputs and activities in the ICF that are important for relationality within health systems and relational community engagement without, decision-makers and managers can accelerate addressing systemic bottlenecks that limit holistic, integrated, and responsive care experiences for patients. They can also tailor services to people's changing needs across the life course. The ICF

can be used to assess and evaluate community engagement practices and lessons learned in a systematic and structured way. The case studies in Section 3 demonstrate elements of the ICF in real-world settings.

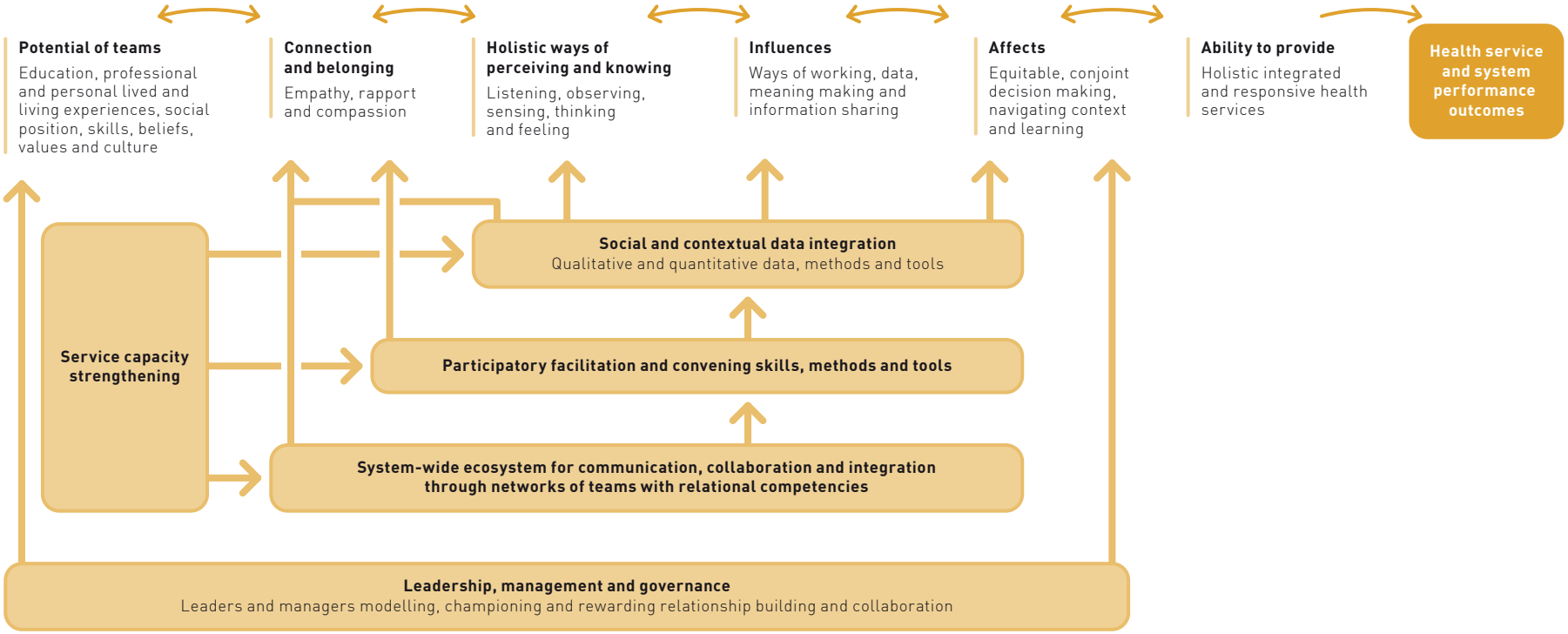
The ICF figure on page 8 summarizes the key themes emerging from the literature and reviewed case studies. Each component is interrelated and operates as a whole. Along the top, the ICF shows how to access and leverage the health and care workforce teams' potential for service design and delivery. The ICF highlights a fundamental change end point – the ability of individuals and teams to provide holistic, integrated and responsive health services – having this goal requires strengthening of relations within and between teams. The ICF emphasizes that health services are delivered *by* people *for* people. Health systems rely on networks of interdependent relationships for administrative, clinical, technical and operational functions. These relationships are often overlooked or inadequately considered in strategic planning and policymaking.[35] (See Appendix 3 for a comprehensive list of relational practices in health systems.)

For this report, the International Federation of Social Workers (IFSW) conducted focus group research with social workers from diverse contexts. For effective community engagement, they recommended:

1. A genuine approach to co-building partnerships.
2. Skills within the health authority of recognizing and working with community leaders, and an understanding of the resources that communities can bring to health outcomes.
3. Recognition that communities are made up of diverse populations, which may require a unique approach within a broader community engagement approach.
4. People must be seen holistically rather than as bearers of illness.
5. Agreement to co-design, co-produce, co-learn, and co-evaluate.
6. Recognition that communities are both geographical and issue based.
7. Engagement is an ongoing process that requires time, commitment, and resources for all sides.
8. The state should be responsible for financial resourcing.

The four boxes at the bottom of the figure show foundational investments needed for individuals and teams in health systems to operate with relational intentionality. These areas are described in more detail below, and are illustrated by the case studies.

How the ICF strengthens relationality in community engagement for health systems



Note: Health service and system performance measures and outcomes of interest will be determined nationally and locally, and span all programs and levels of the health system. Some examples are: access to care (coverage, waiting times, geographical access), quality of care (clinical outcomes, patient safety, equity, people-centeredness, responsiveness), patient experience, efficiency, continuity of care, mortality and morbidity rates, financial protection, resilience, innovation and adaptability.

Social and contextual data integration

The ICF underscores the importance of social and contextual data, requiring integration of basic social science methods – such as key informant interviews, focus groups and qualitative surveys – into health service programming. Employing mixed methods requires minimal specialized skills, and provides valuable insights for decision-making, service design and delivery and advocacy. Embedding these practices in routine services strengthens the quality of collaboration and co-design activities that are usually conducted with diverse stakeholders, including community members. Facilitation and participatory action skills are also crucial.[36,37] Better intersectoral relations and data collaboration between health and social care sectors are important, and often involve multilevel jurisdictional arrangements on data between national and local governments.

Participatory facilitation and convening skills, methods and tools

WHO's conceptual framing for relational community engagement emphasizes the science of communication as 'bioactive', and its role in fostering healthy social connections and interactions.[38] Traditional societies and Indigenous populations have long practiced intentional group convening, an approach also central to non-violence movements.[39] Effective facilitation is crucial for strategic and operational planning, decision-making and implementation of activities at all levels of health systems. Individuals and managers with basic skills can help groups identify assumptions, align shared goals, ensure transparency in decision-making, and create safe spaces for meaningful contributions from people's lived experiences.

Effective facilitation is crucial for strategic and operational planning, decision-making, and implementation of activities at all levels of health systems.

System-wide communication, collaboration and integration

Research shows links between communication and mental health, immune function, recovery prognosis and gene expression in effective clinician–patient relationships.[40–42] The therapeutic relationship in psychotherapy "makes substantial and consistent contributions to patient outcomes independent of the specific type of psychological treatment".[43] Successful clinician–patient relationships also lead to better relational outcomes such as "trust, hope, and a sense of being known".[44] The ICF focuses on networks of teams as being core to health systems, spanning structures, functions and activities.[45] These teams act as 'communities of place' or 'purpose', using professional and informal relationships to meet shared health system priorities. At the organizational level, daily conversations form invisible structuring and feedback loops that influence the system's ability to self-organize and learn.[46,47] Organizations that intentionally improve communication are able to leverage empathy, rapport and compassion to access team resources.[48–50] Health system researchers highlight the interplay between individual skills, knowledge and social networks and established organizational routines and processes as elements that contribute to resilience, help maintain focus, foster diversity, support adaptation and leverage social capital to overcome organizational challenges.[51,52]

Leadership, management, and governance

The field of quality improvement in health systems now recognizes the important role of leaders and managers in taking a "whole-system approach to building responsive and resilient health systems".[53] Leaders and managers can set direction and standards in change management and system-wide learning. Those who proactively address team norms, culture and performance, play a crucial role and have significant positive impact.[54,55]

SECTION 3. LEARNING FROM SELECTED COUNTRY CASE STUDIES USING THE ICF*

Exemplar case studies from Ethiopia, Lao PDR, Qatar, Sierra Leone, Thailand, the UK and US spanning all WHO regions, diverse contexts and various entry points for community engagement, have informed the development of the Integrated Change Framework. The four foundational elements in the ICF consistently capture and incorporate key commonalities, lessons learned and best practices into a comprehensive approach that intentionally embeds community engagement principles and processes and strengthens relationality across all aspects of health service programming. The ICF can also facilitate strategic and operational discussions on health service performance and measurement.[56]

The case studies below are brief summaries and highlight relationship and trust building across different levels and between different stakeholders. (See links in the references section for full descriptions and Appendix 3 for examples of relational practices in health systems.)[57]

CASE STUDY 1. ETHIOPIA: COMMUNITY HEALTH EXTENSION PROGRAMME

2003 to present

Ethiopia's flagship health program[58,59] has nearly achieved universal basic healthcare for its rural population, thanks to strong government commitment, integration of preventative and promotive services, and effective deployment and capacity building of Health Extension Workers (HEWs). HEWs built trust by spending time in communities, listening, and understanding local needs. Community feedback informed training and service adjustments, while real-time data ensured ongoing improvements. The Health Development Army supported HEWs, and highlighted the importance of mutual assistance within health programming.

Health service and system performance outcomes (between 1990-2015)[60]

- Improved access to basic healthcare for rural populations.
- Comprehensive data-collection mechanisms for monitoring and improvement.
- Nearly universal access to health services (92 percent up from 64 percent).
- Integration of HEWs into the broader health system.

Impact (between 1990-2015)[61]

- 67 percent reduction in under-five mortality.
- 71 percent decline in maternal mortality.
- 90 percent decline in new HIV infections.
- 73 percent decrease in malaria deaths.
- Over 50 percent decline in tuberculosis (TB) mortality.

* The case studies present statistics that are reported in the source references and which may not necessarily represent the official WHO statistics.

CASE STUDY 2. LAO PDR: CONNECT INITIATIVE

2018 to present

The CONNECT initiative in Lao PDR[62] focused on building trust between communities and government stakeholders in co-developing tailored community health action plans. It fostered a common understanding between the health and care workforce and local government communities, including political leadership. A multidisciplinary CONNECT team led an iterative learning process that placed communities at the center. The team used arts-based participatory methods for research, engagement and capacity building of government staff, emphasizing community strengths and viewing people as 'solution-holders'. CONNECT is currently transforming relationships across different levels and sectors of government, strengthening the main networks that support primary healthcare teams.

Health service and system performance outcomes

- Improved access and equity in access for maternal and child health and immunization services (pregnant women from lower income families attending antenatal care increasing from 41% to 80% in a several villages in 2020).[63]
- Strengthened connections and formal collaboration to scale CONNECT between the Ministry of Interior and Ministry of Health.
- Support to invest in scaling CONNECT from a wide range of donors and national stakeholders.

Impact

- Increase in community trust and improved relationships between stakeholders.

CASE STUDY 3. QATAR: PRIMARY HEALTH CARE CORPORATION

2017 to present

The Qatar Primary Health Care Corporation[64] emphasized a shared vision of a collaborative environment where multidisciplinary teams across 31 health centers work together to enhance patient communication. There is reciprocal support, with teams sharing ideas and learning from each other through patient engagement coaches and bi-weekly networking events. Effective communication strategies, such as the 'teach-back' method, improved patient satisfaction and trust. This inclusive approach, incorporating patient feedback and cultural considerations, was essential to developing patient-centered communication strategies.

Health service and system performance outcomes

- Improved patient-centered communication across 31 health centers.
- Statistically significant improvements in patient satisfaction.
- Enhanced patient experience and communication effectiveness.
- System-wide improvement in patient-centered care across multiple centers.

Impact

- Improved patient-centered culture evidenced by Excellence award on patient-centered care.
- Empowered Patient Advisors, championing community engagement at national level.
- Enhanced cross-collaboration among multidisciplinary teams evidenced by higher staff survey ratings.

CASE STUDY 4. SIERRA LEONE: COMMUNITY LED EBOLA ACTION

2014 to 2016

In Sierra Leone, the Community Led Ebola Action initiative[65,66] built relationships by fostering feedback between mobilizers and communities through regular visits, mobile communication, and support. This work connected communities with response authorities alongside real-time data collection to inform adaptive response measures. Activities such as body mapping, burial role plays, and involving Ebola survivors in health promotion helped reduce stigma and address community risks. Trust was rebuilt through participatory methods, radio coverage and engagement with religious leaders, moving away from the fear-driven messaging used earlier in the epidemic.

Health service and system performance outcomes

- Effective community-led action planning and surveillance.
- Engagement of over 12,000 communities and 2 million people nationwide.
- Integration of community mobilizers into national outbreak response, and improved relationships between communities and health authorities.
- Development of community action plans across 100 percent of communities with increased community ownership, skills and structures. Increase in safe burials and timely medical referrals.
- High implementation rates for action plans – 85 percent of 63,110 action points.

Impact[67]

- Reduction in Ebola transmission.
- Reduction in stigma associated with Ebola.

CASE STUDY 5. THAILAND: SOCIAL PARTICIPATION

1990s to present

Thailand has used various participatory models in health governance, fostering collaboration between government, citizens and academia to drive reform.[68] Key initiatives include the National Health Assembly, Provincial Health Assembly, Community Health Charters (CHCs), and broad capacity-building efforts. During the COVID-19 pandemic, the Nakhon Pathom Model underscored the importance of open communication to build trust. This model involved the community directly in decision-making, ensuring effective and widely accepted COVID-19 response strategies. Public health and intersectoral programs have leveraged community participation to boost political will for addressing social determinants (e.g., school meals) and health outcomes (e.g., drowning).

Health service and system performance outcomes

- Increased participation in public health policymaking, and creation of non-binding resolutions (civic consciousness).
- Implementation of CHCs and participatory health crisis management frameworks.
- Successful multisectoral collaboration in COVID-19 response and beyond.
- National and local integration of participatory mechanisms.
- Almost universal access to essential health services with increased budget.[69]
- Reduction in out-of-pocket health expenditure. The probability of spending more than 10% of the household budge on healthcare reduced by one third.[70]
- Strengthened health system infrastructure, management of diseases and health promotion.

Impact

- Decrease in child mortality from 37 to 10 per 1000 live births and decrease in maternal mortality from 37 to 12 per 100,000 (1990–2016).[71]
- Success of specific initiatives: e.g. surveillance – relative risk of drowning injury 5.6 times higher in control areas than intervention areas.[72]

CASE STUDY 6. UK: C2 TRANSFORMATIONAL CHANGE

2001 to present

The UK's C2 Transformational Change[73] program brought together local community members and service providers to promote shared understanding and collaborative partnerships. By emphasizing active listening and dialogue, services shifted from a deficit-based view to one that recognized community strengths. This approach built mutual respect, identified barriers to wellbeing, and encouraged collaborative action. The program emphasized continuous improvement through reflection, and supported dispersed leadership through the process.

Health service and system performance outcomes

- Reignited public sector motivation by connecting jobs to purpose.
- New ways of working between service providers and local communities. Change from a deficit model to community members as partners and holders of solutions.
- New collaborative networks and interagency co-operation.
- Enhanced community leadership and involvement.
- Decrease in anti-social behavior and intimidation of residents.

Impact

- Improvements in housing, play areas, traffic calming, health, and social and educational outcomes.
- Increased pride in neighborhoods.
- Improved youth engagement and reduction in truancy rates.

CASE STUDY 7. UK: FROME MODEL OF ENHANCED PRIMARY CARE

2013 to present

The Frome Model of Enhanced Primary Care[74,75] project, (now the 'Mendip model of complex care co-ordination'), integrated community resources with traditional medical care to address physical health and social factors such as isolation. This model included collaboration across family physicians, nurse practitioners, care coordinators, administrators and community connectors. Care was personalized and trust was built through initiatives such as 'talking cafes'. Local businesses were trained as connectors, creating a widespread support network. Multidisciplinary collaboration among healthcare professionals, community leaders, businesses and officials created better health outcomes and significantly reduced emergency hospital admissions, demonstrating the impact of community engagement on wellbeing.

Health service and system performance outcomes

- Enhanced service responsiveness through community mapping and integration of social care through social prescribing and community connectors.
- 14 percent reduction in emergency hospital admissions between April 2013 and December 2017.
- 21 percent reduction in associated healthcare costs (5 percent of total healthcare budget).

Impact

- Improved wellbeing, social connections and belonging.
- Reduced loneliness.
- Improved mental health.

CASE STUDY 8. US: INDIGENOUS HEALTH SERVICES

1997 to present

The US Southcentral Foundation's Nuka System of Care,[76,77] led by Alaska Native peoples, models collaboration and relationship building. Leaders engaged with communities through approaches such as sharing personal stories and admitting mistakes, which fostered trust and openness. The system aligned healthcare with the community's values, focusing on shared responsibility, quality, and family wellness. The model emphasized gathering relational data from the community to overcome barriers, resulting in culturally sensitive care and significantly improved health outcomes and satisfaction.

Health service and system performance outcomes

- Relationship-based care model enhances patient–provider interactions and improved access.
- Indigenous ownership and control over healthcare delivery.
- Integrated and data-driven care – physical, mental, emotional and spiritual wellness.
- Focus on long-term relationships and shared responsibility in healthcare.
- Workforce development.
- Better management of chronic conditions and improvements in health outcome data, utilization metrics and operational efficiencies.

Impact

- Improved overall wellness across generations of Alaska Native peoples.
- Health equality improvements – reduction in health inequities.

SECTION 4. CONCLUSION AND RECOMMENDATIONS

Health systems are complex social, technical, administrative and managerial networks involving various professions and levels of care. Ensuring that health systems are well connected and relationally healthy is a core foundation for restoring trust, building resilience of people and communities, and fostering innovation. These elements are all needed to create quality PHC-orientated health systems, and to achieve universal health coverage. The ICF offers a comprehensive and pragmatic pathway for intentionally and systematically embedding relational processes and practices in health system functions.

Ensuring that health systems are well-connected and relationally healthy is a core foundation for restoring trust, building resilience of people and communities, and fostering innovation.

Governments are called on to address these policy and priority actions for health systems. (The table in Appendix 1 considers the potential benefits, challenges, and resources needed for implementation.)

1. PROMOTE RELATIONAL LEADERSHIP, MANAGEMENT, AND GOVERNANCE

Implement leadership, management and governance policies and practices that focus on building and sustaining relationships at all levels of the health system to drive culture change and improve performance.

Priority actions:

- Develop consensus on adopting a relationship-focused approach to community engagement as an inherent way of working in health systems and across sectors.
- Develop a renewed vision for public sector values and ways of working to engage the health and care workforce and civil service across sectors to reorientate and reconnect health systems to shared values and purpose.
- Invest in adaptive and transformative leadership models and training, including:
    - Peer-learning mechanisms to build cohorts of leaders with competencies and skills to challenge norms and model transformative culture change.
    - Organizational value for leaders who demonstrate transformational leadership and encouragement of continuous learning.
- Support the effective functioning of multidisciplinary and multisectoral teams by:
    - Conducting comprehensive relational assessments for team performance.

    - Setting and reviewing benchmarks for managerial competencies, integrating relational skills, technical knowledge and system-wide learning.

- Establish formal intersectoral collaboration frameworks and platforms that facilitate regular sharing of best practices, joint training programs, and continuous professional development opportunities among health, social and education sectors.

2. STRENGTHEN RELATIONSHIP-BUILDING CAPABILITIES

Strengthen foundational engagement competencies, skill sets and processes within and across health services.

Priority actions:

- Use the ICF to develop national and local benchmarks in relational community engagement competencies, including:
    - a shared language across professions and disciplines, including the use of relevant integrative transdisciplinary frameworks.
    - mapping and assessment of stakeholder relationships in priority care networks.
    - data systems and feedback mechanisms for contextualized service planning and delivery, including relational indicators for performance monitoring and decision-making.
    - participatory facilitation and convening, and communication competencies and skills tailored to generic and specific job functions and roles.
    - immediate and transitional opportunities for in-service training for existing staff, including administrative government employees.
    - strengthened occupational health and support systems to address empathy, rapport and compassion in the workplace.
- Integrate these benchmarks in pre-service education, in-service training, and lifelong learning.
- Invest in local communities' capacities for self -organization and advocacy to build more equitable relationships with government and non-governmental service providers.
- Establish monitoring mechanisms to ensure that community accountability mechanisms and structures are connected to health system planning and decision-making processes.
- Strengthen the relationships between PHC, community health worker programs and social work and align these relationships to shared outcomes.
- Foster routine inclusive, participatory, and multidisciplinary (intersectoral) decision-making processes with service users and communities.

3. INVEST IN TRANSDISCIPLINARY RESEARCH AND PRACTICE DEVELOPMENT

Promote research and practice development that utilizes the ICF to drive innovation and improve health service and system performance.

Priority actions:

- Establish funding for transdisciplinary research and development that uses the ICF to build a shared understanding for research funders and academic institutions.
- Develop and support cross-sectoral research collaborations that bridge the natural sciences, social sciences and humanities to advance methodologies and theories for community engagement, practice and policy in health, ensuring that technology and the arts are fully integrated and leveraged.
- Ensure that evaluative requirements for research impact include the cost-benefit analysis of social interventions such as social prescribing approaches connected to relational and social outcomes to promote health and wellbeing.
- Ensure that relational aspects are a criterion in funding proposals for community engagement research.

APPENDIX 1. POTENTIAL BENEFITS, CHALLENGES AND RESOURCE NEEDS

Potential benefits, challenges and resource needs for each recommendation

Recommendation	Potential benefits	Challenges	Types of resource needs
Relational leadership, management, and governance			
Implement leadership, management and governance policies and practices that focus on building and sustaining relationships at all levels of the health system to drive culture change and improve performance.	• Fosters a unified vision and approach across sectors. • Increases workforce engagement and harnesses their contributions to organizational values, purpose and vision. • Promotes adaptive leadership and continuous learning. • Encourages culture change and innovation within organizations. • Aligns social and health services to better meet community needs.	• Achieving political consensus takes time and resources. • Resistance to change from existing leadership. • Requires investment in training. • Implementation across diverse educational institutions could be challenging.	• Subject matter experts • Stakeholder engagement specialists • Financial • Technological • Time • Organization and administrative • Risk management • Leadership training • Peer-learning platforms • Incentive programs and structures • Facilitators and coaches
Strengthen relationship-building capabilities in health systems			
Prioritize and invest in relationship-building capabilities in health systems by strengthening foundational engagement competencies, skill sets and processes within and across health services.	• Contributes to a self-learning and self-correcting system. • Improves co-ordination and communication within and across the health system. • Enhances team performance and collaborative efforts. • Builds capacity for relational skills in the workforce to build trust and address systemic bottlenecks. • Embeds relational values in the future workforce.	• Establishing benchmarks and monitoring mechanisms can be complex. • Ensuring consistent participation from stakeholders may be difficult. • Mapping and assessing relationships takes time. • Requires ongoing monitoring and feedback. • Potential resistance to new benchmarks and assessment methods. • Managing restructuring and retraining within teams.	• Subject matter experts • Relationship mapping tools and relational assessors • Stakeholder and community engagement specialists • Data analysts and monitoring and evaluation tools • Curriculum development experts • Continuous feedback mechanisms • Facilitators and coaches

Recommendation	Potential benefits	Challenges	Types of resource needs
	• Promotes empathy and compassion in health services. • Encourages community involvement and ownership. • Supports communities to advocate for their health needs. • Enhances accountability and transparency in decision-making. • Strengthens relationships between communities and service providers.	• Requires alignment across various sectors and disciplines.	• Training and development specialists • Risk management
Invest in transdisciplinary research and practice development			
Promote research and practice development that uses the Integrated Change Framework (ICF) to drive innovation and improve health service and system performance.	• Addresses the need for social and relational interventions to effectively address social connection, isolation and loneliness. • Builds on existing research practices and methods across disciplines and reinforces good practice. • Bridges diverse disciplines and accelerates application of scientific research to improve health outcomes. • Innovates and advances theory and practice for community engagement for health. • Accelerates the development of transdisciplinary research methods to address complex, systemic challenges. • Strengthens the science and evidence base informing policy dialogs between stakeholders on community engagement.	• Securing funding and resources to train multidisciplinary research teams in relational research. • Integrating relational aspects into traditional research frameworks. • Sustaining funding and support over the long term. • High initial investment in technology and resources. • Ensuring equitable access to technology across communities.	• Facilitation and convening training • Monitoring systems • Community engagement specialists • Creative professionals • Financial resources • Funding for community initiatives • Logistical support • Leadership training for community leaders • Accountability structures • Partnerships with non-governmental and local organizations • Technology platforms • Funding for technology development • Partnerships with technology and arts organizations • Academic partnerships

APPENDIX 2. CORE COMMUNITY ENGAGEMENT DEFINITIONS

WHO DEFINITION FOR COMMUNITY ENGAGEMENT (DEVELOPED 2017, UPDATED 2020 AND 2024)

"Community engagement is a process of developing and maintaining relationships that enable people to work together to address health-related issues and promote well-being to achieve positive and sustainable health impact and outcomes."

These relationships work together through a process that is founded in empowerment, health promotion, health equity, gender equality, human rights and planetary health.

The process of working together is navigated through dimensions of:

- compatible values, vision and purpose
- interactions that are based on respect, dignity and compassion
- widespread, active and inclusive participation
- equitable, conjoint decision-making
- the equitable dynamic flow of power, control and resources.

And span the micro, meso and macro levels of human systems.

WHO CONCEPTUAL FRAMING FOR RELATIONAL COMMUNITY ENGAGEMENT (2023)

"We live in ongoing systemic processes with one another where every interaction is an intervention and communication is bioactive."

APPENDIX 3. HEALTH SYSTEMS' RELATIONAL PRACTICES AT MICRO, MESO, AND MACRO LEVELS

THE SCIENCE OF SAFETY AND CONNECTION

Forming and maintaining social bonds is deeply rooted in human biology and is essential for human survival, growth, resilience and overall wellbeing. Research shows that the impact of social relationships on mortality risk is comparable to other well-known risk factors.[78] Transdisciplinary frameworks such as Polyvagal Theory (PVT) and Interpersonal Neurobiology (IPNB) are important in relational community engagement. PVT describes the role of the central nervous system in regulating and modulating stress responses and the mechanisms that govern social interactions and communication. IPNB combines neuroscience and psychology to explore how relationships affect brain function, brain development and mental health. Both frameworks emphasize the importance of safe, supportive environments and the inseparability between nervous system states and interpersonal relationships. Consequently, these frameworks are essential for understanding mental health and therapeutic practices. They also inform human resource considerations, capacity building and training.

The following table shows the multiple level of health system interactions, and can be correlated to relational practices in health systems that correspond to each category.

Health system interactions

Lived and living experiences of people		
Micro- (Relationship with self)	**Meso-** (Relationship with others)	**Macro-** (Relationships in systems/ organizations/programs)
Self-awareness Individual understanding of oneself.	**Collective awareness** Shared understanding within groups.	**System/organizational awareness** Understanding of broader context and dynamics of an organization.
Self-reflection An individual process where a person examines their thoughts, feelings, actions and experiences to gain self-awareness and improve personal effectiveness.	**Collective reflection** Group processes where members come together to reflect on shared experiences, group dynamics, and outcomes to enhance mutual understanding, learning and improve collaboration.	**System/organizational reflection** A systematic process where a system/organization/program reviews its strategies, policies, processes and outcomes to identify strengths, weaknesses and areas for improvement.

Lived and living experiences of people		
Self-regulation	**Co-regulation**	**System/organizational regulation**
An individual's ability to manage and control their physiological states, emotions and behaviors through the activation of the autonomic nervous system.	The mutual regulation of group members' physiological states by providing safety and connection cues.	Understanding and managing the physiological states and stress responses of individuals within a system/organization/program to create safe and supportive environments.

Note: Expected outcomes from relational practices include: shifts in perceptions, insights, values, beliefs and behaviors.

Source: Adapted from WHO (2022)[79,80]

THE IMPORTANCE OF ADDRESSING CHRONIC STRESS IN ORGANIZATIONS

Chronically stressed organizations hinder delivery of quality care and compromise patient safety. The Adverse Childhood Experiences (ACEs) survey assesses childhood trauma. Many health and care workers will have experienced at least one traumatic event during their life. High ACE scores are linked to reduced life expectancy and chronic illness such as heart disease, diabetes and autoimmune diseases.[81] Trauma affects trust, communication and relationships, and can lead to withdrawal, aggression, or anxiety. Relationship skills, shaped by early childhood experiences and professional training, require holistic development opportunities throughout professional education and service.[82]

Micro-level practices in health systems

Practices that regulate the central nervous system

Practices	Description
Adequate sleep	Quality regular sleep to ensure that brain restoration processes occur during the sleep cycle.
Biofeedback	Monitoring devices that provide real-time feedback on physiological functions such as heart rate and muscle tension.
Breathwork	Diaphragmatic breathing to activate the parasympathetic nervous system promoting 'rest and digest'.
Chanting, humming and prayer, contemplative and spiritual practices	Stimulates vagus nerve and enhances parasympathetic activity. Supports emotional regulation. When done communally, fosters a sense of belonging and social connection and support.
Cognitive behavioral therapy	Changes negative thought patterns and behaviors.
Cold exposure	Stimulates vagus nerve and enhances parasympathetic activity.
Healthy diet	Supports brain health and stabilizes mood – a diet excluding sugar, processed foods and harmful fats.
Massage therapy	Reduces muscle tension, improves circulation, and promotes relaxation.
Mindfulness and meditation	Builds the capacity for present-moment awareness, acceptance, quietens the mind and integrates multiple sensory data from the body.

Practices	Description
Walking in nature – e.g. forest bathing	Walking and immersing in the sensory experience of forests and parks helps to regulate the nervous system, reduces stress hormones, and improves mood.
Physical exercise	Regular exercise such as walking, yoga and Tai Chi help to regulate the nervous system and reduce stress hormones.
Progressive muscle relaxation	Tensing and relaxing each muscle group reduces physical tension and promotes relaxation.
Social connection	Positive interactions operate as a protective factor, reduce stress, and promote a sense of wellbeing.
Therapeutic activities, such as art and music	Promotes neuroplasticity and brain health, supports trauma recovery by providing non-verbal outlets for processing traumatic experiences, aiding the regulation of the autonomic nervous system, enhances the mind-body connection, promotes physical relaxation, reduces overall physiological stress, enhances mood, and reduces pain.

Micro- and meso-level relational practices in health systems

Practices that foster professional reflection and learning

Practices	Description
Action research	Conducting systematic inquiry into one's own practice to improve effectiveness and understanding.
Case study analysis	Analyzing real-world scenarios to apply theoretical knowledge and reflect on decision-making processes.
Continuing professional development	Engaging in ongoing learning activities to enhance professional knowledge and skills, including attending courses, conferences, and self-study.
Critical incident analysis	Reflecting on specific events or incidents to understand their impact on practice, and learn from the experience.
Learning logs	Keeping a record of learning experiences and reflections over time, often linked to specific goals or objectives.
Mentorship and coaching	Receiving guidance and support from experienced professionals to enhance skills and career development.
Peer review and feedback	Engaging in structured feedback sessions with colleagues to gain diverse perspectives and constructive criticism.
Portfolios	Compiling evidence of learning and professional growth, including reflective writings, project summaries, and feedback from peers.
Professional learning communities	Participating in groups that meet regularly to discuss and reflect on professional practices and share learning experiences.
Reflective dialog	Engaging in conversations that promote deep thinking and reflection on practice, often facilitated by open-ended questions and active listening.
Reflective journaling	Writing regularly about professional experiences and insights to deepen self-awareness and critical thinking.
Reflective practice models	Using frameworks such as Gibbs' Reflective Cycle or Schön's Reflective Model to systematically reflect on and learn from professional experiences.
Safety II	Defines safety in healthcare as the ability to deliver safe care under varying conditions by identifying and learning what an organization does well, rather than focusing solely on failures, to improve safety and operational effectiveness.

Practices	Description
Self-assessment	Evaluating one's own performance and identifying areas for improvement, often using structured tools or frameworks.
Storytelling	Using narratives to integrate lived experiences, values and lessons.
Supervision	Regular meetings with a supervisor to reflect on work practices, discuss challenges, and develop professionally.
Workshops and seminars	Attending educational sessions focused on specific skills, knowledge areas, or reflective practices.

Meso-level relational practices in health systems

Practices that foster collective awareness and collective reflection

Practices	Description
360-degree feedback	Collecting feedback from all directions (peers, subordinates, supervisors) to build a comprehensive view of performance and behavior.
Action learning sets	Small groups meet regularly to reflect on and solve real work problems, with a focus on learning from action and reflection.
After-action reviews	A technique used to analyze what happened, why it happened, and how it can be improved next time.
Appreciative inquiry	A method that focuses on identifying what works well in a group or organization, and how to build on these strengths.
Collective storytelling	Sharing personal and group narratives to build a shared sense of identity and purpose.
Critical incident analysis	A reflective process where groups discuss specific incidents to understand what happened and why, and how to improve responses in the future.
Cultural safety and competence training	Programs aimed at enhancing awareness and sensitivity to cultural and power differences within a team or organization.
Dialog circles	Structured discussions that emphasize active listening and equal participation to build shared understanding.
Digital collaboration tools	Using platforms such as Slack, Trello or Microsoft Teams to enhance transparency and communication within teams.
Fishbowl technique	A group reflection method where a small group discusses a topic while being observed by a larger group, which then reflects on the discussion.
Group debriefing	A structured discussion after an event or activity where the group reviews what happened, what went well, and what could be improved.
Mindfulness and grounding exercises	Group exercises to transition from previous activities and focus collective awareness on the present moment, calm the mind and attune the senses.
Organizational network analysis	Analyzing and mapping informal networks within an organization to understand and improve communication flows.
Peer review and feedback sessions	Groups provide structured feedback on each other's work or performance to foster mutual learning and improvement.
Regular check-ins, stand-ups, 'huddles'	Brief, frequent meetings to update on progress, share challenges, and stay aligned.
Retrospective meetings	Regular meetings, often used in 'agile' and 'scrum' methodologies, where teams reflect on recent work to identify successes and areas for improvement.

Sociometry and sociograms	Techniques for visualizing and analyzing relationships and interactions within a group to improve mutual understanding.
World café	A structured conversational process that fosters open dialog and the sharing of knowledge within large groups.

Macro-level relational practices in health systems

Practices that foster organizational awareness, reflection, and co-regulation

Practices		Description
Organizational awareness	Regular check-ins, stand-ups, 'huddles'	Brief, frequent meetings to keep team members informed and aligned on goals and progress.
	Communication mechanisms, processes, and channels	Establishing well-defined communication pathways to facilitate transparent and effective information flow.
	Management and leadership development programs	Training managers and leaders in emotional intelligence, stress management, and effective communication.
	Communication training	Training in the bioactive nature of communication helps employees understand the impact of their daily interactions.
Organizational reflection	After-action reviews	Structured debriefings after projects or events to reflect on what went well, what didn't, and how to improve.
	Appreciative inquiry	Identifying and building on an organization's strengths and successes.
	Safety walkarounds and safety dialogs	Engages leaders in informal observations and discussions with staff on the work floor to promote continuous dialog about safety and operational issues.
	Team reflection sessions	Regular meetings where teams reflect on their work processes, interactions, and outcomes.
Organizational co-regulation	Mindfulness and stress reduction programs	Implementing mindfulness and stress reduction techniques to help employees manage their stress.
	Creating safe and supportive environments	Ensuring that the workplace environment is supportive and non-threatening.
	Emotional intelligence training	Enhancing employees' ability to understand and manage their own emotions and those of others.
	Social engagement activities	Organizing activities that promote social interactions and bonding among employees.
	Compassion and empathy training	Improves workplace relationships and fosters self-care, collective care, and a supportive and inclusive culture.
	Communication training	Enhances emotional and empathic attunement, authentic interactions; supports conflict resolution in interpersonal, team and organizational interactions; ensures consistency in messaging and communicating the organization's priorities and goals.

ABBREVIATIONS

ACEs	Adverse Childhood Events
CHCs	Community Health Charters
HEWs	Health Extension Workers
ICF	Integrated Change Framework
IFSW	International Federation of Social Workers
IPNB	Interpersonal Neurobiology
PHC	Primary healthcare
PHCC	Primary Health Care Corporation
PVT	Polyvagal Theory
SDGs	Sustainable Development Goals
UHC	universal health coverage
WHO	World Health Organization
WISH	World Innovation Summit for Health

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REFERENCES

1. The International Conference on Primary Health Care. *Declaration of Alma-Ata: International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978*. cdn.who.int/media/docs/default-source/documents/almaata-declaration-en.pdf?sfvrsn=7b3c2167_2 [accessed 30 August 2024].

2. World Health Organization. *WHO Resolution on Social Participation for Universal Health Coverage, Health and Well-being. Seventy-seventh World Health Assembly, Agenda Item 11.1*. 2024. apps.who.int/gb/ebwha/pdf_files/WHA77/A77_ACONF3-en.pdf [accessed 30 August 2024].

3. World Health Organization. *Evaluation of the WHO Community Engagement Research Initiative*. Geneva: World Health Organization. 2023.

4. World Health Organization. *Ottawa Charter for Health Promotion. First International Conference on Health Promotion*. 1986. iris.paho.org/bitstream/handle/10665.2/45793/ottawachartereng.pdf?sequence=1&isAllowed=y [accessed 30 August 2024].

5. World Health Organization. *Evaluation of the WHO Community Engagement Research Initiative*. Geneva: World Health Organization. 2023.

6. Marmot M. Social determinants of health inequalities. *The Lancet*. 2005; 365(9464): 1099–1104.

7. Intergovernmental Panel on Climate Change. *Climate Change 2022: Mitigation of climate change. Working Group III contribution to the sixth assessment report of the Intergovernmental Panel on Climate Change. Summary for Policymakers*. 2022. www.ipcc.ch/report/ar6/wg3 [accessed 30 August 2024].

8. Valentine NB and Bonsel GJ. Exploring models for the roles of health systems' responsiveness and social determinants in explaining universal health coverage and health outcomes. *Global Health Action*. 2016; 9: 29329.

9. World Health Organization. *WHO Global Strategy on People-Centred and Integrated Health Services: Interim report*. Geneva: World Health Organization. 2015.

10. Valentine N et al. Planetary health benefits from strengthening health workforce education on the social determinants of health. *Health Promotion International*. 2022; 37(3): daac086.

11. World Health Organization. *COVID-19 and the Social Determinants of Health and Health Equity: Evidence brief*. Geneva: World Health Organization. 2021.

12. World Health Organization. *Operational Framework for Primary Health Care: Transforming vision into action*. World Health Organization. 2020.

13. World Health Organization, Organisation for Economic Co-operation and Development, and International Bank for Reconstruction and Development. *Delivering Quality Health Services: A global imperative for universal health coverage*. Geneva: World Health Organization. 2018.

14. World Health Organization. *Community Engagement: A health promotion guide for universal health coverage in the hands of the people*. Geneva: World Health Organization. 2020.

15. World Health Organization. *World Health Assembly 76.16 The Health of Indigenous Peoples*. 2023. apps.who.int/gb/ebwha/pdf_files/WHA76/A76_R16-en.pdf [accessed 30 August 2024].

16. Kruk ME et al. High quality health systems in the Sustainable Development Goals era: Time for a revolution. *Lancet Global Health*. 2018; 6(11): e1196–e1252.

17. World Health Organization, Organisation for Economic Co-operation and Development, and International Bank for Reconstruction and Development. *Delivering Quality Health Services: A global imperative for universal health coverage*. Geneva: World Health Organization. 2018.

18. Friedel AL et al. Measuring Patient Experience and Patient Satisfaction – How are we doing it and why does it matter? A comparison of European and U.S. American approaches. *Healthcare (Basel)*. 2023; 11(6): 797.

19. Makary M A and Daniel M. Medical error—the third leading cause of death in the US. *BMJ*. 2016; 353: i2139.

20. Walters KL et al. Growing from our roots: Strategies for developing culturally grounded health promotion interventions in American Indian, Alaska Native, and Native Hawaiian communities. *Prevention Science Journal*. 2020; 21(1): 54–64.

21. Redvers N et al. Relational community engagement within health interventions at varied outcome scales. *PLOS Global Public Health*. 2024; 4(6): e0003193.

22. Baskin C. *Strong Helpers' Teachings: The Value of Indigenous Knowledges in the Helping Professions. 2nd ed*. Toronto: Canadian Scholars' Press. 2016.

23. United Nations. T*ransforming our World: the 2030 Agenda for Sustainable Development*. New York: United Nations. 2015.

24. European Centre for Disease Prevention and Control. *Lessons from the COVID-19 Pandemic – May 2023*. Stockholm: European Centre for Disease Prevention and Control. 2023.

25. Abdul Rahim HF et al. *Our Duty of Care: A global call to action to protect the mental health of health and care workers*. Qatar Foundation and World Innovation Summit for Health. 2022.

26. World Health Organization. *Global Health and Care Workers Compact: Technical guidance compilation*. Geneva: World Health Organization. 2023.

27. World Health Organization Regional Committee for Africa. *Resolution: Strengthening community protection and resilience: Regional strategy for community engagement, 2023–2030*. 2023. www.afro.who.int/sites/default/files/sessions/resolutions/AFR-RC73-R3%20Strengthening%20community%20protection%20and%20resilience%20regional%20strategy%20for%20community%20engagement%2C%202023%E2%80%932030%20in%20the%20WHO%20African%20Region.pdf [accessed 30 August 2024].

28. World Health Organization Regional Committee for the Eastern Mediterranean. *Building resilient communities for better health and well-being in the Eastern Mediterranean Region*. 2021. applications.emro.who.int/docs/EMRC686-eng.pdf?ua=1 [accessed 30 August 2024].

29. World Health Organization Pan American Health Organization/Americas Region. *Strategy and Plan of Action on Health Promotion Within the Context of the Sustainable Development Goals 2019–2030*. Washington, DC: Pan American Health Organization. 2022.

30. World Health Organization European Region. *Risk Communication, Community Engagement and Infodemic Management in the WHO European Region. Investing in preparedness, response and resilience to protect people from health emergencies*. Copenhagan: World Health Organization European Region. 2024.

31. World Health Organization South-East Asia Region. *Draft Strategic Action Framework on Strengthening Community Engagement and Resilience to Health Emergencies in the WHO South-East Asia Region (2024–2027)*. Under development and reviewed for the purpose of this report.

32. World Health Organization Western Pacific Region. *Regional Action Plan on Health Promotion in the Sustainable Development Goals (2018–2030)*. Manila: World Health Organization Regional Office for the Western Pacific. 2017.

33. World Health Organization Western Pacific Region. *A Toolkit on How to Implement Social Prescribing*. Manila: World Health Organization Regional Office for the Western Pacific. 2022.

34. Institute of Medicine (US) Committee on Quality of Health Care in America. *Crossing the Quality Chasm: A new health system for the 21st century*. Washington, DC: The National Academies Press. 2001.

35. Gilson L (ed.). *Health Policy and Systems Research: A methodology reader – the abridged version*. Geneva: Alliance for Health Policy and Systems Research, World Health Organization. 2012.

36. Chevalier JM and Buckles DJ. *Participatory Action Research: Theory and Methods for Engaged Inquiry. 2nd ed*. Abingdon, UK: Routledge. 2013.

37. Bush B et al. Success in long-standing community-based participatory research (CBPR) partnerships: A scoping literature review. *Health Education & Behavior*. 2020; 47(4): 556–568.

38. World Health Organization. *Evaluation of the WHO Community Engagement Research Initiative*. Geneva: World Health Organization. 2023.

39. Kaner S et al. *Facilitator's Guide to Participatory Decision-making*. 3rd ed. San Francisco: Jossey-Bass. John Wiley & Sons, Inc. 2014.

40. Rakel D et al. Perception of empathy in the therapeutic encounter: Effects on the common cold. *Patient Education and Counselling*. 2011; 85(3): 390–397.

41. Yapko M. *Keys to Unlocking Depression*. Los Angeles: Yapko Publishing. 2016.

42. Cole SW. Human social genomics. *PLOS Genetics*. 2014; 10(8): e1004601.

43. Norcross JC and Wampold BE. *A New Therapy for Each Patient: Evidence-based relationships and responsiveness*. New York: Oxford University Press. 2019.

44. Scott JG et al. Understanding healing relationships in primary care. *Annals of Family Medicine*. 2008; 6(4): 315–322.

45. Kalaris K et al. Networks of care: An approach to improving maternal and newborn health. *Global Health: Science and Practice*. 2022; 10(6): e2200162.

46. Suchman AL. Organizations as machines, organizations as conversations: Two core metaphors and their consequences. *MedCare*. 2011; 49(Suppl 12): S43–S48.

47. Senge PM. *The Fifth Discipline: The art and practice of the learning organization*. Revised and updated edition. New York: Doubleday. 2006.

48. World Health Organization Health Services Learning Hub. *The Role of Compassion In Maintaining EHS during the COVID-19 Pandemic*. Geneva: World Health Organization. 2021.

49. Ahmed Z et al. Exploring the impact of compassion and leadership on patient safety and quality in healthcare systems: A narrative review. *BMJ Open Quality*. 2024; 13(Suppl 2): e002651.

50. Addiss DG et al. Epidemiology of compassion: A literature review. *Frontiers in Psychology*. 2022; 13: 992705.

51. Gilson L et al. Everyday resilience in district health systems: Emerging insights from the front lines in Kenya and South Africa. *BMJ Global Health*. 2017; 2(2): e000224.

52. Parrish-Sprowl S et al. Innovations in addressing mental health needs in humanitarian settings: A complexity informed action research case study. *Frontiers in Communication*. 2020; 5: 601792.

53. Sampath B et al. *Whole system quality: A unified approach to building responsive, resilient healthcare systems*. Boston: Institute for Healthcare Improvement. 2022.

54. Kozlowski SWJ and Bell BS. Work groups and teams in organizations. In: Borman WC et al. (eds.) *Handbook of Psychology: Industrial and Organizational Psychology*. Vol 12. Hoboken, NJ: Wiley. 2003.

55. Tannenbaum SI et al. Promoting team effectiveness. In: West MA (ed.). *Handbook of Work Group Psychology*. Hoboken, NJ: Wiley. 1996.

56. World Health Organization and UNICEF. *Primary Healthcare Measurement Framework and Indicators: Monitoring health systems through a primary healthcare lens*. Geneva: World Health Organization and UNICEF. 2022.

57. World Health Organization. *Evaluation of the WHO Community Engagement Research Initiative*. Geneva: World Health Organization. 2023.

58. Admassu M et al. *Overview: Community health workers in Ethiopia*. Exemplars in Global Health. www.exemplars.health/topics/community-health-workers/ethiopia [accessed 30 August 2024].

59. Haile Mariam D et al. *Optimizing the Ethiopian Health Extension Programme: Strategies to address workforce challenges*. African Health Observatory and World Health Organization African Region. 2023.

60. Assefa Y et al. Successes and challenges of the millennium development goals in Ethiopia: lessons for the sustainable development goals. *BMJ Global Health*. 2017; 2: e000318.

61. Assefa Y et al. Successes and challenges of the millennium development goals in Ethiopia: lessons for the sustainable development goals. *BMJ Global Health*. 2017; 2: e000318.

62. World Health Organization. *Bridging the gap: CONNECT update: August 2024*. 2024. www.who.int/westernpacific/news-room/feature-stories/item/bridging-the-gap---connect-update--august-2024 [accessed 30 August 2024].

63. CONNECT Initiative. *Building sustainable primary health care in the Lao People's Democratic Republic through community engagement and trust building*. Geneva: World Health Organization. 2023.

64. Khattabi N et al. Implementing a patient engagement framework in the primary healthcare system in Qatar. *Patient Experience Journal*. 2023; 10(3): 74–80.

65. Bedson J et al. Community engagement in outbreak response: Lessons from the 2014–2016 Ebola outbreak in Sierra Leone. *BMJ Global Health*. 2020; 5: e002145.

66. UNICEF. *Evaluation of UNICEF's Response to the Ebola Outbreak in West Africa, 2014–2015*. New York: UNICEF. 2016.

67. SMAC. *CLEA Field Guide*. Undated. https://health.ec.europa.eu/document/download/2ddf1baa-aed0-4af7-b752-d8b25bd864e3_en?filename=summary_report_goal_en.pdf [accessed 24 October 2024]

68. World Health Organization. *Voice, Agency, Empowerment – Handbook on social participation for universal health coverage*. Geneva: World Health Organization. 2021.

69. Rasanathan K et al. Innovation and participation for healthy public policy: the first National Health Assembly in Thailand. *Health Expectations*. 2012; 15(1): 87–96.

70. Limwattananon S et al. *Universal Coverage on a Budget: Impacts on Health Care Utilization and Out-of-Pocket Expenditures in Thailand*. Amsterdam: Tinbergen Institute. 2013.

71. National Health Security Office. *Learning by Sharing: Thailand's Experiences in MCH*. Bangkok: NHSO. 2020.

72. Sansiritaweesook G et al. Effectiveness of Community Participation in a Surveillance System Initiative to Prevent Drowning in Thailand. *Asia Pacific Journal of Public Health*. 2015; 27(2): NP2677–NP2689.

73. C2 Connecting Communities. *Home – C2*. www.c2connectingcommunities.co.uk [accessed 30 August 2024].

74. We are Connectors. *The Connector Model | Projects | We Are Connectors*. www.weareconnectors.org/projects/the-connector-model [accessed 30 August 2024].

75. Relationships Project. *Case study: Frome Model of Enhanced Primary Care: Harnessing the community cure*. relationshipsproject.org/project/frome [accessed 30 August 2024].

76. Southcentral Foundation. *Nuka System of Care*. scfnuka.com [accessed 30 August 2024].

77. Gottlieb K. The Nuka System of Care: Improving health through ownership and relationships. *International Journal of Circumpolar Health*. 2013; 72: 21118.

78. Holt-Lunstad J et al. Social Relationships and Mortality Risk: A Meta-analytic Review. *PLOS Medicine*. 2010; 7(7): e1000316.

79. World Health Organization. *Evaluation of the WHO Community Engagement Research Initiative*. Geneva: World Health Organization. 2023.

80. Musitia P et al. Strengthening respectful communication with patients and colleagues in neonatal units – developing and evaluating a communication and emotional competence training for nurse managers in Kenya. *Wellcome Open Research*. 2022; 7: 223.

81. Burke Harris N et al. *Toxic Stress: Mitigating Childhood Adversity That Affects Lifelong Physical and Mental Health. Report of the PTSD and Toxic Stress in Children Forum 2020*. Qatar: Qatar Foundation and World Innovation Summit For Health. 2020.

82. Bloom S. Trauma-organized systems and parallel processes. In Tehrani N (ed.) *Managing Trauma in the Workplace: Supporting workers and organizations*. Abingdon: Taylor & Francis Group. 2010.

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