ARTS, GLOBAL HEALTH & COMMUNITY ENGAGEMENT

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This landscape report is designed to be a comprehensive overview of current initiatives in global health, art, and community engagement disciplines. It is by no means exhaustive. Mention of an organization, foundation, or other institution does not imply endorsement. There are no financial disclosures.

Acknowledgements: Sonya Armaghanyan, Nikita Simpson

Global Health Disrupted is a 501(c)3 non-profit organization.
Denver, CO, USA / London, UK

globalhealthdisrupted.org

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LANDSCAPE REPORT 2018

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CONTENTS

INTRODUCTION

In an increasingly globalised world, patterns of human behaviour are changing, and so too are the strategies needed to ensure health and wellbeing. The complexities of human health behaviours are driven by evolving social, structural and corporate forces. Communities, as spaces where health knowledge, behaviours, and empowerment are able to be shaped (or to be challenged), are evolving thanks to increasingly global technology. In this evolving world, we are reckoning with the need to address the complexities of human health-related behaviours in creative and human ways.

The global community is coming to recognise – in a variety of ways and through various fields over time – that behaviour change for health is so much more than the availability of facts, data and evidence. Community engagement for health is one such strategy that enables collaboration and transformation of human health-related behaviours. Whilst the concept of community engagement has been a long-recognised strategy in health and development, it has often been limited by unclear conceptualisation and partial operationalisation; as such the value of true community engagement is only slowly being realised by mainstream health organisations. Beyond community engagement as a tool for health or empowerment, we are interested in its transformative impact on community wellbeing and empowerment. There is an increasing body of evidence to suggest that storytelling, and its engine of empathy, is key to positively changing behaviours, and for our purposes, health behaviours. At a deep neurological level, it has been shown that empathy, particularly when it is framed in a narrative or sensory frame, is more likely to elicit a learning opportunity which is acted on, deeply felt, and remembered than the mere presentation of fact. The arts is one such way to cultivate an environment of empathy and expression. The impact of arts and culture on health is also increasingly recognised; the arts may facilitate a less mechanistic and more meaningful human interaction within the health sciences and promote health through a variety of ways we are only starting to come to terms with.

One of the challenges, as we see it, is to bring these rich fields – arts, community engagement and behaviour change – together and to learn from the existing, diverse fields of practice and enquiry, in order to come to a more complete understanding of human health and wellbeing. The report was drafted to help inform the WHO Draft Strategy for community engagement through the arts and humanities, which aims to use the arts and humanities to catalyse and support countries to engage communities and individuals at local, national and global levels on the key health issues of our time to improve all peoples' health no matter where they live. Through this review, by mapping the current landscape and identifying limitations and gaps, we also hope to contribute to shaping a future research and practice agenda.

We have structured this review into three parts. First, we start with the why. Part One, Why, provides a summary of the theory and concepts of behaviour change, community engagement and the arts and health movements, and suggests why arts and community engagement combined may be effective for changing human health-related behaviours, in order to frame the subsequent sections. In Part Two, Who, we undertake a global environmental scan of initiatives for community engagement in global health through the arts, including policy, funding, organisations, networks and academic bodies. In Part Three, What, we present a scoping 'review of reviews' plus narrative synthesis to present the evidence for what works in community engagement in global health through the arts. Finally, Part Four, How, we present our reflections on the current landscape and some preliminary suggestions about how we may proceed in the spirit of creativity and human wellbeing.

PART 1: WHY

BEHAVIOUR CHANGE, COMMUNITY ENGAGEMENT, THE ARTS FOR HEALTH

1.1 Behaviour change and health: beyond the availability of facts, data and evidence

Human health-related behaviours are complex. At individual and community levels, health-related decisions are in many ways 'unique.' Politicians, practitioners, economists, scholars, marketers, and activists have all grappled with the complexities of human health-related behaviours, and, more importantly, how to change them to benefit health. As such, a vast array of behaviour change theories and practices exist, and health-focused behaviour change strategies continue to evolve.

Behaviour change theories allow an appreciation of the complexity of human behaviour in health-related interventions, targets, relationships, and choices. The Fogg Behaviour Model, for example, conceptualises individual behaviour change as a function of motivation, ability, and triggers (Fogg, 2009). This model is represented by two axes, individual motivation (y axis) and individual ability (x axis), and an 'action line' that represents whether certain triggers for behaviour change would be successful or not. The Theory of Planned Behaviour is a widely cited behaviour theory based in a cognitive approach to explaining behaviour, whereby intention (reflecting attitudes to a behaviour), subjective norms (reflecting societal pressure) and perceived behavioural control (reflecting self-efficacy) converge to influence behaviour change (Armitage &Conner, 2001). The Health Belief Model is also a cognitive model that identifies individual beliefs about health and perceived threats to health, and subsequently how they combine to shape behaviour.

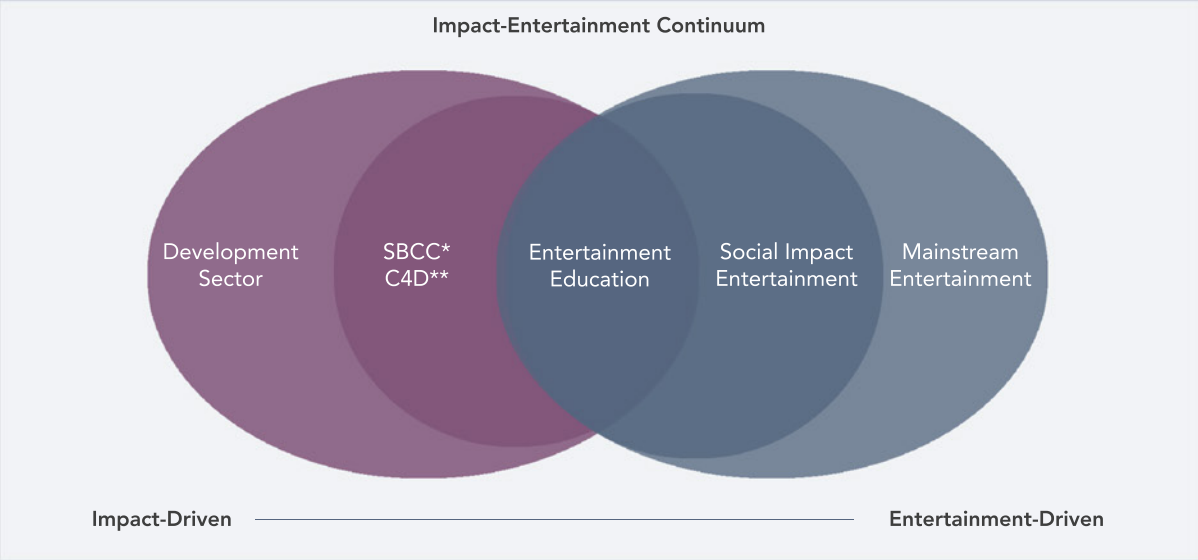
Beyond the individual level, certain behaviour change theories attempt to construct more complex or context-specific notions of behaviour change. For example, Social and Behaviour Change (SBC) Communication approaches consist of a range of tactics to transform social norms and cultural practices over time (USAID, 2014). USAID has invested in SBC with a focus on creating safe spaces for discussion, using mass media for targeted campaigns, mobilizing and engaging communities, influencing policy and promoting empowerment through mentoring and modelling behaviours (USAID, 2017). UNICEF's approach to behaviour change communication "…involves understanding people, their beliefs and values, the social and cultural norms that shape their lives. It involves engaging communities and listening to adults and children as they identify problems, propose solutions and act upon them.

Communication for development is seen as a two-way process for sharing ideas and knowledge using a range of communication tools and approaches that empower individuals and communities to take actions to improve their lives" (UNICEF, 2017). This is outlined more in Panel 1. The 4E's model of consumer behaviour advocates for behaviour-change strategies that encourage (through penalties or rewards), enable (by removing barriers and fostering capacity), engage (through various degrees of community participation), and exemplify (through leading by example or a consistent policy environment) (DEFRA, 2011). Shelton's (2013) conceptualisation explores behaviour change at various levels of the health system: freestanding, personal or lifestyle behaviours; care-seeking behaviour or demand; client adherence and collaboration; provider behaviour; pro-social and anti-social behaviour (behaviours that influence the health of the community at large); and, policy and priority setting.

Panel 1: Social and Behaviour Change Communication and Communication for Development

Social and Behaviour Change Communication approaches consist of a range of tactics to transform social norms and cultural practices over time. USAID has invested in SBC with a focus on creating safe spaces for discussion, using mass media for targeted campaigns, mobilizing and engaging communities, influencing policy and promoting empowerment through mentoring and modelling behaviours. Recently, SBC has worked with new and social media, as well as mobile technology in order to reach communities they wish to influence.

This type of communication strategy has been conceptualised along a spectrum of impact and entertainment (Deml, 2018).

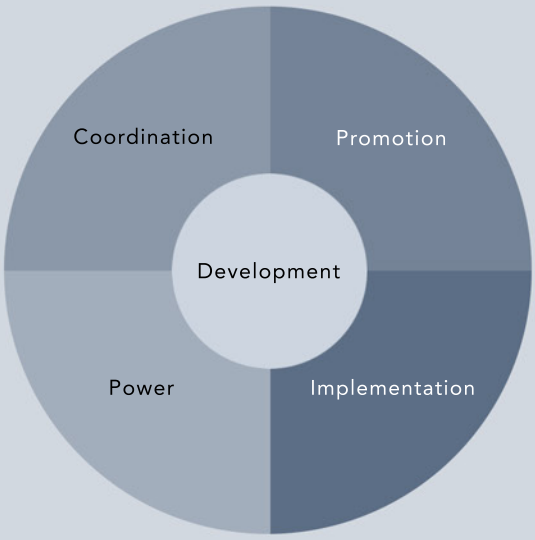


**Social Behaviour Change Communication **Communication for Development*

Reproduced from Deml, 2018

Communication for Development (C4D) is defined as "a social process based on dialogue using a broad range of tools and methods. It is also about seeking change at different levels including listening, building trust, sharing knowledge and skills, building policies, debating and learning for sustained and meaningful change." (2006 World Congress on Communication for Development).

There are four recognised pillars to C4D: promotion, implementation, empowerment and coordination. Promotion (Com 4 Prom) promotes development aid and supports how aid resources are spent. Implementation (Com 4 Imple) support implementation activities at the country and local levels. Empowerment (Com 4 Power) provides local communities with the capacity to use and report on the aid they receive. And, Coordination (Com 4 Coord) ensures that aid activities are coordinated through a range of tools and rules. Communication for Development tools are designed to capture and record, amplify and redistribute, facilitate networking and dialogue, and build capacity (Weigel, 2004).



Adapted from Weigel, 2004.

Despite a rich body of research and practice, health-related behaviour change is "much more difficult than it needs to be"(Kelly & Barker, 2016). At the individual level, technical, narrow, and prevention-focused health-promotion strategies often fail to persuade individuals to actually change their behaviour (Baum & Fisher, 2014). These failures have been attributed to: an (often, false) assumption that appealing to 'common sense' will magically translate to behaviour change; that behaviour change can be driven by 'pushing' messaging onto the individual; that knowledge and information drive behaviour; and the assumptions that people are either always completely rational or irrational actors, rather than agents who navigate solutions that make sense given their circumstances (Kelly & Barker, 2016). A key shortcoming of a utility-oriented or linear concepts of human behaviour is that many health-related behaviours may be not be linear, nor may they be rational. They may also be driven by powerful emotions such as fear, love, jealousy or altruism (Kelly & Barker, 2016). For example, during the West African Ebola outbreak in 2014, devastating delays in control and prevention (and subsequent rehabilitation of survivors) were driven by a combination of mistrust, fear and stigma (Panel 2).

Furthermore, strategies often do not adequately address the underlying factors influencing people's environmental, cultural, and socioeconomic settings (Baum & Fisher, 2014). Beyond the individual level, it has long been recognized that human behaviour is shaped by society, culture, and social norms (USAID, 2017). Structural forces, including growing corporate influences, rapid industrial and technological advancements, use of social media, and large scale human movement – including travel, migration, and displacement – are enormous factors in shaping our societies and subsequently our health (Marmot, 2008; Abubakar, 2018). At a governance level, evidence and facts are necessary but not sufficient to create effective health behaviour change policy and programmes; these efforts must be matched by sustained leadership efforts, partnerships, responsiveness, and reflection (Baum & Fisher, 2014). Beyond predicting, often technically, what will work in terms of behaviour change, inductive approaches to understanding health needs, the social and structural determinants of health behaviour, and strategies that embrace the complexity of human nature, are needed. Understanding and engaging with these complexities is critical if we are to achieve effective behaviour change towards health for all.

This is where creative approaches from outside the health sphere may be useful to engage with individuals, communities and organisations, in order to foster an environment of dialogue, understanding, and empathy. Although many behaviour change strategies recognise the role of reflection and deliberation in achieving change, few enable a space for critical engagement and reflection in order to facilitate change. This is where the arts may be ideally situated. We will now explore the background of community engagement for health, the arts and health, and how these approaches can be combined to facilitate a deeper engagement with human wellbeing and drive change towards health for all.

Panel 2: Misperceptions, mistrust, and fear during Ebola

On the background of coalescing technical and logistical priorities, community conceptualisations of Ebola and local understandings of the disease process and behaviours related to this are at the core of effective control and prevention. Recognised barriers to Ebola spread and containment during the West African outbreak included cultural beliefs and behavioural practices, such as traditional burial practices, reliance on traditional or faith-based healers, community resistance, stigmatization of survivors and health professionals, and ineffective public health messaging that fuelled fear and mistrust (WHO, 2015; WHO, 2018). Of note, misperception, (mis)trust and fear were interrelated factors which emerged as important social phenomenon affecting Ebola control and prevention, and have been well documented by medical anthropologists (Ormidian et al, 2014;Shultz et al, 2016).

Misperceptions of Ebola were various, from the belief that the chlorine sprayed by ambulance workers was toxic, to the erroneous assumption that use of thermometers was a diagnostic test, to the belief that washing with salt and hot water would prevent Ebola (Ormidian et al, 2014; Yamanis et al, 2016; Jalloh et al, 2017). At the most extreme, some denied that Ebola was 'real' (Ormidian et al, 2014).

Mistrust in health systems were related to frustration with lack of health services, experiences of disrespectful care, and inaccessible health messaging (Yamanis et al, 2016). Many believed that government information was too technical, not in local languages, and was only shared in urban areas (Ormidian et al, 2014).

Mistrust and misperceptions often led to fear. For example, some people feared that calling the national hotline to report a case of Ebola would result in that person's death, or that patients would disappear never to be seen again and their bodies would be thrown away (Ormidian et al, 2014; Yamanis et al, 2016). Fear-related behaviours were implicated in the spread of EVD, impeding life-saving treatments, curtailing the availability of medical services, increasing risk of psychological distress, and amplifying downstream cascades of social problems (Shultz et al, 2016).

The combination of misperception, mistrust and fear means that responses to the Ebola crisis, from the community to the health system level, may be compromised. Strategies to enhance understanding and trust, such as community engagement, may lead to reduction of fear and be particularly effective (Jalloh et al, 2017). Further, understanding community concerns and perceptions, as well as the sociocultural context of the outbreak, may improve community engagement and prevent EVD transmission (Carrion Martin et al, 2016). The WHO has recognised the critical need for community engagement in the Ebola response (WHO, 2014).

1.2 Community engagement: complexities and definition

An increasing body of evidence suggests that community engagement strategies – and their engines of participation, dialogue and empathy – are key to positively changing health-related behaviours. Individual and community-level engagement in health policy and research is seen as a necessary prerequisite for the effective adoption of health technologies and behaviours (Tindana et al, 2007), and for the equitable and sustainable impact of such health initiatives (Mannell et al, 2018). In the UK, community engagement is a central strategy for health promotion and the reduction of inequalities (Milton et al, 2011). Community involvement in all phases of health service delivery, from design to governance, can improve health and make policy initiatives more sustainable (Milton 2011; Rifkin, Lewando-Hundt and Draper, 2000; Wallerstein, 2006). Community engagement provides individuals with perceived benefits for their physical and psychological health, self-confidence, self-esteem, sense of personal empowerment and social relationships (Attree et al, 2011), and may contribute to positive health and social outcomes (Hoon Chuah et al, 2018). The WHO recognise community engagement as a cornerstone of quality, safe and people-centred services (WHO, 2017) and that health systems must shift from vertical, top-down, curative paradigm to one that places people at the centre of health services through community engagement in order to achieve universal health coverage (UHC) and the sustainable development goals (SDGs) (Odugleh-Kolev & Parrish-Sprowl, 2018). More and more, advocacy groups are demanding a voice in local, national and global health policy, as reflected by the global People's Health Movement (Health Poverty Action, 2000), and the widely-used slogan 'nothing about me without me' (South African National Adolescent and Youth Health Policy 2017).

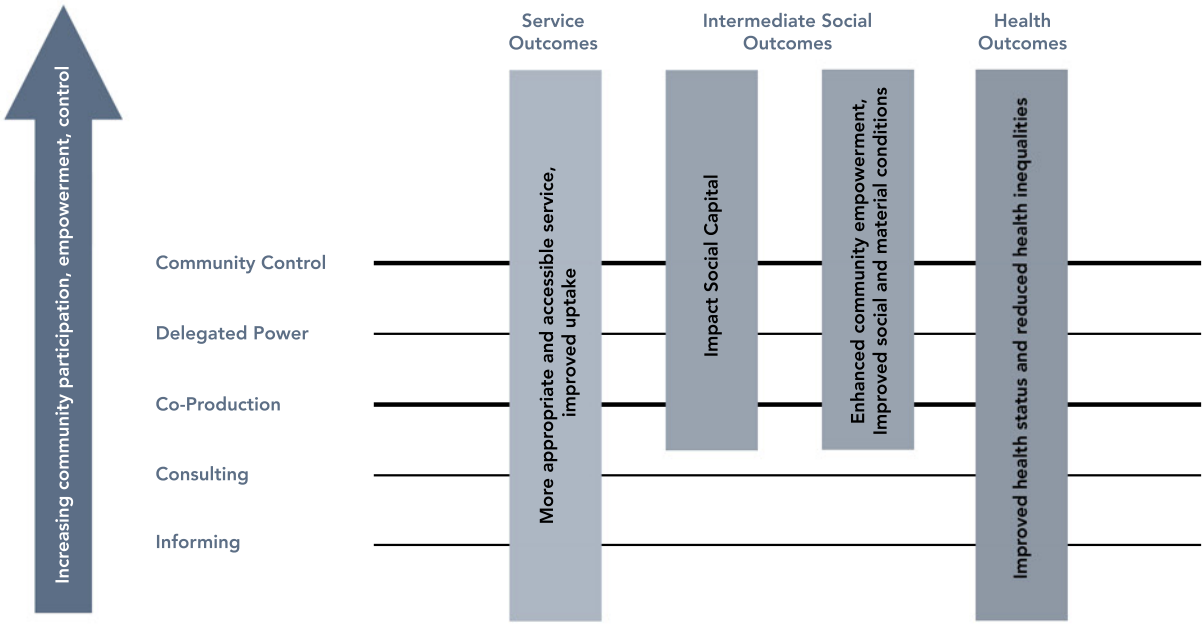
Although community engagement in global health research and practice is recognised as critically necessary, it is often poorly conceptualised and actualised. Community engagement has many overlapping definitions (see Panel 3, below), which may reflect the variety of ways in which community engagement has been used both in the global health arena and beyond (Milton et al, 2011; Bolam et al., 2006; Popay, 2006; Chau, 2007). Multiple, interrelated terms are often used to represent versions of the same or similar activities, such as strategic communication, risk communication, health messaging, social mobilization, community mobilization, community participation, and community ownership. In reality, this means that there are a wide range of interventions with a vast diversity of definitions, practices, and evaluation methodologies (Milton, 2011). Beyond the definition itself, community engagement, as a multifactorial and human process, can be complex and difficult to effectively facilitate. Often, community engagement strategies are conceptualised as a means to an end, or as 'good practice' rather than valuing the process itself and its ethical and philosophical underpinnings. Recently, scholars have called for an ethical orientation of engagement in health research, to generate topics of importance to disadvantaged group and to promote the translation of research into practice that benefits the health of the most marginalised (Pratt and de Vries, 2018).

Another challenge for community engagement in health is in defining what, or who the community is. There is no standard definition of a community. Communities have previously been regarded solely in terms of their geographic proximity, however this conceptualisation was limited, as many people living close by each other may hold different identities and value systems. Nowadays, with increasing global connectivity, communities may form along ideological, language, identity, or cultural lines, and function with various levels of cohesiveness. Campbell and Jovchelovitch (2002) define a community as "a group of people who share a common identity." This means they share an articulate-able identity, share social representations and similar organising worldviews, and share conditions and constraints of access to power (both material and symbolic). In relation to global health research, Tindana and colleagues summarise earlier work by Weijer et al (1999) and Weijer & Emanuel (2000), in defining a community through common culture, traditions, traditions and knowledge, a certain health-related common culture, legitimate political authority, geographic localization, a common economy and shared resources, communication network, and self-identification as a community.

Barriers to and facilitators of effective community engagement have been divided into 'context', 'infrastructure' and 'process' factors (Harden et al, 2015). Contextual factors can be thought of as arising from the quality of existing relationships with communities, as well as from the organisational culture, attitudes and practice of those undertaking engagement. On the community end, barriers to engagement may be historical; poor preceding relations between the organisation and community may serve as a tension, and attempts at engagement may be perceived as a threat. At the organisational level, lack of organisational commitment, resistance to sharing power and control, and a limited value in or vision of engagement may hinder progress (Harden et al, 2015). However, a supportive culture embedded within the organisation from the start and reinforced throughout the engagement may enhance the process. Investment in infrastructure and planning to support community engagement is essential: clarity and transparency, joint decision making, an adequate timeline and budget, dedicated staff, and use of existing networks are critical infrastructural considerations (Harden et al, 2015). Beyond these, support systems and training have been identified as means to build local capacity during the engagement process. Finally, the engagement process should be inclusive, accessible and practical. This means that cultural and languages issues must be considered, as well as equal representation and non-partisanship in all activities. Engagement, ultimately, should be focused on building capabilities in a manner that is congruent with the particular community, in a consistent and sustained manner.

As an umbrella term, community engagement encompasses a range of communication, research, and consultation practices (Wellcome Trust, 2016). Community engagement may involve a range of approaches to involve local communities in health initiatives, including needs assessment, community development, planning, design, development, delivery and evaluation (NICE UK). Community engagement may also be conceptualised as a spectrum or hierarchy of activities, ranging from information communication to full community control.

Figure 1: Popay's spectrum of community engagement in health



Adapted from Popay et al 2006

Popay and colleagues (2006) have conceptualised community engagement as a continuum of practice from informing, to consultation, co-production, delegated power, and community control. This is consistent with the large body of patient engagement literature, which explores how, at the individual level, strategies could be categorised along a spectrum of information provision, patient activation, and patient–provider collaboration (Grande et al 2014). At the community level, differing degrees of engagement may influence accessibility, appropriateness, and uptake of health services, and thus improve population-level health outcomes and reduce health inequalities via intermediary social outcomes such as social capital, community empowerment, and improved social and material conditions.

1.3 Meaningful and effective community engagement: awareness, participation, and agency

Community engagement "…is about people improving their health and wellbeing by helping to develop, deliver and use local services, programmes and interventions" (Harden et al, 2015). This involves a spectrum of awareness, participation, and agency. Strategies of community participation and engagement in health initiatives have been conceptualised as a continuum from less to more participation and control amongst the community involved (Hoon Chuah et al, 2018; Popay et al, 2006). Not only should community engagement raise awareness and understanding of an issue, but it should provide a space for bi-directional communication, empathy, participation and, ultimately, action. This may entail varying degrees of voice (providing views on a local issue), participation (joint planning and delivery of an intervention) and control (community controlled services). Community engagement is a complex process influenced by the context in which it occurs, and factors such as power relations must be carefully considered.

Panel 3: Community Engagement Definitions

WHO SDS, 2017	A process of developing relationships that enable stakeholders to work together to address health-related issues and promote well-being to achieve positive health impact and outcomes
Wellcome Trust, 2016	Engagement is an umbrella term and, as understood by those interested in puablic engagement with research, it encompasses a range of activities. It can span communication of research to public audiences in a unidirectional way, such as through broadcast media, to something that follows a bidirectional communications model in which research or researchers are informed by the perspectives of those outside of research.
Centers for Disease Control and Prevention, US	A process of working collaboratively with and for groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people.
Tamarack Institute, Canada	A method to improve communities by identifying and addressing local ideas, concerns and opportunities.
NICE, UK	Encompasses a range of approaches to maximise the involvement of local communities in local initiatives to improve their health and wellbeing and reduce health inequalities. This includes: needs assessment, community development, planning, design, development, delivery and evaluation.
Department of Health Community Engagement Project UK	A simultaneous and multifaceted engagement of supported and adequately resourced communities and relevant agencies around an issue or set of issues, in order to raise awareness, assess and articulate need, and achieve sustained and equitable provision of appropriate services
Tindana et al., 2007	The concept of engagement in research goes beyond community participation; it is the process of working collaboratively with relevant partners who share common goals and interests. This involves "building authentic partnerships, including mutual respect and active, inclusive participation; power sharing and equity; mutual benefit or finding the 'win-win' possibility" (Zakus & Lysack, 1998) in the collaborative initiative
Harden et al., 2015	Community engagement in public health is about people improving their health and wellbeing by helping to design, develop, deliver and evaluate local services and interventions. Community engagement can involve varying degrees of participation and control: for example, giving views on a local health issue, jointly delivering services with public service providers, or completely controlling services… the more a community of people is supported to take control of activities to improve their lives, the more likely their health will improve (Popay et al. 2007).
UNICEF, 2018	Community engagement "focuses on collective or group participation, not on any particular behaviour. It empowers communities and their social networks to reflect on and address a range of behaviours, issues and decisions that affect their lives and to proactively involved in their development. Community participation is a strategy that raises awareness and strengthens the capacity of both "rights holders" and "duty bearers" to assess, analyze, plan, facilitate, implement and monitor and evaluate interventions that will promote the survival, development, protection and participation of children and women."

1.3 Meaningful and effective community engagement: awareness, participation, and agency

Community participation is pivotal to community engagement initiatives (Hoon Chua et al 2018). Participation can be thought of as active individuals or groups where participants not only provide ideas but are also involved in the intervention itself (Tindana et al, 2007). Effective and meaningful community participation is intertwined with and results in community empowerment (Arendt, 1958). Community empowerment can be conceptualised as a 'sense of community'(McMillan & Chavis, 1986) 'community competence'(Eng & Parker, 1996) 'collective efficacy'(Sampson et al, 1997) 'community capacity'(Goodman et al, 1998) and community 'social capital'(Gillie, 1998). Community cohesion and empowerment may be reflected by local community organisations and networks, civic engagement or participation in these community networks, a strong and positive local identity and a sense of solidarity/equality, and trust and reciprocal help and support between community members (Campbell and Jovchelovitch, 2010).

Through meaningful participation and dialogue, community members have the opportunity to develop critical consciousness, or conscientização, of the social and structural factors influencing their health and develop strategies for addressing them (Smith, 1976). They may be more able to mobilize for change and build social capital, including bonding between community members and bridging between the community and external actors. In terms of behaviour changes, people are also more likely to change their behaviour if they see that liked and trusted peers are changing theirs (Dube & Wilson, 1996).

Ultimately, expanding human agency in health through engagement and participation will enable more effective demand for health services and more effective choices for health. Social capital, such as sociability, social networks, trust, reciprocity, and community and civic engagement, has been positioned as an important driver of public health and has the potential to explain the impact of community level factors on health inequalities (Morgan & Swann, 2004). In other words, community engagement activities, if done well, will strengthen of human capacity to act to promote health and wellbeing at the individual and community levels. Community engagement is also an inherently therapeutic process in and of itself. For example, artistic activities, as core components of community engagement which tap into creativity and provide a form of catharsis, have the capacity to provide a tangible benefit to health and wellbeing. There is an additional positive social psychology that results from engagement, promoting voice and agency. On the one hand, community engagement may improve health via its impact on the development and delivery of more appropriate and accessible interventions; whereas, on the other, it may have a direct positive impact on social cohesion and individual self-esteem and self-efficacy (Hoon Chua et al, 2018). Community engagement interventions can improve health behaviours, health consequences, individual self-efficacy and perceived social support for disadvantaged groups (O'Mara-Eves et al. 2013).

1.4 Why art? Community engagement for health through art

It is argued that art is what make us human. Since we have been able to, humans have employed art, language and storytelling, myths and religion, music and philosophy to understand and record our world (Patel, 2018). Ancient rock art and artefacts reflect how humans represented themselves and communicated, representing issues of universal human importance such as fertility and death (Patel, 2018). Nowadays, the arts have evolved to encompass various branches of creative activity, such as painting, music, literature, dance, sculpture, ceramics, architecture, drama, and media including film, television and photography.

Art is defined by the Oxford Dictionary as "works produced by human creative skill and imagination." Through creativity and imagination, art shifts the focus away from the material, towards the "inner worlds of aesthetics, metaphor, meaning and feeling." Artistic expression can help people to arrive at deeper explanation "...where language alone falls short. Fine art, poetry, sculpture, and creative literature forms, for instance, all reach for more than descriptive logic. Fine art, poetry, sculpture, and creative literature forms, for instance, all reach for more than descriptive logic" (Cosgrave & Kelman, 2018). Art can facilitate remembering, hope, sorrow, rebalancing, self-understanding, growth, and appreciation (de Botton, 2010). In this regard, art is inherently therapeutic and salutogenic.

Community engagement in health through the arts has the capacity to build social and cultural capital and contribute to community empowerment. Culture, in its broadest understanding, encompasses community ethics, rites, spirituality and lifestyle, as well as more traditional forms of art (UNESCO, 1982). Cultural capital may be thought of as culture-based resources such as knowledge that enable people to maintain and promote health behaviours, norms, and values (Bourdieu, 1986; Abel, 2007). As such, these cultural factors link material and social resources, social structures and health. Arts in community engagement also has the capacity to encourage social capital through the forces of bonding, bridging and linking (Morgan & Swann, 2004). Bonding refers to strengthening relationships within groups; arts engagement activities may facilitate bonding through providing space to deepen existing community understanding and relationships through enabling critical and creative reflection. Community engagement through the arts may also facilitate bridging, outward connections between or across groups, by promoting empathy and communication (verbal, or otherwise). Finally, linking between the community and different actors may be more effective when arts and community engagement are combined, to facilitate equitable exchange of information and involvement in decision-making processes.

Participation and community engagement through the arts also has the potential to lead to greater societal cohesion and to overcome pressing social and policy concerns. The UK All-Party Parliamentary Group on Arts, Health and Wellbeing argue that arts may be used to engage with communities, strengthen preventative health strategies, enabling patient agency, improve social care, mitigate social isolation, strengthen local services, enable more cost-effective use of resources, create a more human environment in health and social services, and ensure more equitable distribution of resources and better access to the arts (UK APPGAHW, 2018). NICE guidance on community engagement to improve health recommends that all bodies involved in health research engage in community activities including the use of the arts. When realised effectively, the arts can lead to greater societal cohesion and can help meet major challenges facing health and social care. Therefore, the arts should be at the centre of person- and community-centred care, and should be considered integral to community engagement (NICE 2016).

Community engagement may be effectively facilitated by the arts. Arts-based CE and health promotion has a longstanding history, where storytelling, drama, and music are used in many cultural contexts as means for enforcing belief systems that guide behaviour (Sonke & Pesata, 2014). Examples of community engagement through the arts range from employing visual and graphics methods to facilitate communication, to widespread engagement via social media. Community engagement through the arts is particularly effective because it is simultaneously creative, enjoyable, educative, sustainable, locally relevant, and not driven by a political agenda (Torregiani, 2018). The arts enhance emotional engagement with particular health or social messages, and have the capacity to optimise social learning patterns and provide motivation to change behaviours (Sonke & Pesata, 2014). Creative media, including images, theatre, song, and dance, give meaning to health information and can improve understanding, retention, and utilisation of information (Sonke & Pesata, 2014).

1.5 Framework for community engagement through the arts in global health: awareness, participation, empathy, and action

The underlying hypothesis of this project is that to positively impact health at the community level and with the general public, mere availability of facts, data and evidence, do little to influence ingrained opinions and behaviours of the general public by themselves. There is an increasing body of evidence to suggest that storytelling, and its engine of empathy are the keys to positively changing behaviours, and for our purposes, health behaviours. The assumption of this project is that such engagement should as much as possible be done with local agencies in the modes that mean most to a particular group, whether that is theatre, popular media, sporting events, religious gatherings or even children's games. In every case, the work would strive to be as authentic and evidence-based as possible, even when using fictional forms.

Panel 4: The Arts and Health

The link between art and health has been recognised for a very long time and expressed in a multitude of ways. In Ancient Greece, music was thought to have a mathematical relationship with the Cosmos and assist with healing the soul, which would, in turn, heal the body. The Hippocratic philosophy of "healthy mind, healthy body"… and catharsis was said to be achieved through theatre (Moreland et al, 2012). The USA Bureau of Indian Affairs has catalogued over 1500 healing songs that were seen as integral to health (Harvey, 1980). Biblical texts such as Samuel,16:14-23 contain references to music and healing: "Whenever the spirit from God came on Saul, David would take up his lyre and play. Then relief would come to Saul; he would feel better and the evil spirit would leave him." With Islamic revival of Greek texts, the holistic nature of healing through creative expression was incorporated into hospital design so that bimaristans considered architecture to be as important to wellbeing as water fountains, music, birdsong, and gardens (Patel, 2018).

The relationship between art and health further evolved during the Renaissance and Enlightenment periods. To be an artist during the Renaissance was often synonymous with being an anatomist. Music continued to be used for healing during the Renaissance, where composers such as Zarlino explored the healing properties of harmony (Dobrzynska, et. Al., 2006).During the Age of Enlightenment, with its ideals of reason, liberty, progress, and separation of church and state, a division between science and humanities fields emerged. The scientific method promoted rational, positivist, and mechanistic approaches to understanding the physical world and the nature of humans. The concept of mind-body dualism was formalized into Western thinking by Descartes around this time.

In modern times, arts and health were shaped by wars, epidemics and industrialization. Art such as music and painting was used to treat returned soldier suffering from post-traumatic stress distorder or rehabilitate patients after the Crimean War, World War 1, and World War 2 (Patel, 2018). Around the time of the tuberculosis convalescence in the UK, Adrian Hill coined the term "art therapy" and noticed that art "completely engrossed the mind," and helped "build up a strong defence against his misfortune." This type of therapy began to be explored for institutionalized patients in mental health, prisons, hospitals, aged care, and sanitoriums.

Art therapy became formalised through professional development from the mid twentieth century, with the formation of the American Music Therapy Association in 1950, the British Association of Art Therapists in 1964, American Art Therapy Association 1969, and the Australian, New Zealand and Asian Creative Arts Therapies Association in 1987 (Serlin, 2008; Patel, 2018). However, art therapy is one of many ways in which the arts and health can interact. Participation in the arts and access to a range of arts opportunities are increasing available, and their impact on health and wellbeing outcomes is increasingly recognised by mainstream medicine and valued as a public health tool, once again. Nowadays, Arts in Healthcare, as a movement, is "a diverse, multidisciplinary field dedicated to humanizing the healthcare experience by connecting people with the power of the arts at key moments in their lives. This rapidly growing field integrates the arts, including literary, performing, and visual arts and design, into a wide variety of healthcare settings for therapeutic, educational, and recreational purposes." (Americans for the Arts, 2009).

Our framework brings together three overlapping fields of thought: behaviour change science, community engagement, and arts and health. We believe that, in order to affect meaningful and sustained change for health in the face of global challenges such as epidemics, non-communicable disease, and climate change, we need more than facts, data and evidence. We need to create an environment of empathy and trust, of bidirectional exchange and dialogue, and of collaboration. We believe that the use of the arts in community engagement facilitates an environment conducive to understanding, empowerment, and creative solutions. Through awareness, participation, empathy, and agency, the arts can help communities, practitioners, and policy makers move from knowledge to action.

For our purposes, we choose the simplest definitions. A community is a group of people bound together by a set of shared stories. Community Engagement then becomes participating in that shared story telling process as a primal act of sense-making. Here, community engagement can be thought of as using local forms of gathering and dialogue to create an equitable, participatory and empathic interaction in order to address issues affecting the wellbeing of people who belong to a certain community. This encompasses the need to address locally-relevant health and wellbeing issues using context- and culturally-specific activities. Dialogue refers to the multi-directional transfer of knowledge and information which we believe will enable deeper empathy and understanding for everyone involved and facilitate action based on mutual understanding. Community engagement, in this regard, promotes equitable participation, voice, and responsibilities, and has the potential to challenge hegemonies and overcome asymmetries of knowledge (Foucault, 1980). On a deep biological basis, empathy nurtured through engagement is neither an optional side effect, nor an obstacle to be managed, but the driver of the behavioural change process, a way of triangulating one's own experience and feelings onto the group for common understanding and action. Art is one of the most effective tools for this as it has evolved from the birth of consciousness itself as the frame for this very process. Unlike a positivist scientific method, whose goal is to isolate objective fact and is a separate but complementary process not to be confused, art does not distil objective fact, it creates a personal sense of truth. It is the latter which most often forms the basis of opinion and behaviour based on our unique biology. Fittingly, our definition of art, borrowed from Coleridge, is also the most simple. Art is that which lights and delights.

PHOTO CREDIT: GEORDAN SHANNON

Case Study 1:

Theatre as a Psychosocial Approach in Crisis and Post-Crisis Conditions

Rationale for the approach

In times of crisis, continuous violence and destruction, the existing protective supports are eroded and affected people face a risk of diverse psychological and psychosocial problems at individual, family, community and social levels. War, loss and devastation have a collective impact and disrupt the social cohesion of communities and the existing socio-relational systems, therefore making the process of coping even more difficult. Sense of not belonging and the need to re-define identities take a toll on lives of individuals and can have a chronic negative effect in day to day livelihood activities. Psychosocial wellbeing is not limited only to the individual, but it includes the collective wellbeing of a community, including influences between social factors, cultural elements, and the inter-relation between individual and collective behaviors, thoughts and emotions.

The notion of healing through theatre and drama is not new. Theatre and performance have always been and are an integral part of cultures and traditions. Theatre creates a safe space for people to gather together after crisis in order to re-build sense of community, find their belonging and re-define their identities- all important elements for psychosocial support (Schininà, 2009).

Through storytelling and symbolism, theatre can offer a safe space to express thoughts and emotions about the traumatic events experienced by affected communities and address their consequences in a non-stigmatizing way. Moreover, it allows the affected individuals to assume an ownership of the creative process by being in control of what is told and how, thus empowering them and building sense of trust.

Photo Credit: EVN Community Theatre

Photo Credit: EVN Community Theatre

Theatre interventions in humanitarian work

Today many humanitarian organizations use theatre as an approach for psychosocial support in crisis-affected communities. Some examples include the following:

- The International Organization for Migration uses theatre on systematic basis as part of their psychosocial approach in many crisis and post-crisis situations, such as in Haiti after the earthquake in 2010 (Schininà et al., 2011); in Central African Republic as a response to widespread violence since December 2013 with an aim to re-stabilize the affected communities and create space for dialogue between residents in mixed communities (IOM, 2015); in Libya in 2013 during the reconstruction phase following the war (Social Community Theatre Centre, 2013); in Bissau for the purpose of re-integration of migrants returning from Niger (IOM, 2017).

- The International Committee of the Red Cross (ICRC) used theatre and community drama performances to battle stigmatization against boys and men who were kidnapped and trained as soldiers by the Lord's Resistance Army in the Democratic Republic of Congo (ICRC, 2014).

- UNICEF has widely used theatre and performance under their initiative called Theatre for Development (T4D) to encourage civic dialogue and create a safe space for social debates around sensitive topics in various communities (UNICEF, 2016). For instance, in Botswana youth groups participate in drama workshops which aim to raise awareness about HIV/AIDS and improve skills in prevention (UNICEF, 2013).

- Child protection organizations such as War Child and TdH use theatre techniques (e.g. storytelling, narrative theatre, forum theatre) with vulnerable children and adolescents as part of their psychosocial intervention methods and include the practice within some

Uses of theatre

The cross-disciplinary nature of theatre and its creative process makes it possible to use theatrical tools in various psychosocial support activities, which are not limited to the following:

- communication between an individual and a group, then between a group and wider public, and lastly communication between communities;
- integration and/or re-integration of migrants and refugees into host communities and/or their own communities upon return;
- creating a safe space for shared understanding, tolerance and empathy, thus tapping into a process of community building;
- enabling to reflect on past traumatic experiences and transform them in the now and here in a non-stigmatizing space;
- redefinition of personal identity through play, storytelling, symbolism, physical and emotional projection, and after reconstructing own role in relation to the world and the society;
- creating solidarity in societies through empowerment of individual differences;
- finding answers and understanding loss and grief through symbolism and association;
- enabling the affected individuals to feel their own emotional and mental strength and the ability to be resilient;
- preventing the risk of developing mental disorders by addressing the consequences of trauma in a creative and therapeutic way.

Theatre in crisis and post-crisis situations becomes a creative tool for psychosocial support that facilitates a participatory and playful process for exploration of a new environment, empowerment of differences and shared interests, de-construction and redefinition of identities and roles, shared emotional connectedness, personal and collective reflection through play and symbolism, physical projection of thoughts and emotions with body movement and voice, and once again re-building sense of community and belonging.

Author: **Sonya Armaghanyan**

PART 2: WHO

THE GLOBAL LANDSCAPE OF COMMUNITY ENGAGEMENT, ARTS AND HEALTH

INTRODUCTION

The field of community engagement, arts and global health is evolving. Individual arts and health initiatives, as well as participatory approaches to community empowerment and wellbeing, have a longstanding history around the world. However, we now benefit from the emergence of networks of support and action, large scale evidence synthesis, and formalisation of structures of support for such initiatives, including policy frameworks.

To convene a global strategy for community engagement through the arts for global health, it is important to understand the landscape of activities occurring worldwide. This will enable us to a) identify strengths of and gaps in our field, b) shape a strategy around these strengths and gaps, and c) to coordinate large-scale network of partners and practitioners. Taking a global view ensures that projects and partners from all around the world can be identified and included.

In this section, we undertake a global environmental scan of initiatives for community engagement in global health through the arts. This is intended as an initial step towards understanding the landscape, and, as such, there may be many more activities and organizations beyond this search. We present these results in order to solicit input from our readers and identify additional initiatives worldwide.

METHODS

Search Strategy

We performed an environmental scan of policies, funders, organisations, research bodies, networks, resources, and projects. We did this through a broad internet search using the following terms, which are defined below:

> ***Global Health***: including terms related to health, hospital, and medicine. Defined as collaborative trans-national research and action for promoting health for all (Beaglehole and Bonita, 2010)
>
> ***The Arts***: which included terms such as creativity, music, dance, drama, film, and radio. The expression or application of human creative skill and imagination (Oxford English Dictionary online)
>
> ***Community Engagement***: recognising concepts such as participation, empowerment, mobilisation. Using local forms of gathering and dialogue to create and equitable, participatory, and empathic interaction in order to address issues effecting the wellbeing of people who belong to a certain community (as defined by the WHO Working Group, above)

We searched for activities and initiatives that explicitly targeted health and wellbeing, and also focused on community engagement through the arts. We searched in English and Spanish. We also searched by geographic region, so as to ensure inclusion of examples from around the world. We only included initiatives that met the above definitions, focusing on both community engagement and the arts in global health. We also performed a 'review of reviews,' to identify relevant literature on the evidence for community engagement through the arts in global health. The full academic search strategy and results are detailed further in Part 3.

Analysis

We arranged our results into the following headings:

- Policy and governance
- Funders
- Organisations
- Research bodies
- Networks
- Resources

We then noted the geographic location(s) of the initiative, as well as defining features of the project. This enabled us to undertake an analysis of the distribution and nature of initiatives around the world, and to identify perform a simple gap analysis of the current landscape. In addition, we constructed a global map as a visual representation of the available funding opportunities and the location of their impact.

Finally, we purposively selected a range of exemplar case studies from different locations and using different strategies, to demonstrate the role of community engagement through the arts in global health. These are presented throughout the document.

RESULTS

Policy & Governance

The majority of arts and health policy initiatives arise from Australia, Ireland and the UK.

In Australia, the 2013 National Arts and Health Framework was published to "enhance the profile of arts and health in Australia and to promote greater integration of arts and health practice and approaches into health promotion, services, settings and facilities." The framework is designed as a resource for all agencies, departments and organisations with a role in promoting health and wellbeing. Further, it serves as a blueprint for States and Territories, to evaluate existing programs, and explore new directions and partners.

In the UK, the All Party Parliamentary Group for Arts, Health and Wellbeing was launched in January 2014, and launched a two year Arts, Health and Wellbeing Inquiry in 2015. The Inquiry report, Creative Health: The Arts for Health and Wellbeing, identified three core messages:

1. The arts can help keep us well, aid our recovery and support longer lives better lived.
2. The arts can help meet major challenges facing health and social care: ageing, long- term conditions, loneliness and mental health.
3. The arts can help save money in the health service and social care.

The report demonstrated that art is beneficial at all stages of the life course, and positioned the arts as an innovative strategy to enhance the landscape of health in UK.

The Arts Council Ireland's Arts and Health Policy and Strategy outlines the values that underpin its approach to arts and health practice, as well as strategic national actions. The policy and strategy was developed from consultation with the national arts and health sector, as well as a series of arts and heath events, Vital Signs, in 2009.

In Scandinavia, the Swedish Governmental Commission for Public Health noted the importance of cultural activities and health in national public health work. And, the Norwegian Department of Culture produced a white paper outlining the importance of cultural activities for health and quality of life.

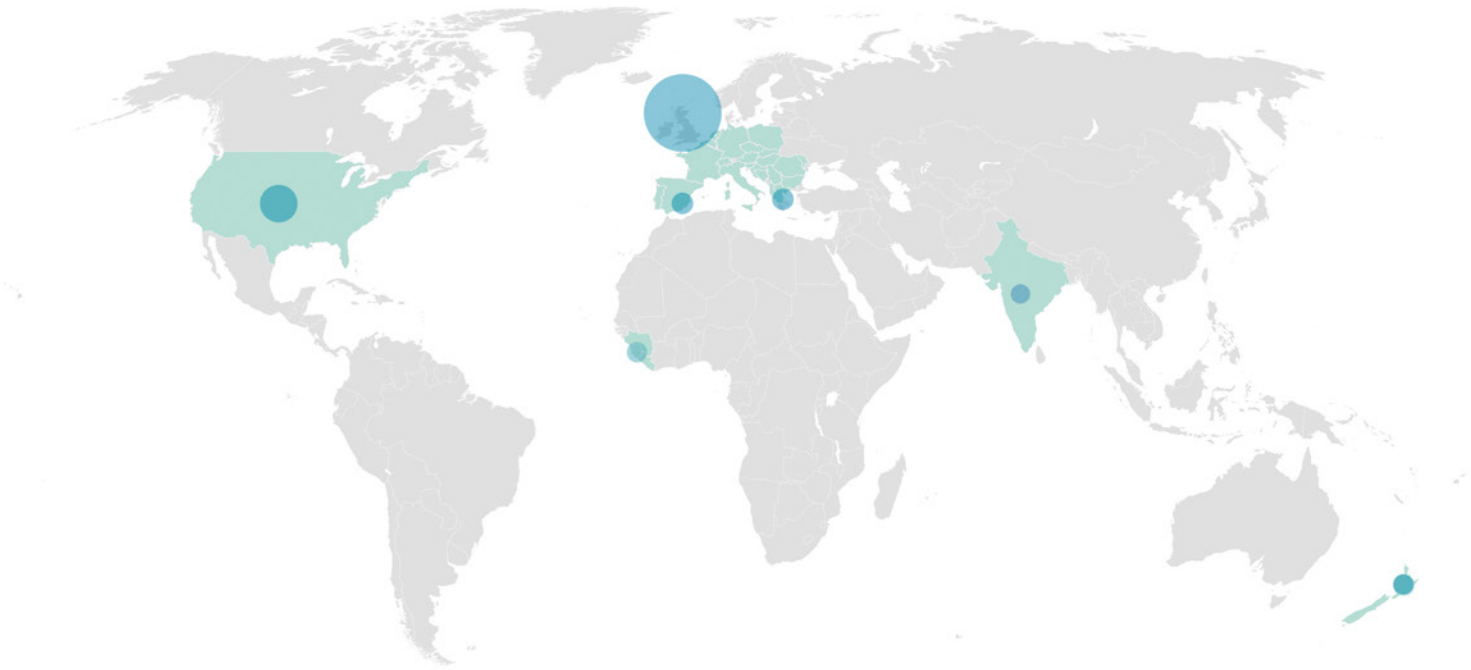
Finally, the Educators Roundtable Initiative in 2017, an initiative between US and UK practitioners and academics, produced a white paper to advance and standardise the language used when referring to the arts and health in higher education.

Funders

The majority of funding bodies that we identified were also located in the Global North, although many had a strategic international focus.

British Academy (UK), Creative NZ (New Zealand), Arts Council England (UK), United Arts Funds (USA), the Paul Hamlyn Foundation (UK) and the Stavros Niarchos Foundation (Greece) explicitly fund arts-oriented projects and programmes, often with a national focus.

Funders with an international health and development orientation include the Wellcome Trust, the Gates Foundation, the Ford Foundation. Their grant-making is often focused on health, community or public engagement activities, or innovative or creative approaches to health and wellbeing. Of these funders, the Wellcome Trust and Gates Foundation support more academic projects, whereas the Ford Foundation supports more impact-oriented initiatives.



We identified three regional network funders. Iberescena, is a Latin American programme to support the exchange and integration of Latin American performing arts activities. The DOEN Foundation supports cultural infrastructure in North, East and West Africa (particularly Mali, Tunisia and Uganda). The Visegrad Fund provides funding to a diverse range of activities with potential to benefit people across the Eastern European region.

In addition, two resources for additional arts and health sources of funding were identified: the Directory of Social Change, and the National Alliance for Arts Health and Wellbeing UK.

Organisations

A large number of international organisations have incorporated aspects of arts, community engagement, or both, into their organisational strategy or operations. For example, UNICEF implements Theatre for Development programme as part of their Communication for Development (C4D). Some health-related themes within their theatre projects include raising awareness about Malaria, HIV/AIDS, and they are also working with local radio stations to create radio-dramas relevant to the local health and development context. USAID has invested in social and behavioural communication for over 35 years, with a focus on creating safe spaces for discussion, using mass media for targeted campaigns, mobilizing and engaging communities, influencing policy and promoting empowerment through behaviour modelling. The IOM, War Child and Terre des Hommes use theatre techniques on regular basis to facilitate psychosocial activities for children affected by crisis and post-crisis situations and have produced publications, manuals, notebooks, articles about psychosocial projects that use various theatre techniques.

The ICRC have also used theatre for mental health and psychosocial support through theatre projects and awareness raising activities. The WHO recognises community engagement for quality, integrated, people-centred and integrated health services. They recognise the dual nature of community engagement as both a function and a process to improve not only health but the quality of health services (WHO, 2017). The ICRC have also used theatre for mental health and psychosocial support through theatre projects and awareness raising activities. The WHO recognises community engagement for quality, integrated, people-centred and integrated health services. They recognise the dual nature of community engagement as both a function and a process to improve not only health but the quality of health services (WHO, 2017).

A few smaller but internationally-focused organisations employ transdisciplinary, creative and innovative approaches to engaging with complex health issues through art. Women and Children First pioneer participatory approaches that support communities to solve problems themselves. The Art & Global Health Center Africa fosters creative leadership and implements innovative arts-based, health-oriented programs that inspire and mobilize. Global Health Disrupted supports small-scale community projects around the world, and uses art in the planning, implementation and evaluation of community-driven health efforts. The SHM Foundation uses knowledge from the humanities and social sciences to understand human motivation and address social challenges. NCDFREE uses social media, design, short film and creative events to promote the importance of non-communicable diseases worldwide. The Soul City Institute for Social Justice uses a combination of mass media, social mobilisation and advocacy, to improve the quality of life and health of young women and girls and the communities they live in in Southern Africa.

At a national or local level there are a range of organisations devoted to the arts, community engagement and health. Stichting de Vrolijkheid is a Dutch art organization that works with children refugees and asylum seekers to bring happiness and sense of belonging. The Presencing Institute uses performing arts techniques to build capacity and conduct action research worldwide to support and scale profound societal innovation. HIVOS, inspired by humanist values, conducts activities which align with their belief that necessary changes should spring from communities themselves – from people at the base of society. Story Center, a US-based non-profit, creates spaces for transforming lives and communities, through the acts of listening to and sharing stories. Hospital Rooms is a mental health charity that co-creates museum-quality pieces of art with patients on secure mental health wards around the UK. Media for Development, Nepal, also focuses on storytelling, using various mediums to communicate thoughts and ideas on issues that affect our lives. The Public Health Film Society in Oxford believes in the power of film to change people's lives, and wants to see this power used to radically change the way people view their own health, the health of their society, and how the health of the world affects us all. SNEHA is a Mumbai-based organisation, taking participatory and approaches to maternal and newborn health, child health and nutrition, sexual and reproductive health and prevention of violence against women and children.

Research Centres

There are a variety of research programmes and partnerships worldwide. Research centres that embrace community engagement, the arts, and health. The Centre for the Arts as Wellbeing (UK) promotes wellbeing in individuals, communities, organisations and the environment, through use of the arts. The Bhekisisa centre for health journalism (South Africa) promotes the role of health journalism and media for health. The UCL Institute for Global Health engages in a range of arts, community engagement and research translation activities worldwide to improve health, particularly in low- and middle-income countries. The UCLA Art & Global Health Center (USA) programs work with local artists and artisans communicating about HIV/AIDS and other public health issues in accessible and entertaining ways. The Arts for Health at Manchester Metropolitan University is the UK's longest established arts and health organisation. The John Hopkins Centre for Communications Programs works on narrative to improve the lives of populations around the globe. In Place of War works mainly in contexts of war, conflict, revolution and areas suffering the consequences of conflict, researching the power of performance with affected communities. Finally, Arts and Health at the University of Florida advances research, education and practice in arts in medicine, locally and globally.

Other universities have promoted specific programmes which use arts in community engagement for heath. These include: HEARTS, The Health, Economic and Social impact of ARTS engagement - a Public Health Study (Royal College of Music UK); Stories Of public health through Local Art-based Community Engagement (SOLACE, Keele University/Philippines); Arts, Health and Wellbeing (Kings College London); DEPTH, Dialogue, Evidence, Participation and Translation for Health (LSHTM); Global Health and Community Engagement in East Africa (Wilkes University); and, the Oxford University Clinical Research Unit-Nepal (OURCU-NP).

Finally, a few initiatives pro-actively incorporate academia, community engagement and the arts. The Universidad Veracruzana, Mexico, offers a world-first Master's degree in health, art and community. They employ a transdisciplinary approach to engage in the study and generation of alternatives that address the problems concerning contemporary society. The Arts & Health Journal provides a pioneering international forum for the publication of research, policy and best practice within the interdisciplinary field of arts and health. St Georges University's Global Health Humanities Hub focuses on bringing together interested academic partners and focuses on storytelling and narrative from a critical perspective in Global Health.

Networks

Networks of arts and health researchers and practitioners have developed worldwide and in various regions. In the UK alone, the London Arts in Health Forum, Arts Health Early Career Research Network, The National Alliance for Arts, Health and Wellbeing, Culture, Health and Wellbeing Alliance, Community University Partnership Programme (CUPP), BIG (British Interactive Group) STEM Communicator's Network, Culture Forum North, North West Arts & Health Network, MARCH: Social, Cultural and Community Assets for Mental Health, and Voluntary Arts are vibrant networks of practice. In Africa, Science Communication Africa, South African Association of Science and Technology Centres, and the Migration and Health Project are networks that focus on communication, health, and human development. In the Americas, Trellis, Informal Science, The American Association for the Advancement of Science's Center for Public Engagement with Science & Technology, and RedPop focus on networks of support for science communication, whereas RedSalud is a health journalism network.

There are also a diverse range of global networks that focus on different aspects of the arts, community engagement, and health. The Mesh Community Engagement Network is a collaborative open-access web space for people involved in community engagement with health research in low and middle income countries. UNESCO coordinates international cooperation in education, science, culture and communication. Public Communication of Science and Technology is an international network of professionals from across disciplines who seek to promote new ideas, methods, intellectual and practical questions, and perspectives on the communication of science and technology. The International Health Humanities Network provides a global platform for innovative humanities scholars, medical, health and social care professionals, voluntary sector workers and creative practitioners to join forces with informal and family carers, service-users and the wider self-caring public to explore, celebrate and develop new approaches in advancing health and wellbeing through the arts and humanities in hospitals, residential and community settings. The World Association of Community Radio Broadcasters is an international non-governmental organization serving the community radio movement, with almost 4 000 members and associates in 150 countries. The Communication Initiative convenes the communication and media development, social and behavioural change community for more effective local, national, and international development action. Shaer Circle is a partnership to explore narrative storytelling as a culturally-relevant approach to responding to trauma from gender-based violence (GBV) against women in high prevalence settings.

Resources

During our search we came across a range of networks that provide resources and connections for specific interest areas. Many of these resource networks were focused on emergency and humanitarian issues. For example, the Arts in Ebola Response and Ebola Response Anthropology Platform were initiated during the West African Ebola outbreak, and recognised the need for the arts and humanities throughout all stages of the response. The University of Florida interdisciplinary Ebola response team is currently developing a Framework for Using the Arts for Health Messaging. The Epidemic Response Anthropology Platform (ERAP) focused more broadly on the role of social science in understanding humans and health during emergency responses for epidemics. There is also a Music in Emergency and Trauma Care Toolkit, and A Communication for Development Platform supporting the role of social sciences in humanitarian action. The Arts in Healthcare for Rural Communities Toolkit focuses more on geographically regional or remote areas, whereas the Participation Resource Centre is a collection for Institute of Development Studies and the International Institute for Environment and Development, and covers participatory methods, approaches and critiques from throughout the world, many of which are not available in libraries. Finally, the USC Global Health Films Database aims to provide a general directory of films highlighting global health topics.

PHOTO CREDIT: GEORDAN SHANNON

Case Study 2:

Tree of life

Tree of Life itself is an arts and storytelling methodology for providing narrative therapy to people who have experienced trauma. Tree of Life therapy was designed by Ncazelo Ncube and David Denborough in Zimbabwe in 2006. It was used to build a therapeutic space for adolescents living with or affected by HIV. Since then it has been used across the world as a tool for healing across different conditions, geographies and populations, helping people to move beyond the violence and abuse that has affected their lives. The methodology is now being integrate into the mental health and psychosocial services in different parts of the world, including countries such as the UK, USA, Australia, Canada, Nigeria, Russia and South Africa.

Narrative Therapy

Narrative Therapy is respectful, non-blaming approach to counselling and community work it centres around people as the experts of their own lives. Narrative Therapy can also be said to be about rich story development. It offers working methodologies that involve re-authoring or re-storying people's lives. It gives people who have gone through significant hardships the opportunity to actively participate in redefining their lives and stepping into a different territory of identity where they do not have to be defined by the problems that they have faced.

In the form of the Tree of Life. It allows participants to explore their 'roots', their strengths, the gifts they have been given through the metaphor of a tree. Participants illustrate their own tree, with each element allowing them to think about a different theme. Participants bring their trees together in a forest. They work to affirm each other's trees, where they can discuss their troubles as 'storms' that they might face together, and the ways they can support one another to weather them.

Phola Campervan that visits Johannesberg townships Source: Phola.org

Trees of Life in Himachal Pradesh, India. Source: Nikita Simpson

"Tree of Life was a gift for me, as an anthropologist working on the mental health of women and girls in the rapidly changing Himalayan village. It allowed me to reveal the hopes, desires, traumas and dreams of my adolescent informants - in a way that interviews or even participant observation could not touch."

- Nikita Simpson, PhD Candidate in Anthropology conducting ethnographic research on women's mental health in rural North India.

Phola

Ncazelo Ncube has launched an NGO based in Johannesberg, South Africa, called 'Phola' to implement the Tree of Life and other culturally sensitive psychosocial support methodologies across the life course. Interventions seek to facilitate healing and recovery assisting those affected to live preferred lives and to be enabled to claim their rights and become agents of social change in their own lives and families and communities. Phola's work is largely collective and collaborative practices that support people who have experienced hardships to come together and be supported to work through these issues together.

Author: **Nikita Simpson**

PART 3: WHAT

WHAT WORKS IN COMMUNITY ENGAGEMENT THROUGH THE ARTS IN GLOBAL HEALTH?

INTRODUCTION

With a vast and dynamic landscape of community engagement, arts and health initiatives worldwide, we now turn to explore the evidence for what works. As identified above, there are an array of community engagement initiatives, targeting various aspects of health and wellbeing through the arts. Beyond the initiatives themselves, it is important to look at the evidence of the impact of such strategies, and to formulate future research strategies.

In order to do this, we performed a scoping 'review of reviews' plus narrative synthesis to present the evidence for community engagement in global health through the arts. This enabled us to form a preliminary typology of arts-based approaches to community engagement, summarise areas of health that have successfully incorporated arts and engagement approaches, explore the gaps in the current evidence, and put forward some preliminary ideas on a future research agenda.

METHODS

We first performed a scoping 'review of reviews' to identify existing literature at the review-level exploring community engagement, the arts and health. We performed the search in October 2018, and used PubMed and SCOPUS search engines. Search terms included Medical Subject Headings (MeSH) and keywords within titles and abstracts relevant to community engagement, arts and global health. The search strategy is outlined below (Panel 5). We included all literature regardless of language or year of publication. We excluded literature that was not a synthesis or review, or did not meet our definition of community engagement. We only included articles that combined aspects of both arts and community engagement, as defined in Parts 1 and 2. This meant that literature focused on unidirectional (push) initiatives were excluded.

Next, we cross-referenced articles and received feedback on these articles from members of the WHO working group. We also performed an additional PubMed and internet search for grey literature using keywords described in Panel 4. Literature from libraries of authors and WHO working group were included in our synthesis, based on their level of expertise and familiarity with these topics.

Two authors/researchers managed the review results and extracted information, including: authorship, location, institution, purpose, methods, engagement strategy, arts strategy, area of health, and results/impact.

Panel 4: Search Terms for Scoping Review

(("Global Health"[Mesh] OR "Community Medicine"[Mesh] OR "Community Health Services"[Mesh] OR "global health"[tiab] OR "international health"[tiab] OR "community health"[tiab] OR "universal healthcare"[tiab] OR "universal health care"[tiab])

AND

("Community-Based Participatory Research"[Mesh] OR "Community Health Planning"[Mesh] OR "Community Networks"[Mesh] OR "Community Participation"[Mesh] OR "Social Participation"[Mesh] OR "community engagement"[tiab] OR "community participation"[tiab] OR "community mobilization"[tiab] OR "participatory"[tiab])

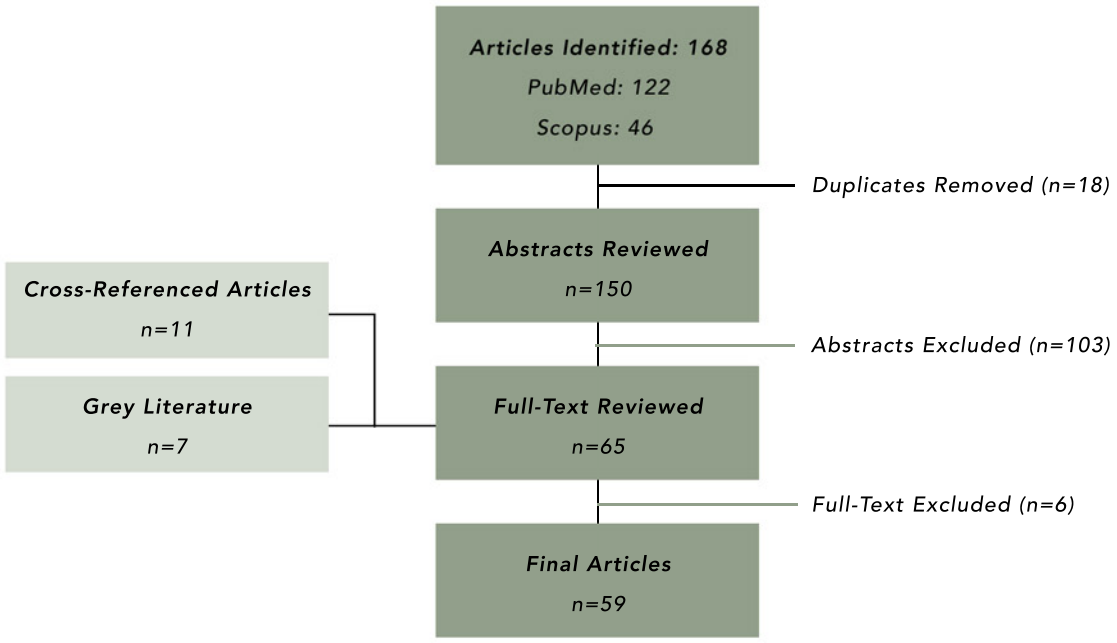
AND

("Art"[Mesh] OR "Music"[Mesh] OR "art"[tiab] OR "creative"[tiab] OR "creativity"[tiab] OR "performing"[tiab] OR "performing art"[tiab] OR "performing arts"[tiab] OR "theatre"[tiab] OR "dance"[tiab] OR "spoken word"[tiab] OR "comedy"[tiab] OR "acting"[tiab] OR "actor"[tiab] OR "actress"[tiab] OR "visual art"[tiab] OR "paint"[tiab] OR "painting"[tiab] OR "graphic"[tiab] OR "graphics"[tiab] OR "comics"[tiab] OR "street art"[tiab] OR "documentary"[tiab] OR "documentaries"[tiab] OR "participatory visual methods"[tiab] OR "poetry"[tiab] OR "poems"[tiab] OR "poem"[tiab] OR "storytelling"[tiab] OR "story"[tiab] OR "stories"[tiab] OR "magazines"[tiab] OR "blogs"[tiab] OR "blog"[tiab] OR "writing"[tiab] OR "prose"[tiab] OR "music"[tiab] OR "musical"[tiab] OR "audio"[tiab] OR "sing"[tiab] OR "singing"[tiab] OR "singer"[tiab] OR "media"[tiab] OR "photograph"[tiab] OR "photo"[tiab] OR "photography"[tiab] OR "film"[tiab] OR "photovoice"[tiab] OR "video"[tiab] OR "videography"[tiab] OR "tv"[tiab] OR "television"[tiab] OR "social media"[tiab] OR "crafts"[tiab] OR "handcrafts"[tiab] OR "sewing"[tiab] OR "sew"[tiab] OR "pottery"[tiab] OR "weaving"[tiab] OR "jewellery"[tiab] OR "jewelry"[tiab] OR "sports"[tiab] OR "exercise"[tiab] OR "sport"[tiab] OR "game"[tiab] OR "games"[tiab] OR "physical activity"[tiab])

AND

("systematic review"[tiab] OR "scoping review"[tiab] OR "environmental scan"[tiab] OR "literature review"))

Figure 2: Scoping Review Results



RESULTS

We identified 59 reviews which explored aspects of community engagement and the arts in global health. These ranged from articles which reviewed specific interventions, through to more general reviews of community-level strategies. Article strategies included literature reviews, scoping reviews, systematic reviews, and intervention-specific reviews. Included articles came from a range of authors, from Mozambique, Pakistan, South Africa, the UK, and USA, and were published from 2002 to 2018.

Defining community engagement

Patient (individual-level) and community (population-level) engagement was conceptualised in various ways throughout the reviews. At the individual level, engagement may refer to the performance of specific "engaged behaviours" or the ability of an individual to perform these behaviours (Milbank 2013). Engagement in healthcare decisions can also be conceptualised as joint empowerment model between patients and physicians, whereby there is a beneficial effect of patients' high internal and concurrent physician-attributed control beliefs on medication adherence (Nafradi et al, 2017). Compassionate care is another terminology used when referring to individual inpatient engagement. Although notable gaps in the literature were identified, patient engagement in the inpatient setting was categorised by Prey et al (2014) into: entertainment, generic health information delivery, patient-specific information delivery, advanced communication tools, and personalized decision support. In conceptualising digital behaviour change interventions, Perski et al, 2017 recognise definitions of engagement derived from computer sciences, where "engagement has traditionally been conceptualised as the subjective experience of flow, a mental state characterised by focused attention and enjoyment;" these tend to differ from the behavioural science literature, where engagement was typically conceptualised as "usage" in terms of time and depth of use (Perski et al, 2017).

At the population level, terminology used to define community engagement was also varied. This has been identified by Swainston and Summerbell (2008) as a considerable concern with implications on their NICE UK review quality. The Culture of Health Action framework promotes health as a shared cultural value, focusing on the drivers of mindset and expectations, sense of community, and civic engagement (Chandra et al 2016). The concepts of social capital (Morgan and Swan, 2004) and cultural capital (Bordieu) have been used as ways to describe the impact of engagement in the arts on health. Greenhalgh et al (2016) draw on business (value co-creation), design (co-design) computer science (technology co-design), and research (participatory research) to define engagement and community participation through co-creation.

In research, the concept of a "Mode 2" relationship, focused on knowledge production rather than knowledge translation, was also highlighted by Greenhalgh et al (2016) when reviewing participation in health systems. The notion of justice and democracy was raised by Nisker et al (2006) to explore how engagement through the arts was important for health and health policy. The importance of health, and promoting health as a shared cultural value will be discussed further below.

Communication and decision-making

Informed healthcare choices may be promoted through a variety of communication techniques. In UK screening programmes, studies reviewed by Fox (2006) demonstrated that providing leaflets or written information increased knowledge, but evidence was limited on if or how this promoted informed choice. One limiting factor was the lack of agreement on the notion of informed choice or how to measure it. van Agt and colleagues (2014) also reviewed the role of interventions to enhance informed decision-making in screening, including decision aids, information leaflets, film, video, counselling and a specific screening visit for informed decision making in prenatal screening, breast and colorectal cancer screening. The evidence here was also limited, although the role of decision-aids was promising, reporting improved knowledge and informed decision making. Trevena and colleagues (2006), in their review of the effectiveness of evidence-based communication tools to increase patient understanding of evidence, found that communication tools in most formats (verbal, written, video, provider-delivered, computer-based) increased understanding but are more likely to do so if structured, tailored and/or interactive. Finally, the use of storytelling, as an illustrative examples of others' experiences was found to change patient decisions, and may help recollection and motivation; however, the evidence was overall insufficient to draw extensive conclusions.

Beyond the individual patient level, communication interventions have been used to enhance decision-making and improve community-level health outcomes. For example, interventions such as education, printed material, telephone calls, and video and web-based strategies offered weak evidence they improved knowledge and reduced racial and ethnic disparities in targeted screening populations (Sajid et al 2012). In HIV care, using peers to enhance engagement conferred positive effects on linkage and retention, although findings were mixed on the impact on ART adherence, viral suppression, and mortality (Genberg et al 2016). The complexities of community engagement strategies are discussed further below.

Community complexities

Different strategies were employed to promote engagement at the community level, and these often involved multi-faceted or multi-level approaches. Swainston and Summerbell (2008) identify seven varieties of community engagement approaches in their review: community coalitions, community volunteers, neighbourhood committees, health promotion councils, peer leadership groups, community champions, and community workshops. In their review of community-based strategies to increase cervical cancer screening, strategies that combined mass media campaigns with direct tailored education were most successful (Black et al 2002). Multi-level community strategies targeting HIV and AIDS prevention for young people involved targeting youths through existing initiatives, targeting youths in the community, targeting all community members through kinship networks or community-wide events. The interventions targeting youths through existing initiatives demonstrated positive potential, although – despite creativity, ingenuity and commitment –there is a paucity of adequate evidence of their effectiveness (Maticka-Tyndale & Brouillard-Coylea, 2006). Also in reproductive health, community-based behaviour change communication interventions such as interpersonal, group and mass media campaigns, were associated with a significant reduction in neonatal mortality and improvement of new born care and breastfeeding (Tilahun & Birhanu, 2011). A systematic review of the effectiveness and economic efficiency of multicomponent programs for community mobilization to reduce alcohol-impaired driving in the US assessed a wide range of alcohol-related concerns in addition to alcohol-impaired driving (Shults, 2009). The multicomponent programs identified included a combination of efforts to limit access to alcohol (particularly among youth), responsible beverage service training, sobriety checkpoints or other well-defined enforcement efforts, public education, and media advocacy. Finally, a review of the processes of community participation in health systems identified strategies such as health promotion, community involvement in governance, and community control of supply chain management (George et al 2015). However, community participation in health systems interventions was variable, with few being truly community directed.

On way to encourage participation is through participatory community approaches. This may range from participatory research strategies to the co-creation of health services themselves. In their review of co-creation in community-based health services, Greenhalgh et al (2016) identify how co-creation strategies in business ("value co-creation"), design ("co-design"), computer science ("technology co-design"), and community development ("participatory research") may better facilitate community participation in health, through encouraging a systems perspective (emergence, local adaptation, and nonlinearity), framing research as a creative initiative, and an emphasis on process. George et al (2015) found that individual motivation, community trust, strong external links, and a supportive institutional processes facilitated community participation, and, conversely, that lack of training, interest and information, were barriers to the process of effective community engagement.

Technology

Nowadays, with increasingly rapid communication and technology transforming health and development in many parts of the world, many engagement strategies have involved aspects of mobile technology, computer technology, and internet technology. In their review of the effectiveness of mobile technology-based health behaviour change, Free et al (2013) found that text messaging interventions, mainly in high-income countries, increased adherence to ART and smoking cessation. There was evidence of a positive impact of text messaging on other health behaviours such as physical activity, alcohol, and sexual health, although these areas lacked high-quality adequately powered trials. eHealth interventions and their impact on patient engagement are increasingly studied, although those reviewed by Barelo et al (2015) only fostered partial dimensions of patient engagement rather than wholistic patient needs. Likewise, video decision aids were found to offer some improved decisions around cardiopulmonary resuscitation, but the evidence was mixed (Jain et al 2012). In decision-making, computerised decision aids did not seem to provide different effects than non-computerised aids, however, greater effects on knowledge and risk perceptions were reported when interactive or personalised media were used (Sheehan & Sherman, 2012). Engagement, as meaningful interaction with digital technology, was seen to be a strong moderator of the influence of digital behaviour change initiatives (Perski, 2017).

Recent reviews note the increasing use of social media and web platforms by patients across the healthcare spectrum. Social media-mediated smoking cessation interventions are feasible, acceptable, preliminarily effective (Naslund et al, 2017). These interventions include tailored content, targeted reminders, and moderated discussions for smoking cessation. In other areas, despite a growing recognition of its utility, evidence related to the efficacy and effectiveness of social media is currently limited, and challenges such as privacy, usability, and misinformation have been raised (Househ et al, 2014). Because of the novelty of these platforms, alongside the increasing uptake and use of participatory, health-enabling technologies, much of the literature reviews the ethics of this new field, and how to balance the need for health information with patient privacy and confidentiality (Househ et al, 2014; Denecke, 2014).

Media

Forms of mass media, such as radio, television, and print media, may expose a high proportion of a population to health and social messaging. In the case of smoking, mass media has the potential to reinforce the socially unacceptable character of tobacco use as well as encourage people to change behaviour (Jepson et al, 2006). There is limited evidence that mass media can reduce the smoking behaviour of young people. Effective media campaigns in this regards had a solid theoretical basis, used formative research in designing the campaign messages, and message broadcast was of reasonable intensity over extensive periods of time (Brinn et al, 2010).

In adults, evidence suggests that comprehensive tobacco control programmes including mass media campaigns can be effective in changing smoking behaviour, although the evidence was derived from heterogeneous group of studies of variable quality (Bala et al, 2008). In sexual health, an exploratory review of HIV prevention mass media campaigns targeting men who have sex with men found mixed results suggesting increasing HIV testing, but failing to impart skills for effective behaviour change. The limitation of mass media, as recognised by Wakefield et al (2014) is that this form of communication is often passively received by target populations. They conclude that mass media campaigns can produce positive (or prevent negative) health-related behaviour changes across large populations, but require concurrent initiatives such as supportive policies, availability of required services and products, and targeted community-based programmes. Jepson et al (2006) also noted that mass media intervention are often only one component of multifaceted interventions, including education and policy.

Culture and the arts

Arts and health, originating largely as a grassroots movement, has been growing, with research on the relationship between cultural participation and health promotion increasingly available (Sonke et al, 2009; Cuypers et al, 2009). Arts in health research were seen to be valuable from both knowledge production and knowledge translation purposes (Fraser & al Sayah, 2011). Visual, followed by performance and literary arts, were the most common types of arts employed in community health research (Fraser & al Sayah, 2011). Everitt and Hamilton (2003) note an emerging professional practice around arts in health in community settings, where community artists are responsive to social concerns and develop innovative, participatory solutions in equitable and respectful ways. In an overview of the current state of the arts in health in the United States, Sonke et al (2009) report growing practice, research and educational opportunities. In the United Kingdom, Clift et al (2009) identify features of arts and health research in the UK relevant to the field's growth: scale, regional variations, mapping of arts and health initiatives, academic conferences and symposia, and the role of key agencies supporting such initiatives.

Involvements in arts and culture has tangible health and social benefits. For example, a review of arts-based activities found a positive impact on cognitive processes, enhanced communication and engagement with creative activities, in elderly patients with dementia (Young, Camic & Tischler, 2015). The National Endowment for the Arts report that involvement in the arts in America is associated with social benefits such as participation in community activities, civic engagement, increased physical activity, and community volunteering. However, these are under threat, especially in young and more marginalised populations (NEA, 2007). In their 2009 review, Cuypers et al (2009) identified studies, including qualitative and quantitative studies, that suggested a positive health effect of participation in cultural activities in Scandinavia. The main effects of participation in cultural activities include social capacity, health-related outcomes, and psychological outcomes and mental health. The review noted the absence of reported (or examined) negative effects of such participation, and also suggested the need for greater research into the biological mediating mechanisms between cultural activities and health (Cuypers et al, 2009).

The Royal Society for Public Health UK, shares the results of Public Art Online, who suggest that arts in health benefit the design of healthcare environments, improve patient health and wellbeing, improve health system function and improve quality of life for staff. However, they too note that evidence in this sector is currently under-developed (RSPHUK, 2013). The UK All-Party Parliamentary Group on Arts, Health and Wellbeing found that involvement in the arts can support health and wellbeing, the arts can help address challenging social issues, and that the arts may be a means to save money in an over-stretched health and social care system (UKAPPGA, 2017).

Participatory visual methods

Participatory visual methods (PVMs) such as photovoice, drawing, painting, mapmaking, image theatre, and digital storytelling, offers a potential opportunity to engage in both research and interventions in global health. The most commonly used methods described in the literature are photovoice and digital storytelling; photovoice involves the participation of community member to document and reflect their reality through photos, and digital storytelling is a short form of digital media production that allows everyday people to share their story (StoryCenter, 2018). In this way, PVMs can facilitate qualitative data gathering, as well as forming a potentially therapeutic and empowering intervention in participants (d'Amico et al, 2106). Among highly participatory projects, photovoice appears to contribute to an enhanced understanding of community assets and needs and to empowerment (Catalani & Minkler, 2010). Although Catalani & Minkler (2010) found no relationship between group size and quality of participation in photovoice, they found a relationship between project duration and quality of participation in driving action-oriented results. In a review on the impact of PVMs on community health workers, O'Donovan et al (2018) found that visual methods can assist health workers reflect on and understand complex health issues, and to identify important community issues to help shape their practice. Quality of participation in interventions employing PVMs was shaped by longstanding relationships between the community and the researcher (Catalani & Minkler, 2010).

Theatre

The performing arts have a long history in community development and overcoming health and social disadvantage. A prominent example of this is the Theatre of the Oppressed, a school of theatre-making and a methodology underpinned by a moral and social ethos to engage and empower communities. The audience are not simply observers; they become actors in the play, and explore, analyse and transform social realities based on participation (Boal, 2003). Armaghanyan (2018) suggests that theatre can be used as a transformative method in humanitarian psychosocial support programmes: "in a space of theatre, humans are creatively enabled to deconstruct and reflect on their identities, thoughts and emotions, and make sense of belonging within their communities and in the world." Kelman and Cosgrave (2018) summarise the benefits of the use of performance art in crisis situations: as a powerful communication tool to foster deep connection, survivor support, and foster community resilience to potential future challenges.

Theatre can also be used as a means of pubic engagement in health-policy development, enabling cognitive ad emotional engagement with issues, and to related the policy to lived experiences. This type of engagement does not come without risks: Nisker and colleagues (2005) identify a potential for harm related to learning or offering personal information in public forums.

Physical activity and the environment

Engagement in physical activity has been positioned as a means of disease prevention, promotion of wellbeing, and of strengthening culture. In a global review of physical activity, walking was the most popular activity in the Americas, Eastern Mediterranean, Southeast Asia and Western Pacific, and soccer was most popular in Europe and Africa (Hulteen et al 2017). Physical activity in elderly populations was motivated by concerns for health healthy ageing (Jenkin et al 2017). Also in the elderly, yoga was found to significantly reduced the depressive symptoms of elderly participants and improved their quality of sleep after 6 months (Wang et al, 2014). A meta-analysis of dance interventions for people with Parkinson's disease found it improved Unified Parkinson's Disease Rating Scale scores, balance and gait compared with no intervention, and also improved quality life compared to exercise alone. In Australian Indigenous populations, social and community connection, facilitated through sports, was found to be an important mechanism for maintaining and strengthening cultural values and identity (Thorpe et al, 2014). Furthermore, "Aboriginal sports teams have the potential to have a profound impact on the health of Aboriginal people, especially its players, by fostering a safe and culturally strengthening environment and encompassing a significant positive social hub for the Aboriginal community." (Thorpe et al, 2014)

Community-level interventions for healthy environments and physical activity are increasingly occurring. In a review of community-based efforts to promote physical activity, Bock et al (2014) identified evidence to supports the effectiveness of community-based physical activity interventions, especially those using personal contact as well as tailored interventions. Community gardening, community farming and other local community-based gardening interventions to prevent overweight and obesity in high-income and middle-income countries was also seen as a potential strategy, with review results anticipated soon (Heise et al, 2017). Finally, in their review of community tools for addressing environmental factors to improve diet and physical activity, Jillcot et al (2007) identified environmental features of low-income communities that could contribute, and suggested employing a community-oriented strategy help identify community resources that support a healthy diet and physical activity.

DISCUSSION

Our review has highlighted the diverse and evolving field of community engagement, arts and health. Although there is extensive literature in community engagement, behaviour change science, and arts and health as separate, distinct fields, only a few reviews bring together both community engagement and the arts and explore who they combine to influence health and health-related behaviours. We identified 59 reviews focused on communication, multi-dimensional community interventions, technology, media, arts and culture, participatory visual methods, theatre, and physical activity and the environment.

In general, reviews pointed to the positive impact of community engagement through the arts on health. These positive effects ranged from improved individual knowledge and decision-making to community-level changes such as civic engagement, community cohesion, and improved population reproductive health behaviours and outcomes. Reviews on technology and social media, whilst recognised as promising and potentially revolutionizing to the field, had significant ethical concerns raised, whereas many reviews in other areas noted an absence of consideration of negative consequences of engagement through the arts. In general, the impact of the arts in health could be summarised by improved social capacity, health-related outcomes, and psychological outcomes. However, most reviews also reported significant limitations in the availability and quality of evidence. Evidence limitations included the quantity of available studies, the quality of the studies available, heterogeneity in the research approach and outcome measures, prevalence of anecdotal evidence, and variation in the definition of engagement itself. Perhaps reflecting the relatively new field of arts and health, many reviews recognise that more mature and comprehensive research approaches are required. Many have argued that RCTs are not suitable to examine the impact of complex community interventions, limited by ethics, time, cost, validity, and feasibility (Sanson-Fisher et al, 2007). Furthermore, arts and engagement initiatives often entail creative and non-linear aspects that make more traditional biomedical research strategies insufficient.

The body of reviews we identified contained a variety of conceptualisations of the term community engagement, and subsequently demonstrated a variety of ways in which community engagement was operationalised. Many reviews of individual-level engagement were grounded in behaviour change theories, defining engagement at the individual level in terms of flow, use, attention, time, and depth of experience. Community-level engagement reviews had less consistent definitions of engagement; this may be due to the lack of common definitions for the terms 'community' 'engagement' and 'participation,' or of a failure of available studies to incorporate a theoretical framework to frame their research. This was recognised by George and colleagues (2015) as a significant limitation of community engagement and health systems research; general under-theorising of these interventions may be a reflection of the breadth and heterogeneity of community engagement/ empowerment/ mobilization/ participation research fields, or, more critically, of the notion that community engagement is simply a 'tag on' activity at the end of health research projects or health interventions. As such, there is a need to engage more critically with community engagement and the arts, and how they shape individual and social agency and dynamics.

In all reviews, the level of de facto individual or community engagement varied, from being passive recipients of knowledge through to active participation in decisions, and ultimately empowerment and control. Many population-level interventions such as mass media relied on 'push' techniques to share information, without explicitly addressing how and in what ways the community engaged with the messages; and, some of the most effective media campaigns required additional resources to support engagement and behaviour change. At individual and group levels, participation was highlighted as a key factors in the success of engagement strategies. Epstein et al (2004), suggest that "informed patients are more likely to actively participate in their care, make wiser decisions, come to a common understanding with their physicians, and adhere more fully to treatment." In their review of communication tools, they suggest five tasks to frame the evidence and encourage participation: understanding patient experience, building partnerships, providing evidence, presenting recommendations, and checking for understanding and agreement. Hesse et al (2013), recognise the role of participation in the cancer prevention "communication revolution," particularly through web and social media platforms. They note the surge in patient engagement in healthcare reflected by energised grassroots activism, use of social networking tools and web search platforms, and enhanced participation in research through novel approaches of citizen science, crowdsourcing, and peer-production. Strategies that have recognised this and engaged patients in their own health care, through participation and knowledge translation, have achieved a positive impact measures of patient knowledge, decision-making, communication and behaviour (Gagliardi et al 2016). This is consistent with broader literature which highlights how strategies of community participation and engagement in health initiatives can conceptualised as a continuum from less to more participation and control amongst the community involved (Hoon Chuah et al, 2018; Popay et al, 2006).

Despite a general recognition of the need for participation, many studies failed to explicitly address aspects of power or control, and how these relate to engagement, behaviour and, ultimately, health. As recognised in Part 1, effective and meaningful community participation is intertwined with and results in community empowerment (Arendt, 1958; Campbell & Jovchelovitch, 2010). Rifkin (see, for example, Rifkin and Pridemore, 2001) has written extensively of the spectrum of participation in community health interventions, and has identified four stages of increasing participation and community transformation: information sharing, consultation, collaboration, and empowerment. These stages represent increasing community power and control in the intervention. This is consistent with Freire's pedagogy, where meaningful participation and dialogue provide the opportunity to develop a critical consciousness, or conscientização, of the social and structural factors influencing community health and develop strategies for addressing them (Smith, 1976). In our review articles, we also noticed a varying level of engagement, ranging from the individual to the group levels. For example, patient-physician community techniques may be used effectively at the individual level although not as effectively at the population level.

We arranged the review findings into a scatterplot (see Figure 3 below), where the level of community participation (individual, group, community) was compared against the level of participation in the engagement initiative (information sharing, consultation, collaboration, and empowerment). We found that many interventions were skewed towards less de facto participation, particularly those focusing on community-level actions. This uncovers a limitation of existing strategies, and may reflect issues of scale, cost, and time, as well as the lack of critical engagement with communities to address issues of power and control. Certain strategies may be naturally limited in their capacity to facilitate empowerment through participation; for example, mass media campaigns lack the ability to drive a collaborative dialogue unless paired with other individual- or group-level interventions.

Rifkin (2014) also argues that community engagement is not simply an instrument for changing community behaviours and health outcomes, it is a process founded on understanding, trust, and transformation. Likewise, Pisani (2018) proposes that community engagement can be thought of as engagement IN research, engagement WITH research, and engagement with science. These stages represent increasingly 'upstream' ways in which communities may be engaged, and also the level of scientific 'sophistication' involved in the process of engagement. In their review of participation in health policy, Nisker et al (2006) remind us of the importance of justice when planning and conceptualising engagement. Thinking of engagement as a process rather than a means to an end, and incorporating a critical view of power in the process, enables us to view community engagement in a different light. For example, beyond participation, strategies that focused on empathy and compassionate interactions, where patients, families and providers were involved as partners, were associated with increases in treatment savings and patient safety in terms of length of stay and reduced medication errors (Hassmiller & Bilazarian, 2018). This literature points to the need to push beyond unidirectional participation towards a more equitable and bi-directional dialogue.

Finally, many articles in the identified reviews were based in high income countries. Interestingly, these mainly involved individual patient communication strategies, technology, or media. There was a trend of low-cost or community-oriented interventions (for example, theatre) being researched in low- or middle-income countries. This reflects a bias of the available research towards higher income countries, and may be a result of funding availability, level of community development or general access to luxuries such as computer technologies, and/or the culture of individualised medicine prevalent in Europe and Northern America. In general, much global health research is initiated by academics in high-income locations (the researchers) without full skill transfer or capacity building for those who are the participants in the research themselves (the researched) in low-income settings. Arts and community engagement strategies, including research, has the capacity to rectify these asymmetries through facilitating meaningful participation and focusing on how the research process may enhance individual agency or community empowerment. This has been recognised in the reviews as an area requiring attention. Despite this, only a few included reviews discussed issues of power or global inequalities such as gender, ethnicity, or poverty, or considered the background of the included studies' authorship.

CONCLUSION

In summary, we performed a scoping 'review of reviews' plus narrative synthesis to present the evidence for community engagement in global health through the arts. We identified 59 reviews, from a range of global locations and focusing on an array of community engagement and arts initiatives, such as communication, multi-dimensional community interventions, technology, media, arts and culture, participatory visual methods, theatre, and physical activity and the environment. Although reviews supported the positive impact of community engagement through the arts on health, their conclusions were considerably limited by the availability and quality of evidence. Other limitations of the reviews included heterogeneity in the definition and use of the terms 'community,' 'engagement' and 'participation,' as well as variable use of theoretical frameworks. Overall, however, the literature paints a positive picture and captures a surge in global interest in community engagement and the arts for health. This review highlights gaps and future research agendas in order to continue to advance this dynamics field towards health (and wellbeing) for all. These gaps and opportunities will be discussed in more detail in Part 4.

Figure 3: Selected reviews arranged according to participation (x-axis) and level of action (y-axis)

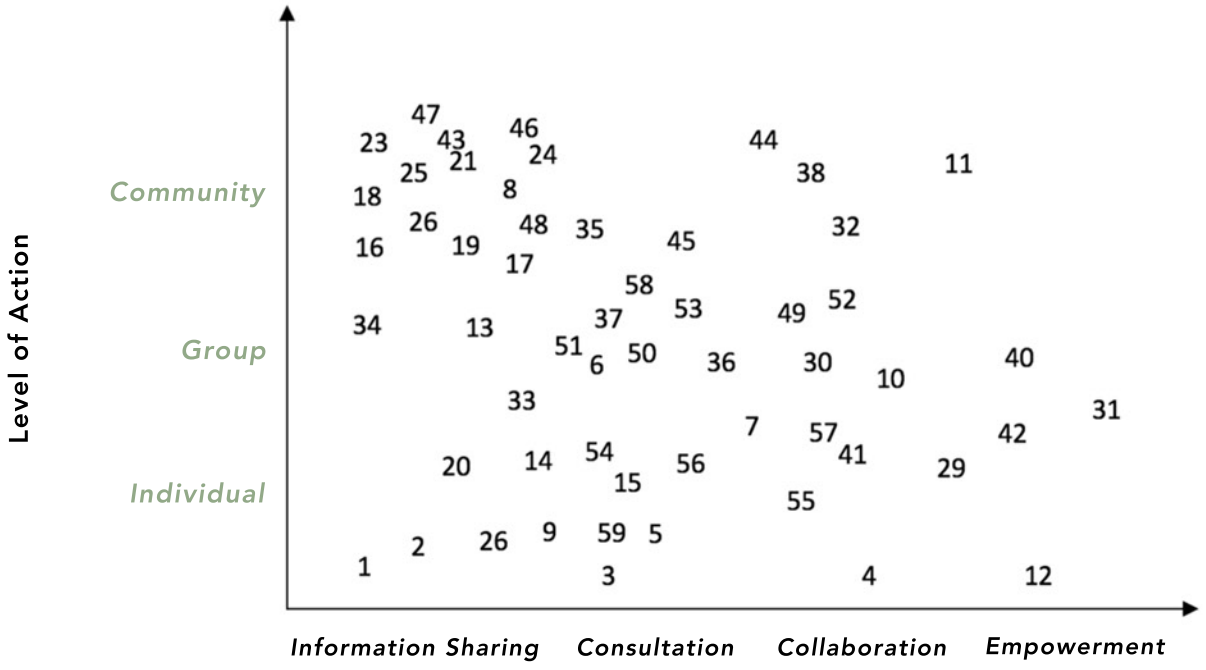


Figure 3 cont'd: List of Reviews Identified

1. Informed choice in screening programmes: do leaflets help? A critical literature review.
2. Interventions to enhance informed choices among invitees of screening programmes-a systematic review.
3. A systematic review on communicating with patients about evidence.
4. Communicating evidence for participatory decision making.
5. Computerised decision aids: a systematic review of their effectiveness in facilitating high-quality decision-making in various health-related contexts.
6. Partnering against cancer today: a blueprint for coordinating efforts through communication science.
7. Patient-mediated knowledge translation (PKT) interventions for clinical encounters: a systematic review.
8. Interventions to improve decision making and reduce racial and ethnic disparities in the management of prostate cancer: a systematic review.
9. Video decision aids to assist with advance care planning: a systematic review and meta-analysis.
10. Improving Engagement in the HIV Care Cascade: A Systematic Review of Interventions Involving People Living with HIV/AIDS as Peers.
11. *eHealth for Patient Engagement: A Systematic Review*.
12. Is patient empowerment the key to promote adherence? A systematic review of the relationship between self-efficacy, health locus of control and medication adherence.
13. Making sense of "consumer engagement" initiatives to improve health and health care: a conceptual framework to guide policy and practice.
14. Patient engagement in the inpatient setting: a systematic review.
15. The Business, Ethics, and Quality Cases for Consumer Engagement in Nursing.
16. The effectiveness of mobile-health technology-based health behaviour change or disease management interventions for health care consumers: a systematic review.
17. Conceptualising engagement with digital behaviour change interventions: a systematic review using principles from critical interpretive synthesis.
18. Balancing Between Privacy and Patient Needs for Health Information in the Age of Participatory Health and Social Media: A Scoping Review.
19. Empowering patients through social media: the benefits and challenges.
20. Ethical aspects of using medical social media in healthcare applications.
21. Systematic review of social media interventions for smoking cessation.
22. An exploratory review of HIV prevention mass media campaigns targeting men who have sex with men.
23. Mass media interventions for preventing smoking in young people.
24. Use of mass media campaigns to change health behaviour.
25. Mass media interventions for smoking cessation in adults.
26. A Review of the Effectiveness of Mass Media Interventions which both Encourage Quit Attempts and Reinforce Current and Recent Attempts to Quit Smoking
27. Do personal stories make patient decision aids more effective? A critical review of theory and evidence.
29. Photovoice: A review of the literature in health and public health
30. The use of participatory visual methods with community health workers: A systematic scoping review of the literature
31. Research as intervention? Exploring the health and well-being of children and youth facing global adversity through participatory visual methods
32. Community gardening, community farming and other local community-based gardening interventions to prevent overweight and obesity in high-income and middle-income countries: Protocol for a systematic review
33. The community network: an Aboriginal community football club bringing people together.
34. Global participation in sport and leisure-time physical activities: A systematic review and meta-analysis
35. Sport and ageing: a systematic review of the determinants and trends of participation in sport for older adults.
36. Systematic review of yoga for depression and quality of sleep in the elderly
37. Community-based efforts to promote physical activity: a systematic review of interventions considering mode of delivery, study quality and population subgroups.
38. A guide for developing intervention tools addressing environmental factors to improve diet and physical activity.
39. Achieving Research Impact Through Co-creation in Community-Based Health Services: Literature Review and Case Study
40. Theatre as a public engagement tool for health-policy development.
41. *Theatre as Psychosocial Approach in Humanitarian Settings*
42. *Performing Arts for Disaster Risk Reduction Including Climate Change Adaptation*
43. A systematic literature review of the effectiveness of community-based strategies to increase cervical cancer screening.
44. Community participation in health systems research: A systematic review assessing the state of research, the nature of interventions involved and the features of engagement with communities
45. Drivers of health as a shared value: Mindset, expectations, sense of community, and civic engagement
46. Effectiveness of Multicomponent Programs with Community Mobilization for Reducing Alcohol-Impaired Driving
47. The effectiveness of community interventions targeting HIV and AIDS prevention at young people in developing countries.
48. Effect of community based behavioural change communication intervention to improve neonatal mortality in developing countries: A Systematic Review.
49. *Cultural activities and public health: research in Norway and Sweden. An overview,*
50. *The state of arts and health in England,*
51. *The state of the arts in healthcare in the United States*
52. *Arts, Health and Community: A study of five arts in community health projects*
53. *The Arts and Civic Engagement: Involved in Arts, Involved in Life*
54. *Creative Health: The Arts for Health and Wellbeing*
55. *Arts, Health and Wellbeing Beyond the Millennium: How far have we come and where do we want to go?*
56. *The effectiveness of community engagement approaches and methods for health promotion interventions*
57. *Dance as an intervention for people with Parkinson's disease: A systematic review and meta-analysis*
58. *The impact of community-based arts and health interventions on cognition in people with dementia: a systematic literature review*
59. *Arts-based methods in health research: A systematic review of the literature*

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Case Study 3:

Arts in the Ebola Response

In the face of limited public health responses during the West African Ebola crisis, and in addition to ineffective health messaging that promoted fear and mistrust, grassroots cultural initiatives were critical elements in the dissemination of health information and ultimately promoting effective behaviours to control Ebola. These initiatives included popular music, murals, performance art and radio drama. The effectiveness of such strategies has led to the recommendation that creative strategies are used as central strategies to behaviour change initiatives, including drama, theatre shows, media, poems, and social media.[1]

Music

Music formed a strong component of the early Ebola response. Initially, improvised rap songs about Ebola by local artists, such as Liberian rap artists Shadow and D12, gained significant traction and topped local charts. Although the initial pop messages were not shaped by public health authorities, the role of music in reaching and connecting with communities was obvious. In response to this this, UNICEF supported local musicians to create songs that were integral to communicating health messages and fighting stigma. A well-known example of this is the song Ebola is Real.[2] Music was often combined with other creative strategies to communicate health messages and strengthen community responses, such as storytelling and drama. In fact, many campaigns utilised different creative elements, including radio, billboards, mobile technologies and other arts-based community mobilisation campaigns.

Radio and Television

Local radio and television, as popular forms of communication and storytelling, were effectively utilised in certain settings. The UNICEF campaign Stop Ebola Now: Through Creative Storytelling, was a campaign in Liberia that used serial radio dramas, and call-in radio to address local concerns about Ebola.[3] In Sierra Leone, the Talking Drum Studio project responded to Ebola by shifting its weekly focus to discussions on Ebola. The hosts were sensitive to local issues, and integrated music, jingles, and drama to provide education and combat myths around Ebola. Idris Elba, an actor of Sierra Leonean descent, played a football coach in an add designed to tackle Ebola.[4] The Spread Knowledge to Stop Ebola strategy, supported by WeOwnTV, was based on participatory film making, whereby local people created short films it their own words about Ebola. This built on Sierra Leonean traditions of oral storytelling.[5] Towards the end of the crisis, PCI Media, in partnership with UNICEF and Vulcan Productions, produced #ISurvivedEbola, which is a series of videos and radio programs featuring Ebola survivors from Liberia, Sierra Leone and Guinea. This was designed to engage Ebola survivors in delivering key messages to the community, to combat stigma, and to highlight hope.[6]

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1. Tambo, et al. Rebuilding transformation strategies in post-Ebola epidemics in Africa. Infectious Diseases of Poverty. 2017;6:71
2. See: https://soundcloud.com/unicef-liberia
3. See: www.mediaimpact.org/ebola/guide.html
4. See: https://www.npr.org/sections/goatsandsoda/2014/12/04/368513073/idris-elba-plays-a-soccer-coach-out-to-crush-ebola-in-new-ad-campaign
5. See: www.sierraleone.weowntv.org
6. See: http://isurvivedebola.org/campaign

Performance

Performance arts used in the Ebola crisis included comedy and participatory theatre. For example, the Pan Family Theatre Group in Port Loko District, Sierra Leone, engaged hundreds of community members in an Ebola-themed comedy, to share the message that Ebola may be almost gone, but awareness was still a matter of life and death. This initiative was supported by UNICEF C4D, and was inspired by the longstanding tradition of using comedy to address social issues in Sierra Leone.[7] On the international stage, Echoes of Ebola was performed on Broadway to as a dark drama exploring what motivates the efforts to treat and eradicate the Ebola virus in Africa.[8]

Visual and Graphic Arts

As frontline forms of health messaging, particularly in areas of low literacy or multiple language groups, visual forms of communication were important elements of the Ebola response. It was important, however, that these messages had to come from local and credible sources. Murals such as 'Ebola Is Real' were painted by local volunteers in Monrovia. It included visual representations common symptoms, basic tips avoiding transmission, and hygiene and cooking instructions. Local artist Stephen Doe says: "I'm convinced that it impacted people's thinking and attitudes, besides the fact that it made the city more beautiful."[9] Also in Liberia, the MoH, WHO and UNIECF engaged a local artist to create a graphic story comic, called 'Spread the Message, not the Virus.'[10]

There has been a lot of attention on the role of arts initiatives following the Ebola outbreak in West Africa. This crisis highlighted the need for local voices, dialogue and communication strategies, using creative and culturally-relevant means. A repository of arts initiatives used in relation to the Ebola crisis has been compiled and can be found at: http://arts.ufl.edu/repos/

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7. See: https://www.unicef.org/infobycountry/sierraleone_86080.html
8. See: http://www.theasy.com/Reviews/2016/E/echoesofebola.php
9. See: http://www.colorsmagazine.com/blog/article/how-ebola-hit-the-wall
10. See: https://liberia.iom.int/graphic-story-spread-message-not-virus

PART 4: HOW

THE ART OF COMMUNITY ENGAGEMENT

"Development seen in a human perspective, rather than grossly in terms of expansion of material means, must take note of the enrichment of people's lives. The arts cannot but have a major role in making our lives richer and finer. In this sense, the creative wealth represented by the tradition and practice of the arts is constitutively a part of the process of development."
Amartya Sen, 2018

Gaps and opportunities

Identifying gaps in the current landscape and evidence enables us to identify future opportunities, both in practice and to shape a future research agenda. In Part 1, we explored the tension between behaviour change and community empowerment, and positioned the arts as one possible solution for engaging humans and transforming community health. In Part 2, we presented a preliminary global landscape of arts, health and community engagement activities, from policy and funding, through to local projects and case studies. We found that, despite exciting resources and initiatives, as well as growing international networks of research and practice, there was an imbalance towards the 'Global North,' particularly in areas of funding and policy. In Part 3, the main gaps we identified included an under-developed global evidence base, under-theorising of arts and community engagement strategies, variable use of arts and community engagement terminology, and geographic inequalities in research, including between 'researched' and 'researcher,' as well as the quantity and nature of academic outputs.

These gaps may, in part, reflect the complexity of the field itself. Arts and health practice, for example, entails an interlinked spectrum of activities that may simultaneously constitute reflection, inquiry, intervention, therapeutic value, and action; as such, the potential scope of activities is exceptionally broad and diverse (Putland, 2008). Arts and health research faces challenges such as disagreement over what constitutes an intervention's 'success,' and excessive focus on impact evaluation, with subsequent inadequate consideration of the process of arts and health practice (Raw et al, 2012). These distinct and diverse fields speak a different language and/or identify different priorities when it comes to health-oriented research and action (Putland, 2008).

All in all, there is an agreement that the arts provides a different quality and depth of space for health interactions, including health research. As Thiele & Marsden (2003, p85) argue, art highlights intrinsic human qualities and skills that are fundamentally valuable to society, and enables communication through multi-sensual or emotional domains. This type of interaction may not be sufficiently captured by linear, positivist methods alone; consideration of more creative and complex strategies to mirror the nature of arts and health interventions are necessary. Likewise, the complexities of community engagement are often difficult to deal with from a traditional public health research standpoint (Sanson-Fisher et al, 2007).

Approaches to evaluating complex interventions have been proposed by the MRC (MRC, 2000; Craig et al, 2008), although these guidelines still promote experimental techniques if possible and do not explicitly recognise the arts. The Aesop Framework for developing and researching arts in health programmes, proposed by Fancourt and Joss (2015), is an example of a strategy that places arts at the centre of research, and allows a more iterative research approach.

Challenges such as those identified above may be addressed as future global priorities, through research, practice, or a combination of both. Despite advanced individual and institutional contributions, a substantial shift in global health research culture is necessary in order to consistently embed a more critical theoretical approach into health engagement activities and research, consider issues of power and agency and how these play out on a global scale, and to embed an inter- or trans-disciplinary approach throughout. Going forward, international, national and local organisations may enable this shift, through a combination of advocacy and action. For example, organisations at any level could proactively incorporate critical and ethical considerations into their activities and evaluation approaches. Further, this area may be a focus of international consensus-building activities or guideline development. Research and activities in arts, community engagement and health may also benefit from the standardised use of terminologies and definitions; this may also be facilitated through shaping global or context-specific guidelines and continuing to strengthen global networks of practice, and may be a strategic future area of focus.

Research horizons

Growing the evidence base and addressing geographic disparities in research will require a coordinated, long-term approach. One opportunity to advance research methodology globally is by drawing on the rich existing evidence available secondary to dynamic grassroots practices worldwide. Evidence synthesis strategies have been recognised by the Alliance for Health Policy and Systems Research as methods that can utilise available case study evidence, combine a variety of different types of evidence, position research in a local context, and recognise multiple, interacting systems and complexities (Langlois et al, 2018). Examples of evidence synthesis approaches include meta-synthesis, critical interpretive synthesis, case study synthesis, systematic reviews, and meta-analyses. Strategies such as meta-synthesis, by allowing research to develop concentrated and high-level interpretations of the available evidence, extend our knowledge and understanding such that the whole is greater than the sum of its parts.

We also identified that, despite the large amount of material on the individual topics of behaviour change, community engagement and the arts, there are comparatively few studies on the areas combined. We have identified some positive results emerging and faint patterns born out, but it still begs the question of why and how they are effective and in which contexts. In this case, realist evaluation approaches may also be a suitable strategy. Realist approaches are increasingly used for understanding complex interventions. They take a realist stance to research, seeing each programme or initiative as an active and open system shaped by social and contextual factors (Langlois et al, 2018). Realist evaluation assumes that each programme is based on some implicit 'theory of change' that needs to be made explicit through wrapping the research process and observations around the initiative itself, often in real time (Pawson and Tilley, 1997). This type of approach highlights: what works, for whom, in what respects, to what extent, in what contexts and how? The combination of realist and evidence synthesis approaches may form part of a future research strategy that will enable the global community to advance research and understanding in this field.

On a different note, participatory forms of research are collaborative strategies to actively involve research scientists, practitioners and community members, that aim to change a particular social reality on the basis of insights obtained by means of the participatory research itself (Berghold & Thomas, 2012). Participatory action research (PAR), as a key example, combines 'action' research – studies conducted in the course of a particular activity to improve the approach of those involved (Hult & Lennung, 1980) – and 'participatory' research – a partnership approach that equitably involves community members, service providers and researchers in all aspects of the research process and in which all partners equally contribute expertise and share decision making and ownership (Israel et al, 2001). This means that traditional boundaries between those researched and those researching are blurred, and bi- or multi-directional information exchange and emancipatory action is possible. Collaborative approaches to research design and implementation such as PAR mirror collaborative approaches to design and involvement in the arts, like co-creation. Participatory approaches have the potential to reflect the creative and non-linear process of the arts, encourage 'upstream' community participation, facilitate multidirectional dialogue and understanding, and empower all those involved. Greenhalg (2016) notes that co-creation models in health have significant potential for meaningful impact, but this impact must take into consideration the nonlinear chains of causation, reflect the dynamic and complex nature of health systems, and address processes as well as outcomes.

Finally, shaping an agenda beyond the practical results of arts in health beyond its own set as a communication tool to a robust exploration of the neurobiological mechanisms behind their effectiveness could yield rich results. New techniques in brain imaging are expanding our understanding of brain structure and function, and has recently been used to explore the impact of the arts from a neurobiological perspective (Lusebrink, 2011; Zaidel, 2014). This is an area for future exploration, and may point the way for even greater understanding of how people can better adopt healthy practices and transform to a higher state of wellbeing

Spectrum of and spaces for arts and community engagement

The arts offer a spectrum of activities and approaches that transgress a single field of practice. Likewise, community engagement involves a spectrum of actions that may encourage participation, from sharing knowledge through to collaboration and empowerment. As meaningful participation increases, so too does the potential for critical consciousness, a deep understanding of structural and social forces shaping community realities, which may ultimately drive meaningful change (Arendt, 1958; Campbell & Jovchelovitch, 2010). This spectrum of participation is not limited to recipients of a particular initiative; participation, dialogue and understanding are multidirectional (and, multiplicative) forces. Beyond patient participation alone, strategies that focused on empathy and compassionate interactions, where patients, families and providers were involved as partners, were associated with increases in treatment savings and patient safety in terms of length of stay and reduced medication errors, as well as improved quality of life for staff (Hassmiller & Bilazarian, 2018). This example points to the need to push beyond unidirectional participation towards a more equitable and multi-directional dialogue.

Often, community engagement strategies are conceptualised as a means to an end, or as 'good practice' rather than valuing the process itself and its ethical and philosophical underpinnings (Pratt and de Vries, 2018). Many advocates recognise that community engagement should not simply be an instrument for changing community behaviours and health outcomes, it should be a process founded on understanding, trust, justice and transformation (Nisker et al, 2006; Rifkin, 2014). Community engagement interventions risk failure without explicitly recognising issues of power, agency and social transformation outlined by numerous critical theorists and community development scholars. Furthermore, the true value of engagement in arts and cultural activities on health may be missed by linking them to a narrow set of predetermined social and economic indicators (Thiele & Marsden, 2003). Thinking of engagement as a process rather than a means to an end, and incorporating a critical view of power in the process, enables us to view community engagement in a different light.

So, how to facilitate this? As we have argued, the arts are uniquely situated to enable a depth, breadth, and quality of engagement across a wide range of settings and at various levels (individual, group, population) worldwide. The arts may also provide space and time for reflection; rare opportunities that are often absent from health systems or public health interventions. On a deep biological basis, empathy nurtured through engagement is neither an optional side effect, nor an obstacle to be managed, but the driver of the behavioural change process, a way of triangulating one's own experience and feelings onto the group for common understanding and action. Art is one of the most effective tools for this as it has evolved from the birth of consciousness itself as the frame for this very process. Unlike a positivist scientific method, whose goal is to isolate objective fact and is a separate but complementary process not to be confused, art does not distil objective fact, it creates a personal sense of truth. It is the latter which most often forms the basis of opinion and behaviour based on our unique biology.

Artificial divisions

All suffering is caused by creating divisions in divisionless space (Dalton, 2018)

The arts and the sciences are often positioned as binary entities. Post-World War II emphasis on intellectual and technical specialisation created a world of "two cultures," the arts and the sciences (Snow, 1959, in McNamee, 2001) where "scientists were not equipped to understand the problems of literature or the humanities, while literary scholars and artists could not fathom what their scientific peers were up to" (McNamee, 2001). This division has continued, leading to increased separation and isolation of these fields from each other, facilitated by academic systems, professional institutions, media and funding (Donald, 2015). Furthermore, the humanities – at times referred to deridingly as 'soft' science – are employed simply as an alternative to the structure and mechanistic nature of much health science, if and when 'hard' health science is perceived to have failed: "amidst the loud, revving engines of medicalization, we need to remain steadfastly focused on interventions and reforms that will influence… fundamental drivers of health inequities" (Lantz, 2018).

The reality is that health and development are intertwined with the cultural identity and life of all people, anywhere in the world (Odhiambo, 2018). Kabanda (2018) argues in his book, The Creative Wealth of Nations, that the arts play an indispensable role in national and international development and the improvement of human lives. He suggests that positioning the arts as central rather than as a peripheral alternative reaps significant monetary and non-monetary benefits to human wellbeing the world over. Frameworks such as the Culture of Health Action framework promote health as a shared cultural value, through shifting mindsets, and fostering a sense of community and civic engagement (Chandra et al 2016). This places simultaneous value on health and culture, and how the two interact, and allows us to reflect on health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1946).

Scholars such as Dalton (2018) recognise the tendency of individuals and institutions to create artificial divisions which have the potential to cause confusion and suffering. No more evident has this been than in western, biomedical approaches to health and healthcare, through vertical and top-down approaches. Although on a global level health is recognised as more than 'merely the absence of disease or infirmity' (WHO, 1946), there is often a disconnect between the notion of holistic health and that of more siloed or biomedical approaches to population health. In the face of a growing non-communicable disease burden worldwide, overstretched health systems, increasingly difficult 'last mile' gains, and the fact that over half the world's population still lacks access to essential healthcare, the global health community is reckoning with the need to look beyond biomedicine and medical technology, and to address the complexities of human health through creative and human ways. To address the complex and multifaceted nature of pressing global health challenges, there is an urgent need for integrating arts and sciences – as well as other fields of enquiry – in the pursuit of human wellbeing.

In the face of these challenges, we feel the answer lies in integrating approaches and placing human wellbeing at the centre, employing various and creative methods in a manner that transcends artificial disciplinary boundaries. As John Maeda, a professor in MIT's Media Lab argues: "There's no reason that a scientist and an artist can't be one and the same person. Our goal should be to produce Renaissance people who take a cross-disciplinary approach to problems, da Vincian people who are interested in everything and can do everything." (Maeda, quoted in McNamee, 2001). Transdisciplinarity is an approach that helps us move beyond interdisciplinary relationships to a field of enquiry that "will not be limited to recognize the interactions and/or reciprocities between the specialized researches, but which will locate these links inside a total system without stable boundaries between the disciplines" (Piaget, 1972, p. 144). As recognised by the Universidad Veracruzana, Mexico, transdisciplinarity allows the researcher or practitioner to situate themselves between, through and beyond the disciplines, thus enabling them to focus on ethics, dialogue, and reflection of how knowledge is acquired (Nicolescu, 2009). As such, it may be another effective strategy and methodological basis to engage with and master the study and generation of alternatives to the problems concerning contemporary society.

CONCLUSION

In this review, we have seen how evidence, data and facts have enabled substantial global advances, but how we remain a long way from realising health for all. The arts and community engagement, although not panaceas, offer an alternative strategy to engage with human complexities and foster empathy and collaboration. We explored the dynamic fields of behaviour change, community engagement, and arts and health, and found evidence to suggest a positive impact on human wellbeing. Despite the gaps in the current landscape and evidence, the information we have encountered paints a positive picture and captures a surge in global interest in community engagement and the arts for health. At the least, the positive indications suggest a fruitful field for further inquiry.

In the face of grand global health challenges, the time is ripe to advance global human and empathy-oriented approaches to health and wellbeing through the arts and community engagement. The importance of the uncommon senseof community engagement has been highlighted by Dalton, who challenges us to "throw away the old playbooks and dance with the reality of the impacted community's truth" (2018). When this uncommon sense of community engagement and the arts is employed, we are able to create a space for reflection, critical engagement, and, importantly, action. There are challenges that come when positioning the practice of arts and community engagement 'between' rather than 'within' a certain field. Our review has attempted to bring together approaches to human health which are already perceived as complex and interdisciplinary in and of themselves.Instead of compartmentalising, we hope this review has been a call to integrating elements of creativity, empathy, and participation to arrive at a deeper, shared understanding of community health and wellbeing.

PHOTO CREDIT: GEORDAN SHANNON

Case Study 4:

Community Engagement and Arts – A Series

HOSPITAL ROOMS

Hospital Rooms' mission is to bring world class art to mental health hospitals. They commission world class artists to work with mental health patients and staff to radically transform locked and secure mental health units with museum quality and compliant art. Together with patients and staff, they make challenging clinical environments imaginative, thoughtful and rejuvenative.

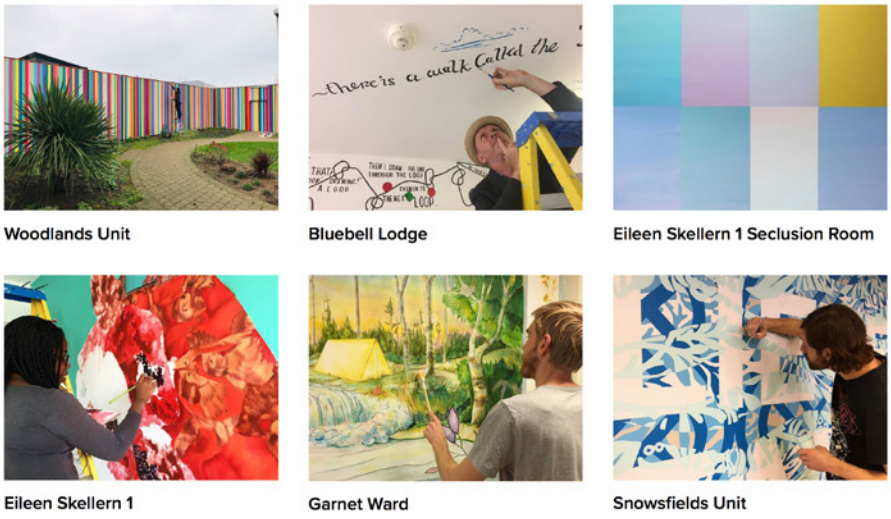


Photo Credit: Hospital Rooms 2018

MAKING TIME

Making Time provides dynamic arts education to all levels of health professionals who deliver care to older people. Their tailored courses equip care giving staff with the skills and materials to lead practical art sessions for older residents and introduce them to the work of artists who have addressed the experience of ageing in their work. Making Time was a proud winner of the Beyond Business and Investec social enterprise scheme, which awards initial investment and ongoing mentorship. It was co-founded by curator Niamh White and artist Tim A Shaw.

Photo Credit: Tim Shaw

DHARAVI BIENNALE

Dharavi Biennale is an art biennale in India that opens up taboos about public health. It is an artistic festival unlike any other. Visitors to the Dharavi (or Alley Galli) Biennale, which launched in February 2015 and ran for three weeks, were confronted with puppet shows about tuberculosis, Bollywood-style portraits of healthcare providers, a quilted map depicting violence hotspots and many more provocative exhibits that encapsulated health education in art. As befits Mumbai's status as one of the largest cities in the Global South, Dharavi alone has one million inhabitants crammed into less than one square mile.

Photo Credit: Hospital Rooms 2018

SHAER CIRCLE

This project establishes a partnership to explore narrative storytelling as a culturally-relevant approach to responding to trauma from gender-based violence (GBV) against women in high prevalence settings. It brings together academics, poets, civil society organisations, and feminist activists working on GBV in the UK and across the Middle East, North Africa and Asia. The partnership includes experts from the medical science (psychiatry, psychology) and humanities (humanitarian ethics, women's studies, and literature studies). Our aim is to develop a therapeutic approach to GBV-related trauma among women in these settings.

Photo Credit: SHAER 2018

THE POT

The Pot, written by Mac Rogers, was produced and performed by World Health Organization staff for World Health Day 2018. The actors were health economists, statisticians, medical officers, interns - none of whom had performed since school days! The performance represented WHO professionals of every shape and rank stepping into the world of performing arts, working together for a common cause: to put a human face on the right to health.

Photo Credit: Steven Senglaub

CONTAGIOUS CITIES

On the centenary of the 1918 flu pandemic, Wellcome is exploring the relationship between cities and infections through Contagious Cities, an international cultural collaboration. Contagious Cities is taking the global challenge of preparing for disease outbreaks and giving it a local cultural context, working with creative people and institutions in New York, Hong Kong and Geneva. Each city is a financial centre with a streak of independence, a significant presence beyond its borders, and a history of dealing with epidemics.

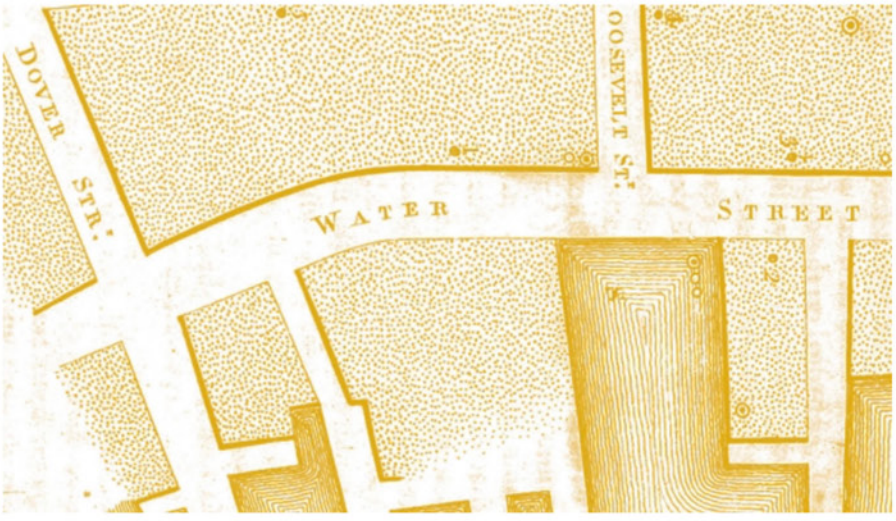


Photo Credit: Wellcome Collection

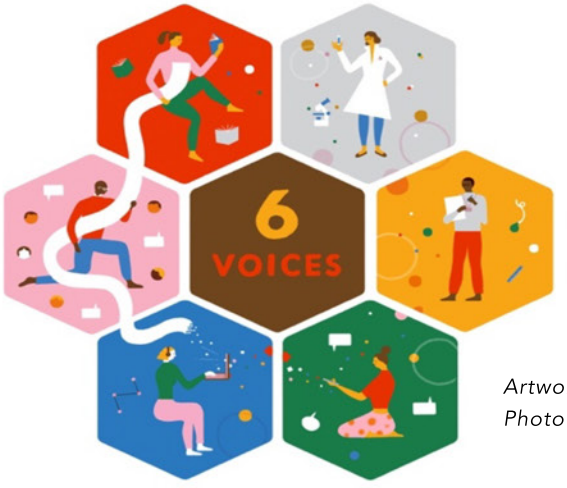
INTERNATIONAL QUIT SODA DAY

International Quit Soda Day, IQSD, is a day to focus our collective energy on decreasing worldwide consumption of soda and sugary drinks. If we reduce consumption of sugary drinks, we will reverse the escalating rates of obesity, diabetes, heart disease, and tooth decay that afflict our communities. IQSD is one day of coordinated activities around the world to raise awareness about the impact of sugar drinks. We use fun and dynamic strategies to engage with young people, from the slums of Nairobi to the streets of LA. We use comics, rap, street art and storytelling to spread these messages.

Photo Credit: Dunk the Junk

160 CHARACTERS

The 160 Characters Project aims to develop a participatory, interdisciplinary methodology for evaluating and scaling-up the 'Khuluma' intervention that provides peer-to-peer psychosocial support groups via text message to adolescents living with HIV in South Africa. The have pioneered the use of the 'six voices' framework. Each of these 'six voices' represents a member of the research team, who bring together the insights of adolescent service users, medical sciences, literature, social science, implementation science, and technology to develop a participatory, creative and interdisciplinary methodology to engage with adolescents



Artwork by Maggie Lee
Photo permission: 160 Characters 2018

BANGLES AND BINDHIS

Nepal has one of the highest rates of child marriage in the world. This public engagement project uses film to engage with communities about the health implications of child marriage. This involves interviews with adults married as children, and a discussion of the causes and consequences of their marriage. Participants decided what they want to communicate, and participated in the making of the film. The project engaged community members at the film showing and afterwards, to define the problem locally, and collectively seek ways to address it.

Photo Credit: Delan Devakumar 2018

SMOKESCREEN

In the Terai district of southern Nepal, a team of UCL researchers combined art and focus groups to understand the lived experiences of women who used indoor cooking stoves. They convenened four focus groups for women from urban and peri-urban areas, as well local artists. The women then met approximately weekly over four months, and produced images related to air pollution. Women identified a number of health effects from air pollution. The main physical effects related to the eye and the respiratory system, and women and young children were seen as most vulnerable. The psychosocial effects of air pollution included reduced food intake by women and lethargy. Suggested solutions included modifications to the cooking process, changing the location of stoves, and increasing ventilation.

Photo Credit: Delan Devakumar 2018

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