



The role of Community Engagement in improving Recruitment and Retention of Health care workers in Rural and Remote areas

Report Commissioned by Scottish Partners of Making It Work: Recruit &
Retain Project



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2 INTRODUCTION

Community engagement is described by the World Health Organisation (WHO 2008) as key to the delivery of health care' and prior to that, by Shisana (1993) as 'a concept essential for securing social justice'. With such appraisal for improving health interventions ethically and efficiently, it is perhaps not surprising that interest has arisen around the role community engagement can play in developing and improving specific aspects of delivering health care systems. The recruitment and retention of health care workers in remote and rural areas is a challenge Scotland shares with many countries internationally. Remoteness, population sparsity factors, geography and transport infrastructure can place significant challenges in delivering good quality health services as near to people living in remote, rural or island communities as possible. This remoteness has also contributed to the difficulties in attracting and retaining healthcare professionals to work in these areas. The implications of such factors for the population's health are felt in terms of accessibility of services and in other direct impacts on a person's health arising from the potential economic vulnerability and social isolation of their remote-rural situation.

Making it work (MIW) is a European project about recruitment and retention of professional staff in remote and rural areas. The project is funded by the Northern and Arctic Periphery Programme (ERDF). Making it Work has developed a framework for workforce stability in rural and remote locations through a 7-year international partnership, building investment recommendations and practical tools for recruiters, supported by evidence and grounded in Northern, rural and remote experience.

This review was commissioned by the Scottish MIW working group and offers a brief overview of the role of community engagement in improving the recruitment and retention of health care workers in remote and rural areas.

Processes of community engagement have the potential to empower communities and improve health services (Rifkin, 1996). Literature addressing the role of community engagement in improve health services is a lot more extensive than was found focusing on the role it can play in improving specific aspects of healthcare systems, such as staff recruitment and retention. Through surveying the landscape of international literature on community engagement, its role in improving health services, and recruitment and retention challenges, the review scopes relevant research, policy documents and other theoretical papers. The overview is delivered in three sections; firstly exploring the concept of community engagement and important community engagement policies to the health sector; secondly identifying the key ways in which community engagement can be effective; and lastly through identifying the values that are best centred to practice ethical and effective community engagement.

3 SCOPING REVIEW

Due to the restricted timeframe allocated for this literature review, a scoping method was chosen because it is the most appropriate method when faced with time and resource constraints (Arskey and O'Malley, 2007). A scoping review applies a wide lens to literature, rather than attempting to delve deeply into it, thus providing a basic overview' rather than a systematic analysis. Instead of producing an exhaustive review of the literature, this report aims to 'map rapidly the key concepts underpinning a research area and the main sources and types of evidence' (Mays *et al*, 2001).

Literature was largely sourced through recommendations from the MIW project staff in the Highlands and internationally. Literature was also collected through searches using key words and references from useful literature. Literature directly relating to the focus of the review was limited so papers with a broad range of focuses has also been collected and findings were drawn from and synthesised. The MIW Scottish Partner steered the aims of the review which were to explore

- ways community engagement effects recruitment and retention in rural and remote areas
- the processes of engagement that are producing these effects
- how health systems can engage with communities ethically and efficiently

4 COMMUNITY ENGAGEMENT

The term communities refers to a group of people who share a common characteristic (Sigerson, 2008). Communities can form around shared identities, health needs, cultures or interests; for example, as a shared geography (Conn, 2011; Mason *et al*, 2005). Communities are formed at different scales; from the local to the international, thus existing within and across each other (Conn, 2011; Bidwel, 2001). While this review is more concerned with geographically remote and rural communities, it is important to note that communities are multiple, interconnected and overlapping, and demographically unique. Furthermore, people that are associated with a community, whether that be health or social need or geography for example, does not necessarily mean that people identify themselves with that community of have strong social networks with a community (Mason *et al*, 2005). The need to understand the nature of the communities within the geographic community for tailored health services necessitates involvement (Conn, 2011; Baatiema *et al*, 2013, Who, 2010, Veitch *et al*, 1999). Public participatory processes can inform on, and should be informed by, the nature of communities (Sigerson, 2008).

'Community engagement', or 'public participation', can be loosely described as the involvement of people in a community on issues that affect them. (Albert and Passmore, 2008; Reed *et al*, 2002). Engaging communities is crucial to providing sustainable and appropriately tailored services for communities and responses to contextually specific challenges (Albert and Passmore, 2008; Reed *et al*, 2002). Community participation can be enacted through several different project stages; in the

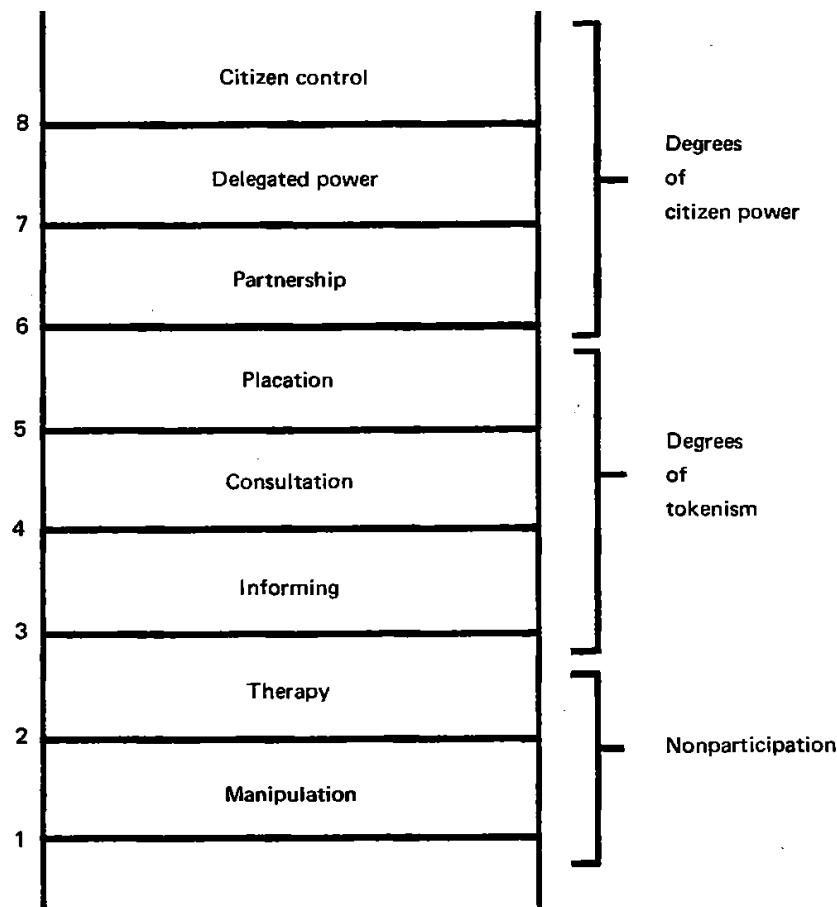
needs assessment, planning, mobilising, implementing and monitoring and evaluation (Reed *et al*, 2002).

However, the space provided for citizen influence in participatory processes varies and frameworks of categorisation have been developed to explore this range. The following sections will explore this range and models for understanding, measuring and assessing participation, as well as key critiques, important policies and advisory reports.

4.1 SCALES OF PARTICIPATION

As community engagement refers to a broad spectrum of citizen power, clarity is needed to avoid miscommunication and misunderstandings. Spectrums for categorising community participation offer a method for providing some clarity. Sherry Arnstein recognised back in 1969 that ‘community participation’ discourse often allowed space for ‘exacerbated rhetoric and misleading euphemisms’ which could disguise non-participatory interventions (Arnstein, 1969). With the aim of better enabling a more enlightened and honest dialogue, Arnstein proposed a ladder of categorisation for understanding forms of ‘community participation’. The 8 rungs on the ladder correspond to different gradients of citizen power commonly categorised under the umbrella term ‘community participation’. The ladder displayed in figure 1 below illustrates the escalation of citizen power from non-participation, degrees of tokenistic participation that continue to deny citizens power, and degrees of citizen power at the top (Arnstein, 1969). While the gradations offer clarity around a confused topic, the model has been criticised for treating ‘participation as empowerment’ and focusing solely on one component of empowerment; ‘control’ (Tritter and McCallum, 2006). It assumes that more citizen control is always better, when different situations are unique and require contextually appropriate methods and levels of engagement (Bowyer, 2018). This illustration of participation is constrained further by treating participation as the aim or end goal, instead of a method or process for achieving an aim (Bowyer, 2018). Afterall, incorporating community participation into health and social programs has the potential to improve health services, as well as empower communities (Rifkin, 1996).

Figure 1



Arnstein (1969) explains how an individual initiative, such as the employment of a citizen without power within a organisation, could be a legitimate or illegitimate act of citizen participation and be used as an example for any of the eight rungs of the ladder. Therefore methods, strategies or actions, are not static, set on a rung, but rather other components influence how these interventions materialise as forms of participations along the spectrum. Therefore, a focus group consisting of community and organisation members aiming to plan recruitment and retention improvement strategies could be situated along any rung depending of how it is conducted and by whom.

A simplified range of 5 categories, also organised along a spectrum of citizen power has been adopted by Albert and Passmore (2008) for the Scottish Government. The scale of categorisation has been adapted from a table to a diagram in figure 2 to illustrate the spectrum.

Figure 2



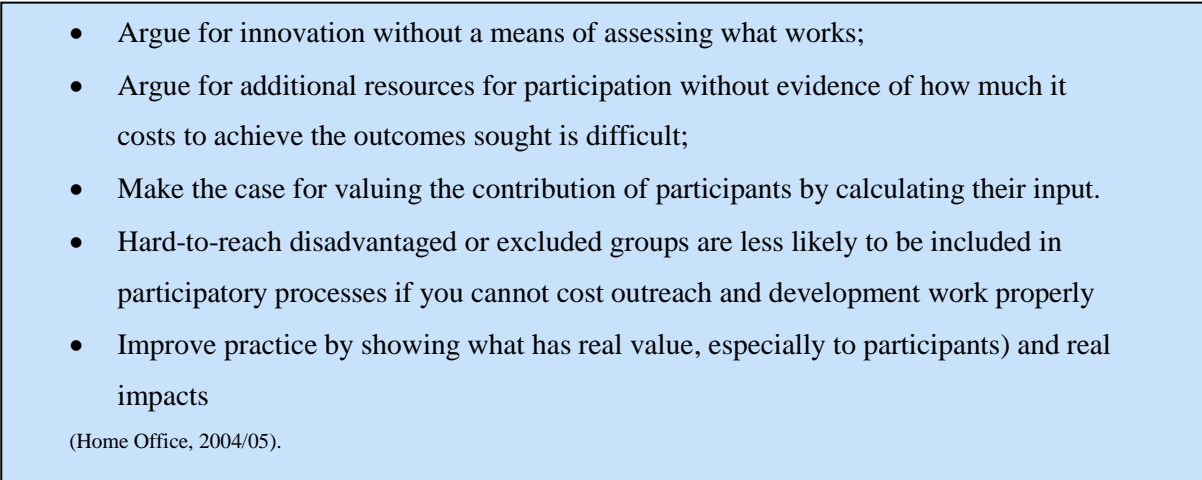
However, Albert and Passmore (2008) critically reduce the spectrum to 4 categories after identifying ‘informing’ as non-participatory as well as citing Morris’s (2006) critique that extended further to argue that ‘participative processes go beyond consultation’. Furthermore, a community engagement toolkit developed in North Dakota parallels these frameworks by identifying community coercion and consultation at the lower end and ‘community engagement’ at the opposite end, and describing it as sustainable community ownership (Centre for Rural Health, 2015). The frameworks suggests that community engagement should offer space for more citizen influence than relationships commonly described as coalition or partnership. Similar to Arnstein’s model, there is a general identification that non-participatory processes are often shoehorned into the community engagement umbrella, but there is a lack of consensus over where ‘participatory’ processes begin.

Alternatively, Curtain (2003), identifies four broad types of practical initiatives; ‘traditional,’ ‘customer-oriented feedback,’ ‘participative innovations’ and ‘deliberative methods’. This method of categorisation identifies different types of participation rather than assessing levels of participation along a spectrum of citizen power. This removes the hierarchical organisation in which greater citizen control is valued as better, to permit different types of participation to be viewed more equally and allow the most appropriate type of engagement to be paired with a community’s’ circumstances.

4.2 MEASURING AND ASSESSING

It is important to honestly assess communicate project’s participatory processes; to firstly ensure that communities feel that their contributions are being heard and taken seriously, secondly to illustrate progress for further support and funding and thirdly so that communities can assess how their current participatory processes suits their circumstances (Bidwell, 2001: Baatiema *et al*, 2013). The British Home Office identifies processes, listed in figure 3 that are made more difficult without doing so.

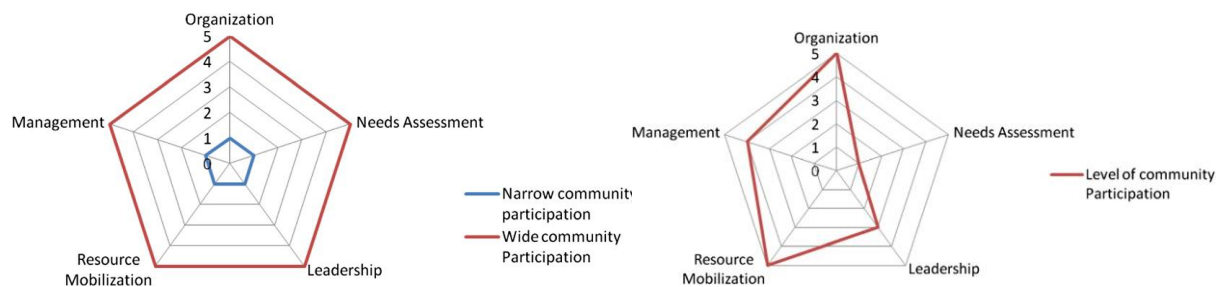
Figure 3

- 
- Argue for innovation without a means of assessing what works;
 - Argue for additional resources for participation without evidence of how much it costs to achieve the outcomes sought is difficult;
 - Make the case for valuing the contribution of participants by calculating their input.
 - Hard-to-reach disadvantaged or excluded groups are less likely to be included in participatory processes if you cannot cost outreach and development work properly
 - Improve practice by showing what has real value, especially to participants) and real impacts
- (Home Office, 2004/05).

Alongside recognising the value of measuring participatory processes, Baatiema *et al* (2013) identify the lack of analytical tools for measuring and assessing. They propose using the spider-gram, shown

in Figure 3 as a methodological tool for assessing community participation interventions. Participation is measured from narrow to wide but is adaptable to other measurement continuums, for example, Draper *et al* (2010) adopts a scale from mobilization to empowerment. Five components are measured; needs assessment, leadership, organisation, resource mobilization and management (Baatiema *et al*, 2013).

Figure 4



Baatiema *et al* (2013) advises that the spider-grams are created collectively with participants to come to a unanimous assessment as was conducted in their case study project in Ghana (Baatiema *et al*, 2013). Therefore, the process of creating spider-grams requires a critical assessment of the level of community involvement, by the participating community, from five different angles, providing a useful tool for assessing, analysing and illustrating participation in a project.

4.3 POLICIES

National governments, international institutions and localised organisations alike, are illustrating increasing policy support for community engagement (Reed *et al*, 2013). Three examples of relevant policy documents to the MIW project, drawn from the World Health Organisation (WHO) and Scottish Government are outlined here:

4.3.1 World Health Organisation

WHO recognised community engagement as an important concept to primary health in the 1978 Alma Ata declaration and later became a core concept in the WHO (2017) framework as ‘engagement and empowerment’. Their policy recommendations concerning improved access to health care staff in rural and remote areas is more useful. It refers to the importance of community engagement rather than discussing it directly. However, it does strongly state that engaging with all relevant stakeholders from the beginning of healthcare planning process is critical to success and recommends ongoing ‘consultative and communicative’ engagement with remote and rural communities. It also adds that selecting the appropriate intervention for an area requires a ‘situation analysis’, and a sound understanding of the geographies of the locality can only be adequately achieved with the input of local knowledge, collected through community engagement. While civil society is identified as a key stakeholder in the planning processes, it is only listed as important actor in 2 of 16 of the intervention

strategies; developing better living conditions for health care workers and offering public recognition measures.

4.3.2 Scottish Government

Two key Scottish documents are relevant to the discussion. First the Scottish Community Empowerment Act (2015) lays out the Governments bold aims to decentralise power through new rights which allow communities to make requests according to their identified needs; and strengthening community planning to enable communities to have a stronger influence in how local services are planned and provided. This Act ensures that the ambitions laid out translate to transformable change by enforcing legal requirements such (1) community planning partnerships', between communities and local authorities and (2) participation requests by the community influence public services must be accepted unless good reason not to is evident.

The second document is a literature review about public value and participation (Albert and Passmore 2008). This review favours a participation spectrum ranging from consultative to deliberative, after concluding that 'informing' is not a participatory method. The research found that while community engagement has increased since 2000, more traditional techniques typically allowing citizens less influential power such as written consultation are still preferred, although it is more common for them to be used in conjunction with newer methods such as focus groups. The report identifies how community engagement allows for multiple perspectives to be heard and understood, improving transparency, trust and accountability, to benefit both organisations and citizens. However, the report adds that these positive outcomes are dependent on citizens and Organisations understanding the value of engagement and showing willingness. Furthermore, procedural barriers to success may include; a lack of clarity of purpose, inconsistent use of terminology, participation overload, accountability issues and participation overload.

Key Points

Community Engagement

- Community Engagement means involving communities on issues that affect them

Scales

- There are multiple frameworks for categorising participation along a scale of citizen power
- Participation is a method not an end goal

Assessing

- It is important to assess participation to review and report progress
- A spider-gram is a useful methodological tool for assessing and illustration participatory interventions

Policies

- The community empowerment act translates participatory aims into legal frameworks

5 THE ROLE OF COMMUNITY ENGAGEMENT

The following section provides a broad overview of the role of community engagement in improving recruitment and retention in remote and rural areas. Five key themes have been identified; direct involvement in planning, creating an attractive community, improving integration, sustaining the relationship and the reduction of health inequalities. Through discussing each theme, it will become apparent that they are interconnected and overlapping to support the importance of each other, thus the following discussions create a broad narrative review of a cross section of literature and illustrative case studies.

5.1 DIRECT INVOLVEMENT IN PLANNING

It is valuable for communities to be engaged from the beginning of any program attempting to respond to recruitment and retention challenges to allow a sense of ownership and responsibility to grow and a shared vision of, and commitment to success to be fostered (Conn, 2011; Veitch *et al*, 1999). Therefore, involving communities in strategy planning processes at the beginning has ongoing benefits (WHO, 2010). This importance of community involved planning is recognised by the Scottish Government in the Community Empowerment Act mentioned previously. Community Planning is outlined in the Act to provide ‘a framework for making public services responsive to, and organised around, the needs of communities’, and has encouraged the development of different approaches to engaging with the public. (Araujo and Maeda, 2013)

Involving communities in the planning and development of their own health care systems allows these systems to be better tailored for the community; using local knowledge and incorporating local concerns. Strasser *et al* (2018) found that small communities that have a history of struggling with recruitment and retentions have moved ‘from perpetual crisis mode’ to ‘planning ahead’. Therefore, communities are often already active in their search for a solution prior to invitation from an organisation and their awareness of the challenges should not be underestimated. Communities interest and willingness to participate in solution finding projects should influence how planning processes are developed. Thus, participation must be thread throughout the planning process and allow changes to be made rather than acting as an exercise ‘bolted on’ to an existing planning model (Strasser, 2018).

Veitch et al (1999) studied two rural communities in Queensland Australia with a high level of GP turnover while they both participated in planning processes to improve recruitment and retention.

Common strategies

- Form a liaison committee to interface with other stakeholders
- Develop information packages for prospective applicants
- Form a welcome process that helps doctors and families settle in
- Address quality and appropriateness of housing
- Sponsor a medical student to spend time in the community
- Consider spouses' education and employment needs (Veitch et al, 1999)

Both communities came to similar strategical conclusions and created similar action plans (Veitch et al, 1999). Thus, while the geographies of the two places were different, they shared their rurality and remoteness, and recruitment and retention challenges, to come up with the common strategies listed in figure 6 below.

The strategies that the communities came up with reflect the strategies advised in reports produced by WHO (2010) and the Scottish government (2008). Thus, as well as planning strategies that strongly reflect the advice of experts, the shared planning allows local knowledge to affect the strategies and craft a local sense of ownership over the process (Veitch *et al*, 2009).

Participants involved in the planning processes in both Queensland communities tended to have been involved in previous attempts to improve the recruitment and retention of medical practitioners and therefore already understood the communities history and challenges (Veitch *et al*, 1999). Therefore some local participants brought additional knowledge around the difficulties in previous strategies and could advise on what has and has not worked well in the past. However, the continual return of the same participants can result in a small non-representative cohort of the community drowning out newer quieter voices (Baatiema *et al*, 2013).

While slowing down processes, good planning and positive community involvement are important for specifically tailoring an intervention to a locality (Veitch et al, 1999). The 2 key reasons for involving communities in the planning process are that (1) communities possess the local and historical knowledge necessary for planning a well-tailored intervention and (2) involving communities throughout the planning process fosters a sense of responsibility and commitment to the successful recruitment of a healthcare worker and their integration into the community.

5.2 CREATING AN ATTRACTIVE COMMUNITY

WHO (2010) identifies sixteen key strategies to improve the recruitment and retention of health care workers in remote and rural areas and identifies 'civil society', operating as active communities, as an important actor in two of the strategies. One of these strategies is to improve the living conditions in

the area for potential employees and identifies the role and responsibility of civil society in creating good housing and schooling for children and creating opportunities for spouses (WHO, 2010).

Good living conditions are vitally important in attracting health care workers to rural and remote areas and encouraging them to stay (WHO, 2010; Araujo and Madea, 2013). Grobler *et al* (2009) identified professional concerns about life in rural areas that act as deterrents; ‘unsuitable pre-service training for rural and remote areas practice, lack of opportunities for further training and career development, low salaries, poor working environments, limited availability of equipment and drugs, insufficient family support, inadequate management and unsupportive supervision’. However, many of the important influencing factors were more general concerns about the region; the quality of schooling available for their children, safety and security, employment opportunities for the partners, quality of accommodation, and more general basic infrastructure such as facilities and transport (Araujo and Madea, 2013).

As well as responding to some of these concerns and making changes, communities need to offer reassurance that while being a change, neither career nor lifestyle will be sacrificed by the move. The Westray community in the Orkney Isles, Scotland, has been highly successful at recruiting and retaining health care staff over the last 8 years. The community has a positive attitude to working alongside NHS Orkney and the Primary Care team on their Island and has taken on responsibility and been active in promoting itself (Mason and Siderfin, 2018). Examples of their input includes meeting and greeting potential candidates; and the local tour guide who offered a guided tour and one to one conversations about the islands with candidates and their families. One of the nurses in Westray stated:

“If I had been single might have just winged it but had family so felt it important to check it out”

The perceived image of a place strongly influences peoples lifestyle concerns about moving to a place (Becker *et al*, 2013). Becker argues that rural communities must appear appealing to both the desired worker and their family.

Therefore, communities that focus on promoting lifestyle as well as employment in the region are generally more successful at recruiting new workers. This signals an advised revision of the current promotional preference for appealing to tourists and people considering short term stays. Therefore, the image promoted must be positive and offer a vivid and honest impression of the community and longer-term lifestyle opportunities.

5.3 IMPROVING SOCIAL COHESION AND INTEGRATION

WHO (2010) report identified public recognition measures as another key strategy for improving recruitment and retention in remote and rural areas. Along with the ministry of health, ‘civil society’

is identified as being a key actor responsible for creating and delivering awards and titles for health care workers. As well as welcoming and showing ongoing appreciation towards healthcare workers in a professional capacity, Veitch *et al* (1999) states that it is important that new workers also feel welcome and appreciated personally. Veitch *et al* state that “‘sociocultural integration’ is the pre-eminent retention issue for rural practitioners and that communities can play an important role in this regard. Therefore, it is important for communities to recognise the responsibility they have in making health care workers feel welcome and involved in the community.

Communities are more likely to be welcoming and help integrate new workers into the community when the new employee was likely to stay more than 2 years (Becker *et al*, 2013). The decrease in effort that results from the knowledge of a planned short stay, in turn creates an environment less likely to encourage new employees to seek longer stays through extensions or reemployment. Therefore, the poorer integration into the community that ‘fly in fly out’ or short-term workers experience, is unlikely to reflect the more positively welcoming experience of new resident workers. When assumed to be as such, the lack of integration acts as a deterrent to longer term employment. Thus, an opportunity to entice familiar workers through improving the integration of visiting workers is not being fully utilised by the community.

Furthermore, communities with a high level of social cohesion are better at integrating new community members. Reed *et al* (2013) found that processes of community engagement can have a cohesive effect on community participants. Therefore, public participatory processes help craft communities that enable new workers to feel welcome, integrate into the community and increase the likelihood of retainment. This is important because societies that are trustful and characterised by reciprocity offer easier environments for new workers to integrate into (Putman, 2000).

5.4 SUSTAINING THE RELATIONSHIP

An ongoing dialogue between communities and health services is important for improving how services are adapted to respond to the changing needs of communities, and in preparing for, responding to, and avoiding crises (Veitch *et al*, 1999). The Scottish National Standards work this notion into their definition of community engagement:

'Developing and *sustaining a working relationship* between one or more public body and one or more community group, to help them both to understand and act on the needs or issues that the community experiences' (SCDC,2008)

Developing and sustaining the relationship between health services and communities is integral to community engagement processes. Similarly, Albert and Passmore (2008) argue that it is important to build in long term sustainability plans into any project. Therefore action plans must be designed to

incorporate long term plans for communities and health services to cooperate ongoingly to manage recruitment and retention challenges.

Community engagement challenges top-down structure of service planning and delivery and allows bottom- up changes to be made (Albert and Passmore, 2008). However Conn (2011) argues that this is a problematic understanding of the relationship between organisations and communities. This understanding of the relationship suggests that both actors are ‘parts of a machine to be fitted together’ when they both have vastly different operating structures. This assumption is problematic for the relationship because it:

‘often leads to an approach that the ‘bottom-up’ needs to behave, and have governance processes, like the ‘top-down’ system, to help deliver services. So the community tends to be used instrumentally by the public services, rather than treated as an independent participant.’ (Conn, 2011)

Therefore, communities must be provided the space to operate in their own way while liaising with organisations free from control or management. Understanding this difference is fundamental to allow community engagement to play an important role in creating a sustainable relationship.

Community engagement can have an important role in improving the relationship between health care organisations and communities. If communities feel as though their contributions have been heard and understood and had an effect in shaping service outcomes, participants can feel empowered to create change, are more likely to trust and feel encouraged to cooperate with the organisation again (Albert and Passmore, 2008). Therefore, forms of participation that are not tokenistic, but allow citizens influential power, are often important for strengthening their relationship.

5.5 REDUCING THE HEALTH INEQUALITY GAP

Community involvement is key to reducing health inequalities (Sigerson, 2008). Community engagement improves health through (1) ‘the development and delivery of appropriate and accessible interventions’ and (2) impact on social cohesion, self -esteem and self-efficacy of participants (Reed *et al* 2002). As well as improving health through challenging isolation, community engagement improves and better tailors health care systems to the needs of the community. Often the members of communities with the greatest health needs are the most disadvantaged and socially excluded but community involvement has the potential to ‘give a voice to the voiceless’ by privileging marginalised voices to ensure that health services take their experiences and concerns to influence how health services develop (Reed *et al*, 2002). Bidwell agrees that community involvement is essential to identifying the health needs of communities and planning and developing services accordingly (Bidwell, 2000). This is important because the current emphasis on ‘workforce,

workforce, workforce' overshadows other service prerequisites necessary for improving recruitment and retention in rural and remote areas (Humphreys, 2009).

key points

Planning

- Communities can, and often already are, acting to find solutions to recruitment and retention challenges
- Involving communities from the beginning encourages a sense of ownership and increases the likelihood of ongoing engagement from communities
- Involvement from the community in the planning process crafts better solutions using local knowledge and historical experience

Creating an attractive community

- The area must be attractive to both the potential recruit and their family, for both career and lifestyle opportunities and long term rather than short term stays.

Social cohesion and integration

- Community engagement can improve social cohesion
- Communities with a high level of social cohesion, trust and reciprocity provide easier environments for integrating new members
- Short term, visiting or 'fly in fly out' workers are often not welcomed in the same way longer stay workers are, which decreases the likelihood of retainment

Sustainable relationships

- Ethical and efficient community engagement can improve and sustain the relationship between health communities and organisations
- Sustaining trust and transparency in the relationship is vital for liaising in solution finding processes in the future

Improving health standards

- Community engagement has a positive effect on tailoring health services for the needs of communities.
- Through developing social cohesion, community engagement can challenge isolation and social exclusion, to protect against poor mental health impactors.
- A healthy community and robust health system creates a stronger foundation for recruiting and retaining new workers.

6 ETHICAL AND EFFICIENT ENGAGEMENT

The following section offers guidance on how to conduct ethical and efficient community engagement using precautionary advice thread through the explored literature. There are different ways of interpreting what constitutes ‘ethical and efficient’ participatory practices. The guidance listed below evokes a reconsideration of current and common models and suggests a critical review of the underpinning principles. Four basic lesson categories have been identified from the literature; willingness and recognising value, equal valuing of knowledges and operational structures, challenging the dominance of traditional methods and clarity and honesty in and of processes. Following this a brief comparative paragraph will explore how this guidance relates to the concept of coproduction.

6.1 WILLINGNESS AND RECOGNISING THE VALUE OF COMMUNITY INPUT

Successful participative interventions rely both on organisations with authoritative power understanding the value of community engagement and a willingness from the community to engage (Albert and Passmore, 2008). Thus, the engagement processes must be genuinely understood and valued by both the organisation and the community. There are several reasons communities’ willingness to participate may vary across geographies. While exploring community engagement in the context of humanitarian aid, Reed *et al* (2002) identifies some of main reasons people are incentivised and disincentivised to participate in community betterment projects.

Incentives	Disincentives
Motivates people to work together	Unfair distribution of work benefits
Obligations of mutual help	Individualistic society and poor sense of community
Seeing a genuine opportunity to better community lives	Feeling that government, agency or organisation should provide
Remuneration	Being treated as helpless

Therefore, ignoring individual’s agency and constructing unfair distributions of effort and benefits, negatively impacts people’s willingness to participate, while mobilising a sense of self and community betterment through solidarity and reciprocity values incentivises. However, these factors were identified in the context of one off emergencies where ‘participation overload’ is less probable.

Participation overload challenges communities’ willingness and is identified as a ‘barrier’ to success for this reason (Albert and Passmore, 2008). Morris (2006) argues that the popularity of public participation has led to an increasing public resentment towards consultation processes. Extensive

consultation processes rarely result in any kind of visible impacts or changes which can create a sense of ‘consultation fatigue’ among participants (Morris, 2006). Secondly, it is argued by Veitch *et al* (2009) that slow progress, unrealistic aims and expectations, and a changing focus allows community engagement strategies to ‘go stale’ and negatively affect participants willingness to engage. To avoid participation overload and better ensure a maintained willingness from the community it is recommended that (1) an assessment of the trade-offs of conducting ‘participatory processes (2) along with an evaluation of best method (3) and an identification of the stage at which the public should engage and (4) what purpose engagement will service is recognised (Albert and Passmore, 2008).

6.2 AN EQUAL VALUING OF KNOWLEDGES AND OPERATIONAL STRUCTURES

An equal valuing of both professional and local knowledge allows for a more respectful engagement and for both knowledges to be well utilised (Conn, 2011). Similarly, Baatiema *et al* (2013) state that local knowledge should be taken as seriously as expert knowledge for community participation to be effective. They warn that a failure to recognise the importance of local voices and knowledges threatens the alignment of the health services with the local context. However expert knowledge is always in a position of power. Baatiema *et al* (2013) argues and adds that this must be recognised and responded to in power sharing participation practices.

Equal valuing of both knowledges and operational structures requires a recognition of their differences (Conn, 2011). Thus the community, and organisation, should not expect each other to organise and operate in a similar way. Community engagement interventions should not force communities to operate within bureaucratic boundaries and be expected to participate in a formal hierarchical way (Conn, 2011). Instead of the trying to fit both structures together as if they are two symmetrical parts of the same machine, they should be understood as organisationally different, interacting, co-existing and co-evolving alongside each other (Conn, 2011).

6.3 A MOVE AWAY FROM TRADITIONAL METHODS

Traditional methods of community engagement, such as written consultation, although often used in conjunction with newer more innovative methods of public participation, continue to be preferred despite an overall increase in public participation (Albert and Passmore, 2008; Mitton *et al*, 2009). Their review suggests that traditional methods should be adapted to better accommodate communities, such as holding meetings at times and places that suits participants. Thus, adapting to Conn’s (2011) argument that the operational structure of the ‘horizontal peer’ should be understood, valued and engaged with in an appropriate way. Albert and Passmore (2008) also recommend that more innovative methods, such as focus groups or online recording platforms allow better communication between organisations and communities, and that methods are built into the operational structures of organisations. Participatory initiatives, whether traditional or innovative, should be tailored to their

context and ambitiously aim to incorporate engagement from all socio-economic groups. Therefore, it is important to consider how inequality effects participation to ensure participatory processes are accessible to marginalised members of communities (Albert and Passmore, 2008).

6.4 CLARITY AND HONESTY IN AND OF PARTICIPATORY PROCESSES

One of Arnstein's motivations to produce a ladder of participation in 1969 was a lack of clarity in community engagement discourse. Despite multiple models of categorisation having been developed since then, poor forms of assessing 'community engagement' interventions persist (Albert and Passmore, 2008; Baatiema *et al*, 2013). 'Arnstein's gap' refers to the common mismatch between the way a process is described compared to its reality (Bailey, 2006). There is a tendency among organisations to allude to a greater level of citizen power in their community engagement strategies than the methods adopted permit (Bailey, 2006).

This common miscommunication, along with other forms of miscommunication during and about participation processes, are important because a lack of clarity, an inconsistent use of terminology and accountability issues, act as barriers to successful participatory processes (Albert and Passmore, 2008). They recommend following a code of good practice by having:

‘a clear and realistic role and remit; ensuring that adequate resources are available; supporting the project with appropriate management and evaluation; building on experience and linking the project with other policies and initiatives; building in long term sustainability.’

These practices should help projects gain the most from the community engagement methods in a transparent and honestly communicated way. This requires projects to recognise a commitment to monitoring and evaluation and operational research (WHO, 2010). This process will help ‘identify challenges and limitations during implementation, assess the degree to which the objectives and goals have been achieved, and identify the need for a new intervention or the need to re-design or modify an existing one’ (WHO, 2010). In doing so the project will better evaluate effectiveness of the project, revise and adapt throughout implementation, capture valuable learnings, build an evidence base, and add to understandings about the workings of interventions in different contexts (WHO, 2010).

6.5 CO-PRODUCTION

To co-produce is to collectively create or construct, and therefore excludes relationships in which power is not shared and changes are not made through collective input. Farmer (2018) argues it is a human right for citizens to be part of their service co-production. The Scottish Community Development Centre (2010) offers the following description;

Co-production essentially describes a relationship between service provider and service user that draws on the knowledge, ability and resources of both to develop solutions to issues that

are claimed to be successful, sustainable and cost-effective, changing the balance of power from the professional towards the service user.

Therefore integral to the concept of co-production is an equal valuing of community and professional input and power sharing. Alexander (2018) reported on the co-production between health and social care service organisations and communities in Orkney, as they jointly designed and implemented services, and although challenging at times, more efficient services were produced, and community ownership and engagement improved. Cahn (2000) developed the four key principles of co-production as; (1) valuing each individual as an asset with the ability to positively contribute to the 'production', (2) to recognise actions such as feminised household labour as work, (3) reciprocity is necessary to trusting relationships and (4) building social capital through social networks. Therefore, the aims underpinning co-production strongly reflect ethical and efficient community engagement.

KEY POINTS

Willingness and recognising the value of community input

- Willingness and valuing of community engagement processes is important for success
- 'Participation overload' is a barrier to ongoing willingness from communities
- It can be avoided by ensuring participation is suitably appropriate

An equal valuing of knowledges and operational structures

- Both expert and local knowledge must be equally valued for both to be well utilised
- Expert knowledge is always privileged but genuine power sharing in participatory processes can challenge this
- Communities and organisations should not be expected to operate in similar ways

A move away from traditional methods

- Public participatory processes are increasing but methods that allow low levels of citizen power are still favoured
- Attempts should be made to accommodate communities and ensure accessibility to the more marginalised members of society through innovate new participatory methods

Clarity and honesty in and of participatory process

- Community engagement continues to be discussed and communicated with poor clarity and can convey misleading results
- Poor communication in and about participatory processes is a barrier to success
- It is important to assess participatory processes to ensure honest reporting

7 CONCLUSION

This report aimed to outline the role of community engagement in responding to rural and remote recruitment and retention challenges through exploring the concept, identifying the ways in which it can be influential and best conducted. It was found that spectrums of community engagement are commonly placed along an axis of citizen power which can provide a useful tool for understanding different types of engagement, but the hierarchical organisation can be unhelpful when identifying appropriate methods for a specific context. The WHO (2010) argue the importance of measuring and assessing participatory and Baatimea *et al* (2013) offer the useful analytical tool of a spider-gram for measuring, assessing and illustrating participatory processes.

Community engagement was then situated in context of improving recruitment and retention in remote and rural areas and five key themes were identified to illustrate its important role.

It was firstly identified how communities' engagement in the planning process not only empowers communities and nurtures a sense of sustainable responsibility, the collaborative process produces more contextually appropriate action plans. Secondly, developing and promoting regions; for lifestyle as well as career opportunities, for families and for long term stays, improves recruitment and retention. Thirdly, improving social cohesion, partly through community engagement, and acting to integrate workers however short their planned stay, increases chances of retainment. Fourthly, ethical and efficient community engagement can improve the dialogue between communities and health service providers to create a sustainable relationship better suited to collaboratively responding to future challenges. Lastly, community engagement can reduce health inequality through improving health services and protecting against poor mental health, which creates a more attractive and healthy community to recruiting to.

It was identified that ethical and efficient participation should aim to: maintain communities willingness through appropriate interventions; recognise the differences and equally appreciate the knowledge and operating structures of communities and health care providers; diverge from traditional participatory methods to become more innovative, inclusive and accessible practices; and ensure clarity and honesty throughout, and reporting on, participatory processes. Parallels were drawn between these themes and the aims of 'co-production' which is rooted in principles of shared power and collaboratively creative aims and solutions.

Involving communities and allowing local knowledge and skills to inform strategies to benefits responses to recruitment and retention challenges. However, this report has also highlighted many of the more indirect ways in which community engagement is influential, such as improving the appeal of the environment to new recruits and. While ethical and efficient community engagement was

outlined, the concept can be 'bolted on' and its influence restrained and static. However, 'co-production' is essentially rooted in shared power and dynamicity, possibly offering an alternative concept to centre in recruitment and retention strategies.

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