BMJ Public Health

Culturally safe community agency health promotion capacity for diverse equity-seeking women: a rapid theoretical review

Elle Nelson,[1] Susmita Susmita,[2] Saleema Allana,[2] Oluwakemi C Amodu,[3] Swarna Weerasinghe,[4] Andrea N Simpson,[5] Erin Ziegler,[6] Anna R Gagliardi [7]

To cite: Nelson E, Susmita S, Allana S, *et al*. Culturally safe community agency health promotion capacity for diverse equity-seeking women: a rapid theoretical review. *BMJ Public Health* 2024;**2**:e001023. doi:10.1136/bmjph-2024-001023

► Additional supplemental material is published online only. To view, please visit the journal online (https://doi.org/10.1136/bmjph-2024-001023).

Received 5 February 2024
Accepted 9 September 2024

[1]University of Toronto, Toronto, Ontario, Canada
[2]University of Western Ontario, London, Ontario, Canada
[3]University of Alberta, Edmonton, Alberta, Canada
[4]Dalhousie University, Halifax, Nova Scotia, Canada
[5]Unity Health Toronto, Toronto, Ontario, Canada
[6]Toronto Metropolitan University, Toronto, Ontario, Canada
[7]Toronto General Hospital Research Institute, University Health Network, Toronto, Ontario, Canada

Correspondence to
Dr Anna R Gagliardi;
anna.gagliardi@uhnresearch.ca

ABSTRACT

Objectives Immigrant and sexually/gender-diverse women (henceforth, women) face inequities in access to and quality of care. As a result, many seek health information from community agencies perceived as culturally safe. We aimed to generate knowledge on capacity needed for culturally safe community agency health promotion.

Design Theoretical rapid review.

Data sources Studies identified in MEDLINE, EMBASE, CINAHL, PsycINFO, Sociological Abstracts, Cochrane Library and the Joanna Briggs Institute Database of Systematic Reviews.

Eligibility criteria Studies published in 2013 or later on health promotion for ethnoculturally, sexually and gender-diverse women led by community agencies (eg, settlement, cultural, support and faith).

Data extraction/synthesis We extracted data on study characteristics, cultural tailoring, implementation with the Reach Effectiveness Adoption Implementation framework and health promotion capacity with the New South Wales framework.

Results We included 19 studies published from 2017 to 2023. Most focused on health promotion to African or Latin American persons in faith-based organisations. Few studies focused solely on women, and no studies focused on or included 2SLGBTQ women. Few studies described cultural tailoring beyond the use of participants' first language. Training of community health workers (CHWs) to deliver health promotion education, and CHW in-person group training of health promotion participants on a wide range of topics resulted in improved knowledge, self-efficacy, intention to modify behaviour, behaviour change and health outcomes. A few studies yielded some insight into what community agencies need to enable health promotion: dedicated funding and personnel, training in healthcare issues, space and partnerships with academic and healthcare organisations.

Conclusions This study confirmed and enhanced our understanding of the health promotion role of community agencies and identified gaps that can inform future research on how to achieve culturally safe community agency health promotion for diverse women.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Because racialised immigrant and 2SLGBTQ (two spirit, lesbian, gay, bisexual, transgender, queer, intersex and others who identify as part of sexual and gender diverse communities) women face inequities in access to and quality of mainstream healthcare, they seek health information from culturally safe community agencies.

⇒ We conducted a theoretical rapid review of published research to describe community agency capacity for health promotion to diverse, equity-seeking women.

WHAT THIS STUDY ADDS

⇒ Among a mere 19 studies included, few focused solely on women and none on 2SLGBTQ women.

⇒ While community agency health promotion on a range of topics improved participant knowledge, self-efficacy, intention to modify behaviour, behaviour change and health outcomes, agency representatives said they needed dedicated funding and personnel, training in healthcare issues, space and partnerships with academic and healthcare organisations.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Gaps in research that warrant future research include insight on how to culturally tailor health promotion and optimise capacity for health promotion in community agencies.

INTRODUCTION

Despite national and international recommendations to improve health across the lifespan for persons who identify as women (henceforth, women),[1 2] Canadian women face inequities in access to and quality of care for many conditions.[3 4] These disparities are heightened in two contexts: ethnoculturally diverse immigrant women and sexually/gender-diverse women, who we henceforth refer to either as 'diverse' or 'equity-seeking' women to acknowledge the healthcare

disparities they face. For example, immigrant women face barriers in access to cancer screening,[5] and prenatal, perinatal and postnatal care.[6] Many transwomen lack a primary care provider with whom they can discuss trans health concerns[7] and report unmet healthcare needs.[8]

These disparities, along with poor healthcare experiences, contribute to diverse women's mistrust and avoidance of mainstream healthcare services in favour of services provided by local, trusted community agencies. For example, a scoping review of 16 studies pertaining to immigrants from 19 countries identified that women's needs were not met because physicians dismissed their concerns[9]; and focus groups with immigrant women from 10 countries revealed that, due to poor healthcare experiences, many refrained from raising concerns or asking questions and even avoided seeking care.[10] Mounting research highlights the value of community-based health promotion. For example, qualitative research with East and South Asian immigrant women in Canada revealed that they preferred accessing health information or services in community settings that included women only and addressed cultural and economic barriers.[11 12] Similarly, a Canadian environmental scan revealed numerous primary healthcare and healthcare navigation services offered to 2SLGBTQ (two spirit, lesbian, gay, bisexual, transgender, queer, intersex and others who identify as part of sexual and gender diverse communities) persons by community-based support groups, although few were dedicated to trans, gender diverse or cisgender 2SLGBTQ women.[13]

Equity-seeking immigrant and sexually/gender-diverse women may prefer to access health information, advice and care via local, familiar community agencies because such services are 'culturally safe'. Community agencies refer to organisations outside of the formal healthcare system such as centres that provide settlement or support services. Cultural safety has been defined as effective care of a person of a particular culture as determined by that person, where culture may include but is not limited to age or generation, gender, sexual orientation, occupation, socioeconomic status, ethnic origin, migrant experience, religious/spiritual beliefs or disability.[14 15] Staff of community agencies, sometimes referred to as community health workers (CHWs) because they often represent target communities, possess knowledge of the sociocultural norms, values and behaviours of equity-seeking clients, which facilitates communication and service provision.[16] We distinguish community agency health promotion from health promotion that takes place in the community (community based) but is led by governmental or healthcare organisations, or by CHWs employed by government or healthcare organisations. While community agencies are well positioned to reduce healthcare inequities, they are often non-profit organisations with limited dedicated staff, infrastructure and funding for health promotion.[17 18]

Healthcare disparities among women are a problem in Canada, which is a multicultural country. For example, nearly half of the population will be immigrants and their Canadian-born children by 2036, and there is a planned influx of 1.45 million immigrants from 2023 to 2025 including a stream for women and sexually/gender-diverse people seeking human rights protection.[19] Such inequities are likely also a problem for many other middle-income and higher-income countries given unprecedented rates of migration internationally.[20] Community agency health promotion could fill gaps in overburdened, under-resourced health systems and reduce healthcare inequities. To support this role, knowledge is needed of the capacity required for community agency health promotion. This knowledge could serve as the blueprint to strengthen and systematise culturally safe health promotion in community agencies, which in turn, could improve the health and well-being of diverse equity-seeking women. The overall aim of this study was to understand what constitutes community agency health promotion capacity for diverse equity-seeking women. The specific objective was to review published research that evaluated health promotion in community agencies for immigrant or sexually/gender-diverse women to describe capacity and yield insight on how to implement it.

MATERIALS AND METHODS

Approach

We conducted a theoretical rapid review. A theoretical review is appropriate when the aim is conceptual and likely to include studies of diverse research design.[21] A theoretical review includes a comprehensive search strategy, eligibility criteria to guide study selection and analysis of data extracted from included studies to generate higher-level conceptual knowledge.[21] We also adopted a rapid review methodological approach because this review was meant to inform subsequent key informant interviews as part of a multiple-methods study.[22] Rapid reviews involve a single language (English), short time frame (last 10 years, 2013+) and no grey literature searching or contact with study authors.[22] Quality appraisal of included studies is not required of either theoretical or rapid reviews.[21 22] Since there are no reporting criteria specific to either theoretical or rapid reviews, we complied with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) to optimise rigour.[23]

Eligibility

Online supplemental file 1 provides detailed inclusion and exclusion criteria. In brief, we included English-language studies of quantitative, qualitative or multiple-methods/mixed-methods design that evaluated community agency health promotion capacity for immigrant or sexually/gender-diverse women from the perspective of women, community agency personnel or involved partners such as healthcare providers, leaders or policy-makers. The health promotion programme had to be led by and situated in the community agency.

Given that exploratory searching to plan the comprehensive search strategy ultimately used had revealed relatively few studies, we included studies even if the health promotion programme was not specific to women so long as the participants were at least 50% aged 18+ immigrant or sexually/gender-diverse women, who we may refer to as 2SLGBTQ while acknowledging that the WHO accepts that the acronym is dynamic and can vary by region or country.[24] For the same reason, we included studies involving African and Latin American women even though studies did not report if those women were immigrants or not; still, the women were ethnoculturally diverse, and those studies could contribute insight into how to promote health to ethnoculturally diverse immigrant women, through community agencies, so we opted to include them. In the absence of a standard definition for organisations in the community that are not part of the formal social services or healthcare systems, for this study, we defined community agencies as organisations such as settlement, cultural, support or faith-based groups that provide or broker health information, education, navigation, referrals or care. Therefore, studies based in governmental (eg, government-run public housing) or healthcare (eg, physician offices, hospitals) settings were not eligible. Similarly, self-help groups were not eligible. As defined by WHO, health promotion capacity refers to the development of knowledge, skills, systems, structures, personnel, commitment and leadership for health promotion, requiring knowledge and skill among individuals, organisational infrastructure and partnerships.[25] Hence, we included studies if they focused on capacity at the organisational or individual (eg, CHW) level provided individuals were affiliated with a community agency. If the same study was published in multiple articles, we included only the most recent or complete article except when essential details about the same study were published in more than one article. However, if the study was conducted in distinct phases (eg, exploratory followed by intervention testing), we included more than one article by the same group. We excluded letters, editorials, meeting abstracts or papers, protocols and reviews but searched the reference lists of relevant reviews for eligible primary studies. We excluded studies that focused on clinical interventions, or where the community agency's role was solely to help recruit research participants or CHWs.

Searching and screening

Online supplemental file 2 provides the strategy used in May 2023 to search MEDLINE, EMBASE, CINAHL, PsycINFO, Sociological Abstracts, Cochrane Library and the Joanna Briggs Institute Database of Systematic Reviews. We searched for studies published from 1 January 2013 to 30 August 2023 to include a 10-year time span as per rapid review methods.[22 23] We developed the strategy with a medical librarian and complied with the Peer Review of Electronic Search Strategy reporting guidelines.[26] The strategy was purposefully broad to be as inclusive as possible given that exploratory searching to plan the comprehensive search strategy ultimately used had revealed relatively few studies; hence, we did not impose a limit to women-only studies. While rapid reviews generally require a single screener,[22 23] ARG (PhD-trained principal investigator experienced in syntheses and healthcare disparities among immigrant women), EN (university undergraduate trainee) and SS (master of public health candidate) independently screened the first 50 search results against eligibility criteria, then met to discuss and resolve discrepancies. They repeated this process for the next 50 search results when screening decisions were fully congruent. Thereafter, EN and SS screened all titles, routinely consulting with ARG to resolve uncertainties. The full-text screening was undertaken concurrent to data extraction.

Data collection

EN, SS and ARG pilot-tested data extraction on five studies, then met to discuss and resolve discrepancies. They repeated this process for another five studies when data extraction was fully congruent. Thereafter, EN and SS extracted data from the remaining included studies, routinely consulting with ARG to address uncertainties. We extracted data on study characteristics (author, publication year, country, aim, research design and participant demographics), community agency type, target group of health promotion programme, details of the health promotion programme or intervention including label used for CHW and description of how programmes were culturally tailored; and results including determinants, participation rates or impacts. In studies that assessed feasibility or impact, we described health promotion programmes or interventions using the Workgroup for Intervention Development and Evaluation Research (WIDER) framework: content, format, delivery, timing, personnel.[27] ARG and EZ (PhD-trained nurse practitioner co-principal investigator experienced in syntheses and healthcare disparities among sexually/gender-diverse women) reviewed all extracted data.

Data analysis

We used summary statistics to report study characteristics, community agency type and target group of health promotion programme and used text and tables to report the details of health promotion programmes or interventions including label for CHWs and study results. In the absence of an established framework of cultural safety, we summarised the details of cultural tailoring. To categorise the implementation and impact of health promotion programmes or interventions, we mapped study results to the Reach Effectiveness Adoption Implementation (RE-AIM) framework.[28] RE-AIM has been widely used to plan, characterise and evaluate the implementation and adoption of healthcare innovations.[28] RE-AIM is composed of five domains: reach (target population), effectiveness (efficacy), adoption (by staff, organisations, systems), implementation (consistency, costs)

and maintenance (use over time). To categorise the way that studies reported results pertaining to health promotion capacity, we mapped components of capacity to the New South Wales Framework for Building Capacity to Improve Health (NSW framework), the most widely cited health promotion capacity-building model.[29] The NSW framework more completely aligns with the WHO definition of health promotion capacity[25] compared with other theories, models or frameworks relevant to public health promotion capacity.[30] The NSW framework includes five action areas: organisational development, workforce development, resource allocation, leadership and partnerships.[29]

Patient and public involvement

The research team included five women advisors, three representing immigrant perspectives and two representing sexually/gender-diverse perspectives. They were involved in developing the application for funding by sharing feedback on the proposal background and methods; and once funded, we met with them to revisit and refine the objectives and methods. As the study progressed, women advisors reviewed and provided feedback to refine eligibility criteria, an interim sample of data extraction, a summary of extracted data and a draft manuscript. Once published, they will review and comment on a one-page public summary of the findings.

RESULTS

Search results

Figure 1 shows the PRISMA diagram. Searching resulted in 1490 items. Removing duplicates resulted in 1370 items. Screening of titles excluded 1278 items. Screening of 92 full-text articles eliminated 73 items for the following reasons: not relevant to or did not include 50%+ diverse women (n=33), did not focus on community-based health promotion (n=36) or ineligible publication type (n=4). Ultimately, we included 19 studies reported in 21 articles. Summary statistics were based on a denominator of 19 studies. Online supplemental file 3 includes data extracted from the included articles.[31–51]

Study characteristics

Table 1 summarises the details of the included studies. Studies were published from 2017 to 2023. The majority of studies were based in the USA (15, 78.9%) plus 2 (10.5%) in Australia and 1 (5.3%) each in Canada and the UK. Regarding research design, most studies were prospective (8, 42.1%) or before-and-after cohort (6, 31.6%) studies. Two (10.5%) studies employed multiple methods, two (10.5%) only qualitative interviews and one (5.3%) study was a randomised trial. Among the included studies, 15 (78.9%) examined the impact of a health promotion intervention, 2 (10.5%) examined determinants of health promotion programme delivery or sustainability and 2 (10.5%) explored components of current or needed health promotion capacity. Eight (42.1%) studies included women only, and the 11 remaining studies included a range of 50.0%–97.0% women. No studies involved sexually/gender-diverse women. All studies involved ethnoculturally diverse persons although many did not specify immigration status: 12 (63.2%) African Black, 6 (31.6%) Latin, 2 (10.5%) Arabic/Middle Eastern and 2 (10.5%) Sikh/South Asian. Agencies engaged in health promotion included faith-based (14, 73.7%), health advocacy (5, 26.3%) and various community or

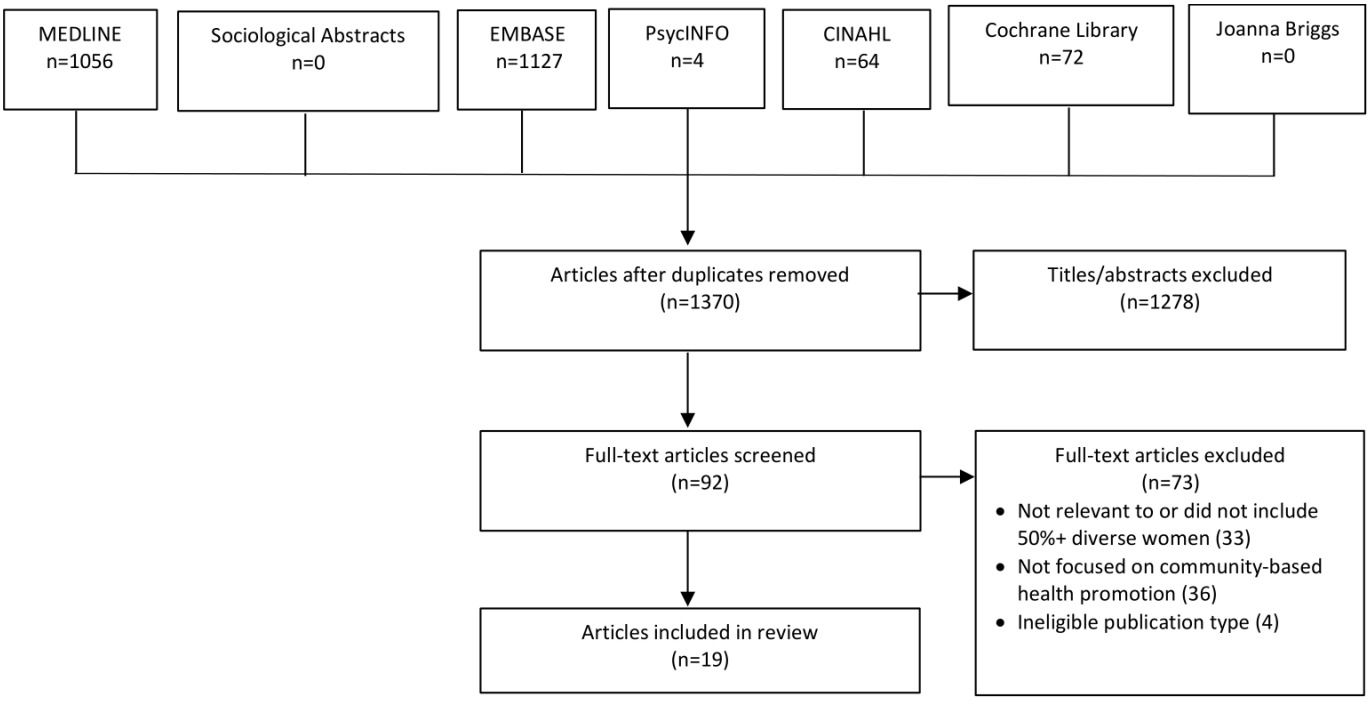

Figure 1 PRISMA diagram. PRISMA, Preferred Reporting Items for Systematic Reviews and Meta-Analyses.

Table 1 Summary of study characteristics

Study (ref)	Date	Country	Research design	Health promotion topic	Women specific	Target group	Agency type	Aim
Filippone[31]	2023	USA	Cohort (interviews)	HIV/STI prevention	Yes	African and Latin Americans	Health advocacy	Pilot test feasibility, acceptability and impact among participants
Majee[32]	2022	USA	Cohort (interviews)	Reduce chronic disease	No	African American	Faith	Explore programme impact on agencies and participants
Power[33]	2022	Australia	Multiple methods (questionnaire, focus groups, interviews)	Cervical cancer screening	Yes	African and Middle Eastern Australians	Community services	Pilot test feasibility, acceptability and impact among participants
Arredondo[34 35]	2017, 2022	USA	Randomised controlled trial (questionnaire, activity and physiological measures)	Physical activity	Yes	Latina Americans	Faith	Asses impact on participants
Wells[36]	2020	USA	Cohort (interviews)	Diabetes prevention	No	African and Latin Americans	Faith	Identify barriers faced by peer educators
Crankshaw[37]	2020	USA	Cohort (questionnaire)	Stomach cancer prevention	No	African Americans	Faith	Pilot test feasibility, acceptability and impact among participants
Brown[38]	2020	UK	Before-and-after cohort (questionnaire)	Maternal health	Yes	African Black women	Faith, health advocacy	Pilot test feasibility, acceptability and impact among participants
Slewa-Younan[39]	2020	Australia	Before-and-after cohort (questionnaire)	Mental health	No	Arabic Australians	Faith, community services	Assess impact on clergy and community leaders
Phillip[40]	2019	USA	Cohort (participation rates)	Lupus management	No	African Americans	Faith, health advocacy, community services	Assess reach of peer leaders
Morales-Alemán[41]	2018	USA	Cohort (questionnaire)	Colorectal cancer, diabetes prevention	No	African Americans	Faith	Assess impact of training on peer leaders
Askari[42]	2018	USA	Cohort (questionnaire)	Dementia	No	Latin Americans	Community service	Assess the impact of training on lay health promoters
Hempstead[43]	2018	USA	Before-and-after cohort (questionnaire)	Breast cancer screening	Yes	African American	Health advocacy	Assess the impact of training on peer educators and of their training on community participants

Continued

Table 1 Continued

Study (ref)	Date	Country	Research design	Health promotion topic	Women specific	Target group	Agency type	Aim
Brand[44]	2018	USA	Cohort (questionnaire)	Capacity for health promotion	No	African American	Faith	To assess link between capacity and programmes
Brand[45]	2017	USA	Qualitative (interviews)	Capacity for health promotion	No	African American	Faith	Identify key elements of health promotion capacity
Northridge[46]	2017	USA	Before-and-after cohort (questionnaire)	Oral health	No	Sikh Americans	Faith	Assess impact on participants of peer-led sessions
Shelton[47 48]	2017 2016	USA	Multiple methods (questionnaire, interviews)	Breast and cervical cancer screening	Yes	African Americans	Health advocacy	Explore determinants of programme sustainability
Schwingel[49]	2017	USA	Before-and-after cohort (questionnaires, interviews)	Physical activity, nutrition and stress management	Yes	Latina Americans	Faith	Assess programme impact on participants and feasibility among promotoras
Banerjee[50]	2017	Canada	Before-and-after cohort (questionnaire)	Physical activity	Yes	South Asian Muslim women	Faith	Assess feasibility, acceptability and impact among participants
Leyva[51]	2017	USA	Qualitative (interviews)	Cancer prevention and screening	No	Latin Americans	Faith	Explore existing and needed capacity

HIV, human immunodeficiency virus; STI, sexually transmitted infection.

support services (4, 21.0%). Studies addressed a wide range of health promotion topics: healthy lifestyle (eg, physical activity, nutrition) to prevent chronic diseases (6, 31.6%), cancer (eg, breast, cervical, colorectal, stomach) prevention and screening (6, 31.6%), mental health (2, 10.5%), agency capacity for health promotion (2, 10.5%) and 1 (5.3%) each for HIV prevention, maternal health, lupus management and oral health.

Programme characteristics

Table 2 describes the components of health promotion programmes or interventions in 15 (78.9%) studies based on the WIDER framework.[27] One study reported only personnel (public health lifestyle coaches, church leaders) and content (healthy lifestyle behaviours) but did not report programme format, delivery or timing.[32] Among the remaining 14 studies, 7 (50.0%) focused on training of CHWs.[36 38 40–43 49] Those individuals were referred to as facilitator, lay health advisor, church leader, congregational health leader, popular opinion leader, community leader, community educator, peer educator (two studies), promotora (three studies) and parent champion. All involved in-person group sessions of didactic lecture and interactive discussion, and four of those studies also provided CHWs with a toolkit they could use for training others. One study trained CHWs in a single 6-hour session, and the remaining five studies offered weekly sessions of 2–3 hours over a range of 2–12 weeks.

Another 7 (50.0%) studies involved CHW training of target participant groups.[31 33–35 37 39 46 50] One of those studies involved only 1-hour physical activity sessions offered three times weekly over 24 weeks.[50] The remaining six studies involved in-person group lecture and/or discussion supplemented with goal-setting, quizzes, videos, role-play, print material, physical activity, follow-up phone calls, mailed handouts or information to share with physicians. Programme duration ranged widely from a single session to two sessions weekly over 2 years.

Apart from offering health promotion via local, familiar community agencies and affiliated CHWs, few (5, 26.3%) studies described cultural tailoring of health promotion programme interventions. In most of those studies, descriptions were vague and did not identify the norms, beliefs or concerns, or specifically what content addressed those issues. For example, 'adapting key messages and developing content to address cultural norms and religious beliefs, knowledge gaps and misinformation',[33] 'while ensuring this information was presented within a culturally valid framework'[39] or 'included content to address concerns in a culturally sensitive manner'.[42] In four studies, the content was delivered in Arabic, Spanish or South Asian language of choice.[39 42 49 50] In two studies, videos featured persons of the same ethnocultural group as participants.[39 42] In one study, content included home-based activities given the influence of family among older Latinas,[49] and in one study, the programme was delivered in the evening so as not to interfere with South Asian women's family responsibilities.[50]

Programme impact

Table 3 characterises implementation and impact based on the RE-AIM framework among 15 (78.9%) studies that evaluated health promotion programme interventions.[30] Few studies examined adoption (1, 6.7%), referring to the number or attributes of agencies or staff that delivered programmes, or maintenance (1, 6.7%), referring to institutionalisation or sustained impact on participants.[34 35] No studies assessed implementation, referring to consistency, fidelity, time or cost. Most (13, 86.7%) studies assessed programme effectiveness, referring to impact on participants. Among those 13 studies, all reported positive impacts including knowledge,[31–33 38 39 41–43 46] self-efficacy,[31 46 50] intention to modify behaviour,[33 43] behaviour change[34 35 37 39 46 49 50] and health outcomes such as improved body mass index[34 35] and decreased anxiety or depression postintervention.[38 49]

Several (9, 53.3%) studies also assessed reach, referring to the number of participants[31 36–38 40 50] or enablers or barriers to participation.[33 36 47–49] Enablers of programme delivery included partnerships, leadership vision and networking, personal motivation among CHWs, CHWs being able to tailor content to the norms and values of participants and deliver programmes in the participants' first language; and use of in-person sessions that enhanced engagement of the participants. Barriers to programme delivery included limited funding and resources, lack of space to deliver training programmes, burn-out among CHWs; the overwhelming complexity and volume of health-related information from the perspective of CHWs undergoing training; and scheduling of training sessions given multiple competing demands (eg, work, family) among trainees (CHWs, participants).

Health promotion capacity

Table 4 characterises the components of health promotion capacity based on the NSW Framework.[29] Among the 19 included studies, most (14, 73.7%) addressed workforce development, referring to training of CHWs and related impacts such as participation rates or learning outcomes.[33–36 39 49 51] Another eight (42.1%) addressed partnerships by naming the entities involved in planning and/or delivering the health promotion intervention and describing the planning process.[31 32 36–38 40 47 48 51] Fewer studies mentioned organisational development such as policies or structures (5, 26.3%),[36 44 45 47 48 51] or resource allocation (5, 26.3%) such as physical, human or financial resources.[36 44 45 47 48 51] Only three (15.8%) studies referred to leadership issues such as vision or skills.[36 47 48 51]

Two (10.5%) studies specifically assessed community agency capacity for health promotion. One study surveyed 108 churches and reported that churches with greater health promotion readiness, defined by physical structure, personnel, funding, cultural/social support

Table 2 Characteristics of health promotion programme interventions

	Programme characteristics by WIDER framework[27]				
Study topic	**Personnel**	**Content**	**Format**	**Delivery**	**Timing**
Filippone HIV/STI prevention[31]	Agency staff (educators, counsellors)	HIV/STI risk management and stigma; strategies for intimate relationship communication; HIV/STI testing information	Lecture Discussion Goal-setting Quizzes	In-person group session	4 sessions/week 120 min each Over 17 months
Majee Chronic disease prevention[32]	Local health department lifestyle coaches, church leaders	Physical activity, healthy eating and self-management	Not reported	Not reported	Not reported
Power Cervical cancer screening[33]	Trained facilitators (volunteers from local community)	Cervical screening testing+Breast and bowel screening, stress management, bone health	Lecture Discussion Print material	In-person or virtual group session	In-person: Single session of 1.5–4 hours Virtual: 1–3, 60–90 min sessions
Arredondo Physical activity[34 35]	Peer leaders (promotoras)	Physical activity Goal setting Overcoming barriers+phone calls addressed barriers to physical activity and solutions	Physical activity sessions (walking, dance)+Discussion Handouts	In-person group meetings+phone calls	2 physical activity sessions weekly over 2 years 3 or 4 30 min phone calls+monthly mailed handout
Wells Preventing and managing diabetes[36]	Diabetes educator from a health quality institute trained volunteer peer educators	6 modules on self-management: problem-solving, decision-making, resource utilisation, partnering with healthcare providers, action planning and self-tailoring	Lecture Discussion+Toolkit including facilitation guide and handouts	In-person group session	1 session/week 90 min each Over 6 weeks
Crankshaw pylori screening to prevent stomach cancer[37]	Study staff shared information, gave breath test; a nurse drew blood sample	Pylori's role in gastric cancer, study protocol and how to register. After the event: test results, recommendation to speak with family doctor	Lecture+single day clinical screening event+mailed letter of test results	In-person group session Mailed documents	1 full day screening event
Brown Maternal health[38]	Parents were trained by research staff to facilitate all sessions	Parenting strategies, links to resources+mental health aspects in parenting, baby's healthy development	Lecture Discussion Socialising+Health education course	Both sessions: In-person group meetings	Both sessions: Weekly meeting 2 hours each Over 12 weeks
Slewa-Younan Mental health[39]	Two clinicians trained religious leaders	Mental health, treatment, stigma	Lecture Discussion Videos	In-person group meeting	Single session 6 hours each
Phillip Lupus management[40]	Clinician, social scientists and study staff trained community leaders	Lupus causes, symptoms, treatment and self-management; and teaching	Lecture Discussions+Toolkit including slides, fact sheets and cue cards	In-person group meetings	Weekly meeting 2–3 hours each Over 4 weeks
Morales-Aleman Diabetes and colorectal cancer prevention[41]	Researchers and healthcare providers trained congregational health leaders	Nutrition, physical activity, stress management, diabetes prevention and management, colorectal cancer screening; and health promotion skills	Lecture Discussion	In-person group meetings	Weekly meeting 2 hours each Over 8 weeks

Continued

Table 2 Continued

Study topic	Programme characteristics by WIDER framework[27]				
	Personnel	**Content**	**Format**	**Delivery**	**Timing**
Askari Dementia[42]	Community agency staff (promotoras)	Dementia, purpose of programme, communication skills, dementia assessment techniques	Lecture Discussion Video	In-person group meetings	2 sessions
Hempstead Breast cancer screening[43]	Clinicians and community agency directors trained peer educators	Breast cancer, screening, resources for breast cancer screening and treatment, and how to provide peer education and support	Lecture Discussion Toolkit (flip chart, handouts)	In-person group meetings	Peer educators Single session, 6 hours Workshops Single session, 60–90 min
Northridge Oral health[46]	Community educators	Access to health and dental insurance, proper oral hygiene, healthy lifestyle behaviours	Lecture Discussion Links to online videos	In-person group meetings	Single session of 60–75 min
Schwingel Physical activity, nutrition and stress management[49]	Promotoras Spanish-speaker member of research team Participants Promotoras	Promotoras Programme content, training skills and strategies Participants Goals and action plan, healthy lifestyle behaviours	Promotoras Lecture Discussion Role-playing Participants Lecture Discussion Phone calls	Promotoras In-person group meeting Participants In-person meetings and group workshop	Promotoras 9 workshops of 2 hours each Participants Single 1-hour meeting+6 workshops (duration not reported) over 6 months+weekly 1-hour phone call over 24 weeks
Banerjee Physical activity[50]	Muslim female kinesiologists who spoke Hindi, Urdu and/or Gujarati	Circuit training	Aerobic and strength training	In-person group activity	1-hour sessions 3 times weekly Evenings Over 24 weeks

WIDER, Workgroup for Intervention Development and Evaluation Research.

and total infrastructure, were more likely to conduct health promotion.[44] Another study found that role clarity and self-efficacy among CHWs, and having academic partners increased personnel retention and the number of health promotion programmes offered.[47 48]

Two (10.5%) additional studies explored current or needed community agency capacity for health promotion. During interviews, 36 church leaders said that they needed funding, personnel, facilities/space, health-related materials and partnerships with academic, healthcare and charitable organisations.[45] Another study involving interviews with 18 church leaders similarly revealed a need for funding, dedicated personnel, training on health-related issues, space and partnerships.[51]

DISCUSSION

This review of community agency capacity for health promotion to diverse women included 19 studies published in 2017 or later. The majority of studies took place in faith-based organisations in the USA and focused on a wide range of health promotion topics for African or Latin Americans. Few studies focused solely on women, and no studies focused on or included sexually/gender-diverse women. Most studies assessed the impact of training CHWs or the impact on participants of training by CHWs, and all of those studies reported beneficial impacts on knowledge, self-efficacy, intention to modify behaviour, behaviour change and health outcomes. Few studies assessed organisational capacity for, or cultural tailoring of health promotion, yielding limited insight on how to design and implement community-based health promotion for ethnoculturally, sexually or gender-diverse women.

Prior research either emphasised the need to address migrant health[52] or described approaches used to assess community-based health promotion capacity. For example, Birgel *et al* conducted a scoping review of 38 studies published from 1990 to 2022 to describe the domains and methods used to assess community capacity for health promotion.[53] Studies assessed nine domains: collaboration, participation, leadership, knowledge and skills, critical awareness and problem-solving, sense of

Table 3 Summary of programme implementation and impact in included studies

	Impact by RE-AIM framework[30]				
	Reach	Effectiveness	Adoption	Implementation	Maintenance
Study	Number, proportion or representativeness of participants; enablers or barriers to participation	Impact on participant knowledge, views, behaviour or health outcomes	Number, proportion or characteristics of agencies or staff that deliver a programme; enablers or barriers to programme delivery	Consistency of programme delivery as intended by agency or staff; time and cost	Extent of programme institutionalisation or long-term sustained use by participants
Filippone[31]	✓	✓	--	--	--
Majee[32]	--	✓	--	--	--
Power[33]	✓	✓	--	--	--
Arredondo[34 35]	--	✓	--	--	✓
Wells[36]	✓	--	✓	--	--
Crankshaw[37]	✓	✓	--	--	--
Brown[38]	✓	✓	--	--	--
Slewa-Younan[39]	--	✓	--	--	--
Phillip[40]	✓	--	--	--	--
Morales-Alemán[41]	--	✓	--	--	--
Askari[42]	--	✓	--	--	--
Hempstead[43]	--	✓	--	--	--
Northridge[46]	--	✓	--	--	--
Shelton[47 48]	✓	--	--	--	--
Schwingel[49]	✓	✓	--	--	--
Banerjee[50]	✓	✓	--	--	--
Total	9	13	1	0	1

RE-AIM, Reach Effectiveness Adoption Implementation.

community, resources, community structure and community power. Studies employed seven theoretical frameworks, including the NSW framework that we employed[28] and seven instruments to assess capacity. The aim of our study, to describe the design and implementation of effective community-based health promotion programmes specific to diverse women, differed from that of Birgel's, which was to describe how community health promotion had been studied. Moreover, it is difficult to compare findings because our study specifically focused on health promotion led by community agencies such as immigrant settlement services, support groups or faith organisations, whereas Birgel did not define 'community', which could refer to groups of people or settings where health promotion is delivered. Other research has focused on the role of CHWs. Similar to prior research,[16] our review revealed that CHWs are referred to by multiple labels. Ahmed *et al* reviewed research on CHWs in low-income and middle-income countries, whereas our review examined community agencies and affiliated CHWs in higher-income countries due to high rates of migration.[54] Sugarman *et al* surveyed and interviewed CHWs employed in government or social service agencies in the American state of Louisiana, which revealed diverse views about CHW roles, training and credentialing.[55] In contrast, our review examined the design and impact of training of CHWs affiliated with community agencies, and CHW impact on health promotion knowledge, behaviour and associated outcomes among diverse women. A systematic review of 61 studies examined CHW training and impact.[56] Unlike our study, CHWs were employed in formal healthcare organisations, but their roles of health education, counselling, navigation assistance and social support improved cancer screening and cardiovascular risk reduction behaviour.[56] Like our study, the length and duration of CHW training varied widely across studies. Another systematic review by McCollum *et al* examined the equity of CHW programmes, but again, CHWs were affiliated with healthcare organisations, and equity was defined in terms of whether health outcomes were improved or not.[57] Hence, our study is unique in that it focused on health promotion specifically for diverse women offered by CHWs affiliated with community agencies that were not governmental or part of the formal healthcare system.

Table 4 Summary of health promotion capacity addressed in included studies

	Health promotion capacity by New South Wales framework[28]				
	Organisational development	Workforce development	Resource allocation	Leadership	Partnerships
Study	Policies/procedures Strategic directions Org structures Management support Reward systems Information systems Quality systems Informal culture	Workforce learning External courses Professional development Education/training Professional support Performance management	Financial resources Human resources Access to information Specialist advice Decision support Admin support Physical resources	Interpersonal skills Technical skills Personal qualities Strategic visioning Systems thinking Visioning the future Org management	Shared goals Relationships Planning Implementing Evaluation Sustained
Filippone[31]	--	--	--	--	✓
Majee[32]	--	--	--	--	✓
Power[33]	--	✓	--	--	--
Aredondo[34 35]	--	✓	--	--	--
Wells[36]	✓	✓	✓	✓	✓
Crankshaw[37]	--	--	--	--	✓
Brown[38]	--	--	--	--	✓
Slewa-Younan[39]	--	✓	--	--	--
Phillip[40]	--	✓	--	--	✓
Morales-Alemán[41]	--	✓	--	--	--
Askari[42]	--	✓	--	--	--
Hempstead[43]	--	✓	--	--	--
Brand[44]	✓	✓	✓	--	--
Brand[45]	✓	✓	✓	--	--
Northridge[46]	--	✓	--	--	--
Shelton[47 48]	✓	✓	✓	✓	✓
Schwingel[49]	--	✓	--	--	--
Banerjee[50]	--	--	--	--	--
Leyva[51]	✓	✓	✓	✓	✓
Total	5	14	5	3	8

The findings of this review give rise to several implications for policy, practice and ongoing research. While few studies specifically or comprehensively examined health promotion capacity, study findings yield some insight into essential components. For example, in interviews, key informants most often mentioned the need for funding, dedicated personnel, training in healthcare issues, space and partnerships. Moreover, determinants of health promotion programme delivery and sustainability can also inform the design and implementation of community agency health promotion capacity. For example, enablers included partnerships, leadership vision and networking, personal motivation among CHWs, CHWs being able to tailor content to the norms and values of participants and deliver programmes in the participants' first language; and use of in-person sessions that enhanced engagement of the participants. Barriers included limited funding and resources, lack of space to deliver training programmes, burn-out among CHWs, the overwhelming complexity and volume of content from the perspective of CHWs undergoing training and scheduling of training sessions given multiple competing demands (eg, work, family) among participants including CHWs undergoing training and target groups receiving training. Community agencies are a preferred source of health advice and information among ethnoculturally, sexually and gender-diverse women, so if they are to fulfil that role, further research is required on how to bolster the components of health promotion capacity that they emphasised. In the meantime, governments and healthcare systems can improve prevention and screening behaviour for equity-seeking women by partnering with

community agencies and investing in the components of health promotion capacity identified here as essential.

Given that most studies evaluated the training of CHWs, or the impact of CHW training on participants' knowledge, self-efficacy, intention, behaviour and health outcomes, CHWs are clearly an essential component of health promotion capacity in community agencies. Prior reviews focused on CHWs employed by government or healthcare organisations,[55–57] therefore, future primary research is warranted on the attributes and roles of CHWs employed by community agencies, particularly those that are not faith based, which predominated agency type in included studies. Furthermore, ongoing research is needed on community agency health promotion specifically for diverse women including immigrants of various ethnocultural groups other than African or Latino Americans, who may or may not be immigrants, and specifically for sexually/gender-diverse women, given that no studies examined community-based health promotion for 2SLGBTQ+ women. Another knowledge gap identified by this review was the lack of detail on cultural tailoring of health promotion programmes apart from the use of first language, videos featuring persons of the same ethnocultural group, and offering programmes in the evening to accommodate ethnoculturally diverse women's home responsibilities. Hence, ongoing research must delve into what constitutes cultural safety of community agency health promotion programmes for different groups of equity-seeking women. Given the wide range of health issues for which diverse women face inequities, not limited to cancer screening[5]; prenatal, perinatal and postnatal care,[6] and unmet healthcare needs,[8] such research might be further scoped by examining how to promote health via community agencies for specific conditions. For example, women in general, and racialised immigrant women in particular, face inequities in access to and quality of cardiovascular care and would benefit from heart health promotion via community agencies.[58]

Strengths of our review included use of rigorous review methods including searching multiple databases,[21 22] and compliance with reporting criteria for reviews and search strategies.[24 26] To enhance methodological rigour, multiple researchers conducted screening and data extraction. To optimise analysis, we organised findings by multiple frameworks to describe and identify gaps in health promotion programme intervention design, programme implementation and components of health promotion capacity using WIDER,[27] RE-AIM[28] and the NSW Framework.[29] Furthermore, the research team, including five diverse women advisors, informed and reviewed all findings. We must also mention some limitations. As in any review, the search strategy may not have identified all relevant studies. Few studies focused solely on women so we included studies where health promotion could benefit women and participants included at least 50% of women. While this decision may have excluded studies that described community-based health promotion, we purposefully chose to include only studies in which at least half of the participants were women to optimise the relevance to women of the evaluated health promotion programmes. Even so, only 42.1% (8/19) of studies included solely women and the remaining studies included a range of 50.0% to 97.0% women; thus, even imposing the seemingly restrictive criteria of 50%+ women did not result in studies that largely focused on women, revealing a gap in prior research on community-based health promotion specifically targeting women. Moreover, only 36.8% (7/19) of studies evaluated the outcomes of health promotion programmes delivered to clients, further emphasising a gap in knowledge about the ideal design of such programmes. Although these gaps mean that we did not fully achieve the objective of this review, gaps represent important knowledge that can inform future research.

CONCLUSION

Given diverse women's tendency to access health information and advice via community agencies, this study aimed to understand the capacity needed by community agencies to offer culturally safe health promotion. Most of the 19 included studies published from 2017 to 2023 focused on health promotion to African or Latin American persons in faith-based organisations. Few studies focused solely on women or specified immigrant status, no studies focused on or included sexually/gender-diverse women, and few studies evaluated the outcomes of health promotion programmes. Training of CHWs to deliver health promotion education and CHW training of health promotion participants on a wide range of health promotion topics using in-person group education sessions resulted in improved knowledge, self-efficacy, intention to modify behaviour, behaviour change and health outcomes, confirming the important role of community agencies and affiliated CHWs. However, the use of the RE-AIM and NSW frameworks to analyse data revealed gaps in knowledge about what constitutes and how to implement community agency capacity for health promotion. Furthermore, few studies described cultural tailoring of health promotion programmes beyond the use of participants' first language. A few studies exploring enablers and barriers yielded some insight into what community agencies need to enable health promotion: dedicated funding and personnel, training in healthcare issues, space and partnerships with academic and healthcare organisations. By revealing aforementioned gaps, this study informs future research on how to achieve culturally safe community agency health promotion for diverse women.

Acknowledgements We thank our women advisors (AM, KP, MM, PL and SC), clinical collaborators (EB, SB, MK and LS) and agency collaborators (Africa Caribbean Heritage Alliance, Calgary Immigrant Women's Association, Moyo Healthcare and Community Services, Pacific Immigrant Resources Society, Windsor Women Working with Immigrant Women) for their contributions to planning and executing this work.

Contributors ARG and EZ conceived and acquired funding for this study and supervised all aspects of its conduct. SA, OCA, SW and ANS contributed to conceiving and planning the study and reviewed all data. EN and SS assisted in searching, screening, data extraction and analysis. All authors drafted the manuscript and approved this final version. ARG accepted full responsibility for the finished work and/or the conduct of the study, had access to the data and controlled the decision to publish. ARG accepts full responsibility for the work and conduct of the study, had access to the data, and controlled the decision to publish.

Funding This work was supported by the Canadian Institutes of Health Research grant number 190090.

Competing interests None declared.

Patient and public involvement Patients and/or the public were involved in the design, or conduct, or reporting, or dissemination plans of this research. Refer to the Methods section for further details.

Patient consent for publication Not applicable.

Ethics approval We did not acquire institutional review board approval because we did not collect data from human subjects. We did not register a protocol for this review.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement All data relevant to the study are included in the article or uploaded as online supplemental information.

ORCID iD

Anna R Gagliardi http://orcid.org/0000-0002-5721-809X

REFERENCES

1 Women's health surveillance report. Ottawa, Canada: Canadian Institute for Health Information; 2003.
2 UN Women. Gender equality in the 2030 agenda for sustainable development. New York, United States: United Nations Entity for Gender Equality and the Empowerment of Women; 2018.
3 Bennett AL, Lavie CJ, Grace SL. Cardiac Rehabilitation Following Acute Coronary Syndrome in Women. *Curr Treat Options Cardiovasc Med* 2017;19:57.
4 Gagné S, Vasiliadis H-M, Préville M. Gender differences in general and specialty outpatient mental health service use for depression. *BMC Psychiatry* 2014;14:135.
5 Vahabi M, Lofters AK, Kopp A, *et al*. Correlates of non-adherence to breast, cervical, and colorectal cancer screening among screen-eligible women: a population-based cohort study in Ontario, Canada. *Cancer Causes Control* 2021;32:147–55.
6 Khanlou N, Haque N, Skinner A, *et al*. Scoping Review on Maternal Health among Immigrant and Refugee Women in Canada: Prenatal, Intrapartum, and Postnatal Care. *J Pregnancy* 2017;2017:8783294.
7 Scheim AI, Coleman T, Lachowsky N, *et al*. Health care access among transgender and nonbinary people in Canada, 2019: a cross-sectional survey. *CMAJ Open* 2021;9:E1213–22.
8 Steele LS, Daley A, Curling D, *et al*. LGBT Identity, Untreated Depression, and Unmet Need for Mental Health Services by Sexual Minority Women and Trans-Identified People. *J Womens Health (Larchmt)* 2017;26:116–27.
9 Filler T, Jameel B, Gagliardi AR. Barriers and facilitators of patient centered care for immigrant and refugee women: a scoping review. *BMC Public Health* 2020;20:1013.
10 Gagliardi AR, Kim C, Jameel B. Physician behaviours that optimize patient-centred care: Focus groups with migrant women. *Health Expect* 2020;23:1280–8.
11 Rathanaswami K. Physical Activity in First Generation South Asian Women Living in Canada: Barriers and Facilitators to Participation (Dissertation). Montreal, QC:: McGill University, 2016.
12 Frisby W. Promising Physical Activity Inclusion Practices for Chinese Immigrant Women in Vancouver, Canada. *Quest* 2011;63:135–47.
13 Higgins R, Hansen B, Jackson BE, *et al*. Programs and interventions promoting health equity in LGBTQ2+ populations in Canada through action on social determinants of health. *Health Promot Chronic Dis Prev Can* 2021;41:431–5.
14 Curtis E, Jones R, Tipene-Leach D, *et al*. Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. *Int J Equity Health* 2019;18:174.
15 Mackean T, Fisher M, Friel S, *et al*. A framework to assess cultural safety in Australian public policy. *Health Promot Int* 2020;35:340–51.
16 Taylor B, Mathers J, Parry J. Who are community health workers and what do they do? Development of an empirically derived reporting taxonomy. *J Public Health (Oxf)* 2018;40:199–209.
17 Najafizada SAM, Bourgeault IL, Labonte R, *et al*. Community health workers in Canada and other high-income countries: A scoping review and research gaps. *Can J Public Health* 2015;106:e157–64.
18 Montemurro GR, Raine KD, Nykiforuk CIJ, *et al*. Exploring the process of capacity-building among community-based health promotion workers in Alberta, Canada. *Health Promot Int* 2014;29:463–73.
19 Morency JD, Caron Malenfant E, MacIsaac S. Immigrant and diversity: population projections for Canada and its regions, 2011 to 2036. Ottawa, Canada: Statistics Canada; 2017.
20 World Health Organization. Global action plan, 2019–2023: promoting the health of refugees and migrants. New York, United States: WHO Press; 2019.
21 Paré G, Trudel M-C, Jaana M, *et al*. Synthesizing information systems knowledge: A typology of literature reviews. *Information & Management* 2015;52:183–99.
22 Tricco AC, Antony J, Zarin W, *et al*. A scoping review of rapid review methods. *BMC Med* 2015;13:224.
23 Moher D, Liberati A, Tetzlaff J, *et al*. Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. *PLoS Med* 2009;6:e1000097.
24 Macdonald V, Verster A, Mello MB, *et al*. The World Health Organization's work and recommendations for improving the health of trans and gender diverse people. *J Int AIDS Soc* 2022;25 Suppl 5:e26004.
25 Smith BJ, Tang KC, Nutbeam D. WHO Health Promotion Glossary: new terms. *Health Promot Int* 2006;21:340–5.
26 McGowan J, Sampson M, Salzwedel DM, *et al*. PRESS Peer Review of Electronic Search Strategies: 2015 Guideline Statement. *J Clin Epidemiol* 2016;75:40–6.
27 Albrecht L, Archibald M, Arseneau D, *et al*. Development of a checklist to assess the quality of reporting of knowledge translation interventions using the Workgroup for Intervention Development and Evaluation Research (WIDER) recommendations. *Implement Sci* 2013;8:52.
28 New South Wales Health Department. A framework for building capacity to improve health. Gladesville, Australia: NSW Health Department; 2001. Available: https://yeah.org.au/wp-content/uploads/2014/07/A-Framework-for-Building-Capacity-to-Improve-Health.pdf [accessed 02 Jan 2024]
29 Bergeron K, Abdi S, DeCorby K, *et al*. Theories, models and frameworks used in capacity building interventions relevant to public health: a systematic review. *BMC Public Health* 2017;17:914.
30 Glasgow RE, Harden SM, Gaglio B, *et al*. RE-AIM Planning and Evaluation Framework: Adapting to New Science and Practice With a 20-Year Review. *Front Public Health* 2019;7:64.
31 Filippone PL, Hernandez Trejo Y, Witte SS. Demonstrating the Feasibility of an Economic Empowerment and Health Promotion Intervention among Low-Income Women Affected by HIV in New York City. *Int J Environ Res Public Health* 2023;20:5511.
32 Majee W, Anakwe A, Onyeaka K, *et al*. Participant Perspectives on the Effects of an African American Faith-Based Health Promotion Educational Intervention: a Qualitative Study. *J Racial Ethn Health Disparities* 2023;10:1115–26.
33 Power R, Ussher JM, Hawkey A, *et al*. Co-designed, culturally tailored cervical screening education with migrant and refugee women in Australia: a feasibility study. *BMC Womens Health* 2022;22:353.
34 Arredondo EM, Haughton J, Ayala GX, *et al*. Two-year outcomes of Faith in Action/Fe en Acción: a randomized controlled trial of

physical activity promotion in Latinas. *Int J Behav Nutr Phys Act* 2022;19:97.
35 Arredondo EM, Elder JP, Haughton J, *et al*. Fe en Acción: Promoting Physical Activity Among Churchgoing Latinas. *Am J Public Health* 2017;107:1109–15.
36 Wells R, Breckenridge ED, Linder SH. Wellness project implementation within Houston's Faith and Diabetes initiative: a mixed methods study. *BMC Public Health* 2020;20:1050.
37 Crankshaw S, Butt J, Gierisch JM, *et al*. The Durham Initiative for Stomach Health (DISH): a pilot community-based Helicobacter pylori education and screening study. *BMC Gastroenterol* 2020;20:261.
38 Brown J, Luderowski A, Namusisi-Riley J, *et al*. Can a Community-Led Intervention Offering Social Support and Health Education Improve Maternal Health? A Repeated Measures Evaluation of the PACT Project Run in a Socially Deprived London Borough. *Int J Environ Res Public Health* 2020;17:2795.
39 Slewa-Younan S, Guajardo MGU, Mohammad Y, *et al*. An evaluation of a mental health literacy course for Arabic speaking religious and community leaders in Australia: effects on posttraumatic stress disorder related knowledge, attitudes and help-seeking. *Int J Ment Health Syst* 2020;14:69.
40 Phillip CR, Mancera-Cuevas K, Leatherwood C, *et al*. Implementation and dissemination of an African American popular opinion model to improve lupus awareness: an academic-community partnership. *Lupus (Los Angel)* 2019;28:1441–51.
41 Morales-Alemán MM, Moore A, Scarinci IC. Development of a Participatory Capacity-Building Program for Congregational Health Leaders in African American Churches in the US South. *Ethn Dis* 2018;28:11–8.
42 Askari N, Bilbrey AC, Garcia Ruiz I, *et al*. Dementia Awareness Campaign in the Latino Community: A Novel Community Engagement Pilot Training Program with Promotoras. *Clin Gerontol* 2018;41:200–8.
43 Hempstead B, Green C, Briant KJ, *et al*. Community Empowerment Partners (CEPs): A Breast Health Education Program for African-American Women. *J Community Health* 2018;43:833–41.
44 Brand DJ, Alston RJ. The Brand's PREACH Survey: A Capacity Assessment Tool for Predicting Readiness to Engage African American Churches in Health. *J Relig Health* 2018;57:1246–55.
45 Brand DJ, Alston RJ. The Brand's PREACH Model: Predicting Readiness to Engage African American Churches in Health. *Health Promot Pract* 2017;18:763–71.
46 Northridge ME, Kavathe R, Zanowiak J, *et al*. Implementation and dissemination of the Sikh American Families Oral Health Promotion Program. *Transl Behav Med* 2017;7:435–43.
47 Shelton RC, Charles T-A, Dunston SK, *et al*. Advancing understanding of the sustainability of lay health advisor (LHA) programs for African-American women in community settings. *Transl Behav Med* 2017;7:415–26.
48 Shelton RC, Dunston SK, Leoce N, *et al*. Predictors of activity level and retention among African American lay health advisors (LHAs) from The National Witness Project: Implications for the implementation and sustainability of community-based LHA programs from a longitudinal study. *Implement Sci* 2016;11:41.
49 Schwingel A, Gálvez P, Linares D, *et al*. Using a Mixed-Methods RE-AIM Framework to Evaluate Community Health Programs for Older Latinas. *J Aging Health* 2017;29:551–93.
50 Banerjee AT, Landry M, Zawi M, *et al*. A Pilot Examination of a Mosque-Based Physical Activity Intervention for South Asian Muslim Women in Ontario, Canada. *J Immigr Minor Health* 2017;19:349–57.
51 Leyva B, Allen JD, Ospino H, *et al*. Enhancing capacity among faith-based organizations to implement evidence-based cancer control programs: a community-engaged approach. *Transl Behav Med* 2017;7:517–28.
52 Puchner K, Karamagioli E, Pikouli A, *et al*. Time to Rethink Refugee and Migrant Health in Europe: Moving from Emergency Response to Integrated and Individualized Health Care Provision for Migrants and Refugees. *IJERPH* 2018;15:1100.
53 Birgel V, Decker L, Röding D, *et al*. Community capacity for prevention and health promotion: a scoping review on underlying domains and assessment methods. *Syst Rev* 2023;12:147.
54 Ahmed S, Chase LE, Wagnild J, *et al*. Community health workers and health equity in low- and middle-income countries: systematic review and recommendations for policy and practice. *Int J Equity Health* 2022;21:49.
55 Sugarman M, Ezouah P, Haywood C, *et al*. Promoting Community Health Worker Leadership in Policy Development: Results from a Louisiana Workforce Study. *J Community Health* 2021;46:64–74.
56 Kim K, Choi JS, Choi E, *et al*. Effects of Community-Based Health Worker Interventions to Improve Chronic Disease Management and Care Among Vulnerable Populations: A Systematic Review. *Am J Public Health* 2016;106:e3–28.
57 McCollum R, Gomez W, Theobald S, *et al*. How equitable are community health worker programmes and which programme features influence equity of community health worker services? A systematic review. *BMC Public Health* 2016;16:419.
58 Mulvagh SL, Colella TJF, Gulati M, *et al*. The Canadian Women's Heart Health Alliance ATLAS on the Epidemiology, Diagnosis, and Management of Cardiovascular Disease in Women - Chapter 9: Summary of Current Status, Challenges, Opportunities, and Recommendations. *CJC Open* 2024;6:258–78.