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Community organizing and public health: a rapid review

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Abstract

Background Advancing health equity is a global priority within public health, requiring a focus on structural determinants of health and power imbalances. Community organizing is one strategy to cultivate community power and advance health equity by challenging oppressive systems. While examples of public health partnering with community-organizing groups and utilizing organizing methods can be found in the literature, these strategies remain an underdeveloped area for practice. This rapid review aims to uncover the benefits, challenges, and outcomes of governmental, non-profit, and academic public health partnering with community organizers and/or applying community-organizing methods.

Methods A rapid review was conducted using PubMed and Cochrane databases. Articles were included if they focused on public health applying community-organizing methods and/or partnering with community-organizing groups, and if they reported benefits, limitations, and/or outcomes for community and/or public health. Eligible articles were primary research, practice reports, or systematic reviews, and were published between 2000 and August 10, 2023. Articles were excluded if they were published outside of Canada, United States, Europe, Australia, or New Zealand; not in English or available online; and unrelated to public health and community organizing.

Results Twenty-four articles met inclusion criteria, including 17 primary research studies and seven practice reports. Topics varied, with environmental health and justice being the most common. Three quantitative articles investigated social capital. Qualitative outcomes revealed 10 themes describing seven benefits and three challenges for public health. Benefits include increased public health effectiveness, set or changed priorities, built community power, enhanced data collection and research, policy changes, built community capacity, and increased social capital. Challenges include administrative barriers, approach differences, and challenges associated with community organizing. Overall, the evidence base reveals a scarcity of research on public health partnering with community organizers or utilizing community-organizing methods.

Conclusion The review underscores the capacity of community organizing to advance health equity, enhance public health effectiveness, and contribute diverse benefits to communities. It emphasizes the value of community-organizing partnerships and methods as promising approaches for public health practice, revealing alignment in addressing social and structural determinants of health. The full French translation of this article is available via https://nccdh.ca/fr/resources/entry/community-organizing-and-public-health-a-rapid-review.

Keywords Community organizing, Community power building, Social determinants of health, Structural determinants of health, Power, Public health practice, Health equity, Rapid review

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Résumé

Contexte Faire avancer l'équité en santé est une priorité mondiale en santé publique, qui exige de mettre l'accent sur les déterminants structurels de la santé et les déséquilibres de pouvoir. L'organisation communautaire est une stratégie parmi d'autres pour cultiver le pouvoir au sein des communautés et faire avancer l'équité en matière de santé en défiant les systèmes oppressifs. Bien que l'on retrouve des exemples de partenariats en santé publique avec des groupes organisateurs des communautés et d'utilisation de méthodes d'organisation dans la littérature, ces stratégies demeurent un domaine de pratique sous-développé. Cette revue rapide vise à révéler les avantages, les défis et les résultats des partenariats gouvernementaux, à but non lucratif et universitaires en santé publique avec des organisateurs communautaires et/ou en appliquant des méthodes d'organisation communautaire.

Méthodes Une revue rapide a été réalisée à l'aide des bases de données PubMed et Cochrane. Les articles ont été inclus s'ils mettaient l'accent sur la santé publique en appliquant des méthodes d'organisation communautaire et/ou en partenariat avec des groupes d'organisation communautaire, et s'ils faisaient état d'avantages, de limites et/ou de résultats pour la santé communautaire et/ou publique. Les articles admissibles étaient des recherches primaires, des rapports sur les pratiques ou des revues systématiques publiés entre 2000 et le 10 août 2023. Les articles étaient exclus s'ils étaient publiés à l'extérieur du Canada, des États-Unis, de l'Europe, de l'Australie ou de la Nouvelle-Zélande; s'ils n'étaient pas en anglais ou accessibles en ligne; et s'ils n'étaient pas liés à la santé publique et à l'organisation communautaire.

Résultats Vingt-quatre articles répondaient aux critères d'inclusion, dont 17 études de recherche primaire et sept rapports sur les pratiques. Les sujets étaient variés, la santé et la justice environnementales étant les sujets les plus courants. Trois articles quantitatifs ont étudié le capital social. Les résultats qualitatifs ont révélé 10 thèmes décrivant sept avantages et trois défis pour la santé publique. Les avantages sont les suivants : une efficacité accrue en santé publique, l'établissement ou la modification des priorités, le renforcement du pouvoir communautaire, l'amélioration de la collecte de données et de la recherche, des changements de politiques, le renforcement des capacités communautaires et l'augmentation du capital social. Parmi les défis se trouvent les obstacles administratifs, les différences d'approche et les défis associés à l'organisation communautaire.

Dans l'ensemble, la base de données probantes révèle un manque de travaux de recherche sur la santé publique en partenariat avec des organisateurs communautaires ou en utilisant des méthodes d'organisation communautaire.

Conclusion La revue souligne la capacité de l'organisation communautaire à faire avancer l'équité en santé, à améliorer l'efficacité de la santé publique et à apporter divers avantages aux collectivités. Il met l'accent sur la valeur des partenariats avec des organisateurs communautaires et des méthodes d'organisation communautaire en tant qu'approches prometteuses pour la pratique de la santé publique, révélant une harmonisation dans la prise en compte des déterminants sociaux et structurels de la santé.

Mots-clés Organisation communautaire, renforcement du pouvoir communautaire, déterminants sociaux de la santé, déterminants structurels de la santé, pouvoir, pratique en santé publique, équité en santé, revue rapide

Introduction

Advancing health equity is a priority for the public health field globally, including in Canada [1]. Health equity is achieved when "all people (individuals, groups and communities) have a fair chance to reach their full health potential and are not disadvantaged by social, economic and environmental conditions" [2]. The concept of structural determinants of health describes how written and unwritten rules, including values, worldviews, policies, and practices, create durable patterns of advantage and disadvantage among socially constructed groups and enshrine structural oppression, including White supremacy [3]. These durable patterns shape the social conditions that impact health and are causes of health inequities [3].

While these enduring patterns that produce health inequities are persistent, they are also unjust and avoidable, meaning they can be changed. Both older and newer scholarship on the social and structural determinants of health emphasizes the redistribution of power as critical to transforming systems, forces, and rules to effectively advance health equity [3–9]. There are various ways to conceptualize power, but in simple terms, "power is the ability to achieve purpose" [10]. Shifting the balance of power relations involves building the power of equity-deserving communities and disrupting the power of interests that oppose health equity [8, 9].

The field of public health has incorporated community empowerment as a strategy since at least the late 1970s [4, 11, 12]. The 1978 Declaration of Alma Ata described

"community participation" in a way that reflects the idea of building community power: "Community participation is the process by which individuals and families assume responsibility for their own health and welfare and for those of the community, and develop the capacity to contribute to their and the community's development. They come to know their own situation better and are motivated to solve their common problems. This enables them to become agents of their own development…" [11]. Community capacity building efforts, such as community development and similar types of public health initiatives, have often included aspects of community power building as a strategy [13].

A growing body of evidence underscores community organizing as one of several crucial strategies for cultivating community power and advancing health equity and justice [13–17]. Building on the work of others, we define community organizing as the processes by which people who have a common identity or purpose unite to build relationships, identify shared issues, collectively analyze those issues to understand structural injustices, develop collective goals based on that analysis, and implement strategies and tactics to reach those goals including: developing leadership skills, activating members for direct action and campaigning, expanding group membership, and building power among the group and broader community to influence decisions, set agendas, and shift worldviews [13, 14, 18, 19]. Community organizers are activists who mobilize communities around specific issues to achieve justice through grassroots power building approaches [15]. Community-organizing groups exist within the non-governmental sector and are structured around the principle that power is rooted in the community itself [15].

While community power building efforts in community capacity building initiatives sometimes overlap with community organizing, we distinguish community organizing from these efforts for several reasons. First, community organizing in North America has a unique history rooted in social work and social justice movements, such as labour, civil rights, and disability rights movements [13]. Second, community organizing is distinctly characterized by its community-centred locus of power and the strategic grassroots actions that result from this orientation [13]. Third, the field of public health has much to learn from community organizers due to their unique approach to health justice [15].

The published literature highlights the benefits of public health researchers and practitioners partnering with community organizers and engaging with community organizing as a strategy to effectively address health equity and justice, and calls for increased efforts in this area [15, 16, 20]. Community engagement, guided by the principle of "nothing about us without us" [21], and intersectoral collaboration are essential public health functions necessary for the transformative change required to advance health equity [22]. These public health functions are strengthened through active involvement in community organizing given its proximity to broader social movements for equity and justice.

While community organizing can be used to advance goals that impede progress toward equity (e.g., organizing against the use of critical race theory or against 2SLGBTQIA + rights), public health can advance its equity work by allying with movements that are evidence-based and explicitly anti-racist, anti-colonial, and anti-imperial, such as Landback and Black Lives Matter movements and movements against state-sanctioned violence and occupation [23]. Supporting public health's ability to partner with community organizers is vital to disrupt the sociopolitical roots of the compounding crises, or wicked problems, that we collectively face [20]. This partnership also responds to existing calls from community organizers to advance collaborative efforts for health equity and justice [24].

Public health has historically collaborated with, and acted as, community organizers and activists in various social reform movements, such as housing, environmentalism, and labour [23]. While power building approaches have been incorporated into public health's community capacity building initiatives, over the last century, the field has become more biomedically and behaviour-focused and less focused on social reform [23]. Examples of public health explicitly partnering with community-organizing groups and utilizing organizing methods can be found in the literature, but these strategies remain a relatively underdeveloped area for public health practice [15]. Furthermore, a search for reviews focused on public health's use of these strategies revealed no such reviews, highlighting a gap in public health's understanding of these approaches. This rapid review therefore aims to support the public health field to understand how the field is situated in relation to community-organizing partnerships and organizing methods, and to uncover the impacts of these strategies.

As a result, our research question is: What are the benefits, challenges, and outcomes of public health partnering with community-organizing groups and/or applying community-organizing methods to advance health and health equity? Answering this research question will contribute to filling the identified knowledge gap and inform public health practice in advancing health equity in collaboration with community organizers outside of a biomedical and behaviour-focused model.

Methods

Study design

Our protocol was informed by rapid review guidelines from the National Collaborating Centre for Methods and Tools [25] and Cochrane Rapid Reviews Methods Group [26]. As the Cochrane guidance sets out, citing Hamel et al., "A rapid review is a form of knowledge synthesis that accelerates the process of conducting a traditional systematic review through streamlining or omitting specific methods to produce evidence for stakeholders in a resource-efficient manner" [26]. We followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines for the identification, screening, and inclusion of studies in this rapid review and subsequent data extraction and synthesis [27]. PRISMA methodology supports a more uniform, thorough and open review process with fewer biases and greater validity of results.

This study was conducted as part of broader work at the National Collaborating Centre for Determinants of Health (NCCDH) on redistributing power to advance health equity [28]. The NCCDH provides the Canadian public health community with knowledge and resources to take action on the structural and social determinants of health and to advance health equity. The two authors comprised the study team and led the study. Advisors included the NCCDH team, who were engaged to review the research protocol and the manuscript. The authors also consulted with an information specialist to guide the review process. The study team met regularly to discuss all aspects of the work.

Search strategy

We collaborated with an information specialist to help inform and conduct the search strategy of the academic literature. The population of interest was public health, which was conceptualized as three groups: governmental, non-profit, and academic. Two interventions were considered: public health partnering with community organizing groups and/or public health applying community-organizing methods. Primary research articles, systematic or other reviews, and practice reports were considered for inclusion. No grey literature was searched. Two databases, Cochrane Database of Systematic Reviews and the National Library of Medicine's PubMed, were searched on August 10, 2023. Search terms included concepts related to public health (e.g., health equity, health inequities, preventive health services, public health, health) and variations of terms related to community organizing (e.g., community organizing, community organizer, community power building, grassroots organizing) found in titles and abstracts (See the Additional file 1: search strategy). Screening was conducted using Covidence software [29].

Screening

The two authors independently screened all titles and abstracts and met to resolve conflicts. Articles were included if they focused on public health practitioners and organizations (population of interest) applying community-organizing methods and/or partnering with community-organizing groups (intervention); included findings about benefits, limitations, and/or outcomes for community and/or public health (context/outcome); were primary research articles, practice reports, or systematic reviews (study type); and were published between 2000 and the date of the search (August 10, 2023). Articles were excluded if they were published before 2000; described work done outside of Canada, United States, Europe, Australia, or New Zealand (so that the findings are relevant to the context in which the authors are working); were not written in English; were not about practice (i.e., if they only focused at the theoretical level); covered community mobilizing rather than organizing (see above for our definition of organizing; while organizing often includes mobilizing, many mobilizing initiatives do not include key components of organizing such as leadership development); or if the abstract was not available online. Screening titles and abstracts produced 85 articles for full-text review, and 77 of those could be retrieved.

The two authors piloted the full-text review for 10 articles, achieving complete agreement on screening results. The remaining 67 articles were divided among the two authors and reviewed by a single author. Each author then reviewed the articles excluded by the other author, and they met to discuss and finalize decisions. Twenty-four articles were identified for inclusion following full-text review. The other 53 articles were excluded for the following reasons:

- 24 based on the population (i.e., public health was not involved).
- 18 based on the intervention (i.e., public health neither partnered with community organizers nor used community-organizing methods).
- eight being the wrong type of article (i.e., neither primary research articles nor case studies).
- three lacking any information about the benefits, limitations, or outcomes of the work described.

Data extraction and synthesis

The two authors conducted data extraction and synthesis using a data extraction table to record information regarding the study characteristics of each article and findings related to the research question guiding this review. Data extraction was piloted for five articles, achieving consistent data extraction results between the

authors. The authors then split the remaining articles and conducted the data extraction, including key study characteristics and quantitative outcomes described in the studies. The authors also conducted a narrative synthesis of qualitative outcomes using an iterative process to identify prominent themes. After reading the articles, each author coded the outcomes and grouped those codes into themes. The authors met to review and refine the themes each identified, and grouped themes into a final set.

Due to time constraints, the quality and reliability of the included studies were not assessed, all data from the studies reviewed were considered equally and not weighted, and qualitative and quantitative results are reported separately.

Results

A total of 227 unique articles were identified for screening in the PubMed search; the search of Cochrane reviews produced no results (see Fig. 1 for the PRISMA flow diagram). After screening, 24 articles were selected and reviewed for key study characteristics, intervention characteristics, and quantitative and qualitative outcomes.

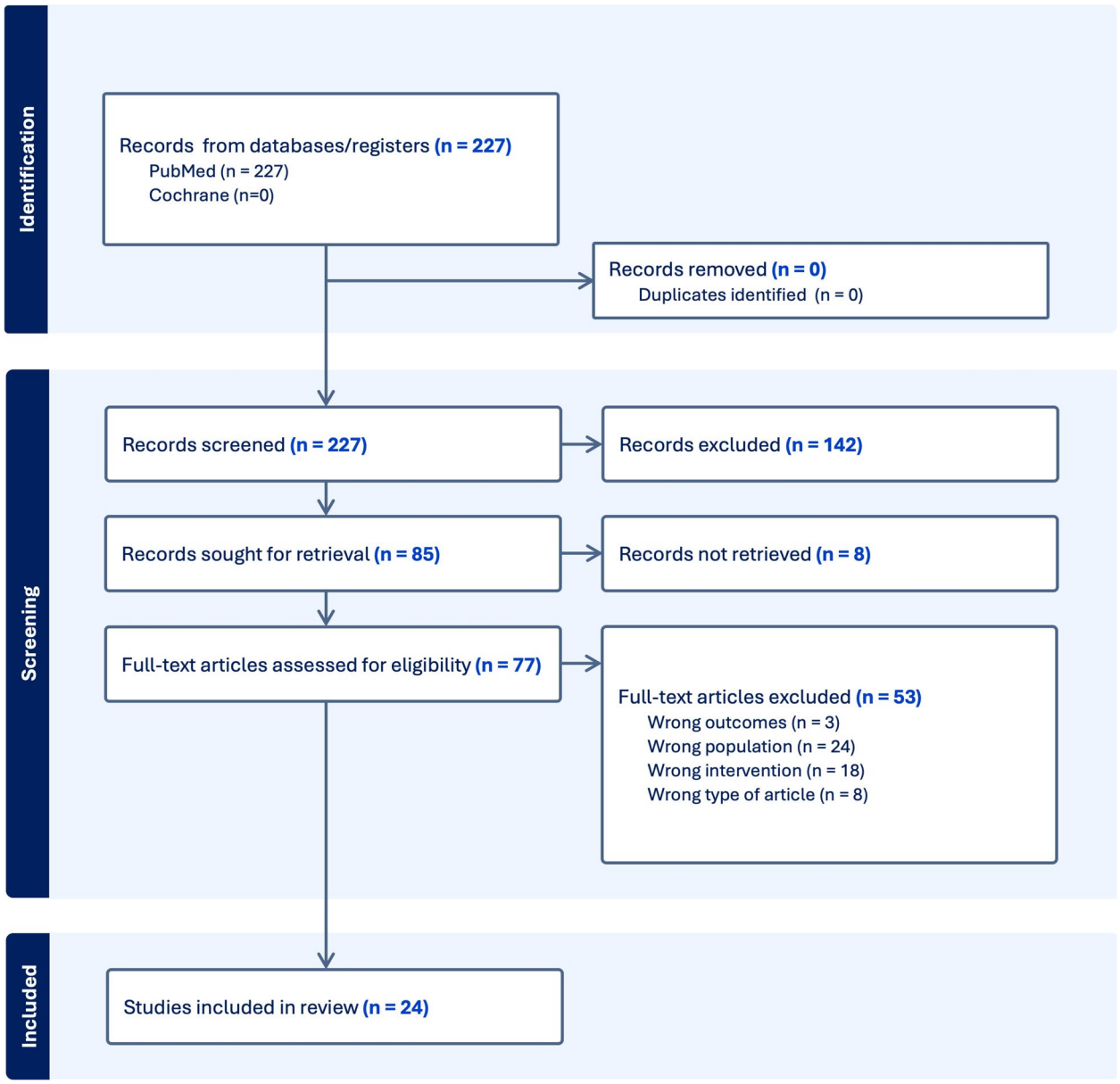

Fig. 1 PRISMA 2020 flow diagram depicting the process of article identification, screening and selection

Descriptive summary of key study characteristics

Characteristics of the included studies are summarized in Table 1.

The 24 articles were published between 2003 and 2023 with no trend in the number of articles published per year. Geographically, 22 articles were set in the United States, one in New Zealand, and one in the United Kingdom. Most of the articles were primary research studies ($n=17$), and the remainder were practice reports ($n=7$). All but three [31, 40, 44] of the included articles had an equity focus (i.e., they involved work with populations marginalized by systems of oppression).

Community organizing was not directly studied in 13 of the articles [31, 33, 36, 37, 39, 41, 42, 46, 48, 50–53]. In these articles, the use of organizing methods by public health and/or public health partnership with community organizers were described and assertions were made about the outcomes associated with doing so. For example, the article by Albright et al. [50] was co-authored by people situated in a community-organizing group, a non-profit, and an academic institution (based on author affiliations), and it reported on a survey about the healthcare needs of immigrants that they had conducted together. In their discussion, they stated, "Rapid data collection grounded in a community power-building approach produced data that enabled the identification of health and social needs," and that "the embeddedness of this research in a community power building model also enabled immediate action and an increased base of independent, committed, and flexible power that helped realize policy change" [50]. While the paper did not provide evidence for these outcomes, we take them at face value and believe they are valuable for data synthesis and public health practice, especially given the scarcity of peer-reviewed literature in which organizing is actually studied. The majority of these articles were descriptive practice reports ($n=7$).

The remaining 11 articles directly studied community organizing or the use of community-organizing methods using qualitative ($n=8$) [30, 32, 34, 35, 43, 45, 47, 49]; quantitative ($n=2$) [40, 44]; or mixed ($n=1$) [38] methods. Qualitative methods varied and included document review, observation, focus groups, interviews, or a combination.

The issues covered in the papers varied greatly, with the most common being environmental health and justice [30, 33, 34, 36, 37, 39, 45, 49]. Other topics included migrant health [50, 51, 53]; social capital [32, 40, 44]; employment and working conditions [46, 51, 53]; chronic disease (through a number of interventions such as recreational access, housing affordability, and discrimination-free neighbourhoods) [41–43]; public health leadership training [32, 51]; narrative change [52, 53]; substance use [31]; mental health [38]; criminal justice [53]; Indigenous health [47]; identity policing [48]; civic engagement [44]; and HIV/AIDs [35]. We note that most of the issues covered, and subsequent interventions, targeted the social and structural determinants of health.

Descriptive summary of intervention characteristics

Regarding intervention characteristics, nine of the articles described instances where public health both partnered with community-organizing groups and used organizing methods. In eight articles, the intervention solely involved public health's use of community-organizing methods, while in seven articles, public health partnered with community-organizing groups. Table 2 presents the more specific interventions public health used within these broad categories. For example, public health worked to build community power as part of its intervention in 14 of the 24 articles. Also, in 14 articles, public health engaged with organizers and/or used organizing methods for research purposes. In nearly all instances where public health partnered with community organizers for research, it pursued both its own agenda and the organizer's agenda, with one exception where public health solely advanced its own agenda [40].

Additionally, specific interventions included public health partnering with organizers outside of a research context for their expertise; training to build public health's capacity to partner with organizing groups; training to apply organizing methods to build capacity as public health professionals; using organizing methods to build its power to achieve health equity goals; hiring organizers to engage impacted communities in addressing health inequities; training or supporting (e.g., financially) community members to organize; and partnering with organizers and/or using organizing methods to engage in community-based participatory research (CBPR).

Summary of quantitative outcomes

All three articles that included a quantitative analysis [38, 40, 44] investigated social capital (i.e., "features of social organization such as connectedness to neighbors and family, norms of reciprocity, and relationships with government or groups unlike one's own" [44]). Two of the three articles showed statistically significant increases in at least one measure of social capital, while the third showed a decrease. Two of the three examined changes in mental health and found that mental health improved slightly, though not statistically significantly. One of those two also measured mental health outcomes using a second metric and found no change. Other quantitative outcome measures (e.g., civic engagement) were only used in one study.

Table 1 Characteristics of included studies

First author, year [citation #]	Setting	Article type	Public health organization(s) involved	Intervention type	Methods used to determine outcomes related to organizing
Brown, 2003 [30]	USA	Primary research	Alternatives for Community and Environment; Columbia Center for Children's Environmental Health; Harvard School of Public Health; West Harlem Environmental Action	Both partnered with community organizers and used organizing methods	Qualitative
Bryant, 2007 [31]	USA	Practice report	Florida Prevention Research Center; Sarasota County Health Department	Used organizing methods	Descriptive
Farquhar, 2008 [32]	USA	Primary research	Lane County Public Health Department; Multnomah County Health Department; Oregon Health & Science University/Portland State University	Used organizing methods	Qualitative
Wing, 2008 [33]	USA	Primary research	Concerned Citizens of Tillery; University of North Carolina	Both partnered with community organizers and used organizing methods	Descriptive
Parker, 2010 [34]	USA	Primary research	Community Action Against Asthma	Used organizing methods	Qualitative
Silvestre, 2010 [35]	USA	Primary research	University of Pittsburgh Medical Center	Used organizing methods	Qualitative
Cohen, 2012 [36]	USA	Primary research	Brown University; Communities for a Better Environment; University of California, Berkeley School of Public Health	Both partnered with community organizers and used organizing methods	Descriptive
DeSouza, 2013 [37]	USA	Practice report	Puget Sound Sage; University of Washington School of Nursing	Partnered with community organizers	Descriptive
Han, 2015 [38]	NZ	Primary research	Counties Manukau Health	Used organizing methods	Mixed
White, 2015 [39]	USA	Primary research	People for Community Recovery; University of Minnesota School of Public Health	Both partnered with community organizers and used organizing methods	Descriptive
Bolton, 2016 [40]	UK	Primary research	King's Health Partners	Partnered with community organizers	Quantitative
Santilli, 2016 [41]	USA	Practice report	Yale School of Public Health	Used organizing methods	Descriptive
Subica, 2016 [42]	USA	Practice report	Praxis Project	Both partnered with community organizers and used organizing methods	Descriptive
Subica, 2016 [43]	USA	Primary research	Praxis Project	Both partnered with community organizers and used organizing methods	Qualitative
MacPhee, 2017 [44]	USA	Primary research	Family Leadership Training Institute	Used organizing methods	Quantitative
Sprague Martinez, 2017 [45]	USA	Primary research	Boston Public Health Commission; Harvard School of Public Health; Somerville Transportation Equity Partnership; Tufts University Department of Public Health and Community Medicine (and others)	Both partnered with community organizers and used organizing methods	Qualitative
Mason, 2018 [46]	USA	Practice report	Kansas City, Missouri Health Department	Partnered with community organizers	Descriptive
Hilgendorf, 2019 [47]	USA	Primary research	Menominee Wellness Initiative	Partnered with community organizers	Qualitative
LeBron, 2019 [48]	USA	Primary research	University of California, Irvine Department of Population Health & Disease Prevention; University of Iowa College of Public Health; University of Michigan School of Public Health	Partnered with community organizers	Descriptive

Table 1 (continued)

First author, year [citation #]	Setting	Article type	Public health organization(s) involved	Intervention type	Methods used to determine outcomes related to organizing
Sprague Martinez, 2020 [49]	USA	Primary research	Boston Public Health Commission; Harvard School of Public Health; Somerville Transportation Equity Partnership; Tufts University Department of Public Health and Community Medicine (and others)	Partnered with community organizers	Qualitative
Albright, 2022 [50]	USA	Primary research	Center for Health Progress; Center for Improving Value in Health Care; University of Colorado School of Medicine	Both partnered with community organizers and used organizing methods	Descriptive
Gaydos, 2022 [51]	USA	Practice report	Human Impact Partners; Santa Barbara County Public Health Department	Partnered with community organizers	Descriptive
Manalo-Pedro, 2022 [52]	USA	Primary research	Filipinx/a/o Community Health Association	Used organizing methods	Descriptive
Heller, 2023 [53]	USA	Practice report	Human Impact Partners; Minnesota Department of Health; San Francisco Department of Public Health; Santa Barbara County Public Health Department; University of Wisconsin Population Health Institute	Both partnered with community organizers and used organizing methods	Descriptive

Table 2 Specific interventions related to community organizing used by public health

Study	Public health intervention								
	Explicitly worked to build community power	**Partnered with organizers and/or used organizing methods as part of a research process**	**Partnered with organizers outside of a research process for their expertise**	**Trained itself to partner with organizing groups**	**Trained itself to use organizing methods to build capacity as professionals**	**Used organizing methods to build its power to achieve health equity goals**	**Hired an organizer to engage impacted communities to address health inequities**	**Trained or supported (e.g., financially) community members to organize**	**Partnered with organizers and/or used organizing methods to engage in CBPR**
Brown, 2003 [30]	X	X							
Bryant, 2007 [31]		X							X
Farquhar, 2008 [32]	X				X		X		X
Wing, 2008 [33]		X							X
Parker, 2010 [34]	X	X					X		X
Silvestre, 2010 [35]		X					X		
Cohen, 2012 [36]		X							X
DeSouza, 2013 [37]		X							X
Han, 2015 [38]							X		
White, 2015 [39]	X	X							
Bolton, 2016 [40]									
Santilli, 2016 [41]		X							
Subica, 2016 [42]	X		X			X		X	
Subica, 2016 [43]	X		X			X		X	
MacPhee, 2017 [44]	X							X	
Sprague Martinez, 2017 [45]	X	X							X
Mason, 2018 [46]	X		X						
Hilgendorf, 2019 [47]			X						
LeBron, 2019 [48]		X							

Table 2 (continued)

Study	Public health intervention								
	Explicitly worked to build community power	**Partnered with organizers and/or used organizing methods as part of a research process**	**Partnered with organizers outside of a research process for their expertise**	**Trained itself to partner with organizing groups**	**Trained itself to use organizing methods to build capacity as professionals**	**Used organizing methods to build its power to achieve health equity goals**	**Hired an organizer to engage impacted communities to address health inequities**	**Trained or supported (e.g., financially) community members to organize**	**Partnered with organizers and/or used organizing methods to engage in CBPR**
Sprague Martinez, 2020 [49]	X	X							X
Albright, 2022 [50]	X	X							
Gaydos, 2022 [51]	X		X	X					
Manalo-Pedro, 2022 [52]	X					X			
Heller, 2023 [53]	X	X	X		X	X			

Summary of qualitative outcomes

Table 3 outlines the main themes identified among the qualitative outcomes in the 24 studies. Seven themes relate to the benefits of partnering with community organizers and/or using community-organizing methods: increased public health effectiveness ($n=19$), set or changed priorities ($n=17$), built community power ($n=15$), enhanced data collection and research ($n=13$), won policy change ($n=13$), built community capacity ($n=16$), and increased social capital ($n=11$). Fewer articles identified challenges, which were grouped into three themes: administrative barriers ($n=4$), approach differences ($n=4$), and challenges of community organizing ($n=4$).

Benefits

Theme 1: increased public health effectiveness Participants in most studies perceived increased effectiveness of public health. Specifically, this theme encompasses outcomes such as heightened responsiveness to urgent community needs [30, 48, 50–52]; increased trust in public health initiatives [41, 45, 47, 51]; improved health outcomes [32, 38, 51, 53]; and enhanced community access to health information [30, 31, 33, 35, 37, 39, 41, 43, 49–52] and research findings [36, 37, 41, 50, 52]. Improved health outcomes included better physical and emotional health within the Latinx community [32]; reduced COVID-19 rates among Latinx migrant farmworkers [51, 53]; and improved mental health among Pacific Island youth [38].

Additionally, two articles described enhanced health promotion efforts [32, 47]. For example, the first article described the increased effectiveness of community health workers in responding to diverse situations using a variety of skills and strategies, which was attributed to their training sessions as community organizers [32]. The second article discussed an enhanced focus on Indigenous approaches to health promotion, centring language, culture, and collectivism, and attributed much of the success to the participation and influence of community organizers [47].

Theme 2: set or changed priorities This theme describes the ability of community-organizing partnerships or methods to establish agendas and drive change in ways that would benefit equity-deserving communities. This manifested in various forms, including influencing priorities in public health [47, 50, 51, 53]; research [30, 37, 45, 48–50]; and advocacy [35, 43, 50, 53] toward a community- or equity-oriented focus. For example, in one article, a director of a local public health department made the following statement about their partnership with a community-organizing group: "This relationship informed my response efforts [to COVID-19] for the Latinx population and helped me allocate resources to address vulnerable populations based on data that I may not have had [otherwise]" [51].

The priorities of community organizers [36, 39, 42, 43, 52, 53] and community members [38, 47] were also influenced or changed. For instance, in White et al. [39], CBPR was used to identify community health issues that informed organizing priorities.

Theme 3: built community power Community power was built by public health sharing its power [33, 42, 43, 45, 48]; developing transformative narratives [30, 47, 52, 53]; working collectively [30, 32, 34, 39, 43, 46, 51, 53]; and embedding community power building directly into research [33]. Public health shared its power by involving communities in the scientific process [33]; funding and supporting community organizers' health equity work [42, 43]; and sharing decision-making power [45, 48]. The transformative narratives used to build community power were grounded in values and concepts such as self-determination, anti-racism, justice, health equity, and liberation.

Theme 4: enhanced data collection and research Using community-organizing methods or partnering with community organizers contributed to the success and increased feasibility of many research projects found in this review. The research questions investigated in these projects were equity-focused and ranged from questions defined by communities themselves to questions defined by researchers. Aspects of data collection and research that were enhanced included participant recruitment, for example increased feasibility of recruitment in surveys and clinical studies through organizers' pre-existing trusting networks and expertise with on-the-ground outreach [33, 35, 37, 41]; validity of data and findings [30, 31, 36, 39, 41, 48–50]; evaluation processes [45, 48]; and ethics [35].

According to Santilli et al., "CARE's community organizing approach—including deep community partnerships as illustrated here, comprehensive outreach strategies, and training local residents as survey staff—led to high community acceptability and participation in the survey and contributed to data validity" [41]. Similarly, Silvestre et al. noted, "Community organizers can ensure that researchers do no harm and that their resources create long-term benefits to the community. They also can assist researchers in successfully interacting with communities

Table 3 Summary of qualitative outcome themes

Study	Qualitative outcome theme									
	1	2	3	4	5	6	7	8	9	10
	Enhanced data collection and research	Won policy change	Ser or changed priorities	Built community power	Increased social capital	Built community capacity	Increased public health effectiveness	Administrative barriers	Approach differences	Challenges of community organizing
Brown, 2003 [30]	X	X	X	X		X	X			
Bryant, 2007 [31]	X	X				X	X	X	X	
Farquhar, 2008 [32]				X	X	X	X			
Wing, 2008 [33]	X			X	X	X	X			
Parker, 2010 [34]		X		X	X	X			X	X
Silvestre, 2010 [35]	X		X		X	X	X			
Cohen, 2012 [36]	X		X		X	X	X			
DeSouza, 2013 [37]	X		X				X		X	X
Han, 2015 [38]			X		X	X	X			X
White, 2015 [39]	X	X	X	X			X			
Bolton, 2016 [40]										
Santilli, 2016 [41]	X	X	X		X	X	X	X		
Subica, 2016 [42]		X	X	X		X				
Subica, 2016 [43]		X	X	X		X	X			
MacPhee, 2017 [44]										
Sprague Martinez, 2017 [45]	X	X	X	X	X	X	X	X	X	
Mason, 2018 [46]		X		X						
Hilgendorf, 2019 [47]			X	X	X		X			
LeBron, 2019 [48]	X	X	X	X			X	X		
Sprague Martinez, 2020 [49]	X		X		X	X	X			
Albright, 2022 [50]	X	X	X	X		X	X			
Gaydos, 2022 [51]		X	X	X		X	X			
Manalo-Pedro, 2022 [52]	X		X	X	X	X	X			X
Heller, 2023 [53]		X	X	X			X			

so that the likelihood of successfully recruiting suitable participants, advancing knowledge, and creating beneficial interventions will be enhanced" [35].

Theme 5: won policy change Numerous health equity-promoting policy wins were achieved across various social and structural determinants of health. Examples include expanded access to public health insurance [50], municipal policy to address food insecurity [41], transit policy reforms [30], housing initiatives [51], legislated paid sick leave [53], and the successful prohibition of a landfill expansion [39]. Additionally, there was increased funding allocated to Treatment Alternative Diversion programs [53] and to schools to procure local produce [42]. Notably, one article detailed an extensive catalogue of "72 policy wins" across six domains: food access, recreational access, housing/shelter access, healthcare access, environmental protection, and children's welfare [43].

Theme 6: built community capacity The capacity of equity-deserving communities was built through leadership development [32, 34, 35, 38, 42, 43, 45, 50, 52] and through the development of skills pertaining to critical analysis [34, 49–51]; research [31, 33, 36, 41]; and policy advocacy [34]. In one study where community health workers were trained in applying community-organizing methods, a participant stated, "The role of community health workers has been good because we have taken away the paternalistic part of the education and offered self-sufficiency as an alternative" [32]. Furthermore, two articles [30, 34] described increased community capacity due to connecting with research or scientific expertise. For example, in one study, "respondents also noted that having established relationships and access to University faculty and their research expertise was an important resource that contributed to an enhanced capacity on the part of the community to address environmental health concerns" [34].

Theme 7: increased social capital Increased social capital was demonstrated through the development of new relationships [33, 41, 45]; growth of community-organizing group membership [36]; built networks or coalitions [34, 35, 41, 49]; and an increased sense of community cohesion, belonging, or unity [32, 34, 38, 47, 49, 52]. When speaking of a community-organized campaign to address mental health challenges of Pacific Island youth, one youth stated, "The best part for me is working with people who have the same goals and share the same interests as me…I like how our community comes together and builds a sense of belonging" [38].

Challenges

Theme 8: administrative barriers Four principal administrative barriers emerged: limited funding [45, 48]; timeline issues such as delays [31] or intense schedules [41]; challenges related to defining roles and responsibilities amidst project changes [31, 45]; and difficulties in hiring [41].

Theme 9: approach differences Differing approaches between community organizers and public health professionals posed another challenge. This was evidenced by differences in values and expectations for the work [31, 34], as well as differences in communication styles [37] and language used [45]. For example, one study described public health researchers as prioritizing objectivity while organizers aimed to simplify complex issues [37]. Researchers in this same article noted that sharing responsibility and power with the community was complex yet the ideal way to conduct CBPR. Another article described how the scientific jargon employed by researchers created language barriers that contributed to power differentials between community organizers and public health researchers [45]. This challenge was addressed through changes in group structure (i.e., subcommittees) and intentional language use by the researchers.

Theme 10: challenges of community organizing Four articles highlighted challenges associated with community organizing. One described the importance of ensuring that the community-organizing group is representative of the community when engaging in CBPR [37]. The other three articles discussed the demands associated with community organizing [34, 38, 52]. Specifically, one article described how the sustained advocacy involved in community organizing can be exhausting [52], while another described the emotional challenges that can arise when engaging peers in new and uncertain ways [38]. The remaining article identified the challenging nature of achieving enough community power to change the status quo [34].

Discussion

This rapid review examined the benefits and challenges of public health involvement in community organizing, with a focus on advancing health and health equity. Despite rich histories of community organizing initiatives around the globe using a variety of organizing methods, all but two of the 24 articles selected were from the United States. We believe this is due to issues with terminology

– the work of community organizing is described differently in various regions of the world and in non-Eurocentric contexts – as well as a disparity in research on this topic.

Notably, environmental justice emerged as the most prevalent topic area for this body of work, possibly due to the strong presence of environmental justice community-organizing groups and the increasing use of CBPR in this domain. Most articles in the dataset demonstrated a consistent trend of using community organizing to advance health equity. However, three articles highlighted instances of academic or governmental public health partnerships with community organizers or use of organizing methods for agendas not primarily centred on health equity [31, 40, 44].

Most of the identified interventions targeting the social and structural determinants of health. This alignment with community organizers, who inherently prioritize these determinants, is not surprising. Public health's increasing emphasis on structural determinants, health equity, and justice naturally aligns with the objectives of community organizers. The recent scholarship reviewed here focusing on relationships between community organizing and public health presents a significant opportunity for public health to engage more deeply in necessary politicization [3, 54, 55] and recommit to its foundational roots that challenged oppressive systems in pursuit of health for all.

The narrative synthesis of qualitative outcomes revealed 10 thematic categories, with seven emphasizing benefits and three highlighting challenges. The challenges identified are operational in nature and may be overcome through efforts such as investing time in building relationships, fostering trust, or gaining skills and competence. The challenge of power dynamics between public health and community organizing groups requires practitioners interested in such collaborations to make intentional efforts to balance power relations.

The demonstrated beneficial outcomes showcase a range of positive impacts for communities. Community benefits, including increased leadership, community power, social capital, and community capacity, play a crucial role in fostering resilient communities, which is particularly important during times of increased climate change-related events and fiscal austerity. Moreover, the benefits found in this review not only extend to communities but also demonstrate positive impacts on public health practice and policy, including enhanced research, knowledge mobilization, responsiveness to community issues, and fostering trust.

Several methodological limitations of this rapid review must be acknowledged. The search terms used were limited and may not have captured all relevant articles on public health and community organizing. However, given our rapid review approach, we accepted a non-exhaustive search strategy. Another limitation was the inclusion of articles that did not specifically investigate community organizing but made claims about its impact, weakening the strength of the evidence considered. Justification for this decision is described above.

Overall, the evidence base reveals a scarcity of peer-reviewed literature on public health partnering with community organizers or utilizing community-organizing methods, indicating an evidentiary gap. We hypothesize that potential reasons for this scarcity may include a lack of familiarly within public health about community organizing; concerns about maintaining objectivity when working with activists; and the relatively recent emergence of initiatives that name themselves explicitly as community organizing in Canada, Europe, Australia, and New Zealand. Alternatively, public health may be doing this type of work but not publishing about it in the peer-reviewed literature, indicating a role for more academic–community partnerships to fill this gap and inform practice. Despite these limitations, this rapid review fills a critical knowledge gap, providing valuable insights into the impact of public health partnering with community organizers or applying organizing methods.

Conclusions

The intersection of community organizing and public health represents a significant avenue for advancing health and health equity. This rapid review fills a knowledge gap by describing the benefits and challenges of public health partnering with community organizers or using community-organizing strategies based on the current peer-reviewed literature. Benefits found include increased public health effectiveness, enhanced community capacity and social capital, and policy wins across various health domains. The review also reveals an alignment between public health and community organizing based on their shared commitment to addressing social and structural determinants of health. The prevalence of positive outcomes for both public health and communities, the demonstrated capacity to advance health equity, and the diverse range of interventions identified in this review underscore the value of community-organizing partnerships and methods as promising approaches for public health practice.

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12889-025-21303-8.

Additional file 1. Full search strategy.

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Authors' contributions
CJ and JCH both designed the review, completed screening and data extraction, analyzed results, and wrote the manuscript. Both authors read and approved the final manuscript.

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Data availability
The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate
Because this study was based on publicly available literature, procedural research ethics board approval was not required.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

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