LEADING A COMMUNITY ENGAGEMENT APPROACH FOR INTEGRAL MISSION IN CENTRAL AFRICA AND SOUTHEAST ASIA

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ABSTRACT

Community engagement is essential in global health mission organizations in order to effectively integrate physical and spiritual health. I experienced a progression in understanding faith-based community engagement in global health during my time as a health director in central Africa and Southeast Asia. The Facilitator phase of this progression leads to understanding the systems and networks as described by the Social-Ecological Model (SEM) and the Holistic Worldview Analysis (HWVA) model. Together, these can be used to guide church workers, faith-based public health practitioners, and development leaders in taking a holistic approach to improving community health and well-being in a way that learns from my experience and focuses on the Facilitator phase as the most effective. Integral mission understands that the physical and spiritual determinants of health are inseparable but is often challenged by diverse partnerships, community beliefs, and assumptions influencing cross-cultural health initiatives. Together, the SEM and HWVA models support a holistic community engagement strategy for integral mission to take place.

PURPOSE OF FAITH-BASED COMMUNITY ENGAGEMENT

The purpose of the community engagement used for this portfolio was to improve community health and wellbeing through local church volunteers. The communities were rural, low-income communities in central Africa and Southeast Asia where the local church played a central role in connecting families spiritually and socially. During my public health training and work as a health director for two different faith-based organizations, I learned the principles of community engagement but quickly realized community expectations can challenge theoretical training. My community engagement approach for integral mission changed as I reframed my role in the context of local staff, local volunteers, and systems for building the capacity of the local team and volunteers. The purpose of this paper is to share my progression and the different cycles I went through to come to understand the role of community engagement through the perspective of a cross-cultural public health professional. The Social-Ecological Model (SEM) and Holistic Worldview Analysis (HWVA) model can be used together to guide cross-cultural community health and development workers through this progression.

Community engagement (CE) is a key term in global development and critical in improving health through community empowerment (Lavery et al., 2010; Musesengwa & Chimbari, 2017; UNICEF, 2015). The lens through which we engage "other worlds" is important in working cross-culturally to understand and improve health (Brisbois & Plamondon, 2018). Community empowerment through engagement can be defined as, "A group-based, participatory, developmental process through which marginalized or oppressed individuals and groups gain greater control over their lives and environment, acquire valued resources and basic rights and achieve important life goals and

reduced societal marginalization" (Maton, 2008). This definition highlights aspects of participation, inclusion, and control. CE is an integral component for sustaining on-going progress well after the program or project is completed (Cheuy, 2018; Howard, 2015). Integral mission is a concept defined by the Lausanne Movement and the Micah Network as the "proclamation and demonstration of the gospel" (Micah Network, 2001). This definition implies that there are social and physical consequences related to gospel proclamation and the change in an individual's heart and attitude in the physical and social context. Integrating a Christian worldview into public and global health initiatives is necessary for moving toward a holistic approach to health and well-being. In the past decade, many organizations, secular and faith-based, have adopted various CE or participatory approaches for community development with limited evidence on characteristics of effective CE models (Musesengwa & Chimbari, 2017; Tindana et al., 2007). Defining the term "engagement" is necessary because it has similarities with participation but also includes aspects of organizational capacity (Jabbar & Abelson, 2011). Participation can simply mean providing input into an idea as well as any level of action or involvement in doing the work. Engagement is different in that it implies the following based on a mutual interest in learning:

1. Agreement around an idea or belief (the Why)
2. Shared decision-making about the process (the How)
3. Active involvement in the work (the What)
4. Shared risk and responsibility for the outcomes
5. Stewardship of available resources

In global health when externally funded international organizations work with impoverished communities, the extent of CE can vary. Program staff assumptions about community knowledge, ability, resources, and beliefs can impede effective CE (Lavery et al., 2010). Funding limitations and staff time can also influence the level of CE in how the program is planned, developed, implemented, and monitored. With these variables, a program can be done to people, it can be done for people, it can be done with people, or it can be done by people. The established and often expected power dynamics surrounding the health organization's work in a community make doing something to or for people the path of least resistance. Government and non-governmental organizations are often driven by the health outcomes stated in the program description or proposal. These assumptions, time constraints, funding priorities, and focus on short-term outcomes can limit overall CE opportunities for true integral mission. The tension behind using people to get work done versus using work to get people done is, ultimately, at the center of an effective CE approach for integral mission.

In my experience as an in-country program director for a church body in central Africa and a global health director for an international faith-based organization, I have experienced each of these limitations and gradually grew in my understanding of effective community engagement that honors the process of integral mission. Moving forward, I believe it is imperative for global health and community development practitioners to adopt a healthy and effective approach to CE that first provides an opportunity for personal self-reflection. Our personal biases and assumptions are often blind spots influencing how we behave and interact with other people. This is critical in the field of integral mission and holistic health ministry when program staff is asked to align physical and spiritual health components into a single CE process. Second, practitioners need to see CE engagement as an outcome in and of itself. The process can be synonymous with discipleship in working with a faith community or local church as individual gifts and talents are identified and valued. Third, retaining human dignity should be a driving motivation for improving long-term health and well-being. In the Christian faith, dignity is based on being created in the image of God. With this understanding, the motivation for engagement is biblical and connected vertically to God and horizontally to others in the community.

PROCESS OF FAITH-BASED COMMUNITY ENGAGEMENT

Faith-based organizations have often relied on the one-way act of giving whether through medical care and clinics or food relief and other forms of humanitarian aid often separated from spiritual engagement. These practices have their place in development but often come up short in

establishing honest and respectful relationships with people that give credibility to the disconnected gospel proclamation. In addition, limited research on effective community engagement practices and metrics has led to a range of CE approaches with some evidence suggesting that diverse cultural perceptions around health require different CE methods (Grinker et al., 2012; MacQueen et al., 2015; Musesengwa & Chimbari, 2017; Tedrow et al., 2012). Challenges to integrated faith-based CE also include how the community is defined and who is involved with the engagement process (Marsh, Kamuya, Rowa, Gikonyo, & Molyneux, 2008). This definition could be based on cultural, religious, social, or economic differences. The past decade has also seen significant increases in public-private partnerships (PPPs) involving government grants and funding to faith-based organizations (Benn, 2017). These partnerships are helpful if initiated with clear expectations but can result in mismanagement of resources leading to distrust between the organization and the community (Nyika et al., 2010). PPPs may also require a separation between the faith-based components and the physical or social activities of the program. While there are benefits to leveraging funding available through such partnerships, they can also hinder the intimate integration of faith in health programming. There is an overall lack of evidence showing how a separate but parallel approach compared to an integrated approach improves physical and spiritual outcomes over the long-term (Bryan, Choi, & Karlan, 2018). An argument can be made that true spiritual transformation can never be measured but several spiritual outcome and instruments exist that measure indicators of discipleship and strength of faith (O'Neill, 2017). An integrated approach has shown to lead to sustained physical and spiritual changes resulting in overall greater social cohesion (Bryan et al., 2018; Long, Paterson, & Bhattacharji, 2017; Rivera & Nickels, 2014). Combining these indicators with physical and social health indicators can lead to a better understanding of how integral mission might lead to a greater sense of purpose and identity in God's love along with an appreciation and recognition of control over one's survival strategy for the benefit of the community.

Participating in CE has led me to consider the following question: What CE models or frameworks are the most important to foster integral mission honoring community values with biblical truths? In the past, the pendulum has often swung in one direction of primarily gospel proclamation to a primary focus on social justice and development at the expense of direct gospel proclamation. The goal of integral mission is to not dichotomize these two areas as separate but as intimately connected to each other. Failure to proclaim the gospel minimizes the change in beliefs and values that are central for behavior change. Failure to address blind spots in the area of physical health leaves a gap in knowing how to deliver a relevant gospel proclamation. CE offers an approach to foster trust between a community and an outside organization as well as with other community members. Other goals of CE include a focus on capacity building, appreciating assets and strengths, and exposing spiritual blind spots connected to an individual's quality of life and purpose. Navigating these goals can be a challenge because it involves an intimate knowledge of community values with biblical truths. It is necessary to find areas of agreement and contradiction between these sources of information. As these areas are identified, integral mission can take place.

The objectives of CE in mission settings can vary depending on the nature or purpose of the organization and the needs or values of the community. The majority of the communities I have worked with in the past were rural communities in low-income countries with limited infrastructure and services. Communities struggled to meet basic needs and often relied on international organizations including churches to provide support such as health care, education, or clinic water. The objectives involved in engaging each community were initially based on these assumptions of what was needed for development. The local church often felt compelled to help but limited in their own resources to address community concerns. The stakeholders included expatriate program staff, local program staff, local church members, and community members.

My experience as a program director, and later as a global health director, went through an evolution in how I worked through the stages of CE. Initially, my education bias and ethnocentrism led me to view low-income communities from a needs-based perspective in terms of knowledge and resources.

The focus was on education or deficits, and I organized training workshops around community health worker, traditional birth attendant, and HIV counseling skills. The focus was centered on what I could do to reduce the overall burden on clinic staff rather than community engagement. I used my public health training in program planning and community health education to fill gaps I perceived as important rather than principles of CE for integral mission. This "doing" led to a significant sense of value, which increased as I was soon recognized as a "leader" in the community within my first two years in the field. Some members of the local church started attending multiple workshops and eventually assisted in conducting subsequent workshops as volunteer trainers. My understanding of CE methods evolved as the volunteer trainers started to receive comments from community members about day-to-day challenges they were facing outside the scope of the specific training. For example, teaching proper hand washing technique was irrelevant when the availability of clean water was extremely limited in the dry season. I realized that a different level of discussion took place when one of the volunteer trainers facilitated a lesson compared to when I facilitated a lesson. After my third year, I started to recognize that I was a "barrier" to local engagement and critical application of the material and resources. Proficiency in the language was an aspect but more importantly, was a level of comfort that opened the door to a deeper, more intimate conversation between the community and the volunteer trainers as representatives of the organization. During my fifth and sixth years, the program pivoted based on this feedback, and I started working to support the local staff and volunteers in their capacity to work with communities to identify priority issues such as clean water. Integral mission did not automatically happen and still required a specific focus on including a spiritual motivation for health.

An example of an activity that helped in understanding this progression in CE was through deep water wells (boreholes). Even though these were based on community-driven priorities, after the wells were drilled some were not being used or simply not functioning. Reasons ranged from the community not understanding how the water pump worked, to distrust and conflict within the community as to who owned the well. At this point, I realized my CE approach was more about my own perceived success and respect in the community rather than increasing the capacities and strengths of the community. This prompted the team to move further along the continuum of CE and requested the communities to form a water committee that was responsible for determining how the use of the well was governed and maintained. This approach brought the program closer to true CE by leveraging local knowledge but still came up short in strengthening integral mission as the primary focus. I started to move into a "facilitator" role by encouraging the local staff to create their own assessment form and process for each community. They set criteria and worked closely with the community to implement specific sanitation goals prior to the actual drilling of the well. This approach helped the community to leverage local assets and time prior to the well and helped strengthen relationships. Meetings were conducted focused on the purpose behind the well as a means to not only give physical water but also to promote spiritual health by helping people see their God-given potential to serve others in the community. This took the form of parents recognizing the value of formal education for their children or youth groups serving the needs of the elderly by offering a water delivery service.

A key transition for me came when my Zambian colleague and friend suggested I not accompany him on community visits. The reason for this being that my presence significantly altered the dynamics between the organization and the community. Looking back, this was due to the following advantages related to the character, faith, and culture of my colleague:

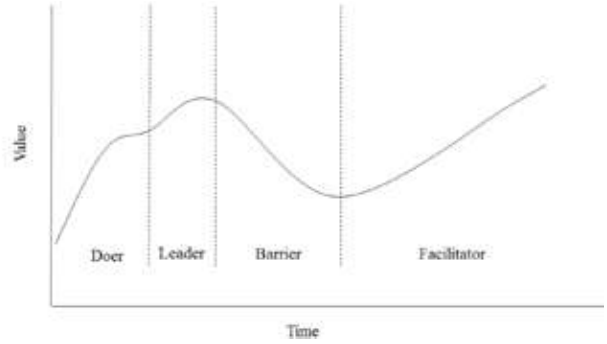
1. Empathy: My colleague could speak from personal experience and express empathy regarding many of the situations individuals were living in.
2. Dignity: My colleague loved and respected the community members as his family and helped them feel empowered to question or raise issues that might be sensitive.
3. Hope: The presence of my colleague traveling to the community on his own gave the community a sense of possibility in seeing a peer with the authority and responsibility to speak on behalf of the organization.

4. Objectivity: Even though my colleague was a peer, he could also be objective as he was not from within the community itself. He was able to listen and facilitate disagreements.
5. Integral Mission: My colleague had a great understanding of both culture and Scripture and was able to address cultural beliefs and behaviors that were not in line with biblical truths.

I understood the need to follow the recommendation from my colleague but also felt frustrated that I would no longer be doing what I was trained to do—develop and conduct community health programs. It can be easy to adopt a gatekeeper mindset, which is aligned with the hierarchical structure of many rural communities in central Africa and Southeast Asia (Tindana et al., 2011). However, this approach also minimizes the transition of power from the gatekeeper to the broader community. This transition forced me to reframe my role, which was a significant challenge for me. I had to identify administrative and systems-level objectives and struggled with understanding why my sense of value and purpose changed. I knew there was more I could have done to support the local staff and volunteers, but I was not able to emotionally or mentally separate myself from my previous role as a public health "doer" and "leader" to a facilitator focused on capacity- and systems-building. I decided to leave the field and return to the US to continue my education. Reflecting back on this decision, I now realize I was in the transition to the fourth phase of the learning cycle and was moving toward reframing my role as a facilitator. The four cycles I observed myself going through were Doer, Leader, Barrier, and Facilitator. Figure 1 shows how these cycles move according to a development worker's sense of value:

Doing the initial work is energizing and rewarding. For many public health and community development workers, interacting with the community is one of the primary reasons for choosing this career path. As the worker shows competency and short-term benefits, the community shows respect further sustaining the sense of value gained in the initial Doer phase. The Doer becomes a Leader. There is a definite learning period in these initial phases and is often longer and less dramatic than shown in Figure 1. I spent approximately three years in these two phases.

Figure 1: Progression of community engagement from the perspective of a cross-cultural community health practitioner.



After the Leader phase, I experienced the Barrier phase where I was not as helpful as I thought and was actually a barrier to true community engagement. It is during this phase that many cross-cultural development workers move to another field to start the process over, or they can continue to the Facilitator phase and learn new skills around developing systems and support networks for the local staff and volunteers. After a period of time, the sense of value starts to return, and the impact is multiplied. This is where true integral mission takes place through community engagement. It is possible to initiate development at any of these phases. However, the hope is that cross-cultural global health practitioners can transition to the "Facilitator" phase as quickly as possible, and the Social-Ecological and HWVA models can accelerate practitioners to this phase. Given the historical perspective and complex partnerships, global health practitioners can lose focus of the progression and get stuck in the "Doer" or "Leader" phases led by the expectations of external organizations to show tangible results and outcomes. It is important to recognize key challenges in successfully transitioning to the "Facilitator" stage turning the traditional top-down decision-making approach to a bottom-up approach for transformational development and authentic community engagement.

A FRAMEWORK FOR FAITH-BASED COMMUNITY ENGAGEMENT

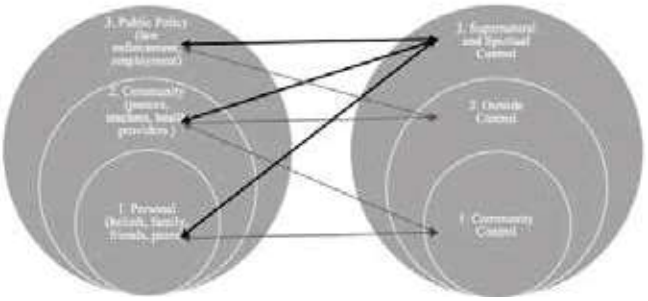
The Social-Ecological and HWVA models have been used extensively in health as theories and frameworks for developing programs (Chambers, 2010; Jayakaran, 2007; Kilanowski, 2017; McLeroy, Bibeau, Steckler, & Glanz, 1988). The Centers for Disease Control and Prevention have adopted the

SEM as a primary framework for understanding the complexity of various health issues including cancer and violence (Centers for Disease Control and Prevention, 2015, 2018). The SEM fits well with global health given its applicability to understanding health behavior beyond the individual level (Elder et al., 2007; UNICEF, 2015). The literature on the HWVA model is limited, but Dr. Jayakaran, the developer of the model, is a leader in integral mission and Christian health mission (Chambers, 2010; Jayakaran, 2002, 2007). It was developed based on personal interactions with communities in rural India and has now been successfully used to develop, plan, and measure integral mission in many countries and settings including local churches in the United States (Jayakaran, 2002). Considering these two models within a CE approach is important for understanding how to plan, implement, and measure the overall impact of integral mission in the community.

The SEM can divide CE into embedded systems or levels (McLeroy et al., 1988). The personal systems (intra- and inter- personal factors) includes characteristics of the individual's direct family, peers, and daily interactions of the home environment. This is the most intimate level of influence. The institutional and community level systems and factors include the relationships with formal and informal social structures such as the healthcare and public health systems, faith institutions, and the education system. The "external" level systems (public policy) are those that influence these relationships in the community, such as policies governing education, employment, or healthcare access. This level is one in which individuals do not have much control but are influenced by what is happening and the decisions that are made in these systems. An assumption that connects the SEM with the HWVA model is that health promotion strategies spanning between these levels are based on the community's beliefs and worldview that inform the determinants of behavior (McLeroy et al., 1988).

Jayakaran's HWVA model contributes to this theory by grounding it in the level of perceived control based on beliefs and worldview that the community engages with each level (Jayakaran, 2007). It recognizes the supernatural or spiritual level as a necessary aspect of perceived control in the community. All communities have a survival strategy incorporating the varying degrees of control within each level. In areas where there is not a clear perceived level of control, the supernatural is attributed with having the control over that area of livelihood. Figure 2 shows how these two models are associated:

Figure 2: Association between the Social-Ecological Model and the Holistic Worldview Analysis model to inform faith-based community engagement.



Community engagement for integral mission relies on understanding how the systems in the three levels influence opportunities and strengths, while the locus of control perceived in each level influences the extent to which communities leverage those opportunities and strengths. Recognizing the supernatural or the spiritual at each level in a community's survival strategy provides a direct connection and understanding of the role of faith and how God is perceived in the community. This lays the foundation for subsequent conversations regarding conflicts, contradictions in cultural beliefs, and uncertainties about purpose and identity. A CE approach for integral mission uses similar participatory learning tools such as community mapping, pairwise ranking, daily schedule analysis, guided focus group discussions, and photo-voice to initiate these conversations. However, the tools need to go further to address the supernatural and spiritual level with the three embedded SEM levels as it influences perceived local control as provided through the HWVA and accompanying Ten Seed Technique (Jayakaran, 2002).

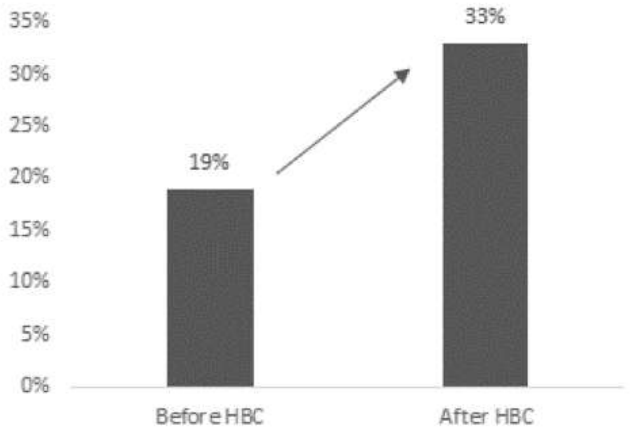
OUTCOMES OF FAITH-BASED COMMUNITY ENGAGEMENT

A CE approach for integral mission has proven to be an important method for sustained outcomes. From my perspective in central Africa, the primary outcome was not necessarily in a specific community change or growth in church attendance but rather the development of local leaders and long-

term community service volunteers. By progressing in this approach, it led to several of the initial volunteers going on to obtain further education, full-time ministry, and work in the public service sector. Some have continued volunteering with the church to continue building and strengthening the local church in serving the community. As a result of this approach, some communities have broken through social barriers and have worked collaboratively to increase economic opportunities. In these same communities, local pastors have commented on improvements in literacy and have noticed greater involvement and participation in Bible study classes and worship.

CE for integral mission also leads to changed beliefs and inclusion. In Malawi, I worked with a local team to incorporate a community engagement approach in developing a ministry for children with disabilities. Based on the cross-cultural experience of the field managers, we were able to progress relatively quickly to the "Facilitator" stage and focus on changing community expectations from the beginning. This was still a challenge and continues to be a struggle but has resulted in a diverse group of local community members learning, growing, and serving to improve families around them. Initially, the program focused on providing adapted worship services for children with physical and developmental disabilities. Incorporating CE led to the development of a home-based rehabilitation component that brought together larger teams of church members interested in being trained as volunteers to provide this service. Initially, the team members were reluctant to work with and interact with children with disabilities. After several workshops, peer mentoring, and relationship building with the families to address the spiritual beliefs surrounding disabilities, the volunteers started to change their own perceptions of different disabilities, and as a consequence, grew in their commitment to this area of service in the community. This approach led to 95% of parents or caretakers of children in the disability program reporting that he/she understands Jesus loves them. This is significant in a culture where having a child with a disability is attached to a spiritual cause (spiritual gap in the HWVA model). As a result, weekly church attendance also increased by 74% among parents/caretakers of children in the program (Figure 3).

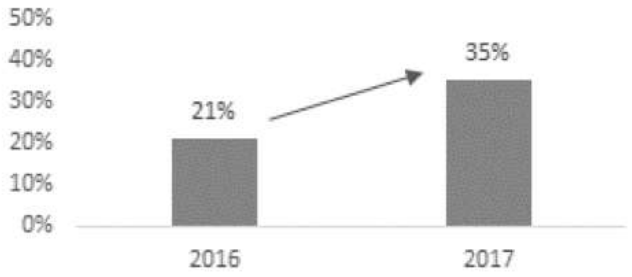
Figure 3: Percent of parents/caretakers reporting weekly church attendance before and after participating in the Kingdom Workers' children's disability program.



Source: Kingdom Workers Malawi disability program evaluation report 2017 (Sherod et al., January 2018). Used with permission.

Regarding community inclusion, 35% of parents/caretakers in 2017 reported a positive change in how his/her child was being treated in the community (second level systems in the SEM), an increase from 21% in 2016 (Figure 4). Physically, all of the parents/caretakers reported an improvement in his/her child's activities of daily living after participating in the program.

Figure 4: Percent of parents/caretakers reporting a positive change in his/her child's treatment by the community.



Source: Kingdom Workers Malawi disability program evaluation report 2017 (Sherod et al., January 2018). Used with permission.

In Southeast Asia, a CE approach for integral mission led to communities learning from and passing on knowledge regarding appropriate technology for clean water. One change that took place as a result of the cross-cultural field manager moving from "Leader" to "Barrier" to "Facilitator," was a focus on local professional volunteers to enhance and support the service of the community volunteers. This is a significant shift in that it highlights and leverages local talent and skills for the benefit of others. It came from

the field manager moving into the "Facilitator" stage and recognizing how to identify the systems needed to support the local staff and volunteers based on understanding the appropriate social and political opportunities. Another lesson learned was that a faith-based CE approach is not about a project or program but a process. As one issue is mitigated in a community, another issue will likely rise up. For example, a lack of access to water can inhibit the need for education as the children are usually given the task for gather water leaving little time for attending school. Once access to water is achieved, a lack of formal education becomes an issue. This provides on-going opportunities to walk with a community in how such challenges can be addressed and transitioning from the first to second level systems in the SEM. The work in Southeast Asia has continued to integrate water with early child education as this progression became a consistent observation from one community to another. In this process, community members worked alongside church members with strong characteristics of faith, honesty, and compassion. This interaction was important in moving toward spiritual conversations to truly integrate physical and spiritual aspects of community health. People do not care what you have to say until they know you care about who they are and feel comfortable discussing spiritual gaps in their lives. This relationship between transitioning to the second level systems in the SEM and moving toward spiritual gap conversations in the HWVA show how the two models work together to support a community engagement approach to integral mission.

REFLECTIVE CRITIQUE

Moving through the "Barrier" stage to "Facilitator" on the path to authentic CE is necessary to appreciate and strengthen the relationships central to integral mission. This transition requires a shift in a global health practitioner's sense of value and is an important component to successfully manage this progression. As I reflected on my own transition, it did not happen naturally but took a trusted friendship to push me through the transition. It is imperative for such honest friendships to guide integral mission as this is the same authentic partnership we wish to cultivate with the community. Vulnerability and humility are essential in this process yet become more difficult as leaders grow in authority and responsibility. It is only through faith that as a leader, I could move from a place of ethnocentrism valuing what I accomplished to a place of compassion valuing what the community was able to accomplish.

Long-term benefits of a CE approach to integral mission include a stronger local church and sense of identity in Christ, greater capacity for solving further problems, innovative use of existing assets within the community, and greater inclusion of the most vulnerable in community development. One of the most significant factors in developing physically and spiritually is navigating through challenges and setbacks. A facilitator is able to capitalize on these situations and help people understand themselves, observe contradictions in worldviews, reflect on their given assets and capacities, and strengthen connections with others around them. Such opportunities can lead to greater community cohesion and an overall higher quality of life physically and spiritually. Poverty and limited economic opportunity might remain, but in reflecting on this approach it has led to the realization that appreciating and honoring the gifts of people is critical to improving overall well-being and joy. Moving toward the role of a "Facilitator" increases the likelihood of recognizing gifts and putting others in positions to learn and grow. Church volunteers have appreciated the opportunity to learn from parents of children with disabilities and identifying how they can support each other. Community leaders have appreciated the benefit of women growing in their ability to read and write, which has positive outcomes for everyone in the family. This focus on facilitating relationships has led people to a relationship with Christ, ostracized children engaged in society, and new perspectives and solutions to chronic community problems.

One of the lessons learned is that a CE approach for integral mission is more about preparing people for a process and facilitating meaningful conversations that encourage holistic thinking. The Social-Ecological and HWVA models provide facilitators with useful tools to ask questions that help identify collaborative opportunities for improving community health. Honoring the relationship between the community, the church, and the facilitator is critical in changing the existing paradigm to community development that

often relies on significant outside control rather than honoring the assets and relationships within and around the community itself. This includes a biblical understanding of God and His love for all people through faith in Christ. A key lesson learned is that these relationships need to include a sharing of risks and open to vulnerabilities on both sides. This allows for assumptions to be identified as it is often these assumptions that can lead to misunderstandings and short-circuit the process for long-term development. The first step is to be clear about our own assumptions of what integral mission means, why it is important, and how it can be practically incorporated into an organizational approach to development.

Understanding the dynamics of a CE approach to integral missions leads to a healthy and biblical understanding of human dignity. An aid-based approach (unconditional giving of resources) is appropriate at times but can also lead to reduced self-esteem and dignity in how external organizations perceive others through a strictly financial or economic rather than a spiritual and relational perspective. Using the Social-Ecological and HWVA models to inform a CE approach, individuals and communities have not only experienced economic growth and access to educational opportunities but also greater sense of well-being and peace in growing in their relationship with God as their Father, Redeemer, and Friend.

References

Benn, C. (2017). Guest introduction: Faith and health in development contexts. Development in Practice, 27(5), 575-579. doi:10.1080/09614524.2017.1330875

Brisbois, B., & Plamondon, K. (2018). The possible worlds of global health research: An ethics-focused discourse analysis. Social Science & Medicine, 196, 142-149. doi:10.1016/j.socscimed.2017.11.034

Bryan, G. T., Choi, J. J., & Karlan, D. (2018). Randomizing religion: The impact of Protestant evangelism on economic outcomes. NBER Working Paper Series, NBER Working Paper No. 24278.

Centers for Disease Control and Prevention. (2015). Social-Ecological Model. Retrieved from https://www.cdc.gov/cancer/crccp/sem.htm

Centers for Disease Control and Prevention. (2018). The Social-Ecological Model: A framework for prevention. Retrieved from https://www.cdc.gov/violenceprevention/overview/social-ecologicalmodel.html

Chambers, R. (2010). Paradigms, poverty, and adaptive pluralism. Working Paper 344. United Kingdom: Institute of Development Studies. TO AUTHOR: This source needs more inofrmation

Cheuy, S. (2018). Community engagement: A foundational practice of community change. Tamarack Institute: 2018 Community Change Festival Series.

Elder, J. P., Lytle, L., Sallis, J. F., Young, D. R., Steckler, A., Simons-Morton, D., . . . Ribisl, K. (2007). A description of the social-ecological framework used in the trial of activity for adolescent girls (TAAG). Health Education Research, 22(2), 155-165. doi:10.1093/her/cyl059

Grinker, R. R., Chambers, N., Njongwe, N., Lagman, A. E., Guthrie, W., Stronach, S., . . . Wetherby, A. M. (2012). "Communities" in community engagement: Lessons learned from autism research in South Africa and South Korea. Autism Research, 5(3), 201-210. doi:10.1002/aur.1229

Howard, T. (2015). Olive branches and idiot's guides: Frameworks for community engagement in Australian wind farm development. Energy Policy, 78, 137-147. doi:10.1016/j.enpol.2014.12.026

Jabbar, A. M., & Abelson, J. (2011). Development of a framework for effective community engagement in Ontario, Canada. Health Policy, 101(1), 59-69. doi:10.1016/j.healthpol.2010.08.024

Jayakaran, R. (2002). The ten seed technique. World Vision China. TO AUTHOR: This source needs more inofrmation

Jayakaran, R. (2007). Wholistic worldview analysis: Understanding community realities. Participatory Learning & Action, 56, 41-48.

Kilanowski, J. F. (2017). Breadth of the Socio-Ecological Model. Journal of Agromedicine, 22(4), 295-297. doi:10.1080/1059924X.2017.1358971

Lavery, J. V., Tinadana, P. O., Scott, T. W., Harrington, L. C., Ramsey, J. M., Ytuarte-Nunez, C., & James, A. A. (2010). Towards a framework for community engagement in global health research. Trends in Parasitology, 26, 279-283. doi:10.1016/j.pt.2010.02.009

Long, K. N. G., Paterson, G., & Bhattacharji, S. (2017). Whole-person health and development: two South Indian initiatives. Development in Practice, 27(5), 760-765. doi:10.1080/09614524.2017.1329401

MacQueen, K. M., Bhan, A., Frohlich, J., Holzer, J., Sugarman, J., & Network, E. W. G. o. t. H. P. T. (2015). Evaluating community engagement in global health research: The need for metrics. BMC Medical Ethics, 16, 44. doi:10.1186/s12910-015-0033-9

Marsh, V., Kamuya, D., Rowa, Y., Gikonyo, C., & Molyneux, S. (2008). Beginning community engagement at a busy biomedical research programme: Experiences from the KEMRI CGMRC-Wellcome Trust Research Programme, Kilifi, Kenya. Social Science & Medicine, 67, 721-733. doi:10.1016/j.socscimed.2008.02.007

Maton, K. I. (2008). Empowering community settings: Agents of individual development, community betterment, and positive societal change. American Journal of Community Psychology, 41, 4-21. doi:10.1007/s10464-007-9148-6

McLeroy, K. R., Bibeau, D., Steckler, A., & Glanz, K. (1988). An ecological perspective on health promotion programs. Health Education & Promotion, 15(4), 351-377. doi:10.1177/109019818801500401

Micah Network. (2001). Micah Network declaration of integral mission. Retrieved from http://www.micahnetwork.org/sites/default/files/doc/page/mn_integral_mission_declaration_en.pdf

Musesengwa, R., & Chimbari, M. J. (2017). Community engagement practices in Southern Africa: Review and thematic synthesis of studies done in Botswana, Zimbabwe, and South Africa. Acta Tropica, 175, 20-30. doi:10.1016/j.actatropica.2016.03.021

Nyika, A., Chilengi, R., Ishengoma, D., Mtenga, S., Thera, M. A., Sissoko, M. S., . . . Kilama, W. L. (2010). Engaging diverse communities participating in clinical trials: Case examples from across Africa. Malaria Journal, 9, 86. doi:10.1186/1475-2875-9-86

O'Neill, D. W. (2017). What works? Evidence on the role of faith in poverty reduction. Christian Journal for Global Health, 4(1), 55-59.

Rivera, J. D., & Nickels, A. E. (2014). Social capital, community resilience, and faith-based organizations in disaster recovery: A case study of Mary Queen of Vietnam Catholic Church. Risk, Hazards & Crisis in Public Policy, 5(2), 178-211.

Sherod, A., Tyrrell, D., Lindloff, M., Duwe, D., Paltzer, J., Hellpap, R., & Brondos, M. (2018). Malawi disability program evaluation report 2017. Milwaukee, WI: Kingdom Workers.

Tedrow, V., A., Zelaya, C. E., Kennedy, C., E., Morin, S. F., Khumalo-Sakutukwa, G., Sweat, M. D., & Celentano, D. D. (2012). No "magic bullet": Exploring community mobilization strategies used in a multi-site community-based randomized controlled trial: Project Accept (HPTN 043). AIDS Behavior, 16(5), 1217-1226. doi:10.1007/s10461-011-0009-9

Tindana, P. O., Rozmovits, L., Boulanger, R. F., Bandewar, S. V. S., Aborigo, R. A., Hodgson, A. V. O., . . . Lavery, J. V. (2011). Aligning community engagement with traditional authority structures in global health research: A case study from northern Ghana. American Journal of Public Health, 101(10), 1857-1867. doi:10.2105/AJPH.2011.300203

Tindana, P. O., Singh, J. A., Tracy, S., Upshur, R. E. G., Daar, A. S., Singer, P. A., . . . Lavery, J. V. (2007). Grand challenges in global health: Community engagement in research in developing countries. PLoS Medicine, 4(9), e273. doi:10.1371/journal.pmed.0040273

UNICEF. (2015). A social and behavior change agenda for inclusion and equity in education. UNICEF Retrieved from https://www.unicef.org/esaro/Program_Brief_-_Inclusion.pdf