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Embedding community development approaches in local systems to address health inequalities: a scoping review

Elizabeth Walters, Gail Findlay, Katherine Curtis-Tyler and Angela Harden

Abstract **Background**: There is a growing evidence base which shows that community development can make an important contribution to reducing health inequalities, but embedding community development as a mainstream approach into local systems is challenging. The literature relevant to the question of how to embed community development approaches is reviewed in this paper.

Methods: Using guidance from the Joanna Briggs Institute, a scoping review was carried out to identify relevant literature. Systematic searches were carried out across multiple databases, experts in the field were contacted and references of included studies were screened. Search results were screened against exclusion criteria. The *Consolidated Framework for Implementation Research* was used as a framework to identify factors hindering or supporting embedding.

Findings: The review identified thirty-five documents which described embedded, or attempts to embed, community development approaches in fourteen different countries. The most common community development approaches were strength-based or co-production. Four studies reported primary research on the embedding process or systems change. Several barriers and facilitators to embedding were identified including those related to funding arrangements, organizational and system culture, building trust with communities and the need for training and support for staff.

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Conclusion: Using an implementation science framework, this scoping review has assessed the nature of the evidence base on how to embed community development. While the evidence base uncovered is currently limited, barriers and facilitators to embedding identified in the review can be used to both inform future attempts to embed community development and provide the building blocks for future primary research.

Background

Health inequalities refer to 'systematic inequalities in health between social groups which are judged to be avoidable by reasonable means' (Marmot, 2015). There are many debates around the causes and the most effective ways to address health inequalities. Whitehead (2007) developed a typology of actions to reduce health inequalities consisting of four main categories: strengthening individuals, strengthening communities, improving living and working conditions, and promoting healthy macro-policies.

The category of 'strengthening communities' focuses on capacity building, social cohesion and support (Whitehead, 2007). These approaches assume that health inequalities are exacerbated by social exclusion and powerlessness within communities and suggest that the most health damaging effects of social inequality can be found within those who are excluded from taking part in society. These can be tackled through either horizontal interventions, which work with communities allowing people to collectively identify and address priorities within their community, and vertical interventions, which build vertical bonds between different groups on the social scale.

One promising way to strengthen communities with a view to reducing health inequalities is through community development. There are a number of definitions of community development (Scottish Community Development Centre, 2011; Nel, 2018). In this paper, we define community development as a way of working directly with communities to build community connectedness, community capacity and empowerment, and enable communities to realize and develop their assets and take action on needs they have prioritized.

There is a growing evidence base which shows that community development approaches can contribute to the reduction of health inequalities (e.g. Woodall *et al.*, 2010; O'Mara-Eves *et al.*, 2013; Brunton *et al.*, 2015; South *et al.*, 2021). For example, in their systematic review, O'Mara-Eves *et al.* found that interventions that include community engagement – a key part of a community development approach – are an effective way to improve health-related outcomes such as behaviours, skills and social support in disadvantaged communities (O'Mara-Eves *et al.*, 2013). Brunton *et al.* (2015)

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found that the higher the level of community engagement, the stronger the beneficial effects. Feelings of engagement can increase social cohesion and empowerment within communities (Cyril *et al.*, 2015), which in turn can improve health outcomes.

Despite research demonstrating the potential of community development approaches, there is little long-term investment in community development with community infrastructure built, and funding offered, only for pilot phases of programmes (Bégin *et al.*, 2009; Bertotti *et al.*, 2012; Kavanagh *et al.*, 2022). Community development can be experienced by stakeholders as a novel and unconventional way of working and evidence suggests that community development requires investment on a long-term basis in order to fully realize benefits (Bertotti *et al.*, 2012; Findlay and Tobi, 2017; Cassetti *et al.*, 2020).

One way to ensure sustained investment and support for community development approaches would be to embed this way of working within systems. Here, the term 'embedding' refers to the widespread implementation of an innovation (Scarborough and Kyratsis, 2022). Scarborough and Kyratsis (2022) suggest that innovations need to be seen as a central concern at a system-wide level rather than in a disjointed way with small individual projects operating only at the edges of systems. The term 'system' includes organizations such as local government, healthcare providers, the not-for-profit and private sector providers.

To date, there have been no systematic attempts to identify and bring together the existing literature on embedding community development. The scoping review reported in this paper aims to map and identify gaps in the existing knowledge on this topic (Khalil *et al.*, 2021). This review is part of a larger research project which is underway on embedding community development approaches in local systems.

This review aims to answer the following questions:

(i) What is the nature of literature available on community development that has become or is becoming embedded within a local system?
(ii) What is the nature of the research which has been conducted on embedding community development approaches within a local system?
(iii) What are the key characteristics of the community development approaches described by the literature which have become or are becoming embedded within a local system?
(iv) What are the key characteristics of the local systems in which they are embedded?
(v) What are the processes, facilitators and barriers which have been utilized or overcome to embed community development within local systems?

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Methods

Protocol development

In July 2021, a preliminary search of PROSPERO, the Cochrane Database of Systematic Reviews and JBI Evidence Synthesis using the terms 'community development' OR 'community engagement' OR 'community empowerment' OR 'place-based approaches' OR 'community centred approaches' identified no existing or ongoing scoping reviews on the topic of embedding community development approaches.

This scoping review followed the Joanna Briggs Institute (JBI) guidance for scoping reviews (Peters *et al.*, 2015, 2020). A protocol was developed and can be found on FigShare (Walters *et al.*, 2022).

Eligibility criteria

Documents were screened against the following criteria:

(i) Not a community development approach

- Community development referred to community-centred programmes, interventions and/or frameworks that work with communities to empower and enable them to identify and take community led action on community perceived needs and on realizing community assets.

(ii) Not embedding

- Embedding referred to long-term adoption and normalization of the community development approaches into a system.

(iii) Not relevant to systems

- Systems or networks of institutions, such as local government, health systems, the not-for-profit and private sector providers. The community development approach had to be either embedded within a system or being attempted to be embedded within the context of a system, to be included in the review.

(iv) Not in English

There was no limit on publication date apart from those imposed by the databases searched.

Search strategy

The search strategy was implemented in three phases as described by Pollock *et al*. (2021). The first was an initial search in MEDLINE using Medical Subject Heading terms (MeSH). Relevant literature was used to identify further search terms, including free-text terms, for the full search.

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In the second phase, search terms identified in phase one were used to search MEDLINE, PsycINFO, SocINDEX and Academic Search Complete (completed in November 2021); and for grey literature, the National Grey Literature Collection (NGLC) and Eldis (completed in April 2022).

The third phase involved screening the references lists of included reports to find further relevant reports. An additional fourth phase was added to the three recommended by Pollock *et al.* (2021): contacting experts for further relevant reports.

Evidence selection

EPPI-Reviewer 4 was used to manage the data in the review (Thomas *et al.*, 2010). Duplicates were removed and 100 titles and abstracts were assessed by four researchers to test an initial draft set of the eligibility criteria. The criteria were revised and the above exercise was repeated until criteria were consistently understood and applied across the review team.

A single reviewer (E.W.) then screened citations on title and abstract. Approximately ten percent of references were double screened at regular intervals for quality assurance, with any discrepancies resolved between the two reviewers. Full reports were obtained for citations which met eligibility criteria and these were re-screened by a single reviewer (E.W.). Fifty percent were double screened for quality assurance.

Data management, charting and analysis

Data were extracted into a standardized extraction form including source type, population, concept, context, research method and key findings (if reports described primary research). Inductive coding was used to identify the characteristics of the community development described in the report. The Consolidated Framework for Implementation Research (CFIR) (Damschroder *et al.*, 2009) was used to code information from reports on the barriers and facilitators to embedding. The CFIR is informed by a range of theories from implementation science and provides a comprehensive understanding of how complex factors interact to affect programme implementation. These factors are organized within five domains (Table 1).

Coding was initially applied to the findings reported in documents which had conducted primary research on the process of embedding or systems change. Further insights were sought from author descriptions in the documents which had not conducted primary research on embedding or systems change. Although not based on empirical findings, the review team were keen to capture the experiences of authors who had described community development approaches that they had embedded or were attempting to embed.

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Table 1 The five domains of the CFIR, adapted from Damschroder *et al*. (2009)

Domain	Definition
1. Intervention characteristics	Key characteristics of the intervention, which is being implemented (e.g. programme cost and resources, adaptability, feasibility and relative advantage compared to other available interventions)
2. Inner setting	Organizational culture, structure and networks
3. Outer setting	Economic, political and social context outside of the organization
4. Characteristics of individuals	Effect of individuals who are involved with implementation
5. Process	The process of changing the system to implement a new innovation

Results

Overview of literature

A total of 4544 titles and abstracts were identified and 3949 were screened once duplicates were removed (Figure 1). A total of 274 titles and abstracts met the inclusion criteria. Subsequently, 251 full-text documents were retrieved and screened against exclusion criteria (the full-text reports for twenty-three titles and abstracts could not be retrieved). Of these, thirty-five documents were included in the review[1].

Publication dates spanned forty-three years. With each decade, publications become more frequent (Table 2).

The earliest document published in 1977 argued that community development should be in mainstream policy-making across a multitude of systems such as the health care, pharmaceutical industries, education, food production, state infrastructure and the voluntary sector, with support from the political system (Ramakrishna, 1977). This systematic scoping review has therefore found that calls to embed community development have been made for over fifty years.

Documents were classified into five different types: journal articles ($N = 20$), reports ($N = 11$), book chapters ($N = 2$), magazine articles ($N = 1$) and working papers ($N = 1$). Documents were classified into those that reported *primary research* ($N = 16$) or those that simply *described* a particular programme(s) ($N = 19$). Descriptive documents often referred to secondary sources, discussing results of previous embedded programmes. Those

1 A full list of documents included in the review is available upon request sent to the corresponding author.

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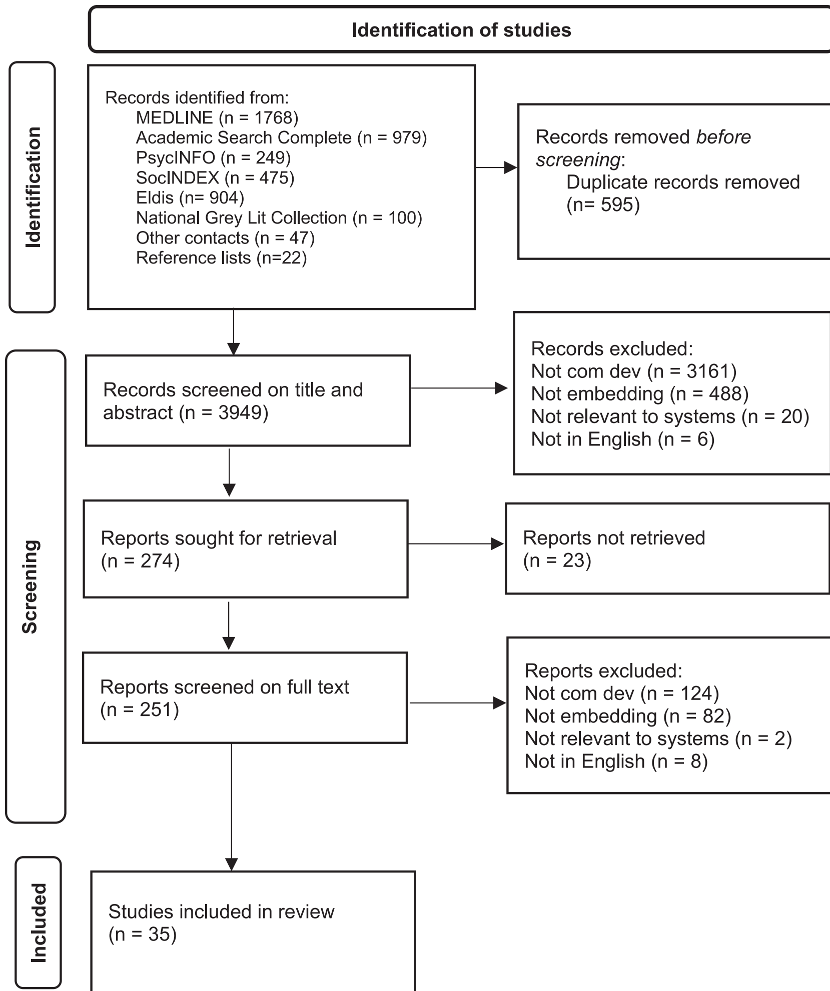

Figure 1 Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews (PRISMA-ScR) flow diagram.

reporting primary research described two types – research on embedding and organizational change ($N=4$) and research into outcomes of programmes ($N=12$). The included documents originated from fourteen different countries, with the United States being the most frequent country of origin ($N=12$), followed by the United Kingdom ($N=5$) and India ($N=5$). The other countries were Italy ($N=2$) and Haiti ($N=2$), and there was one document from each of the following countries: Brazil, Cambodia, Spain, Wales, North Macedonia, Ireland, Canada, Guatemala and Scotland.

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Table 2 Publication date of documents included in the review ($N = 35$)

Publication date	Frequency
1977–1989	1
1990–1999	5
2000–2009	11
2010–2019	14
2020 onwards	3
No date	1

Table 3 Programme aims of the community development approaches ($N = 42$) within the documents included in the review ($N = 35$)

Programme aim	Frequency
Health-specific outcomes	20
Community building	8
Women's empowerment	3
Opportunities for youth	2
Opportunities for children	1
Poverty reduction	1

Characteristics of community development approaches

A total of forty-two cases of embedded community development programmes were presented across the thirty-five documents. Primary programme aims fell into six categories (some programmes had more than one aim) (Table 3).

As mentioned previously, twelve documents reported primary research on the outcome of their community development programme. The findings of programmes which focussed on health-specific outcomes were notable, including improved mental health (Castriotta *et al.*, 2020), decreased pressure on health services (Castriotta *et al.*, 2020), decreased infant mortality (Berggren *et al.*, 1995; Perry *et al.*, 2006), improved general wellbeing (Lambourne and Jenkins, 2020) and a reduction in child injuries (Laraque *et al.*, 1995). Other positive impacts reported from primary research on the outcomes of embedded community development programmes were decreases in the rate of youth crime (Griffith *et al.*, 2008), improvements in child behaviour (Algozzine *et al.*, 2010), greater community connectedness (Barrett and Perry, 2019), poverty reduction (Mascarell, 2007) and increased natural disaster preparedness (Viriya, 2009). Two documents reported it was too early in the evaluation to see any significant effects of the programme (Flynn *et al.*, 1991; The Social Marketing Gateway, 2015).

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Table 4 Programme approaches of the initiatives (*N* = 42) within the documents included in the review (*N* = 35)

Approach	Definition	Frequency
Strength or asset based	A focus on assets and skills communities already have and work with communities to identify how they can use these to address perceived issues	18
Co-production/community engagement	Community participation in the design and delivery of services	14
Deficit or conventional community interventions	External actors intervene to provide community programmes or deliver education	9
Micro-financing	Low-income groups being given loans to invest in their livelihoods	5

Table 5 Frequency of primary part of the system within which community development approaches (*N* = 42) have become embedded within the included documents (*N* = 35)

Primary part of the system	Frequency
Local government	22
Housing association	6
Not-for-profit/community voluntary sector	5
Health services	5
University	3
School	1

Many programmes referred to the use of multiple approaches (Table 4), including some elements which do not fit the definition of community development used in this paper (deficit or conventional community interventions).

Characteristics of local systems within which community development has become embedded

Within the forty-two community development programmes described, the primary part of the system from which they operated from was classified into six different categories (Table 5). The term 'primary part of the system' is used as most initiatives stressed a focus on interdisciplinary working across different organizations.

It was difficult to get a clear picture of how community development within the local system functioned due to a lack of in-depth descriptions. A predominant way of functioning across the documents was the setting

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up community councils or having community leaders drive community development (Ramakrishna, 1977; Flynn *et al.*, 1991; Kadiyala, 2004; Calman, 2005; Díaz-Puente *et al.*, 2008; O'Neill *et al.*, 2008; IPE Global, 2013; Ruano, 2013; CMSPL, 2014; de Andrade *et al.*, 2015; Lambourne and Jenkins, 2020).

Another theme across documents were author descriptions of the political or historical context of the country or system as a contributing factor towards the decision to embed community development (Kadiyala, 2004; Mascarell, 2007; Viriya, 2009; Lahariya *et al.*, 2010; Ruano, 2013; de Andrade *et al.*, 2015; Lambourne and Jenkins, 2020). For example, the decentralization of central governments often required local governmental bodies or community and voluntary organizations to take on responsibilities which would once be centrally managed (Kadiyala, 2004; Mascarell, 2007; Lahariya *et al.*, 2010; Ruano, 2013; Lambourne and Jenkins, 2020).

Research exploring the embedding of community development approaches

As noted earlier, only three documents conducted research on the process of embedding (Ochocka *et al.*, 1999; Chaskin, 2001; McEvoy *et al.*, 2019) and a further study focused on organizational change as a result of an embedded community development programme (Kaplan *et al.*, 2006) (Table 6).

Barriers and facilitators to embedding community development

Barriers and facilitators to embedding community development were identified across all five domains of the CFIR from the four studies which conducted primary research on the embedding process (Figure 2). The synthesis of findings from these four studies are supplemented with insights from authors of the documents not describing research on the embedding process in the narrative below.

Intervention characteristics domain

Community development was perceived by some to be expensive to implement. For example, Kaplan *et al.* (2006) noted that some staff members believed the Bronx Health REACH programme should be stopped during times of economic hardship. Chaskin (2001) found that the most successful broker organizations were those that had a dedicated and ongoing stream of funding to support their work. Funding for embedding community development is discussed further below under 'outer setting'. When community development was perceived as familiar by staff (e.g. when organizations had prior experience of similar programmes), the embedding process was supported with familiarity giving the programme a relative advantage over other programmes.

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Table 6 The included documents which conducted primary research on embedding and systems change ($N = 4$)

Document	Country and study type	Community development approach	System in which embedded
Chaskin, 2001	United States Case study Literature review Key informant interviews	Case study focused on the Neighbourhood Family Initiative – a multisite community collaborative – created as a mechanism to develop relationships between neighbourhood stakeholders and participating organizations Embedding involved the use of broker organizations – intermediary organizations – to facilitate interorganizational relationships and strengthen organizational and community capacity for this way of working	Several examples of organizations using broker organizations are given such as housing associations, community development corporations and local government
Kaplan *et al.*, 2006	United States Interviews with staff members	The Bronx Health REACH coalition – a programme of service and advocacy through community-based initiatives which focus on fitness, nutrition, faith-based outreach, community health advocates, public education and responding to community needs	Coalition is made up of more than 30 organizational members – social service agencies, health care providers, a housing development corporation, an after-school programme and 14 churches
McEvoy *et al.*, 2019	Ireland Case study	Joint Community Participation in Primary Care initiative supporting the involvement of marginalized groups through community development forums	Primary care teams and networks
Ochocka *et al.*, 1999	Canada Participatory action research including focus groups and interviews with staff and senior leaders	Stakeholder participation and empowerment in organizations aiming to implement a participatory management style	Community mental health services in Kitchener-Waterloo, in three different community health organizations (Canadian Mental Health Association, Waterloo Regional Homes for Mental Health and Waterloo Regional Self Help)

Inner setting

The most common barrier and facilitators within this domain were related to the culture of the system or organization. For example, Ochocka *et al.* (1999) found that a shift in central organizational values helped to embed a

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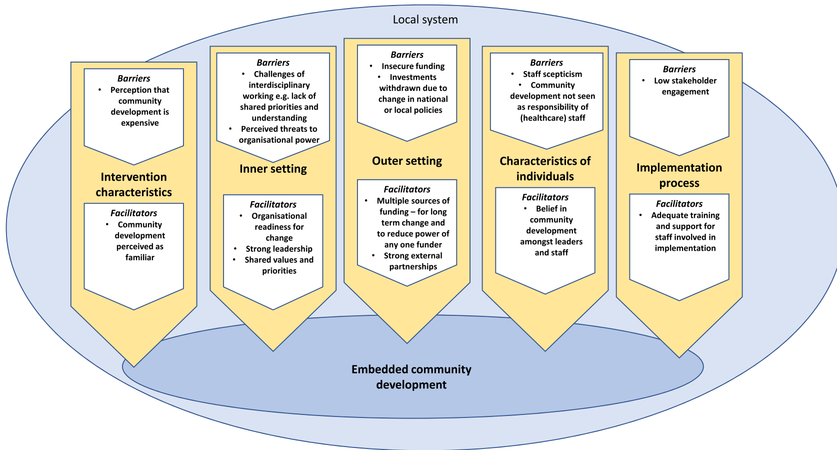

Figure 2 Barriers and facilitators to embedding community development approaches identified in research exploring the embedding process.

participatory approach to mental health services which stressed the value of lived experience to inform choices about care. Organizational readiness for change with strong leadership and a genuine desire to make changes were paramount to success. Shared values and priorities across organizations within a system was identified as a facilitator in Kaplan *et al.*'s (2006) research. The aims of the Bronx Health REACH programme to reduce racial and ethnic disparities in access to high-quality health care resonated across several partners. Several authors of other documents not reporting primary research on embedding also highlighted ways of working such as employing members of the community and adopting a systems lens were important facilitators to embedding (Griffith *et al.*, 2008; O'Neill *et al.*, 2008; Birchall, 2018; The Young Foundation, No date).

Internal ways of working and organizational culture were also found to be barriers to embedding. Chaskin (2001) found that while broker organizations may help to gain community trust, their use can also challenge established power dynamics by introducing a new layer of authority or giving power to the communities they serve. McEvoy *et al.* (2019) found interdisciplinary working to be a barrier to the embedding of community participation in primary care. The diversity in the disciplines and sectors involved in the programme meant that there were differing understandings of what community participation should look like. McEvoy *et al.* (2019) further noted that some healthcare staff did not see community development to be part of their job and were reluctant to commit to the initiative. Differing values and understandings also overlap with the 'individual characteristics' domain of the CFIR (see below).

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Outer setting

Funding was highlighted as a barrier to embedding and organizations across many of the documents were reported to rely on external funding for their community development programmes. Ochocka *et al.* (1999) noted that governmental funding policies were both a barrier and facilitator to creating change, as while they had financial support from governmental sources, there was a constant fear that this funding would be discontinued. Similarly, McEvoy *et al.* (2019) reported that the short-term funding for the embedding of the Joint Community Participation in Primary Care programme they studied was that it would create institutional change over the longer term. The programme was launched at a time of financial growth, and funding diminished over time with interviewees reporting making changes to implementation due to decreased funds. Chaskin's (2001) study of broker organizations also observed central funding decreasing which was likely to impact on participating organizations' ability to be able to continue working with their communities in the same way.

Within the documents which did not report research on the process of embedding, funding was also frequently mentioned as either a barrier or facilitator to embedding (Kadiyala, 2004; de Andrade *et al.*, 2015; Sandel *et al.*, 2016; Tsuchiya *et al.*, 2018). Sandel *et al.* (2016) suggest that investment should come from several different sources to enable embedding over the long term as if one funding stream disappears others may remain. The authors also highlighted that funding often comes with expectation and an agenda and having investment from multiple sources decreases the power of any one funder and increases the power of communities, as also noted by Chaskin (2001).

Gaining the trust of communities and having strong external partnerships were also identified as facilitators to embedding in the outer setting domain, with positive historical relationships (Kaplan *et al.*, 2006; McEvoy *et al.*, 2019) or using third parties (Chaskin, 2001) noted as successful ways to gain community trust.

Characteristics of individuals domain

The characteristics of individuals involved in implementation did not emerge as a strong theme across documents. Kaplan *et al.* (2006) and McEvoy *et al.* (2019) found that staff scepticism and feeling like community development was not an important part of their day job hindered the embedding. The characteristics of leaders were important as already outlined under 'Inner setting'. Strong leadership influenced institutional change (Ochocka *et al.*, 1999) and leaders needed to believe in the approach to influence others (Chaskin, 2001; Kaplan *et al.*, 2006; McEvoy *et al.*, 2019).

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Implementation process domain
There were no clear reoccurring barriers in this domain. Kaplan *et al.* (2006) did find that senior staff struggled with stakeholder engagement in the Bronx Health REACH programme in some programme areas due to high staff turnover. Ochocka *et al.* (1999) and McEvoy *et al.* (2019) found facilitators to embedding to be evaluations that are goal specific and training and support for staff.

Discussion

This review has provided insight into the nature of literature available on community development approaches which have been or are being embedded into a local system, the characteristics of those approaches and the nature of the systems within which they have been embedded. Forty-two embedded community development approaches were identified, and analysis revealed that most programmes either focused on a strength-based or co-production approach to community development. Twelve documents reported on primary research into the outcomes of their programmes, and ten documents described positive impacts of embedded community development approaches, while two documents reported it was too early to draw conclusions from their evaluations. A full assessment of the robustness of this identified research was beyond the remit of this scoping review. Further assessment of these studies and those that focus on other outcomes linked to Whitehead's (2007) approach of 'strengthening communities' is needed to determine whether embedded community development can contribute to the reduction of health inequalities.

While the review found over forty documented examples of community development which had been embedded or where embedding was attempted or in process, only four documents were identified which reported primary research on the process of embedding or on systems change (Ochocka *et al.*, 1999; Chaskin, 2001; Kaplan *et al.*, 2006; McEvoy *et al.*, 2019). This highlights a significant gap in the evidence base. However, the findings from this small number of studies, together with author insights from other documents, provide important and useful insights into the barriers and facilitators to embedding community development. Barriers and facilitators were identified across all domains of the CFIR used to analyse findings including perceptions of the cost of community development (intervention characteristics), organizational factors such as readiness for change (inner setting), funding arrangements (outer setting), attitudes and behaviour of staff involved in implementing community development (characteristics of individuals), and training and support offered to staff involved in embedding community development (implementation process).

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Organizational ways of working and culture and funding and investment were particularly salient in the literature on embedding community development. In this review, organizational culture, shared values and priorities, strong leadership and organizational readiness for change were found to support embedding. In addition, when organizations tried to embed, they took back valuable learning even if the embedding was not fully successful (e.g. changing the way they worked with communities in the future). The findings of this review suggest that more work is needed to develop strategies for how to invest in community development so that it is integrated into usual ways of working (Bégin *et al.*, 2009; Bertotti *et al.*, 2012; Kavanagh *et al.*, 2022). While decentralization was often highlighted by the included documents in this review as a driver for embedding community development, this often puts pressure on local organizations to find funding, and for such funding to be secure and not unduly influenced by any one funders, it ideally needed to come from multiple sources. Similar themes were found in Greenhalgh *et al.*'s (2004) literature review on the spread and sustainability on innovations in health service delivery. For example, they found that the organizational readiness to implement (including key stakeholder engagement and financial resources) were both a barrier and facilitator to long-term change, and additionally central policies which supported the implementation of an innovation increased the likelihood in long-term investment.

It is important to note that some of the barriers and facilitators identified for this review re-occurred across several of the domains of the analysis framework used in this review albeit in different ways. One example of this are the barrier- and facilitator-related funding and investment. When community development is perceived as expensive and there is staff scepticism about its benefits (falling into the 'intervention characteristic' and characteristics of individuals' domains of the CFIR), it is likely to be seen as a 'luxury' or an 'optional extra' in times of austerity. The threat to established power dynamics (falling within the inner setting domain of the CFIR) may reinforce these perceptions which might be further heightened by insecure funding (falling under the 'outer setting' domain of the CFIR). This illustrates the interrelationship between the factors in the different domains and highlights the importance of considering barriers and facilitators across all domains when planning to embed community development. Indeed, the implementation framework developed by Damschroder *et al.* (2009) can be used as a guide to implementation as well as a research tool.

Strengths and limitations

This review has contributed to an emerging literature base on embedding community development within systems. It has identified and brought

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together, in a systematic way, existing relevant literature and highlighted the features of community development approaches and systems within which they are, or are being, embedded, and identified potential barriers and facilitators to embedding such an approach in systems.

However, this review is not without limitations. The review team only had resources to include studies in English. Originally, the team had intended to include documents written in Italian (see Walters *et al.*, 2022), but these documents were removed as the translator became unavailable. Ten of the documents included in the review were sourced from contacts known to the researchers. This strategy is not included as a searching step in the JBI guidance but was found to be beneficial in this scoping review as it allowed inclusion of documents which would not have been found in bibliographic databases of peer-reviewed literature. However, a limited number of experts were contacted largely from the UK so there may well be other relevant documents in the international grey literature that have been missed. Furthermore, the grey literature databases were difficult to use which may have limited the number of relevant documents found. For example, the NGLC had limited functionality which prevented the conduct of an exhaustive search.

Conclusion

There is a growing evidence base to suggest that community development approaches can make an important contribution to improving health outcomes and reducing health inequalities. For these benefits to be fully realized, these approaches need to be embedded within local systems. Using an implementation science framework, this scoping review has assessed the size and nature of the evidence base on how to embed community development. Whilst the evidence base uncovered is currently limited, highlighting a significant research gap, the review has uncovered a number of barriers and facilitators to embedding community development which could be used to inform the implementation of future attempts to embed and provide the building blocks for future primary research in this area. Key barriers and facilitators identified were those related to funding arrangements and organizational culture. There was also evidence on barriers and facilitators related to needs around training and support for staff involved in embedding, building trust with communities and shared values and priorities across organizations within the local system. It is recommended that future research uses a framework such as that used in this review (the CFIR) to both guide and research the embedding process alongside an assessment of the impact of embedding community development on health and health inequalities.

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Supplementary material

Supplementary material is available at *Community Development Journal* online.

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Data availability

There is a footnote which says that a list of the included documents in the scoping review is available upon request sent to the corresponding author.

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