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Research Article

Understanding Community Engagement in Sexual and Reproductive Health and Rights Promotion in the Eastern Cape, South Africa: A Conceptual Framework to Inform Practice

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Background. Community engagement is crucial for effective and sustainable sexual and reproductive health and rights (SRHRs) promotion. Community engagement in community-based health promotion initiatives is contextual and influenced by individual, community, and societal factors. In South Africa, community engagement in SRHR promotion is challenging due to numerous historical and contemporary factors including the socionormative community context and socionormative perceptions regarding SRHR matters. There is little empirical literature to guide community-based practitioners working in health promotion in understanding the contextual influences on community engagement with SRHR promotion generally or in South Africa specifically. *Objective.* This research aimed to explore the influences on community engagement in community-based SRHR promotion initiatives in the Eastern Cape, South Africa. *Methods.* An ethnographic and multiqualitative study was conducted in the Eastern Cape, South Africa, involving 78 purposively and conveniently sampled participants. *Findings.* Three superordinate themes influence community engagement with SRHR promotion in South Africa (i) representations of the issues; (ii) perceived relevance of SRHR issues and SRHR promotion; and (iii) the relational environment, often operating in interactive ways. The themes are presented in a conceptual framework. *Conclusions.* Influences on community engagement in SRHR promotion in the Eastern Cape of South Africa are highly contextual. The conceptual framework arising from the study's findings could be used in community-based health promotion and primary health care in other settings to develop the understanding of factors influencing community engagement in SRHR or other sensitive or emerging health issues, and inform relevant and appropriate design and implementation of community-based initiatives.

1. Introduction

Promoting sexual and reproductive health and rights (SRHRs) is critical to achieving the World Health Organization's agenda of Universal Health Coverage, "Health for All" [1], and the United Nations Sustainable Development Goals relating to good health and wellbeing (goal 3), gender equality (goal 5), and reducing inequalities (goal 10) [2]. South Africa experiences the highest burden of SRHR-related issues globally, largely due to the high burden of HIV [3]. For example, there are an estimated 8 million

people living with HIV (PLWH) in South Africa, accounting for almost 14% of the population and one-fifth of all PLWH in the world [3–6]. To address this, a plethora of community-based interventions have been undertaken over several decades with varying success [5, 7–14]. There have been improvements on SRHR-promoting behaviours such as the uptake of pre-exposure prophylaxis, antiretroviral therapy, and voluntary medical male circumcision [15]. However, other SRHR-promoting behaviours such as correct and consistent barrier contraceptive use, limiting the number of sexual partners, HIV status disclosure, and intergenerational

communication, among others, remain the key challenges [5, 16]. In addition, addressing the underlying sociocultural and sociostructural factors and conditions that influence SRHR also remains challenging [5, 14].

Community engagement is critical for the effectiveness and sustainability of community-based interventions and to advancing SRHR [1, 17]. There is no singular definition of community engagement, but the World Health Organization (WHO) defines it as "a process of developing relationships that enable stakeholders to work together to address health-related issues and promote wellbeing to achieve positive health impact and outcomes" [18] and recognises community engagement as a core competency of SRHR primary care [19]. There is also no singular way of undertaking or evaluating community engagement. However, effective community engagement is recognised as needing to take account of communities' own unique contexts, including the social and structural contexts [20]. A key reason many community-based SRHR-related programs have had limited effectiveness in reducing the burden of SRHR issues and advancing SRHR is that they have not sufficiently considered community needs and context [20–22]. Understanding the community context in which interventions are designed and implemented is essential for program effectiveness and sustainability [7, 23].

A multitude of frameworks exist to guide community engagement practice. For example, widely utilised and cited frameworks from Arnstein [24] and Popay [25] both refer to a continuum of actions which may be undertaken, ranging from tokenistic actions in which the community is the passive recipients of information through to actions which emphasise community control and empowerment. However, these frameworks were conceptualised for application to community processes generally, or in the case of Popay, to community-based health interventions, but not specifically for the context of sensitive SRHR issues. With regards to SRHR issues, Aarø et al. [26] devised a theoretical model of engagement in SRHR-related risk behaviours. However, this model is focused on individual engagement in health behaviours and is underpinned by cognitive-behavioural theory which does not consider the broader socio-ecological context of the community in community engagement. Campbell and Cornish [20] proposed a conceptual framework which highlights three dimensions of the social context important for influencing community engagement in community mobilisation around HIV interventions: the material context (community and program resources available), the symbolic context (the meanings, ideologies, and world views dominant in a society), and the relational context (the nature of group dynamics and leadership structures, including gender relations). This framework focusses on the macrolevel community context as a key setting for, and influence on, community engagement. The framework relates to community engagement in HIV/AIDS interventions specifically rather than the broader suit of SRHR issues but could potentially be generalised more widely.

In summary, despite the acknowledged importance of community engagement in SRHR promotion, there remains a dearth of theory to guide community engagement in primary health care in general [27] and SRHR promotion in particular. Therefore, the aim of this study was to understand and theorise factors influencing community engagement in SRHR promotion within a South African context.

2. Materials and Methods

2.1. Research Design. The research adopted a social constructivist approach [28, 29] utilising symbolic interactionism [30–32] for exploring how individuals made meaning from symbols and social interactions to actively shape their subjective realities. Intersectionality [33] enabled exploration of how factors such as race, class, and gender interacted to influence participants' experiences and perceptions.

2.2. Research Setting. The research was undertaken as part of a Doctor of Philosophy (PhD) research program completed in 2019[34]. Ethics approval was granted by the researcher's institutional ethics committee. The research was undertaken in five communities of the Eastern Cape (Table 1). The lead researcher identifies as etic to the communities and cultures of the research. Permission to enter and engage in communities was sought from the headmen in each community prior to commencement, and a local community member was recruited and trained as a field assistant in each setting to assist with conducting the research.

2.3. Inclusion and Exclusion Criteria. Participants were sought from among SRHR program workers/volunteers and from among the lay community. All participants had to be aged over 13 to participate in the study. The young age for eligibility was appropriate given the epidemiological and social context of SRHR issues in South Africa in which young people, particularly adolescent girls, are identified as vulnerable and a priority group for SRHR promotion [35, 36] and given the prominence of youth and peer-based interventions for SRHR promotion in South Africa [20]. Young people were also considered appropriate to include and to provide informed consent to participate as many young people under the age of 18 years often already undertake roles of responsibility such as head-of-household or caregiver for dependents [37] with more than 15,000 households in the Eastern Cape headed by young people aged under 19 years and more than 2,000 of those headed by a child aged 10–14 years [38]. Participants who were SRHR program workers/volunteers were required to have experience working in the design and/or delivery of a community-based SRHR promotion initiative within the last five years, in order to provide their perspectives about recent experiences of the facilitators and challenges to engaging community members in initiatives. Lay community members were required to have been living in a community in which an SRHR promotion initiative was being delivered within the last five years in order to be able to discuss their personal experiences of engagement or lack of engagement with the initiative.

TABLE 1: Research settings.

Research setting number	Setting description	Geographic and demographic information
1	Major provincial city; Buffalo city Metropolitan municipality	Large port city with substantial economic industries. Population totals approximately 400,000 people in the city, and approximately 700,000 in the broader metropolitan region. Predominantly Black population (70%), followed by White (16%), Coloured (12%), and 2% other ethnicities; has all the amenities of a major city, including access to schools, further education and training institutes, and health and medical facilities
2	Regional city; Buffalo city Metropolitan municipality	Inland city in a metropolitan municipality, with a population of approximately 34,000 people in the immediate city (9,900 households), and 80,000 people in the surrounding region; comprised predominantly of the Black population (65%), with smaller populations of other ethnic groups (Coloured 25%, White 5%, and other 5%); predominantly Xhosa speaking (55%); has all the amenities of a major city, including access to schools, further education and training institutes, and health and medical facilities
3	Periurban community; Buffalo city metropolitan municipality	Xhosa community of approximately 1000 people, located approximately 30 minutes by vehicle from setting one with frequent public taxis to setting one. Housing is traditional mud brick with tin roofs. Homes have no running water supply or sewage, and limited electricity. The community has a number of small local shops and sellers for basic goods, but travel to the nearby city is common for shopping and schooling.
4	Informal settlement community; O.R. Tambo district municipality	Informal settlement community situated within a broader regional community totalling approximately 5000 people. The population is almost entirely Black (99%) and Xhosa speaking (92%). Houses in the settlement community are made of mud brick and cement, with tin roofs. Houses are organised into orderly rows, with each plot demarcated by fencing. Each plot has a tap with running water, but no sewage system. The settlement community and surrounding regional community contains several schools (primary and secondary), churches, health clinic facilities, shops and warehouses, and transport interchange.
5	Rural community; O.R. Tambo district municipality	Traditional Xhosa community of approximately 1500 people, predominantly Black population, but two Coloured families and two Indian families live in the community. Located approximately forty minutes by vehicle from the nearest local municipal town centre (population approximately 3000, comprised of 97% Black population), and one hour by vehicle from the nearest regional city. Housing is traditional mud brick constructions with no running water or sewage system, and limited reliable electricity. The small local community has a medical clinic, two primary schools and a secondary school, several churches and christian missions, and several small shops for buying basic groceries. Hospitals, larger shops, and emergency services are located in nearby towns and centres

*Statistics compiled from 2011 census data [52].

2.4. Participant Sampling and Recruitment. Participants were sampled using purposive, opportunistic, and snowball methods. Initial participants were identified purposively and opportunistically by field assistants and/or the lead researcher. Contact was made with participants either via email (for key contacts in working in organisations) or direct approach (for community members). The study was introduced in either English or isiXhosa using a participant recruitment script. Interested people were provided with a plain language statement and consent form either in written form or read verbally in the participants' language choice of English or isiXhosa. Participants were required to either sign a consent form or provide verbal consent which was digitally recorded. Snowball sampling (both researcher-driven and respondent-driven) was used for further recruitment.

2.5. Data Collection. Ethnographic and participatory qualitative methods were used to collect data. Immersion [39] was initially undertaken by the researcher spending a year living in a Xhosa community in the Eastern Cape prior to the research, and three periods of data collection ranging from two weeks to six weeks over the course of another year.

Participants were offered the choice of semistructured interviews or focus group discussions. Nineteen semistructured interviews involving 22 participants were conducted as six participants chose to be interviewed in pairs with a friend or colleague they were connected to through a program; and six focus groups involving 46 participants (ranging from four to fourteen participants per group) were conducted. A topic guide was developed in English by the researcher, in consultation with the field assistants and tested with each field assistant (Table 2). Interviews and focus groups were conducted either by the researcher (in English), a field assistant (in English and/or isiXhosa), or jointly (in English and/or isiXhosa) to enable participants to express themselves around potentially sensitive issues in whichever language they were most comfortable. The interview duration ranged from 30 minutes to 90 minutes and focus groups from 45 and 90 minutes; all were digitally recorded with additional written notes taken. However, in one research setting, digital recordings were not made due to an equipment malfunction. There, one participant took part in an oral interview while the field assistant took extensive written notes; and six participants opted to receive a written copy of the topic guide and provided written responses in both English and isiXhosa in return. The field assistant clarified written responses with participants where necessary. All interviews, FGDs, and field notes were discussed with the lead researcher and the discussion digitally recorded, and the written questionnaires were provided to the researcher.

In addition, some participants chose to provide data in other ways that were meaningful and comfortable for them including written poetry, demonstrations of work, community walk-throughs, and opportunistic open discussions. Except for opportunistic open discussions, each of these methods was used only once. Some opportunistic

TABLE 2: Example questions from semistructured interviews and focus group guide.

Can you tell me about yourself and any role you may have had in SRHR promotion/experience of SRHR programs in the community?
Can you tell me what "community engagement" means to you if we are talking about SRHR programs in the community?
Can you tell me about the kinds of things that have influenced your engagement with SRHR promotion?
Prompts:
(i) Positive influences which initiated or enhanced
(ii) Negative influences which decreased or inhibited engagement
Clarify and follow-up:
(i) Is that your own view/experience, or are you talking about what you see/hear from others in the community?
(ii) (For focus groups): Is that similar to/different from others in the group? Can you/others tell me about your views/experiences too?
(iii) You have talked about *x* (situation/example). Was that in relation to this community or another community? (if other settings/communities, follow-up, and draw out experiences of different contexts).

discussions were digitally recorded (with consent) when possible; comprehensive written notes were made by the researcher when this was not possible. Two poems written by one participant were treated as written transcripts in data analysis. In all other instances, the researcher recorded data (for example events, quotes and reflections) in a reflective diary.

2.6. Data Analysis. All data were transcribed and translated when required. Data in English were transcribed by the researcher. Data communicated in isiXhosa (fully or partially) were transcribed and translated by a professional service. Data were deidentified and entered into NVivo™ version 10 for management. Data were analysed using inductive thematic and grounded theory methods. First, the lead researcher (GLH) read the transcripts multiple times alongside her reflective diary, for data familiarisation [40]. Then, the researcher openly coded the data by ascribing descriptive words or phrases to data segments. Codes that were similar were grouped together to form concepts (axial coding) [41]. Concepts were reviewed and interrogated, and selective coding [41] was employed in which concepts considered to relate to one another were grouped together to form overarching themes. The development of codes, concepts, and themes was an iterative process and discussed among all authors at each stage of the analysis. All participants were assigned pseudonyms which are used throughout the presentation of the findings of the study.

3. Findings

A total of 78 people participated in the research. Participants were predominantly female ($n = 56$). The vast majority of participants (71 people) identified as Xhosa or other Black South African ethnicity. Five participants

(three males and two females) identified as White South African or European; one male identified as Indian; and one female identified as Coloured. Participants' ages ranged from 16 to 60 years. Most participants ($n = 67$) were either currently or previously involved with SRHR promotion organisations or activities in their communities; 11 participants had no current or prior involvement.

Three overarching themes emerged as key influences on community engagement in SRHR promotion in South Africa: (i) representations of SRHR issues; (ii) relevance; and (iii) the relational environment. These themes operated interactively and across micro-, meso-, and macrolevels of society to influence community engagement. These themes are visually represented in Figure 1.

3.1. Representations.

'Representations' refers to the overarching discursive and symbolic constructions of SRHR issues which influenced community engagement. Representations and their influences were predominantly negative and posed barriers to community engagement.

SRHR issues in this context, particularly HIV and AIDS, were widely constructed as immoral, taboo, shameful, and embarrassing. For example,

> It is still difficult [to talk about SRHR issues] in our communities because people . . . they are interpreting you like you are-eh, [turning to Esihle] Esihle, do you know what I am meaning? What's the word for [lewd]?

> (Thandiwe, adult female, interview 1).

> If you talk about it, they look at you like if you talk about adultery or something like that.. Like, someone who really enjoys talking about sex.

> (Esihle, male youth: interview 1).

This was perceived by these participants to be a barrier to community members engaging with SRHR promotion activities such as awareness raising, advocacy, and health communication campaigns.

Another dominant representation of HIV specifically was as a fatal illness.

> Some of them, maybe they don't accept it [a HIV positive status], or some of them as that maybe, "I am gonna die'. . .There's a lot of stories going around saying that if you are HIV positive you're gonna die this bad [death], or it's gonna be this painful, or in two months you're gonna be dead.

> (Brenda, adult female: focus group 3).

Fatalistic perceptions were considered by participants to inhibit engagement of people living with HIV in SRHR promotion. Notably, this was generally participants' perspective regarding other community members' fatalistic perceptions, rather than an articulation of their own perceptions of SRHR issues.
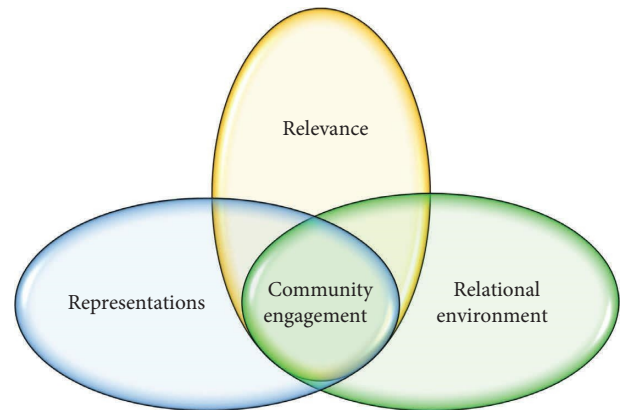

FIGURE 1: Influences on community engagement in sexual and reproductive health promotion in South Africa.

Representations of SRHR issues (predominantly but not exclusively HIV) also related to class and ethnicity. Participants discussed community perceptions of HIV as disease of 'poor people' and of 'Black people.' This also intersected with geographic location, with rurality perceived to be linked to ethnicity (Black) and poorer class:

> Veliswa: Like, they said that "She's high class", right? "You're highly educated, you know about HIV, so why would you go and get yourself HIV positive?"

> Viwe: It's like, it's not a disease for poor people.

> Veliswa: But that's what. . .people in the suburbs say.

> (Veliswa, female youth; and Viwe, male youth: focus group 6).

Participants considered such constructions decreased the perception of relevance of SRHR issues among those who did not identify with the constructions, and that this was a barrier to community engagement with SRHR promotion. A sense of relevance emerged as a separate theme (discussed as follows), yet this example shows the interaction between the themes of 'representations' and 'relevance.'

3.2. Relevance of SRHR Issues and SRHR Promotion.

Having a sense of relevance about SRHR issues and SRHR promotion tended to positively influence community engagement; while conversely, a low sense of relevance posed a barrier to community engagement. A sense of relevance, particularly regarding HIV, was strongly linked with a sense of reality about SRHR issues. For example, Gugulethu's experience reveals how her own direct connection to the illness through a positive diagnosis enhanced her sense of relevance and subsequent engagement with SRHR promotion:

> [When] I got infected I wanted to know more about HIV. So I went [to organisation] and I learnt about HIV. . . . I didn't mind about it [before]. I started minding about it when I was involved, when I saw that among the family there are some people living with HIV.

(Gugulethu, adult female: focus group 3).

In contrast, a low sense of relevance could inhibit community engagement in SRHR promotion.

Like, my family, I don't know of anyone who has HIV and AIDS, so I don't see myself as involving myself in HIV and AIDS. . . .I don't think that I should know much about it cos I don't know anyone who does have it, and I can't help anyone about it, and that's . . . my sense that I have about it. . . .I'm in the mind–it's like, "If I don't know about it, I won't get it. If I know more about it, maybe that's when I'll get it because I'll be involving myself with people around HIV, so I don't wanna do that".

(Viwe, male youth: focus group 6).

3.3. *Relational Environment.* The third theme was the relational environment in which SRHR issues arise and SRHR promotion occurs and includes the contemporary and historical social, cultural, political, and socioeconomic contexts of the community which shape daily life in the community. Influences on and experiences of engagement were strongly embedded within the normative context of individuals' and communities' everyday lived realities, including relationship norms, social group constructions and hierarchies, gender norms, values, and beliefs. Culturally embedded relationship norms had considerable influence on shaping the relational environment, particularly concerning intergenerational relationships:

In our communities we don't talk about sex. No. Even myself I'm not comfortable, as educated as I am, but I'm not comfortable talking about sex with these young ones. . . .. And obviously they will never be comfortable talking to me [about] sex as well. . . .. It's too much. It's really too much.

(Thotyelwa, adult female: interview 12).

Sociocultural norms governing intergenerational relationships interacted with other norms regarding SRHR as taboo, embarrassing, and shameful (which were discussed previously under the theme of "representations') to pose a barrier to engagement with SRHR promotion. This again demonstrates the interactive nature of the key themes.

Other types of relationship norms, such as sibling relationships, peer relationships, and community insider-outsider relationships also had an influence:

There are topics that you feel, 'I can't discuss this with my younger brother'. You know why? Because we end up not being brothers – end up being, wanting to be this father figure to him. . . .. And secondly, maybe he doesn't want me to see how much he knows.

(Paki, male youth: interview 16).

I think it's easier for them to talk with this stranger rather than to the person that they know.

(Nokwanda, female youth: focus group 3).

Regarding why strangers or community 'outsiders' may have a more positive influence on engagement than 'insider' peers or community members, Paki explained:

When the people in our community see a white guy or a white lady, if you call them [community members] they respond because they want to come close to this person. . . .But when we are all Black – as I said, I don't mean to offend anyone by saying this, there's that reluctance. "Who are you? What do you know?" You see? So, "We grow up together", and "Who are you, do you think you know better than me?" You see, there's that mindset. . . . And then, "I know after your grade twelve, you didn't do much". All those things. But when there's someone [from] outside, they come. They want to see this person.

(Paki, male youth: interview 16).

In Paki's view, attitudes of mistrust among local community members towards community "insiders" working as program facilitators arose from local knowledges about the normative social context regarding education, training, and other opportunities. This contributed to negative perceptions about the credibility of the local person and/or program and a subsequent reservation among community members to engage with SRHR promotion.

4. Discussion

While the research sought to explore factors influencing community engagement, it did so by exploring individuals' perspectives and experiences. Participants shared their individual experiences and views, as well as their perspectives about the broader normative community situation. The findings revealed three overarching themes operated independently and interactively and at the individual and community levels to influence community engagement in SRHR promotion. Simultaneously, these factors were shaped by communities' experiences and practices of engagement in SRHR promotion. Thus, experiences of community engagement and the factors influencing community engagement were multidimensional and contextual. The conceptual framework representing the study's thematic findings (Figure 1) may be used to guide and enhance community engagement in SRHR practice.

Veenstra and Burnett [42] argue for "relational" health promotion which challenges the agency-structure dichotomy often applied to understanding engagement in health promotion by examining the relationships between factors and how they shape health promotion engagement. They contend a relational approach to engagement: "sees opportunities for social change in the relationships formed between people, places, spaces, histories, dispositions, beliefs, meanings, and events" (p. 212). The findings of this research resulted in the development of a conceptual framework for understanding influences in community engagement in SRHR promotion (Figure 1) which could contribute to a relational approach by

guiding exploration of the interactions of various factors operating at individual, community, and societal levels in a given context.

This study's findings build on previous theory and frameworks for community engagement. Like Campbell and Cornish's framework [20], the findings go beyond individual cognitive-behavioural theories of engagement to consider the broader social context influencing engagement. This thematic findings of this study extend on Campbell and Cornish's theory and framework [20] by identifying the key theme of 'relevance' in interacting with 'representations' (similar to Campbell and Cornish's 'symbolic content') and the 'relational context' (similar to Campbell and Cornish's 'relational environment'). Therefore, this study's findings emphasise sociocultural experiences and contexts as central to engagement. In addition, this study's findings highlight interacting factors across micro-, meso-, and macro levels of society. For example, the overarching macro level context of communities, including sociohistorical contexts and social conditions including community socioeconomic factors, and overarching cultural norms, values, and beliefs (such as those related to intergenerational factors), are captured by the 'relational context' theme and are found to influence meso level representations of SRHR issues. Meso level factors such as community norms, locally held knowledges, and group-based social identities and interactions are captured by the 'representations' and to some extent 'relevance' themes. Micro (individual) level factors such as individuals' attitudes and beliefs and their direct or indirect exposure to and interactions with SRHR issues are captured by the themes of 'relevance,' and to some extent 'representations' and are influenced by the overall relational context in which individuals live.

The conceptual framework presented in Figure 1 could be used to explore and understand community engagement in sensitive health promotion issues in other settings and to inform health promotion intervention planning and delivery. Understanding the representations of issues, the perceived relevance of the issue, and the broader relational environment, and the factors contributing to those domains in any setting could help ensure culturally contextual and appropriate community-based interventions and enhance community engagement with interventions. Hanson et al. [43] argue for the need for community-based strategies which address the "individual and the immediate social environment influencing his or her behaviours as well as the macrosphere within which societies negotiate life" (p.3). The conceptual framework may assist in interrogating these various levels of interconnected influences.

As community engagement is integral to the success and sustainability of SRHR promotion interventions [44–46], investment should be made at the outset of any intervention planning to engage community members and achieve program goals. For instance, the South African National Strategic Plan on HIV, STIs, and TB 2017–2022 [36] emphasises maximising reach and impact of interventions; this requires community engagement. The National Strategic Plan expired in 2022; so, in its next iteration, it is timely to consider the critical role of community engagement informed by theory to facilitate meaningful practice.

This study's findings are notable in the context of the recent global COVID-19 pandemic. Due to the COVID-19 emergency, much of the public health focus and resources in South Africa were redirected away from HIV toward combatting COVID-19 [47], with a decrease in HIV prevention, testing, and treatment activity [4]. The population profile of COVID-19 in South Africa somewhat mirrors that of HIV; in that, South Africa experiences the highest burden from COVID-19 of any country in Africa [47], and those with HIV are more vulnerable to contracting COVID-19 [4]. However, South Africa's experiences of addressing the HIV pandemic could be leveraged to help address the current COVID-19 situation [4, 47]. A greater understanding of theory underpinning community engagement in health issues, particularly those which may be sensitive, stigmatised, emerging, and/or not yet well understood among the community, could help inform responses. The framework presented in this study could be usefully applied to exploring community engagement in health promotion interventions addressing the COVID-19 pandemic and any future emerging health priorities.

4.1. Limitations. For logistic reasons, the research was carried out in communities in only one province of South Africa (the Eastern Cape). The cross-cultural and bilingual nature of the research and the researcher's position as etic posed potential limitations to community access, data collection, and interpretation. This was mitigated through the researcher's immersion in the field prior to and during the research, and the engagement of locally based field assistants to facilitate in cross-cultural matters. However, having local community members as facilitators could be a limitation, as highlighted by participants in this research such as Paki and Nokwanda in relation to the insider-outsider role of program facilitators mentioned above (under 'Relational Context'). When interpreters are emic to the research culture or setting, participants may have concerns about anonymity and confidentiality, particularly if sensitive or taboo topics are discussed [48]. This could have negatively influenced community members' perceptions of, or engagement with, the research. This could be addressed by offering participants the choice of various field assistants. In addition, field assistants' tacit relationships and assumptions could influence their work, such as in recruitment (for example, who they chose to approach or not approach to participate, and why or why not) [49]. The lead researcher regularly debriefed with field assistants about the research conduct (including recruitment and gaps in recruitment), but the matter of field assistants' relationships, assumptions, and social structures as potential influences in research warrants further consideration in future similar research.

Field assistants were not formally trained interpreters. This may have produced some inaccuracies or bias in interpretations. However, live interpretations provided by field assistants were recorded and later checked and verified using

a professional translation and transcription service and revealed conceptual equivalence [50, 51].

5. Conclusion

While community engagement is often recognised in the literature as a necessary and vital component of intervention planning and implementation and is acknowledged in key South African and global SRHR strategies as necessary for advancement toward SRHR gains, understanding of the complexity of factors influencing community engagement is limited. Although factors influencing community engagement and their interactions and impacts on engagement are highly contextual, the conceptual framework presented illuminates critical themes that could be explored for a nuanced and socioculturally contextual understanding of community engagement and to inform community-based interventions related to sensitive SRHR issues and potentially new, emerging, or poorly understood public health issues in various settings.

Understanding community engagement in sexual and reproductive health and rights promotion in the Eastern Cape, South Africa: a conceptual framework to inform practice.

Data Availability

The qualitative data used to support the findings of this study are available from the corresponding author upon request.

Additional Points

What Is Known about This Topic? (i) Community engagement is critical for the effectiveness and sustainability of community-based health promotion practice. (ii) Community engagement is contextual, and the community context has a particularly important influence in community engagement theory and practice. *What This Paper Adds?* (i) Social representations of SRHR issues: the way they were constructed and represented in society through discourses and symbols that influenced community engagement with SRHR health promotion, predominantly negatively. (ii) The perceived relevance of, and experience with, SRHR issues influenced community engagement either positively or negatively. (iii) The relational environment, including the social, cultural, socioeconomic, and historical context, in which SRHR promotion occurred influenced community engagement. (iv) A new framework to inform community engagement in community-based health promotion initiatives is presented, which may be applied in diverse settings.

Disclosure

This study presents findings from the PhD research project of the lead author. The full thesis dissertation is available from https://dro.deakin.edu.au/articles/thesis/Theorising_community_engagement_in_sexual_and_reproductive_health_promotion_in_South_Africa/21116068.

Conflicts of Interest

The authors declare that there are no conflicts of interest.

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