

Strategic stakeholder engagement for injury care: building consensus in Ghana, Pakistan, Rwanda and South Africa

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Article

Keywords: injury care, health policy and systems research, strategic stakeholder engagement, patient and community engagement, Kingdon, political economy, agenda setting, multisectoral collaboration, participatory statecraft, Ghana, Pakistan, Rwanda, South Africa

Posted Date: August 14th, 2026

DOI: <https://doi.org/10.21203/rs.3.rs-10548838/v1>

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Additional Declarations: No competing interests reported.

Abstract

Injury care requires coordination between communities, health services, emergency responders and local authorities; however, actors rarely deliberate together and little is known about how stakeholders themselves prefer to engage. Policy change is more likely when problems, solutions and political support align, an alignment political actors can manufacture through statecraft. We present a participatory counterpart, building strategic stakeholder engagement in Ghana, Pakistan, Rwanda and South Africa. Eighty-seven injured people, community members, trauma care providers and decision-makers participated in six consensus-building forums, bringing together non-peer policy communities: lived experience of injury, practical knowledge of care systems, and formal responsibility for policy and resources. Stakeholders developed multilevel strategies connected to existing governance, community and data systems: legitimate local entry points linked with decision-making, resources to sustain participation, and explicit attention to exclusion. Political commitment, often considered a precondition for multisectoral action, emerged as something engagement itself can build. We term this participatory statecraft.

Introduction

Health policy and systems research (HPSR) is concerned with how health systems are organised, governed, financed, experienced, can be changed, and how actors, institutions, relationships, values, power and context shape policy development and implementation^{1–3}. In this paper, we report a study developing new forms of engagement and collaboration between health systems and communities in injury care systems across four low- and middle-income settings. Informed by the HPSR tradition, engagement is considered as a relational and embedded process connecting policy, practice, communities and academia in support of systems learning, adaptation and transformation⁴.

Complex health system problems rarely exist within a single sector or policy community. Multisectoral collaboration for health has been described as requiring “business not as usual”: deliberate work to define problems strategically, design context-relevant solutions, relate across sectors, realise change through adaptive learning and capture success over time⁵. Injury care reflects this challenge. Prevention, emergency response, referral, acute care, rehabilitation, social protection and accountability depend on actors across health, transport, emergency services, social welfare, local government, traditional authorities, community organisations and households⁶.

Stakeholder engagement is promoted as a route to more relevant, equitable and usable research and policy. Recent work usefully distinguishes stakeholder engagement from qualitative research: engagement seeks to influence decisions about research priorities, design and conduct, whereas qualitative research primarily seeks to answer a predefined research question⁷. The distinction can also be understood with reference to power: engagement combines stakeholder and researcher decision-making rather than only using participant accounts as data. Stakeholder engagement literature also cautions that the construct is fragmented and contains moral, strategic and pragmatic dimensions: voice and fairness; influence and use; and practical problem-solving in complex settings⁸.

Engagement is therefore not inherently progressive. Without a critical perspective, co-production can inadvertently burden participants, reproduce hierarchies or legitimise decisions already made elsewhere⁹. In global health, measuring co-design by attendance or satisfaction alone risks obscuring whether power, knowledge democratisation and equity are shifting in context and in practice¹⁰. These concerns are especially important where community actors incur higher participation costs, where engagement structures exist without meaningful influence, and where those most affected are least able to shape decisions^{11,12}.

Injury care is an important exemplar. Injuries account for 4.4 million deaths and a significant burden of disability globally, with over 90% of mortality and long-term disability concentrated in low- and middle-income countries (LMICs)¹³. While many injury policies and services exist, implementation challenges persist: delayed transport, weak emergency response, fragmented referral pathways, limited rehabilitation, out-of-pocket costs and poor data all contribute to avoidable harms^{14,15}. Injury care therefore reflects both service delivery and agenda setting challenges: how can people affected by injury, providers and decision-makers define problems, identify feasible responses and build governance processes together?

We sought to build inclusive engagement for injury care in Ghana, Pakistan, Rwanda and South Africa, using Kingdon’s Multiple Streams Framework on priority setting in public policy. Kingdon conceives of policy change as a non-linear and non-rational process

that is more likely when three independent streams come together: (i) 'problems' that are raised and framed in meaningful ways, (ii) 'policy', responses that are technically and politically feasible, and (iii) 'politics', the need for political conditions and actors with the motive and opportunity to adopt solutions enabling policy action¹⁶. The study builds on agenda setting work in burns policy, which has shown how issue characteristics, competing frames and centralised agenda setting can limit programme design and implementation¹⁷.

We used the framework to convene three non-peer policy communities: people affected by injury and community members with knowledge of preventable injury death and disability; trauma care providers and implementers with practical knowledge of injury care systems; and policy or decision-makers with formal authorising power, mandates and resources. The aim was to co-develop strategies for stakeholder engagement in injury care policy, using 'strategic' as developed in social accountability research: multi-pronged approaches coupling community voice with institutional capacity to respond¹⁸.

We also drew on political economy perspectives to examine how actors, institutions, interests, ideas, resources and power shape policy processes and implementation¹⁹. We used this lens to sensitise the deliberations to questions of legitimacy, authority, exclusion, resources and feasible entry points. Stakeholders identified where influence, constraint and opportunity were located. This supported analysis of how bringing together non-peer policy communities shaped engagement strategies for injury care, and why influence, institutional processes and implementation mechanisms varied and converged.

Methods

Study design and settings

We conducted a comparative HPSR study within the NIHR Global Health Group on Equitable Access to Quality Healthcare for Injured People (Equi-Injury)⁵⁷. The study was undertaken across eight rural and urban sites in Ghana, Pakistan, Rwanda and South Africa, selected to reflect diverse governance arrangements, health system structures and injury burdens (Table 1). Phase 1 explored the needs, preferences and priorities for involvement in injury care policy by each stakeholder constituency individually⁵⁸. Phase 2, reported here, brought stakeholder groups together as policy communities to build consensus on shared priorities and develop strategies for sustained engagement. The study was not separately prospectively registered. A shared field manual was developed collaboratively across teams and adapted into country-specific facilitation plans, informed by Phase 1 experience with the same stakeholder constituencies. We performed desk reviews in each country documenting injury care systems, health policy contexts, governance structures, relevant community and accountability mechanisms, and included stakeholder analyses. These informed recruitment, workshop design, analysis and interpretation. Embedded country teams, reflexive practice and triangulation across sites supported rigour throughout.

Table 1
Injury care and engagement systems, by study settings

Country	Population; income category	Injury burden	Decentralisation and governance for health	Injury policy recognition and implementation	Mandated engagement spaces
Ghana	34 million Lower-middle-income	~ 8% deaths 7% DALYs	Moderately decentralised via district health systems and assemblies	Recognised in national NCD, A&E, and road safety policies, weak implementation	District Health Committees; traditional leadership structures
Pakistan	241 million Lower-middle-income	~ 7% deaths	Decentralised (post-18th Amendment); provinces lead, federal system	National Injury Prevention and Health Policy; data and implementation incomplete	Union Councils, Panchayats, emerging digital forums
Rwanda	14 million Low-income	~ 9% deaths 10% DALYs	Strong top-down coordination with local delivery	Integrated into national NCD plan and road safety policy	Many regular community governance processes, district planning units
South Africa	61 million Upper-middle-income	~ 13% deaths (mainly interpersonal violence)	National-provincial-district mix, federal system; traditional authorities recognised	Addressed in NCD strategy and violence/trauma policy	Clinic Committees, District Health Councils, traditional councils

Table 1 here

Analytical framework

Kingdon's Multiple Streams Framework was used to delineate non-peer policy communities: people affected by injury and community members, with experiential knowledge of problems; trauma care providers and implementers, with practical knowledge of feasible responses; and policy or decision-makers, with institutional authority, resources and routes to authorisation¹⁶. Interpretation attended to how actors, institutions, power, resources, legitimacy and exclusion shaped strategies developed in each setting, drawing on political economy perspectives¹⁹. For interpretation, legitimacy referred to stakeholder acceptance of an arena as a suitable channel for raising and resolving injury concerns; and authority referred to statutory or customary power to decide and allocate resources.

Participant recruitment

Eighty-seven participants were recruited from 297 individuals involved in Phase 1 or through replacement recruitment with similar stakeholder characteristics where prior participants were unavailable (Table 2). Participants included injured people and community members, trauma care providers and managers, and policy and decision-makers, spanning health facility managers, civil servants, and national and local policymakers. The term 'policymaker' is imprecise, encompassing multiple roles across levels and sectors; roles, functions and ongoing involvement were documented for all participants. Community Engagement and Involvement (CEI) leads in each study setting supported recruitment, safeguarding, accessibility, language, timing and continuity between phases. They also helped shape workshop agendas and ground rules, supporting inclusive participation of injured people, carers and community members.

Table 2
Multistakeholder workshop attendance by stakeholder group and setting

Workshop (setting)	Injured people and community members	Trauma care providers	Policy and decision-makers	Total (F:M)
Ghana, rural	4 (0:4)	4 (2:2)	4 (0:4)	12 (2:10)
Ghana, urban	4 (2:2)	3 (1:2)	5 (1:4)	12 (4:8)
Pakistan, workshop 1	12 (1:11)	9 (4:5)	7 (2:5)	28 (7:21)
Pakistan, workshop 2	6 (1:5)	4 (2:2)	2 (0:2)	12 (3:9)
Rwanda	6 (4:2)	4 (3:1)	9 (2:7)†	19 (9:10)
South Africa (two days)	4 (4:0)	7 (1:6)	5 (4:1)	16 (9:7)
Total	36 (12:24)	31 (13:18)	32 (9:23)	99 (34:65)
Note: table reports attendance at each workshop as number of attendees (F:M). Participants at Pakistan's second workshop were drawn from the first. In total, 87 unique participants (31 women, 56 men; 30 injured people and community members, 27 providers, 30 policy actors) took part across six workshops. † Includes national-level policymakers.				

Table 2 here

Data collection

Six multistakeholder workshops were conducted January–April 2024. Workshops were informed by the nominal group technique, a structured method for generating, ranking and refining ideas through iterative discussion and feedback⁵⁹. Participants first reviewed Phase 1 results: consensus preferences for involvement in injury care policy, elicited from each policy community separately (Supplementary Table S1). Working first in stakeholder-homogeneous groups to verify and amplify these priorities, then in small mixed groups, they co-developed engagement strategies addressing group formation, implementation processes, communication, evaluation and sustainability. Consensus was defined a priori as cross-group agreement, assessed through: (i) convergence of rankings across rounds; (ii) recurrence of priorities across groups; (iii) stability of final rankings in plenary; and (iv) absence of sustained dissent requiring further deliberation, in line with the nominal group method.

Workshops were adapted pragmatically across settings. Ghana held separate rural and urban workshops owing to distance with one health worker unable to attend following a date change. Elsewhere, workshops convened participants from rural and urban study sites. Pakistan held a second workshop, at participants' request, when time constraints prevented consensus at the first. South Africa held one workshop over two days. Rwanda held one multistakeholder workshop. Plenaries and roundtables were audio-recorded with consent. Workshops used local languages as appropriate and lasted approximately three to five hours. The consensus process is reported in accordance with the ACCORD checklist for consensus methods (Supplementary Table S2).

Analysis

We used rapid qualitative methods, including structured Rapid Research Evaluation and Appraisal Lab (RREAL) sheets, facilitator notes and audio data, to support cross-country analysis⁶⁰. Country teams completed structured synthesis sheets immediately after workshops recording substantive findings and process reflections. These were synthesised into analytic domains: legitimacy/authority; entry points; resources; and inclusion. A central team compared strategies across stakeholder groups and countries, triangulated workshop outputs with desk reviews, and refined interpretations through cross-site discussion.

Reflexivity and ethics

Workshops were facilitated by mixed-gender, multilingual country teams with expertise in injury, health systems and community engagement. Teams used staged group composition, moving from stakeholder-homogeneous rounds, in which each policy community reviewed priorities among peers, to small mixed groups for cross-group deliberation, with rotating rapporteurs and

agreed ground rules to mitigate professional, gendered and linguistic power asymmetries. Facilitators actively managed divergence in session: surfacing disagreement under ground rules that managed dominant voices, returning contested topics to plenary or, where dissent persisted, to further deliberation. The relational and emotional labour of facilitation required high levels of social, professional and research competency. Reflexive practice supported this: within-country debriefs and cross-site exchange examined how positionality and institutional relationships shaped interactions and interpretations (Supplementary Table S3).

Ethical approval

s were obtained from relevant committees in Ghana, Pakistan, Rwanda and South Africa; the University of Birmingham, as sponsor, accepted local approvals in lieu of additional full review. Transport support, refreshments and modest per diems for injured people and community members were provided in accordance with local guidance to reduce barriers to participation. Written informed consent was obtained from all participants.

Portions of the manuscript text were refined using Claude (Anthropic, Claude Fable 5, 2026) for language editing and clarity of expression. All intellectual contributions and conclusions are those of the authors.

Results

Across settings, there was consensus that inclusive engagement required a multilevel strategy: legitimate local entry points linked with practical routes into decision-making, resources to sustain participation, and explicit attention to exclusion. Below, we present a synthetic account of how stakeholders developed engagement strategies across settings. We integrate the workshop deliberations with documentary evidence on governance, policy structures and injury care systems. Consensus criteria were met in all settings (Methods); where convergence required extended deliberation, as in Pakistan, this is reported below.

Legitimacy, authority and entry points

There was broad receptivity to inclusive stakeholder engagement that integrated grassroots perspectives with higher-level support and aligned with existing accountability processes. Decentralised administrative units emerged as important entry points in all settings, with variations by political and institutional contexts.

In Ghana, stakeholders highlighted the need to strengthen connections between communities and national policymakers. Ghana's Local Governance Act (2016) mandates decentralised structures for participation, including district planning, traditional leaders, and sub-district and local action plans²⁰. However, gaps in public education and resource allocation have been documented^{21,22}. During workshops, durbars were identified as key platforms for community members to raise concerns such as road conditions and injuries from domestic falls. The resulting strategy connected district and sub-district structures with traditional authorities, community radio, mobile and digital platforms^{23,24} and in-person forums, making concerns visible within locally trusted spaces and connecting to planning processes.

In Pakistan, stakeholders also prioritised connecting community and national actors. Pakistan's decentralised healthcare governance provides opportunities for localised policymaking, albeit with challenges in consistency²⁵. This was reflected in discussions about community-level strategies to raise awareness of burn injuries and domestic accidents in peri-urban and informal settlements. Parliament and Parliamentary Committees also provide public dialogue entry points; however, limited avenues for consultative policy formulation have been reported in practice²⁵. Pakistan's rapidly evolving digitalisation was seen as an opportunity to bridge gaps in service delivery, policy engagement and governance, particularly in underserved areas²⁶. Three candidate strategies emerged: human resource capacity building, systematic problem identification and needs assessment, and a trauma and injury care advisory group. When time constraints prevented consensus, a second workshop was convened at participants' request, agreeing problem identification and needs assessment as the entry point to which all groups could contribute. The resulting strategy, aligned with the Sindh Health Sector Strategy²⁷, the Pakistan Injury and Prevention Initiative²⁸ and the national health policy²⁹, emphasised community mobilisation and engagement through culturally familiar platforms such as local panchayats and community-based organisations. It prioritised in-person outreach, mobile communication, digital monitoring and trauma registry functions, sustaining participation where formal engagement operates inconsistently and generating evidence for provincial and national policy audiences.

Stakeholders in Rwanda prioritised multilevel engagement similarly connecting communities with higher levels. Post-genocide, Rwanda has gained international recognition for efficiency in public administration and progress towards global development goals, and has established multiple devolved governance mechanisms, including legally mandated structures such as Umuganda, as ongoing efforts to enhance meaningful citizen participation^{30,31}. Administrative structures ensure state presence in the smallest units, enabling strong coordination while maintaining centralised control. Local governance structures were seen as valuable in strengthening trauma response and reporting, such as timely referrals requiring coordination between community health workers (CHWs) and emergency services. The resulting strategy emphasised multilevel coordination, real-time data sharing and capacity building for local officials and providers, specifying named multisectoral roles across health, police, infrastructure and local government, a golden-hour timely-response objective, and quarterly indicators including rural against urban response times, embedding engagement within existing administrative authority and information systems.

South African stakeholders also emphasised connections between local and provincial levels, aligned with formal governance spaces, particularly clinic committees and traditional forums. Blended governance is a key feature of post-apartheid public administration, combining national, regional and local statutory structures with traditional authorities and councils under customary law^{32,33}. Participants shared how clinic committees have been used to escalate community concerns around ambulance delays and violence-related injuries, reinforcing their bridging role. Clinic committees are established, accessible platforms for engagement in health care; however, forms and extents of authority and involvement in decision-making are limited in practice^{34–36}. Stakeholders connected clinic-level participation to representation at district and provincial health forums, with engagement aligned to quarterly provincial reporting cycles. The resulting strategy worked through formal participatory structures while addressing the weak resourcing and embedded social exclusion limiting the voicing of community concerns.

Across settings, local engagement spaces had different forms of authority statutory (district structures, clinic committees), customary (durbars, panchayats, traditional forums) and informational (digital networks). Local arenas needed to be trusted, accessible, legitimately connected to formal decision-making, and capable of connecting across levels. Stakeholders accordingly prioritised blended engagement mechanisms combining in-person and media-based formats, enabling broad participation and feedback beyond formal meetings.

Resources, exclusion and feasibility

Stakeholders highlighted resourcing as critical, and that engagement could not be sustained with goodwill alone. Resource requirements were material: funding, infrastructure, staffing, transport, meeting costs and protected time, and 'soft': professional recognition, training, certification, skilled facilitation, feedback loops, transparency and trust. These were seen as necessary conditions for feasible engagement, particularly for community actors whose involvement had opportunity costs.

Resourcing was a universal priority with specifics that varied by setting. In Ghana, participants stressed financial support and recognition mechanisms, such as training and certification, to empower community-level actors like traditional healers and youth leaders. In Pakistan, resourcing was discussed in terms of funding and technological infrastructure, with strong interest in digital monitoring tools and mobile-based communication platforms to reach underserved communities. In Rwanda, capacity building for local government officials and healthcare professionals was identified as essential for addressing information asymmetries and fostering collaboration, consistent with the government's 2018 decentralisation review, which identified coordination and resource allocation as areas for strengthening³⁷. South African participants underscored logistical support, such as transportation stipends and administrative infrastructure, to strengthen the functioning of clinic committees, especially in under-resourced areas.

Social and organisational hierarchies were openly discussed. Participants highlighted structural barriers affecting marginalised groups, including information asymmetries, gender inequities, and limited awareness of rights and opportunities for engagement. In Ghana, participants described past negative encounters that deterred engagement with health workers, and suggested sidelining in policy processes could be deliberate, reflecting political, personal or resource factors. Fear of authority, rooted in the risk of victimisation, was also noted as discouraging junior actors from proposing change. In Pakistan, participants identified barriers facing vulnerable populations such as youth with disabilities, migrants and ethnic minorities in navigating complex political and administrative environments^{25,38}. In South Africa, intersecting social hierarchies continue to exclude historically disadvantaged

populations despite formal commitments to inclusive governance^{32,39,40}. Rwandan stakeholders echoed these themes, highlighting the importance of fostering environments where citizens feel confident and able to engage.

Across all settings, participants recognised that meaningful engagement requires mobilising resources and navigating entrenched hierarchies. Multisectoral working was identified as a key facilitator, with stakeholders highlighting the need to involve actors beyond the health sector, including religious leaders, educators, social workers, and professionals from law enforcement, fire services, transport and disaster management. Preferred forms and processes of engagement, together with accounts of systemic and contextual constraints, shaped the resulting engagement strategies, summarised in Table 3.

Table 3
Multistakeholder strategies for inclusive engagement in injury care policy, by study setting

Setting	Entry points and levels	Blended mechanisms	Implementation arrangements	Monitoring and accountability	Contributions by policy community		
					Community/patients	Providers	Decision-makers
Ghana	Community, district, national	Durbars and traditional leadership platforms; WhatsApp; local radio; in-person forums	Traditional spaces positioned as entry points to formal planning systems; formal recognition and certification of community actors; delivery through existing hierarchical communication channels	Multi-level committees; peer review; stakeholder reports; documented participation to track progress	Unsafe roads and domestic falls raised through durbars	Facility-community dialogue and participatory engagement	District and sub-district planning routes; recognition and certification of community actors
Pakistan	Local (urban and rural), provincial, national	Panchayats and community-based organisations; door-to-door outreach; media; digital tools; trauma registries	Community trust built through culturally embedded forums; technology-supported outreach; multisectoral alliances; health worker education; political commitment and stakeholder buy-in cultivated from the outset	Dedicated monitoring committee; quarterly reviews; stakeholder feedback; incident reports; trauma registry data	Burns and domestic accidents in peri-urban and informal settlements	Trauma registries and workforce capacity	Alignment with provincial and national policy; parliamentary entry points
Rwanda	Local cells, district, national	Umuganda; CHW networks; digital reporting; formal multisectoral coordination structures	Government-led with formalised multilevel linkages; CHW and local government as connectors between real-time injury response and national policy; training programmes; named multisectoral roles across health, emergency services, police and local government	Golden-hour timely-response objective; injury data analysis including mortality trends; quarterly indicators including rural-urban response times; annual evidence synthesis; stakeholder accountability mechanisms	Timely referral and trauma reporting concerns	Golden-hour response coordination	Ministerial mandates and named multisectoral roles across health, police, infrastructure and local government
South Africa	Clinic catchment, district, provincial	Clinic committees; traditional forums; community radio; in-	Statutory platforms mobilised to amplify marginalised voices;	Quarterly progress reports; injury trend analysis; stakeholder	Ambulance delays and violence-related injuries	Clinic functionality, first responders and CHWs	District and provincial health forums; quarterly

Setting	Entry points and levels	Blended mechanisms	Implementation arrangements	Monitoring and accountability	Contributions by policy community		
					Community/patients	Providers	Decision-makers
		person and virtual forums	dedicated coordinating body; logistical support and sustained relationships to build trust and continuity	feedback for continuous improvement			reporting cycles

Table 3 here

Diverse policy communities conferred new and integrative perspectives

The process convened actors who do not routinely deliberate together, bringing experiential, practical and institutional knowledge into direct exchange. Injured people and community members contributed everyday prevention concerns and lived problems: unsafe roads, household hazards, violence, delayed transport, costs of care and the social consequences of injury and rehabilitation. Providers most often identified service and implementation problems: referral pathways, emergency response, workforce capacity, data and cross-sector coordination. Decision-makers most often identified authorising conditions: mandates, resources, administrative levels, institutional platforms and links to planning and policy cycles (Table 3).

Bringing these forms of knowledge and authority into the same process allowed problem definitions, feasible responses and authorising routes to be discussed together. This was reflected in the resulting strategies as negotiated accounts of how injury concerns could move from community experience into sectoral action, planning processes and governance. The integrative perspective was evident across settings. In Ghana, road and domestic-injury concerns were linked to district planning routes and trusted communication systems; in Pakistan, burn and trauma concerns to community mechanisms and data systems reaching higher policy audiences; in Rwanda, referral and reporting concerns to multilevel coordination and real-time information; and in South Africa, ambulance delays and violence-related injuries to clinic committees and provincial structures.

Convergence and variation

The strategies converged around the need for inclusive, sustained and locally anchored engagement, with differences in locations, processes and functions reflecting wider institutional and political conditions. In Ghana, engagement depended on linking formal decentralisation with customary authority and trusted communication channels. In Pakistan, engagement required flexible, community-anchored mechanisms suited to decentralised governance operating unevenly across sites, while still producing evidence for provincial and national audiences. In Rwanda, engagement could be more formalised when aligned with central coordination, administrative authority and information systems. In South Africa, engagement required support for existing participatory structures alongside explicit mitigation of structural exclusion. Strategies identified where engagement could be embedded, what capacities were required, and exclusions to be mitigated. They also demonstrate why multisectoral collaboration requires attention to political ecosystems, relationships and conflicts, distributed leadership, incentives and implementation conditions (Table 4).

Table 4
Institutional and political conditions and engagement strategies, by study setting

Setting	Institutional and political conditions	Engagement strategy summary
Ghana	Formal decentralisation exists but implementation, public education and resources are uneven; customary authority remains important for local legitimacy.	Use district/sub-district routes, durbars and traditional authorities, with mobile/radio mechanisms to link local injury concerns to planning and accountability routes.
Pakistan	Decentralised governance with challenges in consistency and limited consultative policy formulation mean formal multilevel engagement operates unevenly across sites.	Use community-based organisations, panchayats, in-person outreach, mobile communication and digital monitoring to sustain participation and generate policy-relevant evidence.
Rwanda	Central coordination and dense decentralised structures create clearer routes for linking community, provider and policy levels.	Build on multilevel administrative and health system coordination, strengthening referral, reporting, data sharing and feedback around injury care.
South Africa	Formal participatory structures exist but operate within historical exclusion, unequal resources and under-resourced community health committees.	Use clinic committees, traditional forums and provincial routes while explicitly addressing representation, feedback, transport, administrative support and structural exclusion.

Table 4 here

Across settings, three mutually reinforcing conditions emerged. First, engagement needed predictable and legitimate spaces through which concerns could be raised, framed and connected to decision-making. Second, those spaces needed capabilities: resources, recognition, facilitation, feedback, data, trust and institutional support. Third, both spaces and capabilities required attention to inclusion. Spaces without capabilities risk performative participation, capabilities without institutionalisation risks disengagement, and explicit work on who is absent, who has voice and why mitigates risks of reproducing existing hierarchies. All participants expressed strong commitment to continued collaboration with the research teams, positioning them as relatively neutral arbiters between patients, communities, systems and policy.

Discussion

Injury care has continuous demands: emergency response, referral, cross-sector coordination, data flows and community trust need to function together, and no single stakeholder group can manage them alone. The COVID-19 pandemic demonstrated this at scale and lent new momentum to social participation in health decision-making¹¹. Injury systems in LMICs face these problems permanently. Inclusive policy processes, however, remain the exception. This study responded by coproducing strategic stakeholder engagement in injury care policy with non-peer policy communities across distinct governance contexts. Across all settings, decentralised administrative units emerged as consistent, scalable entry points connecting community-level knowledge with higher-level policy processes, supporting learning as a core systems function⁴¹. Specifics varied by different governance contexts, from formalised multilevel linkages under strong central coordination to community mechanisms where formal structures operate unevenly.

A key feature was connecting actor groups that would otherwise remain disconnected. Evidence from post-conflict settings shows that structured consensus-building can bridge formal and informal systems that rarely interact⁴², and long-term coalitions that embed relational investment show stronger knowledge translation beyond project-bound engagement⁴³. Explicit engagement of this kind remains under-theorised, however^{42,44}. We specify this as strategic stakeholder engagement: extending bounded, instrumentation-led and information-based interventions with strategic approaches that are multi-component and connect citizen voice with institutional capacity to respond^{18,45}.

This finding is consistent with recent critiques of agenda setting theory. While Kingdon treats alignment of problem, policy, and politics as mainly exogenous, recent research has shown that alignment can be actively manufactured by political actors through 'statecraft': curated evidence, strategically designed consultation, coordinated leadership⁴⁶. Our findings provide a participatory counterpart, in which communities, providers, and decision-makers built shared purpose together as active agents of statecraft. Alignment usually driven by political actors was constructed with communities. This reframes political commitment, often identified as necessary for multisectoral action^{47,48}, as something engagement itself can build. Like its governmental counterpart,

participatory statecraft is not neutral; it must identify and challenge the social and institutional norms and hierarchies that shape which problems, solutions, and opportunities become visible. Effective engagement therefore requires understanding how policymakers process evidence and operate within political environments, moving beyond dissemination to engage with power and actor dynamics^{49–51}.

The convening of engagement spaces is critically important. In other work, policymakers themselves identify institutionalised partnerships, researchers' practical and expert advice, leveraged networks, clearly defined roles with conflict resolution, and supportive institutions as key enablers of engagement⁵², converging with the conditions identified here. Researchers, however, often engineer themselves out of engagement, treating withdrawal as the marker of sustainability. HPSR's 'pracademics' provide an alternative role as boundary-spanners creating new deliberative spaces within systems^{3,53}.

The study also reinforces the limits and risks of co-production. Structured facilitation, heterogeneous group composition and reflexive practice were designed to mitigate known harms⁹ (Supplementary Table S3). Structural under-representation of women and lesser-heard voices limited the diversity of perspectives, and participation costs are likely to have fallen disproportionately on community actors^{8,54}. The implication for policymakers and funders is to treat engagement as a core governance function rather than a project activity, institutionalised through mandated representation, formal community and frontline roles, and resourced platforms for dialogue and feedback⁵⁵.

Findings are aggregated consensus outputs, reflecting the nominal group design. The process supported convergence and may have muted dissent, although participants candidly explored sensitivities surrounding social hierarchies, accountability limitations, and marginalised voices. While broad community engagement and involvement activities legitimised and amplified community and women's voices, the relative absence of gendered content may reflect the male-skewed composition of community and policymaker groups⁵⁶. Participants were purposively selected from prior engagement, and because injury types differ in aetiology and actor landscape, strategies may need refinement by injury pattern. The strategies reported here have not yet been implemented or evaluated. They underpinned intervention prioritisation in the wider programme, which will determine their relevance and utility.

Conclusion

This study shows that alignment of problems, responses and political authority through which policy change becomes possible can be constructed with communities rather than for them. Here, stakeholders jointly framed injury problems, appraised feasible responses, and connected them to authorising routes within existing governance. Political commitment, often treated as a precondition for multisectoral action, emerged as something engagement itself can build. Bringing together injured people, community members, health workers, and policymakers across diverse contexts, engagement was embedded within existing accountability structures, surfacing lived and shared priorities, and actionable strategies that no single group could have provided. Meaningful engagement requires resourcing, recognition, institutionalisation, and alignment with specific political, cultural, and organisational contexts. As states navigate compounding challenges, embedding structured dialogue and feedback mechanisms within district and provincial planning cycles offers a practical pathway for institutionalising inclusive policy engagement in injury care and beyond. Embedded researchers, HPSR's pracademics, are well placed to support such spaces.

Abbreviations

A&E, accident and emergency

CEI, community engagement and involvement

CHW, community health worker

DALY, disability-adjusted life year

HPSR, health policy and systems research

LMIC, low- and middle-income country

NCD, non-communicable diseases

NGT, nominal group technique

NIHR, National Institute for Health and Care Research

RREAL, Rapid Research Evaluation and Appraisal Lab

WHA, World Health Assembly

WHO, World Health Organization

Declarations

Data availability: Data are available upon reasonable request from the project principal investigators, subject to ethics approvals and protection of participant confidentiality. Workshop facilitation materials are available on the same basis.

Author contributions: This manuscript has been prepared by the Equi-Injury team. JD and KC designed the study and led the submission of the grant application. ST, JR, ABek, JCB, AnB, Alg, and LD are co-investigators on the NIHR Equi-Injury programme grant who participated in the procedures for work package 1, reported here. ST, JR, ABek, JCB and KC led study sites and oversaw data collection, with overall supervision. LD and AI designed and co-led the stakeholder involvement Work package 1. NT, DFB, ZWA, FSA, HA, ZBC, YC, TM, CL, AEA, RO, DKY, ET, NOM, PN, GU, LN, BTA, AA, LG, NJN, AD, MM, IB, ON, KA, NBS, and NM are significant contributors who collected and analysed country-level data. AP, JW, ABek, AnB, DN, EKA, LN, ET inputted to the design of the overall study. LD drafted the manuscript with Alg and JD. All authors critically reviewed, provided feedback, and approved the final manuscript.

Competing interests: The authors declare no competing interests.

Ethics approval and consent to participate: This study received approval from ethical review boards: Ghana Health Service Ethics Review Committee in Ghana (GHS-ERC 014/09/22); Aga Khan University Ethics Review Committee in Pakistan (2022-7372-23339); Rwanda National Ethics Committee (IRB 00001497 of IORG000110, No 85/RNEC/2023); and Stellenbosch University Health Research Ethics Committee in South Africa (N22/07/079). The University of Birmingham (overall sponsor for this study) accepted the local ethics approvals for this project in lieu of the requirement for full ethics review. Written informed consent was obtained directly from participants.

Funding: This research was funded by the NIHR (award number 133135) using UK aid from the UK Government to support global health research and by the International Strategy Partnerships Fund 23/24, issued by Research England and the University of Birmingham. The views expressed are those of the authors and not necessarily those of the NIHR, the UK Government, Research England or the University of Birmingham.

Acknowledgements: We extend deep gratitude and thanks to all participants, community members, healthcare workers, hospital managers, decision- and policymakers across Ghana, Pakistan, Rwanda, and South Africa who contributed their time, expertise, and perspectives to the multistakeholder workshops on which this paper is based. We acknowledge country teams and wider research centres for leadership in convening, facilitating, and analysing the workshops, and the wider Equi-Injury consortium for their contributions to the programme of work.

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