Is co-production an asset for the future of health promotion?

Glenn Laverack, Dors advisor

Co-production has become a popular term in health promotion with the promise of equal and reciprocal involvement by the end users and the best outcomes for everyone. But there is a contradiction between professional ambitions to increase the choices of others, and the top-down control exerted through many health promotion approaches. Co-production aims to offer something better, new and different. However, is it simply ¨old wine in new bottles¨, a recycling of the terminology, or is it an asset for the future of health promotion?

What does co-production look like in health promotion?

Co-production, co-creation and co-design are terms (referred to here as co-production) based on the principles of equity, diversity, mutual respect, empowerment and trust. Co-production has been applied to many sectors including economics, research, health services, disability, technology and science. Co-production has also become popular in health promotion and is viewed as a people-centred approach to facilitate the design of programs and the use of services, to share responsibility, and to work together in an equal, reciprocal and meaningful relationship ([1]). The goal is to produce the best outcomes for everyone, and that all participants are equally involved in decision-making.

Health promotion is the process of enabling people to increase control over, and to improve their health ([2]), it addresses health inequalities and can also have a clinical function to create more integrated, people centred health care. A top-down health promotion approach views people as the beneficiaries of program outputs in contrast to a bottom-up approach that engages with and identifies local needs to better utilise services and to develop disease prevention and control procedures. Co-production is bottom-up, it shares the same challenges as other community-based approaches

including engagement, building trust, working in areas affected by conflict and devolving responsibility and ownership to the local level.

There is no single definition, no minimum standards or a framework for the design, implementation and evaluation of co-production. Co-production takes various forms and commonly begins by getting the key stakeholders together so they can talk, plan and share lived experiences and different perspectives. The process of co-production aims to create shared interests, to frame the issue, and to provide an opportunity for contribution, reflection, adaptation and agreement ([3]). Similarly, community-based approaches work with stakeholders to plan effective actions, often started and facilitated by outside agents. In the 1960´s, Paulo Freire, for example, developed a bottom-up approach of ongoing community interaction for reflection and action to increase critical awareness ([4]). The Community-Led Ebola Action approach illustrates a modern community-based approach.

Community-Led Ebola Action

Community-Led Ebola Action ([5]), is an effective community-based approach that uses the following steps: preparation, triggering, action planning and follow-up. It encourages communities to take responsibility for local actions by creating a collective sense of urgency to act by realising the consequences of inaction. The approach enables people to make their own appraisal and analysis of a local situation, to work with authorities to consider their needs, and to have more ownership of the outcomes through the development of an action plan. The approach has been used in infectious disease outbreaks to enable communities to decide how they will protect families, ensure safe and dignified burials, respond to sick people, utilise available health services and create a supportive environment for the most vulnerable. It helps to build trust between communities and authorities by listening to local concerns and by promoting local action without the dependency on external support and resources.

As a method and an approach, co-production promises to create a meaningful working relationship, for example, between health professionals and communities and between service providers and users and to offer something better and different to

other bottom-up health promotion approaches. The award winning ¨start something good¨ initiative illustrates what co-production looks like in a contemporary setting.

The ¨start something good¨ initiative

The ¨start something good¨ initiative (Start Something Good - Cwmpas) uses participatory techniques such as a ¨hackathon¨, an event that engages individuals and teams in a workshop to intensively solve problems and to create innovative solutions. Typically, in one day the initiative can identify hundreds of new ideas, feeding off local perspectives, and can prioritise these into just a few that can be used by authorities and businesses to make services more attractive. For example, in community-led housing to bring people together with a shared vision to decide what kind of homes and communities they want to live in. The goal is to create affordable living spaces, with user inputs, and importantly with the support of developers and investors.

The key question is: Does co-production offer something new that can achieve a meaningful working relationship and the best outcomes for everyone, is it an asset for the future of health promotion?

Is co-production an asset for the future of health promotion?

The promise of greater community involvement is an attractive idea for governmental services that want to be seen to be working in a more meaningful way. Co-production could be an asset, allowing all stakeholders to share needs and experiences, guided through a facilitated dialogue, to create more inclusive programs and services. However, co-production as a mainstream approach in health promotion could be problematic and must be supported by the development of specific professional skills and an attitude that communities are valuable, equal partners. Greater transparency and accountability would have to be an integral part of co-production to build the trust between communities and government that is sometimes lacking. Government services would also need to provide extra resources including time, finances and skills and develop a close working relationship with non-governmental partners that have the networks, connections and experience to engage with diverse socio-cultural communities.

Health promotion that carries the label of co-production will be expected to equally represent all stakeholders, have a high level of engagement and the potential to be empowering and transformative. However, without the necessary extra resources to support the implementation and participatory follow-up, co-production and government services can simply pay lip-service to community involvement. The alternative is to sub-contract the process to organisations that can profit from fast-tracking the process of prioritising local needs. However, this rapid process can dilute the quality of new ideas and does not serve the best interests of everyone especially when the control of the outcomes can shift to those stakeholders, investors and developers, with the financial authority, and not to communities.

Empowerment must be an integral part of co-production including a critical understanding by everyone of the underlying causes of the powerlessness and the inequalities that influence people´s lives and health. Co-production is a meaningful involvement, it is not symbolic, not a one-time consultation to design a service or a program by feeding off local ideas, it is about long-term social change and local involvement from the outset and with continued support and follow-up.

Conclusion

If implemented correctly, co-production can be an asset to government services that want to be seen to promote greater community involvement. To do so, will require a clear definition of the terms, a framework for implementation and evaluation and the skills development of health promotion practitioners.

If not implemented correctly, co-production can simply be a hollow promise that perpetuates the social exclusion it seeks to remedy ([6]), without addressing local needs. Who determines what is eligible, what is valuable, and what gets resourced, in a provider-user relationship, can either empower people (bottom-up) or simply contribute to a top-down service delivery. The contradiction between an equal and reciprocal involvement and the control that authorities exert over programs and services will only change when there is a real political commitment to empower the end users.

An informed debate about whether or not co-production is an asset for the future of health promotion must be supported by clear evidence of its promise for the equal involvement and the best outcomes for everyone. Ideally, this would include studies that are co-designed, co-conducted and co-written, such as bottom-up reviews of lived experiences, and follow proper standards for public involvement in research ([7]). Co-production is not a panacea for the future of health promotion and does not presently offer an added value over and above other community-based approaches.

The original English version is available in the following article published on 7th April 2026: La co-produzione è una risorsa promettente per il futuro della promozione della salute? - Dors

Glenn Laverack Bio

He is a social scientist with a distinguished career in international health promotion for 40 years as a practitioner, academic, researcher, and as an adviser to the UN, governmental and to third sector organisations, in more than 50 countries. He is an advocate for the value of involving communities at the centre of health promotion and has a wide range of publications including 28 books in 13 different languages. He has managed several large-scale health promotion programs including in Ghana and India and has worked as a consultant to design and evaluate many projects. He was formerly the Director of Health Promotion, at the University of Auckland, New Zealand and is currently an adjunct full professor at the United Arab Emirates University and an independent adviser and researcher.

References

[1] Redman, S et al. (2021) Co-production of knowledge: the future. British Medical Journal. 2021 Feb 16;372:n434.
[2] Health promotion glossary of terms 2021. Geneva: World Health Organization; 2021. Licence: CC BY-NC-SA 3.0 IGO.
[3] Allen, W. (2025) Designing with the future in mind: Embedding adaptability, learning, and influence from the outset. Designing together: reflections on co-design in complex settings - learningforsustainability.net.
[4] Freire, P. (1973) Education for critical consciousness. New York: Seabury Press.
[5] Social Mobilisation Action Consortium. (2014). Community-Led Ebola Action: Field Guide for Community Mobilizers. Freetown, Sierra Leone.
[6] Chapman et al. (2026) Research Involvement and Engagement. 12: 11. https://doi.org/10.1186/s40900-025-00831-y
[7] UK standards for Public Involvement (2019) UK Standards for Public Involvement

Additional resources

OECD Guidelines for Citizen Participation Processes (2022)
https://www.oecd.org/content/dam/oecd/en/publications/reports/2022/09/oecd-guidelines-for-citizen-participation-processes_63b34541/f765caf6-en.pdf

WHO framework for meaningful engagement of people living with noncommunicable diseases, and mental health and neurological conditions (2023)
https://iris.who.int/server/api/core/bitstreams/08a5abc4-c988-4e0a-9fca-f453bbca616b/content

Voice, agency, empowerment handbook on social participation for universal health coverage (WHO, 2021)
https://iris.who.int/server/api/core/bitstreams/f7980b68-6ce9-4091-b7e2-b32ebafdecea/content