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Social appropriation of knowledge as an expression of University Social Responsibility in health sciences: a scope review.

Apropiación social del conocimiento como expresión de la Responsabilidad Social Universitaria en ciencias de la salud: una revisión de alcance.

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Summary.

Introduction. University Social Responsibility (USR) guides higher education institutions to respond to the needs of society, and in the health sciences, this implies linking teaching, research, and outreach with the health priorities of communities. Furthermore, the social appropriation of knowledge (SAK) represents a co-creation practice with communities. The relationship between USR and SAK enhances educational practices with external communities. **Objective.** To identify and map experiences in which the university health sciences community promotes the social appropriation of knowledge (SAK) in external communities as an expression of USR. **Methods.** A scoping review was conducted that included primary studies relating SAK practices to USR in external communities, promoted by at least one member of a health sciences faculty. The search was conducted in four databases. Data extraction included: study objective, university and community participants, actions, co-creation, and SAK outcomes. **Results.** Two hundred and eighteen records were found, of which seven were included, published between 2013 and 2025. Service-learning modalities predominated, along with an institutional model of medical education with community engagement, a student-led campaign, a dissemination event, and a participatory community research process. The experiences demonstrated different levels of knowledge co-creation, ranging from strategies focused on the unidirectional transfer of information to processes of joint construction with communities. The results included empowerment, knowledge transfer, satisfaction, and strengthening of the university-community link. **Conclusions:** Community service is configured as a relational, sustained process built with communities, rather than as a unidirectional transfer of information. Integrating social responsibility and community service as cross-cutting axes of health sciences training represents an opportunity to train socially committed professionals.

Keywords: University Social Responsibility, Social Appropriation of Knowledge, Health Sciences Education, Learning, Service, Community Participation.

Resumen.

Introducción. La Responsabilidad Social Universitaria (RSU) orienta a las instituciones de educación superior a responder a las necesidades de la sociedad, y en ciencias de la salud implica articular la docencia, la investigación y la extensión con las prioridades de salud de las comunidades. Por otra parte, la apropiación social del conocimiento (ASC) representa una práctica de co-creación con las comunidades. La relación de la RSU y la ASC potencializa las prácticas educativas con las comunidades externas. **Objetivo.** Identificar y mapear las experiencias en las que la comunidad universitaria de ciencias de la salud promueve la apropiación social del conocimiento (ASC) en comunidades externas, como expresión de la RSU. **Métodos.** Se realizó una revisión de alcance que incluyó estudios primarios que relacionaran las prácticas de ASC con la RSU en comunidades externas promovidas por al menos un miembro perteneciente a una facultad de ciencias de la salud. La búsqueda se realizó en cuatro bases de datos. La extracción de datos incluyó: objetivo del estudio, participantes universitarios y comunitarios, acciones, co-creación y resultados de la ASC. **Resultados.** Se hallaron 218 registros de los que se incluyeron 7, publicados entre 2013 y 2025. Predominaron las modalidades de aprendizaje-servicio, junto con un modelo institucional de educación médica con compromiso comunitario, una campaña liderada por estudiantes, una jornada de divulgación y un proceso de investigación participativa comunitaria. Las experiencias evidenciaron diferentes niveles de co-creación del conocimiento, desde estrategias centradas en la transferencia unidireccional de información hasta procesos de construcción conjunta con las comunidades. Los resultados incluyeron empoderamiento, transferencia de conocimiento, satisfacción y fortalecimiento del vínculo universidad–comunidad. **Conclusiones.** La ASC se configura como un proceso relacional, sostenido y construido con las comunidades, más que como una transferencia unidireccional de información. Integrar la RSU y la ASC como ejes transversales de la formación en ciencias de la salud representa una oportunidad para formar profesionales socialmente comprometidos.

Palabras clave: Responsabilidad Social Universitaria, Apropiación Social del Conocimiento, Educación en Ciencias de la Salud, Aprendizaje, Servicio, Participación de la Comunidad.

1. Introduction

Biomedical education aims to train professionals capable of responding to society's health needs. In this context, higher education institutions face the challenge of preparing socially competent and responsible professionals committed to transforming the realities of communities (1). The University Social Responsibility (USR) model guides higher education institutions to respond to social challenges by integrating teaching, research, and outreach with the needs of the population (2).

According to Vallaeys (3), University Social Responsibility (USR) implies a broader view of the professional field that involves understanding the political, social, and economic dimensions of its institutional academic and training activities. In the health sciences, this approach involves developing competencies that transcend technical-clinical training and incorporate ethical commitment, equity, participation, and social transformation (4). Among the strategies for implementing USR are service-learning, community learning, and other participatory methodologies that strengthen the link between the university and society (5).

As part of understanding the social dimension, the WHO (6) has defined community participation as: "the process of developing relationships that enable stakeholders to collaborate to address health problems and promote well-being, thereby achieving positive health impacts and outcomes." Based on this definition, the pursuit of connection between health systems and communities creates the possibility of continuous learning for well-being and the sustainability of care practices. The voice of communities has become much more relevant by focusing on

relationships based on values such as respect and recognition of others, with the aim of identifying the needs felt in their territory through beliefs and customs. In this exercise of recognition, the WHO is clear in indicating that these actions are not only the responsibility of community health personnel, but also include different actors such as policymakers, researchers, and non-governmental organizations.

Several studies have shown positive health outcomes through citizen participation. Haldane et al. (7) indicate that this approach, combined with the Sustainable Development Goals, involves participatory strategies that generate community empowerment and reduce health inequalities; this study contributes to the evidence base that supports the effectiveness of community participation in generating positive results at the organizational, community, and individual levels.

Thanks to community participation and the co-creation of communities, the term Social Appropriation of Knowledge (SAK) emerged, seeking to generate conditions for the use, inclusion, and exchange of knowledge through participatory processes that promote the democratization of science and contribute to the transformation of territories (8). This concept, promoted within the framework of Science, Technology, and Innovation (STI) in Colombia, proves to be an innovative approach that views partnerships as inherent and not imposed by health systems. In the health sciences, this approach allows for the integration of education, research, and outreach with community health priorities, strengthening both community capacities and the training of socially committed professionals. In this context, University Social Responsibility (USR) plays a relevant role by recognizing the University's commitments to society and its communities. In the case of health sciences programs, identifying their characteristics, implementation methods and results will allow us to understand how these initiatives, under the CSU model, strengthen the relationship between the university and the communities and contribute to the social commitment of higher education institutions.

Therefore, the objective of this scope review was to identify and map the experiences in which the university health sciences community promotes the Social Appropriation of Knowledge in external communities as an expression of University Social Responsibility.

2. Methods

A scoping review was conducted following the methodological framework of Arksey and O'Malley (9), with the refinements proposed by Levac et al. (10), and reported according to the PRISMA Extension for Scoping Reviews (PRISMA-ScR) guidelines (11). This design was selected for its suitability in mapping the extent, scope, and nature of the available evidence on a broad and heterogeneous topic, as well as for identifying knowledge gaps. This scoping review did not have a pre-established protocol but followed the methodology described above.

The review question was formulated using the Population-Concept-Context (PCC) framework: What are the practices through which the university health sciences community promotes the Social Appropriation of Knowledge in external communities, and what are their characteristics, modalities, and results? The population consisted of members of the university health sciences community (students, faculty, graduates, administrative staff, directors, or the institution); the concept was the Social Appropriation of Knowledge as an expression of University Social Responsibility, including processes of participation, dialogue of knowledge, and co-creation of knowledge; and the context included communities external to the university, such as educational institutions, vulnerable communities, rural contexts, migrant populations, or people deprived of their liberty.

The literature search was conducted in May 2026 in the PubMed, EMBASE, Epistemonikos, and LILACS databases. The search strategy was adapted to the characteristics of each database and

combined terms related to University Social Responsibility, health sciences, and Social Appropriation of Knowledge, along with related terms such as "community participation" and "community engagement," in order to increase the likelihood of finding international studies. The strategy used in the databases is presented in the supplementary material. The management of bibliographic references and the study selection process were carried out using the Rayyan platform. This selection was performed using a paired approach, and any discrepancies were resolved by reviewing the full text.

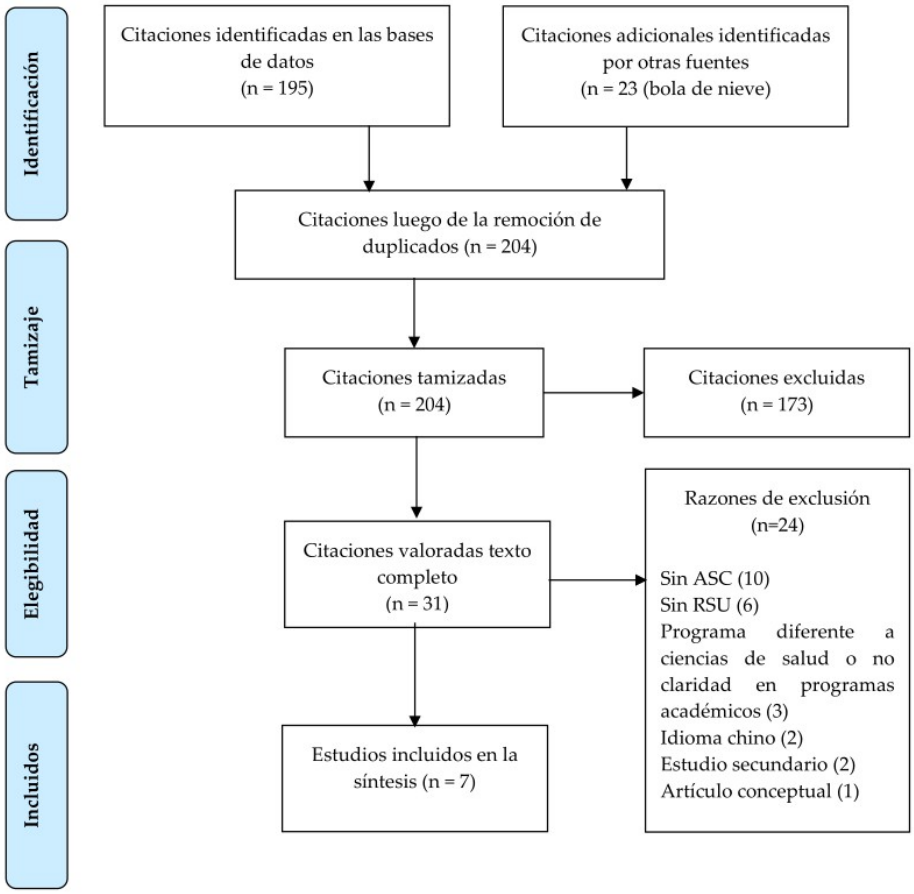
Primary studies published in English, Spanish, or Portuguese were included if they addressed University Social Responsibility or described actions consistent with this approach and developed processes of Social Appropriation of Knowledge in external communities. These processes were understood as initiatives that incorporated context recognition, community participation, and some form of interaction or shared knowledge construction, in accordance with the Public Policy on Social Appropriation of Knowledge within the framework of Science, Technology, and Innovation; especially those that represented its principles: (a) context recognition; (b) participation; (c) dialogue of knowledge and practices; (d) transformation; and (e) critical reflection (8). Furthermore, the studies had to involve at least one member of the university community belonging to health sciences programs. Literature reviews, editorials, letters to the editor, commentaries, conference abstracts, and studies that did not allow for the identification of Social Appropriation of Knowledge processes developed with external communities were excluded.

The following variables were extracted from the included studies: authors, year of publication, site of application of RSU and ASC, objective, university participants, participating community, type of intervention, actions developed, level of community participation, presence of co-creation or shared construction of knowledge and main results related to the Social Appropriation of Knowledge.

3. Results

3.1 Selection of studies

The search identified 218 records (195 in databases and 23 results obtained through snowball sampling). After removing duplicates, 204 records were screened, of which 173 were excluded during the title and abstract review. Subsequently, 31 full-text articles were analyzed, and seven studies were ultimately included in the synthesis (Figure 1). The reasons for exclusion in the full-text evaluation were: absence of the application of the Social Appropriation of Knowledge (n = 10), absence of University Social Responsibility (n = 6), programs not belonging to health sciences or lacking clarity regarding the included programs (n = 3), articles in Chinese (n = 2), secondary studies (n = 2), and conceptual articles (n = 1).



3.2 Characteristics of the included studies

Seven studies published between 2013 and 2025 were included (12–18). Table 1 presents institutional or academic program-based university practices in the health sciences related to community outreach. The studies were conducted in Spain (n = 3), Canada (n = 2), the Democratic Republic of Congo (n = 1), and the last one in Rwanda and Mexico with support from the United States. Students, faculty, and professionals from various health science disciplines participated in these studies, including medicine, nursing, public health, physical therapy, occupational therapy, pharmacy, dietetics, microbiology, and exercise and sports science. Service-learning experiences predominated (12, 13, 17), followed by an institutional model of medical education with a social commitment (14), a community outreach strategy (15), a student-led educational campaign during a health emergency (16), and a community-based participatory research process (18). The community practices represented in the participants, actions, co-creation and results of the ASC are described in Table 2. The participating communities included rural communities, survivors of armed conflicts (12, 16), women deprived of liberty (13), indigenous communities (14), school population (15), people in situations of social exclusion (17) and people who use drugs (18).

3.3 Narrative synthesis of university practices on CSR

3.3.1 Service-learning experiences

Plumb et al. (12) compare two international service-learning initiatives in global health, developed by teams of health science students and faculty from Thomas Jefferson University (in Rwanda) and San José State University (in Mexico). In Rwanda, a village of genocide survivors identifies its own needs and, through community health committees and a "train-the-trainer"

model, implements sustainable income-generating, water, and sanitation projects. In Mexico, host families co-organize the health fair in a reciprocal relationship of cultural exchange. Both descriptive cases illustrate a locally sustainable appropriation of knowledge. A drawback of the study is the lack of a formal impact assessment. Hinojosa-Alcalde and Soler (13) analyze a critical feminist service-learning intervention in a women's prison, resulting from a collaboration between faculty from INEFC–Universitat de Barcelona and the Department of Justice of Catalonia. Students design and implement a physical activity program based on the interests of female inmates, fostering a peer-to-peer relationship that breaks the routine and isolation, improves coexistence, and strengthens the prison-university link. Valderrama et al. (17) describe the service-learning program "Movies in Company for Preventing Diseases," developed by microbiology professors at the Complutense University of Madrid to bring microbiological knowledge to vulnerable individuals. Through multidisciplinary teams of health science students, the program screens films and develops discussions and outreach materials in community centers. This process involves identifying the group's interests beforehand and providing mutual recognition, resulting in high satisfaction and useful information on prevention and hygiene for the participants.

3.3.2 Institutional model of medical education with social commitment

Strasser et al. (14) describe the Northern Ontario School of Medicine, a school created with a mandate of social responsibility to improve the health of an underserved rural region. Through clinical training distributed across more than 70 communities, the school achieves greater retention of professionals in the area, a positive socioeconomic impact, and community empowerment.

3.3.3 Community outreach strategy

Díaz et al. (15) present the activity "Today We're Going to the Emergency Room!", an annual training day led by an educator and healthcare professionals from the Hospital Clínic, the Emergency Medical System (SEM), and the Barcelona Esquerra Primary Healthcare Consortium (CAPSBE). This day is aimed at secondary school students. The study describes the leadership of healthcare professionals and educators affiliated with the University of Barcelona and guides the dissemination of knowledge to an external community (educational centers). Its objective was to present the purpose, content, and logistical-pedagogical aspects of the activity "Today We're Going to the Emergency Room!" and to evaluate the project, which has been running for 15 years, through the opinions of its participants. The experience transfers knowledge about the appropriate use of emergency services and receives a positive evaluation, although the definition of content falls primarily to the organizers.

3.3.4 Student-led educational campaign during a health emergency

Masumbuko-Claude and Hawkes (16) document a community education campaign led by approximately 600 medical students from the Université Catholique du Graben during the Ebola epidemic in eastern Democratic Republic of Congo. The campaign included parades, one-on-one interventions, and messages in religious services and on the radio in local languages. This intervention reached between 5,000 and 10,000 people in a context of conflict and social resistance. Following the outreach, 73% of the community reported a better understanding of Ebola and 71% greater motivation. Although this was an observational study with cultural and linguistic adaptation, it did not measure behavioral change or epidemiological impact.

3.3.5 Community-based participatory research

McBeth et al. (18) describe a co-creation process with people who use drugs in downtown Edmonton, based on participatory community research informed by complexity theory. An academic health team (family medicine and public health) and two medical students, in a support role, co-design the research with peer researchers and a community advisory group, employing micro-narratives (SenseMaker) and art-based mapping. The experience exemplifies the more participatory end of the spectrum: co-production of knowledge and intervention proposals, feedback through a community report, and capacity building for peer researchers.

3.4 Experiences of social appropriation of knowledge

The experiences identified revealed different modalities of Social Appropriation of Knowledge developed by higher education institutions in the health sciences. Service-learning was the predominant strategy and was characterized by integrating academic activities with previously identified needs in the communities, fostering experiential learning and strengthening the link between the university and the community (12, 13, 17). Institutional and community strategies showed diverse approaches to promoting university social commitment (Table 2). Some initiatives were aimed at strengthening regional development through institutional training models with community participation (14), while others prioritized health education and outreach through campaigns or workshops directed at specific communities (15, 16). Finally, one study implemented community-based participatory research, incorporating participants as co-researchers during all phases of the process, from identifying needs to jointly developing intervention proposals (18).

3.5 Mapping the findings on community participation and co-creation

The experiences revealed different levels of community participation. At the extreme end, those with the greatest co-creation involved communities in identifying needs and designing and implementing interventions (12–14, 17, 18). For example, the case of the Rwandan village (12) where trainers are trained and sustainable programs are maintained in areas such as food production, microfinance, communicable diseases like HIV/AIDS, and health promotion through sanitation. In contrast, initiatives focused on educational campaigns and outreach events showed a predominantly unidirectional interaction, although they adapted their content to the sociocultural context of the participating communities (15, 16). The study by Díaz et al. (15) identifies the relationship between high school students and urgent issues focused on youth health promotion and prevention. Although most studies had a descriptive observational approach, the results of community engagement were both positive and heterogeneous. Reciprocal learning is evidenced in: a) the strengthening of local capacities (13,18), b) the transfer of health knowledge (15-18), c) the improvement of coexistence (13,14,17), d) the co-production of knowledge (14,18) and, e) the strengthening of the link between the university and the communities (15,17).

Table 1. Characteristics and university practices of the included studies.

Authors (Year) / Country of the institution / (Reference)	Health science programs/disciplines	Modality of the experience	Target population or community	University Participants	University action
Díaz et al. (2018) / Spain (Barcelona) (15)	Emergency healthcare professionals and teachers (medicine)	Dissemination day aimed at the educational community	Students in the final year of compulsory secondary education	Emergency professionals from the Hospital Clínic and the SEM, doctors from other specialties, family doctors from CAPSBE and a pedagogue; the University of Barcelona provides the classroom.	Annual training day of 4 hours (distributed in two tables and nine modules) on the organization of urgent care and the main reasons for consultation in young people. The session was based on material adapted and reviewed by the educator A drawing contest was held.
Hinojosa-Alcalde & Soler (2021) / Spain (Catalonia/Barcelona) (13)	Sciences of Physical Activity and Sport	critical feminist service-learning	Women deprived of their liberty (women's prison)	81 fourth-degree students of Physical Activity and Sports Sciences (INEFC–Universitat de Barcelona) (24 women, 57 men); university teaching staff; 3 editions (2017–2020).	Design and implementation of a physical activity program (2 sessions/week, 4 weeks) in groups of 2–3 students; prior activities of critical reflection on prison and gender Writing activities in a reflective learning journal.
Masumbuko Claude & Hawkes (2020) / Democratic Republic of the Congo (Butembo) (16)	Medicine	Student-led community education campaign	Community in a conflict context during the Ebola epidemic	~600 medical students from the Université Catholique du Graben (UCG), Butembo; 355 evaluated the campaign	Training (half day) and educational campaign that included parade, speeches, one-on-one interactions, presentations in local languages (French, Swahili) both in religious services and on the radio,
McBeth et al. (2025) / Canada (Edmonton) (18)	Family medicine and public health	Community-based participatory research (CBPR)	People who use drugs	Academic health team (Family Medicine and Public Health, U. of Alberta), a coordinating postdoctoral fellow and two medical students (support role).	Co-design and conduct of participatory research (*SenseMaker micro-narratives* + art-based asset mapping), with iterative analysis.

Plumb et al. (2013) / United States (intervention in Rwanda and Mexico (12)	Medicine, nursing, public health, physiotherapy and occupational therapy, pharmacy	International service-learning (global health)	Rural communities and conflict survivors (village in Rwanda; artisan village in Mexico)	Students of health sciences (medicine, nursing, public health, physical and occupational therapy, pharmacy) and faculty from Thomas Jefferson University (Rwanda) and San Jose State University (Mexico).	Immersion: assessment of community needs. Education in schools (preschool to adults), Conducting health fairs, workshops and public health work.
Strasser et al. (2013) / Canada (Northern Ontario) (14)	Medicine, dietetics and medical assistants	Medical education with distributed community commitment (school with a mandate of social responsibility)	Rural, remote, aboriginal and Francophone communities	Medical students, dietetic interns and medical assistants; 91% from Northern Ontario; faculty and >670 clinical preceptors.	Integrated longitudinal clinical rotation in communities: Students lived in one of the communities learning the fundamentals of clinical medicine with a focus on family and community medicine.
Valderrama et al. (2025) / Spain (Madrid) (17)	Microbiology and related sciences (biology, biochemistry, medicine, pharmacy, veterinary medicine, virology)	Service-learning (science outreach)	People at risk of social exclusion (homeless, prisoners, migrants, people with disabilities, elderly)	Faculty teachers and technicians, hospital staff and pre/postdoctoral researchers (Complutense University of Madrid); >250 students of Biology, Biochemistry, Medicine, Microbiology and Parasitology, Pharmacy, Veterinary Medicine and Virology; >30 instructors (5 editions).	Multidisciplinary teams (3–5 students) that identify needs. They select and screen commercial films about diseases and develop educational materials and recreational activities (bingo, Kahoot, discussions). Three visits per center.

4. Discussion

This scoping review identified the relationship between the Social Appropriation of Knowledge (SAK) and University Social Responsibility (USR) in academic health sciences programs. Although SAK shares elements with community engagement, it recognizes communities as fundamental actors in the construction and exchange of knowledge. This perspective is realized through University Social Responsibility, by promoting scenarios in which the university transcends the classroom and directly understands the social realities of communities. Although university practices used diverse approaches to engaging with communities, service-learning was the predominant strategy (12, 13, 17), and most university-community interactions evolved from knowledge transfer models toward processes with greater community participation and co-creation. These findings suggest that SAK transcends scientific dissemination and represents a way to integrate teaching, research, and outreach with social needs, consistent with the principles of USR. The results are consistent with the approach of Coelho and Menezes (7), who describe service-learning as one of the main educational practices for developing social responsibility in higher education through experiential learning and collaborative work with communities. Similarly, Vallaeys's (3) conception of University Social Responsibility (USR), which emphasizes the importance of the social impacts generated by the university's core functions, aligns with the experiences identified in this review, where education, research, and community outreach were developed in an integrated manner. Furthermore, the theoretical foundations of Service-Learning (8) focus on the dialogue of knowledge, participation, and the collective construction of knowledge—principles that were particularly evident in the experiences with the highest levels of co-creation, such as those described by McBeth et al. (18).

Taken together, these findings are also consistent with international approaches such as accountability in health sciences education (14), community engagement, and co-production, which promote greater social responsibility among different institutions in the health sector and community participation in training, research, and innovation processes. These concepts share with Community Social Action (CSA) the recognition of communities as key actors in identifying needs, jointly constructing knowledge, and developing contextualized solutions. In this sense, CSA can be interpreted as a concept developed in the Latin American context that converges with principles widely recognized in the international literature on university social engagement, community participation, and knowledge co-production.

However, differences were also identified among the experiences analyzed. While some initiatives involved communities in identifying needs, designing interventions, and jointly producing knowledge, others were primarily limited to information transfer through educational campaigns or outreach activities. These findings show that community social responsibility (CSR) is not a dichotomous category, but rather a continuum of community participation, where the degree of involvement of social actors determines the level of knowledge appropriation achieved; that is, the extent to which cognitive, behavioral, and emotional aspects—key elements in learning—are mobilized. This approach to communities has not always been emphasized in previous studies on university social responsibility, which is why the number of studies included in this research is limited.

Despite finding relevant research studying health-related learning in communities supported by university initiatives, no evidence of bidirectional learning processes between the university and the communities was found—a key aspect of the co-creation and knowledge exchange described in Community Service Learning (CSL). Other studies were excluded because their focus was on describing educational strategies without delving into community participation and understanding social voices. Although there are not many studies involving University Social Responsibility (USR) and CSL, it is worth noting that university-community practices describe experiences of community participation that benefit communities in the following ways: a) empowerment processes, b) strengthening of local

capacities, and c) co-production of knowledge. In contrast, those with a predominantly informational focus mainly report knowledge transfer and participant satisfaction. Experiences with greater community participation were characterized by describing broader and more collaborative CSL processes. However, given the predominantly descriptive nature of the included studies, these findings should be interpreted with caution and do not allow for establishing causal relationships between the degree of community participation and the observed outcomes. In this regard, studies with analytical and longitudinal designs are needed to more robustly evaluate this relationship.

From the perspective of health sciences education, the findings of this review have several implications. First, integrating social responsibility strategies into academic programs can strengthen competencies related to communication, interdisciplinary work, the social determinants of health, and ethical commitment to communities. In this sense, socially responsible education requires learning environments that allow students to interact with real-world problems and develop solutions alongside social actors, going beyond the acquisition of technical and clinical skills (1, 4, 5).

Secondly, for higher education institutions, these results can serve as a starting point for incorporating community engagement as a cross-cutting axis of university social responsibility (USR). Strategies such as service-learning, participatory research, and other collaborative methodologies strengthen the university-community link and contribute to ensuring that knowledge generation responds to the social and health priorities of the territories, as described by McBeth et al. (18). Thirdly, from the perspective of university management, it promotes institutional policies that encourage community participation in training, research, and outreach processes, similar to the management model described by USR.

Among the limitations of this review is the methodological design of the included studies, as the findings are mostly derived from observational studies. Consequently, there is a need to develop studies that evaluate the impact of community-based knowledge (CBN) strategies on health indicators, with follow-up longitudinal studies that analyze behavioral changes, the strengthening of community capacities, and the sustainability of knowledge exchange between universities and society. Likewise, it is important to advance the development of conceptual frameworks and standardized indicators that allow for comparison of different approaches to the social appropriation of knowledge across institutions and contexts.

Table 2. Community practices, co-creation and results of the Social Appropriation of Knowledge (SAC).

Authors (Year) / Country (institution / intervention) (Reference)	Community participants	Community action	Co-creation (Two-way feedback)	Results of the ASC in the communities
Díaz et al. (2018) / Spain (Barcelona) (15)	10,260 fourth-year compulsory secondary education students (15–18 years old) from 56 educational centers in the area of influence of the hospital, and their teachers.	They attend the day, ask questions, debate in the classroom and participate in the contest "And you, how do you see emergencies?"; reflection and subsequent debate at school.	There's advance submission of questions, an opinion poll, and a contest (the winning drawing becomes the following year's logo); the educator aligns the dialogue with the center's needs. But the content is unilaterally defined by the organizers (the program has remained unchanged for 15 years).	Good rating (7.5/10); topics related to youth health (drugs, gynecology) received the highest scores; high demand for participation; knowledge transfer on appropriate use of emergency services and prevention. The impact on actual emergency service use was not measured.
Hinojosa-Alcalde & Soler (2021) / Spain (Catalonia/Barcelona) (13)	Between 10 and 15 female inmates volunteer per edition; prison sports instructor; Department of Justice of Catalonia.	Participation in physical activity sessions (cooperative motor games, fitness with music); in some cases, the inmates lead activities (e.g., Zumba). Peer-to-peer relationships.	Joint needs analysis with the instructor and on the first visit; content according to the interests of the women; inmates as instructors; final feedback from inmates, instructor and tutors.	The inmates break routine and isolation, enjoy themselves and actively participate; coexistence among inmates improves; the prison-university link is strengthened (visits to the campus, seminars, job offers).
Masumbuko Claude & Hawkes (2020) / Democratic Republic of the Congo (Butembo) (16)	Butembo community (DRC) in a context of conflict and 'social resistance' to the outbreak; 5,000–10,000 people reached, 319 assessed.	Reception of key messages in public spaces, markets and religious assemblies; they express attitudes and preference for local sources of information.	One-way educational intervention with cultural and linguistic adaptation; partners (WHO, UNICEF, Ministry of Health) provide support; without formal co-design with the community.	73% of the community reports a better understanding of Ebola; 71% is more motivated; 42% prefer local sources. Descriptive observational study: does not measure behavioral change or epidemiological impact.
McBeth et al. (2025) / Canada (Edmonton) (18)	People who use/have used drugs (PWUD) from downtown Edmonton (Canada): structurally vulnerable, homeless, high	Peer researchers (PWUD) and harm reduction workers co-design and conduct the research; PWUD Community Advisory Group; narrate and co-interpret the results.	Co-creation with the community is the central axis (CBPR, peer researchers, process consent, feedback in a community report 'zine').	Co-production of knowledge and intervention proposals with PWUD; community report; strengthening of peer researchers' capacities (entry, training); recommendations for participatory research with PWUD.

	indigenous proportion; 215 participants.			
Plumb et al. (2013) / United States (intervention in Rwanda and Mexico (12)	Village of genocide survivors in Rugerero/Akarambi (Rwanda) and artisan village of Arrazola, Oaxaca (Mexico) rural/vulnerable communities	Rwanda: community health committees, train-the-trainer model, income-generating projects (rabbits, beekeeping, mushrooms), water/sanitation. Mexico: families host, co-organize the health fair, reforestation; artisans visit the U.S.	Above all, the Mexico case (Exchange): a reciprocal, equal relationship, not starting from a 'problem' defined by the university. In Rwanda: needs identified by the community and training-the-trainer.	Sustainable and locally appropriate programs (community gardens, microfinance, HIV/AIDS, water and sanitation); health fair for 400+ people; empowerment through train-the-trainer programs; two-way cultural exchange. Descriptive case studies (without formal impact evaluation).
Strasser et al. (2013) / Canada (Northern Ontario) (14)	Rural/remote, aboriginal and Francophone communities in northern Ontario; health services, hospitals, elders, patients and families (who also act as teachers).	Community members participate in admissions, as standardized patients, preceptors and partners; they receive clinical care from trainees; capacity building and local economy.	Curriculum developed through community consultation; interdependent partnerships with communities, services and professionals; active community in multiple phases of the school.	61% of MD graduates choose family medicine (rural); 65% of residents and ~85% of dietitians remain in the region; socioeconomic impact (≈double the budget), community empowerment and better retention of professionals in underserved areas.
Valderrama et al. (2025) / Spain (Madrid) (17)	Disadvantaged people or those at risk of exclusion (~800): homeless, prisoners, drug/alcohol users, migrants, women at risk, people with disabilities, and the elderly. Partners: 7 NGOs and the Madrid City Council.	They receive scientific information about infectious and non-infectious diseases, companionship and support; they participate in film screenings, discussions and celebrations at their social centers.	First visit to identify the group's interests/needs; surveys of participants and coordinators; students report learning from the people served; final mutual recognition party.	High participant satisfaction; useful information on prevention and hygiene of diseases that interest them; opportunity for socialization, attention and companionship; they value the equal treatment of students.

5. Conclusions

- The findings of this review suggest that the Social Appropriation of Knowledge constitutes a manifestation of University Social Responsibility in the health sciences. The university practices included described service-learning as the most frequent pedagogical modality and identified different levels of community participation, ranging from knowledge transfer to dialogue and co-creation processes.
- The Social Appropriation of Knowledge can be considered a route for approaching communities from university contexts in order to respond to the needs of the communities from a participatory perspective with the advantage of empowering and giving a sense of equity to the knowledge of the university-community binomial.
- This presents an opportunity for academic communities to move from models focused on information transfer toward strategies that promote more active community participation and co-creation of knowledge. It also highlights the need for research with more robust methodologies and standardized indicators to evaluate the impact of these initiatives on student training, community strengthening, and health outcomes.

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