Community engagement for COVID-19 prevention and control: a rapid evidence synthesis

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ABSTRACT

Introduction Community engagement has been considered a fundamental component of past outbreaks, such as Ebola. However, there is concern over the lack of involvement of communities and ‘bottom-up’ approaches used within COVID-19 responses thus far. Identifying how community engagement approaches have been used in past epidemics may support more robust implementation within the COVID-19 response.

Methodology A rapid evidence review was conducted to identify how community engagement is used for infectious disease prevention and control during epidemics. Three databases were searched in addition to extensive snowballing for grey literature. Previous epidemics were limited to Ebola, Zika, SARS, Middle East respiratory syndrome and H1N1 since 2000. No restrictions were applied to study design or language.

Results From 1112 references identified, 32 articles met our inclusion criteria, which detail 37 initiatives. Six main community engagement approaches were identified: local leaders, community and faith-based organisations, community groups, health facility committees, individuals and key stakeholders. These worked on different functions: designing and planning, communication, community entry and trust building, social and behaviour change communication, risk communication, surveillance and tracing, and logistics and administration.

Conclusion COVID-19’s global presence and social transmission pathways require social and community responses. This may be particularly important to reach marginalised populations and to support equity-informed responses. Aligning previous community engagement experience with current COVID-19 community-based strategy recommendations highlights how communities can play important and active roles in prevention and control. Countries worldwide are encouraged to assess existing community engagement structures and use community engagement approaches to support contextually specific, acceptable and appropriate COVID-19 prevention and control measures.

Key questions

What is already known?

- Community engagement is considered a fundamental component during outbreaks and is important to ensure contextually appropriate interventions.

What are the new findings?

- How community engagement can be used for COVID-19 has yet to be thoroughly explored. Findings from this rapid review highlight the main community engagement actors and approaches and the interventions that they conduct within prevention and control of infectious disease. This review also notes the lack of documented community engagement activities from high-income countries.

What do the new findings imply?

- These findings highlight that well-implemented community engagement strategies can be used to support designing of interventions, building trust and community entry, social and behaviour change communication, risk communication, surveillance and contract tracing, and logistical and administrative support during COVID-19 prevention and control responses.

INTRODUCTION

Community engagement within health is crucial to achieve primary healthcare and promote people-centred services. It can support buy-in and sustainability of health interventions, health advocacy, improved quality and satisfaction of services, and contribute to health systems responsiveness and strengthening. Community engagement refers to involvement and participation of individuals, groups and structures within a parameter of a social boundary or catchment area of a community for decision-making, planning, design, governance and delivery of services. It is used as a parent notion with terms like communication, social mobilisation, community participation, community action and empowerment, with emphasis on the agency of community members or groups, considering them as active rather than passive participants.

Community engagement is seen as critical in many health initiatives,
such as for communicable disease\textsuperscript{10} and maternal and child health initiatives,\textsuperscript{13} and more recently has been considered a fundamental component during outbreaks, largely arising during the 2014–2015 Ebola epidemic in West Africa.

The way people interact and live with each other through their structures, as well as their historical pathways, require considerations on how to effectively adapt and respond to any disease outbreak. For example, differences in political–cultural and social structures, systems and processes among communities and social norms and beliefs affect health behaviours and outcomes during outbreaks.\textsuperscript{14} Experience with public health emergencies of international concern highlight the need for contextually appropriate community engagement strategies.\textsuperscript{15–21} Moreover, a recent rapid review noted key lessons in risk communication for control of outbreaks to include communities taking a central role in the response, involving local leaders and groups, tailoring interventions to communities and ensuring a two-way communication.\textsuperscript{17}

Early implementation of prevention and control activities during the 2014–2015 Ebola epidemic had several barriers, including suspicions regarding the existence of the disease and motives of the government and international organisations.\textsuperscript{15,19} To address these barriers, community engagement became a key pillar to the response. Several measures to engage communities were undertaken, including building partnerships with local and religious leaders and working with the community to develop and adjust key messages for behavioural change,\textsuperscript{15,22} and initiation of coordinated response mechanisms, such as Sierra Leone’s Social Mobilisation Action Consortium (SMAC), which supported community engagement activities during the Ebola outbreak from 2014 to 2016.\textsuperscript{23} These measures significantly contributed to the success achieved in controlling the outbreak and ensuring the resilience of the health system.\textsuperscript{9,15,22}

In relation to COVID-19, community engagement can be critical for creating local and context-specific solutions to prevention and control responses.\textsuperscript{24} Through this ‘bottom-up approach’, communities participate in ‘decision-making processes of planning, design, governance and delivery of services aimed at improving population health and reducing health inequalities’.\textsuperscript{5} The COVID-19 pandemic as a total social phenomenon should include actively engaging and adapting local views, voices and concerns in health crisis response efforts.\textsuperscript{24} Moreover, the WHO’s recommended measures to prevent and control COVID-19, such as physical–social distancing, case identification and contact tracing require understanding of the different social dynamics in communities and how these can better be leveraged to minimise the impact of the epidemic.\textsuperscript{25,26} The measures have a huge reliance on communities reigniting the importance of community engagement to build trust and delay disease spread as drug and vaccine development efforts continue.

However, there is concern over the lack of involvement of communities within COVID-19. Rajan and colleagues note the limited number of WHO member states reporting to have a COVID-19 community engagement plan.\textsuperscript{27} The scientific community—mainly drawn by social scientists—has called for the attention of funders and implementers on the relevance of community engagement for COVID-19.\textsuperscript{24} 28–30 with other international stakeholders, including WHO, UNICEF and the International Federation of Red Cross and Red Crescent Societies (IFRC) echoing its importance.\textsuperscript{25} This concern must be understood considering that, at the beginning of the pandemic, there was a tendency to prioritise biomedical and epidemiological interventions even if international stakeholders have early and progressively defined some guidelines on risk communication and community engagement.

Recent reviews on global evidence for COVID-19 have focused on community health workers (CHWs)\textsuperscript{31} providing important evidence and insights to guide response. However, there is no evidence synthesis that addresses how community engagement can be used for COVID-19 prevention and control. Thus, we conducted a rapid evidence review on community engagement for infectious disease prevention and control to learn lessons for COVID-19 and future pandemic response.

**Review focus**

This review wanted to understand ‘how community engagement is used for infectious disease prevention and control during epidemics’. In doing so, we reviewed evidence from previous epidemics and aimed to identify what approaches and community actors are involved, what interventions are conducted, who the target groups of community engagement are and how equity considerations are incorporated, what the linkages and relationship to other health system stakeholders are, and what the main implementation considerations for successful community engagement for infectious disease prevention and control are. To address these questions, we draw on findings from five previous epidemics: Ebola, SARS, Middle East respiratory syndrome (MERS), Zika and H1N1.

**METHODS**

Given the emergency nature of the recent COVID-19 global pandemic, we conducted a rapid evidence review to support timely findings. Rapid reviews are a form of evidence synthesis that tailor the methodology of a systematic review to produce contextually relevant evidence on an arising topic in a timely and efficient manner.\textsuperscript{32} To support the expedited nature of rapid reviews, they can deviate from traditional reviews in several areas, including narrowing the scope, limiting the number of searches or electronic databases, using one reviewer for study screening and selection, and parallelisation of review tasks.\textsuperscript{32} This rapid review followed the methodology that addresses how community engagement can be used for infectious disease prevention and control.
suggested by the Alliance for Health Policy and Systems Research. A co-production team comprising all authors of this paper was established through the collaborative platform ‘Community Health–Community of Practice’, supported by UNICEF.

A protocol was developed and agreed on by the research team, which comprises academics, implementers and policy makers from multiple disciplines and backgrounds. The team then conducted a rapid evidence review of academic and grey literature in May 2020. The main focus of the review was to identify what types of community engagement approaches are used within infectious disease prevention and control, which required articles to describe a minimum of one specific initiative. As such, no criteria for effectiveness or outcomes were applied. Full inclusion and exclusion criteria can be found in table 1.

In line with community agency and taking into account a framework developed by UNICEF and revised by Community Health–Community of Practice, the definition of community engagement adopted in this study covers the range of collaborative processes with community actors that transcend beyond CHWs and includes community groups, informal providers, faith organisations or social networks. We excluded CHW approaches and interventions as reviews of this nature have already been conducted; though we included articles if they described community engagement approaches alongside CHW programmes and narrowed the scope to include five recent infectious disease outbreaks: Ebola, SARS, MERS, Zika and H1N1.

**Databases and snowballing**

In line with rapid review recommendations, we limited our searches to three databases: PubMed, CINAHL and Scopus. We conducted an extensive grey literature and snowball search by reviewing websites of numerous public health organisations and repositories, as well as emailing the authors’ respective networks. Online supplemental file 1 provides a list of snowballing sources and completed database searches. Search terms were in both French and English. In addition, all included articles’ references were checked. To expedite the review process, two authors conducted the database search; three conducted grey literature and snowballing searches; and two conducted reference searching.

**Article screening and extraction**

All returned results were entered into Covidence, a systematic review information management system, where duplicates were removed. The remaining articles were screened at title and abstract stage, and full-text stage independently by two reviewers, with a third resolving any discrepancies. Two team members independently screened all returned snowballing resources at full-text stage, with a third reviewer resolving any discrepancies. All authors participated in the screening.

Predefined and piloted data extraction tables were developed. Two authors initially extracted data from the included articles, with other authors reviewing all extractions for reliability and consistency. Content on community engagement actors/approaches and intervention focus was extracted directly as the articles reported if applicable; however, this often did not occur, leaving the review team to extrapolate and categorise. Given that the research question seeks to identify what has been used, no quality ratings were applied to the included articles.

**Public and patient involvement (PPI)**

There were no funds or time allocated for PPI, so we were unable to involve patients. We encourage throughout the findings for programme and policy makers to involve communities within the design and implementation of their respective programmes.

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Table 1 Inclusion and exclusion criteria

<table>
<thead>
<tr>
<th>Topic</th>
<th>Inclusion criteria</th>
<th>Exclusion criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention/population</td>
<td>Describes a specific community engagement approach or activity</td>
<td>Exclusively community health worker programmes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Structures without community members serving the same community</td>
</tr>
<tr>
<td>Focus</td>
<td>Prevention and/or control of infectious diseases: Ebola, SARS, Middle East respiratory syndrome, Zika and H1N1</td>
<td>Not focused on prevention and/or control of infectious disease</td>
</tr>
<tr>
<td>Scope of intervention</td>
<td>Community level—defined by ‘the social boundaries that define the individuals and households whose health outcomes matter as a health system goal, and also the social context for the relationships that underpin the success of many health systems interventions’</td>
<td>Not community focused</td>
</tr>
<tr>
<td>Time</td>
<td>Published on or after 2000</td>
<td>Published before 2000</td>
</tr>
<tr>
<td>Article type</td>
<td>Primary, empirical studies, of any design, programme reports and descriptions that provide learning on specific CE approaches</td>
<td>Commentaries, abstracts; no specific community engagement approach detailed</td>
</tr>
<tr>
<td>Language</td>
<td>All languages included, searching done in English and some French terms</td>
<td>No exclusion criteria</td>
</tr>
</tbody>
</table>
RESULTS
Database and snowballing searches occurred between 27 April and 2 May 2020. A total of 1112 articles were returned, and after duplicate removal, 956 abstracts were reviewed. In total, 32 articles were identified for inclusion, of which 5 were identified through snowballing (4 from initial grey literature/snowball search and 1 from reviewing included articles’ references) and the remainder through database searches. Figure 1 presents the screening process and results.

In addition to the 32 documents included and reported within, 11 documents that did not address or describe a specific community engagement initiative but did provide overarching guidance to community engagement or aspects of community engagement were identified. These documents were retained to support our interpretation and implementation considerations for community engagement. Online supplemental file 3 includes these details.

Article characteristics
Of the 32 included articles, all but 3 were published on or after 2015, with 1 article published in 2009, 1 in 2010 and 1 in 2012. The remaining were published in 2015 (n=2), 2016 (n=6), 2017 (n=9), 2018 (n=3), 2019 (n=3) and 2020 (n=6). All articles were in English except for one, which was in French. Thirty-two articles were included, but two articles report three and four distinct community engagement initiatives. As such, the remainder of the review will focus on 37 initiatives.

Context and outbreak
Of these 37 initiatives, 28 were for Ebola, with 25 relating to the 2014–2015 West Africa outbreak from Sierra Leone (n=11), Liberia (n=9), Guinea (n=2), Nigeria (n=1), Ghana (n=1) and one mixed-country study. The remaining three Ebola examples were related to the 2018–2020 outbreak in the Democratic Republic of Congo, two of which focused on efforts in Uganda. Five community engagement initiatives were used for Zika within the USA and Puerto Rico (n=3), and one each in Singapore and Uruguay. Four articles were specific to H1N1, with three from Australia and one from Canada. No articles were found that detailed community engagement for SARS or MERS. Figure 2 highlights the examples found per country and topic.

Broad contextual concerns preceding the outbreak refer to poverty, unemployment or economic crisis, health system failure, lack of development infrastructure, colonial/postcolonial factors, ethnic and political conflicts, lack of trust in government and international agencies, traditional practices and rituals that are resistant to change, geographical challenges and mobile populations.

Community engagement approaches and interventions
The review identified six broad types of community engagement actors or approaches, which addressed infection prevention and control through six main channels. As highlighted in table 2, the main actors included community leaders (traditional, religious and/or governing); community and faith-based organisations...

(CFBO); community groups or networks or committees; health management committees; individuals (no further clarification provided); and key stakeholders, which included students, survivors, women representatives, elderly and the youth. These community engagement interventions addressed infection prevention and control through six main channels: designing and planning interventions (including messaging), community entry and trust building, social and behavioural change communication (SBCC), risk communication, surveillance and contract tracing, and broader logistics and administration activities, such as procuring and setting up hand washing stations, constructing facility or record keeping.

From table 2, it can be seen that community engagement was mostly used for social and behavioural change communication and risk communication, followed by surveillance and contract tracing. Many of the reported community engagement activities involved multiple actors and took multifaceted approaches for prevention and control, as can be observed from table 2. For example, Skrip et al detail the Community-Led Ebola Action efforts implemented by the SMAC, which involved local radio stations to provide a platform for engagement with trusted community leaders, survivors and responders; community champions and mobilisers recruited from an existing cohort of CHWs, youth volunteers and people nominated by their communities; and religious leaders to promote key messages and role model behaviours to support community surveillance through standardised monitoring forms and a structured participatory dialogue to identify and address community needs targeting areas of trust building, risk communication and SBCC.

The majority of the community engagement activities were not reported as a component of a larger programme, with the exception of surveillance systems which included community engagement for monitoring at the community level linked to a structured contract tracing system. Online supplemental file 2 includes the extraction data for each article.

Target groups and equity considerations
The majority of community engagement activities had community-wide focus, with no specific equity considerations reported. One article from Kirk Sell et al discusses CFBOs targeting marginalised populations, including non-English speakers and undocumented persons, in the USA for risk communication in relation to Zika. On the contrary, all articles in relation to H1N1 had an equity focus; remote and isolated First Nations communities in Canada and Aboriginal or Torres Strait Islanders communities in Australia. Important to note, however, is that community engagement for these communities was limited to design and planning, with no reported inclusion in implementation of activities.

Specific make-up of community engagement approaches was often not detailed or did not include diversity and representation, though several reported community engagement structures, including representation from Ebola survivors, women within reproductive age and students, and youth.

Health system linkages and support
Of those that provided details on linkages, very few were explicitly linked to other health system components (with the exception of tracing). Community health committees and health management committees that were supporting health facility activities were linked
Table 2  Community engagement actors and their involvement in epidemic prevention and control activities

<table>
<thead>
<tr>
<th>Community engagement actors</th>
<th>Design and planning</th>
<th>Community entry/trust building</th>
<th>Social and behavioural change communication</th>
<th>Risk communication</th>
<th>Surveillance, tracing</th>
<th>Logistics, provision, administration</th>
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</thead>
<tbody>
<tr>
<td>H1N1 (n=2), Zika (n=1), Ebola (n=5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ebola (n=1)</td>
<td></td>
<td>Ebola (n=1), Zika (n=1)</td>
<td>Ebola (n=2), Zika (n=1)</td>
<td>Ebola (n=1)</td>
<td>Zika (n=1)</td>
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<td>Ebola (n=1)</td>
<td></td>
<td>Ebola (n=4), Zika (n=1)</td>
<td>Ebola (n=2), Zika (n=1)</td>
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<td>Ebola (n= 1)</td>
<td>Ebola (n= 1)</td>
<td>Ebola (n= 1)</td>
<td></td>
</tr>
<tr>
<td>Individuals (volunteers)</td>
<td>HC3,40 2017c</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Ebola (n= 1)</td>
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<td>Ebola (n= 1)</td>
<td>Ebola (n= 1)</td>
<td>Ebola (n= 1)</td>
<td>Ebola (n= 1)</td>
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</tr>
<tr>
<td>H1N1 (n=4), Zika (n=1), Ebola (n=2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>12</td>
<td>9</td>
<td>32</td>
<td>29</td>
<td>20</td>
<td>8</td>
</tr>
</tbody>
</table>

*H3C and Le Marcis have four and three examples of community engagement, respectively. For the purpose of this table, to demonstrate frequency of approaches, each example is cited as either a,b,c or d. However, as these come from the same included article, references do not appear this way within the reference list.
to community care centres, and Ebola survivors, leaders and youth groups were used for behavioural change and surveillance, and linked with existing CHWs.

**Best practices for community engagement during epidemic response**

Key barriers and facilitators for community engagement for COVID-19 prevention and control that were extracted from the included studies are presented in figure 3. More broad implementation considerations synthesised from guidance documents are provided in online supplemental file 3, which emphasise the need for community engagement, which has to be context specific as per the cultures, traditions and customs, social norms and collective beliefs. Understanding local realities may require social research, including anthropological studies, if possible, and research to uncover knowledge gaps and existing sociocultural barriers. Community engagement should be an ongoing, collaborative process that starts early with community members who are seen as legitimate actors able to represent and influence the community. Communities should be involved in issue identification and code sign of interventions and response. A two-way dialogue with communities and other stakeholders, essential for trust building, should be established through multiple channels with transparent, accurate and consistent information to help address rumours and misconceptions. Messages should be imparted which are focused, not fear-inducing, respectful, tailored to local contexts, with relatable examples. Regular feedback mechanism for monitoring and course correction that reveal how knowledge, beliefs and practices are changing are also needed for inclusive and meaningful engagement. These considerations are also discussed in a policy brief on this research targeted towards implementers.

Reviewing the aforementioned findings and materials, in addition to considering the unique attributes of the COVID-19 pandemic and important guidance put forth by WHO, UNICEF and IFRC on ‘Community-based healthcare, including outreach and campaigns, in the context of the COVID-19 pandemic,’ had led to development of key programme and policy recommendations for using community engagement in prevention and control approaches. Box 1 summarises these considerations, which aim to guide best practice.

**DISCUSSION**

Engagement lies on a spectrum, from more passive to active involvement. It can consist of providing information and conducting consultation, having involvement via regular interactions throughout the project cycle; and collaboration, which entails working in partnership with shared decision-making that involves communities carrying out critical health systems functions and innovating with localised solutions. Within this review, most included articles could be classified as having involvement, where communities were thoroughly brought in but often did not share decision-making powers. Notably, however, almost all examples of community engagement from high-income contexts consisted of consultation, demonstrating passive involvement with target ethnic and minority population. In addition, very few examples were identified that had an equity focus or strong equity considerations within target groups and engagement actors.

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**Figure 3** Components and implementation considerations of community engagement for infectious disease prevention and control. The main CE actors (who) most common for that specific process are in bold. The length of the bars varies based on the most common way (what) of community engagement as per the reviewed literature. ‘How’ represents key activities that were undertaken within each broader intervention classification. HMCs include community health committees. CFBO, community and faith-based organisation; HMC, health management committees; IEC, information, education and communication; IPC, interpersonal communication.
Box 1  Key programme and policy recommendations for COVID-19 prevention and control through community engagement approaches

- Early discussions and negotiation with communities to understand sociocultural contexts and developing culturally appropriate prevention and control strategies, what types of engagement interventions are safe, feasible and acceptable, and what existing platforms and initiatives can be leveraged to support COVID-19 activities. Best practice, key actors and approaches for this have been outlined previously and in figure 3.
- Communities should co-design and support delivery of prevention and control interventions and messaging (interpersonal communication/information, education and communication), including the development of appropriate, evidence-based messaging. Best practice, key actors and approaches for this have been outlined earlier and in figure 3.
- COVID-19 pandemic management teams incorporate community members into planning, response and monitoring of standard operating procedures. These plans should be disseminated within communities to ensure support. This should include topics of
  - Population movement monitoring, surveillance and contact tracing systems discussed.
  - Community remote monitoring and alert systems.
  - Community response mechanisms if cases occur, including social isolation procedures, enacting contact tracing, quarantine procedures and community quarantine options.
  - Lockdown, isolation or quarantine support, especially for vulnerable populations, including distribution of essential supplies.
  - Referral pathways and medical supply procurement for serious cases.
  - Health and safety considerations should be collaboratively identified and addressed in planning stages. These include the safe structuring of engagement activities, such as delivery mode of engagement; appropriate distancing measures for face-to-face interactions; quarantine or isolation procedures of community; availability of water and sanitation supplies; resource procurement for engagement actors, such as personal protective equipment; and protocols for suspected/confirmed contact with COVID-19-positive persons.

While leadership buy-in is imperative for many community activities, so too is ensuring a balance between power and representation of diverse voices.

Findings from this review highlight a need for more documentation of community engagement activities especially from more diverse geographical settings and across different populations. While some activities are under way, for instance, GOAL Global, based on experience gained from their Ebola response, is implementing community-led action for COVID-19 in numerous countries, or community action networks in Cape Town working together to identify and address the needs of community members, implementers, policy makers and researchers, and encouraged to share learnings from past community engagement initiatives and document ongoing activities for COVID-19.

Interpretation of these findings should be done based on existing context, as the majority of articles were from Ebola response. Ebola had many unique considerations, including lack of trust, fear, rumours and cultural practices around burials and stigma. Engagement of local leaders, those with high levels of respect, were critical to support dismantling some of these notions and working towards prevention and control activities. However, the COVID-19 response may parallel Ebola in many ways, given the social spreading and potential stigma around contracting COVID-19. Additionally, most examples were implemented in low-income countries or in high-income countries where community engagement was used to target minority populations for H1N1 and Zika.

There is a need for more documentation on community engagement from more diverse geographical settings and with different populations. Implementers, policy makers and researchers are encouraged to share learnings from past engagement initiatives and to document ongoing engagement for COVID-19 activities.

Countries with pre-existing community engagement structures with strong ties between health teams and communities can thoroughly and meaningfully embed such actions into national response plans. Recent modelling in Africa, where the large majority of articles including this review are based, has noted that, if not controlled, COVID-19 could result in up to 190 000 deaths and 44 million infections in 1 year alone. Many South Asian countries, which have recently seen exponential increases in COVID-19 cases, have a long history of community health and engagement activities and were some of the first to document the mobilisation of CHWs like India’s accredited social health activists (ASHAs), for COVID-19. Countries without a strong history of community engagement need to identify where this may be most beneficial, for instance, to support ethnic minorities in the global North who in many countries, because of inequitable systems, are being infected and killed at a disproportionate rate.

Community engagement may be specifically appropriate and needed for complex contexts, such as for migrants in humanitarian settings or in urban informal settlements. It is also needed to address more complex situations, such as settings dealing with both COVID-19 and risk of hunger or supporting already overburdened health systems.

Worthy of note are the limitations of community engagement within the COVID-19 context due to restrictions related to large gatherings and traditional face-to-face approaches. Innovative approaches to adapt traditional community engagement approaches may be required, and how governments and organisations overcome these barriers should be well documented, evaluated and shared. If done physically, COVID-19 prevention and control guidelines around physical distancing, wearing of masks and practising good respiratory and hand hygiene should be ensured. Alternatively, new innovations within community engagement may be more suitable, which may relate to technology and digital tools. Emerging examples of community engagement via digital methods in the COVID-19 context have included the involvement of community governance systems and CHWs in garnering acceptance for quarantine measures in China, mobilising local resources and volunteers.
and using social media tools such as WhatsApp to collect health information and communicating COVID-19 messages in Syria, and working with community local and religious leaders to deliberate on facilitators and barriers in the USA and to disseminate COVID-19 information using conference calls.

Key lessons identified (Box 1) in additional to early insights from COVID-19 also highlight the need to seriously consider how and what information is being presented to all stakeholders and especially communities. An overabundance of information, accurate or not, also called ‘infodemic’, may have serious consequences for community stakeholders, not limited to lack of trustworthiness, confusion and resistance. Key to combating infodemics and supporting proper communication will be identifying and dispelling rumours through the use of community leaders, open channels for two-way communication between organisations/government officials and community actors who have been prepared to identify misinformation and to support accurate messaging, and transparent and honest messaging with communities that also addresses and explains any changes to information.

Of further importance is that community engagement does not occur in a vacuum. It should be part of wider systems approaches and initiatives to address COVID-19. Ensuring appropriate health systems supports and buy-in will be fundamental to its success. Additionally, contextual community and implementation factors can largely influence the success of community engagement, with approaches being considered within the wider system of implementation. This may involve improving community capacity and supportive environments for engagement, supporting linkages and supportive policy and funding environments and establishing environments of respect, trust and shared values and goals. Using existing frameworks or standards for community engagement, such as UNICEF’s 16 Minimum Standards for Community Engagement to support planning, implementation and monitoring, is encouraged to support high-quality implementation.

Community engagement supports shaping social dynamics based on power and control that permeate the marginalisation of certain groups. The actors involved in mobilisation efforts and decision-making need to be seen as legitimate by the other members of the community. Recognising that power and legitimacy are contested resources that may be changed over the course of the outbreak is crucial for effective community engagement. It needs to start early and continue after the critical stages of the health crisis to contribute to empowerment and building resilient communities. Addressing COVID-19 will require multisectoral responses and a variety of approaches from biomedical and social sciences. Community engagement should be a fundamental component within all of these responses. Whether it be related to prevention and control, vaccine testing and ethics or resilience and recovery, community engagement can support successful efforts. It can also have fundamental roles in rebuilding a stronger health system after the more acute phase of COVID-19 and supporting an equity-focused public health response. However, for all of these to work, community engagement needs to be meaningful, to follow best practice recommendations and guidelines, and to be specific to the context.

Limitations

As this was a rapid review, our database searching and snowballing were limited in scope and time, which may have resulted in missing articles. In addition, while our search terms attempted to include all relevant topics related to community engagement, and we did include search terms for specific community-based interventions (ie, SBCC and risk communication), this was not exhaustive, which may have resulted in missing articles. Excluding articles with a predominantly CHW focus may have resulted in missing some interventions that detail CHWs and other community engagement actors, though this review did attempt to include such studies. Several articles were limited in detail, and extracting and labelling content were at the review team’s discretion, which may have resulted in incorrect coding on the type of actors and interventions. This may have been particularly relevant in situations where the engagement approaches and interventions conducted were of similar nature, for instance, the distinction between CFBOs and community groups, and SBCC and risk communication. Nevertheless, this review shares important lessons regarding community engagement approaches from past epidemics that should guide COVID-19 response.

CONCLUSION

COVID-19’s global presence and social transmission pathways require social and community responses. This may be particularly important to reach marginalised populations and support equity-informed responses. Previous experience from outbreaks shows that community engagement can take many forms and include different actors and approaches who support various prevention and control activities, including design and planning, community entry and trust building, social and behaviour change communication, risk communication, surveillance and tracing, and logistics and administration. Countries worldwide are encouraged to assess existing community engagement structures and to use community engagement approaches to support contextually specific, acceptable and appropriate COVID-19 prevention and control measures.

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Contributors BG, SB and CL proposed and designed the study. All authors contributed to searching, screening, extraction and synthesis of articles. EM, RN and BG prepared the first draft of the manuscript, with all authors reviewing and providing inputs. All authors prepared and approved the final version of the manuscript. This research is a co-production of the Community Health–Community of Practice of which all authors are members.

Competing interests None declared.

Patient and public involvement Patients and/or the public were not involved in the design, conduct, reporting or dissemination plans of this research.

Patient consent for publication Not required.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement All data relevant to the study are included in the article or uploaded as supplementary information. All relevant data are included as supplementary files.

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ORCID iD Brynne Gilmore http://orcid.org/0000-0003-4496-9254

REFERENCES
34 Collective T. Refining the community health conceptual framework, 2019.


Table 1: Snowballing source and number of returns

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<th>Email list</th>
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Table 2: Database Search Terms for PubMed

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<td>Zika:</td>
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Table 3: Database Search Terms for CINAHL

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Table 4: Database Search Terms for Scopus

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<td>SARS</td>
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Facilitators:

Community Level pandemic committee

Recruitment of members

Pre-existing local leaders

Joint development of pandemic plan

Carter Centre,

Traditional and community leaders combated rumours

Not reported

Decentralized governance system and out

Local partner NGOs

Multi-sectoral plan with committees at

This was implemented under the Ebola Community

mobilization and community committee

leadership (chief and

community leadership groups, religious leaders,

Multiple community

Local leadership, Faith

Schools

Community volunteers

Faith Organisations

village, youth groups

unlike in urban areas

like in rural communities

Chiefs, healers,

nursing station,

different community

Teachers, parents,

Volunteers shared learning with communities and

their communities. CHWs would go door to door with

how they could best enter communities, and then did

entrance to community and houses

BCC messaging for prevention, control and building

jingles

including one-to-one stakeholder meetings,

misconceptions of the trial. Conducted activities

team

with loudspeaker.

activity by using a car

advertisements and

information provision (e.g. the call centre, general community health

experiences, rumours, fears, hopes and successes; 3)

and community level.

Supervised by District

Co-delivering of

Concern Worldwide)

provided

radio facilitated

the response strategy.

Supervision.

team's feedback

projector was used to

copy of the pandemic

Barriers:

limited staff

played, information distributed, hand-washing stations

identified by social mobilisation group, then leaders

contact tracing and health promotion, and contributed

reassurance, helped implement measures such as

social and behavioral dynamics to shape the

community-level pandemic plans.

create up-to-date and culturally-appropriate

strategies

are explicitly addressed.

Barriers:

insufficient details in community-level pandemic plans.

already existed.

cooperation between and within institutions, and lack of

partnerships increases the effectiveness and more

necessary conditions for health system resilience.

communication platforms for CE ahead of a crisis.

solutions to perceived health needs. (4) preference

to contain an Ebola outbreak.

cultural practices as part of preparation efforts.

leaders, faith groups to modify high-risk socio-

experiences with the Liberian government and rebel

holding conspiracy theories. Changing beliefs may

learning processes can have an amplification

positive health messages, abandon negative

informal social

communications campaign and

positive behaviours when still

learning processes can have an amplification

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Supplemental material

on this supplemental material which has been supplied by the author(s)
Community mobilizers who were nominated by community leaders, students, and sport leaders, who trained as mobilizers including women’s leaders, youth leaders, health workers, traditional healers, and Ebola volunteers. Village leaders, community and religious leaders, and Imam/pastor, Traditional chiefs were initially recruited to support Ebola response team had some health awareness in the risk of influenza at home and at community gatherings such as funerals; and providing access to medication, open-defecation, ceremonies and mass animal handling. To UNICEF and the Government for 10.95 millions people. Ethnic and political conflict, no measures that appropriate to be devised for this group. No. Figure. When new Ebola case emerged, the community mobilizers. For the most part, this was accepted as Chiefs were an authority to respective village chief, and which contributed to prolonging the infection prevention through daily and weekly meetings and short seminars. The social mobilisation model had Chiefs activity in the community, and prevention, as well as community engagement. CE is not a ‘one-size-fits-all’. Inflexible or top down strategies are always contested when community members think that their needs are not considered. Community-ownership-model’ had Chiefs activity on topics such as services, consultations, and cooperation between the community and a professional team. All of the social mobilisation initiatives were conducted by the Ministry of Health, which included the establishment of Comités de veille villageois (CVVs) made up of: local elites, health and social function and the economy. Professions such as government health workers, non-governmental organisations, religious leaders, traditional healers, cadets sociaux, and village chiefs were involved in this process. They were also involved in the management of burials, vaccine campaigns, distribution of information leaflets and mosquito repellents in their different contexts of Sierra Leone, Guinea and Liberia. Lack of historical understanding, and doing pre-planning of slogan, distribution of branded t-shirts and banners through the main streets, and not involving the community. With the disease symptoms associated with EVD, community members who were aware of the disease were more likely to report it to the health sector. Community partners had some health awareness in the risk of influenza at home and at community gatherings such as funerals; and providing access to medication, open-defecation, ceremonies and mass animal handling. To UNICEF and the Government for 10.95 millions people. Ethnic and political conflict, no measures that appropriate to be devised for this group. No. Figure. When new Ebola case emerged, the community mobilizers. 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<table>
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<th>Evaluation Components</th>
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<td>Sierra Leone</td>
<td>Ebola Response</td>
<td>Community Health Workers (CHWs)</td>
<td>1. Case identification and referrals. 2. Active case findings with social mobilisation. 3. Establishing teams that can inspect their neighbourhoods to areas with Zika. 4. Building a culture of solidarity. 5. Establishing teams to provide healthcare in remote areas.</td>
<td>1. Increased health awareness. 2. Improved health outcomes. 3. Increased community participation.</td>
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<td>1. Community Health Volunteers (CHVs) 2. Community Health Supervisors (CHSs)</td>
<td>1. Increased health awareness. 2. Improved health outcomes. 3. Increased community participation.</td>
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<td></td>
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<td>Community Health Monitors (CHMs)</td>
<td>1. Community Health Volunteers (CHVs) 2. Community Health Supervisors (CHSs)</td>
<td>1. Increased health awareness. 2. Improved health outcomes. 3. Increased community participation.</td>
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Several resources and tools included in General Risk Communication and General Community engagement and 1. Build trust and community engagement

Community engagement

Ebola

Risk Communication

CE Approach

Zika

Community-led Ebola Action (CLEA) aims to

Ebola

Note:

Toppenberg-Pejcic, D. et al. 2019

Erstad, O'Reilly) 2016

Oxfam (Niederberger, Gerron and

WHO, 2016

Author

Of the 11 guidance documents, the 7 dealt specifically with Risk communication, and of those 4 detailed “RCCE “.

1) Building trust on the ground and with local authorities: (Health officials and local leaders are important partners in outbreak response) during the emergency.

2) Establish lines of action, prepare materials and test them with target audience

2. Have the capacity to work in the local language and dialect of the community.

3. Inform and advise outbreak response pillars about cultural or social specifications to consider for implementing the

3. Ensure that the changing needs of the community are communicated back to key social mobilization, risk

4. Lead to emerge Community Champions, and or new commitment of existing leaders

5. Build on traditional social practices of community cooperation

6. Continual two-way communication

7. Focus and celebrate community-wide outcomes

8. Gain momentum and scale-up

9. Accountable to those we seek to help - systematic and coordinated approach to communication that includes

10. Changing behaviour takes time - we need to understand why people do certain things, and specific barriers to safer

11. Ethics are key - ethical guidelines for community engagement.

12. Sensitivity to local narratives and knowledge systems

13. Go local - community engagement should play central role in emergency response and risk communication.

14 key tips for community engagement:

1. Don’t tell people what to do - recognise that communities are experts. Engage through two-way communication.

2. Use maps and visual aids to help people understand from where their sources, especially were a small group of trusted local

3. Include in local communities, a mix of people who have only recently returned to the area, and witnesses who have been

4. Provide an opportunity for people to talk, and have a chance to speak to ensure they understand are are confident to share

5. Ensure standardized and coordinated messaging, community engagement and risk communication interventions

6. Communicate in the language individuals are most comfortable in - it is important to use the language people prefer

7. Encourage local health workers to speak to the community to ensure they understand are are confident to share

8. Support people to carry out interventions using social mobilisation and engagement.

9. Connect with trusted community influencers as much as possible and disseminate information.

10. Always date stamp your messages

11. Understand networks of past and current relationships within communities. Leverage existing structures (when

12. Understand context of place and people's livelihood activities, a common matching tool for helping communities

13. Practice by asking questions, non-judgmental open-ended questions to the community

14. Include people and addressing deep-seated practices, is required. As/If disease progress adaptations are required and new

Anthropological insights take into account local perspectives and help understand complexity of the problem. However,

Note:

1. Understanding of diversity and varied vulnerabilities within communities is vital. Need to take approaches to

2. Including communities in the design and management of response

3. Using fear to encourage changes in behaviour can be counter productive.

4. Multi-sectoral action to increase transparency, especially in contexts with lack of trust, should be done. Also requires

5. Engaging local leaders to gain permission to enter, 1c. local leaders to be engaged in developing and implementation of

6. Identify, engage and collaborate with CFBOs that can help reach and address the needs of affected communities

7. Focus and celebrate outcomes

8. Build on traditional social practices of community cooperation

9. Continual two-way communication

10. Continual two-way communication

11. Engage diverse community members in time-bound specific activities

12. Continual two-way communication

13. Sensitivity to local narratives and knowledge systems

14. Go local - community engagement should play central role in emergency response and risk communication.

1. The role of local experts. Identification of community members with local expertise and access to community

2. EBOLA pandemic: insights and lessons

3. “Contain and maintain trust about what is known and not known”. Do not dismiss fears, acknowledge and clarify

4. “Share the story” but do not use community engagement. Need to understand and recognize potential cultural or social aspects of the disease.

5. “Contain and maintain trust about what is known and not known”. Do not dismiss fears, acknowledge and clarify

6. “Contain and maintain trust about what is known and not known”. Do not dismiss fears, acknowledge and clarify

7. “Contain and maintain trust about what is known and not known”. Do not dismiss fears, acknowledge and clarify