### Table 1: Description of Community Engagement During Epidemics

<table>
<thead>
<tr>
<th>Author/Reference</th>
<th>Year of Publication</th>
<th>Country</th>
<th>World Bank Classification</th>
<th>Epidemic Type and Date</th>
<th>Description of Community Engagement</th>
<th>Typology classification</th>
<th>Prevention and Control Measures</th>
<th>Gender/Sex considerations for target group</th>
<th>Implementing Agency</th>
<th>Pre-existing initiative of new for epidemics</th>
<th>Duration of programme</th>
<th>Notes</th>
</tr>
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<tbody>
<tr>
<td>Abouelsaad et al.</td>
<td>2017</td>
<td>Libya</td>
<td>Low Income</td>
<td>Ebola Virus Disease</td>
<td>2014-2016</td>
<td>Community volunteers, leaders, volunteers</td>
<td>Behaviour Change Communication, Surveillance, Tracing, Vaccination, Districtwide, Source Reduction</td>
<td>Community wide</td>
<td>Not reported</td>
<td>Ministry of Health and NGOs</td>
<td>New</td>
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<td>2014-2016</td>
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**Legend:**
- **EBDOAC:** Ebola Disease Outbreak and Community Action Coordinating Committee
- **WHO:** World Health Organization
- **BCC:** Behaviour Change Communication
- **CDC:** Centers for Disease Control and Prevention
- **UNICEF:** United Nations Children’s Fund
- **GLO:** Government of Liberia
- **MoH:** Ministry of Health
- **EBODAC:** Ebola Disease Outbreak and Community Action Coordinating Committee
- **UNICEF:** United Nations Children’s Fund
- **Municipality of Salto:** Municipal government of Salto, Uruguay
- **CDC:** Centers for Disease Control and Prevention
- **WHO:** World Health Organization
- **Municipality of Salto:** Municipal government of Salto, Uruguay
- **CDC:** Centers for Disease Control and Prevention
- **WHO:** World Health Organization

**Notes:**
- **New Engagement:** Indicates that the engagement was not part of a pre-existing initiative.
- **Pre-existing Initiative:** Indicates that the engagement was part of a pre-existing initiative.
- **Duration of Programme:** Indicates the duration of the programme or initiative.
- **Gender/Sex Considerations:** Indicates if gender or sex considerations were taken into account for target groups.
- **Implementing Agency:** Indicates the implementing agency responsible for the initiative.
- **Pre-existing Initiative of New for Epidemics:** Indicates if the initiative was specifically created for the epidemic.
This article describes many risk communication initiatives that were implemented in communities during the 2014-2015 Ebola Virus Disease outbreak in Liberia and Sierra Leone. These initiatives involved community members trained by Government agencies, Faith Based Organisations, and local volunteers. The article highlights the role of chiefs in community mobilisation and the importance of engaging pre-existing community networks such as Comités de veille villageois (CVV) in Sierra Leone. It also notes the need for community consultation for appropriate risk communication strategies.

In the context of the 2009 H1N1 influenza pandemic in Mexico, the article mentions the role of community-based participatory research with women in reproductive age. Community consultation for appropriate risk communication strategies is highlighted. This case study briefly notes how chiefs in Mexico communicated with the community through house-to-house contact tracing and social mobilisation.

The article also refers to the role of chiefs in Sierra Leone in managing the Ebola outbreak. Chief Ny Паg, a community leader, was sent in to shut-down and monitor the area. This was met by rioting and government shutdown a local market in the Western Area Rural District. The article describes the challenges and issues it faced in this context.

Health services in China were also mentioned in the context of the 2009 H1N1 pandemic. In the United States during the Zika outbreak in 2016, Faith Based Organisations and community volunteers were engaged in community wide risk communication initiatives. This article provides a comprehensive overview of the various risk communication strategies that were implemented in different contexts.
<table>
<thead>
<tr>
<th>Type of Engagement</th>
<th>Author/ Reference</th>
<th>Typology Classification</th>
<th>Technique Description</th>
<th>Recruit</th>
<th>Facilitator</th>
<th>Barriers</th>
<th>Impacts</th>
<th>Change of Beliefs</th>
<th>Change-Over Time</th>
<th>Recommendations</th>
</tr>
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<tbody>
<tr>
<td>Community leaders, chief and religious</td>
<td>Abramowitz S,, et.al</td>
<td>Community led prevention and RED Strategy, Reach Every District: general</td>
<td>Facilitator: Carter Centre, Awareness and participation in delivering the Development of plan</td>
<td>Not reported</td>
<td>Not reported</td>
<td>Not reported</td>
<td>Community workers carry out communal and door-to-door EVD health</td>
<td>Not reported</td>
<td>Observation of Ebola morbidity and mortality.</td>
<td>1) Maintain clear and consistent messaging; 2) Leverage trusted local leaders; 3) Use media and social mobilization and community activities; 4) Invest in capacity building and empowerment; 5) Utilize surveillance data to inform effective response; 6) Ensure timely and transparent communication; 7) Strengthen supply chain; 8) Work in collaboration with local communities to develop community-level pandemic plans.</td>
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</table>
Public health officials responsible for responding to barriers:

Activities were funded by the Australian Health Management Plan for reducing disease transmission, which had support from the community. The data manager was not reported.

Facilitator: Community outreach activities included a parade with symbolic items that were distributed to the community, and the volunteers were recruited for their community report; however, their community did not get opportunity to communicate with the chief.

Groups included community leaders, health personnel, government representatives, and teachers, who later called a meeting with community mobiliser, volunteers, community leaders, health personnel, government representatives, and teachers.

The community expressed concerns, priorities, and negotiated for operational support. The social mobilisation activities were funded by the Australian Health Management Plan for reducing disease transmission. The campaign was distributed through hand distributing their community report; however, their community did not get opportunity to communicate with the chief.

Cassettes Sociaux (youth traditional healers and Ebola and women, religious leaders), were to be selected to form the local government. CVV were to be selected from the Western Area and teachers, who later called a meeting with community mobilier, volunteers, community leaders, health personnel, government representatives, and teachers.

The training increased awareness of EVD control systems, while monthly meetings were held to discuss the progress of the campaign. The training increased awareness of EVD control systems, while monthly meetings were held to discuss the progress of the campaign. The training increased awareness of EVD control systems, while monthly meetings were held to discuss the progress of the campaign.

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<th><strong>Volunteers from community, who</strong></th>
<th><strong>Community Leaders</strong></th>
<th><strong>Facilitator:</strong> Not reported</th>
<th><strong>Focus Group Discussions and Key Informant</strong></th>
<th><strong>Individuals</strong></th>
<th><strong>Pre-existing groups</strong></th>
<th><strong>Disbelief and distrust from some community members</strong></th>
<th><strong>Meetings and</strong></th>
<th><strong>Community health</strong></th>
</tr>
</thead>
</table>

**Community Champions**

healers and religious leaders

Participatory Design

leadership (chief and

Members; Leaders

supported by Mobilizers (youth

traders

leader, teacher, and several

Champions: Unknown.

Champions: Identified via

Mobilizers: through

having health facility in-

positions that are elected

representation needed

classified by CHM. In evaluation interviews, CHM only

Number of events reported increased with time, as roll-

CHM to CSS 52:1. In tital, 7142 CHM trained across 9

tunities, 1:118, and ratio of

to Community Surveillance Supervisor via phone call.

prevent transmission. Community Champions are

mobilize them for addressing EVD outbreak;

with local and religious leaders; conducted an

consultative meeting with traditional community

condoms and repelle.t

Action Days' where education was spread and

to areas with Zika, 3) building a culture of solidarity

weekly 2) planning ahead for mission trips and travel

establishing teams that can inspect their neighbourhoods

with the government. They had main duties of: 1)

communities. Their input influenced design/approach

on potential solutions for addressing H1N1 in their

any to supervisor who did primary investigation.

small villages within walking distance. Trained to detect

receive patients from DRC.

Interviews with Participatory mapping. Community

Not disclosed

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engagement.

not through

mobilization activities

CBOs

Surveillance

Community

Facilitator:

Not reported

Rudge and Massey.

Nakiire, et al.

Meredith, C.