Table 1: Description of Community Engagement During Epidemic

Author/Reference	Year of Publication	Country	World Bank Classification	Epidemic Type and Date	Description of Community engagement/structure engaged	**Typology classification** (Community groups, social networks, informal networks, local governance/community leadership, education, faith organisations, justice, other)	**Prevention and Control Measure** (Risk-communication, Behavior Change Communication, Surveillance, Tracing, Trust-building, Provision, Source Reduction activities, other)	Target Group(s)	Gender/Equity considerations for target groups	Implementing Agency	Pre-existing initiative of new for epidemic only	Duration of programme	Notes
Abramowitz, et al.	2017	Liberia	Low Income	Ebola Virus Disease, 2014-2016	CE for dissemination and assimilation of information accessed through mass media	Community groups	Behavior change communication	Community wide	Not reported	Jointly implemented by Government of Liberia (GOL) and UNICEF social mobilization teams.	New	Not reported	
Aceng, et al.	2020	Uganda	Low Income	Ebola Virus Disease, 2014-2016	CE for community-based surveillance systems, develop and disseminate risk communication messages.	Community volunteers and leadership	Risk Communication, Behavior Change Communication and Surveillance	Community wide	Not reported	Uganda Ministry of Health (MoH) with technical assistance from WHO, other non-health ministries and partner organisations	New	August 2018- May 2019	
Adongo, et al.	2016	Ghana	Lower Middle Income	Ebola Virus Disease, 2014-2016	Social mobilization and risk communication a for safe burial practices	Faith organisations	Risk Communication	Community wide	Not reported	Ministry of health and partner organisations	New	2014	
Baker, et al.	2020	Liberia	Low Income	Ebola Virus Disease, 2014-2016	Community-based surveillance teams	Community leadership Community volunteers	Behavior Change Communication, Risk Communication, Surveillance, Tracing, Trust building, Infrastructural support to health system	Community wide	Not reported	Ministry of Health and NGOs	New	2014-15	
Basson, et al.	2017	Uruguay	Upper Income	Zika	Social mobilisation	Social groups like community organisations, Schools	Behavior Change Communication	Community wide (whole urban area of the city of Salto)	Not reported	University of Republic, partnering with Ministry of Health, Ministry of Social Development (MIDES) and the Municipality of Salto	New	2011-2013	
Charania and Tsuji.	2012	Canada	Upper Income	H1N1, 2009	Community pandemic committee	Local leadership, faith group representative and educational representative	Planning	Community wide	Not reported	Implementing agency along with existing Band Council federally funded	No	2010	
Dada, et al.	2019	Sierra Leone	Low Income	Ebola Virus Disease, 2014-2016	Community liaison team and Social science team	Locally recruited members	CE for vaccine trials	Trial site- Community wide	Not reported	The vaccine trail team led by EBOVAC1 and supported by EBODAC	Yes	2014-16	
Gillespie, et al.	2016	Guinea, Liberia, and Sierra Leone	Low Income	Ebola Virus Disease, 2013-2016	Communication for development - social mobilization and community engagement	Multiple community partners including religious leaders, journalists, radio stations, and partner organizations	Risk Communication, BCC	Community wide	Not reported	United Nations Children's Fund (UNICEF) implemented with government and civil society counterparts	New	2014-2015	
Gary, et al.	2018	Sierra Leone	Low Income	Ebola Virus Disease, 2014-2015	Community led prevention and control measures	Community members, particularly the Ebola survivor and local leaders supported by youth groups	Surveillance, tracking, Provision, quarantine, BCC	Community wide	Not reported	Not reported	New	2014-15	
Health Communication Capacity Collaboration (HC3)	2017	Liberia	Low Income	Ebola: 2014-2015	Community Leaders: traditional and religious	Local Governance/ community leadership (chief and religious)	Risk Communication, BCC, Trust Building, Case detection	Community wide	Not reported	NGOs, MoH, UN	New engagement	Not reported	This document reports on multiple Social Mobilization and Community Engagement SM/CE activities that occurred across Liberia during the Ebola outbreak in 2014-2015. We have extracted key CE activities that had sufficient detail reported within the document. There are other examples, also other considerations (such as Monitoring and Evaluation for SM/CE) and lists of partners and organisations and types of activities they were involved in (Appendix 1 and 2).
				Ebola: 2014-2016	Community leaders and CHWs	Local Governance/Community leadership (chief and religious)	BCC, Surveillance	Community wide	Not reported	Carter Centre, UNICEF, World Bank, technical assistance from African Union, HC3/CCP, CDC, Tony Blair African Governance Initiative, UNICEF, and WHO.	New engagement	Not reported	
				Ebola: 2014-2017	Care Groups	Community Groups, Community Leaders	BCC	Community Wide	Not reported	Concern Worldwide	New engagement	Not reported	
				Ebola: 2014-2018	Community volunteers	Individuals	BCC, Design	Community Wide	Not reported	PSI and Mercy Corps	New engagement	Not reported	
Ho et al. for Singapore Zika Study Group,	2017	Singapore	Upper Income	Zika: 2016	Grassroots leaders, resident committees, volunteers	Community groups, community leaders, volunteers	Risk Communication, Source Reduction	Community wide	Not reported	Not reported	not reported	Not reported	Supplementary File 1 contains some information on Community engagement activities, not contained in manuscript body.

Jiang, et al.	2016	Sierra Leone	Low Income	Ebola Virus Disease, 2014-2015	Social mobilization for awareness generation	Village leaders, community leaders, religious leaders, and community volunteers	Risk Communication, BCC	Community wide	Not reported	District health management team of the Western Area Rural District and the public health team from China	New	2015	
Juarbe-Rey, et al.	2018	Puerto Rico	Upper Income	Zika	Community based participatory research	Women in reproductive age,mothers, sport leaders, students, and community leaders	Planning, developing, and implementing a risk communication initiative	N/A	N/A	N/A	N/A	January and March 2015	
Kinsman, et. al.	2017	Sierra Leone	Low Income	Ebola Virus Disease, 2013-2016	Community participation in development of messages	Community members including traditional leaders, imams, pastors, women's leaders, youth leaders, health personnel, and teachers	Inputs in development of BCC messages	Community wide	Women in reproductive age groups and pregnant are included	Consortium - Enhancing Learning and Research for Humanitarian Assistance (ELRHA)	New	2014-2015	
Kirk-Sell, et al.	2020	United States	Upper Income	Zika 2016-2017	Faith Based Organisations and Community Based Groups	Faith Organisations, Community Groups	Risk Communication	Community wide	Equity - marginalised populations, non-English speakers, undocumented persons	Government	Engaged pre-existing community groups	Unknown	This article describes many risk communication strategies that were taken in the US during Zika. We have only documented the CE aspects.
Le Marcis, et al.	2019	Guinea	Low Income	Ebola: 2014-2015	Comités de veille villageois (CVV), or village-watch communities AND Cadets Sociaux	Community Groups, Local leaders	Trust-building, Surveillance, Risk-communication	Community wide	Not reported	CVV established by UNICEF in 2014. Cadets Sociaux were active during early 2000 war.	CVV new, cadets pre-existing	Not reported	This article describes the CE intervention of CVV, however it more so describes the issues it faced.
		Liberia	Low Income	Ebola: 2014-2015	Community Liaison	Community leader	Design	Community wide	Not reported	IRC implementing Ebola Treatment Centre, and supported discussions	New	Not reported	
		Sierra Leone	Low Income	Ebola: 2014-2015	Chief	Community leader	Risk-Communication, Shut-downs	Community wider	Not reported	Government	New	Not reported	This case study briefly notes how chiefs were used to support community-level Ebola activities, and then describes a situation where after 2 months of Ebola-free, a new case emerged and the government shutdown a local market in the area. This was met by rioting and violence between communities and police sent in to shut-down and monitor community. Apparently, the Chief (who was supposed to be link to communities for Ebola related activities) was not consulted about the closure and thus could not communicate with community on this.
Li, et. al.	2016	Sierra Leone	Low Income	Ebola Virus Disease, 2014-2016	Community based response strategy in contact tracing and social mobilisation	Community social mobilizer including including community and religious leaders, community activists, primary health-care workers, and volunteers	Risk Communication, tracing, BCC	Community wide	Not reported	Chinese Center for Disease Control and Prevention	New	2014-16	
Maduka, et.al	2017	Nigeria	Low Income	Ebola Virus Disease, 2014-2016	Community mobiliser	Community members trained as mobiliser	House-to-house interpersonal communication (IPC)	Community wide	Not reported	Federal ministry of health set up Ebola Emergency Operation Centre. It partnered with Nigerian Centers for Disease Control (NCDC), in collaboration with partners such as Centers for Disease Control and Prevention (CDC), World Health Organization (WHO), United Nations Children's Fund (UNICEF) and Médecins Sans Frontières (MSF).	New	2014-15	
Massey, et al.	2009	Australia	Upper Income	H1N1	Community consultation for appropriate and culturally safe ways to reduce the influenza risk in communities	Community members from aboriginal population	Planning, trust building	Aboriginal communities	Not reported	Hunter New England (HNE) Aboriginal Health Partnership collaboration between the Area Health Service and all Aboriginal Community Controlled Health Services (ACCHS)	New	2008	

Masumbuko and Hawkes.	2020	Democratic Republic of Congo	Low Income	Ebola Virus Disease, 2014-2018	Student-led educational campaign to increase community awareness and engagement	Medical students fromUniversité Catholique du Graben (UCG),	Risk Communication, BCC	Community wide	Not reported	Université Catholique du Graben (UCG along with Ministry of Health of the DRC, the World Health Organization (WHO), UNICEF, and the Association for Health Innovation in Africa (AFHIA)	Yes	2017-2018	
Mbaye, et al.	2017	Guinea	Low Income	Ebola: 2014-2016	Community Based Surveillance & Sensitization Committee (SABC in french) Religious leaders	Community groups, faith organisations, Community leaders, Community members(youths, women, elders)	Risk communication, BCC, Surveillance, Trust-building	Community wide	Essential commodities(electricity, water...) for Local or ethnic groups and employment, BCC for youths	UN, MoH, NGO, Communities	not reported	2 years and more	As the article focuses at the beginning on community reactions among which resistance. It is relevant to consider the resistance behaviors as a plea for community engagement as they manifest complaints/concerns for not being really involved
McMahon, et al.	2017	Sierra Leone	Low Income	Ebola: 2014-2015	Health Management Committee	Community Groups, community leadership	Provision, Surveillance, Logistics, BCC, Risk Communication	Community wide	N/A	Not clear from article - but usually part of MoH and often supported by NGOs, likely IRC in this case.	Pre-existing	On-going	The majority of this article focused on HMCs, however, some non-HMC members were present within interviews. Notably, some contract tracing community members. However, given the main focus in this article, and how it does not specifically distinguish between different types of CE, we only include HMC.
Meredith, C.	2015	Sierra Leone	Low Income	Ebola: 2014	Community Health Committees	Community Groups; Community Leadership	Case identification and referrals; Risk Communication; BCC; Provision/Logistics	Community wide	N/A	Oxfam, with District Health Management Team, and District Ebola Response Coordination.	Pre-existing WASH programmes	N/A	Community leaders in group too - so multiple 'typology'
Miller, et al.	2015	Australia	Upper Income	H1N1: 2009	Participatory Action Research for redesigning response	Leaders, Individuals	Designing	Indigenous Australians: Aboriginal and Torres Strait Islander people	Indigenous Australians disproportionately affected by H1N1, often due to systematic marginalization.	Academia and Public Health	N/A	One off event	
Munodawafa, et al.	2018	Liberia	Low Income	Ebola: 2014-2015	Traditional leaders, traditional healers and religious leaders	Leaders, Individuals	Trust-building / Community entrance	Community wide	Not reported	County Health Promotion Team, UN Mission in Liberia, Save the Children and Red Cross	New	Not reported	Case study of implementation of Ebola response activities in two rural counties in Liberia: Lofa and Margibi
Nakiire, et al.	2020	Uganda	Low Income	Ebola: 2019	Community Members and Leaders	Informal networks, community leaders	Participatory Mapping	Participants and event locations to ensure multi sectoral representation and incorporate principle locations along community-level movement plans	N/A	Infectious Disease Institute (IDI) Uganda, and Centre for Disease Control and Prevention (CDC)	New	One time event	Ebola outbreak in DRC
Ratnayake, et al.	2016	Sierra Leone	Low Income	Ebola: 2015	Volunteer Community Health Monitors	Individuals	Surveillance	Community Wide	No	Ebola Response Consortium	New	Initiated Feb 2015	
Rudge and Massey.	2010	Australia	Upper Income	H1N1: 2009	Community Members: key informants and stakeholders	Individuals	Design	Community wide	Not reported	New South Wales Department of Health and Aboriginal Community Controlled Health Services	Consultations for specific topic new	Unknown	
Santibañez, et al.	2017	United States - Puerto Rico	Upper Income	Zika 2016	Faith Based Organisations and Community Based Groups	Faith Organisations, Community Groups	BCC, Provision (repellent, condoms), other (inspecting windows, detecting stagnant water)	Community wide	Not reported	Over 100 organised joined alliance with government	Epidemic only	Unknown	Only Box 3 from Article, the rest provides overall guidance but does not detail a CE activity
Sepers, et al.	2019	Liberia	Low Income	Ebola: 2014	Community Leaders	Local Governance/community leadership (chief and religious)	Risk Communication, Surveillance	Community wide	Not reported	MoHSW, WHO and NGOs	Leaders pre-existing, but engaged for Ebola purposes	Reported Feb 2014 - Jan 2015	Evaluating WHO's Ebola Response Roadmap in Margibi County, Liberia. The Road Map had objectives, with one being: achieve full geographic coverage with complementary Ebola response activities within the most affected counties/areas, especially those activities that promoted social mobilization through community engagement.
Skrip, et al.	2020	Sierra Leone	Low Income	Ebola: 2014-2015	Community-led Ebola Action (CLEA) Approach, via community mobilisers and Community Champions	Social Networks, Individuals, Community Leadership	Risk Communication, BCC, Trust-Building	Community wide	Not reported	Social Mobilization Action Consortium	New	November 2014 to December 2015	
Stone, et al.	2016	Sierra Leone	Low Income	Ebola: 2014-2015	Community health monitors	Individuals	Surveillance	Community wide		Ebola Response Consortium, US Centers for Disease Control (CDC) and Sierra Leone Ministry of Health and Sanitation.	New	January 2015 (start), but full implementation June 2015.	

Table 2: Community Engagement Technique Described

Author/ Reference	Name of Engagement	Typology Classification	Composition of community engagement team (including gender)	Recruitment of members	Description of CE/ services delivered / co-delivered by CE	Co-delivering of services with other health actors	Links and relationships with other actors	Monitoring and supervision structures	Training and job-aid provision	Incentives (monetary and non monetary)	Provision of Protective Gear	Contextual Factors:	Key Lessons Reported	Notes:
Abramowitz S., et al	Mass media communications and social learning	Community groups	Not reported	Not reported	Social learning included verbal information sharing, peer-to-peer verbal and text phone communications, public and private conversations, and direct observation of Ebola morbidity and mortality.	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	*Facilitator:* Urban Liberian neighborhoods shared a common media market; *Barriers:* (1) Serious problems of trusting and interpreting information about Ebola due to problems with mass media campaigns' credibility, coherence and lack of specificity of messages (firehose approach) by district in government, (2) Past experiences with the Liberian government and rebel groups using public health and mass media communications campaigns to spread disinformation in order to gain strategic military advantage. (3) Local conditions create conflicts between beliefs and practices, with beliefs losing strength to accommodate current practices (vs normative ideals).	Under extreme public health conditions, local communities can rapidly learn and internalize positive health messages, abandon negative health messages, and refine known health messages. A combination of the formal mass communications campaign and informal social learning processes can have an amplification effect. Beliefs and practices may be inconsistent with people adopting positive behaviours when still holding conspiracy theories. Changing beliefs may have little impact on changing behaviours.	Method is limited, lacking details on data collection and analytical strategies. Social learning theory is applied beyond behaviour to include communication processes.
Aceng J.R, et.al.	Community engagement for risk communication, BCC and surveillance	Community volunteers and leader	Community volunteers, Village health team	Not reported	Carry out communal and door-to-door EVD health education and community surveillance	Community surveillance and health education	District health team comprising of district political, civic, security, and health leadership as well as technical advisors from different partners working in the districts.	Supervised by District health team	Volunteers were trained on EVD screening	Not reported	Not reported	*Facilitator:* Multi-sectoral plan with committees at different administative level, to avoid duplications, identify gaps, monitoring structure. *Barriers:* Large influx of people from DRC, constrain in funding and resources	A county-wide comprehensive plan with committees to monitor at different levels can help in community engagement for communication and surveillance.	The method has limited information about data collection and analytical strategy. Social learning theory is applied beyond its scope from behaviour to communication processes.
Adongo, et al.	Social mobilization and risk communication	Faith Organisations	Traditional and religious leaders	Not reported	Information for the community for safe burial practices during EVD	BCC messages of high risk socio- cultural beliefs	working with committee comprising of Government and nongovernmental partners	Not reported	Not reported	Not reported	Personal Protective Equipment was provided to health facilities, but no mention if were provided to community volunteers	*Facilitator:* Decentralized governance system and out of 5 key areas for planning social mobilization and risk communication constituted was included. *Barriers:* Risky socio-cultural practices for burials, leading to direct contact with dead. Social norms for hand shakes and self-medication.	Need for dialogue and involvement of community leaders, faith groups to modify high-risk socio-cultural practices as part of preparation efforts. Social mobilization through community leaders and culturally appropriate health education are needed to contain an Ebola outbreak.	Got information through cross-referencing: https://apps.who.int/iris/bitstream/handle/10665/145675/WHO_EVD_PCV_Ghana_14_eng.pdf
Baker, et al.	Community Surveillance Team	Community leadership Community volunteers	Community leaders and Community volunteers	Community leaders identified volunteers	Information sharing, planning process, co-identify problems and implement solutions, service provision	Information sharing, advice on planned interventions, surveillance and identifying cases.	Country health team and NGOs	Not reported	High-quality information provision (through fliers, billboard advertisements and radio messaging) between community members and members of the formal and informal health systems.	Autonomy of taking decision and suggesting solutions.	Not reported	*Facilitator:* Use of community resources and their ingenuity to come with solution for resource constrained situation, like community provided food for laboratory technicians, building isolation facilities and taking care of families in quarantine; collecting funds to keep the local radio station functioning for information sharing. *Barriers:* Limited or no avenues for communication with health officials due to understaffed hotlines, lack of visibility of central government officials.	(1) Building of trust and better communication is key for CE, understand community practices and draw on existing social structures and resources. Trust and CE facilitate community buy-in to health initiatives and are essential to health system resilience. (2) Meaningful CE is a critical component for building trust in the health system and ensuring effective response to crises.To achieve meaningful CE, communities should be treated as active participants in—as opposed to passive recipients of—health response efforts. (3) Underlines the importance of communities to carry out critical health system functions and create innovative solutions to perceived health needs. (4) preference for consultation-type CE approach in which health actors sought opinions and advice from communities to more effectively tailor messages and identify new approaches. (5) Health system actors must work to build public trust and communication platforms for CE ahead of a crisis. (6) A fortuitous cycle of increased trust, improved communication and continued meaningful CE—all necessary conditions for health system resilience.	
Basson, et al.	Social mobilisation	Social groups like community organisations, Schools	Teachers, parents, students,representatives of different community organizations, physicians	Not reported	Awareness and participation in delivering the intervention		Intervention teams University of Republic who were partnering with Ministry of Health, Ministry of Social Development (MIDES) and the Municipality of Salto	A household survey aimed at evaluating the information level of the neighbors about the activity	Broadcasting of message about the activity by using a car with loudspeaker.	Not reported	Not reported	*Facilitators:* Higher contact with home owner resulted in cost effective ways of checks of unused containers, high percentage of the delivered bags and removal of breeding areas. *Barriers:* Electoral processes at national and local levels during the scaling up activities created uncertainty and non-availability of residents during day time home visits. Adjusting the time of visits had cost-implications.	(1) Community mobilization and inter-sectoral partnerships increases the effectiveness and more acceptance of an intervention. (2) To obtain the support of public health authorities, and taking into account the cost increase caused by promotional activities for community participation, it is important to underline the positive impact of this participation on the effectiveness and acceptance of the intervention. (3) Community participation can contribute to empowerment if these processes take place over longer periods of time and are accompanied by the creation of opportunities and environments where issues of power and control are explicitly addressed.	
Charania and Tsuji.	Community pandemic committee	Local leadership, Faith representative and educational representative	Representatives from health center, provincial hospital, nursing station, Band Council, education, clergy, Northern (a store), water treatment plant, and emergency medical services	Not reported	Joint development of pandemic plan	Development of plan related surveillance, supplies, services.	Intervention team	Not reported	Each member receiving a personal copy of the pandemic plan during the meeting, a computer projector was used to display the plan and committee's feedback	Community pandemic committees are federally funded	Not reported	*Facilitator:* Community Level pandemic committee already existed. *Barriers:* confusion and lack of preparedness, ill-defined roles and responsibilities of government bodies overseeing the delivery of health care and insufficient details in community-level pandemic plans.	Community-level pandemic plans are dynamic in nature, so there is need to re-assess and modified with community participation on an annual basis and after each public health emergency in order to meet the evolving needs of the community. Moreover community members possess information from their personal experiences and can provide invaluable insight about local values and beliefs to create up-to-date and culturally-appropriate community-level pandemic plans.	
Dada, et al.	Community liaison team (CLT) and Social science team (SST)	Locally recruited members	CLT comprised of nine locally recruited staff employed by the University of Sierra Leone's College of Medicine and Allied Health Sciences (CoHMAS) and two LSHTM supervisors. The SST was comprised of four locally recruited research assistants, a data analyst, a transcriptionist, and an LSHTM social scientist	Not reported	Acted as liaison to the community to make them understand of the trial, its importance, recruit participants and to address any rumours or misconceptions of the trial . Conducted activities including one-to-one stakeholder meetings, group area meetings, public performances and radio jingles	Not reported	To the vaccine trial team	University researcher	Team received background training on clinical trials and were responsible for implementing the CE strategy, monitoring rumors and concerns circulating in the community, and providing information about the trial at national and international levels	Paid from the vaccine trial budget	Not reported	*Barriers:* Delayed response in effectively addressing the outbreak and other factors like mobile populations, lack of trust in governments, weak health systems, poor coordination, inadequate communication strategy, misconceptions around the disease, ignorance of local culture and customs, and lack of involvement of local communities in the control strategies	CE approach delivered in vaccine trial establishes trust between the teams and community members that was reciprocal, relatable, relational, and respectful	Same intervention description can be found in another article Luisa Enria et.al]
Gillespie, et al.	Communication for development - social mobilization and community engagement	Multiple community partners including religious leaders, journalists, radio stations, and partner organizations	Varied community networks of religious leaders, chiefs, healers, mayors and councilors, and other community leaders.	Identifying influential or trusted influential person like in rural communities religious and other community leaders who have extensive reach unlike in urban areas	BCC messaging for prevention, control and building trust	Not reported	Not reported	Local partner NGOs manage key messages,micromapping of communities to improve targeting	Strong protocols to guide all aspects of the response strategy. Different communication tools like Radio facilitated 2-way communication	Not reported	Not reported	*Barriers:* the situation was rapidly unfolding and full of surprises and the communities that were affected the most were largely low-income and remote, and they often held traditional practices and rituals that were difficult to change	Engaging communities early on, understanding social and behavioral dynamics to shape the response, adapting to the evolution of the epidemic and to feedback from communities, and facilitating a more central and active role of communities with mutual accountability mechanisms. There is need identifying trusted local community members to facilitate community entrance and use key communication networks and channels with wide reach and relevance to the community, such as radio in low-resource settings or faith-based organizations.	
Gary, et al.	Community led prevention and control measures	Community members, particularly the Ebola survivor and local leaders supported by youth groups	Ebola survivors, chief of the village, youth groups	Not reported	Health promotion, identifying the sick,contact tracing, isolating, donated land for community care centers, surveillance and case reporting, provision of hand wash points at entrance to community and houses	Health promotion, surveillance, tracing, tracking, isolating	Community health worker	Not reported	Not reported	Not reported	Not reported	*Facilitator:* Local leadership inspired confidence and reassurance, helped implement measures such as contact tracing and health promotion, and contributed to the planning, ideas, and solutions for effective controls. *Barriers:* Delay in response led the community devising self-treatment or other local options	Health messaging is best conducted at household level through local leaders or people who have experienced Ebola first-hand, rather than mass media	
Health Communication Capacity Collaboration (HC3), 2017	Community Leaders: traditional and religious	Local Governance/ community leadership (chief and religious)	Local leaders	Pre-existing local leaders	Traditional and community leaders combated rumours and assisted communities to accept messages. Leaders part of planning, decision-making, discussed how they could best enter communities, and then did the messaging sharing across variety of settings (i.e. Imam in mosque, leaders holding community meetings etc). Supported overcoming community resistance. They also reported suspected cases of Ebola.	Wider implementation of community level services.	NGOs and UN bodies implementing social mobilisation and community engagement/outreach techniques	Not reported	Training conducted for all community and traditional leaders in November 2014.	Given mobile phones.	Not reported	Community resistance to Ebola notices. Pre Existing democracy and peacekeeping work by NGO, meant foundations were already in place, and the relationships established, and leaders trained. Proved invaluable for gaining trust and supporting engagement. Multi-level targeting: messages were identified by social mobilisation group, then leaders engaged, and also radio messages played, movie played, information distributed, hand-washing stations set up.	Including leaders supported appropriate targeting of messages, especially ones that previous produced fear.	These last four examples were all within one report, which documented SM/CE in Liberia during Ebola in 2014-2015. All were under the government led 'Social Mobilization' pillar, that was s structured facilitated and more systematic way of planning and monitoring such activity. Readers are directed to this document for more details on each type of engagement process, as well as monitoring and evaluation and more background to the SM/CE structures in LBeria. Key challenges/recommendations addressed across all four examples, taken from the document, are as follows. Challenges: 1) partner coordination and communication; 2) local partner engagement; 3) community resistance or challenges working in communities; 4) limited research/data from the field; 5) logistical/financial constraints; and 6) working in difficult terrain/challenging environments. Lessons learned: 1) community engagement and ownership are key; 2) utilise Ebola survivors in social mobilization and community activities; 2) invest in capacity building of community structures and systems strengthening at all levels; 4) systematic, sustainable, and targeted approaches work; 5) develop standards for incentives for community work; 6) coordination and communication are essential; 7) facilitate two way communication with communities; 8) work in collaboration with local media; 9) deliver consistent messages and do not oversimplify. Key recommendations: 1) Maintain clear and consistent messaging; 2) establish clear channels for communication; 3) support continuous community engagement; 4) promote key preventive behaviours in community; 5) set up effective reporting and data systems; 6) build capacity of local media; 7) improve partner coordination and communication; 8) establish risk communication systems/protocols; 9) facilitate strategic cross-border and intercultural activities
	Community leaders and CHWs	Local Governance/Community leadership (chief and religious)	Local Leaders and general CHWs	Pre-existing local leaders	RED Strategy, Reach Every District: general Community Health Workers, Chiefs, elders and religious leaders were trained on prevention and surveillance, then formed watch committees to protect their communities. CHWs would go door to door with BCC, and community support was fostered by leaders.	Not reported	Carter Centre, UNICEF, World Bank, technical assistance from African Union, HCI/OCP, CDC, Tony Blair African Governance Initiative, UNICEF, and WHO.	Not reported	Capacity Building Activities' were provided	Notes: provision of logistical support and incentives empowered communities to actively protect and improve their own health	Not reported			
	Care Groups	Community Groups, Community Leaders	10-15 community volunteers	Not reported	Care Group Model: Implemented by Concern Worldwide, care groups are comprised of 10-15 community volunteers who acted as health educators. Volunteers shared learning with communities and helped facilitate behaviour change at the household and community level.	not reported	Concern Worldwide	Met regularly with programme staff (Concern Worldwide) for training, support and supervision.	Met regularly with programme staff (Concern Worldwide) for training, support and supervision.	Not reported	Not reported	*Facilitator:* Trusted members of community were involved in Care Group. Community members were able to receive individual counselling sessions with members. Large coverage area with limited staff resources.		
	Community volunteers	Individuals	Individual (but 15,000 trained)	Not reported	Listen! Learn! Act! (LLA), by PSI, is an innovative, both-up community approach that used community volunteers facilitate discussions across three phases. 1) Listen: during which community members share experiences, rumours, fears, hopes and successes; 3) Learn: during which facilitators made connections between the group and reliable sources of information (e.g. the call centre, general community health volunteers) that would provide correct information supplied by MoH; and 3) Act: where group would identify ways they can make changes based on discussion. Emphasis on promoting communities to take actions to prevent Ebola. Community workers were trained and mentored to deliver thee	Not reported	PSI	Community workers were trained and mentored by PSI	Community workers were trained and mentored by PSI	Not reported	Not reported	This was implemented under the Ebola Community Action Platform (ECAP), a project developed by Mercy Corps. All community mobilizers under ECAP implemented Listen/Learn/Act. The primary aim of ECAP was to coordinate social mobilization across the country and provide support to local NGOs and community groups.	Bottom-up approach, supporting communities to design own plans, trusting local NGOs with outreach responsibility, building capacity that covered entire country through effective community engagement and ownership, leading to behaviour change. Challenges: transportation, community perceptions, health workforce and capacity, poor sanitation and hygiene facilities, leadership, funding, partners in terms of standardizing approach and having presence in communities.	

Ho, et al. for the Singapore Study Group, 2017	Grassroots leaders, resident committees, volunteers	Community groups, community leaders, volunteers	Unknown	Unknown	Grassroots leaders and volunteers distributed information leaflets and mosquito repellents in their communities and reminded people to check for mosquito breeding groups. Resident committees organised garbage/litter collections and surveyed environment for mosquito breeding spots.	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Once Zika had moved to mosquito population, government used community education and engagement for vector control, which contributed to the reduced spread within four weeks. Quick, national, multi-sectoral action was required.		
Jiang, et al.	Social mobilization for awareness generation	Village leaders, community leaders, religious leaders, and community volunteers	Village leaders, community leaders, religious leaders, and community volunteers	Not reported	Improve the public's awareness in order to change behaviors towards EVD control	Not reported	Not reported	Not reported	Multiple stages of intensive training with a major focus on educating the public on how to prevent the transmission of EVD, as well as encouraging people to promptly seek medical care in the event that they experience signs and symptoms associated with the disease	Not reported	Not reported	*Barriers:* Prevalence of *poor* behaviors, including an unwillingness to report Ebola, a preference for traditional healing, and unsafe burials	The training increased awareness of EVD control and prevention, as well as community engagement. It also established a mechanism for coordination and cooperation between the community and a professional team	
Juarbe-Rey, et al.	Community based participatory research	Women in reproductive age,mothers, sport leaders, students, and community leaders	Women in reproductive age,mothers, sport leaders, students, and community leaders	*Community partners* recruited community members	Co-developing three risk communication strategy- Zika awareness health fair, health education through theater, and community forums and workshops.	Not reported	Linkage with academic/ intervention team	*Periodic meetings* were held to update partners, coordinate efforts, examine publicity plans, distribute responsibilities, and identify needs	Use of facilitator guide	Activities were funded	Not reported	*Facilitator:* Partneing with community members allowed for contextualizing risk communication strategies to convey health information in formats that were easily understood and well-received by community members. community members' involvement in planning, developing, and implementing this risk communication initiative contributed to an increased sense of project ownership	Community-based participatory approaches for the design of risk communication and community engagement strategies enables residents in low-income communities to make informed decisions for the protection against Zika virus and other mosquito-borne diseases	
Kinsman, et al.	Community participation in development of messages	Community members including traditional leaders, imams, pastors, women's leaders, youth leaders, health personnel, and teachers	Imam/pastor, Traditional community leader, youth leader, women's group, Traditional healers	The study team introduced to respective village chief, who then called a meeting with key stakeholders, including traditional leaders, imams, pastors, women's leaders, youth leaders, health personnel, and teachers, who later was identified as study respondents	Co-developing messages on topics as ambulances, burial teams, and the use of chlorine	Not reported	Research Consortium team members, representatives from the MoHS, the US Centers for Disease Control, and local NGOs - Focus 1000.	Not reported		Activities were funded	Not reported	*Barriers:* Lessons learned from messaging in previous viral haemorrhagic epidemics were not taken into account, and which contributed to prolonging the outbreak. Also the messaging was top-down without considering the local social-cultural aspects.	Communication with the community and message dissemination should be conducted on a two-way basis, with the use of trusted messengers for each segment of the population	
Kirk-Sell, et al.	Community and faith-based organisations	Faith organisations, community groups	Unknown	Pre-existing groups	Public health officials responsible for responding to Zika highlight the importance of partnerships with CBO and FBO, especially to improve communication with non-English speakers or hard to reach populations. Targeting a variety of different community organisations (women's clubs, garden clubs etc). Also coordinated with community health workers.	Engaged by Government	Not reported	Not reported	Not reported	Not reported	Not reported	*Facilitator:* Pre-existing groups in the community, that the Public Health officers would link with to help support activities.	Deploying messages across multiple platforms, tailoring nuanced messages for target populations.	Note: does not describe any more in-depth what type of CE was done.
Le Marcis, et al.	Comités de veille villageois (CVV), or village-watch communities AND Cadets Sociaux	Community Groups, Community Leaders	CVVs made up of: local elites, official representatives of youths and women, religious leaders, traditional healers and Ebola survivors. Cadets Sociaux (youth groups set up during 2000s in response to conflict).	CVV were to be selected by community members. Cadets sociaux - recruitment not reported	CVV: intended to create a local mechanism for resolving issues around population resistance and epidemiological surveillance. However, the CVV in itself provoked resistance. CVV meant to engage local leaders to 'develop trust' and improve community acceptability of response, but had many struggles, including assault and no admittance to communities. Cadets sociaux challenged and attacked MoH and other outsiders who came into villages. They established own 'watch committees' to protect communities. Community mediation processes (facilitated by WHO) went in to investigate history Ebola development and enable community empowerment and mobilisation.	Not reported	CVV supported by UNICEF	Not reported	Not reported	Not reported	Not reported	*Facilitator:* Strong historical factors influenced the acceptability of CVVs, and the community (largely influenced by cadets sociaux) response to Ministry of Health and external actors efforts. Outsiders were met with violence, leading to arrest of community members. People had large distrust in outsider interventions, and had previous mechanisms for community monitoring. Cadets took it upon themselves to monitor and enforce rules for Ebola. Lack of historical understanding, and doing pre 'ground work' to establish connections meant CVV implementation did not succeed.	CE is not a 'one-size-fits-all'. Inflexible or top down responses are not appropriate. CE requires 'fundamental recognition that within communities power and legitimacy are always contested resources'. CE requires dynamic awareness of history, context and power.	This article presents three case studies, each using different CE within their own contexts of Sierra Leone, Guinea and Liberia. Case studies are detailed individually, but under the same article heading.
	Community Liaison	Community leader	Woman	Nominated by community	Community representative present during planning stages of new Ebola Treatment Centre, who expressed concerns, priorities, and negotiated for services for communities. Also related concerns regarding post-Ebola and the impact of the ETC. Negotiated for hiring quotas from in the community. Also led to youth leadership working with government/NGOs to raise awareness through outreach programmes, and included training of community task-forces. Weekly meetings were held to inform communities of ETC updates. Establishment of new community based organisation called 'Taking Initiatives', and other initiatives from youths have also resulted.	Not reported	IRC implementing Ebola Containment Centre	N/A	N/A	Not reported	Not reported	*Barrier:* Containment measures (cremation of the deceased, lock-downs and ebola treatment centres that did not have capacity to support all those admitted) led to much rumours, distrust and criticism towards government response. A new ETC was being established in a stadium, which was foreseen to be dangerous and also take away jobs and activities for people in that area, who already had several other treatment centres nearby.	Community leadership/representative need to be present during planning stages, to negotiate on behalf of community, which will support more acceptance and appropriate services. Knock-on effects of such engagement may be establishment of other community initiatives that represent community needs.	Article has several aspects of CE: new initiatives, community task forces, etc. but the most discussed was community representation within the ETC planning, which is reported here.
	Chief	Community leader	Not reported	Pre-existing community Chief	Community-ownership-model' had Chiefs activity involved as chief community mobilisers, who would do BCC but also impose unpopular measures (like fines). For the most part, this was accepted as Chiefs were from the communities and were already an authority figure. When new Ebola case emerged, the government took action to shut-down markets in town, without engaging the Chief community mobilisers.	Not reported	Government Ebola task force	Not reported	Not reported	Not reported	Not reported	Chiefs were initially recruited to support Ebola activities within communities, however when a new case emerged the government took action via closing markets without consultation with Chief, and thus Chief did not get opportunity to communicate with community. Additionally, large mistrust in Ebola response to begin with - many community members considered it a money-making operation for organizations and health workers	Meaningful engagement of leaders/CE activities needs to be embedded throughout, and not abandoned during peak crisis times (i.e. new Ebola case in this instance).	
Li, et al.	Community based response strategy in contact tracing and social mobilisation	Community social mobilizer including including community and religious leaders, community activists, primary health-care workers, and volunteers	Community and religious leaders, community activists, primary health-care workers, and volunteers	Community and religious leaders and activists who had a high school or higher education level or had some health educational background were recruited and trained to form the local community response team	Alert case report, contact tracing, and social mobilization.	Contact tracing, house-to-house visits, prepare health facility reports, and community report; Impart messages of EVD prevention to their community members via face-to-face, and also distributing posters and brochures	Not reported	The community mobilisers were supervised by experienced senior supervisors and field supervisors from the Western Area District Health Management Team. They were systematically trained on their roles and how to implement their task in the community	Training workshop on EVD messages like, infection prevention in the community, and skills needed for social mobilization	Not reported	Provision of soap and hand sanitiser	*Facilitator:* Community education and social mobilization could facilitate public awareness and improve the compliance of community members with prevention and control measures in their communities *Barriers:* in absence of an effective EVD vaccine, community-based risk reduction measures were among the best ways to interrupt Ebola transmission and can be effective even in areas with weak health infrastructure	Community-based education for the local residents with face to face communication,especially for the influential community persons is an effective means for BCC. Need to tailor community education to the context of the community.	
Maduka, et al.	Community mobiliser	Community members trained as mobiliser	Not reported	community mobilizers who already had experience working as community mobilizers during supplemental immunization activities	Record keeping of the area which includes the number of households where IPC sessions held, demonstrations, Information, Education, and Communication (IEC) materials distributed, cases of non-compliance and issues/ rumours raised during the session. For IPC community mobiliser visited house-to-house with EVD prevention and control messages relating to the causes of EVD, its symptoms, prevention, treatment, and care	Not reported	The data manager collated data from all the community mobiliser and transmitted them to UNICEF and the operations manager of the communication and social mobilization team at the EOC.	One supervisor was provided to a cluster of five teams and two supervisors to each state. Also, members of the communication and social mobilization sub-team conducted regular field visits to provide supportive supervision for the teams.	one-day training covered basic facts about EVD, its causes, symptoms, and prevention. The training emphasized early presentation for treatment and care in the event of someone developing EVD symptoms. It also emphasized stigma prevention, safe burial practices, and hand-washing demonstration. The methods employed for the training included lectures, role play, individual and group exercises	Not reported	Not reported	*Facilitator:* Use of earlier developed IPC strategy used during infectious disease outbreak in Uganda *Barriers:* Existing risky Cultural practices like self-medication, open-defecation, ceremonies and mass gatherings washing and staying overnight with dead bodies, unhygienic ways of slaughtering domestic animals, the handling of body fluids during childbirth, and washing the corpse of a man	IPC although resource intensive and time-consuming,this strategy has the potential to contribute to improved knowledge on modes of spread, symptoms, and practices on prevention of EVD	
Massey et al.	Community consultation for appropriate and culturally safe ways to reduce the influenza risk in communities	Community members from aborigina population	Not reported	Key stakeholders in these communities identified by the ACCHS and key informants were approached to input into the influenza consultation	Community inputs were provided on issues of reducing the risk of influenza at home and at community gatherings such as funerals; and providing access to health services. Key inputs were provided on the issues of significance of a local resource person, Clear communication, Access to health services, funerals practice and Social and community support issues.	Inputs for joint development of plans for aboriginal population	Policy and program division of the country	Not reported	The implementation team provided input about the nature of influenza, its transmission, and the evolving epidemic during the consultation.	Not reported	Not reported	*Facilitator:* Australian Health Management Plan for Pandemic Influenza was prepared to protect all Australians and reduce the impact of a pandemic on social function and the economy. *Barriers:* Indigenous people are approximately five times more likely than non-Indigenous Australians to be hospitalised for swine influenza and a similar proportion required intensive care treatment. There is no measures that appropriate to be devised for this group.	Measures to reduce the risk of influenza in communities must be developed with the communities to maximise their acceptance. The process of engagement and ongoing respectful negotiations with communities is critical to developing culturally appropriate pandemic mitigation and management strategies	
Masumbuko and Hawkes.	Student-led educational campaign to increase community awareness and engagement	Medical students fromLihiverité Catholique du Graben (UCG),	Medical students	Not reported	Community outreach activities included a parade with branded t-shirts and banners through the main streets and market, speeches with loudspeaker, one-on-one interactions with community members in public spaces,presentations at faith-based gatherings (Sunday church service), and radio announcements	Not reported	Link with ministry of Health and international organisations	Not reported	Students were provided training (one half day) in the biology, transmission modes, and social dimensions of EVD, together with pragmatic strategy and schedule for the community outreach.	The social mobilisation and the campaign was funded	Not reported	*Barriers:* Poverty, HIV/AIDS, and ongoing violent conflict following civil and international wars, fear of EVD since the last outbreak in West Africa, mistrust of national government and international agencies and security concerns	Medical students appear to be well positioned to act as'opinion leaders' and 'social mobilizers' given their tacit cultural understanding and biomedical knowledge, they can tailor health messages, build rapport, increase interpersonal communication, empower community members, and promote optimal health outcomes	
Mbaye, et al.	Community Based Surveillance Committee (SABC in french) Community Leaders	Groups	Youths, other community members, faith and other community leaders	Community driven with the support of international partners	Community death reporting, Sensitization, Controls at entry and exit points of communities, safe corpse management and burials	Anthropologists used as mediators between communities and the health sector		Community meetings	No	Funding from international partner for community projects, food distribution, hand washing kits distribution, free consultations		71% of rural population, Poor access(38.9%) and utilization (18.8%) of health services, Poor geographic reach of health facilities (about 1033 health facilities for 10.95 millions people. Ethnic and political conflicts, Poverty and Youth unemployment.	Community resistance as being a form of expression for populations during an epidemic can prompt community engagement; Communities are not passive during an epidemic, they take initiatives the state of their knowledge and health system/ State/ International community supports.	

McMahon et al.	Health Management Committees	Committee	Volunteers from community, who work together, often in collaboration with health facility staff, to improve community health and give voice to community's needs. Typically include: community chief, female leader, teacher, and several health mobilizers.	Not disclosed, but specific representation needed (i.e. community leader). Often HMCs have some positions that are elected (i.e. female leader) and some by default (i.e. if they have health facility in-charge in them)	*Various* roles across the country. Not standardised intervention. Prior to Ebola: Regular meetings, fundraising, health promotion, engagement with other health workers, accountability (i.e. medicines). During Ebola: Manual labour (building walls, cleaning facilities, digging graves, manning checkpoints). Administration and outreach (records, contract tracing, screening upon entry to health facility), navigating interactions with community members (BCC and trust-building). Acted as link to health workers (i.e. explained community concerns, asked health workers question on behalf of community) and from health workers to community (built trust, explained prevention and control measures to community for acceptability).	Pre-ebola, would travel with health care workers to deliver services, communicate health messages etc. During Ebola, support health facility activities (see roles/types of services).	Health facility, Community Health Volunteers, Contract Tracers	Linked to Health Facility. During Ebola, some HMCs were supported by NGOs, others were not.	Training by NGOs (IRC) mentioned as source of motivation for HMC members. Specifics of training unclear. Pre-existing HMC that likely had some initiation, and were supported by NGOs at times for some activities within.	Varies - sometimes NGO and/or government support in terms of monetary and non-monetary incentives. Contract tracers were to be given monthly allowance, though this did not always happen.	For health workers and burial team members. Not clear if any HMC members were part of these teams.	*Facilitators:* Many listed, see document for more details. Key contextual factors: 1) Pre-existing relationships between HMCs and Health Facility which supported trust and timely action; 2) External inputs (i.e. trainings by NGOs and IPC supplies) provide direction and support; and 3) specific nature of Ebola and recognition of internal action galvanized community action. Article identified facilitators (via intrinsic and extrinsic motivation) and facilitators. Intrinsic motivation: desire to serve and lead, fear of Ebola, pride/trust in health facility and providers. Extrinsic motivation: compensation, recognition of governments limited capacity, recognition of Ebola severity, and NGO support. *Barriers:* Intrinsic - sadness, grief and loneliness, fear of contracting Ebola, concern that government has forgotten them. Extrinsic - community misconception about payment, and community anger at them for 'collaborating' with health system.	Article articulates 4 key lessons learned (Table 3, pg 8), directly quotes as follows: 1) Community leaders, volunteers, and home committee members can perform vital functions during public health emergencies; 2) The importance of community leaders, volunteers and health committee members rests not only in their capacity to carry out manual labor and administrative tasks, bu also in their capacity to mediate between communities and the health system; 3) Positive pre-existing relationships between communities and health workers are a key enabler for community volunteers to engage in difficult tasks during crises, particularly tasks that violate social norms (e.g. burial rituals); and 4) During emergencies, the resilience and capacity of community leaders, volunteers and health committee members can be supported by ensuring clarity among stakeholders about compensation, reassuring community workers that they are not forgotten, providing trainings and equipment, and creating spaces for dialogue between health workers and community workers.	This article elaborates further on role and responsibility of HMCs during Ebola, contextual factors, barriers and facilitators. Refer to article for more specific details and expansion of points reported here.
Meredith, C.	Community Health Committees	Committee; Leaders	Not disclosed.	Not disclosed	Identified barriers to effective prevention, case management and safe burials. Committees developed action plans to address such barriers. This ranged from logistical (fuel for ambulances, water access) to Behaviour Change Communication, and Risk Communication (i.e. dismantling beliefs that bathing in salt water can cure Ebola, and sharing knowledge on burial practices). Also, in one case. noted, conducted case identification and referrals.	Community Health Committees linked with Community Care Centres	Support by DHMT and District Ebola Response Coordination.	Linked to Community Care Centre	Training on communication, to build confidence of Committees, and to build 'kangosa' or gossip channels. Training on Ebola case identification and referrals.	N/A	N/A	Disbelief and distrust from some community members prior to initiating Committees. Pre-existing implementation and relationships by NGO in the context. However, they note Challenges as "coordinating social mobilisation activities in a context where multiple agencies are active in the same communities, each with their own way of working". This was helped in Sierra Leone due to existing 'Social Mobilisation Pillar (SMP) led by Ministry of Health that is an umbrella structure for all community operations. Logistical issues related to geography cover and remote areas, also need to have strong relationships but also be ready to deploy quickly.	Actively involving community health committees in the development of prevention and protection approaches built trust and and increased community willingness to refer and seek treatment. Communities members are able to engage in social mobilisation with harder-to-reach or less likely to disclose populations (i.e. taxi drivers, drug users). Active case findings with social mobilisation important proactive element.	There are two examples in this one article. They are from different countries (Sierra Leone and Liberia) and different examples. Sierra Leone reports on CHCs, whereas in Liberia they discuss case findings using community health volunteers. For the second, it is unclear if these are 'CHWs' or if they are from the communities. Not enough details, so it is excluded.
Miller, et al.	Participatory Design	Leaders, Individuals	Not reported	Community leaders	Focus Group Discussions, interviews and workshops using participatory action research, specific to H1N1 pandemic plans. Community members and leaders identified key considerations for current and future pandemic plans.	N/A	N/A	N/A	N/A	N/A	N/A	*Facilitator:* Communities have previous experience with PAR, involvement of Aboriginal Health and Medical Research Council, multi-disciplinary and staged researchers.	Pandemic response plans need to consider: social aspects of communities including cultural values, norms, family ties, and social networks.	
Munodawafa, et al.	Traditional leaders, traditional healers and religious leaders	Leaders, Individuals	Not reported	Community leaders	Advocacy meetings with Chiefs, traditional leaders and other influential people to obtain support for the Ebola response effort.	UN, International Organisations and Government.	UN, International Organisations and Government.	Not reported	Not reported	Not reported	Not reported	*Facilitator:* Strong relationships with county health teams, multi-sectoral partnerships and interventions. Context of implementation (lack of facilities, roads, infrastructure, water and sanitation etc) at community level left families more vulnerable, and introduced many challenges for care seeking. Infection control for safe burials had much resistance, as these were incompatible with traditional practices.	Multi-sectoral approaches which include social mobilisation were mapped to reduced incidence of EVD. Key lessons reported, relevant to CD: 1) social mobilisation and community engagement (e.g. involving chiefs, elders, religious leaders) were critical for bringing about community/system changes and services. Key recommendations reported 1) assure early and intense CE activities at the local level (i.e. engage chiefs and elders, religious leaders, women and youth and Ebola survivors in key activities such as investigating rumours and diffusing myths) 2) build capacity and sustained leadership within community health committees through training and technical support for essential community processes (e.g. assessment, planning, developing interventions, intersectoral action, monitoring and evaluation).	
Nakiire, et al.	Community Members and Leaders	Members; Leaders	community leaders, informal traders	Purposefully selected	Focus Group Discussions and Key Informant Interviews with Participatory mapping. Community participants describe movement patterns across borders specifically for: those seeking refugee status, conducting trade or business, seeking health care, visiting family. Also mapped health care facilities that receive patients from DRC.	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Findings used to scale-up prevention efforts (via risk communication, community surveillance, screening of travellers etc).		Multiple stakeholders involved in participatory mapping - unclear specific community contribution
Ratnayake, et al.	Volunteer Community Monitors	Individuals	N/A	Volunteers or existing Community Health Workers	Responsible for their own village, or if necessary a few small villages within walking distance. Trained to detect 6 trigger events suggestive of Ebola, and then report any to supervisor who did primary investigation.	Community Surveillance Supervisors and Community Health Officers (MoH staff)	Ebola Response Consortium, International Rescue Committee	Monitors reported events to community surveillance supervisors via mobile phones, the supervisors then conducted preliminary investigations.	Job specific training month prior to actions. Some districts provided informal refresher training. Trained to detect 6 trigger events suggestive of Ebola	Not reported	Not reported	Wider contract tracing was ongoing, this system was to support more efforts at community level. Some of the monitors were previously trained CHWs, and some were also contract tracers. Contextual considerations include: how monitors classify and understand illness, awareness of burial practices and how to identify/importance of reporting, piloting of illness classifications, strong links to wider health system.	CEBS generated alerts for about 1/3 EVD cases. Found to have low sensitivity and positive predictive value, however this is meant as a supplement to a wider tracing system, and the authors noted this was a positive result. Additionally, community monitors found other health issues, including three measles clusters and chickenpox. System may be good to identify cases with no epidemiological links (that contract tracing would usually find), or newly emerging outbreaks. However, still needs thorough coverage, adequate training, and strong links with wider community systems. Before rolled out, validity of the 6 trigger categories need to be tested, and exploration of burial practices would be required, as the monitors did not identify many such incidences.	
Rudge and Massey.	Participatory Design	Individuals	Unknown	Unknown	Focus Group Discussions with 6 different communities on potential solutions for addressing H1N1 in their communities. Their input influenced design/approach to interventions.	N/A	N/A	N/A	N/A	N/A	N/A	*Facilitator:* Pre-existing relationships with communities meant ability to have rapid discussions on such topics.	- identify local 'go to' people, who are trusted and easy to access and who community may turn to for advice; simple, clear information that demonstrates respect; people need information on where to get help and control procedures; infection control messaging should be aligned to reality of Aboriginal communities; people need to have a say in the support provided	
Sanlibañez, et al.	Faith-based and community-based groups	Faith organisations, community groups	Unknown	Pre-existing groups	In 2016, over 100 FBO and CBOs joined an alliance with the government. They had main duties of: 1) establing teams that can inspect their neighbourhoods weekly 2) planning ahead for mission trips and travel to areas with Zika, 3) building a culture of solidarity and commitment to helping on another, 4) educating and empowering community members to help prevent the spread of Zika. they did things such as "zika Action Days' where education was spread and repellent given, inspecting of stagnant water sources and houses with brown screens, education on how to elminate mosquito breeding sites, distributing condoms and repelle.t	Over 100 FBO and CBOs	Not reported	Not reported	Not reported	Not reported	Not reported	*Facilitator:* FBOs and CBOs had direct and existing relationships with communities. They know who is pregnant, where people live, key areas in community etc. They were recognized as first responders in any emergency. Groups joined together, identified common goals and agreed upon roles for groups.		Only reporting Box 3 from article, which describes a CE approach. Rest of article has CDC recommendations for CE, helpful with lessons learned.
Sepers, et al. 2019	Community Leaders	Local Governance/community leadership (chief and religious)	Individual leaders	Pre-existing individuals	Several engagement activities: convened a national consultative meeting with traditional community leaders; conducted community advocacy meetings with local and religious leaders; conducted an engagement programme with community leaders to mobilize them for addressing EVD outbreak; implemented a survivor reintegration programme. Article notes that "[In] Liberia, there was less reliance on community isolation (quarantine) but rather there was emphasis on community self-policing or monitoring, whereby each traditional leader (chief or religious leader) took it upon themselves to enforce policies on visitors, strangers and reporting of sick or decreased."	Several other mobilization activities enacted, though many not through community engagement.	Ministry of Health, Sanitation and Welfare, WHO, The Council of Chiefs and Elders, NGOs	Not reported	Meetings and sensitisation trainings conducted	Not reported	Not reported	Multi-sectoral engagement. CE was part of wider activities including: 1) surveillance, contact tracing and case investigation; ii) case management; iii) safe burials; iv) social mobilization and community engagement and v) delivery of basic services. Prior bad experience with law enforcement, and strong focus on leaders (chief or religious), including support from NGOs and WHO, had government relying on leaders to ensure adherence from communities.	Engagement of community leaders (chief and religious) to support adherence, education, monitoring and reporting within communities.	Table 1 details all implementation components, elements and engaged partners in Ebola response implementation, including all aspects of CE.
Skrip, et al.	Community-Led Abola Action, with community mobilisers and Community Champions	Community Champions, Individuals	Community Champions, supported by Mobilizers (youth workers (18-2 years) who had previously been involved in HIV/AIDS community programme)	Mobilizers: through previous programme. Champions: Identified via community facilitated sessions by mobilisers. Champions: Unknown.	CLEA Approach, a structured participatory approach: Initial visits by mobilisers to communities, mobilisers use structured tools with community group to facilty community inquiry, to facilitate and support community to conduct analysis and develop action plans to prevent transmission. Community Champions are identified, who are focal points and support communities to develop plans. Mobilisers make subsequent visits to communities. Expected that communities identifying priority actions and implementing strategies to address would affect behavioural outcomes.		CLEA approach used within Sierra Leone's Social Mobilization Action Consortium (SMAC).	Follow-up visits by mobilisers approximately every 3 weeks	Trained by mobilisers	Not reported	Not reported	Follow-up visits required, and such visits associated with more satisfied needs. Running of CLEA aligned to more resources in other sectors and areas, which may have supported its success (for instance, community care centres could accept increasing referrals, dignified burial teams and ambulances available). Actions were ones communities know that they can adopt and sustain, that promoted local ownership of the response based on community-defined actions that are protective while consistent with local interest.	Using the approach facilitated actions plans with specific by-laws for implementation, using this and community meetings with local champions facilitated collective buy-in. Follow-up visits by mobilisers were associated with higher prompt referrals. Communities with satisfied capacity had fewer unsafe burials and more prompt referrals. The need for sustained behaviour change in outbreaks may be met by community identification of needs, action plans and implementation (facilitated by Community Champions) and supported by community mobilisers.	Mobilizers do not seem to be community members, but support (trigger) community engagement activities via Community Champions
Stone, et al.	Community health monitors	Community health monitors (Volunteers)	Individuals	ERC identifies community health monitors in collaboration with traditional leaders in each village. 1 monitor for 50 households. 1 Supervisor per Chiefdom. CHMs should be respected residents in their communities with previous experience in a role of responsibility (i.e. teacher). Wherever possible CHMs would be CHWs.	Community members trained to identify 6 trigger events that may be associated with Ebola, and report to Community Surveillance Supervisor via phone call. Ratio of CHM to household was 1:118, and ratio of CHM to CSS 52:1. In trial, 7142 CHM trained across 9 districts, covering approximately 63% of Sierra Leone. Number of events reported increased with time, as roll-out to different districts slower. When operational, 92% of all CHM reported. Large majority of events were not classified by CHM. In evaluation interviews, CHM only recalled 3/6 trigger events. CHMs actively sought information by: speaking to community leaders, visiting households, speaking with other key informants (teachers, health workers).		Wider CEBS system including: supervisor, community health officer, district Ebola response center	Done by Community Surveillance Supervisor. Weekly reporting, even "zero reporting" used as a supervisory tool to check that CHM is still active and looking for triggers.	Trained on 6 trigger events that may be associated with Ebola.	Motorbikes and Mobile phones	Not reported	When possible, previously trained and operational CHWs (Sierra Leone has had community health worker programme since 2006) were used, as they already had relationships with the community which was deemed essential to build trust. District and Chiefdom level stakeholder meetings conducted to get buy-in from local leaders to support community ownership and participation in programme. Failure of closed user group and lack of motorcycles were inhibiting factors. Also, knowledge of CHM: Large majority of events were not classified by CHM. In evaluation interviews, CHM only recalled 3/6 trigger events. 68% noted that the community supported their work. Others noted need for strengthened coordination between CEBS and other Ebola related activities and surveillance. Logistical challenges influenced timeline	Start-up took longer than expected (over 6 months). Importance of stakeholder meetings to get community ownership and acceptance. The implementation of CEBS supported a stronger and satisfying linkage between communities and overall EVD response. More refinement of triggers are needed, and likely more training for CHMs. Community health volunteers are capable of detecting and reporting important health information.	Article also reports on Community Surveillance Supervisors, bu they are often health staff and not situated within community or conducting engagement activities, so this is not reported here.