Understanding Community Engagement for Evidence Uptake in Humanitarian Settings

A Rapid Review of Literature to Guide Development of Elrha Training Materials

Joanna Busza, Independent Consultant

CONTENTS

EXECUTIVE SUMMARY

Community engagement is an ethical imperative for health research and response in humanitarian settings. Increasingly, guidance and resources are being produced to support researchers in planning and implementation of ethical and effective community participation in research. However, while communities can be engaged at any stage from collecting data, designing programmes and introducing services, their specific role in contributing to uptake of new evidence produced through research is rarely described. "Research uptake" is the process through which specific research users engage with the research findings, leading eventually to research impact, including changes to policy and practice. In response to needs articulated by stakeholders of Elrha's Research for Health in Humanitarian Crisis (R2HC) programme, the author was commissioned to develop a training course on 'Community Engagement for Research Uptake in Humanitarian Settings'. As a first step, a rapid literature review was undertaken to inform the content of this course.

KEY FINDINGS

- While community engagement in research is universally recognised as important, it is not always clearly defined or operationalised. Multiple terms are used to describe or replace "community engagement" including "participation", "involvement", and "mobilisation", but these do not always mean the same thing across contexts.
- The dual aims of community engagement in research uptake are both to *empower* people and to *harness their existing power* over intervention success.
- There is a 'continuum of community engagement': from one-off ad hoc interactions, through active collaboration, to more sustained partnerships and, occasionally, true co-creation of research. Researchers can strive to move along the continuum to improve quality and impact of community engagement. This engagement should be considered at each stage of the 'Cycle of Research' to maximise uptake of research.
- Five key components of community engagement are: (1) Building on existing relationships and networks (2) Offering external resources and direction (3) Strengthening leadership and capacity (4) Sharing power and learning and (5) Giving voice and agency to minoritised groups. Supporting researchers in these five components should be a focus of guidance and training.
- Relevant literature on monitoring and evaluation falls into two categories: (1) descriptions of using participatory approaches to engage communities in evaluating and improving programmes as they are implemented, and (2) measuring the extent and depth of community engagement as a process indicator. Measuring engagement, as an indicator of progress toward greater

equity and participation, is a category of activity less frequently addressed in the literature, but some frameworks and tools are available.

- Researchers and health practitioners often lack confidence and experience in how best to initiate and maintain equitable and functional partnerships with affected communities. A range of training programmes are available for researchers, although practical guidance is often limited.
- Outlined in the conclusion are skills, learning and training priorities, based on the literature review, that were identified to inform the Elrha course.

TABLES AND FIGURES

PREFACE

Elrha's R2HC programme aims to improve health outcomes for people affected by humanitarian crises by strengthening the evidence base for public health interventions through research, and maximising the potential to bring about positive change in humanitarian response.

This literature review addressing community engagement for evidence uptake in humanitarian settings, and our broader objective of developing online training on this topic, has been commissioned in response to two drivers. Firstly, we recognised that our existing research impact support and training materials contain limited content on community engagement for research uptake, with the primary focus being on engagement with policy and practice stakeholders. Secondly, researchers funded through the programme articulated a need for practical guidance and support on community engagement in general.

In response, our intention was to develop resources and guidance to fill a specific gap, namely, to define 'best possible' practice guidance for engagement of communities from a *research impact* perspective*,* ie, within the broader context of a stakeholder engagement strategy focused on delivering uptake of research. Our hope was that the training materials would draw on literature that regards community stakeholders as actors with agency and power, rather than passive beneficiaries of research impact.

We recognised that tools and literature from humanitarian settings and complex emergency contexts responding to this specific area of focus would be limited. For this reason, the review has focused on a wider body of work on best practices for engaging communities across the research continuum and literature from comparable development settings has been included. Efforts have been made to draw out the most relevant content from such literature, and all the case examples identified for use in the training materials are drawn from humanitarian crisis settings.

Over time, as the body of evidence grows, and our training course is rolled out and generates feedback, we will revise and update the frameworks, concepts, and practical guidance to ensure it responds to the specific needs and priorities of researchers working in complex and acute humanitarian crises.

This literature review is intended to be a resource to supplement the training course content. We hope you find it useful.

Anne Harmer

Head of R2HC Programme

INTRODUCTION

Community engagement in health research and practice has a long and extensive history. Its conceptual roots lie in the participatory development and Primary Health Care movements, best exemplified by the writings of Paolo Freire in the 1960s and the World Health Organization (WHO) Alma Ata Declaration of 1978. The premise that people should take decisions to shape the determinants of their health and well-being is universally accepted and has both ethical and instrumental dimensions.[1] The former position (community engagement as an ethical imperative) reflects a rights-based ideological position, namely that active participation in the design and delivery of health interventions and services has the potential to be an empowering and transformative experience that increases autonomy, agency and control by people directly affected.[2] The latter position (that community engagement is instrumental, ie, useful at a practical level) is based on empirical observations that active involvement of community members increases the feasibility, acceptability and contextual 'fit' of health programmes, which in turn improves likely effectiveness.[2,3]

Community engagement is widely accepted as an ethical imperative for health research and response in humanitarian settings. Effective community engagement is also considered necessary to ensure new clinical services and health promotion messages are appropriate, acceptable and feasible in any given context. Yet community engagement remains inconsistently defined, without indicators for determining how meaningfully it has been conducted. Numerous terms are used for community engagement including participation, involvement, and mobilisation, and these do not always mean the same thing across settings.

Furthermore, while communities can be engaged at any stage from collecting data, designing programmes and introducing services, their specific role in contributing to uptake of new evidence produced through research is rarely described. "Research uptake" is defined as the process through which specific research users engage with the research findings, leading eventually to research impact, including changes to policy and practice. It is the step before "research use" (changes in awareness, knowledge and skills), and is an important precursor to "research impact", ie, the routine application of new evidence-based behaviours and practices.

Uptake activities are those that help communities understand why and how research was conducted, what the findings mean, and how these might affect health services, behaviours and outcomes. These activities often include events, workshops and distribution of materials to make research results meaningful to non-academic audiences.

This document reviews the ways in which community engagement has been conceptualised and applied to both health research and implementation, with a focus on how these overlap in "research uptake" and with particular reference to programming in humanitarian settings. It brings together literature and examples synthesised from over 75 articles and documents identified through a rapid review (and provided in the Reference list).

RAPID REVIEW: METHODS AND APPROACH

A rapid review was conducted to assess the extent and scope of peer reviewed literature on community engagement for evidence uptake, with a focus on humanitarian settings. The overall purpose of this review was to inform development of an Elrha training course to support grantees in integrating community engagement into their stakeholder engagement strategies, which they are required to produce as grantees of R2HC.

The aim of the review was to bring together knowledge on effective strategies and approaches for engaging communities affected by humanitarian emergencies in applying new knowledge for improving their health. Specific objectives included (1) identifying examples of how community members or their representatives contribute to uptake of research findings in humanitarian settings, (2) highlighting gaps in information on how humanitarian actors should engage community members, and (3) locating training materials addressing these gaps (or determining their lack of availability).

Using PubMed and Google Scholar, searches combining terms related to community, research uptake, application of evidence, and humanitarian contexts were conducted. These included “community engagement”, “research uptake”, “participatory research” and “crisis”, “emergency”, “humanitarian”, “outbreak”, “conflict”, “war”, “epidemic”, “disaster”. Reference lists of identified articles were checked for further relevant citations.

The review was not designed to be either systematic nor comprehensive but narrative; papers identified through the searches were scanned to map key conceptual and operational issues and determine the existence of guidelines, methods, and training resources.

NOTE ON HUMANITARIAN FOCUS OF THE LITERATURE REVIEW

The training is targeted in the first instance at research teams supported by Elrha’s R2HC programme. Grantees are typically undertaking research in complex emergencies or protracted humanitarian crisis settings, engaging with people affected by humanitarian crises, such as refugees, internally displaced persons, and associated host communities. The review first sought to identify literature describing community engagement for research uptake in humanitarian contexts as defined above. Where available, studies tended to focus on longer-term protracted humanitarian contexts rather than acute emergencies or conflict, with the exception of disease outbreaks over the past decade, such as Ebola, Zika and COVID-19. Additionally, literature related to community engagement in humanitarian settings was not often linked to the specific issue of research uptake and use, but was found instead to focus more broadly on community engagement in research production. A larger body of work on best practices for engaging communities across the research continuum was therefore included where strategies and approaches were considered relevant to and adaptable for health research in crises. Specific studies provided as illustrative examples, however, all highlight community engagement initiatives implemented in humanitarian settings.

FINDINGS

COMMUNITY ENGAGEMENT ALONG A CONTINUUM

Community engagement is not always clearly defined and there are no standardised indicators for measuring how meaningfully it has been conducted. Multiple terms are used to describe or replace community engagement including “participation”, “involvement”, and “mobilisation”, and these are also not always used to mean the same thing across contexts. Using a continuum to depict different levels of community engagement makes clear that it is an ongoing process that should consistently strive toward increasing ownership by communities over all aspects of design and delivery of health programmes, including in the production of evidence and identification of best practices.[4-6]

Figure 1 below illustrates the continuum of community engagement as defined in a literature review of community engagement for disadvantaged populations (top row)[7] and as articulated by Elrha for use with its partners in humanitarian research and response (bottom row). While the specific terms that are used in such a continuum may vary, they align with the idea that community engagement is a dynamic process that can change over time, and ideally efforts should be made to move from left to right across the continuum regardless of starting position. Taking an incremental approach is especially relevant to conducting research in challenging humanitarian situations (eg, conflict settings), where it will be extremely difficult or impossible to expect to achieve higher levels of collaboration, partnership and co-creation.

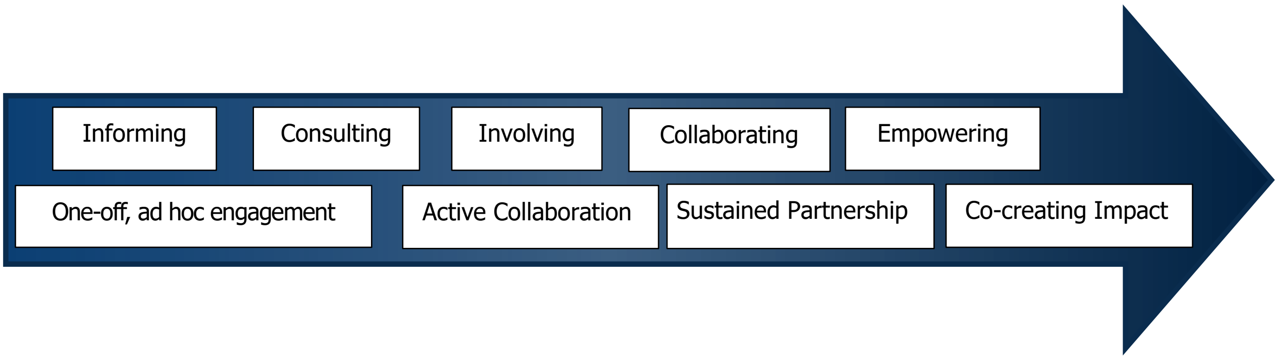


Figure 1: Continuum of Community Engagement

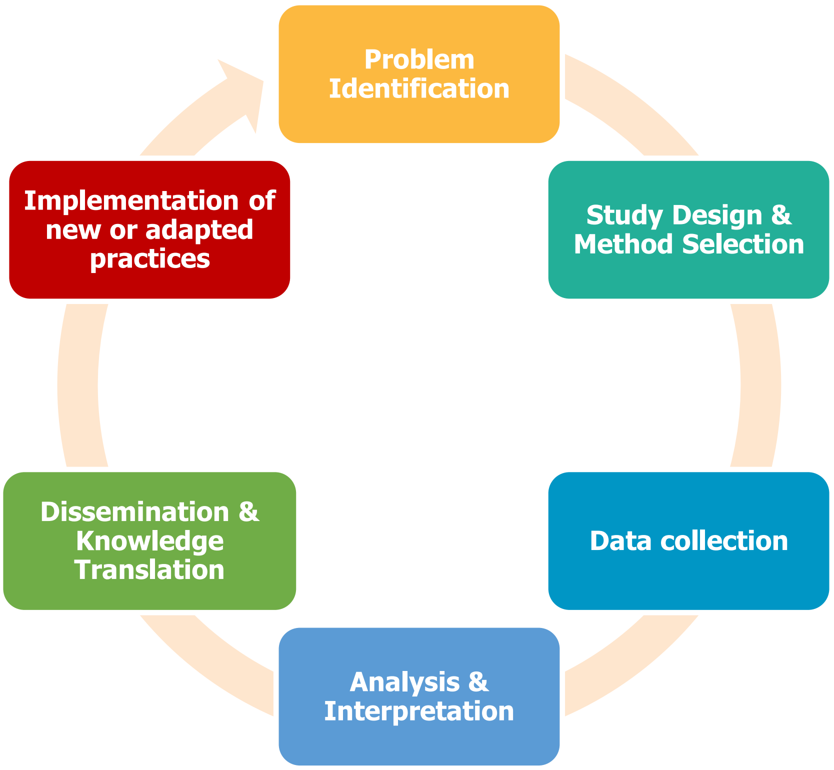
RESEARCH VS PROGRAMME IMPLEMENTATION

Community engagement is cited as central to both research activities and programme implementation. Research requires identifying a problem or question(s), planning a study using methods appropriate to answering the question(s), collecting data, and then analysing and interpreting the data. Applied research uses the results of the study to help inform new or improved practices, procedures or services, which is then integrated into routine programme implementation (or delivery). Thus, "research uptake", as defined on page 5, lies at the intersection of research and implementation.

In some cases, research evidence will have emerged from a study conducted in the same setting and with the same people, in which case "uptake" should be part of the research process.[8] In other cases, new evidence comes from research that has been conducted elsewhere, and "uptake" becomes a precursor to programme implementation, namely ensuring that the new knowledge is meaningfully understood in a way that is suited to the local context, culture, and immediate situation. "Implementation research" is often conducted at this stage, and refers to the study of how best to introduce evidence into routine practice to improve health services and outcomes.[9]

Figure 2 illustrates the research cycle, demonstrating how production of new knowledge feeds into programme implementation by introducing evidence-based recommendations into routine practices and procedures; community engagement is relevant at each stage.[10] Within this model, "research uptake" spans "analysis and interpretation" (supporting communities to understand the evidence and its implications for them) and "dissemination and knowledge translation" (ensuring findings are packaged and presented in ways and through modalities suited to different community members and contexts).

Figure 2: Cycle of Research into Implementation[10]



EXPLORING KEY CONCEPTS

WHAT IS A COMMUNITY?

The US Centers for Disease Control defines community engagement as "a process of working collaboratively with groups of people who are affiliated by geographic proximity, special interests, or similar situations with respect to issues affecting their well-being."[7] This definition suggests that members of a community are likely to have something in common with one another that has direct bearing on their health.

Drawing on health promotion principles,[11] the types of shared attributes considered to be markers of different kinds of "communities" can be specific health conditions (diabetes, pregnancy) or the proximate behavioural and biological determinants of health conditions (smoking, living with a disability). Broader social categories and material conditions also create communities of people who have common vulnerabilities that will affect their well-being, for example marginalised ethnic or religious groups that experience discrimination or persecution, or poorer households who live in substandard housing or polluter neighbourhoods.[12] Individuals may make up parts of several types of communities simultaneously and may or may not self-identify as being part of them (for example, a pregnant woman living in a rural area may consider herself to be part of her village and an active member of a particular religious group, but not necessarily think she has much in common with other women who happen to be pregnant). In times of conflict, whole ethnic or national groups may self-identify together in ways they previously did not, which can both increase community affiliations (feelings of shared priorities across a whole country) or break down previously existing ones (ethnic tensions causing loss of trust within diverse societies).

When planning community engagement, relevant communities need to be determined and defined based on the specific setting, the health issues(s) of interest and, in humanitarian contexts, the nature of the situation (and whether it is acute or protracted). The following are potential communities who might be engaged.[13]

- People with a specific illness (eg, living with HIV)
- Groups with similar patterns of vulnerability (eg, children, refugees)
- Participants in a research study
- People with shared identity or affiliation (eg, religious or ethnic groups)
- Health providers, both formal and informal
- Whole populations in a geographical area affected by the same event (eg, flooded neighbourhood)

Engaging each of these types of communities may require one or more different approaches, particularly in the first instance where it is important to reach into the community, establish links, and build trust. This is easier to do with self-identified communities such as religious or ethnic groups, where there are likely to be traditional hierarchies of influence and authority, or when people with shared interests have already created local community based organisations (CBOs) or networks (eg, women's associations, youth leagues).[14, 15] While there may already be close contact between humanitarian (operational) actors and these different communities, the participation of academic researchers may require new partnerships and collaborative relationships to be introduced.

WHAT IS RESEARCH EVIDENCE AND HOW IS IT TAKEN UP BY COMMUNITIES?

Leresche and Hossain[16] define evidence as the recommendations produced through research for improving effectiveness of health services and practices. Recommendations can refer to specific policies, health systems, clinical procedures, and health behaviours. As mentioned previously, Elrha defines evidence "uptake" as the process through which specific research users engage with research findings. This then leads to its "use" (changes in knowledge, awareness and skills), which in turn can contribute to research impact (behavioural change and implementation of recommendations from research findings). Therefore, activities that facilitate community members' understanding, adoption and use of evidence and/or encourages them to advocate for this among decision-makers (in policy and humanitarian programming) constitute engagement for research uptake.

While many types of stakeholders determine the likelihood of research findings being translated into policy or practice, community members themselves usually need to change their behaviour in some way for the recommendations to be realised. Either they need to change behaviours that directly affect health (reducing risk or increasing preventive measures) or by changing their use of services (preventive and/or curative). Without their agreement, most health interventions would fail, as demonstrated in numerous contexts during Ebola outbreaks, where distrust of health services led to people avoiding clinics for both Ebola care and other health problems and there was tremendous resistance to changing traditional burial practices.[17] Only once traditional authorities, or survivors' groups, or peers from diverse populations were involved in adapting requirements for safely preparing and burying the dead and building trust in clinical staff were health promotion messages translated into action.[18, 19] Resistance to COVID-19 restrictions was also reduced through efforts by pre-existing local organisations.[20, 21] This reality informs a practical view of community engagement, which has an instrumental role in leading to positive change.

Uptake is related to dissemination of research results, but implies a more active level of involvement. It requires that the engagement process consists of more than simple transfer of information about the findings but rather 'packages' these into messages that will resonate with the local population, feel relevant to their needs and concerns, and be realistically actionable. This more interactive approach to communicating evidence is often referred to as knowledge translation. Community engagement requires that community members or their representatives translate the research findings not just literally (ie, into local languages) but into meaningful implications for their health-enhancing and healthcare-seeking behaviour. Participatory dissemination has been described as a two-way dialogue where findings are explained in forums where there can be questions, discussion, and group-based interactions.[22, 23]

In acute crises, such as conflicts, the challenge is to identify ways of engaging with populations who might be displaced or in transit/refugee situations. Both risk behaviours and their determinants may be in flux at this time, necessitating rapid research to understand emerging needs. This research will also need to be accompanied by identification of trusted sources of information and advice within the affected community to be able to communicate health promotion and risk reduction messages relevant to the situation. In the recent Ukrainian conflict, for example, researchers used focus group discussions and interviews to explore the health of Ukrainian refugees in different host countries to develop context-specific interventions, including using different channels of communication based on local preferences.[24]

KEY COMPONENTS OF COMMUNITY ENGAGEMENT FOR RESEARCH UPTAKE

If the principles of community engagement are both to *empower* people and to *harness their existing power* over intervention success, the mechanisms through which these dual aims can be achieved can be summarised as follows: (1) Building on existing relationships and networks (2) Offering external resources and direction (3) Strengthening leadership and capacity (4) Sharing power and learning and (5) Giving voice and agency to minoritised groups.[7, 21, 25]

Building on existing relationships and networks is about taking advantage of collaborations that already exist between researchers (or service providers) and the communities with which they work, or reaching out toCBOs, leaders or social networks. Most community-based research that has included a participatory component will already have established partnerships with local academics, traditional leaders, representatives of specific groups either through collaborative research or through oversight roles eg, Community Advisory Boards (CABs).[18, 26, 27] These organisations or representatives are in a good position to translate findings for the local setting and communicate these through channels that are trusted by community members who might be wary of outsiders' attempts to influence their behaviour.

Example: During the COVID-19 outbreak in Sierra Leone, communities that had been affected by Ebola were distrustful of new infection prevention and control measures. Shui-yi Ho et al (2021) conducted rapid participatory research on perceptions of COVID-19 and control measures among health care workers and local health management committees (elected community representatives). Because the researchers had already worked with district level health networks, they relied on them to help design and conduct the study and then shared the findings through these same networks as quickly as possible, including making physical improvements to facilities that had been requested by research participants. This timely and responsive approach alongside pre-existing trust between the academics and humanitarian actors appeared to increase sustained use of IPC measures introduced into facilities.[22]

Offering new resources and direction refers to the opportunity presented by new evidence for introduction of tools or activities that did not previously exist. These can increase motivation or focus on the behaviours or practices that need to be put into place to improve health. Biomedical tools, staff training, membership of committees that design and execute action plans are all tangible benefits that can help galvanise and provide direction to communities. People are motivated to participate for both *intrinsic* reasons (desire to contribute to society, pride in protecting society or affinity groups) and *extrinsic* reasons (compensation, public recognition).[28-31]

Example: The same research team in Sierra Leone as in the example above had previously addressed the 2014-15 Ebola outbreak. Community members took on a range of roles during the national response, including physical labour (erecting clinic boundary walls and screening booths, spraying chlorine, digging graves) and administrative tasks (contact tracing, home visits, screening patients at facilities).

Provision of training workshops, personal protection equipment, and having a 'dual role' of being part of the community as well as affiliated to the health system provided focus and direction to community engagement activities.[19]

Strengthening leadership and capacity demonstrates commitment to longer term community empowerment. Working to build skills for research and knowledge translation at community level moves beyond one-off engagement. Facilitated group-based discussions and exchange of ideas are often used to bring people together to prioritise problems, diagnose their root causes, and work together to identify and test solutions. External facilitators can help structure discussions or introduce information and resources, but groups themselves devise strategies and put them into action. Group-based problem-solving cycles have been successfully used to improve maternal and neonatal health in both Asia and Africa [32-34] This approach is one way to engage communities in applying evidence from specific health issues to their context and involve them proactively in developing realistic ways of integrating knowledge into practice. Once the structures and skills are in place, they can be used as a platform for other health priorities as they emerge.

Example: The armed conflict in northern Uganda simultaneously contributed to poor mental health and weakened the health system's capacity to address it. A Ugandan NGO initiated a post-conflict mental health intervention based on identifying and strengthening existing social support networks and traditional structures so they could meet the psychosocial and mental health needs of families and communities. Volunteers from Village Health Teams were trained to organise patient support groups and to make referrals to health outreach workers and primary clinics, with additional training provided for management of common mental health disorders. The project led to a larger than expected increase in patients joining support groups and presenting at outreach clinics for care; some support groups addressed broader social determinants of mental health including poverty eg, through shared income generating activities. The combination of medical and social activities suggests the model could address other health issues with psychosocial determinants.[35]

Sharing power and learning is a guiding principle for most of the participatory traditions that underpin community engagement. "Community Based Participatory Research" and "Participatory Action Research" are just two of many terms applied to research that is fundamentally about empowering people to have better control over their own lives and to take action to improve their health and broader well-being.[36, 37] Integral to participatory research is increasing knowledge and skills of *both* community members *and* their academic partners for equitable collaboration.[38-40] Adequate training and preparation of health researchers and implementors for working more collaboratively with communities has been highlighted as a current gap in ensuring that power and learning are genuinely shared.[41]

Example: A mixed methods study on the social and economic impacts of Zika was conducted during the 2014-15 outbreak in Brazil, conducted jointly by Brazilian and UK research teams. The aim of the study was to explore experiences of diverse stakeholder groups affected by Zika, such as mothers of children born with congenital zika syndrome (CZS), pregnant women, and health professionals to identify unmet need for services. Specific efforts were made to 'decolonise' the research collaboration by maximising equitable decision making at each stage and to remain transparent and accountable to research participants, particularly mothers of children born with CZS. Despite these efforts, power disparities remained and tensions emerged between the study teams, and between researchers and community participants. The mothers sometimes felt over-burdened and exploited by the research. The data were used to design and provide support groups and led to an advocacy alliance between mothers of children with CZS and academic researchers, for instance, in supporting the mothers' campaign for their children's inclusion in schools.[27]

Giving voice and agency to minoritised groups is an important consideration to ensure that 'the community' is not assumed to be homogeneous and without differences of opinion or authority. It cannot be assumed that the most visible CBOs or vocal individuals represent the community as a whole.[4, 5, 42] Marginalised groups exist in all societies, and the power to take decisions or influence behaviour is often determined by categories including age, gender, ethnic or religious background, socio-economic position, disability and sexual identity and/or sexuality.[43] These can also overlap to increase vulnerability, eg, poorer women may have less control over the determinants of their health than both wealthier women and poor men; marginalised ethnic or religious groups are often relegated to the least safe or financially rewarding occupations, putting them in lower economic positions and exposing them to specific occupational risks.[44, 45] Depending on the humanitarian context and health issues being addressed, a range of disadvantaged groups may require special efforts to reach and involve them,[7, 25] eg, key populations for HIV prevention, adolescents for sexual and reproductive health, people living with disabilities to ensure service accessibility.

Example: Elderly people (defined as over 65 by the UN) make up an increasing proportion of most populations, including refugees. Humanitarian agencies often focus their attention on other identified vulnerable groups, such as women and children. A qualitative study was conducted in Lebanon among organisations serving Lebanese refugee communities. Findings highlighted that older refugees often had longer-term chronic conditions or disabilities that were not prioritised as highly as needs for other services, and available clinics and WASH facilities were not always accessible to them. Many older people were dependent on other family members for financial support and communication with health providers. Lack of their inclusion in needs assessments and programme planning resulted in unmet need for nutritional, medical and care support.[46]

COMMUNITY ENGAGEMENT IN PRACTICE

EXAMPLES OF ACTIVITIES AND MECHANISMS

Community engagement can be a difficult process as it takes time to identify relevant constituent groups, develop relationships of trust, and apply the core components described above. Most research projects are planned and funded for relatively short time periods, without guarantee of longer-term commitments. Such meaningful engagement is even more challenging in humanitarian settings because research in complex humanitarian contexts often requires greater speed and urgency, accompanied by the need for immediate service provision without much time for tailoring these through formative work.[47] Where conflict or natural disasters have destroyed physical infrastructure, exacerbated social divisions, or created situations of instability and potential danger to community members, humanitarian practitioners and researchers,[48] it may not be possible to initiate new partnerships and participatory processes until greater stability has been achieved.

As a result, integrating community engagement into emergency preparedness measures can be a proactive way to set up systems for involving community members or their representatives at the onset of a humanitarian event. There is a fairly extensive literature addressing participation of communities in the planning process.[49-51] Of relevance to setting the foundations for subsequent research uptake is that preparedness planning can help put several core components of community engagement into place in advance, such as mapping community assets and institutions for the development of collaborative relationships, building their capacity, creating equitable partnerships, and identifying potentially vulnerable or marginalised groups whose voices may need amplification.

Involving communities throughout the research cycle, whether conducted before or during the humanitarian incident or emergency, also sets the groundwork for more meaningful engagement at the time of translating research findings into action. One initial way to increase trusting and effective partnerships is to ensure social science methods (particularly qualitative and participatory approaches) are adequately prioritised.[52] Social science data collection prioritises understanding the experiences and perceptions of people most affected by the phenomena under investigation; tools such as interviews, focus group discussions, or more interactive group-based activities help elevate “beneficiaries” into “experts” and draws out local knowledge and solutions. Bringing social science to the fore of humanitarian research has been shown to increase engagement and participation from the first needs assessment.[53] This helps establish cooperative dynamics between humanitarian actors and the populations with which they work that can then carry forward into sustained community engagement.[24]

As previously mentioned, stakeholder engagement, including for community stakeholders, occurs along a continuum. The specific setting, nature of affected community or communities, and humanitarian context will all influence how effectively community engagement can occur to optimise translation of new evidence into health behaviour and health system practice. The aim is for any given study or programme to reflect on and maximise efforts to move from unidirectional communication toward equitable co-creation. Elrha’s Research Impact Toolkit, an unpublished resource which informs workshops and existing online courses provided to funded research teams, is currently used to help develop skills related to planning and achieving research uptake more broadly, engaging with a wide range of stakeholders.

Table 1 presents activities that have been employed at each stage of the continuum showing increasing community ownership (as defined by Elrha). These are further separated by Research or Implementation, highlighting that there are slight differences in how interactions with communities are envisioned depending on whether the new knowledge that is to be translated into practice has emerged from research conducted in the same setting or is being transferred from elsewhere (ie, new standards or guidance based on identified “best practices”).

Table 1: Routes to Research Uptake Across the Community Engagement Continuum

Level of Community Engagement	One-off, ad hoc Engagement	Active Collaboration	Sustained Partnership	Co-Creation
Communication of Research Findings	• Study dissemination meetings • Distribution of research summaries • Posters/SMS/ radio messages	• Traditional and religious leaders communicate findings • Participatory group discussions for different audiences • Storytelling projects • Public Q&A sessions	• Study Community Advisory Boards (CAB) help interpret data and identify relevant messages • Representatives of target audiences identify implications for specific groups and appropriate means of communication with and about them	• Peer researchers involved throughout research, including data analysis, interpretation and packaging • Implications for programming or further research determined by CBO or other local representatives
Evidence-Based Implementation	• Health promotion meetings • Behaviour change leaflets • Information campaigns • New protocols/ guidelines for providers	• Traditional/religious leaders encourage behaviour change/service use • Peer educators/ “mobilisers” • Community Health Workers • House to house visits • Feedback systems	• Local CBO adapt intervention to their specific context • Participatory monitoring and evaluation integrated into programme • Feedback loops normalised	• Shared discussion of evidence by outsiders and CBO/ local organisations but selection of intervention components and their delivery executed by local organisations only • Systems of transparency and accountability explicitly integrated into provision of interventions and services

At the most basic level, **communicating research findings** is about dissemination of results, which implies a wholly passive role on behalf of communities. Dissemination can be through mass media, mobile phone and social media platforms, or in-person meetings. Often results are provided separately to direct research participants and the wider population. The corresponding activity within an implementation project is unidirectional health promotion or top-down introduction of new protocols or guidelines for service providers to follow. While messages can be repeated, they may not change based on responses to them (unless there are specific monitoring or feedback mechanisms to gauge how effectively they are received). As a result, these approaches are considered to be isolated events (one-off) or sporadic (ad hoc). A billboard poster encouraging people to get the newly available COVID-19 vaccine is an example of ad hoc knowledge transfer.

A more interactive approach is through **active collaboration** with existing community structures or influential organisations/individuals. Working with trusted traditional or religious leaders to build trust in new biomedical tools or preventive behaviours serves two functions: first, it respects the community's own institutions and hierarchies, and second, it usually provides opportunities for the specific messages and means of their transmission to be shaped by those who understand the local community better than outsiders.[15, 25] Other creative means to convey new information in ways that encourage community members to interpret it and consider how it applies to their own realities are through facilitated discussions (sometimes referred to as "community dialogues") or "storytelling" and public theatre performances, where emotive and cautionary tales are shared by community members to illustrate complex messages (and make them more 'real' to different types of people).[23, 54, 55]

As it is difficult to arrange meetings for large numbers of people, peer outreach, home visits, or use of Community Health Workers (or District Management Committees or similar paraprofessional cadres) can increase exposure to health promotion messages.[31, 35, 56] Messages can also be tailored for different groups, ideally with the participation of those groups eg, vulnerable populations, those with specific health conditions, residents of remote locations. "Humanitarian radio" is another example of active collaboration, where programmes are developed and hosted by community members and distribution of radios, organisation of facilitated "listening groups" and "call-ins" or offer opportunities for discussion and feedback.[57, 58]

Sustained partnership implies closer links between community members and researchers or health providers from the design of research or interventions through to their completion. At this stage, local CBO or community representatives are most likely to be involved and must remain accountable to their wider constituency.[59] When developing such partnerships, care must be given to ensure that the most relevant types of people from different (potentially competing) social categories are involved; purposive sampling (where people are selected for diverse perspectives and experiences, including those with less influence or from minoritised groups) is more appropriate than representative sampling (where people are selected for characteristics in the proportions found in the whole population, regardless of how affected they may be by the health issue or humanitarian event).[60]

WHO and other guidelines recommend that public health research teams establish a Community Advisory Board (CAB) to increase community oversight and participation.[61] Members of CABs can be drawn widely from the community or selected from among already existing community leaders with recognised authority. CAB members can work with researchers to interpret findings, consider implications for different population groups, and identify messages or modes of communication most likely to affect behaviour change; for example, in Ethiopia, one study set up separate CABs to represent two different demographic groups (elders and young people) who were considered to have diverging views and communication networks, both of which were important for genuine community engagement.[48]

Finally, **co-creation** occurs when equity has been achieved in relationships between producers and users of knowledge. Social mobilisation, defined as when a community coalesces around a specific issue and works together to assess its root causes, identify priority goals, and work together to achieve these, can both stimulate and result from co-creation. In the former case, researchers or public health practitioners see a common cause with a social movement and contribute their expertise to produce the evidence needed for advocacy or direct action. In the latter, practitioners and communities participate in research or intervention development and then identify wider transformational change to work toward in the process of addressing the initial topic. There are few examples of what might be considered genuine co-creation of knowledge and practice, although some (non-humanitarian) examples from the literature include the global movement for access to HIV treatment[62, 63] and coalitions between sex workers and academics to remove laws criminalising sex work.[64-68]

IMPLICATIONS FOR MONITORING & EVALUATION

The literature on community engagement and monitoring and evaluation falls into two categories: (1) descriptions of using participatory approaches to engage communities in evaluating and improving programmes as they are implemented, and (2) measuring the extent and depth of community engagement as a process indicator.

The first category consists primarily of examples of feedback mechanisms, where opinions of different types of people (for example, programme planners, healthcare providers, target beneficiaries and the wider community) are collected to track ongoing feasibility and acceptability of a service, intervention, or behavioural change. Satisfaction surveys, suggestion boxes, and focus group discussions or interviews can be introduced on an occasional or routine basis; this remains an extractive process where information is collected *from* community members but *by* and *for* planners and providers. Community members can become frustrated if there is no clear action or change taken in response to their feedback, as was documented during the Ebola response in the Democratic Republic of Congo (DRC).[69]

There have been increasing efforts to form stronger partnerships with communities as part of gathering, analysing and responding to feedback. This is in keeping with the *Core Humanitarian Standards on Quality and Accountability*, particularly Commitment 4: "Humanitarian response is based on communication, participation, and feedback".[70] For example, the International Committee of the Red Cross (ICRC) developed their feedback system from DRC for use in other countries during COVID-19, introducing a mix of tools for collecting diverse perspectives on the response through household visits, focus groups, WhatsApp and Facebook platforms, and undertook extensive qualitative analysis of the results in order to tailor programming at both country and regional levels.[20] The system of ongoing feedback loops meant that programme components were regularly being "tweaked" to maintain a good fit with the local context and thus maintain uptake of desired behaviours.

More broadly, the participatory research tradition includes tools and guidance on engaging communities in long term monitoring and evaluation of programmes.[71-73] Approaches include repeat use of "plan-do-study-act" cycles, community monitoring committees, and regular application of qualitative methods to capture evolving experiences of different population groups (eg, photovoice or transect walks).[74, 75] The language of "human centred design" and "adaptive management" practices overlap with participatory monitoring.[76]

Measuring engagement, as an indicator of progress toward greater equity and participation is a category of activity less frequently addressed in the literature. There are a few frameworks and tools for assessing how effectively researchers and service providers have involved local people at different stages. For example, Rifkin and colleagues[77] have proposed five domains for which levels of participation should be measured: needs assessment; leadership; organisation; resource mobilisation; and management. A score, if provided for each domain, can be compared over time. Khodyakov et al[78] designed a scale specifically for community engagement in research. They identify 12 stages for engagement within a joint research project as follows: writing grant proposals, formative research, research design, selecting sampling procedures, recruiting study participants, implementing the intervention, designing data collection tools, collecting data, analysing data, interpreting results, writing reports and journal articles, and presenting findings. Each of these is rated 1, 2 or 3 (from lowest to highest engagement), which can then be calculated into an overall score and compared between projects and over time.

SKILL GAPS FOR COMMUNITY ENGAGEMENT IN PRACTICE

There is widespread recognition that while community engagement is universally recognised as important, it is not always clearly defined or operationalised, and researchers and health practitioners often lack confidence and experience in how best to initiate and maintain equitable and functional partnerships with the communities affected. Humanitarian settings complicate matters due to the likelihood that the research and implementation context will be rapidly changing, unstable, and potentially dangerous. Institutions and infrastructure may be damaged, with previously existing systems disrupted and relationships strained.[47, 49, 52, 79, 80] Humanitarian actors are often struggling to provide life-saving services in a timely and efficient manner, relying on approaches they have used previously at other times and in other places, which may or may not be best suited to the current situation. *Awareness* of inadequate engagement with local people and places struggles to translate into *practice*.

Some of the specific skills related to community engagement for evidence uptake that have been identified as lacking in general health research in low- and middle-income countries are as follows.[8]

- Knowing how to identify representatives of 'community' constituents and/or reach relevant community members in the first instance
- Tailoring messages on evidence and its implications for different groups
- Moving from "instrumental" motivations for engaging local people to more "transformative" relationships that imply greater equity and ownership
- Integrating qualitative data into response systems that usually prioritise quantitative data

EXISTING TRAINING PROGRAMMES/RESOURCES

A scoping review on how to build researchers' capacity for knowledge translation and exchange (KTE) suggested that training should focus on the following.[41]

- Theory and justification for knowledge transfer activities
- Practical approaches to planning and implementing KTE
- Relationship building throughout the research cycle (including understanding cultural differences, creating opportunities for dialogue, establishing trust, and communicating information in bi-directional and tailored ways).

Following the above review, a one-day workshop for Australian researchers was developed and implemented, covering the priority themes. Some of the tools and training resources can be found here: https://www.sickkids.ca/en/learning/continuing-professional-development/knowledge-translation-training/#tools and https://academyonline.sickkids.ca/courses/knowledge-translation/

The ICRC has also developed a one-day workshop on Community Engagement and Accountability (CEA) that covers the following topics:

- What is CEA and why is it important?
- Assessing CEA needs
- Engaging with the community/ How to involve communities in planning
- Integrating CEA into a humanitarian response
- Setting up feedback systems/ adjusting activities based on feedback received
- Involving the community in evaluations

The course materials can be downloaded here: https://communityengagementhub.org/resource/cea-one-day-training-package-english/

Other trainings include Training of Trainers on Community Engagement and Participation, which was conducted in 2019 by Group URD and Action Contre la Faim, see https://www.urd.org/en/event/training-of-trainers-on-community-engagement-and-participation-for-acf/

The READY initiative has online learning resources ("micro-training") available here: https://www.ready-initiative.org/training-page/

The first module is 'Risk Communication and Community Engagement' and consists of seven sessions, each lasting 15-20 minutes. The introductory sessions are followed by seven 'expert interviews' to illustrate real life examples. These similarly last 10-20 minutes each.

RedR periodically runs trainings on involving displaced communities in decision making. These are available online, and are specific to humanitarian contexts, for example the war in Ukraine, see https://www.redr.org.uk/Training-Learning/Events/2023/February/Involving-displaced-communities-in-decision-ma-(1)

Finally, it is worth noting that Elrha already has a library of online training courses and tools in stakeholder engagement and research communications, currently accessible only to grantees of the R2HC programme. The online course due to be developed based on this literature review will be integrated into this library.

CONCLUSION: OUTSTANDING TRAINING PRIORITIES FOR ELRHA ONLINE COURSE

Based on this review of literature on community engagement for research uptake, consultations with experts across the humanitarian response field, and assessment of gaps in existing training opportunities, Elrha (in collaboration with the author) has developed a one-day online training course to support grantees and partners.

The course aims to provide practical and applied guidance on engaging communities at different stages of the 'participation continuum' given that researchers and health practitioners often lack confidence and experience in how best to initiate and maintain equitable partnerships with affected communities. Based on the literature review, the focus of the course is:

- Theory and justification for community engagement in research uptake
- Research uptake activities as part of a holistic research cycle approach (and the need to engage communities throughout)
- Practical approaches to planning and implementing community engagement
- Assessing quality and strength of community engagement and moving "up" the continuum

The course will be rolled out (in 'beta version') to grantees in 2023. Based on feedback, it will be revised and considered for wider promotion for the benefit of the humanitarian health community. For further information please contact r2hc@elrha.org.

REFERENCE LIST

1. Morgan LM. Community participation in health: perpetual allure, persistent challenge. Health Policy and Planning. 2001;16(3):221-30
2. Rifkin SB. Examining the links between community participation and health outcomes: a review of the literature. Health Policy Plan. 2014;29 Suppl 2(Suppl 2):ii98-106
3. Haldane V, Chuah FLH, Srivastava A, Singh SR, Koh GCH, Seng CK, et al. Community participation in health services development, implementation, and evaluation: A systematic review of empowerment, health, community, and process outcomes. PLOS ONE. 2019;14(5):e0216112
4. Marston C, Hinton R, Kean S, Baral S, Ahuja A, Costello A, et al. Community participation for transformative action on women's, children's and adolescents' health. Bull World Health Organ. 2016 ;94(5):376-82
5. Burns D. Deepening and scaling participatory research with the poorest and most marginalised. European Journal of Operational Research. 2018 ;268(3):865-74
6. Ozano K, Dean L, Adekeye O, Bettee AK, Dixon R, Gideon NU, et al. Guiding principles for quality, ethical standards and ongoing learning in implementation research: multicountry learnings from participatory action research to strengthen health systems. Health Policy and Planning. 2020;35(Supplement_2):ii137-ii49
7. Cyril S, Smith BJ, Possamai-Inesedy A, Renzaho AM. Exploring the role of community engagement in improving the health of disadvantaged populations: a systematic review. Glob Health Action. 2015;8:29842
8. Murunga VI, Oronje RN, Bates I, Tagoe N, Pulford J. Review of published evidence on knowledge translation capacity, practice and support among researchers and research institutions in low- and middle-income countries. Health Res Policy Syst. 2020;18(1):16
9. Yapa HM, Bärnighausen T. Implementation science in resource-poor countries and communities. Implementation Science. 2018;13(1):154
10. Glandon D, Paina L, Alonge O, Peters DH, Bennett S. 10 Best resources for community engagement in implementation research. Health Policy and Planning. 2017;32(10):1457-65
11. Abroms LC, Maibach EW. The Effectiveness of Mass Communication to Change Public Behavior. Annual Review of Public Health. 2008;29(1):219-34
12. Phelan JC, Link BG, Tehranifar P. Social Conditions as Fundamental Causes of Health Inequalities: Theory, Evidence, and Policy Implications. Journal of Health and Social Behavior. 2010;51(1_suppl):S28-S40
13. National Institutes of Health. Principles of Community Engagement 2nd Edition. US DHSS, 2011.

14. Campbell C, McLean C. Ethnic identities, social capital and health inequalities: factors shaping African-Caribbean participation in local community networks in the UK. Social Science and Medicine. 2002;55:643-57
15. Torpey K, Kabaso M, Kasonde P, Dirks R, Bweupe M, Thompson C, et al. Increasing the uptake of prevention of mother-to-child transmission of HIV services in a resource-limited setting. BMC Health Services Research. 2010;10(1):29
16. Leresche E, Hossain M, Rossi R, Truppa C, Barth CA, Mactaggart I, et al. Do we really want to know? The journey to implement empirical research recommendations in the ICRC's responses in Myanmar and Lebanon. Disasters. 2022
17. Thiam S, Delamou A, Camara S, Carter J, Lama EK, Ndiaye B, et al. Challenges in controlling the Ebola outbreak in two prefectures in Guinea: why did communities continue to resist? Pan Afr Med J. 2015;22 Suppl 1(Suppl 1):22
18. Kinsman J, de Bruijne K, Jalloh AM, Harris M, Abdullah H, Boye-Thompson T, et al. Development of a set of community-informed Ebola messages for Sierra Leone. PLOS Neglected Tropical Diseases. 2017;11(8):e0005742
19. McMahon SA, Ho LS, Scott K, Brown H, Miller L, Ratnayake R, et al. "We and the nurses are now working with one voice": How community leaders and health committee members describe their role in Sierra Leone's Ebola response. BMC Health Serv Res. 2017;17(1):495
20. Erlach E, Nichol B, Reader S, Baggio O. Using Community Feedback to Guide the COVID-19 Response in Sub-Saharan Africa: Red Cross and Red Crescent Approach and Lessons Learned from Ebola. Health Secur. 2021;19(1):13-20
21. Sumitha TS, Thelly AS, Medona B, Lijimol AS, Rose MJ, Rajagopal MR. Response to COVID-19 Crisis with Facilitated Community Partnership among a Vulnerable Population in Kerala, India - A Short Report. Indian J Palliat Care. 2022;28(1):115-9
22. Shui-yi Ho L, Ratnayake R, Ansumana R, Brown H. A mixed-methods investigation to understand and improve the scaled-up infection prevention and control in primary care health facilities during the Ebola virus disease epidemic in Sierra Leone. BMC Public Health. 2021;21(1):1603
23. McDavitt B, Bogart LM, Mutchler MG, Wagner GJ, Green HG, Lawrence SJ, et al. Dissemination as dialogue: Building trust and sharing research findings through community engagement. Preventing Chronic Disease. 2016;13:150473
24. Maddah D, Salvi C, Vadi R, Mohammad M. Risk Communication and Community Engagement in Action During Ukraine's War. Ann Glob Health. 2022;88(1):102
25. Munyuzangabo M, Khalifa DS, Gaffey MF, Kamali M, Siddiqui FJ, Meteke S, et al. Delivery of sexual and reproductive health interventions in conflict settings: a systematic review. BMJ Glob Health. 2020;5(Suppl 1)
26. Newman SD, Andrews JO, Magwood GS, Jenkins C, Cox MJ, Williamson DC. Community advisory boards in community-based participatory research: a synthesis of best processes. Prev Chronic Dis. 2011;8(3):A70

27. Passos MJ, Matta G, Lyra TM, Moreira MEL, Kuper H, Penn-Kekana L, et al. The promise and pitfalls of social science research in an emergency: lessons from studying the Zika epidemic in Brazil, 2015-2016. BMJ Glob Health. 2020;5(4)
28. Jaskiewicz W, Tulenko K. Increasing community health worker productivity and effectiveness: a review of the influence of the work environment. Human Resources for Health. 2012.10:38
29. Kim DA, Hwong AR, Stafford D, Hughes DA, O'Malley AJ, Fowler JH, et al. Social network targeting to maximise population behaviour change: a cluster randomised controlled trial. The Lancet. 2015.386(9989):145-53
30. Glenton C, Scheel IB, Pradhan S, Lewin S, Hodgins S, Shrestha V. The female community health volunteer programme in Nepal: decision makers' perceptions of volunteerism, payment and other incentives. Soc Sci Med. 2010;70(12):1920-7
31. Kumar V, Kumar A, Ghosh AK, Samphel R, Yadav R, Yeung D, et al. Enculturating science: Community-centric design of behavior change interactions for accelerating health impact. Seminars in Perinatology. 2015 ;39(5):393-415
32. Dharma SM, David O, Bhim Prasad S, Natasha M, Joanna M, Kirti Man T, et al. Effect of a participatory intervention with women's groups on birth outcomes in Nepal: cluster-randomised controlled trial. The Lancet. 2004;364(9438):970-9
33. Tripathy P, Nair N, Barnett S, Mahapatra R, Borghi J, Rath S, et al. Effect of a participatory intervention with women's groups on birth outcomes and maternal depression in Jharkhand and Orissa, India: a cluster-randomised controlled trial. Lancet. 2010;375(9721):1182-92
34. Prost A, Colbourn T, Seward N, Azad K, Coomarasamy A, Copas A, et al. Women's groups practising participatory learning and action to improve maternal and newborn health in low-resource settings: a systematic review and meta-analysis. Lancet. 2013;381(9879):1736-46
35. Baingana F, Mangen PO. Scaling up of mental health and trauma support among war affected communities in northern Uganda: lessons learned. Intervention. 2011;9(3):291-303
36. Baum F, MacDougall C, Smith D. Participatory action research. J Epidemiol Community Health. 2006;60(10):854-7
37. Leung MW, Yen IH, Minkler M. Community based participatory research: a promising approach for increasing epidemiology's relevance in the 21st century. Int J Epidemiol. 2004;33(3):499-506
38. Sadler LS, Larson J, Bouregy S, Lapaglia D, Bridger L, McCaslin C, et al. Community-university partnerships in community-based research. Prog Community Health Partnersh. 2012;6(4):463-9
39. Rifkin SB, Pridmore P. Partners in Planning. London and Oxford: Macmillan Education Ltd; 2001.

40. O'Reilly-de Brun M, de Brun T, Okonkwo E, Bonsenge-Bokanga JS, De Almeida Silva MM, Ogbebor F, et al. Using Participatory Learning & Action research to access and engage with 'hard to reach' migrants in primary healthcare research. BMC Health Serv Res. 2016;16(1):25

41. Jones K, Armstrong R, Pettman T, Waters E. Knowledge Translation for researchers: developing training to support public health researchers KTE efforts. Journal of Public Health. 2015;37(2):364-6

42. Fregonese F. Community involvement in biomedical research conducted in the global health context; what can be done to make it really matter? BMC medical ethics. 2018;19(1):44

43. Marmot M. Achieving health equity: from root causes to fair outcomes. The Lancet. 2007;370(9593):1153-63

44. Iyer A, Sen G, Östlin P. The intersections of gender and class in health status and health care. Global Public Health. 2008;3(sup1):13-24

45. Bowleg L. The Problem With the Phrase Women and Minorities: Intersectionality-an Important Theoretical Framework for Public Health. Am J Public Health. 2012;102(7):1267-73

46. Hachem S, Ali S, Al-Omari S, Abi Chahine M, Fahme SA, Mehio Sibai A. "Older people tend to be invisible": a qualitative study exploring the needs and inclusion of older Syrian refugees in the context of compounding crises in host country, Lebanon. Confl Health. 2022;16(1):61

47. Kohrt BA, Mistry AS, Anand N, Beecroft B, Nuwayhid I. Health research in humanitarian crises: an urgent global imperative. BMJ Global Health. 2019;4(6):e001870

48. Yimer G, Gebreyes W, Havelaar A, Yousuf J, McKune S, Mohammed A, et al. Community engagement and building trust to resolve ethical challenges during humanitarian crises: experience from the CAGED study. Confl Health. 2020;14:68

49. Ramsbottom A, O'Brien E, Ciotti L, Takacs J. Enablers and Barriers to Community Engagement in Public Health Emergency Preparedness: A Literature Review. J Community Health. 2018;43(2):412-20

50. de Vries DH, Kinsman J, Takacs J, Tsolova S, Ciotti M. Methodology for assessment of public health emergency preparedness and response synergies between institutional authorities and communities. BMC Health Serv Res. 2020;20(1):411

51. Abayomi A, Balogun MR, Bankole M, Banke-Thomas A, Mutiu B, Olawepo J, et al. From Ebola to COVID-19: emergency preparedness and response plans and actions in Lagos, Nigeria. Global Health. 2021;17(1):79

52. Bruno W, Haar RJ. A systematic literature review of the ethics of conducting research in the humanitarian setting. Confl Health. 2020;14:27

53. Anoko JN, Barry BR, Boiro H, Diallo B, Diallo AB, Belizaire MR, et al. Community engagement for successful COVID-19 pandemic response: 10 lessons from Ebola outbreak responses in Africa. BMJ Glob Health. 2020;4(Suppl 7)

54. Han HR, Byiringiro S, Lacanieta C, Weston C, Terkowitz M, Reese M, et al. Storytelling training to promote stakeholder engagement in research dissemination. J Clin Transl Sci. 2022;6(1):e5

55. Sule MN, Mosha J, Soboka TE, Kinung'hi SM, Sfynia C, Rafiq K, et al. A novel theatre-based behaviour change approach for influencing community uptake of schistosomiasis control measures. Parasit Vectors. 2022;15(1):301

56. Singh NS, Smith J, Aryasinghe S, Khosla R, Say L, Blanchet K. Evaluating the effectiveness of sexual and reproductive health services during humanitarian crises: A systematic review. PLoS One. 2018;13(7):e0199300

57. Barnett S, van Dijk J, Swaray A, Amara T, Young P. Redesigning an education project for child friendly radio: a multisectoral collaboration to promote children's health, education, and human rights after a humanitarian crisis in Sierra Leone. Bmj. 2018;363:k4667

58. Hugelius K, Adams M, Romo-Murphy E. The Power of Radio to Promote Health and Resilience in Natural Disasters: A Review. Int J Environ Res Public Health. 2019 ;16(14)

59. Alva S, Davis N, Stan L, Pivato I, Sanderson J. Conducting mixed-methods research with Ebola survivors in a complex setting in Sierra Leone. BMC Public Health. 2020;20(1):1346

60. Auerswald CLMDMS, Greene KMA, Minnis AP, Doherty IMPH, Ellen JMD, Padian NP. Qualitative Assessment of Venues for Purposive Sampling of Hard-to-Reach Youth: An Illustration in a Latino Community. Sexually Transmitted Diseases. 2004;31(2):133-8

61. WHO. Working with Community Advisory Boards for COVID-19 Clinical Studies. 2020.

62. Ayala G, Sprague L, van der Merwe LL-A, Thomas RM, Chang J, Arreola S, et al. Peer- and community-led responses to HIV: A scoping review. PLOS ONE. 2021;16(12):e0260555

63. Campbell C. Social capital, social movements and global public health: Fighting for health-enabling contexts in marginalised settings. Social Science & Medicine. 2020 ;257:112153

64. Aroney E. Changing Minds and Changing Laws: How New Zealand Sex Workers and Their Allies Shaped Decriminalisation in New Zealand. Sex Res Social Policy. 2021;18(4):952-67

65. Lyons CE, Schwartz SR, Murray SM, Shannon K, Diouf D, Mothopeng T, et al. The role of sex work laws and stigmas in increasing HIV risks among sex workers. Nat Commun. 2020;11(1):773

66. Boily M-C, Shannon K. Criminal law, sex work, HIV: need for multi-level research. The Lancet HIV. 2017 25 Jan 2017;4(3):e98-e99.

67. Radačić I. New Zealand Prostitutes' Collective—An Example of a Successful Policy Actor. Social Sciences. 2017;6(2):46

68. Platt L, Grenfell P, Meiksin R, Elmes J, Sherman SG, Sanders T, et al. Associations between sex work laws and sex workers' health: A systematic review and meta-analysis of quantitative and qualitative studies. PLoS Med. 2018;15(12):e1002680

69. McKay G, Baggio O, Camara CA, Erlach E, Robles Dios L, Checchi F, et al. The response is like a big ship': community feedback as a case study of evidence uptake and use in the 2018-2020 Ebola epidemic in the Democratic Republic of the Congo. BMJ Glob Health. 2022;7(2)

70. Alliance C. Core Humanitarian Standard on Quality and Accountability. CHS Alliance, Group URD and the Sphere Project, 2014.

71. Bradley JE, Mayfield MV, Mehta MP, Rukonge A. Participatory evaluation of reproductive health care quality in developing countries. Social Science and Medicine. 2002;55(2):269-82

72. Brown CS, Lloyd S, Murray SA. Using consecutive Rapid Participatory Appraisal studies to assess, facilitate and evaluate health and social change in community settings. BMC Public Health. 2006.6:68

73. Platt I. A review of participatory monitoring and evaluation. Concern Worldwide, 1996.

74. Marston C, Arjyal A, Maskey S, Regmi S, Baral S. Using qualitative evaluation components to help understand context: case study of a family planning intervention with female community health volunteers (FCHVs) in Nepal. BMC health services research. 2020;20(1):685

75. Musoke D, Ndejjo R, Lubega GB, Ekirapa-Kiracho E. Use of photovoice to explore the potential role of youth in contributing to maternal health in rural Wakiso district, Uganda. Sexual and Reproductive Health Matters. 2020;28(1):1854152

76. Adam MB, Minyenya-Njuguna J, Karuri Kamiru W, Mbugua S, Makobu NW, Donelson AJ. Implementation research and human-centred design: how theory driven human-centred design can sustain trust in complex health systems, support measurement and drive sustained community health volunteer engagement. Health Policy and Planning. 2020;35(Supplement_2):ii150-ii62

77. Rifkin SB, Muller F, Bichmann W. Primary health care: on measuring participation. Social Science and Medicine. 1988;26(9):931-40

78. Khodyakov D, Stockdale S, Jones A, Mango J, Jones F, Lizaola E. On Measuring Community Participation in Research. Health Education & Behavior. 2012;40(3):346-54

79. Sibai AM, Rizk A, Coutts AP, Monzer G, Daoud A, Sullivan R, et al. North & ;South inequities in research collaboration in humanitarian and conflict contexts. The Lancet. 2019;394(10209):1597-600

80. Vega Ocasio D, Pérez Ramos JG, Dye TDV. Conducting an immersive community-based assessment of post-hurricane experience among Puerto Ricans: lived experience of medical ecology in an environmental disaster and migration. BMC Public Health. 2020 Oct 29;20(1):1628