REVIEW ARTICLE

Strategies for mapping and recruiting community leaders for the development of health surveillance projects and programs: a scoping review

Estratégias para mapear e recrutar líderes comunitários para o desenvolvimento de projetos e programas de vigilância em saúde: uma revisão de escopo

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Abstract

Objective: this scoping review examines evidence on strategies for mapping and recruiting community leaders in health surveillance programmes. **Methods**: searches followed the Joanna Briggs Institute (JBI) methodology and PRISMA-ScR guidelines. The database search was performed in August 2024, covering literature published from 1986 to that date (1986–August 2024), in PubMed, the Virtual Health Library, and public health organization websites (WHO, CDC, PAHO, IFRC); records in English, Portuguese, and Spanish were included, and reference lists were hand-searched. Screening used Rayyan, and eligible documents underwent qualitative content analysis. **Results**: a total of 806 articles were identified after duplicates were removed; of : of these, 29 were read in full, plus 9 identified through reference lists, and 16 were included. Among 40 technical documents, 14 were eligible, resulting in nine selected, for a final total of 25 references. Few studies detailed mapping and recruitment strategies systematically. Key elements included: community involvement in selection, collaboration with local institutions, and provision of training and supervision. A clear distinction between community leaders and volunteers was observed. Only some publications provide concrete evidence on strategies for mapping and recruiting leaders, yet it is possible to identify patterns and similarities across the stages described. Such processes are rarely grounded in reference models or presented in a structured manner. Understanding community profiles, aligning recruitment with local dynamics, and ensuring continuous support are essential to strengthening local health surveillance. **Conclusion:** despite identifying positive programme impacts, the way community representatives are recruited proved to be fundamental to implementation. The literature highlights that strengthening community participation in health requires long-term, process-oriented strategies rather than focusing solely on outcomes.

Keywords: community networks; community participation; community health services; community health workers; public health surveillance.

Resumo

Objetivo: examinar as evidências sobre estratégias para mapeamento e recrutamento de líderes comunitários em programas de vigilância em saúde. **Métodos**: as buscas seguiram a metodologia do Joanna Briggs Institute (JBI) e as diretrizes PRISMA-ScR. A consulta às bases de dados foi realizada em agosto de 2024, abrangendo a literatura publicada de 1986 até essa data (1986–agosto de 2024), no PubMed, na Biblioteca Virtual em Saúde e em sites de organizações de saúde pública (OMS, CDC, OPAS, IFRC); foram incluídos registros em português, inglês e espanhol, e foi realizada busca manual nas listas de referências. A triagem utilizou o Rayyan, e os documentos elegíveis passaram por análise de conteúdo qualitativa. **Resultados**: após a remoção de duplicatas, foram identificados 806 artigos, destes, 29 foram lidos oram lidos na íntegra, aos quais se somaram 9 identificados nas listas de referências, e 16 foram incluídos. na íntegra. Destes, 29 foram lidos na íntegra, aos quais se somaram 9 identificados nas listas de referências, e 16 foram incluídos. Entre 40 documentos técnicos, 14 foram elegíveis, resultando em nove selecionados, totalizando 25 referências. Poucos estudos detalharam, sistematicamente, as estratégias de mapeamento e recrutamento. Os principais elementos identificados foram: envolvimento da comunidade no processo de seleção, colaboração com instituições locais e oferta de treinamento e supervisão. Foi observada uma distinção clara entre líderes comunitários e voluntários. Apenas algumas publicações apresentam evidências concretas sobre estratégias de mapeamento e recrutamento de líderes, ainda que seja possível identificar padrões e similaridades entre as etapas descritas. Esses processos raramente são fundamentados em modelos de referência ou apresentados de forma estruturada. Compreender os perfis comunitários, alinhar o recrutamento às dinâmicas locais e garantir apoio contínuo são elementos essenciais para o fortalecimento da vigilância local em saúde. **Conclusão:** apesar dos impactos positivos identificados nos programas, a forma como o processo é conduzido e os métodos utilizados mostram-se igualmente fundamentais para a implementação ou documentação. A literatura destaca que o fortalecimento da participação comunitária em saúde requer estratégias de longo prazo, orientadas ao processo, e não apenas aos resultados.

Palavras chave: redes comunitárias; participação comunitária; serviços de saúde comunitária; agentes comunitários de saúde; vigilância em saúde pública.

INTRODUCTION

Community participation is a "strategy that provides people with the sense that they can solve their own problems through careful reflection and collective action"[1]. In various countries, community leaders have been mobilized to stimulate social participation and support the work of health professionals, becoming particularly relevant in low- and middle-income countries (LMICs), where they act as a bridge between the community and formal health services.

Involving community leaders is strategic, as local knowledge and social responsibility facilitate engagement as well as care for poorer, vulnerable, and underserved populations[2]. However,

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recruiting the right representatives is not straightforward; it requires careful mapping, selection, recruitment, and role definition to prevent overlapping activities, missed populations, and overburdened leaders.

Work is therefore needed to explore community participation itself and the processes and methods needed to effectively engage community leaders. This review examines the evidence available to guide mapping and recruitment of community leaders specifically for health surveillance programmes.

METHODOLOGY

This review used the Joanna Briggs Institute (JBI) recommendations for systematic scoping reviews and the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR).

To formulate the research question, a Population, Concept and Context (Table 1) strategy was adopted, leading to the following question: What are the main strategies for mapping and recruiting community leaders that have been used in health surveillance?

Table 1. Population, Concept and Context (PCC) strategy definitions

P Population/patients	community leaders
C Concept	mapping strategies; recruitment, sustainable engagement
C Context	Health surveillance

Source: Prepared by the authors

Data Sources

Searches were conducted in the PubMed and Virtual Health Library (VHL) databases from 1986 to August 2024, and included articles in English, Portuguese, and Spanish. The search strategy was: ((“community health workers”)) OR (“community leader”) OR (“community health volunteers”) AND ((“public health surveillance”)) OR (“community-based surveillance”).

Websites of public health organizations including the World Health Organization (WHO), the US Centers for Disease Control and Prevention (CDC), the Pan American Health Organization (PAHO), and humanitarian networks such as the International Federation of Red Cross and Red Crescent Societies (IFRC) were also searched to identify guidelines, manuals, and other non-indexed documents. Reference lists were hand-searched.

Selection criteria

a) Participants: studies involving community “leaders” in the broad sense encompassing community health workers (CHWs), religious leaders, and representatives of institutions such as humanitarian networks and civil society organizations.

b) Objectives: articles and documents presenting strategies for mapping and recruiting community members for health activities

c) Context: strategies for mapping and identifying community participants for health surveillance, health promotion and disease prevention, health education, risk communication, and community engagement. References addressing classification and competencies of community “leaders” were also eligible.

d)Type of Material: original articles, frameworks, guiding documents, manuals, books and book chapters, and other non-indexed documents.

e) Methodological Approach: observational studies, experience reports, case studies, participatory research, action research, intervention research, surveys, and interviews.

Exclusion criteria were editorials, letters to the editor, theses, dissertations, clinical studies, review articles, and articles published in languages other than Portuguese, English and Spanish.

Data extraction and analysis

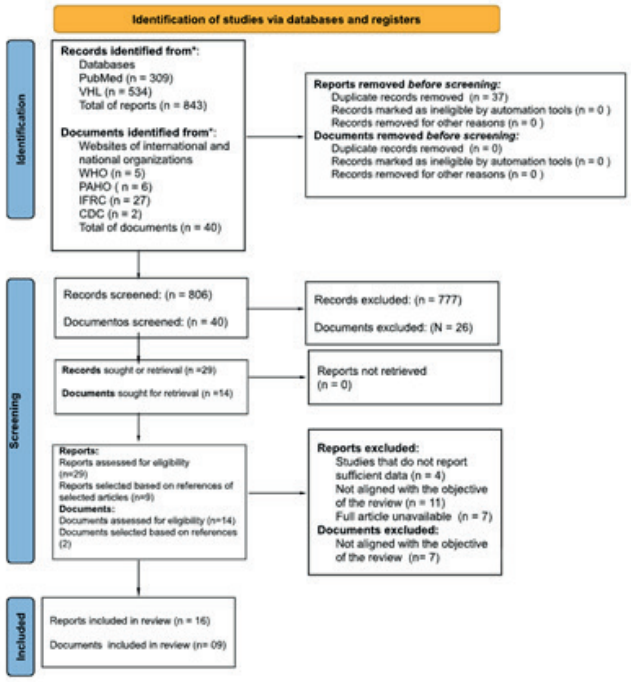
Following scoping review methodology, a qualitative content analysis was conducted on all eligible documents. Data were coded and organized into pre-defined categories to systematize and clarify the information for analysis[3].

ayyan, a web-based application for systematic and scoping reviews,was used for duplicate removal, data organization, and title and abstract screening[4]. Full-text reading and organization of data were carried out using Microsoft Excel®. Three reviewers participated in this review with inclusion by consensus, with the third reviewer mediating if there was disagreement. Results were synthesized following JBI methodological recommendations for scoping reviews[3].

Results and discussion

A total of 843 articles were identified: 309 in PubMed and 534 in the VHL. After duplicate removal, 806 articles were screened: 29 were eligible for full-text reading, including 9 identified through manual search of reference lists. Sixteen of these 29 articles were included in this review. Nine of 14 relevant grey

Figure 1. Study selection flow (PRISMA-ScR).



Formal studies and technical documents were analyzed by the same themes separately, to reflect their different levels of content depth. Of the 16 formal studies, 10 (62.5%) used qualitative methods (interviews, focus groups, case studies); the remainder applied mixed or descriptive methods. Publication dates ranged from 2013 to 2024; implementation periods from 1988 to 2020.

Grey literature predominantly comprised guiding documents, with the exception of The Community Toolbox (University of Kansas).

Programme Contexts

Most reports describe experiences in sub-Saharan Africa and South and Southeast Asia, suggesting these regions may recognize the involvement of community members as a central strategy to expand access to health care and strengthen surveillance activities more (Table 2).

Nepal contributed three studies (18.7%) on the Ministry of Health Female Community Health Volunteer (CHV) programme (established 1988), covering 51,000 volunteers (90% rural) in rural and mountainous areas across four periods, with a high retention rate[5–7].

Three Kenyan studies (19%) described a palliative care CHV training programme for 105 volunteers 8, a community health worker programme providing promotive and preventive health services at household level for pregnant women and children in Kilifi 9, and the Integrated Management of Acute Malnutrition (IMAM) programme (2009), where CHVs conducted case screening, referral, and community mobilization in arid and semi-arid areas[10].

Ethiopia and Uganda reported long-term experiences with the CORE Group Polio Project (CGPP), which trained and mobilized 12,000 community volunteers for polio eradication and disease surveillance across 11 countries (2001–2017), including work with pastoral populations[11], and in border areas with a high risk of transmission from neighboring countries12. Uganda's Healthy Child Uganda (HCU) programme mobilized 404 volunteer CHWs in rural southwestern Uganda[13].

Ghana's two studies (12.5%) both related to the Community-based Health Planning and Services (CHPS) programme (established 1999), addressing community committee roles and Neglected Tropical Disease (NTD) management in endemic districts, with a participatory structure but unclear leader numbers[14,15].

Other contexts included: Dominican Republic (14 volunteers, urban malaria response, 2015–2016) 16; India/Puducherry (65 volunteers, diabetes and hypertension screening)[17]; Myanmar (tuberculosis case-finding) 18; and the Democratic Republic of the Congo (DRC) (233 CHWs and 27 supervisors in the 2018–2020 Ebola Riposte programme)[19].

The Somaliland study is the only one addressing a Community-Based Surveillance (CBS) system directly. The Somali Red Crescent/Norwegian Red Cross Society programme (established 2018, 6 states) started with a feasibility analysis and community consultation, then implemented and evaluated the 'Nyss' signal detection platform used by 239 volunteers across 90 villages.[20].

With regard to the health conditions addressed, maternal and child health featured in five studies (31.25%), covering topics such as vaccination, malnutrition, maternal mortality, and care for pregnant women and children[5,7,10,11,15], poliomyelitis in two studies (12.5%)[11,12] and Malaria, Tuberculosis, Ebola, chronic conditions (diabetes and hypertension), palliative care, and NTDs were each represented by one study.

Institutional arrangements ranged from national governments and NGOs to academic institutions; multi-partner models characterized larger, long-term programmes[7,12,13].

Table 2. Characterization of programs and projects according to author, project name, duration, objectives, diseases, and country

References	Project or program name	Duration	Goal	Diseases	Country
Asegedew et al., 2019	CORE Group Polio Project (CGPP)	2001	Polio eradication, promotion of routine immunization and surveillance of vaccine-preventable diseases (not only for polio but also for measles and tetanus) in hard-to-reach and high-risk areas	Polio	Ethiopia
Valdez et al., 2020	National malaria program	2015-2016	Recruit a cadre of community members called comunitarios (community health workers), to perform active surveillance for malaria	Malaria	Dominican Republic
Losey et al., 2019	CORE Group Polio Project (CGPP)	1999	Polio eradication, promotion of routine immunization and surveillance of vaccine-preventable diseases (not only for polio but also for measles and tetanus) in hard-to-reach and high-risk areas	Polio	Multi Countries (11): Angola, India, Ethiopia, Uganda, Bangladesh, Nepal, Nigeria, Kenya, Somalia, South Sudan and Afghanistan
Rajaa et al., 2022	National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS)	Not informed	Not informed	Diabetes and hypertension	Puducherry
Lee, 2020	The Female Community Health Volunteer (FCHV) programme	1988	Provide community-based outreach services focused on maternal and child health	Maternal and child health	Nepal
Ludwick et al., 2014	Healthy Child Uganda (HCU)	2004	Promote child health in rural southwestern Uganda through education and training of volunteer community health workers	Child health promotion	Uganda
Schwarz et al., 2014	Nepal's Female Community Health Volunteer (FCHV) program	1988	Provide community-based outreach services focused on maternal and child health	Immunizations, vitamin A supplements and maternal-child health	Nepal
Panday S et al., 2024	Female Community Health Programme	1988	Not informed	child mortality and maternal health	Nepal

References	Project or program name	Duration	Goal	Diseases	Country
Lusambili AM et al., 2021	CHW programme	2006	Provide promotive and preventive health services at household level	pregnant women and children	Kilifi (Kenya)
Wambui E et al., 2024	Integrated Management of Acute Malnutrition (IMAM)	2009	Expanding access to community care for common childhood illnesses	Child malnutrition	Loima (Turkana) and Isiolo (Isiolo), arid and semi-arid areas of Kenya
Elias H et al., 2024	Not informed	Not informed	Not informed	Palliative care (PC)	Kenya
Jung J et al., 2024	Not informed	2018	Increase community capacity for early detection of disease outbreaks and strengthen the local response in hard-to-reach contexts through participatory community surveillance.	Health surveillance	Somaliland (regions such as Awdal and Togdheer)
Maung HM et al., 2014	Community Based Tuberculosis Care Programme (CBTC)	2011-2014	increase TB case detection through the work of community volunteers, promoting education, symptom screening, referral, adherence to treatment and support for patients	tuberculosis (TB)	Myanmar (Southeast Asia)
Ankomah SE et al., 2024	Community-based health planning and services (CHPS)	1999	Strengthen the health system in Ghana through community empowerment, involving Community Health Management Committees (CHMCs) and Community Health Volunteers (CHVs) to create a bridge between the community and the formal health system.	national primary health care (PHC)	Ashanti Region, Ghana
OKeeffe J et al., 2023	Riposte	2018-2020	Strengthening community involvement and an early warning system, essential for controlling transmission.	Surveillance and control of Ebola Virus Disease (EVD)	Mambasa, Binase and Salama health zones in the Democratic Republic of Congo (DRC)
Owusu L, et al., 2023	Community-based Health and Planning Services (CHPS)	Not informed	It aims to improve early detection and response to NTDs through the direct involvement of community volunteers.	Neglected Tropical Diseases (NTDs)	Four NTD-endemic districts in Ghana (Ahafo Ano North, Sekyere East, Asunafo South and Asutifi South).

Source: Prepared by the authors

Key terms

There is considerable heterogeneity in the terminology used to refer to community members recruited for the reported initiatives. The most frequent terms were Community Health Workers, mentioned in 10 out of 25 studies (40%)[7–11,13,14,16,17,20], followed by Community Leaders in 4 studies (16%) 21–24 and their Portuguese equivalent Líderes Comunitários in 1 study 25; Community Volunteers 12,18,26 and Female Community Health Volunteer (FCHV) 5–7.

Less frequently used terms included Community-Based Surveillance Volunteers in 2 studies 15,27; Community mobilizers 11; Local FCHV Leadership and Community Health Worker Leader 7; Local Leaders 24 ; and Key Influencers 26, each cited once.

The designations attributed to community members are, for the most part, associated with the main focus of the programmes in which they are involved. The studies do not provide evidence that individuals previously held leadership roles in other sectors. However, based on the reported experiences, it seems clear that community health volunteers and community leaders have distinct profiles. To enable their characteristics and differences to be identified more accurately, the terms "community volunteer" and "community leader" will be used according to the contexts presented in the documents.

Mapping and recruitment

Community leaders and volunteers are recruited in diverse ways. This section addresses the planning, recruitment, and selection stages.

Planning

Only the Community Tool Box highlights planning as an essential first step, proposing reflection on: why recruit, how many and what type of leader is needed, who will recruit, where and when to approach candidates, and how to anticipate obstacles 28.
None of the 16 studies contains any information aimed specifically at planning for mapping and recruitment, and the only study that records that any planning at all was undertaken indicates that this was directed towards the implementation of the programme itself 20.

Mapping and recruitment stages

Three of the nine technical documents describe steps that should be taken in mapping and recruiting community leaders 21,22,28, highlighting four key stages: (1) stakeholder mapping and analysis, (2) structured identification of community groups and sectors, (3) direct contact with potential leaders for recruitment, and (4) training of the recruited actors.

The Community Tool Box suggests identifying and mapping the different sectors of a community (e.g., civil society, for-profit private sector, NGOs, and government) that are fundamental components of the social structure that directly influence people's daily lives[28].

They note that by considering the social organizations and sectors within communities, community health initiatives may be better able to address the interests of those most affected. Mobilized in a coordinated manner, these partners and sectors can enhance the reach, representativeness, and effectiveness of collective actions[28].

The WHO recommends that, following the mapping stage, a stakeholder analysis using exploratory interviews should be conducted to identify their potential roles, such as partner, advocate, informant, funder, provider, regulator, reviewer, consultant, or beneficiary[24].

According to the US CDC, a detailed list of community leaders and their roles can support the construction of a community profile. This typically includes a synthesis of the community's main concerns, demographic information, identification of local organizations, social determinants of health, and other relevant characteristics, which can contribute to a better understanding of the target population and facilitate the design of more effective public health interventions[21].

Depending on the type of project, the technical guidance literature suggested it is essential to invest in training involving all direct and indirect partners to support recruitment[24,28].
In the implementation literature eight of the 16 reports provided information on their mapping and recruitment of community volunteers but with limited detail. It was not possible to determine a sequence of steps; however, some common themes were identified: community involvement in the nomination or selection of participants, institutional support in the selection process, and the importance of training and supervision for encouraging candidates to agree to participate [5–9,12,13,20].

Seven of the eight reports indicated that recruitment directly involved community participation in the selection of candidates, either through nomination or recommendation of participants by their own communities or via direct contact with community members[8,10,12,13,17,19,29]. In two instances, approval was obtained through deliberations in collective forums[14,29].

Direct involvement of local authorities was reported as fundamental to sustainability by two studies, with nomination of candidates by social, religious, or community organizations, district assemblies, or personal appointment by local authorities[14,16].

Four studies reported the importance of standardized and structured training to support recruitment[12,13,17,20]. These sessions aimed to prepare participants to carry out proposed activities and included topics such as community health,

disease surveillance, first aid, and engagement strategies, often adapted to local languages.

The duration of the training varied from one- to 2-3 day training[9,12,13,17] to ongoing training, with multiple awareness sessions conducted over time [13,20] . One long-term programme did refresher training every five years[5]. Only one study analyzed geographic and population distribution to determine the number of active volunteers needed.

Selection criteria

Fourteen of the 16 papers (87.5%) and six of the nine technical guides (66.7%) describe the criteria used to select volunteers. The most recurrent criteria were: residing in the community where they will operate, being well regarded by the local population, being respected within the community, speaking the local language, having influence and trust within the community, possessing basic literacy, and demonstrating willingness to engage in voluntary work[7–9,12,15,17,20–22,24,25,27,29.]

For example, in the CORE Group Polio Project, volunteers were nominated by their respective communities based on their interest in conveying health messages and providing care to the local community, being well accepted by the community, serving as a good role model, speaking the local language, and residing within the community[11].

Technical documents emphasize that more specific criteria can be defined according to the project's focus and target population, considering the needs assessment and analysis conducted for each programm [22].

Implementation phase: Activities developed

Of the 16 included studies, 12 (75%) described activities undertaken by community volunteers in the projects. Of particular relevance to surveillance, nine programmes (56.2%) reported that activities included home visits for active case-finding during epidemics and disease screening[6,8,10,12,15,16,18,29], six reported referral of cases to formal health services and treatment follow-up (37.5%) 6,8,10,15,17,29 though not necessarily for infectious diseases, and five reported active case screening and testing ranging from rapid malaria tests to identification of alerts during Ebola surveillance (31.2%) [10,15,16,18]. Use of technology to support community surveillance was reported only in Somaliland (6.2%)[20].

Beyond this, home visits were the most frequently reported activity encompassing disease screening, malnutrition monitoring and active case finding (eight studies)[6,8,10,12,15,17,18,29]. Health education and counselling focused on prevention of infectious diseases, maternal and child health, nutrition, hygiene, and reproductive health appeared in seven studies (50%)[6,8–10,15,18,29], and support for disease prevention and immunization campaigns, mothers' meetings, vector control, and encouraging care-seeking were reported in five studies (31.2%) [6,12,18,22,29]. One study mentioned that supervision was essential for system functioning, volunteer motivation, and mentoring 7,12,13.

Remuneration

Nine (56%) studies reported providing remuneration or incentives to compensate for the time dedicated by community volunteers. While volunteering remained the foundation of these programmes, different compensation strategies were applied to reduce socioeconomic barriers and promote sustainability [5–7,9,12,13,15,20].

Strategies included: financial incentives (activity-based payments and transport allowances; 7 projects)[6,7,9,13,15,20,29], material incentives (uniforms, mobile phones, work kits; 4 projects) 5–7,13, and social incentives (certificates, public recognition; 4 projects)[6,12,13,15,29].

Impact of the programme

Evidence of the impact of community volunteers can be difficult to separate from other interventions occurring at the same time, and only one study proposed a quantitative impact: Nepal's FCHV programme reported ~50% reduction in maternal mortality (1996–2006), attributed to improvements in child health, primary care utilization, and community recognition of formal health services.

Beyond this, eight of the 16 studies suggested community volunteers had had a substantial impact on the implemented programmes by contributing to outbreak surveillance and response, improvements in maternal and child health, strengthening of immunization, and management of childhood malnutrition, neglected tropical diseases (NTDs), and palliative care[6–10,12,20,29], but provided no concrete evidence.

Characteristics of community leaders and community volunteers
The Community Toolbox defines community leadership as a role exercised by individuals recognized as influential within their local area. This literature describes people who are widely respected by the community, possessing extensive experience and in-depth knowledge of the local context. Authors suggest such leaders are able to understand community needs, dynamics, and challenges in a more direct and informed manner, often with greater insight than external stakeholders, and that their legitimacy stems from social recognition. They are people whose opinions are valued, whose ideas are regarded as relevant, and whose support is frequently essential for the implementation of significant changes[28].

Two technical documents further explore this topic by distinguishing between formal leadership, individuals who hold institutionally recognized roles and who are appointed or elected to represent their communities within organized

spaces, such as health councils, local committees, or governmental programmes, and informal leadership which is exercised by individuals whose activities emerge organically from daily community life and whose recognition derives from their experience, engagement in local initiatives, and deep knowledge of the territory. Their contribution is often less visible to external actors[25,27].

One guide notes that the desired level of participation of each group may vary depending on the aims of the initiative but recommends that, in most cases, these actors should be engaged from the earliest stages and on an ongoing basis. Early engagement tends to strengthen the sense of shared responsibility, increase personal investment in the initiative, and enhance commitment to the community's needs and priorities 21. In some contexts, community leaders take part in the identification and mobilization of community volunteers, support the detection of local health risks, and contribute to overcoming operational barriers in programme implementation. Regarding community volunteers, three studies highlight key characteristics. Volunteers are lay members of the community who receive training to provide basic, voluntary, and non-specialized support, without holding a formal employment relationship within the health system. They may contribute to curative or preventive care, or to community surveillance and disease control activities, despite not being health professionals 14,15. Because they are embedded in the territory, they share the language, cultural references, and close physical proximity to the local population, and the authors say they are strategic assets for preparedness and response initiatives, particularly in remote areas where access to health services is limited[20].

In this review, only a subset of studies addressed the central research question: what are the main strategies for mapping and recruiting "community leaders" in health surveillance? While the documents identified acknowledge that there are methods to map and recruit community volunteers and community leaders, the processes were rarely presented systematically, nor were reference models referred to.

Most programmes were implemented between 1988 and 2005 but published in 2013–2024, reducing opportunities to incorporate lessons into new programmes.

We also found issues related to terminology in trying to answer our question. The aim of most of the identified projects was to identify and recruit 'volunteers', not necessarily community 'leaders', while only one of the projects recruited solely for the purpose of surveillance.

Accepting the variety of terms used and lack of in-depth classification, broadly, volunteers were lay community members trained to support specific activities, with defined responsibilities and legitimacy derived from their institutional affiliation with a programme. Community leaders, by contrast, were individuals locally recognized for their ability to mobilize and influence others, whose legitimacy is built over time through established social relationships and prior engagement within the community. While the two groups had distinct profiles in programmes, we observed that they could perform complementary roles and, in some cases, structured training and sustained support for participation may enable volunteers to transition into leadership roles, thereby reinforcing community representativeness, autonomy and programme sustainability over time.

We found consensus that those recruited should meet minimum criteria to participate in projects and should be at least recognized, if not nominated, by the community itself. However, only one study highlighted the conduct of preliminary research with local partners to verify the feasibility and acceptance of the programme and to identify any ongoing similar initiatives, and only one other emphasized the importance of conducting prior analysis of the geographic area and population size to estimate the number of leaders needed and their representativeness. Recent experience by the authors of this article in an as-yet unpublished introduction of community leader-driven event-based surveillance in Brazil and Cabo Verde suggests these steps are essential to understand which community member profiles are most suitable for each initiative, guide recruitment, and avoid duplication of efforts or failures due to weak understanding of relational and social factors when structuring programmes. Without such background work, there is a risk of adopting generic models that fail to respond to local needs and dynamics.

The importance of developing trust and relationships was rarely described as a necessary process in the reviewed studies, appearing only in technical documents, possibly because these issues were seen as less impactful at the time these programmes were implemented. By contrast, a publication on experiences from the Ebola epidemic in West Africa in 2013-16 states that trust is crucial for ensuring the effectiveness of community participation, and that the legitimacy of and adherence to surveillance activities depend directly on trust between leaders, the community, and health professionals 19, while a 2024 scoping review stressed that engaging community members right from the planning stage increases the likelihood of effective action and strengthens community-authority trust[30].

The literature indicates that the sustainability of programmes depends on continuous community engagement, institutional support, and the existence of permanent mechanisms for incentives, capacity building, and supervision. Studies emphasize ongoing training and supervision as fundamental strategies to support volunteers' performance and strengthen leadership capacities. Projects funded over longer periods tend to exhibit more consolidated organizational structures, a greater number of trained volunteers, and higher levels of sustainability.

Beyond the duration of implementation, coordination

and collaboration among multiple social actors, such as governments, civil society organizations, and educational institutions, contribute to improved recruitment, continuity, and effectiveness of interventions. Conversely, the absence of remuneration or adequate non-monetary incentives has been identified as a critical factor associated with high turnover and a significant barrier to the sustainability of actions. Formal recognition of community-based work, clear role definition, institutional supervision, and the creation of enabling environments for participation therefore emerge as central elements in the consolidation of more equitable, resilient, and sustainable programmes.

Finally, most programmes addressed specific diseases with established protocols; only one (Somaliland) addressed broader surveillance systems. However, we consider many of the lessons identified above also apply to this field of work[20,30].

CONCLUSION

This review demonstrates that, although rationale and methods exist to guide the recruitment of community members to support health programmes, the use and impact of aspects such as structured planning, clear methodological definitions, and in-depth exploration of target communities and potential leaders prior to implementation have not, to date, been well described. This is not necessarily to say they were not used: the experiences analyzed do suggest that involving community members in health programmes is a strategy capable of expanding the reach of interventions, strengthening territorial ties, and fostering more effective and sustainable relationships with the formal health system. However, detailed documentation of more recent experiences of the approaches needed to fully support such community-based strategies is needed, especially in the field of health surveillance given increasing interest in implementing community event-based surveillance globally 31. For those seeking to develop community-based surveillance initiatives, the experiences described in this review underline the importance of understanding community profiles, recruiting in alignment with local dynamics, and providing continuous support to these actors throughout the process. Rigorous use of these steps enables the identification of the most suitable profiles for each context and the creation of conducive conditions for integrated action.

We believe community volunteers and community leaders to be distinct but complementary actors, whose combined engagement can generate significant benefits for health surveillance initiatives. On the one hand, community volunteers can contribute operational support to specific activities, forming a locally-based workforce trained and guided by programme needs. On the other hand, community leaders can provide a mobilization capacity and influence within the territory, which is fundamental to community engagement, adherence, and trust. The combination of these profiles strengthens both implementation and sustainability, enhancing long-term impact. However, this potential can only be realized if community volunteers and leaders are properly mapped and recruited, then adequately trained, motivated, and supervised within an enabling environment that works to ensure financial constraints do not undermine their performance. Incorporating these approaches right from the planning stage may help to establish surveillance systems that are more firmly rooted in the territory, reinforce trust between communities and health authorities, and strengthen local capacity for health response.

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