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What's in a name? Unpacking 'Community *Blank*' terminology in reproductive, maternal, newborn and child health: a scoping review

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ABSTRACT

Introduction Engaging the community as actors within reproductive, maternal, newborn and child health (RMNCH) programmes (referred to as 'community *blank*') has seen increased implementation in recent years. While evidence suggests these approaches are effective, terminology (such as 'community *engagement*,' 'community *participation*,' 'community *mobilisation*,' and '*social accountability*') is often used interchangeably across published literature, contributing to a lack of conceptual clarity in practice. The purpose of this review was to describe and clarify varying uses of these terms in the literature by documenting what authors and implementers report they are doing when they use these terms.

Methods Seven academic databases (PubMed/MEDLINE, Embase, CINAHL, PsycINFO, Scopus, Web of Science, Global Health), two grey literature databases (OAlster, OpenGrey) and relevant organisation websites were searched for documents that described 'community *blank*' terms in RMNCH interventions. Eligibility criteria included being published between 1975 and 1 October 2021 and reports or studies detailing the activities used in 'community *blank*.'

Results A total of 9779 unique documents were retrieved and screened, with 173 included for analysis. Twenty-four distinct 'community *blank*' terms were used across the documents, falling into 11 broader terms. Use of these terms was distributed across time and all six WHO regions, with 'community *mobilisation*', 'community *engagement*' and 'community *participation*' being the most frequently used terms. While 48 unique activities were described, only 25 activities were mentioned more than twice and 19 of these were attributed to at least three different 'community *blank*' terms.

Conclusion Across the literature, there is inconsistency in the usage of 'community *blank*' terms for RMNCH. There is an observed interchangeable use of terms and a lack of descriptions of these terms provided in the literature. There is a need for RMNCH researchers and practitioners to clarify the descriptions reported and improve the documentation of 'community *blank*' implementation. This can contribute to a better sharing of learning within and across communities and to bringing evidence-based practices to scale. Efforts to improve reporting can be supported with the use of standardised monitoring and evaluation processes and indicators. Therefore, it is recommended that future research endeavours clarify the operational definitions of 'community *blank*' and improve the documentation of its implementation.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ While evidence suggests the effectiveness of approaches such as '*community participation*,' '*community engagement*,' '*community mobilisation*,' '*social accountability*' and '*stakeholder engagement*' (collectively referred to as 'community *blank*') in improving reproductive, maternal, newborn and child health (RMNCH) outcomes, there is inconsistency in what these programmes entail when 'community *blank*' work is conducted.

WHAT THIS STUDY ADDS

⇒ This study demonstrates that while there is a large body of literature documenting 'community *blank*' in RMNCH, a relatively small portion of that literature provides detailed description of the activities, purposes and stakeholders involved.

⇒ These findings illustrate little to no pattern in when specific 'community *blank*' terms have been used and that terms are even used interchangeably or synonymously.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ This review helps to capture work that has been done globally since the Alma-Ata Declaration and calls for consistency and clarity in the way 'community *blank*' terms are reported.

⇒ As the majority of documents included in this review come from the scientific literature, it is recommended that the research community ensures the appropriate and intentional documentation of the procedures and processes relating to the implementation of 'community *blank*.'

⇒ Improved documentation, supported by standardised monitoring and evaluation indicators, can inform the design and development of future 'community *blank*' work across settings.

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INTRODUCTION

Health systems that work for and with the communities they serve are essential to achieving quality universal health coverage and the collective commitments agreed in the Sustainable Development Goals. The World Health Organization (WHO) has long recommended a policy framework for a 'people-centred approach to health care, and a balanced consideration of rights and needs as well as responsibilities and capacities of all health constituents and stakeholders.'[1] The Alma-Ata Declaration (1978), which emerged more than 40 years ago, promotes community participation as integral to health systems strengthening efforts.[2] A number of reviews have concluded that there is evidence that involving communities in the co-production of health interventions or programmes is associated with improved health outcomes.[3–10] Perhaps as a result, community-based interventions with components to engage or mobilise communities have been increasingly implemented for health systems strengthening including in research, emergency response and preparedness, as well as in reproductive, maternal, newborn and child health (RMNCH) programmes.[8 11–17]

Programmes that include the community as actors within an intervention rather than just a target audience have grown.[18 19] Evidence describing these approaches draws on a range of different terminology such as '*community engagement*,' '*community mobilisation*,' '*community participation*,' '*community collaboration*,' '*stakeholder engagement*,' '*social mobilisation*' or '*social accountability*' (hereafter, collectively but not exhaustively called 'community *blank*').[17] These terms are often used interchangeably or in combination and appear to pertain to similar activities, or with little to no description of activities entailed or actions taken, leading to a lack of clarity that may reflect and/or cause confusion in both the research[20–22] and programmatic[16 23] settings. As these 'community *blank*' approaches are implemented with varying degrees of success,[16 24–26] ensuring effective knowledge translation requires a common understanding of terminology. Programmes incorporating these approaches rely on good research and evaluation reporting to know how to implement them, highlighting the implications for research on 'community *blank*' and the importance of bridging the research-practice gap.

The purpose of this scoping review was to explore the literature to describe and catalogue the different 'community *blank*' terms and how they were reported and used in the RMNCH literature. The overall objective of this review is to answer the question: *How is 'community blank' for RMNCH reported in the literature?* This is divided into the following subquestions: (1) What are the different activities associated with 'community *blank*' for RMNCH? (2) What is the purpose of implementing 'community *blank*'? (3) Who are the stakeholders (actors and beneficiaries) involved in 'community *blank*' activities?

METHODS

A scoping review was conducted following the methodology described by Arksey and O'Malley and according to the Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRSIMA-ScR) checklist (online supplemental appendix 1).[27 28] The review protocol was prospectively published on the Open Science Framework (https://osf.io/d3cs7/).

Search strategy

The search strategy, developed with expert advice from a librarian information specialist and provided in table 1, was designed around two concepts: terms related to 'community *blank*' and RMNCH terms, using the Boolean operator "OR" in between terms, and "AND" in between concepts. The 'community *blank*' search terminology was informed by search strategies used by previously published reviews of the literature in order to be as comprehensive as possible and capture any potentially relevant literature.[20 29 30] The search was run in seven databases [PubMed/Medical Literature Analysis and Retrieval System Online (MEDLINE), Embase, Cumulated Index to Nursing and Allied Health Literature (CINAHL), PsycINFO, Scopus, Web of Science, and Global Health] on 20 May 2021 and updated on 01 October 2021. Online supplemental appendix 2 provides the detailed search strategy and resulting records across databases. OAIster and OpenGrey were searched for grey literature using a similar but adapted search strategy (online supplemental

Table 1 Search strategy

1	RMNCH (title/abstract)	antenatal OR prenatal OR pregnan* OR matern* OR "child health" OR "newborn health" OR postpartum OR postnatal OR perinatal OR reproductive OR birth OR "family plan*" OR neonat* OR ANC OR PNC OR MNCH OR RMNCH
2	'Community Blank' terms (all fields)	"citizen participation" OR "citizen engagement" OR "collaborative partnership" OR "community action" OR "community advisory" OR "community consultation" OR "community collaboration" OR "community engagement" OR "community involvement" OR "community mobilization" OR "community mobilisation" OR "community liaison" OR "community network*" OR "community participation" OR "grassroots participation" OR "grassroots network*" OR "public engagement" OR "public participation" OR "public representation" OR "participatory action" OR "participatory learning" OR "stakeholder engagement" OR "social engagement" OR "social accountability"

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appendix 3). Fifteen organisation websites were also searched for reports of active community-related programming (online supplemental appendix 4 provides a full list of organisations). Additional snowballing techniques included examining reference lists of included studies as well as reference lists of 40 relevant, previous systematic and/or literature reviews (online supplemental appendix 5). Finally, an additional snowballing technique searching for the specific terms that appeared in papers after screening that were not included in original search results was conducted on PubMed (online supplemental appendix 6).

Eligibility criteria

All document types (peer review, grey literature, policy documents, reports) were included if they examined or described activities working with or involving communities in RMNCH programmes. Articles published on or after 1975 were included to capture the period just prior to the 1978 Alma-Ata Declaration and subsequent years. This scoping review excluded editorials, commentaries, or previous reviews and guidelines that solely included secondary data. It also excluded articles where 'community *blank'* was conducted for the purpose of promoting health research/trials (eg, '*community engagement*' activities undertaken to improve recruitment for a vaccine trial) in part because there are a number of reviews focusing on this topic.[5 20 31 32] While there was no exclusion based on language, searches were conducted in English. Online supplemental appendix 7 details the inclusion and exclusion criteria.

Study selection and management

Records from the search were imported into Covidence,[33] an online information management system. After removing duplicates, two reviewers (SD, OC) independently screened articles by title and abstract. After discussing conflicts, reviewers independently screened articles by full text. A third reviewer (ADB/BG) reviewed and resolved any discrepancies in inclusion at both title/abstract and full text phases.

Data extraction

Two reviewers (SD, OC) extracted data from included documents on the Covidence platform and subsequently exported the data into Excel. Extracted data included: setting, project aim, RMNCH outcome, target population/participants, 'community *blank*' terms used, any formal definitions or frameworks about the 'community *blank*' term, the purpose of 'community *blank,*' the activities or components conducted/description of the programme, and the actors and beneficiaries (stakeholders) involved. The first several documents were double-extracted independently and checked for consistency before authors independently extracted remaining documents. In total, over 25% of documents were double-extracted to provide a quality check and confirm consistency in extraction among reviewers.

Data summarisation and visualisation

Documents were grouped and organised by reported terminology. Specific terms as reported by the documents were captured and grouped where appropriate (eg, '*community mobilisation and sensitisation*' was included in the '*community mobilisation*' category and '*systematic community engagement*' was considered '*community engagement*'). Published documents referring to the same project were also grouped together. The extracted data were cleaned and sorted in Excel according to the review questions in order to describe and qualitatively summarise trends relating to the reported activities, purposes and stakeholders of 'community *blank.'* The data are reported in this review reflect the way authors reported them in the included documents. Tableau[34] was used to visualise the data to illustrate patterns across when or where specific terminology was used and the activities associated with them. Basic descriptive statistics (eg, frequency of occurrence of various terms and activities across the included studies) were calculated and presented.

Findings

A total of 17 371 documents were identified (figure 1) through database searches. A further 257 documents were identified through other sources such as grey literature and reference lists. After removing duplicates, 9779 documents were screened by title and abstract and 534 were screened at full text. Reasons for exclusion (361 excluded documents) can be found in online supplemental appendix 8. In total, 173 documents are included in this review. Fifty publications[35–84] refer to 15 individual projects (online supplemental appendix 9). Where there are examples from the same project, the number of projects is reported in addition to the number of publications. The completed data extraction sheet is included in online supplemental appendix 10. This review reports information from 161 peer-reviewed articles[35–37 39–72 74–197] and 12 grey literature/reports.[38 73 198–207]

Description of included publications

The 173 included documents ranged in document type, study design (if applicable) and scope of implementation. Table 2 provides key summary characteristics of the included documents. The most common study designs were individually randomised and cluster-randomised control trials (n=36), qualitative studies using interviews or focus group discussions (n=31), mixed-methods studies (n=21), descriptive case studies (n=20), and cross-sectional studies (n=12). The earliest published document was from 1979 and over half (n=102) were published between 2017 and 2021. The 173 documents reported on projects in 51 countries across all six WHO regions. The most common WHO region was Africa (n=113) followed by South-East Asia (n=65), Americas (n=18), Western Pacific (n=16), Eastern Mediterranean

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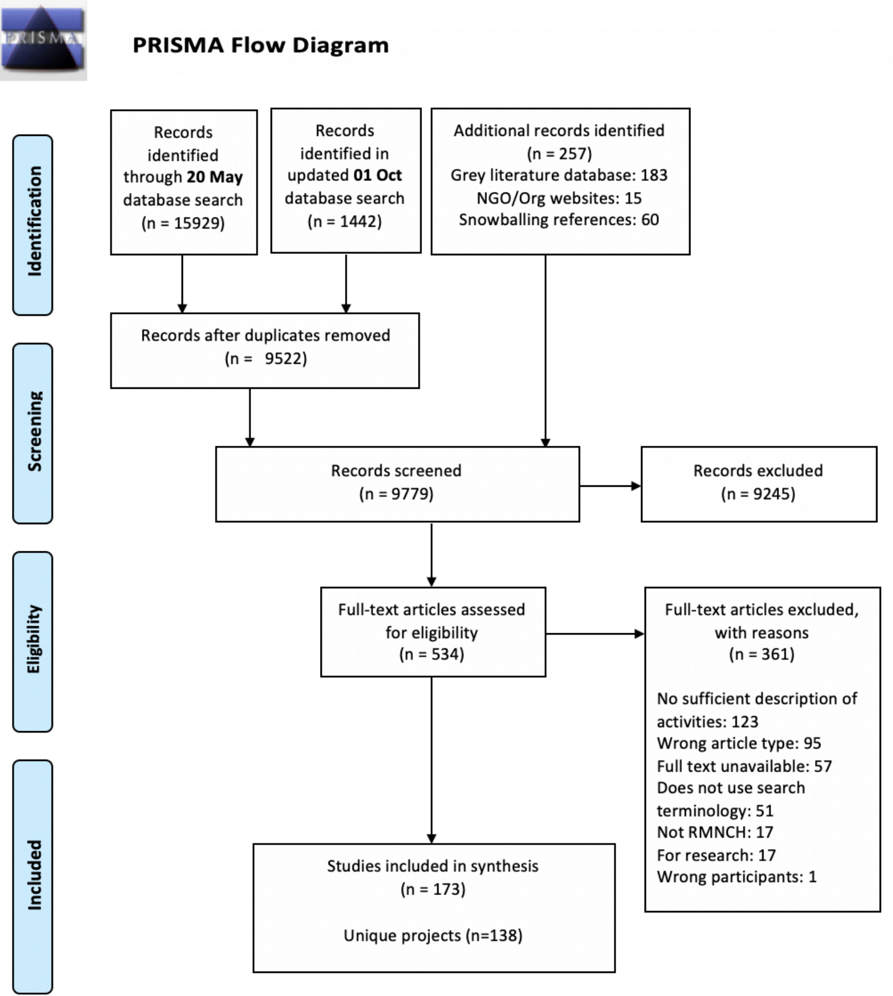

Figure 1 Flow diagram demonstrating study selection process. NGO, non-governmental organisation; PRISMA, Preferred Reporting Items for Systematic reviews and Meta-Analyses; RMNCH, reproductive, maternal, newborn and child health.

(n=15) and Europe (n=3). Of the 173 publications, 169 document experiences in just 12 countries: India (n=27), Bangladesh (n=21), Malawi (n=18), Uganda (n=18), Pakistan (n=16), Zambia (n=13), Nepal (n=11), Ghana (n=10), Kenya (n=10), the USA (n=10), Nigeria (n=8) and Ethiopia (n=7).

While a large number of terms were included in the search strategy to be as comprehensive as possible, 24 distinct 'community *blank*' terms were reported in the 173 documents for a total of 182 times (9 documents using more than 1 term) (online supplemental appendix 11). However, 17 terms were only used once, including 12 which included components of other terms. During the analysis, terms were synthesised into 11 categories. The most commonly used term was '*community mobilisation*' (n=75, 51 projects), followed by '*community engagement*' (n=49, 44 projects), '*community participation*' (n=26, 26 projects), '*social accountability*' (n=17, 14 projects), '*social mobilisation*' (n=7, 7 projects), '*community involvement*' (n=2, 2 projects) and '*community empowerment*' (n=2, 2 projects). '*Stakeholder engagement*,' '*social engagement*,' '*community outreach*' and '*community collaboration*' were all used only once.

To further understand these 'community *blank*' terms, potential patterns and trends across time, region and RMNCH population groups were explored. As demonstrated by figure 2, terms were used relatively consistently across WHO regions. Notably, '*community participation*' was the most common term in South-East Asia. Similarly, the distribution of terms over time can be seen in figure 3. While '*community mobilisation*' was the most used term, there has been a decrease in its use in the most recent five years, coupled with an increased momentum in using the term '*community engagement*.' The 'community *blank*' terms were used across all RMNCH population groups (online supplemental appendix 12). The prevalence of '*social accountability*' in relation to reproductive health outcomes was greater than for other populations across RMNCH groups. For maternal health and newborn health, '*community mobilisation*' has been the dominant term since 1990. Over time, the use of the 'community *blank*' terms for newborn health largely reflects those used for maternal health. Child health programmes most commonly used '*community engagement*,' and this was consistently the more prevalent term used for child health focused activities in the preceding three decades.

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Table 2 Summary table

Author, year (project)	Country	Years of study	Study design	RMNCH target audience	Purpose (categories)	'Community Blank' purpose statement	Term used	Activities/components of 'Community *Blank*'	Involved actors
Africa									
Hounton, Byass and Brahima[139]	Burkina Faso	2001–2006	Quasi-experimental	MN	Health outcomes; care-seeking	Sensitise communities on maternal and newborn care-seeking and practices in order to reduce maternal and perinatal mortality	Community mobilisation	Local leader sensitisation Meetings Awareness/communication Activities Community workshop	Community leaders, community members, health workers, women
Kabore *et al*[144]	Burkina Faso	2014–2015	Cross-sectional survey	R	Care-seeking; knowledge	Promote **family planning** in order to break down the embarrassments, the reluctance and the stubbornness that surrounds the question of the contraception	Community engagement	Health workers disseminate information Public events	Community leaders, community members, district health team, health authorities, health facility management committee, health workers, local authorities, men, women
Babalola *et al*[98]	Cameroon	1997–1998	Cross-sectional survey	RC	Care-seeking; Knowledge; Health outcomes	Increase knowledge and use of **family planning** and contraception	Community mobilisation	Awareness/communication activities Recurring group meetings and discussions	Champions, community members, health workers, households
Mafuta *et al*[154]	Democratic Republic of Congo	2015	Qualitative (dialogue model and focus group discussions)	M	Health outcomes; quality of care	Improve health services responsiveness	Social accountability	Community dialogues	Health workers, health authorities, local authorities, men, women
Argaw *et al*[91]	Ethiopia	2018–2019	Quasi-experimental	MNC	Quality of Care	Improve maternal and newborn care services	Social accountability	Community scorecards/ report cards	Health facility management, community members
Berhanu *et al*[101]	Ethiopia	2016-?	Cross-sectional survey (protocol)	C	Care-seeking	Increase the awareness of newborn and child diseases, the recognition and acceptance of the care provided on the primary level, and the formulation of action plans at the local level	Community engagement	Awareness/communication activities Recurring group meetings and discussions	Community members, men, volunteer health workers
Carnell *et al*[108]	Ethiopia	2003–2008	Quasi-experimental	C	Health outcomes	Improve coverage of six child health practices associated with reducing child mortality	Community engagement	Community champions/ liaisons/mobilisers	Health workers, households, volunteer, health workers,
Chantler *et al*[109]	Ethiopia	2016	Qualitative (in-depth interviews and focus group discussions)	C	Health behaviour; care-seeking	Close the **immunisation** gap and improve the uptake of maternal and child health services	Community engagement	Health workers disseminate information Community meetings	Community leaders, district health officers, health workers, health managers, households, volunteer health workers, women
Karim *et al* (last 10K Ethiopia)[52]	Ethiopia	2010–2015	Cross-sectional	MN	Quality of Care	Ensure healthcare services are responsive to individual and community needs	Community engagement	Health workers disseminate information	Health workers, volunteer health workers, women

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Table 2 Continued

Author, year (project)	Country	Years of study	Study design	RMNCH target audience	Purpose (categories)	'Community Blank' purpose statement	Term used	Activities/components of 'Community *Blank*'	Involved actors
Wereta *et al* (Last 10K Ethiopia)[53]	Ethiopia	2010–2015	Propensity Score analysis	MN	Quality of Care	Improve household and provider healthcare behaviours and practices	Participatory Community Quality Improvement (PCQI)	PCQI Cycle	Community members, health workers, women
Alhassan *et al*[88]	Ghana	2012–2014	Cluster RCT	MC	Health outcomes	Improve the quality of maternal and child care	Systematic community engagement	Community scorecards/ report cards	Community members, community groups, health facility management
Anie *et al*[89]	Ghana	2013–2015	Qualitative (interviews, workshop observations)	NC	Knowledge	Consult stakeholders (leaders and community) to improve knowledge base used to develop a **sickle cell** counselling programme	Community engagement	Stakeholder meetings	Community leaders, sickle cell community
Atinga *et al*[96]	Ghana	2015	Mixed methods: quantitative (cross-sectional survey) and qualitative (in-depth interviews and focus group discussions)	RMCH	Care-seeking	Disseminate information and encourage participation in Ghana's community-based health planning and service (CHPS) programme implementation	Social mobilisation	Recurring group meetings and discussions	Community members, district health managers, health workers, men, women
Awoonor-Williams *et al*[97]	Ghana	1994–2012	Qualitative (interviews)	RMNC	Service delivery	Encourage participation to implement CHPS	(1) Community engagement	Volunteers contribute to service provision	Academia, community members, local and regional health authorities, health workers community members, volunteers
							(2) Social engagement	Community dialogues Local leader sensitisation Meetings	
Blake *et al*[105]	Ghana	2014–2015	Mixed methods: quantitative (facility assessments) and qualitative (prospective policy study)	MN	Care-seeking	Assess and improve maternal and newborn health services	Social accountability	Community scorecards/ report cards	Community members, health workers, health authorities, women
Cofie *et al*[112]	Ghana	Not stated	Qualitative (in-depth interviews)	MC	Quality of Care	Raise community awareness about maternal and child health services and to cultivate community involvement in quality improvement activities	Community outreach	Health workers delivering services Awareness/communication activities Community meetings Local leader sensitisation Meetings	Health workers, volunteer health workers, traditional birth attendants, health facility managers, community leaders, community members, women
Hellerinġer *et al*[137]	Ghana	2011–2013	Quantitative	C	Service delivery	Engage community volunteers to collect vital data records	Community engagement	Community meetings Leaders conduct tasks	Volunteer health worker, community leaders

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Table 2 Continued

Author, year (project)	Country	Years of study	Study design	RMNCH target audience	Purpose (categories)	'Community Blank' purpose statement	Term used	Activities/components of 'Community *Blank*'	Involved actors
Patel *et al*[173]	Ghana	2013–2015	Mixed methods: quantitative (health indicators, surveys) and qualitative (systems appraisal)	M	Care-seeking	Increase capacity in the community to recognise signs and symptoms of emergencies, encourage prompt decision making to seek care, and increase use of an emergency motorbike' referral programme	Community engagement	Participatory planning group Awareness/communication activities	Community leaders, community members, volunteer health workers (ambulance drivers), women
Sakeah *et al*[182]	Ghana	2012–2013	Qualitative (in-depth interviews)	MN	Health outcomes	Promote primary healthcare in rural communities and increase access to healthcare and family planning services	Community participation	Awareness/communication activities Community clinic management Training health workers (clinical) Leaders conduct tasks	Community leaders, community members, health workers, traditional birth attendants, volunteer health workers, women
Gisore *et al*[130]	Kenya	2009–2010	Cross-sectional survey	MN	Care-seeking	Identify resources and solutions within the community to improve maternal and neonatal mortality, with special emphasis on pregnant women and their families	Community mobilisation	Village/community health committees Maternal death review and response	Health workers, volunteer health workers, women
Gitaka *et al*[131]	Kenya	2015–2018	Quasi-experimental	N	Health outcomes	Sensitise community members especially mothers of newborns of improved facilities within their locality	Community engagement	Awareness/communication activities	Community members, health workers, women
Mochache *et al*[161]	Kenya	2013–2015	Pre/postintervention	MNC	Care-seeking	Enhance uptake of select maternal and child health services among women of reproductive age.	(1) Community participation	Local leader sensitisation meetings	Volunteer health workers, women
							(2) Community engagement	Community dialogues	
Turan *et al*[193]	Kenya	2010–2012	Qualitative (in-depth interviews and focus group discussions)	M	Health outcomes	Prevent and mitigate of the effects of **GBV** among pregnant women	Community mobilisation	Volunteers contribute to service provision Training health workers (clinical) Community meetings	Community leaders, health workers, volunteer health workers, women experiencing GBV
Undie *et al* (COMMPAC)[51]	Kenya	2010–2011	Quasi-experimental	R	Care-seeking	Raise awareness of family planning and early pregnancy bleeding	Community mobilisation	Community action cycle	Health authorities, health workers, women

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Table 2 Continued

Author, year (project)	Country	Years of study	Study design	RMNCH target audience	Purpose (categories)	'Community Blank' purpose statement	Term used	Activities/components of 'Community *Blank*'	Involved actors
Undie *et al* COMMPAC)[50]	Uganda	2010–2012	Qualitative (in-depth interviews and focus group discussions)	R	Care-seeking	Increase demand for postabortion care	(1) Community engagement	Community action cycle	Adolescents, community groups, district health team, health workers, marginalised groups; disabled, people living with HIV, men, women
							(2) Community mobilisation	Community meetings	
Lori *et al*[153]	Liberia	2017–2018	Mixed methods: qualitative (in-depth interviews and focus group discussions) and quantitative (GIS data and logbook reviews)	MN	Care-seeking	Scaling up maternity waiting homes	Community engagement	Leaders conduct tasks Awareness/communication activities	Community leaders, community members, health workers, district health team, traditional birth attendants, men, women
Bayley *et al*[100]	Malawi	2011–2012	Mixed methods: surveys included quantitative and qualitative data collection	M	Health outcomes	Identify and review maternal deaths and prevent future deaths	Community mobilisation	Maternal death review and response Community meetings Leaders conduct tasks Awareness/communication activities Mobile clinic Community funds/donations Youth club Peer support Health facility committee	Community members, health workers, health facility committee
Butler *et al*[106]	Malawi	Not stated	Political economy analysis	RMNC	Health outcomes	Support citizens to engage in discussions with district government political and administrative actors	Social accountability	Community dialogues	Community leaders, community members, local authorities, women
Chimpololo and Burrowes[110]	Malawi	2017–2018	Mixed methods: quantitative (questionnaire surveys) and qualitative (in-depth interviews)	NC	Health behaviour; knowledge	Sharing health information related to the eradication of polio, routine **immunisation**, and the control of measles and neonatal tetanus	Social mobilisation plus community mobilisation	Awareness/communication activities Community meetings	Community groups, community members, NGO staff, volunteer health workers
Colbourn *et al*[113]	Malawi	2007–2010	Cluster RCT	MN	Health outcomes	Identify and prioritise maternal and neonatal health problems, decide on local solutions, advocate for, implement and evaluate such strategies	Community mobilisation	Recurring group meetings and discussions	Facilitator (peer), women

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Author, year (project)	Country	Years of study	Study design	RMNCH target audience	Purpose (categories)	'Community Blank' purpose statement	Term used	Activities/components of 'Community *Blank*'	Involved actors
Gullo *et al* (CARE Malawi)[40]	Malawi	2012–2014	Cluster RCT	R	Health outcomes	Improve maternal and reproductive health-related outcomes, such as family planning, antenatal and postnatal care service utilisation, and satisfaction with service	Social accountability	Community scorecards/ report cards	Community members, facilitators, health authorities, women
Gullo *et al* (CARE Malawi)[41]	Malawi	2012–2014	Cluster RCT	R	Health outcomes	Improve maternal and reproductive health-related outcomes—family planning, antenatal and postnatal care service utilisation, and satisfaction with service	Social accountability	Community scorecards/ report cards	Community members, local authorities, women
Gullo *et al* (CARE Malawi)[42]	Malawi	2012–2014	Cross-sectional survey	R	Health outcomes	Improve maternal and reproductive health-related outcomes—family planning, antenatal and postnatal care service utilisation, and satisfaction with service	Social accountability	Community scorecards/ report cards	Health workers, women
Kays *et al*[147]	Malawi	2018–2019	Mixed methods: quantitative (prepost cross-sectional surveys) and qualitative (focus group discussions)	MN	Care-seeking; quality of care	Engage CHWs and clients of **PMTCT** clinical services to identify and solve PMTCT-related issues	Community engagement	Community scorecards/ report cards	Health workers, women (HIV+), women
Kululanga *et al*[150]	Malawi	2011	Qualitative (in-depth interviews)	M	Health outcomes	Encourage husband participation in maternal healthcare	Community mobilisation	Peer support Awareness/communication activities Leaders conduct tasks	Community leaders, health workers, households, men, women
Lewycka *et al* (MaiMwana)[59]	Malawi	2010-?	Cluster RCT	MNC	Health outcomes	Engage women in participatory learning and action cycles to improve maternal, newborn and child health	Community mobilisation	Recurring group meetings and discussions	Health workers, facilitator (peer), women
Lewycka *et al*, 2013 (MaiMwana)[58]	Malawi	2005–2009	Cluster RCT	MNC	Health outcomes; health behaviour	Engage women in participatory learning and action cycles to improve maternal, newborn and child health	Community mobilisation	Recurring group meetings and discussions Peer support	Health workers, facilitator (peer), women

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Rosato *et al* (MaiMwana)[54]	Malawi	2005–2006	Qualitative (in-depth interviews and focus group discussions)	M	Health outcomes	Engage women in participatory and learning cycles to increase knowledge and care-seeking	Community mobilisation	Recurring group meetings and discussions	Facilitator (peer), women
Rosato *et al* (MaiMwana)[55]	Malawi	Not stated	Qualitative (in-depth interviews and focus group discussions)	NC	Health outcomes	Engage women in participatory and learning cycles to increase knowledge and implement activities to improve health	Community mobilisation	Recurring group meetings and discussions	Facilitator (peer), women,
Rosato *et al* (MaiMwana)[56]	Malawi	2005–2010	Cluster RCT	MNC	Health outcomes	Engage women in participatory and learning cycles to increase knowledge and implement activities to improve health	Community mobilisation	Recurring group meetings and discussions	Facilitator (peer), women
Rosato *et al* (MaiMwana)[57]	Malawi	2009–2010	Mixed methods: quantitative (survey) and qualitative (in-depth interviews and focus group discussions)	MNC	Health outcomes	Engage women in participatory and learning cycles to increase knowledge and implement activities to improve health	Community mobilisation	Recurring group meetings and discussions	Facilitator (peer), women
UNFPA[206]	Malawi	2015	Grey literature (report)	R	Quality of Care	Strengthen linkages between sexual/ reproductive health and HIV services	Community engagement	Recurring group meetings and discussions Village/community health committees	Adolescents, community leaders, community members, health facility committees
Akamike *et al*[86]	Nigeria	Not stated	Quasi-experimental	R	Knowledge; care-seeking	Raise awareness, approval and use of **family planning** among women of reproductive age	Community mobilisation	Awareness/communication activities Community meetings	Community leaders, women
Cannon *et al*[107]	Nigeria	2009–2015	Qualitative (key informant interviews and focus group discussions)	MN	Health outcomes	Increase use of misoprostol (for PPH) and chlorohexidine (umbilical cord care)	Community engagement	Local leader sensitisation meetings Community meetings	Community group, community leaders, women
Eze *et al*[124]	Nigeria	2018–2019	Pre/post intervention	M	Knowledge	Improve birth preparedness and complication readiness	Community-participatory behavioural change intervention	Training health workers (clinical) Stakeholder meetings Savings groups/schemes Awareness/communication activities	Community members, health workers, women

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Author, year (project)	Country	Years of study	Study design	RMNCH target audience	Purpose (categories)	'Community Blank' purpose statement	Term used	Activities/components of 'Community *Blank*'	Involved actors
Findley *et al*[125]	Nigeria	2009–2011	Cluster household surveys	MNC	Knowledge; health behaviours; health outcomes	Increase awareness knowledge, and practices of healthy behaviours and respond to financial and transportation barriers to care-seeking	Community engagement	Recurring group meetings and discussions	Health workers, households, volunteer health workers, women
Hammanyero *et al*[134]	Nigeria	2014–2015	Qualitative descriptive, retrospective study	C	Knowledge; health behaviour	Increase **immunisation** coverage	Community engagement	Local leader sensitisation meetings Community meetings Community volunteers share information	Community leader, community members, women
Ogbuabor and Onwujekwe[168]	Nigeria	2015	Qualitative (in-depth interviews, focus group discussions and document analysis)	MC	Care-seeking; health outcomes	Monitoring/maintaining logistics and resources as well as raise awareness among community.	Social accountability	Health facility committee	Adolescents, decision makers, community members, health facility management committee, health authorities, health workers, local authorities, people living with HIV, people living with disabilities, service users
Prata *et al*[176]	Nigeria	2009	Qualitative (interviews)	M	Health outcomes; health behaviour	Increase uptake of misoprostol to prevent postpartum haemorrhage	Community mobilisation	Awareness/communication activities Health workers disseminate information Volunteers contribute to service provision	Health workers, households, traditional birth attendants, women
Slemming, Drysdale and Richter[188]	South Africa	2018–2020	RCT	MN	Health outcomes	Increase care-seeking for ANC/ultrasounds	Stakeholder engagement	Father Invitation Stakeholder meetings	Academia, CSOs, decision makers, district health managers, health workers, men, multilateral organisations, women
Sami *et al*[183]	South Sudan	2016	Mixed methods case study	N	Service delivery	Overcome personal beliefs regarding newborn cord care.	Community engagement	Awareness/communication activities Community volunteers share information	Adults in displaced person camps, women
Ahluwalia *et al*[85]	Tanzania	1997–2001	Qualitative (focus group discussions and programme data)	M	Health outcomes	Discuss, refine and implement transportation and volunteer health workers support plans for their communities	Community mobilisation	Local leader sensitisation meetings Community meetings	Women, community members, community leaders, health workers, NGO staff

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Miltenburg *et al*[160]	Tanzania	2014–2016	Mixed methods: quantitative (programme data) and qualitative (programme data, Interviews, focus group discussions)	M	Care-seeking	Improve rural maternal health	Community participation	Recurring group meetings and discussions	Community groups members, women
Lauria *et al*[151]	Togo	exp 2018–2022	Mixed methods: quantitative (type II hybrid effectiveness-implementation study (stepped-wedge cluster RCT)) and qualitative (key informant interviews)	MC	Care-seeking, health outcomes	Solicit community feedback on implementation challenges, successes and areas for improvement	Community engagement	Community meetings Local leader sensitisation meetings Health worker recruitment	Health workers, community leaders, community members, women
Apolot *et al*[90]	Uganda	2018	Qualitative (in-depth interviews)	MN	Knowledge; service delivery	Improve maternal and newborn health service utilisation and delivery	Social accountability	Community scorecards/ report cards	Adolescents, community members, health facility management
Ediau *et al*[121]	Uganda	2010–2011	Quantitative data analysis	MN	Care-seeking; service delivery	Increase demand for and utilisation of services as well as address quality gaps at a health centre	Community mobilisation plus sensitisation	Village health teams Awareness/communication activities Male group sessions/ husbands forums	Village health teams, men, women
Ekirapa-Kiracho *et al*[122]	Uganda	2013–2015	Quasi-experimental	MN	Care-seeking	Increase utilisation of maternal and newborn services and care practices	Community mobilisation plus empowerment	Health workers disseminate information Awareness/communication activities Savings groups/schemes Partnerships/networks	Business (transport providers), village health team, women
Ekirapa-Kiracho *et al*[123]	Uganda	2017–2018	Mixed methods: quantitative (ANOVA tests run on meeting scores) and qualitative (in-depth interviews and focus group discussions)	MN	Health outcomes, quality of care	Increase utilisation of maternal and newborn services and care practices	Social accountability	Community scorecards/ report cards	Academia, community leaders, community members, district health team, health workers, health facility management, local authorities, women
Katahoire *et al* (CODES)[47]	Uganda	2011–2013	Qualitative (in-depth interviews)	C	Health outcomes	Engage communities and district managers in a common quest to solve local bottlenecks and fostered demand for health service	Community empowerment	U-report and citizen reports Community dialogues Village/community health committees	Community leaders, community members, district health team, health workers

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Muhwezi *et al* (CODES)[49]	Uganda	2012–2016	**Not stated**	C	Care-seeking; service delivery	Promote dialogue between healthcare providers and community members on improving quality of care in family planning and contraception provision	Community mobilisation	Awareness/communication activities U-report and citizen reports Community dialogues	Community leaders, community members, district health teams, health workers
Waiswa *et al* (CODES)[48]	Uganda	2013–2016	RCT	C	Health outcomes; quality of care	Engage communities and district managers in a common quest to solve local bottlenecks and fostered demand for health service	(1) Community participation	Community dialogues Awareness/communication activities	Community leaders, community members, district health teams, health workers
							(2) Community engagement	Community scorecards/ report cards Community dialogues	
Mburu, Iorpenda and Muwanga[157]	Uganda	2006–2009	Retrospective document review	MN	Health outcomes	Reduce the vertical transmission of HIV	Community engagement plus mobilisation	Community volunteers share information Partnerships/networks	Community members, people living with HIV, volunteer peer support workers, women
Mugisa and Muzoora[164]	Uganda	2007–2010	Cross-sectional	MC	Health behaviour	Promote malaria prevention approaches involving use of insecticide treated nets and environment management	Community participation	Community meetings Community volunteers share information Health workers disseminate information Awareness/communication activities	Community groups community members, health workers, women
Ssebagereka *et al*[189]	Uganda	2017–2018	Costing analysis	MN	Care-seeking, quality of care	Foster accountability, utilisation and quality of maternal and child healthcare service	(1) Community mobilisation	Awareness/communication activities	Community leaders, facilitators, decision makers, health facility management, local authorities, women
							(2) Social accountability	Community scorecards/ report cards	
Beck[198]	Zambia	2015–2018	Grey literature (PhD dissertation)	MN	Care-seeking; health outcomes	Increase use of health facilities for delivery	Community mobilisation	Community meetings Local leader sensitisation meetings Steering committee Income generating system	Community leaders, community members, health workers, women
Gill *et al*[129]	Zambia	2006–2008	Case study	N	Knowledge, quality of care	Raise community awareness about newborn survival	Community mobilisation	Community meetings	Community leaders, community members, health workers, traditional birth attendants, men, women
Jacobs *et al*[142]	Zambia	2012–2015	Cross-sectional survey	MN	Care-seeking	Overcome barriers faced by mothers particularly in poor and remote communities and provide hope for neonatal and maternal survival	Community engagement	Safe motherhood action groups	Community groups, traditional birth attendants, health workers, volunteer health workers, women

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Munakampe *et al*[165]	Zambia	Not stated	Qualitative (focus group discussions and observations)	R	Health behaviour; quality of care	Promote dialogue between healthcare providers and community members on improving quality of care in **family planning** and contraception provision	Community participation	Community dialogues	Community members, health workers, teachers, NGO staff, women
Muzyamba *et al*[166]	Zambia	2016	Qualitative (focus group discussions)	M	Care-seeking	Increase care-seeking for **HIV-positive** pregnant women	Community mobilisation	Peer support Establishing partnerships/ networks Volunteers contribute to service provision	Community members, health workers, traditional birth attendants, women
Wilbroad *et al*[196]	Zambia	2014	Qualitative (community conversations)	MN	Care-seeking	Engage communities in maternal and newborn health discussions with the aim of developing community-generated interventions	Community engagement	Community dialogues	Facilitator, community members, women
Chittambo, Smith and Ehlers[111]	Zimbabwe	Not stated	Quantitative, nonexperimental, descriptive exploratory research design	M	Care-seeking	Increase women's participation in ANC	Community participation	Village/community health committees	Women, health worker, women
Skovdal *et al*[187]	Zimbabwe	2011–2012	Qualitative (in-depth interviews and focus group discussions)	RMNC	Health outcomes	Solicit community feedback on a cash transfer programme	Community participation	Leaders conduct tasks Community meetings Community committees	Community group, community leaders, community members
Besada *et al*[102]	Uganda, Democratic Republic of Congo, Malawi, and Cote d'Ivoire	2015	Qualitative (in-depth interviews and focus group discussions)	MN	Care-seeking	Increase male partner involvement in PMTCT services	Social mobilisation	Health workers disseminate information Community dialogues Awareness/communication activities Male group sessions/ husbands forums Local leader sensitisation meetings Peer support	Community members, decision makers, health workers, volunteers, households, women
Magge *et al*[155]	Ghana, Mozambique, Rwanda, Tanzania, and Zambia	2011–2015	Case studies	N	Health outcomes	Improve newborn health	Community mobilisation	Community volunteers share information Safe motherhood action groups Training health workers (clinical)	Community groups, health workers, women
Martin *et al*[156]	Zambia, Mozambique and Uganda	Not stated	Qualitative (key informant interviews and focus group discussions)	CH	Care-seeking	Increase communities and caregiver demand for, utilisation of, and support to the newly introduced iCCM services	Community engagement	Community dialogues	Community leaders, facilitators (peers), health workers, households

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Crankshaw *et al*[115]	Kenya, South Africa, Zambia	2015-?	Qualitative (focus group discussions)	R	Knowledge; care-seeking	Engage community dialogues to increase use of **family planning**	Community engagement	Community dialogues	Community members, health authorities, men, women
Kallander *et al*[145]	Uganda, Mozambique	2011–2015	Cluster RCT	C	Health outcomes	Increase CHW supervision and performance on the coverage of appropriate treatment for children with diarrhoea, pneumonia and malaria	Participatory Community engagement	Village health clubs	Community groups, health workers
Serbanescu *et al*[185]	Zambia and Uganda	2011–2017	Mixed methods: quantitative (population data and health facility data) and qualitative (documents/ programme reports)	M	Knowledge; care-seeking	Reduce deaths related to pregnancy and childbirth by targeting the three delays to care-seeking	Community engagement	Health workers disseminate information Community dialogues Safe motherhood action groups	Community groups, community leaders, health workers, men, women
Sharkey *et al*[186]	Niger and Mozambique	2011–2014	Case study	C	Care-seeking	Generate demand for integrated community case management	(1) Social mobilisation	Awareness/communication activities Partnerships/networks	Adolescents, community leaders, women
							(2) Community engagement	Awareness/communication activities Community dialogues Village/community health committees	
Woelk *et al*[197]	Swaziland, Uganda and Zimbabwe	Not stated	RCT	MN	Care-seeking	Increase demand for, uptake of, and retention of HIV-positive pregnant/postpartum women in maternal health/**PMTCT** services	Community leader engagement	Leaders conduct tasks Community dialogues Peer support	Community groups, community leaders, health workers, women (HIV+)
Americas									
Bhagat *et al*[103]	Canada	Not stated	Case study	M	Care-seeking	Improve the health of pregnant women	Community mobilisation	Awareness/communication activities Recurring group meetings and discussions	Health facility management, health workers, households, women
Cravioto Meneses[116]	Mexico	1997–?	Case study	RMNC	Health outcomes	Incorporate community members into health programme implementation, specifically facility construction activities	Community participation	Volunteers contribute to service provision	Community members, decision makers, volunteers, health workers
Campbell Erwin *et al*7[199]	USA	2015	Grey literature (report)	N	Health outcomes	Motivate community action on neonatal abstinence syndrome	Community engagement	Village/community health committees Stakeholder meetings	Community members, health authorities

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Cotton *et al*[114]	USA	2012–2014	Case study	NC	Health outcomes; knowledge	Bring awareness to the issue of infant mortality and resources in the community to support families.	Community engagement	Awareness/communication activities Community volunteers share information	Academia, households
Darnell *et al*[117]	USA	1997–2004	Case study	N	Health outcomes	Improve targeted indicators of child and family well-being such as low infant birth weight, teen pregnancy, high school graduation and unemployment	Community collaboration	Community committees	Businesses, community leaders, community members, decision makers, faith-based organisations, households, local authorities
Detres, Lucio, and Vitucci[118]	USA	2007–2011	Case study	NC	Health outcomes	Develop strategies for the local service delivery plan	Community participation	Stakeholder meetings	Business, community leaders, community members, district health team officials
Jackson *et al*[141]	USA	Not stated	Case study	MNC	Health outcomes	Advance social justice and equity for African-American birth outcomes	Community engagement	Photovoice Stakeholder meetings	Champions, community members, health providers, local authorities—education, housing, employment, social service, faith-based organisation, men, women
Konrad *et al*[149]	USA	Not stated	Case study	NC	Health outcomes	Implement evidence-based practices through local, faith-based ministries to reduce infant mortality, and improve the health and well-being of African-American women, encourage husband participation in maternal healthcare	Community engagement	Recurring group meetings and discussions	Academia, community groups, local authorities, marginalised groups (African-American, Hispanic communities)
McFarlane *et al*[158]	USA	Not stated	Case study	MNC	Care-seeking; health outcomes	Implement a peer support programme	Community empowerment	Peer support Community committees	Business, health workers, schools, decision makers, local authorities, volunteer peer support workers, women
Patel *et al*[172]	USA	2016–2020	Mixed methods evaluation	MN	Care-seeking; health outcomes	Solicit community input to refine strategies for prenatal care	Community engagement	Stakeholder meetings	Academia, community groups, community leaders, community members, health providers, health authorities, local authorities, women

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Pestronk *et al*[175]	USA	1998–2001	Case study	N	Knowledge; care-seeking	Engage dialogue about the causes of, and potential solutions to, infant mortality	Community mobilisation	Community dialogues Awareness/communication activities Mentorship	Adolescents, community leaders, community members, health workers
Vargas *et al*[195]	USA	2006–2010	Case study	C	Knowledge	Connecting clinical providers with families with children of **disabilities** to improve understanding of challenges and care needs	Community engagement	Stakeholder meetings Steering committee	Community members, health workers, households (with children with disabilities), local authorities
Harkins *et al*[136]	Peru and Honduras	2001–2005	Baseline/endline surveys	C	Knowledge; care-seeking; health behaviour	Reduce deaths due to pneumonia, malaria and diarrhoea	Social mobilisation	Community meetings Community volunteers share information Public events Awareness/communication activities	Community groups, faith-based organisations, health workers, local and regional authorities, teachers, volunteer health workers
Eastern-Mediterranean									
Hoodbhoy *et al* (CLIP)[46]	Pakistan	2014–2016	Cluster RCT	M	Knowledge	Improve birth preparedness and complication readiness and pregnant women's knowledge about pre-eclampsia	Community engagement	Stakeholder meetings Health workers disseminate information	Health workers, men, women
Qureshi *et al* (CLIP)[43]	Pakistan	2014–2016	Cluster RCT	MN	Knowledge	Raise awareness of, and education about, general pregnancy risks and, specifically, pregnancy hypertension	Community engagement	Local leader sensitisation meetings Health workers disseminate information	Health workers, women
Bhutta *et al* (WHO-Aga Khan)[81]	Pakistan	2003–2005	Cluster RCT	MN	Care-seeking	Improve perinatal care	Community mobilisation	Village/community health committees Community meetings	Health workers, traditional birth attendant, women
Bhutta *et al* (WHO-Aga Khan)[82]	Pakistan	2006–2008	Cluster RCT	MN	Care-seeking	Promote maternal and newborn health and reduce perinatal and newborn mortality	Community mobilisation plus organisation	Health workers disseminate information Village/community health committees Leaders conduct tasks	Health workers, traditional birth attendant, women
Akhtar[87]	Pakistan	2011	Qualitative (in-depth interviews and focus group discussions)	MNC	Health outcomes	Create awareness on public health matters	Community participation	Awareness/communication activities	Champions, health authorities, health workers, households, women
Ariff *et al*[92]	Pakistan	2019–2021	Cluster RCT	N	Health outcomes	Reduce neonatal mortality among preterm and low-birthweight infants	Community mobilisation	Recurring group meetings and discussions Community volunteers share information	Champions, households, volunteer health workers

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Gine, Khalid and Mansuri[200]	Pakistan	Not stated	Grey literature (working paper)	RMNC	Care-seeking	Encourage self-help and collective action within the community as well as better linkages with government authorities	Social mobilisation plus community mobilisation	Village/community health committees	Community members, local authorities
Habib *et al*[132]	Pakistan	2013–2014	Cluster RCT	C	Health behaviour	Increase maternal and child health immunisation in insecure and conflict-affected polio-endemic districts	Community mobilisation	Awareness/communication activities One-to-one sessions Recurring group meetings and discussions Local leader sensitisation meetings	Community leaders, community members, women
Memon *et al*[159]	Pakistan	2002–2003	Quasi-experimental	MN	Care-seeking; Health behaviour; Health outcomes	Increase knowledge and awareness of maternal and newborn healthcare practices	Community mobilisation plus education	Village/community health committees Recurring group meetings and discussions	Health workers, community members, women
Only *et al*[169]	Pakistan	2014–2017	Baseline/endline surveys	MNC	Care-seeking	Promote awareness and assist with health campaigns and referrals to the health centre	Community engagement	Village/community health committees	Community members, women
Sadruddin *et al*[181]	Pakistan	2008–2009	Cross-sectional: pre/postintervention surveys	C	Care-seeking	Increase the number of children receiving treatment for pneumonia and severe pneumonia	Community mobilisation	Local leader sensitisation meetings Village/community health committees Community meetings Health workers disseminate information	Community leaders, health workers, local authorities, volunteer health workers, teachers
Turab et al[192]	Pakistan	Protocol—TBD	Cluster RCT	MN	Knowledge	Create awareness and promote maternal, neonatal and child health in the community at household level	Community mobilisation	Awareness/communication activities Community funds/donations	Health workers, households, men, women
Europe									
Tavadze, Bartel and Rubardt[190]	Georgia	2004-?	Mixed methods: quantitative (surveys) and qualitative (in-depth interviews and focus group discussions)	R	Health behaviour; knowledge	Address individual behaviour change, institutional capacity and local social norms to improve adolescent reproductive health	(1) Community engagement.	Awareness/communication activities Community volunteers share information	Adolescents, community members, health workers
							(2) Community mobilisation	Community action cycle Community volunteers share information	
Turan et al[194]	Turkey	1997	Case study	MN	Care-seeking	Improve perinatal health	Community participation	Community meetings Recurring group meetings and discussions	Community members, community leaders, health authorities, health workers, men, pharmacists, local leaders, women

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South-East Asia									
Kim *et al* (Alive and Thrive)[35]	Bangladesh	2016	Cluster RCT	NC	Knowledge	Improve IYCF knowledge and practices	Community mobilisation	Awareness/communication activities	Households
Nguyen *et al* (Alive and Thrive)[36]	Bangladesh	2015–2016	Cluster RCT	MNC	Knowledge	Increase coverage of nutrition interventions, maternal dietary diversity, micronutrient supplement intake and early breast feeding	Community mobilisation	Awareness/communication activities Male group sessions/ husbands forums	Men, women
Afsana, (BRAC)[38]	Bangladesh	2005–2012	Grey literature	MN	Knowledge; health outcomes	Create awareness among the community of maternal and newborn health and act at both individual and collective levels to bring about change in people's practices	Community engagement	Health workers disseminate information Village/community health committees Awareness/communication activities Stakeholder meetings Public events	Champions, community members, health workers, local authorities
Marcil, Afsana and and Perry (BRAC)[39]	Bangladesh	2013–?	Qualitative (key informant interviews, observations, and document analysis)	MNC	Health outcomes	Establish a relationship with communities in order to enable effective scaling up of future health initiatives	Community engagement	Local leader sensitisation meetings Village/community health committees Incorporate community feedback Volunteers contribute to service provision	Community members, NGO staff, women
Azad *et al* (UCL-BADAS)[72]	Bangladesh	2005–2007	Cluster RCT	MNC	Health outcomes	Activate and strengthen women's groups to support them in identifying and prioritising maternal and neonatal problems, to help to identify possible strategies, and to support the planning, implementation, and monitoring of strategies in the community	Community mobilisation	Recurring group meetings and discussions	Facilitator (peer), women
Fottrell *et al* (UCL-BADAS)[74]	Bangladesh	2009–2011	Cluster RCT	N	Health outcomes	Improve newborn survival	Community mobilisation	Recurring group meetings and discussions	Facilitator (peer), women
Fottrell *et al*, (UCL-BADAS)[75]	Bangladesh	2008–2012	Cross-sectional survey	MNC	Health outcomes	Improve child growth	Community mobilisation	Recurring group meetings and discussions	Facilitator (peer), women
Harris-Fry *et al* (UCL-BADAS)[71]	Bangladesh	2011–2013	Cluster RCT	RM	Health behaviour, health outcomes	Priorities health problems and develop action plans to respond	Community mobilisation	Recurring group meetings and discussions	Facilitators (peer), women
Houweling *et al* (UCL-BADAS)[69]	Bangladesh	exp. 2009–2011	Cluster RCT	MN	Health outcomes	Engage women in participatory learning and action	Community mobilisation	Recurring group meetings and discussions	Facilitator (paid), women

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Younes *et al* (UCL-BADAS)[76]	Bangladesh	exp 2009–2010	Quasi-experimental	MN	Health outcomes	Engage women in participatory and learning cycles to increase knowledge and care-seeking	Community mobilisation	Recurring group meetings and discussions	Facilitator, women
Younes *et al* (UCL-BADAS)[77]	Bangladesh	2010–2012	Quasi-experimental	NC	Knowledge; care-seeking; health outcomes	Engage women in participatory and learning cycles to increase knowledge and care-seeking	Community mobilisation	Recurring group meetings and discussions	Facilitator, community members, women
Baqui *et al*[99]	Bangladesh	2003–2006	Cluster RCT	N	Care-seeking; health outcomes	Improve postnatal care practices	Community mobilisation plus behaviour-change communication	Training health workers (clinical) Community meetings Local leader sensitisation meetings Volunteers contribute to service provision	Community leaders, health workers, men, women
Hanifi *et al*[135]	Bangladesh	2017–2018	Mixed methods: quantitative (questionnaires) and qualitative (in-depth interviews and focus group discussions)	RMNC	Care-seeking	Increase utilisation of basic health services	Social accountability	Community scorecards/report cards	Community members, health workers, local authorities,
Hossain and Ross[138]	Bangladesh	1998–2001	**Not stated**	M	Care-seeking, quality of care	Increase utilisation of EmOC services	Community mobilisation	Awareness/communication activities Health workers disseminate information Community volunteers share information Recurring group meetings and discussions Community meetings Community support systems	Community leaders, health workers, NGO staff, men, women
Islam, Islam, and Khan[140]	Bangladesh	Not stated	Qualitative (focus group discussions and observations)	R	Knowledge; service delivery	Increase **family planning**	Community participation	Village/community health committees Health workers disseminate information Community volunteers share information Stakeholder meetings	Service users, community leaders, health workers, volunteer health workers, local authorities, community members, women, men
Kamiya, Yoshimura, and Islam[146]	Bangladesh	2008–2009	Quasi-experimental	M	Knowledge; care-seeking	Improve women's access to and knowledge of maternal healthcare during pregnancy and childbirth	Community mobilisation	Self-help groups	Households, community groups, households, NGO staff, women

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Table 2 Continued

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Riaz *et al*[179]	Bangladesh	Not stated	Cross-sectional	RMNC	Health outcomes	Improve the health of women (reduce maternal mortality) through the proper management of pregnant women	Community participation	Community clinic management	Community members, health providers
Tobe *et al*[191]	Bangladesh	2011–2015	Cluster RCT	MN	Health outcomes, care-seeking	Increase utilisation of maternal and neonatal care provided by skilled providers and qualified facilities	Community mobilisation	Community dialogues Social/resource mapping Advocacy/planning meetings Community support systems	Adolescents, elders, community leaders, community members, freedom fighters, local authorities, persons with disability, women
Nguyen *et al* (Alive and Thrive)[37]	India	2017–2019	Cluster RCT	MNC	Knowledge	Increase coverage of nutrition interventions and maternal nutrition practices	Community mobilisation	Awareness/communication activities Male group sessions/ husbands forums	Community groups, community leaders, health workers, households, men, women
Bellad *et al* (CLIP)[44]	India	2014–2016	Cluster RCT	M	Knowledge	Reduce adverse pregnancy outcomes related to delays in triage, transport and treatment	Community engagement	Community meetings Health workers disseminate information	Community leaders, health workers, households, men, women
Hazra *et al* (Population Council India)[65]	India	2015–2017	Quasi-experimental	MN	Knowledge; care-seeking; health behaviour	Improve maternal and newborn health behaviours	Community mobilisation	Self-help groups Health workers disseminate information Community meetings Public events Awareness/communication activities	Community group, women
Saggurti *et al* (Population Council India)[66]	India	2013–2014	Quasi-experimental	MNC	Health outcomes	Engage women in participatory and learning cycles to increase knowledge and home care practices	Community mobilisation	Self-help groups	Facilitators, women
More *et al*, 2008 (SNEHA UCL Institute of Child Health)[67]	India	exp 2008–2011	Cluster RCT	N	Health outcomes	Engage women in participatory learning and action cycles to increase knowledge and care-seeking	Community mobilisation	Recurring group meetings and discussions	Community groups, community members, facilitator, women
More *et al* (SNEHA UCL Institute of Child Health)[68]	India	2006–2009	Cluster RCT	MN	Health outcomes	Engage women in participatory learning and action cycles to increase knowledge and care-seeking	Community mobilisation	Recurring group meetings and discussions	Community groups, community members, facilitator, women

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Table 2 Continued

Author, year (project)	Country	Years of study	Study design	RMNCH target audience	Purpose (categories)	'Community Blank' purpose statement	Term used	Activities/components of 'Community *Blank*'	Involved actors
Nahar *et al* (UCL-BADAS)[70]	India	2009–2010	Process evaluation and population survey	MNC	Service delivery	Engage women in participatory and learning cycles to increase knowledge and care-seeking	Community engagement	Recurring group meetings and discussions	Facilitator (peer), women
Sinha *et al* (UCL India)[78]	India	2010–2012	Cost-effectiveness study	MN	Health outcomes	Engage women in participatory and learning cycles to increase knowledge and care-seeking	Community mobilisation	Recurring group meetings and discussions	Facilitator (peer), health workers, women
Tripathy *et al* (UCL India)[79]	India	2005	Cluster RCT	MN	Health outcomes	Engage women participatory and learning cycles to increase knowledge and care-seeking and community interaction with health authorities	Community mobilisation	Recurring group meetings and discussions	Community leaders, local authorities, facilitator (peer), women
Tripathy *et al* (UCL India)[80]	India	2011–2012	Cluster RCT	MN	Health outcomes	Engage women participatory and learning cycles to increase knowledge and care-seeking and community interaction with health authorities	Community mobilisation	Recurring group meetings and discussions Village/community health committees	Health workers, local authorities, facilitator (peer), women
Bhargava, Ramji, and Sachdev[104]	India	Not stated	Case study	N	Health outcomes	Identify and respond to the needs of the community in perinatal and neonatal care	Community participation	Community committees	Community members, women,
Deutsh *et al*[119]	India	Not stated	Case study	C	Health behaviour	Support polio eradication through **immunisation**	Community engagement	Public events Local leader sensitisation meetings Community volunteers share information Recurring group meetings and discussions Volunteers contribute to service provision Awareness/communication activities	Champions, community members, community leaders, households
Dongre, Deshmukh and Garg[120]	India	2004–2007	Mixed methods: quantitative (survey) and qualitative (focus group discussions)	N	Care-seeking	Promote healthcare seeking behaviour of families with sick newborns	Community mobilisation	Training health workers (clinical) Self-help groups Community committees	Community groups, health workers, households
Fullerton, Killian, and Gass[127]	India	2001–2002	Mixed methods: quantitative and qualitative (small group interviews and focus group discussions)	MN	Health outcomes	Identifying strategies to raise funds for village health groups	Community mobilisation	Village/community health committees	Community members, community groups, women

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Table 2 Continued

Author, year (project)	Country	Years of study	Study design	RMNCH target audience	Purpose (categories)	'Community Blank' purpose statement	Term used	Activities/components of 'Community *Blank*'	Involved actors
George *et al*[128]	India	2012–2015	Mixed methods: quantitative (surveys) and qualitative (key informant interviews and document analysis)	M	Care-seeking, quality of care	Increase access to facility deliveries by marginalised groups across public and private sectors	Community action	Recurring group meetings and discussions Community scorecards/ report cards Community meetings Maternal death review and response Community volunteers share information Awareness/communication activities	Community members, health authorities, health workers, NGO staff, women
Johri *et al*[143]	India	2014	Cluster RCT	C	Health behaviour	Increase child **immunisation** coverage	Community mobilisation	Awareness/communication activities Recurring group meetings and discussions	Community groups, community members, health workers
Mozumdar *et al*[163]	India	2014	Quasi-experimental	MN	Knowledge	Improve knowledge of home care	Community mobilisation	Self-help groups	Facilitator (peer), community groups, women
Murthy and Vasan[203]	India	2000–2002	Grey literature (report)	R	Knowledge; care-seeking; health outcomes	Increase community interaction with health authorities	Community Involvement	Village/community health committees	Facilitator (peer), women
Papp, Gogoi and Campbell[170]	India	Not stated	Qualitative (in-depth interviews and focus group discussions)	M	Health outcomes	Improve accountability for maternal health	Social accountability	Maternal death review and response Community meetings Health facility checklist	Decision makers, health facility management, health workers, women
Roy *et al*[180]	India	2008–2011	Cluster RCT	N	Health outcomes	Engage women in participatory and learning cycles to increase knowledge and implement activities to improve health	Community mobilisation	Recurring group meetings and discussions Community meetings	Facilitator (peer), women
Sinha[205]	India	2004–2006	Grey literature report (pre/postintervention design)	M	Knowledge	Increase demand quality pregnancy-related services and to build community support for pregnant women to access appropriate care	Community mobilisation	Community meetings Awareness/communication activities	Community group community members, women
Fratidhina *et al*[126]	Indonesia	Not stated	Mixed methods: quantitative (cross-sectional survey) and qualitative (in-depth interviews and focus group discussions)	M	Knowledge	Prevent pregnancy and labour complications	Community participation	Community meetings	Community members, women
Nobles and Frankenberg[167]	Indonesia	1997–2000	Longitudinal survey	MNC	Health outcomes	Increase mothers' participation in children's health	Community participation	Community meetings	Community groups, community members

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Table 2 Continued

Author, year (project)	Country	Years of study	Study design	RMNCH target audience	Purpose (categories)	'Community Blank' purpose statement	Term used	Activities/components of 'Community *Blank*'	Involved actors
Rasyida *et al*[177]	Indonesia	2017	Cross-sectional	R	Knowledge; service delivery	Implement a **family planning** programme	Community participation	Volunteers contribute to service provision	Community members, men, women
Gram *et al* (Makwanpur)[60]	Nepal	2014	Cohort study	M	Health outcomes	Engage women in participatory learning and action cycles to improve women's agency	Community mobilisation	Recurring group meetings and discussions	Facilitator (peer), women
Morrison *et al* (Makwanpur)[62]	Nepal	2009–2012	Cluster RCT	MN	Care-seeking	Engage women in participatory and learning cycles to increase knowledge and care-seeking and community interaction with health authorities	Community mobilisation	Recurring group meetings and discussions Village/community health committees	Health facility managers, health workers, households, volunteer health workers, women
Morrison *et al* (Makwanpur)[63]	Nepal	2009–2010	Qualitative (in-depth interviews)	MN	Care-seeking	Engage women in participatory and learning cycles to increase knowledge and care-seeking and community interaction with health authorities	Community mobilisation	Recurring group meetings and discussions Village/community health committees	Health facility managers, health workers, households, volunteer health workers, women
Morrison *et al* (Makwanpur)[64]	Nepal	2010–2012	Cluster RCT	MN	Care-seeking	Engage women in participatory and learning cycles to increase knowledge and care-seeking and community interaction with health authorities	Community participation	Recurring group meetings and discussions Village/community health committees	Volunteer health workers, women
Pant *et al* (Makwanpur)[61]	Nepal	2013–2014	Feasibility study	C	Health outcome	Implementation of a **child injury prevention** programme identified and incorporated by women's group	Community mobilisation	Recurring group meetings and discussions	Health workers (paramedic), health volunteers, women
Hamal *et al*[133]	Nepal	2016–2017	Qualitative (in-depth interviews)	M	Care-seeking	Improve maternal and newborn health service quality and use	Social accountability	Mothers groups Village/community health committees Community dialogue Community Health Score board	Community groups, health authorities, volunteers, health workers, NGO staff, women
Morrison *et al*[162]	Nepal	2019	Qualitative (in-depth interviews and focus group discussions)	MN	Care-seeking	Increase institutional deliveries and home deliveries attended by trained health workers	Community mobilisation	Recurring group meetings and discussions	Households, volunteer health workers, men, women
Saville *et al*[184]	Nepal	exp 2013–??	Cluster RCT	MNC	Health outcomes	Engage women participatory and learning cycles to increase knowledge and nutrition practices	Community mobilisation	Recurring group meetings and discussions	Facilitators, women

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Table 2 Continued

Author, year (project)	Country	Years of study	Study design	RMNCH target audience	Purpose (categories)	'Community Blank' purpose statement	Term used	Activities/components of 'Community *Blank*'	Involved actors
BADAS, Ekjut, Women and Children First (UK) and UCL (UCL-BADAS)[73]	India and Bangladesh	2004–2008	Grey literature (report)	MN	Health outcomes	Strengthen women's groups to support them in identifying and prioritising maternal and neonatal problems, to help to identify possible strategies, and to support the planning, implementation, and monitoring of strategies in the community	Community mobilisation	Recurring group meetings and discussions	Community members, facilitator (peer), health workers, women
Western Pacific									
Edward et al (World Vis Social Accountability Project)[84]	Cambodia	2013–2017	Quasi-experimental	NC	Quality of care	Enhance community governance and accountability and support to health facility performance for paediatric quality of care	Social accountability	Community scorecards/ report cards	Community members, health facility management, households
Hirayama, Oyama and Asano[201]	Japan	1989–?	Grey literature (case study)	MC	Health outcomes	Promote health and welfare, and prevent diseases for mothers and children	Community participation	Community volunteers share information Recurring group meetings and discussions	Volunteer health workers, women
Ashwell and Barclay[93]	Papua New Guinea	1998–2004	Mixed methods retrospective analysis	RMNC	Health outcomes	Strengthen rural health worker capacity to motivate communities to take responsibility for health	Community engagement	Health workers disseminate information Community capacity building	Community members, health workers, volunteers, health workers, community members, health workers
Khan *et al*[148]	Vietnam	1999–2000	**Not stated**	M	Health outcomes	Improve programme effectiveness and result in greater biological impact on the prevention of iron-deficiency anaemia	Social mobilisation	Steering committee Awareness/communication activities	Community groups, decision makers, district health team, health workers, local authorities, women
Persson *et al*[174]	Vietnam	2008–2011	Cluster RCT	MN	Quality of care	Reduce neonatal mortality through the facilitation of local maternal-and-newborn stakeholder groups	Community mobilisation	Maternal-and-newborn stakeholder groups	Champions, community groups, decision makers, facilitator (paid), health authorities, health workers, volunteer health workers, women
Ratnaike and Chinner[178]	Lao, Cambodia and Vietnam	Not stated	Case study	RMNC	Health outcomes	Establish a community health system	Community participation	Recurring group meetings and discussions	Health workers, facilitators (peer), women
Multiple country studies across regions									
Askew[94]	India, Bangladesh, Pakistan, Sri Lanka and Nepal	Not Stated	Qualitative (case study comparative analysis)	R	Knowledge; service delivery	Provide **family planning** information and services	Community participation	Community committees Health workers disseminate information	Community leaders, community members, decision makers, health authorities, men, women

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Table 2 Continued

Author, year (project)	Country	Years of study	Study design	RMNCH target audience	Purpose (categories)	'Community Blank' purpose statement	Term used	Activities/components of 'Community *Blank*'	Involved actors
Askew and Khan[95]	Bangladesh, China, the Republic of Korea, the Philippines, Thailand	1989	Qualitative (case study comparative analysis)	R	Knowledge; service delivery	Provide **family planning** information	Community participation	Community committees	Community leaders, community members, decision makers, health authorities, men, women
Bone *et al* (CLIP)[45]	India, Pakistan, Mozambique	2014–2017	Cost-effectiveness study	M	Knowledge; care-seeking	Support pre-eclampsia awareness and education around birth preparedness and complication readiness	Community engagement	Community meetings	Community members, women
Edward et al (World Vis Social Accountability Project)[83]	Cambodia, Kenya, Zambia	2013–2017	Quasi-experimental	MN	Care-seeking; service delivery	Enhance community governance and accountability and support to health facility performance for paediatric quality of care	Social accountability	Community scorecards/ report cards	Health facility management, women
Howard-Grabman[202]	Peru, Nepal, Uganda, Egypt and Pakistan.	2007	Grey literature (report)	MC	Care-seeking; health outcomes	Implement community action cycles to identify problems and actions to address the problems	Community mobilisation	Community action cycle	Community leaders, community members, family welfare assistants, health workers, women
Lewis *et al*[152]	India, Ethiopia, Angola, Nigeria and Kenya	2018–2019	Case study	C	Health behaviour	Increase polio and routine **immunisation** through volunteers called community mobilisers	(1) Community mobilisation	Community volunteers share information Recurring group meetings and discussions Community meetings Leaders conduct tasks	Community leaders, community members, health workers, volunteers
							(2) Community involvement	Mothers groups Local leader sensitisation meetings Community volunteers share information	
Pasha *et al*[171]	India, Pakistan, Kenya, Zambia, Guatemala and Argentina	2009–2011	Cluster RCT	MN	Care-seeking; health outcomes	Strengthen community capacity to identify and address barriers to obstetric and neonatal care such as recognition of complications and transportation to a facility to manage the complication	Community mobilisation	Recurring group meetings and discussions Community meetings	Community groups, health worker, women

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Table 2 Continued

Author, year (project)	Country	Years of study	Study design	RMNCH target audience	Purpose (categories)	'Community Blank' purpose statement	Term used	Activities/components of 'Community *Blank*'	Involved actors
Rifkin[204]	Cameroon, South Korea, Hong Kong, Thailand	1990	Grey literature (report of case studies)	RMC	Health outcomes	People participate in the benefits of programmes, programme activities, the implementation of health programmes, the monitoring and evaluation of health programmes, or planning programmes.	Community participation	Village/community health committees Community-based distribution schemes Mothers groups Health workers disseminate information	Community leaders, community members, health workers
World Vision[207]	Armenia, Bolivia, India, Kenya, Malawi, Nepal, Senegal, South Sudan, Uganda and Zambia	2011–2017	Grey literature (report)	RMNC	Health outcomes	Strengthen service delivery systems and structures	Social accountability	Community scorecards/ report cards Awareness/communication activities Community dialogues	Adolescents, community leaders, CSOs, community members, community leaders, CSOs, men, women, people living with disabilities

ANC, antenatal care; BADAS, Diabetic Association of Bangladesh ; C, child; CARE, Cooperative for Assistance and Relief Everywhere; CHW, community health worker; CLIP, Community-Level Interventions for Pre-eclampsia; CODES, Community and District-management Empowerment for Scale-up; COMMPAC, Community Mobilization for Postabortion Care; CSO, civil society organisation; EmOC, emergency obstetric care; GBV, gender-based violence; GIS, geographic information system; HIV, human immunodeficiency virus; iCCM, integrated community case management; IYCF, infant and young child feeding; M, maternal; N, newborn; NGO, non-governmental organisation; PMTCT, prevention of mother-to-child transmission of HIV; PPH, Postpartum hemorrhage; R, reproductive; RCT, randomised-control trial; RMNCH, reproductive, maternal, newborn and child health; SNEHA, Society for Nutrition, Education and Health Action; UCL, University College London; UNFPA, United Nations Population Fund.

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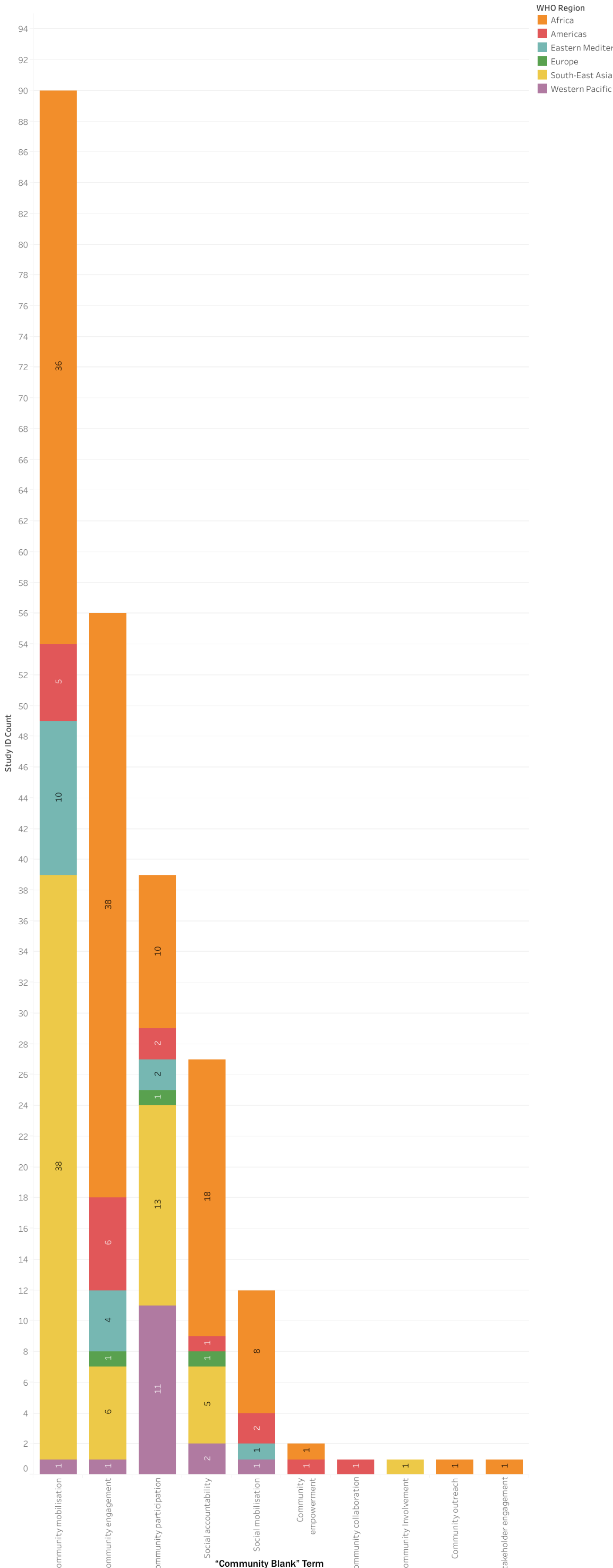

Figure 2 'Community Blank' terms used across WHO regions.

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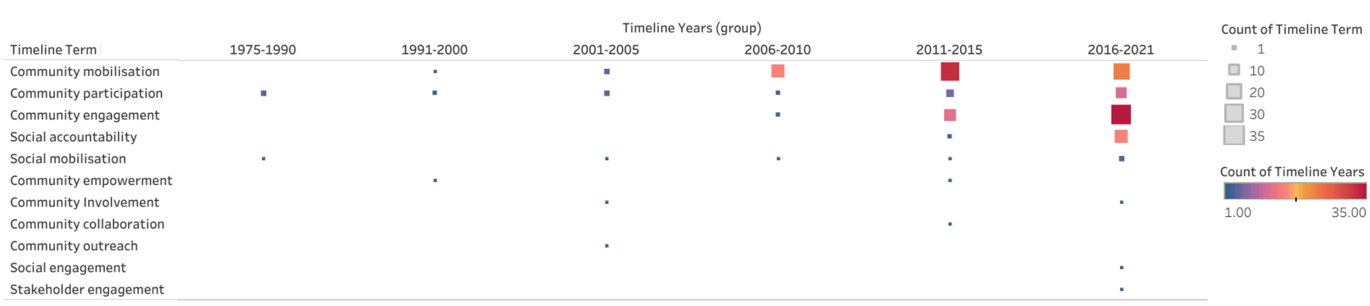

Figure 3 'Community Blank' terms used over time.

Activities

'Activities' refer to the programming, actions or strategies that authors reported as contributing to or part of the 'community *blank*' that was conducted. Table 3 depicts the range of activities or components that were associated with 'community *blank*' terms and are reported as they were extracted from the papers (with some semantic alterations for clarity).

A total of 48 unique activities were revealed across the 173 included studies. For certain terms, specific activities were reported more often (figure 4). For example, reports of '*community mobilisation*' most often referred to recurring group meetings and discussions (n=39; 27 of which are specifically labelled as 'women's groups' in 10 unique projects), awareness/communication campaigns (n=22), community meetings (n=16), and village or community health committees (n=9). While recurring group meetings and discussions were mostly attributed to '*community mobilisation*' (36 out of 49 total mentions), it is important to note that 17 of these publications were reporting on the implementation of the same intervention. '*Community engagement*' activities focused on awareness/communication campaigns (n=9), health workers disseminating information (n=9), community dialogues (n=8), and meeting with communities (n=7) or other stakeholders (n=7) or local leaders for sensitisation (n=7). Similarly, '*community participation*' included community meetings (n=6), awareness/communication campaigns (n=6), information sharing by health workers (n=4) and other community volunteers (n=4), community committees (n=4) and village or community health committees (n=4), and recurring group meetings (n=4). '*Social accountability*' efforts demonstrated the most consistency, typically activities to develop and implement community scorecards or report cards (n=12), followed by community dialogues (n=4).

In total, only 25 activities were mentioned more than twice in the literature and 19 of the 48 activities were attributed to at least three different 'community *blank*' terms. As demonstrated in table 3, only one activity was used with a distinct term more than twice (self-help groups as '*community mobilisation,*' n=5, 4 projects). This demonstrates little to no trend evident in activities used for specific 'community *blank*' terms. The only exception is 'social *accountability*,' largely characterised by community score cards.

Purpose of community 'blank'

Most papers attributed some purpose for the conduct of the community '*blank.*' For those that did not explicitly state the purpose, one was composed by the review team based on the description of the programme. The purposes are classified into seven categories. Improving health outcomes, such as maternal and neonatal mortality and morbidity or preventing disease (n=73), and increasing care-seeking (n=62) were the dominant purposes described. Additional purposes include building knowledge (n=37), affecting health behaviours (n=23), improving the quality of care (n=16), and improving service delivery (n=11). Fifty publications described at least two purposes; for example, six of the '*social accountability*' publications included multiple purposes. While improved health outcomes is the most common purpose across the four main terms ('*community mobilisation*,' 'community *engagement*,' '*community participation*' and' *social accountability*'), one notable difference is that '*social accountability*' was also was the term most associated with improving quality of care (n=5) (online supplemental appendix 13).

On occasion, the purpose of 'community *blank*' was specific to programmatic outcomes. These programmatic outcomes were frequently cited for reproductive and child health. The main programmatic outcome noted for reproductive health was to increase family planning (n=11). For child health, the purposes were to increase care-seeking for pneumonia, malaria and diarrhoea (n=6), immunisation (n=6), injury prevention (n=2), disability care (n=1), and sickle cell care (n=1). For maternal and newborn health outcomes, purposes were specifically to improve nutrition (n=8) or the prevention of mother-to-child transmission of HIV (n=4).

Stakeholders

A range of stakeholders (the actors involved in 'community *blank*' activities as well as the targeted beneficiaries) were examined across publications. Multiple beneficiaries are noted in 97 publications. The primary beneficiaries were women (n=109), newborns (n=80), children (n=48), community members (n=12), men (n=6), households (n=1), adolescents (n=1), health workers (n=1) and service users (n=1). While newborns were the sole beneficiary in 16 papers, they were most often cited as a mother-newborn dyad (n=55), followed by mother-child

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Table 3 Activities, actions and components of work associated with 'community blank' in the literature and their descriptions

Name (n=papers)	Description*	Associated terms
Recurring group meetings and discussions (n=49)	These group meetings provided an avenue for discussions around awareness/education as well as identifying challenges to be addressed. Groups often used flip charts, videos and other pictorial aids in discussion. In two cases, these group meetings implemented the PLA cycle as a methodological tool to identify and address challenges.[160 171] A specifically named recurring group included women's groups, which were facilitated by a trained local peer,[54–59 113] paid facilitator[58 59 67–69 77] or community health volunteers.[61–64 162] In some cases, they were formed by the study being conducted. They include education and information sharing, but almost always involved implementing PLA cycles as a tool in the group (n=29). In one article, the women's group set up an MNH task force[113] and two presented in community meetings to engage the wider community in the implementation of their identified solutions.[71 77] In two cases, women's groups were not specified to use PLA but focused on education[178] or to elicit understanding and preferences for safe delivery.[128]	Community mobilisation (n=36)[54–63 67–69 71–80 92 98 103 113 132 138 143 152 159 162 171 180 184] Community engagement (n=6)[70 101 119 125 149 206] Community participation (n=6)[64 128 160 178 194 201] Social mobilisation (n=1)[96]
Awareness/ communication activities (n=45)	Awareness-raising or communication activities were described in different ways including: sensitisation, education, behaviour change communication and other health promotion initiatives. These types of activities served the purpose of building awareness among community members and/or providing new information or knowledge, for example, relating to how to seek care. They were conducted through a variety of methods including theatre/drama (n=15); print materials such as posters, picture cards, banners and leaflets (n=14); radio (n=11) and television (n=5) broadcasts, music or folk songs (n=7), and dances (n=3). In many cases, the specific avenue of communication was not described explicitly and was referred to as general awareness-creation through mid or mass media (n=14).	Community mobilisation (n=22)[35–37 49 65 86 98 100 103 121 122 132 138 139 143 150 175 176 189 192 205] Community engagement (n=9)[38 101 114 119 131 153 173 183 186 190] Social mobilisation (n=5)[102 110 136 148 186] Community participation (n=6)[48 87 124 128 164 182] Social accountability (n=1)[207] Community outreach (n=1)[112]
Community meetings (n=32)	Community meetings were often established and held through existing forums for meetings as well as meetings specific to the programme. They were facilitated or led by different groups including community leaders or health workers/volunteers. These community meetings brought together the community to announce information, raise awareness/sensitisation, and discuss health issues around pregnancy and birth as well as served as forums to discuss plans being implemented by local groups (such as women's groups).	Community mobilisation (n=16)[50 65 81 85 86 99 100 102 129 138 152 171 180 181 193 198 205] Community engagement (n=7)[44 45 107 109 134 137 151] Community participation (n=6)[126 128 164 167 187 194] Social mobilisation (n=2)[110 136] Social accountability (n=1)[170]
Village/community health committees (n=23)	These health committees are formed of village/community volunteers and facilitators. They serve in varying capacities including providing a forum for community feedback to health providers, running health campaigns, developing activities and meetings, and often serve as a bridge between health providers and health worker and community members.	Community mobilisation (n=9)[62 63 80–82 127 130 159 181] Community engagement (n=6)[38 39 169 186 199 206] Community participation (n=4)[64 111 140 204] Social mobilisation (n=1)[200] Social accountability (n=1)[133] Community involvement (n=1)[203] Community empowerment (n=1)[47]
Health workers disseminate information (n=21)	Health workers were commonly reported to disseminate information and sensitise communities at the individual and household/group level. Health workers conducted group discussions and meetings using tools including pictorial messages, posters and stickers to disseminate health information. They communicated with pregnant women, their families, and local leaders as well as identified women who could benefit from further outreach. This was also described as 'village health teams' in Uganda and specifically named 'home visits' in eight cases.[4346 65 122 138 144 164 181]	Community engagement (n=9)[38 43 44 46 52 93 109 144 185] Community mobilisation (n=7)[65 82 121 122 138 176 181] Community participation (n=4)[94 140 164 204] Social mobilisation (n=1)[102]
Community volunteers share information (n=20)	Community volunteers including local influencers and housewives, sometimes termed liaisons or community mobilisers or peer educators, connected the community with information. These individuals often used one-to-one or group counselling sessions, and provided the community with information supporting the health services such as birth preparedness, facility delivery and polio vaccination. They often the used pictorial messages/pictograms in these sessions/ meetings with pregnant women and families. In nine papers, this was also specifically named as 'home visits'[119 128 136 138 140 152 155 164 201]	Community engagement (n=8)[108 114 119 134 157 183 190] Community mobilisation (n=7)[92 132 138 152 155 190] Community participation (n=4)[128 140 164 201] Social mobilisation (n=1)[136]
Local leader sensitisation meetings (n=18)	This activity describes sensitising leaders for awareness-raising and gaining buy-in for subsequent activities.[99 108 139 161 181 198] Leaders include chiefs, headmen, religious leaders, elders, and other opinion leaders, the community gatekeepers. These sensitisation meetings were described to be undertaken by external project actors[198] or by health workers.[108]	Community engagement (n=7)[39 43 107 108 119 134 151] Community mobilisation (n=6)[85 99 132 139 181 198] Community participation (n=1)[161] Social mobilisation (n=1)[102] Social engagement (n=1)[97] Community outreach (n=1)[112] Community involvement (n=1)[152]

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Table 3 Continued

Name (n=papers)	Description*	Associated terms
Community dialogues (n=18)	Community dialogues are known as a variety of terms including 'community conversations' in the USA, 'bwalos' in Malawi 'durbars' in Ghana 'social audits/dialogues' and 'health assembly' in Uganda. This activity involves multiple phases including preparation, hosting the dialogue, and following up on discussions. The dialogue participants are community gatekeepers and other stakeholders as well as health workers and the community. In a community dialogue, communities voice questions and concerns on health challenges/programmes and identify problems/solutions. These can occur at district or national levels, and one 'bwalo' focused on national government/administrative actors.[106] In one case, community volunteers were trained by the Ministry of Health[161] to facilitate the community dialogues, in another the District health team could select the dialogue host.[49] Two community dialogues were reported to be facilitated by health workers between community members and health providers.[165 186] Two dialogues were reported to result in an action plan[47 196] and one the establishment of a community and facility committee to take forward the actions.[47]	Community engagement (n=8)[48 115 156 161 185 186 196 197] Social accountability (n=4)[106 133 154 207] Community mobilisation (n=3)[49 175 191] Community participation (n=2)[48 165] Community empowerment (n=1)[47] Social mobilisation (n=1)[102] Social engagement (n=1)[97]
Community scorecards/report cards (n=16)	This activity engages communities in planning and monitoring health services through the collaborative design and implementation of community scorecards for service providers and users to rank/rate/grade health services/activities based on a set of metrics—often determined and agreed upon by the community. This is used to analyse changes to service delivery and identify solutions. This activity often involves 4–5 phases to sensitise the community to the efficacy of the activity and convening focus groups[40–42 135] or community meetings[88] to engage in designing the scorecard to grade health services/activities. Community scorecards were used in the health worker-community interface[147] as well as to open dialogue between government representatives, health providers and authorities, and the community.[40–42]	Social accountability (n=12)[40–42 83 84 90 91 105 123 135 189 207] Community participation (n=2)[48 128] Community engagement (n=2)[88 147]
Stakeholder meetings (n=11)	An activity specifically labelled 'stakeholder meetings' involved consulting broader stakeholders to solicit information or engage them in priority setting or for buy-in to a new project.	Community engagement (n=7)[38 46 89 141 172 195 199] Community participation (n=3)[118 124 140] Stakeholder engagement (n=1)[188]
Volunteers contribute to service provision (n=11)	Community volunteers were recruited for multiple reasons: identifying and referring women to emergency services, disseminating information to promote care-seeking or serving as administrators in clinics. Community volunteers were also specifically involved in the construction and maintenance of health facilities (n=2). Volunteers would also conduct social/resource mapping by identifying key informants, creating a list of households, mapping the houses, facilities and community structures systematically, and consulting with local households on the final map product.[39 191] Another volunteer activity involved conducting census to contribute to monitoring and evaluation as well as quality assurance.[39]	Community mobilisation (n=5)[99 166 176 191 193] Community participation (n=4)[116 177 179 182] Community engagement (n=2)[39 97]
Leaders conduct tasks (n=9)	Leaders were described to engage in a wide range of actions or tasks as a component of 'community blank': selecting community volunteers,[137] countering rumours,[152] informing the development of awareness campaigns,[187] donating land, labour and funds to build community health services,[182] enacting by-laws to fine families that did not deliver in health facility and penalise practices/traditions that may pose a risk to pregnant women,[100 182] and coordinating resource emergency transportation[82] and developing strategies and action plans based on local context.[153 197] In one example, prizes were used to incentivise chiefs to encourage men to support antenatal care.[150]	Community mobilisation (n=4)[82 100 150 152] Community engagement (n=3)[137 153 197] Community participation (n=2)[182 187]
Community committees (n=7)	Community committees facilitated a range of community services including raising funds, disseminating information and supporting women in the community. One community committee oversaw cash transfer implementation.[187] They were also sometimes known as 'community coalitions' and 'community collaboratives' which would undertake needs assessment and identify and implement strategies.	Community participation (n=4)[94 95 104 187] Community mobilisation (n=1)[120] Community empowerment (n=1)[158] Community collaboration (n=1)[117]
Peer support (n=7)	Peer support is described as the identification of individuals to serve as 'peer supporters or champions' to act as conduits for sharing knowledge and encourage peers to participate in MNH and PMTCT.[100 102 150] On occasion male peer support actors were tasked to undertake group discussions in community dialogues and health facilities.[102]	Community mobilisation (n=4)[58 100 150 166] Community engagement (n=1)[197] Social mobilisation (n=1)[102] Community empowerment (n=1)[158]
Training lay health workers (clinical) (n=6)	Providing health workers with clinical training was described as a 'community *blank*' activity on seven occasions. This involved training traditional birth attendants on danger signs, care practices, how to identify and refer patients,[182] track immunisation status,[134] stabilise patients,[130] and recognise and support pregnant women experiencing gender-based violence,[192] as well maternal and newborn health rights.	Community mobilisation (n=4)[99 120 155 193] Community participation (n=2)[124 182]
Community action cycle (n=5)	Community action cycles were used to establish trust with the community and work with community members to identify problems and implement solutions.[51 190 202] These can be specifically facilitated by local community health workers.[51 130]	Community mobilisation (n=5)[50 51 130 190 202] Community engagement (n=1)[50]
Public events (n=5)	Public events, named as religious festivals[119] or community festival day for family planning,[144] village health and nutrition days[65] and health fairs[136] were used as activities to promote family planning or celebrate pregnancy.	Community engagement (n=3)[38 119 144] Social mobilisation (n=1)[136] Community mobilisation (n=1)[65]
Self-help groups (n=5)	Facilitators and peer educators led discussions and disseminated information around health. Groups formed for this purpose in India and Bangladesh with this specific name. Three of these self-help groups employed a PLA cycle as a methodological tool in facilitating group sessions.[66 120 146]	Community mobilisation (n=5)[65 66 120 146 163]

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Table 3 Continued

Name (n=papers)	Description*	Associated terms
Establishing partnerships/networks (n=4)	Establishing networks and collaborative partnerships across health professionals, communities, community leaders and health interest groups (such as women or communities with HIV). This also included partnerships with private transport providers for emergency transport.[122]	Community mobilisation (n=2)[122 166] Social mobilisation (n=1)[186] Community engagement (n=1)[157]
Male group sessions/husbands forums (n=4)	Group meetings/sessions specifically targeted men and/or husbands to raise awareness on maternal health issues and encourage male involvement in pregnant women's care.	Community mobilisation (n=3)[36 37 121] Social mobilisation (n=1)[102]
Maternal death review and response (n=4)	A surveillance and response system involving at least one community representative, used to identify the causes of maternal (and neonatal) death and solutions to be adopted at community and facility level.	Community mobilisation (n=2)[100 130] Community participation (n=1)[128] Social accountability (n=1)[170]
Mothers groups (n=3)	Mothers groups were a specifically named group of mothers/women with children convened to discuss maternal health problems as peers.[152 204] When used as a social accountability activity, once, they were described to actively mediate between the community and the health facility.[133]	Social accountability (n=1)[133] Community participation (n=1)[204] Community involvement (n=1)[152]
Health workers delivering services (n=3)	This describes when health workers provided healthcare, supplies or services while being described as a '*community blank*' activity. This included identifying women who can benefit from further outreach or referrals or treating minor ailments.	Community engagement (n=2)[38 43] Community outreach (n=1)[112]
Safe motherhood action group (SMAG) (n=3)	SMAGs were a specifically named voluntary group and trained by the Ministry of Health or health workers on danger signs and for birth preparedness, how to identify and refer women to facilities for care in order to host community meetings to raise community awareness and increase use of facilities for delivery.	Community engagement (n=2)[142 185] Community mobilisation (n=1)[155]
Steering committees (n=3)	Steering committees were often formed to discuss logistics or the planning and implementation of strategies. They were formed of community members and representatives as well as local government and district health officials.	Social mobilisation (n=1)[148] Community mobilisation (n=1)[198] Community engagement (n=1)[195]
Community funds/donations (n=2)	Similar to the savings groups, this activity involved donated funds from the community being used to establish referral/transportation services for emergencies/complications.	Community mobilisation (n=2)[100 192]
Community support groups (CSGs) (n=2)	'CSGs were mentioned in Bangladesh. Government health workers trained the unpaid members of CSGs to identify pregnant women, educate communities on pregnancy-related danger signs and encourage them to use skilled services in the community and health facilities.	Community mobilisation (n=2)[138 191]
Health facility committees (n=2)	Health facilities committees involved facility staff and community representatives meeting monthly to monitor services, and raise awareness[168] as well as advocate and lobby for respectful care.[100]	Social accountability (n=1)[168] Community mobilisation (n=1)[100]
Savings groups/schemes (n=2)	This activity centred around instigating savings groups and emergency funds for care and emergency transportation.	Community participation (n=1)[124] Community mobilisation (n=1)[122]
U-report and citizen reports (n=2)	Data collected from an SMS monitoring tool that can solicit community inputs and administer surveys to inform community dialogues	Community mobilisation (n=1)[49] Community empowerment (n=1)[47]
Advocacy/planning meetings (n=1)	This was described as a community mobilisation activity conducted at the union level.	Community mobilisation (n=1)[191]
Community-based distribution schemes (n=1)	This activity was a contraceptive distribution scheme where community members were recruited to sell/distribute contraceptive devices as well as disseminated family planning information.	Community participation (n=1)[204]
Community capacity building (n=1)	This activity was described as involving communities in the development of a health guide and tool kit, and engage in awareness raising.	Community engagement (n=1)[93]
Community health scoreboard (n=1)	This activity describing engaging the community in the process of developing a public health scoreboard. Indicators were rated collectively on a scoreboard at a public meeting.	Social accountability (n=1)[133]
Community workshop (n=1)	This community workshop included components that resemble a PLA cycle: sensitisation, developing community action plans, formally engage community to implement action plan ('*community engagement*'—signed contract), scale up intervention, monitoring and evaluation.	Community mobilisation (n=1)[139]
Father invitation (n=1)	Fathers or partners were specifically sent invitations to attend antenatal care appointments with pregnant women.	Stakeholder engagement (n=1)[188]
Health worker recruitment (n=1)	The community was involved in the selection/hiring/recruitment of the community health workers.	Community engagement (n=1)[151]
Health facility checklist (n=1)	This activity was described as a top-down social accountability approach, used to measure progress on MNH priorities.	Social accountability (n=1)[170]
Income generating system (n=1)	Hand mills and other services to make profits were used to provide pregnant women with food, soap, mosquito nets, laundry soap, and support the functioning of maternity waiting homes.	Community mobilisation (n=1)[198]
Incorporate community feedback (n=1)	While the article did not describe the specific mechanisms through which this was implemented, this describes activities ensuring there are opportunities and avenues to respond to advice from the community and incorporate their feedback into the programme.	Community engagement (n=1)[39]

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Table 3 Continued

Name (n=papers)	Description*	Associated terms
Mentorship (n=1)	This mentorship intervention specifically targeted adolescents by connecting them to adult mentors in order to increase knowledge and improve self-image.	Community mobilisation (n=1)[175]
Mobile clinic (n=1)	A mobile antenatal clinic was established as one of the community mobilisation action points developed by the community.	Community mobilisation (n=1)[100]
Maternal-and-newborn stakeholder groups (n=1)	This group activity was named in one study and described as similar to women's groups. They followed a problem-solving cycle and were comprised of community health staff, volunteer health workers, community members and women representatives.	Community mobilisation (n=1)[174]
Participatory planning group (n=1)	This group formed by community members used participatory planning methods to design and implement a solution; identification of volunteers to serve as drivers for transportation of emergency obstetric cases.	Community engagement (n=1)[173]
Participatory community quality improvement (PCQI) cycle (n=1)	The PCQI cycle was specifically labelled '*community engagement'* activity in one study, which included seven steps: (1) Consensus building workshop, (2) Identify and meet community representatives, (3) Explore quality with community and health facility, (4) Bridging gap workshop, (5) Develop an action plan, (6) Implement strategy, and (7) A monthly performance review meeting.	Community engagement (n=1)[53]
Photovoice (n=1)	Photovoice was described as the community engagement activity employed in a workshop event to stimulate conversation using principles of appreciative inquiry.	Community engagement (n=1)[141]
Village health club (n=1)	This was a community-led forum led by community health workers who facilitated learning and employed a planning and action cycle to identify challenges and solutions.	Community engagement (n=1)[145]
Youth club (n=1)	Establishing a youth club was described as one of the community mobilisation action points.	Community mobilisation (n=1)[100]

*Note: These activities, actions or components of 'community blank' are what an article reported was done in association with 'community blank.' The description of the activity was taken directly from the explanation within the document that used it. In cases where there was more than one description from multiple documents, the description was synthesised from all the descriptions and developed by the research team.
CSG, community support group; HIV, human immunodeficiency virus; MNH, maternal and newborn health; PCQI, participatory community quality improvement; PLA, participatory learning and action; PMTCT, prevention of mother-to-child transmission of HIV; SMAG, safe motherhood action group.

dyad (n=15) or with other children (n=5). Women (n=39) and children (n=20) were also cited as sole beneficiaries across publications.

In relation to the actors noted, all but one publication described multiple actors involved in the activities, with 141 publications involving at least three actors. In total, there were 35 unique actors cited 665 times across the 173 publications and across the 'community *blank*' terms. Activities including just two actors were commonly health workers engaging directly with women or a facilitator leading a recurring group. Together, health workers (formal/trained) and volunteer health workers (unpaid, trained quickly to conduct similar tasks to formally trained health workers) were the most frequent actor. Figure 5 depicts the 22 different types of actors involved in the 'community *blank*' activities who were cited at

Figure 4 Activities used at least twice in community mobilisation, community engagement, community participation and social accountability.

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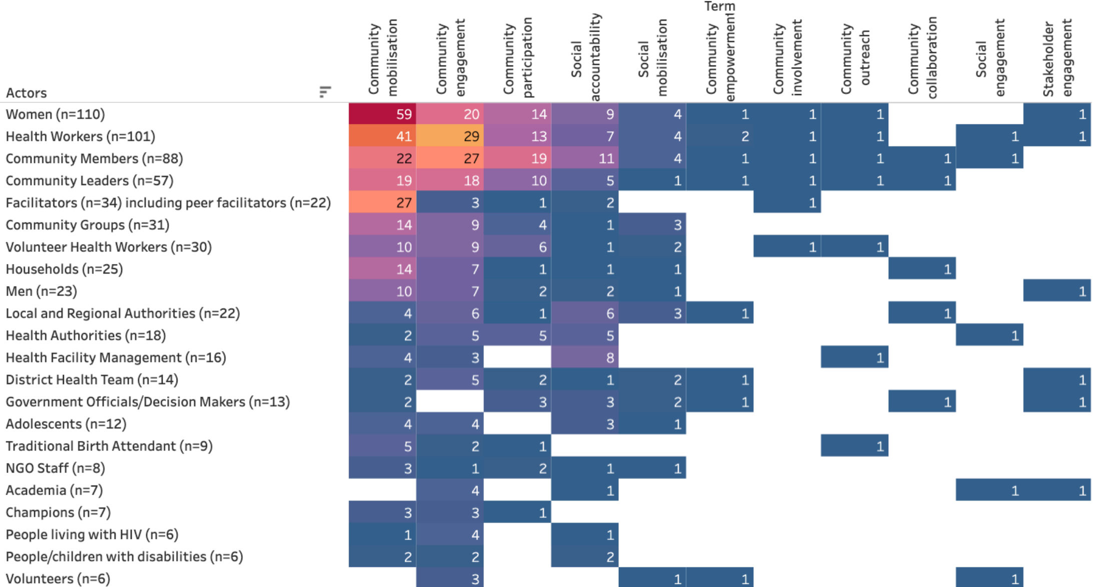

Figure 5 Actors involved in 'community blank' *Note: The numbers in this table may differ from those presented in the text due to the eight included studies that used more than one 'community blank' term. As a result, some actors have been counted twice. For example, if a study described their activities where women were an actor as 'community mobilisation' and 'community engagement' then this is counted in both terms for 'women.'

least five times. This figure highlights that there is no discernible pattern between the type of actors involved and the 'community *blank'* terms. Any actor that was cited more than once was associated with at least two different 'community *blank'* terms, while 25 of the 35 unique of the actors were associated with at least three 'community *blank'* terms.

DISCUSSION

The findings of this review confirm an inconsistency and lack of clarity around the usage of 'community *blank*' terms and provide recommendations to address this gap (box 1).[17 18 208] Across 173 publications, 24 distinct 'community *blank'* terms were used—however many of these were used in conjunction with other terms or were used interchangeably[107 119 128 132 139 143 147 166 176 185 199]—with four dominant terms: '*community mobilisation,*' '*community engagement*,' '*community participation*' and '*social accountability*.' If papers reported a specific definition of 'community *blank*,' these were captured in the data extraction

Box 1 Recommendations

⇒ Clarify and determine consistent operational definitions for 'community *blank'* terms.
⇒ Develop and align to standardised monitoring and evaluation indicators.
⇒ Promote standardised reporting on the implementation of 'community *blank'* procedures and processes in the peer-reviewed and grey literature bases, including reporting the target audience, purpose, activities and the role of the community in the 'community *blank.'*

and are reported in online supplemental appendix 10. The extent and depth of these definitions varied greatly, however the majority did not define how they conceptualised 'community *blank'* or provide a theoretical or formal definition of the term used. While 31 unique activities were reported more than once, 20 of these were associated with at least three distinct 'community *blank'* terms. Twelve of the 17 documents using the term '*social accountability'* described community scorecards, whereas '*community engagement'* and '*community participation'* appear to be very similar (with 10 of their respective activities overlapping).

The timeline of when 'community *blank*' terminology is used illustrates the presence of '*community participation*' since 1975, with newer terms such as '*community engagement'* and '*social accountability'* joining the scene more recently in 2006 and 2011, respectively. Notably, the term '*community mobilisatio*n,' which was the most used term in the included documents, has been consistently present since the 1990s. However, the literature on '*community mobilisation*' referred to 10 unique projects and the final reports for these projects were published in 2017. Relatedly, the identified use of the term '*community mobilisation,'* has since decreased in the past five years. This finding demonstrates the importance, and therefore the responsibility, of the research community in guiding the terms used.

Overall, there is a relatively small body of literature that describes what is being done when these 'community *blank'* terms are used. This is demonstrated by the fact that 123 articles were excluded at full-text phase (figure 1) because they provided no explanation of what was done, even though they included the terms of interest. Within the documents included in this review, the data

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are constrained by the limited level of detail in reporting the procedures and processes involved in implementing 'community *blank*.' There is a limited evidence base to describe the implementation of 'community *blank*' activities: the content, their purpose, the actors and stakeholders involved. Further research to understand the implementation of 'community *blank*' is important to address this knowledge-do gap.

Additionally, the literature base is limited by the dominance of 12 countries (Bangladesh, Ethiopia, India, Ghana, Kenya, Malawi, Nepal, Nigeria, Pakistan, Uganda, the USA, Zambia) which returned five or more publications. This dominance may be due to a lack (or a specific concentration) of funding, lack of activity, or lack of resources to document and report on activities and programming. Consequently, there is a narrow knowledge base of what is happening on a global scale. This gap in the evidence base contributes to the lack of clarity around 'community *blank*' terms, in particular the reporting on implementation. This has implications for the evaluation and translation of knowledge relating to 'community *blank*' across and within contexts.

Previous literature on 'community *blank*' or community interventions for health have put forward theoretical frameworks in attempts to clarify how these interventions are put into practice, including Arnstein's eight-ring 'ladder of citizen participation' and Laverack's nine domains of empowerment.[17 209 210] Similar frameworks describe a range or spectrum of involvement, including the International Association for Public Participation's five levels of inform, consult, involve, collaborate and empower.[211] In the RMNCH field specifically, Gram, Desai and Prost put forward a matrix of the different styles and scopes of involving communities as: classrooms, clubs and collectives.[212] Finally, a WHO guide on health promotion describes four levels of community engagement including approaches that are community-oriented, community-based, community-managed and community-owned.[213] These various frameworks typically describe a spectrum of more to less involvement of the community, yet despite the availability of these frameworks, the findings of this review demonstrate a range of terms are used interchangeably. This may reflect an evolving nature of the 'community *blank*' terms and approaches, further demonstrated by the timeline of their usage. While some have argued that it is neither feasible nor useful to develop standardised definitions of 'community *blank*,' they have also acknowledged the importance of learning from the enabling actors, environments and roles in involving communities.[18 214] These existing frameworks can provide an entry point for promoting conceptual clarity around 'community *blank*,' as well as an opportunity for cross-disciplinary learning.

In order to draw out these lessons, there is a need for conceptual clarity and specificity to enable the adequate documentation of implementation and ensure the translation of knowledge within and across settings.[215 216] Failure to consistently describe 'community *blank*' interventions may also be a consequence of the ongoing lack of clarity in theory and inappropriate research methodologies. Growing calls for the research community to embed complexity and non-linearity in the research process from the beginning may contribute to more reliable documentation that can in turn enable the adaptation and replication of 'community *blank*' activities across contexts and countries.[217 218] It is essential that RMCNH researchers and practitioners that engage in documenting and publishing on 'community *blank*' endeavours more adequately describe and share the content of the 'community *blank*,' its purposes, activities, actors and stakeholders involved. The majority of the evidence in this review comes from peer-reviewed literature; this means that the review reflects the language and experiences of the academic or research community, but it also highlights the potential role of the research community in facilitating dialogues and supporting conceptual clarity for 'community *blank*' terminology.

Additionally, the number of articles that were excluded in this review because they lacked such detail describing the 'community *blank*' points to this great need for clear and consistent documentation. This suggests a potential benefit of global standardised reporting and evaluation tools that can support a consistent use of 'community *blank*' terminology and better descriptions of the content of 'community *blank*' interventions. UNICEF's 'Minimum quality standards and indicators for community engagement' began this effort by proposing 16 core standards each with a set of indicators with the purpose to establish a common language among all stakeholders for defining community engagement principles, key actions, goals and benchmarks.[208] In order to standardise reporting of implementation of healthcare processes, defining the 'construct of interest' to provide clarity is generally considered the first step.[219] In this way, clarity on when to use which 'community *blank*' terminology is warranted. These standardised indicators can include requirements for improved reporting on the content of 'community *blank*,' similar to global reporting standards such as the WHO Programme Reporting Standards for sexual, reproductive, maternal, newborn, child, and adolescent health.[16 220] This could help to redress the current lack of detail available on aspects such as the target groups, purposes, activities and the role of community members in 'community *blank*' interventions. However, it is also important to consider who (ie, practitioners, researchers, donors, etc) would be responsible for ensuring these documentation and reporting standards are met.

Finally, there is a difference between working *in* and working *with* communities. Given the inconsistency and lack of clarity in reporting of 'community *blank*,' this review highlights the need for further investigation into the procedures and processes of 'community *blank*' efforts. It is recommended that future investigation should also include examining the direct level and extent of community members' roles and responsibilities in these activities to better reflect the work being done.

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Strengths and limitations

This review has several strengths and limitations. Most notably, the scope and range of papers included give a comprehensive and holistic look at literature in the RMNCH and 'community *blank*' space. The methodical and systematic search conducted enabled capture of a wide range of experiences as early as 1979, following the Alma-Ata Declaration. While this review did not exclude any studies based on language, the search was conducted primarily in English. This review used a specific search strategy based on the terms of interest, potentially limiting the number of returns. An additional limitation is that this review did not include publications that documented similar 'community *blank*' activities if they did not specifically use the terms of 'community *blank*.' This was due to the aim of the review being to determine what researchers and practitioners are doing when they *say* they are doing 'community *blank*.' As such, the papers included in this review do not represent the literature of all community activities, but rather just those that are ascribed as 'community *blank*' activities. A pivotal example of this is the seminal piece on the 'Warmi methodology,' which did not use any 'community *blank*' term but informed the recurring women's groups across several studies.[221] A similar challenge is demonstrated in the varying levels of detail used to describe the activities or actions associated with 'community *blank*' terms, notably the roles of the community and how they were or were not involved in these approaches. Conducting this review highlighted a limitation in the literature that many studies do not extensively report what they do when they use these 'community *blank*' terms, which required the reviewer team to make some judgements in synthesising and presenting the findings. This limitation of the overall literature base highlights the challenge of how knowledge is captured and shared and therefore how research agendas may contribute to advancing 'community *blank*' practice and policy. Relatedly, the review cannot capture what is not published or readily available. 'Community *blank*' is being used across the globe and being implemented by actors and/or programmes who have not written up and published their experiences in either the peer-reviewed literature or grey literature reports.

CONCLUSION

This scoping review highlights the lack of clarity and inconsistencies in how 'community *blank*' terms are used in the literature, impeding the ability to draw meaningful lessons for implementation. To advance 'community *blank*' for RMNCH, a more comprehensive reporting and documenting of 'community *blank*' implementation processes by researchers and all stakeholders is needed to improve clarity, to avoid confusion in practice, and to facilitate a better understanding of how these approaches work or do not work in a range of settings.[16 23] The promotion of standardised reporting and monitoring and evaluation indicators that can capture the content of 'community *blank*' can support this effort. By clarifying our understanding of what we mean when we say we are doing 'community *blank*' and improving the documentation of 'community *blank*' practices, we can better share learning within and across communities to inform systematic changes and bring evidence-based practices to scale.

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