JOURNAL OF COMMUNITY SYSTEMS FOR HEALTH
2026, VOL. 3
https://doi.org/10.36368/jcsh.v3i1.1260

COMMENTARY

Speaking to the silences on community engagement in pandemic prevention, preparedness and response

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Received 6 November 2025 ; Accepted 8 January 2026 ; Published 18 January 2026

ABSTRACT

The COVID-19 pandemic catalyzed global discourse on pandemic preparedness and the role of communities in prevention, response and readiness efforts. Yet community engagement in pandemic prevention, preparedness and response (PPPR) remains narrowly framed and reduced to social mobilization, sidelining essential lessons from outbreaks that demand communities' endogenous roles in governance. In this paper, we highlight multiple layers of "silences" in literature, policy, and practice across three domains: undefined and invisible engagement structures from community health facility committees interfacing service users, leaders, and providers, to district assemblies, national health assemblies linking subnational units, and supranational civil society mechanisms; power asymmetries that positions communities as tokenistic observers rather than active, equal partners whose local insights shape decisions, exacerbated by elite capture, financial dependence, and exclusion from technical discussions under assumptions of incapacity; and evaluative logics that prioritize health outcomes over process enablers like capacity-building, clear rules of inclusion, adequate resourcing, accountability, and contextual factors. These silences misattribute institutional barriers to community inadequacies. Reversing them requires; deliberate investment in visible and functioning multi-level engagement structures with communities playing a central role in defining them; recognition of communities as equal partners in PPPR discussions and processes whose knowledge and contributions carry equal weight; and evaluation approaches that prioritises agency, accountability and contextual enablers, rather than treating community engagement as a technical intervention judged only by downstream health outcomes.

Keywords: Prevention, preparedness, response, pandemic, COVID

Abstract in Español at the end of the article

INTRODUCTION

The COVID-19 pandemic sparked discussions on the need for pandemic preparedness and the role of communities in prevention, response, and readiness efforts [1]. While communities are sometimes included in these conversations, their role in pandemic prevention, preparedness and response (PPPR) is too often narrowly defined and reduced to social mobilization, guided by top-down approaches whereby communities are simply told what to do [2]. This tendency for a top-down conception of community engagement impedes an open dialogue about what is required to promote community engagement in PPPR. As such, ongoing PPPR discussions often overlook aspects of wholesome community engagement deemed essential by lessons from past pandemics and disease outbreaks including the COVID-19 pandemic [3,4,5].

The silence in both the literature and practice on what truly drives community engagement in health makes these gaps even more challenging to address. Although a number of studies have attempted to document and analyse the factors that contribute to or are obstacles to

effective engagement [6,7,8,9,10] and outline approaches for optimising it [11], most fall short in providing deeper insight into the consequences of inadequate engagement and what should be done to remedy such shortfalls. For example, researchers often evaluate community engagement in health initiatives based on its impact on health outcomes [12], with less attention given to the consequences or costs of excluding communities from these processes, thus undermining advocacy for and prioritization of community engagement. The current literature has also primarily focused on community engagement as a time-bound "intervention" [12], conducted only during a pandemic or disease outbreak — not as an ongoing process or phenomenon existing pre-, during, and post-pandemics and disease outbreaks. This conceptualization creates silences that limit the ability to recognize the endogenous role of communities in PPPR.

Silences also exist in practice, where insights well-documented in the literature are often overlooked or disregarded by policymakers, funders, and even community actors themselves. Learning from the COVID-19 pandemic, global health organizations have invested in PPPR efforts with the majority of funds directed toward areas such as disease surveillance, the health workforce, laboratory capacities, and local manufacturing of vaccines and therapeutics in low- and middle-income countries [13]. Yet, in policy and practice, communities' roles remain comparatively limited, falling short of the evidence and insight in the literature that robust investment is necessary to catalyse the central role of communities in PPPR efforts [14,15].

In this article, we highlight multiple layers of silence on community engagement in PPPR, in the literature, in practice and in ongoing discussions – on issues that, while present in the literature, are often left on the margins or overlooked by those leading PPPR discussions, designing policies, or overseeing implementation. Silences which, if attended to, may improve advocacy and practice of community engagement in PPPR, and which, if reversed, may allow community engagement in PPPR to be 1. recognised at all scales of organisation, 2. given equal weight and value as those of other actors (such as policymakers, funders, and technical experts), and 3. supported in ways that attend to the circumstances at each level, setting, and functions.

STRUCTURES FOR COMMUNITY ENGAGEMENT AT ALL LEVELS OF HEALTH GOVERNANCE

PPPR efforts at international levels are often led and influenced by global organizations with minimal community participation. At the national level, PPPR efforts tend to be government-centric, overlooking the role of communities [4,5]. Contributing to this oversight is the silence in the literature and in advocacy about the structures that facilitate community engagement (and relations among those structures) at all levels of health governance so that it is possible to recognize those structures where and when they exist and recognize their absence. Such structures are often undefined and under-supported. Even when present, they often remain invisible to both internal and influential external actors in a position to shape research, policy and advocacy [8,10].

Considerations of community engagement in PPPR should begin at the community level through the existing formal or semi-formal structures like Community and Health Facility Committees, where service users, traditional and religious leaders, women's and professional groups, and other actors interact with healthcare providers [16]. At the district level, structures such as district assemblies must be made visible and engaged with to inform decisions on issues that can be best addressed by actors at that level [17]. National structures – such as a national health assembly or a committee of community representatives linked to sub-national units – may also exist, legislated to facilitate community engagement in health governance at that level [17]. The considerations should also extend to community engagement structures at the Supranational or international level, such as community groups and civil society organizations, working through them, or engaging directly with governing entities if such structures are absent or ineffective [18]. The utilization of existing broader health governance structures for community engagement in PPPR should, however, account for their current shortcomings and aim to address them, including the tendency for centralisation during disease outbreaks. It should also consider what adaptations are necessary during a pandemic to enable an effective response, as well as which elements should be sustained beyond the pandemic to support ongoing prevention and preparedness efforts, and which elements should be reversed [4,5].

To ensure effective and sustained community engagement in PPPR, there is therefore a need to strengthen or set up where necessary, structures that facilitate it at every level, which requires a reversal of current silence in the literature and in advocacy, making visible the presence or absence of those structures. Such efforts should be done in collaboration with affected communities, allowing them to define the terms of engagement to ensure it does not perpetuate inequality or marginalization. The ability to see them, recognize what they enable and what happens in their absence, is essential for advocacy for their effective set up and support to ensure their optimal functioning at and across different levels of health governance, including PPPR governance. For these engagement structures to be truly effective, several elements are essential. First, capacity must be built on both sides of the engagement, among the more powerful actors in the engagement (often policymakers) and among the less powerful actors (often community members). Second, adequate resources are needed to ensure full and optimal engagement of all actors. Finally, given the tendency for elite capture by powerful actors within communities and external to them, clear rules should be established to govern the engagement, specifying who should be involved and how the engagement

should take place.

COMMUNITIES AS EQUAL PARTNERS AND THEIR CONTRIBUTIONS OF EQUAL VALUE

Effective community engagement requires all actors involved in decision-making to work together to enable it. While community engagement in health governance is often defined in the literature in ways that emphasize the need for communities to be active in decision-making, planning, design, and service delivery [20], what is often absent in the literature is concerted attention to how current practice often positions communities as passive observers commonly invited to decision-making tables to fulfill formalities rather than as active participants who are expected to influence the decision-making process. With this structural disadvantage, those holding power in health decision-making (governments, policy makers, funders, and service providers) determine if, when, and how communities are engaged [4,5], as evidenced in ongoing PPPR discussions, limiting community input and influence over which policies, programs should be adopted and how available funding should be allocated. This silence further limits communities' ability to function as equal partners and their contributions deemed of equal value. A recognition of this structural disadvantage is a precondition for remedying it.

Of the categories of actors (Figure 1) involved in health governance at various levels of governance – policy makers, service providers, and community groups – this structural disadvantage means that the first two are prioritised in ways that put communities' roles in question, or in ways that are rather selective and tokenistic [17]. But marginalization occurs both within and across governance structures. Within structures, policymakers (or more powerful community members) may undermine the input of (marginalised) community members or representatives, prioritizing their own agendas or those of other actors over community needs. Across structures, policymakers may similarly disregard the perspectives of subnational policymakers and service providers, limiting their influence on decision-making. To function as equal and active partners in PPPR decision-making, communities' role must be intentionally designed to address these structural disadvantages and supported as a shared responsibility, reflected in funding, priority-setting, the set-up of engagement structures, the rules of engagement, and the integration of community social and cultural values in efforts to support their engagement in health governance, including PPPR governance [21]. This requires analyses of community engagement in PPPR with a focus on this current asymmetric distribution of power. It also requires systematic assessments of the legal, institutional, financial, and technical resources needed for all actors to participate effectively.

A silent assumption about community groups' lack of technical capacity often excludes them from technical PPPR discussions causing strategies and programs to be developed without benefitting from valuable local knowledge and insights. Another silence in the literature is how community groups' financial dependence on external actors – including in their role as research participants – further undermines their independence and ability to hold health systems accountable, leading to further silences about service gaps and challenges [22].

EVALUATING COMMUNITY STRUCTURES AND COMMUNITY AGENCY FOR THEIR ENABLERS

A key issue often neglected in PPPR discussions is how community engagement is evaluated. Community engagement in health governance has been widely recognized since the 1978 Alma Ata Declaration as essential for reducing health inequalities, promoting social justice, improving pandemic responses, and adherence to outbreak control measures [21]. But its evaluations have mainly focused on its effectiveness in producing the desired health outcomes.

This narrow approach overlooks the complex factors influencing the engagement process and fails to recognize broader benefits, such as increased trust and accountability within health systems. This narrow approach often reduces the true value of community engagement to a single metric, and misattributes its successes or failures, thus creating multiple silences.

One of the consequences of this silence, is that accountability is often missing in evaluations of community engagement [12]. While most evaluations focus on the impact of community engagement on health outcomes, they tend to neglect its crucial role in holding health systems accountable to the communities that PPPR efforts are intended to improve and protect

Evaluating the effectiveness of community engagement in PPPR based on public health outcomes without a deeper understanding of what makes the engagement process itself effective (or not effective when not) can undermine the learning needed to make progress in how community engagement structures could be more effectively set up, facilitated, and supported as part of PPPR. Evaluations should first be clear in framing community engagement in relation to the presence or absence and functioning of structures within which it occurs at various levels of governance, and in relation to how those structures relate to one another within and across levels of governance. Evaluations should also be deliberate in focusing on the conditions that enable the agency of community groups in PPPR – including geographical conditions, and the legal and institutional measures and the financial and technical resources needed for all parties involved to function effectively. Without this deeper understanding reflected loudly in the literature, efforts to strengthen community engagement in PPPR will lack critical insights, miss opportunities to avoid repeating past mistakes and to be better prepared, with communities, for the current disease outbreaks and the next pandemic.

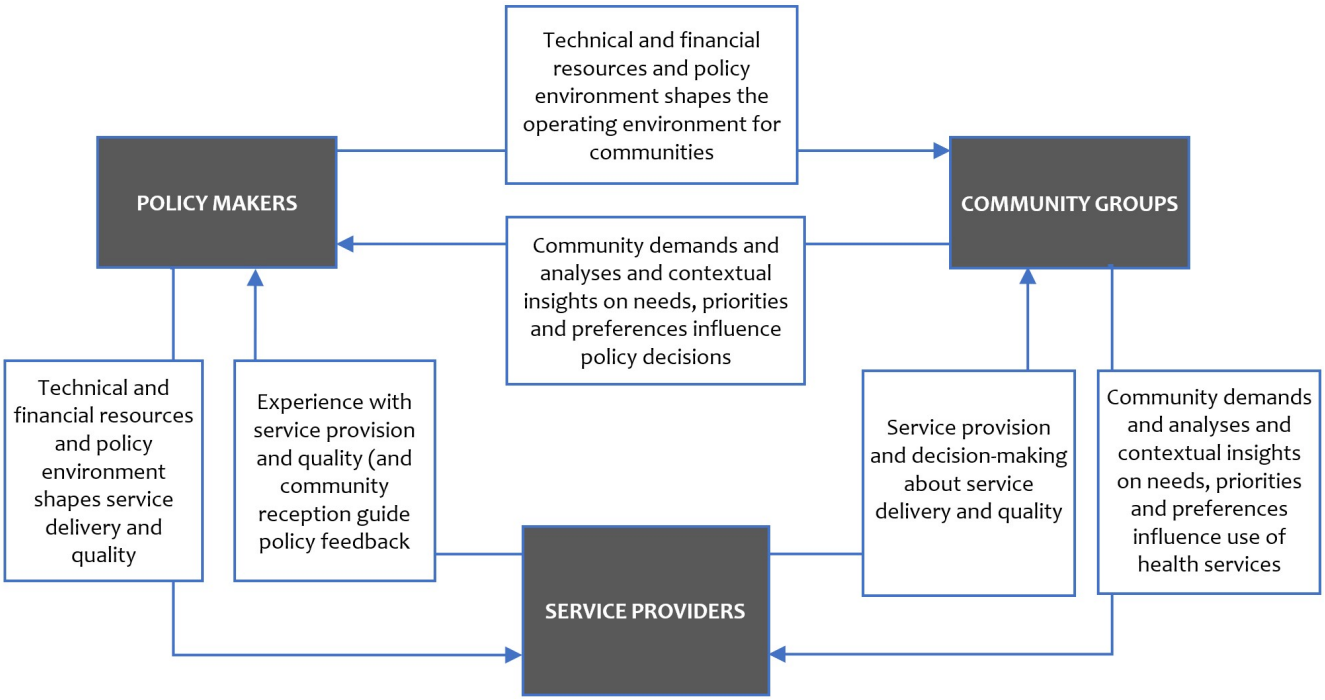

Figure 1. Enablers of community engagement in PPPR relations. Source: adapted from Abimbola (2020) [16]

Legend: 1. The policy-makers box includes the technical and financial resources and the policy environment provided by governments, funders, and policymakers (at various levels of governance), 2. The service providers box represents their decision-making as prescribed in policies made by and within health infrastructure made available by governments, funders and policymakers - at various levels of governance, and 3. The community group box comprises the communities analysis and insights on the contextual factors influencing the use of health services - as made space for by governments, funders, policymakers, and service providers.

CONCLUSION

Community engagement in PPPR should be treated as a core governance function that must be structured, resourced and evaluated with the same seriousness as surveillance, workforce and laboratory systems. Attending to the silences identified in this paper, around governance structures, power asymmetries, and narrow evaluation logics, reveals that what is often framed as "lack of community capacity" is more accurately a product of how institutions design, constrain and value community engagement across levels of health governance. Reversing these silences requires deliberate investment in visible, functioning engagement structures at all levels; recognition of communities as equal partners whose knowledge and contributions carry equal weight; and evaluation approaches that foreground agency, accountability and contextual enablers, rather than treating community engagement as a technical intervention judged only by downstream health outcomes. Doing so would not only correct long-standing inequities in how communities are positioned in PPPR, but would also strengthen the legitimacy, adaptability and effectiveness of pandemic governance, ensuring that future preparedness and response efforts are co-produced with the people they are meant to protect.

DECLARATIONS

AI utilization

Not applicable.

Competing interests

The authors report no conflicts of interest.

Funding

None.

Author contributions

Conceptualization: ML, SA, SB. Formal analysis: ML, SA. Investigation: ML. Supervision: SA, SB. Validation: SA. Writing – original draft: ML. Writing – review & editing: ML, SB, SA.

Data availability

Not applicable.

Acknowledgements

We thank the Malawi civil society advocacy forum members for their insights on community engagement in primary health care and pandemic response which informed the conceptualization of this paper.

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ABSTRACT IN SPANISH

Abordando los silencios en la participación comunitaria en la prevención, preparación y respuesta ante pandemias

La pandemia de COVID-19 catalizó el debate global sobre la preparación frente a pandemias y el papel de las comunidades en los esfuerzos de prevención, respuesta y preparación. Sin embargo, la participación comunitaria en la prevención, preparación y respuesta ante pandemias (PPRP) continúa siendo concebida de manera restrictiva y reducida a la movilización social, dejando de lado lecciones fundamentales derivadas de brotes previos que evidencian el papel endógeno de las comunidades en la gobernanza. En este artículo, destacamos múltiples niveles de "silencios" presentes en la literatura, las políticas y la práctica a través de tres ámbitos: estructuras de participación indefinidas e invisibilizadas, que van desde los comités comunitarios de establecimientos de salud que articulan a usuarios, líderes y proveedores, hasta asambleas distritales, instancias nacionales de salud que vinculan unidades subnacionales y mecanismos supranacionales de la sociedad civil; asimetrías de poder que sitúan a las comunidades como observadoras simbólicas en lugar de socias activas e iguales, cuyas perspectivas locales informen la toma de decisiones, agravadas por la captura de élites, la dependencia financiera y la exclusión de los debates técnicos bajo supuestos de incapacidad; y lógicas evaluativas que priorizan los resultados en salud por encima de los procesos habilitadores, como el fortalecimiento de capacidades, reglas claras de inclusión, financiamiento adecuado, rendición de cuentas y factores contextuales. Estos silencios atribuyen erróneamente las barreras institucionales a supuestas deficiencias comunitarias. Revertirlos requiere: una inversión deliberada en estructuras de participación multinivel visibles y funcionales, con las comunidades desempeñando un papel central en su definición; el reconocimiento de las comunidades como socias iguales en los debates y procesos de PPRP, cuyo conocimiento y aportes tengan el mismo peso; y enfoques de evaluación que prioricen la agencia, la rendición de cuentas y los factores contextuales habilitadores, en lugar de tratar la participación comunitaria como una intervención técnica evaluada únicamente por sus efectos finales en los resultados de salud.

Palabras clave: Prevención, preparación, respuesta, pandemia, COVID

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