

Building trust in humanitarian epidemic response: a scoping review

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Abstract

Trust has become a widely used term in the field of epidemic response and preparedness, yet it remains poorly defined and difficult to operationalise in humanitarian settings. Despite how often it is mentioned as a key component of successful programming, *how* exactly trust is built in practice remains an important question to be answered. The objective of this scoping review was to examine how trust has been conceptualised, implemented, and assessed in humanitarian outbreak response since the 2014 West African Ebola epidemic. A systematic search of six databases yielded 50 publications. A majority of studies were situated in African contexts and addressed a range of infectious disease outbreaks, particularly Ebola, COVID 19, HIV, and cholera, across responses involving a range of humanitarian organisations. The review shows that trust is repeatedly presented as a necessary condition for effective surveillance, vaccine confidence and uptake, acceptance of public health interventions, and participation in community engagement, but was rarely explicitly defined or directly measured. In contrast, the literature described mistrust in considerable detail, often presenting it as rooted in historical injustice, political marginalisation, institutional failure, misinformation, and the practices of the response itself. Trust, however, was less clearly specified, with limited explanation of how it should be built in practice. Common trust building approaches included community engagement, local intermediaries, risk communication, feedback mechanisms, community-based surveillance, and contextual adaptation of humanitarian intervention. However, links between these activities and trust were usually assumed rather than demonstrated. The findings emphasise that, although humanitarian outbreak response has absorbed the lesson that trust matters, it still lacks a clear framework for building and assessing trust in practice. Future work should define trust more precisely, examine the mechanisms through which it is produced, address questions of power and representation, and shift attention from gaining community trust to becoming more trustworthy.

Background

On the 30th May 2026, two weeks after a new Ebola outbreak was announced in the Democratic Republic of Congo, the WHO Secretary general visited affected communities and emphasised the importance of building trust. (WHO 2026). This followed episodes of anxiety and anger in the region where cases had been emerging, including the setting on fire of local treatment centres. ‘Trust’ has become a ubiquitous term in the epidemic response and preparedness. It is now well established both in the academic literature and amongst practitioners that trust is essential for the effective implementation of public health measures and for the uptake of vaccines and treatments, particularly in emergency situations (WHO 2024; Bollyky and Petersen 2024a). Conversely, it has been proven time and time again that without a solid foundation of trust amongst affected populations, even the best planned biomedical responses to infectious disease outbreaks can be quickly derailed. This was eminently visible in the West African Ebola outbreak (2014–2016), which took the lives of over 9,000 people, with Sierra Leone, Liberia and Guinea most affected. Indeed, the Ebola epidemic can be seen as a watershed in thinking and practice in this field, as it sparked a recognition of the non-negotiable need to engage affected communities and build their confidence in the emergency responses being mounted. Copious “lessons

learned” documents and reflections were published in the aftermath of the epidemic to contemplate how, particularly in the early months, as the disease spread seemingly uncontrolled across the regions, key opportunities were missed as people’s understandable fear and long-standing mistrust both in national institutions and international humanitarian efforts, meant that they were reluctant to report illness and deaths and to comply to public health measures (e.g. Panel of Independent Experts 2015; Moon et al. 2015). Anthropological research at the time pointed to the deep roots of mistrust in the region, linked to histories of colonial violence and extraction, poor governance and international exploitation (Wilkinson and Leach 2015; Abramowitz 2017; Benton and Dionne 2015). Further, initial failures to adapt biomedical measures to take into account the lived experiences of those most affected by the outbreak, was identified as a reason for low trust in the early stages (Lipton 2017). Subsequent efforts to rectify this included the novel establishment of community engagement and social mobilisation pillars as central to the humanitarian response apparatus, as well as the responsive adaptation of measures such as safe and dignified burials or the organisation of quarantines in efforts to incorporate local practices and livelihood considerations (Pedi et al. 2017a; Venables and Pellecchia 2017)

The lessons from this epidemic led to significant changes in the international architecture to respond to emergencies, including the formal inclusion of community engagement in the humanitarian cluster system, the establishment of platforms to coordinate community engagement and social science research to identify local perspectives and experiences (like the Collective Service and the Social Science in Humanitarian Action Platform), and efforts to develop ‘community-led’ approaches to epidemic preparedness and response (World Health Organization 2021). And indeed, the challenge of mistrust very soon made a re-appearance and proved once again to be considerably complex during the COVID-19 pandemic as across the world, governments struggled to contain the virus in the midst of scepticism, as decades of social tensions and eroded trust in politics and institutions undermined the effectiveness of response efforts (Leach et al. 2020; Grant 2023; Bollyky et al. 2022). These challenges are even more confronting in the context of humanitarian crisis. In these situations, for example as outbreaks emerge in settings plagued by conflict and displacement, or where epidemics escalate to the point of creating a humanitarian emergency, as the Ebola epidemic did, uncertainty, instability and insecurity further undermine the foundations necessary to gain the trust of affected populations (Lau et al. 2020). Leading humanitarian organisations such as the IFRC go as far as to state that trust is central to their mandate, as ensuring trust in humanitarian actors in times of crisis is seen to be the key to success (Mercado 2020).

We know, then, that trust really matters, so what should humanitarian practitioners do about it? Given how important trust appears to be for the successful implementation of essential interventions in outbreaks in humanitarian settings, it may be surprising that there is no immediately obvious answer to this question. Firstly, there is very little consensus on the definition of trust (Simpson and Storer 2022). Secondly, trust has not only proved an exceptionally slippery concept, but it has also been difficult to address directly through programming (Harriet Dwyer et al. 2025). Community engagement, for example, is often invoked as key for ensuring trust is maintained, yet it is not a single intervention, but rather an

umbrella term for a wide range of activities (from disseminating information to co-production) (Burns et al. 2026) and it is not always explicit how each of these may, in different ways, intervene on the problem of mistrust. In other words, despite how often it is mentioned as a key component of successful programming, *how* exactly trust is built in practice remains an important question to be answered (Mayhew, Kyamusugulwa, Bindu, et al. 2021).

This is what we set out to do in this article. A decade on from the end of the West African Ebola outbreak, and following a flurry of recommendations and new opportunities to test out trust-building efforts across a range of epidemics occurring in humanitarian crises, we ask: what has the humanitarian sector learned about how to act on these lessons? Through a scoping review of the published literature on the topic, we have scrutinised the current evidence on how humanitarian actors conceptualise and operationalise trust, that is, what kind of programmes and activities have been implemented to address the challenge of mistrust in these settings, and what we know about what works and what does not.

Methods

Study design

A scoping review approach was selected to provide an overview of the available evidence in this field, identify key characteristics and factors related to the concept under study, and examine gaps in the existing knowledge base (Munn et al., 2018). The review was conducted in accordance with the framework developed by Arksey and O'Malley (Arksey and O'Malley, 2005). Reporting was guided by the Preferred Reporting Items for Systematic Reviews and Meta Analyses extension for Scoping Reviews (PRISMA) (Tricco et al., 2018), and the SPIDER tool was used to inform the search strategy (Cooke et al., 2012). Given the emerging nature of this field, a scoping review was considered the most appropriate approach, as it allows for the inclusion of diverse forms of evidence, including qualitative, quantitative, and mixed methods studies, thereby capturing the complexity of the phenomenon under investigation.

The scoping review protocol was registered in a dedicated platform : <https://www.protocols.io/edit/trust-in-humanitarian-epidemic-response-jwqccpdsx>

Search strategy

The literature search was designed to address the following research question: What is the current evidence on how trust is produced and made actionable by humanitarian actors in epidemic contexts?

The search strategy was developed by the research team and structured around four key concepts derived from the research question: humanitarian, epidemics, trust, and operationalisation. The sample comprised populations affected by epidemics or outbreaks in humanitarian and crisis settings. The phenomenon of interest was trust in relation to humanitarian actors or services during epidemic response. The evaluation component encompassed any operationalisation of trust, including definitions,

measurement approaches, indicators, and intervention mechanisms intended to build trust. Given the emerging nature of this field, it was important to adopt a broad approach in order to capture any explicit reflection of trust building intervention. The review therefore included peer reviewed publications using empirical study designs, including qualitative, quantitative, and mixed methods studies, as well as discussion and evidence reviews where they described concrete examples of trust building interventions

The electronic databases searched were MEDLINE via Ovid, Web of Science, Scopus, PsycINFO, Embase, and PubMed. In addition, hand searching of key journals and reference lists of included studies was undertaken. The search strategy was adapted to the requirements of each database. The final search was conducted in January 14th, 2026. The full search strategy is provided in the Appendix.

Inclusion criteria

For this review, we selected research which met the following inclusion criteria:

- Publications published from 2014 to 2026
- Publications including any empirical study, literature review, and non-empirical publications
- Publications focusing on humanitarian settings
- Publications addressing an infectious disease epidemic
- Publications examining trust in relation to a humanitarian organisation and affected populations
- Publications providing information on concrete implementation experience of trust building intervention

Exclusion criteria

We excluded publications deemed to be not sufficiently within the inclusion criteria. Specific exclusion criteria were publications describing implementation experience outside humanitarian settings or not involving a humanitarian organisation; publications focusing on trust only in states/government/healthcare workers; publications not related to an epidemic response, publications published out of 2014–2026 period. Publications which were not published in English were excluded from this scoping review. We also excluded publications that does not mention any examples of concrete implementation experience of trust building intervention or publications that addressed trust only at a conceptual level.

Study selection

All identified records were imported into Rayyan, which was used to manage deduplication and the screening process. Titles and abstracts were screened independently by two reviewers according to the predefined eligibility criteria. Potentially relevant articles were subsequently retrieved in full text and assessed independently by the same two reviewers. Any disagreements arising during the screening

process were resolved through discussion, with consultation of a third reviewer where necessary. Reasons for exclusion at the full text stage were documented. The study selection process is presented in a PRISMA flow diagram.

Data extraction

Data were extracted from the included publications using a draft data extraction tool developed by the review team. The extracted information included author, year of publication, title, journal, country and setting, type of epidemic, humanitarian organisation involved, and study characteristics. Additional data were collected on how trust was defined, the type of trust mechanism described, and the indicators used to assess trust building. Particular attention was paid to the ways in which trust was operationalised in practice within humanitarian interventions. The findings were then synthesised thematically, with categories developed inductively from the data.

Findings

Characteristics

Initial database and hand searches yielded 1874 articles. After duplicates were removed, abstract and title screening and full text screening, a total of 50 publications were included for final analysis (detailed in the PRISMA flowchart Fig. 1). The corpus includes research publications (n = 19) among which the most common study type is qualitative research (n = 14), as well as literature reviews (n = 14), and non-empirical publications (n = 16). Geographically, the evidence was concentrated in African contexts (n = 24), with the largest number of studies conducted in the DRC (n = 6). Outside Africa, Bangladesh was the most represented setting (n = 5), while Lebanon, Ukraine, and Palestine were each represented by one study. In terms of disease focus, Ebola was the most frequently represented epidemic (n = 14), followed by COVID 19 (n = 9). HIV was addressed in 4 studies, and Cholera also appeared in 3 studies. Other diseases or themes were much less frequent, including measles, diphtheria, mpox, HPV, and infectious disease more broadly, each appearing once. Regarding humanitarian actors, MSF was named in 6 studies, while IFRC and UNICEF each appeared in 4. Other organisations appeared only once or twice, and several studies did not specify a humanitarian organisation.

Defining Trust

Trust, or rather its lack, was a key point of discussion across all articles reviewed, including as part of their analysis of the challenges of containing infectious disease outbreaks and as motivation for the humanitarian interventions they described. Mistrust was presented as posing a problem to a wide range of dimensions of humanitarian response to epidemics. Byrne et al for example point to how a lack of trust in authorities resulted in poor reporting to epidemiological surveillance, thus allowing for diseases to go undetected. Nasr et al discuss how misgivings about public authority in their case studies of Ukraine, Sudan and Lebanon undermined vaccine confidence, something that was echoed across other

articles, including for example various studies about vaccine uptake amongst displaced people in Cox's Bazaar in Bangladesh (Yusuf et al. 2025; Reda et al. 2025)

The widespread consensus that mistrust is a major challenge for outbreak response can be traced back to the West African Ebola epidemic. Indeed, as anticipated, Ebola featured prominently across our corpus of literature. As Bollyky and Petersen (2024) note, the outbreak marked a turning point in thinking about outbreaks within the global health community, as it brought clearer recognition that effective epidemic interventions strongly depend on the ability of humanitarian actors to build trust amongst affected populations. Given that trust is so central to the articles' understanding of the challenges of mounting effective outbreak response efforts, it is remarkable that very few of the papers explicitly define it. Most of the articles did not engage with social scientific theories on trust but neither did they offer an operational definition, for example of how we might know whether an intervention is trusted or otherwise, or whether it has managed to build trust. As Dwyer et al. (2025) note, it is a difficult and slippery concept to define and ever more difficult to meaningfully integrate in operational programming.

Mistrust, on the other hand, was described in much more detail as many articles invoked trust reactively, that is, emerging through the identification of barriers linked to mistrust in humanitarian interventions (Caleo et al. 2020; Jega et al. 2024; Nasr et al. 2025). A context of mistrust was widely acknowledged to have deep roots. Dwyer et al. (2025), for example, in their review of studies on trust and vaccine confidence in humanitarian settings, emphasise the importance of structural dimensions, noting how it is impacted by historical injustices, political dynamics and inequitable health systems. In some articles, such as Jega et al.'s (2024) review of the Nigerian Red Cross' response to a diphtheria outbreak in Nigeria, a context of mistrust was rather generically attributed to 'cultural' issues or misinformation. Another important dimension of discussions of mistrust was a focus on the practical realities faced by humanitarian workers and, more specifically, how mistrust emerged from the dynamics of the response itself. Indeed, as Pedi et al. (2017) note, during epidemics, mistrust tends to relate to the response apparatus rather than in the outbreak. In the context of an Ebola outbreak in Uganda, Musoke et al. (2025) discuss how mistrust was fuelled by disagreements within the response apparatus as to whether community members could contribute to response efforts and unclear feedback loops that led to resistance when people felt that their questions were not being answered. In a similar vein, Hamuli et al. (2023), presenting a study on local perceptions of humanitarian response in Eastern DRC during the COVID-19 pandemic, report that mistrust grew out of a mismatch between what people expected of the response (e.g. that they provide logistical support for the population to be able to implement protective behaviours such as handwashing) and what they saw, or in this case did not see, on the ground. On the biomedical side of the response, Caleo et al. (2020) note how poor diagnostic definitions can lead to mistrust and undermine self-reporting.

If this literature establishes fairly definitively that mistrust is widespread and a major problem for humanitarian response, it is less easy to parse *how* trust is to be built. In the next sections we will discuss in more details the types of interventions that are presented as an avenue for building trust, yet as we shall see there too, very few studies offer insights into the mechanisms through which these

interventions are intended to achieve trust. Among the nineteen studies that report concrete intervention aimed at fostering trust, for example, very few provide any information on evidence regarding their actual effects on trust. What also emerged from our reading of the literature was a widely shared, implicit assumption that trust is a means to an end for example to “increase acceptability of services”, “improving health service uptake” or “ensure adherence” (Hossain et al. 2025a; O’Keeffe et al. 2023; Polonsky et al. 2022; Ismail et al. 2022; Nasr et al. 2025). This means that, in the articles we reviewed, we did not see it assessed as an outcome. It was not clear, then, how we might determine whether the achievement of those goals could indeed be attributed to the intervention increasing community trust or why a particular activity may have worked or not. In other instances, trust in a particular humanitarian organisation was taken as given, for example both Mercado (2020) and Erlach et al. (2021) state that the IFRC is a trusted organisation and that its “association with impartiality and neutrality...creates an enabling environment for trust”.

A further issue in this context, highlighted by Bollyky and Petersen (2024) in their proposal for a “practical agenda for incorporating trust in pandemic preparedness and response”, is that trust is often viewed as one-directional, something that we also found to be the case in many of the other articles in the corpus. The dominant concern is how to secure trust from the population in humanitarian actors, systems and specific response activities. This also means that the change that is envisioned as necessary is within the population – e.g. through behaviour change—and rarely on how humanitarian actors and programming might change to become more trustworthy. The latter can make a significant difference. Mayhew et al. (2021) for example report an example of a programme that, in response to mistrust in the health system during the 2018 outbreak in Eastern DRC, expanded medical care beyond Ebola. As they note, transformation of interventions is often required to shift mistrust, including engaging local “intellectual leadership” to advise on how such transformation might take place. Other articles, such as Niederberger and Glanville-Wallis (2019) on the same outbreak, emphasise the importance of “closing the feedback loop”, that is, making sure that feedback actually results in action. Similarly, Erlach et al.’s (2021) reflection on community feedback mechanisms (discussed in more detail below) shows how feedback can lead to the introduction of new solutions. For example, they discuss how frequent feedback on the difficulty of practically implementing handwashing guidance resulted in the Red Cross supporting community volunteers to build handwashing stations. Another useful contribution in this dimension is Ryan et al.’s (2019) research with local implementers of the Ebola response in Guinea during the West African outbreak, which outlines the “technologies of trust”, which they adopted to gain the trust of their neighbours during times of crisis, including practicing openness, accountability and reflexivity.

Community Engagement

Community engagement (CE) was one of the most prominent interventions, or set of interventions, identified in our corpus as expected to build trust (n = 42). Musoke et al. (2025) exemplify this by explicitly including building trust as one of the key aims of engagement in their helpful summary of its intended aims: “community engagement seeks to involve communities in the design, implementation

and evaluation of interventions to raise awareness on key issues, build trust between communities and partners, create ownership of interventions and contribute to social cohesion of impacted populations. In addition, community engagement attempts to understand cultural and social practices that drive epidemics, as well as negotiating a contextually acceptable public health response". Across the 42 articles in which CE emerged as a cross-cutting theme, the concept encompassed a wide range of activities, from educational drives on vaccination to much more wide ranging, deliberative interventions such as the engagement of local committees and feedback systems, described in more detail below. Although interventions were not often described in detail, the majority appeared to relate to either information and behaviour change campaigns or community-based dialogue led by local leaders, with a smaller proportion mentioning systematically soliciting feedback from communities, or engaging communities in activities such as surveillance, alert or development of tools such as diagnostic definitions. The co-design of different dimensions of the response was not discussed in detail in any of the empirical articles. The review by Gilmore et al. (2020) identified a handful of examples of this, for example a study about the co-design of messaging around Ebola in Sierra Leone. Interestingly, though outside the scope of this review, many more examples of this appear in Gilmore et al.'s (2020) review from experience with indigenous and aboriginal communities in settler colonial contexts in the Global North. Their review also illustrates a recurring pattern in the corpus, whereby the relationship between CE and trust is often inferred rather than explicitly articulated. Moreover, effective community engagement is rarely defined, which makes it difficult to assess outcomes or compare approaches across settings.

Despite the ambitious aims listed by Musoke et al. (2025), in the corpus the objectives of engagement range widely, from raising awareness, improving acceptability to encouraging ownership and participation, with no explicit theory of change outlined in relation to trust-building. We found very few examples of reported evidence to support that a specific CE intervention had indeed built trust, and how, which is undoubtedly rendered more difficult by a lack of definitional clarity over trust itself. Where CE was seen as successful in "improving trust", e.g. the use of community engagement to select focal points for Community Based Surveillance (CBS) (OKeeffe et al. 2023)—it was not clear how this was ascertained. Instead, trust was often assumed to be self-evident, for example as authors stated that an intervention—e.g. hiring female Community Health Workers (CHWs) for health education in Cox's Bazaar (Reda et al. 2025)—improved trust. One example where some evidence was provided was a survey conducted in Mali which showed that an educational intervention on COVID-19 protective behaviours improved (presumably self-reported) trust in government information (Crippin et al. 2025). This study also showed increase in trust after story-telling and educational sessions through a post-activity survey. Another exception was Kislaya et al.'s (2025) assessment of a dialogue-based awareness raising campaign, but even this did not have a measure for trust and rather assess the effectiveness of the dialogue on level of information post-intervention.

Regardless of this lack of rigorous assessment of the link between CE and trust, there were some examples that were cited across different articles as being particularly exemplary of successful engagement that had been deemed to result in higher levels of trust. The literature on Ebola in for example, highlights the adaptation of burial practices to better align with local norms (McKay et al. 2022;

Ryan et al. 2019; Niederberger and Glanville-Wallis 2019). Description of these adaptations fuelled narratives on the success of community engagement and encourage their systematic adoption (Lees et al. 2020), and the inclusion of CE as a core activity of the outbreak response architecture following the West African epidemic is indicative of this. In this sense, Pedi et al. (2017) offer a fascinating insight into the practical steps that led to the gradual formalisation of CE, including the development of Standard Operating Procedures during the outbreak in Sierra Leone, including efforts to move from one-way messaging to dialogic approaches and efforts to link up CE with supply-side services to foster trust.

The role of local intermediaries

The most frequently recurring finding in the literature was a strong emphasis on mobilizing specific local actors into the epidemic response, and specifically as agents of CE, enhance trust (n = 46). These figures, labelled as local leaders, trusted messenger, or community representatives, are often presented as key connectors who help translate messages, lend legitimacy to interventions, and act as intermediaries between the community and humanitarian actors (O'Keeffe et al. 2023; Fallah et al. 2022; Ryan et al. 2019). When papers are more specific, these actors fall into three broad categories.

First, local leaders encompass a broad range of local actors, including religious leaders, local chiefs, elders, mayors, women leaders, and other key influencers (N = 45). They are described as trusted and credible intermediaries who can legitimize health interventions and improve community acceptance (e.g. Ngwa et al. 2020; Polonsky et al. 2022; Jalloh et al. 2020). Miller et al. (2020) report that the engagement of respected community leaders was key to gaining trust in CHW services, and note that involving traditional and religious leaders in northern Nigeria reduced resistance to polio vaccination and a similar finding by (Ngwa et al. 2020) refers to the inclusion of “bullamas” (community leaders) in Borno state during the cholera outbreak in IDP camps. Similarly, in Liberia, (Fallah et al. 2022) discuss how trusted leaders were able to deliver personalised messages and reduce stigma that was leaving to mobility during the Ebola outbreak. These leaders are assumed to hold authority over the community, or at least over specific social groups, which is often considered as inherently deriving from their social position and to lead to increased trust (Campbell et al. 2022; Gilmore et al. 2020; Fallah et al. 2022). During the Zimbabwe cholera outbreak in 2024, the involvement of survivors was identified as improving trust (presumably because people saw that treatment worked, though this is not explicitly stated) (Munemo et al. 2025). Similarly in the West Bank in Palestine, pre-existing trust in popular committees made up of representatives of people live in camps helped mediate the introduction of preventative COVID-19 measures (Shakhshir and Hammoudeh 2025). In Bangladesh, Akter et al. (2022) suggest that the involvement of “Community Corona Protection Committees” in a Covid-19 response intervention, strengthened trust in the project by acting as an intermediary between community members and service providers.

In many of these articles, there was no explanation of how these actors were identified or according to which criteria, which seemed to suggest an assumption that legitimacy is inherent in their social or formal position. Indeed, some explicitly state this, as one study in Nigeria reported in Ismail et al.'s (2022) review of vaccination in protracted humanitarian crisis which attributes success to local

volunteers to their social position and cultural sensitivity. However, there were also some very interesting discussions in some articles about how power and gender dynamics in some cases undermined the success of “local leadership” in achieving trust during a health emergency. For example, reflecting on the use of ‘community leaders’ in the CBS system for EVD in DRC, O’Keefe et al. (2023) found that this meant integrating ‘traditional structures’ in the response and this at times “exacerbated existing imbalances in power structures and promoted nepotism” in the selection of Community Health Workers. Similarly, Yusuf et al. (2025) found that in promoting childhood vaccination in Cox Bazaar, not all leaders involved in these efforts were trusted, including for example those affiliated with the army. Whilst most of these articles note the problem of power in the selection of ‘local leaders’ retrospectively, as a lesson learned from their projects, two articles reported on proactive efforts to address these dynamics. Niederberger and Glanville-Wallis (2019) for example noted how Oxfam made active efforts to strengthen the role of less accessible groups, and building capacity to ensure they could participate in the development of community action plans for Ebola prevention in DRC. One study warns against presuming in advance who the trusted messengers are and highlights the importance of unpacking structural inequalities to understand what messengers symbolize and which allies are trusted by different community members (Ryan et al. 2019).

Another category refers to community health workers (Crippin et al. 2025; Gil Cuesta et al. 2021). These actors deliver communication or perform surveillance activities as part of CBS and their role usually implies training, supervision, reporting information to response structures (e.g. disease alerts) and engaging in dialogue with affected populations (N = 34). Compared to the leaders, they are described less as symbolic authorities and more as peers and practical trust enablers (Reda et al. 2025; Akter et al. 2022; Miller et al. 2020; Halder et al. 2023). Their selection is carried out by health authorities or humanitarian organizations, or in some instances in consultation with their communities (e.g. O’Keefe et al. 2023) with a particular emphasis placed on their acceptability within the community, often on the basis of their local embeddedness (Miller et al. 2020; Ryan et al. 2019; Halder et al. 2023). In contrast with local leaders whose authority is generally not questioned, legitimacy of community health workers within the population has to be secured through transparent selection ensured by external actors (e.g. a health authority or humanitarian organization). For example, a study from Afghanistan highlights the risks of relying on community leaders for the selection of CHWs, “which led to nepotism” (Miller et al. 2020). Finally, gender was found to be important as across different contexts ensuring that female CHWs were involved increased women’s participation, for example in Jalloh et al.’s (2020) study of social mobilization for vaccination during a diphtheria outbreak amongst Rohingya refugees in Bangladesh. Overall, community health workers appear to occupy a hybrid position between local leaders and workers, with legitimacy grounded both in local recognition and in their technical skills and knowledge.

A last category of local intermediary is local NGOs mentioned in a few studies (Reda et al. 2025; Mercado 2020; Kislaya et al. 2025). Their credibility appears to rest less on formal authority than on longstanding local presence, prior relationships, and embeddedness in existing community structures as for example Red Cross in DRC (Earle-Richardson et al. 2021), or BRAC in Bangladesh (Akter et al. 2022).

Communication pathways

Several studies emphasize communication as a pillar of trust building strategies (n = 46), with a particular emphasis on moving beyond one-way messaging towards more dialogic approaches (Dwyer et al. 2025; Erlach et al. 2021). Communication is often bundled together with community engagement as part of so-called “Risk Communication and Community Engagement” (RCCE) pillars in humanitarian response. Here we focus on the findings specific to the characteristics of communication between response workers and affected populations that are seen to support or undermine trust in outbreak response, even as they are often a key component of broader community engagement interventions.

The articles reviewed emphasise the importance for trust-oriented communication to be based on locally tailored information including culturally sensitive messaging and formats that match local norms (Jega et al. 2024; Jalloh et al. 2020; Hossain et al. 2025b; Dwyer et al. 2025; Halder et al. 2023). In Pedi et al.'s (2017) account of community engagement strategies during the EVD outbreak in Sierra Leone, they mention the importance not only two-way conversations with affected communities but also adaptive messaging, that is, dynamic communication that reflects changes in the course of the emergency as well as feedback from those affected by it. Although some evidence remained of traditional one-way communication (sometimes led by ‘local leaders’ for legitimacy), most articles recognised the importance of dialogue. Good communication is seen to include evidence-based information sharing, where messages are framed around what is known from credible sources and linked to practical guidance (Thomas J Bollyky et al. 2022; Trolle et al. 2023; Gil Cuesta et al. 2021). Additionally, information was found to be most effective when delivered by locally endorsed messengers recognized as legitimate by the community, as mentioned in the previous section (Hossain et al. 2025b; Halder et al. 2023). Language was important too: Ngwa et al. (2020) for example show how the response initially used Hausa to communicate in IDP camps in Borno state about cholera but later realised that Kauri was the majority language and had to shift.

Transparent communication is also mentioned as a key component to enhance trust building, especially highlighting the need for the organizations to acknowledge what is not yet known scientifically (T.J. Bollyky and Petersen 2024b; Ismail et al. 2022; Ryan et al. 2019; Dwyer et al. 2025; Halder et al. 2023). The messengers are also described as more effective when they are trained in soft skills as respectful communication, active listening, and non-judgmental interaction (Gil Cuesta et al. 2021). For example, in Halder et al.'s (2023) study of COVID-19 preventative behaviours amongst Rohingya refugees, respondents recommended that CHWs spend more time in communities and show them respect in their interactions with them. Similarly, in another study on the same topic in Cox's Bazar, building good relationships was listed as key for building trust.

Feedback mechanisms

Across several articles, feedback mechanisms are positioned as instruments for trust building and a very specific type of community engagement and communication approach (n = 20). These mechanisms are intended to capture concerns in real time in order to then act on them, with trust expected to be built

as communities see that they are being listened to (Jega et al. 2024; Heywood and Yaméogo 2022; Ryan et al. 2019; Pedi et al. 2017b; Nally et al. 2024a). Studies describe various frameworks for feedback mechanisms, but arguably the most established and recognised approach is that developed by IFRC. This involves categorising feedback into six domains: questions, statement (rumour, belief, observation), suggestion/request, sensitive or violence-related, appreciation, other (refused dialogue). The narrative, as outlined in detail by Erlach et al. (2021) emphasises the importance of listening to “understand continuously how people perceive disease and response” and translating this into key actions accordingly. In particular they draw on their experience applying this mechanism during Ebola in DRC to highlight its success as it led to adaptations of RCCE (e.g. working with trusted leaders to share information), developing community insights to guide response, advocating for community needs based on feedback and encouraging the establishment of inter-agency working groups for addressing community feedback. The article does not offer specific evidence on whether and how feedback and its associated action did lead to higher trust. In their research on the implementation of this mechanism in DRC, McKay et al. (2022) also point to a significant challenge in ensuring effective uptake of feedback data, due for example to the continued dominance in response structures of biomedical and quantitative approaches to evidence.

A very different type of communication mechanism is CBS, whose success is also described in the literature as relying on population trust (Archer et al. 2023). Indeed, the establishment of community-level systems for feeding information on diseases in the community back up into the public health surveillance system are justified precisely through an appeal to the higher trust that these systems might have in a context where formal structures may be subject to doubts and misgivings. Reporting is most likely to occur when community members perceive the surveillance system as legitimate, safe, and responsive, and when those who collect data are themselves credible within local networks (Byrne and Nichol 2020; O’Keeffe et al. 2023). As we saw above, the inclusion of local intermediaries as focal points in CBS is described as an important pathway to strengthen trust between communities and public health authorities, with the pathways already noted.

Contextual Grounding

A final, less prominent dimension of discussions on trust for outbreak response in humanitarian settings was an appeal to the importance of context (n = 13). Many articles mentioned this in passing, for example noting how information needed to be “contextually appropriate” (Nally et al. 2024b; Pellecchia 2017; Trolle et al. 2023; Ngwa et al. 2020b; Gillespie et al. 2016; Ismail et al. 2022a; Lees et al. 2020), or the importance of adapting messaging to suit local norms and rather vaguely defined cultural practices (Reda et al. 2025a; Halder et al. 2023; Thomas J Bollyky et al. 2022; Hossain et al. 2025). Others mentioned the significance of the historical dimensions of mistrust, pointing for example to colonial history as the root of contemporary hesitance around external humanitarian intervention and long-standing marginalisation that makes people suspicious of government guidance or enforcement during public health emergencies (e.g. Dwyer et al. 2025). Whilst it can be difficult to translate these into the short time frames of emergency response, some studies discuss the role of social science in helping to

understand context and propose recommendations for integrating this into action. Lees et al. (2020), for example, offer an in-depth analysis of the role of anthropologists in the Ebola epidemic, reporting on how their participation was sought as “firefighters” when the epidemic seemed out of control, but highlighting their ability to situate key challenges in context, offer adaptations for interventions (e.g. the changes in burial practices noted above) and putting forward understandings of power within affected populations that could improve the effectiveness of RCCE efforts. Another example of this is offered by Pellecchia's (2017) study of resistance around quarantines in Liberia during the Ebola epidemic, and his suggestion that understandable fears could be contrasted by learning from existing local forms of quarantine that maintained social connections and as such were less harmful for local trust.

Discussion

Reviewing the literature published over the decade since the end of the West African Ebola outbreak has shown that trust has undoubtedly become a major preoccupation for those involved in and researching humanitarian responses to infectious disease outbreaks. The outbreak itself has had a significant impact on the field, with its lessons on the importance of gaining the confidence of affected populations and engaging them in the implementation of emergency response reverberating over time and across different contexts. As shown by the articles discussed in this review, the danger of replicating purely biomedical responses that do not consider the specificity of context and the voices and experiences of those affected is clear across the sector. The articles reflect the emergence of new approaches and systems, including the mainstreaming of community engagement efforts in the humanitarian response architecture, the establishment of new mechanisms for involving affected populations in the reporting of surveillance data through CBS, the wide use of feedback systems to ensure that the concerns of those bearing the brunt of health emergencies are collected in real time and that they shape response activities. Involving ‘local leaders’, ranging from chiefs and religious leaders to informal influencers, has become standard practice as ‘trusted messengers’ are seen to be crucial for ensuring uptake of public health interventions.

As we have identified, however, despite these innovative approaches and the valuable insights gained, particularly regarding the need to secure trust, some gaps remain which may hinder the effective application of these lessons into action. Many of these challenges originate at the conceptual level. Firstly, across the corpus of literature, trust is under-theorized. There are no definitions, whether conceptual or operational. Instead, its implied meaning can be inferred across assumptions. As Schmidt Sane et al (2023) point out, “trust and mistrust are portrayed as binary choices related to individual choices to accept or refuse a variety of healthcare interventions”, mistrust then is a “barrier to clinical intervention”, for example as a hindrance to effective surveillance or vaccine confidence. Schmidt Sane et al then suggest that the “complex processes which generate supposed ‘negative beliefs’ that give rise to suspicions of malicious intent”, such a structural and historical dimensions, are often left unanswered. In the literature we reviewed, some of these dimensions are mentioned in a few articles, for example as Dwyer et al (2025) link vaccine hesitancy and historical injustice. The difficulty arises in relation to the focus of this review – namely, the operationalisation of trust – since it remains unclear whether, and in

what ways, these structural dimensions, even when recognised, are addressed through programming initiatives such as the activity of information dissemination via local leaders. We may say that addressing structural problems and historical inequalities is outside the purview of short-term emergency relief, yet this disconnect between a deeper analysis of the drivers of mistrust and the actual programming reveal a more practical issue. In the majority of the articles reviewed, the problem of mistrust is placed in the affected population. Interventions such as community engagement or communication, and the inclusion of local leaders, are often framed as efforts to lend legitimacy to interventions that are already defined and deemed to be correct. As Mayhew et al note, evidence of meaningful transformation in response activities through co-design with affected populations remains limited.

Feedback loops seem to offer an opportunity for some influence on the nature of programming, yet, as for the rest of the articles, evidence is scarce on whether and how these mechanisms have effectively led to transformative solutions that have indeed been found to build trust. This points to the second operational problem that emerges from lack of conceptual clarity, namely that in the absence of a clear understanding of what trust is in the first place, it is also difficult to determine whether it is being built through programming. And indeed, almost none of the articles offer any evidence of this or propose a theory of change linking, for example, community engagement and increased trust or showing how trust is a mechanism that community engagement engages to achieve some other goal (such as higher vaccination). Indeed, we may also critique the implicit assumption that trust is a means to an end rather than an end in itself when it comes to a genuine commitment to encouraging local populations to shape how a humanitarian response is designed and implemented. As Burns et al. (2026) argue, across the community engagement sector in humanitarian settings, the aims and goals of these endeavours have remained vague without a clear and shared understanding of what its intended outcomes should be and what the mechanisms are for getting there.

Outside of the published literature, there have been some efforts by humanitarian actors, to try to develop this evidence base. For example, IFRC has been working on an impact assessment framework for community engagement as well as a trust index to measure trust in Red Cross society actors across different kinds of humanitarian crisis (Walz et al. 2025). This suggests that more evidence in this space may be forthcoming. It should be emphasised, however, that calling for stronger evidence on how trust is built in practice does not necessarily imply the development of quantitative indicators. Indeed, for a process as complex as trust, it may be useful to think about qualitative approaches to collecting narratives of change (Copestake et al. 2019), which would also allow to account for an appreciation of the deeply contextual, structural and historical factors which may not be easy for an intervention to address but which greatly influence humanitarian actors' ability to gain the confidence of populations.

A final conceptual issue with operational implications that emerges from this literature surrounds the question of power. As we have seen, many of the articles speak of engaging 'local intermediaries' as an effective way to engage communities. The, often implicit, assumption is that having people who are 'local' and somehow socially proximate to the affected population conduct outbreak response activities

lends legitimacy to these endeavours. Other types of legitimacy are also mentioned, though more rarely, such as the experiential legitimacy of survivors. However, as some of the articles themselves acknowledge, there are potential pitfalls in assuming that legitimacy is given or somehow inherent in social position. As we have argued elsewhere, humanitarian efforts at community engagement often fail to consider the empirical operations of power (Author). The very concept of 'community', ubiquitous across the literature, gives the impression of cohesive social units thus obscuring inequities and divisions as well as the simple fact that different social groups may feel better represented by different people. Power also shifts as a result of humanitarian response as the very activities discussed in this article, such as the identification of individuals as 'local leaders', elevates some over others. As two articles in our corpus note, there are ways to address this proactively, for example by identifying groups with less access to power to ensure they are also involved. A more systematic way of doing this is to integrate the mapping of local power in the development of humanitarian response in participatory ways.

The outbreak of Ebola Bundibugyo Virus in Eastern DRC is showing once again the importance of building trust. In a context of intersecting conflict and health system challenges, compounded by an epidemic of a virus that has no licensed medical countermeasures, ensuring that local populations have confidence in public health measures and the humanitarian actors implementing them is one of the only tools available. To support these efforts, the humanitarian sector it will be important to build a stronger evidence base on what works in these challenging situations.

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Figures

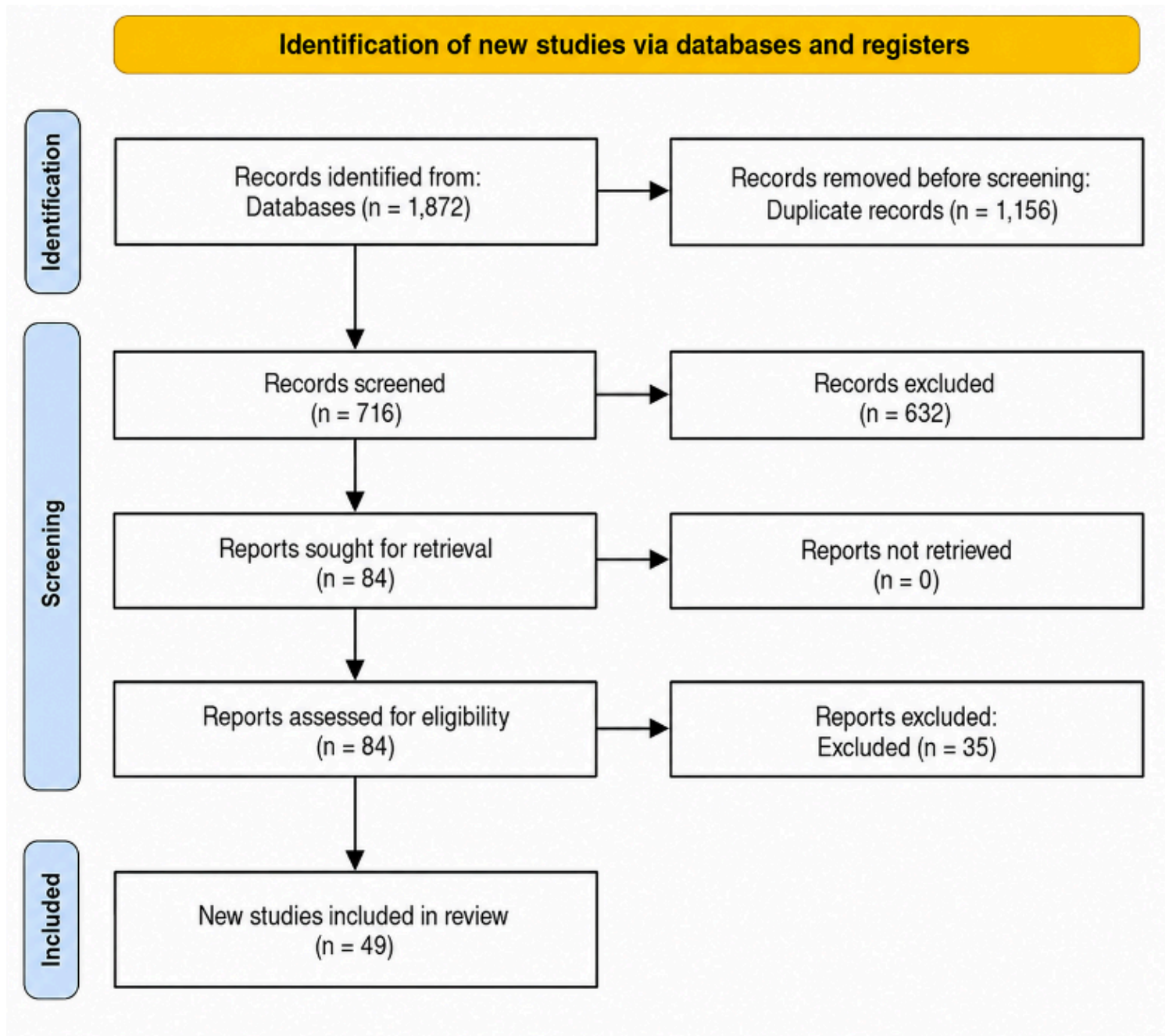


Figure 1

PRISMA flowchart generated via Rayyan