

Supplementary Table 1: Preferred Reporting Items for Systematic reviews Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist (Tricco et al., 2018)

Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist			
<u>Section</u>	<u>Item</u>	<u>PRISMA-ScR Checklist Item</u>	<u>Reported on Page #</u>
TITLE			
Title	1	Identify the report as a scoping review.	1
ABSTRACT			
Structured summary	2	Provide a structured summary that includes (as applicable): background, objectives, eligibility criteria, sources of evidence, charting methods, results, and conclusions that relate to the review questions and objectives.	1-2
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known. Explain why the review questions/objectives lend themselves to a scoping review approach.	2-3
Objectives	4	Provide an explicit statement of the questions and objectives being addressed with reference to their key elements (e.g., population or participants, concepts, and context) or other relevant key elements used to conceptualize the review questions and/or objectives.	3
METHODS			
Protocol and registration	5	Indicate whether a review protocol exists; state if and where it can be accessed (e.g., a Web address); and if available, provide registration information, including the registration number.	4

Eligibility criteria	6	Specify characteristics of the sources of evidence used as eligibility criteria (e.g., years considered, language, and publication status), and provide a rationale.	4
Information sources	7	Describe all information sources in the search (e.g., databases with dates of coverage and contact with authors to identify additional sources), as well as the date the most recent search was executed.	4
Search	8	Present the full electronic search strategy for at least 1 database, including any limits used, such that it could be repeated.	4
Selection of sources of evidence	9	State the process for selecting sources of evidence (i.e., screening and eligibility) included in the scoping review.	5
Data charting process	10	Describe the methods of charting data from the included sources of evidence (e.g., calibrated forms or forms that have been tested by the team before their use, and whether data charting was done independently or in duplicate) and any processes for obtaining and confirming data from investigators.	5
Data items	11	List and define all variables for which data were sought and any assumptions and simplifications made.	5
Critical appraisal of individual sources of evidence	12	If done, provide a rationale for conducting a critical appraisal of included sources of evidence; describe the methods used and how this information was used in any data synthesis (if appropriate).	NA

Synthesis of results	13	Describe the methods of handling and summarizing the data that were charted.	5
RESULTS			
Selection of sources of evidence	14	Give numbers of sources of evidence screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally using a flow diagram.	5
Characteristics of sources of evidence	15	For each source of evidence, present characteristics for which data were charted and provide the citations.	5-6
Critical appraisal within sources of evidence	16	If done, present data on critical appraisal of included sources of evidence (see item 12).	NA
Results of individual sources of evidence	17	For each included source of evidence, present the relevant data that were charted that relate to the review questions and objectives.	6-13
Synthesis of results	18	Summarize and/or present the charting results as they relate to the review questions and objectives.	6-13
DISCUSSION			
Summary of evidence	19	Summarize the main results (including an overview of concepts, themes, and types of evidence available), link to the review questions and objectives, and consider the relevance to key groups.	13-15
Limitations	20	Discuss the limitations of the scoping review process.	15

Conclusions	21	Provide a general interpretation of the results with respect to the review questions and objectives, as well as potential implications and/or next steps.	15
FUNDING			
Funding	22	Describe sources of funding for the included sources of evidence, as well as sources of funding for the scoping review. Describe the role of the funders of the scoping review.	15

Supplementary Table 2: Summary of CBR studies focusing on awareness

Awareness					
Authors	Recruitment	Awareness implemented how?	Sample Characteristics (N, M/F, Mean Age)	Outcome measured by	Study Outcome
Choi et al. (2019)	Where: Suburban Korean Church in Maryland. How: Church announcements and church newsletter 2-3 weeks prior of the screening session at the church.	Culturally adapted K-HEARS (Hearing Equality through Accessible Research and Solutions)	n=15, M-67%, 67.9 (8.1) CPs- n= 15, M-13%, 62.9 (11.6)	Focus groups	Six weeks post-intervention, participants' mean hearing handicap score reduced from 15.7 to 6.4. Communication partners demonstrated improved social-emotional function. Post-intervention focus group revealed increased hearing benefit, confidence in hearing health navigation, and awareness in hearing health among study participants.
Dodds & Harford (1982)	Where: 2 Retirement Homes, 1 Retirement Hotel, 8 Senior Activity Centers, 2 Health Fairs. How: Bulletin Boards, Mail, Monthly Activity Bulletins, Local Newspaper.	Educational Seminars	Specific sample characteristics were not provided.	Questionnaire (not specified)	Positive feedback from those who completed the questionnaire, suggesting many senior citizens are interested in learning more about hearing loss, hearing aids, and aural rehabilitation.
Griest et al. (2007)	Sampling specifics were not provided.	Dangerous Decibels	Total; n=1,028 4th-graders: n=478 4th-grader study group: n=223, M-54% 4th-grader comparison group: n=255, M-56% 7th-graders: n=550 7th-grader study group: n=284, M-52% 7th-grader comparison group: n=266, M-50%	Questionnaires (Ability to retain knowledge and attitudes)	The Dangerous Decibels hearing loss prevention program was effective at producing long-term improvements in the knowledge base of 4th- and 7th-grade students. Future studies should include components on peer pressure and should incorporate repeated, multimodality interventions to increase the likelihood of long-term improvement in adolescents.
Lukes & Johnson (1999)	Where: Mesa, Arizona (Two Junior High Schools) How: Occupational nurses contacted schools in the area. Two junior high	"Hearsafe" video, "Say What? An Introduction to Hearing Loss" audio, and demonstration of hearing protection	Sample characteristics were not provided.	Pretest and posttest.	The success of this pilot study supports the expansion of a partnership between industry and schools with the goal of hearing conservation.

	schools were chosen for the pilot program.				
Martin et al. (2017)	Representatives to the Northwest Portland Area Indian Health Board invited the Oregon Health and Science University Prevention Research Center (PRC) to partner in promoting hearing health among youth in their communities.	Adapted Dangerous Decibels Program.	Specific sample characteristics were not provided.	Survey and continuation of the programs	The intervention was effective at changing knowledge, attitudes, beliefs, and behaviors in the target population
McCullagh, Yang, et al. (2020)	Pre-existing Safety Days protocols for recruitment and consenting participants	Group A: 20-min face-to-face interactive lesson Group B: 20 min face to face interactive lesson + 3 month follow-up Internet based booster Group C: no intervention	Total: n=1,979, M-46% Group A: n=662, M-47%, 9.77 (1.73) years Group B: n=680, M-45%, 9.62 (1.65) years Group C: n=637, M-46%, 9.57 (2.38) years	Martin et al. questionnaires 3 month and 12 month follow ups	This study represents one of very few clinical trials testing the effectiveness of hearing conservation interventions for farm operators or farm youth. Combined face-to-face and Internet interventions were more effective in increasing knowledge and improving attitudes toward use of hearing conservation strategies than comparison groups not receiving the dual interventions.
Smith et al. (2018)	Where: Community setting in the Western Isles of Scotland How: Nurses were invited via invitations distributed to each five locality teams across the four islands.	3-4 hour educational intervention Sensory training workshops	n=41, Specific sample characteristics were not provided.	Pre and post-workshop questionnaires 3 month post-workshop postal questionnaire 6 month post-workshop focus group	Overall participants knowledge and awareness of sensory impairments increased, empathy and compassion for patients with sensory impairments increased, and participants were more likely to refer patients with sensory impairments to specialists.

Supplementary Table 3: Summary of CBR studies focusing on newborn and infant hearing screening and assessment

Newborn and Infants					
Study	Recruitment	Sample Characteristics (N, M,F, Mean Age)	Screening Method Used	Who Performed Screening	Study Outcome
Basu et al. (2008)	Data recorded for 10,074 well babies between March 2004 and December 2005 from The Newborn Hearing Screening Program (NHSP) England. Screening is done through a hospital or community-based.	n=10,074 Gender specifics were not provided. 10 days	OAE and AABR	Health visitors	This study demonstrates that community-based NHSP under-taken by health visitors is an effective method of screening and it has the capacity to meet all the standards set by the national program. This study has demonstrated that it is possible to rehabilitate babies with permanent hearing loss identified by the screen within the timescales set by the program. Specific guidelines are required for the management of children with unilateral hearing loss.
de Kock et al. (2016)	All infants attending the postnatal follow-up visits were offered routine screening as part of the universal screening program.	Total: n=7,452 M-51.7% First stage: 6.1 (8.1) days DPOAE: n=3,573, AABR: n=3,879	DPOAE or AABR	Trained non-professional screeners	Postnatal visits at community-based MOUs create a useful platform for hearing screening and follow-up. AABR technology with negligible disposable costs provides opportunity for AABR screening to be utilized in community-based programs. AABR screening offers lower initial referral rates and a higher true positive rate compared to DPOAE.
Johnson et al. (1990)	Infants were identified by telephoning all 10 special care nurseries in the region once a week or identified from birth registration data.	n=4,116 Gender specifics were not provided, 7-8 months	Distraction testing	Health visitors	The distraction test as routinely applied by health visitors can be a sensitive if somewhat non-specific screening test. The effectiveness of as screening program using the test is severely limited however, by failure to test all the infant population.

Khoza-Shangase & Harbinson (2015)	The study was conducted at a Community Health Centre's MOU department in Gauteng, South Africa. All neonates during a one-month period were potentially included in the study (from 30 August to 30 September 2009).	n=272 M=54.8% Session 1: 4.2 Session 2: 3.9	DPOAEs	Audiologist	Current findings highlight the importance of studying methodologies to ensure effective reach for hearing screening within the South African context. These findings argue for UNHS initiatives to include the MOU three-day assessment to ensure that a higher number of neonates are reached and confounding variables such as vernix have been eliminated.
McPherson et al. (1998)	Eight community health clinics in the northern Brisbane region.	n=2,305 Target Infants =1,305 Gender specifics were not provided. 22.21 months	TEOAEs	Clinic nurses or audiologist	The results suggest that TEOAE screening has potential as a technique in the community health setting but improvements in instrumentation are required to reduce 'could not test' cases and to separate probable conductive hearing loss from cases likely to have other disorders.
Olusanya et al. (2008)	Infants who were attending one of the four Bacille Calmette-Guérin (BCG) clinics between July 2005 and April 2006 were enrolled in the study.	n=2,003, M- 51.1%, 17.7 (19.1) days	TEOAE & AABR	Community health care workers	Routine hearing screening of infants attending BCG immunization clinics by community health workers was feasible and effective for the early detection of permanent congenital and early-onset hearing loss in Lagos, Nigeria.
Olusanya, Ebuehi, et al. (2009)	All mothers attending four of the seven primary health care centers which administered routine Bacille Calmette-Guérin (BCG) immunization from July 2005 to April 2008 were enlisted.	n=7,175, M-52.3%, 16.35 (17.30) days	1st Stage: OAE 2nd Stage: AABR	Community health workers	Community-based UNHS facilitates early detection of infants at risk of sensorineural hearing loss born outside hospitals and the overall performance is comparable to conventional hospital-based UNHS. Maternal education at antenatal clinics may be valuable in addressing the associated risk factors.
Ramkumar et al. (2013)	Mothers at the post-natal ward were informed about the purpose of study and provided with information by the neonatologist and ward nurses.	n=30, M=54.2%, Mean age was not provided. 8-30 days	Tele-ABR and Face-to-Face ABR	Technician, Village health workers, and audiologists	The results suggest that conducting tele-ABR in a mobile van is feasible and produces similar recordings to those obtained in face-to-face mode.

Ramkumar, Vanaja, et al. (2018)	119 children were selected using random sampling from 2880 infants and young children under the age of 5 years who had received DPOAE screening by village health workers .	Total: 2088 Sample: n=119, Infants: n=76, Gender and mean age specifics were not provided.	DPOAE	Village health worker	The validity of DPOAE screening conducted by trained village health workers was acceptable. This study supports the engagement of grass-root workers in community-based hearing health care provision.
van der Ploeg et al. (2012)	All Dutch newborns are offered NHS which is part of the Youth Healthcare Program (YHP)	n=552,820, Gender specifics and total mean age information were not provided.	TEOAE screening in the first two sessions and AABR in the third session.	Nurses	The study shows that the Dutch community-based newborn hearing screening in the youth health care is of high quality. However, both participation in diagnostic testing after a positive screen result and the timing of the diagnostic testing can still be improved.
Parental Perception & Compliance					
Akilan et al. (2014)	A sampling frame of mothers of infants and children under 2 years of age who received hearing screening in all the villages was obtained. Random sampling was conducted to select participants from two villages serviced by each village health worker.	Mothers: n=83, M-0% Children: n=83 Age of mothers: 18–30 years 71 31–40 years 12 Age of children: <2 years 70 >2 years 13	OAEs & Remote ABR	Village health workers- OAEs/Remote audiologist for ABR	Mothers in the community accepted hearing screening services delivered by health workers. The health workers were effective in delivering the services. Pre-school teachers seemed to have played a pivotal role in communicating about the hearing screening program to the mothers. Ultimately, collaborating with local NGO facilitated acceptance and compliance due to the NGOs strong presence in the community.
Danhauer et al. (2008)	Three researchers made initial telephone calls to the babies' parents prior to mailing the questionnaires.	n=150 Babies analyzed: n=34, M-64.7% Responses: n=7 M-85.7%	AABR/Probe of Parents' Perceptions	Level one-Nurses Level 2- Audiologists	This maturing EHDIP generally met national benchmarks and continued to serve the infants and families well. However, parents' compliance with physician visits and audiologic follow-up for habilitation including hearing aids in a timely manner could still be improved.

		No specific mean ages were provided.			
Lin et al. (2004)	From March 2000 to December 2002, two hospitals and four obstetric clinics in Tainan city participated in this study. The subjects were healthy newborns whose parents agreed to pay for otoacoustic emissions (OAE) hearing screening. They were tested in the newborn nursery before discharge.	n=5938, M-51.5%, Mean age was not provided.	The protocol used an initial TEOAE screening followed by a diagnostic ABR	Hearing screener	This study was a cooperative effort between hospitals and clinics and was performed in a pay-for-screening model. The program was feasible and well regarded by parents in Tainan city. The screening rate is acceptable. The referral rate is similar to other studies.
Olusanya, Akinyemi, et al. (2009)	Participants were drawn from a population of mothers previously described in a study who were enrolled for a three-stage infant hearing screening program at the time of attending four community health centers to obtain Bacille De Calmette-Guérin (BCG) vaccinations for their babies.	n= 2,003, M- 50.2%, 17.1 (19.1) days	TOAE & Automated ABR	Community health care workers	Place of delivery was the only factor that correlated albeit marginally with infant hearing screening compliance in this population. The likely influence of issues such as the number of return visits for follow-up services, ineffective tracking system and the prevailing unfavorable cultural perception towards childhood deafness on non-compliance independently or through these factors warrant further investigation.
Owen et al. (2001)	All newborn babies registered with participating health centers were offered neonatal hearing screening by health visitors using OAE during the trial period, January–December 1999.	n=683, Gender specifics were not provided, 18 days	OAEs	Health visitors	HVs are able to perform OAE testing in the neonatal period at home and in local health center clinics. They achieve high population coverage rates and low false positive rates. Universal neonatal hearing screening by HVs using OAE testing is feasible, well received, and could be less demanding of HV time than the current distraction testing. This model of universal neonatal hearing screening should be considered by the National Screening Committee.

Ramkumar, John et al. (2018)	VHWs went door-to-door in 51 villages.	Total: n=1,335 Infants: n=687, Gender specifics were not provided, 1.5	DPOAEs & Remote ABR	Village health workers/Remote audiologist for follow-up ABR	This community-based hearing screening program, tele-audiological diagnostic testing resulted in 86% follow-up compliance, a rate exceeding the Joint Committee on Infant Hearing (JCIH2007) benchmark of 75% compliance for hospital-based programmes. Settings with constrained resources can benefit from a community-based program integrated with tele-diagnostics
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Abbv: AABR-Automatic auditory brainstem response, ABR-auditory brainstem response, BCG-Bacille Calmette-Guérin, DPOAE-Distortion product otoacoustic emissions, EHDIP-Early Hearing Detection and Intervention Program, HV-health visitor, MOUs- Midwife obstetric units, NGO-non-governmental organization, NHSP-Newborn Hearing Screening Program, OAE-otoacoustic emissions, TEOAE-transient evoked otoacoustic emissions, UNHS- Universal Newborn Hearing Screening

Supplementary Table 4: Summary of CBR studies focusing on children hearing screening and assessment

Children Screening/Assessment					
Study	Recruitment	Sample Characteristics (N, Male %, Mean Age)	Screening Method Used	Who Performed Screening	Study Outcome
Akilan et al. (2014)	A sampling frame of mothers of infants and children under 2 years of age who received hearing screening in all the villages was obtained. Random sampling was conducted to select participants from two villages serviced by each village health workers .	n=83 mothers, M-0% n=83 children, Age of mothers 18-30 years 71 31-30 years 12 Age of Children <2years 70 >2years 13	OAEs & Remote ABR	Village health workers- OAEs/Remote audiologist for ABR	Mothers in the community accepted hearing screening services delivered by health workers. The health workers were effective in delivering the services. Pre-school teachers seemed to have played a pivotal role in communicating about the hearing screening program to the mothers. Ultimately, collaborating with local NGO facilitated acceptance and compliance due to the NGOs strong presence in the community.
Berg et al. (2006)	In Kishoreganj, Bangladesh. Sampling specifics were not provided.	n=4,003, M-51.3%, Mean age for the total population was not provided. (2-5 years) 52.5% (6-9 years) 47.5% Subgroup- n=569, M-53.6%, Mean age for the total population was not provided. (2-5 years) 100%	(2-9y) CPA, (2-5y) OAEs and tympanometry	Community health workers	These results suggest that hearing screening using CPA for older (6—9 years) and OAE/tympanometry for younger (2—5 years) children is feasible.

Cedars et al. (2018)	Preschool programs. Sampling specifics were not provided.	Year 1 n=1,436 M-50.8%, 2.1–3.0 =63(4.4) 3.1–4.0 =464 (32.3) 4.1–5.0 =661(46) 5.1–6.0 =248(17.3) Year 2 n=1,821, M-51.4%, 2.1–3.0 = 108(5.9) 3.1–4.0 = 592(32.5) 4.1–5.0 = 816(44.8) 5.1–6.0 = 305(16.7)	CPA and DPOAEs	Audiometrist	The addition of an immediate second-line OAE screen to pure tone screening for preschool children improved both the effectiveness and efficiency of our community-based hearing screening program, and eliminated disparities inability to test associated with age, language, and communication delay. The reduction in referral volume also corresponded to an improvement in follow-up rates, possibly by improving resource allocation.
Dawood et al. (2021)	SHN: schools. CHWs: Early Childhood Development centers, clinics, home visits and health campaigns. Convenience sampling.	n= 6,805 M- 49.6% 7.62 years	hearX Group a hearScreen app	School health nurses/Community health workers	No significant difference between SHNs and CHWs using m-health technology in screening outcomes when controlling for age, headphone type, noise levels, and age.
Eksteen et al. (2019)	Partnerships with local non-profit organizations supporting the preschool centers in the community and introduced the screening program to preschool center principals. Mapped all preschool centers via mobile platform and invited principals to sign a participation agreement. CHWs distributed posters, leaflets, and awareness within the preschool centers	n=8,023 M-49.5%, 1066 children 4 years old 3671 children 5 years old 3286 children 6–7 years old	hearX Group a hearScreen app	Community health workers	mHealth-supported CHW-delivered hearing screening in preschool centers provided a low-cost, acceptable and accessible service, contributing to lower referral numbers to resource-constrained public health institution

Elliott et al. (2010)	Selected local community primary schools and daycare centers. Specific sampling information was not provided.	Total n=743 Hearing Screened n=359, Gender specifics were not provided, 0-4 48, 5-9 412, 10+ 286	Van with wireless broadband Internet connection Audiometric hearing screening	Aboriginal health worker	It is feasible to integrate a mobile telehealth screening service with existing community-based services to provide specialist review and treatment planning at a distance. Community consultation, engagement, and collaboration in all areas of the project have been important.
Gomes & Lichtig (2005)	Where: In the community How: Asked to answer the questionnaire and allow their children to undergo the hearing screening procedures	n=133 M-49.6% 4.23 years	Portuguese adapted Dube (1995) parent-report questionnaire	Volunteers that were local nursery school employees	The results showed that the volunteers reproduced the evaluation of the professional regarding the use of the questionnaire. The questionnaire did not differentiate between the children who failed in the audiological screening from those who did not, suggesting further refinements are necessary.
Holtby et al. (1997)	The 19 primary schools screening for hearing loss was already scheduled to take place in the study period.	n=610 Gender specifics and the mean age were not provided.	Pure tone audiometry screen and impedance screen	School nurses	In choosing the method to be used, it must be borne in mind that the impedance method is technically more efficient but takes longer than pure tone audiometry screening. However, the latter method allows opportunity for other health inquiries in these children.
Harries & Williamson (2000)	Children at their 3-year health check.	n=65 M-51% 3 years	McCormick Toy Test (MCTT)	Health visitors	The results from this small-scale validation study suggest that the MCTT is a useful tool use in the community setting.

Jayawardena et al. (2018)	Advertised with flyers in the community as well as by word of mouth. Local schools were contacted in advance to identify student who would benefit from audiometric evaluation.	n=87 Gender specifics and mean age information were not provided.	Showbox Professional Audiometer on an iPad Mini 2 tablet for play audiometry and otoscopic endoscopy	Community health workers, nursing staff and NGO volunteers	This study demonstrates the feasibility of a non-otolaryngology-based hearing screening program. This may become an important tool in reducing the impact of hearing loss and urologic pathology in areas bereft of otolaryngologists and audiologists by allowing CHWs to gather important patient data prior to otolaryngologic evaluation.
Jayawardena et al. (2020)	In schools by schoolteachers and directors.	n=127 M-39.4% 11.4 years	hearX- hearScreen and HearTest applications and HearScope endoscopic camera for otoscopy	Community health workers/nursing staff	This study demonstrates the utility of an efficient, unified platform for performing pediatric hearing screening in a LMIC. By using a multi-tiered hearing screening paradigm coupled with a mobile otologic endoscope, CHWs can efficiently screen children for hearing loss and associated pathology.
McPherson et al. (1998)	Eight community health clinics in the northern Brisbane region. Sampling specifics were not provided.	n=2,305 Gender specifics were not provided. 22.21 months	TEOAEs	Clinic nurses or audiologist	The results suggest that TEOAE screening has potential as a technique in the community health setting but improvements in instrumentation are required to reduce 'could not test' cases and to separate probable conductive hearing loss from cases likely to have other disorders

O'Donovan et al. (2021)	Recruiting specifics were not stated.	n= 312 Gender specifics were not provided. 24 years	Otoscopy/whispered voice test of hearing	Community health workers	Training of CHWs is feasible and effective in screening for hearing and ear disorders in the community.
Ramkumar, John et al. (2018)	Village health workers went door-to-door in 51 villages.	Total: n=1,335 Children: n=648 Gender specifics were not provided. 1.5 years	DPOAEs and remote tele- ABR assessment	Village health workers/Remote audiologist for follow-up ABR	This community-based hearing screening program, tele-audiological diagnostic testing resulted in 86% follow-up compliance, a rate exceeding the Joint Committee on Infant Hearing (JCIH2007) benchmark of 75% compliance for hospital-based programs. Settings with constrained resources can benefit from a community-based program integrated with tele-diagnostics
Ramkumar, Vanaja, et al. (2018)	119 children were selected using random sampling from 2880 infants and young children under the age of 5 years who had received DPOAE screening by village health workers.	Total: 2208 Sample: n=119, Children: n=43 Gender and mean age specifics were not provided.	DPOAE and Remote tele-ABR assessment	Village health worker Remote audiologist for follow-up ABR	The validity of DPOAE screening conducted by trained village health workers was acceptable. This study supports the engagement of grass-root workers in community-based hearing health care provision.
Smith et al. (2012)	Where: Schools in Cherbourg and the surrounding communities. Sampling specifics were not provided.	n=1,685 M-51% 7 years	Video-otoscopy, tympanometry, pure tone audiometry	Indigenous health workers	The community-based screening service led by local Indigenous health workers and supported by a telehealth link to a tertiary children's hospital has proved to be a feasible method for routine screening of children at risk of hearing impairment

Smith et al. (2015)	Retrospective review of service activity over a six-year period, from Jan 2009–Dec 2014.	n=4,291 Gender specifics and the mean age were not provided.	Video-otoscopy, tympanometry, pure tone audiometry	Indigenous health workers	Results suggest that community-based screening, integrated with specialist ENT services may improve ear and hearing health.
Yousuf Hussein et al (2016)	Participants were selected from the community. Convenience sampling was used to invite all community members.	Total 820 Children n=108 Gender specifics and the mean age were not provided.	hearScreen application	Community health workers	Smartphone-based hearing screening allows CHWs to bring hearing health care to underserved communities at a primary care level. Active noise monitoring and data management features allow for quality control and remote monitoring for surveillance and follow-up.
Yousuf Hussein et al. (2018)	CHWs mapped 250 ECD centers	n=6,424 M-46% 4.94 years	hearScreen application	Community healthcare workers	Early Childhood Development hearing screening programs using an mHealth point-of-care diagnostics and cloud-based data management and referral systems can be successfully implemented by CHWs within LMICs to identify children prior to school entry.

Abbv: ABR-auditory brainstem response, CPA-conditioned play audiometry, DPOAE-Distortion product otoacoustic emissions, ENT- Ear, Nose, Throat doctor, LMIC-low middle income countries, MCTT- McCormick Toy Test, NGO-non-governmental organization, OAE-otoacoustic emissions, SHN-school health nurse, TEOAE-transient evoked otoacoustic emissions

Supplementary Table 5: Summary of CBR studies focusing on adult hearing screening and assessment

Adult Screening/Assessment					
Study	Recruitment	Sample Characteristics (N, M,F, Mean Age)	Screening/Assessment Method Used	Who Performed Screening/Assessment	Study Outcome for Assessment/Screening
Dodds & Harford (1982)	Retirement homes, retirement hotel, senior activity centers, and health fairs. For the homes and hotels through bulletin boards, mailboxes, monthly activity bulletins and local newspaper.	Specific sample characteristics were not provided.	Portable audiometers- air conduction	Graduate students	Suggests that it is feasible to test this population under less-than-ideal conditions if reasonable precaution is used to maintain a quiet room.
Gupta et al. (2020)	Retrospective review of the data contained from the Shruti screening program.	Overall sample characteristics were not provided. HA population: n=120 M-59.1%	ENTreview- Telehealth device	Community health workers	Shruti screening program and referral process has been successful in reaching the rural population in India through telehealth and community involvement.
Haanes et al. (2021)	The Preventive home visits-team contacted every person born in 1941 (76 years old) by phone living in Tórshavn and invited them to participate in the study.	n= 74, M-37.8%, 76 years	KAS screen (Kartlegging av Alvorlig Kombinerte sansetap blandt eldre) [Screening of serious, combined sensory loss among older people] Screening Audiometer, AS608 Interacoustics – air conduction	Nurses	The study found that 77% had some degree of hearing loss indicating that it would be beneficial for mandatory hearing screenings taking place in homes or community health houses conducted by nurses.
O'Donovan et al. (2021)	Recruiting specifics were not stated.	n= 312 Gender specifics were not provided.	Otoscopy/whispered voice test of hearing	Community health workers	Training of CHWs is feasible and effective in screening for hearing and ear disorders in the community.

		24 years			
Jayawardena et al. (2018)	The walk-in clinic at Tawfiq Muslim Hospital in Malindi was advertised with flyers in the community as well as by word of mouth. Local school were contacted in advance to identify student who would benefit from audiometric evaluation.	n=87, Gender specifics and mean age information were not provided.	Showbox Professional Audiometer on an iPad Mini 2 tablet for play audiometry and otoscopic endoscopy	Community health workers, nursing staff and NGO volunteers	This study demonstrates the feasibility of a non-otolaryngology-based hearing screening program. This may become an important tool in reducing the impact of hearing loss and urologic pathology in areas bereft of otolaryngologists and audiologists by allowing CHWs to gather important patient data prior to otolaryngologic evaluation.
Yousuf Hussein et al. (2016)	Participants were selected from the community. Convenience sampling was used to invite all community members.	Total n=820, Adults n=598, Adults M-29.4%, mean age was not provided.	hearScreen application	Community health workers	Smartphone-based hearing screening allows CHWs to bring hearing health care to underserved communities at a primary care level. Active noise monitoring and data management features allow for quality control and remote monitoring for surveillance and follow-up.

Abbv: ENT-ear, nose, throat, HA-hearing aid, NGO-non-governmental organization

Supplementary Table 6: Summary of CBR studies focusing on rehabilitation

Rehabilitation							
Study	Recruitment	Sample Characteristics (N, M,F, Mean Age)	Rehabilitation	Who offered Rehab	Setting	Outcome Measured by	Study Outcome
Borg et al. (2018)	Community workers of local NGOs in 13 sub-districts of Bangladesh selected individuals who could be potential participants.	Total: n=140, M-44%, 15 years Community based: n=77, M-38.7%, 14.8 (2.1) years Centre-based: n=65, M-50.8%, 15.3 (1.9) years	Provision of hearing aids	Community-based group: Community worker Centre-based group: Audiometric technician	Community-based group: In adolescent's homes Centre-based group: Hearing center	(IOI-HA) included in the follow-up questionnaire.	The community-based approach is a viable and effective option for hearing aid delivery in low-resourced settings. The approach needs to be adapted to particular contexts, and possible downsides may need to be counteracted by special interventions.
Choi et al. (2019)	Suburban Korean Church in Maryland. Announcements were made by the church pastor and in the church newsletter 2-3 weeks prior of the screening session at the church.	KAs: n=15, M-67%, 67.9 (8.1) years CPs: n=15, M-13%, 62.9 (11.6) years	Culturally adapted K-HEARS (Hearing Equality through Accessible Research and Solutions with pre-intervention and post intervention focus groups.	Bilingual moderators	Korean church	KAs-Korean versions of HHIE-S, UCLA Loneliness Scale, PHQ-9, SF-12, ALHQ CPs- SOS-HEAR KA CPs- IOI-AI & self-report willing to pay	Six weeks post-intervention, participants' mean hearing handicap score reduced from 15.7 to 6.4. Communication partners demonstrated improved social-emotional function. Post-intervention focus group revealed increased hearing benefit, confidence in hearing health navigation, and awareness in hearing health among study participants
Coco et al. (2019)	Individuals were recruited for participation in the Oyendo Bien study by local Community Health Workers via word-of-mouth, radio advertisements, flyers, a press release to the local newspaper, and community hearing screenings conducted by audiologists.	n=10, Gender specifics were not provided, 73 years	Oyendo Bien (Mexican American cultural adaptation of living WELL with Hearing Loss)	Community health workers	Community Gathering Center	Observation notes were constructed using a sensitizing framework that focused on interactions, reactions to educational information, and how dyads described their communication over the course of the five sessions	The current study demonstrates a phenomenological approach to explore the lived experiences of individuals with hearing loss within a group AR setting. The data in the observations revealed variations in the subjective experience of communication with hearing loss within an AR intervention, highlighting the importance of qualitative study.

						and the HHIE-S Spanish version.	
Emerson et al. (2013)	Camps were conducted with the help of the local government organization and nongovernmental agencies (NGOs), using local propaganda machine which included television broadcasting and advertising in the regional language papers.	n=111, M-57% Total mean age specifics were not provided.	Provision of hearing aids	Community health workers	Camps	APHAB	Results show that trained CHWs are effective in detecting disabling hearing loss and in providing HAs. APHAB can identify and pick up significant improvements in communication in daily activities and provides a realistic expectation of the benefits of a hearing aid. The model of using trained CHWs to provide rehabilitative services in audiology along with self-report outcome measures can be replicated in other developing countries.
Gupta et al. (2020)	Retrospective of the data contained from the Shruti screening program.	HA population: n=120 M-59.1% Mean age was not provided.	Provision of hearing aids.	Not stated. Possibly community health workers in the field and an audiologist at the hospital.	Hospital Hearing Aid fitment and earmold facility (if earmold or fine tuning was required) In the field (if not)	International Outcome Inventory for Hearing Aids	Shruti screening program and referral process has been successful in reaching the rural population in India through telehealth and community involvement.
Marrone et al. (2017)	CHWs contacted participants through other health promotion programs offered by FQHC.	Total: n=21 Participants: n=10 CPs: n=11 Gender specifics and mean age information were not provided.	O'Yendo Bien Programs (Mexican American cultural adaptation of living WELL with Hearing Loss).	Community health workers	Federally Qualified Health Center (FQHC)	2 week post-intervention focus groups and 1 year follow up interviews	Post program focus groups revealed increased self-efficacy and decreases stigma. After 1 year, 7 of 9 participants with hearing loss contacted for follow-up had sought some form of hearing-related healthcare.
Nieman et al. (2017)	Community-dwelling individuals were recruited in partnership with a nonprofit that provides subsidized, independent housing to low- and middle-income older adults. Participants were recruited from three buildings that	n=15, M-46.7%, 70.1 (68.6–76.4) years	HEARS (Hearing Equality through Accessible Research & Solutions) With pre-intervention and post intervention focus groups.	Trained interventionist	Conducted in the participant's buildings.	HHIE-S (Hearing Handicap Inventory for the Elderly-Screening), revised QDS (Quantified Denver Scale of Communication Function), revised	The HEARS (Hearing Equality through Accessible Research & Solutions) intervention is feasible, acceptable, low risk, and demonstrates preliminary efficacy. HEARS offers a novel, low-cost, and readily scalable solution to reduce hearing care disparities and highlights how a community-engaged approach to

	house predominantly low-income and minority, primarily African American, older adults.				UCLA Loneliness Scale, PHQ-9 (Patient Health Questionnaire), SF-36 (Short-Form General Health Survey), IO-AI (International Outcome Inventory-Alternative Interventions) and self-reported willingness to pay.	intervention development can address disparities.
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Abbv: APHAB-Abbreviated Profile of Hearing Aid Benefit, ALHQ-Attitudes towards Loss of Hearing Questionnaire, AR- aural rehabilitation, CP-communication partner, FQHC-Federally Qualified Health Center, HEARS-Hearing Equality through Accessible Research and Solutions, HHIE-S-Hearing Handicap Inventory for the Elderly-Screening, IO-AI-International Outcome Inventory-Alternative Interventions, IOI-HA-International Outcome Inventory for Hearing Aids, NGO- non-governmental organization, PHQ-9-Patient Health Questionnaire, QDS-Quantified Denver Scale of Communication Function, SF-Short-Form General Health Survey, SOS-HEAR- Significant Other Scale for Hearing Disability, UCLA-University of California, Los Angeles

Supplementary Table 7: Summary of CBR studies focusing on cost effectiveness

Cost Effectiveness			
Study	Cost-effectiveness method	Cost information	Study outcome
Grill et al. (2006)	Clinical effectiveness analysis using a Markov Model and a one-way, multiple sensitivity analyses were performed on all relevant parameters, and multivariate simulations were used for probabilistic modelling (Monte Carlo).	Both hospital and community programs yielded 794 QCM at the age of 6 months with total costs of £3,690,000 per 100,000 screened children in hospital and £3,340,000 in community. Simulated costs would be lower in hospital in 48% of the trials. Any statistically significant difference between hospital and community in prevalence, test sensitivity, test specificity and costs would result in significant differences in cost-effectiveness between hospital and community.	The evaluation of the Newborn Hearing Screening Programme will serve as a valuable tool and example to justify and improve large scale screening programs.
Nguyen et al. (2015)	Deterministic and probability sensitivity analyses.	Annual equivalent cost for the total cost of the Deadly Ears Program is 78,243. Annual equivalent cost for the total cost of the MTESS Service is 236,200. The model showed that compared with the Deadly Ears Program, the probability of an acceptable cost-utility ratio at a willingness-to-pay threshold of \$50,000/QALY was 98% for the MTESS service.	The findings of this analysis indicate that, from a health service perspective, the supplemental mobile telemedicine-enabled screening and surveillance (MTESS) service is cost effective compared to the Deadly Ears Program alternative alone.
Ramkumar, John, et al. (2018)	Economic analysis was carried out to estimate cost incurred and outcome achieved for hearing screening, follow-up diagnostic assessment and identification of hearing loss. Two-way sensitivity analysis determined the most beneficial cost-outcome.	Total cost for CBHSP broadband internet for tele-diagnostics: 3,038,671 (Indian Rupees). Total cost for CBHSP with satellite connectivity in mobile tele-van for tele-diagnostics= 3,140,026 (Indian Rupees). Cost difference: \$1.14 per child screened, \$80 per child followed-up, and \$304 per child identified. Patient perspective: Average wage loss and travel cost \$3.	Settings with constrained resources can benefit from a community-based program integrated with tele-diagnostics

Rob et al. (2009)	Sensitivity analysis was applied to test the robustness of results towards the use of alternative values on key parameters, including the proportion of patients wearing hearing aids, the lifetime of the hearing aids, the difference in health state valuation between treated and untreated deafness, and cost of hearing aids.	Active screening and provision of hearing aids at the secondary care level costs around Rs.7,000 (US\$152) per patient, whereas provision of hearing aids at the tertiary care level costs Rs5,693 (US\$122) per patient. The cost per DALY averted was around Rs. 42,200 (US\$900) secondary care level and Rs. 33,900 (US\$720) at tertiary care level. Costs of food and transport ranges between Rs. 2 (US\$0,04) and Rs. 39 (US\$0,83).	Active screening and provision of hearing aids at the secondary care level is slightly more costly than passive screening and fitting of hearing aids at the tertiary care level but seems also able to reach a higher coverage of hearing aids services. Although crude estimates indicate that both passive and active screening programs can be cautiously considered as cost-effective according to international thresholds, important questions remain regarding the implementation of the latter.
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CBHSP-community-based hearing screening program, MTESS- mobile telemedicine-enabled screening and surveillance, QCM- quality weighted detected child months, Rs.- Indian rupee

Supplementary Table 8: Summary of CBR studies focusing on hearing health programs for community workers

Training					
Authors	Type of Training	Sampling (where and how they were recruited)	Sample Characteristics	Outcome measured by	Study Outcome
Alvarenga et al. (2008)	<p>Group A Bauru: 8-hour intervention consisting of audio-visual material along with a manuscript based on the World Health Organization: Primary Ear and Hearing Care Training</p> <p>Group B Sorocaba: 2 meetings consisting of 4 hours with the same intervention, but without the manuscript to follow along. Training was conducted by audiologists.</p>	Sampling specifics were not provided.	<p>Total: n=106</p> <p>Group A: n=31, 29 years</p> <p>Group B: n=75, 32.3 years</p> <p>Gender specifics were not provided.</p>	Pre and post-training questionnaires on the WHO material	The results indicate the effectiveness of the training program for community health agents of a Family Health Program with the use of texts and with an interactive approach
Araujo et al. (2013)	CHWs received training in basic computing during a single, onsite, four-hour session. "Infant Hearing Health" CD-ROM interactive tele-education tool during two four-hour sessions.	Study was performed at the Dental Faculty of Bauru, University of São Paulo as a collaboration among the Telemedicine Program of the Faculty of Medicine, University of São Paulo and the University of the Vale do Itajaí, Brazil. Sampling specifics were not provided.	Total n=90 Group I: n=47 Group II: n=43 Gender and mean age specifics were not provided.	Pre- and post-training questionnaire and 6 months after the training program simulations interactive model through Cybertutor in a two-hour session led by a tutor.	The CHWs ' training in infant hearing health using an interactive tele-educational tool was effective, as the CHW demonstrated significant short-term information retention and applied such data in hypothetical situations representative of their daily activities.
Araujo et al. (2015)	Training involved the prevention and rehabilitation of hearing impairment, organized into five modules.	Twenty-four CHWs with representativeness of different FHS teams in Bauru and who had participated in a training program in the area of infant hearing health, joined the study. Sampling specifics were not provided.	n=24, Gender and mean age specifics were not provided.	After a 15-month period the CHWs completed the same questionnaire that was completed immediately after training.	A significant decrease of the Community Health Workers knowledge on infant hearing health was observed, which demonstrates that the community health workers training should occur continuously.
Coco et al. (2021)	Introductory training sessions: 1 hour and were guided by instructional PowerPoint-delivered	Recruitment of CHWs was done by flyer, e-mail, and	n=12, M-0%, 30–49 17% (2) 50–69	Introductory survey, Intermediate knowledge-	Teleaudiology trainings for CHW's were found to be feasible. Due to the recent

	<p>presentations and group discussion, facilitated by the trainer.</p> <p>Intermediate training session: 1.5 hours, by PowerPoint-delivered presentations and group discussion, facilitated by the trainer which added roles on teleaudiology team and patient safety and confidentiality.</p> <p>Facilitator training lasted a total of 12 hours over 2 consecutive days, a combination of instructional presentations and active learning components.</p>	word-of-mouth at partnering health center.	8% (5) 70–79 17% (2) Not reported 12% (3)	based assessment, Computer Proficiency Questionnaire, Facilitator performance-based assessment, asked to report their understanding of privacy and confidentiality in teleaudiology, and open-ended questions regarding the training and teleaudiology	demand for teleaudiology in the COVID-19 pandemic more research is need in the efficacy, effectiveness, adoption, and implementation of teleaudiology.
Gomes & Lichtig (2005)	Two days of training: lectures, discussions, role play, and videos of the questionnaire being administered.	Volunteers from the local nursery school. Sampling specifics were not provided.	n=7, M-0%, Mean age was not provided.	The k-test was applied in a statistical analysis comparing the registers collected by the community volunteers and by the researcher through the parent report questionnaire.	The results showed that the volunteers reproduced the evaluation of the professional regarding the use of the questionnaire. The questionnaire did not differentiate between the children who failed in the audiological screening from those who did not, suggesting further refinements are necessary.
McCullagh, Cohen, et al. (2020)	Online or face to face training sessions consisting of identifying learning objectives, teaching/learning methods, time allowed, and teaching and learning materials to the coordinators conducted by study personnel.	Safety Day coordinators recruited local volunteers via personal contacts and networking.	n=22, M 21%, 43 years	10-item instrument used to measure the adherence of the lesson delivery to the curriculum. 5-item instrument used to measure the quality of teaching methods.	The study outcome supported the use of community volunteers to implement a tested curriculum for an effective method to provide hearing conservation education to farm and rural youth.
Melo et al. (2010)	8-hour video conference training using the courseware: World Health Organization (WHO) guide - Primary ear and hearing care training resource - basic, intermediate and advanced levels	All the community health agents of the city had no previous experience in hearing health and were invited to take part of the study.	Total: n=50, Face-to-Face: n=31, 30 (7) years Video conference: n=19, 31(8) years Gender specifics were not provided.	Pre and post-training questionnaires on the WHO material	The video conference was effective as a learning tool for the training of community health agents on child hearing health. However, this instrument should be used as a complementary material to the traditional form of training.

Mulwafu et al. (2017)	The training manual was based on both the Basic and Intermediate Manual of WHO Primary Ear and Hearing Care Training Resources.	Health workers were selected among Malawian Health Surveillance Assistants, which is the formal cadre of CHWs in Malawi.	Total: n=57 Control arm: n=28, M-59%, 37 years Intervention arm: n=29, M-54%, 38 years	60 multiple choice questions from the first six modules of the WHO Primary Ear and Hearing Care Trainer's Manual, number of patients with ear or hearing disorders identified by CHWs and number recorded at health centers and focus group discussions	Training was effective in improving the knowledge of CHW in ear and hearing care in Malawi and allowing them to identify patients with ear and hearing disorders. This intervention could be scaled up to other CHWs in low-income and middle-income countries.
O'Donovan et al. (2021).	Two-day workshop by two ENTs and two doctors. Training was based on the WHO Primary Ear Care Manual. Ongoing training took place through WhatsApp.	CHWs were selected and invited from four villages in Seeta Nazigo Parish.	n=13 M-38.5% 44.9 (9.1) years	Observed Structured Clinical Examinations and engagement on the WhatsApp forum.	Training of CHWs is feasible and effective in screening for hearing and ear disorders in the community.
Owen et al. (2001)	An introductory study day and practical training was given by a qualified audiologist. Final supervision and assessment of competence within the health Centre setting was undertaken by an experienced tester.	From four rural and four city health centers. Sampling specifics were not provided.	n=14, Specific sample characteristics were not provided.	Questionnaire (not specified)	Health visitors are able to perform OAE testing in the neonatal period at home and in local health center clinics. They achieve high population coverage rates and low false positive rates. Universal neonatal hearing screening by health visitors using OAE testing is feasible, well received, and could be less demanding of health victors time than the current distraction testing. This model of universal neonatal hearing screening should be considered by the National Screening Committee.
Sánchez et al. (2017)	The Freire Empowerment Education Model (Wallerstein and Bernstein, 1988) was the basis for training. Focus group, 3-hour workshop, and 24-hr multisession, interactive training >6 weeks	CHWs employed by the FQHC in the Platicamos Salud program, now Community Health Services with leadership skills.	n=12, M-0% , 58-73 years	Thematic analysis was completed for the focus group data. Pre- and post-training assessments and case study discussions	Initial results suggest it is feasible to train CHWs to engage community members regarding hearing loss and facilitate culturally relevant peer-health education and peer-support groups for individuals with hearing loss and their family

		Sampling specifics were not provided.			members. In efforts to increase access to audiological services in rural or underserved communities, application of the CHW model with a partnership of audiologists deserves further consideration as a viable approach.
Smith et al. 2018	3-4 hour educational intervention- Sensory training workshops: simulation practice, information on assessment and referral pathway	All nurses in a community setting in the Western Isles of Scotland were invited via invitations distributed to each five locality teams across the four islands.	n=41, Specific sample characteristics were not provided.	Pre and post-workshop questionnaires, 3 month post-workshop postal questionnaire, 6 month post-workshop focus group	Participants had positive perceptions on the training. Overall participants knowledge and awareness of sensory impairments increased, empathy and compassion for patients with sensory impairments increased, and participants were more likely to refer patients with sensory impairments to specialists.

CD-ROM-compact disc read-only memory, COVID-19-Coronavirus infectious disease 2019, ENT-ear, nose, throat doctor, FHS-Family Health Strategy, FQHC-Federally Qualified Health Center, OAE-otoacoustic emissions, WHO-World Health Organization

Supplementary Table 9: Summary of CBR studies focusing on community-based service delivery models

Community-based service delivery model			
Study	CBHR Outcome	Model Details	Study Outcome
Behl et al. (2012)	Knowledge Expansion	The learning community was comprised of administrators and providers from six programs that were providing early intervention therapeutic services via telepractice. Members attended in-person meetings, web-based and phone meetings, and internet-based social media.	The outcomes of the learning community demonstrate that this approach has been a successful medium to foster new knowledge, research, and tools to support telepractice for early intervention services.
Billard (2014)	Primary Ear and Hearing Care for a rural community	"Siutilirijiit" community health workers/interpreters recognized as being part of the Hearing and Otitis Program (HOP) team and can assume their HOP duties (screening a school, assist at the time of audio visit, etc.) while being replaced in their position and "aaniasiurtiapiit" community health workers/interpreters that are occasionally travel to communities at time of audiologist's visit assume office services outside these periods. 6 part time audiologist employed by the Inuulitsivik Health Center. Each audiologist is assigned to one community with two visits a year, one or two weeks/visit depending on community size. Coordinator: An audiologist employed by Inuulitsivik Health Center 1 day/week. Occasionally visits Puvirnitug for training or other coordination tasks. Hearing instrument specialists visits all communities once or twice a year.	An overview of the outreach program Hearing and Otis Program and the challenges the community-based program face.
Borg et al. (2018)	Hearing aid delivery in low-resourced settings.	Community- based model: 1. Initial ear and hearing screen- Audiometric technician at local NGO 2. Ear and hearing assessment- Community worker at participant's home 3. Delivery and fitting of hearing aids-Community worker at participant's home. 4. Earplugs- Soft standard earplug Centre-based approach: 1. Initial ear and hearing screen- Audiometric technician at local NGO 2. Ear and hearing assessment- Audiometric technician at hearing center 3. Delivery and fitting of hearing aids- Audiometric technician at hearing center 4. Earplugs- Custom-made earmold	The community-based approach is a viable and effective option for hearing aid delivery in low-resourced settings. The approach needs to be adapted to particular contexts, and possible downsides may need to be counteracted by special interventions.
Martin et al. (2017)	The intervention was effective at changing knowledge, attitudes, beliefs, and behaviors in the target population	1. Relationships were established with tribal communities. 2. Formal presentations were made to community leadership. 3. Community advisory teams were established. 4. All of the local media and communication networks were included 5. The evidence-based Dangerous Decibels program was presented 6. An	Self-sustaining programs promoting hearing health in all communities were achieved through approval of community leaders and engagement of community members in the design, administration, and evaluation of the effort; use of a well-developed, evidence-based intervention; and high-level

		evening community event was hosted by the Prevention Research Center. 7. Students participated in the Dangerous Decibels Virtual Exhibit 8. The program gradually become self-sustaining	training of local participants who could confidently and effectively continue delivering the program following a gradual transition to independence.
Robler et al. (2020)	More research is needed to prove the effectiveness of the Hearing Norton Sound project.	15 communities were included in the program with stakeholders from healthcare and educational sectors. 11 focus groups pertaining to hearing loss and the proposed screening project. All children underwent the current school screening protocol, mHealth screening, and an audiometric evaluation. The 15 communities were randomized for the telemedicine referral pathway. The community health aides would set up at telehealth appointment with an audiologist for the child and then the audiologist would refer to another telehealth appointment with an otolaryngologist if needed. This was compared to the standard referral process.	Developing a community-involved mHealth screening and referral process.

HOP-Hearing and Otitis Program, NGO-non-governmental organization

Supplementary Figure 1: Distribution of studies across countries

