ZHU FENG

COMMUNITY ENGAGEMENT FOR COVID-19 INFECTION PREVENTION AND CONTROL: A RAPID REVIEW OF THE EVIDENCE

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PREPARE

1. Early discussions and negotiation with communities is critical for understanding socio-cultural contexts and developing culturally appropriate prevention and control strategies

2. Community engagement (CE) should be an on-going process to re-assess and modify activities to deal with the dynamic community-level pandemic plans and meet community's evolving needs and situation

3. CE can help the health workforce, as it allows a multi-sectoral approach, drawing on local resources and expertise to carry out critical health system functions and create innovative solutions

4. CE can help build trust in the health system to counter resistance and non-compliance from the communities facing top-down biomedical and epidemiological control measures during an epidemic

5. Meaningful engagement activities need to be embedded within systems, and not abandoned after the peak crisis time, as they may have the ability to support recovery and resilience efforts

IMPLEMENT

6. There is a need for frequent and open dialogue within CE activities; communities should be treated as active participants in, as opposed to passive recipients of, health response efforts

7. Actors in CE for infectious disease prevention and control are diverse, but the most prevalent are community leaders, community groups (including faith groups), and individuals

8. CE process usually involves identifying groups and individuals at the local level (pre-existing or new); building capacity and sustained leadership through training, technical support like planning, developing interventions, inter-sectoral action, monitoring and evaluation

9. CE is most often used for social and behaviour change communication (SBCC) and risk communication, though it has also supported consultation, surveillance, design and planning, logistics and administration and community entrance. CE can also support referrals via follow-up visits

10. SBCC and risk communication messaging at household level should utilise local leaders, influential community persons or people who have experienced COVID-19, combined with mass media messages tailored to communities' socio-cultural norms, realities and experiences

11. During emergencies, the resilience and capacity of CE actors can be supported by ensuring clarity in regards to roles, and compensation, by providing trainings and equipment, and creating space for dialogue between health workers and CE actors

LEARN

12. CE strategies have been implemented mainly in low-income countries (LIC) during Ebola epidemics, and in high-income countries (HIC) where it has been used to target minority populations for H1N1 and Zika. It can be adapted and replicated among wider population groups

13. There is a need for more documentation of CE activities especially from more diverse geographic settings and with different populations. Implementers, policy makers and researchers are encouraged to share learnings from past CE initiatives and document on-going CE for COVID-19 activities

14. COVID-19's global presence and social transmission pathways require social and community responses. All countries are encouraged to assess existing community engagement structures, conduct contextual assessments, and co-design appropriate strategies for appropriate COVID-19 prevention and control measures.

The integration and involvement of communities in COVID-19 prevention and control is a potential and viable strategy in addressing the pandemic and has been suggested by The World Health Organization, UNICEF and IFRC among others. Indeed, the recommended measures to prevent and control COVID-19 such as physical-social distancing, case identification and contact tracing require understanding of the different social dynamics in communities and how these can better be leveraged to minimize the impact of the epidemic [1].

The need to embrace community engagement (CE) to supplement biomedical or epidemiological interventions during outbreaks is widely acknowledged. Experience from dealing with public health emergencies of international concern such as Ebola, SARS and Zika around the world highlights the need for contextually appropriate CE strategies including communities taking a central or pioneer role, involving local leaders and groups, tailoring interventions to communities and ensuring a two-way communication [4-7]. Moreover, CE was one key component during the 2014-2015 Ebola response in West Africa, where the Ebola control team through a learning based approach/bottom-up approach adapted several measures to engage with the communities including building partnerships with local and religious leaders and working with the community to develop and adjust key messages on behavioural changes [4,8]. These measures and learnings from communities significantly contributed to the success achieved in controlling the outbreak and ensuring health system resilience [2,4,8].

The recent outbreak of SARS-CoV-2 (COVID-19, or coronavirus) that began in late 2019 in Wuhan City in China and spread rapidly to several parts of the world has seen several responses being instituted at different levels to prevent and control the pandemic [9]. These measures include lockdowns and quarantine of large masses of people, contract tracing, surveillance and encouraging of people to adopt social distancing and hygiene measures [9]. However, lessons on community partnerships from previous epidemics have not featured strongly in the covid-19 response [10]. A recent review on global evidence for COVID-19 focused on community health workers providing important evidence and insights to guide response [11].

Box 1: How we are defining Community Engagement (CE)

CE means involvement and participation of individuals, groups and structures within a parameter of a social boundary or a catchment area of a community for decision-making, planning, design, governance and delivery of services [2]. CE implies a multi-sectoral linkage of existing structures and networks that includes community leadership, community groups informal providers, social networks and faith organizations [3].

However, there is no evidence synthesis that addresses how CE can be utilised within COVID-19 prevention and control. This rapid evidence review looks at the community engagement for infectious disease prevention and control, to learn lessons for COVID-19 worldwide and future pandemic response [Box 2].

Box -2: What this review explores

• What CE approaches have been used for prevention and control in outbreaks?
• What interventions and actions does CE address?
• What groups are targeted during CE, and are equity considerations incorporated?
• What are the linkages with health sectors?
• What are the key barriers and facilitators for successful CE?

Methodology Given the emergency nature of the recent COVID-19 global pandemic and to support timely findings, we conducted a rapid evidence review [13] of academic and grey literature in May, 2020. A protocol was developed and agreed upon by the research team, which comprises academics, implementers and policy makers from multiple disciplines and backgrounds, all members of the Community Health – Community of Practice. The main focus of the review was to identify what type of community engagement approaches are used within infectious disease prevention and control [Box 3].
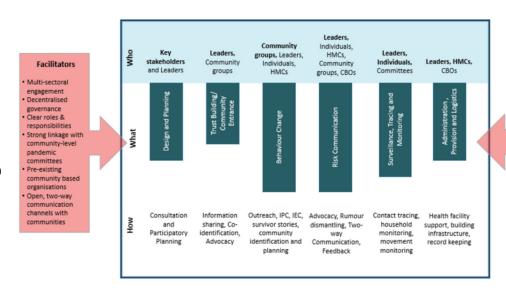
We limited our searches to three databases: PubMed, CINHAL and Scopus. We conducted an extensive grey literature and snowball search by reviewing websites of numerous public health organisations, repositories, and emailing the authors' respective networks. All returned results were input into Covidence and duplicates were removed. The remaining articles were screened at title and abstract, and full-text stages independently by two reviewers, with a third resolving any discrepancies. Two authors initially extracted data from the included articles, with two other authors reviewing all extractions for reliability and consistency.

Box- 3: What the review includes

• Community engagement intervention [involvement of any community members other than CHWs]
• Prevention and/or control of infectious diseases [Ebola, SARS, MERS, Zika and Swine Flu]
• Primary, empirical studies, programme reports published on or after 2000
• No language and geographic restriction

Figure 1 summarises key community engagement for infectious disease prevention and control actors, processes, approaches and identified barriers and facilitators found within this review.

Note : The main CE actors (who) most common for that specific process are in bold. The length of the bars varies based on the most common way (what) of CE as per the reviewed literature.

KEY FINDINGS

- A total of 1112 articles were identified, of which 121 were duplicates. After abstract screening, 181 full-texts were reviewed. In total 32 articles, which describe 37 different CE interventions, were identified for inclusion.

- Of the 37 CE descriptions, the majority [N=28] related to Ebola outbreaks, with six and four for Zika and H1N1 respectively. No examples from MERS or SARS were found.

- Low-income countries had the most examples [N=27], which include Sierra Leone [N=11], Liberia [N=9], Guinea [N=3], DRC [N=2], Uganda [N=1], and Ghana [N=1]. Ten occurred in high-income countries of Canada, United States, Australia, Singapore and Uruguay and are related to either H1N1 (Canada and Australia) or Zika (Uruguay, Singapore and United States).

- Majority of the interventions were new [N=26], i.e. they were initiated in response to the epidemic as opposed to being repurposed during the epidemic.

- Most of the CE interventions designed for prevention and control of the epidemic targeted the wider community [N=32].

- In most cases CE interventions served multiple purposes or activities. Among them SBCC [N=23] and Risk Communication [N=22] were most prevalent. Other activities included surveillance, tracing and monitoring [N=18], design and planning [N=10], their involvement in logistics, administration, Provision [N=7] and trust building [N= 6].

- Various community members, actors and networks were involved in the CE. The most common among them were community leaders, religious and faith groups, community volunteers and mobilisers, youth groups, and students.

- CE examples from high-income contexts mostly involved planning and designing interventions with minority groups, and rarely included community engagement in implementation of prevention and control activities, or wider community considerations.

- There is limited linkage between the community groups and CHWs [N=2]. They were primarily linked with implementing team comprising of bi and multi-lateral organisations [N=12], or a consortium formed by the intervention team or health administration [N=10].

- Training for CE utilised a variety of mediums including lectures, role-play and exercises, and mainly focused on identification of signs and symptoms of the disease, prevention in the community, social mobilisation and dispelling rumours.

- The majority of the articles did not report or did not consider gender and equity aspects. Two interventions focused on marginalised and indigenous population and one-targeted women in reproductive age groups and pregnant women.

- Majority of the community groups and individuals were not provided any monetary incentives, however, most of the interventions were funded to take care of CE activities.

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