Strategic directions for Community Engagement for COVID-19

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1. Background

Involving communities is extremely important in all public health interventions. It should be at the heart of any public health intervention. Prevention and control of COVID 19 pandemic required a drastic behaviour change of the population. At least 80% of the population has to practice social distancing, self-isolation and the personal hygienic measures like frequent hand washing, cough etiquette, and continuous and regular use of personal protective equipment to mitigate the disastrous consequence the pandemic may impose in the country.

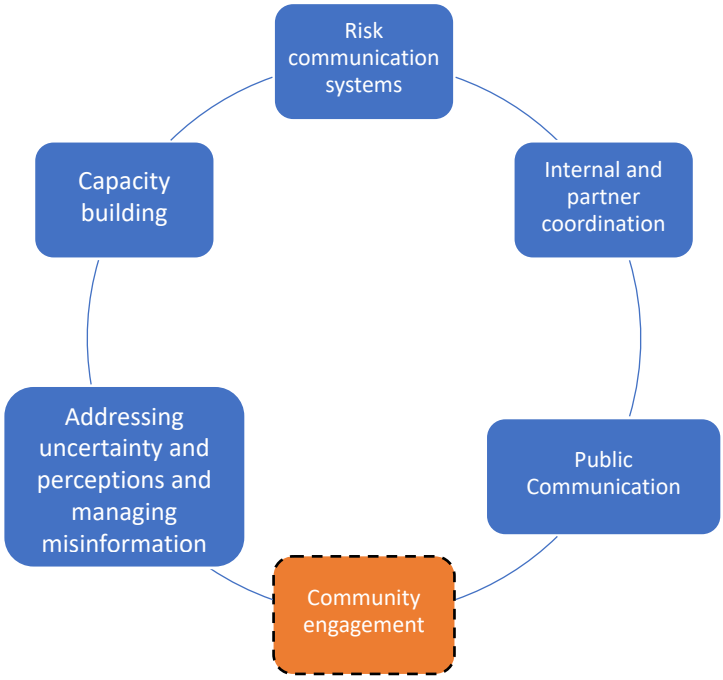
The first patient with the local transmission in Sri Lanka was reported on 11th March and schools and universities were closed on 12th March 2020. Government and private institutions were functioning with the minimal staff along with the government "work from home" policy. Numerous sources like media channels, employers, advertisers, district control teams initiated delivering information to the general public regarding COVID-19. Some behaviour messages were misguiding, some created fear, and some made the disease look quite normal as common cough and cold. The public was flooded with the information. At this point, two consecutive prospective rapid behaviour surveillance surveys were carried by Health Promotion Bureau (HPB) to detect the prevalence of healthy behaviour practices and the availability of the conducive environment in few sentinel sites across the country. The surveys demonstrated that the majority were well aware, and behaviour was changing with regards to the handwashing, cough etiquette etc. Nevertheless, few communities had not adopted protective behaviour and acted as a threat to the other's health by not maintaining social distancing, not revealing symptoms, and not practising home isolation. Furthermore, health care workers were more concerned about their safety. It was evident that the non-contextualized flooding of the information was counterproductive[1].

This document is intended to support the much-needed behaviours expected from individual and communities to prevent transmission of COVID-19 in the country.

1. **Chang, S. L., Harding, N., Zachreson, C., Cliff, O. M., & Prokopenko, M.** (2020). Modelling transmission and control of the COVID-19 pandemic in Australia. arXiv preprint arXiv:2003.10218., **Gamhewage, G.** (2014). An Introduction to Risk Communication. WHO. Retrieved from https://www.who.int/risk-communication/introduction-to-risk-communication.pdf, **Gerrard, M., Gibbons, F. X., & Reis-Bergan, M.** (1999). The effect of risk communication on risk perceptions: the significance of individual differences. Journal of the National Cancer Institute. Monographs, 50011(25), 94–100. doi:10.1093/oxfordjournals.jncimonographs.a024217

2. Overview

This document is based on the WHO risk communication and community engagement (RCCE) checklist[2]. The scope of community engagement is given in the diagram below in the overall RCCE plan.



The community engagement was considered in the view of **ongoing transmission of COVID-19** with **no-community spread** so far and the following areas were focused in this document;

- Maintain two-way communication with affected audiences
- Understand and respond to their concerns, attitudes, beliefs and barriers via hotlines, behaviour surveys etc.,
- Engage communities and vulnerable groups,
- Establish feedback mechanisms with health care workers and communities, monitor those who are affected

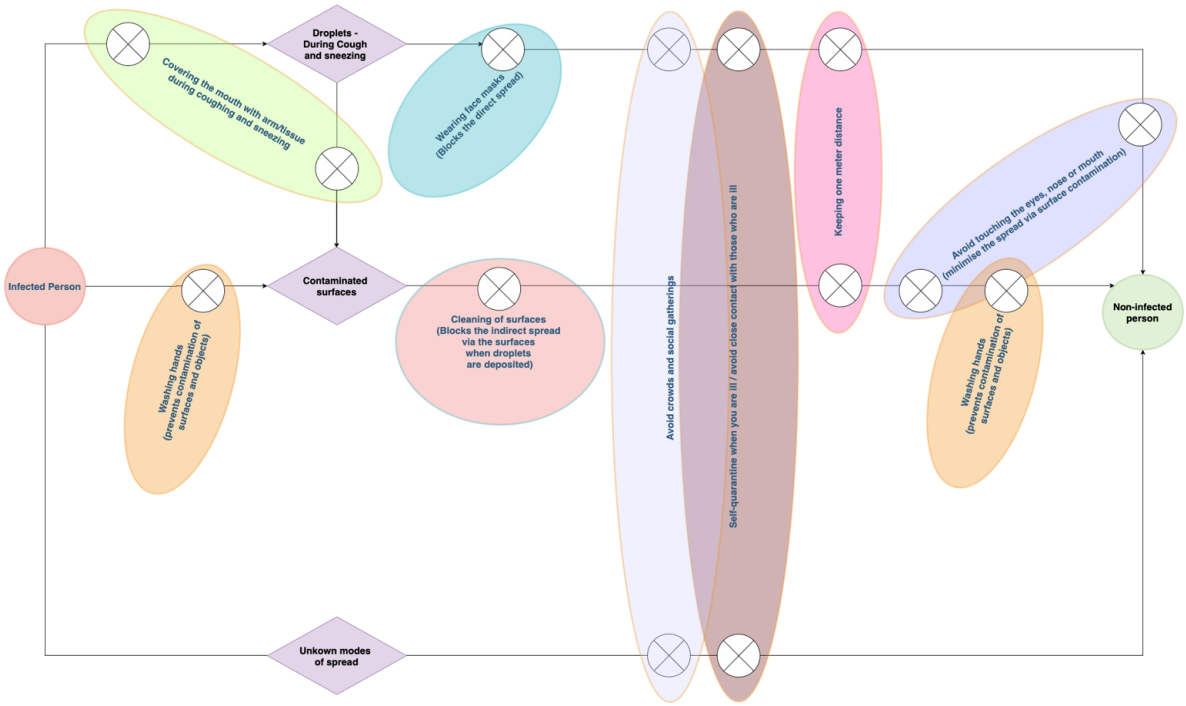
2 **WHO.** (2020). Risk communication and community engagement readiness and response to coronavirus disease (COVID-19) – Interim guidance, Retrieved from https://www.who.int/publications/i/item/risk-communication-and-community-engagement-readiness-and-initial-response-for-novel-coronaviruses-(-ncov)

3. Core behaviours identified for prevention of COVID-19 transmission

The following key behaviours were identified to be practised in the communities. These behaviours are documented in detail in a guide developed by the Health Promotion Bureau[3]. Pathways that the identified behaviours block the transmission of COVID-19 from an infected person is given in the diagram below.

Identified positive behaviours

1. Wash your hands frequently and properly
2. Cover your mouth with your arm when coughing and sneezing
3. Avoid touching your eyes, nose or mouth
4. Always keep a one-meter distance
5. Avoid crowds and social gatherings
6. Use a face mask when you are going out
7. Cleaning the surfaces regularly
8. Avoid close contact with those who are ill
9. Self-quarantine when you are ill

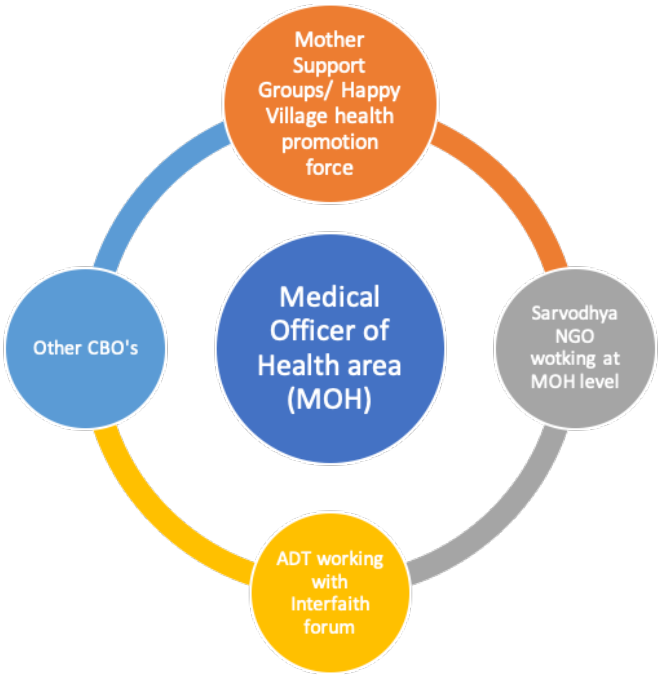


3 **Wijesinghe M.S.D., Bandusena A., Karunapema P.,** (2020). A guide to positive behaviors, their barriers, and facilitating factors to fight COVID-19 in Sri Lanka for new normalcy, Health Promotion Bureau.

4. HPB-Sarvodaya-ADT-CBO model for Community Engagement

The community engagement can be defined as "*involvement of the communities to achieve long-term and sustainable outcomes, process, relationships, discourse, decision-making, or implementation*"[4]. Therefore, we propose the following model based on the Medical Officer of Health areas in the country to strengthen the behaviours expected from individual and communities to prevent transmission of COVID-19 in the country.

HPB-Sarvodaya-ADT-CBO model for Community Engagement



The Health Promotion Bureau (HPB) is the centre of excellence for health communication, health education and promotion. HPB currently have approx. 7000 Mothers Support Groups (MSG) in all MOH areas in the country with a very large network of happy village health promotion force. The MSG's / happy villages are community empowerment groups established to promote the health and well-being of the communities. The coordination of activities of these groups are done at both central level (by HPB) and district level (via Health Education Officers). We are already mobilizing the MSG platform for many COVID-19 related activities. During the lockdown period, the MSG supported many activities initiated in the communities such as contact training, supporting health staff to supporting provision of essential drugs to affected communities.

The Sarvodaya organization is the largest national non-governmental organization and community-based organization in Sri Lanka which plays an active role in over 15,000 villages across 25 districts. Sarvodaya

4 **Center for Economic and Community Development.**, (2020). "What is Community Engagement", Retrieved from: https://aese.psu.edu/research/centers/cecd/engagement-toolbox/engagement/what-is-community-engagement

has a strong presence in all districts with adequate staffing, infrastructure, human resources, vehicles and over 61 years of experience in community mobilization and community leadership.
Alliance Development Trust is also an NGO working with Interfaith religious leaders (including all religions) in the communities with years of experience in stigma prevention and supporting community-based screening for leprosy. They also have a district-level network with MOH level volunteer workers.
We propose a model for community engagement involving the three organizations (HPB, Sarvodaya, ADT) working together with other CBO's at MOH level. The mode of operations will be mobilizing community leaders to promote nine identified behaviours described above, develop model community settings, mapping CBO's in MOH areas, involving vulnerable groups in discussions, strengthening community leadership, mobilizing religious leaders in COVID-19 prevention, distribute IEC material via community networks, prevention of reintroduction of the diseases and, monitoring and evaluation of all community engagement activities conducted. This established model will go beyond COVID-19 and it will also be used in endeavours such as the promotion of health and well-being of the communities in the future.

Strategic Objectives
To develop a MOH level platform to engage the communities
To develop MOH level network of CBO's working with health sector to address the health security and COVID-19

Proposed activities

- All partners engaged in community work self-practice nine identified positive behaviors at home
- Mobilizing community leaders to promote nine identified behaviors
- Identify the potential barriers to carry out the needed nine behaviors (psychological and physical)
- Develop model community settings
- Mapping CBO's in MOH areas
- Involving vulnerable groups in discussions
- Strengthening community leadership
- Mobilizing religious leaders in COVID-19 prevention
- Distribute IEC material via community networks
- Prevention of reintroduction of COVID-19
- Monitoring and evaluation of all community engagement activities

5. Dealing with stigma

Stigmatization of the people affected by COVID-19 will lead to disastrous consequences such as the exclusion of aspects of community life, fear of divulging disease condition to health care staff and ultimately leading to violence in some instances. Therefore, it is vital to address stigma in all forms during community engagement activities in COVID-19 prevention. We propose to adhere to the following guidelines[5] in all community engagement activities to be conducted.

- **Don't** refer to the virus as belonging to someone or a group of people. **Don't** call people with the virus 'cases', 'suspects' or 'victims'. Instead, talk about 'people with the virus'.

- **Don't** talk about 'infecting others' or 'spreading the virus'. Instead, talk about transmission in more general terms.

- **Don't** share personal details (names, locations) of people who are, maybe or have been sick with anyone other than key team members and medical providers. When providing support to households with the virus, do so discreetly and with small teams to minimize attention. Seek to also support surrounding households as a community support mechanism.

- **Don't** spread misinformation or rumours. While there is much unknown about the virus, experts are learning every day. Check the sources of your information and make sure that they are reliable. Spreading false information only creates panic. Remember: it's ok to say 'I don't know'.

- **Be positive!** Share good news – such as examples of neighbours supporting each other – as well as information on the response.

Strategic Objective
To prevent all kinds of stigma due to COVID-19

Proposed activities
- Adherence to above guidelines all times during all COVID-19 prevention activities in the communities
- Reporting of any issues related to stigma pertaining to COVID-19 in the communities to Health Promotion Bureau

5 **OXFAM**., (2020), A guide for community-facing staff, Retrieved from https://reliefweb.int/sites/reliefweb.int/files/resources/gd-covid-19-oxfam-community-engagement-guide-270420-en.pdf

6. Vulnerable groups

The vulnerable groups are the people who are at a higher risk of getting the COVID-19 infection. Most of them are already are at a higher risk of developing the severe form if they are affected by the diseases. Furthermore, they may be already having poor access to optimum health care services. HPB has already identified these groups and developed a map of key stakeholders that can be utilized in addressing the issues of these groups.

Groups identified

Elderly people

People who engage in sex work

Youth

Substance users

People with physical disabilities/ visual impairments/ hearing impairments

People with neurodevelopment and intellectual disorders and people with low reading/ comprehension skills

Estate workers/communities and plantation workers

People who are living in poverty in urban settings and daily wage earners

People with pre-existing conditions (e.g. NCDs)

First Responders

Currently incarcerated people

Essential workers - CMC

Healthcare workers

Persons who have tested positive for COVID-19

Persons entering and returning from quarantine

Free-trade zone workers

People with a mental illness

Pregnant Women and children

GBV survivors

Homeless

Foreign tourists

Women and girls

Transgender individuals and LGB

People living with HIV

People who live in very remote/rural areas

Indigenous people

People living within existing humanitarian emergencies

Ethnic minorities

Potential flood/drought-affected areas

The HPB has already distributed social media contents (messages), PSA, AV/Clips, print materials and shared with many vulnerable groups. Furthermore, the HPB Suwasariya 24-hour telephone hotline is answering all calls made by any affected person including vulnerable groups.

Strategic Objectives
To identify vulnerable groups that needs special attention in the communities
To create a platform to share necessary information with the vulnerable groups
To identify the gaps in addressing concerns of the vulnerable groups

Proposed activities

- Mapping of all potential vulnerable groups at MOH level in the communities
- Identify focal points/platforms that can be utilized as partners in communication and addressing issues related to vulnerable groups
- Create platforms and networks of information sharing
- Empower religious leaders in dissemination of health messages
- Develop a database of messages available for vulnerable groups in all three languages
- Identify the gaps in health messages
- Identify the potential barriers to carry out the needed nine behaviors (psychological and physical)
- Identify the high-risk group where the reintroduction of COVID-19 is a possibility in the communities

7. Sentinel sites and behaviour surveillance

During the COVID-19 epidemic, it was realized that it is important to understand and identify many attributes related to behaviours in the community. Therefore, behaviour surveillance is the key to understanding why individuals and communities behave the way they are. By conducting proper behaviour surveillance, we can identify communities who had not adopted protective behaviour and act as a threat to the other's health by not maintaining social distancing, not revealing symptoms, and not practising home isolation.

The HPB has already identified key sentinel site in each district to provide a behaviour insight about the communities. The identified sites are given below. However, this surveillance system needs to be further strengthened.

District	MOH area	PHM area
Colombo	Homagama	Mawathgama
Gampaha	Attanagalla	Magalagoda
Kalutara	Wadduwa	Maha Wadduwa
CMC	D1 -Modara MH	28, Modara Street
NIHS	Beruwala	Walatara
Galle	Welivitiya Divithura	Akuretiya
Matara	Mulatiyana	Baragama
Hambanthota	Weeraketiya	Medamulana
Badulla	Ella	Maduragama
Monaragala	Monaragala	Hulandawa
Ratnapura	Ayagama	Madabaddara
Kegalle	Deraniyagala	Wattegedara
Kandy	Paathadumbara	Pallethalawinna
Mathale	Yatawaththa	Asgiri Dorakumbura
Nuwara Eliya	Hanguranketha	Akiriya
Anuradhapura	NPC	Mahabulankulama
Polonnaruwa	Elahera	Madudamana
Kurunegala	Alawwa	Alawwa
Puttalam	Aanamaduwa	Thalgaswewa

Ampara	Ampara	Mihindupura
Kalmunai	Akkaraipattu	PHM area - 8
Trincomalee	Kanthale	Agbopura
Batticaloa	Kaaththankudy	Moheideen
Jaffna	Sandilipay	Suthumalai
Vavuniya	Vavuniya	Poonthottam
Mannar	Mannar	Thalaimannar
Mullaitivu	Mallavi	Yohapuram East
Kilinochchi	-	-

Strategic Objectives

To identify key sentinel sites/communities for behavior surveillance for each target audience category

To develop a feedback mechanism at central level to create messages based on behavior data

Proposed activities

- Mapping of all potential behavior sentinel sites at MOH level in the communities
- Identify focal points/platforms that can be utilized in behavior surveillance
- Create online platforms and network for information sharing (mobile apps/ dashboards)
- Empower voluntary behavior reporting at community level via online platforms in the communities
- Support regular behavior research surveys (cross-sectional surveys)

8. Monitoring and evaluation

Monitoring and evaluation is an integral part of any community engagement plan. Tracking the effectiveness of the activities is an important aspect of the future planning process. We have considered many monitoring and evaluation platforms to measure the progress. The following framework[6] is suggested since it is simple and more result-oriented.

Framework for Evaluation of Community Empowerment

1. **Baseline assessment - What was the situation before the empowerment process(es) were introduced?**
    a. What decision-making processes were used before the empowerment activity?
    b. How were local people /officers involved in the old processes?
    c. How many local people were involved in decision-making under the old processes? Were they representative of the target population?
    d. What sorts of decisions were local people /officers involved in?

    Assessment methods

    Self-assessment, stakeholder interviews and focus groups, survey of local stakeholders

2. **Inputs**
    a. How much did the set-up of the **empowerment arrangements cost** (in terms of in-kind contributions) – e.g. time commitment for residents, public sector officers, and voluntary organisations?
    b. How much are the ongoing costs (in-kind) of the process – e.g. time commitment for public sector officers, and voluntary organisations, as well as the public?
    c. What were the main ***financial inputs*** into the empowerment process(es)?

    Assessment methods

    Self-assessment, a survey of local stakeholders, Interviews and focus groups with local stakeholders, previous reports

3. **Process**
    a. Did the introduction of the empowerment process(es) build on other community empowerment initiatives?
    b. Was the process initiated by the local authority/lead service provider, or was it triggered by community-led or bottom-up pressure? Was the local authority supportive?

6 **Department for Communities and Local Government**, (2009). An analytical framework for community empowerment evaluations, SQW Consulting UK, Retrieved from www.communities.gov.uk

c. Was the external support provided? If so, what was it? Who received it? How much did it cost? How long did it last?

d. **Governance arrangements** (Who is involved in the decision-making processes at the local level, What is the community's involvement in checking the progress in implementing its decisions? How frequent is this? And what effect does it have? How does this compare to previous approaches? Who is accountable for ensuring that results from the empowerment process are taken forward?)

e. **How has the empowerment activity been delivered?** And has this changed over time? (How are people encouraged to be involved? What roles do people play? What support is provided to those who get involved and how is this delivered (e.g. is there formal training)?, What decision-making processes have been/are being/will be used? How frequently are decisions taken? What topics are subject to local decision making? How are priorities identifi ed – via evidence, debate and discussion, petitions, another method? Are they the most important for local people? What evidence is there of this?)

f. **Barriers and critical success factors** (What are the main barriers to the set-up and delivery of an empowerment process(es)? What evidence is there of this? , What critical success factors are necessary to ensure the effective delivery of the empowerment process(es)? What evidence is there of this?)

Assessment methods

Self-assessment, a survey of local stakeholders, Interviews and focus groups with local stakeholders

4. Results

A) Outputs

a. **What were the immediate and measurable results of the process(s)?** (Has participation increased as a result of the process? And if so, by how much?, Has the scale of local initiatives and projects increased? If so by how much? How has this changed over time? How is it different from previous arrangements? Have you seen a new level of engagement from participants who were previously disengaged/marginalised, and in what ways?, Has there been an increased use of local services as a result of the empowerment mechanism(s) and what evidence do you have to show this?)

B) Outcomes

a. **How has/have the process(es) changed the behaviour and well-being of those directly and indirectly involved?**

Potential changes to be explored:

i. Improvements in the self-esteem and confidence of participants

ii. A perceived increase in ability to influence local decisions

iii. Increased understanding of the difficult trade-offs required when making decisions about local service provision, and therefore increased perceptions of fairness

iv. Improved appreciation of the needs of others in the community
v. Improved understanding of the issues surrounding resource allocation
vi. Increased engagement from hard-to-reach groups
vii. Increased levels of civic participation
viii. Increased satisfaction with local services
ix. Increased satisfaction with the local area
x. Increased community cohesion
xi. Increased community capacity in an area
xii. Increased social capital (including trust in each other and service providers)
xiii. Increased awareness of empowerment principles and the 'duty to involve' amongst local service providers
xiv. Effective decisions are made in less time than in the past or more decisions taken using the same resources
xv. Better quality decisions, such as fewer reversals of previous decisions
xvi. Allocative efficiency e.g. reallocation of resources to better reflect the wishes of citizens
xvii. Distributive efficiency e.g. reallocation of resources in favour of those in greatest need
xviii. Have the costs of engaging local people in decision making increased, decreased or remained the same as a result of the process?

C) Impacts

a. **What are the possible long term changes that are likely to occur as a result of the empowerment process(es)?**

- **Better local services**
- Increased levels of trust in local service providers
- **Improved quality of life and community wellbeing**
- Enhanced levels of community cohesion
- **Improvements in wider policy outcomes. For instance, health, education, community safety,** etc.
- **Systemic changes to the way public service providers work with local communities to shape local areas**
- **Have there been any unintended outcomes?**
- **Is there any economic case for this intervention?**
    - Have the benefits (outputs/outcomes/impacts) exceeded the costs (inputs and negative unintended consequences)?

- Is this intervention more cost-effective than alternative empowerment mechanisms?

Assessment methods

Self-assessment, a survey of local stakeholders, Interviews and focus groups with local stakeholders