Editorial

The vital role of meaningful community engagement in responding to the COVID-19 pandemic

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Article history

The global coronavirus disease 2019 (COVID-19) pandemic has had an enormous impact on the lives of individuals and communities around the world for much of the past year. In many cases this has led to disastrous dislocation of lives and livelihoods and, sadly, millions of deaths. Public health authorities around the world have scrambled to respond to the scale and complexity of the challenge which has been unprecedented in modern public health history.

Some countries, notably New Zealand, Australia, Taiwan and Vietnam, have managed their response with relative success through a combination of stringently enforced restrictions on movement and social contact, and effective test and trace programs, all underpinned by integrated public communication campaigns. While each of these countries continues to have sporadic community transmission, the structures now in place seem capable of managing these effectively.

Several countries' experiences, including those of Australia and Singapore, have been marked by a period of successful control followed by a serious community outbreak. In both cases, the outbreak accelerated rapidly through communities that were marginalised or disconnected from the mainstream population. This is most striking in the Singapore example where a surge in cases was closely associated with migrant workers living in poor-quality and overcrowded housing.[1,2] In Australia, a major outbreak in Melbourne led initially to a 'hard lockdown' of public housing towers in some of Melbourne's poorest suburbs.[3] Both examples led to considerable public debate about social conditions and infection control, social justice for marginalised groups and, in the Melbourne example, a strong reaction to the use of coercive powers by the government on evidently disadvantaged populations.

These examples indicate that even in countries that have had success in managing the pandemic, communities that are disadvantaged, marginalised or otherwise disconnected from the mainstream of the population remain at higher risk because of their social circumstances and the effects of disconnection. Public education campaigns have been successful in reaching the great majority in the population but have notably failed to reach

identifiable culturally and linguistically diverse (CALD) populations. In responding to this challenge, there is much to be learned from experiences from previous epidemics.

Responses to Ebola outbreaks in the past decade have demonstrated the importance of meaningful community engagement in the long term and successful management of infectious disease outbreaks.[4,5] Experience from the 2014–2015 Ebola outbreak and other epidemics has identified the critical role, for example, of involving community leaders as a conduit for achieving effective communication, and of meaningful community engagement in infection identification and control measures. Long-term community engagement has been essential in sustaining control measures.[6] These and other studies indicate the importance of understanding local customs, beliefs, knowledge and practices, and illustrate how prevention and control efforts need to incorporate meaningful community engagement along with established disease control measures. Disappointingly, the experiences in Singapore and Melbourne, and the experience observable in many other countries, indicate that lessons learned from previous infectious disease emergencies about the active engagement of disadvantaged and disconnected communities were not always systematically incorporated into public health responses to COVID-19.

This issue of *Public Health Research & Practice* includes a paper from Wild and colleagues that highlights the importance of partnership, and codesign in developing COVID-19 health information for CALD communities.[7] On a similar theme, Skouteris presents a compelling argument for meaningful community consultation, collaboration and codesign in developing a long-term recovery plan from the impact of COVID-19 on society and the economy.[8] The paper argues that a strong participatory response from all population groups – including those who are marginalised and vulnerable – can improve equity in health outcomes. This paper also reiterates the need to tailor key public health messages to the diverse populations, building on previous work by McCaffery and colleagues in *Public Health Research & Practice* on the significant variations in public knowledge and understanding of COVID-19, and the need to improve the quality and targeting of communications to diverse populations.[9]

On a similar theme, in another paper in this edition, Parter and colleagues reiterate the importance of Indigenous knowledges and Indigenous cultures of ways of being, knowing and doing being front and centre to public health actions. Their perspective paper goes on to describe deep-seated resistance to identifying and addressing institutional and systemic racism which has sustained "an unacceptable standard approach, for and about Indigenous health instead of with Indigenous peoples".[10] They argue that working at the cultural interface where knowledge systems and cultures can co-exist and thrive is imperative to Indigenous Australians reclaiming pathways to better health.

These papers all highlight the effectiveness of meaningful participation from diverse communities in the design and implementation of public health strategies and programs in delivering more effective and sustainable outcomes. These are lessons long established, but still inconsistently applied.

Peer review and provenance

Internally reviewed, invited.

Competing interests

None declared.

Author contributions

DN is the sole author.

References

1. Koh D. Migrant workers and COVID-19. Occup Environ Med. 2020; 77:634–36.

2. Tan IB, Tan C, Hsu LY, Dan YY, Aw A, Cook AR, Lee VJ. Prevalence and outcomes of SARS-CoV-2 infection among migrant workers in Singapore. JAMA. 2021;325(6):584–85.

3. Silva DS. COVID-19 in the public housing towers of Melbourne: upholding social justice when invoking precaution. Aust N Z J Public Health. 2020;44(5):430.

4. Kickbusch I, Reddy KS. Community matters – why outbreak responses need to integrate health promotion. Glob Health Promot. 2016;23(1):75–8.

5. Laverack G, Manoncourt E. Key experiences of community engagement and social mobilization in the Ebola response. Glob Health Promot. 2016;23(1):79–82.

6. Marais F, Minkler M, Gibson N, Mwau B, Mehtar S, Ogunsola F. Community-engaged infection prevention and control approach to Ebola. Health Promot Int. 2016;31:440–9.

7. Wild A, Kunstler B, Goodwin D, Onyala S, Zhang L, Kufi M, et al. Communicating COVID-19 health information to culturally and linguistically diverse communities: insights from a participatory research collaboration. Public Health Res Pract. 2021;31(1):e3112105.

8. Skouteris H. Addressing health and social care during and beyond COVID-19: the importance of implementation science. Public Health Res Pract. 2021;31(1):e3112103.

9. McCaffery KJ, Dodd RH, Cvejic E, Ayre J, Batcup C, Isautier JMJ, et al. Health literacy and disparities in COVID-19–related knowledge, attitudes, beliefs and behaviours in Australia. Public Health Res Pract. 2020;30(4):e30342012.

10. Parter C, Murray D, Mohamed J, Rambaldini B, Calma T, Wilson S, et al. Talking about the 'r' word: a right to a health system that is free of racism. Public Health Res Pract. 2021;31(1):e3112102.