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Social Mobilization in the Wake of Coronavirus Disease-19: A Brief Report of a Planned Approach to Community Health in Iran

Javad Mirza-Aghazadeh[1], Ali Sadaghianifar[2], Morad Ali Zareipour[2]*, Mohammad Mirza-Aghazadeh-Attari[3], Jila Nagavi Kalejahi[2]

[1]Social Determinants of Health Research Center, Urmia University of Medical Sciences, Urmia, Iran; [2]Health System Research Unit, Health Center of Urmia, Urmia University of Medical sciences, Urmia, Iran; [3]Medical Radiation Sciences Research Center, Faculty of Medicine, Tabriz University of Medical Sciences, Tabriz, Iran

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***Correspondence:** Morad Ali Zareipour, Health System Research Unit, Health Center of Urmia, Urmia University of Medical sciences, Urmia, Iran. E-mail: z.morad@yahoo.com
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Abstract

BACKGROUND: Several plans have been taken by health system to deal with COVID-19. The rapid spread of the virus and the special care that critical patients need put a major pressure on the healthcare system, which may not be able to compensate for its dimensions in various aspects. Therefore, the participation and cooperation of the society in the form of mobilizing the society with the health system will be effective in controlling and preventing this disease.

AIM: The overall purpose of this study is to design a community mobilization framework based on the PATCH Model to prevent the spread and control of coronavirus disease.

METHODS: This community-based research is a type of health system research (HSR) which designs the community mobilization framework based on the PATCH Model

RESULTS: In this project, the community mobilization framework is in the form of the PATCH Model. In this study, interventions and activities will be performed based on the PATCH Model in the neighborhood. Health volunteers consist of popular volunteers, Basij, clerics, neighborhood trustees, donors. After training and issuing the identification card, Corona Anti-Corruption Assistant will start operating. Activities will be purposeful in three areas: education and information, neighborhood surveillance, and disinfection.

CONCLUSION: Community mobilization for disease prevention and control in the neighborhood using the PATCH model as presented will be effective.

The coronavirus disease-19 (COVID-19) pandemic started in late 2019 and swiftly disseminated in Asian countries, such as Iran. In many countries, the pandemic has been controlled using widespread lockdowns, quarantines, and direct involvement of the government [1]. These series of involvements are of greater importance in underdeveloped, overpopulated areas. Unfortunately, not all governments have the needed infrastructure to make these interventions, with these governments mostly being located in poor countries with densely populated cities [2].

To increase health-related behaviors among a population, two distinct areas should be addressed. One being the role of the government and the other the role of the community as a whole. To insure promotion of health in a society, each member of a society must be able to identify the correct actions to preserve a healthy lifestyle, and until all members are able to understand the factors affecting their health, no wide scale governmental intervention can be made [3]. Importantly public interest in health promotion is dependent on active persuasion by the government. As mentioned by the world health organization, participation of the public in health promotion is done through investment of time, resources in a voluntarily manner so that each member of the society can achieve the benefits of health promotion. This benefit is also passed down to each other member of the community and the society as a whole, as responsible and capable individuals are able to act as both enablers, policy makers, and promotors of those policies. This involvement of the public also enables them to participate in agenda setting and determining key priorities in their communities [4].

Planned approach to community health (PATCH) is a systemic stepwise method of health promotion initially presented by the center of disease control and then implemented in numerous settings. This method consists of five phases, including mobilization of communities, collection, and organization of data, choosing health priorities, developing an intervention plan, and finally evaluation of the program [5], [6] (Figure 1).

PATCH was implemented in an underdeveloped suburban neighborhood of a major metropolitan area within Iran and was implemented on a population of 80,000. In the first phase of community mobilization,

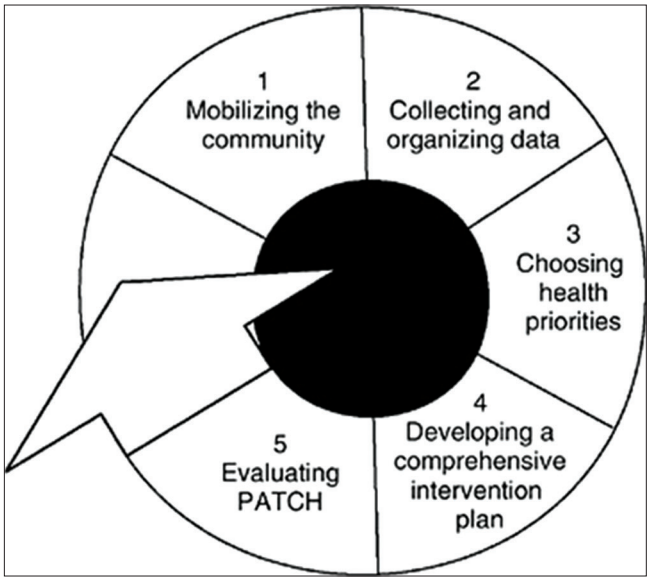

Figure 1: Five-phase PATCH model

various social groups and representatives were educated and involved in the process of policymaking for COVID-19. Multiple committees were formed and different representatives of social groups were included in each of them. These committees acted as mid-level policy developers, and all acted under the umbrella of the ministry of health. Data gathering and management were done by a task force composed of the media, medical specialists, and social workers, who were responsible for gathering data and disseminating it in other committees and the general public. Health priorities were done after an extensive stakeholder analysis and were broken into smaller attainable objectives in different fields.

During this step, groups and organizations such as military, religious scholars, business owners, law enforcement, social workers, and charities were included and were further divided between the most suitable committees.

The execution was done after a primary goal list was constructed, and after each committee had consolidated. This committee was composed of volunteers, public health workers, religious preachers, social workers, doctors (both general practitioners and specialists), law enforcement and the military, and the media. During this phase, many activities with the potential for disease spread were limited or controlled by introducing specific measures. For instance, Friday prayers were canceled, restaurants were closed, small businesses had limitations on the number of customers, and on services, they could deliver. Social groups made sure that unnecessary commute had stopped and that those with pre-existing conditions were isolated. Doctors and healthcare workers were instructed to stratify subjects based on guidelines made available by the ministry of health and revised by the scientific committee and to rule out potential infection if necessary. They were also in charge of referring patients to tertiary care centers and post-discharge care of those infected with the virus.

A financial committee was composed of the chamber of commerce, business owners and governmental institutions to financially support those families with hardship and to support businesses which are temporarily closed. This committee was also responsible for providing the basic protective wearables and disinfectants for wide scale use.

The law enforcement and the military were responsible for holding up the lock down. Volunteers were responsible for implementing the measures in their own communities.

The final phase of PATCH is evaluation of the method adapted. At present, the program has been able to reduce contamination in the aforementioned neighborhood. At present, initial attempts are being made to formulate evaluation methods to quantify the results.

This system was interconnected with the Behvarz program which is the back bone of public healthcare in Iran, especially in sub-urban areas. The volunteers were instructed by Behvarzes and general practitioners and used the already existing infrastructure of the Behvarz program. The central executive functions were coordinated in urban health houses, which were previously used for public health delivery, basic child and neonatal care, and routine pregnancy checkups.

Two dimensions can be considered to promote community health. Activities that involve direct government intervention and strategies; and public action activities that involve community participation. To promote the health of the individual and the society, we need to create the power of proper management and decision-making in all members of society. In other words, as long as people cannot identify and control the factors that affect health, ensuring, and promoting health in the general sense will be unattainable. People's participation in their health is one of the important issues that should be strengthened and encouraged in line with government measures and development sectors. The World Health Organization believes that participation in health is a form of cooperation in which people accept voluntarily or for encouragement and justification, which interacts with health-related interventions and benefits by providing labor or other resources. To acquire, participation is also an empowerment tool through which the local community learns responsibility, diagnosis, and work to solve their health problems and strives to develop their community.

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