Editorial

COVID-19 Pandemic Is a Total Social Fact: Urgent Need for Social Studies on COVID-19 Pandemic

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Marcel Masuss described the total social fact as events or activities that can affect society in all spheres, including economic, legal, political, and religious aspects. Many months after the identification of the first cases of Covid-19, it is now apparent that humanity is faced with a total social fact, not a simple disease. The pandemic has brought considerable changes, which indicate entering a new era (1, 2). Hence, it can be argued that there is an urgent need for applying a social approach to better understand, conceptualize, and analyze the resulted transformations and reordering them (3, 4).

We are still beginners in understanding what has happened and what would become next. Of various social research methods, qualitative and narrative inquiries are one of the best techniques to understand these changes. These techniques can be used to demonstrate discrepancies of various groups in terms of understanding, feeling, and experience regarding COVID-19, which is of crucial importance for planning how to encounter and engage in social responsibility to this pandemic. Unfortunately, there is still a lack of research focusing on these issues, especially in the most impoverished populations that often are affected more seriously by this pandemic.

There are significant but unreasonable dualities in our globalized world, such as center-periphery, north-south, east-west, developed, and undeveloped nations, which would deter the global efforts in managing this pandemic (5). These dualities are potential threats for emerging and reemerging global challenges, which can again engulf and derail the very existence of people living around the world. As told by Andrew Lakoff, bridging these gaps can improve global "preparedness" in coping with the imminent events and pandemics.

In the absence of community engagement, governments will fail in managing pandemics. This engagement should include the involvement and participation of individuals, groups, and community structures for decision-making, planning, design, governance, and provision of services and rectifying health inequities (6). Community engagement not only allows people to play their role as active clients but also, more importantly, allows them to act as partners and owners who effectively communicate and interact. In addition, community engagement would increase social trust, which in turn translates into increased effectiveness and sociable planning and interventions. To reach this goal, communities should be enlightened, empowered, and equipped with understandable and analyzed information.

This needs to be accomplished by academia through community-based participatory researches and should be publicized to reach the community and policymakers (7). We are now more than ever face with the consequences of the historical weaknesses in knowledge translation, which purge the field for the current so-called *misinfodemia*. Unfortunately, few, if any, institutes in most countries and even at the global level handle knowledge translation methodically from beginning to act and then evaluation.

Initially, we had no knowledge about COVID-19, as it was a new disease; however, our knowledge has evolved dramatically and dynamically in the past two years. Ignorance and insouciance and misunderstanding of the magnitude of the threat not only have resulted in misconduct

in policies but also promoted the dissemination of infection in communities. One function of community engagement is risk communication, which its eventual purpose is to empower those at increased risk of the disease to make informed decisions to protect themselves and their loved ones ([8]). Several risk communication models are conjoint in three phases (i.e., Preparedness, Response, and Recovery). Risk communication is a sophisticated issue that requires both planning and resource allocation. Simplifying risk communication to official statements and tardive and ineffective response to the population's needs for knowing the facts and truths on time has resulted in the propagation of canards and weakened the needed support from the community to manage the community pandemic.

Globally, the level of health literacy is low, defined as the knowledge, motivation, and competencies, to access, understand, appraise, and apply information to form a judgment and decide regarding healthcare, disease prevention, and health promotion, which also has had additive detrimental effects on poor health risk communication. Authorities should not blame individuals and communities for their low levels of health literacy. Promoting health literacy is the social responsibility of all stakeholders as well as governmental, non-governmental, non-profit, and private actors, from national to regional levels. In this regard, health professionals, community leaders, and social media can be a unique role because people with low literacy levels trust them. Thus, well-designed information systems that target all age groups with any level of education, as well as their cultural diversities, are required.

COVID-19 pandemic has deteriorated the mental health of societies worldwide. In addition, not only it has worsened the mental health status of those with preexisting psychological diseases, but also resulted in increased incidence of mental disorders, ranging from anxiety, post-traumatic stress disorder, and depression ([9]). Policies that are intended to mitigate and confine the consequences of psychological disorders at the community level are essential.

Since the onset of the pandemic, healthcare providers have experienced worsened mental well-being as well as higher levels of burnout ([10]). Apart from providing medical care, health care providers also play a crucial role in observing psychosocial needs and delivering psychosocial support to their patients, their own families, their colleagues, and the public. Poor risk communication arrangements contributed to worsening mental well-being. Furthermore, mental health interventions were not in place at the right time in this pandemic. We still see the need to incorporate mental health-promoting policies in strategies intended to control the pandemic as well as health planning.

In addition, the capacity of religious-based interventions and clergy consultation can also be used to improve the mental health status of society and to alleviate anxiety and distress. There are evidence indicating the success of religiosity in improving social and community collaboration and engagement during COVID-19. Public policymakers should welcome the potential role of religion. However, communication and dialogue are the prerequisites of this collaboration. According to Iran's experience since the onset of the pandemic, the support of religious leaders in prorogating the gatherings and closure of mosques and holy shrines (as the main religious places) has been useful for controlling the pandemic while avoiding the social consequences of such decisions.

In conclusion, the COVID-19 pandemic calls for the formation and establishment of an interdisciplinary research approach and systematically integrated policies, actions, and agendas.

Social science, with its various tools and perspectives, can provide relevant contributions. Social science studies on COVID-19 could help us in following an evidence-based approach to community engagement; also, such studies are helpful in enterprising preventive and curative interventional strategies intended to control the pandemic.

Footnotes

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