Preparing countries for risk communication and other social science interventions

Dr Gaya Gamhewage
Infectious Hazard Management Department
Three key ideas

1. The 21\textsuperscript{st} century poses \textit{new and fast-moving challenges} for the practice of Emergency risk communication (ERC) and other social science interventions (SSI)

2. Valuable \textit{lessons learnt} in recent epidemics and can direct, at least in part, future preparedness planning

3. Integrating ERC and SSI into national preparedness must
   - take an evidence-based and systems approach
   - involving all of government and key stakeholders across sectors
   - be matched with human and financial resources
   - evolve from technical expertise to include social and operational aspects
What do we understand by emergency risk communication?
Emergency risk communication—
an umbrella term!

- The real-time **exchange** of information, advice and opinions between **experts or officials and people** who face the threat (from a hazard) to their survival, health or economic or social well-being;

- **Purpose** – everyone at risk is able to take **informed decisions to mitigate** the effects of the threat (hazard) – such as a disease outbreak – and take protective and preventive measures and minimize economic, social and political loss

- **Domains** – Communication and Social science interventions from mass communication to community engagement and interpersonal communication.
### Guiding principles for risk communication best practice

1. Create and maintain trust
2. Acknowledge and communicate even in uncertainty
3. Coordinate
4. Be transparent & fast with the first and all communications
5. Be proactive in public communication
6. Involve and engage those affected – not tell them what to do!
7. Use integrated approaches, social science research and approaches to understand perceptions, barriers and enablers
8. Build national capacity, support national ownership
Emergency risk communication: **Uses a mix of tactics and approaches**

1. public communication  
2. media communication  
3. social media  
4. mass awareness initiatives  
5. IEC  
6. health promotion  
7. social mobilization  
8. community engagement  
9. Interpersonal comms  
10. stakeholder communication and political advocacy  
11. partner engagement  
12. political communication  

A moving target with many names

Medical anthropology + Social mobilization + Outbreak communication

Risk communication, Crisis comm; Pandemic comm

Emergency risk communication, Social Mob, COMBI, C4D

Communication + Social science interventions
Early 20th Century: Death and fear

Early 21st century:
- personal protection,
- disruption to life and livelihoods

The present:
- High speed spread, travel and trade,
- influence of information technology,
- access to vaccines and growing vaccine hesitancy,
- economic and political factors and impacts,
- apathy and rumours
- Diminishing trust in authorities
The 21st century – increased vulnerabilities and risks

- Climate change
- Exponential growth of international travel and trade
- Porous borders
- Migrant workers
- Urbanization
- Increased numbers and evolution of vectors
- Risks at the animal-human interface
- Anti-vaccine sentiment and lobby
- Fragmented development policies, funding for pet projects – not for systems development
- Political instability
- Increasing socio-economic disparities within countries
2. What did we learn from recent outbreaks?
The big outbreaks and epidemics

**Outbreak communication**

- SARS 2003
- Pan Flu 2009
- MERS-CoV 2012
- Ebola 2014
- MERS-CoV Korea 2015
- Zika 2015
- Yellow fever Africa 2015

**Risk communication and social mobilization; C4D**

**RC and social science interventions**
Lessons learnt

- SARs
- H5N1/Pan Flu
- MERs
- Ebola (EVD)
- Zika (ZIKV)
- Yellow Fever (YF)

What were the big ERC and SSI considerations?

What did we do right and wrong?

What did we learn for the future?
SARS

- Surveillance, isolation, triage, spatial separation, surge capacities had to be re-thought
- Amplification within health care settings, and through international travel
- Psychological and psychosocial impact
- Economy, travel and trade harmed
- Most evidence used to inform response for ARI comes from the SARS outbreak
- ERC – FEAR! Insufficient attention to perceptions and impact. Biomedical approach, little social science
H5N1: The Dark Ages

- capacity building continues, but measures disproportional and sometimes excessive
- PPE: painting the wrong picture, building fear
- Economic loss to difficult to bear for at-risk populations
- Pushing messages, loss of trust
Pandemic Influenza A H1N1(2009)

- Initially ERC successful – until declaration of pandemic
- The pandemic phases were misunderstood as linking to severity
- Rise of social media but ignored initially by WHO and governments
- Conspiracy theories, loss of trust
A. Health care facility-acquired account for >50% of all secondary cases

B. In households among family members

C. ERC – did not, and still does not reach vast populations of migrant workers
Ebola: Fear, suspicion, lack of trust, power deficit
Ebola

- Led by bio-medical approach, not social science
- ERC – tell people what to do. The did not listen!
- "community resistance" led to killing of responders and amplification of outbreak
- Response teams and agencies competed with one another at the outset
- No real community engagement or use of social science research/evidence base for ERC
- Mass mobilization took up effort and resources but did not really engage communities
Looking back - 7 Lessons learnt

1. **Widespread acceptance** that ERC and CE are essential integral components of emergency work in health, **demand** for improvement

2. We were too **fragmented; too little too late** – fields, disciplines, specialities, agencies

3. **Disconnect between**
   - communications and community engagement;
   - sociologists and anthropologists and programme managers,
   - Responders and community

4. Very **poor listening and adaptability**, poor use of research and knowledge

5. A culture of pushing **messages**, materials and delivery, not focussed on outcomes, not engaging people

6. Risk vs benefit of **branding**, institutional communications

7. **Mandate clash**, blame game. Confusions about **coordination**, leadership and followership
ZIKV

- Started as vector borne disease
- Main concern was microcephaly – SRH services implications
- Vector control challenging and often futile in affected areas
- Social mobilization focused only on vector control
ZIKV RCCE challenges - SRH in the Americas

- 23 million women lack access to contraception; accounts for 75% of unwanted pregnancies
- 22% of adolescent girls start having sex before the age of 15y, the highest in the world
- 4.4 million abortions take place annually in the region with some of the most restrictive laws in the world
  - 95% of them take place in unsafe conditions,
  - resulting in 1,100 maternal deaths every year
  - About 760,000 women are hospitalized for complications
- The region is home to some of the most restrictive abortion laws in the world
- Religious influence
- High rates of sexual violence
  - 1.68m women raped/yr
  - Intimate partner violence ion the region ranges from 23 to 41% (global average is 26%)
- Social disparity: Young, poor, black and brown women are the ones who suffer the most from unreasonable abortion policies (Gideon, Leite and Alvarez Minte, 2015).
Continuum of support needed SRH and Zika

Prevention and delay of pregnancy in women and girls

Antenatal care

Management of newborns with microcephaly

Support to families

Missing interventions

WHO interim guidance available, new Evidence informed Zika-specific guideline coming out in May 2016

WHO interim guidance on psychosocial support to families with babies with microcephaly available
What worked

- Global multi-partner coordination strategy
- 50% of budget for ERC including community engagement
- App and resources
- UNICEF/IFRC/WHO joint approach, tools and messages for RCCE
- KAP Resource pack
Yellow Fever – Angola and DRC
Vector control is challenging!
YF vaccine: New dose, new fears?

With limited global supplies of the vaccine

recommendations of the Strategic Advisory Group of Experts (SAGE), WHO with the Ministry of Health of DRC is using one-fifth of the standard vaccine dose as a short-term emergency measure in Kinshasa to reach as many people as possible.

The dose confers protection for 12 months and longer.

The government has planned a new campaign next year using the full dose when global vaccine stocks have returned to normal.
What worked?

- RCCE part of response strategy
- Guide for social mobilization for YF campaigns
- Guide for ERC including for the fractional dose
- Operational capacity and funds for social mobilization
3. Integrating ERC and SSI into national preparedness
The logic model

Public health event or emergency

PUBLIC INFORMATION
through preferred channels of affected populations

MASS MOBILIZATION
of affected and at risk communities using social mobilization, etc

ENGAGEMENT
of community, family and individuals, including through influencers

OUTPUT
Trusted information reaches people, rumours addressed

OUTCOME
everyone at risk is able to take informed decisions to mitigate the effects of the threat (hazard)

IMPACT
Reduced death, illness and economic and social loss
Emergency risk communication (ERC)

What is emergency risk communication (ERC) targeting?
- Social scientists’ network (Social Net)
- Emergency communications network (ECN)
- Country expert deployment
- ERC at Global & International levels

Global international & national support for response
24/7

Expertise for Emergency risk communication (ERC)

WHO asked to lead
Emergency Risk Communication Core for Highly Infectious Pathogens

Capacity building for countries

Guideline Tools Platform

Member States
Journalists
Community radio
Partners

Unknown
Fear...
Uncertainty...

Outbreaks are contained and controlled...
Informed decisions taken to mitigate threats...

What is the purpose of emergency risk communication (ERC)?

What is Emergency risk communication (ERC)?
The real-time exchange of information, advice and opinions between experts or officials and people who face the threat (from a hazard) to their survival, health or economic or social well-being. Address concerns and fears as well as provide information.

World Health Organization
### Relevant international health frameworks

<table>
<thead>
<tr>
<th>Framework</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WHO Constitution</strong></td>
<td>Health as a human right, social justice. Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people.</td>
</tr>
<tr>
<td><strong>International Health Regulations, IHR (2005)</strong></td>
<td>Risk communication as a core capacity for dealing with health events and emergencies.</td>
</tr>
<tr>
<td><strong>Pandemic Influenza Preparedness (PIP) Framework</strong></td>
<td>Pandemic communication.</td>
</tr>
<tr>
<td><strong>Regional and Programme Strategies</strong></td>
<td>Outbreak response, Global Outbreak Alert and Response Network (GOARN), humanitarian action framework, WHO reform for outbreaks and health emergencies.</td>
</tr>
</tbody>
</table>
IHR core capacity requirements (national, intermediate and local)

Annex 1

8 Core Capacities
- Legislation and Policy
- Coordination
- Surveillance
- Response
- Preparedness
- Risk communication
- Human Resources
- Laboratory

Potential hazards
- Infectious diseases
- Zoonotic events
- Food safety
- Chemical events
- Radiological events

Events at Points of Entry

- In order to implement the IHR, a focus was given to IHR core capacities and potential hazards
- Countries readiness to implement the IHR are measured against these core capacities
- Now supplemented by Joint External Evaluation
- ERC- an essential component of effective response to public health emergencies
JEE- An integrated model for emergency risk communication capacity assessment

*Adapted from new IHR external assessment tool – WHO*

- **Risk communication systems**
  - Strategies, plans, structures, resources, SOPs & exercises to test existing systems

- **Internal & partner communication & coordination**
  - Mechanisms at national, local, international levels with stakeholders (health care workers, NGOs, volunteers, civil society, etc.)

- **Dynamic listening and rumour management**
  - Media & social media monitoring, partner, stakeholder & community feedback, operational research (social science)
  - Knowledge, attitude and practices (KAP) studies, etc.

- **Communication engagement with affected communities**
  - Engagement with directly affected communities or through influencers, awareness raising in participatory approaches, use of community radio, interpersonal communication, etc.

- **Public communication**
  - Media, social media, web, information-education-communication (IEC) materials, social mobilization, etc.
IHR Joint External Evaluation Framework
ERC Capacity: 5 x 5

1. Risk comms systems in place (strategy, plans, SoPs, SIMEX, etc)
2. Internal and partners communication and coordination
3. Public communication
4. Community Engagement
5. Dynamic listening and Rumour Management

5 domains; 5 levels of capacity – 40 countries in 2016
Risk communications capacity EMRO – Ebola 2015

- Plan for community/public engagement available: 47% Yes, 29% Partially, 24% No
- EVD briefing for media engagement: 94% Yes, 0% Partially, 0% No
- Ebola Risk Communications training for MOH staff: 82% Yes, 0% Partially, 0% No
- Main spokesperson(s) for EVD identified: 6% Yes, 65% Partially, 0% No
- SOPs for EVD Risk Communication available: 94% Yes, 0% Partially, 0% No
- EVD Awareness materials disseminated: 59% Yes, 6% Partially, 0% No
- EVD Risk Communications plan developed: 35% Yes, 41% Partially, 0% No

*Based on data from checklists filled by 18 countries
Pandemic Influenza Preparedness (PIP) Framework

- Landmark, innovative public health arrangement to increase global preparedness to respond to pandemic influenza

- Focus is on increasing equity of access to lifesaving measures

- Brings together Member States, industry, other key stakeholders, and WHO

Two objectives on equal footing:

- Improve sharing of influenza viruses with the potential to cause a pandemic among humans

- Achieve more predictable, efficient, and equitable access to benefits arising from the sharing of viruses, notably vaccines and antiviral medicines
Public health control and implications for pandemic risk communication

1. Prevent exposure
   - IPC
   - In society and in care facilities
   - Amplification

2. Protect susceptible populations
   - Vaccination + antivirals and social distancing
   - Migrants & refugees, the poor, other vulnerable groups
   - Health care workers

3. Treat cases
   - Prevent death and severe illness
   - Prevent further transmission
   - Decisions on priority groups

4. Interrupt transmission
   - Environmental
   - Social/behavioural
   - Legal
Risk communication intervention points in epidemics and pandemics

- **Anticipation and preparedness**
- **Emergence** (human-animal interphase)
- **Outbreak** (localized transmission)
- **Containment**
- **Epidemic amplification**
- **Mitigation**
- **Control**
The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

©WHO 2014. All rights reserved.
1 Risk communication partners and stakeholders identified
2 Risk communication plan developed
3 Risk communication implemented or tested in the last 12 months
4 Policies, SOPs or guidelines developed on the clearance and release of information during a public health emergency
5 Regularly updated information sources accessible to media and the public
6 Accessible and relevant IEC materials
7 In PH emergencies populations and public health emergency shared with partners have been informed of a real or potential risk within 24 hours following confirmation
8 Evaluation of the public health communication conducted after emergencies
9 Results of evaluations of risk communications efforts during a public health emergency shared with the global community
3. Integrating ERC and SSI into national preparedness: 4 directions
Integrating ERC and SSI into national preparedness

- take an evidence-based and systems approach
- involve all of government and key stakeholders across sectors, political buy-in
- Evolve from technical to include social and operational aspects
- must be matched with capacitated human and financial resources
Current gaps – evidence based decisions making for ERC

Social science interventions (anthropology, sociology, communication science)

Social science research
- KAPs and mini KAPs
- Focus group discussions
- Community walk
- Key informant interviews

Communication research
- Media and social media monitoring

Feedback from response teams/agencies
Reforming ERC and CE
WHO risk communication (RC) operations model

Integral part of response
Address information needs and address concerns/fears
Work at global, regional and country levels

Triggered by: Incident Management team

- RC Strategy
- Translational communication
- GLOBAL: guidance/services
- COUNTRIES: experts
- Listening and feedback loops
- Review of strategy and products

- Media/SM monitoring
- Event
- Anticipating epidemics

Product dissemination, real-time training, outreach: MOOC, App
4. What support can you expect from WHO?
## Technical, operational and social

### TECHNICAL
1. First ever evidence-based WHO ERC Guidelines – mid-2017
2. WHO epidemic App
3. WHO MOOC platform for outbreak training and learning, as well as real-time updates for ongoing emergencies
4. Expertise and tools for national RCE capacity assessment – JEE
5. Direct support for national capacity building (govt, partners, experts, journalists)
6. PIP funds for pandemic risk communication capacity building

### OPERATIONAL
1. Outbreak-specific RCE strategy
2. Improved coordination with key global pavers: WHO/UNICEF/IFRC joint plans, messages, tools
3. Surge capacity and funds for RCE response

### SOCIAL
1. KAP resource packs
2. Social Net – experts and expertise
3. Training of anthropologists social scientists
Final thoughts…

1. Anticipate future trends and needs; use but don’t depend only on past experience.

2. ERC is not an add on – it’s a public health intervention in its own right: carve out space in the incident management system (IMS), show leadership by developing strategy and budget, managing the ERC operations.

3. Big emergencies by definition exceed existing capacity – establish expert deployment networks and surge capacity

4. Issue global/national ERC strategy and tools to support countries/localities

5. Leverage on-going emergencies to build future capacity for ERC