Module 1 Unit 4

This is a **REQUIRED READING.**

UNICEF. (2014). 20 Lessons Learned to Inform C4D Responses to Ebola Outbreaks, West Africa, 2014. Prepared by developed by UNICEF Programme Division, New York. [7]

20 Lessons Learned to Inform C4D Responses to Ebola Outbreaks, West Africa, 2014[1]

An effective response to a health crisis requires a thorough understanding of socio-cultural, political and economic factors as these can sometimes conflict with methods for treating or containing a disease. Approaches that emphasize community strengthening and participation, as well as partnership/alliance-building have proven to be more effective than top-down communication interventions with exclusive focus on information sharing. These approaches go beyond educating people about health risks. They also facilitate local dialogue and social relationships that empower people to abandon unhealthy traditional practices or harmful norms, and become more resilient to respond to the primary and wider socio-economic impacts of disease outbreaks. The following lessons have been distilled from programme monitoring and evaluation studies, experiences of communication professionals and experts working on a range of recent health crises, as well as published literature.

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What have communication approaches to address health crises[2] taught us?

1. **Dealing with disease outbreaks requires simultaneous attention to biomedical interventions and proactive communication strategies.[3]** Easily transmissible diseases such as SARS and MERS corona virus tend to create a sense of uncertainty and panic, especially in the early stages of outbreak and when coupled with legal and policy level measures such as quarantines and containments. While attention must be placed on detection, treatment and care services and supplies, efforts to provide accurate and timely information from trusted sources about the health threat must be included to address the concerns of populations. Fear due to the unknown nature of an emerging new disease is a natural human reaction. Public authorities should not downplay these emotions but instead counter them by being truthful and by engaging with communities through dialogue and a range of communication channels.

2. **A central and officiating leadership at high levels is critically important for providing technical authority and public accountability.** A key lesson learned from Avian Influenza (AI) outbreaks was that the national emergency communication response planning and implementation should be under the auspices of an administration structure in charge of the entire response efforts and lead by highest levels of officials (e.g. prime minister's office) to ensure rapid decision making; technical authority and accountability; as well as coordinated 'one voice' government response for populations.

3. **Multi-level coordination among communication agencies, as well as communicators, health and emergency experts, is needed for coherence and complementarity.** Various stakeholders responding to a disease outbreak – public health officials, politicians, health care workers, community volunteers – use different vocabularies to talk about a disease. Often, none of them talk about it in a way the public can easily understand. Thus communicators play a critical role in crafting messages that are socially and culturally appropriate. Further communication coordination mechanisms need to be established not only at national levels but also at the sub-national levels, as was demonstrated by the AI experience in Vietnam.

4. **Demand creation and service provision strategies need to be linked and synergised.** A key lesson learned from the Polio Underserved Strategy in India demonstrated that the lack of response to making health and social services widely available compounded the frustration of populations that had been already

[1] *The document was developed by UNICEF Programme Division with inputs from C4D staff in regional and country offices working across a range of health issues including Polio, Avian Flu and Cholera.*
[2] *Includes key lessons learned and evidence from Avian (H1N1) Influenza (AI), Cholera, MERS, SARS and Polio Outbreaks*
[3] *Communication strategies cover risk and outbreak communication, C4D/social and behavior change communication, and community mobilization.*

underserved and compromised the government's and partners' credibility. Services such as testing facilities, case management, and provision of medical equipment need to be swiftly organized, functioning and accessible before demand creation and community sensitization efforts are scaled up.

5. **Practices for effective household management of infected persons should be examined carefully based on disease epidemiology and promoted accordingly**. Experiences in AI, MERS, SARS and polio have demonstrated that promotion of home management including handling of patients and surrounding family members from early stages of disease reduces the burden and cost on health infrastructure and service provision that become overstretched with increasing outbreaks and exacerbate the impact of the health crisis. It should be noted that the applicability of this approach to Ebola response however is currently under discussion.

6. **Participatory and empowerment-based communication approaches strengthen public health responses by integrating the perspectives of local populations into control procedures.** An open dialogue with communities helps create understanding and consensus around key forms of prevention and response behaviours (e.g. hand washing, safe cooking practices, early treatment) as well as challenges faced by community members (e.g. lack of money to buy soap; religious beliefs and practices that prevent adoption of safe practices; quarantine and social distancing). Meaningful dialogue can contribute to the self-efficacy or empowerment of community members to protect themselves and their families. It can also facilitate the identification of existing individual and group strengths, skills, and capacities that contribute to communities' ability to respond effectively even after the heath crisis has been averted, as demonstrated by the communication training and volunteer systems established in Iraq after AI outbreaks. These were subsequently utilized to promote other development programmes for immunization and nutrition.

7. **Educating communities about disease transmission and prevention is not sufficient to promote behavioral changes.** Gaining a greater awareness and deeper understanding of communities' belief systems and practices enables health-decision makers, planners and development workers to adapt control and mitigation messages to the local context; design strategies and establish mechanisms that promote two way communication; address deep-rooted fears and misconceptions; and track changes through relevant and realistic measures. Evidence suggests that providing people with information that allows them to evaluate risk and make rational choices for protecting themselves, their family and community has been effective in influencing behavior change. Second, role modelling by those communicating messages can be an effective stimulus to prompting behavior change as for e.g. community outreach workers emphasizing how they have vaccinated their own children.

8. **Epidemiological and behavioural risk analyses as well as prioritisation of audiences enhances focus of strategies and sharpens messaging.** The polio experience has provided strong evidence on the importance of communication strategies responding not only to behavioural but also epidemiological data for targeting and accuracy of messages. In the case of AI, the first wave of communication did not take into account risk perceptions of difference audiences and instead promoted generic preventive behaviours to all people. Different messages for different audience segments (i.e. wet market workers and poultry transporters as a high risk group; families with backyard poultry as medium risk, etc) would have been more effective in preventing and controlling the early and rapid transmission of the disease.

9. **Mass media outreach activities need to be complemented with active social mobilization efforts.** As the efforts for preventing and responding to AI outbreaks demonstrated, a strong and early focus on and

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investments in developing the interpersonal skills of outreach workers to facilitate adaptation of prevention and control behaviors to local realities and audience segments would have strengthened the integrated communication approach and overall results of interventions. Evidence from the polio outbreak response efforts indicates the need to identify and engage early on key influencers who can foster trust in the health system when there is a break-down, or when political influences impact the way a health response is perceived by communities.

10. **Crisis communication preparedness based on contingency/ scenario planning are central to effective responses**. As the polio, avian influenza and cholera experiences have indicated, investments into building human resources capacity and communication planning systems and infrastructure are the most critical components for a successful response – from the lowest levels in the community outreach systems of the health sector to national and international levels.

What have we learnt from response efforts to contain previous Ebola Outbreaks?

11. **Establishing and sustaining public trust by the government and health personnel is the foundation for all control efforts.** Information management – providing authoritative information through a single and easily available source at regular intervals, is crucial in dispelling fear and rumors within community. The media is critical in building the trust. In Uganda, winning public support and building public confidence was gained through regular one-on-one sessions with key media executives.

12. **The community or village leaders and the community health teams form the pillars of outbreak response.** They provide essential support to formal public health system structures. Controlling the epidemic is about early detection, isolation, treatment of new infections, contact tracing, and safe handling of body fluids and the remains of those who die. Organized and effective response can only happen though listening and promoting dialogue with all stakeholders, and maintaining close contact with affected communities, families and households. In Uganda, this was achieved by building community trust of the public health system, including recruiting support and oversight by formal and informal community leaders including teachers, pastors, traditional healers, and volunteers. Top Ministry officials moved to live in the affected districts to support and direct community control efforts thus inspiring local health workers.

13. **Flatter hierarchies for community sensitisation and mobilization have been more effective in promoting attitude and behavior changes**. Experience has shown that efforts to bring about attitude and behaviour changes among community members are more effective when key community interventions are undertaken by the members of the surveillance teams who are themselves part of the community rather than by doctors or anthropologists, especially those from outside of the community.

14. **Rapid assessments and social research is the foundation of effective social mobilization, communication and outbreak control strategies.** Rapid key informant interviews and focus group discussions held with the social mobilizers, health staff and response teams such as surveillance officers and people in market places and churches were instrumental in gathering information about people's daily lives and steps they were taking or not taking to protect themselves during the crisis as well as traditional beliefs and rituals around health, sickness, death and burials. These helped identify appropriate communication settings and channels

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as well as influential, trusted and credible sources of information who could best deliver messages and promote collective action.

15. **Actionable, clear, concise, consistent and localized messages resonate better with identified audiences.** While messages may be different across local contexts, the key behaviours in relation to the epidemiology must be clear, actionable and consistent during an Ebola outbreak. For the South Sudan Ebola outbreak in 2004 the focus on individual behaviours and community practices was uniformly on preventing contact with infected persons; supporting early detection, diagnosis, case management; social isolation; hand-washing; thorough cooking; handling of corpses and safe burials. The reintegration of and testimonials by those who have been quarantined, recovered and released have especially been useful in dispelling myths about health staff and facilities, motivating appropriate behaviours and reducing stigma.

16. **The use of multiple communication channels and materials is vital for effective control of outbreak.** The impact of broadcast health awareness messages is amplified through distribution of posters and leaflets produced in local languages that address the basic questions and circulating rumors. In Sudan, a leaflet contained a drawing of the isolation ward, so that people could observe a low fence allowing families to see and talk to patients without touching them. It also contained photographs and testimonies of people who had been treated in isolation ward and survived. The control measures were also enhanced through the use of films, local drama and music groups.

17. **The lack of communication infrastructure such as radio, newspapers and telephones in remote locations presents key challenges.** Making use of public gatherings including religious services, specially convened meetings with traditional healers and frequent home visits is necessary to help raise public awareness. Providing basic telecommunications support with solar-panel battery charges for community use is another effective strategy. However, severity of outbreaks at times places restrictions on public gatherings and needs to be carefully considered.

18. **Children are instrumental for implementing positive interventions.** As we have learned from Sudan's experience, children are less likely than adults to use sorcery as an explanation for illness and have no hidden agendas. Health educators should therefore encourage children and adolescents to discuss these ideas with their family and explore ways to engage them as agents to inform and motivate older generations to change.

19. **Well-designed community health interventions and behavior change communication (BCC) strategies can benefit from working closer with Psycho-social support (PSS) services.** Volunteers responding to outbreaks in Uganda indicated that lack of PSS training may have delayed the response for at least 3-4 days. Advanced preparation and PSS training could have been helpful in dealing with elements of fear and stigma experienced both by volunteers themselves as well as those diagnosed with Ebola and their families. Timely provision of PSS alongside BCC interventions can also help address high turnover among the health care workers and assist in recruitment of new staff.

20. **The introduction of technology enabled quick field diagnosis of new infections, communication and rapid initiation of treatment.** Collaborative efforts of partners such as the US Centers for Disease Control and Prevention that brought in the field laboratory, and WHO that provided supplies and technical expertise was a critical game-changer during the Uganda outbreaks. The Ebola specific laboratory results were available within 24 to 48 hours enabling authorities to undertake swift decisions on whether the patient required isolation or whether she/he could be treated on a general hospital ward. The provision of efficient, effective

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rapid healthcare services had a direct and positive impact on the adoption and sustained practice of key individual, family and community behaviours.

What is different this time?

The 2014 Ebola outbreaks in West Africa are the world's deadliest to date and a first for the region. Whereas in the past, the outbreaks were mostly localized and limited to Eastern Africa, in at least three of the West African countries currently impacted – Guinea, Liberia and Sierra Leone, the epidemics have now become generalized. The severity as well as the speed with which the virus is spreading as well as its impact on children and their communities present many particular challenges which will influence the outcome of C4D and social mobilisation interventions.

The virtual collapse of the already fragile and over-stretched health and social services systems in many of the affected countries has serious implications for how rapidly cases are diagnosed and treated as well as the diagnosis and treatment of other persisting diseases or new outbreaks such as malaria and cholera. The lack of adequate Ebola Treatment Units and trained medical staff is leading to challenges in public communication and messaging efforts around mobility, care and treatment. Even as UNICEF and WHO have developed and agreed upon a set of technically sound key messages for social mobilization, the on-ground situation is rapidly evolving and changing, necessitating re-consideration of the feasibility of some of these messages (e.g. home-based care). Efforts to limit mobility through quarantines and curfews in order to contain the spread of the virus has created population strife in several locations as for example witnessed in Liberia, placing restrictions on door-to-door campaigns, interpersonal counseling and limited opportunities for public gatherings.

This is underscoring the necessity for greater dependence on the mass (TV, radio, press) and new media (cellphone) campaigns using a variety of tried and tested approaches to communicate with populations, allay fears and promote behavioural compliance. These approaches must include regular public broadcasts by key responsible actors (highest level government officials) and entertainment education. At the same time, the fears and panic being experienced by populations at large, and affected communities in particular, need to be addressed through localized door-to-door campaigns and sensitive one-on-one communication and counselling grounded in psycho-social support, by trained community based health workers, volunteers and other local youth and women's groups among others. Training for these efforts must incorporate personal safety measures to reduce personal risks of infection. The efforts at community level must by publicly supported by local leaders and important influencers that the communities trust.

At higher decision making levels, advocacy and communication efforts for legal and policy measures need to be grounded in the realities and perspectives of affected communities to ensure that voices of people are not stifled or rights violated, causing further strife and turmoil. To this end, two aspects are worth noting. First, local and international journalists and media spokespersons have an important role to play in creating a supportive environment that is focused not only on problematizing the issue but providing assets/solution based information within and across countries. Second, this information needs to focus on calming public panic and dispelling the many rumours that have arisen given that many of the affected countries are post-war countries that have seen years of inter-ethnic conflicts and civil war. Training of journalists and media spokespersons must go hand in hand with community based communication and social mobilization efforts.

Drawing from the lessons above, several recommendations have been provided ahead to support communication preparedness and response efforts.

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Recommendations for an effective and efficient C4D response to Ebola Outbreaks

1. **Assess and prepare** by estimating requirements across changing scenarios, strengthening human resource systems and infrastructure; communication planning and coordination; development and pre-positioning of communication materials and provision of essential training to community workers and other influencers**.** To that end, (1) identify key partners and update rosters; (2) activate deployment mechanisms and rapid training/ retention mechanisms; (3) prepare LTAs to engage with media outlets and PCAs with NGOs; (4) prepare technically sound, pre-defined messages and materials on key prevention and response behaviours; (4) develop and implement training packages for community engagement; (5) organize early and comprehensive media training; (6) identify and engage key community level influencers (e.g. religious, medical), and children and youth; (7) organize workshops to sensitize response teams to be able to deal with fear and adverse community reactions to the outbreak; (8) establish hot-lines and deliver free radios and mobile phones with solar-panel battery charges for community use.
2. **Mobilise, orient and coordinate** efforts of multiple stakeholders, from global and regional institutions to national and sub-national government entities: (1) Leverage cooperation and rapid information sharing among continental and regional health research networks, governments, development organizations and INGOs. Develop policies and papers that would facilitate collaboration and coordination. (2) Advocate for commitment from top government leadership, integrated with district and community governance and active participation of people themselves. The mobilization of the local government through community, sub-county and district level structures to support the outbreak response activities is key. These local community structures will serve as a liaison between affected families and community. (3) Organize cooperation with other sectors (e.g. health, education, defense, protection, environment) and facilitate collaboration between local authorities and the various international players.
3. **Design and implement** an evidence-based, integrated, and multi-faceted strategy based on the following key elements / principles: (1) develop tools/protocols to conduct a thorough analysis of communication landscape, audience and behavioral risks; (2) engage multi-sectoral design teams composed of epidemiologists, emergency workers, public health specialists, anthropologists, psychologists, etc.; (3) while prioritizing audiences, keep consideration of entire populations rather than just affected and at-risk communities; pay special attention to children, youth and women (4) communicate factual data along with messages about attitude and behavior change; (5) focus on facilitating dialogue and two way communication; (6) adopt a multi-channel approach.
4. **Craft messages** that instil confidence, non-discrimination and not fear, with focus on preventive and treatment seeking actions that are simple and actionable to minimize potential risks; compliance with national policy and legal measures; and services offered to affected and quarantined communities including food aid distribution, water provision and safe burials. Communication efforts should focus not only on the local media coverage, but also on international media outlets. Communication materials and messages should be developed for specific purposes, pre-tested and adapted on the basis of the rapid situational analysis and continuous monitoring of the evolving crisis. The information provided should allow people to evaluate risks and make choices.
5. **Maintain transparency** to prevent suspicion and distrust of international health workers and to promote positive, productive relationships between INGOs and communities. Transparent approaches can include regular public broadcasts, community meetings where feasible, informal interaction with local people, and involving family members in healthcare decisions. However, the severity of current Ebola outbreak cautions against frequent public gatherings. Instead, the use of mass and social media may be more effective to inform the general public. Where more targetted interpersonal communication and counselling efforts are required, community workers needs to be adequately trained and equipped to minimize personal risk of infection.
6. **Leverage strengths and resources** of broad-based, multi-actor partnerships especially around the web and mobile technologies. Strategic use of technology can solve problems of time, distance and coordination in the delivery of services. Technology can also lead to strengthened data collection and analysis to inform policy formulation; to increased aid effectiveness; and greater transparency and accountability. Web and mobile GIS-based platforms can facilitate collection of information from various datasets while enabling partners to identify evolving vulnerabilities alongside critical barriers and bottlenecks. This creates opportunities to monitor progress of programmes and services and resolve them through targeted investments.

Attachments

1. Response Lessons learnt on outbreak control: Ebola, culture, and politics: the anthropology of an emerging disease.

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