

Social mobilization in public health emergencies: Preparedness, readiness and response

Report of an informal consultation

Geneva, Switzerland
10–11 December 2009

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Abbreviations and acronyms

AIDS	acquired immunodeficiency syndrome
CERC	crisis and emergency risk communication
COMBI	communication for behavioural impact
FAO	Food and Agriculture Organization
GAR	Global Alert and Response Department
GOARN	Global Outbreak Alert and Response Network
GTN	Global Technical Network
HIV	human immunodeficiency virus
IEC	information, education and communication
IHR	International Health Regulations
IMC	integrated marketing communication
RM&E	research, monitoring and evaluation
RRECC	readiness–response–evaluation–constant cycle
SARS	severe acute respiratory syndrome
UNICEF	United Nations Children’s Fund
WHO	World Health Organization

1. Background

By their very nature, disease outbreaks can occur at unexpected times and places and may grow rapidly in scale. They also attract considerable attention from the public, media and government agencies. Outbreaks have the potential to severely disrupt community life. They are not isolated events but happen within existing social, cultural, political and economic settings. It is these settings and experiences that greatly influence what affected/at-risk groups, communities and the wider public believe and understand about a public health risk – and ultimately how they will respond to the outbreak and the proposed public health interventions.

Risk-communications approaches have traditionally focused on public relations and the dissemination of public health information via the media. At the same time, social mobilization/communications interventions have focused on affected communities and participatory approaches, viewing affected communities as partners in finding solutions to control and contain the outbreak. Although both use communications techniques and strategies as their foundation, social-mobilization interventions have been particularly important in disease outbreaks where medical interventions do not exist. In these circumstances, public health measures have concentrated on identifying local risk factors to minimize exposure and reduce infection, followed by vigorous health-information campaigns to raise awareness and educate people about the measures needed to protect individuals, families and communities.

Many different communications approaches are critical for effective outbreak management, and provide essential insights and information for response and control measures, as well as ensuring that proper attention is placed on identifying culturally appropriate and feasible risk-reduction actions that will help protect the health of households and communities. Lessons learned from dealing with past infectious disease outbreaks have shown that an outbreak is brought under control only when communities actively participate in control and prevention activities, and are ready to adopt and sustain preventive and mitigation behaviours.

The Global Alert and Response Department (GAR) provides technical and operational support to Member States through World Health Organization (WHO) country and regional offices and wishes to build social-mobilization/communications interventions as one of the core pillars for outbreak alert, readiness, response and control. To this end, this meeting was intended as an informal stock take, and brought together a small group of experts in health communications to review and discuss current opportunities and tools for addressing the cognitive, sociocultural and organizational factors likely to influence the uptake of prevention and control measures in public health emergencies. It is intended that the meeting outcomes will help inform and guide the GAR social mobilization/communication for behavioural impact (COMBI) activities, and lay the groundwork for a larger meeting of social mobilization/communications practitioners to develop norms and standards and identify best practices and lessons learned.

2. Objectives of the meeting

- To review current health-communication conceptual frameworks, methodologies and approaches relevant to public health emergencies.
- To identify opportunities, challenges and barriers for developing norms and standards (best practices) for social mobilization/communication during preparedness, readiness and response.

3. Executive summary

Encouraging the adoption of sustainable healthy practices or practices to reduce risk of exposure and transmission of infectious diseases in outbreaks is a complex process. Public health communication¹ plays a central role – to listen, to inform, to facilitate and to promote participation in preventive and control measures. Despite the unique challenges of communicating during public health emergencies, the meeting reinforced the need for a solid theoretical and planning framework encompassing multiple disciplines (behavioural study, anthropology, psychology, communications) and strategies. Public health communication also needs to be integrated into emergency preparedness, readiness, response and management.

There is a general “under-appreciation” of the overriding behavioural imperative that underlies responding to and managing public health emergencies. Human behaviour often drives epidemic emergence, transmission and amplification. Consequently, human behaviour is critical to epidemic prevention, response and management. This imperative must be explicitly articulated.

As such, public health communication interventions in emergencies should demonstrate:

- an in-depth understanding of the needs of people, communities and agencies;
- grounding in solid communication theories and planning frameworks;

and should:

- explicitly state the behavioural and social results required for the prevention, control and mitigation of the public health emergency.

Public health communication should address the needs and cultural preferences of affected/at-risk groups and communities because:

- affected/at-risk groups and communities are at the centre of risk-management activities;
- communities are the smallest social, economic and political units that can marshal collective resources to respond to a crisis/public health emergency. Communities therefore include settings where people live and work;
- communities are on their own during the first stages of a disease outbreak and again when the outbreak is over;
- recurrent infectious disease outbreaks may have more to do with underlying problems such as local infrastructure, health systems, access to resources, and existing beliefs, behaviours and norms, which require longer-term sustainable inputs;
- it has been demonstrated that appropriate community-preparedness programmes can help mitigate crisis situations and reduce mortality and morbidity.

Public health communication should be a planned multilevel and multifaceted process and not view affected/at-risk groups and communities as ready sources of information and recipients of instruction and advice. This process should be planned and managed to help all

¹ “Public health communication” is defined as the strategic “use of communication techniques and technologies to (positively) influence individuals, populations and organizations for the purpose of promoting conditions conducive to human and environmental health” (Maibach, E, Holtgrave DR. Advances in public health communication. *Annual Review of Public Health*, 1995, 16:219–238). Effective management of public health communications requires the organization and coordination (in harmonization with public health policies and strategies) of the human, financial and technological resources required to plan, implement and evaluate strategic health-communications interventions towards accomplishing a public health goal. Public health communication can be divided into distinct and overlapping specialties such as behavioural communication, media communications, advocacy, outbreak communications, risk communication, social mobilization and entertainment communications.

stakeholders define risks, identify hazards (including cultural and social), assess vulnerability and promote resilience and therefore the capacity to cope with an unfolding public health emergency.

Summary conclusions (see also Section 5)

- Community understanding of diseases and their spread is complex, and yet there is still a tendency to produce generic communication messages and templates to respond to them.
- Human behaviour is critical to epidemic prevention, response and management, but there is a general under-appreciation of the behavioural imperative that underlies responses to public health emergencies. In fact, human behaviour drives epidemic emergence, transmission and amplification.
- Communication can support effective behavioural adaptation by affected/at-risk populations; inform emergency response and event management; and ensure risk assessment and verification include relevant sociocultural behavioural data.
- However, to do so, the programme will need to: establish global, regional and national operational networks; build links with forecasting readiness and preparedness; develop and field-test relevant tools and checklists; document existing evaluations and lessons learned and share best practices; and ensure links with the International Health Regulations (IHR) capacity-building programme.
- The term “social mobilization” does not adequately capture the breadth of communications functions needed for effective outbreak response and management.
- There is a clear mandate for WHO to ensure that this technical area is part of public health planning and service delivery.

Summary recommendations (see also Section 6)

1. COMBI has a proven history of success and should be integrated as part of WHO’s standard emergency alert and response, including integrating communications staff within rapid-response structures.
2. This could be applied and promoted within GAR-specific response and readiness programmes.
3. A recommendation should be made to Member States emphasizing the behavioural imperative in dealing with public health emergencies and the need for strategic communication planning, like the COMBI methodology, alongside medical and technical teams and interventions.
4. To strengthen the case, COMBI success stories and evaluations need to be collected to show “proof of concept”, while monitoring and evaluation systems need to be improved to ensure this is an essential step, built into all COMBI work going forward.
5. Appropriate terms must be developed to clearly differentiate COMBI approaches from “social mobilization” and other terminology felt to be confusing or holding previous associations that do not accurately reflect the behavioural imperative.

4. Presentations

Public health emergencies: preparedness, readiness and response

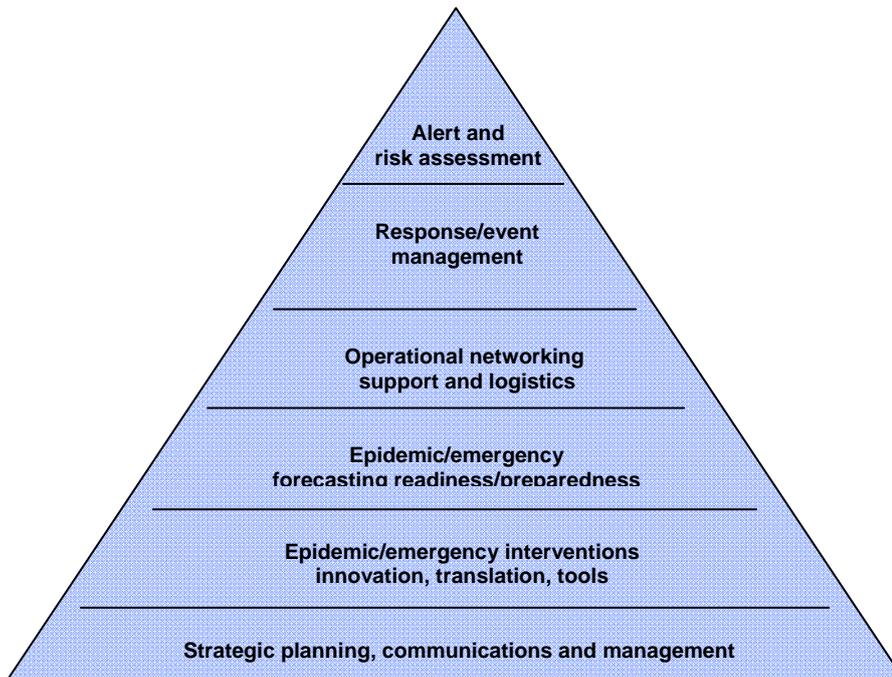
Dr Mike Ryan, Director, GAR

The presentation highlighted and reinforced the relationship between human behaviour and the emergence, amplification and management of epidemics. It outlined the core mandate, challenges and strategic approaches guiding the work of the department, and the justification for communications/social mobilization as a core pillar for public health emergency response and management.

Key points

- WHO has verified more than 3000 events between January 2001 and November 2009. Consequently, epidemics and pandemics are a very real threat and their management often places sudden, intense demands on national and international health systems. They also stress social and political systems and often lead to inappropriate or ineffective adaptive behaviours.
- New or newly recognized pathogens such as avian influenza, severe acute respiratory syndrome (SARS), Nipah, Ebola and Marburg viruses have emerged, as well as the resurgence of well-characterized outbreak-prone diseases such as cholera, dengue, measles and yellow fever. The accidental or deliberate release of biological agents also poses a concern.
- Human behaviour, population density and movement drive epidemics. What people do or do not do can either increase or decrease the risk of epidemic generation or propagation. Poverty, urbanization, population displacement, environmental degradation and complex and natural disasters have changed the profile of epidemic diseases and also the way they are controlled.
- Epidemic diseases and other public health threats will continue to occur because of :
 - efficient adaptation of the microbial world, industrialization and environmental change;
 - poor adaptation of the human world, human behaviour, trade, travel and technology
- The historical record demonstrates that epidemics drive fear. Cultural perception of danger and the causes of illness can lead to losses of livelihood, and behaviours that often incur indirect costs that exceed or exacerbate the direct effects of epidemics. Epidemics and other public health emergencies therefore present a major threat to life, economies and security in an increasingly interconnected and interdependent world.
- Epidemics cannot be managed by technological interventions alone. Experiences from previous outbreaks have shown a rather paternalistic view of how to affect human behaviour mainly through providing instruction. We have since come to realize that community understanding of diseases and their spread is complex, context dependent, and culturally mediated. Therefore, a one-size-fits-all response is not enough. There needs to be an understanding of how a community understands disease before developing effective strategies intended to affect behaviour. This requires a change of approach to recognizing communities as active participants in the response and management process. Communities and individuals will engage and often accept major disruptions if we:
 - build on their knowledge and understanding;
 - offer new knowledge and insights;
 - involve them in shaping the interventions;
 - allow them to trade off the benefits and burdens of engagement and behavioural adaptation.
- WHO's GAR has a triple challenge and mandate:
 - epidemic and emerging diseases;

- all-hazards approach to public health emergencies;
- common operations platform for public health and humanitarian emergencies.
- Core functions of GAR are to:
 - detect, verify and assess events;
 - manage response;
 - plan, prepare, be ready and test;
 - innovate and improve tools/methodologies/standards.
- The GAR mandate and core functions are translated into the following strategic approaches:



- The objective is to ensure that Member States and their communities:
 - can rapidly share information, mobilize resources and implement rational control measures in the face of a major public health emergency;
 - get immediate access to the appropriate expertise and utilize and focus that knowledge to support countries and communities facing disease threats;
 - turn knowledge gained into effective interventions in time to make a difference.

The Global Outbreak Alert and Response Network (GOARN)

Mr Pat Drury, Programme Manager, GOARN

The presentation described the purpose, structure and functions of GOARN. It highlighted key challenges facing GOARN and illustrated that WHO, out of necessity, has come to recognize the importance of public health communications as part of risk management.

Key points

- The primary aim of GOARN is to: coordinate and support rapid international teams; assist countries with disease-control efforts; investigate and characterize events and assess risks; and support national outbreak preparedness. WHO is the primary source of early information about outbreaks of international concern and shares this information with

GOARN. Through GOARN, WHO aims to provide guidance and direct technical assistance and field support to countries, especially in the world's most vulnerable regions.

- GOARN is an informal network of over 200 institutions and is open to all technical institutions, networks and organizations that have capacity to contribute to international outbreak response. What can networks provide?
 - access to resources, information exchange and sharing of best practice, and technology transfer;
 - reduction of vulnerability and strengthened resilience;
 - alleviation of costs, by improving the use/mobilization of resources, and providing surge capacity;
 - strengthened transparency and credibility, enhanced dialogue and building of trust.
- A GOARN operational field response is triggered by a request for assistance from a WHO Member State. There follows a rapid alert, and coordination of an international response team that is institution based, guided by approved terms of reference and a code of conduct. Transparency is ensured by a request for response-team members going out to the whole network. This operational response is supported by standardized deployment, safety and security, and outbreak logistics. Oversight and evaluation is provided by the steering committee.
- The global operational context is the International Health Regulations (IHR)-approved multi-hazard approach, the accumulation of “best practices” in alert and response operations, and a global event-management system built on regional capacity, GOARN and other networks.
- Lessons learned over the last decade include the need to:
 - identify events of international concern quickly and respond to requests for international support;
 - rapidly deploy field teams;
 - coordinate multidisciplinary support of partners, and WHO collaborating centres, and ensure access to global technical expertise and knowledge;
 - rapidly interpret data from the field and develop international technical guidelines and advice;
 - understand local context and continuously adapt to it.
- Numerous examples exist of the role of public health risk communications in effective outbreak management: SARS, avian influenza, viral haemorrhagic fevers – dengue, Ebola, Marburg, Rift Valley; cholera; and, more recently, pandemic (H1N1) 2009.
- What are the current needs of Member States that GOARN is focusing on?
 - technical partnerships and networks to support international health security;
 - real-time information management and communications: field data, and situational reports and other data for decision-making;
 - coordination of response activities;
 - joint risk analysis and decision support;
 - operational and technical planning.

Public health communications: conceptual frameworks and models relevant to public health emergencies

Dr Renata Schiavo, Founder and Principal, Strategic Communication Resources

A detailed summary of this presentation is provided in Annex 1.

The presentation provided an overview of theoretical models, conceptual frameworks and health-communications trends relevant to managing public health emergencies in the 21st century. While acknowledging the unique challenges of communicating in an emergency, the presentation substantiated the need to:

- conduct an in-depth analysis of the needs, cultural preferences and values of people as well as situations affected by and involved in the public health emergency;
- ensure communication interventions are grounded in theory and solid planning frameworks;
- articulate, specify and measure behavioural and social results to be achieved as a result of communication;
- ensure that communication interventions include a variety of approaches that mirror how communication takes place in real life;
- increase understanding of the intrinsic link between “readiness” and “effectiveness of response”.

It also reinforced the critical importance of ensuring high levels of community engagement and participation for the effectiveness of any public health intervention – including communication.

Anthropological approaches: methodologies and tools

Dr Benjamin Hickler, Medical Anthropologist

The session focused on the presentation and discussion of a film documenting the experiences of an anthropological study called “Bridging the gap between awareness and practice: findings from a participatory anthropological study in Cambodia”, carried out by the Food and Agriculture Organization (FAO) in 2008.

Key points

- The aim of the study was to explore and clarify the disconnect between high levels of “awareness” and continuing high-risk behaviours among backyard poultry keepers in rural Cambodia. The study:
 - consisted of 20 participatory discussion groups with 151 men and 190 women in 13 districts in 7 provinces in rural Cambodia;
 - involved both outbreak and non-outbreak sites (poultry and human infections);
 - included multiple observations and key-informant interviews with poultry-buyers and vendors.
- Communications campaigns had focused on four global behavioural interventions developed at an interagency meeting in March 2006. The behaviours were: (1) report, (2) separate, (3) wash and (4) cook.
- High “awareness” of these key behaviours was not being translated into change in behaviour/practices. In fact, many people continued to prepare and consume sick or dead poultry. There were very low levels of use of gloves/masks, low levels of disease reporting, and biosecurity was almost non-existent.
- The study recommended the following:

- build on pre-existing understandings or practices rather than prescribing generic behaviours;
- raise awareness of why the behaviour promoted in a message makes sense from the target audience’s point of view;
- make sure that the practices promoted in information, education and communication (IEC) materials are both practical and effective;
- work with the local taxonomy and understanding of diseases and illness;
- encourage a shift from a “naturalistic” to a “contagion” model of poultry death, as the naturalistic model entails a treatment model of response. The contagion model lends itself to a prevention model of response;
- focus and build on risk perception, not fear;
- work with the indigenous sensibility that “hearing is just hearing; seeing is believing”;
- consider different approaches to households that rely on poultry as assets from those that rely on poultry for income;
- sex should be a primary consideration in developing and evaluating IEC materials and communication strategy;
- pioneer alternative solutions to the simple “separation” messages;
- connect messages to local values and priorities. For example, “family prosperity and well-being” is a good candidate for linking priority messages to a value for which people would indeed go to great lengths.
- The discussion that followed the film recognized that anthropological expertise was not easily available in response to public health emergencies. This may be due to several factors:
 - anthropologists with sufficiently substantial experience to be deployed as experts in international response teams are very difficult to find;
 - managers of public health responses may not understand the role and need for anthropologists as part of public health interventions;
 - there is a belief that ethnographic approaches require significant field experience and intimate understanding of affected communities, which takes years to develop;
 - anthropological approaches do not come with prescriptive solutions but offer insights concerning beliefs and value systems that underpin human behaviour. How these insights are translated into interventions that guide communications and other public health interventions is subject to interpretation by other professionals, and, as such, solutions are difficult to standardize.
- Anthropological approaches can play a significant role to ensure that public health interventions are appropriate, relevant, contextualized, and therefore likely to be adopted by local communities rather than ignored or rejected.

Social mobilization: methodologies and tools – communication for behavioural impact (COMBI) WHO perspective

Dr Everold Hosein, WHO COMBI Consultant and Adviser

The presentation described WHO's framework for planning and implementing communication targeted at securing behavioural results. It highlighted key principles underpinning COMBI planning, the challenges faced in translating knowledge into practice, and how COMBI is strategically geared towards achieving behavioural impact.

Key points

- COMBI can be described as “social mobilization directed at the task of mobilizing all societal and personal influences on an individual and family to prompt individual and family action with respect to specific healthy behaviours”.
- Two mantras of COMBI planning are: (1) do nothing . . . until one has set out specific, precise behavioural objectives, and (2) do nothing until one has carried out a situational market analysis vis-à-vis the behavioural objectives.
- COMBI's behavioural adoption model explains why behavioural impact is often difficult to achieve. Most conventional information programmes focus on the information-giving, awareness-raising part of the behaviour-adoption process. What is very hard to do is to focus on the behavioural component of the model – an area in which the private sector excels.
- COMBI projects have been planned, initiated and implemented by health-education/promotion officers within ministries of health and partner agencies such as the United Nations Children's Fund (UNICEF) in over 50 countries in different settings. Examples include: controlling outbreaks of infectious diseases of viral haemorrhagic fevers; contributing to the reduction of maternal and infant mortality; human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) programmes; decreasing the incidence of household violence; and, more recently, promoting changes in diet and lifestyle.
- Lessons learned from these COMBI experiences are:
 - the COMBI planning process rapidly and systematically fosters two-way dialogue between “communities” and services/organizations – therefore improving community–organization relationships;
 - implementation commitment from local authorities is key;
 - well-researched behavioural goals focus effort and result in clear, consistent messages to support uptake of behavioural practices;
 - strategic planning is a prerequisite to materials production;
 - COMBI is an easily adopted planning framework;
 - good working relationships have been developed with the private sector but these need to be well managed;
 - some organizational restructuring may be required to support multisectoral teamwork.
- Can the COMBI methodology be followed in emergency settings? Experience has shown that COMBI is uniquely suited to planning and implementing communications interventions in public health emergencies.

Risk, crisis and outbreak communication: methodologies and tools – WHO perspective

Mr Gregory Hartl, Team Leader, GAR/H1N1 Communications

The presentation described the five principles underpinning WHO's "Outbreak communication" approach, namely: planning, transparency, announcing early, trust and listening

Key points

- Outbreaks are newsworthy because:
 - they are unfolding events – leading to speculation and great uncertainty;
 - they are unpredictable;
 - behaviour may play a key role in transmission;
 - they are socially and economically disruptive;
 - they have strong political and geopolitical dimensions;
 - they create public anxiety, and often also create anxiety in response-managers and other decision-makers.
- Trust:
 - “The over-arching communication goal during an outbreak is to communicate with the public in ways that build, maintain or restore trust” (WHO Outbreak Communication Guidelines).
- The first announcement is the most critical of all outbreak-communication messages:
 - it must be made early;
 - it is likely to be wrong/changed.
- Transparency:
 - aim for total candour;
 - keep detailed records of decision-making meetings;
 - promise and deliver accountability.
- Listening:
 - decide and declare with evidence;
 - conversation with the public to understand if messages are being received as we would have wanted them to be received.
- Planning – there is a need for endorsement of senior management and political leaders on:
 - first announcements;
 - limits of transparency;
 - who will be the spokesperson;
 - identification of surge capacity;
 - coordination with partners.
- The hardest part:
 - doing things that are counterintuitive;
 - adjustment reaction;
 - trust the public.
- Message-making
 - don't over-reassure;
 - acknowledge uncertainty;
 - share dilemmas (all “unknowns”);
 - don't over-plan for panic and tolerate early over-reactions.

Pandemic H1N1 case study

The presentation also included highlights and discussion on some of the key challenges in communicating risk around the pandemic (H1N1) in 2009.

When the disease first emerged it was very difficult to characterise the outbreak in terms of both numbers and spread, and issues developed about the definition of a pandemic, susceptibility, and the severity of this particular outbreak. By May, issues about what percentage of cases were severe began to emerge and governments started asking WHO to include severity as one of the criteria for going to phase 6.

Issues also arose in relation to over-reaction/media hype, and there has been some discussion about whether WHO fuelled this. In the run-up to phase 6, lessons were learned about how to deal with media needs and the hype surrounding a public health emergency of international concern. After phase 6, when the communications team had been reduced to skeleton size, a "radio silence" allowed others to take centre-stage and more negative stories started about, for example, definition of a pandemic/fake pandemic, and collusion with the pharmaceutical industry. WHO did not proactively or even reactively counter these stories quickly.

Lessons learned from this outbreak have raised several issues for the future, including speed of response and how to better deal with media hype; communicating uncertainty; alleged collusion with the pharmaceutical industry; conflict of interest; vaccination challenges; and what happens post phase 6.

Social mobilization/communications case studies

Ms Aphaluck Bhatiasavi: Avian influenza, Thailand

Mr Max Tello: Yellow fever, Sierra Leone

Dr Raili Suhaili: Dengue fever, Malaysia

Ms Asiya Odugleh-Kolev: Ebola, the Sudan

The case studies came from uniquely different perspectives. The Thailand case study focused on journalists' experiences during the first H5N1 outbreaks, and the tensions and interplay between the media's need for information and "news" and the public health officials' need to provide accurate and factual public health information.

The Sierra Leone case study provided a window into the complex communications and mobilization challenges involved in mass vaccinations for yellow fever.

The Malaysia case study described COMBI planning for an imminent dengue outbreak in 2001, the lessons learned, and how COMBI planning is still being carried out almost a decade later.

The final case study described how the COMBI framework was rapidly applied during an Ebola outbreak in the Sudan.

5. Discussion and conclusions

Participant discussions covered a broad range of issues related to how social mobilization, communication and anthropological interventions are relevant to public health emergencies (primarily epidemics and outbreaks), and in what ways their conceptual frameworks, methodologies and approaches can be applied to support GAR functions and objectives.

Key points

- It was recognized that public health emergencies cannot be controlled and managed solely by technological and message/information-dissemination interventions. Effective responses require multidisciplinary approaches.
- There was agreement that WHO's risk and outbreak communication projects offer a unique opportunity to engage with media/risk-communication practitioners, politicians and policy-makers to promote integrated communication approaches and ensure a wider spectrum of communication functions to be incorporated into the preparedness, readiness, response and management activities for public health emergencies.
- There was acknowledgement that communities' understanding of diseases and their spread is complex, yet there is still a rush to create generic messages and templates and produce simplistic messages on hand-washing and covering coughs and sneezes, for example, and then we wonder why people don't comply.
- There was a consensus that there may be a general "under-appreciation" of the overriding behavioural imperative that underlies responding to public health emergencies. Human behaviour drives epidemic emergence, transmission and amplification. Consequently, human behaviour is critical to epidemic prevention, response and management. This has not been widely understood and explicitly articulated.
- Dissatisfaction was aired by several participants concerning commonly used terms and definitions. More specifically, participants referred to the use of the term "social mobilization" to describe this area of work as well as in association with COMBI. The term does not seem to accurately describe the function or scope of work that this component will cover. Social mobilization can also be interpreted in different ways, and familiarity with the term varies from country to country. It was recognized that many countries follow similar planning processes for communication in outbreaks but do not describe them as "social mobilization". This issue was revisited several times during the two days. The consensus was that the current term did not accurately reflect the breadth of communications functions needed for effective outbreak response and management. Suggestions were made but no real conclusions or recommendations were arrived at. This issue needs to be revisited as soon as possible.

The term "social mobilization" is attributed to UNICEF and emerged from the 1st International Conference on Primary Health Care in Alma Ata, in 1978. The conference was a landmark meeting where health was seen a fundamental human right. The attainment of the highest possible level of health became an important worldwide social goal for everyone. The notion of "community" was broadened to include all actors that could influence the health outcomes of a population. These included: health professionals; journalists; broadcasters; community-development workers; local grassroots organizations; international agencies; and donors. UNICEF dubbed a set of activities "social mobilization", aimed at mobilizing support around a common health objective such as immunizations. For the last decade, WHO has used this term and defines social mobilization as "the process of mobilizing all societal and personal influences with the aim of prompting individual and family action".

- There was agreement that this area of work should focus on how communication can:
 - support effective behavioural adaptation by affected/at-risk groups and populations;
 - inform emergency response and event management;
 - ensure risk assessment and verification include relevant sociocultural–behavioural data.
- To do this the programme would need to:
 - establish operational networks (at global, regional and national level);
 - build links with forecasting readiness and preparedness;
 - develop and field-test relevant tools and checklists;
 - document existing evaluations and lessons learned, and share best practices;
 - ensure links and synergies with the IHR capacity-building programme.
- There was a call for the programme to develop a vision, strategy and plan of work to ensure that this work is carried forward.
- There was a clear mandate for WHO to ensure that this technical area is part of public health planning and service-delivery. Leaving this area for other agencies and nongovernmental organizations greatly impedes the ability of such support agencies to be integrated into the early stages of epidemic assessment and response.
- It was also noted that ministry of health capacities in strategic communication are generally weak. There is great diversity in infrastructure and functions within ministries of health, yet they are responsible for the coordination of communications interventions of a host of agencies and groups working in this area with staff that are highly trained.
- It was recognized that investments would need to be made at the various organizational levels.

6. Recommendations

The group came to the conclusion that COMBI is an extremely valuable and valid planning and response framework that is also suited to outbreak response and control. The branding of COMBI is an issue. COMBI is an inclusive, proven methodology that draws on diverse theoretical models and has already been applied within different country settings. It was clear that COMBI has a strong evidence base and a body of best practises. However, it is not always perceived in this way. The term “communication for behavioural impact/results” does define what the use of this planning framework could achieve, but the acronym does have several limitations and is not as explicit.

Methodology

Participants individually shared their views on how the application of COMBI (and ultimately the integration of a behaviour-oriented approach within GAR public health emergency communication interventions) should be integrated or strengthened within GAR. They also identified potential barriers and opportunities. The full list was generated by the participants and then circulated to all. Each participant was then asked to prioritize the list on a confidential basis (via a paper ballot). The following are the priority areas for action as well as the most commonly identified areas for action.

Priority areas for action

1. Integrate COMBI as part of WHO’s standard outbreak alert and response mechanisms and strategies to generate behavioural results.
2. The department should issue a clearly articulated statement to Member States that emphasizes the overriding compelling behavioural imperative in dealing with public health emergencies and the need for strategic communication planning using for example the COMBI methodology alongside medical technical people/interventions for behavioural impact.
3. Apply and promote COMBI as WHO’s strategic framework for GAR-specific alert, response and readiness.
4. All GAR capacity-building efforts on communication need to emphasize strategic communications planning to promote:
 - a focus on behavioural and social behavioural results;
 - the ability to assess people’s readiness for recommended measures and develop relevant measures (including an analysis of relevant issues, obstacles and social norms);
 - ability to engage community and national partners and establish sustainable partnerships;
 - research into monitoring and evaluation capacity.

Most commonly identified areas for action

(Some are duplicated from above because they were prioritized and common.)

1

- Produce proof-of-concept documentation for evaluation and promotion.
- Develop a guiding vision for COMBI related to GAR.
- Integrate COMBI as part of the WHO/GAR standard emergency response to generate behavioural results.
- Integrate communication staff into rapid-response structures.
- Use COMBI as WHO’s strategic framework for GAR-sponsored capacity-building efforts on communication, which should all emphasize strategic communications planning.
- Focus on behavioural and social behavioural results.

2

- Develop tools to assess people's readiness for recommended measures as well as key issues, obstacles and other relevant factors.
- Promote sustainable partnerships through engagement with community and national partners.
- Strengthen the research-monitoring and evaluation capacity.
- Promote multidisciplinary teams with a ministry of health of people ready for strategic communication planning using the COMBI approach as a critical part of the response to public health emergencies.
- Issue a clearly articulated statement to Member States that emphasizes the overriding compelling behavioural imperative in dealing with public health emergencies and the need for strategic communication planning using for example the COMBI methodology alongside medical technical people/interventions for behavioural impact.

3

- Develop simplified practical tools – checklists on how to implement COMBI in outbreak response.
- Build capacity in COMBI within the organization, ministry of health and partners, with emphasis on existing people that have outbreak experience.
- Expand the pool of COMBI experts, especially those with outbreak experience, and take better advantage of the global technical network (GTN – a global network of COMBI-trained communication and public health specialists).
- Identify COMBI promoters/focal points in each region.

Annex 1: Presentation summary

Public health communications: conceptual frameworks and models relevant to public health emergencies: prepared by Dr R Schiavo

Background and objectives

The scope of this presentation was to review current health-communication principles, conceptual frameworks, theories and strategic approaches, as well as to contribute to identify key elements and best practices that apply to public health emergency communication/social mobilization. The presentation also provided a helpful framework for some of the discussions that took place at the meeting.

This summary is not all-inclusive and focuses solely on some of the key concepts and experiences presented at the meeting.

Public health emergency communication is an evolving discipline/ communication area that is increasingly grounded in process-oriented planning frameworks

The increasing complexity of the public health and aid environments has recently been calling for a more systematic and theory-based approach to public health emergency and risk communication. A discussion of recent trends and evolving needs in emergency and risk communication would not be complete without positioning the evolution of this area within the context of current wisdom, theoretical frameworks, and best practices in the field of health communication.

Public health emergency communication is considered an evolving area of strategic health communication. Within this context, the presentation highlighted key characteristics of health communication in the 21st century that are shared or should be shared by the theory and practice of communicating in times of emergency (see Figs. 1 and 2).



Fig. 1

Communicating about public health emergencies mirrors effective health-communication elements and practices

- ❖ “Careful analysis of situation, opportunities and needs
- ❖ Understanding of constituencies and needs
- ❖ Early agreement on expected outcomes and evaluation parameters; clarity on behavioural results
- ❖ Well-defined communication objectives
- ❖ Strategies designed to meet the objectives
- ❖ Multiple and audience-specific vehicles
- ❖ Adequate funding and human resources”
- ❖ Integration of behavioural, social and organizational outcome objectives
 - Within a behavioural framework that aims at achieving behavioural/social behaviour results at different individual, community, social and organizational levels

Adapted from Schiavo R. *Health communication: from theory to practice*, San Francisco: Jossey-Bass, 2007, Chapter 11, Table 11.1.

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Fig. 2

While all of them are essential to communication effectiveness, it is important to notice here that – as for other forms of communication – public health emergency communication interventions should rely on an in-depth understanding of needs, people and situations; should be grounded in communication theories and solid planning frameworks; and should always aim at behavioural, and social behaviour results. This is in spite of the unique challenges of communicating in time of emergency, which were also reviewed by the presentation (see Fig. 3) and should be obviously considered by emergency communication interventions. Actually, most of these challenges reinforce the need for a solid theoretical and planning framework.

Communicating about public health emergencies also presents specific challenges

- ❖ Uncertain science and certain deadlines
- ❖ Clear/current danger or threat
- ❖ Need to leave no one behind
- ❖ People’s emotional and psychological reaction to crisis
 - Mass phenomenon
 - Should be anticipated and not be simply dismissed as illegitimate
- ❖ Increased need for transparency/trust because of uncertainties
- ❖ No time for message inconsistency/confusion on what people are asked to do
- ❖ Fear of infection/contamination may pose limit to volunteer/community engagement in comparison with natural disasters
 - Ability to adequately prompt/manage volunteer/social-mobilization efforts
- ❖ Doing no further harm always a concern

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Fig. 3

It is also important to remember that communication (outside or within emergency contexts) has been shown to be more effective when it mirrors the variety of approaches (see Fig. 4 for a list of different areas and platforms) and related channels people use to share information about health and illness and public health threats.



Fig. 4

In fact, “communication, and more specifically, health communication, is a common part of social exchanges and contexts, from personal and professional encounters to the mass media [including the Internet] and traditional forms of expressions such as theatre, and poetry, as well as informal conversations in barber shops, churches, restaurants, markets and other public areas”. Health-communication interventions should avoid focusing only on one communication area (for example, mass media or new media communication) and attempt to “match how communication actually takes place” (Schiavo, 2007; Exchange, 2006).

This is particularly important within the public health emergency setting, where the spread of rumours through traditional and interpersonal channels, the potential lack of trust in the information being provided to the public and special groups, as well as low levels of community engagement in complying with recommended emergency measures may jeopardize the effectiveness of all interventions.

Recent publications and top scholars have been calling for a more rigorous application of health-communication theories and best practices to public health emergency communication. This highlights the importance of going beyond some of the traditional features of risk and emergency communication, which tend to focus primarily on: understanding of key population demographics, quality and focus of communication (with some differences between risk and crisis communication), message development, and channel selection. Several models are available (see Figs. 5 and 6), with risk and crisis communication increasingly becoming two merging fields in both theory and practice, as well as relying on multiple communication approaches outside of mass media and new media communication.

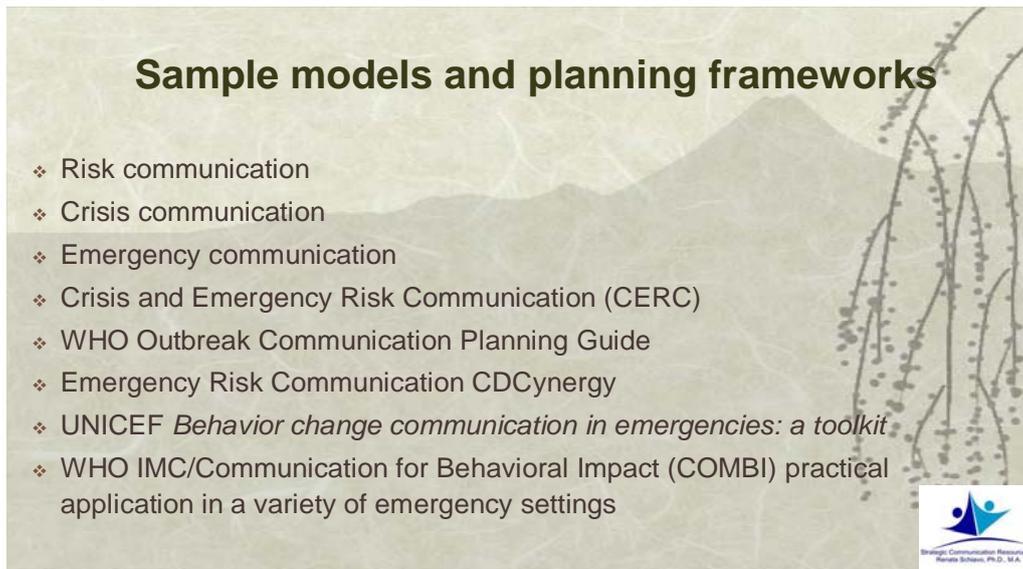


Fig. 5



Fig. 6

Moreover, an increased emphasis is being placed on short-term and long-term behavioural and social behaviour results of public health emergency communication. While short-term behaviours apply to individual, community or social practices that we seek to see adopted by different groups during the acute phase of emergency response, the latter refer to those behaviours and social norms that need to be in place in order to be “ready” to respond. This concept is reiterated in Fig. 7, which calls for revisiting the traditional pre–during–post emergency scenario (in which lessons learned do not necessarily translate into communication readiness/readiness measures for future emergencies. Some authors call this the “disaster rut”), to the readiness–response–evaluation–constant cycle (RRECC) being proposed by this presenter (in which lessons learned are used to address situation- and group-specific needs as well as existing individual and social behaviours, to create long-term readiness for communication response).

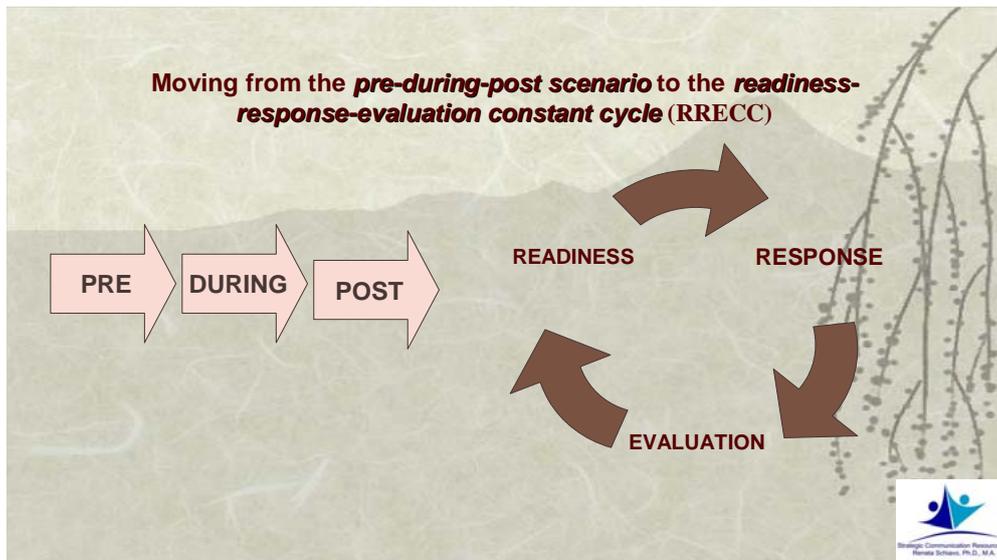


Fig. 7

Lessons learned from past public health emergencies support a central role of communication, link the effectiveness of response to readiness/advance planning, and inform, or should inform, current communication theory and practice

The past decade has marked a number of key events that have changed/are changing the theory and practice of public health emergency communication. In particular, the anthrax crisis and the recent SARS epidemic are regarded as key turning points. Both these emergencies demonstrated the importance – among others – of: advance strategic planning/readiness to respond; national and/or global coordination of all communication efforts; as well as the central role of communication/mobilization, of which citizen engagement/social mobilization is and/or should be a key component (see Fig. 8).

Key turning points: anthrax and SARS

What else we learned

<p>Anthrax</p> <ul style="list-style-type: none"> • If not adequately planned, communication efforts may contribute to confusion :) • One message = one behavior; may not meet needs/risk levels of different groups • Lack of audience-specificity and community engagement may leave out at-risk groups 	<p>SARS</p> <ul style="list-style-type: none"> • Feelings of equality/fairness of measures can boost public support • Need to prepare for potential hoaxes • Existing social norms/practices may prevent implementation of recommended measures; need to be addressed • Importance of: <ul style="list-style-type: none"> • Special response teams of experts • Adequate communication resources/capacity • Adequate number of public health/health workers
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Source: Schiavo R. Mapping and review of existing guidance and plans for community- and household-based communication to prepare and respond to pandemic flu. research report. Research report to UNICEF. New York, UNICEF, 2009.

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Fig. 8

More specifically, the anthrax crisis (which resulted in the deaths of several postal workers in the Washington DC area in the United States of America) revealed that if not adequately planned, communication may contribute to confusion and result in unwanted consequences. Moreover, the lack of audience-/message-specificity and community engagement/mobilization

(in this case, the African–American and hearing-impaired communities where most of the deaths occurred) may leave out at-risk groups, decrease trust in public institutions and, consequently, reduce compliance to recommended behaviours that may help mitigate the impact of a public health emergency. The engagement of community leaders who should participate in communication planning and implementation as well as in reaching out to their own communities is an essential aspect of public health emergency communication and a key lesson from the anthrax case. As a result of the anthrax crisis, health communication emerged as “one of the most important public health disciplines of the 21st century” (US Surgeon General, David Satcher).

Similarly, the SARS epidemic relied on community/social engagement and mobilization for a variety of actions and services (for example home visits and meals delivery) that in some country settings (for example, Canada) facilitated the acceptance of difficult-to-implement mitigation measures such as the quarantine of exposed contacts. Community dialogue and social mobilization are also essential strategies to detect and address existing social norms and practices that may prevent the adoption of recommended behaviours (such as social/physical distancing, which was difficult to implement in many countries and community settings during the SARS outbreak).

Key trends include the integration of different communication theories and areas, a renewed emphasis on behavioural and social behaviour results, and the importance of citizen engagement/social mobilization

In summary – via different examples and relevant analyses – the presentation identified key trends in public health emergency communication. These include:

- the integration of different theoretical frameworks, models and action areas;
- an increased emphasis on emergency readiness, evaluation, capacity-building and risk-reduction;
- the need for clarity of behavioural results/objectives;
- the importance of people-centred/tailored interventions with special focus on:
 - psychological factors and stages of behavioural readiness;
 - key individual, community and social predictors of compliance to recommended emergency behaviours/expected behavioural results;
- a renewed focus on quantitative results;
- the importance of citizen engagement/social mobilization;
- global and local coordination of all communication activities.

Key points from this section are briefly summarized here and include the integration of different communication/mobilization theories and areas that facilitate the assessment of behaviour readiness at the individual, community and population levels and may result in the increased adoption of protection measures among intended groups. There are several examples and models in support of this trend, in both existing public health emergency communication literature and case studies.

Existing models and studies combine crisis- and risk-communication approaches (for example, crisis and emergency risk communication, CERC) and/or support the use of integrated planning frameworks (for example, integrated marketing communication, IMC), with a strong emphasis on research, monitoring and evaluation (RM&E). Others (for example, Paek and others, 2008, who studied behaviour predictability and adoption in reference to the number of Americans who buy or have emergency items at home and may be ready to use them) looked at integrating different theories and approaches to increase behaviour predictability at the public/social level.

Emergency behaviour readiness and subsequent behaviour adoption and sustainability at social, community and household levels is influenced by similar decision-making processes as other health behaviours. More specifically, several experiences have shown that awareness of risk does not necessarily equate with behaviour readiness and compliance. Since emergency behaviour readiness is fundamental to behaviour adoption and sustainability, researching and understanding people's needs, beliefs, attitudes, social norms and current behaviours is a necessary step to addressing potential obstacles and/or reinforcing those factors that may lead to behavioural and social behaviour results in emergency settings. Paek and others (2008) recently linked people's self-efficacy (for example, "I am confident I can buy and stock emergency items and I can use them") and response efficacy/effectiveness (for example, "Stocking emergency items and being able to use them will increase my chance of protection during an emergency") to different levels of emergency/behaviour readiness. It is possible to speculate that different levels of response efficacy/effectiveness are influenced by cultural values, social norms, existing behaviours, beliefs, fears, and attitudes and other key factors that should all be assessed in the early phase of public health emergency communication interventions.

Public health emergency response needs to take into account people's needs and perceptions and plan to address psychological reactions to crisis. Too often, during public health emergency situations, "what is perceived as real becomes real in its consequences" (Center for Risk Communication, Columbia University). Fear, other irrational responses to crisis, and common human emotions may lead to negative behaviours that may increase the burden of public health emergencies. It is important to develop interventions that address key needs, help overcome irrational fears, take into account different stages of behaviour readiness, and give people things to do by recommending specific protective behaviours. Among other things, "anxiety is reduced by action and a restored sense of control" (CDC, 2007).

Finally, WHO's communication/mobilization model – communication for behavioural impact (COMBI) – appears to be well-grounded in current health-communication and -promotion theories and principles, also in the context of public health emergency communication. Therefore, this presentation ended by proposing a few discussion items/questions to identify potential next steps that would aim to: (1) select priority trends that should be integrated by WHO within its current communication approach to public health emergency; (2) identify key steps to integrate current practices with WHO behaviour-centred models such as COMBI; and (3) build capacity at the national authorities and WHO country office levels, to assess emergency behaviour readiness at the community and public levels and to develop tailored interventions.

References

- Exchange. (2006). Integrated Communication. Retrieved March 2006, from <http://www.healthcomms.org/comms/integ/ict-integ.html>
- Paek H. J., Hilyard, K., Freimuth, V., Barge, J. K., & Mindlin, M. (2008). Applying Theories of Behavior Change to Public Emergency Preparedness: Implications for Effective Health and Risk Communication. Paper presented at the annual meeting of the NCA 94th Annual Convention, TBA, San Diego, CA. Nov 20, 2008, available online http://www.allacademic.com/meta/p259806_index.html (Retrieved July 27, 2010)
- Reynolds, B. (2005). Crisis and emergency risk communication. *Applied Biosafety*, 10(1), 47-56. Retrieved July 27, 2010, from <http://www.absa.org/abj/abj/051001reynolds.pdf>
- Schiavo, R. (2007). *Health communication: From theory to practice*. San Francisco: Jossey-Bass.
- Schiavo, R. (2009). *Mapping & Review of Existing Guidance and Plans for Community- and Household-Based Communication to Prepare and Respond to Pandemic Flu*. Research Report. A report to UNICEF. UNICEF: New York, NY, January 2009. http://www.unicef.org/influenzaresources/index_1072.html. Retrieved Nov. 17, 2009

Social mobilization in public health emergencies: preparedness, readiness and response

Report of an informal consultation, Geneva, Switzerland, 10–11 December 2009

- Centers for Disease Control and Prevention (2007). Emergency Risk Communication CDCynergy (CD-ROM) 2007.
- Wojtecki, Jr., J. G., & Peters, R. G. (2000). Communicating organizational change: Information technology meets the carbon-based employee unit. *The 2000 Annual: Consulting*, 2, 175-190. Retrieved July 27, 2010, from the website of the Center for Risk Communication at <http://www.centerforriskcommunication.com/pubs/crc-p3.pdf>

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Individuals marked with * were invited but did not attend.

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