World Health Organization

SEVENTH MEETING OF THE MEMBER STATE MECHANISM ON SUBSTANDARD AND FALSIFIED MEDICAL PRODUCTS
Provisional agenda item 4E

A/MSM/7/4
20 November 2018

"IDEAS": A global communications framework to help combat the threat from substandard and falsified medical products

Outputs from the communications working group established as part of Activity E (communications) approved by the Steering Committee of the Member State mechanism in November 2015 to support the approved workplan

Lead country: United Kingdom of Great Britain and Northern Ireland

INTRODUCTION

1. The Member State mechanism has approved a number of prioritized activities related to substandard and falsified medical products.

2. The communication, education and awareness-raising stream is led by the United Kingdom of Great Britain and Northern Ireland and aims to contribute to the *prevent* element of the overarching three-pronged programme strategy developed by WHO, i.e. prevent, detect and respond.

3. At the outset of the work in January 2016, the scope and approach of this activity were defined as follows:

> "Create a working group to develop and leverage existing recommendations for effective risk communication and recommendations for awareness campaigns on SSFFC[1] medical products and related actions, activities and behaviours."[2]

4. It was agreed that the work should focus on providing practical advice and guidance to Member States and several key elements were identified as being useful outputs from the workstream:

- produce samples of hard and soft copy, video and broadcast material;
- assess the use of social media for raising awareness;

[1] Substandard, spurious, falsely-labelled, falsified and counterfeit, now substandard and falsified.

[2] See A/MSM/3/3, Annex 3 (available at http://apps.who.int/gb/sf/pdf_files/MSM3/A_MSM3_3-en.pdf, accessed 7 November 2018).

- identify the full range of stakeholders and audiences;

- develop key and innovative advocacy material.

5. During the development of the work programme it became increasingly clear from the social, political and economic perspectives that the impact of communication was growing at an unprecedented pace, making it increasingly difficult to develop guidance and strategies – with a significant risk that they would become irrelevant or outmoded almost as soon as they were published.

6. Meanwhile, considerable computing power and technology growth, coupled with similar software advances, are combining to accelerate the reach, influence and immediacy of communication messaging on a daily basis, but this is happening in very different ways and rates across Member States.

7. From the outset, the communication, education and awareness-raising workstream therefore set out to acknowledge these differences and the very local and contextual nature of communications with different audiences, to ensure all Member State communication environments were represented and reflected in the recommendations developed.

8. In order to maintain a global perspective for existing and future communications advice, a communications working group was established early in the work programme, and invitations to join the group were extended to communications professionals across all six WHO regions. Support and contributions to the workstream were then channelled through the group's members, acting as a first-level consultative and critical review body.

9. Beyond the communications working group, the workstream reached out to the broader professional communications community working in Member States, academia and analogous areas of public health, to build a contemporary picture of best practice in communications before developing and testing a bespoke approach to guidance on substandard and falsified medical products.

10. The proposals set out in this document are based on the feedback received, together with the results of a global communications survey and live testing of the framework subsequently developed. (A longer narrative with specific advice is being published separately to coincide with the seventh meeting of the Member State mechanism).

METHODOLOGY

11. With a clear remit to generate practical guidance for Member States, the communications workstream has focused on contemporary best practice thinking and campaign implementation to populate its guidance. In essence, the work programme is constituted of the following elements:

(a) establishment of a body of knowledge – gathering examples and theories of current best practice communications activity, focusing on analogous and comparable public health campaigns and activities;

(b) engagement with interested stakeholders and attendance at relevant events;

(c) aggregation and distillation of understanding applied to communications planning, and ongoing consultation with the communications working group;

(d) feedback to inform a pilot communications survey of working group members;

(e) use of the results and insights from the pilot survey to plan and implement a global communications survey, with all Member States invited to participate;

(f) use of outputs for the communications modelling hypothesis;

(g) live testing with Member States at workshops;

(h) further refinement from hypothesis to communications framework;

(i) concurrent collection and curation of campaign materials from Member States;

(j) concurrent review of social media in 2018 to inform better communications;

(k) progress presentations and plan updates to Steering Committee meetings and annual Member State mechanism meetings in 2016, 2017 and 2018.

BUILDING BLOCKS AND STAGING POSTS

12. Exploring some of the work components in more detail helps to understand the insights gained from the early stages of the work and how these have been applied to create the communications framework.

13. The establishment of a body of knowledge led to a focus on ensuring behaviour change thinking was included as an essential component of communications advice. We need to do more than just provide information to citizens and patients on the risks and dangers associated with substandard and falsified medical products; we also need to engage and motivate them to make positive "considered decisions", thereby adopting safe behaviour.

14. Engagement with interested stakeholders showed the extent to which the whole public health community recognized the risks posed by substandard and falsified medical products and the need to develop integrated strategies throughout the supply chain, from manufacture to consumption, and to use communications at key intervention points with relevant audience groups (health care professionals, influencers, citizens).

15. What we learned from our pilot communications survey of communications working group members confirmed our original hypothesis that what was required was practical guidance, particularly on:

- sharing insights and creating assets;
- support for success measurement;
- showcasing best practice and providing guidance on film, social media and print.

16. When we took the results and insights from the pilot survey and developed the global communications survey in 2017, we largely found confirmation of our initial work. We also looked to understand what Member States were currently doing and there was broad consensus on the challenge that this work represented within a wider public health agenda:

- little original research was being conducted into the use and awareness of substandard and falsified medical products among the public or health care professionals, with informed views suggesting that:
  - for public audiences, social media (or friends and family) were a key channel and influencer;
  - for health care professionals, their professional organizations, government departments and regulators were influential;
- campaigning was mainly directed at population-wide public audiences.

17. Furthermore, as might have been expected from feedback from the pilot study, the global communications survey indicated that Member States were principally looking for guidance on planning, developing and measuring the success of their campaign activities. This feedback influenced both the structure and content of our communications framework.

18. Live testing workshops enabled us to test the validity of our model with a variety of Member States, most recently in Africa, Asia and Europe. In each case, the specific purpose of the workshop was to work with delegates to explore and critique our prototype global communications framework, identify gaps, suggest relevant additions and recommend any additional sources, structures and/or stakeholders. The format was consistent at each event. First, the group was presented with an overview of the role of WHO communications activities in helping to combat substandard and falsified medical products, drawing on the feedback received from the global communications survey, which highlighted the areas in which Member States were active and emphasized the topics on which they were looking for support from the communications programme. The specific nature of substandard and falsified medical products in each country context was then investigated, drilling down into the influence of communications in all senses (broadcast, narrowcast, face-to-face) in each participating delegate's country and, where relevant, comparing the relative impacts. We shared the hypothesis of the new communications framework "IDEAS" and worked through each element in detail, exploring the value that could be added to communication activities by utilizing it. The group(s) then tackled a hypothetical campaign challenge, adopting the principles from the IDEAS framework to test its validity in a potential real-life situation. In each workshop, delegates contributed enthusiastically and energetically to develop solutions providing strong endorsement of the communications framework's value.

19. Feedback aggregated from these workshops informed further refinement of our hypothesis, leading to the final version of the communications framework.

20. In parallel with the design, creation and refinement of the communications framework, we undertook the collection and curation of campaign materials from Member States to best illustrate the scope and range of activity and to generate a digital asset library, in order to inspire new campaigns and serve as templates that could be repurposed or copied for similar communications challenges.

21. A concurrent review of social media in 2018 will give Member States an overview of this increasingly influential component of communications activity and will enable them to integrate it into their communications planning.

22. Finally, regular progress presentations were made to Steering Committee meetings and annual Member State mechanism meetings in 2016, 2017 and 2018, providing project updates and giving these forums the opportunity to critique the work to date and provide further direction going forward.

THE COMMUNICATIONS FRAMEWORK: THE POWER OF IDEAS

23. The communications framework has been distilled into five key elements to provide clarity and brevity. By adopting the thinking set out in the IDEAS model, Member States will be able to create compelling communication initiatives to help combat substandard and falsified medical products.

24. The individual framework components are:

I for **INSIGHT**

- Understanding how and why people (audiences) currently behave the way they do, so as to inform our communications planning

D for **DATA**

- Bringing together all the evidence we have on the topic to ensure credible and solid foundations for advice and guidance

E for **ENGAGEMENT**

- Ensuring a strong connection is made with target audience(s)

A for **ACTION**

- Giving people action to take to adopt good behaviour and reduce their risk of exposure to substandard and falsified medical products

S for SOLUTIONS

- Measuring the impact of campaigns, and using lessons learned to improve future activity planning

25. Each element is described in greater detail below.

(a) HOW WILL **INSIGHT** HELP?

- Insight unlocks our understanding of why people are currently behaving the way they are. It is more than just observation; it gives us a picture of behavioural influences: community, cultural, economic, religious, peer-related, work-based. It helps us to understand how all these influences are working together and gives us clues as to which ones are strongest and how we can address and change them. It helps us to think about where our communications are going to be most effective as a positive intervention and which messages will have the greatest impact.

The importance of understanding audiences.

- Effective communications rely on strong insight to develop compelling messages, delivered through relevant communication channels to create behaviour change.

- Segmenting and targeting audiences improves our efficiency.

– Primary audiences are those we want to directly address with our messages, the people who are directly affected by the problem or best able to address it.

– Secondary audiences are those who influence a primary audience, either directly or indirectly. They may include family members, health care professionals or community leaders who shape social behaviour and treatment practices, influence policies or even people's thinking on medicines.

What methods can we use to generate insight? Representative primary audience-based research will help most.

- It gives us an impartial view of people's current attitudes and behaviours.

- It helps us to build a profile of our most "at risk" groups, so that we can consider whether we need to segment our audiences and develop custom communications for different groups.

- It gives us strong clues as to what messages will resonate with our audiences.

- It identifies barriers to, and triggers of, change.

- It gives us a better understanding of trusted/scalable communication channels to use.

If we cannot commission original research, we need to identify sources of independent observation and combine them with comparable evidence from published and other credible sources, such as clinical data, or similar contemporary studies from recognized expert organizations. How can we find this information?

- Review of any existing published data

- Independent observation: structured field work

- Trusted online data sources: WHO, governments, NGOs

- Reputable and statistically valid global, regional and locally published research

- Comparable and up-to-date evidence from other countries/regions/ districts

- Qualified social listening/media

What should we avoid?

- Unverified anecdotal evidence. This will often mask the true picture or give a distorted result.

- Self-selection research. This can lead to bias based on the recruitment method used (e.g. online surveys can easily exclude non-digital groups).

(b) WHAT ABOUT **DATA?**

Data are very contextual to the topic and the audience, so we need to make sure they are objective, accurate, timely and relevant. What type of data can help?

- Population and audience size data: sizing the task
- Distribution data: understanding where we may need communications to intervene at point of access
- Frequency of use, clinical and prescribing data: how often we need to communicate
- Intermediary intervention data (e.g. role of health care professionals, pharmacies): where trusted influencers can help
- Adverse reaction data: urgency or geographical focus, real data to use in communications campaigns to alert citizens to risks involved

(c) HOW CAN WE SECURE **ENGAGEMENT?**

Blending what we learn from data and insight will point us towards the creation of engaging and compelling communications. We will know:

- what audiences to target with communications
- where to reach those audiences
- what messages they will respond to positively
- when and how frequently we need to publish
- how to generate behaviour change (and feedback where necessary)

(d) WHAT **ACTION** ARE WE LOOKING TO ACHIEVE?

Effective communication is more than just information.

- It provides the knowledge and motivation people need to make informed decisions and good choices.
- It provides the stimulus that people need to make informed decisions.
- It provides the motivation to take action.
- It provides the support to maintain that action.

Using benchmarks of current behaviour from insight and data collection, we can identify the changes we want people to make.

(e) HOW WILL WE KNOW IF OUR **SOLUTIONS** HAVE WORKED?

Measuring inputs, outputs, outtakes, outcomes and impacts will help to create sight lines between the communications we create and the change in behaviour we seek.

- We can measure (or estimate) reach (how many of our target audience saw/were impacted by our communications?) and frequency (how often did they see the campaign?), to start to understand the likely impact. Were we targeting a particular demographic (e.g. young women) or geographical group? What was our penetration of this group?

- We can measure over time how behaviour changes, based on the information we collected through insight and data and by benchmarking existing attitudes and practices, and running audit surveys or collecting data from reputable sources (e.g. registered pharmacies).

- We can investigate in more detail where our communications have had most impact. For example, did our insight lead to messaging that resonated with our audience?

- We can test our activity where the opportunity presents itself. If we have the resources, we can pilot our campaigns to test them in a real-world situation and adjust (if necessary) before wider exposure and expenditure.

Learning from the outcomes of the campaigns we run will lead to improvements in the impact of our future communications, and the building of a useful dataset.

THE FUTURE: 2019 ONWARDS

26. The communications advice handbook, together with the library of existing campaigns and the social media review, will be made available to all Member States in the first instance on the MedNet platform to coincide with the seventh meeting of the Member State mechanism in November 2018. In the future, any specifically commissioned work from WHO on substandard and falsified medical products communications will also be added to the library.

27. The dedicated communications workstream of the overall programme is scheduled to be concluded at the seventh meeting of the Member State mechanism, but given that the model for advice is deliberately practically focused, it is hoped that it will be widely used by Member States and that new campaigns will be added to the digital asset library, so that it can evolve organically and Member States can continue to benefit from the work within a strong guidance framework.

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