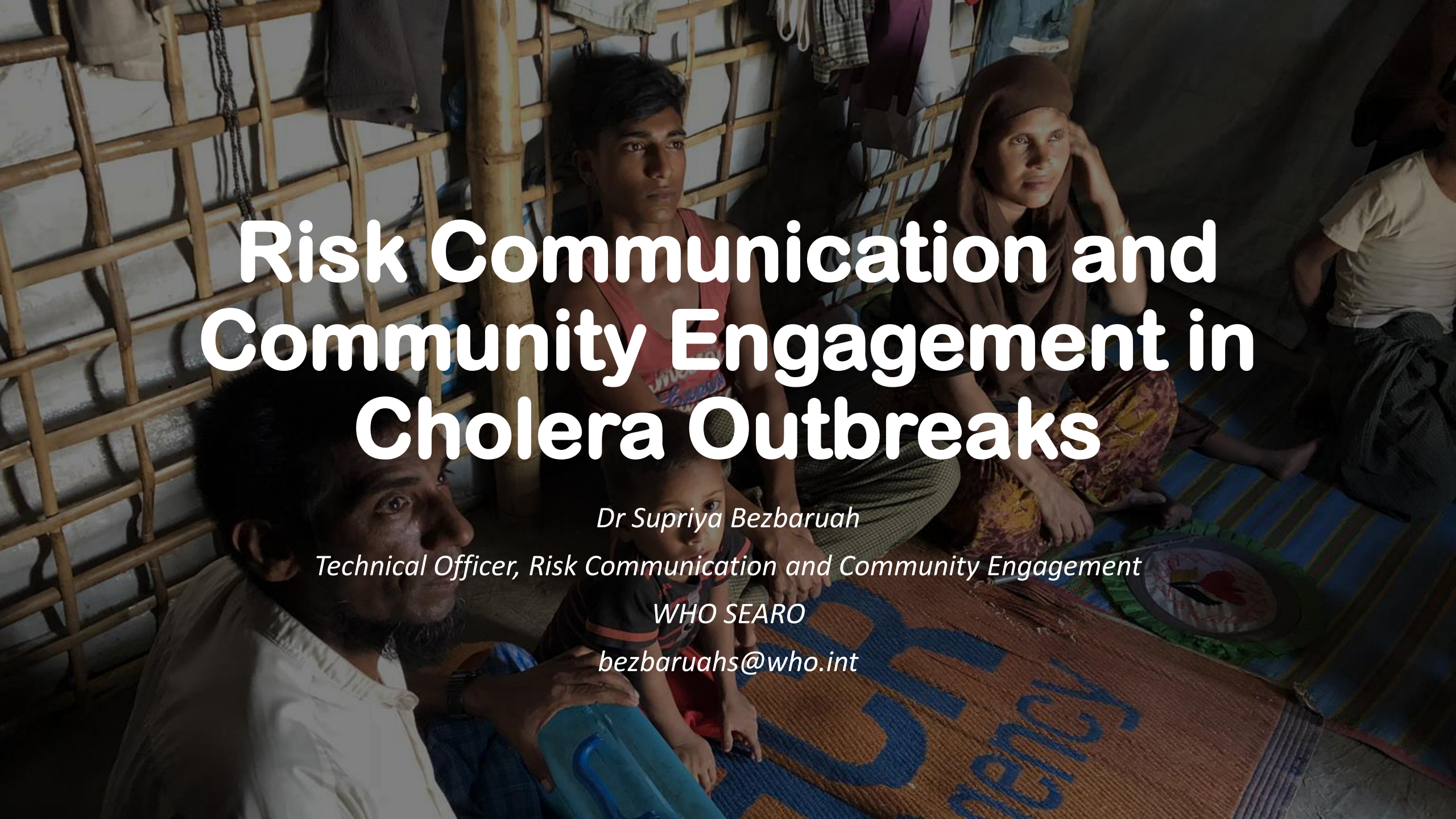

# Risk Communication and Community Engagement in Cholera Outbreaks

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# Why Community Engagement?

People's actions  shape the course of an outbreak

Community engagement therefore needs to be an integral part of every pillar of outbreak prevention and response.

# Surveillance and community

- 2016 WHO Task Force on Cholera Control recommended community-based surveillance
- Focus on “hotspots” increases cost-effectiveness
- Understanding of people’s **migration patterns** needed (e.g., economic migration, pilgrimage)
- Social consequences – potential for **mistrust** and resentment in the targeted “hotspot” community and **resentment** at lower WASH investment in the “non-hotspot” community (e.g., Cox’s Bazar)
- **Cholera perceived as symbol of backwardness** – personal responsibility emphasized, can lead to stigma and lowered community perception of danger

# What we can do

- **Map population movements** (participatory mapping, mobile phone technology) and incorporate into cholera hotspot targeting
- Ensure deep understanding of **social context to avoid stigmatization**
- Communication of epidemiological results or subsequent **messaging should not lead to stigma or scapegoating of one community**

# Exposure determined by mainly social factors

- Poverty and marginalization
- Conflict
- Social position and gender roles
- Livelihoods and occupation
- Immunological naivity
- Physical proximity to cholera patients
- Biological factors – gastric acidity, O-type blood

# Social Context shapes vulnerability

- "Epidemiological polarization across wealth strata" (*Joralemon, 1998*)
- Urban dwellers more likely to get cholera due to overcrowding and lack of sanitation facilities
- Exposure shaped by local behaviours and roles and differences in age and gender can emerge in exposure, e.g., women's caregiving roles
- Livelihoods – fisherfolk
- People's access to health services affected by remoteness, poverty, conflict, social norms

# What we can do

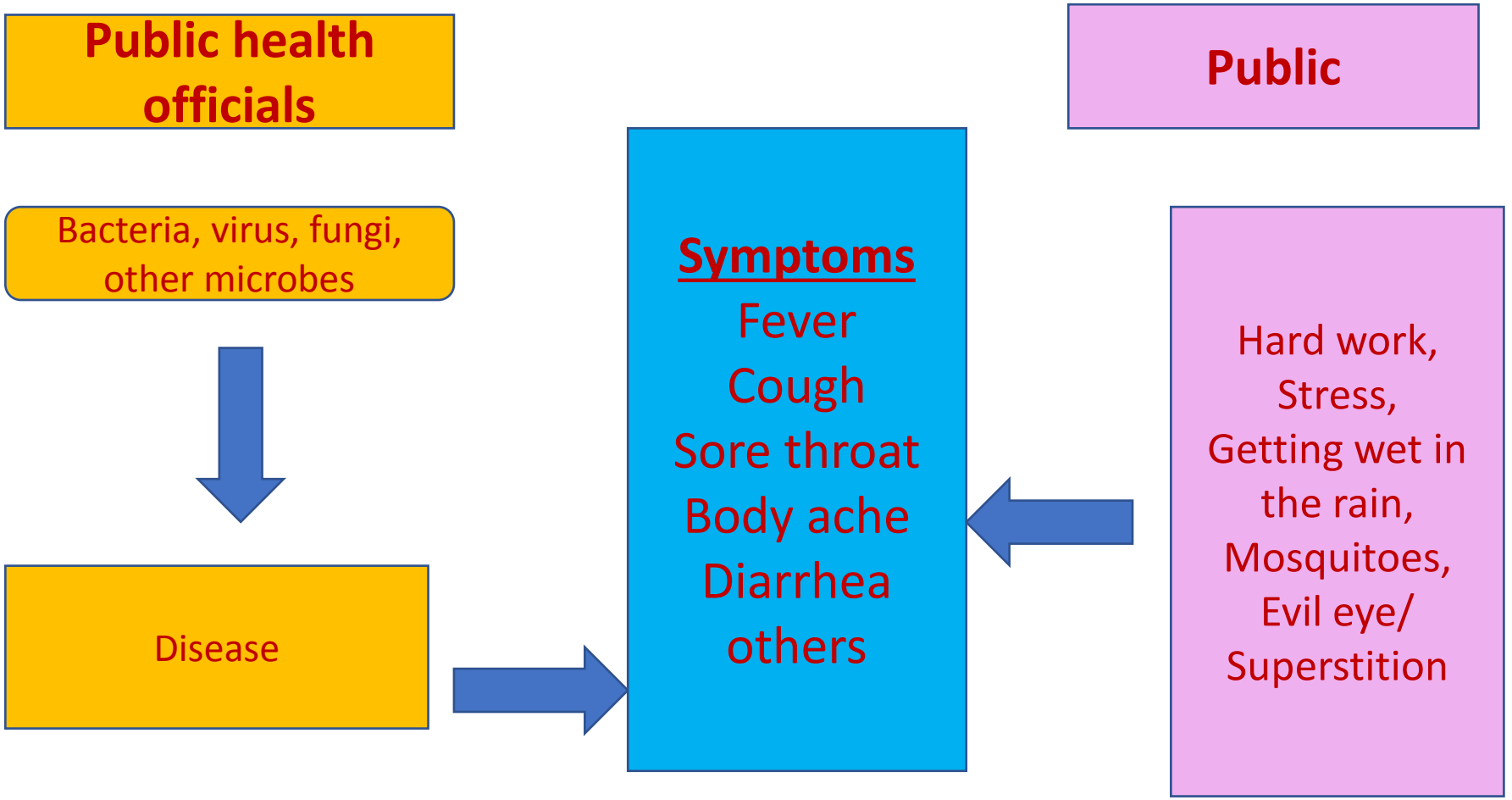
- Conduct **ethnographic rapid surveys** that **identify differences in social roles and responsibilities** to assess differential vulnerabilities
- Assess how different livelihood groups and/or occupations are likely to come in contact with contaminated water or food, and why
- Identify how social difference shapes access to health services.
- Encourage provision of rehydration therapy (homemade or purchased Oral Rehydration Solutions) at the level of the household or the community whenever possible.

*(Ripoll and Wilkinson, 2018)*

# Transmission: Seeing Differently

- Biomedical – usually secondary transmission, contaminated hands, food, water
- People perceive diarrhoea differently – there are already entrenched ideas that may not be biomedical
- Need to explain transmission: focusing on food can lead to confusion and stigmatization of one group (e.g., food vendors) and lack of trust in authorities
- People react to perceived visual risk, e.g., dirt as a form of transmission

# Scientists respond to facts and people respond to PERCEPTIONS




Seeing Differently

# Causes of diarrhea: Some Cultural beliefs

- Foods that are fatty, not cooked adequately, heavy, etc.
- Imbalance of heat and cold that may be associated with foods, exposure to cold weather, seasonal changes
- Normal or poor quality breast milk
- Physical factors, such as a fall or poor caretaking
- Supernatural causes, including possession, sorcery or evil eye
- Pollution from exposure to or inauspicious contact with ritually impure persons or things
- Moral misbehaviour
- Natural consequence of milestones, especially teething, crawling and walking
- Infection, which can be associated with hygiene and sanitation (but which may be difficult to distinguish from ideas about pollution) (Weiss 1988)

# Nuanced messaging

- Public messaging focused only on personal behaviour change can lead to stigma
- Poor people labelled as dirty or filthy
- Class compounded by racism and discrimination
- Leads to distrust in authorities, resistance in response
- Can lead to conspiracy theories if already in a context of distrust of authorities

*(Briggs, 2004; M. Nations & C. Monte, 1996).*

# Positive engagement

- Avoid bans of any kind of food, instead advise consumers to follow hygiene procedures and adequately cook the food. 
- Engage street vendors and roll out training on basic food safety procedures. 
- Ensure the communication campaign focus on water quality and the importance of good hygiene practices and water treatment. 
- Engage the affected communities to hear their narratives of the disease and work with local representatives to design appropriate response measures and risk prevention messages. 
- Communication messages about transmission pathways should not single out particular social groups to avoid stigma and scapegoating. 
- Messages should be not countering alternative causal explanations, but rather emphasize the importance of immediate rehydration and accessing care at health facilities as early as possible.

# Prevention: Motivating people to act

- Good hygiene practices are encouraged
- People respond to their experiences – 80% of cholera cases are asymptomatic – community perception of risk decreases
- Emphasizing notions of “dirt” and visual
- Collective responsibility helps – mobilizing community networks
- Positive pragmatic messaging
- Targeting households at risk can lead to stigmatization
- Healthy hygienic practices should be delivered as an integral part of people’s daily lives

# Vaccination

- Highly effective – 76% - but may need explanation
- **Mistrust** can arise from people getting infected prior to or during vaccination, before the immunity is produced, therefore contracting cholera despite having received the vaccine
- Uptake depends on number of factors, including **perceptions, cost, convenience**
- Rapid survey with an ethnographic component before vaccination, exploring knowledge and attitudes towards the disease, its transmission, treatment and prevention can help

# Health seeking practices: Trust

- Biomedical practitioners, drug vendors, faith healers and others are all equally seen as health providers by the community
- People go to those they trust
- Not all people have equal access to health practioners


# Language is Important

- Language makes a difference in perception. For example, in Bangla, there is no word for dehydration
- Bangladesh: different words for different types of diarrhea, *dasto*, *amasaya, buniaga. Pakistan: dast vs hehza*

- Social discrimination: boys being given ORS in India


Trust is the key

# Knowing is not Doing

# 4 Cs that influence behaviour

**Consumer** (perceived or actual) needs, wants and desires

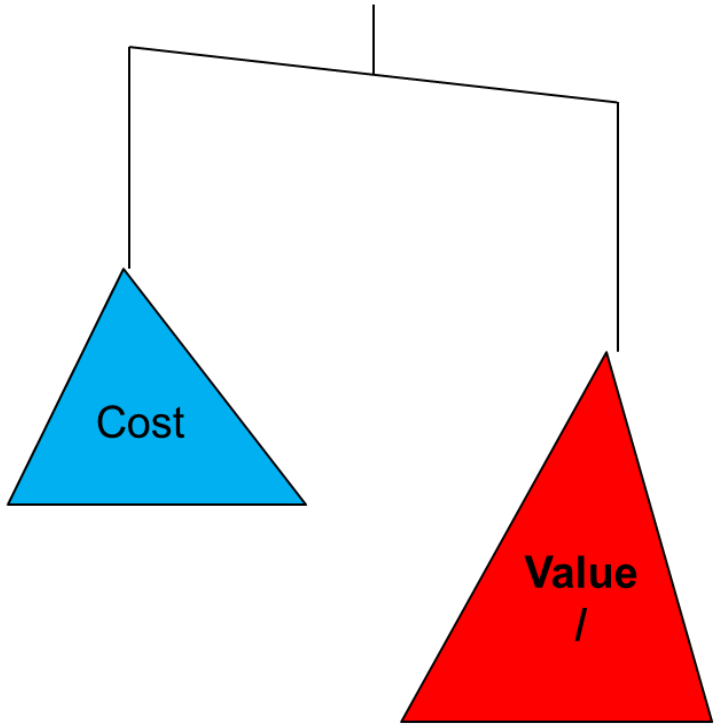
**Cost** (perceived or actual) e.g. price, effort, opportunity

**Convenience**

**Communication** (friends/family/external)

*(From COMBI, based on Health Belief Model, Theory of Planned behavior, Social Cognitive Theory)*

Cost vs value




**Behaviour Adoption**

# Trust is the key

- Respect the community's beliefs
- Explain within the context of their understanding
- Messages should be delivered appropriately to the community, e.g., posters and leaflets won't work for illiterate people
- Need to understand their lives and make suggested interventions convenient and relevant for them

# Integrated communication strategy: Repeat multiple times, multiple ways

Public advocacy and mobilizing decision-makers

Point-of-service promotion

Community mobilization

Promotional materials and advertising

Personal selling and mobilizing local networks and advocates

*From COMBI*


RISK COMMUNICATION SAVES LIVES.
Connecting people and public health.
World Health Organization
Regional Office for South-East Asia
RISK COMMUNICATION STRATEGY
for Public Health Emergencies
in the WHO South-East Asia Region, 2019-2023.
1
LISTENING
• Development of a communication intelligence system to detect needs as well as well as fake news and rumours
• Plan for rumour management, including social media
• Develop capacity and resources to fight fake new
2
SUSTAINABLE STRUCTURE
• Risk Communication unit
• An Action Plan for risk communication
• Dedicated budget during preparedness and response
• Sustained, institutionalized capacity building
3
PARTNERING
• National Task Force with partners
• Coordinated resource sharing
• SOPs for coordinated communication and functions during emergencies
4
STRENGTHENING PUBLIC COMMUNICATION
• Media sensitization on the nuances of public health emergencies
• Partnership with media
• Trained media spokespersons for emergencies
• SOPS for public communication during emergencies
5
ENGAGING COMMUNITIES
• Engagement with key community influencers
• Capacity building of frontline health workers on risk communication
• Systems to partner with community for emergencies
THE 5 PILLARS
TO STRENGTHEN RISK COMMUNICATION IN SOUTH-EAST ASIA

# Acknowledgements

Sources for information for this presentation include:

1. “Social Science in Epidemics: Cholera lessons learned” developed by Social Science in Humanitarian Action www.socialscienceinaction.org
2. Communication for Behavioural Impact (COMBI) https://www.who.int/ihr/publications/combi_toolkit_outbreaks/en/


Thank
you!