Broad Challenges in Health Communication

OVERVIEW

• The competitive health context: establishing programme communication as a distinct sector from advocacy, profile raising and fundraising;
• Communication challenges in TB and polio: some lessons learned;
• Some common challenges facing all health sectors;
• HIV specificities and the long wave;
• Some personal, historical perspectives
• A few broader linked trends in development;
• Commission on the Social Determinants of Health
Since 2000 (from OECD)
Programme communication: the victim of a competitive health context?

- Multiple programmes with principal – and acute – communication challenge to establish profile (internationally and within target countries);
- Programme communication conflated with – and generally the junior part of the same department as – external communication: (e.g. Stop TB, UNAIDS historically, nutrition etc)
- Medical models increasingly rather than decreasingly dominant, focused on treatment rather than prevention or social determinants; Traditional lack of understanding of communication within medical contexts;
- Few if any mechanisms for cross cutting programme communication approaches between health challenges, particularly as the sector becomes more fragmented;
- Coherent planning in country potentially undermined if no coordination between initiatives;
- Most multilateral and bilateral organisations have undergone major reorganisation (focused on decentralisation) – programme communication has generally suffered.
TB: state of play

Stop TB Partnership:

- ACSM country level strategy developed and adopted
- Clearly rooted, structured and articulated to address the challenges of the Stop TB strategy:
  - Case detection and adherence;
  - Stigma reduction;
  - Empowering patients/people with TB;
  - Building political support for TB;
- Working group also produced Patients Charter on TB care, and initiative on community care;
- Substantial technical support for preparation of Global Fund proposals, and substantial funding resulting;
TB: ACSM Framework

• **Strengths:**
  – Product of and rooted within a partnership with significant ownership – developed through inclusive, multistakeholder process; strong patient involvement.
  – Coherent, long term, comprehensive and rooted in the Stop TB strategy;
  – Explanation and integration of different communication approaches;
  – A living document, and continuing point of reference which has resonated widely
  – Context of strong leadership

• **Weaknesses:**
  – Weak link to HIV;
  – Weak link to other working groups (such as DOTS Expansion);
  – Developed for National TB Programmes - limited respect from activists;
  – Translating strategic framework to action - limited implementation plan;
  – Some national TB managers concerned about assumptions (e.g. improving case detection where weak health systems);
  – Heavy dependence on mostly voluntary partners;
  – Technical assistance fragmented and poorly resourced;
  – Under umbrella of external advocacy....but weak on advocacy

• Jury out on whether such a framework – and allied processes – is fundamentally improving action on the ground
TB: the links to CFSC

- Stop TB strategy requires increased case detection: TB communication challenge substantially a traditional behavioural one (if you have a cough for two weeks, see a doctor);
- Stigma and discrimination identified as a major problem, *Patients Charter* (with *International Standards of TB Care*) one key response to asserting patients rights;
- Many of the most successful programmes (e.g. Mexico, Bolivia, Bangladesh) rooted in community/patient empowerment;
- Many failures in TB control associated with stigma and disempowerment; issues of stigma increasingly acute as MDR/XDR TB increase – patients are isolated;
- TB patients are – with some exceptions – transitory because cured (less inclined to build an identity and a movement compared to HIV); nevertheless, increasingly vocal and effective patient movements emerging;
- Activism linked partly to HIV (because TB such a killer of HIV+ people) and partly in its own right.
TB: the link to social determinants

- TB is easily cured using established treatments – the Stop TB strategy focused on treatment;
- A new focus on social determinants of TB:
  - Even assuming all resources raised for Stop TB strategy, incidence expected to decline by around 1% a year;
  - Historically, availability of treatment has been an important but subsidiary factor in declining incidence of TB compared to broader social and economic factors (e.g. UK);
  - In some countries (e.g. Vietnam) with strong and well resourced TB programmes, incidence increasing; in some countries with weak TB (e.g. Indonesia) programmes, incidence decreasing (Knut and Dye);
  - Air pollution, indoor pollution, smoking, nutrition not significantly covered in the Global Plan or in TB programmes (other important factors are stigma, gender etc);
- Almost no discussion in development of Global Plan on potential of TB prevention – social determinants of TB study could help change that
Polio: the last few yards

- Traditional communication/social mobilisation approaches highly effective in wiping out all but a comparatively small number of polio cases on the planet;
- Polio incidence increasing in Nigeria (and linked resurfacings in Somalia, Angola, South Sudan, Namibia and Kenya), and continues in India.
- Communication methodologies to ensure “compliance” in routine immunisation unsuited to many communities who believe they have greater problems and don’t perceive polio as a problem;
- Rumours, boycotts and politicisation of polio immunisation efforts;

- Need for a community based communication strategy that involves community leaders, mobilizers, partnerships with state and private media, and strengthened links with local NGOs and promote ownership.

TAG Recommendation
Some Common Themes

• Barely a single example of a health related agency or programme that has a clear, coherent and needs based long term strategy to use programme communication to achieve its prevention, treatment or other goal.
• Programme communication poorly understood, generally confused with and grouped within external relations;
• Technical support is fragmented, with a variety of actors offering distinct approaches (behaviour change, social marketing, social change) – users find it difficult to know what kind of support they want, and when they know, find they have to make strategic choices – not a coherent whole;
• Competitive tendering and funding arrangements encourage competition rather than complementary collaboration between agencies and approaches;
• The medical/treatment model has been reasserted (principal focus on delivering treatments, developing vaccines, improving diagnostics); social and political drivers arguably less prioritised than a decade ago;
• Sectors are so fragmented that no one responsible for looking at cross cutting themes:
  – Communication environments are changing, but we don’t know how or whether it matters – Horizontally networked environments mean messages more difficult to control, rumours more difficult to combat; and mean people can better organise, mobilise and communicate with each other across distances;
  – People (not only people affected but also journalists etc) are bombarded with many more messages from many more actors; increased coherence at country level important;
Some Uncommon Themes

- HIV/AIDS remains exceptional:
  - long wave;
  - no cure or vaccine;
  - Sparked a social movement focused on an assertion of identity that has not been replicated by any other health challenge; how much does empowerment require the formation of identity?
  - Has succeeded in shaping the agenda not only for HIV but also other related challenges (TB), and the main engine for political mobilisation for health.
Broader debates and trends in Communication for Development

- Conflation of definitions and roles of communication reflects broader problem within the development sector – communication situated increasingly within external relations;
- Attempts to “mainstream” programme communication, with accompanying closure of HQ departments; strategic coherence undermined amidst decentralisation;
- Health – and especially HIV/AIDS - sector a driver for interest in media and communication in 1980s/1990s; then ICTs; now governance and the need to hold governments – and development responses – to account;
Some personal historical perceptions

- Social and political drivers of HIV/AIDS understood since 1986 (e.g. Panos *Aids and the Third World, Blaming Others* etc.)
- HIV a long wave event, with prevention impacts only seriously measurable – and programming ultimately plannable – in the long term;
- This will not happen……the pressures facing organisations in demonstrating clear, quantitatively verifiable results over the short term are too great to be able to invest in the timeframe chosen by the virus. Interventions will never reflect the character of the challenge – history has demonstrated that institutions just don’t work like that.
- There has never been a serious, long term, coherent strategy designed to prevent the spread of HIV/AIDS, let alone one rooted in tackling the underlying drivers of the pandemic.
- 20 years into the epidemic, few initiatives have systematically built communication capacity and expertise on the ground.
- Communication appears to be discredited and poorly understood in the minds of many (activists and mainstream medical community), and within major funding bodies (such as the Global Fund);
- Debates within communication stifled as whole sector diminished, leading to lack of opportunities for systematic learning;
- Commission on Social Determinants of Health an important opportunity for the sector
Commission on Social Determinants of Health and Communication for Social Change

- CFSC focused on using communication to empower people, with an emphasis on:
  - Social and political contexts;
  - Amplifying voices of those most affected;
  - Enabling people most affected to use communication to shape the health/development agenda;
  - Internally driven change;
  - Understanding and helping shape empowered communication environments;
  - A focus on agency by those affected;
- Commission argues that “realising health equity requires empowering people, particularly socially disadvantaged groups, to exercise increased collective control over the factors that shape their health.”