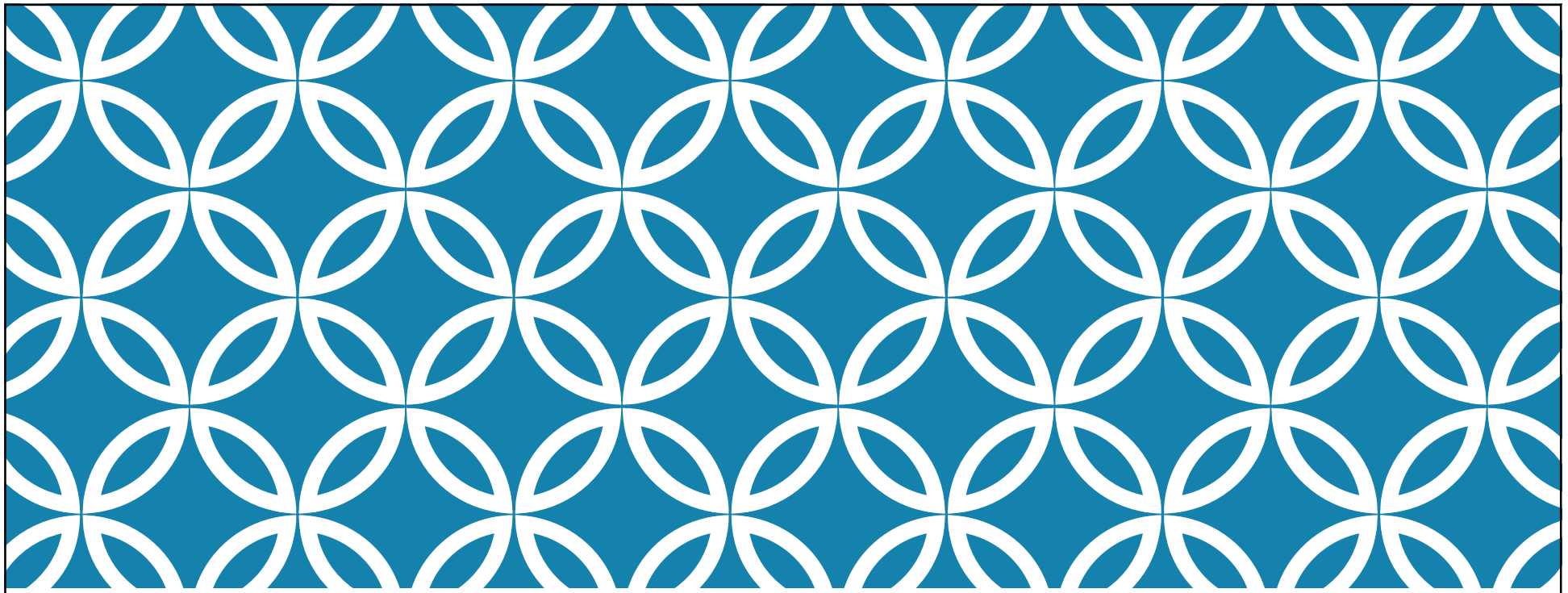
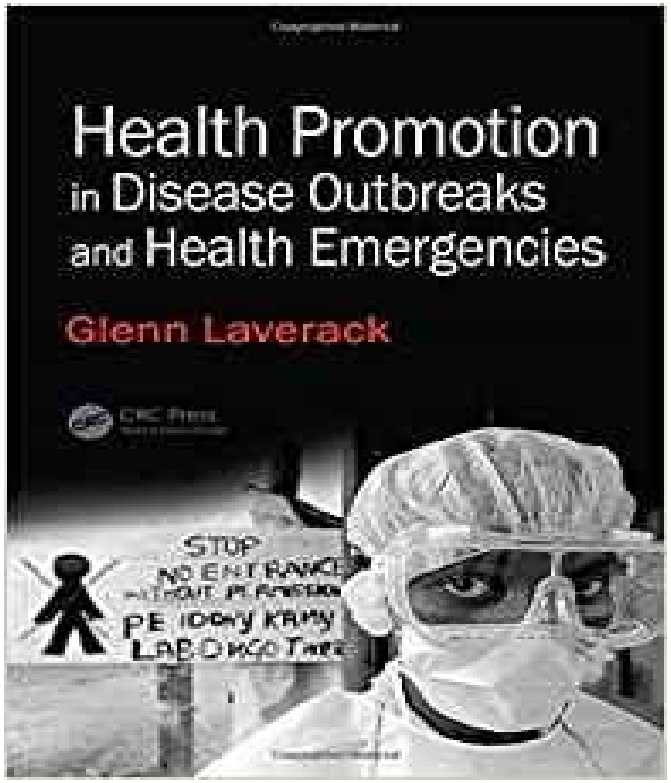


HEALTH PROMOTION IN DISEASE OUTBREAKS AND HEALTH EMERGENCIES

Glenn Laverack

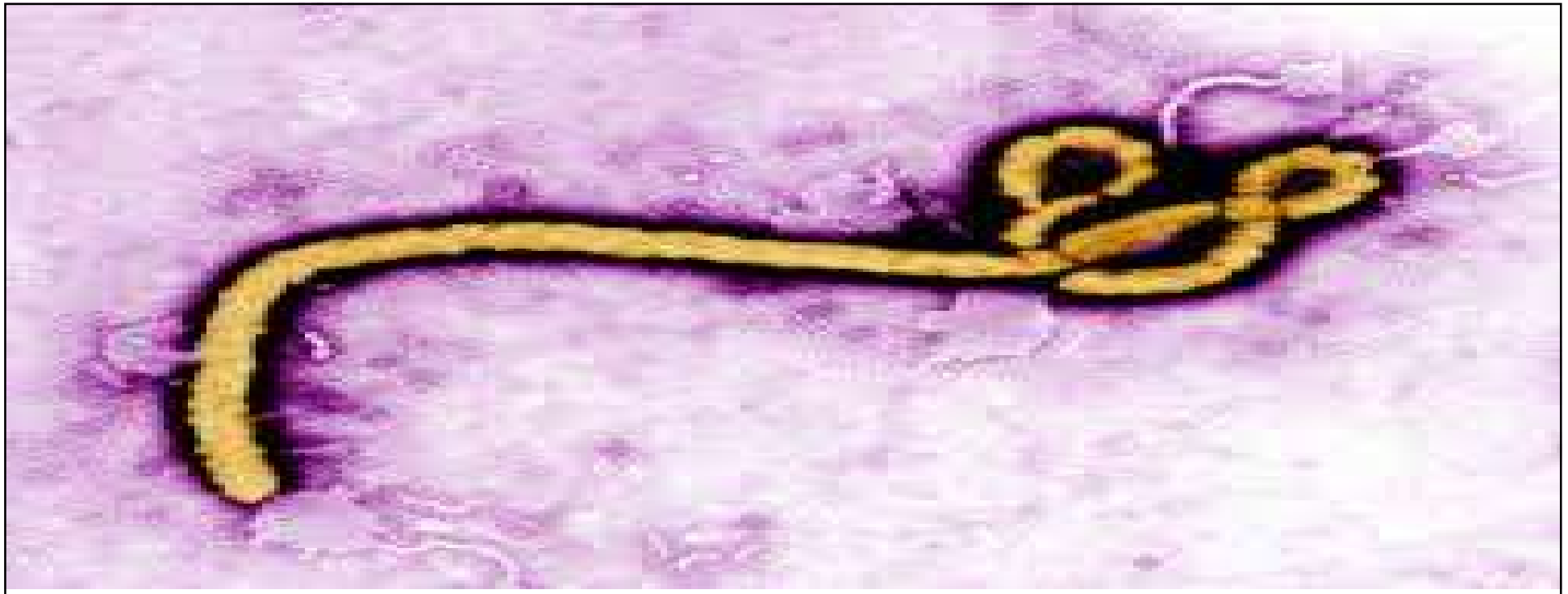

Health Promotion
in Disease Outbreaks
and Health Emergencies
Glenn Laverack
CRC Press
STOP
NO ENTRANCE

1. DISEASE X

A hypothetical, unknown pathogen that could cause the next global health threat.
In 2020 the coronavirus disease (from the SARS-COV-2 virus strain) met the requirements to be the first Disease X.

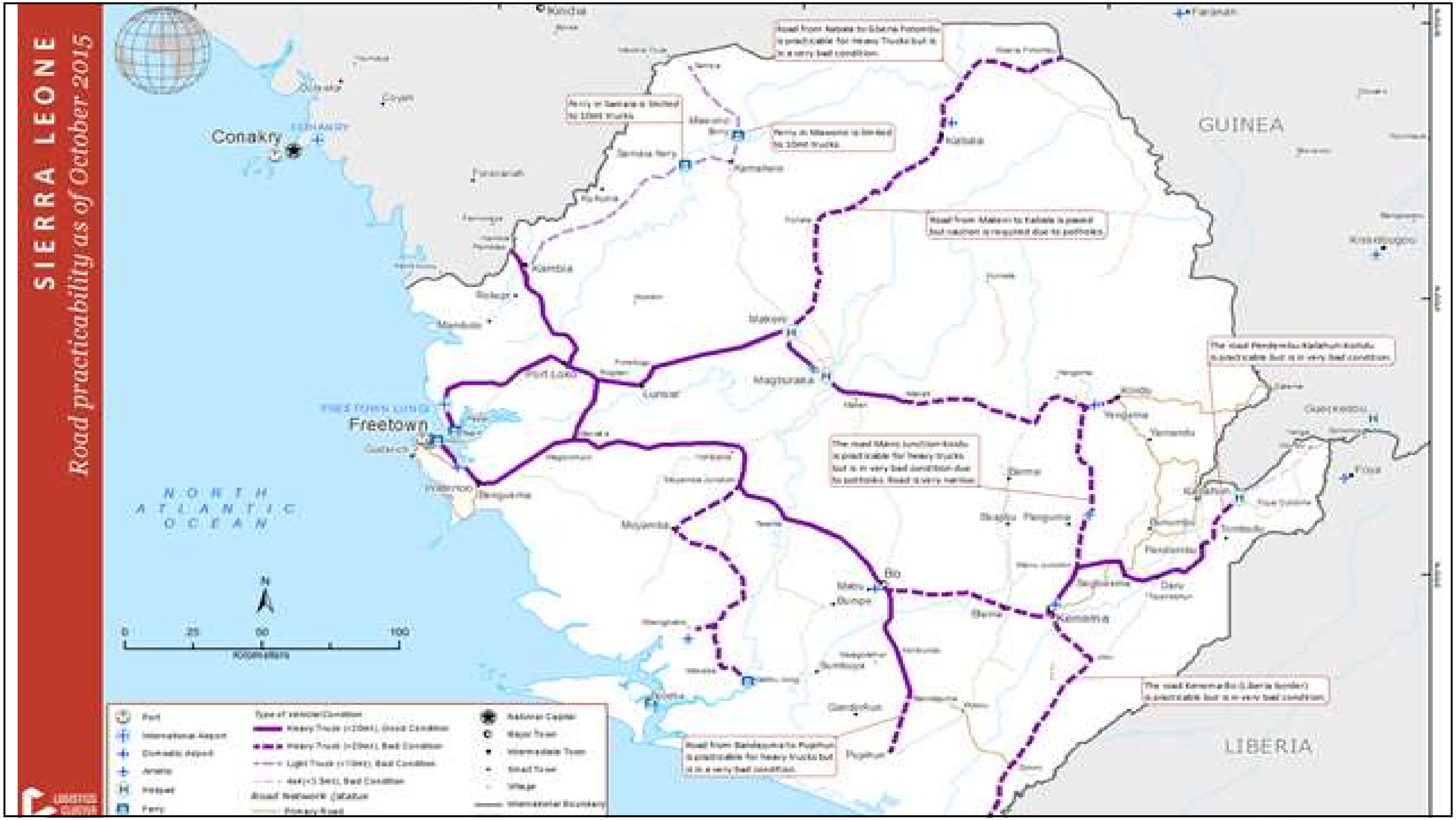
WHO 2018 shortlist of blueprint priority diseases (for future R&D)

1. Crimean-Congo haemorrhagic fever (CCHF)
2. Ebola virus disease strains and Marburg virus disease
3. Lassa fever
4. Middle East respiratory syndrome coronavirus (MERS-CoV) and Severe Acute Respiratory Syndrome (SARS)
5. Nipah and henipaviral diseases
6. Rift Valley fever (RVF)
7. Zika



KEY CHALLENGES IN THE EBOLA RESPONSE WEST AFRICA 2013-2016

UNMEER

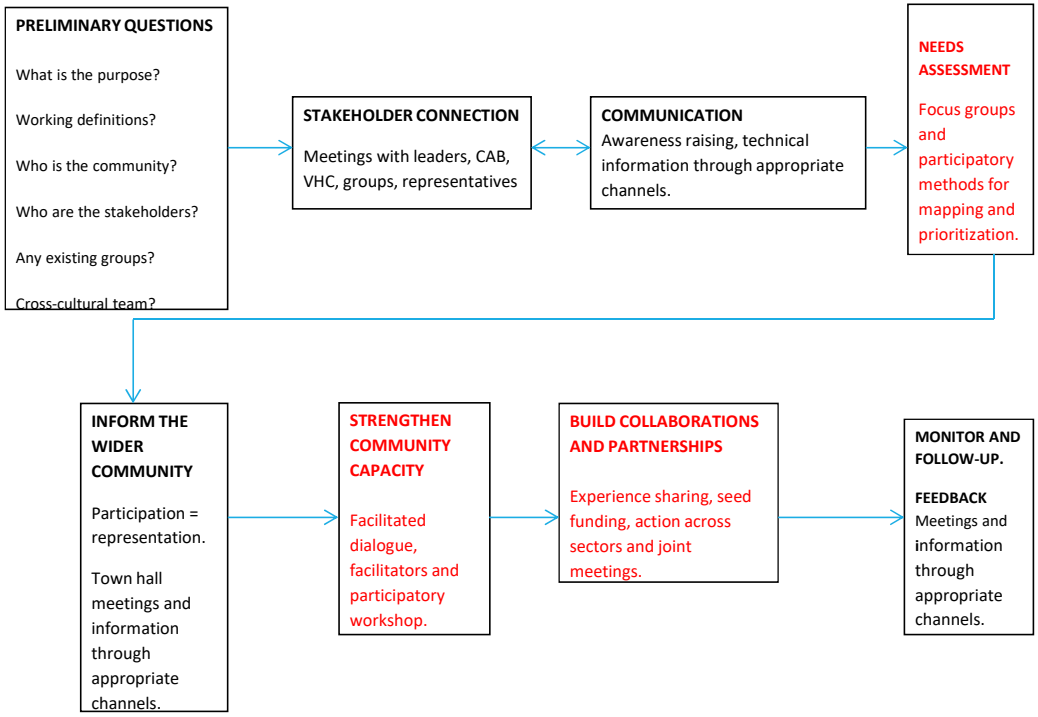

SIERRA LEONE
Road practicability as of October 2015
Conakry
Freetown
GUINEA
LIBERIA
NORTH ATLANTIC OCEAN
Kambia
Port Loko
Lunsar
Makeni
Magburaka
Kabala
Moyamba
Bo
Kenema
Pujehun
0
25
50
100

2. THE COMMUNICATION APPROACH

- A variation in the communication approach across the 3 countries:
- (SL:C4D, Liberia:SBCC, Guinea:Community Committees and radio).

- Deep seated traditional practices.
- Family and community involvement is essential
- Self-management and community control.
- Community-led quarantines.
- Community Led Ebola Response (CLEA).

3. Best practice in community engagement



4. WHAT IS THE ROLE OF ANTHROPOLOGY?

- Anthropological insights can significantly contribute to the control of disease outbreaks.
- Observed that ongoing anthropological work was not widely used in the Ebola response.
- In-depth and long-term inputs.
- Anthropology Vs Social science.
- The translation of anthropological findings into practical recommendations is necessary if it is to play a useful role.

5. COMMUNITY RESISTANCE

PEOPLE DO NOT RESIST CHANGE THEY RESIST BEING CHANGED

Non-compliant behavior was a cycle of unwillingness to change traditional practices compounded by experiences of poor service delivery and weak information flow.

Mistrust, fear and individual and community resistance.

Observed that the nature of the resistance changed overtime: less to more intensive.

Possible to map resistance using GPS.

6. A PHASED COMMUNITY APPROACH

The red phase 

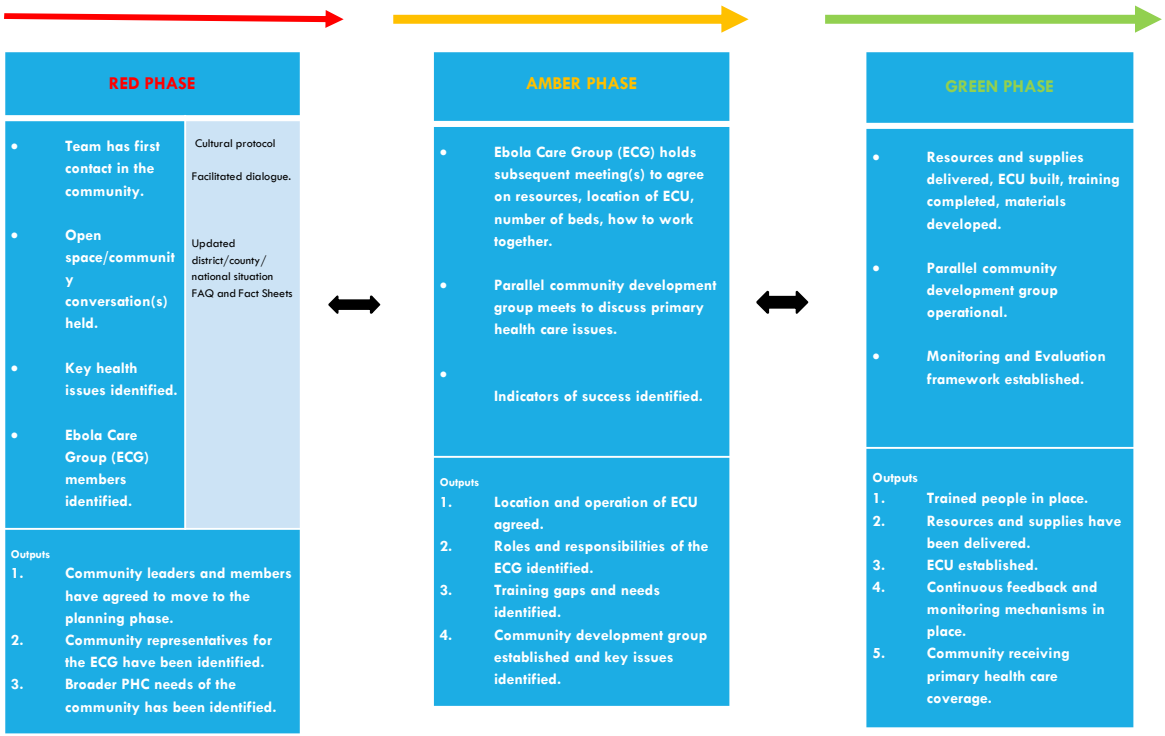
Indicates that community engagement has not yet been achieved. Personnel other than the community engagement team should not approach the community until this phase has been completed.

The amber phase 

Indicates that the community representatives have agreed to the programme to commence.

The green phase 

Indicates that the community representatives have agreed to allow all other personnel into or near to the community in order to implement the programme.


RED PHASE
Team has first contact in the community.
Open space/community conversation(s) held.
Key health issues identified.
Ebola Care Group (ECG) members identified.
Cultural protocol
Facilitated dialogue.
Updated district/county/ national situation FAQ and Fact Sheets
Outputs
1. Community leaders and members have agreed to move to the planning phase.
2. Community representatives for the ECG have been identified.
3. Broader PHC needs of the community has been identified.
AMBER PHASE
Ebola Care Group (ECG) holds subsequent meeting(s) to agree on resources, location of ECU, number of beds, how to work together.
Parallel community development group meets to discuss primary health care issues.
Indicators of success identified.
Outputs
1. Location and operation of ECU agreed.
2. Roles and responsibilities of the ECG identified.
3. Training gaps and needs identified.
4. Community development group established and key issues identified.
GREEN PHASE
Resources and supplies delivered, ECU built, training completed, materials developed.
Parallel community development group operational.
Monitoring and Evaluation framework established.
Outputs
1. Trained people in place.
2. Resources and supplies have been delivered.
3. ECU established.
4. Continuous feedback and monitoring mechanisms in place.
5. Community receiving primary health care coverage.

7. ADDRESSING RUMOURS

Continuous flow of new rumours.

Mistrust, fear, poor information flow and poor professional practices.

Directly influenced vaccination programme delivery.

Rumour identification, investigation and correction.

How to prevent rumour and resistance?

What specialist skills are required?

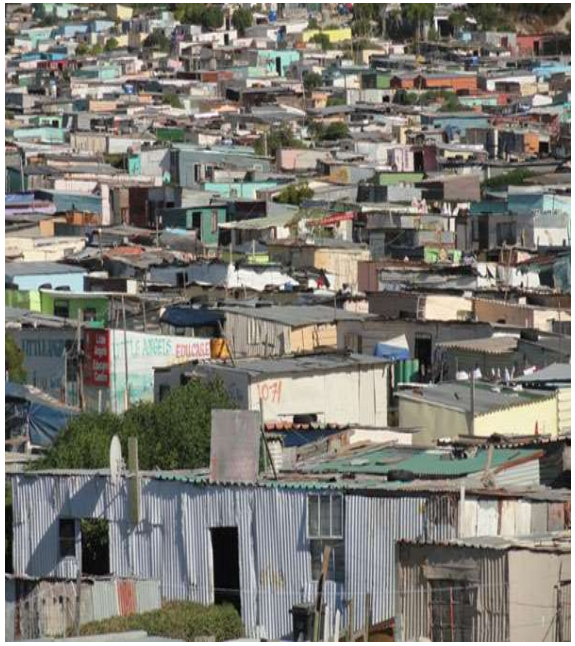
8. THE URBAN / SLUM CONTEXT

Urban and rural contexts present differently unique challenges.

An alternative strategy is needed to the established rural–based approach.

What are the requirements for community engagement and communication in densely populated slum and shanty areas?

Some areas in cities are ‘Off-limits’.



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Infectious Diseases and Immunity

Review Article

Blacker than Black: Failing to Reach Slum Communities in Disease Outbreaks

Glenn Laverack*

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Abstract

Poor economic environments and unstable living spaces, insufficient water supply, inadequate sanitation and high population density create favourable conditions for the spread of infectious diseases. Robust community engagement and communication strategies can help to raise awareness and to develop skills and are crucial to the success of an outbreak response in densely overcrowded urban conditions. Small gains have been made in an urban context and importantly a procedure to reach slum communities in a disease outbreak has not yet emerged. The purpose of this paper is to highlight the urgent need for international agencies to cooperate to develop guidelines on how to effectively reach slum communities in disease outbreaks and to make recommendations for the next steps to resolve the present situation.

Keywords: Community engagement; Disease outbreaks; Slum communities; Civil conflict; Bottom-up

Introduction

Over the past 20 years the number of disease outbreak and health emergency responses has increased. The number of international actors involved in these responses has also dramatically increased, for example, in the 2010 earthquake in Haiti and in the 2015 outbreak of the Ebola Virus Disease (EVD), several hundred international non-governmental organizations were mobilized alongside the United Nations, the government and the private sector, greatly increasing the complexity of the situation. The growing number of such events has placed pressure on the availability of funding and on expectations to quickly control the spread of a disease [1]. At the same time, there has been a realization that the goal of reaching communities through engagement and communication strategies has not succeeded, even though they are crucial to success. In particular, the overcrowded conditions in slums can create favourable factors that promote the spread of infectious and vector borne diseases. Remarkably, a standardised procedure to reach slum communities in a disease outbreak has not yet emerged. The purpose of this paper is to highlight the urgent need for international agencies to cooperate to develop guidelines on how to reach slum communities in disease outbreaks and to make recommendations on what is necessary to resolve the situation.

In this paper an outbreak refers to an increase, often sudden, in the number of cases of a disease above the endemic level in the population within a restricted geographical area or may extend over a much broader area and may last for a prolonged period of time [2]. The UN-Habitat definition of a slum household is used as, a group of individuals living under the same roof in overcrowded conditions and in an urban area who lack easy access to safe water, adequate sanitation or protection against extreme climate conditions and eviction. UN-Habitat estimates that 1.6 billion people live in a slum and in some countries. as much as 90% of the urban population live in slums [3]. Examples of locations that are prone to disease outbreaks and that have large slum populations include Conakry in Guinea, West Africa and Rio de Janeiro in Brazil.

Communities occupy a spatial dimension, such as a rural village or in an urban neighbourhood and a non-spatial dimension that involves relationships between people who can organise themselves for a variety of reasons including for a funeral or to address a shared concern such as gaining better access to safe drinking water [4]. Within the dimension of a community 'settings' offer a further context in which people engage in daily activities such as in schools. Communities and settings provide the opportunity to engage with people to raise awareness, to develop skills, to gain better access to services and protective equipment and to help to improve the physical environment in the control of the spread of an infectious disease [5].

Disease Outbreaks and Slum Communities

Poor economic environments and unstable living spaces, inadequate water supply and sanitation and high population density create favourable conditions for the spread of infectious diseases. Slum areas have poor health and social services and an outbreak response can be impeded by the resistance of the residents, some of whom may be illegally occupying their homes. Community resistance and non-compliant behaviour can be a disruptive feature of a disease outbreak by taking attention away from important issues, by dividing communities and by undermining the positions of the different stakeholders. In practice, this can result in a refusal to take part in vaccination, to report sick family members, to use protective equipment

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9. CROSS-BORDER ISSUES

'Porous international borders'.

Interwoven communities by language, ethnicity, traditions and economy.

Increased foot and bicycle traffic acting as a potential source of infection.

How best to manage: Is a systematic community management approach realistic?

10. THE FUTURE MEANS WORKING TOGETHER

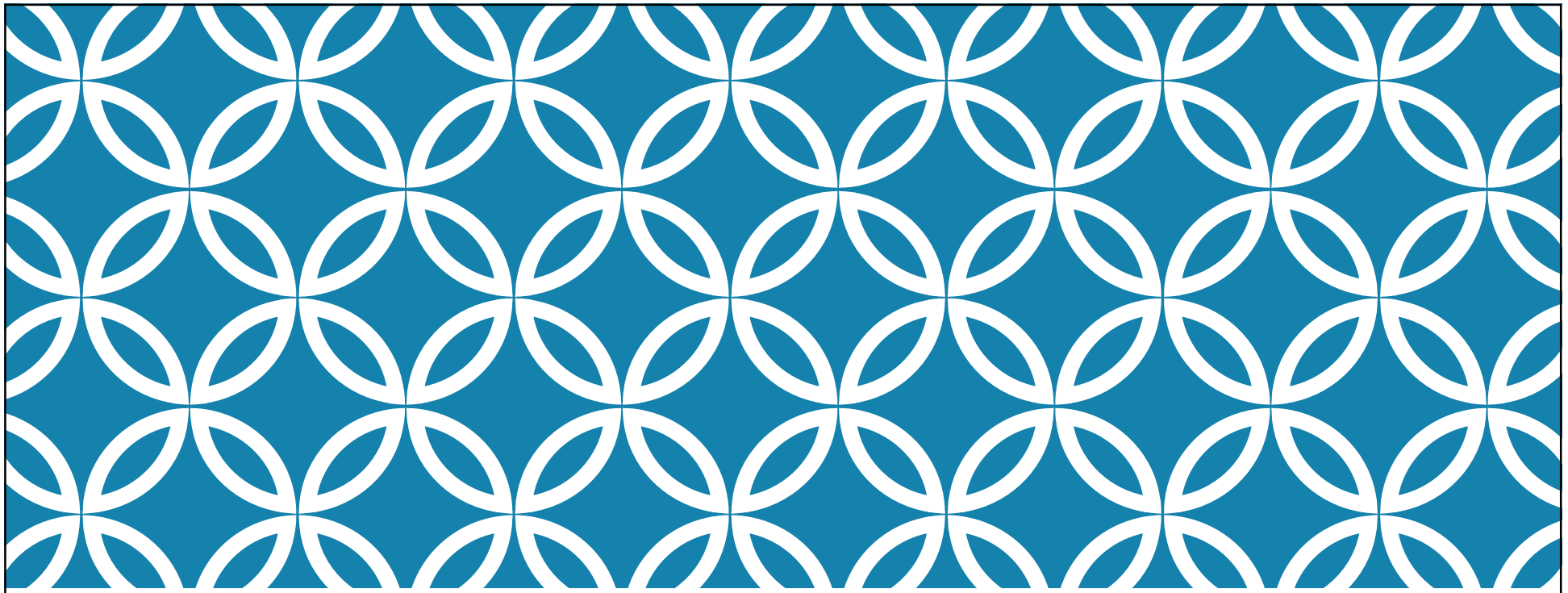
1. Think outside the ‘health box’ for creative partnerships.
2. Enable inter-sectoral work.
3. Create a supportive policy and enforcement environment. TOP-DOWN.
4. Engage with communities. BOTTOM-UP.

EXERCISE:
INDIVIDUALLY OR IN A SMALL GROUP CONSIDER THE FOLLOWING CASE STUDY

Improving face to face communication in a disease outbreak

The findings from the knowledge, attitude and practice (KAP) surveys in Liberia and Sierra Leone during the 2013-2016 Ebola outbreak showed that knowledge levels about the modes of transmission and symptoms were consistently high, often above 90%. This is an endorsement of the mass media communication approach used in the response in a combination with printed materials. The mass media approach was successful in reaching a large number of people, however, the quality and coverage of the interpersonal face to face communication at a household level was variable, sometimes carried out without sufficient discussion of the key concerns in regard to the spread of the disease or without spending any time with the household members to explain the situation. The large number of communicators that had been temporarily employed were often fearful of entering a household and had rapidly been deployed to the community level from other areas (Laverack and Manoncourt 2015).

Identify how you would improve the face to face communication at a household level between the communicator and the household members. What knowledge, skills and resources would you provide and how and to whom would these be given? Refer to the paper provided (Laverack and Manoncourt 2015) for further information.



THANK YOU