

WITH PEOPLE

Communication, Community Engagement, COVID-19, and Preparing for Future Pandemics

A Contribution to the Work of the Independent Panel for Pandemic Preparedness and Response

The Ebola outbreak taught us (again) a community engagement lesson learned many times from many health crises: *At first, the formal response to the Ebola outbreak "paid little attention to working within community structures and did not acknowledge traditional community coping strategies and influences ... Rumors and misconceptions circulated widely because community members mistrusted messaging from formal communication channels ... (this) undermined community confidence, effective social mobilization, and ultimately the response itself (The) resultant communication for development strategy involved a 2-way process for sharing ideas and knowledge ... using a range of communication tools and other approaches that are designed to empower individuals and communities to take actions to improve their lives."*¹

New Zealand has been one of the most successful anti-COVID-19 countries. It focused its communication strategy on "*spurring social change*"; "*the impact on people's daily lives and steps they could take to protect each other*"; "*Unite Against Covid-19*"; "*The aim was to trigger team spirit, not fear*"; "*to bring New Zealanders together*", and "*galvanise them to act*".² This social approach provided the essential collective action foundations for the technical messaging related to individual actions. As recent articles such as Manaakitanga³ indicate, the cultural communication roots for this are deep and need consideration in every context.

These are just two examples of many communication and community engagement lessons learned for human development, including related to pandemics.

People act

There are many thousands of COVID-19-focused communication and community engagement strategies across all countries in response to the pandemic. Just a few examples from this response include:

- ✓ Formation of Community Action Groups engaging local populations [Uttar Pradesh, India]
- ✓ One million plus calls in 3 months on the "Sehat Tahaffuz" Helpline [Pakistan]
- ✓ Podcasts; community radio programs; consultations with specialists on Facebook live [Colombia]
- ✓ Face-to-face information sharing [South, East and North East of Afghanistan]
- ✓ Live talk shows on television; telecoms sending SMS COVID-19 prevention information [Uganda]
- ✓ Discourse with multicultural leaders and networks on cultural and spiritual issues [Australia]
- ✓ Development of the social media community "Jaambaars Corona Solutions" [Senegal]
- ✓ Outreach to and conversations with migrant workers in the meat-packing industry [Ireland]
- ✓ Barrier analysis to identify the key determinants/opportunities for community engagement [Democratic Republic of the Congo (DRC)]
- ✓ Engagement of local media partners in journalism workshops on reporting COVID-19 [many countries]
- ✓ Door-to-door visits using theatre groups to reach households [Malawi]
- ✓ Support to the Black Coalition Against COVID-19, with a focus on healthcare workers and equity [USA]
- ✓ Partnership with Transvanilla - health information for the trans community [Hungary]
- ✓ Work with favela activists building an independent panel to share consolidated data [Brazil]
- ✓ The Aarogya Setu app - source of easy-to-access information for the common people [India]
- ✓ Focus on Black vaccination pioneers as counter to the dominant narrative on race and COVID-19 [USA]

¹ Social Mobilization and Community Engagement Central to the Ebola Response in West Africa: Lessons for Future Public Health Emergencies
<https://www.cominit.com/global/content/social-mobilization-and-community-engagement-central-ebola-response-west-africa-lessons->

² Words Matter: How New Zealand's Clear Messaging Helped Beat Covid
https://www.theguardian.com/world/2021/feb/26/words-matter-how-new-zealands-clear-messaging-helped-beat-covid?CMP=Share_iOSApp_Other

³ The Indigenous Custom behind New Zealand's Strong COVID-19 Response
<https://www.washingtonpost.com/opinions/2021/03/11/new-zealand-covid-19-maori-indigenous-manaakitanga/>

- ✓ The public utilities company databases made available for SMS messaging [Medellin, Colombia]
- ✓ Awareness campaigns in markets and a popular TV show ("Corona Solutions") [Senegal]
- ✓ Conversations with people collecting their milk every morning in milk collection sites [Cuba]
- ✓ Social and behaviour change strategies with community media [DRC]
- ✓ "What's Your Story" sharing and networking platform [South Africa]
- ✓ Trained drama groups to work in hotspot districts [Malawi]
- ✓ Creation of a Day to Mobilize for the Fight against COVID-19 in the Favelas [Rio de Janeiro, Brazil]
- ✓ Dialogue through griots, animation, community relays, capsules in local languages [North Kivu, DRC]
- ✓ Community information centers often housed in people's homes in low connectivity areas or shops outfitted with microphones and loudspeakers to enable citizens around the community to hear crucial announcements [Ghana]
- ✓ Efforts that piggy-back on the city policy of supporting popular culture, arts, youth engagement [Medellin]
- ✓ "Arrar Hota" (Our Voice) radio programme produced by locals in Palongkhali Union [Bangladesh]

Despite the scale reached and the impact that resulted, conducting communication and community action work in the context of a pandemic has proved a struggle. The communication and community engagement perspective and learning, with the important analysis it provides, is often missing from the strategy. Policy and financial support are often weak.

People (should) rule

Pandemics are all about people. Their survival, health, welfare, future, and overall wellbeing are the reason we fight pandemics. An effective pandemic response requires people and their communities to be central actors in the action to prepare for and counter the pandemic threat. With 7-billion-plus people affected in any global pandemic, that action is required across a very broad stage.

Community engagement and communication strategies are essential for that people-focused, large-scale response. If people are not engaged in their communities, workplaces, homes, and countries, then successful pandemic preparation and response are impossible. Communication is essential for that engagement. This necessity applies and is amplified when a technology is involved - for example, vaccines. The technologies underperform if people resist use, do not provide the social permission and agreement that is essential for widespread uptake, or are just unavailable - as is the case with vaccines and digital technologies in far too many fragile contexts.

The overwhelming strength and consequent stress of a pandemic throws powerful searchlights on the structural forces that discriminate. In almost every country, COVID-19 infection and death rates are much higher in economically poor, minority ethnic and language communities - First Nations in Canada, the Black community in the United States, Roma communities in Europe, and so many more. Gender disparities and prejudices are accentuated as domestic violence, discrimination against women in the workforce, unsafe abortions, poor menstrual health, and other gender dynamics are exposed and worsen. Whilst many people will lose jobs and income in a pandemic, others will further boost their significant wealth. If you are a low-pay service worker who has to physically go to work (for example, transport workers) then you place yourself at serious risk ... whilst those who are able to do their jobs from home (often higher paid) can ensure their safety and still earn a living. School meals are vital for the nutritional status of many children - and yet schools closed for long periods of time. Cash transfers from expatriate communities in Northern countries dry up as economies crash. Poverty rates worsen in many of the poorest countries in the South. Digital access varies greatly - for example, by wealth and rural/urban divides.

These and other structural and inequitable forces both drive the nature of a pandemic and highlight the necessity of communication and community engagement for a deep response to future pandemics.

The people focus in a pandemic almost automatically turns to what individuals can and should do. In the case of COVID-19, that involves physical distancing, mask wearing, and hand and surface cleaning. These

behaviours are of major importance. But it is a big struggle to get people to undertake these actions at the scale required. Emotional and/or uninformed reactions are the reasons often used by policymakers for why people do not follow the rules. But these challenges have cultural, economic, and social roots that need to be attended to and worked with for effective pandemic response and preparation.

A large percentage of the world's people live in cramped housing conditions. For far too many people, if they do not work they do not eat. Very high numbers of people are in the "informal" workforce and so lack the securities that come with formal employment. Close physical contact - from hugs to mealtimes - is an embedded way of life in many cultures. Asking people to practice physical distance within a society that is collectivist in nature has an implication on people understanding and acting on the information they are receiving. Raising and caring for children in many cultures is a broad community and extended family role and responsibility. Migrant workers share close living and working conditions. For young people, the need to be social outweighs the calls to stay apart, as they feel strong frustration and come to view themselves as the forgotten ones. In most countries, there are low baseline levels of health and science literacy.

These are just a few drops of oxygen and hydrogen in the cultural, economic, and social ocean that has to be sailed in any pandemic response and preparation.

In every pandemic, people provide impact. Though the credit often goes to technical experts (epidemiologists, virologists, engineers, etc.), with some recognition of message-driven campaigns, it is the communication and community engagement strategies of the people most affected that have real effect. The early **HIV/AIDS** prevention data from Uganda were highly positive due to a successful community engagement strategy - a trend that went into reverse as the strategy became more technical. The expert-driven response to **Ebola** (don hazmat suits, walk into houses, extract bodies, burn the bodies) accelerated infection rates in many countries as it bulldozed over local customs for handling death. People found a way to resist so they could implement their cultural practices, which of course led to a spike in infections. Only when those practices were recognised and worked with was progress made. Ask the **polio** community what happened when people in some of the economically poorest communities in the world (northern Nigeria and northern India) used communication and community engagement strategies to organise mass boycotts in the early 2000s. This dynamic took up to 15 years to reverse through a strategy that involved learning from those communities to focus on community organisation, networks, and local mapping. When there are major **conflict** situations (for example, Colombia and DRC recently), people are all we have to rely on to resolve the issues and move forward. Back to **HIV/AIDS**, who doubts the crucial impact of people living with HIV/AIDS (PLWHA) networks and the gay rights social movement?

People have been crucial in every pandemic response.

The data back this up. Here are just a few examples of credible, at-scale, development issue change research data from communication and community engagement strategies: **1.78 times more likely** to use a modern family planning method; **47% of viewers** with ability to name a development-related action they had taken; **11.6 percentile** educational gain; **1.38 times more likely** to remain uninfected from HIV; a very **low (0.142%) propensity to refuse** oral polio vaccine (OPV); **5.5% increase** in relief expenditures; public funds captured by **corruption down 60%**; **72% increase in girls** having their own savings; **24.6% improvement** in minimum dietary diversity, minimum meal frequency, minimum acceptable diet, and consumption of iron-rich foods; **decline in homicide rates of 66%**; **20% reduction in maternal mortality**; improvement in seat belt use, oral health, alcohol consumption, smoking, and mammogram screening by **r.15 to r.04**. (See Appendix A below for further details and links.)

The direct, positive impact of communication and community engagement strategies is compellingly demonstrated.

Stories from the COVID-19 crisis further illuminate in the starkest terms the requirement for communication and community engagement to be central elements of any pandemic response. In India (and elsewhere), the lockdown forced women and children to stay in abusive homes, thus increasing the risk to both their health and

lives. They were cut off from any kind of external support with neighbours, friends, or extended families. In the DRC, COVID-19 was seen as the white man illness created by white people, requiring divine punishment and viewed as a strategy to reduce high population numbers in the world. In Nigeria, many religious, community, and traditional leaders promoted fake news, conspiracy theories, and unsupported healing methods with claims to have powers, cures, divine authority, and "corrosive anointing". A large section of the Nigerian media bought into this frenzy. In Australia, there was greater reluctance by right-wing voters to be vaccinated, making COVID-19 a political issue. In Zambia, COVID-19 was a Chinese and then a European disease and then a foreign invasion. In the USA, there is a perspective that the Black community has shown reluctance related to vaccines given the experience of a discriminatory health system and past negative experiences with early vaccine testing. In Lebanon, a very practical question is asked: How can a refugee in an informal settlement abide by the message of frequent hand washing? In Colombia, COVID-19 became entwined with the often highly contentious peace process, including the post-conflict and transitional justice debates where public confidence in the government institutions and communications that are so important for an effective response has diminished.

There is no vaccine for these and a myriad of other people-related dynamics. Communication and community engagement strategies are not just required; they are essential.

People support

As we have seen, communities, individuals, civil society organisations, and the communication and community engagement field of work did respond at considerable scale to the COVID-19 crisis. They took on the immediate presenting issues – masks, hands, distance, and surfaces. But they also took on the hard issues, the fertile ground that we have created for pandemics to thrive and spread - inequity, marginalised populations, gender discrimination, policymaker accountability, the need to amplify the voices of the most affected, racial justice, accurate information to counter misinformation, and so much more.

Effective international and national pandemic action (including preparation) requires:

- ❖ The development of policies that create the best possible spaces for effective action;
- ❖ A prominence for the voice, learning, and perspective of those most affected;
- ❖ The provision of accurate information that is clearly updated as that information changes;
- ❖ Regular, independent, data-driven feedback on the progress (or lack thereof) being made; and
- ❖ Financial and technical support that is at levels commensurate with the problems and challenges being faced.

During our March 2021 consultation, we shared our experiences with and assessment of the COVID-19 communication and community engagement performance of government and major international organisations. Please note that this is a compilation of our contributions. As our experiences differed from context to context, not all of the critiques are agreed upon and endorsed by all contributors.

On the **positive side**, there is feedback such as:

- "We can be proud of the global leadership provided by WHO, UNICEF, the UN as a whole, especially given the shocking turn against multilateral cooperation over the past four years."
- "Supported by strong, multichannel communication, the UN system and its allies have held their ground by upholding the primacy of science and facts, and highlighting the imperative of solidarity to defeat a truly global foe."
- "Strong WHO and RCCE [risk communication and community engagement] commitment in many contexts to generating and sharing audience insight."
- "Effective co-ordination mechanisms in many settings – but sometimes assuming that implementation can follow 'tool-making' and guidance in settings where resourcing is not available for localisation and two-way engagement."

- "One excellent response is the People's Vaccine campaign with leadership from UNAIDS, Oxfam, Amnesty International, Open Society Foundations and others." <https://peoplesvaccine.org/>
- "Found the daily updates and fielding questions and answers on TV by the British political team very useful. There was robust debate and questions from ordinary people as well as from journalists."
- "I was impressed by the COVAX initiative and the AU initiatives."
- "It seems to have focused the world a bit on international inequalities and the TRIPS [Trade-Related Aspects of Intellectual Property Rights] issues."
- "Organizations like WHO/OMS, thru PAHO/OPS in our case, are very effective as long as they partner strategically with national, regional and local government/ decision makers."
- "WHO is very well respected and has had a very high profile at the national level debate during the pandemic."
- "Strong articulation of UN System is seen via UNDP, particularly UNICEF / UNFPA / UN Women / WFP."
- "That said, the government appears to have collaborated extensively with these partners, but communication was quite sporadic."
- "The role of COVAX in relation to the availability of vaccines to Africa is positive."
- "WHO, through GOARN [Global Outbreak Alert and Response Network] took center stage in coordinating the global actors, with a place to share information and tools and to help guide a more coordinated response."
- "The Collective Service [for Risk Communication and Community Engagement] was established and has been offering a useful set of guidance and tools though it seems that it took a bit of time to get organized - there was a lot of lesson learning in the process."

Some of the more **negative assessments** include:

- "SOs (social organisations) were not involved in the planning or implementation of community engagement responses of international and regional organizations."
- "The difficulty WHO experienced trying to convince leading politicians in States who pursued isolated policies perhaps to distract their populations."
- "Community-based organisations may have been left out, ignored, or the community-based organisations sensed themselves as irrelevant."
- "Lack of preparedness to deal with the massive information and communication crisis created by the pandemic. "
- "The discussion about the inequality of vaccine distribution seemed to come very late - it was surely predictable?"
- "Low WHO credibility as a result of the global role of the agency."
- "Poor national outbreak/containment communication; limited coordination among development agencies for COVID communication and community engagement."
- "Challenge lies in getting to the grassroots. The formulators of the messages should help facilitate the process of framing those messages into culturally understood images, communications and African traditional frames. As an example for now, in many villages, COVID is considered an urban disease. I got this response when I asked one person why he was not wearing a mask at a tradition meeting: "That is the disease for you people in Lusaka. There is nothing like that here."
- "Technical lead for health education and communication not clear among the various development agencies."
- "Leadership for communication, mobilization and communication was not well resolved in a timely manner."
- "Lack of surge capacity to support communication response and community engagement."
- "Existing communication and mobilisation systems and structures were unprepared and overwhelmed."
- "The response of WHO passes through States' policies but WHO has no power to correct these policies."
- "WHO does not seem to have any power to constrain coercive measures that States may take to lead their populations astray."

- "Failure to strategically apply evidence-based lessons and innovative solutions from several years of health communication interventions in the country."
- "Science-based communication and messaging are neither creative nor implemented at enough scale for different population segments, including young people."
- "International agencies and NGOs [non-governmental organizations] engaged with the media in a patchy and fragmented way."
- "A strategic communication playbook to guide the overall mobilisation response was lacking."
- "One of the challenges that we faced was the complexity of information being presented on the WHO and CDC websites - needed to translate these guidelines into more simple terms and concepts to make use of the information."
- "Agencies were unprepared to communicate the complex and evolving nature of the pandemic."
- "Humility, listening, sharing experiences, innovating, learning from failures, cooperating instead of competing... are key practices and intentions that are needed more than ever."
- "At the current moment, it's disappointing for example to see COVAX roll-out plans that focus solely on the supply side, leaving demand as an afterthought despite the fact that significant portions of populations are either anti-vax or hesitant about receive the shot."
- "Social and Behaviour Change Communication needs to be integrated into national plans and budgets, and sustained."
- "We are once again building the plane to take off and as we fly... next time we may not have time to build anything that can even take off."
- "The shortage of funding."
- "Interventions were too short and most interventions were only funded for 3-5 months."
- "WHO website not as accessible as it should be for varying level of users (scientific community/communication and program practitioners/general public)."
- "The national media mix was not planned resulting in duplication of messages and interventions."
- "Use of Media products that had very little SBCC [social and behaviour change communication] value causing information fatigue amongst consumers (listeners and viewers)."
- "Although awareness was very high comprehensive knowledge was very low resulting in very high stigma, discrimination and conflict between health workers and community members."
- "Although International organizations have provided technical support to governments they have not come with innovative ways to provide this assistance especially within countries/states with political complexities and uncertainty."
- "Some RCCE co-ordination of lower quality - meetings long, didactic, short on diversity - leading to limited engagement."
- "No well-developed mechanism/emphasis to actively engage media as partners globally."
- "Local efforts can fail to engage media effectively due to limited understanding of media dynamics, needs and incentives."
- "I think the Afro [WHO African] region came late to the party."
- "The reaction has been slow and very hesitant, as it has been everywhere."
- "A lot of information was circulated about significant funding, but coordination of these efforts did not seem to be effective."
- "Do global organisations understand the South African media landscape? Understanding our diversity is key to delivering effective campaigns. "

Draft recommendations for discussion

Flowing from the analysis above, a draft set of recommendations follow for consideration by the Independent Panel. These are designed to address and take major steps towards five major themes that emerged in the consultation:

1. Strengthening the engagement of local communities as key actors in pandemic planning and action related to their contexts – pandemic action.
2. Strengthening the ability of people and communities to identify, understand, analyse, interpret, and communicate about pandemics – pandemic literacy.

3. Strengthening the communication and community engagement capacity of the UN system to plan and respond to pandemics – pandemic policies and support.
4. Clarifying the coordination roles and relationships amongst and between UN agencies in pandemic planning and action situations – pandemic coordination.
5. Significantly increasing the funding available for local, national, and international communication and community engagement action related to pandemics – pandemic funding.

As indicated above, these recommendations are presented as starters for discussion. No organisation has formally signed off on these suggestions. There are no formal commitments. However, we wanted to present to the Panel some specific, high-level ideas for your consideration. We would welcome further discussion, using these suggestions as a starting point for working towards the communication- and community-engagement-related recommendations that will be presented to the World Health Assembly.

Draft recommendation 1: That within 5 years, 90% of all communities over 20,000 in population will be able to (a) identify the lead local focal point person for pandemic preparation, (b) list the local government and civil society organisations engaged in pandemic preparation, and (c) outline the major elements of their strategy.

Rationale:

- a. As demonstrated above, local action is essential both for comprehensive coverage and to ensure relevance to and resonance with the local context.
- b. In any endeavour, including pandemics, it is always good to know who is responsible and who is involved.
- c. At national and international levels, policies and strategies can be improved based on the real-life local insights and ideas provided from local plans.
- d. Having a goal and strategy such as this puts a measurable and responsive process in place.
- e. Governments, funders, and technical support organisations will know with whom to relate.
- f. This ensures a locally led process.

Draft recommendation 2: That in any new national pandemic taskforces that are established or in existing national pandemic planning and coordination bodies, 25% of the membership in the core policy and budgeting processes are people from local communities and communication and community engagement practitioners.

Rationale:

- a. Who is at a policy and budgeting "table" has a direct effect on the nature of both the analysis of a situation and the decisions that are made, including the allocation of resources.
- b. Too often, the local community, communication and community engagement perspective, experience, and insight has been missing from those "tables".
- c. This fact reflects the predominant view of people and communities as "targets" and communication and community engagement as a "support" process to the real action.
- d. As seen above, that is an incorrect view and one that weakens the pandemic preparation process and response action.
- e. It is vitally important that the local community, communication and community engagement perspective, experience, and insight are at the table.

Draft recommendation 3: That a major self-standing fund with a target of 1 billion dollars is established to provide direct support for communication and community engagement pandemic planning and action, with local action and planning a priority.

Rationale:

- a. The analysis and action insights above demonstrate the essential importance of communication and community engagement strategies for effective pandemic planning and response.
- b. Effective pandemic planning and response needs to be fully in tune with the local and national social landscape.
- c. Though there is significant communication and community engagement action, the potential impact is not maximised due to the absence of policy focus and financial support.
- d. There is a clear imbalance at present in the generation of resources for medical science strategies (many billions of dollars) and the people-driven response (very little funding). This needs to be corrected for the balanced approach that is required, as outlined above.
- e. Any funds generated and funds established would have to prioritise direct support to local and national action in the global South. There are too many examples of large funds expending primarily on Northern initiatives.
- f. Specific support would be provided for the formation of Community Action Groups that engage all communities, with a priority to include marginalised populations.
- g. There are funds and foundations that could be classified as providing this role and source – for example, GAVI and the Gates Foundation. However, they are heavily biased towards medical sciences and technologies.
- h. A global fund for communication and community engagement would send a clear signal to governments and other funders that this is a major strategic priority – leading to further investment.
- i. Further, more detailed input can be provided on the scope and nature of such a fund.

Draft recommendation 4: That within the UN system, a body is created that has the clear lead role for communication and community engagement related to pandemics with a remit that includes global and regional coordination of all relevant UN entities. Our preference is for a body that sits independent from any one UN entity.

Rationale:

1. Many UN entities can claim a lead role in relation to a pandemic - WHO on the basis of the health elements, UNICEF for the children-related elements, UN Women for the gender dimensions, the World Bank because of the economic implications, World Food Programme related to food supply and nutrition, UNESCO when the pandemic is viewed through an education lens, FAO because of the agriculture and rural development aspects, UNEP as there will undoubtedly be environmental implications, IMO due to the immigration issues that can be central to any pandemic – and many more.
2. To one degree or another, all the organisations above, and others, have relevant communication and community engagement capacities.
3. There are some promising initiatives for cross-organisational collaboration involving the UN and civil society organisations. For example, the "Collective Service for Risk Communication and Community Engagement" provides an experience from which to learn and possibly work. In addition, we understand that there is a new team being established to address "infodemics management" – the learning from that will also be important.
4. Quick and timely regional coordination is vitally important – some regions have been identified as having a slow response to COVID-19, including on communication and community engagement requirements.
5. Though there has been a focus on WHO as the lead in this pandemic, in terms of the communication and community engagement role, we would welcome a further discussion on that determination, and we recommend that a decision is not made without considerable assessment.
6. The essential DNA of WHO is medical science. For many years, it has struggled against that organisational norm and culture when seeking to place a social sciences perspective and analysis at the centre of its decision-making. This includes communication and community engagement action that is directly focused on health issues. It was this dynamic that led to: the creation of UNAIDS; the failure to

recognise the threat to global polio eradication from communities in northern Nigeria and northern India; and the mistaken initial response to Ebola (to name just three examples).

7. Hence, our raising as a possibility for discussion a body that is independent from any one UN entity with a clear mandate from the Secretary General and ECOSOC to harness all their capacities in a coordinated manner at global and regional levels.

Draft recommendation 5: That there is a high priority focus across all development organisations on the provision of accurate information about pandemics and greatly expanded community- and national-level dialogue about that knowledge.

Rationale:

1. There is a pressing need for people to be much better informed and literate on key pandemic issues and the nature of effective responses.
2. Regional and global policies and strategies will have greater resonance and effectiveness if that knowledge is subject to critical review and dialogue with people in national and local contexts – a key process for literacy.
3. The knowledge will be even more pertinent and useful if locally and nationally generated knowledge is also reviewed at regional and global levels.
4. High-priority, at-scale action for pandemic literacy will help to refine the "infodemic" strategy and priorities as both (a) what constitutes essential knowledge is tested and refined in real situations and (b) some of the key questions about the "infodemic" approach are addressed – e.g., who decides and in what contexts what is core information and what is superfluous.
5. This approach and strategy provides a major connection point for relationships with local, regional, global, and social media in all forms.

With many thanks for considering this analysis and the ideas above. We would welcome future discussions as you move towards finalising your recommendations to the World Health Assembly.

Wishing you much strength for your very important work.

Please note: This contribution to the work of the Independent Panel for Pandemic Preparedness and Response is the collective effort of the following people. It does not represent the formal views of their organisations. As with any joint paper produced in a short time frame, there is no guarantee that all the detailed text above is 100% endorsed by all the people and organisations below.

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Appendix A: The Impact Data (a selection)

Communication and community engagement are often criticised for not being able to produce impact data. That is wrong. We have compiled a selection of compelling research-derived evidence for direct impact on key development priorities. [The strategies being researched and the research methodologies used are in brackets.]

- ✓ [1.78 times more likely to use a modern family planning method](#) [Community dialogue; spousal communication; gender dynamics; cross-sectional household surveys at baseline and end-line; Kenya]
- ✓ [47% of viewers with ability to name a development-related action they had taken](#) [Resilience; community connection; television programming; radio discussion; quantitative surveys combined with qualitative research; Bangladesh and Tanzania]
- ✓ [11.6 percentile educational gain](#) [Early child education; early child development; entertainment-education; research-driven action; meta-analysis of 24 studies; multiple countries in South and North]

- ✓ [1.38 times more likely to remain uninfected from HIV](#) [Condom use at sexual debut; communication campaigns; entertainment; multi-stage disproportionate, stratified sampling; South Africa]
- ✓ [A very low \(0.142%\) propensity to refuse oral polio vaccine \(OPV\)](#) [Participation in community meetings; women involvement; local non-governmental organisation (NGO) engagement; qualitative comparative analysis (adapted); Nigeria]
- ✓ [5.5% increase in relief expenditures](#) [Local radio; local language; public accountability; media development; panel data regressions for states and years; India]
- ✓ [Public funds captured by corruption down 60%](#) [Democratisation of knowledge; community organisation; local media networks; repeat public expenditure tracking survey; Uganda]
- ✓ [72% increase in girls having their own savings](#) [Economic empowerment; peer-led platforms; critical dialogue; gender perspectives; baseline and endline survey data; Ethiopia]
- ✓ [24.6 percentage points \(improvement\) for minimum dietary diversity, minimum meal frequency, minimum acceptable diet, and consumption of iron-rich foods](#) [Intensified interpersonal counselling; mass media engagement; community mobilisation; mother-to-mother support groups; randomised controlled trial; Bangladesh]
- ✓ [Improved gender attitudes by 0.2 standard deviations ... programme participants report more gender-equitable behaviour](#) [Participatory classroom sessions; community mobilisation in schools; use of media tools; folk art; randomised controlled trial; India]
- ✓ [Decline in homicide rates of 66%](#) [Municipal investment; neighbourhood infrastructure; participative municipal budgeting; creation of public spaces; permutation tests to estimate differential change; Colombia]
- ✓ [20% reduction in maternal mortality](#) [Participatory women's groups; community mobilisation; systematic review and meta-analysis of randomised controlled trials; Bangladesh, India, Malawi, Nepal]
- ✓ [Improvement in seat belt use, oral health, alcohol consumption, smoking and mammogram screening by r.15 to r.04](#) [Mediated health campaigns; behaviour change; meta-analysis of existing studies; United States]