

# LEARNING FROM EACH OTHER: WHERE HEALTH PROMOTION MEETS INFECTIOUS DISEASES

By: Erik C. Ruland, Irina Dinca, Valerie Curtis, Margaret M. Barry, Karl Ekdahl and Aura Timen

**Summary:** Communicable disease control can benefit from the transfer of knowledge on health promotion. Behaviour change interventions are more effective if they incorporate recent insights on formative research and emotional drivers. By mapping current health communication activities in Europe, a range of perceived needs and a wealth of opportunities emerged. Furthermore, successful interventions in non-communicable disease have shown that political commitment is essential to develop public health policies. In order to get these policies adopted, health professionals need to develop vision, strategy and effective action. As public health budgets are limited 'smart collaboration initiatives' are needed to drive capacity development.

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## Introduction

In order to achieve behaviour change that prevents the acquisition and further spread of infectious disease, one should look at opportunities to improve health promotion and health communication. Taking the perspective of professionals in infectious disease control, this article examines: a new approach in behaviour change; improving health communication for communicable diseases in the European Union (EU); and the observation that policies are more powerful than pills\*.

\* These topics were presented at the 7th European Public Health (EPH) Conference by Dr. Valerie Curtis, Professor Margaret Barry and Professor Simon Capewell, respectively.

## A new approach: Behaviour-Centred Design

Human behaviour is one of the major factors that underlie the emergence and spread of infectious pathogens and as such, represents a key target for developing strategies to combat diseases.<sup>1</sup> Many programmes on infectious disease control involve behaviour change interventions and employ a variety of theoretical models. These tend to focus on rational drivers of behaviour, beliefs and social influences. By contrast, the innovative Behaviour-Centred Design (BCD) approach seeks powerful emotional levers to change behaviour.<sup>2 3</sup>

BCD draws on a classification of fifteen basic motives for human behaviour derived from evolutionary and environmental psychology and neuroscience (see Figure 1). It also seeks to understand how routine and habitual behaviour is embedded in the social and physical settings in which it takes place. Having developed a theory of change for target behaviours, the BCD then uses commercial creative processes to develop innovative interventions. Key lessons are that practitioners need to better understand behaviour through formative research, to use the tools of marketing to optimise interventions and above all, to ensure that interventions are new, creative and surprising, otherwise behaviour will not change.

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Figure 1 shows the fifteen human motives. One or several of these can provide the motives for a change in behaviour. For example, formative research for the SuperAmma-project in India identified that key drivers of handwashing with soap in rural mothers were likely to be: disgust of contaminated hands, affiliation (the desire to adhere to local norms of behaviour) and nurture, where mothers cared about instilling good manners in their children.<sup>5</sup> Working with a local creative agency, the intervention team designed an intervention that used a highly emotional cartoon film, skits about disgusting hands and pledges made in public places.<sup>6</sup> A randomised controlled trial of the intervention showed much better results than similar interventions based on education about only handwashing (see Figure 2).<sup>8</sup>

BCD has been used to change a variety of behaviours, including handwashing, in several countries, food hygiene in Nepal, exercise in Ireland and nutrition practices in Indonesia. It is also being used to improve environmental sanitation in Vietnam and for diarrhoeal disease

control in Zambia. Experience has shown that many of the drivers of disease-related behaviour are not, in fact, health-related and that these drivers are often universal, hence applicable to many different populations. Rather than emphasising the negative effects of becoming infected with an infectious agent and the risk of complications, it emphasises the emotional benefits of behaviour.

### Improving health communication for communicable diseases

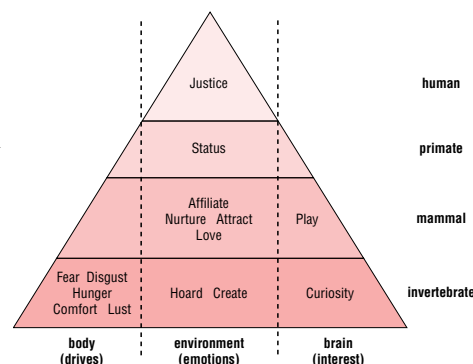
From the new insights formulated in relation to behaviour change interventions, it is a logical step to the more general question: how can the experiences in health communication and health promotion be captured and transferred to communicable diseases?

A consortium of universities from Ireland, Scotland and Spain addressed this question in the Translating Health Communication Project, which ran from 2009-2012. This programme conducted a series of evidence reviews in key areas, mapped current use of health communication activities in the EU/EEA countries, identified perceived needs among key stakeholders, and consolidated the findings in a SWOC-analysis (strengths, weakness, opportunities, challenges).<sup>9</sup>

The study identified a number of key strengths and gaps in the current European evidence base for health communication and communicable diseases. A major strength identified is that during the past decades, a body of knowledge concerning theoretical models and concepts has emerged, including health literacy, health advocacy and promotion of immunisation uptake and behaviour change.

Nevertheless, the level of use of health communication varies considerably between disease groups and between countries, with activities in the areas of HIV/AIDS and vaccine preventable diseases tending to be more sophisticated than influenza and non-HIV/-STIs. There is still limited consensus about concepts related to social marketing, health information-seeking, risk communication, campaign evaluation, trust and reputation management. Furthermore, the specific

**Figure 1:** A new model for determinants of human behaviour: classifying emotional drivers, based on the evolution of the human brain

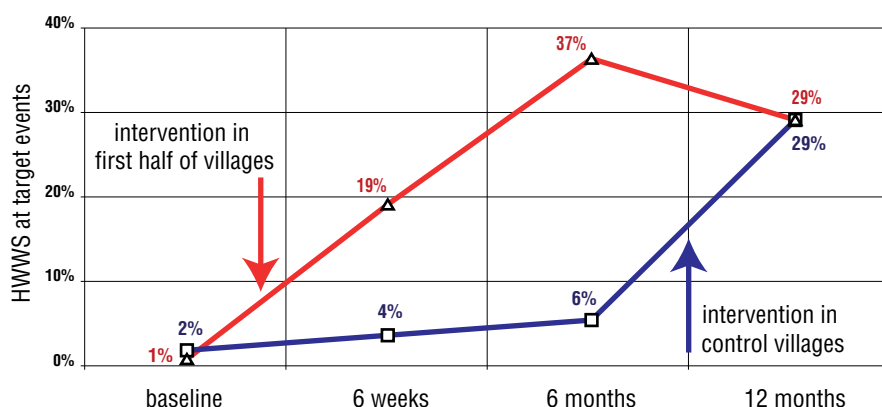


Source: <sup>4</sup>

needs of disadvantaged and hard-to-reach populations are poorly represented in current research.

Enhanced collaboration and building communities of practice around professional networks are needed among those working in the area of health communication and communicable diseases in the region. A shared online interactive health communication resource/platform for the prevention and control of communicable diseases could function as a facilitator of this collaboration. Furthermore, attention should go to the use of new media and investments in formative research and audience segmentation. Keys to success remain the existence of dedicated national budgets and plans and enhancement of education, training and research in health communication.

Consequently, crucial recommendations for capacity development at different levels are required. At the organisational level, health communication should be incorporated into planning and implementation of all public health policies; capacity would be improved by enhanced collaboration between health promotion and health communication. Within Public Health Authorities or Ministries of Health, clear lines of responsibility for communication should be developed, and future communication should include a focus on reducing disparities and inequities. Concerning financial resources, dedicated budgets and

**Figure 2: Results of the SuperAmma evaluation study**Source: <sup>8</sup>

a greater use of evaluation, including cost-effectiveness, would equip policymakers with the relevant evidence.

Concerning practice and research, a greater synergy needs to be fostered to facilitate transnational and transdisciplinary approaches, which could potentially limit costs. Scientists and practitioners should utilise more citizen-centred approaches to promote social dialogue and help build public trust.

“investments in formative research and audience segmentation

Thirdly, at the knowledge management level it is recommended to focus efforts on strengthening the evidence base through conducting systematic evaluation studies that will help identify key indicators of success and best practices, and optimise the transferability of knowledge from non-communicable diseases to communicable diseases. A prerequisite for all this is health communication workforce capacity development, including the articulation of core competencies—the necessary knowledge, skills and abilities in translating policy, theory and research into effective action.

### Policies are more powerful than pills

Starting off from the impressive *Global Burden of Disease study*, Simon Capewell demonstrates that poor diet is accountable for more than 40% of the burden of non-communicable diseases, more than smoking, alcohol and physical inactivity put together.<sup>9</sup> Looking at the fall of death rates due to coronary heart disease in Western countries over the past decades it is arguable that one third is attributable to better treatment, and two third to public health policies that improve risk factors in the population at large. ‘Downstream’ prevention activities targeting individuals consistently achieve a smaller public health impact than ‘upstream’ policies such as regulation or taxes. Population-wide prevention policies prove to be much more powerful, but implementing them is opposed by vested interests of major global companies. The reality for food is that ten worldwide corporations control almost anything we buy in our supermarkets. Capewell cites Moodie in *The Lancet* <sup>9</sup>: “These corporations all behave the same: to maximise profit for their shareholders they put public health aspects at the bottom of their priority lists and undermine effective public health policies and programs”. What can be done about this?

First of all we can be inspired by the successes of the past: sanitation, slavery abolition, immunisation, road safety, smoke free legislation, etc. The lessons learned in all these struggles were the same; they consecutively developed three key elements: *vision, strategy* and *effective action*. An essential part of strategy is, for instance, to connect the issue to people’s

everyday lives; clear evidence and striking actions that capture the public’s attention are needed to withstand authorities and vested interests. Based on these elements the path of effective implementation of public health policies can be described in seven steps, summarised in the verb ‘support’. First, scientific evidence emerges and professional understanding spreads; consequently, professionals accept the paradigm shift. Fourthly, the public and politicians become aware, and gradually supportive. The hard part being that opposition of vested interest is fierce and is only slowly surmounted; not by voluntary agreements or partnerships. At a decisive moment regulation is introduced, often strengthened by taxation, and the new paradigm becomes institutionalised, anchored in social norms.

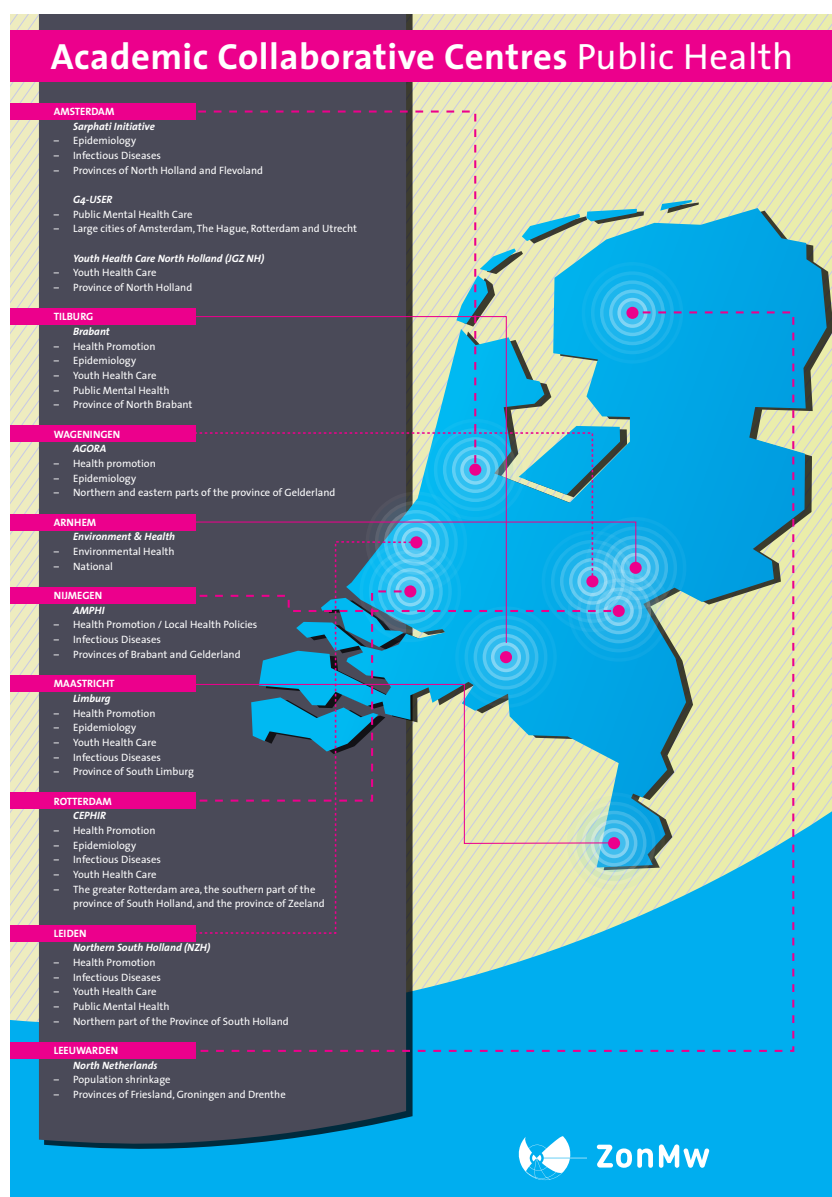
“The conclusion is that politics are inevitable, you either get involved or you watch things fail to happen. So today’s challenges in both infectious diseases and non-communicable diseases resemble the past – they’re substantial, but they can be overcome if we work together.”<sup>7</sup>

### Discussion

What can we learn from each other? The recommendations of the European Centre for Disease Prevention and Control technical report offer a roadmap, which needs a driving force. The reality is that budgets are not bound to increase; therefore, smarter collaboration will have to fuel progress. One way to do so might be the development of Academic Collaborative Centres for Public Health.

In the Netherlands, a nationwide policy to develop these collaborative centres has been put in place since 2004, based on a long-term partnership between community health services and a university. The main purpose of the academic collaborative centre is to improve the knowledge transfer between practitioners, policy makers, researchers and the education sector. The ultimate goal is to improve public health policies at the local level.<sup>8</sup> So far, this policy has been successful and generated a substantial output in PhDs, policy advice and health promotion interventions overarching health communication, health

**Figure 3:** Map of Academic Collaborative Centres Public Health in the Netherlands



Source: <sup>9</sup>

promotion and communicable disease control, and contributing to reduction of inequities. <sup>9 10</sup> Within a period of ten years, eleven academic workplaces emerged (see Figure 3). The question is whether such initiatives might be (or already have been) implemented in other European countries as well and what their significance is in the light of the broader European context. Considering the fact that EUPHA aims to bring together practice, policy and research, it might provide the platform for further studies aiming to identify and promote 'smart collaboration initiatives'.

## Conclusions

The 7th EPH conference yielded valuable lessons to be applied in communicable disease control. The first lesson is the need for more and better formative research. Although there is comprehensive experience with formative research in the context of emerging diseases and crises is very challenging to conduct. Nevertheless, in these particular contexts it is essential that such studies take place in order to formulate the best approach to behaviour change.

“key elements: vision, strategy and effective action”

Historically, in the communicable disease areas, activities are organised around networks of medical professionals, policy-makers and citizens/target groups. The performance of interventions targeting these networks might be quite variable, and lessons learned are not consequently implemented. There is a strong need for leadership from the public health community to address opportunities, promote successful interventions, and collaborate closely with policy-makers. The public health leadership should aim to translate best practices of comprehensive approaches to other complex health issues, like the example of tobacco control policies, into the communicable disease area.

Last but not least, there is a need to think 'out of the box' and bring more innovation in the actions undertaken to prevent and control infectious diseases.

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<sup>7</sup> Video of the second plenary session of the EPH conference 2014. Available at: <http://ephconference.org/conference-2014-glasgow-plenary-sessions-videocasts-150> Based on: Capewell S. Optimal non-communicable disease prevention strategies: pills or policies? *European Journal of Public Health* 2014;24(suppl 2). Available at: <http://dx.doi.org/10.1093/eurpub/cku152.005>

<sup>8</sup> Moodie R, Stuckler D, Monteiro C, et al. Profits and pandemics: prevention of harmful effects of tobacco, alcohol and ultra-processed food and drink industries, *The Lancet* 2013;381(9867):670–9.

<sup>9</sup> Academic Collaborative Centres Public Health [web site]. Available at: <http://www.zonmw.nl/en/programmes/academic-collaborative-centres-public-health/programme/>

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# PUBLIC HEALTH MONITORING AND REPORTING: MAINTAINING AND IMPROVING THE EVIDENCE-BASE

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**Summary:** It is undisputed that reliable and comprehensive health information is needed to support evidence-informed policy-making. This article gives an overview of the drivers and actions that aim to improve the health information infrastructure in Europe. In addition to outlining the status quo of international infrastructure development, this article highlights existing gaps in monitoring health inequalities and in data sources for monitoring morbidity. A sustainable health information infrastructure in Europe, a feasible legal framework as well as opportunities for good-practice exchange would help to overcome information gaps and to improve the possibilities for evidence-informed decision making.

**Keywords:** *Public Health Monitoring and Reporting, Health Information System, Health Inequalities, Morbidity Statistics*

## Introduction

Information on the frequency and distribution of disease, populations' health behaviour, health care utilisation patterns, and other determinants are, amongst others, a prerequisite for evidence-informed (health) policy-making at local, regional, national and international levels. A well-functioning health information system, including

reliable and comprehensive data collection mechanisms and routine monitoring and reporting activities, is regarded as a core capacity for generating evidence-informed (health) policies.<sup>1</sup> Such a health information system can be understood as an infrastructure that allows professionals and lay people to use, interpret, and share information and to transform it into knowledge.<sup>2</sup> It enables decision making