A global communications campaign framework to help combat the threat from substandard and falsified medical products
## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive summary</td>
<td>3</td>
</tr>
<tr>
<td>1. Introduction</td>
<td>10</td>
</tr>
<tr>
<td>2. Methodology</td>
<td>10</td>
</tr>
<tr>
<td>3. Building blocks and staging posts</td>
<td>12</td>
</tr>
<tr>
<td>4. The communications framework: The Power of IDEAS</td>
<td>14</td>
</tr>
<tr>
<td>5. How will Insight help?</td>
<td>16</td>
</tr>
<tr>
<td>5.1 What methods can we use to generate insight?</td>
<td>17</td>
</tr>
<tr>
<td>5.2 What are the traps to avoid?</td>
<td>19</td>
</tr>
<tr>
<td>5.3 Applying insights to inform audience segmentation</td>
<td>19</td>
</tr>
<tr>
<td>6. What about Data?</td>
<td>21</td>
</tr>
<tr>
<td>7. How can we secure Engagement?</td>
<td>22</td>
</tr>
<tr>
<td>8. What Action are we looking to achieve?</td>
<td>24</td>
</tr>
<tr>
<td>9. How will we know if our Solutions have worked?</td>
<td>25</td>
</tr>
<tr>
<td>10. The future: 2019 onwards</td>
<td>26</td>
</tr>
<tr>
<td>Appendices</td>
<td>27</td>
</tr>
<tr>
<td>Appendix 1: IDEAS in Action. Campaign from HSA Singapore</td>
<td></td>
</tr>
<tr>
<td>Appendix 2: Sample Creative Brief</td>
<td></td>
</tr>
<tr>
<td>Appendix 3: 2017 Global communications survey participants by WHO region</td>
<td></td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

The MSM has approved a number of prioritized activities related to substandard and falsified medical products. The communication, education and awareness-raising stream is led by MHRA on behalf of the United Kingdom of Great Britain and Northern Ireland and aims to contribute to the prevent element of the overarching three-pronged programme strategy developed by WHO, i.e. prevent, detect and respond. At the outset of the work in January 2016, the scope and approach of this Activity were defined as follows:

“Create a working group to develop and leverage existing recommendations for effective risk communication and recommendations for awareness campaigns on SSFFC medical products and related actions, activities and behaviours.”

It was agreed that the work should focus on providing practical advice and guidance to member states and key elements were identified as useful outputs from the workstream:

- produce samples of hard and soft copy, video and broadcast material;
- assess the use of social media for raising awareness;
- identify the full range of stakeholders and audiences;
- develop key and innovative advocacy material.

During the development of the work programme it became increasingly clear from the social, political and economic perspectives that the impact of communication was growing at an unprecedented pace, making it increasingly difficult to develop guidance and strategies – with a significant risk that they would become irrelevant or outmoded almost as soon as they were published. Meanwhile, considerable computing power and technology growth, coupled with similar software advances, are combining to accelerate the reach, influence and immediacy of communication messaging on a daily basis, but this is happening in very different ways and rates across member states. From the outset, the communication, education and awareness-raising workstream therefore set out to acknowledge these differences and the very local and contextual nature of communications with different audiences, to ensure all member state communication environments were represented and reflected in the recommendations developed.

In order to maintain a global perspective for existing and future communications advice, a communications working group (CWG3) was established early in the work programme, and invitations to join the group were extended to communications professionals across all six WHO regions. Support and contributions to the workstream were then channelled through the group’s members, acting as a first-level consultative and critical review body.

---

1 MHRA: Medicines & Healthcare products Regulatory Agency
2 Substandard, spurious, falsely labelled, falsified and counterfeit, now Substandard and Falsified.
3 See Appendix 4 for CWG membership.
Beyond the communications working group, the workstream reached out to the broader professional communications community working in member states, academia and analogous areas of public health, to build a contemporary picture of best practice in communications before developing and testing a bespoke approach to guidance on substandard and falsified medical products.

The proposals set out in this handbook are based on the feedback received, together with the results of a global communications survey and live testing of the framework subsequently developed.

METHODOLOGY

With a clear remit to generate practical guidance for Member States, the communications workstream has focused on contemporary best practice thinking and campaign implementation to populate its guidance.

BUILDING BLOCKS AND STAGING POSTS

The establishment of a body of knowledge led to a focus on ensuring behaviour change thinking was included as an essential component of communications advice. We need to do more than just provide information to citizens and patients on the risks and dangers associated with substandard and falsified medical products; we also need to engage and motivate them to make positive “considered decisions”, thereby adopting safe behaviour.

Engagement with interested stakeholders showed the extent to which the whole public health community recognized the risks posed by substandard and falsified medical products and the need to develop integrated strategies throughout the supply chain, from manufacture to consumption, and to use communications at key intervention points with relevant audience groups (health care professionals, influencers, citizens).

What we learned from our pilot communications survey of communications working group members confirmed our original hypothesis that what was required was practical guidance, particularly on:

- sharing insights and assets;
- support for success measurement;
- showcasing best practice and providing guidance on film, social media and print.
When we took the results and insights from the pilot survey and developed the global communications survey in 2017, we largely found confirmation of our initial work. We also looked to understand what member states were currently doing and there was broad consensus on the challenge that this work represented within a wider public health agenda:

- Little original research was being conducted into the use and awareness of substandard and falsified medical products among the public or health care professionals, with informed views suggesting that:
  - for public audiences, social media (or friends and family) were a key channel and influencer;
  - for health care professionals, their professional organizations, government departments and regulators were influential;
- Campaigning was mainly directed at population-wide public audiences.

Furthermore, as might have been expected from feedback from the pilot study, the global communications survey indicated that member states were principally looking for guidance on planning, developing and measuring the success of their campaign activities.

Live testing workshops enabled us to test the validity of our model with a variety of Member States, most recently in Africa, Asia and Europe, and feedback aggregated from these workshops informed further refinement of our hypothesis, leading to the final version of the communications framework.

In parallel with the design, creation and refinement of the communications framework, we undertook the collection and curation of campaign materials from member states to best illustrate the scope and range of activity and to generate a digital asset library, in order to inspire new campaigns and serve as templates that could be repurposed or copied for similar communications challenges.

A concurrent review of social media in 2018 will give member states an overview of this increasingly influential component of communications activity and will enable them to integrate it into their communications planning.

Finally, regular progress presentations were made to Steering Committee meetings and annual Member State mechanism meetings in 2016, 2017 and 2018, providing project updates and giving these forums the opportunity to critique the work to date and provide further direction going forward.
THE COMMUNICATIONS FRAMEWORK: THE POWER OF IDEAS

The communications framework has been distilled into five key elements to provide clarity and brevity. By adopting the thinking set out in the IDEAS model, member states will be able to create compelling communication initiatives to help combat substandard and falsified medical products.

The individual framework components are:

I for INSIGHT

• Understanding how and why people (audiences) currently behave the way they do, to inform our communications planning

D for DATA

• Bringing together all the evidence we have on the topic to ensure credible and solid foundations for advice and guidance

E for ENGAGEMENT

• Ensuring a strong connection is made with target audience(s)

A for ACTION

• Giving people action to take to adopt good behaviour and reduce their risk of exposure to substandard and falsified medical products

S for SOLUTIONS

• Measuring the impact of campaigns, and using lessons learned to improve future activity planning
HOW WILL INSIGHT HELP?

- Insight unlocks our understanding of why people are currently behaving the way they are. It is more than just observation; it gives us a picture of behavioural influences: community, cultural, economic, religious, peer-related, work-based. It helps us to understand how all these influences are working together and gives us clues as to which ones are strongest and how we can address and change them. It helps us to think about where our communications are going to be most effective as a positive intervention and which messages will have the greatest impact.

The importance of understanding audiences

- Effective communications rely on strong insight to develop compelling messages, delivered through relevant communication channels to create behaviour change.
- Segmenting and targeting audiences improves our efficiency.
  - Primary audiences are those we want to directly address with our messages, the people who are directly affected by the problem or best able to address it.
  - Secondary audiences are those who influence a primary audience, either directly or indirectly. They may include family members, health care professionals or community leaders who shape social behaviour and treatment practices, influence policies or even people’s thinking on medicines.

What methods can we use to generate insight? Representative primary audience-based research will help most.

- It gives us an impartial view of people’s current attitudes and behaviours.
- It helps us to build a profile of our most “at risk” groups, so that we can consider whether we need to segment our audiences and develop custom communications for different groups.
- It gives us strong clues as to what messages will resonate with our audiences.
- It identifies barriers to, and triggers of, change.
- It gives us a better understanding of trusted/scalable communication channels

If we cannot commission original research, we need to identify sources of independent observation and combine them with comparable evidence from published and other credible sources, such as clinical data, or similar contemporary studies from recognized expert organizations. How can we find this information?

- Review of any existing published data
- Independent observation: structured field work
- Trusted online data sources: WHO, governments, NGOs
- Reputable and statistically valid global, regional and locally published research
- Comparable and up-to-date evidence from other countries/regions/ districts
- Social listening
What should we avoid?

- Unverified anecdotal evidence. This will often mask the true picture or give a distorted result.
- Self-selection research. This can lead to bias based on the recruitment method used (e.g. online surveys can easily exclude non-digital groups).

WHAT ABOUT DATA?

Data is very contextual to the topic and the audience, so we need to make sure it is objective, accurate, timely and relevant. What type of data can help?

- Population and audience size data: sizing the task
- Distribution data: understanding where we may need communications to intervene at point of access
- Frequency of use, clinical and prescribing data: how often we need to communicate
- Intermediary intervention data (e.g. role of health care professionals, pharmacies): where trusted influencers can help
- Adverse reaction data: urgency or geographical focus, real data to use in communications campaigns to alert citizens to risks involved

HOW CAN WE SECURE ENGAGEMENT?

Blending what we learn from data and insight will point us towards the creation of engaging and compelling communications. We will know:

- what audiences to target with communications;
- where to reach those audiences;
- what messages they will respond to positively;
- when and how frequently we need to publish;
- how to generate behaviour change (and feedback where necessary).

WHAT ACTION ARE WE LOOKING TO ACHIEVE?

Effective communication is more than just information.

- It provides the knowledge and motivation people need to make informed decisions and good choices.
- It provides the stimulus that people need to make informed decisions.
- It provides the motivation to take action.
- It provides the support to maintain that action.

Using benchmarks of current behaviour from insight and data collection, we can identify the changes we want people to make.
HOW WILL WE KNOW IF OUR SOLUTIONS HAVE WORKED?

Measuring inputs, outputs, outtakes, outcomes and impacts will help to create sight lines between the communications we create and the change in behaviour we seek.

- We can measure (or estimate) reach (how many of our target audience saw/were impacted by our communications?) and frequency (how often did they see the campaign?), to start to understand the likely impact. Were we targeting a particular demographic (e.g. young women) or geographical group? What was our penetration of this group?
- We can measure over time how behaviour changes, based on the information we collected through insight and data and by benchmarking existing attitudes and practices, and running audit surveys or collecting data from reputable sources (e.g. registered pharmacies).
- We can investigate in more detail where our communications have had most impact. For example, did our insight lead to messaging that resonated with our audience?
- We can test our activity where the opportunity presents itself. If we have the resources, we can pilot our campaigns to test them in a real-world situation and adjust (if necessary) before wider exposure and expenditure.

Learning from the outcomes of the campaigns we run will lead to improvements in the impact of our future communications, and the building of a useful dataset.

THE FUTURE: 2019 ONWARDS

This communications advice handbook, together with the library of existing campaigns and the social media review, will be made available to all member states in the first instance on the MedNet platform to coincide with the seventh meeting of the member state mechanism in November 2018. In the future, any specifically commissioned work from WHO on substandard and falsified medical products communications will also be added to the library.

The dedicated communications workstream of the overall programme is scheduled to be concluded at the seventh meeting of the member state mechanism, but given that the model for advice is deliberately practically focused, it is hoped that it will be widely used by member states and that new campaigns will be added to the digital asset library, so that it can evolve organically and member states can continue to benefit from the work within a strong guidance framework.
1. INTRODUCTION

In 2012, the World Health Assembly established the Member State Mechanism to address the issue of substandard and falsified (SF) medical products. This mechanism aims at promoting the prevention and control of substandard and falsified medical products and associated activities, through effective collaboration among member states and the secretariat, in order to protect public health and promote access to affordable, safe, efficacious, and quality medical products.

One of the mechanism’s priority activities is to identify major needs and challenges and make policy recommendations, and develop tools in the area of prevention, detection methodologies, and control of substandard and falsified medical products in order to strengthen national and regional capacities.

The MSM has approved a number of prioritized activities related to substandard and falsified medical products. The communication, education and awareness-raising stream is led by the United Kingdom of Great Britain and Northern Ireland and aims to contribute to the prevent element of the overarching three-pronged programme strategy developed by WHO, i.e. prevent, detect and respond.

As a descriptive document with no technical content, this handbook was not subjected to approval by member states, and the information presented is not endorsed by the Member State Mechanism nor by WHO. The content of the handbook corresponds to a compilation of information provided by member states, international organizations, and other non-commercial stakeholders with a stated public health remit.

2. METHODOLOGY

At the outset of the work in January 2016, the scope and approach of this activity were defined as follows:

“Create a working group to develop and leverage existing recommendations for effective risk communication and recommendations for awareness campaigns on SSFFC\(^4\) medical products and related actions, activities and behaviours.”

It was agreed that the work should focus on providing practical advice and guidance to member states and several key elements were identified as being useful outputs from the workstream:

1. Produce samples of hard and soft copy, video and broadcast material;
2. Assess the use of social media for raising awareness;
3. Identify the full range of stakeholders and audiences;
4. Develop key and innovative advocacy material.

During the development of the work programme it became increasingly clear from the social, political and economic perspectives that the impact of communication was growing

\(^4\) Substandard, spurious, falsely labelled, falsified and counterfeit, now Substandard and Falsified.
at an unprecedented pace, making it increasingly difficult to develop guidance and strategies – with a significant risk that they would become irrelevant or outmoded almost as soon as they were published.

Meanwhile, considerable computing power and technology growth, coupled with similar software advances, are combining to accelerate the reach, influence and immediacy of communication messaging on a daily basis, but this is happening in very different ways and rates across Member States.

From the outset, the communication, education and awareness-raising workstream therefore set out to acknowledge these differences and the very local and contextual nature of communications with different audiences, to ensure all Member State communication environments were represented and reflected in the recommendations developed.

In order to maintain a global perspective for existing and future communications advice, a communication working group was established early in the work programme, and invitations to join the group were extended to communications professionals across all six WHO regions. Support and contributions to the workstream were then channelled through the group’s members, acting as a first-level consultative and critical review body.

Beyond the communications working group, the workstream reached out to the broader professional communications community working in Member States, academia and analogous areas of public health, to build a contemporary picture of best practice in communications before developing and testing a bespoke approach to guidance on substandard and falsified medical products.

The proposals set out in this document are based on the feedback received, together with the results of a global communications survey\(^5\) and live testing of the framework subsequently developed. (A longer narrative with specific advice is being published separately to coincide with the seventh meeting of the Member State mechanism.)

With a clear remit to generate practical guidance for Member States, the communications workstream has focused on contemporary best practice thinking and campaign implementation to populate its guidance. In essence, the work programme is constituted of ten elements:

1. Establishment of a body of knowledge – gathering examples and theories of current best practice communications activity, focusing on analogous and comparable public health campaigns and activities;
2. Engagement with interested stakeholders and attendance at relevant events;
3. Aggregation and distillation of understanding applied to communications planning, and ongoing consultation with the communications working group;
4. Feedback to inform a pilot communications survey of working group members;
5. Use of the results and insights from the pilot survey to plan and implement a global communications survey, with all member states invited to participate;
6. Use of outputs for the communications modelling hypothesis;

---
\(^5\) See Appendix 1 for list of member states participating in survey
7. Live testing with member states at workshops;
8. Further refinement from hypothesis to communications framework;
9. Concurrent collection and curation of campaign materials from member states;
10. Concurrent review of social media in 2018 to inform better communications;
11. Progress presentations and plan updates to Steering Committee meetings and annual Member State Mechanism meetings in 2016, 2017 and 2018.

3. BUILDING BLOCKS AND STAGING POSTS

Exploring some of the work components in more detail helps to understand the insights gained from the early stages of the work and how these have been applied to create the communications framework.

The establishment of a body of knowledge led to a focus on ensuring behaviour change thinking was included as an essential component of communications advice. We need to do more than just provide information to citizens and patients on the risks and dangers associated with substandard and falsified medical products; we also need to engage and motivate them to make positive “considered decisions”, thereby adopting safe behaviour.

Engagement with interested stakeholders showed the extent to which the whole public health community recognized the risks posed by substandard and falsified medical products and the need to develop integrated strategies throughout the supply chain, from manufacture to consumption, and to use communications at key intervention points with relevant audience groups (health care professionals, influencers, citizens).

What we learned from our pilot communications survey of communications working group members confirmed our original hypothesis that what was required was practical guidance, particularly on:

- sharing insights and creating assets;
- support for success measurement;
- showcasing best practice and providing guidance on film, social media and print.

When we took the results and insights from the pilot survey and developed the global communications survey in 2017, we largely found confirmation of our initial work. We also looked to understand what member states were currently doing and there was broad consensus on the challenge that this work represented within a wider public health agenda:

- little original research was being conducted into the use and awareness of substandard and falsified medical products among the public or health care professionals, with informed views suggesting that:
  - for public audiences, social media (friends/family) are key channel & influencer;
  - for health care professionals, their professional organizations, government departments and regulators were influential;
- campaigning was mainly directed at population-wide public audiences.
Furthermore, as might have been expected from feedback from the pilot study, the global communications survey indicated that member states were principally looking for guidance on planning, developing and measuring the success of their campaign activities. This feedback influenced both the structure and content of our communications framework.

Live testing workshops enabled us to test the validity of our model with a variety of Member States, most recently in Europe, Asia and Africa. In each case, the specific purpose of the workshop was to work with delegates to explore and critique our prototype global communications framework, identify gaps, suggest relevant additions and recommend any additional sources, structures and/or stakeholders.

The format was consistent at each event. First, the group was presented with an overview of the role of WHO communications activities in helping to combat substandard and falsified medical products, drawing on the feedback received from the global communications survey, which highlighted the areas in which member states were active and emphasized the topics on which they were looking for support from the communications programme. The specific nature of substandard and falsified medical products in each country context was then investigated, drilling down into the influence of key stakeholders and communications in all senses (broadcast, narrowcast, face-to face) in each participating delegate’s country and, where relevant, comparing the relative impacts.

We then shared the hypothesis of the new communications framework “IDEAS” and worked through each element in detail, exploring the value that could be added to communication activities by utilizing it. Next the group(s) tackled a hypothetical campaign challenge, adopting the principles from the IDEAS framework to test its validity in a potential real-life situation. In each workshop, delegates contributed enthusiastically and energetically to develop solutions providing strong endorsement of the communications framework’s value. Feedback aggregated from these workshops informed further refinement of our hypothesis, leading to the final version of the communications framework.

In parallel with the design, creation and refinement of the communications framework, we undertook the collection and curation of campaign materials from member states to best illustrate the scope and range of activity and to generate a digital asset library, in order to inspire new campaigns and serve as templates that could be repurposed or copied for similar communications challenges.

A concurrent review of social media in 2018 will give member states an overview of this increasingly influential component of communications activity and will enable them to integrate it into their communications planning.

Finally, regular progress presentations were made to Steering Committee meetings and annual Member State mechanism meetings in 2016, 2017 and 2018, providing project updates and giving these forums the opportunity to critique the work to date and provide further direction going forward.

---

6 Antwerp, Belgium. European Social Marketing Conference and Workshops
7 Naypyidaw, Myanmar SF Medical Products Workshop by WHO
8 Lagos, Nigeria. Pan-African SF Medical Products Workshop by WHO
4. THE COMMUNICATIONS FRAMEWORK: THE POWER OF IDEAS

The IDEAS communications framework has been distilled into five key elements to provide clarity and brevity, and to focus on sharing practical advice. Where appropriate or relevant we have included links or references to other sources we believe will helpful to member states as they develop their own campaign activities, and we have developed guidance on how best to go about using the framework. The framework is designed to take campaign planning from the overall objective setting to the next level of implementation, thinking about the required component parts of a strong campaign, how they work together for optimum effect and how they can be best deployed.

In developing this framework, we expect member states will adopt the SMART\(^9\) approach to objective setting which will dovetail with the elements of the IDEAS model. In brief the SMART approach comprises:

**Specific:** Objectives should be focused, clear, and unambiguous. Being specific sets expectations on the same level and helps everyone get on the same page. Specific objectives are easier to measure, too.

**Measurable:** Objectives that are measurable allow you to track and report progress; they help define success for your key stakeholders, and in addition, measurable objectives let you know if efforts need to be adjusted to be more effective.

**Attainable:** Objectives that are realistic yet require a stretch or effort to reach them. The objective should not be out of reach or below what is reasonably achievable. Considering resources available to develop implement and monitor the campaign is helpful when thinking about attainable in context.

**Relevant:** Relevance means that objectives are aligned with your public health responsibility.

**Time bound:** Campaigns should have a start and end date to generate focus and urgency in the campaign. Relevant external events should also be considered to provide timeliness to a campaign.

By combining SMART objectives with the methodology set out in the IDEAS framework, we believe member states will be able to create compelling communication initiatives to help prevent the public health risks associated with substandard and falsified medical products.

---

\(^9\) SMART S: Specific, M: Measurable, A: Attainable, R: Relevant, T: Time-bound
The individual framework components are:

**I for INSIGHT**

Understanding how and why people (audiences) currently behave the way they do, so as to inform our communications planning

**D for DATA**

Bringing together all the evidence we have on the topic to ensure credible and solid foundations for advice and guidance

**E for ENGAGEMENT**

Ensuring a strong connection is made with target audience(s)

**A for ACTION**

Giving people action to take to adopt good behaviour and reduce their risk of exposure to substandard and falsified medical products

**S for SOLUTIONS**

Measuring the impact of campaigns, and using lessons learned to improve future activity planning
5. HOW WILL INSIGHT HELP?

Insight is the basis for strong communications, - it gives us a firm foundation from which to develop campaigns and ensures we are grounded in the real lives of our target audience(s), be they whole population, or segmented by geography, gender, age, life stage, or more likely a combination of these.

Insight recognises that peoples' lives are complicated, that they have many and often conflicting behaviours and influences to reconcile and the issue we are keen to communicate may not (or may not seem to be) important to them now.

Understanding this context is invaluable if we want people to make good and informed decisions avoiding unnecessary risks to their health, -- merely presenting information or idealised behaviour may not in itself be sufficiently engaging or motivating to encourage behaviour change.

One of the principle benefits of insight is that it helps to unlock our understanding of why people are currently behaving the way they are. It often surprises us, -- we think we know why people are adopting a particular behaviour, but it is often only based on limited knowledge or anecdotal evidence which is at best masking the true picture and at worst providing a completely erroneous picture. Acting on that superficial or incorrect evidence can lead to communications that are ignored or resisted.

Worthwhile insight needs to be much more than just observation; it goes deeper to give us a true picture of behavioural influences: community, cultural, economic, geographic, religious, peer-related, work-based.

It helps us to understand how all these influences are working together and gives us clues as to which ones are strongest and how we can address and change them. It also helps us to think about where our communications are going to be most effective as a positive intervention and thus to inform the choice of relevant communication channels through which to deliver our messages.

It gives us the opportunity to explore and test existing and new messaging hypotheses to see how these resonate with audiences and enables us to focus our creative development on those which are going to connect most strongly with our audiences.

To improve the efficiency and effectiveness of our campaigns we can also use the outputs from our insight generation to combine with further levels of detail and organisation of our audiences through segmentation and communications targeting.
5.1. WHAT METHODS CAN WE USE TO GENERATE INSIGHT?

When we are seeking to influence citizen behaviour, our communications strategy will be informed in two main ways:

1. Understanding what our audiences think and feel about SF medical products as a topic
2. Understanding what their actual behaviour is in relation to SF medical products.

Research can provide the answers to these questions but can often be conflicting, -- people may think or believe they do one thing but in reality, they don’t, e.g. they may believe they check the authenticity of their medicines but may only give them cursory attention so are vulnerable to substandard or falsified products. By compiling and then comparing both sets of information we can decide what the focus for our communications should be and whether the changes we would like people to make are to their perceptions of risk or the actual risk itself.

Gathering information on citizens’ attitudes and beliefs will form the basis for our insight and shape the communications messages and content we develop. Attitudes and behaviours can change very quickly as citizens knowledge, mobility, economic independence and personal circumstances change or they can remain rooted in traditional or ingrained approaches. In either case what we seek to gain through insight is a contemporary and relevant picture of what is happening now and to set this in the context of likely or potential future changes to enable us to craft messages that will resonate with our audiences and encourage them to adopt safe and considered behaviour.

Representative primary audience-based research will help most to give us this view and commissioning this type of research will also be useful in establishing benchmarks of current behaviour to inform objectives and target setting for campaign activity. It requires appropriate expertise and investment and should be undertaken by a research organisation with specialist experience of citizen-based research in the member state environment.

What can we expect to learn from original research?

We will get an impartial view of people’s current attitudes and behaviours, so that we can build a campaign that addresses how they actually think and feel rather than how we may believe they think and feel

We will be able to build a profile of our key target audiences, so that we can consider whether we need to segment and develop custom communications for different groups, using some of the basic segmentation outlined above, or if we are able to go deeper into demographics and/or psychographics, or perhaps identify a more specific at-risk group, e.g. mothers, students, retired citizens

We will get strong clues as to which messages will resonate with our audiences, so that we can focus on making these messages the best they can be

We will be able to identifies barriers to, and triggers of, change, which may need to our messaging to confront issues e.g. exploding myths that prevent good behaviour, or demonstrate benefits e.g. encouraging adoption of a different way of doing things, by showing how this will be beneficial to the citizen
We will have a much better understanding of which trusted and/or scalable communication channels we should use, as the delivery channel is in itself part of the message, -- if the message comes through a trusted channel citizens are more likely to believe the content and act on the recommendations made. Conversely a poor channel selection may undermine the credibility of the message and have an adverse effect causing mistrust of the message and the recommended action.

Alternatives to original research

Where we are unable to commission original research, we should still aim to gain basic audience insight to inform our communications planning and to ensure our campaigns are relevant and impactful. Methods we can adopt to achieve this include:

Community or audience-based consultation and discussions can be helpful when there is insufficient budget to fund research but there may be staff resources available. However, if they are to be used to gather information through forums such as community focus groups or workshops it is vital that staff have received the correct training to undertake citizen-based insight work  

From an online perspective social listening can provide insight into the motivations and behaviours of connected citizens and is essentially the process of monitoring social media channels for mentions of topics relating to SF medical products generally, or specific products if they have been identified as a current risk. The information gleaned has the benefit of being completely up to date and relevant and can then be used information to develop actionable insights. Those actions can then range from engaging a satisfied stakeholder to shifting the content, tone or targeting of the communications campaign

It is this actionable element of social media listening that differentiates it from social media monitoring, which is more about compiling data, and gathering information about what has already happened rather than looking forward to determine future actions.

Social listening looks beyond, the numbers at the overall mood behind the social media posts—how people actually feel about medical products generally, whether or not they have considered or encountered substandard or falsified products and if so their impact on themselves, friends and family, their communities and importantly the role of public health organisations regulators and enforcement agencies in tackling them. That mood, also known as social media sentiment, is a key part of social listening. Effective sentiment analysis can help you amplify messaging that’s receiving positive interaction, respond appropriately to anything that’s triggered a negative response, and see trends over time that can keep future communication efforts on track. It is often helpful to run social listening in conjunction with core research approaches e.g. focus groups and then compare insights from both sources, to discover further detail and to understand any differences or nuances that should be reflected in messaging through these channels, i.e. do we use the same message consistently across all our channels or does it need to be crafted differently for online audiences?

---

10 Communication Essentials for Member States online course: openwho.org/courses/publichealthcom
5.2. WHAT ARE THE TRAPS TO AVOID?

There may be a temptation to develop campaign based on feedback through the supply chain. This information should always be treated with caution. Unverified anecdotal evidence can often mask the true picture or give a distorted result, which in turn can mean a campaign has the wrong target audience and/or the wrong message. It is important to verify anecdotal feedback in the first instance by tracing the information back to source, (where feasible) or verifying the evidence independently by informed questioning of reliable sources especially qualified intermediaries, e.g. health care professionals.

Self-selection research can often be seen as a low or no cost method of gaining insight particularly through surveys through one of the many proprietary on-line providers. Without adequate and thorough qualifying of respondents and the establishment of representative quotas the danger is that although it can be easy to collect data the results will not be necessarily be representative, e.g.-- bias can easily be introduced by the recruitment method used; online surveys by their very nature will exclude citizens with limited or no online access. Alternatively, if time is limited, responses are slow, and the survey is closed quickly results can be distorted by early respondents or a vested interest group who are encouraged to participate through social media.

5.3. APPLYING INSIGHTS TO INFORM AUDIENCE SEGMENTATION

Segmenting audiences enables us to refine our targets and success measurement and generate audience relevant content that is delivered through appropriate channels. Core segmentation can simply involve thinking about primary and secondary audiences, and their geographical dispersion.

In basic terms primary audiences are those we want to directly address with our messages, the people who are directly affected by the problem or best able to address it. They may include, citizens at a population level, patients, or health care professionals responsible for prescribing or distributing medical products.

Secondary audiences are those who influence a primary audience, either directly or indirectly. They may include family members, friendship groups, community leaders who help shape social behaviour, health care professionals influencing citizens’ thinking on medical products and treatment practices, or policy makers who set the public health agenda and infrastructure.

Overlaying geographic segmentation can further enhance content generation. For instance, citizens living in urban environments may demonstrate divergent behaviours from those in rural situations. Attitudes to differing medicine types (traditional versus pharmaceutical) and access to and choice of medicines can vary significantly so will need to be reflected in messages created. Delivery channels chosen may be much more limited in rural settings and we may also need to factor in varying levels of literacy to optimise communication. Radio for example often proves an ideal medium to dramatize and communicate to hard to reach and/or low literacy audiences. The major benefit of geographic segmentation is that it is straightforward and flexible.
Where appropriate we can add in further levels of segmentation to provide a more sophisticated view of our audiences. These can include:

- Demographic segmentation which divides the audience on the premise that citizens have different attitudes and behaviours according to factors including age, gender, educational attainment, occupation, income, and marital status.

- Behavioural and psychographic segmentation can be useful to understand and address behaviour that is driven by values, attitudes, and opinions and often is strongly influenced by peer groups leading to attitudes and behaviours that are reflective of a group or community.

When considering the level of segmentation to be undertaken it is important to keep in mind that segments are only valuable if there are communications channels available that will target and connect with the segment identified, and that there is budget (or other resources, e.g. face to face communications teams) in place that will allow for comprehensive coverage of the chosen segment. Segmentation requires extra effort and resources (e.g. time to properly segment audiences, funds and staff time to design separate messages and materials, funds to use additional channels). If the budget does not allow for multiple approaches, we must simply identify the most important audience segment to reach and focus on that segment.

In essence, segmentation is one of the core elements that enables audience targeting to take place. By being able to define our audience more accurately, and to understand their current behaviour we can generate communications that will address them much more directly and help us to cut through the general noise level of

When we consider the roles of other stakeholders, particularly health care professionals our approach should be consistent and coherent with our citizens communication but recognise that they are essential influencers in the communications process, and they play an active advisory role in their interactions with citizens. They are trusted advocates, whether that be in primary, secondary, or pharmacy settings.

If our ambition is for them to take a proactive role with their patients, our task is to ensure that as well as the clinical advice and guidance they receive we should develop bespoke communications for them with the clear aim to brief them on our campaign plans and materials and the role we would like them to play in the overall activity.
6. WHAT ABOUT DATA?

Data is very contextual to the topic and the audience, so we need to make sure it is objective, accurate, timely and relevant. Each source will provide part of the picture so in an ideal model we aim to capture data from a variety of sources and combine it to give us both a complete picture of the communications landscape as well as a number of data points that we can use as benchmarks for measuring and reviewing the efficiency of our campaign activity.

So, what type of data is likely to be of most help?

Population and audience size data is essential to understand the size of the task, we are undertaking and thus our ability to set sensible campaign objectives. If we are using SMART\textsuperscript{11} methodology we need to recognise that our objectives are attainable, so if we need to quantify the audience size and consider if we need to or can prioritise parts of that audience for greater impact. Even if we need to communicate at population level we must still quantify our audience size so that we can measure our expected level of penetration of that audience. Where appropriate segmentation will help us to divide up audiences into manageable and targetable groups. We will then be able to formulate the key components of our channel planning and consider how we may achieve them.

In any activity we need to know what will be our campaign reach, i.e. how many within the target audience will see or be exposed to our communications, and then frequency, i.e. how often and how many times? Thinking about the scale of the task in conjunction with our audience insights will then ensure we set attainable and measurable objectives.

If we are targeting an audience of a specific medicine, e.g. an anti-malarial not only can we size the audience segment we can overlay other information such as distribution points. If we are then able to map these points it will help our understanding of where these products are most likely to be prescribed/dispensed/purchased so that we can develop and distribute relevant communications to intervene at these key points of access. We can also take into consideration frequency of use data to ensure our messages match how regularly we need to communicate with citizens.

Adding data on intermediary interventions (health care professionals, pharmacists) who can support communications and reinforce the credibility and importance of our messaging will supplement campaign impact.

Once again, we should try and quantify these opportunities. How many are available in the health care system, where are they located, how many patient interactions do they have? These numbers may only be estimates, but they will still help in our benchmarking and can be improved over time as we develop and implement further campaigns. By trying to identify their locations we can map these against our citizen audiences to see what level of coverage they give us. If citizens are receiving consistent messages through different sources giving them clear and practical advice, we need stand a greater chance of them changing or adopting good behaviour.

\textsuperscript{11} SMART S: Specific, M: Measurable, A: Attainable, R: Relevant, T: Time-bound
As well as trusted influencer information we can also overlay clinical data where there is available. In these instances, we are looking for evidence from healthcare settings that may include adverse reaction data, or geographical focus, or impact real data to use in communications campaigns to alert citizens to risks involved.

The ideal dataset will also blend local/regional/national information, depending on the circumstances but should always try to reflect the ‘on the ground’ situation. This could relate to specific types of medical products and whether the risk is greater from substandard or falsified products and an understanding of the most at risk groups. These will likely be directly linked to the medical products identified e.g. children’s vaccines. Comparable and up-to-date evidence from other countries/regions/ districts

If we cannot commission original research, we need to identify other sources of independent information which requires a systematic approach to reviewing published data and studies. We need to identify credible, evidence based contemporary studies that conform to global research standards and are published from trusted data sources. WHO, government health departments, regulatory authorities and specialist health based, non-government organisations (NGOs) may have commissioned their own research on the topic of SF medical products or more broadly looking at access to medical products.

Studies may also have been published aggregating information from a variety of sources. In each case it will be clear how the final data was collected and interpreted, and the methodology adopted to ensure objective outputs. The information should be available online from the commissioning organisation’s website with clear information identifying how and when it was compiled, when adopting this approach means that we can also broaden the search beyond the member state to embrace other reputable and statistically valid global, regional and locally published research.

7. HOW CAN WE SECURE ENGAGEMENT?

Our task at this stage is to blend what we have learnt from our insight generation and data collection to create compelling and actionable communications. Trying to cover too many elements can be confusing to our audiences so we should aim to focus on a core truth from our research investigation and bring this to life in words and/or pictures. Articulating the problem in a way that resonates with the audience will help to gain their attention.

When we are using film or video opening with a real-life situation that our audience recognises will enable them to relate to the content and follow the narrative through to the advice we are giving. The same applies to audio media such as radio where dramatizing real-life situations will resonate with audiences and lead them into the story or editorial content we have produced. Using animation rather than live actors can both save cost and avoid audiences not relating to the actors chosen.

__________________________

22
Short form social media or online content has to do the same job but in a matter of seconds so will often rely on animations or gif’s\textsuperscript{13} with a simple but direct message. However, in these situations we can often deploy a number of different executions so that we can use a variety and a range of different interpretations of the same core message to connect with audiences.

In print a strong visual will gain us attention which can be followed through with explanations and direction, whether that is long form narrative or simply a headline and recommended route to take.

In every piece of communication it is vital that the audience is given a clear “call to action” (CTA) so that once they have absorbed and understood the message they are quite clear on what they need to do next to protect themselves (or in the case of health care professionals or other relevant intermediaries— their patients) from substandard or falsified medical products.

Production of our media content will be governed by budget availability and our channel delivery. Creative work can be undertaken in house if a team exists to do the work or outsourced to a specialist creative agency\textsuperscript{14}. These can cover all media channels and develop a single core idea which is adapted for each of the channels it is deployed in, or if only a single channel e.g. digital is to be used then a specialist digital creative agency will be suitable.

Where budget is limited reusing or repurposing existing creative, e.g. changing voiceovers to local language, or subtitling in local language can be effective providing the original creative is audience relevant and local culturally sensitive. Alternatively, campaigns run in other member states can act as inspiration for new creative work. (A digital library of member states current creative campaign work is held on MedNet and available for sharing and download.)

The content of our messaging however is only part of the solution. The way we deliver it and the channel options we take are equally important. Planning the most effective routes to reaching our audiences will help us to focus our messaging on the target groups we know are most at risk from SF medical products and minimise media wastage.

Planning will primarily be influenced by budgetary considerations. With significant funds we can consider broadcast channels including TV, radio, cinema, and mass reach print platforms such as press and magazines. Outdoor advertising such as posters and billboards will also have a role to play. The exact mix of the media chosen will be driven by our at-risk audience considering some of the variables mentioned earlier relating to demographics and geographical dispersion and our insight into their behaviour. To optimise this targeting, it should be undertaken by a competent in-house media planning department or if the organisation does not have this facility by an external expert media planning company.

Where budget is not available to use paid media, we will need to rely on our ability to deploy our messaging content through owned and/or earned media channels.

\textsuperscript{13} Graphics Interchange Format;

\textsuperscript{14} A creative brief may help this process. See appendix 2 for example
Owned media is essentially a channel or channels that we already control or one(s) we can create. These could include our organisations website, or our real estate inventory, i.e. hospitals, clinics, and pharmacies where we can display and distribute our materials. Earned media is when citizens, patients, or mass communication media share our SF medical products content, or speak about it via word of mouth, or otherwise discuss it. in other words, the mentions are “earned,” meaning they are voluntarily given by others. Generally, we would like to combine owned and earned media for maximum impact and ideally ensure that we have secured good distribution of our content in owned environments in place before we seed and stimulate earned channels so that citizens have recognised and credible other sources of content to reinforce (or sometimes correct) the information they have picked up through earned channels. In an increasingly digital communications environment many of the earned comment will be distributed through social media channels

Engagement will work best when it blends the learnings from data and insight and applies them to messaging and channel planning. When correctly deployed and implemented it means we will know and can activate:

- What audiences to target with communications
- Where to reach those audiences
- What messages they will respond to positively
- When and how frequently we need to publish

8. WHAT ACTION ARE WE LOOKING TO ACHIEVE?

Effective communication is more than just information. It provides the knowledge and motivation people need to make informed decisions and good choices, the stimulus that they need to take action, and the sources of support to maintain that action over time.

Using benchmarks of current behaviour from insight and data collection, we can identify the changes we want people to make or the new behaviour we want them to adopt and consider how we might best encourage them to take appropriate action.

Our overriding ambition is for citizens to make ‘considered choices’ and these will always be contextual. They will range from ensuring that they take the correct basic medical advice before accessing medical products, to ensuring these products come from a legitimate and trusted source to being aware of the dangers of purchasing products online.

In each case we should be sure that we engage clearly (as described above), and once we have the audience’s attention, we provide them practical and achievable advice in the form of a clear Call to Action (CTA). e.g. where to access objective medical advice, where to go for legitimate products, and what to do when shopping for medical products online.

We also need to provide further advice as a reminder or fall back. This can be a website address, a hotline telephone number or more detailed advice in printed form.
Our aim is always for audiences to make the right decision through the messages we have provided and the opportunity for them to learn more or get further advice if they need it. Finally, to distinguish our advice from other confusing or poor advice and ensure it has legitimacy with our audiences we need to brand the campaigns confidently, ideally with a trusted government department or authority that citizens or intermediary audiences recognise immediately and have complete trust in the advice being given. (If we have a number from which to choose, we can explore which one will be most appropriate with our key stakeholders at our early insight gathering stage)

9. HOW WILL WE KNOW IF OUR SOLUTIONS HAVE WORKED?

Measuring inputs, outputs, outtakes, outcomes and impacts will help to create lines of sight and connections between the communications we create and the change in behaviour we have activated. In order to make sense of a variety of measures it is important at the outset to agree a set of key performance indicators that will show the impact and efficacy of the campaign. These will be defined by our SMART objectives and will be particularly related to the ‘Measurable’ element.

Benchmarking these indicators before running the campaign will establish a baseline which we can then revisit during and after the campaign period to determine its impact and residual benefit. We could expect to see indicators spike during the campaign and then settle after it has concluded. What we will be looking for is long term improvements from the baseline position.

Clearly the actual indicators you choose will be dependent on campaign indicators but for the majority of campaigns, understanding how your audience penetration has changed over time, whether or not their awareness, understanding and attitudes towards SF medical products has shifted, and if you can see a concomitant improvement in risk related behaviour will combine to give a strong view of campaign performance. Specific objectives relating to particular target audience segments or product specific objectives can be overlaid onto this approach.

Outputs can be helpful to give us a good idea of how comprehensive our campaign has been and how efficiently we have implemented it. The sort of data to capture will include the range of creative assets we were able to deploy based on our insight, the spread of media channels we covered, and our efficiency of production, including budget accuracy. These can act as benchmarks and checklists for future campaign activity.

It is when we look at campaign implementation though that we will aim to drill down to the impact of the communications. We should measure (or estimate) reach (how many of our target audience saw our communications and frequency (how often did they see the campaign?)), to begin to understand the likely impact. Were we targeting a particular demographic (e.g. young women) or geographical group (e.g. urban populations)? What was our penetration of this group?
With traditional paid for media audit data will tell us this information, be it national or regional broadcast (TV, cinema, radio), press, magazines or outdoor media i.e. billboards and posters sites. For digital channels where we are buying online advertising, we will be measuring impressions\(^\text{15}\).

Through our owned non-digital channels e.g. primary or secondary healthcare settings, we should be able to estimate our penetration through local feedback or by setting up straightforward reporting surveys (online or buy using field workers), even collecting smartphone pictures of physical materials from practitioners. This valuable information should always be recorded and retained to form the basis of an asset library that can be used to improve materials produced for future campaigns, -- focusing on improving and reusing what works well, and importantly understanding what not to replicate. It will also be helpful to demonstrate on the ground activity in workshops or cross team discussions.

Earned channels measures will be more proxy based, in social media we can see likes and shares and depending on the platform take advantage of their bespoke measurement and analytical tools. Social monitoring focused on metrics, e.g. engagement rates, number of mentions, increase in website traffic combined with social listening focused on sentiment will help build a picture of online activity, which can be supplemented by traffic directed to the website from partner activity, where the campaign assets have been shared with other public health organisations. Data from social monitoring can also be used to test one campaign asset against another when we have multiple creative executions to identify which one has greatest traction with our target audience or if we are segmenting audiences it will help us to test and subsequently match specific creative routes against particular target audiences.

We can measure over time how behaviour changes, based on the information we collected through insight and data and by benchmarking existing attitudes and practices, and running audit surveys or collecting data from reputable sources (e.g. registered pharmacies). We can investigate in more detail where our communications have had most impact. For example, did our insight lead to messaging that resonated with our audience? We can test our activity where the opportunity presents itself. If we have the resources, we can pilot our campaigns to test them in a real-world situation and adjust (if necessary) before wider exposure and expenditure.

Learning from the outcomes of the campaigns we run will lead to improvements in the impact of our future communications, and the building of a useful dataset.

\(^{15}\) Impressions are when an advertisement or any other form of digital media renders on a user's screen. Impressions are not action-based and are merely defined by a user potentially seeing the advertisement.
10. THE FUTURE: 2019 ONWARDS

The communications advice handbook, together with the library of existing campaigns and the social media review, will be made available to all member states in the first instance on the MedNet platform to coincide with the seventh meeting of the Member State mechanism in November 2018. In the future, any specifically commissioned work from WHO on substandard and falsified medical products communications will also be added to the library.

Given the scarcity of original citizen research, and thus little available benchmarking data it is hoped that WHO will be able to contribute to the insight body of knowledge over time.

The dedicated communications workstream of the overall programme is scheduled to be concluded at the seventh meeting of the Member State Mechanism, but given that the model for advice is deliberately practically focused, it is hoped that it will be widely used by member states and that new campaigns will be added to the digital asset library, so that it can evolve organically and member states can continue to benefit from the work within a strong guidance framework.
Appendix 1: IDEAS in Action. A campaign example from HSA Singapore

Insight: If you’ve shopped online you, (or someone you know) may have had a bad experience where what you ordered online wasn’t what was delivered. Medical products ordered online are potentially much more dangerous. The consequences of falsified products can be very serious.

Data: HSA used real data, real contents of tablets and so real symptoms. This was instantly more credible and believable to the target audience.

Engagement: Simple animation graphics tell a story and highlight the risks to citizens.

Action: A clear call to action that makes sense based on what you’ve just seen --- what to do, and what not to do.

Success: The film was widely socialised on YouTube and resonated with audiences.

- View Through Rate of 39.19% or 775,000 views far exceeded industry average of 15%
- View Through Rate was highest for ages 18 to 34 – the target audience group

---

16 The full film animation is available via MedNet
Appendix 2: Sample Creative Brief

Creative Brief

Date: 
Project Name: 
Campaign 
Original Author:

1. The Campaign
   • What is the scope of the campaign?
   • When will it happen and for how long?
   • Which media channels will be using?

2. The Objectives
   • What are communication objectives of the campaign?

3. The Target Audience
   • Describe the target audience
   • How large is the target audience?
   • What insight do we have on the target audience: demographics, geography, psychographics, usage habits; values, attitudes or lifestyles?

4. Current Mind Set
   • What does our target audience think now relative to SF Medical products (or a specific SF medical product)?

5. Personality and Tone
   • What is the tone and manner we should use in our communications?

6. Key Target Audience Understanding and Behaviour
   • What is the most compelling thing we want the target audience to think after they experience the campaign?
   • What is the most compelling thing we want the target audience to do after they experience the campaign?

7. Timing
   • When is the creative work required to be completed?
   • Will the campaign launch in all channels at the same time?
## Appendix 3: 2017 Global communications survey participants by WHO region

<table>
<thead>
<tr>
<th>EUROPE</th>
<th>AFRICA</th>
<th>AMERICAS</th>
<th>EASTERN MED</th>
<th>SE ASIA</th>
<th>WEST PACIFIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Czech Republic</td>
<td>Ethiopia</td>
<td>Argentina</td>
<td>Bahrain</td>
<td>Indonesia</td>
<td>Brunei</td>
</tr>
<tr>
<td>Ireland</td>
<td>Nigeria</td>
<td>Brazil</td>
<td></td>
<td></td>
<td>China</td>
</tr>
<tr>
<td>Italy</td>
<td>Senegal</td>
<td>Colombia</td>
<td></td>
<td></td>
<td>Japan</td>
</tr>
<tr>
<td>Norway</td>
<td>Tanzania</td>
<td>Costa Rica</td>
<td></td>
<td></td>
<td>Malaysia</td>
</tr>
<tr>
<td>Spain</td>
<td>Zimbabwe</td>
<td>Cuba</td>
<td></td>
<td></td>
<td>Republic of Korea</td>
</tr>
<tr>
<td>UK</td>
<td></td>
<td>El Salvador</td>
<td></td>
<td></td>
<td>Singapore</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Guatemala</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>USA</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 4: Communications Working Group Contributing Countries

AFRICA
Nigeria
Senegal
United Republic of Tanzania

AMERICAS
Argentina
Brazil
Colombia
United States of America

EASTERN MEDITERRANEAN
Iran

EUROPE
Italy
Norway
Sweden
United Kingdom of Great Britain & Northern Ireland

SOUTH EAST ASIA
Indonesia
Republic of Korea
Singapore

WESTERN PACIFIC