

Communication is a Public Health Strategy

Tracy Zimmerman

At a time when people are losing faith in public institutions, trust in the North Carolina Department of Health and Human Services is high. Using North Carolina's pandemic journey as a communication case study offers lessons for public health leaders. This article shares communication elements that helped build trust and provides recommendations.

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At a time when people are losing faith in public institutions, trust in the North Carolina Department of Health and Human Services (NCDHHS) is high. Although just as primed as other states to succumb to the politicization of the pandemic and vaccination, North Carolina largely did not. Instead, trust in North Carolina's health information and services was more likely to grow during the pandemic than decline. Trust went up for 35% of North Carolinians, with the highest increases among Black (47%) and Hispanic/Latinx (39%) people [1]. From the outset, the state's goal was for North Carolinians to trust the information they received from NCDHHS, and these findings demonstrate progress toward this goal.

This did not happen by chance. It happened by intentionally incorporating communications into every aspect of our COVID-19 response, which was grounded in a comprehensive operations process to get people testing, vaccines, and a range of services based on real-time data on the ground and adapting to the ever-changing dynamics of the pandemic.

Using North Carolina's journey as a communication case study offers lessons for public health leaders. Those looking for a silver bullet won't find one. What was most novel about our approach was that we did the hard work of outreach, building relationships, and delivering on our promises like equitable distribution of vaccines rather than chasing a magic message. As a result, North Carolinians credited NCDHHS for delivering the health information and services they needed; 82% said that the Department met (59%) or exceeded (23%) their expectations [1].

Early on, former NCDHHS Secretary Mandy Cohen recognized that communication was the linchpin for how North Carolina would fare in the pandemic. She and Governor Roy Cooper set the tone from the top, leading with transparency, listening to North Carolinians, and ensuring that communication staff were at the table and integrated throughout the state's response. Current NCDHHS Secretary Kody Kinsley,

who played an instrumental role throughout the pandemic, continues these efforts.

Our effort to nurture trust promoted equitable health outcomes. Most North Carolina adults (74%) completed their initial series of COVID-19 vaccination, including 99% of those aged 65 and older. There is no gap in initial COVID-19 vaccination between Hispanic and non-Hispanic North Carolinians, and the gap between Black and White North Carolinians is 3%, with no gap in some age groups [2].

Trust is a driver of positive public health behaviors. That's not to say that we didn't make mistakes. We did. But we were able to overcome them because we centered our response on earning trust.

It is impossible to capture the full picture of North Carolina's outreach and engagement response in one article. What follows are six communication elements that were central to building trust, and recommendations for action.

Flood the Zone with Simple, Accurate Information

Many of the "rules" of crisis communication do not apply to public health. When people's well-being is in play, you cannot wait until you have all the facts to share information, nor limit your visibility. Rather, it is imperative to be clear about what you know and what you don't know. Trust isn't built by having all the answers, it's built with honesty and access. You can't overcommunicate in a public health crisis. People need repetition, and they need a consistent presence upon which to rely.

For NCDHHS, this first manifested as daily news conferences. Within the first 18 months of the pandemic, we held more than 150 press briefings and participated in numerous media interviews. We often said the same thing each day. That was okay. It reinforced our message, and we gave reporters an opportunity to ask questions.

Throughout the pandemic, NCDHHS prioritized data transparency to hold itself and its partners accountable to equity in COVID-19 prevention and response. North Carolina has been nationally recognized for its race and ethnicity data quality [3]. At the same time, it is inevitable that there will be

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Address correspondence to Tracy Zimmerman, 1100 Vermont Ave, NW, Suite 200, Washington, DC 20005 (tracy@neimandcollaborative.com).

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The Politics of Health Communications

Christopher A. Cooper

The most important scarce resources in politics are time and attention. Sure, money matters, but savvy politicians can always work their networks to seed, find, or harvest more money. No amount of political savvy or connections can generate more time or attention.

Nowhere is this problem more prevalent than in the area of health policy. Health policy is often highly technical, shrouded in verbiage that is not accessible to the average voter or legislator, and can change rapidly. Combine these problems with the reality that health policy is also extremely important and is the subject of massive lobbying efforts, and it becomes clear that the job of communicating health policy effectively is extremely challenging.

The challenge is even greater in an era of low trust. Trust acts as a lubricant for complicated information. In the absence of trust, each interaction with information has more friction and is more difficult to complete. While trust in institutions has been waning since the early 1970s, the COVID-19 pandemic and related political fallout have reduced trust to levels that border on anemic [1].

Despite the challenges, scholars and practitioners must find a way forward, as health communication is increasingly important to any society, but particularly a democratic republic such as ours where public opinion can still influence public policy. From this vantage point, some citizens' disbelief that face masks can improve public health, for example, is not simply a curiosity; it is necessary to understand and challenge these attitudes to create a better society. Similarly, anti-vaccination sentiment is

more powerful in a democratic republic because it will result in politicians who are less willing to pass policies that encourage vaccinations. Effective health communication, therefore, is as critical to public health outcomes as the knowledge upon which it relies.

Anyone even remotely familiar with health communications has seen rumors and misinformation run amok—rumors and misinformation that, left to spread to the wrong hands, can result in bad public policy and poor health outcomes. A well-meaning practitioner might be tempted to simply try to quash those rumors by directly refuting them. Unfortunately, as political scientist Adam Berinsky demonstrates in a piece in the *British Journal of Political Science*, attempting to publicly quash rumors may actually make matters worse, increasing the prevalence of rumors and misinformation by drawing attention to them [2]. These results follow from other work on misinformation in American politics. A series of papers by political scientist Brendon Nyhan and colleagues demonstrate that correcting misinformation, particularly on controversial, value-laden issues, can generate backlash [3]. The result of that backlash may be that some people will hold onto their misinformation more tightly after being corrected [4]. Nyhan's work also extends to health policy and health communications [5]. For example, he and his colleagues find that correcting misinformation about the Zika virus in Brazil does not seem to change behaviors. Corrections made by people or resources from the opposing party are particularly ineffective and are the most likely to produce

errors when working with so much information from multiple outside sources. When that happened, we acknowledged mistakes, shared what happened, and updated our dashboard. Finally, data need context. Secretary Cohen became famous for her "data days," when she walked the public through the numbers, explaining trends and implications.

Media is an important channel for sharing information but can't be the only one. Your partners can help disseminate information. We went old school and used a "phone tree" model. There was no master list of all NCDHHS stakeholders, so we had to get creative fast. We identified which staff "owned" which stakeholder groups and put that person in charge of dissemination. One person was charged with dissemination to child care and early learning partners, another to legislators, another to higher education, and so on. The communication office wrote regular updates that were sent to more than 40 staff who then sent the updates to their lists. It wasn't high-tech, but it was efficient, and it worked.

Sharing information only works if people understand it.

Too often the COVID-19 information coming from national sources was convoluted, confusing, and full of jargon. Our mantra was: simplify. Our 3Ws and Spanish-language las 3Ms are an example. We asked our health experts to name the top three behaviors—not everything!—people could do before vaccines were available to slow the spread of COVID-19. They told us: wear a face covering, practice social distancing, and frequently wash hands. That was the impetus for **Wear. Wait. Wash.** (Usa una **M**ascarilla. **M**antén la distancia. **L**ávate las **M**anos.)

Recommendations for public health leaders and communicators: *Communicate! Do the interviews. Publish content on your channels. Keep your stakeholders informed. Get creative. Share what you know, and what you don't know yet. Don't sacrifice understanding for precision.*

Do the Research

Research is fundamental to health care. It drives the development of new medicines, vaccines, surgical proce-

negative outcomes [6].

So, what is to be done?

There is some evidence that norming behavior among like-minded people can help—at least in the short run. For example, reminding Republican skeptics that prominent co-partisans support masking, or reminding anti-establishment liberals who are vaccine skeptics that many of their co-partisans support vaccinations, can help shift public opinion and be less likely to backfire. In a piece in the *New England Journal of Medicine*, Richard Baron, M.D., and the aforementioned Berinsky argue that “intentionally recruiting civic-minded people to deliver medical and scientific facts that run counter to the public’s expectations of those people’s own interests might be effective” [7].

As this issue of the *North Carolina Medical Journal* demonstrates, we are living in an area of low trust, and that trust is unevenly spread throughout society. Some people trust more than others and some sources are considered more trustworthy than others. To make matters even more difficult, the specifics of who trusts whom can vary by background, political affiliation, and ideological outlook.

It is not enough for practitioners who wish to accurately communicate difficult information about health and health policy to simply “speak truth to power” and expect outcomes to change. Instead, they must cultivate a heterogeneous network of policymakers and influencers to make the case for them.

From this perspective, health communication in a time of low trust needs to be thought of as a critical process, not a single, invisible act. Research outcomes and preferred health policy must make it from the researcher to a diverse network of sources, who then speak to their respective communities.

Paying attention to the reality of the low-trust environment, the highly technical nature of health communica-

tions, and the fleeting nature of public attention is the only way to achieve the policy and public health outcomes that will ultimately benefit society. NCMJ

Christopher A. Cooper, PhD Madison Distinguished Professor of Political Science and Public Affairs, and director, Public Policy Institute, Western Carolina University, Cullowhee, North Carolina.

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Address correspondence to Christopher A. Cooper, 1 University Dr, Dept of Political Science and Public Affairs, Western Carolina University, Cullowhee, NC 28723. (ccooper@email.wcu.edu).

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dures, and behaviors. So, it’s shocking how little is invested in how to best communicate health information so that people take the desired action. This needs to change.

North Carolina was among the first states—if not the first—to conduct comprehensive, values-based research to understand how people would make decisions about COVID-19 vaccinations. Working with Neimand Collaborative and Artemis Strategy Group, we conducted statewide research to uncover the benefits, emotions, and values needed to create behavior change. These insights allowed us to build a campaign that understood people’s motivations, respected their fears, accounted for the barriers they faced, and created culturally aligned outreach that provided people with confidence to get vaccinated.

Understanding how people make health decisions drives the most efficient and effective use of resources. In the case of COVID-19 vaccines, we learned that while reasons for hesitancy differed across demographic groups, the moti-

vating messages were the same: it was the messenger that mattered. This finding was counterintuitive to many working on the response, who believed that the wide range of experiences across populations—and particularly the injustices experienced by historically marginalized populations—required segmented messaging. Having the research to point to, and having our research team present the findings to groups across the state and answer their questions, kept us from diverting the time and money that would have been needed for segmented campaigns.

Recommendations for national and state public health leaders: Invest in market research and let states and communities know that you are doing it. Research and understand how people make decisions rather than relying solely on message testing. Understand what people value and the trade-offs they make in deciding on behaviors. Share the findings broadly and specifically with those charged with communication. Let people ask questions so they have confidence in the findings. Provide

a slide deck and tools that can be used to build buy-in for the findings to partners.

Engage Trusted Messengers

Public health needs to engage in more of a ground game. Who are the people that a local community trusts? How can you engage others to put their brand behind your message?

We worked with partners and people on the ground to share information and engage people in conversations. Early in the pandemic, Secretary Cohen began holding roundtables with faith community leaders, community advocates, and leaders from historically marginalized groups. Through Healthier Together, the state provided grants to community organizations to conduct vaccine outreach and education, and our efforts to provide turnkey communication tools to groups across the state expanded our community network.

This new base of engagement was instrumental in getting people information they could trust and helped provide critical insight into local influencers. The best messengers are not always who you think. For example, when we saw cases were high and vaccination rates were lower in one of our communities in the east, we learned that the voice that would have the greatest impact was the local funeral director. She agreed to record a robo-call that went to households in that community.

Finally, we created ways for everyone to be involved and put their brand behind vaccines. In 2021, our Bringing Summer Back campaign engaged 350 partners, including businesses, event centers, retail stores, pharmacies, sports leagues, libraries, health care providers, and many others to help people get vaccinated.

Recommendations for public health leaders: *Identify the groups with influence in your community and start building authentic relationships now. Meet with them regularly, listen and learn from them, and show them that their voices are heard with meaningful actions. Earn trust before you need it; these can't be transactional relationships. Create tools that make it easy for all kinds of entities to help.*

Recommendations for communicators: *Play the ground game. Talk directly to people and provide services in the communities in which they live.*

Meet People Where They Are

When it comes to public health campaigns, paid advertising is often a default strategy, but while it can keep messaging prominent, it rarely changes behavior. This was true for vaccines. Advertising had little if any impact on people getting shots. We needed to meet people where they were—mentally and physically.

Once we got past those who were rushing to get vaccinated, people had questions. We made it easy for them to get answers. As of January 2023, North Carolina has hosted 35 live-streamed town halls in English and 13 in Spanish, with more than 430,000 participants. These town halls covered different topics and featured North Carolina medical experts

and people who had been impacted by COVID-19. People asked questions by phone or through social media.

Similarly, we trained more than 125 people to give a COVID-19 Vaccine 101 presentation. The YMCA, education leaders, church groups, business professionals, and many others hosted hundreds of presentations for their communities.

Recommendations for public health leaders: *Listen. Provide opportunities for conversation. Respect people's questions.*

Create Culturally and Linguistically Appropriate Campaigns

Eleven percent of North Carolina's population is Hispanic/Latinx, of which more than three out of four speak a language other than English at home. Yet, until the pandemic, NCDHHS was using Google Translate for its digital content and outsourcing translation of documents, which meant many materials were not available in Spanish. When they were, they were often delayed and not culturally or linguistically appropriate. It's hard to earn trust without demonstrating in action that Spanish-speakers are just as valued as English-speakers. We needed to do much better, and that meant crafting messaging and outreach led by native speakers. We embedded communication partners with expertise in culturally and linguistically appropriate messaging and strategy and worked with NCDHHS's Healthier Together initiative to partner with Hispanic/Latinx community organizations. NCDHHS also hired its first Director of Hispanic/Latinx Policy and Strategy, Yazmin Garcia Rico.

This engagement led to the creation of North Carolina's Spanish-language COVID-19 vaccine campaign, iVacunate! Materials were driven by native Spanish speakers, not translation software. The iVacunate! website became a global source of information. Google designated the site as an authority on a variety of Spanish-language topics and analytics reports show that it directed people to the website no matter where they lived.

Recommendations for public health leaders and communicators: *Commit to providing bilingual public-facing information that is culturally appropriate, responsive, and time sensitive. Work with native Spanish speakers. Collaborate with community groups and stakeholders.*

Fund to Match the Challenge!

I would be remiss if I did not address a game changer in our communication response—money. Very little money is typically allocated for public health communication, despite the large negative impacts that health crises have on people and society. Communication for COVID-19 vaccines was resourced at an unprecedented level. There were millions of dollars available and almost all was reimbursed by the Federal Emergency Management Agency (FEMA). This funding made so much possible—communications, outreach, and equitable distribution of testing, treatment, vaccination, better health outcomes, and lives saved.

Recommendation to policymakers: Fund it.

Conclusion

As the nation embarks on its crisis response postmortem, “trust” has become a focal point—how to build it, rebuild it, earn it, keep it, strengthen it, save it. We can start by recognizing that communication is a public health strategy. Public health efforts cannot succeed solely with strategic communication; however, they fail without it. **NCMJ**

Tracy Zimmerman, BA vice president, Policy and Communications, Neimand Collaborative, Washington, D.C.; former deputy director, Policy and Communications, North Carolina Department of Health and Human Services, Raleigh, North Carolina.

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