Improving Health worker and Community Influencer Competence on Identifying and Managing Misinformation on Routine Immunisation in Niger State, Nigeria

Poster #1

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Background

Health misinformation negatively impacts health seeking behaviour and has the potential to increase morbidity and mortality. In rural communities, health structures and mechanisms for managing infodemics are often weak, as seen during the COVID-19 pandemic, leaving rural dwellers susceptible to mis- and disinformation. There is, therefore, a need to set up mechanisms that leverage community structures to improve health literacy in the communities.

Sources of Health Information

58% Health Facilities

22% Traditional Media

11.7% Community Leaders

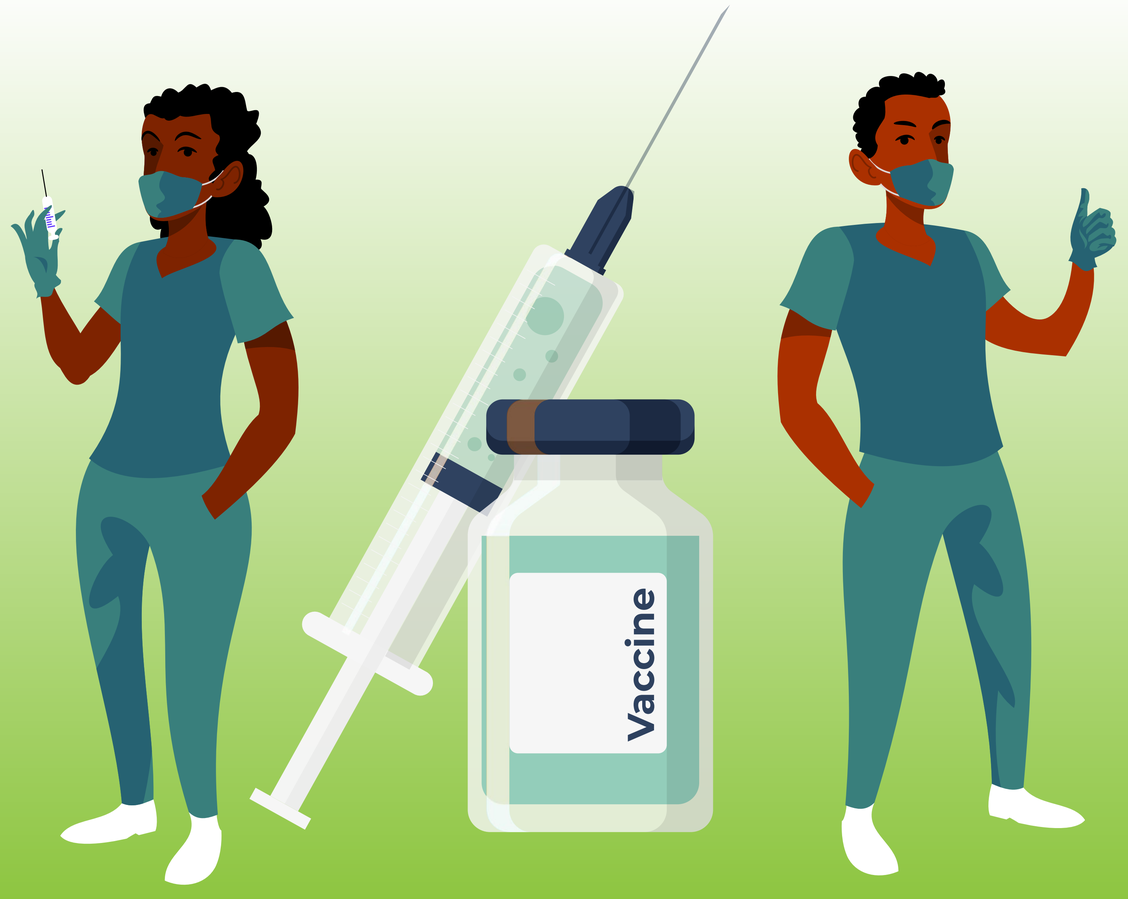
In August 2022, Nigeria Health Watch piloted an offline social listening project in eight Local Government Areas (LGAs) in Niger State, Nigeria, where community members were trained and supported to collect quantitative and qualitative data on prevailing health misinformation in their communities, including on childhood routine immunisation. A key finding from this data was that community members get their health information from three top sources - 58% from health facilities, 22% from traditional media (radio/TV) and 11.8% from community leaders. Interventions were subsequently deployed to debunk identified misinformation in the State using these insights, one of which was a training of Heads of primary health care centres, LGA health educators and ward development committee heads on identifying and combatting misinformation. The aim of the project was to pilot a viable offline social listening mechanism for community-based management of health misinformation in Niger State.

25
Participants Trained

27%
Significant increase in knowledge of social and behavioural considerations for combating misinformation

162
Community members Trained via cascade

50
Healthcare Workers Trained via cascade



Methods

An andragogic approach was used to train primary health care facilities-in-charge, LGA health educators, and Heads of Ward Development Committees (WDCs), influential community leaders tasked with ensuring accountability in the delivery of primary health care services in communities. This included interactive discussions, group work, role play and practise sessions, encouraging equal participation from all attendees. At the training, common misinformation previously identified were discussed and debunked, and participants were trained on social and behavioural methods for combatting misinformation. Participants were subsequently supported with Information, Education and Communication (IEC) materials to conduct cascade trainings in their facilities and communities.

Results

A total of 25 participants were trained from 8 LGAs, and there was a significant increase in knowledge of social and behavioural considerations for combatting misinformation (27%). Feedback from participants was that they had never benefitted from a training targeted at the management of misinformation before, and had found their own bias towards misinformation confronted during the training.

Cascade trainings were confirmed to have been conducted in communities in all 8 LGAs, with health care workers conducting cascades in their facilities and WDC Heads conducting cascades via community meetings in 4 out of 8 LGAs. A total of 162 community members and 50 health care workers have been trained via cascades. An endline survey to check for impact on knowledge, awareness, health seeking behaviour, vaccine hesitancy, etc. will be conducted in February 2023.

Conclusion

Community structures remain a viable, sustainable option for ensuring a consistent flow of accurate health information, and should be leveraged for the management of misinformation both during and outside public health emergencies. This has the potential to improve vaccine uptake and reduce hesitancy.

References

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