

Going beyond access to health information: a pandemic call to action

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About a decade earlier we brought to attention that the lack of access to health information is ‘a social injustice that the global health community cannot afford to ignore’¹ and argued that governments are morally and legally obliged to ensure access to health information. Since then, a lot of progress has been made in the domain including the recent high-profile statement by the World Medical Association that health information ‘is a major contributor to morbidity and mortality, especially in low and middle-income countries (LMICs), and among vulnerable groups in all countries’.² Others have also argued that access to health information is a key component of universal health coverage.³ In the backdrop of the COVID-19 pandemic, we have seen significant investments from multinational agencies, governments, non-profits and private actors to disseminate health information. However, a narrow focus on providing access to health information alone, without any investment or thought on how information can be translated by people to meaningful health outcomes, is proving to be counterproductive.

The need for masks, hand hygiene, physical distancing, stay-at-home efforts, ventilation and vaccinations have been key areas of interest in generating information products.⁴ Billions of dollars and countless volunteer hours are being invested in developing health information materials in myriad formats, with digital and mass media being the preferred dissemination modes. While health information is essential, larger questions remain unanswered. How can people ensure physical distancing in densely crowded urban areas?⁵ How do people struggling to survive purchase masks? How can people living without adequate housing and sanitation comply with hand hygiene and stay-at-home orders?⁶ In many LMICs, the transactional nature of society implies that ensuring physically distanced workplaces, public places and transport, without radical changes in landscape

and deurbanisation of the economy,⁷ is difficult, if not impossible. These issues are discussed, but norm-setting institutions or governments do not act on it. Unpragmatic technical advice, which might be theoretically sound, but practically not feasible, has been met with cynicism and derision by the people, because they further perpetuate inequity and injustice.⁸

Vague assumptions of end-user needs, without any serious attempts to understand the context in which health information is being provided, have led to an inevitable disconnect between health information products and people who use them. Broadly all health promotion theories underline that information alone without social support and ecosystem changes cannot bring positive behavioural change.^{9–10} Naturally, the impact of health information products on transforming health behaviours at the population or community level remains minimal, if at all. Governments have also attempted to shift blame to people^{11–13} when challenged on policy and governance inaction. Providing health information alone should not absolve governments of the responsibility to provide health—a basic human right.

In response to the ongoing humanitarian crisis of COVID-19 in South Asia, many government agencies and volunteer groups have advocated for, and developed information products, which are being disseminated digitally or through mass media. While well intentioned, it has societal consequences, which humanitarian actors need to be cognisant about. Urban, educated and affluent populations, who also have greater access to formal health services, are able to rapidly adopt and use the information to achieve meaningful health gains.¹⁴ Digital dissemination of home management of COVID-19 information contributed to massive hoarding and black marketing of essential medical supplies including oxygen, oximeters and inhalers in urban India. This disturbs the supply chain

logistics across the country. Lower penetration of health information, and paucity of supportive infrastructure in rural areas, means that such action strengthens the forces of inequity and injustice. At a societal level, such actions endanger social cohesion—making the rift between ‘us’ and ‘them’ more obvious. Making digital transmission of information the modality *du jour* is a luxury humanitarian effort which we can ill afford now. Perhaps it will not be an overstatement to say that a digital-only humanitarian response is the ‘eighth sin’ of humanitarian medicine.¹⁵

We urge multinational agencies, governments, global health organisations and humanitarian crisis response groups to not limit themselves to generating health information products. There is a need to systematically invest in efforts to understand the contexts of target audiences; to *a priori* define information needs granularly and consider the direct and indirect impacts of their actions through an equity and social justice lens. Doing rapid research, reflecting on strategies enabling access to health information, outlining and evaluating how different equity groups interact with health information and pondering on the intentional and unintentional consequences of providing health information should be the norm—not an exception. Governments, volunteer groups and humanitarian actors all need to take the onus of transforming health and go beyond the bare minimum of providing access to health information. Investments during humanitarian response are scarce and they need to be distributed across health, not solely on provision of health information. The right to health information sits within the right to health.¹ As such, providing access to health information is a means to an end, and not the end in itself.

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