ENHANCING TRUST IN PUBLIC HEALTH:
WHEN RECOMMENDATIONS CHANGE

In partnership with ASTHO and NPHIC, the Harvard Opinion Research Program is conducting a series of surveys to understand public trust in public health and to provide robust evidence that can help build the foundation for overarching strategy and messaging across many activities in the coming year. This memo showcases select results utilizing data from the second nationally representative survey, this time among 2,821 U.S. adults conducted March 31 to April 12, 2022. Key implications for state, territorial and local health departments were developed from the results and can be used to shape communications and outreach.

KEY FINDINGS

Views of Public Health Update

- Public health agencies at the federal, state, and local level are relatively well-trusted for COVID-19 information.

- While trust has declined since a peak in February 2021, it has also rebounded slightly since the lowest point, measured in February 2022.

Trust & Changing Recommendations

- Those who trust state public health agencies more and less have different views of the reasons why recommendations changed over the course of the pandemic.

- The most trusting believe changes were driven primarily by science, while a majority of those who only trust state public health agencies "somewhat" feel there was also political and private sector influence. The least trusting believe changes were mainly due to political and private sector influence.

Views of Future Recommendations Changes

- The majority of the public supports recommendations for masking across many settings if cases were to rise again. Support does not vary much by the strictness of mask policies (i.e., if recommended or required) or the severity of a future surge (i.e., if vaccines would or would not be effective).

- Those who are less supportive of mask recommendations include those who: do not trust state public health agencies; are unvaccinated; live in rural areas; are White.

IMPLICATIONS FOR COMMUNICATIONS

Foundational Framing Update

- Remember that there is a strong foundation of positive trust in public health at all levels; public perceptions of public health agencies fluctuate as events occur, and they are not in an inevitable downward slide.

- Consider the new opportunities to boost trust while policies and recommendations about protective behaviors are changing during this period.

Messaging as Recommendations Change Now

- Consider the gradient of trust in your jurisdiction.

- Shore up trust among those who are more trusting by leaning on messages that resonate with those groups, such as the role science plays in recommendation changes.

- Address concerns among those who do not trust "a great deal" (but still some) by maintaining a non-partisan approach and keeping distance from corporate influence in communications.

Messaging for Future Changes

- There is unlikely to be a lot of nuance in support for changing recommendations. To communicate effectively, segment the public into groups with aligned support.

- Create packages of messages and approaches for each group to address recommendations for increased protective measures in advance.

- Question old models of trust based on racial/ethnic differences – but don't stop tailored communications to support communities at especially high risk.

Priorities Beyond COVID

- The public has many top priorities for state and local health departments, including infectious diseases, mental health, water quality, chronic diseases, infant mortality, suicide, substance abuse and addiction. Fewer think cigarettes, climate change, or gun injuries should be top priorities.

- There is agreement across those who trust state public health agencies more and less on the top priorities for public health, but these groups vary substantially in their support for lower priority areas.

Building Trust Long-Term

- There may be opportunities to build trust in public health agencies by addressing issues beyond COVID-19.

- Addressing areas that are priorities for a wide range of groups can help build trust, if policies are consistent with their values.

- Consider emphasizing plans to address:
  - Mental health
  - Water quality
  - Chronic illness
  - Infant mortality

METHODOLOGY

Results are based on survey research conducted by Harvard T.H. Chan School of Public Health, in partnership with the Association of State and Territorial Health Officers (ASTHO), the National Public Health Information Coalition (NPHIC), and funded by the Centers for Disease Control and Prevention (CDC). Representatives from all four organizations worked closely to develop the survey question-naires, while analyses were conducted by researchers from Harvard and the fielding team at SSRS of Glen Mills, Pennsylvania. The project team at Harvard was led by Gillian K. SteelFisher, Ph.D., Research Scientist and Deputy Director of the Harvard Opinion Research Program and included Hannah Caporello, Senior Research Projects Manager.

Interviews for Wave II were conducted with a representative sample of 2,821 adults, ages 18 and older, in English and Spanish online (n=2,621) and by telephone (n=200). Online respondents were reached through the SSRS Opinion Panel and the Ipsos Knowledge Panel, each of which are nationally representative, probability-based web panels. Telephone respondents were screened for being non-internet users and they were selected from the SSRS Omnibus, a bilingual survey of cell phone and landline users selected through RDD. Telephone interviews were conducted to ensure that people who do not access the internet were included. The interviewing period for Wave II was March 31 to April 12, 2022. Using parallel methodology, the interviewing period for Wave I was February 1 to 22, 2022.

When interpreting findings, one should recognize that all surveys are subject to sampling error. Results may differ from what would be obtained if the whole U.S. adult population had been interviewed. The margin of error for the full sample in Wave II is ±2.4 percentage points.

Possible sources of non-sampling error include non-response bias, as well as question wording and ordering effects. Non-response in web and telephone surveys produces some known biases in survey-derived estimates because participation tends to vary for different subgroups of the population. To compensate for these known biases and for variations in probability of selection within and across households, sample data are weighted in a multi-step process by probability of selection and recruitment, response rates by survey type, and demographic variables (race/ethnicity, sex, age, education, region, internet access, civic engagement, and urban status) to reflect the true U.S. population. Other techniques, including random sampling, multiple contact attempts, replicate subsamples, and systematic respondent selection within households, are used to ensure that the sample is representative.