Setup and management of COVID-19 hotlines

ABSTRACT

Hotlines are among the most commonly used tools by health authorities in the response to the COVID-19 pandemic in the WHO European Region. They establish a direct link between at-risk populations and emergency responders, improve responders' understanding of people's perceptions, attitudes and concerns, and provide public health advice, counselling and/or referral to other services. COVID-19 hotlines also allow expansion of established hotline practice: COVID-19 hotlines, more than other kinds, are used to conduct listening, or data collection, from calls to inform and adjust the public health response. This document provides details on how to conduct such data collection in a practical and ethical manner, along with best practices for running hotlines for public health emergency purposes. The quick tips provide practical considerations and resources to help professionals working in pandemic response at national and subnational levels to set up and manage national COVID-19 hotlines.

Contents

Introduction

Hotlines are among the most commonly used tools by health authorities in the response to the COVID-19 pandemic in the WHO European Region for three main reasons. First, they establish a direct link between at-risk populations and emergency responders. Secondly, they improve responders' understanding of people's perceptions, attitudes and concerns. Finally, they provide public health advice, counselling and/or referral to other services.

This use of hotlines in public health is not new: common examples include hotlines to quit smoking and so-called crisis lines, such as those for prevention of suicide (Annex 1 provides a list of resources for further reading, including on current uses of hotlines in public health).

COVID-19 hotlines also allow expansion of established hotline practice: COVID-19 hotlines, more than other kinds, are used to conduct listening, or data collection, from calls to inform and adjust the public health response. This document provides details on how to conduct such data collection in a practical and ethical manner, along with best practices for running hotlines for public health emergency purposes generally.

Overall, the quick tips provide practical considerations and resources to help professionals working in pandemic response at national and subnational levels to set up and manage national COVID-19 hotlines.

From a broader perspective, hotlines serve the area of risk communication and community engagement (RCCE). Based on long-standing RCCE evidence and practice, one of the most important and effective interventions in a public health response to any event is to communicate proactively what is known, what is not known, and what is being done to get more information, with the objectives of saving lives and minimizing adverse consequences.

RCCE builds trust in the response and increases the probability that health advice will be followed. It minimizes and manages rumours and misunderstandings that undermine responses and may lead to further disease spread.

Trust plays a central part in the WHO Regional Office for Europe's model for emergency risk communication *(1)*. It is the currency for communicating health risks and is supported by four core capacities: transparency and early announcement, coordinating public communication, listening and two-way communication, and selecting effective channels and trusted influencers. Setting up or adapting an existing hotline[1] builds these capacities and increases trust, which ultimately improves health outcomes and saves lives.

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[1] A hotline is defined as a telephone line that gives quick and direct access to a source of information or help, often at no or low cost to the caller.

Guiding principles in setting up a hotline

Trust

Trust is at the heart of the Regional Office's model for *RCCE (1)* and is a key part of COVID-19 hotlines. Trust should flow in multiple directions in the COVID-19 response: from affected people to emergency responders, from authorities to their people, and among responders and affected people themselves.

Service-oriented, community-led

A hotline must serve at-risk and affected community needs. To understand and address these needs, you should engage communities in every step of the process through focus groups, meetings and community-led design processes, and by collecting feedback on the hotline's usefulness.

Emotional intelligence

COVID-19 hotline operators get calls from people who feel strong emotions: anger, stress, fear. Operators must have strong communication skills, be emotionally intelligent and be able to manage these difficult emotions effectively. They must model empathy, active listening and a non-judgemental attitude.

Evidence-based

COVID-19 hotline operators must be very knowledgeable about the pandemic to answer questions and address concerns quickly. This includes knowledge of national measures and international recommendations (including those from WHO), as well as the reasons and science behind them.

Designing your national COVID-19 hotline

Hotline service goals

The first consideration should be the purpose of your hotline. The team that is setting up the hotline, including community representatives, should ask themselves the following.

- What are the specific community needs we are meeting with this hotline?
- How will we/have we validated this need with the community?
- How are we coordinating with national COVID-19 response actors to include hotline data and feedback to adjust the response?
  - *See "Hotline data for a better COVID-19 response" below.*

Three key hotline purposes to consider are:

- establishing a direct link between at-risk populations and emergency responders;
- improving responders' understanding of people's perceptions, attitudes and concerns; and
- providing public health advice, counselling and/or referral to other services, including appropriate emergency support to people in distress and life-threatening emergency situations:[2] such calls may include COVID-19 related distress or emergencies (like difficulty breathing, or anxiety or panic attacks triggered by concerns about the disease) or other forms of distress and emergencies (such as interpersonal violence, including family or intimate-partner violence, or suicidal ideation) (see, for example, WHO *(2)*); in cases of distress and/or life-threatening emergencies, robust referral to first-responder hotlines is especially important, given the specialized training first responders normally undergo.

Hotline scope and strategy

The next step is considering how your hotline will meet the stated need. Ask your team the following.

- Is providing and collecting information enough, or do we also need a referral system?
  - If yes, how do we train our hotline operators to handle or rapidly and reliably refer distress calls of different kinds?
  - If referral services do not exist, do we have the capacity to train our staff to provide a wider range of support?
- Do we only take calls, or should we reach out proactively to some (vulnerable) groups?
- Do we need to call people back after a period of time?
- What other platforms and services are we using to ensure we are reaching and listening to our target audiences?
- Are we able to stay open 24/7 or, if not, how do we find out when our target audiences are most likely to call?

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[2] See Annex 3 for a sample protocol for receiving a medical emergency call.

Including the most vulnerable

Early on in the process, consider the specific needs of your audiences and the most vulnerable among them, including:

- older people;
- people with underlying conditions;
- people who do not speak the national language(s) or have cultural practices that may have an impact (such as different comfort levels in talking to strangers and/or authorities);
- people with lower access to telephone services; and
- people who are hard of hearing or deaf.

Relationships with related organizations

You should map and partner with organizations (governmental, nongovernmental and international) that already have hotlines in place or may be thinking of creating one. Common hotline topics include suicide prevention, HIV/AIDS, preventing child abuse and quitting smoking.

Hotline data for a better COVID-19 response

Information, or data, from callers to COVID-19 hotlines can help improve the overall pandemic response. Daily collection and weekly sharing of simple caller data can reveal emerging trends in concerns and attitudes, confirm the value of existing response measures, and help advocate for (additional) funding for the hotline itself and other response measures.

Information to collect

Useful categories of data to collect from your COVID-19 hotline include:

- *the total amount and length of calls per shift, to:*
  - identify patterns and peaks in caller volume and assign enough staff at all times
  - prove the hotline's value and mobilize additional resources if needed;

- *anonymous caller data (including age, sex, ethnic group, education level and location) to:*
  - identify patterns in perceptions, attitudes, and behaviours (for example: are certain groups more/less likely to adopt certain protective behaviours?)
    (a clear picture of which groups are more/less likely to behave in certain ways can be a starting point for further research, to understand why this is the case and design appropriate response measures); and

- *frequently asked questions, to:*
  - understand trends in mis/disinformation, rumours, etc.
  - identify opportunities for broad and/or targeted interventions to improve trust, understanding and uptake of recommended public health interventions.

Methods for collecting information

Hotline data can be collected by automated software or by using complex or simple call logs (see Annex 2 for sample operator and manager log sheets). These logs, which document new trends, rumours, topics and the tone of callers, are a living source of intelligence for hotline operators and the COVID-19 response as a whole.

Incorporating data into the COVID-19 response

A summary of daily call logs should inform the COVID-19 response in two main ways. First, supervisors should discuss completed logs with their operators at the end of each shift and brief the incoming shift on any changes. Secondly, the hotline manager should have frequent (at least weekly) briefings with central coordination mechanisms on emerging themes, trends and other conclusions from the call logs. Depending on the topics and themes identified in the logs, the hotline manager should brief different parts of the response – not just the risk communication and community engagement aspect of it.

Staffing

Long wait times and unanswered calls will quickly destroy people's trust in a hotline. To avoid this, you should train and schedule enough staff capacity, including backup for peak hours and periods. Given that Member States proceed through phases of the pandemic in different ways and may see reductions in cases followed by resurgence, it is also advisable to consider mechanisms for scaling up and down in a flexible fashion.

Functions

Below is a list of roles you need on your hotline team. For smaller teams, one person may be responsible for multiple tasks. It is also crucial to include enough risk communication capacity among key staff, including the manager, supervisor, training coordinator and operators.

Hotline manager

The hotline manager takes overall responsibility for the programme. S/he oversees and coordinates all activities, regularly briefs the national COVID-19 response and ensures the hotline is doing its job.

Hotline supervisor for operators

The supervisor oversees, trains and coaches operators on a day-to-day basis. Supervisors ensure that operators have what they need to function, including the latest information, tips on how to handle difficult calls and quick feedback on operators' performance.

Roster or scheduling coordinator

The scheduling coordinator makes sure there are always enough operators and backup capacity to take the volume of calls. This volume is usually somewhat predictable on a daily and weekly basis, with spikes when the hotline opens and when there are major public announcements.

Training coordinator

The training coordinator organizes basic training for new operators and training on new topics as they emerge. This includes training on updated scripts, protocols and messages, additional facilitation skills or unforeseen factors (such as a sudden increase in calls from people who speak another language).

Fundraising coordinator

The fundraising coordinator makes sure the hotline's budget is funded. Depending on national context, s/he will engage national authorities, national and international nongovernmental agencies and organizations, the private sector and other opportunities.

- *See "Sustainability" (below).*

Personnel for administrative functions

Support staff for administration is a crucial part of any operation, including hotlines.

ICT expert

The ICT expert is responsible for the hotline technology, whether it is just telephone lines or also computers and caller logging and analysis software.

Community engagement focal point(s)

Hotlines can reduce community engagement work but not replace it, since a phone call and a face-to-face conversation are two very different experiences.[3] The community engagement focal point connects with other community engagement teams in the response to ensure a personal face for the hotline and two-way flow of information, and can collect additional information on how familiar people are with the hotline, if they use it, and how it can be improved.

Webmaster and website development

Most hotlines have a website for awareness raising, answering frequently asked questions (FAQs) for people who do not want to call, and collecting complaints, suggestions and other feedback.

Marketing and promotion coordinator

The marketing coordinator promotes the hotline in traditional and social media and makes promotion materials available to community engagement teams and the national COVID-19 response.

Monitoring and evaluation coordinator

The monitoring and evaluation coordinator collects and organizes information from different sources that demonstrates the effectiveness of the hotline and any major improvements needed. S/he also liaises closely with operators, supervisors and the hotline manager to support their reporting and feedback mechanisms.

Recruitment and partnering

To find enough qualified staff and volunteers for your team, you should partner with organizations that have strong volunteer programmes and with higher education institutions. For example:

- United Nations sister agencies, like the United Nations Children's Fund (UNICEF)
- the International Federation of Red Cross and Red Crescent Societies (IFRC)
- universities, especially medical schools.

In selecting partners, consider capacity, so-called soft skills such as emotional intelligence, and technical knowledge on public health-related topics.

Training

Your team will need initial and ongoing training in two main areas:

- public health/medical technical (knowledge of COVID-19, including symptoms, preventive behaviours and national response measures); and
- soft skills to successfully handle challenging calls.

Messages, protocols and scripts

The training coordinator should draft a phone script and protocol that provides detailed steps on collecting information from callers and providing information to them.

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[3] As per WHO recommendations, community engagement staff should observe appropriate physical distancing (at least 1 metre) and respiratory and hand hygiene *(3)*.

These scripts and protocols should be updated frequently as the pandemic and public health response evolves. Important sources of information include:

- technical guidance and public information from national and local authorities
- recommendations and guidance from WHO.

The WHO Regional Office maintains a website with the latest information on COVID-19 *(4)*, including risk communication materials, FAQs, technical documents, and links to statements, speeches and regular press briefings.

Emotional and cultural intelligence

To handle difficult calls, operators must develop high emotional intelligence skills, including empathy, patience, a service-oriented attitude and active, nonjudgemental listening. Operators need a sharp awareness of their own background and how it colours their world and perceptions, and should have the ability to place themselves in the shoes of a caller who may have a different experience.

Language

A hotline must often serve groups of people who speak different languages. You should ensure a balanced representation of nationally spoken languages (including languages spoken by significant refugee and migrant populations) during recruitment and scheduling of operators. The best way to do this is to include representatives from the communities as volunteers or staff on your hotline team.

Sustainability[4]

Raising funds to support the day-to-day costs of operating the service is a key element in starting and sustaining a crisis line. Experience has shown that services may spend one or more years fundraising and preparing a funding model that will sustain service operations over time.

Following the same logic for staffing, it is advisable to prepare for flexibly scaling fundraising efforts up and back down depending on the phase in the pandemic and resultant levels of calls.

A crisis line can receive funding from a variety of sources, such as:

- personal donations;
- philanthropic organizations;
- government funding;
- religious entities;
- communication and information technology providers;
- social enterprises (such as sales from second-hand goods);
- community-based fundraising (from community events, for example); and
- in-kind support (including time or infrastructure, such as a building to operate from, or donated telephone and Internet services).

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[4] Adapted from WHO *(5).*

Ethical standards and guidelines

It is imperative that hotline callers are treated with full respect for diversity and that they do not face any discrimination or political, religious or other pressure.

Hotlines should have an ethical document that outlines these standards; the standards, and the consequences of failing to meet them, should be discussed during training sessions. The document should specify the limits of staff and volunteer involvement and obligations concerning respect for callers and maintenance of confidentiality. Ethical standards generally include prohibitions on:

- meeting callers privately or exchanging personal information
- discussing calls with relatives and friends
- telling callers to follow a specific religious or political practice.

Finally, since COVID-19 hotlines are important sources of data from which to adjust the response, care should be taken to guarantee that data are collected ethically and with respect to the rights of callers. Some guiding principles[5] that should be considered include:

- transparency: callers should be informed of how their data and information may be used to improve the national COVID-19 response, and they should be allowed to opt out from their call being logged;
- minimization of purpose, data and storage: collected data should:
  - o only be used for the established hotline purpose
  - o collect no more information than necessary for the established purpose, especially regarding personal information
    - *See "Confidentiality and/or anonymity" (below);*
  - o be stored securely and only for as long as necessary to fulfil the hotline's stated purpose; and
- confidentiality and/or anonymity: collection of personal or identifiable data (name, address, identification number and other identifiable characteristics) should be limited to those data that are absolutely necessary, ensuring anonymity where possible and confidentiality in all other cases.

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[5] Adapted from European Commission *(6)*.

Logistics

A final aspect to consider is the kind of technology the hotline uses and how the technology connects to other tools and channels. Private-sector partnerships with telecom operators may provide valuable opportunities in this area.

Some key things to consider when designing the logistical part of your hotline is that it:

- should be provided free of charge (or at the cost of a local telephone call);
- should consider most calls as a single session with no fixed time limit;
- may include a follow-up call to check on safety and well-being; and
- may provide advice for, or direct referral to, other resources – especially emergency services for callers in acute distress.

COVID-19 hotlines may also be complemented by other services, such as:

- outreach programmes in communities to provide face-to-face help (while maintaining proper physical distancing);
- websites (for access to self-help or other information online, for example);
- responses to text messages, emails, online chats, discussion forums and SMS text messages;
- self-help and other information in different formats (such as leaflets, videos, CDs, DVDs and online self-help programmes); and
- post-pandemic mental health and psychosocial support.

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[8] All resource weblinks were accessed on 23 September 2020.

Annex 2. Hotline log sheets

National COVID-19 Information Hotline

Operator log sheet

Operator name: _____

Date: _____

Shift hours: _____

Number of valid calls*: _____

Do not count prank calls or hang-ups

What were the top three most common topics of calls you received today?

1. _____
   _____
   _____
   _____

2. _____
   _____
   _____
   _____

3. _____
   _____
   _____
   _____

How would you characterize the mood of most people you talked to today?

__Concerned but calm

__Worried

__Angry

__Scared

__Panicked

__Grateful

Please describe any specific rumours or examples of misinformation you heard today.

_____

_____

_____

_____

National COVID-19 Information Hotline

Manager log sheet

Date: _____

Shift hours: _____

Number of operators: _____

Number of valid calls*: _____

Do not count prank calls or hang-ups

What were the top three most asked questions operators received today?

1. _____
   _____
   _____
   _____

2. _____
   _____
   _____
   _____

3. _____
   _____
   _____
   _____

What were the top rumours operators heard today?

1. _____
   _____
   _____
   _____

2. _____
   _____

3. _____

_____

Other observations:

Annex 3. Sample protocol for medical emergency

This annex lists a sample protocol for a medical emergency as an example of a situation in which the hotline operator and manager may have a duty of care towards the caller. Other such situations include violent and/or life-threatening situations, such as interpersonal violence (family, sexual and/or intimate-partner violence, and elder abuse) and suicide. A separate protocol should be developed for each of these situations, and such protocols need to address safety and security issues for victims of violence. This also relates to how victims contact for assistance as they may not be in a position to speak, but operators can listen to cues of background/indirect conversations and respond /refer to emergency services accordingly.

Please note: the sample protocol should not be used verbatim, but should be adapted to the local context. Care should be taken to properly train operators on direct provision of care and on when and how to refer to emergency services – in consultation with said emergency services.

Medical emergency[9]

If the caller reports symptoms such as chest pain (possible heart attack or pulmonary embolism) and appears to be in acute distress (having trouble breathing or talking) and/or thinks s/he may need immediate medical attention, the operator should alert the supervisor and advise the client to hang up and call for medical assistance. If the client agrees and is able to make the call (or has someone else at home who can make the call for them), the operator should say that s/he will call back in 10−15 minutes to make sure the client is OK and medical personnel are on the way. The operator should document the incident in the file notes.

If the caller agrees to an emergency call but is unable to call him or herself, has nobody else with them who can call, or prefers that the operator calls for them, follow the protocol below.

Stay online and proceed as follows:

- make sure you have correct address and phone number;
- put the phone on "mute" and enlist the aid of those around you … send out "Crisis – need help" email to supervisors and managers;
- have the supervisor or manager call for medical assistance from another phone – explain there is a caller on the other line who is having a medical emergency;
- stay on the phone with the caller until help arrives; and
- document in notes, discuss and debrief with supervisor.

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[9] Adapted from: Training for tobacco quit line counsellors: telephone counselling. Geneva: World Health Organization; 2014:107 (https://apps.who.int/iris/handle/10665/113145, accessed 23 September 2020).

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WHO/EURO:2020-1206-40956-55530