



Putting Planning Into Practice: The Communications Response to H1N1

A Global Communications Conference sponsored by the Pan American Health Organization and the United States Department of Health and Human Services

Conference Report and Conclusions

On 22 July 2009, public health communicators from international and national public health organizations, along with top risk communications experts, met in Washington D.C., to share information about their respective H1N1 communications efforts and experiences to date, to assess lessons learned, and to identify common challenges all countries will face as the 2009 H1N1 pandemic continues to unfold.

Public health communicators had been preparing for a pandemic influenza outbreak since 2005, staging simulations, setting up media training and honing risk communication skills. When the novel virus arrived in 2009, however, it was not the long-anticipated avian strain, it lacked the high level of lethality associated with that strain, nor did it initially show up in Asia and spread from there.

Organized by the Pan American Health Organization and the United States Department of Health and Human Services, the one-day conference heard key presentations from communicators at the forefront of the global response to the 2009 H1N1 flu outbreak.¹

The main communication challenges discussed during the meeting included the following:

- Pandemic preparedness planning worked, but the plans didn't, at least not fully.
- The first countries had to deal with media pressures while handling stigmatization, economic losses and rapidly changing guidance.
- International coordination and networking among communicators played an important role in sharing information and unifying messages.
- As risk perception about severity decreased in the Northern Hemisphere, public perception in the South exceeded the risk assessments.
- Comparisons of H1N1 to other outbreaks or diseases diminished the perception of potential risks.
- Despite the projections, there were not many unfounded, sustained rumors in the media.
- Politics affected the outbreak communication responses in countries where elections were scheduled or in progress.
- Efforts to change the outbreak name from Swine Flu to H1N1 largely failed.

¹ Copies of this report are available at (<http://www.etc.org> and www.paho.org/riskcomm). This conference report was prepared with the assistance of Peter O'Malley, Fellow, Centre for the Study of Democracy, Queen's University, Canada.



- The pandemic vaccine, which was not yet ready for the Southern Hemisphere's first wave, poses enormous communication challenges about perceived safety, especially among young adults, pregnant women and other at-risk groups.

Invited by conference organizers Bryna Brennan (PAHO) and William Hall (HHS), the key presenters at the conference, and their major areas of focus, were as follows²:

- Gregory Hartl (WHO) and Daniel Epstein (PAHO) described the enormous media relations complexities and challenges faced when the outbreak was initially reported and as the WHO escalated to pandemic alert levels 4, 5 and 6. In the week following the move to level 6, there were an estimated quarter million news articles in English alone about the H1N1 outbreak.
- Carlos Santos-Burgoa (Mexico), Glen Nowak (U.S.) and Natasha Manjii (Canada) described how these three countries – where the spread of the H1N1 virus was initially detected – activated their pandemic communications plans in a climate of great uncertainty and intense scrutiny from the media and public.
- Maritza Labrana (Chile) described how, as winter approached in the southern hemisphere, her country developed its communications approach to the H1N1 virus by building on and adapting their already-planned seasonal flu campaign.
- Omid Mohit (WHO Cairo) described the special challenges in Egypt associated with clearly communicating personal steps needed to avoid infection from the new H1N1 virus in parallel with a concurrent campaign designed to promote quite different behaviors needed to control an already-existing H5N1 avian flu outbreak.
- Marsha Vanderford (CDC) outlined how the CDC built its principal H1N1 communications products around the Centers' key guidance documents on H1N1 pandemic control and treatment interventions. She described how these "interim" guidance documents, and their associated communications materials, had to be updated quickly on numerous CDC and partner platforms and channels as the underlying public health advice itself evolved.
- John Rainford (WHO IHR Secretariat) led a discussion about the strengths and weaknesses in pandemic communications response to date. He saw clear indications of success in embedding risk communications strategies into national pandemic response plans. He stressed the centrality of communications, since the success of each and every public health intervention used to manage the H1N1 outbreak will require effective communications.
- Bruce Gellin (HHS), Arthur Allen (author, *Vaccine*), and Silvio Waisbord (George Washington University) assessed immunization plans for the U.S, and described communications approaches needed to explain the role of vaccines and immunization so as to help people make informed decisions. Discussion focused on the challenge of doing this in the context of significant uncertainty about the nature, efficacy and safety of the vaccine; uncertainty about the future severity of the

² All conference presentations, the agenda, the list of participants, and this report are available online at http://www.paho.org/english/ad/GlobalCommMeeting_Webpage_Eng.htm



disease itself; and opposition from long-established anti-vaccine activists.

- Risk communications expert Peter Sandman, in his evaluation of the communications challenges around the 2009 H1N1 flu pandemic, urged risk communicators to strive for a balance between provoking panic and creating complacency. He warned against overselling precautionary behaviors that may not be thoroughly effective, while under-emphasizing more difficult interventions that may be required to bring the outbreak under control.

Themes and highlights of the subsequent discussions were as follows:

Theme 1: *Planning helped a lot, less so the plan itself.*

Many presenters and participants indicated that their response to the H1N1 outbreak to date would not have been as effective as it was had they not engaged in serious pandemic planning activities and exercises over the past few years. Planning activity that took place on an accelerated basis after the 2003 SARS outbreak made it possible to respond more quickly, more thoughtfully and more effectively than was the case with that earlier outbreak.

While noting the importance of planning, it was also acknowledged that the *activity of planning*, the associated planning structures and exercises that resulted, and, most importantly, the personal relationships that were created through these exercises, were actually more important to creating an effective response than the actual plans themselves, most of which were quickly overtaken by events.

The limited usefulness of the plans themselves was seen to be, in part, due to the very rapid spread of the H1N1 virus itself, and in part because the 2009 H1N1 outbreak did not match several key assumptions that underpinned most national and international pandemic response plans. Though many of these plans adopted were an “all hazards” approach, most were developed to respond to the potential emergence from Asia of the much less infectious, but much more severe H5N1 avian flu virus.

Overall, the critical importance and usefulness of pandemic response planning was broadly affirmed by presenters and participants.

Theme 2: *We're all in it together*

Most presenters and participants made it clear that while there are important social, political and cultural differences between countries, and even within countries, in a global pandemic we all occupy a shared information marketplace.

For example, when WHO or PAHO provide briefings to news media, country-level news media routinely monitor these events remotely in real-time, and can actively participate through the Internet and global telephone link-ups. Following these briefings, national authorities are quickly solicited for follow-up interviews by national media.

This dynamic was particularly evident when WHO declared pandemic level 6. The resulting explosion of media coverage of this declaration, and the resulting public discussion about the need to account for severity in pandemic response planning, was



informed by a mix of global, regional and national reports and viewpoints.

Similarly, participants noted that country-level authorities are now frequently called upon not just to explain their own planned approaches and interventions to manage the pandemic, they also have to justify why their approaches may differ in key respects from the approaches adopted by international organizations, or employed in other countries.

There was also agreement that national and local stakeholders who are most attentive to the pandemic, and most likely to be engaged in media or public discussion of it, are also taking full advantage of the Internet and other channels to inform themselves about the pandemic. Their information base is clearly informed by perspectives from many sources and many countries.

Participants agreed that, in this globalized shared information marketplace, collaboration among communicators at the international, regional and national levels is increasingly important.

To the degree possible, successful communications about the 2009 H1N1 pandemic will require that everyone know – as best possible, and in as timely a manner as possible – what everyone else is doing, and plans to do. Particular encouragement was given to WHO and PAHO to ensure that country-level communicators have access to new statements and guidance at least at the same time as this information is released to the media.

Theme 3: *One size does not fit all*

Paradoxically, while participants agreed that we are operating in a global communications environment, presentations and discussions at the conference made it clear that there is no “one size fits all” approach that will result in effective communications in all countries.

Most noticeably in this regard, H1N1 flu outbreak communications challenges in the northern and southern hemispheres were noted to be very different in nature. In the north, the H1N1 virus emerged at the end of the winter flu season, just as flu spread typically declines. The situation was reversed in the southern hemisphere, where the virus emerged just in time for their winter flu season.

The resulting communications requirements were therefore very different between north and south. Communicators in the north, especially in the early days, needed to convince people to take the risk of a pandemic and personal infection seriously against a backdrop of stable or declining case counts. Meanwhile, in the south, communicators had to respond to spiraling case counts and, often, health care systems nearing or past peak capacity loads.

Beyond these stark regional differences, presenters and participants also noted the importance of communicators being attuned to social, cultural and other factors among and within countries that can and will create profound differences in how pandemic risks are perceived, and in the appropriate communications messages and tools needed to effectively reach audiences and promote appropriate behavior.



An example of this is the level of importance different countries might place on any pandemic, particularly one that is thought to be of minor severity. A country experiencing an epidemic of dengue fever or malaria or humanitarian crises will be less inclined to adopt disruptive or expensive measures to deal with what they see as the relatively less consequential H1N1 flu virus.

Similarly, countries where poverty is the dominant health determinant, or which have fragile and inadequate public health capacity, will perceive pandemic flu risks, and acceptable control measures, differently than people in a developed country with robust health systems and better health outcomes.

There was general agreement that the most effective antidote to the “one size doesn’t fit all” dilemma is to test and research all pandemic communications with all audiences, to listen actively and constantly to our social and community partners, and to be very committed to taking a “whole-of-society” approach to communications planning and delivery.³

Theme 4: *Communicating amidst great uncertainty*

Presenters and participants at the conference seemed to universally agree that the most important strategic consideration to factor in when planning and implementing communications to support an effective response to the H1N1 flu outbreak can be summarized in a single word: *uncertainty*.

Uncertainty describes our knowledge about the disease itself, and how it will evolve; it describes our incomplete understanding of the efficacy of the various personal and social interventions that may be needed to manage the outbreak and to care for infected people; it describes the precarious ability of many health care systems to manage the impact of the disease on society and on individuals. This uncertainty impacts significantly on our ability to confidently engage in effective risk communicators.

In particular, discussion at the conference about how to promote vaccines and immunization programs to stop the spread of disease underscored the crucial role that uncertainty plays in developing effective communications on the H1N1 flu outbreak.

There is, at present, uncertainty about the efficacy of a future H1N1 vaccine; about when it may be available; about how much will be available and where; about how it will need to be administered; and about its safety, especially with regards to specific at-risk groups, such as pregnant women.

At the other end of the risk-benefit trade-off, there is uncertainty about the severity of the illness produced by the H1N1 virus, now and the future, and about how it is effecting and will effect specific population groups.

In this context, when there is little certainty about the level of risk presented by a disease, and about the efficacy and nature of a major intervention planned to control the disease, then the question becomes: what can be said by public health communicators

³ See [WHO Guidance Document: Pandemic Influenza Preparedness and Response](#) This document discusses the importance of taking a “whole-of-society” approach to pandemic response.



that will be authoritative and prepare people to make informed judgments about their own health choices?

While the participants at the conference struggled to understand the impact of uncertainty on their ability to communicate effectively, there were several points of agreement.

- There is no choice but to communicate as best possible in the circumstances. Public health communicators have a responsibility to prepare individuals, families and communities to make informed, good decisions about their health. Declining to communicate on key issues because of uncertainty is not an option.
- All pandemic communications needs to be based on science, on what we actually know and do not know. We can speak, for example, about what we know about vaccines in general, and about the epidemiology of the H1N1 flu and its impact on high risk groups. Our communications must always be informed by the best available evidence.
- All guidance communicated about the pandemic and the public health interventions needed to manage it must be openly and routinely flagged as being tentative in nature and subject to revision should new evidence become available. If better evidence does emerge, guidance must change, and the changes must be openly communicated in a transparent and timely manner.

Consistent with risk communications theory, and with the WHO approach to outbreak communications⁴, there was a strong consensus that effective communications in an environment of great uncertainty can only be built on a foundation of *trust* between health authorities and the people they serve.

Building and maintaining trust, in turn, requires transparency about what is known and not known, two-way communications, and broad social engagement in the planning and delivery of pandemic communications.

Theme 5: Now comes the hard part

A central theme of the discussions was a candid recognition by participants that while H1N1 communications to date has benefited strongly from previous planning, and while most countries have been able to communicate effectively with their media and citizens in the early days of this pandemic, much bigger challenges loom as the pandemic proceeds.

Some of the major challenges noted, and remedies to address them, were as follows:

- Health authorities and pandemic response planners must continue to ensure that the voices and expertise of communicators are included at all decision-making levels in the planning and delivery of interventions needed to manage the outbreak. To be effective, each and every public health intervention requires

⁴ (See the [WHO Outbreak Communications Guidelines](#), and [the WHO Outbreak Communications Planning Guide](#). Also [Transparency during public health emergencies: from rhetoric to reality](#) O'Malley et al, WHO Bulletin



effective communications. From a public health perspective, communications that results in confusion, misinformation, and loss of trust will lead to increased preventable illness and deaths.

- Given the possibility that the outbreak may come in two or more waves over the next 12-18 months, communicators at all levels – international, regional, national, sub-national – must look ahead realistically to ensure that their pandemic communications capacity can be sustained for the long-term. They will need capacity to respond to an unprecedented demand for information and level of scrutiny from media and public. In most instances, this will require increased numbers of dedicated communications staff and resources.
- Communicators must continue to promote hygiene and personal protection measures that individuals and families can adopt to limit their exposure to the H1N1 virus. As well, communicators need to develop, even on a contingency basis, plans, messages and programs to support all the other public health interventions that may be needed, such as home care, immunization programs, self-isolation, social distancing, and community-level action such as school and business closures. Communications will be needed to facilitate compliance with any required interventions while minimizing personal and community disruption, social dislocation, and potentially significant economic costs that may be associated with these pandemic response measures.
- Communicators need to be prepared to do their best to shape public perceptions of the risks associated with the H1N1 virus in a manner that avoids creating complacency and overconfidence about what must and can be done to manage the outbreak, while avoiding the creating individual and community-level paralysis owing to fear and panic about the challenges posed by the pandemic.

Conclusion

Participants at the conference recognized that effectively communicating on the 2009 H1N1 flu outbreak long-term, on a sustained basis, in a climate of intense scrutiny and great uncertainty, where new and complex issues and concerns will emerge and evolve every day, is going to be very difficult indeed. It was acknowledged, however, that this communications will be central to the public health mission, and that not communicating, or communicating poorly, is not an option.

There was also consensus that the best way to promote effective communications is to ensure that all communications is evidence-informed, culturally appropriate, and well researched. It will also require strict adherence to the principles of openness, transparency and honesty that are needed to foster and preserve the *trust* that is required between public health authorities and systems to best serve their citizens. If that trust is broken, the result will be an increase in otherwise preventable illness and death.

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