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Mapping & Review  
of Existing  
Guidance and  
Plans for  
Community- and  
Household-Based  
Communication to  
Prepare and  
Respond to  
Pandemic  
Influenza

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**RESEARCH  
REPORT**

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January 21, 2009

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# **Mapping & Review of Existing Guidance and Plans for Community- and Household-Based Communication to Prepare and Respond to Pandemic Influenza**

Research Report

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## Glossary: Select Communication and Medical Terms used in the Report

**Communication:** In health settings, *Communication* or *Health Communication* is defined as “a multifaceted and multidisciplinary approach to reach different audiences and share health-related information with the goal of influencing, engaging, and supporting individuals, communities, health professionals, special groups, policymakers and the public to champion, introduce, adopt, or sustain a behavior, practice, or policy that will ultimately improve health outcomes” (Schiavo, 2007, p. 7). *Healthy People 2010* defines health communication as “the art and technique of informing, influencing, and motivating individual, institutional, and public audiences about important health issues. The scope of health communication includes disease prevention, health promotion, health care policy, and the business of health care as well as enhancement of the quality of life and health of individuals within the community” (Ratzan, 1994). At UNICEF, *Communication for Development (C4D)* is a systematic, planned and evidence based strategic process that is intrinsically linked to program elements; uses consultation and participation of children, families, communities and networks, and privileges local contexts; and relies on a mix of communication tools, channels and approaches, to promote positive and measurable behavior and social change.

**Emergency communications** “encompasses the urgency of disaster communication with the need to communicate risks and benefits to stakeholders and the public.” (Centers for Disease Control and Prevention, 2002)

**Hand hygiene** is “a general term that applies to either handwashing, antiseptic handwash, antiseptic hand rub or surgical hand antisepsis” (Boyce & Pittet, 2002).

**Health literacy** is “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions” (Healthy People 2010; Selden, Zorn, Ratzan & Parker, 2000).

**Isolation** “is used to separate ill persons who have a communicable disease from those who are healthy. Isolation restricts the movement of ill persons to help stop the spread of certain diseases. For example, hospitals use isolation for patients with infectious tuberculosis” (Centers for Disease Control and Prevention, 2008).

**Outbreak communications** The communication plan and activities to control and mitigate the spread and impact on morbidity and mortality of the sudden emergence and spread of an infectious disease (outbreak)

**Personal hygiene:** A set of practices, such as cleanliness, that are conducive to preserve and protect individual health

**Physical distancing** Sometimes used as an alternative term to “social distancing”, it refers to measures that increase distance among people and reduce the risk for transmission. For example, physical



distance between people “to between three to six feet: is considered “to reduce influenza transmission risk from coughing, sneezing or speaking” (Kansas State University, 2008)

**Quarantine** “is used to separate and restrict the movement of **well** persons who may have been exposed to a communicable disease to see if they become ill. These people may have been exposed to a disease and do not know it, or they may have the disease but do not show symptoms. Quarantine can also help limit the spread of communicable disease” (Centers for Disease Control and Prevention, 2008).

**Respiratory etiquette** Refers to “respiratory protection and cough hygiene measures, including covering the nose and mouth when coughing/sneezing, using tissues to contain respiratory secretions and dispose of them in the nearest receptacle after use, perform hand hygiene after having contact with respiratory secretions or contaminated objects, etc.” (Minnesota Department of Health, 2008)

**Risk communications** “tries to create awareness in the population, governments and the political community, of the challenges involved in a large emergency in the public health area or in any other related areas” (ElHajji, Lopes & Brennan, 2007). Some of its attributes include: “to inform and increase awareness of security and health risks to which the population is exposed, and to be able to explain risk factors associated to endemics, to environmental accidents and to human activities” (ElHajji, Lopes & Brennan, 2007). Typically, it is a discussion about an adverse outcome and the probability of that outcome occurring. In some instances, risk communication has been employed to help an individual make a choice about whether or not to undergo a medical treatment, continue to live next to a nuclear power plant, pass on genetic risks, or elect to vaccinate a healthy baby against whooping cough. In some cases, risk communication is used to help individuals adjust to the knowledge that something that has already occurred, such as an exposure to harmful carcinogens, may put them at greater risk for a negative health outcome, such as cancer, in the future” (Centers for Disease Control and Prevention, 2008).

**Social distancing** “refers to measures to decrease the frequency of contact among people in order to decrease the risk of spread from communicable diseases. This could include measures such as school dismissal and staying at home when sick” (Centers for Disease Control and Prevention, 2008)

**Social mobilization** is “the process of bringing together multisectoral community partners to raise awareness, demand, and progress for the initiative’s goals, processes and outcomes” (Patel, 2005, p. 53). It’s one of the key areas of health communication that - as for other communication areas - should aim to achieve clear behavioral, social and/or organizational outcome objectives (Schiavo, 2007). At **UNICEF**, social mobilization is a key strategy of **Communication for Development (C4D)** and is intended as the process “to engage and motivate civic society (NGOs, community-and faith-based organizations/networks, etc.) around a common cause, to educate and provide support to communities and families.”



## Executive Summary

The objective of this study is to provide insights on key issues, needs and potential elements that should be considered and/or included in future technical guidance on community- and household-based communications to prepare and respond to pandemic flu. It also served to identify priority steps that should be addressed early on in the process of developing such guidelines. The study was initiated and contracted by UNICEF's Communication for Development (C4D) Unit to strengthen communication planning around pandemic flu and provide much needed guidance to field staff. Some of the study's key assumptions included: (1) that community and household-based communications are of vital importance to adequately prepare and respond to the potential threat of a pandemic; (2) that technical guidelines on pandemic flu communications may be needed to facilitate planning; and (3) that communication preparedness should be considered not only to encourage short-term behaviors and measures that may be needed for outbreak management, but also strategies that aim at long-term behavioral and social results and may help mitigate and/or prevent pandemic flu cases.

Overall, the findings analyzed and discussed in this report support the **need for technical guidance and tools on pandemic flu communications** at the community and household level. They also confirm the **existing divide** in terms of levels of pandemic flu communications preparedness between developing and industrialized countries. As expected, several factors – including lack of adequate resources, conflicting public health priorities, and other key obstacles featured in this report contribute to such divide.

The study also identified several needs, priorities and next steps. That clarity on **behavioral results** of pandemic flu communications interventions may be needed to facilitate planning and implementation at country level. That the **role of local and international agencies in the global coordination of communication efforts** should be further clarified in order to increase synergies and maximize use of existing resources. That **capacity building** both **at the government and community levels** should focus not only on *outbreak communications principles* but also on *much needed disease-specific guidance*. That further emphasis should be placed on **pre-pandemic communications** to address existing behaviors, traditional practices, social norms and other obstacles that may hinder the effectiveness of outbreak communications during an actual pandemic.

Specific findings and recommendations to be considered in the pre-pandemic phase included the **importance of risk assessment and mapping, community consultation** as well as efforts to increase **awareness and preparedness on pandemic flu at the community level** and among **other key audiences who influence community's actions**. Given the critical importance of **communication and social mobilization partners** for all kinds of interventions at the community and household levels, special consideration should be given to capacity assessment and building in this setting. Finally, the study revealed some **confusion about the terminology** used for recommended measures for pandemic flu mitigation (and/or control of other infectious diseases), which should be clarified to enhance communication's effectiveness. All recommended strategies and next steps included in this report reflect the overall analysis of both primary and secondary data as well as much appreciated suggestions and contributions by study's respondents.



## Introduction and Background Information

While it's difficult to predict when the next pandemic influenza (P/I) may occur and how severe it may be, experts agree that it would pose a risk to everyone around the world. For example, in the last few years, there have been several outbreaks of avian flu in North America, Asia, Africa and Europe, which have led to concerns about the possibility that the highly pathogenic avian "H5N1 virus may evolve into a virus capable of human-to-human transmission." (US Department of Health and Human Services, 2008) Moreover, while experts are particularly concerned about the H5N1 virus, this may not be the only cause for a potential pandemic. In fact, it's important to remember "flu viruses are constantly changing and adapting, so it is likely that viruses sufficiently different from 'ordinary' flu strains to cause a pandemic will emerge from time to time," (United Kingdom Department of Health, 2008) which makes the threat of a pandemic always real.

Past flu pandemics (such the 1918 pandemic) as well as recent outbreaks of other diseases (e.g. avian flu and SARS) have pointed to the need for global and country-specific preparedness in which communication interventions and advance planning can play a critical role in emergency and outbreak response. Moreover, well-designed and implemented communication programs may help reinforce and/or establish long-term behaviors and social norms that would help prevent or mitigate potential future epidemics in target communities, households and populations.

In order to respond effectively to the threats that a global pandemic influenza may pose to humanity, it is important to inform and promote changes in the norms and practices of communities and households, so they would build their individual and collective resilience to the risk of transmission of the virus. Since achieving individual and social behavior results require a rigorous, time-consuming and long-term process (Schiavo, 2007), communication interventions need to be considered, planned, and initiated in the pre-pandemic phase. This would enhance the effectiveness of all interventions by increasing compliance to recommended actions in the case of pandemic flu.

In 2006 and 2007, UNICEF received funding from the Government of Japan and USAID to support national governments to respond to Avian and Pandemic Influenza (A/PI). As the science around the possibility of the avian flu virus transforming itself and triggering a global human-to-human pandemic has been uncertain, the primary focus of the communication work across countries at community and household level has been to support national communication programmes to control highly pathogenic avian influenza (HPAI) in poultry, and to prevent human H5N1 infections.



As governments begin to shift focus to pandemic preparedness and response, it's becoming increasingly important to make sure that more extensive communication efforts for communities and households are included. In order to strengthen communication planning around pandemic flu and to provide field staff with suitable and much needed guidance, the UNICEF Communication for Development (C4D) Unit at New York Headquarters initiated and commissioned this study to **map and review existing guidance and plans for community- and household-based communication to prepare and respond to pandemic influenza.**

This study looked at relevant experiences, pandemic flu communication plans, theoretical models, and existing technical guidance. The aim was to extrapolate lessons learned, key success factors, key issues, and potential elements that will inform and shape the future development of technical guidelines and standards to aid field staff to plan short-term and long-term *behavior- and social behavior change-*based communication interventions for pandemic influenza that are aimed at the community and household level.

## Research Objectives

The overall research objectives of this study include:

- To identify key elements and recommendations that should be considered in pandemic flu communication planning at the community and household level
- To map and identify lessons learned, key issues, core theoretical elements and next steps
- To use study information to provide recommendations on key issues and next steps that will feed into the future development of UNICEF technical guidelines for pandemic communication planning and ultimately provide guidance and tools to UNICEF field offices, regional representatives and partners

In order to achieve the above objectives, this report identifies and analyzes:

- Existing standards, models and technical guidance that may apply to pandemic flu communications
- Lessons learned from previous pandemics/ disease outbreaks and health emergency situations (e.g., SARS, Ebola, A/I, Anthrax)



- Existing in-country experiences/plans on pandemic flu communications

## Problem Definition

Research and analysis focused on key factors that should be considered and/or inform the development, implementation and evaluation of pandemic flu communications plans intended to address the needs of communities and households:

- Current gaps/needs/expectations for guidance at country level
- Potential obstacles to the development and implementation of pandemic flu communications
- Level of awareness and knowledge about pandemic flu risk as well as overall government interest in different regions
- Factors influencing communication's planning, quality and credibility (including good practices and key elements to be considered regardless of the communication model being used)
- In-country and global coordination of communication efforts
- Key factors influencing community engagement and risk mapping interventions
- Steps that may need to precede community and household communications
- Potential short term measures versus long-term measures (outbreak management versus preparedness and prevention)
- Examples of existing social norms, behaviors, issues and policies that may affect compliance to mitigation measures that have been implemented in past pandemics and may be relevant to pandemic flu control

This study focuses primarily on community and household communications. Yet, given the interdependence of well-designed communication interventions that are usually intended for multiple audiences and stakeholders, the study also identified some broader needs and potential approaches.



## Core Conclusions and Recommendations

This section highlights key study’s conclusions and recommendations. While some of the findings and recommendations are discussed in more detail and/or reinforced either in the *Reporting, Data Analysis, and Other Observations and Topic-Specific Recommendations* section or in the *Appendices* of this study, this section intends to provide an overview of top needs and priorities that emerged from our findings. In summary, results from the analysis of primary and secondary data point in favor of the **need for comprehensive guidelines for pandemic flu communications planning** as well as the following conclusions and recommendations (organized by topic):

### Differences in Country Contexts/Need for Guidelines

Many of the study’s assumptions on the state-of-affairs of pandemic flu communication planning were validated by this study’s findings. In fact, while industrialized countries (e.g., Sweden, Canada, Norway, UK, US, New Zealand) have developed and continue to update regularly their pandemic flu communications plans, most developing countries reviewed for this study do not have any pandemic flu communications plan (neither as a component of the overall pandemic flu preparedness plan) and/or are in the early phases of developing such plans. Unfortunately, lack of adequate economic and human resources as well as conflicting priorities, such as the control of HIV/AIDS, malaria, and other widespread public health threats, are just some of the many obstacles to pandemic flu communications preparedness in developing countries. Table 1 includes a list of potential obstacles identified by study’s respondents and/or existing literature. While some of them (e.g. low P/I awareness; social norms that may prevent the implementation of potential mitigation measures; limited knowledge on the needs of vulnerable and/or marginalized populations; shortage of public health and healthcare professionals in underserved areas; lack of clarity on expected behavioral results, etc.) may be an issue also in many industrialized countries, their overall impact on communication preparedness and implementation is by far greater and more pervasive in developing countries, and should be addressed by future technical guidance.

**Table 1 - Key Issues and Potential Obstacles to P/I Communication Planning and Implementation**

- Low awareness and knowledge on pandemic flu risk among the general public, local communities and – especially in developing countries – governments and other key organizations. Pandemic flu is often perceived as “the pandemic that never happened,” “not a real threat’
- Conflicting priorities, such as control of HIV/AIDS, malaria, poverty rates, etc, that especially in developing

countries may result in low interest in pandemic flu communications planning among governments in charge

- Existing misperceptions – in many countries and communities – that the existence of a pandemic flu vaccine, which would actually take a minimum of 6 months to be produced from the onset of a pandemic –won’t require other measures
- Lack of/or poor capacity and training in emergency and risk communications as well as issues and communication needs specific to pandemic flu. This applies not only to governments but also to local communities, and communication and social mobilization partners (e.g. religious leaders, teachers, community workers, healthcare professionals, schools, businesses, etc.)
- Lack of clarity/mixed scientific evidence on behavioral results to be promoted and achieved in order to control and mitigate pandemic flu
- Limited knowledge on how marginalized groups may react, and/or should be reached and cared for during a pandemic (e.g., people with disabilities, low socio-economic groups, low health literacy groups, communities with minimal access to the Internet in regions where this is a common communication channel, etc.)
- Existing social norms and socio-economic conditions that may prevent the implementation of recommended measures to mitigate the impact of pandemic flu. For example, social (or physical) distancing may be hard to implement in most countries due to either:
  - Strong family and social values that may encourage people to continue visiting and caring for sick people without observing safety measures (almost all countries/regions reviewed for this study)
  - Traditional practices, such as sleeping with dead people prior to their funeral (for example, Yambio, Southern Sudan – WHO, 2004)
  - Social and individual objections to limiting attendance to churches and other places of worship during a time of crisis in which spiritual comfort is often sought (for example, Canada during SARS)
  - Crowded living conditions that may complicated the implementation of physical distancing from infected family members/significant others (many regions and countries in Asia and Africa)
- Shortage or lack of key supplies, such as tap water and soap, that may prevent implementation of hand hygiene measures (for example, in rural villages in India)
- Strong influence religious leaders may have on compliance to recommended health and social behaviors (for example, in Indonesia in the case of polio immunization)
- Limited knowledge and country-specific mapping of high risk communities
- Cultural attitudes toward health and illness (e.g. proactive versus reactive cultures; fatalistic versus “take-charge” kinds of cultures)
- Lack of trust in communication messages and governments among the general public, special audiences, the mass media and/or specific communities (for example, in New Zealand, Egypt, etc. – see appendix C for a snapshot of these interviews and/or case studies)

- Irrational behaviors, fear of transmission, disbelief and other psychological reactions to crises that may prevent people from complying to recommended measures
- Shortage of public health and healthcare professionals in several developing counties and inner/ rural regions and cities in industrialized countries
- Lack of communication training on how to break bad news, communicate with patients and family caregivers during health crises among healthcare providers
- Limited funds and human resources
- Other kinds of barriers that may be country- or community-specific

Because of the complexity of the issues and obstacles in table 1 as well as the critical and well-established role communication can play in handling health emergencies, the need for adequate guidelines and toolboxes is supported by this study's findings. Such guidelines may help bridge the increasing divide between industrialized and developing countries on pandemic flu communications preparedness as well as provide much needed resources to UNICEF field officers and partners. As reported by several study's participants, in developing countries "the need for guidelines is urgent."

Overall, while these guidelines may more specifically address communication planning at the community and household levels, they would also need to include **guidance on interventions intended for secondary audiences who have an influence on communities and households** (e.g., healthcare professionals, communication and social mobilization partners, local and international NGOs, local public health departments and governments, etc.). **A list of sample obstacles** (e.g., see Table 1) should be also included together with case studies and checklists that may aid field officers to develop strategies to address them via adequate behavioral and social changes at the community and household levels. This may facilitate the implementation of guidelines especially within developing countries and other less privileged contexts. **Key milestones and research steps** (e.g., validation of expected behavioral results within country contexts; community consultation; risk mapping, etc.) that would need to be achieved prior to planning and implementing interventions at the community and household level should also be considered for inclusion. Moreover, while study respondents felt that communication preparedness at the community level makes sense, this would need to be preceded by interventions that seek to **strengthen the capacity of non-governmental communication systems and social mobilization partners**. These and other key issues, priority steps and elements to be considered by potential guidelines are discussed in more detail throughout the following sections of this report.



## Priority Steps

This section describes key steps and issues that were identified by the present study's findings as to be addressed either prior to the development of pandemic flu guidelines (*Clarity on Behavioral Results* and *Role of International Agencies on Global Coordination of Communication Efforts*) and/or in the early implementation phases of such future guidelines and toolboxes (*Capacity Building*).

### Clarity on Behavioral Results

While global consensus on recommended behaviors and social actions to be implemented in the pre-pandemic and pandemic phases may be difficult to achieve because of conflicting scientific evidence, additional clarity on pandemic flu behavioral and social results appears to be a fundamental need among UNICEF field officers and other study participants. This is also a standard good practice in health communication and should be considered for inclusion in future technical guidance.

With that said - in looking at social results, an important principle to be emphasized by technical guidance and future interventions is that "social change is always the result of a series of gradual behavioral changes at the individual, group and community levels. Therefore, behavioral outcomes should remain an important parameter in health communication," as well as throughout different phases of pandemic flu communications planning and implementation. (Schiavo, 2007, p. 54)

While evidence on the effectiveness of potential measures for pandemic flu mitigation may be conflicting, reality is that a consistent set of behaviors is being promoted and recommended in the pre-pandemic phase by many of the industrialized countries reviewed for this study. In fact, existing pre-pandemic communication efforts and plans tend to focus primarily on four key interventions. Such interventions aim at establishing long-term practices and behaviors, which may aid the control and mitigation of pandemic flu as well as other infectious disease outbreaks. These four behaviors include:

- Hand and personal hygiene
- Respiratory etiquette
- Staying home if sick
- Proper and safe care of loved ones who may be sick

Several study's participants felt it may be reasonable and appropriate to promote this set of behaviors at the global level in the pre-pandemic phase. Among them, some respondents also thought that



UNICEF could play a key role in such promotion efforts. This may be of particular importance especially in developing countries – where UNICEF officers and other study respondents seem to feel a strong need for further clarity on recommended actions. Moreover, this set of behaviors almost mirrors those included in FluWise FluCare, a model that resulted from discussions and inter-agency meetings between WHO, UNICEF and other key players.

For measures that may be considered in the case of an actual flu pandemic (e.g., **isolation, quarantine, social/physical distancing, closing of public gatherings and schools, etc.**) and appear to have contributed to mitigation efforts during the 1918 flu pandemic (US Department of Public Health and Human Services, 2008a) and/or other recent disease outbreaks (e.g., SARS), it may be important to start dispelling misconceptions and discuss uncertainties with key audiences already during the pre-pandemic phase. At the minimum, this should be considered and implemented among healthcare professionals, community leaders, and communication and social mobilization partners, so that it would help increase the overall sense of self-efficacy and understanding of potential measures to be encouraged during a pandemic. It may also help community members to become aware of potential resources and communication chains as well as to become increasingly effective in engaging different members of the community. Simulation exercises at the community level to assess different levels of preparedness and initiate the thought process that is needed to achieve behavior and social change in different phases of pandemic flu are also recommended, and are discussed in further detail in other sections of this report.

The community-based model for pandemic flu communications that is being developed by the Academy for Educational Development (AED) - and more specifically, the household and community mitigation components of this model - already incorporates some of the behaviors to be encouraged in the pre-pandemic phase as well as includes approaches to increase preparedness at the community level. (AED, 2008) Finally, while concerns about existing social norms and other kinds of barriers to compliance to potential measures (see table 1, which also includes a few examples of such norms and barriers) were expressed by most study's participants, it was clear that in most countries no specific action to address these obstacles had been implemented yet.

### **Role of Local and International Agencies on Global Coordination of Communication Efforts**

The importance of global and local coordination in handling disease outbreaks and health emergencies is supported by existing literature, emergency communications models, and case studies (see *Reporting, Data Analysis and other Observations and Topic-Specific Recommendations* section) and was also confirmed by this study's findings as a key element of pandemic flu communications preparedness and management. However, while there is a general consensus on the need for collaboration among different government units as well as local, international and multilateral agencies, study findings pointed to existing obstacles to the coordination of communication preparedness and response to



health emergencies. Ideally, such obstacles should be addressed in the pre-pandemic phase to ensure a smooth coordination of all efforts.

For example, at the local government level, interest in pandemic flu communications appears to vary among different government agencies. Where comprehensive pandemic flu communications plans exist, public health agencies and communication departments lead most efforts and in many cases, still in the process of engaging non-health government departments and agencies (e.g. education, interior, security, information, etc.) in communication preparedness. Further clarity on roles and responsibilities, may help rally health and non-health agencies on common objectives. Moreover, early integration of communication teams with public health and medical teams may facilitate communication among different units as well as help build consensus on key communication strategies, messages and activities. Finally, rapid response and coordination teams need to be established at the country and community levels with an eye also to strategies that may help pandemic flu communications become commonplace in different settings and levels of society (see section in this report on *Building Long-time Preparedness*). Because of the difficulties that many countries seem to be experiencing in optimizing coordination efforts, specific guidance on how to implement such steps and mobilize different non-health players and/or establish coordination teams should be considered for inclusion in future guidelines.

At the global level, the need for clarifying roles and responsibilities of different international and multilateral agencies was supported by this study's findings. Because communication takes place at several levels and involve different audiences (e.g. policy makers, governments, community members and leaders, general public, social mobilization partners, healthcare providers, etc.), coordination efforts would be likely to be enhanced by a review and clear definition of competencies, roles, responsibilities, timeframes, existing human resources, funds and potential partnerships that may influence the effectiveness of pandemic flu communications, and more in general, emergency and outbreak communications. For example, UNICEF appears well positioned to continue to play a key role on community and household communications because of its strong communication presence at the field level as well as the agency's engagement on a variety of non-health and health-related issues that involve communities and households. Partnerships with other international agencies as well as leading international and local non-profit organizations (e.g. CORE Group) should be aggressively considered to enhance coordination of all efforts and maximize use of economic and human resources.

UNICEF may want to consider initiating a dialogue with its international partners (e.g., WHO, CDC, PAHO, other UN agencies) and convene an interagency meeting. The 2006 *Inter-Agency Framework for Avian and Pandemic Influenza in the Americas* (PAHO, 2006) could potentially serve as a starting point to (1) discuss its potential applicability and relevance in other world's regions; (b) review what has been already accomplished; and (c) revisit roles and responsibilities in light of emerging needs and new information. Results of such consensus exercise could be considered for inclusion in future guidelines,



so that potential confusions on cascading of information, existing communication resources, and roles and responsibilities of different agencies and players in the global coordination of different kinds of communication interventions (e.g., outbreak communications versus pre-pandemic communications that aim at long-term behavioral and social results; etc.) - which were all highlighted by some of the study's respondents - could be properly addressed and clarified.

### Capacity Building

Results from this study pointed to the need for strengthening communication capacity at the government and community levels. While overall capacity building on emergency and outbreak communications is much needed and critical to all efforts, study findings show that this is a necessary but not sufficient step to the planning and implementation of pandemic flu communications programs. Study's respondents highlighted several needs that are pandemic flu-specific (e.g., research capacity to contextualize potential P/I measures within country contexts and identify cultural and scientific-relevant alternatives; training of local media and social mobilization partners on P/I facts, issues, potential measures and communication strategies; building self-efficacy and communication capacity among healthcare professionals to handle and respond to pandemic flu; etc.) and further support the importance of specific technical guidance on pandemic flu communication planning.

Overall, our findings point in favor of a capacity building approach that would include **guidance on principles and good practices of outbreak and emergency communications models** (see section on *Overview of Theoretical Elements and Good Practices that Are Relevant to P/I Communications*) as well as **disease-specific guidance and training** (e.g. pandemic flu-specific facts, symptoms, communication messages, potential mitigation measures, existing obstacles and relevant strategies to address them, etc.) and specific **communications skills/areas** (e.g., interpersonal communications and community dialogue principles and practices). While some of the study's respondents cautioned against the complexity of handling P/I communication-specific preparedness in countries with a high burden of other diseases, conflicting priorities, and/or limited resources, most participants agreed about the importance to devise tools and materials that would facilitate implementation.

**Key Audiences of Capacity Building Efforts: Local Governments and Other Authorities.** Study findings confirmed the importance of capacity building efforts at the government level, especially in relation to (1) emergency and outbreak communications planning; (2) overall coordination of all efforts among relevant health and non-health sectors; and (3) pandemic-flu specific information, measures, behavioral results, and strategies to address obstacles to communication preparedness. Moreover, governments may benefit of training modules and interventions that would strengthen their skills and capacity on engaging and mobilizing relevant communities and stakeholders. This is particularly important in both low-income and middle-income countries in the developing world.



Along with other international audiences, UNICEF often assists and works with local governments and authorities (both within the health and non-health sectors) and may be well positioned to contribute to specific components of such capacity building efforts once the roles and responsibilities of different multilateral organizations and agencies have been clarified as suggested in the previous section of this report. Also - as mentioned in other sections of this report - the World Health Organization recently developed and updated its outbreak communication guidelines, which may serve as a framework and/or a starting point for capacity building efforts at the government level.

Finally, the development of suitable advocacy strategies and tools on the importance of pandemic-flu communication preparedness (see section on *Raising Pandemic Flu Awareness/Knowledge*) should be considered as part of future guidance to support field officers on their advocacy and government relations efforts especially in countries where conflicting public health priorities and limited resources are often an obstacle to the engagement of local governments on pandemic flu communication preparedness.

**Key Audiences of Capacity Building Efforts: Communication and Social Mobilization Partners.** As previously mentioned, study findings supported that capacity building efforts and guidance should be considered not only at the government level but also at the community level, so that non-governmental communication systems and social mobilization partners would be ready to handle pandemic flu and other health emergencies. While social mobilization may take many forms and include different kinds of partners, its effectiveness as a fundamental area of health communication is well established in different settings, countries and for different health issues and disease areas (Schiavo, 2007). Our review of theoretical models and lessons learned from past disease outbreaks also confirmed the central role social mobilization plays in handling health emergencies (see *Data Analysis, Reporting and Other Observations and Topic-Specific Recommendations*).

As highlighted by study's respondents, the level of preparedness of social mobilization and communication partners (e.g., schools, teachers, community and religious leaders, health and social workers, local NGOs, local media, radio hosts, healthcare professionals, local businesses, etc.) should be assessed in the pre-pandemic phase. This process would help: (1) provide potential partners with resources and disease-specific information that may help them deal with a potential pandemic; (2) gain insights on obstacles, social norms and attitudes that may prevent a swift implementation of control measures; and (3) identify potential communication strategies and culturally competent activities in support of expected behavioral and social results.



Use of interpersonal communications channels and strategies may be best suited to implement potential training sessions at the community level. When and where appropriate, the reach of training sessions could be expanded via webinars, Internet teleconferences, and other new media. Workplaces, school programs and local health centers should be considered as key communication venues as well as potential stepping stones to larger programs on preparedness and prevention at community level. In these settings, simulation exercises may be beneficial to enhance the level of preparedness of key social mobilization and communication partners, and to identify gaps in the skills needed to achieve expected behavioral and social behavior outcomes of pandemic flu communications. The development of pandemic flu-specific checklists for community dialogue on potential mitigation measures as well as existing barriers to implementation should be considered as part of training sessions and modules.

According to study's participants, governments have traditionally taken the lead in building communication capacity within government-led public health systems but in many cases seem have found the process of mobilizing outside leaders and strengthening non-governmental communication systems by far more challenging. This points to the opportunity for a more direct involvement of international agencies and NGOs in building adequate capacity at the community level -and among local communication and social mobilization partners.

**Other Capacity Building Needs Among Special Audiences: Healthcare Professionals and Businesses.**

Study findings supported the need for further advance preparation of key audiences (e.g., local healthcare providers and businesses) who are not only the gatekeepers of relevant information but also provides essential community services. Previous experiences (e.g., 1918 flu pandemic) and recent studies (e.g., KAP studies in Sweden, India) point to the importance of building capacity and skills that may prevent service disruption and confusions in the healthcare and businesses settings (see section on *Lessons Learned from Other Health Emergencies and Disease Outbreaks*). Capacity building efforts should address the potential psychological response of healthcare and business professionals as well as their overall communication capacity.

In the pre-pandemic phase, pre-packaged communication messages, toolboxes, materials and training modules targeted to healthcare providers may need to be developed to: (1) address and prepare them for all potential uncertainties in pandemic flu care and management; (2) provide much needed information on safe care of patients in health emergency situations (especially in the context of infectious diseases such as pandemic flu); and (3) equip providers with much needed communication resources and skills on how to break bad news and/or communicate with family caregivers and patients during a health crisis. Local businesses should be equipped with information on potential mitigation measures, how to manage the psychological response of employees and partners, safety measures, and other to be identified on a country- and business sector- specific basis.



## Pre-Pandemic Communications: Recommended Focus, Potential Interventions and Implications for Guidelines

Outbreak and emergency health communications deal primarily with the control and mitigation of a health crisis by sharing information, and engaging and mobilizing intended audiences to encourage the adoption of short-term behaviors and social actions that may contribute to reducing morbidity and mortality of disease outbreaks. Conversely, pre-pandemic communication efforts lay the ground for the effectiveness of outbreak response by encouraging long-term behavioral and social results that would maximize preparedness and prevention measures.

Study findings pointed to the need for a renewed emphasis on pre-pandemic communications and related guidance. At the minimum, guidance on pre-pandemic communications should focus on the following areas and potential interventions, which are all supported by the study's conclusions:

- *Restoring a sense of urgency about pandemic flu communication planning* at the government and community levels as well as increasing public and community awareness and knowledge on pandemic flu and related resources
- *Assessing community needs, lessons learned from past pandemics, existing communication capacity, priorities and preferences*, to:
  - Identify existing social norms, traditional practices, attitudes and other kinds of obstacles (e.g., the practice of sleeping with recently deceased family members; potential community resistance about staying away from religious venues and worship sites during times of health crises; the influence religious leaders may have on health and social behaviors, etc – see Table 1 for other examples of key issues and potential obstacles), which may prevent a swift implementation of mitigation measures at the time of a flu pandemic
  - Inform capacity building efforts on communication planning/implementation and pandemic flu knowledge of non-governmental communication systems and social mobilization partners, including local media, religious leaders, community health workers and leaders, social workers, healthcare professionals, local medical associations, schools, etc
  - Gain understanding on how different issues (e.g., trust, transparency, accuracy and consistency of information, etc) may affect credibility and quality of community-based communications as well as identify suitable strategies to address these issues at community level
- *Mapping and assessing pandemic flu risk level* to make sure that audience-specific communication interventions are designed to reach vulnerable and marginalized populations and high risk groups/communities



- *Preparing for Different Pandemic Flu and Community Scenarios* by developing adequate toolboxes, models, and audience-specific activities that may help make P/I communication preparedness commonplace

The subsections that follow include a more detailed analysis as well as relevant recommendations on the topics covered above.

### Raising Pandemic Flu Awareness/Knowledge

Lessons learned from previous pandemics and disease outbreaks link low compliance to recommended actions to low disease awareness and knowledge (US Department of Health and Human Services, 2008a)), which may also contribute to enhancing the occurrence of irrational behaviors in response to a health crisis. This observation is one of the key lessons learned from the 1918 flu pandemic (U.S. Department of Health and Human Services, 2008) and was also confirmed by this study's findings in the context of other situations and disease outbreaks.

Several study's respondents expressed great concern about the current low level of pandemic flu awareness in most countries and regions of the world. While this appears to be a key issue in most developing countries reviewed for this study, study participants from some industrialized countries (e.g. New Zealand, Sweden) also reported a low level of pandemic flu awareness among the general public. In Canada, a public consultation on what the public would like to see implemented in preparation for pandemic flu revealed that a majority of Canadians view public awareness and communication efforts on pandemic flu as the best prevention and mitigation method.

Most study's participants also supported the need to prepare communities, households and the general public in the pre-pandemic phase on pandemic flu symptoms, key mitigation measures, as well as credible resources. While this is a very complicated issue, that would require an in-depth analysis of country-specific situations, suitable communication angles, obstacles to implementation, and timeframes and resources to initiate communication about pandemic flu, some common threads emerged from our findings and should be further explored and expanded as part of future technical guidance. These include:

- The importance of carefully crafted communication strategies and messages that would prevent the unnecessary spread of panic among community members and the general public, and/or false rumors about the imminence of a pandemic, which may jeopardize local economic resources (e.g., tourism)
- Early engagement and training of local mass media (e.g., community radio, local reporters, etc.) – a major channel in crisis communications - to increase preparedness on potential coverage of pandemic flu and minimize the risk local media (a) may contribute to misperceptions and confusion



in the pandemic phase and/or (b) mistrust information they would receive from local governments or community spokespeople

- Emphasis on communication activities intended for special populations who may influence community and household leaders and decision-makers (children, health workers, healthcare professionals, social workers, family caregivers, teachers, women's groups, religious leaders, etc.)
- Adequate funds and resources that would allow implementation of pandemic awareness efforts at the community and household levels
- Use of suitable and region-specific communication angles to introduce preliminary messages on pandemic flu preparedness in pre-pandemic phase

**Potential Communication Angles/Entry Points.** Study's findings pointed to seasonal flu as a suitable communication angle to start introducing resources and measures that should be considered in case of pandemic flu in industrialized countries as well as high to middle-income countries in all regions. Several countries are already using and/or considering using this angle at least to start promoting potential pre-pandemic measures (e.g., hand and personal hygiene, respiratory etiquette, staying home if sick, etc).

In low-income countries, which include a vast percentage of developing countries, seasonal flu may not be a suitable angle to introduce information and resources on pandemic flu. Study respondents highlighted that the lack of widespread availability of a seasonal flu vaccine, which in many developing countries is available for fee only in private clinics that are not affordable for large segments of the population, does not support its relevance in low-income country settings. Alternative suggestions included using current outbreaks (e.g. typhoid, dengue, etc.) or natural disasters to start initiating a community dialogue about preparedness for other kinds of disease outbreaks, including pandemic flu. This angle would need to be further explored on a country-by-country basis. Community dialogue and consultation sessions may help identify other suitable angles as well as build interpersonal communications capacity at the community level, so that communication and social mobilization partners would be prepared to plan and implement P/I communications interventions.

**Focus on Local Media.** Several study participants also highlighted the importance of preparing and engaging in the pre-pandemic phase national and local media, including community radios and local reporters. Most mass media do not like to cover what they don't understand, so background sessions and information on pandemic flu as well as ethics and issues on reporting during health emergencies may be suitable tools for local mass media engagement and preparedness.

In the Pacific region, UNICEF has been already conducting a few training sessions aimed at media professional societies and networks by training them to train local reporters. This peer-to-peer



approach seems to be well received by reporters. UNICEF may be well suited to provide guidance and/or facilitate such trainings because of its local staff capacity at the field level. While this is not a traditional function for UNICEF, it may make sense to explore it with other international agencies vis-à-vis local capacity and staff presence.

**Advocacy Efforts at the Government Level.** Study findings also confirmed the importance of developing suitable advocacy strategies and tools that would help restore a sense of urgency about pandemic flu communication preparedness at the government level in countries where high disease burden, conflicting public health priorities and limited resources may restrain potential investments and efforts on pandemic flu communication preparedness. As reported in more detail in other sections, in some countries pandemic flu “is not longer considered a real threat.” Some study respondents suggested that additional resources (e.g., funds, materials, toolboxes, etc.) are much needed and may help governments to become further engaged in preparedness measures. Focusing advocacy efforts on younger government officers - who may be more open to “own” the issue - appears to be another potential strategy according to a few study participants.

Future guidance on pandemic flu communications should include examples of strategies and practical tips on how to identify and develop internal “champions” within local governments; facts and statistics to be used in discussing pandemic flu and its potential impact; key “selling points” in support of pandemic flu communication preparedness. Cases studies and success stories could also be highlighted as part of advocacy efforts to point to the benefits of communication preparedness versus the consequences of delaying the development of suitable plans and actions until the onset of an actual flu pandemic and/or other kinds of public health emergencies. The development of an advocacy strategy (as well as tools to customize it to adapt to local realities) should be discussed with other international agencies and UNICEF’s partners to ensure the kind of international and local coordination that has been shown to be an essential element and good practice of effective outbreak communications and related pre-pandemic preparedness.

### **Community and Household Outreach and Consultation**

Lessons learned from past disease outbreaks as well as the analysis of outbreak and emergency communications models analyzed for this study, showcase that communication quality and credibility is influenced – among others - by issues of public trust and transparency of communication activities. In turn, this may also influence the willingness of intended audiences to act upon the information they may receive. These two important factors (and many others) are included in the recent WHO draft on *Outbreak Communications Guidelines* as well as in our discussion/section on *Lessons Learned from Other Health Emergencies and Disease Outbreaks*.



Our findings highlights that such issues are also quite important in communicating at the community level. This is not only because community members may lack confidence in the information being disseminated by their governments but also because of community-specific dynamics and/or lack of advance preparation in identifying trusted sources of information and adequate spokespeople. Poor interpersonal communications training among community leaders and others who can influence behavioral and social change as well as low health literacy may be other factors contributing to misperceptions about the quality and trustworthiness of communication.

Therefore, a community and household consultation model that is participatory - but yet focused on specific individual and social behavior outcomes - may help community members to reflect on past health emergencies and disease outbreaks as well as identify key factors and communication chains that may contribute to increasing community trust and perceived transparency of future communication activities while gaining knowledge on pandemic flu. In addition, such community consultation model may help:

- Assess lessons learned from past disease outbreaks and related community-based communications
- Survey community needs using past experiences as a framework for discussion
- Build an overall sense of rapport and mutual understanding of needs, situations, obstacles and common solutions among community participants
- Identify community priorities and preferences in relation to recommended behaviors /other measures as well as investments in pandemic flu communications preparedness

Again – and as for other activities identified or recommended so far in this report – a fundamental step in implementing this community consultation model is to empower and train community leaders, relevant groups, and communication and social mobilization partners on interpersonal communications skills, dialogue and group facilitation, and information management as well as overall communication planning and implementation strategies. Of interest, according to study’s participants, a few organizations affiliated with the CORE group (which include Red Cross, Save the Children, AED and other international NGOs) are already focusing on a community consultation model on pandemic flu in addition to their framework for community and household communications we previously mentioned (AED, 2008). Community-based activities have been reported in Egypt and India and appear to be piloted by local affiliates of the national organizations that are part of CORE. In the Pacific region, the Red Cross is also piloting a community model to promote hygiene measures and prepare community members on how to react in case of pandemic flu. Opportunities for partnerships with the CORE Group, or other international and national NGOs should be further considered and evaluated by UNICEF.

Technical guidelines on pandemic flu communications should include practical steps in this direction as well as consider that the development of a pandemic-flu specific consultation model may need the input of local governments, NGOs and sample communities to identify core questions and needs. Moreover, the model may draw on well-established communication methodologies, such as community dialogue, home visits and consultations, and include a strategy for dissemination of these findings that may provide the basis for work in other communities. Finally, issues with funds and resources may prevent the implementation of such model at scale – therefore, most representative communities and high-risk groups may be selected, so that findings may provide a valuable basis for larger interventions.

### **Risk Mapping and Assessment**

Initial observations and assumptions on the need for suitable strategies to reach vulnerable communities and assess their risk and level of preparedness for pandemic flu were confirmed by this study. Study's participants mentioned a long list of communities that during past outbreaks have been left out from traditional communication channels or reached very late in the outbreak phases by key communications efforts and materials.

At the minimum, many study's respondents expressed doubts about whether overall communication efforts had been able to reach those groups with limited literacy and/or poor Internet skills; or who lived in precarious conditions (homeless people); or needed information in languages other than the one of the country where they resided. Overall, other examples of vulnerable and high-risk populations include:

- Isolated communities and villages, where the risk for pandemic flu transmission may be underestimated if we take into account that many community members still need to travel to local markets, schools and health centers to take care of basic living needs
- People with disabilities – and especially women – who in conservative societies and many developing world countries are often exploited by family members and others (Pacific Institute for Women's Health, 2002) and left without the kind of support that may be needed in case of a health emergency
- Elderly people and children (including orphans and households where older children take care of all siblings) who are among high risk groups for some of the life threatening consequences of pandemic flu
- Homeless people who may need shelter as well as medical evaluation during a potential pandemic
- Crowded households where pandemic flu measures such as the isolation of sick family members may be challenging to implement



- Communities where strong religious values may dictate alternative behaviors to those being recommended to mitigate pandemic flu
- Ethnic minorities or high risk groups that because of the stigma associated with high risk may avoid and hide from prevention measures and treatment

While a few risk assessment and mathematical models have been developed and/or are in the process of being developed to assess the risk for introduction of SARS and influenza (the latter to a more limited extent) through international travel and/or at the local and global level (European Commission Sixth Framework Programme, 2008), risk assessment and mapping at the community and household level is still an unmet need in all countries reviewed for this study. Strategies and technical guidance on how to conduct risk assessment and mapping studies at the community and household level should be considered for inclusion in pandemic flu guidelines. This should aim to:

- Identify and map:
  - Communities with high percentages of members from high risk groups
  - Communities that may be most affected by pandemic flu because of living conditions or lack of adequate infrastructure
- Define suitable and culturally competent communication channels and messages to be used in the pre-pandemic and pandemic phases to:
  - Encourage preparedness measures
  - Advocate with local policy makers about steps and resources that may facilitate preparedness
  - Encourage community adoption of long-term and short-term behaviors that may help mitigate the impact of pandemic flu
- Encourage social responsibility in taking care of vulnerable populations via community consultations, and development of practical, audience-specific and behavior-oriented scenarios

As for other interventions at the community level, the actual implementation of risk mapping and assessment would need to rely on local groups and communication partners, who would need to be adequately engaged and consulted on the key elements of training modules and other activities that may facilitate risk assessment and mapping.



## Preparing for Different Pandemic Flu and Community Scenarios

**Pandemic Flu Communications Toolbox.** Several study participants (and almost all respondents in the UNICEF study's group) reported the need for sample materials and messages to be developed in the pre-pandemic phase. Overall, our findings pointed to the importance of a toolbox on pandemic flu communications, which would need to be adapted for use in different communities. As shown by some of the experiences analyzed for this report (e.g. cholera outbreaks in Jordan), the absence of communication templates and materials caused significant delays in providing critical information in developing countries. This toolbox could be developed with the input of UNICEF country and regional officers as well as representatives of sample communities and UNICEF's international partners, so that it would take into account a variety of needs, situations and potential scenarios. Ideally, behavioral and social results that are expected from communication interventions should also be considered for inclusion in this toolbox. Since the integration of multiple of communication areas and channels is a well-established good practice of health communication (see *Overview of Lessons Learned from Other Health Emergencies and Disease Outbreaks*), the toolbox should encourage the use of multiple, culturally and task-appropriate channels and communication areas (e.g. interpersonal, mass media, community mobilization).

Specific examples of potential elements of this toolbox, include:

- Detailed issue management plan, including strategies to address potential communication hoaxes
- Q&A for different audiences (e.g., local mass media, community members, etc.)
- Modules for media training of core national, local and community spokespeople
- Sample communication messages and materials for use at the community and household level
- Guidance on how to assess cultural preferences and other audience-specific parameters that may influence the selection of communication channels and tactics to be used in the pre-pandemic and/or pandemic phase
- Guidance on how to contextualize and adapt sample materials and messages to local needs
- Examples/guidance on potential distribution channels to reach vulnerable populations (e.g. refugees, rural areas, isolated communities, disabled, etc.)

**Use of Mathematical Models to Prepare for Different Community-Based Scenarios.** While the community consultation model we discussed in the previous section of this report may provide useful insights on potential pandemic flu scenarios, mathematical models may also contribute to the overall understanding of different situations and should be considered as a potential intervention to be



implemented in the pre-pandemic phase. Mathematical models have been used for a variety of purposes in public health. Most recently, mathematical models have been used to assess SARS transmission in Singapore by estimating SARS infectiousness as well as drawing preliminary conclusions on the impact of control measures during the actual epidemic (Ma and Lipsitch, 2003). While this kind of simulation is never an adequate substitution for real life situations, it may still help countries and communities to think about key issues within a structured framework.

In the case of pandemic flu, such models could explore different scenarios at the community and household levels and be designed to meet country-specific needs and characteristics. Potential questions to be explored include: (1) expected efficacy of all measures within different local realities; and, (2) potential rates of compliance to recommended behaviors and social actions vis-à-vis several factors and variables, including levels of communication preparedness, community and cultural characteristics, risk level, literacy levels, communication channels and others to be identified. Since mathematical models are used to make predictions and describe potential scenarios in presence of different variables (e.g. communication preparedness versus lack of communication preparedness), results may be used as background information - and a logical framework- as part of efforts that seek to increase interest in pandemic flu communications planning among a variety of key decision makers and partners.

**Simulation Exercises at Community Level.** Study's findings also pointed to the importance of simulation exercises as a last step to communication preparedness. At community level, simulation exercises should be considered as part of capacity building efforts that would be intended for healthcare professionals, community leaders and communication and social mobilizations partners. In fact results from the 2007 influenza pandemic simulation conducted by UNICEF in partnership with the government of Japan, showcased that simulations (UNICEF, 2007):

- Improve planning processes
- Identify gaps and needs in pandemic preparedness and response planning
- Enhance understanding of pandemic influenza
- Increase team spirit

According to study's respondents, a recent national simulation conducted by WHO and the CDC in Indonesia also contributed to increase feelings of self-reliance among participants and to identify existing gaps and needs. Select high-risk communities should be considered for conducting this kind of simulation to identify gaps and capacity building needs among local communication and social



mobilizations partners and healthcare professionals. Technical guidance on how to conduct such simulations at the community level as well as criteria to select these communities that may be the most representative of either large and/or vulnerable segments of the population should be considered for inclusion in potential pandemic flu communications guidelines.

**Building Long-Lasting Preparedness.** Making pandemic flu preparedness commonplace at the community and household levels is definitely a major challenge. As this study highlighted, conflicting priorities, poverty, lack of adequate resources and training, and all other obstacles mentioned throughout this report may prevent communities from adopting long-term measures. Still, the only hope to preparedness relies on adequate pre-pandemic preparation that is clear about expected behavioral and social results; taps into existing resources; seeks to understand community needs via adequate dialogue and consultation models; strives to establish local partnerships and mobilize community members; taps into people sense of solidarity by providing information and tools that would allow them to help others while protecting themselves; advocates for funds and resources with key policymakers; attempts to help recruit young people in public health-related professions, and finally, identifies and communicate with these audiences, such as children, women’s groups, teachers, local business owners, religious leaders and others who may make communication commonplace by bridging generational, class, and cultural divides.

Finally, program planning as well as case studies on well-designed and implemented communication programs provide communication teams with an opportunity to showcase behavioral and social behavior results as well as the overall contribution of the communication field to managing and containing disease outbreaks. (Schiavo, 2007) A well-coordinated and result-oriented effort to compile relevant case studies should be considered for use on a country-by-country basis to advocate for additional funds and resources for communication programming.

## **Reporting, Data Analysis and Topic-Specific Recommendations**

This section summarizes and analyzes in further detail key findings. It’s organized by topic, and serves to reinforce or expands upon concepts, core recommendations and priorities discussed in the previous section (*Core Conclusions and Recommendations*). For additional details on specific case studies, overview of country-specific pandemic flu communications plans and/or status, a list of study’s participants, as well as a list of emergency and outbreak communications models reviewed for this study, see *Appendices* in this report.



## Key Priorities and Needs among UNICEF Regional and Country Representatives

Since the main purpose of this study is to identify issues, elements and next steps that should feed into the development of technical guidelines on pandemic flu communications intended for UNICEF field officers and their local partners, study participants from the study group that was affiliated with UNICEF were also asked to provide suggestions on what they wished to see included in potential guidelines as well as what kind of overall guidance was much needed in the field. Five (5) of the six (6) respondents reported that the regions or countries in which they operated are still in the early stages of pandemic flu communications planning or only have a preliminary skeleton for a communication plan, which is included as a component of the overall P/I preparedness plan (see appendix C for a snapshot on P/I country plans or planning status).

In absence of specific P/I communications plans, respondents felt it would be very difficult to manage a potential pandemic flu outbreak, and to disseminate relevant information on social actions and behaviors that would serve to mitigate the pandemic. Because of the disruption of services and lack of pandemic flu communication preparedness, communication would need to rely primarily on national mass media. In these circumstances, it would be nearly impossible to reach specific communities (especially vulnerable segments of the population) because of the absence of pandemic flu-specific communication preparedness (including lack of local training, resources and sample materials on pandemic flu-related issues). Low awareness of pandemic flu risk at the general public and community levels (and in some cases, at the government level) was also mentioned as a key issue to be addressed. In many cases, respondents referred to the need for advance efforts to establish local and community-based outbreak response and coordination teams, so that they won't need to be assembled in more difficult conditions at the time of a pandemic.

If preliminary - but considerably underdeveloped - pandemic flu communications plans had already been drafted, respondents still highlighted the need to strengthen the capacity of non-governmental communication systems and social mobilization partners (for example, radio hosts, reporters, healthcare workers, religious leaders, schools, community leaders and workers, women's groups, etc.). As previously mentioned, in some regions, governments appear to find difficult to adequately train, prepare and mobilize local community leaders. Therefore, international agencies - in partnership with local and international NGOs - could play a fundamental role in facilitating pandemic flu communication preparedness at the local and/or country levels. Overall, the urgent need for a detailed pandemic flu communication plan - which should include a community and household component as well as consider both the pre-pandemic and pandemic phases - was emphasized by 5 of the 6 respondents. In the Pacific region, a more detailed plan already exists and includes stand-by messages and materials (primarily for national and mass media-focused interventions).

Several obstacles to the planning, implementation and monitoring of pandemic flu communications interventions were identified as part of these interviews and were also confirmed by respondents in the other study’s groups (for a comprehensive list see Table 1 in this report). This section discusses primarily current needs for technical guidance, which are summarized in Table 2 as highlighted by respondents in the UNICEF’s study group.

**Table 2 - UNICEF Regional and Country Representatives – What They Say They Need and/or Would Like to See Included in Future Technical Guidance and Toolboxes**

1. Specific guidance/global consensus on behaviors and public actions to be promoted in case of pandemic flu (P/I)/local outbreaks (or – as alternatively stated by one respondent: “clarity on behavioral results to be achieved by communication interventions”)
  - a. Include pre-pandemic and pandemic phases
2. Key P/I -related messages (as for A/I)
3. Information or further guidance on the process involving all steps of the communication’s cycle
  - a. For example: How to communicate with policymakers, NGOs, communities and households
  - b. Tools that may apply to all kinds of pandemics
  - c. Solid monitoring and evaluation system (realistic and practical)
4. Information on different P/I scenarios and scenario-specific strategies
5. Information/training on risk communications planning/risk assessment among different communities
6. Practical communication tools and sample materials on P/I
7. Adequate research capacity to contextualize expected behavioral results /recommended actions within countries (and practical tools/guidance to implement such research)
8. Assessment of existing capacity/experience of prospective social mobilization partners (for example: religious leaders, schools, NGOs, etc.) in responding to pandemic flu (and practical tools/guidance to conduct such assessment)
9. Global consensus on process-related norms and guidelines to be observed in case of a flu pandemic
10. Guidance on how to reach communities that are isolated/hard to reach

NB: Entries have been ordered by number of mentions. Top three entries = highest number of mentions; last entry at the bottom: one mention only



The variety of existing needs for training and technical guidance highlighted in Table 2 confirms the importance of capacity building at the field and community levels. As previously mentioned, it also showcases the need for combining capacity building efforts that would focus on general emergency and risk communications principles and strategies with training modules, guidance and materials that more specifically address pandemic flu communications and issues. In fact, of the 10 items listed in table 1, seven are specific to pandemic flu, with two of them (1 and 2) being mentioned by most respondents.

In support of the above vision, it may be important to consider that in most situations it would be unfair to assume that people who receive a 2-4 weeks training on any general communication topic (such as emergency and risk communications) would be ready to develop a program on a specific disease area without further assistance and guidance from communication specialists and international agencies. This is particularly relevant at the community level where resources and capacity may be minimal. Therefore, while enhancing field capacity on emergency/ outbreak and risk communications is of critical importance, the need for specific guidance and plans on pandemic flu was clearly expressed by participants in this study group. It was also validated by secondary data analyses as well as other primary data in this study.

Of particular relevance, the majority of the respondents in this study group (5 out of 6) were concerned about the lack of global consensus and specific guidance on individual, community and social behaviors that would need to be promoted and sustained in case of a pandemic. Respondents primarily referred to behaviors and social actions that would need to be adopted during a potential outbreak but were also concerned with measures and behaviors that may aid preparedness in the pre-pandemic phase. A more comprehensive discussion on this topic is included in the previous section on *Clarity on Behavioral Results* in this report.

Other specific needs were either related to the development of stand-by messages and materials on pandemic flu or to the building of specific competencies related to the overall communication cycle. This further reinforces the need for a dual approach that combines capacity building on emergency and outbreak communications with disease-specific guidance that addresses strategies to promote long-term behavioral and social results at the community level.

## Overview of Lessons Learned from Other Health Emergencies and Disease Outbreaks

In the last few decades, “communication has emerged as one of the most important public health sciences of the 21<sup>st</sup> century.” (Surgeon General David Satcher, 2001). On the wake of the 2001 anthrax bio-terrorism attack in the United States, it became clear that timely, strategic, and well-coordinated



communication efforts could make a great difference not only in mitigating the potential life-threatening consequences of bio-terrorism attacks or other health emergencies but also managing people's reaction during crises, so that recommended behaviors and social actions could be adopted and sustained by intended audiences. Similarly, the SARS epidemic reinforced understanding of the central role of communication in improving public awareness and knowledge of health risk as well as helping implement all measures that may help control pandemics.

Some of the lessons learned from the anthrax crisis – which unfortunately led to the death of several postal workers in the Washington DC area (Blanchard and others, 2005) – relate to the importance of (Schiavo, 2007):

- Advance preparation that would also look at existing obstacles, social and cultural norms, audience-specific needs and characteristics, and potential scenarios, which would need to be considered in order to enhance communication effectiveness as well as people's compliance to recommended behaviors and social actions
- Engaging trusted community groups and leaders who may be more effective in reaching vulnerable populations and motivating them to action
- Adequate, culturally competent, and audience-specific messages and channels
- Coordinated efforts and mechanisms, which would ensure message consistency and accuracy as well as adequately address potential issues with public or community trust about emergency or outbreak-related measures and messages

Many of the above lessons learned apply also to other health emergencies and disease outbreak situations that were reviewed for this study, including the 1918 flu pandemic as well as more recent health emergencies such as SARS, a 2004 outbreak of Ebola in Southern Sudan (2004), and recent outbreaks of Avian Flu in a variety of countries (Nigeria, United Kingdom, India and Indonesia). While some of this analysis relied on published case studies and data, other information was collected via in-depth interviews with our study's participants who shared their experience and knowledge on emergency communications and past disease outbreaks. A snapshot of disease- or case study-specific information that was reviewed for this study is included in Appendix A of this report. Following is an overview of common issues, lessons learned and other key factors that emerged from the analysis of different pandemics and disease outbreaks. Such lessons have informed core conclusions and recommendations highlighted in the first part of this report.

1. **Global and in-country coordination of all communication efforts** has emerged as a strategic imperative in emergency and outbreak communications. The SARS epidemic acted as a wake-up call about global interdependence and propelled global coordination at the forefront of all efforts. SARS took only 15 hours to spread from Hong Kong to Toronto – pointing to the importance of

advance preparation and interdisciplinary collaborations both at the global and country levels. As mentioned in the next section of this report, all recent emergency and outbreak communications models analyzed for this study seek to address this need.

2. **Clarifying expected behavioral and social outcomes interventions** and **contextualizing recommended actions to adapt to local realities** emerged as key lessons learned from past outbreak management experiences (especially in the case of avian flu). Study respondents (especially in the UNICEF study's group) were in strong agreement that the existing consensus on key behaviors to be promoted for avian flu mitigation was extremely helpful in mobilizing intended communities and audiences, and facilitated implementation of communication activities.

Several respondents also pointed to the need for adapting recommended actions to suit local needs and cultures. For example, in Nigeria children normally take care of poultry. In absence of pre-pandemic communications on the issue, it was very difficult to keep children away from their assigned chore during the 2006 outbreak of avian flu. Reportedly, some alternative and culturally appropriate measures were devised to address local customs. These included the use of masks by children who were taking care of poultry, so at the minimum they could avoid breathing the feathers' dust. This points both to (1) the need for an in-depth assessment in the pre-pandemic phase of local customs that may be relevant to recommended measures, so that obstacles could be addressed well in advance; and, (2) the importance of building local research and communication capacity, so that interventions could be designed for maximum effectiveness, cultural relevance and sound scientific and medical appropriateness. For example, - in the case of avian flu - pre-pandemic communications could be designed to inform and engage parents about the importance of removing children from traditional chores that may increase the risk for transmission in the case of disease outbreaks.

3. As a follow up to point n.2, lessons learned from past disease outbreaks and health emergencies point to the **central role of communication both in the pre-pandemic and pandemic phases**. While this role is widely recognized by international agencies and governments in both industrialized and developing countries, several past experiences have been focusing primarily on addressing information and needs during an actual outbreak and, for the most part, point to the need for increased communication efforts and disease-specific planning in the pre-pandemic phase. As discussed in the "Core Conclusions and Recommendations" section of the report, such efforts should focus on addressing both capacity building on outbreak communication as well as social norms, levels of knowledge and awareness, risk factors and all other issues that may hinder the effectiveness of communication interventions during an actual outbreak.

For example, during the 1918 flu pandemic, confusion on recommended actions and lack of clarity of some of the communication materials were among key factors limiting compliance to recommended behaviors and public measures among segments of the US population. During that same pandemic, low disease awareness was another factor that seemed to have affected compliance (U.S. Department of Health and Human Services, 2008a). Similarly, during the SARS outbreak, study respondents reported both issues with implementing important measures, such as the closing of churches (e.g., Canada) to which people recur for comfort during times of crises, as well as issues with journalists' trust and overall confidence in the information being disseminated by government leaders (e.g., New Zealand). Disbelief, shock and/or existing social norms all contributed to the above circumstances.

Moreover, the 2004 Ebola outbreak in Southern Sudan (see Appendix A), points to the importance of communication and social mobilization preparedness at the community level as well as considering issues of community trust, compliance to recommended measures (e.g. isolation), risk knowledge, traditional practices, and overall awareness of the disease's signs and symptoms. Addressing these kinds of issues in the pre-pandemic phase – at least by preparing local communication and social mobilization partners – may increase overall compliance to recommended behaviors.

4. **Social mobilization** has been shown to be essential to the containment and management of health crises as well as to the achievement of behavioral, social and organizational objectives that may ultimately improve overall public health outcomes (Schiavo, 2007). For example, in the case of the Ebola outbreak in Southern Sudan we previously mentioned, social mobilization teams were instrumental in communicating with local communities, and dispel people's fears and misconceptions. Such teams included local pastors, teachers and community development workers and leaders, who played a key role in the rapid achievement of outbreak containment results (WHO, 2004). Similarly, during the SARS outbreak in Canada - international and local civic society organizations (e.g., Red Cross, Meals on the Wheels, etc.) were instrumental in helping non-infected contacts to deal with quarantine by providing psychological support, delivering meals and helping them with day-to-day issues (University of Toronto, 2008).
5. **Rapid response teams** - including medical and scientific experts - played a critical role in the control of recent epidemics (e.g. SARS, Avian Flu outbreaks) not only by being in charge of data surveillance and outbreak monitoring, but also contributing to educating health workers and building local capacity on technical aspects of pandemic/outbreak management. Rapid response teams also enabled rapid modification of response in the case of SARS by addressing unexpected issues and recommending adequate measures.

At the same time, lessons learned from past health emergencies (1918 flu pandemic, A/I outbreak in the UK, etc – see Appendix A) point to the importance of early integration of communication as part of outbreak response interventions as well as enhanced collaboration between medical, scientific and communication experts. The early integration of medical and scientific teams with communication teams can further contribute to a swift response and to the development of culturally competent measures and communication strategies. Among other things – it may help enhance coordination between local and national media; increase message accuracy and clarity; provide insights on communication chains, channels and resources as well as strategies to contextualize recommended measures to address local cultures and needs. For example, during the 1918 flu epidemic, lack of culturally competent materials left many people unprotected since information was often confusing and difficult to understand under outbreak pressure (U.S. Department of Health and Human Services, 2008). Similarly, the recent Avian Flu outbreak in Holton, Suffolk in the United Kingdom, pointed to the need for further coordination and advance preparation to address issues of message accuracy, clarity and consistency in different locations. (U.K. Department of Environmental Food and Rural Affairs, 2007) Study respondents from most industrialized countries interviewed for this study advocate for and/or have already developed pandemic flu communication plans in which medical experts and communication experts are increasingly working together as part of coordination teams at the national or local levels. Yet, additional efforts are still undergoing in many countries to establish rapid response teams in this pre-pandemic phase.

6. **Use of multiple, culturally competent and task appropriate media** is a strategic imperative of all communication interventions (Schiavo, R., 2007) both in the pre-pandemic and pandemic phase. The integration of multiple channels (including – for example - mass media communications, social media, and interpersonal communications) has been shown to best suited to achieve behavioral and social behavior results (Curtis, Garbrah-Aiddo, and Scott, 2007; WHO, 2004; UNICEF, 2006). In some cases, community-based events “had the highest behavior change success rate but because television reached a higher number of people, it helped change the behavior of a greater number of people.” (Tulenko, 2007) Therefore, advance preparation in understanding the cultural needs and preferences, and most trusted sources of information among different populations and communities should be included as part of pandemic flu communication planning as well as overall outbreak communication preparedness.

The case studies reviewed for this study used a variety of channels, including the use of texting to reach local farmers in the UK; interpersonal and community-based channels in Southern Sudan and Nigeria; and, traditional mass media and internet-based interventions in Canada. In most cases, several different channels and areas of communication were integrated to maximize the effectiveness of the communication response and create the so-called “resonance” effect (Schiavo, 2007) for which people may hear the same message from many different trusted sources. Finally, it’s important to take into account that while social media (e.g., texting, blogs, mobile technologies,



etc.) are increasingly used as part of health communication and emergency communications interventions, there is not any comprehensive analysis yet that supports their effectiveness in achieving awareness, knowledge, and/or most importantly short-term or long-term behavioral and social outcomes among intended audiences (Abroms, Schiavo, and LeFebvre, 2008). Such impact evaluation should be included in all interventions that consider the use of social media.

7. **Advance preparation to address health workers' and business reaction in the case of pandemic flu** is not currently included in most existing pandemic flu communications plans. Yet, during the 1918 flu pandemic many healthcare providers and business owners stayed home leaving business and much needed healthcare measures unattended (U.S. Department of Health and Human Services, 2008).

Many of the study's participants - especially from countries in an advanced phase of pandemic flu communications planning - supported the need for increased communication planning aimed to address the potential reaction of health care providers, other health workers and businesses. For example, future areas of focus on pandemic flu communication planning in Sweden may include looking at how providers may react to a potential pandemic (especially those providers who are parents and/or may take care of elderly members of their families and/or may have heightened concerns about the risk for disease transmission). In Sweden, a recent KAP and informational needs study on pandemic flu highlighted: (1) the lack of communication competence among Swedish healthcare providers; (2) the need for developing clear and consistent messages on pandemic flu communications priorities; and (3) the importance of establishing in advance overall roles and responsibilities during a potential pandemic. (National Board of Health and Welfare – Sweden, 2008). Similar findings are included in a KAP study recently completed in India, which showcased the need for pandemic-flu and health worker-specific messages and training both on communications and technical aspects (e.g. patient handling) of pandemic flu. (Social and Rural Research Institute, 2008)

Of interest, the United Kingdom pandemic flu communications plan includes a component that looks at providing special advice and support to social workers and healthcare workers in the primary care setting. It also includes a pandemic flu checklist for business and other initiatives and materials that may increase competency and self-efficacy among those audiences during a pandemic. (U.K National Health Services, 2008) Moreover, most UK primary care trusts – which provide primary and community healthcare services in specific boroughs or regions – have developed pandemic flu communications plans and continue to update them regularly. This is in sharp contrast with the current situations in most developing countries that were reviewed for this study where the need for strengthening health workers capacity to deal with pandemic flu is still largely unattended.

8. As expected, **resources** (including funds, human resources and adequate capacity and tools) have been a limiting factor in the management and control of past outbreaks especially in developing countries. For example, during a recent cholera outbreak in Jordan the lack of stand-by materials and messages prevented the timely distribution of information. Materials reached several communities when the outbreak had already occurred, and severely affected many community members. While conflicting priorities and lack of local resources are not easy to address in the short term, the development of a toolbox and guidelines on pandemic flu communications preparedness may aid developing world's countries to address pandemic flu communications' needs within available resources.

## Overview of Theoretical Elements and Good Practices that are Relevant to Pandemic Flu Communications

For the purpose of this study, we reviewed several emergency and outbreak communications models as well as a few strategic communication models that have been recently used for disease outbreak response. For a list of all models reviewed for this study please see appendix B. In conducting this analysis, we kept in mind that one of the main functions of strategic communication models and/or theoretical guidance is to encourage implementation of standard protocols and good practices within a given organization and other groups they may serve or influence. Use of consistent communication models also facilitates program evaluation by contributing to its accuracy since data monitoring and analysis are conducted vis-à-vis the original assumptions of the model being used (Schiavo, 2007).

With that said, it's always likely that different organizations would prefer to use the model they have contributed to develop and that most likely is branded to reflect specific organizational needs and cultures. Therefore, the main purpose of this analysis was to identify essential and/or innovative elements, as well as good communication practices that - regardless of the specific model an organization seeks to use – should be considered and incorporated in pandemic flu communications planning and potential technical guidelines on the subject.

First – and as expected – most models reviewed for this study shared core principles and recommendations, which were also incorporated in capacity building modules and checklists, when available for review (e.g., PAHO's Communication strategy for P/I, WHO Outbreak Communications guidelines, UNICEF checklists as part of the Behavior Change Communications Toolkit, COMBI's manual, etc.). For the most part, such principles and core elements are the same of effective health communication planning, since communicating about health and illness during a health emergency still deals with encouraging and motivating people from different audiences to adopt, sustain and become engaged with behaviors, social practices and/or policies that will keep the public healthy and mitigate

the impact of disease outbreaks. (Schiavo, 2007) Table 3 reviews some of the key elements of effective health communication planning that apply and/or should apply also to health emergency situations. Most of them are included in the majority of emergency and outbreak communications models reviewed for this study.

**Table 3: Key Elements of Effective Health Communication Programs (including during outbreak and emergency situations and in pre-pandemic phases)**

- “Careful analysis of situation, opportunities and communication needs
- Understanding of constituencies and needs
- Early agreement on expected outcomes and evaluation parameters
- Well-defined communication objectives
- Strategies designed to meet the objectives
- Multiple and audience-specific vehicles
- Adequate funding and human resources”
- Integration of behavioral, social, and organizational outcome objectives
  - Within a behavioral framework that aims at achieving behavior/social behavior results at different individual, community, social and organizational levels

**Source:** Adapted from Schiavo, R. Health Communication: From Theory to Practice, San Francisco: Jossey-Bass, 2007, p. 227, Table 9.1. Reference for last bullet point: chapters 9 and 10. Used by permission.

In addition to the general elements identified in Table 3, other core principles and good practices are common to the emergency, outbreak and risk communications models and experiences reviewed for this study. As highlighted by the interviews conducted for this study, special attention should be given to practical toolboxes and information on “how” to implement in the context of pandemic flu planning key elements and good practices that were identified by this analysis. Following is a list and brief discussion of key theoretical elements and good practices that should be covered in technical guidelines for pandemic flu communication.

- As previously mentioned, **global and local coordination among different countries and government units** (health, interior, information, etc.) has emerged as a key success factor and strategic “must” in handling public health emergencies and disease outbreaks. This is also supported by the analysis of existing emergency and outbreak communications models reviewed for this study. Coordination efforts are and/or should be supported by standard protocols, advance preparation, outbreak response teams, capacity building and training on core principles and strategies of emergency and outbreak communications. The development of practical tools on the “how” to implement well-coordinated communication interventions as well as adequate checklists that may be disease-specific (e.g. PAHO checklist on pandemic flu communications) may aid capacity building efforts and overall coordination both at country and global level.
- **Clarity on short-term and long-term behavioral results (outbreak-related measures versus prevention and preparedness-related measures)** was identified as an immediate need by respondents in the UNICEF study group and other key study’s participants, and is also supported as a good health communication practice by many of the models reviewed for this study (WHO’s COMBI, UNICEF Behavior Change Communications Toolkit, FLUWISE FLUCARE, etc.). Differing control measures as part of P/I modeling should be considered by all interventions. For example, during past avian flu outbreaks, quarantine measures varied from mild (e.g., United States) to highly restrictive (e.g., China, Taiwan, Singapore), (Dreyer, 2008). Finally, as highlighted by this study’s findings – a key priority is to build the research capacity of field offices, and communication and social mobilization partners via easy-to-implement tools and training modules on to how identify key barriers and customized all interventions to local cultures.
- **Clear understanding of local attitudes, existing behaviors, social norms, policies and potential obstacles to program implementation** is supported by all models being reviewed for this study and – more in general – is an essential good practice in health communication. While different models may refer to this phase with various terminology and somewhat different approaches (listening, situation analysis and audience profile, situational marketing analysis, etc), they all support extensive formative research as an essential phase of program planning.

Pandemic flu-specific tools and checklists may aid implementation of this research step at the community and household level by including sample questions for each target audience as well as examples of country- and community-specific materials (e.g. case studies on recent disease outbreaks, demographic information collected for other purposes, KAP studies on other kinds of health emergencies or infectious diseases issues that looked at communities and households, etc.) that should be reviewed and could provide valuable background information for pandemic flu communication planning. Community dialogue, and other interpersonal communications and mobilization strategies should be used to maximize the use of participatory research and marketing

strategies for this step. In addition to formative research, the implementation and evaluation well-designed mechanisms for audience feedback (e.g., tracking surveys, in-depth interviews, media monitoring, etc.) should be considered and implemented throughout different phases of program planning and evaluation. The post-consultation draft (Oct. 1, 2008) of the WHO Outbreak Communications Guidelines include and/or refer to a few checklists that are intended for use by national public health authorities and should be considered as background information in developing technical guidance on pandemic flu communications planning at the community and household levels.

- **In-depth knowledge and advance preparation on how to address key psychological aspects of crises and people's potential response to pandemic flu and other emergencies** is a fundamental aspect of communication preparedness. Some of the lessons learned discussed in previous sections of this report as well as in appendix (see for example case study on the Ebola outbreak in Southern Sudan as well as the discussion on the potential response of healthcare professionals in the *Lessons Learned* section of this report) point to the importance of effective strategies and culturally-relevant tools to mitigate fear, feeling of hopelessness, irrational behaviors, etc. Resources to address basic general questions (Are my family and I safe? What should we do?) (US Department of Health and Human Services, CDC) as well as pandemic-flu specific questions (How do I protect my children? Whom should I listen to in relation to medical issues?) may aid the handling of pandemic flu by providing a framework to organize one's thoughts around communication planning as well as anticipate potential questions and related answers. Several of these tools (including sample questions) are already considered and included as part of the Emergency Risk Communication CDCynergy model and could be expanded upon as well as contextualized within local cultures, countries and most vulnerable communities.
- A **renewed focus on core principles of good communication practice** is another key element to be considered in pandemic flu communications planning and – more in general – emergency communications. Of interest, the WHO Outbreak Communications Model, which is currently being finalized, emphasizes – among others – strategies to build public trust and encourage communication transparency. As previously discussed, lessons learned from past disease outbreaks and pandemics show that these two fundamental principles of effective communication (see for example previous mention of anthrax case study) need to be considered in pandemic flu communication planning as well as for other kinds of health emergencies.

While transparency is almost an obvious communication principle, it is still quite far from being formally embedded in the culture and policies of many countries and organizations. Yet, it's a very important principle and one that is perceived as the most innovative component of the WHO model by both the model's authors as well as many of this study's respondents. Further consideration may



be given to implementing transparency policies not only at the national government level but also at the local level by exploring such concept (as well as issues of trust) at the community level. In fact - as currently understood or implemented by a few countries (e.g. China) - national transparency policies would require that citizens are proactive in requiring additional information from their governments in case they feel misled. This may be difficult – at least in the short-term –to implement among vulnerable populations such as minorities, low health literacy groups, women in countries with issues of power imbalance among genders, and all other communities and groups that that may lack feelings of self-efficacy and competence in making requests of their governments. Therefore, community dialogue, participation and mobilization strategies may help identify how communities may relate to these issues as well as strategies, channels and spokespeople to gain community trust on the accuracy and transparency of the information they receive.

- The importance of **emphasizing social mobilization, early community involvement and training, and local partnerships in all communication interventions** is supported by other findings of this study (please see section on *Lessons Learned*) as well as the review of existing models, technical guidance and good practices (UNICEF C4D, WHO’s COMBI etc.). At the community level, special consideration should be given to tools and resources on how to assess - in the pre-pandemic phase - the level of readiness of potential social mobilization partners (e.g., women’s groups, scout clubs, religious leaders, teachers, schools, health workers, community development agencies, social workers, businesses, community radios, theaters, etc.) to respond to a pandemic flu outbreak.
- The **integration and use of culturally competent channels and communication areas** is a well-established communication practice and a key component of most models analyzed for this study. In fact, “communication, and more specifically health communication, is a common part of social exchanges and contexts, from personal and professional encounters to the mass media [including the Internet] and traditional forms of expressions such as theater and poetry, as well as informal conversations in barber shops, churches, restaurants, markets, and other public places. Tactical plans should reflect this diversity of communication approaches and channels to match how communications actually takes place.” (Schiavo, 2007)

Practical guidance on how to assess the task appropriateness, relevance and cultural competency of pandemic flu communications materials, activities and channels should be considered for inclusion in future technical guidelines. Finally, study’s findings suggested the need for guidance on how to identify suitable distribution channels to reach vulnerable populations (e.g. refugees, rural areas, isolated communities, disabled, etc.) who may be the most affected and the slowest to react to the threat of pandemic flu.



## Pandemic Flu-Related Terminology

The review of literature and materials on pandemic flu communications conducted for this study revealed some confusion on the use of technical terms and terminology that relate to potential interventions for pandemic flu. For example, the term “quarantine” is used by some authors to include both the “isolation” of patients and infected contacts as well as restricting and isolating measures (quarantine) that may apply to non-infected contacts.

Similar issues seem to exist about terms such as “social distancing” and “physical distancing” that are generally used to refer to “measures that increase the distance between individuals” (Colorado Department of Public Health and the Environment, 2008) in order to decrease the risk for transmission of pandemic flu and other relevant infectious diseases. “Social distancing” appears to be more commonly used.

While the two terms are sometimes used interchangeably, they often refer to different measures or distances to be respected. Also, “physical distancing” may be easier to understand but is still not ideal from a communication perspective especially in the case of low literacy populations and communities. Moreover, various cultures have different perspectives on what they may consider as a comfortable physical distance from another person during communication (Videbeck, 2007). Therefore, in absence of specific directions, the act of reducing to any extent the physical distance that a specific cultural group is used to observe may be falsely considered sufficient to reduce transmission. Specific instructions on actions to be avoided (e.g. holding or shaking hands, hugging and kissing, avoiding public gatherings, etc.) need to complement all definitions.

While this is not a key focus of this study – and for this reason was not further explored - it’s very important that pandemic flu terminology (especially in relation to recommended interventions) is clarified and consolidated for consistency of messages. Such clarification process would need to take into account limiting factors – that may be associated with different interpretations of terms within different cultures, genders, and literacy, ethnic and age groups. The early integration of communication teams with medical and scientific teams is a fundamental aspect in the process of consolidating and clarifying such terminology.



## Research Methodology

This study included the review and analysis of both primary and secondary data. Secondary data (relevant data that were collected for other purposes) informed understanding of lessons learned and key factors that may affect the effectiveness of pandemic flu communications planning, implementation and evaluation. Primary data were collected via an experience survey that used in-depth qualitative interviews as a research tool. Data collection and analysis was informed by the initial briefing by UNICEF C4D unit as well as by subsequent conversations both with UNICEF and study participants. Additional data were also collected via a comparative analysis of different interventions for past disease outbreaks and health emergencies; pandemic flu communications plans; and risk/emergency/outbreak communications models and experiences. Most data were collected via literature and document review, database and Internet search, and in-depth qualitative interviews.

### Literature and Document Review

The review of existing literature and documents that was conducted for this study includes peer-reviewed, trade and internet articles, PowerPoint presentations, press clips, unpublished reports and handouts, and a variety of publications and materials by different US and international organizations. The review focused on: existing emergency and risk communication models and guidance; country plans and materials on pandemic flu communications; and case studies on past emergency situations, disease outbreaks or pandemics.

### Internet and Database Search/Analysis

For the purpose of this study, we reviewed data from several websites and internet-based publications (e.g. e-journals, e-books and e-newsletters). Examples of websites being reviewed included the pandemic flu websites of relevant countries and public health agencies; online materials on pandemic flu; the US government website on the 1918 flu pandemic, etc.

### Experience Survey/In-Depth Interviews

Secondary data analysis was integrated by data collected via an experience survey that consisted of 19 in-depth interviews with 3 different groups of participants (often referred in this report as study's



groups): (1) UNICEF regional and country officers; (2) representatives of public health agencies or local ministries of health and other government and city officers from countries that have already developed or are developing a pandemic flu communications plan; and (3) representative of national and international organizations and UNICEF partners. A complete list of all study participants is included in appendix D. Three of the interviews (interview with the Public Health Agency of Canada; joint WHO-CDC interview on WHO outbreak communications model/overall strategic thinking; and interview with the Emergency Management team of the Ministry of Health of New Zealand) included more than one participant.

All interviews were conducted by telephone. Each interview last from a minimum of 45 minutes to a maximum of 90 minutes. Although a list of topics to be addressed during in-depth interviews was developed for each of the above categories of participants (see appendix D), as in most experience surveys questions were “open-ended and left the nature of responses open to the person being interviewed.” (Hester, 1996) In depth-interviews were used to:

- Gain insights on specific country plans or levels of pandemic flu communications preparedness as well as country-specific situations, social norms, behaviors and needs
- Understand the strategic perspective of other international and US-based organizations on pandemic flu communications
- Gain further understanding on existing emergency/risk/outbreak communications models by asking questions related to the documentation already being reviewed and/or brainstorming to isolate key elements that may be relevant to pandemic flu communications planning
- Gain understanding of potential communication interventions that could be implemented at the community and household level in the pre-pandemic and pandemic phases and would address specific needs
- Review potential obstacles to the development, implementation and evaluation of pandemic flu communication plans
- Look at common threads among behaviors and social actions being currently recommended as part of pandemic flu communications plans
- Secure feedback on key concepts, ideas and potential recommendations
- Confirm information reviewed in written or online documentation
- Confirm expert opinions and validate data from other interviews



## Assumptions and Limitations of Study

All topics listed in the *Problem Definition* section of this report were found to be relevant to the study's objectives and helped identify key factors to be considered as part of UNICEF's future technical guidelines on pandemic flu communications. In this regard, we can state that the study's original assumptions were confirmed by the collection and analysis of primary and secondary data.

One of the limitations of the study is that the review of relevant literature, documents, Internet and database information, only includes a comprehensive selection of what may be the most relevant and recent thinking on the topic, and is not all inclusive. Similarly, a second limitation of the study is the sample size of the people being interviewed. However, because of: (1) the qualitative nature of the study; (2) the fact that all study participants are experienced in the field of health or emergency communications and/or international development; and (3) the variety of perspectives and experiences, which are also representative of various kinds of organizations, the present analysis still can be considered as valuable background information on the state-of-affairs on pandemic communications preparedness in different world's regions as well as an in-depth review of key elements, next steps, and guidance to be included in potential technical guidelines.

Another limitation of the study is that information on pandemic flu communication preparedness for developing world's countries was gathered primarily via interviews with UNICEF's field officers and – wherever possible – the review of country plans and relevant literature. Conversely, representatives of government departments and public health agencies - who directly worked on the specific country plans - were interviewed on most plans for industrialized countries included in this study. This may account for differences in accuracy of the data presented here.

Finally, a recurring limitation with experience surveys and in-depth interviews may include that the interviewer "do not generally have any way of determining the expertise level of each respondent." (Hester, 1996) However, since all study participants represented either leading organizations in the public health and international development fields, or country governments - and all held senior or middle career positions at their respective institutions - it is fair to assume a significant level of experience. Moreover, the fact that all interviews were conducted by a senior health communication professional - who is accustomed to evaluate experience levels in this field – may limit the applicability of this particular concern in this study. The variety of methods used for data collection and analysis further minimizes this concern.



## Acknowledgements

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## Appendices



## Appendix A

### Lessons Learned from Other Pandemics: Snapshot of Outbreak- or Case Study- Specific Lessons Learned

ANTHRAX US BIO-TERRORISM ATTACK
<ul style="list-style-type: none"><li>• <b>Importance of:</b><ul style="list-style-type: none"><li>▪ Clear, timely, accurate and audience-specific messages</li><li>▪ Credible spokespeople</li><li>▪ Strategic planning and advance preparation</li><li>▪ Coordinated efforts</li><li>▪ Adequate channels</li><li>▪ Community groups/leaders engagement and partnerships</li><li>▪ Public/community trust on overall communication’s process and content</li></ul></li> <li>• <b>One message = one behavior</b><ul style="list-style-type: none"><li>▪ Lack of audience specificity may lead to confusions/leave out vulnerable/at-risk groups</li></ul></li> <li>• <b>Tailored, audience-specific messages = tailored, audience-appropriate behaviors</b></li></ul>

## SARS

- **Wake-up call about global interdependence/need for global coordination of all efforts**
  - SARS took only 15 hours to spread from Honk Kong to Toronto
  - Need for transparency, honesty, and clear global communications and disease surveillance mechanisms
- **Central role of communication in improving public understanding and support of recommended social behavior changes**
- **During past SARS outbreaks, communication's focus on:**
  - Social distancing/isolation/quarantine of patients and direct contacts (all)
  - Respiratory etiquette (all)
  - Handwashing (all)
  - Staying home if sick (all)
  - Use of masks only if sick/need to visit healthcare provider/ hospital and/or for health workers (Singapore, US)
  - Health workers protection measures (all)
    - Proper and safe care of patients
  - Schools closing (Singapore)
  - Limitations on public gathering (all)
- **Communication channels varied by country**
  - Mass media, hotlines, printed materials and health alerts most commonly used
  - Limited community outreach efforts; primarily targeted towards minority populations
    - Yet, missed opportunity to expand/tap in community-based resources/leaders to reach out to hard-to-reach/vulnerable populations (e.g. homeless, disable, refugees, rural areas, etc.)
- **US: Special response teams of mobilized experts enabled rapid modification of response**
- **Public support of difficult-to implement measures (e.g. quarantine) boosted by feelings of equality**
  - Singapore: News on Parliament members/family in quarantine
- **Need for advanced preparation to address communication's hoaxes; simulation models need to "consider imperfect information gathering/new communication's methods (e.g. SMS, cell phones)" - Dreyer, P.**
- **Importance of:**

- Frequent communication
- Global and national coordination
- Limited number of credible national spokespeople as main “connecting doors” with general public
- Specific focus on health workers to minimize infection/transmission
- Engagement/training of different segments of society (public health, law, civic society, community organizations, government, etc.)
- Attention to social norms that may prevent adoption of recommended behavior
- **Social distancing/closing of public gatherings an issue in many countries**
  - “We know from SARS that social distancing would be a problem in case of P/I. It would be difficult to get people stay away from their churches.” - PHA, Canada
- **Limited resources/human capacity - key constraining factors of effective communication**
- **Communication cannot compensate for insufficient number of public health and healthcare professionals**

**SARS – QUARANTINE**

- **Isolations and quarantines seem to be effective, provided people quarantine themselves**
  - Advance preparation/prior communication involving different kinds of professionals much needed to implement quarantine
  - Ethical issues (e.g. transparency, solidarity, equity of care, reciprocity, privacy, stigmatization, etc.) need to be carefully considered in planning phase
- **Control measures varied from mild (US) to highly restrictive (China, Taiwan, Singapore)**
- **Civic society organizations (e.g. Red Cross, Meals on Wheels, etc.) instrumental in helping people in quarantine/non-infected contacts in Toronto**
  - Meal delivery, psychological help, problem solving, etc. helped people deal with day-to-day issues
- **“Differing control measures should be reflected in any modeling of global epidemics” - Paul A. Dreyer, Jr., PhD, RAND**
- **Communication planning should contribute to identify/address cultural barriers/existing obstacles via multidisciplinary and/or community-based partnerships, communication strategies, activities and messaging**

## 2004 EBOLA OUTBREAK – YAMBIO, SOUTHERN SUDAN

- **Communication response based on WHO COMBI model (2004)**
- **Need to understand/counter existing misconceptions critical to communication intervention**
  - Many did not believe outbreak was actually occurring
  - Others convinced that blood/skin samples of patients were being removed and sold
  - Fear of isolation ward
  - Wariness of surveillance teams
  - Irrational behavior (e.g. staying home from 5:00 to 7:00 pm to limit risk for infection)
- **Focus on recommended behaviors/short-term individual and social behavior change**
  - Contact Ebola team within 24 hours after first symptoms
  - Avoid direct contact with patients/sick individuals
  - Refrain from traditional practices such as touching/sleeping with dead people
- **Social mobilization team instrumental in communicating with local communities/countering misconceptions**
  - Included pastors, teachers and community development workers
  - Uniforms increased credibility/community ability to identify team members
  - Central to rapid achievement of outbreak containment results
- **Mix of communication channels helped enhance message exposure/ relevance**
  - Interpersonal communications/interactions at local markets, churches, schools, restaurants, etc.
  - Informational pamphlet
    - Distributed/discussed by social mobilization team
    - Included info to dispel common rumors (e.g. addressing fears of ward by showing pictures of it), address stigma
    - Provided practical tips to address needs of families (e.g. suggesting that families safely talk to loved ones from hospital's fence)

### AVIAN FLU OUTBREAKS – NIGERIA

- **A/I task force facilitated response coordination**
  - FMoH, FMoA, FMol, CDC, WHO, FAO, Nigeria National Vet. Res. Institute, etc.
- **Rapid response team in charge of surveillance/ monitoring also instrumental in health workers education/capacity building at local/federal government**
- **Interdisciplinary collaborations/expertise an essential element of outbreak/communication response**
  - Early liaison with local/federal authorities
  - Early compilation of employee list of poultry producers/ list of hospitals and physicians
  - Community/social workers mobilization quite effective in reaching out to farmers/affected areas
- **Response/communication focus on:**
  - Poultry depopulation
  - Quarantines and contact tracing
  - Limitations on movement of live poultry
  - Farm biosecurity awareness/measures
  - Protection of healthcare workers/hospital staff
  - Human A/I diagnosis and treatment (health workers)
- **Need to plan to mitigate emotional/psychological response to disease outbreak**
  - Many suspected case and patients fled, refused to be tested/ quarantined, lied about health condition
- **Inclusion of team members who spoke several local languages worked well/key factor in outbreak response**
- **Use of interpersonal channels a must to ally concerns/ train local health workers/ farmers/ community workers**

### AVIAN FLU OUTBREAKS – UK (HOLTON, SUFFOLK)

- **Coordinated response a key factor on early outbreak containment**
  - National and Local Disease Control Center(s) quickly established by DEFRA
  - Close collaboration with Health Protection Agency
- **Effectiveness of communication response ascribed to:**

- Formal stakeholder communication on key policies
- Positive messaging targeting industry representatives
- Proactive media relations approach at national level
- Text messaging alerts to farmers; led to increased registration on GB Poultry Register
- **Still to be addressed as part of future A/I communications efforts/ planning:**
  - Insufficient coordination between local and national media activities
  - Need to manage/inform media gathering at infected premises
  - Increased awareness efforts on GB Poultry Register as a tool to control infections/keep track of poultry/cases
  - Need to simplify information on policies, so that they can be easily understood under outbreak pressure
- **Communication chain from IP to LDCC to NDCC to be improved to encourage further coordination/accuracy of messages and activities**

- AVIAN FLU OUTBREAKS – OTHERS**
- **Nigeria/Burkina Faso: Separating children from chickens quite difficult to implement without pre-outbreak preparation**
    - Children’s main chore is to help with chicken’s care
    - Local studies pointed to need to adapt global recommendations/find alternative protection measures to address local culture (e.g., asking children to wear a mask, so they won’t breath the dust from feathers)
    - Need to streamline process/capacity of local countries/communities to conduct research to customize prevention measures/plan in advance and evaluate scientific merit of potential alternative measures
  - **India:**
    - Without advance preparation, difficult to bring together different government units/competencies
    - Need to prepare the public about P/I to accelerate response/ compliance to recommended actions
  - **Indonesia:**
    - Religious leaders need to be convinced/engaged about promotion of poultry etiquette/ handwashing

## 1918 FLU PANDEMIC

- **Although taken unaware by the pandemic, federal, state and local authorities quickly mobilized to fight the disease; understood need for coordination of all efforts**
- **Need for reporting/surveillance became rapidly clear**
- **Hospital beds shortage was addressed by transforming community centers and local schools into emergency hospitals**
- **Censoring of newspapers/other public outlets to control panic/ misinformation did not seem very effective**
- **Posters and printed materials among major communication vehicles**
- **Lack of culturally competent/multilingual materials left many people unprotected**
  - Still, even native English speakers found information confusing, pointing to need for advance preparation/stand-by messages/materials
- **Limited flu understanding/awareness in pre-pandemic phase meant that government directives were often ignored or poorly understood by public**
  - Rapid spread of pandemic also contributed
- **Many healthcare providers/employees stayed home leaving businesses unattended**
  - Need to prepare for people's emotional/ psychological response; develop stand-by messages both on uncertainties and protection measures
- **Key interventions:**
  - Quarantines
  - Closing of public gathering/ school as soon as first signs appeared
  - Ban on public funerals
  - Respiratory etiquette promotion
  - Harsh fines/ imprisonment in case of public spitting
- **Use of masks recommended but not effective in preventing disease**
- **Traditional remedies for cough and cold remained preferred treatment options**



## Appendix B

### **List of Emergency and Risk Communications Models and Other Theoretical Frameworks Reviewed for This Report**

- WHO Outbreak Communications Draft (being revised)
- Emergency Risk Communication CDCynergy
- UNICEF Behavior Change Communication in Emergencies: A Toolkit
- Communication for Behavioral Impact (COMBI)
- AED Planning Strategic BCC for Pandemic Flu framework
- Flue Wise Flu Care
- 2007 P/I Simulation Toll (Japan – UNICEF)
- PAHO – Creating a Communication Strategy for Avian/Pandemic Flu (strategy document and checklist)
- ECDC Toolkit
- Interagency Communication Framework for P/I
- Humanitarian Pandemic Preparedness Initiative

## Appendix C

### Snapshot of Country Plans/Status on Pandemic Flu Communications

<b>CANADA</b>	
<p><b>Current Plan</b></p> <ul style="list-style-type: none"> <li>• Emphasizes national and international coordination/regional collaboration with US and Mexico</li> <li>• Risk communications framework integrated with various communication channels/other models (e.g. social marketing)</li> </ul> <p><b>Unique Approach to Communication Planning and Funding</b></p> <ul style="list-style-type: none"> <li>• Early identification of all communication’s aspects as fundamental public health component/intervention of its own</li> <li>• Dedicated funds for communications planning/interventions; not part of disease area funds</li> </ul> <p><b>Focus of Current Message</b></p> <ul style="list-style-type: none"> <li>• Hand and personal hygiene</li> <li>• Respiratory etiquette</li> <li>• Staying home when sick</li> <li>• Proper and safe care of loved ones</li> </ul> <p><b>Key Program Elements</b></p> <ul style="list-style-type: none"> <li>• Media relations/communications</li> <li>• Citizen Readiness Campaign - sequential messaging related to P/I phases</li> <li>• Family guide on preparedness (under development)</li> <li>• Strong P/I communications group/spokespeople</li> </ul> <p><b>Obstacles to Program Planning/Implementation</b></p> <ul style="list-style-type: none"> <li>• Resources (funds and human capacity)</li> <li>• Contracting of outside resources a complex process in Canada/involves Federal Government</li> <li>• Need for additional research-based evidence on all interventions</li> <li>• Evaluation challenges</li> <li>• Need for improved coordination</li> </ul>	



#### **Other Relevant Facts**

- Low public awareness/interest in P/I
- Seasonal flu considered suitable angle to introduce P/I preparedness
- Global consensus on key actions/behaviors may be difficult to reach but actions currently promoted in Canada may serve as overall measures for P/I and other I/D prevention
- Canada conducted public consultation to assess citizen/stakeholders priorities on P/I, including anti-viral prophylaxis

#### **Public Consultation**

- “Delivered dialogue” sessions with ordinary citizens, national health and non-health stakeholders; 12 sessions in total
- Highlighted need for clear and consistent messaging/communication; emphasis on public education as means of prevention
- Anti-viral stock-pile only for maintenance; no pre-exposure prophylaxis

<b>EGYPT</b>	
<p><b>No formal plan yet – Skeleton of communication component included in overall AI/PI government plan</b></p> <ul style="list-style-type: none"><li>• Government interested in moving forward; still, somewhat more interested in A/I</li><li>• Urgent need for guidelines on P/I communications</li><li>• Pre-pandemic preparation expected to take a long time</li></ul> <p><b>Community/household communications makes sense but need further investigation</b></p> <ul style="list-style-type: none"><li>• Obstacles in Egypt: poverty, despair, conflicting priorities, fatalistic attitude toward health, low health literacy, trust issues, lack of preparedness</li><li>• May make sense to explore model/conduct pilots addressing issues of trust at community level</li><li>• Local health workers, volunteers, NGOs best suited to address community needs/communications in case of outbreak</li><li>• Tap into existing sense of solidarity/volunteerism</li></ul> <p><b>Other ongoing initiatives</b></p> <ul style="list-style-type: none"><li>• Red Cross community model/pilot in 2 villages in 2 districts; focus on preparedness; implemented by Save the Children; questions about reproducibility because of very small scale</li></ul>	

## INDIA



### Current Plans

- None yet. Conversations have somewhat started with government

### KAP Studies Completed

- Need for additional data on secondary audiences/key influencers
- Low P/I risk awareness/knowledge
- Reactive instead of proactive culture
- Schools as common communication venue; yet, differences in children's routine in rural vs. urban areas
- Handwashing difficult to implement in rural areas because of shortage/lack of tap water/soap
- Social distancing/safe care of sick people may be difficult to implement because of social norms/ traditions/ living conditions
- Need to train local health workers on P/I messages/technical aspects/patient handling



## INDONESIA

### **UNICEF in conversation with government to develop P/I preparedness plan**

- Initial focus on 10 cities
- On hold until further definition of coordination issues; KAP underway

### **Communication component focusing on spokesperson preparedness/ materials development**

#### **P/I simulation conducted in April by WHO/CDC**

- FluWise FluCare materials used/distributed as part of exercise
- Helped understand obstacles to effective communications/increase self-confidence among communication partners

#### **Obstacles**

- Funding - 10 cities are not enough
- Uncertainties about government lead; health vs. interior

#### **Other unique considerations/needs**

- Need to make P/I preparedness commonplace; educating children and schools one suitable strategy to address this need
- Compliance to recommended actions/behaviors may vary from region to region; Java usually most compliant to public health recommendations
- Lessons learned from polio immunization/avian flu: need for early involvement of religious leaders/address pockets of resistance to interventions

## JAPAN



**Multidisciplinary *Office of P/I Preparedness and Response* established at the government level**

**Two fundamental functions for communications interventions: information gathering and risk communications**

**Risk communications plan/focus primarily on mass media communications/development of materials and messages**

- Guidelines for P/I risk communications after P/I phase 4 include risk analysis, enhanced information sharing and privacy issues/policies

**2007 influenza pandemic simulation (in partnership with UNICEF) showcased that simulations:**

- Improve planning processes
- Identify gaps and needs in pandemic preparedness and response planning
- Enhance understanding of pandemic influenza
- Increase team spirit

Sources: (1) Ministry of Health, Labour and Welfare. (2008). *Briefing of Japanese preparedness for pandemic influenza*; (2) United Nations Children's Fund. (2007, July). *Influenza pandemic simulation: A participatory tool to promote preparedness and response planning*

**JORDAN AND OTHER COUNTRIES  
IN MIDDLE EAST/NORTH AFRICA**



**No current P/I Communications Plan**

- Focus on A/I only
- Low awareness/knowledge of P/I risk

**Overall lack of preparedness to address any pandemic/ outbreak**

- During cholera outbreak, materials reached people when outbreak's pick had already phased out

**Obstacles**

- P/I is not perceived as real threat
- Inadequate budget

**Community/household communications makes sense but overall P/I communications preparedness should come first**

- Door-to-door outreach are not currently implemented
- Lack of training at the community/health workers level
- Local health centers preferred venue for exchange of health info

## NEW ZEALAND



### Very comprehensive pandemic flu communication plan

- Key component of overall Influenza Pandemic Action plan
- Overarching principle: “Ministry of Health is committed to share with New Zealanders the information that it has on pandemic influenza to allow informed decision-making and action”

### Focus primarily on mass media, social media, Internet and online materials

- Detailed checklists and sample questions for implementation align with different pandemic phases defined by WHO
- Information takes into account cultural diversity with recommended activities and key messages framework for different ethnic groups
- “Getting Ready” brochure and “Stop the Germs” poster available in multiple languages on Ministry of Health’s website (English, Arabic, Chinese, Cook Islands, Hindi, Korean, etc.)
  - Key actions: respiratory etiquette, handwashing, staying away from others when sick and emergency kit preparedness

### Future focus on including grassroots program as part of communication preparedness

- Build partnerships with community groups, NGOs, charitable organizations
- Strategic aim is to tap into community resources/reach different levels of society in case of pandemic flu
- Need to build capacity among local NGOs and community groups

### Low awareness of pandemic flu a key concern

- People seem to have lowered their guard because of misperceptions about ready availability of pandemic vaccine
- Lack of recent mass media campaigns; media needs to continue to stay engaged in pre-pandemic phase
- Seasonal flu angle suitable to increase awareness of pandemic flu in pre-pandemic phase; may be used also to dispel myths about pandemic vaccine



**Other issues/lessons learned**

- During SARS, mass media did not seem to trust government; believed the government may have an agenda
  - Shock and disbelief potential cause for lack of trust

**Overall expectation is that New Zealanders would be compliant to recommended action; yet need to consider that “society is changed since 1918/people may be less compliant”**

## NORWAY



### **P/I communication plan a component of P/I preparedness plan**

- Includes A/I and P/I
- Was developed by looking at best practices
- Stand-by materials (fact sheet, brochure) and website
- In 2008, there was no proactive communication on P/I
- Plans to work on engagement and coordination between levels within health sector
- Low level of interest in P/I communication within non-health sectors (education, transportation, law, etc.); need to improve coordination

### **Pre-pandemic measures include general hygiene, hand hygiene, and respiratory etiquette**

### **Seasonal flu angle suitable to promote pre-pandemic measures; plans to use it more proactively**

### **Recent agreement on pandemic vaccine supply in case of pandemic**

### **Lessons learned from recent *Legionella* outbreak**

- Importance of coordination among different government sectors and between levels within the health sector
- Ready access to medical experts for clearance of communication messages
- Early integration of communication teams with medical teams key to outbreak response

## PACIFIC REGION

### Four pandemic flu preparedness plans already in existence in the region

- Communication included as a key component in all of them
- A/I and P/I – combined approach

### Several scenarios being tested for communications

- Desktop validation
- P/I segment look at: when first case of human-to human transmission occurs, when P/I occurs, etc.

### Recommended measures:

- How to look after someone who is sick
- How to deal with home sick care
- Staying away from crowded place
- Respiratory etiquette
- Handwashing not current emphasized but plans are to include it in future materials

### Communications plans ready to be activated in case of P/I

- Stand-by materials and messages
- Several national stakeholders and spokespeople already activated; plan focuses primarily on use of national and local mass media
- Yes, communication planning has exposed other weaknesses (e.g., data surveillance need to be strengthened)

### In pre-pandemic phase, communications at community and household level should be carefully evaluated under current situation

- Lack of overall preparedness at the community level
- Limited resources
- Need to avoid unwanted panic/potential spreading of false rumors
- Community-based dialogue around “if a P/I occurred” may make sense as part of meetings on other current outbreaks (dengue, diarrhea, etc.); need for significant resources

### Obstacles

- Limited communication capacity at the community level
- Limited radio and broadcast reach
- Need to train mass media; reporting on health issues may be sometimes inaccurate



- Social distancing may be difficult to implement because of existing practices and norms
- Quarantine and border controls very important in case of P/I but has heavy implications in countries that rely on importation of basic goods
- Need for adequate communications monitoring system to address concerns emerged as part of A/I lessons

**Other**

- Few training sessions for local mass media recently implemented via mass media society and networks; train-the-trainer and peer-to-peer communications strategies at the core of this approach

## SWEDEN



### Focus of Current National Plan

- Communicating with the public
  - National tools (P/I call center and website)
  - Media relations/communications
- Investigating existing needs for information/dialogue among public and health care workers
- Coordination among national authorities

### Findings of KAP/Informational Needs Study

- Need to boost communication's competence of healthcare providers/staff; clarify messages on priorities, roles and responsibilities
- Need to engage county counsels to emphasize importance of communication interventions within their regions
- Low P/I awareness among public; need for regular updates/ information about personal action

### Revisions to Current Plan

- Provide support to county counsels/health care workers who in Sweden have primary responsibility for communication with the public/risk communications
- Improve coordination with non-health agencies (e.g. security, police, etc.)
- Prepare national spokespeople and enlarge group to include medical experts/ KOLs

### Actions in Pre-Pandemic Phase

- Focus on personal hygiene
- Use seasonal flu angle to promote behaviors important also to P/I management

### Existing/Potential Obstacles to Planning/Implementation

- Low P/I awareness among non-health agencies/government units
- Timing and coordination of efforts
- Resources (funds and human capacity)
- Limited knowledge on:
  - Marginalized groups (e.g., people with disabilities, low-socio-economic groups, those with low Internet literacy or may need information in English)
  - How to deal with different behaviors/public response to P/I (e.g., those who attempt to flee versus those who want to help)
  - Potential reactions among those healthcare providers who are also parents

## UNITED KINGDOM



### Comprehensive National Plan (including Communication Component)

- Strategic focus solely on influenza pandemic; assumes risk for emergency/re-emergency of new A virus subtype
- Do not cover A/H5NI or seasonal flu; separate programs to address them

### Strategic Objectives

- Increased P/I awareness
- Hygiene promotion
- Contingency preparation on what would be done to detect new/re-emerging virus
- Public support for national response/contingency measures
- Communicate uncertainties/communication chain at national and local, community and individual level (what we can all do)
- Mobilize population as partners in response/promote individual and social responsibility

### Key Elements

- Well-defined system for cascading information
  - Close collaboration between Department of Health, HPA, WHO, local primary care trusts (e.g. Lambert, Hillingdon) /local departments
- Specialist advice and support to local departments, healthcare workers in primary care, social care workers
  - Social care workers/volunteer agencies responsible for community/household communications/assistance
- Multilingual materials and programs
- Active media engagement
- National website, automated flu line, telephone advice and access

### Recent (09/08) updates/guidance on special topics/ audiences (e.g. primary care dentists, surge and prioritization of health services)

Source: Department of Health, United Kingdom. (n. d.). *Pandemic flu*. Retrieved November 18, 2008 from <http://www.dh.gov.uk/en/publichealth/flu/pandemicflu/index.htm>

<p><b>VIETNAM</b></p>	
<p><b>Public Awareness and Behavior Change Communications Component included as part of 2006-2010 country plan for A/I and P/I</b></p> <ul style="list-style-type: none"> <li>• Three specific objectives: Enhanced Coordination of Activities; HPAI Control/Eradication in Agricultural Sector; Influenza Prevention and Pandemic Preparedness in Health Sector</li> </ul> <p><b>Overall Communication Strategy/Framework/Messages/Action Plan steered by dedicated IEC Working Group</b></p> <ul style="list-style-type: none"> <li>• Also responsible for M&amp;E, capacity building</li> <li>• Yet, each sector (operational, agriculture, health) responsible for implementation of campaign activities</li> <li>• One Campaign - Many Sectors</li> </ul> <p><b>Focus of Public Health/Pandemic Flu Component</b></p> <ul style="list-style-type: none"> <li>• Timely reporting of human disease</li> <li>• Personal hygiene and food safety</li> <li>• Compliance with medical regulation</li> <li>• Improved containment if P/I occurs</li> </ul> <p><b>Primary Audience – General Public</b></p> <p><b>Channels used to reach general public</b></p> <ul style="list-style-type: none"> <li>• Health workers</li> <li>• Mass media</li> <li>• School networks</li> <li>• Multiple vehicles and printed materials</li> </ul> <p><b>US Government’s Commitment to provide Assistance (November 2007)</b></p> <ul style="list-style-type: none"> <li>• Preparedness and response</li> <li>• Enhancing human/animal disease surveillance and detection</li> <li>• Research and laboratory diagnostics</li> <li>• Increasing public awareness/strengthening risk communications capacity</li> <li>• Developing P/I preparedness guide for small businesses</li> <li>• Conducting simulation exercises in neighboring countries</li> </ul> <p><b>Unclear about recent (2008) updates/progress (TBD)</b></p> <p><u>Source:</u> Ministry of Agriculture and Rural Development, &amp; Ministry of Health, Socialist Republic of Vietnam. (2006, May). <i>Integrated national operational program for avian and human influenza (OPI) 2006-2010</i></p>	



## **WESTERN AND CENTRAL AFRICA**

### **Communication component included in all government's plans in region**

- Combines A/I and P/I
- So far, major focus/experience on A/I

### **Obstacles**

- P/I preparedness not perceived as key priority within countries/ governments; malaria, HIV/AIDS, overall child survival are
- P/I is considered “the pandemic that never happened”
- Social distancing/separating may be difficult to implement because of existing social norms/strong family ties

### **Key Issues/Opportunities**

- Need to work closely/coordinate with other international agencies
- UNICEF well positioned on compiling info/understanding situation/ needs/cultural background because of extensive work within region
- P/I a better focus for UNICEF because of potential impact among children
- Need to strengthen non-government communication systems (local and national radios, community leaders, churches, schools, etc.)

**Government visibility/funds/pre-packaged programs may be motivating factors for government to act/continue expanding on P/I preparedness**



## Appendix D

### Interviews with UNICEF International Stakeholders – List of Overall Topics

- Overall strategic thinking and guidance on key approaches to pandemic flu communications
- Key elements of strategic models for pandemic flu communications and/or outbreak/emergency communications being developed, adopted or implemented by the organization (including a review of concepts/elements that may be particularly innovative and/or confirmed in their importance by other models/existing literature on the topic)
- Pre-pandemic and outbreak communications: what would make sense to do at the community/household level as well as at other levels of society/specific audiences
- Perceived or existing obstacles to the planning and implementation of pandemic flu communications programs (both at the organizational level and/or in the countries the organization seek to implement such programs)
- Feedback on key behaviors, social norms, policies, and other key factors that influence or should influence pandemic flu communication planning (both in the outbreak setting as well as within the context of outbreak prevention)
- Lessons learned from other disease outbreak/emergency situations (e.g. SARS) and/or implementation of specific communication models at organizational and/or country-level
- Examples of good practices and any existing country level plans that we should include in our review
- Other questions that may be specific to the organization and/or the model they developed



## Interviews with UNICEF Regional and Country Representatives

### List of Overall Topics

- Information on potential existing plans or initiatives on pandemic flu communications
- What would make sense/they would do if there was a pandemic flu outbreak in their region today
- Pre-pandemic and outbreak communications: what would make sense to do at the community/household level as well as at other levels of society/specific audiences
- Region- or country-specific needs, situations and factors that may influence pandemic flu communications planning and implementation
- Perceived or existing obstacles to the planning and implementation of pandemic flu communications programs
- Feedback on key behaviors, social norms, policies, and other key factors that influence or should influence strategic thinking on pandemic flu communications planning (both in the outbreak setting as well as within the context of outbreak prevention in their region)
- Country- and/or region specific lesson learned from other disease outbreak/emergency situations (e.g., SARS, Ebola, any other epidemic)
- Examples of good practices and any existing country level plans that we should include in our review
- Top 3 needs in terms of pandemic flu communications guidance (in other words what they would like to see included in future guidelines UNICEF may develop on the basis of this study's key findings)
- Other questions that may be relevant to a specific country and/or region



## **Interviews with Representatives from Countries that Have Developed/Are Developing a Pandemic Communication Plan – List of Overall Topics**

- Overall strategic thinking on key approaches to pandemic flu communications
- Information on existing or upcoming plans on pandemic flu communications (including a review of elements that may be particularly innovative and/or confirmed in their importance by existing literature/experiences on the topic; any research that was conducted in preparation for the plan and related findings, etc.)
- Pre-pandemic and outbreak communications: what would make sense/are they planning to do at the community/household level as well as at other levels of society/specific audiences
- Perceived or existing obstacles to the planning and implementation of pandemic flu communications programs
- Feedback on key behaviors, social norms, policies, and other key factors that influence or should influence pandemic flu communication planning (both in the outbreak setting as well as within the context of outbreak prevention in the specific country)
- Lessons learned from other disease outbreak/emergency situations (e.g., SARS) and/or implementation of specific communication models/elements of pandemic flu communications plans at country-level
- Examples of good practices and any existing country level plans that we should include in our review
- Other questions that may be specific to the country and/or the plan they developed

### List of Study/Experience Survey's Participants

Name	Title and Affiliation
Al-Bahlani, Sabah	Program Communication Specialist Regional Advisor – Middle East and North Africa Region (MENAR) UNICEF, Jordan
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Public Health Agency of	Several participants



Canada	<p>Leading Contacts:</p> <p>1) Reinert, Chantal Director and Communications Executive</p> <p>2) Manji, Natasha Senior Communications Advisor</p>
Puri, Anu	<p>Program Communication Officer UNICEF, India</p>
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Vanderford, Marsha L.	<p>Director of CDC's Emergency Communication System (ECS), U.S. Centers for Disease Control and Prevention (CDC), Atlanta, Georgia. Chief of the Emergency Risk Communication Branch, National Center for Health Marketing</p>
Woien, Gunhild	<p>Communication Director Norwegian Institute for Public Health Ministry of Health</p>



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