

Leadership in Strategic Health Communication



JOHNS HOPKINS
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Center for
Communication
Programs

**LEADERSHIP IN STRATEGIC
HEALTH COMMUNICATION:
MAKING A DIFFERENCE IN INFECTIOUS
DISEASES AND REPRODUCTIVE HEALTH**

A Workshop Manual
(An initial edition)

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FOREWORD

The Leadership in Strategic Health Communication: Making A Difference in Infectious Diseases and Reproductive Health is an integrated approach to learning health communication. Classroom presentations, discussions and the SCOPE computer exercise create a synergy that greatly enhances communication skills. The P Process is a six step communication framework about which you will learn more each day. It will be the basis of our workshop sessions, SCOPE, and this Workshop manual.

THE WORKSHOP MANUAL

This manual contains the basic information presented in each session of this course. We have designed it to be a reference guide during the workshop and a tool to help you apply workshop lessons after you return home. We have chosen to use the topic of emergency preparedness, specifically on H1N1 as the focus of the manual. Not all the countries in this workshop have a priority interest on HIV or reproductive health but H1N1 is a concern for all. While we focus on this topic, please note that the planning process or approach would be similar for addressing other health issues. As this is an initial edition, we would like to seek your inputs and suggestions on how we can improve the manual's approach and content. The manual starts with an introductory paper on strategic leadership applied to a public health issue—population and reproductive health. We hope that these initial thoughts would encourage discussions on how we can make better use of leadership and management principles to increase the effectiveness of our communication interventions.

SCOPE

SCOPE (Strategic Communication Planning and Evaluation) is an interactive computer software program that gives users a chance to immediately apply classroom skills and lessons. Through its P Process framework, SCOPE encourages users to practice good strategic design principles. Best of all, SCOPE is fun to use—even if you have never used a computer!

Workshop Goal

To deepen understanding of health communication strategic planning through:

1. Self reflection
2. Keen listening
3. Teamwork
4. Positive view of change

We will seek acquire a broad, integrative knowledge as well as sharpen critical thinking and intellectual skills and nurture specialized knowledge and applied learning.

One of our key premises is that the workshop will not end. Thus, rather than filling your heads with new knowledge, we prefer to nurture the spirit of continuous learning and inspire you to broaden your horizons. Our ultimate goal is for you to keep on learning how to work with households and communities in analyzing, designing, developing, implementing, monitoring and evaluating an effective family health communication program. We do not seek excellence, but rather continuous improvement.

WORKSHOP THEMES

During the workshop, people will be sharing a large number of ideas and principles. The challenge of the workshop is to prevent information overload. To help you remember the main lessons of the workshop, we offer the following unifying themes:

- To change others, we may have to change ourselves first
- Listen to learn, learn to listen
- Knowledge grows
- Communication is a process
- Solve problems in stages
- Think big, start small, act now
- Focus demands sacrifice
- Quality costs less
- Team works
- Believe you can make a difference and you will

Workshop Premises

1. You are responsible for your learning.
2. We need to nurture strong professional relationships.
3. People differ in how and what they want to learn.
4. Feedback is essential.
5. The workshop will not end.

We encourage you to consult with any training staff if you have questions about this manual or the workshop. Learn, but do not forget to have fun!

Benjamin V. Lozare, Ph.D, MS
Course Director

SOME THOUGHTS ON STRATEGIC LEADERSHIP IN POPULATION AND REPRODUCTIVE HEALTH

W. Henry Mosley, MD, MPH¹ and Benjamin Lozare, PhD²

**2nd International Conference on Reproductive Health Management (ICRHM)
Bali, Indonesia, 6-8 May, 2008**

“Public health is the application of science in a value-rich environment”

Adetokunbo Lucas

INTRODUCTION - THE ROLE OF LEADERSHIP IN THE 21ST CENTURY

The 21st century will be the century of transformational change – dramatic change driven by major forces globally and locally – political, social, economic, technological and environmental. (Friedman, 2005) These will profoundly affect the capabilities of less developed countries to produce and maintain health and general well being. The challenge is to see these driving forces as an opportunity for positive change rather than a threat to the *status quo*.

To meet this challenge, we, as health professionals, first need to change ourselves – to change our own mental models – our fundamental understanding of how health is produced and how we can facilitate the production of health. We start with shifting the paradigm – from the traditional view that hospitals, health centers, health workers and other technical experts “produce” health – to a recognition that households, particularly mothers, are the primary *producers* of (reproductive) health. Second, we need to transform all of our institutions concerned with health development to take on the task of helping households and

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communities become more competent and resourceful in health production.

Leadership is critical for this transformational change - whether one is creating a new institution or changing an old one. (Kotter, 1996; Senge, 2006) And leaders are needed at every organizational level to nurture innovation and learning. Transformational leaders have three roles:

- **Catalytic** - Generating a shared vision of a health future people want to create;
- **Enabling** – creating a work environment characterized by teamwork, trust, open-mindedness, transparency and shared accountability for all outcomes;
- **Learning** – Encouraging the development of action-learning organizations with the flexibility to change that leverage the vast resources of ordinary people to more effectively and efficiently improve health.

BASIC PRINCIPLES

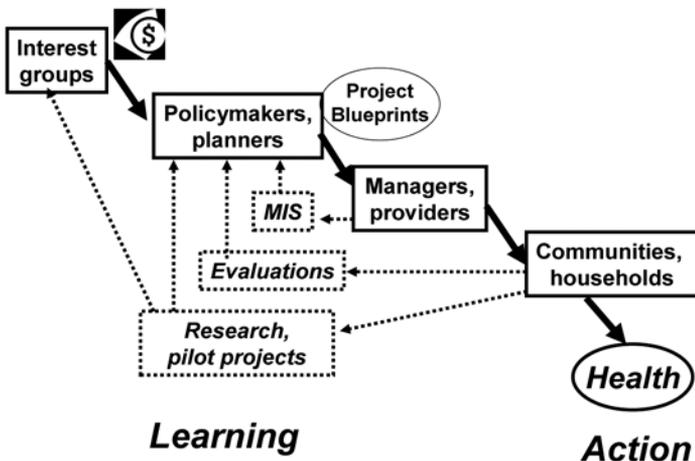
Leadership and management are two sides of the same coin; each is equally essential for any system to achieve its purpose. (Kotter, 1996) Good management guarantees operational stability by assuring that *things are done right* – effectively, efficiently and at the highest level of quality. Leadership is about change, making sure that the *right things are done* – by charting new paths where there are no maps and engaging others in a shared commitment to overcome the inevitable constraints to innovation and reach the goal of better health for all. (Goldratt, 2004; Taylor and Taylor, 2002)

THE TOP-DOWN OR “BLUEPRINT” APPROACH TO HEALTH INTERVENTIONS

While both leadership and management are needed to move any population-based health program forward, serious problems will arise when an intervention strategy requiring leadership and learning to produce fundamental institutional changes is reduced to a series of predefined management tasks that fail to consider the local context.^(Rao and Walton, 2004) Let us begin by examining the traditional way of introducing health interventions in less developed countries that is most familiar to policy makers and program managers. This is the top-down or “blueprint” strategy as depicted in **Figure 1**.^(Korten, 1980)

Figure 1. The top-down or “blueprint” approach to introducing health interventions. (Adapted from Korten, 1980)

FIGURE 1



At the top are powerful interest groups (donors, foundations, NGOs, universities, etc.) usually operating in institutional “silos”

that are focused on a single, or a limited number of diseases (e.g., HIV, malaria and TBC or maternal mortality) or package of interventions (vaccines, ORT, micronutrients, maternity care). These groups generate the funds and develop global/regional strategies to introduce their intervention, often based on “best practices” learned in some particular setting. These are presented to national policymakers and planners who develop the action plans (“blueprints”) for national implementation. These plans are sent to the managers and providers in local level organizations for service delivery. Ultimately, it is the communities and households that accept (or reject) the interventions and produce (or fail to produce) the desired health outcomes. Management Information Systems (MIS) collect service statistics, and specialists collect research and evaluation data from time to time, all of which are sent back to higher levels for analyses and interpretation.

While the blueprint approach may work well for health interventions or logistic operations where individual voluntary choice is absent (e.g., smallpox eradication, food fortification, environmental sanitation, construction of facilities, procurement of commodities, etc.), it has major limitations when it comes to program strategies that require social, economic and cultural adaptations (e.g., family planning, immunizations, use of bed nets, maternity care, nutrition programs, etc.). Among the most serious limitations are:

- the assumption that the experiences of high level professionals (often in a single or limited number of scientific disciplines) armed with the data from “evidence-based research” have sufficient knowledge to prescribe intervention strategies that will be effective in any social context; (Chambers, 1997)
- the short-term time horizon and inflexible project design of most funding agencies, precluding the opportunity to learn from, and adapt to experiences in the field; (Rao and Walton, 2004)
- the assumption that the institutions, personnel and services in national Ministries of Health constitute the “health system”

of a country, so that added investments in these facilities and operations will improve the nation's health; ^(WHO, 2002) and

- the disconnect between the *primary producers of health* in the households and communities (where the action is) from the *information* about what works or fails to work. Particularly, with outsiders gathering, analyzing and interpreting the data (infrequently, and remote from the action), there is usually no deep *understanding* of why the specific outcomes occurred. Thus, *little learning* is taking place, and without learning, there will be no fundamental changes in the health practices of these producers, and thus no "project sustainability".

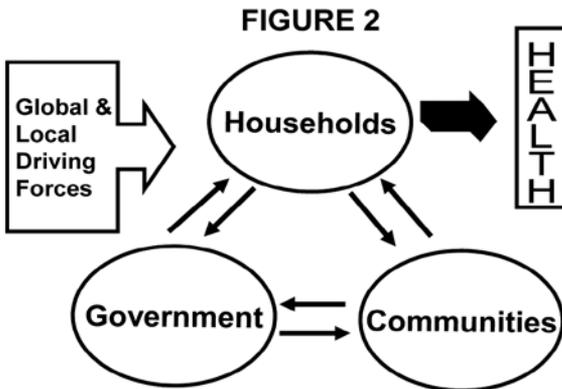
What is the evidence that the top-down approach is flawed? One needs only to look at the great reproductive health disparities across developing countries and the many inequities within these countries after fifty years experience with this top-down strategy. ^(World Bank, 2004) Projects and programs depending on this approach can be expected to produce inequitable outcomes as well as fail to achieve sustainable health gains after the external inputs are removed.

A NEW PARADIGM FOR HEALTH SYSTEM TRANSFORMATION

A. The Household Production of Health Framework

To change the way we act, we must change the way we think. A first step is to change our “mental model” of the “health system” – from believing that Ministries of Health (with their doctors, nurses, hospitals, health centers, etc.) produce health to recognizing that households and communities are the primary producers of health. The key components of the Household Production of Health paradigm are depicted in the systems diagram in **Figure 2**. In this paradigm:

Figure 2. The household production of health framework.



- **Households** produce health, especially women in the case of reproductive and child health. That is the reason that women’s education and gender relations are such powerful determinants of reproductive and child health.
- Households live in the context of **communities** with their diversity of institutions and social relationships – ethnic and religious groups, shops and businesses, health practitioners, cooperatives, political parties, clubs, NGOs, schools, etc. (social capital).

- These are all under the jurisdiction of **government** with its multiplicity of agencies implementing (often divergent) policies by: controlling information; making and enforcing laws and regulations; collecting taxes or providing subsidies; investing in infrastructure and services; and, when there is insufficient information, supporting research.
- Finally, there are powerful **global driving forces** - political, economic, social, technological and environmental. Many actors are involved in this globalization process – national governments, international organizations, multinational corporations - that can impact profoundly on national development and ultimately household health production.

B. Institutional Capabilities for Production

The productivity of every institution in this framework – households, community organizations, government agencies and international groups - can be considered to be a function of three basic capabilities – **resources, practices and values**. Focusing on reproductive health and the household, we can summarize these as follows:

- **Resources** in the household are of two types – material and non-material:
 - o **Material** resources include those items commonly measured in *quantitative* surveys – income and wealth, housing, food, land, water sources, power supply, infrastructure, technologies, etc.
 - o **Non-material** resources include time, beliefs/knowledge, skills, health, ethnicity, language(s), gender, reputation, status, social networks, etc. Quantitative surveys usually ignore most of these or only measure superficial indicators (e.g., knowledge of selected health interventions, ethnic group name, etc.).

- **Practices** encompass everything that household members do in the knowledge/belief that these enhance their health and welfare. These include marriage arrangements, sexual practices, pregnancy, birth and post-partum care, fertility control, preventive and curative practices, feeding practices, hygienic practices, etc. In fact, many well established practices (like female genital mutilation, early marriage, dietary preferences, unhygienic deliveries, etc.) can be harmful to health. Technical interventions are designed to make useful practices more effective, efficient and safe – e.g., ORT, immunizations, contraception, etc. - while IEC and advocacy programs are designed to diminish harmful practices and promote new technologies and their attendant practices.

- **Values** provide the basis for deciding how households and communities are organized, what actions are “right or wrong” and what the criteria are for setting priorities. Typically, these can only be unearthed by deep engagement with the members of the societies of interest.^(Chambers, 1997) In terms of social (health) and economic development, it is possible to broadly contrast values as “progress-resistant” versus “progress promoting”.^(Harrison and Huntington, 2000; Rao and Walton, 2004) Some of these contrasts are given below – with the caveats that these are somewhat arbitrary and that all societies and social institutions lie in a range between the extremes for any of these values:
 - o Hierarchical/authoritarian vs. egalitarian/democratic
 - o Status determined by birth (caste/gender) vs. achievement
 - o Knowledge based on traditions vs. experimentation/learning
 - o Honoring obligations/conformity vs. independence/creativity
 - o Attributing destiny to fatalism/gods vs. self-

reliance/entrepreneurship

- o Past/present oriented vs. future oriented
- o Advancement based on personal relationships vs. meritorious performance
- o Closed-mindedness/intolerance vs. open-mindedness/tolerance
- o Suspicion of “others” vs. trust/mutual respect

VALUES, CULTURE AND DEVELOPMENT

The interdependency and interactions of values, practices and resources can be considered as an institution’s culture. Culture has been called the “DNA of societies” – it is the means by which a society replicates itself from generation to generation.^(Gharajedaghi, 1999) The foundations of any culture are its values, and since values provide for institutional stability, they are hard to change. Consequently, international organizations and government agencies often ignore progress-resistant values when introducing health innovations. Unfortunately, neglecting the cultural context will only guarantee that the new interventions will meet with resistance in traditional cultures, and even those that seemingly succeed will usually not be sustainable when outside forces (e.g., funding, technical assistance, etc.) are removed.^(Rao and Walton, 2004)

This point about the importance of “progress resistant” versus “progress promoting” institutional cultures should not be limited to a discussion of traditional communities in developing countries. All institutions including international organizations, government agencies and even academic centers have cultures that incorporate to various degrees cultural elements that are progress resistant as well as progress promoting. For example, many international organizations and government agencies have strong, controlling hierarchies that promote obedience and conformity. This leads to an institutional climate that discourages creativity and innovation. Highly trained professionals can be closed-minded about the value of other disciplines, much less the contributions that ordinary people can make toward solving problems in their own society.^(Chambers, 1997) And the short time

horizons, inflexibility, and external evaluations of many health projects generally preclude gaining any deep understanding of why things are as they are as a basis for generating fundamental and sustainable social changes. (Rao and Watson, 2004)

LEADERSHIP FOR HEALTH SYSTEM TRANSFORMATION

The household health production paradigm views the nation's health production system like its agricultural production system - where farming households are the primary producers, not the Ministry of Agriculture. Similarly, since the primary producers of health (mothers and other family members) do not work for the government, the health production system can be described as *multi-minded* and highly *decentralized* with a *self-sustaining culture* of production (Gharajedaghi, 1999). Given this paradigm, national health systems do not suffer from a shortage of workers: rather they have millions, who are highly motivated, working 24 hours a day, 7 days a week to protect their lives and the lives of their families! But what most of them lack, particularly the marginalized, are **non-material resources**, e.g.: basic knowledge about hygiene, sanitation, infection control, nutrition, immunization, contraception, the danger signs of pregnancy and childbirth, etc.; skills in recognizing and treating common diseases; and, the freedom to obtain necessary care because of prevailing cultural values and practices.

The challenge of leadership is to learn how to capture the hearts and minds of this vast, diverse workforce and work with them to make the fundamental changes in their values, practices and resource allocations that are essential to produce better health outcomes. At the same time, we need to change many of our own operating principles to assure that the households and communities have the knowledge, skills, technologies and services to more effectively and efficiently produce health. The goal is to increase the **resourcefulness** of households and communities, not just to add material resources.

We are talking about transforming all the institutions in the health production system, and this requires leadership that is visionary, enabling and oriented toward leaning. The leadership tasks are:

- First and foremost to bring together as many actors as possible from every level in the health system around a **shared vision** of a health future that they truly want to create – a vision that they are willing to “pay the price” for, even it means relinquishing cherished traditions and established power relationships. (Senge, 2006).
- Second, by giving a “voice” to those most in need, to **enable people to act** to solve their own problems. (Chambers, 1997; Rao and Walton, 2004). We need to bring down “research” and the attendant learning that it produces to the community and household level. (Taylor and Taylor, 2002) We may need to redefine “evidence” to include simple and practical metrics that communities themselves can collect, analyze, interpret and use to improve their health and well-being. (Chambers, 1997; Friedman, 2005)
- Third, to develop **action-learning** groups to promote a deep understanding among all parties about the values, practices and resources constraining health production and to design, implement and assess the strategies for change. (Marquardt, 2004) In this context, a more powerful question than “What works?” is the question “What will it take to succeed?” (Friedman, 2005)

REACHING THE GOAL – OVERCOMING THE KEY CONSTRAINTS

To advance the population’s health, we are talking about the need for a fundamental **redesign** of the health production system.

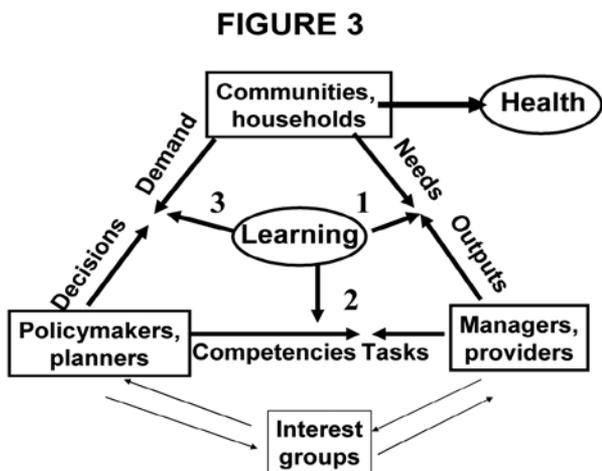
This means changing institutional relationships of all of the key actors from the hierarchical process shown earlier in Figure 1 to a team learning process as illustrated in **Figure 3**. (Korten, 1980; World Bank,

2004) We have the same basic stakeholders - the households and communities, the technical experts involved in specific programs,

and representatives of relevant government agencies.^(Taylor and Taylor, 2002) The “interest groups” representing donors, NGOs or other outsiders no longer control the whole enterprise, but rather share knowledge and provide guidance as appropriate based on international experience.

Creating these new institutional relationships is essential in order to facilitate communication, broaden the base of authority and accountability, and link action to learning at every level.^(World Bank, 2004) Leadership is critical here, because this system transformation requires a radical reorientation in the mindset of all stakeholders – from working in command-and-control hierarchies to working together as a team seeking to reach a common goal.

Figure 3. The action-learning process for introducing and institutionalizing health innovations. (Adapted from Korten, 1980)



Example - Safe Motherhood

The “Safe Motherhood” initiative can be taken to illustrate the potential power of this action-learning approach. A useful analytical framework is the “three-delays” model that classifies the factors leading to high maternal mortality at three levels – the household, the community and the (government) maternity care system. If we consider this model as the “maternal health production system”, we should appreciate that the **goal** of the system is to maximize the production of healthy, surviving mothers.^(Goldratt, 2004) The task of an action-learning organization in any particular setting is to identify the what factors, at what level in the system, constitute the **key constraint**, blocking any improvement in maternal health outcomes. From a systems perspective, it is this key constraint that determines the performance (throughput) of entire system.^(Goldratt, 2004)

In most settings with high maternal mortality, this constraint will be at the household and community level, due to lack of knowledge of all the elements of proper pregnancy and childbirth care or of the danger signs in pregnancy. Additionally, there may be cultural constraints to care seeking. If this is the case, **investing more (material) resources** in Basic or Comprehensive Obstetrical Care Centers (the third delay) will not improve the overall system performance (though it might save a few more lives among those mothers reaching the facilities). What is needed first and foremost is to **focus on the key constraint** at the household level, where the primary need is **non-material resources**. But, given the current power relationships as these relate to decision making in the health production system, serious attention has generally not been given addressing the needs of households and communities. So, what is required first is a change (**redesign**) in these relationships.

Figure 3 can be illustrative of a fundamental redesign of the maternal health production system. This transforms the system by changing the traditional hierarchical relationships to an action-learning team approach. In this redesigned system, there will be

many areas where new kinds of data are needed to generate new understandings about the current realities in order to improve the system's performance. Three areas for action-learning are:

Needs – Outputs With the active involvement of household and communities, every maternal death and morbidity can be identified and the true (cultural, social, economic) causes can be understood on a continuing basis. This provides the basis for learning deeply about the household and community *needs*, particularly relating to the non-material resources and the values constraining better outcomes. The program managers can concurrently learn how to work with communities in their specific cultural context to develop program *outputs* that will acceptably introduce new values, practices, knowledge and skills as well as technologies and services to improve their resourcefulness and in the production of health.

Tasks – Competencies Program managers will need to learn how to do new *tasks* to design, implement and be accountable for programs that promote the household production of health. And this requires that policy-makers and planners learning how to change their own organizational culture by building trust and teamwork that will stimulate innovation and experimentation so that it can assist the managers and providers in gaining the *competencies* to solve old problems and create new solutions to emerging challenges.

Demands – Decisions Policy-makers and planners need to learn how to engage all stakeholders, particularly the most disadvantaged, in a creative partnership that will enable them to effectively express their *demands* and have their voices heard in the halls of power, so that strategic *decisions* affecting health development are responsive to the voices of all sectors of society, not just the elites, technocrats or bureaucrats.

Action-learning is a continuing, iterative process with various groupings of stakeholders studying their situation, trying things out, assessing the results, and making changes based on the results then repeating the process.^(Marquardt, 2004) A major finding of this process will be that there are substantial resources, material and non-material - including the vast numbers of highly motivated primary producers of health, and the creativity and ingenuity of all of the formal and informal health workers and other ordinary people in the system. **Redesigning** the system will permit these people to **reallocate** their own resources towards reaching the shared vision of better health outcomes for all mothers.

LEADER-MANAGERS

We need to nurture leader-managers who can:

1. **Serve as a catalytic force in bringing together action-learning teams involving very diverse stakeholders.**^(Figueroa, 1999) Over time, as confidence grows, these teams will be characterized by:
 - a shared vision of a better health future;
 - a commitment to deeply examine the current reality;
 - an openness to new ideas;
 - a willingness to challenge long standing assumptions
 - an encouragement of innovation and experimentation;
 - acceptance of mistakes as learning opportunities;
 - a shared responsibility for both the successes and failures; and
 - a readiness to change old ways as new evidence emerges;
 - transparency in reporting all actions and expenditures.

2. Work at all levels of the health production system, particularly at the front lines – the “street level” workers (Rao and Walton, 2004). A community midwife can vastly expand her reach and effectiveness by engaging mothers, fathers, traditional practitioners, religious leaders, small businesses and other community members in the vision that “no mother in our community will die of childbirth”. Then she can seek their guidance as together they learn how to bring together her technical knowledge and skills and their resources (material and non-material) to most improve health production in their community.

3. Create an “evidence-nurturing” environment in addition to “evidence-based” thinking. Currently available research does not have all the answers. This is particularly true when it comes to introducing social interventions into complex multicultural societies. Often, the most creative ideas are in the frontiers of science where sharpening of questions is more important than finding answers. We should not be afraid to venture outside of the science of the day to create new knowledge. In the process, we may suffer from false starts and failed ideas but will gain enormously from lessons learned and dramatic new ways of looking at things. (Friedman, 2005)

CONCLUSION

We have introduced a new way of thinking about a country’s “health system” that has relevance for leaders and managers concerned with improving the effectiveness and sustainability of health interventions. Basically, we propose that a nation’s health production system should be looked on like its agricultural production system – just as farming households are the primary “producers” of crops, so all households are the primary producers of health. Correspondingly, just as the role of a Ministry of Agriculture is to help farmers be more productive in their own settings, so the role of a Ministry of Health should be to help

households be more resourceful in producing health. This new paradigm leads to fundamental redefinitions of the “health system” and health production metrics that provide the foundations for transformational change, specifically:

- a nation’s health production system encompasses households, communities and all agencies of government, not just the Ministry of Health and its subsidiaries;
- the capabilities of the health production system are not limited to material goods and technologies but to non-material resources (e.g., time, beliefs/knowledge, social networks, etc.) and, more importantly, cultural values; and,
- the metrics of health system performance must expand from the “hard” measures of organizational inputs, processes, outputs and outcomes to the “soft” indicators of household and community resourcefulness in the production health.

Leadership and learning are the critical elements needed to respond to this new paradigm of the health production system. Leadership is needed at every level since an effective response requires fundamental transformations in the current operating principles (cultures) of the international donors, Ministries of Health and other government agencies as well as of communities and households. And learning at every level is essential to restructure the relationships among agencies and organizations and the people to be able to: understand deeply how health is produced at the household level; facilitate the changes needed to improve the performance of the health production system; measure and monitor household health productivity; and, flexibly respond to new knowledge being generated.

The challenge for the future is fundamental institutional transformation – not just in the ways of thinking and acting by households and communities - but also of governments and international organizations concerned with health development.

To change others, we may have to change ourselves first.

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INTRODUCTION

What is the aim of his manual?

Our aim is to prevent the spread of emerging and re-emerging diseases¹ by communicating knowledge and nurturing values and attitudes that lead to healthy behaviors. If a communicable disease outbreak is imminent and communication plans are not already in place, public health authorities must plan and implement communication quickly – perhaps in days rather than months. This manual is meant to help in such a situation. It is intended to be handy, practical and most useful when quick action is needed. Among the three stages of readiness, response and recovery to an epidemic or pandemic, the response stage, when an outbreak is imminent, is the focus of this manual.

This manual aims to guide health professionals to develop a communication plan quickly, perhaps in days rather than months. To save lives and contain disease that could harm both humans and animals, action must be quick. If not controlled quickly, an epidemic can cause widespread suffering and seriously damage the economy of a nation as well as its social fabric. A pandemic can cause immense losses in both human and material resources all around the world.

In the face of an impending epidemic, communication among the various sectors of society needs to nurture a shared understanding and agreement on what people and organizations should do and to mobilize both material and non-material resources² to do it. Those of us in charge of communication have the responsibility of building this understanding and agreement. Without it, efforts to prevent or control an epidemic will not yield optimal results.

1 This manual will focus on zoonotic diseases—that is, diseases that may infect both humans and other vertebrate animals. Examples of zoonotic diseases include avian flu, swine flu (influenza A(H1N1)), brucellosis, bilharzia, bovine spongiform encephalopathy (or “mad cow” disease), dengue fever, West Nile fever and yellow fever.

2 Non-material resources include leadership, shared vision, teamwork, resourcefulness, creativity, discipline, resilience, etc.

Epidemics and pandemics often appear with little warning and spread rapidly. Much of *what* should be communicated will become clear only as an outbreak develops. Indeed, what should be communicated may change from day to day. In contrast, *how* we will communicate, if an outbreak occurs, should be as clear as possible in advance. Ideally, we should have established coordinating mechanisms and decided on communication channels well before an outbreak strikes, or else we could waste valuable time and resources debating who should do what.

In reality, however, there is not always time to organize in advance. This manual assumes that advance preparation was not possible. Therefore, it is a tool both for quickly organizing *how* to communicate and for understanding *what* to communicate as the emergency unfolds. It is not a manual about communication readiness or building communication capacity over the long term. Also, this manual assumes that there is no time for detailed and sometimes lengthy research and planning processes that would ordinarily precede a systematic communication campaign. Instead, this manual synthesizes lessons from experience around the world as a guide for immediate action.³

In the face of an impending epidemic, communication among the various sectors of society needs to nurture a shared understanding and agreement on what people and organizations should do. Those of us in charge of communication have the responsibility for building this crucial consensus.

We need consensus on how everyone, in their own roles, can contribute and work together, and we need to mobilize both material and non-materials resources throughout society. No single agency, organization or sector can effectively respond on its own. At the same time, uncoordinated multiple responses will likely fall short in some respects and duplicate in others.

³ Whole-of-society approach – a concerted effort of government, business and civil society is crucial. Preparedness at all levels- All levels (local, national, regional and global) should prepare for response to an epidemic or pandemic and for subsequent recovery.

To communicate effectively and act cohesively, we must organize ourselves, our partners in government, private and nongovernmental (NGO) sectors, and our communities and households under a common plan.

While distinct in purpose, both concepts are two-way processes and may use similar means of message transmission. They may differ in scale and in dynamics as personal and institutional factors come into play.

Responding to zoonotic diseases, which infect both humans and other vertebrate animals, demands particularly close teamwork and communications between animal and human health professionals. Similarly, communication professionals must work side by side with animal and human health professionals. There is need for close coordination among technical program managers, operations staff, emergency response staff and behavior change communication managers.

Thus, in this manual the term 'we' refers to communication professionals, animal and human health professionals, and those in other institutions, in communities, and in government and NGO sectors, who will work together on communication to address outbreaks of new and re-emerging diseases. This group forms the 'communication response team'.

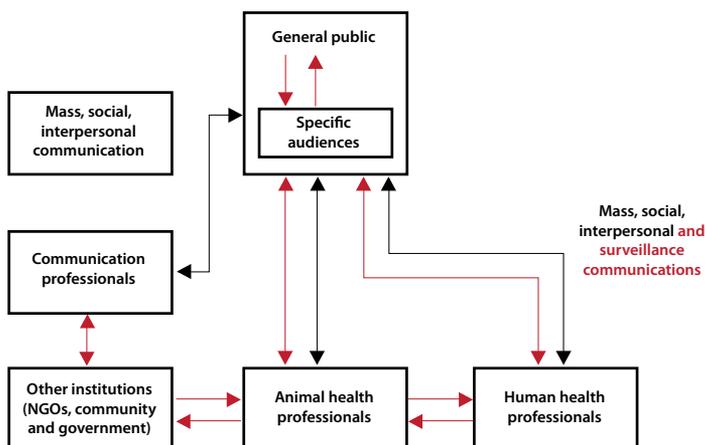
Terminology: 'Communications' versus 'communication'

This manual makes a distinction between the terms 'communications' and 'communication'. By 'communications' we mean operational information flows such as the transmission of analysis and action on epidemiological surveillance information from the field. By "communication' we mean to inform the public or specific stakeholders and receiving feedback from them through mass media, social media and interpersonal communication. This manual covers both 'communications' and 'communication'.

Illustration 1 shows that communications and communication are integral parts of a systems approach to crisis communication

in public health emergencies. The lines in red refer to communications, while the lines in black refer to communication. It is important to understand the difference between communications and communication and how both are essential dimensions of what we do. A failure in one could have serious consequences for the other.

Illustration 1- A systems approach showing the flow of communications and communication in public health emergencies⁴



While distinct in purpose, both concepts are two-way processes and may use similar means to transmit messages. They may differ in scale and in dynamics, however, as personal and instructional factors come into play.

How to use this manual

This manual contains three parts. The first part, **Worksheets**, consists of seven worksheets. The worksheets can serve as

⁴ Whole-of-society approach – a concerted effort of government, business and civil society is crucial. Preparedness at all levels- All levels (local, national, regional and global) should prepare for response to an epidemic or pandemic and for subsequent recovery.

stand-alone, easy-to-use guide to planning and implementation. Completing all the worksheets in order generates a comprehensive strategic communication plan.

We can follow the templates in the seven worksheets as presented or adapt them to suit our needs.

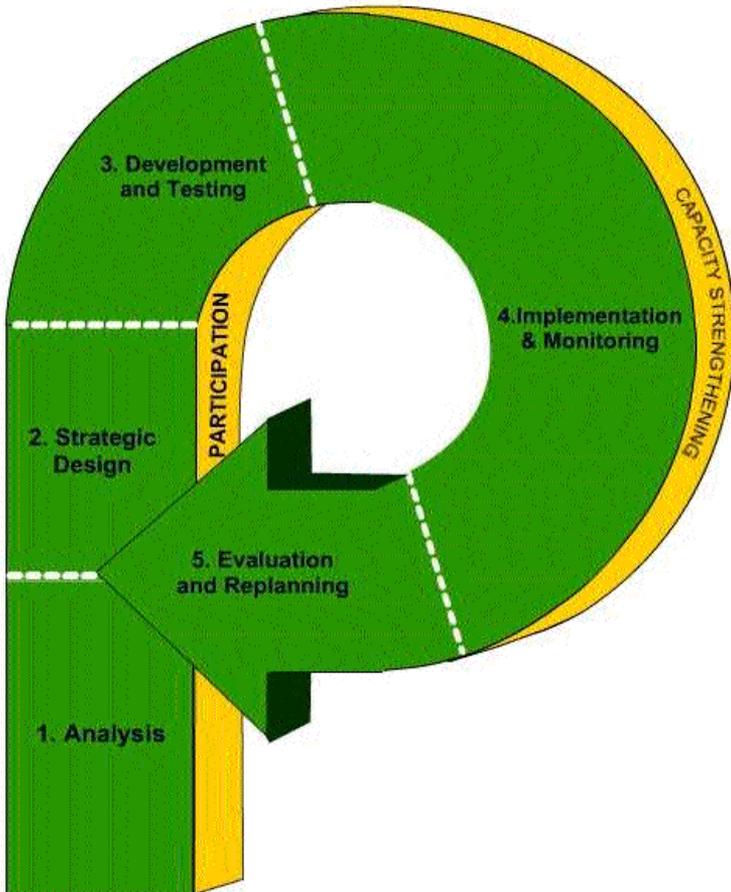
The second part consists of the **Worksheets Guide**, which should help those with limited background in health communication to understand and complete the worksheets. The guide consists of an intro and six chapters, each covering a step in the process of planning a health communication intervention using the P Process framework (see explanation following). We can fill out the worksheets without going through the guide if we have the knowledge and skills to do so.

The **Worksheet Guide** has the following features:

1. **The step-by-step guide** provides additional explanations for completing the worksheets. The step-by-step guide also can be read separately to understand how to develop a component of a strategic communication plan.
2. **Illustrations** are examples of what the step-by-step guide describes.
3. **Case studies** document instances from around the world that provide insights and lessons learned. Some of these case studies concern other health issues, not necessarily new or re-emerging diseases.
5. **Rubrics** are checklists or evaluation criteria that can help users determine whether they are on the right track.

The third part is the **Reference** section. Here we can find current information and technical guidelines for responding to emerging and re-emerging communicable diseases.

THE P PROCESS THE COMMUNICATION PROJECT PLANNING PROCESS:



The P Process

Consider the P Process Framework

The P- Process is a six step health communication planning process (the sixth step is re-planning which repeats the process). It is a practical, simple and easy to use planning tool that guides the health communication planner through the planning process.

THE STEPS OF THE P-PROCESS INCLUDE:

1. Analysis

Analysis is the first step to effective communication, just as it is the first step in any effective action. In-depth understanding of the problem, the people, existing policies and programs, active organizations, and communication channels is essential to changing health knowledge, attitudes and behavior. Qualitative as well as quantitative information is needed. The stronger the foundation of knowledge the stronger the program.

The problem. A good way to start is to define vision for health shared by the households, community and government. A shared vision describes what we want to happen. We can follow this step with a description of the current situation with respect to the shared vision. A logical next step is to define the current destination which describes what will happen if we keep things the same. Then we can ask why there is a difference between our shared vision and the current situation. The answer suggests what the health problem is.

In addition to the steps above, you also would benefit from a review of existing health and demographic data, survey results, study findings, and any other available data to be sure you understand what the basic health, social, or economic problem is for the people involved.

Programs and policies. Review existing health programs and policies: what is legal; where and what supplies and services are available. Identify strengths and weaknesses in service delivery and interview policy-makers and gatekeepers. Communication programs should accentuate the positive, avoid the negative, and maximize access and quality.

The audience. Look for the geographic, demographic, economic, social and psychological factors that shape people's behavior. These include differences in knowledge, attitudes, practices, and advocacy; in age, sex, literacy, income, fertility, personality,

life-style, values; or in other individual and community variables and mass media exposure. Segment and profile—that is, identify distinct audience segments that are most likely to respond to different appeals. Develop a psycho-graphic profile of audience segments. Listen and learn.

Leading organizations. Identify organizations—public or private—that have the competence, commitment, clout, coverage, and continuity to carry out a communication program. Focus on leaders, interested cooperating agencies, and potential corporate and commercial sponsors who can provide continuing support.

Communication capacity. Assess availability, reach, and costs of broadcast, print, and clinic-based media and community activities. Identify the communication habits and media access of primary and secondary audiences.

2. STRATEGY DESIGN

Every communication program or project needs a strategy design. At this stage decisions are made on the seven key elements described below. Thus the strategy design translates a sound analysis into a direction and a road map to reach the agreed upon objectives.

SMART objectives. Set communication objectives that are; Specific, Measurable, Appropriate and action-oriented, Realistic, and Time-bound (SMART). Select key audience segments and quantify the changes in knowledge, attitudes, behavior, or advocacy expected within a specific time.

Positioning. Design your communication programs to show the intended audiences a clear benefit from the services, supplies, or practices promoted. Through positioning, you can create a specific image or marketing niche for organizations, services, products, or other health practices. By knowing and listening to your audience, you can position the program to help meet an important unmet need of the intended audience segments.

Behavior change model. State explicitly the assumptions about people's behavior underlying your basic strategy and positioning. Explain why, how, and in what order you expect people to make the desired changes in their health knowledge, attitudes, intentions, behavior, and advocacy.

Media and activities. Select a lead media and supporting media. Include community mobilization and interpersonal communication among family, friends, community, social networks, and service providers. Plan a coordinated multimedia approach for a synergistic impact.

Strategy design statement. Prepare a brief strategy design statement that spells out your objectives, intermediate steps and sub-objectives, positioning, the behavior change theory you are applying, and the major activities to achieve that behavior change.

Implementation plan. Spell out management responsibilities. Prepare a line-item budget. Develop a work timeline with regular benchmarks to monitor progress and document and report the status on a regular basis.

Evaluation. Plan to measure the expected changes in your audience using multiple data sources. Plan evaluation and collect baseline data before implementation begins.

3. DEVELOPMENT AND TESTING

Message development combines science and art. Messages must not only be guided by the expert analysis and strategic design conducted in the first two stages, but also they must have the emotional power and artistry to influence people who are neither expert nor actively involved in the program—a dual challenge.

Message concepts. Develop message concepts in the form of preliminary illustrations, key words, theme lines, or story boards that reflect the overall strategic design. For maximum impact,

make your messages clear and simple. Avoid complexity. Focus demands sacrifice. Offer benefits and practical solutions that meet people's needs. Use strong visual images.

Health professionals. Work closely with health professionals to ensure that technical information is accurate and to win their ongoing support.

Communication professionals. Work closely with the best communication professionals and creative talent available to produce a high-quality product—whether it be a poster, brochure, song, drama, television spots, or multimedia campaign. Identify talent in the private sector that understands and cares about the issues you are promoting.

With creative and committed professionals, follow the Seven Cs of effective communication to transform well-researched concepts into persuasive products.

Pretesting. Pretest and retest concepts with groups or individuals representative of the intended audiences and gatekeepers to find out what works for them. Encourage audience participation. Give special attention to pictures or other nonverbal materials that might be easily misunderstood. Pretest any existing materials before reproducing them for other audiences to be sure the content is clear and effective.

Revise for audiences and gatekeepers. Revise any materials that are not well remembered, understood, and relevant or are controversial or offensive to the intended audience. Be ready to make unanticipated changes. Double-check materials intended for mass media (especially television and film) with media and political gatekeepers since these products are the most likely to stimulate controversy.

Produce efficiently and promptly. Produce high-quality materials in sufficient volume, since this is cost-effective, and promptly so that products are available as soon as needed. High

quality materials are most likely to hold their value, to be reused many times, and to generate revenue.

4. IMPLEMENTATION & MONITORING

Good management follows the strategy and implementation plan, assigning clear responsibilities and setting up coordinating mechanisms. Implementation emphasizes maximum participation, flexibility, and on-the-job training. Monitoring tracks outputs to be sure that all activities take place as planned or, if problems arise, that they are promptly addressed.

Results orientation. Focus attention and energy on achieving results, not protecting existing institutions, practices, or procedures.

Training and capacity-building. Plan for training and performance improvement at all levels. Provide continuing opportunities for on-the-job training. Emphasize both individual skills and institutional capacity in order to build a critical mass of communication experts who share the same conceptual framework, pursue the same strategic goals, and apply well-developed technical skills.

Organizational climate. Create an organizational climate that expects and values creativity, cooperation, and achievement. Recognize and reward high-quality work at all levels.

Coordinating group. Organize a Communication Technical Group to maximize cooperation. Together develop and follow an implementation plan with a schedule and budget. Share information.

Dissemination plan. Develop and follow a dissemination plan. Combine government, private voluntary sector, and commercial resources for maximum coverage.

Monitor outputs and activities. Check production, performance, volume, quality, and distribution of all outputs. Monitor adherence to output and schedules. Observe relationships among agencies, including service providers, and strengthen cooperation. Share reports.

Respond to feedback. Respond promptly to correct problems and fine-tune program operations. Keep high-level officials informed and encourage them to welcome feedback and rapid responses.

Monitoring feedback and revision are essential to success. Personnel should be rewarded for identifying problems early and making needed corrections. Monitoring should lead to specific improvements such as displaying posters in more conspicuous places, broadcasting at more popular times, changing characters in dramas, involving important groups previously omitted, or shifting internal workloads and responsibilities. Revision often demands as much creativity and planning as the original design.

5. EVALUATION & REPLANNING

Impact evaluation shows whether a program has met its objectives, changed knowledge, attitudes or behavior of the intended audiences, or influenced policy-making. Programs that are not evaluated waste time and money because they have little impact on future development. By identifying the effects of different activities on different audiences, sound program evaluation can support program advocacy, stimulate program improvements, and guide cost-effective funding allocations in the future.

Early planning: Plan impact evaluation at the beginning, not the end of a program. Design it as carefully as the program itself. To demonstrate change, you will need before and after data and, if possible, a comparison group or measures of exposure that can control for possible biases. Include relevant questions on other surveys where feasible. Budget for internal or external evaluations at a level proportionate to the program budget.

Behavior change model. Ensure that programs follow a proven behavior change model specified in the strategic design, such as the Steps to Behavior Change that can predict how people will respond. Develop indicators or subobjectives to help show not only whether but also how and why change occurred. These indicators will be essential in the monitoring and evaluation of the program.

Different evaluation methodologies. Look at different ways to collect and analyze data—for individuals, couples, communities, service sites, or regions. Use both qualitative and quantitative methods. Use different designs, such as pre- and post-surveys, exposed and control groups, longitudinal panel surveys. Use different types of analysis, such as multiple regression and path analysis, to measure and attribute behavior change precisely to communication activities.

Cost-effectiveness - Identify program costs. Measure cost-effectiveness of communication programs in changing knowledge, attitudes, behavior, and advocacy. Calculate comparative cost-effectiveness of various media and activities.

Evaluation dissemination - Share evaluation results widely with participants, colleagues, officials, donors, and experts. Use reports, publications, meetings, e-mail, the Internet, and mass media. Reports should be understandable to the intended audience, and meet their information needs, whether they are one-page press releases for the news media to peer-reviewed articles and books for experts.

Determine future needs - Results demonstrate where follow-up is needed and where program activities can be extended.

Revise/redesign program -A good evaluation will show if the program is weak and where it needs revision in design processes, materials, or overall strategies and activities. Alternatively, and sometimes simultaneously, it will show what works and how to

replicate positive impact. Program staff may have to return to the analysis stage if the situation changes markedly or if new causes are found for problems being addressed.

Communication is an ongoing process, not a one-time effort or product. Significant sustained changes in attitudes, behavior, and community norms require time and repeated effort. Therefore the P Process is continuous and cyclical. It builds systematically on experience and adjusts to changing needs.

Evaluation findings - Learn from monitoring and evaluation what program elements are most effective. Find out why they influence audiences. Build on proven strengths. Share findings with all stakeholders and correct weaknesses.

Changing conditions - Conduct a rapid analysis to see how policies, programs, and other conditions have changed since the initial analysis. Redefine objectives, positioning, and strategy to meet new needs.

Scaling up - Expand programs to cover new geographic areas, types of service, audiences, or goals. Build on success to maintain program momentum.

Resources and sustainability - Early on, plan and mobilize resources for continuity. Ensure that existing resources will continue, or identify new resources. Plan for long-term sustainability. Utilize support from governments or other donors, providers, clients, or commercial sources.

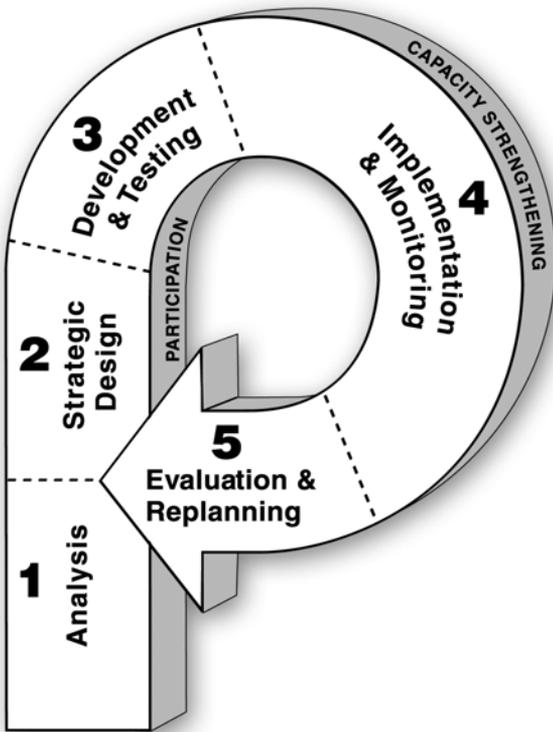
Service integration - Promote linkages among related services to improve client access. Look for economies of scale and shared interests. Promote multiple reproductive health care services where feasible. Plan to measure the cost-effectiveness of new program combinations and promotion.

Coalitions and advocacy - Build coalitions to support programs. Train and support clients and providers in advocacy. Look

for support in related health, environment, women's, social, professional, and community groups. Build a critical mass of supporters with expectations of continued high-quality service.

Throughout the process, keep in mind...

Participation -A strong communication program should fully engage multiple stakeholders at the national, district, and community level.



Capacity strengthening -A successful plan always considers ways to build capacity at the institutional and community level

Remember that...

Monitoring and feedback are essential elements of good management.

Well managed and facilitated strategic communication programs can have a measurable impact.

A well-managed program tracks outputs to ensure quality and timely delivery throughout the program period.

Program effectiveness and sustainability are enhanced by involving stakeholders whenever possible.

Involving stakeholders ensures that programs match their needs, and it builds their capacity to communication program in the future.

The organization of the worksheets and the worksheets guide corresponds to the six stages of the P Process framework:

1. Analysis
2. Strategy development
3. Creative approaches and materials development
4. Implementation
5. Monitoring and evaluation
6. Lessons learned and re-planning.

These six core segments aim to answer six key questions:

1. What is the communication problem?
 - a. What do we want to happen?
 - b. What is happening now?
 - i. What will happen if we do not act?
 - c. Why is there a difference between what we want to happen

and what is happening now?

- i. Program analysis
- ii. Audience analysis
- iii. Root cause analysis

2. What do we need to do?

- a. Who should our communication engage?
- b. What changes would we want our intended audiences to make?
- c. What major benefit of change will best motivate our intended audiences?
 - i. What support points can help make the key benefit more convincing?
- d. What strategic approach will best convey our message?
- e. What channels or media mix will best suit our audiences?
- f. How will we know whether we are on track and having an impact?

3. What creative approaches and materials do we need to develop?

4. How do we make things happen?

5. How do we know that we are making progress and achieving our desired impact?

6. How do we learn from the experience and plan for continuity?

The table below shows how the questions match the steps of the P Process process

P Process	Questions
1. Analysis	1. What is the communication problem?
2. Strategy development	2. What do we need to do?
3. Creative approaches and materials development	3. What creative approaches and materials do we need to develop?
4. Implementation	4. How do we make things happen?
5. Monitoring and evaluation	5. How do we know that we are making progress and achieving our desired impact?
6. Lessons learned and re-planning	6. How do we learn from experience and plan for continuity?

What is different with new and re-emerging diseases?

Designing communication campaigns for new and re-emerging diseases such as pandemic influenza and swine flu presents some unique challenges. Compared with communication campaigns for health promotion, communication interventions during epidemics or pandemics may differ in terms of:

1. High levels of uncertainty. New and re-emerging diseases present highly dynamic situations. Changes in their direction may be difficult to predict. For example, a pandemic may come in cycles, each of which can last from six to eight weeks. It is unpredictable which cycle will be most virulent. While vaccines may have been developed, it is not certain that sufficient supply can be made available when needed. Also, disease organisms may evolve quickly into new forms that resist the available vaccine.

2. Strong rumor environment. Public health emergencies may create an environment that spawns rumors—a situation in which the issues are salient and yet information is scarce. People will likely act on the basis of whatever information they have,

regardless of its accuracy. There is an urgent need to monitor rumors and counteract them quickly. Static communication plans risk becoming irrelevant. We need to be able to adapt to rapidly changing situations, both in the epidemic itself and in people's perceptions and reactions.

3. Widespread bereavement. In public health emergencies the ratio of psychological illness to physical injury could range from 10 to 1 to as high as 100 to 1, depending on the nature of the emergency. If there are many deaths, widespread grief could, cause further psychological damage. High casualties also may present unique challenges if cultural bereavement rituals conflict with public health practices.¹ Communication plans must also take into consideration varying individual resilience and community hardiness.

4. Severity of financial losses. When property damage is extensive (as in livestock culling), those affected need quick assistance and reassurance that they will be helped to get back on their feet. Failure to respond quickly to their needs could generate social tension that could make a difficult situation worse.

5. Unfamiliarity with isolation and quarantine, and resulting stigma. While we may rely largely on vaccines and other medications and on voluntary practices such as social distancing, it may be necessary to impose isolation or quarantine at some point in an epidemic. Stigma, fueled by fear, is likely to develop. People's unfamiliarity with these measures presents unique challenges for communicators.

6. Prime importance of trust and credibility. Trust and credibility always are important in communication, but in an emergency they have the highest priority. The public deserves the truth always. Studies show that panic situations do not happen often and are most rare when the public perceives

¹ In some cultures close physical contact with the deceased is expected of members of the family. In highly contagious situations such as an Ebola epidemic, such practices can increase the spread of the disease and resulting mortality.

communication to be honest and candid. A big challenge for us is the fact that some trust-building measures may be counter-intuitive (for example, acknowledging uncertainty or refraining from excessive reassurance). In this regard also, “embracing error” is of outmost importance. Mistakes should be acknowledged and corrected, not denied or hidden.

7. Need for a unified voice. Since the environment will likely be conducive to rumors and misunderstanding, it is important that all spokespersons are well briefed on the key messages and communication strategies. The often suggested practice of appointing a single spokesperson will be challenging to put into practice, however. The news media will most likely have a wide range of information sources. A more realistic strategy is to have clear “talking points” for people likely to have contact with the media.

8. Important ethical considerations. The University of Toronto Joint Centre for Bioethics has identified four key ethical issues that usually arise during communicable disease outbreaks:²

1. Health workers’ duty to provide care
2. Restricting liberty in the interest of public health, such as by quarantine
3. Priority setting, including allocation of scarce resources such as vaccines and anti-viral medicines, and
4. Implications for global governance, such as travel advisories.

The communication response team can play a big role in helping achieve a consensus on how best to address these ethical issues well before the next outbreak of a communicable disease. This requires an effective ‘communications’ process to reach decisions that will guide ‘communication’ of emergency procedures.

9. Strong need for a coordinated, systematic but flexible response. Response to communicable disease outbreaks requires demand effective communications and communication

2 Stand Guard on Thee, Ethical Considerations in Preparedness Planning for Pandemic Influenza, A Report of the University of Toronto Joint Centre for Bioethics, 2005.

Communication professionals play a crucial role in enhancing both communications and communication processes to ensure a coordinated, systematic but flexible response. For example, we could facilitate a process so that we can decide early whether there would be just one spokesperson during emergencies or whether we should have a set of uniform “talking points” that everyone can rely on when talking with media. Even more critical is how we can decide what messages we should be communicating as the epidemiologic situation and scientific knowledge about the disease rapidly evolve.

10. Scenario planning is crucial.

Planning for an emergency is often something that we postpone, as there may be more urgent things to do at the moment. The nature of emerging and re-emerging diseases, however, requires that preparedness planning should be one of our highest priorities. We need clarity in what we need to do before a communicable disease outbreak strikes and in what we need to do during an emergency.

As much as possible, we need to make our “what if” decisions before an outbreak. This is called ‘scenario planning’. Scenario planning is not about predicting the future. It is about assessing ahead of time which courses of events would be most likely to happen and how we could best respond to each of them. With scenario planning, we could simplify our decision-making process during a crisis. Our decisions could focus on determining which situation is occurring and which action or set of plans we would need to activate that is appropriate to the emerging situation.

11. The need for a human rights based approach to a communicable disease outbreak.³

We need to consider many human rights questions in the context of public health imperatives, including:

³ “Human Rights Considerations With Regard to Pandemic Influenza”, UNICEF, 29 June 2009. See “Checklist for Pandemic Influenza Preparedness and Response Plans” in Reference Section for a useful resource to identify groups that may be disproportionately affected or excluded from pandemic flu responses.

- a. Respect for human rights during testing, quarantines and restrictions on movement.
- b. Prioritization of access to health care and medication.
- c. The state's obligations in terms of planning and preparedness for children.
- d. Tailoring responses to meet needs of all without discrimination
- e. Mitigation of economic impacts of disease outbreak, including those of false alarms or scares, for vulnerable and marginalized populations

12. The need for understanding the preparedness, response and recovery stages.

An epidemic or pandemic can cost us dearly. The effectiveness of our response to an epidemic or pandemic will depend on how well we carry out tasks during the preparedness, response and recovery phases. Preparedness refers to early planning and organization long before an epidemic happens. The response stage concerns what we do when an outbreak occurs or is about to happen. The recovery stage describes what we do to restore normalcy.

Ideally, we need to decide on the following during the preparedness stage, long before an outbreak strikes:

1. An incident command system or emergency response system:
This concerns establishing coordinating mechanisms, roles and responsibilities. It will be discussed in the Worksheet Guide.
2. An incident action plan: who will do what under which circumstances and how.
- 3..Our preventive communication plans that we should implement as early as possible before an outbreak.
4. A set of communication plans for different scenarios during an outbreak.

While we may not have had the opportunity to decide on the above beforehand, we can keep them in mind as we respond to an outbreak and take every opportunity to improve our long-term preparedness. Similarly, we can use the recovery stage as early preparation for possible outbreaks in the future.

If early prior planning has not taken place, we hope that this toolkit of planning worksheets can assist health professionals to quickly develop and implement an appropriate health communication campaign.

Worksheet 1 – What is the communication problem? (Analysis)

The purpose of this worksheet is to define clearly what we want to achieve—that is, the results (primary goal) that we would like to see. Secondly, we describe the current situation with respect to our primary goal. Thirdly, we ascertain why there is a difference between our primary goal and the current situation. Our answers will help us formulate our strategic communication objectives and key messages in Worksheet 3.

1.1 What do we want to happen? (primary goal)

Now that we have an impending outbreak, what is the immediate change that we want to see in our community (or country)? From the perspective of our communication response team, what would we like to happen? Is this primary goal shared by all of the stakeholders (households, government and community)? Is our primary goal motivating enough to secure commitment among our partners to overcome any obstacles?

We can write our primary goal in the form of a descriptive paragraph or a story.

Example (descriptive paragraph):

Households, communities and government are working together so that everyone knows the importance of preventing influenza A(H1N1) transmission. There is universal knowledge

about the importance of securing medical attention promptly if symptoms appear. People understand the value of washing hands, covering the mouth when sneezing, and avoiding contact with others should symptoms develop.

Example (story form):

Jose and Maria are in primary school. In their health class they learned about the risks of influenza A(H1N1), its symptoms, means of transmission and prevention. At home, they shared their knowledge with their parents and siblings and encouraged everyone to wash their hands frequently, cover their mouths when sneezing and let others know promptly should symptoms appear.

1.2 What is happening now? (current situation)

Please describe what is happening in our community (or country) now with respect to the primary goal. Given the same dimensions listed in the primary goal, what is the current situation? Do all the stakeholders agree with our description of the current situation? Is our description clear and concise?

(Note: If we described our primary goal in the form of a story, we advise that we use a story as well in describing the current situation. Use a descriptive paragraph if we used the same in our primary goal.)

1.3 What will likely happen if we don't act? (current destination)

Focusing on the same dimensions listed in the primary goal and current situation, describe what will likely happen if we don't act. Please keep the description clear and concise. The purpose of this question is to clarify for everyone what the consequences of inaction are. Our response to this worksheet can serve as the basic premise of our advocacy statement—what will happen if we don't act or we continue with 'business as usual'.

1.4 Why is there a difference between what we want to happen and what is happening now? What are the root causes of this difference?⁴

Who should we engage as audiences in our communication effort?

Every health communication campaign can have two sets of audiences. We can describe the first as audiences on the 'program' side since they are part of our team. These could include donors, staff of international agencies, policy makers, program managers, human and animal health workers, media professionals, environment experts, educators and other opinion leaders. We can describe the second set as audiences on the 'client side' since they would be part of the public that we would like to serve and help. These could include infants, children, adolescents, elderly, farmers, poultry growers, livestock caretakers, etc.

⁴ Root cause analysis involves asking a series of 'why' questions. We start from the central question of why is there a difference between what we want to happen and what is happening now. Each answer is subjected to more 'why' questions until we feel that going further will bring us to dimensions that we cannot act on or influence.

Given our analysis of why there is a difference between our primary goal and our current situation, what audience segment(s) should we focus on? Should we focus on audiences on the program side, client side, or both? Given the complexity of the problem, we may want to list the different audiences that we may want to reach.

Audiences to consider

Program side	Client or audience side
Donors	Women
Policy makers	Children
Program managers	Farmers/poultry growers
Human health workers	Senior citizens
Animal health workers	Youth
Media professionals	Business sector
First responders	Travel industry workers
Private practitioners	Schools, universities
Pharmacists	Correctional facilities
Civil society	Food industry workers
Hospital administration	
Border officials	

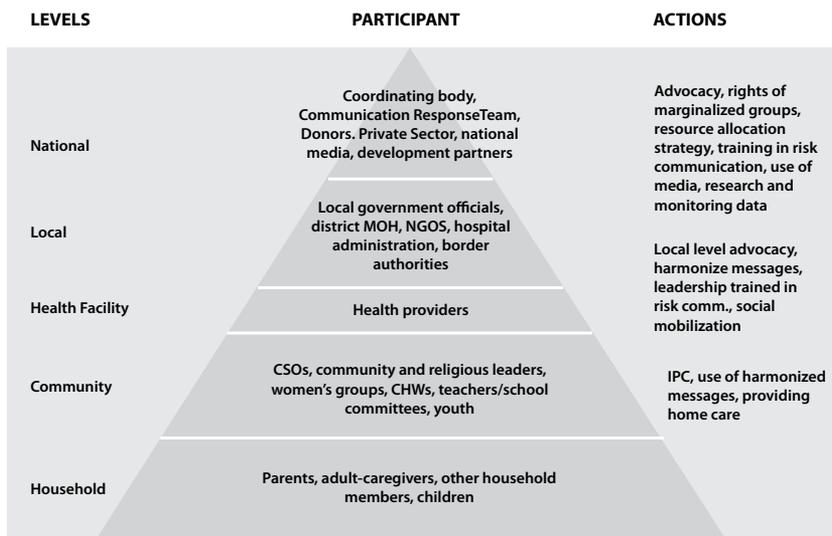
Another way to consider possible audiences is to use the UNICEF's Communication for Pandemic H1N1 Influenza Response Framework (See illustration 2 below).

1.5 How do we put ourselves into the shoes of our intended audiences? How do we develop a clear visual image of our audience segments?

The first step in putting ourselves in the shoes of our intended audiences is first to remove our own. Often we see communication situations from a program perspective, not from the perspective of our audiences. We need to suspend our perceptions, biases and judgments and visualize how our intended audiences perceive the communication situation.

A good technique to use is to develop a composite, or representative, depiction of a member of our key audience segment. It would help to choose a name and select a photo that would provide us with a visual representation of our typical audience. What are his/her socio-demographic characteristics?⁵ What are his/her psychographic characteristics? What does he/she consider of value? What are his/her needs and motivations?

We may describe our audience in the form of a story or in descriptive paragraphs. We may have to describe in this way each audience segment that we intend to engage, communicate or dialogue with.



⁵ Psychographic characteristics go beyond the commonly used demographic variables of audience segmentation, e.g. age, gender, education levels, income levels and urban/rural residence. Psychographic characteristics add psychological variables such as emotions and values, e.g. fear levels, efficacy levels, etc. See Points to consider in this worksheet.

Points to consider

To understand our audiences, we may want to consider how they stand with respect to the following: (If data are not available, please make a best estimate.) Our answers can help us design more effective messages in the next worksheets.

Low Medium High

1. Knowledge of means of transmission
2. Knowledge of means of protection
3. Believe that they can do something about it
4. Fear levels about the issue
5. Perceived social support available
6. Efficacy (confidence to act) to respond in general as individuals
7. Efficacy to respond in general as a group
8. Personal efficacy to practice specific protective measures
9. Group efficacy to practice specific protective measures

1.6 Prioritize our audience segments within the context of our communication objectives.

1.7 Who are the influential people in our audiences' social networks that could influence their behaviors?

Worksheet 2: What are our strategic communication objectives? What would we like our chosen audience(s) to do? What is the key benefit our intended audience would appreciate most? How do we best communicate our key messages? (strategy design)

The aim of this worksheet is to describe our strategic communication objectives and decide on the key benefit that could motivate our audiences to change their behavior. In other words, through this worksheet we will state clearly what we would like our audience to do and why they should do it. We will also develop a media plan for communicating our messages.

2.1 What dimensions of the health issue do we need to keep in mind while designing our communication strategy??

Examples of dimensions of the health issue

- Severity of problem
- Speed of growth or spread
- Impact on vulnerable groups – e.g. pregnant women, children and elderly
- Impact on health workers or first responders
- Absence of preventive or treatment medications
- Strengths/weaknesses of health infrastructures
- Human rights dimensions
- Ethical issues
- National and international coordination on communication efforts

2.2 What specific behaviors do we want our audiences to do?

WHO/UNICEF recommended behaviors:

To reduce transmission of respiratory diseases:

- Keep distance from someone who is coughing or sneezing
- Stay home if you feel ill
- Cover your coughs and sneezes
- Wash your hands with soap and water

To lessen health impact

- Give sick people a separate space at home
- Assign a single caregiver to a sick person
- Give plenty of fluids to the sick person
- Recognize danger signs and seek prompt care

Source: WHO/UNICEF. Behavioural interventions for reducing the transmission and impact of influenza A(H1N1) virus: a framework for communication strategies. 2009

2.3 Given our understanding of the reasons for a difference between what we want to happen and what is happening now, define the communication objectives for our chosen audience(s). Use the SMART criteria.

Ensure that our communication objectives address the root causes or constraints that we have identified in our previous analyses.

SMART Communication Objectives

- Specific
- Measurable
- Action-oriented
- Reach high
- Time-bound

A good communication objective describes clearly what we would like our chosen audience to do—that is, what behavior we would like him or her to adopt.

The following are examples of communication objectives:

After our campaign:

1. Everyone will have themselves vaccinated against seasonal flu.
2. People will wash their hands thoroughly before preparing any food.
3. People will cover their mouth when they sneeze.
4. The public will have greater confidence in taking collective action to prevent panic and hysteria. They will have greater trust in government and civil society and will work with them to help prevent the spread of disease.

(Optional) Consider some of the behavioral theories that we are familiar with. What are some of the theoretical assumptions underlying the basic strategy and approach?

2.4 What are some expected barriers that could prevent our audiences from changing?

2.5 What experiences do our audiences have that could be important to our campaign? Have they experienced health crises before which were not managed effectively and which could make them more skeptical now? Or which were managed very well and thus would make our audiences have relatively higher expectations?

2.6 What key benefits would best persuade our intended audiences to change their behavior?

Think of possible benefits of changing behaviour that are most likely appeal to our audience.

If we have time, pre-test the possible benefits through focus group discussions with our chosen audiences. What is the winning key benefit? What are the support points? If we do

not have time for pre-testing, in the collective judgment of our stakeholders, which key benefit would influence our audience(s) to change their behavior? (The wording of the key benefit statement is not necessarily what will appear in our communication materials. The key benefit statement is the brief or guide for those who will design or produce our communication materials.)

Key benefit statement

If you, [intended audiences], choose to [desired behavior], then you will benefit by:

1. Benefit A _____

2. Benefit B _____

3. Benefit C _____

Note: There are several key benefit options being asked here. The idea is for us to pre-test them in a focus group if we have time. If there is no time for a focus group discussion, we should choose one key benefit that we think will appeal most to our intended audience. Our intended audiences are asking, "Give me one good reason that I should change". They are most likely not asking, "Give me ten good reasons that I should change". To communicate effectively, we need to keep our messages simple and practical.

Support points to the chosen key benefit ⁶

2.7 What is the 'Big Idea', or creative concept that we can use to best frame our campaign.

By 'big idea', we mean a visual hook or concept that could provide our campaign higher visibility and greater impact. We want our campaign to be memorable—a message our audiences can easily recall.

Describe how we can best frame or present our message with a 'big idea', or creative concept. For example, the ubiquitous "red ribbon" is universally recognized as the symbol for the fight against HIV/AIDS. The widely popularized symbol has helped increased awareness about HIV/AIDS and united diverse communication campaigns through this universal symbol.

⁶ Support points should support the selected key benefit, not add new messages. Examples include testimonials from credible sources, facts or data.

2.8 How can we best communicate our messages? What is our media mix?⁷ (media plan)

Media mix refers to selection of media that we will use in our campaign and our corresponding allocation of resources. We will choose the appropriate media mix, deciding which will be our primary medium and our secondary media.

2.8.1 What are the media preferences of our intended audiences?

Inter-personal	Community-based or social mobilization	Mass media
Individual appointments	Folk theater	Print
Hotlines	Group discussions	Radio
Home Visits	Public Meetings	Television
Peer Education	Rallies/Marches	Computers/ Internet
Models/Exhibitions	Facilitated Training	Film
Voluntary Counseling and Testing	Slide shows	Outdoor media (billboards etc.)
	Community radio	Collaterals (caps, t-shirts, match boxes, etc.
Health facilities	Video forums	Social media ¹¹
	Bulletin boards	
	Traditional media	
	Classrooms	
Other media?	Other media?	Other media?

⁷ See UNICEF media comparison chart in the Worksheet Guide section.

⁸ Social media refers to media where users or audiences generate and share information and ideas, e.g. Wikipedia, social networking channels such as Facebook and Twitter, bulletin boards, on-line forums, etc.

Given the wide flexibility and range of interventions available for a communication program, if the table above does not contain certain media that we would like to use, please describe them below:

2.8.2 Which will be our primary media? Which will be our secondary media? How much resources will we allocate for each medium in our media mix or media plan?

2.8.3 Are there special events or seasons that we need to consider in our media plan?

Points to consider

1. Festivals, sports events, etc.
2. National holidays or celebrations
3. Agricultural/business fairs
4. Weather/seasons – e.g. season for flu, stomach illnesses
5. Health events, e.g. World TB day, World HIV/AIDS, Children's Day,
6. Others

2.8.4 Which media scheduling technique best fits our objectives and resources?

Points to consider

Continuous – Continuous broadcast/distribution of messages with no variation in pressure (appropriate in rapidly spreading epidemics)

Flighting – Broadcast/distribution of messages with periods of inactivity (used to prevent audience fatigue, extend limited resources, take advantage of limited media time or space)

Pulsing – Broadcast/distribution of messages with varying degrees of pressure, periods of intense activity followed by periods of less intense activity (used to extend limited resources, take advantage of limited media time and space)

2.8.5 Are there any geographical factors to consider?

Points to consider

1. Variations in needs and behavior (where the disease outbreak or threat is)
2. Media infrastructure availability
3. Policy – focus on under-served audiences (e.g. areas of poverty, where women and children are most vulnerable). We need to be mindful that groups that are most at risk in an epidemic are often those with least access to communication media.

2.8.6 How can we continuously develop ‘special relationships’ or ‘stand-by agreements’ with select media outlets so that we can make full use of them when crises break out?

Worksheet 3 – Creative approach, development of materials and pre-testing (creative development and pre-testing)

The aim of this worksheet is to describe the steps that we will follow in developing our materials and how we would pre-test them (if time permits). We will also consider how we can inspire creativity among members of our team.

Now that we have decided on our media plan, the next step is to develop our communication materials. We need to ask ourselves:

3.1 How can we best engage our intended audiences (and all stakeholders) to help us design our materials?

3.2 How can we best encourage creativity among members of our team and our stakeholders?

3.3 How do we best translate the key benefit into creative messages? What will those messages be?

3.4 How can we quickly pre-test our key messages and materials? (While time may be short, we need to make an effort to pre-test.

3.5 In what ways can we quickly revise our key messages and materials based on our pre-test findings?

Worksheet 4 – Implementation

The aim of this worksheet is to describe how we can best implement our planned activities and tasks.

To strengthen the implementation of our communication campaign, we need to consider the following:

4.1 Identify the lead organization and our collaborating partners.

4.2 Define the roles and responsibilities of each partner.

4.3 Clarify how we will promote teamwork and synergy.

4.4 Outline a timeline for implementing our activities (see Worksheet Guide for a template).

4.5 What steps can we take to simplify tasks? How do we minimize procedural delays in rapidly moving to scale in epidemic/pandemic situations?

4.6 What steps can we take to enable our team members to act?

4.7 Develop a budget and assign responsibility for fiscal authority.

4.8. Develop a management plan memorandum of agreement. (See example below)

Question	Response
1. The lead organization is:	
2. The responsibilities of the lead organization are:	
3. The collaborating partners are:	
4. Collaborating partners are responsible for:	
5. Timeline and milestones	
6. Budget	
7. Monitoring and evaluation	

Worksheet 5 – Monitoring and evaluation

Our aim in this worksheet is to describe the steps to monitoring and evaluating the effectiveness of our communication response. Given the emergency nature of the situation, we will focus more on monitoring rather than evaluation.

After completing this step, you will have:

1. A design outline for monitoring the process and/or evaluating the impact of outbreak communication activities.
2. A list of potential indicators and data sources for process monitoring and/or impact evaluation.
3. A timeline for collection of data and other information needed for process monitoring and/or impact evaluation.
4. A plan for analyzing and using data generated by monitoring & evaluation activities.
5. A plan for sharing data with others.

Key concepts and definitions

Inputs

- Refers to effort and resources expended to achieve program goals.
- Indicators of inputs may include human, financial, institutional or technical resources including materials and activities that our program uses or mobilizes to make outbreak communication possible and effective.

Outputs

- Refers to results of our effort.
- Indicators of outputs may include both intermediate, process-related outputs (e.g. people trained, journalists engaged) and longer-term effects on various groups of audiences and stakeholders (e.g. editorials published, communities mobilized, fear reduced).

Impact

- Refers to results that can be attributed to our efforts
- Requires satisfying criteria for attribution, including change, association between inputs and outputs, time order, taking account of confounding factors, conceptual coherence and others.

Quantity

- Refers to numeric measures of inputs and/or outputs
- Indicators may include how many activities were done, how many materials were produced, how many journalists were trained, how many articles appeared in the newspaper, etc.

Quality

- Refers to how well a program did in relation to an agreed upon standard or target for performance
- Indicators may include quantitative and qualitative measures such as input/output ratio, how well the

implementation conformed to the implementation plan, descriptions of how people are better off as a result of our efforts, a comparison of input and output levels with targets, and so on.

5.1 Which is our top priority, monitoring or evaluation?

Monitoring program activities and how to improve the implementation process (Skip the list below if our priority is evaluation only)

► Monitoring program activities and how to improve the implementation process (Skip the list below if our priority is evaluation only)

List the program activities we want to monitor.
(Note that these should be consistent with the decisions made in earlier worksheets.)

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.

(If more than 10 activities, duplicate this table and continue the list.)

► Evaluating program outputs or effects and how to improve future outbreak communication

List the outputs or effects we want to evaluate. Consider the process of collecting data and eliminate indicators that may be too difficult to measure.

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.

(If more than 10 outputs or effects, duplicate this table and continue the list.)

5.2 Indicators and data sources

Start building an indicator table by copying the entries from section 5.1 into this table and listing possible indicators for each. See the Worksheet Guide section of this manual for indicator suggestions.

Monitoring		
Activities to monitor (copy from section 6.1)		Indicators
1		
2		
3		
4		

5		
6		
7		
8		
9		
10		
(If more than 10 activities, duplicate this table and continue the list.)		

Evaluation		
	Outputs/effects to evaluate (from section 6.1)	Indicators
1		
2		
3		
4		

5		
6		
7		
8		
9		
10		
(If more than 10 activities, duplicate this table and continue the list.)		

5.3 Classify the indicators that we have listed in terms of whether they are measures of effort or effect and whether they are measures of quantity or quality. The matrix below could serve as a handy framework.

	Quantity	Quality
Effort	How much did we do?	How well did we do?
Effect	Is anyone better off?	

Ref. **Trying Hard Is Not Good Enough**
Mark Friedman, 2005

5.4 Using the timeline that we developed in the Worksheet 4—Implementation, define appropriate milestones to mark progress of our effort.

1. _____
2. _____
3. _____
4. _____
5. _____
- Etc. _____

5.5 Who can best help us analyze our data? For example, universities? Research agencies? Government research staff?

5.6 How can we best disseminate our monitoring and evaluation data to relevant actors (especially to our audiences)?

5.7 How can we best ensure that lessons learned are shared with and understood by all?

5.8 How can we help ensure that relevant actors take appropriate actions based on our monitoring and evaluation data?

Worksheet 6 – How do we plan for continuity?

The aim of this worksheet is to plan for the near future, using our experience. We want to identify key lessons learned and deduce best principles (in addition to best practices). We will be filling out this worksheet continuously as we implement our communication activities.

6.1 How can we best capture or document the lessons or insights gained from our experience?

6.2 What were some of the most important lessons learned from our experience? What did we do very well? What could we have done better?

6.3 How can we best apply what we have learned to prepare more effectively for future outbreaks or epidemics?

THE SIX QUESTIONS

- 1. What is the communication problem?**
- 2. What do we need to do?**
- 3. What creative approaches and materials do we need to develop?**
- 4. How do we make things happen?**
- 5. How do we know that we are making progress and achieving our desired impact?**
- 6. How do we learn from experience and plan for continuity?**

This section of the manual provides more guidance to those who want help in answering the questions in the Worksheets. Users can refer to this guide as they are filling out the Worksheets. We will find the in the left hand margins the Worksheet questions that specific information in this section aim to address.

The Worksheets will help us to focus on the strategic planning process and to accomplish it quickly. The process combines strategic planning and performance evaluation, and it focuses on results. Overall, the Worksheets pose these overarching questions:

- What is the current situation?
- What needs to change?
- What are we going to do about it, and who will do what?

As we work together to fill out the Worksheets, it is useful for team members to constructively express different views and judgments. Answering the questions together encourages each of us to listen to others. In the end we find that we all are trying to accomplish the same thing. We are committed to the same task. In other words, “we share the same flag!”

CHAPTER 1 - HOW DO WE ESTABLISH PARTNERSHIPS AND COORDINATING MECHANISMS?

Chapter Goal

This chapter helps us focus on the need to establish partnerships and coordinating mechanisms. It helps us to decide who will be important and helpful partners in our Communication Response Team, to clarify roles and responsibilities and to develop coordinating mechanisms.

1.1 What infectious disease(s) outbreak do we want to prevent and/or address? What unique characteristics of this disease do we need to consider in our communication campaign?

We need to understand the nature of the disease because that greatly influences what goals we set for our communication strategy. (See Technical Reference Section for information about emerging and re-emerging diseases.) Specifically, we need to understand how the disease spreads and how we can prevent or treat it. We need to answer such questions as these:

- Will this health issue affect the whole population or only a sub-population, e.g. farmers and their families, young children, fishing communities (bilharzias)?
- Will there be sub-populations at greater risks? If so, who?
- Is the health issue limited to certain geographical areas or environmental conditions, e.g. malaria, bilharzias?
- Would an outbreak be rapid, or would it give us some time to prepare and organize?
- What kind of contact transmits the disease—e.g. Through coughs and sneezes? Through contact with body fluids? Can the disease be passed from animals to humans?
- How easily is the disease transmitted?
- Is a vaccine available, and how effective is it? Are treatment medications available, and how effective are they?

It is important that public health professionals recognize how a disease progresses through different phases in an epidemic and adapt their strategies, approaches and actions accordingly. The World Health Organization (WHO) has developed a global influenza preparedness plan that defines the stages of a pandemic, outlines the role of WHO, and makes recommendations for national measures before and during a pandemic. While WHO developed these phases with global influenza in mind and with a global perspective, the concepts apply to most contagious diseases and to situations at the country level. The phases are:

Pre-pandemic period

Phase 1: Viruses are circulating within animals only. An influenza virus subtype that has caused human infection may be present in animals. If present only in animals, however, the risk of human infection or disease is considered to be low.

Phase 2: An animal virus is known to have caused an infection in a human being. There is a potential of pandemic threat because the virus strain has mutated, making transfer to a human possible.¹

Phase 3: Small clusters of human beings have contracted the virus in one community. There is potential for spread of the virus if others outside that community come into contact with people who are infected.

Phase 4: Human-to-human and animal-to-human virus transmission is causing outbreaks in many communities, and more people are getting sick in those communities. While a pandemic is more likely, it is not a forgone conclusion at this point.

Phase 5: Human-to-human transmission is taking place in at least two countries in one WHO region. At Phase 5 most countries are not affected (yet), but a pandemic is considered imminent. During

¹ The risk of human infection or disease resulting from circulating strains in animals determines the distinction between phases 1 and 2. Phase 2 means that risk of human infection has increased. The distinction is based on various factors and their relative importance according to current scientific knowledge. Factors may include pathogenicity in animals and humans, occurrence in domesticated animals and livestock or only in wildlife, whether the virus is enzootic (endemic in humans) or epizootic (epidemic in humans), geographically localized or widespread, and other scientific parameters.

The distinction among phases 3, 4, and 5 is based on an assessment of the risk of a pandemic. Various factors and their relative importance according to current scientific knowledge may be considered. Factors may include rate of transmission, geographical location and spread, severity of illness, presence of genes from human strains (if derived from an animal strain).

this phase governments and health officials must be ready to implement their pandemic mitigation plans.

Pandemic Period

Phase 6: Community outbreaks are taking place in more than one WHO region. By definition, a pandemic is underway. Illness is widespread. Governments and health officials are working to curtail spread of the disease and to help their populations deal with it using preventive and treatment measures.

Post peak period

After a period of increase in the rate of infections reported, the spread of the disease begins to wane. The key need at this point is to be prepared to prevent a second wave.

Post pandemic period

Return to normal seasonal influenza levels.

We can consider Phase 1 as a steady endemic state. The time span for phases 2 through 6 may take place over several months to many years.

1.2 What do we want to achieve with our communication response?

Our communication campaign can help achieve one of these goals or multiple goals:

1. Reduce transmission of disease
2. Mitigate health impact
3. Lessen panic and social disruption
4. Establish credibility and trust among actors
5. Help communities and families recover from the disease
6. Create a more favorable climate for future preparedness.

We need to take into account that a health crisis can evolve rapidly. As the **Communication Response Team**, we must

be aware of the dynamic nature of our tasks. While all of the objectives above are worthy, our priority objectives may change as the epidemic grows or wanes. There may also be other epidemiological, political, economic and social considerations. Every team member needs to understand, support and be able to articulate what it is that we want to achieve at any given time.

For instance, previous pandemics have been characterized by waves of disease activity spread over months. Once the level of disease activity drops, a critical communications task will be to balance this information with the caution that another wave can happen. Pandemic waves can be separated by months, and an immediate “at-ease” signal may be premature.

In the case of post-pandemic period for influenza A(N1H1), experts expect that the pandemic virus will behave as a seasonal influenza A virus. At this stage, it will be important to maintain surveillance and update pandemic preparedness and response plans accordingly. An intensive phase of recovery and evaluation may be required.²

1.3 How can we enable animal and human health personnel to work more closely together?

It is crucial that animal and human health professionals work together. Without such collaboration, any attempt to address emerging and re-emerging diseases may face significant challenges. Since viruses found in animals can mutate and infect humans, animal health personnel should immediately alert human health personnel and provide them with needed information whenever any disease outbreaks among animals happen. However, in most countries, reporting systems are centralized or vertical and community level animal health workers would communicate with central levels first before they would communicate with community level human health personnel. Since time is crucial, it is important that we explore how to promote stronger collaboration among government institutions at different levels.

2

At the country level we can foster teamwork by nurturing an environment where people feel that they are “all working for the same flag”. This means encouraging all to focus on the agreed-upon primary goal and not on individual institutional missions and responsibilities. It may be useful if appropriate authorities can highlight the need for and mandate the collaboration of animal and human health personnel.

1.4 How can we quickly engage households and communities to participate in our efforts?

To meet the challenge of emerging and re-emerging diseases, we, as health professionals, may first need to change ourselves—to change our own mental models, that is, our fundamental perception of how health is produced and how we can facilitate the production of health.³

We start with shifting the paradigm from the conventional view that hospitals, health centers, health workers and other technical experts “produce” health to recognition that households, particularly mothers, are the primary producers of health. Second, all health institutions need to take on the task of helping households and communities become more competent and resourceful in producing health.

We can consider two competing models of public health. In the first model health institutions fight disease to save people. In the second model health institutions enable people to fight the disease by preparing them with appropriate information and skills. Experience shows that the second model, one which focuses on enabling people to fight disease, is the more effective and sustainable one.

³ By community, we mean civil society such as NGOs, professional associations like medical associations, community based organizations, religious organizations, civic organizations, etc.

By households, we mean our audiences, specially women and children and other vulnerable groups.

We need to ensure from the start that the **Communication Response Team** has members who represent households and communities. True, all of us could claim that we could play this role, since we belong to households and communities. We need to recognize, however, that by training we see health situations through the lens of public health professionals. Health communication campaigns have greater chance of success when communities and households participate in all aspects of planning, implementation and evaluation. Since cultural literacy or awareness (knowledge of local culture and beliefs) is a key factor in effective communication, we need to seek representation from the geographical areas where we plan to focus on. We can select representatives of communities and households from leaders of local organizations as they are easily visible. We can also choose from members of local health committees or health boards.

1.5 How do we best select the right partners?

Our success will be enhanced if we engage others and secure their help. Epidemics and pandemics are complex, large-scale events. We cannot achieve much if we do not work with others.

Thus, one of our first tasks is to select our partners, or stakeholders. The selection is crucial: The right partners can help us succeed, while the wrong ones can reduce our effectiveness. While we may be tempted to mobilize everyone, careful selection of partners may be more prudent. A good stakeholder segment may be smaller than most people think. Often, a careful selection of the right stakeholders may yield more results than selection of a broad one. To mobilize a wide range of organizations with divergent interests may require more effort and yet produce fewer results. A more focused campaign, engaging stakeholders with strong shared interests, may have more impact.

1. Inter-ministerial task force (if any)
2. Ministry of Health
 - Office of Epidemiology
 - Office of Communication
3. Ministry of Agriculture
 - Veterinary inspectorate/agency
 - Other relevant offices
4. Ministry of Information
5. Ministry of Social Welfare
6. Ministry of Defense
7. Emergency Preparedness Office (if any)
8. Office of President/Prime Minister
9. Parliament or Congress
10. Pharmaceutical industry
11. Medical associations
12. Private and public media
 - Radio
 - Television
 - Print
 - Information technology
 - Social media organizations
 - Folk media organizations
13. Religious sector
14. Relevant NGOs
15. Community organizations
16. Donor agencies
17. International agencies
 - a. UNICEF
 - b. WHO
 - c. FAO
 - d. World Organization for Animal Health

Three questions can help us identify the right partners:

1. Who will be most affected by the health issue that we are addressing?
2. Who can help make a difference in resolving this health issue?
3. Who are most willing to collaborate?

Answers to these questions can generate a list of potential partners. In addition, it may be useful to establish a core team at the start—a group representing the most important players that we want to involve. This core team can help evaluate the list and generate further options.

We should also assess institutional capabilities: Which agencies, public or private, have the interest, capability and desire to help us conduct communication campaigns to address new and re-emerging diseases? Which agencies have the resources that would be needed in our campaign? Which agencies have the legal mandate to provide us with assistance? An assessment of the communication capabilities of organizations should examine:

- How relevant organizations relate with one another
 - Independence
 - Interdependence
 - Competition
 - Conflicting relationships.
- Which organizations have media facilities that we can use? For example, printing press, radio stations, TV stations, websites.
- Which organizations are tasked with information responsibilities? Ministries of Information, government public relations offices, NGOs, etc?

We may also have to engage media organizations and media professionals who could help foster a two way communication between us and the public. There are many media professional

associations that we can enlist. We should look at them as equal partners and not just as a facility that can provide us with service. They are also important sources of technical expertise and not just channels of communication. In many ways, they may have a unique understanding of our intended audiences.

Once we have identified our stakeholders, we need to engage them and nurture a strong team. To nurture effective teams, it may be useful to emphasize that:

1. Strong teams develop when there is a strong commitment to a primary goal. A collection of individuals is not a team if they do not have a common objective or do not understand fully why they are in the group.
2. Teams multiply results but divide the effort. TEAM means Together Everyone Achieves More.
3. A strong team consists of people with diverse skills
4. In a team there are no unimportant roles. Each role is important.
5. A team can only be as strong as its weakest link.

To put these principles into action, we need to:

1. Encourage “blurring” of organizational boundaries by highlighting a common goal. “We all share the same flag” is a powerful theme that can unite people.
2. Recognize the value that each partner brings to the table.
3. Encourage the participation of all partners in the team and prompt “silent voices” to speak up.
4. Nurture positive relationships through social or non-professional activities that stakeholders can participate in.
5. Help everyone appreciate that creativity involves recognizing the creativity of others and not just one’s own.

Building a strong team is an investment, not a cost. The benefits of a strong team outweigh the time and effort put into building it.

We also need to consider how best to coordinate the partners:

- Coordination by existing authority – e.g. through a legal mandate
- Coordination by negotiated authority – e.g. through consensus
- Coordination by standardization or plan – through adherence to a common planning process
- Facilitative coordination – through participation and discussion.

A special challenge arises when circumstances require us to work with partners who have conflicting interests with us or with other stakeholders. While conflicts are very much part of public health situations, emergency situations call for decisive and rapid response. There may be little time for conflict management interventions with members of our team. Clarifying the primary goal among stakeholders helps avoid and minimize conflicts.

As part of the World Bank Avian Flu Preparedness project, the Armenian government created an Inter-ministerial Task Force on Avian Flu Preparedness in 2006. This was a first in the Caucasus region and noteworthy for the task force's effort to promote teamwork among animal and human health workers. A fulltime secretariat supports the Inter-Ministerial Task Force. It has produced and distributed avian flu communication materials and has developed a website and a hotline that provide immediate information to the public. Recently, the Armenian government expanded the task force's mandate to cover food safety, swine flu and other zoonotic diseases such as brucellosis. Lessons learned from the Armenian experience include:

1. The importance of clarity in the legal mandate of the Inter-ministerial Task Force, allowing it to have wider latitude in its operations.
2. The differences between animal and human health professionals are deeply rooted and require strong political will and effective leadership to overcome.
3. An Inter-Ministerial Task Force needs sufficient material as well as non-material resources to operate effectively.

1.6 How do we quickly develop a "surge capacity" for behavior change communication (BCC)?

A health emergency may dramatically raise the demand for communication expertise and materials. Present capacities may be inadequate and there may be a need to quickly develop increased or "surge" capacities. Compliance with existing procurement procedures may still prevail even in an emergency situation.

We may need to assess current BCC capacity both within and outside our organization and to issue Long Term Agreements

(LTAs) for provision of technical assistance in development of communication materials with appropriate parties as soon as we can. These LTAs can then be activated as needs arise. By coordinating closely with other organizations, both international and national, we should be able to identify and rapidly deploy BCC experts at short notice.

1.7 How can we ensure a human rights perspective in our overall planning and implementation?

The organized response to major outbreaks of disease can generate questions about the way people are treated, including questions about inequities in health care provision, confidentiality, informed consent and other, similar issues. For example, the 2002 Severe Acute Respiratory Syndrome (SARS) outbreak in China raised questions about involuntary testing and detention. While the avian influenza scare in 2003/04 in Asia (primarily in Vietnam) saw small numbers of human infections, there were forced culling of birds and restrictions on movement of agricultural produce, with economic consequences. The recent swine flu scare in 2009 also led to forced quarantines in several countries, both industrialized and developing.⁴

Respect for human rights is an issue that concerns everyone involved in the response. While it may be beyond the capacity of communication efforts to resolve these issues, a reasonable communication goal is to promote a meaningful dialogue among stakeholders to reach consensus. Recent experience suggests we need to consider how to respect human rights when we are:

- Testing, quarantining and restricting movement
- Prioritizing access to health care and medication.
- Implementing the state's obligations to protect children.
- Tailoring responses to meet needs of all without discrimination
- Mitigating economic impacts of disease outbreaks,

⁴ "Human rights consideration with regard to pandemic influenza", UNICEF, 29 June 2009, unpublished paper.

including those of false alarms or scares, for vulnerable and marginalized populations.

Our communication measures should not only emphasize health measures to be taken but also make clear that no one (especially children and women) should be discriminated against or neglected due to their health status, age, ethnic origin, migratory status or nationality. Our communications effort should quickly identify areas where deteriorating economic conditions are causing severe health consequences and focus attention in these areas. Usually these areas will have higher poverty levels making their populations more vulnerable. We should take into consideration that prices of food products may rise and food supply may be disrupted during health emergencies.⁵

1.8 How can we help assure that specific ethical issues are considered in our overall planning and implementation?

Disease outbreaks could also raise ethical issues. These include:

1. The duty of health workers to provide care during communicable disease outbreaks
2. Possible restriction on liberty such as quarantine
3. Setting priorities for distribution of scarce resources such as vaccines and anti-viral medicines
4. Balancing health and economic concerns arising from global governance implications such as travel advisories, which could affect tourism and commerce.

While resolving these ethical issues may also be beyond the scope of communication, we can contribute significantly by promoting meaningful dialogue among stakeholders.

We can foster understanding of the need to strike a balance among people's rights, interests and values. The United Kingdom Committee on Ethical Aspects of Pandemic Influenza suggests a draft framework composed of seven ethical principles (and a

5 Ibid

composite principle of good decision-making). See table below.

Principles	Content
1. Treat people with concern and respect	This means that: <ul style="list-style-type: none">• Everyone matters• People should be kept informed• People's choices should be respected as much as possible
2. Minimize harm	This includes physical, psychological, social and economic harm
3. Fairness	This means that: <ul style="list-style-type: none">• Everyone matters equally• People with equal chance of benefiting from an intervention and should have equal chance of receipt• Good reasons are needed to treat some people differently from others: non-discrimination
4. Working together	This means: mutual aid, personal responsibility and sharing information

5. Reciprocity	This means supporting those who are asked to face increased risks or burdens during a pandemic
6. Keeping things in proportion	This means providing: accurate information and action that is proportionate to the potential risks and benefits
7. Flexibility	This means adapting to new information and changing circumstances
8. Good decision-making	This includes: openness and transparency, inclusiveness, accountability and reasonableness, which includes a basis in appropriate evidence and ensuring that decision is practicable

Source: United Kingdom draft ethical framework for pandemic influenza planning. Eleventh Futures Forum on the Ethical Governance of Pandemic Influenza Planning. p.16. World Health Organization, Europe. 2008

By clarifying two principal considerations, we may facilitate decision-making processes in setting priorities: utility to society and equity. Decisions based on utility could give essential health service workers first-priority access to preventive and therapeutic measures for themselves, so as to ensure continuity of health service provision. In contrast, decisions based on equity could give priority to medically worst-off patients, those at greatest risk of dying, or particularly vulnerable groups. An open, honest and meaningful dialogue where all views are heard could contribute to resolving this dilemma.

Other considerations could include the following:

- Principle of maximization: to do the most good or to maximize health protection with the limited resources available. Stakeholders may decide to save the most lives using quality or disability-adjusted life years (QALYs or DALYs) or life-years gained. Stakeholders may also decide, based on economic utility, that priority should go to crucial economic institutions such as those providing essential services and products, e.g. food, water, emergency services, electricity.
- Ensuring equity and fairness. This means giving equal weight to the equal claims of individuals, which should prevent discrimination against or favoritism to certain groups such as residents of one area rather than another. A second implication is that different priorities are given to unequal claims. For instance, those who are medically worse off may have stronger claims to life-saving care than healthier people; high-risks groups may have stronger claims than low-risk groups, and young people may have stronger claims than elderly ones.⁶
- Ensuring fair procedures and accountability. This principle is more concrete. It involves publication of clear and fair ethical principles for decision-making, their justifications, ensuring consultation among stakeholders, and ensuring clear and transparent procedures, policies, plans and actions during a health emergency.⁷

1.9 How do we best coordinate our national communication effort with those of international agencies (WHO, UNICEF, World Bank/IMF, USAID, other donor agencies)?

Disease outbreaks often require multilateral response. Since disease outbreaks do not respect national boundaries, governments need to work with international agencies and

6 “Eleventh Futures Forum on Ethical Governance of Pandemic Influenza Preparedness”, World Health Organization Europe, 2008.

7 Ibid

with other governments, especially with those in neighboring countries.

Previous disease outbreaks (the avian flu scare in the Caucasus region in 2007, for example) have led citizens of one country to listen to broadcasts from neighboring countries who communicated more relevant information than their own government. Since information now flows readily across national boundaries, people may become confused if messages from different sources (or governments) are not in harmony. Also, governments are obligated to conform to international standards set by appropriate international bodies or agencies and therefore would need to coordinate their efforts to addressing disease outbreaks.

It is essential for us to advocate clear lines of authority and responsibility for coordinating with international agencies. While human health personnel would have direct communication lines with the World Health Organization, animal health personnel may also have direct communication links with the World Animal Health Organization. It is crucial to maintain international level contacts in harmony with international and national goals.

1.10 List the key tasks that we need to carry out and decide who will be accountable for each of them.

We are still organizing at this stage and have not reached the planning for implementation point. The following steps may help us list the key tasks that we need to carry out and decide who will be accountable for them.

1. Choose a facilitator for our Communication Response Team
An effective facilitator should have the following characteristics:
 - a. Be a good listener – To answer the worksheets, we need a facilitator who can make people comfortable to talk, ask related questions, probe for clarity, challenge inconsistent statements, and encourage “silent voices”.

- b. Be results focused – understand clearly what a meeting seeks to achieve and communicate it often to the team.
 - c. Be an analytic and strategic thinker who can communicate effectively the results of discussions.
 - d. Be perceived as credible, impartial and trustworthy.
 - e. Be able to ensure participation while ensuring order- keep discussions moving and promote constructive dissent.
2. Build trust, credibility and sense of ownership among members of our Communication Response Team

A team is a team because it is focused on a shared goal. While we may not have the time to nurture teamwork, a clear sense of direction and purpose could generate a collective perspective and sense of ownership among our team members.

Action is eloquence. We can also generate trust and credibility by doing what we say we will do and do it at the highest standard possible.

3. Breakdown the primary goal into areas of responsibilities and delegate authority and accountability

Our primary goal is the end result. We also have to define measurable objectives and action steps that would enable us to achieve our primary goal. We also have to allocate resources, define target dates for completion and identify staffing support that may be needed.

1.11 How do we best develop coordinating mechanisms? Is there an existing 'Incident Command System' or 'Emergency Response System' or any similar structure in place? Has this system been activated? What is the role of communication in this system?

After forming our team, we need to agree on roles and responsibilities and the means for coordinating action. We need to be clear not only about our goals but also about the best

Illustration – The Incident Command System – An example of an Emergency Response System

The Incident Command System (ICS) is a standardized, on-scene, all-hazard management concept. The concept grew out of wildfire suppression efforts in California in the 1970s, when emergency personnel recognized that policemen, firemen, emergency medical teams and other first responders have different organizational cultures and speak with different jargon. In emergencies these first respondents could not communicate with one another. (Note: While UNICEF may not be involved in “outbreak” communication efforts, understanding the Incident Command System may be valuable to appreciating effective coordinating mechanisms.)

The Incident Command System consists of organizational hierarchies, procedures and communication guidelines that aim to promote effective communication, systematic emergency planning, and accountability. The ICS observes the following key principles:

1. **Unity of command.** There is always one incident commander, and all emergency personnel report ultimately to him or her regardless of which agency or organization they come from.
2. **Common terminology** – All communication are in plain. Participants in the Incident Command System never use abbreviations or technical jargon.
3. **Management by objective.** The Incident Commander articulates what needs to be achieved and ranks these tasks by priority. They are as specific as possible and follow the SMART criteria:
 - Specific
 - Measurable
 - Action-oriented
 - Relevant
 - Time-bound
4. **Flexible/modular organization** – The Incident Command System is organized so as to expand or contract as needed by the incident’s scope, resources or circumstances.
5. **Span-of-control** – The ICS requires that any one person’s span of control should be between three and seven individuals, with five being ideal. One manager should not supervise more than seven people.

Source: Barnett D. Incident command system. 2009.

way to reach our goals. A good illustration of a coordinating mechanism here is the **Incident Command System** (also called an Emergency Response System) (see illustration).

We facilitate coordination in a public health emergency when we adhere to the following concepts or principles (as adapted from ICS principles):

1. Honesty is a cardinal rule. This principle is the foundation of good coordination. Good relationships emerge when people trust each other. Relationships matter when we are in stressful situations, especially those when human and animal lives are threatened..

2. The safety of the health worker and other emergency personnel is of prime importance. We cannot help others if our own safety has been compromised. We need to consider:

- **Mental health. Health workers must be skilled and confident in working under stressful conditions.** There are two important points to consider:
 - **Every health worker must have a family emergency plan.** The minds of health workers must be at peace. This starts with a family emergency plan. When health workers know that their families have an emergency plan that will work, their minds will have something less to worry about and they can focus better on their work. Studies have found that a significant percentage of health workers in the US consider the safety of their families foremost in their minds when they are in the field responding to emergencies.
 - **Health workers must be prepared to respond to psychological illnesses.** Studies also have found that the ratio of psychological illnesses to physical illness ranges from 10 to 1 and as high as 100 to 1, depending on the nature of a public health emergency, e.g. pandemics, natural disasters, terrorism events, etc. Psychological illnesses include post traumatic syndromes, anxiety attacks, panics, severe depression,

and shock. Health workers must be alert to and confident and skillful to address psychological illnesses.

- **The physical health of emergency personnel is important**, as they must keep functioning under stressful conditions. While the public recognizes and rewards heroic acts, health workers should appreciate that it is their primary duty to remain functional so that they can continue to help others. When health workers become ill, injured or die, they can no longer contribute. Health and emergency workers have to take risks to carry out their duties, but they must be mindful that their continued safety and health are important to the safety and health of others.

3. Communication Response Team must prepare an Incident Action Plan. An Incident Action Plan specifies a coherent means of communicating the overall objectives for dealing with the incident, the overall approach and the strategy that will be used.

4. The response team must practice comprehensive resource management. This key management principle demands that all assets and personnel during a public emergency be properly tracked, deployed, and accounted for. The Incident Command System provides clear guidelines on good practices for comprehensive resource management.

5. Integrated communication is crucial. A common communication plan ensures that all responders can communicate with one another during an emergency. Communications equipment, procedures and systems must operate across jurisdictions and organizational levels. Plain language (not abbreviations and jargon) communicates best.

- **Health workers must have copies of “telephone trees” at home and at work.** Since everything starts with emergency first responders and health workers, it is crucial to have a “telephone tree” as well as back-up communication plans. A “telephone tree” is a call list that prepared beforehand. The list describes clearly who will call whom during an emergency. This list ensures that we do not have to call

everyone ourselves but simply tap into the “telephone tree” and start a chain of contacts. An emergency message is passed quickly through a telephone tree, and confusion is minimized. Everyone must have a copy of the telephone tree at home and at work so they can access it when roads become impassable and communication channels are impaired and cannot reach their respective offices.

- **A back-up communication plan describes how to communicate with one another if telephone lines and cell networks (and perhaps even some mass media) fail.** A back-up communication plan can involve two-way radios or agreed-upon rallying points, where health and emergency personnel can gather in situations when communications systems fail. The standard operating procedures, or SOPs, should specify the location of these rallying points and when to use them. Health workers should know their rallying point. Two-way radios must have sufficiently charged batteries at all times. It is crucial to conduct drills so that everyone can become familiar with emergency communications equipment meant for use during emergencies.

6. Alternative routes. Every emergency plan must specify alternative routes. Epidemics can lead to quarantine of some areas. In natural disasters, some roads may not be passable. Every health worker must know the alternative routes to follow if they are called in an emergency when some roads are blocked.

While the Incident Command System is organizational and managerial in nature, the presence (or absence) of an Incident Command System has profound implications for any communication effort designed to address new and re-emerging diseases.

1.11 Is there any existing structure (e.g. Inter-ministerial Task Force) with a legal mandate to coordinate communication regarding any disease outbreak? If yes, how do we fit in? If

none, can we initiate securing the required legal mandate for the communication response team that we are creating?

It is important to clarify the legal mandate and authority to respond during emergencies. Legal issues may arise such as those concerning insurance liabilities, obligations of the state and public officials, responsibilities of health personnel and others relating to the health emergency.

In an emergency, everything would be under close public scrutiny. It may help to consult with appropriate legal experts to clarify policies, laws and standard operating procedures.

1.12 Is there a spokesperson(s) appointed to speak with the media? Please identify this person(s).

A health emergency requires clarity on who should deal with the news media. This may involve appointing a well-trained spokesperson and making sure that person has access to accurate, timely, and credible information. In some circumstances, it may not be feasible to assign this responsibility to just one person (or group of persons); the media may be aggressive in soliciting information from a wide range of sources. An effective way of ‘staying with the message’ is for the Communication Response Team to define clear talking points for distribution to people who the media would likely contact. There must be clear instructions to stay with the message and, as much as possible, refer journalists to the appropriate spokesperson.⁸

1.13 Name key people to constitute a small rapid decision-making cell, within our Communication Response Team, that can decide on key issues/messages when an epidemic or pandemic takes unexpected turns.⁹ As much as possible, develop possible scenarios of what can happen and

⁸ Talking points usually consists of no more than five key messages that someone speaking with media could focus on. Messages are usually more effective when repeated clearly and unambiguously.

⁹ This could be members of our core team.

decide early on how we should respond under different circumstances. Our rapid decision-making cell would then be able to focus on which scenario is unfolding and act accordingly.

Since disease outbreaks can develop in unexpected directions. It is crucial that the **Communication Response Team** work closely with those in charge of epidemiologic surveillance. We also need to work closely with those who formulate scientific or technical guidelines on what to do in a given scenario.

Our Community Response Team should remain flexible at all times. Since time may be critical, a few of its key members should constitute a small cell for rapid decision-making. By developing different scenarios and deciding early on what to do if a particular scenario unfolds, we can simplify decision-making. Our cell could focus on determining which scenario is happening and implement the appropriate courses of action that have been decided beforehand.

THE SIX QUESTIONS

- 1. What is the communication problem?**
2. What do we need to do?
3. What creative approaches and materials do we need to develop?
4. How do we make things happen?
5. How do we know that we are making progress and achieving our desired impact?
6. How do we learn from experience and plan for continuity?

CHAPTER 2 – WHAT IS THE COMMUNICATION PROBLEM? (ANALYSIS)

Designing good health communication campaign starts with analysis of the problem that we are trying to address. Before we can define our goals and decide on a strategy, we first need to determine what the problem is.

A health or a communication problem is an undesirable situation that we would like to remedy or change for the better. A health problem concerns the overall health situation (e.g. an epidemic is spreading), while the communication problem concerns the specific aspect of the health problem that communication can address (e.g. people do not know what to do).

To do what is right we need to know what is true

Our primary goal could concern either a health problem or a communication problem, but our strategic communication objectives should always be focused on a communication problem. The strategic planning process involves transforming the health problem into program objectives (e.g. prevent the spread of disease) and the communication problem into communication objectives (e.g. educate people as to what they can do).

A common but seriously flawed approach to strategic planning consists of three questions:

1. Where are we now? (Situation analysis)
2. Where do we want to go? (Strategic objectives)
3. How do we get there? (Strategy)

The answers to these questions are usually referred to as situation analysis, strategic objectives and strategy. There are some disadvantages to this approach.

1. Situation analysis usually turns out to be more descriptive than analytical, often a mere listing of health indicators.
2. Situation analysis is often a depressing exercise and people usually scale down their expectations and consequently lower their choice of strategic objectives.
3. Does not encourage fundamental changes. There is often little connection between the “analysis” and strategic objectives and between objectives and strategy.

“There is nothing more pathetic than a man with eyesight but no vision.”

Helen Keller

An Alternative Approach to Analysis and Strategic Planning

Here is an alternative approach. We meet with our stakeholders to clarify our primary goal, what exactly do people want to happen? As mentioned earlier, this would likely be a program goal (e.g. incidence rates will be brought under control within three weeks.)¹⁰. Then, collectively we make an overall appraisal of the current health situation with respect to our primary goal and ask why there is a difference between our primary goal and the current situation, focusing on the communication dimension. Our answers to this question constitute the health communication problem.

A key advantage to this approach is it is based on a participatory process of all stakeholders. We seek consensus among our stakeholders about what we want to happen, what is happening now and why there is a difference between the two. Secondly, we foster a stronger analytical mindset by asking the question “why”, a perspective which is lacking in the conventional strategic

¹⁰ There could also be situations where the primary goal could also be communication oriented (everyone will properly wash their hands before and after eating) as set by public health authorities. To simplify, we assume that the primary goal in our campaign is a health goal and our strategic communication objectives focuses on behaviors that communication can address.

planning questions. Asking the question “why” may change our current view of the situation and thus our choice of solutions.¹¹

A disadvantage is that we may not have enough time to secure as much participation as we would like in view of the imminent outbreak.

We summarize this approach in seven questions.

2.1 What do we want to happen (and when)? (primary goal)

2.2 What is happening now? (current situation)

2.3 What will likely happen if we don’t act? (current destination)

2.4 Why is there a difference between what we want to happen and what is happening now? What are the root causes of this difference? (key constraint or core problem).

2.5 How can we prioritize our audience segments within the context of our communication objectives? (audience segmentation)

2.6 Who are the key people in our audiences’ social networks who could introduce information and encourage behavior change in the network? (audience network analysis)

2.7 How do we put ourselves into the shoes of our intended audiences? How do we develop a clear image of our audience segments? (audience profile)

¹¹ Jumping to a quick solution may not always give us the most appropriate answer. A car overheats. The driver puts more water. The car runs but overheats again. The process is repeated. When the driver asked himself—why is the car overheating? He looked under the hood and noted that the radiator was leaking. The right solution was not to put more water but to plug the hole in the radiator. The question “why” highlighted the root cause of the problem—there was a hole in the radiator.

Let us address the worksheet questions.

2.1 What do we want to happen? (primary goal)

What is the immediate change that we want to see in our community (or country)? From the perspective of our communication response team, what would we like to happen? Do all stakeholders (households, government and community) share this primary goal? Is our primary goal motivating enough to secure commitment among our partners to overcome any obstacles?

Why start with what we want to happen and not with a description of the current situation, as is a common practice? The answer is that constraints that exist in the current situation should not limit our goals. The purpose of a primary goal is to raise our sights so that we can change the current situation and improve things. If we let the current situation determine our goals, we may scale down our aims because of existing constraints. Instead, we can set a more ambitious goal and then consider how to eliminate constraints to reaching it.

We can call what we want to happen our primary goal, a strategic goal based on scientific or technical understanding of the health situation. The key point is being clear. Also, we should describe what we want to happen in a positive manner.

When we discuss and decide on the primary goal, it is useful to encourage constructive disagreement. Differences of opinion should be aired and resolved so that we can reach a true consensus. As long as we agree on the primary goal, we can make critical decisions and move forward. If we disagree on our primary goal, however, differences of opinion surface again and again throughout planning and implementation.

A key point is to make our primary goal clear, using language that is concise and easy to understand. Also, we should describe the goal in a positive manner. The goal statement should have the following elements:

1. Mention of the stakeholders who are actively engaged (government, communities and households)
2. A positive verb that indicates the action that we want to achieve¹²
3. A visible or measurable outcome
4. A time frame for achieving our goal
5. An appreciation of how potential audiences may perceive our primary goal.

It can be helpful to cast the primary goal as a story, picturing in words how we want the world to look.

2.2 What is happening now? (current situation)

Please describe what is happening in our community (or country) now with respect to the primary goal. Along the same dimensions described in the primary goal, what is the current situation? Do all the stakeholders agree with our description of the current situation? Is our description clear and concise?¹³

Our description of the current situation should match each element of our primary goal. Later we will ask, “Why is there a difference between the two?”

A crucial principle to keep in mind in describing the current situation is the principle of “embracing error”. To do what is right, we need to know what is true. We should acknowledge threats, weaknesses, limitations, and mistakes so that we can learn from the experience and make corrections. Trying to hide embarrassing facts could allow the situation to become worse. Hiding errors could force us to repeat them. Furthermore, we cannot change what we do not acknowledge. If there is a shortage of vaccines,

¹² “We” here could mean members of our Communication Response Team or larger entity to which we belong.

¹³ Note: If we described our primary goal in the form of a story, it is helpful to use a story as well to describe the current situation, or else to use a descriptive paragraph if we used the same for our primary goal.

for example, we need to acknowledge that and decide how to obtain more as well as how best to use what is available.

Illustration of primary goal statement

Here is an example of a primary goal in a situation in which epidemics seem to be developing elsewhere in the world but our country hasn't seen cases yet and has some time to prepare.

At the end of the month:

People (i.e. communities and households) are working closely so that the country is highly prepared to respond to outbreaks of infectious disease.

For their part, authorities have established an Incident Command System (or Emergency Response System) that clarifies roles, responsibilities and procedures during emergencies.

People understand the means of transmission and risks of infectious diseases as well as the best ways to prevent them. They do not see preventive measures as inconveniences but rather as valuable steps that everyone should take to prevent the spread of disease.

Mass media professionals work closely with health authorities to convey accurate and timely information to the public. Communication materials presenting clear guidelines have been produced before any emergency and are ready for quick distribution. Channels for immediate feedback and reporting are well known and can be used effectively.

Our description of the current situation should be factual, concise and verifiable. Again, constructive exploration of differing

opinions may help us arrive at a true consensus. We should make optimal use of the diverse membership of our Communication Response Team to generate a broad view of the current situation.

Illustration of current situation statement

Consider the following example of a primary goal, which matches the example in 2.1, above:

At present, households, communities, animal and human health government personnel are not working together to prepare for an outbreak of infectious diseases. Each of these actors develops their respective prevention plans without coordinating with others. Resources are wasted through duplication of efforts, and often there is conflict among the actors.

There is no existing Incident Command System. Previous efforts to respond to health emergencies were fragmented and did not yield optimal results. While there have been write-ups of lessons learned, it seems that people are not learning from experience.

Most people do not know the means of transmission, risks of infections and means of prevention of infectious diseases. Most engage in risky behaviors and are unaware of the danger they could face if infection becomes widespread.

Mass media professionals are not cooperative and look at health authorities with suspicion. Communication materials have not been prepared. Channels for feedback have not been established, and people do not know where to go for information or to share what they know.

2.3 What will likely happen if we don't act? (current destination)

In this step we will envision what would happen if we continue with “business as usual” or if we do not act. Understanding clearly what could happen, we may be able to strengthen our motivation to act and to motivate others as well. The ‘current destination’ statement helps clarify advocacy message. It is not used in our gap analysis (see 2.4).

Again, we should describe the current destination in a simple and factual manner. Our goal is to motivate people to act, not to create an epidemic of fear. If estimates are made, we should be clear about the source of information and data. For example, the table below shows what could happen in the US under two scenarios, a moderate influenza epidemic and one that is severe.

Table 1. Number of episodes of illness, health care utilization and deaths associated with moderate and severe pandemic influenza scenarios¹⁴

Characteristic	Moderate (like 1958/68)	Severe (like 1918)
Illness	90 million (30%)	90 million (30%)
Outpatient medical care	45 million (50%)	45 million (50%)
Hospitalization	865,000	9,900,000
ICU care	128,750	1,485,000
Mechanical ventilation	64,875	745,500
Deaths	209,000	1,903,000

Source: United States Department of Health and Human Services Pandemic Influenza Plan, as cited in Crisis and Emergency Risk Communication: Pandemic Influenza, Centers for Disease Control, August 2006.

¹⁴ Estimates based on extrapolation from past pandemics in the United States. Note that these estimates do not include the potential impact of interventions not available during the 20th century pandemics.

Illustration of current destination statement

"If we continue to be unprepared for outbreaks of infectious diseases, then the country may suffer significant loss of lives and livestock should an epidemic occur. The economy may suffer as tourists fail to come and traders refuse the country's products and services. The country would be in crisis."

2.4 Why is there a difference between what we want to happen and what is happening now? What are the causes of this difference? Where in the chain of causes will intervention have the greatest impact within the time available?

Given the best points of intervention, who can change the situation? That is, which audience segment(s) should our communication address? Should we focus on certain audience segments on the program side, on client side, or both?

These four questions are interrelated:

- Why is there a difference between what we want to happen and what is happening now?
- What are the proximal and distal causes of this difference?
- Where are the best places to intervene in the chain of causes?
- Who should we engage as audiences in our communication campaign?

Levels of determinants

Most public health problems arise because of multiple causes. They usually cannot be attributed to only one cause. Indeed, the most immediate and obvious causes themselves have deeper causes lying behind them in a chain of causality. For example, the proximal cause of brucellosis is contact with infected meat or placenta of infected animals, or consumption of unpasteurized

milk or cheese. A more distal determinant is poor sanitation and hygienic practices. These in turn can be the result of low health literacy and knowledge. Thus, the difference between what we want to happen and what is happening now can be explained at several different levels.

At the most basic level is a biomedical explanation. For example, the influenza A(H1N1) virus is causing flu. That is the most immediate explanation of infection.

Other determinants are relatively close or proximal, to the difference. Behavioral determinants often fall into this group. For instance, sneezing and coughing without covering one's mouth and nose is a proximal cause. If people change their behavior, this will likely have an immediate impact as it may reduce overall transmission rates.

But we can look further down the causal chain. We can ask why people do not cover their mouths and noses when they sneeze or cough. This could be due to a long habit. It could also be because they may not know that this is important to prevent the spread of disease. We can then ask why is it that they do not know? This may lead us to some structural reasons such as an ineffective health communication infrastructure. Changing the more distal root causes may have more lasting impact. At the same time, however, the impact of addressing root causes may not be immediate.

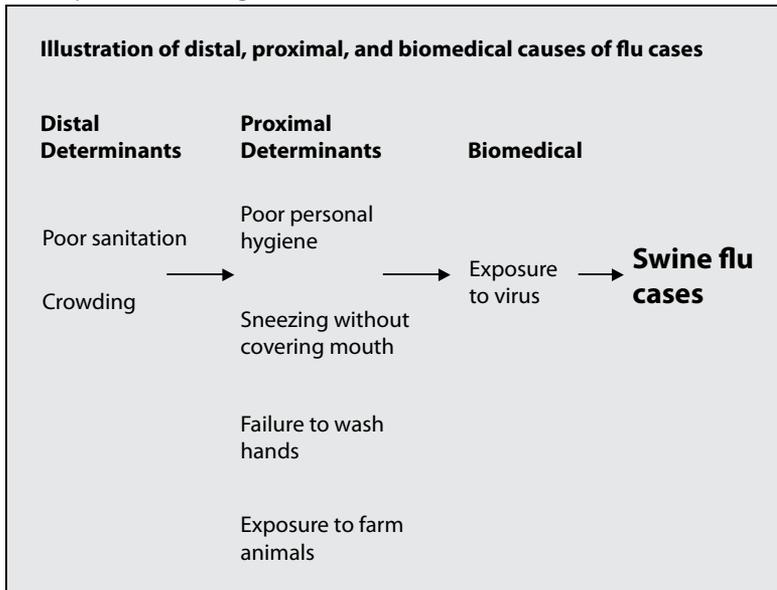
Root cause analysis

One way to look at the entire chain of causes, to decide where to intervene, is to use the 'root cause' analytical technique. In this technique we ask a series of 'why' questions. We ask 'why' of our answer to the question, "why is there a difference?" And then we ask 'why' of that answer, and so on. The idea is to keep asking why until we reach a point when it is no longer practical to do so. The answers should be within our sphere of influence, meaning that we can do something about the situation. The last set of variables when we choose to stop asking 'why' can be considered the root

causes. We can write our answers on cards and post them in causal order on a board or wall to construct a logic tree.

Using root cause analysis, we can track the chain of causes from the bio-medical to the root (see Illustration). Then we can examine each cause in turn and decide where we can best break the chain.

An important strategic choice is the level at which to intervene.



Should we intervene at the bio-medical level? proximal level? distal level? or at all levels? Given that time and resources will likely be constrained, we need to make a decision. We are looking for causes that are (1) susceptible to feasible and timely intervention; and (2), if addressed effectively, will contribute the most to achieving our objectives. If time is of the essence, we may choose interventions at the bio-medical or proximal levels only, e.g. a campaign to prevent exposure to the virus by promoting social distancing and the practice of hygienic habits. If time is available, or if we choose to intervene at several levels in

any case, then root causes become more relevant. In medicine we avoid addressing only symptoms and instead focus prevention and treatment on root causes. Although alleviating symptoms may help reduce discomfort, the condition may continue unless the root causes are addressed. Thus, medical doctors focus on resolving infections even while alleviating fever or swelling, which are the result of infection.

Out of our root cause analysis, our response to the question, “Why is there a difference?” might include the following causes that communication could effectively address:

1. There is no effective communication campaign to educate people about swine flu and how to avoid transmitting it.
2. People do not pay attention to swine flu or similar infectious diseases when the threat is low, e.g. no active cases in the country or in the region.
3. People feel that swine flu is the concern of authorities and that they cannot do anything about it.

Identifying the right audiences

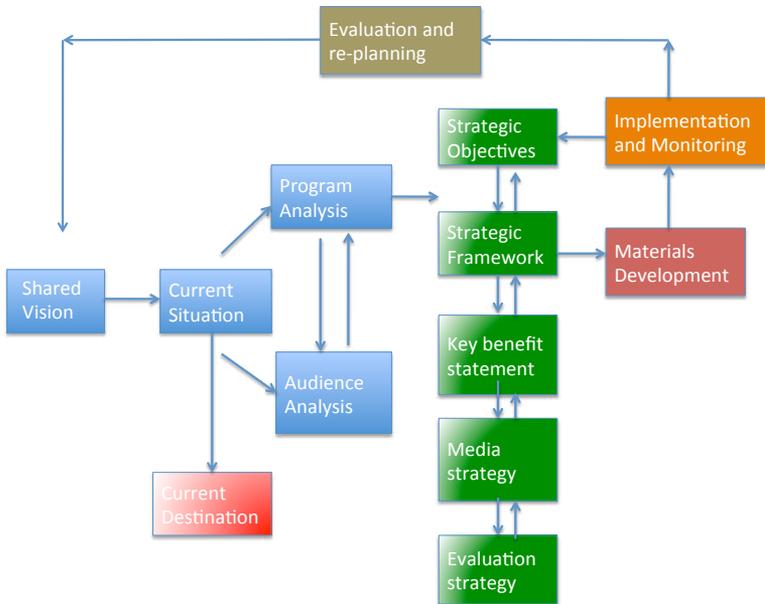
Whether we choose to focus at the biomedical/proximal level or to address more distal determinants as well, we now have to answer the fourth question: “Who should we engage as the audiences in our campaign?”

What we want to find out is who can make a difference to the situation. Who should act or change? Audiences on the program side (e.g. policy makers, program managers, health workers, media professionals)? Audiences or audiences on the client or public side (e.g. women, children, vulnerable populations)? Or some from both sides?

A good way to answer this question is to examine two dimensions—(1) the strengths and weaknesses of our current program as well as the opportunities and threats facing it and (2) the needs and perspectives of our clients or audiences. The first is

called program analysis, while the second is 'audience analysis' or 'audience analysis'.

The illustration below shows the path that we are taking.



Program analysis and SWOT

We usually conduct program analysis first. A technique commonly used in program analysis is the SWOT framework. SWOT stands for strengths, weaknesses, opportunities and threats.

To use the SWOT framework, we ask the following questions:

- What are the strengths and weaknesses (internal) of our health program?
- What opportunities and threats (external) to our program exist?

- Which audiences on the program side could help us make significant strides toward our goals?
- How can we best describe the profile of these audience segments?

The rationale for program analysis is the principle, “To change others, we may have to change ourselves first”. Commercial marketers make a distinction between “product or service problems” and “selling problems”. If a product or service has defects, we may need to address these defects first before promoting our product or service in the market. If we do not, our sales could trigger complaints about the quality of our product or service. Program analysis aims to identify and address weaknesses in the program that limit the program’s effectiveness or could make the clients—that is, the public—unhappy.

It is useful to start with a review of the literature. There may be existing studies on program strengths and weaknesses. We assume that we will not have time to commission new studies. Assuming that our Communication Response Team consists of people who are familiar with the capabilities of the agencies represented in our team, we may be able to reach consensus quickly on our strengths and weaknesses as well as the opportunities and threats that we face. Using SWOT analytical techniques, we can explore the program weaknesses and identify corresponding audiences that we would need to reach to add strength.

Audience segmentation and analysis

From the results of our audience analysis, we expect to identify the audience segments that we aim to reach. We call this process ‘audience or audience segmentation’.

Audience segmentation is the process of dividing audiences up into logical groups to improve the fit among audiences, messages, products and services, and channels. As an illustration of the concept of fit, television may not be the best medium in rural areas where few people have access to it. Another example is

the point that radio may not be the best medium for selling cars, as the visual appeal of a car is a major selling point. Television or print would be a better fit.

It is tempting to try communicating to everyone rather than to segments of the population. If we do not segment our audiences, however, we risk developing a communication campaign so general in scope that it seems to address no one, and then no one makes significant changes as a result. We segment audiences for three reasons:

1. Groups of people have different information needs and differ as to what benefits or presentation appeals to them
2. We may not have enough resources to reach everyone.
3. We need to choose between intensity and reach.

Intensity describes the number of times an intended audience receives a message. Reach refers to the number of intended audiences exposed to our campaign at least once. There is a trade-off between intensity and reach. When intensity is high, reach is relatively low, and vice versa. Resources spent on intensity cannot be used to increase reach and vice versa. For instance, we can either broadcast our spots in all radio stations (wide reach) or use only a few radio stations in a specific geographical area (high intensity). We can also choose to distribute 10,000 posters throughout a country (wide reach) or distribute this number in only three provinces, states or regions (high intensity).

After conducting our program analysis, we then consider potential audiences on the client side. In audience analysis we usually look at the bio-medical or proximal levels of determinants, since that is where human behavior usually falls in the causal chain. We may consider interventions that focus on biomedical measures such as medications, immunizations and personal hygiene.

Audiences to consider:

Program side	Client or audience side
Donors	Women
Policy makers	Children
Program managers	Farmers/poultry growers
Human health workers	Senior citizens and noncitizens
Animal health workers	Youth
Media professionals	Employers
First responders	Travel industry workers
Private practitioners	Teachers and school administrators
Pharmacists	Officials at correctional facilities
Leaders of civil society organizations	Food industry workers
Hospital administrators	
Border officials	

Understanding the nature of the disease that we are addressing helps us decide whom to address. For instance, if the disease is food-borne, then food industry workers, farmers and poultry growers may be important. If the disease is transmitted by skin contact or through coughs and sneezes, we may want to focus on travel industry workers, schools and universities, correctional facilities, etc.

To help segment audiences on the client side, we also can answer the following questions:

1. Who are the most vulnerable populations?
2. Who are the most likely transmitters of the disease?
3. Who can make a difference to the public's behavior? For example, schools? parents?

4. Who can help disseminate our messages? For example, school children? religious leaders?

The two tables below illustrate how our analysis can help determine who our intended audience should be and the type of communication intervention that we can consider.

Illustration — Program side

Needs/ Weaknesses	Audiences	Communication Interventions
Policy	Policy makers	Advocacy
Non-material resources	Program managers, health workers	Enlist/assign effective leaders
Financial resources	MOH/MOA/MOI Parliament/Congress Donors	Resource generation campaign
Human resources	Program managers, health workers	Enlist help from other sectors
Community resources	Health workers	Community mobilization
Client support	Health workers	Client support campaign
Management	Program managers	Enlist/assign effective managers
Monitoring and evaluation	Program managers/ researchers	Enlist/assign researchers from universities and research institutions

Illustration — Client side

Needs/ Desired behaviors	Audiences	Communication Interventions
Knowledge	General or specific populations	Knowledge campaign
Attitude or agreement/ disagreement	General or specific populations	Attitude or persuasion campaign
Individual behavior change		Behavior change campaign
Social or group behavior change	Social groups/ community organizations	Social or group behavior change campaign
Maintenance of behavior	General or specific populations	Behavior maintenance campaign
Help others	General or specific populations	Personal advocacy campaign

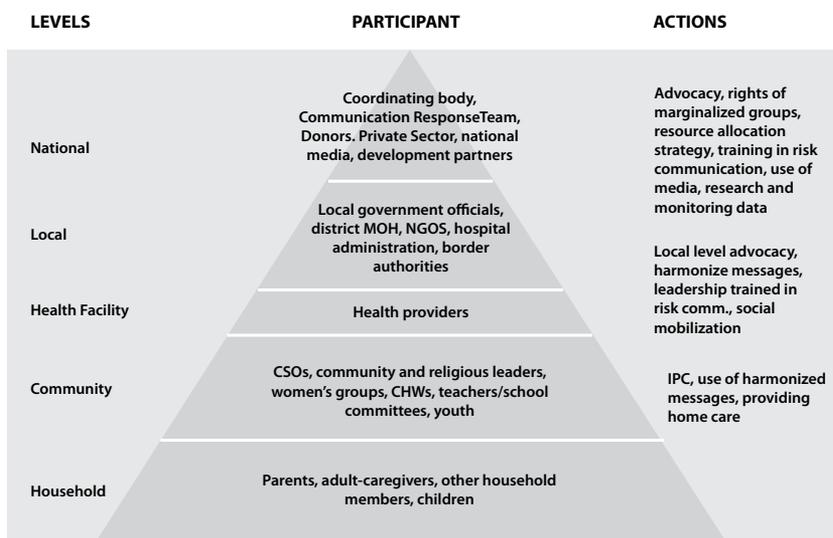
These two tables above give us an overall picture of the range of needs that we may have to address, the audiences that we need to engage and the type of communication intervention that we may have to use.

Another way to synthesize what we have discussed and to help us segment our audiences is to use UNICEF’s Communication for Pandemic H1N1 Influenza Response Framework (see Illustration, next page). On the left side, are level at which we may choose to operate, ranging from national to community or household level. In the middle (within the triangle) are the possible audiences that we may want to reach. On the right are actions that we may consider.

UNICEF's Communication for Pandemic H1N1 Influenza Response Framework

Source: Social Mobilization and Behavior Change Communication for Pandemic Influenza Response: Planning Guidance, Academy for Educational Development, September 2009

2.5 How can we prioritize our audience segments within the context of our communication objectives?



This may be one of the most challenging tasks that we face. Because resources are scarce, we cannot reach everyone, and so we must prioritize our audiences. There are many considerations, and some of them may be controversial.

A practical approach is to consider our primary goal and to determine which audience segment could best help us achieve it. This should be largely a question of science. For example, if the primary goal is preventing the spread of disease, which audience segment could most help reduce the spread of disease? Or, if the primary goal is reducing the sum total of suffering, which audience segments are most vulnerable to infection and likely to suffer most from its consequences? We must consider at the same

time how much our efforts—that is, communication—can benefit the audience group in question. For example, a poor population in remote mountains might suffer greatly in an epidemic. If messages cannot reach them, however, or they have no power to act on the messages, they may not be the most appropriate focus for communication efforts.

Values also come into play in prioritizing audience segments. One ethical criterion that is widely used in public health, although seriously questioned by many, is the ‘fair innings argument’. The fair innings argument takes the view that there is some span of years—perhaps 70 years—that we consider a reasonable lifespan (for a person to have had ‘fair innings’). In this view anyone who does not reach 70 has been short-changed, while those over 70 have received a bonus. Thus, according to this argument, life-saving resources should go first to those below the threshold age.¹⁵

In practice, decisions about segmentation also are difficult because, like any other allocation of scarce public resources, they arouse political interests. Each group will use its political power to try to assure that resources come to it. The groups with the greatest political power, however, are not necessarily the groups that science or ethics would give the highest priority.

Similarly, most members of the team, such as international organizations, government ministries, and NGOs, have organizational mandates to serve certain populations. Each will naturally tend to see prioritization from the viewpoint of those it serves and to champion their interests. Thus, even within the team decisions about prioritizing audience segments are likely to provoke debate.

15 The fair innings criterion, however, becomes debatable if a choice has to be made between, for example, an 18-year-old who uses recreational drugs and has no job and a grandfather who is devoted to his grandchildren and does volunteer work to help the poor. From this point of view a different criterion may seem more appropriate: Who will make the most contribution, if they live a full lifetime, to the welfare of society as a whole?

2.6 Who are the key people in our audiences' social networks who could introduce information and encourage behavior change in the network?

Almost everyone belongs to a social network. Communication does not happen in a vacuum but instead always occurs within a social and cultural context. Networks often influence behaviors by transmitting (or suppressing) certain information rather than other information or by adding a value judgment to information. Why do some social networks transmit information more quickly and farther than others? What are the shared priorities and interests of a network's members that influence what they communicate with each other? Answers to such questions can help us design communication more effectively.

Social group networks are important in our work. Reaching the right people in the right network can result in rapid spread of the message through the network. Thus, we need not reach everyone (as is necessary in a broadcast network, by comparison), but instead we reach the pivotal people in a social network and rely on the natural communication patterns to spread the word within the network.

Identifying and making use of the influential people in our audiences' social networks can take creative thinking. For instance, children have proved to be an effective communication channel to reach parents. Health behaviors that children learn in school (e.g. frequent washing of hands, covering of mouths when coughing or sneezing) may transfer to parents upon their children's encouragement.

2.7 How do we put ourselves into the shoes of our intended audiences? How do we develop a clear image of our audience segments?

To communicate with the intended audiences, we need to understand them. In an emergency situation, we need to understand them quickly. We can quickly review existing survey data and research literature. The experience of key stakeholders

also could help us understand our audience segments, but we may not have time to commission new formative research.

A key task is to develop a psychographic profile of our typical audience. A psychographic profile is a description of a audience segment that includes psychological variables, such as motivation, emotions, attitudes, outlook on life, and lifestyle, and not just demographic information. (In contrast, a demographic profile would focus exclusively on demographic variables—age, gender, education level, income level, religion, etc.) Profiling an imaginary individual who would be typical of the group, and giving him or her a name, works better than compiling a dry statistical description of the group as a whole. To imagine communicating with an individual person helps everyone on the team be creative.

Illustration of a psychographic profile on the program side

Peter Smith is a joint secretary in the Ministry of Health. As a long-time civil servant, he is used to handling competing priorities. At present, the Minister of Health has been pressuring him to address several issues that donor agencies have been raising. On top of this, he has to meet deadlines to submit the health budget for the following year as well as to defuse a conflict among his immediate staff. His usual approach is to address the most pressing issue of the day. Developing a preparedness plan for swine flu is at the bottom of his priority list since not a single case has been reported in the country yet. He is annoyed that the news media are highlighting the ministry's lack of preparedness to address swine flu.



Illustration of a psychographic profile on the client side

John is an accountant working in the capital city. He is well versed in his field but hardly has time to learn more about other issues. He skims the newspaper but listens more to music when he is relaxing than to broadcast news programs. He hardly watches TV. He knows very little about avian flu, how it is transmitted and how one can prevent it. His family likewise lacks information about avian flu. They erroneously believe that, since they live in the city, they do not need to worry. John is worried, though, about whether he can go to football games if there is some threat of an epidemic. He does not think he or any member of his family is vulnerable to avian flu.



It can be helpful to choose a portrait photo to represent our profiled audience. Having a photo, we can more easily imagine how the audience looks and feels. This photo can be enlarged and posted in work areas to remind everyone who our audience is.

We may also want to review the Points to Consider presented in the Worksheet (see below).

Points to consider when profiling a audience segment

To understand our audiences, we may want to consider how they stand with respect to the following: (If data are not available, please make a best estimate.) Our answers can help us design more effective messages in the next worksheets.

	Low	Medium	High
1. Knowledge of means of transmission			
2. Knowledge of means of protection			

3. Fear levels about the issue
4. Perceived social support available
5. Perception of own efficacy (confidence to act) in general
6. Perception of efficacy, in general, to respond as a group
7. Perception of own efficacy to practice specific protective measures
8. Perception of group's efficacy to practice specific protective measures

In this chapter, we have clarified our primary goal and described the current situation. We have also predicted where the current direction would lead us if we do not act. We also have determined why there is a difference between what we want to happen and what is happening now and where we might best intervene. Now we are ready to determine our communication strategic objective and choose the strategy that we will use.

THE SIX QUESTIONS

1. What is the communication problem?
2. What do we need to do?
3. What creative approaches and materials do we need to develop?
4. How do we make things happen?
5. How do we know that we are making progress and achieving our desired impact?
6. How do we learn from experience and plan for continuity?

CHAPTER 3 – WHAT DO WE NEED TO DO? (STRATEGY DEVELOPMENT)

Chapter Goal

Worksheet 3 helps us define our strategic communication objectives, the key message/benefit that we want to convey and our overall strategic approach. The worksheet also helps us determine the communication channels that we plan to use.

The next stage in our process is to answer the question, “What do we need to do?” Based on what we have learned in the analysis stage, we now can develop the communication strategy that will best fit the situation. Our strategy is one of the most important elements in our plan. It provides the driving force to everything that we do. Our strategy should provide synergy, consistency, harmony and direction to all our actions.

Our strategy should specify:

1. The specific action(s) or change(s) that we want our selected audience segment to make (Strategic objectives). We base these objectives on our analysis of the situation and the public health goals set by health authorities.
2. The benefit that will best motivate our audience segment to act or change as we intend (Key benefit).
3. The positioning statement that will best frame and deliver our message ('Big idea,' or creative approach).
4. The communication channels, or media mix, most appropriate for our audiences (Media mix).
5. How we will know whether we are on track and having an impact (Monitoring and evaluation).¹⁶

The following questions will guide our strategy decisions:

3.1 What are our communication objectives? What do we want our intended audiences to do, and when?

Our strategic objectives should clearly specify two things: the WHAT—what we want our audiences to do—and the corresponding WHY.

We can base the WHAT of our strategic objective on the reasons for the difference between our primary goal and the current situation. Through root cause analysis we can identify what changes will best achieve our primary goal. Bringing about these changes will be our strategic objectives.

We also can and should derive our strategic communication objectives from the larger public health objectives defined by health authorities. For instance, in a pandemic flu situation, public

¹⁶ While we monitor throughout a project and evaluate at the end, we need to design these processes early. Thus, monitoring and evaluation are normally part of the strategy design process. Worksheet 6 poses the questions concerning monitoring and evaluation, and Chapter 6 is the corresponding guide.

health measures may include isolation, quarantine, social/physical distancing and the closing of public gatherings and schools, as took place during the 1918 flu pandemic and during recent disease outbreaks such as SARS. If such orders are given, our communication objective may be to enhance compliance with these measures.

This example illustrates how the WHY is important to strategic objectives. When we ask people to change, we have a reason. If we do not clearly state WHY, however, people may not be convinced, and they may even be suspicious. The same WHAT with different WHYS are not the same things. If health authorities restrict freedom of movement and limit gatherings, we need to explain that the reason is to slow the spread of infection, and not to punish people. If people understand the reason, they may be more supportive.

Communication objectives are different from program goals. For instance, communication campaigns focus on increasing knowledge, changing attitudes and encouraging specific behaviors, and not reducing or containing disease. That is a public health goal, and the communication objectives should contribute to achieving it. Communication professionals recognize that communication is just one component of a larger effort.

As discussed in Step 2 (Chapter 2), we can have two sets of audiences—those on the program side, such as policy-makers, program managers, health care workers, media professionals and donors, and those on the client, or audience side, such as household heads, women, children, vulnerable groups and adolescents.

If our audiences are on the program side, our strategic objectives might be to bring about such behaviors as the following:

- Allocate more resources to address the emerging disease or imminent epidemic
- Implement the health policies or protocols that have been decided upon

- Serve as communication channels to help reach our intended audiences on the client side
- Authorize or help to enlist human resources from other sectors.

Illustration – Communication Objectives

By time X, 75% of the adult population will:

1. Know the importance of staying home when one feels ill
2. Keep their distance from someone who is coughing or sneezing
3. Cover their coughs and sneezes
4. Wash their hands with soap and water.

By comparison, for audiences on the client side, our objectives might be to bring about adoption of four specific behaviors that communication efforts have focused on in recent outbreaks:

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

Experts note that evidence is conflicting as to whether these measures can mitigate pandemic flu. Still, it is reasonable to promote these behaviors in pre-pandemic phases. Some specifically noted that international organizations such as UNICEF can play an important role in these efforts.¹⁷

The following table lists the behaviors that WHO and UNICEF recommend to prevent and contain infectious diseases such

¹⁷ Mapping and Reviewing of Existing Guidance and Plans for Community-Based Communication to Prepare and Respond to Pandemic Influenza, UNICEF, 2009

as avian influenza and swine flu. When a vaccine is available, encouraging people to be immunized and explaining where to get the vaccine would likely be key communication objectives.

WHO/UNICEF recommended behaviors

To reduce transmission of respiratory diseases:

- Keep a distance from someone who is coughing or sneezing
- Stay home if you feel ill
- Cover your coughs and sneezes
- Wash your hands with soap and water.

To lessen health impact:

- Give sick people a separate space in the home
- Assign a single caregiver to a sick person
- Give the sick person plenty of fluids
- Recognize danger signs and seek prompt care.

Source: WHO/UNICEF. Behavioural interventions for reducing the transmission and impact of influenza A(H1N1) virus: a framework for communication strategies. 2009.

In formulating our communication objective, we should describe the intended behavior clearly, in measurable terms and within a specific time frame. A good communication objective follows the SMART criteria:

3.2 What are some expected barriers that could prevent our audiences from changing?

SMART Communication Objectives

Specific
Measurable
Action-oriented
Reach high
Time-bound

Changing behavior is much easier if there are no barriers to prevent audiences from changing. Unfortunately, this is rarely the case, and it is also likely that there are incentives for people not to change. If we understand our intended audiences, however, and know what these barriers are (or incentives not to change), we can work to overcome them.

Some of the more common types of barriers to behavior change are:

- Inertia or habit: People are more comfortable doing things the same way that they always have done.
- Fear: People anticipate some negative outcomes of the change.
- Lack of confidence or low self-efficacy: Some do not believe that they can change.
- Potential embarrassment. If the new behavior is not already common, some may not want to be seen as different.
- Negative experience: Some audiences may have experienced poor management of health crises and may be cynical or resistant to change.

We can help people to overcome each of these barriers. To do so, we need to understand what they are and how they prevent our intended audience from acting.

In an impending or ongoing epidemic particularly, managing fear is key. For people to appreciate a health threat, it may be necessary to raise their level of fear. Fear arousal requires careful handling, however. Too much fear can paralyze people into inaction. Too little fear arousal may leave people indifferent.

Here are more examples of communication objectives:

- I. After our campaign (by time X), the following would have become the norm:
 1. Use a tissue to cover the mouth and nose when coughing or sneezing
 2. Use their upper sleeves if they don't have a tissue
 - By time X, the public will have greater confidence in taking collective action to prevent panic and hysteria. They will have greater trust in government and civil society and will work with them to help prevent the spread of disease.

Research findings suggest that we should not increase fear levels without at the same time suggesting what actions people can take. People are less fearful when they feel that they can act to stave off a threat. Knowledge, skills and cues for action should be provided along with suggestions for action. Kim Witte has developed a guide for framing messages involving fear arousal.¹⁸ In 2006 the Egyptian government, in collaboration with the Johns Hopkins Bloomberg School of Public Health, applied this model to prepare successfully for avian flu. See boxes.

¹⁸ Kin Witte. Putting the Fear Back into Fear Appeals: The Extended Parallel Process Model. Communication Monographs, Volume 59, December 1992,329-349.

Extended Parallel Process Model

Witte's Extended Parallel Process Model (1992) seeks to explain both when and why fear appeals work and when and why they fail or even have counterproductive effects.

People can be so frightened that they cannot act. They deny or defensively avoid facing a threat. Or fear can motivate change; people perceive a risk and take action to reduce it. According to Witte's model, how people react depends on their evaluation of the threat presented and of the recommended action to counter that threat.

First, people appraise the threat described in a message. The greater and more relevant the threat seems, the more individuals believe that they are susceptible to a serious threat and the more motivated they are to begin the second appraisal--an evaluation of the efficacy of the response recommended. If, in contrast, people perceive the threat as irrelevant to them or insignificant, then they have no motivation to process the message further, and they simply ignore the fear appeal.

Witte suggests that fear arousal messages need to address four questions:

- Threat (fear) component
 - Severity of threat: Is it serious, or severe?
 - Susceptibility to threat: Can it happen to me?
- Efficacy (response) component
 - Response efficacy: Does the response work?
 - Self-efficacy: Can I do the response?

Witte points out that increasing the threat component of a message without a corresponding increase in the efficacy component could lead to such undesirable results as panic or paralysis.

This model can apply to group behavior as well as to individual behavior: Can this happen to us? Can we, together, do the response?

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Case Study – The Egyptian Avian Flu 2006 Rapid Response Campaign

To address the threat of avian flu in 2006, the Egyptian government in collaboration with Johns Hopkins University conceived a communication preparedness plan. The goals of the plan were to increase:

- Knowledge of:
 - transmission modes
 - symptoms in humans
 - symptoms in birds
 - protective behaviors
- Efficacy to practice protective behaviors
- Practice of protective behaviors.

Preparations began well in advance of any outbreak. Storey and Hess applied Witte's model to design messages that addressed the threat of avian flu in Egypt.

Severity

- Getting an avian flu infection would be very serious.

Susceptibility

- It is possible that I could get infected with avian flu.

Response efficacy

Correct handling of live birds is an effective way to avoid becoming infected with avian flu.

- Correct handling of poultry for food (washing and cooking birds and washing hands and utensils) is an effective way to avoid becoming infected with avian flu.

Self-efficacy

- I am confident that I can protect myself from becoming infected with avian flu.

For a collective, or group context, the campaign offered these messages:

Severity

- Avian flu is a serious problem in Egypt.

Susceptibility

- It is possible that the avian flu problem in Egypt will increase in the coming days.

Response efficacy

- Correct handling of live birds is an effective way to prevent a national epidemic of avian flu.
- Proper handling of poultry for food (washing and cooking birds and washing hands and utensils) is an effective way to prevent a national epidemic of avian flu.
- Collective efficacy
- I am confident that Egypt can avoid a national epidemic of avian flu.

On February 17, 2006, the first H5N1 cases were confirmed. That same day the government launched the pre-planned national campaign. Within 24 hours TV spots had reached 86% of Egyptian adults (PARC Media Monitoring, 2006). Three months later 71% of people surveyed reported take at least one new protective

action (EHCS, 2006). The public was impressed with the speed of the government's response because all communication materials were prepared beforehand.

3.2 What benefits would best persuade our intended audiences to change their behavior?

We want people to wash their hands, stay at home when ill and cover their mouths when they cough or sneeze. Why would they want to do so? What benefit will they get from doing so? Identifying and clearly presenting key benefits is crucial to effective messages.

Every message should offer a key benefit that encourages the intended audience to change. Simply repeating the desired behavior, such as "wash your hands," "stay home when ill" or "cover your mouth when coughing or sneezing", is not likely to be as effective as also describing a key benefit.

In general, benefits fall into one of these groups:

- 1. Social approval** – this is what others expect of you
- 2. Prestige**—doing something that is respected or envied by society.
- 3. Fear reduction**—decreasing fear by acting as suggested
- 4. Health and life enhancement**—perceived health benefits, avoidance of pain, disease or death
- 5. Economic**—action could lead to saving money or making money
- 6. Conformity**—everyone is doing what is suggested.

Many—perhaps most—benefits include a social element in their appeal. People behave as they do in part because they want others to approve of them, to like them, or to be attracted to them.¹⁹

The statement of the key benefit guides creative directors and writers to develop messages and materials that will best convey the key benefit. The exact words of the key benefit statement will not necessarily come out in the messages. Rather, the creative directors and writers will seek to express the key benefit statement in the most effective language and creative presentation. Also, the key benefit statement serves as a brief or instruction to spokespersons to guide their interactions with the news media.

It is important to remember that the key benefit should be seen from the perspective of our audience segment. It is up to creative directors, producers or script writers to couch the key benefit in ways that appeal to the people addressed.

How can we decide on the key benefit? If we do not have time for formative research, but we can quickly review available information to decide what benefit to highlight. There may be findings from recent focus group discussions, sample surveys and observation methods (even if these concern other health issues). From these we may be able to deduce which type of benefit would appeal most to our audience segment.

Choosing the one key benefit for a group of intended audiences and promoting that one benefit is crucial. The point is to associate the key benefit with the product or behavior in people's minds. As a result of years of promotion of the same benefit, people easily think of 'luxury' when they see a Mercedes car or 'safety' when they hear mention of Volvo.

¹⁹ Charles Revlon of Revlon Cosmetics has been quoted as saying, "In the factory we make cosmetics. In the store we sell hope!" Every marketing professional knows that merchants do not sell toothpaste. Instead, they sell the benefits—"white teeth" or "beautiful smile"—to make the user more attractive to others, "fresh breath"—to avoid embarrassment, or "cavity-free"—to avoid pain and cost.

In communication to reduce the spread of infection, a key benefit with a strong social element may be especially important while there is no vaccine available. Behaviors such as covering one's mouth and nose while sneezing and staying home if ill do not protect the person performing the behavior; there is no direct health benefit to that person. Instead, these behaviors protect others from being infected by that person. Thus, messages will need to imply an underlying social benefit for people who adopt these behaviors—for example, others will approve of them or will be more willing to be near them. In contrast, promotion for vaccination can invoke the direct benefit of personal protection as well as social benefits (see box).

The key benefit may differ for different messages and audience groups. Livestock farmers may find an economic benefit more important than a personal health benefit. Even with the same message, the key benefit for different groups may be different. For example, promotion of sneeze and cough etiquette to children and to mothers is likely to evoke different benefits.

3.3 Framing our message

Illustration of a key benefit statement to promote vaccination

If you choose to be vaccinated against H1N1 influenza, then you will benefit by:

- 1. Reducing your personal risk in contracting H1N1 influenza
- 2. Having the satisfaction that you have contributed to controlling the spread of this disease to your family and community
- 3. Staying healthy so that you can care for your family.

Hand in hand with choosing the key benefit goes the concept of positioning our message. People receive messages within a particular context, not in a vacuum. How we frame a message shapes this context. Positioning the message is one of the most important steps in effective communication. An appropriate position to aim for in most outbreak communication is that of credibility and trust. We would like our intended audience to regard us as caring, competent and credible sources of information.

An example illustrates the concept of framing: If we ask someone to lift a series of weights starting with 5 kilograms, 6, 7, 8, 9 and lastly 10 kilograms, that person will likely describe 10 kilograms as heavy. On another day, if we ask the same person to lift a series of weights starting with 15 kilograms, 14, 13, 12, 11 and lastly 10 kilograms, that person will probably describe 10 kilograms as light. In this example the series of weights provided different frames, or contexts, which led to differing perceptions. The people who framed maternal health as 'safe motherhood' have couched maternal health in terms of a highly valued role. Similarly, the term 'child survival' frames child health.

When we say that pre-testing is an investment and not a cost, we have framed the idea of pre-testing as an essential step, not a luxury that can be cut when resources are scarce. Similarly, we can frame emergency preparedness as a prudent investment, not a wasteful cost.

It is important for us to understand our audiences' experience in recent health emergencies so we can frame our messages in a more appropriate manner. Most likely, this is not the country's first health crisis or the first communication campaign to address a health crisis. Our audiences probably have seen health crises before. Depending on their experience, some may be cynical or skeptical about our messages, or they may have expectations higher than we can meet.

For example, if pandemic alert levels were raised recently, but the disease did not cause as many deaths or illnesses as expected, some people may not give much credence to future warnings and calls for safety measures.

Inconsistent policies in the past also can be damaging. For example, if poultry growers were reimbursed for culling their flocks but pig farmers were not reimbursed immediately, no doubt there were complaints and unhappiness. This could make pig farmers suspicious, resentful of and resistant to our initiatives. This happened recently in one country in the Caucus region. Authorities told pig farmers to cull their pigs and informed them that “international experts” would determine how they will be compensated. It took more than a year for them to be reimbursed. Since actions are eloquent messages, authorities could have expressed their care for pig farmers who have just lost their livelihoods by giving them modest loans. The farmers could pay back these loans when reimbursements are paid. Most farmers unfortunately live on a hand to mouth existence and culling their livestock is disastrous.

3.4 What is the ‘big idea’, or creative concept, that can frame our campaign?

Now that we have defined our key message, one that conveys the behavior change that we seek and the corresponding key benefit, our next step is to decide on the ‘big idea’, the creative concept or approach that would best communicate our message. By ‘big idea’, we mean a visual or aural hook or concept that gives our campaign high visibility and greater memorability.

An example of a “big idea” is the Johns Hopkins Hospital’s highly successful “WIPES Hand Hygiene campaign which produced a threefold increase in hand hygiene compliance rising from 21% in October 2007 to 66% in January 2009. WIPES is an acronym for:

- W**ash/clean hands
- I**dentify and isolate early
- P**recautions use (gowns, mask and gloves)
- E**nvironment kept clean
- S**hare the commitment, raise your hand.

The 'big idea' was the symbol of a raised hand with fingers spread to represent the five points of the acronym WIPES. The raised hand became a crucial behavior that addressed a key barrier. Research showed that junior hospital staff members were reluctant to remind senior staff to observe hand hygiene. The raised hand became a combined greeting and farewell gesture as well as a reminder to observe hand hygiene. Posters were made featuring top University officials such as the university president, hospital director and department heads raising their hands accompanied by the WIPES messages. (Photos of posters to be placed here).

Another example of a "big idea" is the ubiquitous red ribbon that is universally recognized as the symbol of the fight against HIV/AIDS. This widely popularized symbol has helped increase awareness about HIV/AIDS and has linked diverse communication campaigns around the world. Similarly, people all over the world know the location of a McDonald's hamburger outlet when they see its big 'golden arches'. Those yellow arches are the big idea.

Once we have agreed on our 'big idea', we should pre-test the entire approach. Pre-testing is a process of asking representative members (we may not have time to draw a random sample) of our intended audience groups, as well as stakeholders such as donors, policy makers, program managers and health care providers, to evaluate our concept or message. Pre-testing is an investment, not a cost. While pre-testing may take some time and money, the knowledge it returns can be crucial. The purpose of pre-testing is to make sure that our approach appeals to the perspectives and ideas of our audiences and stakeholders. Pretesting should also reveal any unintended errors or gaffs that could prove controversial or embarrassing. Based on our analysis of the feedback, we can then make appropriate revisions. Pre-testing before production helps avoid costly mistakes.

3.4 How can we best disseminate our messages? What is our media mix?²⁰ (media plan)

Our next step is to develop our media strategy—to choose communication channels, or the media mix, that will be most appropriate for our intended audience. We need a media plan that will define:

- Which combination of media we will use
- How often we will use each medium
- The timing and deployment of our media use
- Our investment in each medium.

A key question in developing our media plan is, “Which is more important to reaching our strategic goals—reach or intensity?” Reach is the total number of households or individuals reached by a particular campaign. In contrast, intensity refers to the average number of exposures that each household has throughout the campaign.

Within any given media budget there is a trade-off between reach and intensity. Resources spent on one cannot be spent on the other. For example, we can either choose to broadcast radio spots across all stations (broad reach) or concentrate (high intensity) on a few stations catering to a specific segment. Similarly, we could also choose to distribute 10,000 posters all over the country (reach will be high but intensity may be low) or to distribute the 10,000 posters only in selected provinces (intensity will be greater but reach will be less).

In general, we may aim for broad reach when there is an epidemic and everyone needs to know what to do. Alternatively, we may choose to go for intensity if the outbreak is concentrated in one geographical area or audience segment or if the behavior that we want to change is complex and challenging for the audience.

²⁰ See UNICEF media comparison chart in the references section

We can also have a mix depending on messages. For messages to the general population on avoiding transmission, we may choose to go for broad reach. On the other hand, if messages specifically address poultry growers or pig farmers, we may want to focus on media designed to reach them such as farm journals, farm programs on radio, etc.

3.4.1 What are the media preferences of our intended audiences?

Our intended audiences are the primary consideration for our choice of media. If most of our intended audiences are illiterate, we would not want to use print media. If most of our intended audiences listen to the radio, we may want to make radio our primary medium and use other media as support media.

While mass media broadcast to a wide audience, we may be able to focus on our audience segment through careful selection of time of broadcast and the type of program that serves as a platform, e.g. sports events when our audiences are males or young people or broadcast programming for children when they are our intended audiences.

3.4.2 Which will be our primary media? Which will be our secondary media? How much resources will we allocate for each medium in our media mix or media plan?

There is no magic medium. What counts most is craftsmanship, how we use each medium. A well produced radio spot may prove to be more effective than a poorly produced TV spot.

At the same time, however, each medium does have intrinsic advantages and disadvantages. For instance, television and film can present attractive visuals. We can place music on radio. Print can provide more information. The table below compares the different media.

Medium	Advantages	Disadvantages
Print	<ul style="list-style-type: none"> • More permanent record • Mass coverage or local • General audience or special interest • Details possible • Low initial cost • Authoritative/influential • Tangible, can be passed along 	<ul style="list-style-type: none"> • For literates only • Reproduction quality/color may be poor • Limited design or make-up control
Radio	<ul style="list-style-type: none"> • Immediacy • Low production cost • Flexibility • Mass coverage or local • Some selectivity • Broad reach • High frequency possible 	<ul style="list-style-type: none"> • No visuals • Often must share listeners' attention • Fragmentation (people failed to tune in the beginning of message) • Transitory
Television	<ul style="list-style-type: none"> • Intrusive—sight, sound, motion • Reach or frequency • General audience but some selectivity • High prestige 	<ul style="list-style-type: none"> • High costs of production • Long lead time for production • More urban than rural, higher income than poor • Limited availability

Outdoor/transit	<ul style="list-style-type: none"> • Boosts identification and awareness • Support media/reminder • Directional/functional (e.g. "this way to clinic") 	<ul style="list-style-type: none"> • Limited messages • Reproduction quality/color • Variable visibility/fading/ wear/dirt
Folk media	<ul style="list-style-type: none"> • Audience familiarity • Audience engagement • Culturally appropriate 	<ul style="list-style-type: none"> • Limited reach • High cost • Limited number of skilled performers

The medium needs to fit the message. For example, if we need to show the symptoms of a disease, TV or print will fit, but radio will not. If a well-known personality is our spokesperson, radio and TV appearances may work better than print.

In an emergency speed is crucial. Generally, radio would be fastest to get out a message. In fact, people are accustomed to turning on their radios when important events are developing rapidly and they want the latest news. Also, it is easy to update information on the radio. In areas where people have high access to the Internet, we may also want to use the World Wide Web for quick transmission of messages.

We may also consider which media policies are relevant to our campaign. For instance, we may be able to secure free air time or print space to communicate emergency messages. We may also want to know media policies about privacy of patients and confidentiality of certain information.

Another key question is, “How can we achieve optimal synergy in our media selection?” One good practice is use of the “one sight, one sound” principle. This principle calls for using the same logo, key message, music theme, or actors in all materials. Often it is the ‘big idea’ that ties all materials together. The ‘one sight, one sound’ principle gives audiences a cue that materials and messages are part of one campaign. For example, the characters in a drama conveying our message can also appear in posters, brochures and other printed materials. The ‘one sight, one sound’ principle gives audiences a cue that materials and messages are all part of one campaign.

Another way to increase synergy is to use secondary media in support of the primary medium. Often a medium that is less costly but has less impact, such as billboards, supports a more expensive primary medium, such as TV. Or we may use radio to provide attention-getting music and then support it with greater depth of information in print.

Social Media

A recent development in media use is the rapid growth of social media. Social media are the various electronic tools, technologies and applications that facilitate interactive communication and content exchange, enabling users to move back and forth easily between the roles of audience and content producers. Examples include Wikipedia, Facebook, Flickr, YouTube, and blogs.

3.4.3 Which media scheduling technique best fits our objectives and resources?

A media plan or schedule describes the media to be used and the number and timing of placements for each medium. Some specialized practitioners of advertising focus on drawing up such plans and buying media time and space.

Tips for Using Social Media

Experts on the use of social media in risk communication offer tips for using social during emergencies.²¹ Some of these tips include:

Make social media efforts message-driven, not channel driven.

- Avoid elitism—the belief that the people in charge know more and that the general public behaves irrationally.
- Use social media to support a unified message that is also spread by other media. Do not create a new message for social media.
- Make sure you can receive public input.
- Make use of every possible teaching opportunity

There are three types of media schedule.²¹

1. Continuous. Continuous and sustained advertising with little or no variations in pressure. Used primarily when we have:

- Serious health problems, such as some epidemics;
- Many lives are at stake, as in certain pandemics or epidemics, or
- Long-term issues, such as HIV/AIDS, malaria, or hepatitis.

2. Flighting. Flighting refers to periodic waves of advertising interspersed with periods of total inactivity. We use this type of schedule when:

- Resources are scarce, and we cannot afford continuous advertising.
- There is potential for audience fatigue. People may tire of

²¹ Special Report: Expert Round Table on Social Media and Risk Communication During Times of Crisis: Strategic Challenges and Opportunities. Timothy Tinker, ed. Booz Allen Hamilton, Inc. and David Fouse, American Public Health Association, 2009.

seeing the same TV spot time after time.

- Media time is not available at the times we want.

3. Pulsing. A combination of the two above. There is a continuous base of support augmented by intermittent bursts of activity. We use this type of schedule when:

- We want to stretch resources;
- There is opposition; contrary messages may increase when there is a lull.
- Continuing vigilance is necessary;
- Using a variety of media may help. Pulsing can be done by alternating media – e.g. magazine—TV—magazine—TV.

Points to consider about geography

Experts on the use of social media in risk communication offer tips for using social during emergencies.²¹ Some of these tips include:

1. Variations in needs and behavior (where is the disease outbreak or threat?)
2. Availability of media infrastructure
3. Policy consideration, such as a focus on under-served areas (e.g. areas of poverty, where women and children are most vulnerable). We need to be mindful that groups most at risk in an epidemic are often those with least access to communication media.

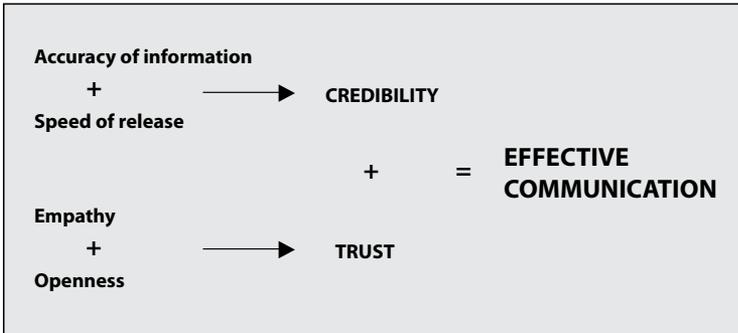
3.4.4 Are there any geographical factors to consider?

The migration patterns of birds influences where avian influenza spreads. In general, rural areas may be more vulnerable to zoonotic diseases because of the presence of farm animals. Thus, we may need to consider in our media planning which parts of a country are vulnerable to emerging and re-emerging diseases.

3.4.6 How can we develop continuing special relationships or 'stand by' agreements with selected media outlets so that we can collaborate with them fully and quickly when crises break out?

It is a principle of good media planning and public relations to nurture relationships with journalists and other media professionals long before we need their services. We should treat journalists and media professionals with respect and as equal partners, and not simply as passive resources to use when needed. We have to recognize that they have a job to do, and they will help us do our job when we help them do theirs. Of course, interests do not always coincide. For instance, journalists may feel obliged to find and report contrary or critical points of view, while, for our part, we do not want conflicting messages to confuse people. Continuously reaching out to journalists and media professionals is a must, and listening to them could give us valuable insights.

The figure below shows the elements of effective communication both with the public and with media professionals.



Source: Crisis and Emergency Risk Communication, Centers for Disease Control, 2006.

Credibility comes from the accuracy of our information and the speed of its release to the public. Trust comes from empathy and openness. By building credibility and trust, we can develop

relationships with journalists and other media professionals that will enable us to work with them closely during health emergencies.

THE SIX QUESTIONS

1. What is the communication problem?
2. What do we need to do?
3. What creative approaches and materials do we need to develop?
4. How do we make things happen?
5. How do we know that we are making progress and achieving our desired impact?
6. How do we learn from experience and plan for continuity?

CHAPTER 4 – WHAT CREATIVE APPROACHES AND MATERIALS DO WE NEED TO DEVELOP?

Chapter Goal

Worksheet 4 helps us understand the process of developing materials so that we can work effectively with artists, creative directors and producers. The worksheet guides us through creating materials that embody our 'big idea', or creative concept.

Note: In this chapter we assume that we will obtain the creative services of communication professionals such as advertising agency creative directors, artists, producers, script writers and others.

4.1 How can we best engage our intended audiences (and all stakeholders) to help us design our materials?

In the past, pre-testing has been the chief way that intended audiences contributed to materials development. Current practice, however, recognizes the value of engaging intended audiences in all aspects of communication planning. Input from audience segments at every step will go far toward keeping us on track. Audiences' continuous input avoids mistakes that could require costly and time-consuming back-tracking. Therefore, we need to actively recruit representatives of our audience segments to join our team. For example, if farmers or poultry growers constitute our key audiences, we need to reach out and seek their views. If pregnant mothers are our intended audiences, we need to solicit their concerns and perspectives.

Once we have formed an initial focus group representing our intended audience segment, we may be able to secure these audiences' continuing help throughout the planning and development process. This would save time recruiting new people for future focus groups or pre-testing, too.

4.2 How can we quickly pre-test our key messages and materials?

Even though time may be short, we need to make every effort to pre-test. The 'big idea', discussed in Chapter 3, should have been pre-tested with intended audiences, program managers and other key gatekeepers. As we begin developing specific ideas for materials,²² these, too, need pre-testing with representative intended audiences and all stakeholder groups, such as policy makers, program managers, health workers, NGO staff, community leaders and households. Our goal is to ensure that our materials are easy to understand, create the intended impression, and are appropriate to the social-political-cultural context of our

²² We use the term 'materials' to include any format that embodies our messages. This could include intangible products such as radio spots and even the appearances of a spokesperson on a TV news broadcast.

audiences. We also should pre-test with technical experts to make sure that materials are scientifically accurate. Pre-testing results guide the revision of materials.

To obtain audiences' feedback early in the materials development process, communication professionals pre-test intermediary forms such as story boards, script outlines, and mock-ups of posters and brochures. Storyboards or concept boards are rough outlines of materials presented in visual form. Storyboards usually consist of a series of illustrations or photos depicting how a TV spot or drama will be presented.

If time is really short, we can pre-test ideas and materials with our staff members. We can ask them to suspend their thinking as professionals and instead put themselves into the shoes of our audiences.

Sometimes pre-testing turns up differences of opinion between intended audiences on the client side and key gatekeepers or stakeholders. It may be necessary to share pre-test results with our pretest subjects and seek consensus or compromise. Once we are satisfied with revisions, we can translate the 'big idea' into specific communication materials, as described in our media plan.

4.3 How can we best encourage creativity among our team members and stakeholders?

Creativity is not easy to define. For our purposes, creativity means that people have fresh perceptions, make insightful judgments, and recognize important connections among ideas or events that others miss.

When an epidemic is imminent, we may not have much time to engage in extended creative processes. We have to develop materials quickly and disseminate them. This is one reason it is important to have creative communication professionals on the core team from its start. At the same time, with a little encouragement, all team members can contribute creative

ideas. Here are some ways to encourage creativity among team members:

- Look at problems and situations from as many viewpoints as possible.
- Encourage as many different ideas as possible.
- Solicit 'off the wall' and unlikely ideas.
- Ask for a 'no-cost' idea, something that we can implement at little or no cost. Not every solution to a problem requires money.
- While our work deals with serious matters, we can still encourage playfulness in our discussions. Playfulness allows people to see things from different perspective and thus encourage creativity. Playfulness, however, must be accompanied by endurance and perseverance.
- Recognize that true creativity means recognizing the creativity of others and not just pushing our own ideas.

4.4 How can we best translate the key benefit into creative messages? What will those messages be?

A practical and useful way to translate our key benefit into creative messages is to adopt the 7Cs of effective communication. We call them the seven Cs since each one starts with the letter C. Keeping the seven Cs of effective communication in mind helps when brainstorming messages. Then checking proposed messages against each of the seven Cs helps assure that messages will have impact (Credit to James Williams, former Associate Director for Strategic Planning, Center for Communication Programs).

The seven **Cs** are:

1. **Command** attention
2. **Clarify** the message
3. **Communicate** the key benefit clearly
4. **Cater** to heart and head

5. **Consistency counts**

6. **Create trust**

7. **Call for action.**

1. Command attention. Our audiences must pay attention to our message before it can have any effect. People do not read every ad in a magazine. Nor do they watch every single TV ad broadcast. People are bombarded by hundreds of mass media messages every day. They choose which ones they will pay attention to. Thus, first impressions are crucial. We need to make our materials as attractive or as attention-getting as possible. To command attention, communicators use sound, silence, color (or lack of it), bold typefaces, eye-catching photographs, and attractive visuals and page layout.

2. Clarify the message. People best understand messages that are simple and clear. Communicators should simplify messages as much as possible. People's capacity to understand varies, and we need as many people as possible to understand our messages correctly. In any case no one, no matter how intelligent, objects to clarity. Less is more.

A key principle among communication professionals is 'less is more'. A few brief, well-crafted messages probably will be more effective than many long and detailed messages. Communication professionals give up some less important points to sharpen the message. As communicators like to say,

"Focus demands sacrifice."

While multi-tasking is highly popular, the maxim "focus demands sacrifice" says that we need to give up something if we want focus. We cannot do everything at once if we want to do one thing well. Similarly, we should not give our intended audiences too much information if we want them to focus on some key messages.

3. Convey the key benefit clearly. Imagine our intended audiences all wearing buttons that say, “How does that help me?” Communication professionals do not just give commands and expect people to respond positively. They know that we need to motivate people by explaining clearly how they will benefit.

4. Consistency counts. There are different ways to convey or express messages, and different formats and channels. Reaching people in multiple ways is good, but the core idea and key benefit should remain the same throughout. Repetition helps. People may need more than one exposure to our message before they respond. They may need reminders, too, to maintain new behavior.

As mentioned in Chapter 3, communicators often apply the “one sight, one sound” principle to assure consistency. This means using the same logo, same typefaces, same music or jingle, same actors (or models) in all our materials. When people see them, they know that the materials are part of a single campaign. They feel more confident that the campaign is being conducted by communication professionals.

5. Cater to heart and head. Communicators seek to appeal to both reason and emotion. People usually do not act on reason or emotion alone but rather on the two combined. Working together, rational and emotional appeals can make our campaign more effective.

6. Create trust. People listen more to people they trust. The intended audiences need to feel that the people or organizations behind the message have their interests at heart. This assurance usually is not stated outright but rather is conveyed in the style and appeal of the message. Particularly in the choice of a spokesperson, it is important either to find a public figure whom the audiences already trust or to choose a health expert with a trustworthy manner as well as appropriate credentials. Of course, the messages themselves must always be accurate, relevant, and dependable.

7. Call for action. Effective communication materials do not just educate, they also call for action. Communication materials must say clearly what audiences can do to obtain the key benefit. Often, the call to action is the first, most immediate step that people should take—and an easy one. Thus, health communication materials often suggest, “See your health provider now”, or “Go to the nearest clinic”, or “Call the hotline at ...”. These are calls for action. Without a direct call for action, how will audiences know what to do?

4.5 How can we create effective communication if we have no time at all for pre-testing and revision before releasing materials?

We can adopt the “action learning” strategic approach. This approach assumes that much still remains to be learned about preventing and treating avian flu and zoonotic diseases, but that fact cannot delay action. Rather than pursuing quantitative targets that rest on a set of pre-established assumptions, the action learning approach focuses on learning from errors and quickly correcting them in the course of an activity. It helps to start small, if possible—that is, to focus on a small geographical unit, such as a community, village or county, and, through a combination of action and learning processes, determine how best to solve a given problem on a larger scale. In contrast with strategic planning, the ‘strategic learning’ approach contends that people do not need to know everything before they can act and that people can and should learn continuously how to improve their actions.

A comparison of the two approaches is shown below:

Conventional planning	Action-learning approach
<p>We know what to do 'Experts' should define quantitative targets.</p> <p>External experts monitor and evaluate.</p>	<p>We need to learn what we need to do.</p> <p>All stakeholders should assess their situation and determine how they can progress from one logical stage to another.</p> <p>The people themselves monitor and evaluate.</p> <p>They gather statistics for the community and share information with everyone.</p>

By adopting a learning mind-set, we create an environment that nurtures quick response to feedback. A program relying on the action learning approach needs to be well embedded in the community so that the community contributes its responses and views frankly and fully and this input, in turn, guides the program's course of action.

Lessons on Effective Communication Learned from Avian Influenza and SARS Experiences

The avian influenza and SARS experiences have lessons to teach concerning effective communication. These lessons were extracted from two surveys of communication experiences in several recent epidemics. The Waisbord report²³ is based on 19 program reports and 14 national surveys in countries affected by avian flu as well as eight in-depth interviews with communication

23 Waisbord S. Assessment of UNICEF-sponsored communication initiatives for prevention and control of avian influenza. Final Report for UNICEF. March 2008.

officers in the field. The Schiavo paper²⁴ looks more broadly at lessons learned from avian flu, SARS, Ebola and anthrax outbreaks. Schiavo conducted 19 in-depth interviews with a variety of experts working on communication, emergency operations and public health from national and global agencies. The lessons learned are summarized below:

1. Communication interventions can increase knowledge. Reports show that knowledge about modes of transmission, symptoms, safe ways of disposing of sick/ or dead birds and of prevention increase after communication interventions.
2. Increases in knowledge in and of themselves do not necessarily translate into effective behavior changes.
3. Communication interventions should go beyond information transmission, given that lack of knowledge is not the only or even the main obstacle to performing desired practices.
4. Communication should be integrated with initiatives that reduce obstacles to practicing healthy behaviors. Often, recommended behaviors are not feasible—even if an individual is motivated. Beyond seeking to change individual's knowledge and attitudes, there is a need to remove policy, physical and economic barriers to new and healthier behavior.
5. Easy access and trust are two key considerations in the selection of communication channels. Both will differ for different audiences.
6. Engaging trusted community groups and leaders may reach vulnerable and marginalized groups better than disseminating centrally generated messages through the mass media.
7. Communication should address local attitudes and stigma that may be associated with the recommended behaviors.

24 Schiavo R. Mapping and review of existing guidance and plans for community and household based communication to prepare and respond to pandemic influenza. Research report for UNICEF. January 2009.

8. Messages should clearly tell the benefits that the intended audiences will reap if they practice the recommended behaviors. Benefits should not be limited to conventional public health goals but also include economic rewards that can come from the desired behavior.²⁵

9. It is important to clarify behavioral and social outcomes and adapt recommended actions to local context.

10. Coordination among government counterparts, development partners and UN agencies is crucial for effective communication with harmonized messages.

11. Early integration of medical and scientific teams with communication teams can contribute to swift response and to the development of community resilience during an outbreak.

12. Timely, strategic and well-coordinated communication efforts could make a difference not only in mitigating the consequences of an emergency, but also in managing people's reactions during crises. Well-managed, credible communication increases the likelihood that people and communities will adopt recommended behavior and actions.

13. The early participation of key private-sector partners such as physicians and pharmacists and businesses is important so they will take their roles in reducing transmission and mitigating the health, social and economic impact of the disease.²⁶

²⁵ We may also wish to consider emotional benefits, such as knowing that one is protecting one's family or contributing to the welfare of one's community. These can be powerful motivations, in a crisis, probably more powerful than economic arguments and probably much more than public health!

²⁶ As cited in *Social Mobilization and Behavior Change Communication for Pandemic Influenza Response: Planning Guidance*, Academy for Educational Development, September 2009.

THE SIX QUESTIONS

1. What is the communication problem?
2. What do we need to do?
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- 4. How do we make things happen?**
5. How do we know that we are making progress and achieving our desired impact?
6. How do we learn from experience and plan for continuity?

CHAPTER 5 – HOW DO WE MAKE THINGS HAPPEN?

Good management is essential to the effective implementation of any health communication program. Management means

Chapter Goal

Worksheet 5 describes how we can best carry out our planned activities and tasks.

the ability to start, change and stop. That is, managers can start desirable activities, change plans when necessary and stop unproductive activities.

In implementing our plan, we have to focus on three things: competence, opportunities and commitment.²⁷ We must have the skills to carry out our tasks. We should always be on the

²⁷ Drucker P. Five Most Important Questions You Will Ever Ask About Your Nonprofit Organization, Peter Drucker Foundation, Jossey-Bass Publisher, San Francisco, 1993.

lookout for opportunities to exploit. Lastly, our focus should be on what we really believe in, as nothing is done well unless people are committed.

Organizations, like communication, must sacrifice for focus. We achieve best results by focusing on key actions, not diffusing our efforts by trying to do everything. An important question to ask ourselves is, “How can we, with the limited resources that we have, make the most difference?”

The following questions can guide us in implementing our communication campaign more effectively.

5.2 Given that people tend to do things as they have done before—actions that may have contributed to the current situation—what should we do differently?

We can learn from the past. If previous campaigns were too diffused, we need to ensure that this time we will be more focused. If past communication efforts were implemented too slowly, then we need to be more responsive. If risk communication campaigns in the past did not inspire trust and credibility, then we need to know why and to change the way we work.

As we carry out activities, even if they have been carefully planned, we need to keep alert to the possibility that change might be needed. To enhance our effectiveness, we can:

1. Critically review the following:
 - What are we doing now?
 - What is this task meant to accomplish?
 - Does this contribute to achieving our primary goal? Why do it at all?
2. Assess how everything fits.
 - Determine how to optimize the whole system, not component parts
 - Look for critical links and strengthen them
 - Test changes and fine tune

3. Eliminate what does not need to be done
4. Break down organizational boundaries. Promote teamwork.

5.3 Who should do what and when? Define the roles and responsibilities of each partner.

Plans are not self-implementing, and good intentions are not enough. To nurture effective action, we all have to be clear about who should do what and when. Unless we designate someone to carry out a decision, that decision is ineffective.

A common mistake is jumping into action without a plan that brings together the various elements of a project. This is like making a film without a script, with a director “writing” a script or just muddling through while on location.

At other times, a manager circulates a health communication plan among senior staff but not to lower-level staff who will actually carry out the plan. People may know their tasks but not understand how their tasks fit in a larger scheme.

It is useful to spell out our assignments and agreements openly so that everyone understands not just their own roles and responsibilities but those of others as well. This will allow us to concentrate on real issues and avoid some conflicts over roles. Also, since roles are interconnected and one person’s actions affect others’, we need to ensure that communication is free-flowing among staff and management as well as with audiences, stakeholders and public health specialists.

In the left column the table below poses essential questions about how roles and responsibilities for implementation are organized. In the right column are examples of answers to these questions.

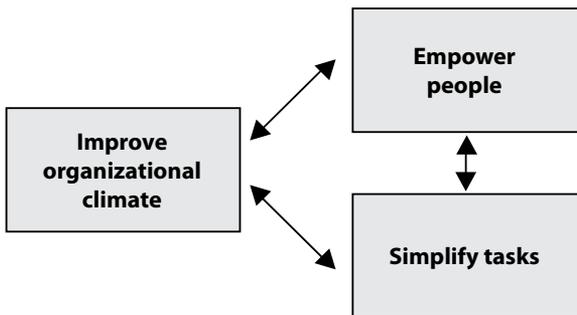
Questions	Responses
1. The lead organization is:	Inter-ministerial Task Force
2. The responsibilities of the lead organization are:	Leadership, overall management, organization, coordination, advisory meetings, management of subcontracts
3. The collaborating partners are:	UNICEF, MOH, Veterinary Inspectorate, local advertising agency, PR organization, NGOs, medical associations, mass media associations
4. Collaborating partners are responsible for:	<p>UNICEF – provides technical inputs</p> <p>MOH – provides technical inputs, services and information</p> <p>Veterinary Inspectorate – provides technical inputs, services, information, technical assistance to farmers</p> <p>Local advertising agency- helps design communication strategy, provides creative materials, recommends media plan, buys media time</p> <p>PR company- provides PR services, liaison with media, trains spokespersons, provides press kits</p> <p>NGOs – provides services and information</p> <p>Medical associations – provide technical inputs, information and services</p> <p>Mass media associations – provide media support</p>

5. Timeline and milestones	List of milestones Time completed 1. Organizing 2. Communication analysis 3. Strategy design 4. Development of materials 5. Implementation 6. Monitoring and evaluation 7. Re-planning
6. Budget	Time period Line item Amount
7. Monitoring and evaluation	Comparison of timeline, milestones and actual performance as well as effects and effectiveness.

5.4 How do we promote teamwork and synergy? How do we improve organizational climate?

We can promote teamwork and synergy by focusing on three key moves. The first is to improve the organizational climate within our Communication Response Team. The second is to enable people to act. The third is to simplify tasks.

Illustration 1 - Process to promote teamwork and synergy in our campaign



Improve organizational climate

The primary task of a manager is to improve organizational climate. When organizational climate is restrictive and not supportive, management of people and tasks becomes extremely difficult.

Organizational climate is the way it feels to work in an organization or team. Do people look forward going to work, or do they dread it? Do they feel inspired and motivated to execute their tasks, or are they bored or confused? Do they take the initiative and practice creativity? Do people feel that there are unnecessary bureaucratic rules and procedures? Do people feel that they are trusted? Is teamwork strong or weak? These are some of the many dimensions of organizational climate.

The manager's role in managing the organizational climate involved embedding the organization's guiding beliefs in the mission, goals, structures, and working procedures of the group. There are several determinants of organizational climate—environment, strategy, systems, attitudes, and management behavior. Among these five, the literature suggests that management behavior is the most important determinant of organizational behavior. We do not need money to make people they are part of a team, that they are trusted, that they are recognized for their efforts.

Often, we are tempted to look at solutions to management issues in terms of securing more material resources. However, we can consider that non-material resources (leadership, shared vision, creativity, teamwork, resourcefulness, resiliency, etc.) play a significant role in shaping organizational climate. Non-material resources may even have advantages that material resources may not be able to match:

1. We do not need parliaments or donor agencies to allocate non-material resources.
2. Non-material resources grow with use, they do not get depleted.

3. We can use non-material resources to generate material resources but not as easy vice-versa.
4. Non-materials resources may not have practical limits.
5. Non-materials resources are found within and everywhere.

5.5 How do we enable members of our team to act?

UNICEF adopts the human rights based approach in its programming and fosters enabling environments in its management style. An enabling environment nurtures:

- spaces for plurality of voices and narratives of communities
- listening, dialogue and debate
- the active and meaningful participation of children and women.
- Leaders and managers know that they cannot do things alone. They make things happen through people. Thus, it is crucial to nurture an environment where people feel empowered and encouraged to take initiative and act.

Empowering people involves:

- Communication
- Problem-solving
- Decision-making.

Listening to our team members is one of our most important task as a manager. Communication is a two way process and to improve communication within our team, we need to share what we think as well as listen to others.

Every communication campaign generates problems. As managers, one of our key obligation is to help people learn to solve their own problems. Sometimes we may have to step back and give our staff some space to think and act on their own. A good principle to consider is to “get out of the way”.

How to make better decisions is what we should aim for, not how to make “perfect” decisions. Since we are dealing with an imminent outbreak, we must be decisive as time is short.

In battling new and re-emerging diseases, leadership is crucial. Leaders are needed at every organizational level to nurture learning and innovation because these diseases can spread quickly, the situation can change by the hour, and initiative, creativity, and flexibility are needed throughout the team.

Communication leaders have three roles:

- Catalytic: Generating a shared vision of a health future people want to create;
- enabling: Creating a work environment characterized by teamwork, trust, open-mindedness, transparency and shared accountability for all outcomes;
- Learning: Encouraging the development of flexible action-learning organizations that leverage the vast collective resources of ordinary people to improve health.

To catalyze people to action, leaders nurture a shared goal or vision. Without a pull toward a shared goal which people truly want to achieve, the forces for status quo can be overwhelming. Change starts when people are dissatisfied. We must harness this dissatisfaction to galvanize people to action, to take risks, to experiment and learn.

To enable people to act, we can do the following:

1. Secure people’s participation and share the ownership of plans from the start. Overcome our own fear that empowering people will diminish our own authority. Power shared is NOT power diminished. Power shared is power multiplied.
2. Set the example by acting on our primary goal.
3. Be ruthless in keeping focus on our primary goal.
4. Define accountability for key result areas.
5. Reward progress.

6. Find out what people think is going on.
7. Clarify what is important and encourage initiative. People hesitate less when they know what is important and they feel confident that others share the same perception.
8. Understand the dynamics, results and impact of performance measurement.
9. Institute training and retraining (when time permits).
10. Drive out fear.
11. Provide people with tools and resources that they need.
12. Get out of the way of those who are doing a good job.

As mentioned in Chapter 4, there is growing interest in the concept of “action learning”, a concept that which could help build flexibility into our mind-sets and our communication activities. A key tenet of action learning is that our knowledge is often incomplete and imperfect, but we do not need to know everything before we can act. Particularly in the midst of rapidly changing events, we can keep an open mind at all times and nurture a process of continuous learning. By contrast, a technical approach to planning assumes fixed inputs, goals, processes and timelines. A technical approach presumes doing something that one has done before. In an outbreak of disease many in our team may not have had the experience of dealing with the consequences of an epidemic—and, indeed, the disease may well be somewhat or very different from those responsible for previous epidemics.

5.6 What steps can we take to simplify tasks? How do we minimize procedural delays and rapidly scale up in epidemic/pandemic situations?

We can simplify tasks by listening to those who do the work. Frontline health workers often have valuable insights that remain untapped. In many instances they can clearly see the consequences of decisions and policies because they are on the

ground. Often, 'experts' in central offices may have the greater say in how a plan will be implemented, and yet their perspective may be more distant from realities in the field.

To strengthen quality and simplify tasks, a health communication manager can:

1. Learn from those who are doing the work.
2. Encourage initiative and resourcefulness.
3. Demonstrate management's commitment by continuously seeking excellence in design, production processes and services, not just in products.
4. Consistently seek quality solutions, not always the cheapest ones.
5. Improve by one percent, continuously. The Japanese refer to the principle of continuous improvement as 'kaizen'. The core idea is to act quickly but to improve continuously. 'Kaizen' contrasts with long-term planning processes that require long lead times.

Team meetings may be more productive if we reduce time for reporting on what people have done since the last meeting. Instead, we can change our agenda to cover:²⁸

1. New data on the curves we are trying to turn
2. New information on the stories that lie behind those curves
3. New partners that we have engaged
4. New information on what works
5. New information on material and non-material resources—both those newly available and those newly needed
6. Important changes in our action plan and budget
7. Insights gained and lessons learned.

28 Friedman, 2005 p. 126

Such an agenda may encourage a different type of meeting and change our thinking process as well. Each time that we meet, we strive to improve our action plan.

Such an agenda may encourage a different type of meeting and change our thinking process as well. Each time that we meet, we strive to improve our action plan.

THE SIX QUESTIONS

1. What is the communication problem?
2. What do we need to do?
3. What creative approaches and materials do we need to develop?
4. How do we make things happen?
5. How do we know that we are making progress and achieving our desired impact?
6. How do we learn from experience and plan for continuity?

CHAPTER 6 – MONITORING AND EVALUATION

Chapter Goal

Worksheet 6 aims to describe how we will monitor and evaluate our communication response. Given the emergency nature of the situation, we will focus more on monitoring than on evaluation. Monitoring helps us keep our fingers on the pulse of our intended audiences, a most important task. We expect to work with research professionals on these activities.

Monitoring generally refers to keeping track of events as they take place. Its central purpose is helping management make program adjustments to maximize impact. In contrast, evaluation generally refers to an assessment after the program has finished or a phase of the work has ended. Its central purpose is taking stock of what has been accomplished and what has been learned. In a rapidly changing emergency situation, where fast action is necessary, monitoring—and heeding its findings—is especially crucial.

As mentioned in Chapter 3, we design our monitoring and evaluation plan early in the strategy development stage. We would be too late if we start thinking about our monitoring and evaluation once when activities are already underway or even completed. From the beginning everyone on our team should understand and participate in planning monitoring and evaluation activities.

While all team members should participate in their planning, monitoring and evaluation generally require special expertise—not only in designing the research but also in analyzing the collected data, interpreting the meaning of findings, and writing clear reports. It is best to obtain the help of monitoring and evaluation professionals, usually from our own agencies or universities and research institutes. This chapter aims to cover basic evaluation concepts so that we can have a more productive working relationship with researchers.

After completing this worksheet, we will have:

1. A design outline for monitoring the process and immediate effects of outbreak communication activities and usually also for evaluating their impact.
2. A list of potential indicators and data sources for monitoring and evaluation
3. A timeline for collecting data and other information
4. A plan for analyzing the data and for applying findings to improve our efforts.
5. A plan for sharing findings with others.

KEY CONCEPTS

The following definitions of key terminology may help us understand the language of evaluators.

Inputs

- Refers to effort and resources expended in pursuit of program goals
- Measures of input may include human, financial, institutional or technical resources including materials, and activities that our program uses or mobilizes.

Outputs

- Refers to the products or services produced by our efforts
- Indicators of outputs may include both intermediate, process-related outputs (e.g. people trained, journalists engaged, editorials published, radio spots broadcast) and immediate as well as longer-term effects on various groups of audiences and stakeholders (e.g. communities mobilized, fear reduced, people vaccinated).

Impact

- Refers to results—intended and unintended—that can be attributed to our efforts
- Requires satisfying criteria for a causal relationship such as attribution, change, order in time, taking account of confounding factors, and conceptual coherence.

Quantity

- Refers to numeric measures of inputs, outputs, or processes
- Quantitative indicators may include how many activities were done, how many materials were produced, how many journalists were trained, how many articles appeared in the newspaper, how many people called the hotline, etc.

Quality

- Refers to how well a program did by comparison with an agreed-upon standard or target for performance
- Indicators may include both quantitative and qualitative measures such as input/output ratio, how well the implementation adhered to the plan, descriptions of how people are better off as a result of our efforts, a comparison of input and output levels with targets, cost-effectiveness and cost-benefit calculations and so on.

Monitoring and evaluation process

A key component in our effort is determining whether our progress is going according to plan (monitoring; sometimes called 'formative evaluation') and, in the end, what has happened as a result—good and bad, expected and unexpected (summative evaluation). The two processes are closely linked.

Monitoring

The goal of monitoring is clear; we want to answer the question, "How are things going?" Our aim is to detect departures from our expectations and then to respond quickly and appropriately. Monitoring is a continuing activity and very much an integral part of the management process.

Rare does everything go according to plan. Deviations normally occur. Some deviations are positive—we achieve more than what we had planned. Other deviations may be negative—we make mistakes or accomplish less than planned. The key is to detect these changes quickly and, if needed, to take action.

At the same time, conditions change. Opportunities to do more may arise, or a change may put our plans off-target. In epidemic situations it is likely that events will take unexpected turns. We need to be always on the lookout for evolving threats as well as potential opportunities. Monitoring helps us to do that.

Monitoring accomplished little, however, if we do not act on its findings. We need to be flexible enough to respond—and bold enough. If we learn of successes, we want to scale them up. If we identify bottlenecks, we need to relieve them. Making use of monitoring results often requires acknowledging our mistakes and correcting them (see box).

Embrace error to improve impact

A valuable principle that we should adopt is ‘embrace error’. This means acknowledging mistakes so that we can correct them. It is hard to change what we do not acknowledge.

To embrace error is not easy. Many go through a series of stages before they acknowledge error:

- | | |
|---------------|---|
| 1. Denial | “There is no error. We are doing fine”. |
| 2. Depression | “Everything is so bad that we can’t handle it”. |
| 3. Blaming | “The fault is not ours. Others created this problem”. |
| 4. Embrace | “The responsibility is ours. We can change.” |

To deny an error is to allow it to grow. Diseases often spread when we do not recognize the early stages of an epidemic. Decisive action is often the key to correcting errors as it is to stopping epidemics.

A monitoring plan begins with the description of what we plan to do, when we aim to complete the task, and what level of quality we want to achieve. The plan should then specify the answers to four questions:

1. What will we most want to know on an ongoing basis?
2. What indicators will best reflect or represent that information?
3. How we will gather the data on these indicators?
4. How we will analyze those data and use the results to inform management decisions?

What should we monitor? In general, we need to monitor:

1. Program processes and outputs: Are we doing what we want to do and producing what we intend to produce at the right quantity, at the right time, and in the right quantity? Are our messages and materials being disseminated to the intended audience groups with satisfactory intensity and reach?
2. Immediate, or proximal effects, which give the first indication whether our efforts are having an effect. We might want to keep track of levels of exposure to messages among our intended audiences, their uptake of messages (correct recall, for example), their opinions or feelings about our messages, and whether they have as yet taken any action in response.

Monitoring of program implementation should be sure to cover not only development and production but also dissemination. Our materials will be effective only if our intended audiences are exposed to them. Many communication campaigns have failed because materials were produced but not disseminated effectively. In an emergency dissemination must be fast, and so tracking the pace of dissemination is especially important.

Who should monitor the progress of our campaign? One good answer is: every member of our team. The best 'quality inspector' is the worker himself/herself. Without a spirit of accountability and commitment throughout the team, monitoring would be a very challenging process. We need to ensure that every member of our team not only knows their tasks but also takes responsibility for their performance.

Evaluation

Evaluations are usually conducted to answer two questions. The first is: Did the project achieve its goals? While evaluation literature is full of jargon describing different types of impact, a practical approach is to focus on our primary and secondary goals and determine whether they have been met.

The second question is: What lessons can we learn from our experience? While much attention has been given to the first goal of evaluation, discovering what we have learned may be equally important. We want future interventions to benefit from both our mistakes as well as from our successes.

To design an appropriate evaluation to our communication campaign, we need to:

1. Clarify our communication objectives and measures of outcome
2. Describe the data that we would need to collect
3. Select the best methods and procedures for analyzing the data
4. Develop, pre-test and revise our evaluation instruments
5. Collect, code, process and analyze data
6. Plan for the effective distribution of findings
7. Share findings, and ensure that appropriate actors learn from the findings and take appropriate actions.

Let us now address the worksheet questions.

6.1 What results or outcomes do we expect to achieve in our communication campaign

Planning for monitoring and evaluation starts with a review of the outcomes or results that we want to achieve. It would be useful to go back to our answers on Worksheets 2 and 3. In reviewing our primary goal, we should clearly focus on the communication objectives, not program objectives. For example, ensuring proper procurement, distribution and administration of vaccines is a program objective. Effectively encouraging people to get vaccinated is a communication objective.

6.2 What indicators can we use to measure these results or outcomes? How do we measure our outputs? Our impact or effects?

We can categorize all measures of performance into quantity and quality of effort and effect. The distinction between quantity and quality concerns how much did we do versus how well we did it. The difference between effort and effect is simply the difference between how hard we tried and where we made a difference in the lives of our intended audiences. We can measure all four. The matrix below shows how we can categorize our indicators according to these four dimensions.

	Quantity	Quality
Effort	How much did we do?	How well did we do it?
Effect	Did people adopt the behavior we recommended?	

Source: Freedman M. *Trying Hard Is Not Good Enough*. 2005.

What makes a good indicator? Here is one set of criteria:²⁹

1. Communication power. Will the indicator communicate to a broad and diverse audience? We can call this the ‘public square test’. If we had to stand in a public square and explain the results of our campaign to our neighbors, what two or three pieces of data would we use? If we bring a thick report with lots of tables and numbers, the crowd may thin out fast. People do not want to try to digest large pieces of data in a short time. The policy-makers who may be the intended audience for your findings

²⁹ Frieman M. *Trying Hard Is Not Good Enough*. Victoria, British Columbia, Trafford Publishing, 2005).

report will be no different in this regard from your neighbors in the town square.

2. Proxy power (or representative power). Does the indicator say something of central importance about the result? Can this measure stand as proxy or representative for the results that we aim to achieve? Data tend to run in herds. If one indicator is going in the right direction, usually others are also. We may not need 20 indicators telling us the same thing. Some indicators may have greater proxy power than others, however, so wise selection is important.

3. Data power. Can we obtain good-quality data on time? Can we collect data that are reliable and consistent? To what extent can we collect data at various levels—the national, state or provincial (or city) and community levels, for example?

We can rank possible indicators high, medium or low on each criterion and select those that rank high on all three criteria. These will be indicators that communicate well something of central importance about the result and for which we have good data.

6.3 What monitoring indicators will tell us if we are on the right track?

We can use the same criteria for choosing monitoring and evaluation indicators. That is, we can choose monitoring indicators in terms of their communication power, proxy power and data power.

An important concept in monitoring is baselines. Baselines are pre-implementation measurements. They have two aspects: a historical aspect that tells us what has happened and a forecast aspect that shows where we would be headed if we did not act (recall Worksheet 2—the concept of current destination). If we do not have baseline data, we can create working versions based on group consensus about history and what the future would look like if we do not act.³⁰

30 Ibid. pp.59-60

Looking at the forecast part of the baseline, we can ask our team if the expected trend line is acceptable or not. Seeing what is likely to happen if we don't act can motivate our team.

Baselines with forecasts are important to monitoring because they allow us to define success as "turning the curve" away from the baseline or "beating the baseline". Current practice often looks for point-to-point improvement (e.g. 'increase X behavior by Y percent'). Most baselines in the real world do not operate that way, however. Due to the many different factors affecting them, they are continuously changing. They may be on a course, perhaps in the wrong direction, and that course has momentum. 'Turning the curve' is a common-sense approach to gauging success. We aim to correct a trend line that is not headed in the desired direction.

Start building the indicator table in the worksheet by copying the entries from Chapter 3 into this table and listing possible indicators for each. Then rate each indicator by the three criteria discussed in section 6.2.

6.4. How and when do we collect our data?

Once we know what indicators we will use to measure our performance, we need to draw a list of tasks for collecting and analyzing data. Professional assistance from researchers and evaluators could help us avoid costly mistakes and save us time.

Here is a template that we could use:

Task/Activity	Start time	Completion	Responsible Parties
---------------	------------	------------	---------------------

1. Develop research instruments
2. Pre-test
3. Revise
4. Draw sampling design
4. Select sample

6. Administer questionnaire/collect data
7. Code responses
8. Analyze data
9. Write draft and review
10. Finalize report
11. Draw up plans for sharing
12. Share results

6.5 How can we know what is going well and where improvements are needed?

Because we aim to improve our performance through monitoring and corrective action, we would like to find out specifically what is going well and where performance can be improved. To do this, we can compare the list of activities that we planned to do with current progress.

We can assess performance by collecting appropriate data on our indicators and analyzing them by:

- Comparing current performance with expectations set in the plan.
- Comparing current performance with past performance.
- Comparing our performance with others, for instance, with other countries who are addressing similar issues.
- Comparing our performance with known standards e.g. best practices

6.6 How do we translate findings of our monitoring into action?

Action is eloquence. We need to translate the results of our monitoring into action. Epidemics or pandemics demand decisive action.

The team should meet regularly to look at the latest monitoring findings. This is a good format for these meetings:

- “Here is where we are doing well.”
- “Here is where we are not doing as well as we would like,”
and
- “Here is what we can do to get better.”

6.7 What can help us do better, including low-cost or no-cost ideas?

A most important question to ask if a program or part of it is lagging behind expectations is, “What will it take to succeed?” To answer this question, people often look backward and ask, “What has worked in the past?” Thus, they deprive themselves of new ideas and approaches. Research to date may not have all the answers that we need. Thinking beyond research findings is often the most creative part of communication work. If we limit ourselves to only what has been tested (and therefore ‘evidence-based’), we may be depriving ourselves of a wide range of ideas, including possibly better solutions that deserve to be tried.

We cannot always improve everything by committing more resources to it. Asking for ‘off the wall’, low-cost or even no-cost ideas forces people to think creatively. We may benefit more from more resourcefulness than from more resources.

6.8 How can we share our monitoring and evaluation results and encourage people to act on them?

Good monitoring and evaluation consists of:

1. Clear thinking – scientific rigor
2. Profound learning – lessons learned
3. Correct action – translation of findings into action.

Evaluators often pay a great deal of attention to scientific rigor. While this is essential, we must recognize that it is not enough. We also need to ensure that donors, policy makers, program

managers, health workers, communities and households learn from the evaluation and take appropriate action.

It is important to plan early how best to disseminate evaluation results. We need to answer the following questions:

1. Who wants to know the findings of our evaluation? Who needs to know? Who can act on the findings?
2. How do we go beyond the usual dissemination to program managers and policy-makers and reach out to households and communities as well?
3. How do we make evaluation findings easy for laypeople to understand?
4. How do we show different groups that they have a stake in the findings?
5. How do we translate our findings into actionable steps? (We cannot assume that others will interpret the findings and figure out what to do.)
6. What are the best means to share our findings with all—press releases, formal reports, briefings, media kits, scientific conferences, workshops?

Now we are ready to consider how to document lessons learned and apply them to future campaigns.

THE SIX QUESTIONS

1. What is the communication problem?
2. What do we need to do?
3. What creative approaches and materials do we need to develop?
4. How do we make things happen?
5. How do we know that we are making progress and achieving our desired impact?
6. How do we learn from experience and plan for continuity?

CHAPTER 7 – LESSONS LEARNED AND RE-PLANNING

Chapter Goal

The aim of Worksheet 7 is to plan for the near future, using our experience. We want to identify key lessons learned and deduce best principles (in addition to best practices). We will be filling out this worksheet continuously as we implement our communication activities.

A most important activity for our communication team is to celebrate success as well as to reflect on the lessons learned from our efforts. Communication is a process that never ends. Every project has valuable lessons and insights that could benefit future projects.

In the long run we need to nurture leader-managers in disease prevention and control who serve as catalysts, bringing together very diverse stakeholders in action-learning teams. Over time, as confidence grows, these teams will be characterized by:

- a shared vision of a healthier future
- commitment to deeply examine current reality
- willingness to question long-standing assumptions
- readiness to change old ways as new evidence emerges
- openness to new ideas
- encouragement of innovation and experimentation
- acceptance of mistakes as learning opportunities
- shared responsibility for both successes and failures
- transparency in reporting all actions and expenditures.
- recognition of our debt to the future—to pass on what has been learned

7.1 How can we best capture or document the lessons and insights gained from our experience?

A saying in evaluation research is, “If it is not documented, it does not exist.” This means that valuable experience, if not shared, could easily be forgotten. Documenting lessons learned and insights gained should be an integral part of what we do.

While learning is a responsibility of everyone on our team, it may be useful to designate a small group that has ongoing responsibility to capture and document lessons and insights. The group does this both throughout the process and, on reflection, after it is finished. Lessons can take many forms. Data are not the only source of information about people and programs. Knowledge, which comprises not only information but also understanding that goes beyond the numbers, is often best communicated in such forms as anecdotes, recorded dialogues, pictures, video and of course face-to-face discussion. Often, a story, which puts a human face to a situation, conveys lessons learned more deeply and with greater nuance than an expository statement.

7.2 What are the most important lessons learned from our experience? What did we do very well? What could we have done better?

To answer these questions well, we need to seek many different perspectives in addition to our own. Experts are not the only ones who have information and knowledge. We need to learn the views and insights of the various stakeholders. Particularly important are the views of the community and our audiences on the client side. Often we can tap this knowledge without a formal process. We can take frequent walking tours of communities or neighborhoods and talk with people there. Also, we can participate in community meetings, ask questions and listen to people's points of view.

7.3 How can we best apply what we have learned to prepare more effectively for future outbreaks or epidemics?

We probably will experience more epidemics and pandemics in our lifetimes. Will we be better prepared next time?

It is important to work for the future at all levels of the health care system, particularly at the front lines—the “street-level” workers . By communicating the vision that “new and re-emerging disease will not threaten our community”, community health workers can greatly expand their reach and leverage the commitment and contributions of parents, children, traditional health practitioners, religious leaders, small businesses and other community members. Then, together, the formal health care system and the community can learn how to bring together their technical knowledge, skills and resources (both material and non-material) to produce better health.

It will be important to create an ‘evidence-nurturing’ environment in addition to ‘evidence-based’ thinking. Currently available research findings do not have all the answers. This is particularly true when it comes to introducing social interventions into complex, multicultural societies. Often, the most creative ideas lie on the frontiers of science, and we must sharpen the questions

before we can find answers. We need the courage to venture beyond today's science to create new knowledge. In the process we may experience false starts and failed ideas, but ultimately we will gain enormously from lessons learned and dramatic new ways of looking at our world and ourselves.

Concluding Words

Having answered the worksheets, we should by now have all the elements of a sound communication campaign to address emerging and re-emerging diseases. Implementing our plan is our next challenge. We have all the ingredients for success as we have laid a solid foundation for communicating with our intended audiences.

This simple guide is but one of many tools that are available to you to help you develop, implement and evaluate a health communication campaign. There are hundreds of books, manuals, trainers and experts that can teach you how to get better results.

Still, it may be useful to reflect that answers may not lie in our tools. Tools are important. They help us do our jobs better. But in critical moments, even the best tools break or fail to capture a crucial point. What counts most is our judgment. How we choose to act.

While financial resources are important, what is more powerful is the combined energy of people and the non-material resources in communities that may have remained untapped. What if people change their behavior? What if 1,000 communities 'turn the curve'? Whether or not we achieve all that we aim for, changing the lives of people in 1,000 communities will be a remarkable accomplishment. Publicizing this achievement creates energy that could motivate others to follow. Sharing success is a good way to breed success.

REFERENCE SECTION

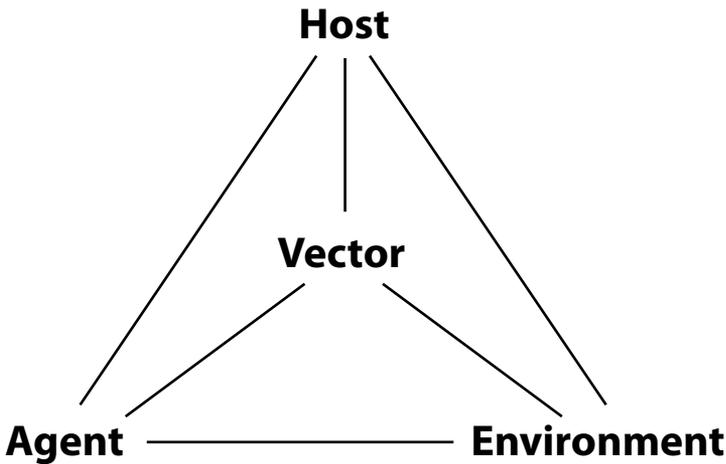
The aim of this section is to acquaint users of this manual with some key terminology regarding infectious diseases. We expect that we will be working closely with public health professionals and we would like to be able to communicate with them more effectively. Understanding some of the basic concepts of how infectious diseases spread and knowing basic facts about some of the diseases that we will likely confront may be of great value. This section consists of:

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BASIC FACTS ABOUT INFECTIOUS DISEASES

Human disease results from an interaction of a host (a person), the agent (e.g. a bacterium) and the environment (e.g. a contaminated water supply). Often a vector (carrier) such as the mosquito or the deer tick may also be involved.

Illustration 1 - The epidemiologic triad of a disease



Source: Gordis, Leon. Epidemiology. W.B. Saunders Co. 1996

The agents of major infectious diseases are bacteria, viruses, fungi, protozoa or multi-celled parasites. An aberrant protein called prion is associated with a number of diseases such as bovine spongiform encephalopathy.

BACTERIA

Bacteria are living, single-celled organisms that can grow and reproduce outside of the body if given the appropriate nutrients.

Billions of bacteria inhabit the skin, throat, mouth, nose, large intestines and vagina. Most are harmless to humans. Some of the common diseases caused by bacteria include:

1. Tuberculosis
2. Strep throat
3. Diphtheria
4. Whooping cough
5. Pneumonia
6. Meningitis
7. Typhoid fever
8. Cholera
9. Brucellosis
10. Anthrax
11. Tetanus
12. Bubonic plague
13. Gonorrhoea
14. Syphilis
15. Typhus
16. Leprosy
17. Bubonic plague

VIRUSES

A virus (from the Latin virus meaning poison) is a small infectious agent (often a hundred times smaller than bacteria) that can only replicate inside the cell of an organism. Viruses can infect animals, plants and even bacteria. Although there are millions of different types of viruses, only about 5000 have been described in detail to date.

Experts differ in opinions on whether viruses are a form of life or are organic structures that interact with living organisms. Some described them as “organisms in the edge of life”. Viruses have two or three parts. The first are genes made from either DNA or RNA, long molecules that contain genetic information. All have a protein coat that protects these genes and some have an envelope of fat that surrounds them when they are outside a cell.

Viruses can be inactive for long periods of time, sometimes months. Others die quickly when outside the human body, e.g. HIV. Some can survive extreme conditions such as treatment with alcohol and drying in a vacuum. In this form, they are known as virions. Once they attach themselves into an organism, they become active and multiply. They do not grow from cell division since they are acellular (no cellular structure). Instead, they use the metabolism and processes of a host cell to produce multiple copies of themselves. Antibiotics do not have any effect on viruses but a few antiviral drugs and vaccines have been developed. Some of the more common viral diseases are:

1. Common cold
2. Influenza (seasonal, avian and H1N1)
3. Ebola
4. Chicken pox
5. AIDS
6. SARS
7. Hepatitis A
8. Cervical cancer
9. Dengue fever
10. Neonatal herpes simplex
11. Herpes genitalis
12. Japanese encephalitis
13. Poliomyelitis

14. Rabies
15. Yellow fever
16. Foot and mouth disease
17. West Nile fever
18. Rubella

FUNGI

A fungus is a single-celled or multi-cellular organism that can cause infections in healthy persons. Fungal diseases are called mycoses and those affecting humans can be classified into four types:

1. Superficial –those that grow only on the surface of the skin or hair.
2. Cutaneous mycoses – grows in the superficial layers of skin, nails or hair such as athlete's foot and ringworm.
3. Subcutaneous mycoses –those that penetrate below the skin to involve connective and even bone tissue
3. Systemic or deep mycoses- those that infect internal organs and become disseminated throughout the body.

PARASITES

A parasite is a multi-celled (some may be single-celled) living organism which develops a type of symbiotic relationship with a host. An example of a parasite is the plasmodium falciparum which causes a severe form of malaria. Other examples of parasites are flukes, tapeworms and fleas. A parasitic disease is an infectious disease caused or transmitted by a parasite. Many parasites do not cause diseases per se. But in a parasitic relationship, the parasite often benefits at the expense of the host, usually an organism of a different specie. The following are examples of parasitic diseases.

1. Onchocerciasis or “river blindness
2. Body lice
3. Hookworm disease
4. Tapeworm
5. Parasitic roundworm disease
6. Malaria

PRION DISEASES

Prion diseases or transmissible spongiform encephalopathies (TSEs) are a family of rare neurodegenerative disorders that affect both humans and animals. Experts believe that the causative agent is a prion, an abnormal transmissible agent that can induce folding of normal cellular prion proteins in the brain, leading to brain damage. Human prion diseases include:

1. Fatal familial insomnia
2. Creutzfeldt-Jacob disease
3. Gerstmann0Straussler-Scheinker Syndrome
4. Kuru

H1N1 – SWINE FLU

What it is

Influenza viruses happen naturally among pigs, hogs and boars. Swine influenza is contagious among swine and can make some pigs seriously ill. It is not common for swine flu viruses to affect humans.

However, like all influenza viruses, swine flu viruses change constantly. In occasional cases, transmission to humans do happen, usually in people who have contact with infected animals .

Transmission

Pigs can transmit swine flu viruses to people and people can transmit the same to pigs. These likely happen when people work in close proximity to infected pigs such as in pig barns or livestock areas. Human to human transmission can also occur.

Person to person transmission occurs through coughing or sneezing of people with infections. People may also become infected by touching objects (called fomites such as door knobs, telephone receivers, television remote controls) with flu viruses on it and then touching their mouth or nose.

Food, when properly handled or cooked (internal temperature at 160 degrees Fahrenheit or 71 degrees Celsius) cannot transmit swine flu.

Symptoms

The most common symptoms of H1N1 influenza in humans are similar to seasonal flu symptoms

- Fever
- Sore throat
- Cough
- Body aches
- Fatigue or lethargy
- Chills
- Runny nose

Emergency Signs

Reports have been made of some people experiencing diarrhea and vomiting associated with H1N1 flu. People with chronic conditions such as diabetes, asthma and congestive heart failure may experience worsening of their symptoms. Those with severe symptoms should see a doctor immediately. In children, some emergency signs that require prompt medical assistance include:

- Rapid breathing or trouble breathing
- Bluish skin color
- High or prolonged fever
- Not drinking enough fluids
- Inability to wake up
- Unable to interact
- Extreme irritability and not wanting to be held

In adults, some emergency warning signs include:

- Difficulty in breathing or shortness of breath
- Pain or pressure in chest or abdomen
- Sudden dizziness
- Near-fainting or fainting
- Confusion
- Severe or persistent vomiting
- High or prolonged fever

Treatment

Health care providers may prescribe different treatments according to severity of illness. A doctor may prescribe antiviral drugs that may come in the form of pills, liquids or inhalers. Most people get better without antiviral medicines. Other flu treatments may include:

Σ Plenty of rest

Σ Medications to bring down fever

Σ Drinking plenty of water

If complications happen, hospitalization may be required. Patients may be given oxygen or respirators. Children or teenagers should never be given aspirin without first consulting a healthcare provider.

Prevention

A vaccine is available and is recommended for certain groups.

Other preventive measures include:

- Frequent washing of hands with soap and water especially before eating and after sneezing or coughing
- Use alcohol gel products if available to clean hands
- Covering mouth and nose with elbow or sleeve when sneezing or coughing. Throw away tissues after use. Washing of hands after sneezing or coughing.
- Avoid close contact with sick people.
- Avoid touching one's eyes, nose or mouth.
- Stay in good health. Get enough sleep and be physically active.
- Drink plenty of fluids and eat nutritious foods.

AVIAN INFLUENZA***What it is***

Avian influenza is an infection caused by avian (bird) flu viruses which occur naturally among birds. Wild birds worldwide carry the virus in their intestines but may not get sick from them. Avian flu is highly contagious among birds and can make domesticated fowl like chickens, ducks and turkey seriously ill and kill them.

Infected birds shed influenza virus in their saliva, nasal secretions and feces. Infection among domestic poultry may take two forms, a "low pathogenic" form that may go undetected as they produce mild symptoms (such as ruffled feathers or decrease in egg production). The other, a "highly pathogenic form" spreads more rapidly and can cause mortality rates between 90% -100%, often within 48 hours.

Transmission

Avian influenza virus usually refers to influenza A viruses found mainly in birds but infections with these viruses can occur in

humans. Confirmed cases of human infection from several subtypes of avian influenza infection have been reported since 1997. There are three subtypes of influenza viruses (H1N1, H1N2 and H3N3).

Direct contact with infected poultry or surfaces and objects contaminated by feces from infected birds are the main routes of human infection. Exposure is most likely during slaughter, de-feathering, butchering and preparation of poultry for cooking.

Symptoms

The most common symptoms of avian influenza in humans are similar to seasonal flu symptoms

- Fever
- Sore throat
- Cough
- Body aches
- Fatigue or lethargy
- Chills
- Runny nose
- Emergency Signs

Emergency signs are similar to those of seasonal influenza. People with chronic conditions such as diabetes, asthma and congestive heart failure may experience worsening of their symptoms. Those with severe symptoms should see a doctor immediately. In children, some emergency signs that require prompt medical assistance include:

- Rapid breathing or trouble breathing
- Bluish skin color
- High or prolonged fever
- Not drinking enough fluids
- Inability to wake up
- Unable to interact
- Extreme irritability and not wanting to be held

In adults, some emergency warning signs include:

- Difficulty in breathing or shortness of breath
- Pain or pressure in chest or abdomen
- Sudden dizziness
- Near-fainting or fainting
- Confusion
- Severe or persistent vomiting
- High or prolonged fever

Treatment

Health care providers may prescribe different treatments according to severity of illness. Two drugs (in the neuraminidase inhibitors class) oseltamivir (also known as Tamiflu) and zanamivir (Relenza) can reduce the severity and duration of illness. An older class of antiviral drugs, the M2 inhibitors amantadine and rimantadine could be used but resistance to these drugs can develop rapidly and this could significantly limit their effectiveness. Most people get better without antiviral medicines. Other flu treatments may include:

- Plenty of rest
- Medications to bring down fever
- Drinking plenty of water

If complications happen, hospitalization may be required. Patients may be given oxygen or respirators. Children or teenagers should never be given aspirin without first consulting a healthcare provider.

Prevention

Vaccines effective against pandemic flu take time to develop. Commercial production usually become available several months after the start of a pandemic. Other preventive measures include:

- Frequent washing of hands with soap and water especially before eating and after sneezing or coughing

- Use alcohol gel products if available to clean hands
- Covering mouth and nose with elbow or sleeve when sneezing or coughing. Throw away tissues after use. Washing of hands after sneezing or coughing.
- Avoid close contact with sick people.
- Avoid touching one's eyes, nose or mouth.
- Stay in good health. Get enough sleep and be physically active.
- Drink plenty of fluids and eat nutritious foods.

WEST NILE VIRUS INFECTION

What it is

West Nile virus is an infection spread by mosquitoes. The condition ranges from mild to severe and cause deaths. The West Nile virus was first identified in 1937 in Uganda. This virus is a type of virus known as a flavivirus.

Transmission

Experts believe that the virus is spread when a mosquito bites an infected bird and then bites a person. Mosquitoes carry the highest amounts of the virus in the early fall, usually late August to early September. Few people develop severe disease or even notice any symptom at all. Risk factors include:

1. Older age
2. Pregnancy
3. Conditions that weaken the immune system
4. Recent chemotherapy
5. Recent organ transplants

Symptoms

A mild form of the disease has some or all of the following symptoms (usually last 3-6 days):

1. Fever
2. Headache
3. Abdominal pain
4. Back pain
5. Diarrhea
6. Sore throat
7. Nausea
8. Vomiting
9. Lack of appetite

With a more severe form of the disease, the following symptoms can also occur:

1. Confusion or change in ability to think clearly
2. Loss of consciousness
3. Muscle weakness
4. Stiff neck

Prognosis or likely outcome of a mild West Nile virus infection is excellent.

Treatment

Antibiotics will not help since the disease is not caused by bacteria. Standard hospital care may help decrease risk of complications in severe illness. Researchers are testing whether ribavirin, an antiviral drug used to treat hepatitis C may be helpful.

Tests to diagnose West Nile virus include:

1. Complete blood count (CBC)
2. Head CT scan
3. Head MRI
4. Lumbar puncture and cerebrospinal fluid (CSF) testing

Prompt medical attention is important. If severely ill, the sick person should be brought to an emergency room immediately.

EBOLA HEMORRHAGIC FEVER

What it is

Ebola hemorrhagic fever is a severe, often fatal disease in humans and non-human primates (monkeys, gorillas and chimpanzees) that was initially recognized in 1976. The disease is caused by an infection with Ebola virus (named after a river in the Democratic Republic of the Congo (formerly Zaire) in Africa). The virus is one of two members of the a family of RNA virus called the filoviridae.

Transmission

Infections with Ebola virus are acute. There is no known carrier state. Because the natural reservoir is unknown, the start of an outbreak in humans has not been determined. The Ebola virus species have displayed the ability to spread through airborne particles under research conditions but this has not been established among humans in real-world settings.

Symptoms

The known incubation period ranges from 2 to 21 days. The onset of illness is abrupt and characterized by:

1. Fever
2. Headache
3. Joint and muscle aches
4. Sore throat
5. Weakness
6. Diarrhea
7. Vomiting
8. Stomach pain

Researchers do not understand why some recover from Ebola hemorrhagic fever and others do not.

Treatment

There is no standard treatment for Ebola. Patients often receive supportive therapy consisting of balancing a patient's fluids and electrolytes, maintaining their oxygen status and blood pressure and treating complications.

Prevention

There are few established prevention measures because the identity and location of the natural reservoir of the Ebola virus are unknown. Among health care providers, techniques used when Ebola case has been established include wearing of protective clothing, such as masks, gloves, gowns and goggles; the use of infection control measures, including complete equipment sterilization and isolation of Ebola cases. The aim is to avoid any person's contact with the blood or secretions of the patient. Contact with the body of a deceased patient is avoided.

MULTI-DRUG RESISTANT TUBERCULOSIS

What it is

Multi-drug resistant TB also referred to as MDR-TB is a form of tuberculosis resistant at least to two of the frontline drugs used to treat tuberculosis—isoniazid (INH) and rifampicin (RMP). A forthcoming study by Johns Hopkins researchers that will appear in the *International Tuberculosis and Lung Disease Journal*, January 2010, documents a strain of anti-biotic resistant tuberculosis that actually thrives in rifampicin.

Pulmonary tuberculosis usually attacks the lungs but can also affect other parts of the body. WHO estimates that about 2 million die from tuberculosis each year and a growth of MDR-TB is of grave concern. XDR-TB is extremely drug resistant tuberculosis

to most effective anti-TB drugs, first line and second-line medications.

Transmission

Transmission occurs when infected people cough, spit, sneeze or expel infectious aerosol droplets (even when speaking) and others are nearby. A sneeze can release up to 40,000 droplets. People with prolonged contact with infected persons may have infection rates as high as 22%. A person with active but untreated TB may infect 10-15 people each year. Patients whose immunity has been compromised by other diseases such as AIDS are highly vulnerable to TB.

MDR-TB usually develops due to poor compliance to earlier treatment regimen.

Symptoms

The common symptoms of TB include:

1. Chest pains
2. Coughing for more than three weeks
3. Coughing up blood
4. Fever
5. Chills
6. Night sweats
7. Loss of appetite
8. Weight loss
9. Fatigue
10. Pallor

MDR-TB manifests itself when patients do not respond to treatment or show signs of getting worse. Diagnosis may take 6-16 weeks as extensive laboratory tests are required to differentiate MDR-TB from more common tuberculosis.

Treatment

Treatment for MDR-TB and XDR-TB is the same and may require extensive chemotherapy up to two years. Second line drugs are more toxic than first-line drugs and may cause serious complications or side-effects.

Prevention

Country tuberculosis programs should adhere to international standards and ensure compliance of patients to recommended treatment. TB programs should provide proper diagnosis and treatment to all TB patients, including those with drug-resistant TB; assuring regular, timely supplies of all anti-TB drugs; proper management of anti-TB drugs and providing support to patients to maximize adherence to prescribed regimens.

MDR TB and XDR-TB cases should be placed in a centre with proper ventilation, and contact with other patients should be minimized, particularly those with HIV, especially in the early stages before treatment has had a chance to reduce the infectiousness.

Highlights of WHO Outbreak Communication Guidelines

The WHO Outbreak Communication Guidelines provide evidence-based, field tested communication guidance to promote the public health goal of rapid outbreak control with least disruption of society. Experts made a thorough review of the literature and distilled the following list of best practices:

1. The overriding goal for outbreak communication is to communicate to the public in ways that build, maintain or restore trust.

- The consequence of losing public trust can be severe in health, economic and political terms.
- Senior management must endorse trust building but there are barriers:
 - Trust building measures may be counter-intuitive such as acknowledging uncertainty or avoiding excessive reassurance.

- Trust among communicators, policy makers and health professionals is crucial. This is called the “trust triangle”.
- Trust in communicating with the public is critical in both directions.
- Mechanisms of accountability, involvement and transparency are important to build and maintain trust.

2. Announce early

The parameters of trust are established in the outbreak’s first official announcement. The message’s timing, candor and comprehensiveness may make it the most important of all outbreak communications.

- In today’s globalized, wired world, information about outbreaks cannot be hidden.
- People are likely to overestimate the risk if information is withheld.
- An announcement must be made when public behavior might reduce risk or contribute to containment of the disease.
- The small size of an outbreak is no reason to withhold information.

There are some problems to consider:

- Rapid announcements may surprise some important partners who may not agree with the initial assessment.
- Early announcements are often based on incomplete and sometimes erroneous information.

The benefits of early announcement outweigh the risks and risks can be minimized with appropriate outbreak messages.

3. Transparency

Maintaining the public's trust throughout an outbreak requires transparency (i.e. communication that is easily understood, complete and factually accurate).

- Transparency provides many benefits, including demonstrating that how even at a time on uncertainty, outbreak managers are seeking answers.
- Transparency can provide incentives for deliberative and accountable decision-making.
- Total candor must be the operational goal consistent with generally accepted individual rights such as patient's privacy.
- Many barriers may block transparency
 - Economic arguments versus human health concerns
 - Media preparation should be an essential component of professional development of public officials.

Transparency by itself will not produce trust. People must see competent decisions. In general, greater transparency means greater trust.

4. The public

Understanding the public is critical to effective communication.

- Risk communication is dialogue. It is not "decide and tell" strategy.
- "Communications surveillance" is understanding the public's beliefs, opinions and knowledge.
- Representatives of the public must be brought into the decision-making process.
- Public concerns, even if unfounded, must be appreciated.
- Risk communication messages should include information about what the public can do to make themselves safer.

5. Planning

The decisions and actions of public health officials have more effect on trust and public risk perception than communication.

- Have a risk communication plan ready before it is needed.
- The need to acknowledge uncertainty must be conveyed to senior managers.
- Issues of first announcements, limits of transparency and other communication components should be agreed upon with senior management and ideally by policy makers before a crisis breaks.

