Behavior Change Communication for Pandemic Influenza Response: PLANNING GUIDANCE
PREAMBLE:

This publication is the product of ongoing collaboration over the past four years between UNICEF and AI.COMM, a USAID project managed by AED, to design and implement effective communication programs in developing countries, first for avian influenza and more recently for pandemic influenza preparedness and response. AI.COMM has been USAID’s principal mechanism for developing communication strategies and tools to prevent and control influenza outbreaks, including those approaches discussed in the framework of this document—behavior change communication, social mobilization, policy advocacy, and risk communication. In addition to sharing this framework, UNICEF bases its approach to communication on the human rights principle that children and adolescents, their families, and communities have the right to information, communication, and participation. Thus, UNICEF promotes full participation, gender equity and social inclusion in the development process in general, and in communication in particular.

ACKNOWLEDGEMENTS:

This document was jointly prepared and funded by UNICEF and AI.COMM. The writing team was led by Rebecca Fields from AI.COMM and Judith Graeff from UNICEF/New York. Drafts of the document were reviewed by staff from UNICEF, AI.COMM, and USAID, including: Françoise Vanni (UNICEF/Mexico); Surangani Abeyesekara and Patricia Portela Souza (UNICEF/Bangladesh); Sahar Hegazi (UNICEF/Egypt); Tran Tung (UNICEF/Asia Pacific Shared Services Centre); Pornthida Padthong (UNICEF/Thailand); Natalie Fol and Fabio Friscia (UNICEF/West and Central Africa); Paula Claycomb, Teresa Stuart, Neha Kapil, and Jesus Lopez-Macedo (UNICEF/New York); Anton Schneider (AI.COMM/Thailand); Eleanora De Guzman (AI.COMM/Vietnam); Cecile Lantican (AI.COMM/Lao PDR); Yaya Drabo (AI.COMM/West Africa); Phil Sedlak (AI.COMM/Nepal); Soliman Farah (AI.COMM/South Asia); Mark Rasmuson and Dee Bennett (AI.COMM/Washington); and Kama Garrison (USAID/Washington).
### TABLE OF CONTENTS

3  Preamble and acknowledgements
7  Introduction
7  Intended users of this planning guidance
8  Technical basis of communication for the H1N1 influenza pandemic
8  A coordinated approach to communication planning
9  Focus on social mobilization and behavior change communication
10 Planning for different scenarios
12 Lessons learned from past epidemics
12 Communication for pandemic response: Key elements
   • Communication objectives
   • Key participant groups
   • Desired and feasible behaviors
   • Adapted messages
   • Credible sources of information and appropriate channels
   • Advocacy
   • Partners for social mobilization
   • Behavior change communication
   • Risk/outbreak communication
   • Research and monitoring
21 Bringing communication key elements together for action
22 Suggested resource materials

Text boxes and figures

8  Text box 1: WHO/UNICEF recommended behaviors
9  Text box 2: Egypt: National multi-disciplinary/agency coordination body
11  Text box 3: Lessons learned on effective communication from avian influenza and SARS experiences
20  Figure 1: Communication for pandemic H1N1 influenza response: levels, participants, actions
INTRODUCTION

In June, 2009, the World Health Organization officially declared that a global pandemic of type A (H1N1) influenza was under way. One of the critical interventions to limit the transmission of the disease, mitigate its health impact, and contain the social and economic disruption it may cause is to ensure the ongoing provision of effective communication.

This document provides an overview of strategic communication as it applies to pandemic influenza in low and middle income countries. It is based both on technically sound communication principles and recent experience in several countries that have been proactive in communication efforts related to pandemic and avian influenza.

The purpose of this document is to provide a framework and guidance to planners for developing country-specific social mobilization and behavior change communication strategies for pandemic influenza. These strategies incorporate communication objectives, participant groups, desired behaviors, types of messages, selection of channels, and approaches to communication planning and implementation in support of country-level efforts for pandemic influenza response.

A key component of the social and behavior change communication process is to integrate the involvement of marginalized and hard-to-reach groups in communication planning and implementation so that they become active participants - not just passive recipients of information. Involvement not only helps to adapt communication strategies and messages to the local context, but also connects the perspective of minorities and the hard-to-reach to upstream policy advocacy regarding pandemic response issues—for example, steps to take to reduce inequities in economic impact. In addition, access to limited supplies of vaccine and anti-viral medications could become a critical issue. Communication should play a role in advocating for equitable access, in accordance with official medical recommendations for the use of these products.

Some countries may choose to use this guidance to help develop a focused plan of action for immediate response, while others may find it useful in drafting a broader, longer-term strategy. This decision will be made depending upon national needs, capacity and the extent of communication planning that has already been carried out for pandemic influenza. For example, in countries with no, or very few, cases of type A H1N1 (2009) influenza despite the pandemic, this time of heightened global awareness can be used as an opportunity to prepare and to strengthen ongoing development and communication initiatives.

INTENDED USERS OF THIS PLANNING GUIDANCE

This guidance document is intended primarily for those who are already familiar with the basic principles of communication planning and implementation. It is not a detailed, “how-to” document with step-by-step instructions on each aspect of
communication planning and implementation, but rather a concise overview of communication as it pertains to pandemic influenza. For readers seeking more detailed information, the Resources section of this document provides references and electronic links to additional documents and websites.

This document might also be shared with governments, donors, and within one’s own organization to advocate for adequate human, financial and material resources to plan and implement effective communication during a pandemic.

TECHNICAL BASIS OF COMMUNICATION FOR THE H1N1 INFLUENZA PANDEMIC

The approaches and content reflected here support the current recommendations on pandemic influenza of the World Health Organization and other international health partners. Because the actual course of disease for pandemic (H1N1) 2009 cannot be predicted with certainty, and because the effectiveness of some public health interventions is still being determined, readers are encouraged to consult WHO information sources on a regular basis. These sources present clearly the recommended actions that national communication initiatives are to promote; key behaviors are described in Box 1. As the technical response to the pandemic continues to evolve, so must communication efforts to support that response.

WHO/UNICEF recommended behaviors:

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

TO LESSEN THE 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

*WHO/UNICEF: Behavioural interventions for reducing the transmission and impact of influenza A (H1N1) virus” June, 2009

A COORDINATED APPROACH TO COMMUNICATION PLANNING

National governments are the lead authority on pandemic response and communication. Because pandemic influenza has social and economic consequences as well as health consequences, representation from a wide range of development partners, both public and private sector, needs to contribute to both pandemic preparedness and response. Coordination is also the key to success in planning and implementing strategic communication for a situation as complex as pandemic influenza.

National governments have found that working through a designated coordination body with membership to reflect the broad range of partners and stakeholders improves the planning and delivery of an effective response, including communication. Rather than creating a new group, some countries have chosen to make use of existing coordination bodies, adjusting their membership to address

1 For current, authoritative information on the evolving global situation, readers should consult the WHO website on pandemic (H1N1) 2009 influenza http://www.who.int/csr/disease/swineflu/en/index.html
the particular circumstances of pandemic influenza. For example, if a coordinating
body already exists for avian influenza, its terms of reference and membership can
be revised to include representatives from the Ministry of Education (as Egypt did,
shown in Box 2). The H1N1 (2009) pandemic has shown that policy decisions on
school closings require the input of ministries of education. In addition, the potential
communication network of national and private education systems can play an
important part in the pandemic influenza response.

Some countries have found it useful to establish a small task force – linked to
the overall coordination body for pandemic influenza—to deal specifically with
communication planning and implementation. A sample terms of
reference for a communication task
force is available on

These coordination bodies
should create the platform for
communication partners to work
closely with health officials and
councillors, plan what information
will be disseminated, and decide
how this will be accomplished. The
expertise of behavior and social
change communication specialists
complements that of epidemiologists
and biomedical experts. Both
types of capabilities are needed to
assure that the correct information reaches intended population groups in a way that
stimulates the desired actions. As much as possible, representatives of key minority
and vulnerable groups should participate in coordination bodies and planning
activities. This helps to ensure that communication reaches these groups effectively
and that their voices are heard during the pandemic.

In most countries, national coordinating bodies for communication will also need to
establish linkages with structures at sub-national (e.g., district) levels. Communication
officials at these levels play an important role in identifying the local populations
who are particularly vulnerable or marginalized and in further adapting messages,
channels of communication, and specific communication activities to reach them.
Communication officials at district and/or municipal levels can also work with local
resources such as community radio stations, local businesses, community groups or
structures, and religious leaders to reach out to different segments of the population.

**FOCUS ON SOCIAL MOBILIZATION AND BEHAVIOR CHANGE COMMUNICATION**

When an outbreak occurs, the first task of the communication team is to carry out
risk/outbreak communication. This is the communication process during any
emergency when national and local government authorities transmit correct
Risk communication is an important component of the overall communication needed during a pandemic, and if implemented well, goes far in supporting the government’s credibility in handling the emergency. This strategy alone, however, is not enough to mobilize the population to help in reducing transmission and mitigating the health, social, and economic impact of the pandemic. Thus, communication must also use social mobilization, behavior change communication, and policy advocacy through a variety of channels and through broader partnerships with education, water and sanitation, humanitarian groups, private sector stakeholders, etc. This multi-faceted approach helps to ensure that key segments of the population are hearing and understanding correct information.

This document focuses specifically on social mobilization and behavior change communication at the community level—to complement risk communication.

**PLANNING FOR DIFFERENT SCENARIOS**

While this guide focuses on communication activities needed during a local outbreak, advance planning is crucial to ensure that those activities take place in a coherent and effective fashion. As an outbreak progresses in a country, communication strategies will need to address the changing scenarios:

a. No cases of H1N1 influenza have been detected in the country (pre-outbreak)
b. At least one confirmed case of H1N1 has been detected in the country
c. A full outbreak of H1N1 is under way in the country
d. An epidemic wave of H1N1 has passed.

As of mid-2009, the great majority of countries had detected at least one case of pandemic (H1N1) 2009 influenza and many have experienced a full outbreak. Those that have already acquired experience in communication to support pandemic influenza response have the opportunity to feed that experience into future planning. Countries may also be able to build communication planning for pandemic influenza into standard, annual, emergency preparedness plans. Several of the steps described in this guide should be included in such planning to minimize last-minute commotion and confusion. These steps include reviewing existing demographic and social data to identify key participant groups and credible channels of communication; designing and pre-testing messages and materials; pre-positioning production agencies for materials, broadcast programming; establishing lines of communication with radio and TV stations; and pre-arranging with theater groups. All of these activities can be initiated in advance of an outbreak. However, actual production of communication materials and roll out of activities should be held until the timing is appropriate.

Advance planning should also include how to change communication as the response to the spread of the virus unfolds—in terms of both

Advance planning is critical but must be flexible enough to accommodate changes in the evolving situation with pandemic influenza.
LESSONS LEARNED ON EFFECTIVE COMMUNICATION FROM AVIAN INFLUENZA AND SARS EXPERIENCES

These “lessons learned” have been extracted from two surveys of communication experiences gained from several recent epidemics. The Waisbord report\(^2\) 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 officers in the field. The Schiavo paper\(^3\) looked more broadly at lessons learned from avian flu, SARS, Ebola and anthrax outbreaks—conducting a literature review and 19 in-depth interviews with a variety of experts working in communication, emergency operations and public health, from national governments and global agencies. The consistency of response is striking. The lessons learned are summarized below. Full versions of these reports can be found on: www.influenzaresources.org

1. Communication interventions have been reportedly effective in increasing knowledge. Reports show that knowledge about modes of transmission, symptoms, safe ways of disposing of sick/dead birds and prevention increased after communication interventions.

2. Increases in knowledge do not necessarily translate into effective behavioral changes. This leads to a considerable knowledge-practice gap. Few behavioral changes were found after communication interventions, even when knowledge about prevention and transmission increased.

3. Communication interventions should go beyond information transmission given that the 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 to do—even if an individual is motivated. Wider practice of recommended behaviors is often enhanced by changing policy, physical, and economic barriers rather than focusing communication on individual attitude and knowledge.

5. Easy access and trust are two key considerations in selecting communication channels. These elements will be different for different audiences—thus segmenting audience groups is a critical part of the planning process.

6. Engaging trusted community groups and leaders may be more effective in reaching vulnerable/marginalized groups than disseminating centrally-generated messages through mass media.

7. Communication should address local attitudes and stigma possibly associated with doing the desired behaviors.

8. Messages should clearly tell people what benefits they would reap if they were to practice the recommended behaviors. Benefits should not be limited to conventional public health goals such as “achieving healthy communities/families” or “preventing disease”. They should also consider a host of immediate social and economic rewards that can be associated with desired behavior.

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

10. Coordination among government counterparts, development partners and UN agencies is crucial for effective communication with harmonized messages. This avoids confusion that can impede widespread adoption of recommended behaviors.

11. Early integration of medical and scientific teams with communication teams can further contribute to a 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 reaction during crises. Well managed, credible communication increases the likelihood that recommended behaviors and social actions will be adopted by the population.

13. Early participation of key private sector partners, such as physicians and pharmacists, and commercial sector businesses and employers is important so they will take their role in reducing transmission and mitigating the health, social and economic impact of the disease.


\(^3\) “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, Renata Schiavo, January, 2009.
public health policy and any social reaction to the response and the disease itself. An important part of planning, then, is to decide how key communication partners will remain in contact if working conditions change radically during the pandemic.

LESSONS LEARNED FROM Past EPIDEMICS

While communication for pandemic influenza has its own unique attributes, a useful body of knowledge exists from outbreaks over the past ten years of Severe Acute Respiratory Syndrome (SARS), avian influenza, and Ebola virus that can guide current communication initiatives. These are summarized in Box 3.

COMMUNICATION FOR PANDEMIC RESPONSE: KEY ELEMENTS

In the current response to pandemic (H1N1) 2009 influenza, some countries are able to build upon the communication strategy and activities conducted for avian influenza and pandemic preparedness. Other countries are less well prepared. In either case, it is important to find a balance between working rapidly to implement the communication necessary for the response while also respecting the fundamentals of effective social and behavior change communication—the use of evidence, participation, and adaptation.

In order to find this balance, it is useful to rely on existing resources as much as possible. For example, planners can use existing demographic and social data (such as from Demographic and Health Surveys – DHS) for selecting participant groups and communication channels; or they can use existing networks at the community level for social mobilization and behavior change communication.

The following key elements should be included in a communication strategy to support a country’s response—particularly at the community level—to the current pandemic influenza.

COMMUNICATION OBJECTIVES: For communication to be effective, especially at a time of a pandemic when there is uncertainty about how it will affect a country, key partners and stakeholders should reach consensus at the national level on the objectives of communication. This should happen before an outbreak occurs in the country. On a generic level, these objectives include the following:

- Help to reduce transmission of disease
- Mitigate health impact
- Minimize panic and social disruption
- Help governments provide credible information during response

Some countries will use this current pandemic to develop a comprehensive, long-term strategy to encompass newly emerging infectious diseases and pandemics. Other countries will modify an
existing strategy developed for avian influenza and pandemic preparedness, or develop a brief strategy just to address the current pandemic.

Regardless, the strategy should describe how communication will use a combination of advocacy, social mobilization and behavior change communication through a variety of channels to achieve each objective. For example, to reduce disease transmission:

- advocacy to make appropriate policy changes can be carried out with public and private schools and major employers;
- social mobilization activities can be implemented to create a supportive environment for recommended hygiene and cough etiquette behaviors;
- behavior change communication activities can be conducted to tailor messages to the needs of each participant group, including school children, people at work, parents, and slum dwellers.

Any communication strategy should include an action plan to guide communication activities for immediate implementation.

**KEY PARTICIPANT GROUPS:** Many communication professionals use terms such as target group or target audience to indicate the segments of the population for which the communication is intended; these terms suggest a passive recipient of information. This document, however, uses the term “participant group” to designate the people at various levels who need to take action for an effective communication response to the pandemic. Suggested participant groups at all levels and the actions they can take to support appropriate pandemic response are illustrated in Figure 1 on page 20.

The selection of key participant groups should be based on data from previous research, current programs, and communication initiatives.

Variables to consider when selecting key participant groups are:

- **Epidemiological evidence**—Pandemic (H1N1) 2009 mostly affects pregnant women, young people (between 5 and 24 years of age), and people with preexisting health conditions such as asthma, diabetes and obesity. Readers are encouraged to check www.who.int for updated information.
- **Socially-marginalized groups**, such as slum dwellers, minorities, and women are vulnerable to social and economic consequences of any emergency.
- **Language groups**—including languages used by indigenous or immigrant groups; such groups risk being excluded from the information flow.
- **Urban and rural populations** have access to different channels of information.
- **Children and adolescents** are vulnerable to H1N1 disease, and country experience indicates that they are at risk of abuse during a prolonged pandemic. They also risk having interrupted schooling. Children in orphanages,
correctional institutions, migrant/refugee camps, and boarding schools might have no one to advocate for their right to equal access to care.

Marginalized groups: An important consideration in pandemic response is how to involve and reach socially-marginalized groups in a country. The very fact that they are marginalized (by ethnicity, race, religion, economic means, displacement, profession) means that they are rarely involved in decisions affecting their well-being and have less access to information and services. Communication for social and behavior change emphasizes inclusion of the marginalized in all steps of the communication process, yet in a pandemic response mode, planners are often pressured to get one set of messages out to the “general public” as rapidly as possible. Understanding this reality, following are some possible ways to increase meaningful engagement of and reach to marginalized groups.

a. Work with the government to map traditionally marginalized groups in the country and advocate for commitment that they will be reached during the pandemic.

b. Identify humanitarian groups (such as the International Red Cross/Crescent, Médecins Sans Frontières, Catholic Relief Services, and UN humanitarian agencies) that could reach marginalized people and orient/equip these agencies with appropriate communication materials.

c. Involve local leaders or advocacy groups for the marginalized in various aspects of pandemic response (not just in pre-testing materials!). Representatives can participate in planning how to disseminate prevention messages to their respective group(s); help adapt messages to the lifestyle reality of their group; and update the group continually as the pandemic progresses.

These steps might be politically sensitive and will take time and resources just when they are scarce. But the benefits to the country will be great if marginalized populations feel more engaged and therefore more likely to take appropriate action in a time of national alert.

DESIRED AND FEASIBLE BEHAVIORS: In May 2009, WHO and UNICEF disseminated eight key behaviors (shown in Box 1) that will help to reduce transmission and lessen the health impact of the (H1N1) 2009 influenza. Countries may also choose to adopt some non-health behaviors to the essential list, such as infant feeding, child protection, and continued learning during school closures.

With these behaviors as a starting point, it is important to seek wide participation in how these behaviors can be adapted to the local context. In addition to discussions within the national coordination body, representatives of key minority groups, youth, or other important segments of the population can be included on planning and message design teams.

Addressing feasibility: In an effort to respond rapidly, some planning teams may not see the need to adapt recommended behaviors to the realities of the population. Failure to go into more detail about the feasibility of recommended behaviors, however, risks lowering both the effectiveness and the credibility of communication efforts. For example, how will people cover coughs and sneezes if no cloth or
Disposable tissues are available? How can sick people stay home if their family depends on their daily earnings? How can transmission be reduced in schools where frequent hand washing and physical distancing are not possible? How can public transport or daily marketing be made safer? Taking the time to address these issues in developing a list of feasible behaviors will improve their widespread adoption.

Making some behaviors feasible for individuals is often better addressed at the policy level. The last two questions above might be better addressed with temporary policy changes rather than an emphasis on individual behavior change. To lower transmission at work settings—another example—temporary changes in scheduling, work space and work processes could improve hand washing possibilities, facilitate safe disposal of tissues and face masks, and lower occasions for close contact. Communication plans should include policy advocacy to trigger timely and appropriate decisions by government and pandemic partners to support adoption of recommended behaviors to scale.

**ADAPTED MESSAGES:** Sometimes the first reaction planners have to the time pressure during pandemic response is to develop generic messages based on scientific evidence alone. Planners often think that translating generic messages into multiple local languages is a sufficient way to adapt them. However, messages based exclusively on technical content are unlikely to be fully effective in promoting desired behaviors and social action. Messages need to reflect local perceptions of risk and disease transmission and an understanding of the perceived consequences to performing desired behaviors. Emotional appeal is also important in message development. In some countries, social research data will be available to inform the design of messages. But if not, it will be particularly important to conduct a small number of focus group discussions with selected participant groups to assure (at a minimum) that messages are understood and acceptable. As stated earlier, representatives of key participant groups should participate in communication planning (such as message development workshops) to facilitate adaptation of messages to these groups.

One serious issue that has arisen in some countries that have been hard hit by the 2009 influenza pandemic is stigma against sick people and members of their households. Communication teams should anticipate this possibility and revise their messages as needed to promote supportive actions and care toward those who are directly or indirectly affected by pandemic influenza.

**CREDIBLE SOURCES OF INFORMATION AND APPROPRIATE CHANNELS:** The channels to use during the pandemic are likely to vary widely depending upon how different segments of the population (participant groups) access and use information. As much as possible, planners can use existing data to determine access and credibility of communication channels for the participant groups mentioned in the communication
strategy. For example, there may be substantial differences between urban and rural areas regarding access to and credibility of messages provided through mass media.

In the early stages of a country’s response to the pandemic, radio, TV, and flyers/posters are often the channels of choice. Their advantage is their broad reach and ability to handle “fast-breaking news”. But many countries have discovered that as the pandemic continues, other channels need to be used to reach effectively different participant groups such as school children, pregnant women, indigenous peoples. For example, interpersonal communication from trusted sources is likely to be important to reach marginalized populations or those outside the reach of broadcast media. (See section on partners for social mobilization below).

Interpersonal communication (IPC) channels, having limited reach, can reinforce and personalize the general information provided through mass media channels and can provide opportunities for dialogue and problem-solving that other channels cannot. In a highly contagious influenza pandemic, however, the use of IPC might be limited because of potential transmission opportunities. Ways to use IPC without close physical contact include using megaphones, remaining outside during household visits, and not giving handouts.

Health care providers and community health workers can play a role in IPC during the pandemic. Yet, when an outbreak occurs, health care services can be overwhelmed and health workers are likely to be overtaken by clinical duties; so their role as communicators can be greatly compromised. While they cannot provide typical health education sessions during an outbreak, they can learn to communicate with patients and families during clinical care. Thus, health workers should be prepared so that they can provide key information, respond to the concerns of their patients, and communicate their patients’ concerns onward as needed. The national and local coordinating bodies should determine who will take responsibility for communication training of health workers so that it is integrated into the national communication plan.

The education system is an important communication channel in pandemic response—both through policy decisions and through promoting preventive behaviors while schools are in session. Behavior change communication can reach students through age-appropriate lessons, games and songs as well as through

<table>
<thead>
<tr>
<th>COMMUNICATION CHANNELS</th>
</tr>
</thead>
<tbody>
<tr>
<td>MASS MEDIA: Television, radio, newspapers, posters, billboards, leaflets</td>
</tr>
<tr>
<td>TRADITIONAL MEDIA: folk theatre, puppets, poetry/song, social &amp; religious gatherings</td>
</tr>
<tr>
<td>INTERPERSONAL COMMUNICATION: household visits, courtyard meetings, health education, social mobilization, school activities</td>
</tr>
<tr>
<td>NEW MEDIA: Cell phones, SMS, internet (websites, blogs, Twitter), telephone hotlines</td>
</tr>
</tbody>
</table>
peer group interaction. Teachers and students are often seen as credible sources of information and can be mobilized for outreach to the community.

Many countries are experimenting with new media (see text box) to help in pandemic communication. While cell phone ownership is high in many countries, information coming via SMS is usually not seen as credible. Use of cell phones, where available, might be used more effectively to update and coordinate field workers and social mobilization partners. The use of multiple channels is important for effective communication, but keeping efforts coordinated and information consistent across channels is a major challenge during pandemic response. Advanced planning and an active national communication coordination body will help to minimize confusion.

ADVOCACY: During the response to the pandemic, advocacy can be used with various ministries outside of health (for example, education, child welfare, tourism) to engage them in policy decisions at the national level to help reduce transmission and mitigate the social and economic impact. Examples of such policy decisions include whether to screen passengers at airports and place other restrictions on travel; and whether to use school closure or class dismissal as public health measures. Additional advocacy efforts may be needed to convince non-traditional partners, such as private sector organizations and businesses, that they have a stake in pandemic response. For example, factory owners, the private education system, and agri-business can be called upon to adjust temporarily their employment policies regarding absenteeism. (See “Desired and Feasible Behaviors” to see how policy change can help make desired behaviors more do-able for individuals.) All organizations should be urged to adopt business continuity measures, but this is especially important for those organizations providing essential services to the public.

Advocacy at the sub-national levels is also critical for coordinated planning and implementation to reach to the community level. In large countries or those with decentralized political systems, provincial/district authorities may be called upon to develop their own preparedness and response plans. At the very least, local authorities need to be oriented on the government’s response plan so that they can guide implementation in their area and communicate to their constituents in harmony with national decisions. Coordination of social mobilization and other community-level initiatives to reduce transmission might also rest with sub-national communication teams. Therefore, national communication planners should engage representatives of key sub-national levels to develop realistic implementation plans.

PARTNERS FOR SOCIAL MOBILIZATION: Before an outbreak occurs, a few key groups should be selected and agreements made about how they will be used for communication during the pandemic response. Civil society organizations, religious and community leaders, private sector health providers and

Before an outbreak, enlist the support of:

- Civil society organizations and NGOs
- Religious and community leaders
- Private health providers and pharmacists
- Major employers and private industries
- Networks such as teachers and student peer groups
pharmacists, major employers, NGOs and other development agencies are some of the partners to mobilize during the pandemic to reach out to people at the community level. Existing networks outside of the health sector can also be important partners in communication. These may include hygiene promoters in water and sanitation programs, community catalysts/mobilizers, agricultural extension workers, micro-credit groups, educational networks such as teachers, administrators, and student peer groups, and village development committees. One country successfully engaged herbal medicine vendors in rural markets to transmit prevention messages to their clients.

It is particularly important to find groups which can reach and are credible to some of the minorities, socially marginalized and other participant groups identified in the communication strategy.

To assure that these groups communicate correct information effectively, specially-adapted materials and orientation to their use will be important components of the communication plan. A monitoring plan that includes tracking how mobilizers are to deliver messages as the pandemic unfolds will be important to harmonize messages, minimize the spread of rumors, and maintain morale. Two-way communication between mobilizers and their field supervisor/leader should be agreed upon. For example, planners could explore the use of regular contact by mobile phone.

**BEHAVIOR CHANGE COMMUNICATION (BCC):** Behavior change communication focuses on individuals and their behavior. This guidance focuses on BCC and how it is effectively combined with other communication approaches to support pandemic response. Specifically, the role of BCC during the pandemic is to inform and motivate individuals to adopt the behaviors recommended to prevent contracting the H1N1 virus, limit its spread to others and to promote home care of the sick. These messages to individuals are spread through various channels which were described above. One effective way to motivate individuals is to engage popular and trusted personalities in addition to the official government spokespersons as sources of information.

Using a combination of mass media, interpersonal communication and traditional media will increase the effectiveness of messages to different participant groups. Examples of the kinds of materials and messages focusing on the individual and what he/she should do during the pandemic can be found on these (among other) web sites: www.pandemicpreparedness.org and www.influenzaresources.org.

**RISK/OUTBREAK COMMUNICATION:** As stated earlier, this is the term used for the communication between health and government authorities and the population of a country in a pandemic situation before and in response to an outbreak in that country. It is well documented that when government and other authorities are transparent by providing timely and correct information to the population, their efforts to reduce transmission and mitigate the impact of the pandemic are more successful. Effective risk communication, however, takes planning and capacity building, including:

- Identification and training of spokespersons from government and other selected agencies—for coordination and consistent messaging
• Media training and continued orientation—for informed and balanced reporting
• During response: regular updates to the public from authorities via mass media; maintenance of quality websites and other information sources; regular updates to hard-to-reach groups via pre-arranged communication channels; monitoring for reach and rumors.

**RESEARCH AND MONITORING:** Research during planning is important to understand participant groups’ perceptions of risk and feasibility of protective behaviors and to prepare/adapt messages and materials. Because of the time constraint, planners should use existing data sources as much as possible. For example, Demographic and Health Surveys (DHS), carried out in many countries, contain useful descriptive information about households and communities which can help inform the design of actionable messages and identify the most effective channels for communication. Previous research conducted for avian influenza, child survival, nutrition, personal hygiene, child protection, HIV/AIDS prevention, etc. that emphasized social and cultural determinants are good sources of evidence to help make the pandemic communication more strategic.

Given likely resource constraints, it may not be possible or essential to carry out quantitative baseline surveys about knowledge, attitudes, and behaviors specifically relating to pandemic influenza. While it would be desirable to have this information in order to measure the effectiveness of communication activities, it is likely to be more useful if the limited resources available are applied to pre-testing and monitoring activities, as described below.

**Pre-testing:** All communication products, including the feasibility of recommended behaviors, need to be pre-tested in a systematic way with the intended participant group. Taking time and resources to test messages and materials for comprehension and acceptability with communities before being approved by government authorities/communication committees will be more effective in achieving communication objectives. If possible, negotiate a contract in advance with a local research firm, experienced in communication pre-testing, so that it can be rapidly deployed when the communication messages and materials are ready.

**Monitoring** plans do not need to be extensive. They should match the level of effort devoted to pandemic-specific communication. Basically, the reach of communication through the most heavily-used channels (including the deployment of social mobilizers) should be monitored frequently during response—especially to track efforts to reach socially marginalized and hard-to-reach populations. Proxy indicators

If resources for research and monitoring are limited, focus on

- existing sources of information (such as household surveys)
- formative research to understand perceptions of risk and feasibility of protective behaviors and
- pre-testing of communication products and messages
- monitoring the reach of communication channels to key participant groups
FIGURE 1
COMMUNICATION FOR PANDEMIC H1N1 INFLUENZA RESPONSE

<table>
<thead>
<tr>
<th>LEVELS</th>
<th>PARTICIPANT*</th>
<th>ACTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>Local government officials, district MOH/MOE team, NGOs, hospital administration, border authorities</td>
<td>Advocacy for government transparency and appropriate policy decisions; rights of marginalized groups protected; continuous work through national coordination bodies to support pandemic response; resources allocated for communication; strategy and materials developed; authorities and media trained in risk communication; use of mass media; collection, analysis and use of research and monitoring data</td>
</tr>
<tr>
<td>Sub-national</td>
<td>CSOs, community and religious leaders, women’s groups, CHWs, teachers/school committees, youth groups</td>
<td>Local level advocacy for transparency and coordination of communication and public health response; harmonize messages; leadership trained in risk communication; social mobilization</td>
</tr>
<tr>
<td>Health facility</td>
<td>Health providers (public, private &amp; faith based)</td>
<td>Through IPC, use harmonized messages about reducing transmission and providing home care.</td>
</tr>
<tr>
<td>Community</td>
<td>Parents, adult care-givers, adolescents, other household members, children</td>
<td>Use traditional media, social mobilization, BCC in community and schools to reduce transmission, facilitate home care and social support.</td>
</tr>
<tr>
<td>Household &amp; Individual</td>
<td></td>
<td>Practice behaviors for home care, to reduce transmission, and mitigate social impact.</td>
</tr>
</tbody>
</table>

*Participants are decision makers and stakeholders who need to take the actions described.

BCC – behavior change communication  MOH – Ministry of Health
CHWs – community health workers  MOE – Ministry of Education
CSOs – civil society organizations  NGO – nongovernmental organization
can also show indirectly whether communication is “working”. For example, the appropriate use of health services (with mild cases of influenza staying home), the number and duration of rumors, incidences of unrest/violence related to the pandemic are possible proxy indicators.

Monitoring data are only worth collecting if they are put to use. They can be used for purposes ranging from informing decisions to modifying communication activities or messages. In addition, information about rumors (picked up from communication monitoring) should be shared with national and sub-national authorities so that they can address such issues early and effectively.

**Evaluation:** Evaluation looks at the outcome and impact of interventions. In pandemic influenza response, evaluation is particularly challenging because communication strategies to reduce transmission and mitigate impact can change as the outbreak progresses, and limited human and financial resources can influence the scope and quality of interventions. These factors, as well as the relatively short time for implementation, affect the kinds of outcomes that can be realistically measured to evaluate communication initiatives for the H1N1 pandemic. Further experience in communication during the pandemic will aid in the development of meaningful indicators of effective social and behavior change communication during an influenza pandemic.

**BRINGING THE KEY ELEMENTS OF COMMUNICATION TOGETHER FOR ACTION**

This planning guide has been created to highlight the key elements necessary for communication to promote appropriate behaviors during an influenza pandemic. It is widely recognized that human behavior is a key ingredient in slowing the transmission and mitigating the impact. The pandemic situation poses many challenges to achieving wide scale behavior change to reduce transmission and mitigate impact. For that reason, it is unlikely that communication objectives can be met simply by conveying key information to the public at large. Instead, multiple communication approaches are needed at different levels, involving partners ranging from high-level leaders and policy makers to sub-national health officials and personnel, to local leaders and stakeholders, to the particular communities affected by the pandemic. The perspectives that each group represents and the actions that each can take constitute essential contributions to limit the pandemic’s impact.

The pyramid in Figure 1 illustrates multilevel participation and the relationship between levels, participant groups, and actions to bring about effective communication for pandemic influenza. The exact levels and participant groups may differ among countries, and the actions presented may also vary to some extent; but the notion of different, complementary actions by different participants to bring about strong and effective communication remains as a fundamental principle.
SUGGESTED RESOURCE MATERIALS

The Humanitarian Pandemic Preparedness (H2P) Initiative, UNICEF, and their partners have worked closely with WHO and other public health agencies to develop a range of guidance documents and communication materials. These agencies and others maintain websites with specific links to the H1N1 pandemic. As these sites continue to evolve and additional resource materials are made available, readers are advised to check the websites listed below on a periodic basis.

- Multi-agency link for avian and pandemic communication resources: www.influenzaresources.org
- H2P link for communication resources: www.pandemicpreparedness.org

Useful resource documents include the following:

- Drawing Attention to Pandemic Influenza through Advocacy. March 2009. Available at: http://avianflu.aed.org/globalpreparedness.htm
- Global Preparedness for Pandemic Flu – Advocacy Kit. Available at: http://avianflu.aed.org/globalpreparedness.htm
- “Spreading the Word: Preventive Messages about Flu”. Training module for community health responders. Available on the H2P Website or on the CORE Group website at: www.coregroup.org/h2p
- “Terms of reference for a national Avian and Pandemic Communication task force” www.influenzaresources.org