Executive summary

The Workshop on Enhancing Communication around Influenza Vaccination was held in Atlanta, USA from 11 to 13 June 2013. It was attended by more than 90 participants from 31 different countries, representing developed and developing countries, national governments, vaccine manufacturers, health-care professional associations, media representatives and development partners. The workshop is part of a series of workshops that have been held to support the WHO Global Action Plan on Influenza Vaccines (GAP) and global influenza pandemic preparedness. The GAP promotes the expansion of influenza vaccine production capacity, including the establishment of new production facilities in countries and regions previously lacking capacity to ensure rapid and equitable access to influenza vaccines in the event of a pandemic. It also promotes evidence-based national policy development to increase access, up-take and use of influenza vaccines and research to develop better influenza vaccines. Communication plays a key role throughout these components and processes and is critical for establishing and maintaining public confidence in seasonal and pandemic influenza vaccinations.

The objectives of the workshop were:

- To bring together key stakeholders to identify and discuss common concerns and challenges in communicating the importance and benefits of seasonal influenza vaccination, addressing misinformation and promote acceptance by health professionals and the public, and in identifying effective communication tools.
- To provide a forum to discuss evidence-based mechanisms, best practices and effective models for strengthening national and regional communication capacities for influenza vaccination, including innovative use of a wide range of media tools.
- To delineate national and regional policy issues, priorities and options for building sustainable communication capacities in the short-, medium-, and long-term for seasonal influenza and pandemic preparedness.

The expected outcomes of the workshop were to reduce communication barriers that hinder seasonal and pandemic flu vaccine use through improving planning and application of effective communication practices, and to solicit commitment from participants to strengthen national and regional communication capacity through fostering collective learning and relationship building between different stakeholders.

A significant output from the workshop was the distillation of the work generated over two-and-a-half days into a global generic framework. This framework comprises four essential building blocks and two cross-cutting functions that a national communication system should have to be able to routinely and effectively communicate risk for seasonal and pandemic influenza.

It was reinforced during the workshop that the decision to accept vaccination for various vaccine-preventable diseases, including influenza, is complex. Despite the fact that seasonal influenza vaccines have been proven to be safe and effective, the uptake is far below what recommended internationally. In addition, the annual nature of seasonal influenza vaccines increases the difficulty for adults to decide to get vaccinated.
Communication as a science and discipline can offer a large range of opportunities to improve and support public health practice - provided public health professionals adopt a more sophisticated model of human communication to better reflect how communication takes place in real life.

There was an acknowledgment by the workshop audience that people are not passive recipients of messages and it is therefore important to understand the kind of conversations taking place concerning influenza and influenza vaccinations in health care and community settings. Directly responding to people’s concerns and needs is key to enhancing communication around influenza vaccinations. In order to achieve this level of public engagement and dialogue, influenza communication strategies must move beyond purely “messaging” and “information dissemination” to integrated communication approaches that also identify health care workers as vaccine recipients who require specific and tailored communication interventions. The interactions between health care providers and patients was highlighted as a key focus for influenza communication: to increase vaccination levels among health care workers to protect this valuable workforce; and to strengthen health care workers’ role as advocates. Strategies to engage health care providers, stakeholders and the broader public need to be within strategic and operational planning and as such, effective vaccine communication can benefit from supporting the development of a robust national communication system which contributes to the development of evidence-based policies, promotes and maintains trustful relationships, and supports the careful planning and design of appropriate health interventions.

There was a recognition of the systemic, reflexive, relational, and performative nature of communication in public health that requires an integrated and holistic framework. Such a framework needs to: a) identify essential communication structures and functions that can hinder or facilitate national influenza programmes; b) strengthen communication capacities of both communication and non-communication staff that need specific communication skills, competencies, tools, methodologies to improve the quality, timeliness and relevance of influenza data and information for decision-making and communication strategy development and implementation; and 3) improve processes and procedures that allow information flows throughout the system to enhance the overall performance of influenza programmes and allow for ongoing adaptations to vaccine production, delivery and promotion strategies.

To address a, b and c, above, a significant outcome of the workshop was distillation of four essential building blocks and two cross-cutting functions needed for an effective national communication system to able to routinely develop and execute appropriate and relevant context-specific national communication plans and strategies for seasonal and pandemic influenza.

Table 1: Proposed framework that describes the building blocks of an effective national communication system
The communication context of seasonal and pandemic influenza vaccination

Three basic questions that anyone who is considering influenza vaccination will ask are:

1. Why should I be vaccinated?
2. Will the vaccine potentially cause harm or put me at risk?
3. Is the vaccine effective at preventing influenza?

If there is no satisfactory response to any one of these questions, the potential exists for myths and misunderstandings concerning influenza vaccination to emerge. In addition, influenza vaccinations are complicated by the constant changes in the influenza virus itself which requires that circulating viruses are well-matched with vaccine viruses. This can be difficult to explain especially against the backdrop of anti-vaccination lobbyists and groups, particularly in developed countries. In fact, it is in these countries that vaccine refusal and vaccine confidence issues are concerning public health officials. The SAGE Vaccine Hesitancy Working Group is looking at barriers to vaccine uptake when access is not the primary issue, but one of confidence, complacency or convenience.

- The factors that contribute to lack of confidence and complacency are complex with no single causal factor or event leading to vaccine refusal.
- The impacts of waning confidence in vaccines can take months or years to manifest.
- Early detection and timely response to vaccine concerns can prevent loss of public confidence in immunization, limit programme disruptions and avert potential disease outbreaks.

One of the major factors hindering effective influenza communication was the narrow application of communication based on a mechanical transmission model. There was an invitation to think differently about communication in public health and to embrace 21st century scientific communication thinking going beyond messaging facts and providing information. The distinction was made between: communication as a science and a discipline; communication as a profession; communication and the industries that profit from it; and communication methodologies, strategies, tactics, tools and channels. The analogy was made that if current approaches to building health communication capacity in countries were compared to the way laboratory capacity was built – the focus would have mainly been on how to “give the results to the patient”.

Communication is **Systemic**. Conversations about influenza vaccination and interactions are simultaneously taking place in different settings at different levels within and outside the health systems.

Communication is **Reflexive**. These conversations and interactions shape what people think and do about influenza vaccinations.

Communication is **Relational**. Trustful relationships are at the heart of communicating effectively.

Communication is **Performative**. Every job function has a communication (competency, skill, tools, procedures) component. The individual’s communication ability will always impact performance and
Table 2: Verbatim feedback from the working groups in session 1

<table>
<thead>
<tr>
<th>Exploring assumptions, challenges and successes in current influenza vaccination campaigns</th>
</tr>
</thead>
</table>

**Government Health Care Workers Perspective**

<table>
<thead>
<tr>
<th>Obstacles</th>
<th>Success Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Lack of motivation (poor/insufficient information, cost, risk perception, mistrust, health literacy, culture).</td>
<td>1. Strong leadership at all levels and political will.</td>
</tr>
<tr>
<td>2. Lack of resources and capacity (human, financial, logistical, administrative).</td>
<td>2. Clear targeted and tailored implementation plan.</td>
</tr>
<tr>
<td>3. Lack of political commitment and leadership.</td>
<td>3. Quality access and availability of vaccines (sustainable supply and distribution system).</td>
</tr>
</tbody>
</table>

**Government Policy Perspective**

<table>
<thead>
<tr>
<th>Culturally specific determinants that need better understanding</th>
<th>Obstacles</th>
<th>Success Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Low priority in policy and programme priorities (structural determinants, access, availability, costs).</td>
<td>2. Access: increasing vaccine availability and making it easier for people to get the vaccine.</td>
<td>2. Programmatic capacity building.</td>
</tr>
<tr>
<td>3. Relationships with stakeholders (media, governments, NGOs).</td>
<td>3. Awareness and acceptance: means of communication through effective channels using appropriate messaging at multiple levels; from national champions to local community leaders.</td>
<td>3. Evidence-based information that is timely and accessible.</td>
</tr>
<tr>
<td>4.</td>
<td>4.</td>
<td>4. Key role of health care workers.</td>
</tr>
</tbody>
</table>

**Industry Perspective**

<table>
<thead>
<tr>
<th>Priorities for sustainability of success factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure regular monitoring and evaluation of programme (perception, coverage, cost and disease).</td>
</tr>
<tr>
<td>Create mechanisms to involve stakeholders in planning, implementation and monitoring of the plan.</td>
</tr>
<tr>
<td>Develop context-specific roll out plans.</td>
</tr>
<tr>
<td>Strengthen the role of health care providers.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Priorities for sustainability of success factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early engagement of partners (pre-crisis).</td>
</tr>
<tr>
<td>Targeted messaging, tailored to local cultural context.</td>
</tr>
<tr>
<td>Ensuring information accuracy and transparency.</td>
</tr>
<tr>
<td>Try to incorporate two-sided communication.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Priorities for sustainability of success factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve communication at all levels (national and local levels). “Think global act local”.</td>
</tr>
<tr>
<td>Need for GAVI investment case.</td>
</tr>
<tr>
<td>Using trusted local leaders to deliver messaging.</td>
</tr>
<tr>
<td>Key role of health care workers in access, awareness and acceptance.</td>
</tr>
</tbody>
</table>
The essential building blocks of a national communication system

Communication policy, planning and strategy

The lack of a policy was cited as a key obstacle for influenza programmes. An explicit influenza vaccination policy can achieve several things: it defines a commonly agreed goal; it outlines vaccination priorities and the expected roles of different groups; it reduces vaccine hesitancy and it ultimately builds consensus and informs people. Clear policy guidance based on evidence and data with specific recommendations for seasonal influenza and pandemic influenza is therefore important. Such evidence and policies can advocate for resources and investments and build political will. Communication supports the development and implementation of these policies as well as translating them into a language which will resonate with policy makers, partners and the public. Findings from a survey of members from the World Medical Association (WMA) noted that physicians stressed the need for more information and global advocacy on the need for vaccination.

Communication research, monitoring and evaluation

Just like any other public health intervention, it is essential to develop meaningful and measurable metrics for communication to evaluate progress and results against communication strategy objectives and against agreed public health goals and objectives. Monitoring and evaluating progress and achievements in communication are fundamental to knowing how well communication is doing to contribute to public health outcomes.

Unlike other interventions, measuring communication effectiveness is not easy. Measuring exposure and awareness are only minimally helpful and need to focus on the desired outcomes using sound and robust methodologies combining qualitative and quantitative methods. Current evidence shows that communication in public health is often not measured, when it is measured – it is not done well, and measurement is rarely well-funded. It is essential to continuously monitor (listen to) behaviors and “conversations” using various tools (social networks analysis, surveys, interviews, observations, etc.). The on-going “listening” and evaluation results should feed directly into a mechanism to adjust the outreach and decision-making processes at the political, programmatic and technical levels.

The working groups highlighted the need to set up mechanisms for ongoing feedback from health care workers, the public and other stakeholders in influenza programming and strategy development.

Partnerships, stakeholders, and public engagement

Engaging and partnering with stakeholders. Partners are essential to support all aspects of influenza programmes from strategy design to implementation to evaluation. Developing effective partnerships are much easier when there are well-formulated policies leading to clearly defined public health goals, objectives and strategies. To plan partnerships strategically and for mutual benefit, some steps were identified among the participants:

- Develop a clear map of the stakeholders involved in the area, including policy makers, healthcare workers, technical government offices, individuals, civil society, media, industry, lobbies, opinion makers/leaders, etc.
• Determine the most effective partners who could also benefit from the partnership.
• Engage the relevant community and the media through well established, transparent and trust-based channels.
• Develop a network of champions (at the professional, community and institutional level) and rely on their position and influence to develop and convey messages.
• Invest time and resources in developing national, provincial and community level networks.
• Set up surveillance mechanisms (listening surveillance) for early detection of wrong/misleading messages that can undermine progresses in vaccination coverage.
• Set up strong coordination and management mechanisms, avoiding duplications and confusions in roles and responsibilities.

**Engaging and partnering with the media.** Presentations and the panel discussion provided substantive lessons learnt from working with media and the relations between public health officials and media representatives during past events, especially Pandemic (H1N1) 2009. An on-going and transparent process for information sharing is vital to build and maintain trustful relationships. The media is one of the many ways to convey information and media engagement strategies need to be part of an integrated communication strategy. The following is worth noting:

• Journalists work on deadlines, may cover many different topics, have different levels of understanding and, consequently, have a learning curve and require a constant education process.
• Provide easily available resources that can be understood.
• Repetition and reiteration of key messages are needed.
• Know how to speak and communicate with the media.
• Say what is known and say what is not known.

The top common mistakes made by health officials:

1. Not giving out any information. A vacuum in information allows the imagination to run wild.
2. Not saying anything is a missed chance to tell your story.
3. Delays in information.
4. Over-promising – “we will save you no matter what”.

**Engaging and partnering with the public.** Public engagement requires an intimate understanding of influenza vaccinations from the perspective of those who will benefit. How health messages and information are interpreted cannot be controlled because it is filtered through individual, family and community experiences and interpretations. Research has shown that effective engagement around risks need to include four components summarized in a model that was shared called the IDEA1 model.

The model begins with **internalization** to capture and hold the attention of different audiences to understand the specific threat they face. The greater extent to which the conversation can be adapted to the specific threat to a specific region or demographic group in the larger audience, the more likely there is to be a connection with the audience. Next, some degree of **explanation** is needed which includes a brief description of what is happening, how the risk developed, and what can be expected in the immediate future. In this manner, explanation involves the blending of science and practical experience. The third step in the model is to

---

1 Presented by Prof. Timothy Sellnow, University of Kentucky
provide audiences with suggestions for meaningful actions they can take to help protect themselves and their loved ones. Once there is internalization and some acquired understanding of a risk event, individuals will seek advice on how to reduce their personal risk. If there is failure to provide this advice, the situation is complicated by adding feelings of helplessness and fatalism to an already difficult situation. Neither of these emotions is helpful in risk management. The final stage in the model is distribution. Public health officials need to be cognizant of the shifting preferences audiences have for seeking and receiving information. Most importantly, the diversity and disparity of access to information in a large audience must be noted. While some segments of our audiences have ready access to all forms of new and traditional media, others have little or no access to either. The disparity and diversity must be considered at all times as choices are made in how information is packaged and disseminated to avoid leaving any segment of an at-risk population uninformed.

Communication capacity building and training

Building and strengthening communication capacities of different actors and stakeholders who contribute to influenza programmes to meet their goals is key and can be done through targeted and joint partner training. Different professional groups, job functions, individuals, teams and organizations will need different kinds of skills, competencies, tools etc. Groups targeted for training could be: communication staff; communication focal points; health-care providers; policy makers; administrators; and reporters and media. Resources, tools and scientific expertise need to be made available to all stakeholders, and health officials should make themselves available to help build the understanding of stakeholders and especially the public and the media. Strengthening the link between communication scientists and communication practitioners is to make sure that the discipline informs good practice and good practice in turns shapes the further development of theory and models. Investments in professional development are also essential especially in non-emergency situations before a crisis occurs.

It was clear that there are different communication specialties needed for different areas of public health. There is no longer a “one-size-fits-all” approach and there is a need for a senior level of strategic communication thinkers, and planners to bring the various communication elements into a coherent framework. It was helpful to understand “capacity” and “capability” in the following diagram adapted from one of the presentations made during the workshop.

---

2 Adapted from the model presented by Neha Kapil, Communication 4 Development (C4D) Specialist, UNICEF
Several examples of capacity building activities where presented during the workshop from key partners.

There is a growing demand for communication expertise as the global communication landscape continues to change and develop and public health challenges become more complex and require multi-sectoral and multi-level collaboration and coordination. There is a need for advanced skills and systems for strategic communication planning, research, monitoring and evaluation with a focus on its contribution to achieving public health outcomes. Effective capacity development goes beyond “training” and includes, capacity and skills assessments, on-the-job support, mentoring, tools, surge capacity investments and investments in the communication systems, procedures and processes that support and affect health system performance. Competency-based approaches that support the achievement of minimum standards of performance related to core communication roles linked to job functions are essential.

Knowledge translation and Information Communication Technologies (ICT)

Bridging the knowledge practice gap and integrating ICTs to support the four core building blocks of a communication are key to ensuring that the system is efficient and effective and is in line with the developments and application of tools and technologies outside of the health sector. ICT skills and knowledge are particularly essential for health staff to work in a 21st century information society.

Throughout the workshop the relationship between healthcare providers and patients/consumer was highlighted as critical. Given the significance of this relationship, the ability for health care workers to translate scientific and technical knowledge in a way that reassures, satisfies and responds to the needs and concerns of vaccine recipients and their caregivers in diverse populations is important. Especially in an age where access to information on vaccines is readily available from many different sources. Because the way humans interact with each other is generally unconsciously learned behaviour, which in turn become habitual patterns, health care providers are often unaware that they can consciously plan for and manage this process. Attention needs to be paid to building communication skills in self-reflection and the application of appropriate techniques and strategies to ensure that the interaction between health care providers and patients are optimized to limit misunderstandings related to decision making and vaccine uptake.

Conclusions

This document summarizes the presentations and discussions that took place throughout the workshop and which culminated in a description of the basic components and elements needed in a system of communication to enhance influenza communication. Further work is needed to review this framework in a regional and national context. It can be helpful as a starting point for assessing the robustness of the influenza programme through a “communication lens” to determine what may or may not exist and/or what may or may not be working well. The primary focus of the workshop has been on understanding communication as a system of interconnected interactions and relationships between people within and external to the health system. These interactions in the form of conversations are taking place between individuals, teams, and organizations. Enhancing influenza communication will require tools, skills, methodologies and processes tailored to key areas of focus for influenza. Through this understanding, practical and measureable improvements can be made at specific entry points which directly and indirectly influence the availability, accessibility and uptake of life-saving vaccines.
Overall, participants improved their knowledge on planning of effective communication practices to reach all the relevant audiences, with a specific focus on fostering collaboration between private and public sector stakeholders in order to reduce communication barriers that hinder seasonal and pandemic influenza vaccine use.

This event helped in relationship building between different stakeholders leading to commitment from participants to strengthen national and regional communication capacity, and exploit the synergies between communication channels for seasonal flu vaccination and pandemic influenza response.
Annex 1: Workshop process and methodology

The workshop brought a diverse and unique group of professionals together who have extensive experience and specialized expertise in areas relevant to communication and influenza.

Workshop proceedings followed a participatory and planned process which provided opportunity to hear expert opinion through short formal presentations that provided a background for understanding the context and specific issues related to the topics being addressed. Subsequent break-out sessions (supported by a facilitator and a rapporteur) enabled in-depth discussions to ensure that every voice was heard. An opportunity to validate the outputs of the break-out group discussions as well as to pose questions and ask for clarity on the outputs of other groups were provided through plenary presentations.

Table 2: The logical flow and content of the workshop sessions.

<table>
<thead>
<tr>
<th>Session 1</th>
<th>Explained the purpose, objectives of the workshop and the process and methodologies being used to reach workshop outcomes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 2</td>
<td>Set the global and situational context, including WHO role in capacity building and research agenda setting. Focused collective attention on the situation and highlighted controversial/difficult issues (i.e. vaccine efficacy, target vs. risk groups, side effects, etc.) and identified issues relevant for improving influenza immunization coverage to be explored in detail.</td>
</tr>
<tr>
<td>Session 3</td>
<td>Identified critical obstacles that impede success and key factors that contribute to success from the perspective of major stakeholders. (Session 4: feedback of group work in plenary)</td>
</tr>
<tr>
<td>Session 5</td>
<td>Focused on mass communication channels (traditional and new) and lessons learnt post-SARS and post-H1N1. It highlighted positive and negative experiences and how these have changed media management and media communication strategies from the perspectives of public health agencies, governments and senior print and broadcast journalists.</td>
</tr>
<tr>
<td>Session 6</td>
<td>Provided an exploration of cutting-edge 21st century communication science and findings from the existing body of communication evidence relevant for vaccines. Presentations were made from communication scholars, practitioners and industry.</td>
</tr>
<tr>
<td>Session 7</td>
<td>On the basis of the issues discussed and information generated in sessions 2-6, participants were tasked with describing key components of an effective health communication system able to contribute to public health programmes and significantly improve influenza vaccination coverage.</td>
</tr>
<tr>
<td>Session 8</td>
<td>Through role plays, this session provided opportunities to reflect on and appreciate the complexities and importance of interpersonal communication as it occurs in the health care and community settings and how this affects decision making. (Session 9: feedback of group work in plenary)</td>
</tr>
<tr>
<td>Session 10</td>
<td>Addressed how to measure effectiveness and impact of communication from the perspective of both the public sector and industry.</td>
</tr>
<tr>
<td>Session 11</td>
<td>Focused on the future and the development of national action plans to improve communication capacities for seasonal and pandemic influenza vaccination at national and sub-national level. (Session 12: feedback of group work in plenary)</td>
</tr>
<tr>
<td>Session 13</td>
<td>Looking forward, this session provided examples and lessons learnt from programmes that have developed effective partnerships and also looked at the progress and way forward for research needed to improve communication around influenza vaccination.</td>
</tr>
</tbody>
</table>
Annex 2: Presentations and Panel discussions (for copies of the presentations see WHO website)

“Seasonal and pandemic influenza vaccines: myths and facts“, Daniel Miller, Director International Influenza Unit, US-HHS

“Vaccine refusal and vaccine confidence” Report from the SAGE Working Group on Vaccine Hesitancy and the Global Project to Monitor Public Confidence in Immunization, Sue Goldstein, Programme Director, Soul City and Elisabeth Eckersberger, London School of Hygiene and Tropical Medicine

“What’s the point of communication?” Ms Asiya Odugleh-Kolev, WHO

“WHO media engagement strategies for vaccination: lessons learnt from acute public health events”, Gregory Hartl, WHO (via teleconference)

“Lessons learnt from work with media during the Pandemic (H1N1) 2009: Mexico’s experience”, Dr Ljubica Latinovic, Ministry of Health, Mexico

Panel discussion with Ms Miriam Falco, CNN Health Producer and Ms Betsy Kay, Wall Street Journal.

“Communicating confidence in crises: meaningfully addressing public perception” Prof. Timothy Sellnow, Kentucky University

“21st century communication for 21st century public health challenges” Prof. John Parrish-Sprowl, Indiana University

“Integrating and harmonizing communication to meet business objectives: the experience from industry” – Julian Ritchey, Sanofi Pasteur

“Demystifying social media: applying science and a new communication paradigm” – Dr Angus Thompson, Director, Vaccination Policy & Advocacy Sanofi Pasteur

“Communicating risks about influenza vaccine safety and efficacy with health care workers”, Dr Cecil B. Wilson, President, World Medical Association (WMA)

“Measuring and evaluating communication in industry” Mr Julian Ritchey, Sanofi Pasteur

“Measuring and evaluating communication in public health” Prof. John Parrish-Sprowl, Indiana University

“Lessons learned from global, regional and national capacity building initiatives”, Ms Neha Kapil, Communication-for-Development Specialist, UNICEF

“Building effective partnerships and coalitions for influenza: lessons learnt from CDC”, Dr Kristine Sheedy, Associate Director of Communication Science, National Center for Immunization and Respiratory Diseases, CDC

“Research to improve communication around influenza vaccination: Progress and way forward”, Dr Jan Hendriks, WHO

Workshop Facilitators

Dr Alba Maria Ropero Alvarez, WHO/PAHO
Ms Alicia Kimbrel, US HHS
Dr Christine Kisia, WHO/AFRO
Dr Gretchen Michael, US HHS
Ms Hayatee Binti Hasan, WHO/HQ
Dr Jan Hendriks, WHO/HQ

Ms Jessica Kiernan, US HHS
Mr John Spangler, US HHS
Ms Melanie Schuster, WHO/HQ
Ms Nathalie Likhite, WHO/EURO
Mr Peter Merkt, US HHS
Dr Supriya Bezbaruah, WHO/SEARO
Dr Shafiqul Hossain, WHO/WPRO