(H1) Using Surveillance Information in Communications, Marketing, and Advocacy*

R. Elliott Churchill

The difference between the right word and the almost-right word is the same as the difference between lightning and the lightning bug.

Mark Twain

(H2) Introduction

Information is the primary tool of public health practice. Surveillance is the primary means of obtaining the data that are analyzed and translated into information. In moving one step further into the realm of influencing policy and decisions made by governments or by individuals, information is translated into messages – units of communications science that tell their audiences how to respond to particular pieces of information. This process sounds deceptively simple. Unfortunately, it is so difficult that wars, failed personal relationships, broken businesses, and

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* A great deal has been written about dissemination of information in government settings -- both in domestic and international contexts. Unfortunately, to date, very little is available in the peer-reviewed literature on the art and science of communications in the public health arena. The author has included a number of guidelines, checklists,

other disastrous or painful consequences have been associated with inadequate or inappropriate communications, marketing, and advocacy throughout human history. With increasing urgency, public health professionals have begun to understand their need to become adept in the art and science of using surveillance information in communications, marketing, and advocacy. In the world of the 21st century, these areas are not reserved for the commercial sector alone. Scientists must understand the principles of the two-way passage of information. Time-honored practice in public health has involved a great deal of **dissemination of information** (a one-way process) but very little **communications** (a two-way process) involving disseminated information, followed by feedback.

As is the case with much of public health practice, the principles and practice of communications science, marketing, and advocacy are similar in domestic and international settings. However, it behooves public health practitioners everywhere to be sensitive to the fact that the unfortunately overused concept of the "global village" may be trite, but it is also accurate. Things that happen in health in one country are highly likely to have an effect on at least the adjoining countries and may have an effect half-way around the world. Airplanes are extremely efficient "hosts" for the transmission of infection and other problems of public health consequence.

In the sections that follow, communications, marketing, and advocacy strategies that are based on surveillance information and are applied in numerous public health settings are discussed in the

context of data, information, and messages (See also Chapter 7 for a discussion of communications efforts within the public health system).

(H2) Some Pitfalls in Communications

Communications can be helped or hindered by relations between the public health system and the mass media. It is wise for public health staff to remember at all times that they do not have in common all the goals and objectives aspired to by representatives of the mass media. The latter view themselves as watchdogs for the public and are also in a competitive, entrepreneurial system. The public health system is certainly vitally concerned about the welfare of the public, but, whereas the approach of the mass media tends to be "the news regardless," the approach of the public health system is often constrained by the dictate of "do no harm" (from the Hippocratic oath). This lack of intersection of goals and objectives on the part of the two groups, a different approach to deadlines (the journalist *must* meet deadlines; the health scientist will work as long as necessary to try to find top-quality results), and a different set of terminology (Madison Avenue jargon versus scientific jargon -- each a language within itself) make collaboration between public health scientist and professional journalist a massive challenge. Fortunately, the tension created by these points of non-correspondence between public health and mass media can be used to good effect -- and with the public as the ultimate beneficiary of the efforts of people in both categories. However, the interrelationships must be carefully cultivated, gently managed, and constantly reviewed and revised as needed.

Other important issues may include the level of security (and secrecy) assigned to health-related information. In the political system of the former Soviet Union, for example, all surveillance data were considered classified information and were controlled by the military authorities. Reports from surveillance systems throughout 11 time zones were collected, compiled, shipped to Moscow, and stored in locked rooms for security purposes. The concept of putting the information to use in order to improve the system never occurred to the managers of the public health system and certainly never occurred to the military (Personal Communication, Deputy Minister of Health, Russian Federation, 1995).

Another problem that relates to quality of data-information is to be found in public health systems that include a punitive aspect. If data collectors (or data analysts) know that the reaction to their sending in reports of unusually high numbers of cases of rabies among humans this year will lead to jail time or a reduced paycheck, the chances are that the number of reported cases of rabies will closely resemble last year's reported number. This manipulation of numbers leads very quickly to a disrespect for numbers in general distrust for any conclusions or recommendations derived from the surveillance system in question. An example of this type of distortion in a surveillance system is provided by the results of a recent epidemiologic study conducted in the Central Asian Republic of Kazakhstan. Results from this study showed that the infant mortality rates reported by the system, over time, were approximately one-half the rates that would be calculated if World Health Organization parameters were applied. This optional use of definitions made the level of the problem represented by infant mortality to appear to be

relatively small when, in fact, in WHO terms, it would represent a serious problem. (Personal Communication. USAID Liaison Officer, Almaty, Kazakhstan.).

(H2) The Role of Communications in Public Health Surveillance in Developing Countries

(H3) Problems of Perception

One reason for a surveillance system's not functioning at its optimal level is that the people who manage it are trained that it is enough to provide information to health officials without translating, communicating, explicating, and advocating for the results obtained through their data. In many countries, problems associated with this orientation are often compounded by problems created by firmly established patterns for the flow of information (e.g., orders flow down from the top of a strongly centralized system, while data and information flow upward). Nothing flows across (e.g., from regional to regional health centers, from village to village data registrars, and the like). No information or messages are returned from the central depository to the source of the data (at the bottom of the system), and the people at the base level of the system have no idea that the information they sent to the top could have useful applications for their own programs. Furthermore, the idea of sharing information with peers in neighboring villages (states, provinces) is not likely to occur because there is no tradition for such openness. Instead, they wait for a directive to be sent from the central office, for a shipment of drugs and other standard supplies, and continue to do business as usual. They count the number of condoms

distributed, the number of oral-rehydration kits given out, and the number of vaccinations administered. This is passive public health.

An effective communications program, applied in the context of an at least partially devolved public health system, can go a long way toward creating an environment in which data and information are translated into messages that are used throughout the public health system and beyond – to attain the goal of improving the public's health.

Three serious problems that are present in many public health systems in the developing world are not problems of science, not problems of fact (From the author's presentation to a meeting of the senior staff of the Minister of Health, Republic of Georgia, Summer 1996.). Instead, they are problems of perception, of attitude. First, many people do not want to change – they are, if not comfortable with the way they do their work, at least accustomed to the way they work now.

Second, if one asks who the decision makers are in a public health system, many staff members will identify people above themselves in the system. They use the pronoun "we" to describe the people who do the work, but they use the pronoun "they" to describe the people who make decisions. In fact, in a devolved, de-centralized system, this perception can be not only dangerous but destructive. It is important to make a commitment to accuracy, to precision, to dissemination of information and the conveying of messages in a timely fashion and to the appropriate audiences. But public health staff must also make a commitment to make decisions and to provide resources in the form of reports and recommendations to the managers of the

health system who are above them. The attitude of health staff must not be "That's not my job" but "How can I help?"

The third problem relates to the belief on the part of many people that technology is magic. "If only I had enough computers" is a common statement in many public health systems. Computers **are** useful tools – but it is a big mistake to assume that they do things **better**. They make it possible for people to do **more** things and to do **more things faster**, but they do not do anything **better** than can one human being equipped with the appropriate knowledge and a piece of paper and a pencil.

(H3) Problems of Management

Communicating with others about important health messages, and seeing those messages acted upon through changes in policy, allocation of resources, or changes in behavior represent the culmination of a long process of collection, analysis, communication, and follow up. Successful communications requires that someone apply marketing, human psychology, interpersonal relations, persuasion, and other subjective strategies, in addition to all of the tools and techniques of science.

(H3) Problems of Definition

The definition of "public health surveillance" has often been interpreted to mean dissemination of information within the public health system. Since the advent of HIV/AIDS, however, CDC has aimed at addressing a far more wide-reaching target audience than its original one of "state and local health departments." (CDC Mission Statement, 1985). Traditionally, public health surveillance managers have focused on the dissemination of information within the public health system. The distinction between "communications" and "dissemination" is not only important, it is critical to understanding what actually happens with public health information versus what public health workers **think** happens with it. The distinction is also key in planning, implementing, and evaluating programs that involve communications in public health practice.

The paragraphs below attempt to

- define communications in the context of public health practice,
- discuss how communications can be integrated into the infrastructure and the operational structure of public health information systems, and
- provide some guidelines for evaluating and modifying communications strategies as needed.

(H4) Defining Communications

Communications is a process that involves at least two people in an effort to convey, receive, interpret, and agree upon the meaning of **data**, **information**, or **messages**. The purpose of this process from the point of view of the person or agency that disseminates data, information, or

message may be to inform, to influence, to motivate, to persuade, or some combination of these or other activities. The purpose of this process from the point of view of the person or agency that receives data, information, or messages may be to learn, to use as the basis for decision-making, to reject, to discredit, to reinterpret and use for other purposes, to sell, or some combination of these or other activities. In other words, we use the term "communications" to describe **the process in which we use language or images (symbols) to share meaning with other people.**

The basic reporting unit of science is the **fact** (a piece of information), whereas the basic reporting unit of communications is the **message**. This is one reason that scientists and communicators must struggle in their efforts to collaborate – or even to understand each other. Scientists are trained to discover, to record, and to convey facts – not messages. And how do facts and messages differ?

Communications takes facts and "packages" them to convey meaning. When everyone agrees on that meaning, there should be no problem. However, recipients often receive different messages from a single communications effort. Communications may be unsuccessful because information is not sent at the proper time or not made available to the appropriate audience. Communications is a strong and powerful tool. In looking at communications, we also need to be aware that there is a difference between the medium and the message, and that technology does not necessarily bring correct answers to our problems.

(H4) How Data, Information, and Messages from Surveillance Systems Fit into the Communications Construct

In communications, we are involved with **data**, **information**, and **messages**. Data are the smallest units of description; they may be expressed in words, numbers, or other symbols. Information is made up of data that have been interpreted to provide meaning and context. Finally, the message is the so-called bottom line in the communications process. It intends to convey the reaction that is appropriate on the part of the recipient (See Table 16-1 below).

Table 16-1. Transition from Data through Information to Message.*

DATA	→	INFORMATION	→	MESSAGE
The smallest units of measurement numbers, symbols, words (no context provided).		Data with enough context provided to allow people to analyze and determine meaning.		Information with the addition of interpretation. Answers such questions as "what does this mean to me?" "Why should I care?" "What am I supposed to do about it?"

Now let us look at an example of this data-information-message series from public health.

DATA	→	INFORMATION	→	MESSAGE
"1,000 cases of measles"		"This is a 50% increase from last year."		"Have all infants vaccinated for measles before their first birthday."

Or

DATA	→	INFORMATION	→	MESSAGE
"1,000 cases of measles"		"This is a 50% increase from last year. (Five cases have been fatal.")		"Every infant in this country can be vaccinated for measles

for less money than it

takes to care for five

cases that lead to

complications and death."

These examples show the progression from data to message. The data are simply values. There is not enough context provided to evaluate the import of the data. What is the time period? Who is the population affected? How does the number compare with reports for previous years? When we move on to information, we are given the data but are also provided with enough context (time, place, person) to be able to do at least **some** assessment of the meaning of the data. We know, for example, that if 1,000 cases of measles represents 50% more than were reported last year, there is some sort of a problem of public health relevance. The message is based on the information provided, but the message goes a step further and tells people what they are supposed to think about the information or why they are supposed to care about it. Why is it important to me? What am I supposed to do with this? Why should I care? One set of data and file of information can be used to craft many different messages. The points that are emphasized depend on many factors including interest, resources, and audience.

The statement, "Let the data speak for themselves," is insufficient. Surveillance provides information for action. We therefore need to supply the content and message to provide the basis

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- Model created for classroom use by the author at the University of Kansas, 1968.

for appropriate and conclusive actions. Often the critical step of surrounding (translating) the data with a clear message is omitted, which leads to frustration on the part of the transmitter ("Why don't people use my information?") and the recipient ("What should I do with this information?").

Officials who convey their data (or even "information") to media representatives, elected officials, or the general public often cannot understand why these groups of people do not immediately comprehend the meaning, value, and relevance of the information they have provided. Their target audience (the sub-group of the population that they are most desirous to reach and convert to their point of view), in the meantime, may not understand the meaning of information conveyed in terms of risks, rates, or other biostatistically derived relationships, or they may not appreciate the relevance of things reported in terms of "...per 100,000 population" or "...per 1,000 live births." They may not appreciate the value of the information they receive because they do not know whether or how this information relates to them in particular – either as individuals or as members of a group. Finally, elected officials or other persons who set policy and allocate resources usually have limited knowledge of the subject matter. Thus, it is difficult for them to compare the gravity, relevance, and value added by recommendations based on public health information and messages with the gravity, relevance, and value added by material that relates to such frequently competing priorities as

- a water supply that is adequate for personal, commercial, and industrial needs;
- pollutants in the environment;
- adequate road, rail, and water shipping; expansion of industrial zones;

- shifting populations; displaced populations; and

- quality and capacity of schools.

With these things in mind, it becomes easier to see why policy setters and legislators want to know costs, the true value of the benefits of those costs, and how reliable the information is.

(H2) The Mechanics of Communications

Communications is a process – not a product. Because the process of communications is a loop, it requires not only the effort of the communicator to convey the desired information, it also requires the attention, the cooperation, and the understanding of the recipient before communication has actually occurred.

Figure 16-1 shows a diagram of the communications process.

In the model of communications (developed by the author for classroom use, Georgia State University, 1985), there are at least six components: the sender, the message, the receiver, the channel, the impact, and the evaluation. In order to succeed at communications, all of these factors must be taken into consideration and decisions made about each.

(SENDER) Who is the most appropriate person (organization) to convey this message?

(MESSAGE) Exactly what message is it you want to convey? "It is 10 o'clock" is a fact, or a piece of information – not a message. "It is 10 o'clock; do you know where your children are?" is a message.

(RECEIVER) How can you describe the targeted audience or audiences? Is it one population (e.g., teenagers), or is it components of several different populations (e.g., all people who smoke cigarettes)? What are these people like? Is it, in fact, an audience that represents part of the public? Or is the targeted audience part of the "establishment"? (for example, politicians or public health officials).

(CHANNEL) How best can you reach your intended audience? Can you reach them through any mass communications medium? What do they read? Do they watch television more than they read?

(IMPACT) What do you want to happen as a result of your message being sent and received? What action do you wish to be taken?

(EVALUATION) What will you change before trying to share this message with this audience again?

(H2) Public Health Strategies and Programs in the Open Marketplace

One of public health's most important messages is this: "By modifying behavior and changing life style, the public can make substantial gains in their overall health and live longer, more active lives." Public health would like for this message to be applicable to every man, woman, and child in the world. The question is how to **reach** people with the message, how to **persuade** them that the message is true and that it applies to them, and how to **convince** them to take the required actions to reach the health objective carried in the message. The research component of this process is called "marketing" and the application component is called "advocacy."

(H3) The Marketing Component

Countries throughout the world have a successful communications model for marketing in the form of advertising for commercial goods. Advertising campaigns are carefully researched, attractively packaged, directed very carefully at a well-defined audience, and evaluated painstakingly and extensively. Why? Money, of course. If you don't do these things, your competition will, and his or her product will capture the imagination of the public, and your product will likely fail. Marketing, whether it is applied to commercial products or to life-style choices for healthful living, is the process of researching to determine what approaches will work most effectively with which targeted audiences in order to achieve the originator's desired result (i.e., the "purchase" or a product or the "purchase" of an idea that leads a person away from a behavior that puts him/her at risk of having a health problem).

How does this relate to public health communications based on surveillance information? Public health planners can learn what advertising technology and psychology do and how the process works. Public health is competing with messages from the mass communications industry, which tries to persuade people to buy a product. Very often, public health messages ask people to change often pleasurable types of behavior (e.g., eating fatty foods, smoking, or consuming alcoholic beverages).

So how can public health ever hope to succeed with messages that people would prefer not to hear? Several factors are important.

- Public health workers must develop a rapport with our public that is based on reliability and truthfulness. The public must believe that public health messages tell the truth and do so because the public health system wants what is best for its clients.

- Public health workers must be patient and persistent. A public health information campaign usually requires several years to become successful; people generally will not pay attention to or believe messages that advocate changes in behavior right away. (An exception to this pattern is represented by bulletins or public service announcements provided to the public during or immediately following an emergency situation. People generally do respond quickly to such messages – if they can understand what it is they are supposed to do.)

- Public health workers must repeat, modify, and update. The main points of the message must be presented repeatedly, but in novel and different ways over time. The

messages must be couched in current idiom and presented through up-to-date technology.

- Public health workers must use all appropriate avenues. A multi-media approach is more likely to capture the attention of the audience and to reach all components of a diverse audience.

- Public health workers must ultimately speak person-to-person. The mass media effort must be augmented by more personal interventions and the organization of community resources at the local level. Public health must recruit persons in every community it seeks to serve who can serve as spokespersons for the messages the community needs to hear.

For example, in 1993, one of America's professional basketball superstars announced that he was HIV positive. He denied being a homosexual or injecting drugs, and the public was left to assume that he was infected through a heterosexual contact. A national AIDS hot line had been established a few years earlier by CDC so that persons could use a telephone and receive information and be directed for counseling about HIV/AIDS. Figure 16-2 shows what happened to the pattern of the use of this hotline after Ervin "Magic" Johnson held his press conference. After many months of fairly consistent call-in rates of 2,000 attempted calls per day, the 24-hour period following Magic's press conference saw 151,000 attempts to use the HIV/AIDS hotline. This level of use persisted for several weeks. Public health officials had been warning for a long time that HIV/AIDS was not just a problem for homosexual males and users of intravenously injected drugs, and had insisted that it was a threat to the entire country. Now, suddenly, people

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believed. If this could happen to Magic Johnson, it could happen to them. Figure 16-2 also demonstrates that this initial level of concern does not usually continue without reinforcement. The pattern of use of the hot line returned to pre-Magic levels by the end of that same calendar year.

(H3) The Advocacy Component

Communications campaigns should be attractive, appealing, and persuasive. They must overcome the public's suspicion about the motives of the public health system (learned partly from experience with the commercial world and, unfortunately, learned partly from negative experiences with public officials). **Why** do the public health system care what happens to them? **What** does the public health system (or the politicians) expect to get out of this? More important, **what** will the public (target audience) get out of this that they actually want?

The first step in a public health advocacy program is to answer these questions.

    a) What do I want to say? (MESSAGE)

    b) To whom do I want to say it? (AUDIENCE)

    c) Through what means can I convey it most effectively? (CHANNEL)

    d) When will it have the most advantageous effect? (TIMING)

    e) What do I want to have happen as a result of my message? (IMPACT)

    f) How will I assess the effect of my message? (EVALUATION)

    g) How will I improve the message for its next presentation? (MODIFICATION)

The second step in a public health advocacy plan is to set up an collegial relationship with representatives of the mass media. Such a relationship between public health and the media is essential in many public health settings. The media know that their audience is interested in health issues; the media want to provide information and messages about things of interest to their public; the media (at least in most countries) are supported by advertising or foundation funding and can conduct more expensive and extensive campaigns than are most ministries of health or local health agencies. The key in this setting is to establish the common goal that makes the campaign "good" for the media (owners, investors, audiences) and "good" for the interests of public health (i.e., something that leads to an improvement in the pubic's health).

(H2)The Need for Effective Relations with the Mass Media in Public Health Marketing and Advocacy Programs

When people speak of "the media," they generally mean the channels through which people convey information and attempt to communicate with individuals or groups of people. The office telephone, for example, is a simple communications medium or channel, and it is primarily designed to allow one person to make voice contact with one other person. It has little amplification capability over a face-to-face discussion between two people. Commercial television, on the other hand, is a medium or channel through which a person has the potential of reaching millions of other people – verbally and visually and in a current time frame. Television is an excellent example of a "mass communications" medium. Other mass media currently in widespread use include radio, print, and computer-based telecommunications. All of these media

represent potential tools for public health communications, marketing, and advocacy strategies. The key is in finding out how to access, recruit, and use them.

(H3) Science and the Media

Public health officials – indeed, scientists in general – are often reluctant to deal with representatives of the mass media. There are many reasons for this. First, scientists as a group prefer controlled, measured settings and processes. The more people are involved in a process, the less predictable that process becomes. For more-or-less complete predictability, a scientist is safest in the controlled confines of the research laboratory.

Second, scientists spend a great deal of time and effort learning their science. With their understanding comes an entire system of jargon – terms, expressions, and descriptions that they and other scientists in their field understand readily. It is not necessarily easy to translate the language of science into everyday language. Most scientists prefer to "talk science" to other scientists because the effort they must expend in conveying their messages is considerably less than that required to make their information understandable to people outside their particular field of science.

Third, many scientists have had disappointments in their dealings with the media – because of misquotations, distortion, broken promises to publish or broadcast a message, and the like. At least some of these disappointments result from the media's need to convey information in a

novel way, which enables them to make a financial profit in an extremely competitive business. Many such disappointments thus reflect the unfortunate consequences of the conflicting priorities of the scientist and the reporter.

While admitting the validity of these concerns, and the many others that may apply in the scientist's dealing with media representatives, the fact remains that we live in an era of mass communications, and a great many people receive their health messages through these media. CNN International is viewed around the world. Electronic mail and other telecommunications devices connect even very remote areas with the mainstream of information with which the world's people are being bombarded.

(H3) Public Health Science and the Media

Perhaps more than scientists in general, public health scientists in particular must get their messages -- their advocacy -- about control and prevention of illness, disability, and death to the people who need to hear them. Typically, this means working with media representatives – producers, editors, and reporters of information.

At the receiving end of the information are the target audiences – those of public health and those of the media. A **target audience** is that sub-group of a population for which a particular message is believed to have the most relevance. A message may also be directed at secondary (less accessible, less well-defined, less important) or even tertiary target audiences, but it is of

extreme importance to determine the primary target audience for every public health message and to assure that the message is appropriately crafted, timed for greatest impact, and conveyed through the medium most likely to reach that audience.

An extremely important concept in managing the creation and dissemination of public health messages is the "**SOCO**" (single over-riding communications objective), developed at CDC several years ago by staff in the Office of Health Communications. The SOCO is the essence of the message that needs to be conveyed. The SOCO needs to be simply and clearly stated – so that the media and the target audience reached through the media have no problem in understanding the meaning of the SOCO, as well as which attitudes or actions of the target audience represent the focus of the message.

Public health scientists should not only learn to be responsive to media representatives, but to **seek out** and cultivate positive relationships with the media. They should become proactive rather than remaining reactive, and they should learn to operate on a positive and straightforward basis in order to retain control of the agenda and the content and tone of the messages they want conveyed.

Just as many scientists are reluctant to deal with media representatives because of past negative experiences, media representatives also often justifiably complain that scientists are not receptive to the constraints and demands under which the mass media operate: extremely short turnaround

times, changing priorities, and pressure to compete for media market share with radio or television stations or other media units.

Most media representatives are ethical, conscientious, hard-working people – who serve as representatives for the public in its ongoing quest for well-being. The mistakes they make – the misquotations, the incorrect interpretations – often result from the fact that, despite their best efforts, they do not really understand what the scientists are saying. Scientists often speak in technical, and perhaps jargonistic, rather than plain language. They may also overwhelm media representatives with too much information or present information in vague, general terms and couched in risks and probabilities that do not make clear the message (i.e., the SOCO) the scientists intend to convey.

All of these problems can be solved with the qualities described below.

- Truth and honesty on the part of all participants in the process.
- Trust, developed among scientists and media representatives, that all are out to achieve the same objective: good information provided in a responsible manner to the targeted audience in an appropriate time frame. The motivations may differ (e.g., profit for the media and public health for the scientist), but that is not a problem if the mutual trust is established, earned, and maintained.
- Time, enough to allow the scientist to be comfortable with the quality of the information provided and not so much that the media's deadlines are missed. Compromises are required on all sides.

(H2) Communications Programs Based on Surveillance Information

Effective use of existing health-related information, including that from surveillance systems, requires that communication occur among health-care professionals, health-related organizations, government agencies, the private sector, the media, and the individual citizen. Leaders in health, education, government, industry, labor, and the community must all be involved if a comprehensive and effective health communications strategy is to be implemented.

Health communications strategies can be designed to inform, influence, and motivate target audiences in setting policy or making other decisions that have a positive impact on public health.

Health Communications **CAN**

- Remind audiences of knowledge, attitudes, or behavior that have an impact on health
- Create attitudes to support change for a particular policy or action
- Increase awareness of a health problem, concern, or solution
- Demonstrate skills or technology
- Increase demand for health services and for health-affirming policies

Health Communications **CANNOT**

- Take the place of adequate or appropriate health services

- Produce changes in attitudes and behavior unless other program elements support and sustain the changes

- Be equally effective in addressing all health problems for all people

Therefore, health communications (marketing and advocacy components) should be included as **one** key element in an integrated program designed to address a health problem or to convert health policy to action.

Public health communications is related to "bottom line" ideas – that is, to shopping, to buying (or spending), and to selling. What is being shopped for is health – by the individual and his or her public health program. What is being sold are ways to obtain that health. And the buying (or spending) involves public health providers (who "spend" their efforts and their resources to provide health) and all of the recipients of public health programs (the people who "buy" health – including the governments, the private sector, and the individual).

(H3) Crafting a Public Health Communications Plan

Effective health communications strategies must be based on a clear understanding of the needs and perceptions (attitudes) of the target audience(s). This means that considerations about the audience must be built into the communications strategy from the beginning, and it means that evaluation and revision, as needed, are critical components of the successful communications program. (See **Appendix 16 - 1** for material on the creation and use of a health communications

plan and **Appendix 16 - 2** for guidelines and check lists for communications programs and strategies.)

(H3) Evaluating Public Health Marketing and Advocacy Programs/Projects

Integral to health communications marketing and advocacy programs is an assessment of its impact. Evaluation should be incorporated early into the overall communications plan and not left to be dealt with as an afterthought. Evaluation may continue for weeks, or even months or years, but it needs to be begun early – often before the messages are conveyed and often continued for as long as the immediate effects of the communications effort are still discernible. The sections below cover the rationale for evaluation and describe some tools and processes that can be applied.

(H4) Reasons for Evaluation

There may be more specific reasons in particular settings, but the rationale evaluation generally includes several of the following:

- Determining what has been achieved

- Measuring progress (relative to stated objectives)

- Improving the monitoring process

- Identifying strengths and weaknesses

- Determining whether the effort was effective

- Determining the associated cost benefit

- Collecting information for future efforts

- Sharing experiences with others

- Improving effectiveness of future efforts

- Allowing for more efficient future planning

The reasons for evaluation given above are the scientific reasons. There may also be some relational or "human-based" reasons, that relate to authority rather than science. However, they must still be acknowledged. Some of these reasons are shown below.

- Because a funding agency has asked for it

- Because the ministry has asked for it

- Because sponsors want to decide whether to continue their support

- Because program staff want to try out some new evaluation techniques

- Because new material is needed for publicity purposes

(H4) What Evaluation Can and Cannot Do

Often, more is expected of evaluation than the process of evaluation has been designed to give in return. An honest evaluation does not CHANGE the results of a presentation or program. It merely documents them. So the primary products of an evaluation are likely to include the following:

- the primary achievement or failing

- the changes that are needed

- the strengths that can be built upon

- the information needed for decision making

- the wider contexts and implications of the effort

When programs or projects consist primarily of qualitative rather than quantitative factors, it becomes much more difficult to apply the results of evaluation. Such factors as human behavior, abilities, attitudes, values, and motivations, interpersonal relations, and perceptions may indeed be the primary "measures" of a communications effort. Evaluators can describe these attributes, but applying them in efforts to modify communications efforts can be very difficult.

Evaluation is the only means of confirming, objectively, that the result of a communications program was the desired and planned one. The more objective and broad-based an evaluation is, the more credibility it has with those who will determine whether the communications effort has been a success, whether it is worth continuing or replicating, or whether it should be discontinued.

(H2) Summary

Data and information from surveillance systems represent the building blocks from which public health communications, marketing, and advocacy strategies can be conceived, planned, and applied. Mere collection and reporting of public health information may not have the desired
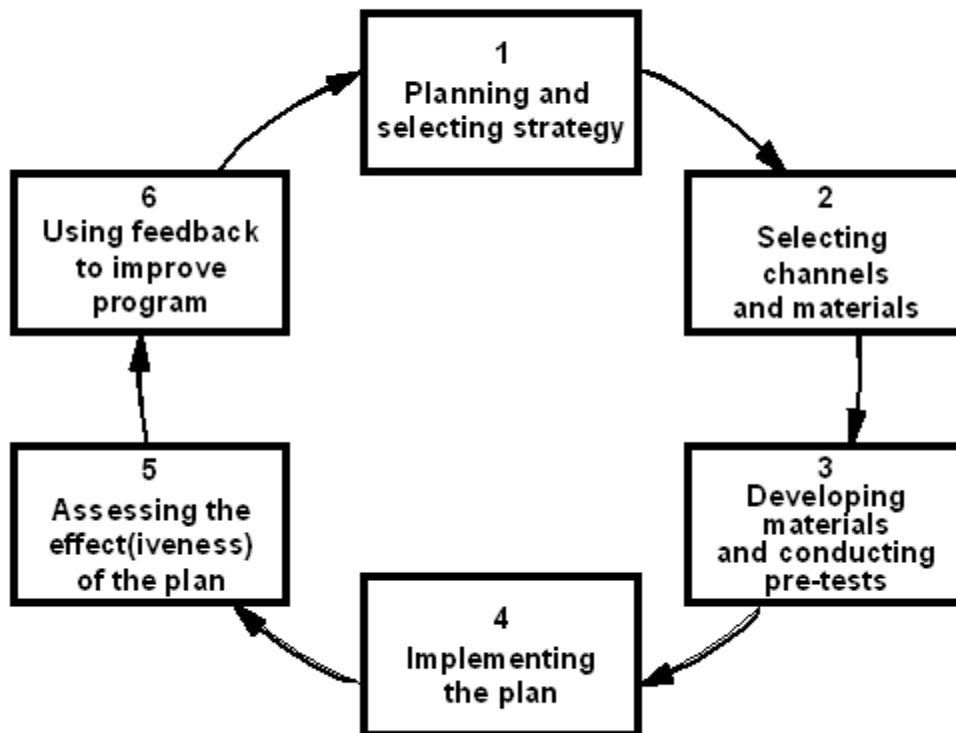
effect on policy or on positive changes in public health practice, as well as on educating

audiences about control and prevention of health problems.

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The Health Communications Planning Process

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         ┌─────────────────┐
         │        1        │
      →  │  Planning and   │  ↘
         │ selecting strategy│
         └─────────────────┘
┌─────────────────┐         ┌─────────────────┐
│        6        │         │        2        │
│  Using feedback │         │    Selecting    │
│  to improve     │         │   channels      │
│    program      │         │  and materials  │
└─────────────────┘         └─────────────────┘
      ↑                              ↓
┌─────────────────┐         ┌─────────────────┐
│        5        │         │        3        │
│  Assessing the  │         │   Developing    │
│  effect(iveness)│         │    materials    │
│   of the plan   │         │ and conducting  │
│                 │         │   pre-tests     │
└─────────────────┘         └─────────────────┘
      ↖       ┌─────────────────┐      ↙
              │        4        │
              │  Implementing   │
              │    the plan     │
              └─────────────────┘
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(H3) Step 1. Planning and Selecting Strategy

1. What is the status of the health problem of concern? What is known about it? (including scientific data and public perceptions)

2. What additional (or new) information is needed before the program can be planned?

3. Who is (are) the targeted audience(s)? What is known about these people? How reliable is the information? How stable (likely to change) is the information?

4. What is the proposed change in (policy, treatment, legislation, service, or other activity that is proposed to solve or decrease the problem)?

5. What measurable objectives can be used to define and then to assess the level of success of the program?

6. How can progress be measured – i.e., what evaluation tools will be used?

7. What should the target audience be told?

(H3) Step 2. Selecting Channels and Materials

Note: If Step 1 is not done carefully and accurately, step 2 becomes more difficult. This magnification of error, omission, or flawed logic continues and amplifies throughout the communication process. It is clearly to the advantage of program managers to plan and implement each step carefully and deliberately. In this setting, surprises are likely always to be unpleasant.

1. What existing materials can be adapted for use for the program?

2. What channels (e.g., mass media, work site, face-to-face) are most appropriate for reaching the targeted audience(s) with this information?

3. What formats are most appropriate for the messages and the selected channels (e.g., booklets, videotapes, town meetings, telephone interviews)?

(H3) Step 3. Developing Materials and Conducting Pre-Tests

Steps 1 and 2 represent most of the planning. At step 3 program messages begin to craft the actual program.

1. What are the different ways in which the message can be presented (e.g., primarily visual, primarily language, encouragement, warnings)? medium, level, tone, frequency of

message, context of message (what other messages appear near this message?), and many other factors affect this sub-type.

2.   How does the target audience react to the message concept(s)?

3.   Does the audience
   ● understand the message?
   ● remember the message? how long?
   ● accept the importance of the message?
   ● agree to the proposed solution to the problem described in the
     message?

4.   How does the audience respond to the format of the message?

5.   Does feedback from the audience indicate that message or format needs to be modified?

6.   How can the message be promoted, the materials be distributed, and progress of the strategy tracked?

(H3) Step 4. Implementing the Plan and Preparing for Evaluation

1.   Does the message move appropriately and effectively through the intended communications channels?

2.   Does the target audience react as it is intended to (i.e., by paying attention, by being interested, by understanding the message, by being convinced of the importance of the message)?

3.   Do any existing channels need to be replace or new channels added?

4.   What aspects of the program seem to be having the strongest effect?
5.   Do changes need to be made to enhance the effect of the program?

(H3) Step 5. Assessing the Effect(iveness) of the Plan

1.   Are the program's objectives being met?

2.   Can the results that are being measured be attributed completely to the program, or are other factors playing a role? If the latter, take time to assess these contributing factors insofar as possible.

3.   How effectively and efficiently has each step of the program of planning, implementation and assessment been handled so far?

(H3) Step 6. Using Feedback To Improve the Program

Using all of the information gathered during Steps 1 through 5, answer the following questions:

1.   Why did the program work or not work as it was intended to?

2.   What changes in the program are needed to improve the likelihood (or level) of success?

3.   What lessons have been learned about the public health network, the target audience, the media, or the message that can be usefully applied to a revised version of this program or to another public health communications program?

(H2) APPENDIX 16 - 2

(H2) Guidelines and Check Lists for
 Public Health Communications Programs and Strategies *

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* Material developed by Churchill for classroom use at the University of North Carolina and the University of Kansas, as well as for numerous CDC programs, 1965-the present.

(H3) Checklist for Public Health Practitioners To Use in Dealing with Media Representatives

1. Prepare fact sheets (statements about problem to be discussed) for reporters about all problems to be covered. Keep them updated.

2. Avoid jargon.

3. Respect reporter's deadlines.

4. Always be polite and straightforward.

5. Always tell the truth. If information is not available or unreliable, say so.

6. Always have your own agenda set the SOCO (or message you need to convey) and stick to it. Answer the reporter's questions insofar as possible, but return to your own agenda.

7. If you are not sure about a question (the meaning of the question, or you simply do not hear it), ask the reporter to repeat it.

8. If you do not know an answer, and it is within your area of responsibility try to find it. If it is outside your area, do not try to answer it. Admit that you do not know.

9. Stick to facts; do not offer your own opinions.

10. Explain the context and relevance of your message (e.g., public health significance).

11. Make notes (or a tape) of the meeting (interview).

12. Provide feedback to the reporter and his/her editor on the results of your interaction.

(H3) A Proactive Approach to Media Relations for the Public Health Practitioner

1. Study the patterns and type of reporting in the area, and determine which media representatives appear to be most knowledgeable, most responsible, and most effective. Then contact them.

2. Write and state clearly and concisely the facts and the desired messages.

3. Explain the relative importance of the issues discussed and how they fit into the overall context of public health practice.

4. Maintain an image (and the integrity to back it up) of truthfulness, expertise, and candor.

5. Respond to media representatives when contacted.

(H3) Guidelines for News Releases

News releases are intended to take the place of a person-to-person interview. The subject must be of sufficient interest and very current.

1. Make sure the item is of sufficient interest and scope to make it worthwhile for media representatives to use it.

2. Distribute only to a list of media representatives pre-selected on the basis of a) their documented interest in public health issues, b) the appropriateness of their target audiences for your purposes, and c) their past responsiveness and responsibility. However, provide all these media representatives with copies of the news release.

3. Use the inverted pyramid style of writing: Most important items first, tapering down to detail.

4. Open the press release with a summary lead: a paragraph in which you answer Who? What? When? Where? Who cares? and How? There may or may not be a need to answer "Why?," depending on the subject matter.

5. Make the news release no longer than two pages.

6. Use short, straightforward sentences. Define any necessary specialized terms, but generally avoid using jargon or specialized vocabulary.

7. Provide direct quotations, with the source and credentials of that source provided.

8. Consider providing audio or video segments to accompany the news release, if appropriate. If not feasible, supply appropriate still photographs and useful graphic material to illustrate or dramatize the message in the press release.

(H3) Sample News Release

Called Dateline	**May 20, 1994**	**Centers for Disease Control and Prevention**
Source	**Contact: Dr. S. A. Smith**	
	Investigative Epidemiologist	
Organization	**National Center for Infectious Disease**	
	Telephone: (404) 933-2121	

Summary Lead

Infectious disease investigators at CDC announced today that an outbreak of meningitis at the U. of Ga. Athens Campus is now under control.

Text

More than 100 students and staff at the University have had a laboratory-conformed diagnosis of meningitis in the past week. Meningitis, a potentially serious infection, is caused by a bacterium. More than 50% of all known cases of this disease have led to complications, and 10% of patients have died.

Tag   **– More – (means continue on next page)**

"This outbreak at (U of) Georgia is certainly serious," acknowledges investigative epidemiologist, Dr. S. A. Jones, "but we are now confident that it is under control."

Ill students and staff have been hospitalized and placed in strict isolation for their protection and the protection of other patients and hospital staff.

In addition, all known contacts of students and staff with meningitis have been given chemoprophylaxis against meningitis. This means that even if they do become infected and have the illness, they should only have mild cases.

Text

"Each year," says Dr. Jones, "we see outbreaks of meningitis on college campuses. Groups settings and the age of the university population make the risk of this infection higher for these people than it is for the population in general."

CDC does not recommend that all school- and college-age young people be vaccinated at this time.

Attachments   **Attachments – (List)**

Close
Indicates
End....   **30**

(H3) Guidelines for Fact Sheets

The public health fact sheet is a brief (no more than two pages) report that describes background and context for a particular health problem. For example, a fact sheet on hurricanes, intended for general audiences in the United States, would

- describe the mechanisms that cause hurricanes,
- tell when and where hurricanes usually occur,
- give some examples of detailed (unusual, particularly hazardous, etc.) problems associated with hurricanes, and
- provide recommendations for actions to be taken by target audiences if a hurricane occurs.

Fact sheets are often used by journalists and other media representatives as reference material when they prepare their reports. Fact sheets ("back-grounders") may be kept and used several times before they need to be replaced with more current information. They are also useful to the public health staff who prepare them, because fact sheets in reporters' files can obviate the need for public health staff to answer the same questions over and over again as different reporters (and members of target audiences) call with inquiries.

(H3) Guidelines for Dealing with a Health Crisis

A health crisis is an unplanned event that triggers a real, perceived, or possible threat to the well-being of the public (or some segment of it), the environment, or the affected health agency.

Many times, organizations do not handle crisis situations as effectively as they might. Two major problems related to such failures can be solved by foresight and planning.

1. **The failure to react quickly enough.** In a crisis situation, the first 24 hours are critical. If you do not provide the facts and the implications of those facts, the media and the public will speculate and form opinions on their own.

2. **The failure to name a primary person** (and one who is experienced in media matters) to be "the voice" for your organization. Multiple voices, even when delivering the same information, may be perceived as conveying different messages. If a reporter states that "Dr. Jones <u>said</u> everything was fine – but he <u>looked</u> worried and seemed to be in a big hurry," Dr. Jones may have done more harm than good by serving as agency spokesperson. Of course, in this case one might also accuse the reporter of being irresponsible for speculating on the mood behind the scientist's words.

    It is almost impossible for different people to convey <u>exactly</u> the same message - even if they read from the same prepared script. More than one person, even when delivering the same information, may be perceived as conveying different messages.

Defining the problem accurately
- If there are delays in response on the part of the appropriate agency, the media and the public will define the problem for themselves – perhaps inaccurately.

- On the premise that "bad news is **always** news," it is important to remember that a shift from "safety violation" to "a history of cover-ups" can occur easily and rapidly.

- It is important to anticipate (or determine) how (and when) the media will report the problem so your agency can react calmly or responsibly **or** make an appropriate announcement before the story appears in the popular media.

Enlisting the aid of the media

Since the media **will** be involved, regardless of whether you want them to be, acknowledge the role they can play in assisting you to deal with the problem.

Some of the ways to channel the media's interest and efforts:

- assisting in pre-crisis education

- conveying warnings
- conveying instructions or other information to target audiences
- reassuring the public
- de-fusing inaccurate rumors
- assisting in the response effort
- providing health officials with updated information on conditions beyond the health agency
- soliciting and obtaining help from the outside as needed

The most frequently asked questions by media and public:
- What happened?
- When and where?
- Who was involved?
- What caused the situation?
- How was this allowed to happen?
- What are you doing (going to do) about it?
- How much (what kind) of damage is there?
- What safety measures are being (will be) taken?
- Who (what) is to blame?
- Do you (your agency) accept responsibility?
- Has this ever happened before? With what result?
- What do you have to say to those who were injured (endangered, inconvenienced, etc.)?
- How does (will) this problem affect your operations?

Guidelines for the agency spokesperson:
- Do not give names of injured or dead until next-of-kind have been officially notified.

- Acknowledge responsibility, but avoid prematurely assigning blame. Assure the media that results of the investigation will be given to them.

- Avoid conjecture, speculation, and your own personal opinions.

- Always tell the truth. Admit it if you do not know the answer to a question.

- Prepare a brief written statement, and make it available to the media representatives (include background information and accompanying photos, audio and video tapes, as appropriate).

- Do not give exclusive interviews. Schedule a press conference for all media representative, and give them all the same information at the same time. If a prepared statement will be read (and no questions will be answered until later), say so at the beginning.

- Be as accessible as possible to take follow-up inquiries from the media so that it does not appear that you are hiding from them.

- Stay calm.

Naming the agency spokesperson:
- Many people cannot be effective representatives of their agencies to the media.

- The primary spokesperson should have the following attributes
  ▸ key position (administration or public affairs)
  ▸ experience in dealing with media
  ▸ responsible, calm, and confident manner
  ▸ ability to speak clearly (accent, quality of voice) and convincingly.

Summary:
- Silence kills. It is equated by the media and the public alike with guilt.
- Do not delay. The first 24 hours are critical.
- Permit controlled access to the site (or the agency premises) as soon as possible.
- Only speak the facts and messages that apply.
- If a question cannot be answered because the spokesperson does not know the answer or because the answer is confidential information, say so. Follow up on promises to get answers to questions.
- Monitor media reports. Correct any incorrect information and clarify points of confusion as needed.

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