



PANDEM-2

PANDEMIC PREPAREDNESS AND RESPONSE

Pandemic Communications Toolkit

Deliverable D5.2

31 Jan 2022



This project has received funding from the European Union's Horizon 2020 research and innovation programme under Grant Agreement No. 883285

The material presented and views expressed here are the responsibility of the author(s) only.
The EU Commission takes no responsibility for any use made of the information set out.



PANDEM-2

Pandemic Communications Toolkit

Document date: 31 January 2022

Document version: 1.0

Deliverable No: D5.2

Deliverable type: Report

Dissemination Level: Public

Full Name	Short Name	Beneficiary Number	Role
NATIONAL UNIVERSITY OF IRELAND GALWAY	NUIG	1	Coordinator
FRAUNHOFER GESELLSCHAFT ZUR FOERDERUNG DER ANGEWANDTEN FORSCHUNG E.V	FRAUN-HOFER	2	Beneficiary
UNIVERSITE CATHOLIQUE DE LOUVAIN	UCL	3	Beneficiary
PINTAIL LTD	PT	4	Beneficiary
FOLKHALSOMYNDIGHETEN	FOHM	5	Beneficiary
RIJKSINSTITUUT VOOR VOLKSGEZONDHEID EN MILIEU	RIVM	6	Beneficiary
CARR COMMUNICATIONS LIMITED	CARR	7	Beneficiary
TERVEYDEN JA HYVINVOINNIN LAITOS	THL	8	Beneficiary
INSTITUTUL NATIONAL DE SANATATE PUBLICA	NIPH	9	Beneficiary
ROBERT KOCH-INSTITUT	RKI	10	Beneficiary
STICHTING KATHOLIEKE UNIVERSITEIT	RUNMC	11	Beneficiary
CLARISOFT TECHNOLOGIES ROM SRL	CLARISOFT	12	Beneficiary
OSTERREICHISCHES ROTES KREUZ	ORK	13	Beneficiary
EPICONCEPT	EPIC	14	Beneficiary
INSTITUTO NACIONAL DE EMERGÊNCIA MÉDICA	INEM	15	Beneficiary
TRILATERAL RESEARCH LTD	TRI	16	Beneficiary
ISTITUTO PER L'INTERSCAMBIO SCIENTIFICO	ISI	17	Beneficiary
ASSOCIAZIONE DELLA CROCE ROSSA ITALIANA	ITRC	18	Beneficiary
INSTITUTO NACIONAL DE SAUDE DR. RICARDO JORGE	INSA	19	Beneficiary

Executive Summary

Work package 5 (WP5) in PANDEM-2 addresses the critical challenge of providing effective and timely communication in a pandemic health emergency. Previous work in Task 5.1 focussed on the theoretical groundwork and established essential components for effective communication. Building on this, Task 5.2 aimed to develop practical recommendations for end-users involved in public health pandemic communication. With support and feedback from the PANDEM-2 end-users, deliverable D5.2 provides templates and guidelines for the most common ways of pandemic communication. These templates are intended to be used and adapted freely by the project end-users and be versatile enough to fit crisis communication needs during any sort of outbreak as well as an organization's need. Especially for smaller organizations, with fewer staff and a small or non-existent communications department, these templates can serve as a basis to lighten the workload of the responsible communication staff and allow them to exchange relevant information with the public in a short amount of time. Templates for contact lists shall further serve as an incentive and motivator for end-users to identify relevant stakeholders within their respective countries and beyond, whose contact details are valuable to ensure fast and efficient communication. A second virtual work package 5 (WP5) end-user workshop was conducted to give experienced staff the chance to test and evaluate the developed guidelines and templates in order to increase their quality and effectiveness.

Responsible Authors	Benjamin Kaluza [FRAUNHOFER], Maike Overmeyer [FRAUNHOFER], Silke Römer [FRAUNHOFER], Sonja Grigoleit [FRAUNHOFER], Sebastian Wagner [FRAUNHOFER], Laura Daly [CARR], Pearse Corcoran [CARR], Bronagh Kelly [CARR]
Contributions from	Charlotte Larsson Sandén [FOHM], Henrik Josephson [FOHM], Berend Beishuizen [RIVM], Anne-Romy Peelen [RIVM], Fanni Appelberg [THL], Liina Voutilainen [THL], Anna Katz [THL], Claudia Houareau [RKI], Alma Tostmann [RUNMC], Maartje van Geel [RUNMC], Camilo Palacio [ORK], Adriano Valentini [ITRC], Ricardo Mexia [INSA], Marta Barreto [INSA]

Table of Contents

1	Introduction & Background	6
1.1	Project Overview.....	6
1.2	Objectives of WP5: Pandemic Communication	6
1.3	Theoretical Background.....	7
2	Approach	10
2.1	Scope and limitations	10
2.2	End-user Involvement	10
2.2.1	End-User Validation Workshop	11
2.2.2	End-User Questionnaires and Guideline review	11
3	Results	13
3.1	Nominated communication coordinators of stakeholder organisations	13
3.2	Contact lists of key individuals and organisations	14
3.3	Action plans for stakeholders	16
3.3.1	Crisis Communication Strategy Generation Guidelines	21
3.3.2	Specific checklists for different organisation types and communication aspects	21
3.3.3	Case study: New Zealand.....	25
3.4	Guidelines and Templates for Public information	31
3.4.1	Press Release Template Guidelines.....	31
3.4.2	Web Information and Influencer Involvement.....	34
3.4.3	Templates and checklists for Social Media, FAQs and Helplines	36
3.4.4	Information to be included for briefings for politicians, media, and spokespeople.....	42
3.5	End-User Validation Workshop.....	45
3.5.1	Discussion Group: SARS.....	46
3.5.2	Discussion Group: Ebola	48
3.5.3	Discussion Group: COVID-19	50
4	Impact & Conclusion	52
5	References	53
6	Appendices	56
6.1	Appendix 1: End-user Workshop	56
6.2	Appendix 2: End-user Questionnaire	58
6.3	Appendix 3: Crisis Communication Principles	61
6.4	Appendix 4: Communication Contact List	62
6.5	Appendix 5: Press Release Template	63
6.6	Appendix 6: Media Contact Template.....	64
6.7	Appendix 7: Communication Checklist.....	65

List of Figures

Figure 1: Overview structure of the PANDEM-2 work package 5: Pandemic Communication.....	6
Figure 2: Generalised essence of necessary decisions and subsequent actions for stakeholders regarding a crisis communication strategy (both in general and in the context of a pandemic).	18
Figure 3: Generalised tasks for checking (grey boxes) and adjusting (green boxes) prerequisites for implementing crisis communication strategy and plans plus caveats (orange box) in a pandemic context.	19
Figure 4: Results from EU project CrisComScore, "overview of elements of the Crisis Communication Scorecard" (Vos et al., 2011, pp. 29-30)	20
Figure 5: COVID Alert Levels system (four phases) (Mindfood 2020) and Traffic Lights (three phases) (New Zealand Government 2022)	28
Figure 6: Overview of the section "Communications and health education" within the Stamp It Out phase (New Zealand Ministry of Health 2017: 85).....	30
Figure 7: The 3 R's: Review, Recognise, Respond (Murthy et al., 2021).....	39
Figure 8: Sample – HSE (Ireland) COVID-19.....	40
Figure 9: Sample – New Zealand COVID-19.....	41
Figure 10: View of the workshop whiteboard applying the task 5.2 pandemic communication templates (Story 1: SARS).	46
Figure 11: Crisis Communications Lifecycle, CDC, 2017	61

Abbreviations and Acronyms

CDC	Centers for Disease Control and Prevention
CERC	Crisis and Emergency Risk Communication
COVID-19	Coronavirus disease, an infectious disease caused by the SARS-CoV-2 virus first identified in 2019
D	Deliverable
ECDC	European Centre for Disease Prevention and Control
EFSA	European Food Safety Authority
EU	European Union
EWRS	Early Warning and Response System
FAQ	Frequently Asked Questions
HIV	Human Immunodeficiency Virus
HSE	Health Service Executive (Ireland)
IATA	International Aviation Transport Association
IHR	International Health Regulations
ISBN	International Standard Book Number
MERS	Middle East respiratory syndrome
MS	Microsoft
NGO	Non-Governmental Organization
NHS	National Health Service
NPHE	National Public Health Emergency Team
NZ	New Zealand
NZIPAP	New Zealand Influenza Pandemic Plan
PANDEM-2	(A project receiving funding from the European Union's Horizon 2020 research and innovation programme under Grant Agreement No. 883285)
PPE	Personal Protection Equipment
PR	Public Relations
PSA	Public Service Announcement
RCCE	Risk Communication & Community Engagement
SARS	Severe Acute Respiratory Syndrome
SMS	Short Message Service
UX	User eXperience
WHO	World Health Organization
WP	Work Package

1 Introduction & Background

1.1 Project Overview

The aim of the PANDEM-2 project is to improve the capacity in pandemic planning and response of European Union (EU) member states by implementing and demonstrating important novel concepts, resources and IT systems. To achieve this, the project works closely with national, EU and international stakeholders to develop and demonstrate innovative solutions to pandemic management and planning.

Technical solutions of PANDEM-2 include the integration of pandemic-relevant data from numerous sources, including international systems (Go.Data outputs, EWRS, TESSy, etc.), participative surveillance (Influenzanet, Studybugs, etc.), from laboratory (next generation sequencing) systems and from social media (Twitter, Reddit). participatory surveillance systems (e.g., Influenzanet) and social media (e.g., Twitter, Reddit). This data will be accessible and analysed via an online dashboard, designed and built to support the specific needs of pandemic managers (public health agencies responsible for pandemics), hospital managers and first responders in Europe. The PANDEM-2 dashboard will also facilitate predictive modelling of pandemic spread, and impact on resource management and mapping of workforce capacity.

A second focus of PANDEM-2 is on non-technical innovations for pandemic preparedness, by creating and delivering resources, innovations and training for pandemic communication. Communication between pandemic management stakeholders and the public continues to represent a critical challenge. Overall, the PANDEM-2 project will assist the relevant authorities to make rapid, evidence-based decisions in response to a pandemic and supply them with the resources to communicate these decisions effectively to citizens of EU member states.

1.2 Objectives of WP5: Pandemic Communication

At the onset of and during a pandemic, ensuring effective and timely communication is a key priority for stakeholders in public health. Within the PANDEM-2 project, this critical challenge is addressed in WP5: Pandemic communication. In order to progress from theory to action, WP5 is structured in several tasks building on each other, following a waterfall logic (Figure 1).

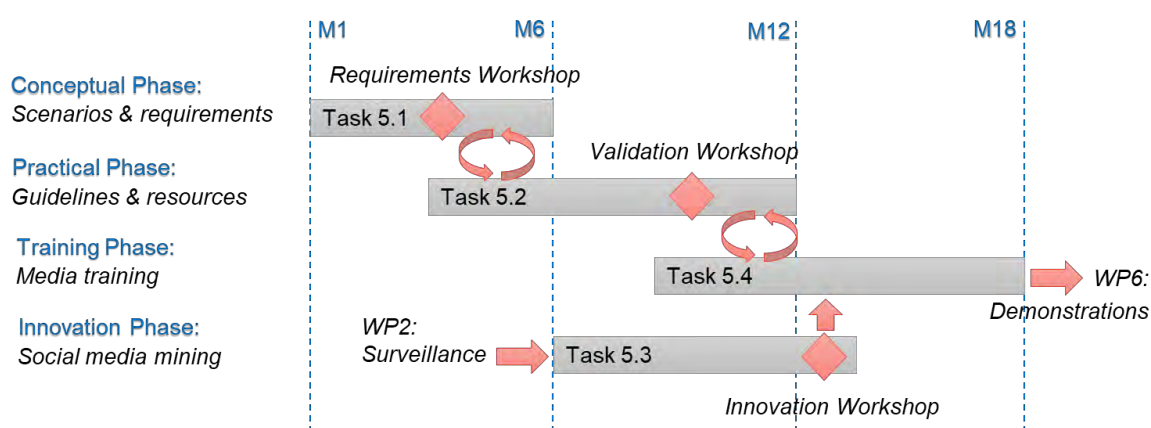


Figure 1: Overview structure of the PANDEM-2 work package 5: Pandemic Communication

Task 5.1 represents the conceptual phase, building on input from the previous PANDEM phase 1 project (How et al., 2017) and features a state-of the art analysis, comprising of findings of academic research, practical application examples and end-user requirements. In the related PANDEM-2 deliverable 5.1 (D5.1) “Scenarios Analysis and Pandemic Communications Requirements Statement”, several key elements are covered, ranging from a methodological framework for analysis, the theoretical background of pandemic communication, to existing guidelines as well as end-user perceptions and needs related to pandemic communication. Key findings of task 5.1 are structured in “Knowledge Bases” to provide a clear and concise overview that can be subsequently used.

Task 5.2, outlined in this deliverable, represents the practical application of pandemic communication principles and is building on key elements identified in the theoretical overview (see section 1.3). Here, we ask how theoretical findings can inform the practical work of end-users in public health or responder organisations in a pandemic situation. This deliverable addresses a series of previously identified common problems and challenges in pandemic communication and identifies how they can be mitigated by previously established templates and resources and how end-user organisations can establish those and customize them for ready use before a crisis.

Further work in WP5 will then target how pandemic communication may benefit from innovative approaches in other areas (task 5.3), e.g., what can be learned from sentiment analysis of Twitter messages based on a social media mining approach (co-developed with WP2). To include an external view, task 5.3 identifies and interviews influencers in the current COVID-19 pandemic and invites external stakeholders to an innovation workshop.

Task 5.4 is finally summing up and testing previous findings, developments and innovative ideas in a pandemic communicator media training. The training syllabus is validated in training with participants that undertake “real” media interviews which are then assessed by professional communicators. Results of the media training will then feed into the large-scale PANDEM-2 table top and full-scale exercises in work package 6.

1.3 Theoretical Background

Effective and timely communication at the onset of and during a pandemic is cornerstone of the pandemic response for public health and responder organisations. In order to provide practical guidance which is grounded in scientific evidence and informed by end-user experiences, this deliverable is building on the Knowledge Bases which were developed in PANDEM-2 D5.1.

Focal topics for the “Knowledge Bases” were defined by addressing research gaps in pandemic communication as identified by the PANDEM phase 1 project (How et al., 2017). For each “Knowledge Base” key take-away messages were provided in D5.1 and refined in four overview tables (see D5.1). The four “Knowledge Bases” are:

- I. The Concept of Trust in Risk Communication
- II. Misinformation & Disinformation in Pandemics
- III. Commercial Lessons
- IV. Practical Application of Pandemic Communication

These “Knowledge Bases” directly relate to some of the main concerns of PANDEM-2 by combining theoretical reflections with practical applications and end-user perspectives, in order to generate

relevant findings on modern, transparent and dialogue-based pandemic communication for further use throughout the project.

Deliverable 5.1 selected a systematic approach to pandemic communication which aims to provide key take-away messages that can be used by the project, end-users, policy makers, and researchers. The state-of-the-art analysis thereby revealed that communication strategies and communicating with the public must be largely independent of the pathogen type. While the nature of the pathogen and thus the pandemic surely influences *what* needs to be communicated, it does typically not determine *how* communication strategies need to be implemented. Instead, communication approaches depend more on the information available at a given time and on the different phases of pandemic management (preparedness, response, recovery). Although these phases could still be divided in sub-phases (especially in the response phase) the broader categorisation proved to be most useful to distinct communication phases and was consequently adopted throughout the “Knowledge Bases”.

Findings

Trust between the public and health agencies needs to be built and maintained before, during and after a pandemic, with different actions required depending on the pandemic phase. Health agencies need to invest into building a trusted relationship with the public *before* a pandemic by actively engaging with the citizens. Identifying shared values can be the basis to build good pandemic communication strategy and pre-emptively work against misinformation. During the response phase, trust needs to be upheld by communicating open and honestly, even if messages change with emerging new information. It is vital to acknowledge that it will be unavoidable that institutions and the public will have to deal with uncertainties during the pandemic. Creating an in-group mentality by appealing to social norms and values (identified during the preparedness phase) can help to maintain and strengthen trust. In the aftermath of a pandemic, it is important to recognize that some things may have not gone as planned. In order to learn from the mistakes made, communicators need to reconnect with the public, agencies need to demonstrate that they are willing to identify and learn from the mistakes that were made.

With an increase in available information via social media, the danger of having messages corrupted by mis- or disinformation dramatically increased. It is thus imperative to already lay the groundwork during the preparedness phase, before any pandemic outbreak, to educate and sensitise the public on how to spot and deal with false information. This includes, analogous to establishing trust, active work to establish the organization as a reliable and trusted source for information, but also training for journalists, a repository for fact checking tools and resources, as well as developing alerts on social media that flag misinformation and disinformation. In the response phase, the organization needs to build on their previous work, actively engage the public in communicating the risks and measures and constantly monitor and adjust strategies to counter misinformation/disinformation. This last step is also vital for the recovery phase, during which previous performances need to be re-evaluated and adjusted.

Lessons from marketing and public relation (PR) teach that there is never just one “public”. Accordingly, messages need to be targeted to individual groups and audiences. Regardless of the pathogen, key audiences, vulnerable groups and ways to reach them need to be identified before any pandemic starts. Similarly, ground rules with the media need to be set and discussed well before a pandemic outbreak and a crisis response team must be established which includes at least one communications expert. The media landscape needs to be surveyed to determine platforms that are

either not being used by target audiences or have not been added to the communication plan because they are new. During the response phase, the communications team then needs to stick to the previous plan, following the guidelines to communicate most effectively and communicate the most essential information needed to reassure the public. Facts must be provided without overloading the intended audience. Constant monitoring and evaluation of the communication performance and outcome are necessary to ensure successful communication. In the aftermath, re-evaluation of mistakes and successes is necessary, as well as communicating to the public that they are now in a period of recovery and reconstruction.

Lastly, different practical insights into a crisis and, more specifically, pandemic communication can also contribute to an improvement of communication tactics. By examining lessons learned from civil aviation, the need for a comprehensive communications plan and training thereof becomes apparent. In order to be ready during a pandemic, the developing and training needs to happen during the preparedness phase, mirroring the insights from marketing and the fight against misinformation. End-user partners also stressed the importance of being prepared before a pandemic outbreak. The preparedness phase should be used to train team members in various types of communication, like TV interviews, press conferences and writing press statements. Smaller, non-pandemic outbreaks could function as a sort of test of communication strategies. During the response phase then, communicators should stick to the plan that is in place, but always be flexible enough to adapt to the current circumstances. Collaboration with the media and the public is vital, even during the response phase, to stay connected to the needs and concerns of the target audience. As in any other phase and area, transparency and honesty regarding the information communicated is of highest importance. During the recovery phase, crisis managers and crisis communicators need to re-evaluate past performances, without blaming and shaming others for mistakes and wrong-doings. Crisis communication in civil aviation emphasises that only through investigating and evaluating past performances and mistakes, true learning and improvement for future crises is possible.

2 Approach

2.1 Scope and limitations

Building on the theoretical background and practice experience summarized in D5.1, the work for this deliverable set out to establish a portfolio of resources for pandemic communication, outlined in section 3. These resources are adaptable to various pandemic scenarios and contexts and represent a foundation to establish further communication strategies upon.

However, as outlined in section 1.3, the work in WP5 refrained from defining particular communication strategies and resources based on pathogen-specific pandemic scenarios, the work is rather oriented towards the available information or pandemic phase. This approach was reinforced in end-user participation workshops, where all participants from across Europe were familiar with the different phases of pandemic management, which allowed them to quickly work together in identifying challenges and best practices in pandemic communication. Beyond the pandemic phases, several practical resources have shown an even higher level of universal utility, i.e. for the duration of whole pandemics, where further sub-categorization is consequently obsolete (contact lists, communication resources etc.). As a result, the work in this deliverable focussed on developing most practical resources to have a general utility and more generic applicability.

Moreover, end-user feedback verified that pre-populated templates are of limited use for pandemic communication officers in public health. Specifications for such templates would be easily all too narrow, as one can rarely predict exact circumstances the communicators would need to react to, either when confronted with a particular pathogen, in a specific pandemic phase or within a unique societal context. The feedback within the end-user validation workshop (section 2.2.1) confirmed as well that, rather than providing specific templates for rare situations, end-users profit more from a good description of how to adapt generic templates for a specific use. Clear “how-to” guidelines, combined with appropriate examples, can thus be helpful addition to the communication work of public health stakeholders. Consequently, this deliverable aims to provide generic and adaptable templates, which are rapidly adaptable by pandemic stakeholders to the given situation.

Lastly, the level of funding and thus own resources and training for pandemic communication varies largely for public health services across EU member states, across organisation sizes and organisational connectiveness. Within organizations and particularly when expanding pandemic response teams in a crisis, communicators bring different levels of experience. It is thus vital to provide a baseline of easily accessible generic resources, as presented in section 3.

2.2 End-user Involvement

To provide relevant and usable communication templates and resources, the work in this deliverable strongly builds on the expertise of the consortium end-users, combined with own media expertise in public relations (CARR) as well as additions from desk research, e.g., on existing guidelines, resources and stakeholder landscapes (FRAUNHOFER).

Previous work in the deliverable D5.1, namely the end-user requirements workshop, set the base on which practical resources were to develop on. Concerns were voiced, e.g., how to communicate effectively with illiterate, vulnerable or non-native speaker groups; problems how to effectively train a core communication team in peace time, in order to rapidly expand it in a crisis; how to create visually appealing infographics; how to work on expectation management with the population and avoid

pandemic fatigue. These real-life communication challenges of the ongoing COVID-19 pandemic were thus considered to shape practical resources in this deliverable.

2.2.1 End-User Validation Workshop

Within this task 5.2, a second workshop with the consortium end-users was held on 28/10/2021, in order to test and validate the communication templates and guidelines. The process to set up the validation workshop aligned with the previous workshop method and process (see D5.1), namely the voluntary participation of our consortium end-users and anonymisation of content based on their professional experiences.

Similar to the end-user requirements workshop, the workshop was held in virtual format, using the conference software MS Teams and the online whiteboard tool Miro in parallel (for the workshop agenda, see appendix 6.1). After a welcome reception, a brief overview of WP5 and findings of the first task (and the related D5.1) were presented in the plenary conference call, with a review of the “Knowledge Bases”. In the following, the draft templates and their handling were presented (how to set up a press release, to create web information, build a social media strategy and how to populate FAQ and helpline information). Before moving to break out sessions, participants got an introduction to three pandemic settings, “three stories” based on real pandemic communication crisis events (detailed information in section 3.5) which were used as context to discuss and apply the communication templates for break out groups.

Each break out group focussed on one pandemic setting for 45 min to discuss a communication strategy and apply the developed resources, before moving to a second discussion round with a different pandemic setting. For this, parallel sessions were created using the break-out room function of MS Teams and received a link to a virtual whiteboard, where the group collectively assembled their contributions. Participants were tasked to address the following questions:

- Which groups would you address?
- Which channels and media would you use for that?
- Which information is most relevant for these group and channels?
- Which (relevant) information might not be available? Which (available) information might not be shared?

Final findings and discussion spotlights of each board were summarized and brought back to the plenary for participants to comment. The workshop ended with a final tour de table, where participants could share novel input that they took from the workshop.

2.2.2 End-User Questionnaires and Guideline review

To better capture current practice and challenges in public health pandemic communication, a survey was conducted among end-user partners of the PANDEM-2 project. We chose to refrain from direct interviews to limit the work burden on consortium end-users (response to the 4th COVID-19 wave) and collected standardized feedback with the help of a questionnaire. This questionnaire was designed to identify who in the end-user organisations is devising the pandemic communication strategy, how someone from outside can contact their communications coordinator, who external stakeholder organisations are, which need to be contacted during a pandemic, whether the organisations provide action plans for them and inquired about internal communication guidelines (see appendix 6.2).

The questionnaire results formed the basis for sections 3.1, 3.2, 3.3, and 3.4 in order to create a practical pathway for users of the PANDEM-2 resources to identify who needs information from them (outwards, see 3.1), who they need to be able to contact (see 3.2) and to form a general understanding of processes in stakeholder organisations around them (see 3.3).

In order to protect the anonymity of the participating end-users, returned questionnaires were pseudonymised by using a unique identifier number and a reference list separate from the completed questionnaires. Please refer to D8.2, which outlines the safety measures FRAUNHOFER will implement to prevent unauthorised access to participant's personal data, which will include FRAUNHOFER's plan to pseudonymise the data collected from participants. As all participants are part of the PANDEM-2 consortium, it was not necessary to obtain a separate informed consent and thus the lawfulness of processing is covered by the Grant Agreement for the entire project.

Data privacy concerns needed to be also carefully addressed in designing the questionnaire. As the collection and publication of direct personal contacts to form a contact list (3.2) would be unlawful, consortium end-users were asked to provide contact details of relevant organizations in their respective countries only in the form of functional e-mail addresses for specific positions /functions (i.e. addresses that were not connected to an individual but the position they held and would be passed on to the next person that in the same position). This way, contact lists would remain up-to-date even if the personnel changes over the years.

Partner organisations were further asked to provide existing internal resources, such as communication guidelines. As these internal documents are typically confidential, they could be reviewed for best practice examples but not shared in their entirety.

Feedback to the questionnaire (see appendix 6.2) was, unfortunately, very diverse and limited. While some end-users were able to provide the information requested through the questionnaire (contact details, communication guidelines, etc.), others were either not able (no such information exists) or not allowed to (information is classified as confidential).

The end-user feedback in questionnaires raised additional question regarding the level of detail, the provided contact lists should entail. One end-user reported that such a list would easily contain over 300 contacts that would be relevant and vital to pandemic communication and that the collection of said details would take a very long time and effort. Secondly, questions arose, who would benefit from these contact lists, as end-user partners from other EU-countries would find no use in detailed lists from any country but their own.

While these points surely are hindering a practical implementation, the importance of having all relevant contact details as part of a pandemic communication plan remains unchanged. Throughout all guidelines reviewed under D5.1, it has been stressed repeatedly how necessary it is to include availabilities of all parties involved before a pandemic occurs (International Aviation Transport Association (IATA), World Health Organization (WHO) etc.). The feedback from the end-users further underlined this point, as they reported such lists would be very useful in any pandemic scenario, despite the effort it would take to collect all information.

Therefore, the decision was made not to collect a large number of contact details for each end-user partner, but instead to provide templates of such lists with suggestions who should be included in these lists. This way, end-user organisations would still need to take the time of collecting contact details, but would not need to share this sensitive information with any third party, nor would they become part of any public website or deliverable.

3 Results

In any sort of crisis, cooperation and communication between the actors involved is vital to effective crisis management. This is, naturally, also true in the case of a pandemic and includes both communication between organizations and the public, as well as between organizations. How to best communicate with the public as an actor has been covered in the previous deliverable (D5.1) and will be further elaborated on below (further see the Crisis Communication Principles outlined in appendix 6.2). Thus, a closer look at communication between organizations and institutions is necessary at this point.

Following the approach as outlined in chapter 2, and as previous work in WP5 showed the limited applicability of pathogen-specific pandemic scenarios and overly specific resources to pandemic communication, the practical resources presented in this chapter were consequently developed with focus on their general utility. In order to allow potential use of the developed resources in all pandemic phases, they are not tailored to overly specific pandemic situations with pre-populated templates. Instead, the resources in the following chapters are designed to:

- Give the user background information why and where the resource can be of help
- Give an impression of what a generic solution/template/strategy can look like
- Describe how the user can adopt, adjust or implement the suggested resources.

Further practical examples of real-life communication strategies and adoption of generic resources are referenced in the respective result sections or can be found in the appendices.

3.1 Nominated communication coordinators of stakeholder organisations

One lesson taught by civil aviation crisis preparedness is that every organization and institution should have a designated communication coordinator or officer. They are responsible for all communication efforts being distributed in the name of the organization. Ideally, they lead a communications team, supporting them in their efforts. In smaller organizations, this is unfortunately, not always the case. In some cases, responsibilities are less clear and communication coordinators are responsible have other additional roles within an organization.

It is, thus, imperative that responsibilities are clear before the start of a pandemic (or crisis in general). In case of a public health emergency, someone from outside of the organisation can then contact the communication coordinators directly and quickly. In some cases, contact details are only known among the "stakeholder network", presumably as to shield them from a wave of inquiries and requests.

If contact details are publicly available, it is advisable to use a functional mail account or phone number. This way, the personal information of the communication coordinator is protected and contact details remain up-to-date even if the coordinators vacate their position (both temporarily and permanently). Additional channels of contact might be known to "professionals of the (public) health sector and the government", and instead of or in addition to a communications coordinator the crisis management team might be addressed. Some end-users responding to the questionnaire stressed the aspect that public health emergencies are communicated via "different rapid alert systems between authorities" or point out the European Early Warning and Response System (EWRS) or the International Health Regulations (IHR).

Most national public health institutions, non-governmental organisations (NGOs) and further institutions that answered the questionnaire have a public relations (PR) department and/or a press

department devising the communication strategy in case of a pandemic; typically, other units contribute and/or the head of the institution/management is involved. In at least one case, there is a designated communications officer.

It is strongly recommended by PANDEM-2 WP5 that any organization

- a) Has a designated communication coordinator and make their existence known within the organization, as well as how they can be reached; the position of communication coordinator should have their own functional e-mail address, e.g. communication@organization.org, that will be passed down to whoever holds the position;
- b) Includes a list of communication coordinators from other partner or stakeholder organizations in their crisis management plan, as well as their contact details (ideally functional e-mail addresses and phone numbers as these will stay valid no matter how much time passes);
- c) Regularly re-evaluate the names on the list and categorize them on the context they would be needed in (public health emergencies require different contacts as opposed to other crises).

The form in which these lists are kept (electronically, analogue) depends on the organization and their respective circumstances. It should, however, be kept in mind that they should be accessible by more than one person, to make sure someone will always be able to access the list. Key stakeholder organisations, mentioned by PANDEM-2 end-user partners, in case of a public health emergency include the national ministry of health plus - depending on the kind of public health emergency -

- Regional organisations responsible for health,
- Additional national institutions (e.g. regarding animal health, food safety, radiation and nuclear safety; risk assessment; ministry of interior and/or civil protection; foreign office),
- International stakeholders (WHO, European Centre for Disease Prevention and Control (ECDC)) and other countries via EWRS and IHR, and
- Further potential stakeholders (e.g. medical associations, professional societies, laboratories).

Key stakeholder organisation pointed out by NGOs concentrate on national organisations, namely the ministries of health, ministry of interior (or civil protection department, national crisis and disaster management staff), head of government.

Although lists like these are very time consuming to create and update and their usage implies the need to consider data protection regulations (i.e. GDPR compliance), the time and effort spent on them will be worthwhile in the next (public health) crisis. A template that can be used as a contact list can be found in section 6.4. Depending on the organization and its needs, it can be extended or customized as needed; the organizations given are suggestions to include based on the work of WP5.

3.2 Contact lists of key individuals and organisations

Any of the guidelines reviewed in D5.1 and D5.2 emphasize the necessity of including contact details of relevant individuals and organizations in a pandemic management plan (or any form of crisis management plan for that matter) (e.g., IATA, WHO). Not being able to reach relevant parties in a crisis or pandemic can lead, in the best case, to a delay in procedures and measures taken and, in the worst case, information not being passed along and wrong decisions are made.

Questionnaire responses have listed a number of relevant contacts for each organization in case of a public health emergency (see 6.2 Question 5). These included a number of governmental health departments and ministries (e.g. Federal Ministry of Health, National Ministry of Health) as well as

other ministries (e.g. Ministry for Internal Affairs). Additionally, other potential stakeholders like medical associations, laboratories and professional societies, along with regional organisations with responsibilities for health were mentioned.

Questionnaire respondents differed greatly regarding the number of agencies and organisations to contact in case of national public health emergencies. Due to a small number of participants per country in the PANDEM-2 project, the survey cannot be regarded as representative. Differences in the number of contacts given could be justified with the different organisations and their responsibilities within the respective national public health systems.

Required list of contacts also vary depending on the kind of public health emergency. An outbreak of the avian influenza or Ebola would require a different set of contacts than a Severe Acute Respiratory Syndrome (SARS) outbreak. To include every organisation and agency to contact for each possible scenario (or even only for the three scenarios identified by the PANDEM-project) would encompass hundreds of contacts and would be highly individualized for each respective organisation. For this purpose, similarly to the contact lists for section 3.1, a more sensible solution to compiling contact lists is to allow end-user partners to take on this task for themselves. The contact lists suggested in this section, as opposed to the ones in 3.1, are targeted more inwards. The contact details from external stakeholders should be kept for cases of public emergencies, etc. The template provided in the appendix (section 6.4) can easily be adapted for that purposes and extended as much as needed.

Building on the responses of the PANDEM-2 end-users, the following categories are recommended to be included in the relevant contact lists for a national crisis communication plan regarding pandemics:

- National stakeholders
 - National ministry of health
 - National focal points for EWRS and IHR
 - Further national stakeholders in case the communication plan foresees a direct contact (instead of indirect communication, via the ministry of health):
 - National ministry of interior
 - Foreign office
 - National organisation for risk assessment
 - National organisation for civil protection
 - depending on the kind of public health emergency additional national institutions regarding
 - Animal health,
 - Food safety,
 - Radiation and nuclear safety
- Regional organisations responsible for health
- International stakeholders, depending on the kind of emergency
 - WHO, ECDC and other countries via EWRS and IHR - via national focal points
- Further potential stakeholders
 - Medical associations
 - Professional societies
 - Laboratories

That list has to be accompanied by additional information, such as who has to contact whom, when/how fast/via which communication channel, what should trigger this at all and a plan B (and C, D...) if the initial contact procedure fails.

For example, there might be one national communication platform that can be accessed by all stakeholders. However, at least for the case that this platform is unavailable at all or for some stakeholders (e.g., due to a power blackout), there has to be a robust routine of who is contacting whom. Typically, a first responder organisation might concentrate on national organisations, namely the ministries of health, ministry of interior (or civil protection department, national crisis and disaster management staff), head of government - plus their established (national and/or international network of cooperating first responder organisations.

3.3 Action plans for stakeholders

The following disclaimer for a pandemic plan also applies for any kind of more or less detailed action plan: *“A pandemic plan is thus a living document which is reviewed at intervals and revised if there is a change in global guidance or evidence-base; lessons learned from a pandemic, an exercise, or other relevant outbreak; or changes to national or international legislation related to communicable disease prevention and control”* (European Centre for Disease Prevention and Control, n.d.). Having pointed out this caveat, this text section deals with potential action plans for stakeholders. This kind of action plan is embedded in a broader context:

Most countries will have a national pandemic strategy, at least regarding influenza. On the one hand, these strategies might also include guidelines and action plans for stakeholders for crisis communication; on the other hand, crisis communication guidelines and action plans might be absent or rather generic. Additionally, there might be different crisis communication guidelines or action plans on different levels (international/national/regionally/organisational level).

The interaction landscape of public health agencies and other governmental bodies, responder organisations and further stakeholders is not the same in all countries. While there are some commonalities, there may be profound differences in the number of stakeholders involved and the type of network (e.g., central or decentral). Therefore, the action plans given in this chapter are as general as necessary due to this framework while aiming at being as detailed as possible.

To start with, it is very likely that stakeholders like hospitals, security, police, governments already do have a (general) communication strategy.

For the case that no general communication strategy exists in the first place, we like to recommend to (A) define a general communication strategy that should be embedded into existing overarching institutional strategies, reflect existing structures and define, if necessary, additional functions like a communication office(r), and (B) identify probable typical types of emergencies your organisation might be facing in the future - pandemics might only be one type of emergency among many others - and add more details to the general strategy for each type of emergency (e.g. specific contact lists, priorities). Aspect (A) goes beyond the scope of this project and task, thus we will concentrate on aspect (B) regarding public health emergencies, especially pandemics. The following guidelines should ease the customisation of existing communications plans for public health emergencies, and the accompanying checklist should help to take all relevant perspectives into account.

Generalised action plan for crisis communication in a pandemic context:

1. Crisis communication strategy development

Regardless the organisation type, the first step of an action plan includes the task for the head of the organisation to **check for a crisis communication strategy**. If not already ticked off before the crisis, the action items must be dealt with at the beginning of the crisis, in parallel with and in addition to the initial response.

Things to take into account:

a. Don't reinvent the wheel.

The following advice is applicable for any type of organisation and crisis (not only for local authorities facing COVID-19): "[...] Don't reinvent the wheel. Dust off your Council's Plan and remind yourself of your vision and key priorities. The world has changed, but the issues that were important before the pandemic and lockdown still matter. The challenge is to refocus your vision, reset your priorities and work with residents, partners, communities and businesses to lead your council into the future with confidence. Most visions are general and all-encompassing so how does yours look through a COVID-19 lens? [...]"

b. Guidelines, templates and instructions to consider:

- i. An overview of important aspects is given in the upper part of ➡ Figure 2.
- ii. Use general guidelines for creating or updating a crisis communication strategy in a pandemic context (see ➡ section 3.3.1).
- iii. Additional existing checklists for your type of organisation
These checklists might be published (for selected examples regarding the stakeholder analysis please see ➡ section 3.3.2) or accessible via your organisation's network.
- iv. Optionally have a look at the real-world example described in ➡ section 3.3.3.
- v. Take guidelines and templates for public communication via different channels into account that are given in ➡ section 3.4 and the appendices (from appendix 6.2 on), respectively.

2. Crisis communication strategy implementation

As soon as a crisis communication group or crisis communication manager is appointed and a (crisis) communication strategy is in place, the strategy has to be implemented.

- a. The general typical aspects of crisis communication strategy implementation are given in ➡ Figure 2.
- b. More details on typical tasks for checking and adjusting prerequisites for implementing crisis communication strategy including caveats in a pandemic context are pictured in ➡ Figure 3.

3. Crisis communication strategy review

If both strategy and responsible group or person are in place and there is no immediate crisis, there should be a **communication strategy review** at least every four or five years (or less, in case that other organisational strategy reviews undergo a shorter cycle) and a compact revision at the end of a recovery phase of a crisis.

This review action can be combined with implementing reoccurring actions regarding communication training and communication network building or "maintenance".

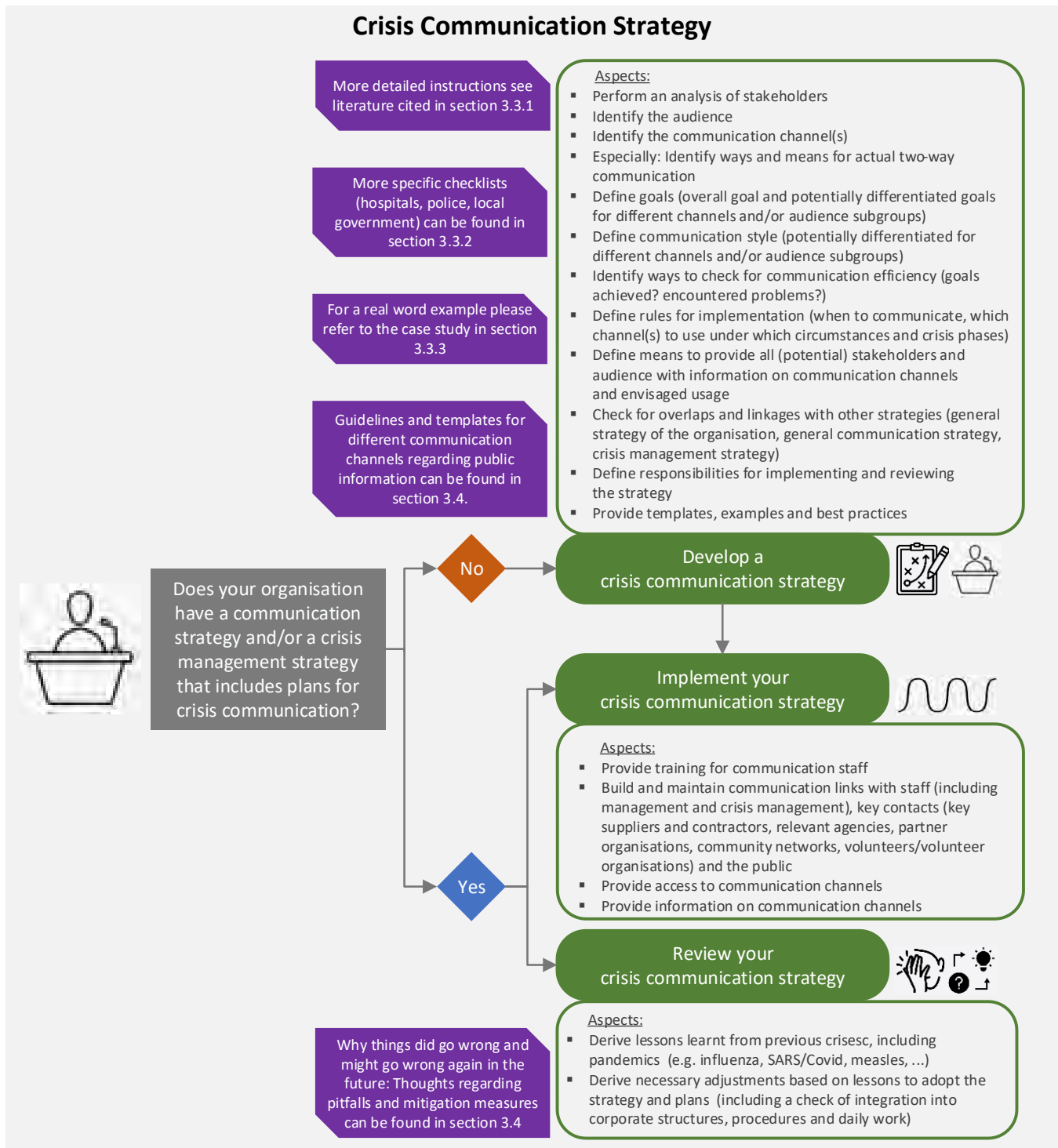


Figure 2: Generalised essence of necessary decisions and subsequent actions for stakeholders regarding a crisis communication strategy (both in general and in the context of a pandemic).

In practice, the implementation of the action plan and related strategies can especially be hampered by the different circumstances (see also orange box in ➡ Figure 3). These include missing staff and capacities, especially caused by illness; to some extent, this can be handled on the basis of a schedule of stand-in arrangements (to be defined in the communication strategy), but there will be a threshold when the actual communication has to be downsized to a minimum. For hospitals and the police, this

minimum will be the internal communication, the communication with partners, and the focused upstream communication regarding administration, needed in order to fulfil the mission of the organisation. For political bodies at the top of the hierarchy, this will include dedicated communication with the public. Further potential drawbacks include missing communication channels or technical issues regarding communication channels causing delay in communication.

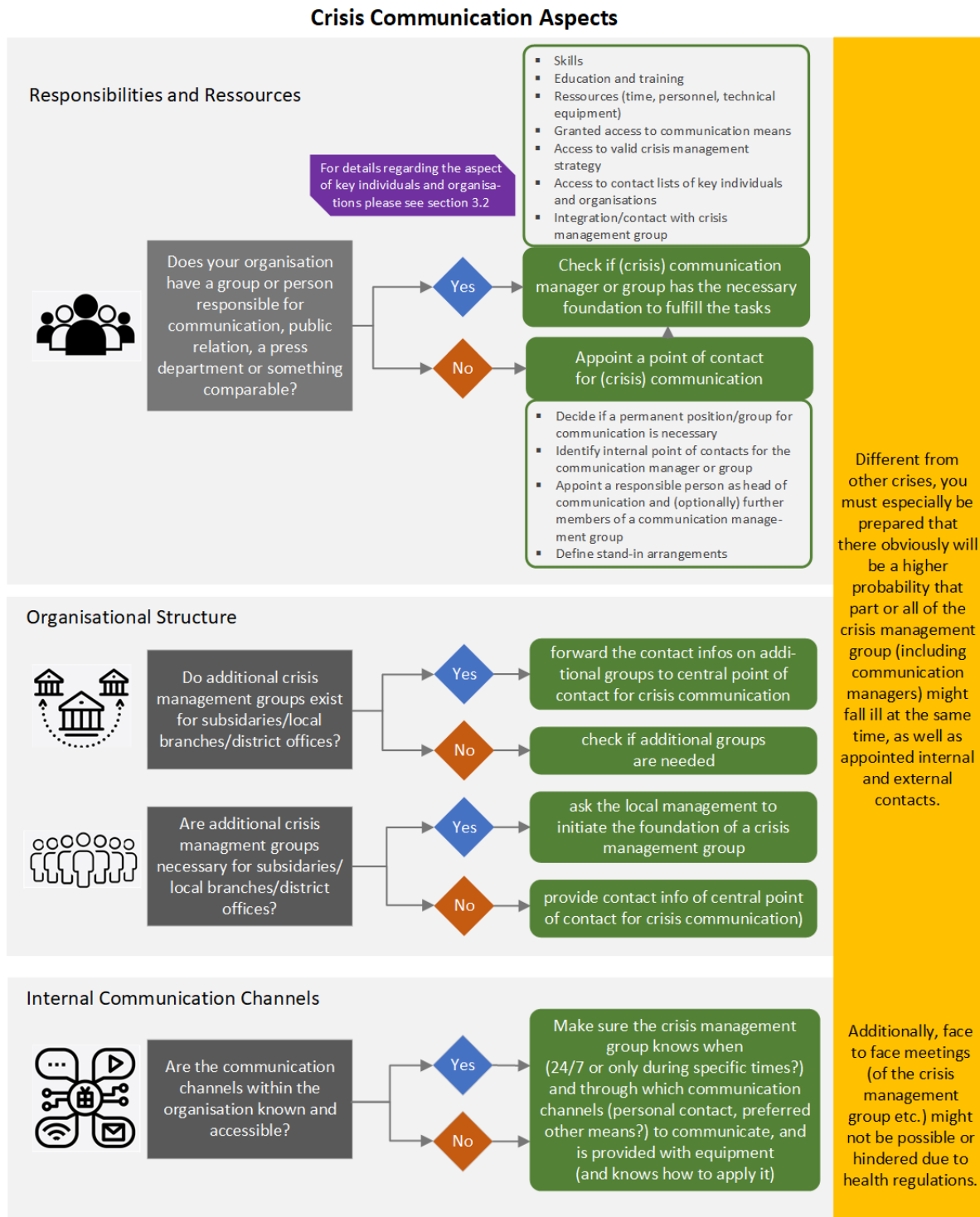


Figure 3: Generalised tasks for checking (grey boxes) and adjusting (green boxes) prerequisites for implementing crisis communication strategy and plans plus caveats (orange box) in a pandemic context.

As already stated, the tasks of a communication coordinator in the context of a pandemic are dependent on the phase of the respective crisis. A good overview of the tasks has been given in the outcome of the EU project CrisComScore (Figure 4).

Time	The phases of a crisis and emergency management activities	Communication tasks (to be further specified per task by listing performance indicators)	Stakeholder groups		
			Citi- zens	News media	Response organisa- tion/ network
Before	[1] Preparation: (prediction, prepared- ness and mitiga- tion)	1.1 Knowing the public groups and their media use	x		
		1.2 Monitoring of risk perception and general public understanding of risks	x		
		1.3 Contribution to the general public preparedness	x		
		1.4 Establishing cooperation with news media and journalists for crisis situations		x	
		1.5 Improving preparedness in the organisation and in the network of response organisations			x
		1.6 Improving network facilities and availability of manpower			x
		1.7 Improving information exchange and training of crisis communication activities in the organisation and within the response network			x
During	[2] Warning	2.1 Targeting and distribution of warning messages	x		
		2.2 Issuing instructions to public groups and monitoring reactions	x		
		2.3 Informing the news media		x	
		2.4 Information exchange and coordination in the organisation and within the response network			x
After	[3] Crisis response: (emergency)	3.1 Instructions on how to prevent further damage	x		
		3.2 Clarifying the situation to help public groups to cope with the situation	x		
		3.3 Continuous monitoring of needs and perceptions of public groups	x		
		3.4 Direct means of communication	x		
		3.5 Designated crisis agency spokes-people and services for journalists		x	
		3.6 Assist cooperation in the organisation and within the response network			x
	[4] Reconst- ruction: (recovery)	4.1 Instructions for recovery efforts	x		
		4.2 Stimulating a more accurate public understandings of the recovery and ongoing risks	x		
		4.3 Ongoing monitoring of needs and perceptions of public groups	x		
		4.4 Ongoing media relations		x	
		4.5 Stimulating cooperation and coordination in the organisation and within the response network			x
	[5] Evaluation	5.1 Supporting reflection	x		
		5.2 Evaluation and conclusions for the future via media and public debate		x	
		5.3 Supporting evaluation and learning about communication in the organisation and within the response network			x

Figure 4: Results from EU project CrisComScore, "overview of elements of the Crisis Communication Scorecard" (Vos et al., 2011, pp. 29-30)

Before detailed guidelines and templates for public information are given in section 3.4, the following sections highlight crisis communication strategy generation guidelines (section 3.3.1), add some more specific checklists for different organisation types (section 3.3.2), illustrates the aspects of the action plan discussed above, using the example of the COVID-19 response in New Zealand (section 3.3.3).

3.3.1 Crisis Communication Strategy Generation Guidelines

A resource that is both detailed with respect to the many facets of crisis communication and focussed on specifics of a pandemic is the documentation of the 2016 WHO emergency risk communication (ERC) training course. Unfortunately, its documentation may not have been updated since (the WHO website for the training has lately been displaying a “maintenance break”), but it nevertheless gives a good overview and valuable accentuations. The course comprised the following modules (World Health Organization, 2016):

- A. Course introduction
- B. Risk communication
 - B1. International health agreements
 - B2. Building and maintaining trust
 - B3. Risk Communication strategies
 - B4. Public communication for health emergencies
 - B5. Community engagement
 - B6. Coordination and stakeholder engagement
 - B7. Questions on emergency risk communication
 - Internal and external communication coordination
 - B8. Dynamic listening and rumour management
- C. Risk communication Strategies
 - C1. A systems approach to emergency risk communication (ERC)
 - C2. Emergency risk communication policy
 - C3. Strategies for emergency risk communication
 - C4. Simulation and other exercises
 - C5. Monitoring and evaluation
- D. Risk communication tools
 - D1. Setting Communication Objectives: SOCO
 - D2. Spokesperson Tips
 - D3. Message and materials development
 - D4. Resources
- E. Exercises

An up-to-date overview on the multiple facets of crisis communication can be found in the previous deliverable D5.1.

3.3.2 Specific checklists for different organisation types and communication aspects

This section focusses on additional advice to facilitate the central stakeholder analysis for a stakeholder analysis of a specific organisation, especially for identifying and characterising audience subgroups.

Primary and secondary audience

For all communication plans, the following differentiation is necessary (RCCE, 2020):

1. Primary audience: People most at risk / vulnerable population
2. Secondary audience: People who act as spokespeople or representatives

Typical audience subgroups of companies, public health institutions and local governments

For a typical **company perspective**, the following differentiation is a good general starting point for a stakeholder analysis:

- Media
- Public
- Clients and customers
- Investors and shareholders
- Employees
- Government or semi-state bodies
- Family or next-of-kin

In addition to these general categories, a **public health institution** would make further distinction regarding audience and other stakeholders: (World Health Organization, 2017)

- "Individuals who make decisions about their own health and that of their families (such as whether to take children to a health care provider for screening, practice hand hygiene in the homes, or travel to a country where infectious diseases are circulating).
- Health care providers who make decisions about screening, diagnostics, treatment, and recommendations for patients (such as whether to screen HIV patients for tuberculosis, counselling pregnant women about travel to areas of circulating virus, or recommending vaccinations for children).
- Policy-makers at national and subnational levels with responsibility for their residents' health (such as investing in training health workers, building emergency operations centres, or funding vaccine programmes).
- Communities who make decisions about shared space, activities, and services with health consequences (such as clean-up of standing water in community squares, creation of walking and exercise space within neighbourhoods, location of health facilities in proximity to residences.).
- International organizations and stakeholders who make decisions about funding and implementing health programmes (such as assisting countries in health systems strengthening, funding programmes to reduce chronic diseases, providing support for public health research).
- WHO staff who make decisions about programmes, coordination, human and financial resources, and how they speak to external partners and colleagues about WHO."

While a national public health organisation might have the duty to inform and probably also give advice to others mainly on national level, a good starting point of a stakeholder analysis for crisis communication for a **regional or local authority** might typically comprise the following (slightly modified list, based on public information in the context of COVID-19 response plans (Reading Borough Council, 2020)):

- Care homes
- Social care services
- Schools, universities and/or other educational establishments
- Hospitals
- Primary care facilities
- Travellers (both returning travellers from abroad and people planning to leave the region or travelling within the region)
- Homeless population
- Social housing
- Leisure facilities
- Libraries and other cultural facilities
- Retail and the town centre
- Transport hubs
- Offices/workplaces
- Food outlets/licenced premises
- Council-run buildings
- Places of worship

Generalised checklist of categories for further stakeholder analysis steps

- Location: general whereabouts of people
 - o People in affected neighbourhoods
 - o People in at-risk areas

This is mainly a geographical aspect on a larger scale (and might also be important regarding travel advice or travel restrictions).

- On a more local scale, the following – typically highly frequented places – location and associated population can be considered:
 - o Locations:
 - Schools, educational establishments
 - Hospitals, medical facilities, care facilities
 - Traffic and transport nodal points
 - Administrative building with or without access for the public
 - Businesses
 - Places connected with leisure and recreation (sport, culture, dining)
 - Places of worship
 - o Population subgroups typically present at these highly frequented places (in the context of education, health, labour, leisure time):
 - School children, students
 - teachers and staff at educational establishment
 - Patients, people in need of care (at home or in residential care communities)
 - Health personnel, caregivers, staff at medical facilities or care facilities
 - Police, first responders
 - Visitors, performers, staff and first responders at mass events
- Mobility: People with actual or supposed higher mobility
 - o Migrants,

- o Refugees,
- o Travelers,
- o Businesses
- Population subgroups with respect to susceptibility and vulnerability
 - o Differentiation between age groups
 - Babies
 - Young children (up to 12 years old)
 - Secondary school children (aged 13 to 17 years)
 - Young adults (aged 18-30 years)
 - Older adults (70+ years old)
 - o People with low immunity, pre-existing illness or pre-existing condition
 - o Pregnant women
- Population subgroups with respect to assumed reachability and/or communication patterns (including the involvement of spokespersons or representatives),
 - o Community organizations such as religious groups, village groups, civil society organizations, businesses, and public and private institutions
 - o Indigenous people
 - o Gender diverse/LGBTQ+ communities
 - o People affected by natural disasters (e.g., bushfires, floods, hurricanes) or power black-outs
 - o People with life-threatening conditions (e.g., immunocompromised patients)
 - o Hearing-impaired community
 - o Vision-impaired community
- Further aspects

Please be aware that all the above lists are not exhaustive and may need individual adjustments for each organisation and crisis, especially based on the specifics of the biological agent causing the pandemic (ways of transmission).

- o For example, depending on transmission of pandemic agent additional or more specifically defined parts of the population might become relevant audience subgroups:
 - transmission via food: food industry,
 - transmission via animals: farmers/food industry, or pet owners or residents of wildlife habitat, respectively
 - transmission via sexual intercourse: civil society (youth also via teaching staff, parents, peers); aid agencies addressing sexual violence; sex workers

Aspects for choosing communication channels for dedicated messages

For the identified audience (and audience subgroups), compare the communication channels of your organisation and the following (non-exhaustive) list of potential sources of information your envisaged audience might actually use; this might help to specify the channel or to identify the need for an additional channel, for example through multipliers like community leaders, influencers or local persons of trust:

- Radio
- TV
- WhatsApp
- Social Media (no WhatsApp)
- Health unit/Health care worker
- Family members
- Friends
- Community health workers
- Local or national public health (Ministry of Health)
- Red Cross Red Crescent volunteers
- Other community mobilisers
- Community leaders
- Religious leaders
- Traditional healers
- Traditional midwives
- Any person from the community
- Other peer groups or person of trust

Crisis communication in pandemic context might also serve for encouraging, nudging (up to forcing) or discouraging (up to prohibiting) certain **behaviour patterns**, respectively. In case more insight into this topic is needed for preparing or adjusting a (crisis) communication strategy, we recommend the **emergency risk communication evaluation model** (Seeger et al., 2018) already referred to in D5.1.

Before detailed guidelines and templates for public information are given in section 3.4, the following section illustrates the aspects of the action plan discussed above, using the example of the Covid-19 response in New Zealand.

3.3.3 Case study: New Zealand

This concise case study presents an overview of the (re-)development of a national epidemiological decision-making framework for the development and communication of an effective and rapid response to an emerging pandemic. Concurrently, adaptable factors and possible deficits are identified.

New Zealand's response to the COVID-19 pandemic through its elimination strategy is considered one of the best in the world (for an overview of features that distinguish the elimination strategy from mitigation and suppression, see Baker et al. 2020). Specifically, the type of crisis communication used by the government during the 2020 lockdown is judged by social scientists as particularly successful (cf. e. g. Beattie & Priestley 2021). This response was by no means implemented quickly and at short notice but was based on deliberations that had taken place beforehand. Ideally, lessons learned from previous pandemics inform subsequent ones. When the COVID-19 pandemic broke out, the New Zealand Government did have a pandemic plan encouraged by the World Health Organization (WHO) titled "The New Zealand Influenza Pandemic Plan: A framework for action" (NZIPAP). Even though this plan had been drawn up for a different emergency it served as the starting point for the "COVID19-National Action-Plan".

The **New Zealand Influenza Pandemic Plan: A framework for action** (NZIPAP) that was released in August 2017 sets out the actions that need to be taken across government to prepare for and respond to an influenza pandemic (New Zealand Ministry of Health 2017). It is worth noting that the initial plan was amended to consider the experience of the 2009 influenza A (H1N1) pandemic and it was stated that the plan could be “adapted and applied to any pandemic, irrespective of the nature of the virus and its severity”. The action plan it contains summarises the phases (international and New Zealand-specific) of a pandemic and provides guidance on the actions that can be taken in each phase, the individuals or agencies responsible for these actions and the authority under which actions can be taken. The flexible approach adopted is consistent with the WHO recommendation that while individual nations should use WHO phases to inform national planning, this planning needs to reflect the local situation.

For each phase of the New Zealand Pandemic Influenza Plan, there is a detailed description of the actions required, the responsibilities of the actors/stakeholders and the respective statutory support. As the phases constitute the general framework, they will be presented first. On the whole, the NZIPAP is divided into the following six phases, which are loosely based on the WHO's definitions for classifying a pandemic:

1. **Plan For It** (Planning and preparedness)
2. **Keep It Out** (Border management)
3. **Stamp It Out** (Cluster control)
4. **Manage It** (Pandemic management)
5. **Manage It: Post Peak** (Transition to Recover From It phase, and planning for a resurgence or second wave)
6. **Recover from It** (Recovery)

This six-phase strategy should be understood as being specifically tailored to national needs and includes dynamic trigger points to mark the transition between phases. It is important to know that the plan is primarily aimed at two things: First, it aims at mitigation, i.e. reducing the impact of the pandemic on the population rather than trying to end it. According to Kvalsvig and Baker (2021), this approach was based on the assumption that the planned pandemic was caused by influenza and that previous experience with influenza pandemics suggested that elimination was not feasible. As a consequence, the NZIPAP assumed that a vaccine would be developed fairly quickly after the outbreak of the pandemic, as would be expected for influenza, where there is an established global production capacity that needs to reformulate the vaccine regularly to respond to changes in the circulating virus. This is closely linked to the second objective of the plan, “flexibility”: Based on the influenza-specific assumptions described above, the core objective was to keep transmission and severity low while distributing the vaccine that was already available. Kvalsvig and Baker (2021) observe that despite the fact that the plan's approach, according to its authors, should also apply to other respiratory pandemic-type pandemics, it does not discuss how different transmission characteristics might require a different type of response. Of course, these very specific basic assumptions diverge from those of a pandemic situation such as COVID-19. Therefore, the original plan had to be adjusted to focus on an excluded, yet well-described, strategy of pandemic control, namely *elimination* (Kvalsvig & Baker 2021: 146).

Kvalsvig and Baker (2021) see an important turning point in New Zealand's COVID-19 strategy resulting from a report by the *WHO China Joint Mission*, which stated that transmission of SARS-CoV 2 could be contained. The **National Action Plan** (New Zealand Ministry of Health 2020) that emerged from this

insight was nevertheless labelled as a supplement. According to its authors, it was not intended to replace other operational plans, but can be read alongside them, such as the COVID-19 Māori Response Action Plan, the Ministry of Health, Health & Disability Response Plan and the New Zealand Influenza Pandemic Plan. As part of the elimination strategy, all activities focused on achieving and maintaining "zero COVID-19". This was crucial when no treatment options and especially no effective vaccinations were available.

The National Action Plan was designed for the short term and ran alongside a four-level COVID-19 warning system. The alert levels were set by the government and indicated what health and social measures needed to be taken in the fight against COVID-19. Services such as supermarkets, health services, emergency services, utilities and goods transport continued to operate at each level. They are:

Level 1 - Prepare (disease is contained)

Level 2 - Reduce (disease is contained, but risks of community transmission growing)

Level 3 - Restrict (heightened risk that disease is not contained)

Level 4 - Eliminate (likely that disease is not contained)

The restrictions were to be understood as cumulative, i.e. at alert level 4, all restrictions of alert levels 1, 2 and 3 applied. Moving to the next phase of the COVID-19 plan, the government decided on working with a simplified visual framework in December 2021 (see also Figure 5). The "traffic light" is designed to give a new framework to the introduction of vaccine passes as a part of public life. The "My Vaccine Pass" will allow shops to open and events to take place safely. My Vaccine Pass is the official record of the COVID-19 vaccination status for use in New Zealand. The new framework is intended to give as much certainty and stability as possible for people and businesses, reducing the need for widespread lockdowns (cf. <https://covid19.govt.nz/traffic-lights/covid-19-protection-framework/>).

COVID Alert Levels	Traffic Lights (2nd December 2021)
<h2>NEW ZEALAND COVID-19 ALERT LEVELS</h2> <h3>WHAT YOU NEED TO KNOW</h3> <div> <div>1</div> <div> PREPARE - Disease is contained <ul style="list-style-type: none"> Border restrictions to minimise risk of importing COVID-19 Contact tracing Stringent self-isolation and quarantine Intensive testing for COVID-19 Physical distancing encouraged Mass gatherings over 500 cancelled Stay home if you're sick, report flu-like symptoms </div> </div> <div> <div>2</div> <div> REDUCE - Contained, but risk of community transmission growing <ul style="list-style-type: none"> Border restrictions maximised Further restrictions on mass gatherings Social distancing on public transport encouraged Limiting domestic travel encouraged Employers to work from home, stagger shifts etc to limit contact Over 70s and those with pre-existing conditions to stay at home </div> </div> <div> <div>3</div> <div> RESTRICT - Risk that disease is not contained <ul style="list-style-type: none"> Travel in areas with clusters or community transmission limited Affected educational facilities closed Mass gatherings cancelled Public venues such as gyms, libraries, museums, cinemas, food courts closed Some non-essential businesses should close, alternative work arrangements required GPs to move to virtual or phone consultations Elective health services and procedures in hospitals deferred and healthcare staff reprioritised </div> </div> <div> <div>4</div> <div> ELIMINATE - Likely that disease is not contained <ul style="list-style-type: none"> People instructed to stay at home All educational facilities closed All businesses closed except for essential services (e.g. supermarkets, pharmacies, clinics) and lifeline utilities Rationing of supplies and requisitioning of facilities All travel severely limited Major reprioritisation of healthcare service </div> </div>	<div> <div>Red</div> <div> Life at Red <ul style="list-style-type: none"> Wear a face covering on flights, public transport, taxis, shops, education (Year 4 and up including tertiary) and public venues (mandatory) You can visit public places like libraries and museums (with limits based on the size of the venue) Go to workplaces. Where appropriate staff may work from home Go to education places like schools and ECE (with health measures and controls in place) </div> <div> My Vaccine Pass allows you to go to the following:[*] <ul style="list-style-type: none"> Cafes, restaurants and bars Gatherings like weddings and funerals, and gatherings at home Indoor and outdoor events Close-proximity businesses like your hairdresser The gym or other member-based businesses like dance or martial art studios <p>You can also attend tertiary education in person (capacity limits will apply based on venue size).</p> <p><small>[*]Up to 100 people based on the size of the venue. For gatherings at home, you can have up to 100 regardless of the size of the house.</small></p> </div> <div> Without My Vaccine Pass there are restrictions that apply: <ul style="list-style-type: none"> Only allowed contactless pickups at cafes, restaurants and bars Only attend small gatherings of up to 25 people. If held at home, maximum of 25 people regardless of the size of the house Cannot attend indoor or outdoor events, like concerts Up to 25 people can attend outdoor community gatherings with uncontrolled access Only distance learning for tertiary education </div> </div> <div> <div>Orange</div> <div> Life at Orange <ul style="list-style-type: none"> Wear a face covering on flights, public transport, taxis, shops and public venues (mandatory) You can visit public places like libraries and shops (with limits based on the size of venue) Go to workplaces Go to education places (with health measures in place) </div> <div> My Vaccine Pass allows you to go to the following with no limits: <ul style="list-style-type: none"> Cafes, restaurants and bars Gatherings like weddings and funerals, and gatherings at home Close-proximity businesses like your hairdresser The gym or other member-based businesses like dance or martial art studios </div> <div> Without My Vaccine Pass there are restrictions that apply: <ul style="list-style-type: none"> Only allowed contactless pickups at cafes, restaurants and bars Small gatherings can be up to 50 people, based on the size of the venue. If held at home, maximum 50 regardless of the size of the house Cannot attend indoor or outdoor events Outdoor community gatherings with uncontrolled access have a maximum of 50 people Cannot go to the gym or other member-based businesses like dance or martial art studios Cannot visit close-proximity businesses like hairdressers </div> </div> <div> <div>Green</div> <div> Life at Green <ul style="list-style-type: none"> Wear a face covering on flights (mandatory) Visit public places like libraries and shops Go to workplaces Go to education places </div> <div> My Vaccine Pass allows you to go to the following with no limits: <ul style="list-style-type: none"> Cafes, restaurants and bars Gatherings like weddings and funerals, and gatherings at home Indoor and outdoor events Close-proximity businesses like your hairdresser The gym or other member-based businesses like dance or martial art studios </div> <div> Without My Vaccine Pass you can go to the following (with limits):[*] <ul style="list-style-type: none"> Gatherings like weddings and funerals Close-proximity businesses like your hairdresser (with masks and scanning in) The gym or other member-based businesses like dance or martial art studios <p><small>[*]Up to 100 people based on the size of the venue.</small></p> </div> </div>

Figure 5: COVID Alert Levels system (four phases) (Mindfood 2020) and Traffic Lights (three phases) (New Zealand Government 2022)

Managing anticipated information needs

The NZIPAP (New Zealand Ministry of Health 2017) already contains sections that correspond to the anticipated need for information. Each of the phases contains a function that is labelled “Communications and health education”. These sections list the communication objectives relevant for the respective phase. They are all subject to the basic objectives of crisis management as stated in the document:

“The provision of information on an influenza pandemic needs to be timely, deliberate, accurate, authoritative, planned and sustained, with the aim of establishing and maintaining mutual understanding between those managing the response and between agencies and the public.”

Key objectives are to:

- maintain public confidence in the response and in agencies’ competence and capability
- be proactive and provide information before people know they need it

- be flexible enough to respond to unforeseen or changing circumstances
- ensure those who need information and advice, including external and international agencies
- and non-governmental organisations get accurate, consistent, and timely information and advice on which to base their own communications and responses
- create a level of public awareness and a sense of urgency appropriate for the level of risk without creating alarm or panic
- be open and honest in raising awareness of the potential consequences of an influenza pandemic
- discuss all potential threats and ensure audiences are aware of them
- ensure New Zealanders and overseas visitors have clear and simple information about how to prepare themselves and their families/whānau for a pandemic, and where to get help
- ensure the public receives clear and frequent information about the steps to take to protect themselves and others (e.g. health and hygiene messages such as the importance of handwashing, cough etiquette, social distancing, and self-care).

(New Zealand Ministry of Health 2017: 104)

Within the **Stamp It Out phase**, for instance, recommendations can be found that directly relate to the implementation of actions concerning crisis communication (New Zealand Ministry of Health 2017: 85). Figure 6 below neatly illustrates how the function is divided into individual actions, how responsible stakeholders are appointed and how reference is made to the necessary legal basis and existing information from the earlier publications. While there is no reference to legal documents in the *Authority* column in this specific excerpt, elsewhere one finds references to different sections of the *Health Act 1956*, the *Epidemic Preparedness Act 2006* or the *Civil Defence Emergency Management Act 2002*, which provide legal backing for the implementation of the measures.

Function	Action	Responsibility	Authority	Further information from NZIPAP 2010
Communications and health education	• Coordinate communications to foreign governments and New Zealanders overseas about the situation in New Zealand.	Ministry of Foreign Affairs and Trade	No powers required	Part A, Intersectoral Response, External work stream
		Ministry of Health, with the support of other agencies as required	No powers required	Part C and Appendix A, Public Information Management Strategy
		All agencies, Ministry of Health, DHBs and PHUs, with the support of other agencies as required		
	<ul style="list-style-type: none"> • Implement a multi-media campaign fronted by a trusted authority figure covering: <ul style="list-style-type: none"> – hygiene – social distancing – self-care and caring for others – staying safe – limiting spread – control interventions – accessing advice and help • Distribute information to their staff, sector and clients through their normal channels at national and local levels. • Ensure material is customised and uses appropriate channels to reach populations who may be more susceptible, such as: <ul style="list-style-type: none"> – Māori – Pacific peoples – non-English-speaking communities – vulnerable groups, as informed by epidemiological data. • Expand the capacity of telephone helplines to meet an increase in demand from the public and health professionals. • Distribute situation reports and intelligence summaries. • Provide customised information to overseas visitors in New Zealand. 	Ministry of Health, DHBs and PHUs	No powers required	
		Ministry of Health, with the support of other agencies as required	No powers required	Part C and Appendix A, Public Information Management Strategy
		All agencies, Ministry of Health, DHBs and PHUs, with the support of other agencies as required		
		Ministry of Health, DHBs and PHUs	No powers required	
		MBIE – in liaison with the Ministry of Health, Tourism New Zealand and the Tourism Industry Association	No powers required	

Figure 6: Overview of the section “Communications and health education” within the Stamp It Out phase (New Zealand Ministry of Health 2017: 85)

The National Action Plan only includes minor additions in relation to the management of public information. For instance, it provides guidance on supporting the operational response: monitoring public and media responses and passing on information to intelligence and other relevant agencies. Other guidance is aimed at supporting other functions to ensure that all staff involved in public relations activities have up-to-date and relevant information to share with the public.

Learnings and recommendations

Experience with the original Influenza Pandemic Plan has shown how dangerous it is to have a pandemic plan that is too pathogen-specific. Assumptions based on handling one pathogen are not necessarily transferable to another, and identifying and discarding unhelpful assumptions can cost valuable time (cf. Kvalsvig & Baker 2021). To broaden this limiting view, it is therefore suggested that a pandemic action plan should focus primarily on developing an adaptive response framework for pandemics that are:

- **At least moderately transmissible:** i. e. they have the potential to infect a large proportion of the population;
- **At least moderately severe:** they impose a high morbidity and/or mortality burden, either generally or in specific populations;
- **Require additional controls** over and above standard infectious disease control measures that are currently in place;

- **Show uncertainty and are not fully characterised:** a newly emerging, rapidly evolving pandemic requires application of the precautionary principle until the full extent of the risk is better understood.

(Kvalsvig & Baker 2021: 148)

In terms of pandemic crisis communication, both the original New Zealand Influenza Pandemic Plan and the new National Action Plan maintain a concise structure. For each phase, there are clearly named and delimited addressees and stakeholders, as well as a checklist for the implementation of the corresponding task, so that a coordinated internal and external communication is guaranteed. In their interconnectedness, both plans offer a wide range of response options for various stages of a pandemic, from which the required ones can be taken out of the structure and be adapted as needed.

It is understood that this brief overview of idealised procedures needs to be contrasted with their actual implementation following the containment of the pandemic. However, one thing that the review of New Zealand's approach has demonstrated indisputably is how fundamental knowledge sharing becomes at the various points identified in a pandemic situation. The following section presents a selection of templates and provides guidance on how to share and disseminate information effectively and quickly.

3.4 Guidelines and Templates for Public information

Two-way public communication both on and offline is vital for fostering and maintaining compliance with public health advice. Below is a bank of practical guidelines and templates informed by different triggers in pandemic risk/crisis communication. Effectively, they can be tested as a preparedness measure within pandemic management. Some areas covered below do not fit into a strict template format, either because of their inherently restrictive form (e.g., Tweets are too short to fit them into a unified template) or because they are too complex to begin with (e.g., briefings for politicians). In these cases, however, guidelines are still provided that give end-users guidance on how to publish information on social media or what information to provide to politicians.

For other areas, templates will be provided in the appendices and more detailed guidelines and “how to’s” can be found in the sections below. The guidelines can function separate from the additional templates and can be used as a reference and step-by-step advice for communication in times of a public health emergency situation.

3.4.1 Press Release Template Guidelines

A customizable template for press releases can be found in section 6.5. A detailed explanation on how to use it and how to write press releases in general follows below.

Description & Explanation

A crisis communication press release is a written piece of communication that defines a crisis the organisation and its stakeholders are facing and a concrete plan to mitigate its damage or serve those impacted.

It helps stop the risk of speculation around the crisis definition and organisation's response by transparently communicating the facts and establishing a central source of information from the company (Rudder 2020).

Who Should Use this Template and When?

With the essential preparation measure in place, a press release should be crafted and delivered by the crisis communications team assigned to the pandemic. In many cases, the pandemic managers including frontline staff are often informing the press release with informative data. For that reason, having a two-way line of communication between both groups is paramount.

Based on the crisis communication lifecycle, a press release should be used as new and important information that its stakeholders should be aware of arises throughout a pandemic.

This would include the onset, recovery and any instances in between. When news of a pandemic is emerging, it's an effective and compact method of getting information distributed quickly. Additionally, it can provide bitesize information for social media to disseminate the information further.

How to Plan a Press Release

Planning for any type of press release should always begin with defining your target audience. If you are targeting multiple audiences, you should tailor your press release specifically to each one, which could mean publishing it in a different form of communication. By conducting this targeted planning, you will help ensure that the right message is getting to the right people. There are a series of questions you can ask yourself to facilitate this:

- Who do you want to reach?
- What is their perspective likely to be?
- What do they already know?
- What will they want to know?
- What do you need them to know?

By planning the target audience for your press release you are essentially filling in the blanks as this analysis will inform its content, style and channel of communication. Depending on your organisation type, your press release can be uploaded to your **company website** as well as distributing it to the **media**. Once identified, consider the target audience as a persona:

- Where are they located?
- What are their needs?
- What related knowledge and/or experience do they have?
- What resources do they have access to?

For example, if your aim is to inform a specific age range of the elderly group in a local region of your country then you may decide to target your release towards media journalists in the most accessible and popular print/broadcast news outlets amongst this group. On the other hand, if you want to inform people within the 18-25 age group in the Western region of your country about protective measures that apply to them within their area, then you could send the release to the most popular online news desks or broadcasters with this area as this age group is generally more likely to read their news online.

Having a good understanding of the national and local journalists in your country will benefit this decision-making process.

How to Write a Press Release

- A press release must be to the point and use accessible language
- The first couple of sentences should provide the most essential information
- When deciding what that information to include in your release, follow this simple baseline:
 - **Who** is the press release for or about?
 - **What** has happened and what information do they need to know?
 - **When** did it happen and when will the response take place?
 - **Where** did it happen and where will the response take place?
 - **Why** is this happening?
 - **How** is it happening?
- The structure of the release should begin with:
 1. Lead
 2. Body
 3. End note i.e. additional information and contact details
- Where suitable, the release should also include a credible quote ideally from an industry expert.
- Any evidence-based information used should be backed with a readily available internal explanation that can be provided to the media if questioned

Press Release Checklist

1. Define your goal and objective
2. Define your target audience
3. Identify the appropriate channel(s) of communication
4. Define the crisis, concerns and/or issues surrounding it
5. Define your response
6. Identify your media contacts and spokespeople

Examples from COVID-19

- Example Press Release from Irish Health Service: HSE outlines main cocooning measures (<https://www.hse.ie/eng/services/news/media/pressrel/hse-outlines-main-cocooning-measures.html>)
- Example Press Release: COVID-19 study: 8.4% of Belgian health workers have antibodies to SARS-COV-2 (<https://www.sciensano.be/en/press-corner/covid-19-study-84-belgian-health-workers-have-antibodies-sars-cov-2>)
- Example Press Release: Single Case of Covid-19 Confirmed in New Zealand (<https://www.health.govt.nz/news-media/media-releases/single-case-covid-19-confirmed-new-zealand>)

3.4.2 Web Information and Influencer Involvement

Web information

Definition and Explanation

“The purpose of an information centric website is to convey specific, helpful information to a specific user/audience so that the reader learns something new or understands a topic better. These websites are geared around more actionable information and may contain “how to’s”, tips and tricks, fix and repair, guidance, support information, directions, instructions, etc.” (D’Ambra, 2018)

The best websites are easily accessible with simple design and all the information about a project or business clearly laid out. It is important to let people know who you are and what you do right away, so they do not feel confused when they visit your website.

As a communication method, websites can host static or dynamic information. Static information includes that which does not change that often such as a long-standing campaign on protection from a virus or registration forms for vaccinations. Dynamic information on the other hand is information that is being regularly updated such as daily case numbers or the latest health advice. Dynamic information is also tailored to social media as an additional channel if the information requires rapid pick-up.

Who Should Use this Template and When?

By and large, these template guidelines could be used by your organisation’s web design/UX team but they are also valuable for crisis communicators and pandemic managers to be aware of for time sensitive cases. Generally, your website should also be updated as new and often more stable information arises.

In the digital world, it is important your stakeholders know you are taking immediate action to assess the situation. Issuing a press release and updating your website should work in sync; when issuing a release, upload it to an easily findable “Media Centre” on your organisation’s website as well as sending it to the media. All press releases should be archived on the site too.

How to Update your Website in a Crisis:

1. Update your Website Header

Your site header is a good place to present top line important information about the crisis so that every person that goes to your site can quickly find the latest information about the pandemic and how it relates to your organisation. This can be done in two ways:

(a) Update your Menu/Navigation:

To make it easy to find your crisis content, add a link in your main navigation to your crisis landing page. Be sure to keep the title of the new navigation item short. For example: “COVID-19”

(b) Create an alert bar

Having a sitewide alert bar is a great way to draw attention to a crucial issue in a pandemic scenario. For example, you can use an alert bar to inform visitors about the latest health advice, confirmed daily case numbers or colour coded statuses for an area or region.

2. Update your Homepage

When people visit your website, your **homepage** is likely the first thing they will see. That is why keeping it updated is crucial, but with things in flux during a crisis, that is even more important. Include the most important and essential information you need visitors to know at a particular time. Spotlight other important pages on your site including a link to your FAQ page to ensure visitors are aware of it.

Website updates and alerts may be more time consuming to create so preparing a holding statement is one way to ensure your actions are being seen by external audiences. Front and centre presence on your homepage should be priority.

The European Food Safety Authority (EFSA, 2016) state that you can use a holding statement “reactively or, if appropriate, proactively with the media” and post it on your website in the short-term until more information is known. The holding statement should address the three fundamental questions your audience and the media will ask when an incident occurs: a) What happened? b) How did it happen? c) What are you doing about it?

3. Create a landing page for crisis related information

Make sure to change the page often, especially when new information is released or new advice and scientific findings evolve. If they affect your organisation, outline how you’ll be implementing anything new and how that will impact your stakeholders. Every time you update it, you can spread the word on social media by sharing a link.

4. Update your FAQ Page

If your organisation does not have an FAQ page its recommended to create one in response to a public health crisis. An ongoing health crisis changes daily so a FAQ section is a great place to address that and share your updates. Local and national media especially need to answer public questions about the management of the crisis and how your organisation is adapting to restrictions due to the virus. Continue to add relevant information to your FAQ page, such as how you’re working to keep members of the public safe, opening hours, contact information and so on.

5. Accessibility

Accessibility should be available throughout your website regardless of whether a crisis is happening or not however, it is crucial when providing information that protects human life. Ensure that your updated information surrounding the ongoing health crisis is provided in the used languages within your region and that its available to vulnerable groups such as non-native speakers by providing the most important information in more widely spoken languages like English and French.

Examples

- Singapore Civil Defence Force (<https://www.scdf.gov.sg/>)
- New Zealand “Unite Against Covid-19” Website (<https://covid19.govt.nz/>)
- HSE - Ireland’s Health Service Website (<https://www.hse.ie/eng/>)

Influencer Involvement

Complementary to the work done in task 5.3, research was conducted how to best provide influencers with the appropriate information to promote and amplify an organisation’s message. The sole

identification of influencers who are willing to engage and who's brand is congruent with the organisation's public image is a complex and difficult task in and of itself. Legal and ethical considerations limit the pool of potential participants as well as the range of engagement. The process of identifying and contacting influencers in task 5.3 was an exemplary process in terms of difficulty and limitations.

Finding "generic" influencers is typically not possible and highly dependent on the type of public health emergency as well as the point in time. The dynamic landscape will make any list of possible candidates quickly outdated and not appropriate. Organisations need to put a great deal of effort and thought into the support they want from any type of influencer. Poorly executed campaigns can quickly derail the intended message, erode trust in the organisation and cause negative and harmful effects within the public.

Building on the end-user feedback from WP5's first workshop in 2021, it is important to stress the involvement of "offline influencers", i.e. community leaders on a local level. Identifying and involving these influencers is crucial for an organisation to ensure a lasting and effective communication with local communities and can be vital to reaching smaller communities and vulnerable groups.

Information provided to influencers should largely be congruent with the information given on an organisation's website and social media pages. The value provided by including influencers is not achieved by providing them with "secret" information but instead by making sure they communicate understandably and comprehensively to their target audience. Their job is to reflect and amplify the organisation's message in a clear and concise manner.

3.4.3 Templates and checklists for Social Media, FAQs and Helplines

Social Media Strategy

A complete crisis communication strategy must include social media. Otherwise, your organisation is missing a vast audience and a viable research and engagement method. American integrated technology platform Civicplus (2021) suggest some core reasons why social media is essential to your crisis communications strategy:

- News generally breaks on social media first
- Surpasses geographical boundaries
- Often informed by first-hand but unofficial sources
- Facilitates two-way communication with stakeholders
- Its networked structure helps disseminate messages further and with minimal cost

How are pandemic managers using it?

- A source of information
 - People turn to search engines and social media as a first port of call for information meaning that an organisation's digital presence becomes an increasingly important asset and communications channel for protection of human life.
- Accessibility
 - One of the key reasons that social media is effective in reaching people in an emergency is because most will carry their mobile devices with social media apps

installed. However, this does not mean forgetting those who don't have access to social media who will need the message relayed in different format.

- As an influence on public response to outbreaks
- Global, national and/or local reach
- Speed of delivery

Context

Consider the context of your social media post – are you running a digital health information campaign spread out over a number of weeks or are you providing up to date information in the middle of a growing crisis? In other words, your objective will depend on the scenario and the type of organisation communicating, some of these may include:

i. Inform – providing vital data, advice or resources to your target audience

Examples (from Ireland (“HSELive”) or New Zealand (“minhealthnz”)):

- Explainer on cocooning
(<https://twitter.com/HSELive/status/1245006688320663556>)
- Explainer on social distancing
(<https://twitter.com/HSELive/status/1241059428981510144>)
- PPE requirements for workers
(<https://twitter.com/minhealthnz/status/1243728288490459137>)

ii. Announce – Releasing new key information, like changes in health and safety measures or important milestones

Example:

- First day with no deaths from COVID-19
(<https://twitter.com/HSELive/status/1265271334675845120>)

iii. Awareness – Increasing the public's knowledge on the disease and pandemic

Examples:

- Video on COVID-19 symptoms
(<https://twitter.com/HSELive/status/1243151886242451456>)
- COVID-19 symptoms infographics
(<https://twitter.com/HSELive/status/1247549946489946113>)

iv. Behaviour change – Encouraging or inspiring positive actions from the public

Examples:

- Video on behaviours to prevent the spread of the virus
(<https://twitter.com/HSELive/status/1239563610730479617>)
- Thread on how to shop safely during the pandemic
(<https://twitter.com/HSELive/status/1252550329088069633>)
- Video on teaching children how to wash their hands
(<https://twitter.com/HSELive/status/1251858087134150660>)
- The importance of maintaining social distancing
(<https://twitter.com/minhealthnz/status/1250910284757086208>)

v. Provide updates/credibility – Being a reliable, objective source on pandemic developments for the public

Examples:

- Sharing of resources
(<https://twitter.com/HSELive/status/1244955873786593280>)
- Weekly live updates on pandemic developments
(<https://twitter.com/HSELive/status/1249640048586342408>)

- Daily update on pandemic
(<https://twitter.com/minhealthnz/status/1247356208207368194>)
- vi. **Collect info etc.** – Using the public’s feedback/concerns to inform the content, and opening a dialogue with followers
Examples:
 - Responding to fears of disinformation from the public
(<https://twitter.com/HSELive/status/1252902465495695360>)
 - Responding to concerns around COVID-19 contamination in food
(<https://twitter.com/HSELive/status/1255512916482093056>)
 - Response to children’s fears of getting a COVID-19 test
(<https://twitter.com/HSELive/status/1263802239912742912>)

Choosing your Platform(s)

Like a press release, the social media channel that you use to share your message will depend on the target audience. Consider the target audience’s age, geographical location, interests, attitudes to the pandemic and media consumption preferences before selecting suitable platforms.

- **Twitter** (part of Twitter Inc.) is a popular source for live information. Posts are limited to 280 characters or lower, which limits the platform to short-form content. Influencers are not common on Twitter, however, “thought leaders” often emerge on various topics – for example, in Ireland, Ciara Kelly, Tony Holohan and Gavin Reilly emerged as information resources and opinion leaders on the COVID-19 pandemic.
- **LinkedIn** (belonging to Microsoft) is the ideal platform for communicating with employees, employers and business owners. Influencers are not commonplace, however, “thought leaders” in a particular industry can often go viral.
- Influencers are commonly found on **Instagram** (part of Meta Platforms, formerly known as Facebook Inc.). More than half of the global Instagram population worldwide is aged 34 years or younger (<https://www.statista.com/statistics/248769/age-distribution-of-worldwide-instagram-users/>).
- **Facebook** (part of Meta Platforms, formerly known as Facebook Inc.) is the most popular social network worldwide. The platform is community-based, and influencers are not commonplace. (<https://about.facebook.com/company-info/>).
- Over 60% of **TikTok** (belonging to ByteDance) users are under 29 years old. TikTok content thrives on virality, comedy and a sense of shock. Influencers are commonly found on TikTok. (<https://www.businessofapps.com/data/tik-tok-statistics/>).
- **Your organisation’s social media account** can also be utilised as a live information hub for target audience’s such as journalists and other media. Therefore, responses to online questions from journalists or members of the public should be measured and follow a common structure to present consistency/control (see Covello’s Message Map, D5.1).

Guidelines for Creating Social Media Posts

“The principle of the 3 Rs—Review, Recognize, and Respond—refers to the ongoing cyclical process of developing an effective social media communication strategy and evaluating the impact of that strategy [Error! Reference source not found.]. It’s a systematic way to characterize the information needs of a target population and to ensure that social media messages are effectively meeting the needs of that population (Murthy et al., 2021)”



Figure 7: The 3 R's: Review, Recognise, Respond (Murthy et al., 2021).

FAQ (Frequently Asked Questions)

Definition and Explanation

This section is a list of answers to common questions about a specific role, service or product. For pandemic managers, FAQs are created for public information campaigns. They also serve as a central reference for locating answers to common questions.

As end users play a role in the development, and current events also shape new information, they typically evolve over time. For example, a new variant may impact international travel or school closures. The public health agency may clarify new information in their FAQ so that end-users can find the answer without needing to email the company. This cuts down on technical support, saving time with responding to new developments.

Who Should Use this Template and When?

By and large, these template guidelines could be used by your web management team. The FAQ's should be implemented early on in a response to a pandemic type situation but only when information is readily available.

During pandemic type situations, it's important that the information that is published is digestible, easily understood and builds on past questions.

Frequently Asked Question (FAQ) sections are an opportunity to connect with your desired end users and by extension it is a real opportunity to find out what they're thinking about.

A good FAQ section:

- Provides a concise response quickly and effectively
- Empowers the end-user to confidently use the site
- Assists the user complete a booking for a vaccine/book an appointment
- Reassures a user about taking the next action
- Instils trust in a user that if there is an issue, it can be resolved
- Reduces the burden on customer service facing roles

Being forced to contact a site owner because you do not understand part of the process or need vital information to complete your action creates friction.

FAQ Best Practices

As you consider compiling a set of questions, it might not be immediately clear where to start. By understanding a few best practices, it is very manageable.

- Write your question from the perspective of the end user
- Use language that your user will understand
- Write your FAQ as concise, informative, and directly answer the question
- Present your FAQ in the most visually organized manner
- Feature top questions at the top of the page
- Keep information up to date

Examples from COVID-19

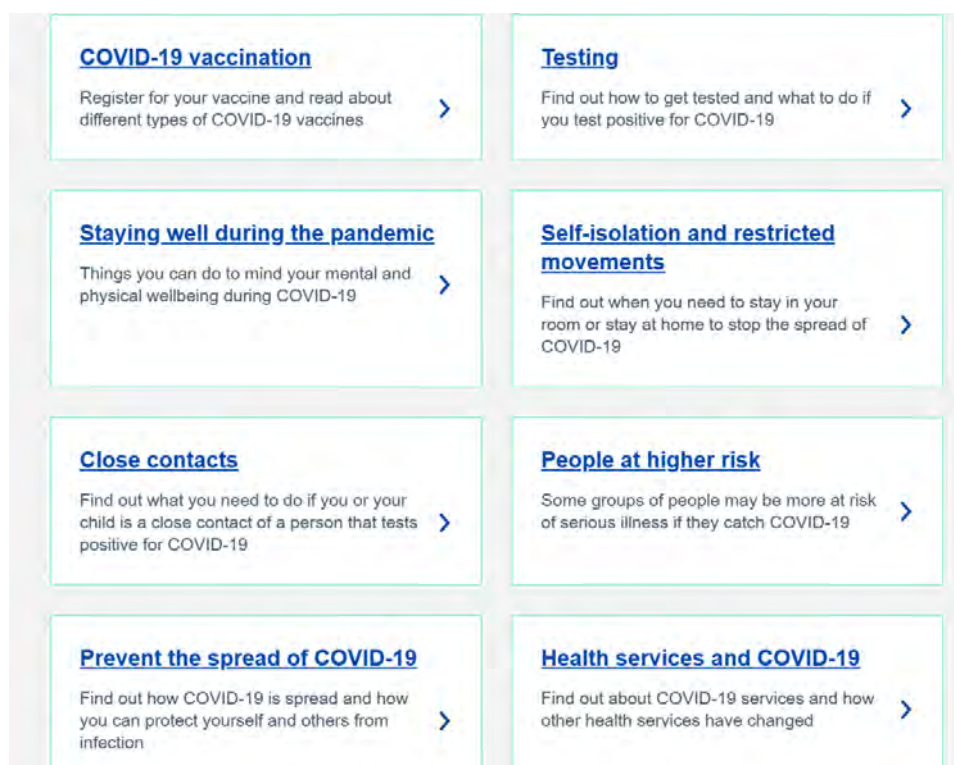


Figure 8: Sample – HSE (Ireland) COVID-19

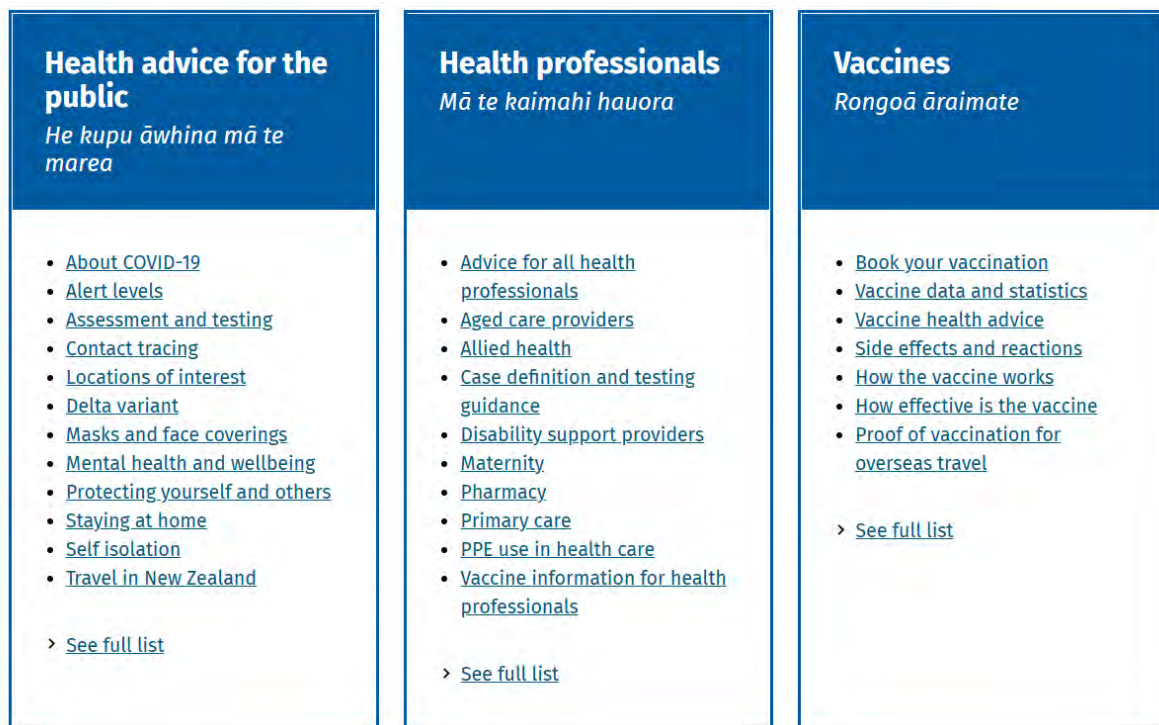


Figure 9: Sample – New Zealand COVID-19

Helplines

Other than FAQ sections on a website, helplines are of a much more complex and dynamic nature. Staff manning the helplines are required to be prepared for a number of different questions and to be able to quickly respond to highly specific inquiries from the public. Especially for larger organisations, helplines can be the only personal point of contact for the public (other than a generic e-mail address or the FAQ section).

In order to properly prepare helpline staff for their day-to-day work, information provided in the FAQ section can serve as an ideal basis. Although some inquiries might require more specific information, the majority of calls will come from people either unable or unwilling to consult the FAQ section on the organisation's website, some might be in need for some further explanation or clarification. Thus, making sure helpline staff has a thorough understanding of the information provided in the FAQ section is vital for a functioning helpline. Staff, however, also needs to be able to either refer to or consult with experts if more detailed or specific information is required.

It is also highly recommended to make sure helpline staff is briefed on a regular basis on new developments, e.g. a change in quarantine rules for the public. Once new measures are announced by the organisation, helplines will be the initial starting point for the public to explain and elaborate on the effects of these measures. Just like staff need to be proficient in the "general" information, they will need to be thoroughly briefed on new information as soon as possible.

3.4.4 Information to be included for briefings for politicians, media, and spokespeople

As mentioned in PANDEM-2 deliverable 5.1, effective public communication remains vital for maintaining compliance with public health advice. Below is information to be built upon in crisis situations. These will be built upon in task 5.4.

Politicians and Government

A major challenge for governments during the current pandemic is the difficulty faced in providing clear and consistent advice, arising from the many unknowns and uncertainties which are symptomatic of an evolving crisis.

Key information to give during the first response to the crisis is:

1. Define the crisis:

- describe the extent of the situation,
- who is or can be affected by the crisis

2. Location:

- The location of where the crisis is ongoing and where it could possibly spread to
- The initial response to a crisis should be as factual and concise as possible. This communication should provide concrete and practical information.
- Crisis and emergency responses function better if a government has as much information as possible and if they are designed and implemented in consultation with crisis affected communities and stakeholders.

It is important to:

- 1) Set up ways for information collection on the crisis, and
- 2) Create a Crisis Committee – Apart from government agencies and experts, governments and political parties can acquire information through several channels. The global nature of a pandemic means that there is a wide range of sources, experiences and lessons learned to draw upon.

Outline a response as quickly as possible, while ensuring strong preparation. Do not rush a response. Incomplete and factually incorrect communication will cause confusion and may lead to a loss of control. Politicians, parties and elected and government representatives should conduct active outreach during a crisis. Examples of participatory activities that politicians can conduct during a pandemic are outlined below:

- E-mail/SMS platforms will allow politicians and parties to continue using direct lines of communication with voters or supporters. E-mail and SMS messages are invaluable mechanism to maintain contact.
- Writing letters or sending out pamphlets/flyers, preferably with a return address so people can reply, is a proven way of keeping in touch with voters and supports.
- Putting up banners at public spaces or taking out newspaper advertisements in targeted media outlets. These serve to get party messages across to a large audience and can include references for further communication.

- Digitally broadcast parliamentary committee meetings or other (local) political decision meetings, related to the crisis, live on parliamentary websites or YouTube and allow questions or citizen engagement.
- Rather than organising a physical town hall meeting, organise online virtual town halls on social media platforms with party supporters and members.
- Regularly post speeches, press briefings and videos online through your social media accounts on issues related to the crisis. These can be videos from politicians personally, reinforcing public service announcements (PSAs) or public health messages, messaging from the party or other party leaders on the crisis.
- Support or initiate social media support campaigns aimed at resolving the crisis.
- Use webinars to educate citizens on emergency measures, what they can do to help resolve the crisis.
- Actively engage citizens on social media by asking questions or seeking feedback on decisions to show that their opinion matters.
- Organise informal surveys with digital focus group discussions, online polls or digital citizen survey questionnaires to gather information from citizens about the crisis, emergency response measures and their concerns and needs;
- Set up a training website aimed at educating citizens on how to prevent, identify, and treat the virus. These platforms can also include other valuable information that help people cope with the pandemic. For example, parenting tips during social distancing, information on how to telework effectively, tips on how to deal with anxiety and activities to keep your family entertained while stay-at-home measures are in effect.
- Visualize your message: people process visual information better and more easily than reading. Ensure to use pictures, videos, images and examples in your language rather than just posting long statements. Develop website pages containing explanatory videos explaining the crisis. These can be shared to media outlets and via social media ensuring that there is uniformity in messaging.
- Engage your audience and be interactive: social media is a two-way street, so invite participation. Allow people to respond or interact with you directly. Show them you are listening and taking them seriously.
- Use popular hashtags or support existing public initiatives in response to the crisis. Leaning into popular user-generated content is a good way of ensuring your messages will reach a larger audience.
- Work with the media. Updates about the crisis should be given frequently depending on the scale and duration of the crisis, this can range from two or three times a day, to once a week. Different methods can be used for updates. These can include press conferences, press releases, expert briefings, televised speeches, and visits to crisis-affected locations to inform the public. It is important that governments, parties and elected representatives remain visible and vocal during a crisis. It is almost impossible to communicate too much during a crisis. However, a lack of communications and updates almost always results in dissatisfaction and criticism from citizens. In order to best prepare for engaging with journalists, e.g., in an interview (see appendix 6.6).

Media

Reporting during a crisis needs to be based on facts as much as possible. People are already insecure due to the crisis, so governments and elected representatives need to show that they are in control of the crisis as much as possible. The best way to do this is to show that they take the crisis seriously and base decisions on available facts and expert opinions.

In the case of a pandemic, it is important that public health experts, virologists, epidemiologists, microbiologists and health care professionals are included in the conversation and political decision-making in response to the crisis. Media outlets and journalists should ensure to include these individuals in their reporting.

Updates about the crisis should be given frequently. Depending on the scale and duration of the crisis, this can range from two or three times a day, to once a week. Different methods can be used for updates. These can include press conferences, press releases, expert briefings, televised speeches, and visits to crisis-affected locations to inform the public (see appendix 6.6 for a template for journalist interaction).

An increasing problem during a crisis is the spread of misinformation and disinformation, also known as fake news. This means false or factually incorrect information spread deliberately or unintentionally to deceive or create misunderstanding. Disinformation and misinformation can lead to serious problems during a crisis. Apart from causing confusion, fake news can exacerbate or prolong a crisis and therefore needs to be contained and countered as much as possible.

Throughout the crisis, it is important that citizens can get information about the crisis. In the case of a pandemic, people will want health advice on when to contact a doctor if they have symptoms, testing, areas that have been affected, how to access emergency measures and so on. Tools should include a free text number, call centre, email address, Twitter and Facebook account and WhatsApp number (or whatever the most popular communication platforms are) that people can contact to gather information related to the crisis or ask questions.

Spokespeople

The challenge of pandemic communications is to convince people to cooperate with guidelines, in a landscape where information can be initially scant, evolves and requires response in real-time, meaning best-practices change frequently.

Spokespeople are the individuals that will be front and centre in times of a crisis. They need to be able to succinctly deliver comprehensive information in simple terms.

They need to be individuals that the layperson trusts and showcase empathy and understanding to the target audiences.

The development and training of spokespeople will be built upon in Task 5.4.

Counteracting Misinformation

1. Make sure that people know only to consult and trust information from official government or trusted communication channels.
2. Identify widely shared disinformation or misinformation through social media monitoring and make sure it is publicly debunked and countered.

3. Call out, condemn and name public figures that promote the spread of fake news or those who are trying to exploit COVID-19 for personal gain.
4. Do not, under any circumstances, share or promote potential misinformation or disinformation as a government representative, political party or elected representative. When in doubt about the correctness or origin of news messages do not share it.
5. Educate people to check the source of news that is shared and crosscheck to see who else is reporting the story. If well-known media outlets are not covering the news, it is most likely fake news.

3.5 End-User Validation Workshop

On the 28th of October 2021, members of the consortium end-user group attended the end-user communication resource validation workshop to evaluate how new PANDEM-2 resources can support public health agencies and responders in their pandemic communication strategy. Overall 23 participants from 10 organisations (PANDEM-2 public health agencies and responder organisations as well as academic staff) used and discussed the draft communication templates developed in this task. Templates presented were based on the valuable end-user input in the previous workshop (Task 5.1) and included press release and social media templates, as well as guidelines for creating web information and FAQs. After establishing the agenda and the workshop aim, results of the previous task were recapped, namely the Knowledge Bases (I. The Concept of Trust in Risk Communication; II. Misinformation & Disinformation in Pandemics; III. Commercial Lessons; IV. Practical Application of Pandemic Communication). In three separate discussion groups each centred around different pandemic scenarios (or stories), participants then discussed which ones of the generic templates can be used and how those can be customized towards relevant pandemic setting (Figure 10). The pandemic stories were created using real-life pandemic communication challenges covering outbreaks in three fictitious countries (Alphalandia, Betalandia and Gammalandia) in (appendix 6.1). Two stories also focused on pathogens, which will likely play a role in our upcoming PANDEM-2 table top exercises and demonstrations (i.e. Ebola, Influenza). Participants addressed the following questions:

Questions:

- Which groups would you address?
- Which channels and media would you use for that?
- Which information is most relevant for these group and channels?
- Which (relevant) information might not be available? Which (available) information might not be shared?

Overall discussions highlighted the necessity to provide “How-to” guidelines for adopting the generic templates, rather than providing pandemic specific but not universally applicable pre-fixed templates. Further, participants said that generic templates may in fact be helpful, as i.e. the large amount of press releases which needed to be issued during the COVID-19 pandemic did in fact require some degree of automatization with only quick adaptation of a generic template. Detailed feedback to the templates from respective discussion groups is listed in chapters (3.5.1 to 3.5.3).



Figure 10: View of the workshop whiteboard applying the task 5.2 pandemic communication templates (Story 1: SARS).

3.5.1 Discussion Group: SARS

Story: An outbreak of SARS in Hanoi and Hong Kong has reached Alphalandia. Here, the public health board reports 217 probable or suspect cases of SARS and 9 related deaths. All cases have occurred in persons who have travelled to an affected country or had contact with SARS cases in the household or in a health-care setting. As of today, a global cumulative total of 2601 cases of SARS, with 98 deaths, have been reported from 17 countries, which represents an increase of 85 cases and 9 deaths

compared with the last update two days ago. The development of a diagnostic test, which is being pursued around the clock by the WHO collaborating network of 11 laboratories, has proved more problematic than hoped. Three diagnostic tests are now available and all have limitations as tools for bringing the SARS outbreak quickly under control. However, based on data from the SARS foci in Hanoi and Hong Kong, basic diagnostic and treatment knowledge is available: a) the incubation period has been estimated to be 2-7, but usually 3-5 days. The most common early symptoms in patients progressing to SARS have included fever (100%), malaise (100%), chills (97%), headache (84%), myalgia (81%), dizziness (61%), rigors (55%), cough (39%), sore throat (23%) and runny nose (23%). Intensive and good supportive care, with and without antiviral agents, have improved prognosis for patients.

News Inject: (none)

Discussion:

Both participant groups generally agreed in the identification of the relevant target audiences. As in this story the main drivers of the emerging pandemic were travellers returning from affected countries or regions, a specific focus was to communicate to returning travellers. While generally all travellers entering the country should be addressed it was decided that it would be important to address particularly the subset of travellers beginning their trip in the affected region. Moreover, people who knowingly were in direct contact with these traveller (family, friends, co-workers) need to be made aware of the health threat. The health threat needs hereby to be specified by clearly communicating the symptoms in the absence of a diagnostic test. Thus, end-users discussed that, while the general information about the disease needs to be communicated to the general public, there needs to be more specification, to first and foremost address travellers *with symptoms*.

The second group put a stronger focus on communication to the health care workers. They emphasised that for an adequate response of the healthcare system the diagnosing physicians need to be very quickly made aware of the range and the most typical combination of symptoms ahead of time. An effective way to communicate here could be to directly approach physician associations and use them to disseminate the information to the local (public) health stakeholders. This can and should be accompanied by specific and relevant website updates. A further stakeholder group to approach early would be long-term care facilities to ensure vulnerable groups can take precaution early.

Both groups indicated that a first press release would always be the starting point of approaching and informing the general public. The structure here would follow the presented template: it needs a clear headline and short, core messages. It to serve the clear purpose to reduce further transmission. Additional (i.e. more medically detailed information) would be moved to the editor's note.

Longer discussions were had to define the how general or specific the title should be phrased. In our example story, it is crucial to reach all potential first infected travellers returning home, before or immediately after they had contact with more people in their normal environment. On the other side, due to the nature of the vague symptoms, it is important not create a general scare in the population, as a surge of worried people with vaguely flu-like symptoms flooding the hospitals could quickly overwhelm the healthcare system and hinder an effective pandemic response. Under a header "Symptomatic patients should present to a Health Unit" there could be a more specific description with high attention on the symptoms: that people with at least 1-3 symptoms are addressed. Furthermore, this first communication should clearly state the action required for these people, i.e. to reduce contacts when symptomatic. Participants of the second group had additional discussions to

identify which details should be left out: the press release needs to carefully avoid stigmatisation of particular groups.

Participants of both groups were stating that they would generally use all channels available to inform stakeholders and broadcast their message to the public and that thus the social media templates would be all of relevance. Their creativity was however going in different directions: as the first group predominantly discussed travellers, they suggested to inform via electronic signs, displays or news boards directly on the airport, and approach the airline twitter feeds, travel agencies or the IATA to distribute the information as well. The second group was listing here which health care groups would need to be directly approached.

As a follow up step to the first press release, the public health organisation would hold a press conference. Particularly the questions raised by the press and attendees at this stage could serve to form a basic FAQ collection. The creation of a more formalised FAQ could then follow the steps described in the FAQ template section and be further used to provide material and train the public health helpline staff.

Recommendation regarding the PANDEM-2 communication templates:

The participant discussions highlighted that, when issuing any press release, it is imperative to first define for yourself *why* you do want to issue a press release. Generally speaking, there would be two types of motivations when issuing a press release as public health agency:

- a) Informing the population that the public health agency is surveying the situation, gathering data, and something is being done and more information will be shared in the future. This would serve to calm people down and make sure no rumours are going around.
- b) To ask the population or specific groups to take action. The action would depend on the stage we are in (here: take precaution, no proper diagnostic test available). People are thus required to come forward to the health system and take protective action.

As outlined above, it is important to define the target groups and consequently the messaging not too narrow, to ensure that also people with potential secondary infections are alerted, but also not too wide as to create unfounded worry in the population which could overwhelm the health care system. Secondly, participants emphasized how essential it is to be quick with a first response to establish yourself as a trusted source, “to claim ownership of the emerging story”, to make sure future media coverage and the public information searches originate from the public health agency’s information. A further improvement on the templates could be the use of information videos, similar to the WHO information videos which were released at the beginning of the COVID-19 pandemic.

3.5.2 Discussion Group: Ebola

Story: The Health Board of Betalandia announced that a Liberian national has been diagnosed with Ebola in a hospital in Betalandia and 8 days later he died. The other three cases diagnosed in the Betalandia were two nurses of the Liberian as well as a physician returning home from working with Doctors without Borders in Guinea. Hundreds of people were tested or monitored for potential Ebola virus infection, but the two nurses were the only confirmed cases of locally transmitted Ebola. The two nurses recovered from the disease. These cases of Ebola set Betalandia in a state of fear. In an opinion

poll Ebola was ranked the third most urgent health problem – higher than cancer or heart disease. Many people felt personally threatened.

News Inject: *West African community members were subject to considerable stigma due to fear of Ebola*

West African immigrant communities have been particularly affected by the public hysteria fomented by the response of many states to Ebola. For example, in response to parents' fears, public health officials consulted by school districts allowed those school districts to exclude students from schools after trips to African countries without Ebola outbreaks, reinforcing the belief that anyone associated with Africa represented a risk. While the public health authorities did not officially back those actions, they could have done more to publicly oppose them.

Discussion:

In the two discussion groups the participants decided to address all citizens and as a special group also the physicians and healthcare staff. However, they decided the difference between a press release for all the citizens and for only the healthcare staff is not very different. They would only put more technical/medical details, which are probably more difficult to understand for other citizens. Additionally, the health care staff should be informed about organisational changes during the pandemic phase. This group can also be reached via professional ways instead of via a press release.

It was also mentioned that it is a problem that we do not reach certain groups of the population and that we need specific ways (perhaps easy to understand videos or personal chats) to reach them.

They would use all types of media to address the citizens – press releases, social media items, videos and also interviews via radio or television. It was commented that especially videos with an easy to understand content could help to reach citizen, who might not like to read text. In a pandemic situation it is necessary to have a communication task force, which is ready to speak via the radio and TV to avoid giving the floor to so-called “experts”, who might misinform the population. The staff of this task force should be trained for these situations. It is necessary to make sure that they speak of facts and not of opinions.

The main message (headline of press release) for the case of Ebola should be to stay calm, to reassure that the situation is under control. However, other participants said that “under control” might be too positive and that it would be better to say that the health care system is monitoring the situation. It was said that one should mention that the health care system is prepared to deal with the outbreak.

Most participants said that they would share everything they know about the disease and the situation at hand with the citizens. There was, however, some discussion regarding the exceptions. All agreed that personal information (e.g. the name) and the specific medical situation of the patient should not be shared with the public. Some said that it may be helpful to report about the occupation of the patient and where he/she comes from, so that the citizens understand that only a very small group of people is at risk (e.g. travellers from an affected country or persons working for doctors without borders). Some said that it would be good to share all the details of the disease and other said, that perhaps they would not mention the high death rate of Ebola to avoid alarming the citizens. In any case they said that it is necessary to inform about the symptoms, the incubation period, how the virus transmits and also who is at risk and who should be in quarantine. For the case of Ebola only travellers and persons with direct contact to Ebola patients should be monitored for symptoms. It is advisable to

specifically advise travellers coming from affected countries to monitor themselves regarding the symptoms of Ebola.

As an additional part the participants recommend to give information about a possible help line or a FAQ webpage of the organisation or other links, where readers could get more information about the disease.

Regarding social media it was said that the type of media depended on the type and age of reader. It is important to know which media the citizens use. For some groups it makes more sense to produce short video clips to transmit the content. It is also important to respond to rumours in social media chats in order to prevent misinformation. In these chats it should be repeated who is at risk and what the citizens should do. Especially in social media it is important to explain the correct behaviour in this situation (which situations to avoid, who should be monitored for symptoms).

Additionally, it was recommended to address specific groups like schools directly with targeted messages. It was also suggested to give a webinar about Ebola and invite the press.

Recommendation regarding the PANDEM-2 communication templates: It was recommended to use infographics to be able to transmit the content to the citizens in an easy-to-understand way. The participants also asked to get some guidelines about when to update information and how frequently the organisation should release media items. It is necessary to change the message as the situation is evolving. It was also suggested to have a checklist of what to do after an outbreak (e.g. inform travellers).

3.5.3 Discussion Group: COVID-19

Story: COVID-19 is already a pandemic with 125,260 confirmed cases and 4,613 deaths worldwide (with around one third of the cases and deaths having occurred outside of China), and the WHO risk assessment is "very high" on a global level. The knowledge about the virus and disease includes symptoms (cough, fever, and breathing difficulties; according to current data, 80 % (including pneumonia) of the cases are mild, approximately 14 % experienced severe disease and 6 % were critically ill), incubation period (5 to 6 days in most cases), means of detection (can be detected in samples taken from the respiratory tract 1 to 2 days before and up to 3 to 7 after the onset of symptoms), and the assessment that people with chronic health problems and older people are at greater risk of developing severe symptoms. In the country Gammalandia, the Health Board announced 10 new cases, bringing the total number of confirmed cases in the country to 27. The new cases confirmed the transmission of the virus locally. People who have returned from designated risk areas have to stay at home for 14 days and monitor their health.

News Inject: (none)

Discussion:

In both discussion rounds, the identified groups to address were

- people with health problems,
- older people,
- people who travel (especially across country borders),
- and the population in general.

Suggested channels and media included tv and social media for a broader audience, plus dedicated media/channels for travellers, both online (websites with information about travelling) and offline (information at transport hubs like airports, harbours, train stations, maybe also road crossings).

The most relevant information for all identified groups included the fact that the disease is now spreading in the country, information on how the virus is spread, known symptoms, who is most susceptible, and advice on how to act (especially when experiencing symptoms). The advice on how to act would also address travel advice - and all this information would be the basis for a press release. Relevant travel advice would give answers to the questions if it were ok to travel at all, what reasons are known to avoid travelling, and what to additionally consider if travelling (what is a risk area? where are risk areas? what rules apply in a risk area or after returning from a risk area?).

The timeframe for further discussion allowed a discussion on either social media or on FAQ, and both discussion groups headed for FAQ.

Thus, the social media channel was discussed briefly with the main outcome that social media should be used in addition to other communication channels to further directly spread the information regarding the pandemic. The information on social media should go beyond plain links to other websites with more information by duplicating the message content spread via the other channels. However, it was expected that both language and sign language should be adopted for social media.

The subsequent focus on FAQ resulted in a collection of question that should be addressed, including the questions of known symptoms (in more detail than in a press release) and what to do when experiencing symptoms (e.g., who with what symptoms should visit a doctor?). Other aspects have been phrased as necessary information to be part of a FAQ, though not yet in the form of a question, i.e. information on who has a higher risk, information on diagnostic options, information on treatment option, information on the global information, information on (travel) regulations, also in other countries, countries (i.e. potential travel destinations) with highest risks.

The questions which (relevant) information might not be available or which (available) information might not be shared did not play a major role in either discussion group. However, when discussing the topic of FAQs, one perspective expressed was to provide "everything" that is known, which raised the question how to define "everything", because existing data and information typically go beyond what can be presented in a FAQ section on a website in an understandable format without being processed (filtered/clustered/commented/visualised/...).

Recommendation regarding the PANDEM-2 communication templates: It was stressed that messages in different languages will be needed, depending on the situation in the specific country or region (including travellers from abroad). Regarding an overview, visualisation should include an overview map (global plus maybe also local vignettes). The wording and concepts used by different communicators in different channels should be similar, different terms for the same issue should be avoided. It was deemed optimal to be able to effectively communicate without the need of specific terms (like "indecent").

4 Impact & Conclusion

Task 5.2 aims to give end-users practical guidelines on how to improve their communication in times of public health emergencies. This deliverable provides both guidelines as well as templates to serve this purpose. Together with the feedback from PANDEM-2 end-users, requirements were assessed based on provisional templates in another round of the WP5-questionnaire and workshop. Based on the feedback, this deliverable includes templates for public communication as well as instructions on how to use them or how to go about communicating with the public, in general.

Building on the work of D5.1 and the developed “Knowledge Bases”, D5.2 focuses firstly on ensuring that the previously identified areas, such as “trust” and “misinformation” are addressed, and secondly on how to maintain consistent and credible communication in times of a public health emergency. The provided contact list template is supposed to help motivate end-users to think about all relevant stakeholder and communication contacts that need to be contacted in a crisis. Ultimately, who needs to be contacted is highly dependent on each organization, and contact lists are very organisation-specific. Thus, the decision was made not to compile contact lists that would become outdated before the project’s end, but rather incentivise end-users to collect and store these lists for themselves. Instead, D5.2 gives examples and ideas of who should be included and how, i.e. to make sure that e-mail addresses are functional instead of personal, so that message is being received by whomever holds the position. The provided contact list template is customizable and extendable for any organizations’ needs and preferences and the categories given are based on suggestions from end-users, as well as the research done in Task 5.1.

The templates and guidelines are developed for an organisation's external communication with the public. A project internal end-user workshop was hosted to “test” an early version of the templates to get feedback on what can be improved. A frequent request was to receive more guidance on how to use them, explaining step by step what to do and when to do it.

The guidelines and templates are aimed at end-users who have only recently had to put more effort in communication during the COVID-19 pandemic and who are possibly working with none or a smaller communications team. At the same time, they can easily be used by more experienced communications departments to enrich their respective communication plans. The next logical step is therefore to put the templates and guidelines to use. The upcoming media training within WP5, as well as a third end-user workshop in the spring of 2022 will help reveal if the material developed actually helps to improve the work of an organisation’s communication department. The twofold aim is to familiarise end-users with the use of the templates and to further improve them. This way, end-users can be sure that they are prepared as much as possible for any future public health emergencies.

5 References

- Baker, M. G., Kvalsvig, A., & Verrall, A. J. (2020). *New Zealand's COVID-19 elimination strategy*. The Medical Journal of Australia, 213(5), 198-200.e1. <https://doi.org/10.5694/mja2.50735>
- Beattie, A., & Priestley, R. (2021). *Fighting COVID-19 with the team of 5 million: Aotearoa New Zealand government communication during the 2020 lockdown*. Social Sciences & Humanities Open, 4(1), 100209. <https://doi.org/10.1016/j.ssaho.2021.100209>
- Centers for Disease Control and Prevention (CDC). (2017). *Crisis and Emergency Risk Communication (CERC). The Crisis Communication Lifecycle*. Retrieved 15th December 2021 from: https://emergency.cdc.gov/cerc/cerccorner/article_051316.asp
- Civicplus (2021). *The Importance of Social Media in Crisis Communications*. Retrieved 15th December 2021 from: <https://www.civicplus.com/civicroady/crisis-communications-guide>
- D'Ambra, S. (2018). *What is the Purpose of a Website?* ClearTech Interactive. Retrieved 20th January 2022 from: <https://www.clear.com/what-is-the-purpose-of-a-website.html>
- European Centre for Disease Prevention and Control. (n. d.) *Why is pandemic preparedness planning important?* Retrieved 20th January 2022 from: <https://www.ecdc.europa.eu/en/seasonal-influenza/preparedness/why-pandemic-preparedness>
- European Food Safety Authority, 2016. *Best practice for crisis communicators. How to communicate during food or feed safety incidents*. Retrieved 20th January 2022 from: https://www.efsa.europa.eu/sites/default/files/crisis_manual_160315.pdf
- Folkhälsomyndigheten (2019). *Pandemiberedskap. Hur vi kommunicerar – ett kunskapsunderlag*. Retrieved 17th January 2022 from: <https://www.folkhalsomyndigheten.se/publicerat-material/publikationsarkiv/p/pandemiberedskap-hur-vi-kommunicerar-ett-kunskapsunderlag/>
- How, A.-L., Browsers, L., Tegnell, A., & Bucht, G. (2017). *PANDEM project: D2.1: Threat analysis and Scenarios*. EU H2020 grant agreement 652868. <https://pandem-2.eu/wp-content/uploads/2020/12/D2.1-PANDEM-Threat-analysis-Scenarios.pdf>
- Kvalsvig, A., & Baker, M. G. (2021). *How Aotearoa New Zealand rapidly revised its Covid-19 response strategy: lessons for the next pandemic plan*. Journal of the Royal Society of New Zealand, 51(sup1), 143-166. <https://doi.org/10.1080/03036758.2021.1891943>
- Mindfood (2020). *BREAKING: NZ at alert level 3 and will move to lockdown in 48hrs*. Mindfood media. Retrieved 20th January 2022 from: <https://www.mindfood.com/article/breaking-nz-at-alert-level-3-and-will-move-to-lockdown-in-48hrs/>
- Murthy, B. P., LeBlanc, T. T., Vagi, S. J., & Avchen, R. N. (2021). *Going Viral: The 3 Rs of Social Media Messaging during Public Health Emergencies*. Health Security, 19(1), 75–81. <https://doi.org/10.1089/hs.2020.0157>
- New Zealand Government. (2020). *National Action Plan Version 3. National Crisis Management Centre*. Retrieved 20th January 2022 from: <https://covid19.govt.nz/assets/resources/legislation-and-key-documents/COVID19-National-Action-Plan-3-as-of-22-April-extended.pdf>
- New Zealand Government (2022). *COVID-19 Protection Framework*. Retrieved 15th December 2021 from: <https://covid19.govt.nz/traffic-lights/covid-19-protection-framework/>

- New Zealand Ministry of Health. (2017). *New Zealand Influenza Pandemic Plan: A framework for action*. 2nd ed. Wellington. Retrieved 20th January 2022 from: <https://www.health.govt.nz/system/files/documents/publications/influenza-pandemic-plan-framework-action-2nd-edn-aug17.pdf>
- Reading Borough Council. (2020). *Reading COVID-19 Outbreak Control Plan*. Retrieved 20th January 2022 from: <https://www.reading.gov.uk/coronavirus-covid-19/reading-covid-19-outbreak-control-plan/>
- Rudder, Alana. (2020). *How to Write a Crisis Communication Press Release in 5 Steps. Fit Small Business*. Retrieved 20th January 2022 from: <https://fitsmallbusiness.com/how-to-write-crisis-press-release/>
- Seeger, M. W., Pechta, L. E., Price, S. M., Lubell, K. M., Rose, D. A., Sapru, S., Chansky, M. C., & Smith, B. J. (2018). *A conceptual model for evaluating emergency risk communication in public health*. *Health Security*, 16(3), 193–203. <https://doi.org/10.1089/hs.2018.0020>
- Vos, M., Lund, R., Reich, Z., & Harro-Loit, H. (Eds.). (2011). *Developing a Crisis Communication Scorecard: Outcomes of an International Research Project 2008-2011 (Ref.)* (Jyväskylä Studies in Humanities 152). University of Jyväskylä. Retrieved 12th December 2021 from: <https://cordis.europa.eu/docs/results/217/217889/final1-book-criscomscore-9789513942618.pdf>
- World Health Organization. (2016). *Risk communication: Training*. Retrieved 11th May 2021 from: <https://www.who.int/risk-communication/training/Module-A.pdf>
<https://www.who.int/risk-communication/training/Module-B1.pdf>
<https://www.who.int/risk-communication/training/Module-B2.pdf>
<https://www.who.int/risk-communication/training/Module-B3.pdf>
<https://www.who.int/risk-communication/training/Module-B4.pdf>
<https://www.who.int/risk-communication/training/Module-B5.pdf>
<https://www.who.int/risk-communication/training/Module-B6.pdf>
<https://www.who.int/risk-communication/training/Module-B7.pdf>
<https://www.who.int/risk-communication/training/Module-B8.pdf>
<https://www.who.int/risk-communication/training/Module-C1.pdf>
<https://www.who.int/risk-communication/training/Module-C2.pdf>
<https://www.who.int/risk-communication/training/Module-C3.pdf>
<https://www.who.int/risk-communication/training/Module-C4.pdf>
<https://www.who.int/risk-communication/training/Module-C5.pdf>
<https://www.who.int/risk-communication/training/Module-D1.pdf>
<https://www.who.int/risk-communication/training/Module-D2.pdf>
<https://www.who.int/risk-communication/training/Module-D3.pdf>
<https://www.who.int/risk-communication/training/Module-D4.pdf>
- World Health Organization (2017). *WHO Strategic Communications Framework for Effective Communications*. World Health Organisation.
<https://www.who.int/mediacentre/communication-framework.pdf>
- World Health Organisation, United Nations International Children's Emergency Fund & International Federation of Red Cross and Red Crescent Societies. (2020). *RCCE Action Plan Guidance: COVID-*

19 preparedness & response. [https://www.who.int/publications/i/item/risk-communication-and-community-engagement-\(rcce\)-action-plan-guidance](https://www.who.int/publications/i/item/risk-communication-and-community-engagement-(rcce)-action-plan-guidance)

6 Appendices

6.1 Appendix 1: End-user Workshop

PANDEM-2 End-User Communication Resource Validation Workshop

28 October 2021
(via MS Teams videoconference)

Thursday, 28 October 2021, 10:00 – 13h00 (CEST)	
Plenary Session	
10:00-10:10	Welcome & objectives of the workshop
10:10-10:30	Presentation of D5.1 results: Knowledge Bases
10:30-10:45	Introduction to the pandemic settings & communication templates (Miro whiteboard tool and discussion in Teams)
Breakout to parallel web-sessions	
Three Parallel Sessions	
10:45-11:20	Group discussions: application of communication resources to pandemic settings (Each group discusses a different pandemic story, participants decide on content and means of communication)
11:25-12:00	Second Group discussion, with focus on a different pandemic setting
12:00-12:15	Coffee break
Plenary Session	
12:15-13:00	Key findings presented by Table Hosts Discussion of potential application and final wrap-up

Three stories

Fraunhofer INT

28th of October 2021

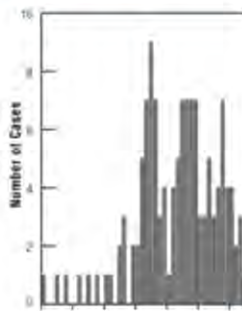
This project has received funding from the European Union's Horizon 2020 research and innovation programme under Grant Agreement No. 883285

The material presented and views expressed here are the responsibility of the author(s) only. The EU Commission takes no responsibility for any use made of the information set out.

PANDEM-2

PANDEMIC PREPAREDNESS AND RESPONSE

Story 1: SARS (2003)



217 probable or suspect cases of SARS have been reported in country x. There have been 9 deaths. All cases have occurred in persons who have **travelled to an affected country** or had contact with SARS cases in the household or in a health - care setting.

Intensive and **good supportive care**, with and without antiviral agents, have improved prognosis.

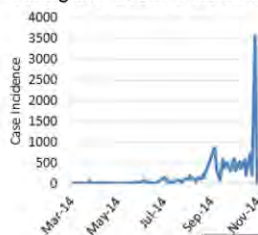
As of today, a cumulative total of 2601 cases of SARS, with 98 deaths, have been reported from 17 countries. This represents an increase of 85 cases and 9 deaths compared with the last update two days ago.

The development of a **diagnostic test**, which is being pursued around the clock by the WHO collaborating network of 11 laboratories, has proved more problematic than hoped. Three diagnostic tests are now available and all have limitations as tools for bringing the SARS outbreak quickly under control.

The most common early **symptoms** in patients progressing to SARS have included fever (100%), malaise (100%), chills (97%), headache (84%), myalgia (81%), dizziness (61%), rigors (55%), cough (39%), sore throat (23%) and runny nose (23%).

Story 2: Ebola (November 2014, outside Africa)

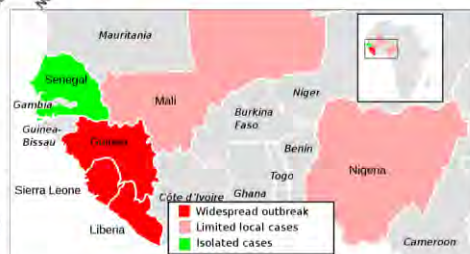
The Frequency of New Cases in Africa during the Ebola Outbreak of 2014



A traveller from Liberia became ill with symptoms compatible with Ebola after his arrival in Country X. He died in the hospital. Two nurses who cared for him also became infected with Ebola. Both nurses recovered.

An opinion poll revealed that the public in country X ranked Ebola as the third-most-urgent health problem facing the country.

Hundreds of people were tested or monitored for Ebola virus infection in Country X.



About half the public (45%) of country X was worried ("very worried" or "somewhat worried") that they or their family would become sick with Ebola.

Story 3: COVID-19 (European Country – March 2020)

SITUATION IN NUMBERS
total and new cases in last 24 hours

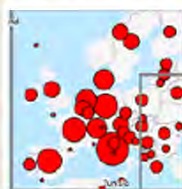
Globally
125 260 confirmed (6741 new)
4613 deaths (321 new)

China
80 981 confirmed (26 new)
3173 deaths (11 new)

Outside of China
44 279 confirmed (6915 new)
1440 deaths (310 new)
117 countries/territories/
areas (4 new)

WHO RISK ASSESSMENT

China Very High
Regional Level Very High
Global Level Very High



The Health Board announced 10 new cases, bringing the **total number of confirmed cases to 27**. The new cases confirmed the **transmission of the virus locally**.

People who have returned from the risk areas have to stay at home for 14 days and monitor their health.

*The symptoms of COVID-19 are similar to **flu symptoms**. The virus can cause cough, fever and breathing difficulties. According to current data, 80% (including pneumonia) of the cases are mild, comparable to the common cold. Approximately 14% experienced severe symptoms and 6% fell critically ill.*

In most cases, the incubation period of the disease is 5-6 days, but the virus can be detected from the samples taken from the respiratory tract 1-2 days before and up to 3-7 days after the onset of symptoms.

People with chronic health problems and older people are thought to be at greater risk of developing severe symptoms.

6.2 Appendix 2: End-user Questionnaire

PANDEM-2 WP5.2 – Communications End-User Questionnaire

Dear PANDEM-2 end-users after your valuable contributions to our Task 5.1, we once again ask for your input for our Task 5.2. In this, we are tasked to provide reviewed and updated communication guidelines, resources and tools to our end-user partners.

We are aware that some of the information requested below might not be easy to come by or to share with us. Nevertheless, we would kindly ask you to share with us as much as you can and we will treat the information with great care.

1. Please give the name of your organization

2. In your organization, who is devising the communication strategy in case of a pandemic?

- Designated communications officer

Yes	No
-----	----

- PR Department

Yes	No
-----	----

- Other (please specify)

Yes	No
-----	----

3. In case of a public health emergency, how can someone from outside of your organization contact your communications coordinator?

4. If available, please give the functional e-mail address (e.g. PR@organization.com).

5. What are key stakeholder organizations which you may need to contact in case of a public health emergency, either for inquiries or to share information?



6. If possible, please indicate below how to best contact them (please do not provide personal telephone numbers or e-mail addresses. Only give functional e-mail addresses if available, otherwise leave blank)

7. Based on your COVID-19-Pandemic experience, which contact details/channels were missing at the beginning of the pandemic or would have been helpful?

8. Did you support pandemic communication in cooperating agencies?

Hospitals	Yes	No
Police	Yes	No
Government agencies	Yes	No

9. Did you provide communication action plans for any of these actors (see above)?

Hospitals	Yes	No
Police	Yes	No
Government agencies	Yes	No

If so, please specify

Hospitals	
Police	
Government agencies	

10. For the purpose of Task 5.2, Work Package 5 is tasked to reviewing existing communication guidelines from its end-user partners. If available, please provide any communication templates that your organization uses.

11. If available, please provide any internal communication guidelines that your organization uses/provides by attaching them to the e-mail together with the filled-out questionnaire.

12. The PANDEM-2 project aims to provide templates and checklists for formats that allow the public to ask questions, seek reassurance and provide feedback, e.g. Helplines or question- and-answer-fora. Do you have some form of helpline for the public?

Yes	No
-----	----

13. Does your organization provide your staff with guidelines regarding these helplines?

Yes	No
-----	----

If available, please provide these guidelines by attaching them to your response e-mail.

14. Does your organization interact with Influencers (community leaders, media or sports personalities, etc.) in order to increase your organization's visibility within the public sphere?

Yes	No
-----	----

If yes, please elaborate your involvement/interaction:

What would be interesting to learn from influencers about public health communication strategies in the Covid-19 pandemic?

6.3 Appendix 3: Crisis Communication Principles

Crisis Life Cycle

A good starting point for pandemic managers using the templates is to answer the following baseline questions:

- Who is it for?
- What is happening?
- When is it happening?
- Where has/is it happening?
- Why has/is it happening?
- How has/is it happening?

The information used from these baseline questions will be influenced by different influential variables and dynamics of the pandemic that will change the tone, style and in some cases, the channel of communication. Within these variables is the phase at which the pandemic lies: preparedness, crisis response (onset/ongoing) or recovery and with that said, it's crucial that a strategic approach communicates at every stage. In the case of recurring viruses such as the common influenza, the time of year or season may also come into consideration.

Fail to Prepare, Prepare to Fail

The preparedness phase is a critical time to set out a robust crisis communications plan with a leading team. It occurs before the onset of the health emergency and caters for the development of strong key messages, target audiences, resources, test measures and stakeholder needs. The timeline of an emergency is unknown therefore, with your plan already in place this will allow an agile response.

The CDC's Crisis and Emergency Risk Communication (CERC) states that the crisis response is most probable phase where incompatible communications such as mixed messages and misinformation are likely to occur. Their guidelines echo the critical importance of understanding your target audience because as *"emergency response progresses, available information and audience needs will change. Communication resources and strategies must adapt to meet these evolving needs"* (CDC, 2017)

It's recommended that crisis communications principles and best practices are followed in the crisis response phase and these should be modified as the crisis moves from the onset of the emergency to an ongoing pandemic. The PANDEM-2 project has revised novel literature on pandemic communications and consolidated these best practices into a table of adaptable guidelines, view it here.

A logistical method to managing a health pandemic given their unprecedented nature is to approach it with this phased outlook. The CERC further suggests that a "one size fits all" approach to crisis communications will inevitably fail as all crises will go through all five stages outlined in their Crisis Communication Lifecycle (Figure 11) however, the length of time in each stage and more specifically for each audience and geographical area affected will vary as the virus spreads (CDC, 2017).

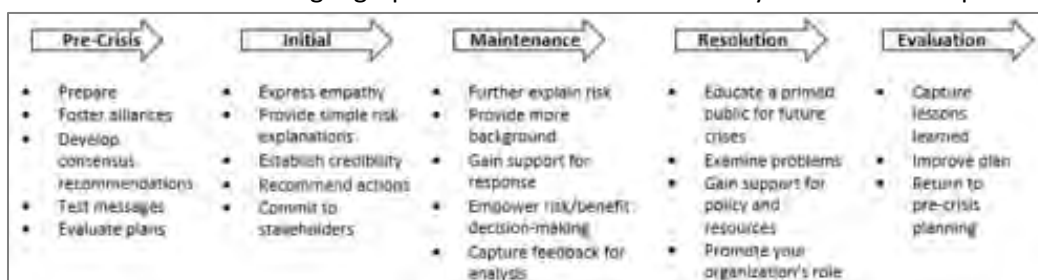


Figure 11: Crisis Communications Lifecycle, CDC, 2017

6.4 Appendix 4: Communication Contact List

Category/area (e.g. health, security, etc.)	Organisation	Title / Position of the contact person (e.g. communications manager)	Name (optional)	Phone number	E-mail address / functional mailbox	Deputy/ Substitute	Phone number	E-mail address
	National ministry of health							
	Regional ministry of health							
	Public health department							
	Additional national institutions (e.g. regarding animal health, food safety, radiation and nuclear safety; risk assessment; ministry of interior and/or civil protection; foreign office)							
	International stakeholders (WHO, ECDC) and other countries via EWRS and IHR							
	Further potential stakeholders (e.g. medical associations, professional societies, laboratories)							
	First responder organisation							
	Press (e.g. regional newspaper(s), TV stations, Radio)							

6.5 Appendix 5: Press Release Template

General Press Release Template

[Any relevant logos of the organization should be placed in the header for recognition]

Release Date: This informs the journalist on when the press release should be issued and provides a timeline for when your organization can begin to expect questions and queries.

Headline:

This should be catchy and to the point, ideally no more than one sentence in length. Essentially, it should capture why the reader of the press release should care about the matter.

Paragraph 1:

This should include the most newsworthy information i.e. WHO is it about, WHAT is happening, WHEN is it happening, WHERE is it happening, WHY is it happening/should people take action, HOW can people do this/find more information (should at the very least include: who, what, when and where)

Paragraph 2:

Other important and essential details backed up with credible, expert led quotes.

Closing Paragraph:

Any additional details, contact information, web links etc.

End: Mark the end of the press release with: **ENDS**

Contact Information: Designate one or two communications and/or PR contact to answer the media's queries and facilitate up to date information on the crisis and your response. This should include their name, working title, email and phone number.

Editor's Note: Include any additional notes the editor should be aware of here. This is optional and can be used to elaborate on a point made within the body of the press release for example, listing the most common symptoms connected to an infectious disease or outlining the role of a mentioned organisation.

6.6 Appendix 6: Media Contact Template

Image of journalist	First Name Last Name, Position Publication
CONTACTS	PR/Communications contacts
AGENDA	Date and time of meeting
Zoom/Teams LINK	If applicable
FURTHER DETAILS	Email: Twitter:

MEETING BACKGROUND
Briefings and interviews will happen as part of a strategy to communicate to the public developments in the outbreak of a particular pandemic.
Depending on developments, discussions will focus on the outbreak, the latest developments and provide stakeholders and citizens with key advice, takeaways and lessons around the pandemic.

ABOUT Journalist:
Depending on the interview, this section will outline the journalist, their position and what they normally look to cover and do within interviews. The section will also map out the journalist's biography and how their background is influenced by the subject area.

Publication PROFILE:
Depending on the journalist, this section will outline the publication and what they specialise in. We would also outline what the specific process would be during any potential interview, for example:
The interview process is as follows:

- Journalist will send over the questions he plans to ask, or at least a top line view, to allow for sufficient preparation.
- The interviewer can approach a conversation in various forms i.e. conversational, abrasive...etc
- Journalist will then edit the transcript and in some cases may send over the interview for approval

RECENT Interview:

- [Links to previous interviews](#)

QUESTIONS:
The journalist if they choose to, may have had time to develop some targeted questions that he will run through during the interview. Please find these below:

- For those who may not know you, can you tell us little about who you are and what you do?

INTERVIEW GUIDANCE:

- Please be conscious that nothing will be "off-the-record".
- Please keep your answers concise where possible.
- Be wary of leading questions – do not be tempted to just agree if it is not your opinion.
- Don't feel compelled to answer questions you're unsure on – the PR team will follow up with the journalist on questions that were not answered in the first instance.
- Please do not reference customers or data unless they have been approved for PR outreach.

6.7 Appendix 7: Communication Checklist

An example of a communication checklist was provided as part of the best practice review of communication guidelines provided by Pandem-2 end-user partners in the questionnaire feedback (Appendix 6.2). The following example is taken from Folkhälsomyndigheten (2019), pp. 22; presented in own translation.

✓	Activities below	Comment
Interpandemic phase (the time between pandemics)		
<input type="checkbox"/>	Develop a communication plan with clear channels to ensure fast and correct dissemination of information, to both authorities and the general public.	
<input type="checkbox"/>	Review the communication readiness in the organization.	
<input type="checkbox"/>	Establish collaboration groups for communication and coordinated information during a pandemic for national, regional and local level.	
<input type="checkbox"/>	Develop strategies to relate to on social media, to meet rumours and have conversations with the target groups.	
<input type="checkbox"/>	Develop FAQs, checklists and overall common messages.	
<input type="checkbox"/>	Communicate pandemic preparedness in other relevant contexts, e.g. in emergency preparedness and influenza surveillance.	
<input type="checkbox"/>	Establish documentation routines for decisions made during a pandemic.	
<input type="checkbox"/>	Practice emergency communication.	
Activation and pandemic phase		
<input type="checkbox"/>	Activate and maintain collaboration groups for communication and coordinated information during a pandemic.	
<input type="checkbox"/>	Update the communication plan, FAQ, checklists and common messages.	
<input type="checkbox"/>	Maintain documentation routines for decisions made during the pandemic.	
<input type="checkbox"/>	Use reconciliation points for ongoing follow-up of the communication efforts, and adjustments during the course of events.	
<input type="checkbox"/>	Monitor social media, respond to rumours and have conversations with the target groups.	

**Transition phase (pandemic is about to pass)**

- ☐ Follow up and evaluate the communication planning. Set aside resources for evaluation
- ☐ Make documentation and decisions made during the pandemic available
- ☐ Take advantage of personal experiences and impressions, in ongoing follow-up and evaluation
- ☐ Follow up documentation routines
- ☐ Review your reconciliation points for ongoing follow-up and adjustment during the course of events – did it work?

Messages at the beginning of, and during a pandemic

Nobody knows how serious the situation can be in the beginning, but follow the news and listen to the authorities' assessment of the situation. Communicate continuously what is being done to find out more

Communicate:

- ☐ What the situation means for the public.
- ☐ What decisions are made due to the situation, why and what they mean.
- ☐ Where the public can turn for information and ask questions.
- ☐ Every employee in health and care can turn to get information and ask questions.
- ☐ How to get information in languages other than Swedish
- ☐ How to avoid becoming infected or infecting others – wash your hands, sneeze and cough in the armpit and stay home if you feel sick.
- ☐ How to take care of yourself and others at home.
- ☐ What applies to groups with specific needs, such as pregnant women, children, the elderly and other medical risk groups.
- ☐ What applies to Swedes who are abroad or come home from a trip.
- ☐ What it means to be vaccinated, why there is a reason to do so and if there are any risks involved.
- ☐ How vaccines work, and if and where it is available.
- ☐ The most effective way to prevent a serious illness with the flu is vaccination



Activities below

Comment

Message at the beginning of, and during a pandemic



Resources where the public can find information:

- At 1177.se (on the web) and tel. 1177, you can get information about what applies if you have questions about health and medical care or feel sick.
- On the national web portal Krisinformation.se you can get information about the situation, the authorities' responsibilities and work and find answers to your questions.
- You can call the national information number 113 13 if you as a private person have questions and wonder about the situation.
- The drug information on tel. 0771-46 70 10 answers your questions about drugs: how do they work, how should they be taken and stored, and what about side effects?