D 3.3 – Communication Guidelines

WP3 (LMU)

September 27 2013
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D 3.3 – Communication Guidelines

WP3 – prepared by LMU

September 27 2013
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1- Introduction – aims of the guide

All the key stakeholders - health care professionals, health authorities, general population and media – must be able to work together to mitigate effects of a health emergency situation. As the HealthC project states, this is only possible if extensive preparedness planning programmes are in place and if communication tools and guidelines are available in advance for all stakeholders. A key element in this approach is training and capacity building efforts aimed to develop crisis communication and management skills. In particular this needs to allow a continuous and reliable information exchange. Different information channels will need to be engaged: from traditional media such as television and newspapers to social networks, blogs and websites.

For this reason, the central goal of the project is to develop, design and test a training course aimed at improving health crisis communication skills of health care professionals, especially health care managers, who are working in different institutions in local, regional, national or supra-national settings.

This guide is aimed at individuals or organizations who wish to become actively engaged in teaching health crisis communication skills and facilitating this knowledge transfer.
2 - What should be the content of training courses?

The choice of the content for training courses depends on a number of factors. These are summarized in the figure below. In essence, the content depends on the health topics to be addressed, the type of stakeholders that will be invited and the mission of your organization. For example, if the mission of your organization is to engage health professionals through e-learning, the topics and the stakeholders who may benefit from such courses will be limited to the topics and stakeholder areas that intersect your organization mission. In addition, not all health crisis communication topics will be of interest to all the stakeholders. Thus only the black area in the middle represents the content that should be addressed at the training courses.

Fig. 1 – Factors involved in the definition of the content of training courses

In practical terms, the content of health crisis communication courses will be governed either by the need to address a certain issue or will reflect the desires of the particular stakeholder group. Ideally, the two should coincide: the stakeholders should choose the topic that you are actually also interested in and vice versa.

The objectives of the training courses also depend on whether the course content is driven by a topic or by stakeholders. If it is topic driven, the objectives are primarily to bring stakeholders up to speed on certain pressing issues, being it for example latest trends in emerging diseases or new communication technologies. The objective is to raise awareness and knowledge base. If the content is stakeholder driven, the objective is likely to respond to the specific needs of the target audience. These may be for example to fill in certain knowledge gaps. Here, the objective is generally related to capacity building and raising knowledge base. However, as indicated above, stakeholder and topic needs could coincide. In such cases, the objective of the course could be many-fold.

For the purpose of training courses envisaged by the HealthC project, it is expected that the objectives and the content of the courses will be mainly driven by the needs of the target groups.
3- Who should be the target groups for health crisis communication training?

As indicated before, the content of health crisis training courses depends on the interaction of three primary factors: the mission of your organization, the topics and the target groups to be addressed. Thus one of the tasks of those designing health crisis training courses is to decide which target group they wish to address. This is not an easy task.

One way to go about it is to identify the key stakeholders in health crisis communication. The following figure identifies the key stakeholders and the interactions between the key stakeholders in a health crisis situation.

*Fig. 2 – Key stakeholders in health crisis communication.*

Engagement with the public requires a lot of (financial) resources and clear and specific objectives. In order to reach the broadest audience, the strategy is likely to include PR activities. These can for example address issues such as protection against flu. Engagement with the media on the other hand could take form of courses based on participatory principles, where a dialogue and exchange of information and knowledge is essential. The engagement
with health authorities or health professionals is perhaps the most challenging and arguably most important, as these two groups stand at the epicentre of any health crisis. It is for these two groups that a clear strategy needs to be developed to address the question what should be the content of the health crisis training courses. Basis for this strategy should be data available from representative surveys that not only address the two stakeholder groups but also take into account their role in combating health crisis situations.
4- What should be addressed by health crisis training courses?

When designing a training course, especially a specialized training course such as for health crisis communication, attention needs to be given to answer questions related to interest in training courses and needs of the target groups, including attitudes to new media. In the case of the HealthC project, the target groups are the health authorities and health professionals. The following pages provide a summary of findings of a survey carried out by Ludwig Maximilians University that attempt to answer some of these questions.

The target groups addressed in the survey were health authorities (health managers as well as communication managers) and health professionals (hospitals managers as well as health care personnel) across Europe. Altogether, 473 people answered the questionnaire. 33 % came from governmental and health authorities, 47 % from hospitals and medical care. Another 18 % of the sample stated to work in other organization types and were therefore not part of the addressed target group (health authorities, medical care). These 18 % were removed from the sample, ending up with 382 respondents from the relevant groups.

Out of these 382 individuals the majority works on local levels (52 %), another third (33 %) on regional level, only 14 % work on national levels, 2 % on another level. The professional area of the respondents involves 37 % individuals working in media/health care, 31 % working in management, 12 % working in communication and 21 % working in other professions. Regarding the different countries the respondents are working in we have 24 % working in Italy, 20 % in Germany, 17 % in Spain, 13 % in Denmark, 6 % in Portugal and 21 % in other countries.

The survey was divided into two parts. The first part was concerned with the possible use of new communication channels such as social media, twitters, internet in general. This information was deemed important as means of finding out to what extent new communication media should become part of teaching courses and modules. The second, more extensive part, was concerned with questions related to structuring of the teaching courses.

For complete description of the survey methodology, please see the enclosed annex. In addition, please also consult the following documents: Health focus group reports and good practice handbook, all prepared as part of the HealthC project.
Survey Part 1- Attitudes towards new media

Usage

The majority of professionals working in health authorities or health care are already used to using new communication channels in their daily work: 37 % use new media every day, 21 % use them at least several times a week. Another fifth of the participants are using new media channels between once a week and once a month, and 15 % use them less frequently, 7 % even never (see Fig. 3).

![Fig. 3 – Usage of New Media](image)

Surprisingly, there is a slight tendency that respondents working in hospitals, medical care centers or medical practises are using new media more often than governmental and health authorities. However, computing a Chi$^2$-test shows not significant difference between the two groups (Fig. 4).
Fig. 4 – Usage of New Media by Type of Organisation

N=330, Chi$^2$=7.76, n.s., categories „once a week“, „2 to 3 times per month“ and „once a month“ are summed into „once or several times a month“, categories « less frequently » and « never » summed into « less frequently »

Fig. 5 shows remarkable differences between the five countries, in that usage of new media is higher in Portugal and Spain as compared to the other countries. Against this background, it is important to consider that a training course that is based on e-learning only will not reach all relevant stakeholders, especially not in Denmark, Germany and Italy.

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1 The Chi$^2$-Test is a statistical test used to analyse the statistical significance of group differences. If the test is significant in a statistical sense (the probability of error is less than 5%, that is p<.05), we can assume the observed differences in the data to hold true for the examined population, if not, the observed differences might be due to chance.

2 In this case, the test was not significant (n.s.), thus the above described differences might be due to error rather than describing a true difference in the population.
Improving Crisis Communication Skills in Health Emergency

Fig. 5 – Usage of New Media by Country

<table>
<thead>
<tr>
<th>Country</th>
<th>Every day</th>
<th>Several times a week</th>
<th>Once or several times a month</th>
<th>Less frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denmark</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Germany</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Italy</td>
<td></td>
<td></td>
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<tr>
<td>Portugal</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Spain</td>
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</tr>
</tbody>
</table>

N=235, Chi²=46.69, p<.001, categories “once a week“, “2 to 3 times per month“ and „once a month“ are summed into „once or several times a month“, categories « less frequently » and « never » summed into « less frequently »

Attitudes towards new communication channels

Current developments in health risk and crisis communication show that social media channels are becoming more and more important: the public uses social media to share their daily problems, thoughts and questions, they use social media in order to observe current events and thus it is advisable for health authorities and health care to use these media channels in order to spread their information among the public – also as a direct information channel not distorted by journalists. However, new media channels not only bring along advantages, they may also cause new problems. Against this background, we assessed the stakeholders’ attitudes towards and thoughts about new social media.
Fig. 6 – Attitudes towards new media

N=292-318, Means based on Likert-Scale from 1 « totally disagree » to 5 « totally agree »

Fig. 6 shows a rather sceptic view of new communication channels by our target groups. People agreed most strongly to the maintenance of traditional media channels in addition to new channels. In addition they agreed to the problem, that social media can get out of control and lead to misinformation. This might at least in part be explained by the fact that the respondents feel there is a lack of knowledge regarding the adequate use of social media and mostly agree to the need of training on adequate use of social media. Against this background it is important to include information on the use of social media into training courses aimed at the chosen stakeholders. This in order to make them better prepared for the use of this important communication channel.

Comparing respondents’ attitudes towards new communication channels by organization type, we find almost no differences, expect with respect to lack of capacity to use social media and efficient reach of journalists. In both cases, professionals working in medical care agree more strongly to these statements. However, the general pattern shows that both stakeholder groups struggle with the same scepticism regarding the use of social media for crisis communication (see Fig. 7).
Comparing the five countries in respect to their attitudes towards new media we find remarkable differences again. Spanish respondents agreed less to all of the statements showing both less scepticism towards the usage of new media channels and less enthusiasm about their advantages. German and Italian participants instead show a stronger agreement to most of the statements, indicating both more scepticism and more enthusiasm. All countries associate new media channels both with potentials and hazards (Fig. 8).
**Fig. 8 – Attitude towards new media by country**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Denmark</th>
<th>Germany</th>
<th>Italy</th>
<th>Portugal</th>
<th>Spain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintenance of traditional channels in addition to...</td>
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<tr>
<td>Need of training on the adequate use of social media</td>
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<tr>
<td>Social media can get beyond control and lead to...</td>
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<tr>
<td>Lack of knowledge on how to use new communication...</td>
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<tr>
<td>Social media offer better access to specific target...</td>
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<tr>
<td>Useful information channel to the public</td>
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<td></td>
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<tr>
<td>Lack of capacity to use social media</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Social media allow quick and up-to-date communication</td>
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<tr>
<td>Real-time monitoring tool on the concerns and...</td>
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<tr>
<td>Efficient reach of journalists through social media</td>
<td></td>
<td></td>
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<tr>
<td>Direct interaction and feedback improve crisis...</td>
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<td></td>
</tr>
<tr>
<td>Correct wrong statements in the media through social media</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No proper reach of the target group</td>
<td></td>
<td></td>
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</tbody>
</table>

N=208-226, Means based on Likert-Scale from 1 « totally disagree » to 5 « totally agree », ANOVAS indicate all comparisons between the countries to be significant at least on the 5%-level, except for « direct interaction and feedback », « correct wrong statements in the media », « no proper reach of the target group »
Survey Part 2 - Structuring of training courses

Interest in training courses

Respondents’ interest in training courses is high. More than two thirds of the stakeholder groups stated to have or probably have interest, only 7% said to have no interest and another 7% to have rather no interest. Thus, developing training courses for the stakeholders within this project is definitely a measure most people are in need and favour of (see Fig. 9).

Comparing the two stakeholder groups (Fig. 8) we find no significant difference, thus indicating that both groups are equally interested in the courses.
However, comparing the 5 partner countries we find — in a statistical sense — significant differences again. That is, Spain and Portugal are more in favor of the training courses as compared to the other countries, and people from Denmark are less enthusiastic about them, however still showing nearly half of the Danish respondents to be interested or probably be interested in the training.
We also tested the question whether there was a relationship between attitudes towards new media and interest in training in order to find out, whether a lack of interest might result from negative attitudes towards new media. As figure 12 shows there are hardly any differences between people who are interested in the training (answers “yes”, “probably”) or who were not sure or not interested (answers “maybe”, “rather not”, “no”, “don’t know”).

Fig. 12 – Interest in Training by Attitude towards New Media

N=290-317, Means based on Likert-Scale from 1 « totally disagree » to 5 « totally agree », T-Tests show no significant differences between the groups on a 5%-level, except for “Social media can get beyond control and lead to misinformation”, p<.05.

Another indicator for peoples’ interest in the central project outcome is that more than two thirds would also be willing to take part in the pilot test. 65% of two primary target groups (health authorities and health care) and 64% of the whole sample (also including the other professions here) stated that they would be willing to take part. In addition, 209 people from the primary target groups and 253 people from the whole sample, respectively, inserted their email adress in order to be updated in future and invited to the training.
Experiences with E-Learning Tools

Since the Health C project aims to develop e-learning tools for the training we also asked the respondents whether they already had experiences with e-learning and how they evaluated their experiences. More than two thirds of the relevant stakeholder groups (68%) stated to have experiences with e-learning. People working in health care have even more experience as compared to governmental and health authorities (Fig. 13).

Fig. 13–Experiences with E-Learning Tools by Organization Type

Comparing the five partner countries we find Spain and Denmark to have even more experience (more than 80%), while Germany, Italy and Spain have less experiences with e-learning (Fig. 14). However, also in Germany with the lowest experience rate (48%) nearly half of the respondents have already participated in an e-learning course.
Again, there are hardly any relationships between attitudes towards new media channels and experiences with e-learning (see Fig. 15), indicating that e-learning is a suitable platform for health authorities and health professionals independent from partly negative attitudes towards using social media as a channel in crisis communication.

**Fig. 14 – Experiences with E-Learning Tools by Country**

![Chart showing experiences with e-learning tools by country]

N=231, Chi²=28.04, p<.001

**Fig. 15 – Experiences with E-Learning Tools by Attitudes towards New Media**

![Chart showing experiences with e-learning tools by attitudes towards new media]

N=289-316, Means based on Likert-Scale from 1 « totally disagree » to 5 « totally agree », T-Tests show no significant differences between the groups on a 5%-level, except for “Social media can get beyond control and lead to misinformation”, p<.05, and “Social media allow quick and up-to-date information”, p<.05
Participants, who had indicated to have experience with e-learning, were also asked to rate these experiences on a 5-point scale from very negative to very positive. As Figure 16 shows the respondents have a very positive view of e-learning: 30% rate their experience as very positive and another 49% rate them as rather positive.

*Fig. 16 – Evaluation of Experiences with E-Learning*

![Pie chart showing evaluation of experiences with e-learning](image)

N=196 (only answered by those, who have experience)

*Fig. 17 – Evaluation of Experiences with E-Learning by Organization Type*

![Bar chart showing evaluation of experiences by organization type](image)

N=196, Chi²-test not valid due to too many cells with an expected count less than 5
This view holds true for participants both from governmental and health authorities as well as from health care (see Fig. 17). Similarly, we find only slight differences between the five partner countries (Fig. 18).

Fig. 18 – Evaluation of Experiences with E-Learning by Country

N=127, Chi²-test not valid due to too many cells with an expected count less than 5

Preferences regarding training courses

In order to get an idea how the training courses should be designed we also asked the survey participants about their preferences regarding training courses. First of all, they had to indicate whether they generally preferred e-learning based courses, classroom based courses or a mix of both. As Figure 19 shows the majority of the respondents prefers a mix of both.
A comparison between the two stakeholder groups shows no significant difference (see Fig. 20), whereas we find slight differences between the five countries. Participants from Denmark,
Germany, Italy and Spain clearly prefer a mix of e-learning based and classroom based learning, whereas the preferences in Portugal are not as clear. Looking at e-learning based trainings only we find a higher percentage of people preferring this form in Portugal and Italy as compared to the other countries (Fig. 21). Against this background, the results rather speak for a training course that combines both elements of a classroom based training with e-learning applications.

**Fig. 21– Type of Learning Course Preference by Country**

![Bar chart showing the type of learning course preference by country](image)

N=217, Chi2=24.06, p<.01

In thinking about the e-learning based course, it is also relevant to find out, which capabilities and tools are important for the participants. Against this background, we provided a list of several possibilities that can be integrated in an e-learning platform and asked the participants to rate them on a five-point scale from 1 “not important at all” to 5 “very important”. Figure 22 shows the mean value for each of the tools. As the means show there is no tool, which is not important for the stakeholders. Furthermore, the tools that are most important are self-text questionnaires, text documents, messaging applications, images and videos, whereas chat applications, RSS-Feeds, and social network applications are at the lower end of the scale. All in all, this shows a preference for the more traditional (one-way) tools of e-learning, whereas the newer and more interactive tools are less important. However, this might also be explained by the fact, that people have fewer experiences with newer applications and therefore are hesitant to find them important.

Comparing the two stakeholder groups with regards to their preferences of capabilities and tools on an e-learning platform we find hardly any difference (see Fig. 23). Only for text documents we find a significant difference indicating a slightly higher preference of text documents by health authorities.
Fig. 22 – Importance of capabilities and tools on a Web-E-learning platform

N=183-295, Means based on Likert Scale from 1 « not important at all » to 5 « very important »

Fig. 23 – Importance of capabilities and tools on a Web-E-learning platform by Organization Type

N=183-297, Means based on Likert Scale from 1 « not important at all » to 5 « very important », t-tests shows no significant differences except for text documents (t=2.05, p<.05)
Improving Crisis Communication Skills in Health Emergency Management

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Fig. 24 – Importance of capabilities and tools on a Web-E-learning platform by Country

N=136-214, Means based on Likert Scale from 1 « not important at all » to 5 « very important », ANOVAS show significant differences for link list (F=6.08, p<.001), discussion forums (F=7.15, p<.001), social network applications (F=9.34, p<.001), RSS-Feeds (F=8.37, p<.001) and chat applications (F=7.35, p<.001)
Comparing the five partner countries we find no differences in the perceived importance of applications that are generally important to the stakeholders, namely self-test questionnaires, text documents, messaging applications, images and videos. However, the newer and more interactive elements (especially discussion forums, social network applications, RSS-Feeds and chat applications) are rated significantly less important by the Danish and German stakeholders as compared to the others (see Fig. 24).

**Learning styles**

Apart from the preference of specific tools it is also relevant to know how people prefer to learn. Therefore, we provided a list of statements on learning styles and asked the respondents to rate their agreement to the items on a five-point scale. Figure 25 shows that respondents mostly want to be provided with information or like to search for information. They also agree to be able to understand news ideas and concepts easily and want to discuss what they learned with others, like their work to be evaluated and find contact to other participants important. Interestingly there is less agreement regarding both working alone and working in groups. Thus, in spite of the fact that respondents are hesitant regarding interactive capabilities and tools (as was shown in the previous step), it is obviously important for them, to have the chance to discuss things online rather than in groups.

*Fig. 25 – Learning Style*

N=312-319, means based on likert scale from 1 « totally disagree » to «5 « totally agree »
Comparing the two stakeholders groups we find no difference relevant to the development of the training courses (Fig. 246), whereas there are significant differences between the five partner countries with regards to most of the items. As the results show, stakeholders from Germany and Denmark are less willing to work in groups, get into contact with other participants and discuss what they learned with others, whereas stakeholders from the other countries are more sociable (Fig. 27).
Fig. 27 – Learning Style by Country

- I like to be provided with information
- I like to search for information
- I want to discuss what I learned with others.
- I can easily understand new ideas and concepts.
- I like my work to be evaluated.
- It is important for me to have the chance to get in contact with other participants.
- I generally accomplish what I set out to do.
- I like to work in groups.
- I like to work alone.

N=223-228, means based on likert scale from 1 « totally disagree » to 5 « totally agree », ANOVAS show significant differences for all items (at least on 5%-level), except for « I like to search information » and « I can easily understand new ideas and concepts »
Finally, we also wanted to know how much time the participants were willing or able to spend with a training course per week over a period of four weeks. As Figure 28 shows the majority is willing to spend 1 to 2 hours, and another third prefers 3 to 4 hours. Thus, a training course that takes about 2 to 3 hours per week will probably satisfy most of the participants.

Fig. 28 – Available Time for the Training Course per Week

![Pie chart showing available time for the training course per week]

N=300

Fig. 29 – Available Time for the Training Course per Week by Organization Type

![Bar chart showing available time for training course per week by organization type]

N=300, Chi²=7.94, n.s.
While the two stakeholder groups again showed no difference (Fig. 29), stakeholders from different countries have slightly different preferences regarding the duration of a training course (Fig. 30). Whereas Portuguese and Spanish stakeholders would spend mostly 3 to 4 hours, Danish, German and Italian stakeholders rather prefer the shorter version. However, the differences only mirror a slight difference between 1 to 2 or 3 to 4 hours, therefore, also against this background a training course of about 2 to 3 hours duration would probably be the best solution.
5 – Summary and Conclusions

Developing content for training modules and then actually implementing training courses is not an easy task. This is especially true for difficult and sensitive topics such as health crisis communication. The key in designing such courses is to well know the target groups. It is for this reason that an extensive survey of two main stakeholder groups: health authorities and health professionals. The survey was conducted in Europe.

The results show that stakeholders working in health or governmental authorities and health care are used to using new communication channels in their daily work. However, there is certain scepticism to use social media as a communication channel in health emergencies. Probably, this scepticism arises mainly from the fact that the stakeholders don’t feel educated enough to use social media effectively and see a need of training on the adequate use. Thus, it is important to include knowledge on the use of social media into the training courses for the stakeholders.

In general, preparing training courses for the stakeholders is a crucial issue, since more than two thirds of the relevant stakeholders would be interested in participating in a training course and 253 respondents inserted their email address in order to be involved in the next steps of the project. However, preparing the training courses as an e-learning platform without any classroom based elements might not be the optimal solution. While people have quite a lot experiences with e-learning already and rate them positively overall, nearly 70 % prefer a mix of e-learning and classroom based learning. Of course, it is a matter of manageability and cost effectiveness, if it will be possible to include classroom based elements for stakeholders that are distributed all over Europe.

As for the specific design of the training courses the results indicate to include all of the proposed capabilities and tools, since the stakeholders rated none of them as not important. In comparison with other tools, they judged social network applications, RSS-Feeds and chat applications as least important. However, this might be due to the fact that they have not enough experience and knowledge regarding these tools. Taking people’s preferred learning styles into account we see that people do find it important to discuss what they learned with others – in addition to information provision and search. Therefore, applications that enable discussions and share of ideas should definitely be integrated into the e-learning platform.

Finally, asking the respondents how much time they would be willing to spend with the training course per week over a period of four weeks indicated that something between 2 and 3 hours will be suitable.

Comparisons between the two stakeholders groups did not reveal considerable differences. Comparisons between the five partner countries showed interesting differences, however, all in all the differences are quite small – even if significant. Therefore, there is no need to design
training courses differently for different stakeholder groups, while some small modifications may be needed for individual countries that are likely to be split into two regions: North and South Europe.
6 - ANNEX - Methodology of the survey

The central goal of the Health C project is to develop, design and test a training course aimed at improving crisis management and crisis communication skills of health authority staff members.

Against this background, a standardized quantitative online survey was conducted to assess perceived strengths and weaknesses, threats and opportunities among the relevant stakeholder groups (health authorities, health care professionals) in the partner countries (SWOT analysis, WP3) as well as perceived potentials and limitations of social media, experiences with e-learning and preferences regarding e-learning tools and learning styles of the primary target groups of the project. This report contains the results of the survey with regards to the questions relevant for developing the training courses.

Data for this report have been collected with an online survey conducted as collaboration between WP2 and WP3, which ran at European level from July 5th to August 16th 2013, obtaining a total of 431 responses.

Questionnaire

In order to collect the data for both the SWOT analysis and the guidelines for the training courses, a standardized quantitative online survey was conducted. The questions were developed against the background of previous research findings in the field and on the basis of the results obtained from the focus groups that were conducted in Germany, Italy and Portugal as part of WP2. Further ideas for the questionnaire originated from a common discussion between all project partners during the Health C meeting in May in Munich.

After developing the questions the questionnaire was programmed as an online survey, which provides the advantage to conduct quantitative surveys rather quickly and with a wide geographical distribution, which was crucial in this project. The first version of the questionnaire was developed and programmed in English. After several pre-tests with the project partners and the German stakeholders, who had taken part in the German focus group, the questionnaire was slightly adjusted and then translated into all partner languages (German, Italian, Portuguese and Spanish) and programmed in the respective languages. Only the partner from Belgium (HOPE) used the English version of the questionnaire (not Flemish or French), since they were addressing a European sample of stakeholders. After finalizing all versions of the questionnaire the partners distributed the URL to their respective questionnaire version with a standardized email invitation that was prepared in advance. Two reminders were sent out during the following weeks in order to increase response rates.
The questionnaire started with an introduction page outlining the aims of the project, the involved partners as well as the specific goals of the survey (see Annex for a reprint of the English version of the questionnaire). Also confidentiality and anonymity was guaranteed to the respondents and access to the training materials was ensured in return for answering the questionnaire. At the beginning we assessed a few details about the respondents, namely type of organization, area of work, durance of work in this professional area, country and operational level of the work the respondent was involved with in order to be able to describe the sample and compare different stakeholder groups. The second part dealt with questions relevant to the SWOT analysis (see report D 2.2 carried out by HOPE). The questions relevant to this analysis were assessed in part 3 (questions 10, 11) and 4 (questions 12 to 21).

Part 3 – new social media: In question 10 we assessed how often the respondents were using new communication channels such as social networks, online video channels and blogs. In question 11 we assessed the stakeholder’s attitudes towards such new communication channels. A list of 13 statements was developed on the potentials and limitations of social media in health crisis communication and respondents were asked to indicate their agreement or disagreement to these questions with a five-point scale. In addition, respondents could also choose the answer “don’t know” in case they weren’t able to give an answer.

Part 4 – training courses: Question 12 asked whether respondents were willing to attend a training course in crisis communication. Question 13 assessed, whether respondents had experiences with e-learning. If yes, they were also asked, how they evaluated their experiences (from very negative to very positive, or don’t know) in the following question. Question 15 asked what type of training course the respondents would prefer (e-learning based, classroom based or a mix of both). With question 16 we asked more specifically how important specific capabilities of tools were for the respondents within an e-learning platform. Respondents had to rate the importance of 11 tools or capabilities on a five-point scale (again they also had the possibility to state “don’t know”). Question 17 asked, how many hours the participants were willing to spend with a course (5 answers were provided between less than 1 hour per week and more than 6 hours per week). In the next step we asked for learning preferences and learning styles. Again, 9 statements were provided and respondents had to rate their agreement or disagreement on a five-point scale.

Finally, we provided the possibility to insert an e-mail address, if respondents were interested in the results of the study. They could also indicate whether they were willing to participate in the pilot test of the training, at the end of the questionnaire.
Sample

The target groups addressed in the survey were health authorities (health managers as well as communication managers) and health professionals (hospitals managers as well as health care personnel). Altogether, 473 people answered the questionnaire. 33 % came from governmental and health authorities, 47 % from hospitals and medical care. Another 18 % of the sample stated to work in other organization types and were therefore not part of the addressed target group (health authorities, medical care). These 18 % were removed from the sample, ending up with 382 respondents from the relevant groups.

Out of these 382 individuals the majority works on local levels (52 %), another third (33 %) on regional level, only 14 % work on national levels, 2 % on another level. The professional area of the respondents involves 37 % individuals working in medical/health care, 31 % working in management, 12 % working in communication and 21 % working in other professions. Regarding the different countries the respondents are working in we have 24 % working in Italy, 20 % in Germany, 17 % in Spain, 13 % in Denmark, 6 % in Portugal and 21 % in other countries.

The results from the survey are described for the whole sample (N=382) as well as in comparison between our two target groups (health authorities versus health care) and between the five partner countries (Denmark, Germany, Italy, Portugal, Spain). Belgium is not included in the comparison, since HOPE distributed the survey not within Belgium, but to a geographically distributed group of people, many of them from our five partner countries. Therefore, the participants recruited by HOPE were, if possible, integrated into the other five partner countries.
Dear participant,

Thank you very much for your interest in this survey which is part of the EU-funded project “Improving Crisis Communication Skills in Health Emergency Management” (Health C). The project aims to understand challenges and solutions in crisis communication during health emergencies. For further information, please visit the project website following this link: http://www.healthc-project.eu.

Your experiences and your opinions are very important to us. Completing the questionnaire will only take about 10 minutes. Of course, your responses will be treated confidentially and analyzed anonymously.

We will use the results of this study to improve guidelines for health crisis communication in Europe and create a tool kit and training materials that aims to support different national health authorities and health professionals in the EU to communicate effectively in health crises situations.

In return for your assistance in this study, we will provide you the access to the training materials, when ready, free of charge. If you are interested, just type your email address into the open field at the end of the questionnaire, which will be registered separately from your survey answers to keep anonymity.

Thank you in advance for participating.

https://www.soscisurvey.de/admin/preview.php?questionnaire=HealthC_EU&mode=print
1. For which type of organization do you work?

- Governmental and health authorities
- Health consulting agencies
- Research & education organizations
- Voluntary Associations
- Health professional or medical associations
- Insurance companies
- Hospitals, medical care centers, medical practices
- Other, please specify [ZE01_05]

2. In which area do you work?

- Research
- Management
- Communication (Press Department/Public Relations)
- Administration
- Medical/health care
- Training
- Other, please specify [ZE01_06]

3. For how long have you been working in this professional area?

[ ] years

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4. In which country do you work?

- Belgium
- Denmark
- Germany
- Italy
- Portugal
- Spain
- Other, please specify [ZE01_07]

5. At which operational level is your work carried out mainly?

If you have more than one professional area or work on different operational levels, please indicate the level at which you work mainly.

- Local (city, town, county)
- Regional (federal state, region)
- National (country)
- Europe
- Worldwide

6. In your opinion, what are the crucial factors for effective health crisis communication?

<table>
<thead>
<tr>
<th>Factor</th>
<th>not important at all</th>
<th>very important</th>
<th>don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication competence of health authority staff and health experts</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td></td>
<td>☐</td>
</tr>
<tr>
<td>Understanding the news production process</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td></td>
<td>☐</td>
</tr>
<tr>
<td>Monitoring and evaluation of communication activities</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td></td>
<td>☐</td>
</tr>
<tr>
<td>Regular cooperation between all stakeholders involved in the crisis communication process</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td></td>
<td>☐</td>
</tr>
<tr>
<td>Maintenance of trust in health authorities</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td></td>
<td>☐</td>
</tr>
<tr>
<td>Quick provision of information</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Availability of a designated spokespersons</td>
<td>☒ ☐ ☐ ☐ ☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>A common understanding and definition of health crises</td>
<td>☒ ☐ ☐ ☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Disclosure of uncertainties</td>
<td>☒ ☐ ☐ ☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Involvement of health professionals (e.g., physicians, nurses) in the communication process</td>
<td>☒ ☐ ☐ ☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Consistent and reliable information in all communication channels</td>
<td>☒ ☐ ☐ ☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Involvement of local organizations in the information exchange process</td>
<td>☒ ☐ ☐ ☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Use of external communication experts</td>
<td>☒ ☐ ☐ ☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Sense of responsibility of the media to provide adequate information</td>
<td>☒ ☐ ☐ ☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Involvement of voluntary organizations in the communication process</td>
<td>☒ ☐ ☐ ☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Establishment of a standardized communication procedure (guidelines) within an organization</td>
<td>☒ ☐ ☐ ☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Knowledge of the target groups and how they get their information</td>
<td>☒ ☐ ☐ ☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Identification and use of suitable media channels</td>
<td>☒ ☐ ☐ ☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Others, please specify [ZEO1_01]</td>
<td>☒ ☐ ☐ ☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

7. Considering these factors again, according to your view and experience, how much do these factors need to be improved in order to achieve effective crisis communication?

<table>
<thead>
<tr>
<th>Sense of responsibility of the media to provide adequate information</th>
<th>no need to improve</th>
<th>much need to improve</th>
<th>don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ ☐ ☐ ☐ ☐</td>
<td>☒ ☐ ☐ ☐ ☐</td>
<td>☒ ☐ ☐ ☐ ☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

| A common understanding and definition of health crises | ☒ ☐ ☐ ☐ ☐ | ☐         |
| Consistent and reliable information in all communication channels | ☒ ☐ ☐ ☐ ☐ | ☐         |
| Identification and use of suitable media channels | ☒ ☐ ☐ ☐ ☐ | ☐         |
| Monitoring and evaluation of communication activities | ☒ ☐ ☐ ☐ ☐ | ☐         |
| Availability of designated spokespersons | ☒ ☐ ☐ ☐ ☐ | ☐         |
| Involvement of voluntary organizations in the communication process | ☒ ☐ ☐ ☐ ☐ | ☐         |
| Quick provision of information | ☒ ☐ ☐ ☐ ☐ | ☐         |
| Involvement of health professionals (e.g., physicians, nurses) in the communication process | ☒ ☐ ☐ ☐ ☐ | ☐         |
8. Below you find a list of potential threats to effective crisis communication. How strongly, do you think, do these factors affect crisis communication?

<table>
<thead>
<tr>
<th>Threat</th>
<th>Not Important</th>
<th>Very Important</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neglect of a health crisis situation due to different political priorities</td>
<td>0 0 0 0 0 0</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Social, cultural and linguistic diversity in Europe</td>
<td>0 0 0 0 0 0</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Insufficient collaboration at European level</td>
<td>0 0 0 0 0 0</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Different knowledge backgrounds</td>
<td>0 0 0 0 0 0</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Economic crisis situation in Europe</td>
<td>0 0 0 0 0 0</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Unforeseen reactions on the part of the public/media/other stakeholders</td>
<td>0 0 0 0 0 0</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Different administrative backgrounds</td>
<td>0 0 0 0 0 0</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Increasing mobility of individuals across borders</td>
<td>0 0 0 0 0 0</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Different legal backgrounds</td>
<td>0 0 0 0 0 0</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Increasing importance of social media in the society</td>
<td>0 0 0 0 0 0</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Others, please specify [ZE01_03]</td>
<td>0 0 0 0 0 0</td>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>
9. Here is a list of important societal developments that can provide opportunities for effective crisis communication. How strongly, do you think, do these developments contribute to a more effective crisis communication?

<table>
<thead>
<tr>
<th>Development</th>
<th>Less important</th>
<th>Very important</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placing crisis communication higher on the political agenda</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Increasing role of social media in our society</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Transnational coordination</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Economic crisis as an opportunity to do things differently</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Learning from each other’s experiences in the EU</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Increasing mobility of experts across borders</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Others, please specify [ ZE01_04 ]</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

10. One of the most notable developments in present times is the rise of new communication channels (e.g. social media, online video channels, blogs). How often do you use such channels in your professional life?

- Every day
- Several times a week
- Once a week
- 2 to 3 times per month
- Once a month
- Less frequent
- Never

11. Here are several statements about the potentials and limitations of new communication channels (e.g. social media, online video channels, blogs) in health crisis communication. How strongly do you agree or disagree to these statements?
12. As already mentioned, the Health C-project aims to create a tool-kit and training material that aims to support health authorities and professionals to communicate effectively in health crises. Would you be interested in attending a training course in crisis communication?

- Yes
- Probably yes
- Maybe
- Rather not
- No
- Don't know
13. Do you have experiences with e-learning tools?

- Yes
- No

14. How would you rate these experiences?

- Very negative
- Rather negative
- Neutral
- Rather positive
- Very positive
- Don't know

15. What type of learning course would you prefer? Please mark your preferred option.

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16. Thinking of an e-learning platform on the Web. How important are the following capabilities or tools for you?

<table>
<thead>
<tr>
<th>Capability</th>
<th>not important at all</th>
<th>very important</th>
<th>don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Images</td>
<td>0 0 0 0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Chat application</td>
<td>0 0 0 0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Messaging application (e-mail)</td>
<td>0 0 0 0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Wiki (interactive content management system)</td>
<td>0 0 0 0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Text documents</td>
<td>0 0 0 0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Discussion forum</td>
<td>0 0 0 0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Link list</td>
<td>0 0 0 0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Videos</td>
<td>0 0 0 0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Social network application</td>
<td>0 0 0 0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>RSS-Feed</td>
<td>0 0 0 0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Self-test questionnaire</td>
<td>0 0 0 0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

17. If you think of a one-month-training course. How many hours per week would you be willing to spend with the course?

- Less than 1 hour per week
- 1 to 2 hours per week
- 3 to 4 hours per week
- 5 to 6 hours per week
- more than 6 hours per week

18. Here are a few statements about learning preferences and learning styles. How strongly do you agree or disagree to these statements?

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19. You have nearly completed the questionnaire. Thank you very much! If you have any suggestions or questions, please leave a comment below. We appreciate your feedback.

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20. If you are interested in the results of our study and in getting access to the the training materials, please enter your e-mail-address in this field or send an e-mail to Dr. Constanze Rossmann. It will be stored separately from the rest of your answers.

---

21. Before finally implementing the training course, we will implement a pilot test phase. Would you be willing to participate in this pilot test?

- Yes
- No
Thank you for participating!

We would like to thank you for helping us.

Dr. Constanze Rossmann, Dr. Paul Pochan, Jasmin Maschke, Department of Communication Science and Media Research, University of Munich, Health C-Project Number: 527535-LLP-1-2012-1-PT-LEONARDO-LMP