

**Evaluation and Assessment of H1N1 Outreach
in the African, African American, American Indian/Alaska Native
and Russian/Ukrainian Communities**

**A report to Public Health—Seattle & King County
July 2010**



**Prepared by the Center for MultiCultural Health
in partnership with Afrique Service Center
and the Urban Indian Health Institute**

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Introduction

From April – July 2010, the Center for MultiCultural Health (CMCH) and its community partners—Afrique Service Center and the Urban Indian Health Institute—conducted an evaluation and assessment of H1N1 outreach in the African, African American, American Indian/Alaska Native, and Russian/Ukrainian communities in King County. As outlined in Public Health—Seattle & King County’s (PHSKC’s) request for proposals, the purpose of the evaluation and assessment was to assist PHSKC in assessing the effectiveness of outreach strategies used by PHSKC during the 2009 H1N1 influenza response; how communication currently works within culturally specific communities; and special considerations for successful communication in an emergency.

CMCH used a four-step process for the project: 1) review of internal documentation regarding communication and outreach to African, African American, American Indian/Alaska Native, and Russian/Ukrainian communities during the 2009 H1N1 influenza response; 2) focus group with PHSKC staff regarding the 2009 H1N1 influenza response in the African American community; 3) key informant interviews with community leaders from the African, African American, and Russian/Ukrainian communities; and 4) “community conversations”/focus groups with Africans, African Americans, and Russians/Ukrainians, particularly those at highest risk for H1N1. CMCH contracted with the Urban Indian Health Institute (UIHI) to conduct key informant interviews with community leaders from the American Indian/Alaska Native communities and community conversations/focus groups with American Indians/Alaska Natives. UIHI is submitting findings in a separate report to PHSKC.

Through the evaluation and assessment, CMCH proposed to answer the following questions:

- What did community leaders hear about H1N1, both personally and in their respective communities?
- What did community members hear about H1N1, and what action(s) did they take in response to the information they received?
- What do community members know about H1N1, and what was their experience with the H1N1 vaccine?
- Where and how do community members get information about health-related issues?
- Where do community members go for information and/or services on urgent health issues such as H1N1, and what are barriers to accessing these community resources?
- How do cultural beliefs and practices influence knowledge, attitudes and beliefs about urgent health issues such as H1N1?
- What types of messages about urgent health issues are most important for community members?

Methods

1. Review of internal documentation

As outlined on its website, PHSKC formed a Vulnerable Populations Action Team (VPAT) to “coordinate countywide preparedness efforts with a wide variety of community partners.” One of VPAT’s activities was to create a Community Communications Network (CCN) to improve PHSKC’s ability to reach out to communities that may not access traditional communication channels. The CCN currently includes more than 200 community partners including representatives from the African, African American, American Indian/Alaska Native, and Russian-speaking communities.

During the 2009 H1N1 influenza response, VPAT sent e-mail communications to the CCN. *CMCH completed a review of the following communications provided by Ms. Robin Pfohman, VPAT Program Manager:*

- E-mail communication dated October 20, 2009 (including “H1N1 PH Ctr Vax” in English and “H1N1 Vaccine Facts” in English, Chinese and Spanish) requesting the CCN’s support in notifying clients and community members about the H1N1 vaccine
- E-mail communication dated October 23, 2009 announcing that Public Health H1N1 vaccination clinics for the uninsured would suspend operations
- E-mail communication dated November 2, 2009 informing the CCN that there was still a short supply of H1N1 vaccine and that PHSKC would be working with pharmacies to provide vaccines to people at high risk for H1N1
- E-mail communication dated November 6, 2009 (including “What Your Clients Need to Know Before They Go To A Pharmacy” in English) informing the CCN that participating pharmacies would be distributing vaccine to participating pharmacies during the week of November 9, 2009
- E-mail communication dated November 16, 2009 updating the CCN about vaccine availability
- E-mail communication dated November 18, 2009 (including “Looking for H1N1 (swine) flu vaccine in King County?” in English) updating the CCN about additional distribution of vaccine through participating pharmacies
- E-mail communication dated December 20, 2009 (including the “Public Health H1N1 Vaccination” flyer in English) notifying the CCN that the flyer and other educational materials were available in multiple languages on PHSKC’s website
- E-mail communication dated December 15, 2009 (including the “FREE Swine Flu Vaccinations” flyer) notifying the CCN that free H1N1 vaccinations would be offered to qualified individuals by PHSKC, HealthPoint and Sea Mar Community Health Centers
- E-mail communication dated January 20, 2010 (including another version of the “FREE Swine Flu Vaccinations” flyer) notifying the CCN that free H1N1 vaccinations would be offered to qualified individuals by PHSKC and HealthPoint; that the “Concerned about H1N1 (swine) flu vaccination for yourself or your child?” was available in an additional eight languages; and that the Flu Hotline* was transitioning to recorded messages in English and Spanish only

In addition, CMCH reviewed PHSKC’s “H1N1 influenza (swine flu)” webpage, <http://www.kingcounty.gov/healthservices/health/preparedness/pandemicflu/swineflu.aspx>, and the “Vulnerable Populations Action Team” webpage, <http://www.kingcounty.gov/healthservices/health/preparedness/VPAT.aspx>, including corresponding subpages.

*PHSKC established a toll-free Flu Hotline for King County residents. Callers could hear information in English and Spanish 24 hours a day. Individuals with limited English proficiency and TTY Relay users could receive information in their home language via interpreter/via TTY during normal business hours (Monday through Friday from 9 a.m. to 5 p.m.).

2. Focus group with PHSKC staff

CMCH staff conducted a 90-minute focus group with six PHSKC staff regarding the 2009 H1N1 influenza response in the African American community:

- Ms. Carol Allen, Community Health Educator, King County Health Action Plan
- Ms. June Belefond, Educator Consultant III, Community Based Public Health Practice
- Mr. Greg Wilson, Environmental Health Services Division
- Ms. Karen Hartfield, Project Program Manager III, Prevention Division, HIV/AIDS Program Administration, Care
- Ms. Blishda Lacet, Project Program Manager III—REACH Program, Prevention Division, Chronic Disease/Healthy Aging
- Ms. Ngozi Oleru, Director, Environmental Health Services Division

During the focus group, CMCH staff explored issues including:

- Strategies used during the 2009 H1N1 influenza response that were most/least effective in the African American community
- Barriers in increasing awareness about H1N1 among African Americans
- How to design outreach and communication efforts in the African American community

Please refer to Appendix A for the “Focus group protocol—PHSKC staff.”

3. Key informant interviews—community leaders

CMCH staff completed key informant interviews with 14 community leaders—six from the African (i.e., Ethiopian, Eritrean and Somali) community, five from the African American community, and three from the Russian/Ukrainian community. *We conducted 30- to 45-minute, face-to-face, semi-structured key informant interviews with the following individuals:*

African community leaders

- Mr. Assaye Abunie, Program Director, Ethiopian Digital & IT Services and Multimedia Resources & Training Institute
- Ms. Mulumebet Retta, Chair, Ethiopian Community Mutual Association
- Mr. Mohamed Sheikh Hassan, Director, Afrique Service Center
- Ms. Ayan Qumane, Secretary of Muslim Students Association and Assistant Teacher for Afrique Service Center
- Ms. Mehret Mehanzel, Co-Founder and Teacher, Black Star Line African Centered Family Educational Collective
- Mr. Amanuel Yohannes, Director, Salaam Urban Village Association

African American community leaders

- Ms. Nichelle Alderson, Chair, Health Committee, Seattle Chapter of the NAACP
- Ms. Andrea Caupain, Executive Director, Central Area Motivation Program
- Dr. Ben Danielson, Medical Director and Pediatric Physician, Odessa Brown Children’s Clinic
- Ms. Elizabeth Thomas, retired nurse, Odessa Brown Children’s Clinic (additional affiliations with the Equal Start Community Coalition, First Place School and Mary Mahoney Professional Nurses Organization)
- Ms. Jeri White, Executive Director, Southeast Youth and Family Services

Russian/Ukrainian community leaders

- Ms. Vasilina Martemiak, Producer, Salon of Poetry in Seattle/Salon Poezji w Seattle
- Ms. Nataliya Prsyazhnyuk, Program Director, Circle of Friends
- Mr. Anatoliy Sholom, Publisher, *Nashy VESTI* (Russian newspaper)

During these interviews, we explored issues including:

- Community knowledge, attitudes and beliefs about H1N1
 - What they heard about H1N1, both personally and in their respective communities
 - What community members heard about H1N1 and what action(s) they took in response to the information they received
- How to design outreach and communications efforts
 - Where and how community members get information about health-related issues
 - Where community members go for information and/or services on urgent health issues such as H1N1 and barriers to accessing these community resources
 - How cultural beliefs and practices influence knowledge, attitudes and beliefs about urgent health issues such as H1N1
 - What types of messages about urgent health issues are most important for community members

Please refer to Appendix B for the “Key informant interview—community leaders.”

Community conversations/focus groups

CMCH staff conducted nine, 90- to 120-minute community conversations/focus groups—four with individuals from the African (i.e., Ethiopian, Eritrean and Somali) community, three with individuals from the African American community, and two with individuals from the Russian/Ukrainian community. A total of 89 individuals—42 Africans, 27 African Americans, and 20 Russians/Ukrainians—participated in the community conversations.

For each group, CMCH: 1) worked with community partners to recruit individuals to participate; 2) hosted the community conversations at sites that were comfortable for participants; 3) arranged refreshments; and 4) paid \$50 stipends to participants. For the community conversation with Somalis, we contracted with Afrique Service Center to: 1) recruit individuals to participate; 2) host the community conversation; and 3) arrange refreshments. We paid the \$50 stipends directly to participants.

African community

CMCH conducted four, 90-120-minute community conversations with:

- A group of Ethiopian men (n = 10)
- A group of Ethiopian women (n = 10)
- A group of Eritrean men and women (n = 11)
- A group of Somali men and women (n = 11)

African American community

CMCH conducted three, 90-120 minute community conversations:

- Residents and staff of Aridell Mitchell Home (n = 10)
- Members of Emerald City Community Seventh Day Adventist Church and other individuals from the African American community (n = 10)
- Members of New Hope Missionary Baptist Church (n = 7)

Russian/Ukrainian community

CMCH conducted two, 90-120 minute community conversations with:

- A group of younger Russian-/Ukrainian-speaking people (n = 10)
- A group of older Russian-/Ukrainian-speaking people (n = 10)

Before starting the community conversations, the facilitators asked participants to complete a survey that included questions regarding:

- Demographics
- Knowledge, attitudes and beliefs about H1N1
- H1N1 vaccine experience
- Outreach and communications efforts

For those who were unable to read the form, the facilitators read the questions and answers. With verbal permission from the participants, they audiotaped the discussions.

During the community conversations, we explored issues with participants including, but not limited to:

- Knowledge, attitudes and beliefs about H1N1—what they heard about H1N1 and what action(s) they took in response to the information they received
- H1N1 vaccine experience
- How to design outreach and communications efforts—where/how they get information about health-related issues; where they go for information and/or services on urgent health issues such as H1N1; what types of information about urgent health issues are most helpful

Please refer to Appendix D for the “Focus group survey—community members” and to Appendix E for the “Focus group protocol—community members.”

Findings

1. Review of internal documentation

The following are key findings from the review of internal documentation:

- During the three-month period from October 20, 2009 through January 20, 2010, the CCN received nine communications. In some cases, the VPAT sent communications within days of each other (e.g., communications on October 20 and October 23).
- Many of the communications contained duplicate information/information that was included in earlier messages.
- The communications appeared to primarily focus on vaccine availability. None of the communications appeared to address potential community/cultural concerns about H1N1.
- Many of the communications were long and included detailed information that may not have met the needs of individuals with low health literacy.
- In the “Basic flu information” section of PHSKC’s “H1N1 influenza (swine flu)” webpage, translated publications were available in four languages for the East African, Russian and Ukrainian communities—Amharic, Somali, Russian and Ukrainian. Translated publications included: 1) “When to seek medical care for possible influenza, including H1N1 influenza (swine flu)”;
- 2) “Home with Flu”;
- and 3) “H1N1 (swine flu) vaccination for pregnant women.” None of the information appeared to have been translated into Tigrigna. “Quick Flu Tips for Parents” appeared to have been translated into Russian only.
- In the “For King County schools, child care and early childhood programs” section of the webpage, none of the information appeared to have been translated into other languages (other than the publications listed above).
- In the “For businesses and employers” section of the webpage, none of the information appeared to have been translated into other languages, other than public education materials available in other sections of the webpage. These public education materials included: 1) “Concerned about H1N1 (swine) flu vaccination for yourself or your child?” (translated into Amharic, Oromo, Somali, Tigrigna, Russian, Ukrainian); and 2) “Home with Flu” (translated into Amharic, Somali, Russian and Ukrainian). The Public Service Announcement was translated into Spanish only.
- In the “For community organizations and human service providers” section of the webpage, some of the information was translated into various languages for the East African, Russian and Ukrainian communities. Translated publications included: 1) “Looking for H1N1 (swine) flu vaccine in King County?” (translated into Amharic, Somali, Russian, Ukrainian); 2) “Free H1N1 Clinics for Children in April” (also available in Amharic, Oromo, Somali, Tigrigna, Russian, Ukrainian); 3) “When to Get Medical Help for H1N1 (Swine) Flu (translated into Somali, Russian, Ukrainian).
- In the “Public education materials” section, none of the information appeared to have been translated, other than those materials listed above.
- Although materials were available in multiple languages, the artwork appeared to be the same in each publication.

2. Focus group with PHSKC staff

The group felt that PHSKC was effective in reaching out to African immigrants during the 2009 H1N1 influenza response. They noted that public education materials were available in several African languages including Amharic, Tigrigna and Somali. However, the group did not feel that PHSKC was effective in specifically reaching out to African Americans.

The group stated that the media played a major role in increasing awareness about H1N1 and that CNN was instrumental in increasing knowledge and awareness about H1N1 in the African American community. They acknowledged that PHSKC had some visibility in the media, but felt that the spokespeople were not culturally appropriate and, therefore, not effective in reaching the African American community. Some group members stressed the importance of targeting African American men because they do not tend to access health care services on a regular basis.

In addition, the group felt that the media and health care providers were encouraging people to get vaccinated, even when there was a vaccine shortage, and that messages about priority groups for vaccination were unclear. They also felt that there were clear messages for pregnant women to get the H1N1 vaccine, but that it was difficult to encourage pregnant women to get vaccinated because of concerns about vaccine safety. The group noted that many African Americans were reluctant to get vaccinated because of long-standing distrust of PHSKC/the government and drug companies. Therefore, they said that community members often waited to get vaccinated until stories surfaced about people dying or because they felt that they would develop natural immunity to H1N1. In general, the group felt that community members were more likely to get the H1N1 vaccine if they had a personal relationship with a trusted health care provider and/or believed that getting the vaccine would help protect their family members. Some group members shared their observations that few African Americans seemed to get vaccinated (e.g., only about 10 of 800 people vaccinated at Columbia Public Health Center were African American; no African Americans in line for vaccinations on the Eastside).

The group indicated that PHSKC employees convened to brainstorm how to reach out to the African American community during the 2009 H1N1 influenza response and compiled a list of community groups and organizations that should receive information about H1N1. However, they felt that PHSKC did not follow through in reaching out to groups/organizations that are connected to the African American community—barber and beauty shops, churches, community centers, libraries, schools, senior centers, social groups (Boule, Breakfast Group, First Thursday Seattle, The Links) and sports groups. In addition, the group noted that PHSKC was not prepared to go into the broader community to deliver messages about H1N1. For example, PHSKC staff were given fact sheets to distribute to public schools. However, the group commented that some schools closed during the outbreak and that many African American children were not attending school because schools in their neighborhoods were closed. At the same time, they acknowledged that the African American community is disperse, so there are challenges with community outreach and communications. In terms of maximizing the reach and impact of information, the group talked about being genuine and honest, building personal relationships with community groups and organizations that are connected to the African American community (Center for MultiCultural Health), working with community leaders (trusted health care providers such as Dr. Ben Danielson and Dr. Maxine Hayes and politicians such as Larry Gossett and Norm Rice), and using culturally appropriate media outlets (community newspapers such as *The Facts* and *The Seattle Medium*, radio stations such as KKNW 1150 AM, KRIZ 1420 AM/KZIZ 1560 AM, KMCQ 104.5 FM, KUBE 93.3 FM).

The group noted that PHSKC had provider focus groups on H1N1 (primarily related to the H1N1 vaccine vs. general information about H1N1), but that no focus group was done with providers who target African Americans. In general, they felt that the focus groups were not effective in reaching providers.

The group also expressed frustration that they are not at the table and/or not heard within the broader system at PHSKC. They felt that PHSKC's efforts could have been more effective and that they could have helped more with outreach to the African American community, if they had been truly involved at the beginning of the outbreak and throughout the outbreak response.

Key informant interviews—community leaders

African community leaders—Ethiopian

- *Mr. Assaye Abunie, Program Director, Ethiopian Digital & IT Services and Multimedia Resources & Training Institute*

Mr. Abunie stated that he heard about H1N1 from the media—television (CNN and KOMO 4) and radio (NPR)—and from the Internet. He heard that H1N1 was a “killer disease” that affected children and older adults more than others and that there was initially a vaccine shortage. After hearing about H1N1, Mr. Abunie had additional questions about whether or not H1N1 was a man-made virus and about vaccine side effects and how effective any available medications may be.

Mr. Abunie said that community members heard that H1N1 was a “killer disease” that kills people in a short period of time and that children and older adults are more vulnerable than others. He said that many parents were scared to hear that children were considered to be vulnerable. Mr. Abunie reported that community members heard that they should avoid crowded areas and that there was a vaccine shortage. He identified a number of questions that community members had about H1N1, including whether or not H1N1 was from birds or pigs and about vaccine safety and side effects, the curability of H1N1, effectiveness of any available medications, and how to prevent and get treated for H1N1. Mr. Abunie reported that community members avoided crowded areas (e.g., public transportation), washed their hands and/or used hand sanitizer frequently, and, in some cases, went to the emergency room or stayed home, if possible. He also reported that some community members got vaccinated, but that lack of accurate information and outreach—especially to low-income people and people with lower levels of education—fear of vaccine side effects, and the reports of vaccine shortage were barriers for many in getting vaccinated.

In terms of where individuals in the Ethiopian community get information about health-related issues, Mr. Abunie indicated that community members get information from the media—television (Ethio Youth Media and Andenet TV/Seattle Community Access Network), radio (Ethiopian radio journalist Ms. Nigist Selfu’s program on KLF 1590 AM), and newspapers (*Salon Ethiopia*). In addition, he indicated that they get information from community groups/organizations—including the Abole, Ethiopian, Gondar, Oromo and Tigray networks; Seattle Baro and Seattle Dashen Sports Clubs; and Ethiopian Educational Cultural and Sport Center—and family members and friends. Mr. Abunie suggested that the reach and impact of information shared through these media/venues could be maximized through organizing group discussions, health fairs, workshops, mass media and work with community-based health councils. Mr. Abunie felt that community members are aware of community health centers (Center for MultiCultural Health) and private providers (Group Health Cooperative, Pacific Medical Centers) where they can get information and/or services on urgent health issues such as H1N1, but that culture, language, and lack of outreach by service providers to community-based organizations were barriers to accessing information/services through these venues. He felt that these barriers could be addressed by having service providers increase community outreach and work with Ethiopian community-based organizations (Ethiopian Community Mutual Association, Gondar Mutual Association, Oromo Community Center, Tigray Community Association).

Mr. Abunie noted that community members often want to try traditional methods of addressing health issues before Western medical approaches. He also noted that they typically do not access preventive services, but go to health care providers only if they are ill. Mr. Abunie suggested that messages about urgent health issues stress the importance of prevention and disease impact on the community. He also suggested that community members need to be involved, so that messages are culturally and linguistically appropriate. Finally, Mr. Abunie said that he was not contacted by

PHSKC or others about reaching out to community members about H1N1, but that, as a community leader, he broadcasted a program about H1N1 on Ethio Youth Media. In the future, he felt that he could share information through a variety of media outlets, organize group discussions and workshops, and work with community-based health councils.

- *Ms. Mulumebet Retta, Chair, Ethiopian Community Mutual Association*

Ms. Retta said that she heard about H1N1 via the media—television (channels 4, 5 and 7), radio (NPR 88.5 and 94.9 FM), and newspapers (*Seattle Times*/internet-based)—as well as through health care providers and her workplace. She heard that H1N1 was a dangerous communicable/viral disease. Ms. Retta heard that the H1N1 vaccine was available in many places, but that there was an occasional shortage and that priority was given to children, older adults and those with other health problems. She also heard that there were people who were initially unable to get vaccinated, but that eventually everyone got the vaccine. Ms. Retta was aware that the H1N1 vaccine was different from the seasonal flu vaccine. After hearing about H1N1, she had additional questions about how people get the virus and how to prevent infection.

Ms. Retta stated that community members heard that H1N1 was a “killer disease” and that the H1N1 vaccine was different than the seasonal flu vaccine. She stated that community members also heard about occasional vaccine shortages and that some people were not able to get vaccinated. Ms. Retta indicated that community members had many questions about H1N1 including how it is transmitted. She said that community members avoided kissing people, stayed home if they were sick, and washed hands and used hand sanitizers frequently. At the same time, Ms. Retta noted that many community members believe that life is pre-destined; they believe that, if it is your time, you will die, and, if not, you will not die. She also noted that some community members believed that eating hot pepper in their food protected them from H1N1.

In terms of where individuals in the Ethiopian community get information about health-related issues, Ms. Retta said that they get information from the media—television (Andenet TV/Seattle Community Access Network), radio (Ethiopian radio journalist Ms. Nigist Selfu’s program on KLFE 1590 AM), and newspapers (*Salon Ethiopia*)—as well as through community groups/organizations (Ethiopian Community Mutual Association) and family members and friends. She suggested that the reach and impact of information shared through these media/venues could be maximized by keeping information simple and in community members’ home language (Amharic) and having information shared by someone from the Ethiopian community. Ms. Retta felt that community members are aware of community health centers, public health centers and other health care institutions (Harborview Medical Center) where they can get information and/or services on urgent health issues such as H1N1, but that there are cultural and linguistic barriers and, in some cases, immigration status issues, that cause barriers to accessing these community resources. She indicated that patient and provider education and interpretation services could help address these barriers.

Ms. Retta said that community members tend to use herbal or other traditional methods of healing before accessing Western medical care. Therefore, community members often seek help late, even with urgent health issues such as H1N1. Ms. Retta felt that giving factual information about urgent health issues and working with community leaders and educated people in the community to deliver information are critical. She noted that she received many e-mail messages from PHSKC. In response, Ethiopian Community Mutual Association organized two community meetings with health care professionals and broadcast a television program on Andenet TV/Seattle Community Access Network with opportunities for viewers to call in and ask questions of invited experts. Ms. Retta indicated that she and other community leaders can play similar roles in educating community members about other urgent health issues.

African community leaders—Eritrean

- *Ms. Mebret Mehanzel, Co-Founder and Teacher, Black Star Line African Centered Family Educational Collective*

Ms. Mehanzel said that she heard about H1N1 via radio (NPR), Black Star Line African Centered Family Educational Collective, and Odessa Brown Children's Clinic. She heard that H1N1 was deadly and stronger than seasonal flu and that children, elderly people and pregnant women were vulnerable. In addition, Ms. Mehanzel heard that the H1N1 vaccine was different from the seasonal flu vaccine and that there was a vaccine shortage. She noted that she had additional questions about how to prevent exposure to H1N1 and the anticipated duration and impact/strength of the H1N1 outbreak.

Ms. Mehanzel indicated that community members heard about H1N1 and heard the same information that she did. She said that community members had additional questions about what would happen with H1N1 in the future and how to protect their families. Ms. Mehanzel noted that the majority of community members got vaccinated, but there was some fear about vaccine effectiveness and safety. In addition, she noted that community members limited large social gatherings, kept sick children home and consulted with community nurses, and washed hands and used hand sanitizers frequently. Ms. Mehanzel mentioned that it was challenging for community members to stay home when they were sick.

In terms of where individuals in the Eritrean community get information about health-related issues, Ms. Mehanzel reported that community members get information from Black Star Line African Centered Family Educational Collective, Odessa Brown Children's Clinic and PHSKC and that the reach and impact of information shared through these venues could be maximized through partnerships with community leaders. She felt that community members are aware of community health centers, public health clinics and other health care institutions where they can get information and/or services on urgent health issues such as H1N1 and that there are no barriers to accessing these community resources.

Ms. Mehanzel stated that cultural beliefs greatly influence community members' knowledge, attitudes and beliefs about urgent health issues such as H1N1. She suggested that messages about urgent health issues emphasize how to prevent exposure and where to get services, as well as affirm cultural practices such as having a healthy organic diet, bathing, steaming with eucalyptus leaves and using essential oils. Ms. Mehanzel indicated that she was not contacted by PHSKC or others about reaching out to community members about H1N1, but that she had a community meeting in which she shared information about H1N1. She felt that she and other community leaders could play a role in learning about urgent health issues such as H1N1 and then talk about resources and organize meetings.

- *Mr. Amanuel Yohannes, Director, Salaam Urban Village Association*

Mr. Yohannes indicated that he heard about H1N1 from the media—television (CNN) and newspapers (*Seattle Times*). He heard that H1N1 was a “killer disease” that came from chickens and that children and older adults were particularly vulnerable to H1N1. In addition, Mr. Yohannes heard that there was a vaccine for H1N1, but did not hear about vaccine shortage. He noted that he had additional questions about how to avoid getting infected.

Mr. Yohannes reported that community members heard about H1N1 and heard the same information that he did. He said that community members had additional questions about how to avoid getting infected and that elders got vaccinated and stayed away from farming areas.

In terms of where individuals in the Eritrean community get information about health-related issues, Mr. Yohannes indicated that they get information from the media—television (local channels), radio (NPR) and newspapers (*Seattle Times*). He also indicated that they get information from DSHS, public health and schools and that the reach and impact of information shared through these media/venues could be maximized through partnerships with community groups and organizations such as Salaam Urban Village Association. Mr. Yohannes felt that community members are aware of community health centers, public health clinics (Columbia Public Health Center, North Public Health Center) and other health care institutions (Center for MultiCultural Health, Group Health Cooperative, Harborview Medical Center, University of Washington) where they can get information and/or services on urgent health issues such as H1N1, but that culture, lack of health insurance and difficulty in getting appointments were barriers to accessing information through these venues. He felt these barriers could be addressed by clinics being more accommodating to newcomers.

Mr. Yohannes said that community members have little knowledge about prevention and often delay seeking medical care. He felt that it was important to educate community members about the importance of having regular semiannual check-ups. Mr. Yohannes indicated that he was not contacted by PHSKC or others about reaching out to community members about H1N1 and did not take any action related to H1N1 because of lack of funding. In the future, he said that he and other community leaders could disseminate information about urgent health issues such as H1N1 and connect community members with service providers. He also said that public health departments should work closely with groups such as Salaam Urban Village Association.

African community leaders—Somali

- *Mr. Mohamed Sheikh Hassan, Director, Afrique Service Center*

Mr. Hassan reported that he heard about H1N1 from the media—television (KING 5), radio (NPR/94.9 FM) and newspapers (*Seattle Times*). In addition, he reported that he heard about H1N1 from PHSKC (Robin Pfohman) and through an Islamic scholars' paper. Mr. Hassan heard that H1N1 was a “killer disease” that affected children, pregnant women, and older adults more than others and that there was initially a vaccine shortage. Despite the information that he received, he had additional questions about how H1N1 is transmitted, the best ways to prevent infection and availability of the vaccine.

Mr. Hassan indicated that community members heard about H1N1 and that children and pregnant women were particularly vulnerable. He said that community members were very disturbed to hear that children were particularly vulnerable to H1N1. Mr. Hassan stated that community members heard that the vaccine had a component from pork, that the H1N1 vaccine was different than that for seasonal flu, and that there was a vaccine shortage. He also stated that community members had additional questions about H1N1, specifically about how the disease started and if it started in Mexico, whether or not pork created the problem of H1N1, and whether or not the H1N1 vaccine contained pork. Mr. Hassan noted that community members received hand sanitizer from PHSKC and washed their hands frequently. He noted that many community members avoided crowded areas/spaces (e.g., public transportation), cancelled community events and stayed home, if possible. Mr. Hassan reported that some community members got vaccinated, but that fear of vaccine safety and the reports of vaccine shortage were barriers for many in getting vaccinated. In addition, he mentioned that language was a barrier to getting information about H1N1 and that getting information via their children was not well-accepted.

In terms of where individuals in the Somali community get information about health-related issues, Mr. Hassan indicated that community members get information from television (Somali television programs), community groups (Afrique Service Center), and family members and friends and that they do not read brochures and other written materials. He felt that community members are aware of community health centers, public health clinics and other health care institutions where they can get information and/or services on urgent health issues such as H1N1, but that culture, language and transportation were barriers to accessing information/services through these venues. Mr. Hassan felt that these barriers could be addressed through hiring Somali staff and increasing the availability of interpreters. He did not have any suggestions for addressing transportation barriers. Mr. Hassan commented that other places such as Afrique Service Center were considered true community resources and recommended that health care providers connect and create working relationships with community leaders, so that they can educate and disseminate information to community members.

Mr. Hassan noted that community members often want to try religious or traditional methods of addressing health issues before Western medical approaches. He also noted that they typically do not access preventive services, but go to health care providers only if they are ill. Mr. Hassan suggested that messages about urgent health issues be holistic and stress the importance of community members caring for each other. Finally, Mr. Hassan said that he was contacted by PHSKC (specifically Robin Pfohman) about reaching out to community members about H1N1, and that, as a community leader, he educated community members about H1N1 and its impact and how to protect themselves.

- *Ms. Ayan Qumane, Assistant Teacher for Afrique Service Center and Secretary of Muslim Students Association*

Ms. Qumane said that she heard about H1N1 from the media—television (KOMO 4) and radio (NPR/94.9 FM)—and from the mosque, family members and friends. She heard that H1N1 was a deadly disease that came from Latin America and had something to do with pigs. However, Ms. Qumane also heard that people who do not eat pork can still get H1N1. She heard that H1N1 was like seasonal flu, but perhaps more severe (including fever, headache and vomiting), and that this information was confusing. Ms. Qumane did not hear that it was more serious for some groups, but, like other diseases, may affect infants and older adults more than others. She heard that H1N1 was spreading during air travel and that people with H1N1 should not travel. Ms. Qumane also heard that people should seek immediate help if they are sick. She had additional questions about the number of people in Seattle who were diagnosed with H1N1, “natural” ways to prevent infection (e.g., diet, washing hands), and the cost of the vaccine.

Ms. Qumane said that community members heard about H1N1 through the media and knew that H1N1 was a serious/urgent health issue, but did not necessarily hear that there were some groups for which H1N1 was more serious than others. In addition, she said that community members were aware of the vaccine, but did not know there was a shortage. Ms. Qumane reported that community members were not sure if they would get H1N1 because they do not eat pork and if they needed to get the vaccine, how urgent it was and where to get it. She noted that community members were talking about H1N1 and that information was provided at the mosque. Ms. Qumane also noted that people seemed to be washing their hands frequently, not touching door handles and staying home if they were severely ill. She said that some community members got vaccinated, but that lack of clear and specific information—especially for people who do not speak English—cost/lack of insurance and concern about vaccine safety were barriers for many in getting vaccinated. Ms. Qumane noted that much of the information about H1N1 was “huge” and “confusing.”

In terms of where individuals in the Somali community get information about health-related issues, Ms. Qumane indicated that community members get information from television (local channels and Somali television programs), community groups (Afrique Service Center), mosques, schools, health care providers, and family members and friends. She suggested that the reach and impact of information shared through these media/venues could be maximized by attending community gatherings and communicating face-to-face in Somali. Ms. Qumane felt that community members are aware of community health centers (Rainier Park Medical Clinic), public health clinics (Columbia Public Health Center) and other health care institutions (Harborview Medical Center, University of Washington) where they can get information and/or services on urgent health issues such as H1N1, but that lack of health insurance was a barrier to accessing information/services through these venues. She felt that these barriers could be addressed through increasing health insurance coverage and decreasing out-of-pocket costs.

Ms. Qumane stated that culture and religion are powerful in terms of health. She suggested that messages about urgent health issues emphasize the importance of seeking help, even if there are concerns about cost, and of the community helping each other out and taking care of vulnerable groups. Ms. Qumane said that she was not contacted by PHSKC or others about reaching out to community members about H1N1, but that, as a community leader, she convened community gatherings and discussions. In the future, she felt that she could educate and provide transportation to community members, with appropriate training and support.

African American community leaders

- *Ms. Nichelle Alderson, Chair, Health Committee, Seattle Chapter of the NAACP*

Ms. Alderson said that she heard about H1N1 vaccine everywhere—via television, newspapers, community groups and organizations, churches/mosques/religious institutions, schools, health care providers, and family members and friends, as well as PHSKC, internet and work. She heard that it was important to get vaccinated and that H1N1 was more serious for young children and the elderly. Ms. Alderson indicated that she heard about the vaccine shortage and wondered if there was a shortage in areas that were not heavily populated by people of color. She had additional questions about H1N1, including risks for H1N1 and how to prevent it, signs and symptoms of infection, and how to distinguish it from seasonal flu.

Ms. Alderson said that community members heard about H1N1 and that it was more serious for young children and the elderly. She said that community members did not have additional questions about H1N1 and that they were opposed to the vaccine because of resistance to being “guinea pigs.” Ms. Alderson said that community members washed hands and used antibacterial soap and hand sanitizers frequently and that they avoided large public gatherings (e.g., community events), stayed home when they were sick and encouraged co-workers to stay home if they were sick.

In terms of where individuals in the African American community get information about health-related issues, Ms. Alderson reported that community members get information via the media—television, radio and newspapers—as well as community groups/organizations, schools, health care providers, family members, friends and other places such as grocery stores. She suggested that the reach and impact of information shared through these media/venues could be maximized by dispelling long-standing myths about medical experimentation. Ms. Caupain said that community members are aware of community health centers, public health clinics and private providers where they can get information and/or services on urgent health issues such as H1N1, but that the cost of health care services, lack of health insurance, lack of transportation, and lack of knowledge about

how to obtain no/low-cost services were barriers to accessing information/services through these venues. She felt that these barriers could be addressed through helping community members access information about how to obtain no/low-cost services and through outreach to homeless people via shelters and the *Real Change* newspaper.

Ms. Alderson stated that community members are not “apt to jump when they’re told to jump” and that H1N1 was perceived as just another “scary” disease. She said that she was not contacted by PHSKC about reaching out to community members about H1N1 and did not take specific actions as part of the NAACP Health Committee, because the Committee was not in place at that time. Ms. Alderson indicated that community leaders can play a role in educating community members about urgent health issues such as H1N1 and, in general, in encouraging community members to establish a relationship with a primary care physician and seek regular medical care vs. using emergency rooms.

- *Ms. Andrea Caupain, Executive Director, Central Area Motivation Program (CAMP)*

Ms. Caupain indicated that she heard about H1N1 via television (CNN, local news outlets), community leaders and partner organizations, schools, and family members and friends. She heard that H1N1 was devastating, particularly for older adults and those with compromised immune systems, and that there was a vaccine shortage. Ms. Caupain had additional questions about vaccine effectiveness and how the H1N1 and seasonal flu vaccines might affect each other. She also had questions about what precautions CAMP should take to educate and protect its staff, so they could continue to provide services in the event of a mass outbreak.

Ms. Caupain said that community members heard about H1N1 on television and via word-of-mouth and noted that, in immigrant and refugee communities, a lot of information about H1N1 was shared via word-of-mouth. She indicated that community members had additional questions, but that she was uncertain about their actual questions. Ms. Caupain commented that many community members had misinformation about the H1N1 vaccine effectiveness and side effects and that there were both community members who believed that it was important to get the vaccine and others who did not want to get the vaccine because of fear of vaccine side effects.

In terms of where individuals in the African American and immigrant and refugee communities get information about health-related issues, Ms. Caupain indicated that community members get information from the media—television and newspapers (hard copy only)—as well as schools, health care providers, and family members and friends. She suggested that the reach and impact of information shared through these media/venues could be maximized by coupling the information with other information that is easily received and by simplifying messages (e.g., information from PHSKC and other agencies with clear, simple messages like “wash your hands”). Ms. Caupain said that community members are aware of community health centers (Country Doctor Community Health Centers, Odessa Brown Children’s Clinic) and other health care institutions (Harborview Medical Center, Swedish Medical Center) where they can get information and/or services on urgent health issues such as H1N1, but that apprehension about seeking health care services due to miseducation/misinformation and cost were barriers to accessing information/services through these venues. She felt that these barriers could be addressed through cultural competence and education from trusted advocates—people who look like them and speak in language that they will understand.

Ms. Caupain stated that cultural beliefs and practices strongly influence immigrants and refugees’ knowledge, attitudes and beliefs about urgent health issues such as H1N1 and that religious beliefs play a major role in whether or not to seek advice from a health care provider. She also stated that some undocumented people will not seek services from any entity that is perceived as having a

relationship with the U.S. government. Ms. Caupain added that information should be presented in a culturally relevant manner, because some communities are suspicious about information provided to the general public. She noted that information should address concerns about the outbreak, not necessarily where the virus came from or how it came to the U.S. Ms. Caupain suggested that messages about urgent health issues be simple and include what steps community members should take to prevent or decrease their chances of getting sick, signs and symptoms, and where community members can seek services. She indicated that she was not contacted by PHSKC, but that CAMP staff disseminated information about H1N1 to clients and talked with them about the H1N1 vaccine. Ms. Caupain noted that community-based organizations can create or identify trusted advocates that community members can turn to for information about urgent health issues such as H1N1, if they are apprehensive about “formal sources” (e.g., government entities, health care institutions). She further noted that PHSKC should do specific, coordinated outreach to community-based organizations and make it easy for community members to access information.

- *Dr. Ben Danielson, Medical Director and Pediatric Physician, Odessa Brown Children’s Clinic*

Dr. Danielson reported that he initially heard about H1N1 in the medical literature and, later, from PHSKC in February/March 2009 through mobilization activities. He said that the initial academic interest about H1N1 in the medical literature later turned into discussion regarding whether or not H1N1 would rise to the same level as the 1918 “Spanish Flu” pandemic. Dr. Danielson indicated that his patients heard about H1N1 from news sources and flyers posted by PHSKC and community partners. He also indicated that some of his patients wondered if H1N1 was overplayed or underplayed and whether or not there were different messages for less empowered vs. more empowered neighborhoods. In addition, Dr. Danielson noted that, in the midst of the economic crisis, his patients had concerns about where resources would be allocated and whether or not everyone would have equal access to services.

Dr. Danielson indicated that he and his staff participated in a number of PHSKC-sponsored meetings about H1N1 and had to share information with patients and interpret information coming out about vaccine shortages and plans for distribution vs. how the vaccine seemed to be handled at a practical level. He said that there were families—both African American and not—who expressed deep reservations about vaccines in general and about the safety of a vaccine like H1N1 that is developed quickly. Dr. Danielson felt that community members heard the messages about washing hands and gradually listened to the messages about staying home when sick. He noted that there was a lot of information management related to H1N1 and that messages changed over time, creating some discomfort among community members. Dr. Danielson commented that some of the messaging evolved appropriately, but some could have been better, in terms of hitting “the right mark early on.” He said that the media contributed to “scare mongering” (e.g., Madrona Elementary School and subsequent school closures) and created fear among families.

In terms of where individuals in the African American community get information about health-related issues, Dr. Danielson talked primarily about the importance of correct, straightforward and consistent messaging that includes visuals. He said that messaging from the health care system is often full of language that is vague and unnecessarily complicated, but commented that PHSKC has become relatively good at incorporating good visuals into its messaging. Dr. Danielson suggested that the reach and impact of information shared through these media/venues could be maximized through consistent messages (with visuals) spread throughout the community and through having trusted people to address community members’ concerns. He said that it was hard to say if community members are aware of community health centers, public health clinics and other health care institutions where they can get information and/or services on urgent health issues such as H1N1. Dr. Danielson said that barriers to accessing these types of community resources include

literacy—both health literacy and literacy in English. He noted that the health care community relies a lot on the written word, but that it is not always effective. Dr. Danielson also talked about community members' distrust of and misperceptions about the health care system and confusion and lack of understanding about prevention due, in part, to outlier cases (e.g., individual who gets the flu after receiving a flu shot) and historical problems with the planning, development and distribution of vaccines (e.g., swine flu in the 1970s).

Dr. Danielson stated that cultural beliefs and practices influence a community's knowledge, attitudes and beliefs about urgent health issues such as H1N1. He said that many communities believe that the health care system may or may not make people sicker and, therefore, there is not reason to access health care services if they are healthy. Dr. Danielson commented that community members often have cultural beliefs and practices that they are reluctant to share with traditional health care providers and that, until health care providers are able to appreciate all of the decision-making that goes into how a family manages wellness, no single intervention, process or program will be all that successful. He also commented that being a patient is a very disempowering position in American society.

Dr. Danielson stressed the importance of keeping health issues in perspective. He noted that the H1N1 outbreak was costly and that it is critical to remember not to devalue other health messages (e.g., diabetes, heart disease, hypertension, obesity) that are very important. Dr. Danielson stated that he was contacted by PHSKC and others about reaching out to community members about H1N1 and commented that there was some level of information overload. He also commented that a lot of the messaging regarding H1N1 could have been simpler and shared in ways that were less overwhelming for community members. Dr. Danielson noted that constant updates with no new information were overwhelming for health care providers and that some providers began reviewing information less critically or simply deleting e-mail messages that they received about H1N1. He said that .

- *Ms. Elizabeth Thomas, retired nurse, Odessa Brown Children's Clinic (additional affiliations with the Equal Start Community Coalition, First Place School and Mary Maboney Professional Nurses Organization)*

Ms. Thomas stated that she heard about H1N1 via television (KOMO 4), schools and health care providers (Odessa Brown Children's Clinic, Seattle Children's Hospital). In addition, she noted that quite a few children at First Place School got sick and had difficulty fighting their illness. Ms. Thomas said that the initial information about H1N1 was conflicting and scary and that "H1N1" was a confusing term for some community members. She knew that H1N1 was a very serious health issue and understood that those with compromised immune systems were vulnerable to H1N1. However, she indicated that the vaccine shortage was the biggest problem during the outbreak. Ms. Thomas noted that, even as a health care professional, she wanted additional information about how to respond to H1N1 because the vaccine was not initially available for people her age.

Ms. Thomas indicated that community members heard about H1N1 via the news. She said they heard that H1N1 is a virus, but were confused by messages that H1N1 was serious and an urgent health issue, but they may or may not need to seek medical care. In addition, Ms. Thomas said that those who sought medical care were often told that they should just monitor their illness and that was also confusing. She noted that community members were interested in getting the H1N1 vaccine, but had questions about the vaccine shortage. Ms. Thomas mentioned that she referred children from First Place to Odessa Brown Children's Clinic, but Odessa Brown did not have the vaccine. She also mentioned that the vaccine was eventually available at local pharmacies (Bartell Drugs, Walgreen), but some community members were reluctant to get vaccinated at pharmacies and those who chose to get vaccinated at pharmacies ended up standing in long lines. Ms. Thomas commented that the vaccine distribution system could have been better. She said that hand sanitizer

was everywhere in the community and that community members washed hands and used hand sanitizer frequently and covered their mouths when coughing and sneezing. Ms. Thomas commented that the H1N1 outbreak really created awareness about how to avoid spreading germs. She noted that community members would stay home if they had a temperature, but that many parents struggled with whether or not to send their children to school if they had low-grade temperatures because their work schedules made it difficult to stay home with children.

In terms of where individuals in the African American community get information about health-related issues, Ms. Thomas indicated that community members get information via television and health care providers. She suggested that the reach and impact of information shared through these media/venues could be maximized by having written information distributed at community centers and through existing or newly created coalitions of community groups and organizations (Equal Start Community Coalition). Ms. Thomas said that community members are aware of community health centers (Carolyn Downs Family Medical Center, Country Doctor Community Clinic, 45th Street Medical Clinic, Odessa Brown Children's Clinic) and other health care institutions (PHSKC) where they can get information and/or services on urgent health issues such as H1N1, but that accessibility/transportation and not having a medical home/usual source of medical health were barriers to accessing these community resources. She felt that these barriers could be addressed by getting community leaders and community organizations (e.g., Equal Start Community Coalition) more involved in getting information out to community members. However, Ms. Thomas noted that information is often available, but there is no money to get the information out to community members.

Ms. Thomas stated that some community members—particularly older people—are scared about urgent health issues such as H1N1. She said that community members wonder if H1N1 is “the real thing” and if they are being given experimental treatment. Ms. Thomas felt that community members need to know that it is important to address urgent health issues such as H1N1 to take care of themselves and their families. She stressed the importance of information that is culturally relevant and specific, working with community leaders and churches to share information with community members, and meeting community members “where they are.” Ms. Thomas indicated that she was not contacted by PHSKC or others about reaching out to community members about H1N1. However, in the future, she suggested that PHSKC compile contact information for community leaders, so that they can mobilize them to get involved and answer questions about urgent health issues such as H1N1.

- *Ms. Jeri White, Executive Director, Southeast Youth and Family Services*

Ms. White said that she heard about H1N1 via the media—television (KING 5 news, commercials) and newspapers (*Seattle Times*)—as well as through e-mail messages from PHSKC (specifically June Beleford) and family members. She heard that H1N1 was the worst type of flu/deadly and that the regular flu shot was not effective in preventing H1N1. Ms. White stated that it was discouraging to hear that H1N1 was deadly, but that there was really nothing that health care providers could do to help those who contracted H1N1. After hearing about H1N1, she had additional questions including when the H1N1 vaccine would be available and how to tell the difference between H1N1 and seasonal flu.

Ms. White indicated that community members were discouraged by the lack of availability of H1N1 vaccine, but, in some cases, were scared to get the vaccine because they remembered that people who got vaccinated during a previous flu outbreak got sick. She also indicated that some community members felt like people were trying to kill them with a vaccine that may actually give them H1N1. Ms. White noted that community members had additional questions about where to get the H1N1 vaccine and vaccine safety. She said that community members may have used hand sanitizer to avoid

getting sick or passing H1N1 to others and that she encouraged her staff to stay home if they were sick and to stay away from those who were sick. Ms. White felt that some community members may have been vaccinated if they had a good relationship with health care providers, but that, for the most part, community members did not get vaccinated.

In terms of where individuals in the African American community get information about health-related issues, Ms. White stated that community members get information via the media—television (local stations) and newspapers (*The Facts*, *The Seattle Medium*)—as well as through health care providers. She suggested that the reach and impact of information shared through these media/venues could be maximized through media campaigns promoting community health centers and public health clinics and community-based health fairs with churches. Ms. White also suggested that health care providers need to better understand that community members will only access medical care when they are seriously ill and understand the importance of meeting community members where they are with health information. She felt that community members are aware of community health centers (Carolyn Downs Family Medical Center, Odessa Brown Children’s Clinic) and public health clinics (Columbia Public Health Center) where they can get information and/or services on urgent health issues such as H1N1. However, Ms. White said that many community members think that these institutions are for “yuppies” (Country Doctor Community Clinic), poor people or just for children. She noted that people with children feel good about Odessa Brown Children’s Clinic because of its affiliation with Seattle Children’s Hospital. However, Ms. White also noted that she and other community members believe that you get sub-standard care at community health centers and public health clinics because doctors in these types of settings are not as qualified as those in the private sector. She suggested that these barriers could be addressed by increasing knowledge and awareness that these institutions have well-qualified doctors and that some are affiliated with larger institutions (e.g., Group Health Cooperative, Swedish Medical Center) and convenient. Ms. White felt that larger institutions should promote their affiliation with community health centers and public health clinics.

Ms. White stressed that there is a “long memory of terrible things,” so the last H1N1 outbreak was in some community members’ minds. She said that H1N1 should not have been referred to as “swine flu” and that switching the term to H1N1 midway through the outreach did not dispel community members’ fears. She stated that the health care community has to be careful about the terminology that it uses and that “scared straight” (e.g., reports of the number of people who were dying) is not necessarily effective or encouraging. Ms. White felt that simple, straightforward information, not “scared straight” tactics, was most important for the African American community. In addition, she noted that working with churches and community organizations and posting information on websites and listservs are important strategies. Ms. White stressed that people often cannot come to meetings because of work, family and other commitments, so educators must be willing to meet community members where and when it is most convenient for them. She felt that she and other community leaders could facilitate access to community resources and noted that e-mails from known and respected people will encourage recipients to read e-mail messages. Ms. White also noted that community leaders and pastors should be featured in marketing campaigns.

Russian/Ukrainian community leaders

- *Ms. Vasilina Martemiak, Producer, Salon of Poetry in Seattle/Salon Poezji w Seattle*

Ms. Martemiak reported that she heard about H1N1 via the media—television (ABC news, Russian Television Network), radio (Russian and American radio) and newspapers (Russian)—as well as through churches/religious institutions, schools, health care providers, and family members and friends. She heard that H1N1 was more serious than seasonal flu and that the H1N1 vaccine was different from the seasonal flu vaccine. Ms. Martemiak said that community members heard that the

H1N1 vaccine was different from the seasonal flu vaccine and that there was a vaccine shortage. She also said that community members had questions about the cause of H1N1. Ms. Martemiak stated that community members washed hands and did not go out when they were sick to avoid getting sick or passing H1N1 to others.

In terms of where individuals in the Russian-speaking community get information about health-related issues, Ms. Martemiak reported that community members get information via the media—television (Russian Television Network), radio and newspapers (Russian newspaper *Perspectiva*)—as well as through churches/religious institutions, schools, health care providers, and family members and friends. She suggested that the reach and impact of information shared through these media/venues could be maximized by having more information in Russian. Ms. Martemiak indicated that community members are aware of public health clinics (Eastgate Public Health Center) and private providers (Dr. Bardman, Dr. Gan, Dr. Grinberg, Dr. Storozhuk) where they can get information and/or services on urgent health issues such as H1N1. She did not feel that there were any barriers to accessing these community resources.

Ms. Martemiak felt that accurate information, not “scare tactics,” was most important for the Russian-speaking community. She said that she was not contacted by PHSKC or others about reaching out to community members about H1N1, but that she and other community leaders could play a role in providing accurate information about H1N1 including asking those who contracted H1N1 to speak out about their experiences.

- *Ms. Nataliya Prisyazhnyuk, Program Director, Circle of Friends*

Ms. Prisyazhnyuk said that she heard about H1N1 via television (Seattle news) and at Circle of Friends (adult day health center). She heard that H1N1 was a serious/urgent health issue, that there were groups for which H1N1 was more serious than others and that there was a vaccine shortage. Ms. Prisyazhnyuk said that she had additional questions about H1N1 including whether or not the strains of H1N1 changed over time, complicating the manufacturing of the vaccine. She indicated that community members heard the same information about H1N1. Ms. Prisyazhnyuk indicated that some community members got vaccinated for H1N1, washed hands, covered their mouths when coughing and stayed away from others who were sick. In addition, she indicated that the RN at Circle of Friends presented information about H1N1 to participants.

In terms of where individuals in the Russian-/Ukrainian-speaking community get information about health-related issues, Ms. Prisyazhnyuk stated that community members get information via television (news) and Circle of Friends. She felt that community members are aware of public health clinics where they can get information and/or services on urgent health issues such as H1N1, but that there are linguistic barriers to accessing these community resources. Ms. Prisyazhnyuk said that these barriers can be addressed through interpretation.

Ms. Prisyazhnyuk noted that many Russians/Ukrainians do not believe in vaccination because of lack of knowledge. She felt that presentations by health care professionals or other trusted individuals (e.g., Program Director at Circle of Friends) were most important for the Russian-/Ukrainian-speaking community. Ms. Prisyazhnyuk indicated that she was contacted by PHSKC (Lydia Ortega) and that she made sure that the RN at Circle of Friends gave brief daily messages about H1N1 and that instruction about proper hygiene was posted in the bathroom. In the future, she felt that she and other community leaders could share current information about H1N1 and other urgent health issues with community members to reduce the spread of H1N1.

- *Mr. Anatoliy Sholom, Editor, Nashy VESTI (Russian Newspaper)*

Mr. Sholom reported that he heard about H1N1 via the media—television (ABC, CBS, FOX news), radio (Russian and American stations) and newspapers (for Russian-speakers)—as well as through churches/religious institutions, and family members and friends. He heard that H1N1 was very serious and that there was a vaccine shortage. Mr. Sholom said that he did not have any additional questions about H1N1. He indicated that community members heard about H1N1 and were frightened about the negative information they heard about the virus. Mr. Sholom noted that community members had additional questions about the cause of H1N1 and how the outbreak started. He said that community members washed hands and used hand sanitizer, took vitamins, avoided public places and stayed home when they were sick, in response to H1N1.

In terms of where individuals in the Russian-speaking community get information about health-related issues, Mr. Sholom stated that community members get information via the media—television (news stations), radio, newspapers (Russian and other local newspapers), churches/religious institutions, health care providers, and family and friends. He felt that community members are aware of public health clinics and local stores (i.e., pharmacies) that provided the H1N1 vaccine and libraries where they can get information and/or services on urgent health issues such as H1N1. He did not feel that there were any barriers to accessing these community resources.

Mr. Sholom suggested that accurate information, not “scare tactics,” are most important for the Russian-speaking community. He said that he was not contacted by PHSKC or others about reaching out to community members about H1N1 and that he did not take any specific action to reach out to community members about the H1N1 outbreak. In the future, Mr. Sholom felt that he and other community leaders could play a role in providing accurate information to and hosting dialogues with community members about urgent health issues such as H1N1.

3. Community conversations

Summary—community conversation surveys

As outlined in the “Methods” section, CMCH conducted nine community conversations with 89 individuals. Before starting the community conversations, the facilitators asked participants to complete a survey. *The following are tables and summaries of the community conversation surveys:*

The following table provides a demographic profile of 88 of the 89 participants:

Table 1: Demographic Characteristics (n=88)

	N (%)
Age	
<20	9 (10%)
20-24	10 (11%)
25-29	7 (8%)
30-34	11 (12%)
35-39	8 (9%)
40-44	5 (6%)
45-49	4 (5%)
50-54	14 (16%)
55-59	7 (8%)
60-64	5 (6%)
65-69	1 (1%)
70-74	2 (2%)
75+	5 (6%)
Gender	
Female	54 (61%)
Male	34 (39%)
Race*	
African/Black/African American	68 (72%)
American Indian/Native American	4 (5%)
White	19 (20%)
Other	3 (3%)
U.S.-born (n=85)	
Yes	27 (32%)
No	58 (68%)

*Some respondents selected more than one race. “Other” included “10% Creole,” “Latino,” and “Puerto Rican.”

Table 1: Demographic Characteristics (n=88) (continued)

	N (%)
Country of origin (n=61)	
Ethiopia	21 (34%)
Eritrea	10 (16%)
Somalia	11 (18%)
Russia	6 (10%)
Ukraine	7 (11%)
Other**	6 (10%)
Length of time in the U.S. (n = 61)	
≤1 year	7 (11%)
1-5 years	24 (39%)
5-10 years	16 (26%)
≥10 years	14 (23%)
Educational level (n=85)	
Less than high school	28 (33%)
High school graduate/some post-secondary	48 (56%)
Bachelor's degree	6 (7%)
Master's/other advanced degree	3 (4%)
Living with children <18 years of age (n=86)	
Yes	52 (60%)
No	34 (40%)

**Respondents reported their country of origin as Moldova (5) and Armenia (1).

The following table provides information on the community conversation participants' English proficiency and language spoken at home.

Table 2: English Proficiency and Language Spoken at Home (n = 88)

	N (%)
English proficiency—spoken	
Do not speak English	9 (10%)
Speak English, but not very well	27 (31%)
Speak English well	25 (28%)
Speak English very well	27 (31%)
English proficiency—written	
Do not read English	8 (9%)
Read English, but not very well	22 (25%)
Read English well	28 (32%)
Read English very well	30 (34%)

Table 2: English Proficiency and Language Spoken at Home (n = 88) (continued)

	N (%)
Language spoken at home*	
English	27 (31%)
Amharic	19 (22%)
Somali	11 (12%)
Tigrigna	11 (12%)
Russian	10 (11%)
Ukrainian	4 (5%)
Other**	6 (7%)
Language spoken at home—written (n=86)	
Do not read home language	2 (2%)
Read home language, but not very well	10 (12%)
Read home language well	18 (21%)
Read home language very well	56 (65%)

*One respondent reported speaking more than one language at home (English and Amharic).

**Three respondents reported speaking Romanian at home, and two reported speaking Moldavian. One respondent did not specify language spoken at home.

The following table provides information about community conversation participants' knowledge, attitudes and beliefs about H1N1:

Table 3: Knowledge, Attitudes and Beliefs (n=88)

	N (%)
Heard about the outbreak (n=84)	
Yes	81 (96%)
No	3 (4%)
How/where heard about H1N1*	
Television	66 (75%)
Radio	32 (36%)
Newspapers	25 (28%)
Community groups/social service organizations**	41 (46%)
Churches/mosques/religious institutions	13 (15%)
Schools	12 (14%)
Health care providers	26 (30%)
Family members	20 (23%)
Friends	24 (27%)
Other	9 (10%)

*Some respondents selected more than one option.

Table 3: Knowledge, Attitudes and Beliefs (n=88) (continued)

	N (%)
H1N1 spreads from person to person (n=85)	
Yes	75 (88%)
No	0 (0%)
Don't know	10 (12%)
Can catch H1N1 by eating pork (n=86)	
Yes	20 (23%)
No	47 (55%)
Don't know	19 (22%)
Are medicines to treat H1N1 (n=84)	
Yes	59 (70%)
No	11 (13%)
Don't know	14 (17%)
Is a vaccine for H1N1 (n=83)	
Yes	68 (82%)
No	6 (7%)
Don't know	9 (11%)

The vast majority of respondents (96%) reported that they heard about the H1N1 outbreak. Most heard about the outbreak through multiple sources, and media was clearly an important source of information. Three-quarters of respondents indicated that they heard about the H1N1 outbreak via television. More than one-third (36%) said that they heard about the outbreak via radio; two respondents reported that they heard about the H1N1 outbreak via Russian television and radio.

Community groups/social service organizations were also an important source of information about the H1N1 outbreak. Nearly half of respondents (46%) indicated that they heard about the H1N1 outbreak via community groups/social service organizations. Seven respondents reported that they heard about the outbreak through Afrique Service Center, and two reported that they heard about the outbreak through CMCH. Among those who indicated hearing about the H1N1 outbreak via other sources, two respondents reported that they heard about the outbreak through work and PHSKC. Others reported hearing about the H1N1 outbreak at the mall and through the school nurse, students and teachers; “vocation in China”; an individual he/she knew who had H1N1; and DSHS. Two respondents did not specify how/where they heard about the outbreak.

Most respondents were aware that H1N1 spreads from person to person (75%), there are medicines to treat H1N1 (70%) and there is a vaccine for H1N1 (82%). However, nearly one-quarter (23%) thought they could catch H1N1 by eating pork.

The following table provides information about community conversation participants' H1N1 vaccine experience.

Table 4: H1N1 Vaccine Experience

	N (%)
Tried to get the vaccine (n=84)	
Yes	36 (43%)
No	48 (57%)
Able to get the vaccine (n=40)	
Yes	32 (80%)
No	8 (20%)
Location of vaccination (n=33)	
Regular doctor/healthcare provider	10 (31%)
Hospital	9 (27%)
Pharmacy	2 (6%)
School	4 (12%)
Work location	5 (15%)
Other	3 (9%)
Level of difficulty in trying to figure out where to get the vaccine (n=75)	
Not difficult to find	45 (60%)
Somewhat difficult to find	19 (25%)
Very difficult to find	11 (15%)
Others in household tried to get the vaccine (n=85)	
Yes	25 (29%)
No	60 (71%)
Household members' success in getting the vaccine (n=27)	
Yes	16 (59%)
No	11 (41%)
Preferred location for getting the vaccine*	
Regular doctor/health care provider	38 (32%)
Hospital	24 (20%)
Pharmacy	25 (21%)
School	4 (3%)
Work location	6 (5%)
Other	23 (19%)

*Some respondents selected more than one option.

Table 4: H1N1 Vaccine Experience (continued)

	N (%)
Reason for preferred location*	
Cost	11 (17%)
Convenience	32 (48%)
Trust	32 (48%)
Less exposure to sick people	6 (9%)
Familiarity	19 (29%)

*Some respondents selected more than one option.

Less than half of respondents (43%) reported that they tried to get the H1N1 vaccine. Unfortunately, the number of respondents who reported that they tried to get the vaccine (n = 36) did not match the number who commented on their ability to get the vaccine (n = 40). However, since 80% of respondents indicated that they were able to get the H1N1 vaccine, it seems reasonable to conclude that most were able to get the vaccine. Again, the number of respondents who reported that they tried to get the vaccine did not match the number who comments on where they got the vaccine (n = 33). However, it seems reasonable to state that most got the H1N1 vaccine at their regular doctor/healthcare provider or hospital. Of those who reported getting the vaccine from other venues, work (15%) and school (12%) were relatively popular venues. While less than half of respondents reported that they tried to get the H1N1 vaccine, 60% felt that it was not difficult to find figure out where to get the vaccine.

Among respondents, less than one-third indicated that household members tried to get the H1N1 vaccine. Again, the number of respondents who reported that household members tried to get the vaccine (n = 25) did not match the number who commented on their ability to get the vaccine (n = 27). However, since nearly 60% of respondents indicated that their household members were able to get the H1N1 vaccine, it seems reasonable to conclude that most were able to get the vaccine.

More than half of respondents (52%) reported that they would prefer to get vaccinated for H1N1 at their regular doctor/healthcare provider or hospital. Twenty-one percent (21%) said that they would prefer to get vaccinated at a pharmacy; nine specifically named Walgreens. Of the 23 who responded “other,” eight respondents indicated that they did not have a preference, and six indicated that they would not get the vaccine. Other respondents indicated that they would prefer to get vaccinated at Afrique Service Center (2), PHSKC (2), public location (2), community center, facility provided by the Department of Early Childhood Education, and mosque.

The following table provides information about outreach and communications venues preferred by community conversation participants:

Table 5: Outreach and Communications

	N (%)
Resources for information about health-related issues	
Television	52 (20%)
Radio	13 (5%)
Newspapers	17 (7%)
Community groups/social service organizations	41 (16%)
Churches/mosques/religious institutions	10 (4%)
Schools	7 (3%)
Health care providers	43 (17%)
Family members	22 (9%)
Friends	29 (11%)
Internet	11 (4%)
Other	9 (4%)
Know about community resources for urgent health issues (n=84)	
Yes	65 (77%)
No	19 (23%)
Resource for urgent health issues*	
Regular doctor/health care provider	54 (47%)
Community health centers	26 (23%)
Public health clinics	15 (13%)
Other	20 (17%)

*Some respondents selected more than one option.

The top three places where respondents reported getting information about health-related issues were television (20%), health care providers (17%), and community groups/social service organizations (16%). Of those who reported getting information from community groups/social service organizations, eight specified Afrique Service Center, and one each specified CMCH and the Eritrean community. Of the nine who responded “other,” three respondents said they get information about health-related issues from work. Other respondents said they get information from “books, periodical and airport” and from the Seattle Public Library. Two respondents did not specify where they get information.

More than three-quarters of respondents (77%) stated that they knew about community health centers, public health clinics and other health care institutions where they could get information and/or services on urgent health issues such as H1N1. Nearly half indicated that they would go to their regular doctor/healthcare provider for information and/or services. Nearly one-quarter indicated that they would go to a community health center. Of those nine, six specified Sea Mar Community Health Centers (including two who specified the Burien Medical Clinic), and the remaining three specified International Community Health Services, Odessa Brown Children’s Clinic, and Neighborcare Health/Rainier Beach Medical & Dental Clinic. Of the 20 who responded “other,” four said that they

would go to Afrique Service Center, and three said that they would go to work for information and/or services on urgent health issues. Other respondents reported that they would go to CMCH, emergency (room), epidemiology lab, friends, others, respected community organization members and South Seattle Community College. One respondent indicated that he/she did not know where to go.

African community

- **Community conversation with Ethiopian men**

CMCH talked with ten (10) Ethiopian men, 27 to 59 years of age. All of the participants were foreign-born, and participants had been in the U.S. for one to 28 years, with a mean length of time in the U.S. of approximately 11 years. All reported that they speak Amharic at home; some reported that they speak Amharic and another language (e.g., English, Tigrigna). Sixty percent (60%) reported that they speak English “very well” or “well.”

Knowledge, attitudes and beliefs about H1N1

Participants said they heard about H1N1 and knew that it was a serious disease that had killed people. Some participants were aware that certain groups (e.g., children, pregnant women, older adults, people with other health conditions) were more vulnerable than others. However, there were variations in participants’ thinking about the origin of H1N1. Some participants heard that H1N1 started in Mexico and was transmitted by pigs. One participant heard that people contracted H1N1 by touching pigs, and another participant said that he and his family avoided pork products. One participant heard that it was a mixture of bird and swine flu. Another participant heard that it came from China and stopped going to Chinatown/ International District to shop because he feared for his children’s safety.

Some participants talked about cultural beliefs and practices that influence community members’ knowledge, attitudes and beliefs about urgent health issues such as H1N1. One participant said that Ethiopians do not need vaccines or medicine for the flu because they are strong, and the flu is not a disease that is very serious. Another participant talked about using traditional herbal treatments (i.e., steaming eucalyptus and ginger leaves).

All of the participants knew that there was a vaccine shortage, and most expressed concern about vaccine safety and side effects. Some participants expressed concern that H1N1 and the vaccine were part of an experiment on certain communities. Participants agreed that the commercial media might exaggerate the situation because they rely on advertising revenue. They said that they trust NPR because it is nonprofit. In addition, they said that they trust Ethio Youth Media and *Salon Ethiopia* newspaper because they are in Amharic.

In terms of actions taken to avoid getting sick or passing H1N1 to others, participants noted that they stopped shaking hands and washed hands and used hand sanitizers frequently. In some cases, participants reported that they stopped sending their children to school and considered staying home when they were sick.

H1N1 vaccine experience

Only one participant reported getting the H1N1 vaccine, and he got vaccinated because he is a caregiver and it was mandated by his employer. Most participants were concerned about vaccine safety and side effects and noted that they did not know anyone in the Ethiopian community who got sick or died from H1N1. Some of the participants felt that they were not vulnerable to H1N1 because they do not eat pork products. In general, participants said they would get the H1N1 vaccine, if it were mandated by their employers, if they had flu symptoms, and/or if there were a strong awareness campaign coordinated by community leaders and PHSKC and reinforced through community media such as Ethio Youth Media.

Outreach and communications efforts

If they heard about another virus like H1N1 that was suddenly making a lot of people sick, all of the participants reported that they would turn first to the media (Ethio Youth Media, *Salon Ethiopia* newspaper) and family members and friends for information. Many participants reported that they would turn to the Internet, and some participants said they would turn to their primary doctors or look for information on posters. Participants stated that information on the nature and severity of the virus, how the virus is transmitted, which groups are most vulnerable, signs and symptoms of illness, and cost and side effects of vaccines and other treatment would be the most helpful information, if there were another virus like H1N1 that suddenly made a lot of people sick.

- **Community conversation with Ethiopian women**

CMCH talked with ten (10) Ethiopian women, 23 to 37 years of age. All of the participants were foreign-born, and participants had been in the U.S. from one to 14 years, with a mean length of time in the U.S. of approximately five years. Ninety percent (90%) reported that they speak Amharic at home; some reported that they speak Amharic and another language (e.g., English, Tigrigna). Sixty percent (60%) reported that they speak English “very well” or “well.”

Knowledge, attitudes and beliefs about H1N1

Participants said they heard about H1N1 and knew that it was a very contagious and serious disease that had killed people. Some participants were aware that certain groups (e.g., children, pregnant women, older adults) were more vulnerable than others.

All of the participants knew there was a vaccine shortage, and most expressed concern about vaccine safety and side effects, particularly because the vaccine was new. However, all agreed that it was a good idea to get vaccinated. In terms of actions taken to avoid getting sick or passing H1N1 to others, participants noted that they avoided public places like malls and parks and washed hands and used hand sanitizers frequently. In some cases, participants indicated that they were encouraged by their health care providers to keep their children home and stay home if they were sick. A few participants reported having flu-like symptoms during the outbreak. However, two participants said they just drank fluids, as recommended by their health care providers, but did not stay home. One participant reported going to the hospital and getting sick leave.

H1N1 vaccine experience

More than half of the participants reported getting the H1N1 vaccine. Most got vaccinated because they are caregivers and it was mandated by their employers. One participant said that she was pregnant and got the H1N1 vaccine because it was recommended by her health care provider. Of those who did not get vaccinated, all noted that there were long lines, and many expressed concern about vaccine side effects and safety or just general lack of trust in the health care system. Two participants expressed concern about the cost of the H1N1 vaccine. All of the participants said they would get the H1N1 vaccine if they had flu symptoms and if they saw sick people in the community. Some participants said they would get the vaccine if it were mandated by their employers and offered in a convenient location (e.g., school, workplace).

Outreach and communications efforts

If they heard about another virus like H1N1 that was suddenly making a lot of people sick, participants reported that they would turn to a variety of sources including their primary doctors, clinics/health centers, schools, workplaces, and family and friends for information. Participants stated that information on how the virus is transmitted and how to prevent spreading the virus to others, signs and symptoms of illness, how to manage illness, and cost of vaccines and other treatment would be the most helpful information, if there were another virus like H1N1 that suddenly made a lot of people sick.

- **Community conversation with Eritrean men and women**

CMCH talked with 11 Eritreans—seven men and four women, 18 to 49 years of age. All of the participants were foreign-born, and participants had been in the U.S. for less than one year to six years, with a mean length of time in the U.S. of approximately 2.5 years. All reported that they speak Tigrigna at home; some participants reported that they speak Tigrigna and another language (e.g., Amharic, English). One participant reported that he does not speak English, and more than 45% reported that they speak English, but not very well.

Knowledge, attitudes and beliefs about H1N1

Most participants said they heard about H1N1 and that it was a very serious disease that had killed people. They noted that community members were scared about H1N1 and talked about H1N1 daily. A few participants reported that they had not heard about H1N1 until this community conversation or thought that H1N1 was not serious. Of those who heard about H1N1, all heard that it was transmitted by air and through contaminated pork products. A few participants thought that H1N1 came from Mexico or was also transmitted via birds. Some participants were aware that certain groups were more vulnerable than others.

All of the participants knew that the H1N1 vaccine was different from the seasonal flu vaccine. Some participants heard that there was a vaccine shortage. Others heard that there was no shortage, but that the vaccine was expensive. In terms of actions taken to avoid getting sick or passing H1N1 to others, participants noted that they avoided people who were coughing, avoided using public transportation, and washed hands. One participant reported wearing a mask.

H1N1 vaccine experience

Only one participant reported getting the H1N1 vaccine, and the participant got vaccinated at a pharmacy (Walgreens) and used insurance to pay for the vaccine. Some participants reported that they were not afraid of the H1N1 vaccine, but did not get vaccinated because they were not sure about the effectiveness of the vaccine. In addition, some reported that others did not get the H1N1 vaccine because of lack of information about the vaccine and concerns about cost. In general, participants said they would get the H1N1 vaccine, if it were an emergency, if they felt that it was really protective, and if community members were dying.

Outreach and communications efforts

If they heard about another virus like H1N1 that was suddenly making a lot of people sick, participants reported that they would turn to a variety of sources including the media—television, radio and newspapers—as well as their health care providers, mosques, schools, workplaces and friends for information. Some mentioned that they saw information about the H1N1 vaccine on the bus. Participants stated that information on where the virus comes from, how it is transmitted and how to prevent spreading the virus to others, and how to manage illness would be the most helpful information, if there were another virus like H1N1 that suddenly made a lot of people sick.

- **Community conversation with Somali men and women**

CMCH worked with Afrique Service Center to recruit participants. Dr. Solomon Tsegaslassie, Project Coordinator for CMCH facilitated the discussion, and Ms. Ayan Qumane provided interpretation services and took notes. They talked with 11 Somalis—seven men and four women, 19 to 63 years of age. All of the participants were foreign-born, and participants had been in the U.S. for two to ten (10) years, with a mean length of time in the U.S. of five years. All of the participants reported that they speak Somali at home. Nearly 28% reported that they do not speak English, and nearly 55% reported that they speak English, but not very well.

Knowledge, attitudes and beliefs about H1N1

Participants said they heard about H1N1 and knew that it was a very contagious and dangerous/deadly disease that killed more people than seasonal flu. All of the participants felt that H1N1 came from pigs. Participants indicated that they were worried about getting infected, because they heard that H1N1 was contagious. They noted that some people in Somalia were even concerned about H1N1.

In terms of actions taken to avoid getting sick or passing H1N1 to others, participants talked about cleanliness and reported washing hands frequently. In some cases, participants reported that they stopped buying food from places that sold pork products. Other participants talked about relying on Allah's protection.

H1N1 vaccine experience

Participants indicated that they tried to get vaccinated to avoid getting H1N1. One participant noted that he/she tried twice to get vaccinated and was told that it was for more vulnerable people. Most participants said that they did not have health coverage and that cost was a major barrier to getting the H1N1 vaccine.

Outreach and communications efforts

If they heard about another virus like H1N1 that was suddenly making a lot of people sick, participants reported that they would turn to their community center and community leaders and members for information. They noted that their community leaders are more likely to be knowledgeable about new and deadly diseases. In addition, participants said that they would talk with their doctors and follow their directions on what to do to avoid getting sick. Participants stated that information on the effects of the virus and how to prevent getting sick.

African American community

- **Community conversation at the Aridell Mitchell Home (for pregnant and parenting teens)**

CMCH recruited participants and facilitated the discussion. Ms. Devon Love, Project Coordinator for CMCH, facilitated, and three CMCH staff observed. Ms. Love talked with ten (10) women, 16 to 61 years of age. As outlined earlier, all were residents and staff of the Aridell Mitchell Home.

Knowledge, attitudes and beliefs about H1N1

Participants said they heard about H1N1 and knew that it was a serious disease that had killed people. Some participants were aware that certain groups (e.g., pregnant women, older adults, people with weak immune systems) were more vulnerable than others. One participant heard that Asian people were affected by H1N1. A number of participants heard that H1N1 started in Mexico, and one participant heard that it started in birds and spread to pigs. A number of participants heard that H1N1 was

transmitted through pork products and that it was important to avoid eating pork products. Two participants felt that it was important to specifically avoid pork from Mexico, and one participant reported taking precautions around Mexican people. Another participant heard that people could get H1N1 from Asian people.

Most of the participants heard that there was a vaccine for H1N1. A number of participants expressed concern about vaccine safety, including mercury in the vaccine. Two participants noted that they did not get vaccinated because they heard the vaccine could cause paralysis. Two participants noted that they did not get vaccinated because they heard that four people died from the vaccine, and another participant reported that she did not plan to get the vaccine, but her doctor made her get the vaccine because she was pregnant.

In terms of actions taken to avoid getting sick or passing H1N1 to others, participants stated that they avoided people who were sick, stayed home/encouraged others to stay home if they were sick, and washed hands and used hand sanitizers frequently. Two participants reported wearing masks or scarves, and one participant said that she used bleach on all of her dishes. Another participant avoided Chinatown/ International District and those she heard had H1N1.

H1N1 vaccine experience

Most of the participants said that they did not try to get the H1N1 vaccine. Some participants indicated that they do not like vaccines in general, and other participants expressed concern about vaccine safety. Two participants stated that they did not get vaccinated because they did not want to get sick. Some of the participants heard that there were long lines for the H1N1 vaccine, but assumed that lines were not long in the African American community because of community resistance to treatment. A few participants wondered (or were even suspicious) about why the vaccine was not free everywhere, if H1N1 was such a serious health issue.

Outreach and communications efforts

If they heard about another virus like H1N1 that was suddenly making a lot of people sick, most participants reported that they would turn to health care providers (including school and public health nurses) and family member and friends for information. Some participants reported other sources including their pastors/religious leaders, health information lines, and community leaders (specifically Devon Love at the Center for MultiCultural Health). Participants stated that information on the nature and severity of the virus, how it is transmitted and how to prevent spreading the virus to others, which groups are most vulnerable, and how to manage illness would be the most helpful information, if there were another virus like H1N1 that suddenly made a lot of people sick. A number of participants suggested that information on H1N1 should have been made into a movie or video and should have been available in a variety of places (e.g., clothing stores, clubs, libraries) and in a number of different languages.

- **Community conversation at Emerald City Community Seventh Day Adventist Church**

CMCH recruited participants and facilitated the discussion. Ms. Love talked with ten (10) individuals—three men and seven women, 28 to 86 years of age. As outlined earlier, the group included both church members and other individuals from the African American community.

Knowledge, attitudes and beliefs about H1N1

Participants said they heard about H1N1 and knew that it was a serious disease. Some participants were aware that certain groups (e.g., children, older adults, people with breathing problems) were more vulnerable than others. A number of participants heard that H1N1 started in China, and some heard that it started in Mexico and originated in/was transmitted via pigs.

The majority of participants knew that the vaccine for H1N1 was different than the vaccine for seasonal flu, and all of the participants were aware that there was a vaccine shortage. Some participants felt that the media exaggerated the severity of H1N1 and were confused about the change in terminology from swine flu to H1N1. A number of participants expressed concern that H1N1 and the vaccine were part of yet another experiment on the African American community, while others expressed general concerns about vaccine safety (e.g., how the vaccine might affect those with prior/underlying health conditions, mercury in the vaccine). In addition, some participants had reservations about the vaccine because they knew health care professionals who did not get vaccinated.

In terms of actions taken to avoid getting sick or passing H1N1 to others, participants stated that they prayed, avoided crowded communities and people who were sick, stayed home/encouraged others to stay home if they were sick, and washed hands and used hand sanitizers frequently. Some participants reported using gloves and/or wearing masks.

H1N1 vaccine experience

Only one participant reported getting the H1N1 vaccine, and the participant said that “the experience was a mess.” The participant indicated that she tried to get the vaccine at three different sites, before finally getting vaccinated at Walgreens. The majority of participants stated that they did not get vaccinated because they were concerned about vaccine safety and/or have gotten sick (or known others who have gotten sick) from the seasonal flu shot. In general, cost was not a concern for participants. Participants indicated that they would be more willing to get vaccinated for H1N1 if they had more information about the vaccine, were vulnerable to H1N1 (e.g., have underlying health conditions, eat pork), and/or had someone close to them who contracted H1N1.

Outreach and communications efforts

If they heard about another virus like H1N1 that was suddenly making a lot of people sick, most participants reported that they would turn to government agencies (DSHS, PHSKC), family member and friends who are health care professionals, staff in health and human service organizations (CMCH), and the Internet for information. A few participants noted that they do not turn to pastors/religious leaders for information on health issues. Participants stated that information on where the virus came from, how it is transmitted and how to prevent getting sick/spreading the virus to others, how to manage illness, and where to go for more information/services would be most helpful, if there were another virus like H1N1 that suddenly made a lot of people sick. A number of participants suggested that information on urgent health issues such as H1N1 should be clear and consistent and available in convenient locations in the community.

- **Community conversation at New Hope Missionary Baptist Church**

CMCH recruited participants, and Ms. Love facilitated the discussion. She talked with seven individuals—one man and six women, 41 to 60 years of age—and all were church members.

Knowledge, attitudes and beliefs about H1N1

Participants said they heard about H1N1 and knew that it was a serious disease that had killed people. A few participants heard that H1N1 came into the U.S. from another country; one participant heard that it came from Mexico.

Participants knew that there was a vaccine for H1N1, and all were aware that there was a vaccine shortage. They were generally confused about the term “swine flu” and commented that the name confused and scared people. The majority of participants indicated that they did not trust the H1N1 vaccine. Some participants stated that they did not trust the vaccine because it seemed to have been

developed so quickly. Others commented that there was a swine flu outbreak many years ago and that people got sick after getting the vaccine and/or that they got sick after getting the H1N1 or seasonal flu vaccine.

In terms of actions taken to avoid getting sick or passing H1N1 to others, participants stated that they avoided crowded areas/stayed home, avoided people who were sick, and washed hands and used hand sanitizers frequently. Some participants reported distributing or receiving masks.

H1N1 vaccine experience

Despite concerns about the H1N1 vaccine, the majority of participants reported getting vaccinated. A number of participants said they got vaccinated because they are health care workers and it was mandated by their employers and/or because they have chronic conditions or live/work with people who are vulnerable to H1N1. Some participants commented that they had to wait to get the vaccine. Of those participants who did not get vaccinated, several indicated that they do not like vaccines in general, and some participants felt that they were not vulnerable to H1N1. Participants indicated that they would be more willing to get vaccinated for H1N1 if they had more information about the vaccine and if the vaccine was offered in convenient locations in the community. A number of participants felt that the media created fear and panic about H1N1 that H1N1 was less serious than the media made it seem.

Outreach and communications efforts

If they heard about another virus like H1N1 that was suddenly making a lot of people sick, most participants reported that they would turn to health care professionals—including family member and friends who in the health care field—for information. A few participants noted that they would not turn to community leaders or anyone who might heighten anxiety for information. Participants stated that information on the nature and severity of the virus, how it is transmitted and how to prevent getting sick, which groups are most vulnerable, how to manage illness, and where to go for more information/services would be most helpful, if there were another virus like H1N1 that suddenly made a lot of people sick. A number of participants indicated that they want to hear information from trusted sources (CDC, public health, medical experts) vs. the media.

Russian/Ukrainian community

- **Community conversation with older Russian/Ukrainian-speakers at the Center for MultiCultural Health**

CMCH recruited participants. Ms. Irina Busenbark, Case Manager for CMCH, facilitated the discussion, and another CMCH staff member took notes. Ms. Busenbark talked with ten (10) individuals—four men and six women, 50 to 86 years of age. All of the participants were foreign-born, and participants had been in the U.S. for nine to 19 years, with a mean length of time in the U.S. of approximately 15 years. Six reported that they speak Russian and three reported that they speak Ukrainian at home; some participants reported that they speak Russian/Ukrainian and another language (e.g., Armenian, Azerbaijani). About 55% reported that they do not speak English, and 45% reported that speak English, but not very well.

Knowledge, attitudes and beliefs about H1N1

All of the participants said they heard about H1N1. Participants believed that H1N1 was different than seasonal flu, but did not feel that it was important to get vaccinated. Some participants stated that they remembered a swine flu outbreak in China and Europe during the 1960s.

In general, participants knew that there was a vaccine for H1N1, but said that they did not have any concerns about H1N1. All were aware that there was a vaccine shortage, and some wondered why the vaccine was not free, if H1N1 was such a serious health issue.. In terms of actions taken to avoid getting sick or passing H1N1 to others, participants stated that they avoided public places or wore masks when they went to public places, stayed home if they were sick, and washed hands and used hand sanitizer frequently.

H1N1 vaccine experience

Only three of the participants got vaccinated for H1N1. Of these participants, two got vaccinated because it was recommended by a health care professional, and one got vaccinated because she is a caregiver and it was mandated by her employer. Some participants did not get vaccinated because they heard that people who got the H1N1 vaccine got sick. Other participants said that they did not feel that it was necessary to get vaccinated because they did not feel sick. One participant said that she was afraid of getting a shot. Participants said that there was nothing at the moment that would make them more willing to get vaccinated for H1N1. They felt that more time was needed to study H1N1.

Outreach and communications efforts

If they heard about another virus like H1N1 that was suddenly making a lot of people sick, most participants reported that they would turn to their family doctors or other health care professionals for information because they trust doctors. Two participants said that they would turn to the Internet for more information. Participants stated that information on the cost of the vaccine would be most helpful, if there were another virus like H1N1 that suddenly made a lot of people sick.

- **Community conversation with younger Russian-Ukrainian speakers at the Center for MultiCultural Health**

CMCH recruited participants. Ms. Busenbark facilitated the discussion, and another CMCH staff member took notes. Ms. Busenbark talked with ten (10) individuals—two men and eight women, 21 to 49 years of age. All of the participants were foreign-born, and participants had been in the U.S. for three to 13 years, with a mean length of time in the U.S. of eight years. Four reported that they speak Russian (one both Russian and English), and two reported that they speak Ukrainian (one both Russian and Ukrainian) at home. Three reported that they speak Romanian, and two reported that they speak Moldavian. Two-thirds reported that they speak English “very well” or “well.”

Knowledge, attitudes and beliefs about H1N1

All of the participants said they heard about H1N1. Some participants heard that it was more serious than seasonal flu, while others did not believe that H1N1 existed.

In general, participants knew that there was a vaccine for H1N1. However, a few participants were concerned that the vaccine would make them sick, and others felt that they would not get vaccinated unless the vaccine was required. All were aware that there was a vaccine shortage. In terms of actions taken to avoid getting sick or passing H1N1 to others, participants stated that they avoided public places (particularly shopping malls), stayed home if they were sick, and told their children not to have close contact with sick classmates.

H1N1 vaccine experience

None of the participants got vaccinated for H1N1. In addition to being concerned that the vaccine would make them sick, they stated that they did not trust the vaccine because it seemed to have been developed so quickly. Participants generally felt that it would take years to make a quality vaccine. They also felt that the vaccine was created by drug companies for commercial interests and that the

companies just decided that now was a good time to sell the vaccine. Participants said that there was nothing at the moment that would make them more willing to get vaccinated for H1N1. They indicated that more time was needed to study H1N1.

Outreach and communications efforts

If they heard about another virus like H1N1 that was suddenly making a lot of people sick, participants reported that they would turn to family members and friends for information. A few participants said that they would also turn to health care professionals or their pastors for additional information. Participants stated that information on the nature and severity of the virus, how it is transmitted and how to prevent getting sick, how to manage illness, and where to go for more information/services would be most helpful, if there were another virus like H1N1 that suddenly made a lot of people sick. A number of participants indicated that they want to hear information from trusted sources (health care professionals at public health clinics) vs. the media.

Key Themes

- **Knowledge, attitudes and beliefs about H1N1**

Across communities, key informants and community conversation participants generally reported that they and other community members heard about H1N1 and were aware that there was a vaccine for H1N1. They talked about anxiety and confusion—both personal and in the broader community—about H1N1 and the vaccine. Some referred to H1N1 as a “killer disease” or indicated that H1N1 was “scary.”

Among key informants and community conversation participants, there were varying levels of knowledge about H1N1, and there was some misinformation about the origin of H1N1, how the virus is transmitted and which groups are most vulnerable. In the Somali community, there seemed to be significant confusion about H1N1. For example, there were questions about whether or not H1N1 started in pigs and if those who do not eat pork were vulnerable to H1N1 and if the vaccine contained pork. Some of these questions were also raised in other communities. In addition, key informants and community conversation participants indicated that the use of the terms “H1N1” and “swine flu”—and just the term “swine flu” alone—was confusing to community members.

In general, key informants and community conversation participants reported more frequent handwashing and use of hand sanitizers and avoiding large groups of people/public places to avoid getting sick or passing H1N1 to others. They also seemed to understand the importance of keeping children home and staying home if they were sick, but a number commented that taking leave from work would be challenging.

Key informants and community conversation participants expressed significant concerns about H1N1 vaccine safety and side effects. In addition, many reported apprehension—and, in some cases, lack of trust—about who was disseminating information about H1N1 and the vaccine (e.g., government, health care system, pharmaceutical companies, media) and why. In the language of one key informant, some wondered if certain communities were being used as “guinea pigs” and if information/services were equitably distributed across racial/ethnic and geographic communities. Most indicated that they were aware of the vaccine shortage.

- **H1N1 vaccine experience**

As outlined earlier, key informants and community conversation participants generally reported that they and other community members were aware that there was a vaccine for H1N1, and most indicated that they knew that the H1N1 vaccine was different from the seasonal flu vaccine. However, less than half of community conversation participants reported that they tried to get vaccinated. Both key informants and community conversation participants also reported low levels of vaccination in their respective communities. Some commented that vaccine availability contributed to low levels of vaccination, but concern about vaccine safety and side effects—for H1N1 and vaccines, in general—seemed to have more impact on community members’ willingness to get the H1N1 vaccine. Some wondered how the H1N1 vaccine could have been developed so quickly and/or worried that the vaccine was new, and, as outlined above, some questioned if H1N1 and the vaccine were being tested in certain communities. Others wondered why the vaccine was not free if it was so important to get vaccinated.

More than half of community conversation participants reported that they would prefer to get vaccinated for H1N1 at their regular doctor/healthcare provider or hospital. Healthcare institutions commonly mentioned by key informants and community conversation participants included community health centers (Sea Mar Community Health Centers, Odessa Brown Children’s Clinic), public health clinics (Columbia Public Health Center) and other institutions (Harborview Medical Center, University of Washington). Some community conversation participants also reported that they would be willing to get vaccinated at a pharmacy, and Walgreens was commonly mentioned by those participants (43%).

Convenience and trust in healthcare providers, pharmacists and others to know about vaccines and what they are doing were major factors in community members' willingness to get the H1N1 vaccine and choice of vaccination venue. Cost did not seem to be a major factor for most community conversation participants.

- **Outreach and communications efforts**

The top three places where community conversation participants reported getting information about health-related issues were television, health care providers, and community groups/social service organizations, and key informants also reported these as primary sources of information. Family members and friends were also primary sources of information. For those from the African and Russian/Ukrainian communities, media in their home languages were important sources of information.

Key informants often talked about the importance of face-to-face communication—individual-level outreach, community meetings/group discussions—and working with community leaders to disseminate information and connect community members with services. Some indicated that they had shared information about H1N1 or would be willing to do so in the future with appropriate training and support. Both key informants and community conversation participants indicated that it is critical to have trusted individuals—including community leaders and other spokespeople—who are culturally and linguistically appropriate, stress the importance of prevention, and affirm cultural beliefs and practices and other traditional methods of addressing health issues. Across communities, they commented that community members do not access health care unless they are sick, so it is difficult to encourage preventive measures such as vaccination. A number of community conversation participants confirmed this reluctance to seek preventive services in stating that they did not get vaccinated because they did not know anyone who contracted H1N1 and/or that they would be willing to get vaccinated if it were an emergency/they saw others who were sick.

Considerations—Outreach and Communications

- **Develop culturally and linguistically proficient public education materials that are specific to each community**

As outlined in the “Findings” section, some of the materials on PHSKC’s “H1N1 influenza (swine flu)” webpage were available in multiple languages, but the content and artwork appeared to be the same in each publication. In addition, communications to the CCN appeared to primarily focus on vaccine availability, and none of the communications appeared to address potential community/cultural concerns about H1N1. Therefore, PHSKC should consider developing culturally and linguistically proficient public education materials that are specific to each community.

Specific suggestions include:

- Work with the CCN and other community groups/organizations to develop culturally and linguistically proficient public education materials that are specific to each community
 - National Center for Cultural Competency, A Guide to Choosing and Adapting Culturally and Linguistically Competent Health Promotion Materials, http://www11.georgetown.edu/research/gucchd/nccc/documents/Materials_Guide.pdf
- Ensure that public education materials meet the needs of individuals with low health literacy
 - U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, Health Literacy Online, <http://www.health.gov/healthliteracyonline/>
 - National Cancer Institute, Clear & Simple: Developing Effective Print Materials for Low-Literate Readers, <http://www.cancer.gov/cancerinformation/clearandsimple>

- **Streamline messages and be strategic about the frequency of communications**

While key informants and community conversation participants generally reported that they and other community members heard about H1N1 and were aware that there was a vaccine for H1N1, they expressed anxiety and confusion about H1N1 and the vaccine. Therefore, PHSKC should consider streamlining messages and being strategic about the frequency of communications about urgent health issues such as H1N1.

Specific suggestions include:

- Streamline messages and be strategic about the frequency of communications to the public
- Streamline messages to the CCN, minimizing duplicate information to the extent possible
- Be strategic about the frequency of e-mail communication to the CCN, and personally engage the CCN (face-to-face or via phone), whenever possible
- Explore ways to streamline messages and be strategic about the frequency of communications to healthcare providers
- Ensure that messages to all audiences are coordinated and consistent

- **Expand and strengthen relationships with community groups/organizations**

While some key informants indicated that they were contacted by PHSKC about reaching out to community members about H1N1, others did not. Therefore, PHSKC should consider expanding and strengthening its relationships with community groups/organizations that are connected to communities of color and immigrant/refugee communities to enhance and improve communications about urgent health issues such as H1N1.

- **Use personal communication to engage communities of color and immigrant/refugee communities in public health issues**

Key informants often talked about the importance of face-to-face communication—individual-level outreach, community meetings/group discussions—and working with community leaders to disseminate information and connect community members with services. Therefore, PHSKC should consider using personal communication, as well as expanding and strengthening relationships with community groups/organizations, to engage communities of color and immigrant/refugee communities in public health issues.

- **Enhance and improve communications about all vaccines, including H1N1**

Concern about vaccine safety and side effects—for H1N1 and vaccines, in general—seemed to have significant impact on community members’ willingness to get the H1N1 vaccine. Therefore, PHSKC should consider enhancing and improving communications about all vaccines, including H1N1, to address community members’ concerns.

- **Promote urgent health issues such as H1N1 within the broader context of health promotion and disease prevention**

Key informants and community conversation participants commented that community members do not access health care unless they are sick, so it is difficult to encourage preventive measures such as vaccination. Therefore, PHSKC should consider addressing public health issues generally and urgent health issues specifically within the broader context of health promotion and disease prevention.

- **Address broader community concerns about the government, health care system, pharmaceutical companies and the media**

Many key informants and community conversation participants reported apprehension—and, in some cases, lack of trust—about who was disseminating information about H1N1 and the vaccine and why. Therefore, PHSKC should consider addressing broader community concerns about the government, health care system, pharmaceutical companies and the media in communicating with communities of color and immigrant/refugee communities about public health issues generally and urgent health issues specifically.

Appendices

Appendix A: Focus group protocol—PHSKC staff

Appendix B: Key informant interview protocol—community leaders

Appendix C: Focus group survey—community members

Appendix D: Focus group protocol—community members

**Appendix A:
Focus group protocol—PHSKC staff**

Focus Group Protocol

Name of facilitator: _____

Name of notetaker/observer: _____

Date of focus group: _____

Location of focus group: _____

Checklist

- Sign-in sheet completed and collected?

Introduction

Thank you very much for taking the time to participate in this discussion. Before we begin, we would like to share the purpose of the discussion.

The Center for MultiCultural Health and its community partners are conducting interviews with community leaders and focus groups with members from the African American, African immigrant, American Indian/Alaska Native, and Russian/Ukrainian communities to better understand how H1N1/swine flu information was received in communities of color and immigrant & refugee communities. We are talking with you and other community leaders about H1N1/swine flu; effectiveness of outreach strategies used during the 2009 H1N1 influenza response; and how communication works in the African American community, including communication channels, trusted sources of information and how future information about urgent health issues should be provided.

We will summarize what we learn from you and other community leaders and members in a report to Public Health—Seattle & King County. This discussion will take about 90 minutes. The discussion is voluntary, and you can choose to not answer questions or leave the discussion at any time. With that in mind, do you agree to participate in the discussion?

To ensure that our notes are accurate, may we audiotape this discussion?

IF “YES,” TURN ON THE TAPE RECORDER AND CONTINUE WITH THE INTRODUCTION.

IF “NO,” PROCEED WITH THE DISCUSSION AND TAKE WRITTEN NOTES.

Do you have any questions about the project?

IF “YES,” ANSWER THE QUESTIONS.

IF “NO,” PROCEED WITH THE DISCUSSION.

1. What strategies used during the 2009 H1N1 influenza response were **most effective** in increasing awareness about H1N1 among African Americans, particularly those at highest risk for H1N1 (i.e., pregnant women; children and young adults 6 months to 24 years of age; persons ages 25-64 years old with health conditions that could make them dangerously ill from the flu; and household members and caregivers of children younger than 6 months in age)?

What strategies were **least effective**?

[PROBES: EDUCATIONAL MATERIALS/FLYERS, OUTREACH TO COMMUNITY GROUPS AND ORGANIZATIONS, OUTREACH TO HEALTH CARE PROVIDERS]

2. What strategies used during the 2009 H1N1 influenza response were **most effective** in encouraging African Americans to get vaccinated, particularly those at highest risk for H1N1? What strategies were **least effective**?

3. What are the most significant barriers in increasing awareness about H1N1 among African Americans?

4. Where do individuals in the African American community get information about health-related issues?

[PROBES: TELEVISION, RADIO, NEWSPAPERS, COMMUNITY GROUPS/ORGANIZATIONS, CHURCHES/MOSQUES/RELIGIOUS INSTITUTIONS, SCHOOLS, HEALTH CARE PROVIDERS, INTERNET, FAMILY MEMBERS, FRIENDS]

Note: Please list specific television/radio stations, newspapers, groups/organizations, websites, etc.

5. When you consider how and where African Americans get information about health-related issues, what advice do you have for maximizing the reach and impact of information shared in those ways?

6. What places are considered community resources for information and/or services on urgent health issues such as H1N1? What, if any, barriers are there to accessing these community resources? How can these barriers be addressed to best meet the needs of African Americans?

[PROBES: COMMUNITY HEALTH CENTERS, PUBLIC HEALTH CLINICS, PRIVATE PROVIDERS]

Note: Please list specific sites.

7. How do cultural beliefs and practices influence African Americans' knowledge, attitudes and beliefs about urgent health issues such as H1N1?

8. What types of messages on urgent health issues such as H1N1 are most important for African Americans?

[PROBES: HOW CAN WE INCORPORATE/BUILD ON COMMUNITY STRENGTHS AND ASSETS IN THESE MESSAGES?]

Do you have any additional comments or questions related to H1N1?

[IF "YES," RECORD AND ANSWER THE QUESTIONS. IF "NO," THANK THE PARTICIPANTS AND CLOSE THE DISCUSSION.]

Appendix B:
Key informant interview protocol—community leaders

**Evaluation and Assessment of H1N1 Outreach
Key Informant Interview**

Name of interviewer: _____

Date of interview: _____

Location of interview: _____

Introduction

Thank you so much for taking the time to talk with me. Before we begin, I'd like to share the purpose of the interview.

The Center for MultiCultural Health and its community partners are conducting interviews with community leaders and focus groups with members from the <<insert community>> to better understand how H1N1 information was received in communities of color and immigrant & refugee communities. We are meeting with you and other community leaders to talk about community knowledge, attitudes and beliefs about H1N1; effectiveness of outreach strategies used during the 2009 H1N1 influenza response; and how communication works within the community including communication channels, trusted sources of information and how future information about urgent health issues should be provided.

We will summarize what we learn from you and other community leaders, as well as from community members, in a report to Public Health—Seattle & King County, the agency that is funding this project. In the report, we would like to list the names of the community leaders that we interview and may include quotes from the interviews without names attached.

Do you agree that we may list your name and include quotes—without your name attached—in our report?
 Yes No

IF "YES," CONTINUE WITH THE INTRODUCTION.

IF "NO," DOCUMENT REASON(S): _____

This interview will take about one hour. The interview is voluntary, and you can choose to not answer interview questions or stop the interview at any time. With that in mind, do you agree to proceed with this interview?
 Yes No

IF "YES," CONTINUE WITH THE INTRODUCTION.

IF "NO," DOCUMENT REASON(S) AND THANK THE INTERVIEWEE FOR HER/HIS TIME: _____

To ensure that my notes are accurate, may I audiotape this interview? You may ask me to stop the tape at any time during the interview. Yes No

IF "YES," TURN ON THE TAPE RECORDER AND CONTINUE WITH THE INTRODUCTION.

IF "NO," PROCEED WITH THE INTERVIEW AND TAKE WRITTEN NOTES.

Do you have any questions about the project?

IF "YES," ANSWER THE QUESTIONS.

IF "NO," PROCEED WITH THE INTERVIEW.

Information about interviewee

Name: _____

Title: _____

Group/Organization: _____

Gender: Female Male

For leaders from immigrant and refugee communities only

Country of origin: _____

Primary language: _____

Interview conducted in? _____

Length of time in the U.S.? _____ months/years (circle one)

Description of Group/Organization

1. Please describe your group/organization.

a. When was your group/organization established (year)? _____

b. Please describe your clients/members (e.g., gender, age, languages spoken, place of residence etc.)?

c. Do you provide health-related services?

Yes No

If “yes,” please specify the types of services provided.

d. What other types of services do you provide?

Community Knowledge, Attitudes and Beliefs about H1N1

2. Did you hear about the H1N1 influenza, or swine flu, outbreak?

- Yes No (SKIP TO QUESTION #7)

3. Where did you hear about H1N1/swine flu?

Television (please specify): _____

Radio (please specify): _____

Newspapers (please specify): _____

Community groups/organizations (please specify): _____

Churches/mosques/religious institutions

Schools

Health care providers

Family members

Friends

Other (please specify): _____

4. What did you hear about H1N1/swine flu?

[PROBES: DID YOU THINK THAT H1N1 WAS A SERIOUS/URGENT HEALTH ISSUE? DID YOU HEAR ABOUT GROUPS FOR WHICH H1N1 WAS MORE SERIOUS THAN OTHERS? DID YOU KNOW THERE WAS A VACCINE FOR H1N1 THAT WAS DIFFERENT FROM THE VACCINE FOR SEASONAL FLU? DID YOU HEAR THAT THERE WAS A SHORTAGE OF H1N1 VACCINE?]

5. After hearing about H1N1/swine flu, did you have additional questions?

- Yes No (SKIP TO QUESTION #7)

6. What additional questions did you have?

7. Did community members hear about H1N1/swine flu?

- Yes No (SKIP TO QUESTION #13)

8. Please share any information you have about what community members heard about H1N1/swine flu.
[PROBES: DID COMMUNITY MEMBERS THINK THAT H1N1 WAS A SERIOUS/URGENT HEALTH ISSUE? DID COMMUNITY MEMBERS HEAR ABOUT GROUPS FOR WHICH H1N1 WAS MORE SERIOUS THAN OTHERS? DID COMMUNITY MEMBERS KNOW THERE WAS A VACCINE FOR H1N1 THAT WAS DIFFERENT FROM THE VACCINE FOR SEASONAL FLU? DID COMMUNITY MEMBERS HEAR THAT THERE WAS A SHORTAGE OF H1N1 VACCINE?]

9. After hearing about H1N1/swine flu, did community members have additional questions?

- Yes No (SKIP TO QUESTION #11)

10. What additional questions did community members have?

11. Did community members take action to avoid getting sick or passing H1N1/swine flu to others?

- Yes No (SKIP TO QUESTION #13)

12. Please share any information you have about actions that community members took to avoid getting sick or passing H1N1/swine flu to others.

[PROBES: DID COMMUNITY MEMBERS GET VACCINATED FOR H1N1? DID COMMUNITY MEMBERS WASH HANDS/USE HAND SANITIZER MORE FREQUENTLY? DID COMMUNITY MEMBERS STAY HOME IF THEY WERE SICK AND/OR ENCOURAGE FAMILY MEMBERS TO STAY HOME IF THEY WERE SICK? WERE THERE BARRIERS TO COMMUNITY MEMBERS TAKING ACTION TO AVOID GETTING SICK OR PASSING H1N1/SWINE FLU TO OTHERS?]

Designing Outreach and Communications Efforts

13. Where do individuals in your community get information about health-related issues?

Television (please specify): _____

Radio (please specify): _____

Newspapers (please specify): _____

Community groups/organizations (please specify): _____

Churches/mosques/religious institutions

Schools

Health care providers

Family members

Friends

Other (please specify): _____

14. Are individuals in your community aware of community health centers, public health clinics and other health care institutions where they can information and/or services on urgent health issues such as H1N1?

Yes No (SKIP TO QUESTION #19)

15. What places are considered community resources?

Community health centers (please specify): _____

Public health clinics (please specify): _____

Private providers: _____

Other (please specify): _____

16. Are there barriers to accessing these community resources?

Yes No (SKIP TO QUESTION #19)

17. What are those barriers?

18. How can these barriers be addressed to best meet the needs of your community?

19. When you consider places where individuals in your community get information about health-related issues (REFER BACK TO QUESTION #11), what advice do you have for maximizing the reach and impact of information shared in those ways?
20. How do cultural beliefs and practices influence your community's knowledge, attitudes and beliefs about urgent health issues such as H1N1?
21. What types of messages about urgent health issues are most important for your community?
[PROBE: HOW CAN WE INCORPORATE/BUILD ON COMMUNITY STRENGTHS AND ASSETS IN THESE MESSAGES?]
22. Were you contacted by Public Health—Seattle & King County or others about reaching out to community members about H1N1?
- Yes (please specify): _____
- No (SKIP TO QUESTION #24)
23. Please describe what actions you took in reaching out to community members about H1N1?
24. What role can you and other community leaders play in communicating about urgent health issues such as H1N1?
25. Do you have any additional comments or questions?

IF "YES," RECORD AND ANSWER THE QUESTIONS.

IF "NO," THANK THE INTERVIEWEE AND CLOSE THE INTERVIEW.

Appendix C:
Focus group survey—community members

Focus Group Survey

Demographics

1. What is your age? _____ years
2. What is your gender?
 Female Male
3. What is your race? (CHECK ALL THAT APPLY)
 African/Black/African American
 American Indian/Native American
 White/Caucasian
 Other (please specify) _____
4. Were you born in the United States?
 Yes (SKIP to #7) No
5. Where were you born (country)?
 Ethiopia
 Eritrea
 Somalia
 Russia
 Ukraine
 Other (please specify) _____
6. What year did you come to the United States? _____
7. What is your zip code? _____
8. What is the highest grade or year of school you completed? _____ grade
9. How well do you speak English?
 I do not speak English.
 I speak English, but not very well.
 I speak English well.
 I speak English very well.
10. How well do you read English?
 I do not read English.
 I read English, but not very well.
 I read English well.
 I read English very well.

11. What language do you speak most of the time when you are at home?

- English
- Amharic
- Oromo
- Tigrigna
- Russian
- Ukrainian
- Other (please specify) _____

12. How well do you read the language that you speak most of the time when you are at home?

- I do not read that language.
- I read that language, but not very well
- I read that language well.
- I read that language very well

13. Are you living with children under the age of 18?

- Yes
- No

Knowledge, Attitudes and Beliefs about H1N1

14. Did you hear about the H1N1 influenza, or swine flu, outbreak?

- Yes
- No (SKIP to #16)

15. Where did you hear about H1N1/swine flu? (CHECK ALL THAT APPLY)

- Television (please specify) _____
 - Radio (please specify) _____
 - Newspapers (please specify) _____
 - Community groups/social service organizations (please specify) _____
-
- Churches/mosques/religious institutions
 - Schools
 - Health care providers
 - Family members
 - Friends
 - Other (please specify) _____
-

16. Do you think that swine flu (H1N1) virus spreads from person to person?

- Yes No Don't know

17. Do you think you can catch swine flu (H1N1) by eating pork?

- Yes No Don't know

18. Do you think there are medicines to treat swine flu (H1N1)?

- Yes No Don't know

19. Do you think there is a vaccine for swine flu (H1N1)?

- Yes No Don't know

H1N1 Vaccine Experience

20. Did you try to get H1N1/swine flu vaccine?

- Yes No (SKIP to #23)

21. Were you able to get it?

- Yes No (SKIP to #23)

22. Where did you get the H1N1/swine flu vaccine?

- My regular doctor or healthcare provider
 Hospital (please specify) _____
 Pharmacy (please specify) _____
 School
 Work location (please specify type of work that you do) _____
 Other (please specify) _____

23. How would you describe your experience trying to figure out where to get vaccine?

- Not difficult to find
 Somewhat difficult to find
 Very difficult to find

24. Did anyone else in your household try to get an H1N1/swine flu vaccine?

- Yes No (SKIP to #26)

25. Were they able to get it?

- Yes No

26. Where would you prefer to get vaccinated for H1N1/swine flu? (CHECK ALL THAT APPLY)

- My regular doctor or healthcare provider
- Hospital (please specify) _____
- Pharmacy (please specify) _____
- School
- Work
- Public location
- I wouldn't get the vaccine
- Other (please specify) _____
- No preference (SKIP TO #28)

27. Why would you prefer that option? (CHECK ALL THAT APPLY)

- Cost
- Convenience
- Trust/I trust the people here to know about vaccines and what they are doing.
- Less exposure to sick people
- Familiarity/ I know the location, or I have gotten vaccines and/or medicine there before.

Outreach and Communications Efforts

28. Where do you get information about health-related issues?

- Television (please specify): _____
- Radio (please specify): _____
- Newspapers (please specify): _____
- Community groups/organizations (please specify): _____

- Churches/mosques/religious institutions
- Schools
- Health care providers
- Family members
- Friends
- Internet (please specify): _____
- Other (please specify): _____

29. Do you know about community health centers, public health clinics and other health care institutions where you can get information and/or services on urgent health issues such as H1N1?

- Yes No

30. Where would you go for information and/or services on urgent health issues such as H1N1/swine flu?

My regular doctor or healthcare provider

Community health centers (please specify): _____

Public health clinics (please specify): _____

Other (please specify): _____

Appendix D:
Focus group protocol—community members

Focus Group Cover Sheet

Name of facilitator: _____

Name of notetaker/observer: _____

Date of focus group: _____

Location of focus group: _____

Partnering community group: _____

Focus group conducted in? _____

Checklist

- Surveys completed and collected?
- Educational materials distributed?
- Sign-in sheet completed and collected?
- Stipends distributed?

Focus Group Questions

Introduction

Thank you very much for taking the time to participate in this discussion. Before we begin, we would like to share the purpose of the discussion.

The Center for MultiCultural Health and its community partners are conducting interviews with community leaders and focus groups with members from the <<insert community>> to better understand how H1N1/swine flu information was received in communities of color and immigrant & refugee communities. We are talking with you and other community members about H1N1/swine flu; effectiveness of outreach strategies used during the 2009 H1N1 influenza response; and how communication works in the <<insert community>> including communication channels, trusted sources of information and how future information about urgent health issues should be provided.

We will summarize what we learn from you and other community members, as well as community leaders, in a report to Public Health—Seattle & King County, the agency that is funding this project. This discussion will take about one hour and 15 minutes. The discussion is voluntary, and you can choose to not answer questions or leave the discussion at any time. With that in mind, do you agree to participate in the discussion?

To ensure that our notes are accurate, may we audiotape this discussion?

IF “YES,” TURN ON THE TAPE RECORDER AND CONTINUE WITH THE INTRODUCTION.

IF “NO,” PROCEED WITH THE DISCUSSION AND TAKE WRITTEN NOTES.

Do you have any questions about the project?

IF “YES,” ANSWER THE QUESTIONS.

IF “NO,” PROCEED WITH THE DISCUSSION.

Knowledge, Attitudes and Beliefs about H1N1

1. What do you know (or what did you hear) about H1N1/swine flu?

[PROBES: DID YOU THINK THAT H1N1 WAS A SERIOUS/URGENT HEALTH ISSUE? DID YOU HEAR ABOUT GROUPS FOR WHICH H1N1 WAS MORE SERIOUS THAN OTHERS? DID YOU KNOW THERE WAS A VACCINE FOR H1N1 THAT WAS DIFFERENT FROM THE VACCINE FOR SEASONAL FLU? DID YOU HEAR THAT THERE WAS A SHORTAGE OF H1N1 VACCINE?]

2. What concerns, if any, did you have about H1N1/swine flu?

3. What actions, if any, did you take to avoid getting sick or passing H1N1/swine flu to others?

[PROBES: DID YOU WASH HANDS/USE HAND SANITIZER MORE FREQUENTLY? DID YOU STAY HOME IF YOU WERE SICK AND/OR ENCOURAGE FAMILY MEMBERS TO STAY HOME IF THEY WERE SICK?]

H1N1 Vaccine Experience

Note: Ask the notetaker/observer to review the surveys, so that you can ask questions #3 and/or #4, as appropriate.

4. For those of you who tried to get the H1N1/swine flu vaccine, why did you try to get vaccinated? Tell me about your experience.

[PROBE: WHAT BARRIERS, IF ANY, DID YOU FACE IN GETTING VACCINATED?]

5. For those of you who did not try to get the H1N1/swine flu vaccine, what were your reasons?

[PROBES: DID YOU THINK THAT H1N1 WAS NOT A SERIOUS/URGENT HEALTH ISSUE? DID YOU HEAR THAT THERE WERE LONG LINES FOR THE H1N1 VACCINE? DID YOU THINK THAT THE VACCINE FOR H1N1 WAS INCLUDED IN THE VACCINE FOR SEASONAL FLU? WERE YOU CONCERNED ABOUT VACCINE SAFETY? WERE YOU CONCERNED ABOUT COST OR OTHER ISSUES?]

6. What, if anything, would make you more willing to get vaccinated for H1N1/swine flu?

Outreach and Communications Efforts

7. If you heard about a virus (like H1N1/swine flu) that is suddenly making a lot of people sick, who would you turn to or where would you turn first for information? Why?

[PROBES: HEALTH CARE PROFESSIONALS? STAFF IN HEALTH AND HUMAN SERVICE ORGANIZATIONS? COMMUNITY LEADERS? RELIGIOUS LEADERS? FAMILY AND FRIENDS?]

8. When there is a virus (like H1N1/swine flu) that suddenly makes a lot of people sick, what information would be most helpful to you?

[PROBES: WHAT ARE THE RISKS OF THE VIRUS? HOW DO I PREVENT GETTING THE VIRUS AND SPREADING IT TO OTHERS? WHERE DO I GO TO GET MORE INFORMATION AND/OR TREATMENT? WHAT IS THE COST OF PREVENTIVE SERVICES/TREATMENT?]

Do you have any additional comments or questions related to H1N1/swine flu?

[IF "YES," RECORD AND ANSWER THE QUESTIONS. IF "NO," THANK THE PARTICIPANTS AND CLOSE THE DISCUSSION.]