Meeting Report

Workshop on Risk Communications for Public Health Emergencies

Manila, Philippines
15-17 November 2011
WORKSHOP ON RISK COMMUNICATIONS FOR PUBLIC HEALTH EMERGENCIES

Manila, Philippines
15–17 November 2011

Convened by:

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE WESTERN PACIFIC

Not for sale

Printed and distributed by:

World Health Organization
Regional Office for the Western Pacific
Manila, Philippines

May 2012
NOTE

The views expressed in this report are those of the participants and consultants in the Workshop on Risk Communications for Public Health Emergencies and do not necessarily reflect the policies of the Organization.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for the participants of the Workshop on Risk Communications for Public Health Emergencies, which was held in Manila, Philippines from 15 to 17 November 2011.
CONTENTS

1. INTRODUCTION ........................................................................................................ 1
   1.1 Objectives ............................................................................................................. 1
   1.2 Organization of the workshop .............................................................................. 2
   1.3 Opening remarks ................................................................................................. 2

2. PROCEEDINGS ......................................................................................................... 4
   2.1 SESSION 1: Setting the context for the health emergency communications .................................................................................................................. 4
      2.1.1 Asia Pacific Strategy for Emerging Diseases (2010) ...................................... 4
      2.1.2 Key principles on communications in a health emergency ......................... 4
      2.1.3 Discussion ...................................................................................................... 5
   2.2 SESSION 2: Poster presentations on distilling lessons from Pandemic (H1N1) 2009 ..................................................................................................................... 6
      2.2.1 Group 1: Cambodia, Hong Kong (China), Indonesia and Malaysia ....................... 7
      2.2.2 Group 2: China, Fiji, Papua New Guinea and Singapore ......................... 8
      2.2.3 Group 3: Brunei Darussalam, Republic of Korea and Viet Nam .................... 9
      2.2.4 Group 4: The Lao People’s Democratic Republic, Mongolia, New Zealand and the Philippines ................................................................. 10
   2.3 SESSION 3: Synthesizing our risk communications experience from Pandemic (H1N1) 2009 ............................................................................................................ 11
      2.3.1 Overview of the Pandemic (H1N1) 2009 Medial Project ............................... 11
      2.3.2 Summary of the country reports on Pandemic (H1N1) 2009 Media Project .......................................................................................................................... 12
      2.3.3 Global lessons on risk communications ...................................................... 13
      2.3.4 Panel discussion: key lessons and gaps in health emergency communications ....................................................................................................................... 13
   2.4 SESSION 4: Communicating risks in a health emergency – scenario-based exercise ......................................................................................................................... 16
      2.4.1 Group 1: Dapdap Group ................................................................................. 17
      2.4.2 Group 2: Panda Group ................................................................................. 17
      2.4.3 Group 3: Iceland Group ................................................................................... 18
      2.4.4 Panel discussion – reinforcing principles of risk communications in public health emergencies ......................................................................................... 18
   2.5 SESSION 5: Harnessing risk communications capacity in the Region .......... 20
      2.5.1 ASEAN Risk Communications Strategy ....................................................... 20
      2.5.2 APSED (2010): Emergency Operation Centre (EOC) ................................ 21
      2.5.3 Risk assessment capacity ............................................................................. 21
      2.5.4 APSED (2010) workplan for risk communications ................................... 22
      2.5.5 Discussion: Towards complementation ....................................................... 23
2.6 SESSION 6: APSED (2010) risk communications workplan development ................................................................. 24

2.6.1 Group 1 (Dapdap): Summary of agreements .......................... 24
2.6.2 Group 2 (Panda): Summary of agreements ......................... 25
2.6.3 Group 3 (Iceland): Summary of agreements ....................... 25

2.7 SESSION 7: Strengthening partnerships and capacity development for risk communications ..................................... 26

2.7.1 Cambodia: APSED (2010) National Risk Communications Workplan ............................................................... 26
2.7.2 China: APSED (2010) National Risk Communications Workplan ................................................................. 26
2.7.3 Hong Kong (China): APSED (2010) National Risk Communications Workplan ...................................................... 27
2.7.4 The Lao People’s Democratic Republic: APSED (2010) National Risk Communications Workplan ................................. 27
2.7.5 Papua New Guinea: APSED (2010) National Risk Communications Workplan ......................................................... 28
2.7.6 Viet Nam: APSED (2010) National Risk Communications Workplan ................................................................. 29

2.8 SESSION 8: Summary and agreements .................................. 30

2.8.1 Highlights of the regional synthesis report on pandemic (H1N1) 2009 media messaging and reporting project ........ 30
2.8.2 Closing remarks .................................................................. 31

3. CONCLUSIONS AND RECOMMENDATIONS .......................... 32

3.1 Conclusions ................................................................................. 32
3.2 Recommendations ....................................................................... 33

ANNEXES:

ANNEX 1 : Programme of Activities ................................................. 35
ANNEX 2 : List of Participants, Temporary Advisers, Observers and Secretariat ................................................................. 39
ANNEX 3A : Guidelines for Poster Presentation ................................ 47
ANNEX 3B : Facilitator’s Guide for the Poster Presentation .......... 49
ANNEX 5A : Guidelines for the Scenario-Based Exercise .............. 55
ANNEX 5B : Scenario-Based Exercise – All Paper Injects .......... 63
ANNEX 5C : Scenario-Based Exercise – Screen Injects ............... 77
ANNEX 6 : APSED (2010) Workplan on Risk Communications ............ 83

Keywords:
Communication/Emergencies/Disease outbreaks/Communicable disease control/Pandemics/Risk Management/Disaster planning/Communicable diseases, Emerging diseases
About 50 participants from 15 countries and areas in the Asia Pacific region attended the Workshop on Risk Communications for Public Health Emergencies, held from 15 to 17 November 2011 in Manila, Philippines. The workshop, organized by the WHO Western Pacific Regional Office, brought together communications focal points from ministries of health, technical advisers and representatives of partner agencies.

The workshop provided a venue to share and reflect on national and regional experiences with risk communications from past health emergencies, particularly in response to pandemic (H1N1) 2009. Discussions during the workshop highlighted the importance of distilling lessons and sharing best practices from experiences of Member States.

Building on lessons learnt from pandemic (H1N1) 2009, participants recognized the value of having risk communications procedures, protocols, mechanisms and human resources in place and functional in case of a public health event. Recent outbreaks, natural disasters and food safety events experienced by countries and areas in the region have highlighted the need for ensuring that the capacity is available for health emergency communications.

The workshop consisted of technical presentations, poster sessions, panel discussions, a scenario-based communications exercise and group planning. The scenario-based exercise provided a strategic opportunity for Member States to gain insight into the challenges of ensuring timely and transparent communication to the public during a health emergency situation.

Agreement and support were obtained to implement the Asia Pacific Strategy for Emerging Diseases (APSED, 2010) risk communications workplan in order to meet the core capacity requirements of Member States under the International Health Regulations (IHR, 2005). Participants developed country workplans in line with the regional framework, and agreed to institutionalize a functional mechanism, structure or team for health emergency communications within the Ministry of Health.

Risk communications is fundamental in managing public health emergencies and in ensuring a sense of trust during times of uncertainty. Participants made a commitment to ensure sustainable health emergency communications capacity within the Ministry of Health and requested WHO to continue to provide technical support to countries and areas, in collaboration with other partners and stakeholders.
1. INTRODUCTION

Public health emergencies are inevitable, unpredictable events that are usually characterized by uncertainty, confusion and a sense of urgency. These events can have both direct and indirect social and economic impacts that may have far greater implications and repercussions. While it is not possible to prevent health emergencies, their adverse direct and indirect impacts can be mitigated through effective risk communications.

Risk communications is critically important in managing any acute public health event, especially in the early stage when decisive action has to be taken. Effective risk communications can help people overcome fear and anxiety, make informed decisions on how to protect themselves, and build or maintain their trust in health authorities.

Risk communications involves the proactive exchange and evaluation of information among stakeholders and the establishment of appropriate and effective communication actions and responses. The objectives are to build public trust, to enable and empower populations to adopt protective measures, to reduce confusion and to facilitate enhanced surveillance. Messaging during a health emergency is anchored on risk assessment results, taking into consideration the level of uncertainty and insufficiency of information. Risk communications during a health emergency comprises the initial announcement and information dissemination through the mass media.

1.1 OBJECTIVES

The objectives of the workshop were:

(1) to share and reflect on national and regional experiences with risk communications from past health emergencies, particularly in response to pandemic influenza A(H1N1) 2009;

(2) to distil lessons learnt, identify challenges and share best practices on risk communications approaches from past health emergencies; and

(3) to develop and agree on workplans for national and regional capacity development on risk communications in line with the Asia Pacific Strategy for Emerging Diseases (APSED, 2010) and the Association of Southeast Asian Nations (ASEAN) risk communications strategy.
1.2 ORGANIZATION OF THE WORKSHOP

The Workshop on Risk Communications for Public Health Emergencies was held from 15 to 17 November 2011 in Manila, Philippines.

The workshop, organized by the WHO Regional Office for the Western Pacific, was attended by about 50 participants, technical advisers and observers from 15 countries and seven partner agencies. Representatives from WHO Headquarters, the South-East Asia Regional Office and country offices were also in attendance.

A List of Participants and Programme of Activities are found in Annexes 1 and 2, respectively.

1.3 OPENING REMARKS

Dr Takeshi Kasai, Director, Division of Health Security and Emergencies, WHO Regional Office for the Western Pacific

Dr Takeshi Kasai, Director of the Division of Health Security and Emergencies of the WHO Regional Office for the Western Pacific, delivered the opening remarks. He thanked the participants for their involvement in the workshop, and highlighted the importance of the discussions and outputs to be generated from the meeting.

Dr Kasai emphasized that countries and areas in the Western Pacific Region are prone to emerging diseases and public health emergencies, and as these threats have become more complicated, the role of health emergency communications has become very crucial. It is imperative to better understand the pitfalls in communicating risks and to appreciate the communication capacities needed as part of the health emergency action.

The participants were encouraged to maximize the opportunity to discuss capacity issues and to come up with concrete strategies and actions in line with APSED (2010). Since the challenges are huge, collective action can be more effective and efficient through closer coordination and by combining expertise and resources.
Dr Kasai also acknowledged the complementary efforts of partners and stakeholders in the field of risk communications, and assured them of WHO’s continuous collaboration and partnership. He encouraged them to continue to work together to better coordinate and maximize resources.

Dr Kasai stressed that communication gives a human face to the public health mission and motivated the participants to work towards having the best tools and capacities in risk communications.
2. **PROCEEDINGS**

2.1 **SESSION 1: SETTING THE CONTEXT FOR HEALTH EMERGENCY COMMUNICATIONS**

2.1.1 **Asia Pacific Strategy for Emerging Diseases (2010)**

*Dr Chin Kei Lee, Team Leader, Emerging Disease Surveillance and Response, WHO Regional Office for the Western Pacific*

When APSED was developed in 2005, it was designed to meet the challenges of emerging diseases that pose serious threats to regional and global health security. Its implementation strengthened national core capacities and demonstrated the value of sharing a common framework among countries in line with the International Health Regulations (IHR, 2005), as well as for pandemic preparedness.

The APSED approach has been proven to be effective, and in order to sustain momentum for regional health security, Member States agreed to develop an updated strategy for implementation for another five years. Accordingly, APSED (2010) was designed to address existing gaps and to guide efforts in the prevention and control of emerging diseases and other public health emergencies. APSED (2010) builds on the achievement of the original APSED, while recognizing variations in existing capacity. It also widens its scope to include other acute public health threats (e.g. food safety and health threats due to natural disasters).

As with the previous strategy, the revised APSED (2010) includes risk communications as one of the key focus areas. Although this focus area has three components, health emergency communications is the priority for capacity development.

2.1.2 **Key principles of communications in a health emergency**

*Ms Asiya Odugleh-Kolev, Technical Officer, WHO Headquarters*

Public health emergencies are generally high-profile events. As such, the demand for information from the public and media during a health emergency is likely to exceed normal dissemination capacities. While many aspects will be similar to routine communications, and will build on existing systems and approaches, health emergency communications pose unique challenges, particularly in terms of transmission, speed and efficacy of message.
A combination of factors makes communication in emergencies different: fear and anxiety is high; there is very limited information; and action needs to be taken quickly.

Thus, the key objectives of health emergency communications are to build trust, to enable and empower populations to adopt protective measures, to reduce confusion and to facilitate enhanced surveillance.

Although health emergency communications is very different than routine communications, the underlying standards of practice are the same: methodology is needed; communication must be built on evidence and good practice, drawing upon existing models, theories and frameworks; and it must be applied within existing health systems, infrastructure, public health strategies, policies and guidelines.

The key principles in health emergency communications that should be practised by organizations and response agencies, technical teams and individuals are building trust, announcing early, transparency, understanding the public and planning.

2.1.3 Discussion

The current definition of risk communications under APSED (2010) – where it defines how health emergency communications, operational communications and behaviour change communication fit together and complement each other – is very constructive as it shows the inherent values of each component in the context of public health. It also clarifies the differences as well as the interface among these different components, and what capacity gaps currently exist. Participants expressed appreciation of the inclusivity of the APSED (2010) risk communications components.

One of the crucial elements of health emergency communications is the first announcement, as people need reassurance in times of uncertainty. With more sources of information available, including traditional and social media, it becomes more complicated to leave a communication vacuum in times of a health emergency, as people will fill the vacuum through various channels. Another important element is transparency, as the public needs to feel that the government is open to sharing information.

When there is no public health emergency, it is imperative to reflect on important lessons learnt and build on preparedness efforts. This is also the time to focus on and better understand approaches for behaviour change communications. The private sector is a good source for learning how to improve behaviour change communication approaches, as they are able to connect effectively to the emotions of the public. Knowing the perceptions and belief systems of the public, and conducting an assessment of the communication approaches are important strategies in improving future strategies.
Based on previous country experiences, strengthening operational communication as well as behaviour change communication approaches is key to ensuring that the communication response in a public health emergency is more efficient, and tools are in place to generate greater impact for the intended audience.

2.2 SESSION 2: POSTER PRESENTATIONS ON DISTILLING LESSONS FROM PANDEMIC (H1N1) 2009

In order to capture succinctly the risk communications challenges, lessons learnt and best practices from pandemic (H1N1) 2009, a poster presentation was organized during the workshop. Through the posters, Member States described their experiences with a pandemic that threatened the health of people all around the world, causing much anxiety and having far-reaching health, social and economic impacts.

Weeks before the workshop, participants were given guidelines on how to prepare the posters, what would be the focus and content areas, as well as some presentation requirements (see Annex 3 for the Guidelines for Poster Presentation).
During the session, participants were divided into four smaller groups to present their posters. Each group was asked to:

- review how the pandemic (H1N1) 2009 event occurred and progressed in the countries and areas of the Asia Pacific Region and identify the highlights of the response measures that were implemented on health emergency communications;
- describe the government's health emergency communication arrangement, procedures and protocol;
- highlight the methods by which the government communicated with the media during the pandemic and any change in approach over the course of the pandemic and understand what worked, what did not and why;
- identify key achievements, main challenges and gaps that were faced related to health emergency communications and how the challenges were addressed; and
- share case study examples of either good or poor public health emergency communications during the pandemic and some analysis of the outcomes.

After the poster presentation in small groups, a group summary was shared in the plenary for discussion and identification of achievements, lessons learnt and gaps (see Annex 4 for the Facilitators’ Guide and the Group Discussion Questions).

### 2.2.1 Group 1: Cambodia, Hong Kong (China), Indonesia and Malaysia

All countries and areas in the group have the organizational structure, intra- and inter-agency coordination mechanisms, collaboration arrangements with regional and international organizations and preparedness plans in place for risk communications, with technical experts responsible for its implementation. Although two of the countries and areas have government-controlled media, the main communication channel of the countries in the group during pandemic (H1N1) 2009 was the media.

In terms of achievements, group members agreed that they all benefited from the availability of preparedness plans that they used during the response to the pandemic. This enabled them to convey consistent messages to internal and external partners, ensuring that the same message went out to all stakeholders and the public. The support of private sector (non-media) organizations for community mobilization was also appreciated in proactively sharing information to the media in a timely manner. In all countries and areas in the group, studies carried out after the event demonstrated an increased public awareness on health issues, particularly on pandemic (H1N1) 2009.
The main gaps in the communications strategies that were acknowledged by the participants included how to address the market-driven media, how to sustain post-event communications, insufficient funding, lack of information and no structure to support communications.

For future action, group members considered identifying alternative communication channels, updating their communication plans, mobilizing additional resources, putting in place a structure and/or system to carry out public perception assessments (before, during and after the events), and formalizing regional networks for communications.

2.2.2 Group 2: China, Fiji, Papua New Guinea and Singapore

Group members agreed that one of the major highlights of risk communications during pandemic (H1N1) 2009 was having appropriate risk communications strategies for the different phases of the pandemic. They also took a “whole of government approach” (both for technical and non-technical issues) that enabled them to facilitate public–private partnerships. Their transparent information sharing made these countries gain public trust at the most crucial time of the pandemic.

The key decisions and actions that the countries considered as their achievements during the pandemic were the capacity to provide appropriate information to the media in a timely manner and in obtaining feedback through various sources. Effective public communication and behaviour change campaigns contributed to the limited number of cases and also boosted the relationship between the government and the media institutions. Emergency preparedness plans were backed up with legislation and political support.

The group identified the following obstacles in doing better work on health emergency communications: limited resources, inconsistent and/or contradictory information, incongruent interest between the experts and the media, lack of platforms to disseminate messages to the public and lack of a mechanism for better management of timely, accurate and simple information.

To better prepare for future health emergencies, members of the group agreed on the following action points: implement the APSED (2010) and IHR (2005) strategy for risk communications; strengthen the capacity of Emergency Operations Centres (EOCs); agree on mechanisms for an international risk communications platform; facilitate sharing of surveillance information; and strengthen behavioural change communication approaches.
2.2.3 Group 3: Brunei Darussalam, Republic of Korea and Viet Nam

The countries in this group had varied experiences with risk communications during pandemic (H1N1) 2009. In Brunei Darussalam, the pandemic came late and at a time when the population was already aware of the disease happening in many parts of the world. In the Republic of Korea, where infection and death rates were high, the Government engaged only traditional, privately owned media, and did not take into account online media. In Viet Nam, the early response structure paved the way for good dissemination of information, supplemented with extensive and government-controlled press (including online media). The Government also used existing medical networks for its risk communications.

The following decisions and actions were considered by the group to be achievements during the pandemic: (1) close media and government relations that enhanced cooperation for effective public health messaging; (2) evaluation of public trust in the government’s communications; (3) good information management systems; and (4) utilization of the existing health communications networks at all levels of the government.

Based on the group’s experience, two of the main gaps in risk communications were the lack of media skills of the health professionals and the media’s limited understanding of disease outbreaks. Limited monitoring and evaluation of the effectiveness of the messages was also identified as a major gap.

In countries where social networks are widely used by the public, failure of the government to provide timely information often results in mistrust. This usually happens when the value of social media is underestimated and the focus remains on traditional news media (e.g. newspapers, TV and radio).

Moving forward, the following key actions are needed: (1) incorporating social media into the health emergency response system; (2) educating the public about response to public health emergencies; (3) developing a system to monitor and evaluate health emergency communication responses and continuous training; and (4) conducting simulations and exercises.
2.2.4 Group 4: The Lao People’s Democratic Republic, Mongolia, New Zealand and the Philippines

During the height of pandemic (H1N1) 2009, governments of countries in this group were taken aback by the intense information demands of the media on issues involving public health emergencies. The pandemic revealed the need for dedicated communications expertise within the ministry of health.

The group highlighted the importance of integrating communications into planning and response and recognizing communications as a technical expertise. The emergency management function and plan were developed and established during the pandemic.

The group considered the following as their key achievements: (1) coordination and cooperation across health and non-health agencies; (2) consistency of messaging among stakeholders; (3) openness and accessibility of the governments to develop trust; and (4) the ability to reach the isolated communities.

Amidst the achievements, main gaps were also pointed out: lack of trained and dedicated media spokespersons; limited resources to deal with the surge capacity; limited capacity to manage the new media; and lack of mechanisms to handle cross-agency coordination arrangements from the beginning of the outbreak.

For future actions, group members agreed to formalize their risk communications roles in the context of APSED (2010), to prioritize regional investment in country-level risk communications planning and capacity development (forums, training and tools development), and to strengthen cross-government coordination for health emergency communications.
2.3 SESSION 3: SYNTHESIZING OUR RISK COMMUNICATIONS EXPERIENCE FROM PANDEMIC (H1N1) 2009

This session aimed to synthesize lessons from the pandemic experience. It was conducted using a combination of plenary presentations on key themes and panel discussion with the technical advisers.

2.3.1 Overview of the Pandemic (H1N1) 2009 Media Project

Ms Joy Rivaca Caminade, Technical Officer (Risk Communications), Emerging Disease Surveillance and Response, WHO Regional Office for the Western Pacific

In 2009–2010, the H1N1 pandemic threatened the health of people all around the world, causing much anxiety and having far-reaching health, social and economic impacts. The pandemic spurred extensive public health activity in all settings, including media-based public health communications.

The WHO Regional Office for the Western Pacific invited 15 ministries of health to implement a project to assess the extent, nature and success of media messaging during pandemic (H1N1) 2009. The project involved a retrospective review of all ministry of health and WHO press statements (e.g. press releases, conferences and interviews) as well as sample national media reports (related to the press statements) during the study period (25 April 2009–14 August 2010). In-depth interviews with key stakeholders were also conducted.

The project was expected to generate the following: (1) country-specific reports on media messaging and reporting during the H1N1 pandemic; (2) a published compilation of the country-specific reports; (3) media monitoring tools that could be used in any public health event; and (4) a regional database/network of WHO, ministry of health and media agency health emergency communication focal points.

Preliminary results from the project were presented in the workshop for initial review as well as for use as input in the succeeding discussions during the workshop.
2.3.2 Summary of the country reports on Pandemic (H1N1) 2009 Media Project

Mr Adam Craig, Consultant, Emerging Disease Surveillance and Response, WHO Regional Office for the Western Pacific

All countries participating in the project noted the importance of clear and targeted risk communications messaging during a public health emergency. Countries used a combination of media-based crisis communication and health promotion activities to meet their public health communication objectives. Media-based emergency communication and health promotion (before and during an event) were seen as complementary and necessary components of a comprehensive risk communications strategy.

During the pandemic, the number of press releases issued by countries participating in the in-depth analysis ranged from 10 to 145. Similarly, the methods that ministries of health and WHO used to disseminate information to the media ranged dramatically, from simply issuing written press statements to undertaking a combination of information dissemination methods including government-initiated media interviews, website updates and press conferences.

Analysis indicated that the two most common content areas of country-issued press releases were epidemiological updates (56%; range: 15% to 93%) and information about national response activities (20%; range: 10% to 44%). Releases also contained behaviour change messages, but they were secondary to the above-noted key content areas. These content areas likely reflected the media (and public’s) information demands at the time.

Based on the preliminary report, some of the conclusions from the study were as follows:

- Mass media communication is a key public health tool, not just a public relations exercise.
- Clear, agreed and tested internal communication mechanisms enable and empower the media function of the ministry of health.
- Media spokespersons and/or units need to be a central part of emergency response teams.
- Government messages must be the first, must be correct, must be credible in times of emergencies and must acknowledge uncertainties.
- Fostering trust between the government and the media can aid clear and accurate reporting.
- Emergency situation guidelines for the media may assist national governments in meeting their communication objectives.
2.3.3 Global lessons on risk communications

Mr Thomas Abraham, Journalism and Media Studies Centre, University of Hong Kong

Lessons learnt during pandemic (H1N1) 2009 on risk communications can be summarized into three main areas:

(1) The public and public health sector perceive risks very differently during a pandemic. The challenge is to devise a way to use communication to bridge this gap.

(2) There is a need to integrate emergency and outbreak communication tools with long-term health communication strategies.

(3) The public health sector needs to understand how to communicate risk to rural communities.

Risk communications needs to act as a bridge between expert assessments and public assessments of risk, where the outcome is a shared understanding of risk, and a consensus on what needs to be done. This reinforces the message that risk communications is not about putting out messages and persuading the public to accept them, but a process of reaching consensus. This, however, changes during an emergency situation where people need to know quickly what to do.

Disease outbreaks and the emergence of new diseases happen at the level of communities, and often at the animal–human interface. Models for community-level risk communications should be established to actively engage communities in managing risks.

2.3.4 Panel discussion: key lessons and gaps in health emergency communications

Moderator: Mr Adam Craig, Consultant, Emerging Disease Surveillance and Response, WHO Regional Office for the Western Pacific

The objectives of the panel discussion were intentionally broad in order to capture key lessons learnt from pandemic (H1N1) 2009 in terms of public health emergency risk communications and to identify the gaps in national and global responses.
Panel members
Panel members were Dr Husnina Ibrahim, Senior Principal Assistant Director, Ministry of Health, Malaysia; Ms Bey Mui Leng, Director, Corporate Communications, Ministry of Health, Singapore; and Mr Thomas Abraham, Journalism and Media Studies Centre, University of Hong Kong, Hong Kong (China).

The panel discussion ran for 40 minutes and covered the following issues and/or questions:

■ Reflect on your experience during the pandemic and, in broad terms, how well you think the public health system did with regard to media-based risk communications during the emergency. Why do think this?

■ What were the critical events and/or situations that challenged your jurisdiction’s media communication efforts? Reflect on why they were challenges for your organization, what impact they had, how they were handled and what you or your organization learnt from them.

■ What were some of the notable successes in public health risk communications during the pandemic? Reflect on the factors that led to these successes and how these factors could be capitalized on for capacity development and response activities.

■ The pandemic reinforced the public health system’s appreciation of the important role risk communications plays in emergency responses. What are the major (internal and/or external) barriers to strengthening public health risk communications capacity in the region, and how can these challenges be addressed? What would you suggest doing to address them?

■ You are about to outline your advice to the ministers on what needs to be done to bolster risk communications capacity in the region in preparation for another influenza pandemic. What are the three key points of advice you would give?
**Discussion**

Based on Singapore’s experience with severe acute respiratory syndrome (SARS) in 2003 and pandemic (H1N1) 2009, it was noted the importance of identifying a central source of information to establish linkages with technical experts in the field, such as WHO, and to communicate with the media. The single source of information enabled Singapore to ensure consistent messaging.

During health emergencies, media communication is one component of a spectrum of activities that needs to be done right because of its high-intended value. Communication from the senior management down to the other members of the organization should also not to be missed out.

In Malaysia, the Government views communication as a critical component of its preparedness effort. It works hard to ensure that stakeholders coordinate during public health events, that networking arrangements are in place, that culture and ethnicity are addressed when communicating risk to the public, and that staff commitment is developed. As a result, the public is assured that the Government is protecting its people.

Infectious diseases, outbreaks and health emergencies are considered highly political issues in many countries because of the economic, social and political consequences of these events. This amplifies the need for transparency in communication, in developing trust and in responding to issues in a timely manner. Trust is fragile and can be destroyed with just one mistake. It is usually tougher to regain trust if it has been lost.

In New Zealand, the Government develops key messages at national level that can be slightly modified for various audiences. Overall, however, the messages conveyed to communities remain consistent.

In many government health agencies, roles are structured horizontally, making establishing relationships challenging. The presence of command-and-control structures would help facilitate coordination arrangements and operationalize a feedback mechanism.

Understanding the public’s perception of the way communication should be handled is crucial. Yet, this aspect of communication remains to be one of the least understood and most challenging. It is imperative to conduct more research on public perception and to tap available resources (such as academic institutions) to understand the nuance of public perception. Methodologies, tools and skills also need to be developed.
2.4 SESSION 4: COMMUNICATING RISKS IN A HEALTH EMERGENCY – SCENARIO-BASED EXERCISE

To increase participants' appreciation and understanding of the concept of risk communications in the context of a health emergency, this session was designed for participants to work through scenarios inherent in an emergency situation. The exercise also intended for participants to identify key principles and strategies of risk communications and its application in a health emergency and to start thinking of some of the existing capacity gaps at the country level and the needed actions to apply, integrate and institutionalize health emergency communication functions.

Participants were divided into three groups to discuss the given scenarios and to agree on specific decisions and actions (see Annex 5 for the Guidelines for the Scenario-Based Exercise).

During the exercise, groups were given three injects and 30 minutes to work on the tasks required for each scenario. After completing the tasks for the third inject, the groups were given another 15 minutes to debrief, to reflect on their experience and to synthesize their actions. Based on the exercise, groups identified the following and reported back in the plenary session:

- five most important elements of health emergency communications,
- five important decisions to make for communications, and
- five key capacities needed for health emergency communications.
2.4.1 Group 1: Dapdap Group

The most important elements of health emergency communications identified by this group were support for preparedness, evidence-based decision-making and proactive action, credible spokespersons, and mechanisms to engage stakeholders.

In times of health emergencies, the ministry of health should make the following strategic decisions: define roles and responsibilities; implement the risk communications plans and identify resources; ensure timely and transparent communication; and coordinate surveillance and risk assessment.

As part of the health emergency plans, the ministry of health should have a team of communication professionals with the right skills at all levels and capacity development should be sustained. A culture of being responsive, accountable, flexible and adaptable should be developed. The communications team should take a leadership role in communicating risk to the public and other stakeholders, and in coordinating partner relations. Best practices need to be documented for knowledge sharing.

2.4.2 Group 2: Panda Group

Maintaining trust and cultivating better relations with the media were two of the key elements identified for health emergency communications. Equally important elements were establishing mechanisms to improve coordination and communication with stakeholders and local communities, setting up monitoring and evaluation systems and conducting public perception studies. A proactive disease surveillance and information sharing system underpins the functionality of health emergency communications.

At the time of health emergencies, the ministry of health should be proactive in addressing stakeholder concerns and in advocating for community action. It is critical that risk communications strategies allow for risk assessment results to feed into key messages. Targeting the primary audience will ensure proper use of resources and more effective results.
In terms of capacity, the communications team within the ministry of health needs to develop skills in media relations, social media liaison, resource mobilization, communications planning and communications training.

2.4.3 Group 3: Iceland Group

This group identified several practices in their own countries that could hinder efficient risk communications in times of emergencies. The issues that need to be addressed by governments include: developing trust; ensuring transparency; listening to the public; making early announcements; and planning. They also need to address intra- and inter-agency coordination, clearly target their audiences and tailor their messages accordingly.

During health emergencies, governments should strategically and quickly act on identifying roles and responsibilities of key staff (i.e. who is doing what and when) and seek advice from experts on issues that affect the nature of the public health emergency. Equally important is setting up a communications team for the event (based on existing protocols and plans), identifying channels of communications and planning the content and timing of the messages.

Communications teams within ministries of health need to develop core capacities for resource mobilization, collaboration development (including risk assessment team, partnership arrangements with relevant ministries, media, nongovernmental organizations, private sector), media surveillance, managing an emergency risk communications operation centre, and risk communications planning.

2.4.4 Panel discussion: reinforcing principles of risk communications in public health emergencies

Moderator: Dr Darren Hunt, Acting Director of Public Health, Ministry of Health, New Zealand; Panel Members: Leaders of Dapdap, Panda and Iceland Groups

After a presentation of the group reflections, the team leaders of the three groups that participated in the scenario-based exercise acted as panel members in a discussion on the capacity development considerations for health emergency communications that could be derived from the exercise.
Discussion

Communications is an important part of any government’s health programme. Some of the key points that governments should consider in order to be effective in communications include the following:

- Governments should establish their role as the trusted and credible source of information at all times, but most especially in times of emergencies and uncertainties.
- Government officials need to develop pragmatic thinking in protecting public health. It is also crucial to decide on the appropriate mechanisms for health emergency communications, whether in terms of developing new arrangements or building on existing mechanisms.
- The principle of collaboration and coordination needs to be applied in such a way that various priorities are strategically linked with each other (e.g. risk assessment and its implication for response and action). Mechanisms should be put in place to foster coordination among stakeholders such as local and international media and relevant government agencies.
- One of the challenges in preparing for health emergency communications is the application of principles into concrete, on-the-ground actions. This usually necessitates conducting emergency drills in order to develop an “instinct” for what to do during emergencies. Leadership training may also be provided.
- The emergence of the social media makes information readily-available in real time. Governments should find ways to maximize the potential of the social media to make information available as quickly as possible.
- The triggers for shifting to emergency mode and the communications implications for the shift are less understood on the ground. Understanding these triggers and the appreciation for the needed actions are critical to ensure that the needed resources are allocated for health emergency actions.
- Governments need to develop their ability to manage a sudden influx in communication requests during a public health event, i.e. surge capacity.
- A regional framework for health emergency communications needs to be developed and agreed upon to ensure coordination and to develop a sense of shared responsibility for the region’s health security.
2.5 SESSION 5: HARNESSING RISK COMMUNICATIONS CAPACITY IN THE REGION

Risk communications is one of the capacity development requirements mandated under IHR (2005), and one of the pillars of APSED (2010). Given the global and regional frameworks, initiatives have been developed to support capacity development for risk communications. This session talked about the initiatives of WHO and ASEAN to support its Member States to develop this core capacity, as well as other initiatives with a direct link to successful operationalization of risk communications functions.

2.5.1 ASEAN risk communications strategy

Dr Husnina Ibrahim, Senior Principal Assistant Director, Ministry of Health, Malaysia

In order to comply with IHR (2005) requirements, and in line with APSED (2010), the Association of Southeast Asian Nations (ASEAN) developed and implemented a Communication and Integration Strategy under the ASEAN Plus Three Emerging Infectious Diseases Programme (funded by the Australian Agency for International Development, or AusAID). One of the projects related to risk communications was the establishment of the ASEAN Risk Communications Resource Centre, hosted by the Ministry of Health, Malaysia. The initiative, which was endorsed in July 2010 at the ASEAN Health Ministers Meeting held in Singapore, aims to contribute to capacity development of ASEAN Member States.

The overall goal of the Centre is to establish a central capacity within ASEAN to provide leading edge training and research in risk communications for emerging infectious diseases. The Centre will also ensure that capacity-building activities will be based on the needs of the Member States, and that the rich experiences of the countries on risk communications will be systematically shared among countries as part of the Centre’s research and training programme.

Various activities are scheduled in the next five years, based on the workplan developed by the Member States. The current challenge is to ensure that activities involving communications teams within Member States complement each other, and that duplication is minimized if not avoided. One of the immediate activities for which WHO can provide technical support is the conduct of training for trainers on risk communications, scheduled by ASEAN for its communications focal points.
2.5.2 APSED (2010): Emergency Operation Centre (EOC)

Dr Li Ailan, Medical Officer (International Health Regulations), Division of Health Security and Emergencies, WHO Regional Office for the Western Pacific

Public health emergency preparedness is a new APSED focus area. It is critically important for countries and areas to prepare a response to acute public health emergencies in order to mitigate the negative impacts on health, the economy and social development. Steps taken to strengthen public health emergency preparedness should build on the foundation laid for pandemic influenza preparedness and the important lessons learnt from the response to pandemic (H1N1) 2009.

Countries are encouraged to prepare a public health emergency response plan (PHEP) that incorporates a common platform for command, control and coordination of response operations. Also, under APSED, each country is expected to develop a national command and response structure and a common response operation platform – Emergency Operation Centre (EOC) – so that PHEP can be rapidly implemented when required.

Together, PHEP and EOC enable timely decision-making and response, which are needed to handle the rapidly changing nature of public health emergencies, increasing public pressure, and legal requirements under IHR (2005). The PHEP and EOC also provide a streamlined structure to connect them with other focus areas and components, such as surveillance, risk assessments, response, risk communications, response logistics, coordination of surge capacity, and health care facility and point-of-entry preparedness.

2.5.3 Risk assessment capacity

Dr Ruth Foxwell, Epidemiologist, Emerging Disease Surveillance and Response, WHO Regional Office for the Western Pacific

Risk assessment, as a key component of an effective, evidence-based decision-making process, enables countries to adopt an integrated, multidisciplinary approach to public health emergencies and to build capacity in surveillance and response. Evidence-based decision-making through risk assessment provides policy-makers with defensible proof for their decisions and actions, which enables them to cope better with public pressure and the unpredictability and uncertainty of public health events. Risk assessment also serves as the base for risk communications, which governments are mandated to do to protect public health.
In the next five years, reliance on information from various sources to assess risk will be more pronounced as diseases become more complicated and various hazards could affect national borders. Risk assessment not only provides an evidence base for decisions, but also optimizes resource use and improves the timeliness of response. To do all of these effectively, however, evidence from surveillance must be accurate and timely.

Under APSED (2010), Member States are encouraged to develop capacity for risk assessment at the country level in a systematic way and to set up operational links between risk assessment and risk communications in a coordinated manner.

### 2.5.4 APSED (2010) workplan for risk communications

APSED (2005) raised the profile of risk communications, and paved the way for Member States to develop national and regional plans that were put to test during pandemic (H1N1) 2009, and other outbreaks of diseases such as H5N1, dengue and leptospirosis. In addition, APSED also provided an opportunity for key personnel to receive training on risk communications and media relations.

Moving forward, APSED (2010) recognized a gap in capacity for risk communications during public health events in many countries and areas in the Asia Pacific region, and therefore gives priority to developing systems, procedures and structures to strengthen capacities for in-country health emergency communications. APSED (2010) advocates that a structure, team or mechanism should be established and/or developed to proactively and efficiently coordinate health emergency communications.

In five years, it is envisioned that a sustainable and integrated health emergency communications system will exist within each ministry of health, and that a communications structure, team or mechanism will be in place to ensure effective linkages with other sectors during public health emergencies. A coordination arrangement will be established with the health promotion and/or education unit and other stakeholders, both for public health emergencies and for long-term social mobilization programmes. An institutionalized system will be functional and provide an interface for the risk communications team to work closely with surveillance, risk assessment and response during health emergencies and for prevention and response actions.
APSED (2010) also advocates for the development of a mechanism for efficiently generating feedback from the public and documenting lessons and best practices from past health emergencies. This will ensure that lessons from field experiences are used to improve future risk communications strategies. Human resource development programmes will be available to ensure career advancement of risk communications professionals and the sustainable availability of the expertise within the ministry of health.

2.5.5 Discussion: Towards complementation

Risk communications, especially in the context of a health emergency, should be understood as more than just giving information to the public, in the same way that it is more than just transmitting risk assessment results to a wider audience. Risk communications should be contextualized as a two-way process and an integral element within the overall risk management framework.

Risk assessment results would provide a key input in the messages communicated to the public, in the same manner that risk communications also feeds into the risk assessment process and provides the human factor. Given the interdependence of these two disciplines, the establishment of a systematic link is critical to ensure that messaging is coordinated and based on scientific evidence.

The interface between risk assessment and risk communications also provides opportunities for the development of capacities, especially in strategic communications, public perception assessment (media feedback), behaviour change analysis, etc. It also provides an opportunity to bring in other expertise in order to balance the scientific results with the human factors of risks.

Based on country experiences with various risks, the application of risk communications is a sophisticated process and often multi-faceted based on the evolving nature of the public health emergency. The key is to ensure that the risk communications system is robust enough to cope with the challenges. Building and maintaining a strong system will depend not only on capacity development of key staff, but also on continuous policy advocacy for sustainable support for risk communications.
2.6 SESSION 6: APSED (2010) RISK COMMUNICATIONS WORKPLAN DEVELOPMENT

Participants were divided into three groups to review the draft APSED (2010) workplan on risk communications (see Annex 6 for the Draft APSED 2010 Workplan on Risk Communications). Each group was requested to answer the following questions:

(1) What do you think of the proposed vision and strategic directions for risk communications in our region? How should we move towards a common vision collectively in the next five years?

(2) Do you think the proposed actions contained in the APSED (2010) workplan are important and feasible for countries? Why? What would you suggest as additional and/or priority activities for countries and for WHO? Provide timeline.

At the end of the discussion, groups provided a quick summary of what was discussed, highlighting key aspects of capacity that need to be addressed nationally.

2.6.1 Group 1 (Dapdap): Summary of agreements

Group 1 unanimously endorsed the vision and actions within the APSED (2010) workplan on risk communications. Most countries in the group were already integrating these actions into their national workplans to varying degrees. The group’s suggestions and comments focused on clarification and expansion of the workplan rather than change of direction.

All countries in the group have existing structures that can be further developed to cover health emergency communications. Coordination arrangements are also in place, but the degree of functionality varies across countries. They all agreed that working mechanisms are to be functional in five years but recognized that this would require more structure, resources and commitment.

The group believed that most of the milestones at the country level are achievable, but the regional activities and mechanisms are more challenging, although desirable. They also suggested including a knowledge management component in the workplan – to collect and share best practices regionally and nationally (as a role of WHO perhaps?) and to build on existing mechanisms to avoid duplication. Monitoring and evaluation could also be added.

For capacity development, there are provisions to use existing systems and processes to formalize the desired outcomes, e.g. competencies. Activities in the workplan could be made more outcome-focused to allow individual countries the opportunity to develop what works for them.
2.6.2 Group 2 (Panda): Summary of agreements

The current vision advocates for sustainability of risk communications within the ministry of health through the existence of a risk communications team or structure and a career development programme for staff. For this to happen, there would have to be strong linkages/coordination mechanisms agreed upon and the location of the risk communications team/division is clearly defined within the ministry.

Although common activities have been identified, implementation might differ in each country. The capacity development aspect of the workplan should be sufficiently supported with training and the development of core competencies. Appropriate use of technologies and methods should be encouraged, when possible. As with any other new initiatives, getting into the political agenda would generate the needed policy support for institutionalization.

In terms of complementing efforts, partnerships could be established with organizations and institutions with risk communications programmes, such as the ASEAN Plus Three Emerging Infectious Diseases Programme, especially in the conduct of training and in documentation of best practices.

2.6.3 Group 3 (Iceland): Summary of agreements

Strong ties and coordination arrangements with international experts such as WHO would lead to complementation of work and better use of resources. The group also suggested to focus some of the key areas of capacity development on policy-makers (to advocate for institutionalization) and to hasten community participation and mobilization (to ensure sustainability).
2.7 SESSION 7: STRENGTHENING PARTNERSHIPS AND CAPACITY DEVELOPMENT FOR RISK COMMUNICATIONS

Based on the APSED (2010) workplan for risk communications, representatives from Member States were asked to develop national workplans in line with APSED. Some of these representatives volunteered to share and present their outputs during the workshop to generate feedback and to ensure consistency with their neighbours.

2.7.1 Cambodia: APSED (2010) National Risk Communications Workplan

Dr Teng Srey, Vice-Director, Communicable Disease Control Department, Ministry of Health, Cambodia

Cambodia’s vision and overall objectives are in line with the APSED (2010) workplan. To implement the workplan at the country level, advocacy and integration activities will focus on human resources development (from the national to the district levels), improvement of internal communication with partners working on the same issues, and increased involvement of stakeholders for resource mobilization.

To realize the institutionalization of the risk communications functions, both short- and long-term plans need to be developed, as well as an organizational communications strategy. A system to generate feedback and contribute to future risk communications strategies is also a priority. Standard operating procedures and protocols for health emergency communications need to be developed, tested and periodically updated.

2.7.2 China: APSED (2010) National Risk Communications Workplan

Dr Li Jie, Vice-Director, Training and Education Division, Health News and Communication Centre, Ministry of Health, China

China is confronted with multiple challenges, including a huge population, a lack of budget for risk communications, expansive rural areas, low health literacy (6.8%), widespread preference of health officers to dictate the way the media receives information instead of adjusting to the needs of the media, and a limited capacity to relate to both traditional and social media.
Under the APSED (2010) workplan, the Ministry of Health aims to assist its provincial-level political promotion, enhance district- and county-level risk communications capacity through trainings, refocus training activities from theory to best practices (with the help of WHO), improve risk communications research (to consider social and cultural contexts, advocate for increased resource allocation for health and develop its education and behaviour change programmes.

2.7.3 Hong Kong (China): APSED (2010) Risk Communications Workplan
Dr Choi Mei Yee, Head, Emergency Response and Information Branch, Center for Health Protection, Department of Health, Hong Kong (China)

In Hong Kong (China), risk communications is an essential part of all contingency plans. Also, there is a designated team and spokespersons for crisis communication, supported with regular training and a redeployment plan to address surge capacity.

The Government has a panel of experts that advises the Center for Health Protection on risk communications strategies and approaches, shares its views on the relevance and effectiveness of messages, provides guidance on public perception, points out potential blind spots for risk communications, and gives independent assessment and feedback on the effectiveness and relevance of risk communications actions implemented by the Center. Under APSED (2010), the Government will continue all efforts and also explore more ways to use new and evolving media.

2.7.4 The Lao People’s Democratic Republic: APSED (2010) National Risk Communications Workplan
Dr Khamphithoun Somsamouth, Deputy Director, Center for Information and Education for Health, Ministry of Health, Lao People’s Democratic Republic

The vision of the Lao People’s Democratic Republic for its workplan is to ensure better coordination among health and non-health stakeholders at all levels in order to deliver specific risk communications messages to the different target audiences during health emergency events. The Government’s main activities will focus on strengthening its task force and establishing a risk communications network at the provincial and district levels, advocating to politicians and policy-makers, and developing a monitoring and evaluation
framework for risk communications, among others. One of the cross-cutting issues to be
addressed will be surveillance and investigation, which will focus on ensuring that risk
assessment is done to support development of messages and conceptualization of
campaigns.

Some of the challenges in moving the workplan forward will be strengthening the
competency of staff to translate risk communications principles into action, building
capacity to implement interventions, getting policy support for risk communications,
which is considered a new concept in the country, appointing a skilled focal person for
risk communications as a member of a national emergency taskforce, and working with
multiple stakeholders to ensure coordinated intervention.

2.7.5 Papua New Guinea: APSED (2010) National Risk Communications
Workplan
Dr Ennio Kuble, Consultant, Multimedia, National Department of Health,
Papua New Guinea

APSED (2010) is in line with the Department of Health’s National Plan 2011–2015 and the
Government’s Medium-Term Development Goals (MTDG) for 2011–2020. The Government
acknowledges WHO’s technical support in the development of the risk communications
workplan plus other APSED (2010) components. Thus, Papua New Guinea’s workplan
on risk communications covers the three elements and the various activities identified as priorities: health emergency communications; operational communications; and behaviour change communications.

Some of the activities put forth in the workplan are strengthening communications
mechanisms and development of appropriate standard operating procedures for media
response; monitoring and analysis; skills training for spokespersons at all levels;
maintaining formal linkages with stakeholders at all levels; conducting feedback and
impact evaluation of emergency communication during health emergencies;
synthesizing lessons learnt and best practices from past health emergencies; developing
national guidelines and tools for behaviour change communications for all relevant
hazards; and advocating and strengthening the Healthy Islands concept to ensure
sustainability.
2.7.6 Viet Nam: APSED (2010) National Risk Communications Workplan

Dr Nguyen Thi Lim Lien, Deputy Director, National Center for Health Education and Communications, Ministry of Health, Viet Nam

In Viet Nam, all media organizations are owned and controlled by the Government and are managed and supervised by Viet Nam’s Ministry of Information and Communications. Although a health emergency communication procedure is in operation, it uses a one-way channel and there is no feedback mechanism. During health emergencies, daily press reviews are done and reports are prepared for the Ministry of Health. However, the country’s media structure limits the transparency of information from the government sector.

Viet Nam’s risk communications workplan for APSED (2010) will focus heavily on the structural arrangements, development of coordination mechanisms and strengthening of partnerships and linkages. It will also improve advocacy for policy and programme support and enhance career development for staff working on risk communications.
2.8 SESSION 8: SUMMARY AND AGREEMENTS

2.8.1 Highlights of the regional synthesis report on pandemic (H1N1) 2009 media messaging and reporting project

Mr Adam Craig, Consultant, Emerging Disease Surveillance and Response, WHO Regional Office for the Western Pacific

While differences in approach and social structures exist across the region, there are common health emergency communication principles that are shared by all countries that participated in a project to assess the implementation of media-based crisis communication by Member States across the Western Pacific Region during the H1N1 pandemic. The five outbreak communication principles articulated in the WHO Outbreak Communication Planning Guide (2008) were understood and valued by all participants and countries. These principles also served as the cornerstone for the outbreak communication capacity-building work undertaken by the WHO Regional Office for the Western Pacific Region and its partners through APSED. However, there are gaps between understanding the principles and the capacity to implement related action in some contexts.

Member States reported many lessons in media-based emergency communication from their pandemic experiences. Many of these experiences were unique to the individual countries and hence have been captured in their own national analysis, while others were shared by many countries. Specifically, most countries valued the importance of the following elements of health emergency communications:

- well-developed emergency communication plans in place before an emergency;
- media-savvy spokespeople who have the support they need to proactively engage the media;
- strong operational communication protocols and systems in place that ensure rapid and accurate transfer of information between different arms of government and consistency in public messaging;
- timely and regular information to the media to manage rumours that may develop;
- gaining and maintaining the public’s (and the media’s) trust;
- understanding the public’s information needs and responding to them appropriately; and
- efficient handling of information provision to the media to avoid being overwhelmed by demands for information.

Some challenges were faced by Member States when implementing media-based emergency communication, such as the following:

- All countries noted the challenges faced in developing somewhat complex public health messages in a time of high anxiety and limited information.
Ensuring adequate human resources were available for media-based risk communications during the emergency was reported as a challenge in all settings but particularly in resource-poor developing countries. Some country reports noted that while adequate information was provided to journalists a lack of understanding of the pathogenesis of the influenza virus or general lack of understanding of public health responses resulted in incorrect, and sometimes sensationalized, reporting that provoked public anxiety. Information demands placed upon ministries of health during emergency situations will, in the short term, likely be overwhelming. To manage the impact of this, it is important that systems are in place to ensure that the surge in information demand does not derail broader disaster response activities. Finding the right balance between the early reporting of information to the media and information verification/confirmation raised anxiety. Some countries reported experiencing logistical, cultural or language barriers when delivering messages to citizens in remote locations or from diverse ethnic or language groups.

2.8.2 Closing remarks

Dr Chin Kei Lee, Team Leader, Emerging Disease Surveillance and Response, WHO Regional Office for the Western Pacific

Dr Lee thanked the participants for the excellent discussion and collaboration, and for sharing their experiences and lessons during the workshop. He also expressed appreciation for their contribution to the successful implementation of APSED (2005) and once again rallied their support for the seamless transition to APSED (2010). Dr Lee reiterated that the region faces many challenges, but with thoughtful preparation, the region may be able to ensure a shift from a nationally response-driven framework, to regionally preparedness-driven framework that is integrated and sustainable.

Dr Lee also expressed his warm appreciation of the support and collaboration of partners, especially from the Member States, and ended with an affirmation of WHO’s commitment to continue to work together beyond the workshop.
3. CONCLUSIONS AND RECOMMENDATIONS

3.1 CONCLUSIONS

The workshop made the following conclusions:

3.1.1 Participants recognized that health emergency communications is a fundamental component in managing public health emergencies and in ensuring a sense of trust during times of uncertainty. As part of the International Health Regulations (IHR, 2005) core capacity requirements, participants agreed that developing sustainable health emergency communications capacity within the ministry of health is essential.

3.1.2 Participants acknowledged the significant contribution of the Asia Pacific Strategy for Emerging Diseases (APSED, 2005) to the introduction and implementation of risk communications as part of their public health actions.

3.1.3 Building on lessons learnt from pandemic (H1N1) 2009, participants recognized the value of having risk communications procedures, protocols, mechanisms and human resources in place and functional in case of a public health emergency. Recent outbreaks, natural disasters and food safety events experienced by countries and areas in the region have highlighted the need for capacity in health emergency communications.

3.1.4 APSED (2010) provides a common regional framework for Member States to develop national and local capacities, including increasing readiness for public health emergency response. Participants agreed to operationalize the APSED (2010) workplan on risk communications, and reviewed and agreed to the overall strategic directions and priority actions. The workplan provides guidance for countries to develop or improve national capacities in health emergency communications based on the agreed strategic direction and workplan. Some countries and areas have started developing their workplans using APSED (2010).

3.1.5 Participants acknowledged the inputs shared by the Association of Southeast Asian Nations (ASEAN) and Plus Three countries for its regional initiatives on risk communications and how these initiatives could contribute to the implementation of APSED (2010).
3.2 RECOMMENDATIONS

The workshop made the following recommendations:

3.2.1 Member States should participate in the planning and review process for APSED (2010).

3.2.2 Member States should implement the APSED (2010) workplan on risk communications.

3.2.3 Member States should use the APSED (2010) workplan to further improve health emergency communications for public health emergency response. A designated focal point or person should facilitate the development and implementation of national and local action plans, to include:

- ensuring that a functional mechanism, structure or team for health emergency communications will be institutionalized within the ministry of health;
- establishing a structure or mechanism to proactively and efficiently coordinate health emergency communications during public health emergencies, and to ensure that health emergency communications is a key component of public health measures;
- developing strong linkages to systematically coordinate health emergency communications with risk assessment, surveillance and response, as well as with relevant sectors;
- developing and testing working mechanisms such as procedures, guidelines and protocols;
- supporting the development of feedback mechanisms to inform health emergency communications and taking into account the use of appropriate technology;
- ensuring sustainable support for the institutionalization of health emergency communications as a core function within the ministry of health; and
- developing the structure for career progression for health emergency communicators to ensure availability of expertise for the ministry of health.

3.2.4 WHO should incorporate the suggestions and recommendations from the workshop into the APSED (2010) workplan on risk communications.

3.2.5 WHO should continue to provide technical support to countries and areas to ensure implementation of the APSED (2010) workplan and to meet the core capacity requirements of the Member States under IHR (2005). WHO should work in collaboration with other partners and networks to operationalize APSED (2010).
Workshop on Risk Communications for Public Health Emergencies
15–17 November 2011, Manila, Philippines

Programme of Activities

Day 1 – Tuesday, 15 November 2011

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:30–09:00</td>
<td>Registration</td>
</tr>
<tr>
<td>09:00–10:00</td>
<td>Opening session</td>
</tr>
<tr>
<td></td>
<td>Welcome and opening remarks</td>
</tr>
<tr>
<td></td>
<td>- Dr Takeshi Kasai, Director, Health Security and Emergencies</td>
</tr>
<tr>
<td></td>
<td>WHO Western Pacific Regional Office (WPRO)</td>
</tr>
<tr>
<td></td>
<td>Self-introduction</td>
</tr>
<tr>
<td></td>
<td>Overview of objectives and agenda</td>
</tr>
<tr>
<td></td>
<td>Nomination of Chairs</td>
</tr>
<tr>
<td></td>
<td>Administrative announcements</td>
</tr>
<tr>
<td></td>
<td>Group photo</td>
</tr>
<tr>
<td>10:00–10:30</td>
<td>Coffee break</td>
</tr>
<tr>
<td>10:30–11:20</td>
<td>Session 1: Setting the context for health emergency communications</td>
</tr>
<tr>
<td>10:30–10:50</td>
<td>Asia Pacific Strategy on Emerging Diseases (APSED 2010)</td>
</tr>
<tr>
<td></td>
<td>- Dr Chin Kei Lee, Team Leader, Emerging Disease Surveillance and Response (ESR), WHO/WPRO</td>
</tr>
<tr>
<td>10:50–11:10</td>
<td>Key principles of communications in a health emergency</td>
</tr>
<tr>
<td></td>
<td>- Dr Asiya Oduglel-Kolev, Technical Officer, WHO/HQ</td>
</tr>
<tr>
<td>11:10–11:20</td>
<td>Questions and clarifications</td>
</tr>
<tr>
<td>11:20–12:00</td>
<td>Session 2: Distilling lessons from Pandemic (H1N1) 2009</td>
</tr>
<tr>
<td></td>
<td>Poster session (all country participants) GROUP WORK</td>
</tr>
<tr>
<td>12:00–13:00</td>
<td>Lunch (Ballroom II)</td>
</tr>
</tbody>
</table>
13:00–14:00  **Session 2: (continued)**

13:00–13:30  Poster session  *(all country participants)*  **GROUP WORK (continued)**

13:30–14:00  Feedback from the poster session groups

**14:00–15:30  Session 3: Synthesizing our risk communications experience from Pandemic (H1N1) 2009**

14:00–14:20  Overview of the Pandemic (H1N1) 2009 media project

  - Ms Joy Rivaca Caminade, Technical Officer (Risk Communications), ESR, WHO/WPRO

14:20–14:50  Summary of the country reports

  - Mr Adam Craig, Consultant, ESR, WHO/WPRO

14:50–15:15  Global lessons on risk communications

  - Mr Thomas Abraham, Journalism and Media Studies Centre, The University of Hong Kong

15:15–15:30  Questions and clarifications

15:30–16:00  Coffee break

**16:00–17:30  Session 3: (continued)**

16:00–17:00  **PANEL SESSION:** Key lessons and gaps in health emergency communications

Panel Members:

  - Dr Husnina Ibrahim, Senior Principal Assistant Director, Ministry of Health, Malaysia

  - Ms Bey Mui Leng, Director, Corporate Communications, Ministry of Health, Singapore

  - Mr Thomas Abraham, Journalism and Media Studies Centre, The University of Hong Kong

17:30–20:00  Welcome cocktails *(Music Bar Foyer)*
Day 2 – Wednesday, 16 November 2011

08:30–08:40  Wrap-up of Day 1

08:40–10:00  Session 4: Communicating risks in a health emergency: Scenario-based exercise
              GROUP WORK

10:00–10:30  Coffee break

10:30–12:00  Session 4: (continued)

10:30–11:15  Scenario-based exercise GROUP WORK (continued)

11:15–12:00  PANEL SESSION: Reinforcing principles of risk communications in public health emergencies
              Moderator: Dr Darren Hunt, Acting Director of Public Health, Ministry of Health, New Zealand
              Panel Members: Group Rapporteurs

12:00–13:00  Lunch: (Ballroom II)

13:00–15:00  Session 5: Harnessing risk communications capacity in the Region

13:00–13:20  ASEAN risk communication strategy
              - Dr Husnina Ibrahim, Senior Principal Assistant Director, Ministry of Health, Malaysia

              - Dr Li Ailan, Medical Officer (IHR), WHO/WPRO

13:40–15:00  Risk assessment capacity
              - Dr Ruth Foxwell, Epidemiologist, ESR, WHO/WPRO

15:00–15:15  APSED (2010) workplan for risk communications
              - Ms Joy Rivaca Caminade, Technical Officer (Risk Communications), ESR, WHO/WPRO

15:15–15:30  Discussion: Towards complementation

15:00–15:30  Coffee break

15:30–17:30  Session 6: APSED (2010) risk communications workplan development
              GROUP WORK
<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:30–08:40</td>
<td>Wrap–up of Day 2</td>
</tr>
<tr>
<td>08:40–10:30</td>
<td><strong>Session 6: (continued)</strong></td>
</tr>
<tr>
<td>08:40–09:30</td>
<td>Report back of the group outputs</td>
</tr>
<tr>
<td></td>
<td><em>Group Rapporteurs</em></td>
</tr>
<tr>
<td>09:30–10:00</td>
<td>Discussion</td>
</tr>
<tr>
<td>10:00–10:30</td>
<td><em>Coffee break</em></td>
</tr>
<tr>
<td>10:30–12:00</td>
<td><strong>Session 7: Strengthening partnerships and capacity development for risk communications</strong></td>
</tr>
<tr>
<td>10:30–12:00</td>
<td>National actions in institutionalizing risk communications capacity</td>
</tr>
<tr>
<td></td>
<td><em>Country plans presentation</em></td>
</tr>
<tr>
<td>12:00–13:00</td>
<td><em>Lunch: (Ballroom II)</em></td>
</tr>
<tr>
<td>13:00–15:00</td>
<td><strong>Session 8: Summary and agreements</strong></td>
</tr>
<tr>
<td>13:00–13:30</td>
<td>Presentation of the highlights of the regional synthesis report on media reports on Pandemic A(H1N1) 2009</td>
</tr>
<tr>
<td></td>
<td><em>Mr Adam Craig, Consultant, ESR, WHO/WPRO</em></td>
</tr>
<tr>
<td>13:30–14:00</td>
<td>Presentation of the regional and country level workplans on risk communications</td>
</tr>
<tr>
<td></td>
<td><em>Dr Chin Kei Lee, Team Leader, ESR, WHO/WPRO</em></td>
</tr>
<tr>
<td>14:00–14:30</td>
<td>Summary and recommendations</td>
</tr>
<tr>
<td></td>
<td><em>Dr Chin Kei Lee, Team Leader, ESR, WHO/WPRO</em></td>
</tr>
<tr>
<td>14:30–15:00</td>
<td>Discussion and agreements on next steps</td>
</tr>
<tr>
<td>15:00–15:30</td>
<td><em>Coffee break</em></td>
</tr>
<tr>
<td>15:30–16:00</td>
<td><strong>Session 9: Closing session</strong></td>
</tr>
</tbody>
</table>
World Health Organization

Workshop on Risk Communications for Public Health Emergencies
15–17 November 2011, Manila, Philippines

List of Participants, Temporary Advisers, Observers and Secretariat

1. PARTICIPANTS

WESTERN PACIFIC REGION

BRUNEI DARUSSALAM

Dr Yusma Jeffrin Dato Md YUSOF
Medical Officer
Department of Health Services
Ministry of Health
Commonwealth Drive
Bandar Seri Begawan
Tel. No.: (673) 238 2652
Fax No.: (673) 238 2652
E-mail: jeffyusof@gmail.com

Mr Nazdeny Ardian JOHAN
Public Relations Officer
Ministry of Health
Commonwealth Drive
Bandar Seri Begawan
Tel. No.: (673) 238 0989
Fax No.: (673) 238 3016
E-mail: nazdeny.johan@moh.gov.bn

CAMBODIA

Dr TENG Srey
Vice Director
Communicable Disease Control Department
Ministry of Health
# 151-153 Kampucheak Krom Avenue
Phnom Penh
Tel no.: (855) 1283 6868
E-mail: tengsrey72@yahoo.com

Mr SOK Samnang
IT Officer
Communicable Disease Control Department
Ministry of Health
# 151-153 Kampucheak Krom Avenue
Phnom Penh
Tel no.: (855) 1273 8394
Fax no.: (855) 2388 2317
E-mail: samnang_lati@yahoo.com
CHINA

Ms Li Jie  
Vice Director  
Training and Education Division  
Health News and Communication Center  
Ministry of Health  
Building 12, Block 1, Anhua Xili  
Andingmenwai Dajie Chaoyang District  
Beijing 100011  
Tel. No.: (8610) 6424 5767  
Fax No.: (8610) 6426 5461  
E-mail: honri@126.com

Ms MI Yanping  
Director  
Office of Health Emergency  
Ministry of Health  
No. 1 Nanlu  
Xizhimenwai  
Beijing 100044  
Tel. No.: (8610) 6879 2350  
Fax No.: (8610) 6879 2590  
E-mail: miyp@moh.gov.cn

HONG KONG (CHINA)

Dr CHOI Mei Yee  
Head  
Emergency Response and Information Branch  
Center for Health Protection  
Department of Health  
1/F 147C Argyle Street  
Kowloon  
Tel. No.: (852) 2125 2888  
Fax No.: (852) 2713 1941  
E-mail: smychoi@dh.gov.hk

FIJI

Dr Lisi Penelope FINIASI  
Acting Senior Medical Officer  
Ministry of Health  
P.O. Box 144, Seagaqa  
Tel. No.: (679) 938 7342  
Fax No.: (679) 886 0030  
E-mail: dr.finiasi@gmail.com

Ms Rosita MALA  
Acting Health Inspector  
Tavua Health Office  
P.O. Box 301, Tavua  
Tel. No.: (679) 668 0500/927 0311 (mobile)  
Fax No.: (679) 668 0924  
E-mail: rosita_mala@yahoo.com

LAO PEOPLE'S DEMOCRATIC REPUBLIC

Dr Sibounhom ARCHKHAWONGS  
Director  
Disease Prevention Division  
Department of Hygiene and Prevention  
Ministry of Health  
Vientiane  
Tel. No.: (856 20) 9980 4821  
Fax No.: (856 21) 241 924  
E-mail: sbh_dohp@yahoo.com

Dr Khamphitthoun SOMSAMOUTH  
Deputy Director  
Center for Information and Education for Health  
Ministry of Health  
Vangxay Village, Xaysetha District  
Vientiane  
Tel. No.: (856 20) 2222 4262  
Fax No.: (856 21) 223 723  
E-mail: ksomsamut@hotmail.com
MALAYSIA

Ms Zawaha IDRIS
Principal Assistant Director
Institute for Health Behavioral Research
Ministry of Health Malaysia
Jalan Rumah Sakit Bangsar
59000 Kuala Lumpur
Tel. No.: (603) 2082 1400
Fax No.: (6016) 284 4204
E-mail: hjhzawaha@yahoo.com; zawaha@iptk.gov.my

Mr Sasithera Krishnan Kutty NAIR
Senior Assistant Director
Health Education Division
Ministry of Health Malaysia
Level 6, Block E10, Complex E
Federal Government Administrative Centre,
62590 Putrajaya
Tel. No.: (603) 8883 4429
Fax No.: (63) 8883 4472
E-mail: sasitheran@moh.gov.my; sasi_theran@yahoo.com

MONGOLIA

Mr CHOIROG Urtanasan
Spokesperson
EWAR Unit
National Center for Communicable Diseases
Ministry of Health
Nam-Yan-Ju Street, Bayanzurkh District
46210 Ulaanbaatar
Tel. No.: (976) 9915 0594
E-mail: urtaa_ch@yahoo.com

Ms Sarantuya ALTANSUKH
Spokesperson
Office of the Minister's Affairs
Ministry of Health
Apt.-10, Building-40, Khoroo-18
Bayanzurkh District
Ulaanbaatar
Tel. No.: (976) 8811 9617
E-mail: tumen_sar@yahoo.com

NEW ZEALAND

Dr Darren HUNT
Acting Director of Public Health
Ministry of Health
No. 1 the Terrace
P.O. Box 5013
Wellington 6145
Tel. No.: (64) 4816 2000
Fax No.: (64) 4496 2191
E-mail: darren_hunt@moh.govt.nz

Mr Spiros ANASTASIOU
Strategic Communications Manager
Ministry of Health
P.O. Box 5013
Wellington 6145
Tel. No.: (64) 4816 2036
Fax No.: (64) 4496 2010
E-mail: spiro_anastasiou@moh.govt.nz

PAPUA NEW GUINEA

Ms Rosheila DAGINA
Technical Officer
Emergency Surveillance and Response
National Department of Health
P.O. Box 807
Waigani
Tel. No.: (675) 323 6179
Fax No.: (675) 323 6179
E-mail: rdagina@gmail.com; rosheila_dagina@health.gov.pg

Mr Ennio KUBLE
Consultant
Multimedia
National Department of Health
P.O. Box 807
Waigani
Tel. No.: (675) 301 3827
Fax No.: (675) 301 3742
E-mail: enio_kuble@health.gov.pg
PHILIPPINES

Ms Rosemarie AGUIRRE
Health Education and Promotion Officer V
National Center for Health Promotion
Department of Health
Bldg. 18, San Lazaro Compound
Rizal Avenue, Sta. Cruz
Manila
Tel. No.: (632) 743 8438
Fax No.: (632) 743 6110
E-mail: rgaguirre@yahoo.com

Ms May Elenor DE GUZMAN
Supervising Administrative Officer
Media Relations Unit-OSEC
Department of Health
Bldg. 1, San Lazaro Compound
Rizal Avenue, Sta. Cruz
Manila
Tel. No.: (632) 711 6105
E-mail: mayelenor@yahoo.com

REPUBLIC OF KOREA

Dr Dong-Woo LEE
Epidemic Intelligence Service Officer
Korea Centers for Disease Control
and Prevention
543 Yeonje-ri, Gango-Myeon
Cheongwon-gu
Chungcheongbuk-do
Tel. No.: (8243) 719 7252
Fax No.: (8243) 719 7259
E-mail: aryumput2@gmail.com

SINGAPORE

Mr Joshua WOO
Manager, Media Relations
Ministry of Health
College of Medicine Building
16 College Road
Singapore 169854
Tel. No.: (656) 325 1346
E-mail: joshua_woo@moh.gov.sg

VIET NAM

Dr NGUYEN Van Hien
Head, Communication-Network
Direction Division
General Department of Preventive Medicine
Ministry of Health
135/1, Nui Truc, Ba Dinh
Hanoi
Tel. No.: 844) 3736 8159
Fax No.: (844) 3736 7853
E-mail: hienytdp@yahoo.com

Dr NGUYEN Thi Kim Lien
Deputy Director
National Center for Health Education and Communications
366 Doi Can, Ba Dinh
Hanoi
Tel. No.: 844) 3762 2196
Fax No.: 844) 3832 9241
E-mail: kimlien1001@gmail.com; lienxbyh@yahoo.com

SOUTH-EAST ASIA REGION

INDONESIA

Ms Hikmandari ABUDARI
Head, General Affairs
Public Communication Centre
Ministry of Health Indonesia
Jl. H.R. Rasuna Said Blok, X5 Kav. 4-9
Jakarta 12950
Tel. No.: (6221) 5290 7416-9
Fax No.: (6221) 5290 7421
E-mail: hikmandari@yahoo.com

Dr Utami MURTI
Head
Public Communication Centre
Ministry of Health Indonesia
Jl. H.R. Rasuna Said Blok, X5 Kav. 4-9
Jakarta 12950
Tel. No.: (6221) 5290 7416-9
Fax No.: (6221) 5292 1670
E-mail: murti_utami@yahoo.com
2. TEMPORARY ADVISERS

Dr Husnina IBRAHIM
Public Health Specialist
and Senior Principal Assistant Director
Surveillance Section
Disease Control Division
Department of Public Health
Ministry of Health Malaysia
Level 4, Block E10, Complex E
62590 Putrajaya, Malaysia
Tel. No.: (603) 8883 4392
Fax No.: (603) 8888 6271
E-mail: husnina@moh.gov.my

Ms BEY Mui Leng
Director
Corporate Communications/
Press Secretary to Minister of Health
Ministry of Health
College of Medicine Building
16 College Road
Singapore 169854
Republic of Singapore
Tel. No.: (65) 6375 9050
Fax No.: (65) 6325 1686
E-mail: bey_mui_leng@moh.gov.sg

Mr Thomas ABRAHAM
Director
Public Health Communication Project
Journalism and Media Studies Centre
Eliot Hall
The University of Hong Kong
Pokfulam Road
Hong Kong
Tel. No.: (852) 2219 4017
Fax No.: (852) 2858 8736
E-mail: thomas@hku.hk

3. OBSERVERS/REPRESENTATIVES

ASEM INITIATIVE FOR THE RAPID CONTAINMENT OF PANDEMIC INFLUENZA (ASEF)

Ms Naoko NODA
Advisor
ASEM Initiative for the Rapid Containment of Pandemic Influenza
Asia-Europe Foundation
31 Heng Mui Keng Terrance
Singapore 119595
Republic of Singapore
Tel. No.: (65) 6874 9752
Fax No.: (65) 6872 2246
E-mail: naoko.noda@asef.org; noda_naoko@jics.org.jp

CANADA-ASIA REGIONAL EMERGING INFECTIOUS DISEASE (CAREID)

Mr John RAINFORD
Director
Risk Communications
Public Health Agency of Canada
Canada-Asia Regional Emerging Infectious Disease (CAREID) Project
380 Hunt Club, Ottawa
Ontario 5902A
Canada
Tel. No.: (613) 960 2576
Fax No.: (613) 941 3605
E-mail: john.rainford@phac-aspc.gc.ca
CENTRE FOR GOVERNANCE AND PUBLIC POLICY (CGPP)

Dr Sara DAVIES
Senior Research Fellow
Centre for Governance and Public Policy
Griffith Asia Institute
Griffith University
Nathan
Queensland 4111
Australia
Tel. No.: (617) 3735 7742
Fax No.: (617) 3735 7737
E-mail: sara.davies@griffith.edu.au

INTERNATIONAL FEDERATION OF RED CROSS AND RED CRESCENT SOCIETIES (IFRC)

Ms Cecilia ANSHELM
Regional Health Coordinator for Southeast Asia
International Federation of Red Cross and Red Crescent Societies
South East Asia Regional Delegation
170/11-12 Sukhumvit Soi 16
Bangkok 10110
Thailand
Tel. No.: (662) 661 8201 Ext 200
Fax No.: (662) 661 9322
E-mail: cecilia.anshelm@ifrc.org

UNITED NATIONS CHILDREN’S FUND (UNICEF)

Dr Ketan CHITNIS
Regional HIV/AIDS Specialist
(Knowledge Generation)
UNICEF ASIA Pacific Shared Services Centre (APSSC)
10 Phra Atit Road
Bangkok 10200
Thailand
Tel. No.: (662) 356 9451
Fax No.: (662) 280 5941
E-mail: kchitnis@unicef.org

WORLD ORGANISATION FOR ANIMAL HEALTH (OIE)

Dr Mary Joy GORDONCILLO
Project Officer
World Organisation for Animal Health
OIE-Sub-regional Representative for South-East Asia
c/o DLD, 69/1 Phaya Thai Road
Ratchathewi
Bangkok 10400
Thailand
Tel. No.: (662) 653 4864
Fax No.: (662) 653 4904
E-mail: m.gordoncillo@oie.int

4. SECRETARIAT

ASSOCIATION OF SOUTHEAST IAN NATIONS (ASEAN) SECRETARIAT

Dr Ferdinal FERNANDO
Assistant Director/Head
Health and Communicable Diseases Division
Cross-sectional Cooperation Directorate
ASEAN Socio-Cultural Community Department
The ASEAN Secretariat
70 A Jalan Sisingamangaraja
Jakarta
Indonesia
Tel. No.: (6621) 724 3372
Fax No.: (6621) 724 8234
E-mail: ferdinal.fernando@asean.org
WHO MONGOLIA

Ms Zolzaya Zevseg
Communication and Health Promotion Officer
World Health Organization
Representative Office in Mongolia
Ministry of Health
Government Building 8
Olympic Street-2
Ulaanbaatar
Mongolia
Tel. No.: (976) 1132 7870
Fax No.: (976) 1132 4683
E-mail: zevsegz@wpro.who.int

WHO VIET NAM

Ms Laura NGO-FONTAINE
Risk Communications Officer
World Health Organization
Representative Office in Viet Nam
63 Tran Hung Dao Street
Hoan Kiem District
Hanoi
Socialist Republic of Viet Nam
Tel. No.: (844) 943 3734; 35
Fax No.: (844) 943 3740
E-mail: ngofontainel@wpro.who.int

WHO/SOUTH-EAST ASIA REGIONAL OFFICE

WHO INDONESIA

Ms Nursila DEWI
Risk Communication Officer
World Health Organization
Country Office for Indonesia
Bina Mulia I, Floor 9
Jl. HR. Rasuna Said Kav 10 Kuningan
Jakarta 12950
Indonesia
Tel. No.: (6221) 520 4349
Fax No.: (6221) 520 1164
E-mail: dewin@searo.who.int

WHO HEADQUARTERS

Ms Asiya Odugleh-KOLEV
Technical Officer
Emerging and Dangerous Pathogens
Global Capacities Alert and Response
Health Security and Environment
World Health Organization
20, Avenue Appia CH-1211
Geneva
Switzerland
Tel No.: (4122) 791 4568
Fax No.: (4122) 791 4667
E-mail: oduglehkoleva@who.int

Ms Apha luck BHATIASEVI
Technical Officer (Communications)
Global Capacities Alert and Response
World Health Organization
20, Avenue Appia CH-1211
Geneva
Switzerland
Tel No.: (4122) 791 2958
Fax No.: (4122) 791 4667
E-mail: bhatiaseviap@who.int
In order to capture succinctly the risk communications challenges, lessons learnt and best practices from pandemic (H1N1) 2009, a poster presentation is being organized for all country participants during the Workshop on Risk Communications for Public Health Emergencies on 15–17 November 2011 in Manila, Philippines.

The posters will enable countries to describe their experiences during a pandemic that threatened the health of people all around the world, causing much anxiety and having far-reaching health, social and economic impacts. It will be used as a tool of exchange among participants on how the H1N1 pandemic spurred health emergency communications, and the mechanisms put in place to address health emergency communications challenges.

**Suggested content of the poster presentation**

To prepare for the poster presentation, the following guidelines can be considered:

- Summarize the evolution of pandemic (H1N1) 2009 in the country, including key dates, events and response activities.
- Provide a brief overview of the country’s media context and/or landscape, answering questions such as how many media agencies are there in the country, what are the people’s main sources of information, what is the reach of the media organizations and what is the relationship between the media and the government, given the political, social and economic context of the country?
- Give a description of the government’s health emergency communications arrangement, procedures and protocol. Include a flow diagram of the linkages between the risk assessment results with the internal message development, approval and release procedures. Identify the strengths and weaknesses of the protocol/procedure.
- Highlight the methods by which the government communicated with the media during the pandemic (include frequency and nature of the methods, including social media). Note the change in approach over the course of the pandemic and describe what worked, what did not and why.
- Identify two to three key achievements and two to three main challenges that were faced related to health emergency communications. Include also any changes put in
place to address the challenges. Identify factors and/or conditions that would necessitate the need for health emergency communication approaches.

- If available, include a case study example of either good or poor public health emergency communications during the pandemic in your country, and the analysis of the outcomes. You can include newspaper clippings or video clips to support the case study.

**Poster format**

The recommended size of the poster is A1 portrait (841 mm X 594 mm), although this can be flexible. There are three options for submission of the poster.

1. Submit your poster to the Secretariat when you register on 15 November 2011, and WHO will place it in the appropriate location at the venue. We need confirmation of this option by 10 November 2011.

2. Send to WHO Secretariat an electronic copy of the poster on or before 10 November 2011, and WHO will print the poster for you. Please send the material to Joy Rivaca Caminade (e-mail: caminadej@wpro.who.int).

3. If a poster cannot be produced, prepare maximum of eight A4 slides with the relevant information and e-mail them to caminadej@wpro.who.int on or before 10 November 2011. WHO Secretariat will put together the slides and will print them out in poster format.

The poster will be displayed and presented by a designated country participant at the meeting venue.

If you have any questions or require clarifications regarding the poster presentation, please do not hesitate to contact:

**Ms JOY RIVACA CAMINADE**

Technical Officer (Risk Communications)
World Health Organization (WHO)
Regional Office for the Western Pacific
Tel: (+63-2) 5289959 (GPN 89344)
Mobile: (+63-918) 9064191
Email: caminadej@wpro.who.int; joyrivaca@yahoo.com

Thank you in advance for your participation.
In order to capture succinctly the risk communications challenges, lessons learnt and best practices from pandemic (H1N1) 2009, a poster presentation is being organized for all country participants during the Workshop on Risk Communications for Public Health Emergencies on 15–17 November 2011 in Manila, Philippines.

The posters will enable countries to describe their experiences during a pandemic that threatened the health of people all around the world, causing much anxiety and having far-reaching health, social and economic impacts. It will be used as a tool of exchange among participants on how the H1N1 pandemic spurred health emergency communications, and the mechanisms put in place to address health emergency communications challenges.

Objectives of the poster session

- Review how the pandemic (H1N1) 2009 event occurred and progressed in the countries and areas of the Western Pacific Region and understand the highlights of the response measures that were implemented on health emergency communications.
- Describe the government’s health emergency communications arrangement, procedures and protocol.
- Highlight the methods by which the government communicated with the media during the pandemic and any change in approach over the course of the pandemic and understand what worked, what did not and why.
- Identify key achievements, main challenges and gaps that were faced related to health emergency communications and how the challenges were addressed.
- Share case study examples of either good or poor public health emergency communications during the pandemic and some analysis of the outcomes.

The review of the health emergency communications of countries and areas will provide a good basis for moving forward and for the preparation for any future public health emergencies.
Format of the poster session

Country participants will be divided into four groups. Posters will be displayed in clusters and according to group assignments. The venue for the poster session is Ballroom 2.

Table. Proposed group allocation

<table>
<thead>
<tr>
<th>GROUP 1</th>
<th>GROUP 2</th>
<th>GROUP 3</th>
<th>GROUP 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant</td>
<td>Indonesia</td>
<td>Papua New Guinea</td>
<td>Viet Nam</td>
</tr>
<tr>
<td>Participant</td>
<td>Malaysia</td>
<td>China</td>
<td>Brunei Darussalam</td>
</tr>
<tr>
<td>Participant</td>
<td>Cambodia</td>
<td>Fiji</td>
<td>Republic of Korea</td>
</tr>
<tr>
<td>Participant</td>
<td>Hong Kong (China)</td>
<td>Singapore</td>
<td></td>
</tr>
<tr>
<td>Observer</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Temporary Advisers (can choose own group in preparation for the panel session)

| WHO Facilitators | Sila, Aphiluck and Debbie | Asiya and Ruth | Laura and Tim | Adam and Zola |

For each group, members are to:

1. nominate a rapporteur who will lead the poster presentation, facilitate questions and discussion within the group and present a summary of the discussion in plenary;
2. nominate a participant to present the poster for their country;

Each county participant will present his or her poster to the other participants in the group (about 5 minutes). Each presentation will be followed by questions and discussions within the group.

After all of the country presentations, the facilitator will prompt further discussion in the groups.

Proposed questions for discussion within the group:

- How did pandemic (H1N1) come into their country? What was the timeline? What health emergency communications actions and decisions were implemented?
- What were the decision-making and clearance procedures and structures used for H1N1 response?
- How can we ensure that health emergency communications structures and/or people are part of the national and/or local command and control structure for emergency response?
- How were the decisions on health emergency communications approaches and strategies made? What were the triggers? What information was used for make the decisions? What were the factors that facilitated decision-making?
- Based on what we have learnt from the pandemic response, what do you think could be improved for future health emergency communications (e.g. risk assessment approach, evidence-based intervention, expert advisory, balanced decision, information sharing among countries)?
- What would you do differently if a pandemic occurred six months from now?
Wrap-up

At the end of the presentation and discussion, please wrap up by providing a quick summary of what was learnt from the country poster presentations and discussion in the group. Highlight key points that may be important for future public health emergency preparedness and response.

At the conclusion of the session, encourage participants to view poster presentations of the other countries.

*After the poster session, please remind participants to report back to the conference room at 16:00 for a short panel discussion, during which rapporteurs will report the summary of lessons learnt from pandemic (H1N1) 2009, based on the poster session.*
Workshop on RISK COMMUNICATIONS for Public Health Emergencies
15–17 November 2011, Manila, Philippines

Facilitator’s Guide: Panel Session
Key Lessons and Gaps in Health Emergency Communications
(Scheduled 15 November 2011)

PANELLISTS
- Dr Husnina Ibrahim (Focal Point for Risk Communications, ASEAN and Ministry of Health, Malaysia)
- Dr Bey Mui Leng (Director, Corporate Communications, Ministry of Health, Singapore)
- Dr Thomas Abraham (Director of the Public Health Communications Programme University of Hong Kong)

DISCUSSION FACILITATOR
- Mr Adam Craig (Public Health Consultant, Risk Communications Focal Point for the WHO Regional Office for the Western Pacific during the H1N1 pandemic)

OBJECTIVES OF THE SESSION
The objectives of the session are quite broad:
- to capture key lessons learnt for public health emergency risk communications from the H1N1 pandemic; and
- to identify gaps in national and global responses.

Given the breadth of this scope and time available, panellists will have the flexibility to draw on real-life examples to highlight points and to keep the discussion grounded and relevant. Also, while the topic is specifically about the H1N1 experience, examples from other similar infectious disease public health emergencies could be drawn upon during the discussion.

FORMAT OF THE SESSION
Given the panel discussion will be in the late afternoon, when delegates’ focus may be lagging, it is proposed that the session be run in an interactive way. The panel will be set up as an informal interview style format where the discussion facilitator poses pre-scripted open-ended questions to the panel followed by individual or multiple panellist responses.
To keep the audience engaged, questions will be invited from the floor throughout the panel as well as at the end.

The panel area will be set up to facilitate an informal and open discussion.

**TIMING**
The panel will run for approximately 40 minutes, with 20 minutes for questions from delegates. The introduction and wrap-up will take approximately 10 minutes.

**PANEL QUESTIONS**
Proposed panel questions are noted below. Please prepare to speak for 2 to 3 minutes in response to each question. Further, if you have additional relevant questions that you would like to speak to, please send them to the discussion facilitator.

**PROPOSED PANEL QUESTIONS**
- To begin, I’d like to ask each of you to reflect on your experience during the pandemic and, in broad terms, how well you think the public health system did with regard to media-based risk communications during the emergency. Why do think this?

- What were the critical events or situations that challenged your jurisdictions’ media communication efforts? Reflect on why they were challenges for your organization, what impact they had, how they were handled and what you or your organization learnt from them.

- What were some of the notable successes in public health risk communications during the pandemic? Reflect on the factors (circumstances, actions, systems, etc.) that led to these successes and how these factors can be capitalized on for (1) capacity development and (2) response activities.

- I think we all accept that the pandemic has reinforced the public health system’s appreciation of the important role risk communications plays in emergency responses. What are the major (internal and/or external) barriers to strengthening public health risk communication capacity in the region and how can these challenges be addressed? What would you suggest be done to address them?

- Now, hypothetically, you have all been invited as public health risk communications advisers to the ASEAN Meeting of Health Ministers. You are about to outline your advice to the ministers on what needs to be done to bolster risk communications capacity in the region in preparation for another influenza pandemic. What are the three key points of advice you will give?
Objectives of the exercise

- To increase participants' appreciation and understanding of the concept of risk communications in the context of a health emergency, by going through scenarios inherent in an emergency situation.
- To enable participants to identify key principles and strategies of risk communications and its application in a health emergency.
- To start thinking of the existing capacity gaps at the country level and the actions needed to apply, integrate and institutionalize health emergency communications functions.

Exercise mechanism

Participants will be put into three groups that will be assigned a facilitator from the WHO Secretariat to guide the process.

1. Participants should decide on names for their groups to identify their outputs. Decisions and actions will be written on colour-coded metacards.

2. For each group, assign the following:
   - rapporteur to be responsible for leading the discussion, deciding what action to take and reporting the results.
   - inject monitor to keep track of the injects as they arrive and to relay them to the group;
   - recorder to take note of all actions and decisions on a log sheet; and
   - timekeeper to ensure that groups complete the tasks within the allocated time.

3. There will be three injects throughout the exercise. Groups will be given 30 minutes to work on the tasks required for that scenario.

4. Once the time allocated is over, end work on that scenario and move on to the discussion of the new inject. There is no need to revise or go back to the previous outputs, as events are not necessarily sequential.
Rules

- Each scenario will happen; the key is to identify the decision points and key actions from the scenario.
- The information given in the injects for the series of events in the scenario may or may not be linked. This is intentional. As in real life, events, information and media reports do not follow a systematic flow.
- The information given to the groups with every inject is the only available information. There is no one to give additional information or assumptions.

Context

ANJORI is a developing country divided into two main islands. It is composed of 86 provinces and has a total population of 120 million people. Administratively, it has a decentralized system of government. ANJORI shares borders with six neighbouring countries.

Although the country’s economy thrives more on its agriculture, fisheries and industrial exports, it also derives a significant part of its income from the tourism sector. The country is home to many natural tourist attractions as well as modern recreational facilities. It has a well-developed tourism programme and regularly hosts sporting, educational and tourism events.

ANJORI has a number of diseases endemic to the country, such as influenza and dengue fever, as well as waterborne and foodborne diseases like cholera. For the past several years, it also registered an increased number of hand, foot and mouth disease (HFMD) cases with some fatalities. In 2011, the number of HFMD cases was unprecedented.

Additional exercise inputs

- Fact sheet about ANJORI
- Map of the country
**Exercise scenario**

**INJECT 1: Local media reports on HFMD cases**
Time to accomplish tasks: 30 MINUTES

The local media in *Dapdap City*, the third biggest province located in the central part of ANJORI, reported an increasing number of hand, foot and mouth disease (HFMD) cases in the past two weeks. From an average of 30 patients a day admitted in hospitals, the number has increased to 80. For 9 April 2011, alone, 85 patients were admitted and five were in serious condition, requiring a respirator.

The number of children being hospitalized every day has almost doubled to an average of 20 in the recent past. So far this year, out of the 600 children who contracted the disease, mostly belonging to Dapdap City, three had died. Doctors in the city hospital are worried because there are usually no fatalities in the early part of the year. Normally, HFMD peaks between October and December, but there were also many cases from March to May.

**WHAT IS KNOWN**
- There is no vaccine against HFMD and the best preventive method is to keep the environment, food and drinks hygienic.
- The Department of Education and Culture of Dapdap City has ordered primary schools and day care centres to carry out preventive measures against HFMD and other infectious diseases.
- Although there were sporadic news reports of cases in neighbouring provinces, this was the first news that landed on the front page of the provincial daily newspaper.
- The surveillance system shows increased reporting of HFMD cases in most of the central provinces.
- The city is a highly urbanized area, but it also has some of the most beautiful beach resorts in the country, including a protected coral reef and diving site.

**WHAT IS NOT KNOWN**
- Not known if all the cases were confirmed as HFMD.
- Not known if there were other possible causes and if there was a link among the cases.

**TASK**
You are the responsible team for risk communications in the Department of Health and Well-Being of ANJORI. Given the scenario, address the following concerns:

- What important decisions and key actions need to be taken immediately?
- At this stage, what message/s do you need to send and to whom?
- With whom do you need to coordinate and for what?

**Additional exercise inputs**
- Fact sheet about HFMD
- Sample news reports
**INJECT 2: Widespread HFMD cases and deaths mean wider media attention**

Time to accomplish tasks: 30 MINUTES

The provincial and national media report the following:

- **5 May:** Provincial News – Six babies die of HFMD in Dapdap and disease has spread to 13 provinces.
- **14 May:** National News – HFMD kills nine, and now affects 24 provinces.
- **24 May:** National News – Doctors discover new virus causing HFMD. The coxsackie B2 virus, which is more dangerous than the EV71 virus, makes the patient’s condition worsen quickly, sometimes leading to death. The media report many hospitals identifying the new virus as responsible for the deaths.
- **7 June:** Many parents decide to stop sending their children to schools for fear of infection, and some primary schools and day care centres have closed indefinitely.
- **HFMD now affects 35 provinces,** with most of the outlying provinces sending their severe cases to Dapdap City for treatment. News reports show overcrowded hospitals and dying patients and children.
- **There is no media report mention of any action from the Ministry of Health.**
- **Newspaper columns have started to ask questions about the government action.**
- **People are anxious and worried for the safety of their children in schools and day care centres.**

**RUMOURS**

- Facebook and Twitter accounts have been set up by a parent of a child who died from HFMD, telling the story of how her child died with no help.
- Chloramine B disinfectants distributed by the local governments for disinfection, have been rumoured to be ingested by children, and mothers have mixed them in food with the belief that doing so would increase protection.

**TASK**

The Minister of Health and Well-Being has organized a high-level committee to address HFMD in the country. As the responsible team for risk communications in the communicable disease prevention department of the Ministry, how would you address the following concerns:

- **How would you prepare for the first meeting if you knew that you would be asked for suggestions relating to communications?**
- **What important decisions and key actions would you recommend taking immediately?**
- **At this stage, what message/s do you need to send and to whom?**
- **With whom do you need to coordinate and for what?**

**Additional exercise inputs**

- Facebook account with some entries on HFMD cases
- Sample news reports
**INJECT 3: Increasing political interest as the country prepares for an international event**

**Time to accomplish tasks: 30 MINUTES**

By August, the number of HFMD cases had reached more than four times higher than the previous year. Children under five accounted for more than 96% of the HFMD cases. As of September, ANJORI had 35 000 cases of HFMD, resulting in 81 deaths of children and affecting 57 provinces. The situation prompted the President of the country to order all departments in the government ministries to double their efforts to stop the spread of the disease.

The media accused the government agencies of delaying a proper response to the disease, unwittingly or otherwise, and predicted that the situation would worsen. The Minister's action was also criticized as being too late. The Facebook and Twitter accounts (with thousands of fans and followers all over the world) provided daily accusations of the Ministry' of Healths inaction.

By the end of September, HFMD had become a nightmare for parents, with the number of cases reaching 55 000, with 160 deaths affecting 80 provinces. The President continues to challenge the Health Ministry for being unable to control an "easy" disease.

By the end of November, there have been almost half a million cases of HFMD all over the country. Almost 1000 have died and the majority were children. The media continue to show images of overcrowded hospitals, and many traditional and social media report the cases every day. Some international media have also shown reports of tourists getting infected; three tourists died from HFMD after visiting ANJORI. The disease has also spread to five of the six neighbouring countries, although there is no evidence that the disease was imported from ANJORI.

In two weeks time, on 1 December 2011, ANJORI is going to host an international Boy and Girl Scouts camp in the province of MOBO, located in the northern part of the country. The camp, which is expected to last for seven days, will draw participants from 27 countries, with children ranging in age from 8 to 10 years. The country is expecting around 2000 international guests composed of children, parents and school administrators.

Some of the participants and parents are having second thoughts about attending the camp, based on what they hear and see about the HFMD cases. Embassies from the participating countries are requesting information on the measures being taken by the Ministry of Health and Well-Being. Facebook and Twitter have become sources of information on the "real" situation in the country.

**TASK**

The Health Minister called on the communications team and showed disappointment for the bad media coverage of the HFMD situation. In addition, there is increasing pressure from the organizers of the Boy and Girl Scouts camp to aggressively address the risk of HFMD in the campsites. A multisectoral meeting was organized by the Ministry of Health and Well-Being to discuss the issue, and inform the stakeholders of the Ministry’s actions. A communications plan was one of the key topics for discussion.

Given the scenario described, how would you address the following concerns:

- How would you prepare for the multisectoral meeting? What would be the main components of your communication plan?
- What important decisions and key actions would you recommend the Minister take immediately to balance pressure from the President and the increasing public concern?
- At this stage, what message/s do you need to send, to whom and how?
- With whom do you need to coordinate and for what?
Additional exercise inputs
- TV news report with the ANJORI President's statement on the HFMD situation
- Description of the camp site and a profile of the participants to the international event

Debriefing
At the end of the task for Inject 3, each group will be given another 30 minutes to debrief, reflect on and synthesize their experience. Based on the exercise, and going through the scenario, groups will identify only the following:

- five most important elements of health emergency communications
- five important decisions to make for communications
- five key capacities needed for health emergency communications.

Participants can discuss many things within the time period, including the rationale for the choices, but they have to trim down their presentation to the points indicated above.

The overall rapporteur/team leader of the group will be asked to prepare a presentation and deliver it during the succeeding panel discussion.
### GROUPINGS: Scenario-based Exercise

<table>
<thead>
<tr>
<th>Group 1</th>
<th>Group 2</th>
<th>Group 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall Exercise Leader:</strong> <strong>Dr Darren HUNT (NEZ)</strong></td>
<td><strong>Dr TENG Srey (CAM)</strong></td>
<td><strong>Ms MI Yanping (CAM)</strong></td>
</tr>
<tr>
<td>Dr Yusma Jefferin Md YUSOF (BRN)</td>
<td>Mr Nazdeny Ardian JOHAN (BRN)</td>
<td>Dr Sibounhom ARCHKHAWONGS (LAO)</td>
</tr>
<tr>
<td>Mr SOK Samnang (CAM)</td>
<td>Ms Li Jie (CHN)</td>
<td>Dr Khamphithoun SOMSAMOUTH (LAO)</td>
</tr>
<tr>
<td>Dr CHOI Mee Yee (HOK)</td>
<td>Dr Lisi Penole FINIASI (FIJ)</td>
<td>Ms Zawaha IDRIS (MAA)</td>
</tr>
<tr>
<td>Dr Sibounhom ARCHKHAWONGS (LAO)</td>
<td>Dr Khamphithoun SOMSAMOUTH (LAO)</td>
<td>Ms Zawaha IDRIS (MAA)</td>
</tr>
<tr>
<td>Mr Sasitheran Krishnan NAIR (MAA)</td>
<td>Mr CHOIROG Urtnasan (MOG)</td>
<td>Ms Sara ALTANSUKH (MOG)</td>
</tr>
<tr>
<td>Mr Spiros ANASTASIOU (NEZ)</td>
<td>Ms Rosheila DAGINA (PNG)</td>
<td>Mr Ennio KUBLE (PNG)</td>
</tr>
<tr>
<td>Ms Rosemarie AGUIRRE (PHL)</td>
<td>Ms May Elenor DE GUZMAN (PHL)</td>
<td>Dr Dong-Woo LEE (KOR)</td>
</tr>
<tr>
<td>Mr Joshua WOO (SIN)</td>
<td>Dr NGUYEN Van Hien (VIE)</td>
<td>Dr NGUYEN Thi Kim Lien (VIE)</td>
</tr>
<tr>
<td>Dr Utami MURTI (INO)</td>
<td>Dr Abudari HIKMANDARI (INO)</td>
<td>Ms Naoko NODA (ASEF)</td>
</tr>
<tr>
<td>Mr John RAINFORD (CAREID)</td>
<td>Dr Sara DAVIES (Observer)</td>
<td>Ms Cecilia ANSHELM (IFRC)</td>
</tr>
<tr>
<td>Dr Ketan CHITNIS (UNICEF)</td>
<td>Dr Ferdinal FERNANDO (ASEC)</td>
<td></td>
</tr>
<tr>
<td><strong>Moderator:</strong> <strong>Dr Husnina IBRAHIM</strong> (Technical Adviser)</td>
<td><strong>Moderator:</strong> <strong>Ms BEY Mui Leng</strong> (Technical Adviser)</td>
<td><strong>Moderator:</strong> <strong>Mr Thomas ABRAHAM</strong> (Technical Adviser)</td>
</tr>
<tr>
<td><strong>WHO Technical Support Team</strong></td>
<td><strong>WHO Technical Support Team</strong></td>
<td><strong>WHO Technical Support Team</strong></td>
</tr>
<tr>
<td>Aphaluck BHATIASEVI (HQ) — Synthesis</td>
<td>Asiya Odugle-KOLEV (HQ) — Synthesis</td>
<td>Adam CRAIG (WPRO) — Synthesis</td>
</tr>
<tr>
<td>Laura NGO-FONTAINE (VIE) — Note taker</td>
<td>Zolzaya ZEVSEK (MOG) — Note taker</td>
<td>Nursila DEWI (INO) — Note taker</td>
</tr>
<tr>
<td>Timothy O’LEARY (WPRO) — Evaluator</td>
<td>Ranil APPUHAMY (WPRO) - Evaluator</td>
<td>Ruth FOXWELL (WPRO) — Evaluator</td>
</tr>
<tr>
<td><strong>WHO Admin/Logistics Support</strong></td>
<td><strong>WHO Admin/Logistics Support</strong></td>
<td><strong>WHO Admin/Logistics Support</strong></td>
</tr>
<tr>
<td>Meg Dichoso</td>
<td>Don Rivada and Pettie Santiago</td>
<td>Elizabeth Mangali</td>
</tr>
</tbody>
</table>

**Overall Exercise Manager:** **Dr Darren Hunt**  
**Exercise Simulator:** Joy Rivaca-Caminade  
**Overall Inject Monitor:** Mr Don Rivada
World Health Organization

Workshop on Risk Communications for Public Health Emergencies
15–17 November 2011, Manila, Philippines

Scenario-based Exercise – All Paper Injects

Map of the Decentralized Republic of Anjori

This is an exercise message.
CONTEXT

ANJORI is a developing country divided into two main islands. Administratively, it has a decentralized system of government. It is composed of 86 provinces and has a total population of 120 million. ANJORI shares borders with six neighbouring countries.

Although the country’s economy thrives more on its agriculture, fisheries and industrial exports, it also derives a significant part of its income from tourism. The country is home to many natural tourist attractions as well as modern recreational facilities. It has a well-developed tourism programme and regularly hosts sporting, educational and tourism events.

ANJORI has a number of diseases endemic to the country, such as influenza and dengue fever, as well as waterborne and foodborne diseases like cholera. For the past several years, it also registered an increased number of hand, foot and mouth disease (HFMD) cases with some fatalities. In 2011, the number of HFMD cases was unprecedented.
Decentralized Republic of Anjori
COUNTRY PROFILE

BASIC FACTS ABOUT ANJORI
- Country in the Western Pacific Region
- Two-party state
- Population – 120 million
- 45% are under 15 years old
- 30% live in urban areas
- Livelihood subsistence on agriculture (35%), fisheries (20%) and tourism (15%)

INFRASTRUCTURE
- Safe water – most of the population depends on the use of water from deep wells
- Electricity – available in most cities and towns; irregular access but available in rural areas
- Roads – relatively poor: city centres connected by concrete roads and highways; rural areas linked by dirt roads
- Mode of transport – private cars and public transport: national train system and connecting bridge between two islands

CULTURE AND SOCIETY
- Mixed religions; majority Catholic
- Strong family and community ties
- Community leaders (72% are women) are powerful; positions handed down to family members
- High literacy rates among rural populations and ethnic minorities
- Several ethnic groups speak their own language

MEDIA
- Majority of the country has access to TV and radio, 75% have access to the Internet
  - Television
    - 1 government-controlled station and 3 privately owned stations; relatively no censorship
    - 3 free stations from neighbouring countries
    - 80% have access to cable TV
  - Radio
    - Popular in rural areas
    - Relatively no censorship compared to TV
  - Print media
    - Several national, regional and local newspapers
    - More popular in urban areas
    - Relatively no censorship by the government
    - Access to international media
    - People are media savvy

PUBLIC HEALTH SYSTEM
- Devolved health system
- Several rural health facilities (mostly private and charging expensive fees)
Scenario-based Exercise – All Paper Injects

INJECT 1: 09:15
Local media reports on HFMD cases

The local media in Dapdap City, the third largest province located in the central part of the country, has reported an increasing number of hand, foot and mouth disease (HFMD) cases in the past 2 weeks. From an average of 30 patients a day admitted in hospitals, the number has increased to 80. On 9 April 2011 alone, 85 patients were admitted and five were in serious condition requiring a respirator.

The number of children being hospitalized every day has almost doubled to an average of 20 in the recent past. So far this year, out of the 600 children who contracted the disease, mostly belonging to Dapdap City, three had died. Doctors in the city hospital are worried because there are usually no fatalities in the early part of the year. Normally, HFMD peaks between October and December, but there were also many cases in the period from March to May.

WHAT IS KNOWN

- There is no vaccine against HFMD and the best preventive method is to keep the environment, food and drinks hygienic.
- Dapdap’s Department of Education and Culture has ordered primary schools and day care centres to carry out preventive measures against HFMD and other infectious diseases.
- Although there were sporadic news reports of cases in neighbouring provinces, this was the first news report that landed on the front page of the provincial daily newspaper.
- The surveillance system shows increased reporting of HFMD cases in most of the central provinces.
- The city is a highly urbanized area, but it also has some of the most beautiful beach resorts in the country, including a protected coral reef and diving site.

WHAT IS NOT KNOWN

- Not known if all the cases were confirmed as HFMD.
- Not known if there were other possible causes and if there was a link among the cases.

**TASK (to be accomplished in 30 minutes):**

You are the responsible team for risk communications in the Department of Health and Well-Being of ANJORI. Given the scenario, address the following concerns:

- What important decisions and key actions need to be taken immediately?
- At this stage, what message/s do you need to send and to whom?
- With whom do you need to coordinate and for what?
Scenario-based Exercise – All Paper Injects

INJECT 2: 09:45
Widespread HFMD cases and deaths mean wider media attention

The provincial and national media report the following:

- 5 May: Provincial News – Six babies die of HFMD in Dapdap and disease has spread to 13 provinces.
- 14 May: National News – HFMD kills nine, and now affects 24 provinces.
- 24 May: National News – Doctors discover new virus causing HFMD. The coxsackie B2 virus, which is more dangerous than the EV71 virus, makes the patient’s condition worsen quickly, sometimes leading to death. The media report many hospitals identifying the new virus as responsible for the deaths.
- 7 June: Many parents decide to stop sending their children to schools for fear of infection, and some primary schools and day care centres have closed indefinitely.
- HFMD now affects 35 provinces, with most of the outlying provinces sending their severe cases to Dapdap City for treatment. News reports show overcrowded hospitals and dying patients and children.
- There is no media report mention of any action from the Ministry of Health.
- Newspaper columns have started to ask questions about the government action.
- People are anxious and worried for the safety of their children in schools and day care centres.

RUMOURS

- Facebook and Twitter accounts have been set up by a parent of a child who died from HFMD, telling the story of how her child died with no help.
- Chloramine B disinfectants, distributed by the local governments for disinfection, have been rumoured to be ingested by children, and mothers have mixed them in food with the belief that doing so would increase protection.
**TASK (to be accomplished in 30 minutes):**

The Minister of Health and Well-Being organized a high-level committee to address HFMD in the country. As the responsible team for risk communications in the communicable disease prevention department of the Ministry, how would you address the following concerns:

- How would you prepare for the first meeting if you knew that you would be asked for suggestions relating to communications?
- What important decisions and key actions would you recommend taking immediately?
- At this stage, what message/s do you need to send and to whom?
- With whom do you need to coordinate and for what?
HFMD is a common infectious disease of infants and children. It is characterized by fever, painful sores in the mouth, and a rash with blisters on hands, feet and also buttocks.

HFMD is caused by viruses from the group called enteroviruses. This group has many different types of viruses including polioviruses, coxsackieviruses, and echoviruses. HFMD is most commonly caused by coxsackievirus A16, which usually results in a mild self-limiting disease with few complications.

HFMD is also caused by enterovirus 71 (EV71), which has been associated with serious complications, and may be fatal.

**FREQUENTLY ASKED QUESTIONS ON HFMD**

*Is HFMD the same as foot-and-mouth disease in animals?*

No, HFMD is not to be confused with foot-and-mouth (also called hoof-and-mouth) disease, which is caused by a different virus and affects cattle, sheep and pigs.

*How serious is HFMD?*

Most people with HFMD recover fully after the acute illness.

- HFMD caused by coxsackievirus A16 infection is a mild disease, and nearly all patients recover in 7 to 10 days without medical treatment. Complications are uncommon.
  - Dehydration is the most common complication of HFMD infection caused by coxsackieviruses; it can occur if intake of liquids is limited due to painful sores in the mouth.
  - Rarely, patients with coxsackievirus A16 infection develop “aseptic” or viral meningitis. In this case, the person will have a fever, headache, stiff neck or back pain, and may need to be hospitalized for a few days.
HFMD caused by EV71 has been associated with meningitis and encephalitis, and on occasion can cause severe complications, including neurological, cardiovascular and respiratory problems. Cases of fatal EV71 encephalitis have occurred during outbreaks.

**How soon after exposure do symptoms of HFMD appear?**

- The time period from infection to onset of symptoms is usually 3–7 days.
- Fever, lasting 24–48 hours, is often the first symptom of HFMD.

**What are the symptoms of HFMD?**

- The disease usually begins with a fever, poor appetite and malaise, and frequently with a sore throat.
- One or 2 days after fever onset, painful sores develop in the mouth. They begin as small red spots that blister and then often become ulcers. They are usually located on the tongue, gums and inside of the cheeks.
- A non-itchy skin rash develops over 1–2 days with flat or raised red spots, some with blisters. The rash is usually located on the palms of the hands and soles of the feet; it may also appear on the buttocks and/or genitalia.
- A person with HFMD may not have symptoms, or may have only the rash or mouth ulcers.

**How do you get HFMD?**

- HFMD virus is contagious and infection is spread from person to person by direct contact with nose and throat discharges, saliva, fluid from blisters, or the stool of infected persons. Infected persons are most contagious during the first week of the illness, but the period of communicability can last for several weeks (as the virus persists in stool).
- HFMD is not transmitted to or from pets or other animals.

**Who is at risk for HFMD?**

- Everyone who has not already been infected is at risk of infection, but not everyone who is infected becomes ill.
- HFMD occurs mainly in children under 10 years old, but most commonly in children younger than 5 years of age. Younger children tend to have worse symptoms. Children are more likely to be susceptible to infection and illness from these viruses because they are less likely than adults to have antibodies and be immune from previous exposures to them. Most adults are immune, but cases in adolescents and adults are not unusual.

**Can you be infected with HFMD more than once?**

Yes, infection only results in immunity to one specific virus; other episodes may occur following infection with a different member of the enterovirus group.
What about pregnant women?

- Ideally, pregnant women should avoid close contact with anyone with HFMD and pay particular attention to measures that prevent transmission.
- Pregnant women are frequently exposed to enterovirus infections, including HFMD. They may cause mild or no illness in a pregnant woman. Currently, there is no clear evidence that maternal enterovirus infection, including HFMD, is associated with any particular adverse outcome of pregnancy (such as miscarriage, stillbirth or congenital defects). However, pregnant women may pass the virus to the baby if they are infected shortly before delivery or have symptoms at the time of delivery.
- Most newborn infants infected with an enterovirus have mild illness, but a few may develop an overwhelming infection of many organs, including liver and heart, and die from the infection. The risk of this severe illness is higher for newborn infants infected during the first two weeks of life.

How is HFMD treated?

- Presently, there is no specific treatment available for HFMD. Patients should drink plenty of water and seek symptomatic treatment to reduce fever and pain from ulcers.

Recommendations

There are no specific antiviral drugs or vaccines available against non-polio enteroviruses causing HFMD. The risk of infection can be lowered by good hygiene practices and prompt medical attention for children showing severe symptoms.

To the public

Preventive measures for HFMD include:

- frequent hand washing with soap and water, especially after touching any blister or sore, before preparing food or eating, before feeding young infants, after using the toilet and after changing diapers;
- cleaning contaminated surfaces and soiled items (including toys) first with soap and water, and then disinfecting them using a dilute solution of chlorine containing bleach;
- avoiding close contact (kissing, hugging, sharing utensils, etc.) with children with HFMD;
- keeping infants and sick children away from kindergarten, nursery, school or gatherings until they are well;
- monitoring the sick child’s condition closely and seeking prompt medical attention if there is persistent high fever, decrease in alertness or deterioration in general condition;
- covering mouth and nose when sneezing and coughing;
- properly disposing used tissues and diapers into waste bins that close properly; and
- maintaining cleanliness of home, child care centre, kindergarten or school.
In August, the number of HFMD cases had reached 35,000, more than four times higher than last year. Children under five accounted for more than 96% of the HFMD cases. As of September, ANJORI had 81 deaths in children and affected 57 provinces. The situation prompted the President of the country to order all departments in the government ministries to double their efforts to stop the spread of the disease.

The media accused the government agencies of delaying a proper response to the disease, unwittingly or otherwise, and predicted that the situation would worsen. The Minister’s action was also criticized as being late. The Facebook and Twitter accounts (with thousands of fans and followers all over the world) provided daily accusations of the Ministry’s inaction.

By the end of September, HFMD had become a nightmare for parents, with the number of cases reaching 55,000, with 160 deaths affecting 80 provinces. The President continues to challenge the Health Ministry for being unable to control an “easy” disease.

By the end of November, there have been almost half a million cases of HFMD all over the country. Almost 1000 have died and the majority were children. The media continue to show images of overcrowded hospitals and many traditional and social media cover the cases every day. Some international media have also run reports of tourists getting infected; three tourists died from HFMD after visiting ANJORI. The disease has also spread to five of the six neighbouring countries, although there is no evidence that the disease was imported from ANJORI.

In two weeks time, on 1 December 2011, ANJORI is going to host an international Boy and Girl Scouts camp in the province of MOBO located in the northern part of the country. The camp, which is expected to last for seven days, will draw participants from 27 countries, with children ranging in age from 8 to 10 years. The country is expecting around 2000 international guests composed of children, parents and school administrators.

Some of the participants and parents are having second thoughts about attending the camp, based on what they hear and see about the HFMD cases. Embassies from the
participating countries are requesting information on the measures being taken by the Ministry of Health and Well-Being. Facebook and Twitter have become sources of information on the “real” situation in the country.

**TASK (to be accomplished in 30 minutes):**

The Health Minister called on the communications team and showed disappointment for the bad media coverage of the HFMD situation. In addition, there is increasing pressure from the organizers of the Boy and Girl Scouts camp to aggressively address the risk of HFMD in the campsites. A multisectoral meeting was organized by the Ministry of Health and Well-Being to discuss the issue, and inform the stakeholders of the Ministry’s actions. A communications plan was one of the key topics for discussion.

Given the scenario described, how would you address the following concerns:

- How would you prepare for the multisectoral meeting? What would be the main components of your communication plan?
- What important decisions and key actions would you recommend the Minister take immediately to balance pressure from the President and the increasing public concern?
- At this stage, what message/s do you need to send, to whom and how?
- With whom do you need to coordinate and for what?
Decentralized Republic of Anjori

FACT SHEET

BASIC FACTS ABOUT ANJORI
- Country in the Western Pacific Region
- Two-party state
- Population – 120 million
- 45% are under 15 years old
- 30% live in urban areas
- Livelihood subsistence on agriculture (35%), fisheries (20%) and tourism (15%)

INFRASTRUCTURE
- Safe water – most of the population depends on the use of water from deep wells
- Electricity – available in most cities and towns; irregular access but available in rural areas
- Roads – relatively poor: city centres connected by concrete roads and highways; rural areas linked by dirt roads
- Mode of transport – private cars and public transport: national train system and connecting bridge between two islands

CULTURE AND SOCIETY
- Several ethnic groups speak their own language

MEDIA
- Majority of the country has access to TV and radio, 75% have access to the Internet
- Television
  - 1 government-controlled station and 3 privately owned stations; relatively no censorship
  - 3 free stations from neighbouring countries
  - 80% have access to cable TV
- Radio
  - Popular in rural areas
  - Relatively no censorship compared to TV
- Print media
  - Several national, regional and local newspapers
  - More popular in urban areas
  - Relatively no censorship by the government
  - Access to international media
  - People are media savvy

PUBLIC HEALTH SYSTEM
- Devolved health system
- Several rural health facilities (mostly private and charging expensive fees)
DEBRIEFING: 10:45

At the end of the task for Inject 3, each group will be given another 30 minutes to debrief, reflect on and synthesize their experience. Based on the exercise, and going through the scenario, groups will identify only the following:

- five most important elements of health emergency communications
- five important decisions to make for communications
- five key capacities needed for health emergency communications

Participants can discuss many things within the time period, including the rationale for the choices, but they have to trim down their presentation to the points indicated above.

The overall rapporteur/team leader of the group will be asked to prepare a presentation and deliver it during the succeeding panel discussion.
Workshop on Risk Communications for Public Health Emergencies
15–17 November 2011, Manila, Philippines

Scenario-Based Exercise – Screen Injects

Decentralized Republic of Anjori

Public health system
- Devolved health system
- Several rural health facilities (mostly private and charging expensive fees)
Scenario-Based Exercise – Screen Injects
World Health Organization

Workshop on Risk Communications for Public Health Emergencies
15–17 November 2011, Manila, Philippines

Scenario-Based Exercise – Screen Injects

Mobo Province (Campsite)
Workshop on Risk Communications for Public Health Emergencies
15–17 November 2011, Manila, Philippines

Scenario-Based Exercise – Screen Injects
Scenario-Based Exercise – Screen Injects

CREDITS:
Graphics concept of all design: Don Rivada and Elizabeth Mangali
Exercise Administrator: Ma Carmela Dichoso
Exercise Support: Novelina Zapanta and Ma Perpetua Santiago
## 1. Vision *(What is to be seen in five years?)*

Risk communications is institutionalized within the ministry of health as an essential component of the health emergency response actions, and integrated into routine functions.

By the end of five years,

- **A structure, team or mechanism** is established and/or developed to proactively and efficiently coordinate health emergency communications during public health emergencies. The team also ensures application of health emergency communications principles for routine prevention and response measures.

- **Linkages and coordination arrangements** systematically integrate risk communications with risk assessment, surveillance and response, as well as with relevant sectors. Coordination arrangements between the three components of risk communications – health emergency communications, operation communications and behaviour change communications – ensure that these components are integrated as part of the overall preparedness and response plans.

- **Working mechanisms** (procedures, guidelines and protocols) are developed and tested to ensure that the public is at the centre of health emergency communications activities and facilitate timely and transparent communications to the public. Feedback mechanisms are in place to feed into future actions, and also take into account the use of appropriate technology.

- **Advocacy** for health emergency communications adapts an approach where communication practitioners and risk managers are provided an opportunity to apply risk communications principles in emergency situations in country or within the region. The experiential advocacy approach facilitates sustainable support for the institutionalization of health emergency communications as a core function within the ministry of health.

- **Career development** for health emergency communications ensures availability of expertise within the ministry of health and facilitates professional growth for health emergency communicators.
2. Stages *(Describe the stages in moving from the current status to the Vision.)*

**Stage 1: Advocacy and integration**
A sustainable and integrated health emergency communications system exists within the ministry of health, where a communications structure, team or mechanism ensures effective linkages with other sectors during public health emergencies. A coordination arrangement is established with the health promotion and education units and other stakeholders, both for public health emergencies and for long-term social mobilization programmes.

A mechanism is in place for collecting feedback from the public based on the social, cultural and political contexts of the intended audience. Standard operating procedures (SOPs) and guidelines are developed, tested and regularly updated.

**Stage 2: Institutionalization for sustainability**
An institutionalized system is functional and provides an interface for the health emergency communications team to work closely with surveillance, risk assessment and response during health emergencies and for prevention and response actions. A mechanism for efficiently generating feedback from the public and documenting lessons and best practices from past health emergencies is operational and ensures that results are used to improve future health emergency communications strategies.

Human resource development programmes are available to ensure career advancement of professional health emergency communicators and the sustainable availability of expertise within the ministry.

3. Key milestones *(key expected results to be achieved collectively by a defined time frame)*

<table>
<thead>
<tr>
<th>Year</th>
<th>Focal points and teams for health emergency communications identified</th>
<th>Guidelines for health emergency communications and media response, monitoring and analysis developed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 3</td>
<td>Health emergency communications structure or mechanism established</td>
<td>Protocols and procedures for health emergency communications developed, tested and updated</td>
</tr>
<tr>
<td>Year 5</td>
<td>Functional regional health emergency communications network organized</td>
<td>Health emergency communications principles, SOPs and mechanisms applied during public health events</td>
</tr>
</tbody>
</table>
4. Components (list the components of the focus area)

- **Health emergency communications** – rapid dissemination of information and health messages to target audiences during a health emergency. The objectives are to build public trust, to enable and empower populations to adopt protective measures, to reduce confusion and to facilitate enhanced surveillance. Messaging during a health emergency is anchored on risk assessment results, taking into consideration the level of uncertainty and insufficiency of information. This component includes the initial announcement and information dissemination through mass media.

  As **health emergency communications** is a less developed and often neglected area during a health emergency situation, this is the priority component of the APSED (2010) workplan on risk communications.

- **Operation communications** – timely exchange of information among internal stakeholders including health authorities, clinicians, laboratories, decision-makers and other disciplines and sectors. Effective operation communications ensures coordinated response and keeps decision-makers informed of the situation, enabling them to make informed choices on possible next steps and policy changes. Operations communications also takes into consideration inter-country communications, especially when disease outbreaks or public health emergencies affect cross-border areas.

- **Behaviour change communications** – establishment and implementation of health promotion programmes for prevention and control of emerging diseases and other threats to public health, including the promotion of protective behaviours and social mobilization during public health emergencies. Behaviour change communications adopts a long-term approach and necessitates working closely with communities.
5. Activities *(For each component, list priority activities according to the stage of implementation.)*

<table>
<thead>
<tr>
<th>Stage 1 Activities (Advocacy and integration)</th>
<th>Stage 2 Activities (Institutionalization for sustainability)</th>
</tr>
</thead>
<tbody>
<tr>
<td>⊗ Review lessons learnt on health emergency communications from pandemic (H1N1) 2009 and other public health events.</td>
<td>⊗ Develop and test guidelines and protocols integrating surveillance, risk assessment, response and for media analysis.</td>
</tr>
<tr>
<td>⊗ Appoint and sustain a health emergency communications team or person within the ministry of health, supported by training and development of competencies.</td>
<td>⊗ Develop structure and career development opportunities for health emergency communicators to ensure sustainable availability of expertise within the ministry of health.</td>
</tr>
<tr>
<td>⊗ Establish a structure or mechanism to proactively and efficiently coordinate health emergency communications during public health emergencies.</td>
<td>⊗ Conduct regular health emergency skills training and workshops for professional development, knowledge sharing and publication.</td>
</tr>
<tr>
<td>⊗ Develop and test health emergency communications procedures, guidelines and protocols (including interface with other existing programmes of the ministry of health).</td>
<td>⊗ Organize a professional network with agreed competency requirements.</td>
</tr>
<tr>
<td>⊗ Organize regular national and regional meetings to sustain interest for health emergency communications.</td>
<td>⊗ Convene regular consultations on the use of appropriate technology for health emergency communications.</td>
</tr>
<tr>
<td>⊗ Develop appropriate feedback mechanisms to inform health emergency communications.</td>
<td>⊗ Proactively conduct advocacy activities to ensure sustainable support for the institutionalization of health emergency communications as a core function within the ministry of health.</td>
</tr>
<tr>
<td>⊗ Develop and conduct national and regional disease- or hazard-specific health emergency communications exercises (as needed).</td>
<td></td>
</tr>
<tr>
<td>⊗ Conduct regular national and regional exercises and hands-on training on health emergency communications using real events in country and within the region.</td>
<td></td>
</tr>
</tbody>
</table>

6. Key activities for the coming year *(key common activities to be completed collectively in the coming year, e.g. July 2011–June 2012)*

- Synthesis of lessons learnt from past emergencies
- Development of structure (mechanism, teams, focal points, etc.)
- Development of SOPs based on real-life events
- Skills training on health emergency communications