ASIA-EUROPE FOUNDATION

Kami Sedia Membantu
KEMENTERIAN KESIHATAN MALAYSIA

Risk Communications for Public Health Emergencies:

Bridging the National Mechanism with Healthcare Workers

WORKSHOP REPORT

2-4 SEPTEMBER 2015 | LANGKAWI, MALAYSIA

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THIS WORKSHOP WAS CO-ORGANISED BY

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BACKGROUND

Since 2010, the Asia-Europe Foundation (ASEF) Public Health Network, with strong support from the **Government of Japan**, has worked to strengthen multi-sectorial pandemic preparedness and response, within countries from the Asian and European regions. Recent highly publicised emergencies such as the **Ebola epidemic** in West Africa, the **Nepal Earthquake** and the **Middle East Respiratory Syndrome Coronavirus (MERS-CoV)** outbreak in the Republic of Korea have demonstrated the impact and geo-political nature of natural hazards and public health crises. These events have proven themselves able to destabilise a country or multiple countries, an entire region and perhaps the world.

Training on risk communications emerged as a common need across all sectors. With the goal of further strengthening this discipline as part of overall emergency preparedness, ASEF implemented 2 workshops on risk communications in 2013 and 2014. Participants from across both regions came together to share communication challenges and lessons learnt from real-life cases of public health emergencies.

Healthcare workers (HCWs) are on the front lines in health emergency and natural hazard event that have a direct impact on them as well as those affected. These high-risk events vary widely in nature and scope but share one common characteristic: how well these events are managed relies heavily on how well national authorities communicate before, during and after these events. In countries where a national mechanism to coordinate communication is not in place, HCWs may receive conflicting information from multiple agencies. Different stakeholders may have varying levels of expertise, interest and perception of risk. The risk perception of HCWs may be different from that of national authorities due to their proximity to a public health event.

The ASEF mandate for this risk communications workshop in 2015 continued. This year, ASEF, with the generous hospitality of the **Ministry of Health, Malaysia,** *addressed this vital need by bringing experts across Asia and Europe to discuss gaps in this area of work. The workshop was comprised of presentations of cases from selected public health emergencies.*

INTRODUCTION

Public health emergencies are unpredictable and unprecedented events characterised by complexity, confusion, fear and uncertainty. These events have socio-economic impacts that detrimentally affect the areas or countries in which they occur. Recent public health events such as the Ebola epidemic in West Africa, the Nepal Earthquake and the MERS-CoV outbreak in the Republic of Korea and Thailand had implications that went beyond the health sector. Some public health emergencies stigmatise those affected, harm national and global economies and can become the catalyst for the breakdown of an entire region. Of those most affected, healthcare workers (HCWs) are, more often than not, at highest risk.

ASEF Public Health Network supports the global mandate under the International Health Regulations [IHR (2005)], monitored by the World Health Organization (WHO), that aim to prevent, protect against, control and respond to the international spread of disease while avoiding unnecessary interference with international travel and trade.

The International Health Regulations (2005) are an international law that entered into force on 15 June 2007 and are binding on 194 countries across the globe. They were revised as a response to an emerging profile of highly pathogenic diseases. The increased mobility of populations and their interconnectedness ensure that previously localised public health events now have the potential to turn into global epidemics. This makes the IHR (2005) central to ensuring global public health security.

Under the IHR (2005), risk communications is one of the core capacities essential in the early detection and rapid response to emerging infectious disease outbreaks. While it is not possible to prevent these health emergencies, their adverse impact can be mitigated through effective risk communications. The ability to immediately communicate risks to frontline healthcare workers and the public is at the heart of any effort to manage threats to global health security. And risk communications runs through every aspect of integrated public health systems.

The ASEF Public Health Network organised a risk communications workshop attended by senior representatives from several countries from the Asian and European regions (see Annex 1, List of Participants).

Recently profiled public health emergencies have underscored the risk of travel-related cases of highly pathogenic diseases being imported into unaffected countries. Appropriate levels of preparedness demonstrate that rapid containment is possible if emergency preparedness and response is a primary focus.

ASEF's workshop was accompanied by a simulation that tested current risk communications strategies but also laid the foundation for the development of new ways of thinking in this area of work.

Workshop Objectives

The objectives of the workshop were to:

- Identify the core elements that facilitate and/ or hinder reflecting the voices from healthcare workers in national risk communications strategies
- Develop recommendations for strengthening national risk communications strategies that incorporate needs from both national authorities and healthcare workers

Methodology

The Warning Project (www.warningproject.org) was engaged as facilitators for this event. Employing a workshop model that focused on theory, case studies, practical application and the latest in adult learning technology developed by the Warning Project, the workshop content was spread across 2.5 days and divided into 4 distinct sessions:

DAY 1 — DAY 2 — DAY 3 Half Day

Session 1: Risk Management Transparency

Case Study:
Risk Management Transparency in the Cases of MERS-CoV in the Republic of Korea and Thailand

Session 2: Communications Coordination during Emergencies and Other High Risk Events

Case study:
Communication Coordination during the Earthquake in Nepal

Session 3: Dialogue with Those Affected and Involved on the Front Lines

Case Study:
Ebola in West Africa

Session 4: Monitoring and Evaluation of Risk Communications Performance during Emergencies and Other High Risk Events

Case study:
2011 Christchurch Earthquake

Review of Sessions and Adoption of Risk Communications Strategies and Recommendations

For the duration of the workshop, when questions were asked to the participants, all groups were requested to register their responses on voting pads (i.e. "clickers") which each person received at the beginning of the workshop. After voting on each question, an immediate display of corresponding responses was reflected back to the group via the PowerPoint/ projector screen.

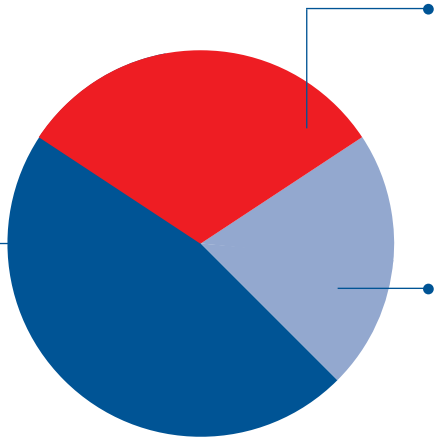
Pre-workshop Assessment Results

An online survey in advance of the workshop was sent to all participants. Out of 48 participants, 40 respondents submitted the pre-workshop form to the Warning Project facilitators. The results provided the foundation for the workshop, allowing facilitators to understand the following:

- The profile of attendees
- Participants' challenges in the area of risk communications in the emergency context
- Where to focus efforts and discussion in order to address and overcome these challenges, reinforcing existing capacities where required or supporting the development of new capacities, as needed

All the questions asked were related to risk communications. As part of an analysis in plenary by the lead facilitator, a few questions were set apart and answered back to all participants at the beginning of the workshop. This was to provide a clear understanding of the current mind-set and capacities of attending participants. This left facilitators with a clearer picture of overall needs and capacities. Some of the key questions presented back were the following, along with interesting comments made by some respondents.

1. Among the below, which definition of emergency risk communications best reflects your current understanding?



46.7%
Risk communications is a process that gives the public access to information on the emergency and advises them on protective behaviours they should adopt to minimise their exposure to potential risks.

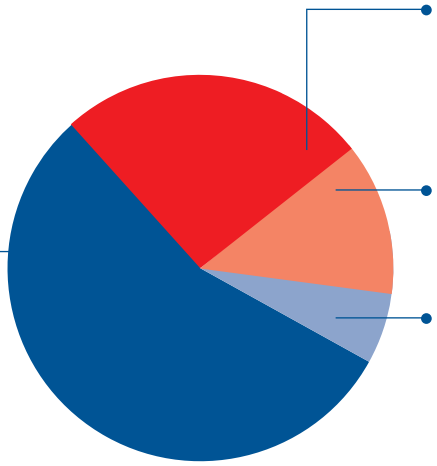
33.3%:
Risk communications is a dialogue between those responding and those affected and supported by the dissemination of essential information that informs critical decision-making.

20%:
Risk communications is an interactive process of information/ opinion exchange between certain individuals, groups and institutions that occurs before a specific health problem/ emergency is addressed.

Key comments from respondents:

- *"There is a fourth option missing which includes engagement before an incident."*
- *"This is an 'ideal', not often easy to achieve (e.g. during the tense and rapidly evolving situations of a crisis/ emergency, where it can be difficult to have this 'dialogue.)"*
- *"We don't use the terminology 'risk communications', instead we include this approach into 'health promotion'."*

2. The response that best describes the role emergency risk communications play in your programme or specific area of work is...



53.3%
The role that emergency risk communications plays varies.

33.3%
Emergency risk communications is entirely integrated in my programme/ area of work.

10%
We do not engage in risk communications.

3.3%
We employ emergency risk communications expertise and strategies to help us develop posters, information pamphlets and brochures, similar to health promotion.

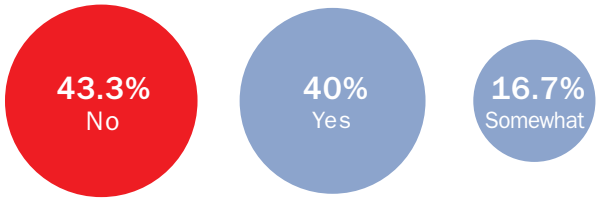
Key comments from respondents:

- *"I feel like our country's emergency risk communications is not so finished that it can be integrated into all the areas of work."*
- *"We often lack the resources to incorporate emergency risk communications into our programmes."*
- *"Ebola is presenting a window of opportunity currently, bringing the issue of failure to communicate and engage with the affected to the table."*
- *"Risk communications should be more than an 'opinion exchange'."*

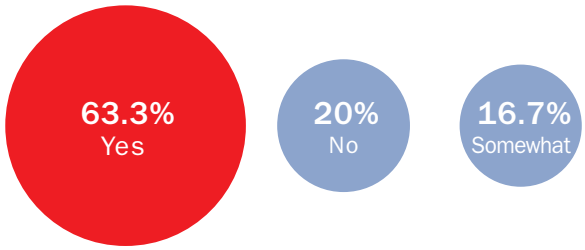
3. Top priority activities in your current risk communications strategies (ranked by respondents)

1. (Top priority) Media relations
2. Information, Education, and Communication materials
3. Social media
4. Community engagement
5. (Low Priority) Social mobilisation

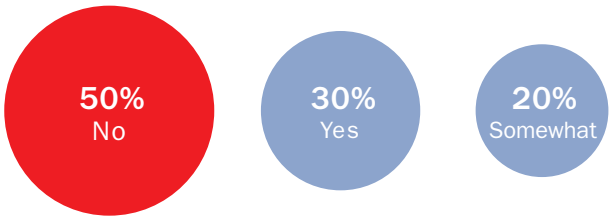
5. Has your programme, team or organisation conducted research on the knowledge, attitudes and perceptions of some of your target populations (i.e. vulnerable communities, target groups, etc.)?



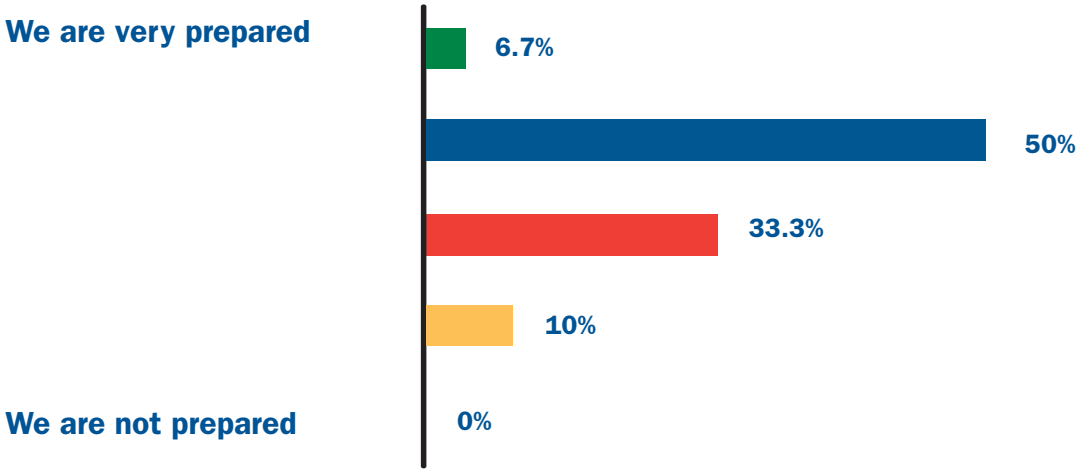
4. Does your programme, team or organisation have a list of communication partners? If so, are you in regular contact with these partners?



6. Has your programme, team or organisation put in place a system for evaluating the impact of your communications strategies/ activities to see if they are working?



7. On a scale of 1 to 5, how would you currently classify your country or organisation's level of risk communications preparedness?



SESSION 1:
Risk Management Transparency

Key Transparency Barriers:
1. Ensuring leadership engagement/ endorsement
2. Lack of guidelines/ policies

Key Transparency Abilities:
1. Rapid approval of warnings and advisories
2. Adherence to decision-making principles – in a regulation, policy or guideline

Scenario

The first session of the workshop began with the exposition of a core element of risk communications that is **risk management transparency.** The session started with a scenario wherein participants were given the following pieces of information:

- Two cases of unusual, serious illness in children
- Symptoms consistent with *flesh-eating disease*
- BUT it is different, no obvious sign of infection or exposure, patients not responding to antibiotics
- Boys go to the same school, families know each other
- Lab analysis just started
- Fear is that illness could be infectious
- Two competing risk communications strategies:
  1. immediate communication; or
  2. wait until lab analysis is complete

In session 1 the participants confronted a practical challenge of deciding what and when information should be released. They were also asked to think about what information needed to be withheld about this emerging public health problem. It was the hope that at the end of the session, participants understood the role of information in the context of emergencies. Specifically that information was instrumental in:

- Helping at-risk populations take informed decisions and adopt protective behaviours
- Obtaining the trust required to prepare populations for potential threats to public health and how to respond to them
- Complementing existing surveillance systems
- Coordinating with partner internal and external to health
- Minimising and mitigating socio-economic disturbances

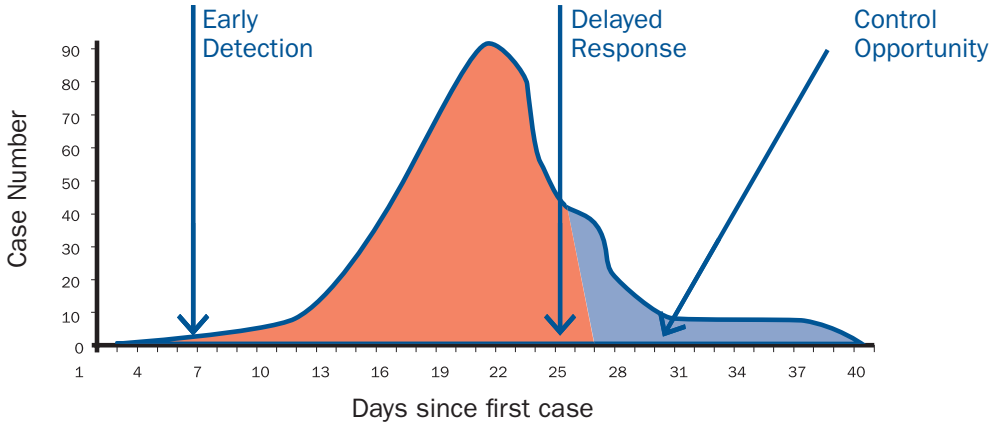
Experience has shown that transparency in the context of risk communications is invaluable if emergency/ response managers seek to gain and/ or maintain public trust. Without trust, it would be difficult, even impossible, to convince those at-risk to adopt protective behaviours in an emergency. The initial session introduced participants to a simple scenario that had the potential to turn into a public health emergency. Each scenario was followed by a question about transparency, prompting groups to discuss each question and make decisions based on the information given to them at that time.

Theory

The management of information related to an emergency, including the first announcement warning a population of a potential risk, helps ensure that those at real or potential risk can protect themselves and that trust between authorities, populations and stakeholders is maintained and strengthened. A lack of transparency might result in rumours or misinformation/ misconceptions related to a disease outbreak/ emergency, making a difficult situation even more complex. This results in public health challenges and problems beyond the health sector, impacting the politics and economy of an affected country.

FIGURE 1

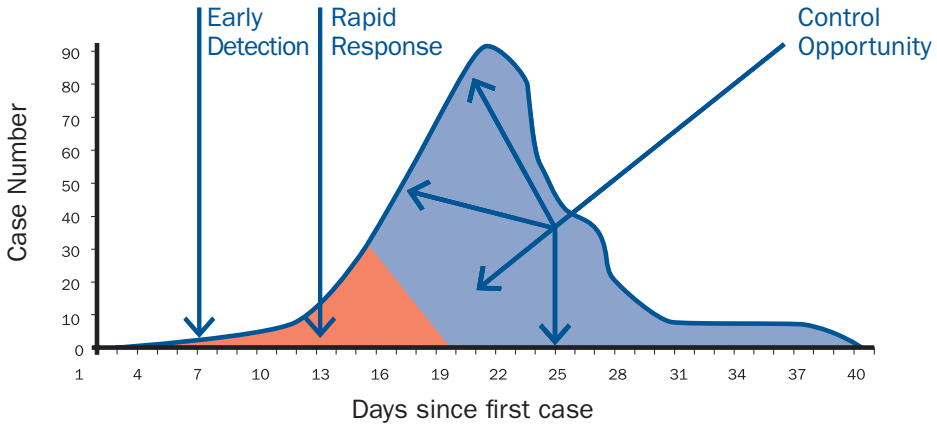
Goal of Emergency Risk Communication



In an outbreak situation, there can be a long gap between the first detection of cases and the confirmation of the illness or the source of illness. If emergency managers and decision-makers await lab confirmation before announcing the outbreak and giving the public advice to protect themselves, this leaves them with very little time to try to control the outbreak (see figure 1). The worst of it may have passed by the time decision-makers can communicate with certainty.

FIGURE 2

Goal of Emergency Risk Communication



The facilitator postulated that any response strategy would depend on the effectiveness of risk communications. Using a typical epidemiological curve, the facilitator indicated that the earlier an emerging threat is identified and announced, the more time decision-makers have to control the spread and reduce its impact on public health (see figure 2). Every rapid response strategy must include risk communications. Alternatively, the later a potential threat is announced to the public, the more drastically reduced opportunity to control disease spread is.

CASE STUDY:
Risk Management Transparency in the Cases of MERS-CoV in the Republic of Korea and Thailand

Overall Discussion Synopsis

The lead speaker for Session 1 was Ms Aphaluck Bhatiasevi, Risk Communications Officer for the World Health Organisation (WHO), accompanied by panellist, Mr Michael McCluskey, journalist and broadcast manager. Ms Bhatiasevi spoke about her recent experience in managing communications during the Middle East respiratory syndrome coronavirus (MERS-CoV) outbreak in the Republic of Korea and how this influenced the management of the imported case of the disease in Thailand. Both staged an engaging discussion with participants. Mr McCluskey also spoke about his experience as a journalist and how transparency is crucial to every aspect of the emergency response process. Both made the point that information gathering and public information sharing was critical to transparency. With Mr McCluskey stating, "Saying 'I don't know' is empowering, as long as you give people the information that you do know."

Background

An infectious disease outbreak affecting one country, can easily cross the border to other countries via air travel. MERS-CoV has had significant impact not only in the Middle East, where the disease was first discovered in the Kingdom of Saudi Arabia in 2012, but worldwide. The novel coronavirus, part of the same family as the Severe Acute Respiratory Syndrome (SARS), has made its mark outside of the region, posing great risk to countries across the world.

As of the 8th September WHO has been notified of 1,517 laboratory-confirmed cases of infection with MERS-CoV, including at least 539 related deaths.

On 20 May 2015, the Republic of Korea (Korea) notified WHO of its first laboratory-confirmed case of MERS-CoV. A 68 year-old male who had returned to the country after visiting several MERS-CoV affected countries in the Middle East was the first imported case of the virus in the country. This initial infection resulted in additional hospital-based infections of the disease—bringing the total number of cases to 186 including 36 deaths.[1]

Neighbouring countries in the Asian region were on high alert. Thailand, in particular, remained vigilant due to the high media attention garnered by the Korean outbreak and the frequent travels between the two countries. The first laboratory confirmed case of MERS-CoV in Thailand was documented on 18 June. The imported case was a 75 year-old male traveller from Oman. The patient was hospitalised while in Oman between 8-9 June. His condition did not improve. He still travelled to Thailand for medical reasons and was checked-in to a large private hospital. Treated as a MERS-CoV suspect case due to his travel from the Middle East, the patient tested positive for the virus.

[1] "Middle East Respiratory Syndrome coronavirus (MERS-CoV) – Saudi Arabia", WHO Disease Outbreak News, http://www.who.int/csr/don/08-september-2015-mers-saudi-arabia/en/, (September 8, 2015).

Risk Management Transparency Dilemma

This is a case study that involved two countries and how they managed to announce to the public a first imported case of a novel virus and subsequently handled issues of transparency soon after. The difference being, one country (i.e. Thailand) had the opportunity to learn from the other's experience (i.e. Korea), quickly picking up the lessons learnt and applying it to their immediate context, ensuring that transparency was timely and managed well. The overarching dilemma or challenges related to risk management transparency in both these instances are the following:

- The balance between the **public's right to know and individual/ patient's right to privacy**
- The balance between **lack of information vs information overload**
- How **timeliness and transparency** is determined – when and how much
- **Health/ national authorities in a vulnerable situation** – complex outbreak, lack of control on the concerned hospitals, lack of information (when faced with uncertainty or incomplete information, what must be done)

Korea Dilemma

MERS-CoV was a disease seemingly isolated to the Middle East. High risk of importation to Korea seemed unlikely. So much so that MERS was unfamiliar to the country's healthcare workforce, therefore, the proper infection prevention and control (IPC) procedures had not been updated to accommodate the highly infectious virus.

The resulting outbreak turned out to be large and complex, garnering high media and public attention. The public was angry and afraid. They felt that the government was not giving them enough information about the situation and appropriate advice on how they could protect themselves. The information vacuum created became a breeding ground for rumours and speculation, further aggravating the already tense situation.

Public trust in the government officials' ability to manage this outbreak was swiftly declining. The rapid evolution of the outbreak and its unfamiliar characteristics left national officials in a vulnerable situation, unsure of what information to release in a timely manner. Barriers to risk management transparency in this case were:

- **Private hospitals implicated:** Most cases were occurring in private hospitals or hospitals managed under different government bodies.
- **Social media gets involved:**
    - A blogger stated that the 1st week of June was the darkest period in "Modern Korean history" as the public fears over MERS-CoV increased, while the government was "quiet".
    - Switching Twitter to private for a day (4 June) by Korean CDC triggered an outcry from not only the scientific community but also the public.
    - Korean digital media platforms (e.g. Pressian.com and Newstapa.org) challenged the Ministry of Health, and compiled and put out names of hospitals with MERS-CoV patients.
    - Several websites also created their own compilation of information and maps on MERS-CoV cases.
- **Rapidly evolving situation:** The public felt that no substantial information was coming from the government and there were concerns on whether officials had a "handle" on the situation.
- **Uproar from local authorities:** On 7 June, the Mayor of Seoul requested Ministry of Health to publicly reveal names of hospitals treating MERS-CoV patients.
- **Uncertainty/ incomplete information:** Before the joint Ministry of Health/ WHO investigation, WHO did not have much information and therefore could not provide information internationally on what was happening in Korea.

Thailand Dilemma

Thailand was fortunate in that the first imported case was in a foreign national who was admitted to a private hospital soon after his arrival in the country and did not further spread the virus to others. Also, Thailand was able to watch and glean lessons learnt from the Korean MERS-CoV outbreak. The increased media attention of the latter ensured that Thailand and its emergency response and risk communications staff were on high alert. The country even adapted its Ebola response plan to the MERS-CoV context.

Due to previous issues of internal politics surrounding the Ministry of Public Health (MOPH), the Thai media was, initially, sceptical of the government's response. Being conscious of this scepticism, the MOPH sought to dispel this, coming up with an emergency management and risk communications strategy that would show that they were ready and able to prevent the spread of the virus in country.

Risk Management Transparency Solution

Korea Solution

Nine days after Korea notified WHO of the outbreak, the Minister of Health issued a public apology, acknowledging previous events and addressing the public's future concerns. Bringing in WHO to work with the Ministry of Health on a joint investigation also worked to instil trust lost during the early stages of this outbreak. The joint outbreak investigation on 9-13 June opened up the floor for frank and open discussion with Korean authorities. Critical recommendations were provided and serious action was taken to implement those recommendations, including:

- **Strengthening infection prevention and control procedures** (IPC) in all healthcare facilities
- **Improvement of the triage** of patients – all with fever being asked about history of contact with potential MERS-CoV case(s)/ visit to hospitals treating MERS-CoV patients
- Recommendations to **re-open schools** as outbreak was confined to healthcare facilities and not in the community

A joint press conference was held on 13 June to announce these recommendations. The message was balanced with caution to the public that the situation "could get worse before it got better". This was a great strategy to ensure that the mistake of overly reassuring the population was not made, in the event that the situation did take a "turn for the worse". Initially, the public remained sceptical of WHO and the Ministry of Health, however, after seeing the recommendations taken seriously by national officials and hospital personnel, public confidence and trust were gradually regained—the greatest imperative of risk management transparency.

Some key events that also helped were:

- The working relationship between **Ministry of Health, Korea, and WHO improved substantially after the face-to-face interactions** from the joint mission resulting in open and transparent discussions.
- **Ministry of Health, Korea, published names of health care facilities** with MERS-CoV cases from 7 June, following a request from the Mayor of Seoul – more than 40 hospitals were named, including the Samsung hospital.
- **WHO published the names of health care facilities** with MERS-CoV cases from 10 June - 17 July to the international audience.
- On 10 June, the **President of Korea cancelled her travel to the U.S. which reflected strong political commitment** from the government.

The overall effect was positive – tourism saw an increase once again and public confidence and trust in the government increased, as well as lessons learnt documented for future emergencies.

Thailand Solution

After notifying WHO of the first laboratory confirmed case on 18 June, MOPH moved the patient and his close contacts from a private hospital to a MOPH isolation facility.

The MOPH then activated its emergency operations centre or "war room", holding daily taskforce meetings and immediately requesting for WHO presence in these meetings, a first, concrete step towards transparency. Subsequent actions were also taken that demonstrated to the public how serious the MOPH was at ensuring rapid containment of the virus.

External Risk Management Transparency Actions

- **The MOPH actively provided information on MERS**, as well as the difference between MERS, SARS, H1N1, H5N1 on the web.
- **The MOPH was active on social media** – both for internal communications and public communications.
- **The MOPH was active in translating facts and key messages** into info-graphics.
- The MOPH reached out to embassies of countries from where contacts were identified to provide support in terms of translation and food (this was during the Ramadan period).
- **The MOPH was quick to dispute rumours and misinformation.** An example of this was when a photo of an Ebola drill went viral in social media, claiming that additional MERS-CoV cases were detected. The MOPH worked to dispute the rumour over social media and traditional media.
- **Daily media briefings were held by the MOPH.**
- The regular MOPH 24/ 7 hotline was strengthened with surge staff and information.
- MOPH conducted 2 **perception surveys** within 3 weeks, up until a week after recovery of the confirmed case.
- **Village health volunteers** were provided with information on an almost daily basis so that they could raise awareness within their communities even though MERS-CoV was "the talk of the town" only in the capital city.

Internal Risk Management Transparency Actions

- **The MOPH had rigorous internal communication** - with all departments across at the central level, with all provincial health chiefs and with all risk communications focal points at the regional levels (12 regions on a daily basis in the 1st week and then down to every 2 - 3 days in the 2nd week)
- **Media monitoring** (mainstream and social) occurred on a daily basis and strategic planning of communications was conducted
- Issued daily **situation reports**

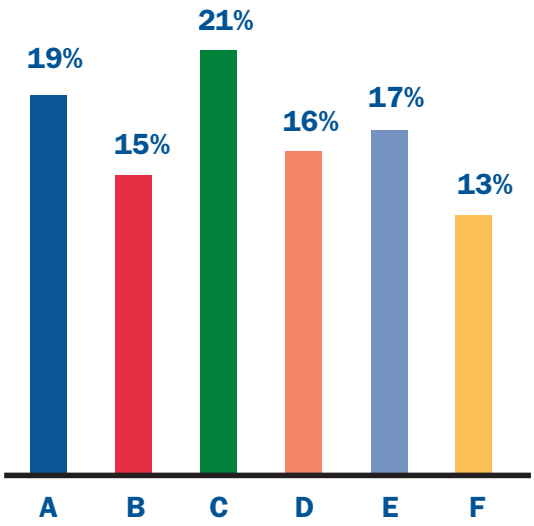
The first confirmed case did not turn out to be a "super spreader" with 80% of his contacts followed-up and very close contacts effectively categorised as "high risk contacts". Embassies and social media were also used to identify contacts, with the MOPH ensuring close coordination with the Ministry of Foreign Affairs (MOFA), strategically briefing key countries on the situation as it evolved.

Group Responses

Groups were asked a series of questions related to the scenario as well as workgroup tasks to draw out their responses to key priorities related to this core risk communications component.

An overwhelming majority (70%) agreed that authorities should communicate a serious, emerging risk immediately. While over half (57%) said that organisations resist complete transparency due to incomplete information.

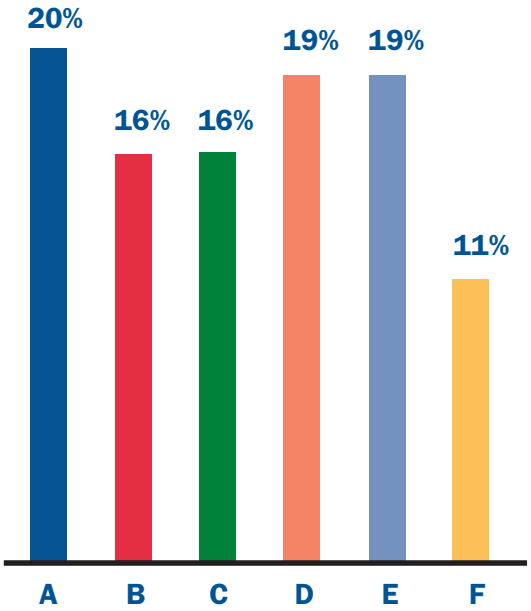
In terms of transparency, groups were asked to rank the common weaknesses that represent the most significant barriers to success:



In terms of transparency, rank the common weaknesses which represent the most significant barriers to success.

A. Lack of guidelines and policies
B. Limited budget and human resources, including advocacy
C. Ensuring leadership engagement and endorsement
D. Emergency communication exercises and training
E. Practical tool and template development
F. Others

13% of respondents answered "Others". Arguments to support this response were rooted in the lack of credibility of those giving the information and problems with image of the organisation or reputation. When prompted to list their responses on recommendations for international best practice in this section, 3 responses were highlighted:



In terms of transparency, rank these abilities in terms of international best practice.

A. Rapid approval of warning and advisories of a real or potential public health risk
B. Ability to issue warnings or advisories of a real or potential risk during non-business hours, for example, in the evenings and on holidays
C. Capacity to ensure hard to reach and minority populations are informed through translated and tailored materials.
D. Adherence to decision-making principles - in a regulation, policy or gideline - on the timely public release of information
E. Ensuring event transparency is evaluated against agreed upon principles
F. Others

Several picked ***A) Rapid approval of warnings and advisories of a real or potential public health risk - if information needed to be disseminated quickly then a system for rapid clearance of this information needs to be in place prior.*** And ***E) Ensuring event transparency is evaluated against agreed upon principles - in order to have rapid approvals first there must be agreed upon principles*** that define transparency for an organisation. Also, ***D) Adherence to decision-making principles*** - if principles are clear, then organisations can abide by an outlined rapid clearance process.

SESSION 2:
Communication Coordination during Emergencies and Other High Risk Events

Key Coordination Barriers:
1. Ensuring leadership engagement/ endorsement
2. Lack of guidelines/ policies

Key Coordination Abilities:
1. Identification/ engagement of focal points
2. Communication coordination structure
3. Sharing risk communications messages and strategies during a serious public health event

Scenario

The second session of the workshop addressed the challenges of communication coordination in emergencies. The natural evolution of emergencies demand that health authorities be able to effectively engage and coordinate public communication with other involved organisations, including designating roles and responsibilities of lead and supporting agencies.

For the second portion of the scenario participants were introduced to another evolving section of the scenario and given some information that was confirmed as well as information that had yet to be confirmed primarily about the source of the deadly infection.

After the scenario, the participants understood the following facts:

- Increasing profile of the disease: staff and the community have been alerted and there is currently intense and provocative media coverage.
- The lab results indicated that the cause is not flesh-eating disease, but it was inconclusive.
- The first case has died and the second case is rapidly deteriorating.
- A new case was identified, who was an elderly woman with no link to school or neighbourhood.
- The link among the three patients was that they all attended a local festival and ate food there. The catering company, EATEX, was raised as a suspect of the source of the disease.
- EATEX is aware of the suspicion by local health authorities and threatened legal action if they are publically identified without evidence.
- Food safety authorities were encouraged to respect regulations.
- A communication coordination strategy is required.

The resulting situation in the scenario required participants to develop a communication coordination strategy in order to disseminate essential information, understand what other partners were going to say and understand what communication capacity was at their disposal.

Theory

Communication coordination helps take advantage of available public communication resources and allows for coordinated messaging, reducing the possibility of confusion and overlap and strengthening the reach and influence of the advice provided. This is key during emergencies as most of them are cross jurisdictional and complex. Better understanding between other partners ensures a better result, allowing organisations to use and leverage existing capacities of partners to meet strategic communication objectives. The goal in emergencies is to: **Cooperate + Collaborate + Coordinate**. Yet, what actually happens in the field is that organisations and their partners tend to **Contradict + Confuse + Compete** with one another. Inter/intra organisational rivalries do not disappear during crises. In fact, territoriality, suspicion and even secrecy increase in these instances.

CASE STUDY: Communication Coordination during the Earthquake in Nepal

Overall Discussion Synopsis

The lead speaker for Session 2 was Dr Natasha Reyes, Manager of Emergency Response Unit of Médecins Sans Frontières (MSF) Hong Kong. She spoke about her recent experience as lead Medical Coordinator for MSF in Nepal days following the disaster. She recounted the challenge of communication coordination in the context of such an event. The overall coordination during the event was a complex undertaking, so communication followed suit. The imperative in a situation like this was the ability to understand what mattered and what did not in terms of communication coordination. Instead of focusing on the differences, she urged participants to focus on the common objectives and messages between organisations, from that point on it would be easier to move forward.

Background

On 25 April at approximately 11:56 am local time a 7.8 magnitude earthquake struck Nepal[2], with the epicentre in the Lamjung District, just northwest of Kathmandu and south of the China border.

The Nepal earthquake (also known as the Gorkha earthquake) killed over 9,000 people, injuring over 23,000. It was recorded as the worst natural disaster to strike Nepal since the 1934 Nepal-Bihar earthquake.

Apart from devastating local districts, the massive earthquake also triggered a deadly avalanche on Mount Everest, killing at least 20 people. This would go down in history as the deadliest day on the mountain ever to be recorded. Entire villages were decimated, leaving hundreds of thousands of people homeless and afraid to re-enter homes and buildings because of continued aftershocks and tremors. Access to those affected areas was blocked and a communication blackout was present in some remote areas. This made it difficult for responders, including search and rescue teams, to evacuate victims and to meet the needs of those affected. When access did clear, however, evacuation was well-executed by the Nepal army and commissioned private helicopter companies.

[2] "Nepal: Earthquake 2015 Office of the Resident Coordinator - Situation Report No. 01", United Nations Office for the Coordination of Humanitarian Affairs (UN OCHA) Situation Report, https://www.humanitarianresponse.info/en/system/files/documents/files/nepal_sitrep_25apr2015.pdf, (April 25, 2015).

Communication Coordination Dilemma

As one of the many response agencies deployed to this humanitarian disaster, it was MSF's job to make sure it was aligned with other partners in the field. The hope was that this alignment would then lead to more efficient, effective and coordinated health messaging. Though MSF had strong relations with those involved, partner coordination in this evolving context and emergency environment presented real challenges due to system and logistical issues such as:

- **Influx of responders/ agencies:** large numbers/ teams from hundreds of humanitarian organisations, who were not well-informed or properly briefed on the response approach[3]
- **Absence of communication mechanism:** there was no single chain of communication among the actors (e.g. military, Ministry of Health, international non-governmental organisation (INGOs), local non-governmental organisations (NGOs)), and the different lines were not coordinated efficiently (i.e. especially among local military, foreign military and the civilian response).
- **Insufficient information to local authorities:** information flow from national to district level was insufficient, causing friction at times between the local and international players.
- **Issues with access to those affected:** logistics and resources were great concerns, the emphasis being on the difficulty experienced reaching isolated communities, which were more often the hardest hit.
- **Emergency plans/ guides do not follow real-life:** due to the magnitude of this event, the implementation of guidelines, plans and policies was not always the case. The situation was a rapidly evolving one, more like moment-by-moment, rather than day-by-day. So the quick shift in realities was difficult to translate to immediate operational actions. In Dr Reyes' words, "What you see on paper is not the reality on the ground".

Partner communication coordination in times of peace is, in and of itself, a herculean task. But when set against the backdrop of a massive earthquake, any type of coordination, at times, seemed almost impossible.

Though the daily Health Cluster (HC) meetings were helpful, there would still be instances wherein MSF would receive reports of un-coordinated drops in the middle of nowhere from international military helicopters/ airplanes of food or hygiene essentials. This was because some international military partners were not coordinating effectively with the local authorities and military, therefore communication of these drops was not properly broadcast or made known to those affected. This was otherwise an avoidable waste of resources.

Also, there was no established sub-cluster for communications within the HC during the first few weeks of the response. This made communicating across multiple partners difficult. Without a proper communication coordination mechanism, MSF team was unable to fully understand the following:

- **Messengers and the message:** who was doing/ saying what and where
- **Partner capacity:** which partners had certain capacity for information dissemination with existing channels in-country, who had prepared health messages already in the local languages
- **Partner location:** which partners had established hubs in the affected areas or access to the local leaders and communities in the affected districts/ areas

[3] "Lessons Learned for Nepal Earthquake Response", Assessment Capacities Projects ACAPS.org, http://acaps.org/img/documents/l-acaps_lessons_learned_nepal_earthquake_27_april_2015.pdf, (April 27,2015).

Solutions Taken

In the absence of a broader communication coordination mechanism between partners, MSF decided to focus on activities that were within its immediate control prioritising the following:

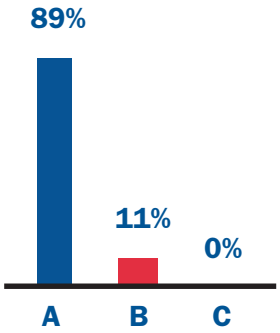
1. **Internal coordination within the organisation:** this involved setting priorities, frequent use of satellite phones and helicopter trips to ensure cohesion between field teams and the coordination team, ensuring health promotion was integrated into other activities that involved/ required proactive health messaging (i.e. mobile clinics, mental health interventions because people were still traumatised by the continued aftershocks).

2. **Coordination with other actors whenever/ wherever possible:** this entailed attending the daily Health Cluster and Foreign Medical Team (FMT) meetings to coordinate with other actors and share information from the MSF field teams on the on-going needs in the affected areas, the priorities and the actions. Also, this served as a forum for MSF to understand what other partners were doing. Besides coordinating where possible with their counterparts, MSF made it a point to attend bi-lateral meetings attended by district government authorities, to ensure local authorities were apprised and aware of what MSF was doing and where. This was critical because it was often found that local and national authorities were not sufficiently involved in planning and discussions related to international response interventions.

MSF found that raising coordination issues in meetings was helpful, which resulted in some improved form of coordination. Online resources such as The Humanitarian Response (https://www.humanitarianresponse.info/en/operations/nepal) also helped MSF to understand who was doing what and where, allowing the organisation to identify potential areas for future communication coordination throughout the course of the event.

Group Responses

Groups were asked a series of questions related to the scenario as well as workgroup tasks. When groups were asked what, for them, the primary objective of their communication coordination strategy was, the majority (89%) answered ***A) Ensuring consistent public messaging among involved organisations***, as most participants viewed this as a priority rooted in the necessity of being "consistent" in your messaging. 11% of participants responded with ***B) Leveraging partner communication capacity.***



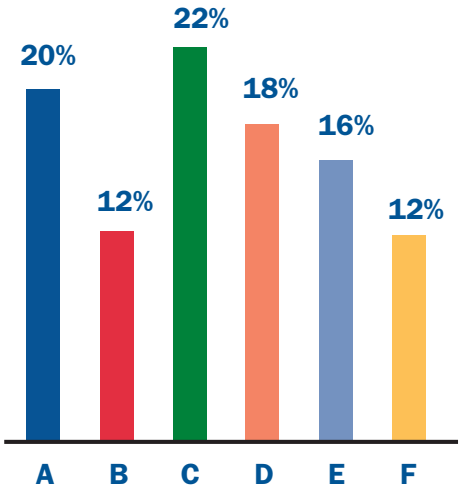
For the Communication Coordination Strategy, what is your primary objective?

A. Ensuring consistent public messaging among involved organisations
B. Leveraging partner communication capacity
C. Managing potential partner conflict

No one chose ***C) Managing partner conflict,*** which was the correct answer, according to the lead facilitator. However, upon further discussion, some participants did express that C was also a plausible choice, as it would ensure that both A and B would be accomplished as well. The second question, "In the Communication Coordination Strategy, who is your communication priority?", the majority answered "mass media" explaining that the reach of this target group was much broader. This answer ranked above other options such as: food safety authorities, family of victims, EATEX officials, other health authorities and health care workers.

When asked, "If no agreement can be reached on whether or not to warn of potential EATEX risk, what do you do?" 71% answered that they would move on with the warning instead of focusing on reaching an agreement among partners, citing that the communication objective in this instance was to save and protect the public.

For the workgroup tasks, groups were asked to rank the common weaknesses that represent the most significant barriers to success:

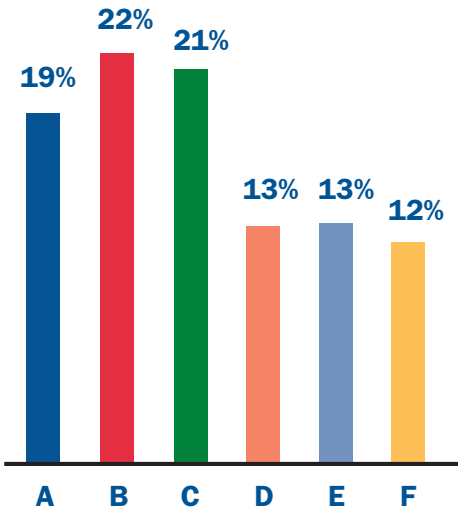


In terms of communication coordination, rank the common weaknesses which represent the most significant barriers to success.

A. Lack of guidelines and policies
B. Limited budget and human resources, including advocacy
C. Ensuring leadership engagement and endorsement
D. Emergency communication exercises and training
E. Practical tool and template development
F. Others

A) Lack of guidelines and policies as well as ***C) Ensuring leadership engagement and endorsement*** were the top answers. Some comments made also stated the fact that communication coordination in a rapidly evolving emergency environment was a huge challenge and not as easy to execute when in the field. Further stating, each organisation and agency have their own culture, ways of doing things mandates, and this can sometimes be a challenge to coordinate on agreed upon messaging.

When asked "Which of the following groups of stakeholders was most important to engage?", some participants answered that those who actively support their decisions, those who oppose them and those who are indifferent should be engaged. Some groups mentioned that the particularly dissenting/ opposing voices had to be actively engaged. Not doing so in a timely manner would result in potential problems "down the road". In terms of communication coordination, groups were asked to rank these abilities in terms of international best practice:



In terms of communication coordination, rank the abilities in terms of international best practice.

A. The identification/ engagement of partner public communication focal points
B. The establishment of a communication coordination structure (e.g. Committee)
C. The ability to share risk communication messages and strategies during a serious public health event among partner organisations
D. The ability to effectively access emergency risk communication capacity among public health emergency partners
E. Engagement of community networks to access/ engage district language and cultural groups
F. Others

B) The establishment of a communication coordination structure (e.g. Committee) and ***C) The ability to share risk communications messages and strategies during a serious public health event among partner organisations and institutions*** were top choices.

Those who answered "Others" mentioned the need for a "space for dialogue" and flexibility in the area of communications coordination due to the rapidly evolving nature of emergencies. Comment on the desire to have sociologists of disasters in meetings and the comparison between an authoritarian regime where people listen and things are "just done" as opposed to the more democratic way of communicating (i.e. coordination being a democracy of sorts) was also raised as an important consideration.

SESSION 3:
Dialogue with Those Affected and Involved on the Front Lines

Key Listening/Dialogue Barriers:
1. Weak levels of leadership engagement and endorsement
2. Lack of guidelines and formal listening procedures

Key Listening/Dialogue Abilities:
1. Gathering/processing the views and perceptions of individuals, partners and communities affected
2. Adapting communication strategies based on findings
3. Reflecting community perspectives back into emergency management decision making

Scenario

In the third session of the workshop, the core component of listening and dialogue with those affected was addressed. Listening to those affected and involved is a crucial capacity to ensuring communication efforts are effective and support sound emergency management decision-making. Understanding community perceptions of risk and acting on that understanding by adapting communication messages, materials and strategies require meaningful engagement with those affected and involved.

For the next exercise of the scenario, there were an increased number of cases and deaths as the disease is a relatively new virus that is not responsive to anti-biotics. This creates increased attention in the media and outside the immediate community and country. All that participants know is that the mode of transmission is food, however some evidence indicates that close contact with affected individuals can also promote disease transmission. The national authorities' recommended strategy is a self-quarantine of a large number of potentially infected people. It is also revealed that there is a high concentration of new cases in the area of Downville. It seems that the population is not complying with the self-quarantine, the question is "why?". After the scenario, participants were apprised of the following facts:

- There are 1,000 cases and 100 deaths – potentially putting the case fatality rate at 10%
- EATEX-D is a new illness, and does not respond to anti-biotics
- Threat is worldwide news, creating worldwide concern
- Likely mode of transmission is food, but also close contact with an infected person
- **Control Strategy: self-quarantine of 10,000 potentially infected citizens**
- Concentration of new cases in specific neighbourhood: **Downville**
- No difference in risk management/ risk communications strategies across the city
- No obvious reason why behaviour change strategy not working in this area
- **Question: why wasn't the recommended control strategy working?**

Sample social media posts related to the scenario were presented to participants, indicating low public risk perception. This was potentially the reason why there was low compliance to the recommended control strategy.

Sample Twitter feed out of Downville
AlexaT So tired of covering for coworkers with suspected #EATEX-D. Seriously? Take some medicine and get back to the office already!
MikeyB0Y EATEX-D quarantine? I'm a vegetarian!! #quarantine
Nadia28 Downvile self-quarantine not so bad. Back home the government would just shoot everyone -- 100% compliance! #quarantine

Web Analytics – Downville		
	Week 1	Week 2
Searches EATEX-D	150,000	30,000
Official website visits	10,000	500
Related social media activity	high	low

Theory

This section focused on the importance of public risk perception and how it is seen as one of the best indicators of individual behaviour. Also discussed were various factors that influence individual behaviour in emergencies such as:

- Perceived Risk
- Confidence in suggested measures
- Confidence in ability to complete measures
- Risk information source and credibility
- Social norms and pressures -- cost of behaviour change

The facilitator talked about a situation post 9/ 11, wherein the United States' Department of Homeland Security established a terrorist warning system. The system's effectiveness faded over time as people adjusted to the constant warning of risk.

Oftentimes, sustained alerts and warnings of potential problems can desensitise people to a specific threat. From a messaging standpoint, communication experts should be sensitive to the warning context of every risk communications strategy to avoid being accused of "crying wolf".

The facilitator reminded participants that when developing messages, communication experts also need to understand the comprehension and literacy level of their audience. For example, when developing messages, communicators must consider that some of the population may be illiterate or lack developed literacy skills, therefore messages developed in a complicated manner using complex text will not be well understood by significant target groups, including many of those at risk of a given problem. However, research into health communication materials demonstrates that risk related information is often complex in text and format, making it inaccessible for those with the greatest information need.

The facilitator then spoke about the "common knowledge effect", when people tend to exaggerate how much of their knowledge is shared by others. We know further that behaviours during serious events reinforce behavioural norms predicting that this tendency would be clear. This has implications for messaging, especially under the pressure of an acute situation. Here, communicators tend to develop messages that assume greater public understanding than what actually exists.

During the theory presentation, the facilitator talked about the outbreak of Marburg haemorrhagic fever in Angola 2005 as an example of "listening in action". In this case study, the facilitator was able to demonstrate to the audience how public risk perception was not carefully considered, which impeded the effective management of the emergency. He also highlighted that when the cultural traditions and beliefs of those affected were considered, the behaviour change objective was achieved.

CASE STUDY:
Ebola in West Africa

Overall Session Synopsis

The case study presentation was led by Ms Fernanda Falero from Médecins Sans Frontières (MSF) Spain, accompanied by panellist Mr Daniel Schmidt, Communications Adviser from Norwegian Institute of Public Health. Ms Falero presented the Ebola ring vaccination trial which was first introduced in Guinea. Mr Schmidt presented his experience of being deployed to Liberia through the Global Outbreak Alert and Response Network (GOARN) as part of the broader Ebola outbreak response. He screened a video of the Enviromental and Occupational Health Training conducted by Ministry of Health, Liberia, and WHO, which he was a part of.[4]
Both presenters emphasised the importance of dialogue and listening to the needs of those affected and at-risk, underscoring the importance that cultural beliefs and tradition play in the development of the risk perception of individuals and/ or their community.

Emergency communicators and responders should not "blame" the affected if infection control or rapid containment of the virus is not immediate. Instead, an in-depth understanding of their cultural traditions, attitudes and perceptions must be understood in order to formulate appropriate, life-saving messages. The knowledge gathered must feed into response operations or it becomes useless.

Background

The Ebola Virus Disease (EVD) outbreak in West Africa to date, has claimed over 11,000 lives, affecting over 28,000 people since its genesis in a remote forest in Guinea.[5] The largest EVD outbreak ever recorded, its unprecedented size and scope, ravaged three West African countries (Guinea, Liberia and Sierra Leone) long-plagued by civil unrest, economic challenges and weak health systems.

Resistance to comply with the imposed control measures was a common denominator in the societies and communities of the three countries. Nevertheless, the most reluctant was the Guinean society. In March 2015, one year after the official declaration of the epidemic in the country, new cases continued to appear despite the huge deployment of resources into the response. In Lower Guinea (Basse Guinée), EVD continued to take innocent lives, with no end in sight.

The Geneva consortium, spearheaded by WHO, was created in August 2014 as a response to this unique outbreak. This group of professionals was charged with the task of choosing a number of rapid tests, treatments and preventive vaccines for EVD to be tried in extraordinary circumstances. There was an agreement between the consortium and the Guinean government to deploy the clinical trial of the Vesicular Stomatitis Virus-Ebola Virus Vaccine, otherwise known as the r-VsV-EBOVD vaccine in Conakry. The trial consisted of two protocols: one on Phase IIb (this trial was to test preliminary efficacy, whereas Phase II tests for large scale safety, therefore Phase IIb follows Phase II) for frontline workers and another one on Phase III designed for "ring vaccination" of contacts of a confirmed EVD case. The trial aimed at verifying the safety and efficacy of the vaccine.

[4] "Training of Environmental Health Technicians (EHTs) in Liberia", https://www.youtube.com/watch?v=QYMXBAyFtd8
[5] "2014 Ebola in West Africa—Case Counts", US Centers for Disease Control and Prevention, http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/case-counts.html, (September 15, 2015, updated).

Listening/ Dialogue Dilemma

The healthcare workers (HCWs) faced two big challenges:

- HCWs needed to develop an effective communication campaign that involved dialogue with those affected, including frontline HCWs to understand their perception about the trial. In case of a positive perception of the vaccine trial, this may as well mean that everyone would want to be vaccinated. This led to the second challenge.
- Effectively communicating a trial v.s. a mass vaccination campaign posed a real challenge as to how to make the public understand that only members of the community who fit the trial criteria would be vaccinated.

The perceived illegitimacy and mistrust that existed towards the national leaders and spokespeople did not contribute to any fruitful dialogue. This "loss of trust" by the public was something that MSF had to overcome. Information was one-way, going from the emergency responders/ outbreak managers to the public. This lack of dialogue created a vacuum, where inaccurate information was being shared and rumours were created and quickly spread.

Based on the recent findings of WHO's external review panel found on the Report of the Ebola Interim Assessment Panel (http://www.who.int/csr/resources/publications/ebola/report-by-panel.pdf), one of the major failures in the EVD outbreak has been the community engagement and awareness. There are several reasons for this, but two main points in particular stood out:

- The **approach of the response**, and
- The **communication strategies utilised** (i.e. lack of targeted messages and adapted material development, which considered the cultural attitudes, perception and traditions of the affected)

The **approach of the response**, especially during the acute phase of the outbreak mainly focused on the isolation of cases. The **communication strategies utilised** paid little to no attention to health promotion and emergency risk communications activities, such as speaking to communities in their local languages and spreading Ebola awareness messages.

In some instances, instead of being listened to, the communities affected were "blamed" for spreading the disease because of their deeply rooted ties to their culture, behaviours and tradition. There was no incorporation of community initiatives into the response.

Solution Taken

To overcome these significant challenges, it was essential to understand dynamics of the situation in order to properly plan the communication strategy for the r-VsV-EBOVD vaccine trial. Using a three-pronged structure, MSF focused on:

- The **epidemiological evolution** of the disease
- The **response** itself (i.e. who is doing what and where, and how are they doing it?)
- The **reaction of the public/ those affected** to the two previous points, taking into consideration current rumours circulating, their knowledge, their attitudes and their perceptions

The primary goal was to conduct an investigation using the above-mentioned structure, ensuring an inclusion of the public's perception in relation to a possible vaccine for EVD. The results of the findings were positive. People were tired of the disease and desperate for a solution they would later call "l'air d'espoir" (the spirit of hope).

The r-VsV-EBOVD vaccine trial started in March 2015, exactly one year after the declaration of the outbreak in Guinea. The main objective was to ensure that the public understood that this was a trial and not a mass vaccination, and what this meant in terms of criteria for participation (i.e. who would be prioritised and receive the vaccine). With all the data gathered using the three-pronged structure, the team developed a risk communications strategy for **3 audiences**:

Since the trial had two protocols; 1) for frontline HCWs and 2) for "ring" vaccination of contacts of confirmed EVD cases. The communication activities decided on were to:

- Engage in a **targeted information and mobilisation** campaign
- Ensure key **spokespersons and other key players had essential information or "talking points"** to ensure that messaging was consistent and accurate
- Engage the press and main bloggers from the beginning and create a dialogue space with them in order to have certain control over the messages spread

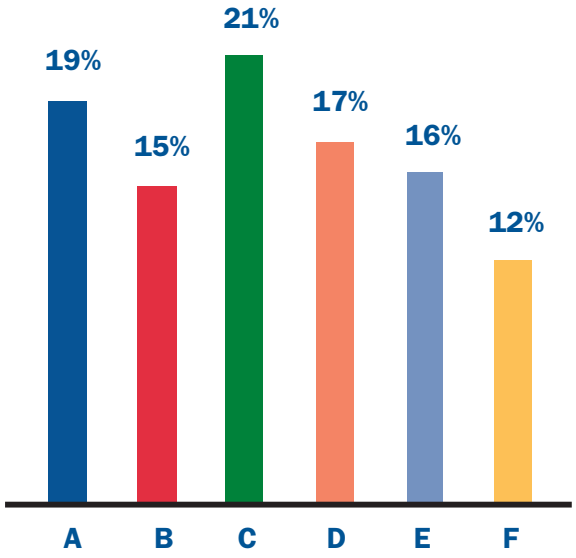
The kick-off the campaign was comprised of the following action items:

- **Effort to rebuild trust with the media and the public:** authorities from the Ministry of Health and WHO were vaccinated in a press conference to demonstrate vaccine safety.
- **Ensuring control of the main messages:** a brief note and a dossier were prepared and distributed to all representatives present in the event.
- **Ensuring leaders and influencers played a key role:** at the same time, the plan previewed the mobilisation of these key actors where the epidemiological data would take us following the contacts.
- **Ensuring consistent messaging:** finally, all actors working on the social mobilisation sector were to be given the key messages so their people on the ground could react to questions, this was done to make sure that messages were "on point" and harmonised across the board.

The strategy aimed at "bombarding" the general public with a harmonised message and to engage those directly implicated with a targeted, more personalised campaign.

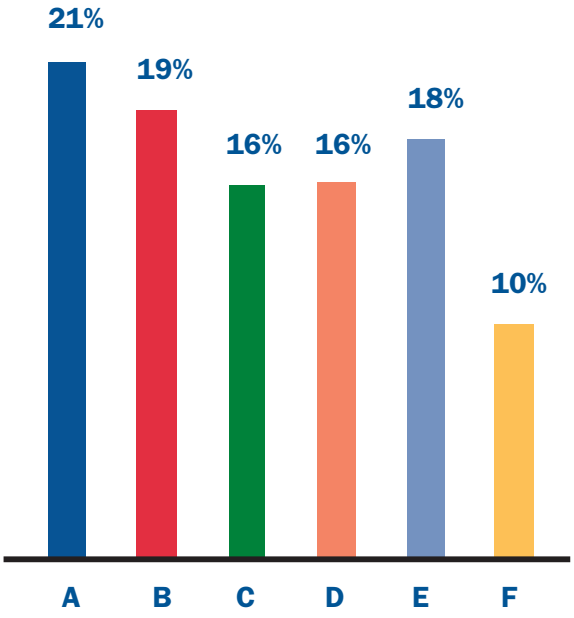
Group Responses

In terms of dialogue with those affected and involved, groups were asked to rank the most significant barriers to success. ***C) Weak levels of leadership engagement and endorsement*** and ***A) Lack of guidelines and formal*** **listening procedures** were top choices. As for dialogue with those affected and involved, groups were asked to rank these abilities in terms of international best practice, ***A) Gathering and processing the views and perceptions of individuals, partners and communities affected*** and ***B) Adapting communication strategies based on dialogue findings*** were top choices.



In terms of dialogue with those affected and involved, rank the most significant barriers to success.

A. Lack of guidelines and formal listening procedures
B. Inadequate budget and human resources support
C. Weak levels of leadership engagement and endorsement
D. Lack of emergency engagement exercises and training
E. Practical tools and templates to support dialogue
F. Others



In terms of dialogue with those affected and involved, rank these abilities in terms of international best practice.

A. Gathering and processing the views and perceptions of individuals, partners, and communities affected
B. Adapting communication strategies based on dialogue findings
C. Monitoring media and social media, tracking: questions, information needs, points of confusion, rumors
D. Effective and efficient tools and templates to support the listening process
E. Reflecting community perspectives back into emergency management decision making
F. Others

Groups that picked “Others” for both questions stressed that knowledge/ data gathered need to be operationalised or fed into the response operations mechanism or it became useless and of no consequence. At present, in recent emergencies, participants noted that there was still a stark disconnect between dialogue/ listening findings and the overall emergency response. Another key comment made was related to social media, stating that though social media commentators comprise the minority of the population because of the platform they hold, they appear to “represent” the majority. This is of note, because much of the listening function also takes place on social media.

SESSION 4:
Monitoring and Evaluation of Risk Communications Performance during Emergencies and Other High Risk Events

Emergency Risk Communications Evaluation Barriers:
1. Low levels of leadership engagement/ endorsement
2. Inadequate budget and human resources support
3. Lack of monitoring and evaluation training/ capacity

Emergency Risk Communication Evaluation Abilities:
1. Establishing clear risk communications objectives
2. Monitoring system (e.g. media/ social media)
3. Integration into preparedness strategies

Scenario

The fourth session of the workshop addressed the core component of risk communications during and post-emergency known as risk communications evaluation. As the scenario advances, it was evident that the self-quarantine initiative was generally successful and had a strong community engagement. The total number of cases was 1,500, including 150 deaths.

Even with the success of the quarantine, some of the facts at the end of the scenario revealed to participants were that post-emergency tourism decreased, while stigma of those potentially at risk and affected increased. Internal and external tension also increased along with a series of lawsuits. There was a consensus that a risk communications evaluation of the broader communication response was in order.

Theory

This critical component of risk communications closely follows the previous one -- listening/ dialogue. This is a step that is often overlooked in emergencies because it is a challenge to do in the middle of an emergency and there is not enough impetus to follow through with it post-emergency. However, in order to understand the effectiveness of the strategies implemented, one must understand what impact they have had on those affected and at-risk. When risk communications strategies are effective, they help limit disease spread, establish and/ or maintain public trust and mitigate any negative socio-economic consequences due to the emergency.

When one understands how the risk communications activities carried out influenced behaviour change, altered risk perception and minimised societal disruption (i.e. travel and trade, economy), the better success is measured.

The facilitator spoke about the two main challenges to implementing risk communications evaluation:

- In the risk communications evaluation process, what to evaluate needs to be identified. This means that an agency/ organisation must have clear risk communications objectives or key performance indicators (KPIs) that underscore what success looks like.
- In the post-event environment - after any emergency, managers, responders and field teams are exhausted. Inter-organisational tension is followed by the "blame game", with people asking "how could we have done better?" and "whose fault is it that we didn't?"

CASE STUDY: 2011 Christchurch Earthquake

Overall Session Synopsis

The speaker for this final session was Mr Andrew Holden, Editor-in-Chief from Fairfax Media, a leading Australian broadsheet headquartered in Melbourne. For this session, Mr Holden urged the audience to ponder the question "what does success look like?" in the area of risk communications in emergencies. He further encouraged participants to constantly ask the question "what are we pursuing here?" in reference to proper communication evaluation founded on public transparency with the goal of wanting to be believed and trusted by the public. He used his personal experience during the 2011 Christchurch earthquake to dovetail the evaluation component and how it would look in practice.

Background

On 22 February, a massive earthquake registering a magnitude 6.3 on the Richter scale struck Christchurch, the major city, on New Zealand's South Island. The disaster caused widespread damage, claiming 185 lives, with almost 7,000 people treated for minor injuries.

The collapse of the Canterbury Television building (CTV) killed 115 people, while another 18 persons died when the Pyne Gould Corporation (PGC) building was destroyed. 8 more persons were killed when rubble fell on a bus filled with passengers, while around Christchurch 28 more people lost their lives in the aftermath of the disaster. The earthquake would go down as the second worst natural disaster in the country's history.

The government declared a national state of emergency which was held until 30 April 2011. Prior to the 2011 disaster, Christchurch's infrastructure was already weakened by a 7.1 magnitude earthquake that occurred in September of the previous year.

The Dilemma of Monitoring and Evaluating Risk Communications Performance in Emergencies

Evaluation of communication interventions and strategies in emergencies is an essential step that typically follows the dialogue process with those affected. The "honesty" of monitoring and evaluation is key, acting as a gauge that measures the true effectiveness of any organisation's communication efforts.

If you want your communication interventions to have an impact in:

- Limiting disease spread,
- Reinforcing public trust, and
- Strengthening your organisation's relationship with its partners,

a proper evaluation will then allow you to see what changes need to be made to improve communication activities. The dilemma of risk communications monitoring and evaluation in this instance asks these important questions:

Do the current risk communications interventions have an impact *on behaviour change, risk perception or societal disruption?*

Have ***people's attitudes, opinions, response and behaviour changed*** *as a result of these interventions?*

Are those most affected and at-risk ***understanding the health messages****?*

Solution Taken

In the aftermath of the Christchurch earthquake the team at The Press did what most journalists do. They acted as a "witness" in those immediate moments post-quake and told the story "as they saw it."[6] The earthquake devastated the news office, killed a colleague in the accounts department, yet the Editor-in-Chief was still able to marshal the remaining members of his team out of the crumbling news building.

Publishing a paper after such a disaster seemed an impossible task, but the preceding September quake and thousands of aftershocks after it had forced the newsroom to relocate a number of times already, including its printing plant in the outskirts of town. This became the base after the February quake. In addition, a national IT system meant colleagues at other papers elsewhere in New Zealand were able to help build The Press. The editions themselves provided the public with basic information in a familiar and readily available form.

In this age of social media, the amount of time people have access to information has shifted from hours to "instantaneous". In the middle of an emergency, this type of narrative "real-time" chronology and evaluation can be a challenge, given the constantly evolving scenarios that characterise most crises.

[6] "Christchurch Quake—What we know", The Age World, http://www.theage.com.au/world/christchurch-quake--what-we-know-20110222-1b3cx.html, (February 22, 2011).

However, it is important to remember that "honesty in evaluation" is a critical aspect of emergency response improvement. Here are some potential questions risk communications experts can utilise to evaluate their interventions in the midst of an emergency (see below).

Sample Risk Communications Evaluation Questions during an Emergency:

- *What impact are risk communications activities and interventions having with target groups and partners?*
- *Are there changes in what people are saying and doing as a result of these efforts?*
- *Are these activities having a positive or negative impact in preventing further disease spread?*
- *Are the messages for those affected and at-risk reaching them and are they being understood?*
- *Are communication resources being used effectively?*
- *Are planned risk communications activities being carried out in a timely manner?*
- *Are all these activities within the budget allotted?*
- *Are people attending the events we are staging (i.e. organised events, information sessions, town hall meetings)?*
- *Are we adapting our interventions to ensure that they are directly responding to the needs of those affected and at-risk?*

The above questions can help keep you on track, however, this begs the question, "where do I get the answers to these questions?". Some suggested sources of information could be:

- Outbreak or healthcare staff involved in the emergency
- Representatives of target groups and partners
- Field teams who interact with local communities and groups
- Mainstream and social media
- Stakeholder discussions (i.e. focus groups, community interviews, door to door surveys)

Post-Emergency Evaluations

Risk communications evaluation post-outbreak can help an organisation identify and address areas for improvement, given that they are honest about how the work was carried out. This honesty allows risk communications teams to better prepare for future challenges.

The leadership of any organisation plays a vital role in ensuring this evaluation is done properly. A suggested avenue for this would be an audit of the risk communications strategy, carried out by an external, independent evaluator. For an organisation to maintain and protect its credibility, it is essential that the evaluation be shared publicly. Transparency ensures and maintains public trust.

The definition of successful evaluations are ones that are:

For a more grounded look at "what to ask" in a post-outbreak risk communications evaluation, some sample questions are as follows:

Sample Post-Emergency Risk Communications Evaluation Questions:

- *Did the risk communications interventions use existing systems and take advantage of the communication capacity of partner organisations?*
- *Were public communications coordinated among other partners during the emergency?*
- *Did national authorities ensure that information about the emergency was released in a timely manner? (i.e. first announcement) And were the messages that followed transparent?*
- *Did risk communications experts engage in community dialogue to understand the knowledge, attitudes and perceptions of those affected and at-risk?*
- *Were the results from the dialogue fed back into the overall emergency management system, and were health messages adapted to these findings?*
- *Did we use our emergency risk communications plan? Was it useful or not?*
- *What were the weaknesses of our interventions? What lessons have we learnt that we can apply to future emergencies?*

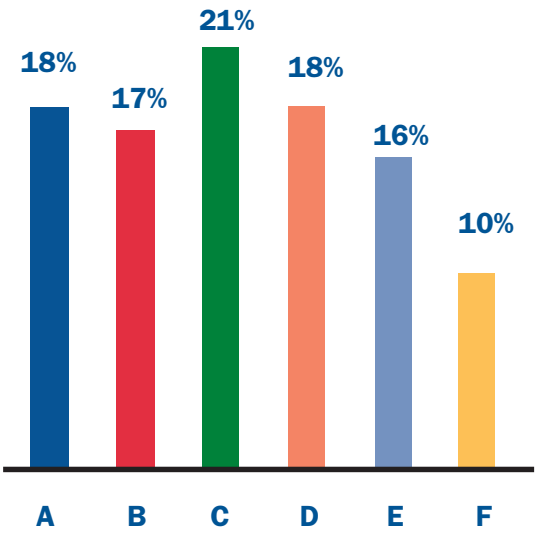
Group Responses

One of the first questions presented to the groups was, "What typically happens after a serious emergency or crisis?". Each group was asked to choose from the following responses:

A. Someone gets fired
B. New investments are made
C. New institutions are created

A majority of groups cited ***B) New investments are made***. This was supported by the plenary discussion during the case study portion facilitated by Mr Holden. Participants agreed that the process of risk communications evaluation must be established within the overall emergency planning cycle, which requires some level of investment.

The groups were then asked to rank the most significant barriers to success in this context:

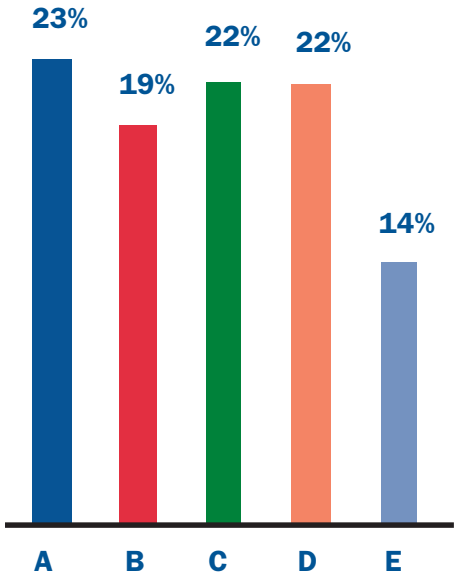


In terms of Monitoring and Evaluation, rank the most significant barriers to success.

A. Lack of guidelines and formal evaluation procedures
B. Inadequate budget and human resources support
C. Weak levels of leadership engagement and endorsement
D. Lack of monitoring and evaluation training/ capacity
E. Practical tools and templates to support monitoring and evaluation
F. Others

The majority answered ***C) Weak levels of leadership engagement and endorsement***, as the most significant barrier to success. This was closely followed by ***A) Lack of guidelines and formal evaluation procedures*** and ***D) Lack of monitoring and evaluation training/ capacity.***

These responses reiterated the comments made during the case study session, emphasising the need for leadership to be behind an initiative like this. For evaluation to be part of the planning cycle, leadership must advocate and support it.



In terms of Monitoring and Evaluation, rank these abilities in terms of international best practice.

A. Establishing clear risk communications objectives prior to and during an event
B. Documenting lessons learned and releasing them publicly
C. Real time monitoring system (e.g. tracking media and social media activity)
E. Integration of evaluation outcomes into preparedness/ planning strategies
F. Others

When asked to rank these risk communications evaluation abilities in terms of international best practice, the majority answered ***A) Establishing clear risk communications objectives prior to and during an event***. This response was also supported by the previous facilitated discussion as participants mentioned the pressure organisations had from leadership to "move on" to the next emergency or event, while the need for having clear risk communications objectives (i.e. key performance indicators) was a real priority.

The consensus was that organisations must prioritise and invest in the function of evaluation, not just to have documented lessons learnt but rather to have these lessons "operationalised" in time for the next emergency. This is not only critical to ensure better response results in future, but also serves to safeguard an organisation's credibility thereby strengthening/ maintaining public trust in their ability to manage a high-risk event.

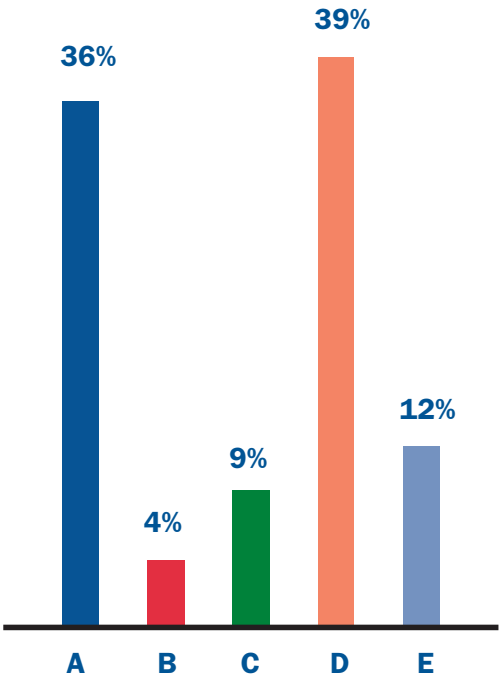
PRIORITY RECOMMENDATIONS

The final day of the workshop was centred on securing priority recommendations from each individual participant in attendance. During the previous 2 days of the workshop, all of the responses were in the context of the assigned groups (8 groups in total), wherein group members registered their votes on the voting pads (i.e. "clickers"). For this session, the facilitators distributed voting pads to each individual, requiring each person to log their vote for each question. It must be mentioned that for this session, individuals were required to each have a voting pad yet all voting pads were not working (4 total pads).

For the final session, the objectives of the half-day were to:

1. **Isolate key barriers to implementing national risk communications strategies**
2. **Develop recommendations for strengthening national risk communications strategies**

The first questions asked was "What should be the top priority activities in your current emergency risk communications strategies?" the top response was **D) Community Engagement**



What should be the top priority activities in your current emergency risk communication strategies?

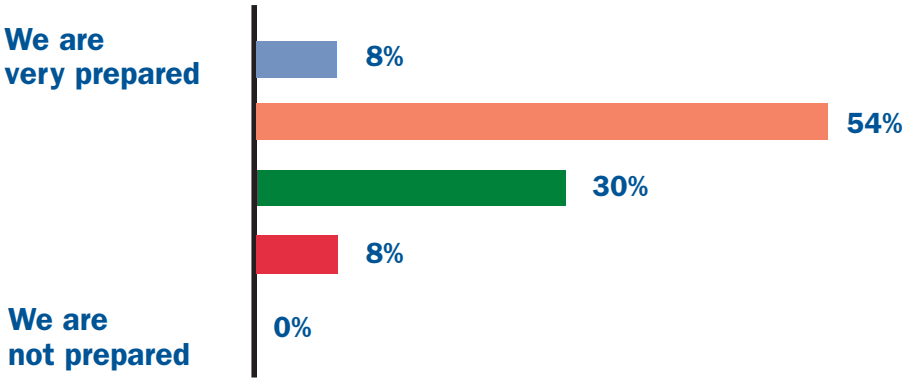
A. Media relations
B. Information, Education, and Communication materials
C. Social media
D. Community engagement
E. Social mobilisation

The facilitator then compared this to the pre-workshop survey responses wherein ***A) Media relations*** was the top priority.

Now, the same participants selected ***D) Community engagement*** as a top priority closely followed by Media relations. The shift in priorities was interestingly noted by all participants, the hope being all were illuminated from the previous sessions, which thereby influenced this slight shift in response.

When asked, "On a scale of 1-5, how would you currently classify your country or organisation's level of emergency risk communications preparedness?", the majority answered they are prepared, which was also similar to the responses garnered from the pre-workshop survey results.

On a scale of 1 to 5, how would you currently classify your country or organisation's level of emergency risk communications preparedness?



The facilitator reflected that, in previous Warning Project workshops, this percentage of "readiness" is normally not as high, therefore, it was encouraging to see that in this instance preparedness levels were increased.

PRIORITY BARRIERS AND ABILITIES/ RECOMMENDATIONS

Proposed Recommendations for Strengthening National Risk Communications Strategies

1. ***Risk Management Transparency Priorities***
   - *Rapid approval of warnings and advisories*
   - *Adherence to decision-making principles – in a regulation, policy or guideline*

2. ***Communication Coordination Priorities***
   - *Identification/ engagement of focal points*
   - *Communication coordination structure*
   - *Sharing risk communications messages and strategies during a serious public health event*

3. ***Listening and Dialogue Priorities***
   - *Gathering/ processing the views and perceptions of individuals, partners and communities affected*
   - *Adapting risk communications strategies based on findings*
   - *Reflecting community perspectives back into emergency management decision-making*

4. ***Risk Communications Evaluation Priorities***
   - *Establishing clear risk communications objectives*
   - *Monitoring system (e.g. media/ social media)*
   - *Integration into preparedness strategies*

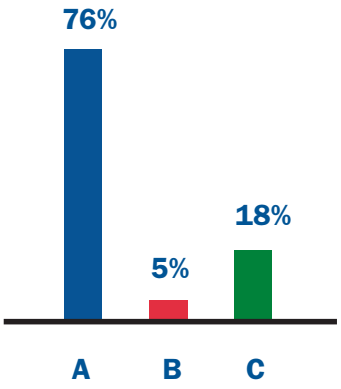
1. RISK MANAGEMENT TRANSPARENCY PRIORITIES

Key Discussion Points

In previous discussions 70% of participants agreed that they would communicate a serious, emerging risk immediately, prior to lab or other confirmation, while 57% believed that organisations resist transparency due to incomplete information. The consensus for the session was that risk management transparency is a crucial issue in supporting all emergency risk communications objectives.

Key Risk Management Transparency Barriers

The majority of 76%, agreed that ***1) Ensuring leadership engagement/ endorsement*** and ***2) Lack of guidelines and policies*** as main barriers to transparency. For those who debated this, some responses were related to "operationalising" transparency. They cited that a transparency guideline or policy was needed, but more importantly was a mechanism to ensure it was put into practice.



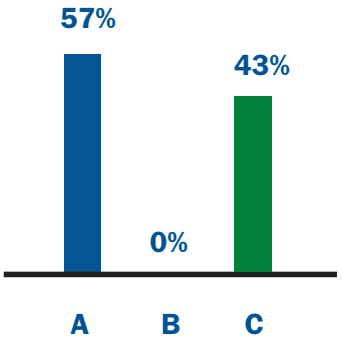
Key transparency barriers:
1) Ensuring leadership engagement/ endorsement
2) Lack of guidelines/ policies

A. Endorse
B. Reject
C. Debate

Key Risk Management Transparency Abilities

The majority of 57% endorsed ***1) Rapid approval of warnings and advisories*** and ***2) Adherence to decision making principles in a regulation, policy or guideline*** as key priorities in the context of this risk communications principle. 43% of participants who wanted to debate this selection mentioned that spokespersons are very limited in what they can and cannot say.

Also mentioned was the political reality of emergencies where a transparency policy is no longer within the control of a Ministry of Health. Transparency policies look good "on paper" but participants stated that there was still a struggle on ensuring the policy was followed.



Key transparency abilities:
1) Rapid approval of warnings and advisories
2) Adherence to decision making principles – in a regulation, policy or guideline

A. Endorse
B. Reject
C. Debate

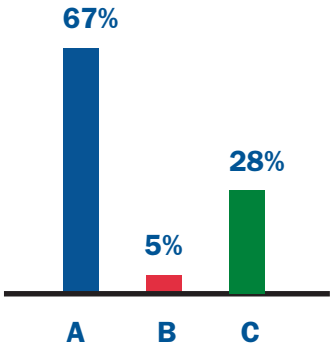
2. COMMUNICATION COORDINATION PRIORITIES

Key Discussion Points

During session 2, 71% of participants said that they would warn the public of a potential public health risk even if a compromise cannot be reached amongst other involved partners.

Key Communication Coordination Barriers

67% of participants agreed that ***1) Ensuring leadership engagement and endorsement*** and ***2) Lack of guidelines/ policies*** were main barriers to effective communication coordination. The 28% of respondents who debated this mentioned that it was up to them to engage leaders, through finding "common ground" and a common objective within the context of emergencies. Also there needs to be focus on how to address the practical realities that impede effective coordination, perhaps understanding the perspectives of the leaders would help in achieving this.



Coordination barriers:
1) Ensuring leadership engagement and endorsement
2) Lack of guidelines/ policies

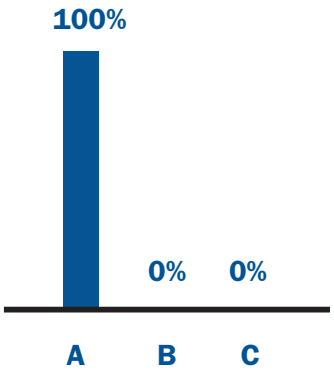
A. Endorse
B. Reject
C. Debate

Key Communication Coordination Abilities

100% of participants endorsed the key coordination abilities of:

1) Identification/ engagement of focal points
2) Communication coordination structure
3) Sharing risk communications messages and strategies during a serious public health event

They noted that these components would facilitate effective communication coordination in an emergency. It is important to note that several participants mentioned that coordination in non-emergency settings or "times of peace" was also crucial.



Coordination abilities:
1) Identification/ engagement of focal points
2) Communications coordination structure
3) Sharing risk communications messages and strategies during a serious public health event

A. Endorse
B. Reject
C. Debate

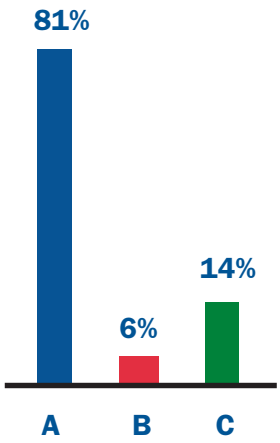
3. LISTENING/ DIALOGUE PRIORITIES

Key Discussion Points

The main message of this session was that "we should not put the blame on the affected", instead as communicators we must understand where they are coming from. If we attempt to understand the affected, then we should also do the same for the leaders. The goal is to spark behaviour change with those affected by the emergency but also with the leaders managing the emergency, as needed. An important point made on using social media to "listen" was that, more often than not, social media commentators are the richest and youngest of the public, which is not representative of "the vulnerable and affected". With that, there was consensus that every group needed to be addressed in an emergency, including dissenting voices.

Key Listening/ Dialogue Barriers

81% agreed that ***1) Weak levels of leadership engagement and endorsement*** and ***2) Lack of guidelines and formal listening procedures*** were priority barriers to effective listening/ dialogue with the affected. The 14% that debated this mentioned that the barrier was that there were not enough experts who understood how to do this, stating that guidelines are fine, but the key was in operationalising this process in an emergency.



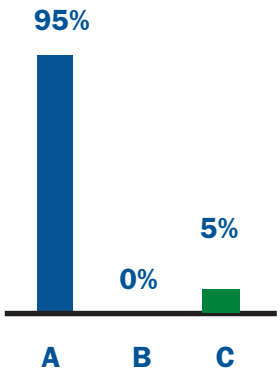
Listening/ Dialogue barriers:
1) Weak levels of leadership engagement and endorsement
2) Lack of guidelines and formal listening procedures

A. Endorse
B. Reject
C. Debate

Key Listening/ Dialogue Abilities

95% of participants endorsed these 3 key abilities as priorities under this risk communications principle:

1) Gathering/ processing the views and perception of individuals, partners and communities affected
2) Adapting risk communications strategies based on findings
3) Reflecting community perspectives back into the emergency management decision-making



Listening/ Dialogue abilities:
1) Gathering/ processing the views and perceptions of individuals, partners and communities affected
2) Adapting communication strategies based on findings
3) Reflecting community perspectives back into emergency management decision making

A. Endorse
B. Reject
C. Debate

4. RISK COMMUNICATIONS EVALUATION PRIORITIES

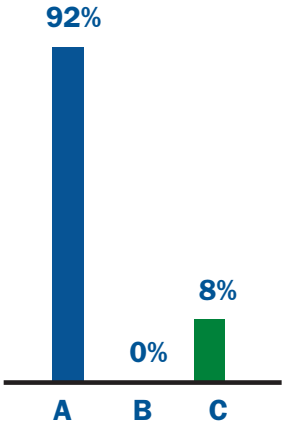
Key Discussion Points

During the final session key discussion points were centred around risk communications evaluation as part of the overall planning cycle. Participants recognised that the strong push to move on to the next emergency undermined a proper post-emergencies evaluation. The development of agreed upon key performance indicators was seen as a priority as well as investment in the function of proper and transparent communications evaluation. All agreed that the theory of evaluation was essential but its operationalisation was the real priority.

Key Risk Communications Evaluation Barriers

92% of participants agreed that the following were barriers to proper communication evaluation:
1) Low levels of leadership engagement/ endorsement
2) Inadequate budget and human resource support
3) Lack of monitoring and evaluation training/ capacity

Further stating that resources for training on how to do this should also be reflected and that leadership engagement was also crucial to seeing that this was not just on paper but also executed in practice.



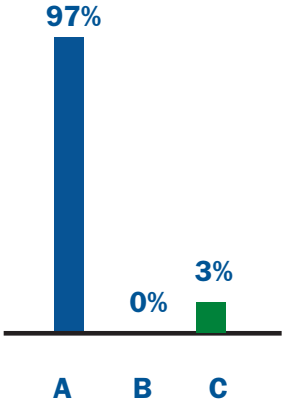
Evaluation barriers:
1) Low levels of leadership engagement/ endorsement
2) Inadequate budget and human resources support
3) Lack of monitoring and evaluation training/ capacity

A. Endorse
B. Reject
C. Debate

Key Risk Communications Evaluation Abilities

97% of participants agreed that these were key abilities under this component of risk communications:
1) Establishing clear risk communications objectives
2) Monitoring system (e.g. media/ social media)
3) Integration into preparedness strategies

Some participants mentioned that public risk perception should also be placed under this section as well, ensuring that the monitoring system is also measuring this. Equally important is being able to gauge what the public thinks of the response as well. Several participants mentioned that they want the capacity to be able to monitor this kind of feedback.



Emergency Risk Communications Evaluation abilities:
1) Establishing clear risk communications objectives
2) Monitoring system (e.g. media/ social media)
3) Integration into preparedness strategies

A. Endorse
B. Reject
C. Debate

TESTIMONIALS BY PARTICIPANTS

"This was a fascinating workshop, an all-too-rare opportunity for frontline journalists to sit in a room with those on the 'other side' of crisis communications and hear of their challenges and perspectives. It left me with a heightened appreciation of what they do, and how mainstream media need to understand its role in helping its community in such circumstances."

Mr Andrew HOLDEN, Australia

"The workshop highlighted a significant need to improve the capacity of agencies and emergency health professionals to communicate effectively with communities. While there is strong understanding of the need to maintain accurate information to communities and maintain integrity, there is a lack of understanding of the need for rapid and timely information where the 'whole picture' is not fully known. The whole sector has a need to lift its capacity to communicate vital information to the community in a timely and accurate manner."

Mr Michael MCCLUSKEY, Australia

"The risk communication workshop organised by ASEF is significant to bringing together practitioners from a range of expertise and from countries in the region to form a network for effective communication for public health emergencies.''

Ms Aphaluck BHATIASEVI, Thailand

"The workshop was very useful to share and learn experiences. I think that I have learnt deeper than I had ever done through this workshop's modules. I will apply this module into the Lao context and am ready to conduct trainings for rapid response team at the provincial level in my country."

Dr Khamphithoun SOMSAMOUTH, Lao PDR

"This is a great initiative! Pulling all these actors from different sectors and giving them a prime opportunity to sit together and discuss risk communication can only lead to a more efficient emergency response in the future."

Dr Natasha Theresa REYES, Philippines

ANNEXES:
Annex 1: List of Participants

Name	Designation	Organisation
Dr Ahamad JUSOH	Head of Outbreak and Disaster Sector, Disease Control Division	Ministry of Health, Malaysia
Mr András TENGELITS	Head of Communication	National Public Health and Medical Officer Service, Hungary
Dr André PERALTA-SANTOS	Medical Doctor – Public Health Specialist	Lisbon Regional Health Administration – Public Health Unit, Portugal
Mr Andrew HOLDEN	Editor in Chief	Fairfax Media, Australia
Ms Anete JANSONE	Public Relations Specialist	Centre for Disease Prevention and Control, Latvia
Ms Anindhitya ANINDHITYA	Technical Officer for Media	ASEAN Secretariat
Ms Aphaluck BHATIASEVI	Technical Officer (Risk communications)	World Health Organization
Ms Barbara Maria BÜRKEN	Training Expert	Robert Koch Institute, Germany
Mr Daniel SCHMIDT	Advisor	Norwegian Institute of Public Health
Ms Denisa Georgiana JANTA	Epidemiologist	National Centre of Communicable Diseases Surveillance and Control-National Institute of Public Health, Romania
Dr Don Eliseo III LUCERO-PRISNO	Associate Professor	Xi'an Jiaotong-Liverpool University, China
Ms Fernanda FALERO	Health Promotion and Anthropology Advisor	Médecins Sans Frontières Spain
Prof Girts BRIGIS	Professor, Department of Public Health and Epidemiology	Riga Stradins University, Latvia
Dr Hiroshi MIZUSHIMA	Chief Senior Researcher	National Institute of Public Health, Japan

Name	Designation	Organisation
Dr Khamphithoun SOMSAMOUTH	Deputy Director	Ministry of Health, Lao PDR
Ms Kristin SKODJE	Senior Communication Adviser	Norwegian Institute of Public Health
Dr Lavinia Cipriana ZOTA	MD, Senior epidemiologist	National Centre for Surveillance and Control of Communicable Diseases – National Institute of Public Health, Romania
Ms Margit GOVERS	Senior Communications Officer	Dutch National Institute for Public Health and the Environment (RIVM)
Dr Massimo CIOTTI	Deputy Head of Unit Public Health Capacity and Communication/ Head of Section Country Preparedness Support	European Centre for Disease Prevention and Control
Ms Mei Ji CHIU	Senior Manager/ Corporate Communications	Ministry of Health, Singapore
Mr Michael MCCLUSKEY	International Media and Broadcast Consultant	Michael McCluskey Media / Sole Operator, Australia
Mr Michael GLEN	Technical Officer	ASEAN Secretariat
Dr Minh Chau LUU	Vice Head of Division of Health Education and Communication, Division of Health Education and Communication, General Department of Preventive Medicine	Ministry of Health, Viet Nam
Mr Mitja VRDELJA	Head of Communication Unit	National Institute of Public Health of Slovenia
Dr Mohd Hisham AHMAD KUSAIN	Medical Officer	Langkawi District Health Office, Malaysia
Mr Muhamad Alif IBRAHIM	Executive, Department of Clinical Epidemiology	Tan Tock Seng Hospital, Singapore
Dr Natasha Theresa REYES	Manager, Emergency Response Support Unit	Médecins Sans Frontières Hong Kong
Dr Nick PHIN	Professor	Public Health England
Dr Nuska CAKS JAGER	Head, Planning and Preparedness Group	National Institute of Public Health of Slovenia

Name	Designation	Organisation
Dr Pahurat Kongmuang TAISUWAN	Head of Network and Image Development, Bureau of Risk Communications and Health Behavioural Development, Department of Disease Control	Ministry of Public Health, Thailand
Mr Pervez Majeed	Correspondent/ Presenter	Freelancer/ Radio Kashmir (All India Radio)
Dr Pornsak KHORTWONG	Regional Health Officer	International Federation of Red Cross and Red Crescent Societies, South-East Asia Regional Delegation
Ms Raina NIKIFOROVA	Epidemiologist	Centre for Disease Prevention and Control of Latvia
Dr Ralf REINTJES	Professor, Epidemiology and Surveillance/ Adjunct Professor, Infectious Disease Epidemiology	Hamburg University of Applies Sciences, Germany/ University of Tampere, Finland
Dr Ramon Lorenzo Luis GUINTO	Campaigner, Healthy Energy Initiative	Health Care without Harm-Asia, Philippines
Mr Sasitheran KRISHNAN KUTTY NAIR	Health Education Officer, Health Education Division	Ministry of Health, Malaysia
Ms Srisaran DHIRADHAMRONG	Deputy Director	National Security Development Centre for the Developing Countries in Asia Pacific
Dr Sulaiman CHE ROS	Consultant Epidemiologist	Ministry of Health, Malaysia
Ms Tatjana FRELIH	Head of Communication Unit	National Institute of Public Health of Slovenia
Dr Teng SREY	Deputy Director, Department of Communicable Disease Control Department of Communicable Disease Control	Ministry of Health, Cambodia
Ms Theresia PUSPITAWATI	Lecturer, Researcher, Writer	Respati University Yogyakarta, Indonesia
Mr Trob LORN	Officer of Preparedness and Training department	National Committee for Disaster Management, Cambodia
Dr Win MAR KYAW	Senior Epidemiologist, Department of Clinical Epidemiology	Tan Tock Seng Hospital, Singapore

Name	Designation	Organisation
Dr XIE Rui Qian	Director, Division of Information Management/ Division of News Communication	Chinese Center for Health Education
Dr Xuan Thuy LE	Senior Officer, Division of Health Education and Communication, General Department of Preventive Medicine	Ministry of Health, Viet Nam
Ms Yasmine AL KOURDI AL ALLAF	Health Promotion & Socio-Anthropology Advisor	Médecins Sans Frontières - Operational Section Belgium
Dr Yasuhiro ISHIMINE	Chief Senior Researcher	National Institute of Public Health, Japan
Dr Zawaha IDRIS	Senior Principal Assistant Director	Ministry of Health, Malaysia

Annex 2: Delegation Welcome Speeches

WELCOME REMARKS

by Dato' Dr Norhizan Ismail, representing YBhg. Datuk Dr Lokman Hakim Sulaiman, Deputy Director General of Health (Public Health), Malaysia

First and foremost I sincerely thank the Asia-Europe Foundation (ASEF) for inviting me to this workshop on "Risk communications for Public Health Emergencies: Bridging the National Mechanism with Healthcare Workers". Ministry of Health, Malaysia is delighted that ASEF has chosen Malaysia and specifically the island of Langkawi to hold this very important workshop. I, the Kedah State Health Director, wish to welcome all of you especially our foreign guests and delegates to our beloved country Malaysia Truly Asia and Langkawi island.

We do concur with ASEF that risk communications is indeed an important aspect of the management of public health emergencies. We believe no country is immune to public health emergencies. We only differ in terms of its frequencies and more importantly its scale, magnitude, seriousness and impact.

Throughout the world, waves of natural disaster events caused deaths and affected several million people. A strong tremor had shook Iran in December 2003 claiming 26,000 lives and caused massive destruction. The South Asian Tsunami with a magnitude of 9.3 in December 2004 took 230,000 souls across 14 countries in Asia including Malaysia. This was followed by tremors in China and Haiti in 2008 and 2010. Pakistan was flooded in July 2010, which affected over 20 million people, and losses amounted to 43 billion dollars across the country. The Japanese tsunami in 2011 resulted from an earthquake of magnitude 9, with the nuclear aftermath still affecting the country till now with more than 8,000 people still missing. This year, we witnessed several devastating earthquakes around the world, most significantly the Nepal Earthquake and closer to home in Sabah, Malaysia.

Internationally Reported Losses in 1990 to 2014 show 1.2 million people were killed due to disasters, with several billion others also affected due to being displaced and losing homes. The damages and destruction cross many countries and communities, with some of them in remote area and difficult to reach areas.

Malaysia has its fair share of disasters. Over the years, a few important major disaster events have marked our nation which claimed many lives and caused considerable damages to the community; such as the ferry terminal collapse in Penang in 1988, fireworks factory explosion in Sungai Buloh in 1991 and Highland Tower collapse in 1993. We were also affected by the Genting landslides in 1995, followed by Post Dipang mudslides in 1996. On Christmas night of 1996, Greg tropical storm battered Borneo's west coast, bringing the death toll to 230. The storm destroyed more than 4,000 houses, and left some 3,000 people homeless.

Biological disaster events have also affected the country. The Penang cholera outbreak in 1996 recorded 1,182 cases, enterovirus encephalitis outbreak in 1997 caused 31 deaths and the Nipah virus in Negeri Sembilan and Perak in 1999 recorded 265 cases. While in 2009, 17,253 cases were reported throughout Malaysia during the H1N1 pandemic.

The year of 2013 recorded a few more disaster events that shook our country. The 2013 Lahad Datu standoff was a military conflict that started on 11 February 2013 and ended on 24 March 2013. This was followed by the Southeast Asian haze crisis from June to July 2013 that affected several countries in the Southeast Asian region, including Malaysia. On 23 June, the Air Pollution Index (API) in Muar, Johor spiked to 746 which was almost 2.5 times above the hazardous level. It resulted in an emergency declared in Muar and Ledang, leaving the towns in virtual shutdown. While the Genting Highlands bus crash on 21 August 2013 was the deadliest road accident to occur in Malaysia with 37 passengers killed.

In 2014, we suffered multiple tragedies as a nation. How can we forget MH370 and MH17, with so many lives lost and many questions still remain unanswered. As many of you know, Malaysia has had to respond to one of the worst floods disaster in recent history that devastated East Coast of Malaysia Peninsular, Sabah and Sarawak in December 2014.

Even though we do have the usual annual floods, but this time around everyone was caught by the element of surprise, the hallmark of an emergency. No one expects the flood to rise so very rapidly, in such a short time and resulting so devastatingly! The initial frozen reaction from shock was quickly followed by an overwhelming national response on aids. Unfortunately, the failure to obtain critical information on flooded locations' accessibility and safety as well as lack of information on the available resources led to an un-coordinated efforts and delays or failures of some aid to reach their intended destinations beside the unfortunate death of a relief worker. It represented an important moment in Malaysian history and the health management's capability to respond.

We do realise that risk information itself is a significant element in managing any emergency. Therefore, we also recently held a similar national scientific meeting with the theme "Major Incident & Disaster Management: Bridging The Gap" which brought together all those involved in various public health emergencies and disasters, to share our local experiences, our remedial efforts and to address our shortfalls. As such I believe the outcome of this workshop will further complement our efforts in perfecting our response to future public health emergencies.

We are glad that ASEF through its Public Health Network has conducted several workshops to address various aspects of risk communications. Malaysia is proud to be designated as the proponent country on risk communications for ASEAN countries and the ASEAN Risk Communications Resource Centre (RCRC) was set up and sited in Malaysia. We had developed a generic training module on risk communications for ASEAN countries and consistently conducted training on an annual basis since 2009. However, this year we plan to review the training module to ensure its comprehensiveness and relevance. In addition, subject to the availability of funds, we also plan to hold in 2016 the first regional conference on risk communications to enable the sharing of experiences and research on risk communications for ASEAN countries and other global players.

Therefore, we are delighted to formally receive the invitation by ASEF to assist in holding this workshop. I am glad our officers have been of assistance to the organiser to ensure this organisation of this workshop is a success. In addition, we are glad to jointly meet part of the expenses incurred. We embrace this co-operation as an initial step towards further collaborations between ASEAN and ASEF on risk communications. Thus we welcome ASEF to participate in both the workshop to review the training module and the upcoming ASEAN Regional Risk Communications Conference in 2016. The co-operation can be on technical matters, logistics and finance. We believe the pooling resources and sharing of experiences and efforts will lead to optimisation of resources in ensuring better outcomes.

We are delighted that good progress is continually being made in establishing the appropriate risk communications mechanisms in managing public health emergencies. I am told this workshop will expose you to various scenarios during public health emergencies and you will be guided by the workshop consultants in appropriately dealing with each scenario. Beside the lessons learnt from this workshop, I would call on all participants and consultants to further enhance their networking and to share their experiences on risk communications for any public health emergency they had. Last but not least, I would like again to thank ASEF, the ASEAN Secretariat and the health staff of the Ministry and state of Kedah for their tireless efforts and dedication in planning and making this workshop possible.

Finally I sincerely wish to all participants success in their deliberations in the workshops and would like to invite all our foreign guests to extend their stay and discover the delights of the legendary Langkawi Island which has so much to see.

WELCOME REMARKS

by Mr Yoshinobu NOZAKA, First Secretary, Health, Labor and Welfare Attaché, Embassy of Japan in Malaysia

Many of you may know well about the 'ASEM Initiative for the Rapid Containment of Pandemic Influenza', which the Government of Japan has supported. But please allow me to briefly explain our Government's intention and overview the initiative.

Controlling public health issues is a basis for social and economic development. In today's globalised and interdependent world, no country can achieve its goals on national public health issues by itself alone. Public health not only directly affects the lives of individuals of a nation but also has impacts beyond borders. The visible example is a challenge of infectious diseases. In recent years, we have experienced the outbreak of pandemic Influenza (A/ H1N1), the serious Ebola outbreak and the outbreak of the Middle East respiratory syndrome coronavirus, or, MERS.

At the 7th ASEM Summit in 2008, there was an urgent need to address the challenges of combating avian influenza and a possible human influenza pandemic outbreak. In order to tackle this common challenge, ASEM leaders pronounced their strong determination, which led to the launch of this initiative in 2009.

The initiative consists of two components, namely, the Stockpile Project of anti-viral drugs and equipment which are to be delivered in an emergency operation upon the occurrence of pandemic influenza, and the ASEF Network for Public Health. The ASEF Network for Public Health is expected to complement the stockpile component by enhancing preparedness and response through workshops and training and strengthening a network in the field of health and infectious diseases, which can contribute to make the emergency operation smooth and successful.

The ASEF Public Health Network seeks to become a unique participatory platform that encourages public health dialogue and cooperation in Asia and Europe. The Network facilitates multi-stakeholder partnerships between representatives from governments, international organisations, business corporations and non-profit organisations, and also exchanges of knowledge and experience between health and non-health sector actors.

This workshop's topic "Risk communications for Public Health Emergencies: Bridging the National Mechanism with Healthcare Workers" is another example of collaboration among multi-stakeholders. The workshop pays attention especially to the relations between national authorities and health workers. It is absolutely necessary that all players working in the field of medical care, especially healthcare workers, who are next to patients suffering from infectious diseases and have a risk of secondary infection, receive adequate information and proper guidance from national authorities. This workshop will highlight the importance of communications among them.

Since 2013, with the aim of addressing this risk communications issues, collaboration between Asia and Europe has been promoted, in terms of capacity building that enhances the pandemic preparedness and response, through a series of workshops having already been held twice so far. From this morning, you must have been well informed through lectures from and discussions with experts and specialists working in the front line of healthcare. I very much hope that this 3 day workshop will be a great opportunity for all of you to learn on risk communications and bring back the outcomes to your countries.

Finally, I wish to end my remarks by expressing my sincere hope together with that of my government to see further advancements through this event in establishing a platform for enhanced collaboration on risk communications and other health issues between Asia and Europe.

POST-WORKSHOP SURVEY RESULTS

Participants were asked to fill in a survey after the workshop for evaluation. 45 surveys were collected out of 48 participants. The feedback indicated overwhelmingly positive responses from the participants, where 94% of the respondents stated that the objective of having a lively discussion to share experiences and different perspectives was achieved at the workshop, with 47% answering "fully achieved". 89% of them said their expectations were met, with 25% of them "fully met".

Participants' responses included:

- "Excellent combination of short lecture, sharing of real-life experiences, discussion and opportunities to share individual and group opinions";
- "The theory/ research/ case study/ survey and experience were used wonderfully";
- "I have learned many things from the examples presented. They will be useful to improve our country";
- "This is a well-structured dialogue using valid pre-prepared issues and solutions that can be discussed and prioritised, designed to deliver outcomes";
- "The way the project is organised made the participants discuss and share their experiences and ideas. We have received the basis of the risk communications and understand more than before we came here. Very comprehensive".

One notable recommendation from the participants was to "open a space for the participants to give their own recommendations", expressed in: "It is a good idea to accompany the debates with pre-conceived answers but at the same time it is reductive and does not allow a lot of discussion on new ideas and recommendations to emerge"; "I think the method is very effective in reaching consensus, but it limited the discussion and creativity"; and "Let workshop participants come up with their own solutions and recommendations".

While the participants appreciated the scenario-approach as a useful introduction to each session, the plot was seen "too Western", "limited and simplistic", thus it "should be more identifiable" and "evidence-based". It was suggested to make the connection between the scenario and case studies clearer.

In terms of structure of the workshop, 36% of the respondents wished more time to be allocated to presentation of theory, research and case study. 16% chose decision-making tasks for less time allocation. As much as 53% of the respondents answered that the balance was right with comments such as "The module enabled knowledge and experiences shared and gained as fast as possible." Several participants requested more "public health/ statistic knowledge", "research and evidence" and "evidence-based experiences" for theory section.

88% of the respondents stated the workshop was "robust (53%)/ extremely robust (35%)" in comparison with other related workshops they have attended. 71% of the respondents thought the usage of interactive response technology (i.e. clickers for voting) was useful as expressed in: "the dynamic voting was extremely useful and something I will consider using in my own work".

Both facilitation and logistical arrangements received positive feedbacks as: "One of the best facilitation team I have ever met!" and "Perfect support and organisation and before and during the workshop". Some respondents suggested shuffling the seating arrangement on the Day 2 to change the group dynamism so that they can have "more different views and discussions, more opportunities to hear about other countries and cultures, more different people to come forward and speak as well". A couple of respondents noted the different knowledge level on risk communications, and one suggested circulation of background reading materials prior to the workshop.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