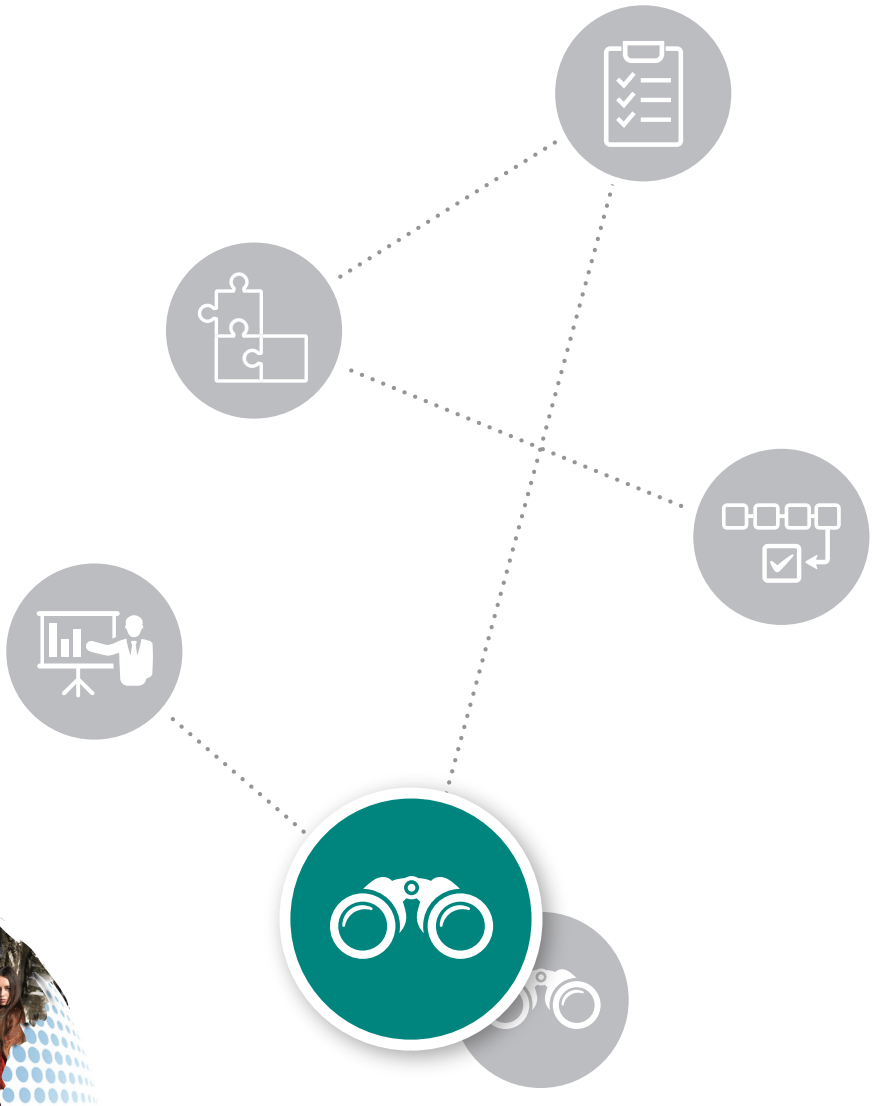
World Health Organization
REGIONAL OFFICE FOR Europe

National health emergency risk communication

Capacity-mapping package
Four-core capacity method



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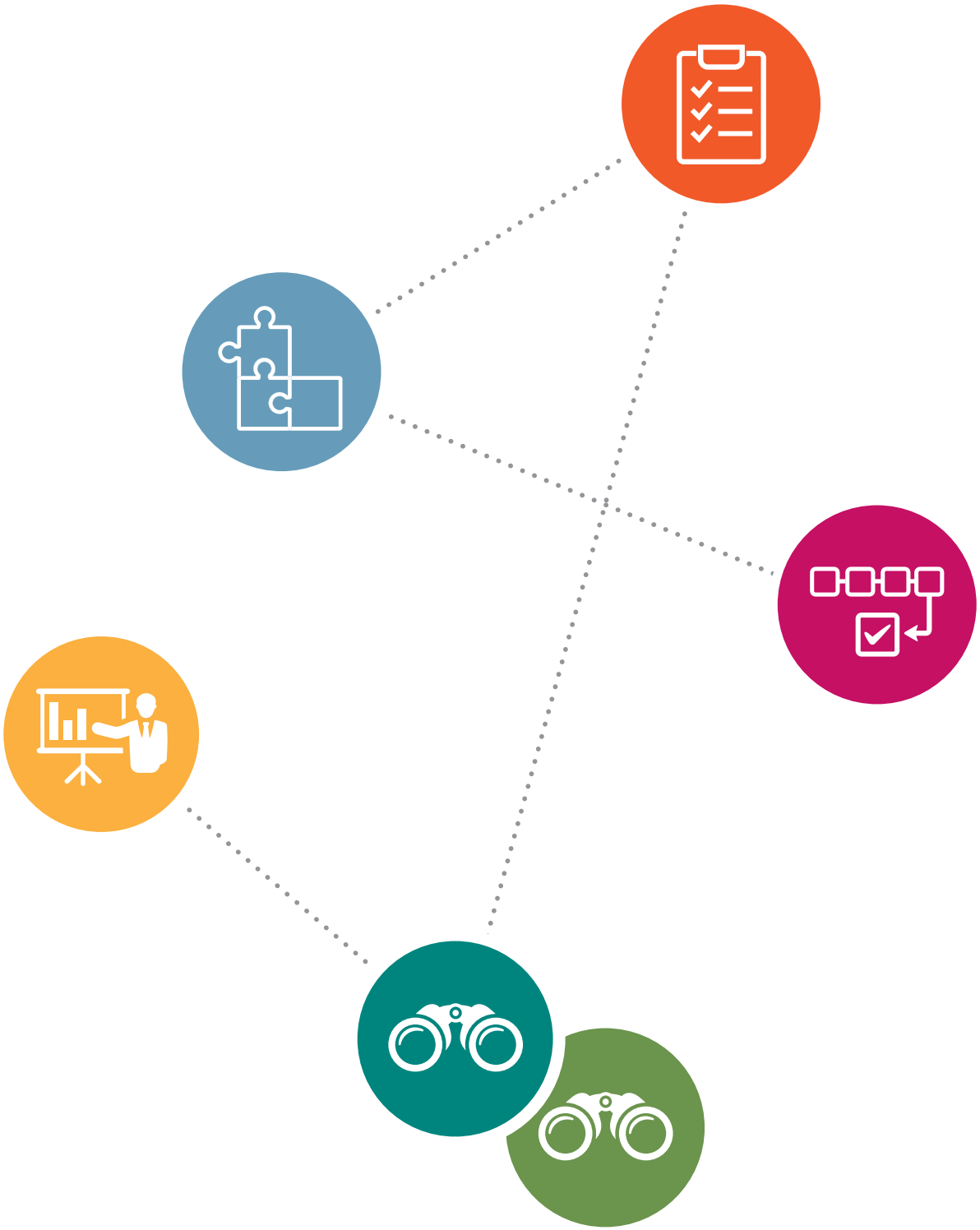
Keywords

EMERGENCIES
RISK
COMMUNICATION
DISASTER PLANNING
DISEASE OUTBREAKS
CAPACITY BUILDING
EUROPE

Layout: 4PLUS4.dk

Contents



Emergency risk communication and the five-step capacity-building package

Background

Despite progress in recent years, several core capacities for the International Health Regulations (2005) (IHR) still require improvement. The capacities are those for detecting, assessing, notifying and reporting events, and responding to public health risks and emergencies of national and international concern, as stipulated in articles 5 and 13 and Annex 1 of the IHR.[1]

Emergency risk communication (ERC) is one of the eight core functions that WHO Member States must fulfil as signatories to the IHR. ERC helps to minimize deaths, disease and disability by engaging various stakeholders, including the public, by rapid, transparent information exchange, taking into account their social, religious, cultural, linguistic, political and economic contexts. ERC is also a component of global and country preparedness for an influenza pandemic within the pandemic influenza preparedness framework.[2]

Ministries of health increasingly recognize that ERC is an essential component of emergency response and is critical for managing risks. Member States have thus called on the WHO Regional Office for Europe to develop innovative tools and approaches to improve the way in which they communicate during emergencies.

1 The International Health Regulations (2005) can be found at: http://www.who.int/ihr/en/.

2 The pandemic influenza preparedness framework can be found at: http://www.who.int/influenza/pip/en/.

ERC capacity-mapping within the five-step capacity-building package

In February 2017, the WHO Regional Office for Europe launched a capacity-building package on ERC in five steps to support country development or strengthening of ERC under IHR (Fig. 1). The five-step package is a unique, sustained, country-tailored capacity-building project in ERC. It comprises:

1. Training
2. Capacity-mapping
3. Plan writing
4. Plan testing
5. Plan adoption

The aim of ERC capacity-mapping – step two of the ERC five-step package – is to support countries in identifying their ERC strengths and weaknesses before WHO collaborative capacity-building. This activity is often conducted in conjunction with training and/or writing an ERC plan.

Fig. 1. ERC five-step capacity-building package

Step 1. Training

ERC training sessions are tailored to meet needs and gaps identified in national ERC plans and documents. Through a mix of lectures, skill drills and media tips, participants learn and practice effective communication in public health emergencies. The training is designed for epidemiologists, experts in pandemic preparedness and vaccination and emergency response and communications specialists.

Step 2. Capacity mapping

The ERC capacity-mapping tool is used to identify needs and gaps in order to strengthen national ERC. The aim is to review priorities for intervention to be included in the ERC plan and in a national ERC capacity-building roadmap.

Step 3. Plan writing

The plan template supports and facilitates the development of a tailored national multihazard ERC plan. The Regional Office also assists countries in adapting and integrating the ERC plan into their national preparedness and emergency response plans, according to their governance structure.

Step 4. Plan testing

The WHO Regional Office for Europe provides support for testing the ERC plan in multisectoral simulation and table-top exercises in:

- health emergencies: disease outbreaks (including pandemic influenza), natural disasters and humanitarian and environmental crises;
- ERC principles: early, transparent communication, communication coordination, listening and community engagement, effective channels and key influencers.

Step 5. Plan adoption

On the basis of the results of the simulation exercise, the Regional Office makes recommendations for updating the national ERC plan and facilitates its integration into national preparedness and response plans.

As part of the process, the Regional Office supports the development and implementation of a capacity-building roadmap based on identified priorities. The roadmap can include ERC training and workshops for different audiences and integration of ERC into technical capacity-building activities and field simulation exercises.



ERC capacity-mapping

ERC capacity-mapping

Capacity-mapping overview

ERC capacity-mapping can be considered a two-part process. The capacity-mapping tool can be used for a national "self-assessment", usually by a ministry of health and its partners. Following or in conjunction with a self-assessment, a mission to the country can further identify and link capacities in order to bridge gaps in a national ERC system.

Sample agenda

DAY 1			
Time	**Content**	**Format**	**Facilitator(s)**
8:30–9:00	Registration		
Session 1	**Welcome and introduction to emergency risk communication (ERC)**		
9:00–9:30	Official welcome to workshop by leaders	(Insert presenter) – Plenary	Ministry of Health and WHO country and regional offices
9:30–10:00	Overview of the International Health Regulations (2005) (IHR) and national emergency preparedness and readiness	(Insert presenter) – Plenary	WHO Regional Office
10:00–10:30	Introduction to ERC capacity-mapping	(Insert presenter) – Plenary	WHO Regional Office
10:30–11:00	Coffee or tea break		

DAY 1 (continued)			
Time	**Content**	**Format**	**Facilitator(s)**
Session 2	**ERC capacity-mapping**		
11:00–12:30	Parallel sessions • Group 1: Ministry of health capacity: press office, community engagement, health hotline and other communications units • Group 2: National emergency management sector capacity: emergency operations centre, ministry of the interior emergency unit, department of defence, other government response entities	Group work and presentations – Breakout and plenary	WHO Regional Office and participants
12:30–13:30	Lunch		
Session 3	**ERC capacity-mapping (continued)**		
13:30–15:00	Parallel sessions • Group 1: Ministry of health emergency operations capacity: emergency operations centre, field epidemiology programme, any division deployed during a public health emergency • Group 2: One Health partners' capacity: communication and other key representatives from the ministry of agriculture, OIE, FAO, etc.	Group work and presentations – Breakout and plenary	WHO Regional Office and participants
15:00–15:30	Coffee or tea break		
Session 4	**ERC capacity-mapping (continued)**		
15:30–17:00	Parallel sessions • Group 1: Ministry of health capacity to handle other public health threats: Influenza, vaccine-preventable diseases, food safety, mass gatherings, chemical, biological, radiological and nuclear threats, etc. • Group 2: United Nations partners' capacity: communications from e.g. UNICEF, UNDP, UNFPA, OCHA	Group work and presentations – Breakout and plenary	WHO Regional Office and participants

DAY 2			
Time	**Content**	**Format**	**Facilitator**
8:30–9:00	Arrival of experts		
Session 5	**ERC capacity-mapping (continued)**		
9:00–10:30	Parallel sessions • Group 1: Subnational or provincial ministries of health or health department capacity • Group 2: NGOs and civil society capacity: Red Cross or Red Crescent, NGOs that work with hard-to-reach populations	Group work and presentations – Breakout and plenary	WHO Regional Office and participants
10:30–11:00	Coffee or tea break		
Session 6	**ERC capacity-mapping (continued)**		
11:00–12:30	Parallel sessions • Group 1: Hospital system capacity: national hospital association, primary, secondary and/or tertiary hospitals • Group 2: Other government partners capacity: ministries of education, environment, tourism, finance, press office of the president or prime minister	Group work and presentations – Breakout and plenary	WHO Regional Office and participants
12:30–13:30	Lunch		
Session 7	**Writing results**		
13:30–17:00	WHO Regional Office for Europe compiles results	Group work	WHO Regional Office

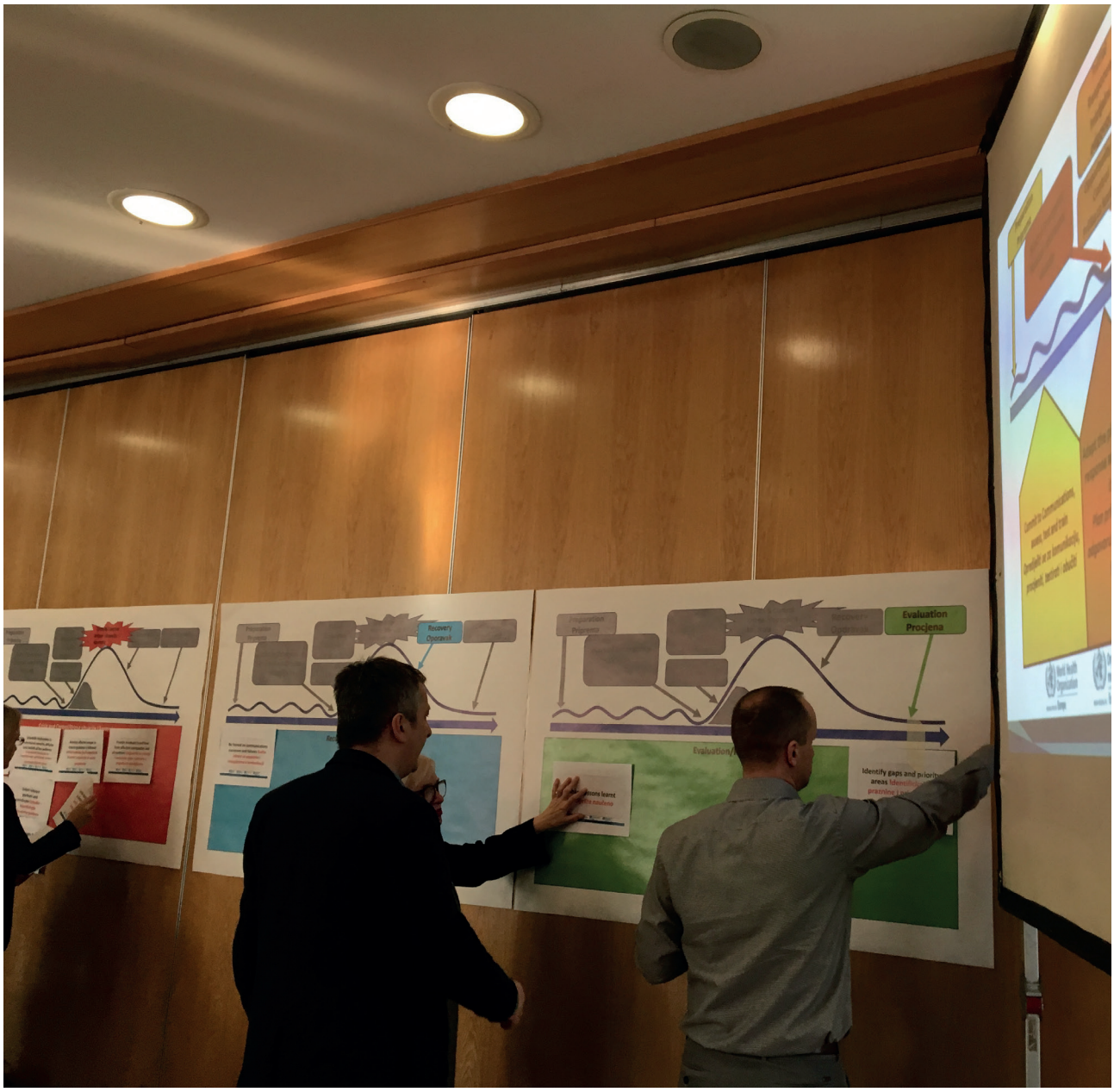


Photo credit: WHO

Sample preparation checklist

Documents to be reviewed and sent

Please review the following documents:

☐ ERC capacity-mapping workshop checklist (this document)

☐ Mission schedule (2-day capacity mapping and other activities as planned)

To be sent:

☐ Mission budget

☐ Agenda

☐ Other activity agenda(s)

☐ Mission print list

Documents to be provided and reviewed before the mission

Before conducting an ERC capacity-mapping workshop, review of the following documents and references – when available – will provide background on the host country's risk communication planning and functions.

☐ Joint external evaluation: summary and recommendations

☐ Risk communication plans or components of other plans

- Ministry of health internal crisis communications plan
- Government communications office crisis communications plan

☐ National emergency response plan for an epidemic or pandemic of a human communicable disease

☐ Pandemic influenza preparedness plan

☐ Plans and materials for vaccine events

☐ Reports from previous risk communication trainings

☐ Recent studies of knowledge, attitudes and practice conducted in the country

☐ Results of studies on how national or segments of the national population seek trusted health information

☐ News stories about recent national emergencies

☐ Organizational charts of communication capacity units

☐ Recent national public health risk assessments

☐ WHO country operations plan

Participants to include in ERC capacity-mapping workshops

Those individuals who are required are indicated with an asterisk (*)

Emergencies usually require an organized multisectoral response. An effective ERC response is no exception. At a minimum, conflicting communication messages, plans and methods will cause confusion and reduce trust and, at worst, will result in negative public health outcomes. It is suggested that all relevant stakeholders be included in training and in subsequent planning to ensure agreement and consensus before an emergency.

Ministry of health representatives

Numerous sectors and individuals within ministries of health must be coordinated in order to respond effectively with ERC. The following are typically involved (or should be involved) in coordinating risk communication.

- ☐ health communication staff at national and subnational levels, to include:
  - public relations officers in the ministry of health*
  - spokesperson(s)*
  - community engagement and/or social mobilization personnel and/or health promotion and education, etc.*
- ☐ ministry of health staff who lead emergencies in known threats (e.g. communicable diseases, pandemic or avian influenza, foodborne illness, antimicrobial resistance, chemical, biological, radiological and nuclear disasters, natural disasters)*
- ☐ health staff in epidemiology, immunization and influenza*
- ☐ ministry of health public health unit
- ☐ health emergency operations centre staff*
- ☐ health emergency staff at subnational levels
- ☐ national institute of public health*
- ☐ any other staff in areas identified in recent national risk assessments.

Participants to include in ERC capacity-mapping workshops (continued)

Those individuals who are required are indicated with an asterisk (*)

Partners external to the ministry of health

Clear communication depends strongly on coordination of all voices during an emergency. Therefore, determination of duplication and gaps in capacity, best practices and challenges with partners in the ministry of health and with external organizations will assist the ministry in identifying cost-effective capacity-building activities and designing a cross-cutting risk communication strategy for health emergencies.

- ☐ government communications office
- ☐ communication and response staff from the host country's administration for civil protection and disaster relief*
- ☐ communication and response staff from the national ministries of e.g. agriculture*, education, defence, the environment*, information, rural development
- ☐ representatives of national and subnational emergency operations centres and other responders.*

United Nations and nongovernmental organizations (NGOs)

The goal of a partner assessment is to ensure that their capacities are identified, to avoid duplication or identified gaps in planning.

- ☐ WHO staff*
- ☐ United Nations partners (e.g. UNICEF, OCHA)*
- ☐ Red Cross and Red Crescent and Crystal Societies*
- ☐ NGOs with relevant interests or mandates
- ☐ health service providers, associations, etc.
- ☐ civil society groups

Capacity-mapping logistics

Venue

- ⊙ One or two meeting rooms are required for this activity
  - If such rooms are not available at the ministry of health, other facilities should be found.

- ⊙ If the activity is to include parallel sessions, it is best to have two meeting rooms that can each seat enough participants and contain:
  - one table with enough seating for the host country participants, a facilitator and translator (if needed)
  - a projector and projector screen for PowerPoint presentations.

Materials

- ⊙ Each participant should have printouts of all materials and worksheets required for the workshop (to be provided by the WHO Regional Office for Europe ERC team) – see checklist for printing and translation.

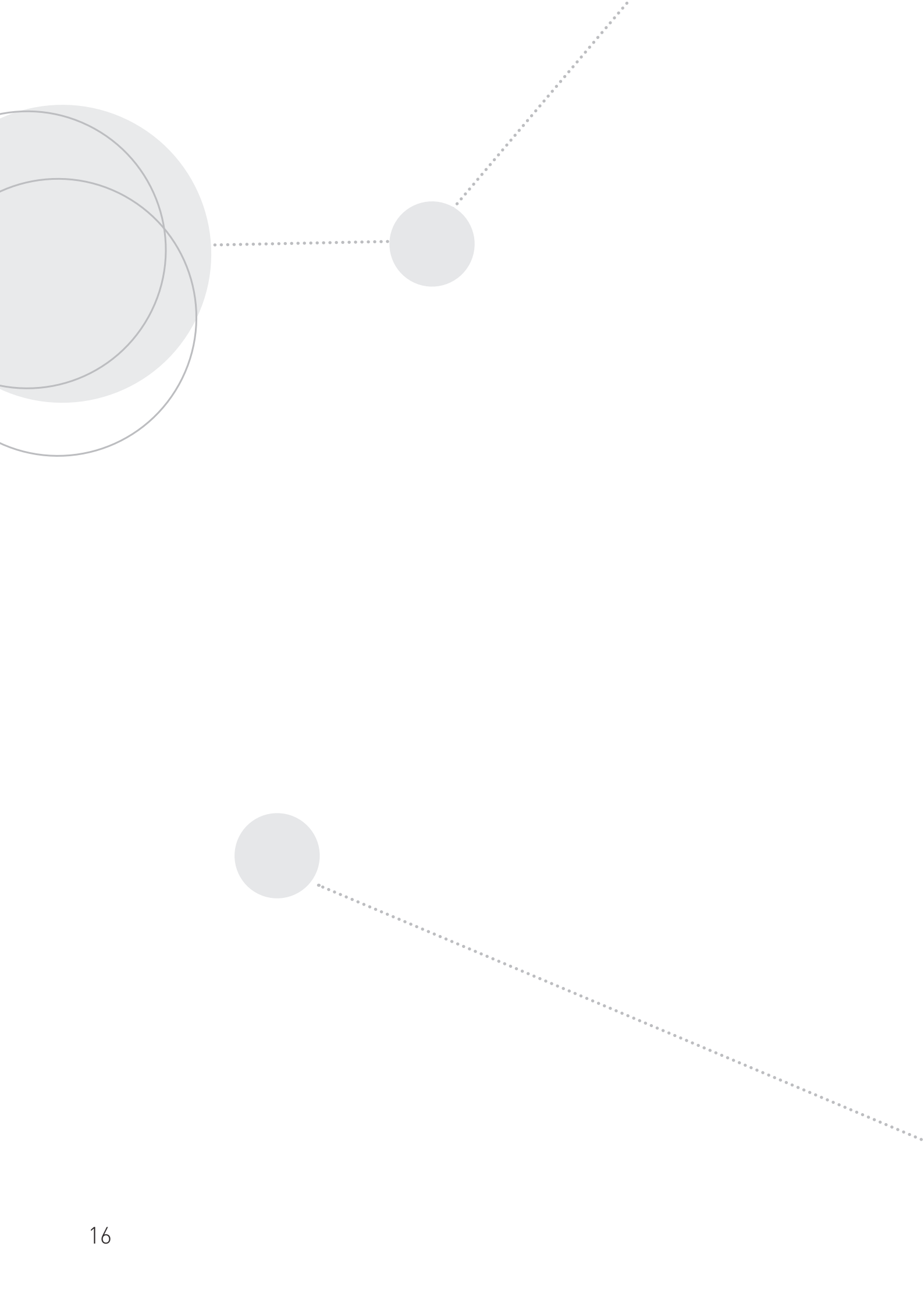
Translation

- ⊙ If translation is needed:
  - All materials should be translated.
  - Simultaneous interpretation must be procured.

Capacity-mapping materials and checklist for printing and translation

ERC capacity-mapping materials can be downloaded from this website			
Link to Dropbox or SharePoint site			
No.	**Title of document to be translated, printed and/or saved on a memory stick**	**No. of copies**	**Approximate number of pages/ words in English**
1	Mission schedule	1 copy per participant	1 page/400 words
2	Capacity-mapping agenda	1 copy per participant	2 pages/325 words
3	Capacity-mapping evaluation	1 copy per participant	6 pages/650 words
4	Capacity-mapping introduction (PPT)	1 copy per participant or shared electronically	39 slides

Photo credit: WHO



National health ERC capacity-mapping tool: four-core capacity method

Target audiences

The target audiences for this capacity-mapping tool include national and subnational emergency response and communications officials in ministries of health, agriculture, emergencies, tourism and finance and responding partners in hospitals, community outreach, civil society and nongovernmental organizations (NGOs) and business sectors.

Purpose

Member States in the WHO European Region should have multisectoral ERC capacity to address all hazards. The purpose of capacity-mapping is to clearly identify national risk communication capacity in a phased approach to the different stages of an emergency.

The four-capacity method assesses national preparedness for each of the four capacity areas: (i) transparency and early announcement of a real or potential risk; (ii) coordination of public communication; (iii) listening and two-way communication; and (iv) selecting effective channels and engaging key influencers, throughout the lifecycle of an emergency.

The goal is to promote behavioural change and to reduce or mitigate the expected impact of the health hazard before, during and after the event.

Results

Once capacity has been mapped, countries will have nationally focused results that can be shared with the WHO Regional Office for Europe ERC team. In collaboration with national counterparts, the Regional Office can support development of an action plan that includes:

- common, regular communication practice that can be intensified for use during an emergency;
- guidance on effective coordination to ensure that "the whole is greater than the sum of its parts", by identifying and connecting the capacities of different communication response actors (e.g. press office and community engagement, health education and health promotion) to provide a greater benefit during an emergency;
- tangible recommendations to fill gaps and improve the country's four key ERC capacity areas; and
- best practices that could be replicated in other countries.

Photo credit: WHO

National capacity-mapping instructions

In order to make useful changes to the national ERC response, this and future activities to identify capacity must be conducted truthfully and critically. Systematic improvement cannot be made without knowing the true baseline ERC capacity.

- Review the definitions of the emergency response phases, ERC capacity areas and the ERC capacity-mapping scale.
- Consider and answer the questions on national ERC experience.
- Answer and rank the indicators in the four ERC capacity areas: transparency and early announcement, coordinating public communication, listening and two-way communication and selecting effective channels and trusted influencers.
- For each indicator, provide support in the form of policies, documentation or examples.
- Work with communication responders in other departments to map capacity. Try to answer all the questions in the tool. If you are unable to answer some questions, gain an overall idea of the strengths and challenges to capacity rather than providing an exact answer for each indicator.
- Questionnaires for mapping partners and media are annexed to this document. They can be used by you or during a capacity-building mission to determine the strengths and challenges of your national ERC response system.

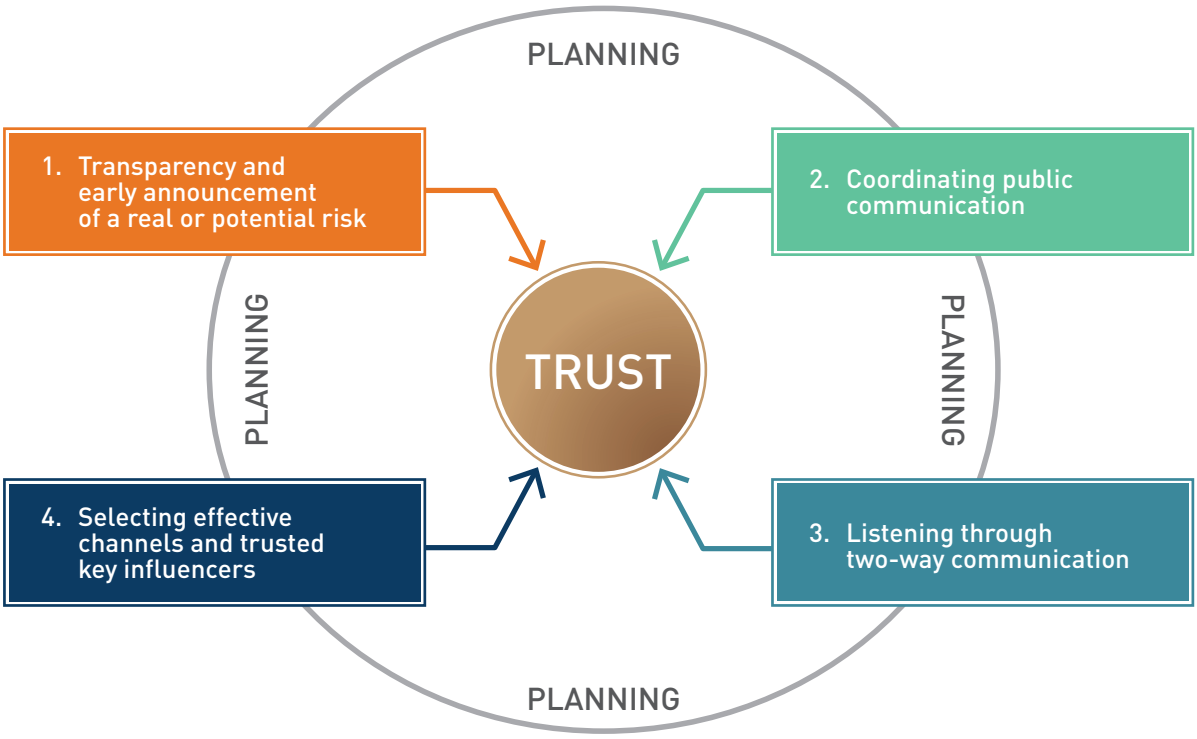
Photo credit: WHO

Definition of national ERC core capacities

The four ERC core capacities contribute to the development and maintenance of trust.

The role and importance of trust in all communication are central. Responders must communicate with stakeholders and the public in ways that build, maintain or restore trust, as this increases uptake of guidance. Key trust-building mechanisms in the lifecycle of a crisis include: ensuring timely, accurate, transparent communication; coordinating public communication; listening through two-way communication; and selecting effective channels and engaging key influencers (Fig. 3).

Fig. 3. The four ERC core capacities



1 Transparency and early announcement

Maintaining the public's trust throughout an emergency requires constant transparency, including providing timely, complete information about a real or potential risk and its management. The first announcement frames the risk and addresses concerns. New developments should be communicated proactively during an outbreak as they occur. Communications must state transparently what is known and what is not yet known. When there is transparency, people are more likely to trust the responders and follow their recommendations.

The elements could include: an agreed ERC policy and procedures to support transparency and early announcement, ensuring that the ERC function is represented in management meetings and providing training in ERC for key staff.

2 Coordinating public communication

Proactive external public and internal communication and coordination with partners before, during and after an emergency are crucial to ensure effective, consistent, trustworthy risk communication that both provides information and addresses public concerns. As a result, public communications resources will be effectively used, confusion reduced and outreach and influence strengthened.

The elements could include: identifying and training spokespeople in ERC; identifying and training an ERC team to support the spokespeople; and a policy and procedures for ERC coordination and release of information that is agreed with key partners and agencies within the government.

3 Listening through two-way communication

Community engagement is not an option. Communities must be at the heart of any health emergency response. It is essential to know which people to target, how they understand and perceive a given risk and their beliefs and practices; otherwise, the decisions and behavioural changes necessary to protect health may not occur, and social or economic disruption may be more severe.

The elements could include: systems and resources for regular (at least daily) monitoring of mainstream media and social media; systems for collecting feedback and listening for rumours among at-risk populations (e.g. through formative research); and a system for the ERC team to review feedback and act on it.

4 Effective channels and key influencers

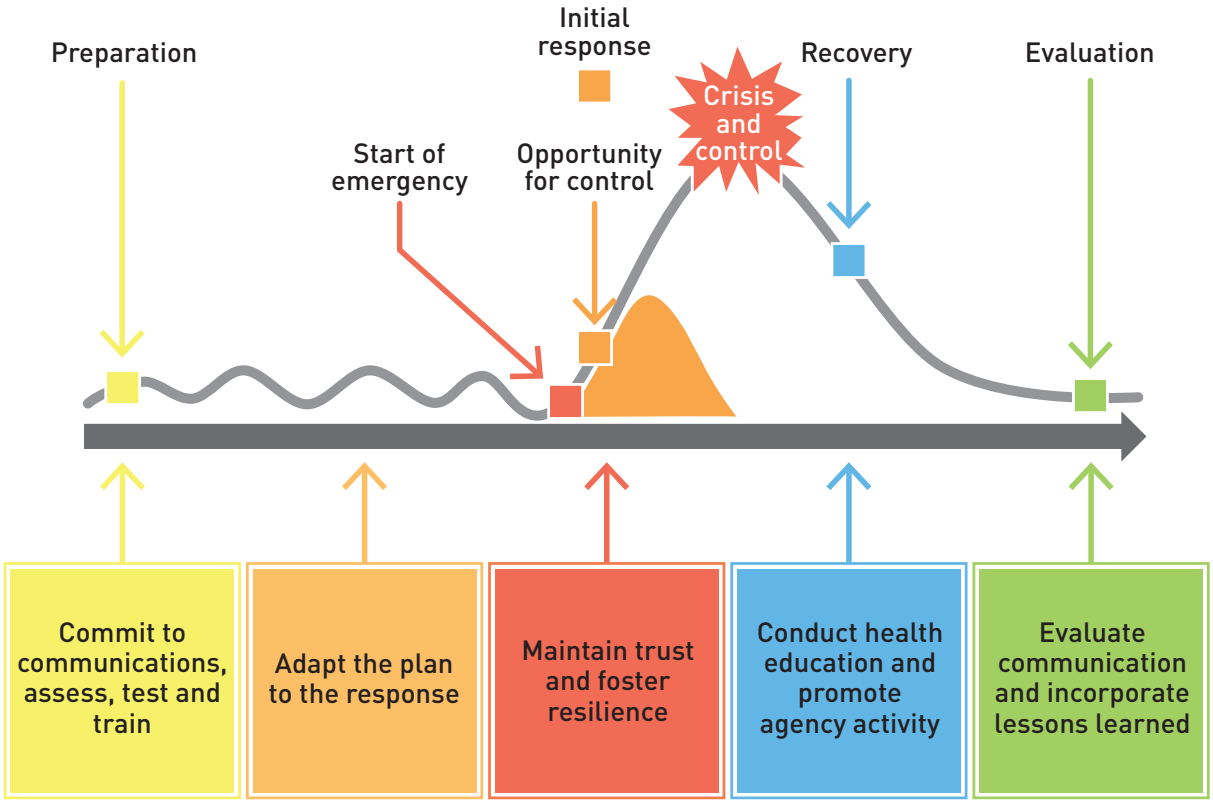
Once the audience has been identified, the right channels to reach them must be selected. The channels that work best depend on the local context and the audience. The most effective channels are usually those used by the targeted audience. These can include media, Internet, social media, hotlines and SMS. Influencers have a critical role in delivering messages, as they are trusted opinion-makers who are often part of the community.

The elements could include: an ERC team with the skills and capacity to analyse access to communication channels and to select those used by the targeted audiences; and strong partnerships with stakeholders and influencers in the wider community.

Emergency response phases

For communication purposes, the lifecycle of an emergency, disaster or crisis (Fig. 2) comprises the following phases: (i) preparedness and operational readiness, (ii) initial response, (iii) crisis response and control, (iv) recovery and (v) evaluation. Each phase requires specific, timely interventions.

Fig. 2. Phases of the emergency lifecycle



Preparedness and operational readiness

This phase is continuous, rather than an event, and requires extensive planning and coordination through regular assessments and training. The needs and challenges for each type of emergency can be anticipated and preliminary materials prepared.

Preparedness: Action taken in anticipation of an emergency to facilitate a rapid, effective, appropriate response. ***Are you planning for the future?***

Operational readiness: Organization, planning, funding, exercise and training to be ready to respond to priority hazards, threats and risks. ***Can you activate your plan tomorrow?***

Initial response

The first few days of an initial response may pose many challenges due to fear, confusion and uncertainty. The general public requires timely, accurate information about the situation and what is being done to address it.

Crisis response and control

Throughout the response, public concerns and fears must be understood and taken into account, and rumours and misinformation must be identified and addressed. Once a rumour is created, it can spread fast among people who have genuine difficulty in understanding the threat and the necessity of protective behaviour. Effective two-way communication, taking into account people's perceptions and concerns, is essential to maintain trust and improve health outcomes.

Recovery and evaluation

The recovery and evaluation phases of a response are critical, although they are underprioritized. Risk communications should be assessed during and at the end of an emergency to understand achievements and modify interventions if necessary.

The data collected can be used systematically to update strategies, plans, messages and risk communication materials. Special attention should be paid to reviewing transparency, early announcements, coordination of public communication, listening and two-way communication, selecting effective channels and engaging influencers.

Photo credit: WHO

Scale of ERC preparedness and operational readiness

	ERC capacity Preparedness and operational readiness scale
1.	**Not prepared** *Not recognized as a capacity need*
2.	**Low preparedness** *Recognized as a capacity need but has limited capacity*
3.	**Moderate preparedness** *Capacity exists with functional lead but with limited scope*
4.	**Prepared but not operational** *Capacity exists with functional lead and vetted by key stakeholders but not tested*
5.	**Prepared and operational** *Capacity exists with functional lead and has been tested or used in exercises or event response*

Questions on national ERC experience

ERC preparedness Country experience
1. What are your greatest concerns in communicating public health risks to your population?
2. Can you describe the communication preparedness and response activities used in a past large-scale planned event (e.g. pilgrimage, large sporting event)?
3. Can you describe the communication preparedness and potential response activities planned for a future large-scale planned event (e.g. pilgrimage, large sporting event)?
4. Can you describe the communication response activities used in a past public health emergency?
5. On a scale of 1–10, with 1 = "no trust" and 10 = "complete trust", how do you think the national population would rate their trust in the Ministry of Health, and why?

ERC preparedness (continued)

Country experience

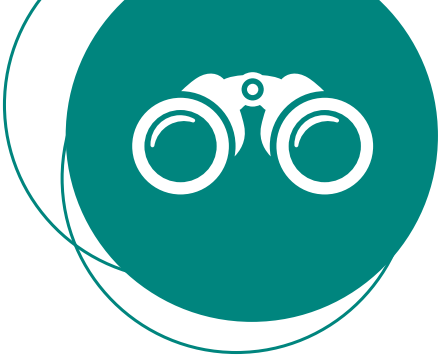
6. Where do key groups of your population seek health information that they trust?

7. What communication-related functions within your organization do not work well (e.g. audience research, media response, communication or message coordination)? How would you suggest that these be improved?

8. What communication-related functions within your organization do you consider are working well? Share a best practice in communication response.

9. Describe any collaborative communication activities within the Ministry of Health; e.g. emergency operations have a communications function; the press office works with community engagement, health education or social mobilization staff; communications personnel in various areas, such as influenza and immunization, meet and work together regularly.

10. Describe any collaborative communication activities with other health response partners, such as from the ministries of agriculture, emergency and tourism.



ERC capacity-mapping tool by capacity

1 Transparency and early announcement: mechanisms and examples

Describe the mechanisms within the communication response system that ensure transparency and early announcement. Please provide examples.

Transparency and early announcement *indicators*	Not prepared	Low preparedness	Moderate preparedness	Prepared but not operational	Prepared and operational
a. Transparency and sensitive country discussed among all layers of organization					
b. Ministry of health and government counterparts and other stakeholders consulted					
c. Procedures for timely, transparent sharing of information products agreed upon and included in preparedness or operational readiness plans (internal to response agency)					
d. Clearance procedures for messages and products defined and included in preparedness or operational readiness plans (internal to response agency)					
e. Procedures for timely, transparent sharing of information with partners agreed upon and included in preparedness or operational readiness plans (external to response agency)					
f. Procedures for clearance of joint messages and products with partners defined and included in preparedness or operational readiness plans (external to response agency)					
g. Roster of spokespersons (lead, back-up and/or subject matter experts) established and included in preparedness or operational readiness plans					

Transparency and early announcement *indicators*		Not prepared	Low preparedness	Moderate preparedness	Prepared but not operational	Prepared and operational
	h. Spokespersons (lead, back-up and/or subject matter experts) trained					
	i. Templates designed for messages about multiple hazards or key public health threats recognized in recent risk assessments and included in preparedness or operational readiness plans					
	j. Protocols and strategies for transparency and early announcement tested regularly or in recent exercises (past 12 months) and included in operational readiness plans					
	k. Plan and templates to manage uncertainty (e.g. communication within 48 hours, templates for holding messages) agreed upon					
	l. Strategy to rapidly share stories, photos and videos to illustrate key messages and recommendations					
	m. Ability to initiate monitoring and data collection on effective transparency and early announcement					
	n. Plan to consistently share decision-making about new or changed recommendations agreed upon					
	o. Ability to initiate health education to inform the population of future threats					
	p. Ability to conduct an "after-action review" to identify strengths and challenges in transparency and early announcement					
	q. Ability to integrate lessons learnt from the "after-action review" into future response plans					

2 Coordinating public communication: mechanisms and examples

Describe ways in which communication to the affected population is coordinated and meets their information needs. Please provide examples.

Coordinating public communication *indicators*		Not prepared	Low preparedness	Moderate preparedness	Prepared but not operational	Prepared and operational
	a. Communication capacities of all relevant stakeholders assessed					
	b. Communications staff organized into regional, national and subnational networks to facilitate coordination and sharing of materials and methods					
	c. Updated contact lists of identified partners (other agencies, organizations, community planners, health care workers, NGOs, etc.) included in preparedness or operational readiness plans					
	d. Communication roles and responsibilities agreed upon in standard operating procedures (SOPs) and included in preparedness or operational readiness plans					
	e. Joint agency communication teams established, with defined roles and responsibilities					
	f. Budget prepared for communication (including scaling-up)					
	g. Protocols and strategies for coordinating public communication tested regularly or in a recent exercise					
	h. Ability to meet the demand of extensive mass media enquiries					
	i. Designated communication staff or a mechanism to shift staff priorities to respond to a potential public health emergency ("surge staff")					
	j. Strategy or templates to create timelines for communication activities and products					

Coordinating public communication *indicators*		Not prepared	Low preparedness	Moderate preparedness	Prepared but not operational	Prepared and operational
	k. Plan for determining emergency-specific internal and external communication roles and responsibilities					
	l. Mechanism to ensure consistent, coordinated messaging and dissemination with partners and response agencies					
	m. Ability to initiate monitoring and data collection on effective coordination of public communication					
	n. Communications staff members trained in specific response roles (i.e. risk communication, social mobilization, media response)					
	o. Agreements with partners to issue joint press releases					
	p. Agreements with partners to use each other's resources					
	q. Agreements with partners to publish joint publications					
	r. Ability to assess budget shortages in order to advocate for future emergency response funds					
	s. Ability to assess cross-agency coordination (strengths, challenges, etc.) to improve future plans					
	t. Ability to conduct an "after-action review" to identify strengths and challenges in coordinating public communication					
	u. Ability to integrate lessons learnt from the "after-action review" into future response plans					

3 Listening through two-way communication: mechanisms and examples

Describe how your agency engages with its populations prior to and during an emergency. Please provide examples.

Listening through two-way communication *indicators*	Not prepared	Low preparedness	Moderate preparedness	Prepared but not operational	Prepared and operational
a. System established for continuous monitoring, verification and response to rumours (media, social media, hotline, etc.)					
b. Target audiences identified, including at-risk and hard-to-reach populations, health care workers, pregnant women, etc.					
c. Mechanisms established to understand concerns, knowledge, attitudes, practice (KAP) and beliefs and trusted sources of information, preferred communication channels and languages of target audiences.					
d. Messages about public health threats identified in recent risk assessments tested and included in preparedness or operational readiness plans					
e. Protocol established for when and how to address rumours and included in preparedness or operational readiness plans					
f. "Surge staff" (may work in health promotion or education department) identified, trained and with practice in community engagement included in preparedness or operational readiness plans					
g. Formal, continuous contact among staff trained and with practice in engagement with the media and community (may work in health promotion or education department) included in preparedness or operational readiness plans					
h. Protocols and strategies for listening through two-way communication tested regularly or in a recent exercise and included in preparedness or operational readiness plans					

Listening through two-way communication *indicators*		Not prepared	Low preparedness	Moderate preparedness	Prepared but not operational	Prepared and operational
	i. Ability to identify and respond to subject-specific rumours or misinformation through effective communication channels (e.g. media, social media, hotlines)					
	j. Ability to rapidly access key audiences (e.g. affected population, health care workers) to provide updated information and for formative research					
	k. Strategy and templates created for conducting formative research (e.g. rapid KAP survey, focus groups)					
	l. Strategy and templates created for rapid testing of messages					
	m. Mechanism in place to include the findings of formative research on rumours and audiences into communication response					
	n. Translation services procured or on standby					
	o. Ability to initiate monitoring and data collection on effective listening and two-way communication					
	p. Mechanism in place to use feedback through health hotline or formative research (i.e. KAP surveys) for decision-making					
	q. Mechanism in place to ensure that the results of social media and media monitoring are rapidly assessed, addressed and used in decision-making					
	r. Mechanism in place to ensure that affected populations follow health guidance					
	s. Ability to prepare messages rapidly to respond to population perceptions, findings from media monitoring and other feedback					
	t. Ability to conduct open discussions of post-emergency implications with affected audiences					
	u. Ability to conduct an "after-action review" with affected audiences to identify strengths and challenges in listening and two way communication					
	v. Ability to integrate lessons learnt from the "after-action review" into future response plans					

4 Effective channels and trusted influencers: mechanisms and examples

Describe the communication channels and key influencers that your agency uses to communicate with your populations and how those channels or key influencers were considered to be effective.

Effective channels and trusted influencers *indicators*	Not prepared	Low preparedness	Moderate preparedness	Prepared but not operational	Prepared and operational
a. Updated contact lists for effective communication channels per target audience included in preparedness or operational readiness plans					
b. Updated contact lists for identified trusted influencers per target audience included in preparedness or operational readiness plans					
c. Distribution systems for tested messages (e.g. media, social media, SMS, partners listserv) included in preparedness or operational readiness plans					
d. Media partnering activities (e.g. educational sessions, site visits) conducted regularly					
e. Intent to conduct press briefings at regular intervals with equitable, easily accessible communication methods (e.g. toll-free phone lines) included in preparedness or operational readiness plans					
f. Information, education and communication materials developed for common or likely events according to a recent risk assessment included in preparedness or operational readiness plans					
g. Ability to disseminate messages and materials rapidly in an equitable manner to all effective channels included in preparedness or operational readiness plans					
h. Protocols and strategies for effective communication tested regularly or in a recent exercise and included in preparedness or operational readiness plans					

Effective channels and trusted influencers *indicators*		Not prepared	Low preparedness	Moderate preparedness	Prepared but not operational	Prepared and operational
	i. Ability to send messages and materials to effective communication channels for targeted audiences					
	j. Ability to activate trusted influencers for targeted audiences					
	k. Ability to collect data on media, social media and hotline usage					
	l. Ability to initiate monitoring and data collection on use of effective channels					
	m. Ability to maintain regular, transparent communication through the channels used by the audience					
	n. Ability to establish the most appropriate mix of channels to reach target audiences					
	o. Ability to maintain consistent contact with key influencers and affected target audiences (community engagement)					
	p. Ability to effectively phase out use of emergency-specific channels (e.g. emergency-specific web sites, social media)					
	q. Ability to conduct an "after-action review" to identify strengths and challenges in using effective channels					
	r. Ability to integrate lessons learnt from the "after-action review" into future response plans					

Annex 1.
Questionnaire for partner mapping

PARTNER NAME OR ROLE: _____
1. Which are your primary target audiences? With which individuals or groups do you communicate most often?
2. How do you communicate with these audiences?
3. What are your greatest concerns in communicating risks to your population?
4. Can you describe the communication preparedness and response activities undertaken by your organization in a past large-scale planned event (e.g. pilgrimage, large sporting event)?
5. Can you describe the communication preparedness and potential response activities planned for a future large-scale planned event (e.g. pilgrimage, large sporting event)?
6. Can you describe the communication response activities used in a past public health emergency?

7. On a scale of 1–10, with 1 = "no trust" and 10 = "complete trust", how do you think the national population would rate their trust in your organization, and why?

8. Where do key groups of your population seek health information that they trust?

9. What communication-related functions within your organization do not work well (e.g. audience research, media response, communication, message coordination)? How would you suggest that these be improved?

10. What communication-related functions within your organization do you consider are working well? Share a best practice in communication response.

11. Describe any collaborative communication activities between your organization and the Ministry of Health (e.g. communications personnel from your organization and from the Ministry meet and work together regularly).

12. Describe any collaborative communication activities with other response partners (e.g. ministries of agriculture, emergency and tourism).

13. Describe mechanisms within your organization's communication response system to ensure transparency and early announcement. Please provide examples.

14. Describe ways in which communication to the public through your organization is coordinated and meets the information needs of the affected populations. Please provide examples.

15. Describe how your organization engages with its populations prior to and during an emergency. Please provide examples.

16. Describe the communication channels and key influencers that your organization uses to communicate with your populations and how those channels or key influencers were considered to be effective.

Annex 2.
Questionnaire for media mapping

MEDIA OUTLET NAME/ROLE: _____
1. Who are your primary target audiences? With which individuals or group do you communication most often?
2. How do you communicate with these audiences?
3. What are your greatest concerns in communicating health-related risks to your target audiences?
4. Can you describe the communication preparedness and response activities undertaken by your media outlet in a past public health emergency?
5. Describe how you receive information on potential news stories from the Ministry of Health.
6. Describe how you receive information on potential news stories from other emergency response agencies.

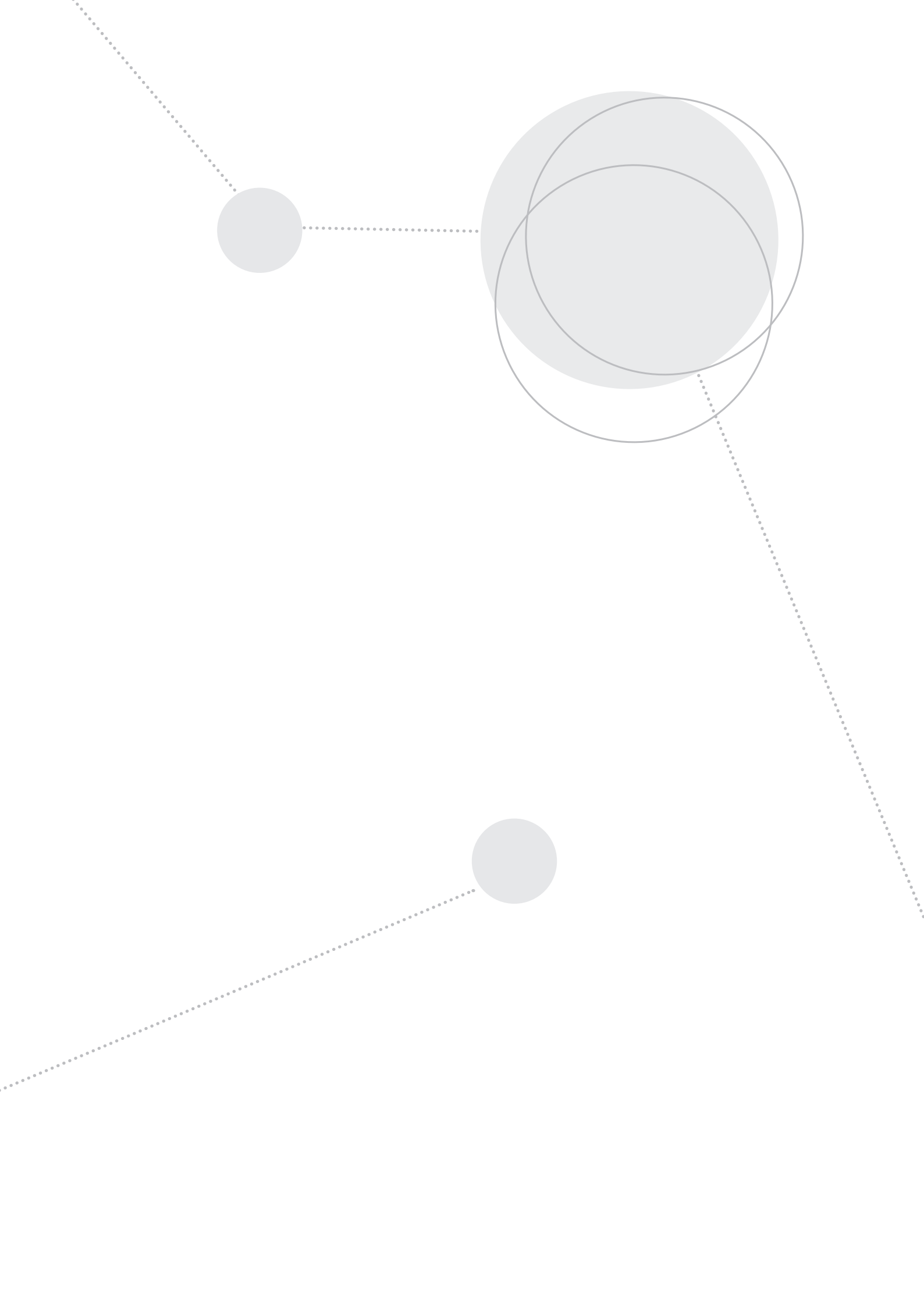
7. Could the way in which you or your media outlet receive(s) information from the Ministry of Health or other response agencies be improved? If so, how?

8. Describe ways in which the Ministry of Health or other response agencies could better ensure transparency and early announcement of emergency events through the media. Please provide examples.

9. Describe ways in which the Ministry of Health or other response agencies could better ensure that coordinated communication to affected populations through the media meets their information needs. Please provide examples.

10. Describe how your media outlet engages with its populations prior to and during an emergency. Please provide examples.

11. Note to facilitators: include specific questions on advising the media on improving coordination according to feedback received from the Ministry of Health or partners about media engagement.



The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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