Global Health Security Action Group Communicators Network Meeting March 2-4, 2010

MEETING SUMMARY

MITA KAIGISHO
Tokyo, Japan

Day 1 AGENDA

Meeting Chairs:

Klaus Riedmann, Federal Ministry of Health, Germany
Bill Hall, Department of Health and Human Services, United States

Tuesday, March 2

H1N1 - Lessons learned in risk communications, discussion of future communications challenges

9:30 a.m.	Registration
10:00 a.m.	Welcome and Review of Agenda
10:15 a.m.	Discussion of lessons learned
11:15 a.m.	*Break*
11:30 a.m.	Discussion of lessons learned
12:30 p.m.	*Lunch*
2:00 p.m.	Discussion of lessons learned/future challenges
3:45 p.m.	*Break*
4:00 p.m.	Discussion of future challenges
5:30 p.m.	*Reception*

SUMMARY

Mr. Nozaki welcomed participants to Japan and to the Global Health Security Action Group (GHSAG), Communicators Network Meeting. He invited Mr. Mugitani to make a welcome address.

Mr. Mugitani thanked the participants for gathering in Tokyo. He noted that as a member of GHSI he had attended a number of meetings and GHSI and GHSAG have been very useful as fora for exchanging information in a timely manner, of which exchange of information on H1N1 has been a good example. He expressed the hope that the meeting would be a fruitful one for all participants.

Mr. Nozaki then introduced all the participants and asked the chairpersons, Klaus Riedmann, Federal Ministry of Health, Germany, and Bill Hall, Department of Health and Human Services, United States to take charge of the meeting.

Dr. Riedmann expressed his pleasure at being in Japan. He noted that the meeting would be discussing H1N1 on the first day of the meeting, followed by discussion of generic plans for known and unknown agents. The third day of the meeting would discuss a future path for GHSAG and a work plan for 2010-2012.

Dr. Hall expressed appreciation to the Japanese hosts for arranging the meeting. As the first day is really to discuss the lessons learned, he noted that it would be advisable to go round the table and hear from each participant about the challenges that are being faced. After that the group could move on to discussion of what needs to be included in the document to be submitted to the ministerial in Mexico in November.

H1N1 - Lessons learned in risk communications, discussion of future communications challenges

Discussion of lessons learned

France: In France presently we have quite a lot of problems with H1N1, with investigations being implemented by the Ministry of Health. There are many questions that the ministry must address about the financing and strategy for the H1N1, including addressing questions about why so much money is being used for vaccines, etc. There is also an investigation by the Senate and another one by the parliament about vaccination

complaints. All eyes are on the ministry and there is much work to do. There are also problems of communication to the public, explaining what measures have been taken and why. The issue now is to maintain the trust and confidence of the people of France.

Japan: In the same way as France, a review has begun in Japan, but the largest issue is that ministry preparedness was for H5N1 and it is now being criticized for not being flexible enough in responding to H1N1. The ministry is now looking into revising vaccination-related legislation. The aim is to review the existing preparedness plan. There will be an election in the summer and it will be necessary to reach some conclusions before the election is held.

UK (Dr. Graham): In the UK the vaccination program is continuing and while there has been some criticism of over-reaction, public criticism has been muted. There have not been formal calls for a review. There is an upcoming report on the handling of H1N1. The biggest issue to address is what to do with the surplus vaccine. Another issue is ongoing negotiations with GSK about cancelling orders for further vaccination doses.

US (Dr. Rutz): The situation in the US is somewhat similar to the other countries in that there has been a waning interest in vaccine and there is a surplus. Since the H1N1 pandemic began, approximately 57 million people in the US are estimated to have been infected, representing an infection rate of 20%, which is high for a new disease. The rate of disease has gone down remarkably in recent weeks, which is surprising as February and March are usually the peak months for influenza. CDC has sentinel surveillance in place and is able to show that most of the circulating influenza is H1N1, but very few other A-strains. The deaths for influenza in the US stand at just under 11,000 and this is considerably below the seasonal average, although this could be due to the fact that deaths from seasonal influenza are estimates, while deaths from H1N1 are exact. The other point worthy of note is that while seasonal influenza usually attacks children and the elderly, H1N1 has been seen to attack previously healthy people in middle age.

Co-Chair (Germany): From the infection rate of 20%, do you have any projections about how bad the next influenza season will be?

US (Dr. Rutz): The H1N1 season started last year at the end of the influenza season, and went on through the summer, which is very unusual for influenza. It is possible that H1N1 could flare up in the spring, but it is as yet an unknown element. The death rate among the elderly has been very low.

Co-Chair (US): There have been a number of opinion polls in the US and the public feels that the government response was a good one. Criticism is being targeted at the vaccination program and there has been discussion about what the government is doing to invest in new technologies to improve its response to any future new wave of influenza. One of the unique things the US did in purchasing vaccines was that it had contracts in place for H5N1, and those contracts were modified for production of H1N1. The capacity was established to produce 250 million vaccines in bulk antigens. Currently 155 million doses of vaccine have been distributed and about 90 million Americans have been vaccinated. There are about 75 million doses remaining in the form of bulk antigens, which has a longer shelf life and it is hoped it can be used to create a trivalent seasonal vaccine. While some countries have started to wind down their vaccination programs the US is still encouraging people to get vaccinated. The US is getting close to the point of announcing a future path and what it will do about a trivalent vaccine. An official review has just been launched in the US government and will have five phases. There will be individual interviews with people who worked on the program and a report which will be merged with other reports from other federal departments.

Germany: In Germany the situation is probably the same as everywhere else. As far as vaccination is concerned nothing much is happening now. Contracts have been negotiated down from 50 million doses to 34 million doses. Vaccination coverage is roughly 10% of the population. The WHO has not directly recommended a trivalent vaccine and has just noted that the three strains should be covered. The influenza vaccines actually belong to the 16 States of Germany, with the central government only engaged in negotiations about the vaccinations. What it is necessary to explain now is why the death rate has been much lower than a standard influenza season. For Germany the first significant wave has come to an end. The big question is how it will continue.

Co-Chair (US): There is a point at which we will have to address when the pandemic is over.

WHO: It is the WHO assumption that any country that has a seasonal vaccination program will use a trivalent vaccine rather than anything else. What you have to look at when considering whether H1N1 is a pandemic or a seasonal virus is to look at its behavior. Currently H1N1 is still behaving as a pandemic. It is important to avoid confusion about pandemic and seasonal viruses. The Emergency Committee of the WHO just decided that there would be no phase change, judging that the H1N1 has not yet passed its peak. This decision may make activities more difficult for northern hemisphere countries, where the major wave seems to be waning. The Emergency Committee meeting involved very

interesting discussions and ultimately the disadvantages of moving to a post-peak phase were judged to outweigh the advantages. The H1N1 vaccine which is still in bulk could still be used in countries that do not have seasonal vaccination programs, and could use vaccines in monovalent formulations. The only country in the world to have had two distinct peaks is the US, and some countries have still not had their first peak, so there is still a great deal of uncertainty about the future path of the virus.

US (Dr. Rutz): I think that one of the issues in identifying first and second peaks is that the H1N1 virus is so mild that its diagnosis may be missed. We were faced with a pandemic and we opted for a prudent response and that is something we should be proud of.

Co-Chair (Germany): I will run through the status from Canada, Mexico and Italy, which could not attend the meeting today. In Canada, 45% of the population has been vaccinated. In Italy vaccinations cover 10% of the population and Italy is also renegotiating vaccine contracts. In Mexico vaccinations are just beginning and Canada provided five million doses to Mexico. Most of the GHSAG countries are trying to renegotiate their vaccination contracts.

Co-Chair (US): We have talked about challenges in the months ahead. It may now be useful to talk about the product we need to distill from our discussions. I would like to talk about my image of what we should achieve through GHSAG.

In January a meeting of the Pandemic Working Group was held and there was enthusiasm for the Communicators Group to make the first efforts to address lessons learned. A list of questions was distributed to GHSAG members prior to this meeting. We need to discuss the usefulness of the GHSAG meeting and consider what elements we need to improve upon.

Co-Chair (Germany): There was a meeting in Ottawa in June last year where we discussed challenges. There are already some results available from our activities and clear goals and outlines of what senior officials expect from us. What we need to discuss is: i) the product we are going to provide to the pandemic working group, and ii) what focus this product/report should have. One focus we must have is on GHSAG and how it has functioned. A starting point for this is to present a history of GHSAG and how it was anticipated it would work prior to the pandemic and how it actually worked when the pandemic had begun. GHSAG can be used operatively in a crisis and we need to decide how we can use this meeting in the future. We should therefore consider how GHSAG worked in a crisis.

UK (Dr. Graham): In terms of the network there is a real need for absolute cohesion between communications and policy. Through joining the network it was possible to see what was happening around the world from people we could trust.

US (Dr. Rutz): Technical information sharing was a success of GHSAG. The Mexican response was admirable in the early stage of H1N1 when it closed down Mexico City. The vaccine development, coordination and distribution strategy was highly successful and these efforts were facilitated by GHSAG.

France: It is too early to evaluate each national strategy about H1N1. It is very important for us to show that we are not alone in the world and that we are working with colleagues in other countries. It is also important to work with the WHO. We have many challenges over the next few months and if we are able to write a number of questions and respond to these questions it would be a good starting point for a document.

Co-Chair (Germany): I agree that it would be a good idea to identify what we want to input into the lessons learned. We should also identify the challenges we face.

Co-Chair (US): I think it is possible to take a step back and touch upon some of the broader communications issues. One of the things we have learned is something about the nature of pandemics, namely that they are not appearing all around the world all at the same time. Another issue is addressing challenges that pop up unexpectedly, in addition to those that we have already anticipated.

Co-Chair (Germany): What I think we should be aware of is that we are not writing a H1N1-focused pandemic plan. We need to identify the main questions we need to address. The next step is then evaluation and the third point is the lessons learned and challenges faced.

UK (Dr. Graham): With regard to the safety of vaccines, this was raised as an issue in the UK. Trust in vaccines is a big issue that needs to be dealt with. Vaccine manufacturers in the UK are already very concerned about this issue.

UK (Dr. Lightfoot): The Communicators did a fantastic job. There are a number of challenges and issues outstanding and there will be inquiries into the pandemic response in each country. We must get a list of what did not work properly so we can tell the rest of the world and the public. The spread of influenza is inevitable in today's globalized world. Any attempts to contain influenza will not work and border closures will not work. In this

context, it is good that ministers made the announcement that border closures are not an effective means of containing influenza. In the UK we tried to implement a containment strategy, which was extremely hard work and did not work effectively. We must be honest about what does and does not work.

Break

Co-Chair (Germany): Based on the set of questions that was distributed prior to the meeting, I have tried to put them into more general topics. As was said before the break I would suggest we break down our discussion into the following:
1) Risk communication principles
2) Preparedness plan
3) Challenges
4) GHSAG Network

So, with regard to the first point, risk communication principles, what were our experiences of the implementation and practice of these principles?

Co-Chair (US): I think the one area in which we failed was anticipating when vaccine would be ready and how many vaccines would be required. There was a lot of desire to have a great deal of vaccine available right away and this turned out not to be the case.

Co-Chair (German): I think we forgot to look at the public perception of H1N1. This was something, in Germany, that was overlooked. We completely underestimated the influence of groups or organizations against vaccination. We do not know whether this communication failure will have a negative impact in future influenza seasons.

US (Dr. Rutz): What should we have heard from the public that would have informed our planning?

Co-Chair (Germany): The public polling showed that the public did not view H1N1 as a threat and there were public questions over vaccine safety.

UK (Dr. Lightfoot): We only just coped in the first wave of influenza under the National Health Service. In the UK influenza was therefore perceived as a threat and continues to be so.

WHO: In the very early days, back in April, there was a huge amount of media attention, which created its own momentum. This created a disjoint between what the WHO was saying and what the media were reporting. The media perception is now that the risk of H1N1 was overplayed, but efforts were made initially not to overplay the threat. Around September we started having discussions about whether we should recalibrate the message we were sending out.

UK (Dr. Graham): The key thing is that in the UK we recognized that this would be a huge media issue. We therefore mobilized a large press team to deal with the media response. Our chief medical officer was established as the trusted voice in the media regarding the pandemic status, with regular press conferences providing information. This strategy was largely successful and the media tended to follow the information detailed in the chief medical officer's briefings. A key message for the GHSAG to send out is the importance of communications-related personnel to be present at every crisis-related meeting. It is essential to work closely with communications colleagues in order to provide timely information to the public. We quickly built up a network of stakeholder organizations which would be able to talk to their own respective audiences.

US (Dr. Rutz): We failed at having communicators at the meetings where major decisions are made initially, and our use of the term "swine flu" was a mistake we still have to live with. It is essential for communicators to be engaged from the outset.

UK (Dr. Lightfoot): The issue of "swine flu" terminology was also raised in the UK, but by the time it was being used in the media it was too late to change the name and the Ministry was therefore obliged to use the "swine flu" label.

WHO: The main discussion at that point was focused on stigmatizing a geographic area, which resulted in the "swine flu" terminology.

Co-Chair (Germany): I think that once a name has emerged in the media it is inevitable that it will become the common usage. Nomenclature is an issue that could be addressed as a challenge, as is the need to have communicators at the table of decision-making meetings.

US (Dr. Rutz): We have created a lot of confusion that can be traced to the initial error made in terminology.

Co-Chair (Germany): In the past pandemics have been named geographically, but there was resistance to stigmatizing a certain region on this occasion.

France: In July in France we prepared a strategic plan against "global flu," which included various strains, but that was not approved. Also "swine flu" terminology was all changed (in all posters and publicity) to "pandemic flu" which resulting in the public being confused. The public were faced with too much information from the media and we were not able to provide a clear message. In August and September organizations that are opposed to vaccinations implemented large-scale petitions against vaccinations and afterwards it was difficult to respond to the negative momentum that had been created. The ministry provided daily updates on its website, etc., but this was not sufficient in terms of engagement with stakeholders and the information was too late to be effective.

US (Dr. Rutz): What do you mean by providing "too much" information?

France: The problem was that the message emanating from the ministry was clouded by over-information from the media.

WHO: There is a problem about developing messages fast enough and GHSAG could be useful for such efforts. It is also important to address various stakeholders in society. The rapid move from phase three through to phase five by the WHO over the course of a few days created an "overdrive" in the media.

US (Dr. Rutz): Could we prevent such a tendency in the future?

WHO: We will be reviewing the WHO pandemic framework in the coming months and the review will be extensive.

Co-Chair (Germany): One question we need to address is how we communicate our planning strategies effectively, concentrating on being transparent and forthcoming with information without contributing to media frenzy.

Japan: In Japan we failed to have specific contact with medical doctors and the disjoint between government and the medical community became apparent.

UK (Dr. Graham): I agree that we were a victim of our own success in communicating our pandemic response plans. There was a tendency to issue all prepared information regarding pandemics, which flooded the media with information.

UK (Dr. Lightfoot): One terrible mistake in the UK was that our modelers stated that the UK could expect 55,000 deaths and 1,000,000 new infections a day. Modeling and response measures are completely different, and adaptive decision making is essential for response teams in a way that is not applicable to modelers.

Co-Chair (Germany): I agree that we failed to adapt our reactions to the low severity of this pandemic. It is essential to be responsive and not stick to plans that have been prepared beforehand.

UK (Dr. Graham): It is important to provide background information on a pandemic but continue to provide responsive updates that adapt to the realities of any given situation.

Co-Chair (US): From a practical perspective, modelers were not helpful for the US either, as was the case in the UK. As communicators, we are at an interesting nexus where we engage with leadership policy and discussions, while we also have interaction with the public. I think we should be active raising the points we have just identified with other fora. The US website had been called "pandemicflu.gov" and when the pandemic arrived the US changed the name of the website to "flu.gov." The concern was that the US would be perceived as declaring a pandemic prematurely and for exaggerating the effect of the H1N1 outbreak in the US. It is important to consider what the term "pandemic" means to the public and journalists. Proactive education is therefore an important theme we need to address.

UK (Dr. Lightfoot): In defense of modeling, it has been useful in a response to foot-and-mouth disease in the UK. In the case of SARS, modeling was also useful for the WHO.

Co-Chair (Germany): I think we have covered the risk communication principles and the basic aspects of preparedness planning. After the break we should go on with a discussion of the challenges we face. I suggest that we address the communication issues we faced during the crisis.

Lunch

Discussion of challenges

Co-Chair (Germany): We will now move to discuss the challenges we face, particularly communication challenges.

Co-Chair (US): Does this include discussion of challenges in the coming months?

Co-Chair (Germany): It can do, but we need to address the challenges arising from lessons learned. We could start with the challenges that we had thought we might have to face, including the topic of masks.

UK (Dr. Lightfoot): The issue of masks was a big issue for us in the UK as we had heard that France had purchased masks for the entire population. The Health Protection Agency produced a paper on masks. We were saying that masks for the well public served no purpose. What saved us was that discussion of masks came up at an early stage and we stuck to our original policy. Eventually the issue of masks turned out to be a non-event for the media and no questions were asked, following a prime minister's statement that "masks do not work."

France: We are sticking to our policy of advising people to wear masks if they are ill. We will probably keep the message about masks in place for the next seasonal flu also. We attempted to impress upon people the importance of wearing a mask if they have the symptoms of influenza and before they see a doctor. In our pilot test in a town in the Vosges mountains the pharmacies prepared a kit against influenza, including masks, disinfectant gel and medication against fever. These kits proved to be popular and could be a useful tool in the future.

Co-Chair (Germany): In Germany there was an initial phase in which stocks of masks ran out, but this was due to the fact that there are very few masks available on the market. It did not become an issue in the media however.

UK (Dr. Lightfoot): GSK have produced a mask impregnated with citric acid that kills the influenza virus and that will be a useful product in the future. The idea implemented by France of an influenza kit is also a good one.

Co-Chair (Germany): As the UK mentioned with the example of GSK impregnated masks, it is important to monitor the emergence of new products and their usefulness.

UK (Dr. Lightfoot): For communication messages it is necessary to amass the evidence from public health interventions so that a position can be developed for the GHSAG to advocate.

Co-Chair (Germany): The pandemic in the last few months has made it easy for the politicians to stick to the strategy they had agreed on. Given the mild impact of the pandemic the issue of border closing did not arise, however this could have been different if the pandemic had been more severe.

US (Dr. Rutz): When we talk about initial control measures we need to set reasonable expectations so that governments are not criticized for the measures they take. I think we also need to talk about hand hygiene.

UK (Dr. Lightfoot): As communicators we should be thinking about stating the specific objective of a particular measure in an upfront manner. For example, in the case of border closures it should be made clear that border closures are not effective in keeping influenza out. Entry screening will give you a picture of the virus, but what is most important is to provide air passengers with comprehensive information.

WHO: Faced with the political reality vs. the public health logic it is inevitable that situations such as border closures will arise.

US (Dr. Rutz): We need to consider the fine line communicators must walk between political realities and basis in scientific fact. For example, the implementation of thermal scanners at airports is of little scientific benefit, but it makes for great theater.

UK (Dr. Lightfoot): It is very difficult to translate border controls, exit/entry screening, etc., into effective results, although it is a fact that there may be media pressure for such response measures, which serve to raise expectations that are too high.

Co-Chair (Germany): We must bear in mind that we are communicators and we may sometimes have to communicate information that is made on the basis of political decisions with no basis in scientific fact. That is a reality we have to live with.

UK (Dr. Graham): In the UK we made efforts to show coverage of vaccines in cool storage as a means of boosting public confidence.

UK (Dr. Lightfoot): It might be a good idea to go back to the Pandemic Influenza Working Group and ask what stage they have reached in discussing such issues and what their positions are on masks, border closures, etc.

Co-Chair (Germany): I think that is a very good idea.

US (Dr. Rutz): The practical approach that Dr. Riedmann has just spoken about is very sobering. I think it is important that as communicators we tell our political leaders about the risks involved in implementing certain measures.

France: We must wait for the results of evaluations on the spread of the virus depending on the measures taken by various countries. We must proceed with caution.

UK (Dr. Lightfoot): One mystery in the first wave of influenza in Europe was the UK was badly hit, but France was hardly affected at all, despite the fact that in the initial period France had far more arrivals from Mexico than the UK.

Co-Chair (Germany): It is important that we make efforts to explain the differences in how pandemics affect different countries or regions.

UK (Dr. Lightfoot): Would it be a good idea to create some questions to put to the Pandemic Influenza Working Group?

Co-Chair (Germany): Another point that I wanted to cover was the issue of hygiene recommendations as a measure against influenza. Although we have no concrete evaluations, we do have a wealth of experience. From the outset, hand-washing campaigns were available when nothing else (vaccines, etc.) was.

Co-Chair (US): I think we all did a good job in improving hygiene.

France: We have to maintain such efforts in the future.

UK (Dr. Lightfoot): There is scientific evidence for hand-washing, particularly in schools. Hand-washing should become a legacy issue because if everybody continues washing hands it will have a positive impact on public health. We should not return to the old reality, but instead return to a new reality as a good means of responding to future pandemics.

Japan (Mr. Yahata): In the household setting in Japan efforts are being made to encourage hand-washing and gargling.

Co-Chair (US): In the US we have also made efforts to encourage children to wash their hands.

Co-Chair (Germany): Moving on to the topic of vaccinations, one of the major challenges we did not anticipate was concerns about vaccine safety. In Germany there were problems of coordination between the federal/State level and responsibility for implementing policy. It may be the reality that responsibility lies at the State (Länder) level, but the public and the media hold the federal government responsible. Public health regulators were suspected of being too close to vaccine manufacturers and some media critics accused governments of imposing untested vaccines on a wary public. We should have been more forthright in communicating vaccine issues to the public. From our point of view we made some mistakes, but the largest of these was a failure to maintain contact with stakeholders and keep them updated on vaccine information.

Co-Chair (US): In the US we were extremely sensitive to the safety issue, given the 1976 swine flu incident. Past history was a significant factor influencing decision-making in response to this pandemic. Vaccine demand was high in the time until the vaccine became available.

Japan (Mr. Kiuchi): The Japanese government is also sensitive to safety issues. The government did not recommend people to take the vaccine, but ensured that people could have the opportunity to be vaccinated if they so wished. It is important to take into account the various political situations.

Co-Chair (US): If that is so, how did the government respond to questions from the public such as "should I take this vaccine?"

Japan (Mr. Kiuchi): For H1N1, we said that we would provide information, and that the public should decide for themselves.

UK (Dr. Graham): In the UK we were reliant on information from the Joint Committee on Vaccination, and it was difficult for the government to make an outright recommendation for people to receive a vaccination, particularly given that there were not sufficient quantities for the entire population.

Co-Chair (US): That would have been difficult in the US, because it would have been difficult to justify why the US government was buying so many vaccine doses and not recommending their use. Our stance was that we would provide enough vaccine for every American to be vaccinated.

US (Dr. Rutz): Another point in the US was that because the country is so large it created regional differences in vaccine supply and availability. The States looked to the federal government for advice and also implemented policies themselves, including compulsory vaccinations for healthcare workers.

UK (Dr. Graham): It is important to provide detailed information about vaccine ingredients and why they are not dangerous. Vaccine safety was the biggest issue for us and generated many questions.

UK (Dr. Lightfoot): We eventually overcame the concerns over safety by pointing out that the ingredients of the vaccine were safe and were already in common use.

Co-Chair (Germany): I think that people would have been more receptive to vaccinations if the pandemic had been more severe. It is important to have many information sources and other items prepared but it is equally important not to assume that what has been prepared is unchangeable.

UK (Dr. Graham): We spent a great deal of money on campaigns. We also had a mass stockpile of paper to enable us to distribute flyers door to door, if it had been required. I am not saying that we should spend inordinate amounts of time on preparing information, but it is very often small items of information that are most persuasive (vaccine ingredient information, for example).

US (Dr. Rutz): What happens if we get another H1N1 wave? Is our credibility now so strained that we would have problems in responding to a near-future flare up of H1N1?

Co-Chair (Germany): I think that if we talk about future pandemics it must be made absolutely clear that it would be another, separate pandemic, because this one is not yet over.

US (Dr. Rutz): One of the things we have talked about is about how our credibility has already been strained and how we should deal with that.

Co-Chair (US): We know that many people did not get vaccinated because of the mildness of the pandemic and fears over safety. We must address the problem of credibility.

WHO: There are limits to what risk communication can achieve.

UK (Dr. Lightfoot): Influenza viruses are unpredictable. H3N2 has not appeared this year. We are expecting H1N1 to be the seasonal influenza next year, as more people will have antibodies, although it will still be different from standard seasonal influenza, which affected the elderly, whereas H1N1 does not. The next wave of seasonal influenza is in May in the Southern Hemisphere and this would provide an excellent opportunity to regain some credibility when the next season comes around in the Northern hemisphere. We are considering issuing an advisory that anyone traveling to the Southern hemisphere should get vaccinated.

If this had been a very severe pandemic, you would have found that the UK and other countries had got an order in at an early stage for vaccines for the entire population, whereas other countries had none. The question is how to work with the WHO to ensure better levels of equality.

Break

Co-Chair (Germany): For your information, Dr. Härtl has informed us that the WHO will begin its review in mid-April. The review process of the EU is ongoing and an evaluation of the response and of vaccine strategies is currently being implemented. In early July there will be a large conference, hosted by Belgium, focusing on four topics for H1N1, one being communication.

Returning to our discussions I would ask you to provide your opinions on what we would do differently in the future, either within the network or related to H1N1 response.

Co-Chair (US): One thing that we observed on multiple occasions was that the challenges were different for each country, and in retrospect this was due to the fact that the pandemic behaved differently in these different countries.

US (Dr. Rutz): We need to be very careful about criticizing other people's decisions, as situations vary from country to country.

Co-Chair (Germany): I think we have already stated certain issues that implicated that we would do certain things differently. In order to get an overview I would suggest that we go round the table to enumerate the measures we would approach in a different way.

UK (Dr. Lightfoot): I sometimes feel we were a little bit slow in responding to this pandemic. Last year on March 12 we had a telephone conference and Mexico first mentioned that it had widespread incidence of influenza. By March 22 a number of persons had died in Mexico. On April 18 H1N1 was identified by the US. If this were to be replayed again I would seek to send a multi-disciplinary team into the source country, including a communications team, because information gathering and provision at the earliest stage is critical.

Co-Chair (US): I agree entirely with what you have said about the importance of communication in the early stages.

Co-Chair (Mexico): I think that we were very lucky that Mexico was a member of the G7+ grouping.

US (Dr. Rutz): The International Health Regulations (IHR) give us a mechanism to bring colleagues into a situation at the very first sign of trouble.

WHO: We have a screening process where we get things in from all over the world. IHR is a formal mechanism and countries tend to be reluctant to use it. We have a variety of informal networks that we can utilize, including GHSAG. In the case of this pandemic it would not have been possible to use the IHR early in the emergence of the pandemic.

In terms of action items, I would like to suggest the usefulness of telephone conferences, even very short ones for keeping everyone up to date on the latest development.

Co-Chair (Germany): I would like to ask you all for one item that you would change as you look back on our response to the current pandemic.

France: I would like to ask Dr. Hall about his opinions on table-top exercises, bringing the media into the planning and response process.

Co-Chair (US): In the experience of the US the table-top exercises were highly successful in helping journalists understand underlying issues better. These exercises helped both side

(public health and media) learn about each others' needs and expectations. Exercises had the additional benefit of educating reporters about vaccine adverse events.

Co-Chair (Germany): It is important to bear in mind that the tabloid media in particular will act against you if they have decided to do so. I do not see much hope in attempting to persuade the entire media to provide on-message reporting.

US (Dr. Rutz): By and large health reporters have a conscience and if you attempt to help them understand what you are aiming to achieve they will generally work with you.

France: I think table-top exercises are more useful and persuasive than using ministry press conferences, which some people may be wary of.

Co-Chair (US): In our case, the content of all these table-top exercises is entirely off record. They are exercises that are based on trust and a free exchange of opinions between government and journalists.

Co-Chair (Germany): I would now like you to respond to the question of what you would do differently in the event of a future pandemic. My point is to improve media relationships.

UK (Dr. Graham): My point would be "don't wait for the WHO to declare a pandemic." Speedy reactions are vital when dealing with communications.

UK (Dr. Lightfoot): The WHO pandemic phases are important for legal reasons.

Japan: Communication among all government bodies is also very important, not just within health ministries.

US (Dr. Hall): The one thing we would like to do more of is to engage in outreach to local media. H1N1 pandemic in the US was managed by the federal government. However, once the vaccination program began it became a state issue. Each state/territory had a different vaccine distribution program and these differences led to report confusion. It is therefore essential to build relationships with local media.

Germany: Another thing we must address in the future is "uncertainty." We must be upfront about what uncertainty exists and explain planning assumptions, the rationale for current decisions and apparent discrepancies. Transparency is also important.

France: Coordination between politicians and technical communication is also vital. Another point is better communication between public health officials and health professionals. There is a need for more face-to-face interaction.

Co-Chair (Germany): I would now like to ask for your expectations for the GHSAG Network and what we should change.

France: For technical subjects the network works quite well. What is missing is sometimes efforts to consider strategy in greater detail. We are usually so busy with other tasks we never stop to think about strategy.

US (Dr. Rutz): If we are faced with another pandemic we may not have the time to provide further assistance to each other and it is important to consider this realistically. It may be advisable to establish a vehicle for sharing information.

UK (Dr. Lightfoot): I think that we have established this network as a trusted body and it is therefore simple for us to contact each other via telephone. This telephone contact needs only to be systemized.

WHO: My experience of the acute phase was that the media issues were relatively simple. It was later when it was necessary to do more talking. If we get into another acute phase there is probably no necessity to talk every day, or if so, only briefly.

UK (Dr. Lightfoot): This network was invaluable for collecting information and sharing with each other. One idea is to implement a "bird-table" style telephone conference where participants only speak if they have information to share. This would keep the telephone conference very short and provide valuable information efficiently.

Co-Chair (Germany): These types of calls are valuable for discussing and understanding trends, including escalation, resolution and important changes.

US (Dr. Rutz): Such a brief conference call could comprise a predetermined template, for example:

- "heads up" – warn network of issues you are dealing with that may affect them;
- "quick wins" – solutions to a problem that worked well;
- "appeal for help" – seek counsel on difficult issues; and
- "trends" – escalation, resolution, important changes in circumstances.