Training Workshop on Adverse Events Following Immunization (AEFI) Causality Assessment and Communication Capacity Building for Immunization

12–16 May 2014
Manila, Philippines

World Health Organization
Western Pacific Region
Participants of the Training Workshop on Adverse Events Following Immunization (AEFI) Causality Assessment and Communication Capacity Building for Immunization, 12-16 May 2014, Manila, Philippines
REPORT

TRAINING WORKSHOP ON ADVERSE EVENTS FOLLOWING IMMUNIZATION (AEFI)
CAUSALITY ASSESSMENT AND COMMUNICATION
CAPACITY BUILDING FOR IMMUNIZATION

Convened by:

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NOTE

The views expressed in this report are those of the participants in the Training Workshop on Adverse Events Following Immunization (AEFI) Causality Assessment and Communication Capacity Building for Immunization and do not necessarily reflect the policies of the World Health Organization.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for the participants in the Training Workshop on Adverse Events Following Immunization (AEFI) Causality Assessment and Communication Capacity Building for Immunization, which was held in Manila, Philippines from 12 to 16 May 2014.
SUMMARY

The immunization landscape has changed in recent years. The use of vaccines in the World Health Organization (WHO) Western Pacific Region is also expanding, as new vaccines are being developed and becoming available. Immunization programmes are implementing large-scale activities to achieve regional goals and targets. Though vaccines are among the safest of pharmaceuticals, occasional or clusters of adverse events do occur and may threaten the acceptability of immunization programmes.

A surveillance system for adverse events following immunization (AEFI) is established in most Member States but the quality and performance of these vary across the Region. A national expert committee on AEFI causality is established in most Member States; however, guidance is needed to periodically review cases and conduct a formal causality assessment. Recent vaccine safety issues and responses in some Member States have highlighted the importance of having quality surveillance mechanisms for AEFI in countries of the Region.

Effective communication of the benefit of vaccines and vaccination is an essential component of successful immunization programmes, including for increasing coverage. In spite of vaccines having an enviable benefit and safe track record, in many countries, concerns about vaccines and immunization programmes appear to be rising.

A training workshop on “Adverse events following immunization (AEFI) causality assessment and communication capacity building for immunization” was held in Manila, Philippines, from 12 to 16 May 2014. A total of 34 participants from nine Member States of the Region attended the training.

At the end of the workshop, participants should:

1. have understood the causality of AEFI and acquired the relevant skills to develop and/or strengthen causality assessment for AEFI in Member States;
2. have acquired the skills needed to communicate effectively about immunization;
3. reviewed the findings of the communication capacity assessment and developed national action plans; and
4. have discussed and considered the engagement of and collaboration with different stakeholders on developing action plans.

The first two days of workshop (12–13 May) were dedicated to AEFI causality assessment and the last three days (14–16 May) to communication capacity building for immunization. Dr Mark Jacobs, Director, Combating Communicable Diseases, delivered the opening remarks on behalf of Dr Shin Young-soo, WHO Regional Director for the Western Pacific. The workshop consisted of a mixture of plenary sessions, group work and role plays, and was facilitated by staff from WHO headquarters and the Regional Office for the Western Pacific.

The AEFI training was focused on developing or strengthening the quality of the AEFI causality assessment in Member States. On day 1 of the AEFI part of the workshop, definitions and classifications of AEFI, investigation and the causality assessment scheme were presented and discussed in detail. Group work exercises were also conducted. A set of core variables was developed by WHO and shared with participants to compare with their national investigation forms in the group work. Three Member States – China, Japan and Viet Nam – shared their experiences of and lessons learnt on responses to vaccine safety incidents in their countries. The
The sessions on day 1 focused on establishing the principles, and delineating personal expectations for a high-challenge and low-risk learning environment. Participants were provided with an update and progress on regional capacity-building efforts for risk and crisis communication under the Asia Pacific Strategy for Emerging Diseases (APSED). Experiences and lessons learnt were shared from immunization programmes for human papillomavirus (HPV), maternal immunization for influenza and polio, as well as an orientation on available resources of the Expanded Programme on Immunization (EPI) for communication in the Region. Next, the global and national context was set for the training workshop through presentations. The results of the national communication system assessments were shared and discussed. The day concluded with an exercise that established the common challenges currently being faced by national immunization programmes.

Day 2 began with an appreciation of the systemic and complex challenges being faced by national immunization programmes that have decreased immunization coverage rates and increased vaccine hesitancy. A new paradigm for public health communication was introduced, founded upon communication as a complex science and from a health systems perspective. It was recognized that engaging with the public in ways that build trust in immunization programmes was different in a twenty-first century communication environment. The skills-building session introduced essential communication skills in preparation for a long case study where an opportunity was provided to apply these skills.

The long case study continued on day 3 and focused specifically on stakeholder and media engagement. The day concluded with a wrap-up of the work so far, followed by a session that looked into the future to identify short-, medium- and long-term investments needed for a communication system that contributes to immunization programmes. The workshop ended with an evaluation and closing remarks by Dr Sergey Diorditsa, Expanded Programme on Immunization (EPI) Team Leader in the WHO Regional Office for the Western Pacific.
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AEFI</td>
<td>Adverse Events Following Immunization</td>
</tr>
<tr>
<td>AFP</td>
<td>Acute Flaccid Paralysis</td>
</tr>
<tr>
<td>APSED</td>
<td>Asia Pacific Strategy for Emerging Diseases</td>
</tr>
<tr>
<td>CDC</td>
<td>Center for Disease Control and Prevention</td>
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<tr>
<td>CFDA</td>
<td>China Food and Drug Administration</td>
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<td>CIOMS</td>
<td>Council for International Organizations of Medical Sciences</td>
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<tr>
<td>EPI</td>
<td>Expanded Programme on Immunization</td>
</tr>
<tr>
<td>FAQ</td>
<td>Frequently Asked Question</td>
</tr>
<tr>
<td>FDA</td>
<td>Food and Drug Administration</td>
</tr>
<tr>
<td>GACVS</td>
<td>Global Advisory Committee on Vaccine Safety</td>
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<td>GAP</td>
<td>Global Action Plan (for Vaccines)</td>
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<tr>
<td>HPV</td>
<td>Human Papillomavirus</td>
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<tr>
<td>IHR</td>
<td>International Health Regulation</td>
</tr>
<tr>
<td>NHFPC</td>
<td>National Health and Family Planning Commission</td>
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<tr>
<td>NIP</td>
<td>National Immunization Programme</td>
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<tr>
<td>OPV</td>
<td>Oral Polio Vaccine</td>
</tr>
<tr>
<td>SIDS</td>
<td>Sudden Infant Death Syndrome</td>
</tr>
<tr>
<td>SOCO</td>
<td>Single Overarching Communication Objective</td>
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<td>WHO</td>
<td>World Health Organization</td>
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ANNEX 2 TIMETABLE

Keywords:

Immunization/Vaccination/Communication/Capacity building/Risk management
1. INTRODUCTION

The Training Workshop on Adverse Events Following Immunization (AEFI) Causality Assessment and Communication Capacity Building for Immunization was held in Manila, Philippines, from 12 to 16 May 2014. A total of 34 participants from nine Member States attended the training.

1.1 Objectives

At the end of the workshop, participants should have

1. understood the causality of AEFI and acquired the relevant skills to develop and/or strengthen causality assessment of AEFI in Member States;

2. acquired the skills needed to communicate effectively about immunization;

3. reviewed the findings of the communication capacity assessment and developed national action plans; and

4. discussed and considered the engagement of and collaboration with different stakeholders on developing action plans.

1.2 Opening remarks

Dr Mark Jacobs, Director, Division of Combating Communicable Diseases, World Health Organization (WHO) Regional Office for the Western Pacific, delivered the opening remarks for both training workshops on behalf of Dr Shin Young-soo, WHO Regional Director for the Western Pacific.

Dr Jacobs stated that the immunization programme is one of the most cost-effective interventions in reducing mortality and morbidity. Over the years, this programme has grown tremendously to meet the demand in Member States.

In the Western Pacific Region, surveillance systems for AEFI are established in most Member States but the quality of these and their performance varies from country to country and within countries. WHO has been playing a strong role in helping Member States to build capacity in the AEFI surveillance system. Recently, WHO updated the definitions and classifications of AEFI, developed a set of core variables and revised the AEFI causality assessment scheme. The WHO Regional Office for the Western Pacific also extensively updated the immunization safety surveillance guidelines, which are now widely used in countries, both within and outside the Region.

Dr Jacobs emphasized that goals and targets have been set for immunization programmes in the Region. Effective communication of the benefits of vaccination is essential to increase coverage and reach these goals and targets. Issues regarding vaccine confidence, complacency and convenience can lead to less-than-optimal immunization coverage, resulting in the inability to reach the level of herd immunity needed to prevent certain diseases and reach the Region’s goals and targets.

He further stated that this training workshop would help to build the necessary capacities in AEFI causality assessment and the communication aspects of immunization programmes. These skills will help key staff to conduct causality assessment and communicate more effectively – both internally and externally – during a crisis.
2. PROCEEDINGS

2.1 Adverse events following immunization (AEFI) causality assessment

2.1.1 Expectations and overview of the training

Dr Md Shafiqul Hossain, Technical Officer, Expanded Programme on Immunization (EPI), WHO Regional Office for the Western Pacific, presented an overview of the AEFI causality assessment part of the workshop. Dr Hossain explained the reasons for emphasizing only on causality assessment of the AEFI surveillance system and described the design of the training modules. He then shared the two-day agenda with the participants.

2.1.2 Vaccine safety incidents and causality assessment process

Dr Koji Nabae, Deputy Director, Ministry of Health and Labour Welfare, Japan presented vaccine safety incidents associated with human papillomavirus (HPV) in Japan. Due to restriction in sharing information, the details of the presentation are not given in the meeting report.

Ms Xu Disha from the Center for Disease Control and Prevention (CDC), China presented vaccine safety incidents associated with the hepatitis B vaccine in 2013/14 in China. Ms Disha described the AEFI surveillance system, causality assessment committee and causality processes in China.

A total of 18 AEFI cases were reported from November to December 2013. The national AEFI committee was involved during the investigation and causality assessment processes. WHO experts were also invited to join the investigation. After a thorough investigation, one case was found to have anaphylaxis, probably due to hepatitis B vaccine (vitamin K1 cannot be ruled out), and 17 cases were coincidental.

Ms Disha mentioned that the Government of China has established a working group consisting of the China Food and Drug Administration (CFDA) and National Health and Family Planning Commission (NHFPC) for AEFI incidents. The following actions were taken immediately after the incidents.

1. The vaccine was suspended.
2. The two batches of vaccines involved (C201207088 and -90, Bio Kangtai) were suspended on 13 December 2013 (day 1).
3. All hepatitis B vaccines manufactured by Bio Kangtai were suspended on 20 December 2013 as case reports were accumulating.
4. A field investigation and factory inspection were conducted.
5. Staff was sent to Hunan (where the cases occurred) and Guangdong (where Bio Kangtai is located).
6. Raw materials, production procedure, quality control, etc. were inspected by national and provincial Food and Drug Administration (FDA) inspectors.
7. Intensive AEFI surveillance and daily data analysis were conducted.
8. Official guidance was provided on hepatitis B vaccination.
Vaccine coverage was monitored.

She mentioned that for communication purposes, two joint press conferences were held by the NHFPC and CFDA on 24 December 2013 and 3 January 2014. Moreover, interviews and special programmes were aired on the State TV and frequently asked questions (FAQs) were issued on the official websites of NHFPC and China CDC.

Some other follow-up actions were taken, such as a survey of public confidence in the hepatitis B vaccine and popular science features via websites or social networks.

Dr Nguyen Van Cuong, National EPI Manager, Viet Nam shared the experiences of vaccine safety incidents associated with the pentavalent vaccine in 2012/2013 in Viet Nam.

Dr Cuong mentioned that the provincial AEFI committee conducts the causality assessment and reports to the higher level of the Ministry of Health. The national AEFI causality committee conducts a causality assessment of those incidents in which the provincial committee has not been able to reach a conclusion. It provides quality control and feedback on the functioning of the system.

A total of 43 cases were reported; 27 died and 16 recovered. After thorough investigation and causality assessment, the causality committee classified the incidents as given below.

<table>
<thead>
<tr>
<th>Classification</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consistent due to vaccine product-related reaction</td>
<td>9 (no death)</td>
</tr>
<tr>
<td>Inconsistent due to underlying or emerging conditions, or conditions caused by exposure to something other than vaccine</td>
<td>17 (14 deaths)</td>
</tr>
<tr>
<td>Indeterminate (unclassifiable) due to inadequate information</td>
<td>17 (13 deaths)</td>
</tr>
<tr>
<td>Total</td>
<td>43 (27 deaths)</td>
</tr>
</tbody>
</table>

A response was given, including in the mass media at the provincial and national levels. The National Immunization Programme (NIP) also participated in the interview with the media and provided information related to AEFI cases.

Dr Cuong concluded by stating the following challenges faced by Viet Nam:

1. Lack of training in risk communication
2. Limited information on AEFI cases
3. Preparing a communication strategy and materials for the public (media), healthcare workers and decision-makers.

2.1.3 Concepts and definitions

Dr Michael Steven Gold, Temporary Adviser to this workshop and member of the Global Advisory Committee on Vaccine Safety (GACVS), presented the concepts and definitions of AEFI. Dr Gold described the life cycle of a vaccine and national regulatory functions in terms of sources of vaccine procurement.

He shared the new definition of AEFI and pharmacovigilance. The definition of an AEFI is any untoward medical occurrence which follows immunization and which does not necessarily
have a causal relationship with the usage of the vaccine. The adverse event may be any unfavourable or unintended sign, abnormal laboratory finding, symptom or disease.

Dr Gold then described the difference between vaccines and drugs. He also shared the WHO/Council for International Organizations of Medical Sciences (CIOMS) cause-specific types of AEFI with examples and photographs.

These include the following:

1. Vaccine product-related reaction
2. Vaccine quality defect-related reaction
3. Immunization error-related reaction
4. Immunization anxiety-related reaction
5. Coincidental event.

In conclusion, Dr Gold provided definitions of causality, causality assessment, serious and severe cases, clusters, and so on.

2.1.4 Investigation of AEFIs

Dr Abdoureza Esteghamati, WHO Consultant, delivered a presentation on investigation of AEFI cases. In his presentation, he first stressed on the importance of investigation. He then described the cases that should be selected for investigation, and when and who to investigate. He mentioned that preparation has to be made prior to the investigation.

Dr Esteghamati detailed five steps in the process of investigation of AEFI cases:

1. Confirm information in report.
2. Investigate and collect data.
   (a) about the patient;
   (b) about the event;
   (c) about the suspected vaccine(s); and
   (d) about other people.
3. Assess the immunization service by:
   (a) making enquiries; and
   (b) observing the service in action.
4. Collect specimens when applicable
   (a) from the patient; and
   (b) of the vaccine.
5. Conclude investigation.
Laboratory testing may sometimes confirm or rule out the suspected cause but should be done on a clear suspicion and not as a routine, and never before a working hypothesis has been formulated.

Dr Esteghamati concluded by saying that suspending vaccination totally is rarely necessary but it may be necessary to suspend vaccination temporarily pending the outcome of investigation, e.g. a serious immunization error.

2.1.5 Investigational framework for AEFI clusters

Dr Esteghamati presented the investigational framework for clusters of AEFI. Cluster investigation begins by establishing the case definition and identifying all cases that meet the case definition. He described many scenarios with examples of how to investigate AEFI clusters.

When an AEFI cluster has been identified, cause-specific definitions provide a framework for investigation and causality assessment. Usually, the key considerations will be to investigate the possibility of a vaccine quality defect as well as whether an immunization error has occurred. For relatively new vaccines or established vaccines used in new target populations, a cluster may represent a previously unrecognized vaccine product-related reaction. Knowledge of the background incidence of events that may occur in causal relationship with a vaccine is, therefore, essential for assessing a cluster in terms of the strength of the signal it may provide.

Participants were then divided into six groups for group work on investigation by using WHO-developed scenarios of AEFI cases. At the end of the group work, the rapporteurs of the groups presented in the plenary session.

2.1.6 AEFI causality assessment

Dr Madhava Ram Balakrishnan, Medical Officer, Department of Essential Medicines and Health Products, WHO headquarters, began by reviewing the definition and types of AEFI again with participants.

Causality assessment is the systematic review of individual or population data about an AEFI case to determine the likelihood of a causal association between the event and the vaccine/s received. He highlighted the importance of causality assessment for AEFI.

Causality assessment is important for:

1. identification of vaccine-related problems;
2. identification of immunization error-related problems;
3. excluding coincidental events;
4. detection of signals for potential follow up, testing of hypothesis and research;
5. provision of a basis for estimation of rates of serious AEFIs;
6. comparison of AEFIs between vaccine brands; and
7. validation of pre-licensure safety data with comparison of post-marketing surveillance safety data.
Dr Balakrishnan described the prerequisites for causality assessment:

1. The AEFI case investigation should have been completed.
2. All details of the case should be available at the time of assessment.
3. There must be a "valid diagnosis". The valid diagnosis refers to the extent to which the unfavourable or unintended sign, abnormal laboratory finding, symptom or disease is defined.

He described the steps of causality assessment with examples:

Step 1: Eligibility - to determine if the AEFI case satisfies the minimum criteria for causality assessment

Step 2: Checklist - to systematically review the relevant and available information to address the possible causal aspects of the AEFI

Step 3: Algorithm - to obtain a direction as to the causality with the information gathered in the checklist

Step 4: Classification - to categorize the AEFI's association with the vaccine/vaccination based on the direction determined in the algorithm.

Dr Balakrishnan mentioned that in case multiple vaccines have been used during the same AEFI, each vaccine should be assessed separately. If there are multiple AEFI in one patient, each event should be listed separately and a specific eligibility question (step 1) asked and independently evaluated. He concluded by saying that the quality of the causality assessment depends on factors such as the effectiveness of the reporting system and the quality of the causality review process.

2.1.7 AEFI causality assessment – definition and case studies

Dr Esteghamati mentioned that case selection for formal causality assessment is very important. WHO suggests that any serious AEFI, clusters and events above the expected rate/severity, significant events of unexplained cause within 30 days of vaccination and other AEFI cases such as events causing significant parental or community concern should be sent for causality assessment.

Dr Esteghamati described two case studies on causality assessment; meningococcal conjugate vaccine and seizures, and oral polio vaccine (OPV) and acute flaccid paralysis (AFP). He also provided many practical examples in relation to the case studies.

Participants were then divided into six groups for group work on a short case study and a long case study. At the end of the two group work sessions, the rapporteur of each group presented the findings in the plenary session.

2.1.8 Approach to AEFI causality assessment

Dr Michael Steven Gold presented an approach to causality assessment. He provided death scenarios in different categories of the causality assessment and reviewed along with the participants following the causality assessment classification.

Dr Gold also described the approach to causality assessment in cases of suspected anaphylaxis and suspected sudden infant death syndrome (SIDS) following immunization. He provided many references and practical examples related to the cases.
2.1.9 AEFI causality assessment – follow-up actions

Dr Balakrishnan said that follow-up activities should be based on the findings of investigations, causality assessments and recommendations by investigation/expert committees. Major follow-up actions may have an impact on the national immunization programme as well as on regional and global programmes and planning. He explained the importance of follow-up based on the findings of the causality assessment. Follow-up actions prevent additional cases from occurring, ensure/enhance the safety of immunization programmes, promote transparency and accountability, and reduce political and economic implications.

The general principle of follow-up action is to treat the patient, take local corrective actions according to the available data/information, communicate early to the patient, media and others, and inform various stakeholders. However, if necessary, specific actions should also be taken after AEFI classification.

At the end of this session, participants were divided into nine groups to review the draft guidelines for vaccine safety communication.

2.2 Communication capacity building on immunization

2.2.1 Expectations

Ms Asiya Ismail Odugleh-Kolev, Technical Officer, Capacity Assessment, Development and Maintenance, WHO headquarters, described (i) the objectives of the workshop, (ii) the workshop process and methodologies, and (iii) the expected outputs. She emphasized that the training had been specifically designed to be centred around the participant’s needs, knowledge and skills, and that each session and each day progressively built upon the previous one. Participants would be expected to demonstrate skills acquisition and application, develop their own personal plans for continuing skills development, and establish next steps to strengthen the capacity of their communication systems for immunization programme. Ms Odugleh-Kolev gave a summary of what each day would comprise. This was followed by an introduction of the trainers and facilitators.

2.2.2 Establishing ground rules

Ms Claudia Nannei, Technical Officer, Public Health, Innovation and Intellectual Property, WHO headquarters, led participants through an exercise to establish common ground rules that would ensure that participants and facilitators co-constructed an optimum learning environment that was “high challenge, low threat and safe”. It was important for participants to be fully involved in the process and able to ask questions, contribute from their own experience and learn from others.

2.2.3 Personal learning objectives

Ms Odugleh-Kolev led participants through an exercise to identify specific learning objectives. Each participant was given a work sheet in which they were asked to identify personal learning objectives for what they wanted to “know”, “feel” and “do” at the end of the workshop. Opportunity was provided for individuals to share their learning objectives in the plenary. The following is a summary of the group objectives:

**I want to know:** good strategies for communicating adverse events following immunization, best practices from other countries, how to engage with stakeholders, the process of communication, how to approach anti-vaccine groups, how to engage with community members, how to explain to mothers about immunization and AEFI.
I want to feel: satisfied about the training, confident in communicating about AEFI, relieved that the process is over and confident because of my newly learned skills, improve my skills/capacity to communicate for EPI.

I want to do: review communication plans and adjust them according to new knowledge, take the new knowledge back to my colleagues/country EPI staff, have the possibility to develop a workshop for my colleagues on communication for immunization.

The evaluation at the end of the training was linked to these objectives to see how well the training helped them achieve their personal objectives.

2.2.4 Regional communication capacity-building initiatives

Ms Joy Rivaca Caminade, Risk Communication Officer, Emerging Disease Surveillance and Response, WHO Regional Office for the Western Pacific, gave a presentation on the capacity-building work being done under the umbrella of health security and the International Health Regulations (IHR, 2005) to help Member States develop risk communication capacities to deal with natural and human-induced disasters. This is currently being carried out under the Asia Pacific Strategy for Emerging Diseases (APSED), which has raised the profile of risk communication and encourages countries to establish three communication functions: (1) operational communication, (2) health emergency communication, and (3) behaviour change communication.

2.2.5 Group exercise

Participants were asked to individually think of an immunization programme that had been particularly challenging and to think of as many obstacles/challenges that had blocked its launch, success or progress. They were then asked to share their lists with others in the group and to identify the most common ones, writing one challenge on each coloured post-it note. The groups then placed their post-it notes on a wall chart where they were shared, discussed and clustered together. This exercise identified and prioritized risk and crisis communication challenges faced by immunization programmes in the Region. This provided the context and driver for building capacity in immunization communication in Member States.

Challenges identified by participants: the public (losing confidence in vaccines, disbelief in government statements, poor knowledge of parents, difficulties in explaining new vaccine technology, lack of mother’s awareness of the benefits of immunization, public has little
tolerance of AEFI, public anger); minorities (remote areas, vulnerable and hard-to-reach groups, sociocultural diversities of many tribes, migrant populations); health systems (capacity of the health facility at the community level, rapid turnover of personnel, unfriendly health workers, poor skills for communicators, change of leadership/management); stakeholder coordination (relationships with related organizations, lack of coordination between experts in various fields, coordination among stakeholders when implementing new vaccines); resources (funds, limited budget, complacency); media (rumours during campaigns, sensationalism by journalists); lobbyists (anti-vaccine groups).

2.2.6 Communication to support vaccination

A series of presentations were given, showing examples and lessons learnt from immunization programmes: HPV, Dr Kimberly Fox, Technical Officer, EPI, WHO Regional Office for the Western Pacific; Influenza maternal immunization, Dr Justin Ortiz, Technical Officer, WHO headquarters; and Polio end-game strategies, Ms Liliane Dalila Boualam, Technical Officer, EPI, WHO Regional Office for the Western Pacific. Dr Hossain gave a presentation on EPI resources for communication available in the Region.

2.2.7 Global and national context of immunization communication systems

Two presentations provided the background for the training workshop. The first presentation by Ms Nannei provided an overview of the Global Action Plan for Vaccines (GAP) and feedback from the last global workshop supported by GAP. This was on influenza communication and took place in Atlanta in June 2013. This meeting brought together a wide cross-section of stakeholders and the output was a framework that described essential building blocks for a national communication system that is able to support improvements in influenza vaccine coverage. The Atlanta framework highlighted the complexity of communication as a system of interconnected interactions and relationships between people within and external to the health system. It stressed the need for different communication specialties and that a “one-size-fits-all” approach is not helpful. There is a need for a senior level of strategic communication thinkers and planners to bring the various communication elements into a coherent framework.

The next presentation by Professor John Chetro-Szivos, WHO Consultant, gave feedback from the national-level surveys (based on the Atlanta framework) conducted in four Member States of the Region. The surveys were carried out prior to the training workshop. In summary:

(1) Key building blocks of a communication system appear to be in place at the national level.

(2) There is a need for more responses.

(3) Progress has been made; however, there is room to strengthen the key building blocks of communication system/cross-cutting functions to support immunization efforts.

(4) This kind of research is critical to know where we can make a difference. The research tool must be adapted and translated into the local language for it to be effective.
2.2.8 Group exercise part 1

Participants were asked to work in their country groups. For each of the building blocks (categories) identified in Atlanta, they were asked to identify 3–5 issues that they felt were important and needed to be addressed. The purpose of this exercise was to validate the survey findings from the countries that provided data and to provide an opportunity for those countries that did not do the surveys to assess their own communication gaps. The findings from the group work were discussed in the light of the challenges identified by the group in the morning exercise, as there should be a correlation between them.

2.2.9 Group exercise part 2

Participants were asked to think of their communication system as a living system and to choose a person or animal that symbolized how well their communication system for immunization was working. They were then asked to draw it as a picture. This exercise was linked to the previous exercise and deliberately used metaphor or simile as a device to encourage new insights and stimulate out-of-the-box thinking.

2.2.10 Communication as a complex science

Professor John Chetro-Szivos, WHO Consultant, gave a presentation on the latest scientific findings, evidence and trends in the discipline of communication. Professor Chetro-Szivos spoke about how communication is the primary social process. Not only does communication play a role in brain construction, but every conversation also has an afterlife, and through reflexive action, constructs reality as we understand it.

2.2.11 Health systems in relation to routine and emergency immunization

Following on from the communication science presentation, Ms Odugleh-Kolev gave a presentation that applied the current scientific thinking to public health communication and immunization. She underlined the importance of focusing on a national communication system. When we view health systems and immunization programmes as being linked and supported by an underlying network of relationships and interactions within and between service providers and service users, we can get a better sense of where we need to improve communication. This goes beyond an approach that focuses only on a “shopping list of interventions” delivered to various audiences and media messaging.

2.2.12 Skills building and preparation for case study

Professor Chetro-Szivos led this session as a preparation for the role-playing sessions in the long case study. He highlighted several important concepts:

(1) Recognition of a level of interdependence with others. Communication is a shared activity. It is not what I say; it is what we do together.

(2) A recognition that our implicit theory of communication may leave us unable to think of communication in another way.

(3) Joint action tells us that what one person is thinking is not as important as the patterns of interaction between people.

(4) Joint action is engagement with others, which requires an understanding of wholeness, coordination and willingness to engage in dialogue, where we listen and speak with our whole being, fully aware that we are creating a moment of interaction with another.
Professor Chetro-Szivos conducted an activity that demonstrated these notions. He asked participants to work in pairs and to each draw a picture together without speaking. This activity underscored that in order to draw a coherent picture together, we communicate a lot, even when we do not talk. In fact, we cannot afford not to communicate. Professor Chetro-Szivos spoke about patterns of interaction, the context of communication and recognition of context markers, and how to ask questions in ways that are constructive and logical.

Participants were asked to take these concepts and apply them in the long case study, which placed in them situations where they had to use their communication skills, knowledge and tools to develop a communication strategy for an immunization programme in a fictitious country.

2.2.13 Long case study

The long case study was set in a fictitious country in Asia. Participants were divided into four groups and they were given the role of a multidisciplinary team from the Ministry of Health in Cosmopolis. The team had been asked by the Health Minister to develop a communication strategy for the influenza immunization programme targeting health-care workers and pregnant women. The Minister was particularly concerned because a previous measles campaign had been associated with AEFI and communities had been rejecting vaccines. Facilitators were given roles and scripts in the scenario.

Pre-planning

Participants were taken through several exercises that began with pre-planning. They were asked (i) to identify major concerns and why these were concerns; (ii) to take stock of the information they had and what was missing for them to be able to design an appropriate strategy; and (iii) to identify immediate steps and priority actions.

Community-level communication

Following the pre-planning, participants were provided with the opportunity to carry out primary research and go into the community and talk to people to collect information. They interviewed key members of the community, e.g. midwife, pregnant woman and her family, village leader, local media, etc.

The next step was to provide participants with time to make sense of the information they had collected, including their observations. They were asked (i) to list all the new information that they had collected and did not know before they went into the community; (ii) to specify the behavioural objective of their communication strategy; and (iii) to describe some key elements of their communication strategy and the activities that would be included in their plan. All the groups presented in the plenary session, where their presentations were discussed and feedback provided by members of their own teams, participants in other teams and facilitators.

Communicating with stakeholders

The teams had been taken through a process to develop a communication strategy that included (i) specific behavioural and communication objectives, and (ii) a strategy to help them achieve their behavioural and communication objectives. Next, participants were asked to engage with different stakeholders who needed to support and contribute to the plan. Each group was assigned a stakeholder and asked to meet with their stakeholder and make a presentation to convince them to support their communication strategy and to agree to commit their support. They were given the following stakeholders: health-care workers, policy-makers, a women’s association (nongovernmental organization) and an anti-vaccine group.
Teams were asked to work on this overnight and given more time in the morning of the following day to finalize their presentations. Each team presented to their “stakeholder” in a role-play situation in the plenary. After they had finished, they were provided with time to reflect upon and discuss how they had done. Key learning from the skills development session was reinforced throughout these role plays through feedback from other teams and facilitators.

Communicating with the media

Mr Christian Lindmeier, Acting Public Information Officer, WHO Regional Office for the Western Pacific, gave a presentation on communicating with the media. He spoke about the need to develop a single overarching communication objective (SOCO) and limit messages to not more than three. He stressed the need to say what you know and acknowledge what you do not know, avoid speculation, not lie and stress what you are doing. The groups then did an activity where they developed SOCOs for the scenario. This was followed by a mock press conference for each group conducted in the plenary with cameras. Feedback was provided to each group, stressing what they did well and areas that needed improvement.

2.2.14 Wrap-up and summary

Long case study

Ms Odugleh-Kolev gave an overview of the different activities required to develop a relevant and effective communication strategy, how to communicate the strategy and seek commitment and support from stakeholders. She linked this to best practice and key steps in developing any kind of communication strategy:

1. Identify the preliminary behavioural objectives.
2. Conduct a situational market analysis.
3. Refine the behavioural objectives, and state your communication objectives.
4. Design an overall strategy.
5. Prepare an implementation and monitoring and evaluation plan.
6. Prepare a budget.
7. Implement and monitor the strategy, identify trends and adapt if necessary.
(8) Evaluate to improve performance and give feedback.

The generic steps above would remain the same, but the context may change, depending on the nature and size of the immunization campaign. It became clear that effective communication was needed as the team moved through the steps. Participants explored and practised new ways to ask questions to elicit more informative responses from stakeholder groups within the case study. Questions beginning with “how” provide more robust explanations, and questions with “who, what, where and when” can provide more descriptive information to inform the approach and messaging. For example, asking “why” questions can be leading or accusatory and may place respondents in a defensive position. Participants were asked to explore the different perspectives of stakeholders to better understand how questions could be framed and what types of communication channels could be used.

Through the case study, participants were encouraged to build trust and credibility in every interaction with key stakeholders and the community through the way they communicated and interacted. Even when health officials gather information through surveys and interviews, staff should all be well prepared to answer questions and provide information to the various partners they are working with. Health officials should consider developing and disseminating consistent messages with relevant staff, and anticipate problems and rehearse answers to expected questions. Transparency and openness of communication, along with sincere efforts to build mutually beneficial partnerships can help create a cadre of allies and advocates for the cause.

The lessons learned and reflections on the role-play exercise are expressed in the participants’ own words below:

“Interviews are really important, and it is important to gather information before making decisions. The way we interpret information is based on our own perspective and experiences. We need to bring together health objectives to combine well in the context and perspective of adopting stakeholders.”

“Communication objectives will help you achieve your behavioural objectives, and behavioural objectives help guide your conversations with stakeholders.”

“Communication is about talking to each other to help us plan well. The exercise gave us opportunity to ask questions and connect communication objectives to programme objectives.”

“During interviews – ask ‘how, when, where’, and NOT ‘why’ or simple yes/no questions. These skills are also helpful personal social techniques. For different target groups we should have different objectives and communication approaches. It is important to hear from all stakeholders and rely on them to achieve the health goals and objectives. It is important to understand their perspectives on what methods will succeed.”
2.2.15 Wrap-up of overall training

Ms Caminade synthesized the training of the past three days. She began with a reminder of the training objectives, then gave an overview of the content of each day and finished with the diagram below. This then took participants to the next steps of how to start applying new knowledge, skills and insights at the country level.

2.2.16 Next steps for communication systems strengthening

Participants were requested to work in their country groups for the final exercise. They were instructed: (i) to identify one immunization programme as a starting point for improving communication capacity on immunization; (ii) to identify key external stakeholders and important relationships among these stakeholders; (iii) to identify internal functions/technical teams within the Ministry, which have an important communication role; (iv) to describe key communication inputs/investments needed to improve these external and internal “communicative relationships”, e.g. policies, training, tools, methodology.

Participants were then asked to write the top three communication inputs/investments on post-it notes and to place them against a timeline of short term, medium term and long term. The post-it notes were then positioned on a big wall chart with the nine Member States marked on it. The findings of the exercise were discussed in the plenary session.

Key points from the discussion

Many new ideas and concepts were introduced over the three days. In particular, the concept of understanding immunization communication as a system connected to and supporting immunization programmes to determine and achieve their targets was logical, and made technical and operational sense to the participants. It was clear that participants were excited and eager to
apply such thinking in their own contexts and they acknowledged that this was the beginning of a transformative process.

It was also clear that change would take time and that the partnership and collaboration established at this training between EPI managers, national regulatory authorities and health promotion and communication staff would be critical for making realistic and incremental improvements in communication capacity on national immunization. It was recognized that improvements and investments in communication capacity on immunization has the potential to significantly enhance the performance of all immunization programmes and is essential to improving coverage rates, address hesitancy and mitigate potential crises as a result of AEFIs.

It was agreed that WHO would make available to participants planning templates to help Member States determine how and where to improve their communication systems for immunization based on the actions stated by Member States during this session.

2.2.17 Results of evaluation of the training

<table>
<thead>
<tr>
<th>Did the workshop address communication relevant to you?</th>
<th>About the Same</th>
<th>Improved</th>
<th>Improved Significantly</th>
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<tbody>
<tr>
<td>Strategies for immunization communications is</td>
<td>0%</td>
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<td>50%</td>
</tr>
<tr>
<td>Capacities needed for immunization communications is</td>
<td>0%</td>
<td>58%</td>
<td>42%</td>
</tr>
<tr>
<td>Development/revision of national communication action plans is</td>
<td>0%</td>
<td>77%</td>
<td>23%</td>
</tr>
<tr>
<td>Methods of engaging and collaborating with stakeholders is</td>
<td>4%</td>
<td>38%</td>
<td>58%</td>
</tr>
<tr>
<td>How to explain immunization and AEFIs</td>
<td>0%</td>
<td>69%</td>
<td>31%</td>
</tr>
<tr>
<td>How to approach anti-vaccine groups is</td>
<td>0%</td>
<td>73%</td>
<td>27%</td>
</tr>
</tbody>
</table>

| My feeling of confidence to share communication skills with colleagues and stakeholders is | 0%             | 46%      | 54%                    |
| Confidence to train colleagues about communication and capacity building for immunization is | 0%             | 50%      | 50%                    |

<table>
<thead>
<tr>
<th>To what extent have you improved your understanding of the communication process?</th>
<th>Not valuable</th>
<th>Somewhat valuable</th>
<th>Very valuable</th>
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</thead>
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<tr>
<td></td>
<td>0%</td>
<td>59%</td>
<td>42%</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Rating individual components</th>
<th>Theoretical foundations of communication</th>
<th>0%</th>
<th>54%</th>
<th>46%</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Long case study 1 - Community interviews for strategy development</td>
<td>0%</td>
<td>38%</td>
<td>62%</td>
</tr>
<tr>
<td></td>
<td>Long case study 2 - Media session</td>
<td>0%</td>
<td>35%</td>
<td>65%</td>
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</table>

<table>
<thead>
<tr>
<th>Overall, how would you rate the workshop?</th>
<th>Needs significant improvement</th>
<th>Satisfactory</th>
<th>Exceeded expectations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>42%</td>
<td>58%</td>
</tr>
</tbody>
</table>

3. CONCLUSIONS

Participants were appreciative of the technical content and methodology of both parts of the training. A few Member States had already expressed interest to WHO for technical support and training in strengthening AEFI causality assessment.

Specific Member States also expressed interest to WHO in introducing and establishing a systems approach to public health communication for their immunization programmes.

Suggestions include the following:

1. Adapt and translate the current systems tool for more robust data. This would help to generate a national profile of gaps and strengths, and formulate a national plan of action.
(2) Implement capacity-building interventions for communication in a few vaccination programmes at the subnational level.

(3) Develop, implement and measure the impact of targeted communication training programmes tailored to a range of professional groups.

Dr Sergey Diorditsa, Team Leader, EPI, WHO Regional Office for the Western Pacific delivered the closing remarks. He thanked the facilitators for their hard work and appreciated the wonderful cooperation of the participants during both workshops. The Regional Office would follow up requests by countries for specific activities to build capacity and systems in country.
ANNEX 1

LIST OF PARTICIPANTS, TEMPORARY ADVISERS, CONSULTANTS, OBSERVERS AND SECRETARIAT

1. PARTICIPANTS

CAMBODIA

Dr Samley Keo, Senior Staff, National Immunization Program, National Maternal and Child Health Center, Ministry of Health, 151-153 Kampuchea Krom Street, Phnom Penh. Tel. No.: (855) 12 759947. Fax No.: (855) 23 426257. E-mail: keosamley@gmail.com/samleykeo@yahoo.com

Mr Kong Heang Kry, Vaccine and Cold Chain Officer, National Immunization Program, National Maternal and Child Health Center, Ministry of Health, 151-153 Kampuchea Krom Street, Phnom Penh. Tel. No.: (855) 12 964889. Fax No.: (855) 23 426257. E-mail: kongheangkry@gmail.com

Dr Yong Vutthikol, Responsible for Surveillance Disease, National Immunization Program, National Maternal and Child Health Center, Ministry of Health, 151-153 Kampuchea Krom Street, Phnom Penh. Tel. No.: (855) 12 897043. Fax No.: (855) 23 426257. E-mail: yongvutthikol@gmail.com

Mr Uy Sokchamroeun, Staff, Physico-Chemical Analysis Section, National Health Product Quality Control Center, Ministry of Health, 151-153 Kampuchea Krom Street, Phnom Penh. Tel. No.: (855) 10 474869. E-mail: uy.sokchamroeun9@gmail.com

CHINA

Dr Xu Disha, Epidemiologist, National Immunization Program Chinese Center for Disease Control and Prevention, 27 Nanwei Road, Xuanwu District, Beijing 100050. Tel. No.: (8610) 831 66393-6. Fax no.: (8610) 631 71724. E-mail: xuds@chinacdc.cn

Dr Yu Wenzhou, Professor, National Immunization Program, Chinese Center for Disease Control and Prevention, 27 Nanwei Road, Xuanwu District, Beijing 100050. Tel. No.: (8610) 831 59800. Fax No.: (8610) 831 59800. E-mail: yuwenzhou2012@163.com

Ms Xiong Yan, Principal Staff Member, Bureau of Disease Prevention and Control, National Health and Family Planning Commission, No. 1 Xi Zhi Men Wai Nan Lu, Xicheng District, Beijing 100044. Tel. No.: (8610) 68792356. Fax No.: (8610) 68791794 E-mail: xiongyan@nhfpe.gov.cn

Mr Cheng Yi, Program Officer, Department of Communications, National Health and Family Planning Commission, No. 1 Xi Zhi Men, Wai Nan Lu, Xicheng District, Beijing 100044. Tel. No.: (8610) 687 92026. Fax No.: (8610) 687 92087 E-mail: cy19801980@163.com
ANNEX 1

Ms Miao Liang, Attending Doctor, No. 16 Hepingli Zhonglie, Dongcheng District, Beijing 10013. Tel. No.: (8610) 644 07100. Fax no.: (8610) 644 07101. E-mail: lmiao168@hotmail.com.

Ms Wu Yali, Hebei Health and Family Planning Commission No. 42 Hezuo Road, Shijiazhuang, Hebei 050051. Tel. No.: (86 311) 87043766. Fax No.: (86 311) 86930073. E-mail: wuyl@hebwst.gov.cn.

Dr Kopkeo Souphanthong, Deputy Director, Maternal and Child Health Center, Ministry of Health, Km 3 Thadeua Road, Vientiane. Tel. No.: (856) 021 452519 / (856) 021 452563. Fax No.: (856) 021 452519-20. E-mail: kopkeo@hotmail.com.

Dr Chansay Pathammavong, Deputy Manager, National Immunization Program, Maternal and Child Health Center, Ministry of Health, Km 3 Thadeua Road, Vientiane. Tel. No.: (856) 021 312352. Fax No.: (856) 021 312120. E-mail: chansay_epi@yahoo.com.

Dr KenChanh Sanaphayphan, Head of Unit Responsible on Data Management and Supervision, National Immunization Program, Mother and Child Health Center, Ministry of Health, Km 3 Thadeua Road, Vientiane. Tel. No.: (856) 021 217607. Fax No.: (856) 021 217607. E-mail: skenchanh@yahoo.com.

Dr Latsamy Thammavong, Deputy Chief, Mother and Child Unit, Hygiene and Health Promotion Department, Ministry of Health, Km 3 Thadeua Road, Vientiane. Tel. No.: (856) 021 217607. Fax No.: (856) 021 217607. E-mail: tlatsamy62@yahoo.com.

Dr Rohani Binti Jahis, Head of Vaccine-Preventable Diseases and FWBD Control Sector, Disease Control Division, Ministry of Health, Level 3, Block E10, Complex E, Federal Government Administrative Centre, 62590 Putrajaya. Tel. No.: (603) 601 6765; (603) 8883 4411 Fax No.: (603) 8889 1013. E-mail: rohbj@moh.gov.my

Dr Aminah Bee Mohd Kassim, Senior Principal Assistant Director Family Health Development Division, Ministry of Health Malaysia Level 7, Block E10, Precint 1, Federal Government Administrative Centre, 62590 Putrajaya. Tel. No.: (603) 8883 4003 / +6019-238-5097 Fax No.: (603) 8888 6175. E-mail: aminahbee@moh.gov.my.

Madam Rokiah Isahak, Head of Pharmacovigilance Section, Centre for Post Registration of Product, National Pharmaceutical Control Bureau, Ministry of Health Malaysia, Lot 36 Jalan Universiti, 46350 Petaling Jaya, Selangor. Tel. No.: (603) 7883 8470/ +6019-578 6192 Fax No.: (603) 7956 7151. E-mail: irokiah@bpfk.gov.my.
ANNEX 1

Madam Azila Azmi, Health Education Officer, Health Education Division, Ministry of Health Malaysia, Level 3, Block E10, Complex E Federal Government Administrative Centre, 62590 Putrajaya. Tel. No.: (603) 883 4228 / +6019-350 6595. Fax No.: (603) 8888 6200. E-mail: azilaazmi@moh.gov.my.

MONGOLIA
Dr Narangerel Dorj, Director, Division of Public Health, Ministry of Health, Government Building VIII, Olympic Street-2, Sukhbaatar District, Ulaanbaatar – 51. Tel. No.: (976) 9914451. Fax No.: (976) 11263631. E-mail: naraa61us@yahoo.com.

Dr Altanzul BAYARAA, Programme Manager, National Immunization Programme, Immunization Division, National Center for Communicable Diseases, Ministry of Health, Nam Yan Ju Street, Bayan Zurkh District, Ulaanbaatar – 51. Tel. No.: (976) 9116 3332. E-mail: altanzul.need@yahoo.com

Ms Undral Baasandorj, Spokesperson, Ministry of Health, Government Building VIII, Olympic Street-2, Sukhbaatar District, Ulaanbaatar – 51. Tel. No.: (976) 99049360. E-mail: undral@moh.mn

Ms Jargalmaa Luvsanchultem, Communication Officer, Ministry of Health, Government Building VIII, Olympic Street-2, Sukhbaatar District, Ulaanbaatar – 51. Tel. No.: (976) 91989799. E-mail: jargalmaa@moh.mn

PAPUA NEW GUINEA
Dr William Lagani, Manager, Family Health Services and AEFI Focal, Point, Department of Health, P.O. Box 807, Waigani, National Capital District. Tel. No.: (675) 301 3707. E-mail: lagani.william@gmail.com.

Mr John Gordon Honani, Technical Officer, Radio, Social Mobilization and Communications, Multi Media Health Promotion Branch, Department of Health, P.O. Box 807, Waigani, National Capital District. Tel. No.: (675) 301 3826. Fax No.: (675) 301 3742 E-mail:

PHILIPPINES
Ms Luzviminda Garcia, Supervising Health Program Officer, Women Child and Family Health Cluster, Family Health Office, Department of Health, San Lazaro Compound, Sta Cruz, Manila 1014. Tel No.: (632) 732 9956. Fax No.: (632) 732 9956. E-mail: luzgarcia@ymail.com

Ms Rosemarie Aguirre, Health Education and Promotion Officer V, National Center for Health Promotion, Department of Health, Building 18, San Lazaro Compound, Sta. Cruz, Manila 1014. Tel. No.: (632) 651 7800 local 2701. Fax No.: (632) 743 8438. E-mail: rgaguirre@yahoo.com.
ANNEX 1

Ms Ma. Arlene Arbas, Health Education and Promotion Officer IV, National Center for Health Promotion, Department of Health, Building 18, San Lazaro Compound, Sta Cruz, Manila 1014. Tel. No.: (632) 651 7800 local 2828. E-mail: rlnrbas@gmail.com

Ms Lanette Lee Querubin, Food-Drug Regulation Officer III, Food and Drug Administration, Civic Drive, Filinvest City, Alabang, Muntinlupa City 1781. Tel. No.: (632) 807 8275. Fax No.: (632) 807 8511. E-mail: llaquerubin@fda.gov.ph

REPUBLIC OF KOREA

Dr Taeun Yang, Principal Researcher, Division of Vaccine-Preventable Diseases Control, National Immunization Program, Korea Centers for Disease Control and Prevention, Osong Health Administration Complex, 200 Osongsaengmyeong2-ro, Osong-eup, Cheongwon-gun, Chungcheongbuk-do 363-951. Tel. No.: (8243) 719 6829. Fax no.: (8243) 719 7379. E-mail: taeun.yang@gmail.com

Mr Yuh Seog Choi, Health Communication Researcher, Division of Vaccine-Preventable Diseases Control, National Immunization Program Korea Centers for Disease Control and Prevention, Osong Health Administration Complex, 200 Osongsaengmyeong2-ro, Osong-eup, Cheongwon-gun, Chungcheongbuk-do 363-951. Tel. No.: (8243) 719 6833. Fax No.: (8243) 719 6859. E-mail: cys8785@gmail.com

VIET NAM

Dr Dao Quang Vinh, Vice Head, General Division, The Cabinet Office Ministry of Health, 138-A Giang Vo Street, Ba Dinh, Ha Noi. Tel. No.: (844) 627 32177. Fax No.: (844) 627 32255. E-mail: vinhdq62@gmail.com

Dr Nguyen Van Cuong, Deputy Manager, National Expanded Programme on Immunization, National Institute of Hygiene and Epidemiology, 1 Yersin Street, Ha Noi. Tel. No.: (844) 39725745. Fax No.: (844) 8213783. E-mail: cuongepi@yahoo.com

Dr Phi Van Kien, Officer, Division of Vaccine and Laboratory Management, General Department of Preventive Medicine, 135 Nui Truc Lane, Ba Dinh District, Hanoi. Tel. No.: (844) 38462364. E-mail: phivankien@gmail.com

Mr Do Vo Tuan Dung, Official, National Center for Health Communication and Education, Ministry of Health, 366 Doi Can Ba Dinh, Ha Noi. Tel. No.: (844) 38327510. Fax No.: (844) 38329341. E-mail: dovotuandung@yahoo.com
ANNEX 1

2. TEMPORARY ADVISERS

Dr Michael Steven Gold, Associate Professor, Women’s and Children’s Hospital, Discipline of Paedics, 75 King William Road, Adelaide 5000, Australia, Tel. No.: (+61) 413 855993. Fax No.: (+618) 8161 7031. E-mail: michael.gold@adelaide.edu.au

Dr Koji Nabae, Deputy Director, Division of Tuberculosis and Infectious Disease Control. Ministry of Health, Labour and Welfare, Government of Japan, 1-2-2 Kasumigaseki Chiyoda, Tokyo 100-8916, Japan. Tel. No.: (+813) 3595 2257. Fax No.: (+813) 3581 6251 Email: nabe-koji@mhlw.go.jp

3. CONSULTANTS

Dr Abdoulreza Esteghamati, Professor of Pediatrics, Tehran University of Medical Sciences, Tehran, Islamic Republic of Tehran. Tel. No.: (+98) 22241672. Mobile No.: (+98) 912 1211760. E-mail: esteghamati@gmail.com

Dr John Chetro-Szivos, Professor, Department of Communications Media, Fitchburg State University, 166 Chestnut Street, Gardner, MA 01440, United States of America. Tel. No.: (987) 665 3251. Email: jchetro@fitchburgstae.edu

4. OBSERVERS

UNICEF, VIET NAM

Dr Ketan Chitnis, Head, Communication for Development Unit, UNICEF Viet Nam, 81 A Tran Quoc Toan, Hanoi, Viet Nam. Tel. No.: (844) 39425706. Mobile No.: +84974338840. E-mail: kchitnis@unicef.org

DEPARTMENT OF HEALTH AND HUMAN SERVICES, U.S.A.

Ms Alexandra Ganim, International Policy Analyst, Pandemic and Emerging Threads, Office of Global Affairs, Department of Health and Human Services, Washington, D.C., United States of America. Tel. No.: +1 202 2601901. E-mail: Alexandra.Ganim@hhs.gov

5. SECRETARIAT

Dr Mark Jacobs, Director, Division of Combating Communicable Diseases, World Health Organization, Regional Office for the Western Pacific, United Nations Avenue, 1000 Manila, Philippines. Tel. No.: (632) 5289701. Fax No.: (632) 5211036. E-mail: jacobsma@wpro.who.int
ANNEX 1

Dr Sergey Diorditsa, Team Leader - Expanded Programme on Immunization Acting Director, Combating Communicable Diseases, World Health Organization, Western Pacific Regional Office, U. N. Avenue, 1000 Manila, Philippines. Tel. No.: 632 528 9045 Fax No.: 632 521 1036. E-mail: diorditsas@wpro.who.int

Dr Md. Shafiqul Hossain, Technical Officer, Expanded Programme on Immunization, World Health Organization, Western Pacific Regional Office, U. N. Avenue, 1000 Manila, Philippines. Tel. No.: 632 528 9033. Fax No.: 632 521 1036. E-mail: hossains@wpro.who.int

Mr Christian Lindmeier, Acting Public Information Officer, External Relations and Communications, World Health Organization, Regional Office for the Western Pacific, United Nations Avenue, 1000 Manila, Philippines. Tel. No.: (632) 528 9992. Fax No.: (632) 521 1036. E-mail: lindmeierch@wpro.who.int

Ms Joy Rivaca Caminade, Risk Communication Officer, Emerging Disease Surveillance and Response, World Health Organization, Regional Office for the Western Pacific, United Nations Avenue, 1000 Manila, Philippines. Tel. No.: (632) 528 9986. Fax No.: (632) 521 1036. E-mail: caminadej@wpro.who.int

Dr Chham Samnang, Technical Officer, Measles Elimination and High Risk Communities Expanded Programme on Immunization, Office of the WHO Representative in Cambodia, P.O. Box 1217, Phnom Penh, Cambodia. Tel. No.: (855) 23 216610. Fax No.: (855) 23 216211. E-mail: chhams@wpro.who.int

Dr Xia Wei, Technical Officer, Expanded Programme on Immunization, Office of the WHO Representative in the People's Republic of China, 401, Dongwai Diplomatic Office Building, 23, Dongzhimenwai Dajie, Chaoyang District, 100600 Beijing, People's Republic of China. Tel. No.: (8610) 6532 7190. Fax no.: (8610) 6532 2359. E-mail: xiaw@wpro.who.int

Dr Zuo Shuyan, Technical Officer, Expanded Programme on Immunization, Office of the WHO Representative in the People's Republic of China, 401, Dongwai Diplomatic Office Building 23, Dongzhimenwai Dajie, Chaoyang District, 100600 Beijing, People's Republic of China. Tel. No.: (8610) 6532 7189. Fax No.: (8610) 6532 2359. E-mail: zuosh@wpro.who.int

Dr Sodbayar Demberelsuren, National Professional Officer, Expanded Programme on Immunization, Office of the WHO Representative in Mongolia, Post Box – 663, Ulaanbaatar-13, Mongolia. Tel. No.: (976) 11 327870. Fax No.: (976) 11 324683. E-mail: demberel@wpro.who.int

Dr Siddharta Datta, Technical Officer, Expanded Programme on Immunization, Office of the WHO Representative in Papua New Guinea, P.O. Box 5896, Boroko, National Capital District, Papua New Guinea. Tel. No.: (675) 3257827. Fax No.: (675) 3250568. E-mail: dattas@wpro.who.int

Ms Maricel Castro, Technical Officer, Expanded Programme on Immunization, Office of the WHO Representative in the Philippines, National Tuberculosis Centre Building, Second Floor, Bldg. 9, Department of Health, San Lazaro Hospital Compound, Sta. Cruz, 1000 Manila, Philippines. Tel. No.: (632) 5289062. Fax No.: (632) 3106550. E-mail: castoma@wpro.who.int
ANNEX 1

Dr Jayaprakash Valiakolleri, Technical Officer, Expanded Programme on Immunization, Office of the WHO Representative in South Pacific, P.O. Box 113, Suva, Fiji. Tel. No.: (679) 3304600. Fax No.: (679) 3234166 and 3234177. E-mail: valiakolleri@wpro.who.int

Ms Laura Ngo-Fontaine, Communications Officer, Office of the WHO Representative in Viet Nam, P.O. Box 52, Hanoi, Viet Nam. Tel. No.: (844) 3 9433734. Fax No.: (844) 3 9433740. E-mail: ngofontainel@wpro.who.int

Dr Madhava Ram Balakrishnan, Medical Officer, Safety and Vigilance, Essential Medicines and Health Products, Health Systems and Innovation, World Health Organization, Avenue Appia 20 1211 Geneva 27, Switzerland. Tel. No.: (+41 22) 79 13789. E-mail: balakrishnanm@who.int

Ms Asiya Ismail Odugleh-Kolev, Team Leader, Behavioral and Social Interventions, Support to IHR Capacity Development Unit, Global Capacities, Alert and Response Department, World Health Organization, Avenue Appia 20, CH-1211 Geneva 27, Switzerland. Tel. No.: (+41 22) 79 14568. Fax No.: (+41) 22 791 4721. E-mail: oduglehkoleva@who.int

Ms Claudia Nannei, Technical Officer, Public Health, Innovation and Intellectual Property Essential Medicines and Health Products, Health Systems and Innovation, World Health Organization, Avenue Appia 20, 1211 Geneva 27, Switzerland. Tel. No.: (+41 22) 79 15078. E-mail: nanneic@who.int

Dr Justin Ortiz, Technical Officer, Initiative for Vaccine Research, Immunization, Vaccine and Biologicals, Family, Women’s and Children’s Health, World Health Organization, Avenue Appia 20, 1211 Geneva 27, Switzerland. Tel. No.: (+41 22) 79 14224. E-mail: ortizj@who.int
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