Roundtable Discussion Report

Southeast Asia Health Security Roundtable Series: Leadership and Communication During Major Epidemics

Singapore

24-25 May 2024

List of Abbreviations

ACPHEED	ASEAN Centre for Public Health Emergencies and Emerging Diseases
ASEAN	Association of Southeast Asian Nations
DFAT	Department of Foreign Affairs and Trade
HITAP	Health Intervention and Technology Assessment Program
MFA	Ministry of Foreign Affairs
PCR	Polymerase chain reaction
SARS	Severe acute respiratory syndrome
SCP	Singapore Cooperation Programme
WHO	World Health Organization
UNPAD	Universitas Padjadjaran

Foreword

It is our privilege and pleasure to present the findings from the third Southeast Asia Health Security Roundtable Series, which focused specifically on the critical issues of leadership and communication during major epidemics.

This Roundtable was convened by the Asia Centre for Health Security under the auspices of the Saw Swee Hock School of Public Health, National University of Singapore. As with the earlier Roundtables in Jakarta and Bangkok, we worked in close collaboration with Universitas Padjadjaran, Indonesia, and the Health Intervention and Technology Assessment Program, Thailand. The Southeast Asia Health Security Roundtable Series is supported by Australia's Department of Foreign Affairs and Trade, with the third edition also supported by the Ministry of Foreign Affairs Singapore Cooperation Programme.

This report captures the collective insights arising from presentations and discussions among a diverse group of thought leaders and experts from the region who convened in Singapore on May 24-25, 2024. The prolonged COVID-19 pandemic – which spanned over 3 years – repeatedly highlighted the crucial need for strong, adaptive and effective leadership and communication. This is true not just within individual nations but across the region and globally, as it is evident that no single country can navigate such pandemics in isolation.

Throughout the Roundtable, we repeatedly learned about the importance of the whole-of-government approach in crisis management, as well as the concept of and challenges associated with a whole-of-society approach. The experiences shared by experts from the ASEAN countries also underlined the importance of having in place multi-faceted communication strategies along with the principles of clear, consistent, and transparent communication. Such leadership and communication expertise will need to be developed and retained in "peace time", well before any pandemic or other crisis begins.

Our goal with this report is to raise awareness of actionable strategies and insights that can bolster country and regional health security to policymakers, health professionals, and other relevant stakeholders. We believe that the lessons distilled from these discussions can serve as one cornerstone for future responses to public health emergencies, ensuring that our communities are better prepared, more resilient, and more united in their efforts.

Last but not least, we would like to thank all participants and contributors whose expertise and dedication have enriched this Roundtable. It is our collective responsibility to take

these and other lessons forward, enhancing our preparedness and response capabilities for a future pandemic, which is a matter of “when” and not “if”.

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Introduction

The COVID-19 pandemic exerted a global toll on all aspects of human health and activities, resulting in over 6.4 million deaths after 2.5 years [1]. There have been over 13.5 billion doses of vaccines administered as well over the past 3 years [2]. But the countermeasures have also been remarkable. It has been the most terrible pandemic in living memory, but also one where scientific and technological advancements have made rapid strides.

The dominant narratives during the pandemic have come from high-income western countries as well as larger Asian countries such as India and China. However, there are also important and unique experiences from the diverse smaller countries within Southeast Asia [3]. Amidst the challenges wrought by COVID-19, Association of Southeast Asian Nations (ASEAN) countries have garnered invaluable insights into the nuances of pandemic management and response. From the rapid deployment of vaccination campaigns and distribution to the establishment of regional surveillance networks, and community engagement, the pandemic experience offers a rich tapestry of lessons and opportunities for collaboration [4].

Effective communication and visionary leadership are linchpins in our collective resilience against epidemics. The COVID-19 pandemic has illuminated both the successes and areas for improvement in our response efforts to major public health crises, underscoring the pivotal role of transparent communication in disseminating accurate information and fostering public trust. Likewise, visionary leadership, characterized by agility, empathy, and collaboration, remains indispensable in navigating the complexities of public health emergencies and galvanizing coordinated action across borders.

Efforts to bridge the gap in regional cooperation during times of public health crises are not novel. ASEAN countries had previously pledged to coordinate communication exchanges. In April 2020, the ASEAN Health Minister, chaired by the Health Minister of Indonesia, convened a video conference among member states to amplify regional cooperation through real-time information exchange, coordination of cross-border health responses, and institutionalize preparedness, surveillance, prevention, detection and response mechanism [5].

The “infodemic” comprised of the spread of misinformation and disinformation in the wake of COVID-19 has also been a crucial topic among ASEAN countries and was addressed with utmost gravity in April 2020 at the Declaration of Special ASEAN Summit, in which ASEAN Leaders committed to enhancing effective and transparent public communication

on issues related to the pandemic and encouraged regional information sectors “to strengthen cooperation in countering misinformation and fake news”. [6]

As we reflect on our collective response to the pandemic, the Roundtable series offers a unique opportunity to explore avenues for enhancing inter-country communication protocols, streamlining data exchange mechanisms, and strengthening our region’s health security architecture through dialogue, cooperation, and joint action. Participants will have the chance to exchange insights and engage in dialogue that cultivates actionable strategies for bolstering inter-country communication. They will also identify key challenges, explore innovative solutions, and forge collaborative pathways that can enhance our collective resilience in the future.

Objectives of the Roundtable Series

The main objective is to support regional and national capacity building to detect and respond effectively to infectious disease outbreaks by promoting regional dialogue on health security. International and regional thought leaders are invited to share:

- Diverse experiences and challenges throughout the COVID-19 pandemic,
- Leadership models in the management of health security challenges at the country, regional and global levels, and
- Preparation for future outbreaks at the country level and coordination at the regional level.

This, by extension, will facilitate exchange between countries to reflect upon and learn from each other’s experiences and plans and build networks to support future regional coordination. Specific objectives for the Singapore Roundtable include:

- Sharing of experiences in the coordination and management of the COVID-19 pandemic with regards to communication infrastructure and strategies,
- Developing a deeper understanding of agile leadership and crisis communication, and
- Country sharing to adopt best practises with regards to communication strategies and leadership style.

Background

The Roundtable in Singapore was hosted by the Asia Centre for Health Security, Saw Swee Hock School of Public Health, National University of Singapore in collaboration with Universitas Padjadjaran (UNPAD), Indonesia, and Health Intervention and Technology Assessment Program (HITAP), Thailand. It was supported by Australia's Department of Foreign Affairs and Trade (DFAT) and by the Ministry of Foreign Affairs (MFA) Singapore Cooperation Programme (SCP). It is part of a series aiming to capture the diverse experiences of countries during the various phases of the COVID-19 pandemic, as well as their preparations for future outbreaks. It followed the first Roundtable in Jakarta, Indonesia, organized by UNPAD and focused on the economic ramifications of the pandemic; and the second Roundtable in Bangkok, Thailand, organized by HITAP and focused on the health systems impact of the pandemic.

The first Roundtable: Recap from 'Economic Response to COVID-19 and Future Pandemics'

The pandemic caused a 'triple crisis' in the public health, economics, and social sectors of countries worldwide. The recap of the first Roundtable in this series highlighted the three-pronged strategy adopted by the government of Indonesia:

- To accelerate recovery in the public health sector
- Maintain business continuity, and
- Strengthen the government's structural reforms.

Key principles of Indonesia's national economic recovery program were budget flexibility, transparency, efficiency, and accountability. Data availability, accuracy, and timeliness of data were critical to pandemic recovery.

Sharing sessions further explored the economic response to COVID-19 in different countries, with recommendations at both the country and regional levels captured in Table 1. A concluding remark from the first Roundtable was to urge ASEAN Member States to strengthen collaboration to manage public health emergencies in the future.

The second Roundtable: Recap from 'Health System Impact of Pandemics'

The second Roundtable in this series emphasised the need to understand the scale of health system impact of a pandemic, otherwise response efforts are more reactive than

proactive. If the scale of impact can be rapidly evaluated, response efforts will be more effective. The need to identify where there are accessibility gaps in the public health system was also emphasised, as well as the importance of harmonizing response efforts across sectors through collaboration.

The sharing sessions revealed several emerging or adaptive features of national and subnational response efforts. These include:

- Technology-driven healthcare services
- Decentralizing the system of health care and service provision
- Mobilizing adapted healthcare facilities, such as hotels
- Public-private partnerships
- Developing regulations around health information and health data usage
- Increasing the fiscal budget allocated to address healthcare infrastructure gaps

However, whilst these features strengthened the public health response, it was made clear that equity implications in terms of the reachability, affordability, and effectiveness must be considered when introducing innovations. Recommendations from the second Roundtable are captured in Table 1.

One of the concluding remarks from the second Roundtable was to strategize dissemination of the insights generated from this series, to increase the likelihood of action instead of just rhetoric.

Table 1 Recommendations from the first and second Roundtables

Recommendations	Country level	Regional level
First Roundtable: Economic Response to COVID-19 and Future Pandemics	• Strengthen leadership and effective communication • Earlier border closures and identify the 'best' lockdown scenario • Optimize and digitalize public health data • Maintain and mobilize sufficient reserve funds • Proactively engage in international collaborations	• Establish Memoranda of Understanding between ASEAN Member States to facilitate (formal) relationship-building • Establish clear channels and mechanisms for communication between Member States • Operationalize the ASEAN Centre for Public Health Emergencies and Emerging Diseases • Develop data sharing platforms • Establish a regional laboratory network • Harmonize regulatory standards and processes • Conduct resource mapping exercises and mechanisms for sharing resources • Establish joint reserve funds
Second Roundtable: Health System Impact of Pandemics	• Foster partnerships between public and private healthcare providers • Co-create policies, regulations, and tools with various stakeholders for evolving technologies • Invest in primary healthcare clinics and health information systems for early warning • Build capabilities that allow the public health system to remain flexible in dynamic situations • Develop a well-trained workforce and Community Healthcare Worker network • Effective communication and engagement with communities • Maintain public trust in government and in science	• Enhance regional collaboration among ASEAN Member States • Joint capacity strengthening of human resources, research, laboratories, surveillance, early warning systems, secured data sharing, pooled procurement, and other concerted pandemic response efforts

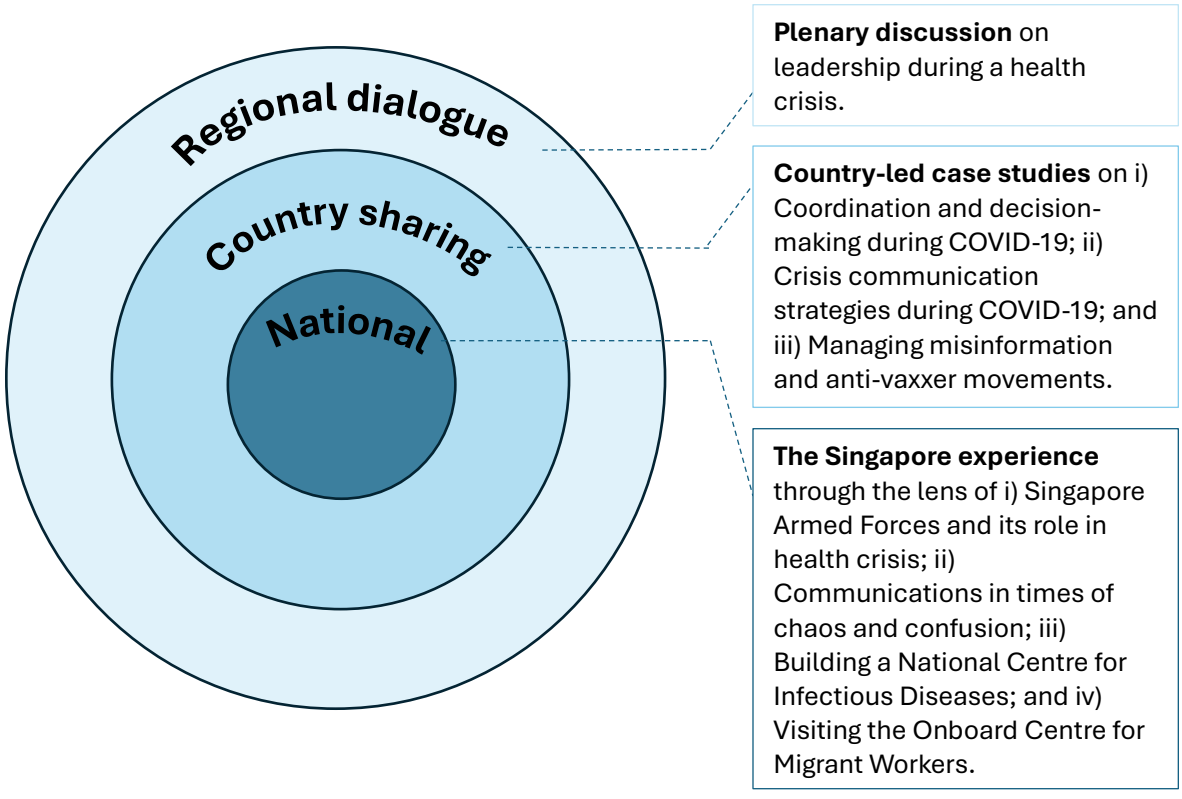
The third Roundtable: Leadership and Communication During Major Epidemics

Structure and Format

Participants of this Roundtable represented a diversity of expertise and experience from ten countries in Southeast Asia. They joined the Roundtable as representatives from their respective government agencies, departments, and COVID-19 taskforces, as well as from academic institutions and civil society.

The format of the third Roundtable was discussion-based, facilitated by a faculty member. The Roundtable facilitated participants exchanging insights and learnings, as well as informing future plans in pandemic preparedness and response. Topics included decision-making during the COVID-19 pandemic, role of a national outbreak centre, crisis communication, and management of misinformation, with country-led case studies and plenary presentations to further discuss the topics introduced. The sessions and presentations conducted during this Roundtable are illustrated in Figure 1.

Figure 1 Overview of sessions and presentations at the third Roundtable



Key Themes

The discussion on leadership and communication during health crises over the course of the two-day Roundtable could be distilled into three major themes:

I. Whole-of-government and whole-of-society approaches
II. Adaptive crisis leadership
III. Clear, consistent and transparent communications

I. Whole-of-Government and Whole-of-Society Approaches

The COVID-19 pandemic required multi-sectoral, multi-stakeholder coordination across both government and society. A whole-of-government approach engaged all relevant ministries and agencies across all sectors, whilst a whole-of-society approach engaged the private sectors, academia and research sectors, and importantly, civil society and communities. This section spotlights whole-of-government and whole-of-society approaches from the COVID-19 experiences in Malaysia, Singapore, Indonesia, Vietnam, Laos, Cambodia, the Philippines, and Thailand.

Coordination across government and society

In Malaysia, once it became clear the COVID-19 pandemic would overwhelm the health system, the Ministry of Health's response structure was supplemented by a multi-agency Greater Klang Valley Task Force. This Task Force, like many other countries' Task Forces, comprised representatives from across government and across society, including the Prime Minister's office, the military, various ministries, health-related NGOs and other partners. The Task Force took over key responsibilities such as digitizing surveillance, standardizing strategies using a military operational approach, coordinating social and welfare initiatives with community groups, and mobilizing public-private partnerships to increase the capacity of the healthcare system.

A country like Malaysia faces a unique challenge as an upper middle-income country: whilst no longer eligible for aid, many countries in this income bracket are also not resourced enough to develop all the infrastructure they need. Whole-of-government approaches are thus critical to optimize resources across a number of different ministries and agencies where feasible. Other countries that are vast in size, diverse in geography, or devolved in governance may experience their own unique challenges coordinating across government and across society. But in the case of Malaysia, achieving a whole-of-

government approach then ensured that decision-making was balanced and well-informed, leading to more appropriate response efforts.

Coordination across government also requires coordination across different laws and regulations. All countries in Southeast Asia are State Parties to the WHO International Health Regulations (2005), and many countries also have domestic laws, such as a Communicable Disease Act, as well as emergency decrees that were enacted during the COVID-19 pandemic. To better prepare for future health emergencies, mapping the legal environment to understand how different health and non-health laws relate to one another and what impact they have on managing a crisis was highlighted.

Cooperation with the military

Coordinating with the military to respond rapidly and effectively to the COVID-19 pandemic was a feature of most, if not all, countries' strategies. Whilst military involvement may be perceived negatively by the public, their assistance proved vital during the acute phase(s) of the COVID-19 pandemic. For instance, in Singapore, when transmission escalated in migrant workers' dormitories or in Malaysia, when the burden of COVID-19 exceeded hospital beds. It was emphasised that different countries have different sensitivities with regards to military involvement, and therefore country-specific approaches to facilitate cooperation during a crisis will be necessary.

In Singapore, a whole-of-government approach to the COVID-19 response involved activating intra-Ministry response teams, as well as establishing an inter-ministry task force (Multi-Ministry Task Force). When the scale of the pandemic took a turn for the worse and transmission spread rapidly in migrant workers' dormitories, the Ministry of Health requested the assistance of the military. The military, including the police force and civil defence, provided extensive support in areas like logistics, laboratory testing, and field operations, and increasing capacity at isolation facilities and workers' dormitories.

In contexts where borders are porous or where governance is heavily devolved, the military can also play an important role in managing the movement of people along and across borders. In Cambodia, for example, the military played an important role managing the movement of migrant workers across Cambodia's borders with its neighbouring countries, also setting up testing facilities to control transmission among this population. In the Philippines, where there are over 1,500 mayors and over 80 governors who can, by law, enact their own resolutions and ordinances, the military were critical in subnational coordination. A key lesson is to explore how to best leverage the relationship between health and military sectors, to understand how crises can be jointly managed in the future.

Partnerships with the private sector

An important lesson from countries' experiences of the pandemic was the value of active collaboration with the private sector. Mobilizing public-private partnerships to address gaps in health system capacities was a key success factor in the COVID-19 response, and a hallmark of a whole-of-society approach. In Singapore, public-private partnerships enabled the use of private hospital beds, as well as converting venues such as convention centres and malls to COVID-19 care facilities. These partnerships were welcomed and were considered a 'win-win' for both sectors. In response to future health emergencies, it was recommended that these partnerships are mobilized at the beginning of an outbreak, rather than when the health systems are near their breaking point.

Community engagement and outreach

Communities are central to a whole-of-society approach. The varied economic and sociocultural impacts of the COVID-19 pandemic demanded community participation in countries' response efforts. In Indonesia, community groups and leaders were involved to localize and adapt communication to the appropriate audience and context, whilst different digital platforms were leveraged to achieve wide reach and engagement. Similarly in Brunei, communication tools were designed to ensure that important information reached every community in every part of the country, for example through official press statements, infographics, social media, traditional media, and mobile alerts, and as quickly as possible. In Vietnam, where around 60% of the population live in rural, remote areas, a Task Force was convened to visit every household and ensure that important information reached all communities.

In many countries, community leaders and representatives were continuously engaged to disseminate key messages and public health communication throughout the pandemic. As an example, the Lao PDR government partnered with WHO to access more remote and harder-to-reach communities, to understand how many cases of COVID-19 they were managing and how they were responding. In Thailand, there are over 1 million village health volunteers who form an extensive network of community-based healthcare, and a link between the community and the Ministry. During the pandemic, these volunteers were a core part of the response strategy, conducting contact tracing and vaccinations.

The COVID-19 experience in Singapore highlighted how important it is to increase the health literacy and health awareness of the public in peacetime, and work closely with community groups, to better engage communities in risk communication during a crisis.

A whole-of-region approach

While national preparedness is important, regional preparedness and collaboration across ASEAN member states is equally important. As highlighted during the plenary discussion on leadership during a health crisis, it is critical to have good working relationships between neighbouring countries, and to know the relevant point-persons and counterparts to facilitate rapid and direct communication regionally. Shared priorities and needs in ASEAN include data sharing agreements, harmonized policies and standards, joint procurement mechanisms, and operationalizing regional response coordinating bodies like the forthcoming ASEAN Centre for Public Health Emergencies and Emerging Diseases.

Box 1 Key lessons for whole-of-government and whole-of-society approaches

Key lessons for whole-of-government and whole-of-society approaches

1. In large-scale health crises, all sectors and stakeholders will be affected. Preparedness and response efforts must be coordinated across government, at national and subnational levels, and across society.
2. In resource-constrained contexts, whole-of-government approaches can be a way to optimize resources across different ministries and agencies.
3. Whole-of-government and whole-of-society approaches can help to ensure that decision-making balances the evidence and expertise from a diversity of stakeholders, leading to more informed and appropriate response efforts.
4. Understanding the legal environment and the legislation that directly or indirectly impacts a health crisis can enable better coordination across government and across society.
5. Understanding how to best leverage the capabilities of the military, and to foster a strong relationship between the military and the public health sectors, can be an asset to emergency response efforts.
6. Mobilizing public-private partnerships early in the response efforts can help to alleviate capacity gaps and shortages.
7. Understanding and engaging communities through their leaders or representatives is at the core of a whole-of-society approach; and should be a focus of peacetime efforts, as well as emergency response.
8. Coordinating efforts regionally is as much of a priority as national preparedness and response efforts; each country is only as strong as its neighbours.

II. Adaptive Crisis Leadership

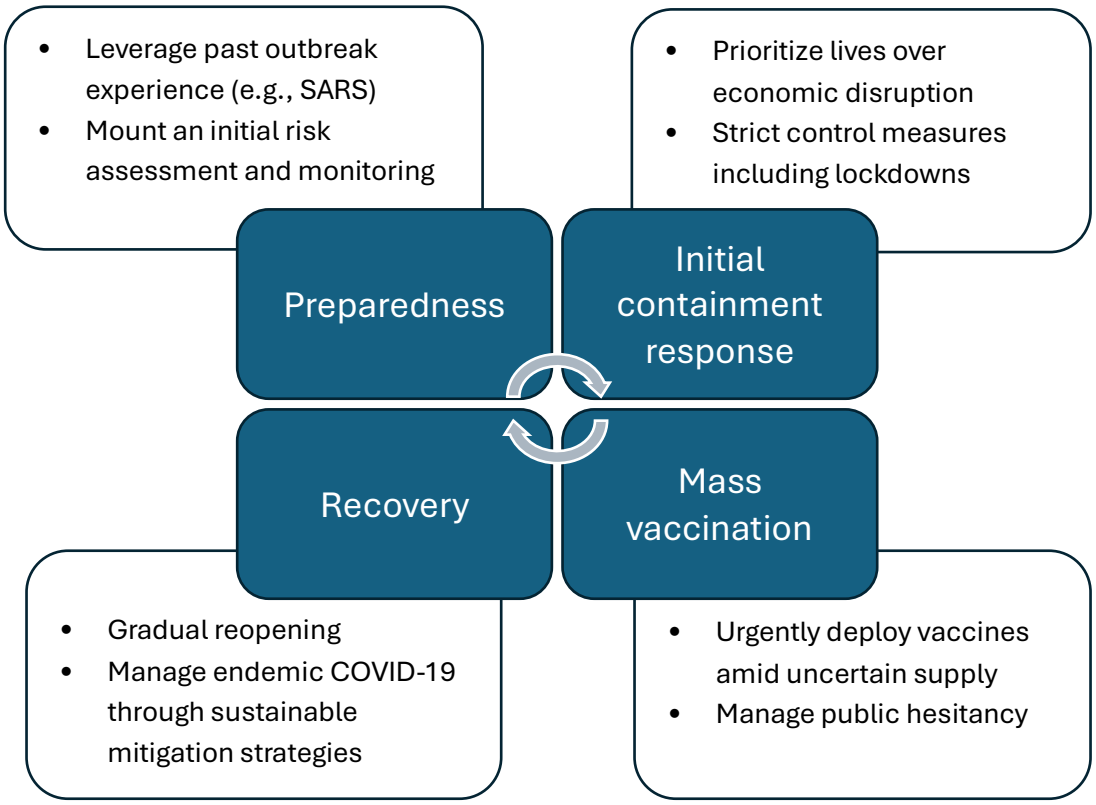
The evolving nature of the COVID-19 pandemic necessitated rapid decision-making by leaders based on incomplete data and shifting evidence. Adaptive leadership that could balance lives and livelihoods, weigh complicated trade-offs, and pivot strategies amid uncertainty proved crucial across the pandemic's phases. There were four main phases of the COVID-19 response described by various country representatives, as illustrated in Figure 2. This section spotlights experiences from Singapore, Malaysia, Thailand, Brunei, and Indonesia to illustrate the issues that leaders had to make difficult choices around in each phase of the pandemic, and how they did so.

Protecting lives and livelihoods

Leaders needed to determine which public health measures to impose while trying to minimize socioeconomic harm. In the initial response phase in many countries, decision-making prioritized lives over livelihoods. As the science and evidence on COVID-19 became available, decision-making could balance how best to control transmission without sacrificing the economic and social sectors. Many countries reiterated the need to share and integrate data across different sectors and branches of government, to enable rapid and evidence-informed decision-making during different phases of the pandemic.

Whole-of-government and whole-of-society approaches also allowed for a diversity of expertise within leadership structures, to weigh the impact of certain measures on both lives and livelihoods. Balancing lives and livelihoods was particularly important in countries where there is a large informal sector that was disproportionately impacted by restrictive public health measures. In Thailand, steps are being taken to amend the Communicable Disease Act to address, for instance, the financial cost of quarantining on the individual, and how people can earn an income during the acute phase of a health emergency. In all countries, the transition to the vaccination phase of the pandemic was critical to save lives whilst restoring livelihoods. To achieve high vaccination rates required high resource investment in all countries – from a country as small as Singapore to a country as diverse and devolved as the Philippines – demonstrating the level of effort often required to make decisions that protect both lives and livelihoods.

Figure 2 Phases of the COVID-19 response



Setting the appropriate level of COVID-19 control measures

Inevitably, decisions involved trade-offs with the acceptable trade-offs dependent on what each society relatively values such as freedom, social cohesion, the economy, public health, etcetera. Decision-makers needed to act in the context of uncertainty, often without all of the knowledge and evidence required, and with the possibility that a decision made one day could be outdated the next. With any decision taken, there may be unintended consequences, and these were the circumstances decision-makers in all countries had to contend with. In each country context, it was important the COVID-19 control measures were determined appropriately, without an overreaction nor complacency from those in the decision-making seat. One of the perceived strengths of the response in Singapore, for example, was the measured approach towards ramping up and cooling down COVID-19 control efforts.

Taking a whole-of-government and whole-of-society approach reflects a tradition of collective leadership in countries like Singapore that can help to ensure decision-making is measured and appropriate to the situation. It is often desirable to have diversity of

expertise within leadership, but what is more important is that once a decision is taken, there is collective political support and commitment toward implementation. Having a certain level of cohesion within leadership is important to drive decision-making, though this can be challenging to achieve in contexts where there is political instability or a high degree of devolution in governance.

Prioritizing scarce resources

Every country faced a shortage of COVID-19 related medical supplies and equipment at one point in the pandemic. In addition, there were high-risk groups more vulnerable to COVID-19 infection, and difficult decisions had to be made to prioritize scarce resources like ICU beds, ventilators, and vaccines to protect these groups.

In Singapore, for example, to address the shortage of reagents for PCR testing, pooled testing was introduced, which was able to clear large groups of people with minimal reagents. In Thailand, the gap between the demand and supply of COVID-19 vaccines was significant. Initially, the government could not afford vaccines for the entire population and solved this problem by procuring a mix of different COVID-19 vaccines whilst still complying with scientific recommendation. Academic and research institutions also partnered with one another, and with hospitals, to train laboratories in more rural or remote provinces and extend laboratory services throughout the country. A key lesson from the COVID-19 experience in Thailand was the value of business contingency plans for hospitals and other business, industries, and organizations, as well as the need for resource mapping for medical supplies and workforce.

Establishing strong relationships with the military, the private sectors, and community groups during the response efforts helped in many ways to extend the resources of the public health sector. For example, the military helped to manage cross-border movement of people; the private sector provided additional quarantine and treatment facilities; and community leaders helped spread key messages and public health communication. But the scarcity of resources in some countries more than others also underscored the need for stronger regional collaboration and cooperation, to pool resources and establish joint procurement mechanisms where possible, as well as joint stockpiling as a regional preparedness measure. For example, in Indonesia, multi-pronged efforts were needed to ensure the availability of COVID-19 drugs and vaccines, including strengthening domestic pharmaceutical resilience, participating in global multilateral mechanisms, and engaging in international collaboration networks.

Safe reopening of economic and social sectors

Developing safe reopening plans for workplaces, schools, and travel had to be balanced against transmission risks. In Malaysia, leaders sought data not only from within their country context, but from other countries in other regions. Convening expert advisory groups to obtain and review that data, and subsequently inform the decision-makers, was important to establishing a recovery strategy.

Safe reopening required close coordination and cooperation between different stakeholders, either at a national or regional level. In Thailand, to begin relaxing measures for the tourism sector, public health leaders coordinated closely with the airline, hotel, and insurance industries to establish safe reopening protocols. In Brunei, social responsibility was also emphasised as part of the country's crisis communication strategy to foster public cooperation with public health measures. In some countries, such as Singapore and Malaysia, safe reopening of parts of the economy required close bilateral coordination and cooperation. For example, if the causeway between these two countries was closed, it would cost thousands of people their jobs. The decision was thus taken to close the causeway to tourists, but to keep it open to certain sectors of the economy to allow workers to cross.

Learning the lessons

To navigate these high-stakes choices across multiple sectors, robust decision-making processes that could rapidly integrate input from scientific advisors, economic experts, operational implementers and political considerations proved valuable. During the plenary discussion on leadership during a health crisis, leadership in every country were urged to internalise and share the lessons learnt from their experience of the COVID-19 pandemic. In Singapore, an After Action Review was conducted to review the response efforts, reflect and draw lessons; but it was important not to over-customize the lessons to the specific experience of COVID-19. 'Fighting the last battle' was not a mentality to adopt.

The importance of training the next generation of public health leaders with a vigilant mindset and understanding of the experiences was also emphasized. This could be done via case studies in leadership and management courses, as well as via tabletop exercises.

Box 2 Key lessons for adaptive crisis leadership

Key lessons for adaptive crisis leadership

1. Adaptive leadership is characterised by the ability to balance lives and livelihoods; navigate decisions involving trade-offs; and pivot strategies amid uncertainty.
2. Additional qualities that underpin an effective response are collective leadership and cohesive leadership.
3. Decision-making must be informed by scientific data and evidence, and data must be readily and rapidly accessible across government and across society during a health crisis.
4. Establishing strong relationships with key stakeholders in non-government sectors, including the military, businesses and industries, and community groups, extends the capabilities and resources of the public health sector to respond more efficiently and effectively than if it worked in silo.
5. Establishing strong relationships regionally is key to boost regional preparedness and response efforts, and work toward a common standard.
6. Building collaborative relationships at subnational, national, and regional levels helps to forge a pathway through a health crisis and into the recovery phase.
7. Embedding the lessons learnt within public health structures and systems – through training, case studies, and tabletop exercises – is key to preparing for the next health crisis, but the principles of an effective response should matter more than the specific lessons.

III. Clear, Consistent and Transparent Communications

In each phase of the pandemic, there were also a set of considerations for communications. In many countries, decision-making hinged on clear, consistent, and transparent communications – the policy and the communications had to work hand-in-hand. Many aspects of communicating the risks, uncertainties and policies in order to maintain public trust and confidence were critical challenges during the COVID-19 pandemic. Many countries learnt 'the art' of communicating in ways that the layman can understand whilst still being informed by science. There is no 'one size fits all' for crisis communication. This section highlights the key principles of crisis communication from the COVID-19 experience in Thailand, Laos, Brunei, Vietnam, the Philippines, Cambodia and Singapore.

Key principles of crisis communication

- Communication needs to be centralized by providing a singular message that is disseminated across government, and by authorizing spokespersons to be the official face and voice of public health communication. This ensures there is both consistency and clarity to the communication, which helps ensure a cohesive and collective national response to the pandemic. Too many 'talking heads' can result in conflicting information or misinformation, and cause confusion amongst the public, which ultimately undermines response efforts. In the Philippines, for example, the devolved system of governance meant there were many voices and channels to communicate with different constituencies. To streamline the messaging, a set of talking points were distributed to politicians across the country. Rather than diminish their platform, it was about giving them the right tools to communicate with. In Cambodia, there were authorized spokespersons at subnational levels too.

- Involving national leaders in crisis communication, as well as other role models in government and society (such as social media influencers), increased the impact of the messaging. It lends credibility to the communication, which is key. The Sultan of Brunei, for example, was the first recipient of a COVID-19 vaccine in the country, leading by example to increase vaccination rates and reduce vaccine hesitancy. In Singapore, for major decisions, the Prime Minister would lay out the situation and the directives for the public.

- Leveraging traditional and non-traditional media to disseminate important information as quickly and as widely as possible. Different medial channels included official press statements, townhalls, infographics, social media, televised news, broadcast news, and mobile alerts. Maintaining a high level of routine

engagement with the public was key, and using creative media strategies to inform the public and raise awareness helped. For example, in the Philippines, people are still reliant on television and radio, particularly in geographically isolated areas. To explain misinformation surrounding COVID-19, the government commissioned dramas, which provide to be more effective than providing scientific explanations through healthcare workers.

- Partnering with academic and research institutions, who are reputable and well-trusted in society, to communicate the scientific justification and evidence behind key decisions can help to foster public trust, confidence, and cooperation. In Thailand, for example, there was initially some hesitancy among the public to accept mixed COVID-19 vaccinations. To assure the public that mixed vaccinations were as effective, leaders collaborated with academic and research institutions to provide a sound evidence base for their decision-making.

- Partnering with community leaders, who are considered the gatekeepers of the community, can provide access to vulnerable and/or remote populations, and help to disseminate key public health messages, risk communication, and information to these harder-to-reach areas. In Laos, for instance, where there are over 40 ethnic groups to coordinate and communicate with, these communities trust and listen to their leaders. It was vital that the village leaders and village health centres were engaged directly, particularly during the vaccination campaigns.

- Devoting resources to continuously monitor and rapidly counter mis/disinformation, as well as address any of the public's concerns, was crucial. In Brunei, for example, there was a dedicated 'cops comms' team who conducted media listening and uploaded messages on Instagram to dispel in mis/disinformation. In Vietnam, the Ministry of Health coordinated with the Ministry of Information and Ministry of Police to combat fake news in the media and block accounts disseminating mis/disinformation. In the Philippines, the government partnered with the biggest social media platforms such as Facebook, Google, TikTok, and Twitter to identify fake news and have the original posts removed.

- Being transparent about the uncertainties, the gaps in scientific knowledge and evidence, and the policy options and missteps (where appropriate) is important. Being transparent not only engenders public trust, it helps to manage the public's expectations of government and how it can or cannot respond to the pandemic. Being transparent also requires knowing when to release information to the public

to avoid confusion or panic, mistrust, and information overload. Staging communications was a key component of countries' strategies to maintain a singular and consistent narrative.

- Framing communications through an empathetic lens to assure the public whilst also instilling public trust, confidence, and calm throughout the different phases of the pandemic. Positive public messaging was a key part of the communication strategy in Brunei, with one of the key messages for recovery being how the government cares about the public's wellbeing. The same approach was taken in the Philippines, where messaging aimed to have a positive to neutral tone. Whilst the information is the same, the way it is communicated should be catered to different audiences, such as the general public, the elderly, vulnerable populations, migrant workers, parents, etcetera.

Maintaining public trust and confidence

A key objective – and, consequently, a result – of effective crisis communication in all countries was public trust and confidence. Without the public's trust and confidence in the country's leadership and decision-making, cooperation to implement and adhere to public health measures at different phases of the pandemic was challenged. In countries like Singapore, there was a high level of public trust in the government prior to the COVID-19 pandemic, which helped foster social cohesion and a sense of social responsibility to comply with public health guidance. It is important to build public trust and confidence in public health in peacetime, such that it can be readily tapped during a health emergency. It also proved important to invest in tools to monitor and evaluate public sentiment, to understand what messages are gaining or losing traction as a way of better understanding the public's concerns. In the Philippines, for example, metrics helped the government navigate where to put more or less attention, and what issues or concerns to prioritize in terms of messaging. Maintaining trust and confidence also extended to relations between neighbouring countries, especially for the number of cross-boundary issues the COVID-19 pandemic posed.

Strengthening crisis communication

In many countries, the COVID-19 pandemic highlighted the importance of effective crisis communication and the need for dedicated training in crisis communication in the public health workforce. In the Philippines, for example, medical experts received training on how to work effectively with the media. In Cambodia, there are around 3,000 rapid response teams deployed across the country who received training in crisis communications in order to effectively deal with local media, which proved especially important in times where

public trust in politicians was low. Crisis communications training in Cambodia worked both ways, and the media were invited to join training sessions to ensure that the right messages are disseminated to the public. The pandemic also highlighted the need to strengthen local health communications infrastructure, particularly in countries that are geographically vast and diverse.

Box 3 Key lessons for clear, consistent and transparent communications

Key lessons for clear, consistent and transparent communications

1. Centralizing communication and maintaining a singular narrative ensures the messaging is both clear and consistent, which in turn helps to foster a cohesive response to the pandemic.
2. It is vital that information is communicated transparently and timely to manage the public's expectations whilst maintaining their trust, and to frame the messages with empathy and positivity.
3. Involving national leaders and other role models lends a level of credibility to the communications, which garners public confidence.
4. Communication strategies should leverage both traditional and non-traditional media to reach all segments of society, as different populations rely on different types of media. It is important that strategies can be catered.
5. As reputable and trusted figureheads, partnering with academia or research institutions and with community leaders to deliver important information can increase the impact and reach of communications.
6. Mis/disinformation must be routinely monitored and rapidly countered. It may require cooperation with spokespersons or trusted voices to dispel fake news; the social media industry to remove fake news posts or accounts; and relevant ministries in information and technology to coordinate efforts.
7. Maintaining public trust and confidence is both an objective and an outcome of effective crisis communication; and efforts to increase the level of trust and confidence should continue during peacetime.
8. The public health workforce and media both require dedicated training in crisis communications to ensure the right public health messaging is disseminated and to facilitate greater cooperation between these two actors.

Conclusion

One critical point that was raised again at the closing session of the Roundtable was the importance of looking beyond national borders, establishing and/or strengthening regional collaboration mechanisms across the ASEAN community for shared health security. The need for a soft network of knowledge, expertise, resources and colleagues willing to convene and to connect across ASEAN was also highlighted. The importance of regional collaboration and preparedness had also been emphasized at earlier Roundtables in Jakarta and Bangkok.

The participants also discussed the dissemination of insights from the Roundtable series, and agreed that these should reach key policy- and strategic decision-makers in ASEAN governments, as well as at a regional level. A package of recommendations and key insights will be developed from all three in-person Roundtables in the series (Economic Response, Health Sector Impact, Leadership and Communication), which will then be shared at the final virtual Roundtable of the series for feedback and further discussion.

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Annex

Agenda

Time	Topic/Description	Speaker/Facilitator
Day 1		
9:00 – 9:30	Registration	
9:30 – 9:45	Welcome Remarks	Prof Hsu Li Yang (NUS) & Dr Paul Huleatt (Australian High Commission, Singapore)
9:45 – 10:00	Opening Remarks	Prof Kenneth Mak (DGH, MOH)
10:00 – 10:10	Photo session	
10:10 – 10.30	Morning coffee break & networking	
10:30 – 10:50	Introduction of participants & facilitators	
10:50 – 11:30	Recap of Jakarta & Bangkok Roundtables	Prof Auliya Suwantika (UNPAD) & Mr Manit Sittimart (HITAP International)
11:30 – 12:30	Coordination and decision-making during COVID-19: Country sharing and lessons learnt for the future	BG Dr Mohd Arshil bin Moideen (Malaysia) & Dr Soawapak Hinjoy (Thailand) Facilitator: Prof Hsu Li Yang (NUS)
12:30 – 13.30 Lunch		
13:30 – 14:30	Singapore Armed Forces and its role in Health Crises	Dr Lo Hong Yee (TTSH; former CMC, SAF)
14:30 – 15:30	Crisis communication strategies during COVID-19: Country sharing	Dr Martina Kifrawi (Brunei) & Ms Bahagiati Maghfiroh (Indonesia) Facilitator: Prof Hsu Li Yang (NUS)
15:30 – 15:45	Afternoon coffee break and networking	
15:45 – 16:40	Leadership during a health crisis: Dialogue	All participants Speaker & Facilitator: Adjunct Prof Derrick Heng (DDGH (Public Health), MOH)
16:40 – 17:00	Summary of the day & Close	Prof Hsu Li Yang (NUS)
18:00 – 20:30 Dinner & Reception		

Day 2		
8:00 – 8:30	Registration	
8:30 – 11:30	Visit to the Onboard Centre	
11:30 – 12:30	Communications In Times of Chaos and Confusion A Singapore Case Study	Ms Yeo Wen Qing (MOH)
12:30 – 13:30 Lunch		

13:30 – 15:00	Building a National Centre for Infectious Diseases: Singapore	A/Prof Shawn Vasoo (NCID) All participants Facilitator: Prof Hsu Li Yang (NUS)
15:00 – 15:15	Coffee break and networking	
15:15 – 16:30	Managing misinformation and anti-vaxxer movements: Country sharing	Dr Beverly Lorraine C. Ho (Philippines) & Dr Teng Srey (Cambodia) Facilitator: Prof Hsu Li Yang (NUS)
16:30 – 17:00	Closing Remarks	
End of Roundtable		

Participant List

No	Country	Organisation and Department	Name	Designation
1	Brunei	Ministry of Health, Department of Policy and Planning	Ms Azzyati Filzah Jamain	Acting Chief Executive Officer / Administrative Officer Special Grade
2		Ministry of Health, Brunei Centre for Disease Control and Prevention	Dr Martina Kifrawi	Head of Priority Diseases Unity
3	Cambodia	Ministry of Health	H.E. Dr Mao Tan Eang	Under Secretary of State
4		Ministry of Health, Communicable Disease Control Department	Dr Teng Srey	Deputy Director
5	Indonesia	Ministry of Finance, Fiscal Policy Agency	Mr Abrian D. Firmansyah	Policy Analyst
6		National Development Planning Agency (BAPPENAS)	Ms Bahagiati Maghfiroh	Young Expert Planner to the Deputy for Human, Community and Cultural Development
7	Lao PDR	Ministry of Health, National Centre for Laboratory & Epidemiology	Dr. Bounthanom Sengkeopraseuth	Head of Epidemiology Division
8		Lao Tropical & Public Health Institute	Dr Latsamy Siengsounthone	Director-General

9	Malaysia	National Defence University of Malaysia	Brigadier General Dr Mohd Arshil bin Moideen	Dean and Public Health Medicine Specialist
10		ASEAN Health Cluster 2	Dr Chong Chee Kheong	Senior Health Advisor
11	Singapore	Ministry of Health	A/Prof Marc Ho	Group Head, Policy and Systems, Interim Communicable Diseases Agency
12		Ministry of Health	Ms Georgina Lim	Assistant Director, Communicable Diseases Policy and Preparedness
13	Thailand	Ministry of Public Health, Office of International Cooperation, Department of Disease Control	Dr Soawapak Hinjoy	Director
14		Prime Minister's Office	Ms Worawan Plikhamin	Deputy Secretary-General
15	The Philippines	Oxford University Rhodes Trust, Atlantic Institute	Dr Beverly Lorraine C. Ho	Senior Fellow
16		Ateneo School of Government, Health Governance Program of the Ateneo Policy Center	Prof Kenneth Hartigan-Go	Senior Research Fellow and Program Director for Leadership & Innovation
17	Timor-Leste	Ministry of Health	Dr Merita Antonia A. Monteiro	President, National Institute of Public Health
18		Ministry of Health	Dr Frederico B. A. dos Santos	General Director of Technical-Scientific
19	Vietnam	Hanoi Medical University	Dr Do Thi Thanh Toan	Head, Department of Research Methodology and Biostatistics and Head, Department of Training, Scientific Research and International Collaboration
20		Ministry of Health, General Department of Preventive Medicine	Dr Nguyen Luong Tam	Vice Director