Risk Communications for Public Health Emergencies: What to Learn from Real-life Events

WORKSHOP REPORT
2-3 OCTOBER 2014 | OSLO, NORWAY
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<table>
<thead>
<tr>
<th>Page</th>
<th>Section</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>06</td>
<td>BACKGROUND</td>
<td></td>
</tr>
<tr>
<td>08</td>
<td>CASE STUDIES</td>
<td>2011 CHRISTCHURCH EARTHQUAKE</td>
</tr>
<tr>
<td>10</td>
<td></td>
<td>SARS, H5N1, AND H1N1 IN SINGAPORE</td>
</tr>
<tr>
<td>12</td>
<td></td>
<td>2014 EBOLA OUTBREAK IN WEST AFRICA</td>
</tr>
<tr>
<td>13</td>
<td>WORKING GROUP DISCUSSIONS</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>SIMULATION EXERCISE &amp; MOCK PRESS CONFERENCE</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>POST-PRESS CONFERENCE DISCUSSION</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>LIST OF PARTICIPANTS</td>
<td></td>
</tr>
</tbody>
</table>
At the 6th ASEM Summit (ASEM6) in 2006 in Helsinki, Finland, ASEM leaders expressed their determination to combat avian influenza and a possible human influenza pandemic. Subsequently, the ASEM Initiative for the Rapid Containment of Pandemic Influenza, financially supported by the Government of Japan, was launched at the 9th ASEM Foreign Ministers’ Meeting (ASEM FMM9; 2009, Hanoi, Viet Nam). Since then, the 2 components of the Initiative (ASEM stockpile of antivirals and personal protective equipment; and Asia-Europe Foundation (ASEF) Public Health Network) have contributed to strengthening ASEM partners’ capacity for preparedness for and response to public health emergencies, including pandemics.

The ASEF Public Health Network is a participatory platform that encourages public health dialogue between actors from health and non-health sectors across Asia and Europe. From 2010 to 2013, the Asia-Europe Foundation (ASEF) Public Health Network implemented the “Accurate Scenarios Active Preparedness (ASEF–ASAP)” project to strengthen multi-sector pandemic preparedness and response.

The project utilised a scenario approach to address the uncertainty of future pandemics and to assess the existing pandemic preparedness mechanisms in likely future settings. In this process, a series of workshops engaged experts from both health and non-health sectors to develop scenarios, to test pandemic preparedness of several selected sectors — human security, passenger air transport and food supply security — and to formulate recommendations for those sectors.

Among the recommendations developed from the process, risk communications emerged as one of the common concerns across multiple sectors. In response, the ASEF Public Health Network, in collaboration with the Coordinating Ministry of People’s Welfare of Indonesia, organised a workshop titled “Effective Risk Communication for Public Health Emergencies and the Role of Social Media” (3-4 June 2013, Bali, Indonesia). The workshop brought together communication experts from government agencies, international organisations, non-governmental organisations, the private sector and the media. The workshop generated several approaches to communicating risks in public health emergencies, mainly involving top influencers in risk communications to reach target audiences, integrating the media and the community into the emergency risk planning process, and developing an open-source big data management system for health-related risk communications.

In addition to the workshop participants who supported the value of sharing lessons from real-life public health events, experts who were consulted encouraged ASEF to contribute to strengthening countries’ capacities for managing public health events, required by the International Health Regulations (IHR, 2005) and the Asia Pacific Strategy for Emerging Diseases (APSED, 2010). Both of the frameworks address “risk communications” as part of the core capacities and focus areas for surveillance of and response to emerging diseases and other public health emergencies. Drawing upon its facilitation of collaboration between health and non-health sectors, ASEF Public Health Network seeks to mainstream risk communications for public health emergencies as a common area for Asia-Europe co-operation in health.

As part of this endeavour, ASEF Public Health Network, together with the Research Council of Norway, organised a workshop titled “Risk Communications for Public Health Emergencies: What to Learn from Real-life Events” on 2-3 October 2014 in Oslo, Norway.
By looking at selected real-life public health emergencies over the past decade, participants
• Evaluated the challenges and capacity needs that impact the communications of public health emergencies
• Identified the core elements of functional lessons learned from health emergency communications

ASEF brought together 20 professionals
• Communication experts from government agencies and international organisations
• Representatives from the private sector with experience in crisis communications
• Health specialists with considerable media experience
• Academics who specialised in health communications
• NGO officials involved in health promotion and community health

Over the course of a 2-day workshop, the process to achieve the objectives included:
• Presentations of cases of public health emergencies
  - 2011 Christchurch Earthquake
  - SARS, H5N1, and H1N1 in Singapore
  - 2014 Ebola Outbreak in West Africa
• Working group discussions to analyse key elements of effective risk communications in the selected cases
• A simulation exercise based on a fictional case of public health emergency

This report provides highlights of the workshop proceedings and the outcome of a simulation exercise developed by the participants of the workshop.
CASE 1:  
2011 CHRISTCHURCH EARTHQUAKE

Speaker: Dr Alistair R. G. HUMPHREY, Medical Officer of Health, Canterbury District Health Board, New Zealand

In emphasising the importance of effective crisis management, Dr Humphrey quoted a remark by BAN Ki-moon, the Secretary-General of the United Nations, addressed to the United Nations International Strategy for Disaster Reduction (UNISDR) Global Platform (10 May 2011, Geneva, Switzerland), “Success is measured by what does not occur: The school that did not collapse. The building that did not fall. The village that was not destroyed.”

Drawing on the example of the earthquake in Christchurch, New Zealand in 2011, Dr Humphrey first introduced the New Zealand’s legislative background to its emergency preparedness, including the New Zealand Civil Defence and Emergency Management Act 2002 and The New Zealand Health Act 1956. He mentioned that preparation for possible pandemics turned out to be useful in the case of an earthquake.

Dr Humphrey explained the role of the Medical Officer of Health and their special powers in emergencies. The example of collaboration with the media, where the media became part of the pandemic meetings and joined the planning process of communication, was given to highlight the importance of involving the community in the response to a crisis.

The importance of building trust through quality communications was also emphasised. In Canterbury, community self-help was encouraged during the H1N1 pandemic, with messages such as “We [the government] may not be able to care for you: Our health staff may be sick. Staff may be caring for their families,” “You must be able to care for yourselves,” and “You must know your neighbours.” Communication media included TV, leaflet drops, print media and website. Many of these messages and media were used again during the Canterbury earthquakes.

In presenting what constituted successful aspects of pandemic response in Canterbury, Dr Humphrey emphasised “trust” that was built through “3Cs”: Clear information, Collaborative response, and Clear budget for response.

4 Photo by Alexandralaw1977 / Shutterstock.com
In relation to this, Dr Humphrey shared 3 lessons that Canterbury had learned from the pandemic:

• **Lesson 1 – Use credible, articulate spokespeople**
  Just as Rudy Giuliani, Mayor of New York City during the 9/11 attacks in 2001, conveyed 3 elements – honesty, empathy, hope – in his message to public, Sir Bob PARKER, former mayor of Christchurch, played an important role in communication with the public by stating, “We have people to find,” “We will grieve together,” and “In this space will grow a city renewed.”

• **Lesson 2 – Maintain diverse, open communication**
  It is important to establish and maintain communication in a crisis through diverse and open communication channels, e.g. face-to-face contact at community briefings, mailbox leaflet drop, free phone lines, websites, social media, newspapers, TV, radio, etc. This will accommodate various needs and constraints that the public may have in receiving and contributing information.

• **Lesson 3 – Build self-reliant/resilient communities**
  In line with a message that encourages knowing one’s neighbours, building community resilience is critical in effective preparedness for and response to any type of emergency.

Dr Humphrey then raised the idea of an all-hazards approach with respect to health and emergencies. Health is affected in different ways through emergencies but there are consistent messages that can be applied to most situations, especially in relation to water and sanitation. Dr Humphrey emphasised that there is no such thing as a “public health emergency” because all emergencies are health emergencies. In the case of Christchurch’s earthquakes, there were no disease outbreaks after the quakes. A health campaign was run at the time of the earthquakes but the community was also very aware of good handwashing practices after the H1N1 pandemic.

Lastly, Dr Humphrey talked about the efforts that had been made in addressing psychological trauma after the earthquakes. The communication challenges in the recovery phase differ from the kinds of challenges in the short- and medium-term. The example of the “All Right? (http://www.allright.co.nz)” campaign was discussed. This initiative started a community conversation, addressing post-earthquake psychological, physical and financial stress and trauma.

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5 Photo by Lakeview Images / Shutterstock.com
Dr Menon outlined some of the lessons that the Singapore government learned from managing the outbreak of the Severe Acute Respiratory Syndrome (SARS) in 2003. SARS was Singapore’s first experience in managing a pandemic and, in many ways, a defining moment in Singapore’s history. The experience in confronting SARS has shaped the way in which Singapore will manage future pandemics, particularly in the area of building trust in government and inter-agency collaboration.

Given its size and population density, Singapore had its own strength and challenges in managing a pandemic. SARS was seen as a potential threat to the very existence of Singapore as a small city-state. The severity of the outbreak extracted a heavy toll on the victims and their families, had a considerable impact on the domestic economy, affecting visitor arrivals, hotel occupancy, the retail sector, joblessness, and led to estimates of a real decline in GDP. Dr Menon stressed that the vulnerability of a small nation made the measures taken by Singapore reasonable, though often seen as draconian, in the short run.

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6 Data on the impact of SARS on Singapore’s domestic economy presented by Dr Menon were extracted from a variety of sources. One example is the Monetary Authority of Singapore (MAS) Annual Report 2003/2004: http://www.mas.gov.sg/annual_reports/annual20032004/econ_spore.html
Dr Menon introduced a variety of examples of health promotion campaigns. These included: the “Contact Bowl” campaign, where visitors to the shopping malls were encouraged to drop off their name cards to help in tracking shoppers in the event of infection detected within the premises of the shopping mall; the Environment Ministry’s “Singapore Okay” campaign; and the “I am Cool” campaign, where hotel employees and hawker food workers co-operated to show that they did not have fever on any particular day by displaying an “I am Cool” sticker to assure the customers coming into contact with them. These campaigns demonstrate the need to build community trust and confidence in government actions during a pandemic.

Following the case of SARS, Dr Menon discussed the lessons, observations and insights that the Singapore government gathered from their recent experience with H1N1. In managing H1N1, Singapore and Hong Kong undertook a containment approach while New York City adopted a mitigation approach. Comparing the different approaches and their reasoning between these 3 cities, Dr Menon reviewed some international criticism of the measures taken by Singapore. By referring to the consensus in the literature on potential benefits and cost-effectiveness of a range of non-pharmaceutical interventions such as school closures, border screening with thermal scanners, quarantine, and social distancing measures, Singapore government’s position was clarified that it is better to err on the side of over-reaction than under-reaction.

The element of fear was repeatedly raised as a means to raise people’s level of awareness and alertness. Challenges in changing people’s behaviours were also mentioned, drawing the example of “clinic-hopping”: patients going from one clinic to another in search of the diagnosis and prescription they want, which subsequently poses a risk of spreading virus. During the question and answer session, it was recommended that the importance of integrating a good level of self-efficacy and response-efficacy should lead to taking certain measures. Furthermore, Dr Menon elaborated that the level of fear increases when risk is communicated, but if people are given clear instructions that are implementable, the level of fear drops.
Speaker: Ms Nyka ALEXANDER, Communications Consultant with the World Health Organization

Ms Alexander’s presentation provided background on the countries most affected by the current Ebola outbreak – Guinea, Sierra Leone, Liberia – and the history of how the outbreak developed. She also presented the communications challenges that authorities in Sierra Leone have faced as of late September 2014, which was when she left the country.

The first case of the current outbreak occurred in Guinea, unbeknownst to all, in December 2013. The alert was raised in Guinea on 23 March 2014. Since there had never previously been an outbreak of Ebola in Guinea and Ebola’s symptoms resemble those of other diseases, it took months for authorities to identify the cause of the illness. The disease was new for the public as well, which had to learn how to recognise the disease, and what actions to take if they or a loved one was ill.

Once the disease spread to Liberia and Sierra Leone, one tactic used by the government in Sierra Leone was a house-to-house campaign to raise awareness about the disease. While the campaign met this overall goal, the house-to-house campaigners faced challenges in persuading people to follow the recommended measures and seek medical treatment because they were hesitant to go to treatment centres or send their family members there out of mistrust or fear. Healthcare workers also faced psychological obstacles as they were told not to touch the patients and isolate them – the opposite of what they are trained to do or their humanitarian compassion compels them to.

On 24 August 2014 the World Health Organization (WHO) was notified of a further outbreak of the Ebola virus which had been detected in an extremely remote area of the Equateur Province in the Democratic Republic of the Congo. This outbreak was not related to the one in West Africa.

Ms Alexander showed a film produced by WHO, “Ebola Outbreak Response in the Democratic Republic of the Congo (https://www.youtube.com/watch?v=2JWn9JyeufU)”. The film provided a snapshot of how the response was conducted through co-ordination amongst the Ministry of Health of the Democratic Republic of the Congo, WHO, Médecins Sans Frontières (MSF) and other humanitarian organisations.
WORKING GROUP DISCUSSIONS

After the 3 presentations, the participants were divided into 3 groups to discuss the questions that the speakers proposed on the respective cases. The participants were requested to come up with key elements in effective risk communications, which can be applied beyond each specific case. These key elements are centred on:

- **Actors – who does it (risk communications)?**
- **Actions – what do we do?**
- **Methods / Media – how do we do it?**
- **Target – for/to whom do we do it?**

### CASE 1: 2011 CHRISTCHURCH EARTHQUAKE

1. What legislative mandate do you have in your own countries for involvement in emergencies, e.g. does the health sector have specific powers, what is the importance of communication?
2. What messages do you wish to convey to the public, what techniques might you use, and how would you build trust?
3. What health issues would you expect for different kinds of emergency? Is health ever not an important consideration?
4. Who has experienced the recovery phase of a disaster? What kind of problems does a community experience in the years following a disaster? What communication techniques are required to address these problems?

Dr Humphrey’s group discussion focused on the question number 2.

### I. ACTORS – WHO DOES IT?

- Actors of risk communications include: government (politicians, national government, local government, ministry of health); community leaders; spiritual leaders; international organisations (e.g. World Health Organization (WHO)); experts (doctors, academics, scientists)
- A spokesperson must be well-known in the communities of the target group(s) to ensure credibility of the information and be someone with whom people feel share suffering.
- Speakers need to be mindful of setting a right tone in their messages to create an appropriate level of alertness in the society.
- There should be communication specialists on full-time basis.
- Capacity building for multi-disciplinary teams is important. One example is to train doctors and school teachers to be messengers for the public.

### II. ACTIONS – WHAT DO WE DO?

- In delivery of a message, “honesty, empathy & hope” are important. In order to have these elements in crisis communication, risk communications need to identify purpose, target audience, strategies, messages and communication tools.
- To generate hope, people need to be provided with a support system, e.g. mental health support.
• The purpose of crisis communication is to build the public trust and avoid panic. Panic is caused by dissemination of information that is hostile or opposite of public health facts and that is destructive to communities of a target audience.
• Messages to the public should include solutions.
• People may be given some room/ability to make their own decisions and commitment to solve the problem.
• Recommended measures should be grounded by scientific evidences.
• Sending out simple messages over and over again helps people to soak in information.
• Appropriate strategies must be deployed in order to allocate necessary resources to the target population(s).
• It is important not to play a blame game because marginalised populations are vulnerable to become scapegoats.

III. METHODS/MEDIA – HOW DO WE DO IT?
• Communication tools can include both controllable and uncontrollable social media. Modes of communication may include the Internet, text messages, smart phone applications, exhibitions for children, and essay or poster competitions.
• It is useful to raise awareness through organising extra curricula activities and public meetings or debates.
• Using communication methods that appeal to peoples’ intuition is important for successful social marketing.

IV. TARGET – FOR/TO WHOM DO WE DO IT?
• The target audience could be general public or specific populations.

* TOPICS RAISED
The group proposed that any risk communication campaigns should consider the political and social context of each country. The group also discussed a marketing approach at the government level for effective behavioural changes. While some participants expressed concern that the term “marketing” might not be accepted in earning credibility in the context of risk communications from scholarly and government points of view, examples of the government health authority “selling ideas” and the public “buying the ideas” were shared. The group defined “social marketing” as a term for non-commercial purposes and discussed its usefulness in risk communications. It was still mentioned, however, that the use of the concept of “marketing” could have a negative impact, depending on how it is used.
CASE 2: SARS, H5N1 AND H1N1 IN SINGAPORE

1. Earning the trust and confidence of the public is difficult at the best of times. Fear is the dominant factor in any public health emergency. How do you go about getting people to be aware of the risk and to believe that effective protective actions are available and have confidence in them? How do you influence social behaviour and, in short, manage how you communicate the risk accurately whilst preventing mass panic?

2. Is culture an “enabler” or a “constraint”? How is it an “enabler” and a “constraint”?

3. What is the value of active citizenry and strong communities in building a society’s ability to absorb shocks, as well as to learn and overcome adversity?

Dr Menon’s group discussion focused on the question number 1.

I. ACTORS – WHO DOES IT?

• Governments have obligation to communicate risk through a 2-way exchange (advising and listening).
• Governments are to be encouraged to prepare themselves in anticipation of crises.

II. ACTIONS – WHAT DO WE DO?

• Context of the risks (earlier similar risks, current situation, uncertainties) needs to be explored.
• Risk, crisis and natural disasters should be differentiated.
• Resources for good communication (funds and human resources) need to be made available.

III. METHODS / MEDIA – HOW DO WE DO IT?

• It is contested whether to call an event a crisis or not. If it is called a crisis, in what tone should it be communicated? The point at which a risk will become a crisis needs to be defined by the governing authority.
• Both traditional and social media should be used for distributing messages. Tone and discourse to be used should be considered.
• Framing of messages should take into account past and current discussions about the issue in traditional and social media. By doing this, public health communicators can build on what people already know and understand about the issue and develop messages that are sensitive to the community’s fears and beliefs.
• Within communities, there will be variations in the availability of technology. These need to be taken into account when preparing for crises.

IV. TARGET – FOR/TO WHOM DO WE DO IT?

• For communications to be effectively targeted, key groups need to first be identified. Key influencers and people who are well connected to their communities also need to be found.

* TOPIC RAISED

The group discussed that culture plays a role in how people assess government information. This means that there will be variations in how people, in different cultures in Asia and Europe, interpret and act upon government-generated communications. The group also suggested that variations in culture be taken into consideration in planning the impact of communication and its delivery methods.
The questions that Ms Alexander initially proposed for group discussion were as follows:
• What would you say in the first announcement in an as-yet unaffected country?
• What would you want the house-to-house campaigners to convey to the people?
• How would you adapt messaging in response to results of a house-to-house campaign, feedback from the public, and deaths and cases identified?

Using the above 3 questions as a starting point, however, Ms Alexander’s group first decided 2 different settings: the countries severely affected by Ebola and the countries not yet affected. In each case, the group elaborated on answers to the below questions:

1. What do we communicate?
2. How do we keep up hope and address fear?

COUNTRIES THAT ARE ALREADY SEVERELY AFFECTED BY EBOLA

I. ACTORS – WHO DOES IT?
• The main actor will be local health authority.

II. ACTIONS – WHAT DO WE DO?
• In conducting risk communications, it is important to listen and empower communities through frequent, 2-way communication and updates from local leaders and health officials.

III. METHODS / MEDIA – HOW DO WE DO IT?
• Multi-channel communication by using different communication methods, e.g. radio, SMS, is effective.
• It is important to reflect the local community’s voice in addressing the crisis. One example is to hold community memorial services. Culture-specific conditions also need to be considered.
I. ACTORS – WHO DOES IT?

• The main actor will be local health authority.

II. ACTIONS – WHAT DO WE DO?

• Focus on preparedness (see below)

III. METHODS / MEDIA – HOW DO WE DO IT?

• Certain level of fear is good to alert people but should not be excessive. Fear and efficacy of the response should be balanced.
• Public communication should focus on preparedness (understanding the level of public knowledge and misunderstanding) and awareness education.
Examples of the preparation strategies include:
  o Point-of-entry assessment
  o Engaging the health community in communication by launching online media and web presence
  o Producing customised information by using local languages and human face
  o Conducting survey of healthcare workers for the public information
  o Engaging the media in planning with health community, e.g. simulation exercise
  o Timely release of information
  o Pre-test of public messages, e.g. panel discussion with representatives from different sectors

IV. TARGET – FOR/TO WHOM DO WE DO IT?

• The central health authority needs to inform both healthcare workers and the public of the risk of Ebola.

* TOPIC RAISED

The group discussed the importance of community-level involvement in the context of personalised communication and elements that need to be considered: available technologies, cultural sensitivity around death, involving traditional leaders in local community, etc.
SIMULATION EXERCISE &
MOCK PRESS CONFERENCE

On the second day, the participants were divided into 2 groups to conduct a simulation exercise of a fictional health emergency case. Based on the analysis done on the previous day, the participants were tasked as the first response multi-disciplinary task force to prepare a statement for a press conference.

Simulation Story – MARV in Matongé

In the district of Matongé in the centre of Brussels, the capital of Belgium, a child of a Ugandan family gets haemorrhagic fever within 36 hours after the family’s arrival from Kampala, Uganda.

A bat bite on the boy shortly before leaving Kampala will turn out later to be the cause of infection. The family got into Belgium based on false papers and is afraid to contact the authorities. They also refuse to go to a doctor or a hospital for proper treatment. Only “inside” Matongé people have contact with the sick child and the family.

The child has died due to massive internal bleeding (as autopsy will show later) and 2 community workers and a local midwife have first symptoms of the same disease. They all had contact with the sick child. The midwife goes to the emergency room of the local hospital in Parc Leopold and reports to have seen the same alarming symptoms in at least 5 people including her. She is immediately transported to the specialised infectious diseases unit of the CHU Saint-Pierre hospital in Brussels.

The Lake Victoria Marburg Virus is isolated from the midwife’s blood sample and reported to the Belgian authorities as the first case of Marburg virus disease (MARV) in Europe since 1967. This alarming news is not yet reported to the public.

Meanwhile at Matongé, a second family member and 1 community worker have deceased overnight. The First Response Multi-Disciplinary Task Force is contacted and members are asked to stand by in case of further deterioration and/or spread. The CHU Saint-Pierre hospital is nominated as temporary headquarters as well as a crisis centre.

Due to a “friend of a friend”, the local Brussels TV-channel reports on the Ugandan family and the suspicious deaths but the journalists cannot confirm any possible cause. Several other regional media (Flemish and Walloon) are picking up the story. The Belgian authorities cannot comment yet but plan to announce more news within 48 hours.

An uncle from Liége who visited the family on day 2 and a neighbour of the family in Matongé are hospitalised within the first week after arrival of the Ugandan family. On day 7, Brussels counts already 9 confirmed cases whereas 3 cases are fatal. Liége has 1 confirmed case hospitalised at Sart Tilman hospital. Antwerp has 1 suspected but non-located case reported by healthcare workers.

The Antwerp case has no clear connection with the Matongé family. The patient, and assumingly his sister, disappeared after visiting the polyclinic of the Institute of Tropical Medicine 2 days ago. They registered under a false name when they came to the polyclinic.
The First Response Multi-Disciplinary Task Force has its first emergency meeting.

Mission for the groups
1. Design a response plan based on the information you have so far. This plan should contain ‘working elements’ that were discussed on Day 1.
   You have approximately 2 hours to prepare a detailed plan including step-by-step actions for the upcoming week(s).

2. Communicate this plan to the media and public during a press conference (the assumption is that the plan is approved by Belgian authorities).
   The press conference will last for a maximum of 20 minutes and a Q&A session for 15 minutes will follow immediately after your press conference.

Press conference at CHU Saint-Pierre hospital

In the middle of group work, a “complicator” as below was introduced to both groups.

The Antwerp Police Department has located the brother and sister in the city centre and the 17-year-old boy’s condition has severely deteriorated. The sister has remained without symptoms until now. Most alarming is the news that both took the same flight with Brussels Airlines from Kampala as the Matongé family a week ago. The boy was sitting directly next to ‘patient 0’ on the airplane.
GROUP 1: PRESS CONFERENCE

The presenters consisted of 3 people; Director and a Member of the Multi-Disciplinary Task Force and Doctor from the Institute of Tropical Disease, “Dr BATS”.

On the side sat other members – Director and another representative of the CHU Saint-Pierre hospital, Director of Public Health Institute. The press conference was chaired by the Press Officer.

The director of the Multi-disciplinary Task Force announced the purpose of the press conference, followed by an explanation of the cases by a member of the Task Force.

Doctor from the Institute of Tropical Disease explained the symptoms of the disease, routes of infections, an incubation period, prevention measures, instructions for suspected patients and prospects of developing a cure (no vaccines currently available, but trial medications in process of authorisation).

The Director of the Multi-disciplinary Task Force shared information on the measures that have been taken so far and on the 24-hour hotline and on-line chat services via a dedicated web site. The public was assured that there would be a press conference with updates every morning.

GROUP 1: Q&A SESSION

Q: Are Congolese people at risk because of Ugandans?
A: We do not know which groups of people are particularly at risk. We only know that there was a case from Ugandan families in Matongé. We will need to wait for further information.

Q: What is the content of the risk assessment? Do we have risk from local bats?
A: Local bats have been tested and there is no risk of infection. Risk assessment involves identifying which groups of people are at risk and who had contact with the patients, including the passengers on the plane.

Q: What is the general recommendation for people?
A: It will be general pre-cautions including washing hands, avoiding crowded places, and following general hygiene procedures.

Q: Is MVD not a biological attack?
A: We do not see it as a biological attack. The pattern of spread is not the same as the biological spreads. There is no indication that there is terrorism at this moment.

Q: No containment measures to be taken?
A: Since it is not an air-borne infection, there is no need to close institutions and public places at the moment.

Q: What happened to the patient who died?
A: He is rested in the hospital, waiting for the medical examination.

Q: Do you intend to cancel the flights between Kampala and Brussels?
A: No. There is not enough evidence to support cancellation of the flights or the border closure.

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Members: Alautiah MIFTAHAYATI, Anna ADAMKIEWICZ, Daniel SCHMIDT, Harald HORNMOEN, Izabella LASKOWSKA, May LWIN, K. U. Menon, Natalie MAROUN, Patrick BRASSEUR, Ryoko EBINA
Is there a significant possibility that it is out of control?
There is an implication that not every detail is known. But it is also very important not to invite over-reactions, because we have to look at this in the context of other types of viruses that have come into our country. Typically, XYZ virus, which comes every winter, kills about 40-50 patients every year. And ABC virus also has a high fatality rate of 20% to 30%. So, at this point, with the fatality numbers that we are seeing now, we want to be very observant of the situation but we do not want to necessarily alarm the citizens.

Why did it take so long (to come up with a plan)?
It has been 4 days and the team has been working diligently. Explained was what the team has been working on for the last 4 days.

Are there any effective herbal medicines?
No. There is no effective medicine available in Belgium at the moment, including herbal medicines. But we are currently in negotiation with Canada, where trial medicine is available.

What would be the worst case scenario from a tropical disease expert’s point of view?
The team is doing its best to prepare for the worst case scenario. However, it is not realistic to discuss it with the public as we do not want to spread unnecessary anxiety. However, if the disease were not contained, it could affect all of Europe and there is certainly a risk of it becoming a global pandemic.
Marburg virus has a 60 per cent mortality rate. Its symptoms include a fever, body aches and a headache that are very similar to influenza. It is however only spread through contact with bodily fluids, so it is not highly contagious.

Health and community workers are now focusing on reaching people who have had contact with sick people in the Matongé community. A free clinic has been established for anyone in the Matongé area who is feeling unwell with flu-like symptoms. People can attend the clinic without their usual identification card.

People who have a fever, body aches and a headache are strongly recommended to see their doctor, particularly if they have had contact with the Matongé community. We are also working on reaching the contacts of 2 sick people who travelled to Antwerp.

The system is well placed to cope with the arrival of this disease and we are taking all necessary measures to treat the people with it and prevent its spread.
To successfully prevent the further spread of Marburg virus we will require the support and co-operation of everyone in the community.

Thank you again for coming today. The First Response Multi-disciplinary Task Force will now explain more about the response and will be able to answer your questions.

The spokesperson explained the case of diseased patient and current death tolls. He reassured the public that it is confined to a small number of people then explained the route of transmission, symptoms, and recommendations for those who have symptoms. The spokesperson repeated not to worry.

The Intelligence Representative stated that the current case is an incidental and an imported case. He then explained in detail the incubation period, symptoms and causes of death (organ failure). It was mentioned that there is no confirmed treatment and that vaccines are under trial. People were encouraged to avoid contact of bodily fluids with the suspected patients and to use protective gear when caring for patients.

The Operations Officer explained the resources available for the local community and healthcare professionals. Logistics Officer gave assurances that the necessary equipment is stocked and ready.

The representative from Social Services informed the public of the free health clinics in the community and gave assurances that the treatment would be available without requiring to provide identification. She expressed her wish to work with religious leaders to reach out to more people.

The representative from Local Community gave assurances that the outreach plan for schools and public places, including religious establishments, would be developed.

The Communications Officer reassured the public that timely updates would be given and bilateral communications were happening.

The representative from Transport Authority explained the measures taken in transportation. The alert level was heightened. However, there is no restriction for travels as there is no need to do so.

The National Focal Point for the International Health Regulations (IHR) reported that national authorities had informed the World Health Organization (WHO).
GROUP 2: Q&A SESSION

Q What is the procedure if you suspect that you are sick?
A All doctors in Brussels are now informed. Go see your doctor. It is not dangerous to go to a hospital because of the transmission method.

Q What is the treatment?
A It is only to manage the symptoms. There are better chances of survival if you are receiving proper care. It is not an active treatment but conservative treatment.

Q Is it not a biological attack?
A We have no source to believe that it is a biological attack. If we are provided with the source, we will be willing to look into it.

Q What happened to the 2 people who travelled to Antwerp?
A Tracking is on the way, but there is no evidence.

Q Is there a need for quarantine?
A We are dealing with a national crisis. It is more important to work with the affected community rather than to isolate them, because isolation often drives into more problems.

Q Matongé is known for its spa resort. Is there a risk?
A We already trained spa workers in the community. It depends whether you had contact with patients or not.

Q What about illegal immigrants?
A Free clinic is available without ID.

Q Many tourists come for a big sporting event. How many cases do you require to restrict travel?
A Generally speaking, travel restriction and isolation are not effective measures. We do not have sufficient ground to support travel restriction.

Q How do you expect us to believe that everything has been taken care of within 5 days?
A Spokesperson repeated the measures taken and requested people not to panic.
It was odd to have a multi-disciplinary team press conference where all the members are present. It is important that the team is multi-disciplinary, but usually 1-3 people suffice to hold a press conference.

Group 2 used the spider diagram to draw the chains of infections. It is a common way to understand the cases.

It is good to write down assumptions and check whether the assumptions are plausible. While it is not realistic to track everyone in the same flight, it is desirable to contact as many people as possible.

“Paper plan” was used to write down what planned actions are and what kind of brainstorming needs to be done for these actions.

List of stakeholders was used to identify all the stakeholders, various target audiences and means to reach them according to the level of risk.

Communication plan was used to identify target audience of initial communication and to decide a target group to send a message to.

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It was difficult to think about the technical part, e.g. tracking passengers, and the communication plan at the same time. More time was spent in developing the technical part, which was, though, essential to determine what to communicate.

Tension between communication and politics was discussed. Politicians are seen not to trust the communication team and to consider communication experts as not very technical. In some ASEM countries, there is no communication specialist in the Ministry of Health.

Timeliness of communication was emphasised. It is better to communicate the facts at the moment rather than later.

GROUP 1

The group spent a great deal of time trying to identify the objective of the press conference. The result was not satisfactory to all the members. It was also challenging to balance between over-reaction and under-reaction. Some participants agreed that the main objective was to alert the public about the current situation and communicate the seriousness, but some other participants were more cautious not to make people panic.

Once the objective was determined, the next step was to develop a communication plan and action plan.

Communication encompasses more than simple dissemination of information.

It is sometimes seen as advertising. Communication is one of the actions of the management as well as an output of the management. It is 2-way because there will be reaction from the audience.

It is important not to mention the specific ethnicity. The area of patients’ cases can be identified, but there will be every kind of people who walk in and out of the area.

It is important to emphasise humanitarian perspectives to avoid stigma and to ensure access to anonymous healthcare.

Most striking difference between the 2 groups was the table set-up. Group 1 had 3 main spokespeople while Group 2 made everyone speak in turn.

GROUP 2

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