High-level Meeting on Risk Communications for Public Health Emergencies: “Risk Communication & Leadership during Health Emergencies”

14-15 June 2017
Seoul, Korea
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“Announce early, be transparent and build trust with the people affected”. This has been the World Health Organization’s (WHO’s) advice on how health authorities should communicate about outbreaks, and other such health threats, since 2005*. The risk communication experts ASEF engages with from both Europe and Asia support these principles. However, there are still many instances of health authorities delaying their communication or withholding key information. There are a variety of reasons why this happens, but the most frequent one is “politics”.

The political interface is where emergency risk communication theory collides with the realities of government. Announcing an outbreak, or other such health emergency, has impacts beyond the health sector. It can impact trade, tourism, agricultures and the livelihoods of thousands of citizens working in those sectors. Other sectors will almost always have an interest in health emergencies. So too will the political level of government, which is ultimately accountable to the people for how the emergency is managed.

Between 2013 and 2016 the Asia-Europe Foundation (ASEF) held 4 workshops with risk communication experts from Asia and Europe. At the 2016 workshop, which was co-hosted in Stockholm by the European Centre for Disease Prevention and Control (ECDC), the political interface was identified as one of the key challenges countries need to address in their risk communication preparedness.

The 2017 High-level Meeting, co-hosted in Seoul by the Korean Centers for Disease Control and Prevention (KCDC), was a different type of meeting. It brought together senior officials and risk communicators to explore good practice in managing the political interface, and to make recommendations. This report is a record of what they discussed and the recommendations they agreed.

* Outbreak Communication Guidelines, WHO, Geneva, 2005
Welcome and Opening Remarks
Dr Ki-Suck JUNG / Director, Korea Centers for Disease Control and Prevention (KCDC)

Ladies, gentlemen, distinguished guests from home and abroad, I welcome all of you to Seoul – one of the oldest and biggest cities in the World. I am particularly happy to welcome: Ambassador Karsten WARNECKE, Executive Director of the Asia-Europe Foundation; Dr Margaret HARRIS, Spokesperson at World Health Organization headquarters; and Mr Yuji AMAMIYA, Director of the Ministry of Foreign Affairs in Japan.

Thank you all for taking time out to join this High-level Meeting on Risk Communication. I thank CDC officials and public health communication or healthcare authorities from 18 countries around the world. I also thank distinguished guests from Korea for making significant contributions to the development of public health policies and risk communication.

This Meeting puts together experts on risk communication and public health from international organisations to share up-to-date information for the improvement of public health, to update each other on current challenges and to explore solutions together. This is a milestone event since it is the first conference held by KCDC regarding risk communication.

We live in the age of One Health. Epidemics cross the boundaries between animals and humans, and borders do not mean much in responding to infectious disease outbreaks. In this regard, I believe it is critical that nations around world share their experiences and lessons learned. We should build together crisis management capabilities including risk communication. Public health authorities in Korea are making constant efforts to build stronger crisis response capabilities. We are also working hard to enhance international public health collaboration with Western Pacific nations. Nevertheless, emerging infectious diseases may pay us a threatening visit any time, and anywhere. Pre-crisis preparedness and peacetime drill are one of the most important ways to prevent and manage crises. It is for this purpose that KCDC is holding this High-level Meeting in Seoul on Emergency Risk Communication, in partnership with the Asia-Europe Foundation.

Communication is an essential part of crisis management, from begin to end. The core value of KCDC is communication and trust. KCDC’s policies have been developed based on this. Being trusted is KCDC’s current utmost goal, because we lost some trust several years ago. In order to achieve this goal, KCDC definitely needs communication that is rapid, transparent and evidence-based.

We believe that the prevention and control of diseases is enabled by the capability to respond to crises and by cooperation between government and civil society. The reason why experts from all over the world are gathered here today is to find ways to better communicate and cooperate in times of public health crisis, and to earn public trust. Effective communication is not possible without trust. I hope we are able to find the best risk communication strategies here at this meeting; by sharing our ideas; and by engaging in active and sincere communication.

I deeply thank again our co-hosts, the Asia-Europe Foundation, WHO officials and experts from diverse fields for providing great support for this important event. The Republic of Korea is committed to collective global efforts towards public health risk communication management. We also promise to share information with other nations and international organisations, and willingly provide technical support for relevant programmes.

I hope today’s meeting will be a great success; and I encourage your thoughtful advice and active participation. I also hope many experts from abroad will find their time here rewarding and take home beautiful memories of Korea.
Dr JUNG, colleagues, ladies and gentlemen, I am delighted to be back in Seoul. I represent the Asia-Europe Foundation. We work under the umbrella of a political process called the Asia-Europe Meeting (ASEM) that has been existing for the past 20 years. ASEM brings together 30 countries from Europe and 21 countries from Asia, as well as the European Union and the ASEAN Secretariat. The Asia-Europe Foundation (ASEF) was founded with the purpose of bringing together not politicians and government officials, but people. ASEF works to bring together the civil societies of Asia and Europe. Our goal is to promote understanding and cooperation between the peoples of the two continents. ASEF has been doing this for 20 years.

ASEF covers six thematic areas in its work: culture, education, sustainable development, public health and economy. Every year we do about 25 to 30 projects with over 100 activities. We partner with over 100 partner organisations. We have about 3,000 participants annually in our projects and activities, and an outreach to millions via our online platforms.

The ASEM Initiative for the Rapid Containment of Pandemic Influenza was launched at the 9th ASEM Foreign Ministers’ Meeting in 2009 in Hanoi, Viet Nam. Financially it was, and is, supported by the Government of Japan. The Initiative is geared towards combatting avian influenza and a possible future human influenza pandemic. Since 2009 the initiative has developed 2 key components:

- Stockpiling of Anti-viral Drugs and Personal Protective Equipment
- Public Health Network

In a nutshell, the ASEF Public Health Network is a participatory platform to encourage public health dialogue between the actors from health and non-health sectors across Asia and Europe. Through sharing good practices and analysing lessons learned, ASEF Public Health Network contributes to building ASEM partners’ capacity for managing health emergencies.

Since 2014 the ASEF Public Health Network has implemented 4 workshops on different aspects of risk communication. Strengthening risk communication, as you all are very much aware, is one of the common recommendations from a series of past workshops on multi-sector pandemic preparedness and response. Risk communication is also one of the 8 core capacities identified under the International Health Regulations (IHR), which all WHO Member States are required to comply with. The IHR direct and govern particular WHO and State Parties activities to protect the global community from public health risks and emergencies that cross international borders. Over the past 4 workshops on risk communication, public health events or emergencies examined include: E. Coli in Germany; the Japanese earthquake and tsunami; the 2003 SARS outbreak, H5N1 and H1N1 influenza viruses in Singapore; the Christchurch earthquake (New Zealand); the Ebola outbreak in West Africa; the Nepal earthquake; the MERS Coronavirus outbreak in Korea and Thailand; and Dengue Fever on the Island of Madeira, Portugal.

In the most recent workshop, co-organised in September 2016 with the European Centre for Disease Prevention and Control (ECDC), 6 key challenges in the implementation of emergency risk communication were identified:

1. Resources
2. Monitoring and evaluation
3. Community engagement
4. Uncertainty management
5. Emergency risk communication integration in the preparedness cycle
6. The political interface

We have gathered here for the next 2 days in Seoul, home of KCDC, to address the sixth challenge identified in 2016. The political interface is often a tough topic to broach, even though political commitment is essential to make risk communication effective. Political support is important to protect the public from health threats, as well as to prevent consequences to non-health sectors such as countries’ economy, trade and tourism industries.

That said I would like to thank my fellow colleagues from all the various Ministries of Health across Asia and Europe for taking the time out from your busy schedules to be here for the next two days. The work that you do is not easy, and is often riddled with challenges. Thank you and I wish everyone all the best for fruitful group discussions. May the solutions developed here today and tomorrow make a difference to people’s lives in the future.
Understanding Emergency Risk Communication and Its Implications

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Keynote Speech: Are we going the right way after MERS in Korea? Risk Communication Approach

Dr PARK’s presentation looked at Korea’s experience of, and lessons learned from, the outbreak of Middle East Respiratory Syndrome Coronavirus (MERS) in 2015.

In particular it focused on:

1. What happened during the 2015 outbreak?
2. Why did MERS spread so rapidly?
3. What was the socio-economic impact?
4. Why was the economic impact out of proportion to the threat?
5. KCDC’s current risk communication systems and guidance

What happened in the 2015 MERS outbreak?

The outbreak started on 20 May 2015. There had never been a case of MERS before in Korea, so the doctors who initially saw the patient thought he had a bad case of influenza. The epi-centre of MERS infections is Saudi Arabia and it is linked to contact with camels. Saudi Arabia is almost the other side of the world from Korea: MERS was perceived as a very exotic disease, and media interest was high. The index case in the outbreak was a 68-year-old man who had been on a business trip in Bahrain, Saudi Arabia, Qatar and the United Arab Emirates. He had arrived back in Korea via Qatar on 4 May and did not become ill until 11 May. The patient went to three large hospitals for treatment before finally being diagnosed with MERS on May 20. This means there was a period of 6 days when he was travelling around visiting hospitals. During this time, he infected a further 30 people with MERS in Pyeongteak hospital.

The 14th case infected by the index case travelled all the way to one of Korea’s biggest general hospitals and waited for some time in its crowded Emergency Room. He became a “super spreader”, infecting a total of 91 other people. In fact, persons infected by him account for almost half of the total number of cases in the outbreak (91 out of 186 cases or 49%).

(see table on next page)
The incubation period for MERS is about 2 weeks. The graph above shows the epidemic and its various phases. Several infected people travelled while still incubating MERS. Korea has a very good transportation system with bullet trains and city metros, so they could go a long way with the virus. The graph and the map above show which towns across Korea saw MERS cases. In total there were 186 cases of MERS, including 38 deaths (case fatality ratio: 20.4%). Nearly 17 thousand people had been quarantined for two weeks either at home or in hospitals.

Why did MERS spread so rapidly and extensively in Korea?

There are a number of factors. The first of these was lack of awareness and lack of preparedness. The public health system had heard about MERS from WHO, did not make any preparations. The result was the system took too long to identify the first MERS case to arrive in Korea.

Then when public health officials began doing contact tracing the criteria they used were too restrictive. They only quarantined and monitored people who had been within 2 meters of a MERS case for over an hour. It subsequently turned out that several people who had been in crowded Emergency rooms or hospital wards with the MERS cases, but who did not fit the 2 metres / 1 hour criteria, became infected. These people were not quarantined and so travelled without restriction around Korea taking the virus with them.

Another key structural problem was the way healthcare was organised in Korea then. Nearly 90% of hospitals and clinics are privately owned, whereas they are funded and regulated by the National Health Insurance which is a state run company. Their strategy for containing the cost of healthcare in Korea has been to encourage competition between healthcare facilities. This has been successful in that healthcare is relatively cheap in Korea. But it means Koreans can and do go directly to hospital for treatment, rather than seeking a referral from their family doctor (which, in theory, they are meant to do). Most hospital doctors are paid based on the number of patients they see, so they have no incentive to turn patients away. This means there is quite an overuse of hospital
services in Korea. It also means Emergency Rooms in Korean hospitals tend to be crowded. The low price of hospital services means there is a low level of investment in Emergency Rooms, so infection control is not as good as it could be.

Patients typically have large groups of family and friends going to hospital at the same time to visit them. Family members often stay 24/7 at the hospital to take care of their relative, and eat meals with them. Quite a number of cases in the MERS outbreak were therefore among families and friends of patients.

Another weak point in 2015 was the absence of guidelines and manuals for outbreak response. Where these did exist, they had not been tested. They were usually too theoretical and not practical enough. There were no national risk communication guidelines.

Dr Park highlighted that in 2015 the Korea public health authorities did not have enough field epidemiologists and other outbreak response staff with Epidemic Intelligence Service training. Korea had an Epidemic Intelligence Service (EIS) training programme but the people who do this are mostly young professionals in their 20s. Many of them do it as their military service. But after 30 months of training they go off and do something else. Very few stayed in the public health system. This has been changed and there is more retention of EIS trainees. But in May 2015 Korea had too few EIS staff trying to trace highly mobile patients, who had often visited multiple hospitals or doctors. In 2015 the public health authorities also had no powers to stop people who might have been exposed to the virus from travelling. All these challenges were before in addition to the problems surrounding risk communication.

Risk communication failures in the 2015 MERS outbreak

1. Failure to disclose. In Dr Park’s view the biggest problem in 2015 was the late disclosure of information. The first MERS case was confirmed on 20 May 2015. It was not until 8 June that the Ministry of Health released information about which hospitals the index case had visited. In other words, there was a delay of 18 days.

   This failure to disclose was not just a communication failure. It was a disease control failure. This was the conclusion of a paper published by a group of Korean experts after the outbreak: communication failures contributed to the wide and rapid spread of MERS in Korea. Families of patients did not have any information about whether MERS was spreading at the hospital their relative was in. They therefore did not have the opportunity to avoid going to affected hospitals. In a similar way, the failure to disclose meant people did not know if they had been in close proximity to a MERS case. When they got ill, they sometimes did not realise it was MERS and did not report to the authorities. This all made it more difficult to identify new MERS cases, track people potentially exposed to MERS and quarantine them. The failure to disclose made the outbreak bigger than it needed to be.

   The failure to disclose was also damaging from a psychological and emotional perspective. People want to know information about threats that may affect them or their families. They want to be able to protect themselves. When the authorities have this kind of information but will not share it, people get angry. They feel fear, stress, frustration – maybe even depression or outrage. This is what happened in May and early June 2015. Korean citizens started to make their own map of where they thought the MERS cases were. The government was not giving information, so people looked for information from other sources like their friends, their neighbours or the internet. Rumours started, and these provoked more rumours in a kind of snowball effect. Even though the government repeatedly said the map produced by citizens was inaccurate, most people believed the map.

2. Over reassurance. During the 2015 outbreak one of the health authorities’ key messages was that people were only at risk of infection if they were within 2 meters of a MERS case for more than one hour. This turned out to be a simplistic and over-optimistic view of the risk: numerous people were infected in crowded Emergency Rooms who did not meet the 2 meters / 1 hour criteria. This over reassurance was at the base of a lot of the distrust that developed against health authorities.

“People want to know what is going on during Public Health Emergencies because they want to protect themselves.

Lack of information disclosure makes people learn on rumours.”
3. Power struggle between different authorities. The national government kept telling people “you are OK”. But local governments started saying to people “you are not OK”. In particular the Mayor of the Seoul Metropolitan Government went on live television and gave the message, “you are not OK”. People got frustrated by this lack of coordination between the different levels of government.

What was the socio-economic impact of MERS?

There was a huge social reaction to the MERS outbreak. Normally busy shopping districts were empty. Lots of people wore face masks. And people believed rumours and misinformation, such that you could catch MERS from deer or bears (in fact the animal reservoir of MERS is camels). But because the government was not communicating, rumours filled the information vacuum.

The climate of fear and rumours had a major impact on Korea’s economy, especially on the tourism sector. In May 2015, there was nearly a 40% drop in the number of tourists visiting Seoul and an 18% drop in customers going to Seoul’s shopping malls. Tour operators and hotels laid off staff. Some businesses went bankrupt. Summer is usually the peak time for exhibitions and tourist events, but many of these had to be cancelled because people stopped travelling. Jeju Island off the coast of Korea is a popular destination for Chinese tourists. There were no cases of MERS on Jeju Island, but the Chinese tourists didn’t know this so stayed away.

Economists estimate that the MERS outbreak cost the Korean economy between US $10 and 20 billion. This is between 8% and 16% of Korea’s monthly GDP. Or somewhere around the total annual GDP of Honduras (US $19 billion), Jamaica (US $14 billion) or Madagascar (US $11 billion).

On 10 June 2015, the government of Korea and the World Health Organization (WHO) established a Joint Commission to review the MERS outbreak. The WHO team was led by Assistant Director-General Dr Keiji FUKUDA and included Dr Margaret HARRIS. Bringing in WHO was a crucial step towards re-building trust with the Korean public. But even though the Joint Commission recommended against closing schools because of MERS, some schools and kindergartens closed all the same. Many Korean families nowadays have only one child, so parents can be very protective. There is a famous photo from 2015 (below). It shows a young Korean couple getting married. Both bride and groom are wearing face masks and so are all of the guests. The photograph might have been a joke, but it captured the public mood of that time.
Why was the economic impact out of proportion to the threat?

On 29 July 2015, the journal *Nature* published an editorial on the Korean MERS outbreak. It concluded that “The episode was tragic, but its economic and social impact was disproportionate. If the world is to respond effectively to infectious disease outbreaks, then the authorities, the media and communities must pay more attention to risk communication.”

That was the conclusion of *Nature*, but it also came to be the conclusion of the Korean government. Back in 2015 one of the things the Korean authorities failed to appreciate is the difference between perceived risk and real risk. The two things are totally different.

KCDC needs to keep feeding people information and acknowledge their emotions if we want to narrow the gap between perceived and real risk. It’s not easy, but we are trying to do that.

### Communication and Trust

Dr PARK quoted and endorsed the message of KCDC Director Dr JUNG in his opening address “good communication is not possible without trust”. It is important also to engage with communities and get them to make their own decisions about behaviour change. Building and maintaining trust is therefore KCDC’s number one objective.

### Lessons learned from MERS

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<th>Korea has a long list of lessons learned from the 2015 MERS outbreak. In the area of public health structures these include:</th>
<th>Key health lessons learned in the area of risk communication include:</th>
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<td>• Revising Korea’s public health laws and regulation in order to prevent, detect, respond effectively. A reviewed Infectious Disease Control and Prevention Act was passed by the National Assembly in June 2016</td>
<td>• Improving citizen and media trust is crucial, because loss of trust leads to loss of money, job, life, etc.</td>
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<td>• Establishing the Emergency Operations Centre (EOC) operating 24/7 within KCDC and practicing many exercises</td>
<td>• Communication should be not from government &amp; expert’s perspective, but from survivor and patients’ perspective</td>
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<td>• Improving the referral system to hospitals with the aim of controlling “doctor shopping”</td>
<td>• The difficulty of changing perceptions and behaviour</td>
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In 2016 KCDC established its Office of Communication, headed by Dr PARK. This reports directly to Director Jung and also works closely with the Emergency Operations Centre when needed. It currently has 12 staff.

KCDC and its Office of Communication are committed to learning the lessons from MERS. In 2016, Korea had an outbreak of tuberculosis (TB). KCDC’s media communications disclosed the name of the hospital, gave details of the symptoms of TB and what people should do if they think they are infected. More recently, Korea had an imported case of Zika. KCDC released the name of the medical facilities where the cases were treated, and also gave information on infection risks and symptoms.
One legacy of 2015 is that Korea still has “suspect cases” of MERS from time to time. KCDC sends the media a weekly bulletin identifying the hospitals where “suspect cases” are being tested.

In 2015 KCDC did not have any risk communication guidelines. When the Office of Communication started up, it made use of WHO’s Outbreak Communication Guidelines (2005) and US CDC’s Crisis Emergency Risk Communication Manual (2014). However, in 2017 KCDC has adopted its own risk communication guidelines along with Standard Operating Procedures for Risk Communication for Public Health Emergencies. These can be downloaded in English and Korean from KCDC’s website. The diagram below is an extract from the KCDC guidelines and summarises the basic principles to follow:

### 5 Basic Principles of Risk Communication

1. Control Situation
2. Minimize Risk
3. Protect Organization
4. Secure Understanding of the Public
5. People’s Trust

### Objectives of Risk Communication for Public Health Emergencies

To respond to risk appropriately so as to prevent or minimize negative outcomes, and thus to protect the public, stakeholders and the organization from damages of the risk.

### KCDC Risk Communication Network

KCDC’s Office of Communication works with a network of partners and stakeholders – see the diagram below.
In Korea 40 million people out of a population of 50 million use smartphones. High speed internet available almost everywhere. KCDC therefore focuses a lot of effort on network based, internet based, mobile communication. It communicates via Facebook, via Korea's biggest search engine and via Twitter. Information releases are put out via multiple channels to ensure wide and rapid dissemination.

Final thoughts – the essence of risk communication

Dr PARK ended by reflecting on the essence of risk communication.

The WHO definition is: Risk communication includes the range of communication capacities required through the preparedness, response and recovery phases of a serious public health event to encourage informed decision making, positive behaviour change and the maintenance of trust.

The US CDC says that: Risk communication can help you provide the public with information to make the best decisions within incredibly challenging time constraints and to accept the imperfect nature of choice.

Dr Park's own working definition, based on his experience is:

1. Communicating the risk/the crisis to the public by spreading information rapidly, accurately, and transparently
2. Letting/guiding the public to narrow the gap between the real (objective) risk and the perceived (subjective) risk in PHEs (Public Health Emergencies)
3. Empowering the public to make the informed decision based on each individual’s own circumstance, which leads to minimizing the socio-economic loss of the society and the lives of the public

Biography

Kisoo PARK

Dr Kisoo PARK completed his education with Master of Graduate Journalism and Broadcasting from the Graduate School of Journalism & Mass Communication, Yonsei University in August 2009. He received his Ph.D. from the Department of Journalism and Communication, Graduate School of Kwangwoon University in February 2009 and ABD, from the Department of Public Health, College of Medicine, Korea University in February 2015.

Dr PARK is currently the spokesperson of Centers for Disease Control and Prevention, Korea and an Adjunct Professor in the Department of Health Policy and Management, Korea University. Prior to his current roles, he was the Deputy Spokesperson of MOHW, Korea from 2011 to 2015.
How Risk Communication plays an important role in Public Health Emergencies

Panel discussion

This panel discussion looks at how risk communication has played out in real life emergencies by sharing case studies and lessons learned from their organisations.

Panelists

Ms Joy Rivaca CAMINADE / World Health Organization Western Pacific Regional Office (WHO-WPRO)

Ms Karen TAN / Ministry of Communication and Information (MCI) Singapore

Dr Iris HUNGER / Robert Koch Institute (RKI) Germany

Ms Andrea WÜRZ / European Centre for Disease Prevention and Control (ECDC)

Topics covered

- How risk communication supports the response to health emergencies
- Examples of recent risk communication successes, best practices or challenges
- Experiences of working with high-level officials during emergencies
- Communication coordination and capacity

Ms Joy Rivaca CAMINADE expressed the view that risk communication is key to saving lives and mitigating risk during a public health emergency. This is especially the case at the early stages of an outbreak, when there is much uncertainty. People need information and guidance from the authorities on how to protect themselves, their families and their livelihoods. Providing this information – based on what you know at that stage – is a core risk communication task.

A second way in which risk communication supports the response is by embedding risk communication in the organisation’s preparedness and response plans. Risk communication needs to be linked to the risk assessment procedures, and it needs to be part of the overall response strategy of health authorities and governments.

Ms CAMINADE also emphasised the importance of addressing the needs to the vulnerable populations and the importance of addressing the psychosocial needs of the affected population, especially the most vulnerable. If the authorities neglect risk communication there will be rumours, anxiety, and even panic or stigmatisation in affected communities.

Regarding recent successes Ms CAMINADE pointed to work being done in the implementation of the Asia Pacific Strategy for Emerging Diseases and Public Health Emergencies (APSED) in support of developing systems and capacity for emergency risk communication as mandated under the International Health Regulations (IHR).
Ms CAMINADE cited China’s risk communication about human cases of avian influenza A (H7N9) during the 2013 outbreak as an example of good practice. The Chinese government was proactive in making sure that all the information they gathered was made available to the public. The H7N9 outbreak took place in the age of social media and it was the first outbreak where WHO used Twitter as the first point of information on new cases. Putting out official information by a WHO Tweet was significantly quicker than updating WHO’s website. Social media was also used to complement the traditional means of gathering rumours and in myth busting. WHO has subsequently used Twitter updates and other social platforms on cases in other outbreaks.

Other key lessons learned in recent outbreaks are the importance of countering rumours quickly in the “social media age” and the importance of coordinating messages between the different levels of WHO – country level, regional office level and global level.

On the subject of interaction with high-level officials, Ms CAMINADE noted the importance of evidence. Governments are often reluctant to communicate proactively about health emergencies because they perceive it will damage the economy. The evidence from Dr Kisoo PARK’s analysis of the 2015 MERS outbreak in Korea shows the opposite: that failure to communicate proactively can do huge damage to the economy. Risk communicators need to gather the evidence to make this case. Senior officials like to ask: “how do you provide evidence that your risk communication is effective?” Risk communicators need to do better at ‘monitoring and evaluation’ of their activities so they are better able to answer this question.

Ms CAMINADE pointed out that countries in WHO’s Western Pacific Region are diverse. It has some of the smallest island nations and the world’s most populous country, China. Nonetheless, one common theme across the region is the limited resources available for risk communication. Training people is not enough. Risk communication teams need sufficient resources and other enabling factors such as agreed policies and procedures. These make the system sustainable and not over reliant on one or two key individuals, who will at some point change jobs or retire.

Ms Karen TAN / Ministry of Communication and Information (MCI), Singapore

Ms Karen TAN started by saying one of her key lessons learned during SARS is that to communicate effectively during a crisis you need to know what people are thinking. This will enable you to “plug the gaps” and give people information that is valuable to them.

The most intense period of the SARS outbreak in Singapore was March to May 2003. A key challenge at the start of the outbreak was that the disease did not have a name. Eventually it got given the name Severe Acute Respiratory Syndrome, shortened to the acronym SARS. Singaporeans said this stood for “Singaporeans Are Really Scared”. They were scared of taking taxis, because maybe the taxi driver had just taken a SARS case to the hospital. They were sacred even of nurses, because the nurses were wearing their uniforms in a hospital where there were SARS cases – people were scared they could be contaminated just from touching the uniform. People were scared of losing their lives, of losing their loved ones. But they were also scared that the economy would suffer, that tourists and regular customers would not return.

The way the Singapore authorities countered this fear was by giving the population many things to do. For example, voluntary organisations were given the task of delivering food to people who had been put in quarantine. Singapore developed the concept of “Whole of Society” response to a crisis.
1.2 How Risk Communication plays an important role in Public Health emergencies

Ms TAN summarised her top five lessons from SARS as:

1. **It is important to be prepared, but to be flexible.** You may need to adapt your plans in light of developments that cannot be predicted in advance. For instance, after SARS Singapore prepared a lot for a future influenza pandemic. The planning assumption was that the pandemic would start in the Western Pacific Region, whereas the 2009 pandemic actually started in Mexico. Another example is that after SARS, Singapore built up a “surge capacity” system where staff from the primary healthcare sector got a bigger role in emergency response. This relieves some of the pressure on hospital emergency rooms. What happened in the 2009 pandemic is that most cases were dealt within special Pandemic Influenza Clinics in the primary care sector.

2. **Guard against complacency.** Health authorities must always be prepared for the next crisis. Singaporeans have a tendency to leave everything to the government. They think it is the authorities’ role, and not theirs, to prevent the spread of diseases. The authorities therefore need to keep on communicating about the importance of action by individuals to prevent diseases.

3. **The importance of transparency and honest public communication.** During SARS the Singapore authorities created a website with clear information about what they know, what they don’t know and what they are trying to find out. This honesty and transparency is the foundation of trust and confidence in the authorities.

4. **The need to build credibility with the population.** Credibility needs to be built in times of peace, and not just during a crisis. Trust is a continuum. It cannot be build overnight just by saying “please trust me”. Transparency needs to be embedded in what health authorities do on a routine basis, in order to work effectively during an emergency. By being transparent in their routine work health authorities can build a bank of trust and credibility with the population.

5. **Response must take a Whole of Government – and if possible a Whole of Society – approach.** Ms TAN explained Singapore’s concept of “Whole of Government” emergency response. The Ministry of Health takes care of health sector response. However, other key sectors likely to be impacted – such as transport, education, border control, etc. – are brought together under a Homefront Executive Group. The Homefront Executive Crisis Group then reports to a Ministerial Committee. The Ministry of Communication and Information (MCI) is involved – and takes the lead – on the information management part of this. MCI clears the narrative and establishes the “lines to take” when speaking to the media. All Government departments and agencies must then take note of the central narrative and communicate based on the lines established.

Another lesson learned during SARS is the importance of considering emotional and psychological dimension of communication. Effective risk communication is not just “facts, facts, facts”: you also need to empathise with people’s concerns. During the SARS outbreak the Ministry of Health and Ministry of Education agreed to close schools for 12 days, even though the evidence base for this measure was weak. The government communicated transparently that this measure was not evidence based, but is being done to address public fears about SARS.

They can draw on this during a crisis. During SARS Singapore implemented quite a severe policy of home quarantine orders. Thousands of people were under home quarantine orders at one point. But the health authorities managed to get public support for this. Ms Tan attributed this to the trust the health authorities had built with Singaporeans in the years and months before SARS.
Social media can be a challenging area for coordination. When rumours or untruths appear there some government officials are tempted to think: “It’s just people chattering on social media. The chatter will soon fade away. We can ignore it”. The analysis of Singapore’s MCI is that if people throw mud on social media for long enough, eventually some of it sticks. MCI therefore has guidance on how to counter “DRuMS” on social media: Distortions, Rumours, Untruths, Misunderstandings and Smears. In Ms TAN’s view, the key to success is being very rapid in your tactical response. You cannot just wish for the DRuMS to go away. If a department does not want to respond then MCI will take the lead and craft a response. This happens routinely, during times of peace, as well as in crises. Ms TAN regarded responding to rumours as good practice in developing communication coordination and crisis “battle rhythm” across government.

Ms TAN shared that Singapore puts its emergency coordination systems, such as the Homefront Executive Group, into operation quite regularly. For example, the police recently arrested a young woman suspected of ISIS related activities. This was not just an issue for the Ministry of Home Affairs, it was also an issue for departments across Government such as the Ministry of Education and the Ministry of Religious Affairs. In short, then, using the coordination structure during peace time is key to successful coordination during emergencies.

Discussing Singapore’s Standard Operating Procedures for risk communication, Ms TAN said the information management system is very clearly defined. Any big issues that impact the public go through MCI. Within MCI there is an Information Operations Centre, which acts as a focal point for cross-government communication coordination. During an emergency what the authorities do is at least as important as what they say in creating public confidence. The Information Operations Centre therefore brings together information operations and tactical response.

Questions from the floor

How do you deal with the media sensationalising issues and spreading rumours?

Ms TAN’s answer regarding media sensationalism and rumours was that governments and health authorities need to beat their drum louder than the other guys. They need to be rapid and proactive and push their message out using multiple channels. For example, Singapore currently uses Facebook, Twitter and even chatbot to get its information out. Ms TAN saw reaching people’s mobile devices as key as this is the first place many people see news these days.

Has Singapore used WhatsApp as a channel for communication?

Ms TAN stated that WhatsApp is becoming an increasingly important information sharing services in Singapore. Because WhatsApp is a closed service MCI cannot systematically monitor what is being said on it. However, it seems WhatsApp is often used to share misinformation and rumours. On those occasions when MCI has become aware of a rumour circulating on WhatsApp it has sometimes put them into the public domain – for example, briefing TV or newspapers – so that MCI could rebut the rumour. The Singapore government also has a website called “Factually”. This sets out the facts about an emergency or health issue one by one, and is another important tool to counter rumours.

Dr Iris HUNGER / Federal Information Centre for Biological Threats and Special Pathogens, Robert Koch Institute (RKI), Germany

Dr Iris HUNGER explained that the Federal Information Centre for Biological Threats and Special Pathogens was set up in 2001 following the Anthrax letter incidents in the US to respond to the perceived threat of bioterrorism. Since 2001, the Centre’s role has evolved. Bioterrorism is seen as one among several threats associated with special pathogens. The definition of “special pathogens” now includes Ebola, Plague, Anthrax and pox viruses as well as biological toxins such as Ricin and Botulism toxin. These are dangerous pathogens that most doctors rarely encounter. A special effort is therefore needed to provide information and training around how to respond to them. The Centre provides this knowledge, training and specialist response capacities.
### Topics covered

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<th>The role of Germany’s Federal Information Centre for Biological Threats and Special Pathogens</th>
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### Challenges / lessons learned from other recent health emergencies

- **Zero cases of Ebola infection** occurred in Germany during the 2014-2015 outbreak and no German citizens were infected in West Africa. Nonetheless, 4 non-German experts suspected of having Ebola received treatment in Germany. 3 had already developed Ebola Virus Disease while in West Africa and were evacuated for treatment. The other was a South Korean doctor who received a needle stick injury while treating an Ebola patient in West Africa and was evacuated to Germany for observation (though did not develop the disease). The first Ebola case arrived in Hamburg in August 2014. The other cases came to Frankfurt and to Leipzig in early October.

Risk communication around these cases was not particularly challenging. Germany has a network of hospitals that have the expertise and facilities to treat patients under Bio-safety Level 4 (BSL4) conditions. They have established credibility over the years, so people in Germany associate these hospitals – along with pictures of people in bio-safety suits – with safety and security. These BSL4 centres do quite a lot of routine risk communication during peace time. They tell people what they do and how they guarantee safety. So, communicating about these four cases being treated in BSL4 centres was not difficult.

### Communication coordination

Risk communication around the overall public health threat from Ebola, however, was very challenging. People worried about whether the health authorities would recognise an Ebola case quickly enough if an infected person entered Germany. And they worried about the risk of infection if an unrecognized Ebola case was out in the community. The objective risk of this happening was very low, but people still worried about it.

Dr HUNGER observed that every country seems to have a crisis that acts as a “wake up call” to improve its emergency response and risk communication. The 2011 outbreak of Enterohemorrhagic E. coli (EHEC) certainly produced a number of lessons learned for Germany. The 2011 outbreak produced a very large number of cases – close to 4000 – including more than 50 deaths. Quite a number of children were affected; but the majority – unusually for such an outbreak - were adults. Many were seriously ill. There was a lot of pressure to identify the source of the outbreak. Dr HUNGER discussed how these pressures led Regional level politicians to wrongly identify Spanish cucumbers as the probable source of the outbreak. Dr HUNGER also discussed the different partners and players at Federal and Regional level involved in the response. Coordinating actions and communications between these different partners was challenging given their differing mandates. For example, in the very early stages of the investigation, there were differing views about whether to advice against eating salads given the differing mandates.

Dr HUNGER gave as an example of best practice an RKI initiative from 2010 to communicate routine disease prevention messages in times of peace to prepare for future emergencies. This idea followed the 2009 influenza pandemic and a realisation that many of its key messages – for example, on handwashing or staying at home when sick – are still applicable in times of peace. The campaign was called “We against Viruses”. RKI and other German health agencies reused and adapted TV spots and posters from the 2009 pandemic on topics such as hand-washing and “stay at home when you are sick”. The posters from this campaign are still on display in many schools and in work places. Hand-washing is probably always a good message – but it is especially relevant during an epidemic.

On the subject of communication coordination and working with high-level officials, Dr HUNGER noted that experts at RKI provide evidence for decision making work on the basis of carefully weighing the pros and cons of different options. They are used to dealing with uncertainty and talking in relative terms or calculating probabilities. But politicians have to deal with the public. They want short and clear messages and absolute terms. The politicians increasingly understand it’s not so easy to be short, clear and absolute when dealing with emerging risks. Nonetheless, they still press the experts to be short, clear and absolute. Another key difference between politicians and experts is the time frames they work in. Scientists usually work in a long-term time frame. Politicians want short term answers. Experts like to move forward cautiously, while politicians feel compelled to move quickly. Dr HUNGER gave the example of a discussion on whether to communicate about a possible case of Lassa Fever based on just an initial test. The experts persuaded the politicians to wait a few hours for the result of confirmatory tests (which turned out to be negative) before communicating.
**Ms Andrea WÜRZ / European Centre for Disease Prevention and Control (ECDC)**

Ms Andrea WÜRZ explained that ECDC’s mandate is to provide risk assessments and scientific evidence about infectious diseases, and to put forward options for outbreak response and control. It is up to the European Commission and EU Member States to then undertake risk management actions. ECDC supports cross-border risk communication by, for example, preparing suggested key messages and answers to Frequently Asked Questions. ECDC bases these on the scientific evidence, and Member States can then decide whether they use them in their risk communications.

A key challenge in multi-country emergencies is **how to ensure coherence and coordination** in risk communication. The EU has a body called the Health Security Committee (HSC), coordinated by the European Commission, which brings together high-level public health officials from the Member States. There is a network of risk communicators from Member States’ health authorities linked to this Committee. When an outbreak happens, the network holds regular teleconferences. ECDC joins these to discuss key communication challenges and what the key messages should be. ECDC will frequently develop suggested “lines to take” and share these with the HSC Communicators’ Network. The Network discusses these and tries to facilitate communication coordination between Member States. ECDC has structures to coordinate with other key partners such as WHO and with other EU agencies, for example with the European Food Safety Authority in case of foodborne outbreaks. Maintaining these structures enables the Commission and ECDC to convene people during critical incidents, and facilitates communication coordination.

Since 2013 there is an official EU Decision (Decision 1082/2013) that strengthens coordination among Member States and the European Commission when responding to serious cross-border health threats. This includes articles on the importance of coordinating crisis and risk communication. Communication coordination is therefore recognised as an important issue at the highest level in the EU.

Ms WÜRZ gave her view that **key to effective response and risk communication** in outbreaks is having clear and consistent messaging on: What is the risk? How is the disease spreading? What can people do to protect themselves and their families? Also, what are the health authorities and other partners doing to respond to the outbreak?

Turning to **lessons learned** Ms WÜRZ observed that each emergency has its own challenges and its own issues. The **influenza pandemic** of 2009 was the first time ECDC faced a major health threat (ECDC had been operational since 2005). The 2009 pandemic tested all the systems of communication preparedness ECDC had put in place. The evaluations of ECDC’s response showed it needed to revise and strengthen its risk communication and coordination systems. Ms WÜRZ discussed a number of these such as reinforcing the communication section with additional staff and streamlining the message clearance system.

ECDC learned further lessons during the **Ebola outbreak in West Africa (2014-2015)**. An initial challenge was putting the risk posed to Europe into perspective. There were a lot of media reports and false alarms about suspected Ebola cases in Europe and, linked to this, the fear that Ebola would start spreading in Europe. ECDC’s messages on Ebola therefore focused on “how does the virus spread” – and also how does it not spread. ECDC also developed messages on what was being done at EU level to respond to the outbreak: this included EU support to the response in West Africa as well as preparedness measures being put in place in Europe. There was also a lot of message development and coordination with Member States on communication aimed at frontline health professionals who may have to deal with medically evacuated Ebola cases.

More recently ECDC has been working on Zika Virus. A key activity on this was strategic communication planning, because the outbreak has been occurring in other regions of the world. ECDC analysed possible triggers for media interest
about Zika in Europe. ECDC then planned for the communication response – for example, by developing key messages. The lesson learned was the importance of planning ahead and trying to anticipate high media attention.

Regarding how ECDC assists countries in developing or maintaining risk communication capacity, Ms WÜRZ says ECDC meets regularly with its counterparts in Member States and hosts events such as capacity building workshops. A recent example was a meeting with communicators from Member States looking at the challenges of using social media for risk and crisis communication. Countries presented their experiences – including what went well and what went less well. Other capacity building / maintaining activities ECDC does are developing guides and tools to support effective risk communication, and facilitating sharing of best practices between Member States.

In 2016 ECDC engaged in a project looking at core competencies for preparedness in general. One elements of this project was looking at core competencies for emergency risk communication. In other words, defining the key skills and knowledge needed to be effective in risk communication. The list ECDC produced included many of the areas of skill and knowledge being discussed at this KCDC/ ASEF high-level meeting.

Ms WÜRZ highlighted the following competences in relation to working with the political interface:

The list of core competences was sent for consultation with public health experts working in Member States and other countries. ECDC's report on core competencies will be published shortly on the Centre's website.

What changed in ECDC's clearance processes following the evaluation of its response to the 2009 influenza pandemic?

ECDC changed the management work flows in its Public Health Emergency (PHE) plan so that the communication function is part of the PHE / incident management structure, proactive communication strategy is discussed rather than just reacting to developments in the media.

Ms Karen TAN of Singapore was asked about the importance of coordinating messages with international partners, as well as across national government. Ms TAN acknowledged the importance of this. Singaporeans look at many different websites and compare what different international bodies are saying. In her view WHO and US CDC are particularly important and trusted, so it is important to be consistent with their messages. “It is very important to look at what other players are saying, and not to try to create your messages in a vacuum. For example, during the MERS CoV outbreak in Korea in 2015 we followed very closely what KCDC was saying.”

Since SARS in 2003, Singapore has built partnerships with third part agencies. Having a network of partnerships with key opinion leaders and influencers is an important way to reinforce the credibility of health authorities. What Singapore did during SARS was to open up all government statistics and invite WHO to come in and have a look. WHO was also invited to attend government emergency management meetings. This gave the media and the public a strong message that the government was being transparent.

Asked about how often Singapore activates its Homefront Executive Group for emergency coordination, Ms TAN replied “Many, many times!” There is a very clear protocol on who does what and who is responsible for what. This means Singaporean officials know who to contact in a crisis, or even a pre-crisis,
How to make coordination across government work

There was a discussion on how to make coordination across government work when many Ministries are involved in an incident. A participant shared their experience of responding to a large food poisoning incident linked to contaminated alcohol. A total of 8 Ministries were involved in the response, including the Ministry dealing with regulation of alcohol, the Ministry of Commerce, the Ministry of Tourism and the Ministry of Industry as well as the Ministry of Health (which was in the lead). Getting consensus on messages with such a large group took a long time and was not very satisfactory. The panel was asked for ideas on how to reduce the length of time it takes to agree messages across government. The panel’s ideas or observations included:

- Having high-level political commitment to the principles of Whole of Government communication and proactive risk communication;
- Having Standard Operating Procedures agreed in advance detailing who does what, and who leads on what in different emergency situation. These Procedures can also set time limits for responding when an agency or ministry is consulted on messages or materials;
- Conducting communication coordination exercises during times of peace. This helps risk communicators in different parts of government build working relations with their counterparts. “Once you have established a working relationship with someone then coordination works more effectively”;
- Giving joint press conferences. This produces very rapid coordination as you decide in real time which government ministry or agency will answer which question from the media;
- Being very clear about who leads on which issue, and then have Ministries or agencies communicate only on their area of responsibility.

Risk perception assessments

Ms Joy Rivaca CAMINADE of WHO-WPRO raised the importance of doing risk perception assessments when developing messages. In the incident raised by the participant (poisoned alcohol from rice wine) the initial key message proposed was for people to stop drinking this product. The reality, though, was that people were not prepared to do this. Gathering information about the affected communities’ fears and perceptions helped develop a more effective key message.

During an outbreak of acute watery diarrhoea in another WPRO country, people were not acting on their key messages. Dialogue with people in the affected villages showed they did not realise children can die from acute diarrhoea. Once they got news that children in neighbouring villages had died from diarrhoea then they started acting on the government’s prevention messages. Producing risk perception assessments helps produce more effective messages. It also increases the credibility of the risk communication function in the emergency response team and is a real value added for communicators to bring to the decision-making table.

Communicating uncertainty about Zika Virus

There was a discussion on the Zika Virus and how to communicate with the uncertainty surrounding its health impact. One particularly tough area is what advice to give to pregnant women who may have been infected with Zika, given the uncertainty of the risks to their unborn child. In some Zika affected regions in 2016 women were asking for advice on whether to terminate their pregnancies or stop efforts to conceive.

Ms Karen TAN expressed the view that is better to err on the side of caution, especially during crises. It is good to give people some anticipatory guidance about risks they might face so they can prepare for them. This was the approach Singapore took during the 2009 influenza pandemic: the authorities warned there may be some deaths once the virus started spreading in Singapore.
**Biographies of Panel Members**

**Joy Rivaca CAMINADE**

*Technical Officer (Risk Communications), World Health Organization – Regional Office for the Western Pacific*

Ms Joy Rivaca CAMINADE is a Technical Officer (Risk Communications) at the World Health Organization – Western Pacific Regional Office (WHO-WPRO). She works under the WHO Health Emergencies Programme and provides support to countries and areas in the Western Pacific for national capacity development in risk communication in line with the requirements of the International Health Regulations (IHR, 2005) and the Asia Pacific Strategy for Emerging Diseases and Public Health Emergencies (APSED III).

Joy also serves as the risk communication focal point in WPRO during outbreaks and public health emergencies and oversees the development and implementation of risk communication plans as part of health response operations. Joy is a development communication practitioner with about 25 years of professional experience in the field of programme management, public information, emergency and risk communication, social mobilisation, community engagement and knowledge management. She is skilled in the development and implementation of communications programmes, especially in the context of public health emergencies and disease outbreaks.

Joy has been deployed to high-profile public health emergencies to manage communication response. During the Ebola outbreak in Sierra Leone in 2014-2015, she coordinated the risk communication and community engagement activities of the World Health Organization (WHO), and later on as part of the United Nations Children’s Fund (UNICEF) team.

In 2016, she was also deployed to Tonga for the Zika emergency response and to Solomon Islands in the Pacific and Samoa in the Philippines for the diarrhoea outbreaks. From July to September 2016, Joy was deployed to the Republic of Congo to support the Africa Regional Office of WHO for the yellow fever response in Angola and the Democratic Republic of Congo.

**Karen TAN**

*Senior Director, Ministry of Communication and Information, Singapore*

Ms Karen TAN is Senior Director/Public Communications in the Ministry of Communications and Information, Singapore. She is responsible for driving and coordinating Whole-of-Government public communications, including national marketing and sustained messaging to obtain the public’s understanding, trust and support for policies and programmes. Specifically, Karen directs and plans national marketing efforts to ensure amplification of messaging and national narratives on a sustained basis.

Karen is also leading the planning and coordination of the Whole-of-Government’s effort in crisis communications. This involves development of strategic communications plans for different scenarios and establishment of processes and systems to strengthen crisis communications for national level crises to ensure timely information management. Prior to her current position, Karen served at the Ministry of Health (Singapore) for 10 years. At the Ministry of Health, she served concurrently as the Director of Corporate Communications and Press Secretary to the Minister of Health.

During that time she was responsible for strategic communication planning, media relations, issues management, corporate publications, community relations and public consultation. Karen was responsible for all aspects of mass communications during the SARS epidemic in 2003 and the influenza A (H1N1) pandemic in 2009.

**Iris HUNGER**

*Deputy Head, Federal Information Centre for Biological Threats and Special Pathogens, Robert Koch Institute, Germany*

Dr Iris HUNGER works at the Federal Information Centre for Biological Threats and Special Pathogens (IBBS) at the Robert Koch Institute in Berlin. The responsibility of IBBS is to strengthen national public health preparedness and response capabilities to biological threats caused by highly pathogenic or bioterrorism-related agents. From 2006-2011 Iris headed the Hamburg Research Group for Biological Arms Control at the University of Hamburg, Germany, where her work focused on bioweapons non-proliferation and arms control, security aspects of the life sciences, and the role of civil society in preventing the (re)emergence of biological weapons.

She also held positions at the Office for Disarmament at the United Nations in Geneva and the Planning Staff of the Federal Foreign Office in Berlin. She is the author of “Bio weapons control in a multipolar world. The role of trust in international relations” (2005) and co-editor of “Bio preparedness and public health. Exploring synergies” (2013). Iris holds a Master’s Degree in Biochemistry and a PhD in International Relations.

**Andrea WÜRZ**

*Expert, Communication Capacity Support, European Centre for Disease Prevention and Control*

Ms Andrea WÜRZ joined ECDC in 2006, and is currently a communication expert at ECDC’s Public Health Capacity and Communication Unit. Her activities currently focus on the development of communication tools, guides and capacity building activities to support countries in effective risk communication for prevention of infectious diseases, and in the context of preparedness planning.

Andrea’s professional experience includes corporate communications and press and media work. She studied journalism and has a postgraduate degree in international relations (Central University of Venezuela), and a Master in EU Law and Economics (Spain).
1.3

Health, Trade, Tourism and Beyond

Panel discussion

This panel discussion explores emergency risk communication from the perspective of senior officials. The panel focuses in particular on the issue of communication coordination, and how economic and diplomatic considerations interact with emergency risk communication.

Panelists

Dr Shoji MIYAGAWA / Director, Infectious Diseases Information Surveillance Office, Tuberculosis and Infectious Disease Control Division, Health Service Bureau, Ministry of Health, Labour and Welfare, Japan

Ms Rhonda OWEN / Department of Health, Australia

Dr Francisco GEORGE / Directorate General of Health, Portugal

Dr Patrizia PARODI / Ministry of Health, Italy

Dr Shoji MIYAGAWA noted that Japan has a lot of experience of emergencies, like big earthquakes. For example, there were big earthquakes in Kumamoto and Tohoku in the last few years. Japan has also seen outbreaks of food poisoning. All these events have shown the importance of risk communication and in particular the importance of the role of the national government alongside the role of local government. The national government in Japan has been developing several organisations and schemes to respond to emergencies.

Particularly when there’s an infectious disease outbreak, the Japanese authorities produce science-based factual information for the public and other sectors. Dr MIYAGAWA regarded having a rigorous risk assessment as key to this. It helps people understand the situation and the government response and the measures we have to take. The risk assessment guides the response as well as the risk communication.

The risk assessment report will contain the factual information the authorities need to communicate. Japan has a National Institute for Infectious Diseases which has experts in epidemiology, microbiology and virology. The Institute provide the Ministry of Health with risk assessments and other expert information directly and also via the Institute's website. The Ministry bases its risk communication on the information and assessments from the Institute.

Topics covered

- Importance of risk communication during high-profile emergencies
- The link between risk assessment and risk communication
- Achieving One Voice communication
- The One Health approach to human and animal health
Dr MIYAGAWA talked about his experience of communication coordination and the concept of One Voice communication. In his experience of infectious disease events in Japan, the Ministry of Health communicates with other sectors and agencies as well as the public. The Japanese government aims to be transparent and provide factual information. Nonetheless, it is important not to release information that identifies individual persons infected with a disease. Health officials therefore need to be clear about what they can and cannot say to the media. To implement this in practice, the Ministry produces media “talking points” which spokespeople use for answering media enquiries. The Ministry of Health provide these to spokespeople across the different government departments and agencies with an interest in the event or emergency. This ensures spokespeople give out consistent and coherent information. It also reduces the risk that someone in government releases inappropriate information that identifies the infected person or persons.

Dr MIYAGAWA is qualified as a Veterinary Surgeon in Japan. This is useful as, under Japan’s health regulations, the Office he runs is responsible for control of zoonoses, as well as purely human pathogens. This helps achieve a One Health view of animal and human health issues.

**Question from the facilitator**

Does Japan evaluate psychological factors and the likely impact on the public of its risk communication, when doing risk assessments?

Dr MIYAGAWA said Japan does not evaluate these under its risk assessments. However, the Ministry of Health does try to gather feedback on the public’s response to its communication. The Ministry then develops frequently asked questions (FAQ) documents based on feedback about questions of most concern to the public.

There was a short general discussion on the issue of evaluating impact and effectiveness of risk communication. The view was expressed that all countries struggle with monitoring and evaluation of risk communication. It is an important topic for further discussion.

**Ms Rhonda OWEN / Assistant Secretary, Health Emergency Management Branch, Department of Health, Australia**

Ms Rhonda OWEN explained the division of responsibilities for health emergencies in her country. Australia is a federal country. The States and Territories in the federation have the primary responsibility for responding to outbreaks or health crises. The Federal Government’s role is a coordinating one. It gets involved only when the emergency is of a scale that affects several States and/or Territories, or if it overwhelms the ability of a State/Territory to cope with it. In big outbreaks the Health Emergency Management Branch will tend to have big role, but in small outbreaks it has just a small role.

Ms OWEN expressed the view that senior officials have an absolutely critical role in risk communications, mostly because they play a key liaison role with government ministers, the States and Territories, the key technical experts and the communicators. These are the people that risk communication needs to be coordinated with. Senior officials have a key role in making this as they attend meetings with counterparts from other parts of government where communication coordination/Whole of Government communication can be agreed. They can also give a “Whole of Government” perspective to discussions in the health department. In a crisis that is led by another department or agency, the communication experts from health will not necessarily be at those meetings; they will need to rely on their senior officials to get this perspective. It is critical therefore for senior officials to understand the risks assessment and the key risk communication messages being proposed.

In health emergencies, the Australian government establishes inter-departmental meetings to bring together all the departments and agencies that have a role to play. These meetings are attended by senior officials. Their purpose is to share all important information about the emergency, make sure
everyone involved has the same understanding of the risk, and an appreciation of how communication by one agency impacts other parts of government.

Senior officials also have a key role in coordinating with States and Territories. There is a national high-level committee that brings together the States and Territories and the Federal Government during emergencies. This discusses and agrees on risk communication messaging, coordination of communication, and roles and responsibilities. All of Australia’s emergency plans have a communication component, and these address communication coordination to some extent. It is always good, however, to have a discussion on coordination when the emergency happens, to agree how it should work.

Ms OWEN observed that one of the most critical roles for senior officials with respect to risk communication is that they are the people who negotiate with health ministers. It is the senior officials who agree with Ministers on which response measures to prioritise and how to allocate funding. Again, this makes it critical for senior officials to understand the risk and the intervention proposed and have the skills to advocate it effectively. Senior officials can help ensure the intervention and the funding is proportionate to the risk.

Asked about example of recent risk communication, Ms OWEN mentioned the 2014-2015 Ebola outbreak. The risk of seeing an Ebola case in Australia was very low. The only real risk was health workers returning from Africa. Nonetheless it was an emotive subject, so the Department of Health put in place a quite substantial Australian response to Ebola. Senior officials understood the risk in terms of the feelings of the Australian public as well as the clinical risk.

During the H1N1 influenza pandemic of 2009, senior officials had responsibility for purchasing vaccines. The purchasing decisions had to be made very early in the pandemic, before the risks were fully known. They had to act on the basis of what they knew at that early stage. Linked to this is an important role for senior officials during peace time to educate government ministers on things that might happen. This includes stopping the collection of data when necessary. This was evident in the 2009 pandemic where, early in pandemic, the federal Department of Health collected hospitalisation data from States and Territories and published updates three times a day. It wasn’t long until States and Territories became overwhelmed by collecting this data, and so they stopped. The need to stop reporting this data as it became more unreliable had to be explained to the Federal Government. In planning for future influenza pandemics, Australia is developing a system similar to that in the UK. Australia’s pandemic plan provides that health authorities will look at the first few hundred cases in quite some detail – but then at a certain point the authorities will stop collecting detailed data. This will be explained in advance to politicians to avoid repeating the issues with reporting seen in 2009.

In 2016, with the emergence of Zika Virus as a concern there was a huge amount of communication carried out in Australia to clinicians, to the public and travellers in particular. This risk communications changed a lot over time as scientific understanding of the risks from Zika evolved. It was important for health officials involved in communicating to the media, or with the political level of government, to keep up with those changes in the science – and how this affected Australia’s risk communication messages. The challenge was to aim for consistency in an evolving environment.

Advice on how mid-level officials working in risk communication can work constructively with senior officials.

It is critical for communicators to work with senior officials in peace time. She advised communicators to be part of the emergency preparedness process: they should get involved with developing the plans and then the exercises to test them. Ms OWEN also noted that preparedness plans always have communication parts to them, but that these don’t often get tested in exercises. It is important to make sure the risk communication part of preparedness plans are exercised, which can create valuable opportunities for communicators to engage with senior officials in peace time.

Engaging with senior officials is a bit easier during a response. In Australia, incident management teams with a relatively flat structure are set up to respond to emergencies. These teams will always include one or more communication
staff, and they will work directly with the senior official(s) leading them. The flat management structure of incident management teams also has the advantage of keeping the clearance procedures simple and consistent.

On the subject of coordination of workflows and Standard Operating Procedures, Ms OWEN stated that risk communication is a central pillar of Australia’s Standard Operating Procedures for emergency response. When Australia sets up an incident management team to respond to an emergency there is always a well-defined communication role in it. In times of peace, communication coordination works on the basis of communicators working with their senior officials and the senior officials bringing a “Whole of Government” perspective.

In Ms OWEN’s view, two critical issues for communication coordination are the timing of the announcement and which department / agency is in the lead. Australia has the Australian Government Crisis Management Framework, which has been agreed across Government. This defines who is responsible, who leads the communication, and which other departments / agencies are involved in any given emergency situation. For example, Australia’s Department of Foreign Affairs will be in the lead for the response to a tropical cyclone in Fiji but the Department of Health will have a big role to play too. Conversely, for a health crisis in Australia the Minister of Health will be in the lead. Knowing who is in the lead is critical for coordination, so the Crisis Framework is a very useful tool.

The Australian Government Crisis Management Framework helps inform all preparedness plans. It points the way for defining who is responsible for what. It does this in quite some detail. During a foodborne outbreak the lead department or agency can change as the outbreak evolves. This has to be incorporated into health sector preparedness plans. For example, at the start of an outbreak it will be the health department at State level in the lead. If the outbreak grows in size the food safety people at State level become involved. If the outbreak spreads to another State or Territory then the Federal Government takes on a coordinating role. If imported food is implicated then the Federal Department of Agriculture has a key role. If you manage your communication wrongly during a foodborne outbreak you can have a major impact on an industry or company. Someone therefore needs to oversee the timing of communications and their accuracy.

Foodborne outbreaks are a great example of balancing what the economic factors are against the practical and public health factors. It’s crucial that cross-departmental meetings occur in these emergencies so that the right compromises can be found, and all aspects of government policy are taken into consideration. The Government does not want to destroy a whole industry just by poor communication or by not engaging widely enough. It’s really important in these situations that cross-department and cross-State and Territory discussions occur.

Crucial to all this is also what governments and health authorities do in peace time. The challenge is to make sure that we exercise on communication coordination during peace time, and that communication people work with senior officials. One thing they need to work on is agreeing what is their single point of truth. Ms OWEN said in the health sector the single point of truth is WHO, but who does the Australian public go to? The health authorities need to do enough in peace time so that the public knows where to go for reliable information. It is important to respond well and communicate well during small events so that large events can be managed a little easier.

Questions from the facilitator

How to balance the desire for political coordination against the need for timely coordination?

There is an understanding across the Australian government that departments need to respond rapidly when consulted about risk communication messages. However, getting out a statement rapidly is often a challenge, especially when you yourself don’t have much information on what is happening.

Did Australia have mechanisms or systems to avoid communication becoming “stuck in the 7th circle of messaging agreement?”

There was further discussion on the issue of communication coordination. One participant expressed frustration at their experience of inter-departmental communication coordination meetings. Some departments send junior officials to these meetings. They do not have authority to agree on messages, they merely report back to their department. This slows down, or even blocks agreement of messages.
Ms OWEN replied that in Australia it is a requirement that officials attending inter-departmental and high-level committees during an emergency must be decision-makers. They cannot just collect information: they must be able to reach agreements. Ms OWEN also thought it important to have mechanisms to formally report back from coordination meetings. It needs to be an automatic part of the role of focal points and other attendees.

**Dr Francisco GEORGE / Director-General, Directorate-General of Health, Portugal**

Dr Francisco GEORGE introduced his role as Director-General of Health in Portugal. Although he is a senior official working closely with the Minister of Health, the Director-General is non-political and independent. Neither the Minister of Health nor the Government can remove the Director-General of Health during his or her mandate. The Director-General is appointed for a period of four years, and this can be renewed several times. The Director-General of Health is simultaneously the Chief Medical Officer and the National Authority on health. This gives the Director-General an important role in coordinating the management and communication around outbreaks. In particular, the Director-General is the spokesperson during health emergencies or incidents.

Portugal is a medium sized country with 10.3 million people. It is made up of a mainland and two islands. One of these islands is Madeira. A few years ago, Portugal faced a major public health event on Madeira in 2012. This was the first ever outbreak of Dengue Fever on the island. The Ministry of Health managed this outbreak together with the regional authorities. On the Portuguese mainland in 2014 there was a major outbreak of Legionnaires’ Disease near Lisbon, with 400 cases hospitalised. Most cases were in intensive care, and 14 died, all within a period of 2 weeks. The health authorities did a risk assessment and identified the sources of the outbreak. Dr GEORGE, as Director-General for Health, then had the task of being outbreak spokesman.

Dr GEORGE shared with the audience that Portugal has two ongoing outbreaks in June 2017. One of these is a measles outbreak, which is nearly over. It started with cases imported from Central Europe. Portugal has high vaccination coverage, so the outbreak is now coming under control. Most cases infected in Portugal were adults, and most of these were in healthcare staff. This is likely because the staff was not vaccinated. Vaccine hesitancy and vaccine scepticism are big problems across Europe. Anti-vaccine groups have caused gaps in vaccine coverage in many European countries, which is one of the reasons Europe is regularly seeing measles outbreaks. Fortunately, the number of new cases in the current outbreak in Portugal has decreased, and the outbreak should soon be over.

The other ongoing outbreak is an outbreak of sexually transmitted Hepatitis A virus (HAV). This has been challenging to control because there is no HAV vaccine available on the market. The big vaccine manufacturers are not able to produce more and no vaccine supplies are available to Portugal from other EU countries. The outbreak therefore cannot be controlled with a targeted vaccination programme.

Dr GEORGE stated that Portugal is preparing for the possibility of a Zika outbreak on the Island of Madeira because the Aedes aegypti mosquito is established there. Portugal is also concerned about the risk of Yellow Fever because of the major outbreaks happening in Brazil and Angola. Portugal has strong connections to both these countries, with many flights every day. The Aedes aegypti mosquitoes in Madeira are capable of spreading Yellow Fever, so Portugal is being vigilant about the threat of a possible outbreak.

Dr GEORGE explained how communication coordination is achieved in Portugal during emergencies: there is a law and the most important Standard Operating Procedures are very clear. The Director-General chairs
an Emergency Committee. The declaration of an outbreak, such as for Dengue Fever in 2012 and the current Hepatitis A Virus (HAV) and measles outbreaks, takes place after deliberation in this Committee. The Director-General of Health identifies the problem and brings it to the attention of other departments via the Committee, whilst also keeping the Minister of Health informed. The Minister of Health in turn reports to the Prime Minister. The Director-General should normally keep in close contact with the Minister of Health speaking on the telephone several times a day, when needed. The Minister needs to be briefed on current and upcoming challenges. For instance, one of the challenges with the current HAV outbreak is that people under 40 have no natural immunity against the virus.

Dr Patrizia PARODI / Senior Officer, Directorate-General for Health Prevention, Ministry of Health, Italy

| Topics covered | 
| --- | --- |
| Division of responsibilities for health emergencies in Italy | Regarding the division of responsibilities of emergencies, Dr Patrizia PARODI explained that Italy has a federal national public health system. The Ministry of Health is in charge of guiding and coordination activities, but organization and practical implementation of actions is the responsibility of regional and local health services. Dr PARODI works at national level for the Directorate-General for Prevention in the Ministry of Health. She is in charge of vector-borne diseases and zoonoses. In Italy, food safety and veterinary services are part of the responsibility of the Ministry of Health. |
| The Ministry of Health's system for emergency risk communication | Dr PARODI briefly described the **Ministry of Health’s system for emergency risk communication**. The Ministry has a Communication Directorate which interacts with the officials in charge of an emergency to decide the best communication strategy, including messages, communication channels, target audiences, and so on. It is the same procedure for infectious diseases, chemical threats, and other hazards. The Ministry of Health uses different channel of communication, including social-media. A call centre is permanently available, while a hot line can be activated in case of an emergency. This happened most recently with the **Zika Virus threat**. Dr PARODI noted that during recent emergencies, international organisations such as WHO and ECDC have played a very important role in coordination of messages between different countries. |
| Interaction between health and other policies | Regarding **interaction between health and other policy considerations**, Dr PARODI noted that veterinary measures have a major impact on trade. This impact comes from the Agreement on the application of the sanitary and phytosanitary measures (SPS Agreement) of the World Trade Organization. The SPS Agreement establishes specific rules to notify emergency measures to other countries. This was the case, for instance during the BSE (“Mad Cow disease”) crisis in Europe. In 2016, for instance, 104 emergency public health measures in animal health, food safety, and plant health potentially affecting international trade were notified. Italy strongly supports the Health in All Policies approach, based on intersectoriality. During peace time, the Ministry of Health regularly interact with the Ministry of Foreign Affairs, Ministry of Environment, Regions, Municipalities, etc. In Dr PARODI’s opinion it is important to establish good communication channels with counterparts across government during times of peace. Otherwise it is very difficult to build these relationships during emergencies. |
| Recent emergencies – Zika Virus | Regarding **recent emergencies or incidents**, Dr PARODI said the **Jubilaeum event 2015-2016**, and the **Zika Virus epidemic 2016-2017**, were both big challenges for Italy, particularly given the importance of its tourism sector. It was therefore very important to disseminate the messages approved by the Ministry of Health to all stakeholders and ask their cooperation in disseminating information on protective measures. During the Zika epidemic, all relevant epidemiological information was shared with the Ministry of Foreign Affairs to update the web site “Safe travelling”, with the Border Posts, with the Ministry of Economic Development, with the Police and Armed Forces, with the Ministry of Tourism and with the Italian Civil Aviation Authority. Following the Ministry of Health’s communication, several airlines issued a re-book policy allowing options for passengers travelling to/from destinations affected by Zika Virus. |
| Vaccine hesitancy | 
| The 2007 Chikungunya Fever outbreak in Emilia-Romagna region | 
| Preparation for risk communication in future mosquito-borne disease outbreaks | 
| Evaluation of Zika risk communication |
The Ministry asked travel agencies to inform travellers, and particularly pregnant women, at risk destinations. Specific measures were shared with the airlines and the civil aviation authority about mosquito and insect eradication on planes.

Dr PARODI also discussed the problem of vaccine hesitancy in Italy. Since the beginning of 2017, Italy recorded about 3,000 measles cases. In recent years vaccine coverage in Italy has fallen significantly, but the situation was not been perceived as an emergency. There had not been a national communication campaign on vaccination since 2004. However, the Minister of Health and the Minister of Education are now in the process of issuing a joint decree on obligatory vaccination for school-age children. In addition, emergency risk communication has been strengthened using TV, radio, newspapers, and other media. The Ministry of Health approved a new communication strategy on vaccination including a new website opened on this topic. It gives accurate information to families about vaccination and encourages them to get their children vaccinated. The Ministry is also proactively communicating the benefits of vaccination via television and radio. The anti-vaccine campaigners are very vocal in Italy, so the Ministry needs to work hard to counter their messages.

Other recent health emergencies mentioned by Dr PARODI included the 2007 Chikungunya Fever outbreak. This affected a limited area of Emilia-Romagna region and was the first Chikungunya outbreak in Europe. It started in the summer, the worst possible time for tourism. The outbreak was primarily managed by the local and regional health authorities, with the Ministry of Health and National Institute of Health playing a supporting role. Successful case finding and vector control stopped the spread of the disease fairly quickly.

In the area of risk communications, the response team conducted a KAP Study (Knowledge, Attitude, and Practice) and held meetings to gather feedback from affected communities. They went house-to-house to explain what people need to do to protect themselves. There was a policy of separating the institutional communication and partnership communication from communication to the public. The institutional and partnership communication was done by the Director-General of Health and targeted the region, Municipalities, and Police etc. Communication with the public via the mass-media was assigned to one single spokesperson in the press office.

Intersectoral collaboration during the Chikungunya outbreak worked well, due to pre-existing partnerships. The lesson learned was that emergency communication should be started before the emergency, with the training of staff and the preparation of the organization model. In preparation for future mosquito-borne outbreaks the health authorities opened a dedicated website “Tiger mosquito on line” (www.zanzaratigreonline.it). Dr PARODI considered this a best practice for preparedness and dissemination of information, as it includes data on monitoring activities, maps, activities to be implemented by citizens, schools, Municipalities, Local Health Services, and Regional Health Authorities.

More recently, after WHO declared complications linked to Zika Virus a public health emergency of international concern (2016), the Ministry of Health played the lead role in Italy’s response. The Aedes albopictus mosquito is endemic in Italy, and is capable of spreading Zika. There are a lot of travels between Italy and the Americas so the risk of Zika Virus being introduced is seen as very real. Up to now, however, Italy has recorded only a limited number of imported cases. Zika was included in the surveillance and response plan for arbovirus in 2014. Since 2016 Italy has added risk communication as a key pillar to this plan and a big effort was made to disseminate information. At the moment Italy is evaluating the risk communication activities implemented in 2016 on Zika, using a small retrospective KAP survey on international travellers. This is done in order to better plan the Ministry’s communication strategy for the future. It is the first time the Ministry has done such an evaluation.

Inputs for potential cooperation
Dr Francisco GEORGE noted that Portugal shares many of the same concerns about the Aedes mosquito that Dr PARODI had expressed. He wondered whether it might be valuable to organise a meeting between Portugal, Spain and Italy to discuss this topic, and offered to help set such a meeting if Italy was interested.
More information on the “anti-vaccine lobby”: who are these people and what motivates them?

Dr PARODI answered that, unfortunately, the anti-vaccine campaigners in Europe include some medical doctors. This is why the latest Italian National Vaccination Plan includes provisions to sanction medical doctors that don’t recommend vaccination to their patients. They can be excluded from the college of physicians, which means they can no longer practice medicine. Dr GEORGE of Portugal stated his country also sanctioned doctors who don’t recommend vaccination.

There was a request to hear more details about Italy’s plans to evaluate its Zika risk communication.

Dr PARODI explained that Italy had had about 70 imported cases of Zika. The Ministry of Health wanted to understand a bit more about how these people became infected. Did they know that they were travelling to Zika affected countries? What information had they received about Zika before travelling? Where did they get the information from? What channels did they use? The method used in the evaluation study is structured telephone interviews with these cases. Dr PARODI and her colleagues developed a questionnaire at national level, and then sent it to the regions to conduct interviews with the imported Zika cases in their areas. It took a while to get the study approved by the Ethic Committee. But (as of June 2017) interviews have been taking place, and initial results indicate that generally people were aware of the risks. The measures they took, though, were generally limited. They used mosquito spray. But, it seems people going on holiday to Caribbean islands are not inclined to cover up with long trousers and a long-sleeved shirt!

Whether or not Australia’s incident management system includes public health risks from chemical or environmental threats?

Ms OWEN stated that it does. Australia has a couple of levels of crisis management frameworks. There is an overarching national crisis framework that covers everything, and then below that is a specific health crisis framework. The health framework has 4 pillars:

- Infectious diseases and environmental threats
- Emerging issues
- Emerging threats
- CBRN (Chemical, biological and radio-nuclear threats) / bio-terrorism

Australia is slowly updating all its plans to make them consistent. This means they do similar things, and have similar communication coordination in each different emergency scenario.

Regarding radiological incidents the most recent one the Department of Health had to respond to was the Fukushima emergency in Japan. This was an interesting one as Australia’s health response to Fukushima was all about risk communication (no other response measures were viable for Australia).

Whether or not the countries on the panel have specialised risk communication roles in their emergency response structures? – and if so, where it fits in?

Ms OWEN had already outlined how risk communication fits into Australia’s incident management team system. Dr GEORGE stated that for Portugal risk communication is the function of the Director-General for Health.

Dr MIYAGAWA stated that in the Ministry of Health in Japan there are some officials dealing with public communications, but this is just the coordination between the divisions of the bureaus. Communication to the media is done by the senior officials in the bureau responsible for a particular issue or incident. For infectious disease events, this means that it is the responsibility of either Dr MIYAGAWA or one of his colleagues.

Dr Patrizia PARODI stated that in Italy there is a Directorate for Communication under the Minister of Health. This works horizontally with the other 11 Directorates of the Ministry, depending on the issue. There was a discussion about the importance of Standard Operating Procedures (SOPs) and other such protocols defining which department or agency leads on which issue, and how coordination should work. It was agreed it would be valuable to include some examples of such SOPs or protocols in the final report. There was a question raised as to whether it is always possible to achieve “One Voice” communication in complex emergencies involving several government departments as well as different layers of government. Panel members acknowledged that this could be challenging, but said it was still possible to achieve One Voice – and that this should be the aim.
Biographies of Panel Members

Shoji MIYAGAWA

*Director, Infectious Diseases Surveillance and Information Office, Tuberculosis and Infectious Disease Control Division, Health Service Bureau, the Ministry of Health, Labour and Welfare, Japan*

Dr Shoji MIYAGAWA graduated from the Veterinary School of the Osaka Prefecture University and joined the Ministry of Health and Welfare in 1987. He was appointed Technical Officer of the Food Safety Division, World Health Organization (WHO), Geneva in 1994 and Counsellor of the Permanent Mission of Japan to the United Nations, New York in 2008. He has been working mainly in the Ministry of Health, Labour and Welfare, Japan on regulatory aspects on food safety and public health. He is the Director of Infectious Diseases Information Surveillance Office since April 2015.

Rhonda OWEN

*Assistant Secretary, Health Emergency Management Branch, Department of Health, Australia*

Ms Rhonda OWEN has been a member of the Australian Government Department of Health for 13 years. She is a qualified epidemiologist with a special interest in communicable diseases.

Rhonda has managed a number of national surveillance programs in vaccine preventable diseases and lead national surveillance team in the Australian Government’s response to the 2009 H1N1 Pandemic.

Rhonda is now responsible for managing the Health Emergency Management Branch within the Department of Health which involves management of a number of key emergency preparedness and response functions. These include the preparation of emergency response plans, the management of Australia’s human biosecurity arrangements, the National Medical Stockpile and also the national coordination of health emergency response arrangements, including public communication and messaging. Rhonda was most recently responsible for managing Australia’s response to the global Zika virus outbreak at a national level.

Francisco GEOrGE

*Director-General, Directorate-General of Health, Portugal*

Dr Francisco GEOrGE is a Medical Doctor (graduated in 1973 from University of Lisbon) and Specialist in Public Health.

He was a WHO staff member, Medical Officer, namely World Health Representative (WR) in the Republic of Guinea-Bissau and Coordinator of the “Global Program on AIDS” for the Southern region of Africa, based in Harare (1980-1991).

He was also Medical Officer at district level in Portugal (1991-2000) and Portuguese Deputy Director General of Health (from 2001 to 2005). He is currently Director General of Health (since 2005) and Portuguese National Health Authority.

He is a member of the Portuguese Delegation at the World Health Assembly and the Regional Committee of EURO (2001-present). At EU level, he is a member of the High-Level Committee on Health and of the Health Security Committee (2001-present), founding member of ECDC (2005), member of the Chief Medical Officer’s meetings (2005-present), Portuguese alternate at WHO Executive Board (2005-2008), Member of the Standing Committee of the Regional Committee of WHO EURO (2014-present).

He is also Invited Professor of Public Health at the NOVA University of Lisbon, Coordinator of research projects on Public Health, several publications and keynote speaker on public health matters, Member of the Portuguese Associations of Epidemiology and Virology, Awarded the “Grande Oficial da Ordem do Infante D. Henrique” (National Order of Prince Henry the Navigator) by the President of the Portuguese Republic (2006).

Patrizia PARODI

*Senior Official, Directorate-General for Health Prevention, Ministry of Health, Italy*

Dr Patrizia PARODI, from the Italian Republic, has a scientific and administrative background as she received a university degree cum laude in veterinary medicine, a post-graduate certificate in animal health and animal production, and a post graduate certificate in health statistics, with a focus on socio-health management. More recently she received an advanced degree in International Business and Law and a degree and master degree in administration where she focused on the World Trade Organisation and its the Agreement on the application of the sanitary and phytosanitary measures (SPS Agreement).

She joined the Ministry of Health in 1994. Overall, she has 32 years of professional experience, 22 at Ministry level in Italy, where she holds the position of senior official.

She has about 15 years of experience in project cycle management. In Africa, Central America, Central Asia, and East European Countries she implemented a number of technical assistance activities and development projects, with the position of team leader, coordinator, desk-officer, public health expert, agri-vet expert, food safety expert and international trade (SPS) expert. She has good communication skills and ability to communicate with people at all levels, developed during her diversified work experience, both in the field and in the administration.
Risk Communication in Action

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The session started with a voting exercise which involved participants answering multiple choice questions using an anonymised online polling system.

These provided an interesting snapshot of the professional profile of the participants, and how risk communication is organised in the countries represented at the Meeting.

Does your country have a risk communications plan as part of a natural response plan?

- **YES**: 26%
- **NO**: 74%

If your answer is yes (that you have a plan)
Has it been tested through an exercise(s)?

- **YES**: 20%
- **NO**: 80%

In your country, is risk communication considered as part of risk assessment processes?

- **YES**: 18%
- **NO**: 82%

Following an emergency or exercise, does your country conduct after action reviews to learn which actions worked well and which could be improved upon?

- **YES**: 17%
- **NO**: 83%
If your answer is yes (that you conduct after actions reviews) Do they include risk communications response factors?

- - - - YES  
- - - - NO

Do you have a plan to communicate with visitors or those that don’t speak the native language of your nation?

- - - - YES  
- - - - NO

In your organization, who speaks during emergencies?

- - - - one lead spokesperson  
- - - - a team of experts trained as spokespeople  
- - - - one lead spokesperson + experts trained as backup  
- - - - only the minister (director) is the spokesperson

Have you had to alter a communications plan because of unexpected cultural dynamics in your country?

- - - - YES  
- - - - NO
Emergency Simulation Exercise: a novel avian influenza virus in a EurAsian country

The group activities using simulation exercise (SIMEX) were implemented for the most of Session II and all of Session III. The participants formed groups of 5 or 6 each to discuss about the issues presented in the scenario and then asked to vote on the options for action (see table below). There was a limited set of options for action to choose from, and some variations in the options selected between different groups were discussed in the plenary. The groups also shared their thinking on the challenge posed by the scenario, and how best to address it.

Group decision making challenge (example)

Based on what you know, what is the most significant communication coordination risk?

- Lack of “One Voice” communication from government undermines authority and credibility
- Conflicting and potentially confusing safety advice to people at risk
- The media trying to create or sensationalise conflict between government Ministries

Scenario Setting: About the fictitious country of Eurasiastan

Key facts about Eurasiastan

- Medium income country;
- Capital is Eurasiastan City;
- Parliamentary democracy, next elections due 15 July 2017;
- Eurasiastan City and the Eurasiastan Sea Coast have become an important tourist destination in recent years;
- More than half the tourists visiting Eurasiastan come from neighbouring country of Covfefestan;
- Covfefestan is a rich country. Investment from Covfefestan has been major factor in developing tourism on Eurasiastan Sea Coast;
- ... and its Region of Asefia
  - The region of Asefia is the poorest and least developed part of Eurasiastan;
  - Many people are subsistence farmers;
  - People in Asefia follow a traditional animist religion in which Shamans play an important role;
- Eurasiastan City is a long way from Asefia. There is some mutual distrust and misunderstanding between the capital and this region;
- Blossom and Cloud Region are also poor. However, Cloud Region has a rapidly developing tourism sector based on visitors from Covfefestan coming to see its spectacular mountains.
Scenario I: Illness of unknown origin in remote village

You are responsible for advising the Director for Public Health of Eurasiantan on emergency risk communication. You are based in the Ministry of Health in the capital city, Eurasiantan City. A district health officer in the remote region of Asefia has reported a cluster of severe illness in a village. There are unconfirmed reports on Social Media of a large die-off of wild birds and poultry in this village. The top influenza expert in the Ministry is worried.

What We Know
- There are unconfirmed reports on Social Media of a large die-off of wild birds and poultry in this village;
- The top influenza expert in the Ministry is worried.

What We Don’t Know
- How many people are ill;
- What is causing illness;
- Has there really been a die-off of poultry/wild birds;
  > If so, what caused poultry/birds to die.

Two competing views about Ministry’s risk communication strategy:

1. Immediate communication about potential risk;
2. Wait until Ministry knows all the facts.

Scenario II: 24 hours after initial reports

Local health officials in Asefia tell you they are investigating 6 cases of severe illness among 2 families of poultry farmers. They have sent samples to the national laboratory to test for various pathogens, including avian influenza.

The Director for Public Health decides to issue a media statement on the situation in Asefia. She asks you to advice on the content of the statement.

Scenario III: 48 hours after initial reports

You receive a telephone call from the head of the national laboratory. She informs you that the 6 cases from Asefia are infected with a novel (i.e. previously unseen) avian influenza virus. Dead poultry in the village of Wo-ar-ning tested positive for the same virus.

The government does not want to acknowledge an outbreak of avian influenza. It will lead to trade partners banning poultry products from Eurasiantan. This would have a “devastating effect” on Eurasiantan’s farmers. It could also have an impact on Eurasiantan’s important tourism sector.

Outbreak investigators think all cases were infected by exposure to sick poultry (chickens, ducks). However, it is possible human-to-human transmission took place in one household.

Group Activity

A pre-planned meeting between the Ministers of Foreign Affairs of Eurasiantan and Covfestan is about to take place in Eurasiantan City. Covfestan has indicated that it wants to discuss the outbreak in Asefia and its implications for Covfestan. Prepare your delegation (Minister plus two advisers) for the meeting.

[The groups were divided into 2 countries: Covfestan and Eurasiantan].
### Additional Info

<table>
<thead>
<tr>
<th>For Covfefestan group only</th>
<th>For Eurasiastan group only</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Covfefestan imports a lot of poultry (ducks, chickens) from Eurasiastan but it also produces poultry too. In recent months the price of poultry has been very low. Farmers in Covfefestan have complained of unfair competition from “low quality” and “unclean” farmers in Eurasiastan</td>
<td>• Eurasiastan exports more to Covfefestan than it imports</td>
</tr>
<tr>
<td>• The Ministry of Agriculture has information from well-placed sources that there is an out of control outbreak of avian influenza in Eurasiastan. If it spreads to Covfefestan your exports of poultry will be banned, costing your farmers millions of dollars</td>
<td>• Eurasiastan receives investment and development aid from Covfefestan</td>
</tr>
<tr>
<td>• The Ministry of Agriculture wants a ban on all imports of poultry from Eurasiastan</td>
<td>• However, Covfefestan is dependent on Eurasiastan for access to the sea</td>
</tr>
<tr>
<td>• The senior influenza expert at Covfefestan CDC believes that a new and deadly human pandemic virus may be emerging in Asefia, Eurasiastan</td>
<td>• Covfefestan exports a lot of manufactured goods. 75% of these exports go by sea from a port near Eurasiastan City</td>
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<td></td>
<td>• The Eurasiastan Ministry of Foreign Affairs believes this gives them some economic leverage vis-à-vis Covfefestan</td>
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<tr>
<td>• The Minister of Health believes it is his duty to warn citizens of Covfefestan about this potential threat to their health</td>
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</table>
Meanwhile Ministry of Agriculture launches nationwide campaign with message "delicious cooked chicken is safe and healthy to eat". (See image on the left).

Media starts to comment on apparent inconsistency.

The avian influenza outbreak has spread from Asefia to farms in neighbouring Regions of Blossom and Cloud. Communities in Asefia are resisting attempts by Ministry of Agriculture teams to cull their poultry flocks – even though farmers get compensation for birds destroyed.

Farmers in Asefia are selling their birds in Blossom and Cloud regions to escape the cull.

Health promoters from Ministry of Health have been talking to community leaders and farmers in Asefia. It seems people in Asefia follow a minority religion. Ducks and chickens have a deep and important spiritual meaning for them. These birds must be slaughtered in a respectful way. Farmers and communities are offended by the way Ministry of Agriculture workers (most of them from Eurasiastan City) kill these spiritually important animals. They are particularly offended that dead birds are put into sacks. Communities believe this is stopping the birds’ spirits leaving their bodies, bringing terrible bad luck.

This scenario led to discussions on the challenges involved in arguing for a new approach when feedback shows a key response intervention is not working; and how to conduct effective community engagement.

The scenario then ended with the outbreak coming under control and Eurasiastan health officials being asked to identify lessons learned / priorities for improvement.
The dilemmas identified by the discussions using SIMEX are summarised in table 1.

**TABLE 1 – The specific risk communication dilemmas looked at during the exercise**

<table>
<thead>
<tr>
<th>First announcement – when to inform the public about a potential health threat</th>
<th>Integrating risk communication into the overall response</th>
<th>Challenges linked to communication coordination across government and with stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transparency – how much to disclose, being transparent about what is being done</td>
<td>Communication coordination / negotiation between governments</td>
<td>Communication coordination / negotiation between governments</td>
</tr>
<tr>
<td>Communicating uncertainty</td>
<td>What to do if feedback shows key outbreak intervention is not working</td>
<td>Identifying points for improvement after an outbreak – and ensuring these are incorporated into an updated response plan</td>
</tr>
</tbody>
</table>

Areas that proved most contentious among participants were “first announcement” and how to respond if another government department is not willing to work in good faith on communication coordination.

First announcement is simple, at the level of theory *(see picture below)*. If you warn people about the threat to their health early in an outbreak, they have more opportunity to act to protect themselves and their loved ones. This should lead to a smaller outbreak.

**Communications and the Epi Curve**

![Epi Curve Diagram](image-url)
In the reality of government, though, health authorities need a certain minimum amount of evidence before they start warning the public. They are sensitive to the credibility they will lose with the public, and from other government departments if they are seen to “cry wolf” too often. There are also pressures from other departments, and economic interests. In the scenario at the 14-15 June meeting, the fictional country had a large poultry export sector. This translated into pressure on the public health sector not to talk about the possibility of an avian influenza outbreak until this was confirmed. A decision tool on transparency developed by The Warning Project was presented:

![Decision-Making Algorithm/Tool](image)

It is advised that transparency should be balanced with acknowledging uncertainties around the information. These should be acknowledged proactively. The uncertainty should also be put into context, as far as possible. For example, put bounds on the uncertainty but putting forward the range of potential outcomes or clarify you are more certain on some elements than others.

How to ensure communication coordination across governments is a key focus of the meeting conclusions. Views differed as to how the ministry of health should respond to this: whether it should redouble its efforts for coordination within government, or whether at some point it might be necessary to “go it alone”.

Result of the discussions
Conclusions

page 43 – 51
Summary of the High-level Meeting and Recommendations on: Risk Communication & Leadership during Health Emergencies

How the recommendations were developed

Participants were reminded of the meeting objectives and 5 themes were assigned to the groups.

Objectives of the High-level Meeting

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>To strengthen decision makers’ capacity to support Emergency Risk Communication (ERC) for Public Health Emergency (PHE)</td>
<td>To recognise the complexity and the role of ERC in a context of crisis management, including its influence beyond the health sector</td>
<td>To identify difficulties in making decisions and communicating with the public in PHE from high-level officials’ point of view</td>
<td>To explore and integrate workflow coordination between high-level officials and their respective ERC spokespersons</td>
<td>To develop recommendations on actions needed to prepare for future public health events and ERC</td>
</tr>
</tbody>
</table>

5 thematic areas assigned

1. Understanding the challenges of effective risk communication during health emergencies
2. Understanding the challenges for risk communicators and senior officials working together
3. Identifying examples of risk communication best practice
4. Identifying examples of risk communication coordination best practice
5. Actions needed to prepare for future public health events regarding emergency risk communication

Outputs from the group discussion

1. Challenges of effective risk communication during health emergencies

- lack of coordination among one health stakeholders;
- communicate at the appropriate level (local - state - federal);
- political approval/go ahead - delays in releasing information about (potential) health threats;
- non-availability of formal risk communication plan/strategies;
- monitoring and evaluation of risk communication;
- irresponsible media;
- ensuring that risk communication is part of the risk assessment process;
- maintaining risk communication capacity during non-emergency times;
- engaging rural community and those with low literacy;
- non-availability of resources/funds for action in risk communication plans;
- rumours/misconceptions;
- lack of having appropriate message based on evidence (social/cultural/taboo);
- transparency in action is key;
- absence of guidelines and SOPs for risk communication during health crises;
- dealing with cultural/religious beliefs - how to adapt messages;
- unexpected results - how to anticipate and be prepared to communicate;
- how to reach difficult / special target audiences (foreigners, disabled);
- different information from different stakeholders - how to deal with different views/priorities of the same problem and make your point.
Challenges for risk communicators and senior officials working together

- even when there’s an agreed upon plan between ministries - it’s difficult to follow through/adhere to during emergencies;
- understanding the vested interests of other parties for good negotiation outcomes;
- poor/no guidelines;
- competencies not assigned clearly;
- speak/understand “different languages”;
- understanding each other agendas and priorities;
- the senior officials don’t use social media - although they should.

Examples of risk communication best practices

- evaluation of effectiveness - review of response to include communication;
- lead agency to be clear while coordinating - write an emergency communications protocol;
- decision-makers must be at the table during key meetings;
- peace time regular preventive campaigns to be used while in crises;
- joint press conferences - health and others;
- trust building (during peace time) rumour control;
- set up the hotline;
- identify spokesman;
- stakeholders involvement;
- timely, trust, transparent, control rumours/misinformation, media monitoring;
- DRUMS - distortion, rumours, untruths, misinformation and smears;
- psychosocial aspect of communication (to be addressed);
- one voice approach + timely;
- good connections/communication network created during peace time;
- have a friendly attitude towards neighbouring countries;
- training of field epidemiologists outbreak responders in emergency risk communication;
- training of leaders in emergency risk communication;
- addressing uncertainty in risk communication response plans.

Examples of effective risk communication coordination

- inter-ministerial communications coordination committees.

Actions needed to prepare for future public health events regarding emergency risk communication

- build reputation as a trustworthy source of information patiently and continuously;
- helpful to have risk communication protocol samples from other countries to show the ‘rules’ and ‘agreements’ regarding who communicates when during emergencies;
- cross-government emergency communication coordination exercises - at least one per year;

Others

- For the role-play (in future emergency simulation exercises) we should invite animal health sector to attend;
- Need for politicians to recognize importance (and necessity for money) for base of experts.

3 This was added to allow participants to share other thoughts inspired by the Meeting that didn’t fit under other headings.
Recommendations adopted by the High-level Meeting

01
Ensure cross-government team including communications is established during non-emergency times to include all government level response agencies.

02
Establish cross-society consultation channels for communication coordination during times of peace. Consider including all government level response agencies, civil society and private sector in these.

03
Create SOPs that define clear communication roles and responsibilities per agency/per situation as well as coordination procedures.

04
Conduct communication coordination exercises and ensure that communication is part of cross-sectoral emergency response exercises during times of peace. Include national response agencies, regional response agencies, civil society and potentially private sector and the media.

05
Conduct risk communication training for leaders, field epidemiologists, healthcare workers and other first responders.

06
Consider creating a message bank of pre-tested messages/images that can/should be re-tested and refined when needed with target audiences.

07
Establish a rumour management and response system that address Distortion, Rumour, Untruths, Misinformation and Smears (DRUMS).

08
Ensure those attending cross-government coordination meetings, including communicators, have decision making power.

09
Consider beginning all formal communications response plans with clear statement of VALUES.
### Final Recommendations

17 recommendations were identified from the group activities, and these were endorsed by participants at the plenary during session 4.

| 10 | Conduct disease prevention campaigns during non-emergency times to maintain behaviour change/community engagement capacity and develop/test effective messages. |
| 11 | Supporting scientific evidence base to include development of protocols to use, promote and disseminate results from rapid response studies. |
| 12 | Build and maintain expertise base for risk communication and foster research into evidence for effective risk communication methods. |
| 13 | Advocacy for long term investment in sustainable emergency risk communication systems. |
| 14 | Risk communication planning should include tools, protocols, exercises and practice for leaders to effectively and professionally address transparency and uncertainty. |
| 15 | Map communities, communication channel preferences, risk perceptions, knowledge attitudes and beliefs in partnership with health promotion colleagues. |
| 16 | Use an all hazards approach when developing risk communication plans and ensure that risk communication is part of an overall emergency plan. |
| 17 | Ensure that emergency risk communication is an equal response partner to that of epidemiology, laboratory, logistics, etc. in all phases of an emergency response (pre-event/preparation, initial response, emergency response and recovery and evaluation). |
High-level Meeting on Risk Communications for Public Health Emergencies

Dr Margaret HARRIS / Spokesperson and Technical Officer, Social Science Interventions, Infectious Hazard Management, World Health Organization HQ

Statements by Participants

Dr HARRIS’s presentation focused on WHO Guidelines on Emergency Risk Communication that are currently being finalised in Geneva. It seems there is much similarity between the recommendations the High-level Meeting endorsed and what WHO will propose in its evidence based Guidelines.

The reason for producing WHO Guidelines was that earlier WHO work on risk communication could easily be dismissed by other public health colleagues as “merely describing what practitioners do” – or “just opinion-based-stuff”. It lacked credibility in the public health world because it did not have an evidence base to show that what was being recommended actually works.

In order to develop the new Risk Communication Guidelines, WHO conducted reviews of both qualitative and quantitative studies and put together some very complex evidence constructs. There is an increasing amount of experience of using risk communication as an intervention during emergencies. It is now seen as being an emergency response intervention in its own right. Risk communicators are increasingly able to say there is good reason for what they do. Despite this, it is often difficult to insist that there is good evidence. This was one of the challenges in producing the Guidelines.

WHO deems that by using the term Guidance you are saying to all Member States “you should do this”. If this has resource implications, such as the need to employ people in a specific function or to prioritise one policy over another, WHO needs to show it has looked at the evidence. Indeed, it needs to show not just that it has looked at it, but that it has analysed it for proof of an effect or benefit that can be achieved by doing what WHO recommends.

WHO has a grading system for evidence that looks at whether an intervention has been objectively compared to other interventions. WHO looks at, for example, whether one HIV drug has been looked at in comparison to another HIV drug. Has there been a randomised control trial where one drug was given to one group and the other one to the other? If so, which group showed more positive effect and most limited harm? This works very well for medicines. But it is a lot harder to make this model work when you are looking at something as complex as a risk communication intervention. Nonetheless WHO has tried to analyse the evidence.

WHO went through some very long systematic reviews on the evidence for risk communication interventions. Sometimes what these produced was more of a signal than a clear effect. The WHO team analysed whether they thought the studies were done in a rigorous way. They looked at whether there were several studies that all reached the same, or similar, conclusions. And they also looked at whether studies showed indications of potential harms. This was all collated and then presented to a group of people who leading emergency risk communication practitioners and academic experts. This Guidelines Development Group included Karen TAN of Singapore and Kisoo PARK of Korea as an external reviewer.
The importance of building trust, and engaging with communities and affected populations

Integrating risk communication into existing national and local emergency preparedness and response structures, including building capacity for risk communication

Emergency risk communication practice from planning, messaging, channels and methods of communication and engagement to monitoring and evaluation

Before presenting the headline recommendations from the Guidance, Dr HARRIS noted that they are all issues that were discussed during the High-level Meeting.

Building trust

To build trust, risk communication interventions should link to functioning and accessible services (there’s no point telling people to go to the clinic if the clinic is not working), be transparent, timely, easy-to-understand, acknowledge uncertainty, address affected populations, link to self-efficacy (tell people what they can realistically do to protect themselves and their families) and be disseminated using multiple platforms, methods and channels.

Communicating uncertainty

Communication by authorities to the public should include explicit information about uncertainties associated with risks, events and interventions and indicate what is known and not known at a given time.

Engaging communities

Identify people that the community trusts and build relationships with them (it’s best to do this during peace time) and involve them in decision-making to ensure interventions are collaborative, contextually appropriate and that communication is community-owned.

Strategic emergency risk communication planning

Must occur well in advance, and be a continuous process with a focus on preparedness as well as response. Planning should be sensitive to stakeholders’ needs, participatory, responsive to the context and incorporate feedback from affected groups.

In detail:
— Planning functions best through collaboration among constituent groups. Health and emergency response agencies, emergency systems, and other public services need to collaborate and establish communication networks in preparation for events. Potentially at-risk communities and populations should be involved at the planning stage wherever possible;
— Communication planning must consider the community structures, cultures, and lifestyles of different segments of the public and further, design disaster education and preparation around these social structures;
— Involve multiple channels and means of communicating disaster and emergency messages (understand your channels and involve them);
— Include mechanisms for monitoring and assessing effectiveness of messages and adjusting them as necessary.

Researchers conducting systematic reviews of evidence for WHO were asked to look for the best ways to monitor risk communication interventions, and to adjust the interventions in light of the results. The reviews found absolutely no evidence. It seems no one is currently publishing research on these topics. There is much talk within the expert community of the importance of monitoring and evaluation, but very few people seem to be actually doing it in the area of emergency risk communication.

Dr Harris expressed the view that this situation would have to change if risk communication is to be taken seriously as a response intervention. The classic biomedical interventions, such as use of medicines or vaccines, monitor, evaluate and adjust in light of results found. Risk communication must do this too.

Preview of forthcoming WHO Guidelines on Risk Communication

Dr HARRIS reported three big themes that came through from the evidence reviews:

1. The importance of building trust, and engaging with communities and affected populations
2. Integrating risk communication into existing national and local emergency preparedness and response structures, including building capacity for risk communication
3. Emergency risk communication practice from planning, messaging, channels and methods of communication and engagement to monitoring and evaluation

Statements by Participants

The Guidance is now going through the final stages of the process in WHO, where another independent group look at them to see whether the team producing it really looked at the evidence properly. This group will make a decision in principle in the coming weeks on whether the Guidelines can proceed to publication.

(follows on the next page)
Preparing during peacetime

This is the "golden time" – before the emergency happens.

Emergency risk communication as a strategic role: Emergency risk communication should be a designated strategic role in global and national emergency preparedness and response leadership teams.

Coordination and information systems: Develop and build on agency and organizational networks across geographic, disciplinary and, where appropriate, national boundaries. Tailor information and communication systems to the needs of users and involve local stakeholders to guarantee the flow of information across sectors (maybe one organization is best reached through WhatsApp, and another via its Landline number. You need to know these things ahead of an emergency).

Building capacity: Preparation and training of personnel for emergency risk communication should be organized regularly and focus on coordination across agencies.

— The evidence available to WHO on this topic was poor. This is worrying as WHO has invested a lot in risk communication training over the years, but no one has evaluated whether this had an impact. It was, however, very clear that where organizations included a significant risk communication stream in their crisis simulation exercises they learned a lot. This enabled them to improve and further develop their capacity. This happened not just in the risk communication team but also in the other key players in emergency response. The field epidemiologists and other response leaders began to better understand why and how to use risk communication.

Funding: Emergency risk communication requires a defined and sustained budget which should be a part of core budgeting for emergency preparedness and response.

— This is an area where there was no evidence in the published literature. The WHO team therefore widened its search to look at whether anyone had mechanisms for risk communication funding.

For example, though WHO talks about advocacy for funding, no one has yet looked at how to define or separate out a risk communication budget. There was nothing in either the grey literature or academic literature about risk communication funding.

— Normally under WHO’s processes, when there is no evidence the Guidelines Development Group does not make any recommendations. However, in this instance the Group felt so strongly that this is where risk communication fails, they decided to put forward a recommendation. This fits very much with discussions on the sustainability of risk communication capacity that took place at the High-level Meeting.

Monitoring, evaluating and adjusting interventions

Research is required to establish best mechanisms and methods for rapidly evaluating emergency risk communication interventions and incorporating evaluation findings and feedback from stakeholders and communities to inform and improve ongoing and future responses.

— Dr HARRIS commented that this would be an excellent subject for a research-based PhD thesis! Research is urgently needed on the best methods for rapidly evaluating whether risk communication interventions are working or not.

Messaging

Risk should not be explained in technical terms as this is not helpful for promoting risk mitigation behaviours. Consistent messages should come from different information sources and emerge early in the outbreak. Messages should promote specific actions people can realistically take to protect their health.

Using social media

Social media should be used to engage the public, facilitate peer to peer communication, create situational awareness, monitor and respond to rumours, public reactions and concerns during an emergency, and to facilitate local level responses. Social media and traditional media should be part of an integrated strategy with other forms of communication to achieve convergence of verified, accurate information.

— Academics have done numerous studies on social media. This is because it generates the type of data that can be used for quantitative studies. This meant there was some rather strong evidence on how social media is reaching people in different parts of the world – from China, to Africa, to Australia. Social media can be a really good tool for listening, to find out what communities are thinking, and also to detect and understand rumours. It can also be used for responding to rumours. One of the interesting things that emerged from the evidence is that when the government tries to brand itself using hashtags during an emergency it is often rejected by the community of Twitter. Using a hashtag that organically emerges during an emergency – for example #bushfires during an Australian bush fires emergency – seems to be a better strategy.

— Using these media successfully often requires having a staff member who is an expert in them. This didn’t make it into the Guidelines as a recommendation because it has significant resource implications. However, according to Dr HARRIS, the evidence strongly supports recruiting a dedicated social media officer during times of peace as part of the emergency risk communication team. This will enable them to get to really know the social media community in the organisation’s area ahead of an emergency, and ideally build up some trust with them. Nonetheless, the recommendation the WHO team finally made was that countries should have an integrated social media and traditional media function. There is evidence that what works most effectively is a convergence of messages from different channels. They do not need to be exactly the same, but they need to be consistent. When people hear similar messages via multiple channels they are more likely to believe them.
Dr Harris concluded her presentation by saying that the High-level Meeting had been the best risk communication meeting she had ever been to. She congratulated the organisers on putting together a brilliant forum, but also especially thanked her fellow participants for their excellent contributions.

Dr Harris’s presentation produced questions and comments about use of Social Media as a channel for emergency risk communication. The participants who spoke agreed strongly with Dr Harris’s comment that it is useful to have a staff member who “knows and loves” this channel as part of the risk communication team. Preferably, the organisation should establish its presence on social media in times of peace.

There was a discussion on the recommendation that risk communication should be a strategic function within the overall response team. This produced consensus in favour of adding a recommendation to this effect to the recommendations of the High-level Meeting (see recommendation 17).

Biography

Margaret Harris / Spokesperson and Technical Officer, World Health Organization HQ

Dr Margaret Harris is a medical graduate from the University of Sydney who, following working as a doctor in the NSW public health system became the health correspondent for the Sydney Morning Herald, covering the arrival of HIV in Australia and major health reforms in Australia. She was later appointed Hong Kong correspondent for the Sydney Morning Herald/Melbourne Age and during this period, covered the emergence of avian influenza in Hong Kong (1997) and SARS (2003). It was during the SARS outbreak that Dr Harris decided to go back into public health, and after completing a Masters’ degree in International Public Health, majoring in public health advocacy, Dr Harris undertook missions for WHO and UNICEF in risk communications/community engagement for vaccination in Niger and the Democratic Republic of Congo during 2008/2009. In 2010 she joined WHO Geneva to work on research priorities and use of evidence for production of WHO guidelines, then moved into risk communications, working in Sierra Leone, Liberia and Guinea during the West African Ebola outbreak (2014-2016), participating in the joint WHO-KCDC mission to evaluate the July 2015 MERS outbreak in the Republic of Korea and the global risk communications/community engagement response to Zika virus in 2016. At present Dr Harris is working with the WHO risk communications team to finalise the first evidence based risk communications guidelines, developed by an international group of risk communications experts, based on evidence retrieved via systematic searches of the last ten years’ experience of risk communications practice.
Closing Remarks
Distinguished guests, ladies and gentlemen, first I would like to extend on behalf of the Government of Japan my sincere gratitude to ASEF for their dedicated efforts to bring about a meaningful outcome of the project on risk communication. I also would like to express my Government’s deep appreciation to the Korea Centers for Disease Control and Prevention for its active participation and kind support for this event.

It is my great pleasure to deliver a closing statement at the High-level Meeting on Risk Communication for Public Health Emergencies. Controlling public health issues is a key basis for social and economic development. In today’s globalised and interdependent world no country can achieve this goal of controlling public health issues on its own. Public health issues do not only affect people’s lives within one country: they also have an impact beyond national borders. In fact, mankind has continued to suffer from serious transnational spread of infectious diseases such as pandemic influenza, Ebola, MERS Coronavirus and Zika Virus – and this risk continues to exist.

Having such concerns in mind, the Government of Japan supported the ASEM Initiative for the Rapid Containment of Pandemic Influenza in 2009, with approximately 32 million US dollars of initial funding. This initiative consists of two components, namely

1. The ASEM stockpile of antiviral drugs and personal protective equipment;
2. The ASEF Public Health Network.

The first of these delivers drugs and equipment within the ASEM area, whenever necessary, if an emergency case of pandemic influenza is detected. The second is expected to complement the stockpile component by enhancing governments’, organisations’ and peoples’ preparedness and response through workshops and training. It also contributes to strengthening networks in the field of health and infectious diseases with a view to making emergency operations easier and more successful. At the 10th ASEM Summit in October 2014 ASEM leaders recalled in their statement the importance of tourism.

They viewed it as an engine for growth, a source for the creation of decent jobs and a crucial tool for people to people connectivity between Asia and Europe. Since then Japan has organised two events focused on promoting tourism, held respectively in 2015 and 2017. However, promoting tourism is on one hand enriching people to people connectivity, but on the other hand may lead to increased risk of spreading viruses carried by travellers. In this regard, I consider that the ASEM Initiative for the Rapid Containment of Pandemic Influenza is playing a significant role in addressing such threats when promoting tourism.

The ASEF Public Health Network seeks to become a unique participatory platform that encourages public health dialogue and cooperation in Asia and Europe. The Network facilitates multi-stakeholder partnerships between representatives from governments, international organisations, business corporations and non-profit organisations. It also facilitates the exchange of knowledge and experience between health and non-health sector actors.

Today’s meeting focused mainly on the role of government administrators and decision makers when an infectious disease outbreak occurs. The meeting paid attention especially to how the government brings an initial response to a public health emergency, and how it handles and controls it subsequently. To this end I would like to thank all the speakers for their thought provoking suggestions, and especially the Korean Government for sharing the lessons learned from the spread of the MERS Coronavirus in 2015. I also hope that the participation of Dr Shoji MIYAGAWA and Dr Manabu HASEGAWA, both from the Japanese Government, was helpful in strengthening members’ capacity to react in public health emergency cases.

I very much hope this High-level Meeting was an opportunity for all participants to learn more, and bring back the fruit of new knowledge to your countries.

Thank you very much for your attention.
I wish you all a safe journey home.
<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>08:30 - 09:00</td>
<td>Registration</td>
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<tr>
<td></td>
<td><em>(Place: 31/F Mozart Hall, Hotel President)</em></td>
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<tr>
<td>09:00 - 09:20</td>
<td>Day 1: Welcome and Opening Remarks</td>
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<tr>
<td></td>
<td><em>Facilitators: Mr Ben DUNCAN &amp; Ms Melinda FROST</em></td>
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<tr>
<td></td>
<td><em>Dr Ki-Suck JUNG / Director, Korea Centers for Disease Control and Prevention (KCDC), Korea</em></td>
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<tr>
<td></td>
<td><em>Ambassador Karsten WARNECKE / Executive Director, Asia-Europe Foundation (ASEF)</em></td>
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<tr>
<td>09:20 - 15:30</td>
<td>Session I: Understanding Emergency Risk Communications and its Implications</td>
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<tr>
<td>09:20 - 10:30</td>
<td>1.1: Keynote Speech: Are we going the right way after MERS in Korea? Risk Communication Approach</td>
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<td><em>Dr Kisoo PARK, Spokesperson, Korea Centers for Disease Control and Prevention (KCDC), Korea</em></td>
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<tr>
<td>10:30 - 11:00</td>
<td>Coffee break</td>
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<tr>
<td>11:00 – 12:30</td>
<td>1.2: How Risk Communication Plays an Important Role in Public Health Emergencies</td>
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<td>Purpose: This session aims to demonstrate the importance and influence of risk communications by sharing examples from the past public health events.</td>
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</table>
|              | *Case Study/Panel Discussion:*
|              | *Ms Karen TAN / Ministry of Communication and Information, Singapore* |
|              | *Dr Iris HUNGER / Robert Koch Institute, Germany*                    |
|              | *Ms Joy CAMINADE / World Health Organisation Western Pacific Regional Office (WHO-WPRO)* |
|              | *Ms Andrea WURZ / European Centre for Disease Prevention and Control (ECDC)* |
| 12:30 – 13:30| Lunch break                                                          |
| 13:30 – 15:00|                                                                  |
| 15:00 – 15:30| Coffee break                                                         |
| 15:30 – 17:30| Session II: Risk Communication in Action (Emergency Simulation Exercise) |
| 15:30 – 16:00| 2: Introduction and first session of Emergency Simulation Exercise |
|              | Purpose: This and other sessions in the exercise will challenge participants to develop strategies and take decisions to address problems arising in simulated (but realistic) emergency situations |
| 17:15 – 17:30| Wrap-up of Day 1                                                     |
| 19:00        | Welcome Dinner                                                       |
|              | *(Place: 19/F Ivy Hall, Hotel President)*                           |
### DAY 2
Thursday, 15 June 2017

**THEME 2**

**How Can We Overcome Challenges in Risk Communication and the Political Interface?**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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</table>
| 08:30 – 09:00 | **Registration**  
*Place: 31/F Mozart Hall, Hotel President*                                         |
| 09:00 – 09:30 | **DAY 2: Day 1 Summary and Re-introduction of Scenario**  
*Facilitators: Mr Ben DUNCAN & Ms Melinda FROST*                                      |
| 09:30 – 12:45 | **Session III: Risk Communication in Action 2**  
*(Emergency Simulation Exercise cont..)*                                                  |
| 09:30 – 10:15 | 3.1: Group Discussion and Feedback to Plenary  
*Purpose: This session continues and develops the scenario from Day 1 to present participants with a new set of emergency challenges, against which they must develop strategies and take decisions* |
| 10:15 – 10:45 | / Coffee break                                                                             |
| 10:45 – 11:30 | 3.2: Group Discussion and Feedback to Plenary  
*Purpose: a third and final set of challenges require a response from participants*     |
| 11:30 – 12:30 | 3.3: Group Discussion and Feedback to Plenary  
*Purpose: Building upon and refining strategies developed in previous sessions – developing them into conclusions and recommendations* |
| 12:30 – 14:00 | / Lunch break                                                                               |
| 14:00 – 16:15 | **Session IV: Conclusions**  
*4.1: Defining Solutions – Summary of the High-level Meeting and Recommendations on: “Risk Communication & Leadership during Health Emergencies”*  
*Purpose: Participants will debate and develop final consensus on recommendations and conclusions from the High-level Meeting*  
*4.2: Statements by Participants*  
*Dr Margaret HARRIS / World Health Organisation (WHO)*  
*16:15 – 16:35* | **Closing Remarks**  
*Mr Yuji AMAMIYA / Director, Asia-Europe Cooperation Division, Ministry of Foreign Affairs, Japan*  
*Dr Geneviève BARRÉ / Director, Political & Economic Department, Asia-Europe Foundation (ASEF)*  
*Dr Kisoo PARK / Spokesperson, Korea Centers for Disease Control and Prevention (KCDC), Korea* |
| 15:15 – 15:45 | / Coffee break                                                                             |
| 15:45 – 16:15 |                                                                                 |
| 16:15 – 16:35 |                                                                                 |
### Annex II - List of Participants, Facilitators & Organisers

#### Country Representatives (listed by country alphabetical order)

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms Rhonda OWEN</td>
<td>Assistant Secretary, Health Emergency Management Branch, Office of Health Protection</td>
</tr>
<tr>
<td>Prof Charles GUEST</td>
<td>Chief Health Officer</td>
</tr>
<tr>
<td>Mag Irene KASZONI-RUECKERL</td>
<td>Senior Policy Officer</td>
</tr>
<tr>
<td>His Excellency Phay SIPHAN</td>
<td>State secretary &amp; Spokesperson for Royal Government of the Kingdom of Cambodia</td>
</tr>
<tr>
<td>Dr Teng SREY</td>
<td>Deputy Director, Communicable Disease Control Department</td>
</tr>
<tr>
<td>Ms Merja RAPELI</td>
<td>Ministerial Advisor, Preparedness Unit</td>
</tr>
<tr>
<td>Ms Johanna SAUKKOMAA</td>
<td>Communications Director</td>
</tr>
<tr>
<td>Mr David HEARD</td>
<td>Director, Directorate of the Communication and Dialogue with the Society Division</td>
</tr>
<tr>
<td>Dr Sophie MONTAGNON</td>
<td>Medical Advisor, Alert and Crisis Division</td>
</tr>
<tr>
<td>Dr Iris HUNGER</td>
<td>Deputy Head of the Federal Information Centre for Biological Threats and Special Pathogens</td>
</tr>
<tr>
<td>Ms Fidelma BROWNE</td>
<td>Head of Communication Programmes and Campaigns, Communications Division</td>
</tr>
<tr>
<td>Dr Patrizia PARODI</td>
<td>Senior Officer</td>
</tr>
<tr>
<td>Dr Manabu HASEGAWA</td>
<td>Councillor, Coordination Office of Measures on Emerging Infectious Diseases, Office for Pandemic Influenza Preparedness and Response</td>
</tr>
<tr>
<td>Dr Shoji MIYAKAWA</td>
<td>Director, Infectious Disease Surveillance and Information Office, Tuberculosis and Infectious Disease Division, Bureau of Health</td>
</tr>
<tr>
<td>Dr Sibounhom ARCHKHAVONG</td>
<td>Deputy Director General, Department of Communicable Disease Control</td>
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<td>Mr Phoumy BODHISANE</td>
<td>Director, Centre for Information and Education for Health (CEIH)</td>
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<td>Dr Narangerel DORJ</td>
<td>Director, Division of Surveillance and Emergency Operation, Department of Public Health</td>
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<td>Ms Togootoi AMARGARGAL</td>
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<tr>
<td>Dr Malik Muhammad SAFI</td>
<td>Director, Programmes, JEE Focal person/HPSIU:HR-GHSA</td>
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<td>Dr Francisco GEORGE</td>
<td>Director-General</td>
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<td>Dr Cristina ABREU SANTOS</td>
<td>Team Coordinator, Support Unit of the National Public Health Officer and Public Health Emergencies Management</td>
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<tr>
<td>Ms Karen TAN</td>
<td>Senior Director, Public Communications Division</td>
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<td>Dr NGUYEN Dinh Anh</td>
<td>Director General, Health Communication and Reward Department</td>
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<tr>
<td>Dr THAO Vu Cong</td>
<td>Senior Official, Department of Science, Education, Social and Cultural Affairs</td>
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#### International Organizations

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<tr>
<td>Ms Joy CAMINADE</td>
<td>Technical Officer (Risk Communications), Division of Health Security and Emergencies</td>
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<tr>
<td>Dr Nickolas DELUCA</td>
<td>Associate Director for Communications, Centre for Global Health</td>
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<tr>
<td>Dr Margaret HARRIS</td>
<td>Technical Officer, Social Science Interventions, Infectious Hazard Management Department</td>
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<tr>
<td>Ms Andrea WÜRZ</td>
<td>Expert in Communication Capacity Support</td>
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#### Facilitators

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<tr>
<td>Mr Ben DUNCAN</td>
<td>Director for Europe</td>
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<td>Ms Melinda FROST</td>
<td>Director of Knowledge Management</td>
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#### Organisers

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<td>Ambassador Karsten WARNECKE</td>
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<td>Dr Genevieve BARRÉ</td>
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<tr>
<td>Ms Riko KIMOTO</td>
<td>Project Executive, Political &amp; Economic Department</td>
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<td>Ms Ayesha ISKANDER</td>
<td>Project Officer, Political and Economic Department</td>
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<tr>
<td>Ms Crystal KOH</td>
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<td>Ms LIM Bee Gnoh</td>
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<td>Ms Jimin HWANG</td>
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<td>Dr JUNG Ki-Suck</td>
<td>Director</td>
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<td>Dr PARK Kisoo</td>
<td>Spokesperson</td>
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<tr>
<td>Mr CHOI Yuh-Seog</td>
<td>Assistant Director, Office of Communication Department</td>
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Korea Centers for Disease Control and Prevention (KCDC) is a Korean governmental agency founded in 2004, developed and organised from the Korea National Institute of Health with a purpose of establishing a safe health management system and administration of more effective disease control. The mission of KCDC is to protect citizens from diseases and create a healthy society, free of disease concerns. In this manner, KCDC continuously works on strengthening its public health emergency response capacity in order to effectively respond to national health emergencies during any new epidemic outbreak. Over time, KCDC has developed a systematic disease control response mechanism through research, investigation, and surveillance of disease.

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