



SIXTH FUTURES FORUM

on crisis communication



Reykjavik, Iceland, 10–11 May 2004

KEYWORDS

COMMUNICATION
DISASTER PLANNING
EMERGENCIES
CRISIS INTERVENTION
PUBLIC HEALTH ADMINISTRATION
RISK MANAGEMENT
DECISION MAKING
PUBLIC RELATIONS
EUROPE

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ISBN 92 890 1067 3

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1. Why WHO held a Futures Forum on crisis communication

“When a public health emergency (or crisis) occurs, communication is going to directly influence the evolution of the events.”

When facing a crisis arising from an epidemic, accident, natural catastrophe or terrorist attack, public health decision-makers have to be prepared not only for what to do but also for what to say. Ensuring that their response is professionally coordinated across the sectors is the first challenge. However, unless the public is clear about what to do and why, the management of such a crisis can create confusion, anxiety and a breakdown of trust. Communication will directly influence how events evolve. It may fan public fears or may encourage behaviour that contributes to control.

This Futures Forum of High-level Decision-makers was based on the exchange of experience on communicating in crisis. The purpose of the Futures Forum was to learn from one another and to better understand the dynamics of communicating in a health crisis by hearing from colleagues who had faced public health crises. The Futures Forum also aimed at generating insight into some of the policy tools Member States are already using and can recommend for communicating in a crisis.

This theme of crisis communication links with the Fifth Futures Forum on Rapid Response Decision-making Tools in December 2003 in Madrid (1). The Fifth Futures Forum dealt with case studies requiring rapid response, such as the heat-wave epidemic in France and Portugal in summer 2003. Although that Futures Forum mainly focused on early detection of and preparedness for crisis, failures in communication were found to be key features of crises. For example, France experienced a period of excess mortality during the period of extreme heat in August 2003. No press conferences were held, and there were few direct interventions in the mass media offering information and scientific advice. Silence from authorities may have fanned public fears and undermined confidence that authorities had the situation under control. The heat-wave crisis unfolded not only due to the excess mortality but also to a decline of the public trust in decision-makers (1).

Based on the findings of the Fifth Futures Forum, it was decided that the Sixth Futures Forum would deal with crisis communication. The Forum was held in Iceland, where people have to constantly live with natural health risks such as earthquakes, volcano eruptions and storms. Iceland has implemented an effective emergency communication system and adopted one basic telephone number (112) for all incoming emergency calls in 1995. Iceland recently opened a central emergency coordination centre bringing under one roof the coordination of the services related to health, police, coast guard, armed forces, the judiciary, civil protection and the services of the voluntary emergency sector.

Sixth Futures Forum on crisis communication

This report grew out of the Sixth Futures Forum. The report has four sections. Following this introduction, **section 2** explains the working definition of crisis communication used in the Futures Forum. **Section 3** is devoted to case studies on crisis communication, dwelling on the perspectives of decision-makers. This section deals with cases on dioxin (case 1), avian flu (case 2), severe acute respiratory syndrome (SARS) (cases 3 and 4) and risk communication on measles, mumps and rubella (MMR) vaccination, bovine spongiform encephalopathy (BSE) and variant Creutzfeldt-Jakob disease (vCJD) and health care errors (case 5). **Section 4** contains conclusions. The report contributes to a set of policy tools for high-level decision-makers to be developed towards the end of this Futures Forum series on tools for decision-making in public health.



2. How this Futures Forum defined crisis communication

Crisis is an unstable situation of extreme danger or difficulty. It indicates a turning-point, usually a deterioration of a situation. It arises when local health systems on which people depend are overwhelmed and cannot or do not respond to the demands or needs. Crisis is an imprecise term. “Crisis communication” means communicating in times of crisis. It can be a mechanism to tackle a crisis by exchanging information. It can also stand for failures in communication that cause crises. In health, crisis and communication are closely linked. All health crises are also communication crises (1).

Crisis often leaves uncertainty about the epidemic potential of an event. Epidemics can evolve without a crisis, and crisis can evolve without an epidemic (1). In countries with a high level of health literacy, crisis is often accompanied by the health-literate public blaming decision-makers. In addition, emotional connotations such as fear and panic are often elements of a crisis because each person is uncertain about how a crisis might affect his or her life. The mass media typically trigger these dynamics.

The notion of crisis communication is closely linked to communicating in disasters or emergencies. The terms crisis, emergency and disaster all define critical situations with different and common features. Different economic and political cultures use these terms differently. WHO defines an emergency as a disastrous event in which the needs and available resources are imbalanced and has mostly applied this concept to developing countries. In western European countries, “disasters” and “emergencies” are often events that have a more certain epidemic potential compared with crises, which have a political connotation.

Another notion related to crisis is “health risk”. Health risks, or threats, like crises, involve emotional connotation and uncertainty regarding health and economic effects. Health risks and the probability of them being realized played a major role in case 1 on the dioxin crisis in Belgium, case 2 on SARS risk in Norway and case 3 on the SARS epidemic in Ontario, Canada. These health risks were characterized by invisibility. Risks may develop into a crisis, either when public trust in decision-makers’ control is at stake or when health risks lead to notable attention in the press and thus the awareness of the population, as in case 3 on the SARS epidemic in Ontario and during the BSE crisis in the United Kingdom.

Risk communication is part of crisis communication. This is two-way communication between stakeholders (such as decision-makers or experts) and the public about the existence, nature, form, severity or acceptability of risks.

Health risks to a population can be attributed to several causes, including environmental and other external hazards such as in case 1. Health risks can also occur in personal settings, owing to personal lifestyle, the adverse effects of health care or errors in diagnosis or treatment, such as presented in case 5, where health system failures have played a major role.

Sixth Futures Forum on crisis communication

Concerns about health risks may arise in different ways in popular sources. For example, human interest stories have a high potential to be newsworthy. Pressure groups can cause a high chance of mass-media effect when they arouse interest in mass-media coverage of a health risk.

Crises have several stages, and different tasks can be attributed to each stage in managing a crisis. Crisis communication is only a small part of a crisis. The Sixth Futures Forum focused on crisis communication, as does this report. It takes a decision-makers' perspective and reflects the views of a sample of countries from western Europe. The next section illustrates decision-makers' perspectives on crises that arise in the context of dioxin, SARS, avian flu, MMR vaccination, BSE and health care errors.



3. Case studies

Case 1. Dioxin crisis in Belgium

“When a health risk arises, provide the information you have about the risk and what is being done about it. Withholding information puts you at risk of a decline of public confidence and crisis.”

Background

Dioxin is a general term relating to a group of lipid-soluble chemicals. Polychlorinated biphenyls (PCBs), which certain industries use for products such as transformers, insecticides and others, are classified as dioxin-like chemicals. They are stable, which means that they accumulate in the environment and in fatty tissues in organisms and that they resist degradation and metabolism. They can be destroyed by incineration at temperatures exceeding 850°C. Their half-time in the body is seven years on average. When dioxins move up the food chain, their concentration increases. Not all dioxins are toxic. PCBs are among the toxic dioxins. A single high dose of a toxic dioxin can be lethal; lower longer-term exposure is linked to impairment of the immune system, the nervous system, the endocrine system and reproductive functioning (2). PCBs are associated with skin eruptions, pigmentation and swelling of the eyelids. Contamination is usually reported by industrialized countries and often in the context of food contamination (Italy in 1976, the United States of America in 1997 and Belgium in 1999), since many industrialized countries have better food surveillance monitoring and capacity to detect dioxin than many developing countries. Because the mechanism of causing cancer is controversial and the methods used in determining the acceptable daily dose of dioxin exposure vary, threshold doses differ widely between countries. WHO has established a tolerable daily intake of 1–4 picograms of dioxin per kilogram of body weight. The current daily intake in industrialized countries is in the range of 1–3 picograms per kilogram of body weight (2).

Sequence of events

The full sequence of events was clearly outlined later in the crisis (3).

On 19 January 1999, a storage tank of Verkest, a fat- and oil-processing producer of plant and animal feed in the northwest Flemish part of Belgium, was contaminated with dioxin.

Several possible sources of dioxin were identified which might have led to the contamination of the tank. The tank contained animal fat: 80 tonnes of recycled animal waste from a company in Spain called Fogra that had collected the animal fat from restaurants, slaughterhouses and waste disposal units. Verkest added 50 tonnes of animal fat. It is assumed that the contaminated fat either came from Fogra or from the recycled oils of animal grease that Verkest had added.

The stage of waste disposal or transport at which the content of the tank was contaminated was never ascertained, but mass-media reports suggested later in summer 1999 that motor oil or other industrial oil was either intentionally or accidentally mixed with the animal fat.

On 19 January, the animal tank in the contaminated tank was processed to produce animal feed, and Verkest supplied some of the contaminated animal feed to several other feed-mill companies between 20 and 27 January for the production of animal feed in Belgium, the Netherlands and France.

During February, a company that produces animal feed noticed health effects among hens eating its feed and started an investigation that concluded that the fat in the animal feed may have caused the problem. In the middle of March, a sample of feed produced in January was sent for laboratory testing. On 19 March 1999, Belgium's Ministry of Agriculture and Ministry of Public Health were alerted of a possible dioxin contamination of chicken and eggs. This contamination was confirmed on 26 April.

During May, the government traced the distribution of contaminated fat between January 19 and 31, identified the other affected feed producers in Belgium, France and the Netherlands, notified the authorities in France and the Netherlands and identified the companies that had bought feed from Verkest. In addition, hundreds of poultry farms were investigated for dioxin contamination.

Test results in May revealed high dioxin levels in hens and eggs from farms receiving feed from the involved animal feed producers. On 27 May, the government placed these animal feed producers under surveillance. Their chicken and egg products were traced.

The first press release was launched on May 27, and the members of the European Union were informed officially about the contamination. On 28 May 1999, Belgium's Minister for Public Health announced a ban on sales of poultry and eggs in Belgium and removed these products from the shelves. One day after the announcement, the national and international press started reporting massively on the dioxin contamination in Belgium and strongly accused the government of having covered up the problem for months. The international press covered the crisis for about 3.5 months with hundreds of articles.

On 1 June 1999, the Government of Belgium opened a Web site with facts, dates and the health risks due to dioxin contamination. Addresses, phone numbers and reports were released to the public. Call centres were established for consumers. It extended the sales ban on poultry and eggs, and on 2 June, pork products were banned.

Farmers, food producers, food wholesalers and retailers started to complain about losses of income and reputation, and several companies closed down.

Belgium's Minister for Agriculture and Minister for Public Health resigned on 1 June.

The European Commission issued a press release on 2 June requesting European Union countries to destroy all potentially contaminated feed, poultry and egg products and permitting a ban on uncertified imports from Belgium. Many European Union countries reacted by recalling poultry and egg products from Belgium; some

went even further in banning all meat and animal feed imports from Belgium, and the United States and Singapore banned all European food imports. On 4 June, the European Commission extended its restrictions to milk and other dairy products, pork, beef and other products from suspected farms. Disagreements between the European Commission and the Government of Belgium were reflected in different press releases and were heavily covered by the national and international mass media.

Various stakeholders in Belgium, including industry, the agricultural sector, the voluntary environmental protection sector, government officials in Belgium, consumer groups, government officials in other countries and the national and international mass media started to communicate based on diverging interests, arguments and “facts”, causing enormous confusion (Fig. 1).

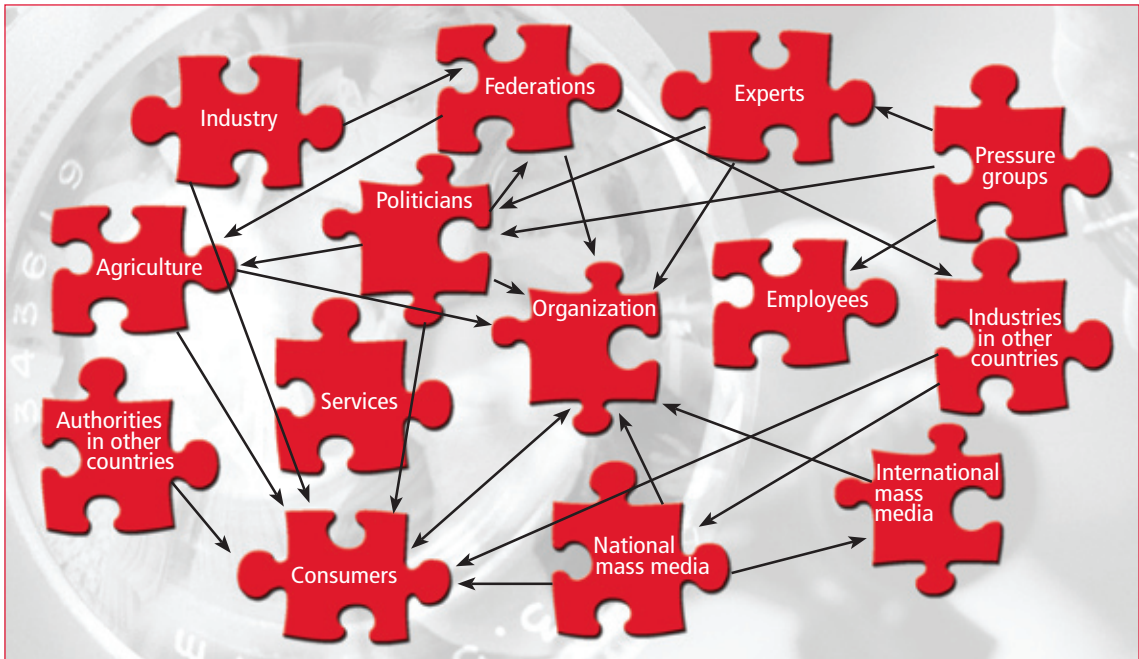


Fig. 1. Communication channels between the different stakeholders and audiences in Belgium's dioxin crisis

On 4 June, the Government of Belgium published a list of products connected to Verkest. Centres to collect the products on the list were established, and products connected to Verkest were incinerated.

A press release on 5 June aimed to reassure the population about its concerns for consumer health. It explained that contamination was due to a one-off event and that the consequences were now increasingly under control. The release summarized the action taken, and the government also disclosed its disagreement with the European Commission.

On 7 June the Netherlands' Minister for Agriculture resigned in the context of being accused of having delayed notification of potentially dioxin-contaminated poultry and eggs linked to fat imports from Belgium.

The European Commission released information about the measures taken at the level of the European Union.

On 10 June, farmers in Belgium blocked traffic between the border with France and the border with the Netherlands, protesting export bans.

During June, several countries reported elevated levels of dioxin in chicken products imported from Belgium. The mass media reported this extensively. Discussions about new safety standards and a European food safety authority were initiated. Towards the end of June, the economic impact of the crisis became prominent, and the Government of Belgium estimated the economic loss in the agricultural and food industry sector to amount to more than US\$ 1.5 billion.

During July, the European Commission and the newly elected Government of Belgium continued to disagree on import regulations governing farming products from Belgium and the acceptable PCB concentration thresholds.

Finally, on 6 August 1999, the Government of Belgium issued a directive in compliance with the regulations of the European Commission that each animal or derived product had to be accompanied by a certificate of analysis of PCB and/or dioxin absence.

On September 20, a certification programme was initiated that introduced mandatory PCB and dioxin testing for all remaining farms in Belgium.

What started as a health crisis in Belgium became a political, economic and social crisis stretching far beyond the Belgian borders. The crisis also increased awareness of health risks from dioxin exposure and caused countries to introduce more routine checks for dioxin and PCBs.

Challenges in crisis communication

Perhaps the greatest challenge in crisis communication during Belgium's dioxin crisis was the high degree of uncertainty about what exactly had happened to cause the release of dioxin to the environment and its uptake by animals through feed. This also applies to the unknown rate of dioxin exposure of the population of Belgium at the outset of the crisis. The crisis was caused by a one-shot incident that was restricted in time but was difficult to trace back. In particular, the link between the feed and the dioxin contamination of animal herds was not obvious. The opinions of scientific experts massively diverged on the causality of events, and this confused the messages provided to the public. Another problem concerned the massive interest of the international mass media in this matter, which in turn increased anxiety within Belgium.

Many challenges were beyond the control of Belgium's authorities. Some relate to the uncertainties and negative reputation of dioxin as a potential carcinogen and endocrine disrupter. For example, before the crisis European countries differed in the levels of acceptable dioxin concentrations in products.

Communication was poorly coordinated within Belgium between its various food-producing and agricultural stakeholders and interest groups, but also between Belgium and the European Commission as well as among European Union countries.

Discussion

- In case of crisis, first decide what to do and then communicate. In the dioxin crisis, the Government of Belgium may have taken appropriate actions but failed to communicate these actions.
- The case study showed the importance of early communication about health risks that arise suddenly and what the government is doing in managing that risk. Covering up of risks and information vacuums can lead to serious loss of the public's confidence in decision-making, confusion and anxiety. In this dioxin crisis, lack of communication caused the mass media and the public to focus on the government's perceived failures in managing the crisis rather than the deficiencies in the food industry that had caused the problem.
- In addition to early communication, the case also illustrates the importance of a proactive communication strategy driven by authoritative and reliable information rather than speculation from the mass media. The mass media often search for what is hidden. Waiting until the mass media detect a problem puts governmental officials in a defensive position, and they then often say things that they do not want to say.
- In crisis communication, care needs to be exercised in deciding who communicates to the press. In Belgium, it was disadvantageous that the people managing the crisis were the ones communicating to the press. This posed an extra burden on them, not only in terms of time but also in terms of psychological pressure when the mass media started to say that the government had lost control over the crisis.
- No standard rules can be established for health ministries on who should communicate – each ministry in each country has to decide on what is appropriate for the country.
- Whoever speaks to the press in a crisis requires assistance from communication specialists, who may be in a better position to understand and advise how to respond to the questions of journalists.
- Crisis communicators and journalists need to maintain mutual professional respect and trust for each respective role in times of crisis. Journalists are neither friends nor enemies of health authorities in times of crisis; they simply do their job. Nevertheless, crisis communicators need to be skilled communicators to prevent misunderstanding and confusion. They also need to have technical understanding of the health risks and yet be able to express complex content in simple words.
- The job of journalists is to ask questions. They may ask for personal opinions when scientific evidence is still lacking, such as: "What do *you* think?" or "What do *you* believe?". These questions provide a possibility for going beyond official positions. However, communicators have the right to refuse to answer questions, especially when they go beyond one's area of work.
- The case illustrates that the Government of Belgium and the European Commission did not coordinate their crisis communication. Direct cooperation, instead of an interaction of blaming and shaming, might have been more effective in gaining the public's confidence.

Case 2. Avian flu alert in Austria

“Mass-media work has to be set up before a crisis starts. To improve links in times of crisis, I regularly talk to journalists I trust, and sometimes I give them background information for their ‘own’ information.”

Background

Avian influenza is an infection of birds caused by the influenza virus strain A. There are several subtypes of the virus with different levels of pathogenicity. The subtypes that are less pathogenic can mutate to higher-pathogenicity forms, with high mortality of up to 50%.

Outbreaks of avian influenza in poultry are considered rare historically, with 21 outbreaks from 1959 to 2003 that remained geographically delimited (4). Nevertheless, recent outbreaks have a new dimension of geographical and international spread and economic effects. New countries are experiencing outbreaks of highly pathogenic strains of avian influenza in poultry and do not have experience in coping with these outbreaks.

Transitions from animals to humans have been rare, as reflected in the low numbers of human infections. Despite the announcement on 27 September 2004 by Thailand’s Ministry of Health of a possible human-to-human transmission in a family cluster, there is still no evidence of efficient pathogenic human-to-human transmission. However, there are concerns that efficient human-to-human transmission could be possible in the future: either through the exchange of gene segments when humans are simultaneously infected or through a mutation of the virus during human infection (4). In this respect, much attention focuses on the virus strain H5N1 of avian influenza, which is a fairly new virus type considered adapted for efficient transmission. The virus is able to acquire genes from viruses infecting other animal species. It has been shown to mutate rapidly and has high pathogenicity, which means that it can potentially cause severe disease in humans. When concurrently infected with human and with avian influenza strands, the human could serve as a “mixing vessel” whereby a novel virus subtype could arise with potentially high human pathogenicity. With the emergence of such a new virus subtype, the general population would probably have no immunity against this virus, and existing vaccine would not be effective. This is the background against which there are major concerns of a possible influenza pandemic. Such a pandemic in principle could be as deadly as the “Spanish” flu in 1918, which caused as many as an estimated 50 million deaths.

Sequence of events

Several local outbreaks of avian viral influenza A among humans have been reported in the last eight years. In Hong Kong Special Administrative Region, China, in 1997, avian influenza A (strain H5N1) led to 18 detected infections with 6 deaths. This outbreak coincided with infection outbreaks of H5N1 virus in poultry farms and markets (4). The immediate culling of this poultry is believed to have averted a pandemic (5). In 1999, two cases of avian influenza A (strain H9N2) were reported. In 2003, Hong Kong Special

Administrative Region reported another two cases of avian influenza A (strain H5N1), one of which led to death. The Netherlands reported 87 cases of avian influenza A (strain H9N2) with one lethal case, a veterinarian.

The avian influenza in 2004 started with a report of three laboratory-confirmed cases, two children and one adult, by Viet Nam on 13 January, and of two laboratory-confirmed infections of children in Thailand on 23 January. In both countries, the agent was associated with avian influenza strain H5N1 and directly linked to outbreaks of pathogenic infections in poultry in seven Asian countries since December 2003. Further cases were reported in Viet Nam and Thailand accumulating to a total of 36 cases, and 23 deaths, until 22 March 2004.

In British Columbia, Canada, two cases of avian influenza of a different strain H7 were confirmed on 31 March.

In January 2004, Austria's Federal Ministry of Health and Women appointed the Institute for Virology as the national reference laboratory for avian influenza infections. It issued several recommendations to the public. One recommendation urged populations at risk (poultry workers and others) to wear masks and eye protection when feeding poultry. The population at risk was granted influenza vaccination and antiviral prophylaxis with oseltamivir. Recommendations for influenza vaccinations were issued for travellers, and general warnings were issued on visiting chicken farms and markets with live poultry. The general population was offered free influenza vaccination.

At the same time, the Federal Ministry of Health and Women started negotiating about the availability and price of antiviral medicines and vaccines cultivated through cell cultures.

In February 2004, the draft of a preparedness plan for an influenza pandemic was finalized, and regional public health authorities were charged with developing a vaccination strategy and a distribution concept.

Communication strategies and operations

Communication on health risks in Austria is normally based on proactive communication through television, print media, Internet media and professional, popular and other journals. They aim to increase the perception of health risks among the population in advance of the crisis. The mass media are used as a tool to make health risks more visible. The Federal Ministry of Health and Women has developed and released to the population several crisis scenarios and their modelled responses by the health authorities. Preparedness plans and response capacity are made public with the aim of increasing public acceptance for preventive measures and the purchase of materials (such as vaccine stockpiling).

Qualified people undertake early or timely risk communication, aiming to prevent panic. Although ministerial communications recognize health risks, they also provide reassuring messages. These contain, for example, information about measures for managing the risks. They can easily be developed when preparedness plans are available and response capacity is sufficient with respect to laboratory capacity, availability of sufficient medicine and stockpiled vaccine and well-trained health personnel.

The mass media concept in Austria's pandemic plan foresees two stages of risk communication; one in the phase between pandemics and one in the various phases of a pandemic.

For the phase between pandemics, risk perception is increased through continuous information on preparedness plans and capacity-building taking place before and during the influenza season. Press releases are prepared and an influenza web site is established. A call centre is instituted that can be contacted with a toll-free emergency number. The official spokesperson of the Federal Ministry of Health and Women is involved in all of these activities.

During the pandemic phase 0 level, the Ministry releases information on the health threat and possible necessary measures. If necessary, a hotline is established. In pandemic phase 1, when WHO confirms the pandemic threat, the Federal Ministry of Health and Women establishes a pandemic crisis committee. The committee releases information daily on health threats and necessary measures. Health politicians in Austria have agreed to be accessible to the mass media in this phase 1 of an influenza pandemic. Hotlines are established at the national and regional levels. In phase 2, the pandemic crisis committee releases information on the development of the pandemic and reports on the impact of the measures taken. At this phase 2, health politicians have agreed to be accessible to the mass media. In phase 3 of the pandemic, the pandemic crisis committee declares the end of the first wave of the pandemic, presents a report and informs about a possible second wave.

During the avian flu alert in Austria, most of the principles developed for the influenza pandemic were applied. Due to the uncertainty of the level of health risks posed by the outbreaks of avian influenza among poultry and among some humans in Asia, it was decided to work towards a one-voice strategy for communication. For this purpose, all relevant stakeholders were called in for consensus, through meetings of the federal sanitary and immunization councils, involvement of all regional health authorities and an association of the leading experts in Austria in the fields of virology, immunization and epidemiology.

An afternoon meeting of all participants at the national and regional levels, as well as policy and expert levels, decided that one of the epidemiologists, a talented communicator, would be the key coordinating communicator of the avian flu alert.

Others were also charged with communicating to the press. The Federal Minister for Health and the State Secretaries for Health attended press conferences. The Director General for Health and the experts deployed by the Ministry also sought continuous press presence.

The veterinary and human health measures were constantly released to the mass media, updated on the Ministry's web site and published in professional and popular journals.

Key messages were drafted and repeatedly communicated (*Box 1*).

Box 1. Key messages on avian flu communication in Austria in 2004

- Avian flu is a disease of animals!
- There is no avian flu in Austria.
- Avian flu cannot be transmitted through food.
- There is no evidence that human-to-human transmission has occurred.
 - Medicines against influenza can also help against avian flu.
- Nevertheless, we are preparing for the worst-case scenario of an influenza epidemic in Austria and are working on a preparedness plan.

Box 2 illustrates an example of the sequence of mass-media events.

Box 2. Examples of a sequence of mass-media messages by a Secretary of State for Health

- 3 February 2004: Secretary of State for Health: caution in travelling to Asia
- 10 February 2004: invitation to a press conference with Federal Minister for Health Rauch-Kallat: avian influenza "Austrian preparedness plan"
- 13 February 2004: avian influenza: Secretary of State for Health at a special meeting of the Council of Ministers in Brussels
- 24 February 2004: avian influenza: recent knowledge from China

Box 3 provides an example of a position statement by the Supreme Health Council on the topic of avian flu (translated from German).

Box 3. Statement by the Supreme Health Council on the topic of avian flu

Currently there is no danger in Austria!

In Asia there is currently an outbreak of a severe contagious animal epidemic (avian flu), which is caused by an influenza virus of birds. Very rarely, this virus can be transmitted to humans who come in direct contact with infected animals or their excrement.

So far very few people who have had contact with infected animals have become ill. Until now, the disease has led to the death of 20 people. Transmission between humans is theoretically conceivable, but during this outbreak, such transmission has not been proven.

The veterinary authorities have introduced rigorous measures to prevent the spread of the epidemic to Austria.

There are currently no signs of a human influenza pandemic – a worldwide outbreak of a dangerous epidemic!

Discussion

- In situations where the population faces a sudden and uncertain health risk, health authorities need to communicate the level of uncertainty.
- Having a communication strategy and mass-media links in place before a crisis starts is useful. This requires keeping continuous links with the mass media and can be achieved, for example, by regularly giving them health information and briefings. Establishing links with trustworthy newspapers and journalists is especially important.
- The communication experiences in Austria showed that using a one-voice principle to communicate in a crisis may be valuable. However, the discussion of the case also indicated that this may not always be realistic. For example, one argument raised was that scientific statements always differ from those of decision-makers. Sometimes it will have to be carefully decided what to disseminate at the political level and what at the scientific level. Another aspect is that one-voice communication may be more challenging in countries in which authority for public health is extensively delegated to the local and regional levels. Further, one-voice communication requires that health authorities be ready to take the lead in a crisis. This requires high self-esteem among health officials, potentially also towards the officials of other sectors.
- Interviews during crises will preferably be live, not taped, to avoid being quoted out of context. Interviews given during times of crisis must also be planned, as time is scarce in crises. Avoiding having health authorities make too many announcements is a challenge.
- The experience in Austria illustrates a systematic risk communication approach on avian influenza. However, one can never be sure that the sequence of communication will be the same in times of crisis. Sometimes it is the critical moments when communication systems prove their worth.



Case 3. SARS alert in Norway

“Can one extrapolate the success of a communication strategy in tackling a potential health crisis to its use in an actual crisis?”

Communication about SARS in Norway started on 13 March 2003, one day after WHO issued its global alert. Information was placed on Norway’s national health web site. On 14 March, SARS was massively covered in Norway’s leading newspapers. On 16 March, technical information was distributed to the health sector. No cases of SARS were recorded. The communication strategy was independently assessed in June 2003.

Communication strategies and operations

Norway’s communication strategy had been informed by the lessons learned after the Chernobyl nuclear accident in 1986. More recently, Norway had developed communication components in its preparedness plan for an influenza pandemic. The communication strategy on SARS was driven by the need for national intersectoral cooperation, timeliness, accuracy and relevance of information provided to the public, with the aim of sustaining the public’s confidence in the capability of the government to tackle a possible outbreak of SARS. Consistency of messaging between various authorities was an aim. Frequent news output was aimed at reducing the impact of conflicting reports on the disease. Communication incorporated information derived from WHO and other international organizations. Political, administrative and budgetary limitations posed constraints. Three press conferences were held and 15 press releases disseminated. Web sites were updated continuously, and a weekly newsletter was issued. In addition, a SARS press room was established, and a special telephone line offering advice and counselling.

Evaluating communication

An independent professional assessor evaluated the communication strategy in June 2003 through an interview-based survey. Anonymity of the interviewees was ensured. Interviewees were medical officers and journalists.

The survey revealed that more than 70% of the interviewed medical officers were satisfied with the quantity, quality, timeliness, consistency and reliability of the information the health authorities provided. Ten per cent found the information to be insufficient, and 6% responded that it was excessive.

Most of the journalists surveyed were equally satisfied with the information provided. About half the journalists surveyed were satisfied with the number and the scope of press conferences the authorities held. However, interestingly, some journalists had suspected that there had been cases of SARS in Norway that the authorities had not disclosed.

A key question remained unanswered: whether the same communication strategy would have been equally successful if it had been applied in a situation in which Norway had been exposed to SARS infections.

Discussion

- Having a communication strategy in place, even if there is no crisis, can help to rapidly develop a communication plan when a crisis unfolds.
- A crisis communication plan requires background to the problem; an indication of the goals and objectives of the plan (inform, persuade or motivate?); and the designation of its target audiences.
- Journalists' questions in a health crisis are somewhat predictable. What has happened? Where has it happened? Who is affected? When did it happen? Why did it happen? What is being done about it? Will it happen again?
- Discussion arose on the question of ownership aspects of crisis communication. It was illustrated that institutional dynamics can sometimes predetermine contacts with the press. For example, one example was given by which communication staff tended to monopolize the relations with the press, which sometimes can cause difficulty for journalists who may be interested in following up with decision-makers directly. It was also pointed out that, in times of crisis, care should be taken in providing scientists with supporting roles but not to authorize them to speak on behalf of the health authorities.
- Communication plans need to be monitored in times of crisis and evaluated after the crisis.
- It remains unknown whether the same communication strategy would have been successful if it had been applied in a country that had been exposed to SARS.

This was the starting question for the next case on SARS crisis communication in Ontario, which had experienced 247 probable cases of SARS, 128 suspected, 44 deaths due to SARS and up to 20 000 people quarantined to protect them from SARS infection.

Case 4. SARS crisis in Ontario

“In the ten days before the Easter weekend in April 2003, thousands of citizens of Ontario were in quarantine at home.”

The sequence of events

The following gives a consecutive sequence of the events when the SARS crisis unfolded in Ontario, Canada (Fig. 2).

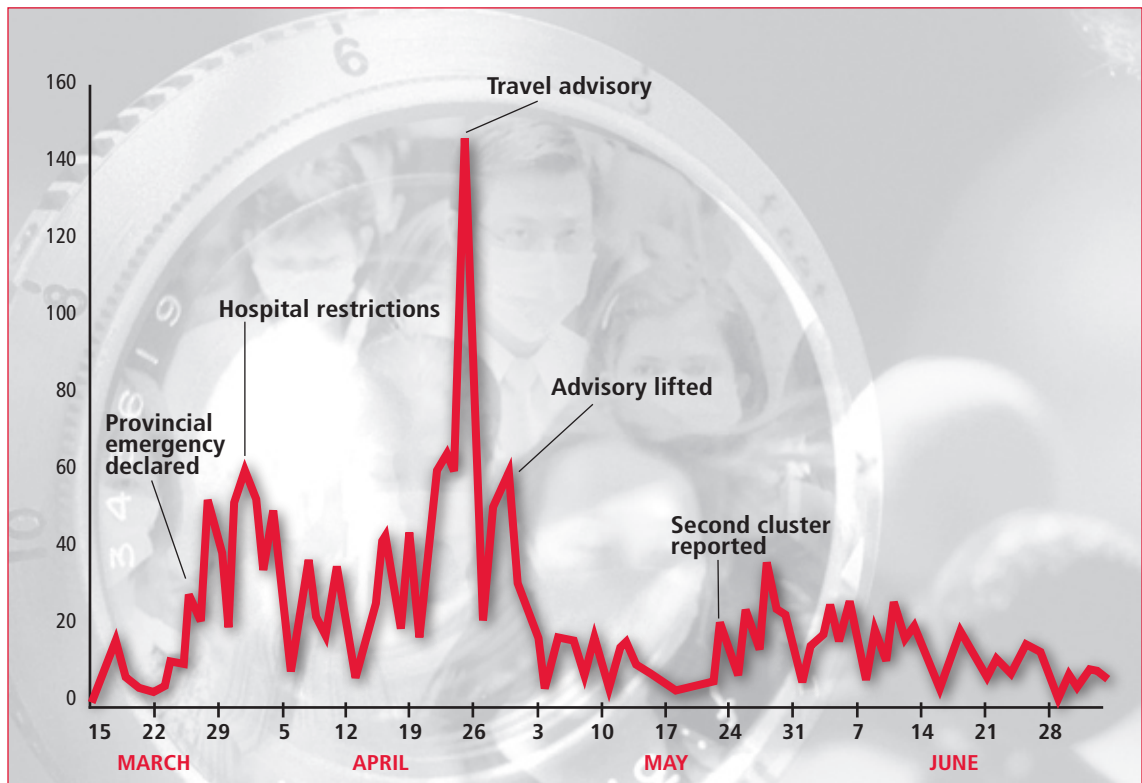


Fig. 2. Key SARS events and mass-media coverage (millions of media impressions)

SARS hit Canada in mid-March 2003 (Fig. 2). The first moderated press conference on the likely exposure to SARS of the population of Ontario, about 11 million people, was given on Friday, 14 March. During this press conference, the Ontario Ministry of Health and Long-Term Care alerted health care providers and the public about four cases of atypical pneumonia. The four cases occurred in one family in Toronto, the index family, that had travelled back home from an affected area in Hong Kong. Two of these initial cases resulted in death. Work started in trying to locate people who had been in contact with the infected cases of the family.

On 26 March, Ontario declared SARS a provincial emergency. This was a time when many health care providers, backed by government, started to isolate people that had been in contact with SARS. During the

last days of March, hospital restrictions started. The restrictions cancelled all elective surgical procedures, limited the visits of patients' relatives and restricted patient transfers between hospitals. The patients and visitors at many health care facilities were screened for high temperature.



Fig. 3. Hospital access restrictions for visitors in Canada

In the ten days before the Easter weekend in April 2003, more than 3000 citizens of Ontario, including health care professionals, mostly in the Toronto area, were in quarantine at home. A travel advisory was issued on 26 April with effect on the community levels and lifted one week later.

On 24 May, health authorities reported that two clusters of cases were undergoing investigation for respiratory infections. All cases under new clusters were linked to the original cluster cases, and no case of SARS has been reported since.

Crisis communication strategies and operations

Communication strategies adhered to the goals of managing the crisis itself (to protect the Ontarian public) and minimizing geographical spread while protecting and minimizing disruption in the Ontarian health system. Another aim was to minimize potential social and economic disruption in the province. Communication was to be guided by the objectives of educating and informing and was to reassure the public that the system was adapting to meet the challenge – a balance that turned out difficult to strike. One of the key and perhaps most challenging principles of communication was the need to protect the privacy of affected cases versus the need for transparent communication. Operational tactics in communication targeting the public and health care providers were reviewed daily.

As part of the strategy, it was aimed to demonstrate government leadership in managing the crisis. Communication about health risks was often directly linked to calls for action.

Judgements in communication were based on the best available evidence at that time and on ethical considerations. An important target was to reach out to all health care professionals working at the public health care services and hospitals. In particular, for health care providers, who were at higher risk of exposure than the general population, the communication team in the Ontario Ministry of Health and Long-Term Care came to realize the importance of disseminating consistent, timely and frequent messages from the central provincial platform. As a rule, the communication staff were to be accessible, open and fact-driven. A communication “war room” was established, as was a communication executive director whose task was to coordinate all emergency communication and the communication team. They worked up to 18 hours every day for about 15 weeks in a row.

Internally, daily telephone conferences were moderated at the beginning of the day involving officials, experts and communication staff. For stakeholders in the health care system (such as health politicians, civil servants in health and associations of health professionals), individual calls were made to attempt to harmonize communication. These stakeholders also received regular bulletins by e-mail and had access to a password-protected web site. During the peak of the crisis, one press conference was given at 15:00 each day. Overall, more than 100 press conferences were held. The selected spokespersons were either officials or experts. The press conferences were complemented with paid advertising events. The web site of the Ministry of Health and Long-Term Care was constantly updated with information and daily fact sheets and questions and answers for people.

The afternoon press conferences were mainly targeted at citizens, but additional phone lines were established at the central provincial level, offering advice specifically to health professional staff in hospitals and health care centres. In addition, regular letters were sent to the college of physicians. Directives were issued regularly.

Separate communication advice was offered to those under quarantine and their family members to prevent them from becoming infected. Dedicated SARS phone lines were set up in public health units and community care centres. These phone lines enabled people in isolation to be counselled and supported in getting groceries and other supplies delivered. The provincial SARS telephone line in Toronto registered about 10 000 calls per day.

Challenges in crisis communication

At the outset of the crisis, there were many operational challenges in crisis communication due to this fine balance between the confidentiality of patient data and transparency. In particular, did privacy rights prevent sharing of information that would have been necessary to combat the epidemic? A similar challenge was to balance information on health risk with the need to reassure the population that the health system was adapting to meet the challenge. This became more and more important, as public anxiety became intense. Communication had to combat a rising trend of xenophobia towards people suspected of having SARS, towards Asians and towards health care professionals. For example, people noted that taxi drivers refused to pick up nurses as clients.

Other problems concerned the uncertainty of information – not only in lack of case definitions but also reliable data on the health service utilization of patients with symptoms of pneumonia. The provincial government discovered during the SARS crisis that, owing to an inadequate information system, it had no clear way to obtain reliable information about who sought access to hospitals and other health services.

Later this was found to be one of the main reasons for the lack of ability to assess the spread of SARS, which was mainly transmitted through hospitals in Ontario. For example, the absence of reliable information on health service utilization in hospitals made it unclear whether cases reported in hospitals indicated cumulative cases of SARS in a particular hospital or rather reflected trends of infections in the whole population. There was also poor communication between the hospitals and public health and care institutions.

The mass media were very interested, requesting a vast amount and frequency of information. Sometimes the communication team felt that the mass media were driving the agenda. The press conferences were complicated to manage, since the communication team had to communicate to people who were fairly knowledgeable about the health risks of SARS and to people who were not, and thus considerable confusion arose.

A particular challenge was associated with failures in international communication, including two main problems. One problem was that messages targeting the local population were picked up and broadcast all over the world, which greatly increased international disclosure of the local problems in combating SARS. It may well have added to the distress of the citizens of Ontario, who came to learn about the SARS epidemic in Ontario through the international mass media and started to wonder whether the problem they were facing was really that serious. A second problem concerns the international health community, in particular WHO. Ontario, being a provincial government, is not an official counterpart of WHO, and channels to communicate with WHO were complex.

Other problems in crisis communication were deficiencies in communication between health care providers. The systems of hospital infection control within hospitals failed in part, because mechanisms were lacking between hospitals to share information about SARS infections among themselves. Another problem was the lack of consistent messages coming from providers. Different hospitals issued inconsistent advice, sometimes advising the rigorous isolation of cases and sometimes solely using protective equipment in dealing with the cases. It became clear that hospitals should not be blamed, as scientific evidence on the proper degree of isolation of infected and suspicious cases was largely lacking. Although the Ontario Ministry of Health and Long-Term Care issued directives to hospitals aiming to offer advice, answers to the most essential questions such as: “How much do we need to isolate suspected cases?”, “Can we just ‘try to stay away?’” or “Can we just wear masks to prevent infections?” could not be supported by evidence of the best method of dealing with suspected cases.

Communication related to people under quarantine turned out to be extremely challenging. At times, thousands of people were under quarantine, some people who had been in direct contact with suspected and probable cases, some health care workers and everyone under investigation. Many cases were isolated because the number of suspected cases was large. Challenges of quarantine communication were related to the multiple audiences and the fact that many health care professionals were among those quarantined – and they required different levels of communication. Yet at the same time, consistency was required in communicating to those under quarantine.

The members of the communication team in the Ontario Ministry of Health and Long-Term Care also faced anxiety and uncertainty about contracting SARS themselves, and a few individual members of the communication team sought medical surveillance themselves.

Evaluating communication

The communication representative of the Ontario Ministry of Health and Long-Term Care felt that much of the communication activity for the public had worked, with respect to a systematic messaging process, with single daily mass-media briefings and focused stakeholder calls. The editorial from *The Toronto Sun* on 8 June 2003 was complimentary: “From the outset, they held frank daily news conferences to keep people informed on the severity of the outbreak.” Some stakeholders in the health care system confirmed this, such as John Service, Director of the Canadian Psychological Association, who was quoted in *The Toronto Star* on 7 May 2003: “The key was the early decision by public health officials to provide reliable and regular information to the public. By establishing public trust, they prevented uncontrollable anxiety, fear and panic from sweeping the city.”

Further, it was felt that the objective of educating the public about the health risks of SARS had been achieved. The team felt supported with appropriate expert spokespersons and political fortification where appropriate.

The 2003 national phone survey of 1500 people conducted in April 2003 confirmed some of the assumptions. For example, close to four fifths of Ontarians responded that they had been exposed to “a lot” of information on SARS. The survey respondents believed that information was accurate with respect to the number of infected cases.

A full report on all aspects of management of the SARS crisis was published in 2004 (6).

Discussion

- Crisis communication strategies can vary for different audiences, such as the public, health care providers and stakeholders in the health care system. Communicators need direct communication channels to the target audience to be effective.
- This case study re-emphasized what had been discussed in previous case studies: there is no rule on who best communicates in a crisis, be it a spokesperson, a health executive, a politician or an expert. There will be crises when each of them may need to communicate, but it needs to be clear who communicates what and when. Up to the end of the Futures Forum, the participants were not certain about the design and structure of the crisis communication team.
- Disclosure of health risks is inevitable together with messaging that something is being done about it. Health risk communication to the public, or other audiences, should contain guidance to them about what they can do about it.
- The Ontario crisis on SARS demonstrated that crisis communication is a separate task from managing the crisis and from decision-making.
- During a crisis, many individuals work with total devotion to combat the crisis. However, failures in coordinating one-voice messages and clarifying responsibilities and roles in communicating in crisis will probably remain a key challenge in any future health crisis.

Case 5. Communicating health risks: experiences from the United Kingdom

“Capture, analyse and act on information.”

Concerns about health risks arise in the mass media in different ways. For example, they can emerge as an individual story that induces substantial human interest. They can also be published as clinical observations, or they can be noted in routine surveillance data. Pressure groups may push concerns through to the mass media. Occasionally concerns are based on Internet claims. Sometimes mass-media stories result from investigative journalism. They may also be the outcome of epidemiological or clinical research.

This section summarizes some observations on crisis communication in the United Kingdom. Experiences on communication related to health risks and crises are regarded from the perspective of public health, the mass media and individual consumers, and the general population as recipients of messages. Illustrations are drawn from three examples in the United Kingdom: MMR vaccination; BSE and variant Creutzfeldt-Jakob disease (vCJD); and high-profile failure of health services.

MMR vaccination

MMR is a three-part vaccine that immunizes children against measles, mumps and rubella.

In 1988, the MMR combination vaccine was introduced in the United Kingdom with a major mass-media campaign, curtailing the single measles, mumps and rubella vaccines. Health professionals and the general population were initially positive towards immunization, so that immunization coverage reached well over 90% in the early 1990s. Initially the vaccination was introduced at 20 months and the second dose at 3–5 years. This later was changed, with vaccinations given at 12–15 months and a follow-up booster injection just before starting school.

Controversy about the vaccination occurred in 1998, when the mass media reported on a possible causal relationship between MMR vaccination and autism as well as bowel disease. These reports were based on publications in medical journals on small case series that reported an association between MMR vaccination and autism. The mass media picked these up and fuelled the controversy with stories of individual cases of coincidence of the MMR vaccination and the onset of autism. In addition, criticisms emerged, claiming that the product licence and market approval of the MMR jab in 1988 had been premature. As a result of the increased mass-media attention, a vivid scientific and public debate emerged.

The government took a clear position that currently available scientific evidence does not support the hypothesis that MMR vaccination causes autism. This position has recently been supported by several population-based observational studies (7–9).

However, the research community is still not unanimous on this matter. Although the government took a clear stand, the mass media and the public trusted and believed the researchers who claimed a causal link between MMR vaccination and autism. This has changed the population's perception of the risk of vaccination, reflected in a decline of MMR immunization coverage to well below 90%.

The government was increasingly seen as denying choice and being intransigent. The concept of achieving herd immunity in a population group and statistical evidence that a causal link between MMR and autism exists proved to be less relevant in the public reaction than individual case histories.

Thus, to date reconciling general acceptance of MMR vaccination has not been possible, and many parents in the United Kingdom remain concerned about the effect of vaccinations on their child's health. This is the background against which the dialogue between a public health official and a concerned parent in *Box 5* illustrates difficulty in communication.

Box 5. Dialogue between a public health official and a concerned parent illustrating difficulty in communicating about the risks of adverse effects in MMR vaccination

Parent: My child has autism. He was developing perfectly normal until he had the MMR vaccine; then everything changed.

Response: Autism is a disease of childhood that occurs around the same time as the MMR jab. The fact that the two happen together does not mean that one causes the other. It is a coincidence.

Parent: Does anyone know what causes autism?

Response: No, not really.

Parent: Hasn't it been increasing since the 1980s when MMR started to be used?

Response: Yes, but the autism rise started before MMR came in. Numerous expert scientific committees have examined the link between MMR and autism, and no link has been shown.

Parent: Research has shown that autism is induced by MMR; so is bowel disease. I have read the papers on the Internet.

Response: This is poor-quality research that has not been replicated by other researchers. Again, I can assure you that this work has been looked at by a number of expert committees, and the researcher's claims have been rejected.

Parent: The research shows that single vaccines are safer than the combined triple MMR vaccine. Why won't the government give parents choice?

Response: If we did that it would mean six injections spread out. Children would be at risk between injections. Measles and the other diseases can cause serious illness, even death. There have been outbreaks in other countries when uptake levels have fallen. MMR is a very effective vaccine with an excellent safety profile. It has been used around the world for decades and proved its value in saving lives. There has been no serious safety concern in that time.

Parent: I still can't understand why parents who want the single vaccine can't have the right to have it. I'm going to France to get it.

This dialogue illustrates some misconceptions in communication. The responses to the parent's concerns do not rule out the concerns.

Health-literate consumers increasingly require a new language to define risks. The terms "safe" and "unsafe" are no longer sufficient. They neither reflect the risk-to-benefit relationship nor the specific health risk to which an individual may be exposed even if is considered to be low in a general population.

BSE and vCJD

The experience on the BSE crisis in the United Kingdom provided numerous lessons on crisis communication.

Health authorities were largely unsure about how openly it should be said that the situation was uncertain. They were also ill-prepared for journalists asking the typical questions such as "Who knew what when?" and "What did they do?". Like elsewhere, health authorities in the United Kingdom found it difficult to acknowledge that they had a serious problem. Hardly any official stood up in public and said: "We do not know.". Another observed failure was that, although more and more information was gathered, the information was not used for actionable decisions. Action instead became extremely distorted. In essence, there was no systematic framework for assessing the health risks posed by BSE and for acting accordingly.

Filling a void, the mass media became a primary disseminator of health information and interpreted the health risks due to BSE. They, too, have been criticized for adversely affecting consumer behaviour because they engendered fear about BSE. Headlines such as "BSE deaths up 300%" may have hyped up the public rather than informing them. Other criticism claimed that the press reported inaccuracies and misinterpretation, which heightened public fear and led to public scepticism regarding the government's competence.

But beyond detecting immediate operational dynamics and failures, the BSE crisis uncovered numerous system failures, such as organizational fragmentation, territorialism and rivalry, which hampered effective crisis communication.

Perhaps one of the most worrisome observations from the BSE crisis is that the health authorities failed to understand and predict the perception of the public, patients and the mass media of the health risks BSE posed. Developing communication strategies that take the perspective of the public is difficult, but a communication strategy must take account of the public interest. Sometimes this requires weighing options to strike a balance to meet the public interest, such as balancing full transparency with the need for security, and balancing providing the full story with the need for reassurance. Further, as a general rule, health authorities in crisis have to communicate empathetically and with respect for individual tragedies.

Health care errors

Individual tragedies also play a major role in story lines about health care errors.

In January 2001, a boy sought treatment for leukaemia at Queens Medical College. Leukaemia can be cured. But the boy died several days after admission.

Leukaemia can be cured; how could this tragedy happen?

The death was caused by a catastrophic mistake: the administration into the spine of a chemotherapeutic medication (vincristine) made for intravenous injection. History saw itself repeated: since 1985 at least 23 cases have occurred of people – usually children – being killed or paralysed in similar circumstances from the incorrect administration of drugs by spinal injection. A factor that may have contributed to the mistake is that the design of the pre-filled syringes for intravenous injection resembles the design of those intended for the spine.

An investigation was initiated, simulating every step from hospital admission of the boy up to his death. The investigation detected a comprehensive health service failure with about 40 errors leading to the fatal chain. The 40 errors can be classified into a number of problems of system and process design: a weak safety culture; inadequate operational practices; a lack of explicit protocols; training; communication failures; and poor technical design of medical equipment and packaging.

The mass media attention was great, focusing on the human tragedy of a young boy who was a victim of a health care error. Headlines such as “Cancer boy dies after blunder over injection”; “Teenage patient dies after doctors’ injection mistake”; and “Teenager given wrong drug dies” illustrate the mass media’s interest in developing a story line, presenting the human side of an incident and perpetuating conflict.

Nevertheless, the implications of the incident stretch beyond an individual tragedy. The case illustrates that health care errors, like population health risks, can be the initial indications of a weak health system.

Some of the system failures refer to traditional cultures among health professionals. For example, loyalty between colleagues can act against the interest of patients. In addition, health professionals have acquired cultures of secrecy when making mistakes. This has been possible because few good data allow quality to be systematically monitored. Further, health professionals have generally not yet improved their understanding of the relevance of the systems and processes safeguarding high quality of care.

Good and ethical health risk communication requires a set of principles: high-quality assessment of science, a full evaluation of risks and benefits, a consistent approach to health risk assessment across different risk areas, a clear framework for interventions, integrity, a realistic sharing of uncertainty and greater participation of the public in health risk deliberations.

Conclusions

The following main conclusions have been drawn from these three examples.

- The emergence of health risks and the failure of public services often take place in a climate of mistrust, suspicion, blame and retribution.
- The public understanding and perception of risk are very different to health professional perspectives, and communication strategies need to take account of these differences.
- Organizational culture is vital to recognizing and dealing properly with health risks.
- A clear framework is needed for risk assessment and decisions on risk control.
- Good and appropriate communication is an essential tool of public health decision-making.

The following section includes views and conclusions of participants of the Futures Forum, questions that remained unanswered and recommendations by WHO.



4. Conclusions

4.1 Views and conclusions of participants

In many countries in which consumers are becoming increasingly health literate, communication is a feature of a health crisis. It can be both means and end to a crisis. In general, participants of the Futures Forum broadly agreed that effective risk communication has become a key responsibility of public health professionals, with several goals, according to the state of the crisis: to inform, to persuade and to motivate. Participants agreed that crisis communication is sensitive to context and situation and that crisis communication has to take into account various legitimate stakeholders such as health journalists and health executives, who all have to do their diverse jobs. Thus, there are no “one size fits all” recommendations. The conclusions from this Futures Forum were agreed to be a wide set of principles and measures for decision-makers to consider when crises arise.

For the situation during a crisis, participants agreed that health executives are advised:

- to be proactive and start public communication as early as possible at the outset of a crisis, as information has a calming effect by itself, even if it is about health risks;
- to be available for the press and to communicate regularly in a crisis, but to avoid over-communicating – in general, daily press conferences are required only in the peaks of a crisis;
- not to compromise in ensuring the competence in communication and public health of the person charged with communicating to the press – regardless of whether that person is a spokesperson, the person in charge of managing a crisis or his or her subordinate;
- to combine information about health risks with advice for the public on how they can react to threats themselves;
- to communicate simply, accurately, transparently, without being patronizing and in due time before action is taken;
- to be honest and to avoid keeping health information secret but also to allow for reassurance of the public;
- to be clear about what one knows and what one does not know (yet);
- to not feel inferior to the press when admitting that evidence is lacking;
- to ensure consistency in the messages communicated to the press by the health authority (targeting a single-voice effect);
- to get the numbers right for accurate presentation and concrete action;
- to show respect for and empathy with public anxiety and to communicate accordingly;

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- to try to understand the public's interests and what the mass media are looking for in a story and to foster synergism accordingly;
- to organize structured contacts with the press;
- to consider holding joint press conferences with other relevant public and private authorities;
- to decide on the design and structure of communication teams in crisis and to pay attention to the capacity of the team over the time frame of the crisis, including fatigue and exhaustion; and
- to maintain close contacts between the teams managing the crisis and the communication team.

Between crises, participants advised health executives:

- to ensure that communication does not stop, as it can be useful to acquaint the public with the concept of health threats in general and not only as a component of health crises;
- to take communication seriously as an essential part of the response to a health crisis and thus as part of emergency preparedness planning;
- to develop communication infrastructure (such as press materials and plans) and well-trained public health professionals;
- to include communication in all public health programmes, especially in preparing responses to health threats;
- to ensure that training in communication is an integral part of any public health training;
- to prepare strategic communication plans that distinguish between the different scenarios of alert, alarm, crisis, emergency and disaster;
- to talk regularly to the press to get them used to communicating with individual health executives and not just when there is a crisis; and
- to be prepared for the worst – maintain regular health risk communication.

4.2 Open questions

Nevertheless, the Futures Forum also concluded with a number of open questions, including the following.

- How can public needs and expectations be better met when communicating health risks and communicating in crisis?
- How can the nature and quality of the relationship with journalists and the mass media be improved? What practical action can be taken to improve these relationships?
- What is a good team – structure and design – in handling a crisis and in communicating in crisis?
- How can rapidly emerging crises be detected? How can networks be improved to inform colleagues, nationally and internationally?
- How can public confidence in health authorities be improved?
- How can work on risk communication and the identification of good communication tools be better coordinated between agencies and governments across Europe?
- What are the most important data for surveillance and monitoring in detecting health risks and crises?

4.3 The Seventh Futures Forum

Policy-makers need to use crisis communication as a tool to achieve the best possible health outcome, deriving from a situation of certain or uncertain health risk. The objective of achieving better health outcome optimally drives good crisis communication strategies.

The Seventh Futures Forum will be held on 11–12 November 2004 in Malta. The Futures Forum will continue the theme on tools for decision-making in public health. The next Futures Forum will focus on unpopular decisions in public health.



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ISBN 92 890 1067 3