

CRICORM - "PROJECT ON CRISIS COMMUNICATION IN THE AREA OF RISK MANAGEMENT": ANALYSIS OF COMMUNICATION PROCESSES (Carmelo Scarcella, ASL Brescia)

2014, Number 2

One of the main activities of the European "Project on crisis communication in the area of risk management" (CriCoRM) was the analysis of communication strategies and processes that are performed during crisis situations (e.g. H1N1 pandemic flu).

For the analysis of the communication strategies and processes:

- a literature research was conducted using literature databases (e.g., Communication and Mass Media Complete), libraries, and institutional websites (e.g., EU, Robert-Koch-Institut). Thus, 135 documents on theoretical background of and existing guidelines on crisis communication were identified, 66 reports on communication during health crises and evaluations as well as 152 empirical studies. The identified documents are listed in an Endnote-literature database, and abstracts were written for the most relevant papers.
- 4 qualitative interviews were conducted with communication and health experts. The interview partners belonged to German health institutions and medical associations, specifically the press department from the Robert Koch Institute, the Federal Centre for Health Education, Hartmannbund (physician association) and the Federal Ministry of Health.
- A quantitative standardized questionnaire was prepared based on the qualitative interviews, scientific studies, theoretical framework and feedback from project partners. The survey was distributed via email among all of the 1406 identified key stakeholders, including health authorities, health professional organizations, patient organizations, and the media, both on EU level and on national and regional levels of the ten selected EU countries (Spain, Italy, Portugal, France, Germany, Belgium, Sweden, Czech Republic, Romania, U.K.). The questionnaire contained 29 questions on crisis management, information sources, cooperation with other stakeholders, factors for effective crisis communication, problems during the H1N1 pandemic, coordination by the EU, and formal aspects on personal/organizational attributes.
- A quantitative content analysis was conducted for the 10 selected EU countries (Spain, Italy, Portugal, France, Germany, Belgium, Sweden, Czech Republic, Romania, U.K.). For the content analysis a standardized codebook was developed applicable for to all three data sources, namely newspaper coverage, press releases and discussion threads. The codebook defined the specific categories to be coded and provided guidelines in order to standardize the coding process among all involved

Summary

CriCoRM - "Project on crisis communication in the area of risk management": analysis of communication processes	01
Ebola virus disease	02
Risk communication in the field of health. Ebola as a case in point.	04



coders. The coding was implemented on two different coding levels.

The results of the above-mentioned activities have allowed to point out some important aspects.

1) Regarding the different use of the media, in particular the social media during the health emergency, it is came to light:

- different peaks in communication of press releases and media;
- high rate of articles and press releases lacking background information (mostly dissemination);
- main topics in forums differ from coverage (general health aspects and medical measures);
- amplification of risks in press coverage as compared to press releases (more conflict, more dramatization, more risk related frames).

2) Regarding the individual behaviours, in particular for the vaccination:

- remarkable differences between country groups (vaccination and mortality rate). There is a coincidence of articles with more detailed information, combined use of fear appeals and self-efficacy, alarming and reassuring articles in countries with lower mortality and higher vaccination rate;
- sceptic view on vaccination is in line with the vaccination hesitancy;
- uncertainty plays an important role in online discussions.

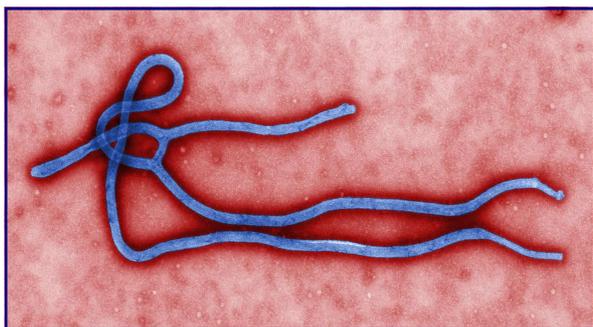
Furthermore, the results:

- underline existing guidelines for crisis communication and persuasion need for improvement in meeting the needs both the media and the public;
- forums can also serve as a communication channel spreading information people are in need of further via interpersonal communication;
- on-time monitoring of forum discussions during health crises can provide insight into public reactions and needs. Online discussions forums provide great opportunities to monitor public needs and sorrows and get into direct contact with the public.



EBOLA VIRUS DISEASE (Francesco Castelli, Lina Rachele Tomasoni and Maria Chiara Pezzoli , University of Brescia and Spedali Civili of Brescia)

Ebola virus, belonging to the Filoviridae family, has first been identified in 1976 in the Democratic Republic of the Congo (former Zaire) during an epidemic of haemorrhagic fever in the river Ebola



Valley . The virus, of which we know 5 different serotypes (Zaire, Sudan, Reston, Bundibugyo, Tai Forest) has been implicated on slightly more than 20 self-limiting epidemics with high case-fatality rates but limited to tens of hundreds of subjects living in rural areas in Central Africa (Democratic Republic of the Congo, Sudan, Uganda, Gabon).

The epidemiologic characteristics of the Ebola epidemic that started on December 2013 in West Africa are completely different. At 17th December 2014 the



epidemic, that has been officially notified to the World Health Organization only on March 2014, has interested over 18.000 cases and caused over 7.000 deaths

(apps.who.int/iris/bitstream/10665/145679/1/roadmapsitrepre_17Dec2014_eng.pdf?ua=1), even if these number are probably underestimated by 70-250% according to some authors.

The infection, whose natural reservoir is probably to include some specific species of bats (fruit bats), spreads by contact of contaminated fluids (blood but also vomitus, stools, urine, sweat, genital fluids, saliva) of mucosae or broken skin of forest primates and, accidentally, humans. The spreading of the epidemic in West Africa, a geographical area that had never experienced Ebola before, has been facilitated by the high density of the population in Guine (Conack), Sierra Leone and Liberia and by the complex traditional burial rituals that have inadvertently contributed to the spread of the disease.

The fragile health systems of the Countries involved, two of which had experience a bloody civil war in recent years, had been unable to cope quickly with the epidemic and have rapidly been overwhelmed. Over 600 local health workers have been infected and half of them have died in areas where the ratio physicians/population is between 1:10.000 and 1:100.000. Even the intervention of the UN Mission for Ebola Emergency Response (UNMEER), may only offer a hospital bed to 30-50% of the notified cases.



Among hospitalized cases in West African hospitals the case –fatality rate is high, exceeding 60%. On the contrary the case-fatality rate among those infected persons, mainly workers of humanitarian organizations, who were evacuated to North American or European hospitals was much lower - about 25% - suggesting the importance of aggressive supportive therapy.

In fact, in the absence of effective specific antiviral treatment (among experimental antivirals are Favipiravi, TKM-Ebola, Brincidofovir, BCX-4430, and immune therapy has also been advocated by using convalescent plasma/blood or monoclonal antibodies Z-Mapp), aggressive supportive treatment and blood transfusion are essential to maintain hydration coupled with antibiotic treatment (<http://www.cdc.gov/vhf/ebola/treatment/index.html>; Petersen E, Maiga B. Guidelines for treatment of patient with Ebola Virus Diseases are urgently needed. International Journal of Infectious Diseases 2015, 30: e85-86).

Outside the affected area, imported cases have been reported in Spain (1), USA (1 traveller, 1 health worker), but also in bordering Countries such as Nigeria, Senegal, Mali. In these Countries, isolation of patients and contact tracing and monitoring have been effective to contain the spreading of the infection among the population.

Although the media coverage of the epidemic has sharply decreased after the possibility of spreading in western countries with advanced health system proved extremely unlikely, it is clear that only an intensive international effort could be able to win the epidemic and limit the huge damage, both human lives and economic distress, for western Africa.



RISK COMMUNICATION IN THE FIELD OF HEALTH. EBOLA AS A CASE IN POINT.

(Claudia Zanini and Sara Rubinelli, Swiss Paraplegic Research and University of Lucerne)

Risk communication: aims and principles

Risk communication aims to fill the gap between public knowledge and scientific assessment of risk. It does it by translating scientific findings and probabilistic risk assessment into understandable terms, by helping people interpret risk numbers and put the risks affecting them into a broad framework, and by building credibility and trust.

The US Centers for Disease Control and Prevention (CDC) have three main principles of good risk communication, namely:

- **Be first:** Provide the information as soon as possible. People fill the information vacuum with information reported in the media, offered by interest groups, or based on public fears and concerns.
- **Be right:** Tell people what you know and what you don't know. Do not hide information with the aim of "protecting" people or avoid panicking. Panic seldom occurs and, as explained above, information vacuum can be problematic.
- **Be credible:** Do not over reassure and acknowledge uncertainty. The main benefits of anticipatory guidance, as conceptualized by Sandman and Lanard (2004), are that people are not taken unawares, can prepare themselves and, consequently, can better deal with the situation when it comes. This approach is especially of value when bad news are likely to come, and when there is a new threat where uncertainty and mistakes can occur.

Ebola as a case in point

The most recent example of health threat is the Ebola virus. Suddenly Ebola entered the everyday news

with alarming tones and with images of suffering or dead people, and health professionals in protective suits wearing masks. In the media it was often presented as a life threatening condition that spreads quickly and for which no treatment is available. *How did US officials communicate on the topic? We report here two examples of optimal practices and two examples of suboptimal practices, as analysed by Sandman and Lanard (<http://www.psandman.com/col/Ebola-2.htm>).*

In the first example of optimal practices, the CDC Director acknowledged that sooner or later there would have been Ebola cases in the US:

"We know that there are travellers from places where there is Ebola, we know it's possible that someone will come in, if they go to a hospital and that hospital doesn't recognize it's Ebola there could be additional cases where their family members could have cases. That's all possible. But I don't think it's in the cards that we would have widespread Ebola in this country"

(Tom Frieden, CDC Director, August 3, CBS program "Face the Nation").

Frieden anticipated bad news, did not ignore or overlook people's fears, and was transparent about possible developments of the Ebola outbreak in the US. The day this happened, Americans were less shocked, because it was somehow expected. On the contrary, if Frieden would have over-reassured and stated that Ebola in the US was unlikely to happen, he would have risked losing credibility and people's trust. Losing people's trust is dangerous for crisis management, because *«the less people trust those who are supposed to protect them, the more afraid the public will be and less likely they will be to conform their choices and behaviour*



with outbreak management instructions» (WHO Outbreak Communication Guidelines).

The second example of optimal practice is related to the first case of Ebola in the US, the Duncan case:

“While it is not impossible that there could be additional cases associated with this patient in the coming weeks, I have no doubt that we will contain this”

(Tom Frieden, CDC Director, September 30, press statement on the day of the announcement of the first case of Ebola in the US)

Here, Frieden showed his confidence in the American health system procedures and in its ability to avoid the spread of the virus. Despite reassuring the population on this point, the CDC Director acknowledged that the risk of additional cases in relation to this first case was real.

Concerning the examples of suboptimal practices, the first example is a Frieden statement during a news conference, namely:

“The disease is not contagious during the incubation period, and patients do not transmit it until they develop symptoms. And those with symptoms will probably feel sick enough to stay home. People are highly unlikely to catch the disease on the bus or subway”

(October 2, reported in the New York Times)

The CDC Director was overly reassuring and overly simplifying a complex issue. If it might be true that asymptomatic patients are not contagious, it would have been fair to admit that the line between asymptomatic and symptomatic is not so neat. Moreover, the symptoms are not always clear from the



beginning and people might not stay home and potentially spread the virus.

The second case of suboptimal risk communication is a news release from the hospital in Dallas in relation to the Duncan case. When Mr. Duncan arrived at the hospital, the symptoms of Ebola were not recognized and the patient was sent home. Being sent home, Mr. Duncan put at risk of infection all the people who got in contact with. Despite this situation, no acknowledgment of mistakes and no apologies appeared in the media release:

“We would like to clarify a point made in the statement released earlier in the week. As a standard part of the nursing process, the patient’s travel history was documented and available to the full care team in the electronic health record (EHR), including within the physician’s workflow. There was no flaw in the EHR in the way the physician and nursing portions interacted related to this event”

(Texas Health Dallas Presbyterian Hospital, October 2, news release)

Acknowledging errors and apologize to people is crucial in crisis communication, because it ensures some credibility and some people’s trust.

As the journalist James Thurber once said: *“Precision of communication is important, more important than ever, in our era of hair trigger balances, when a false or misunderstood word may*

create as much disaster as a sudden thoughtless act”. In the context of risk communication, this claim can be read as an appeal to health organizations to take care about the information they deliver in presence of a health threat for the public.



Newsletter

Publication on line registered to the Court of Brescia, number 35/2009 of the 30/06/2009

Editor in chief

Dr. Carmelo Scarcella

Editorial Board

Prof. Umberto Solimene	- University of Milano
Prof. Peter J. Schulz	- University of Italian Switzerland, Lugano
Prof. Francesco Castelli	- University of Brescia
Prof. Pietro Baroni	- University of Brescia
Prof. Umberto Gelatti	- University of Brescia
Prof.ssa Sara Rubinelli	- University of Lucerne

www.publichealthcrisis.eu