

ASEM Partners' Guide for Risk Communications for Public Health Emergencies

How Can We Include Migrants and Ethnic Minorities – No One Left Behind –

Risk Communication, Public Health Emergencies & Including Migrants and Ethnic Minorities

Inclusion is at the core of the United Nation's 2030 Agenda for Sustainable Development. It is reflected in the pledge made by World leaders in 2016, to "*leave no one behind*", and in the Agenda's vision of a "*just, equitable, tolerant, open and socially inclusive world in which the needs of the most vulnerable are met*" (paragraph 8).

Migrants and ethnic minorities can be among the most vulnerable groups in our societies. They are sometimes described by health officials as the "*hard-to-reach group*" because our health information and prevention measures often do not reach them. However, a better way to think of them is that they are "*under-served communities*". It is up to the health system to find out how to reach and engage with these communities. If we do not, then we fail in our duty to "*leave no one behind*".

On 10-11 October 2018, senior health officials and communicators from across Asia and Europe met in Paris to discuss this challenge. This is the report of their discussions.

Contents	05
Introduction	03
Keynote Speeches	06
<i>Engaging with Communities and Communicating Health Risks in a Diverse Social-Cultural Context</i>	07
Ms Aphaluck BHATIASEVI / World Health Organization (WHO)	
<i>Communicating to, and about Refugees and Migrants, the Myths, the Barriers and the Skills</i>	10
Ms Cristiana SALVI / World Health Organization (WHO) Regional Office for Europe	
Discussion	15
Section I: What is the Reality of Risk Communications When It Comes to Including Migrants, Ethnic Minorities and Temporary Residents?	16
<i>Communicating to such a Diverse Group</i>	17
Dr Dominik ZENNER / International Organization for Migration (IOM)	
<i>Working with Different Kinds of Migrants</i>	18
Mr Demos KROUSKOS / Centre for Culture, Ethnicity and Health, Australia	
<i>Experiences as advisor to France's Minister of Health during the 2014 -2015 Ebola Epidemic in the West African Countries of Guinea, Sierra Leone and Liberia</i>	20
Ms Mayada BOULOS / Former Counsellor to the French Health Minister during the 2014-2015 Ebola Crisis	
Questions & Answers	22
Section II: Including Migrants & Ethnic Minorities into Risk Communication	23
<i>Different Approaches in Risk Communication to Overcome the Language Barrier in Thailand</i>	24
Dr Pahurat K. TAISUWAN / Ministry of Public Health, Thailand	
<i>The Barriers that Public Health England Experienced when Trying to Communicate to Migrants</i>	25
Ms Laura WOODWARD / Public Health England (PHE)	
<i>Dealing with Rumours</i>	26
Mr Gary LOW / Ministry of Communication and Information (MCI), Singapore	
<i>Health Literacy and Producing Accessible Information for Different Groups</i>	27
Ms Cécile ALLAIRE / Santé publique France	
<i>How Communication Tools are Developed in France</i>	29
Ms Sandrine RANDRIAMAMPINANINA / Santé publique France	
Questions & Answers	30
Section III: Risk Communication in Action - Emergency Simulation Exercises – Part 1	31
Risk Communication in Action - Emergency Simulation Exercises – Part 2	40
Summary & Recommendations	50
Special Session: The Ethics of Emergency Risk Communication	54
Annex I: Programme	58
Annex II: List of Participants	60
Comments from Santé publique France	63

Keynote Speeches



Ms Aphaluck BHATIASEVI / World Health Organization (WHO)

Engaging with Communities and Communicating Health Risks in a Diverse Social-Cultural Context

Lessons learned from the 2014-2015 Ebola Outbreak in West Africa:

Effective risk communication is an essential component of emergency response. Risk communication is a relatively new area for WHO. It is therefore developing its approach with partners – particularly those such as UNICEF and the Red Cross that work extensively on emergencies.

WHO'S WORK RELATED TO RISK COMMUNICATIONS

The Health Emergencies Programme

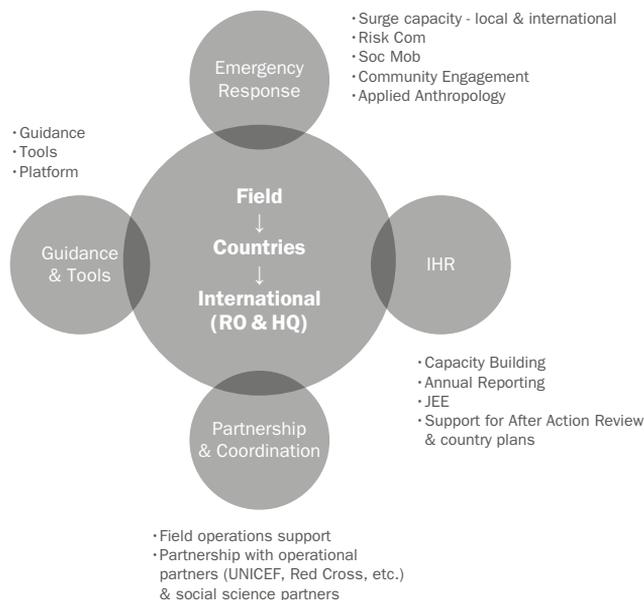
The health emergencies programme works at global level (from WHO's headquarters in Geneva) at the continental or regional level from Regional Offices such as WHO Europe or WHO Africa, and at the national level where emergencies happen. Risk Communication is embedded in the Infectious Hazard Management division of the emergencies programme at WHO headquarters.

The work of the Social Science Intervention and Risk Communication (SSI & RC) team is broadly divided into four clusters, illustrated in the diagramme on the next page.

Diagram 1 >>

What are we doing in SSI & RC for Health Emergencies

Diagram 1



OpenWHO

openwho.org

OpenWHO is an online platform where health workers around the world, and indeed everyone else, can access free online training courses. There is a whole set of courses on emergency risk communication on this platform. There are also courses on many of the technical aspects of pandemic preparedness, and surveillance, prevention and control of a range of diseases.

When a major outbreak happens, WHO Health Emergencies Programme (WHE) can rapidly produce and disseminate training courses for frontline responders via this platform. These are produced in the local languages of the country experiencing the outbreak as well as languages used by international responders supporting the response.

International Health Regulation (IHR)

Under the IHR, member states are obliged to report every year on the state of their Core Capacities to detect and respond to health threats. One of these Core Capacities is risk communication. Over the last few years, there have been a Joint External Evaluations (JEEs), a process of member states having peer-reviews of their Core Capacities by international teams of experts. WHO has provided technical support and experts to these JEEs in a range of areas, including risk communication and community engagement. JEEs identify some gaps, or areas that need strengthening in member states Core Capacities. Very often, risk communication is one of the areas where there are gaps or things that need strengthened. Countries follow up on JEEs by developing National Action Plans to strengthen their Core Capacities. Again, WHO offers technical support to countries in implementing the improvements in these Plans, including in the area of risk communication.

Migrants, minorities and internally displaced populations

It is noted that there is an inaccurate association of migrants or minorities group with infectious diseases. This frame of mind must be changed. The international institutions and national governments at a meeting such as this have a most powerful voice and should use it to reframe the debate.

An example – Vaccine against Diphtheria in Cox’s Bazar, Bangladesh (2017)

“tried to raise the voice of the people in migrant communities”

Through conducting a quick study (using social science methods), it was discovered that parents were afraid to take their children to receive the vaccine, as well as a number of other barriers to vaccination:

- > Vaccination sites were moving every day, causing confusion
- > The vaccination teams did not speak the language or know the culture of the people in the camps.

How do we communicate in the language that we would expect to be communicated in?

It was mentioned how, working through volunteers/community influencers in and amongst the people at the Cox’s Bazaar camp, the response team recorded people from the migrant community speaking about the vaccination campaign. They spoke about the benefit and importance of vaccinating children for Diphtheria, and also when and where the vaccination teams would be. Using these techniques, the response team was able to turn the situation around and achieve a high level of vaccine coverage in the second round of the vaccination campaign. This then stopped the outbreak.

An example – Ebola outbreak in Equateur Province, Democratic Republic of Congo (2018)

Community engagement can be vital during an emergency. In Equateur Province there was tension between two ethnic groups, the Twa people (also known as Pygmies) and the economically and socially dominant Bantu people, and Ebola was affecting everybody. WHO worked to reduce the tension by having people from the two communities come and work together to support the response. They recruited from both groups when building up surveillance and logistics functions, as well as in community mobilisation teams.



Some of the little things we change can make a lot of difference

We tried to be inclusive and look beyond the emergency response, and it also supported the public health work with we are doing

This is just the beginning and your voice is the largest and the strongest. We need to work with you more. This is an opportunity. We cannot afford to lose any more time. We learnt a very bitter lesson from Ebola in 2014. We must go beyond what has been expected in the past



Ms Cristiana SALVI / World Health Organization (WHO), Regional Office for Europe

Communicating to, and about Refugees and Migrants, the Myths, the Barriers and the Skills

Debunking the myths around migrants

In the past few years, WHO Europe has established a migration and health programme to look at the public health aspects of mass migration into the European Region. Since 2011, with the large-scale migration caused by conflict in Syria, migration has been high on the political agenda in Europe. WHO focuses on the health aspect, but it can sometimes be difficult to untangle health from the political aspects. This is especially the case when it comes to risk communication.

The myth that migrants spread infectious diseases

It is noted that host communities often perceive migrants as potential infectious disease risks. In terms of understanding this perception, we must analyse the host community as well as the host government when we try to address this misconception.

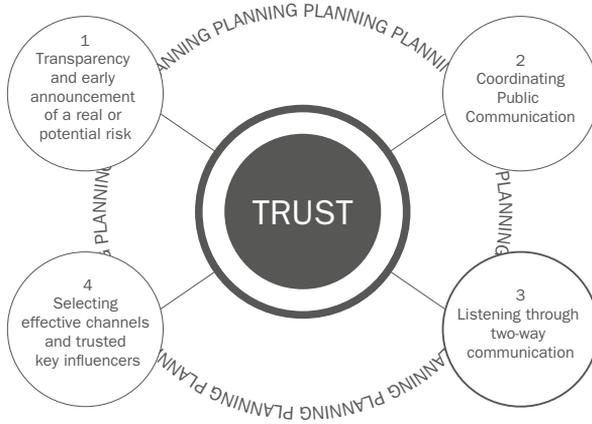
Understanding community perception:

WHO Europe uses targeted media, social media and blog monitoring to gain insights into risk perceptions in specific countries or communities. However, it is possible to gain a deeper insight by using formative research techniques such as:

- > Intercept interview
- > Focus groups
- > Social science surveys to measure Knowledge, Attitudes, Beliefs, Behaviours, Perceptions and Practices (sometimes referred to as KAP surveys)

4 capacities needed for effective emergency risk communication (WHO EURO)

Diagram 2



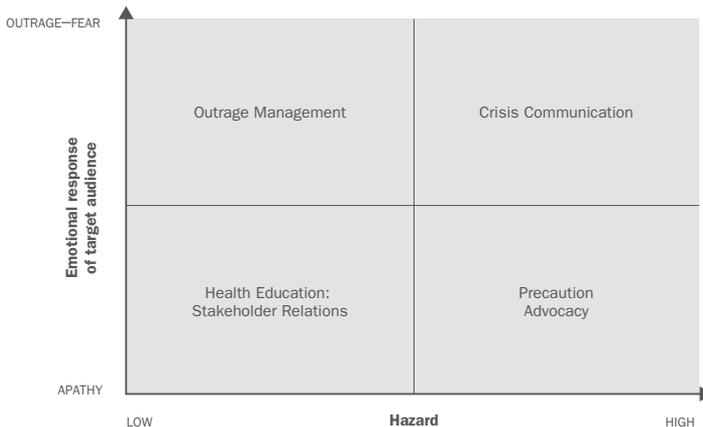
These 4 capacities help build trust in the target audience. A focus on capacities 3 and 4 (Listening to the target audience and selecting effective channels / intermediaries to reach it) highlighted the importance of understanding the audience’s perception of the risk it faces.

For example, the audience may be very fearful and outraged about something that poses no more than a low-level risk. Conversely, the audience may be unaware or apathetic about something that poses a high-level of risk to them. The aim of risk communicators is to get the audience’s level of fear / outrage aligned with the level of risk they face. The audience can then take appropriate and proportionate measures to protect themselves.

Very often, there is a mismatch between the audience’s perception of (and reaction to) a risk and the objective reality of that risk.

Perception is a Reality in Risk Communication

Diagram 3



Examples of risk perception analysis

Ebola epidemic in Guinea, West Africa in 2014 when the epidemic started: The affected communities in Guinea did not have a good understanding of the risk they faced. There had never been an Ebola outbreak in Guinea before then. Even though the level of hazard was high, people in these communities perceived the risk as being low. Using the matrix, it is easy to see that the risk communication strategy needed to be one of **precaution advocacy**. The response team needed to raise the level concern in the affected communities so as to motivate people to protect themselves.

Europe in 2014: The perceived risk of Ebola in Europe was very high with an increased level of panic among people. Yet the level of risk to people in Europe from the outbreak was very low. The appropriate risk communication strategy in Europe on Ebola in 2014 was therefore one of **outrage management**.

At the peak of the Ebola emergency in Guinea 2015: The risk from Ebola was high and people in Guinea perceived it to be high. The risk communication strategy was therefore one of **crisis communication**.

“ ”

When we talk about communication strategy, we should not only consider the hazard. If you don't combine the risk and the perception of the risk, you can forget about effective communication

Applying the risk perception matrix (Diagram 3), to **migration and infectious disease**, the hazard to people in the host community is low. However, many host communities perceive a high risk to them. Therefore, the appropriate risk communication strategy is **outrage management**. The key to doing this effectively is to **appreciate the concerns and respond with the facts**.

List of frequently asked questions relating to migration and health

CONCERN	Refugee and migrants import infectious diseases
FACT	In spite of the common perception there is no systematic association with infectious diseases.*
CONCERN	Refugees and migrants bring Tuberculosis (TB) to Europe
FACT	TB is primarily related to poverty. What we have seen from many countries is that very often migrants or refugees get sick a few years after they arrive at host countries if they have poor living conditions. Europe has one of the highest rates of Multi-drug resistant TB in Eastern Europe and Central Asia, independently of migration.
CONCERN	Screening refugee and migrants keeps infectious disease away
FACT	WHO does not recommend obligatory screening of refugee and migrants because it is not cost-effective. It also creates dilemmas about treatment (when, where, who pays) if the screening identifies a disease. Instead, WHO recommends is that health checks are offered to migrants, covering both infectious diseases and non-communicable diseases, and eventually access to healthcare. The results of the screening must never be used as a justification to deport a migrant or refuse an application for asylum.

* concerns (and appropriate responses) may vary from country to country

Box 1: How to overcome difficulties

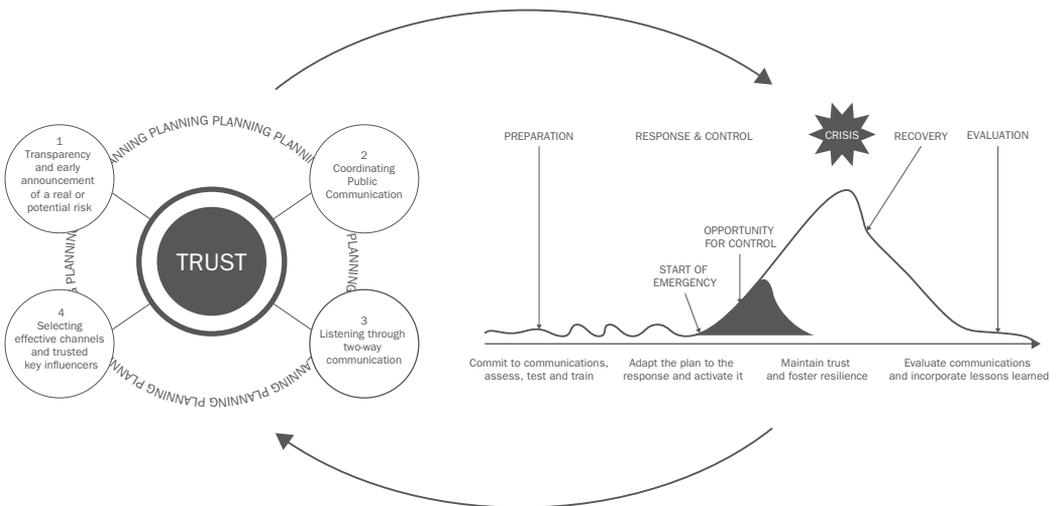
An example – Turkey – Turkey has the largest population of migrants in WHO’s European Region, and indeed globally, hosting some 4 million people who have fled the civil war in Syria. WHO Europe is working with the Government of Turkey on a flagship programme on best practice in migrant health. This involves training Syrian healthcare workers and integrating them into the Turkish healthcare system. In this way, they can care for the Syrian refugees and migrants in Turkey using appropriate language and culture. Currently, this programme has trained 1800

Syrian doctors and nurses, along with interpreters who serve as patient guides.

Identifying the right channels and the right influencers: Use the community, and the people in it who are trusted by our audiences. Healthcare workers are some of the most important influencers when communicating with the public. This is because they are widely trusted and they are on the frontline of the health system - their job brings them into regular contact with people that need healthcare or who are concerned about their health.

Building the skills

Diagram 4



How to build the skills needed for effective risk communication: WHO Europe’s approach is to link the 4 key capacities that feed trust to the life cycle of an emergency

(see Diagram 4 above). WHO Europe is looking at each of the capacities in each of the phases of the emergency (preparedness, crisis control, recovery and evaluation).

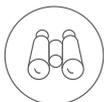
Emergency Risk Communication: 5-Steps for Capacity Building

An iterative process to develop, test and adopt national health ERC plans and to integrate them into new or existing national action plans for emergency preparedness and response under the IHR.



1. TRAINING

ERC training sessions are tailored to meet needs and gaps identified in national ERC plans and documents. Through a mix of lectures, skill drills and media tips, participants learn and practice effective communication in public health emergencies. The training is designed for epidemiologists, experts in pandemic preparedness and vaccinations and emergency response and communications specialists.



2. CAPACITY MAPPING

The ERC capacity-mapping tool is used to identify needs and gaps in order to strengthen national ERC. The aim is to review priorities for intervention that will be included in the ERC plan and in a national ERC capacity building roadmap.



3. PLAN WRITING

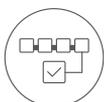
The plan template supports and facilitates the development of a tailored national multi-hazard ERC plan. The Regional Office also assists countries in adapting and integrating the ERC plan into their national preparedness and emergency response plans, according to their governance structure.



4. PLAN TESTING

The WHO Regional Office for Europe provides support for testing the ERC plan in multisectoral simulation and table-top exercises in:

- health emergencies: disease outbreaks (including pandemic influenza), natural disaster and humanitarian and environmental crisis;
- ERC principles: early, transparent communication, communication coordination, listening and community engagement effective channels and key influencers.



5. PLAN ADOPTION

On the basis of the results of the simulation exercise, the Regional Office makes recommendations for updating the national ERC plan and facilitates its integration into national preparedness and response plans. As part of the process, the Regional Office supports the development and implementation of a capacity-building roadmap based on identified priorities. The roadmap can include ERC training and workshop for different audiences and integration of ERC into technical capacity-building activities and field simulation exercises.

This is a new, innovative way in which WHO Europe is supporting capacity building in its region. As of October 2018, approximately 15 countries are involved in the programme and the programme has been endorsed by all 53 countries of the WHO European region.

Countries can enter the programme at any of the different Steps, depending on their needs. This programme brings together public health specialists and risk communication specialists to build the countries' emergency risk communication capacity. Its goal is to help countries progress towards the writing, testing and formal adoption of a risk communication plan.

1. How can we get government buy-in for risk communication strategies?

The examples discussed include the social and political context of the Ebola outbreak in North Kivu. The situation there is complex, politicised and sensitive. WHO needs to reach out to many different political groups with influence in the affected communities. Once done successfully, the politicians go on local radio stations and communicate agreed messages on Ebola. Another way of engaging politicians is to work with youth groups, as politicians pay attention to these groups. Youth groups can be more easily motivated as they are enthusiastic about working to help their community.

It was noted that there are two aspects to every emergency: the tragedy and the opportunity. The opportunity comes from the fact that during an emergency, governments are much more receptive to taking action to improve their emergency response capacity. This can be a good time to get political buy-in to risk communication strategies and investments.

Other means to get political buy-in mentioned in this discussion were:

- > Highlighting the **cost of inaction**.
- > Highlighting countries' obligation under the **IHR** to develop and maintain Core Capacities for detecting and responding to health emergencies. These IHR Core Capacities include risk communication.

2. How can governments engage communities to work with them during an emergency?

Motivating communities can be a challenge. For example, in rural Guinea in the 2014–2015 Ebola outbreak, community elders were engaged by WHO as they were considered the wise people of the community. Their motivation for working with the response team was to help their own people, and they were respected and listened to. However, when the outbreak moved into the cities, the intermediaries there asked for money.

However, as soon as communities in the cities knew that WHO was paying the intermediaries, they stopped trusting the intermediaries.

Every kind of work with communities requires an investment. However, sometimes providing resources to enable intermediaries to work, for example phone credit or money for transport, is more appropriate (and more effective) than paying a wage. Very simple acts such as providing food at a meeting or giving T-shirts to volunteers, can go a long way in motivating people. As it makes them feel appreciated and part of a group. All these approaches are worth considering, but not all will work in every situation. The approach always needs to be tailored to the context and values of the community you are trying to motivate. As always: know your community.

3. How can we strike a balance between the urgent need to act during an emergency and getting an in-depth knowledge of the culture and context of the community before you communicate?

One expert who has been involved in many emergencies expressed the view that it is not very difficult or time consuming to get the level of understanding you need. There will usually be sufficient information you can access via the Internet: news reports, social media postings, websites of civil society organisations and community groups, government statistics and reports, academic papers, paper and reports from think tanks, and so on there is a surprising amount of relevant information available when you look for it. Another way to get the understanding you need is to talk to people from the community.

It was expressed that the starting point for all risk communication interventions should be understanding the risk perception of your target audiences. This should form a baseline against which you measure progress. The formative research methods outlined during the keynote session (intercept interview; focus groups; social science (KAP) surveys) can be extremely useful. They, can mostly be done very quickly. It is advised that all messages created must be tested to ensure they are culturally appropriate.

What is the Reality of Risk Communications When It Comes to Including Migrants, Ethnic Minorities, and Temporary Residents?

This section aims to explore the current situation of emergency risk communication to migrants and ethnic minorities from the perspective of different stakeholders.



Dr Dominik ZENNER / International Organization for Migration (IOM)

Communicating to such a diverse group

The general challenge all migrants have is access to information from their host country. This can be due to language barriers, but also to social or cultural factors. For example, migrants may access media and information from their country of origin in preference to their host country. That said, migrants from high income countries being well paid and high status jobs, generally have no problem accessing information during a health crisis. Their employers will generally look after them very well. Health authorities need to focus on the most vulnerable and go that extra mile to help them, so that they have equitable access to health protection. This refers to the poorer and more marginalised migrant communities where many migrants have uncertain legal status.

3 main barriers to communicating to migrants

1

Uncertain legal status, coupled with “hostile” migration policies in many host countries

2

Low socio-economic status and lack of access to mass media in host country

3

Language and linguistic barriers

The participants were reminded of the **Vienna Convention**¹ and that all member states have a legal responsibility under this convention to protect the health of all migrants on their territory, regardless of their status.

¹ [International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, 2003](#)

An example to overcome these barriers

Communication to survivors of the Grenfell Tower fire in London (2017): British authorities granted a migration amnesty so that survivors, many of whom were low-income migrants (and some with uncertain legal status), could seek and receive care without the fear of being detained or deported. Having a communication strategy in place to reach the most vulnerable in these situations is key.

Various methods used by IOM to overcome communication barriers:

- > Working with cultural mediators from the community you are targeting
- > Mapping exercises to better understand leaders, influencers and networks within a community, coupled with micro stratification of different groups
- > Working with leaders and civil society organisation within target communities

The key is to know your community.



Mr Demos KROUSKOS / Centre for Culture, Ethnicity and Health, Australia

Working with different kinds of migrants

Migrant groups are very diverse, and it is important to avoid generalisation. The Centre for Culture, Ethnicity and Health (CEH) is funded by the Victorian Government to improve the capacity of health workers and health services to better respond to the needs of immigrant and refugee communities.

Since the end of World War II in 1945, there have been government programmes encouraging skilled workers to migrate to Australia to help develop the economy. In the 1970s and 80s Australia had a programme to resettle refugees after the Vietnam War. More recently, Australia has worked with UN agencies to resettle humanitarian migrants and refugees.

The focus of the Centre's work is on the most marginalised and disadvantaged migrants - this is the best use of CEH resources, especially when it comes to emergency risk communication.

Barriers and ways to overcome them

<p>1</p> <p>Establishing a relationship of trust with the organisations or communities' health authorities want to engage with is the biggest challenge. Without a foundation of trust, it is a struggle to implement any sort of communication strategy</p>	<p>2</p> <p>The second biggest challenge is gaining a comprehensive set of insights into the context and values of the communities, and how these impacts the “social determinants of health”. These determinants as including issues of gender, sexuality, education and socio-economic status.</p> <p><i>“If we can address those, we will have a much better understanding of what we are trying to achieve”.</i></p>
---	---

Box 2: What is the Centre for Culture, Ethnicity and Health, in Australia?

Established in 1994, the Centre of Culture, Ethnicity and Health is a non-governmental organisation that provides services to public and private healthcare organisations in Australia. It is unique as it works at the intersection of communication and health, particularly the health of migrants and refugees. Its overall aim is to improve the health and wellbeing of migrants and refugees in Australia. The Centre works with health service providers such as hospitals, community organisations and government agencies to help them to improve their interaction with migrants.

The services the Centre provides include:

- Health sector capacity-building;
- Research, policy and evaluation;
- Developing knowledge and literacy hubs;
- Developing information resources and health promotion materials for migrants;
- Providing cultural competency and health literacy training to staff from health service providers; and
- Providing consultancy services.



Ms Mayada BOULOS / Former counsellor to the French Health Minister during the 2014-2015 Ebola Crisis

Experiences as advisor to France’s Minister of Health during the 2014-2015 Ebola epidemic in the West African countries of Guinea, Sierra Leone and Liberia

What sort of issues relating to migrants and migration came up during the Ebola epidemic?

Equity was a key issue. West African migrants living in France (primarily from Guinea) who regularly visited family and friends there, were the most exposed to the risk of Ebola infection. They were also the least well informed about Ebola and how to protect themselves from it. An extra effort was needed to target this community, to raise their awareness about the risk, and to promote best practices in terms of prevention and early warning if they became sick.

Dealing with the perceived risk and actual risk of Ebola was a major part of Ms Boulos’s work. Many people perceived a large risk from contact with people from Africa, when the actual risk was small to non-existent. Preventing or at least limiting feelings of anxiety and panic among the population – and countering stigma – was a challenge.

Finally, there was the issue of informing healthcare staff on how to spot possible Ebola cases, how to manage them, when to report them and the need to use personal protective equipment.

How the French authorities communicated with groups at high risk

The French Ministry of Health communicated with travellers going to Guinea and other affected countries, as well as aircraft and airport personnel. Traveller information on Ebola in West Africa was handed out on departure and on arrival. Each airport had a written procedure of what to do in case a traveller with suspected Ebola infection arrives.

France has a concept of “republican equality”: all citizens should be treated equally, and no specific group should get special treatment. Until recently, the idea of communication targeting a particular ethnic group was seen as discrimination or providing “special treatment”. This sort of targeted communication was new, and not easy, in the French context.

An example: Communicating about Ebola with the Guinean community in France

Guinea is a French speaking country. Despite not having a language barrier with Guinean migrants in France, there were some cultural barriers. The starting point for the Ministry of Health's communication strategy was to overcome the barrier that these migrants would not be proactive in search for information about Ebola. The authorities therefore had to bring the information to them. This was done by targets:

- > Specific channels, such as community media used by Guineans
- > Specific places, such as Guinean markets or workers' hostels where community members go
- > Specific people of influence in the community

As always, building and maintaining trust with the community was of key importance. In particular, the health authorities engaging in top down communication to the migrants was not enough. A communication strategy was needed to get community members talking to their peers about Ebola as well. Peer-to-peer dissemination of information, use of community networks and empowering healthcare professionals to communicate about Ebola became a big part of the strategy. So too did communication via teachers: they educate the children about Ebola and then the children educate their families.

To avoid discrimination and stigma, the Ministry of Health communicated via the mainstream media at the same time as doing targeted communication to the Guinean community. It was important to share information with the wider public and provide them with the facts about Ebola, so they understand that contact with migrants would not put them at risk. ***"We need to address the host community as well as the migrant community to avoid myths and stigma."*** In emergency situations you must be proactive, not just reactive ***"don't let the perception take the lead"***.

Questions & Answers

How do we build cultural competencies?

It is important to work with both migrants and healthcare staff. Health literacy programmes can help migrant communities access the health system more effectively (e.g. visiting a General Practitioner rather than going to hospital). They can also empower migrants to manage their own health, for example by accessing prevention programmes. Cultural competency training helps healthcare staff provide a better service to migrants.

Training the trainer programmes on cultural competency can be a useful way to spread cultural competency. They should not just focus on healthcare professionals though. For example, this type of training can also be useful for law enforcement professionals. Several countries are trying to embed cultural competency training into the curriculum of Public Health Schools. The WHO Regional Office for Europe has initiated an annual summer school on migrant health. This aims to build member states' capacities and share experience in a similar way to WHO Europe's online knowledge hub².

Developing strategies to communicate with migrants

The example was given of developing a HIV prevention strategy targeting a migrant community. In order to better understand the community, colleagues developing the strategy went to places frequented by that community, such as night clubs, to get an immediate insight into the behaviours and environment of people potentially at risk. In this way they were quickly able to develop an appropriate strategy.

² <http://www.euro.who.int/en/health-topics/health-determinants/knowledge-hub-on-health-and-migration>

Reaching migrant communities and sub-groups within them

It was stated that in France, when there is no emergency, reaching representatives of migrant communities is quite easy. Traditional media channels can often be effective in reaching community leaders.

What can be more difficult is reaching specific sub-groups within migrant communities, such as young people. Ways to reach young people include targeting:

- > Social media
- > Places young people frequent on a regular basis
- > Embedding messages in popular TV shows

Young people often use specific words or codes, both in the host country language and migrant languages. It is important to understand these when communicating with them.

It was stated that grouping within migrant communities can sometimes be a barrier to communication. The example given was of Somali migrants living in the UK. Some of these migrants are devout Muslims, while others are not very religious. Using a Somali cultural mediator who is religious may not be effective if the individuals you want to engage with are not religious.

Other ways of engaging with migrant communities

- > Develop a bespoke communication toolkit to reach specific communities
- > Get feedback from community radio stations to learn more about the targeted community's concerns (what questions are they asking) and risk perception.

Including Migrants & Ethnic Minorities in Risk Communication

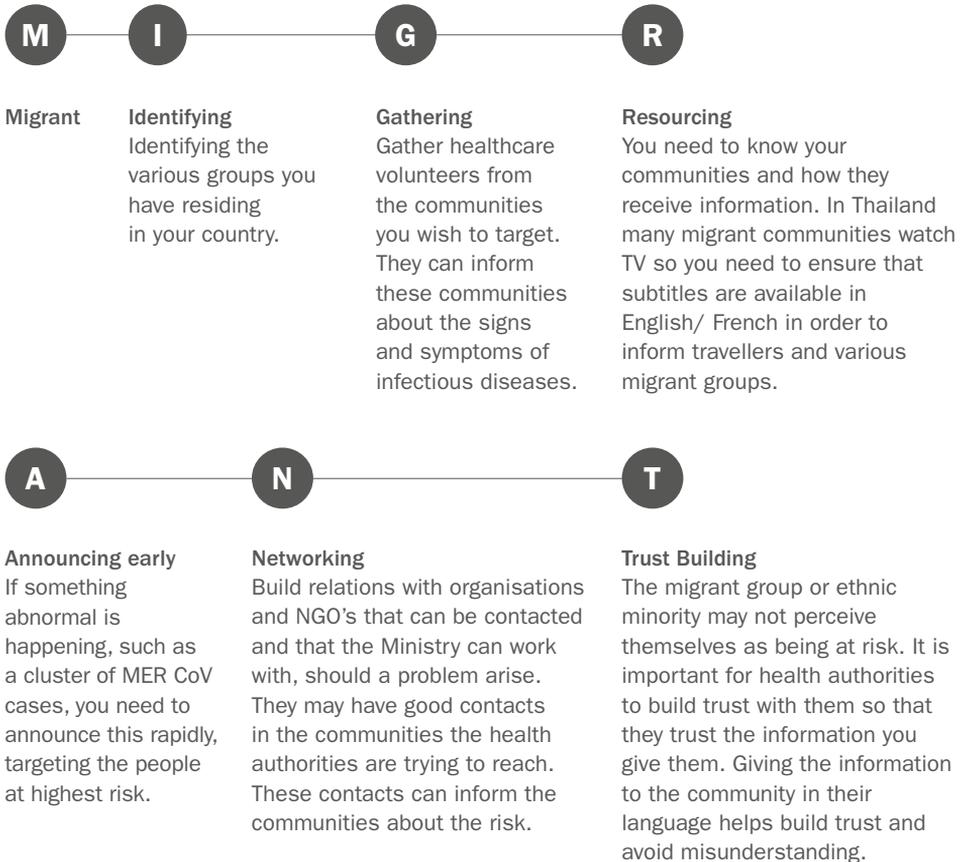
This section aims to share countries' experiences of risk communication to migrants and ethnic minorities before, during and after public health emergencies.



Dr Pahurat K. TAISUWAN / Ministry of Public Health, Thailand

Different Approaches in Risk Communication to Overcome the Language Barrier in Thailand

Thailand’s approach to communicating risk to migrants





Ms Laura WOODWARD / Public Health England (PHE)

The Barriers that Public Health England Experienced when Trying to Communicate to Migrants

1. Language

They overcome this by having translation services available in hospitals via telephone – and face to face when possible.

2. Lack of understanding of how the UK's health system works.

Many migrants do not understand that in the UK National Health Service (NHS), the usual way to access care is via a General Practitioner. All migrants living in the UK have the right to register with a General Practitioner and this is key to accessing health care (PHE supports programmes that help migrants register with a General Practitioner).

3. The “fear factor” that if they connect with health services, they will alert the police / migration services.

There needs to be a strict firewall between police and health services to provide reassurance to migrants who may have uncertain legal status.

4. Restrictions on access to specialist care and hospital services.

In some instances, the NHS will not provide these services to undocumented migrants.

Focus

Language and Cultural Barriers – the issue goes beyond the health literacy of migrants - **socio-economic status** must also be considered. Information must be adapted to the audience to ensure that the message is getting across, despite potentially lower levels of health literacy. Communicators need to understand who they are tailoring the information for and be aware of how they express what they want the audience to do.

They should not rely on the norms of how to communicate in their own culture - they should adapt to the audience's norms, whether they use non-verbal communication such as photos, or videos explaining the health protection measures or treatments being used. An individual needs to understand what is happening to them in order to accept the intended message.



Mr Gary LOW / Ministry of Communication and Information (MCI), Singapore

Dealing with Rumours

The Singapore Government employs a multi-pronged approach to address DRUMS (Distortions, Rumours, Untruths, Myths, Smears) relating to government policy, or incorrect assertions on matters of public concern that can harm Singapore's social fabric.

- D**
Distortions
- R**
Rumours
- U**
Untruths
- M**
Misinformation
- S**
Smears

DRUMS travel further and faster than real facts, as they are emotionally charged and exciting. People can easily select their news sources and set up 'echo chambers' that may not have balanced views or journalistic integrity. Social media platforms may lend themselves to different forms of content engagement and conversations, and different groups of people may react to sensational news in emotionally-charged ways. Facts, on the other hand, are rational and authoritative – government agencies and official sources thus face a challenge in clarifying DRUMS as clarifications are rarely shared widely.

There are serious challenges and real risks posed by deliberate online falsehoods, which include harming national security and inciting public unrest and violence. A Parliamentary Select Committee was recently formed in Singapore to examine the issue of fake news. The Committee consulted businesses, experts and individuals and put forth 22 recommendations in all, including public education measures, legislation, and urging technology companies to take proactive steps to tackle fake content on their platforms.

To address rumours and misinformation in a timely manner, MCI releases informational articles through the Gov.sg Factually website and social media platforms. Over the years, the site has addressed inaccurate assertions about various matters, such as housing, the economy and finance. For example, during the Zika outbreak, Gov.sg Factually allayed public misperceptions about the virus. This is part of the government's efforts to ensure Singaporeans have access to accurate information on important matters. The government also works with the media and other partners such as community leaders to address DRUMS.

The government also organises public engagement sessions for different communities, and develops content such as videos and infographics to communicate facts via various platforms. Organisations such as the Media Literacy Council and government agencies such as the National Library Board (NLB) have put in place programmes to help build Singaporeans' media and information literacy, in order to foster discernment and critical thinking in their consumption of information on digital platforms.



Ms Cécile ALLAIRE / Santé publique France

Health Literacy and producing accessible information for different groups

In 2018, Santé publique France produced a comprehensive guideline book on accessibility of health communication. One concept in the guideline that is relatively new in France is health literacy.

Health literacy is based on a definition of “literacy” as being:

“the ability to identify, to understand, to interpret, to create, to communicate, to compute and to use written or oral materials or information, to participate in society”

Put more simply, being literate means more than just the ability to read information. You also need to have the ability to use it. Different tools have been developed to measure literacy. Santé publique France has based its health literacy actions on a survey developed by OECD³ and conducted in 40 countries. The result of this show that 53% of adults in the 40 countries surveyed do not reach level 3 literacy.

This is considered to be the minimum level to be counted as literate. Put differently, the majority of adults do not have the skills to use information to meet the demand of everyday life.

“Literacy is limited”

Through this finding, it may be perceived that the need of migrants and ethnic minorities do not vary as much from the needs of the majority of the population. However, it must be noted that some groups have more difficulties for example migrants, elderly, disabled people, or other populations with challenges in accessing health information.

What impact does limited literacy have on health?

Lower levels of literacy are associated with less positive health behaviour and health outcomes. For example, people with low literacy are less likely to access disease prevention such as screening or testing. They are also less likely to access primary care / General Practitioner services are more likely to be admitted to the hospital. There is a clear correlation between low literacy and poor management of chronic diseases. In summary, people with low literacy have difficulty using health services, understanding health information, and interacting with health professionals.

3 [PIAAC survey of Adult Skills, OECD, Paris, 2014.](#)

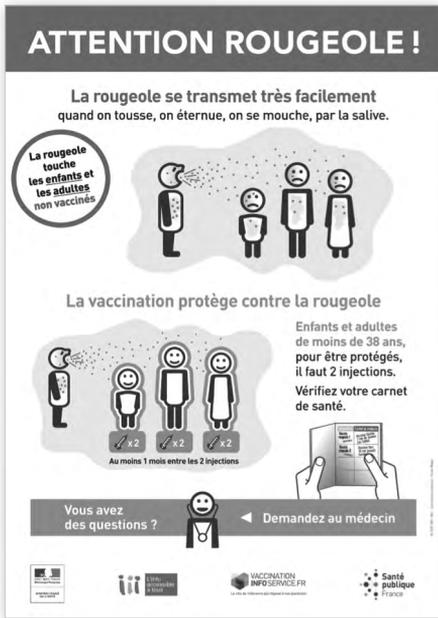
Recommendation

Santé publique France’s guideline on accessibility recommends aims for a “universal design” in health communication materials. They should be at a level that people of all levels of literacy, including low literacy, should be able to comprehend.

The universal design makes the use of pictures and use simple vocabulary to convey their message. In principle, materials following these principles should be accessible to migrants and ethnic minorities with a low understanding of the host country’s language, as well as people with low literacy in the host community.

Building the skills

Picture 1



The poster on the left (Picture 1) was produced for Roma migrants and traveling communities in France during a recent measles outbreak in their community. Santé publique France created it by applying the recommendations in the guideline on accessibility and it was pretested within the Roma community. It was distributed as posters and was also posted on Facebook. People were asked to share the image with their Facebook friends.

The image only has 2 messages: if it had many messages it would be less accessible. For each message there is one picture, accompanied by clear words and sentences. There are always one or two words associated with each picture. This is an example of what you can create when you apply the recommendations in Santé publique France’s guideline.



Ms Sandrine RANDRIAMAMPIANINA / Santé publique France

How communication tools are developed in France

In France, it is ensured that all communication materials are accessible; both to people in the general population with low literacy and also to migrants.

Santé publique France communicates with migrant communities on a long-term basis, and not just in the context of emergencies.

Santé publique France’s communication strategy towards migrant communities was born out of the National Plan against HIV. It led to two key principles of the HIV Plan being included in the strategy:

1

Migrants should be treated as a regular part of France’s multicultural society. They should therefore be included in every communication equally as any other population group

2

Even though migrants must be treated as a regular part of French society, they should also be treated as a specific group.

This translated into a dual communication approach, where the communication tools developed were universal and inclusive but at the same time included bespoke communication tools were developed to specifically target migrants.

Using the example of the national HIV prevention campaign, messages were developed for the general population and broad-casted on mainstream TV channels. In addition, add-outs containing the same message but showing migrants would be shown on the same media outlets. This was the inclusion side of the approach.

Supplementing the main campaign, bespoke communication toolkits were developed to target specific migrant populations. The messages used for these campaigns were based on deep insights into the social and cultural codes of the communities being targeted.

Including migrants in the general health communication strategy is important in France. It is a way to include them in the society and to remind them that they are not just “migrants”, but part of the French society.

Questions & Answers

The ideas of society and community in France, and how these differ from other countries

While there are lots of communities in France, the Republican ideal of the equality of all citizens is very important. When people move to France, they are expected to embrace the values of the French society, and being an equal member of the French society is one of these values. This does not mean that migrant communities do not exist. Community leaders can and have been used to disseminate important messages. But the French are generally reluctant to divide their society into different communities. Care has to be taken when choosing which communities to target.

Finding the resources needed to monitor for fake news or rumours

The challenge of getting the resources needed to monitor and combat fake news:

Even though there are other competing priorities, it was argued that politicians should value efforts to combat fake news as they are also a victim of it. It was also stated that the technology and tools needed to monitor for fake news are not very expensive. The major investment is staff time. When it comes to combating fake news or rumours, the key factor is being able to communicate quickly. This needs senior management or commitment at a political level and a willingness to empower communicators to act. If the authorities react quickly to a rumour or fake news on social media, the mainstream media will usually pick up and report this – which means your information reaches a wider audience.

Nonetheless, having resources certainly helps in the fight against fake news. For example, having a budget to promote messages on social media platforms such as Facebook can greatly boost the outreach.

⁴ [PIAAC survey of Adult Skills, OECD, Paris, 2014.](#)

Commercially available brand monitoring services can give information on which (social) media your audiences are consuming. This can help authorities better target their response. There are also commercially available services that can help authorities monitor more effectively. The quicker you identify and respond to rumours or fake news, the more likely you are able to stop them.

Cost of inaction: When looking at the cost of monitoring for and reacting to rumours or fake news, we should also talk about cost of inaction. The cost of inaction is the risk that the rumour or fake news spirals out of control. Much more effort and resources will then be needed to try and control it.

How the relationship between host and migrant communities impact risk communication strategy

The host communities' expectations and relationships with migrant communities: This impacts the risk communication strategy used. Is it effective to include migrants in general campaigns, or are campaigns that target specific migrant communities better? This may depend on the context. It was pointed out that migrants are not the only demographic that needs to be looked at. Communicators also need to focus on age, gender and socio-economic status.

Health literacy during health emergencies

There is research that health literacy and the ability to process information naturally falls when people are under stress in an emergency. This should be borne in mind when doing risk communication in an emergency. Health literacy levels are not being regularly monitored in most countries. Based on the OECD⁴ study, we must always consider a large proportion of our audiences have low health literacy. Communicators need to take care in deciding what information to disseminate and how to explain it.

Risk Communication in Action

pages 31 — 39

Emergency Simulation Exercises – Part 1

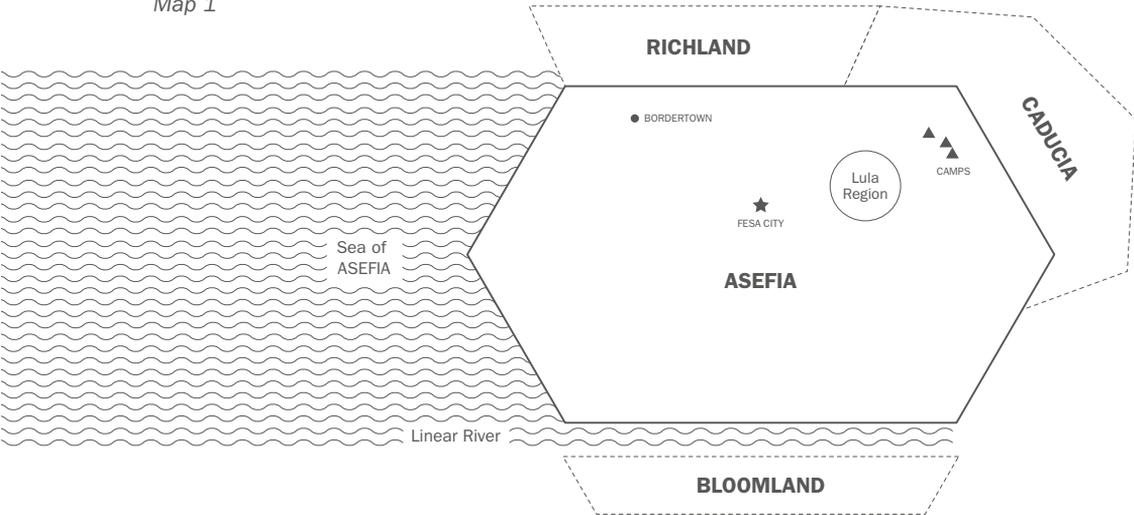
pages 40 — 49

Emergency Simulation Exercises – Part 2

Emergency Simulation Exercises (Part 1) Scenario Setting

You are the official responsible for emergency risk communication of the ASEFIA Public Health Agency. ASEFIA is a fictional country created for the purposes of the exercise. Its Public Health Agency is based in the capital, Fesa City – see map below.

Map 1



ASEFIA is a middle-income country that has achieved high economic growth in recent years. Its booming economy and events in neighbouring countries mean there are now hundreds of thousands of migrants – some with families in the country.

Some ASEFIANS feel uneasy about the number of migrants living in their country. Migration and ethnic diversity are sensitive issues in ASEFIA.

Social Media and Rumours

12 October 2018: Fesa University of Technology (FUT) in ASEFIA's capital city has built itself an international reputation in recent years. FUT attracts fee-paying students from all over the world, including many students from Africa. Students and academics from across the world are traveling to Fesa City for the start of a new term at FUT. ASEFIANS love social media. 70% of ASEFIANS have smartphones. The most widely used social media platform is **Socialgramme**, which allows instant sharing of videos, photos and text by anyone with a smartphone.

16:30 on 12 October 2018: You look at Socialgramme and see the top story in Fesa. It is a photo showing an aeroplane being boarded by people wearing biohazard suits accompanied by the text "ASEFIA Airlines Flight 99. We are being put into quarantine because an African passenger has Ebola. Pray for us"

Most staff and managers will leave for the weekend at 17:00. In fact, some have already left.



Decision making challenge 1.1

Identify three priority actions the official responsible for emergency risk communication should take between 16:30 and 17:00.

Sample answers

- > Alerting key staff to stay in the office to help deal with the incident and briefing senior management as priority actions
- > Preparing a holding statement as journalists would soon be asking for comments about the Socialgramme post. This statement would say the ASEFIA Public Health Agency is aware of the story on Socialgramme and is investigating the situation
- > Contacting the airport or Ministry of Transport to verify the alleged incident

#EbolaFesa #Flight99

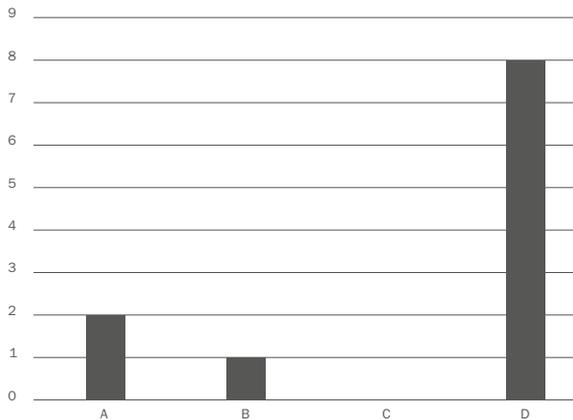
As the evening progresses there are many more Socialgramme posts from people claiming to be passengers on Flight 99. Risk communication counterparts in the Ministry of Transport, Ministry of Interior and the airport are unavailable. But journalists from mainstream media are contacting the ASEFIA Public Health Agency asking for comment. Someone had posted a video of people in bio-hazard suits carrying a passenger off what is claimed to be Flight 99. There is a credible rumour that this video will be the headline story on ASEFIA TV's 19:00 news bulletin. This is the most widely watched news programme in ASEFIA.

Decision making challenge 1.2

Which one of the following is your top priority between now and 19:00 (when #Flight99 becomes headline news)?

<p>A</p> <p>Keep trying to contact Ministry of Transport, Ministry of Interior and airport to get official information</p>	<p>B</p> <p>Call ASEFIA TV and offer a spokesperson for interview</p>
<p>C</p> <p>Prepare a press release</p>	<p>D</p> <p>Prepare Socialgramme post – health authorities are investigating incident and ready to respond</p>

Sample answers



Justification

- > Social media was seen as the fastest and most effective way to publish a statement ahead of the 19:00 news bulletin. The story had begun on Socialgramme and that is the channel that most of the audience is still looking at.
- > There might be an issue with the organisation’s clearance procedures for a press release which could be too slow to issue a press release in time for the 19:00.
- > The majority favoured making a short statement in a controlled format (Socialgramme or possibly a press release) rather than putting up a spokesperson for an interview on the news. Given how little verified information ASEFIA Public Health Agency has, they feared the spokesperson could be made to look incompetent.
- > Putting a spokesperson on the 19:00 TV news could be seen as a way of showing empathy and establishing trust.

Finally, some official information

18:20 on 12 October 2018: The Airport Authority has been in contact stating that they have a blood sample to send to your laboratory. The person under investigation is a 22-year-old Congolese student who travelled from Kinshasa via Brussels to Fesa City. He became ill with a headache, muscle-aches and fever during flight from Brussels to Fesa International. Given the ongoing Ebola outbreak in the Kivu region of Democratic Republic of Congo (DRC), the airport activated its contingency plan for the arrival of a passenger with a high-risk contagious disease.

A cross-government incident team is now being activated. The passengers on Flight 99 are still quarantined at the airport.



Above: Map of Democratic Republic of Congo (DRC) with Kinshasa marked with a circle on the left and Kivu drawn on the right. The distance between them is approximately 1,500 kilometres by air.

Decision making challenge 1.3

The incident management team and the MoH ask you to draft a media “line to take”. Which one of the following do you propose?

A

A 22 year-old Congolese man who became ill with fever during Flight 99 has been sent to hospital for tests. This is a routine precaution. Other passengers and crew are not at risk.

B

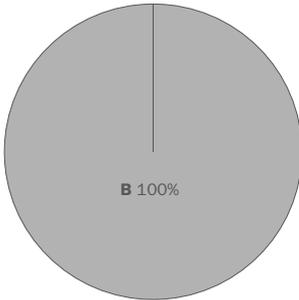
A passenger on Flight 99 became ill with fever during the flight. The passenger had recently been in DRC. The cause of illness is under investigation. Ebola is one among several possible causes being tested for. We will keep you updated.

C

A 22 year-old Congolese student at FUT who became ill with fever during Flight 99 is being tested for a range of diseases, including Ebola. The test results will be available at 12:00 tomorrow.

Sample answers on the next page >>

Sample answers



A 0% B 100% C 0%
(7 Participants)

Justification

- > None of the statements proposed were perfect (the exercise was designed this way – otherwise the task would be too easy).
- > The statement in A that “other passengers and crew are not at risk” is false reassurance - the health authorities cannot, at this stage, guarantee there is no risk.
- > Statement C gives so much information about the passenger who became ill that people may be able to identify him.

Decision making challenge 1.4

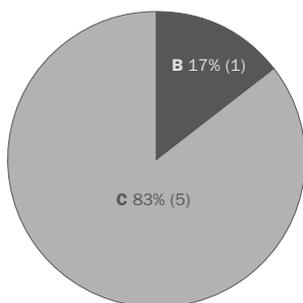
19:00 on 12 October 2018: Some posts on Socialgramme say the passenger under investigation for Ebola vomited in the aisle of aeroplane. Official information on what

happened is not yet available. The Director of Public Health wants you to post a Socialgramme message **immediately** to “reassure” quarantined passengers.

Which one of these messages do you post?

<p style="text-align: center;">A</p> <p style="text-align: center;">Please be reassured: you are not in danger</p>	<p style="text-align: center;">B</p> <p style="text-align: center;">The risk to passengers is low. You will be free to go soon</p>
<p style="text-align: center;">C</p> <p style="text-align: center;">You can only catch Ebola from contact with body fluids of an infected person. Speak to health officials at the airport if you have any concerns</p>	

Sample answers



A 0% B 17% (1) C 83% (5)
(6 Participants)

Justification

- > Again, none of the statements were perfect.
- > Statement A, however, is a bit too absolute in its reassurance. The delivery of the statements such as “be reassured” or “don’t panic” to people faced with an emergency can be counterproductive.

Rumours are flying

20:15 on 12 October 2018: Following the evening news #Flight99 and #EbolaFesa the top items on Socialgramme.

A rumour gaining a high interest is that the passenger under investigation is a medical student at FUT who had spent December volunteering at an Ebola treatment centre in Kivu Province, DRC. Socialgramme users are asking “*how many more Congolese medical students are heading to FUT carrying Ebola?*” There is also much debate and confusion about the risk to passengers, air crew, first responders and hospital workers.

You are just back from a meeting with the incident management team where you learned the passenger under investigation is an engineering student who spent all his holidays in Kinshasa, thousands of kilometres away from Kivu. He did not vomit in the aisle, he did it in the toilet.

08:00 on 13 October 2018: Most of the mainstream media channels reported the incident at Fesa International airport in a balanced way. They repeated the government message that this was a precautionary measure. There continue to be many rumours on Socialgramme, including that the passenger under investigation is a medical student returning from Kivu Province, DRC.

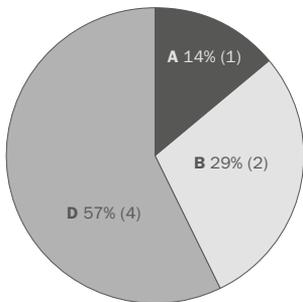
There was also racist connotation to some of the Socialgramme posts. Two mass-market newspapers ran scare-mongering articles about “*imported death*”. One is headlined “*hospital of fear*” and quoted anonymous health workers in Fesa City Hospital treating the passenger under investigation. One says “*now we risk getting it from Congolese doctors, as well as Congolese patients*”.

Decision making challenge 1.5

Fesa City Hospital employs hundreds of African healthcare workers. The hospital Director and the Ministry of Health are concerned these HCWs may be stigmatised or abused. Which one of the following do you propose?

<p>A</p> <p>Continue attacking the rumour that Flight 99 passenger is a medical student from DRC</p>	<p>B</p> <p>Develop a social media campaign to explain how Ebola transmits and why ASEFIANS won't catch it from HCWs (African or otherwise)</p>
<p>C</p> <p>Photo opportunity of Minister of Health with African HCWs</p>	<p>D</p> <p>Press briefing by Chief Medical Officer to explain facts about Ebola and why ASEFIANS won't catch it from HCWs</p>
<p>E</p> <p>Statement by medical & nursing professional bodies</p>	

Sample answers



A 14% (1) B 29% (2) C 0% D 57% (4) E 0% (7 Participants)

Justification

- > Since social media is still the key channel for this story, a social media campaign would be the most efficient and effective option for countering the stigma.
- > Since the story is now in traditional news media, a high-profile intervention was needed – such as a press briefing by the Chief Medical Officer. In a real emergency, participants felt they might pursue all or several of the options simultaneously.

Box 3: The Basic Law of Rumors⁵**R~I x A**

R = the **REACH**, intensity, duration, and reliance on a rumour

I = the **IMPORTANCE** of the rumour to the audience, if true

A = the level of **AMBIGUITY** or uncertainty surrounding the rumour for the audience

Scale for I and A: 0 = non-existent, 10 = extreme

What this law tells us is that simply denying a rumour is not enough. This does not get rid of the ambiguity, and may even increase it. If the authorities say "no comment" or just stay silent, this really increases ambiguity.

Rumours fly in the absence of news. Therefore, health authorities need to give the public the most accurate possible news, promptly and completely. They need to announce early when an incident happens, be transparent and show empathy. They also need to listen to the public.

12:00 on 13 October 2018: the laboratory test results are available. The passenger with fever has malaria, not Ebola.

⁵ [Adapted from Chorus, A. \(1953\). The basic law of rumour. The Journal of Abnormal and Social Psychology, 48\(2\), 313-314.](#)

Emergency Simulation Exercises (Part 2)
Scenario Setting

You are the official responsible for Emergency Risk Communication in the ASEFIA Public Health Agency, based in the capital, Fesa City.

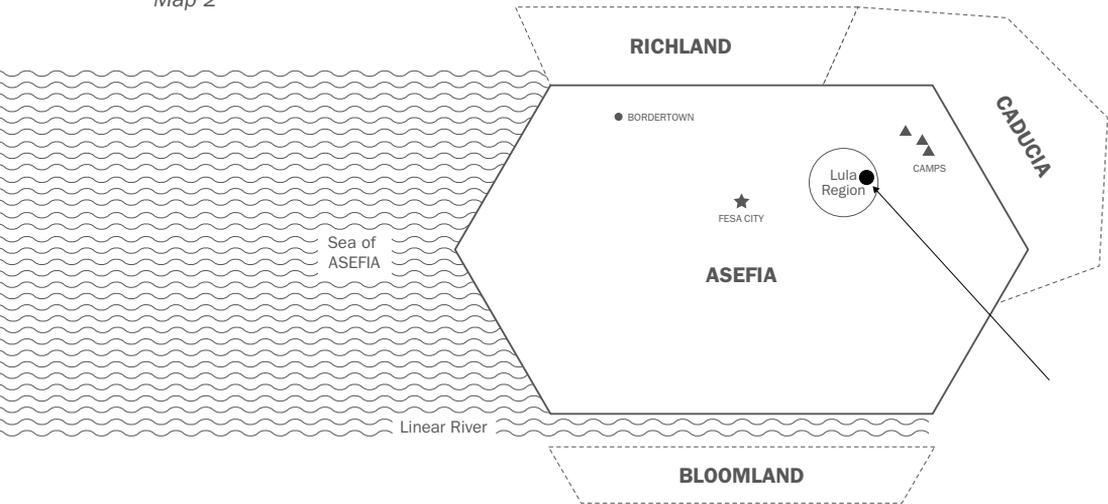
ASEFIA is a middle-income country that has achieved high economic growth in recent years. Its booming economy and events in neighbouring countries mean there are now hundreds of thousands of migrants – some with families in the country. Some ASEFIANS feel uneasy about the number of migrants living in their country. Migration and ethnic diversity are sensitive issues in ASEFIA.

Who are the migrants in ASEFIA?

> High skilled (and well paid) international workers in ASEFIA’s financial services, technology and mining sectors.

- > Lower skilled workers in agriculture, manufacturing and hospitality sectors. Mostly from Bloomland and Caducia. Some work in the informal economy without visas nor residency permits.
- > Since 2015, there has been a big influx of refugees and irregular migrants due to economic and social upheaval in CADUCIA. Some of these are in camps, but more are in cities – especially Fesa.
- > ASEFIA has become a transit country for refugees / migrants from Afghanistan, Iraq, Eritrea and other countries trying to get to Richland. Many of these are in and around the city of Bordertown.

Map 2



Measles outbreak begins

February 2019: The measles season has begun across Asia and Europe. Measles vaccine coverage among ASEFIANS is over 95%. Very few measles cases were reported over past 4 years and ASEFIA was certified by WHO as measles-free in 2018.

Nonetheless, measles experts in ASEFIA Public Health Agency (APHA) warn there is a risk of measles outbreaks among certain under-vaccinated populations.

>>

APHA's analysis shows < 50% measles vaccine coverage among:

- > CADUCIAN infants born in 2015 onwards. Many live in close proximity in the reception camps.
- > CADUCIAN infants living in poorer districts of Fesa City.
- > Migrant workers from BLOOMLAND. Many live in close proximity in workers' hostels in the agricultural region of LULA.
- > Some low income, low literacy ASEFIAN communities in Fesa City.

4 February 2019: APHA in Fesa City receives a measles surveillance report from the agricultural region of Lula:

- > 6 measles cases have been confirmed in a worker's hostel on a commercial flower farm.
- > 10 more workers are ill with measles symptoms: all Bloomlanders.
- > Lula Public Health department expects more cases in coming weeks.

Box 4: The pathogen that will cause the emergency - Measles

What is the Measles virus?

It belongs to the *paramyxoviruses* group and is only found in humans. Measles is highly contagious, with a basic reproduction rate (R0) of 16. This means that, in a population without widespread immunity, one person with measles will go on to infect a further 16 people.

Measles produces a distinctive skin rash and spots in the throat approximately 8 to 12 days after infection. However, in the early stages of the infection, a person with measles may show no symptoms or non-distinctive symptoms such as coughing or fever. They may still be going to school or work and infecting other people. The measles virus spreads when an infected person coughs or sneezes. The virus can remain active (and infectious) in the air or on surfaces up to 2 hours after it has been coughed out. Measles is a dangerous infection. It can lead to complications such as pneumonia, encephalitis and otitis media. Even in developed countries with good healthcare systems, about one in affected thousand with measles dies.

Measles is known as a childhood infection because, in the past, very few people got through childhood without having it. These days there are safe, cheap and effective vaccine against measles which offers life-long protection. It is on the vaccination schedule of nearly every country worldwide. WHO has set a goal of eliminating measles in at least five WHO regions by 2020. Most countries in the Americas have achieved measles-free status. Several countries in WHO's Western Pacific Region have achieved this status. But a majority of countries still experience measles outbreaks.

One of the major challenges in eliminating measles is that it is a highly infectious virus. 95% of people in the community need to be vaccinated in order for it to achieve "herd immunity" - in other words, you need to have this level of vaccination to be confident that if a measles case is imported into the community it will not start an outbreak.

>>

Even if a country achieves 95% measles vaccine coverage nationwide, it may still experience measles outbreaks if the unvaccinated 5% is concentrated in specific communities or sub-populations in the country.

The example was given of the Netherlands which has a nation-

wide measles vaccination coverage of between 95% and 96%. In 2013 there was a measles outbreak among certain communities in the Netherlands that refused vaccination for religious reasons.

Therefore, even if a country has an overall high measles vaccine coverage, outbreaks can still happen in unvaccinated or under vaccinated groups.

Decision making-challenge 2.1

You are part of an emergency task force created to launch an emergency measles vaccination programme in Lula. Migrant farm workers from Bloomland are the key target group. Most have poor or no understanding of Asefian.

A strategy note is being prepared along with a request for resources. Each group is asked to contribute:

1. 3 bullet points on communication strategy
2. 3 bullet points on the resources you will need

>>

Sample answers

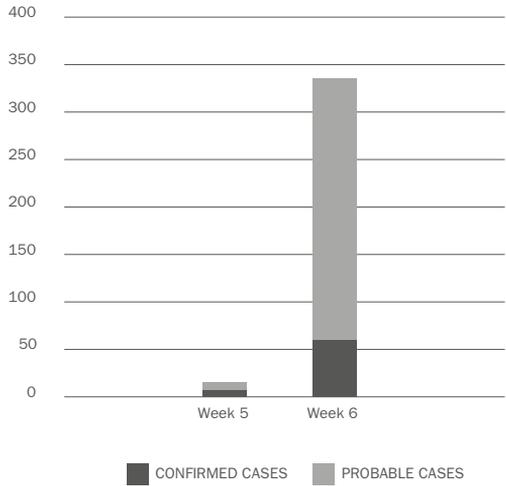
	1. Communication Strategy	2. Resources needed
A	<ol style="list-style-type: none"> 1. Work with community-based organisations (NGO's) to understand characteristics of the population 2. Use formative research methods to assess information needs and preferred channels of communication of the population 3. Use local champions/influencers to address fears among undocumented migrants 	<ol style="list-style-type: none"> 1. Cost for translation and communication tools 2. Human resources 3. Vaccine-related costs (supply chain/delivery/administration)
B	<ol style="list-style-type: none"> 1. Make it known that the general population of ASEFIA are protected but that a specific group were under-vaccinated: they are the target of the campaign 2. Clearly explain that vaccination is the best and safest way to prevent infection by the measles virus and outline what measles is. 3. Outline that public health authorities are carrying out the vaccination campaign FREE OF CHARGE. 	<ol style="list-style-type: none"> 1. Translators and the resources necessary to translate information 2. Ask "Bloomland" (neighbouring country) for certain materials to aid the campaign as it is in their best interest that we successfully manage the outbreak. 3. Cultural mediators
C	<ol style="list-style-type: none"> 1. Intense education campaign, culturally adapted to the context explaining measles and its associated risks 2. Encourage people to get involved in the process/campaign by coming forward with their health complaints 3. Identify and engage with influential community leaders 	<ol style="list-style-type: none"> 1. Human resources 2. Financial resources

Additional information about the Bloomlander community in the Lula Region:

- > Most come from the rural areas of Bloomland: highly skilled at harvesting flowers.
- > Poor understanding of Asefian language.
- > 30% to 40% unable to read or write.
- > Low health literacy – widespread belief that illnesses are caused by witchcraft/angry spirits.
- > Some have mobile phones.
- > The Bloomlander migrant's main source of news and information is word of mouth.
- > Radio Flora – Bloomland language local radio in Lula region – is widely listened to.

ASEFIA Public Health Agency launches emergency vaccination campaign in Lula Region

The measles outbreak spreads rapidly through the Bloomlander community in the Lula Region. Over the next couple of weeks there are hundreds of cases.



13 February 2019: The official responsible for emergency risk communication at ASEFIA Public Health Agency receives a report from colleagues in the Lula region. The emergency vaccination campaign aimed at Bloomlanders migrants is encountering difficulties. The uptake of vaccination, so far, is low. The Bloomlanders seem reluctant to go to medical centres.

Intercept interviews conducted by the response team in Lula suggest various reasons for this reluctance:

1. Concerned that health authorities will ask about work permits – many Bloomlanders are working illegally
2. Opening times of clinics not convenient for people who work
3. Rumours about vaccine causes Bloomlanders to go sterile
4. Belief that traditional Bloomland remedies offer best protection against illness

Decision making-challenge 2.2

The emergency response team lead asks you to develop a communication plan to increase vaccine uptake by Bloomlanders in Lula.

- > What are the top 3 actions you propose?
- > Which organisations / stakeholders do you need to partner with?

Sample answers

	Actions	Organisation/Stakeholders
A	<ol style="list-style-type: none"> Dual strategy of face-to-face communication and radio to communicate to Bloomlanders in Lula. Training should also be included e.g. peer education in this regard Military intervention and support (to prevent attacks on healthcare personnel and to help gain access to areas) Engage with public administration and local politicians 	Engage with community-based organisations which are already established in this area.
B	<p>Mostly similar to group A above but conditionally,</p> <ol style="list-style-type: none"> Putting vaccinations at worksites as people often do not have time to go to vaccination centers 	<ol style="list-style-type: none"> Based on the action of making on-site vaccination available, in order to work with employers to ensure they are onboard with this course of action. Work with family associations/ community-based organisations e.g. Churches
C	<ol style="list-style-type: none"> Make a statement to address the rumours using radio/face-to-face communication on-site. This statement would explain the effectiveness of modern medicine, such as vaccination. Coordinate with law enforcement/local authorities to ensure that anyone who comes forward with their illness will not be prosecuted or be deported. To extend the opening hours of health and vaccination centers 	<ol style="list-style-type: none"> Collaborate with health authorities of the country Law enforcement agencies Media – radio, journalists etc NGO Community leaders and community centres.
D	<ol style="list-style-type: none"> Set up a mobile clinic where people can frequent regularly and offer information and vaccination 	Similar as above

It was noted that **employers benefit opportunistically** from the work of illegal migrants and once they fall ill employers want to get rid of them. It would be good in situations similar to this, to find 1-2 employers and **stress to them the**

importance of this workforce for the local economy and that they (as employers) could protect them through vaccination. Such proactive actions would also act as a powerful message to both the host population and the migrant populations that they are wanted.

The measles outbreak spreads to Fesa City

March 2019: By early March the measles outbreak among the Bloomlander community in the Lula Region has peaked. The outbreak has spread to unvaccinated members of the Caducian migrant community in the Lula Region. By mid-March there are reports of measles cases in a poor district of Fesa City where many Caducian migrants live.

25 March 2019: The official responsible for risk communication attends a meeting of the emergency response team at the ASEFIA Public Health Agency. The measles

outbreak in Fesa City is growing. There is now a significant number of cases among Caducian infants. There are now reports of ASEFIAN teenagers in a neighbourhood near the Caducians becoming ill with fever and rash. They are from a low income, low literacy ASEFIAN community where a cohort of children and adolescents born between 1995 and 2010 missed out on measles vaccination. It is decided to launch emergency vaccination campaigns aimed at both communities.

Decision making-challenge 2.3

- | | |
|--|---|
| <p>1 <u>Develop a communication strategy to support the CADUCIAN community to vaccinate infants (0 to 3 year olds).</u></p> | <p>> Produce 3 bullet points on their communication strategy</p> |
| <p>2 <u>Develop a communication strategy to support low income ASEFIAN community to vaccinate 10 – 23-year olds.</u></p> | <p>> Think about what further information they would want about the community they are aiming their communication at</p> <p>> Think about how to avoid confusion with the campaign aimed at the other community</p> |

Sample answers - 1. The communication strategy that could be used to support CADUCIAN community to vaccination infants (0 to 3 years old)

	Communication Strategy	Further Information	How to Avoid Confusion
A	<ol style="list-style-type: none"> 1. Target mothers: best target to address vaccination of infants 2. Coordinate with clinics that provide vaccination 3. Engage with local leaders to disseminate key messages 	<ol style="list-style-type: none"> 1. Constant surveillance reports about vaccine coverage 2. Capacity search 3. Monitor and evaluate if our message is having the desired impact – it may transpire during the course of the campaign that some messages are not effective 	<ol style="list-style-type: none"> 1. Be clear on age group differences 2. Peer information on how to access services and where to find these services

B	<ol style="list-style-type: none"> 1. Target parents of children who are 0 to 3 years 2. Take into account the care pathway of healthcare facilities 3. Specifically address the community through community media to avoid confusion 	<ol style="list-style-type: none"> 1. Need to know the size of the 0 to 3 years age group in that population 2. Information regarding the healthcare seeking behaviours of this population and whether it differs from ASEFIANS: this includes their culture and beliefs <p><i>*Although this campaign specifically targets children 0 to 3 years, those who are not vaccinated are welcome to attend the clinics. Therefore, it could be used as part of a wider vaccination campaigns.</i></p>	
----------	--	--	--

Sample answers - 2. To support vaccination of 10 to 23 year olds in low-income ASEFIAN community

	Communication Strategy	Further Information	How to Avoid Confusion
A	<ol style="list-style-type: none"> 1. Provide information in schools with facts and information about vaccination and measles. 2. Set up vaccination clinics in schools 	<ol style="list-style-type: none"> 1. Profile on travel patterns 2. Updated surveillance data 3. Information about education level given the low level of health literacy observed among this group 	<ol style="list-style-type: none"> 1. Active information campaigns on social media 2. Actively inform the population about the situation to reduce any panic among this population.
B	<ol style="list-style-type: none"> 1. Need to involve and incentivise the youth associations and schools as well as the Department of Education. 2. Community health volunteers and orient them 3. Combat rumours on social media 4. Buy loud speakers for bikes so that people can hear the messages 	<ol style="list-style-type: none"> 1. Updated epidemiological/ surveillance data 2. Monitor and evaluate the campaign 	<p>Similar to the above</p>

Real-life experiences exchanged

A recent Meningococcal W vaccination campaign in a European country that targeted a specific age group of children:

This campaign caused a lot of confusion - when free vaccinations for children in a specific age range was announced, parents with children of all ages arrived at vaccination clinics asking for the vaccine. The lesson learned from this experience was the importance of appointing one specific person or agency to be the

communication focal point. They must anticipate the questions likely to be asked by health professionals, schools and parents.

Peer-to-peer education: A YouTube movie of a young girl who lost her sister due to meningococcal infection was used and successfully reached groups with lower levels of literacy. This was considered as peer-to-peer education.

The measles outbreak in ASEFIA is contained: time for an After-Action Review

May 2019: Thanks to the efforts of the emergency response team and their risk communication strategy, the measles

outbreak in ASEFIA was brought under control. The emergency is over. It is now time to conduct an After-Action Review.

Decision making-challenge 2.4

The Director of ASEFIA Public Health Agency wants to systematise all the best practice that happened in the emergency – and identify ways to be better prepared for future emergencies. She has asked you to:

- > Propose 4 priority actions to ensure ASEFIA is well prepared to communicate with migrant communities in any future outbreaks or emergencies
- > Briefly describe 4 best practices for emergency risk communication to migrants to go in a Practitioners’ Guide (1 bullet point each)

**Sample answers
PRIORITY ACTIONS**

- > Establish political support
- > [Regular] mapping and analysis of risk groups, audiences, stakeholders, leaders in communities
- > Engage with and build networks with, community leaders and influencers (including community media) in time of ‘peace’ (or non- emergency)
- > Conduct emergency simulation exercises (SIMEXs) on risk communication

- > Emergency risk communication (ERC) training for migrants
- > Develop materials (IECS) for different channels
- > Health literacy programmes for healthcare workers and communities
- > Cultural competency training for healthcare workers
- > Recruit healthcare workers and healthcare intermediaries from migrant communities
- > Build ERC capacity in migrant communities so the community can co-develop health communication and risk communication in future emergencies
- > Build sustainable risk communication and community engagement capacity
- > Establish a dedicated emergency risk communication budget
- > Establish indicators then use them to monitor and evaluate

Best practices for emergency risk communication (ERC) to migrants identified by groups

- 1 Peer-to-peer communication
- 2 Use of visual materials
- 3 Use simple, easy to understand language
- 4 Storytelling and examples from people in community
- 5 Hotline to answer questions
- 6 Face to face communications at places migrants gather (e.g. workplaces, hostels, markets, social activities)
- 7 Pool of translators and interpreters
- 8 Adapt existing materials (remember to pre-test!)
- 9 Use community intermediaries
- 10 Use relevant media (radio, TV etc.) and social media
- 11 Targeted SMS messages
- 12 Strategy for conflict resolution
- 13 Mobilise community groups and networks (women, youth, church/mosque/temple, volunteers etc)
- 14 Incentives (in some situations)
- 15 Engagement and empowerment of community
- 16 Co-design communication materials and campaigns
- 17 Sharing and documenting lessons learned
- 18 Pre-testing of messages
- 19 Ongoing evaluation and monitoring of impact
- 20 Risk communication has a seat at the table in the emergency management team
- 21 Prepare and disseminate (in relevant languages) frequently asked questions (FAQ) documents
- 22 Make use of the literature review on risk communication to migrants available at www.Mdpi.com

Summary & Recommendations

Barriers to effective emergency risk communication with migrants and ethnic minorities

1

Language

2

Culture

3

(Health) Literacy

4

Physical barriers

5Uncertain legal status of migrants
(and sometimes minority communities)**6**Diversity/sub-groups within migrant
/ ethnic minority communities**7**Risk perception among migrant
/ ethnic minority communities**8**Lack of access to information
in host country**9**

Fear of stigma, racism and discrimination

10

Economic barriers / poverty

11Lack of cultural competence
in host-country health system**12**Lack of political will - risk/health
communication to migrants (or ethnic
minorities) not always seen as priority
by host-country health system**13**Migrant health/ethnic minority
health issues can become politicised**14**Migrants often move within
and between countries

Solutions to overcome barriers to effective emergency risk communication/best practices

SOLUTIONS FOR ADDRESSING BARRIERS

- > Understanding perceptions and concerns
- > Culturally and ethically appropriate interventions
- > Engage trusted influencers/health mediators
- > Peer-to-peer communication
- > Use of visual materials
- > Use simple, easy to understand language
- > Story telling & examples from people in community
- > Hotline to answer questions
- > Face to face communication at places migrants gather (e.g. workplaces, hostels, markets, social etc.)
- > Adapt existing materials (remember to pre-test!)
- > Pool of translators and interpreters
- > Prepare and disseminate (in relevant languages) frequently asked questions (FAQ) documents
- > Translation of messages in spoken languages
- > Risk communication has a seat at the table in the emergency management team
- > Strategy for conflict resolution

BEST PRACTICES IN EMERGENCY RISK COMMUNICATION TO MIGRANTS AND ETHNIC MINORITIES

- > Use relevant media (radio, TV etc) and social media
- > Targeted SMS messages
- > Balance between inclusiveness and specificity
- > Communication based on literacy levels (visual, storytelling)
- > Health focused messages (clearing legality concerns)
- > Expression of empathy
- > Mobilise community groups and networks (women, youth, church/mosque/temple, volunteers etc)
- > Incentives (in some situations)
- > Engagement and empowerment of community
- > Co-design communication materials and campaigns
- > Sharing and documenting lessons learned
- > Pre-testing of messages
- > Ongoing evaluation and monitoring of impact
- > Make use of the literature review on risk communication to migrants available at www.Mdpi.com

Recommendations

1

Ensure political support and financial investment across government in communication / engagement with migrant and ethnic minority communities.

2

Embed risk communication targeted to migrants and ethnic minorities into strategic emergency response plans (e.g. specific sections and dedicated resources).

3

Start engaging with migrant and ethnic minority communities in “*peace time*” (i.e. before or between emergencies). In particular, aim to identify and engage with communities’ trusted influencers (peer networks, community leaders, health mediators, healthcare workers, NGOs), and preferred communication channels (e.g. community radio, websites, social media).

4

Know your communities!
Ways to do this include:

- a** Building up knowledge about how migrant/ethnic minority communities seek health information, who they trust on health issues and what their level of health literacy is.
- b** Using formative research (focus groups, intercept interviews, KAP studies) to understand risky behaviours, health beliefs, barriers to prevention in target population.
- c** Establishing mechanisms to rapidly gather data on migrants’ knowledge, attitudes, beliefs, perceptions and practises (so-called KAP factors) in relation to specific health threats.

5

Target both migrant and host communities during health emergencies.

6

Ensure messages are understood by target audiences and are culturally / ethnically appropriate.

7

Monitor risk perceptions among all target audiences for early / pro-active communications.

8

Establish mechanisms for fast-tracked interventions.

9

Develop contingency plans and materials on emergency risk communication to migrants/ethnic minorities and test them through emergency simulation exercises (SIMEXs). Update these plans and materials based on gaps identified in the SIMEXs, and build the needed capacities.

10

Aim to “*co-design*” your risk communication with relevant people (for e.g. peers, influencers) from the community you are targeting.

Special Session: The Ethics of Emergency Risk Communication

Feedback and observations from

Dr Marc GUERRIER / Committee Member, Committee for Ethics and Deontology,
Santé publique France; Medical Doctor and Ethicist

Ethical issues that often arise during disease outbreaks

- > Restrictions on liberty (within country, at borders)
- > Duty to work (e.g. for health workers, essential services, public officials)
- > Duty to comply with mitigation measures (e.g. wear masks, wash hands)
- > Confidentiality/privacy when contact tracking or conducting disease surveillance
- > Vaccination (Who first? What to do about refusal?)
- > Access to care (equal access for all?)
- > Preventing increased discrimination or stigma against the already marginalised (irregular migrants, socially isolated or vulnerable ethnic groups)
- > Triage (who gets treated first at ICU?)
- > Other vulnerable populations or difficult settings (prisons, psychiatric wards, care homes, the elderly)
- > End of life (scarce human resources)
- > Burial practices/handling of corpses (dignity versus disease transmission risks)
- > Medical research (target population, aim, international uptake)
- > Public information/inclusiveness

The Internet is full of useful information regarding ethics in emergency outbreaks, as well as preparedness plans created by groups who incorporated ethical issues/principles into their strategies. It is highlighted that ethical principles are broad and are supposed to be used to respect and promote fundamental values such as:

- Health, liberty and human rights
- Justice and equity
- Efficiency and effectiveness
- Accountability, community professionalism and scientific integrity
- Civic and personal responsibility

These principles may be useful to write down and keep in mind during the planning and preparing for an outbreak or emergency response.

Ethical dilemmas surrounding public health and public health emergencies

During emergency and crisis situations, the rationale behind the tough decisions and actions taken (examples outlined above) must be communicated to the public. For example: why some groups were vaccinated but not others; or why certain burial procedures were put in place. In such instances, it can be useful to refer to legal frameworks and specific laws. It was emphasised that communicating on ethics is a very useful skill.

Trust: It was highlighted that the issues of building trust also come up frequently when developing ethical frameworks for emergency planning and preparedness. Trust cannot easily be built from scratch during an emergency. Having a foundation of trust with communities and groups prior to an emergency is fundamental to having a constructive relationship with them during the emergency.

“What are the public health needs?” is the first question health officials need to ask when an emergency happens. However, this gives rise to additional difficult questions and challenges. For example, having to choose between using limited resources for reinforcing intensive care units in hospitals, or for running emergency vaccination programmes. In order to make such

“life or death” decisions, health officials must look deeper into the question, and the ethical considerations surrounding it, to reach an answer they believe is ethically correct. The theme of this conference - “how do we include migrants and ethnic minorities” brings with it questions on equity, “leaving no one behind”, and inclusiveness.

Ethics and Communication – a Tool to Answer Difficult Questions

The spokespeople and communicators should think about the **importance of integrity as a personal value**, and the value of being a communicator during a crisis - “how will what we say impact and influence our audiences”.

Communicators hold a specific role as **mediators** between medical staff, scientific experts, and government stakeholders. There is a **dialogue between entities which is rarely mutual**. In this instance, communicators must **use ethical principles to aid in this mediatory aspect of their work**.

On the issue of **limited resources**, it is noted that this is not just a problem associated with healthcare but **also for communicators**. If communicators want to communicate risks equitably throughout the population, they must use resources in an equitable way. Ideally, this should mean finding resources to communicate effectively with hard to reach groups such as migrants, ethnic minorities, people who have hearing or visual impairments and the elderly. However, resources are limited, and **choices must be made on who will be targeted by the communication strategy**. Having a **pre-planned decision-making process** that has been agreed on, and tested, prior to the emergency is very helpful for communicators facing these dilemmas.

How to handle different cultural values is always an issue when communicating about ethics. The rationale and ethical values underlying the choices health officials make can be understood in different ways by

different groups. That is because the cultural context and how values are understood or applied can be very different. For example, in the mid-2000s the US federal authorities advised states to develop policies on how to use scarce resources in hospitals intensive care units in the event of a severe influenza pandemic. Despite a supposedly similar ethical framework, states came up with very different policies. Some decided they would treat patients on a “first come, first served” basis. Other States decided to prioritise specific groups such as the young or people with underlying conditions. People may ask how and why such choices were made.

Identifying values, goals, anticipating public health needs, and decision-making processes for risk communication in emergencies take time. They also require a lot of participation from partners and stakeholders to achieve wide acceptance and support. This cannot happen during an outbreak – there is no time. It needs to be done ahead of an emergency. In other words, it is something we need to be doing now.

Ethical frameworks do not give an automatic answer like an algorithm. They just give a starting point for discussion and can provide multiple different answers depending on how they are applied.

Annexes

Joint event

Asia-Europe Foundation
(ASEF)

Santé publique France

ASEM Partners' Guide for Risk Communications for Public Health Emergencies

How Can We Include Migrants and Ethnic Minorities – No One Left Behind –

DAY 1

Wednesday, 10 October 2018

THEME 1

Risk Communications for Public Health
Emergencies (PHE): Including Migrants &
Ethnic Minorities into Risk Communications
– *“No One Left Behind”*

08:30 - 09:00

Registration / (Welcome Desk: 3rd floor)

09:00 - 09:20

Welcome & Opening Remarks

Dr Jean-Claude DESENCLOS / Deputy Director
for Science, Santé publique France / General
Secretary of International Association of
National Public Health Institutes (IANPHI)

Mr Toshihiko HORIUCHI / Minister, Embassy
of Japan in France

Mr SUN Xiangyang / Deputy Executive Director,
Asia-Europe Foundation (ASEF)

09:20 - 15:30

Session I: Understanding Emergency
Risk Communications & its inclusions
of minority groups

09:20 - 10:30

1.1: Keynote Speeches
*“Engaging with Communities and
Communicating Health Risks in a Diverse
Social-Cultural Context”*

Ms Aphaluck BHATIASEVI / World Health
Organization

*“Communicating to, and about, migrants in
Europe: the myths, the barriers and the skills”*
Ms Cristiana SALVI / World Health Organization,
Regional Office for Europe

10:30 - 11:00 / Coffee break

11:00 – 12:30

1.2: What is the reality of risk communications
when it comes to including migrants, ethnic
minorities and temporary residents?

Purpose: This session aims to explore current
situation of risk communications for PHE from
the different perspectives

Panel Discussion:

Dr Dominik ZENNER / International
Organization for Migration

Mr Demos KROUSKOS / Centre for
Culture, Ethnicity and Health, Australia

Ms Mayada BOULOS / Senior Communication
Consultant, Former French Health Minister
Counselor during 2014-2015 Ebola Crisis

12:30 – 13:30 / Lunch Break

13:30 – 15:00

1.3: Including Migrants & Ethnic Minorities
into Risk Communications

Purpose: This session aims to share experience
of including migrants and ethnic minorities into
risk communications before/during/after public
health emergencies

Case Study / Panel Discussion

Dr Pahurat K. TAISUWAN / Ministry of
Public Health, Thailand

Ms Laura WOODWARD / Public Health England
Mr Garry LOW / Ministry of Communication
and Information, Singapore
Ms Sandrine RANDRIAMAMPINANINA
& Ms Cécile ALLAIRE / Santé publique France

15:30 – 16:00

59

2.1: Ice-breaking session & introduction
to the exercise

16:00 – 17:15

2.2: Group Discussion & Feedback to Plenary

17:15 – 17:45

2.3: Special session: the Ethics of
Emergency Risk Communication.

Feedback and observations from
Dr Marc Guerrier, Committee Member,
Committee for Ethics and Deontology at Santé
publique France, Medical Doctor and Ethicist

19:00 / *Gala Dinner*

(Venue: Loft C, level 3, Paris Marriott Rive Gauche
Hotel & Conference Center, Paris 14th district)

15:00 – 15:30 / *Coffee Break*

15:30 – 17:45

Session II: Risk Communication in Action 1
(Emergency Simulation Exercise)

2: Introduction & 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

DAY 2

Thursday, 11 October 2018

THEME 2

How Can We Overcome Challenges of Risk
Communication to Leave No One Behind?

Purpose: Building upon and refining strategies
developed in previous sessions – developing
them into conclusions and recommendations

08:30 - 09:00

Registration / (*Welcome Desk: 3rd floor*)

12:30 – 14:00 / *Lunch Break*

09:00 – 09:30

Day 1 Summary & Re-introduction of Scenario

14:00 – 16:15

Session IV: Conclusions

09:30 – 12:30

Session III: Risk Communication in Action 2
(Emergency Simulation Exercise cont..)

14:00 – 15:15

4.1: Defining Solutions – Summary of the
High-level Meeting & Recommendations on:
“How Can We Include Migrants & Ethnic
Minorities in Risk Communications?”

09:30 – 10:15

3.1: Group Discussion & 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

Purpose: Participants will debate and develop
final consensus on recommendations and
conclusions from the High-level Meeting

15:15 – 15:45 / *Coffee Break*

10:15 - 10:45 / *Coffee Break*

10:45 – 11:30

3.2. Group Discussion & Feedback to Plenary

Purpose: a third and final set of challenges
require a response from participants

15:45 – 16:15

4.2: Statements by Participants

Ms Cristiana SALVI / World Health Organization,
Regional Office for Europe

11:30 – 12:30

3.3. Group Discussion & Feedback to Plenary

16:15 – 16:35 / *Closing Remarks*

Mr SUN Xiangyang / Deputy Executive Director,
Asia-Europe Foundation (ASEF)

Mr David HEARD / Director, Communication
and Dialogue with the Society Department,
Santé publique France

NAME	DESIGNATION	ORGANISATION	COUNTRY
Country Representatives (listed by country in alphabetical order)			
Mr Demos KROUSKOS	Director	Centre for Culture Ethnicity and Health	Australia
Dr Ashish Kumar SAHA	Director, Management Information System	Directorate General of Health Services, Ministry of Health & Family Welfare	Bangladesh
Mr Jan EYCKMANS	Head of Corporate Communication & Spokesperson	Federal Public Service of Health	Belgium
Dr Angel KUNCHEV	Chief State Health Inspector	Ministry of Health	Bulgaria
Dr LY Sovann	Director, Communicable Disease Control Department	Ministry of Health	Cambodia
Dr TENG Srey	Deputy-Director, Communicable Disease Control Department	Ministry of Health	Cambodia
Ms XI Jingjing	Director of General Office	Chinese Center for Disease Control and Prevention	China
Dr ZHANG Yanping	Deputy Director of Public Health Emergency Center	Chinese Center for Disease Control and Prevention	China
Dr Glenn LAVERACK	Honorary Professor, Health Promotion	University of Southern Denmark	Denmark
Mr Andras BANYASZ	Chief Specialist	Health Board of the Republic of Estonia	Estonia
Ms Mayada BOULOS	Senior Communication Consultant, ex French Health Minister's Counselor	HAVAS	France
Dr Patrick BRASSEUR	Director, Communication Department	Directorate General for Health	France
Ms Julie SOMA	Communication Account Director, Crisis Communication	Directorate General for Health	France
Dr Marc GUERRIER	Member of the Committee for Ethics and Deontology	Santé publique France	France
Ms Sandrine RANDRIAMAMPINANINA	Communication Account Director	Santé publique France	France
Ms Cécile ALLAIRE	Accessibility Project Manager	Santé publique France	France
Ms Vanessa LEMOINE	Press Office Manager	Santé publique France	France
Ms Juliane SEIDEL	Epidemiologist	Robert Koch-Institute	Germany
Mr Maurice KELLY	Communications Manager	Health Service Executive	Ireland
Dr Patrizia PARODI	Senior Officer, Directorate General for Health Prevention	Ministry of Health	Italy
Dr Kumiko IGARASHI	Deputy Director, Coordination Office of measures on Emerging Infectious Diseases / Office for pandemic influenza and new infectious Diseases Preparedness and Response	Cabinet Secretariat, Government of Japan	Japan
Dr Tatsuhiro ISOGAI	Director, Infectious Disease Information Surveillance Office, Tuberculosis and Infectious Diseases Control Division Health Service Bureau	Ministry of Health labour and Welfare	Japan
Dr Sisavath SOUTTHANIRAXAY	Deputy Director General, Department of Communicable Diseases Control	Ministry of Health	Lao PDR
Dr Laura PULE	EM doctor, Chief specialist of Department of Disaster medicine preparedness planning and coordination	State Emergency Medical Service	Latvia
Ms Alina ŽILINAITĖ	Public Relations Projects Manager	Ministry of Health	Lithuania
Dr Tanya MELILLO FENECH	Consultant In Public Health, Infectious Diseases and Migrant Health, Infectious Disease - Prevention and Control Unit	Ministry of Health	Malta
Ms Amarjargal TOGOODOI	Public Administration Management Press Officer	Ministry of Health	Mongolia
Dr Kyaw Khine San	Assistant Director, Disaster and Public Health Emergency Response Unit, Department of Public Health	Ministry of Health and Sports	Myanmar
Dr Albert VOLLAARD	Infectious Disease Specialist, National Coordination Center for Infectious Disease Control	National Institute for Public Health and the Environment (RIVM)	Netherlands
Dr Faith ALBERTO	OIC - Director IV	Department of Health	Philippines
Mr Piotr WYSOCKI	Chief Specialist	National AIDS Centre	Poland
Dr Isabel CRAVEIRO	Researcher, Institut of Hygiene and Tropical Medicine	NOVA University of Lisbon	Portugal
Ms Karen TAN	Senior Director, Public Communications Division	Ministry of Communications and Information	Singapore

NAME	DESIGNATION	ORGANISATION	COUNTRY
Country Representatives (listed by country in alphabetical order)			
Mr Gary LOW	Deputy Director, Campaigns and Production Department	Ministry of Communications and Information	Singapore
Ms Nuša KERČ	Senior Communication Officer - Deputy Head of Communication Department	National Institute of Public Health	Slovenia
Dr Fernando SIMÓN SORIA	Director, Coordinating Centre for Health Alerts and Emergencies	Ministry of Health, Consumers and Social Welfare	Spain
Dr Pahurat Kongmuang TAISUWAN	Deputy Director, Bureau of Risk Communication and Health Behaviour Development, Department of Disease Control	Ministry of Public Health	Thailand
Dr Witoon ANANKUL	Director Division of Public Health Emergency Management (DPHEM)	Ministry of Public Health	Thailand
Ms Laura WOODWARD	Senior Communications Manager	Public Health England	United Kingdom
Dr Giri SHANKAR	Professional Lead for Health Protection	Public Health Wales	United Kingdom
Dr NGUYEN Dinh Anh	Director General, Health Communication and Reward Department	Ministry of Health	Viet Nam
International Organisations			
Ms Aphaluck BHATIASEVI	Technical Lead, Social Science Interventions and Risk Communication, WHO Health Emergencies Programme	World Health Organization (WHO)	
Ms Cristiana SALVI	External Relations Manager, Health Emergencies & Communicable Diseases	World Health Organization, Regional Office for Europe (WHO-EURO)	
Dr Dominik ZENNER	Senior Migration Health Advisor EU/EEA/NATO	International Organisation for Migration (IOM)	
Ms Andrea WÜRZ	Expert Communication Capacity Support	European Centre for Disease Prevention and Control (ECDC)	
Dr João RANGEL DE ALMEIDA	Portfolio Development Manager	Wellcome Trust	
Observer			
Dr Mohamed Abdelrahman Yousif NOUR	Public Health Specialist, Health Protection & CDC	Ministry of Public Health	Qatar
Organisers			
Mr SUN Xiangyang	Deputy Executive Director	Asia-Europe Foundation (ASEF)	
Ms Riko KIMOTO	Project Manager, Sustainable Development & Public Health Section	Asia-Europe Foundation (ASEF)	
Ms Trishia OCTAVIANO	Project Executive, Political and Economic Department	Asia-Europe Foundation (ASEF)	
Mr David HEARD	Director, Communication and Dialogue with Society Division	Santé publique France	
Ms Maïka KRACHER-SOLOMON	Communications Account Director, Communication and Dialogue with Society Division	Santé publique France	
Ms Anne ROBION	Head of Institutional Promotion Unit, Communication and Dialogue with Society Division	Santé publique France	
Ms Anne-Catherine VISO	Deputy to the Director of the Science and International Office	Santé publique France	
Facilitators			
Mr Ben DUNCAN		Facilitator	
Prof Ralf REINTJES		Facilitator	
Ms Sinéad WOODS		Facilitator	



10-11 OCTOBER 2018

HIGH-LEVEL MEETING ON RISK COMMUNICATIONS FOR PUBLIC HEALTH EMERGENCY



10-11 OCTOBER 2018, PARIS



10-11 OCTOBER 2018, PARIS

HIGH-LEVEL MEETING ON RISK COMMUNICATIONS FOR PUBLIC HEALTH EMERGENCY



10-11 OCTOBER 2018, PARIS

HIGH-LEVEL MEETING ON RISK COMMUNICATIONS FOR PUBLIC HEALTH EMERGENCY

WELCOME

HIGH-LEVEL MEETING ON RISK COMMUNICATIONS FOR PUBLIC HEALTH EMERGENCY

Dr Pahurat K. TAI SUWAN
Ministry of Public Health,
Thailand

Mr Garry LOW
Ministry of Communication
and Information, Singapore

Ms Laura WOOD
Public Health E

10-11 OCTOBER 2018, PARIS

HIGH-LEVEL MEETING ON RISK COMMUNICATIONS FOR PUBLIC HEALTH EMERGENCY

Mr Demos KROUSKOS
The Centre for Disease
Prevention and Control,
Greece

Ms Mayada BOULLOS
Senior Communication
Consultant

Communication is not a part-time job

Mr David HEARD / *Director, Communication and Dialogue with Society Division, Santé publique France*

Communication is a priority issue in crisis management. It is not something to be started when science is over, it is not something to take into consideration only when people want to know and start to ask. Communication issues are to be considered from the very beginning of an emergency outbreak, and that is the reason why we need a dedicated communication team, with specific attention both to what scientist say, but also to the way it will be understood: the “two-way communication” mentioned by the WHO.

Communication also requires specific skills and specific techniques, which you cannot just “copy/paste” from one situation to another or from one country to another.

You cannot do that either within a specific population, from one target group to another, especially if they have different cultural origins. Of course, preparedness is essential, and of course having a crisis communication protocol ready for use is a great security if you have to face a public health emergency. However, I want to recall the fact that there is no ready-made solution in communication, no universal response. Communicating is fitting a specific message to a specific target in a specific situation. It requires both creativity and a great knowledge of the way the Media works – including the new “social” Media - but also of the beliefs and habits of the population we are targeting.

About the Editor

Mr Demos KROUSKOS

CEO North Richmond Community Health
Director, Centre for Culture Ethnicity and Health,
Australia

Mr KROUSKOS's professional interests include health and cultural diversity; health issues affecting refugees and migrants; improving the health of socially and economically disadvantaged communities; health equity and human rights; health of Aboriginal Australians; the development of ethical health care practice; and improving the consumer experience of healthcare.



About the Organisers

The Asia-Europe Foundation (ASEF) promotes understanding, strengthens relationships and facilitates cooperation among the people, institutions and organisations of Asia and Europe. ASEF enhances dialogue, enables exchanges and encourages collaboration across the thematic areas of culture, education, governance, economy, sustainable development, public health and media.

ASEF is an intergovernmental not-for-profit organisation located in Singapore. Founded in 1997, it is the only institution of the Asia-Europe Meeting (ASEM).

ASEF runs more than 25 projects a year, consisting of around 100 activities, mainly conferences, seminars, workshops, lectures, publications, and online platforms, together with about 150 partner organisations. Each year over 3,000 Asians and Europeans participate in ASEF's activities, and much wider audiences are reached through its various events, networks and web-portals.

For more information, please visit
www.ASEF.org

Santé publique France was created on 27 April 2016 as the national public health agency, resulting from the merging of the French Institute for Public Health Surveillance (InVS), the French Institute for Health Promotion and Health Education (Inpes) and the Establishment for Public Health Emergency Preparedness and Response (Eprus).

Santé publique France serves the population in all aspects of public health based on scientific knowledge, data and information. It supports the government and society in improving the health and well-being of the population. Santé publique France has a population-based approach with the objective of reducing social health inequalities in all areas of public health: infectious diseases, non-communicable diseases, environmental health and occupational health.

For more information, please visit
www.santepubliquefrance.fr