It's such a beautiful sunny day out there and this is such a crowded time of year that we really appreciate you turning out for this the fourth in the series of 4 Voices from the Vanguard lectures.

You know, my partner in crime, Dan Colley, who is the Director of the Center for Tropical and Emerging Global Diseases here at UGA and he is sitting down here in the front row. We really can't thank you enough for your continuing participation in this lecture series. It's been a great reward for us to see you all here and I know some of you have come again and again which is just great.

There are few thank you's that I'd like to issue at this last lecture. First of all, to the Office of the Provost, without whose financial support we wouldn't be able to do this. Franklin College, we appreciate being recognized as a blue card event, which I know brings some of you here to us tonight. I'd like to thank Professor Julie Moore who's Parasites and Plagues course also motivates many of you to join us.

That's a great course. These events do require some technical expertise which is certainly not my area and for that, we owe 2 people from Grady...
College who do this and do it so smoothly. Diane Murray, our Director of External Affairs who is down in the front and Anettra Mapp, the administrator for the Knight Health Programs whose watching from up above. If you would just join me for a minute in thanking them for everything they do. [ Applause ]

I would also like to thank the Grady Ambassadors who time after time hand out the programs and add a note of class to this event. Tonight is really special for me. It brings together two of the world's leading experts on communicating with journalists. I've been in hundreds of press conferences as a reporter, and you know the difference between the good public relations or news office people and the not so good ones. And we have two of the very best with us tonight, not just Dick Thompson, our featured speaker but also Dr. Vicki Freimuth whose going to introduce him. We're so pleased to have Vicki here at UGA. She not only has a deep theoretical and academic background in health and risk communication, but she's walked the walk. She was the Director of the Office of Communications at the Centers for Disease Control during...
The anthrax attacks, during SARS, and she lived through some pretty exciting times there. So, let's get Vicki out here and she'll tell you something about Dick. [Applause]

Vicki Freimuth: Thank you. Since tonight is the last in the series of this year's lectures, I'd really like for us to take a moment to recognize the work of both Pat Thomas and Dan Colley who have been organizing this fascinating series. [Applause] Thank you. I am particularly pleased that tonight the organizers have chosen to include a risk communication expert as one of the featured speakers in this series. Too often, the communication is overlooked in crisis planning, but it's always to thing that gets blamed in the after analysis and I think once people and organizations have been through a crisis they begin to recognize what the important role that communication plays. And we are very fortunate that that field is very well represented by Dick Thompson. His responsibility is truly awesome and this is from someone who felt like her responsibility was awesome, but he
Thompson.txt

must break the bad news about infectious disease to the entire world, which is a very challenging activity.

I first met Dick in 2001, right after he had taken this position at the World Health Organization.

I was, as Pat told you, then Director of Communication at CDC and we were all in the middle of one of the series of crisis, this time it was SARS and I actually didn't know until today that apparently, Dick is credited with coining the label for SARS and I didn't know that until I read it today.

I especially have appreciated since that time the leadership that Dick has shown by gathering many of the risk communication experts across the world and having them develop a set of best practices for outbreak communication. And these practices are being used and disseminated throughout the world.

Before Dick joined WHO, he was a science reporter and war correspondent. He worked for TIME magazine in San Francisco and then in Washington D.C. Dick has a unique perspective of having been a reporter for a major news organization and now the spokesperson for a major international agency.

I am really looking forward...
Please join me in welcoming Dick Thompson.

[Applause]

Dick Thompson: Thank you very much.

See if I can get this off... and turn this on.

Thank you all for coming.

It's after midnight in Geneva, where I live and was until yesterday.

So I needed a little pick me up here.

It's hard to be described as a communication expert, especially a risk communication expert.

I guess that's true, but it also tells you a lot about risk communication experts.

We seem to come from very diverse fields.

There is not the kind of training that we would hope to be in place and that we are all moving for right now.

People learn pretty much as it happens. Just to tell you a little bit about, because I'm supposed to talk about myself.

About how you get to be a risk communication person, my first professional job, one I had for 10 years was as a bartender and I worked in the restaurant business for a long time, sometimes substituting as a cook and I learned something that was really very important as a communicator.
Thompson.txt
<time begin="00:07:13.10"/>And I think it's something that is lost on a lot of communicators. We spend a lot of time thinking about messages, but we don't often think about listening.

So, being a bartender was my first life and let me see if I can make this work. This was my second. I worked with TIME magazine for a very long time. This was actually the last cover I did about the human genome.

I wrote about a book called Volcano Cowboys which I found is not in your bookstore. It's also crossed the one million mark on Amazon, so it may be hard to find anywhere.

I was a bureau chief for TIME in South Asia which meant that I covered a number of conflicts in that area including the fall of Kabul.

I covered several administrations. I worked in the White House a lot, got to fly on both the old and the new Air Force One.

So, I had a broad background as a journalist, and that was my second life. It came to an end in 2001 when my magazine was acquired by America Online and I entered journalism at a time when I thought it was a very robust field, it was driven by ideology.

I went into journalism and...
Thompson.txt

I went into college in 1971 and, in college during the Watergate year, and it was a time of high ideals and noble purpose. I felt that journalism was really an important function in a democracy. I still feel that way. I'm a little sorry about what's happened to it and I think what has happened to it is that it has become much more of a business than it used to be and this has changed the face of journalism. But I was fortunate enough in 2001, when I was offered early retirement to have a friend of mine who worked at the World Health Organization ask if I wanted to come and work for the World Health Organization and without knowing much more about it then it was in Europe, which I thought had a long vacation, short work weeks, and was a pretty comfortable lifestyle because you could get to Paris in three and a half hours. I decided to take that job. And this is what I do now.

The idea of breaking bad news I think is contained in this cartoon. The idea in outbreaks, "as we interrupt this emergency breaking news bulletin with an even scarier emergency breaking news bulletin."
outbreaks of international importance. These are of small localized epidemics of diseases like SARS, Ebola, plague, anthrax, Marburg. Usually they erupt in Africa, parts of Asia. We spend, yeah, I'll get this right soon. We spend a lot of time thinking about what makes outbreaks special and why do they offer such special communication challenges because a number of countries have found it difficult to announce that they have an outbreak. This is the very first step in controlling an outbreak, because if countries don't announce that there is a problem then, we can't really respond. We can't begin even the basic epidemiology. We certainly can't begin responding. We came face to face with this after our experience with China and SARS in which China delayed for such a long time the very fact that they had hundreds and thousands of cases, hundreds and thousands of cases of SARS. So, we wanted to find out what is it about outbreaks that makes it so difficult for countries to talk about. And we looked a long time at these.
Outbreaks have several unique characteristics or so we thought at the time. But these are events that begin and we don’t know where they’re going. They unfold before our eyes.

Is it a single case of anthrax or is it just a first case of anthrax? Is it the first outbreak of Ebola? Is it localized? Is it spread? So, when outbreaks happen we really don’t know the dimensions of the outbreak and it will take sometime before we know that. And there are also unpredictable events.

You can come very close to controlling an outbreak, you can be very confident that it is nearly over and the next thing you know, you have a new outbreak of the same disease 10 miles away. This happened to Toronto. They thought that they had SARS under control in one area, they came to Geneva, asked us to lift a travel ban, we did and then they had another outbreak.

The next two features being unfolding and unpredictable are probably the most important. I’ll show you in a minute, are probably the most important.
when it comes to countries announcing outbreaks because even if they want to announce, they want to know that they have their facts in front of them and you can't know that in the beginning of an outbreak. You cannot know it. And that means that countries have to say, I don't know, but this is where we are at the moment. This is the information we have now. And that's very, very difficult for countries to do for lots of reasons, because behavior plays a key role in transmission, but more importantly, because there are social and economic consequences. And that means political consequences to announcing an outbreak. So, an outbreak isn't just a public health event. It can be an international event. It can be an economic event. It can hurt trade and tourism. how it's seen in the world. And this creates a sense of anxiety in the public and as we've looked at this, what we found was the more important anxiety is response managers. They become very, very anxious and what they try to do
Their communication is to reassure the public. Yes, we're worried about this, but we don't want to create panic. I can't tell you how many times we've heard that we don't want to create panic. So, we are going to mislead the public. We are going to say that we know something. We know the dimensions of the outbreak or we know how to control it, something like that. And then very shortly, it's seen that they don't know how to control it. And so they lose credibility from the start and these are always news worthy events. Very often countries that I deal with, in Africa and Asia, will say they know how to control the press and they do. There's no doubt about it. Unless there's an international event because international events bring in international reporters. And so the normal way that they've been dealing with the press, issuing a statement that may not be right, whatever, this event carried to a new scrutiny. So, this would cause them some problems.

Dick Thompson: Okay, so...
This is where we begin our day in Geneva. This is the outbreak response room. It's called the Strategic Health Operations Center (SHOC) and we actually used to meet in a much smaller, more unpleasant room but after SARS, we were given some money to create something like what they have at the CDC in Atlanta.

Each morning at nine o'clock, disease experts sit around this table and they'll go through the overnight reports of outbreak confirmation, rumors. We'll understand, we'll get a better understanding of where we are with an outbreak. We'll get reports, at least once a year and sometimes twice a year of a smallpox outbreak. Smallpox has been eradicated for 30 years or so. Nevertheless, we keep getting reports. So, what we have to do is to verify the reports and that starts in this room. Each report is assigned to one of the disease experts. They'll contact one of our country offices, they'll ask the Ministry of Health for what's going on, about what's going on. And then we'll begin a process of either assisting the country or discounting it as false rumor.
Thompson.txt

outbreak that we would get. <br/>
<time begin="00:16:39.01"/>We began in early 2005. <br/>
<time begin="00:16:42.17"/>We began hearing reports of a

pneumonic <br/>
plague in a place called Ituri. <br/>
<time begin="00:16:49.86"/>Ituri is up in the northeast

of <br/>
the Democratic Republic of Congo. <br/>
<time begin="00:16:56.44"/>There was a large pit not as

large <br/>
as your stadium but a large pit <br/>
<time begin="00:17:03.66"/>where somebody discovered a
diamond. <br/>
<time begin="00:17:06.36"/>Over night something like

7000 people <br/>
moved into this pit searching for diamonds. <br/>
<time begin="00:17:12.12"/>They're in an area about a

quarter <br/>
of the size of your stadium. <br/>
<time begin="00:17:16.55"/>They're digging around. <br/>
<time begin="00:17:17.86"/>They spend all day in this

pit. <br/>
<time begin="00:17:21.09"/>They are coughing, there is

plague in <br/>
the area and plague gets passed around. <br/>
<time begin="00:17:25.55"/>Now, as soon as it was

confirmed that it <br/>
was plague, 4000 of those people vanished. <br/>
<time begin="00:17:32.47"/>They just went away. <br/>
<time begin="00:17:35.14"/>They disappeared back to

their hometown. <br/>
<time begin="00:17:38.52"/>So, what we had to do was

try <br/>
to try to track down where they'd gone. <br/>
<time begin="00:17:45.39"/>We had to alert people. <br/>
<time begin="00:17:46.33"/>We had to let them know if

they were <br/>
sick that this is what they should do. <br/>
<time begin="00:17:49.80"/>We had to get medicines into

the area. <br/>
<time begin="00:17:51.40"/>So this is a pretty typical

outbreak <br/>
response. Not the typical outbreak response: <br/>
<time begin="00:17:56.44"/>This is a picture of

Uige. <br/>
<time begin="00:17:59.34"/>Uige is in Northern
Angola. <br/>
<time begin="00:18:02.25"/>This is an area that has been pretty much devastated by 25 years of civil war. <br/>
<time begin="00:18:11.73"/>It's close to the border with DRC. <br/>
<time begin="00:18:14.64"/>There is something like 10,000 land mines still in the area. <br/>
<time begin="00:18:23.29"/>In early 2005, we got a report indirectly from an Italian pediatrician, <br/>
<time begin="00:18:31.36"/>there was an Italian NGO working in the area and this woman had a number of children who were dying everyday on her and they were dying with unusual fevers and bleeding. <br/>
<time begin="00:18:47.26"/>She managed to get a sample out. <br/>
<time begin="00:18:50.09"/>It was sent to the CDC where it was confirmed to be Marburg hemorrhagic fever. <br/>
<time begin="00:18:56.99"/>Angola asked for assistance and it's interesting that one of the first types of assistance that they asked for was communication. <br/>
<time begin="00:19:05.93"/>And this is something that happens more and more frequently now. <br/>
<time begin="00:19:09.90"/>They didn't follow much of the advice that we gave them but they recognized right of that they did the communication assistance. <br/>
<time begin="00:19:21.02"/>This is Dr. Pierre Formenty, like many people at WHO, he comes to us from MSF. <br/>
<time begin="00:19:28.32"/>He is probably, I can't think of
anyone else who has more experience in the field dealing with hemorrhagic fevers. He is a father of two and I don't think he spent a Christmas with his family in the last five years because for some reasons, hemorrhagic fevers seemed to erupt in the winter time. So, he is often in the field. He looks a little concerned here but I think he is trying to impress upon these people the importance of wearing this equipment. This is personal protection equipment. Whenever a person is infected with a hemorrhagic fever, they become more infectious, the sicker they get and they are most infectious at the time they die. This is a problem especially for families that go through traditional burials of people because they'd spend a lot of time touching the body and preparing the body for burial. In some cultures in Africa, it is important that everybody who knows this person touches the body because that shows that they didn't place a curse on that person. That wasn't the case in Uige. In Uige there was a ritual pouring of water over the body and then those people attending
the funeral would drink this water, thus, spreading the disease. And this Uige eventually became the largest outbreak of hemorrhagic fever that we'd ever seen. This is what happens in the field.

You see a person here who has just taken a throat swab from, this person just died recently. Canada had set up a mobile field hospital which is probably unique in the world I think because it requires a safety level that is a very high level and it is hard to deploy in the field. So, this person will take a sample, as you'll see the body has to be carefully cared for and especially during burial.

We bring an anthropologist to these kinds of situations so we can understand what the burial rituals are and offer substitutions in areas where people have to touch the body. We can say that the spirit of this person has been transferred to a tree and if you touch the tree it's the same thing. And this actually works. It's a kind of communication.
challenge that, you get a range of communication challenges in my job. Another communication challenge is that these people are wearing white. We didn't realize it at the time, but white is a symbol of witchcraft. And this created a huge problem. The other problem here and we jump ahead is that this is how people would leave the WHO Emergency Center. It was very important that we confirm that everybody had put on their personal protection equipment properly even though it was 105 degrees and that they would be driven out to the site. Actually, it wasn't very long before people started stoning these trucks. And it became very dangerous for them and we had to stop our work and it didn't happen here but in other places hemorrhagic fevers can be very dangerous for healthcare workers, they've actually been killed. And the reason being is that families are encouraged to send their sick loved one to the local hospital. That person would go in the hospital and die. And people naturally start thinking that something is happening in this hospital, it's killing my family, and
the people doing the killing are the people who work there. So, it is not unusual that...

I'm sorry it is unusual but it does happen that people get killed. Healthcare workers are killed during hemorrhagic fever outbreaks. Emotions run very high. This is a new and extremely difficult way, difficult disease that people have. But by listening to what's going on between now I think is extremely important. We can respond to factors that most people would consider irrational and that's an important thing about listening and about communicating. And you often hear things that won't make sense to the technical side. During SARS, a lot of people, especially in Asia started wearing masks. And we were asked to comment about that and I went to our technical group and I said, what do you think about these surgical masks that are open on the side and have cute drawings on the front. Are these actually preventing any illness? The answer was, no certainly not. I mean there's no eyewear. There's nothing. The masks are open. It's not good thing to do and...
so as the sound

technical person following our technical

<time begin="00:25:06.85"/> guidance I went out and said,
you know

you're really not protecting yourself.

<time begin="00:25:12.06"/> I hope I wouldn't do that

again because it was a huge mistake.

What people were saying and what

I wasn't listening to was the fact

to do, but<br/>
I'll talk more about SARS in a minute.

They wanted something to do to protect themselves.

So, once we finally figured out that this kind of scene was frightening the people.

We had them dress in their personal protection equipment outside the home that they were visiting.

So, you would see somebody that looks like your neighbor and you'd see them put this on and things got much better from that point.

Well, things got a little bit better from that point.

There were traditional healers who actually began selling a potion that would protect people from Marburg and if your family member had it and if you thought you had it, you could go to this traditional healer and buy this potion. But the trouble was that in Uige, this isn't true in all of Africa but certainly in this corner of Africa, it was felt that the only good medicine was injected.

So, this potion which I don't
think was helping people very much was given to people with dirty needles. So somebody who is a little sick or may have been infected with Marburg would come along and get his shot of Marburg protection drug and the next person would come along who maybe wasn't infected and they would get a shot in the same needle, and thereby exchanging blood and spreading the disease. This was another communication challenge that we had. I like this picture because I think it shows exactly how the population felt about us for the first three weeks we were there. This little guy was being taken to a hospital. He'd been in contact with Marburg victim and he was being taken for testing. He would be isolated in the hospital and the way he is looking at the WHO worker I think says a lot how they felt about us. This is a bad photograph because this healthcare worker should be better protected. He certainly should be wearing mask. But I think what this says is that in these kinds of situations when a child is crying, very hard to maintain that equipment. This now is...you can see this people
dressed in personal protection equipment. This is now our major concern, a virus H5N1. This is a highly pathogenic avian influenza virus. I spend my life talking about this now and I don’t know if it is actually something that you’ve spent much time thinking about or hearing about but for the last three years we’ve been talking a lot about how this virus is a virus which can ignite the next pandemic. This is a scene that, it’s a picture, a classic picture that usually goes in every pandemic presentation that I’ve been to, anyways. It’s a makeshift hospital from the 1918 Spanish flu pandemic. 1918 was actually the single most deadly infectious disease event in history. For that short of period of time, nothing, not the Black Death, nothing killed more people than this pandemic. And so what we hear a lot now is, you know the pandemic’s coming, the pandemic’s coming, and then they show this picture. This is a huge communication challenge. It’s a communication challenge for us because we really don’t know what the next pandemic would look like. We don’t know how deadly it would be.
We have lots of ideas, we have a couple of nightmares but we don't know when the next pandemic will start. There certainly will be a pandemic. There's no reason to believe that there won't be a pandemic. They've occurred, they've been documented since the 1500s and really there will be another pandemic. We don't know if it'll come from the virus that we're monitoring but this virus has two of the three characteristics of pandemic virus. It jumps from animals to people and it causes severe disease. It causes severe disease because this is a virus entirely new to the human immune system. Should this virus acquire the third characteristic and that is easily moving from one human being to another in the same way that seasonal influenza moves, that would ignite a pandemic. And what that pandemic would look like, nobody can say. Many of you may have lived through one pandemic, the 1968 pandemic. And when you tell that to people at my age, anyways, they will certainly not remember that as a major public health event. That's because fewer than a million people died in that pandemic.
an excess number of deaths worldwide that is. So it was a very, very mild pandemic.

So it was a very, very mild pandemic. Like 1918, but they're certainly not all like 1968, so how do we communicate? How do we talk about what the pandemic that people should prepare for? That nations should prepare for? How do we tell them about what they should prepare for?

And so, this is where I want to jump back to SARS because it was SARS actually that allowed WHO to develop the foundation for how it talks about outbreaks and other public health emergencies. When I came to WHO there was a lot I didn't know, but the most important thing I didn't know was there was no real communication structure. Not, only was there no risk communication structure and there was none.

The new Director General had decided that divisions, departments could have their own communication personnel, although they didn't give them terms of reference so they would know what their job was. And people who were running these departments thought...
that the best communicators were reporters. I don't think that's true.

I think reporters spend most of their careers being used by communicators and so those are the people they should have been hiring. What they went out on hired people like me. And then SARS came along.

This is a sketch of an event that occurred in Hong Kong in February of 2003. A man staying in the Metropole Hotel, he was a physician from the province of Guangdong which is above Hong Kong. He came to this hotel, he stayed one night, he stayed in Room 911 and all of the little figures that you see, the boxes are rooms on that floor, but the figures you see are the people he infected in that one night. The next night he was in a hospital. The night after that he was on a respirator and shortly he died. Nevertheless, these people, very few of them lived in Hong Kong, why would they be there staying?

Traveling. They went to Hanoi, they went to Canada, they went to Singapore. They just started spreading the disease all around and it wasn't very long.
before we had reports of a very large outbreak. We'd actually had reports coming in about this time. We didn't know. Certainly, it took us months to piece together this information, but about this time, we were getting reports into that nine o'clock meeting that I showed you of strange events, strange happenings in Guangdong, the province of Guangdong in southern China. There was a big run on vinegar. Vinegar is thought to be a disinfectant and it's something that the Chinese buy in great quantities when they're concerned about flu or whatever. So, there was a big run on vinegar. We began getting e-mails and SMSs. SMSs are a very important communication tool in Asia, especially in China, about strange infectious disease events. There was one report which turned out to be true of a patient who was transferred from one provincial hospital to a large central hospital. The people who transferred him in that ambulance, the nurse, doctor and driver all became infected and they all died.
So, we'd been picking up these reports. We were asking the Ministry of Health of China about them, and we were not getting any information at all. And then this event happened. We were completely unaware of it until we began getting reports first from Hanoi. One of the people who had gone to the Metropole Hotel, a New York businessman went on to Hanoi, became very sick, and was put in a hospital. He didn't respond to antibiotics and his condition declined. That's when this man in the brown suit, Dr. Carlo Urbani who was our Infectious Disease person in Hanoi, was called to the hospital to look at this guy. He was concerned, very concerned. He looked at the test results. He gathered samples from this person and had them sent again to the US CDC. Dr. Urbani was a very interesting guy. He worked, like a lot of people, he had worked at MSF and he was head of the Italian MSF. He was part of the small group who picked up the Nobel Prize that was awarded MSF I think in 1999. Dr. Urbani became sick.
himself and he would within a month of visiting the hospital he was dead himself.

So shortly after Dr. Urbani was hospitalized, we realized and the government of Vietnam realized that they needed assistance, and so there is a global network that we have at WHO.

It sort of like a group of volunteer fire department people and they work at different institutions all around the world and we can say that we need an epidemiologist who speaks Portuguese for a place like Uige.

This is the team that assembled in Hanoi. This happened at a time when there was a lot of global bitterness about what was going to happen in Iraq. There were arguments in the UN in New York and globally about what was going to happen but this is truly an international team.

We have people from France, here, from Italy, the woman I care for dearly Dr. Eileen Plant is in red and she was the team leader. All of these people received and responded to a notice that said, "We have an outbreak of an unknown disease and it is so infectious that it's claimed our infectious disease expert, and do you mind giving up..."
everything you're doing and going off and responding to this outbreak?"

And we had number of people who replied. And it was a good thing that we have a large number of people who replied because these people all needed to be changed out.

The outbreak went on for such a long time.

This is another spreading event.

And this is an image that actually, I'm not a comfortable flyer and so this is something else that adds to the things I think about when I'm on an airplane.

Anyways, I don't know if you can make it out but the man in red is the person who is infected when he got on this plane.

All the other colors are people who were infected when they disembarked from the plane.

So, this was a spreading event that occurred on an airline.

This too, actually there is another story about this and that is that one of the people on this airplane was a Chinese official.

He became somewhat sick, but he goes on to a meeting in Bangkok.

This is a flight from Hong Kong to Beijing.

This person goes on to Bangkok shortly after this flight and on the flight back, he seats next to an (ILO) International Labor Organization official.
and he infects him and that person dies. So, this is what we think about when we think about disease spreading events. When we think about how H5N1 would spread we think about situations like this, the Hotel Metropole and this Air China flight. Actually, SARS was not that easily spread. It was what we call short distance droplet, so, about three feet or so, two, three feet. If you are in coughing range you might become infected and that's why a lot of hospital healthcare workers became infected because they worked around patients often without protection. Pandemic influenza will spread in an entirely different way. It'll be much easier to spread. Many people in this room would become infected if I were infected. It isn't just three feet away. It is a much greater distance. There is an argument there. It's unclear what that distance is and what the spread is like but it's certainly spread much easier. So, when we think about how a pandemic virus would spread, we have an indication...
of how it might spread from these spreading events but it would be much more severe. So, the life as a communicator during an outbreak is well, especially a global health event. In journalism they say if you go to work in public relations like I did, I left journalism and I became a flack for the World Health Organization, they call that crossing the street. At least they used to call it crossing the street. You work on the other side of the street. I don't think that's right, you work on the other side of the wall. because it's very hard to see what's going on. I realize now that a lot of what I did as a reporter was a gross approximation to what was going on. If I worked very, very hard on something as I did with the Clinton Healthcare Plan, I worked three months inside the White House while they were developing that plan. It's still an approximation. But what you don't know is on the other side of that wall that's also an approximation of what's going on. They don't know, they've got
an idea, they may have, they certainly have a better idea than any reporter would have

but there are lots of things they don't know, nevertheless, we began getting hundreds of calls, hundreds and literally thousands of e-mails. So, I was pretty much alone and we went out and I made a case for hiring another person. So, we doubled our communications staff and very quickly learned that there's no way we can respond to this. I was taking calls at three a.m. from reporters in Hong Kong and they would go right on through into midnight or later from reporters in Toronto or on the East Coast. It just kept going on and on and on initially, I thought it's important to respond to as many people as possible, big mistake, but I thought that what we should do is just be out there and answer every question so we can answer questions. The problem is that you just physically can't do that so we have to develop a couple of ways of responding to questions. We developed a web update in which we thought we were hearing the same questions over and over, so we would do a web update the following day answering those questions and that went out everyday. We also developed something
we called a virtual press conference which is something else we've stole from CDC and that is because Geneva is actually in a little remote corner of Europe, it isn't a big news hub. We set up a way for reporters to call in and we had a video feed going out and radio quality sound and we would sit down for an hour or 45 minutes usually, the best expert that we could find on our team who had some time to talk and that usually no one really had any time because we were all working very long hours, we were working everyday, seven days a week. We had this emotional blow over losing Carlo Urbani. We didn't really know, is this just the beginning? It seems to be limited to hospitals but then there was an apartment building in Hong Kong, Amoy Gardens, where a number of people were infected as the virus changed. So, there were lots of things that kept us on edge. It was a very, very tense time but one of the interesting things is that there were no big shouting matches inside, internally. There was a lot of pressure, there were certainly a lot of emotion, but it didn't spill out. Actually, it did when it was
over and it was a kind of unpleasant for a while but during that time, people just kept working.

Our lead influenza person, Dr. Klaus Stohr, his mother became very sick. She was taken to the hospital. She lingered in the hospital and she eventually died. Our lead influenza person, Dr. Klaus Stohr, his mother became very sick. She was taken to the hospital. She lingered in the hospital and she eventually died. He never attended the funeral. He didn't go to the hospital. I think that's the most extreme example of personal pressure but there was a lot of personal pressure on this very small team. I heard that CDC at that time had something like 33 communication people working, is that right?

We had 42 people in our entire group, we counted everybody. We had 42 people so it was a lot of work for a lot of people. I heard that CDC at that time had something like 33 communication people working, is that right? Something like that? We had 42 people in our entire group, we counted everybody. We had 42 people so it was a lot of work for a lot of people. I heard that CDC at that time had something like 33 communication people working, is that right?

One of the things we wanted to know was how honest should we be? I felt that we were doing great work. We were small team working hard and I thought all we had to do was throw the door open, allow people to come in, say what we thought at the time, just to be a good
<time begin="00:47:19.98"/><clear/>And one spokesperson at WHO
<time begin="00:47:25.43"/><clear/>It ran worldwide, said
"people are not responding to antibiotics and antivirals,"
<time begin="00:47:31.10"/><clear/>it's a highly contagious
disease and it's moving by jet, until we can get a grip on it.
<time begin="00:47:36.42"/><clear/>I don't see how it will slow down.
<time begin="00:47:38.76"/><clear/>It's bad." I think that now
is not a very good quote and why isn't it good?
<time begin="00:47:52.78"/><clear/>I think it is accurate, it's how I felt, that's me.
<time begin="00:47:58.44"/><clear/>It's how I felt, <time begin="00:48:00.79"/><clear/>It's how many of us
felt. <time begin="00:48:03.31"/><clear/>We were very, very anxious
about this. <time begin="00:48:06.20"/><clear/>I think what's wrong with
this quote is the line I don't see how it will slow down.<nolabel/><time begin="00:48:11.62"/><clear/>And I would not say that
again because I do know how things slow down now.
<time begin="00:48:18.61"/><clear/>This is just a lack of experience.
<time begin="00:48:21.78"/><clear/>The other outbreaks I showed
you, <time begin="00:48:28.78"/><clear/>and the Marburg in Uige, they
all used the same basic techniques of contact tracing.
<time begin="00:48:37.54"/><clear/>Isolating people, pretty rudimentary stuff, but it works.
<time begin="00:48:44.70"/><clear/>And it worked for SARS and it
worked for those other diseases as well.
<time begin="00:48:48.32"/><clear/>How am I doing? <time begin="00:48:49.40"/><clear/>Not too well.
<time begin="00:48:50.09"/><clear/>Okay, so after SARS, we
developed.
we decided that we better have a more solid intellectual foundation for what we were going to say with our communication and we developed something I'm very proud of, although I played a minor role in it, and that was to develop outbreak communication best practices. We spent a year going through the literature and we found what we thought were five important features that influence communication during an outbreak. We took those five features to a meeting of 85 outbreak managers that we brought together in Singapore and we asked them to look at these features and get their feedback. They endorsed these features and now these are what we're telling countries, this is the guidance that we're giving countries about how to communicate during outbreaks. And it is interesting, the number one feature, the over-arching communication goal during an outbreak is to communicate with the public in ways that build, maintain or restore trust. I thought the outbreak managers themselves would not agree with that. But as you saw in Uige, you have to be able...
Thompson.txt
to listen to people, to build their trust,<br/>
so they'll actually do what you say<br/>
they endorsed this trust feature.<br/>
This first announcement is something<br/>
that troubles a lot of countries.<br/>
We encourage them to go out as rapidly as possible.<br/>
It is very difficult to do because the information at the beginning of an outbreak is uncertain,
it's incomplete. They're very likely to be wrong.<br/>
New York, when it announced West Nile virus said that this was St. Louis encephalitis.<br/>
And they were wrong about it but they were right about how it was transmitted and so going out early allowed people to take measures that protected them. Even though they were wrong they did the right thing.<br/>
We encourage transparency that communication should be "easily understood," complete and free of deceit. That's an important phrase and very difficult for some countries to do.<br/>
We now call listening, surveillance because it sounds technical<br/>
and all of this has to be planned in advance.<br/>Essentially, and what I don't tell people is
that this is all adds up to tell the truth as fast as you can and
then listen to what people say. This is my boss now, Margaret Chan.
Margaret was Head of the Hong Kong Department of Health during the first H5N1 outbreak in 1997. And she and I have talked a long time about how we communicate about the pandemic, and the best thing we can say is that, we don’t know. We’ve gone three years now without a pandemic that we’ve been warning about, is this Y2K of public health? The answer is we don’t know. When is the next pandemic going to start? How bad is it going to be? We don’t know. It’s the most honest answer we can give. It is unsatisfactory, but that’s where we are. This slide is supposed to tell you that we’ve been teaching countries to follow these best practices and actually Egypt is one of the best countries to employ this. Egypt has a very, very bad problem with H5N1 now. It actually had a cluster cases of a Tamiflu resistant and that’s the only drug really
that works against the H5N1.<br />
People actually developed a resistance to this drug and it was very difficult position for Egypt to talk about because Egypt is especially dependent on tourism. So, to talk about having the next pandemic in your country and that it's now resistant to Tamiflu is very difficult for them to do and nevertheless they've done it. I put this up because I think it's the best example of country using outbreak communication techniques right now, but the same time I've worked with a government in Africa that had a hemorrhagic fever outbreak, was in a meeting with the Ministry of Public Health in which they had planned in detail how to get rid of the bodies using the military to move bodies and bury them in the middle of the night so that people wouldn't be afraid and panic. So, we're making some advances but you move ahead and you slip back. As I was preparing for this, I read through again, Carlo Urbani, The Viet Nam Journal, and in it he writes that "the joys of life: to savour what each horizon brings, to offer this to your children, to get excited with new discoveries, to rejoice in sharing. This fills my heart with energy and..."
allows for the work that one does to improve some small corner of the world. This is productive.

More than worrying about how much I will earn, I will worry about how well I work in the movement towards poverty alleviation and the access to health care for the forgotten." And that's Carlo.