

Risk Communication Strategy

for Public Health Emergencies
in the WHO South-East Asia Region

2019–2023



World Health
Organization

REGIONAL OFFICE FOR

South-East Asia

Risk Communication Strategy

for Public Health Emergencies
in the WHO South-East Asia Region

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Foreword



Risk communication plays a critical role in preserving health, protecting dignity and saving lives during acute public health events. When emergency strikes, rumours or fake news have immense potential to create panic and distrust in affected communities, and in doing so, to impede public health interventions. Risk communication is therefore the bridge between health actors and the public during emergencies and is one of the core capacities identified in the International Health Regulations (IHR) (2005).

The importance of effective risk communication has been demonstrated in recent global emergencies, from the Ebola outbreak in West Africa in 2014-15 to the 2018 Nipah virus outbreak in Kerala, India, and the ongoing Rohingya humanitarian emergency in Bangladesh. This is with good reason. In an emergency, creating public awareness is not enough. Awareness must spur action. To bring that about, an understanding of the needs and perceptions of affected communities, and the factors influencing and driving their behaviour, is required to communicate to and motivate them accordingly.

Also critical is the timeliness of risk communication, especially to mitigate rumours and counter false information and fake news. To this end, having risk communication systems and plans in place as an integral part of emergency preparedness is crucial. To facilitate this, the IHR joint external evaluation (IHR-JEE) guidelines identify five areas of risk communication: risk communication systems; partner coordination; public communication; community engagement and perception; and risky behaviour and misinformation. Member States must build capacity in each of these areas.

In Member States across the WHO South-East Asia Region, risk communication capacities have been evaluated either as part of IHR-JEEs or through mechanisms such as after-action reviews following emergencies. The findings from these evaluations have formed the basis of the “Regional Risk Communication Strategy for Public Health Emergencies 2019–2023”. As the following pages outline, this Strategy is intended to guide national risk communication action plans to strengthen national capacities. The goal here is “Five in Five”: to achieve adequate capacity for risk communication in the five key areas, in five years, as part of the steps taken to scale up national emergency preparedness. In facilitating this, the following document will lead to a stronger, safer Region.

A handwritten signature in blue ink, reading "P. Khetrpal".

Dr Poonam Khetrpal Singh
Regional Director
WHO South-East Asia Region

Glossary of terms

Community: A group of people, often living in a defined geographical area, who may share a common culture, values and norms, and are arranged in a social structure according to relationships that have developed over a period of time

Community engagement: The process by which community-based organizations and individuals build a long-term relationship with collective vision for the benefit of the community.

Communication: Imparting or exchanging of information by speaking, writing or using some other medium.

Crisis communication: Communication required to minimize the impact of a crisis – for example, an unexpected or threatening event – in order to ensure the situation gets better or does not worsen.

Emergency: An event or threat that produces or has the potential to produce a range of consequences that require urgent, coordinated action.

Emergency preparedness: Knowledge, capacities and organizational systems developed by governments, response and recovery organizations, communities and individuals to effectively anticipate, respond to and recover from the impact of likely, imminent, emerging or current emergencies.

Emergency risk communication (ERC): An intervention performed not just during but also before (as part of preparedness activities) and after (to support recovery) the emergency phase, to enable everyone at risk to take informed decisions to protect themselves, their families and communities against threats to survival, health and well-being.

Epidemic: Occurrence in a community or region of cases of an illness, specific health-related behaviour or other health-related events clearly in excess of normal expectancy. The community or region and the period in which the cases occur are specified precisely. The number of cases indicating the presence of an epidemic varies according to the agent, size and type of population exposed, previous experience or lack of exposure to the disease, and time and place of occurrence.

Hazard: A possible threat or source of exposure to injury, harm or loss – for example, conflict or certain natural phenomena.

Pandemic: An epidemic occurring worldwide, or over a very wide area, crossing international boundaries, and usually affecting a large number of people.

Risk: Combination of the probability of an event and its consequences. Risk results from interactions between natural and human-induced hazards, vulnerability, exposure and capacities.

Risk communication: Real-time exchange of information, advice and opinions – between experts, community leaders or officials and the people who are at risk – that is integral to any emergency response.

Executive summary

Emergencies are unpredictable and often devastating. A range of factors, including geographical and socioeconomic situations, make Member States of the WHO South-East Asia Region vulnerable to public health emergencies. Successful implementation of public health interventions, which are essential for preventing and mitigating emergencies, will occur only if the public understands the necessary interventions in their own context and are convinced of and adhere to these. In our digital hyperconnected age, the instant spread of fake news and rumours increases the challenge.

The public and the affected community are equal partners in an emergency. Risk communication forms the bridge that connects public health and the public, and works to convince people to act to reduce the risk in an emergency, taking into consideration their needs, perceptions, traditions and cultures. It is a core capacity under the International Health Regulations (IHR) (2005), and all Member States are obliged to strengthen their risk communication capacities.

Some key concepts that make risk communication work are as follows:

- Perceptions of risk, rather than technical assessment of risk, motivate people's action. Perceptions of risk are usually emotion-based and influenced by local and cultural factors.
- People understand according to their own experiences. Risk communication must be contextual.
- Human beings often display "herd behaviour" and follow leaders in an emergency. It is important to engage the right leaders and influencers in a community.
- Behaviour change for uptake of public health interventions is a process. It requires multiple ways of communication, repeated strategically multiple times, from multiple sources.
- In an emergency, people are in a state of fear and do not always think rationally. Thus, risk communication needs to appeal to the heart and instinct.

The five WHO risk communication principles – trust, transparency, announcing early, listening and planning – incorporate those concepts.

Situation analysis of risk communication in the Region

An analysis of evaluations of risk communication in the five areas identified by the IHR joint external evaluation (IHR-JEE) tool – risk communication systems; internal and partner coordination; public communication (including media communication); community engagement; and addressing perceptions, risky behaviour and misinformation – revealed the following:

1. Risk communication systems need to be in place in all Member States. These include an all-hazards risk communication plan, a risk communication function and focal point in

all Ministries of Health. Member States have limited technical and financial resources in this area, and these need to be strengthened.

2. Cross-agency coordination of communication is seen as a strength in at least four Member States, and most have some mechanism of coordination in place. However, more proactive engagement is needed with all stakeholders and with local governments.
3. Public communication, particularly media communication is strong in most Member States, with media spokespersons appointed. However, targeted and strategic communication based on an understanding of audience needs could be strengthened. All Member States need to strengthen social media communication. Communication impact also needs to be evaluated.
4. All Member States have strong systems in place for community engagement, with networks of community health workers and volunteers. They also have strong relationships with local community leaders, including religious leaders. They need to be trained in risk communication for public health emergencies .
5. As Internet and mobile penetration increases in the Region, rumours, fake news and misinformation can go viral and spread in minutes. Standard operating procedures (SOPs) for monitoring rumours and fake news, public perceptions and concerns, and proactive mitigation measures need to be in place in most Member States, along with the budget and resources.

Five in Five: The Regional Risk Communication Strategy

The Regional Risk Communication Strategy aims to strengthen capacity in the five areas of risk communication in five years (2019–2023). Each Member State is unique and national risk communication plans will need to take the specific needs of that Member State into consideration, but this Strategy provides a framework and guide to shape the national plans.

1. Develop a risk communication structure for public health emergencies in all Member States.

Member States are encouraged to have a risk communication structure in place, comprising a risk communication unit (depending on the country size and resources), a plan that is regularly reviewed and updated, and adequate financing and human resources. WHO will support Member States to develop a national risk communication plan and SOPs, and to build capacity.

2. Ensure that mechanisms are in place at the regional, national and local levels so that all voices are consistent and coordinated in public health emergency preparedness and response.

This can be achieved if Member States map all stakeholders and their roles in emergencies, have SOPs for stakeholders' functions and a coordination plan. WHO can provide support through tools and templates for partner coordination, and dissemination of lessons from emergencies across the world.

3. Ensure strengthened regional and national capacity for proactive, dynamic public communication to address public perceptions and concerns.

Public communication can be strengthened by having SOPs in Member States on media and social media, an identified media spokesperson, as well as regular sensitization of the media on key public health emergency issues. WHO can support Member States to develop tools and templates for mapping, a repository of risk communication material and templates, and capacity-building.

4. Develop systems and processes to ensure that community perceptions and concerns are understood and integrated into public health emergency considerations.

Member States already have networks of community health workers and volunteers in place and their risk communication capacity needs to be strengthened and integrated into regular work. To ensure optimal engagement, community-based organizations and their roles need to be mapped. Doctors are trusted by communities and can be trained in risk communication. Mapping and sensitization of community influencers is also needed. WHO can provide support by documenting and disseminating lessons learnt from the Region and beyond, identifying and engaging regional-level influencers, developing tools and regionwide capacity for community engagement and social science interventions.

5. Ensure adequate and sustained capacity to **anticipate and combat fake news**, rumours and **misinformation** during public health emergencies.

Combating fake news and misinformation in real time is critical. Member States should have an effective plan and system for monitoring, analysing and responding to rumours and fake news such as hotlines and regular media and social media analysis. WHO can provide support through regional social media maps, tools and guides, and by disseminating global evidence and best practices on fighting fake news and misinformation.

Cross-cutting regional role for WHO: The five prongs

Risk communication for public health emergencies is a common need across all Member States and there are many common challenges. The WHO Regional Office for South-East Asia can play a crucial role in strengthening risk communication across the Region by:

1. creating awareness of and advocating for the importance of risk communication. Sensitize decision-makers on emergency risk communication, and mobilize resources for risk communication for public health emergencies;
2. providing technical support to Member States. Develop risk communication templates and support for capacity-building and surge capacity, as well as for monitoring and evaluation;
3. enhancing risk communication in the Region. Build a regional pool of emergency risk communication experts; develop a course/module on emergency risk communication;
4. developing tools, guides and resources. Develop tools and guides for risk communication needs, including for monitoring and evaluation;

5. developing and disseminating evidence, research and documentation. Document best practices and innovations in the Region for each of the risk communication pillars, commission research on the spread of fake news in public health emergencies and develop tools to help Member States build capacity in the different areas of risk communication.

Monitoring and evaluation

A monitoring and evaluation framework is being built into the risk communication strategy, with regional five-year indicators.

Conclusion

In summary, risk communication is a continuous and inclusive process that requires listening and building platforms for dialogue. Importantly, it requires leadership and support from the top levels of government.

Introduction

1.

Why risk communication is needed in public health emergencies

A rapidly changing world – presenting with unprecedented human population growth, urbanization, climate change, ecological changes, increasing human-animal proximity, some negative effects of new technologies and other factors – has led to an increased frequency of emergencies, including public health emergencies, in recent decades. The WHO South-East Asia Region is particularly vulnerable to both geophysical and biological hazards, with over 900 disasters recorded in the past decade, or an average of one natural or man-made disaster every four days. Such emergencies have caused tens of thousands of deaths, and economic losses totalling billions of dollars.

Emergencies are unpredictable and often devastating. The extent to which emergencies, particularly public health emergencies, can be prevented or mitigated depends on geographical conditions as well as the socioeconomic, cultural and political situations in which they occur. The active involvement of the people affected, therefore, is core to emergency preparedness and mitigation.

WHO's Strategic Framework for Emergency Preparedness notes that "community members are the first responders – and the first victims – of any emergency and, as such, essential members of the preparedness process". If people are aware of what they need to do, and if they are convinced and find it convenient to do so, their actions will reduce the impact of the emergency. However, if people do not follow evidence-based public health interventions – whether handwashing; or burying the dead only with appropriate protection, in cases of viral diseases such as Ebola – the emergency is likely to escalate.

How people behave tends to determine the course of a public health emergency. Indeed, there have been cases reported, such as during the Ebola outbreak of 2014 in West Africa, where the community has been so hostile to responders that other public health interventions could not even begin till risk communicators engaged with the community and won their trust.

Risk communication and community engagement is, therefore, a critical public health intervention. It is a core pillar of the International Health Regulations (2005), which all WHO Member States have endorsed and with which they are legally mandated to comply. Risk communication can be considered a global public good, as it is an intervention that saves lives.

Making risk communication work in emergencies

Risk communication in public health emergencies, according to WHO, is real-time exchange of information, advice and opinions between experts and officials or people who face a hazard (related to health, economic or social well-being) or threat to their survival, so that they are motivated towards appropriate action to protect themselves and others.

Communicating about risk in emergency situations is complex and challenging. It constantly evolves, as society and technology for social outreach evolve. Some of the key concepts for successful risk communication are described below:

6. Perceptions of risk, rather than assessed technical risk, drive human action. Risk Communication needs to address that perception

Risk perception among the public differs from risk perception among experts. Experts are analytical and view risk as high when there is a high probability of death/disability, financial or political loss. Public perception of risk is far broader and emotion-based. It commonly takes into account three broad factors: “dread” (the gut-level, emotional reaction to the risk), “familiarity” (whether it is an old or new risk) and “number of people exposed to the risk”. To ordinary people, perceived risk is as real and important in decision-making as assessed risk is to experts. It is perceived risk to which people will react.

Public perceptions of risk	
Less concerned about health risks that are	More concerned about health risks that are
Voluntary (e.g., smoking)	Involuntary (e.g., exposure to pollution)
Familiar	Unfamiliar
Controllable	Uncontrollable
Controlled by self	Controlled by others
Just	Unjust
Chronic	Acute
Diffused	Focused in time and space
Not fatal	Fatal

7. People understand according to their own experience. *Risk communication has to be contextual*

Human brains interpret messages they receive according to their experiences. These can be very different from what those who sent the message intended. Therefore, it is important that all risk communication messages are contextual, and are being understood as intended.

A person's environment and past experiences shape his/her understanding of risk, and what is acceptable and what is not. Most people also follow peers and influential people and social/cultural norms, because they like to "fit in". Another factor that drives behaviour is convenience. On the other hand, anything perceived as leading to loss of dignity or reputation will discourage action, even though it might be materially beneficial.

8. People display "herd behaviour". *engaging the right leaders and influencers in a community is important.*

Risk communication attempts to reduce risk by convincing the public to take up appropriate health interventions. Evidence shows, however, that adoption of a new idea, behaviour or intervention does not happen simultaneously. Some people are more apt to adopt the innovation; others wait and watch, and decide after positive feedback from early adopters. Therefore, risk communication should target the influencers in order to drive action in the entire community.

9. Behaviour change for public health intervention uptake is a process, not an event. *It requires multiple ways of communication, repeated strategically multiple times, from multiple sources.*

The purpose of risk communication is to inform the public about risks so that they can take informed decisions about preventive and protective behaviours, e.g., handwashing to prevent the spread of a virus. However, in individuals, uptake of new ideas is a process covering many stages¹

¹ Based on Stages of Change Model (Prochaska and DiClemente , 1977, 2014)



10. In an emergency, people are not rational, so risk communication needs to appeal to the heart and instinct

In an emergency or stress situation, human beings are primed for survival. They are usually aggressive, or panicky and ready to run – a “fight or flight” situation. In this state, it is difficult to absorb complex new information. Therefore, messages need to be simple, emotional and repeated, usually through a trusted source.

The hazard-outrage ratio: Strategies for four risk communication scenarios

Understanding public perception is critical for effective risk communication. It can be argued that the role of public health emergency risk communication is to communicate to the public in ways such that its (the public’s) perception of risk changes to approximate that of the experts.²

² Based on the risk perception theory proposed by behavioural scientist Paul Slovic.

International risk communication specialist Mr Peter Sandman condenses public risk as a function of hazard and outrage (people's perception of risk). He proposes strategies for four scenarios:

- ⦿ **Precaution advocacy:** When hazard is high and outrage is low, the task is alerting insufficiently upset people to serious risks.
- ⦿ **Outrage management:** When hazard is low and outrage is high, the task is reassuring and calming excessively upset people about small risks.
- ⦿ **Crisis communication:** When hazard is high and outrage is also high, the task is helping appropriately upset people cope with serious risks with the message 'We'll get through this together'.
- ⦿ **'Sweet spot':** When hazard and outrage are both intermediate; this is a safe situation but **dialogue** with people should continue

Public perception of risk in SARS (2003)

- ⦿ 8096 cases , 774 deaths globally
 - ⦿ Global economic cost estimated at US\$ 30–US\$ 100 billion
 - ⦿ Approximately US\$ 3–US\$ 10 million per case
 - ⦿ Indirect cost solely driven by public perception of the risk of being infected. Industries such as tourism, which support many livelihoods, crashed.
 - ⦿ Stigma also reported as some newspapers in Europe portrayed it as an 'Asian' disease.
- 

WHO risk communication principles

Based on the evidence and factors that influence risk communication, WHO has developed five key “Risk Communication Principles”:

Principle	Description
Trust	Creating and maintaining trust is the bedrock of risk communication in emergencies. Emergencies are periods of high emotion and uncertainty, and in such situations, people tend to follow sources they trust. People trust those who they feel are credible – people they love, people and experts they respect, people who in their past experience or in their environment have proven to “do good”. It is critical to note that trust, once lost, is difficult to regain.
Transparency	Transparency in communication is essential for building trust, and even more essential for not losing trust. This includes conveying uncertainty and not concealing negative information. Conveying information in a transparent yet convincing manner that does not create panic requires risk communication skill and expertise.
Announcing Early	Early announcement of an emergency and dissemination of available information, even if incomplete, creates public confidence in the authorities, and builds trust. In a 24x7 hyperconnected world, the speed of announcement is also critical to prevent the spread of rumours. Dissemination of information from multiple sources, therefore, further reinforces messages.
Listening	Listening and understanding public perception forms the basis of a risk communication strategy. Information needs to address public fears and concerns, and be projected in a manner that the public and stakeholders see as relevant to their lives. Listening also enables early identification of rumours and misinformation.
Planning	An emergency is usually unpredictable, and when it occurs immediate action needs to be taken. Planning, building capacity, engaging with communities and the media, and establishing systems and structures, need to be done before an emergency actually happens.

Analysis of the risk communication situation in the SEA Region

The countries in the South-East Asia Region vary widely in terms of their geography, economy and degree of vulnerability to hazards. This is also a Region of huge social and cultural diversity, with communities of thousands of different ethnicities, each with their own traditions and beliefs, over 1000 different languages spoken, and various ways of receiving and responding to information about emergencies. All of these factors influence the risk of hazards, and affect the impact of risk communication in public health emergencies.

Previous emergencies, whether in the Region or elsewhere, have pointed to the criticality of the five pillars on which effective risk communication and community engagement stand. These five pillars form the basis of the International Health Regulations (IHR) 2005 External Evaluation for countries. They are:

1. Risk communication system
2. Internal and partner coordination
3. Public communication for emergencies
4. Communication engagement with affected communities
5. Addressing perceptions, risky behaviours and misinformation.

Reviews from past pandemics

Reviews of the response to the last influenza pandemic, the 2009 A(H1N1) pandemic, in various countries highlighted the need for the following:

- ◉ A systematic, coordinated approach to risk communication
- ◉ Good planning and resources
- ◉ Effective listening and understanding of risk perceptions

- ◉ Targeted messages to vulnerable populations based on community perceptions
- ◉ Key role of community health volunteers as a trusted source for risk communication.

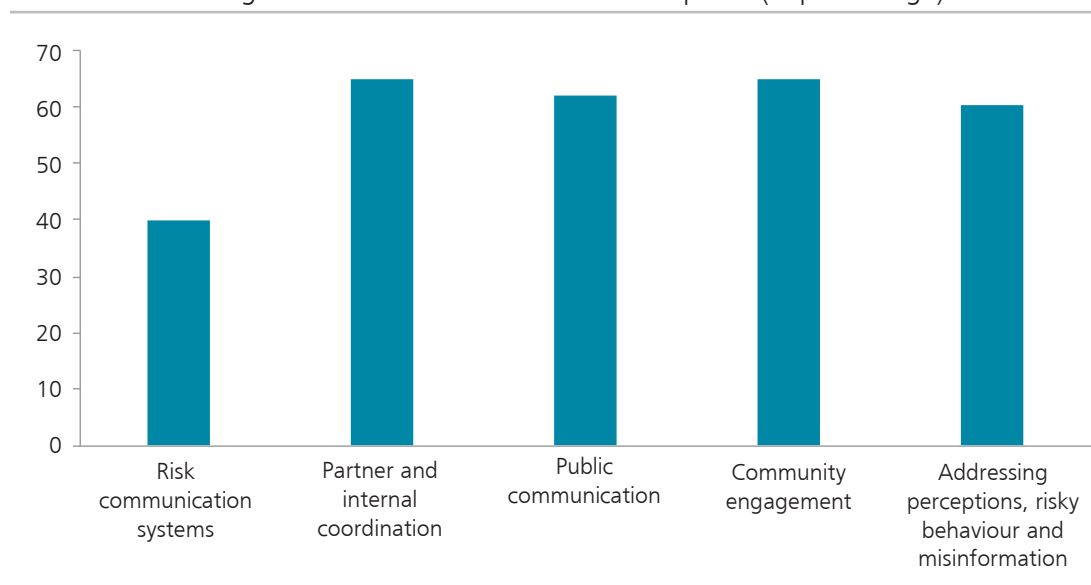
These volunteers form a critical bridge between authorities and the affected community. They have a dual role: conveying and explaining community perceptions to the authorities; and communicating risk to the community.

Situation analysis from IHR monitoring and evaluation

This situation analysis is based on information obtained from the following: State Party Annual Reporting (SPAR) on risk communication; the results of the joint external evaluations (JEEs) in those countries that participated; and inputs from IHR national focal points and risk communication experts³.

Eight countries participated in the JEE. Their risk communication capacities varied widely. However, it was apparent that the weakest area across the Region was risk communication systems.

Average JEE scores in risk communication pillars (in percentage)



³ Participants at the Regional Workshop of IHR National Focal Points, New Delhi, India, 25–29 March 2019.

Risk communication systems and structure

Only one country in the Region, Thailand, has all of the following: a **dedicated national risk communication unit** for public health emergencies; an all-hazards **risk communication plan**, complete with a **chain of command** right to the local level; **staff** with **defined responsibilities**; as well as a **dedicated budget**. Most countries do not have a dedicated risk communication unit or dedicated risk communication staff for public health emergencies, or an overarching approach to activities across all risk communication pillars.

Strengths

- ◉ All countries have media units in different government departments, which may coordinate with their ministries of communication/information during an emergency.
- ◉ Most countries have a health promotion unit within the Ministry of Health. It tends to work across a range of health issues, and not specifically emergencies. Usually the health promotion unit is separate from the media unit.
- ◉ Most countries have risk communication plans for specific diseases but not an all-hazards plan.

Gaps/challenges for most countries

- ◉ The need to develop an integrated, multihazard risk communication plan, test it, and regularly update it.
- ◉ A risk communication function and focal point in all ministries of health, with specific terms of reference (the role is different from that of a media spokesperson).
- ◉ Technical and financial resources in this area need to be strengthened.
- ◉ More training needs to be given on risk communication for health personnel and an increase in the number of emergency communication specialists at all levels.

Internal and partner coordination

The JEE reports indicate internal and partner coordination is strong in most countries of the Region.

Strengths

- ◉ At least four countries have mentioned cross-agency communication coordination as their strength, with both formal and informal mechanisms in place, and with emphasis on emergency response frameworks and plans.
- ◉ Two countries have even tested communication coordination in simulation exercises.
- ◉ Some mechanisms of communication coordination among different agencies are in place, such as websites and text message/WhatsApp groups.

Gaps/challenges for most countries

- ◉ More proactive engagement with all stakeholders, with SOPs that define communication roles and responsibilities for partners, and to strengthen coordination and collaboration across sectors is needed.
- ◉ Early warning and information systems are currently managed separately by each agency. This needs to be done together.
- ◉ Strengthened stakeholder mapping and engagement and coordination, beyond government agencies, to include civil society organizations, private sector companies and other non-state actors is needed.
- ◉ Coordination with local government needs to be enhanced in many countries.

Public communication

Traditionally, risk communication for public health emergencies had primarily emphasized public communication. Not surprisingly, this area is strong across the Region. Public communication involves communication through mass media, whether through announcements in the news, or information campaigns using posters, radio and TV spots, social media, and other means.

Strengths

- ◉ Almost all countries in the Region have trained media spokespersons. Many have dedicated communication units in the Ministry of Health or in other government departments such as the Prime Minister's Office. Such communication units also have responsibility for communicating on health emergencies.
- ◉ The communication units generally have strong relationships with the media at the national level, and streamlined ways to reach out in emergencies.

- ◉ A majority of the ministries of health in Member States of the SEA Region are active on social media, with a dedicated website, handle or page through which information on risks of public health emergencies is communicated. Even so, the level of activity varies widely.
- ◉ Proactive pre-emergency preparedness messaging is reported from most countries during seasonal emergencies such as dengue outbreaks, floods and seasonal influenza outbreaks.
- ◉ Senior leaders and spokespersons participate in trainings regularly to refresh their media skills.
- ◉ Journalists are sensitized regularly in most countries on issues of public health importance.

Gaps/challenges in most countries:

- ◉ Communication strategies need to be tailored to wide and different audiences. The WHO South-East Asia Region is one of the most populated and culturally, linguistically, religiously and ethnically diverse regions, and effective communication needs to consider all these factors.
- ◉ There is a need to evaluate public communication, and have evidence-based communication conveyed in a way that will lead to behaviour change.
- ◉ Use of social media needs to be strengthened and made more effective. This requires an understanding of the nuances of social media, including which type is most popular with which group; how messages are most effectively portrayed on different platforms; and also the timing of each message on each media platform. Social media needs proactive and appropriate communication.
- ◉ Trainings on public communication need to be strategic and systematic, and conducted regularly.
- ◉ A vital need identified across the Region is to strengthen monitoring and evaluation of the impact of public health emergency communication.
- ◉ Sensitization of journalists on the nuances of public health issues needs to be frequent as there is often a high turnover.

Community engagement

Strengths:

- ◉ All externally-evaluated SEA Region countries report strong systems in place for community engagement.
- ◉ All countries have a network of community health workers and health volunteers. They are usually associated with the health promotion unit in the Ministry of Health. Noteworthy examples of country-specific initiatives include in-service training on risk communication skills for community health workers in Sri Lanka; and the Indonesian initiative of “Disaster Alert Villages” (Kampung Siaga Bencana), where community areas are prepared to undertake all aspects of community-based disaster management, including risk communication.
- ◉ Many countries also have MoUs signed with civil society and community-based organizations for implementation of a range of public health initiatives, including risk communication for public health emergencies.
- ◉ Community engagement networks are strong. Community health workers (CHWs) and community health volunteers (CHVs) have strong relationships with the communities they serve, as well as engage frequently with community leaders, including religious leaders.

Gaps/challenges in most countries:

- ◉ CHWs and CHVs usually focus on regular health issues such as maternal and child health. Their role and skills for communicating risk in public health emergencies – when the situation is developing rapidly, communities are in a state of fear and have to be convinced to act quickly – needs to be strengthened.
- ◉ Resources and capacities are needed for community engagement and communication, especially at the local level. So is more training in community engagement and communication for medical professionals.
- ◉ Evaluation tools are needed for risk communication for community engagement. An evaluation/feedback system from affected communities, incorporated into the risk communication strategy, would help in engagement with those communities.

Addressing perceptions, risky behaviours and misinformation

Public health emergency practitioners find themselves fighting two outbreaks – one of the disease and one of rumours and misinformation. With increasing mobile and Internet penetration in the Region, rumours spread in minutes to a wide audience. Addressing perceptions, risky behaviours and misinformation is an increasingly important pillar of risk communication in public health emergencies.

Strengths:

- Indonesia and Thailand have rumour monitoring systems in place, with SOPs and dedicated staff for monitoring media, social media and public opinion and perceptions for rumours.
- Indonesia has pioneered a “Turn Back Hoax” programme, with a dedicated website for the public to report rumours and have rumours clarified.
- Most countries have hotlines during emergencies to inform the public and in turn collect public feedback.
- Ministries of Health of most countries have a strong media presence, although the level of systematic analysis of public response on those platforms varies.

Gaps/challenges in most countries:

- Most countries do not have a system to proactively mitigate rumours at an early stage except by issuing media statements.
- While hotlines serve to inform the public, they are not always fully functional.
- Countries do not always have the resources and capacity, both financial and human, to analyse public perceptions that can be gathered from calls to the hotline.
- Media monitoring to identify or respond to rumours and misinformation needs to be strengthened in order to respond to rumours on time.
- Health professionals, including doctors, nurses and community health workers and volunteers, are trusted sources on health whom people go to for advice and clarification when there is uncertainty, such as in emergency situations. However, in a majority of countries training on monitoring and dispelling rumours and on risk communication skills has not been imparted to health professionals.
- At the provincial and local levels, adequate numbers of suitably trained public and community risk communication staff need to be available.

Information sources trusted by the public

To achieve risk communication goals and make an impact, it is critical to know which sources of information people use and which they trust or prefer. The public gets information primarily from traditional media, social media and from community health workers, with mid-media (such as local street plays, theatre groups, films) also having an impact on specific issues at the local level.

Sources of information about health

While there is no published data specifically on information sources for public health emergencies in the WHO South-East Asia Region, various surveys provide indications of trusted sources of health information.

The three preferred and most trusted sources for general health information are:

- ◉ medical doctors
- ◉ word-of-mouth information through friends and family
- ◉ television.

Media landscape in the 11 countries of the South-East Asia Region

Media, including social media, is very influential, but its reach is nevertheless limited. In countries such as Myanmar, Nepal and Timor-Leste, 30%–50% of men and women do not regularly access any form of mass media, including television, newspaper and radio. The Region is steeped in rich cultural traditions, and the community plays a very important role in how information is obtained and perceived by people.

General sources of information:

- ◉ **Television:** It is the most popular source of information, particularly in urban areas, with three quarters of the population watching television at least once a week in Bangladesh, India, Indonesia, Maldives, Sri Lanka and Thailand. It is less popular in Nepal and Timor-Leste. There is also an urban-rural differential.
- ◉ **Radio:** Radio has extensive reach in countries of the Region, particularly in rural areas where it is a very important source of information.

- ◉ **Newspapers:** Newspaper consumption is limited to the literate population and varies in range and reach in different countries. India has among the highest levels of newspaper reach, at 39% (2019). In Maldives, all newspapers are only available in digital format (apps and websites) with only one outlet producing printed newspapers, and that is also available in e-format on their website.
- ◉ **Mobile phones, Internet and social media:** Mobile phone ownership and use is high (above 80%) in most SEA Region countries. In Indonesia, for example, as many as 91% of the population owns a mobile phone. Mobile phones are more commonly used in urban rather than rural areas. With cheaper smartphones and mobile data, Internet penetration is deepening. On average, approximately 50% of the population in the SEA Region has access to the Internet, and this is growing rapidly, especially among the young. Social media use is also on the rise – while Facebook and WhatsApp are the most popular, other platforms are also important. Instagram is rising in popularity among the youth. In Thailand, the Japanese brand “Line” is popular, while in the Maldives, “Viber” is commonly used. Twitter remains a favourite with public figures, policy-makers and journalists.
- ◉ **Community health workers and volunteers:** All countries of the Region have cadres of community health workers and volunteers. They usually have access to villages and households, and are critical for direct community engagement and mobilization. They play a crucial role in preventing or responding to emergencies. This is especially among hard-to-access populations or in “media-dark” areas, such as remote rural regions, and with poorer or socially excluded groups.

Lessons learnt from recent emergencies

Lessons documented on risk communication from public health emergencies globally can help the SEA Region strengthen its risk communication response. A synthesis of evidence from documented lessons from emergencies across the world, such as the A(H1N1) pandemic of 2009, the Ebola outbreak in West Africa in 2014, and the MERS-CoV outbreak in the Republic of Korea in 2015, and the WHO guidelines on risk communication, “Communicating Risk in Public Health Emergencies” is presented below.

1. Planning is critical and so is context

Effective strategic communication planning begins much before a crisis. It involves a number of steps, including creating a strategy and framework for communicating with all stakeholders; training communications personnel; creating a network of partners with defined roles and responsibilities; and securing funding. Strategic planning efforts must take into account the role of culture in preparation and response. This helps contextualize efforts to meet the needs of diverse populations. A critical lesson is that a “one size fits all” approach does not work.

2. Engaging communities – creating ownership

Analysis of documented evidence strongly underlines the importance of engaging local communities in effective emergency communication, from engaging with and building on local leadership and organizational structures to using local staff, communication patterns, networks and languages; and to tailoring interventions for local communities. Communities need to be involved in processes well before the emergency occurs, so that they own the process – from initial assessment to intervention implementation and evaluation.

Community engagement and building trust work together. Local leaders play a vital role in building trust and engaging the community; this has been reported during the Ebola response and polio eradication programmes. However, not all “locals” have an equal trust-building effect. As was reported during the West African Ebola virus disease outbreak, people did not trust some of the leaders or influencers paid and engaged for the task, and later volunteers were used to address this issue.

3. Building trust

Higher trust in the ability of public officials and governments to respond to a public health emergency is associated with a greater likelihood of recommended actions being adopted. If people think a system is unlikely to help them, they will not use it. Disrespectful treatment of people by health-care workers erodes trust.

Several factors predict a higher level of trust, including:

- organizational reputation,
- quality of stakeholder relationships,
- acknowledging uncertainty in messages,
- being transparent and not concealing negative information,

- fairness in the treatment of populations,
- speedily disseminating information and intervening,
- preventing dissemination of conflicting information by different agencies, and
- seeking inputs from the public and encouraging participatory dialogue and community involvement in pre-event planning and exercises as well as in the design and testing of communication plans.

4. Coordination and information sharing

Coordination and information sharing between agencies and government units is important in emergency risk communication. Risk communication efforts are more likely to be effective when a strong working relationship between different teams and responders has existed prior to an emergency incident. The presence of a designated risk communication officer/unit often improves information sharing. It is also important to address technology gaps in resource-poor areas, integrate nongovernmental organizations (NGOs) into the emergency management information system, and develop capacity to monitor and use relevant social media apps.

5. Proactive social media usage

With its explosive growth in the Region, social media is a key source of information and perception forming. Social and traditional media need to be part of an integrated strategy with other forms of communication to achieve convergence of verified, accurate information. Social media may be used to engage the public; facilitate peer-to-peer communication; create situational awareness; monitor and respond to rumours, public reactions and concerns during an emergency; and facilitate local-level responses. Social media is also used as a disease- and rumour-surveillance tool.

One study found that 87% of doctors in Brazil use WhatsApp to communicate with patients, one of the highest such rates in the world. In West Africa, chat apps, especially WhatsApp, were considered better than text messaging/SMS because they are cheaper.

In the United States, during the Zika outbreak most people received information from TV, radio, social media and blogs. Even so, Centers for Diseases Control (CDC) Atlanta, and family doctors were considered the most credible sources. Studies have demonstrated that people who used government sources or conventional media for health information were more likely to be knowledgeable about Zika than those who relied on friends, family or social media.

6. Media to be made a partner in protecting people

The media has the power to shape public discourse on outbreaks and emergencies. Hence it is important for emergency responders to collaborate with the media in emergencies. For this, they need to develop robust relationships and agree on common goals in risk communication. It is strongly recommended that public health officials and the government engage in pre-crisis planning and communication training with the media prior to any new outbreaks.

Forging ahead: The regional strategy to build risk communication capacity

Vision

The South-East Asia Region will have sustainable capacity in risk communication and will reach a state of readiness to respond effectively to a public health emergency.

Goal: Five by five

In five years, sustainable and dynamic risk communication systems are established at the national level in all countries for public health emergencies, with dedicated risk communication professionals, tools and budgets, through the five pillars of risk communication:

1. Risk communication structures
2. Internal and partner coordination
3. Public communication
4. Community engagement
5. Listening and fake news and misinformation management.

The power of five

The **five pillars of the Regional Risk Communication Strategy** mirror the **five areas identified in IHR** for risk communication capacity-building, to be

achieved in **five years**. Capacity needs to be built in the preparedness phase of an emergency, to achieve readiness for response.

1. Risk communication structure for public health emergencies in all countries

Lessons learnt from public health emergencies have revealed the critical importance of having a risk communication structure in place. Risk communication is essential for public “buy-in” and action towards interventions that will prevent or mitigate the risks. However, a unit is needed to take ownership of and lead the strategy for risk communication and ensure that it is coordinated and effective.

Role for Member States

- ◉ A risk communication unit within the Ministry of Health is important. This unit would have expertise in the various areas of risk communication, such as media and social media specialists, social anthropologist/sociologist, video/photo specialist, design specialist, etc. These areas of expertise are currently often found in a media unit, and in the health promotion unit. A combination of expertise from these units is needed for effective risk communication.
- ◉ An all-hazards risk communication strategic plan and SOP is also needed under the umbrella of the National Action Plan for Health Security (NAHPS).
- ◉ To implement the plan, a dedicated budget for risk communication is essential.
- ◉ Before developing a national plan, capacity mapping and stakeholder mapping for risk communication is essential.
- ◉ This system will therefore comprise a risk communication unit, a plan that is regularly reviewed and updated, a multisectoral risk communication taskforce with adequate financing and human resources, and SOPs.
- ◉ Evidence reviews show that the development of laws, regulations, policies and frameworks in support of emergency risk communication helps in ensuring effective emergency risk communication.
- ◉ Risk communication capacity needs to be developed among epidemiologists and other public health experts. Evidence shows there is high trust among the public for doctors, medical professionals, and community health workers. This trust needs to be leveraged through risk communication training, so that these professionals provide timely and accurate information on risks.

Role for WHO

- ◉ Support Member States in the development of a national risk communication plan and SOPs.
- ◉ Support Member States in national-level capacity-building for risk communication.
- ◉ Develop training modules and partner with suitable institutions and establish regular training courses to build a pool of experts for risk communication in public health emergencies in the Region. These experts could be deployed for surge capacity.
- ◉ Advocate with donors for more resources to establish risk communication systems.

2. Ensure mechanisms are in place at the Regional, national and local levels so that all voices are consistent and coordinated in public health emergency preparedness and response

An emergency is a dynamic, fast-changing situation. It involves many organizations at various levels, each with different priorities to communicate. To the person on the ground, however, this means a bewildering variety of messages, and information that is sometimes contradictory. This can be confusing at best, and arouse suspicions about their veracity at worst. Therefore, coordination of communication is important. This also leads to better response overall.

Role for Member States

- ◉ Map all stakeholders in the emergency and their role, including all “Partners” – agencies or organizations that have a working relationship with the nodal national outbreak management agency (usually the Ministry of Health) and are actively involved in planning or implementing a response.
- ◉ Standard operating procedures (SOPs) of stakeholders’ functions and a coordination plan to understand how, when and where they communicate with each other.
- ◉ Establish a national task force on risk communication, involving all stakeholders as well as members of other task forces, to plan and integrate risk communication into each area of the response. The nature of relationships that exist between organizations often has an impact on the organizations’ ability to manage the emergency.
- ◉ Plan for coordinating resource sharing to optimize impact.

Role for WHO

- ◉ Develop templates for SOPs for effective partner coordination.
- ◉ Regularly disseminate lessons learnt from emergencies across the world on ways to improve partner coordination.
- ◉ As the lead for the health sector, play a coordinating role in strengthening relations with other communication partners and stakeholders.

3. Ensure strengthened Regional and national capacity for proactive, dynamic public communication, to address public perceptions and concerns

Public communication can be broadly defined as information to and from the public, made available through a variety of channels. Public communication for emergencies consists of five parts:

1. Listening to and understanding public perceptions, concerns and fears.
2. Developing messages that address those perceptions and concerns.
3. Identifying appropriate channels through which those messages can be disseminated, including news media through press conferences and press releases, public service announcements and advertisements, posters, and other means.
4. Managing communication through social media channels not only for disseminating information but also for actively listening and responding to public concerns and quelling rumours.
5. Designating, training and supporting credible and effective spokesperson/s who will be the face of the nodal agency and the task force, and provide regular updates to ensure transparent communication and build public trust.

Role for Member States

- ◉ Map how different audiences get their information according to geography, income, literacy level, gender and other parameters.
- ◉ Develop a media/social media strategy.
- ◉ Identify spokespersons.
- ◉ Have dedicated social media staff or ongoing access to an external resource.
- ◉ Have a system for regular media and social media monitoring.

Case: Multiple communication channels used for Zika virus-related communication in Brazil

In Brazil, the Ministry of Health (MoH) and UNICEF used multiple channels including mass media, interpersonal communication, community stakeholders, and social media to reach out to different audience groups and influence behaviour change around Zika and vector control. MoH, different states and large municipalities developed and disseminated a high number of TV and radio spots, and posters with creative solutions. Radio spots were created using the voice of an actor popular in regions with high prevalence of Zika.

Government health community agents conducted interpersonal communication during routine home visits. Through its existing “Seal of Approval” platform, UNICEF mobilized municipalities and trained local-level stakeholders on a series of actions (including presentations in associations, educational walks, collective cleaning, education-entertainment in schools, and outreach to community networks). Communication materials were disseminated to 1700 out of around 5500 municipalities in the country. The MoH and UNICEF also used social media channels like Facebook, Twitter, Instagram and YouTube to inform the public and dispel rumours.

- ◉ Have ready message themes based on evidence, for common emergencies.
- ◉ Sensitize the media to develop media capacity for public health emergencies.
- ◉ Sensitize senior media decision-makers on the importance of public health emergencies and the socio-economic impact.

Role for WHO

- ◉ Develop media maps for the Region.
- ◉ Support Member States in developing a media and social media strategy for public health emergencies.
- ◉ Develop key message map templates for priority emerging infectious diseases and health aspects that may occur in natural and humanitarian emergencies.

- ◉ Develop a repository of communication material templates that can be adapted by any country to its context for public health emergencies.
- ◉ Conduct spokesperson trainings for senior health officials across the Region.
- ◉ Conduct regular trainings to sensitize media in the Region on issues and nuances of public health emergencies.
- ◉ Develop templates and SOPs for effective use of social media by Member States.

4. Develop systems and processes to ensure that community perceptions and concerns are understood and *integrated* into public health emergency considerations

It is community-level action that determines how effectively an emergency can be managed. WHO defines community engagement as “the process by which community-based organizations and individuals build a long-term relationship with collective vision for the benefit of the community”. Community engagement is a sustainable mechanism as it empowers local people with the knowledge, skills, capabilities and social capital networks to not only contain current emergencies but also prevent and respond to future risks.

Community engagement has been a critical method in health promotion and an integral part of disease control, such as TB or HIV/AIDS or smallpox elimination, but it has not been used systematically and effectively for emergency preparedness and response.

Case: Involving faith-based leaders in H1N1 response in Bangladesh

During the H1N1 outbreak in Bangladesh in 2009, UNICEF partnered with the Religious Ministry’s faith-based organization, and conducted a national conference and subsequent training of trainers programme for imams (religious leaders). The national conference was inaugurated by the Prime Minister and attended by 2500 imams. Over a period of 3–4 years, these trainers went on to train other imams at the upazilla (sub-district) level. In collaboration with the National Institute of Mass Communication, UNICEF produced a television programme for imams that was broadcast every Thursday evening on the state-owned TV channel *BTV*. Imams would interact with the general public the next day during Friday prayers at mosques, using instructional materials (sermon booklets) provided to them.

Community mobilization efforts need to be led by a partnership between local government authorities and local community leaders. Once built and sufficiently strong, this relationship can be employed to respond to multiple types of hazards. Such voluntary mechanisms can be especially effective in low-resource settings where health departments and municipal bodies may be short-staffed or have limited funding.

Role for Member States

- ◉ Map community-based organizations and their roles.
- ◉ Identify influencers or influencer groups for each community, sensitize them to public health emergencies.
- ◉ Build risk communication capacity of community health workers and volunteers and integrate it into their regular work with communities.
- ◉ Develop capacity for clinicians at the local level to communicate risk.
- ◉ Developing a system through which views of community health workers on community needs and fears are captured.
- ◉ Integrating these views into risk communication as well as wider emergency responses.

Role for WHO

- ◉ Document lessons learnt and best practices and innovative ideas for effectively engaging communities.
- ◉ Develop tools and supporting Member States in sensitization of community leaders on public health emergencies.
- ◉ Identify, engage and sensitize Regional-level influencers on public health emergencies.
- ◉ Develop regionwide capacity for community engagement and social science interventions through trainings such as WHO-Socialnet.

5. Ensure adequate and sustained capacity to anticipate and combat fake news, rumours, and misinformation in public health emergencies

A rumour is defined by the Merriam-Webster Dictionary as “talk or opinion widely distributed with no discernable source; a statement or current report without known authority for its truth”. It may arise from misunderstanding of a situation, which “mutates” and changes as it spreads, or be a deliberate falsehood. It can spread by word of mouth, by traditional

news media, or social media. Rumour management involves understanding the nature and content of circulating rumours, ascertaining their veracity and addressing them appropriately so that they may not cause harm to the population during emergencies.

Technology has blurred the lines between real and fake news. Fake news goes viral within seconds, and studies show that people are three times more likely to spread fake news than the truth on social media platforms like Twitter. In this situation, monitoring public perceptions, through regular and social media, as well as qualitative inputs from key informants, provide ways to identify rumours. Mitigation of rumours and fake news, therefore, requires the following steps:

1. Constant rumour and communication surveillance to pick up signals of fake news or myths and misinformation.
2. Proactive sharing of facts.
3. Constant engagement with both the primary audience and the secondary audience, through virtual and face-to-face means.

Role for Member States

- ◉ Establish relations between community workers, influencers, and others.
- ◉ Establish a system for rumour tracking and analysis through:
 - ◉ regular media and social media monitoring
 - ◉ a hotline
 - ◉ web/mobile phone-based rumour tracking mechanism
 - ◉ community-based networks and CHWs capturing rumours.
- ◉ Plan for rumour management
- ◉ Respond promptly to rumours, with facts and through multiple channels by multiple trusted and credible sources:
 - ◉ have SOPs in place
 - ◉ identify and train trusted persons and influencers to respond
 - ◉ identify channels for response.

Role for WHO

- ◉ Develop regional social media mapping

- ◉ Develop SOPS and templates for planning for and establishing communication surveillance systems that will monitor and analyse public concerns, fake news and misinformation in public health emergencies.
- ◉ Develop tools and guides to support Member States in surveillance and analysis of fake news and misinformation.
- ◉ Develop regional resources and expertise on social media surveillance and analysis of fake news related to public health emergencies.
- ◉ Conduct research on common/frequently heard myths and rumours that circulate in the Region.
- ◉ Disseminate global evidence and best practices on fighting fake news and misinformation and adaptation of those learnings/tools and techniques for public health emergencies.

Case: Dynamic listening in action: using social media to listen to the public concerns around Zika in Brazil

In Brazil, the Ministry of Health and UN and other partner agencies used social media to listen to the public and to place interactive content to influence behaviour change. They analysed what people and social media users in the Latin American region were discussing with respect to Zika virus disease, vectors, mosquitoes, dengue and chikungunya. A daily social media report was created.

This assessment provided insights into public perceptions and also highlighted rumours. For instance, in February 2016, a misconception that vaccines for chickenpox and rubella were to blame for the increase in cases of microcephaly was making rounds on social media in Brazil. Another rumour was that a larvicide, not the mosquito-borne Zika virus, was to blame for a surge in cases of the birth defects known as microcephaly. It was widespread on Facebook and Twitter in Brazil and abroad. This misinformation was also posted by a popular American actor on his Twitter account and retweeted by his followers. The Brazilian government used its official press statement, Facebook and Twitter accounts to quickly respond and counter these rumours. A further social media analysis was conducted for the different countries in Latin (South) America.

4.

Cross-cutting regional role for WHO – the five prongs

Risk communication for public health emergencies is a common priority need across all countries in the Region. There are also many common challenges. By sharing experiences, countries in the Region can learn from one another. The WHO Regional Office for South-East Asia has an important role to play in strengthening risk communication across the Region, and this section elucidates this role.

1. Create awareness and advocacy on the importance of risk communication

- ◉ Develop an advocacy plan and advocacy products on the critical need for risk communication to achieve other public health goals in emergencies
- ◉ Advocate to donors on enhanced support for risk communication
- ◉ Sensitize decision-makers on risk communication at high-level meetings such as the Regional Committee sessions.
- ◉ Sensitize emergency decision-makers on risk communication.
- ◉ Conduct risk communication workshops for leaders and Incident Managers.

2. Provide technical support to Member States

- ◉ Develop templates and SOPs for each of the pillars that Member States can adapt.
- ◉ Support Member States as needed, particularly in:
 - ◉ development of national risk communication plans
 - ◉ capacity-building of national risk communication experts
 - ◉ surge capacity during an emergency
 - ◉ monitoring and evaluation of impact of risk communication activities.

3. Enhance risk communication capacity in the region

- ◉ Build a pool of experts for surge through a Regional emergency risk communication deployment training and Simex.

- ◉ Develop a course/module on risk communication for public health emergencies
- ◉ Develop and maintain a risk communication/social science network as part of IHR Knowledge Network
- ◉ Facilitate trainings across the Region to build risk communication skills of doctors and health professionals
- ◉ Include risk communication as a core component of public health courses
- ◉ Facilitate inter-country exchanges so that countries in the Region can learn from each other's experiences
- ◉ Conduct a regional simulation exercise for risk communication in public health emergencies.

4. Develop tools, guides and resources

- ◉ Develop tools and guides for risk communication needs, such as effective partner coordination; mapping stakeholders
- ◉ Develop tools, guides and SOPs on conducting communication surveillance – monitoring and analysing public fears and concerns, and fake news and misinformation
- ◉ Develop tools for monitoring and evaluation of the impact of risk communication plans and activities
- ◉ Develop resources on public health emergencies that can be accessed by the media and public

5. Develop and disseminate evidence, research, and documentation

- ◉ Document best practices and innovations in the Region for each of the risk communication pillars.
- ◉ Document common beliefs and perceptions related to public health emergencies in countries.
- ◉ Commission research on how rumours spread in public health emergencies in the context of South-East Asia, including identification of common pathways and trigger points.
- ◉ Publish findings to share SEA Region experiences and evidence with the global community.
- ◉ Develop tools to help countries build capacity in different areas of risk communication.

An all-hazards approach to risk communication

WHO's Strategic Framework for Emergency Preparedness identified two broad categories of emergencies:

1. Emergencies due to natural hazards.
2. Emergencies due to human-induced hazards.

Emergencies due to natural hazards are further classified into:

- a. Biological hazards (local and national outbreaks and pandemics).
- b. Emergencies due to hydrometeorological and geophysical hazards. These include earthquakes, volcanic eruptions, tsunamis, floods, cyclones.

Emergencies due to human-induced hazards are further classified into:

- a. Technological hazards. These include oil spills, chemical and radioactive spills.
- b. Societal hazards. These include social upheavals such as humanitarian crises.

Each of these is a unique situation, with unique public health needs and, therefore, unique risk communication objectives and actions. The following risk communication approaches are suggested when an emergency occurs.

Risk communication strategy for each type of emergency

Natural hazards: Biological

Situation: A regional and national disease outbreak of communicable disease is likely to be an outbreak that both health officials and the public are familiar with and have experience of – for example, a dengue or diarrhoeal outbreak. As such the public, while worried, is less likely to panic. However, people are likely to follow traditional beliefs and remedies.

In this situation basic prevention interventions will be known, and messages and communication strategies that have been successful in the past would have been documented.

Strategy: The strategy will aim to limit the spread of the outbreak. The risk communication response needs to be very swift, and seek to create awareness, get people to take up preventive action, and prevent rumours, as well as encourage those who are sick to seek treatment.

Natural hazards: Biological (pandemic or pathogen with pandemic potential)

Situation: Outbreaks of pathogens with pandemic potential are likely to be of emerging or re-emerging diseases that could spread rapidly across borders and have high mortality and morbidity. There is likely to be limited knowledge about the infection and its spread. Public cooperation will be needed to ensure it does not spread to other countries and become a pandemic. A pandemic of this nature brings fear, widespread panic and great uncertainty. It is large and global in scope. Therefore, communication needs to have a national as well as international focus.

Strategy: An initial rapid assessment for risk perception in the affected community, public and the media will provide intelligence on how the public sees this outbreak. If awareness of the outbreak and perception of risk is lower than it should be, then a communication strategy should be designed to instigate appropriate fear and concern to motivate people to act. If risk perception is too high and people are panicking, then communication should focus on means to restore calm among the public.

In such situations, it would help to have two parallel strategies. The first would focus on the affected community, to meet its needs and help it act to mitigate the outbreak. The second would focus on other parts of the country and internationally, on regions that may not be directly affected but may panic on hearing about the outbreak. The strategy therefore should be to reassure people and also enable them to take protective action.

Natural hazards: Hydrometeorological and geophysical

Situation: Hydrometeorological and geophysical hazard emergencies – earthquakes, tsunamis, floods, cyclones – are sudden and unexpected. However, vulnerabilities can be mapped and preparedness work can be done in advance. Such events commonly cause widespread injuries. As homes are destroyed, families are displaced. Clean water is likely to be scarce and food sources limited; so water, sanitation and nutrition are likely to be major health issues. Many are likely to suffer from post-traumatic stress disorder (PTSD). Those living in crowded conditions in camps for internally-displaced persons (IDPs) are likely to be at risk of communicable diseases, but may not have their medical records with them. Floods and cyclones are also followed by waterborne diseases. However, these are situations that

the country may have experienced before, and so there is likely to be some familiarity and historical memory.

Strategy: Since such emergencies are sudden, there is likely to be some public panic (unless there has been adequate early warning). Outrage among the affected people is likely to be high, so the communication will focus on managing such outrage and creating awareness on health risks that may occur and protective action that is needed.

Human-induced hazards: Technological

Situation: Emergencies due to technological hazards are usually unexpected and result in loss of life or harm to people. Sometimes there are long-term effects, such as due to toxins and radioactivity.

Strategy: Since this emergency is most likely due to human error, anger against the authority – outrage – can be predicted to be extremely high, irrespective of the level of risk. So communication strategies will need to combine outrage management and crisis communication. The panic and anxiety due to sudden human-induced emergencies usually result in a plethora of rumours, and proactive rumour mitigation needs to be a priority.

Human-induced hazards: Societal

Situation: Emergencies due to societal hazards evoke intense emotions – deep fear, denial, hopelessness, stigmatization (sometimes), and extreme distress. This is worsened if the situation compels people to leave their homes and live in IDP camps. People generally rely on past experience to guide their beliefs and hopes, and often refuse to trust anything that contradicts their experience.

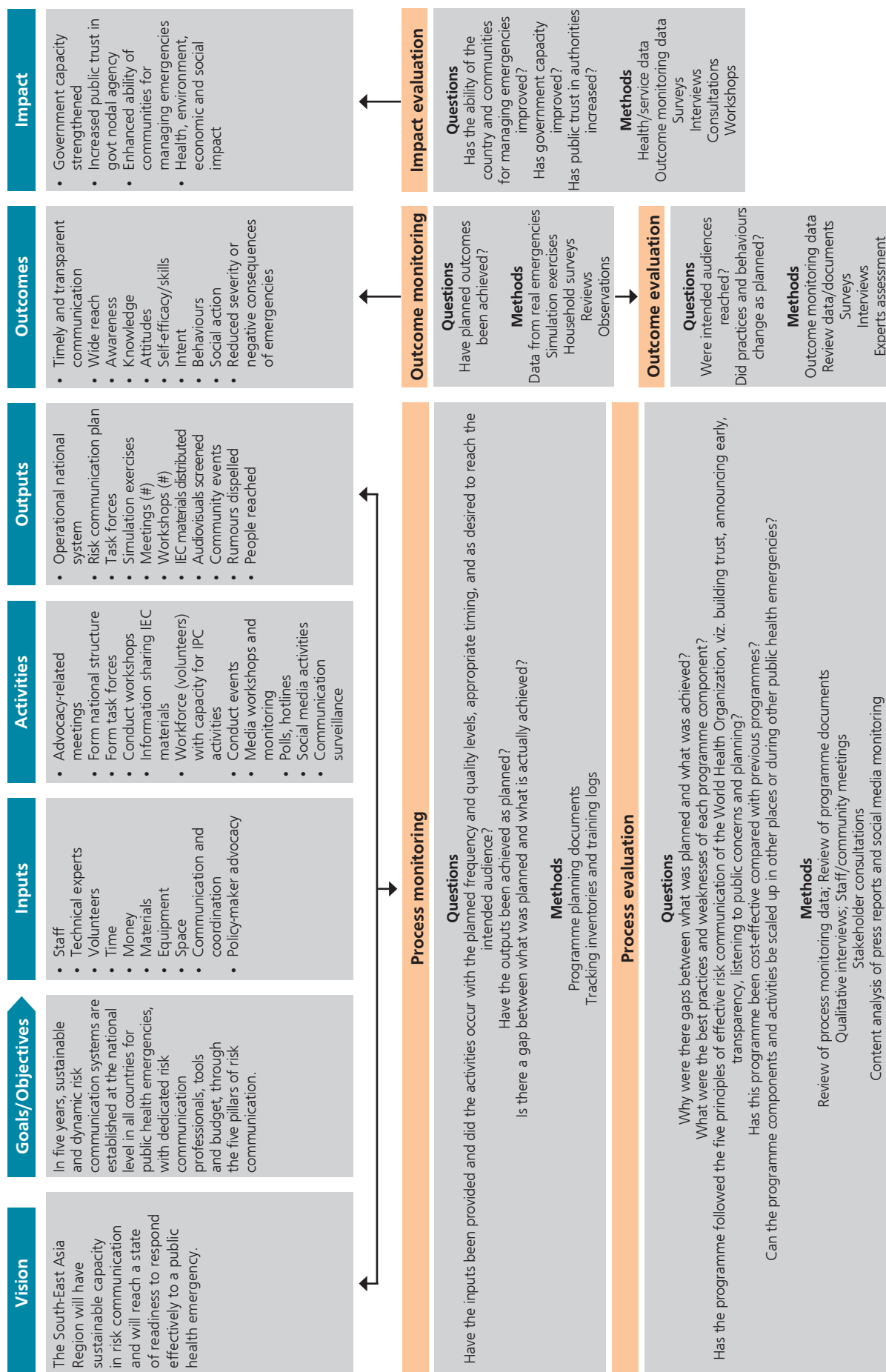
Strategy: Emergencies due to societal hazards often capture the interest of the wider national/international community, and have political/social implications. Inevitably it becomes necessary to address such perceptions and the situation tends to demand a crisis communication approach.

The risk communication strategy has to focus on reducing distress first, as strong emotional responses make understanding and acting on information difficult. People also find it hard to process different messages, and often the first message they hear is the one they believe.

Monitoring and evaluation

5.

Monitoring and evaluation are two separate but integrally linked processes to determine whether the strategy is being implemented as planned, and whether it has the desired outcome and impact. These should, therefore, be built into the risk communication strategy and plan. The following is the logic model of a monitoring and evaluation framework for risk communication.



Regional five-year indicators:

Pillars	Indicator	Baseline	Target	Date	Frequency
Risk communication systems	All countries in the Region have an all-hazards national risk communication plan	1	11	2023	N.A.
	All countries in the Region have a dedicated risk communication unit or expert with the Ministry of Health for public health emergencies	1	11	2023	N.A.
	All countries have dedicated budgets for risk communication	1	11		N.A.
Internal and partner coordination	A partner coordination plan and SOP template with clear roles and responsibilities, and how to coordinate in an emergency, is developed	0	1 plan	2021	N.A.
Public communication	All countries have identified spokespersons for the media	tbc	11	2023	
	Key officials are trained on spokespersons and media management	tbc	50	2023	Annual training
	Media persons sensitized on public health emergencies	tbc	100	2023	Annual training
Community engagement	Community health workers and volunteers trained on risk communication for public health emergencies	1	100	2023	Annual training
	Regional community leaders sensitized on public health emergencies	0	30	2023	Biannual workshop
Listening, fake news and misinformation	All countries have communication surveillance and analysis systems in place	1	11	2023	N.A.

Conclusion

The SEA Region is vulnerable to a range of disasters. It is also considered one of the hotspots of emerging infectious diseases. Capacity urgently needs to be strengthened for readiness for any emergency. Listed below are key considerations for strengthening risk communication for all hazards.

Risk communication requires leadership and support from the top levels of government

Priority and support from the top levels of national governments will ensure that risk communication as a component of emergency management gets the required financial and human resources in the planned budgets. This will enable capacity-building and sustainable implementation of the all-hazards risk communication strategy.

Risk communication is a continuous and inclusive process

Risk communication is required in all phases of the emergency management cycle – from the pre-emergency or preparedness phase, through response and recovery. The public, affected groups and stakeholders need clear explanations of the risks associated with the specific hazard, including the health, social and economic consequences. Any plan for communicating or managing an emergency will not be completely effective or sustainable unless it is developed in collaboration with stakeholders and local communities.

Risk communication needs to think nationally and act locally

Ultimately emergencies hit specific geographies and local areas. Actions taken in local areas determine the strength of the response as well as human fatalities or quantum of property destroyed. Therefore, it is important to ensure not just a national system but equally strong local systems. Along with local authorities, local community volunteers and local influencers and leaders have to be involved, trained and empowered.

Risk communication must be inclusive, with a special focus on vulnerable groups

While risk communication is useful to all, it is particularly helpful to the poor and vulnerable. Hence the risk communication task forces must identify groups at highest risk as well as those that are vulnerable and marginalized and provide them with targeted messaging and information support.

Risk communication requires listening

Governments have to carry out periodic surveys and opinion polls to understand public knowledge, perceptions, attitudes and beliefs about various hazards and emergencies. This is helpful in the design of public communication materials. Pre-testing communication materials is also a form of listening. Further, social media monitoring systems are required because rumours and misinformation often spread through social media.

Risk communication needs to build platforms for dialogue

A credible platform for dialogue between the nodal agency and the public should be developed to clearly discuss contested opinions or different interpretations of available evidence. Platforms that enable broad stakeholder engagement in preparedness, response and recovery processes are required. This will help collaboratively address people's concerns and encourage stakeholders and communities to take ownership of these processes. Such dialogue platforms also build trust in the authorities.

Risk communication needs partnering with media

Information vacuums created during emergencies get filled with misinformation or sensational news. After all, a media outlet's priorities may not align with those of the government. However, workshops and sensitization can help create awareness of the key issues and bring these different priorities closer.

Risk communication requires monitoring and evaluation, and capacity-building

Monitoring and evaluation must be built into the risk communication plan right at the start to assess if activities are being conducted as planned; if there is a need for mid-course corrections; if those most at risk are able to access information and the required support; and to learn from the past. Capacity-building is required at all levels, national to local, especially for setting up operational systems, partnering with media and social media

Annex

Resources

- ◉ Communicating risk in public health emergencies: a WHO guideline for emergency risk communication (ERC) policy and practice. Geneva: World Health Organization; 2017. Licence: CC BY-NC-SA 3.0 IGO. <https://www.who.int/risk-communication/guidance/download/en/>
- ◉ WHO Outbreak Communication Guidelines. Geneva: World Health Organization; 2005. https://apps.who.int/iris/bitstream/handle/10665/69369/WHO_CDS_2005_28_eng.pdf?sequence=1
- ◉ COMMUNICATION FOR BEHAVIOURAL IMPACT (COMBI): A toolkit for behavioural and social communication in outbreak response. Geneva: World Health Organization; 2012. https://apps.who.int/iris/bitstream/handle/10665/75170/WHO_HSE_GCR_2012.13_eng.pdf?sequence=1
- ◉ Glanz, K., Rimer, B. K., & Viswanath, K. "V." (Eds.). (2015). Health behavior: Theory, research, and practice (5th ed.). San Francisco, CA, US: Jossey-Bass.

The critical role played by risk communication in public health emergencies in the twenty-first century has been widely recognized. For public health interventions to achieve their goals, public cooperation is essential. Indeed, a single piece of misinformation or rumour that goes viral on social media can undo months of progress. Risk communication is therefore the bridge between public health and the public during emergencies and is one of the core capacities identified in the International Health Regulations (2005). The “Regional Risk Communication Strategy for Public Health Emergencies in the WHO South-East Asia Region 2019–2023” lays down a framework for Member States and WHO to strengthen this critical capacity in five key areas – risk communication systems, internal and partner coordination, public communication, community engagement, and public perceptions, risky behaviour and misinformation.

