Narrative Report 2

Response to COVID-19 through risk communication: Sri Lankan experience

Priyanga Diloshini Ranasinghe*, Palitha Karunapema, Sherine Balasingham, Niluka Gunathilaka

Health Promotion Bureau, Ministry of Health, Sri Lanka

*Correspondence: priyangan@yaho.com

<https://orcid.org/0000-0001-8145-7288>

DOI: <https://doi.org/10.4038/jccpsl.v26i5.8341>

Received on 17 May 2020

Accepted on 6 June 2020

Summary

First case of unknown pneumonia was reported in Wuhan City, Hubei Province of China on 31 December 2019. Since then, fast spread of rumours and myths were noted around the world and among Sri Lankans too. Health promotion Bureau (HPB) identified the need of a risk communication plan and also to activate and strengthen the prevailing rumour monitoring, reporting, verification and mitigation system. The HPB highlighted the issue of this novel virus at Influenza steering committee on 9 January 2020 organized by the Epidemiology Unit and informed that HPB has activated the rumour monitoring system.

Risk communication refers to the exchange of real-time information, advice and opinions between experts and people facing threats to their health, economic or social well-being. It will enable people at risk to take informed decisions to protect themselves and their loved ones (1-2). Thus, it is an essential component of an effective response to public health emergencies to proactively communicate what is known, what is unknown and what is being done to get more information, with the objectives of saving lives and minimizing adverse consequences. HPB initiated the preparatory phase activities as the focal point of risk communication in early January. Locally and globally available plans of risk communication were reviewed (3-5). Risk communication plan for the preparatory phase and initial response phase and flow chart for the COVID-19 were completed by 25 January 2020 at the stage of no reported cases. Country- or region-specific risk communication plans were not available in public domain for the best of our knowledge. This narrative report highlights the risk communication process implemented for COVID-19 in Sri Lanka mediated by HPB, the risk communication focal point for the Ministry of Health Sri Lanka.

Public health response and its impact

Risk communication was focused under five key areas: risk communication system, internal and partner communication, public communication, communication with affected communities and dynamic listening and rumour management.

• Risk communication system

Availability of a risk communication framework for HPB was the key to strengthen the risk communication system. The National Risk Communication Plan for Avian Influenza (3), developed by HPB was the base for initial planning. Further, risk communication plans were developed pro-actively for each stage of transmission; preparation and initial response phase of risk communication targeted for zero cases/few sporadic cases, crisis communication for cluster transmission stage with lock down status and cluster transmission stage with gradual exit from lock down as a guide for action. Risk communication flow chart was used as a simplified guide for action (Figure1).

The Health Promotion Bureau advocated the importance of a well-established risk communication system to ensure the trust of people, credibility and transparency of information and importance of naming and publishing the spokespersons for Ministry of Health, Sri Lanka, at the first meeting held at Ministry of Health chaired by the Director General Health Service (DGHS) on 27 January 2020, even before the first patient was reported in Sri Lanka. Director General of Health Services, Deputy Director General of Public Health Services (DDG PHS-I) and Chief Epidemiologist were identified as spokespersons as a positive response to advocacy done by HPB. Risk communication, spokespersons and credible information sources were included from the first national guideline on COVID-19 issued in January 2020.

Existing system was available to liaise with director general government media and all mass media networks through the Media and Publicity Unit of HPB. Further, a social media network including an official social media web page with blue tick verification and communication network with

Figure1: Risk communication flowchart

public, official trilingual website, audio visual (AV) unit with a studio geared to develop AV material, IEC development unit, Community Health Promotion Unit and Family Health Unit working with volunteer groups at grass root level for health promotion, Behaviour Surveillance Unit to conduct behaviour research and all units working with different settings at community level e.g. village, hospital, workplace, school, preschool. Furthermore, the linkage with the public health system at grass root level was utilized for communication activities and the health education officers (HEO) at district level could mediate the process. Capacity building of provincial and district health authorities and consultant community physicians on risk communication along with a risk communication drill conducted in December 2019 and regular capacity building sessions for HEO further strengthened the risk communication system. The preparedness and response activities in the risk communication system be informed and continually optimized according to community feedback through on-going behaviour surveillance and public concerns identified through 24/7 call centre, social media and mass media analysis.

● Internal and partner communication

Health Promotion Bureau maintained a regular communication with DGHS, Secretary Health, additional secretaries, DDG PHS, Epidemiology Unit, Quarantine Unit, Disaster Preparedness and Response Division (DPRD), National Institute of Infectious Diseases (NIID/IDH) and Medical Research Institute to update on public concerns and identify the communication requirement of key stakeholders. The HPB actively participated in regular meetings held by the DGHS and National Operation Centre for Prevention of COVID-19 Outbreak (NOCPCO). Quick and real time communication channels were maintained for rumour verification and content development for public communication with the main stakeholders. It further actively contributed for regular meetings with the partners in health sector and multi-sectoral partners conducted by DGHS. Task force was developed by the Sri Lankan government with multi

sectoral involvement for preparedness and response and HPB represented the committee on communication.

The HPB maintained the linkage with mass media network to strengthen the partnership with the Ministry of Health. Mass media supported the risk communication process throughout and HPB participated in the meetings of heads of media stations at regular intervals. It further prepared and disseminated the recommendations for ethical reporting on COVID-19 to the media through DGHS.

Internal communication platforms were strengthened not only within the central level but also with the health care staff at district and field levels. The social media platforms were used to communicate as well as to coordinate the risk communication activities in the community and district level.

Quick communication network was maintained with the World Health Organisation, Country Office and also with South East Region Office and Headquarters Geneva and other development partners at regular intervals to ensure collaborative work to combat COVID-19. Further, continued collaboration was maintained with other UN agencies and non-governmental organizations for risk communication and community engagement.

Furthermore, as the problem evolved partners and the sectors to be communicated were increased. Advocacy to political hierarchy, religious hierarchy, private sector, Ministry of Tourism, Ministry of Education, Ministry of Local Government and many other sectors was conducted by HPB.

● Public Communication and community engagement

Effective public communication is focused through different channels and platforms leaving no one behind. Communication target groups were identified at each level of transmission and message sequencing was done accordingly. Communication was targeted for the general public, high risk groups and vulnerable groups. Vulnerable groups varied with the level of the spread of the disease. At the initial stage, the main focus was on travellers from

China and later the travellers from any country. Public communication conducted through announcements within the airbus, at immigration counters before immigration clearance as video clips in Sinhala, English, Tamil and Chinese languages as well. Further, leaflets, placards, pull up banners were displayed at airports/ports. Advertisements on key prevention measures targeting the general public were developed and disseminated through electronic media. Further, these were aired frequently including prime time slots by all media without any payment for airtime. Key messages were developed in parallel to the stage of transmission and nature of movement restrictions.

The “Stay Home” campaign was conducted at the stage of lockdown while the communication package was implemented using scenario-based communication methods to prepare the public to adapt to the new normal lifestyle, at the stage of gradual exit from lockdown strategy while local clusters of transmission were yet being reported.

Mass media (News, Discussions as talk shows and myth busting sessions), social media (HPB social media web pages, communication and video

channels), HPB official website, telecommunication networks, webinars, online meetings/teleconferences, announcements by public addressing system at community level and health education will be continued to be used as communication channels. Television advertisements, video clips, animations, leaflets, posters, telephone ringing tones, songs, internal memos, circulars, and guidelines are continuously being developed and disseminated. Triangulation of the methods was used for public communication. Spokespersons conducted press conferences/briefings regularly. It maintained a good collaboration with mass media and created opportunities for technical experts to educate the public on a daily basis across all media. An average of 963 calls (Figure 2) were received per day during the month of March via the 24/7 call centre service (1999) maintained at HPB for one to one public communication, where the majority were queries on symptoms of the disease, availability of diagnostic facilities, the possible exposure to infected asymptomatic cases and quarantine procedures.

The official website of HPB provides real time updates and a dashboard with analysis on local and global data and remains a source of dissemination of

Figure 2: Summary of the calls received by Suwasariya Hotline (1999), HPB during 1st March – 31st March 2020

Figure1: Risk communication flowchart

IEC material to all relevant stakeholders and direct access to social media platforms of the HPB. The webpage has recorded 49,30,803 views from mid-March to 31 May 2020. The official verified Facebook page (over 450, 000 followers) and average 2 million of reach per week, verified Twitter account (over 12,000 followers), verified Instagram account, Viber group (around 370,000 subscribers) and a branded YouTube channel available for HPB are utilized for risk communication.

• Communication with affected communities

The affected communities were identified and mapped continuously by the Epidemiology Unit. Type of the affected communities varied with the dynamic and evolving situation of the disease spread. At initial stages, National Institute of Infectious Diseases (NIID) hospital staff directly communicated with patients and probable patients while Minister of Health, DGHS, HPB, Epidemiology Unit, Quarantine Unit, DPRD and other key stakeholders from health and non-health sectors were involved in communication with relevant local and international organizations with regards to foreign patients/probable patients. Gradually, with the spread of the disease from zero cases to community clusters, the affected communities were identified as patients, probable patients, close contacts of patients, people in quarantine centres and people who are home quarantined. Hospital as well as field health care staff directly communicate with the affected communities through direct conversations, over the phone, home visits, public addressing system, trusted influencers and IEC materials. Both hospital and field health staff extend a committed and dedicated service including the communication engagement with affected communities throughout the day.

The importance of being empathetic to all those who are affected, regardless of their community, ethnicity, or nationality and the fact that they have not done anything wrong, and they deserve our support, compassion and kindness was conveyed to all health staff. Risk communication training was conducted to representatives from the initial 17 nominated hospitals for COVID-19 at the initial stage.

Furthermore, the guidance was provided to all provincial/district level health authorities including the fact that photos or videos of patients and their close contacts, those under quarantine and their residence should not be taken or publicized through any media by health workers creating uneasiness and stigma to the affected communities.

• Dynamic listening and rumour management

“Fake news is spreading faster than the virus”, thus tackling infodemic is equally important as dealing with the epidemic. Rumour monitoring, identification, verification and management system is maintained to ensure correct information to the public. Rumours are monitored through continuous analysis of social media, mass media and calls received at the 24/7 call centre of HPB. Through the established quick communication channels, the rumours/misinformation is verified and reported. Media analysis was done manually through separate teams while a software was also tested as a trial for rumour monitoring using specific key words for tracking.

Rumour management was done by triangulation of methods through social media/mass media and clarifications by call centre and other reporting mechanisms. HPB mediates to provide information promptly and accurately to the public. Dynamic listening is the key to identify public concerns mostly done through 24/7 call centre (hot line 1999). Public concerns, concerns from the health sector and rumours are compiled daily and reported to the spokespersons on a regular basis. Myth busting sessions are conducted regularly with mass media to reinforce the correct information.

Challenges

Risk communication should be based on facts and evidence. However, some officials publicize their personal opinion in mass media and contradictory information could confuse the public. Rumour management and myth busting through all available communication platforms, regular updates by spokespersons, daily technical update and description from the Epidemiology Unit through

mass media was the key to overcome this challenge. Lack of a platform for real time direct communication with the provincial and district level health care officials is noted as a gap. Establishment of webinar system facilities to be connected real time with district level officials being coordinated and proactive planning for risk communication to face the next level of disease containment strategies were identified as the steps to overcome the above challenges.

Strengths and way forward

The HPB had the existing networks and communication platforms to be effectively utilized for public communication in this pandemic. Effective long-standing partnership with mass media networks, 24/7 call centre for the public, well established social media platforms are the major strengths that will be continuously utilized for risk communication. Risk communication on COVID-19 will be continued in collaboration with the key stakeholders and with close monitoring of public concerns throughout the process. Evidence on behaviour research will be utilized while a social behaviour change approach is planned to be implemented to ensure the sustainability of preventive behaviours. Risk communication processes will be maintained and accelerated accordingly to the level of risk and public perceptions based on risk communication framework (Figure 1).

Author Declaration

Acknowledgements: All technical unit heads and teams of HPB

Author contributions: PK guided the risk communication activities as the Director HPB, PDR

led the risk communication unit HPB. SB led the Suwasariya call centre and NG served the risk communication unit as the registrar. PDR developed the manuscript. BS and GN contributed to the development of the manuscript. PK revised the manuscript.

References

1. WHO. *Communicating Risk in Public Health Emergencies: a WHO Guideline for Emergency Risk Communication (ERC) Policy and Practice*. Geneva: World Health Organization, 2017. Available from: <https://www.who.int/risk-communication/guidance/download/en/>.
2. WHO. *Risk Communication Strategy for Public Health Emergencies in the WHO South-East Asia Region: 2019-2023*. New Delhi: Regional World Health Organization. Office for South-East Asia, 2019. Available from: <https://apps.who.int/iris/handle/10665/326853>. Accessed 19 March 2020.
3. Health Promotion Bureau. *Risk Communication Plan – Avian Influenza. 2019*. Colombo: Ministry of Health, Sri Lanka.
4. WHO. *WHO Global Influenza Preparedness Plan; The Role of WHO Recommendations for National Measures Before and During Pandemics*. Geneva: World Health Organization, 2005. Available from: https://www.who.int/csr/resources/publications/influenza/WHO_CDS_CSR_GIP_2005_5.pdf.
5. WHO. *Risk Communication and Community Engagement Readiness and Response to Coronavirus Disease (COVID-19): Interim Guidance*. Geneva: World Health Organization, 2020 (WHO/2019-nCoV/RCCE /v2020.1). Available from: <https://www.who.int/publications-detail/risk-communication-and-community-engagement-readiness-and-initial-response-for-novel-coronaviruses>. Accessed 19 March 2020.