World Health Organization

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Ministry of Health

المركز العالمي لطب الحشود
GCMGM
Global Center for Mass Gatherings Medicine

Risk Communication Capacity Assessment

Saudi Arabia – Nov 8-12, 2015

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National Risk Communications Capacity Assessment Mission

Riyadh, Mecca and Medina –Kingdom of Saudi Arabia (KSA)

November 8 – 12, 2015

Executive Summary

The Kingdom of Saudi Arabia's Ministry of Health (MoH), Global Center for Mass Gathering Medicine (GCMGM) with technical support from the World Health Organization (WHO) conducted a national risk communication capacity assessment on 8 – 12 November 2015. The assessment team visited and held interview sessions with officials of the MoH communication and response units as well as other internal and external stakeholders in KSA. The assessment findings and recommended next steps are presented in five domain areas: Risk Communication Systems, Internal and Partner Communication and Coordination, Public Communication, Communication Engagement with Affected Populations and Dynamic Listening and Rumour Management.

When reviewing aggregate quantitative and qualitative data from the assessment process, the six assessors ranked the Saudi Arabian Ministry's risk communication capacity on a five point scale (no, low, moderate, high and advanced capacity) as such:

- Risk Communication Systems – low capacity
- Internal and Partner Communication and Coordination– low capacity
- Public Communication – moderate capacity
- Communication Engagement with Affected Populations – low capacity
- Dynamic Listening and Rumour Management - moderate capacity

Successful communication during emergencies happens when relevant, consistent yet current guidance is provided to affected populations from trusted sources of information in a comprehensible language and through familiar channels for information seeking. Since affected populations vary in terms of their education, literacy level, choice of information sources, etc., ministries of health must understand their population, tailor information to the population needs and disseminate the information through all appropriate channels. This requires harmonising a unified, non-duplicative approach with internal MoH communication functions as well as synchronised approaches with external partners with a concentrated focus on community engagement and research. In order to achieve this, the WHO assessment team made a series of detailed recommendations.

Conclusions:

The MoH should begin by developing a formal risk communications system that can utilize the skills and experience of existing units routinely and activate many more units during emergencies. This system should be considered an iterative process requiring an endorsed plan that relies predominantly on exercises and evaluations to improve skills, systems and strategies. Communications outreach from the MoH should begin to incorporate more internal and external partner resources and access to their audiences while strengthening internal community engagement programs. These programs embrace and reinforce two-way communication with affected populations, audience analyses and message and materials testing to better ensure message absorption, adoption and nimble response to rumour and misperceptions. Finally, the risk communication system including the current media communication function within the MoH should adopt a more proactive approach to better meet the information needs of KSA citizens and other at-risk populations.

Specific recommendations:

- Create and sustain a risk communication unit within the MoH.
- Write a formal MoH risk communications plan, endorsed by leadership, shared with response partners, regularly tested and altered as needed.
- Echo the risk communication function at the national level to the sub-national and directorate levels.
- Develop a formal coordination with external communications departments.
- Support expansion of the hotline to include surge capacity and data analysis capabilities.
- Establish monitoring and evaluation systems including feedback system for emergency responses and exercises and ongoing communication campaigns.
- Establish Memoranda of Understanding (MoU) with other government agencies for specific functions related to communications before, during and after emergencies according to most likely and threatening public health risks.
- Conduct partner mapping.
- Budget to support an internal cross-cutting program and external stakeholder engagement requirements.
- Require mandatory feedback and provision of resources to support regular evaluations or after action reviews for exercises and responses to further improve on internal and external partner communication coordination.
- Develop internal web portals and content syndication to more easily share MoH material and information with partners' websites.
- Set up a communication strategy including well established procedures that proactively reach out to a variety of media platforms.
- Conduct target audience analyses.
- Use multilingual solutions.
- Include social mobilization and community engagement in the national risk communication strategy.

- Build a community engagement function for emergency risk communication response from existing health promotion functions in the MoH but processes, structures and content should be based on formal assessments.
- Conduct systematic capacity building and include all parties involved in social mobilization and community engagement.
- Make formal testing of materials and messaging a standard practice.
- Create a multi-channel, multi-partner system for listening and rumour management that includes targeting of affected populations and a formal mechanism to choose rumours/misunderstandings of public health concern and change communication messaging to address them.
- Activate primary healthcare unit level communicators/educators, directorate level communicators, as well as the RRTs, to regularly conduct focus groups, intercept interviews, message tests, etc. with segments of the population during an emergency.

Next steps:

- The MoH should establish a risk communications working group or identify a risk communication focal person to ensure that risk communication activities are taken forward. The MoH should immediately look into its existing structure and ensure that all levels will be represented in the risk communication working group.

- The MoH should begin to draft a risk communication strategy and plan and bring high level stakeholders (internal and external) for a strategic planning review to include commitments of staff, time, activities and financial resources to be used during preparedness and emergency activation phases.

- The MoH should also have a scenario based session with key members of the national and international media to develop media plans for emergencies that meet the needs of media (deadlines, easier methods to get press statements, etc.)

- The MoH should develop the standard operating procedures to provide specific directions on communication tasks that need to be performed in preparation for, during and after an outbreak; as well as to provide communications guidance during mass gatherings.

- The MoH should initiate the conduct of risk communication orientation workshops across all levels in the KSA system to increase awareness and acceptance of the approach as an integral component of public health emergency response.

Background

The Kingdom of Saudi Arabia's (KSA) Ministry of Health (MoH) recognizes the importance of effective communication in the management of public health emergencies. Effective risk communication not only saves lives and reduces illness; it enables countries and communities to preserve their social, economic and political stability in the face of emergencies. Additionally, people have the right to know how to safeguard their health and have a responsibility to take informed decisions to protect themselves, their loved ones and those around them. Poor communication during public health emergencies can lead to the spread of diseases, create fear and civil unrest and devastate communities and local industry.

In order to strengthen national capacity to respond to public health threats, risk communication has been identified as an essential component and is one of eight core capacities outlined in the International Health Regulations (IHR, 2015).

The KSA MoH has, to date, held a high-level workshop on emergency risk communication, which was organised in Riyadh on 4-6 August 2015. The sensitisation workshop which was jointly organised by the MoH, the Global Centre for Mass Gathering Medicine (GCMGM) and the World Health Organization Regional Office for the Eastern Mediterranean Region (WHO-EMRO), trained public health policy-makers, planners and other decision-makers in communicating risk during emergencies - in particular, the health risks associated with mass gatherings - to a wide range of audiences, including the media. The workshop raised awareness about the crucial role of risk communication in any health systems response to an emergency.

In view of this, the WHO has been guiding KSA on the approach to take in order to strengthen national emergency risk communication capacity. In mid-October 2015, GCMGM requested WHO's support to conduct a risk communication capacity assessment designed to obtain information on the current structure and processes in communications. Since the GCMGM requested the assessment, special focus was paid to communication before, during and after the Hajj, the largest annual mass gathering in the world when 2 to 3 million Muslim pilgrims from more than 180 countries converge on the country's holiest sites.

A team of WHO staff and consultants with support from MoH staff conducted the capacity assessment between 8 and 13 November 2015 in Riyadh, Medina and Mecca, in preparation for the development of KSA's national risk communication strategic plan.

Assessment methodology

A team of six communication experts from the WHO headquarters, WHO-EMRO, WHO Saudi Arabia country office and WHO Lebanon country office, with support from four GCMGM staff, conducted the assessment of the KSA MoH's risk communication capacity. The assessment group split into three simultaneous missions in Riyadh, Mecca and Medina. Each sub-team met with national and subnational response and communication representatives from organizations such as the MoH, emergency response units, Ministry of Agriculture, Ministry of Interior (Civil Defence) and the Ministry of the Hajj. (See full list appendix 2)

Initially the assessment team planned to use a Pandemic Influenza focused assessment instrument (appendix 3) very similar to the IHR risk communications capacity assessment. However, a new assessment tool (appendix 4) had been drafted just prior to the mission. The assessment team resolved to use the new draft instrument alongside the former Pandemic Influenza IHR tool. The combination of the two tools allowed for both quantitative and qualitative data gathering. The quantitative data provided a more accurate ranking of the strengths and weaknesses of existing risk communication capacities, while the qualitative instrument provided flexibility and allowed assessors explore different strategies for improving risk communication capacities in KSA.

Assessors generally worked in teams of two to conduct interviews with officials and in a few instances clients from each of the organizations and departments listed in appendix 2. The assessors recorded the sessions with an audio device to capture a detailed account of responses and to gain insight into risk communication capacity in the MoH as well as formal linkages with internal and external partners. Each interview lasted approximately 60 – 90 minutes.

Interviews were conducted until Saturation was achieved to ensure all areas were effectively covered by the responses. Qualitative data triangulated from different sources to enhance data quality was coded and analysed systematically by the assessors. Using the five domain categories of *Risk Communication Systems, Internal and Partner Communication and Coordination, Public Communication, Communication Engagement with Affected Populations and Dynamic Listening and Rumour Management;* the team considered the qualitative and quantitative data collected and assigned descriptive capacity ranking (none, low, moderate, high and advanced capacity) to each domain. Assessors then divided the domain areas and collated findings and recommendations for each of the domain areas. Subsequently, assessors refined and finalised the findings and recommendations.

National and local assessment process

Overview of assessment in Riyadh

Riyadh, Saudi Arabia's capital is situated on a desert plateau in the centre of the country. It is the largest city in the country with a population of close to 6 million people. It is of strategic importance for the Kingdom because of its role as the financial and administrative hub that hosts the government including ministries as well diplomatic missions and educational, financial, agricultural, cultural, technical commercial and social organizations. The assessment process began and was focused in Riyadh because, while all emergencies are local, Riyadh's government bodies will likely manage majority of the responses, coordination between response parties at the national level and communication to international media and agencies.

Overview of assessment in Mecca

It was important for the mission to extend its assessment of the MoH regional communication capacities to Mecca because it is the capital of KSA's Makkah Region and also known as the holy capital of the Kingdom. The city is located 70 km inland from Jeddah. Its resident population is roughly 2 million people (legally registered), however its visitors are more than triple this number

every year during the Hajj (pilgrimage) and Umrah seasons that continues for around eight months of the year. The pilgrims arrive from around 180 countries of the world with different languages, backgrounds, cultures, social behaviors, food habits and health status.

The mass gatherings in a very limited geographical area during a short period of time expose the city to public health risks. Additionally, large numbers of non-nationals live in Mecca in closed and hard –to- access communities under poor living conditions. They resist any contact with the government-provided services because they fear deportation back to their home countries. This picture, as well as the rapidly changing global epidemiology of public health threats, created the need to explore the communication capacities, resources and plans available in the MoH in Mecca and the need to establish a risk communication platform to enhance preparedness and response to risks and emergencies.

Overview of assessment in Medina

Medina city is the capital of the Al Madinah Region of KSA. The city contains al-Masjid an-Nabawi ("the Prophet's Mosque"), and is the second-holiest and important Islamic pilgrimage destination after Mecca. In addition to the sacred core of the old city, Medina is a modern, multi-ethnic city inhabited by Saudi Arabs and an increasing number of expatriate workers: other Arab nationalities, South Asians and Filipinos with a total number of inhabitants of 1.3 million. During the hajj season an additional 1.25 million pilgrims are expected in the city. The city is currently served by the newly opened (6 months ago) Prince MoHammad Bin Abdulaziz Airport. Medina has a hot desert climate; summers are extremely hot with daytime temperatures averaging about 40°C. Temperatures above 45°C are not unusual between June and September.

The mass migration during the Hajj is unparalleled in scale, and pilgrims face numerous health hazards. The extreme congestion of people and vehicles during this time amplifies health risks, such as those from infectious diseases. Since the Hajj event is determined by the lunar calendar, it places a demand on public health preparedness capabilities. Due to international travel and the potential for globalization of infectious disease agents and other public health threats, the assessment of risk communication capacities in Medina is essential for clear understanding of risk communication at the national level.

Results, Recommendations and Sample Strategic Plans

This section describes the assessment team's findings and their subsequent recommendations. These findings and recommendations were presented to the MoH in a workshop for key stakeholders within the ministry. After the initial presentation, workshop participants chose a few recommendations per domain area and developed an initial strategic plan for implementation of that recommendation. It should be noted that the recommendation chosen and listed in this section does not necessarily constitute any priority over the other recommendations. Therefore, it is suggested that the MoH conduct a more thorough review of recommendations to determine priorities in terms of importance, work that builds a foundation for other recommendations and simply ease of actualization (*'low hanging fruit'*).

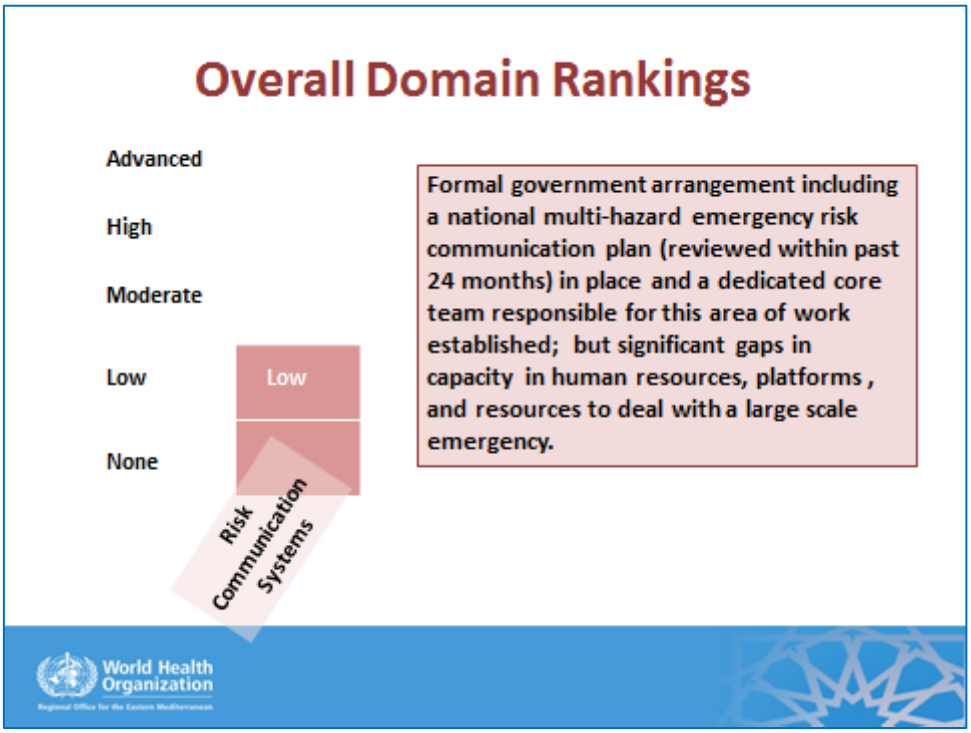
Risk Communication Systems

Formal government agreements with sustained budget, trained staff, and plans that are exercised and revised regularly

Findings

- **Recent MERS-CoV outbreaks in Saudi Arabia have proved the need for a formalized risk communication unit within the MoH**. Most countries with established and functional risk communication systems built on the experience of an emergency that drastically proved the need for better information to the public during emergencies. Likewise, during this assessment process, several external partners interviewed urge the MoH to take the lead in this area of cooperation and response. Of note, national ministries of health often coordinate risk communication with other responding ministries and agencies in emergency preparedness and activation phases.
- At present **there is no designated unit for risk communication** for health hazards in MoH. There are operational units of communication dedicated to media, social media, public relations and health education/communication. These units have isolated risk communication functions and are currently not operating as a coordinated unit.
- **There is no endorsed and tested risk communication plan that includes staff, partners, standard operating procedures (SOPs), indicators and evaluation processes.** There seem to be several disease specific plans in place (MERS-CoV and the Hajj), but they are not tested and widely shared among cross-cutting response functions with the MoH.
- Currently there are **no formalized linkages with other response organizations and little connection with external communication departments**. While there has been some linkage with response ministries through the MoH Command and Control Centre (CCC), future response collaborations are not articulated in terms of roles and responsibilities, lead agency, lead spokes agency (per potential threat) and interagency collaboration mechanisms for primary risks.
- There is **no official, standardized monitoring and evaluation system for communication response** or communication materials or campaigns. There are ad hoc after action reviews of MERS-CoV and the Hajj without clear indication that communication plans and response patterns are changed for future responses and without evidence of a tested process for

dissemination of results to internal and external communication response partners. Materials and messaging tests among target audience are rare and centred on emergency health campaigns. Information, Education and Communication (IEC) messages are approved (not necessarily tested) by the CCC and MoH.



Recommendations (see appendix 1)

- **Create a sustained risk communication unit within the MoH** for the future. Select staff for their ability to partner with others. Provide regular training and exercises for this unit. The unit should focus on communication to the public during emergencies yet develop materials, messages, plans, partnerships and researches at-risk populations during preparedness (non-emergency) times.
- **Write a formal MoH risk communications plan, endorsed by leadership, shared with response partners, regularly tested and reviewed as needed.** The plan to include internal and external response units and stakeholders needs to be developed for preparedness and activation phases. Once a plan is established, an agreement with all activation partners should be written and included in the plan.
- **Echo the risk communication function at the national level to the sub-national and directorate levels**. The risk communication system should be copied at the directorate level to what extent it can to provide a two way information loop between the national level, affected directorates and non-affected directorates. Research, materials and messages should be shared by all.
- **Develop a formal coordination with external communications departments during times of non-emergencies – shift to Joint Information Center during emergencies.** There should be written and endorsed agreements that describe roles, responsibilities, how

agencies interoperate according to suspected risks as well as designs for regular exercises and evaluations.

- **Support expansion of the hotline to include surge capacity and data analysis capabilities.** Data from the hotline should be used to identify health related rumors and communicate to quell the rumors.
- **Establish monitoring and evaluation systems including feedback system for emergency responses and exercises and ongoing communication campaigns.**

Summary of group discussion top recommendations Risk Communication Systems

From the list of *Risk Communication Systems* recommendations submitted by the WHO assessment team, a MoH work group selected the following two and developed next steps needed in order to actualize these improvement measures.

- **Recommendation: Create a sustained risk communication unit within the MoH**
  - **Next steps:**
    - Brief His Excellency, the Minister of Health (H.E MoH) on the findings of the assessment mission, highlighting this recommendation as a priority.
    - Submit to H.E a concept note on the rationale and importance of establishing a risk communication unit.
    - Provide a proposal of the resources, roles and responsibilities, budget, structure of the proposed unit.
  - **Timeline:**
    - According to the group work (headed by the GCMGM Director) there are already actions aiming at materializing the recommendation, so the timeline for putting it into force is end of December 2015.

Recommendation: Develop a formal coordination with external communications departments during times of non-emergencies – shift to Joint Information Center during emergencies

- **Next steps:**
  - Find a mechanism to ensure sustained coordination among all external communications department.
  - Develop guidelines reflecting the roles and responsibilities of these departments routinely and during emergencies.
  - Set a leadership mechanism to decide who will lead during an emergency. A theme-based leadership approach is suggested.
  - Update the contact list of all external communications departments.
- **Timeline:**
  - End of December 2015.

Further recommendations developed by the group discussion that might be considered:

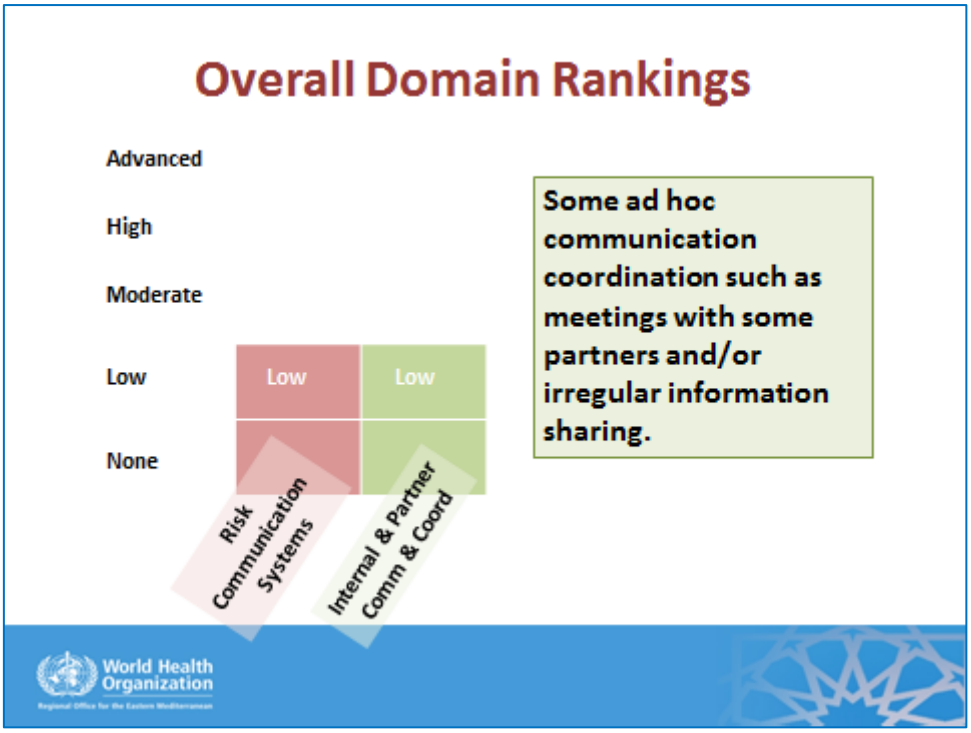
- **Empower the communications departments in the regions (Mecca, Medina and other regions)** in terms of budget allocation, human resources, and training opportunities especially in the aspect of risk communication.
- **Analyze the health situation and living conditions of the closed non-Saudi communities** to plan for the risks they might cause or be exposed to and build awareness campaigns and community mobilization activities around these risks.

Internal and Partner Communication and Coordination

Formal agreements between internal, government and external partners regarding joint communication response that is exercised, defined roles and shared resources

Findings

- **Poor coordination of resources and information within the MoH is costing time, resources, morale and confidence of its internal and external partners**. Within the MoH, often information and decisions made at the higher levels of management do not trickle down to other staff in the various units and departments and also the platforms they support. Information concentrates itself at the top level of management, which compromises decision-making at the lower levels of management.
- Coordination and communication functions are reportedly better performed during an outbreak, with significant resources allocated for surveillance and response. Before and after outbreaks, focus is somewhat diluted for implementing key preparedness interventions. **Accountability is split between different MoH departments and units as well as other government ministries**. Evaluations of responses are carried out semi-regularly but on an ad hoc basis, dependent upon the will of the unit, department and ministerial leadership.
- **The MoH keeps a list of these partners that is updated periodically but there is no established mechanism for updating information.** Other ministries work with the MoH during emergencies such as the Ministries of Interior and Agriculture. Communication with such ministries depends on the emergency and is irregular and ad hoc.
- **Government partners involved in previous emergency operations with the MoH, expressed willingness to collaborate further with the MoH to build a unified emergency preparedness and response system**. In some cases, these external partners may be perceived more favourably by the public (e.g. Civil Defence during the stampede; Ministry of Agriculture during MERS-CoV outbreaks). In the meetings with government partners, they expressed the need for an emergency plan for infectious diseases, which includes all partners. All external government partners met in Mecca referred to the civil defence as the best lead during huge emergencies, however, will look to the MoH as a lead during public health crises.
- **External Partnerships with the MoH are few. Expansion of partners, resource and skill mapping and consistent engagement before, during and after emergencies is inadequate**. Coordination with partners such as WHO for technical expertise, the Red Crescent Society (RCS) for logistical purposes (ambulances, movement of emergency materials), health care centres and even the private sector can enhance understanding of affected populations and distribution of health information during emergencies. A visit at the primary care healthcare center (PHC) at Al Safia located at the Haram exit revealed that the private sector helps to fill funding and communication gaps for certain activities. The PHC had posters of health awareness materials and leaflets in English, Arabic and Urdu, however, there was no assurance of consistent messaging through these various materials and platforms. Some of the platforms (i.e. electronic screens) were provided by pharmaceutical companies and medical devices companies which could present a conflict of interest issue with the MoH.



Recommendations

- **Establish Memoranda of Understanding (MOU) with other government agencies for specific functions related to communications before, during and after emergencies according to most likely and threatening public health risks**. Develop SOPs for emergency surveillance and response as well as preparedness, which include clear roles and responsibilities for the MoH and its government and external partners, as well as a tracking and feedback mechanism for compliance.
- **Conduct partner mapping.** Map partner communication staff, skills and internal functions to cover potential areas for collaboration in emergency response, surveillance and preparedness-related functions, including in the mobilization of resources. Develop a plan for partner engagement, which includes regional partners.
- **Budget to support an internal cross-cutting program and external stakeholder engagement requirements.** To ensure a sustainable system, a distinct budget for risk communication to support preparedness, surveillance and response activities is needed. The budget should encompass support for MoH communication units to work on preparedness activities during non-emergency times and to provide surge capacity to the risk communications unit during emergencies. Similarly, the budget should help support a Joint Information Center (JIC) -like function to ensure that external partners are able to closely work with the MoH and utilize and distribute MoH key messages.
- **Require mandatory feedback and provision of resources to support regular evaluations or after action reviews for exercises and responses to further improve on internal and external partner communication coordination.** Financial and human resources (technical/programme management) should also be allocated for regular performance evaluations of MoH departments, units and staff at the top and lower levels of

management. This should encompass after action reviews following every activation of a risk communications and JIC activation. Feedback on the results of the evaluations to all relevant stakeholders should be mandatory. Results of exercise and response reviews should not be punitive but should be used purely to improve the plan and systems.

- **Develop internal web portals and content syndication to more easily share MoH material and information with partners' websites:** Create simple platforms to facilitate, coordination, transparency, visibility and accountability in internal communications, e.g. monitored regular and timely intranet postings of activities and achievements of MoH departments, agencies and health system actors as well as regular town hall meetings with all stakeholders.

Summary of group discussion top recommendations Internal and Partner Communication and Coordination

From the list of *Internal and Partner Communication and Coordination* recommendations submitted by the WHO assessment team, a MoH work group developed next steps needed in order to actualize these improvement measures.

- **Next steps:**
  - Identify main stakeholders and co-develop a risk communication multi-hazard strategic plan and SOPs, which include clear roles and responsibilities for each stakeholder within the MoH, other government ministries and external partners.
- **Timeline:**
  - 31-Dec-2015

- **Next steps:**
  - Identify a team that can be the custodian of the plan. The team should have experience in public health, emergencies and communication (including media relations and community engagement), and have advanced skills in strategic programme management.
- **Timeline:**
  - 31-May-2015

- **Next steps:**
  - Drills to implement plan
- **Timeline:**
  - June 2015

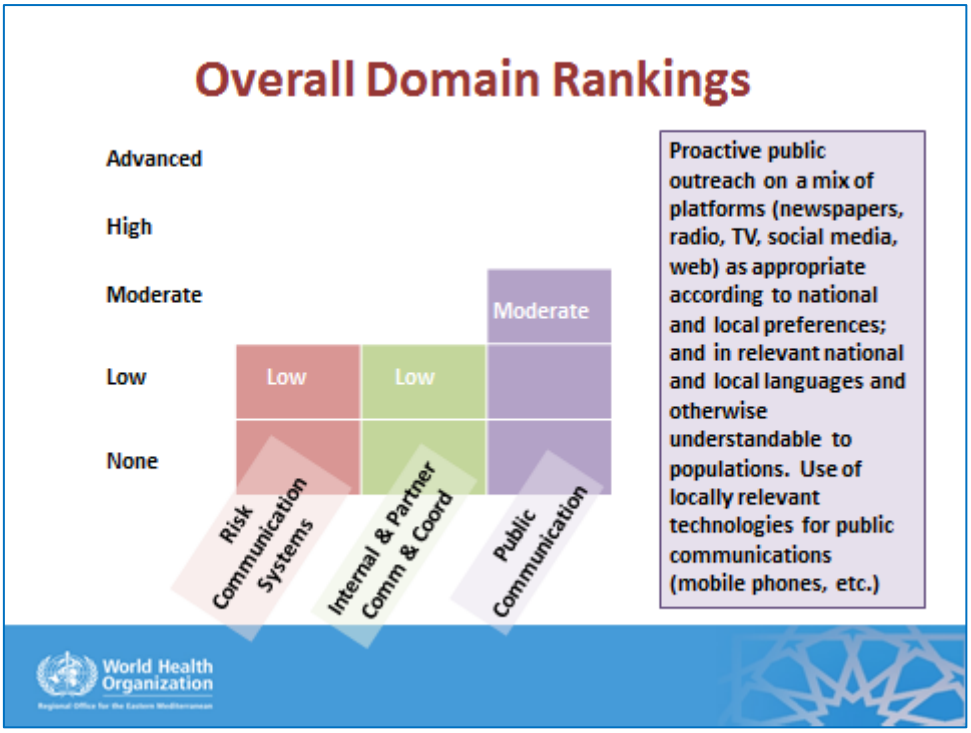
- **Next steps:**
  - Inform all stakeholders about the evaluation of the plan, revise the plan.
- **Timeline:**
  - Not committed to

Public Communication

Use of media and trained spokespeople that is proactive and strategic based on continuous audience analysis

Findings

- **There is a public communication unit and team; however, the written procedures for public communication are not well developed and non-existent for emergencies.** The public communication team is under the public relations unit at central level in Riyadh, and also at both directorates in Mecca and Medina. Official spokespersons are identified at central and regional levels (around 26 officially designated spokespersons for MoH). By practice, every region communicates about its own activities (and not the others) and for major incidents they refer the media to Riyadh.
- There is public outreach on a mix of platforms (newspapers, radio, TV, social media and web) at central level and to a lesser extent at regional levels, however **there's no written and disseminated communication strategy and the approach is not always proactive** especially at regional levels.
- **Communication materials and messages are produced mainly in Arabic, apart from the hajj where materials are available in 7 languages. However, there was an excellent example of an external university partnership that addressed the need for multi-lingual services.** The public information is solely produced in Arabic and uses Arabic speaking channels (newspapers, radio, TV) and there is no outreach to international media. The website is translated to English and regularly updated at central level; however the regional webpages are not up to date. The health awareness materials for pilgrims in Mecca and Medina are sometimes translated to other languages but not in a systematic way. One of the best practices that we noticed during our visit to Ohud Hospital in Medina, is the use of "on-call" volunteer translators for more than 20 languages, through an agreement with the Islamic University in Medina. Those translators can be called by the hospital at any time to provide instant translation via telephone for the patient and the healthcare worker, at no cost. This kind of smart solutions can be disseminated for other hospitals and PHC in Medina and Mecca regions.
- **There is an over-reliance on social media at the central level** without evidence of message absorption. Target audience analyses to better understand message comprehension, language preferences, trusted info resources and preferred communication channels are not conducted systematically.



Recommendations

- **Set up a communication strategy including well established procedures that proactively reach out to a variety of media platforms** (newspapers, radio, TV, social media, web) in several languages to target communications messages to specific audiences; which includes establishing local and international media channels (updated lists and channels), and considers regular media briefings.
- **Conduct target audience analyses** to understand languages, trusted info resources and preferred communication channels that feed in the communication strategy which can be optimized accordingly.
- **Conduct regular and ongoing journalist engagement events** such as monthly short sessions on health issues that pose a risk to KSA's population and scientific desk reviews for a more in-depth look at what staff are doing in the MoH. A training of journalists for better reporting on scientific and technical information related to public health. This is key as stopping rumours and non-verified (with MoH) information circulating through social media is a challenge and is time-consuming. Overtime, media partnerships can help build trust between journalists and the MoH.
- **Use multilingual solutions** for health awareness materials targeting pilgrims and other expats and foreigners living and working in KSA.

Summary of group discussion top recommendations Public Communication

From the list of *Public Communication* recommendations submitted by the WHO assessment team, a MoH work group selected the following three recommendations and developed next steps needed in order to actualize these improvement measures.

Recommendation: Set up a communication strategy including well established procedures that proactively reach out to a variety of media platforms

- **Next steps**
    - MoH should establish a risk communication unit with designated staff, who will be trained by WHO.
- **Timeline**
    - next 2 – 3 months

Recommendation: Conduct target audience analyses

- **Next steps**
    - A strategic planning on public communication should take place. This will include situation analysis on how KSA is communicating with the public, as well as the media habits of various communities/groups in KSA.
- **Timeline**
    - next 6 months

Recommendation: Use multilingual solutions

- **Next steps**
    - Conduct a health profiling of communities including language use. This will be the basis for identifying target audiences for various communication activities.
- **Timeline**
    - next 6 months

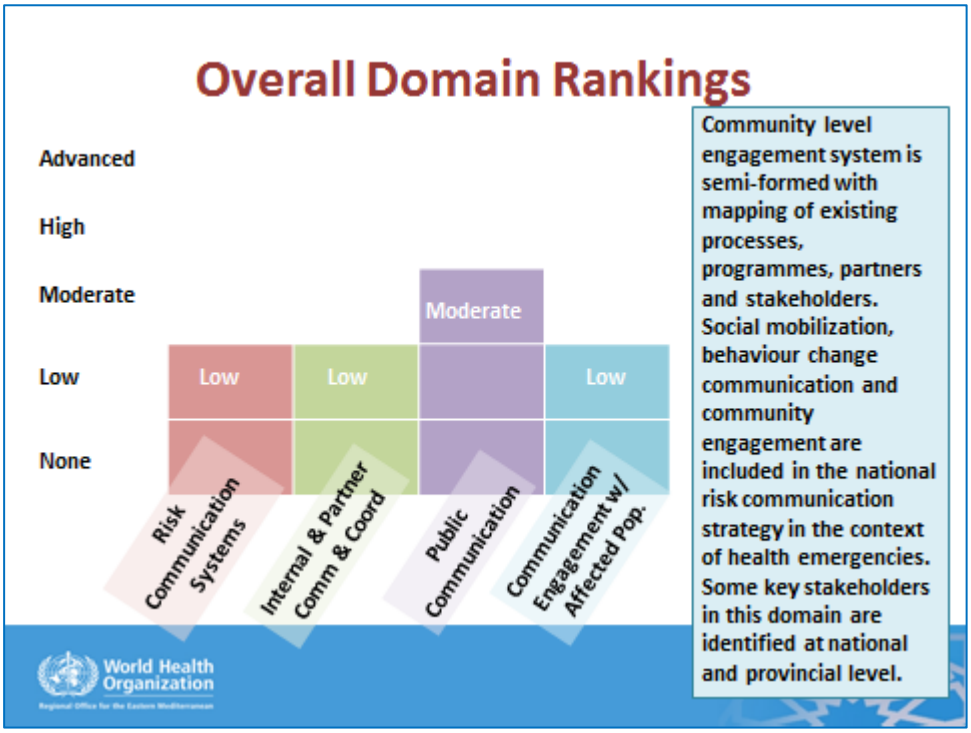
Communication engagement with affected population

A trained and robust operation that regularly communicates with communities during emergency and non-emergency times - a system that works with community based organizations and channels of trust

Findings

- Overall, **social mobilization and community engagement efforts are currently limited within the MoH to certain health days and campaigns**. MERS-CoV, a current health threat in the country, has included some school based campaigns and awareness raising sessions in shopping malls. However, several departments are currently in a process of expanding their efforts in social mobilization. Also, a new and improved MERS-CoV campaign including social mobilization is being developed.
- **External partnerships and coordination, particularly in community engagement with affected populations, could greatly enhance communication response strategies.** Several internal and external stakeholders are involved in community outreach activities, such as MoH department of health promotion, MoH media department, Ministry of Agriculture, heath care facilities and others. There's a great deal of work being done that could enhance an emergency response, however, these entities have little coordination. In addition, some stakeholders involved in the emergency response, such as MoH infection control unit and emergency department are not involved in social mobilization of communities although they have access to affected communities.
- No exercises have been conducted to map partners and stakeholders, define processes or to conduct analysis on stakeholders, their preferred or trusted communication channels. **The previous efforts in social mobilization and community engagements have not been evaluated.**
- Community engagement is focused on materials development. **Materials are developed by different entities and stakeholders with little or no coordination regarding consistency of messaging**. Some health facilities develop their own materials, whereas others use materials provided by the health directorate. Testing of materials happens on an ad hoc basis only.
- **People who engage with affected populations, such as health educators, staff members of primary healthcare units and others, are usually not trained in risk communication or emergency response.** For example, public health teams whose responsibility is contact tracing of Middle East Respiratory Syndrome Corona virus (MERS-CoV) cases and further prevention of the virus within affected communities, have not received trainings in risk

communication.



Recommendations

- **Include social mobilization and community engagement in the national risk communication strategy** including monitoring and evaluation to ensure effective coordination of the efforts.
- **Build a community engagement function for emergency risk communication response from existing health promotion functions in the MoH but processes, structures and content should be based on formal assessments** such as population segmentations, at-risk populations, trusted information sources, language, literacy level and preferred media channels (social media, mass media etc.).
- **Conduct systematic capacity building by including all involved in social mobilization and community engagement**. People involved need both knowledge and skills in risk communication. Community engagement personnel and volunteers should be trained to be deployed to emergency location during emergencies.
- **Make formal testing of materials and messaging a standard practice** to ensure effectiveness and message absorption. A standard system and structure for message testing is recommended.

Summary of group discussion top recommendations Communication engagement with affected population

From the list of *Community engagement with affected population's* recommendations submitted by the WHO assessment team, a MoH work group selected the following recommendation and developed next steps needed in order to actualize these improvement measures.

Recommendation: Include social mobilization and community engagement in the national risk communication strategy

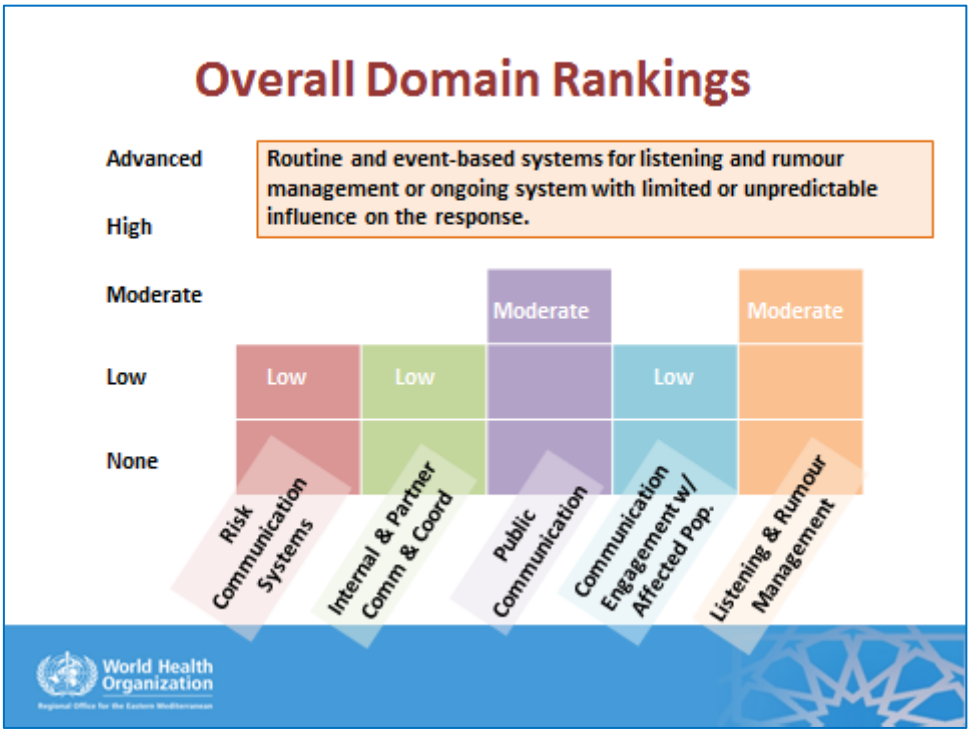
- **Next steps:**
    - A multi-sectoral group of experts in communication need to be formed to develop social mobilization and community engagement plan to be included in the national risk communication strategy. The group needs to include experts who are currently working in different ministries and departments, community leaders, non-governmental and governmental organizations relevant to risk communication to ensure coordination. The process reflects inclusion of all and ensures well-structured plan for social mobilization within the national risk communication plan.
    - After the structure and coordination mechanism is laid down in the national plan, comprehensive situation analysis and assessment about affected populations is needed. This will ensure that community engagement is relevant, effective and messaging encourages behaviour change. The national plan lays down who is responsible of the various assessments and activities that will be carried out.
- **Timeline:**
    - The work can be accomplished with a period of 6 months.

Dynamic Listening and Rumour Management

Routine and event based system for rumour and misperception information gathering that feeds back into a decision making process and effective communication in response

Findings

- **Perceptions and rumours are not systematically monitored** and this occurs on an ad hoc basis. There is very limited analysis of 937 (24/7) and 800 (8hrs/daily) calls. Primary healthcare unit teams that conduct awareness sessions in malls have a daily report that may also capture rumours and issues that they learn from public interaction but these reports and findings are not analysed or further shared with anyone.
- In Medina, **media monitoring is regularly conducted; however, there is no mechanism in place to process information, make decisions and use them as part of the overall structure of public health emergency preparedness and response plan**. Currently, the media monitoring system seems more reactive than proactively strategic. At the national level, media monitoring through social media seems more focused on MoH reputational management than on capturing health misperceptions and questions from target populations. In Makkah, CCC depends on MOH in responding to rumours during normal times. During emergencies, civil defence handles rumours. The MOH has a reactive approach in dealing with rumours but they respond and curb rumours through statements and press releases.
- **Training of rapid response teams (RRT) on how to communicate Infection, Prevention and Control (IPC) reviews to healthcare workers improves dynamic listening of healthcare workers but RRT training and responsibilities could be enhanced for a stronger role in communication response.** These are the first to engage affected populations and can be a valuable and trusted channel to communicate.



Recommendations

- **Create a multi-channel, multi-partner system for listening and rumour management that includes targeting of affected populations and a formal mechanism to choose rumours/misunderstandings of public health concern and change communication messaging to address them.** It is important to work directly with communities through community discussions, utilise 937 hotline, and engage the RRT and primary healthcare unit health educators. Furthermore, it is important to analyse toll free hotline phone calls to determine question trends from the population.
- **Activate primary healthcare unit level communicators/educators, directorate level communicators, as well as the RRTs, to regularly conduct focus groups, intercept interviews, message tests, etc. with segments of the population during an emergency** to have frequent updates on rumours, misperceptions, local knowledge, attitudes and behaviours of the population. This should be coupled with reports from ongoing audience analyses per recommendations in the *Communication Engagement with the Affected Populations* section and support existing activities within primary healthcare unit community outreach programs..

Summary of group discussion top recommendations Dynamic Listening and Rumour Management

Recommendation: Activate primary healthcare unit level communicators/educators, directorate level communicators ,as well as the RRTs, to regularly conduct focus groups, intercept interviews, message tests, etc. with segments of the population during an emergency

- **Next steps:**
    - Establish a unit/team/head under the risk communication department leading this project.
    - Identify key stakeholders at primary healthcare unit level communicators/educators centrally and regionally.
    - Identify the segments of the population.
    - Build the capacity of the communicators by continuous training and assessment.
    - Monitor performance and feedback.
- **Timeline:**
    - 3-6 months

An alternative developed by the group discussion that might be considered:

Recommendation: Build a system for listening and rumour management via community discussions and 937hotline, by analysing questions trends from the population, and engaging the rapid response teams and primary healthcare units' health educators.

- **Next steps:**
    - Set up a software system for wide media monitoring and general perception of the public.

    - Test the system to cover at least 80% of the population.
    - Set thresholds to detect rumours and generate alerts.
    - Build the capacity of the system users and analysis skills.
    - Establish an escalation matrix, accountability matrix, where everyone knows what to do when and how.
- **Timeline:**
    - 3 months after approval of the budget for the system

Conclusion and next steps

- The MoH should establish a risk communications working group or identify a risk communication focal person to ensure that risk communication activities are taken forward. The MoH should immediately look into its existing structure and ensure that all levels will be represented in the risk communication working group.

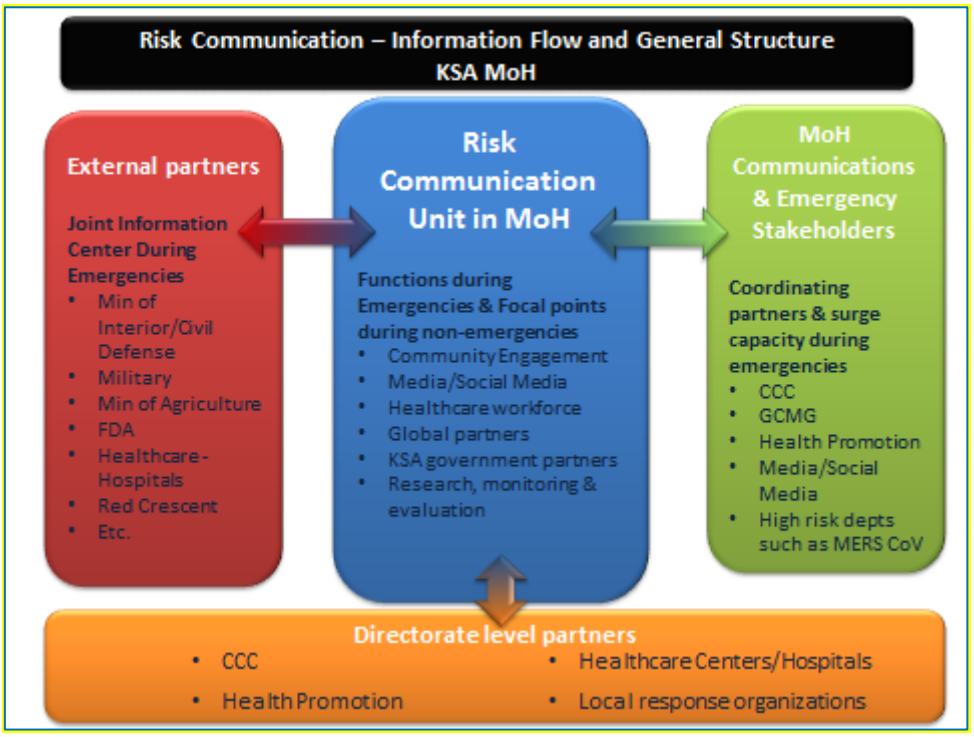
- The MoH should begin to draft a risk communication strategy and plan and bring high level stakeholders (internal and external) for a strategic planning review to include commitments of staff, time, activities and financial resources to be used during preparedness and emergency activation phases.

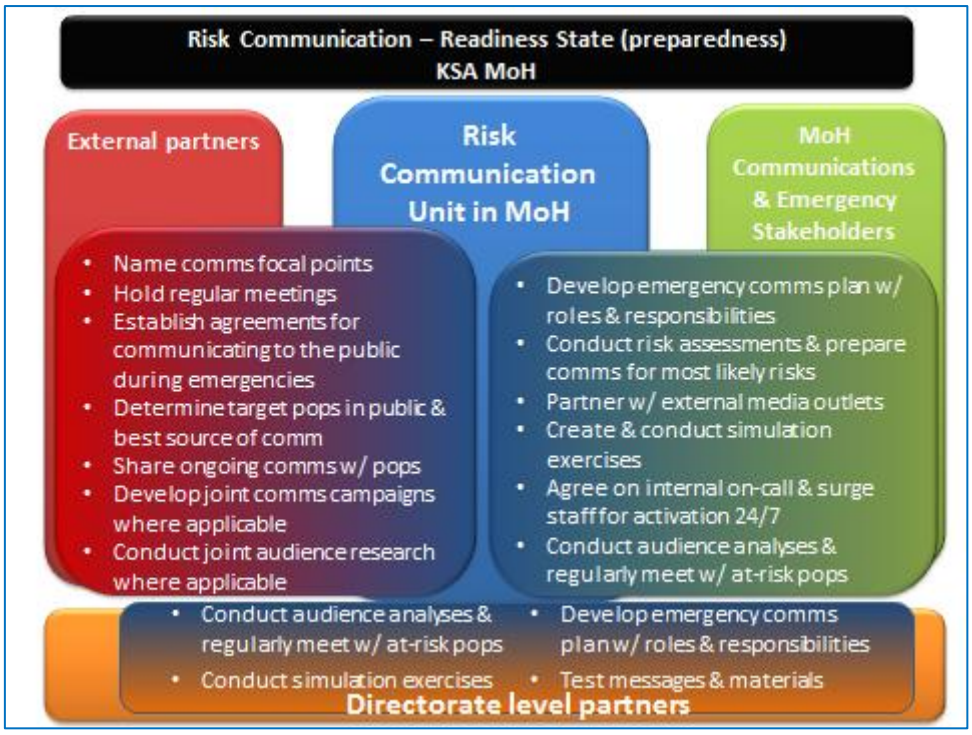
- The MoH should also have a scenario based session with key members of the national and international media to develop media plans for emergencies that meet the needs of media (deadlines, easier methods to get press statements, etc.)

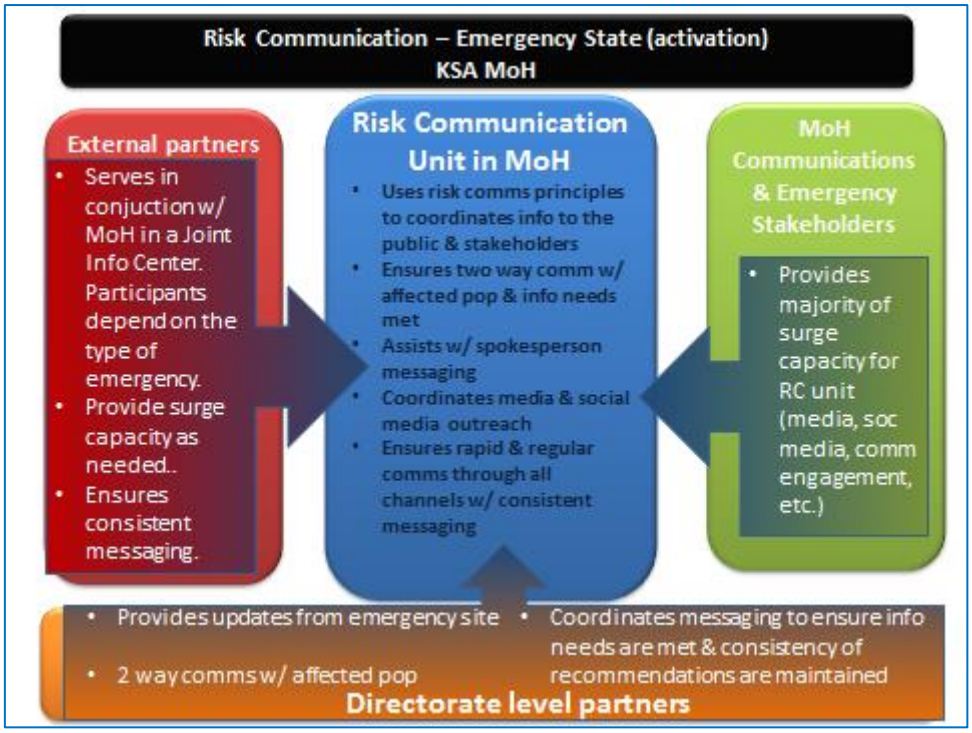
- The MoH should develop the standard operating procedures to provide specific directions on communication tasks that need to be performed in preparation for, during and after an emergency as well as to provide communications guidance during mass gatherings.

- The MoH should initiate the conduct of risk communication orientation workshops across all levels in the KSA system to increase awareness and acceptance of the approach as an integral component of public health emergency response.

Appendix 1 –Proposed Information/Work Flow for Risk Communication Unit in KSA MoH with preparedness and activation phases






Risk Communication – Emergency State (activation)
KSA MoH
External partners
Serves in conjuction w/ MoH in a Joint Info Center. Participants depend on the type of emergency.
Provide surge capacity as needed..
Ensures consistent messaging.
Risk Communication Unit in MoH
Uses risk comms principles to coordinates info to the public & stakeholders
Ensures two way comm w/ affected pop & info needs met
Assists w/ spokesperson messaging
Coordinates media & social media outreach
Ensures rapid & regular comms through all channels w/ consistent messaging
MoH Communications & Emergency Stakeholders
Provides majority of surge capacity for RC unit (media, soc media, comm engagement, etc.)
Provides updates from emergency site
2 way comms w/ affected pop
Coordinates messaging to ensure info needs are met & consistency of recommendations are maintained
Directorate level partners

Appendix 2 -Assessment interviewees and organizations

Internal, Ministry of Health: *Platforms:* CCC, Infection Prevention and Control (IPC), Health Electronic Surveillance Network Medina); *Departments:* Commander, Deputy Commander, Media and Public Relations, the Situation Room, Health Promotion, Health emergency department (Mecca)Laboratories and Blood Banks (Medina), supervision committee on Hajj and Umrah (Mecca) *Stakeholders:* Rapid Response Teams/Public Health Division, community teams, Healthcare Workers (HCW), Control Tower, MoH Hospitals, Public Health Centres (PHC),

External Partners, Government: Ministry of Interior (Civil Defence), Ministry of Agriculture, Ministry of National Guard (National Guard), Civil Aviation.Amanat Al-Assemah (Municipality of the holy capital Mecca), Jeddah Airport and Jeddah Islamic seaport

External Partners, Non-governmental and international organizations: Red Crescent Society (NGO), WHO, Private Sector.

Riyadh interviewees:

Deputy Minister for Public Health, Ministry of Health (MOH)

Supervisor General of the Relations, Media and Health Awareness, MOH

MERS-coV Program Coordinator & Health System Advisor, Deputyship of Public Health, Ministry of Health, Riyadh, Saudi Arabia

Director General, Health Emergency General Department, MOH

Representative from Infection Control, MOH

Pediatric Infectious Diseases Consultant/Director of Infection Control, Prince Mohammed bin Abdulaziz Hospital, Riyadh

Representative from Ministry of Agriculture

Representative from Primary Healthcare Centers

Mecca Interviewees:

General Director of Health Affairs, Makkah Region

Assistant Director of Health Affairs, Makkah Region

Head of Preparatory Committees for Hajj

General Supervisor for Hajj and Umrah, Ministry of Health, Makkah

Director of Hajj and Umrah Administration of Health Affairs, Makkah

Director of Emergency and Crisis Department, Makkah

Director of Public Relations, Makkah

Director of Al-Noor Hospital, Makkah

Medical Director in Al-Noor Hospital, Makkah

Director of King Faisal Hospital, Makkah

Saudi Red Crescent, Makkah

Holy Makkah Municipality

Health Control Centers Manager in King Abdulaziz International Airport, Jeddah

General Director of Hygiene, Holy Makkah Municipality

Manager Editor of Makkah Center

Technical Manager of Kadba and Hajera PHC Centre, Makkah

Command Control Center, Makkah

Jeddah Islamic Seaport

Medina Interviewees:

General Director of the Directorate of Health Affairs in Medina region.

Assistant Director for Healthcare Services

Deputy General Director

Head of Command and Control Center (CCC) in Medina Region.

Head of Infection Control in the CCC in Medina region

Responsible for the capacity platform at the CCC in Medina region

Head of Emergency and Disaster in Medina region

Head of Clinical Operations at CCC Medina region

Representative from the Public Health Section of the Directorate in Medina region

Deputy Director of Public Relations, Health Directorate Medina

Deputy Director of Infection Control

Infection Control Doctor in the Infection Control Department in Medina region

Immunization Coordinator, Medina region

Director of e-health, Medina region

General Director of Laboratories and Blood Banks

Director of Civil Defense in Medina region

Chairman of Emergency Medicine Department, Ministry of National Guard

Head of Public Relations, Ministry of Agriculture, Medina region

Veterinary, Ministry of Agriculture, Medina region

General Director, Saudi Red Crescent, Madina branch

Emergency Medicine Specialist, Saudi Red Crescent, Madina branch

Director of the Directorate of Points of Entry, Prince Mohammad Bin Abdulaziz International Airport

General Manager, Ohud Hospital, Madina (MERS designated Hospital)

Director, Al Safia Healthcare Center, Haram Al-Madina

Journalist, Al Ouyoun Newspaper, Medina

Appendix 3 –Risk Communication Capacity Assessment Tool 1

Assessing National Emergency Risk Communication capacity

Kingdom of Saudi Arabia

Draft Questionnaire

Communications Capacity Building Unit
Department of Communications
Office of the Director-General, WHO
January 2015

This tool is adapted from the **Protocol for Assessing National Surveillance and Response Capacities for the International Health Regulations (2005).**

These questions should be answered by the MoH communication unit. The tool should be shared with the Unit in advance if possible. It can be completed

1. by the national counterpart responsible for risk communications
2. jointly by national and international experts or as part of a mission, or
3. in a workshop with the relevant stakeholders who will be part of the communications response in an influenza pandemic.

This Tool is produced as part of WHO's work on supporting countries to establish or build their risk communications programme.

1. Communications coordination

1.1. Is there a designated unit for risk communication?
Yes ▭ No ▭ Unknown ▭ Not applicable ▭

1.2. Is this unit officially responsible for the coordination of all stakeholders in communications?
Yes ▭ No ▭ Unknown ▭ Not applicable ▭

1.3. Is there an inventory of all the communication partners, focal points and stakeholders in the country (government, non-government, private, institutions, etc.)?
Yes ▭ No ▭ Unknown ▭ Not applicable ▭

1.3.1. List partners:

1.4. Is there an inventory of the communication capacities of partners and stakeholders?
Yes ▭ No ▭ Unknown ▭ Not applicable ▭

1.5. Are there written and agreed protocols or SOPs defining the roles and responsibilities of various partners/stakeholders?
Yes ▭ No ▭ Unknown ▭ Not applicable ▭

1.5.1. If yes, are they disseminated?

2. Effective and transparent information dissemination

2.1. Is there a written regulation, policy or guideline on the accurate and timely release of information during a public health emergency/pandemic?
Yes ▭ No ▭ Unknown ▭ Not applicable ▭

2.1.1. If yes, has it been disseminated to all partners, levels and sectors?

2.2. Is there a designated spokesperson, and back-up, identified for communication during an emergency/pandemic?
Yes ▭ No ▭ Unknown ▭ Not applicable ▭

2.3. Is there a process in place for expediting approvals for information release?
Yes ▭ No ▭ Unknown ▭ Not applicable ▭

2.4. Are there procedures in place for clearance by scientific, technical and communications staff before the release of information during an emergency/pandemic?
Yes ▭ No ▭ Unknown ▭ Not applicable ▭

2.5. Are there procedures or protocols established on the dissemination of information during public health emergencies/a pandemic?
Yes ▭ No ▭ Unknown ▭ Not applicable ▭

2.6. How is information disseminated?

2.6.1. Media interviews

Yes ☐ No ☐ Unknown ☐ Not applicable ☐

2.6.2. Press briefings

Yes ☐ No ☐ Unknown ☐ Not applicable ☐

2.6.3. Press releases

Yes ☐ No ☐ Unknown ☐ Not applicable ☐

2.6.4. Press conferences

Yes ☐ No ☐ Unknown ☐ Not applicable ☐

2.6.5. Internet discussion groups

Yes ☐ No ☐ Unknown ☐ Not applicable ☐

2.6.6. Frequently asked questions

Yes ☐ No ☐ Unknown ☐ Not applicable ☐

2.6.7. Community meetings

Yes ☐ No ☐ Unknown ☐ Not applicable ☐

2.6.8. Radio discussions (radio talk shows)

Yes ☐ No ☐ Unknown ☐ Not applicable ☐

2.6.9. Television

Yes ☐ No ☐ Unknown ☐ Not applicable ☐

2.6.10. Radio

Yes ☐ No ☐ Unknown ☐ Not applicable ☐

2.6.11. Newspapers

Yes ☐ No ☐ Unknown ☐ Not applicable ☐

2.6.12. Website

Yes ☐ No ☐ Unknown ☐ Not applicable ☐

2.6.13. SMS text messaging

Yes ☐ No ☐ Unknown ☐ Not applicable ☐

2.6.14. Hotlines

Yes ☐ No ☐ Unknown ☐ Not applicable ☐

2.6.15. Social media

Yes ☐ No ☐ Unknown ☐ Not applicable ☐

2.6.16. Listservs

Yes ☐ No ☐ Unknown ☐ Not applicable ☐

2.6.17. Emergency alert systems

Yes ☐ No ☐ Unknown ☐ Not applicable ☐

2.6.18. Interpersonal communication channels

Yes ☐ No ☐ Unknown ☐ Not applicable ☐

2.6.19. Public meetings

Yes ☐ No ☐ Unknown ☐ Not applicable ☐

2.6.20. Community leaders

Yes ☐ No ☐ Unknown ☐ Not applicable ☐

2.6.21. Community groups

Yes ☐ No ☐ Unknown ☐ Not applicable ☐

2.6.22. Other:

Yes ☐ No ☐ Unknown ☐ Not applicable ☐

If yes, please provide details:

2.7. Is there a website or webpage available and accessible to media and the public for information dissemination?
Yes ▭ No ▭ Unknown ▭ Not applicable ▭

2.7.1. If yes, how often is it updated: _____ and by whom:_____

_____

3. Listening and understanding public and partner risk perception

3.1. Is there a mechanism in place that ensures that the views and perceptions of individuals and communities affected by public health emergencies/ a pandemic are taken into account at this level?
Yes ▭ No ▭ Unknown ▭ Not applicable ▭
3.1.1. If yes, describe:

_____

3.2. Has an assessment of risk perception been carried out?
Yes ▭ No ▭ Unknown ▭ Not applicable ▭
3.2.1. If yes, is there a process for integrating this information into the public health emergency/pandemic influenza response decision-making process?
Yes ▭ No ▭ Unknown ▭ Not applicable ▭
3.2.2. If yes, please describe details:

_____

4. Social mobilization and communication in support of community based interventions

4.1. Have appropriate community messages and information, education and communication materials been developed for various public health events?
Yes ▭ No ▭ Unknown ▭ Not applicable ▭
4.1.1. If yes, also for pandemic influenza?
Yes ▭ No ▭ Unknown ▭ Not applicable ▭
4.1.2. Have community messages and information, education and communication materials for pandemic influenza been tested and updated as needed?
Yes ▭ No ▭ Unknown ▭ Not applicable ▭

_____

4.2. Are there established procedures for managing rumours during a public health emergency?
Yes ▭ No ▭ Unknown ▭ Not applicable ▭
4.2.1. If yes, describe (who, how, what, when, outcomes):

_____

5. Emergency communication plan

5.1. Is there a plan for communication during a public health emergency in general or pandemic influenza specifically?
Yes ▭ No ▭ Unknown ▭ Not applicable ▭

5.1.1. If a communication plan exists, does it: (check all that apply)
5.1.1.1. Identify key audiences
Yes ▭ No ▭ Unknown ▭ Not applicable ▭
5.1.1.2. Include strategic coordination of communication with partners
Yes ▭ No ▭ Unknown ▭ Not applicable ▭
5.1.1.3. Set out ways to understand the needs, concerns and attitudes of the key audiences and feed this information to the outbreak management team
Yes ▭ No ▭ Unknown ▭ Not applicable ▭
5.1.1.4. Have tested messages that meet audience needs
Yes ▭ No ▭ Unknown ▭ Not applicable ▭

5.1.1.5. Have messages that have been reviewed for technical soundness and refined as needed
Yes ▭ No ▭ Unknown ▭ Not applicable ▭
5.1.1.6. Identify the right channels and formats by which to disseminate these messages
Yes ▭ No ▭ Unknown ▭ Not applicable ▭
5.1.1.7. Have the appropriate tools identified for the distribution of messages (i.e. situation reports, press releases, fact sheets, frequently asked questions, information materials)
Yes ▭ No ▭ Unknown ▭ Not applicable ▭
5.1.1.8. Identify partners through which messages can be disseminated
Yes ▭ No ▭ Unknown ▭ Not applicable ▭
5.1.1.9. Identify roles and responsibilities
Yes ▭ No ▭ Unknown ▭ Not applicable ▭
5.1.1.10. Identify the appropriate spokesperson
Yes ▭ No ▭ Unknown ▭ Not applicable ▭
5.1.1.11. Ensure that the communication to individuals, families and communities is consistent and expresses concern for lives and livelihoods, and identifies and uses appropriate media channels (printed press, radio, television, internet site)
Yes ▭ No ▭ Unknown ▭ Not applicable ▭

5.2. Have communication staff been trained on communication plans, incl. the pandemic influenza plan?
Yes ▭ No ▭ Unknown ▭ Not applicable ▭

5.3. Have pandemic influenza communication plans been tested?
Yes ▭ No ▭ Unknown ▭ Not applicable ▭
5.3.1. If yes, what was done (describe when, how, who was involved, etc):_____

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6. Communication evaluation

6.1. Is there a framework to evaluate the effectiveness of communications efforts?
Yes ▭ No ▭ Unknown ▭ Not applicable ▭

6.2. Is there a process that allows for the testing of communication strategies and activities with representative target audiences?
Yes ▭ No ▭ Unknown ▭ Not applicable ▭

6.3. Was an evaluation of the effectiveness of communications carried out during the last public health emergency?

Yes ▭ No ▭ Unknown ▭ Not applicable ▭

6.4. Was an evaluation of the effectiveness of communications carried out after the last public health emergency?

Yes ▭ No ▭ Unknown ▭ Not applicable ▭

6.5. How are evaluations findings integrated into the broader emergency management system to better identify challenges, and adapt and improve communication strategies (describe):

Appendix 4 –Risk Communication Capacity Assessment Tool 2

Item #	Grading/Domain	Questions – please provide explanation and examples to each question	Other sources of information
1	**Risk Communication Systems**		
1.1	No formal government risk communication arrangement. (No)	1.1.1 Is there a function for risk communication in your national response plan? **Yes** ☐ **No** ☐ 1.1.2. Are there communications personnel or government departments that informally respond to public information needs during emergencies? **Yes** ☐ **No** ☐	☐ National response plans – communication sections ☐ Organizational chart ☐ Other?
1.2	Formal government arrangement including a national multi-hazard emergency risk communication plan (reviewed within past 24 months) in place and a dedicated core team responsible for this area of work established; but significant gaps in capacity in human resources, platforms , and resources to deal with a large scale emergency. (Low)	1.2.1. Is there a permanent or surge staff dedicated to risk communication during emergencies? **Yes** ☐ **No** ☐ 1.2.2. Are the roles and responsibilities of the risk communication staff articulated in a response plan? **Yes** ☐ **No** ☐ 1.2.3. Are there significant improvements that could be made in the staffing, platforms, financial resources or other factors to improve communications with the public and partners during emergencies? **Yes** ☐ **No** ☐	☐ Emergency risk communications staff plans ☐ Job descriptions for communication staff members ☐ Other?
1.3	Formal government arrangements and systems in place with standard operating procedures and capacity with multi sectoral and multi-stakeholder involvement, but insufficient allocation and	1.3.1 Are there shared communication plans, agreements and/or standard operating procedures between other response agencies such as public safety, law enforcement, hospitals, emergency response, Red Cross/Crescent and/or government agencies such as Ministries of Defense, Agriculture, Food/Drug, etc.? **Yes** ☐ **No** ☐	☐ Shared agreements with response agencies ☐ Emergency response budget sample

Item #	Grading/Domain	Questions – please provide explanation and examples to each question	Other sources of information
	alignment of human and financial resources. (Moderate)	1.3.2 Is there a dedicated budget line for communications personnel, materials and activities for emergencies? **Yes** ☐ **No** ☐	☐ Meeting notes ☐ Other?
		1.3.3. Does communication to the public during an emergency automatically revert to another government agency besides or in conjunction with the Ministry of Health? **Yes** ☐ **No** ☐	
1.4	Fully operational national system established meeting criteria of all previous levels, with reasonable skilled and/or trained personnel and volunteers, and financial resources and arrangements for scale up as evidenced by a simulation exercise or tested by a real health emergency. (High)	1.4.1. Are the plans tested on at least a yearly basis? **Yes** ☐ **No** ☐	☐ Exercise plans and results ☐ Training workshop objectives/results ☐ Message clearance plan ☐ Other?
		1.4.2 Is training provided to the risk communications personnel for response to local hazards? **Yes** ☐ **No** ☐	
		1.4.3 Is there an agreement internal to your agency for clearance of messaging to the public? **Yes** ☐ **No** ☐	
1.5	Lessons learnt from capacity level 1.4 integrated into the revision of the national plans and the continuous strengthening of the system. Regular allocation of resources to maintain and grow the system. (Advanced)	1.5.1 Have alterations been made to response plans based on lessons learnt from exercises or actual responses? **Yes** ☐ **No** ☐	☐ Plan alterations ☐ Mechanism of sharing plan alteration ☐ Long term budget plan ☐ Other?
		1.5.2 Have communications response staff been made aware of and/or trained on response plan alterations? **Yes** ☐ **No** ☐	
		1.5.3 Is there a dedicated budget for the communications system to be sustained and to grow? **Yes** ☐ **No** ☐	
2	**Internal and Partner Communication and Coordination**		
2.1	No coordination platform and mechanisms for internal and	2.1.1 Is there a mechanism informally or formally to coordinate communication internal to your agency during an emergency?	☐ Internal and external coordination events

Item #	Grading/Domain	Questions – please provide explanation and examples to each question	Other sources of information
	partner communication for engaging key national, local and international stakeholders (including health care workers). (None)	**Yes** ☐ **No** ☐	☐ Other?
		2.1.2 Is there a mechanism informally or formally to coordinate communication among national stakeholders and response agencies during an emergency? **Yes** ☐ **No** ☐	
		2.1.3 Is there a mechanism informally or formally to coordinate communication among international stakeholders and response agencies during an emergency? **Yes** ☐ **No** ☐	
2.2	Some ad hoc communication coordination such as meetings with some partners and/or irregular information sharing. (Low)	2.2.1 Have there been incidents where stakeholder/partner agencies have released information that was inconsistent or contradicted your agency's information during an emergency? **Yes** ☐ **No** ☐	☐ Response reports ☐ News stories during past emergencies ☐ Other?
		2.2.2 Have there been incidents where valuable time was taken because of a lack of agreement regarding which agency would respond during an emergency? **Yes** ☐ **No** ☐	
		2.2.3 Do you have an example of an emergency or event that could have been better coordinated between partner agencies? **Yes** ☐ **No** ☐	
2.3	Communication coordination exists but with limited partner and stakeholder engagement including health care workers, civil society organizations, private sector and other non-state actors. (Moderate)	2.3.1 Is there a formal mechanism to coordinate communication with the hospital and healthcare sector during an emergency? **Yes** ☐ **No** ☐	☐ Plans for communication coordination with external agencies ☐ Other?
		2.3.2 Is there a formal mechanism to coordinate communication among civil society organizations during an emergency? **Yes** ☐ **No** ☐	
		2.3.3 Is there a formal mechanism to coordinate communication with the private sector during an emergency? **Yes** ☐ **No** ☐	

Item #	Grading/Domain	Questions – please provide explanation and examples to each question	Other sources of information
2.4	Effective, regular communication coordination with all partners required by all preceding levels, and their coordination tested by a simulation exercise or tested by a real health emergency. (High)	2.4.1 Has your organization conducted an exercise testing communication coordination with partner organizations? **Yes** ☐ **No** ☐ 2.4.2 Has your organization responded in an actual emergency that tested communication coordination with partner organizations? **Yes** ☐ **No** ☐	☐ After action reports from exercises or emergency responses ☐ Other?
2.5	Effective, regular and inclusive communication coordination with partners and stakeholders including definition of roles, sharing of resources and joint action plans. (Advanced)	2.5.1 Does your organization regularly develop communication response plans together with external partner and stakeholders? **Yes** ☐ **No** ☐ 2.5.2 Does your organization have a coordinated budget for communications response with external partners and stakeholders? **Yes** ☐ **No** ☐	☐ Agreed upon response plan and coordinated budget plan for emergency communications ☐ Other?
3	**Public Communication**		
3.1	No central unit or locus for public communication, reactive, ad hoc media outreach. (None)	3.1.1 Does your organization have a formalized function to communicate with the public? **Yes** ☐ **No** ☐	☐ Organizational chart ☐ Other?
3.2	Public communication unit or team exists, government spokesperson identified and	3.2.1 Does your organization have a designated and trained public spokesperson? **Yes** ☐ **No** ☐	☐ Media department strategy

Item #	Grading/Domain	Questions – please provide explanation and examples to each question	Other sources of information
	trained, procedures for public communication in place. (Low)	3.2.2 Does your organization have a communication team dedicated to media and social media outreach? **Yes** ☐ **No** ☐	☐ Other?
3.3	Level 2 (limited capacity) plus proactive public outreach on a mix of platforms (newspapers, radio, TV, social media, web) as appropriate according to national and local preferences; and in relevant national and local languages and otherwise understandable to populations . Use of locally relevant technologies for public communications (mobile phones, etc.) (Moderate)	3.3.1 Does your organization conduct target audience analyses to better understand audience language, trusted information resources and preferred communication channels? **Yes** ☐ **No** ☐	☐ Community outreach plans ☐ Media response plans ☐ Other?
		3.3.2 Does your organization have a communication strategy that proactively reaches out to a variety of media platforms such as newspapers, radio, TV, social media, web in order to target communication messages to specific audiences? **Yes** ☐ **No** ☐	
		3.3.3 Does your organization provide information in local languages as needed by the audience? **Yes** ☐ **No** ☐	
3.4	There is planned communication with continuous engagement and proactive media outreach (including regular media briefings) guided by risk communication best practices and achieves comprehensive geographical coverage, evidenced by regular coverage of health issues and risks in relevant languages; as well as by media and social media activity during an emergency. (High)	3.4.1 Does your organization conduct media research to determine message reach among target audience members? **Yes** ☐ **No** ☐	☐ Community outreach plans ☐ Media response plans ☐ Other?
		3.4.2 Does your organization alter public health messaging according to geographic location, language and media preference? **Yes** ☐ **No** ☐	
		3.4.3 During emergencies or exercises, does your organization provide regular media briefings and updates through mass and social media? **Yes** ☐ **No** ☐	
3.5	The government, partners and diverse media outlets are engaged	3.5.1 Does your organization contribute to an evidence base of what communications methods best enabled target audiences to change	☐ Communication

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	in robust and increasingly responsive collaboration to provide health advice, including addressing people's concerns and rumours; and address misinformation. (Advanced)	behaviour during emergencies? **Yes** ☐ **No** ☐	research protocols and publications (formal/informal) ☐ Examples of rumours and methods for handling them ☐ Other?
		3.5.2 Does your organization share experience and new strategies with partner organizations to continually improve communication response? **Yes** ☐ **No** ☐	
		3.5.3 Does your organization monitor for rumours and misinformation and when found address the issues rapidly? **Yes** ☐ **No** ☐	
4	**Communication Engagement with Affected Communities**		
4.1	No arrangement exists to systematically engage populations at community level for emergencies. There may be social mobilization, health promotion or community engagement on health risks for maternal child health, immunization, malaria, TB and HIV/AIDS, polio, NTDs and other developmental programmes but these are not systematically used for emergencies. (None)	4.1.1 Does your organization have a social mobilization, health promotion or community engagement department that is used for communication response during emergencies? **Yes** ☐ **No** ☐	☐ Organizational charts ☐ Other?
4.2	Community level engagement system is semi-formed with mapping of existing processes, programmes, partners and stakeholders. Social mobilization,	4.2.1 Does your organization have a social mobilization, health promotion or community engagement department that regularly works with a risk communications and/or media department within your organization? **Yes** ☐ **No** ☐	☐ Reports on local at-risk populations ☐ Risk assessments that

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	behaviour change communication and community engagement are included in the national risk communication strategy in the context of health emergencies. Some key stakeholders in this domain are identified at national and provincial level. (Low)	4.2.2 Does your organization have a social mobilization, health promotion or community engagement department that has already outlined basic information on at-risk populations and information needs for the most likely local public health threats? **Yes** ☐ **No** ☐	address most likely local public health threats ☐ National response plan – communication section ☐ Other?
		4.2.3 Is social mobilization, health promotion or community engagement included in the national response plan? **Yes** ☐ **No** ☐	
4.3	Stakeholders mapped at provincial/district and local levels, decentralized system (including financial and human resources) in place for community engagement involving community and religious leaders, community based organisations (CBOs), and other decentralized teams. Standard practice of developing information education communication (IEC) materials with the involvement of community and key stakeholders. Community consultation mechanisms are in place (e.g. hotline, surveys, etc.) (Moderate)	4.3.1 Does your organization have a social mobilization, health promotion or community engagement functions working at district/provincial levels? **Yes** ☐ **No** ☐	☐ Organizational charts ☐ Materials testing protocols ☐ Communication campaign strategy examples ☐ Other?
		4.3.2 Do district/provincial level community engagement functions work in vertical fashion that enables national level leadership to both learn from districts and share lessons learned with other districts? **Yes** ☐ **No** ☐	
		4.3.3 Do community outreach programs regularly conduct information education communication (IEC) materials testing with members of the target audience? **Yes** ☐ **No** ☐	
4.4	Regular briefing, training and engagement of social mobilization and community engagement teams including volunteers. Mechanisms to harness scale up	4.4.1 Does your organization regularly provide information sharing or training opportunities between experienced community engagement experts and volunteers or potential surge capacity to be used during emergencies? **Yes** ☐ **No** ☐	☐ National response plan – communication section ☐ Surge capacity plan

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	capacity exist and are operational. Feedback loop from listening (Domain 5) into community engagement is operational. (High)	4.4.2 Does your organization have a plan to scale up existing community engagement capacities to be deployed during emergencies? **Yes** ☐ **No** ☐	☐ Data from public health hotline (relevant questions from the public, etc.) ☐ Other?
		4.4.3 Is there an ongoing and functioning feedback loop between at-risk or affected populations and response agencies? **Yes** ☐ **No** ☐	
4.5	Communities are equal partners in risk communication process as evidenced by the review of a simulation exercise or tested by a real health emergency. (Advanced)	4.5.1 Does your organization regularly and rapidly change messaging to address audience feedback, misinformation and questions? **Yes** ☐ **No** ☐	☐ Community outreach plan ☐ After action report from actual emergency or exercise ☐ Other?
		4.5.2 During the last actual emergency or exercise was there a clear function to receive audience feedback or questions? **Yes** ☐ **No** ☐	
		4.5.3 Is there an ongoing and functioning feedback loop between at-risk or affected populations and response agencies? **Yes** ☐ **No** ☐	
5	**Dynamic Listening and Rumour Management**		
5.1	No system exists to identify or response to rumours, and misinformation; nor to understand and analyse public concerns and fears. (None)	5.1.1 Does your organization have a formal communication function to monitor and address rumours and misinformation? **Yes** ☐ **No** ☐	☐ Media response plans ☐ Other?
5.2	Ad hoc systems for listening and rumour management, including through health care workers, but not fully used to guide the response. (Low)	5.2.1 Does your organization have ad hoc methods in which to hear about some rumours regarding public health issues (health care workers, hotline information, etc?) **Yes** ☐ **No** ☐	☐ Data from public health hotline (relevant questions from the public, etc.) ☐ Other?

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5.3	Routine and event-based systems for listening and rumour management or ongoing system with limited or unpredictable influence on the response. (Moderate)	5.3.1 Does your organization have a method for addressing rumours and misinformation? **Yes** ☐ **No** ☐ 5.3.2 Does your organization monitor the effectiveness of methods or messages used to disprove a rumour or correct misinformation? **Yes** ☐ **No** ☐	☐ Media response plans ☐ Other?
5.4	Strong system for listening and rumour management on a permanent basis which is integrated into the decision-making and response actions for public communications (Domain 3), Communication Engagement with Affected Communities (Domain 4), as well as for internal and partners communications (Domain 2). (High)	5.4.1 Does your organization regularly collect rumours and misinformation, the methods and messages to address them and shares them with partners to ensure message consistency? **Yes** ☐ **No** ☐ 5.4.1 Does your organization consider communication feedback including rumours and misinformation from the public in its decision making process to improve communication response? **Yes** ☐ **No** ☐	☐ Media response plans ☐ Data from public health hotline (relevant questions from the public, etc.) ☐ Other?
5.5	Misinformation and rumours have little or minimum traction because risk communication is effective; the public(s) trust official health advice; and desired behaviour change is evidenced where appropriate. (Advanced)	5.5.5 Does your organization regularly evaluate its communication response and ability to address rumours and misinformation to determine that actions changed behaviour and/or stopped the rumour from spreading? **Yes** ☐ **No** ☐	☐ Media response plans ☐ Other?