



TRUST DEFICIT IN GOVERNANCE RELATED TO COVID-19 RISK COMMUNICATION IN PAKISTAN

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Abstract

This study aims to explore the reasons for the trust deficit in risk communication mediums designed by the government of Pakistan. Effective risk communication is vital to prevent the emergence of more COVID-19 cases and for the government to ensure that the people trust it and follow the set guidelines. The study highlights the gaps between the general public and the risk communication and community engagement platforms designed by the government. This study was conducted using primary and secondary methods of research. Primary data was collected using an online group discussion on Facebook. A group was specially created to discuss matters related to COVID-19 risk communication in Pakistan, and the collected data was then analyzed using discourse analysis. Moreover, as part of secondary research, documents and content including the National Action Plan designed by the government of Pakistan and Risk Communication and Community Engagement (RCCE) material was reviewed. Risk communication mediums such as the government's official online portal (covid.gov.pk), WhatsApp chatbot, and the COVID-19 helpline were used to triangulate the research results. The study concludes that the reasons for trust deficit are an overabundance of information, the government's weak policy implementation structure, lack of health-education, and stigmatization of the disease. Effective modes of risk communication can prevent the virus from spreading further and lower the incidence of cases, while decreasing the burden on healthcare facilities. To prevent the disease from spreading, it is integral for the government to gain public trust and get people to follow the issued guidelines.

Keywords: COVID-19, Risk Communication, Trust Deficit, Governance, Pakistan



Introduction

The COVID-19 pandemic, accompanied by an infodemic, has adversely impacted both world citizenry and governing institutions at varying magnitudes. An infodemic is “an over-abundance of information- some accurate and some not- that makes it hard for people to find trustworthy sources and reliable guidance when they need it” (PAHO and WHO, 2020). The overabundance of information and misinformation makes it hard for people to differentiate between what is true or false, leading them to a state of vulnerability. Lack of (accurate) information during a health crisis causes chaos which can be avoided with better planning if people know the correct facts and figures (UNICEF, 2020). It also spreads fear and causes stigmatization of the disease. Rumors and misinformation accompanied by a lack of information from public health officials have caused an infodemic in Pakistan.

Trust deficit means that the level of trust is lower than it should be. Trust is a “scarce societal resource” (Graves, 2013). Its deficit in governance implies that people are skeptical of the government’s abilities and intentions (Ahmed, 2020). According to Gallup Pakistan, one in three Pakistanis continues to be skeptical of the number of cases of COVID-19 being reported by the government (Gallup and Gilani Research Foundation, 2020).

Pakistan’s healthcare apparatus is a mixed system of large and small primary healthcare facilities in urban cities and small clinics in rural areas. Private healthcare sector along with NGO’s and philanthropic agencies work together with the system in order to support Pakistan’s healthcare requirements (WHO, 2018). The public health system is reportedly facing challenges because of low accountability within the government, inadequate staff and skilled professionals, and poor resource allocation across different levels of healthcare (WHO, 2018). The inherent problems of corruption, undue political involvement, and trust deficit, combined with the COVID-19 infodemic, inadequate health-literacy, and an underdeveloped public health system have made the country vulnerable to second and third waves of the pandemic. Pakistan’s healthcare system ranks 154th out of 195 countries (Fullman, Lozano, & Murray, 2018). The healthcare system alone cannot withstand the stress of a pandemic. Therefore, it is integral for the population to follow preventive measures to protect themselves from the disease. Improving public health via education, policymaking and scientific research for disease prevention can reduce the burden on Pakistan’s healthcare industry.

Health education is an essential tool that can be used to improve public health (Porat, Nyrup, Calvo, Paudyal, & Ford, 2020). Public health focuses on the prevention, detection and response of diseases and health conditions, and not the treatment of populations (CDC Foundation, 2020). This can be done via promoting healthy lifestyles and encouraging research of disease and injury prevention. During the Ebola epidemic of 2014-2016, Sri Lanka practiced Health Education combined with Behavior Change Communication according to the cultural and ethnic values of the citizens. The Sri Lankan government adopted a community participatory approach to bring about behavior change to focus on prevention rather than cure. Public health experts introduced culturally appropriate communication strategies by understanding the information ecosystem of the country. They built trust with informal leaders of communities to bridge the trust gap between the public and government (Rupasinghe, 2020).

There is a lack of data related to pandemic preparedness and the importance of public health in containing communicable disease outbreaks in Pakistan. Pakistan is one of the only two countries where the poliovirus is still an endemic because of the misconceptions about the vaccine, insecurity within the country, and a frail healthcare system (Shah, et al., 2016). One of the reasons for failure of polio eradication from Pakistan is the limited involvement of local communities and no measures to educate them according to their cultural values and concerns. Instead of following the programs set up by international organizations the government of Pakistan needs to adopt a bottoms-up approach and take ownership of the issue (Asghar, 2020).

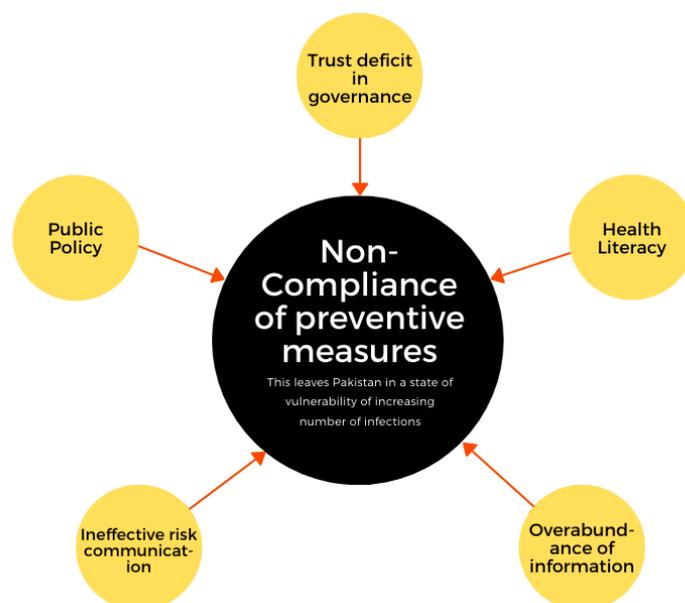


Figure 1: The conceptual framework forming in this study is that the current infodemic (overabundance of information), trust deficit in governance, current standard of health literacy, the policy framework in place and ineffective risk communication from the government's end, all lead to non-compliance of preventive measures to control COVID-19. This leaves Pakistan in a place of vulnerability to increased rates of infections. Public policy related to pandemic preparedness and management should include health literacy and behavior change communication to make risk communication more effective. This improvement in the policy will train people to verify information, filter out misinformation and incorporate the preventive measures required to prevent the disease.

This study explores the reasons behind the trust deficit in risk communication mediums designed by the government of Pakistan. Its theoretical framework draws on the Foucauldian framework of discourse. According to Foucault, a French philosopher associated with the structuralist and post-structuralist movements, discourse is a mediating lens that allows reality to be viewed in context to its effect on culture. Discourse builds knowledge, knowledge builds power, hence discourse produces and reproduces knowledge and power simultaneously (Thomson, 2011). In Foucault's words, discourse analysis is the same as unearthing "the history of the present" (Kupe, 2012). In this situation, the power relationship between the government and the general public will be viewed using discourse analysis. This study uses Foucault's theory of discourse as the lens to assess the dynamics of language and trust between government and people in light of the current standing of health literacy and policy framework for risk communication in Pakistan. Discourse relates language to texts and their contexts. Discourse analysis is used to explore how language shapes certain phenomena.

Literature Review

Trust Deficit in Governance

Trust deficit in governance is not new in Pakistan. It exists in most sectors such as public health (Irfan & Ijaz, 2011), education (Talpur, 2018), law enforcement (Shah S. Q., 2016), and the economy (Ahmed, 2020). A few reasons for the trust deficit in the economic context are poor governance, unnecessary political intervention, corruption, and weak implementation structures. This lack of trust has resulted in rampant tax evasion ensuing the country's tax payment rate lowest

in the world (Rehman & Usama, 2019). According to the 2020 report published by Transparency International, Pakistan's Corruption Perception Index (CPI) was 32 (0 being highly corrupt and 100 being highly clean) and the country ranks at 120 among 197 countries for the level of corruption (Transparency.org, 2020). Powerbrokers in the country use their political influence to by-pass the law for personal gains (Faisal & Jafri, 2017). Therefore, law enforcement is inefficient. Patterns similar to by-passing tax laws can be observed in following the standard operating procedures (SOPs) of the COVID-19 response, and the government's failure in getting the public to conform to them (Dawn News, 2020).

This theme covers literature related to the importance of citizen's trust, the significance of effective risk communication, and incidences of deliberate data tampering. Lessons from the failure of eradication of the poliovirus can be used to come up with a stronger and more effective response for COVID-19 (Asghar, 2020). Trust deficit in governance is one of the reasons why poliovirus is still prevalent in Pakistan (Asghar, 2020). Asghar (2020) argues that because of a top-down approach where communities were simply expected to get vaccinated for polio, people were not receptive to the urgency and importance of it. He recommends that real partnerships with local input should be used instead, as was done in South Waziristan (Asghar, 2020). The literature includes the examples of developed countries such as New Zealand that used effective risk communication to contain the virus using good governance and smart leadership. Their key premise was to build citizens' trust through providing transparency about government decision making (Wilson, 2020). However, the same solution cannot be adopted by Pakistan since it is a developing country and is notorious for corruption. There was a literature gap related to the impact of effective risk communication and the level of trust related to COVID-19 in developing countries with lower resources.

The overabundance of information, misinformation and status of health literacy

In-depth interviews

The reviewed literature highlights the importance of scientific thought and reasoning, health literacy, the influence of religious conservatism, and the politicization of the pandemic. COVID-19 is a global outbreak that has affected 220

countries all of which have some common grounds helping to relay information across borders (Zainul, 2020). This influx in the volume of information amplified via social media has led the world towards an infodemic (Pan American Health Organization, 2020).

While in Pakistan's context, misinformation and rumors involve socio-political and religious influence which needs to be addressed accordingly, the existing literature mainly talks about the infodemic in a global context. Health literacy is defined as, "the degree to which individuals have the capacity to obtain, understand, communicate and apply basic health information and services needed to improve one's health" (Jabeen, Rehman, Masood, Mahmood, & Mashhadi, 2018).

Religious conservatism also played a strong hand in spreading disinformation in Pakistan. Molana Fazal-ur-Rehman, a Pakistani politician and president of Jamiat-e-Ulema (a sunni Deobandi religious political party), claimed that just as an infected person sleeps, the virus also sleeps (Dekhtay Raho TV Official, 2020). Other religious personalities publicly refused to avoid congregational prayers in mosques (ur-Rehman, Abi-Habib, & Mehsud, 2020).

Such statements shared by religious leaders on national television undermine what public health experts demand in the given context. While the country was in lockdown and people were being encouraged to stay at home by the government, politically motivated and factually unchecked statements downplayed the situation causing more confusion among them. The implication of such rumors is that people who follow these leaders do not comply with the SOPs, in this case it was to avoid public gatherings at mosques. Pakistan was the only country that did not ban public gatherings at mosques during the first pandemic wave in the country (ur-Rehman, Abi-Habib, & Mehsud, 2020). This problem being exclusive to Pakistan was not discussed in the reviewed literature, therefore it is important to highlight it and come up with alternate effective risk communication strategies.

Importance of effective risk communication

A 2016-17 quantitative study conducted in Pakistan on the effectiveness of public messaging with regards to polio vaccination, family planning, HIV Aids, and breast cancer awareness highlighted the importance of public health awareness campaigns as drivers of behavior change for the public. (Hanan, Saleem, Khawar,

& Arshad, 2019). The same study concluded televised campaigns as more convincing means for public behavior change in comparison to print media. Effective means of public health awareness other than mass media outreach include on-ground mobilization and digital media platforms (ICRC, 2019).

Sri Lanka's experience with Ebola using community participatory approaches were reviewed, Incorporating community dialogue and involving informal community leaders to communicate with the public in order to deal with misinformation proved successful in Sri Lanka (Rupasinghe, 2020).

Moreover, to control the infodemic, citizens should be encouraged to verify information before sharing it (Zainul, 2020). Zainul (2020) also suggests that proportionate punishment should also be decided for those who spread disinformation with the intent of creating panic. The existing literature only talks about recommendations to address the infodemic due to the new nature of the problem. These are only policy recommendations at the moment. As part of this research study, the guidelines for controlling misinformation and effective risk communication will be analyzed from the official document of National Action Plan for Corona Virus (Covid-19) Diseases.

New Zealand was able to curb the virus because of its effective planning and ability to communicate clear consistent messages while empathizing with its citizens (McGuire, Cunnigham, Reynolds, & Mathews-Smith, 2020). Crisis leadership and communication by the New Zealand Prime Minister played a critical role in increasing public trust, therefore getting them to abide by the prescribed preventive measures. It is important to highlight here that in Pakistan's context the general level of trust is already low, thus these measures alone cannot be expected to be effective.

Effective risk communication is crucial for containing public health emergencies (Zhang, Li, & Chen, 2020) Taking poliovirus as an example, Pakistan is one of the only two countries that has failed to eliminate poliovirus because of the misinformation and rumors about the vaccine, poor health systems, lack of health literacy, and resistance from religious parties such as Tehreek-e-Taliban (Shah, et al., 2016).

It is integral that Pakistan improves its risk communication for COVID-19 for two reasons:

1. To prevent the resurgence of any more waves. Unless people follow precautionary measures, the country will remain vulnerable to more cases of the disease. Since the disease is contagious, it is imperative that the virus is contained. The country will remain vulnerable until everyone gets vaccinated.
2. Developing trust now will also help with handling future health crises. South Korea had the MERS epidemic in 2015 and COVID-19 in 2020. South Korea learned from its mistakes in risk communication in 2015 and improved its risk communication for COVID-19 and was successfully able to contain the pandemic (Bautista, 2020).

Design And Methods

An exploratory study is most appropriate for topics that are new and not studied comprehensively in the past (Singh, 2007). I chose this design as it complements the research question, the kind of resources available, and the limited timeframe of the study.

I used a combination of primary and secondary research methods for data collection. Online group discussions were used for primary research, and content and document analysis for secondary research. Primary data was collected through group discussions conducted online. This ensured that the regulated health guidelines are not violated in the research process. As Facebook is the most commonly used social media platform in Pakistan, with 39 million users (Social, DataReportal, Hootsuite, & Facebook, 2020), participants were recruited from advertising the research on Facebook groups centered on COVID-19 emergency updates. The primary data collection continued from October to November 2020.

A closed private group was created on Facebook with the name 'Risk Communication related to COVID-19 in Pakistan'. The group was advertised with the tagline *Your Thoughts Matter*. The group along with the purpose of the study was advertised on two Facebook groups designed for COVID-19 emergency updates. The first group had 56000 members and the other had 331000 members. Each group has hundreds of new posts, therefore the ad initially perished in the multitude of other posts. Then special assistance was sought from the group admins to promote the ad for this research.

The group was moderated by the lead researcher. The participants were recruited via purposeful sampling. There were twenty-six participants, all of them older than 18 years of age and residing in Pakistan during the first wave of COVID-19. It was important to select people who were living in Pakistan during the first wave because they needed to be present in the country ensuring that they had actively observed the situation around them. The data collected was coded thematically using MaxQDA and then analyzed to answer the research question.

Initially, around 40–45 people were requested to join the research group. The group had membership questions which asked the potential participants if they would be willing to be part of the research. Those who said yes were allowed and those who refused were denied. This brought down the number of members to 26. These members were asked to read and sign the consent form. The consent form was in English and included a video with Urdu translation of the form. All 26 members signed the form and agreed to be a part of the study but only 18 responded to the prompts posted on the group and the remaining 8 made zero responses.

One question was posted per day and the participants were notified via WhatsApp, in case they missed the Facebook notification. Participants were reminded once after twelve hours to respond to the question again.

Since people's responses were already in a textual form, therefore transcriptions were not required. Participants used a combination of lower case and upper-case alphabets in their responses to express their emotions. Some participants also used emoticons instead of words to share their responses. For a few questions, people also reacted to other people's comments through the likes and wow reacts signifying that they agree with what the other person is saying or a piece of information was new for them.

The most helpful feature of using an online Facebook group discussion was that each comment was there for other participants to see. Therefore, the comments were open for discussion throughout the data collection timeframe. However, after posting the first three questions it was observed that the participants' level of enthusiasm had reduced. It is projected that the observation is based in the lack of personal connection between the researcher and the participants. Participants' information was protected by restricting access to the Facebook group. Once the data collection was completed, all participants were removed

from the group. The data for content and document analysis was publicly available, therefore protecting it was not a major concern. However, all data was protected on the main researcher's password-protected device.

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For the purpose of triangulation, content analysis was done to analyze the official online portal for COVID-19 and other services such as their WhatsApp chatbot and the public awareness dialer tune. Lastly, the Risk Communication and Community Engagement section in the National Action Plan for COVID-19 designed by the Government of Pakistan and the Ministry of National Health Services was analyzed. The purpose of doing primary and secondary research was to triangulate data and ensure the reliability of results.

Content analysis of the national COVID-19 website and the WhatsApp chatbot was fairly simple and straightforward. Analyzing the website and the WhatsApp chatbot service gave information about the strengths and weaknesses of the already existing risk communication and public awareness mediums. Lastly, pages 104 to 108 from the National Action Plan for COVID-19, authored by the Government of Pakistan were analyzed. These pages included the Risk Communication and Community Engagement plan for COVID-19 and the IEC (Information, Education, and Communication) Materials for COVID-19. This was done to find out what was the government's plan for risk communication and public awareness when Pakistan was only anticipating the health crisis. Content and document analysis of the aforementioned resources was essentially done to triangulate the acquired primary data (See Appendix B for list of questions).

Presentation And Analysis Of Data

Foucault describes power as an instrument that enables certain knowledge to be produced and known and the same power also controls how much knowledge is accessible by people (Given, 2008). The collected data was analyzed using Foucauldian discourse analysis, to explore reasons for trust deficit in governance

related to COVID-19. One of the key aspects to consider here are the power relations between the government and the public to understand how this effects the discourse related to COVID-19.

According to the World Health Organization, Risk Communication is defined as: The exchange of real-time information, advice, and opinions between experts and people facing threats to their health, economic or social well-being. The ultimate purpose of risk communication is to enable people at risk to make informed decisions to protect themselves and their loved ones (WHO, 2020).

The relevant details from the National Action Plan (NAP) for COVID-19 to help answer this research question were found in the Risk Communication and Community Engagement (RCCE) Section.

Pakistan had already started preparing for the virus before the first case was diagnosed in the country. The main objective of the NAP was to “ensure the current outbreak is contained,” and “to strengthen country and community engagement response to potential events due to COVID-19” (Government of Pakistan; Ministry of National Health Services, Regulation and Coordination, 2020). The last strategic development goal quoted in the same document is to “expand scope of community ownership and understanding in the population through risk communication and engagement.”

In the annexure, a detailed plan for RCCE is given and its core objectives are to “educate on COVID-19 and its prevention, to address misconceptions, to build trust in GOP’s preparedness and responseto COVID-19.” Prevention comes from raising public awareness and effective risk communication. Transparency in matters related to COVID-19 epidemiology will build trust in governance and address misconceptions.

To implement the directives of the NAP, a helpline was introduced along with a WhatsApp chatbot and a website. The helpline directs people to healthcare personnel who are trained to answer questions people may have related to the pandemic. The WhatsApp chatbot has a variety of features and is an automated service that functions in multiple languages. It is simple to use, and its multiple features include basic information and preventive measures related to COVID-19; guidelines to self-assess for COVID, links to public awareness videos, daily epidemiological updates, and connectivity to a doctor. While most of these features work, few of them such as epidemiological updates and connect

to a doctor are unresponsive.

The data available on the COVID-19 Website is summarized in Table 1.

Material for Risk Communication	Checklist	Material available	Frequency of updating information	Language
Real-time information	✓	Number of cases, deaths, recoveries, tests (daily and cumulative). Data visualized using bar graphs and line graphs. Provincial data only. City wise data unavailable.	Data is updated every day once between 8 am and 10 am.	English only
Material for Health Awareness	✓	Common symptoms. Myths and facts about the disease. Frequently asked questions Transmission and Prevention Videos about COVID-19	Occasionally updated. Most data was updated in March only.	Everything in English other than the public awareness message videos that were recorded in Urdu. 3 posters in Urdu also. (attached in the appendices)
Material for Economic Well-being	✓	Video messages of the Prime Minister's Press Conferences that briefly talk about the current economic standing.	Updated in March 2020 only.	Urdu
Material for Social Well-being	✓	Guidelines for different protocols such as social distancing, wearing masks, reopening, Ramadan, and Eid.	Updated Monthly	In English and Urdu both.

Table 1: A summary of data available on the COVID-19 website (Government of Pakistan)

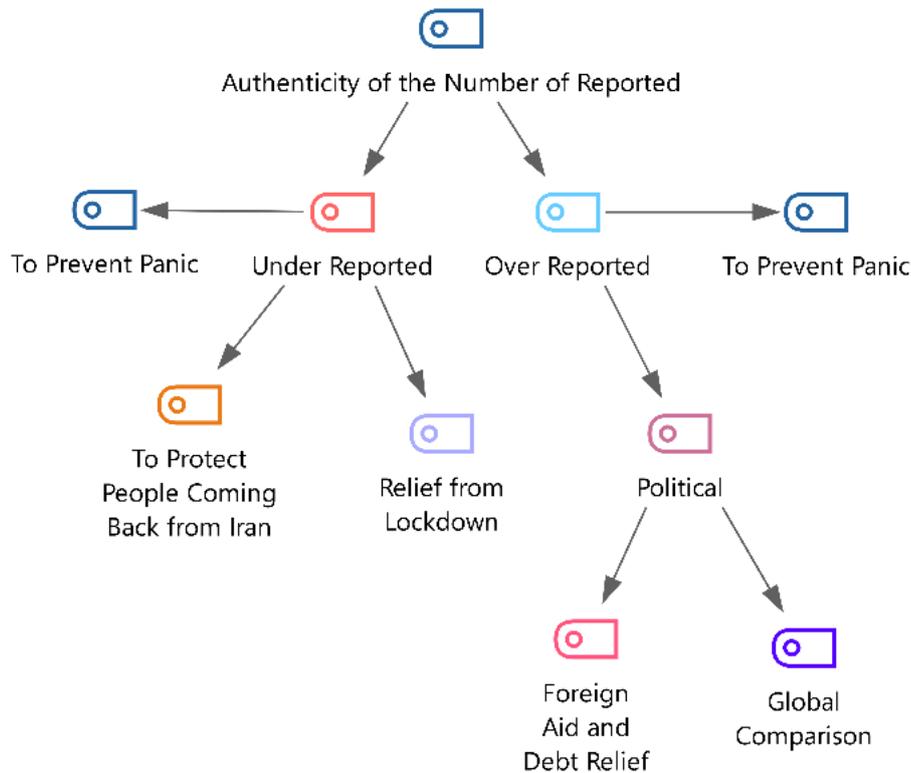


Figure 2

As part of the primary research to explore reasons behind trust deficiency in governance related to risk communication related to COVID-19 in Pakistan during the first wave, the participants from the online group discussions were asked a few questions about the different risk communication mediums initiated by the GoP as part of their RCCE plan.

When asked about the authenticity of the daily epidemiological updates, none of the participants believed that the numbers being reported were accurate. Some participants said that the numbers were under-reported while others said that they were over-reported (see Figure 2). The reasons for doubts in the accuracy of the numbers of cases are summarized in Figure 3. All responses showed underlying reasons behind of the lack of trust.

A participant said, *“I think the numbers have always been underestimated. It may not be deliberate at first but the government hasn’t taken any measures to make their reporting efficient. The COVID testing is not easily accessible to everyone. Having seen the situation of SOPs in Karachi, I highly doubt that Pakistan has successfully contained*

the COVID disaster.”

The collected responses suggested that situation of implementing precautionary measures and following SOPs was not supporting the number of cases being reported.

Another participant said, “I thought that the numbers released by the government are inflated to gain access to maximum public funds (taxes) which would then be misused due to widespread corruption.”

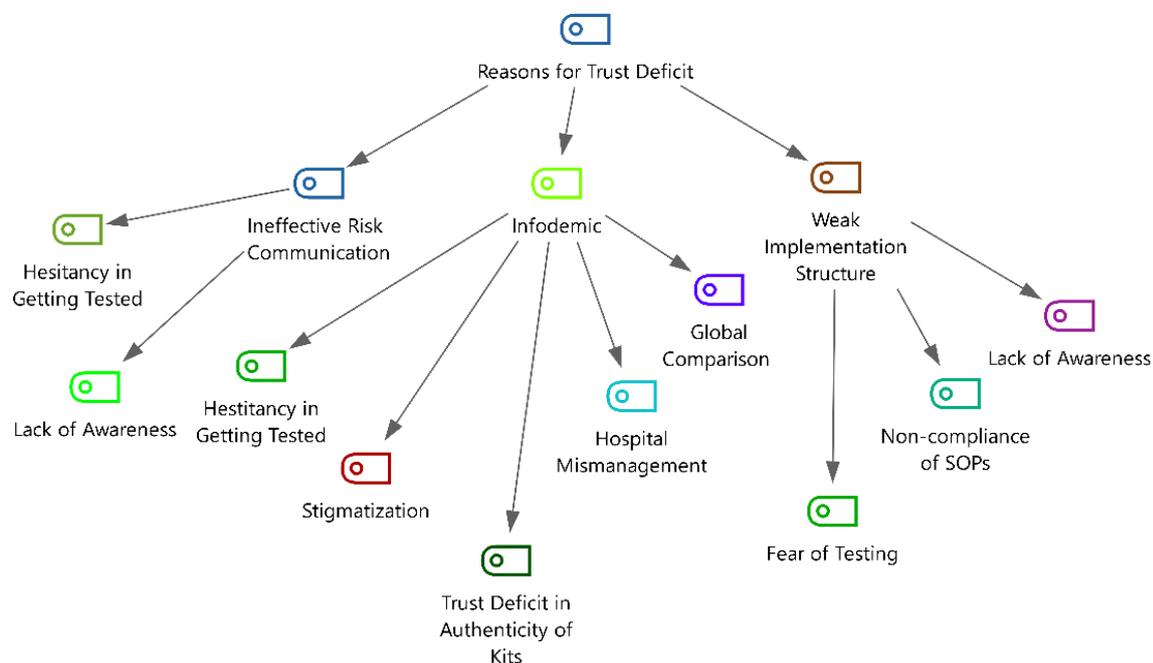


Figure 3: Reasons for trust deficit in accuracy in the number of reported cases.

The reasons for the trust deficit were thematically divided into three categories. Ineffective risk communication, infodemic, and weak implementation structures. Participants reported that they did not trust the number of cases being reported to be accurate because enough tests were not being conducted due to fear of testing, rumors about inauthentic testing kits, stigmatization, and a general lack of awareness.

One of the participants said, “The number of cases in developed countries was high and it was hard to believe that a developing country where people rarely follow rules and safety precautions, would have lower cases.”

Participants were asked if they ever had the chance to use the COVID-19 Helpline, the WhatsApp chat service, and the COVID-19 online portal. The responses are summarized in Figures 4, 5, and 6.

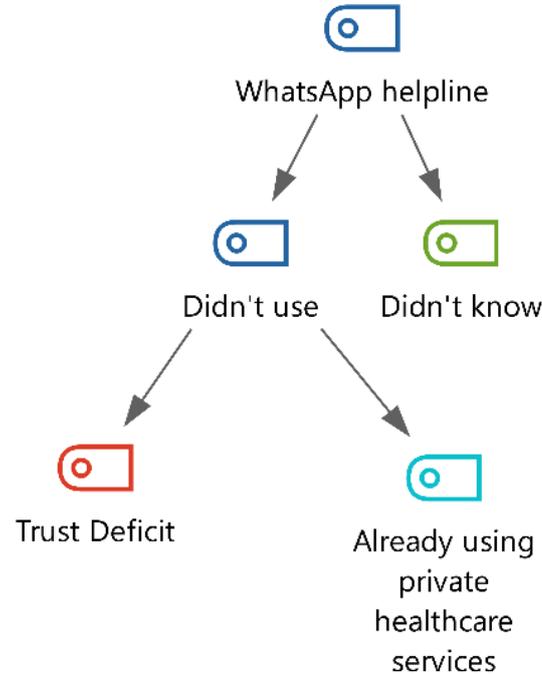


Figure 4: Participants were asked if they ever used the COVID-19 Helpline

Few participants used it and found it helpful, and one did not receive any response from the helpline. This helpline was contacted multiple times for the purpose of this research and all those times it was unresponsive as well. Most participants did not know about this helpline which highlights that the problem is not with the medium but with the marketing strategy. One of the participants commented, “*I was unaware of the existence of a functional COVID helpline.*” Other participants knew about it but did not use it as they had access to private healthcare.

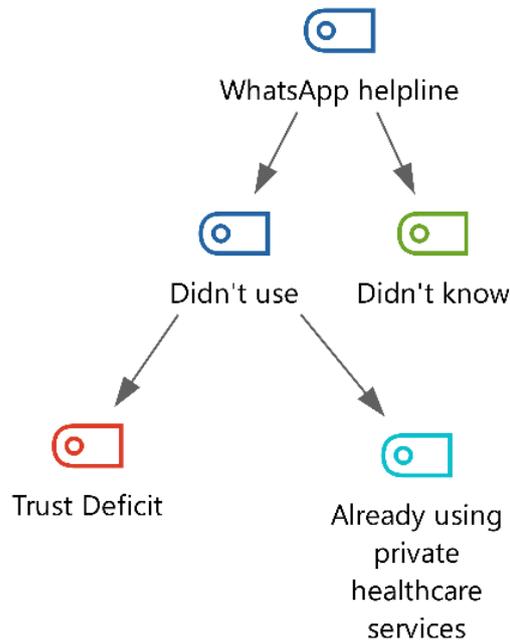


Figure 5: Participant responses when they were asked if they ever used the WhatsApp Helpline

Participants were asked if they used the WhatsApp helpline and their responses showed traces of trust deficit. One of them said, “*Nope...the government does very good with its awareness policies (sarcasm).*”

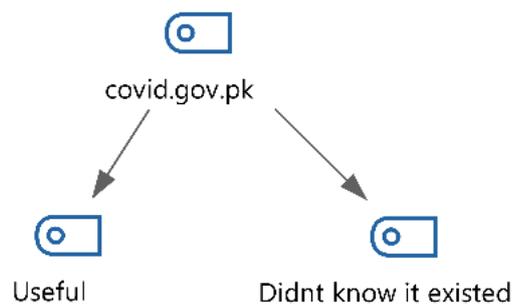


Figure 6: Participant responses when they were asked about their experience using the COVID-19 Website.

Most participants found the website very useful and had positive feedback to give. A participant said, “*It’s my go-to website for checking the numbers daily. I guess it entails all the necessary information.*”

Lastly, the dialer tune was the single medium of risk communication which was appreciated by all participants (see Appendix D). One of the participants said, *“I think the caller tune played the best part in raising awareness. It prevented people from just skipping over the news. The other modes for increasing awareness were effective to some extent but not as effective as this.”*

Another participant commended the usage of dialer tunes and said, *“I believe that dial tune was the most effective awareness technique because it ensured that the message was delivered regardless of the socio-economic background of any individual. The message was also precise and unskippable which made it further effective.”*

Discussion

COVID-19 is a communicable disease and as long as it is not completely eradicated or an effective vaccine becomes available, Pakistan will remain vulnerable to more outbreaks of the disease. It is very important that along with providing primary healthcare services, risks of the virus are also communicated effectively with the public. Considering Pakistan’s political and socio-economic landscape, trust deficit in governance is very common. With problems such as belief in religious conservatism (Saleem, 2020), low health education, and lack of scientific knowledge the people of Pakistan are more vulnerable to being misguided by an overabundance of information (Shah S. B., 2020). In addition to that, Pakistan is notorious for corruption and its citizens are aware of its reputation (Transparency.org, 2020). Hence, the trust deficit. One of the identifying markers of trust deficit are that people do not follow the directives of the government (Lord, 2019). This was reflected in the situation in Pakistan during the first wave of COVID19, when people were not following the standard preventive measures released by the government. Lockdowns were enforced, however people were rarely observed wearing masks or following any other SOPs like social distancing.

After analyzing the collected data for reasons for trust deficit in governance related to COVID-19 risk communication during the first wave, the following themes emerged:

To answer the research question of reasons for trust deficit in governance related to COVID-19 risk communication during the first wave, the following themes emerged.

Overabundance of information (infodemic)

Participants from the online group discussions had the opinion that the government under-reported the numbers of cases to show that they had the situation under control while the numbers were much higher. More reasons for under-reporting were to protect the pilgrims coming back from Iran. As one of the participants said, *“I think the government definitely underreported. But then I think people were scared of getting tested also so that might be a contributing factor. Deaths that were actually [due to] COVID weren’t reported as that..... someone I know really well told me about how it’d spread quite a bit amongst the Shia community especially amongst their house help/drivers etc. and the government was actively keeping it hush hush right after Ziarat.”*

It is important to note that there is a lot of speculation here. This indicates that there is a definite lack of trust in governance. The fear of testing mentioned above can also be connected to the fear of stigmatization. These misconceptions need to be cleared using effective means of risk communication.

Another participant was of the opinion that, *“I think the government tampers with numbers of cases according to its economic needs.”*

Some participants thought that the numbers were being over-reported, *“Looking at the high increasing rate during the months of March & April I felt as if the numbers are being overstated...It could be because of the financial assistance & debt service relief offered to the developing countries by the IMF.”* All these comments show traces of political reasons for misreporting the number of cases.

Ineffective risk communication and health education

The main reason for believing that the number of reported cases is incorrect is because the number of daily tests being conducted were insufficient. The issue with tests as quoted by the participants was lack of awareness, inaccessibility because of high costs, trust deficit in authenticity of free testing kits being provided by public healthcare providers, fear of testing and isolation and fear of stigmatization. One of the participants commented, *“I think number was underestimated, maybe because most cases go unreported, people didn’t care to go for tests or maybe only one person of a family got tested and rest believed they also got corona and took same medicine. Social labelling was another factor which restraint people to report COVID cases.”*

Weak implementation structures

One of the major reasons why people found it hard to believe that the cases were decreasing was the observation of SOP non-compliance in their surroundings. The real situation out in the streets when the lockdown was eased was not being reflected in the number of cases. One of the participants said, *“I think the numbers have always been underestimated. It may not be deliberate at first but the government hasn’t taken any measures to make their reporting efficient. The COVID testing is*

not easily accessible to everyone. Having seen the situation of SOPs in Karachi, I highly doubt that Pakistan has successfully contained the COVID disaster.”

The Ministry of Health, Regulation and Coordination along with the Government of Pakistan started working on risk communication for COVID-19 well before the first case was diagnosed in Pakistan. They published their first poster (see Figure 8) in January and the NAP on February 11th, 2020. They started digital marketing for RCCE and launched a website. The website had multiple features such as daily epidemiological updates, healthcare information, frequently asked questions, official guidelines, and public service messages. Most information on the website is only in English, because of which the accessibility of the website is very low. Only a few video public messages were in Urdu, which were short video clips of the Prime Minister’s press conferences. The content also included discussions on the country’s economic conditions and the looming hunger crisis of the working-class. In one of the videos the Prime Minister has been recorded saying that COVID-19 is like an ordinary flu and nothing to worry about (covid.gov.pk, 2020). This is something that was noticed and remembered by a lot of people. A participant commented on one of the clips from the press conference and said,

“It was always an Average opinion of a common man not the statement of any state’s prime minister with correct numbers, facts and figures, it was completely based on assumptions and unreasonable suggestions. Like a confused common citizen.”

The website had the link to one video by WHO which described what Coronavirus is but that video was also in English and required some level of background in secondary level biology to understand. All in all, the website is a great platform,

but it is accessible only to people who have access to internet and technology, understand English, and have basic knowledge of science and math to be able to interpret graphs. The government had been proactive in developing this tool, but it can be modified to cater to more people for raising public awareness.

The 1166 helpline and WhatsApp ChatBot designed for RCCE were mostly not used by participants of this study because preferred private healthcare over public facilities. However, the most interesting thing about the WhatsApp ChatBot is that it is available in all regional languages, which makes it very accessible for a larger pool of people.

The most appreciated tool was the dialer tune which was described in the online group discussion as *“inclusive, precise and un-skippable”*. It lists down all the required preventive measures except for highlighting the importance of wearing a face mask when a person is around other people. Moreover, a participant pointed out, *“The caller tunes played a pivotal role. However, like every other factor it was only effective for a short period of time because then you keep on hearing it and it has little to no importance.”* Hearing the same speech and the same tone repeatedly makes it redundant and ineffective in the long run, so it is important that the dialer tunes keep changing.

Lastly, in all the RCCE tools a common factor observed was that none of them emphasized on wearing a face mask. The guidelines section on the online COVID-19 Health Advisory Platform had one document for mandatory use of face mask, which was also dumped down along with numerous other documents, lost in the clutter. A Public service message poster was published in March (see Figure 9) which says that a mask is only to be worn when taking care of a COVID patient, when one contracts the virus, or in case of symptoms of flu. It is understandable that back then, this was all the information the Ministry of Health had, and they had to prevent people from hoarding supplies and leave PPE for health professionals. Soon the WHO declared that wearing a mask is extremely important and recommended using materials other than the regular surgical masks (WHO, 2020). The Ministry of Health, however did not update this information. The website still shows the same posters that were designed back in March 2020. With latest scientific research and findings, the people responsible for these RCCE tools need to update them so people can have access to the latest information.

Conclusion

The study attempted to explore the reasons behind the trust deficit in governance related to COVID-19 risk communication in Pakistan. Weak implementation structures, excessive politicization of the pandemic, and the government's reputation as a corrupt entity were major factors for trust deficit in governance related to COVID-19. Lack of scientific knowledge, religious superstition, and the infodemic made people more susceptible to falling prey to misinformation.

Effective risk communication is integral for the social, physical, and economic well-being of the citizens of a country. It is their fundamental right to be informed about what is going on and be shown a clear picture. The findings of this research concluded that while the government of Pakistan was seemingly proactive in handling the pandemic, there is significant room for improvement. Although initiatives like installing a helpline and preparing IEC material even before the diagnosis of the first case in Pakistan are commendable, effectiveness of these tools are questionable.

Firstly, the IEC and RCCE material needs to be marketed properly. Analysis from the data collected indicated that most of the study participants were not aware of the existence of these services. Secondly, the website needs to be translated into Urdu and other regional languages to make the material more inclusive and accessible. The material also needs to be updated according to the new directives of WHO and CDC while emphasizing more on preventive measures such as the use of facemasks. They should also encourage the use of fabric masks and give clear directions on how to make masks on your own (WHO, 2020).

Thirdly, the research participants found the COVID-19 awareness dialer tune to be very useful. The government should look into multiple dialer tunes that keep changing regularly to prevent people from getting desensitized to it. Lastly, it is highly important that whatever information is disseminated as part of the RCCE, it should be fact-checked, backed by scientific reasoning, and should be updated regularly. Politicians and religious preachers need to be brought on the same page and sensitized about COVID-19 so that they can be examples for the general public to follow. Following the example of Sri Lanka, as discussed in the literature above, it would be helpful to train informal community leaders to encourage people to follow SOPs and help with contact tracing. These leaders can also help with combating misinformation by directly guiding their communities

with scientific research findings.

To conclude, Pakistan has the right platforms for risk communication. It just needs to work on its objective of “building trust in GoP’s preparedness and response to COVID-19” (Government of Pakistan; Ministry of National Health Services, Regulation and Coordination, 2020). One approach to bridge this trust gap is to make the existing sources of communication more accessible and inclusive by introducing regional languages for information dissemination, simplifying the content, and regularly updating it. There is a need to effectively market the official communication platforms to help increase the number of service users while regulating the reliability of these information sources.

Risk communication is an important part of healthcare provision. Effective modes of risk communication can help contain the virus and lower the incidence of cases, eventually reducing the burden on healthcare facilities.

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Appendices

Appendix A: Acronyms

RCCE: Risk Communication and Community Engagement

IEC: Information, Education and Communication Material

NAP: National Action Plan

PAHO: Pan American Health Organization

WHO: World Health Organization

SOPs: Standard Operating Procedures

MERS: Middle East Respiratory Syndrome

GOP: Government of Pakistan

CDC: Centers for Disease Control and Prevention

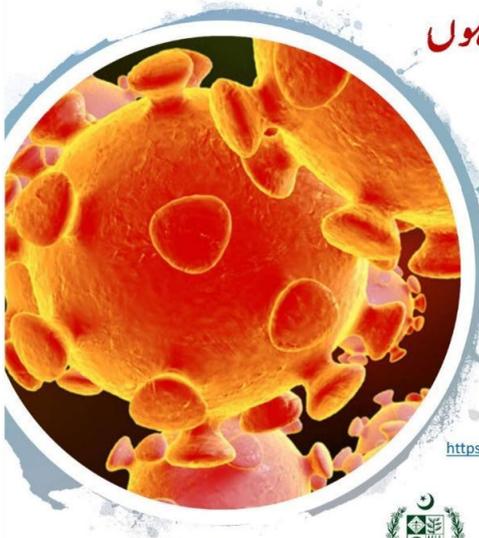
Appendix B: Material Used

Documents used:

1. National Action Plan for Corona Virus (Covid-19) Disease Pakistan.

Content used:

1. Covid-19 Website
2. Covid-19 WhatsApp Helpline 03001111166
3. Dialer Tune
- 4.



نوول کورونا وائرس سے متعلق افواہوں سے پریشان نہ ہوں

پاکستان میں تاحال (30 جنوری 2020) کورونا وائرس کا کوئی کنفرم مریض نہیں آیا۔ لہذا کورونا وائرس سے متعلق پھیلتی افواہوں پر یقین نہ کریں۔

اگر آپ پچھلے 14 دن کے اندر چین کے شہر وہان سے واپس آئے ہیں اور آپ کو کھانسی، بخار اور سانس لینے میں شدید دشواری ہے، تو ہی ڈاکٹر سے رابطہ کریں۔

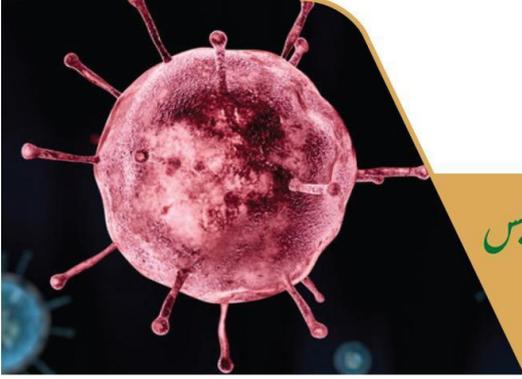
اور اگر آپ پچھلے 14 دن سے پاکستان میں ہیں تو فی الحال آپ کو کورونا وائرس سے کوئی خطرہ نہیں ہے۔

مزید معلومات کے لئے ہماری ویب سائٹ وزٹ کریں <https://www.nih.org.pk/novel-coronavirus-2019-ncov/>

فیسلڈ ایپیڈیمیا لوجی اینڈ ڈیزیز سروس ویلنس ڈویژن
قومی ادارہ صحت، حکومت پاکستان




5.



Government of Pakistan
Ministry of National Health Services,
Regulations & Coordination

بیرون ملک باخصوص چین اور ایران سے واپس آنے والے مسافروں کے لئے ہدایات

آپ کو صحت کا جو فارم (ہیلتھ فارم) دیا جائے، اسے لازمی پر کریں اور داخلی راستے پر تعینات صحت کے عملے کے حوالے کریں۔ اس ہدایت کی خلاف ورزی پر آپ کو ملک میں داخلے سے روکا جاسکتا ہے۔
چین اور ایران میں سفر کے چودہ دن کے اندر بخار، کھانسی، سانس میں تکلیف یا جسم میں شدید درد کی شکایات ظاہر ہوں تو:

ہیلپ لائن 1166 پر رہنمائی کے لئے رابطہ کریں	
کرونا وائرس کے علاج کے لئے مخصوص کئے گئے بڑے ہسپتال میں کرونا سیکشن سے رجوع کریں۔	
ڈاکٹر کو اپنے چین اور ایران کے سفر اور بیماری کی علامات کے بارے میں ضرور بتائیں۔	
ہدایات کے مطابق ہسپتال میں ہی رہیں اور دوسرے لوگوں سے میل جول بند رکھیں۔	
اپنے منہ اور ناک کو ماسک سے ڈھانپ کر رکھیں۔	
کھانسنے اور چھینکتے ہوئے منہ کو ٹشو یا آستین سے ڈھانپیں (ہاتھوں سے نہیں)۔	
ہاتھوں کو صابن سے اکثر ہیں سیکنڈ تک دھوئیں۔ صابن یا پانی نہ ہونے کی صورت میں ہینڈ سینیٹائزر کا استعمال کریں۔	

مزید معلومات کے لئے:



صحت مند پاکستان

1166 پر رابطہ کریں

corona.info@nhsr.gov.pk

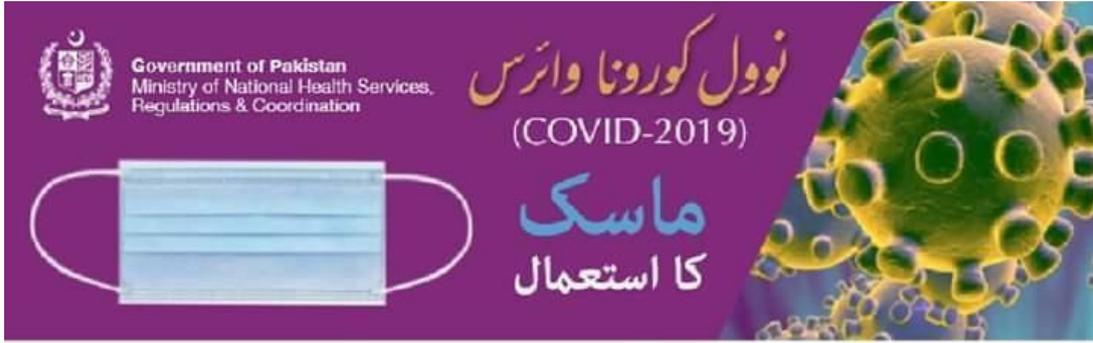
www.nhsr.gov.pk

ہیلپ لائن

ای میل

ویب سائٹ

6



ماسک صرف مندرجہ ذیل لوگوں کو پہننا چاہئے

جو کرونا وائرس انفیکشن کا شکار ہوں	
جو کرونا وائرس میں مبتلا مریضوں کی دیکھ بھال کرتے ہیں (مثلاً ہیلتھ ورکرز)	
جو عام نوعیت کے نزلہ زکام اور فلو کا شکار ہوں	

ایک سپیشل ماسک ہے اور صرف ان لوگوں کو استعمال کرنا چاہیے جو کرونا وائرس کے مریضوں کی دیکھ بھال کرتے ہیں۔

N95 ماسک

مزید معلومات کے لئے:



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ای میل

ویب

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