LEVERAGING BEHAVIOURAL SCIENCE TO PROMOTE SAFE PRACTICES: LESSONS FROM WAVE 1 of COVID-19 IN PUNJAB

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EXECUTIVE SUMMARY

How can behavioural science be applied in public health communication to influence the adoption of safer practices? We answer this question in the context of COVID-19 through our research in Punjab on barriers to adoption of preventive behaviours such as early reporting of symptoms and testing. The study also helped us document generalisable lessons that could aid the development of future public health campaigns.

As part of its response strategy at the onset of the pandemic, the Government of Punjab (GOP) launched ‘Mission Fateh’ to bring people together to halt the spread of the Novel Coronavirus through “Discipline, Cooperation and Compassion”. Various stakeholders, including politicians, musicians and influencers endorsed the mission to enhance reach and engagement. While GoP’s efforts were focused on raising awareness about preventive behaviour and promoting collective action, it continued to face challenges with regard to early reporting of symptoms and timely testing.

IDFC Institute, in collaboration with Noora Health’s Associate partner in India, Aurora Health Innovations LLP (hereafter referred to Aurora Health), extended support to GOP by developing a campaign to reinforce the importance of getting tested in time. Given the effectiveness of applying behavioural science to nudge behaviours in a public health context such as the Swachh Bharat Mission or the campaigns targeting awareness around HIV/AIDS in India, we decided to use this lens to inform our research and campaign design process. We gathered data from preliminary interviews with communication experts and key stakeholders in Punjab through a needs finding exercise with community members in two states – Punjab and Maharashtra. We also incorporated lessons from three successful communication campaigns – Singapore, Taiwan and New York – that were effective in meeting the evolving communication needs during COVID-19.

The behaviour change communication and behavioural science experts shared valuable insights on the campaign development process based on their experiences of working on successful public health campaigns. They also highlighted various biases and social norms that influence people’s behaviour – these were reinforced by data from the field on barriers to adopting preventive behaviours. We found that behavioural patterns are influenced by key biases that make people either overestimate the risk involved, inducing panic and affecting their ability to take appropriate action, or underestimate the risk involved making them overconfident and negligent when it comes to taking adequate precautions.

Some of the biases which play a key role in influencing people’s risk perception include optimism bias, just world fallacy and availability bias. In addition to these biases, existing social norms in India further had an impact on adoption of preventive behaviours. Findings also indicated that there were low levels of awareness about COVID-19 health services and of people’s experiences of recovering from COVID-19, indicating lack of government-citizen dialogue. A lot of the fear and hesitancy about accessing services stemmed from individuals’ unfavourable experiences with the public health
system or from news reports. However, the prospect of putting family members at risk emerged as a clear motivator to access public health services, report symptoms or get tested.

Our campaign, conceptualised with a ‘Care and support’ angle, aimed to highlight empathy and support on behalf of the public health system and urged people to get tested as a precaution to keep their families safe.

The campaign voice was embodied by a memorable mascot named ‘Dr. Saab’ – a friendly neighbourhood doctor with a colourful personality whose priority was to make medical care easily accessible. The idea was to develop a persona that could convey the key messages in a simple, memorable and relatable manner. A mix of channels spanning digital and print was used to disseminate campaign content. The campaign was also tested on the basis of four key behavioural science parameters – understanding, recall, sentiments and behavioural indicators – to gauge comprehension levels and degree of resonance with elements like the mascot, tagline and visuals. The poster was compared with a poster developed on the same theme by the government that had been circulated widely. Results of the rapid testing demonstrated that respondents who saw our poster understood that the main message was to get tested in time for COVID-19 to curb the spread of the disease and protect one’s family, and that calling the 104 helpline to get tested was the main message in the other poster.

The campaign was disseminated through both traditional and social media and reached approximately 27,77,875 people. Campaign materials were posted on official channels including GOP, Chief Minister’s Office (Punjab), Punjab State Advisory Council, Punjab Covid Bulletin and various District Public Relations Office (DPRO) pages. The posters, videos and jingles were circulated across all 22 districts in the state through the Department of Information and Public Relations. Working closely with government stakeholders helped us gain a clear understanding of how to fill gaps in communication that would facilitate behaviour change. Additionally, building relationships with stakeholders from civil society ensured that we understood the pulse of the community and crafted communication that would resonate with people. Because of our relationships with local stakeholders, we were also able to test our materials and use the feedback to make improvements that were feasible given the timeline at hand.

One thing that became clear to us through the process was that communication cannot solve some of the key systemic challenges that have been heightened during the pandemic – but it can influence behaviour because the degree of trust in the government largely determines people’s risk perception and their adherence to preventive behaviors during a crisis. We discuss opportunities that governments can explore to strengthen government communication efforts, and supplement them with policy and procedural interventions like training frontline workers on patient care and empathy. This will go a long way towards reducing fear and hesitation at the prospect of accessing government healthcare services.
(1) INTRODUCTION

At the onset of the pandemic, several state governments launched campaigns to build awareness about COVID-19, and promote preventive behaviours like mask wearing and physical distancing. The importance of getting tested early to curb the spread of the disease and place less strain on the public health system was also highlighted repeatedly through communication efforts. However, in Punjab, we learned from our partners that people hesitated to access government health services because of a lack of trust in the healthcare system and fears about treatment and cure. Given this backdrop, GOP approached IDFC Institute to support them with a communication campaign that could help address this issue.

IDFC Institute collaborated with Noora Health to develop a campaign to promote testing for COVID-19 in Punjab. The project was funded by a grant from Omidyar Network’s Rapid Response Grants Initiative through United Way Bengaluru (UWBe). Given our existing project partnerships with the Behavioural Insights Team (BIT) and a range of communication experts from the Track 2 COVID-19 task force anchored by IDFC Institute, our natural inclination was to apply a behavioural science lens to the campaign development process to nudge people towards sustained practice of safe behaviours. Additionally, most communication campaigns are focused on raising awareness, and do not take into consideration the barriers to adoption of recommended behaviour (e.g. biases and norms) or adequately explain the rationale behind why certain behaviours are promoted. The opportunity in this context was to build the case for why behavioural science should be an integral part of any communication campaign design, especially in a public health context.

While we had been initially briefed about the possible reasons for low testing rates in Punjab, we conceptualised the focus of our campaign – addressing barriers of fear and stigma – after speaking with government officers and NGOs working on the field, and collating data from communities on specific dimensions of fear and stigma that were preventing people from getting tested at the onset of symptoms. We carried out this exercise through 1) Interviews with communications experts, behavioural scientists, and on-ground practitioners aimed at understanding key principles to incorporate in our content; 2) Needs finding surveys aimed at identifying specific problems that communities are grappling with; 3) Content development based on learnings from the first two stages; and 4) Rapid testing of existing and newly development content based on understanding, recall, sentiments and behavioural intention.

Through this engagement, we aimed to build a case for the application of behavioural science while developing a public health campaign. This is especially true in the case of this pandemic where a lot of material was put out on preventive behaviours and need for collective action. Our research showed that desired behaviours may not be followed due to inherent biases and social norms rather than lack of awareness. For example, while doing some of our stakeholder interviews, we heard that locals in a village were worried about wearing a mask and practicing social distancing if the elders were not...
doing so. They were afraid this would be disrespectful towards the elderly. Not attending family
functions during festivals was also viewed as disrespectful towards the hosts and traditions. Keeping
the behavioural lens in mind while developing a public health campaign helps tackle these biases
and norms.

While our aim is to document lessons for policymakers and practitioners that can inform the
development of future health campaigns, it’s important to note that the aspects of fear and stigma
addressed in our campaign were specific to the first wave of the COVID-19 pandemic. As we roll out
multiple vaccines across the world today, the issues facing people are different. We know more about
the virus and how to tackle it than we did when the campaign was developed. Through this report, we
hope to capture our learnings from working with the Punjab government in real time as the pandemic
was unfolding. The steadily rising cases necessitated working with tight timelines to get materials out
in the public domain and influence behaviour. This meant prioritising certain feasible channels to
disseminate campaign messages, and altering the iterative nature of material development which
resulted in us not being able to make changes to the content after the rapid testing exercise.

In the following section of this report, we set the context by highlighting the importance of using
behavioural science frameworks to develop public health communication content, particularly taking
into account Punjab’s cultural context. Section 2 outlines the methodology of the overall initiative,
section 3 documents findings from each stage of the research, section 4 focuses on the campaign
development, section 5 discusses the rapid testing results, section 6 captures key learnings and
section 7 concludes.

1.1. Importance of Behavioural Science in Communication

Preventing the spread of COVID-19 fundamentally depends on changing and sustaining certain
behaviours. For instance, mask wearing, washing your hands frequently and physical distancing can
be challenging to keep up, especially as fatigue sets in. Given that human behaviour, with all its
irrationality and inconsistency, is key to fighting the pandemic, it follows that behavioural science
could have some important insights (Vedavalli and Shah, 2020). While we all wait to get the COVID-19
vaccine, consistent practice of preventive behavior is the best way to protect ourselves from this virus.
One way to nudge people from intention to action is via effective communication.

There has been a lot of mixed messaging around the pandemic in the early days – how the novel
coronavirus spreads, what the safety measures are, and so on. While some of this mixed messaging
can be attributed to evolving information about COVID-19 itself (both for citizens and governments),
in other cases, it was due to a lack of a cohesive communications strategy. For instance, in March
2020, there was little knowledge available on how exactly the virus spreads. Additionally, rapidly
changing guidelines and lack of information around availability of supplies created uncertainty when
the first national lockdown was announced. The resultant panic led to overcrowding at local stores
and hoarding of supplies. In other words, absence of clarity in communication was a critical factor that influenced this behaviour.

Research has shown that incorporating behavioural insights into communication can make it more effective, especially during previous health crises such as that of Ebola in West Africa (Balsari-Palsule, 2020). Various frameworks have been conceptualised to aid this alignment, including RESPONSE (Jones et al, n.d.) and MINDSPACE (Dolan et al, n.d.). During the COVID-19 pandemic, several firms and experts asserted that behavioural science can be a useful tool to curb the spread of the pandemic. For instance, FinalMile created A Playbook for Pandemic Response to provide practitioners with a toolkit to design and implement behavioural interventions based on behavioural insights and human-centered design (FinalMile, 2020) and ideas42 published Behavioural Science Tips for COVID-19 Communications (ideas42, 2020). Both resources demonstrate that there are multiple ways in which policymakers can apply behavioural science while developing communication campaigns.

As the COVID-19 pandemic progresses, Martinez et al (2020) claim that “The key is for the [communications] campaigns to adapt to changing circumstances, to circulate both good and bad news on the illness and change people’s risk perceptions.”

India had the second-highest number of COVID-19 cases in the world when the study was conducted. This can be attributed to several factors, primarily during the first wave of infections, including the country’s large population, poor infrastructure to facilitate the adoption of preventive behaviours, lack of reliable sources of information in some instances and information overload in others, cultural aspects and the festive seasons in various parts of the country. Given the rapidly evolving nature of information on COVID-19, it is more important than ever to run campaigns that inform citizens of key developments and tackle the behavioural issues that cause cases to rise in the first place. Veering away from the standard education and awareness trajectory and approaching this issue from a behavioural lens to better address the “why” rather than the “what” will give us better results in terms of compliance, and also result in a long-term shift in people’s choice architecture.
(2) METHODOLOGY

The study aimed to understand barriers to practicing safe behaviours like early reporting of symptoms and testing. We began with secondary research, undertaking a literature review of behavioural science-based initiatives in public health communication.

In the second stage, we conducted interviews with behavioural science and behaviour change communication experts to glean insights into designing effective public health campaigns, and to identify behavioural biases at play in the context of COVID-19. The third stage involved consultations with a range of key stakeholders from Punjab to understand manifestations of fear and stigma that prevented people from accessing public health services. Needs finding surveys were subsequently conducted in the fourth stage to garner insights from communities. The campaign development took place in the fifth stage – a few community members in Chandigarh field tested materials to ensure language and cultural elements were appropriately depicted. Dissemination took place in the sixth stage and the rapid testing exercise was conducted shortly after. We would have ideally liked to make a few changes to the creatives based on the rapid testing results, but we unfortunately did not have the time due to the urgency of making the campaign widely accessible. Additionally, the scope of the study in Maharashtra was limited to a needs assessment survey, again due to time constraints. The learnings, while applicable in the context of COVID-19, will provide lessons for future health campaigns as well.
Findings

The results of the four main stages of the study are presented in this section. Section 3.1 details learnings from our expert interviews, Section 3.2 outlines the insights from key stakeholders that informed the campaign design and Section 3.3 presents the results from the needs finding exercise conducted in Punjab with references to insights from Maharashtra.

3.1. Interviews with Communication Experts

We interviewed communication experts, on-ground practitioners and behavioural scientists. These interviews were conducted to understand their experiences with health communication and understand potential gaps. The learnings from these interviews informed the conceptualisation of our communications content. The experts are as follows:

1. Priya Agrawal, Founder-Director, Antarang Foundation
2. Biju Dominic, CEO, Final Mile
3. Jamie Foehl, Senior Behavioural Researcher, The Center for Advanced Hindsight, Duke University
4. Amrita Kapoor, Chief HR & Mentor, Swadhaar FinAccess
5. Abimanyu Kotwal, Program Associate, Aurora Health
7. Kalyani Rajan, Former Senior VP & Head Thompson Social, Strategic Communication for Social Good
8. Luke Ravencroft, Director, Singapore, Behavioural Insights Team
9. Neela Saldanha, Behavioural Advisor; former Founding Director, Centre for Social and Behaviour Change
10. Ashutosh Wakankar, Co-founder, Cracker & Rush

A key insight that emerged across the interviews was that humans tend to resist change. Our brains are not equipped to adapt to new situations quickly – a characteristic that has accentuated the problems of the pandemic. It is important, however, to acknowledge that people are afraid for good reason; the novel coronavirus is unknown and unsettling. It is almost like the reverse concept of ‘savouring’. For instance, planning and going on a vacation is associated with positive savouring, while the possible outcomes of COVID-19 which weigh on the mind are negative. Yet, against all odds, people seem to be practicing preventive behaviours, which is commendable given that these are new behaviours. It has been relatively easy to get people to wear a mask in the span of a few weeks given that years of urging people to wear seatbelts has not yet translated into adequate levels of action. However, there is still a long way to go. The experts spoke about a few biases that would have to be overcome in order to sustain preventive behaviours such as mask wearing and hand hygiene. They
also spoke to us about important aspects to keep in mind while designing the campaign in order to ensure better compliance and combat inherent biases within people.

A. Components of developing an effective campaign

1. Crafting messaging

a. Keeping it simple

People don’t have time or the mental bandwidth to process complicated information, and with the kind of information overload we witnessed during COVID-19, it becomes even harder to draw and sustain people’s attention. One way to ensure retention is to keep text on communications material to a minimum. In fact, in light of communication on COVID-19, the Behavioural Insights Team found that keeping the message and design simple increased retention (Brown et al, 2020). Simplifying the message lets people know exactly what to take away from the communications content in terms of the problem and solution, i.e. how they should modify their actions to stay safe and healthy. For example, in New York, the main catch phrases that were repeatedly used were ‘Stay Home. Stop the Spread. Save Lives’. ‘Mask Up America’, ‘New York tough’. Such simple and clear messaging resonated with the citizens of the state. Despite accusations of mismanagement of the pandemic, one of the things that worked well in Andrew Cuomo’s campaign was the simple and consistent design of the presentations. When information is presented in a way that requires minimal mental effort, it lets people make decisions based on their ‘System 1’ thinking which taps into intuition and emotion, leading to ‘cognitive ease’. If people have to engage their ‘System 2’ mode of thinking which logically analyses information, it will involve more effort to comprehend, therefore they may be less likely to take action.

b. Leveraging the positives

It is extremely important to be careful with fear-based communication because if messages amplify fear, they have to be accompanied by useful guidance and promote self efficacy or reinforce one’s confidence and ability to take the required precautions. Creating communication that encourages empathy, uses positive psychology and negates fear-mongering news via communication of positive news is important and can help nudge people towards desired behaviours, such as hand hygiene and mask wearing in the context of COVID-19.

c. Consistent and coordinated messaging

Messages need to be consistent for them to stick in people’s minds. There are plenty of lessons to learn from multinational brands. For instance, one automatically associates ‘Just do it’ with Nike or ‘Have a break’ with KitKat, because the messaging has been consistent. In terms of health communication, consistent messaging can help encourage the uptake of safe

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1 According to Daniel Kahneman, 2002 Nobel Memorial Prize winner in Economic Sciences, “System 1” is fast, instinctive and emotional; “System 2” is slower, more deliberative, and more logical.
behaviours. We see this in the case of Taiwan, which instituted a transparent platform to share important epidemic information via a Central Epidemic Situation Command Center, building trust with its citizens. It ran an integrated mass media campaign on social media, radio television etc. to ensure consistency in messaging. Similarly in Singapore, members of the task forces, scientists, policymakers and other experts were encouraged to interact with the press on a daily basis, providing timely updates on how the situation was evolving. They ensured that messages coming from these different sources were largely consistent. In contrast, inconsistent messaging with rapidly changing goalposts is likely to result in people giving up and turning away from the communication. In general, a good strategy involves several touchpoints (physical and virtual) of the same message, but with varying degrees of information. For instance, a catchy visual-based poster with minimal text could be a starting point for the core message, and then follow-ups via digital mediums, videos and so on can elaborate and explain the message further, while also reinforcing the core message.

2. Improving memorability

a. Viral element
Most successful communication designs contain a viral element, which allows them to be shared widely, thereby reaching a larger population. For instance, during the AIDS campaign, Bollywood actress Shabana Azmi’s advertisement message was vivid: Chhoone se AIDS nahi hota. Chhoone se sirf pyar phailta hai (Touch doesn’t spread AIDS. Touch only spreads love). This message helped curb the spread of misinformation that AIDS is spread through touch, while also alerting people to the prevalence and risks of the illness. In Taiwan, the state hired comedians to create viral content, such as memes and videos, spreading information about the virus and related safety measures.

b. Relatability
For messages to effectively reach and appeal to people, they need to be relatable. That is, the message needs to resonate with a person’s identity. Examples are a good way to rally people towards a cause or practice safe behaviour. In our campaign, we tried adding relatability via personalisation, and focused on people and their ties to their family, spreading the message that getting tested not only keeps you safe, but also protects your family. Mascots also help with relatability. We see that Taiwan used an animal mascot to spread the message about preventive behaviours. In Singapore, posters were released in multiple languages so all communities could relate to it.

c. Popular personalities as sources of information
Using influencers such as actors, cricketers, religious leaders and so on can strengthen a communications strategy, as many of these personalities have mass appeal and are seen as credible sources of information. For health-related
communication, doctors and medical personnel are usually viewed as the most credible sources, and community gatekeepers are a close second. Third come celebrities; however, they must be responsible in their actions and words. For example, if an actor says, "Wear a mask", and is then photographed in public without one, public trust in the message gets eroded. In certain settings, religious and political leaders also have some clout. Different influencers should be chosen based on their appeal in different localities. In general, people seem to trust local rather than national authorities. For COVID-19, using celebrities to not just spread information but also share their experiences, especially those that have contracted and recovered from the virus, can be useful in easing fear and stigma and reminding people that anyone can be susceptible to the virus. However, using influencers can involve major financial resources. In the case of Taiwan, their vice president, an epidemiologist by training, led the public information campaign from the office of the president. This lent a great deal of credibility as a figure of political authority who was also a subject matter expert led the campaign. In Singapore, Lee Hsien Loong was the face of the campaign. Having a person of authority like the Prime Minister communicate information at frequent intervals helped combat misinformation and fear, which were significant threats during the initial days of the pandemic.

3. Visual elements and design

a. Visual element
An ideal communications campaign is predominantly visual to facilitate ease of comprehension across segments of age and class. Campaigns that draw on and stir emotions make content memorable. Further, visual content can be used by frontline workers to explain messages like the importance of physical distancing during the COVID-19 pandemic to low income/rural communities.

b. Cultural elements in design
Cultural sentiments need to be taken into account in communications design. They enable acceptance and relatability and can play a role in nudging people to take a specific action or adopt prescribed behaviours. For instance, people find it disrespectful to wear a mask or practice social distancing within their communities if elders or respected authorities are not wearing a mask and maintaining distance. These cultural aspects hinder the practice of preventive behaviours. Hence while communicating about safe behaviours like 'wear a mask' and 'maintain physical distance', it is important to spread the message that these behaviours are not disrespecting elders in the community but keeping them safe. Similarly, it is important for the communications material to be in languages that people understand. In a diverse country like India with a large migrant population, it is not enough to communicate merely in the regional language, but also in other
languages. While one will reassess the steps taken by the Governor of New York in the light of recent accusations, Cuomo tapped into the cultural ethos of New Yorkers. He used their sense of identity to build optimism by citing contextual examples of New York rising from the 9/11 and 2008 financial crisis. This evoked sentiments of having gone through a lot together and highlighted people’s resilience. One of the popular phrases used was ‘New Yorkers will keep New Yorkers safe’.

4. Identifying channels/ mediums of communication

While designing communications content, it is also important to keep in mind the channels and mediums through which the material will be disseminated to the intended audience. During COVID-19, social media (Facebook, TikTok, etc.) and WhatsApp appeared to be prominent modes of communication and worked effectively across geographic areas and social classes. However, misinformation started spreading quickly and the only way to counter this effect is to ensure that only credible, verified information is circulated on these platforms. To tackle misinformation, Taiwan set up a FactCheck Center that identified and took down any fake news online within an hour of finding it and issued clarifications to the public. Experts suggested that scratch card campaigns in urban and peri-urban areas across states like Maharashtra and Rajasthan also seem to work well, and that television is a big source of information, especially for rural and urban poor households. Further, in rural areas, COVID-19 related posters were strategically placed at places like panchayat offices and vegetable markets that are frequently visited by village dwellers. Singapore used platforms like Twitter, Facebook, Instagram, Telegram, Youtube, and even TikTok to reach different sections and age segments of society.

5. Evolving Communication

Since the pandemic is constantly evolving, it is critical to make sure that messaging is constantly updated and relevant. While simple educational material was necessary during the onset of the pandemic back in March 2020, today, there is a need to creatively package information and add elements of readability, relatability and interest. Due to the information overload and fatigue, people may prefer to tune out when it comes to updates on the pandemic even though it may be important to know them. It is also important to retain what is still relevant. For example, today, the three Ws (wear a mask, wash hands, watch your distance) need to still be reinforced even though new information is available. Communication should also be timely, which can be difficult to get right, especially in uncertain circumstances such as this pandemic. In Singapore, the Prime Minister directly reached out to citizens to update them on the situation. The government of Singapore used WhatsApp to share regular updates with over a million people subscribing to this service. The high availability and timeliness of information instilled public trust in the government’s efforts.
Of the insights received from expert interviews, trust, memorability and having a face to the campaign that was relatable were the key takeaways for us. How we incorporated these findings into our campaign is explained in Section 4.

B. Behavioural biases and manifestations at play in the context of COVID-19

1. Optimism bias
   Everyone lives in their own social bubble, irrespective of their background and think that they and their families are not really at risk of getting COVID-19, i.e. it happens to other people. This is because behaviourally, people tend to overestimate the probability of positive events and underestimate the probability of negative events happening to them in the future (Sharot, 2011). Ensuring factual presentation helps control the risk perception of people who are more likely to suffer from optimism bias or the tendency of people to overestimate the probability of nothing happening to them. Chief Minister and Health Minister of Kerala, as a part of their press conference everyday ensured that the state of COVID-19 was clearly presented and explained. People were taken into confidence while communicating the situation which led to better compliance and helped combat optimism bias.

2. Just world fallacy and availability bias
   The idea that people’s actions always lead to fair consequences is known as just world fallacy. In the case of COVID-19, people may believe that those who get sick did something wrong and brought it upon themselves. Availability bias is a tendency to think of examples that come readily to mind and seem more representative of a certain situation than what is actually the case. At this point in the pandemic, almost everyone knows somebody who has tested positive for the virus. Often, it is also possible to trace why and where they got COVID-19. Thus, availability bias reinforces the just world fallacy.

3. Stigma
   The pandemic has led to an “in group - out group” phenomenon in some parts of the country, where certain people are treated differently because of their known/suspected status. This is similar to the case of Singapore where COVID-19 outbreaks in foreign worker dormitories led to stigmatisation. To combat this, the Singapore government established hotlines for mental health. Conspiratorial thinking and misinformation also drive fear and stigma, which could be exacerbated by locational or ethnic differences.

4. Fear
   There are two extreme manifestations of fear among communities. On one hand, there is fear of the disease itself, which cripples one from behaving rationally due to panic. On the other end, there is denial of the virus for fear of being made to adjust to a curtailed sense of freedom. Both extremes are reactions to fear. Further, for the most part, the media has built a narrative of fear but not told people how to deal with it. In Taiwan, the government
established helplines that people could call into with their queries regarding the virus. Those in charge of responding were trained in using empathy in their communication to help assuage people’s fears.

5. **Fatigue**
   Since India’s approach to COVID-19 was centered around a lockdown, people soon became tired of staying indoors. This led to fatigue in following preventive behaviours. Apart from adhering to strict lockdown requirements, an overload of information on COVID-19 through extensive media coverage also overwhelmed people.

6. **Social Norms**
   Social norms influence group behaviour and hence are harder to change. With the onset of COVID-19, festivals and family gatherings were restricted for safety reasons. However, since community is an integral part of Indian culture, people a) feared that they would offend their relatives if they didn’t meet them, and b) experienced loneliness due to the prolonged period of separation. Tackling behaviour keeping religion and social norms in mind can be tricky as there is a risk of stigmatising a particular segment of society. And balancing these concerns while discouraging meetings without adequate safety measures is a major challenge.

These issues need to be addressed while developing communication campaigns. The following lessons on content messaging and design provide guidance on how to do so.

### 3.2. Key Informant Interviews (KII)

Government stakeholders in Punjab observed that citizens with COVID-19 symptoms were not reporting them early or getting tested in time. We conducted stakeholder interviews and surveys to understand the resistance. Respondents reported low trust in the public health system, stigma associated with COVID-19 due to the lack of confidentiality, fear of contracting the virus and misinformation as the main barriers to accessing testing services. The interviews also highlighted behaviours that government health workers and other frontline workers could adopt in order to build a rapport with community members they engage with.

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<td>District Administration</td>
<td>4</td>
</tr>
<tr>
<td>Local NGOs - PSACS, Aradhaya, Abhvaykti Foundation, Pahal, Patiala Foundation, Har haath Kalam</td>
<td>6</td>
</tr>
<tr>
<td>Doctors - Civil Hospital, COVID-19 Nodal Officer</td>
<td>2</td>
</tr>
<tr>
<td>Academics</td>
<td>2</td>
</tr>
</tbody>
</table>
A. Reasons for not getting tested for COVID-19

1. Fear of isolation and alienation during treatment
   People were already fearful of the uncertainty of the disease, and reported that the fear of loneliness only exacerbated the anxiety around contracting the novel coronavirus.

2. Low trust and poor perception of the public health system
   a) Quality of services
      Lack of confidence in the quality of health services (questions around accuracy of the test results and timeliness of the results) and fear of what happens at the COVID-19 health centers (quality of care, loneliness in quarantine centers) due to reports in the media and the experiences of neighbours, friends or family.
   b) Behaviour of police, health officials and other frontline workers
      The dominant perception was that the officials don’t behave well with patients who report symptoms. People were also scared of being taken against their will to quarantine centers because of the lack of faith in government facilities, and the uncertainty around treatment and cure.

3. Low privacy and confidentiality of COVID-19 status and stigma
   a) The lack of discretion around COVID-19 status
      This leads to social ostracisation, which was one of the reasons cited for not getting tested. People reported circulation of messages on Whatsapp regarding COVID-19 positive cases’ names and addresses, stickers placed outside buildings while sealing containment zones, and so on which led to social ostracisation.
   b) Stigma
      Stigma stems primarily from the degree of fear and uncertainty associated with the disease. There is a lack of awareness about transmission routes, spread and cure and, as a result, people who have recovered from COVID-19 continue to be ostracised by religious groups, social circles and even by close relatives. People are concerned that their livelihood, housing, and basic social structure will be affected with a COVID-19 positive test (consider the impact of COVID-19 throughout one's entire life).
   c) Pervasive blame on COVID-19 positive patients
      Given all the fear messaging around COVID-19, the KIIs highlighted the need to normalise contracting the disease. The overarching message needs to communicate that it is alright if someone has COVID-19 (remove any individual blame) and that they will recover if specific steps for care and recovery are taken in a timely manner.
4. Lack of clear information

a) Unclear information on what happens if tested positive
Information about COVID-19 was communicated in a way that causes fear unnecessarily without communicating important, direct information of what people need to do, where they need to go and what they should expect. Some people may not know that home quarantining is an option for them if they test positive. There is also lack of information on what happens after a person recovers, which leads to the tendency to stigmatise infected people even post recovery.

b) Misinformation
Local and often non-scientific remedies and rumours on what will happen if one visits a doctor with COVID-19 or non-COVID-19 symptoms, malpractice by local doctors, and so on.

c) Knowledge about whether one should get tested in case of no symptoms
Largely, people do not know that you can be asymptomatic and still spread COVID-19. Without symptoms, there isn’t a trigger to get yourself tested.

d) Media reports taking precedence over official communication
Fear due to media reports and the lack of timely information/updates from the government.

B. Behaviours that need attention

1. Preventive behaviors
The basics of mask wearing, hand hygiene and social distancing still need to be discussed. Waning levels of seriousness about taking precautions were reported by all individuals interviewed, hence messaging needs to reinforce and reiterate the rationale of preventive behaviours to promote community vigilance.

2. Empathy and care
People who have had COVID-19 do not feel like they are cared for – in fact many felt like they were being harrassed. There is a need to create virtual or distanced support circles of care for COVID-19 positive patients. For some, telecalls by the government and partners to check on them felt like harassment, whereas other calls from doctors were received as care.

3.3. Needs Finding Results
We carried out this study in two states in India – Maharashtra and Punjab. The details of the locations and the sample size are presented below. However, given that project implementation focused on Punjab, the Maharashtra results are mentioned in brief.
Surveys and interviews with people recruited from the Mumbai, Pune and Nagpur district hospital and Ludhiana were conducted through August 2020 to understand community perspectives of fear, stigma and misinformation around COVID-19. The respondents were family members of mothers who gave birth at medical colleges in the four districts within the last year. In Maharashtra, community members from Dharavi, Asia’s largest slum, were also recruited in September 2020. Trained data collectors administered a 20-minute survey or interview over the phone.

In Maharashtra, we spoke with 17 people through qualitative interviews and with 74 people through the survey. In Punjab, we spoke with 23 people through qualitative interviews and 82 people through the survey in mid-August 2020. We selected participants through a convenience sampling strategy. The survey and qualitative interviews focused on capturing prevalent fears, stigma and misinformation, and source of information. In Punjab, we also conducted structured interviews with key stakeholders such as representatives from NGOs, district officials and doctors on the topics of fear, stigma and misinformation, during the last two weeks of July 2020.

The needs finding results are broadly structured around participants’ basic knowledge about COVID-19, people’s responses to scenario-based questions, perceptions of COVID-19 and our main findings on fears described by people. We selected Maharashtra and Punjab to conduct needs finding surveys and interviews due to initial traction with state government leaders and the COVID-19 pressures at the time; Maharashtra faced the highest burden and Punjab experienced high mortality rates.

A. Demographics

For Punjab, we conducted qualitative interviews with 23 people and had 82 people take the survey. The demographics of the respondents are as follows:

- People between 19 and 52 years, with the median age being 28
- 48.78% of respondents were women
- 45.12% respondents were homemakers, 6.10% were unemployed. The remaining 48.78% were employed in private, public or small businesses
- 7.32% of participants had a household member who had an illness or health consideration which is high risk for COVID-19 complications (e.g. cardiovascular disease, lung disease, diabetes, pregnant women or recently delivered women)
- 24.39% held BPL (Below Poverty Line) cards
- 14.63% had been to school, 28.05% completed primary education (5th standard), 36.59% medium education (10th standard), 12.20% completed 12th standard, and 8.54% graduation (college course)
- 30.49% people lived with someone aged 60+
For Maharashtra, we conducted qualitative interviews with 17 and had 74 people take the survey. The demographics of the respondents are as follows:

- People between 18-50 years, with the median age of 30
- 32.4% of the respondents were women
- 25.7% respondents were homemakers, 14.9% were unemployed. The remaining 59.5% were employed in private, public or small businesses
- 7.32% of participants had a household member who had an illness or health consideration which is high risk for COVID-19 complications (e.g. cardiovascular disease, lung disease, diabetes, pregnant women or recently delivered women)
- 64.86% held BPL (Below Poverty Line) cards
- 10.8% completed primary education (5th standard), 47.3% medium education (10th standard), 23.0% completed 12th standard, 14.9% graduation (college course), and 1.35% a post-graduation course. The remainder did not attend school
- 29.73% people lived with someone aged 60+

B. Knowledge about COVID-19

Figure 1

1. Respondents exercise their personal judgement to determine if symptoms are severe enough that they should get tested, which could be a cause of delay in testing.

Overall, survey and interview respondents in Punjab were able to identify COVID-19 symptoms (such as cough, fever, and breathlessness). Fever (86.59%), cough (86.59%), runny nose (56.10%), throat irritation (52.44%) and breathing difficulty (47.56%) were the top five cited symptoms. Upon
recognition of symptoms, 87.71% of survey respondents said they would not wait more than three days to get tested. However, the nature of symptoms (mild or severe) influenced test-seeking behaviour.

In response to being asked how they would manage symptoms, people reported that they would self-treat for mild symptoms or during the initial days with symptoms (for example, with lukewarm water gargling and turmeric milk). The majority of the interview participants said they would go to the doctor if they had COVID-19 symptoms. As one participant mentioned, the logic is that if the symptoms do not subside and continue or get worse, people are then compelled to get tested.

“For mild symptoms, I will go for home remedies. For severe symptoms we will go to a doctor for consultation and get ourselves tested. If symptoms prevail beyond 14 days we won’t take a chance.”

The majority of the respondents also believed they did not need to report COVID-19 symptoms if they were mild.

Similar findings emerged from the Maharashtra sample regarding knowledge of COVID-19 symptoms and exercising personal judgement on when to get tested.

2. There are low levels of awareness about people’s experiences of recovering from COVID-19 and about COVID-19 health services. Respondents assumed that if they were practicing necessary preventive behaviours, they didn’t need to think about the eventuality of contracting COVID-19.

Across both survey and interview participants, very few participants knew people who had tested positive for COVID-19. Among survey participants, 12.20% of people knew someone who had contracted the virus. This indicates that people’s perceptions of COVID-19 health services are shaped by stories heard through word-of-mouth, media reports and rumours. Even if people interact with someone who has had COVID-19, chances are that the infected individual may not share their experiences as the following quote explains. From the key informant interviews, it was inferred that this resistance could be due to lack of confidentiality around who tests positive.

“I know people who have tested positive with COVID-19. Four days back I got to know about a person testing positive and today it’s my neighbour. Nobody has shared any experiences with me.”

Aside from the COVID-19 hotline, most people were not aware of other COVID-19 health services (such as testing services, quarantine services and different health clinics). As a result, what little people do know comes from secondhand information or from others’ experiences of government health services.

“I don’t have any faith/trust in the services provided by the government. My sister-in-law was admitted for her delivery at a government hospital. They conducted the COVID test as a part of their
protocol but we are yet to get the reports. They keep on postponing saying that reports are not yet ready!"

3. The majority of respondents would opt for government quarantine to ensure that their families don’t contract the disease, and to receive timely treatment. Those who would avoid them are concerned about the quality of services and being away from the care and support that their families provide.

Figure 2

The majority of survey respondents mentioned they would prefer a government quarantine centre to isolating at home. For people who opted for home quarantine, the top reasons included being afraid of government quarantine (73.33%), the presence of family caregivers at home (46.67%), peace of mind that they aren’t being exposed to other diseases at home (23.33%), and concerns about the availability of resources within hospitals (23.33%).

Respondents who opted for government quarantine thought about their family members’ safety and the low cost incurred for treatment (government services are either free or offered at nominal cost). People who selected this option also believed that they would get timely or proper treatment at government facilities.

Maharashtra respondents reported similar reasoning for opting for home or government quarantine.

C. Scenario-based questions


Note that this question allowed participants to select multiple answers, which is why the percentage tallys exceed 100.
Most respondents believed that one can recover from COVID-19 so long as the patient gets the treatment that they need. As the following quote indicates, the onus is placed on the individual to take adequate precautions to avoid getting the disease, and to ensure they get timely treatment for recovery if they do get sick.

“If they follow practices, they will recover soon. If they don’t, then they have to bear the consequences. They should keep themselves warm, should not drink cold water or eat cold items, eat food rich in antioxidants, wear a mask etc.”

When asked whether specific communities (based on religion, caste, profession) were responsible for spreading COVID-19, people overwhelmingly said they disagreed that reasons for the illness can be attributed to any particular group.

In Maharashtra, individuals were blamed less if they contracted COVID-19: “If people get COVID-19 it is their fault because they didn’t practice the right or necessary behaviors” (41% of participants agreed with the statement vs. 65% in Punjab). Similar to Punjab respondents, Maharashtra respondents overwhelmingly did not agree that specific communities (based on religion, caste, or profession) were responsible for spreading COVID-19.
D. Perceptions of COVID-19

Mixed opinions on the nature of support respondents would extend towards those with COVID-19 – ranging from complete avoidance to offering support and seeking to understand people’s experience while physically distancing.

When asked about how they would treat someone with COVID-19, most respondents didn’t know anyone who had tested positive. Responses on how people would treat COVID-19 positive individuals ranged from not helping at all for fear of infection, to helping as long as they could prioritise their personal safety and keep their physical distance as much as possible, to outrightly saying that everyone deserves care without discrimination.

When asked how they would treat people who had recently returned from government quarantine centers, most respondents reported that they would respond similarly to how they would treat someone with COVID-19. Most participants were keen to learn about the experiences at government facilities, while some preferred to avoid interaction altogether. A key point that people had varied opinions on was whether someone could still be contagious upon returning from a quarantine centre.

“We would not like to meet the person after 14 days, even though they are back from quarantine because we are scared of getting infected. We should not encourage gatherings. We will learn about their experience about the facilities provided like bed, food, and treatment.”

Similar to participants in Punjab, Maharashtra interview participants offered to help and support COVID-19 infected neighbors (e.g. bringing food, support with chores).

E. On Fear

Figure 4:
1. Predominant fears were about the risk of COVID-19 and financial implications of getting COVID-19

When asked about their main fears and concerns, people mentioned their family's health, followed by unemployment and financial impact if one was infected.

“What will I feed my kids if myself or my spouse gets infected? We would be unemployed for days (means loss of pay for days). People will obviously try to avoid us as we are infected and it would lead to stigma. People would avoid coming near us.”

2. Respondents were divided in their concerns about contracting the disease; this may be due to optimism bias

When survey respondents were asked if they were worried about their family getting COVID-19, 47.56% reported that they were very worried, whereas 42.68% reported that they were not worried at all. These largely mixed results could be due to just world fallacy wherein people falsely believe that they are less at risk of contracting COVID-19 given that they are practising the necessary COVID-19 preventive behaviours or that they have not contracted it so far and possibly will not in the future.

“I am not afraid of getting affected by COVID-19 as I am very cautious.”

“Nothing is going to happen or why should I get scared as I am following the protocols. I never get out of my home. So why will I get COVID-19?”

With the safeguard of preventive behaviour, potentially risky behaviour like stepping outside is considered acceptable. 93.9% of people agreed it was alright to go outside as long as they stayed at least one metre away from people while wearing a mask.

Given that there is evidence of asymptomatic spread, it becomes that much more important that 1) people are educated on asymptomatic spread; and 2) preventive behaviours like mask wearing and physical distancing are consistently reinforced.
3. Care for family seems to be the main motivation for health seeking behaviour

Figure 5:

In Maharashtra, family safety was also mentioned as the prime reason to worry, followed by fear of the disease and complications. This also links to the action bias in behavioural science, where people are incentivised to act to gain control over a situation and tackle a problem. In this case, protecting one’s family is a strong motivator for health seeking behaviour.
CAMPAIGN DEVELOPMENT

Based on the insights gleaned from the research, we organised frequent stakeholder consultations and ideation sessions to anchor the campaign development process. This enabled us to verify data, incorporate suggestions and capture learnings from other campaign experiences.

Stakeholder consultations

A range of themes emerged from our analysis of the research findings. These were shared with a core group of key stakeholders who gave us periodic feedback on aspects like validity, relevance, cultural appropriateness and applicability. In many ways, the data from the field reinforced the responses from the key informants, giving us a clearer picture of the direction the campaign needed to take. Establishing a good working relationship with government stakeholders helped us develop a nuanced understanding of ground realities, receive critical and timely feedback and gain access to existent communication materials, so we could improve rather than replicate efforts.

Identification of key messages to trigger intended behaviour change

The themes that emerged during the data collection included:

- Low degree of trust in health care system
- Lack of awareness of government services and knowledge of how to access them
- Misinformation
- Fear and stigma due to experiences with health services, and uncertainty about the disease (treatment and cure) and protocols (home isolation, quarantine)
- Emphasis on individual responsibility to curb the spread / “just-world fallacy”

Zeroing in on the issues to address through communication and arriving at the specific key messages that would trigger action entailed rounds of brainstorming and revisiting the data to a) ensure alignment with the findings; and b) ground them in cultural context and current climate. E.g. Misinformation was a significant topic at one juncture due to a flood of news reports on organ harvesting when people visited hospitals for treatment. Rumours were reported as one of the main reasons for fear around treatment, which translated into people not reporting symptoms or testing in time. The team had to take a call on whether the campaign should clarify the facts or whether that was best left for an official government channel. Our findings revealed that people were most concerned about quality of service given the volume of negative stories in the media, and, of course, certain first-hand experiences. Communication should, therefore, make a case for why people should ‘risk’ accessing services.

After another round of consultations with our core stakeholder group, we decided to deep dive into reasons why people would consider testing and build on that specific behaviour in order to motivate
people to get tested. The data indicated that people are likely to get tested because they care about the health of their families and would not want to put them at risk. Getting timely help would ensure quicker recovery, protect family members and curb the spread of the virus. The slogan, “If you love your family, get tested”, was conceptualised to tap into sentiments of love/care/support in order to motivate people to test. We also sought to balance that with information and facts, i.e. where, when and how to get tested. In behavioural science terms, we tried using the affect heuristic, i.e. dependence on good/bad feelings in response to stimuli to change behaviour.

We chose ‘care and support’ as the campaign approach to anchor the idea, tagline and narrative in values that we believed were important to build trust and cooperation – not just in the healthcare system, but also among communities. This also potentially helps people resolve cognitive dissonance, i.e. a tension between two feelings such as what individuals want to do and what is societally beneficial. Cooperation comes into play when people adhere to practising safe behaviours to curb the spread. ‘Care’ manifests in ensuring feedback mechanisms at public health facilities, clear systems of grievance redressal, transparency of process and demonstration of accountability. These aspects clarify institutional intent to citizens and reinforce the importance of empathy in interactions – a concern people had reported while interacting with frontline workers.

The following table demonstrates how each of the research findings were referred to while formulating the campaign design.

<table>
<thead>
<tr>
<th>Findings from needs assessment</th>
<th>Barriers to desired behaviour or behavioural change</th>
<th>Campaign solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>People exercise their personal judgement to determine if symptoms are severe enough that they should get tested, which could be the cause of delay in testing</td>
<td>There is general hesitancy to access COVID-19 services which is complicated by experiences with the health care system and misinformation due to rumours and fake news</td>
<td>The campaign voice is credible, trustworthy, engaging, empathetic and inclusive – factual information is balanced by tapping into emotions to connect with audiences</td>
</tr>
<tr>
<td>64.3% reported that doctors and physicians were the most trusted messengers for information on COVID-19</td>
<td>People will pay heed to the sources of information that they perceive as credible</td>
<td>Dr. Saab, the campaign mascot, is a friendly neighbourhood doctor who acts as a bridge between the community and the healthcare system, and reinforces the importance of</td>
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74% reported that their main concern was the safety of their family – a strong motivator to engage in preventive behaviours or access health services in a timely manner. Emotions strongly affect health-seeking behaviour – the choice to test would be influenced by concern for the health of family members. Therefore, the campaign theme, ‘Care and support’ is reinforced consistently. The tagline, “If you love your family, get tested” appeals to one of the strongest motivators for behavior change and seeking health services: care for one’s family.

47.56% reported that they were very worried, whereas 42.68% reported that they were not worried at all. People are divided in their concerns about contracting the disease. These largely mixed results could be due to an optimism bias, where people falsely believe that they are less at risk of contracting COVID-19 given that they are practising necessary COVID-19 preventive behaviours or that they have not contracted it so far and possibly will not in the future. Inclusion of clear information on what happens during testing and that reinforces ‘Care and support’ – health authorities recommend timely treatment because they care.

Though 90.24% reported that they have enough information on COVID-19, they are unclear about services and testing protocols. People need clear information on why, where and how to get tested to reduce barriers to adopting that preventive behaviour. The creatives explain the basic ‘why’ and ‘how’ questions on testing and encourage people to call the 104 or download the COVA app to clear their doubts. Clear call to action across communication materials to call 104 or check the COVA app if they have doubts of when to get tested.
65.9% believed that if people contract COVID-19 it was their fault because they did not practise the right or necessary behaviours.

The just world fallacy or just world hypothesis is the cognitive bias that a person’s actions bring morally fair and fitting consequences. Thus, it is the assumption that noble actions are eventually rewarded and evil actions eventually punished.

The campaign uses the care and support theme to normalise the possibility of getting COVID-19 and reiterate the fact that people need not fear accessing healthcare services.

The next step was to flesh out a campaign idea. This entailed thinking of ways to package the insight and information so as to be catchy, visually appealing and memorable, and resonate with the target audience. We asked our core stakeholder group various questions to understand the community: What are the preferred modes of communication? What kinds of content do they consume frequently? Who do they deem credible sources of information? What channel facilitates reflection and dialogue? Who are the influencers and how best can we multiply reach? What tone is best suited for the issues we want to talk about – do we want to be educational, entertaining etc. The creative process even went into details about the need for a spokesperson for the campaign to persuade/motivate people to test, and what should she/he look, think, sound and behave like to strike a chord with the most number of people. Are they in line with how we want to approach communication? Some aspects we used as a checklist:

- Build a narrative – Storytelling is a compelling form of communication to weave a narrative across platforms. Stories inspire and teach people about life, behaviours and best practices
- Package the idea – Select channels and build alignment across formats
- Maintain uniformity and coherence across elements
- Arrive at sustainable ways for health workers to sustain the campaign
- Capture cultural nuances that resonate with the audience
- Incorporate feedback mechanisms at every stage of the process to ensure that language, tone and visual representations are appropriate and engaging

**Conceptualisation of execution routes**

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**Campaign components**

A mascot and a tagline were selected as elements that could creatively weave the materials together into a toolkit format to aid recall and build memorability. A mascot also lends itself to building a larger narrative on safe behaviour and gives government bodies the flexibility to adapt to different storylines based on evolving health priorities.

**a) Tagline**

The tagline “Get tested for COVID-19 to protect you and your family” conveys the importance of timely COVID-19 testing and reinforces the ‘Care and support’ angle that guided the creative execution.

**b) Mascot**

It was necessary to develop an authentic campaign voice that resonates with the target audience given the sensitivities around communication during the pandemic. The task at hand was to create a credible source of information that people can trust and relate to. We decided to develop a character to communicate campaign messages who is a medical professional, but not from the formal government health system to build trust and acceptance. A large portion of the Punjabi population has relatives who have migrated abroad, hence choosing a character who has recently moved back gives his persona a degree of relatability. The exposure to other cultural contexts also adds flair to his storytelling style.

Dr. Saab is a friendly, well-respected doctor with a colourful personality whose priority is to make medical care easily accessible. He runs his own clinic and likes to spend time understanding people’s illnesses, giving them the support they need to heal. He believes in the “power of family”, is inclusive and respects the cultural values of the communities around him.

**c) Toolkit**
We mapped out the most effective channels of communication based on key determinants of reach and engagement, and prioritised them based on feasibility of execution given the tight timeline at hand. The toolkit, developed in three languages, comprised:

- Posters
- Audio jingles
- Videos
- Comic strip
- User guides
- Campaign brief

**Selection of channels for dissemination**

We arrived at dissemination channels in consultation with the key stakeholder group to ensure engagement and reach. During the planning phase, communication channels were mapped in each of the five districts. We prioritised mediums that would maximise opportunities to promote campaign messaging.

**Dissemination**

The campaign materials were uploaded on 13 district Facebook and Twitter channels with an average following of 1500-2000 people per channel. The materials were also posted on 5 GOP and Chief Medical Officer (CMO) Punjab Facebook and Twitter channels that had between 150,000 and 171,000 followers per channel. Handles that posted the content included: Government of Punjab, CMO Punjab, Punjab State Advisory Council, District Public Relations Office (DPRO) and Punjab Covid Bulletin, Department of Information & Public Relations. The campaign materials were also displayed in 22 districts across the state of Punjab through the Department of Information and Public Relations. The DPROs facilitated installation of four standees per district (88 locations in total) in Government of Punjab offices. An estimated 1,287,000 people were reached through the activity. The videos and jingles were played on newly inaugurated IEC vans in all 22 districts across various locations for one month, reaching out to an estimated 604,500 people. The campaign reached 1,891,500 people directly and an average of 386,375 people through digital channels.
(5) RAPID TESTING

To understand how our poster compared to an official Government of Punjab poster with similar messaging, we showed both posters to beneficiaries of Noora and Aurora Health’s partners, Ambuja Cement Foundation, in Barnala and Roopar (districts of Punjab). We partnered with Ambuja Cement Foundation because their programmes focused on alleviating poverty among economically disadvantaged populations, a similar demographic to our target audience. Trained data collectors administered a 20-minute survey over the phone to 74 people who had WhatsApp installed. They were shown the poster for 30 seconds over Whatsapp before proceeding to ask questions. Half of the participants saw the GoP poster and the other half saw the poster we designed. The aim was to get feedback on the three parameters outlined – recall, beliefs and behavioural intentions. These parameters were adapted to the Indian context, based on an approach used by BIT.

a. Behavioral Intentions
   It’s hard to capture how people will eventually behave. Since measuring if the poster was effective in changing behaviour is hard to capture, we attempt to understand what people intend to do after viewing the content. While viewing these results, it’s important to remember that there is always a gap between one’s intentions and actions. So instead of looking at the absolute number, we focus on the differential between the two posters. In general while using this parameter to test, one should remember that as intentions increase there will be an incremental increase in actions as well. This is by far the most important aspect to consider while testing communications content.

b. Recall and Awareness
   This parameter was chosen to measure how much of the key message and its components people were able to recall and understand correctly. It is the second most important component we tested for. While we test for recall, we recognise that recalling something 10 minutes after an event vs. a few weeks later is very different. However, if the recall of a message is high during testing, there is a likelihood that some aspect of the message will be remembered by people even a few weeks down the line.

c. Beliefs and Perceptions
   Since beliefs and perceptions play a critical role in influencing behaviour, we wanted to understand people’s perceptions of the virus. While testing for beliefs and perceptions, it’s important to remember that sometimes while testing, people will tell you what they believe is socially acceptable even though their real belief might be different. You can account for this while framing the questions.
Results showed that people who saw our poster understood that the main message was to get tested for COVID-19 (35 vs. 29) and the people who saw the GoP poster identified calling 104 as the main takeaway (14 vs. 0). Detailed outcomes are presented in the findings section.

While we understand that it isn’t possible to conduct full fledged impact evaluations during time sensitive health campaigns like this one, it’s very important to embed some form of feedback mechanism that allows one to test and alter campaign material based on how people react to it. Rapid testing serves this purpose and can be done without taking much time. It does however have a cost element, which can be minimised by doing it digitally.

**Posters**

*GoP Poster*

*Aurora Health and IDFC Poster (tested in Punjabi)*

*Translation of GoP Poster:* If you or any of your family members are having COVID-19 symptoms then go to the nearest hospital to get tested. You can call up ‘104’ to know about the government and private hospitals. For the test you don’t need any prescription. Have symptoms get tested quickly. Be active – to save yourself from Corona.
LEVERAGING BEHAVIOURAL SCIENCE TO PROMOTE SAFE PRACTICES: LESSONS FROM WAVE 1 OF COVID-19 IN PUNJAB
Audio and Video link: [http://bitly.ws/dRkg](http://bitly.ws/dRkg)

5.1. Results

1. Behavioural Intentions

How likely are you to get tested if you have mild COVID-19 symptoms (e.g. fever, cough, sore throat, shortness of breath)?

More respondents who saw the Dr. Saab poster were certain of getting tested (39% vs 33%).

2. Recall and Awareness

What is the main thing this poster is asking you to do?

When asked, “What is the main thing the posters were asking you to do?”, people responded saying the design of our poster (Dr. Saab poster) communicated the importance of getting tested for COVID-19 more than the GOP poster, although the GOP poster communicated calling 104 better given the bolded layout. Unprompted, 83% people identified 104 as the number to call for a CoVID-19 test.
looking at the GOP poster vs 76% people who identified 104 for the Dr. Saab poster.

People who saw the Dr. Saab poster gave more clear and unambiguous responses around getting tested given mild symptoms that don’t require hospitalisation. To improve the Dr. Saab poster, a suggestion would be to highlight the call to action better – in this case, calling 104 – and explain that one can call the number to get tested.

3. Beliefs and Perceptions

In your opinion, why is timely testing important?

Individual and family motivational factors appear to encourage people to get tested for COVID-19. Given this, we also wanted to understand the motivational factors communicated by each poster. We asked, “In your opinion, why is timely testing important?” Since it was an open-ended question, responses were coded and categorised. For both the posters, the participants considered timely testing important for the sake of their family followed by personal and societal well being. More people mentioned family as a motivating factor among those who saw the Dr. Saab poster (34% vs. 25% for the GOP poster), which was its key message, along with containing the spread of the virus (16% vs. 3%).

Did any of your ideas about testing change after seeing this poster?

Around 35% of the people who saw both posters said they experienced changes in the way they perceived testing. Among those who saw the GOP poster, 54% mentioned that testing is compulsory or important, and 15% mentioned one can call 104 if they have questions.

Among those who saw the Dr. Saab poster, 77% mentioned that testing is compulsory and 15% mentioned the importance of testing for good health. These responses also clearly show that people viewing the GOP poster recall 104 better.

Finally, we also asked open-ended questions for any additional thoughts on how the posters may have changed opinions and general feedback.

- For both posters, around 26 people (13 for each poster) said they had certain preconceived ideas that changed after seeing the poster, which includes the importance of testing, that they can call 104 if they need additional help, and the need to test for the safety of one's family.
- When asked about general feedback for the Dr. Saab posters, suggestions included writing out symptoms and distribution plans. Feedback for the GOP poster was to add other contact information aside from the 104 numbers, adding details on other preventive measures and COVID-19 symptoms.
The results showed that the Dr. Saab poster communicated the importance for timely COVID-19 testing better than the GOP poster. However, we could have made the additional message of calling 104 for clarifications clearer and more prominent. We were unable to do another iteration of the materials due to time and resource constraints. However, feedback mechanisms should ideally be embedded across stages of campaign development, especially in public health communication where the goal is to improve well-being and potentially save lives.
(6) **KEY LEARNINGS**

Developing a behaviour change campaign during a crisis like COVID-19 was a challenging exercise. There was limited or rapidly changing knowledge about the disease, minimal scope to do any kind of baseline assessment, and no time to make iterations to the materials or evaluate their effectiveness due to our degree of involvement in the dissemination process. The goal was to get a campaign with a sound strategy out as quickly as possible to reduce barriers to early reporting and testing. Our access to key stakeholders (community members, government officials, communication experts and civil society members) who were eager to contribute with a wealth of insights made this possible. We’ve documented some of our key learnings from the process below and hope they will be useful for practitioners planning similar interventions.

1. **Understand the present knowledge levels of key stakeholders and leverage inputs to establish a firm foundation**
   Civil society organisations and government officials are most in tune with field realities. Apart from knowledge about the situation, they can provide rich insights on behaviour patterns and cultural contexts. Leverage their knowledge and experience by building relationships and engaging with them at all key junctures of the campaign development. Our access to senior government officials, doctors, professors and social mobilisers helped us gain multidisciplinary perspectives that strengthened conceptualisation of issues, and of corresponding solutions that would resonate with communities.

2. **Reinforce the need to go beyond merely circulating information and education**
   The health communication structure varies from state to state. Some IEC (Information, Education and Communication) departments have turned into SBCC (Social and Behaviour Change Communication) cells. However, the dominant form of communication remains ‘raising awareness’ and educating people about dos and don’ts. While information is necessary, the process of behavioural change requires understanding barriers to change and nudging people to adopt healthy practises by developing interactive, engaging materials that enable reflection and action.

3. **Strategically work through tight timelines, limited information and fewer feedback loops**
   During a crisis like COVID-19, guidelines and protocols tend to change rapidly which means embedding a significant degree of flexibility in your campaign. Suggestion and feedback processes for collateral development can easily be long and drawn out when multiple stakeholders are involved. Throughout the process, our team learned to prioritise elements we sought feedback on and communicated the timeline implications of certain types of iterations. We also found it helpful to develop prototypes with reasoning so government officials, who were busy handling the crisis on the frontlines, could share quick inputs. We
were lucky to have team members located in Punjab working closely with our government partner who could provide us with context and additional guidance on what might work. We also managed to test content and obtain quick feedback from community members through their networks.

4. **Prepare a coordinated launch plan**
   While identifying avenues for dissemination for optimum reach and engagement, work closely with the teams responsible for dissemination to prepare a coordinated launch plan. This ensures that there is no time lost between campaign development and implementation.

5. **Engage institutions/establishments to scale up campaign efforts**
   As we return to a relative state of ‘normalcy’, governments should encourage institutions to play a central role in upholding safety protocols and influencing collective adherence. They should demonstrate a higher level of responsibility – whether it means creating additional facilities or affecting changes to their infrastructure. A rating system or accreditation could be explored to incentivise the adoption of stringent safety standards. E.g. establishments could have a signboard outside that reads ‘This Enterprise is COVID Safe’ – similar to Tripadvisor/Zomato/Swiggy ratings.

6. **Track progress and measure impact**
   Having certain metrics in place to evaluate the campaign trajectory helps periodically assess the campaign strategy and its effectiveness. It also provides space for course correction and revisiting of priorities that may be required to ensure engagement.

7. **Be mindful of aspects that communication campaigns alone cannot solve for**
   While behaviour change campaigns have the potential to improve public health outcomes, they do need to be backed by institutional efforts to improve quality of services and ease of access. Inconsistencies on both fronts will make it challenging to convince people to adopt recommended behaviours and thereby impact the campaign’s delivery and credibility.
CONCLUSION

The manifestations of fear and stigma witnessed during COVID-19 were exacerbated due to the novelty of the virus. The lack of any prior knowledge about the disease and uncertainty around the science coupled by speculative media reports made for a challenging environment while working on the campaign strategy. The tenuous relationship between caution and panic needed to be carefully considered along with the respect for personal agency while recommending behaviours that would improve health outcomes.

The next challenge, quite understandably, was to understand how to sustain preventive behaviours – especially as fatigue sets in, estimation of risk goes down and desensitisation takes place. Until substantial progress is made in vaccinating the entire population, practising ‘Covid-Appropriate Behaviours’ is a key component of the government’s vaccination communication strategy.

The exercise provided us with rich insights on how people were individually coping with the pandemic on various levels, and collectively coping as a society with its implications. Through the data garnered, we were able to understand barriers to adopting safe behaviours and motivators to leverage while designing content. We were able to identify common gaps in communication strategies – integral components of any effective response plan. As alluded to earlier, behaviour change campaigns do have the potential to create significant shifts in behaviour patterns, but it is important to note that communication interventions alone cannot be a panacea. They need to be supplemented by institutional intent to improve quality of services. For instance, if frequent handwashing is a behaviour that is being promoted, making structural changes to the environment like installing no-contact soap dispensers and sanitiser stations with foot pedals at public spaces can go a long way in improving compliance. Incentives can also be a useful measure, but if incentives reduce intrinsic motivation, they become futile. It is important to stay in tune with how people respond to evolving protocols and identify triggers that have an emotional quotient so as to motivate them to stay safe. Trust has and will continue to play a significant role, more so as the vaccination drive picks up momentum. It is important for policymakers to deepen their engagement with communities to improve public health outcomes – a task that cannot be achieved without collaboration and active participation from all segments of society.
7.1. Communication campaigns referenced

Case study 1: Taiwan COVID-19 strategy

21 January 2020 marked Taiwan’s first recorded case of the novel coronavirus. Despite its proximity to China, ground zero of the outbreak, as of 15 March 2021, Taiwan has 990 confirmed COVID-19 cases and 10 deaths. While the country did have the benefit of lessons from previous public health emergencies like SARS, timely and effective communication played a crucial role in fighting the current pandemic.

1. Mass communication, transparency/credibility and tackling misinformation

The Taiwan government undertook a massive mass communication campaign, collaborating with private actors to get messages such as ‘wash hands’ and ‘wear masks’ out on a large scale. It instituted a transparent platform to share important epidemic information via a Central Epidemic Situation Command Center, building trust with its citizens. Shapiro (2020) notes television briefings and media/press conferences facilitated by the Health Minister Chen Shih-chung allayed the public’s fears. To tackle the inevitable misinformation associated with digital campaigns, Taiwan established the Taiwan FactCheck Center (Tu, 2020). Each department also has its own Meme Engineering Team. Within an hour of finding fake news online, departments would take it down and issue clarifications to the public. The state also created animal mascots to spread awareness about preventive behaviours, and remind people to follow them. Further, a ‘mask map’ app highlighted pharmacies across the country selling protective gear such as masks, face shields and gloves, as well as the quantities of each that these locations have. These ‘epidemic prevention maps’ helped reduce panic and guided citizens to the right place for necessary supplies.

2. Investment in technology

The country’s investment in technology (Aron, 2020) complemented the public health campaign. Updates were also shared widely on social media, radio and other platforms. Other mediums of communication involved helplines and chat lines, with those in charge of responding trained in using empathy in their communication. The government established hotlines to provide the right information to people who, understandably, had several questions about the new disease. Via LINE (a software similar to WhatsApp used by over 20 million people in Taiwan), the Ministry of Health and Welfare began sharing updates about the COVID-19 situation.

3. Viral content

The state hired comedians to create viral content, such as memes and videos, spreading information about the virus and related safety measures.
4. **Infrastructure changes**

   In addition to communication, infrastructure changes guided by behavioral science principles were also necessary. For example, creative measures to ensure social distancing in public spaces such as restaurants includes large stuffed animals being placed between seats to encourage a six foot distance between patrons. This inanimate object gave a false sense of the area being crowded and helped nudge people maintain distance between themselves.

**Case study 2: Singapore COVID-19 strategy**

Singapore, with its proximity to China, has also fared well in containing the virus so far. The first COVID-19 case in the country was discovered on 23 January 2020. On the administrative side, a host of measures were undertaken, including setting up task forces, imposing a lockdown, and so on (Das et al, 2020). However, citizen education and awareness was at the forefront. Singapore’s public health campaign was extensive, ensuring that it reached all citizens irrespective of where they were located and what language they spoke.

1. **Use of technology-based communication**

   A COVID-19 Symptom Checker allowed citizens to review their symptoms for the virus and seek advice on next steps. Various hotlines were established for mental health, the elderly, Stay Home notice-related matters, and so on. On a more infrastructural side, several processes, such as payment platforms and schooling resources, were digitised and shared widely by the government. Moreover, there was even a One Service app through which a sort of community policing model was adopted. Messaging apps like WhatsApp were used to share regular updates. The government’s chatbot on WhatsApp had over a million subscribers. The high availability of information instilled public trust in the government’s efforts.

2. **Role of experts**

   Task forces, scientists, policymakers and other experts were encouraged to interact with the press. Task forces did so on a daily basis, sharing information on COVID-19 developments. It also helped that the messages coming from these different sources were largely consistent. Some videos featured scientists – credible sources of information on the science of the virus.

3. **Use of multiple platforms**

   Posters in local languages were placed across the country early on to spread awareness. Additionally, citizens were kept engaged through social media and other online platforms, where they could partake in the process of information dissemination and awareness. The platforms spanned Twitter, Facebook, Instagram, Telegram, Youtube, and even TikTok to reach different sections and age segments of society.
4. **Role of private sector**

It wasn’t just the government; private actors such as brands also stepped up to aid the communication of COVID-19 related information. For instance, Prudential Singapore launched the ‘Together Let’s #DOGood’ campaign to spread positive news and encourage harmony. Mediacorp, an entertainment group, wrote and sang a song to raise awareness of and cheer on frontline workers.

7.2. **Rapid testing results**

1. **Recall and Awareness**

What is the main thing this poster is asking you to do?

<table>
<thead>
<tr>
<th>Poster</th>
<th>Dr. Saab (N=38)</th>
<th>GoP (N=36)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To get tested for COVID</td>
<td>35</td>
<td>29</td>
</tr>
<tr>
<td>2. To protect my family/avoid putting them at risk</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>3. To call 104</td>
<td>0</td>
<td>14</td>
</tr>
<tr>
<td>4. Download the COVA app</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>5. Wear a mask</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>6. Other (specify)</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>

What number can you call if you want to get a COVID-19 test? (unprompted)

<table>
<thead>
<tr>
<th>Poster</th>
<th>Dr. Saab (N=38)</th>
<th>GoP (N=36)</th>
</tr>
</thead>
<tbody>
<tr>
<td>104</td>
<td>29</td>
<td>30</td>
</tr>
<tr>
<td>Any other number except 104</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Don’t know</td>
<td>8</td>
<td>1</td>
</tr>
</tbody>
</table>

2. **Beliefs and Perceptions**

In your opinion, how important is it to get tested for COVID-19 if you have symptoms?
In your opinion, why is timely testing important?

<table>
<thead>
<tr>
<th>Poster</th>
<th>Dr. Saab (N=38)</th>
<th>GoP (N=36)</th>
</tr>
</thead>
<tbody>
<tr>
<td>For family’s sake</td>
<td>13</td>
<td>9</td>
</tr>
<tr>
<td>For personal sake</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>For society’s sake</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>For test/treatment sake</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>To contain spread</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Others</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>

Did any of your ideas about testing change after seeing this poster?

<table>
<thead>
<tr>
<th>Poster</th>
<th>Dr. Saab (N=13)</th>
<th>GoP (N=13)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Yes? specify</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>2. No</td>
<td>24</td>
<td>22</td>
</tr>
<tr>
<td>3. Don’t know</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

**3. Behavioural Intentions**

How likely are you to get tested if you have mild COVID-19 symptoms (e.g. fever, cough, sore throat, shortness of breath)?
<table>
<thead>
<tr>
<th>Poster</th>
<th>Dr. Saab (N=38)</th>
<th>GoP (N=36)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. No chance</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>2. Unlikely</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3. Likely</td>
<td>20</td>
<td>22</td>
</tr>
<tr>
<td>4. Completely certain</td>
<td>15</td>
<td>12</td>
</tr>
</tbody>
</table>
(9) REFERENCES


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Shapiro, D. (2020). Taiwan shows its mettle in coronavirus crisis, while the WHO is MIA. *Brookings Institution*. Available at: https://www.brookings.edu/blog/order-from-chaos/2020/03/19/taiwan-shows-its-mettle-in-coronavirus-crisis-while-the-who-is-mia/
