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**Rooted
in Trust**

INFORMATION ECOSYSTEM PREPAREDNESS FOR HEALTH EMERGENCY RESPONSE

WHAT CAN WE DO NOW TO COMMUNICATE
BETTER IN THE NEXT CRISIS



Authors

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About Rooted In Trust

This research report was developed under the Rooted in Trust project, a global pandemic information response project that, between 2020 and 2023, has aimed to address the rapid spread of rumors and misinformation related to health issues during and after the COVID-19 pandemic. The project is funded by the USAID Bureau for Humanitarian Assistance (BHA) and managed by Internews. The project employed a four-pronged methodology: (1) Understanding the Information Ecosystem, (2) Listening to communities and tracking rumors, (3) Fostering two-way communication through community engagement and local media work, and (4) Liaising with humanitarian and health organizations, and providing evidence to guide risk communication and community engagement (RCCE) work according to communities' needs, ultimately pushing for greater accountability to affected populations (AAP) and trust-building among Information Ecosystem actors.

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DEFINITIONS AND ACRONYMS

Information Ecosystem: The Information Ecosystem is the combination of information providers, channels, platforms and tools that people have at their disposal to access, share and create information. Internews Information Ecosystem Framework maps the available information supply, demand and the complex relationships between the different actors, to make it easier to understand and improve the overall quality of information available in a specific community.

Information Ecosystem Actors: Entities, organizations, and individuals play roles in the information ecosystem by producing or sharing information. This is never static, and actors can vary depending on the community, the languages spoken or the specific risks we are looking at, among other factors. In this paper, we refer to actors as 1) Health System Stakeholders, 2) Humanitarian Organizations, 3) Media Organizations, and 4) Community actors (community leaders and Civil Society Organizations - CSOs).

Acronyms

AAP

Accountability to Affected Populations

BHA

Bureau for Humanitarian Assistance

CSO

Civil Society Organizations

CwC

Communication with Communities

DRC

Democratic Republic of Congo

IE

Information Ecosystem

IEA

Information Ecosystem Assessment

NGO

Non-Governmental Organization

Two-way communication: The process of exchanging information between two parties, where both sender and receiver are encouraged to provide feedback. In the humanitarian system, two-way communication is often used to create feedback loops with crisis-affected communities as part of Accountability to Affected Populations (AAP) and Communication with Communities (CwC) approaches. This enables communities to shape the agenda, respond to provided information with new insights, questions, or criticism. In this paper, we also use this concept to demonstrate the vital feedback loops among stakeholders in a healthy information ecosystem.

Infodemic Management: Systematic use of risk-based analysis to manage and reduce the infodemic's impact on health behaviors during emergencies.

Risk Communication: Real-time exchange of information, advice, and opinions between experts/officials and those facing hazards or threats. The goal is informed decision-making and protective measures.

Community engagement: Developing relationships and structures to involve communities in creating humanitarian, emergency, and health responses. The goal is community participation in decision-making throughout project cycles.

PPPR

Pandemic Prevention, Preparedness and Response

RCCE

Risk Communication and Community Engagement

SBCC

Social and Behavior Change-Communication

UN

United Nations

USAID

United States Agency for International Development

WHO

World Health Organization

INTRODUCTION

The detrimental effects of the COVID-19 pandemic, along with heightened risks increasing the potential for future health emergencies, have prompted a collective reevaluation of health emergency preparedness from various perspectives. International agencies, heads of states, and the public health community are deeply engaged in reassessing the role of health in global security. Discussions are underway regarding amendments to the International Health Regulations,¹ aligned with new agreements for pandemic preparedness and response. Consequently, strengthening health system capacities, promoting the One Health approach, and advocating for whole-of-government and whole-of-society solutions are some of the processes prioritized to anticipate and prevent future pandemics.

The importance of communication in preparing for and responding to health emergencies has long been recognized by public health experts and authorities. Risk communication is indeed one of the eight core functions that WHO Member States must fulfill as signatories to the International Health Regulations. As such, it is included as one of the core elements to be strengthened and implemented within national and local structures as part of WHO's Strategic Framework for Emergency Preparedness.²

Furthermore, the recent United Nations General Assembly Declaration on Pandemic Prevention, Preparedness, and Response (PPPR)³ has acknowledged the need for more robust measures to address the negative impacts of infodemics, including health-related misinformation, disinformation, hate speech, and disease-related stigmatization. The document also recognizes the crucial role of timely, accurate, and evidence-based information in building trust in public health systems and authorities.

We would argue that access to such information is crucial, and we appreciate the recognition of infodemic-related structures as central to health emergency preparedness. Nevertheless, further steps need to be considered to build trust. These require sustained and adequate structures that go beyond standalone “information-based interventions” and consider longer-term, ecosystem-building approaches. In this sense, programs that focus on communication as a standalone method for influencing concrete behaviors often rely on debated assumptions: ⁴

- **Information alone does not guarantee protective or adaptive behaviors during crises.** Behavior-change communication (BCC) programs often overlook the multiple factors influencing decision-making in emergencies, including trust in response actors and rapidly changing situations. They often lack a comprehensive, long-term perspective.
- **Standalone information-based interventions emphasize ‘rational’ decision-making,** neglecting the complexity of choices people face during crises (including the choice for inaction) and the gap between knowledge and actual behavior.*
- **Top-down approaches to behavior change communication disregard community participation in creating, prioritizing, and sharing information.** They also overlook the agency of individuals in trusting and acting on information based on their values, beliefs, and contexts.

All these points stress the importance of recognizing agency and choice, crucial elements in building trust in health information and communicators⁵ - while considering the long-term context of environments and communities. Therefore, it is essential to recognize

* We refer here to situations where individuals or communities may possess knowledge and information on a specific issue pertaining to healthy behaviors, protective measures, rationale for public health decision-making, among others, etc. but struggle to transform that knowledge into the expected ‘rational’ behavior change, suggesting that options are not available or actionable; other options may be of higher priority at the moment, inaction is chosen or even resistance is shown against the recommendations.

the role of information ecosystems (IE) in promoting community resilience and readiness against health emergencies, allowing communities to access, create, and disseminate critical information to understand the challenges they face, adapt to rapidly changing scenarios, and make decisions to protect themselves and their loved ones.⁶

In this way, robust information ecosystems enhance health crisis responses by providing timely, accurate, and widely accessible information to all involved in the response, fostering informed decision-making and coordinated actions.

In the context of health emergencies, flaws in the adequate exchange of information can result in negative impacts on individuals' health. They may become confused about which protection measures to take, where to access care, or how to behave during emergencies. This can also lead to increasing mistrust in those responsible for safeguarding public health, as we are currently witnessing in this post-pandemic era.

WHAT IS AN INFORMATION ECOSYSTEM?

The Information ecosystem is the combination of information providers, channels, platforms and tools that people have at their disposal to access, share and create information. The Internews Information Ecosystem Framework aims to map the available information supply, demand and the complex relationships between the different actors, to make it easier to understand and improve the overall quality of information available in a specific community.⁷

Information ecosystem preparedness for health emergencies refers thus to building resilience for health communicators and information response actors ahead of the hazardous event, identifying gaps in capacities, systems, processes and structures and finding relevant solutions that are community-led and sustainable in time. This will ultimately ensure actors and networks can function collectively in the face of health-threatening events.

As such, building a strong and resilient information ecosystem as a means for strengthened health emergency preparedness means all actors:

- Have access to locally relevant, timely and actionable information (not only about health-related issues and science or facts, but also about decisions made, intentions, plans, gaps and challenges);
- Have capacity that encourages critical evaluation and use of information;
- Have access to resources or mechanisms to verify information and contextualize it when they have questions;
- Have the ability, capacity and resources to plan and implement as emergency stages evolve; and
- Can inform other responsible actors about their needs, concerns, questions and ideas.

It is, therefore, crucial that strategies aimed at preventing, mitigating, and responding to future health emergencies incorporate the strengthening of information ecosystems as

a core element. To achieve this, a pivotal step for health communicators is to shift our understanding of communication. We must move from a static, one-way process where 'experts' convey information to 'communities' and let go of the assumption that providing

ing their lived experiences and belief systems, is essential to ensure that communication is both relevant and actionable.

Considering communication as a dynamic and two-way process provides a more accurate portrayal of how information circulates within communities. In this perspective, all actors in the ecosystem continuously generate, share, consume, and evaluate information for decision-making. This multidimensional understanding of information landscapes helps in identifying various structures operating at the hyper-local, national, regional, and global levels, contributing to communication processes. It also enables the identification of gaps in the exchange of information between systems, facilitating collective functioning and rapid responses.

A narrow view of communication may overlook relevant actors within the ecosystem who possess unique insights into the community's priorities and needs but are unprepared to address them. This can perpetuate a top-down approach to what should be communicated and how, rather than fostering collaboration with community structures. Ultimately, an information ecosystem approach broadens the capacity of other community actors, such as local media and CSOs, to hold responders accountable for decisions made before and during emergencies, ensuring that communities remain at the forefront of preparedness efforts.

WHO ARE THE ACTORS IN THE INFORMATION ECOSYSTEM?

Any entity, organization or individual can become a relevant actor of the information ecosystem as they produce and/or disseminate information. This is never static, and actors can vary, depending on the specific target community, the languages spoken or the specific risks we are looking at, among other factors.⁸ National or local media, authorities, humanitarian organizations, community leaders, CSOs and community members are just some of the actors that often interact in the information landscape.

facts alone is sufficient to persuade people. Responding to contextual needs, considering the realities of the people we engage with, includ-



PURPOSE OF THE RESEARCH

This research aims to gather and contextualize evidence with the goal of improving our understanding of preparedness from the perspective of information ecosystem approach. We hope this research provides some insights into the different ways the information ecosystem – and its actors' capacities - could be strengthened to serve broader goals on health emergency prevention and preparedness. Or conversely, how broader preparedness strategies can integrate information ecosystem actors' capacities into broader efforts to achieve operational readiness and health system resilience.

Through this research we aim at exploring the current gaps of information ecosystem preparedness for health emergencies through the conceptual lens of network-building, which sheds some light on potential strategies to build more solid processes, systems and capacity for effective Risk Communication and Community Engagement (RCCE) in health emergencies.

The research is guided by three main objectives:

1. To deepen our understanding of the diverse challenges and gaps faced by information ecosystem actors to be better prepared for a health emergency,
2. To identify the obstacles hindering cooperation for strengthened preparedness capacity in information responses during a health emergency, and
3. To identify strategies, approaches and interventions that can contribute to a healthier information ecosystem better prepared to face a health emergency, contributing ultimately to greater preparedness.

While the research focuses on existing gaps and barriers encountered in information ecosystems, we acknowledge that a myriad of work has already been done, and efforts to strengthen information ecosystems are already underway. Our concentration is on the gaps (section 1) and barriers (section 2), and we present existing practices and efforts as part of the strategies and recommendations that can be potentially enhanced and expanded across various contexts.

Scope, methodology, and limitations

This research was conducted in the Democratic Republic of Congo (DRC), Mali, and South Sudan. These contexts were selected due to their regional proximity, similarities in terms of the severity of humanitarian crises, and the resemblance of their national health systems, which are tiered and decentralized, with primary health care provided by community health centers. This approach allows for some level of comparability in the results.

While acknowledging the diversity of information ecosystem actors in health emergencies and overall health information, this research focuses on four distinct groups of stakeholders: (1) health system stakeholders, including emergency coordination/RCCE focal points, service management, and healthcare workers; (2) humanitarian organizations involved in the health response; (3) media organizations generating information across various formats and scales; and (4) community actors, encompassing community leaders, associations, and grassroots initiatives.

In total, 41 in-country semi-structured Key Informant Interviews (KIIs) were conducted between May and June 2023 with representatives from the mentioned categories of actors. Identifying data, such as personal names, organizations, and roles, have been anonymized to encourage participants to speak freely. Interviews were conducted both remotely and, where possible, in person. The distribution of

interviews was as follows: 15 in the DRC, 12 in Mali, and 13 in South Sudan. After data collection, the team implemented a coding approach focusing on thematic analysis. While there were established (deductive) parent codes organized around the three main research objectives, each coder was also able to inductively propose emerging themes related to preparedness challenges, tensions between actors, and possible recommendations or preparedness strategies.

The research has encountered several limitations that should be considered in the analysis and inform future research efforts. Firstly, the focus was on deriving generalized preparedness recommendations for humanitarian contexts rather than comprehending the specificities of each context, resulting in interviews conducted primarily at the national level, limit-

ing insights into hyperlocal nuances. Future research could adopt a more localized approach within each country. Secondly, the research was conducted in only three African countries, highlighting the need to explore similar questions in a broader range of global locations. Thirdly, challenges arose in steering interviews toward a clear understanding of research objectives and questions due to the novelty of the topic and varying understanding of concepts like infodemic management, RCCE, and the information response among interviewees. Lastly, there may be other relevant actors in the information ecosystem not covered in this study, such as the education sector, additional health system stakeholders, or armed groups. Exploring these aspects in future research could enhance our understanding of information ecosystem preparedness and contextual needs.



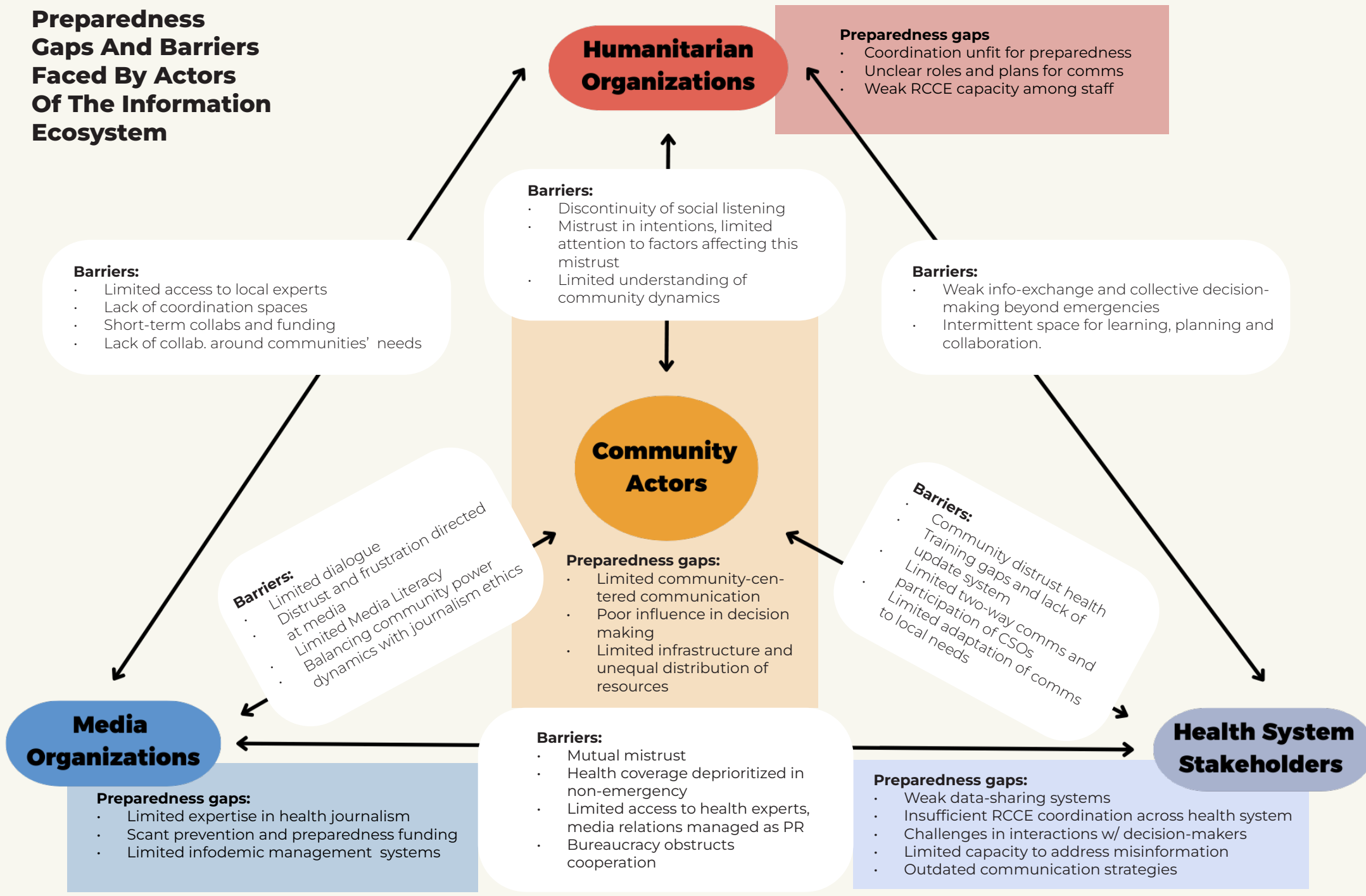
FINDINGS

The findings section is divided into two parts. The first section presents the preparedness gaps faced by each Information Ecosystem actor in responding effectively to a health emergency. The second section presents the barriers encountered in the interaction and cooperation between these actors. We delve into each relationship and emphasize the primary obstacles that hinder strengthened preparedness in the dynamics of information exchange, coordination, and collective response.

The following diagram illustrates our main findings and serves as a guide to explore the primary challenges faced by each actor and how these challenges also impact their interactions with other actors. This diagram is intended to highlight the key areas of concern that need to be addressed in information ecosystem preparedness.



Preparedness Gaps And Barriers Faced By Actors Of The Information Ecosystem



Humanitarian Organizations

- Preparedness gaps**
- Coordination unfit for preparedness
 - Unclear roles and plans for comms
 - Weak RCCE capacity among staff

- Barriers:**
- Discontinuity of social listening
 - Mistrust in intentions, limited attention to factors affecting this mistrust
 - Limited understanding of community dynamics

- Barriers:**
- Weak info-exchange and collective decision-making beyond emergencies
 - Intermittent space for learning, planning and collaboration.

Community Actors

- Preparedness gaps:**
- Limited community-centered communication
 - Poor influence in decision making
 - Limited infrastructure and unequal distribution of resources

- Barriers:**
- Community distrust health update system
 - Limited two-way comms and participation of CSOs
 - Limited adaptation of comms to local needs

- Barriers:**
- Mutual mistrust
 - Health coverage deprioritized in non-emergency
 - Limited access to health experts, media relations managed as PR
 - Bureaucracy obstructs cooperation

- Barriers:**
- Limited access to local experts
 - Lack of coordination spaces
 - Short-term collabs and funding
 - Lack of collab. around communities' needs

- Barriers:**
- Limited dialogue at media
 - Distrust and frustration directed at media
 - Limited Media Literacy
 - Balancing community power dynamics with journalism ethics

Media Organizations

- Preparedness gaps:**
- Limited expertise in health journalism
 - Scant prevention and preparedness funding
 - Limited infodemic management systems

Health System Stakeholders

- Preparedness gaps:**
- Weak data-sharing systems
 - Insufficient RCCE coordination across health system
 - Challenges in interactions w/ decision-makers
 - Limited capacity to address misinformation
 - Outdated communication strategies

SECTION 1: PREPAREDNESS GAPS FACED BY EACH INFORMATION ECOSYSTEM ACTOR

This section addresses the primary preparedness gaps encountered by actors in the information ecosystem. This examination also extends to internal tensions within actor groups. We particularly focus on their roles in information response, their participation in information production and dissemination, and their

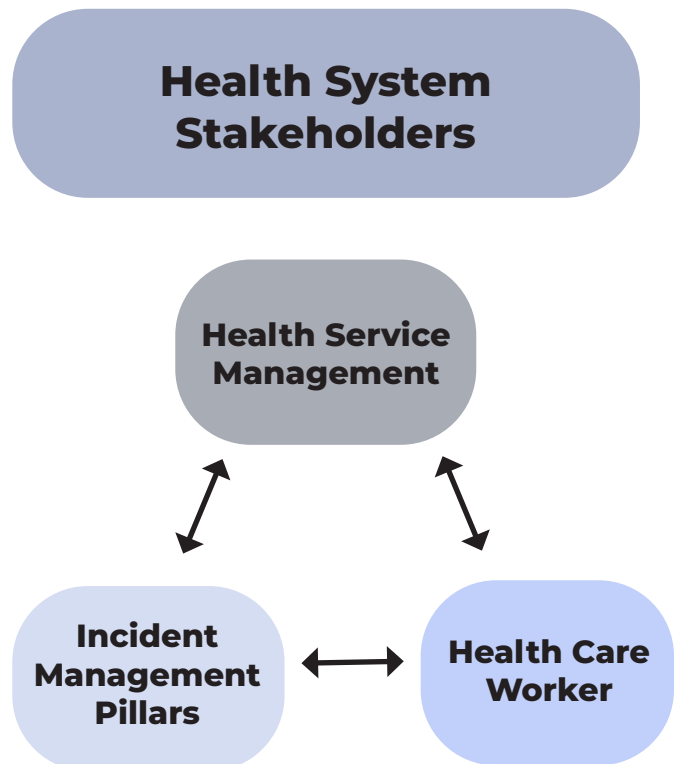
engagement with communities both during and after emergencies. An understanding of the key gaps faced by each actor in this context is crucial for a more comprehensive understanding of the barriers to effective coordination, processes, and systems within the ecosystem.

GAPS: HEALTH SYSTEM STAKEHOLDERS

Health System Stakeholders: In this report we refer to health system stakeholder as 1) health emergencies coordination or RCCE focal points within Incident Management teams (these include both national staff within Ministry of Health and/or international staff in a supporting role), 2) health service delivery management, mostly at the provincial or local level, including both from public, private and faith-based entities and 3) health care workers involved in direct care and engagement with patients

PREPAREDNESS GAPS

- Weak data-sharing systems
- Insufficient RCCE coordination across health system
- Challenges in interactions w/ decision-makers
- Limited capacity to address misinformation
- Outdated communication strategies



1. Weak data sharing systems: Health system stakeholders often struggle with inadequate internal data sharing systems for RCCE. These issues encompass the absence of standardized data collection and sharing methods, resulting in challenges when exchanging information among various actors in the health system (both at national and sub-national levels) and when sharing it with humanitarian organizations or international health agencies. The lack of common approaches, indicators, and terminology in RCCE complicates the compilation of diverse datasets and the assessment of response effectiveness. Furthermore, there is a lack of documented lessons from previous emergencies regarding the health system's information response, making it difficult to determine benchmarks and establish systematic information sharing for future crises.

prove the translation of technical information and policy into digestible risk communication activities to ensure health system stakeholders were adequately informed on the latest health information,



in turn equipping them to share relevant information via their respective channels. It was also noted that enhanced coordination between public and private sectors was needed. The lack of coordination between these sectors, except for limited interaction with faith-based health centers, was highlighted by a healthcare worker in Mal



“The challenge we see is that RCCE has no fine-tuned approach (...) I have never seen indicators of RCCE. [It] is a kind of input, but it needs to have measurable indicators (...). It is shared by different pillars and implementors. RCCE is cross cutting [and it] has marginal contributions among several pillars. So that marginal contribution of RCCE should be somehow measurable. [Because] indicators are not yet defined (...) the constructs and concepts are not clear to implement by policy makers and mid-level decision makers that implement RCCE.”

- Incident Manager, South Sudan.

2. Insufficient RCCE coordination among health system actors: There is insufficient internal coordination for information response among health system stakeholders. This not only impacts the ability of health care actors to inform their patients adequately, but it also impacts their ability to understand rapidly changing decision-making and adapt services/care according to latest events (particularly in rural or isolated areas). For example, in South Sudan it was noted the needs to im-



“That is what is missing, except in terms of collaboration, there is no private and public collaboration at all, apart from the centers I mentioned, the faith-based health centers. For it to have a good collaboration between the private and the others, it will be necessary that the private organize themselves a little more, [...] I think it would be beneficial and useful, [...] very advantageous for us, the private sector, but also for the community.”

- General Practitioner, Mali.

3. Challenges in interactions with decision-makers: Because of the fragmented coordination and challenging processes for internal information exchange, interactions with decision-makers within the emergency coordination are rare. The lack of understanding



of decisions taken and alignment with local contexts' priorities can cause disagreement on policy decisions during emergencies, impacting the guidance provided by health centers to communities. As such, public health guidance can end up being contradictory, incomplete or irrelevant. For example, in Mali not all health care workers were aligned with the policies on vaccination and public health measures taken during the COVID-19 pandemic, perhaps also influenced by the volume of misinformation being shared and the lack of guidance provided within the health system.



“It is about how to identify false information. [...] So that too, we can have an awareness of this at the community level, but even before the community, at the level of health actors, response actors, some health workers were not in perfect agreement, [with] the same level of information or agreement on vaccination and the measures to be taken. [...] we need training, awareness.”

– Health Cluster Coordinator, Mali.

4. Limited capacity to address misinformation in a timely manner: There is limited infodemic management resourcing and capacity among health system stakeholders, especially at the sub-national level. This highlights the need for training, financial support, human resources and monitoring structures, not only to communicate throughout the emergency, but also to address misinformation and questions as the emergency evolves.

5. Outdated and ineffective communication strategies: Health actors with an RCCE function often lack up-to-date communication strategies. These strategies lack monitoring and evaluation frameworks and fail to provide flexibility and adaptability in the face of common disease outbreaks. For example, communication plans are rarely updated with mapping of key stakeholders, informed by current partnerships or supported by collaborative communication resources that can be quickly used if needed.

GAPS: HUMANITARIAN ORGANIZATIONS

Humanitarian Organizations: In this report, we use the term 'humanitarian organizations' to describe organizations that adhere to humanitarian principles and aim to prevent, alleviate, and mitigate human suffering during emergencies, armed conflicts, or crises. Specifically, in this text, humanitarian organizations refer to those involved in health responses and RCCE programming, which may also intersect with other sectors such as protection, livelihoods, and WASH. Humanitarian interviewees in this research represent various roles within these organizations, ranging from health emergency coordination to project management, and specialization in RCCE or social and behavior change communication (SBCC), among others.

Humanitarian Organizations

PREPAREDNESS GAPS

Coordination unfit for preparedness

Unclear roles and plans for comms

Weak RCCE capacity among staff

1. Coordination unfit for preparedness purposes:

There is limited coordination among partners for emergency prevention and preparedness, with efforts primarily focusing on immediate response. This approach hinders the development of long-term strategies and the establishment of initiatives for prevention that include and consider aspects of the information ecosystem. RCCE tends to be an afterthought, receiving attention only when an emergency arises. This issue is especially prevalent at the sub-national level, where sectorial coordination is lacking or dysfunctional in the absence of significant emergencies, despite acute health needs and ongoing disease outbreaks. Additionally, there is a gap in collaborative evaluations of emergency responses that could provide continuous insights for future crises. Coordination mechanisms are swiftly disbanded after the emergency response, and local and international personnel depart without adequately transferring knowledge about what worked and what did not, leaving local structures without essential recorded lessons.

2. Unclear roles and plans: Consistent with the previous point, contingency communication plans are often absent, and even when they exist as part of national risk communication plans, diverse partners' capacities are

“At the local level, cluster groups do not function, or they are dysfunctional (...) we should work in the frame of alert prevention. Collaboration between the different actors must be continued, so actors are ready to respond when there is an alarm. (...). It is important to foster coordination between the actors that work in a specific area and have a relevant role in the health alert, including NGOs, community networks and media”

– Head of International NGO, Mali.

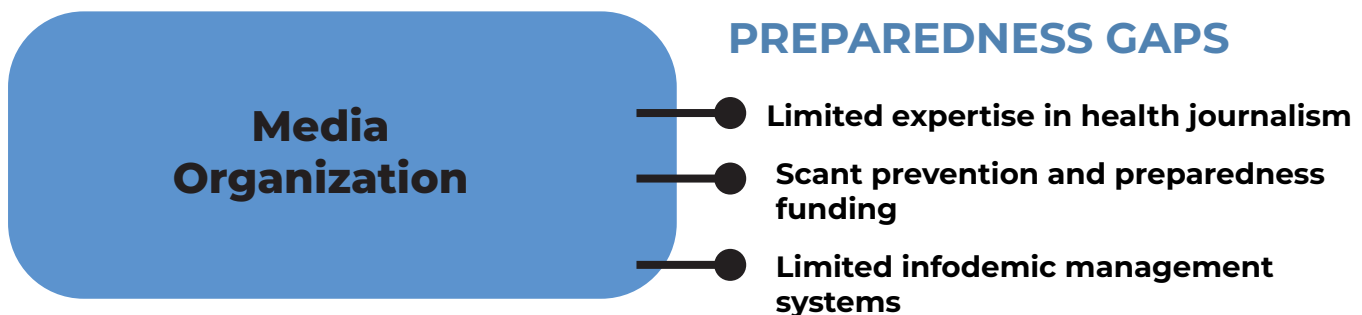
not always considered. These plans frequently exhibit fragmentation, resulting in redundant efforts and gaps during emergency response, especially at the sub-national level, where coordination is often more ad hoc. Typically, community actors and local media are excluded, rendering it challenging to establish collaboration lines beforehand.

3. Weak RCCE capacity among staff: Humanitarian organizations identified a deficiency in RCCE technical capacity among their staff. They recognize the necessity to train rapid response teams to act as conduits for community insights during their deployments. Additionally, there is a recognized need to educate technical officers, program managers and leadership about the significance of social listening and how to utilize it in their programs

to inform wider preparedness efforts. There is also a need to create capacity among field workers to be equipped with updated disease prevention information and responses to common rumors. Such training would enhance the capabilities of those already working within the community and cultivate an environment where addressing rumors, misinformation, and misperceptions becomes a standard practice over time.

GAPS: MEDIA ORGANIZATIONS

Media Organizations: In this report, we use the term “media organizations” to encompass the information generated by various media organizations, including broadcast, digital, and print media, in formats like news, investigative reporting, digital content, talkback radio/TV, live interviews, lifestyle, and educational programming, among others. The interviewees in this report represent professional media organizations and associations that support media practitioners.



1. Limited expertise in health journalism:

Journalists often lack the necessary knowledge in health reporting and may require training in complex health topics and data journalism. Interviewees consider this training crucial, not only to better analyze technically complex information during health emergencies but also to effectively cover stories that promote preventive measures and discuss the need for population-wide preparedness interventions such as vaccinations.

2. Inadequate funding for prevention and emergency preparedness:

Insufficient resources hinder the ability of media to support disease prevention and health literacy efforts as part of population preparedness. Short-term funding makes it difficult to strengthen

“It would require having a team identified from each media house [to] be trained in health reporting. And this training should not be once. It should be something every three months. You bring them together, you train them on health issues, in health reporting. So (...) that whenever something happens, you have the contacts, but you also have some basic [knowledge]”

- Media, South Sudan

in-house capacities and equipment, impacting their ability to respond effectively to health emergencies, including addressing misinformation and fact-checking. Media is sometimes supported by development actors – not necessarily connected to emergency response – and funds support infrastructure building and technical capacities. However, these are rarely connected to the role of media in health preparedness.

3. Limited systems in place to identify and respond to misinformation. Media organizations observed the need to have broader access to audiences’ information needs and conversations to be able to prepare preemptively for misinformation i.e. having specialized training and support to set up social listening systems and adequate processes to assess and fact-check rumors.

GAPS: COMMUNITY ACTORS

Media Organizations: In this report, we use the term “media organizations” to encompass the information generated by various media organizations, including broadcast, digital, and print media, in formats like news, investigative reporting, digital content, talkback radio/

TV, live interviews, lifestyle, and educational programming, among others. The interviewees in this report represent professional media organizations and associations that support media practitioners.

Community Actors

PREPAREDNESS GAPS

- Limited community-centered communication
- Poor influence in decision making
- Limited infrastructure and unequal distribution of resources

1. Limited mechanisms to inform community-centered communication practices: In health crises and even during non-emergencies, communities struggle to access timely, relevant information that addresses their specific concerns and needs. This scarcity of information contributes to the spread of false content

and erodes trust in health guidance. The primary issue is the lack of community-focused communication protocols and practices that inform decision-makers during preparedness.

2. Limited influence on response and preparedness decision-making: Communities often perceive engagement with stakeholders in these efforts as insufficient, imbalanced, or tokenistic. Inadequate engagement occurs when well-resourced community actors dominate participation in the response, sidelining inclusive community participation. Tokenistic involvement leads to superficial inclusion, lacking genu-



ine decision-making influence. Overall, weak participation results in non-localized responses that fail to address community needs.

3. Limited infrastructure and unequal distribution of financial resources among communities: The scarcity and unequal distribution of financial and infrastructural resources negatively affect the information ecosystem of communities and some groups within. On one side, we observed gaps in access to necessary telecommunication infrastructure like the internet, television, radio, or smartphones, particularly accentuated for populations in isolated areas. For example, in Mali, complaints were raised about the lack of radios or televisions in IDP camps, limiting their access to health information from outside the camp. On the other hand, CSOs explained their resource limitations in conducting RCCE activities, such as information production, dissemination, and feedback escalation. This challenge becomes more pronounced during preparedness stages when funding is constrained.



“When Covid started, only a small circle of international NGOs could participate in meetings, for example at the level of the Ministry of Health. So, they need to open these meetings much more to small organizations. Because otherwise these small organizations that are all over the territory get ignored, large organizations take time before they can act. While these smaller organizations are represented everywhere, or they live in the communities. So, this platform needs to exist so that they can integrate these meetings”

– **Community Organization Coordination, Mali.**



SECTION 2: BARRIERS IN THE INTERACTION AND COOPERATION BETWEEN INFORMATION ECOSYSTEM ACTORS

In this second section, we examine the barriers that affect the interaction and coordination between actors, especially regarding their RCCE. We emphasize key areas of concern within each relationship and highlight the impacts this has on the broader ecosystem. We pay particular attention to gaps in prepared-

ness planning and the relationships between actors beyond the emergency. It is within the core of these issues that the concept of information ecosystem preparedness can be conceptualized.

BARRIERS:

HEALTH SYSTEM STAKEHOLDERS ↔ **HUMANITARIAN ORGANIZATIONS**

Highlight:

- Intermittent relations and fragmented collaboration on RCCE beyond emergencies

Key Impacts:

- Compromised ability to focus on information ecosystem preparedness efforts.
- Preventing humanitarian orgs. to prepare adequately and adapt programming as needed.
- Impacting possibilities for learning through sector wide RCCE evaluations, mapping of existing actors for contingency plans and collaboration to strengthen health systems through two-way communication.

Health System Stakeholders

- Weak RCCE coordination and knowledge transfer at sub-national level

- Weak RCCE coordination and knowledge transfer at sub-national level

Humanitarian Organizations

The relationship between health system stakeholders and humanitarian organizations is characterized by weak information exchange and decision-making beyond emergencies. The lack of cross-sectoral and nexus-minded coordination on RCCE when emergencies are over compromises the ability of health system actors and humanitarian to focus on information ecosystem preparedness efforts. Collaboration mechanisms often rely on meetings which are postponed or canceled as the emergency is over. This contributes to fragmented communication on core issues, preventing humanitarian organizations to prepare adequately and adapt programming as needed. For example, humanitarian organizations observed the slow or delayed receipt of key information of actions taken by authorities and their recommended public health interventions during health emergencies, ultimately impacting their ability to inform communities and generate the necessary information response.

These intermittent relations also impact the options for learning through sector wide RCCE evaluations, mapping of existing actors for contingency plans and collaboration to strengthen health systems with a wider lens that incorporates two-way communication and community involvement.



“The key is to ensure that information flows horizontally and not vertically [so] everyone has it at the same time. When it is vertical, it goes from chief to chief until it goes down to the bottom, but if everyone has the information at the same time, that is good. I do not want to suggest that there should be a new structure or a new mechanism. We can simply strengthen the existing [one].”

- RCCE and SBC Specialist, Mali

This is especially felt at the sub-national level, where expertise/deployment of resources is often available at the onset of the emergency yet transfer of knowledge or system-building for local structures is curtailed when coordination structures are dismantled.



BARRIERS:

HEALTH SYSTEM STAKEHOLDERS ↔ **MEDIA ORGANIZATIONS**

Highlight:

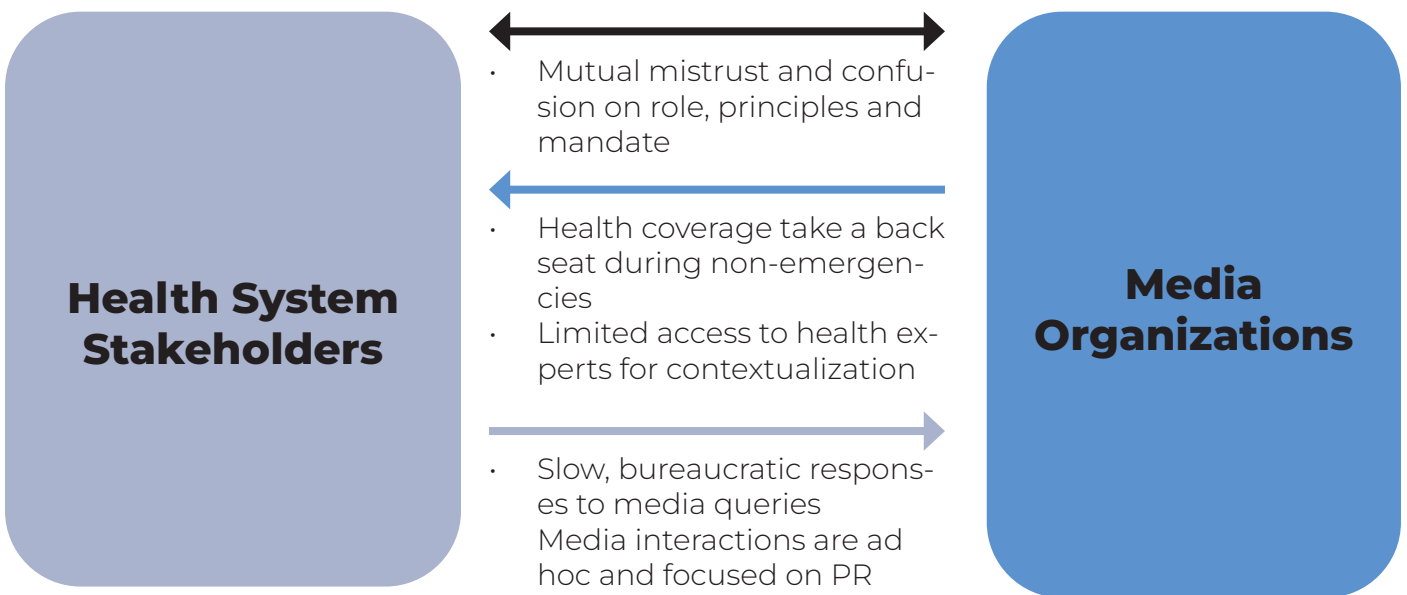
- Continued suspicions, lack of access to expert health information and inadequate engagement

Key Impacts:

- Compromised ability to focus on intentions and information are not trusted, relations are not strengthened and collaborations to strengthen local structures in the information ecosystem are curtailed.
- Impacts on the ability of media to support health literacy/disease prevention.
- Information provided by media turns out to be de-contextualized, untimely, inaccurate or irrelevant for their audiences.
- Media look for information in less reliable sources, increasing the chances for misinformation spreading.

Both actors lack trust in each other, mainly due to limited understanding of their roles and principles, as well as political and social tensions related to contextual dynamics. Health actors do not fully trust journalists to convey health information without bias, and journalists mistrust health actors' transparency. Media organizations feel excluded from meaningful conversations with responders despite seeking collaboration in information response. This lack of trust in each other results in exclusion of media from multistakeholder planning for preparedness and RCCE. This is a lost opportunity to have media contribute to contingency plans that incorporate their unique vantage point.

Contact between these two actors is established ad hoc and for specific purposes. As such, media lacks access to local health experts who can contextualize health information and public health measures during emergencies. Due to long bureaucratic processes, media often encounters barriers that prevent them from quickly interviewing experts lower in the hierarchy, such as health care workers or local technical officers in NGOs/agencies. These staff possess valuable local knowledge, yet they are not often al-





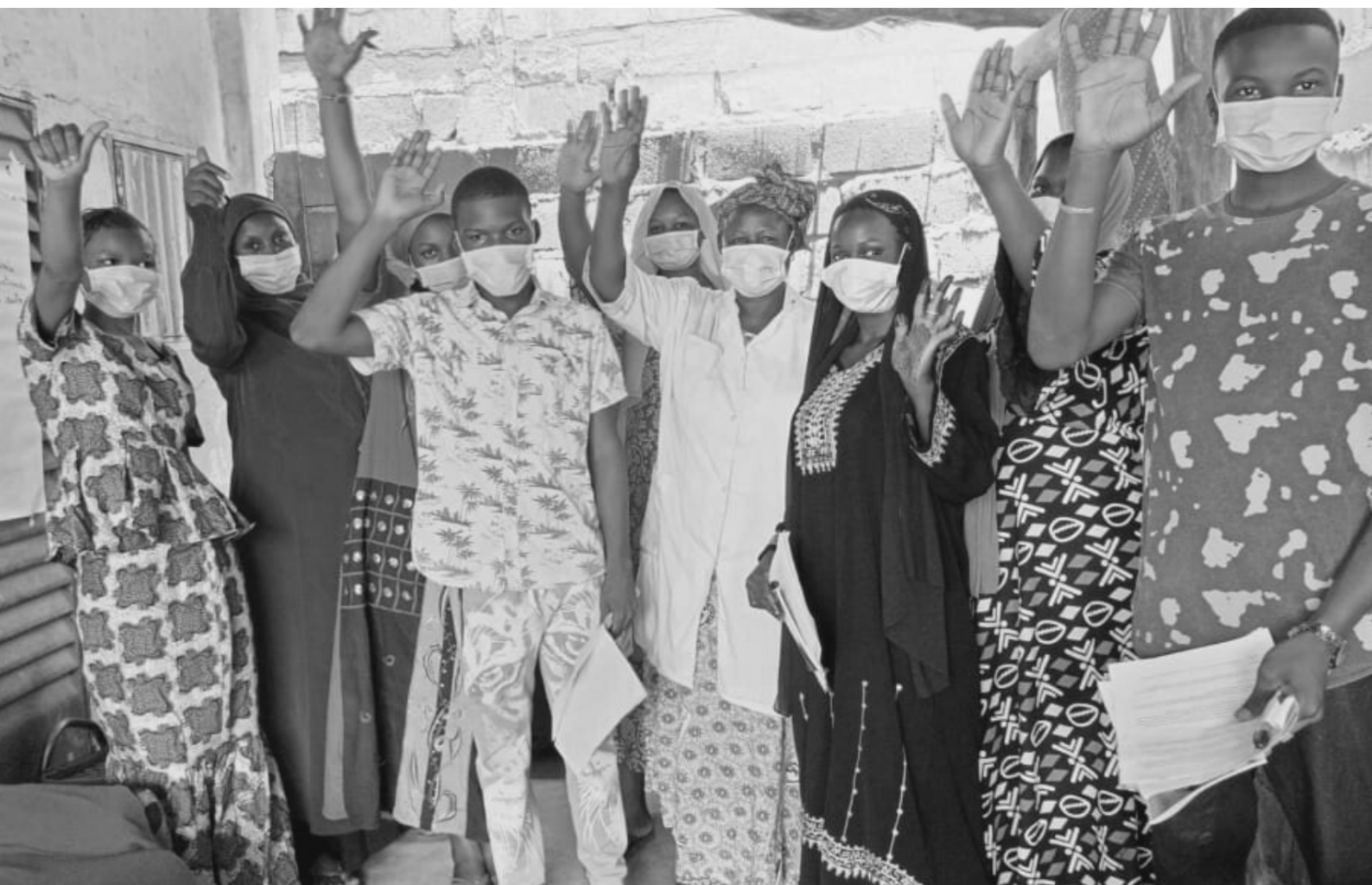
lowed to talk to reporters. On the other hand, authorized representatives can rarely provide insights into local events or useful information for journalists that help shape relevant stories for their audiences. While waiting for the authorized spokesperson to grant an interview, media experiences considerable time pressures. These delays affect the relevance of their reporting and the potential of informing audiences about risk pathways or public health decisions taken as part of community protection. During non-emergency periods, access to health experts becomes even less of a priority for the media as their attention shifts to other issues. This affects the information provided to the audience regarding preventive measures like vaccinations and environmental interventions such as WASH (Water, Sanitation, and Hygiene).

As observed, health system actors need to adapt protocols and the way they relate to media with more transparency, being able to better address uncertainty and communicate technically complex information in a digest-

“You want to investigate something e.g. there is an outbreak of cholera... The people who are affected are talking about it. Anyone from the health or the NGOs working in health, [...] they will never talk to you. [...] so that is the kind of challenge that we have. And they are always suspicious that you are going to do something unprofessional, something unethical... They keep coming and interfering”

- Media, South Sudan

ible way. Journalists, on the other hand, require better reporting skills for health information and, in some instances, stronger institutional codes for ethical journalism/protocols on how to report on sensitive issues and support the public good.



BARRIERS:

HEALTH SYSTEM STAKEHOLDERS ↔ **COMMUNITY ACTORS**

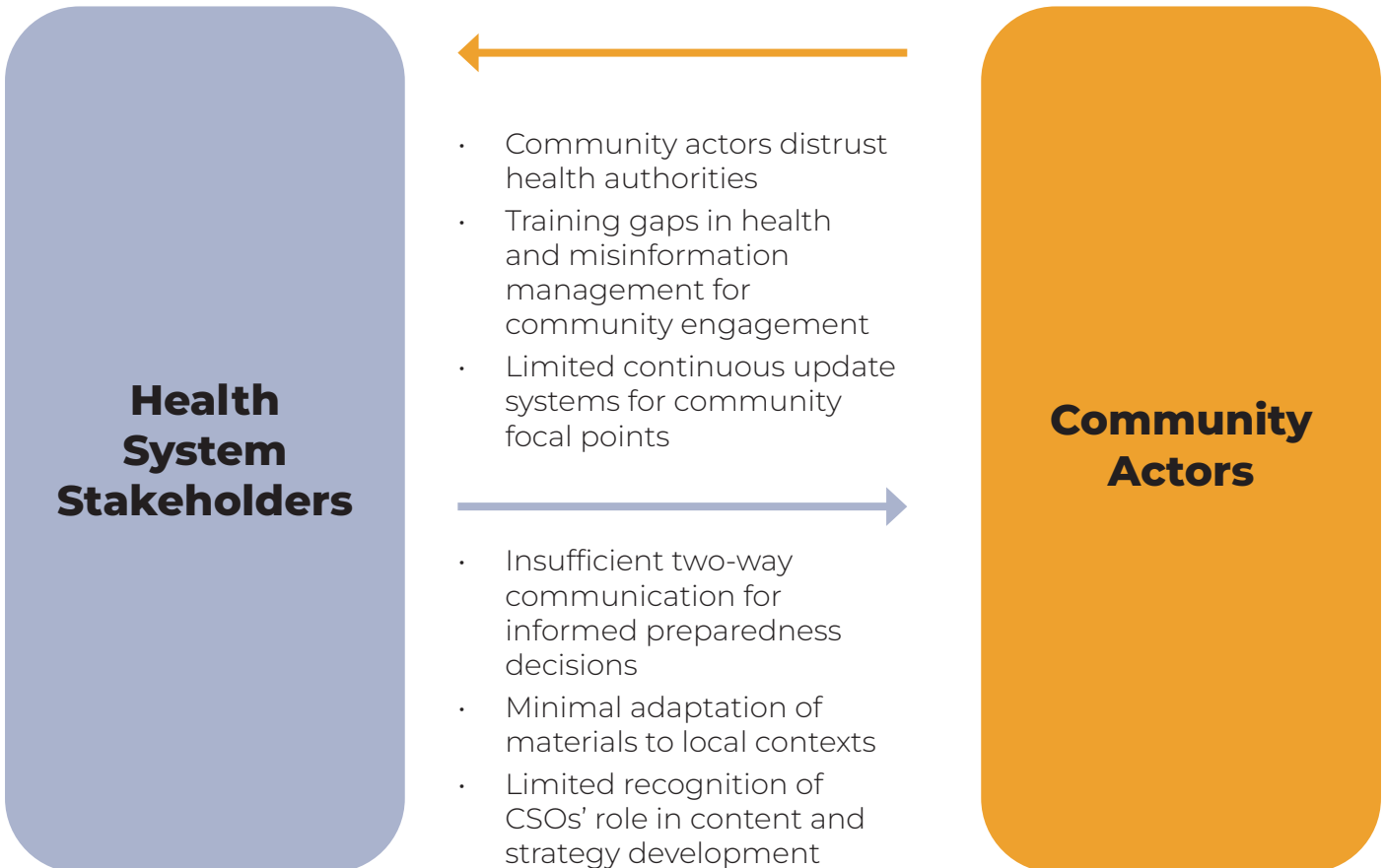
Highlight:

- Top-down approaches and missed opportunities for collaboration with local structures.



Key Impacts:

- Lack of two-way communication systems impact the relevance of the information provided to people prior to and during health emergencies.
- Mistrust in health authorities results in less engagement interest from community leaders to support disease prevention efforts and facilitating preparedness interventions.
- Community focal points provide fragmented and confusing guidance on disease prevention or public health.
- Inability of CSOs, community leaders and HCWs to respond to fast-evolving misinformation.
- Missed opportunities to find locally led solutions informed by community structures.



Limited two-way communication systems hinder national health actors in making community-informed decisions for emergency preparedness. This reduces community involvement in shaping information responses and affects the relevance of information during health emergencies. It also limits health authorities' ability to tailor communications to diverse groups with barriers to information access. As such, health system stakeholders often fail to understand diverse communities' specific needs and contexts, hindering effective communication on disease prevention that could contribute to broader health literacy and communities' preparedness.

CSOs noted that health authorities tend to overlook their potential, particularly faith-based organizations (FBOs), as advocacy platforms and gateways for community information sharing. They are rarely involved in designing and adapting communication materials, leading to a disconnect of health information with community realities. In this sense, it was noted that community focal points are not always well-equipped or trained to translate complex health information and science, or to identify and address misinformation, resulting in fragmented and confusing guidance for community members.



“I think it would be particularly good to involve them [community leaders and religious leaders], and then train them on how to convey information whether during normal periods or in case of health emergency. Otherwise, they can be good listeners to their communities, but nevertheless they do not have enough capacity [to respond accurately].”

– Health care worker representative,
Mali

All of this contributes to community leaders CSOs to continuously mistrust health authorities and their actions, making it difficult to collaborate further as part of preparedness efforts. This lack of trust and the exclusion of communities from planning undermines compliance and uptake of public health countermeasures e.g., around vaccines, which affect, in return, community leaders' desire for involvement in preparedness efforts and dissemination of information during prevention campaigns



BARRIERS:

HUMANITARIAN ORGANIZATION ↔ **COMMUNITY ACTORS**

Highlight:

- Lack of structures to involve and understand communities' dynamics as part of preparedness efforts.

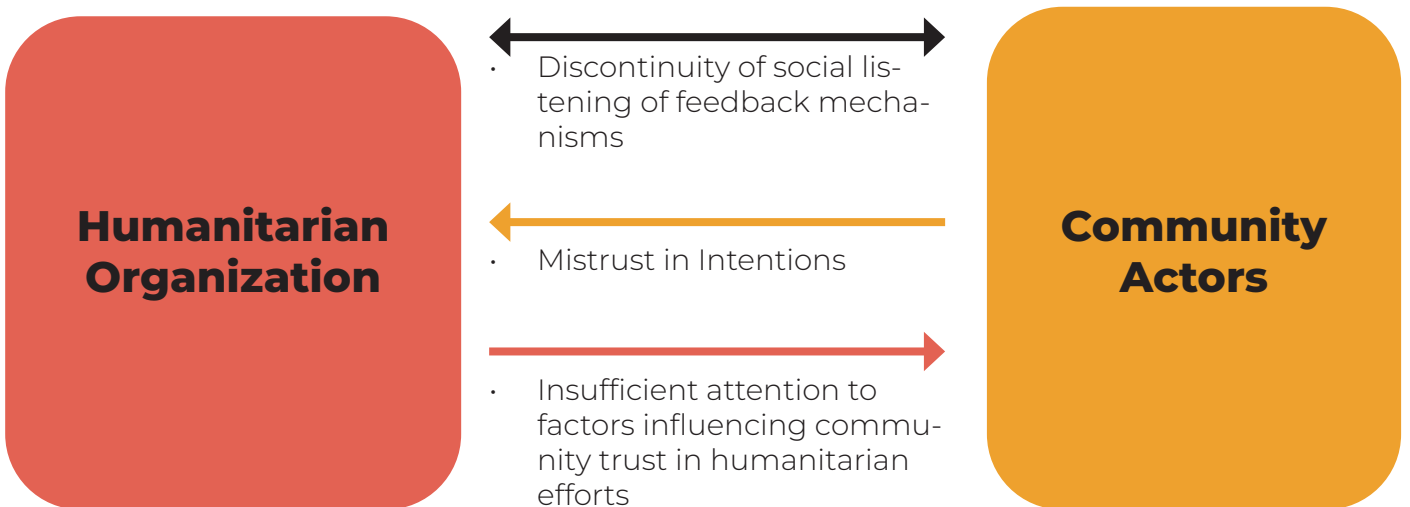
Key Impacts:

- Limited participation of community actors in coordination structures and decision-making, affecting the ability of humanitarian and health agencies to reinforce local health system and information ecosystem structures.
- Ineffectiveness, irrelevance of programming and exclusion of certain groups during health emergencies.
- Increasing mistrust and limited adherence of communities to public health guidance during an emergency.
- Difficulties to shape RCCE activities along communities' specific needs and realities.

Community structures are inherently diverse, offering the benefit of representing various voices. However, their heterogeneity can create logistical challenges when involving them in decision-making. **In some cases, humanitarian organizations have been unprepared, lacking an understanding of these structures, their power dynamics, and the best approach for engagement.** This lack of comprehension or mapping of community structures leads to inadequate participation of certain groups or voices in coordination and decision-making.

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Limited collaboration with local structures also affects humanitarian organizations' ability to both gather and disseminate information beyond emergencies. This lack of integration with local structures can hinder an organization's readiness to engage with and respond to communities during emergencies. Short-term programming, sporadic funding, and a culture of relying on international experts during outbreaks restrict the value of maintaining permanent structures for prevention or leveraging existing local expertise.

Furthermore, historical tensions stemming from numerous factors, such as colonial pasts, lack of transparency, or corruption, have fractured trust relations between hu-



humanitarian organizations and community structures. In many cases, these historical and ongoing tensions are not considered and integrated into the design of emergency response and programming. This poses a significant barrier to the relationship of those actors and can even result in a backfiring of some of the attempts by humanitarian organizations to respond to the emergency. As the literature suggests, trust is a dynamic process that takes time to establish, and once lost, it is complicated to regain. What both actors found is that pretending to involve communities once the crisis has hit without a previous honest exercise of reparations, listening, and trust-building can end up backfiring.

Often, community feedback mechanisms or social listening efforts focus solely on specific outbreak-related issues. As emergencies wane, these efforts may be discontinued or deprioritized, limiting humanitarian capacity to understand broader health information needs. This discontinuity also hinders disease prevention



“To integrate these clusters, there are often many conditions. You must be this, you must be that, you must have such budget that you can make available, you have to be an international organization, you [need to] have such human resources. So, all of these are brakes for organizations, for certain organizations to be able to participate in these clusters.”

- CSO, Mali

and identifying service gaps for broader health emergency preparedness. It impacts community trust and engagement, as reduced services and interest from agencies may be perceived. Humanitarians should invest in continuous social listening and community feedback mechanisms addressing emerging community concerns. Maintaining permanent two-way communication channels promotes informed preparedness and fosters trust with communities.



“There is a reluctance on the part of the community. [...] There are many [...] external stakeholders who come with a lot of money, without involving the local community. They have made some kind of money demonstration [...], which will increase hatred within the affected community, to the point of creating resistance in it.”

- Humanitarian Organization, DRC



BARRIERS:

MEDIA ORGANIZATION ↔ **HUMANITARIAN ORGANIZATIONS**

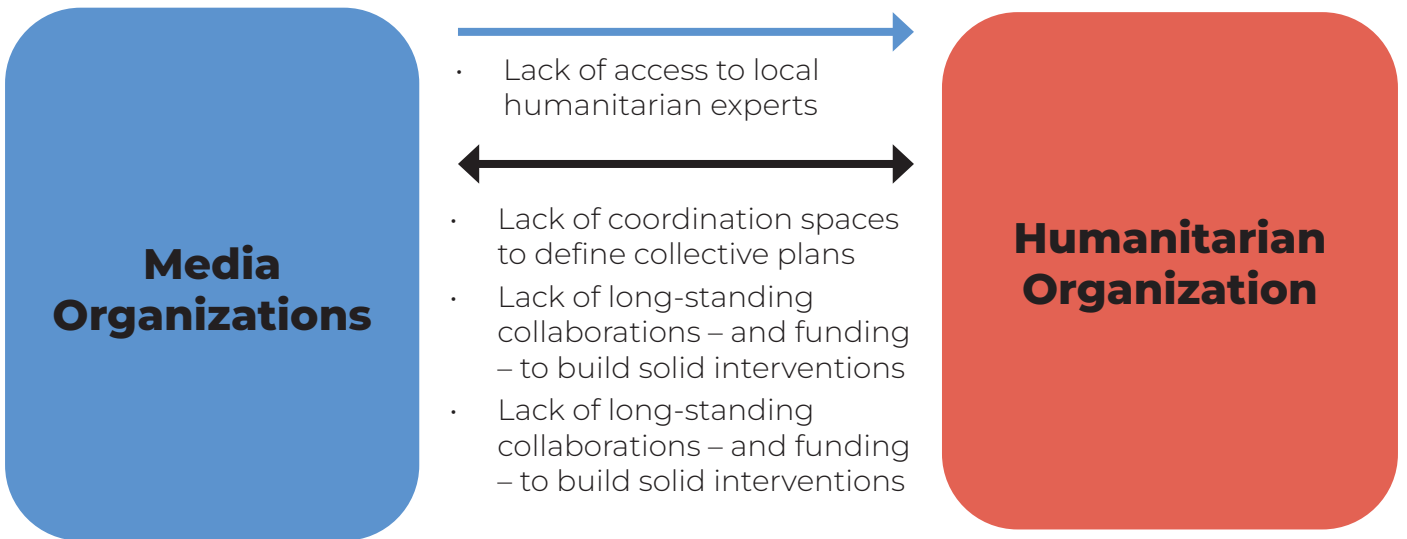
Highlight:

- Lack of coordination spaces and missed opportunities for collaboration around community information needs.



Key Impacts:

- Without access to experts, media is unable to contextualize information and struggles to understand decision making, resulting in fragmented, or incomplete coverage of health emergencies.
- Without common spaces for regular exchange of information and building trusting relations, media struggles to position themselves as relevant partners in the RCCE field.
- The lack of acknowledgement of local media as a trusted actor from the community results in a missed opportunity for the establishment of formal social listening systems that could provide data and better inform humanitarian organizations about concerns, rumors and questions from communities (as well as service gaps or other challenges that impact health)



Like the obstacles faced in their interaction with health system actors, media faces limited access to local humanitarian experts for contextualization of technical data in relevant languages. This hinders the ability of journalists to better understand humanitarian dynamics, the principles (and jargon) behind humanitarian action and decision-making processes that pertain to public health measures but also to

other relevant areas impacting communities such as protection needs, displacement patterns or armed conflict along the evolution of an emergency. The lack of common platforms to coordinate and discuss collective actions is another factor that contributes to the fragmented communication between these two actors ahead of an emergency.



“Now with other health structures, [...] especially with NGOs, it is difficult to get some information. Because they will say that we must make a letter, we must make a request. Sometimes when there are emergencies, we cannot make a letter or wait until the response from Bamako or until the response from Paris, the response of the United States, or the response of such structures from other countries... So, when an NGO comes to intervene in the health or emergency fields, they only have to [...] facilitate access to local journalists because emergencies do not wait. It is necessary to give real-time information to avoid disasters.”

- Local Media, Mali.

Short-term collaborations and budgets also hinder the development of trusting working relations between humanitarian organizations and the media. The delineation of common objectives and identification of spaces for complementary work are often interrupted by new priorities on both sides, with the consequent decline in attention, funding, and allocation of resources. There is thus a need for longer-term collaborations that support network building with local media and strengthen their role in health promotion, as well as keeping humanitarian and health actors accountable for decisions taken pre and during health emergencies.

In this sense, the potential role of local media in addressing community information needs and doing so in a way that resonates with their peers' reality is often overlooked by humanitarian RCCE programming. Hu-

manitarians relate to the media for visibility purposes (external communication) rather than understanding the unique vantage point of interactive radio stations or local influencers who can foster conversations with their audiences, identify concerns, and address health misinformation. This results in missed opportunities to establish formal social listening mechanisms, which not only inform about rumors and questions but also about gaps in health services or other challenges faced by communities in healthcare provision, especially in isolated areas where local media could be strong partners.



“From my experience, media usually comes in as an ad-hoc activity or an ad-hoc strategy [...] I do not agree. Media should be a critical component of risk communication and community engagement coordination mechanism. A representative from the media should always be represented in this coordination mechanism and partnership. Now we are seeing whenever there is an emergency, the media come. But the media should be part of the strategic development. They should be part of the coordination mechanism. they should be part of also standardization of message.”

-Humanitarian Organization, Health Programming, DRC.



BARRIERS:

COMMUNITY ACTORS ↔ MEDIA ORGANIZATIONS

Highlight:

- Outlet for frustrations, insecurity and mistrust on the media coverage

Key Impacts:

- Journalists are unable to cover events, get testimonies from people affected by crises or access certain areas due to fears to their safety, resulting in communities being underserved on news and quality information or underrepresented in national coverage.
- Media is unable to provide quality information that is not aligned with certain community actors' interests and beliefs, even when that information can be useful for audiences' decision-making during emergencies.
- Communities, especially remote ones where the media floods in when an emergency hits, are unaware of their rights and the possibilities for engagement with journalists, resulting in over resistance and increasing mistrust.



Media Organizations



- Limited dialogue between media and CSOs for trust-building and preparedness



- Distrust and frustration directed at the media during emergencies
- CSOs and community focal points lack guidance on the role of media



- Journalist and informant safety in health emergencies
- Balancing community power dynamics with journalism ethics in crises

Community Actors

Safety concerns arise for journalists and community informants engaged in health emergency coverage, exposing them to physical risks and heightened community tensions. Due to limited interaction with other responders, local media might become the sole communication link between communities and response information. Consequently, they serve as a primary outlet for community frustrations stemming from the crisis, unanswered questions, or high-risk rumors. This contributes to scenarios where it becomes dangerous for media to operate, such as covering events, talking to affected populations, denouncing irregularities, or sharing official information.

The diversity of community structures and power dynamics also poses challenges to media-community collaborations. Community leaders do not universally represent or earn trust from all members. Political inclinations create followers and opponents, impacting media partnerships and their ability to reach or be trusted by audiences or specific groups within. While enhancing accountability with certain segments of the population, it might alienate others. Navigating these complexities demands time and resources to map and track community changes during a preparedness phase. Health and humanitarian organizations must also be aware of these relations and understand the existing obstacles to reaching vulnerable groups with relevant and accurate information.

Finally, weak media literacy among community members leads to fears over data safety and privacy, hindering their willingness to engage with media and respond to questions. There is confusion about the role of journalists and the principles under which they are guided. The lack of media literacy prior to an emergency made it hard for this relationship to flow smoothly in certain cases, limiting the ability of media to report on events affecting communities.



“We’ve also seen a case in Bentiu where community members can even arrest a journalist. So that is the extreme where, you know, they just say, ‘What have you come to do? And we did not invite you,’ and so on and so on, and they end up arresting somebody.”

— Media representative, South Sudan.



“How does a common person there, a community there, understand the role of media? Because sometimes when we go down there to journalists, we go down there to the community to assess the situation. How are they grappling with this kind of situation? They do not even want to talk to the media. Why? Because they see that [it] is a different thing [...] do not talk to the media for fear, lack of understanding. Number two, also for fear that the information they give [...] is against the will of government and then they will be targeted.”

- Media Organization, South Sudan

CONCLUSION AND RECOMMENDATIONS

Information ecosystems play a key role in supporting an effective response to health emergencies. However, it does not always receive appropriate attention in emergency preparedness planning. While RCCE methodologies are recognized as a core element in preparedness and response frameworks, they are often approached in the form of static, one-way communication, failing to create a dialogue with community questions and concerns or capture the complex dynamics of information access, use, production, and consumption during health emergencies.

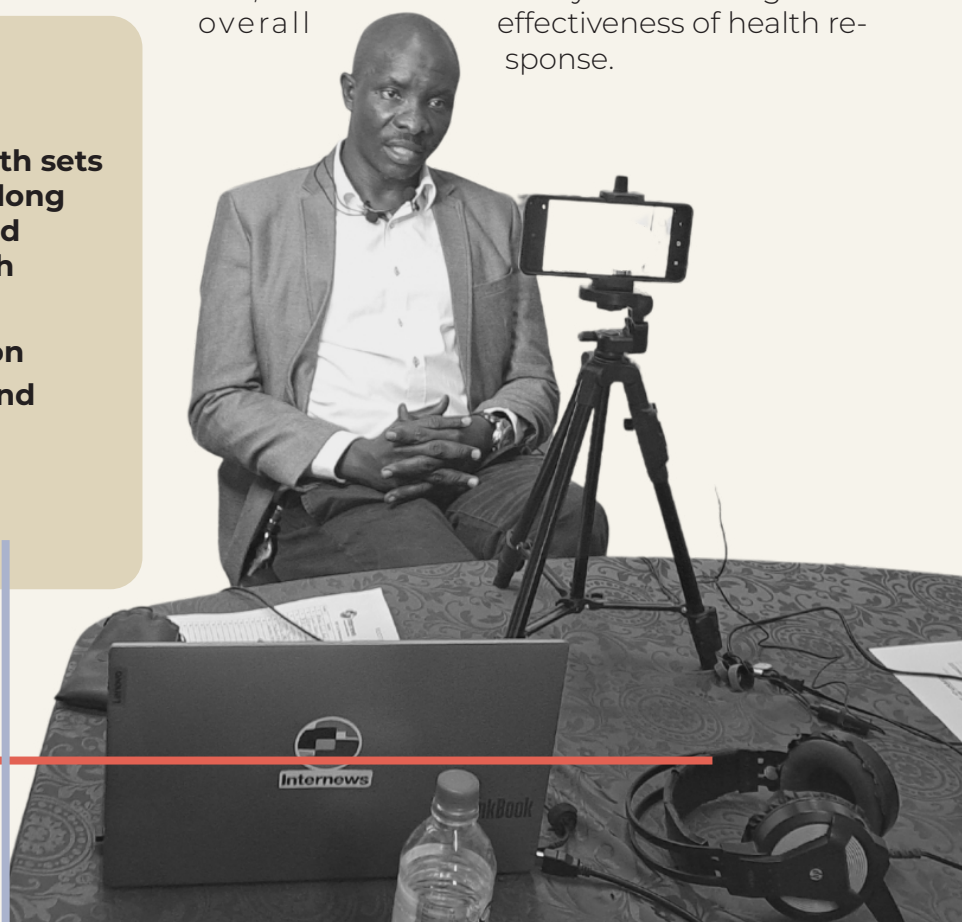
This study identifies several challenges that information ecosystem actors in humanitarian contexts face. First, we mapped out the diverse gaps and needs faced by information ecosystem actors to be better prepared for a health emergency. Secondly, we identified the obstacles hindering interaction and cooperation among these actors, ultimately impacting their ability to exchange information, coordinate, and respond collectively amidst a health crisis.

In this section, we present the common areas of concern that emerge from the analysis of both sets of findings. We present them along with recommendations grouped around the core pillars of health emergency preparedness⁹:

- **Governance and coordination**
- **Information management and planning**
- **Capacity building**
- **Finance**

We do so by looking at the main themes identified throughout the findings in an attempt to integrate the information ecosystem lenses into broader preparedness frameworks. Most recommendations were identified through conversations, drawing inspiration from existing information ecosystem strengthening efforts. Our key informants played a crucial role in shaping these recommendations, and some of them are built upon the learnings from the Rooted in Trust project.

We are aware that any attempt in the direction of integrating the information ecosystem lenses into broader conversations on health emergency prevention and preparedness requires greater discussions across the health community. But from here, we want to make a call to consider the resilience of an information ecosystem as a pivotal function of emergency response – and emergency prevention. We have seen how this can significantly contribute to mitigating and preventing the effects of misinformation, increasing engagement of communities with health recommendations, improving trust relations among response actors, and thereby enhancing the overall effectiveness of health response.



GOVERNANCE, COORDINATION, AND COLLABORATION

Main areas of concern

- **Limited leadership and lack of coordination structures fit for IE** preparedness, especially at the local level (coordination is emergency-bound)
- **Organizational and management culture prioritize top-down approaches** rather than community engagement throughout
- **Lack of coordination structures that recognize the role of community actors** and local media and incorporate them into decision-making.
- **Weak multi-stakeholder networks at the local level fuel mistrust** among actors (especially between health system stakeholders/hum orgs and local media/CSOs)
- **Limited commitment for long-standing collaborations** that support system and capacity building at the local level, impacting the ability of community actors to react when the emergency breaks

Recommendations

- **Information Ecosystem preparedness should be integrated into national strategies** for emergency preparedness, including financing – with a focus on local IE preparedness.
- **Strengthened coordination among IE actors should be considered, building on the multidimensional character of information landscapes** and the different actors involved. This coordination could complement RCCE objectives incorporating a preparedness perspective. This requires strong leadership and commitment (also from donors) to maintain continuous finance and support for collective preparedness structures.
- **Community engagement should be integrated into governance,** coordination and

partnership building, with CSOs being part of decision-making at all jurisdictional levels.

- **RCCE actors should ensure further engagement with private health service delivery** and faith-based health centers, so official public health information is accessible to all stakeholders delivering care. Relationships with other sectors should also be considered e.g. the education sector.
- **Internal coordination among health system stakeholders for RCCE and infodemic response needs to be strengthened at the local level,** ensuring that updates on public health decisions, technical guidance, and misinformation responses reaches managers of health centers and health care workers – especially those in isolated areas.



INFORMATION MANAGEMENT AND PLANNING

Main areas of concern

- **Inadequate mapping of IE actors and consequent planning leading to inefficiencies in RCCE/information responses** when emergencies break out i.e. duplication, underserved areas, local actors ignored, unclear responsibilities.
- **Limited mechanisms to consult communities and CSOs during planning phases** leading to lack of understanding of communities' information access, use and production dynamics Inadequate data systems on community information needs and misinformation serving all actors and information responders, including health care workers.
- **Inadequate internal systems for information sharing among health system stakeholders** leading to confusion on health measures taken and decision-making during emergencies.

Recommendations

Data-sharing and information systems

- **Collective data systems should be established to compile social listening data and inform actors on rumors, concerns or questions circulating within the community.** The system should consider how to gather and analyze the different data sources and types of data from different organizations and ensure timely sharing with key stakeholders so they can address information gaps and potential risks from their unique mandates.
- **Health Information Systems should incorporate relevant community feedback/social listening data** to inform decision-makers and other functions of incident management on the necessary adjustments of health programming, gaps in health service delivery or emerging needs e.g. surveillance and health service deliv-

ery functions; and simultaneously health workers and rapid response teams on the ground so that they can adapt plans and responses in real-time.

Planning

- **Preparedness plans should incorporate an information ecosystems lens** to ensure at the onset of an emergency relevant information reaches stakeholders involved in risk communication, community engagement, reporting, etc. These plans should be **informed by proper understanding of local information ecosystem dynamics.** Information Ecosystem Assessments (IEA) should be conducted to understand communities' practices in relation to the use of and access to information and have a clear map of relevant actors to tap into. Stakeholders should consider principles of inclusion and differentiated information response.
- **Mechanisms should be in place to conduct assessments of IE preparedness, with a special focus on local media and CSOs gaps.** This can guide activities of health and humanitarian organizations, aiming at supporting those needs. IE Preparedness Assessments should focus on:
 - **Gaps** faced by IE actors to be able to support local health emergency response adequately.
 - **Barriers** preventing IE actors from exchanging relevant, timely and accurate information for decision-making.
 - **Structures needed to be strengthened** to ensure adequate mobilization of IE actors in health emergency times.
- **Contingency plans should incorporate relevant actors with clear roles, responsibilities and interaction lines,** ensuring everyone understands what they need to do when an emergency hits.

CAPACITY: SYSTEMS, PROCESSES AND TRAINING

Main areas of concern

Communities informing RCCE, media work and health decision-making

- **Dismantlement of social listening mechanisms after emergencies or narrow scope of mechanisms (single-issue focus)** leading to limited alert system on gaps and needs in non-emergency times; scarce capacity of communities to lead social listening and escalate concerns to IE actors and health decision-making.
- **Limited processes and systems in place to ensure community actors lead communication production** and dissemination during an emergency to make it relevant and contextual to communities' needs.

Strengthening structures for misinformation response

- **Limited capacity of IE actors to identify and respond to misinformation** (especially among local media, CSOs and health workers)

Ensuring technical health expertise reaches IE stakeholders

- **Inadequate processes to ensure accurate health information reaches local media and CSOs** (when existing, this may be decontextualized, untimely, irrelevant), limited access to local health experts.
- **Lack of training of local media, CSOs and community leaders in health information**

Recommendations

Communities informing RCCE, media work and health decision-making

- **Technical experts and managers should be trained in the value of community engagement.** Health workers and Rapid

Response Teams should also be trained so they can adapt to community dialogues during their day-to-day work.

- **Community actors should be supported to implement locally led social listening systems** so they can inform responders/health system structures about areas for intervention to build preparedness. It can also ensure easier entry points to the community if an emergency breaks out. Capacities and pathways should be assessed and leveraged around different areas:
 - **Training of staff** on principles of social listening, methods of data collection and data analysis. If actors are present in a humanitarian context, all these initiatives must be approached from a protection and AAP angle.
 - **Establishing systems to ensure timely referral of concerns.**
 - **Defining protocols for information response** and closing the loop on what communities have shared.
- **Partnerships with community actors should be prioritized to ensure information is adapted to local languages,** preferred formats and context. Media should be open to adapt content according to audiences' needs, promoting two-way participatory formats.

Strengthening structures for misinformation response

- **Local RCCE focal points should set up a mechanism to update health workers regularly on the main rumor trends and information needs among communities.** This system would help these frontline workers to be better prepared to respond to the questions of patients and communities when needed.
- **Health system stakeholders should be trained in misinformation management** and the importance of addressing concerns

at an early stage. These trainings should be adapted to the distinct roles i.e. RCCE/Incident Management Coordinators should receive training to design effective rumor tracking and response programming while health service managers or health care workers should receive training on how to fact check and use reliable sources.

- **Media should invest in systems that monitor misinformation circulating among audiences** and establish internal processes for fact checking with systematic access to local health experts and reliable sources. Health partners should support efforts as part of preparedness funding, ensuring media queries are clarified in a timely manner.

Ensuring technical health expertise reaches IE stakeholders

- **Health system stakeholders and humanitarian organizations should revise bureaucratic processes** of external communication departments to increase media access to health experts. This is needed to reduce clearing protocols, so more technical focal points -especially those at the local level, who know the details of what’s going on- can update media on a regular basis.
- **IE actors should be trained in complex technical areas of public health**, including health system functioning, communicable diseases management and prevention or decision-making in emergency interventions. This way IE actors will be better prepared to communicate and interpret authorities’ decisions during emergencies



RESOURCES FOR INFORMATION ECOSYSTEM PREPAREDNESS

Main areas of concern

- **Inadequate resources for IE and/or RCCE preparedness**
- **Lack of resources for local actors to sustain health information provision** and build community's preparedness and health literacy ahead of emergencies.
- **Inadequate resources to ensure coordination and information-exchange** for prevention and preparedness purposes.

Recommendations

- **Long-term funding must be prioritized**, either through domestic budgets or foreign aid, to strengthen and sustain national RCCE capacities that enhance preparedness plans and integrate Information Ecosystem strengthening as a fundamental element. Relying on one-off information interventions or health campaigns won't foster resilient information landscapes.
- **More resources should be allocated for sector wide RCCE preparedness coordination** and surge support to local and national structures, facilitating stronger connections among local IE actors.
- **Funds should be transferred to community actors to spearhead social listening, rumor tracking, and response continuously.** In resource-scarce settings, encouraging volunteer-based systems is an effective way to maintain ongoing discussions about health concerns, build trust, and guide interventions.
- **Funds for content creation and communication should be prioritized for actors operating at the local level.**
- **Longer-term funding for local media and CSOs must be part of preparedness budgets.** For instance, allocating more resources for multimedia equipment or working

on public-private initiatives to expand telecommunication systems into isolated regions.



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