Evidence-based guidance on COVID communications: Seven core principles

These principles can be applied to a range of communication tasks when engaging the public in public health behavioural mitigations in relation to the pandemic, including physical distancing, mask wearing, handwashing, and vaccination. They are for use by ministers, local authorities, public health officials, and anyone else communicating with the public.

1. Invoke shared identities to promote cooperation[1]

Communicators should be ingroup members. When people see each other as 'us' or 'we', they are more likely to trust each other, to influence each other, to assume shared goals (and try to align goals), and support each other. This means they will listen, believe and internalize messages coming from 'us' more than messages coming from 'them'. So make shared identity salient.

2. Invoke 'our' group's values and norms[2]

What does it mean to be a group member? Emphasise the values and norms we share. We wear masks, get vaccinated etc. because our values include caring for each other and looking after the most vulnerable. This is how we express who we are as a community.

3. Convey what 'we' _do_ do, not just what 'we' _should_ do[2]

Messaging that conveys what we should do but includes images of people doing the opposite could backfire. The images and stories of public rule-breaking in the tabloid press criticized the rule-breakers but also conveyed that this behaviour was common (which it wasn't). This can lead people to conclude 'we might as well do this, as no one else is following the rules'.

4. Inclusion[3]

Stigmatizing those not adhering or those disagreeing weakens the sense of togetherness and solidarity that is needed for overall public adherence; so avoid blaming groups of people. Strengthen inclusiveness and the extent to which the recommendations are ingroup (rather than outgroup) by including the public in the development of the recommendations.

5. Self-relevance of information[1]

The public need risk information and information on efficacy of countermeasures, as these are key predictors of adherence. BUT identity is the prism through which information is interpreted. Risk and efficacy information need to be identity-relevant. For example, in the early days of the pandemic, healthy young people could discount messaging about 'protecting yourself'. Messaging about the risk to their family members and their community was more self-relevant.

6. Don't equate measures with restrictions & changes in measures with 'freedom'[4]

Measures need to be understood and framed in terms of collective care and concern, rather than personal restriction. Presenting changes in measures as 'freedom day' and similar can wrongly communicate absence of risk.

7. Support works better than coercion and threats[1, 5, 6]

Research suggests that support works better than coercion in engaging the public in mitigation behaviours. Belief that 'we're all in it together' was more important than threats of coercion as a predictor of adherence. Coercion can backfire. Modelling found that increased fines would put people off coming forward for testing. Generally, threats and punishment damage the relationship between authority and public.

More about us: Facilitating the public response to COVID-19 by harnessing group processes

1. Drury et al. (2021). *BJPsych Open, 7*(1), E11. doi:10.1192/bjo.2020.139
2. Neville et al. (2021). *Social and Personality Psychology Compass*. doi:10.1111/spc3.12596
3. Drury et al. (2020). The Psychologist
4. Reicher (2021). iNews.
5. Independent SAGE (2021). Briefing note on use of punishments in the Covid response
6. Epton et al. (2021). https://doi.org/10.31234/osf.io/rn4vb

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