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# JEDDAH TOOL

## FOR MASS GATHERINGS HEALTH RISK ASESSMENT

# USER GUIDE

GLOBAL CENTER FOR MASS GATHERINGS MEDICINE
(GCMGM)

V.2

APRIL 1, 2020

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# BACKGROUND

Protecting human health is a key goal of the interventions that are implemented to manage public health risks and strengthen health security at mass gatherings (MG). Risks assessment at MGs involves detecting and ranking health risks, assessing the mitigating capacity of the health system and recommending appropriate measures for risk mitigation, prevention and control.

Building on the Sendai Framework for Disaster Risk Reduction, the Jeddah tool was initially conceptualized as a holistic health emergency risk assessment framework in partnership with the World Health Organization Eastern Mediterranean Regional Office (WHO/EMRO).

In 2016, the tool was further developed to help identify, prioritize and analyze MG health risks based on a widely accepted functional correlation between hazards, vulnerabilities and capacities:

Risk ∞ Hazard magnitude X Vulnerabilities)/Capacities.

As an outcome of the first Hajj strategic health risk assessment, the Global Center for Mass Gatherings Medicine (GCMGM) and WHO jointly organized an international technical consultation on health risk assessment tools for MGs in January 2017. The technical consultation adapted the tool as the Jeddah tool for MGs risk assessment and recommended the standardization of the hazard prioritization and weighting matrixes.

This document provides a step-by-step guide for public health personnel to conduct an all-hazard strategic health risk assessment at MGs using the Jeddah tool.

## OBJECTIVES OF JEDDAH TOOL

- To evaluates the likelihood of occurrence and impact of hazards
- To provide understanding of the root causes of health emergencies
- To provide baseline data that can be used for research and preparedness planning
- To enhance the inter-sectoral coordination and collaboration for risk mitigation

## DEFINITION OF TERMS

**Health risk:** The probability of health consequences from the interaction of hazards, vulnerabilities, and capacities

**Hazard:** A dangerous phenomenon, substance, human activity or condition that may cause loss of life, injury or other health impacts, property damage, loss of livelihoods and services, socialand economic disruption, or environmental damage.

**Vulnerability:** The characteristics and circumstances of a community, system, or asset that make its us ceptible to the damaging effects of ahazard.

**Capacity:** The combination of all the strengths, attributes, and resources available within a community, society, or organization that can be used to achieve agreed goals.

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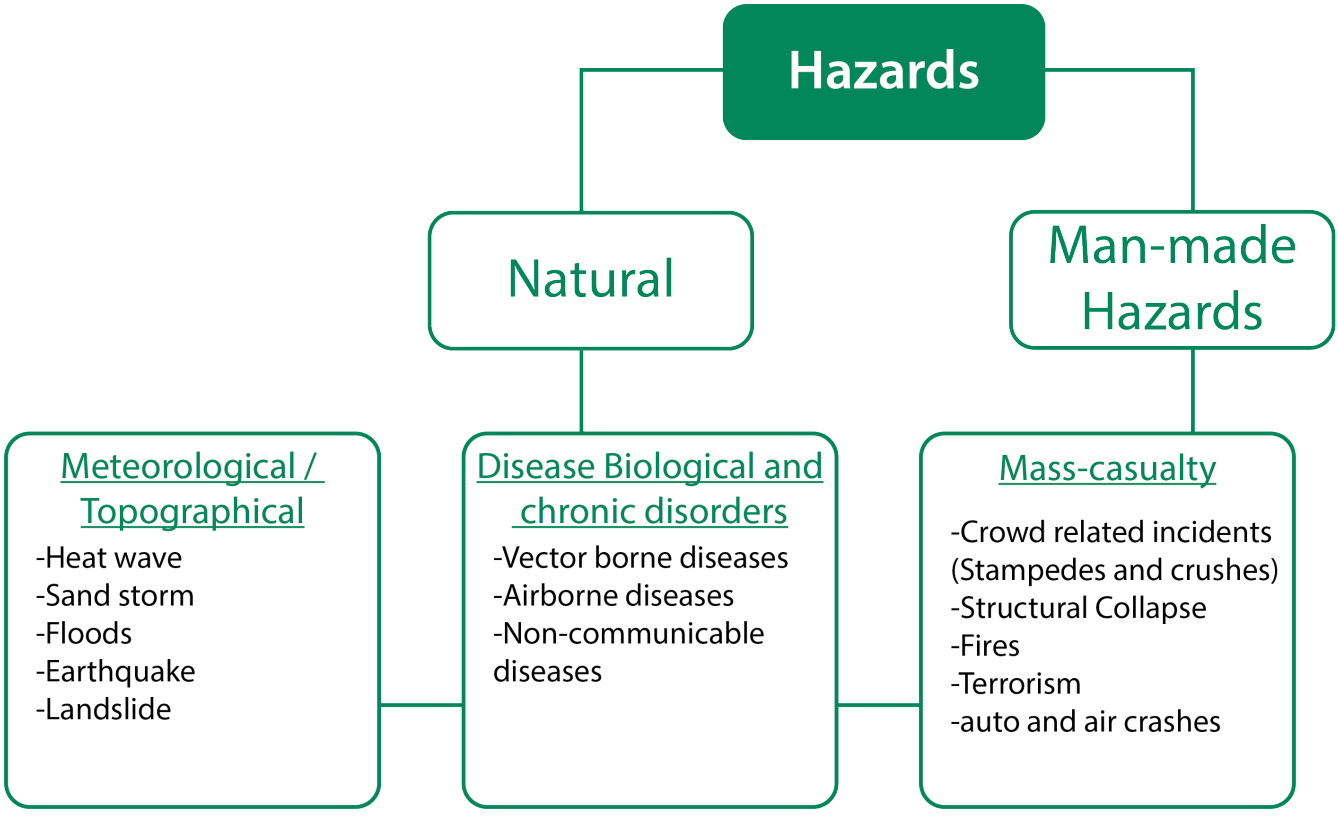
## A. Identify all the hazards that might constitute a threat to the mass gatherings using the matrix in Table 1 and Figure 2

**Table 1: Hazard Identification Matrix based on epidemiological characteristics**

| Type | Definition of Hazard | Source of data |
|---|---|---|
| 1 | Hazard was reported in the past during the MG | Literature, Government, reports, Historical archives |
| 2 | Current local, national or international public health event(s) | Surveillance reports News items Government reports |
| 3 | Hazard may occur based on experience from similar events/context | Literature Government reports |
| 4 | Hazard may occur based on changing hazard/vector characteristics | Published/Unpublished Literature Government reports |
| 5 | Hazard may occur based on changing host characteristics | Published/Unpublished literature Government reports |

**Figure 1: Hazard identification matrix based on hazard type**



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## B. Prioritize the identified hazards to focus on the most important hazards that could pose a threat to the MG using the frequency matrix in Table 2&3

**Table 2: prioritization matrix**

| Hazard | Frequency | Magnitude | Exposure | Hazard score |
|---|---|---|---|---|
| | 1 (min.) to 5 (max.) | 1 (min.) to 5 (max.) | 1 (min.) to 3 (max.) | F × M × E(max 75) |

**Table 3: Criteria for mapping frequency, magnitude and exposure**

| Frequency mapping | Category |
|---|---|
| Hazard is reported yearly/ each time MG is hosted/endemic disease in area/city hosting MG | 5 |
| Hazard was reported at least once during the MG in last 5 years or is currently reported as a national event/outbreak e.g. MERS in Saudi Arabia | 4 |
| Hazard was reported at least once during the MG in last 6-10 years/endemic diseases in country of MG attendee/ infectious diseases currently reported internationally e.g. Ebola | 3 |
| Hazard was reported at least once during the MG in >10 years | 2 |
| No previous event/hazard reported | 1 |
| **Magnitude mapping** | **Category** |
| Mortality or critical injuries/illnesses with long-term or permanent incapacitation >1/10,000 population | 5 |
| Mortality or critical injuries/illnesses with long-term or permanent incapacitation >1/100,000 population<br>Or serious injuries/illnesses >1/10,000 population | 4 |
| Mortality or critical injuries/illnesses with long-term or permanent incapacitation >1/1,000,000 population<br>Or serious injuries/illnesses >1/100,000 population | 3 |
| Mortality or critical injuries/illnesses with long-term or permanent incapacitation >1/10,000,000 population<br>Or serious injuries/illnesses >1/1,000,000 population | 2 |
| Mortality or critical injuries/illnesses with long-term or permanent incapacitation <1/10,000,000 population<br>Or serious injuries/illnesses <1/1,000,000 population | 1 |

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**Table 3: Criteria for mapping frequency, magnitude and exposure**

| Exposure mapping | Category |
|---|---|
| General population | 3 |
| Vulnerable groups in population. eg Healthcare workers, elderly | 2 |
| Only MG attendees | 1 |

## C. Select the hazards with the highest prioritization scores (Table 4), benchmarking based on the availability of resources for the RA, including time, personnel and data

**Table 4: Example of some prioritized Hazards during Hajj in Saudi Arabia**

| Hazard | Frequency | Magnitude | Exposure | Hazard score |
|---|---|---|---|---|
| | 1 (min.) to 5 (max.) | 1 (min.) to 5 (max.) | 1 (min.) to 3 (max.) | F × M × E(max 75) |
| Stampede | 4 | 5 | 2 | 40 |
| MERS-COV | 4 | 3 | 2 | 24 |
| Seasonal Influenza | 5 | 2 | 3 | 30 |
| Heat Illness | 4 | 3 | 3 | 36 |
| Food Poisoning | 5 | 3 | 2 | 30 |

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## D. For each hazard, conduct vulnerability assessment using the indicator matrix in Table 5, 6or 7

**Table 5: Vulnerability risk characterization for infectious pathogens**

| Risk domain / Indicator area | 1 | 2 | 3 | 4 | 5 | score |
|---|---|---|---|---|---|---|
| Proportion of cases with severe illness | <1% | 1-3% | 3-5% | 6-10% | >10% | |
| Case fatality rate(CFR) | <0.5% | 0.6-1%s | 1-2% | 3-5% | >5% | |
| Endemicity | Not yet reported in countries of attendees or MG host country | Only imported cases in countries of attendees | locally transmitted in countries of attendees | Only imported cases reported in MG host country | Endemic/ locally transmitted reported in MG area/ country | |
| Route of transmission | STDs | Blood-borne | Feco-oral/ vector borne | Contact | Airborne/ droplet | |
| Vaccine effectiveness | >90% | 80-90% | 60-79% | <60% | No licensed vaccine | |
| Vulnerable population | None | Vulnerable group among attendees | All MG attendee | Vulnerable groups in population | All | |
| Effective cure | >90% | 70-90% | 40-69% | <40% | None | |

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**Table 6: Vulnerability risk characterization for non-infectious hazards**

| Risk domain / Indicator area | 1 | 2 | 3 | 4 | 5 | score |
|---|---|---|---|---|---|---|
| Morbidity rate | <1 /1000000 population | >1 /1000000 population | >1 /100000 population | >1 /10000 population | >1 /1000 population | |
| Percentage with permanent disability | <1 /1000000 population | >1 /1000000 population | >1 /100000 population | >1 /10000 population | >1 /1000 population | |
| Mortality rate | <1 /1000000 population | >1 /1000000 population | >1 /100000 population | >1 /10000 population | >1 /1000 population | |
| Frequency of reporting | Nil previous report during the MG | At-least 1 incident/ case reported in >10 years | At-least 1 incident/ case reported in last 6-10 years | At-least 1 incident/ case reported in last 1-5 years | Reported during each MG/ annually | |
| Vulnerable population | None | Vulnerable group among attendees | All MG attendee | Vulnerable groups in population | All | |
| Prevalence of risk factors in the population | <1% | 1-5% | 6-10% | 10-20% | >20% | |
| Type of risk factors | None | Modifiable during MG (short term) | Modifiable before MG (long term) | Both modifiable and non-modifiable | Non-modifiable | |

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## E. Assign weights to each vulnerability indicator (Table 7) and obtain the weighted score (Table 8)

**Table 7: criteria for assigning weight to vulnerability indicator**

| Indicator type | Weight |
|---|---|
| Estimates effective counter measures, permanent complications and the fatal consequences of hazards eg CFR, mortality rate | 5 |
| Estimates routes of transmission, endemicity, morbidity rate , therapeutic and other preventive measures for hazards | 4 |
| Estimates the risk factors/psycho-social and economic outcome | 3 |
| Related to health status of general population | 2 |
| Non-health related | 1 |

**Table 8: Weighted score calculation matrix for each vulnerability indicator**

| Risk domain / Indicator area | 1 | 2 | 3 | 4 | 5 | Score (S) | Weight (W) | Weighted Score (WS) |
|---|---|---|---|---|---|---|---|---|
| Proportion of cases with severe illness | <1% | 1-3% | 3-5% | 6-10% | >10% | 3 | 4 | 12 |
| Case fatality rate (CFR) | <0.5% | 0.6-1% | 1-2% | 3-5% | >5% | 4 | 5 | 20 |

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## F. For each hazard, conduct capacity assessment using the indicator matrix in Table 9, 10 or 11

### Table 9: Capacity indicator matrix for infectious hazards

| Scoring criteria / Indicators | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| **Coordination** Updated plan for coordination and incident management exist | Updated multi-sectoial plan for coordination and incident management exist | Updated ntra-agency plan for coordination and incident management exist | Updated ntra-department/ unit plan for coordination and incident management exist | planfor coordination and incident management is not updated/ not fully established | planfor coordination and incident management is unavailable |
| Designated Incident managers have requisite skills | Designated incident managers have appropriate licenses/ qualifications, and have participated in at least 2 refresher courses (including drills and simulation exercises) in past 12 months | Designated incident managers have appropriate licenses/ qualifications, and have participated in at least 1 refresher course (including drills and simulation exercises) in past 12 months | Designated incident managers have appropriate licenses/ qualifications, and have participated in at least 1 refresher course without drills and simulations exercises in past 12 months | Designated incident managers DO NOT have legal authority/ appropriate licenses/ qualifications, AND/OR have NOT participated in any refresher course in past 12 months | Incident managers are not designated |
| **Infection Prevention and Control (IPC)** Updated IPC guideline is implemented in designated health facilities (HF) | Updated IPC guideline is are implemented in > 80% HF | Updated IPC guideline is are implemented in 60-80% HFs | Updated IPC guideline isimplemented in 50-59% HFs | Updated IPC guideline is implemented in <50 HFs/ not updated or partially implemented in >50% of HF | IPC guideline isnot implemented/ are not monitored in HF |
| HF staff have valid basic infection prevention and control skill license (BICSL) | >90% of HF staff have valid BICSL license | 70-90% of HF staff have been trained (BICSL licensed) | 50-69% of HF staff have been trained (BICSL licensed) | <50% of HF staff have been trained (BICSL licensed) | IPC training for HF staff is unavailable |
| Compliance with respiratory triage protocol | >80% of HF are compliant with respiratory triage protocol | 60-80% of HF are compliant with respiratory triage protocol | 50-59% of HF are compliant with respiratory triage protocol | <50% of HF are compliant with respiratory triage protocol | Compliance with respiratory triage protocol is not monitored |

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| Scoring criteria / Indicators | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| **Rapid Response Team (RRT)** RRT is established for public health threats | Appropriate RRTs are designated and assigned (having clear roles and mandate) for the MG | Appropriate RRTs are designated and assigned (having clear roles and mandate) at regional public health level | Appropriate RRTs are designated and assigned (having clear roles and mandate) at central/ national public health level | RRTs are designated but lacks clear roles and mandates | RRTs are not yet designated |
| RRT receive sufficient training within last 12 months | Completed at-least 2 accredited trainings in last 12 months, including drill and simulation exercise | Completed at-least 1 accredited training in last 12 months, that includes drill and simulation exercise | Completed at-least 1 accredited training in last 12 months, without drills and simulations | Completed at-least 1 unaccredited training in last 12 months, | Yet to complete any formal training in last 12 months |
| **Disease Surveillance System** An enhanced surveillance system with real time (near-real time) reporting | Existing case-based + syndromic + event-based surveillance with real-time reporting) | Existing case-based + syndromic surveillance system only with real-time reporting) | Existing case-based surveillance system only with electronic reporting | Existing case-based reporting system, with manual reporting | No identified disease surveillance system |
| Case definitions are disseminated to HFs | Appropriate case definitions have been shared with >80% of HF | Appropriate case definitions have been shared with 60-80% of HF | Appropriate case definitions have been shared with 50-59% of HF | Appropriate case definitions have been shared with <50% of HF | Case definitions are not developed |
| **Laboratory Capacity** Access to point of care diagnostic/screening test | Point of care diagnostic/ screening testing available in > 80% of HF | Point of care diagnostic/ screening testing available in 60-80% of HF | Point of care diagnostic testing available in <60% of HF | Point of care diagnostic/ screening test licensed but unavailable | Point of care diagnostic/ screening test not licensed |
| Access to confirmatory diagnostic test | Confirmatory diagnostic test is accessible locally (same city/town) | Confirmatory diagnostic test is accessible at state or regional level | Confirmatory diagnostic test is accessible nationally | Confirmatory diagnostic test is accessible internationally | Confirmatory diagnostic test is unavailable/ inaccessible |
| Laboratory turn-around-time (TOT) | Time to confirmation of diagnosis < 6 hours | Time to confirmation of diagnosis 6-12 hours | Time to confirmation of diagnosis 12-24 hours | Time to confirmation of diagnosis 24-48 hours | Time to confirmation of diagnosis > 48 hours |

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| Scoring criteria / Indicators | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| **Risk Communication** Availability of MG-specific risk communication strategy/plan | MG-specific risk communication strategy/plan is developed or reviewed with the last 2 years | MG-specific risk communication strategy/plan is developed or reviewed with the last 3-5 years | National risk communication strategy/plan is developed or reviewed with the last 5 years | Risk communication strategy/plan is NOT reviewed for > 5 years | Risk communication plan is not developed |
| Health promotion messages are disseminated to MG attendees | Health promotion messages are translated and disseminated to > 80% of MG population | Health promotion messages are translated and disseminated to 60- 80% of MG population | Health promotion messages are translated and disseminated to 50-59%% of MG population | Health promotion messages are translated and disseminated to <50% of MG population | Health promotion messages are not developed |
| **Case Management** An updated national-case management protocol is disseminated to HF | A national-case management protocol is disseminated to >80% of HF | A national-case management protocol is disseminated to 60-80% of HF | A national-case management protocol is disseminated to 50-59% of HF | A national-case management protocol is disseminated to <50% of HF | A national-case management protocol is not developed |
| Adequate supply of materials, including drugs and personal protective equipment (PPE) | Adequate supply of materials, including drugs and PPE in >80% of HF | Adequate supply of materials, including drugs and PPE in 60-80% of HF | Adequate supply of materials, including drugs and PPE in 50-59% of HF | Adequate supply of materials, including drugs and PPE in <50% of HF | The supply chain is not monitored |

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**Table 10: capacity indicator matrix for external causes of morbidity and mortality**

| Scoring criteria / Indicators | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| **Coordination/ incident management** Updated plans and procedures for coordination and incident management exist | Updated multi-sectorial plans and procedures for coordination and incident management exist | Updated intra-agency plans and procedures for coordination and incident management exist | Updated intra-department/ unit plans and procedures for coordination and incident management exist | Plans and procedures for coordination and incident management is not updated/not fully established | Plans and procedures for coordination and incident management is unavailable |
| Designated Incident managers have requisite skills | Designated incident managers have appropriate licenses/ qualifications, and have participated in at least 2 refresher courses (including drills and simulation exercises) in past 12 months | Designated incident managers have appropriate icenses/ qualifications, and have participated in at least 1 refresher course (including drills and simulation exercises) in past 12 months | Designated incident managers have appropriate licenses/ qualifications, and have participated in at least 1 refresher course without drills and simulations exercises in past 12 months | Designated incident managers DO NOT have legal authority/ appropriate licenses/ qualifications, AND/OR have NOT participated in any refresher course in past 12 months | Incident managers are not designated |
| **Communication** Formal inter-agency communication plans | Formal inter-agency secured communication plans exist | Formal intra-organizational secured communication plans exist | Formal intra-department (unit) secured communication plan exist | Informal communication channels only | Communication plans and channels are unavailable |
| **In-patient bed density** Number of in-patient beds/10,000 population | ≥10 beds | 7-9 beds | 4-6 beds | 2-3 beds | <2 beds |
| **Core healthcare workers' density** Number of core healthcare workers/10,000 population | >34 HCWS | 30-34 HCWs | 25-29 HCWs | 20-24 HCWs | <20 HCWs |

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| Scoring criteria / Indicators | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| **Pre-Hospital triage management** Updated IPC SOPs and Guidelines for EMS staff | Updated pre-hospital triage management protocol exist as part of general emergency plan | Updated pre-hospital triage management protocol exist as part of MoH (organizational) emergency plan | Updated Pre-hospital triage management protocol exist but not linked to a broader emergency plan | Pre-hospital triage management protocol is not updated | Pre-Hospital triage management protocol does not exist |
| IPC training for EMS staff | >80% of emergency staff had accredited refresher courses (including drills) in pre-hospital triage management within last 1 year | 50-80% of emergency staff had accredited refresher courses (including drills) in pre-hospital triage management within last 1 year | < 50% of emergency staff had accredited refresher courses (including drills) in pre-hospital triage management within last 1 year | The pre-hospital triage management refresher courses for emergency staff were NOT accredited/did not include drills in last 1 year | The pre-hospital triage management refresher courses were not available in last 1 year |
| **Risk Communication** Availability of MG-specific risk communication strategy/plan | MG-specific risk communication strategy/plan is developed or reviewed with the last 2 years | MG-specific risk communication strategy/plan is developed or reviewed with the last 3-5 years | National risk communication strategy/plan is developed or reviewed with the last 5 years | Risk communication strategy/plan is NOT reviewed for > 5 years | Risk communication plan is not developed |
| Health promotion messages are disseminated to MG attendees | Health promotion messages are translated and disseminated to > 80% of MG population | Health promotion messages are translated and disseminated to 60- 80% of MG population | Health promotion messages are translated and disseminated to 50-59%% of MG population | Health promotion messages are translated and disseminated to <50% of MG population | Health promotion messages are not developed |
| **Emergency Response time:** Average emergency response time for EMS providers | <10minutes | 10-20minutes | 20-30minutes | 30-60 minutes | >60 minutes |
| Average transit time for EMS ambulances to hospitals | <10minutes | 10-20minutes | 20-30minutes | 30-60 minutes | >60 minutes |

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**Table 11: capacity indicator matrix for non-communicable diseases (NCDs)**

| Scoring criteria / Indicators | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| **Screening for NCDs/chronic diseases** Updated inter-country NCD/chronic diseases screening guideline for MG exist | Updated inter-country NCD/chronic diseases screening guideline for MG exist | Updated national NCD/ chronic diseases screening guideline for MG exist | Updated organizational NCD/chronic diseases screening guideline for MG exist | NCD/chronic diseases screening guideline for MG is not updated | NCD/chronic diseases screening guidelineis unavailable |
| **Access to health services** proportion of MG population with access to free health services during MG | >80% of MG population have access to free health services during MG | 60-80% of MG population have access to free health services during mg | 50-59% of MG population have access to free health services during MG | <50% of MG population have access to free health services during MG | There are no free health services at MG |
| **Core healthcare workers' density** Number of core healthcare workers/10,000 population | >34 HCWS | 30-34 HCWs | 25-29 HCWs | 20-24 HCWs | <20 HCWs |
| **In-patient bed density** Number of in-patient beds/10,000 population | >7 beds | 5.1-7beds | 3.1-5 beds | 3.1-5 beds | <1.5 beds |
| **Case management** Accessibility of updated case-management guidelines for NCDs | An updated national-case management protocol is disseminated to >80% of HF | An updated national-case management protocol is disseminated to 60-80% of HF | An updated national-case management protocol is disseminated to 50-59% of HF | An updated national-case management protocol is disseminated to <50% of HF | A national-case management protocol is not developed |
| Proportion of staff who received training in case management of NCDs within last 1 year | >80% of core health workers (doctors and nurses) had accredited refresher courses in case management within last 1 year | 60-80% of core health workers (doctors and nurses) had accredited refresher courses in case management within last 1 year | 50-59% of core health workers (doctors and nurses) had accredited refresher courses in case management within last 1 year | <50% of core health workers (doctors and nurses) had accredited refresher courses in case management within last 1 year | The case-management refresher courses were not available in last 1 year |

| Scoring criteria / Indicators | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| **Referral system** (Formal inter-country referral system for NCDs) | Formal inter-country referral system for NCDs exist | Formal inter-organizational referral system for NCDs exist | Formal intra-organizational referral system for NCDs exist | Informal referral system for NCDs exist | No referral system for NCDs exist |
| **Health Promotion** Relevant health promotion messages are disseminated to MG attendees | Health promotion messages are translated and disseminated to > 80% of MG population | Health promotion messages are translated and disseminated to 60- 80% of MG population | Health promotion messages are translated and disseminated to 50-59%% of MG population | Health promotion messages are translated and disseminated to <50% of MG population | Health promotion messages are not developed |

## H. Calculate average score for each indicator area, then assign weights to each capacity indicator (Table 12) and obtain the weighted score (Table 13)

**Table 12: Criteria for assigning capacity indicator weight**

| Indicator | Weights |
|---|---|
| Non-MG health | 5 |
| Non-Health Impact/Response/Recovery | 4 |
| Health Impact/Response/Recovery | 3 |
| Preparedness | 2 |
| Mitigation/prevention | 1 |

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**Table 13: Obtaining the weighted score for each indicator area**

| Indicator area | Average score (S) | Indicator weight(W) | Weighted score (WS) |
|---|---|---|---|
| Coordination | 2 | 4 | 8 |
| Infection Prevention and Control (IPC) | | 5 | |
| Rapid Response Team (RRT) | | 4 | |
| Disease Surveillance System | | 5 | |
| Laboratory Capacity | | 4 | |
| Risk Communication | | 4 | |
| Case Management | 1 | 3 | 1 |

I. Sum the total vulnerability and capacity weighted score for each hazard to obtain the **Risk Score**

J. The risk score is assigned a **risk level** based on the difference between the highest expected risk score and the lowest expected risk score

## LOWEST EXPECTED RISK SCORE:

sum of total vulnerability and capacity weighted score, if all indicator scores were 1.

## HIGHEST EXPECTED RISK SCORE:

sum of total vulnerability and capacity weighted score, if all indicator scores were 5

| | |
|---|---|
| **Low risk** | **0-25$^{th}$ percentile** |
| **Moderate risk** | **26-50$^{th}$ percentile** |
| **High risk** | **51-75$^{th}$ percentile** |
| **Very high risk** | **76-100$^{th}$ percentile** |

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For example: Risk score (R)=250, lowest expected risk score (L)=100, highest expected risk score (H)=500 (the risk score lies between 100 and 500)
H-L =400
Since there are 4 risk levels, 400/4=100
Add 100 to the lowest risk score to obtain the percentile range
Low risk= 100-200
Moderate risk=201-300
High risk=301-400
Very High risk=401-500
Therefore, the risk estimate from the value of R, would be moderate risk

## I. Conduct Reputational Risk Assessment

| Risk Level / Indicator Area | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| Dimension of MG | Local | National | Regional | International |
| Nature of Hazard | Endemic diseases in countries of MG attendees | Local disease outbreaks (without significant risk of extensive geographical spread e.g food poisoning) | International/national disease outbreaks ( significant importation/ exportation risk) | Pandemics/PHEIC/ intentional acts of terror |
| Number of Fatalities | None | 1-4 deaths | 5-10 deaths | >10 deaths |
| Number of attendees | <1000 | 1,000-5000 | 6,000-10,000 | >10,000 |
| Media Coverage | Local media | National main stream media | Regional media/ significant national social media | International media |

| Risk Category | Score |
|---|---|
| Low Risk | <6 |
| Moderate Risk | 6-8 |
| High Risk | 9-11 |
| Very High Risk | 12-20 |