Compliance with physical distancing measures for COVID-19 and implications for RCCE in Eastern and Southern Africa (April 2020)

This brief reports on attitudes and practices relating to physical distancing measures in Eastern and Southern Africa in the context of the current global COVID-19 outbreak. Where relevant, it also includes insight and learning from the Ebola outbreaks in West Africa and the Democratic Republic of Congo. It sets out practical considerations for the formulation of communication strategies and messaging on the subject of physical distancing related to COVID-19, taking into account the numerous challenges regarding implementation and mitigation of harmful effects that exist in the region, and cognisant that distancing may, in some settings, have adverse effects and contribute directly and indirectly to COVID-19 related deaths.

This brief was developed for the Social Science in Humanitarian Action Platform (SSHAP) by Anthrologica on request of UNICEF Eastern and Southern Africa Regional Office. It aims to provide practical recommendations for response partners working in the COVID-19 response across the Eastern and Southern African context. The brief was reviewed by colleagues at the London School of Hygiene and Tropical Medicine, UNICEF ESARO, UNICEF CASS, IFRC and the Institute of Development Studies. It is the responsibility of SSHAP.

Summary considerations

In this brief, we use the term "physical distancing" to refer to individual distancing (use of non-contact greetings, maintaining a given distance between individuals, staying at home) and community distancing (closure of schools, workplaces and places of worship, cancellation of mass gatherings such as festivals and sporting events, and in some places prohibition of public transport).[1]

Numerous factors influence compliance with physical distancing measures in Eastern and Southern Africa. Potential or actual negative consequences of distancing may deter people from complying with directives or have long-term detrimental effects if they do so. The factors outlined in this section should be taken into account when designing risk communication and community engagement (RCCE) strategies. Available measures and ways to mitigate negative consequences should be incorporated into messaging. Research evidence is provided in the following sections to contextual the key considerations outlined below.

Current distancing policies in the region and public reactions:

- Countries across Southern and Eastern Africa have introduced a range of physical distancing policies in relation to the COVID-19 pandemic. These include self-isolation for people with symptoms and people vulnerable to contracting the virus; the banning of public or large gatherings or limiting attendance at these; the closure of schools, bars, restaurants and other public venues; the closure of international borders and airports and restrictions on internal travel and public transport.
- Many people are attempting to comply with such measure to avoid contact with others and to wash their hands when water is available. However, items such as hand sanitiser are not available for most and quarantine is considered a luxury. Citizens in various countries have expressed fear about the effects distancing measures will have on their already precarious financial situation and livelihoods.
- Some countries have deployed intelligence, police and defence forces to enforce distancing measures. There have been reports of violence against those not complying with measures in a number of countries.

Factors influencing compliance with physical distancing:

Economic factors: Many people in the region live precariously and must leave their homes on a daily basis to carry out informal sector work. Robust mitigation strategies will be required to support those with the least economic resources, and to avoid exacerbating existing inequalities and inequities.

Population density: The Eastern and Southern African region is highly and often densely populated, with many live in overcrowded informal settlements in urban areas. In such settings, avoiding crowded areas or proximity to others is highly challenging. Studies show that individuals residing in informal settlements experience upto three times as many contacts as those from high-income neighbourhoods.

Institutions with vulnerable populations: Populations in certain institutional settings such as prisons, refugee camps, camps for internally displaced persons (IDPs), and care facilities for the elderly, may face challenges adhering to physical distancing policies. In some cases, prisoners have been released to reduce overcrowding, and restrictions have been placed on visits to care facilities for the elderly.

Conflict settings: Human movements (troops, militia, refugees and IDPs) can make physical distancing a challenge in conflict settings. The risk of harm from conflict may be considered greater than the risk of disease, reducing the motivation to comply with directives.

Social structures and networks: Large, multigenerational households and limited housing space make it difficult to maintain distance from others or to self-isolate within the home, particularly when sharing water and sanitation facilities. Young people, and particularly adolescents in the region usually have more contacts than their older counterparts. School closures can have adverse effects beyond limiting education including exposing young people to sexual violence and exploitation, child labour, early marriage and teenage pregnancy.

Medically vulnerable groups: Those with pre-existing health conditions such as diabetes, lung and heart disease and nutritional deficiencies are more vulnerable to COVID-19 infection and may need targeted distancing measures and shielding.

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Socially vulnerable groups: Some groups, such as HIV patients who seek treatment confidentially, victims of sexual and domestic violence and street children may face additional risks under physical distancing measures.

Level of trust in authorities and the international response: Political and historical contextual factors leading to low levels of trust in the state or the international response can result in people's limited willingness to comply with distancing guidelines. Positive and negative experiences with physical distancing policies during previous public health emergencies can also have an effect on current behaviours.

Understandings of disease causation and healing: Various understandings of disease causation and healing, whether stemming from religious or cultural beliefs or from conspiracy theories, can influence people's decisions to comply with public health guidance.

Burials and funerals: Preparing the deceased, burials and funerals are important socio-cultural events that often involve large groups of people, and sometimes involve activities that elevate the risk of transmission of infectious diseases (such as washing and touching the deceased).

Religious beliefs and practices: Faith practices such as mass prayer gatherings are an essential part of life for many in the region. Places of worship are high-risk venues for transmission of COVID-19, yet their closure could have adverse social and psychosocial effects. Religious centres can be influential in terms of disseminating both information and misinformation about disease outbreaks. Many religious centres are now broadcasting their sermons via television, radio and the Internet.

Greetings: In many countries in the region, handshaking and/or embracing as forms of greeting are important aspects of social life. While a change in such practices can result in social tensions, experience also shows that people are often willing to adapt such behaviours to reduce risk.

Mis- and disinformation: Misinformation has been circulating on social and other media about the origin and transmission pathways of COVID-19. Misinformation and disinformation can influence people's motivation to comply with distancing measures.

Community-led distancing measures: In some cases, local distancing mechanisms to contain disease transmission already exist and have evolved through prior experience with outbreaks in the community. These should be taken into account when designing current distancing measures and related communication strategies.

Messages and community engagement about physical distancing measures:

- Numerous studies in the region have shown that people are willing to adapt their customary behaviours (e.g., related to funerals, greetings etc.) to reduce risk of disease transmission, if they are provided with accurate information through trusted channels. Public health measures and their implications must be fully explained to the population.
- Efforts to raise awareness of and encourage physical distancing need to take into account the wide range of factors that influence compliance, and must include information on measures and support structures that are in place to mitigate the negative effects of distancing.
- Approaches to risk communication and community engagement should be holistic. Messages should be clear, simple, practical, specific and locally contextualised. Messages should be provided in local languages and include pictoral representations for illiterate populations.
- Messages should explain why measures are required, how long they will be in place (where possible), and include practical information about what people need to do.
- Messages should emphasise the importance of social connectedness, social responsibility and solidarity, considering ways this may be upheld in different contexts.
- The potential psychosocial effects of distancing measures should be considered, and actions to mitigate these should be encouraged, including exercise and remote contact with friends and family (e.g., via telephone or the Internet when possible).
- Messages should take into account and be sensitive to local community understandings of COVID-19.
- Messages should consider and complement any community-led or religious-led physical distancing measures already in place.
- It may be useful to target key messaging to specific population groups, such as adolescents, the elderly, inhabitants of informal settlements, or influential members of the community.
- In places such as refugee and IDP camps, where compliance with physical distancing is challenging, it is important to raise awareness about other preventive measures, such as handwashing, and ensure that key behaviours can be facilitated.

Engaging and communicating with communities at a distance:

- Trusted communication methods, channels and networks should be used where possible. These may be adapted so that engagement follows the requirements of local distance policies.
- Recognised influential individuals should be encouraged to safely share information within their immediate area through their own local channels, or further via telephone and online networks. They should be encouraged to share feedback and concerns that they receive from people in their networks.
- Other methods for communicating at a safe distance include interpersonal interactions through telephone hotlines and using the internet and social media for two-way communication. Information can also be shared through loud speakers and through printed materials (e.g., posters and leaflets distributed at health facilities or shops if safe to do so).
- Working with religious institutions to ensure they are delivering accurate information is important. It may be possible to work collaboratively with churches and mosques to provide up-to-date information and to communicate with communities through their various engagement platforms including social media, television and radio channels.
- Frontline health workers and other essential workers who must have physical contact with people can be enlisted to engage effectively with community members in their proximity. They should be briefed on good interpersonal communication, provided with accurate and up-to-date information, and know how to record and deal with feedback, concerns or complaints. They should be provided with skills to maintain their own safety whilst interacting with people at the community level.

General considerations and definitions

In this brief, we use the term "**physical distancing**" to refer to individual distancing and community distancing (see above).[1] Quarantine and travel restrictions are sometimes also referred to as distancing measures.[2] Understanding what distancing means in a given context will depend on the country policy and the way in which these measures are communicated to the public. While such measures may be commonly referred to as "**social distancing**", we, in line with the WHO[3] and other social scientists[1], encourage use of the term "physical distancing" for two reasons. First, distancing measures seek to encourage *physical distance* in an effort to slow the spread of disease. It is important, however, that whilst practicing physical distancing, people maintain and even increase *social proximity* through non-physical means, for example through social media platforms and communications technology. These channels can provide vital practical and emotional support to individuals, particularly the most vulnerable, in order to manage the psychosocial effects of physical isolation[5,6] Second, the term "social distancing" has in the past been used negatively to refer to the practice of maintaining distance from individuals from a different socio-economic background, from those who have a mental illness or an illness such as HIV, due to stigma.[7,8] Such negative connotations should be actively avoided.

Distancing measures for an infectious disease outbreak can be unrealistic in many low- and middle-income country settings. For fragile economies, sustained distancing measures may have profound negative long-term consequences that, unaddressed, have the potential to outweigh the immediate (health-related) consequences of COVID-19. Financial considerations can influence people's willingness and ability to comply. As such, it may be more prudent to focus efforts on protecting and isolating the most vulnerable in society, rather than encouraging possibly untenable distancing measures for whole populations.[9] Nonetheless, actions to encourage feasible physical distancing measures can help to slow the spread of disease and should be considered in conjunction with other basic public health measures such as handwashing. Messaging should take into account the effects and practicalities of physical distancing in any given context.

Current distancing policies in the region and public reactions

In March 2020, countries across Southern and Eastern Africa started to implement a range of physical distancing policies in relation to the COVID-19 pandemic. Measures can change rapidly and partners should consult government authorities for up-to-date information on the situation in their operational areas. In short, most governments in the region have encouraged people to stay at home and self-isolate for 14 days if they are unwell with symptoms consistent with COVID-19 infection. In addition, most countries have banned public or "large-scale" gatherings, including weddings, funerals, political rallies and sporting events, or have limited the number of people who can attend these events. The number of people permitted to attend gatherings differs between countries. All countries in the region have closed schools,[10] and most have closed bars and restaurants. Additional measures include border and airport closures for all commercial travel, advice against all internal travel and public transport restrictions.[11,12,13,14,15,16,17,18,19]

The table below presents an overview of social distancing policies in place in Sub-Saharan Africa at the time of writing

	Government measures that promote physical distancing to curb the spread of COVID19.	Countries																				
		Angola	Botswana	Burundi	Comoros	Eritrea	Eswatini	Ethiopia	Kenya	Lesotho	Madagascar	Malawi	Mozambique	Namibia	Rwanda	Somalia	South Africa	South Sudan	Tanzania	Uganda	Zambia	Zimbabwe
Individual	Advise to keep personal physical distance (including, not shaking hands, touching, work from home, etc.)	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Mandatory stay at home (except for medical care, and to get lifesaving supplies)	x	x			x	x	x	x	x	x[1]			x			x			x		x
	Advise to wear facemasks in public										x											
Community	Restrictions to social gatherings (including limiting the number of guests, or setting up additional IPC measures)	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Suspension of public gatherings with many people (between 10-100 people varying per country)	x	x	x		x	x	x	x	x		x	x	x	x	x	x	x	x	x	x	x
	Public places that don't provide essential services closed (restaurants, bars, sport facilities, etc.)	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Social services provided (suspension of utility bills, water distribution, early hand-out pensions, tax and financial relief etc.)		x				x	x		x			x	x	x		x			x	x	x
	Public transport restrictions (e.g. sick people can't travel, a set maximum capacity of travellers, etc.)	x	x		x	x	x	x	x	x	x[1]	x	x	x			x	x	x	x		
	Measures taken to limited contact with the elderly and prisoners (limiting or prohibiting visitation; partial release of prisoners, etc.)	x	x				x	x	x			x				x	x	x[6]		x	x	x
	Entry restrictions to those from COVID affected areas	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Obligatory government or self-quarantine for travellers for COVID affected countries (14 days)	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Land borders closed and international commercial flights suspended, citizens advised to remain in country or abroad	x	x	x		x	x	x	x	x[4]	x		x[2]	x[3]	x	x	x	x		x		x[3]
	Advise against or restrictions around non-essential internal travel (e.g. to other cities/districts)	x	x			x	x	x					x	x[5]			x	x		x		x
	Enforcement through deployment of police or security forces and application of penalties	x	x	x			x	x	x	x	x	x		x		x	x	x		x		x

Sources: Ministry of Health Websites from included countries.

1. A full lockdown is currently only ordered for the three cities of Antananarivo, Fianarantsoa and Toamasina. **2.** The *Ponta do Ouro* border with South Africa is currently closed. **3.** Partial border closure as South Africa has closed the border with Namibia. **4.** South Africa has closed its borders and has closed off Lesotho, a land-locked country surrounded by South African territory. **5.** Beginning 27 March, a 21-day lockdown of the regions of Erongo and Khomas was announced, whilst inter-regional travel was allowed for the commuter towns of Okahandja and Rehoboth. **6.** South Sudan's government has asked to release some female prisoners.

Public reactions and enforcement: Citizens in countries including Kenya[20] and Uganda[21] have expressed fear about the effects distancing measures will have on their already precarious financial situations. In South Sudan, refugees have reported concern about what will happen to them when national borders close, including whether aid delivery will continue, and when police, military and National Security forces begin to enforce measures.[22] In Nairobi, quarantine is considered a luxury only possible for the wealthy and middle-class. Many people are attempting to avoid contact with others, as well as washing their hands when water is available, but items such as hand sanitiser and face masks are not available for most.[1] Some countries, including Ethiopia[23], Malawi[13], South Sudan[24], Uganda[25], South Africa[26] and Zimbabwe[27] have deployed intelligence, police and defence forces to enforce distancing measures.[28] Punishment for non-compliance differs across countries but can include large fines or imprisonment.[29] There have been local news reports of violence inflicted upon those not complying with measures in a number of countries including against shopkeepers, street vendors and public transport operators attempting to continue their economic activities in the face of restrictions.[30,31,32,33,34,35,36] Often, heavy-handed efforts at enforcement violate the distancing measures they are attempting to enforce. Numerous motorists have been arrested for defying bans on movements,[34,35,37]. In response to reduced schedules, some minibus drivers have been found to be transporting 50% more than the permitted number of passengers.[37]

Factors influencing compliance with physical distancing measures in the region

Economic factors: Many people in the region live precariously and leave their homes on a daily basis to carry out informal sector work, such as trading goods or driving *boda-bodas*, or must leave their homes to fetch water or use the toilet.[20,38,39] If no alternative source of income is available, people may have no choice but to leave their homes to continue their economic activities, potentially coming into close contact with others in public spaces or on public transport.[40,41,42] In a number of countries, there have been reports that casual labourers who have lost their jobs or been ordered to stay home as a result of the pandemic are fleeing urban centres on foot in an attempt to join their families in rural areas where subsistence may be more available.[1,44] Others have crossed international borders illegally in order to access social security grants.[45] Large segments of populations that are unemployed rely on the economic activities of others, and there will be a significant knock-on effect across the economies of all countries in the region.[1] Whilst a small minority of the population have more resources and are able to take measures to work from home, stockpile supplies and use a private vehicle when necessary, populations who have the most limited economic resources will be disproportionately affected by the distancing measures.[31] This has the potential to exacerbate already existing inequalities and inequities. It should also be noted that many unofficial workers such as market sellers, seamstresses, domestic workers, nannies, cleaners and cooks are women, sometimes very young girls, and this group could be greatly affected.[47]

A number of countries are now rolling out measures to ease financial hardship for individuals and this may help to enable compliance with distancing measures. Such measures include door-to-door distribution of essential goods,[48,49,50] easing of loan repayment conditions,[51] implementation of fixed prices on food, caps on the quantities of consumer products individuals can buy,[52] construction of temporary shelters for homeless people and the identification of quarantine and self-isolation sites for people unable to self-isolate at home.[53] Non-government actors are also stepping in to provide relief. As part of the Global Humanitarian Response Plan, in March 2020, the United Nations Central Emergency Response Fund identified a USD 2 billion financing requirement for a nine month period to support humanitarian agencies to provide assistance to the most vulnerable, including women and girls, refugees and IDPs. Assistance will include measures related to food security, physical and mental health, water and sanitation, nutrition and protection.[54,55] In light of school closures, the World Food Programme (WFP) is providing take-home rations and home delivery of food.[56] There are also instances of private companies[57] and private benefactors[49,58] providing relief.

Population density: Densely populated places can precipitate infectious disease outbreaks.[59,60,61] The Eastern and Southern African region is highly populated, with around 439 million inhabitants.[62] Although the vast majority of the region remains rural, Africa is one of the fastest urbanising regions in the world, with Johannesburg-Pretoria and Nairobi among its megacities.[63] In the whole of sub-Saharan Africa, 55% of the urban population are estimated to be living in overcrowded informal settlements.[64] These factors make it very difficult for people to avoid crowded areas and physical proximity to others when asked to do so.[41] A study during the outbreak of Ebola in Liberia in 2015 found that individuals residing in the most impoverished settings in Monrovia, such as slum neighbourhoods, experienced three times as many contacts during their infectious period and were associated with 3.5 times as many secondary cases as those from high-income areas.[65] There is a real risk that the impacts of COVID-19 will be greater on the urban poor than on other groups. Mitigating the difficulties of controlling infectious disease in densely populated areas is vital.[66,67] In Kenya for example, the UN and partners are taking steps to ensure people living in informal settlements have access to running water and are therefore able to facilitate basic public health measures to stem transmission.[68] The governments of Uganda and Rwanda are installing hundreds of handwashing points around their capital cities and other towns.[69,70] Similar measures, and more, will be needed in other countries.

Institutions with vulnerable populations: Groups in certain institutional settings face specific challenges adhering to social distancing policies. Incarcerated persons are particularly vulnerable when there are high rates of prison overcrowding[71,72] and due to the prevalence of pre-existing health challenges among this population.[73] Some countries have released prisoners to ease overcrowding in prisons, including those convicted of minor offences and female prisoners with babies.[74,75,76] In addition to prisons, refugee and IDP camps in the region are overcrowded, usually with inadequate water and sanitation, making it very difficult to maintain distance in these settings. Elderly residents in care facilities may also be particularly vulnerable. In Ethiopia, visiting hours to public and private care facilities for the elderly have been limited.[77]

Conflict settings: In conflict settings, furthering a political cause or continuing efforts to restore security may be considered more important than complying with distancing measures. Likewise, the risk of harm from conflict may be considered greater than the risk of harm from disease, and measures aimed at mitigating transmission may seem disproportionate to the risk of contracting the disease. Both state and non-state armed forces may not be able to practice appropriate physical distancing measures whilst they are mobilising.[78] Research has indicated that the movement of troops in South Sudan, for example, facilitated communicable disease outbreaks such as HIV/AIDs.[79] In addition, conflict settings have a high number of IDPs, refugees and others fleeing violence who often find themselves in unhygienic and overcrowded camps[80,81] where distancing is nearly impossible.[1,82,83] Security issues limit their ability to live in settlements where physical distancing measures might be more feasible. Nonetheless, communication about the health risks inherent in camp settings must caution against the risks of voluntary departure from protection sites, in order to avoid encouraging residents to flee into unsafe and conflict-affected areas.[84]

Social structures and networks: A number of factors related to social structure and social networks in the region create challenges for physical distancing measures.[85] Large household sizes and limited housing space make it difficult to maintain distance from others or to self-isolate, particularly when sharing water and sanitation facilities.[9] Early survey data from an ongoing study in Ethiopia by the national Public Health Institute shows that 64% of respondents do not have a separate room in their household to enable quarantine or self-isolation.[86] A result of both economic and cultural factors, the multigenerational nature of many households provides the opportunity for disease to spread between age groups, putting vulnerable elderly family members at risk.[41,87] Many rely on family and other members of their social network to provide care, healthcare, food and other basic needs, as well as companionship. In the absence of alternative support, individuals will suffer if denied contact with their communities. In sub-Saharan Africa (with perhaps the exception of South Africa[88]), the elderly most often live with their children or extended family and take care of their grandchildren,[89] which makes them particularly vulnerable to COVID-19 transmission. Older adults may also be more vulnerable from an economic perspective. There are few formal pensions or other social welfare schemes available to elderly people in the region, and those that exist often pay minimal benefits.[90] While digital access lags behind other regions, the last decade has seen an expansion in access to mobile phones across Africa. Access is far higher than actual ownership, since phone sharing is widespread.[91] This may contribute to mitigating the psychosocial effects of isolation in some cases, as well as facilitating continued support with basic needs.[92] It should be recognised, however, that sharing of mobile devices of any kind may increase risk of the transmission of COVID-19 if strict hygiene measures are not followed.

Physical distancing measures may differentially affect young versus older people, and urban versus rural residents. Studies in South Africa[61], Uganda[93], Zimbabwe[87] and Kenya[94,95] found that young people, and particularly adolescents, have more contacts than their older counterparts, particularly those in school. In Kenya, school students in rural areas were found to have twice as many contacts as their semi-urban peers.[94] While young people tended to mix largely with people of a similar age, there was substantial mixing between age groups, particularly within households.[61,93] School closures can have the adverse effect of enabling children and adolescents to mix more with other members of the community, including adults, and to engage in risky behaviours such as unprotected sex, binge drinking and drug use.[78] It can also expose young people to other risks such as violence, sexual violence and exploitation, transactional sex, child labour and early marriage.[96,97] Lessons from the Ebola outbreak in West Africa showed that school closures can contribute to higher rates of teenage pregnancy.[98] A study in a South African township found that social mixing patterns differed significantly to comparable European studies, with the number of close contacts 40% higher in the township.[61] This is likely to be comparable to slums and peri-urban settlements in other parts of the region. Local variations in contact patterns should therefore be taken into account when identifying distancing strategies and determining their likely impact on transmission.[99]

Medically vulnerable groups: Those with pre-existing health conditions, particularly diabetes, lung and heart disease and nutritional deficiencies are the most vulnerable to severe and fatal forms of COVID-19,[100,101,102,101,103] and may need specific support with regard to distancing measures and shielding. Individuals with these conditions are often elderly, implying increased risk. There is a high prevalence of non-communicable diseases in the region, in particular hypertension and diabetes, as well as undiagnosed or poorly managed HIV and TB. Emerging studies indicate that people with lung damage caused by TB are likely to be at increased risk of infection with COVID-19.[104] There is limited data on other comorbidities that may be prominent in the region, such as malnutrition (acute, severe and chronic), Acute Respiratory Infections and untreated HIV.[105] Globally, 5.8 million people die from Acute Lower Respiratory Infections each year, and 50% of these deaths occur in sub-Saharan Africa.[106,107] Pregnant women may also be more vulnerable to COVID-19[108] and may face challenges in accessing ante and post-natal care when hospitals are reoriented to respond to the COVID-19 outbreak.[109]

Socially vulnerable groups: Some groups may face additional risks under physical distancing measures as a result of their social vulnerability. HIV patients who seek treatment confidentially may no longer be able to find safe mechanisms to leave home to seek treatment, which could have long-term and life-threatening impacts.[110,111] Victims of sexual or domestic violence may be at greater risk if both the victim and their abuser are confined to the house.[111] Individuals whose living depends on transactional sex may accept greater risks to offset loss of income. Children reliant on food programmes (e.g., street children or those living in extreme poverty) could lose access to the only nutritional support normally available to them. A decline in routine vaccination could also have significant ramifications. A recent UNICEF report in the DRC highlighted that the redirection of attention and investment towards Ebola resulted in nearly 6,000 children dying of measles in 2019.[112]

Level of trust in authorities and the international response: In settings in which there is a long history of conflict or oppression and a low level of trust in authorities, there may be less willingness to comply with distancing guidelines issued by the state.[113] Previous outbreaks show how historical and political contextual realities can influence people's decisions. During the influenza epidemic of 1918, for example, people across Africa blamed the disease on the presence of Europeans and considered colonial medicine to be an imperialist strategy. This caused contract workers to flee, spreading the disease to more remote areas.[78] More recently, decades of conflict, tension and shifting allegiances laid the foundation for a deep mistrust of the international response to the West Africa (2014-16) and DRC (2018-2020) Ebola epidemics.[114] Coupled with a lack of two-way communication and a disjuncture between biomedical interventions and local cultural practices and beliefs, people challenged the implementation of certain protective measures such as visiting Ebola Treatment Centres and registering cases.[115] Such experiences are relevant to the current outbreak of COVID-19 in Eastern and Southern Africa, particularly as the disease was imported to the region from abroad. Positive and negative experiences with physical distancing policies during previous public health emergencies (including HIV/AIDs, cholera and Ebola) also have the potential to influence perceptions of current response mechanisms.[116]

Understandings of disease causation and healing: Previous disease outbreaks in Africa have highlighted how differing understandings of disease causation and healing can influence people's decisions to comply with public health guidance. In West Africa, strong beliefs surrounded the Ebola virus, and some local healing practices, including in churches, involved touching patients' bodies which elevated risk of transmission.[113] Some people also believed that the virus was manufactured by Western governments, or that it had been intentionally fabricated for political purposes and did not exist.[1,115,117,118] COVID-19 has provided a new platform for revitalised conspiracy theories, including that the virus was engineered by China, the United States or large pharmaceutical companies.[92] The IFRC has collected relevant perception data from sub-Saharan African countries on the COVID-19 which includes statements such as: "*China has created this virus to make money*" (DRC); *"Coronavirus was manufactured by US Governments to destabilise the Chinese government"* (Kenya); "*Coronavirus is a result of the weapon industry and is manufactured as a biological weapon"* (Burundi).[119] Such theories can fuel suspicion towards authorities and their motives for introducing public health measures.

Burials and funerals: Across the region, burials and funerals are important socio-cultural events that often involve large numbers of people.[113] Entire neighbourhoods and villages are known to attend, along with family members and friends of the deceased visiting

from other parts of the country and even abroad.[120,121] Funerals and the related practices that surround them are linked to broader socio-cultural markers including social structure, religion, group identity and politics.[120] The social obligation to attend funerals is significant, and a failure to perform burials in the correct manner can have negative repercussions for the family and community of the deceased. In many communities, such as the border communities in South Sudan for example, burials involve activities such as washing, touching, dressing and transporting the deceased to their natal village. These activities can pose a risk in the context of transmissible disease outbreaks and may need to be adapted.[121] The social importance of funerals and the associated risk for disease transmission has also been noted in other parts of Africa.[115,121] It has been repeatedly demonstrated, however, that when the reasons for adaptating practices related to handling the deceased, burials and funerals have been properly communicated, people are willing to adapt their customs to reduce the risks, particularly when governments and response teams work with the community to arrive at mutually agreed and acceptable cultural adaptations.[121,122,123,124] The WHO and IFRC have prepared guidelines for managing dead bodies in the context of COVID-19, and outline some of the ways in which cultural and religious traditions can be respected whilst adhering to safety guidelines.[125,126]

Religious beliefs and practices: Faith practices such as mass prayer gatherings are considered an essential part of life for many in the region,[9] and many view the phenomenon of disease through a religious lens. Gatherings for worship are high-risk for transmission of COVID-19 unless appropriate distance is maintained at all times. Yet, the closure of places of worship would disrupt support systems and may have adverse psychosocial effects.[127] Religious centres may also be influential in terms of providing both information and misinformation about disease outbreaks. Christianity and Islam both promote some form of physical distancing for different purposes and these are being taken up by religious leaders in response to COVID 19[128,129]. During the Ebola outbreak in West Africa, some churches spread differing ideas about disease causation and advocated healing practices that were potentially risky, including touching patients.[113,118] Others warned their congregations against touching sick people and suspended the practice of shaking hands and delivering Holy Communion.[118] In West Africa, there have been negative reactions, including riots, to the closure of places of worship (Senegal) and incidences of 'super spreading' events at evangelical church sessions (in Burkina Faso[130]and South Africa[131]). However, in many cases churches are encouraging their congregations to stay home and observe distancing measures, and are broadcasting their sermons via television, radio and the Internet.[132]

Greetings: In many African countries, handshaking and/or embracing are important aspects of social life. In Botswana and neighbouring parts of South Africa, it is common for people to greet each other with a kiss on the lips. Such gestures express solidarity, hospitality and acceptability,[133,134] and are an entrenched part of religious and socio-cultural practices.[135] The Ebola outbreaks in Africa showed that changes in such practices can result in social conflict, for example, with people misunderstanding the reasons a friend or acquaintance declined to shake hands.[133,135] However, experience also shows that people are willing to adapt their behaviours to reduce risk if the measures and their implications are properly explained, and if suitable and pragmatic alternatives are agreed. For example, in Liberia, Sierra Leone and Uganda, people stopped customary physical greetings during Ebola outbreaks as a result of the information provided about disease transmission, and created innovative ways to greet each other (e.g., tapping shoes).[122,133,136,137,138]

Misinformation: The spread of mis- and disinformation about a disease, its causation and transmission pathways can influence people's perceptions of distancing measures.[92] A multitude of misinformation has been circulating on social media in relation to COVID-19. For example, statements that the virus cannot live in hot and humid weather[119] has led some people in South Sudan to dismiss the distancing guidance as irrelevant to them.[22] Messages have also spread that *"black people are immune to COVID-19"* (Malawi) and "*black people can't die of coronavirus because it is a disease of white people"* (DRC).[119] Various reported prevention measures and cures for the virus have also been circulating[92] (e.g. drinking garlic water),[119] which if believed could also lead people to disregard distancing advice. As emphasised above, however, when provided with accurate information through trusted channels, people repeatedly adapt their behaviour to reduce risk and protect themselves and their networks.[139]

Community-led distancing measures: In some cases, local distancing mechanisms to reduce disease transmission already exist and have evolved through prior experience with outbreaks in the community. For example, localised strategies for containing disease in Liberia[140] encompass excluding strangers from the community, prohibiting visitors from sleeping in one's home, mandating a 21-day quarantine period prior to entering the community, ensuring community members maintain distance from sick people or the deceased (including within their household), and managing resource provision for those in quarantine or isolation. During the 2014-2016 Ebola outbreak, community task forces and block watch teams were set up to identify cases and to monitor compliance.[140] In Uganda, the Acholi people have a similar set of community-based rules that are to be strictly followed in the event of a dangerous infectious disease.[141] Community dynamics and leadership must be taken into account when considering the likelihood of adopting and sustaining distancing measures. An ethnographic account of two neighbouring villages in Sierra Leone affected by Ebola showed the influence that local leaders and their interpretations of distancing guidelines, as well as their political motivations, can have on transmission outcomes. One village, whose chief attempted to hide Ebola cases, recorded 20 deaths, with over 25% of the village population falling ill. The other village was compelled by its chief to isolate itself, including from the neighbouring village, and recorded no cases.[1]

Implications for risk communication and community engagement

There are a number of factors that should be considered when planning risk communication and community engagement strategies in any emergency context, as clearly set out in recent guidance (listed below). However, there are some specific considerations relevant to COVID-19. The following addresses: a) considerations for messaging and community engagement about physical distancing; and b) practical considerations for engaging with communities whilst maintaining distancing.

Messaging and community engagement about physical distancing: Any efforts to raise awareness of and encourage physical distancing need to take into account the wide range of factors that influence compliance, as detailed above. Approaches to risk communication and community engagement should be holistic, practical and locally contextualised. Messages should explain why the measures are required and, wherever possible, for how long they will be in place. They should include practical information on what people need to do, and what people can do (or what measures are in place) to mitigate any negative effects the distancing measures may cause. Communicating the message is not enough if behaviour change is not feasible. For example, messages encouraging people to stay home should be accompanied by information about available support mechanisms to ease the burden on those with few resources. Messages about not shaking hands should explain the reasons why and suggest culturally acceptable alternatives. Ways

to enable and encourage the continuation of essential services such as vaccinations, nutrition and HIV treatment should be considered. Further, messages encouraging physical distancing should emphasise the importance of social connectedness and solidarity as an antidote to distance and should consider ways social connectedness may be maintained in different contexts. Messages should encourage social responsibility and the ethos that "*we are all in this together*."[1] The potential psychosocial effects of distancing measures should be considered, and actions to mitigate negative effects of isolation encouraged, including exercise and contact with friends and family via non-physical means, such as telephone or Internet if possible.[143] Messages should take into account local community understandings of the disease and should be provided in local language. They should consider and complement any community-led or religious-led physical distancing measures already in place, and build on previous experience with physical distancing.

It may be useful to consider focusing on specific groups, such as adolescents, who have been found to be the most active group in social mixing in several settings.[61,95] Some groups, such as women and young people, may have less access to messages and less influence over the implementation of distancing measures within the household or community. As such, it is important to identify groups or individuals that influence health behaviour, and to target messages at those groups to gain wide acceptance. These influencers may include men, older women, and traditional and religious leaders. In situations in which compliance with physical distancing measures is challenging, such as urban informal settlements, refugee and IDP camps, efforts should be made to actively facilitate preventive measures, for example by providing water and soap or hand sanitiser, and messages should raise awareness on transmission dynamics, preventive behaviours and basic public health interventions.[41]

Engaging and communicating with communities from a distance: In line with general principles of communicating in emergencies,[144] trusted communication methods and channels should be the starting point, but should be adapted as necessary to reduce transmission risk. For example, at the time of writing, the South Sudan Red Cross was mobilising their country-wide network of 1400 volunteers, most of whom gained experience and built relationships through Ebola preparedness initiatives, to engage with communities on how to protect themselves from COVID-19.[145] BBC Media Action has produced a guide on conducting community engagement at a distance in Bangladesh, and many of the recommendations are also applicable in the Eastern and Southern African context. The guide emphasises that it is advisable to use established and trusted networks to share information by phone or online; that group leaders or key interlocutors can be encouraged to share information within their local area through their own safe mechanisms, or further via their phone or online networks; and that these same group leaders and influencers should be encouraged to share feedback and concerns that they receive from their networks, and these should be recorded. The guide also suggests other methods for communicating, including utilising existing hotlines, distributing posters at health facilities or shops, using the Internet and social media for two-way communication, and setting up fixed loudspeakers within the community.[146] Frontline health workers and others who are required to have continued face-to-face engagement with people in the community can be enlisted to communicate messages as part of their routine work. They should be briefed on good interpersonal communication, have accurate and up-to-date information, and know how to record and deal with feedback, concerns or complaints.[146] A resource specifically focused on risk communication for health workers has been published by WHO.[147] Some governments are already making use of their existing social media channels to communicate health messages to the public, as well as expanding to other platforms such as WhatsApp.[148] It is imperative to engage religious leaders of all denominations, since many people in the region view disease through a religious lens and will receive and trust messages sent by their faith-based leaders. Working with religious institutions to ensure they are delivering accurate information is key, and it may also be possible to work collaboratively with churches and mosques to communicate with communities through new and established institutional platforms including social media, television and radio channels.

Useful risk communication and community engagement guidelines (illustrative, not comprehensive)

- CDAC Network. *How To Guide on Collective Communication and Community Engagement in Humanitarian Action*. http://www.cdacnetwork.org/contentAsset/raw-data/cca52f57-4f06-4237-9c18-37b9e8e21a18/attachedFile2
- IFRC. *COVID-19: Community Engagement Hub*. https://www.communityengagementhub.org/what-we-do/novel-coronavirus/
- WHO. *Pass the Message: Five Steps to Kicking Out Coronavirus*. https://www.who.int/news-room/detail/23-03-2020-pass-the-message-five-steps-to-kicking-out-coronavirush
- UNICEF. Minimum Quality Standards and Indicators in Community Engagement. unicef.org/mena/reports/community-engagement-standards

Contact

If you have a direct request concerning the response to COVID-19, regarding a brief, tools, additional technical expertise or remote analysis, or should you like to be considered for the network of advisers, please contact the Social Science in Humanitarian Action Platform by emailing Olivia Tulloch (oliviatulloch@anthrologica.com) and Santiago Ripoll (s.ripoll@ids.ac.uk). Key Platform liaison points include: UNICEF (nnaqvi@unicef.org); IFRC (ombretta.baggio@ifrc.org); and GOARN Research Social Science Group (nina.gobat@phc.ox.ac.uk).

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