CELLULE D'ANALYSE
EN SCIENCES SOCIALES | CASS

Social Science Support for COVID-19: Lessons Learned Brief 1

What social sciences researchers working in humanitarian contexts (Sub-Saharan Africa) should be asking in COVID-19 and why

22 May 2020

Context

Since August 2018, an Ebola epidemic has continued to spread throughout the east of the Democratic Republic of the Congo (DRC), resulting in 3404 cases and over 2240 deaths, including many women and children. Despite cases continuing into 2020 (including new cases in April, two days before the anticipated declaration of the end of the outbreak) a new world-wide pandemic began. COVID-19, a novel coronavirus, originated in Wuhan, China, and has since spread to 213 countries, areas or territories and infected over 2.7 million people[1], including healthcare workers (HCWs).

In February 2020, the first case was announced in Africa, and as of April 2020, cases have been confirmed across 52 countries.

While prediction models for the spread of COVID-19 across the continent vary, the forecasting of the secondary impacts of the outbreak on health, poverty and stability of already fragile settings are consistent. COVID-19 adds to the burden of endemic infectious diseases and conflict facing many countries in the region, with impacts compounded by conditions of limited water, sanitation and hygiene (WASH) coverage, and population overcrowding. Communities and humanitarian actors working to support the COVID-19 response within these contexts are presented with the challenge of preventing the overwhelming of health systems and diversion of resources critical to addressing existing needs.

The Social Sciences Analysis Cell (CASS)

The Social Sciences Analysis Cell (CASS), established during the DRC Ebola outbreak (2018-present), is a unit set up by UNICEF, together with national and international, operational and academic partners to operate under the Ministry of Health (MoH) response lead. The Cell conducts mixed methods, operational social sciences analyses to support the response actors, strategies and interventions. The purpose of this Cell is to provide integrated analysis to facilitate understanding and monitoring of epidemiological, behavioural and perception trends as the

outbreak and its responses evolve, and together with partners, apply results of analyses to motivate real operational change and improved community health outcomes. As part of the Ebola outbreak response, the CASS **conducted 57 field studies, and together with the MoH and response actors, developed 112 recommendations.**[2] Following from the success of this model, the CASS aims to replicate this role across several countries in Sub-Saharan Africa, adapting to new contexts presented by outbreaks such as the current COVID-19 pandemic.

Lessons learned briefs

The CASS has drafted a set of briefing documents outlining key lessons learned from social sciences analyses during the DRC Ebola outbreak response, aiming to connect findings from the research conducted by the CASS with recommendations for supporting and improving the approach to tackling COVID-19 and its secondary impacts in Sub-Saharan Africa.

The CASS Briefs do not imply comparatives between the diseases. While the Ebola virus has a higher mortality rate than COVID-19, it is far less transmissible being a disease where a reasonable level of physical contact with a symptomatic person is required in order to contract the virus. Conversely, COVID-19 is spread via droplets, up to two metres from one person to another, often before the onset of symptoms. This presents challenges for containment and prevention activities and elevates the risk of exposure to outbreak responders.

Despite these differences, the social and behavioural sciences studies, recommendations, and resulting documented lessons learned can **provide key guidance and important considerations for COVID-19 response and research teams operating in similar contexts across the continent.**

> *The briefs address the following topics:*
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> **Brief 1: Social Sciences Research questions we should be asking in humanitarian contexts under COVID-19**
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> Brief 2: Gender inclusiveness in COVID-19 humanitarian response operations
>
> Brief 3: Humanitarian programme recommendations for COVID-19 based on social sciences evidence from the DRC Ebola outbreak response
>
> Brief 4: Social sciences evidence on barriers to healthcare seeking during the DRC Ebola outbreak

CASS research tools, raw data, presentations, analysis and monitoring of research recommendations to action (MONITO) are available online: Ebola drive and COVID drive.

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1   Updated case number statistics are provided daily by the World Health Organisation
2   For a complete list of all CASS Studies conducted during the Ebola outbreak response, please consult the study tracker (LINK)

Brief 1: What social sciences researchers working in humanitarian contexts (Sub-Saharan Africa) should be asking in COVID-19 and why

There can be a tendency when first starting research around a topic, or responding in a crisis, to rapidly try to gather as much data as possible, as quickly as possible. Whilst this can result in a rich dataset of useful information, it may not be the best use of time, and may overlook key thematic data needed to influence humanitarian programme interventions.

This brief was developed based on evidence and lessons learned from CASS studies, to guide social scientists working in humanitarian programmes, or actors seeking to use social sciences research inside their COVID-19 response in Sub-Saharan Africa. It provides **a summary of suggested key social sciences research questions and their rationale to support and inform in operational field research and response programming in the Sub-Saharan African context.**

> **Key social sciences research themes to study:**
> 1. Health services: Access and use (trends and impact over time)
> 2. Perceptions of (impact, feasibility etc) infection prevention and control (IPC) and other public health measures
> 3. Gender- inclusiveness: Impacts of public health and IPC measures on the socially- and biomedically-vulnerable
> 4. Community perceptions of response actors and community trust
> 5. Language, cultural norms, social network and communication analysis

Key research questions

Theme 1: Understand the perceived and real impact of COVID-19 on health seeking behaviour (HSB): changing trends in services perception, access and use

What do we want to know?

- Perception of any changes in health services (access, scope, availability) since the start of the COVID-19 outbreak, and if this matches reality (i.e. actual availability of services)
- Perceptions and beliefs of primary and secondary consequences of COVID-19 infection, and whether these perceptions impact HSB
- Perceived, lived and reported barriers to accessing care (structural, political (policy), physical (movement), environmental, behavioural (individual, of others), perceptions of risk (fear))
- The impact of community knowledge and awareness of COVID-19 (disease, symptoms, transmission and prevention methods) on HSB
- If changing trends in HSB of bio-medically vulnerable or socially vulnerable individuals differ from other groups[3]
- If individuals, groups or communities turn to alternative providers for healthcare needs (e.g. pharmacies, traditional healers, unofficial and official health services)
- Changes in use of healthcare services (trends in health services data, MoH)
- The impact of different policies (e.g. free healthcare) on HSB

Why do we want to know this?

The degree to which health seeking behaviour of the population may be affected by COVID-19 response (and IPC policies is unknown. Healthcare provision and resources may be redirected towards the COVID-19 response, and no longer be available to address other health issues. Community perceptions relating to changes in health services provision or ability to access them may also affect HSB, regardless of whether service provision has changed. Priorities of individuals and communities may change, with increased domestic responsibilities, particularly for women, relating to childcare and care for sick relatives. Health facilities[4] may start charging for services in order to make up for lost income[5]. Communities may begin to perceive healthcare facilities as places of infection (risk). Early reports suggest potential threats to healthcare access presented through COVID-19 could disproportionately impact vulnerable groups (e.g. survivors of sexual and gender-based violence (SGBV), people living with HIV, women with sexual and reproductive health (SRH) needs, children requiring vaccination).

HSB data that can be collected in *real time* can provide an early warning and allow for immediate action to be taken and services to be adapted accordingly, ensuring that the needs of the

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3 Bio-medically vulnerable are those at greater risk of contracting or having severe case of COVID-19, due to age or co-morbidity CDC, WHO). Socially vulnerable are those who are at risk of the secondary impacts of COVID-19 response interventions (e.g. confinement). This includes women with SRH needs, survivors of SGBV, malnourished children and adults, those living in slum settings or without access to water and sanitation.

4 A health facility refers to any structure providing formal or informal healthcare, including state-run health centres, hospitals, private health centres, traditional healers and birth attendants, and pharmacies

5 In the first months of free healthcare in the Eastern DRC Ebola response, private clinics who were losing patients were accused of charging more to make up for loss in patient numbers (see study link)

population continue to be met. Potential changes in HSB trends could be monitored over time to identify the impact of different IPC policies as they are established, in addition to changing perception of the disease itself.

When able, social sciences data should be compared to, and complimented by, health services data (provided by the governments, MoH) to monitor any changes in trends of use by services type.

A CASS study looking at changing perceptions and uses of health services is ongoing in the DRC. A link to the terms of reference (French) may be viewed here.

Lesson(s) learned from Ebola outbreaks

The West African Ebola outbreak (2014-2016) saw huge declines in the use of health services, including maternal, child and reproductive health, as well as SGBV services. To mitigate these impacts, in the DRC outbreaks (Equateur 2018 and East 2018-present) free healthcare policies were set up (to varying degrees and adapted over time). Although community perceptions studies reported distrust in the quality of free care, rapid community studies on health seeking behaviour (including documenting health centre patient registries) quickly highlighted huge increases in the use of free healthcare services. Data were matched with trend analyses for the use of centres which triangulated community reports of overcrowding in health centres. This data contributed to a greater understanding and explanations for high levels of nosocomial infections, including

for children under 5. Without understanding and monitoring these trends using mixed methods studies, response actions could not have considered the potential impacts of overcrowding on infection rates, on delayed care for patients and on possible negative impacts on the quality of care.

Epidemiological data analysis and health services use monitoring

Changing trends in the use of health facilities and specific services may be monitored through: (1) monthly healthcare services database analysis (often limited to public services, however, provides useful insight) and, in short term, (2) weekly phone calls with selected MoH health facilities to collect key epidemiological (quantitative) data. **Social sciences analysis should be conducted to complement and provide explanation to any visible changes in the data**. This will provide an early trigger system to highlight both changes in care access (including services for high-risk groups), and health impact in communities. Special attention should be given to numbers for standard access to SRH and SGBV services, and retention of women on HIV prevention programmes (esp. prevention of mother-to-child transmission (PMTCT)). A small sample of health facilities offering maternal, child and adolescent health (MCAH) and SRH services should be selected, and monthly reporting data and perceptions from healthcare workers monitored.

Theme 2: Understand the feasibility of practicing public health and social measures (PHSM), home and community-based IPC measures, and the perceived effectiveness of these approaches

What do we want to know?

- How communities perceive the risk of COVID-19 (knowledge of the disease outside of the region, if COVID-19 risk is perceived as real and to what degree, how COVID-19 is compared to other familiar health risks)
- What IPC mechanisms (country, community, household) currently exist, and their use, acceptance and perceived efficacy (applied or used in previous outbreaks)
- If communities are aware of the recommended IPC measures for COVID-19
- If the recommended IPC measures are perceived feasible, supported at household and community level, and if communities feel able to participate in and practice these measures, if not why
- Perceived ability to practice physical distance, to self-isolate or to shield a vulnerable in the household
- Household and individual capacity to make and wear a mask
- Individual willingness to participate in contact tracing and to be tested
- The perceived (reported) impact of COVID-19 and the associated mitigation strategies on men, women, adolescents, children and the elderly
- Perceived potential adverse secondary impacts of IPC measures, and the factors likely to impact willingness to follow IPC measures
- Healthcare workers' perception of COVID-19, the risks to themselves, their ability and willingness to adapt their behaviour at work and at household level
- Community suggested IPC measures, why communities believe they will work and if it is feasible to reinforce them formally

- How adherence to IPC measures may be limited by income and socio-economic status
- How and what IPC measures may restrict access to essential services (food, security, healthcare etc.)
- How and what IPC measures may impact physical and mental wellbeing

Why do we want to know this?

For Public Health, Social and IPC measures to be effective, communities need to believe they work, and be willing and able to practice them. Acceptance relies on feasibility of adherence, and a belief that the impact will be positive. During the Ebola response, studies on community perceptions on IPC highlighted distrust caused by the engagement of non-local IPC response teams. A study looking at community perception of COVID-19 IPC measures, and perceived obstacles to participation and practice is ongoing in the DRC.

Social sciences analyses during the Ebola response in the DRC saw that in heavily affected regions, people reported a "high impact" of the outbreak on socio-economic status, and access to basic services. Amongst children and adolescents, this impact was felt more prominently by the more "vulnerable". Reduced access to basic services and financial resources may limit the ability of the population to conform to household and community IPC measures.

PHSMs are an important strategy to slow transmission of COVID-19 and reduce the burden on health care systems, however, effective implementation of PHSMs requires public

support and adherence. Understanding perceptions around PHSM can result in improved communication and response strategies, which will can result in greater participation and effectiveness of the measures. Understanding perceptions (including perceived capacity to participate and engage in PHSM) can identify more locally and community appropriate approaches, which can mitigate negative secondary impacts and improve overall community engagement.

Theme 3: Gender Inclusiveness – Understand the impact of public health and IPC measures on the socially- and biomedically-vulnerable

What do we want to know?

- Gender inclusivity of data collection tools (not only sex, age, but also socio-economic information and considering context)
- The groups affected by the outbreak (not only the bio-medically vulnerable), and how they are affected
- Traditional male and female roles (across different age groups) in society, and how do these impact the risk of exposure to both bio-medical and social vulnerabilities (involving understanding gendered power structures and distribution of resources)
- Ability of women to design, influence and implement household and community IPC measures and safely protect themselves
- How gender roles may evolve as the outbreak progresses and under specific response mechanisms, and the inequitable impact that this has on HSB of men and women
- Actual and potential primary and secondary impacts of women's engagement in the response
- Social epidemiological trends resulting from the outbreak, or caused by the outbreak/ its response

Why do we want to know this?

Early data from research conducted in other affected countries suggests that men may be more at risk than women of dying from COVID-19 due to sex-based immunological or behavioural differences. However, gender inequities can be exacerbated in an outbreak context, reinforcing social vulnerability for women. Already responsible for most household and domestic work, women are more likely to lose their jobs, become carers for elderly relatives and children out of school, and be exposed to COVID-19 infection as frontline healthcare and unpaid care workers.

Furthermore, women will suffer from reduced access to medical care, being disproportionately at risk of the adverse effects of resource reallocation which affects provision of care relating to SRH (including access to ante and postnatal care, contraception and safe abortion), and SGBV. The diversion of attention and resources away from SRH and SGBV services may result in exacerbated maternal mortality and teenage pregnancy, and increased incidence of HIV and STI transmission. Reports from IRC/ CARE International and UN Women further address the secondary health and socio-economic impact of COVID-19 for women.

In efforts to combat Ebola in the DRC, attention and resources were diverted away from health facilities providing essential non-Ebola care such as vaccination, leaving already vulnerable groups more susceptible to preventable diseases such as measles and cholera. Since January 2019, there have been over 6,200 deaths from measles.

The first surveillance reporting forms used during the DRC Ebola outbreak response lacked key, gender-specific information (pregnant or breastfeeding, socio-demographic information), which limited analysis and understanding of response impact. In addition to disaggregation by age and sex, surveillance forms and data, as well as vaccination forms, must capture data on occupation (considering roles such as traditional healer, pharmacist), socio-economic status, and whether a woman is pregnant or breastfeeding (two separate indicators). In low- and middle-income countries (LMIC) information on HIV, TB, malnutrition status should be considered. Without this data from onset, key explanations in outbreak trends could be missed.

Theme 4: Understand and Monitor the perception of response actors and activities (government (including healthcare workers); INGOs; UN)

What do we want to know?

- The history between communities and response (government, national and humanitarian) actors in intervention areas
- Whether response interventions and priorities match those of the communities
- Which interventions and actors are trusted and viewed positively, and why?
- Community perception of response actors and activities, and the outcomes that they anticipate and desire from the response (positive and negative)
- Community perceptions of and engagement with response actors and activities to ensure that the right, trusted groups are included, and that the response is perceived in ways which ensure and facilitate acceptance
- Changes in dynamics between healthcare workers and communities
- Any perceived changes (loss, reduction, increase) in humanitarian assistance, and if yes how are they perceived (e.g. resented)

Why do we want to know this?

From the first months of the DRC Ebola outbreak, analysis reported perceptions that response actors had been absent from the humanitarian crises faced prior to Ebola, and that priorities of the Ebola response seemed to differ from those of the communities, creating distrust. Response measures were perceived to restrict liberties and were often imposed with use of force and sanctions, thus further fuelling distrust.

Communities must be able to positively engage with, and trust response actors and their activities in order to generate impact. This was a challenge during the DRC Ebola outbreak, where many communities were quick to mistrust all parties involved in "Ebola business". Links to two CASS studies highlighting community mistrust may be found as links under the following subject headers: contact tracing, Ebola treatment centre (ETC). For any progress to be made in a COVID-19 response, communities need to be on board, involved during the planning and implementation of a bottom-up approach to prevention and control.

Theme 5: Language, social norms, social network and communication analysis

What do we want to know?

- What communication channels, formats, and methods are accessible, used and trusted in the communities? (Variations in age, gender, literacy level, socio-economic status)
- What languages are preferred and used by different gender and age groups?
- How do social structures and traditional gender roles impact access and exposure to different communication channels? (Previous studies show that women have specific information needs, and ways in which they would like it communicated (studies one, and two).
- What information sources are available, accessible, accessed and trusted by community members? (Different target groups: children, adolescents, women, men, elderly)

Why is this important?

Two studies were conducted by Translators without Borders (TWB) in the DRC during the Ebola outbreak showing that the appropriate use of language in local dialects is essential to communicate with local communities. The use of a language that people do not fully understand creates confusion and distrust. Literacy levels must also be considered, as there may be instances where pictures and diagrams as well as audio are more appropriate communication methods.

In addition, an understanding of existing community and household social structures, as well as trusted information sources are essential prerequisites for the design and development of IPC measures. This should help highlight influential communication channels and language to play a central role in information dissemination.

How should language be considered in studies?

1. Studies should seek review by language experts and always be conducted in local language(s) by male and female research staff fluent in these languages
2. Studies (also on other topics) should include four language questions to close the gap in humanitarian data on language
3. All communication materials should be reviewed by study language experts (these can be community members) and field-tested to mitigate the use of sensitive language

How can we collect the information?

Under COVID-19 movement and physical distancing restrictions, as much as possible, all interviews should be conducted by telephone. To ensure that this does not limit participation, the following should be considered:

- Ensure that all phone calls and contact costs are incurred by research teams
- When calling, communicate the estimated duration of the questionnaire/ survey and offer to call at another time if more convenient
- Confidentiality: ensure that all calls are conducted by research teams in private spaces with minimal background noise, and permission is sought if the interview is recorded or notes taken
- Data collection methods should follow appropriate ethic approval procedures within each country

Both quantitative and qualitative data should be collected to address each of the recommended research questions. Specific data collection methods will be elaborated on in any new study terms of reference, and may include the following:

- Questionnaires with healthcare workers to explore remarked changes in access (Likert scale scoring 1-5), with space to expand on answers qualitatively

- Real time monitoring through questionnaires (Likert scale scoring 1-5) with women from high-risk groups to highlight health facilities perception and access changes
- Cohort studies (qualitative and/ or quantitative) with specific community groups to provide cross-sectional analysis of e.g. changes in perception and access of health services over time, evolving knowledge of disease and perception of response actors (this should include young women and mothers)
- Telephone interviews with individuals in households (numbers generated at random, and through snowball sampling (method currently employed in IPC behaviour and perception study).
- Telephone interviews with HCWs at selected MoH facilities (those most likely to be exposed to COVID-19 cases through their work, or usually required to care for high risk/ vulnerable patients)
- Qualitative data collected through in-depth interviews and focus group discussions with random or purposively selected individuals from vulnerable and low risk groups in communities to provide explanation for causes of changes in perception and access

How this data can and could be used

Data relating to changing trends in HSB may be used to influence and mitigate, with immediate action, any negative impacts on health service access and availability associated with COVID-19 response policies. Knowledge of perceived barriers and their causes, in addition to corresponding qualitative data providing some explanation for these causes, is integral to facilitating the removal of these barriers. Options, depending on capacities for interventions, may include setting up localised clinics, facilitating transport, ensuring communication on the availability and safe access to services. All further analyses conducted by the CASS may be used to improve and influence COVID-19 responses and ensure that programmes and interventions are making evidence-based decisions. Connections and partnerships with other organisations and UN agencies will be created to ensure that recommendations are taken on board and acted upon.

The Social Sciences Analysis Cell- CASS: contact and brief development

If you have a direct request concerning the CASS, regarding a brief, tools, additional technical expertise or remote analysis, or should you like to be included in CASS research, network, partnerships or team, please contact the CASS by emailing Simone Carter (scarter@unicef.org) and Jerome Pfaffman Zambruni (jpfaffmann@unicef.org). Key contributing CASS members include GOARN Research (nina.gobat@phc.ox.ac.uk), Anthrologica (oliviatulloch@anthrologica.com), MSF-Epicentre (Pascale.LISSOUBA@epicentre.msf.org), HHI (ppham@hsph.harvard.edu; pvinck@hsph.harvard.edu), Gillian McKay from LSHTM (Gillian.Mckay@lshtm.ac.uk), TWB (christine@translatorswithoutborders.org), ITM (WVDamme@itg.be, vvanlerberghe@itg.be), IFRC (ombretta.baggio@ifrc.org), NOVETTA (roneill@novetta.com)