

CELLULE D'ANALYSE EN SCIENCES SOCIALES | CASS

Social Science Support for COVID-19: Lessons Learned Brief 3

Humanitarian programme
recommendations for COVID-19 based on
social sciences evidence from the DRC Ebola
outbreak response

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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:

Brief 1: Social Sciences Research questions we should be asking in humanitarian contexts under COVID-19

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](#).

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 3: Humanitarian programme recommendations for COVID-19 based on social sciences evidence from the DRC Ebola outbreak response

This brief was developed for actors working “on the ground” in outbreak response in humanitarian programmes and contexts. It **addresses recurrent programme recommendations, including strategies, interventions and activities, which resulted from social sciences analyses** conducted by the CASS during the Ebola outbreak in the DRC (2018-2020), **and how these could be considered in COVID-19 programme development (interventions and strategies).**

Evidence-based humanitarian response recommendations

Recommendation 1: Invest in health systems strengthening and the protection of healthcare workers

Evidence from the Ebola Response

According to analyses, approximately 5% of all positive Ebola cases during the Ebola outbreak in the DRC were HCWs. Additionally, CASS qualitative studies on [community perceptions and utilisation of health services](#) and [traditional practitioners](#) suggest that families in the DRC may visit several different types of health facility (e.g. a traditional practitioner, health post, health centre, or hospital), for a single illness³, potentially putting more health workers at risk of exposure to infection through these visits.

In the DRC context, traditional practitioners are particularly trusted by communities, and for certain illnesses are the first point of entry into the healthcare system by many families. A CASS study on [traditional practitioners](#) during the Ebola response in the DRC found that many traditional practitioners felt underrepresented in response activities, including a lack of involvement in training and infection prevention and control (IPC), which left them feeling unable to protect themselves or their patients from Ebola. Despite this, traditional practitioners remained a primary healthcare choice for many individuals and there is [some evidence](#) indicating high incidence of nosocomial transmission as well as Ebola cases which passed through traditional practitioners.

A CASS study on [Ebola infections among children under 5](#) also highlighted an insufficiency of personal protective equipment (PPE) at health facilities throughout the DRC Ebola outbreak, particularly amongst HCWs coming into contact with children. This was particularly concerning given the [epidemiological evidence](#) highlighting that as of January 2020, children under 5 comprised [15% of the total confirmed Ebola cases](#). Additional studies on [nosocomial infections](#) and [IPC in health centres](#) also reported that despite the risk of Ebola transmission for children under 5, IPC measures were not followed during consultation and treatment of those seeking care in community clinics. Parents of child cases reported an insufficiency of beds for patients, over-crowding, water shortages, and a lack of PPE for health care workers.

Why health systems strengthening is important for the COVID-19 response

The novel coronavirus which causes the disease Covid-19 is so far thought to be more infectious than the Ebola virus⁴, and may in addition, unlike Ebola, [be spread](#) by those who are [asymptomatic](#). This puts HCWs (including traditional healers and informal health providers) at greater risk of infection if not properly protected, given the health seeking practices of the population [outlined above](#). Furthermore, if existing healthcare facilities lack the necessary and appropriate IPC measures (as is the case in the DRC and many Sub-Saharan African countries), they are at risk of becoming a source for COVID-19 nosocomial transmission. Sufficient healthcare capacity and resources should be available to ensure uninterrupted provision of non-COVID care, including routine vaccination and reproductive health services.

How to incorporate health systems strengthening into the COVID-19 response

- Reinforce and invest in existing healthcare facilities (limit building [parallel structures](#) that fail to reinforce [what already exists](#)), including informal facilities (e.g. traditional practitioners)
- Provide PPE and IPC and training on use for all HCWs (including traditional practitioners) and cleaners (including systematic follow-up to ensure proper usage)
- Work with existing health systems (through the MoH) to identify appropriate mechanisms for COVID-19 referral structures

3 Multiple facilities were often visited if patients continued to present symptoms, or if there was a belief for better care elsewhere. As well, depending on the perceived cause of the sickness (e.g. if it were first believed to be poison and later believed to be malaria, the type of facility visited would vary).

4 The reproduction rate (Ro) for [COVID-19 is 5.7](#) is over four times the Ro for [Ebola of 1.3](#)

Recommendation 2: Invest in clear, adaptive and responsive communication

Evidence from the Ebola Response

Using correct images and information in local languages that respond to people's questions:

Throughout the DRC outbreak, a [lack of understanding of symptom of Ebola](#) was found to have multiple negative impacts. For the first 10 months of the response, posters and communication materials presented severely sick individuals haemorrhaging and vomiting. However, in reality, during the early stages of Ebola infection, the sick present symptoms similar to malaria, including fever, muscle pain and headache. Communities found the messaging around symptoms to be confusing and lacking in coherence. This was compounded by the use of technical and [unfamiliar vocabulary](#) and a lack of support for communication in [local languages](#). Several studies found that this [caused distrust](#) amongst communities in accepting referrals to the Ebola Treatment Centre (ETC), in willingness to accept safe burials, and accusations of [false diagnoses](#) and of “Ebola business”⁵ (Ebola alerts in exchange for money). [Feedback from IFRC](#) found similar community distrust caused by a lack of correct communication on symptoms. Comprehension and uptake of prevention information were low where people felt their questions were met not with [answers](#) but only with instructions about the behaviour to adopt. Some individuals and communities rejected information provided in terms that were perceived as harsh and disrespectful.

Communication on trials (vaccination):

Potentially due to the experimental nature of the Ebola vaccine, communication tools on vaccination and inclusion and exclusion criteria during the response were not developed. The response lacked any material to explain ring vaccination or the different phases in “experimental” vaccine development; processes which were often difficult to explain, and understanding was low as a result. Further, vaccination consent forms were not well-adapted to the local context (they were written in French, English or academic-level Swahili), and [often misunderstood](#) and therefore distrusted. [Quantitative CASS studies](#) suggest that communities felt they had a lack of knowledge on [vaccinations](#). In [several surveys](#), communities reported that there was “too much” information about Ebola in general, yet, that [response teams were unable to address the questions the communities were raising relating to vaccination](#). This lack of clarity seemed to fuel distrust and rumours about the vaccine (how it worked, that it was dangerous, who received it etc.).

Why clear, adaptive communication is necessary for the COVID-19 response

Clear, adaptive and accountable communication means addressing the questions that matter to communities and those affected by an outbreak. It also means ensuring that communication means and methods are adapted regularly to meet information needs and respond to rumours. Information should be provided in the right local language and using the preferred format and delivery platform for different groups. Early symptoms of COVID-19 may be confused with other illnesses such as malaria and flu, in addition to Ebola. This emphasises the importance of clear communication on the different response and behaviours required for each illness, particularly for communities

who have been heavily exposed to messaging around illnesses with similar symptoms. The experience from Ebola has highlighted the need for information and communication (including mechanisms and audiences) to evolve, responding to changes in community needs and the outbreak itself.

There is a need to ensure coordination among different community feedback mechanisms run by different organizations to address people's questions and concerns in a timely and concerted manner- a failure to do so from the beginning of the response may have contributed to the failure to earn the trust of affected communities from the onset.

How to incorporate clear communication into the COVID-19 response

- Provide information on the disease as soon as possible before rumours start to spread
- Engage with any rumours rather than dismiss them, to try to understand their origins and undermine them with improved messaging
- Consolidate and streamline messaging to avoid having contradictory information from multiple sources
- Provide detailed information in easy to understand language on all symptoms in the appropriate local languages, making comparatives to other symptoms and illnesses to facilitate understanding, in methods that communities prefer
- Prepare standardised and jointly agreed answers for potential questions from communities based on feedback mechanisms, and update these in response to information about changing questions and concerns
- Provide clear information for affected communities about response interventions and activities in a pro-active and consistent manner, supporting information about what to do with explanations of why it is necessary
- Be transparent with the community in terms of the limitations of information or response strategies
- Set up mechanisms to adapt and change communication based on needs (feedback mechanisms) and avoid relying only on print materials which require regular adaptation (cost implications)
- De-sensationalise (normalise and de-dramatise) the disease by comparing it to other similar illnesses. This includes removing references to: “this disease kills” from communications and using positive, “can do” messages that reinforce social solidarity.
- Anticipate any misgivings to the response, such as providing justification for prioritizing Coronavirus over other epidemics such as Measles
- Field-test communication tools before dissemination to avoid unintended confusion or misunderstanding

5 Throughout the outbreak, the large-scale international response, spending millions on has often been perceived as a business which has [fueled distrust in interventions](#)

Recommendation 3: Importance of using trusted response workers

Evidence from the Ebola Response

Evidence from [CASS studies](#) during the DRC Ebola outbreak suggests that communities had more trust in response teams and HCWs who were recruited locally, from their community or region, and who spoke the same language. [A qualitative study](#) conducted by CASS on the trust between communities and health workers since Ebola suggests that confidence in diagnoses and test results was related to the test being conducted in a local healthcare facility and by a known and familiar healthcare worker. Unlike normal healthcare services, Ebola testing was carried out in Transit Centres (TCs) or ETCs. Despite being centrally located, ETCs remained foreign concepts, and were often distrusted by many communities and families. They were largely operated by international or non-local HCWs unknown to the community, a factor which contributed to a loss of confidence in diagnoses and fed the spread of misinformation within and between communities.

Community distrust of Ebola response workers is perceived to have resulted in numerous attacks on response workers and [resistance to response activities](#), specifically regarding safe and dignified burials, decontamination, being [transferred to the ETC](#), and vaccination.

Why it is critical to have trusted response workers in the COVID-19 response

As COVID-19 is a novel disease, gaining the trust of at-risk and affected communities will be necessary in order to ensure their cooperation and engagement with IPC measures, and to limit the adverse health and socioeconomic consequences of the outbreak. It will be essential to recruit local HCWs who are well-known and trusted by their communities, as well as community members themselves to participate in communication and sensitisation programmes. It is important to work through traditional and religious leaders, as opposed to outsiders, to ensure local knowledge and buy-in, to build trust, to undermine rumours, to avoid an alienating top-down approach, and to ensure communication to the population is conducted in the local dialect.

How to ensure trusted response workers are incorporated into the COVID-19 response

- Use social sciences and rapid studies to understand and map trusted sources and mechanisms for COVID-19 information
- Recruit locally (minimise international staff, or staff from different regions of the same country)
- Ensure the inclusion of trusted leaders (informal leaders, youth, women, religious leaders)
- Work through existing health care structures
- Build up the capacity of local HCWs, hygienists and community health workers (CHWS) (IPC, vaccination, health promotion etc.)

Recommendation 4: Ensure inclusive health and outbreak monitoring for all age groups (including children)

Evidence from the Ebola Response

[Epidemiological evidence](#) from the DRC Ebola outbreak found that children under 5 comprised an important and higher than expected number of cases. As of January 2020, children under 5 represented [15% of the total confirmed cases](#), a percentage higher than compared to [data](#) from the [West African](#) outbreak. [Epidemiological analysis](#) from the DRC found that children were [less likely to be listed as contacts](#), and when listed, less likely to be followed up by contact tracers, when compared to adults. Children under 5 (who were confirmed cases) were also less likely than adults to be transferred to an ETC, when they presented at a health centre. [Analysis](#) suggests that children under 5 may have had specific exposure to Ebola infection, including through high risk behaviours at both community and health facility level. At the community level, families would avoid vaccination and surveillance teams, avoid health centres with a triage, and often practice self-medication. Parents of child cases also reported witnessing an insufficiency of beds for patients, over-crowding, a lack of water, and a lack of PPE for HCW⁶ which may have contributed to nosocomial infection.

Additionally, both [parents and HCWs expressed difficulty in recognising Ebola symptoms in children](#), as what they observed were not what they considered to be typical Ebola symptoms (“wet” symptoms such as vomiting, bleeding or diarrhoea). Furthermore, one of the most reported symptoms amongst adults is pain. Young children experiencing pain would be less able to express their symptoms to parents or doctors, which may have further contributed to challenges in case diagnoses.

Why age inclusion is necessary for the COVID-19 response

As the DRC Ebola response demonstrates, disease outbreaks can affect different age groups in different ways. Current [COVID-19 evidence](#) suggests that the elderly are at greater risk of severe infection requiring hospitalisation. However, it will be important to look at other age groups as well, especially young children, to understand their specific vulnerability and risk factors (including social vulnerabilities and secondary impacts of the outbreak). It is also important to consider that children may become exposed to other illnesses which could be overlooked or misdiagnosed due to the attention being placed on COVID-19. During the Ebola outbreak, children under 5 were most likely to become infected from inside a healthcare facility, and while children may be less at risk of COVID-19, the risk of nosocomial infection for other illnesses remains. Evidence from CASS studies during the DRC Ebola outbreak highlights the critical importance of considering age from the offset in response planning and implementation and ensuring that no potentially vulnerable groups are neglected⁷.

How to incorporate age inclusion into the COVID-19 response

- Collect age disaggregated data
- Closely monitor age groups within epidemiological trends (including non-COVID health data)
- Collect and monitor symptoms by age groups
- Ensure communication on the virus and IPC measures are delivered in an age-appropriate manner
- Provide clear information on age-specific differences in and difficulties to diagnose symptoms

⁶ This study found that, children under five were most often infected inside healthcare facilities

⁷ Early into the DRC Ebola response, children were not considered at risk of contracting Ebola, and infection rates were not monitored

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 (jpgaffmann@unicef.org). Key contributing CASS members include GOARN Research (nina.gobat@phc.ox.ac.uk), Anthrologica (oliviatalloch@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)