PERC

Partnership for Evidence-Based COVID-19 Response

RESPONDING TO COVID-19 IN AFRICA:

USING DATA TO FIND A BALANCE

PART II

Six months in, the indirect impacts of COVID-19 take a toll on health, social and economic outcomes

African Union

AFRICA CDC
Centres for Disease Control and Prevention
Safeguarding Africa's Health

Ipsos

NOVETTA

RESOLVE TO SAVE LIVES

Vital Strategies

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

WORLD ECONOMIC FORUM

World Health Organization

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Executive summary

Six months into the COVID-19 pandemic, governments have had to make tough decisions about how best to protect the public's health first and foremost, while also safeguarding livelihoods and reducing the social harm that can come with bringing many society activities to a near halt. Generally, African Union (AU) Member States have confirmed fewer cases per capita compared to other regions of the world. Reported cases peaked in late July and early August—driven by the epidemic in South Africa—and have since tapered off; however, data on testing capacity indicates many cases are going undetected. This report—which is the second in the Partnership for Evidence-Based Response to COVID-19's (PERC) "Responding to COVID-19 in Africa: Using Data to Find a Balance"—analyzes multiple data sources to help governments as they navigate the pandemic, which does not yet have an end date in sight.

A PERC survey (conducted in 18 AU Member States between 4 and 17 August 2020) found high support for PHSMs. Most respondents also reported adherence to wearing a mask, washing hands, and watching their distance from others, reported adherence to measures that restrict economic activity and limit public gatherings were much lower. This is expected, as many governments have loosened these measures since June. However, the survey uncovered tension between respondents' desire to reopen the economy and anxiety about how doing so could affect their health.

Close to half of respondents in need of care missed or delayed health services, and a similar percentage reported difficulty accessing medication. Nearly a quarter attributed missed services to worry of catching COVID-19, either in travel to their destination, or directly from the health facility. Seven in 10 respondents reported that their household income in the previous week was smaller compared to the same time last year, and the same proportion reported problems accessing food in the previous week.

RECOMMENDATIONS

1. **Strengthen data collection for swifter, more effective action.** Governments' ability to manage this pandemic and other health threats for the long term will depend on their ability to collect core information about cases, as well as the virus's impact on access to health care unrelated to COVID-19 and its effect on food insecurity and income loss. Governments must collect consistent data on health care worker COVID-19 infections, mortality and recovery rate.

2. **Continue tailoring PHSMs to balance containing the pandemic with minimizing burdens on the population.** Personal protective measures—wearing a mask, washing hands and watching distance—are low cost and have high acceptance and high impact. These measures are critical in controlling the outbreak while reopening the economy.

3. **Increase health facility capacity to maintain essential health services and engage communities to restore demand.** Governments and international partners must do more to protect health care workers by increasing the availability of personal protective equipment (PPE) and training on infection prevention and control (IPC), as well as health care worker access to testing. And through risk communication, community engagement, and improvements in health care services, governments must encourage people to seek the necessary care.

4. **Prioritize evidence-based measures to increase food security and economic recovery.** Governments should take steps to alleviate food insecurity through cash transfers, or, where these are not feasible, direct food support, with a particular focus on the lowest income households and vulnerable populations. Governments must prioritize deep, sustained measures to support the economic recovery of their people. Where there are existing social insurance and social protection systems, relief efforts should leverage them.

5. **Address misinformation and continue to build trust.** Governments should engage community and religious leaders to understand misinformation that is circulating and then work with them to address it by sharing consistent, simple, evidence-based messages through these trusted messengers.

About this report

This report was produced by the Partnership for Evidence-Based Response to COVID-19 (PERC), a public-private partnership that supports evidence-based measures to reduce the impact of COVID-19 on African Union (AU) Member States. The aim of this report, and the partnership in general, is to help governments determine the acceptability, impact and effectiveness of public health and social measures (PHSMs) for COVID-19, including their secondary impacts on health, food security and the economy.

The report draws on findings from a telephone poll of more than 24,000 adults in 18 AU Member States (conducted between 4 and 17 August, 2020) as well as social, economic, epidemiological, population movement, media and security data. Briefings on each of the 18 AU Member States are available at: https://preventepidemics.org/covid19/perc/.

This is the second regional report in PERC's "Responding to COVID-19 in Africa: Using Data to Find a Balance" series; PERC's first regional report, published in May 2020, similarly combined multisectoral data, including findings from a survey conducted in 28 cities across 20 AU Member States.[1] Since the first report, PERC has published a series of biweekly updates, which can also be accessed at the link above.

PERC PARTNER CONTRIBUTIONS

The African Union, through the Africa Centres for Disease Control and Prevention (Africa CDC): Provides overall technical and ethical oversight; data collection, analysis and ownership; product review and final clearance; dissemination and promotion of PERC guidance; support to AU Member States to adapt PERC recommendations.

Resolve to Save Lives, an initiative of Vital Strategies: Provides overall technical oversight and project implementation; development of PERC dashboard and analytical plan; implementation of opinion polls, including survey design, data analysis and reporting; production of PERC reports and guidance; support to AU Member States to adapt PERC recommendations.

World Health Organization (WHO): Provides technical leadership and capacity building support; ensures new evidence is quickly adopted by and shared among Member States. WHO will leverage the close links with a range of United Nations agencies at the country and regional level to promote multisectoral action to mitigate socioeconomic impact at the country and regional level through United Nations agencies.

UK Public Health Rapid Support Team: Development, dissemination and promotion of PERC guidance; support to AU Member States to adapt strategy according to evidence.

World Economic Forum (WEF): Provides overall project management support; partnership engagement; distribution of PERC guidance through WEF platforms.

Ipsos: Provides survey implementation; collects "big data" related to population movement; development of the dashboard for PERC reporting.

Novetta Mission Analytics: Provides analysis of traditional and social media narratives.

[1] Partnership for Evidence-Based Response to COVID-19. (September 2020). Responding To COVID-19 In Africa: Using Data To Find A Balance. Retrieved from https://preventepidemics.org/wp-content/uploads/2020/05/PERC_Regional_5-6-2020.pdf

METHODOLOGY

This report, and the accompanying AU Member State briefings, combine data from a wide variety of sources to offer a broad picture of both the current dynamics of COVID-19 in Africa and the impacts, both economic and social, that measures to slow the spread have had on people, families and communities.

Epidemiological data: Africa CDC provided epidemiological data on cases and deaths and testing data for the period 15 February 2020 to 10 September 2020.

Surveys: Ipsos conducted telephone interviews with 24,041 adults aged 18+ in 18 countries from 4 to 17 August 2020. The questionnaire was developed by Resolve to Save Lives, Ipsos and members of the PERC consortium. Samples were drawn to be nationally representative of each AU Member State; weighting was applied by gender, urban/rural and geographic region to align the final data with the population.[2]

Media monitoring: Novetta Mission Analytics analyzed traditional news as well as Twitter and Facebook posts from sources in Africa that were related to public health and social measures (PHSMs) from 1 May to 17 August, 2020. Media monitoring and analysis captures the views and opinions expressed by a subset of the population that is actively engaged in public debates and discussion through online and social media. These data are qualitative and are not intended to be representative of the views of the wider population.

PHSMs and other government measures: Data on PHSMs were drawn from ACAPS's COVID-19 Government Measures Dataset and the Oxford Coronavirus Government Response Tracker. Data on economic relief measures was drawn from these sources as well as the World Bank's "Living Paper" on Social Protection and Jobs Responses to COVID-19.

Mobility data: PERC analyzed data collected by Google from its account holders, focusing on visits to recreation and retail locations[3] from 1 March to 10 September, 2020.

Incidents of unrest and violence: PERC analyzed data on security incidents collected by the Armed Conflict Location & Event Data (ACLED) Project[4] from 1 March to 30 August, 2020.

For full details on data sources and methods, see https://preventepidemics.org/wp-content/uploads/2020/05/PERC_DataSources.pdf.

[2] The percentages reported in Ipsos charts may be different from percentages reported in other PERC products and communication of this data. Differences may be reconciled by investigating the denominator used, as indicated in each instance of use.
[3] Google COVID-19 Community Mobility Reports. (2020). See how your community is moving differently due to COVID-19. Retrieved from https://www.google.com/covid19/mobility/
[4] The Armed Conflict Location & Event Data Project (2020). Disaggregated Data Collection, Analysis & Crisis Mapping Platform. Retrieved from https://acleddata.com/#/dashboard 12
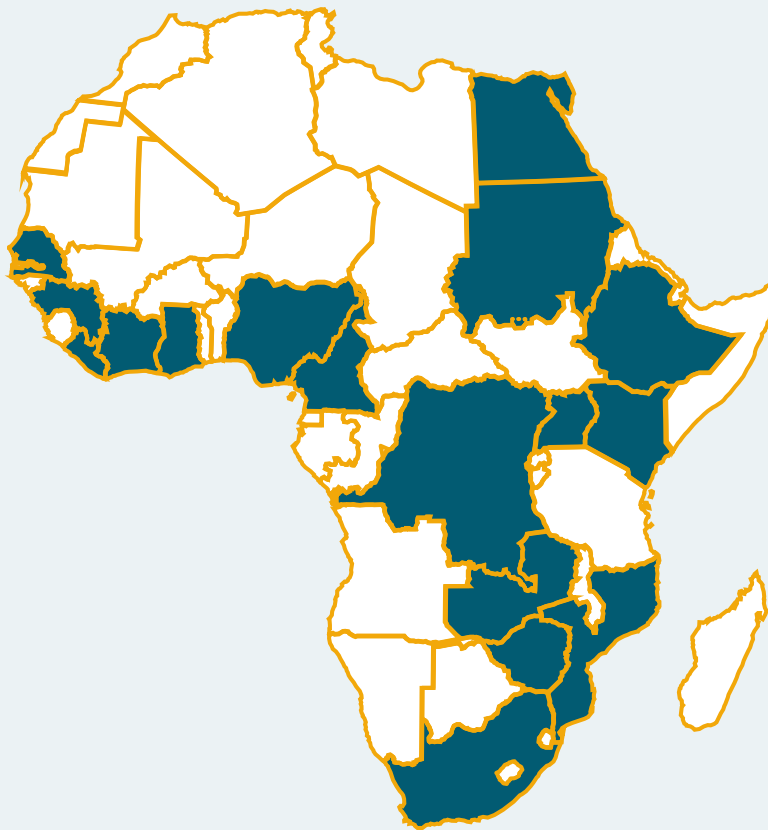
GRAPHIC 1

18 AU Member States Surveyed

|	
Cameroon	Mozambique
Côte d'Ivoire	Nigeria
DRC	Senegal
Egypt	South Africa
Ethiopia	Sudan
Ghana	Tunisia
Guinea	Uganda
Kenya	Zambia
Liberia	Zimbabwe

Update on epidemic and response

The trajectory of COVID-19 across Africa remains uncertain

Since February, when Egypt reported the first case of COVID-19 in Africa, AU Member States have reported COVID-19 epidemics of vastly different intensities. The total number of reported cases per capita and current trends in new cases vary widely: in the month of August, Liberia reported a total of 2.32 new cases per 100,000 people, while South Africa reported over 230 per 100,000 people.

Many AU Member States experienced an exponential growth in cases much later than countries in other regions and have consistently confirmed fewer cases per capita.[5] The case-fatality ratio (CFR) for COVID-19 in Africa is lower than the global CFR, suggesting disease outcomes have been less severe among African populations. Scientific understanding of the virus is still evolving, and many variables may contribute to this difference, including population density and age distribution, governments' experience with previous outbreaks, prevalence of non-communicable diseases, and even prior exposure to coronaviruses. Moreover, capacity to detect COVID-19 plays a major role in the number of new cases and deaths reported.

Some countries may be experiencing more extensive outbreaks than reported. Governments that report COVID-19 data infrequently or inconsistently, or that lack the supplies (e.g., testing kits and reagents) or personnel to conduct sufficient tests may be missing many COVID-19 cases. Any definitive assessment of the trajectory of the pandemic across Africa is also muddied by the lack of data on the indirect effects of the epidemic, such as access to and utilization of health services for non-COVID-19 care, food insecurity and income loss.

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[5]   Resolve to Save Lives (2020, August 26). Update on COVID-19 in Africa. Retrieved from https://preventepidemics.org/covid19/science/insights/update-on-covid-19-in-africa/
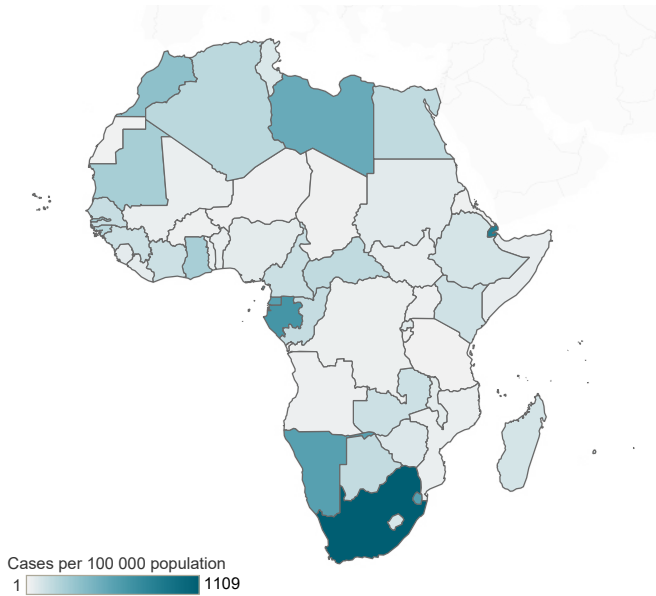
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GRAPHIC 2

Cases per capita are highest in South Africa, which accounts for more than half of all reported cases in Africa.

Cumulative cases per 100,000 people by country in Africa as of 10 September.

Cases per 100 000 population

1   1109
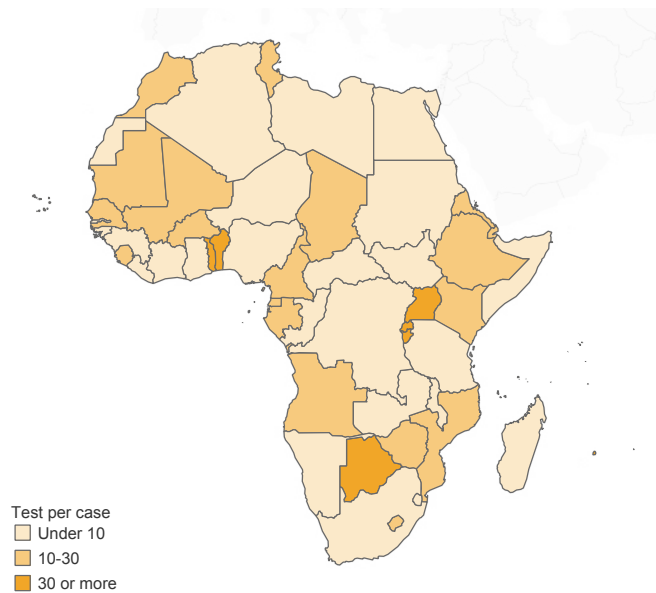
GRAPHIC 3

A majority of AU Member States report fewer tests per confirmed case than WHO's recommended benchmark.

Tests per confirmed case ratio across Africa as of 10 September; WHO recommends 10-30 tests per confirmed case as a benchmark of adequate testing.

Test per case
- Under 10
- 10-30
- 30 or more
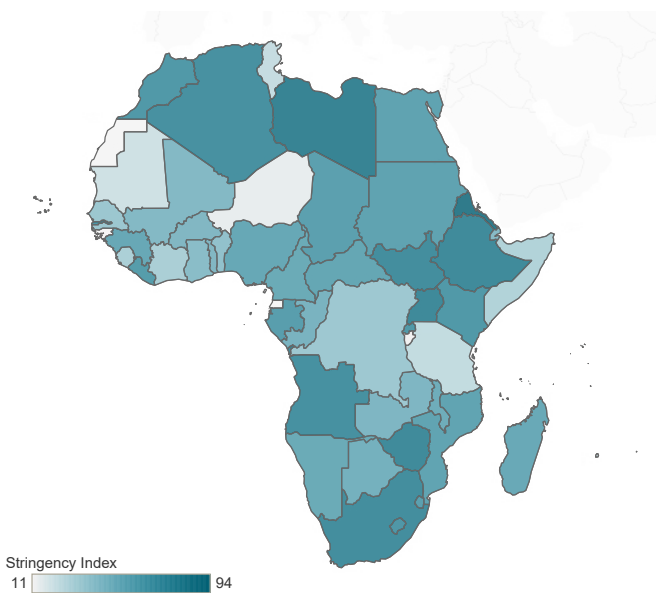
GRAPHIC 4

Even with recent relaxing of some measures, most AU Member States continue to have numerous PHSMs in place.

The Oxford Stringency Index is a composite measure based on nine indicators, which include school closures, workplace closures, and travel bans, which are rescaled to a value from 0 to 100 (100 = strictest). This map shows stringency as of 10 September and does not indicate how strictly PHSMs are enforced.[6]

Stringency Index

11   94

[6]   For more information on the Stringency Index, visit https://www.bsg.ox.ac.uk/research/research-projects/coronavirus-government-response-tracker.

Countries are using PHSMs to balance lives and livelihoods

Even before they had identified their first cases, most AU Member States swiftly implemented PHSMs ranging from recommendations to abstain from handshakes and increase hand-washing, to more restrictive measures, such as government-enforced cancellation of sports matches and religious gatherings. The most stringent measures included closing businesses and schools and issuing stay-at-home orders and curfews. PERC's first report on Using Data to Find a Balance—which surveyed respondents in 28 cities between 29 March and 17 April—found that although support for PHSMs was generally high, measures that limited economic activity were less accepted.

With strict PHSMs implemented early, AU Member States were largely able to contain the virus between March and May. Minor loosening of PHSMs in June and July coincided with an increase in reported cases across the continent (Graphic 5); however, the epidemic rapidly grew in South Africa (Graphic 6). The average stringency across all states has continued to decrease gradually.
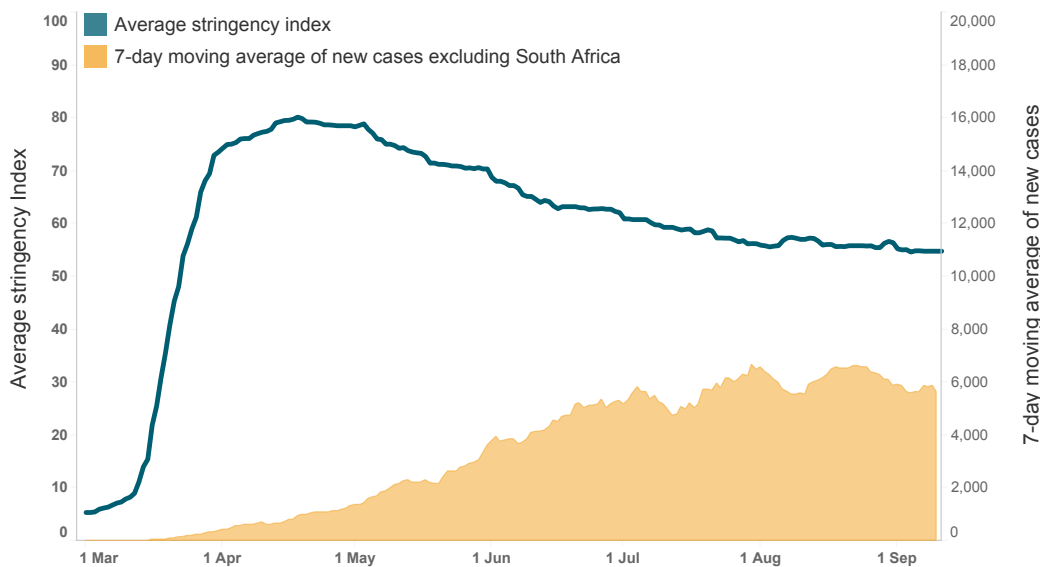
GRAPHIC 5
Average stringency index and 7-day moving average[7] of new cases across all of Africa (excluding South Africa)
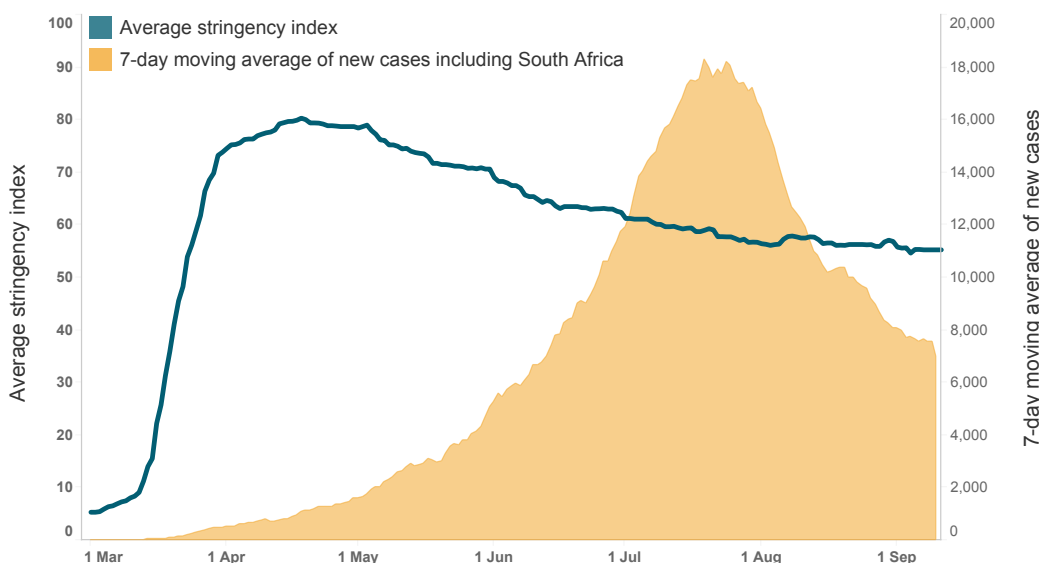
GRAPHIC 6
Average stringency index over time and 7-day moving average of new cases across all of Africa (including South Africa)

[7] Using the 7-day moving average is the best way to see the trend overtime, controlling for inconsistencies in data reporting.

Mobility rapidly decreased following the implementation of PHSMs in March and April, and has been increasing since May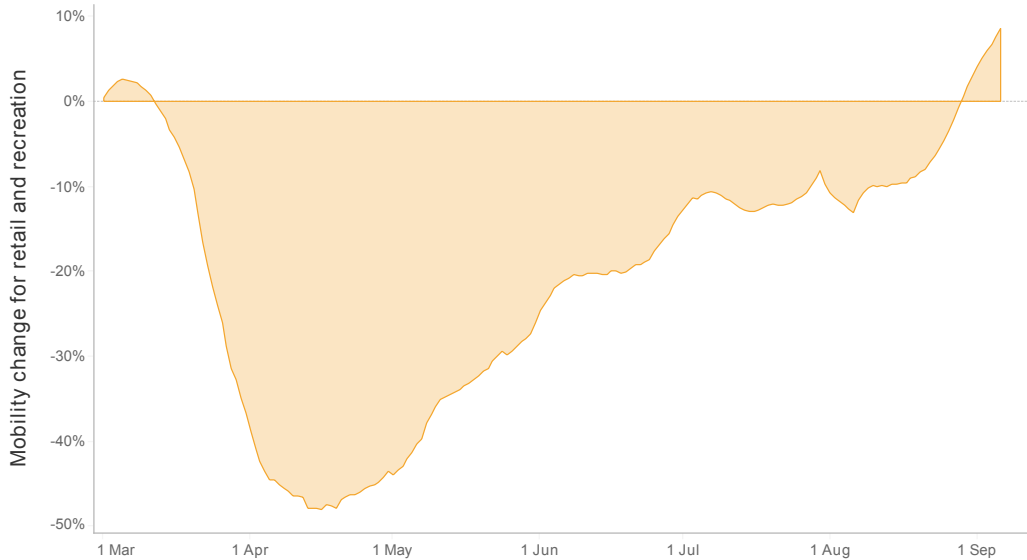 as PHSMs were relaxed. As of 10 September, the 7-day average change in mobility is near or above pre-COVID-19 levels in countries with available data.

GRAPHIC 7

7-day moving average of mobility change for retail and recreation between 1 March and 10 September. The baseline is 15 February, representing pre-COVID-19 mobility. Note: this does not control for seasonality and only includes analysis of 27 countries with available data on mobility.

Link here for list of AU Member States used for analysis

PHSMs likely slowed the spread of the virus, but their economic and social costs were substantial. Many governments have since loosened restrictions, allowing some economic activity to resume while maintaining face mask mandates and capacity limitations (e.g., in restaurants, on public transportation). However, in the face of rising caseloads, some countries have reinstated certain measures (see Box 1). Many have avoided returning to full lockdowns by targeting measures to the local context, for example, by limiting them to geographic areas experiencing more severe outbreaks, or to groups that are particularly vulnerable to disease. As the epidemiological situation continues to evolve at both national and local levels, taking a flexible approach to implementing PHSMs is important, as well as communicating frequently—and transparently—with the public about why certain PHSMs are required given the current status of the epidemic.

BOX 1

AU MEMBER STATES ARE ADAPTING PHSMS TO FIT THEIR CURRENT EPIDEMIOLOGICAL STATE.

- After lifting its national lockdown in April, **Rwanda** focused on controlling local transmission by imposing local lockdowns in high burden areas of Kigali.

- In **Côte d'Ivoire**, after ending bans on public gatherings in May, the country reinstated capacity limitations in June to curb growing caseloads.

- **Kenya**, **South Africa** and **Zimbabwe** all reported rising cases once lockdowns were lifted, which prompted reinstatements of national lockdowns and extensions of curfew policies.

# Support for PHSMs is high, but self-reported adherence is mixed

Public support for PHSMs is still relatively high in the 18 AU Member States surveyed by PERC. Though this suggests that most people have basic knowledge of COVID-19 and the measures that can prevent its spread, self-reported adherence to these measures was much lower among respondents.

Self-reported adherence was highest in AU Member States with stringent PHSMs (e.g., Uganda) and/or a high incidence of COVID-19 (e.g., South Africa), and lowest in countries with fewer PHSMs in place (e.g., Tunisia). Most followed a similar pattern: support for and self-reported adherence to personal measures[8] were higher than for measures that restrict economic activity[9] and public gatherings.[10]

A majority of respondents (85%) reported wearing a face mask in public in the previous seven days, but a lower share (60%) said they avoided religious gatherings and only half reported staying home instead of going to work, school or other regular activities. Lower self-reported adherence to public gatherings and economic measures is expected, as most AU Member States have relaxed stay-at-home orders, and many have allowed religious services to resume so long as people adhere to mask-wearing and the number of attendees is limited.

Low adherence to economic measures is consistent with increased food insecurity and income loss uncovered in this survey; many people have no choice but to return to work to survive. Safeguarding people as they return to work will require adherence to low-cost, high-impact personal measures, which may mitigate the need for more restrictive measures in the future.

Self-reported adherence is much lower than than support for most PHSMs, particularly for measures that restrict economic activity.
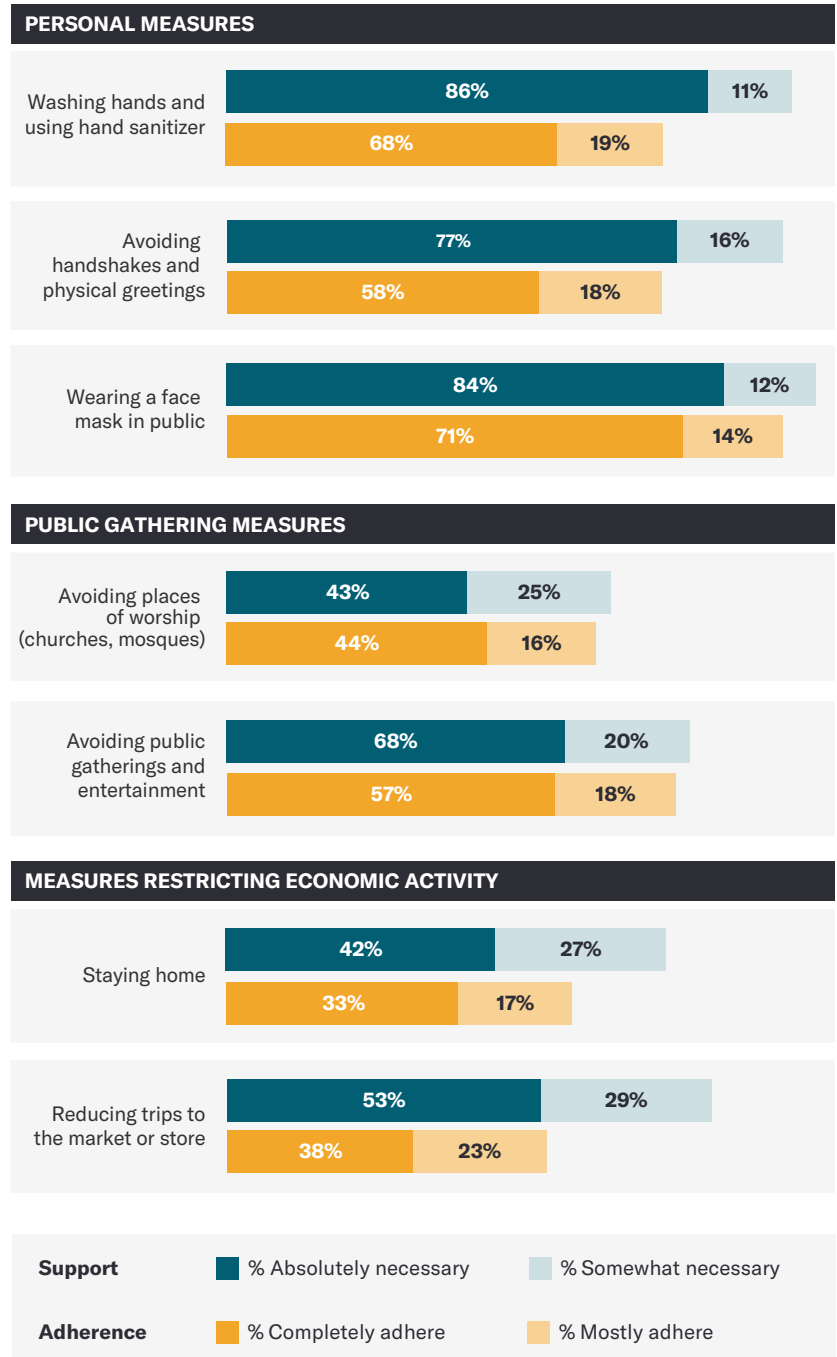
GRAPHIC 8

Percentage of respondents that reported the specified PHSM is absolutely/somewhat necessary (support) and, separately, percentage of respondents that said they completely/mostly adhered to the specified PHSMs in the previous week (adherence).

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8   Personal measures include washing hands, wearing a mask and avoiding physical greetings.
9   Measures that restrict economic activity include staying home from work, school or other activities, as well as reducing trips to the market.
10 Measures that restrict public gatherings include avoiding public gatherings, places of entertainment, and religious services.

BOX 2

SUPPORT FOR AND SELF-REPORTED USE OF FACE MASKS IS HIGH ACROSS AU MEMBER STATES SURVEYED.

Masks are an effective and relatively inexpensive way to slow COVID-19 transmission and prevent death.[11] All AU Member States require people to wear face masks in public (except for Sudan, where mask-wearing is only recommended), and some impose fines for failing to do so. While self-reported adherence to mask-wearing was relatively high overall, there are marked differences between AU Member States: 97% of respondents in South Africa reporting wearing a mask in the previous week, while only 48% of respondents in Tunisia did.

As the pandemic continues to evolve, ensuring that people continue to wear masks—and know where, when and how to wear them correctly—will remain critical to limiting the transmission of the virus.

96% of respondents have masks ready to wear
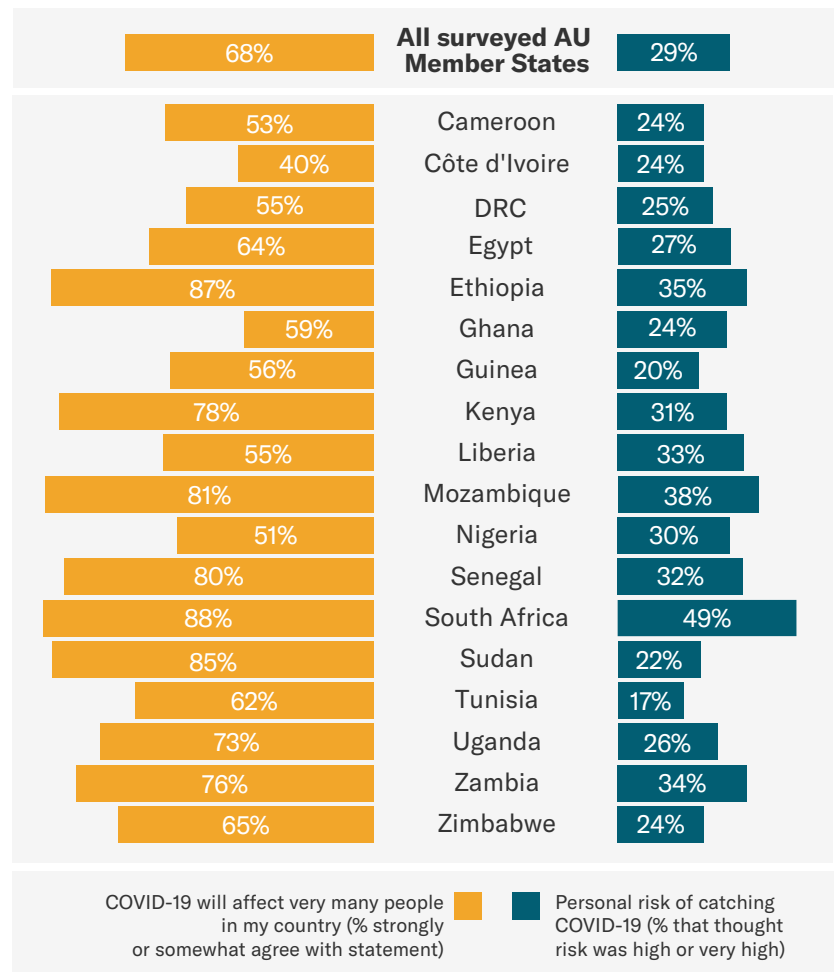
85% of respondents wore masks in previous week

GRAPHIC 9
Percentage of respondents that reported they have a mask and wore it in the past week (adherence)

Risk perceptions are evolving

As is the case in any outbreak, people's understanding of their personal risk of catching COVID-19 (their "personal risk perception")[12] affects how likely they are to support and engage in preventive behaviors.[13] The survey found that while more than two-thirds of respondents agreed that many people in their country would be affected by COVID-19, less than one-third (29%) believed their own personal risk of infection was high. A notable outlier is South Africa, where nearly half of respondents (49%) said their risk of catching the virus was high (the higher caseload in South Africa may had led to a heightened awareness of the virus).

GRAPHIC 10
Percentage of respondents that report their risk of catching the virus is high/very high and that strongly/somewhat agree who COVID-19 with affect very many people in their country.

Most respondents thought COVID-19 would be a major problem for their country, but thought their risk of catching it was low.

	COVID-19 will affect very many people	Personal risk of catching COVID-19
All surveyed AU Member States	68%	29%
Cameroon	53%	24%
Côte d'Ivoire	40%	24%
DRC	55%	25%
Egypt	64%	27%
Ethiopia	87%	35%
Ghana	59%	24%
Guinea	56%	20%
Kenya	78%	31%
Liberia	55%	33%
Mozambique	81%	38%
Nigeria	51%	30%
Senegal	80%	32%
South Africa	88%	49%
Sudan	85%	22%
Tunisia	62%	17%
Uganda	73%	26%
Zambia	76%	34%
Zimbabwe	65%	24%

COVID-19 will affect very many people in my country (% strongly or somewhat agree with statement)

Personal risk of catching COVID-19 (% that thought risk was high or very high)

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[11] Chu, D. K., Akl, E. A., Duda, S., Solo, K., Yaacoub, S., Schünemann, H. J., ... & Hajizadeh, A. (2020). Physical distancing, face masks, and eye protection to prevent person-to-person transmission of SARS-CoV-2 and COVID-19: a systematic review and meta-analysis. The Lancet. Retrieved from https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31142-9/fulltext

[12] People's beliefs in their personal risk can be dynamic through the course of an epidemic, increasing and decreasing depending on reported epidemiological data, shifts in media focus and trust in governments. People may also report low beliefs in their personal risk because they believe they are taking the proper precautions to prevent them from contracting the virus.

[13] Brewer NT, Chapman GB, Gibbons FX, Gerrard M, McCaul KD, Weinstein ND. Meta-analysis of the relationship between risk perception and health behavior: the example of vaccination. Health Psychol. 2007;26(2):136-45.

The survey also uncovered tension between respondents' desire to open the economy and concern about how doing so could affect their health. Six in 10 respondents agreed that the health risks of COVID-19 are minimal if social distancing rules are followed, and agreed the economy needs to be reopened. But seven in 10 said that thinking about resuming normal activities made them feel anxious. As a whole, the data suggest that people across the AU see COVID-19 as a serious threat, but that for many, the economic and social burdens of PHSMs may outweigh their personal risk perception of catching the virus.

BOX 3

NEGATIVE MEDIA COVERAGE CRITICIZED GOVERNMENTS FOR HARSH ENFORCEMENT OF MEASURES AND ALLEGED CORRUPTION.

30% Positive Coverage	**48.5%** Neutral Coverage	**24.5%** Negative Coverage
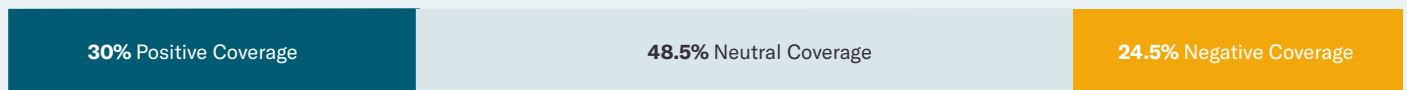
GRAPHIC 11

Sentiment analysis of traditional news and social media posts pertaining to PHSMs between 1 May and 17 August, 2020. Coverage categorized as "positive" or "neutral" typically encourage adherence to PHSMs, reports factual information, or expresses support for the government's efforts to limit transmission. "Negative" coverage typically discourages adherence or criticizes government response.

Most traditional news and social media posts originating from AU Member States about PHSMs were neutral to positive in tone (e.g., providing information about changes in restrictions or sharing resources on preventing COVID-19 spread). These findings align with the high support for PHSMs found in the survey.

However, on social media, there was some negative coverage of government COVID-19 responses and criticism of police violence in enforcement of PHSMs. In July, a Facebook user in Nigeria alleged government corruption, writing, "Do Nigerians really care about covid-19? People [are] hungry and dying in tens daily. And politicians and their cohorts seized the latest window to loot what belongs to Nigerians."

A minority of social media users voiced opposition to PHSMs, arguing that the economic burdens outweigh the risk of the virus, or highlighting that some lacked the basic necessities to adhere to PHSMs. On 7 August, a Twitter user in Zimbabwe posted an image of people waiting for water, writing, "#ZimbabweanLivesMatter... residents queueing for water. A lot of urban residents in Harare are experiencing water shortages and this is exposing them to poor quality drinking water and the risk of COVID-19."
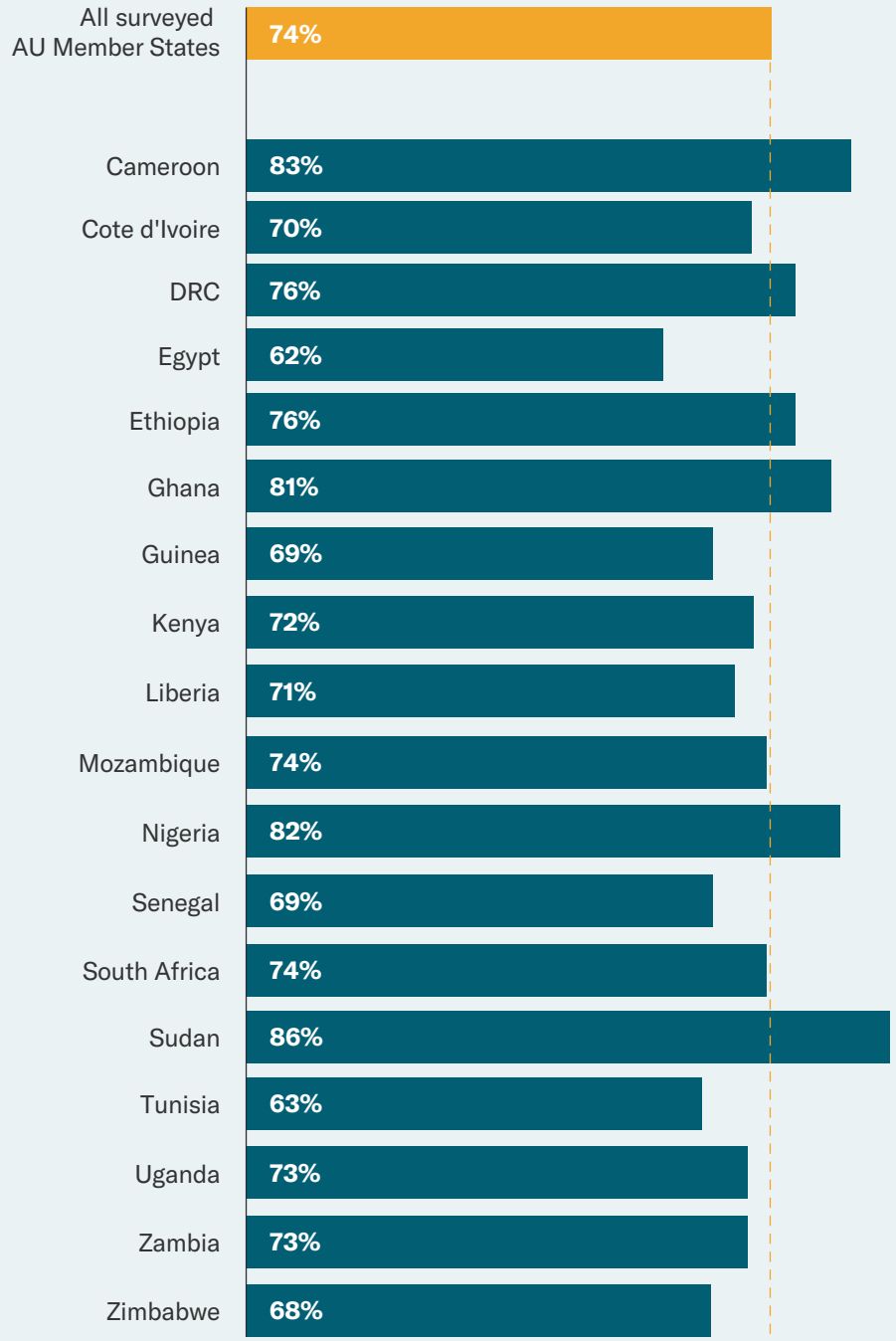
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BOX 4

MISINFORMATION IS SPREADING.

While most respondents indicated basic knowledge of COVID-19, survey data show that belief in misleading narratives about the virus is common, particularly those positing foreign interference in treatments and vaccines. About three in four survey respondents agree with either assertion that foreigners were discrediting African medicines or that foreigners were testing vaccines on Africans; skepticism toward vaccines was particularly prominent in social media posts originating in South Africa, Kenya, Nigeria and the Democratic Republic of the Congo.

A minority of posts downplayed the severity of COVID-19, comparing it to the common cold, while others deemed it a "plandemic" (a reference to a conspiracy theory that claims that COVID-19 was manufactured by the global elite in order to profit from selling a vaccine). Although Facebook, Twitter and YouTube eventually barred content related to the "plandemic" theory, the term was mentioned in more than 24,000 posts from Twitter users in Africa between 1 May and 17 August, 2020.

These findings suggest an urgent need for strong risk communication and community engagement to dispel misinformation about the virus, and to help ensure that people will adopt a COVID-19 vaccine when one becomes available.

Three-quarters of respondents found misinformation about foreign interference with COVID-19 treatments and/or vaccines credible.

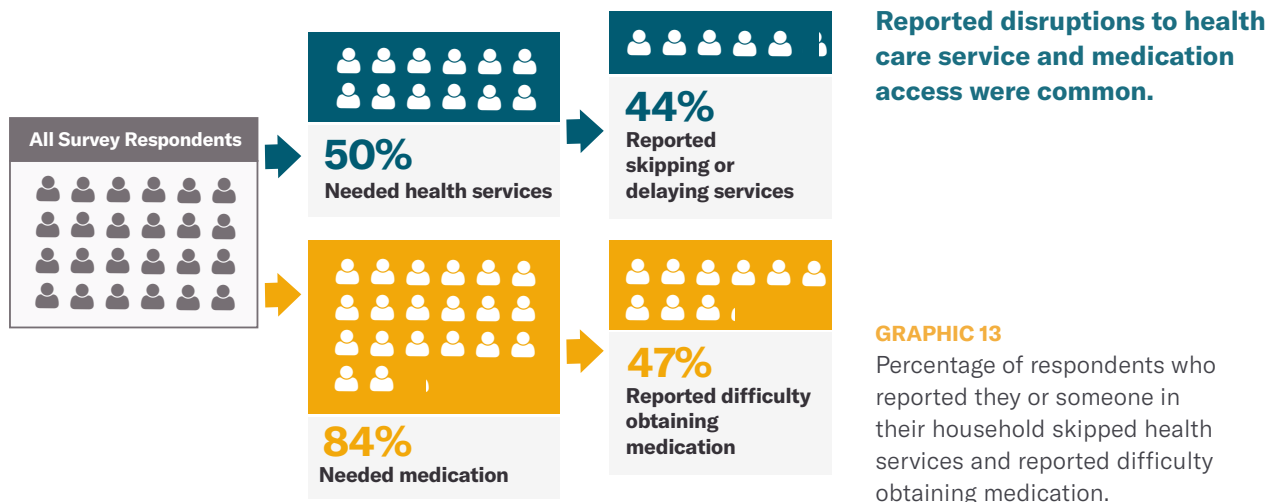|	
All surveyed AU Member States	74%
Cameroon	83%
Cote d'Ivoire	70%
DRC	76%
Egypt	62%
Ethiopia	76%
Ghana	81%
Guinea	69%
Kenya	72%
Liberia	71%
Mozambique	74%
Nigeria	82%
Senegal	69%
South Africa	74%
Sudan	86%
Tunisia	63%
Uganda	73%
Zambia	73%
Zimbabwe	68%

GRAPHIC 12

Percentage of survey respondents who believed either statement: "Foreigners are testing a COVID-19 vaccine on us" and/or "Foreigners are discrediting African medicines that could cure COVID-19"

Secondary impacts of COVID-19 and PHSMs

The secondary impact of the COVID-19 response has been significant, affecting access to essential health services, increasing food insecurity and threatening livelihoods. Data suggest that the pandemic has widened existing inequities. Effects have been most severe for already vulnerable people, such as those with lower incomes or longstanding illnesses.

HEALTH CARE

COVID-19 is preventing people from accessing needed health services for non-COVID-19 care and threatening an already scarce health care workforce. Close to half (44%) of respondents in need of care delayed or skipped a healthcare visit, and a similar percentage (47%) reported difficulty accessing medication. Nearly a quarter of respondents who delayed or deferred care attributed this to concerns about catching COVID-19, which suggests mobility limitations by themselves are not the main obstacle. Reported barriers varied significantly among countries (see Box 5), and are likely a reflection of structural and financial challenges that predate COVID-19, as well as the current scale of the epidemic and stringency of PHSMs in effect at the time of the survey. A statistically significantly higher share of urban residents reported missing or delaying care (48%) compared to rural residents (40%), which may be due to the more stringent, targeted PHSMs in cities. People with longstanding illnesses were also more likely to report challenges accessing health services and medication.

All Survey Respondents

50%
Needed health services

44%
Reported skipping or delaying services

84%
Needed medication

47%
Reported difficulty obtaining medication

Reported disruptions to health care service and medication access were common.

GRAPHIC 13
Percentage of respondents who reported they or someone in their household skipped health services and reported difficulty obtaining medication.

BOX 5

OBSTACLES TO HEALTH SERVICE ACCESS VARY SIGNIFICANTLY BETWEEN COUNTRIES.

These variations highlight the need for governments to monitor access and identify barriers at a near-local level as much as possible to implement appropriate interventions.

- One-third of respondents in **Cameroon** reported they couldn't afford health care (compared to 17% among all countries), highlighting how the economic toll of COVID-19 may be affecting health care access.

- In **Uganda**, 60% of people reported health facilities were too far or transportation was not working (compared to 14% among all countries), indicating mobility restrictions on public transportation may have impacted some peoples' ability to travel for care.

- More than four in 10 respondents in **Sudan** that reported disruptions said it was because health facilities were closed (compared to 14% for all countries); this is in line with media reports of health clinics closing due to health care worker and equipment shortages.

The types of services missed often align with the burden of disease in a given country (e.g., in Tunisia and Sudan, where rates of diabetes are high, disruptions to diabetes services were higher than in other countries surveyed), as well as the types of disease that require more frequent health visits.
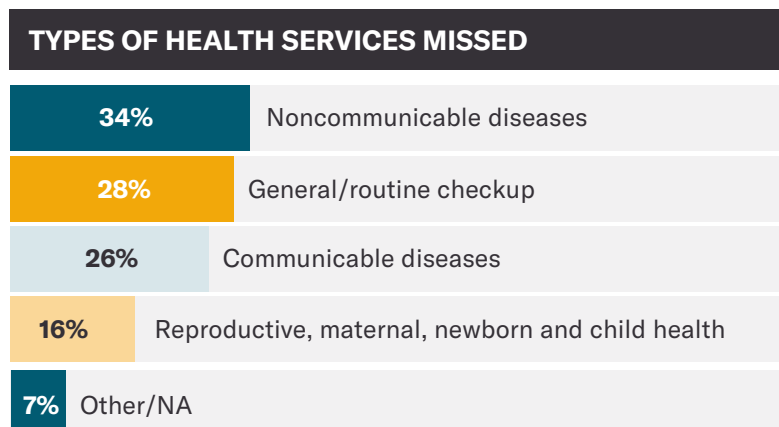
While it is unsurprising that general/routine checkups were commonly delayed or skipped (people may have chosen to wait until circumstances improved to seek non-emergency care), these visits are critical for screening and treatment for both communicable and noncommunicable diseases, as well as referrals for family planning and antenatal care. Over one-third (34%) of respondents reported they missed or delayed visits for noncommunicable disease-related issues, with disruptions to care sought for cardiovascular disease, diabetes and respiratory/asthma reported most commonly. 16% of respondents reported disruptions to reproductive, maternal, newborn and child health, with disruptions more common in countries with high birth rates (such as Uganda, Nigeria and Ethiopia).

In countries with the most reported disruptions to communicable disease care, missed visits for suspected malaria were most common; disruptions were also more prevalent in countries with a high burden of the malaria (e.g., Uganda, Cameroon and Nigeria). Overall, significant missed visits for malaria care aligned with growing reports of outbreaks across Africa. Disruptions to other communicable-disease care were less frequent, but could have major health consequences at both the individual and population level: 4% of respondents reported disruptions to vaccinations, 2% for HIV treatment, and 1% for tuberculosis..

Worried about going out/risk of catching COVID-19 at health facility	**26%**
Couldn't afford it	**17%**
Health care facilities have been closed	**14%**
Health care facility too far away	**14%**
Health care facilities too busy	**14%**
Couldn't get to health care facility due to lockdown/curfew	**14%**

Fear of catching COVID-19 and cost of services were the most common barriers to accessing care.
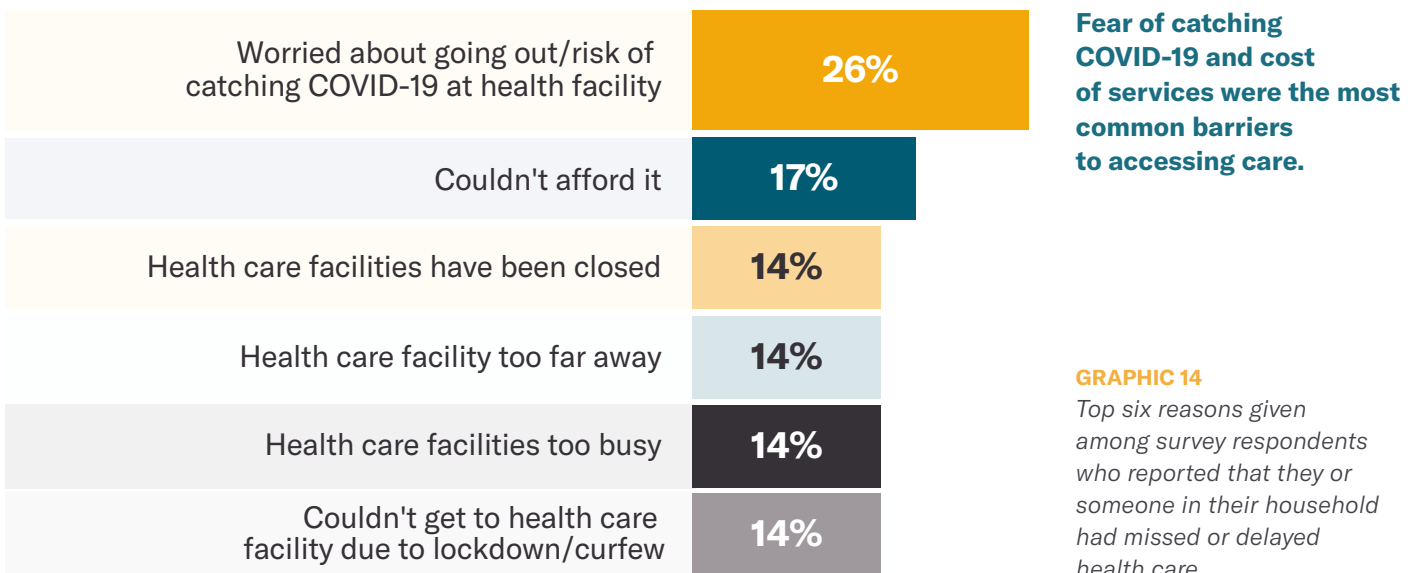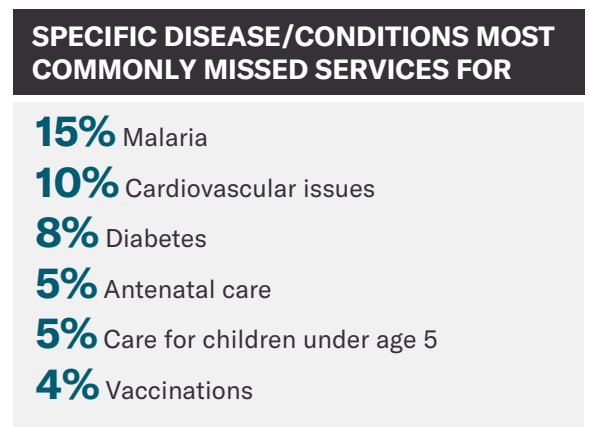
GRAPHIC 14
Top six reasons given among survey respondents who reported that they or someone in their household had missed or delayed health care.

Disruptions to services were universal across types of health care.

TYPES OF HEALTH SERVICES MISSED

34%	Noncommunicable diseases
28%	General/routine checkup
26%	Communicable diseases
16%	Reproductive, maternal, newborn and child health
7%	Other/NA

GRAPHIC 15

SPECIFIC DISEASE/CONDITIONS MOST COMMONLY MISSED SERVICES FOR

15% Malaria
10% Cardiovascular issues
8% Diabetes
5% Antenatal care
5% Care for children under age 5
4% Vaccinations

GRAPHIC 16

While only 1% of respondents reported disruptions to needed mental health services, almost one in three people reported experiencing mental health symptoms related to COVID-19. Reported rates of mental health issues were highest for those with the lowest income, people with longstanding health issues and people reporting that they or someone in their household had been infected with COVID-19. With access to mental health care in Africa low prior to the pandemic, unmet need is likely even higher now.[14]

BOX 6

IMPACT ON HEALTH CARE WORKERS

As of 9 September, AU Member States have reported nearly 42,000 COVID-19 infections in health care workers.[15] This is likely a fraction of the true caseload: many countries are not reporting data on health care worker infections. Lack of data on COVID-19 infections, mortality and recovery among health care workers obscures our understanding of health care worker safety, and makes it difficult to develop tailored policy solutions and mobilize resources to protect them. Failure to protect health care workers endangers patients as well. Superspreading events can occur in health facilities, and if health care workers are known to have high rates of COVID-19 infection, people may be less likely to seek care, for COVID-19 or for other illnesses.

An important contributing factor is undoubtedly the scarcity of personal protective equipment (PPE) for health care workers, such as masks, gloves and gowns. There are widespread reports of shortages; in many places, health care workers must risk their own lives in order to treat others. Proper infection prevention and control training is also limited, and as of 2019, one in four health care facilities around the world lacked basic water services, affecting nearly 2 billion people.[16]

The lack of protection afforded to health care workers has led to wide scale protests since the start of the pandemic: between March and August, there were nearly 300 COVID-19-related protests by health care workers across the African continent. The majority of protests demanded proper compensation for hours worked and PPE to protect health care workers from COVID-19.
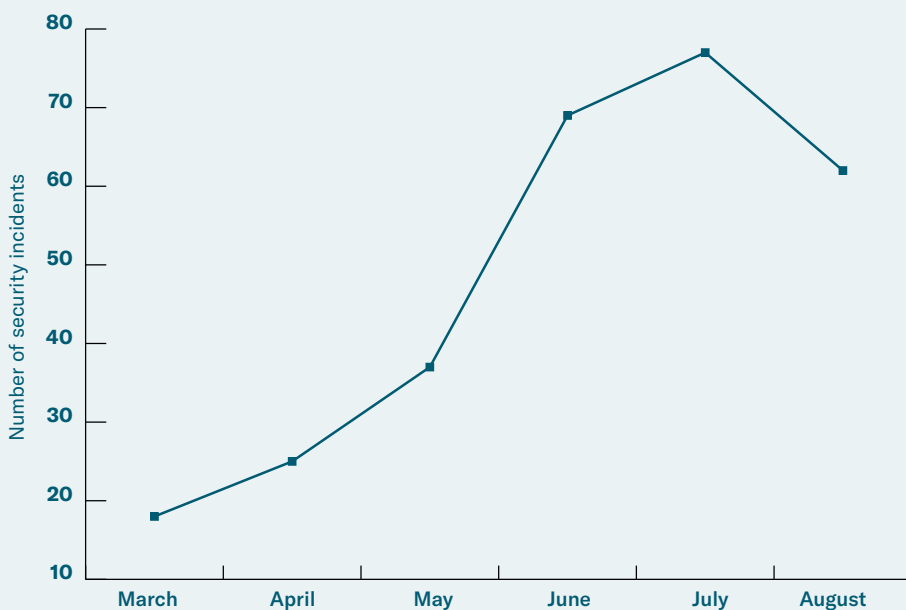
There were a total of 288 health care worker protests related to COVID-19 in Africa between March and August 2020.

GRAPHIC 17
Number of health care worker protests across Africa

14   Sankoh, S., Sevalie, S., Weston, M. Mental Heath in Africa. The Lancet: Global Health. September 2018.
      https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(18)30303-6/fulltext#:~:text=Partly%20as%20a%20consequence%2C%20the,is%2014%20per%20100%20000
15   World Health Organization, Regional Office for Africa. (2020, September 9).COVID-19: Situation update for the WHO Africa Region. Retrieved from
      https://apps.who.int/iris/bitstream/handle/10665/334234/SITREP_COVID_19_WHOAFRO_20200909-eng.pdf
16   World Health Organization. (2019, April 3). 1 in 4 health care facilities lacks basic water services – UNICEF, WHO. Retrieved from
      https://www.who.int/news-room/detail/03-04-2019-1-in-4-health-care-facilities-lacks-basic-water-services-unicef-who#:~:text=WHO-,1%20in%204%20health%20care,basic%20water%20
      services%20%E2%80%93%20UNICEF%2C%20WHO&text=One%20in%20four%20health%20care,Sanitation%20and%20Hygiene%20(JMP)

FOOD SECURITY

In May 2020, PERC's first Using Data to Find a Balance report highlighted concerns about access to food during the pandemic, with over 80% of survey respondents in some AU regions anticipating that they would exhaust their food supplies during a two-week lockdown. In the months since, food insecurity has proven a widespread problem, with access deteriorating further in some countries—particularly those already facing humanitarian or refugee crises.

Overall, seven in 10 survey respondents reported problems accessing food in the previous week; this was more commonly attributed to increased prices or lost income than to market access, food shortages or mobility restrictions. Food insecurity has risen for both urban and rural residents, and across income levels (though not entirely evenly: while 79% of the poorest households were affected, 66% of the highest income households were).

In late June, the Famine Early Warning Systems Network (FEWS NET) estimated the pandemic had coincided with a 25% increase in food assistance needs continent-wide.[17] The impact has varied geographically, likely due to local factors, including locust swarms and floods in Eastern Africa, tensions between armed groups and regional conflicts, populations of refugee and internally displaced people, and the ongoing consequences of climate change.[18] In many cases COVID-19 has exacerbated pre-existing challenges, particularly for people living in poverty in urban areas who rely on the informal sector for employment.[19] FEWS NET pointed to loss of employment and income, border closures that limit labor migration including for agricultural cultivation, and restrictions on livestock markets as main contributors.

EMPLOYMENT AND HOUSEHOLD INCOME

The COVID-19 pandemic has devastated livelihoods, with 70% of people reporting that their household income for the previous week had fallen compared to the same time last year. Because people with lower incomes are more likely to have experienced income declines, this has effectively exacerbated existing inequalities. Whereas six out of 10 households with at least US$500 in monthly income experienced declines, almost eight out of 10 households with less than US$100 in monthly income did.

While economic losses have affected all sectors and income groups, losses appear to be greater for those already marginalized.[20] In South Africa, workers with verbal contracts were twice as likely to lose jobs between February and April compared to workers with written contracts, and two-thirds of lost jobs were held by women.[21, 22] Women in Zambia have also been disproportionately affected by reductions in work hours.[23]

All surveyed AU Member States reported high levels of food insecurity and income loss.

72% Experienced any barrier to food access	
70% Experienced income loss	
14% Received government assistance	
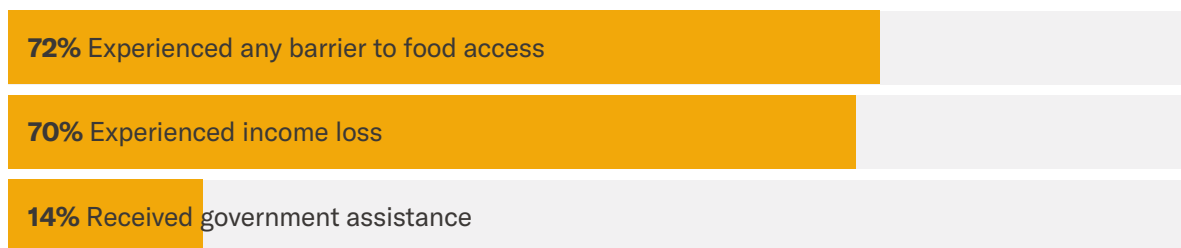
GRAPHIC 18
Percentage of respondents reporting experiencing burdens and any received government assistance

17   Famine Early Warning Systems Network (FEWS NET). (2020, June 29). COVID-19 pandemic drives global increase in humanitarian food assistance needs: Labor migration restrictions limit seasonal income earning opportunities and crop production potential. Retrieved from https://fews.net/global/alert/june-29-2020

18   Famine Early Warning Systems Network (FEWS NET). (August 2020). East Africa: Crisis (IPC Phase 3) or worse outcomes remain widespread due to multiple shocks. Retrieved from https://fews.net/east-africa/key-message-update/august-2020

19   Famine Early Warning Systems Network (FEWS NET). (2020, August 28). COVID-19 pandemic drives global increase in humanitarian food assistance needs: As internal movement restrictions ease, limitations to cross-border labor movements remain in place. Retrieved from https://fews.net/global/alert/august-28-2020

20   For example, a survey in Côte d'Ivoire found that people without work contracts were more likely to have seen their hours or earnings fall.

21   Spaull, N., Ardington, C., Bassier, I., Bhorat, H., Bridgman, G., Brophy, T., Budlender, J., Burger, R., Burger, R., Carel, D., Casale, D., Christian, C., Daniels, R., Ingle, K., Jain, R., Kerr, A., Köhler, T., Makaluza, N., Maughan-Brown, B., … Zuze, L. (2020). NIDS-CRAM Synthesis Report Wave. Working Paper Series, 17. Retrieved from https://cramsurvey.org/wp-content/uploads/2020/07/Spaull-et-al.-NIDS-CRAM-Wave-1-Synthesis-Report-Overview-and-Findings-1.pdf

22   Innovations for Poverty Action. (n.d.). Analyse de l'enquête RECOVR en Côte d'Ivoire. Retrieved from https://www.poverty-action.org/sites/default/files/Cote%20d%27Ivoire%20RECOVR%20Survey%20Analysis_French.pdf

23   https://www.poverty-action.org/sites/default/files/Zambia-RECOVR-Survey-Analysis.pdf
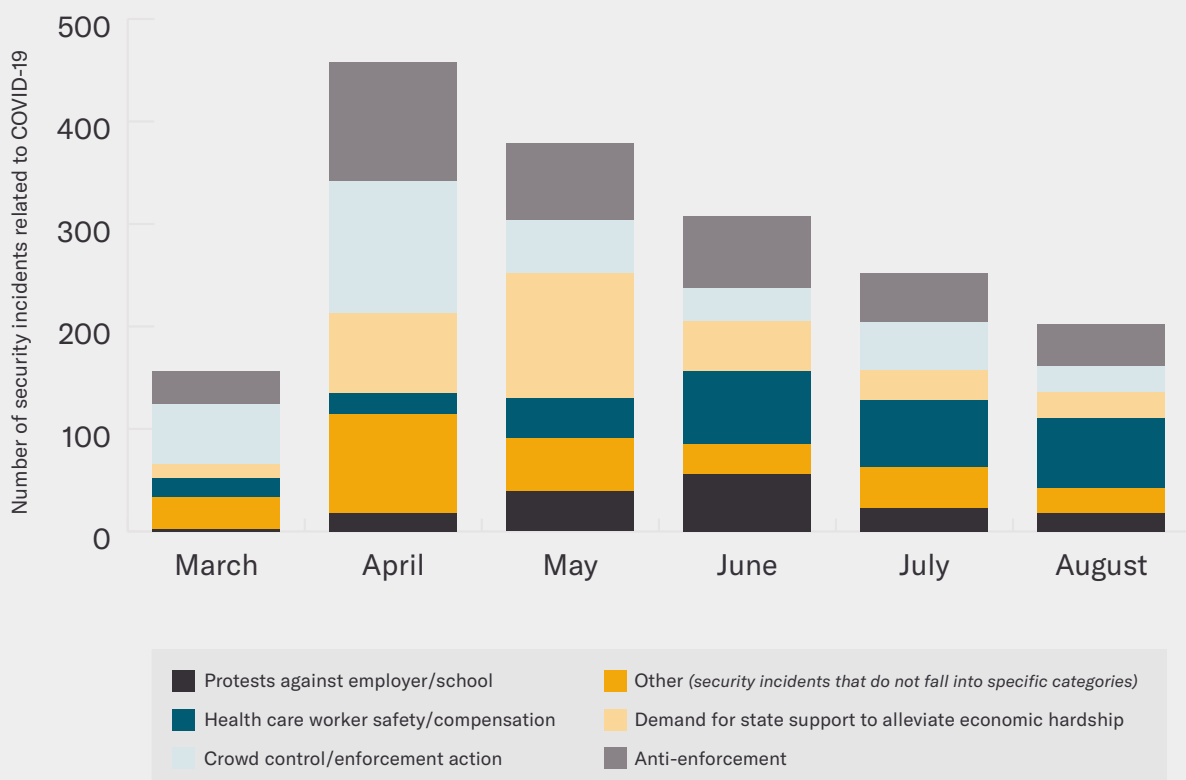
Just as income has fallen, the burden of unpaid work has increased. In PERC's survey, 38% of respondents reported their unpaid responsibilities around the household, including caring for children and elderly family members, increased as a result of the pandemic, leaving them with less time for income-earning activities. Nearly half of people (44%) in households with incomes under US$100 per month saw their responsibilities increase.

SECURITY

A rise in unrest—including peaceful protests as well as riots and violence by and against civilians—can affect adherence to PHSMs and serve as a warning sign of the burden such measures are imposing on people. From 1 March to 30 August 2020, there were more than 1,700 security incidents related to COVID-19. Incidents appeared to peak in the period from April to June, when PHSMs were most stringent; these months saw the highest number of crowd control/enforcement actions, in which state actors (i.e., police or paramilitary forces) enforced PHSMs. In a number of instances, state enforcement of PHSMs led to civilian injury and death, and protests against state violence ("anti-enforcement incidents") often followed. The total number of incidents is highest in Northern Africa (particularly Morocco, Tunisia, and Algeria), driven in large part by movements organized by economic and industrial groups demanding more government assistance.

Security incidents related to COVID-19 were highest during most stringent PHSMs in April to June.

Legend:
- Protests against employer/school
- Health care worker safety/compensation
- Crowd control/enforcement action
- Other (security incidents that do not fall into specific categories)
- Demand for state support to alleviate economic hardship
- Anti-enforcement

GRAPHIC 19
Frequency and nature of security incidents across Africa from March to August 2020.

The reach of preliminary relief measures

Governments in AU Member States have responded to these secondary impacts with relief measures, but the support offered has been insufficient.
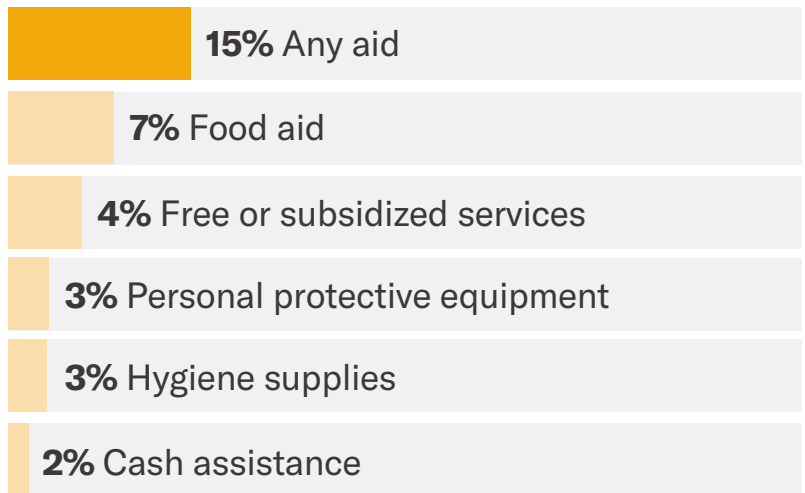
Of the 18 AU Member States included in the PERC survey, almost all had announced some form of emergency assistance to offset households' economic losses by early September. The most common measures included cash transfers, food distribution, distribution of hygiene supplies and PPE, and reduced fees for electricity, water and mobile payments.

But these measures have reached only a small share of the households that had experienced income losses. While 70% of survey respondents said their income had fallen relative to last year, only 14% reported that they had received any additional assistance from the government over the previous month.

Countries varied widely in the share of the population that reported receiving emergency support in the previous month (from 63% in Senegal and 22% in South Africa to only 3% in Mozambique). Countries that reached a higher share of their population favored measures like in-kind distribution of food and supplies or waiving fees for public utilities, which give households less flexibility in meeting their needs than would cash support.

Nor have relief measures been effectively targeted to those most in need. According to PERC's survey data, of people with a monthly household income of less than US$100, only 12% received any assistance, a statistically significantly lower share than the 16% of the highest income group that reported receiving assistance. People who experienced income losses were no more likely to have received government support than those who had not. Across many countries, there was widespread criticism in traditional news and social media that support was used as a political tool.
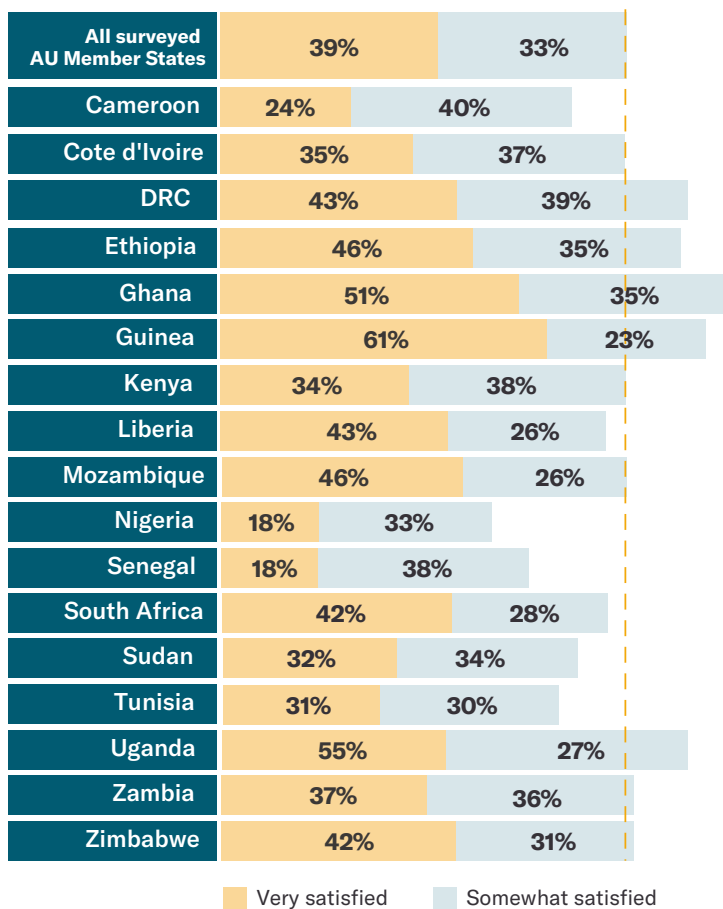
Food assistance was the most common type of aid received.

15% Any aid

7% Food aid

4% Free or subsidized services

3% Personal protective equipment

3% Hygiene supplies

2% Cash assistance

GRAPHIC 20
Percentage of survey respondents receiving government assistance in the previous month that they do not usually receive.

Almost three-quarters of respondents reported satisfaction with government response, with satisfaction higher than 80% in five countries.

	Very satisfied	Somewhat satisfied
All surveyed AU Member States	39%	33%
Cameroon	24%	40%
Cote d'Ivoire	35%	37%
DRC	43%	39%
Ethiopia	46%	35%
Ghana	51%	35%
Guinea	61%	23%
Kenya	34%	38%
Liberia	43%	26%
Mozambique	46%	26%
Nigeria	18%	33%
Senegal	18%	38%
South Africa	42%	28%
Sudan	32%	34%
Tunisia	31%	30%
Uganda	55%	27%
Zambia	37%	36%
Zimbabwe	42%	31%

Very satisfied   Somewhat satisfied

GRAPHIC 21
Percentage of respondents who were "very" or "somewhat" satisfied with government response to COVID-19

Limited data hinder effective response by governments and local authorities

Half a year into the pandemic, many governments in AU Member States are still not reporting key data necessary to understand the spread of the disease, the capacity of the health system to effectively respond to the outbreak, and related disruptions to the economy, the health system and society - potentially due to resource constraints. This limits the speed and impact of efforts made to manage their local outbreaks.

DISEASE SITUATION

Many countries are not reporting epidemiological data often enough. Key indicators are not reported systematically across the region; these include new confirmed and probable cases and deaths (broken down by age and sex), percentage of positive tests, daily hospitalization rates, and diagnostic turnaround time. This makes it difficult to understand the contours of the outbreak in a specific country as well as across the region. Proper registration of death and its related causes are necessary to report timely mortality data.
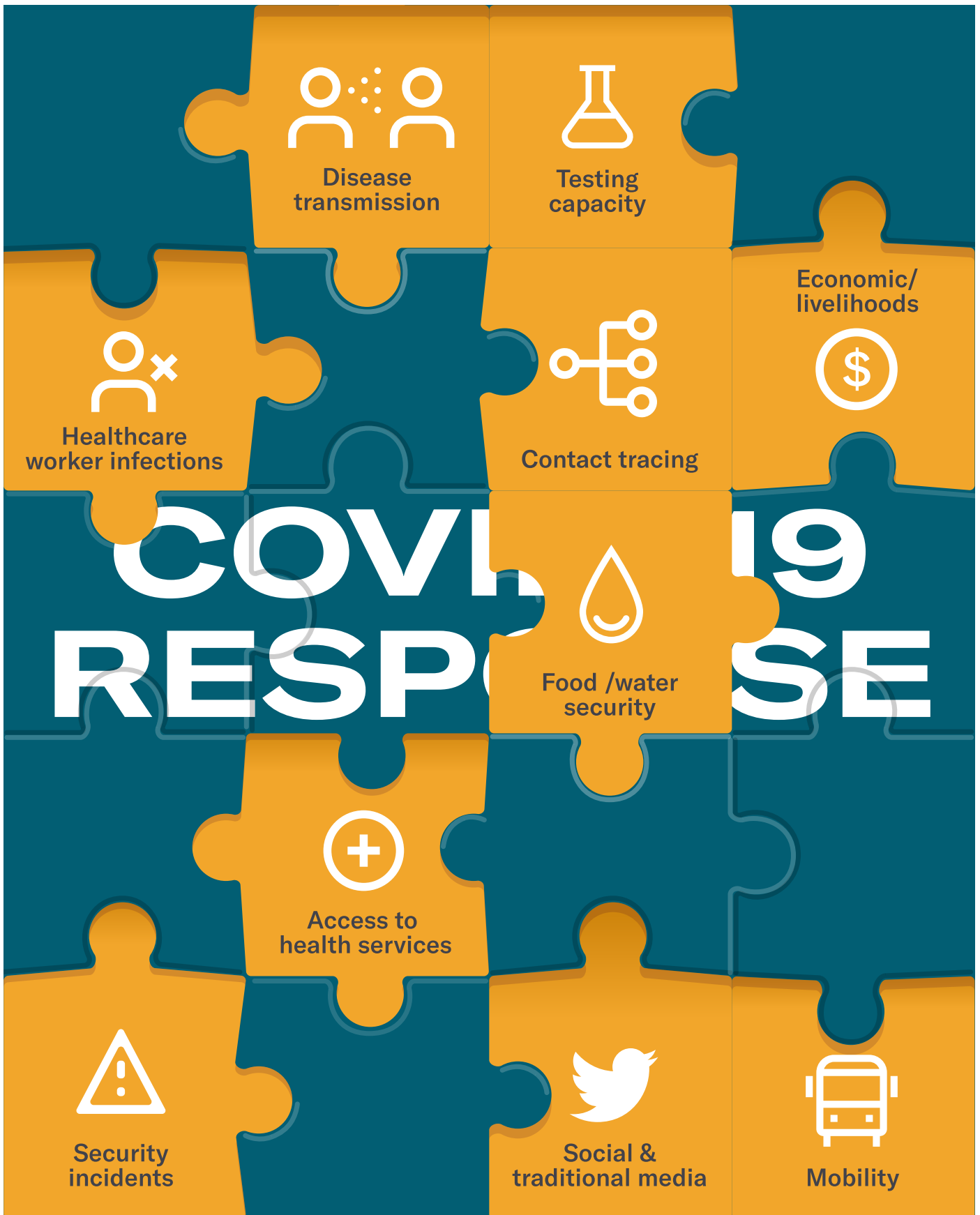
HEALTH SYSTEM CAPACITY

Data on public health and health system capacity are also frequently absent from public reports. Data missing include indicators on public health strategies such as contact tracing as well as essential functions of the health system itself, such as the COVID-19 protocols in place and IPC training at health care facilities, hospital bed utilization, and health care worker infections and death. Moreover,

there is a lack of systematic data on the effects of the pandemic on access to and utilization of health services unrelated to COVID-19, as well as disruptions to the medical supply chain.

ECONOMIC AND SOCIAL BURDEN

Data on economic and social disruptions are instrumental in understanding the secondary effects of PHSMs and how well communities can adhere to them. Of particular importance are data that would help governments to target assistance to those with the most economic and other vulnerabilities. While there are ad hoc surveys ongoing in particular countries and vulnerability analyses that rely on pre-existing data, there are few systematic efforts to dynamically track income, social stability, and access to water, food, and essential services.

The absence of these data makes it difficult to calibrate PHSMs in a way that balances lives and livelihoods. As governments start to relax PHSMs and economies reopen, having reliable, near-real-time data on rates of community transmission and adherence to preventive measures will be critical for public administrations, local authorities, business owners and workers themselves. It will also help governments decide where to focus the strictest measures and provide the most testing, despite limited resources. Limited data also means it is difficult to establish travel restrictions or quarantine measures based on a standardized understanding of COVID-19 risk by country or region.

COVID-19 RESPONSE

Disease transmission

Testing capacity

Economic/ livelihoods

Healthcare worker infections

Contact tracing

Food /water security

Access to health services

Security incidents

Social & traditional media

Mobility

GRAPHIC 22

Recommendations

Refer to resources section for more information, including specific resources from PERC partners.

1. Strengthen data collection for swifter, more effective action.

Anticipating a pandemic that could extend for many months to come, countries should let public health and evidence lead. Developing and reinforcing systems to monitor and report crucial data will not only help to guide the COVID-19 response, but will also strengthen surveillance, health and social protection systems for the future. Building on systems that are already in place, governments should identify gaps and invest in data collection, analysis and reporting that will facilitate swift, effective responses. Governments' ability to manage this pandemic and other health threats for the long term will depend on their ability to collect core information about cases, as well as the impact of the virus on access to health care unrelated to COVID-19 and its effect on food insecurity and income loss. Priorities should include:

- Core indicators about cases and the public health response, including infections and death among health care workers

- Data on utilization of health services, to measure the indirect health impacts of COVID-19

- Seroprevalence studies

- Rapid mortality surveillance

- Data on social and economic impacts

Wherever possible, governments should communicate the disease situation clearly to the public, and ensure that local decision-makers have access to needed data through suitable means (e.g., situation updates, dashboard). Having a clear picture of the pandemic in a country builds trust and may also encourage the public to maintain adherence to prevention measures even as disease prevalence begins to fall.

2. Continue tailoring PHSMs to balance containing the pandemic with minimizing the burdens on the population.

The challenge for governments during COVID-19 is to ensure that the public has an accurate understanding of its risk and manages it effectively through adherence to recommended PHSMs. In conjunction, governments must also ensure that perception of risk is not so high as to cause undue distress, including neglect of essential needs (e.g., skipping necessary health services). Key strategies for governments should include:

- Rather than rely on society-wide lockdowns, **governments and international partners must do more to "box in" the virus**, by ensuring an adequate supply of testing kits and reagents to identify positive cases, tracing their close contacts, and isolating cases. To furnish testing supplies and mobilize expertise towards this goal, Africa CDC recently launched the Partnership to Accelerate COVID-19 Testing (PACT): Test, Trace, Treat.[24]

- **Make it as easy as possible for communities to adhere to personal protective measures,** "the 3 W's"—wearing a mask, washing hands and watching distance. These measures are low cost, and have high acceptance and high impact. They are critical in controlling the outbreak while reopening the economy. Countries should ensure these laws are applied fairly, so that enforcement against non-compliance doesn't inadvertently harm vulnerable populations more than it helps them. Punitive measures should be avoided at all costs.

- **Favor those PHSMs that narrowly target areas with the highest levels of community transmission, limit non-essential gatherings, or protect higher-risk populations.** This could include retaining restrictions on large gatherings and entertainment venues. It might also mean adopting PHSMs for age groups that are most at risk. Statistical modeling suggests that such measures, combined with a robust system for testing and tracing, can reduce disease transmission with far less burden on the economy.[25]

[24] Africa CDC. (2020, June 4). Partnership to Accelerate COVID-19 Testing (PACT) in Africa – Resources. Retrieved from https://africacdc.org/download/partnership-to-accelerate-covid-19-testing-pact-in-africa/
[25] Acemoglu, D., Chernozhukov, V., Werning, I., & Whinston, M. D. (2020). Optimal Targeted Lockdowns in a Multi-Group SIR Model (Working Paper No. 27102; Working Paper Series). National Bureau of Economic Research. Retrieved from https://www.nber.org/papers/w27102

3. Increase health facility capacity to maintain essential health services and engage communities to restore demand.

The survey highlighted that governments and their international partners need to act quickly to restore access to health services for care unrelated to COVID-19 and to build back public demand for services. Every health facility must have COVID-19 protocols in place that are communicated clearly to staff (and patients) and have adequate personal protective equipment. This must be accomplished first before engaging communities to increase demand for services.

- **At the health facility level, proper equipment and basic necessities, such as water and electricity, should be prioritized**. In some AU Member States surveyed, health facilities were shuttered due to shortage of health care workers, proper equipment and supplies of medicines. Governments and their partners need to ensure that these facilities can open again, and that the staff are safe. Where resources allow and people have access to phones or internet, hospitals could explore opportunities for telemedicine.

- **Health care workers should receive special protections from governments and their international aid partners immediately**. Increasing the availability of PPE and training on infection prevention and control is essential, as well as prioritizing health care worker access to testing, COVID-19 therapeutics and an eventual vaccine (when available). Health care workers also need fair compensation for their work and proper benefits, including paid sick leave and free mental health care.

- **At the community level, governments must engage trusted community and religious leaders to encourage people to seek care for health services unrelated to COVID-19, including mental health care**. Governments should focus efforts on ensuring people know what health services are available at health facilities, and on increasing demand for the most critical services (such as immunizations, provision of lifesaving medications, emergency care, reproductive, maternal and child health care, and mental health care). Clear guidance should be provided to the public on how to access health facilities, as well as the measures taken to ensure that they, and their families, will be safe when they do so.

4. Prioritize evidence-based measures to improve food security and support economic recovery.

As much as possible, governments must limit the secondary impacts of COVID-19, which this survey has identified are major problems (and will continue to be throughout the course of the pandemic). Efforts should be focused on low-income groups and vulnerable populations.

- **To alleviate food insecurity, governments should implement cash transfer programs, or, where these are not feasible, direct food support, with a particular focus on the lowest income households and vulnerable populations**.[26] Governments should monitor markets and prices and work collaboratively to address disruptions to supply chains. The African Union and UN Food and Agriculture Organization have made protecting agriculture systems and supply chains a focus of their response, with a Taskforce on COVID-19 impact on Food Security and Nutrition in Africa.

- **Where there are existing social insurance and social protection systems, relief efforts should leverage them**, increasing the value of support and expanding programs vertically to cover people forced into poverty by the pandemic.[27] To help ensure that limited resources reach those most in need, relief measures should have transparent eligibility criteria, use delivery mechanisms that can reach vulnerable people, and build in mechanisms for independent audit, grievance and redress.

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[26] PHSMs need not interfere with food access: in early June, Mozambique coordinated the temporary closure of its markets so they could be physically reorganized for disinfection and to facilitate physical distancing measures.

[27] This enabled South Africa and Tunisia to reach a significant share of their populations; 12% and 9% of respondents reported receiving cash assistance in the PERC survey. Other countries, such as Ghana and Senegal, waived or subsidized fees for existing services that already reach a large share of the population.

5. Address misinformation and continue to build trust.

Governments should engage often and early with community and religious leaders to understand the misinformation that is circulating, and work with them to address it quickly by sharing consistent, evidence-based messages via these trusted messengers. Many of these narratives are most prominent on social media, and it is important that governments monitor Twitter, Facebook and other digital channels to identify misinformation. Vaccine misinformation narratives are notoriously difficult to correct, and communicators must be careful that efforts to correct them do not backfire. Messaging should be simple and use visual aids where appropriate, to make correct information "stick." Communication should occur early and often. Addressing misinformation now around COVID-19 vaccines will be critical to uptake when a vaccine becomes available.

Six-months into the pandemic, it is clear that the effects of the response will be felt long term; certainly on our health systems and economy, but also

Conclusion

on our communities and psyches. The survey findings on the secondary impacts of the pandemic are striking. With so many reporting income loss, food insecurity, and disruptions in access to health services, support from governments and their international partners is needed now more than ever. Support in the form of financial and technical assistance is critical, as is in halting the spread of global misinformation. In the coming months, and throughout the course of the pandemic, the PERC team will continue to release analysis of multisectoral data and share key insights on how governments can best balance this data for decision-making, while weighing the secondary impacts of PHSMs, to limit the spread of the virus.

Resources

To access COVID-19 guidelines and resources, visit the Africa Centres for Disease Control and Prevention's (Africa CDC) COVID-19 Resources page and the World Health Organization's Country & Technical Guidance on COVID-19 collection. For information on country-level data from PERC's survey and other resources from PERC, visit the PERC partnership page. You can also access the following COVID-19 resources from Resolve to Save Lives (RTSL), an initiative of Vital Strategies:

- COVID-19 Playbook

- Staying Alert: Navigating COVID-19 Risk Towards a New Normal

- COVID-19 Science Hub; COVID-19 Response Center for Cities

- COVID-10 Risk Communications Hub

More specific guidelines and resources are listed below for each recommendation.

Recommendation 1:
Strengthening data collection for swifter, more effective action

Key data to be collected should include:

- Core indicators about cases, testing and the public health response should be collected, including demographic variables such as age and sex, as well as clinical characteristics such as underlying conditions and the severity of the illness. Data should include infection, mortality and recovery among health care workers and contact tracing.

  - Africa CDC: FIND partner to build capacity for COVID-19 rapid diagnostic tests in Africa

  - Resolve to Save Lives: Essential information for states and counties to publicly report (to be adapted for local context)

  - RTSL: Guide for Analysis of Respiratory Syndromic Surveillance Data

  - The Partnership to Accelerate COVID-19 Testing (PACT): Monitoring and Evaluation Framework for the Partnership to Accelerate COVID-19 Testing

  - WHO: Guidance on conducting a country COVID-19 intra-action review

  - WHO: Technical kit on COVID-19 surveillance, case investigation and epidemiological protocols

  - WHO: Public health surveillance for COVID-19: interim guidance

- Data on utilization of health services, to measure the indirect health impacts of COVID-19.

- Africa CDC: Guidance for the continuation of essential health services during COVID-19 pandemic.

- Seroprevalence studies to gauge the overall population's exposure to the virus.

  - Africa CDC: Generic protocol for a population-based, age- and gender- stratified sero-survey study for SARS-CoV-2

  - RTSL: Estimating Excess Mortality from COVID-19

- Rapid mortality surveillance, where traditional vital records systems can't keep up with a fast-moving virus, will allow policymakers to make timely decisions based on the current trajectory of the epidemic.

  - Africa CDC: Revealing the toll of COVID-19 technical package for rapid mortality surveillance and epidemic response

- Social and economic impact data should be collected at frequent intervals to inform response decisions as well as efforts to alleviate burdens.

  - A promising approach being used by several countries (Ethiopia, Nigeria, Uganda, Burkina Faso, Malawi, Mali) in collaboration with the World Bank is to leverage an existing household survey panel to run high-frequency phone surveys.

  - The National Income Dynamics Study – Coronavirus Rapid Mobile Survey (NIDS-CRAM) in South Africa is an academic-led partnership using a similar approach.

Recommendation 2:
Continue tailoring PHSMs to balance containing the pandemic with minimizing the burdens on the population

- Africa CDC's communication materials: Simple instructions on how to wear a face mask; Community use of face mask

- Africa CDC: Guidance on community physical distancing during COVID-19

- Africa CDC: Guidance on easing lockdown

- Africa CDC: Environmental decontamination in the context of COVID-19 (for businesses, public transport, etc.)

- RTSL: Promoting mask-wearing during the COVID-19 pandemic: A policymakers guide

- Inter-Agency Standing Committee: Interim guidance on PHSMs for COVID-19 in low-capacity and humanitarian settings

Recommendation 3:
Increase health facility capacity to maintain essential health services and engage communities to restore demand

- Africa CDC: Strategies for managing acute shortages of personal protective equipment during COVID-19 pandemic

- Africa CDC: Guidance for the continuation of essential health services during COVID-19 pandemic

- Africa CDC: Guidance for mental health and psychosocial support for COVID-19

- Africa CDC: COVID-19 Infection Prevention and Control: Your Questions Answered

- Africa CDC: Hand washing facility options for resource limited settings

- WHO: Maintaining essential health services: operational guidance for the COVID-19 context interim guidance

- WHO: Tailoring malaria interventions in the COVID-19 response

Recommendation 4:
Prioritize evidence-based measures to increase food security and economic recovery

- Center for Global Development: Digital Technology in Social Assistance Transfers for COVID-19 Relief

- UK Department for International Development (DFID): Health and socio-economic impacts of physical distancing for COVID-19 in Africa

- Famine Early Warning System Network (FEWS NET): COVID-19 Pandemic Impacts on Food Security

- Innovations for Poverty Action: RECOVR Research Hub

- RTSL: Using cash transfers to mitigate the impacts of public health and social measures

Recommendation 5:
Addressing misinformation and continuing to build trust

- Africa CDC: Webinar: Misinformation around COVID-19 (EN) – Africa CDC

- WHO: Improving vaccination demand and addressing hesitancy

- WHO: Community-based health care, including outreach and campaigns, in the context of the COVID-19 pandemic

- WHO: Coronavirus disease (COVID-19) advice for the public: Mythbusters

- WHO: Risk communication and community engagement readiness and response to coronavirus disease (COVID-19)

- The Lancet: COVID-19 vaccine trials in Africa