EXECUTIVE SUMMARY

Norms, beliefs, & practices relevant to the prevention of COVID-19 in the Middle East & North Africa: a literature analysis

JANUARY 2021

Disclaimer

This technical paper is intended to disseminate analytical contributions on the risk communications and community engagement COVID-19 response in Eastern Mediterranean/Middle East and North Africa (MENA) region, which is co-led by World Health Organisation (WHO), UNICEF, and International Federation of the Red Cross (IFRC). The literature review was prepared by Anthrologica, and institutionally commissioned by UNICEF MENA regional office, Communication for Development section.

The findings, interpretations and conclusions expressed in this paper are those of the authors and do not necessarily reflect the policies or views of UNICEF and its partners.

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This literature review was commissioned by the UNICEF Regional Office for the Middle East and North Africa (MENA) to identify what may influence sustained observance to COVID-19 prevention and risk reduction behaviours in the Middle East and North Africa (MENA) and inform its work on Risk Communication and Community Engagement in response to the COVID-19 crisis.

The literature analysis was conducted by Anthrologica in May-August 2020. The research team comprised Olivia Tulloch (consultancy lead), Nadia Butler (principal author and research lead), and Soha Karam (Arabic language research lead).

Contributions were made by Anthrologica research associates Tamara Roldan de Jong and Emelie Yonally, with support from Anthrologica interns Kelilah Liu (NYU, New York) and Rama Alhariri (NYU, Abu Dhabi). Eva Niederberger, Leslie Jones and Katie Moore from Anthrologica provided support at various stages of the work.

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Executive summary

Purpose and objectives

This literature review identifies factors which may influence sustained observance to COVID-19 prevention and risk reduction behaviours in the Middle East and North Africa (MENA). The work was commissioned by UNICEF Middle East and North Africa Regional Office (MENARO). The review and its recommendations are designed to be of operational use to UNICEF and partners, and all relevant actors, with regard to the design of effective context-relevant risk communication and community engagement (RCCE) strategies, guidance and tools and to identify areas for further research, in the specific context of the Middle East and North Africa.

The review focuses on social and cultural barriers and enablers to a number of practices relating to prevention, detection and response to COVID-19. Specifically: effective hand and respiratory hygiene; physical distancing, immunisation, testing, case reporting, contact tracing, health-seeking, antenatal and PNC care-seeking, quarantine and isolation, home-based care and shielding of high-risk populations. These practices or public health measures have been variously recommended or mandated by governments and international organisations across the region. They were identified as key practices for the prevention of subsequent waves of COVID-19 as restrictions and lockdown measures are eased.

Methods and conceptual framework

A ‘structured’ review of the scientific literature was carried out and analysed using a thematic synthesis methodology. Published scientific literature relating to all 20 countries in the region was accessed in English, Arabic and French. The scientific data were complemented with grey literature, media reports and perception data to provide additional insight into current events and perspectives in the region.

The Behavioural Drivers Model (BDM) was used as a framework for conceptualising the relevant behavioural influencers. The Model groups all behavioural drivers into three main categories: psychology, sociology and environment.

Summary findings

Human behaviours can be hindered or enabled by multiple drivers: personal characteristics or psychology of the individual; social influences, norms and pressures in society; and features of the broader environment or context of which an individual is a part. Although the review focused on a large and diverse region, some patterns emerged, due to commonalities of culture, religion, state-citizen relations and displacement of peoples. These findings should be viewed as a starting point for more contextualised formative research on specific populations. A limitation of the study was a lack of published data in some thematic areas and an imbalance in the amount of data for each country, making it difficult to draw conclusions about pan-regional influencing factors.

Personal characteristics

Personal characteristics contributing to low compliance with the relevant public health measures across populations included male gender, lower education level, age (both older and younger), and rural location. In the case of gender, it was evident that men's usual social and professional or labour activities led them to leave the home more often and socialise more frequently, which had implications for distancing and quarantine. In general, studies have also found that men tend to be more prone to taking risks and less likely to adopt preventive behaviours than women. Knowledge level, in itself a predictor of compliance, had similar influencing factors to compliance levels. Lower knowledge was associated with male gender, lower education, lower income, rural location, and older age.

Context

Displacement and migration exacerbate difficulties faced by the general population in following recommended basic protective measures, including handwashing, maintaining physical distance and isolating at home, due to their often crowded and precarious living conditions. Religion featured as both an enabler and a barrier to various behaviours. While religious beliefs about disease origins and treatment can be a barrier to the adoption of certain behaviours, religious teachings in line with public health measures can be harnessed, and religious institutions have shown flexibility and adaptability in interpreting scripture in a way that is synchronised with public health requirements. In addition, populations facing multiple challenges or emergencies may not prioritise COVID-19, since the disease may be considered an insignificant threat compared to that of the hunger, poverty, homelessness and desperation they may be experiencing.

Psychology

Interest, attitude and self-efficacy featured as important drivers for many risk behaviours. People's perceived risk of a practice (e.g. risk of side-effects from vaccination, losing income as a result of quarantine) weighed against the potential gains (not getting sick, not being stigmatised) and contributed to their level of interest in carrying out the practice. People's values (such as a desire to "do the right thing"), alongside their emotions (e.g. fear of getting sick, disgust at having dirty hands) were also important influencers. In terms of their self-efficacy, people's emotional wellbeing and 'decision autonomy' contributed to their likelihood or ability to decide to take a particular action (e.g. people who relied on family members to make decisions were prevented from accessing healthcare). Awareness and knowledge were underlying drivers to all of these factors. Lower knowledge levels around COVID-19 were generally associated with lower rates of compliance. Differing understandings of disease aetiologies or lack of knowledge about infectious disease influenced behaviours around treatment and prevention for infectious diseases.

Sociology

Social influence and meta norms were key drivers for some behaviours. People were driven by social norms and social pressure to practise measures such as handwashing. Role models (whether positive or negative) were strong influencers, as were stigma and discrimination. For example, children washed their hands to avoid being stigmatised by other children, while Afghan migrants in Iran experienced reduced access to healthcare because of stigma. Meta-norms, including gender ideologies, power dynamics and moral norms were also key drivers.

For example, women in the MENA region are more likely to stay at home than their male counterparts and are also more likely to require input from family members (especially male) on decisions about their actions. This has implications for practices such as complying with quarantine or curfew, and for health-seeking. Moral norms related to religion were a strong driver, and could act as both a barrier or an enabler to certain practices.

Environment

Structural factors, including access and quality of services and resources, living conditions, infrastructure and trust in governing entities were key themes affecting compliance. Access to resources such as soap, water and sinks for handwashing or COVID-19 test kits had implications for whether people could carry out these practices. Lack of functioning or accessible health services, particularly in conflict settings, had implications for healthseeking and case reporting behaviours. Overcrowded living or working conditions, as well as overcrowding in mass prayer gatherings, had implications for distancing and hygiene, as well as people's abilities to quarantine or self-isolate. Meanwhile, the level of popular trust in the government emerged as a key theme influencing compliance with COVID-19 prevention measures. In the Gulf countries, there tends to be a high level of trust in the government. In other countries, a lack of transparency, the curtailment of free speech and the expansion of state powers in the context of COVID-19 have exacerbated historical state-public mistrust and consequently led to a disinclination of people to follow government-directed prevention measures. The communication environment, and people's access to factual and scientific information that is accurate, timely and communicated by trusted sources and though trusted media is key. Public figures, and particularly religious leaders, have often been key to promoting specific behaviours to the population. Awareness campaigns, by both governments and external cooperation, have been found to be effective in promoting certain behaviours.

Translating findings to recommendations and considerations for RCCE and further research

As restrictions to manage the pandemic have evolved, there has been tendency for people to relax and become complacent about following preventive measures. Complacency will need to be managed, and sustainable, long-term preventive practices fostered in the long term. RCCE strategies will need to continue to provide information about the level of risk and encourage people to continue to practice behaviours to protect themselves and others. Risk communication approaches and content as well as community engagement strategies will need to adapt from a context of emergency and uncertainty to one of status quo, encouraging sustainable, habitual behaviour. RCCE will need to contribute to shifting social norms and maintaining and supporting those new norms over time.

Substantial efforts have been made to share information on COVID-19 at large scale. These efforts are most effective when there is strong ***understanding of contexts, people, behaviours and practices*** including systematic measurement of behaviour change. The following recommendations have been developed from the literature review and should be considered in efforts to design RCCE strategies to contain and manage COVID-19 in countries across the MENA region. Due to the broad nature of the review, these recommendations are pan-regional, not country- or population-specific. They should be seen to be a starting point for further research that could provide more granular and nuanced consideration of issues in specific contexts.

Formative research and monitoring for strategies or interventions in some populations is needed.

The review found that available evidence was skewed towards some countries in the region and certain thematic areas. There were limited data from the Maghreb region, and the large migrant populations in the GCC. Adoption of preventative health behaviours is correlated with perceived risk of COVID-19, and perceptions of risk are also variable. For many in the region, COVID-19 is not their upmost priority and it is difficult to incorporating restrictive public health measures into their daily lives. Lower awareness and compliance with protective measures was identified in some groups. Overall men were more prone to taking risks and specific strategies should be considered to address this. While structural factors such as the need to work must be considered, it may also be useful to appeal to a sense of social responsibility, such as their role in protecting female or elderly members of their families. Specific interventions should also be designed to engage **young people** who perceive themselves to have limited risk, highlighting the risks but also incorporating the notion of social responsibility and their collective duty to protect all community members. In addition, specific attention is needed for key vulnerable groups: the **elderly**, those with **lower income** and those with a **lower education** level, **refugees, IDPs and migrant**s. People's priorities, practices and behaviours are constantly evolving and information related to this will need to be regularly updated.

Recommendations:

1. Prioritise research to fill gaps in knowledge gaps, including: i) the causes of vaccine hesitancy in the region and attitudes towards the new vaccines; ii) understanding behavioural influencers relating to detection and response measures: e.g. testing, case reporting and contract tracing, quarantine; iii) under-represented geographic and thematic areas.
2. Invest in ongoing monitoring and evaluation and acknowledge that behavioural changes are not only a result of RCCE but are also linked with the access to and quality of service delivery.
3. Complement existing survey data with in-depth qualitative research with different population groups where feasible and appropriate (e.g., in-person focus group discussions and interviews and telephone interviews as well as the existing online surveys and polls).
4. Evidence generated should then be used to develop targeted strategies for high risk and vulnerable groups: identify the level at which to interventions should be targeted (e.g. individual, household, community, broader society) and the various entry points. In some cases it may be appropriate for interventions to be multilevel and multi-pronged.

RCCE should be relevant to the target group: Understand the communication environment and harness social media.

For each target group, it is important to take time to find out what they already know, what information they are lacking and what they would like to know more about. In this way, messages will be relevant and useful and message fatigue can be avoided. Different groups have different communication preferences, social media has high penetration in some parts of the region and can effectively reach many people, yet some population groups, such as migrant workers, may have lower online access. When targeted carefully to the needs of different groups social media can have considerable potential for strengthening risk

communication and public health promotion. As well as 'pushing' information, social media can be effectively used to gather information and to conduct rapid polling.

Different groups also have diverse concerns, for example it may be important to communicate to refugees that they can access medical assistance even if they lack legal residence, while, in economically vulnerable groups it will be important to provide information to people about how they can comply with protective measures without jeopardising their livelihoods.

Recommendations:

1. Local assessments should map the communication ecosystem in conjunction with analysis of the local political economy. This should include people's favoured channels, trusted sources of information, levels of literacy, health literacy and media literacy, the ways in which different groups prefer to and are able to receive and share information.
2. Mapping should include the potential use of digital RCCE strategies as well as effective ways to communicate with population groups with low levels of digital literacy.
3. Avoid standardised interventions (e.g. broad awareness campaigns) that do not address the specific barriers or enablers relevant to a specific behaviour for a specific group of people in a specific context. Communications about risk should be as closely tailored to individual groups as is feasible.

Social norms can be harnessed to enable positive behaviours: Capitalise on best practices, identify trusted voices and work with people's faith

As well as addressing **barriers** to risk communications and community engagement, attention should be paid to **enablers** as well. In general, people behave in ways they believe to be acceptable and expected by others in their society. For example, if improving hand hygiene is the goal, it is possible to design interventions that increase the perceived social support for handwashing. Positive social norms and values can be encouraged and harnessed (such as respect and protection for the elderly), while norms that pose more of a risk, such as sharing hoses during waterpipe smoking, can be addressed by explaining the risks and proposing alternative behaviours that will be acceptable to people.

It is important to identify trusted experts and social influencers (who are often more trusted than official sources). With regard to religion, for example, Islam has strong and highly relevant teachings about quarantine, isolation, hygiene and health-seeking. Religious teachings can be harnessed to encourage people to voluntarily adopt positive behaviours in line with their faith. Religious leaders have an essential role in how people interpret and apply religious teachings. They can help to ensure that effective measures of infection prevention and control are set at places of religious congregation, within family homes, and a range of public settings.

Careful consideration needs to be given to power relations, spheres of influence and potential conflicts of interest. This is particularly important in those parts of the region where there is poor trust in the state or poor public-state relations. In some contexts, it may not be appropriate to engage with religious leaders and the religious and political context (both nationally and at the sub-national level) must be taken into account. Other successful influencers in the region included television celebrities, health workers, government officials

and peers. These stakeholders can help dispel mis- and disinformation and can be involved in constructive communication

Recommendations:

1. Develop a structured approach to document and share evidence on what has worked well (and less well) and why. It should include analysis of strategies and targeted actions that have worked at scale or have potential to work ***at scale***, as well as assessment of strategies that have been targeted to ***localised needs*** and priorities, including engagement with different vulnerable and marginalised population groups.
2. For each target group, to map the key trusted influencers and interlocutors and engage with these multiple stakeholders.
3. Craft messages from within groups, not extraneously, and with actors who have the legitimacy to speak to the group and to redefine norms or realign beliefs with practices.

People should be active agents of health prevention, detection and response: Invest in the rapid operationalisation of community feedback

It is essential that the priority needs and concerns of communities are at the forefront of response interventions. Levels of trust in the state are variable in the region, and locally specific community engagement efforts must respond accordingly. Low levels of trust have been attributed to the failure to provide opportunities for people to be involved in the decisions that affect them. Trust can be reinforced by community engagement but takes time to build, so where possible community engagement should build on initiatives that are already successful, following the accepted principles of encouraging two-way dialogue, creating space for people to ask questions and for their needs and involvement to be reflected in future engagement. This is particularly relevant in fragile contexts where trust in public authority has been eroded. In the context of a pandemic, some decisions need to be made quickly and at the central level, but it remains important to continuously seek and use opportunities to meaningfully involve communities and identify locally appropriate solutions. RCCE strategies are likely to be more successful if they are co-designed through community-centred approaches, capitalising on already existing local knowledge and networks.

Recommendations:

1. Assess the level of community engagement in the response; collect community feedback systematically and frequently and use it to adapt and improve RCCE strategies, and service. Where necessary review how information is collected and conveyed, and the relevance of information in circulation.
2. Evaluate gaps by triangulating information from different sources to identify common trends in perceptions, behaviours and knowledge and how these can be addressed. Defining overarching themes and modalities for data collection in line with key indicators will further help to ensure data collected is usable and useful.
3. Aim to build a high level of engagement and not be extractive, particularly when interacting with population groups who are already under substantial pressure. Involve local actors and frontline workers in the analysis of data to ensure findings are appropriate and applicable. findings should be disseminated findings and used.

Ensure credible sources and types of information: identify misinformation and disinformation and address stigma.

Communications are most effective when they are solution-focused, and promote self-efficacy, hope and agency. Building on existing strengths can help mitigate fear and foster compliance with public health recommendations. Mis- and disinformation proliferate in disease outbreaks and a lack of scientific evidence can create a vacuum that is filled by speculation. Rumours often reflect underlying anxieties or pre-held social or political positions and beliefs and it is important to appreciate and address their underlying causes. It is useful to consider the extent to which different population groups are able to adapt to (constantly) evolving guidance and how they deal with conflicting information. Stigma around COVID-19 has emerged as a deterrent to practices such as testing, case reporting and healthcare seeking. There are numerous examples of specific populations and minorities being singled out and labelled as carriers of the disease. The language used in communication campaigns matters.

Recommendations:

1. Identify and address incorrect information rapidly, this can be very effective and creates space for reliable information to circulate.
2. Foster honest and consistent dialogue about new evidence and knowledge.
3. Formulate information and messaging that avoid the stigmatisation of certain groups.

Secondary impacts of COVID-19 measures are disproportionate for some people: Support vulnerable groups

It is important to address the wider (secondary) impacts of COVID-19, how these may affect the population over time, and how longer-term negative impacts may be mitigated. Meaningful communication should acknowledge local realities as people may be facing multiple crises. Considerations of risk must include dimensions beyond biomedical risks and take account of risks associated with health, behaviour, socio-economic realities, psycho-social impact and the policy environment. In the case of supporting **adolescent refugees**, for example, various activities have been recommended including providing information about financial support, establishing hotlines to discuss violence and abuse, incorporating positive coping strategies across programmes (e.g., to avoid alcohol and drugs) and supporting youth to be involved in volunteer activities. For vulnerable people to be willing to **shield themselves from social contacts**, high-risk individuals and the communities they live in must trust in the public health response and be supported. In the MENA region it is important that the wider community acts as a support system in any shielding or homecare efforts. Effective communication between caregivers at home and health professionals is essential to ensure adequate care if being provided and to link with referral services. Protecting vulnerable people remains extremely complex **for displaced people living in camps** and it is essential that they are fully and effectively engaged in discussions relating to the public health measures that affect them.

Recommendations:

1. Pay attention to the secondary effects of public health measures, which may act as a deterrent to compliance.
2. Identify and communicate risks specific to population groups and particularly those who are shielding or being cared for at home.

3. Carry out research on the secondary health impacts of COVID-19 and the corresponding shifts in people's health-seeking behaviours for other acute and chronic illness.
4. Take into account people's psychosocial wellbeing and consider including messages that offer ways to improve and maintain this.

Work towards regional cooperation and collaboration

Noncompliance and complacency towards COVID-19 measures have been observed globally. The pandemic has highlighted geo-political tensions and the economic impact is stark. COVID-19 has identified the need for strengthened global coordination and collective action for a coherent response. This is even more important between MENA countries, as it is a region where commonalities can be used to the advantage of all. Shared goals and consistent approaches to communication and particularly community engagement should be mutually reinforcing among key population groups with shared cultural, social or religious values, and these can then be further tailored to the most local context as appropriate.

Recommendations:

1. RCCE partners should share information in a timely manner and agree joint approaches to collaborate with other response pillars and decision-makers, creating positive collective action.
2. Multi-agency platforms should be used to develop communication about emerging evidence that can be furthered tailored to local contexts.


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