



RESPONDING TO COVID-19  
IN AFRICA:

# USING DATA TO FIND A BALANCE



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# Executive summary

African Union (AU) Member States responded quickly to COVID-19 with public health and social measures (PHSMs)—the most effective tools for combating a rapidly spreading infectious disease in the absence of effective treatments or vaccines—and this has given them an early advantage in suppressing the virus. But humankind’s struggle with the microbe will be a marathon, not a sprint, and AU Member States are facing a crisis that will continue to unfold over many months.

In this report, the **Partnership for Evidence-Based Response to COVID-19 (PERC)**, a consortium of global public health organizations and private sector firms, brings together findings from a survey conducted March 29–April 17, 2020 in 28 cities across 20 AU Member States, along with epidemiological measures of disease transmission and indicators of population movements and unrest, among others. Synthesized, these data provide a first-of-its-kind snapshot of baseline conditions in Africa during this rapidly evolving pandemic.

## FINDINGS

At this early phase of the pandemic, the surveyed populations exhibit many similarities, both in terms of their general knowledge about the virus and their attitudes toward government responses. But as the numbers of people infected increases and governments respond differently, these populations may diverge in their levels of adherence to PHSMs.

Most AU Member States implemented PHSMs swiftly, while recorded caseloads were still low, but mobility data reveal differences in the speed with which people adhered to restrictions. People currently support PHSMs, but that consensus may be weak. A large share of the population anticipate that a prolonged quarantine would result in food insecurity and grave financial hardship.

If governments do not adapt PHSMs to local needs and mitigate their most serious adverse effects, adherence to the measures will deteriorate and AU Member States risk unrest and violence. The proliferation of peaceful protests demanding government relief is evidence of the strain some people are already under and highlights gaps in current responses.

It is crucial that Member States continue to monitor and act on a variety of data to inform the public health and social measures they implement. There is still much to learn about COVID-19 and Member States need to continue to share what they’ve learned with the global community. The Partnership for Evidence-Based Response to COVID-19 will regularly update these analyses, producing a weekly summary of key indicators, and updated regional data on a rolling basis. AU Member State briefings with more detailed data are [available here](#).

## RECOMMENDATIONS

1. While caseloads remain low, **build public health capacity** to test, trace, isolate, and treat cases—the necessary foundation for reopening society.
2. **Monitor data** on how PHSMs meet local COVID-19 conditions and needs, and to determine when and how to lift them in a way that balances lives and livelihoods.
3. **Engage communities** to adapt PHSMs to the local context and effectively communicate about risk to sustain public support, achieve widespread adherence, and shield vulnerable populations.

## 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 AU Member States.

PERC member organizations are: **Africa Centres for Disease Control and Prevention**; **Resolve to Save Lives, an initiative of Vital Strategies**; the **World Health Organization**; the **UK Public Health Rapid Support Team**; and the **World Economic Forum**. **Ipsos** and **Novetta Mission Analytics** bring market research expertise and years of data analytic support to the partnership.

PERC collected social, economic, epidemiological, population movement, and security data from Member States to help determine the acceptability, impact and effectiveness of public health and social measures for COVID-19. PERC has translated these findings into actionable guidance for governments and policymakers, and is working with governments to mitigate unintended social and economic disruptions of interventions to address COVID-19.

### PARTNER CONTRIBUTIONS

**Africa Centres for Disease Control and Prevention (Africa CDC)**, the **UK Public Health Rapid Support Team**, and other partners analyzed the data and generated policy and guidance. Africa CDC is a specialized technical institution of the African Union leading the continental response to COVID-19. Within the PERC collaboration, Africa CDC is providing technical leadership on generating and communicating data-driven evidence for public health social measures as a leverage for policy decisions in Member States.

**Ipsos** and **Novetta Mission Analytics** collected and helped analyze data on the acceptability, impact, and effectiveness of public health and social measures.

The **World Health Organization (WHO)** provided technical leadership, shaping strategy by ensuring that new evidence is quickly adopted by Member States to adjust their COVID-19 response interventions. WHO will also play a key role in capacity building and ensuring that best practices are quickly 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.

**Resolve to Save Lives, an initiative of Vital Strategies**, assisted Africa CDC in analyzing the data and generating tailored guidelines for each country to support implementation of their own public health and social measures.

**World Economic Forum** is leveraging its vast networks of public- and private-sector partners to accelerate the dissemination of real-time data across the African continent.

PERC's reports, including regional and country-level briefings, are available at <https://preventepidemics.org/coronavirus/perc/>. PERC produces a weekly summary of key indicators, and updated regional data are available on a rolling basis.

# Introduction

By May 2020, nearly every country in the world had confirmed cases of COVID-19, with more than 3 million reported globally. To suppress transmission of the virus, countries have adopted an array of public health and social measures (PHSMs), ranging from abstaining from handshakes and increased hand-washing, to more restrictive measures such as canceling sports matches and religious gatherings, to the most severe measures such as closing businesses and schools and requesting that all residents stay at home.

These measures are a potent tool for curbing the spread of COVID-19 but have social and economic costs, requiring policymakers to weigh lives against livelihoods. Ultimately, choosing an optimal set of policies means finding a balance: measuring the rapidly evolving impact of the virus, adapting preventive measures to local needs and capacities, and mitigating the measures' most adverse effects.

Low- and middle-income countries have limited resources for mitigating the pandemic and the social and economic disruption it creates. PHSMs will reduce transmission of COVID-19, but as their toll on social and economic life, governments will face mounting pressure to loosen the measures.

This report gathers real-time information about the dynamics of the pandemic, governments' responses to it, and people's perceptions of both, and provides recommendations on how governments can implement PHSMs to save lives, while at the same time balancing the economic and social hardships they can cause.

# Background

Epidemiological data show that most AU Member States are still at an early or expanding phase of the COVID-19 pandemic. The virus reached Africa later than other continents, and though the number of confirmed cases in Member States remains low, it is growing quickly. Because AU Member States are generally conducting fewer diagnostic tests than other regions, the true number of infections is likely to be much greater than currently known (see page 7).

Governments in Africa reacted swiftly to COVID-19 by phasing in PHSMs, the most effective means available for suppressing transmission of the virus. The timely deployment of these measures may have given Member States an early advantage in suppressing viral transmission: while it is difficult to measure the precise impact of any single intervention, AU Member States have yet to document the spiraling caseloads seen in parts of the United States and Europe. The initial response in Africa was guided by the experience of countries that first saw the surge in cases, and it will be important for countries around the world to continue to learn from each other's experiences. But as the pandemic continues, AU Member States should chart their own courses, tailored to the severity of the epidemic and other local conditions.

For PHSMs to remain effective, people must understand them and be willing and able to adhere to them. In addition to tracking the spread of COVID-19, governments must consider the public's general perception of risk from the disease and attitudes toward potential and ongoing PHSMs, and must identify barriers to adherence in both the short and long term. This will help governments tailor their interventions to local conditions, and accompany them with relief measures that make them sustainable over time.

## Risks of implementing PHSMs without considering local context

Decisive application of PHSMs has successfully slowed the spread of COVID-19 in a number of countries, including Italy, China and South Korea. But these measures can have adverse consequences for social and economic activity that could outweigh health benefits, especially in resource-constrained settings.

**Economic hardship:** Workplace closures, quarantines and stay-at-home orders can cause sharp drops in income for all workers, particularly day laborers and those in the informal economy who have little safety net or much recourse for lost wages.

**Food insecurity and malnutrition:** People who have lost wages can afford less food, and disrupted supply chains may further constrict food supply and boost prices. Closing or limiting access to marketplaces can cause additional hardship, as people may not have resources to buy or store large stocks of food.

**Violence:** When people have little trust in government response, and authorities fail to engage relevant stakeholders and community leaders in the design and application of public health and social measures, the daily hardships of enduring a pandemic can spark outbreaks of violence, as seen on several occasions during the 2014-2015 West Africa Ebola outbreak.<sup>1</sup> Restrictions in movement and social isolation caused by epidemics, coupled with increased social and economic pressures, have also increased violence against women.<sup>2</sup>

1 Cohn, S., & Kutalek, R. (2016). Historical Parallels, Ebola Virus Disease and Cholera: Understanding Community Distrust and Social Violence with Epidemics. *PLoS currents*, 8.  
2 World Health Organization. (2020, April 7). COVID-19 and violence against women: What the health sector/system can do. Retrieved April 27, 2020, from <https://apps.who.int/iris/bitstream/handle/10665/331699/WHO-SRH-20.04-eng.pdf>

# The spread of COVID-19 in Africa

Many AU Member States have critical gaps in epidemic preparedness (including a limited health workforce and little capacity for providing critical care<sup>3</sup>) that make them particularly vulnerable to negative social, economic and health impacts of the pandemic. But the explosive growth in COVID-19 cases seen in other parts of the world has not yet materialized in Africa.

**The relative youth of the population may be protective.** Current data suggest that older people infected with COVID-19 are at significantly greater risk of severe illness. But in sub-Saharan Africa only 3% of the population are 65 years or older, and 43% are less than 15 years old. This is in stark contrast to other regions such as the European Union, where 20% of the population are 65 years or older and only 17% are under 5.<sup>4,5</sup> Because older people are fewer in number in many AU Member States, it may also be easier to shield them from infection.

**Early, decisive action taken by many African governments may have slowed transmission.** South Africa declared a national state of disaster and implemented a nationwide lockdown before reporting its first COVID-19 death. Uganda suspended public gatherings before the first documented case in the country. Nigeria began screening passengers at international airports nearly one month before the first case was detected. These and other early actions likely reduced spread of the virus.

**But AU Member States may yet enter a phase of more rapid disease transmission.** In many countries around the world, the first observed cases were among travelers and their close contacts, and it was weeks before the countries documented widespread community transmission. If this pattern repeats in AU Member States, they may still experience exponential growth of cases as community transmission accelerates, particularly if PHSMs are lifted prematurely or if community adherence declines.

The low number of observed cases may not reflect the actual prevalence of infection. As of April 23, 2020, there were 26,144 COVID-19 cases reported in Africa and 1,247 deaths.<sup>6</sup> But estimates based on the infection fatality rate (the percentage of deaths among all of those who are infected with COVID-19) suggest that cases have been undercounted. A recent estimate concluded that COVID-19 had a case fatality rate of .66%.<sup>7</sup> By that measure, the total number of cases expected to result in 1,247 deaths would be closer to 200,000—eight times the number of recorded cases.

3 Finnan, D. (2020). Lack of Covid-19 treatment and critical care could be catastrophic for Africa. RFI Retrieved from <https://bit.ly/2SduDE1>

4 <https://data.worldbank.org/indicator/SP.POP65UP.TO.ZS>

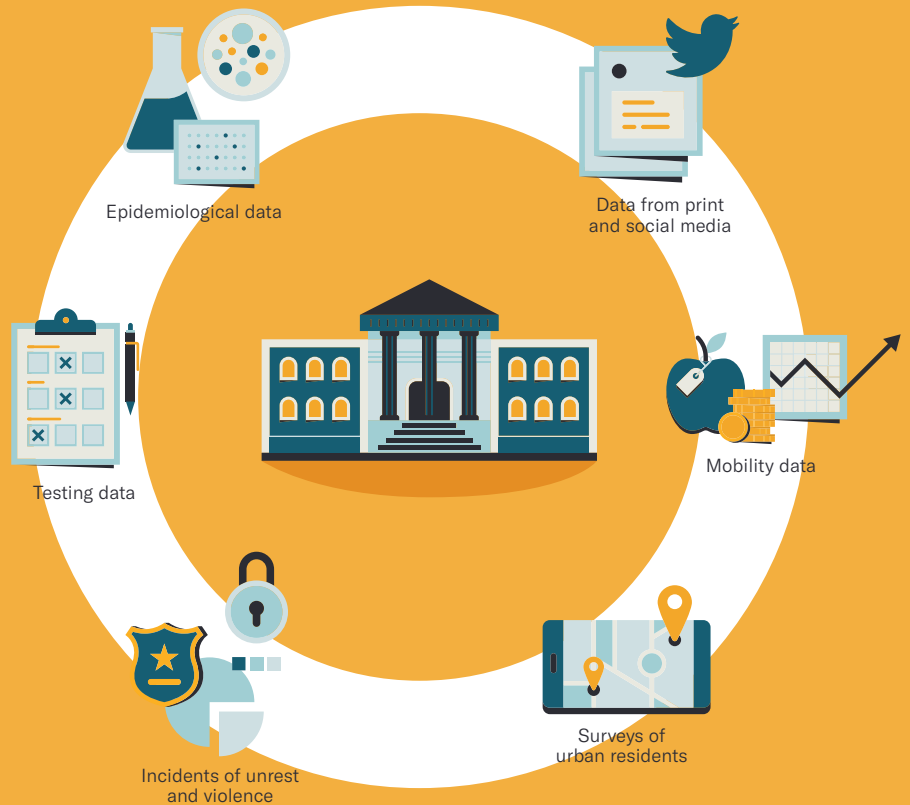
5 <https://data.worldbank.org/indicator/SP.POP0014.TO.ZS?view=chart>

6 Africa CDC. (2020). COVID-19. Retrieved from <https://africacdc.org/covid-19/>

7 Verity, R., Okell, L., Dorigatti, I., Winskill, P., Whittaker, C., Imani, N., et al. (2020). Estimates of the severity of coronavirus disease 2019: a model-based analysis. *The Lancet: Infectious Diseases*, online only. [https://doi.org/10.1016/S1473-3099\(20\)30243-7](https://doi.org/10.1016/S1473-3099(20)30243-7)

# Sources of data

This regional 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 economic and social impacts that measures to slow its spread have had on people, families and communities.



**Epidemiological data:** PERC analyzed data on diagnosed cases and deaths collated by European CDC to identify AU Member States with accelerating outbreaks.<sup>9</sup> Two epidemiological “triggers” were used to identify these Member States: three consecutive days of 10% or greater growth in confirmed cases, or a doubling time of less than five days.

**Testing data:** PERC analyzed publicly available data from the Our World in Data statistics and research site.<sup>10</sup>

**Incidents of unrest and violence:** PERC analyzed data on security incidents collected by the Armed Conflict Location & Event Data Project<sup>11</sup> from Jan. 29 to April 25, 2020.

**Surveys of urban residents:** From March 29 to April 17, 2020, PERC conducted surveys across 28 cities in 20 AU Member States (see list at right), drawing from all AU regions, to assess the impact the crisis was already having on people and their attitudes toward PHSMs being implemented. The survey focused on large population centers vulnerable to rapid transmission. Survey coverage and field dates are summarized in Annex 1. Further waves of research are planned for the coming months, with the data in this report serving as a baseline.

**Data from print and social media:** Novetta Mission Analytics analyzed print media and Twitter posts related to COVID-19 by users in Africa, and contrasted information disseminated by government and health officials with narratives circulated by the public. The results highlight gaps in knowledge, the prevalence of misinformation, and unmet community concerns about the implementation of PHSMs.

**Mobility data:** PERC analyzed data collected by Google from its account holders in 25 AU Member States, focusing on visits to recreation and retail locations.<sup>12</sup> (from February 16 to April 26, 2020)

**More detailed information about data sources are summarized in Annex 2.**

**Cities included in survey:**

- Abidjan, Côte d'Ivoire
- Accra, Ghana
- Addis Ababa, Ethiopia
- Cairo, Egypt
- Casablanca, Morocco
- Conakry, Guinea
- Dakar, Senegal
- Dar Es Salaam, Tanzania
- Durban, South Africa
- Goma, DRC
- Harare, Zimbabwe
- Johannesburg, South Africa
- Kampala, Uganda
- Kano, Nigeria
- Khartoum, Sudan
- Kinshasa, DRC
- Lagos, Nigeria
- Lusaka, Zambia
- Maputo, Mozambique
- Mombasa, Kenya
- Monrovia, Liberia
- Nairobi, Kenya
- Pretoria, South Africa
- Rabat, Morocco
- Tunis, Tunisia
- Yaoundé, Cameroon
- Zanzibar, Tanzania



9 <https://www.ecdc.europa.eu/en/geographical-distribution-2019-ncov-cases>  
 10 <https://ourworldindata.org/coronavirus>  
 11 <https://acleddata.com/#/dashboard>  
 12 <https://www.google.com/covid19/mobility>

# Understanding Knowledge and Attitudes About COVID-19

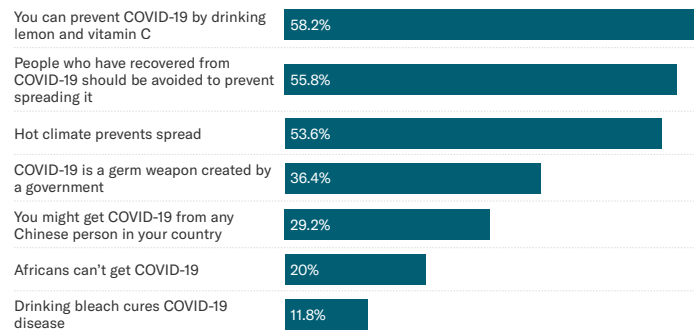
## Survey Results

### Knowledge about COVID-19

Across urban populations in the 20 Member States surveyed, there was widespread awareness of COVID-19 and its symptoms. But the data also indicated systematic gaps in knowledge. One of eight (13%) respondents were unaware that infected people may not show symptoms until 5-14 days after being infected.

### Awareness of COVID-19 is almost universal (over 98%) across Member States but significant misconceptions exist

Percentage believing false statement is definitely or probably true



**One third (32%) of respondents said they did not have enough information about the coronavirus.**

**24%**

want more information on how to protect themselves and their families

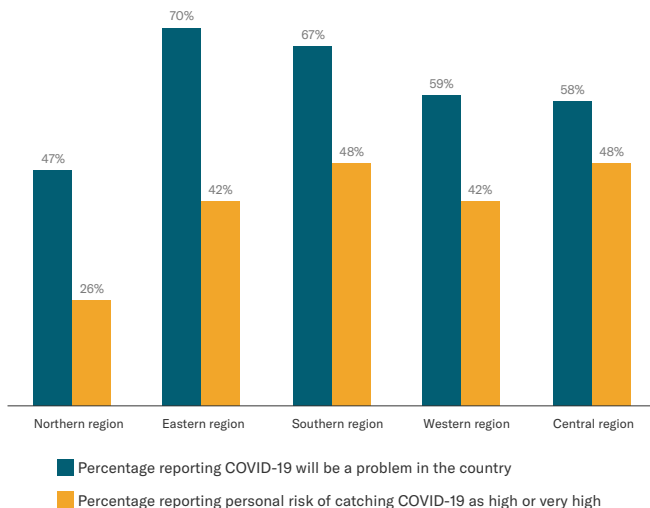
**22%**

want more information on how COVID-19 spreads

**17%**

want more information on what causes COVID-19

**Across the 5 African regions, respondents said they thought the virus posed a bigger risk to the Member States than it did to them as individuals**



### Perceptions of risk related to COVID-19

Survey results indicate that, while the majority of respondents believe COVID-19 poses a significant national challenge, their perception of their own risk of catching the disease is far lower. Close to two-third (62%) of respondents anticipate that the coronavirus will be a “big problem” in their Member States, but only 44% think that they will be at high risk of catching it.

This low perception of personal risk could jeopardize adherence to PHSMs, particularly those that are maintained for long periods of time, or that require personal sacrifices.

# Attitudes towards public health and social measures and overall government response

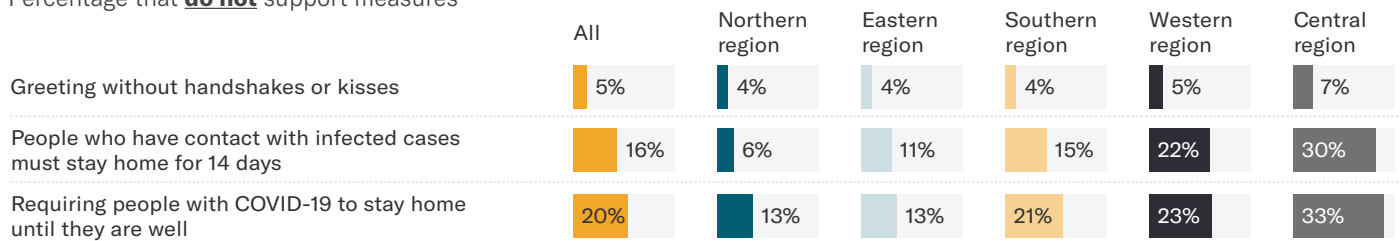
## Support for personal measures

The surveys found almost universal support for adopting new personal measures for reducing disease transmission, such as refraining from handshakes and kisses as a form of greeting.

There was also widespread support for disciplined hygiene measures, but adherence varied significantly. Many social media users, especially in the urban settings of the Central and Southern regions settings, highlighted the “incomprehensibility” of being instructed to wash hands regularly when their access to water was limited.

## Opposition to personal PHSMs was generally low

Percentage that **do not** support measures



## PERC’s analysis of print and social media identified several trends



**Personal hygiene and hand-washing measures** were widely discussed on Twitter, with government ministries, international organizations and embassies promoting the measures. Twitter users drew attention to water insecurity as an obstacle to adhering with hand-washing measures, particularly in Cameroon, Gabon, Libya and Zimbabwe. Civil society groups in Nigeria encouraged use the use of soap and hand sanitizer gel before ablutions and prayer, a topic that may grow in salience during Ramadan.

**Food security** was cited as a pressing concern for poor populations throughout Africa, particularly in the Southern, Central and Eastern regions. A wide variety of groups and individuals expressed concern over deepening food insecurity in Zimbabwe. There, the alternative media outlet The Feed Zimbabwe actively reported on the issue, tweeting on April 27 that shortages had forced Zimbabweans to dispense with physical distancing measures in order to queue for food.

**Physical distancing measures** were discussed in the context of public markets, which users across the continent cited as a site where adherence was low. One Moroccan reporter shared a video of a crowded market with the caption, “#Corona Morocco, quarantine is just on social media, reality is a different case.” Twitter users in Burundi described low adherence to physical distancing there, criticized the government for offering little guidance, and expressed concern about events and rallies related to the upcoming Burundian election on May 20.

**Government lockdown orders** were also a prominent topic of discussion. In Northern region, where some Member States loosened travel restrictions and curfews for Ramadan, Twitter users offered a mix of responses: some celebrated the chance to visit family while others criticized the policy change as sentimental and dangerous. Twitter users in South Africa were notably supportive of their president Cyril Ramaphosa. Several videos purporting to show protests and violence in response to the lockdown were revealed to be doctored.

## Support for restrictions on public gatherings and essential services

Survey data show almost universal support for responding to COVID-19 by restricting public gatherings. Respondents also generally supported restrictions on religious gatherings.

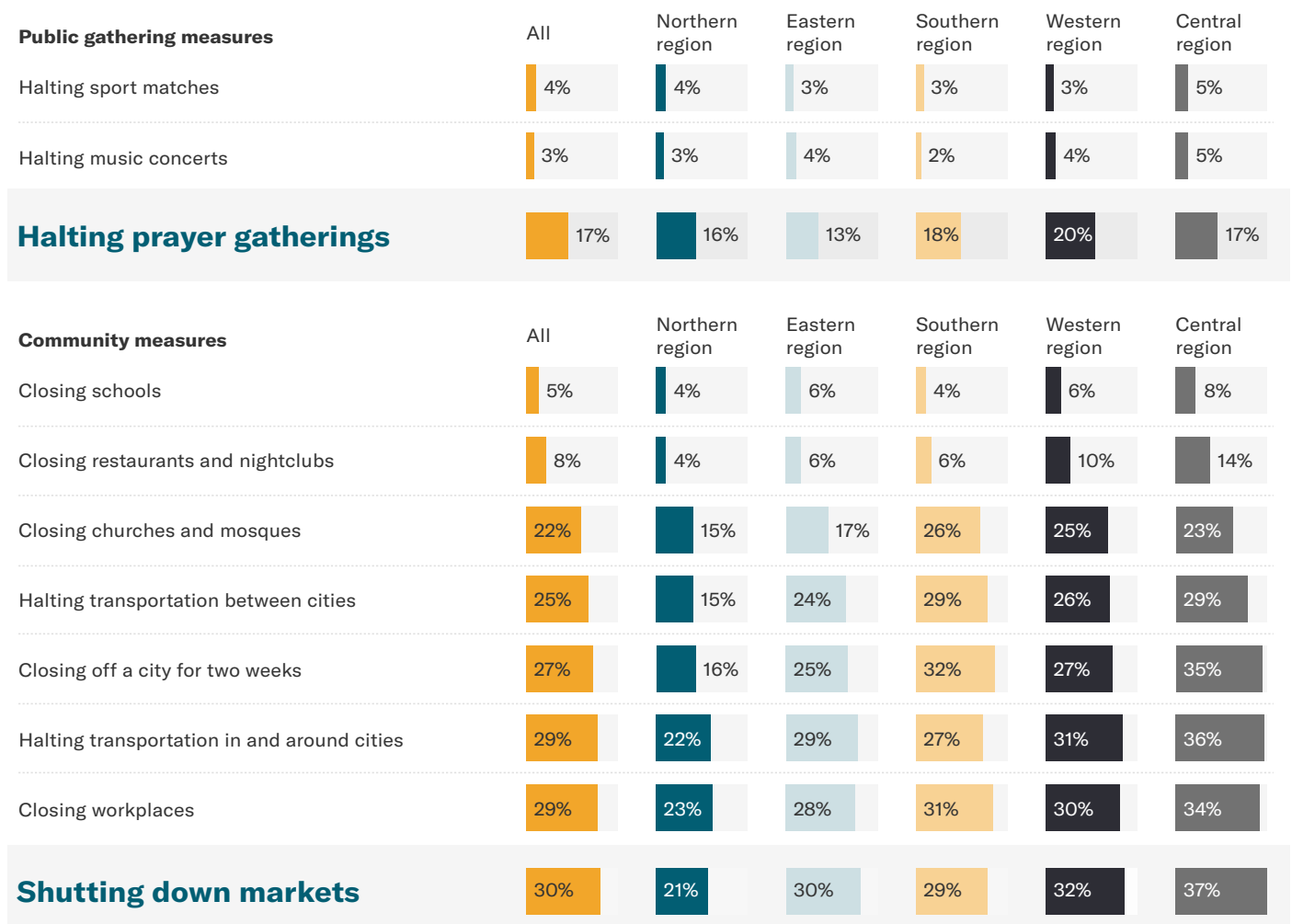
When prompted for alternatives to in-person prayer and religious gatherings, the most frequently cited solution was TV or internet broadcast of services (48%) followed by radio broadcasts (46%). The survey found less support for shutting down spaces and services that are essential to the economy including access to markets.

The survey was conducted from late March to mid-April, shortly after most PHSMs went into effect; these strong levels of support may wane over time, as negative impacts and barriers to implementation grow. Opposition may also be much higher among vulnerable groups, such as day laborers or traders, who may have been underrepresented in the survey sample.

**When prompted for alternatives to in-person prayer and religious gatherings, the most frequently cited solution was TV or internet broadcast of services (48%) followed by radio broadcasts (46%).**

## Opposition was highest to measures such as closing workplaces and shutting down markets

Percentage that **do not** support measures



## Barriers to PHSM adherence

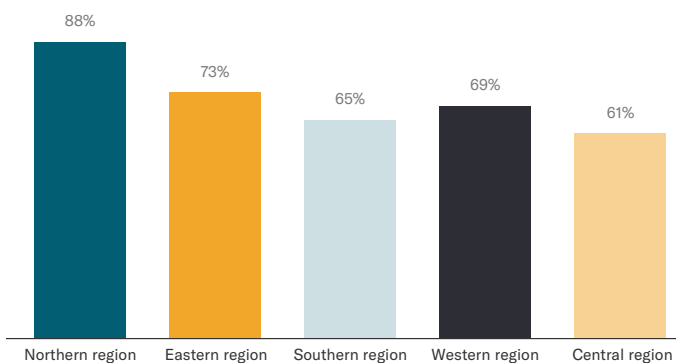
On average, survey respondents estimated they would run out of money in 12 days and food in 10 days. The lowest-income households expected to run out of food and money in less than a week.

In Nigeria and Kenya, social media users noted that hunger in urban centers was forcing them to violate stay-at-home orders in order to search for food.

Survey data indicate that both public attitudes and physical constraints will pose challenges for isolating sick people. Overall, a majority of respondents (59%) said they lack physical space to isolate sick people: in 12 of 20 Member States, fewer than half of respondents said they had a separate room to isolate someone who is ill. 20% of respondents opposed home isolation for infected people, though this varied by region, ranging from 13% opposition in the Northern and Southern regions to 32% in the Central region. A similar share of respondents opposed requiring those who came into contact with infected people to self-quarantine: 16% overall, ranging from 6% in the Northern region to 30% in the Central region.

**Nearly a third (30%) of women said that, if schools were closed, they would not have someone who could take care of their children.**

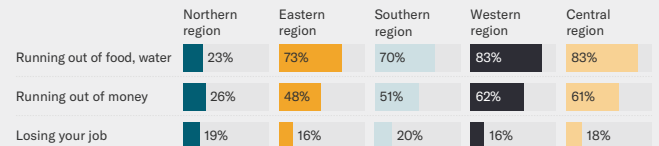
### How satisfied are you with your government's response to COVID-19?



## For vulnerable groups, adhering to PHSMs is a choice between COVID-19 and hunger.

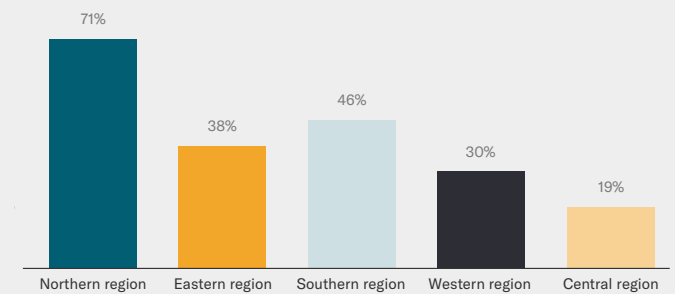
### Barriers to stay-at-home orders high

Percentage that would face barriers to a 14-day stay-at-home order



### Barriers to isolation of sick family members

Percentage who do not have physical space to isolate sick people



## Satisfaction with government response to COVID-19

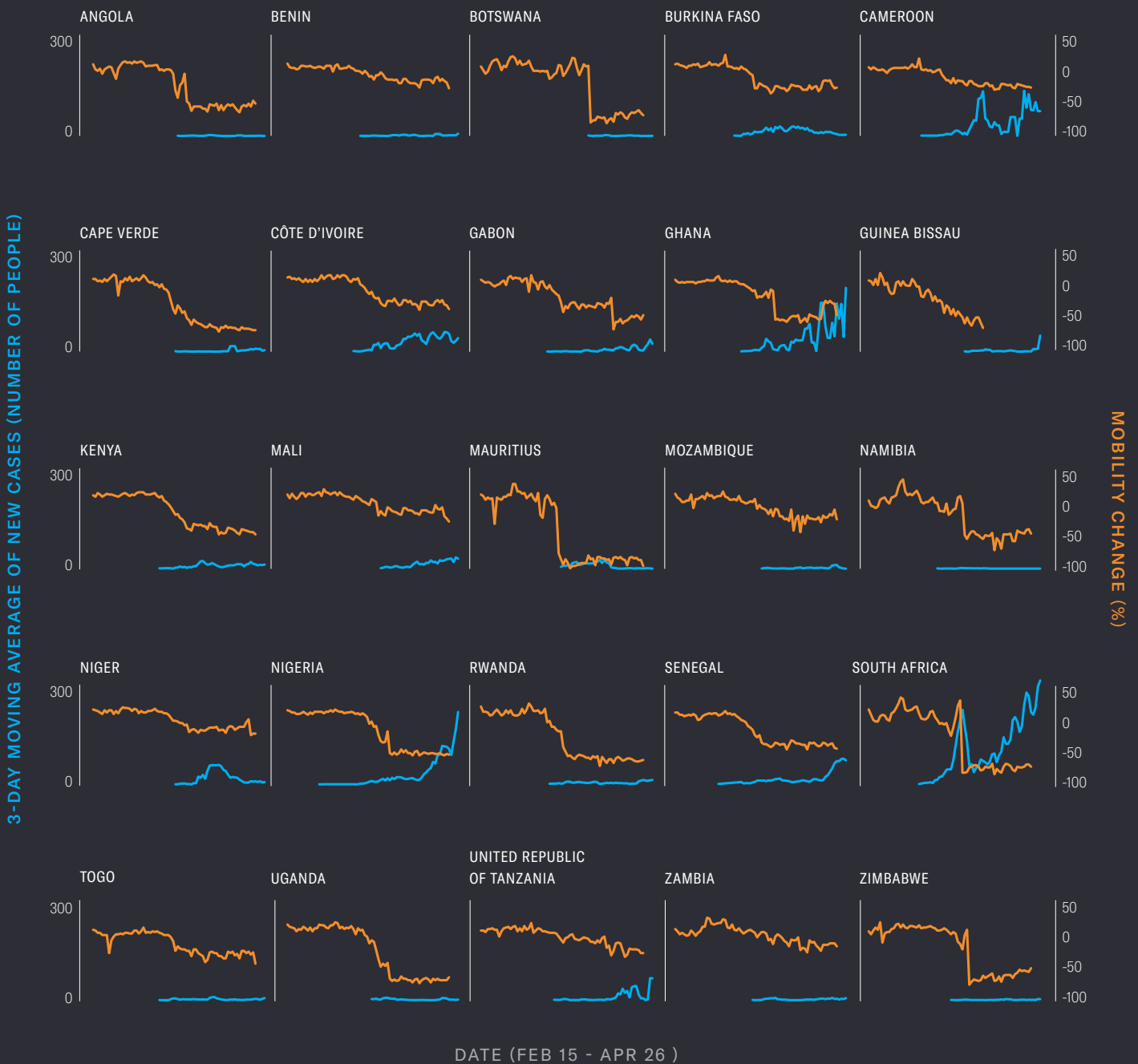
A majority of respondents said they trusted information from the government, but respondents ages 18 to 25 were less likely to do so (61%) than those over 46 years old (74%).

Across most of the continent, analysis of social and print media indicated more positive than negative perspectives of governments' management of the epidemic. Attempts to provide relief packages to counter economic effects of PHSMs were particularly well received.

## Adherence to public health and social measures

Data aggregated from the movements of mobile phone users can be used to measure the adherence to PHSMs that restrict movement or impose physical distancing. Member States with a steep drop-off in mobility can have greater confidence their people are embracing prescribed public health and social measures. Taking this data on adherence into account, Member States may see where further communication or new interventions are merited.

**Change in Cases and Population Mobility from February to May 2020**



● 3-day moving average of new cases (number of people)

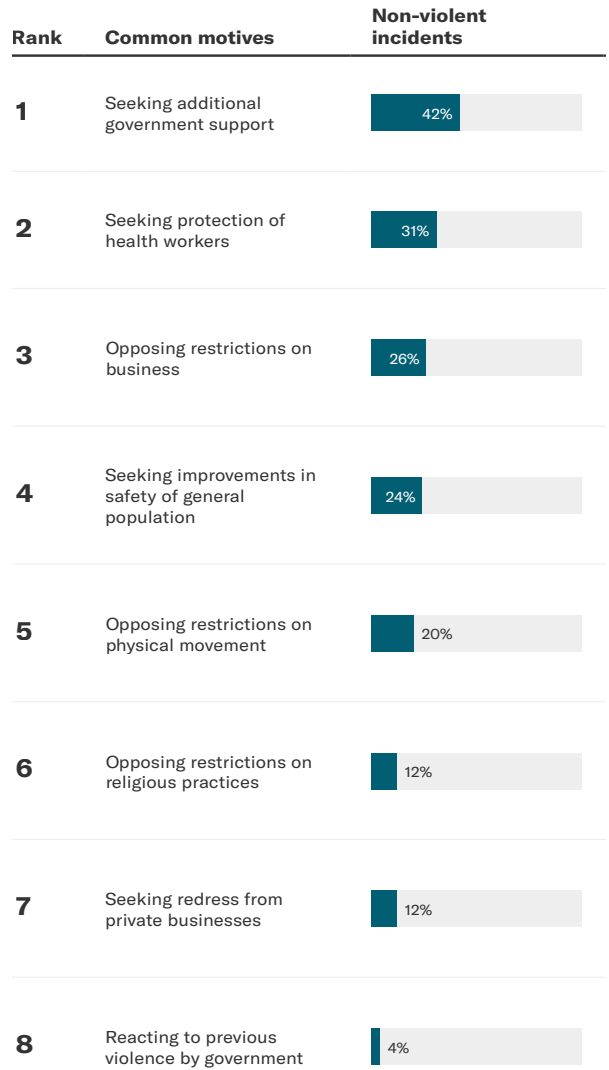
Mobility change for retail and recreation (percentage) ●

## Security incidents related to COVID-19

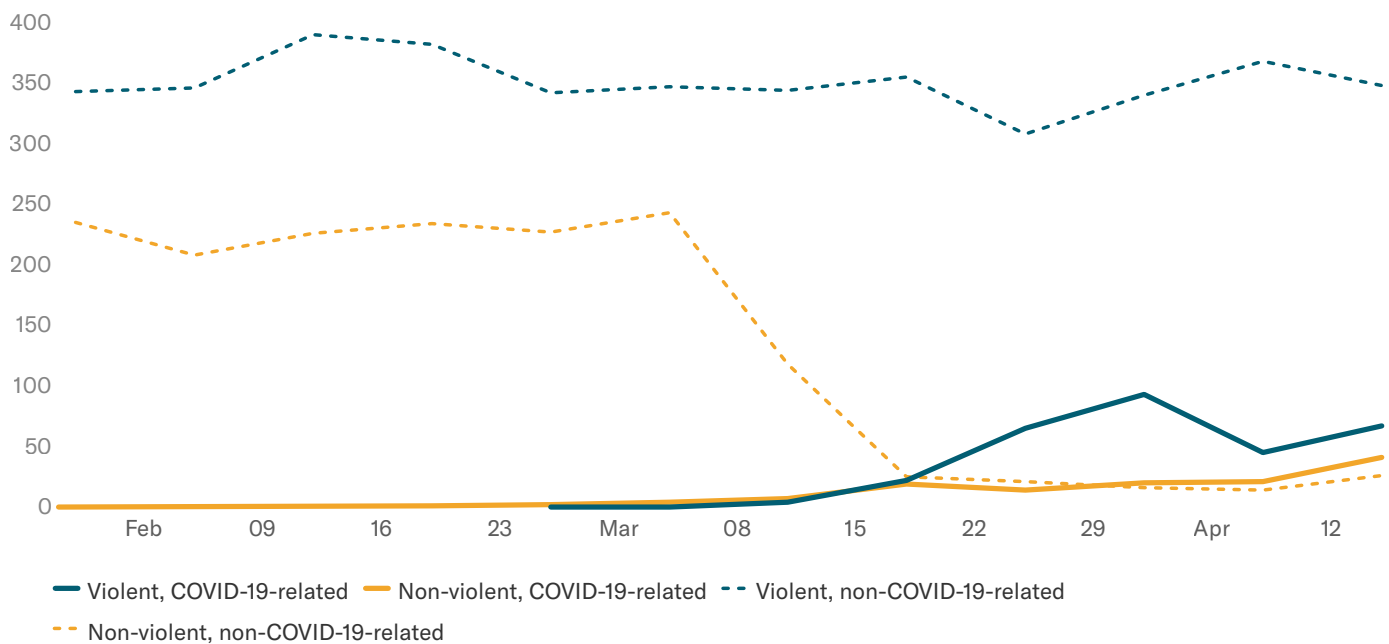
Security incidents—including peaceful protests as well as riots and mass violence by and against civilians—can be an important bellwether. A rise in unrest or insecurity can affect adherence to PHSMs, serve as a red flag of the burden such measures are imposing on the population, and illuminate unwarranted violence by police or military forces enforcing the measures.

PERC’s analysis shows that as COVID-19 caseloads grow and restrictions are imposed, so has the number of related security incidents. The underlying data categorizes incidents as “violent” if participants perpetrate violence or if they provoke a violent state response, regardless of any violence on the part of the protesters. By this admittedly broad definition, the increase was primarily in violent incidents rather than non-violent ones.

The three most common motives for non-violent protests were to demand better protection for health workers, to call attention to the economic and food insecurity effects of PHSMs, and to demand increased government support to mitigate them.



## Security incidents by type (violence by any party)



# Recommendations

## Build public health systems for a lasting recovery

AU Member States' early implementation of PHSMs slowed early spread of COVID-19 and bought them time. While caseloads remain low, governments should build their public health capacity to test, trace, isolate, and treat cases. These steps are essential to box in the virus, the necessary foundation for reopening society.

Part of building capacity for a lasting recovery is to sustain some of the essential services for conditions other than COVID-19, such as maternal care, malaria and vaccination programs. During the Ebola epidemic more people died because of Ebola than from it. It's imperative governments maintain essential services safely, as well as prioritize protecting health care workers from all types of infection.

## Monitor data on how public health and social measures meet local COVID-19 conditions and needs

No two communities affected by COVID-19 looked the same. Policymakers must collect and analyze a range of information including health, social, economic and security data and review the data in combination. This holistic view allows decision-makers to understand how communities are able to adhere to public health advice and learn the barriers to implementation. By understanding the impact on the disease and livelihood, policymakers are better placed to adapt PHSMs, provide targeted mitigation measures and ensure they can loosen restrictive measures safely.

Policymakers should continue to monitor for signs of unrest so they can better address the underlying causes and maintain support for lifesaving measures.

This data should also guide when and how to adapt or even lift restrictions, balancing lives and livelihoods. Where restrictions are jeopardizing food security, governments should adapt measures to keep markets accessible and consider direct transfers of food.

## Engage communities to adapt PHSMs to the local context and effectively communicate about risk to sustain public support

The survey found high acceptance of public health and social measures among communities, however there were significant barriers reported to maintain PHSM adherence. Policymakers must work with communities to reduce the impact of PHSMs on livelihood without sacrificing the effectiveness of distancing measures.

The survey data show that many people feel COVID-19 poses a big problem for their Member State but that their personal risk is relatively low. Policymakers should close this gap by conveying the shared nature of COVID-19 risk within a community, by leveraging mass media that is most accessible and commonly used, particularly by vulnerable populations, and by engaging trusted local leaders whenever possible. It's also critical that COVID-19 response leaders clearly communicate about where their community is in the outbreak curve (little spread, some spread, extensive spread) and which behaviors are needed to prevent new infections at that time. Doing so will increase support for cohesive, community-wide efforts and broader adherence to PHSMs.

**During a pandemic, governments should communicate through the media channels that allow them to reach the most people, particularly vulnerable populations. Most respondents used national television as their "normal" media source (62%), followed by social media including Facebook, YouTube, and Twitter (29%), radio (27%), and international television channel (18%).**

## Conclusion

Africa's swift response to the COVID-19 pandemic has bought valuable time for governments to build public health systems to find, stop and prevent new cases. It's also critical that governments continue to use real-time data to learn how their communities are adapting to PHSMs.

Member States should establish clear criteria for relaxing and reimposing PHSMs, choosing context-specific indicators that reflect the balance of governmental priorities, and share this information with the public often and clearly.

Relief measures to reduce negative impacts of PHSMs should be implemented to support communities to adhere to the prevention measures. When governments do lift restrictions, it is critical that they do so gradually, relaxing measures that are most detrimental to the community before less disruptive ones. Governments should remain prepared to reinstate PHSMs should cases increase and engage continually with affected communities to keep them informed and involved.

PERC will continue to provide updated data throughout the COVID-19 response. Governments should also design systems to capture data, learning what works best in their contexts.

## Additional resources

### Related resources from **Africa CDC**

- [Guidance on Community Social Distancing During COVID-19 Outbreak](#)
- [Africa CDC Guidance for Assessment, Monitoring, and Movement Restrictions of People at Risk for COVID-19 in Africa](#)
- [Africa Joint Continental Strategy for COVID-19 Outbreak](#)
- [Recommendations for a Stepwise Response to COVID-19](#)

### Related resources from **Resolve to Save Lives**

- [Using Public Health and Social Measures to Reduce COVID-19 Transmission](#)
- [Implementing Public Health and Social Measures: Using Data to Find the Balance Between Public Health Outcomes and Social and Economic Impact](#)
- [Adapting Public Health and Social Measures for Resource-Constrained Settings](#)
- [Using Communication to Support Implementation of Public Health and Social Measures](#)
- [Legal and Ethical Considerations for Public Health and Social Measures](#)
- [Data insight: COVID-19 in Africa](#)

### Related resources from **WHO**

- [Guidance on Community Social Distancing During COVID-19 Outbreak](#)
- [WHO Strategy for COVID-19 Outbreak](#)
- [Non-pharmaceutical public health measures for mitigating the risk and impact of epidemic and pandemic influenza](#)
- [WHO guidance on public health measures in countries experiencing their first outbreaks of H5N1 avian influenza](#)

### Information about data sources available here:

<https://preventepidemics.org/coronavirus/perc/data>

## Annex 1: Ipsos survey methodology

In four Member States that had not yet introduced PHSMs at the time of data collection (Ethiopia, Côte d'Ivoire, Cameroon and Mozambique), respondents were sampled by random walk and in-household Kish-grid sampling methods for face-to-face interviews. In 16 Member States that had already implemented PHSMs, interviews were conducted by telephone, and respondents were sampled by random digit dial incorporating landline and mobile phones. Data are representative of the populations of the urban area from which they were sampled, and are unweighted.

In total, 158,709 people were contacted; 16,442 refused to participate; and final results are based on completed interviews conducted with 20,990 adults.

Region	Member State	Coverage	Sample size	Method	Fieldwork Dates
Western region	Liberia	Monrovia	1,059	CATI	April 4 - April 7, 2020
	Ghana	Accra	1,001	CATI	March 29 - April 1, 2020
	Nigeria	Lagos	513	CATI	March 30 - April 2, 2020
		Abuja	110		
		Kano	445		
	Guinea	Conakry	1,034	CATI	April 2 - April 5, 2020
	Senegal	Dakar	1,039	CATI	April 1 - April 4, 2020
Côte d'Ivoire	Abidjan	1,036	CAPI	April 1 - April 4, 2020	
Eastern region	Kenya	Nairobi	822	CATI	March 29 - April 1, 2020
		Mombasa	209		
	Uganda	Kampala	1,073	CATI	March 29 - April 1, 2020
	Ethiopia	Addis Ababa	1,021	CAPI	March 29 - April 1, 2020
		Dar Es Salaam	842		
	Tanzania	Zanzibar	261	CATI	March 30 - April 2, 2020
Sudan	Khartoum	1,101	CATI	March 30 - April 2, 2020	
Northern region	Egypt	Cairo	1,098	CATI	March 30 - April 3, 2020
	Morocco	Rabat	450	CATI	April 1 - April 17, 2020
		Casablanca	595		
Tunisia	Tunis	1,004	CATI	April 2 - April 15, 2020	
Central region	Cameroon	Yaoundé	1,042	CAPI	March 31 - April 3, 2020
	Democratic Republic of the Congo	Kinshasa	708	CATI	April 1 - April 4, 2020
		Goma	301		
Southern region	South Africa	Johannesburg	463	CATI	April 2 - April 6, 2020
		Pretoria	331		
		Durban	305		
	Zimbabwe	Harare	1,034	CATI	April 1 - April 4, 2020
	Mozambique	Maputo	1,057	CATI	March 29 - April 3, 2020
	Zambia	Lusaka	1,035	CATI	March 30 - April 2, 2020

## Annex 2: Other data sources

**Epidemiologic data:** The European Centre for Disease Prevention and Control (ECDC) collects and disseminates data on new COVID-19 cases and deaths per AU Member State on a daily basis.<sup>8</sup> Using population data for 2018, we calculated the case-fatality rate (CFR), the two- and three-day moving average of the number of new cases and deaths, and the epidemic's doubling time (i.e. the number of days it took for total reported cases to double).

**Public health and social measures (PHSMs):** ACAPS, a nonprofit, nongovernmental project that provides international, independent humanitarian analysis, collects information on 35 types of PHSMs from a variety of publicly available sources including governments, media outlets, United Nations agencies and other organizations.<sup>9</sup> Recorded data include Member State of implementation, date of implementation, and status. ACAPS records changes or modifications to existing measures as a new record. For this analysis, and with the input from a group of experts, the 35 types of measures from ACAPS were grouped into 11 categories. In a few cases, where the date of implementation was unknown, the date of entry into the dataset was substituted. The date a Member State first initiated a category of public health and social measure was attributed to the first reported measure in that category. Like all data, these records are subject to limitations due to delays in reporting, errors in classification, or inadvertent exclusion.

**Security incidents:** The Armed Conflict Location & Event Data Project (ACLED) is a disaggregated data collection, analysis, and crisis mapping project. Data from Jan. 29 to April 25, 2020 were analyzed. ACLED differentiates between peaceful protests and all other incidents. All incidents with the category label "strategic developments" were removed, as many of these include policy changes by states that may tangentially relate to security (i.e., the imposition of disease-related curfews) but which are not outside of the usual scope of government policymaking.

**Mobility data:** Google has published COVID-19 Community Mobility Reports,<sup>10</sup> which use aggregated, anonymized data to chart movement trends over time by geography, across different high-level categories of places. Data are derived from mobile phones of users who have opted in to "location history" for their Google account and may not be representative of the general population. The dataset shows visits and length of stay at different locations compared to the median value for the corresponding day of the week during the five-week period from Jan. 3 to Feb. 6, 2020. For this report, data were analyzed for "retail and recreation" locations, which captures mobility trends for places like restaurants, cafes, shopping centers, theme parks, museums, libraries and movie theaters.

**Social media data:** Novetta Mission Analytics reviewed public Twitter posts and print news from 329 African media outlets for COVID-19 narratives, collecting 4,498 quotes in 932 traditional media articles and 2,282 tweets over a 30-day period. The collated data were geotagged and categorized by potential obstacles for implementing public health and social measures, a taxonomy that was used for subsequent qualitative analysis.

<sup>8</sup> European Centre for Disease Prevention and Control. (2020). COVID-19. Retrieved from <https://www.ecdc.europa.eu/en/Covid-19-pandemic>

<sup>9</sup> ACAPS. (2020). #COVID-19 Government Measures Dataset. Retrieved from <https://www.acaps.org/covid19-government-measures-dataset>

<sup>10</sup> 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/>