COVID-19 Plan
and Strategy for Communication
In ECOWAS Member States

Findings of a socio-anthropological survey (Cape Verde, Burkina Faso, Côte d'Ivoire, Guinea-Bissau, Sierra Leone)

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Bernard Seytre
bnscommunication
7 rue Ledion, 75014 Paris
Telephone: + 33 6 03 54 88 13
seytre@bnscom.fr

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Abbreviation

ECOWAS: Economic Community for West African States
EBV: Ebola Virus Disease
WHO: World Health Organization
WAHO: West African Health Organisation

Caveat

In this report, "coronavirus" refers to SARS-CoV-2 and "COVID-19" refers to the disease for caused by the virus.

In order to limit erroneous answers du to a possible confusion between asymptomatic and symptomatic infection, or between the coronavirus and COVID-19, for the socio-anthropological survey we used the expression "COVID-19 disease" in questions about symptomatic infection.

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1. Executive Summary

Nine months following the advent of the COVID-19 pandemic on the African continent, the West African Health Organisation (WAHO) decided to reflect on the communication on COVID-19, after the virus had ushered in an acute health crisis in Africa and as the coronavirus infection takes hold in the long term. The challenge is to bring about greater respect for barrier gestures[1].

Applying a *health literacy*[2] approach, we wanted to evaluate the knowledge and perceptions of the population on the SARS-Cov2 epidemic and sought answers to several questions:

- What is the reach of communication messages targeting the populace?
- What are the peoples' perceptions about COVID-19, the prevention messages and the bearers of these messages?
- Are there messages that need to be changed to strengthen COVID-19 prevention and, if so, how?
- Do we need to send out new messages?

To obtain these answers, we carried out a quantitative socio-anthropological survey in five ECOWAS countries, which highlighted the progress and weaknesses of knowledge on COVID-19.

Acquired knowledge:

- Almost the entire population has heard of the coronavirus and the majority have some idea of what a virus is.
- The main symptoms of COVID-19 are widely known, with the exception of anosmia and agueusia (loss of smell and taste).
- The vast majority of the population is aware of protective measures (93% to 99.75%) and their usefulness (60.75% to 96.71%).

Limitations:

- The vast majority of the population is unaware that coronavirus carriers may have no symptoms, which is the case for 80% of infected people in Africa, this asymptomatic carrier status being the reason why protective measures are recommended to the entire population and vaccines will be proposed[3].
- A significant part of the population thinks that COVID-19 is not present in their country.
- The vast majority of the population believes that they are at risk of contracting COVID-19 when attending a health facility, which contributes to a decrease in the demand for care resulting in increased morbidity and mortality due to diseases other than COVID-19.

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[1] Our direct observations in the five survey countries, documented by photos, show that, with the exception of Cape Verde, the overwhelming majority of the population does not wear masks in places where it is recommended or compulsory, such as on public transport or at gatherings.

[2] Nutbeam D., *Health Promotion International*, Vol. 15, N°3, Oxford University Press, 2000. Freedman D.A. et coll., « Public Health Literacy Defined », *Am J Prev Med*, 2009;36 (5), pp. 446-451.

[3] https://www.afro.who.int/fr/news/les-facteurs-sociaux-et-environnementaux-consideres-lorigine-des-faibles-taux-de-COVID-19-en

- The risk factors for severe forms of COVID-19 such as age and chronic disease are insufficiently known, making it difficult for people at risk to understand that they need to protect themselves from the coronavirus, and for their loved ones that they need to protect them.

We therefore propose a four-pronged communication strategy:

→ Explain how the coronavirus may be transmitted by asymptomatic people.

→ Show that COVID-19 exists in the ECOWAS countries.

→ Reassure people over their concerns about the risk of contracting the coronavirus in health facilities and encourage them to continue to use them.

→ To undertake communication targeting young people, appealing to their sense of family, fraternity and responsibility.

Moreover, the messages and tools of communication should be revisited to include missing messages or strengthen existing ones (anosmia, ageusia, risk factors).

Some Member States also need to design communication plans geared toward filling specific gaps in the understanding of COVID-19 by their people.

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WAHO adds new COVID-19 tools to those it has already produced in line with the communication pillars:

- 3 animated videos
- 3 bills
- 3 posters

2. Socio-anthropological Survey

2.1.   Team

Coordination

Bernard Seytre, bnscommunication, Paris, seytre@bnscom.fr

Lead investigators

Burkina Faso: Blahima Konaté, INSS/CNRST, Ouagadougou, kobla70@hotmail.com
Cape Verde: Crisanto Barros, University of Cape Verde, crisantobarros@gmail.com
Côte-d'Ivoire: Blé Yoro, Université Houphouët Boigny, Abidjan, yoroble94@yahoo.fr
Guinea-Bissau: Amabelia Rodrigues, Bandim Health Project, Bissau, Guineae-Bissau,
a.rodrigues@bandim.org
Sierra Leone: Philip Bona, Freetown, Sierra Leone, Philipbona3@gmail.com

2.2.   Protocol

2.2.1. Objectives

Provide objective information for the design of a communication strategy aimed at getting the people of ECOWAS to observe the barrier measures to protect themselves against SARS-CoV-2, the virus that causes COVID-19.

As the purpose of communication is to engender the desired behavioural change in people, the survey dwelt on the reasons that may help or hamper acceptance of messages promoting this behavioural change.

Specific Objectives:
1.   Determine the representations of:
     -    barrier measures,
     -    messages received on COVID-19.
     -    the carriers of messages on COVID-19,
2.   Find out what is known about COVID-19

2.2.2. Study sites

We selected five countries representing the ECOWAS region: Burkina Faso, Sierra Leone, Côte d'Ivoire, Guinea-Bissau and Cape Verde, having regard to linguistic, geographical and socio-economic diversity.

Localities:

Burkina Faso: Bobo-Dioulasso (Bolomakoté secteur 6, Koua secteur 25), Ouagadougou (Nioko secteur 43, Bendogo secteur 41)
Cape Verde: îles de Santiago (Praia, Pedra Badejo), São Vicente (Mindelo) and Sal (Espargos)
Côte-d'Ivoire: Abidjan (Cocody, Koumassi, Abobo, Yopougon)
Guinea-Bissau: Bissau (Antula, Cuntum, Missira, Plack), Canchungo
Sierra Leone: Freetown (Central, Westend, Eastend) , Waterloo, Mcdonnalds, Tombo, Sessex, River n°2

2.2.3. Methodology

The study was conducted using a quantitative approach through the application of a structured survey administered face to face.

To determine the sample size in each country, we use the formula $N = Z^2 (pq)/i^2$ where:
N: sample size
Z: reduced deviation of 1.96 corresponding to a 95% confidence interval
p: default estimated prevalence of 50%.
q: 1-p (50%)
i: degree of accuracy (5 %).

The size obtained is 384 people, which we will round up to 400 per country, i.e. 2,000 in total.

These 400 respondents were chosen to represent the middle and working classes, those who have regular work or live in the informal economy. Results from other surveys, personal observations and information from the grey literature suggest that these categories of the population are both more exposed to SARS-Cov2 (use of public transport, use of markets, densely populated dwellings) and comply less with preventive measures than the more privileged class.

The sampling was carried out according to the demographics of each country, and distributed as follows:
- males/females
- 18-24 years
- 25-59 years
- 60 years and +

Households were surveyed in each zone. The first household was chosen at random, and then one household out of six was surveyed, in order not to concentrate the survey in one area of the chosen catchment area. Only one person was interviewed in each household, chosen at random if several people met the criteria.

Exclusion criteria:
- mental disability,
- senility,
- a disease for which people feel unable to answer questions.

Responses were anonymous.

Face masks were given to all the survey administrators. Depending on local conditions, they entered the results online, on a tablet or smartphone, or collected them on a printed form and entered them later online, through a computer.

Since all respondents were adults and there were no questions pertaining to their health, we did not submit our protocol to an ethics board.

Survey date:
Burkina Faso: 18-30 October
Cape Verde: 16-22 October
Côte-d'Ivoire: 16-20 October
Guinea-Bissau: 4 - 20 November
Sierra Leone: 19-30 October

2.2.4. Challenges Encountered

The survey administrators declared that they were independent academics and were not working for the government. Very few people approached refused to participate, except in Sierra Leone.

Refusal to respond

196 people declining to respond, ¾ of which in Sierra Leone, for 2000 forms filled, representing 8.92 % (2.67 % without Sierra Leone), which makes the results representative.

Burkina Faso: 8 people (1.96%) who cited the frequency of surveys, their ignorance about COVID and even lack of time, declined to answer.

Cape Verde: 22 people (5.21%) cited lack of time, because this was not going to change their lives, fear of exposure to COVID-19, or said they did not want to interfere with elections.

Côte-d'Ivoire: 10 people (2.43%) refused because the government failed to deliver on its promise to help poor households, they said.

Guinea-Bissau: 4 people (1%) refused to answer, three of whom cited a lack of time and one for lack of interest.

Sierra Leone: 152 people (27.53%) refused to respond claiming that the survey was going to use them to make money without any benefit to them personally, or that the government was only looking for data to seek funding from the international community.

Corrected mistakes

Some survey administrators made mistakes in the sex and age distributions. The excess questionnaires in some categories were randomly deleted and new people surveyed in categories that had a deficit.

No particular difficulties were encountered, with the exception of a relatively high number of often aggressive refusals recorded in Sierra Leone. In Cape Verde, the survey coincided with election campaign, but the survey administrators avoided political meetings and there was no problem.

2.2.5. Data on respondents

The tables below show the sex and age distribution of respondents.

	Female	Male	Total
Burkina Faso	206	194	400
Cape Verde	199	201	400
Côte d'Ivoire	192	208	400
Guinea-Bissau	215	185	400
Sierra Leone	195	205	400
Total	1007	993	2000

Table 1: Sex-wise distribution of respondents

|	18-24 years	25-59 years	< 60 years	Total
Burkina Faso	271	105	24	400
Cape Verde	78	261	61	400
Côte d'Ivoire	168	210	22	400
Guinea-Bissau	92	270	38	400
Sierra Leone	74	274	52	400
Total	683	1120	197	2000

Table 2: Age-wise distribution of respondents

2.2.6. Similar results for both sexes and all ages

The results are not significantly different according to the sex and age of the respondents, which is why we do not provide a breakdown by sex and age in the rest of this report, with the exception of the results mentioned in Chapter 3.4.

One of the questions asked respondents, for example, whether they find the advice to keep a distance of at least one metre useful to protect themselves from COVID-19. As young people have a more intense social life and have more and closer human contacts than adults, we could expect different answers depending on their age. However, 89.02% of respondents under 25, 90.09% of those aged 25-59, and 90.36% of those aged 60 and over answered yes.

We asked "How confident are you in what you are told about COVID-19 by…" with 5 possible choices ranging from "Very confident" to "Highly suspicious." We could have expected that the results about "Social media" would be somewhat different according to the age groups. Yet, they do not differ significantly between age groups, with the exception of Côte d'Ivoire.
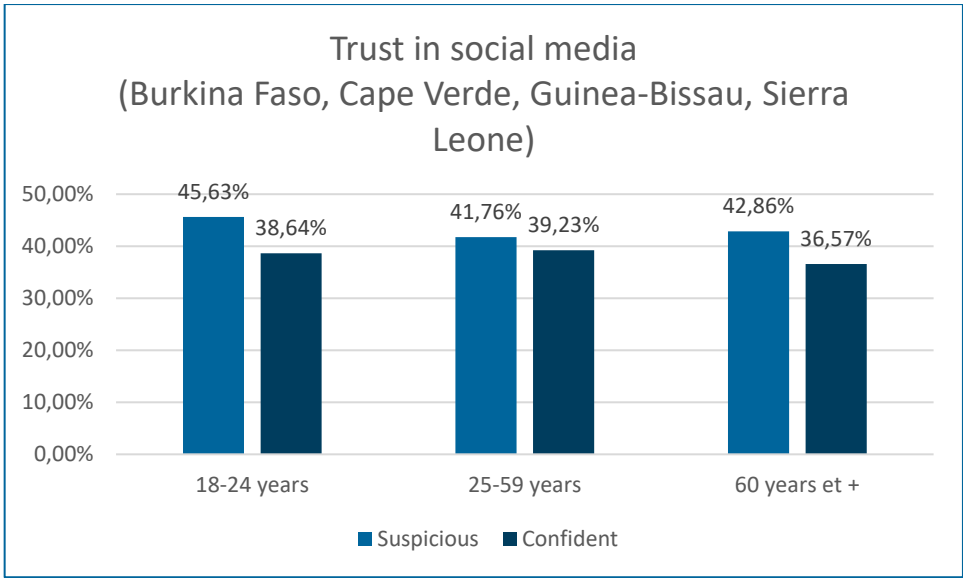
Figure 1: Trust in social media

Similarly, we could expect differences in response between men and women on the usefulness of messages about staying at home. Number of "yes" responses was close between the two sexes, with 79.94% amongst females and 76.74% amongst males.

3. Findings of the Socio-anthropological Survey[4]

3.1.   Acquired knowledge

The messages on the symptoms of COVID-19 and the barrier measures over the last seven months have, undoubtedly, penetrated the population very well.

3.1.1. Widespread knowledge about the virus

97.60% of respondents have "heard about coronavirus." Similar results were recorded in all the countries (from 95.25 % in Guinea-Bissau to 99.50 % au Burkina Faso and Cape Verde). As we shall see further (3.3.1), close to 10 % of respondents, however, do not believe that the virus is real.

Moreover, 78.75% of respondents answered "yes" when asked: "Do you know what a virus is?", with significant differences from country to country: 65.50 % in Guinea-Bissau, 79.25 % in Burkina Faso, 80.50 % in Sierra Leone, 81.75 % in Côte d'Ivoire and 86.75 % in Cape Verde.

→   The fact that almost the entire population has heard about the coronavirus and that a vast majority claims knowledge of what a virus is, provides an anchor for communication to highlight the distinction between being infected by the coronavirus and having COVID-19.

3.1.2. Excellent knowledge of the symptoms

Asked "which of the following symptoms may be attributed to COVID-19?" 11 multiple choice answers were supplied, of which one was a symptom of tuberculosis and another a symptom of the Ebola Virus Disease (EVD).

Respondents have a sound knowledge of COVID-19 symptoms which have been widely communicated (fever, cough, breathing difficulty), but few know about loss of smell and taste, with the exception of Cape Verde where those two symptoms are known by 89.75 and 88.50% of respondents, respectively. With the exception of Cape Verde, the affirmative responses in the following graph will be 54.81% for loss of smell and 53.56% for loss of taste.[5].

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[4] The majority of the questions had multiple choice answers, with the respondent having to choose between "yes", "no" and "no opinion" for each answer. Since the results in this report refer only to "yes" and "no" responses, the total does not add up to 100%.

[5] According to a telephone survey conducted by Ipsos for PERC, in early April 2020, cough was considered a symptom of COVID-19 by 84% of Ivorians, fever by 83%, and breathing difficulties by 62%. These levels were 74%, 82% and 70% in DRC, 81%, 66% and 59% in Nigeria, 65%, 66% and 46% in Guinea Conakry and 70%, 79% and 74% in Ghana, 65%, 53% and 44% in Liberia.

Knowledge of COVID-19 symptoms
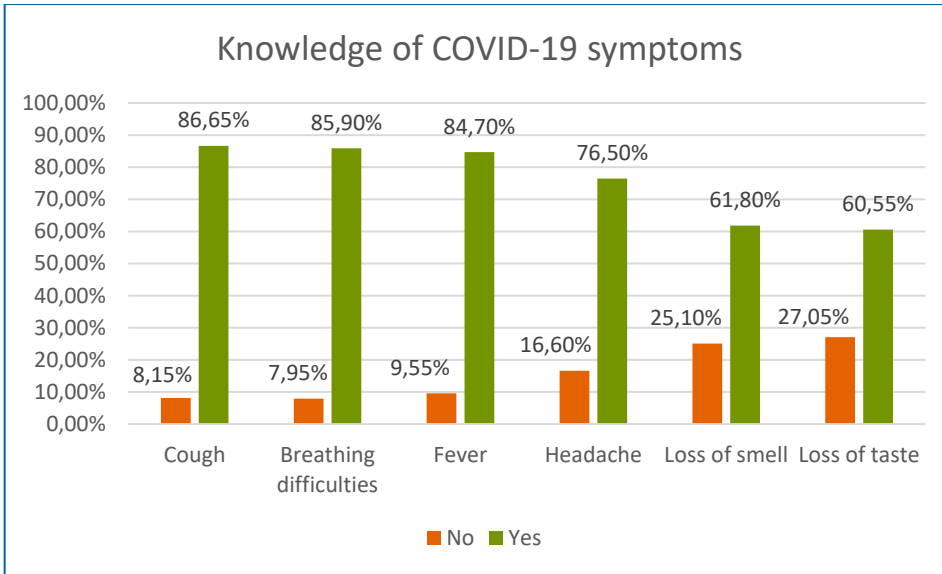
Figure 2: Knowledge of COVID-19 symptoms

→ Knowledge of most of the symptoms may be considered a given, but care should be taken to ensure that communication material systematically mention loss of taste, and smell amongst the symptoms of COVID-19.

3.1.3. Perfect knowledge of barrier measures

We asked respondents whether they had heard a number of messages and, when the response was yes, we asked whether they thought "such advice is useful for protecting oneself against COVID-19". Almost all of them have heard the messages on the barrier measures, and a great majority beliefs that those measures are effective for preventing the disease in Cape Verde, in Burkina Faso and in Guinea-Bissau.

In the graphs below, the response to the question on the usefulness of the preventive measures are calculated based on all respondents, indicating thus the proportion of the population which believes the measures are useful[6].

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[6] According to a survey conducted by Ipsos for PERC, by telephone in early April 2020, 90% of Guineans and Nigerians think that washing their hands protects against COVID-19, 92.00% of Ghanaians and 86% of DRC inhabitants.

Keeping a distance of 1 meter

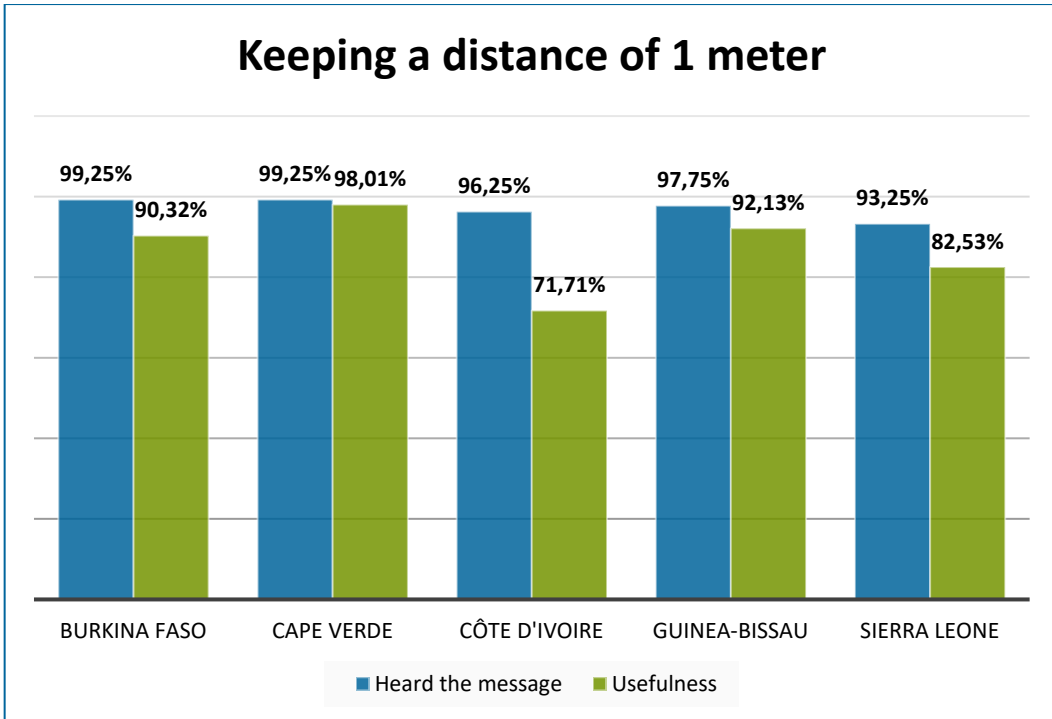|	Heard the message	Usefulness
BURKINA FASO	99,25%	90,32%
CAPE VERDE	99,25%	98,01%
CÔTE D'IVOIRE	96,25%	71,71%
GUINEA-BISSAU	97,75%	92,13%
SIERRA LEONE	93,25%	82,53%

Figure 4: Keeping a 1 metre distance

Do not shake hands

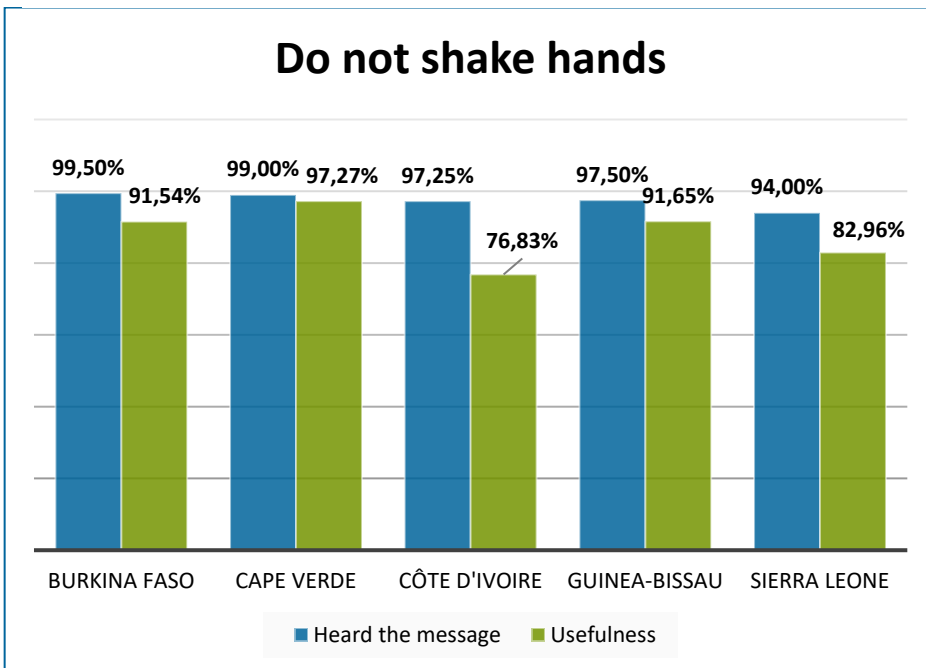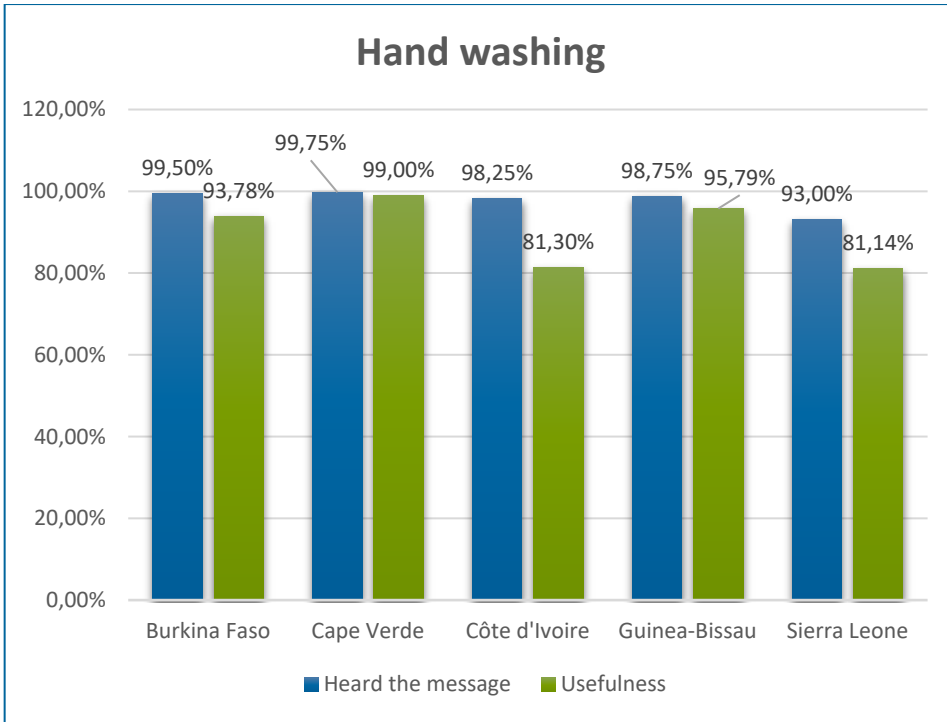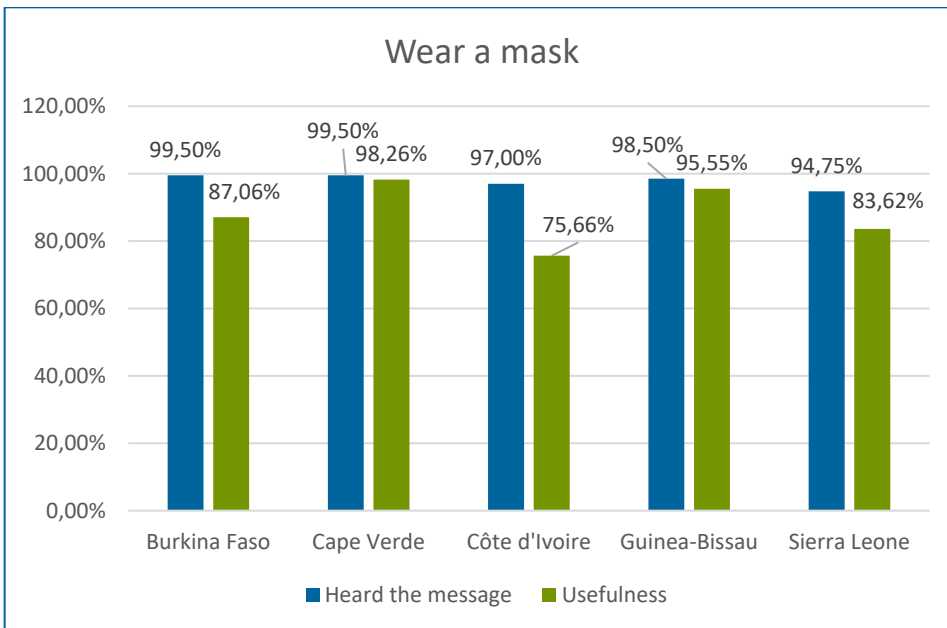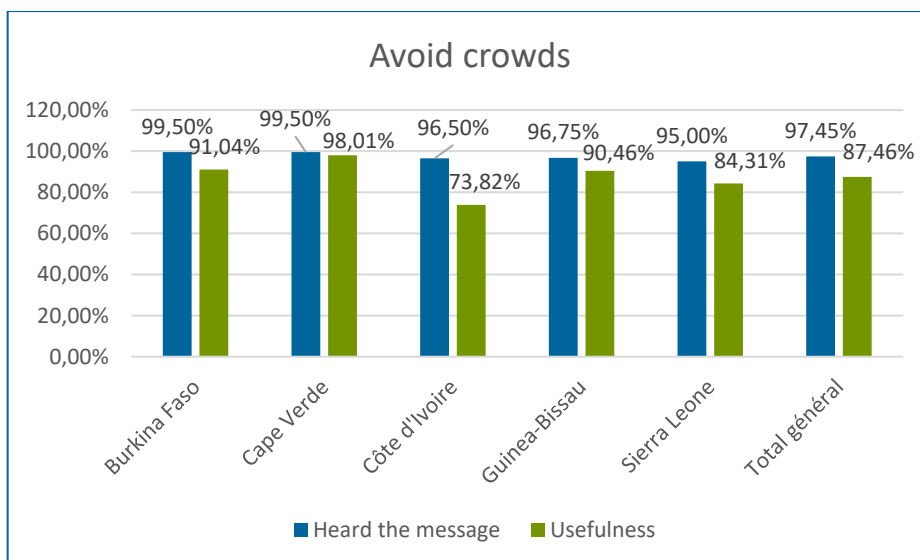|	Heard the message	Usefulness
BURKINA FASO	99,50%	91,54%
CAPE VERDE	99,00%	97,27%
CÔTE D'IVOIRE	97,25%	76,83%
GUINEA-BISSAU	97,50%	91,65%
SIERRA LEONE	94,00%	82,96%

Figure 3: Do not shake hands

Figure 5: Hand washing

Figure 6: Wear a mask

Figure 7: Avoid crowds

The graph below, which shows the average affirmative responses to the question on the usefulness of the five preventive measures, shows that the results vary between countries. Cape Verde recorded excellent results, Guinea-Bissau and Burkina Faso[7,8], but inadequate in Sierra Leone and especially in Côte d'Ivoire[9]. The limited uptake of the messages is not because people have not heard them, since 93% to 95% of respondents (depending on the message) have heard them in Guinea-Bissau and 96.25% to 98.25% in Côte d'Ivoire.

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[7] According to a telephone survey of 450 people conducted in Burkina Faso by the Centre d'Excellence en Pratique Statistique & Informatique (CEPSI), in April 2020, 74.40% of people thought that "with the wearing of a mask there is no risk of infection within one meter».

[8] According to the PMA Burkina Faso survey, women considered as "measures to be taken to reduce the risk of contracting COVID-19": avoid shaking hands 95.50%, wear a mask 95.50%, keep a distance 96.20%, use of hand sanitizer 94.50%, and wash with soap 95.90%.

[9] The results of the survey conducted by Ipsos for PERC are significantly different for Côte d'Ivoire. According to this telephone survey conducted at the beginning of April 2020, 92% of Ivorians believe that hand washing prevents the disease, compared to 81.30% according to our results.
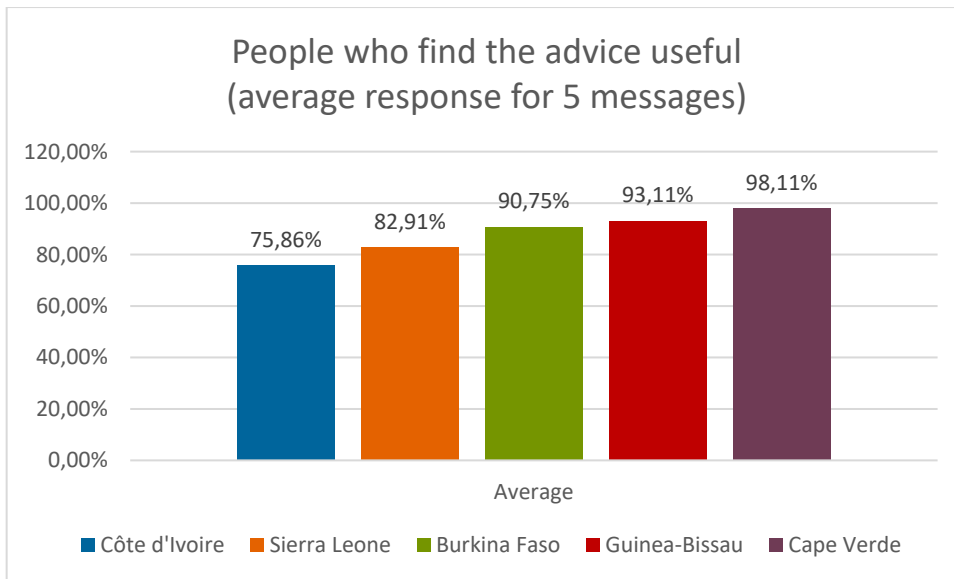
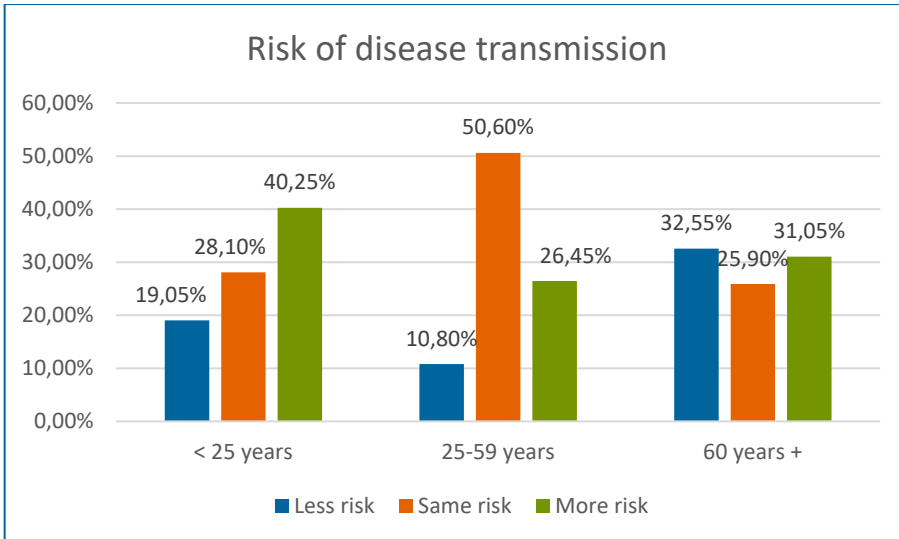*Figure 8 : People who find the barrier measures useful*

Respondents also know that the preventive measures protect them (91.50%) and protect others (85.05 %), with the levels again being lower in Côte d'Ivoire, where 85.00% of respondents think that the measures protect them and 66.25% think it is for the protection of others.

→   In Burkina Faso, Cape Verde, and Guinea-Bissau knowledge of the barrier measures could be said to be guaranteed. There's a need for communication around this in Sierra Leone and especially in Côte d'Ivoire, where people have heard the messages but are insufficiently convinced.

3.2.   Inadequate level of knowledge

3.2.1. Lack of knowledge about asymptomatic infection

The majority of respondents know that the risk of being ill is higher among those aged 60 and over (3.2.4). We also asked the question: "Do these age groups represent more, as much or less risk of transmitting the disease than others?". Only 34.86% only of respondents gave the correct answer: the same risk in all three age groups. This shows a lack of awareness of the fact that the risk of coronavirus infection and transmission is the same at all ages, beyond childhood.

Risk of disease transmission

Age group	Less risk	Same risk	More risk
< 25 years	19,05%	28,10%	40,25%
25-59 years	10,80%	50,60%	26,45%
60 years +	32,55%	25,90%	31,05%

*Figure 9: Risk of disease transmission according to age*

While it is widely known that advanced age is a risk factor for serious disease, there is a great deal of misunderstanding that everyone, with the exception of children, runs the same risk of being infected with the coronavirus and of transmitting it.

To the question "Who can transmit COVID-19 to you? "90.95% answered "A sick person", with few differences between countries, and only 20.10% answered "A person who is not sick", with large differences between countries.[10].

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[10] According to the PMA Burkina Faso survey 72.90% of women believed that "only people with symptoms are contagious".
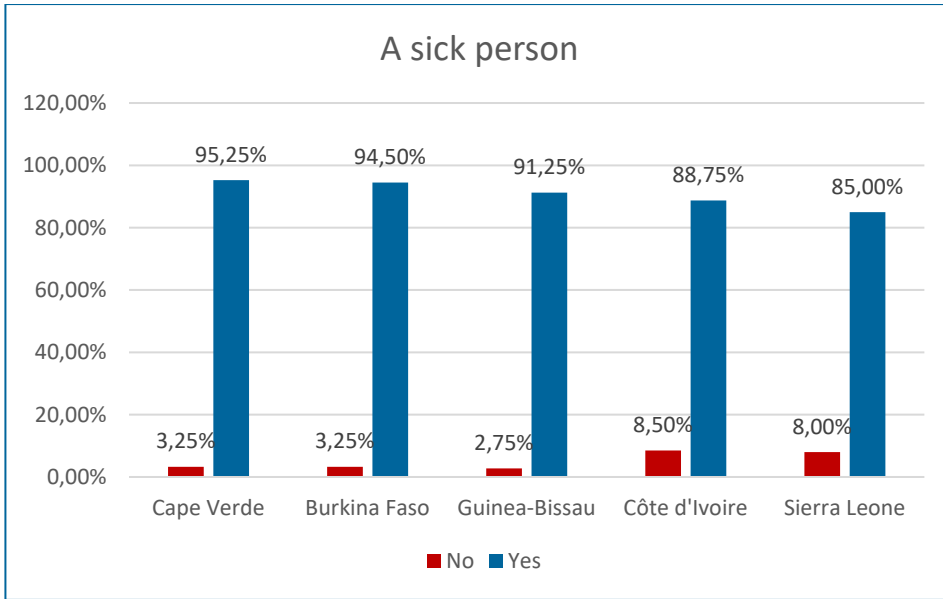
*Figure 11: Who can transmit you COVID-19 (sick persons)*
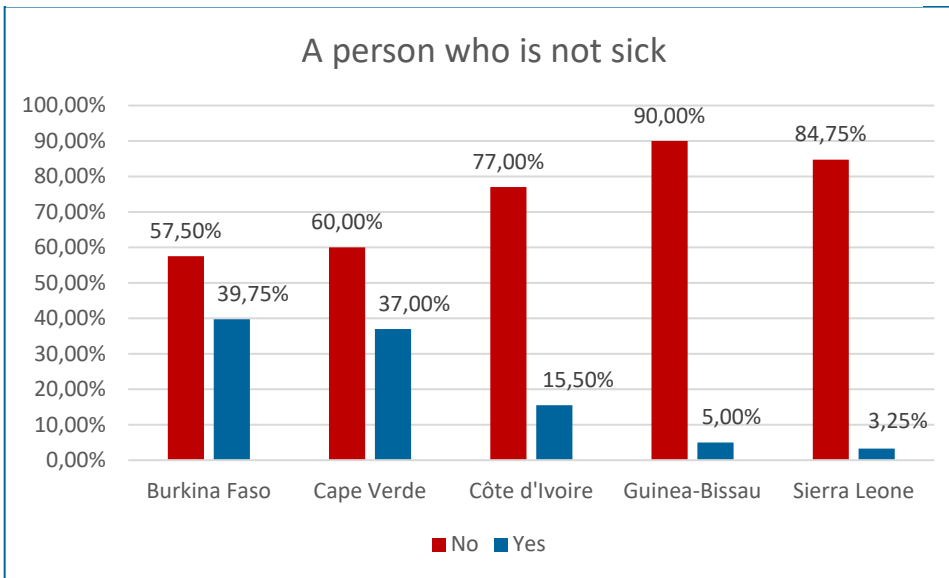
Figure 10: Who can transmit you COVID-19 (not sick persons)

To the more specific question: "If I tell you that the disease is caused by a virus, a coronavirus, in whom can we find this virus?" 73.25% replied "Only people who are sick with COVID-19" and 31.35% "Everyone, even people who are not sick". [11] There are significant differences between countries, with a minimum of 10.25% in Guinea-Bissau and 14.25% in Sierra Leone.

10.25% (Guinea-Bissau) to 50% (Burkina Faso) of people only know that asymptomatic individuals can carry the virus. Ignorance of asymptomatic infections is a major obstacle to compliance with prevention measures. It is precisely because the virus is transmitted by people with few or no symptoms that these measures are recommended to the entire population and not just the sick.

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[11] According to a telephone survey conducted by PERC in Nigeria, 82% of respondents knew that an infected individual may be symptom-free for 14 days, which might seem to contradict these results. But the question asked only about the sick and whether it is true or false that an infected person can be asymptomatic for 14 days before becoming ill.
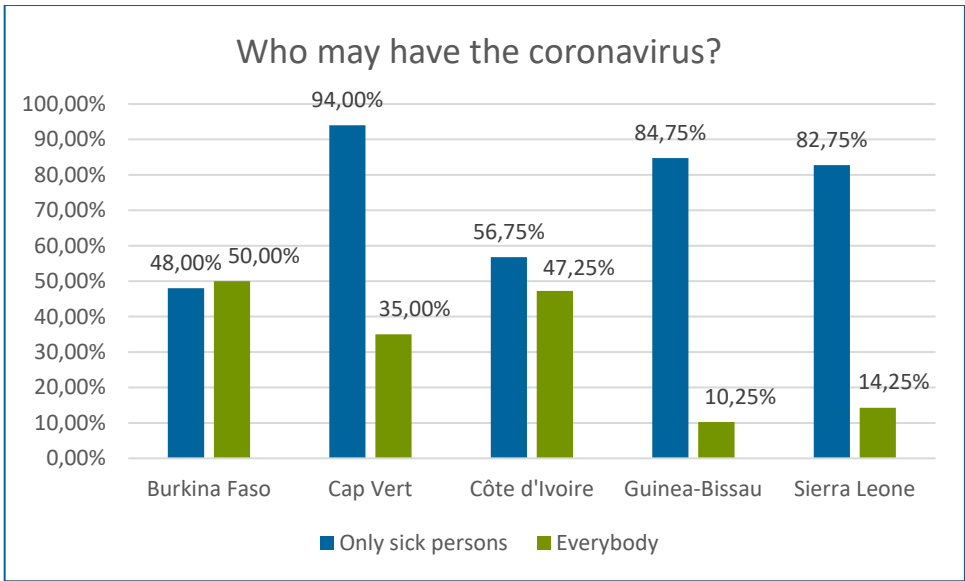
Figure 12: Who may have coronavirus?

The risk of transmission by a healthy individual is perceived to be lower than by animals, meat or eggs, which in reality represent no risk (3.3.2). 20.10% of people only think that a healthy person can transmit COVID-19.
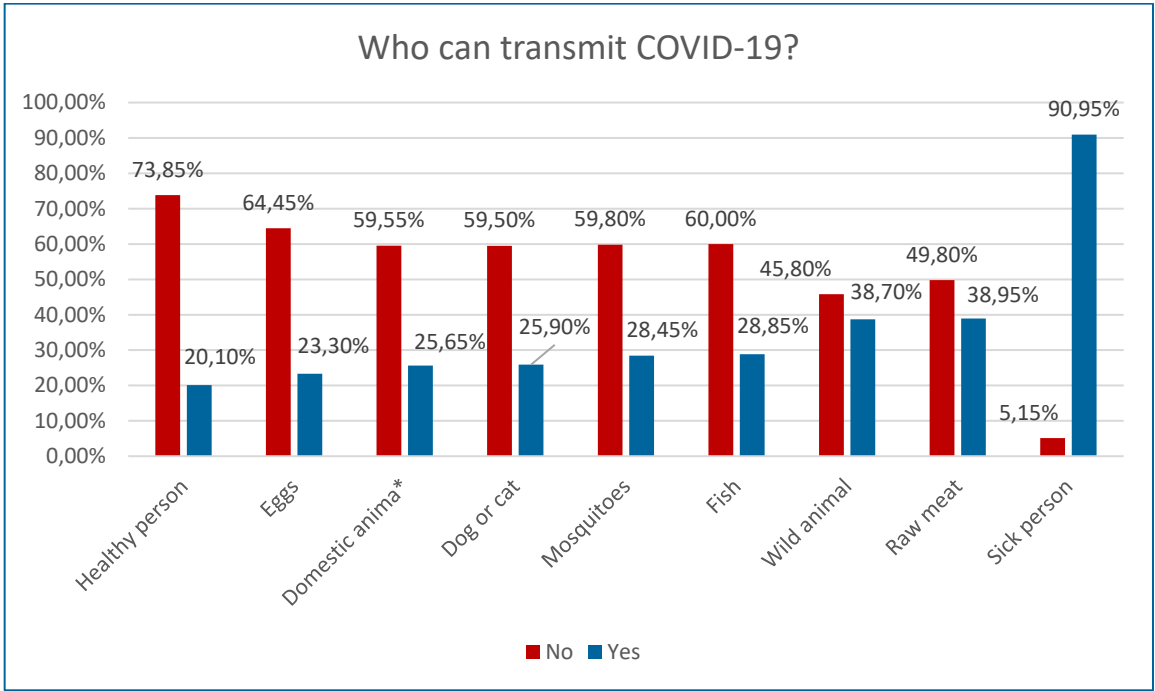
Figure 13: Who can transmit COVID-19? (animals and people)

→ Only a minority of the people (20.10%) knows that asymptomatic subjects can transmit SARS-CoV-2, a major hurdle to compliance with the preventive measures. This must be made a communication priority.

3.2.2. Inadequate knowledge of anosmia and ageusia (loss of smell and loss of taste)

Although most COVID-19 symptoms are quite widely known (3.1.2), it is not the case for the loss of smell (anosmia) or of taste (ageusia), known by about 60% of respondents.

	Loss of sense of smell		Loss of taste	
	No	Yes	No	Yes
Burkina Faso	35,50%	57,00%	35,50%	57,25%
Cape Verde	5,50%	89,75%	8,25%	88,50%
Côte d'Ivoire	25,75%	56,50%	30,00%	53,00%
Guinea-Bissau	15,25%	60,50%	16,50%	60,50%
Sierra Leone	43,50%	45,25%	45,00%	43,50%
GRAND TOTAL	25,10%	61,80%	27,05%	60,55%

Table 3: Loss of smell and taste

→ Care should be taken to ensure that anosmia and ageusia are mentioned in communication media amongst the symptoms of COVID-19.

3.2.3. Knowledge of risks related to morbidities differs from country to country

We listed seven types of conditions. Respondents had to choose the risk of COVID-19 from:
- more risk
- as much risk
- less risk
- no answer

Four of the items were risk factors for serious forms of the COVID-19 and three others were added in order not to limit choice to the actual risk factors (pregnancy, tobacco and alcohol use).

Knowledge of the risk factors differed for each factor and per country.

Hypertension and cardiovascular diseases (CVD), diabetes and lung diseases are risk factors well known to respondents in Burkina Faso, Cape Verde and, to a lesser extent, Guinea Bissau, as shown in the tables below. They are less widely known in Côte d'Ivoire and almost not known in Sierra Leone.
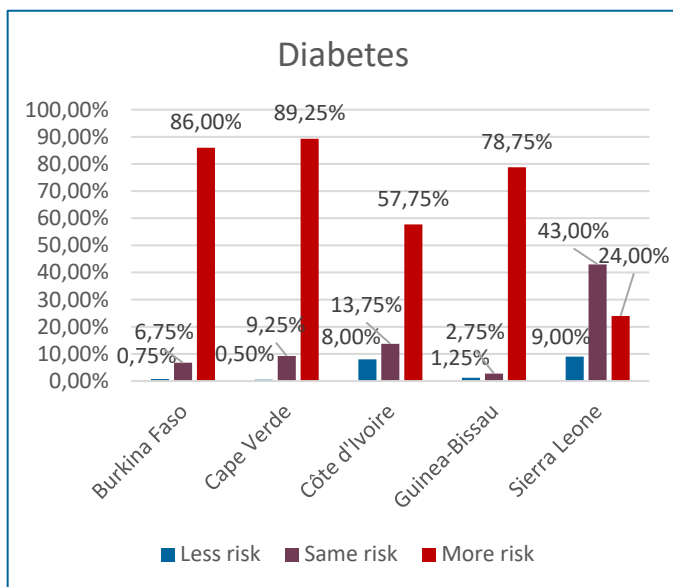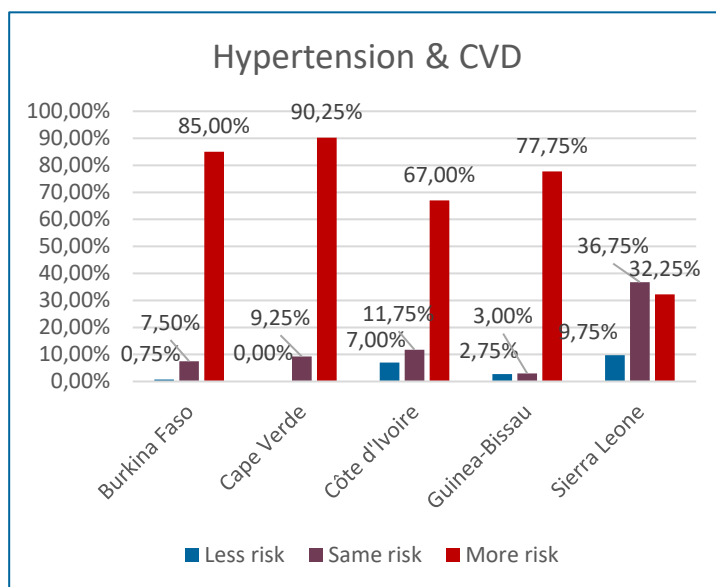

Figure 15: Diabetes
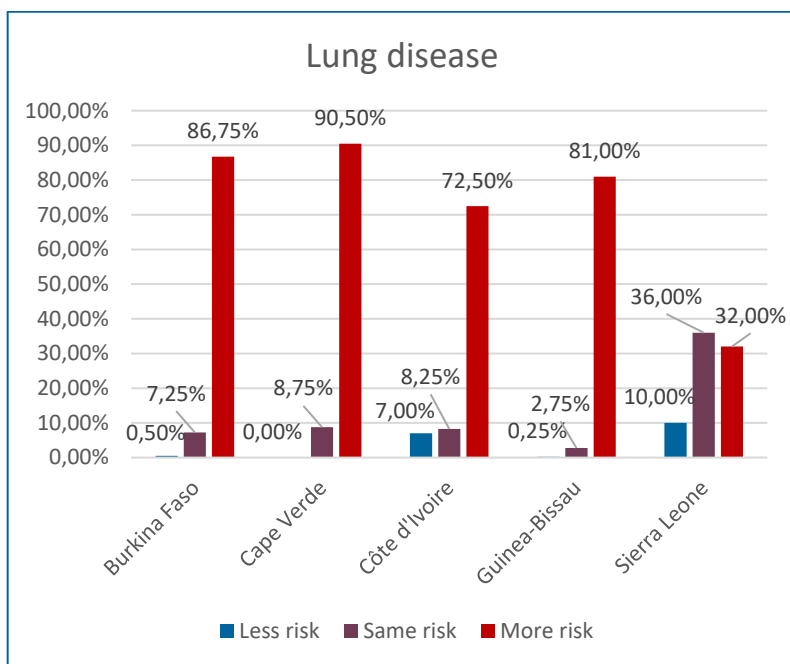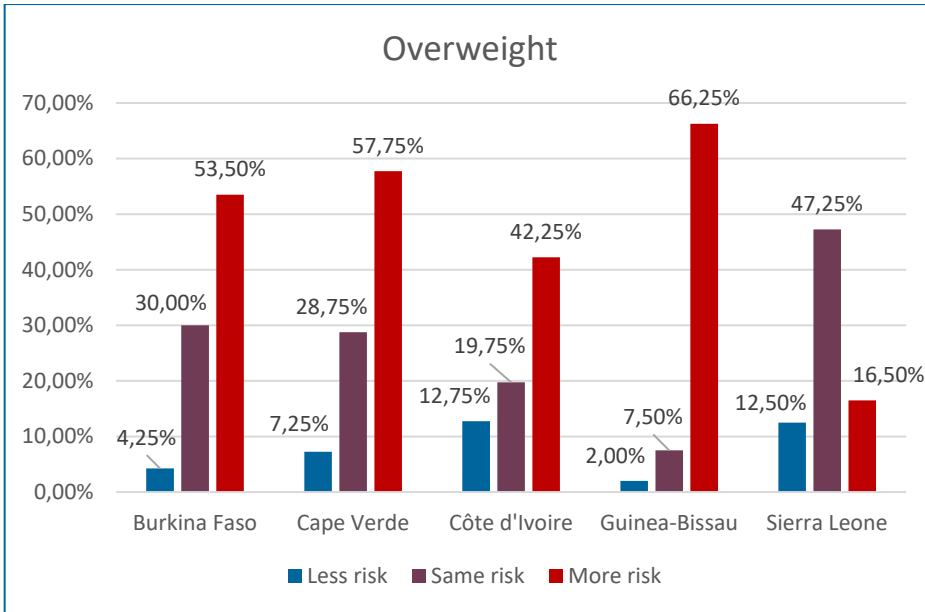

Figure 14: Hypertension & CVD

Figure 16: Lung disease

The proposed risk factor "Overweight" is, on the other hand, less known in all the countries but, yet again, even less in Côte d'Ivoire and Sierra Leone.

Figure 17: Overweight

The average of positive answers ("more risk") for the four risk factors shows differences between the five countries: these factors are well known in Guinea Bissau, Burkina Faso and Cape Verde, insufficiently in Côte d'Ivoire and very insufficiently in Sierra Leone.
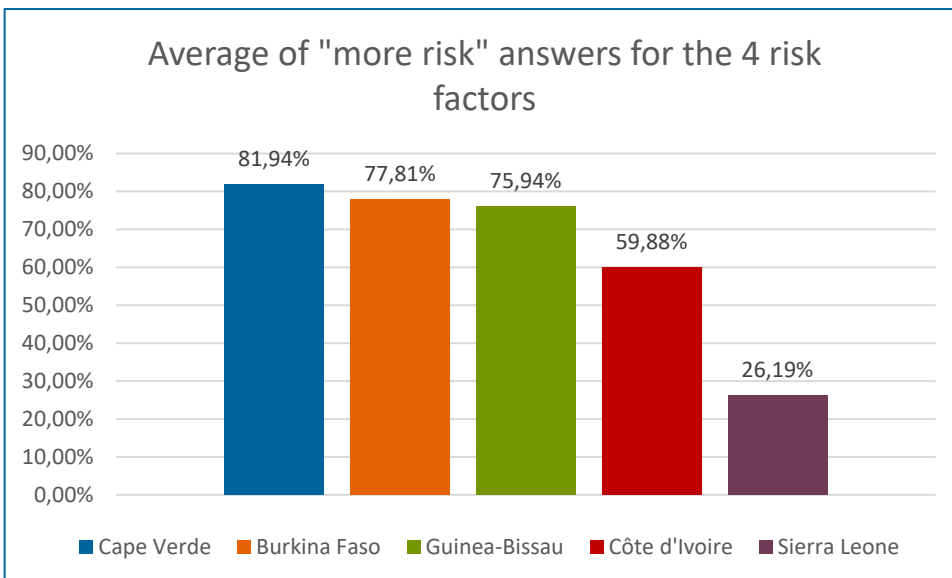
Figure 18: Knowledge of the 4 risk factors

→ Knowledge of obesity as a risk factor needs to be improved in all countries. In Côte d'Ivoire and Sierra Leone, knowledge of all the risk factors must be boosted.

3.2.4. Knowledge of risks related to age differs from country to country

A question as to whether "people of this age bracket run an equal or less risk than the others of getting sick with COVID-19" with multiple choice answers covering three age brackets, shows that people in Burkina Faso, Côte d'Ivoire and Guinea-Bissau have a good level of knowledge[12] (more than 70%), but inadequate in Sierra Leone and Cabo Vert (less than 50 %)[13].
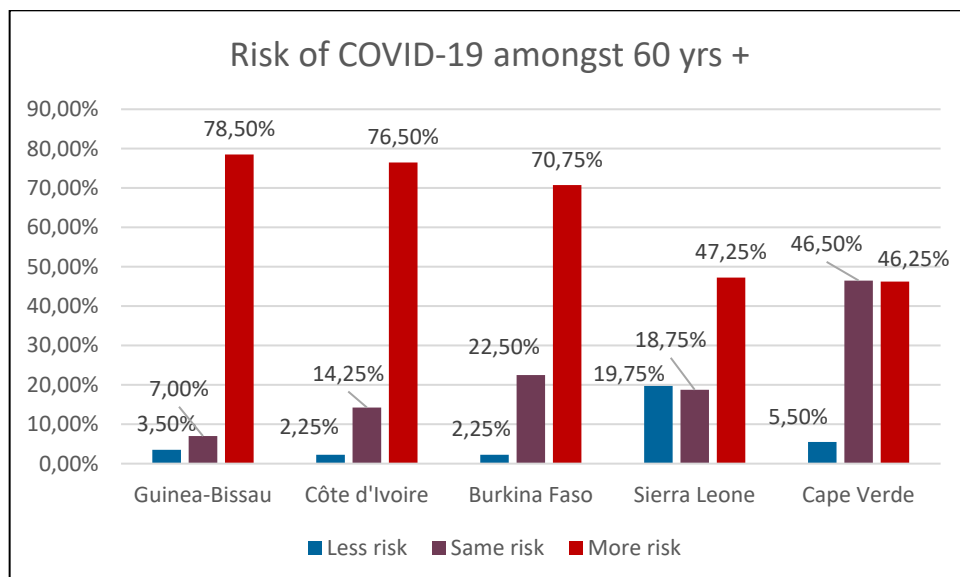

Figure 19: Risk of COVID-19 amongst persons 60 yrs +

→ Knowledge of age as a risk factor is well established in Burkina Faso, Côte d'Ivoire and Guinea-Bissau but needs to be improved in Cape Verde and Sierra Leone.

3.2.5. Confidence in the message carriers

We asked respondents about their trust in what various sources "tell them about COVID-19".

It turned out that the "trust" answers for "social media" (as formulated in the questionnaire) were the lowest, while, logically, the "distrust" ones were the highest. These results put into perspective the impact of the "infodemics" (an abundance of often erroneous information that circulates essentially on social networks) which is the subject of many studies, especially since trusting social networks does not mean that one believes everything they convey. It should be pointed out that the youth doesn't trust more the social media than people in higher age brackets (2.2.6).
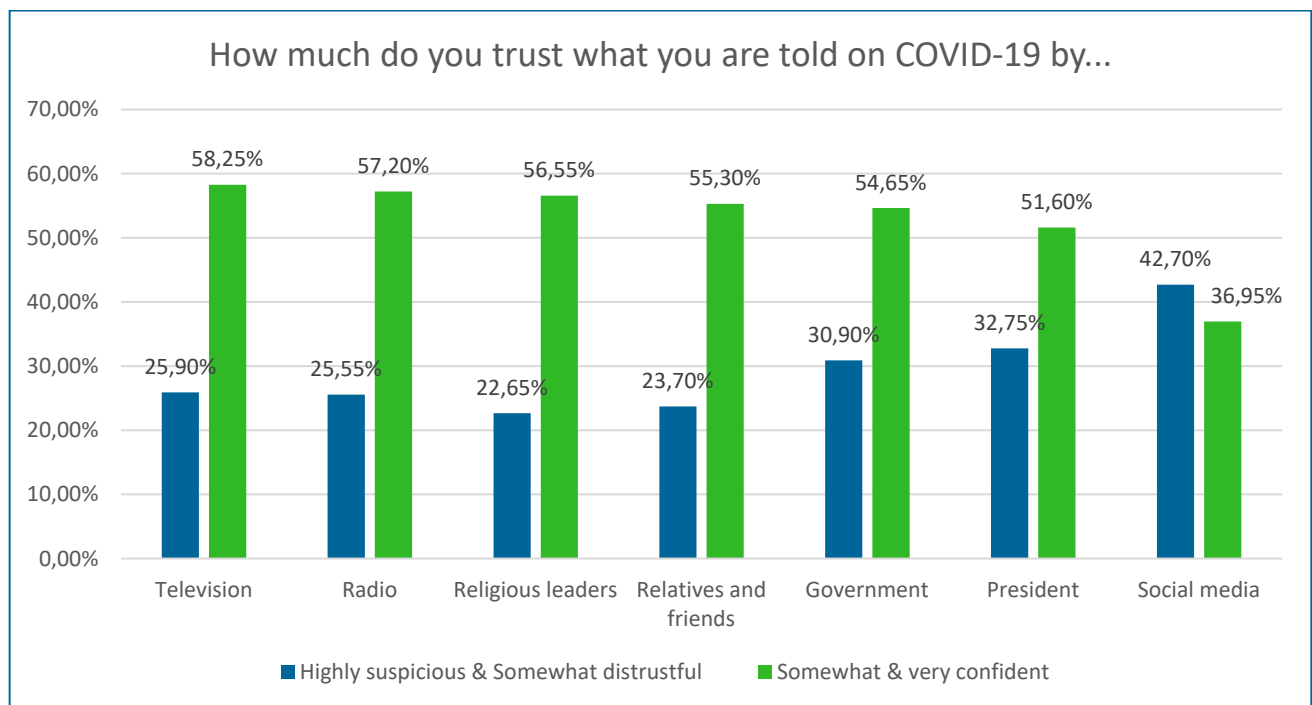
The results are very similar in all countries, with the exception of trust in religious leaders and social networks, which is, in both cases, significantly lower in Cape Verde (in the following figures

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[12] According to the CEPSI telephone survey in Burkina Faso, already cited, 92.5% of people thought that "the elderly are more vulnerable to illness caused by COVID-19".

[13] A study conducted in Guinea by the African Centre of Excellence for the Prevention and Control of Communicable Diseases, Gamal Abdel Nasser University of Conakry, and reported on 1 May 2020, provided very similar results. 64.70% of respondents felt that older people "are more likely to die from COVID-19", 28.20% "everyone", 1.40% "adults", 0.80% "youth" and 0.80% "children ».

we don't report the "neither suspicious nor trusting" answers, which explains that the totals are not 100%) [14,15].

How much do you trust what you are told on COVID-19 by...

	Highly suspicious & Somewhat distrustful	Somewhat & very confident
Television	25,90%	58,25%
Radio	25,55%	57,20%
Religious leaders	22,65%	56,55%
Relatives and friends	23,70%	55,30%
Government	30,90%	54,65%
President	32,75%	51,60%
Social media	42,70%	36,95%

Figure 20: Trust in what sources say on COVID-19

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[14] PMA Burkina Faso conducted a telephone survey of 3,525 women in the country in early July 2020. The sources of information deemed reliable by urban women, the focus of our survey, were social networks for 38.10%, radio 86.50% and television 89.50%.

[15] According to a telephone survey conducted in Senegal in April 2020, the source of information on COVID-19 is for 96.60% of the population television, radio or newspapers, 51.20% social media, 26.50% family or neighbours, and 3.40% religious leaders (Enquête téléphonique sur la crise du Covid au Sénégal, A. Le Nestour, S. Mbaye and L. Moscoviz). The results cannot be compared with our own, as our study does not focus on the use of these channels, but on the confidence one has in them.
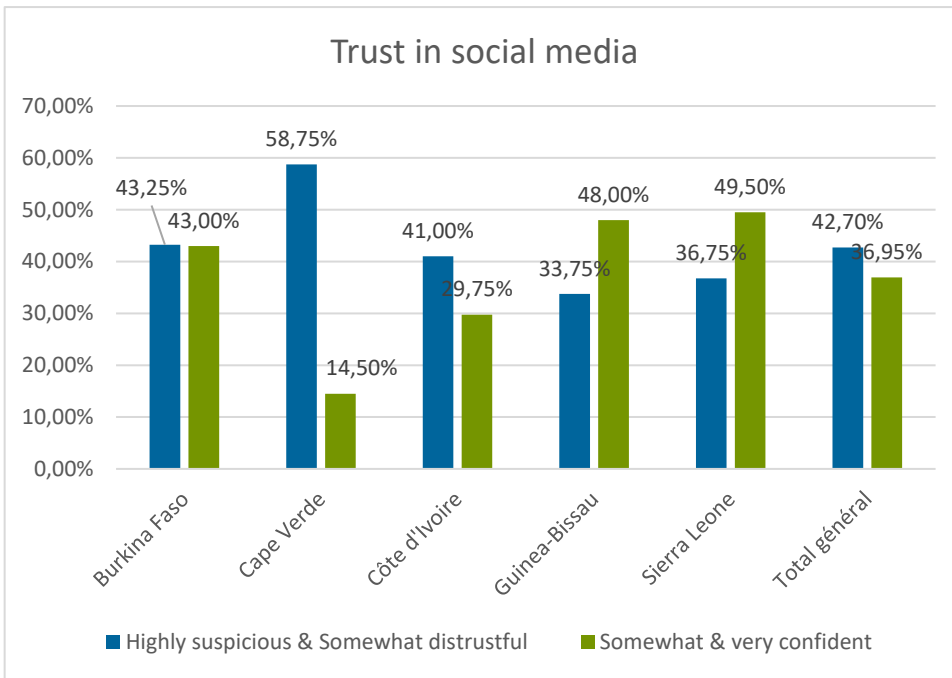
Figure 22 : Trust in social media
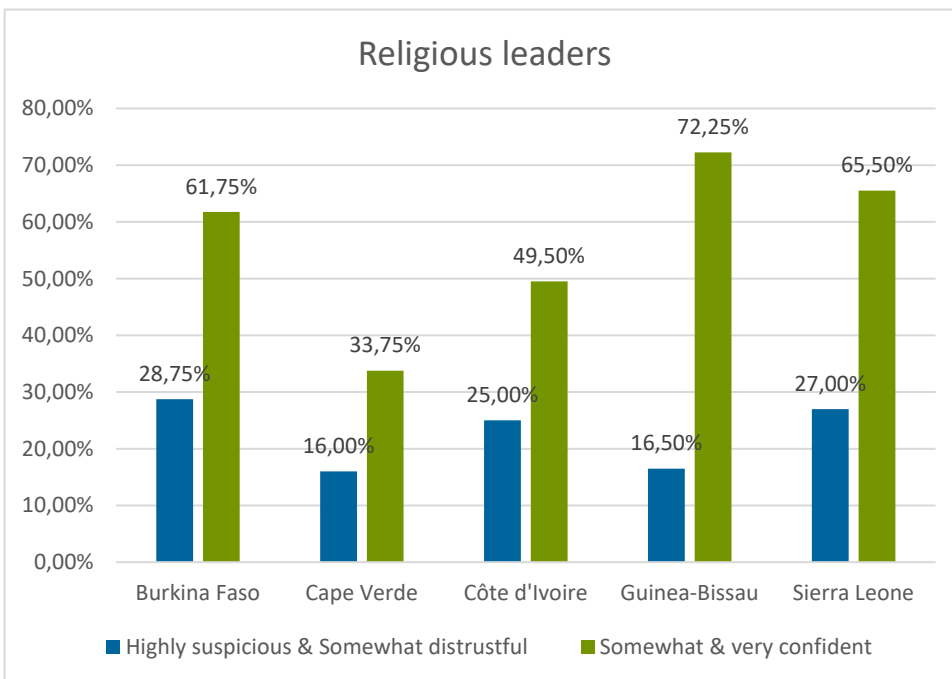
Figure 21 : Trust in religious leaders

→ Television and radio are the sources of information most trusted by people and are, therefore, the preferred channels of communication. Social networks should still be used especially to target the youth you have a higher tendency of using them.

3.2.6. Awareness of the toll-free line

The existence of a toll-free number is very widely known and a majority of respondents were aware of it.[16].

Awareness of the existence of a toll-free number
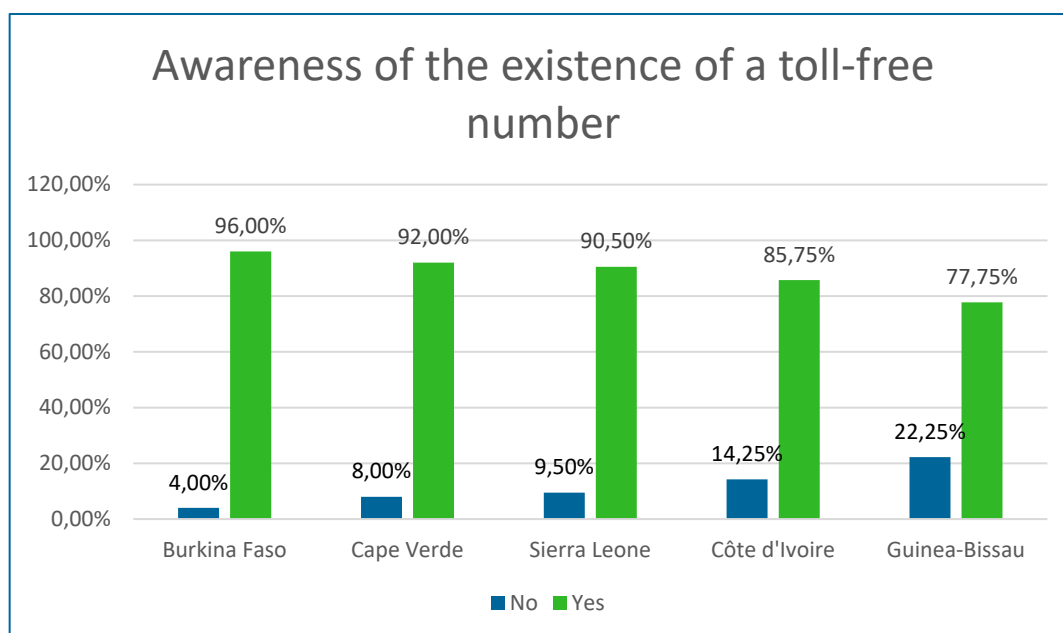
Figure 23 : Knowledge of a greennumber

However, people still quite did not know why they should call the toll-free number. One of the aims of the toll-free number is to avoid patients going directly to a health facility. Whereas 71.10% of respondents answered "Call the toll-free number" to the question "What should you do if you think you might be ill with COVID-19?", 61.65% said they would go to a health centre, 53.70% stated they would go to an emergency department and 44.25% said they would go to any health facility.

→   Toll-free numbers are widely known by the population, but messages about them should always be accompanied by the information that they should be called before going to a medical facility if one thinks he or she has signs of COVID-19.

3.3.   False notions

Respondents were asked if they had heard a series of misconceptions, including those identified as the main circulating rumors, in various surveys[17].

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[16]According to the PMA Burkina Faso study, 87.60% of urban women were aware of the existence of a toll-free number.

[17] Notably: *Responding to COVID-19 in Africa: Using data to find a balance*, PERC (Ipsos survey), 5 May 2020 and *Stop fake news, directory of misinformation/deconstruction Guinea*, https://guinea.unfpa.org/fr/publications/stop-aux-infox-COVID-19.

Among these misconceptions, we distinguish between those which are likely to have an impact on compliance with preventive measures (3.3.1) or on health (3.3.4), and which should therefore be targets for communication, and those which we assume have little or no impact (3.3.2, 3.3.3).

3.3.1. Denial of the reality of the virus and the disease

The main misconception that may hinder compliance with prevention measures is the belief that COVID-19 does not exist. Denial is low, but with very notable differences between countries, since it is shared by only 2.75% of respondents in Cape Verde, 9.25% in Guinea-Bissau, 10.75% in Burkina Faso[18], 18% in Côte d'Ivoire and 20.25% in Sierra Leone.[19]
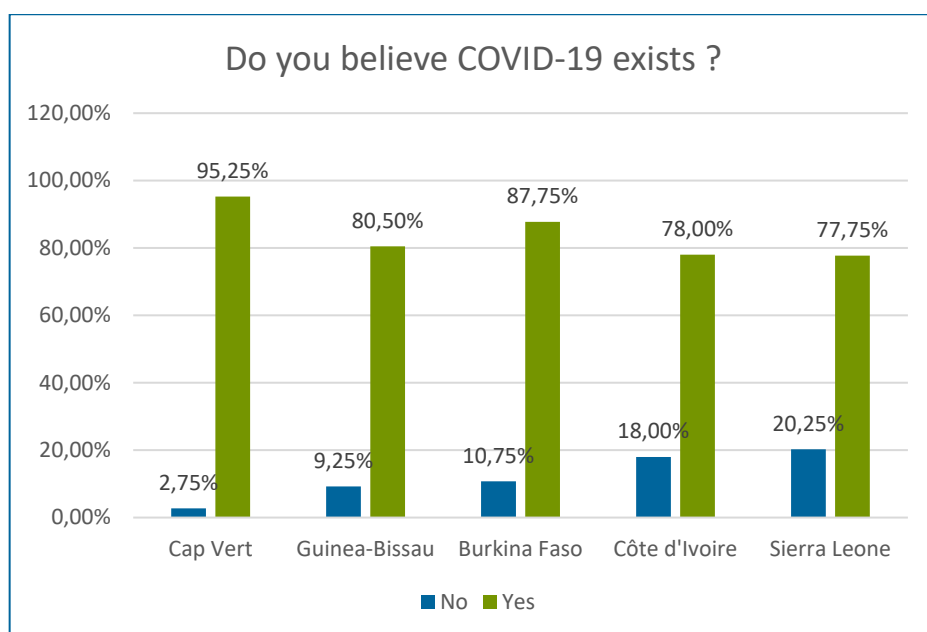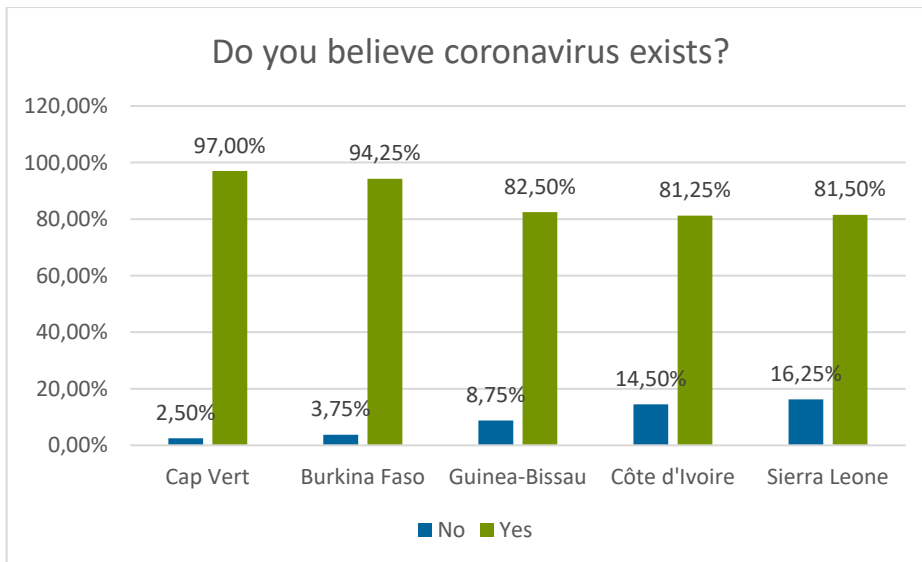

Figure 24 : Do you believe COVID-19 exists?

Expectedly, the percentages of respondents doubting the existence of the virus are close to the previous ones, but they are slightly lower in all the countries: 2.50 % in Cape Verde, 3.75 % in Burkina Faso, 8.75 % in Guinea-Bissau, 14.50 % in Côte d'Ivoire and 16.25 % in Sierra Leone.

We conducted in-depth interviews with 24 people in Burkina Faso, Côte d'Ivoire, and Sierra Leone. Those who doubted COVID-19 exists, which were the majority of the 24, stated that the disease is present on other continents, but is not in their country. We can hypothesize that a good number of the people who responded that COVID-19 exists think that it does it elsewhere else, but not in their country.

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[18] According to the CEPSI phone survey, which included 450 persons in Burkina Faso, in April 2020, 96% of people thought that the coronavirus in present in their country.

[19] The level is identical to the last two countries in Nigeria. According to the Nigeria Centre for Disease Control, to the question "Do you think Coronavirus is real in Nigeria?" 19% answered "no" and 12.00% "I don't know" (data as of 04/11/2020).

Figure 25: Do you believe coronavirus exists?

Among the people who think that COVID-19 does not exist, 63.52% think that the "whites" invented it, 33.20% think that Americans invented it, and 48.77% think that the government invented it.

→ A sizeable fraction of the population denies the existence of SARS-CoV-2 and COVID-19 in their country. This belief has a direct impact on adhesion to the barrier measures and specific communication is needed.

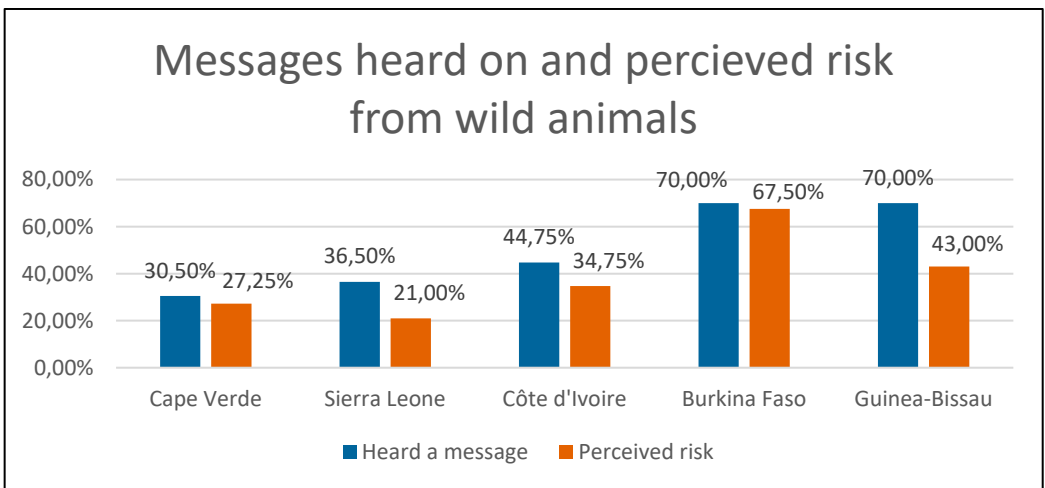## 3.3.2. Misconceptions about the risks of coronavirus infection

Among the most reported misconceptions are those about transmission from wild animals (38.70%), farm animals (25.65%), dogs or cats (25.90%), undercooked meat (38.95%) or eggs (23.30%), and mosquitoes (28.45%).). With the exception of mosquitoes, these unfounded risks have been popularized by messages contained in posters and videos that seem to be not widely broadcast today.[20]

The graphs below show that the proportion of people who believe these misconceptions is directly related to the proportion of people who have heard these erroneous messages. This correlation is less pronounced for wild animals, which are often considered to cause disease, but is particularly clear for fish or eggs, which are generally not thought to cause disease. It is likely that the source of these last two misconceptions is exclusively the erroneous messages mentioned above. This underscores the importance of professional and scientifically sound development of health communication strategies and messages.
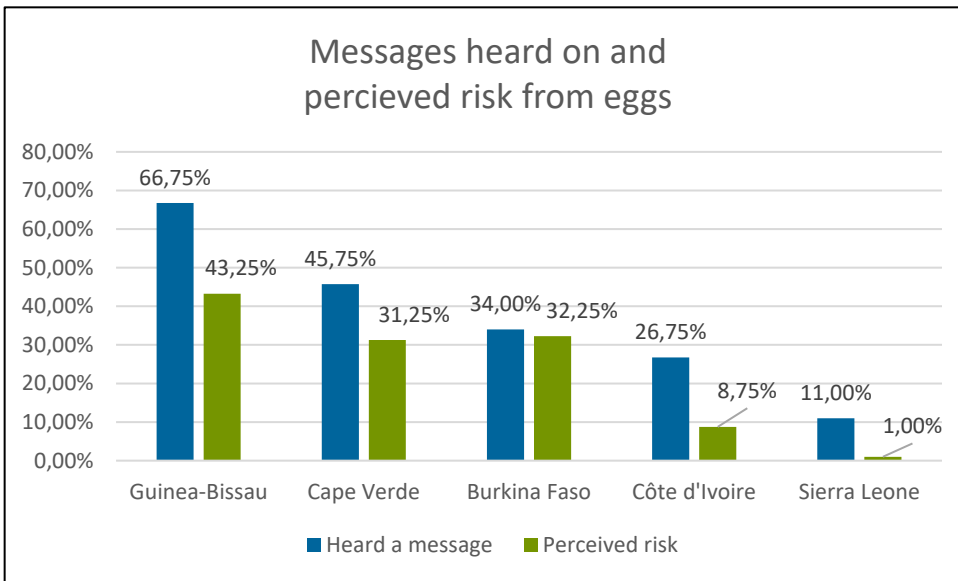
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[20] These messages seem to have been withdrawn following the publication of B Seytre's article. Erroneous Communication Messages on COVID-19 in Africa, Am J Trop Med Hyg. 2020 Aug;103(2):587-589. doi: 10.4269/ajtmh.20-0540. Epub 2020 Jun 3.
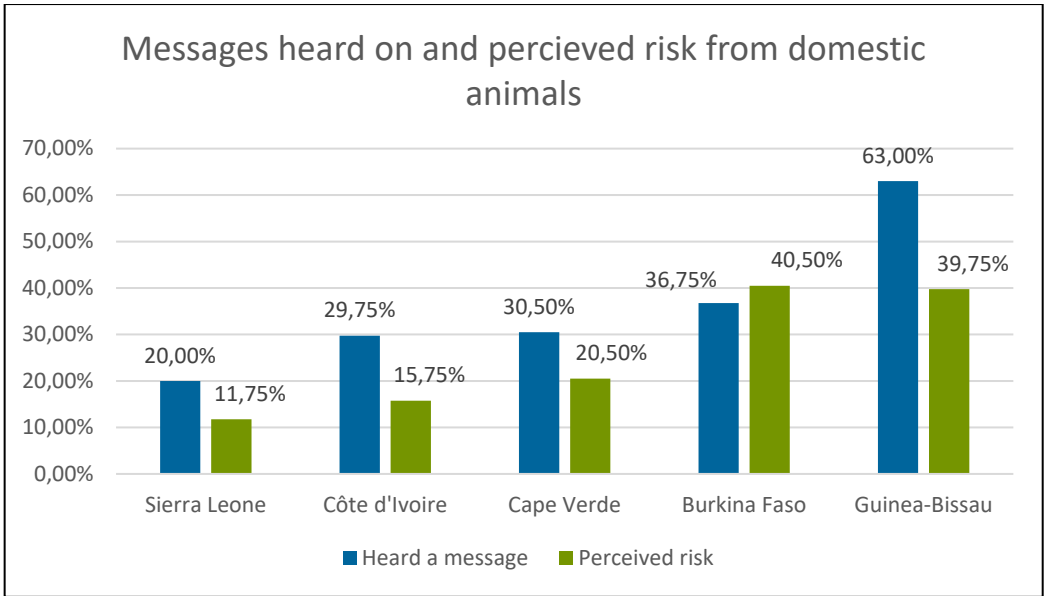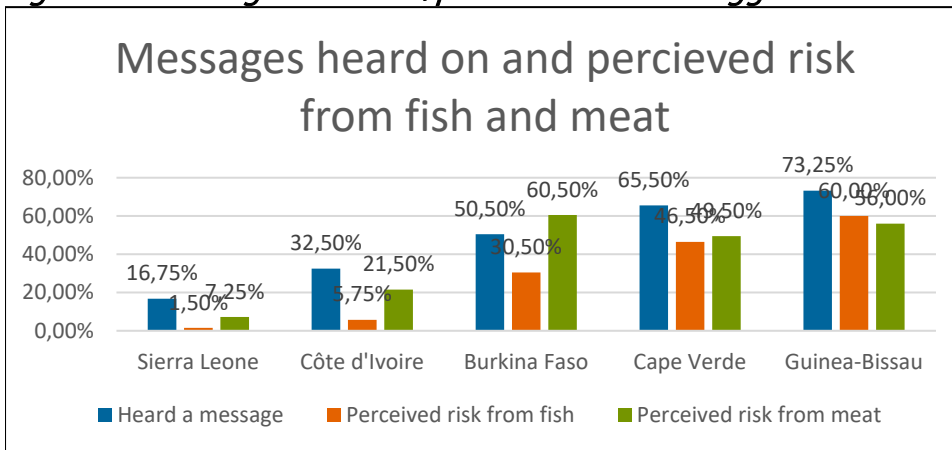
Figure 26: Messages heard on/perceived risk from domestic animals

Figure 27: Messages heard on/perceived risk from wild animals

Figure 29 : Messages heard on/perceived risk from eggs

*Figure 28 : Messages heard on/ perceived risk from fish and meat*

→ Misconceptions about the risks of infection are shared by a substantial part of the population. They might cause confusion and relativize the importance of adhesion to the barrier measures, but it would be pointless to devote communication efforts to rebutting them.

3.3.3. Misconceptions about COVID-19 protection

Respondents were asked "Do the following circumstances or measures reduce the risk of having COVID-19?". There were 14 possible answers, some of which, such as the climate of Africa or the genetic make-up of Africans, are hypotheses put forward by scientists, the reality of which is still being debated.

38.45% of the respondents think that a "traditional medicine treatment" and 53.35% that a "modern medicine treatment" can reduce the risk of getting sick, which is erroneous but has sometimes been put forward by African or European doctors or African governments.

There are instances where a very high proportion of the population believes that products that have no protective effect, and may even be dangerous, protect against COVID-19, with notable differences between countries. "Drinking a disinfectant" is, for example, perceived as providing protection by 1.25%, 3.25% and 3.50% of the population in Cape Verde, Burkina Faso and Côte d'Ivoire, but 12% in Sierra Leone and 48.25% in Guinea-Bissau. For tea the proportion ranges from 13.75% in Burkina Faso to 59.25% in Guinea Bissau and for "drinking bleach" from 1.50% in Côte d'Ivoire to 64.75% in Guinea Bissau. The average of seven misconceptions is: Burkina Faso 14.29%, Sierra Leone 14.54%, Côte d'Ivoire 14.75%, Cape Verde 24.86% and Guinea-Bissau 51%.[21]
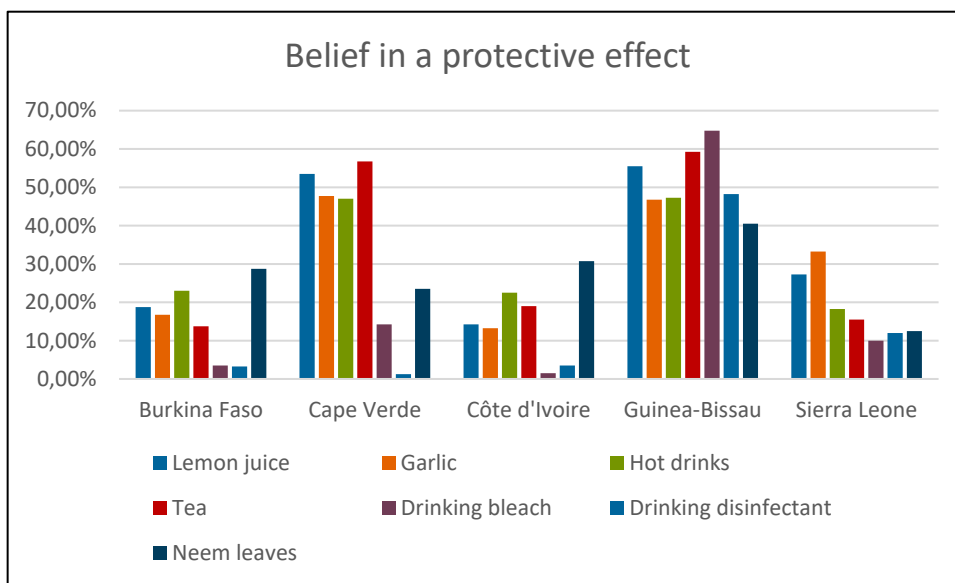
Figure 30: Belief in a protective effect

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[21] According to a PERC survey conducted by telephone in late March - early April 2020 in 20 African countries, 57% of the population believe that lemon juice protects against COVID-19 and 13% believe that it can be cured by drinking bleach. In Nigeria, 51% of people think that garlic can cure the disease and 21% by drinking bleach, and 66% think that lemon juice and Vitamin C protect against COVID-19. In Ghana 74% of people think that lemon juice and Vitamin C provides protection, 38% think that garlic can cure COVID-19, and 22% think that Africans cannot get the disease. In Côte d'Ivoire 30% think that lemon juice and vitamin C provide protection and 5% that drinking bleach can cure the virus.

→ A number of misconceptions about prevention measures are generally shared by a minority of the population, except in Guinea-Bissau. They might relativize the importance of the barrier measures.

3.3.4. A very high level of mistrust of health structures

Numerous articles and reports have highlighted the disruption of health care services caused by the mobilization of health care structures to fight COVID-19[22]. We assessed the population's perception of the risk of contracting the coronavirus in a health care facility, a perception likely to lead to a decrease in demand for care.

67.15% of respondents believe they are at risk of contracting COVID-19 by going to a health facility, with levels ranging from 41% in Sierra Leone to 92.5% in Burkina Faso.
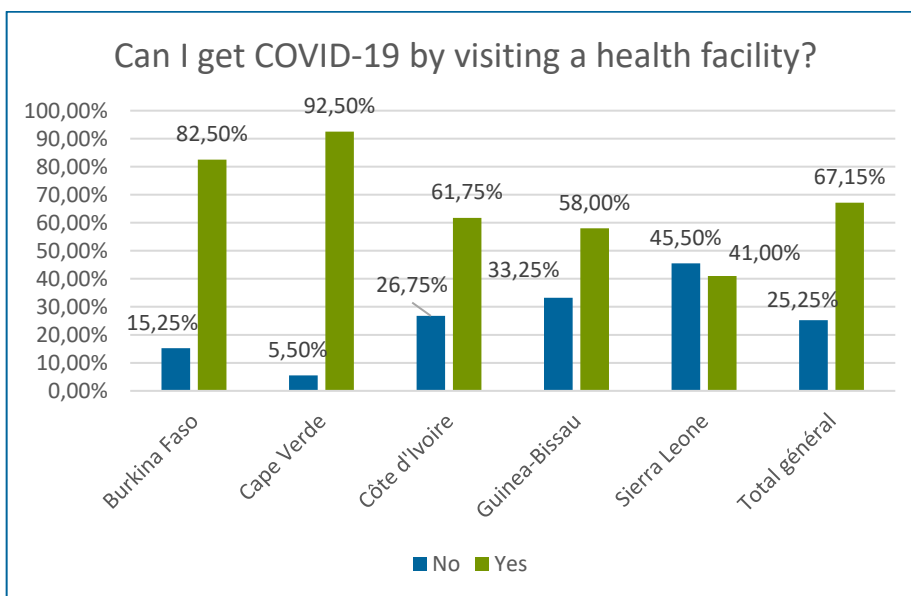

Figure 31: Risk in a health facility

→ The fear of contracting COVID-19 in a healthcare facility is a hindrance to the use of these facilities. This must be made a communication priority.

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[22] See, for example, the WHO Africa office press release of 5 November 2020 "Easing COVID-19 impact on key health services"».

3.4.   Youth

As noted (2.2.6), the conceptions of 18-24 year olds on the COVID-19 are generally no different from those of the rest of the population. The perceived age-related risks of COVID-19 are an exception.

The majority of them is rightly aware that they are less at risk from COVID-19 than older people, and know this more than respondents in other age groups. They are also more aware than other age groups that the risk is higher among those aged 60 and over.
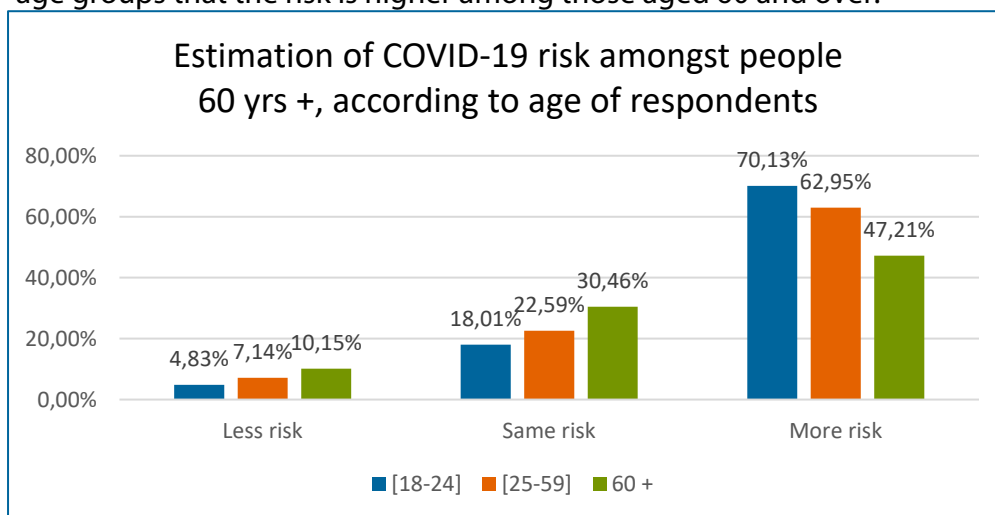
Figure 32: Risk amongst people aged 60 and +
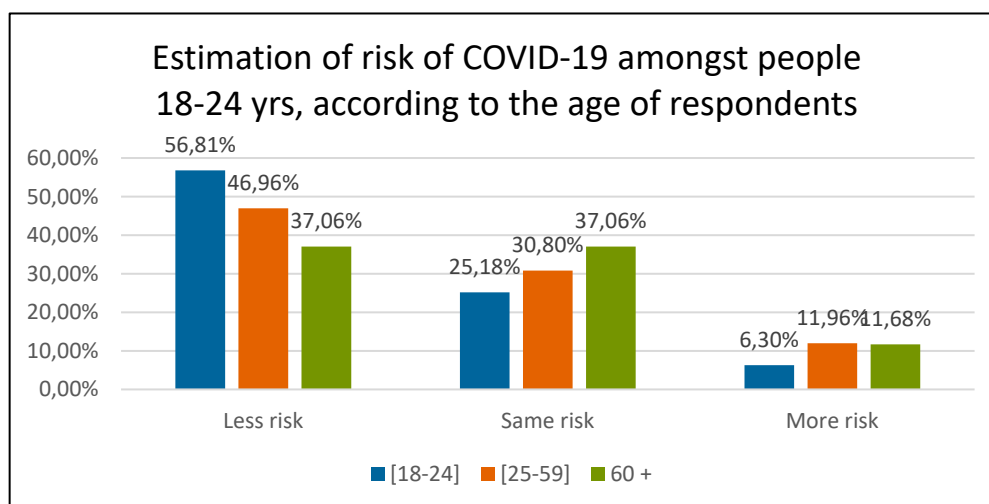
Figure 33: Risk among 18-24 yrs old

→   The communication should take into account the fact that, on the one hand, young people know that they are less at risk from COVID-19 than the rest of the population and that, on the other hand, they are particularly aware of the fact that people aged 60 and over are especially vulnerable.

4. Communication Strategy

4.1.   Summary

The results of the socio-anthropological survey provide a snapshot of the population's knowledge and perceptions about COVID-19, its 'health literacy' on COVID-19, which highlights, on the one hand, acquired knowledge and, on the other hand, ignorance and misconceptions which are obstacles to adherence to preventive measures and to vaccination.

If the symptoms of COVID-19 and the recommendation of preventive/ non-pharmaceutical measures must continue to be included in what we will describe as "routine" communication, it would be useless today to devote special efforts to them.

On the other hand, we suggest that major communication efforts should be concentrated on four main areas:

1.   Ignorance of transmission by asymptomatic individuals
2.   Doubts on the reality of COVID-19 in the country
3.   Fear of visiting health facilities
4.   Lack of awareness among adolescents and young adults

In addition, messages about symptoms of COVID-19 should include loss of smell and taste, which are specific signs of the disease, and messages about toll-free numbers should state that these numbers should be called before visiting a health care facility if signs of COVID-19 are thought to be present.

Finally, specific communication plans need to be deployed in some countries.

4.2.   Transmission by asymptomatic individuals

Our survey shows a very serious lack of knowledge about the transmission of the virus by asymptomatic people. However, a large proportion of SARS-CoV-2 infections are due to asymptomatic people, either because they have not yet reported the disease or because they will not do so[23]. Asymptomatic infections are prevalent among young people and three-fifths (3/5) of the population of sub-Saharan Africa are under 25 years of age[24]. According to the WHO, 80% of cases in Africa are asymptomatic[25].

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[23] Moghadas SM, Fitzpatrick MC, Sah P, Pandey A, Shoukat A, Singer BH, Galvani AP. The implications of silent transmission for the control of COVID-19 outbreaks. Proc Natl Acad Sci USA. 2020 Jul 28;117(30):17513-17515. doi: 10.1073/pnas.2008373117. Epub 2020 Jul 6. PMID: 32632012; PMCID: PMC7395516.
Michael NL. SARS-CoV-2 in the U.S. Military - Lessons for Civil Society. *N Engl J Med.* 2020 Nov 11. doi: 10.1056/NEJMe2032179. Epub ahead of print. PMID: 33176076.
[24] *Profil démographique de l'Afrique*, United Nations, Commission économique pour l'Afrique, mars 2016.
[25] https://www.afro.who.int/fr/news/les-facteurs-sociaux-et-environnementaux-consideres-lorigine-des-faibles-taux-de-COVID-19-en

The transmission of the virus by asymptomatic individuals is the very reason for recommending preventive or non-pharmaceutical measures to the general population. If only symptomatic people were contagious, as in the case of Ebola infection, for example, these measures would only concern the sick and their relatives. Knowing about asymptomatic transmission is an essential part of a good understanding of the barrier measures, an understanding that is indispensable for adherence to any prevention measure and to vaccination.

The vast majority of the population has heard of the coronavirus and a good number say they know what a virus is. Communication messages distinguishing between coronavirus and COVID-19 can therefore be understood: coronavirus can infect everyone, all infected people can transmit it, but not all infected people develop signs of COVID-19.

Evidence and explanations about asymptomatic carriers will also help to counter the belief that COVID-19 does not exist: the virus is present in a community where the disease is not very visible.

The foremost priority of communication must therefore be to convey the information that the coronavirus, which can cause COVID-19, can be transmitted by anyone, including perfectly healthy people, who will never have any symptoms of the disease.

4.3.   Reality of COVID-19

A portion of the population knows that COVID-19 exists in Europe, China, and the Americas, because they see images of sick and diseased persons on foreign TV channels and on social medias, but doubt that it exists in their country.

A second priority of communication must be to get national TV channels and radios to hear stories on people sick with COVID-19 and on relatives of diseased persons.

4.4.   Use of health facilities

Articles, reports and position papers have drawn attention to the fact that the pandemic is leading to dysfunctional care provision, reduced prevention, diagnosis and treatment, and that the resulting morbidity and mortality could be higher than those directly caused by SARS-CoV-2.

Measuring attendance at health facilities was not within the scope of our work, but we show that the population overwhelmingly believes that they are at risk of contracting COVID-19 in a health facility (3.3.4). This perception is likely to have a major negative impact on the demand for prevention and care.

The third communication priority must be to reassure the population about the risk of being infected with the coronavirus in a health facility.

4.5.   Raising awareness amongst the youth

The results of the survey show that young people know that they are less at risk of COVID-19 than older people, which can only encourage them to disregard the recommended preventive

measures (figure 32). They also highlight that young people are more aware than the rest of the population that older people are at risk.

It would be wrong to focus communication towards young people on a COVID-19 risk that is contrary to scientific reality and their knowledge. Instead, communication can be based on their knowledge that older persons are at risk of serious forms of harm and appeal to their sense of family and solidarity.

The fourth communication priority is to find a language and produce communication tools adapted to adolescents and young adults.

5. Communication Plans

5.1.   WAHO-lead communication

5.1.1. Media

Online press conference for media with an African audience, local or based in Northern countries (RFI, BBC, Jeune Afrique, etc.), to present the results of the socio-anthropological survey and the communication strategy. Drafting of a press kit. These actions will be decided and detailed with the WAHO communication department.

5.1.2. Member States

Organisation of a webinar to present the results of the socio-anthropological survey and the communication strategy.

Organisation, where necessary, of a webinar for each country in the survey.

Provision available to Member States the communication tools corresponding to the priorities of the communication strategy[26] :

Asymptomatic Transmission
- A one-minute video. 45 secs.: « Who can transmit COVID-19 ? »
- A poster for billboards and for all formats: «Who transmits the COVID-19? »
- A bill: « One may look healthy but transmit the corona virus»

Use of health facilities
- A one-minute, 40 secs video.: « Continue to visit health facilities! »
- A poster for billboards and for all formats: « Continue to visit health facilities! »
- A bill: « Continue to visit health facilities! »

Raising awareness amongst the youth
- A 2-minute, video. : « Be stronger than corona! »
- A poster for billboards and for all formats: « I am young and responsible! »
- A poster: « Youngman/woman : protect your loved ones against COVID-19 »

Launch the production of videos filmed in hospitals, to show COVID-19 cases, with interviews of health care workers and interviews of influencers what have had the disease.

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[26] Videos, posters and bills relating to the priority areas of the communication strategy were produced thanks to the support of the French Red Cross.

5.2.   Communication by Member States

National communication plans should make a great effort on the four pillars of the communication strategy by deploying new communication tools, mobilizing the media, development initiatives targeting the youth.

5.2.1. Communication Tools

The Communication plan must provide for a dissemination of the new tools of communication large enough to make an impact in terms of improving the knowledge and perceptions of peoples' knowledge in a few months, on the pillars:
- transmission by asymptomatic persons,
- reality of COVID-19,
- use of health facilities,
- raising awareness amongst the youth.

This plan may use the tools produced by WAHO (5.1.2) or others produced at the national level.

Alongside the foregoing, the communication tools used since the start of the epidemic must be reviewed to check that:
- Loss of taste and smell are listed among the symptoms of Covid19[27].
- Obesity as a risk factor for developing a serious form of COVID-19 is mentioned.
- The tools mentioning the toll-free number should state that if you suspect you may have COVID-19, you should call the toll-free line before going to a health facility.

5.2.2. Media

The priority pillars should be explained to the media.

- Press briefing to present the results of the survey and the three priority pillars (4).

- Transmission by asymptomatic individuals
  - Identification of cases of persons infected by an asymptomatic person and facilitation of televised and radio reporting on the cases.
  - Facilitation of interviews of doctors by televisions and radios on the subject of asymptomatic transmission.

- Reality of COVID-19
  - Production of a series of short videos filmed in hospitals, to be given to national TV channels for broadcasting during the daily news programs.

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[27] WAHO has produced an animated video, a video based on interviews, a poster and a bill on COVID-19 mentioning these two symptoms. You can download them from the WAHO website or request them from the Communication Department.

- Use of health facilities
  - Facilitation of TV and radio reports in health facilities to show the precautions to be taken.
  - Facilitation of TV and radio interviews with doctors on the consequences of interrupting prevention, screening and care.

- Youth:
  - Facilitate interviews with influencers

5.2.3. Raising awareness amongst the youth

Raising youth awareness should be the subject of a specific communication plan, having regard to national conditions and possibilities.

Such a plan may include:
- Mobilisation of "ambassadors" or influencers likely to be listened to by young people: sportspeople, singers, musicians, Youtube players, etc.
- Communication targeting youth associations: census, making contact, sending communication tools produced by WAHO or nationally produced tools.
- Dissemination of the communication tools aimed at young people in high schools and universities.
- Putting on line and promotion on social networks of the animated video "Be stronger than the coronavirus!".

5.2.4. Côte d'Ivoire, Sierra Leone and Cape Verde

The survey reveals a lack of knowledge and a relatively high presence of doubts that require specific communication plans in these countries for which we provide some indications here.

Existence of coronavirus

Communication on the reality of COVID-19 must be especially reinforced in these three countries.

Knowledge of risk factors

In Côte d'Ivoire and, even more, Sierra Leone, communication must emphasize that morbidities are risk factors for serious COVID-19. (3.2.3 and 3.2.4).

Age-related risks must be the subject of communication efforts in Sierra Leone and Cape Verde (3.2.4).

Barrier measures

In Côte d'Ivoire, almost the entire population has heard the messages about preventive measures, but a significant proportion does not believe in the usefulness of these measures (3.1.3). A communication plan is needed to explain the messages heard.

6. LIST OF TABLES AND FIGURES

7. APPENDICES:

The appendices are available as a separate file.

Survey Questionnaire

Burkina Faso Report

Cape Verde Report

Côte d'Ivoire Report

Guinea-Bissau Report

Sierra Leone Report