SYNTHESIS:
RCCE STRATEGIES TO OVERCOME COVID-19 FATIGUE IN THE EASTERN MEDITERRANEAN, MIDDLE EAST AND NORTH AFRICA

In situations of long term or protracted emergencies, populations can suffer from fatigue or complacency about the measures designed to protect them. This brief focuses on social and cultural influences for sustained COVID-19 prevention and risk reduction behaviours in the Eastern Mediterranean / Middle East and North Africa (MENA) region. COVID-19 has shifted from an acute to a chronic crisis, and strategies to encourage the public to continue with protective behaviours are essential. The brief can be read in conjunction with previous briefs by the Social Science in Humanitarian Action Platform (SSHAP) on prevention measures in the context of COVID-19.[1–3] A second brief relating specifically to vaccination behaviours in the region is forthcoming.

The brief synthesises evidence published by UNICEF in a comprehensive review of the scientific and grey literature and the media.[4] It is intended to inform the development of risk communication and community engagement (RCCE) strategies and regional guidance and tools as the COVID-19 crisis evolves; operational considerations based on the findings are set out at the end of this synthesis. It was developed for SSHAP by Anthrologica on request of UNICEF MENA Regional Office with contributions from the regional RCCE Interagency Working Group and UNICEF country offices. The brief is the responsibility of the SSHAP.

BACKGROUND

The MENA region is highly diverse, incorporating low-, middle- and high-income countries and with several on-going and large-scale humanitarian emergencies. Many MENA countries suffer from constrained resources and infrastructure, which are exacerbated in areas with conflict and instability and fragile governance.[5] Nearly every country in the region hosts refugees and/or internally displaced populations (IDPs). In response to the pandemic, all countries have introduced some form of public health measures to reduce transmission of COVID-19 with varying degrees of success. However, these measures have also led to substantial negative socio-economic impacts,[6] which challenge people's ability to sustain motivation and adhere to key preventive behaviours.

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'Pandemic fatigue' (demotivation to follow recommended protective behaviours[97]) and complacency are affected by a range of factors and community concerns that cannot be anticipated nor well understood without engaging with communities. For any given individual or group, several social and cultural drivers operating at different levels will influence their behaviour. It is the task of those working on RCCE to identify the different drivers for the behaviours within populations, identify barriers and enablers to the desired action, and consider creative ways to address the barriers and harness the enablers. It is particularly important to take a positive view wherever possible, and to recognize that most people will try to do the right thing. Positive stories of practical coping can help to make guidance seem practical and 'doable'. They can nudge people forward, empathising, and reflecting real life, appealing to the heart - rather than only the head.

REVIEW: LOCAL EVIDENCE ON PREVENTION MEASURES

This section synthesises findings from qualitative and quantitative studies on certain prevention behaviours identified as relevant to pandemic fatigue in the region. Full methodology and more country-specific findings are found in the longer review.[4]

MASK-WEARING

Knowledge

High awareness of the importance of mask-wearing to prevent infection has been found across countries in the MENA region since the outbreak of COVID-19.[7–13] However, the data indicate that more than knowledge is needed for behaviour change. In studies across the region, the belief that wearing a mask would protect from infection was not always found to translate into a willingness to wear a mask. For example, while a study (in Egypt) found that 75% of participants believed mask wearing would protect them from infection, only 35% stated they would be willing to wear one.[7]

Attitudes and social drivers

Evidence suggesting gendered differences in mask-wearing has been seen, for example among Hajj pilgrims. Women were more likely to wear a face covering (not a 'mask' per se) in public for religious reasons; however they did not cover their faces when in their tents with other women. Since men wore masks for hygienic, rather than religious reasons, it was reported more likely that they did so both inside and out of their tents.[14]

Communities and religious leaders in the region have historically shown flexibility in or willingness to promote public health measures. For example, in 2009 the Grand Mufti of Saudi Arabia distinguished between "covering the face" and wearing a mask in response

to the reported belief by many women that they should not cover their face while in the sacred state of Ihram.[15] As an exemplary and respected religious leader and communicator, the Mufti was able to redefine religious norms in a way that was sensitive to the conflict between traditional norms and disease prevention behaviours.[15]

Different and changing messages from global health authorities about mask-wearing throughout the evolution of the pandemic has been suggested as a contributing factor for community ambivalence and low uptake of mask-wearing.[8] The precedent of recommended mask wearing as a public health measure in some countries affected by MERS-CoV outbreaks which may continue to influence acceptance.

Behaviour

Studies suggest the use of face masks was highly variable across the region, although this may reflect that the epidemic emerged at different times across the region and the use of masks also changed over time. Above 60% was reported in studies from Iran,[12,13] Egypt,[16] and Algeria,[17] lower use between 20% and 60% was reported in Saudi Arabia[18–20] and Syria;[21,22] 12% was reported in Morocco.[23] Media reports on COVID-19 have reported low mask use and defiance of requirements to wear a mask in several countries (Iran,[24] Bahrain,[25] Djibouti[26] and Syria[27,28]). In Kuwait, the government decided not to lift a partial curfew at one point, due to citizen's failure to wear masks,[29] whereas limited enforcement of mask-wearing was cited as a factor influencing mask use in Iran.[31] Some studies suggest older people and males were less likely to wear a face mask than younger people and females (Iran,[12] Saudi Arabia, Kuwait, the UAE, Qatar, Bahrain and Oman[30]).

HAND HYGIENE

Knowledge

Studies found "high levels" of awareness of the importance of handwashing,[7,8,10,19,22] including among sub-populations of refugees, host communities and university students,[9,32] internally displaced women and children,[33,34] and health workers and religious scholars. [35,36]

Attitudes & Social Drivers

Social norms and pressures, role models, faith and religious practices were found to influence handwashing behaviours. Motivating factors for washing hands included fear of contagion[37,16] disgust at the dirt,[38,33,34] a positive feeling of cleanliness and calmness,[34,38] and a desire to feel more attractive.[34] Those who were aware of other's expectations to wash their hands or had strong role models were also driven to practise good hygiene to conform to those expectations or moral values or to impress others.[34–36,38,39] Influencers

included parents (particularly mothers) and older siblings,[34] professional peers,[35] and public figures.[36] Internally displaced children (Iraq) mentioned washing their hands to avoid being stigmatised by other children.[33,34] Conversely, a lack of strong role models or social pressure to wash hands led to poorer handwashing practices in some contexts, as was the case for some displaced children and nurses.[34,38] Health workers in one study mentioned a fear of offending patients if they washed hands in their presence.[40]

Faith and religion-based practices were found to shape compliance with hand hygiene measures. The data available in the region was specific to the Muslim faith and highlighted that handwashing is considered a fundamental tenet of Islam.[18,36] Obligatory ritual handwashing is part of daily life for Muslims.[35,41,42] While Islam's prohibition of alcohol has been reported to contribute to reluctance to use alcohol-based rubs in many communities, religious institutions exercised a tolerant and adaptive approach to the use of alcohol for health purposes[41,42] and many religious scholars have concluded that the use of alcohol-based hand rub does not conflict with religious beliefs.[43]

Pilgrims in a sacred state of Ihram are not permitted to use scented soap, and although unscented soap may be available, most pilgrims at the Hajj reportedly wash their hands using only water.[42] The consideration of the right hand as being used to handle pure things and the left to handle impure things is another teaching of Islam that could be harnessed in a way that restricts the spread of disease.[44]

Behaviour

Hand hygiene was documented as substantially improved across multiple countries as a result of COVID-19 campaigns and other interventions[33] (Qatar,[45] Egypt, including migrants,[16] Iran,[13] Iraq,[46] Jordan, including refugees,[9,32] Sudan,[47] Morocco,[23] Algeria[17] and Syria[21]). For example, in a Syrian study, 91% of respondents claimed to practice better hand hygiene than before the lockdown.[21]

Structural Barriers

Lack of supplies such as soap and hand sanitiser, and infrastructure such as clean water and sinks were reported as major barriers at health facilities,[38,36] in camp settings,[48,33,34] at mass prayer gatherings,[42] and in communities.[22,48] Other barriers included secondary effects of hand washing: dry skin, allergy, pain to wounds on the hand, and dislike of the smell of alcohol.[34,38,40,41,43] Those suffering from trauma or depression also found it more difficult to maintain good hand hygiene.[34,49]

PHYSICAL DISTANCING

Physical distancing means keeping a safe space between people (usually those who are not part of the same household). It can be achieved by individuals staying at a certain distance (at least one metre) from each other; practising non-contact greetings; limiting gatherings and the number of people attending them; staying at home when possible; and self-isolation of people with COVID-19 symptoms or positive test results.

Knowledge

A wide range of studies showed high region-wide awareness of the need for physical distance to avoid spreading infection. Where data were available, the awareness of the value of staying at home and avoiding crowds was also "generally high" (Jordan[48]), and as high as 99% in Saudi Arabia[8,20] where awareness campaigns seem to have positively impacted people's commitment to staying home.[10,50] The Saudi government acted early in the pandemic, launching multiple campaigns as well as health mobile telephone apps and call centres. In one Saudi Arabian study, 78% of participants stated that the Saudi Ministry of Health was their primary source of information.[50] It was suggested the successful approach may be due to lessons learned during the MERS-CoV outbreak of 2012. The bulk of the strategy involved online communication, and it should be noted that the majority of participants in the aforementioned study were younger, while studies involving older participants found lower awareness levels.

Attitudes and Social Drivers

Across the region, many countries reported high willingness to comply with recommendations, however social norms and attitudes, faith and religious practices, influencers and role models, gender norms, the threat of stigma, and trust and politics affected compliance with physical distancing measures.[19,20,22] There were numerous studies documenting behaviours influenced by Islam, fewer were available in relation to the other religions practiced in the region.

Greetings serve the purpose of establishing social bonding, allocating status, displaying courtesy and maintaining social cohesion and studies showed that proper greetings are of great importance to Muslims in the region.[14] This may contribute to the continued used of contact greetings observed in some countries. The review did not find literature related to greetings for other religious groups. Inviting people to one's home can be linked to social status and prestige and is often seen as a moral duty (e.g. Egypt[51]). Forsaking house visits could signify a loss of status, influence and even community leadership.[51]

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Faith and religious practices are known to have a strong influence on how people understand the world. Sometimes this can occur in ways that conflict with public health measures. Studies across the region found that the commonly held belief among some groups that Allah is responsible for disease and will protect believers from infection influenced people's attitudes and behaviours concerning preventive measures.[9,30,48] Research among Muslim populations found that some practices conflicted with physical distance guidance, whereas other public health measures are endorsed by the Quran, and have been used to encourage people to stay home and to practise self-quarantine and self-isolation.[44,52–55] In Morocco and Kuwait believers protested against the closure of mosques by organising marches and turning to social media to proclaim their refusal of all precautionary measures, asserting that the virus could be challenged through the power of faith.[52] Frustration and resentment was also expressed at the cancellation of collective religious practices, particularly during Ramadan.[51]

Role models and influencers can influence compliance and attitudes towards prevention measures. For example, tribal sheikhs in southern Iraq reduced public gatherings and limited greetings to handshaking rather than kissing, demonstrating that norms can be adapted.[56] In countries including the UAE,[57] Palestine[58] and Lebanon,[59] social media users, celebrities and well-known brands adopted the #StayAtHome hashtag to encourage people not to leave their homes.[57,60] Religious leaders have used their authority to reassure disappointed pilgrims that Muslims are rewarded even for the religious intention of performing Hajj and that everything is determined by the will of Allah.[61] However, poor examples set by authority figures, such as holding news conferences in a room packed with journalists, may have undermined general population compliance.[62,63]

Gendered norms were also reported to influence behaviours. Some research documented that women were more likely to require input from family members (particularly males) on decisions about their actions. This had implications for practices such as complying with quarantine or curfew, and for health-seeking. Research of populations undertaking the Hajj found men to be more mobile than women, who tend to stay in their tents. Generally there are different risk factors for both sexes, as men are more exposed to crowded conditions with large numbers of people, while women tend to be in close quarters with other women for longer periods.[14]

Stigma was identified as a barrier to compliance in some settings as exclusion from the workforce and traditional systems of support resulted in instable and crowded living conditions. This was documented by lesbian, gay, bisexual, trans and queer (LGBTQ) communities [64] and internally displaced people.[65]

Political context and trust in authorities was also found to shape compliance with physical distancing measures. For example, in the Maghreb, low levels of reported trust in the government and health service providers has been attributed to the long-term lack of 'health democracy' and the failure to provide opportunities for people to be involved in the decisions that affect them.[66] In Algeria, parts of the community initially saw COVID-19 as a political manoeuvre to contain the protests occurring in the country. However, later in the pandemic organisers urged their followers to abandon protests in compliance with public health measures.[67] While there is some evidence that severe penalties and presence of the military may be more acceptable or effective in parts of the region,[48] militarised approaches to enforcement tend to exacerbate existing suspicions of political interference.

Behaviour

Physical distance: Compliance with the recommended physical distance was not always practised or feasible. Reports from across the region describe densely packed public transport systems, and non-adherence to distancing measures in public spaces, businesses, shops, markets, streets and workplaces[26,27,29,63,68,69,70] In several contexts, an easing of lockdown restrictions appeared to encourage people to relax other prevention measures such as individual spacing.[68,71,72] There are also examples of government officials failing to follow physical distancing regulations.[62,63,73]

Non-contact greetings: Reported efforts to interrupt contact greetings have been inconsistent. Some studies recorded continued widespread greetings with handshaking, kissing and hugging, [13,47] others have reported high avoidance of contact greetings.[9,32]

Mass gatherings: Religious, social and political gatherings are numerous in the region. More than 3 million pilgrims gather in Mecca for Hajj, twenty million visit Qom and 10 million visit Karbala each year. It has been argued that crowded conditions and practices carried out during pilgrimages contributed to spread of COVID-19.[14,15,19,42,74] While religious beliefs and institutions are sometimes at odds with public health recommendations, they have also been instrumental in supporting them: adapting prayer gathering practices, urging those with flu-like symptoms not to attend, and restricting the number of pilgrims.[75,76] Despite the high level of acceptance of the need to suspend public gatherings and social visits,[8,20,45,47,77] public and private gatherings for weddings, mourning ceremonies and birthdays were reported.[78–81] Political protests have occurred in numerous countries despite COVID-19 containment measures, including in Lebanon[82], Iraq[83], Sudan[84] and Morocco[85]. In Egypt, rallies have been held to protest against the restrictions.[86] While general compliance with bans on gatherings in Jordan is thought to be attributable to significant penalties for not complying.[48]

Staying home: In a number of studies the majority of respondents reported trying to stay at home when requested except to purchase essential items or during emergencies.[13,16,45] Further, when people left their homes, there was a widespread tendency to try to avoid crowded places,[16,21,32,47,87] although not all,[12,13,22,88] Women in the region were more likely to stay at home than their male counterparts, while men's usual social, professional or labour activities led them to leave the home more often and socialise more frequently, which had implications for distancing and quarantine.[12,45,48,89] Smoking shared 'shisha' waterpipes in cafes is a popular social activity particularly for males in the region. Some smokers are reported to have started bringing their own waterpipes or purchasing single-use hoses, although elderly men were more likely to share reusable hoses.[90,91]

Isolation: The literature shows a high level of general approval towards isolation of people showing symptoms of COVID-19,[8,16,20,47] and high levels of agreement to self-isolate if diagnosed with COVID-19.[92] However, one study identified that of IDPs, refugees and returnees, fewer than 25% indicated that they would be willing to self-isolate if they experienced symptoms of COVID-19.[46] A health ministry poll conducted in June found that only 32% of people were following the rules on self-isolation[70] and in another study, male migrants, rural populations, less educated respondents and those who had been married were less likely to be willing to self-isolate.[16]

Structural Barriers

Underlying structural issues such as food security, living and working conditions and everyday imperatives – such as work and access to food, water or aid – influenced people's actions and become barriers to compliance with public health measures. Many people reportedly had no choice but to leave home for basic supplies, work or seeking health services.[62,84] or stated that staying at home was difficult.[48,88]

For many vulnerable groups, individual distancing was not feasible. Low-income groups, migrant workers, refugees and IDPs tend to live, work, commute and dine in crowded conditions.[93,94] A lack of an acceptable environment in which to self-isolate was identified as a barrier among displaced populations.[46] The high numbers of young people testing positive for COVID-19 in the UAE has been attributed to the fact that a large percentage of the country's population is made up of male, young migrant workers who live in high-density conditions, often who did not take precautions during home-isolation.[95] There were also reports of migrant workers forcibly isolated in crowded labour accommodation or quarantine facilities without water or critical medical care.[96] Victims of domestic and gender-based violence may also lack an acceptable environment in which to self-isolate.

SUMMARY CONSIDERATIONS: OVERCOMING FATIGUE

Drawing from the longer review,[4] and recent WHO policy recommendations,[97] the following considerations promote a better understanding of, and engagement with, communities and the hardships they face, and greater attention to local ownership and management of risk. These considerations are made with a view to normalising and sustaining key prevention behaviours in the region in the context of response fatigue and successive waves of COVID-19. Strategies will need to be adjusted according to the evolution of the epidemic in each country (including availability of vaccines) the real and perceived health and economic risks, and local public reaction to measures taken thus-far.

LOCALISE AND CO-DESIGN COMMUNICATIONS TO PREVENT FATIGUE AND BUILD TRUST

Simple, direct messages were necessary and important in the early stages of the pandemic, but communities and the systems that serve them can become weary of restrictions or desensitised to repetitive or inconsistent messaging. Across the region, knowledge and awareness are generally high and continuing to repeat the same simple messages may be counterproductive. Risk communication and strategies to engage with communities need to adapt from short-term to long-term thinking, encouraging sustainable behaviour and new social norms that are safe. Centralised messaging is unlikely to be the most effective way of achieving this. RCCE strategies are more likely to be successful if they are co-designed through community-centred approaches, capitalising on existing local knowledge, capacities and networks.

ENCOURAGE COMMUNITY AGENCY TO DEVELOP "COVID-19-SAFE" OPPORTUNITIES

Movement restrictions are often considered as a limitation to genuine community engagement. As governments and partners move beyond short-term uncertainty and emergency actions towards long-term management of COVID-19, investment in community systems emerges as an essential element. For example, governments tended to ban social gatherings across the board, whereas particular low-risk communities or regions could be supported to trial conducting certain "COVID-19-safe" events and share their experiences (for example by door-to-door visits by volunteers).[98] Religious leaders could be engaged to advocate for greater personal responsibility and community agency to manage protective behaviours and local risks safely and aligned with their teachings.

Across the region, as governments have eased restrictions, people tended to also relax their personal protective measures. Increasing economic pressure over time forces many to accept greater risks to stay economically active. Localised RCCE efforts can address these

trends by creating opportunities for different groups in communities to identify locally-appropriate solutions to mitigate COVID-19 risks that also reflect their economic and social contexts.

ADDRESS STRUCTURAL BARRIERS AND SHIFT AWAY FROM APPROACHES THAT ARE NOT PRACTICABLE

The emphasis on simplicity in the core hygiene messages has, at times, overlooked challenges such as lack of infrastructure, the complexity imposed by the conflict and instability experienced across the region. Groups with particular challenges, such as migrant workers and displaced people, require specifically targeted interventions that take into account the structural issues they face. Consideration of structural barriers and the secondary impacts of COVID-19 – such as access to work, health services and aid, water and food remains important. Working with communities to understand the local situation is essential for crafting strategies that are feasible, sustainable and effective.

HARNESS RELIGIOUS LEADERS AND TEACHINGS AS ENABLERS

Religious institutions have shown flexibility and adaptability in interpreting scriptures in a way that is synchronised with public health requirements. Expanding this approach will necessarily involve understanding the values and norms associated with the various faiths in the region, as well as within different subgroups, and aligning approaches with those values and norms, rather than opposing them. It should be noted that in some contexts, religious leaders may not be effective influencers, particularly where there are underlying sensitivities and conflicts which have undermined trust in them. The religious and political context (both nationally and locally) must be taken into account.

CHECK REPRESENTATIVENESS AND BEHAVIOURAL COMPLIANCE OF INFLUENCERS

Various types of influencers have been effective at raising the profile of positive norms and prevention behaviours, religious leaders, entertainment and sports celebrities, and health workers (who were among the most credible). It is important to match the diversity of subgroups who are to be reached with the right influencer/s, and via the most effective channels for each subgroup. Carry out rapid assessments to identify what kind of interlocutors are most trusted by different groups. Maintaining a consistent public image of influencers can be challenging. It is especially important for leaders in public office – the rule-makers - to follow the rules and model recommendations. A single appearance in the media doing 'the wrong thing' can undermine the entire response. Peer to peer approaches designed to engage young people should be implemented to help address their lower perceived risk.

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ADDRESS GENDER-RELATED RISKS

Cultural and religious traditions underpin gendered social norms across the region, presenting both inhibiting and enhancing risk factors for males compared to females. For example, lower awareness and compliance tend to be reported for males in general compared to females. Men tend to have more freedom of movement and general autonomy, are more prone to taking risks and less likely to adopt preventive behaviours. This supports a case for a strong and consistent gender lens to address factors such as religious practices, mobility in the community, personal protection, and decision making.

HARNESS MEDIA, ESPECIALLY SOCIAL MEDIA

Mis- and disinformation proliferate in disease outbreaks, and poor communication of scientific evidence can create a vacuum filled by speculation. Rumours often reflect underlying anxieties or previously held social or political positions. Social media is commonly used, but the full potential of social media for promoting public health and addressing mis-information has not been realised in the region. Local assessments are needed to fully differentiate preferred channels, trusted sources of information, levels of literacy, health literacy and media literacy, and preferred languages and formats for receiving and sharing messages. As well as providing information and promoting positive behaviours, efforts to use social media for gathering information and conducting rapid polls should be considered.

FOCUS ON EMPATHY AND COMMUNICATIONS BASED ON VALUES

Fear of COVID-19 has often been used to motivate behaviour, however overuse of fear can result in inaction or poor compliance. For example, fear of contracting COVID-19 can stop parents from vaccinating their children, sending them to school or seeking health services. To counter this possibility, it is important to promote practical actions that people can control and that take into account their realities (for example, multi-generational families).

With strong religious and cultural values evident across the region, it will be useful to reflect empathy for the hardships endured, and emphasise collectivism and responsibility for protecting the family and building the resilience of the community. It is important that young adults, who are not afraid of COVID-19, do not become vehicles of transmission within multi-generational households. It is also important to recognise that people need social interaction and communal events can be vital to community cohesion. Safe and viable alternatives should be suggested, such as online memorial events, limited gatherings observing physical distancing and personal protective behaviours etc.

BE AWARE OF THE INFLUENCE OF POLITICS ON TRUST

The effectiveness of responses has relied on a high level of public trust and compliance with advice on specific hygiene measures and broader public health measures, both of which are important functions of RCCE. However, in some cases COVID-19 is framed as part of existing political struggles. Trust varies according to different groups (refugees, migrant populations, youth et al.) and political environments (e.g., fragile states, Maghreb nations or Gulf States). The political context must be taken into account when developing strategies for RCCE. They should be feasible, equitable and designed with broad representation of communities, and sensitive to national and local tensions.

RECOMMENDATIONS TO IMPROVE DATA FOR RCCE

Gaps still exist in the evidence around social and cultural drivers for compliance with specific prevention behaviours in the region. Contextual research can also help to understand the secondary effects of prevention measures and how these influence the ability or motivation to adopt preventive behaviours.

Specifically:

- Research collaboration: Strengthen collection coordination, analysis, access and use e.g. through data dashboards
- Methods: Complement existing quantitative data about 'what' is happening with 'why' (qualitative data) with a view to communities as the unit of analysis; aim for multiple time series on selected data points
- Data sources: Triangulate behavioural data with epidemiological data and policy data to inform decisions
- Research gaps: Expand efforts to address gaps in evidence:
    - Subpopulations - geographical areas (e.g. the Maghreb region, active conflict zones), ethnicities, vulnerability (e.g. migrants in the GCC, LGBTQ, elderly people, people living with disabilities, women and people living with co-morbidities)
    - Emerging topics: barriers and enablers to vaccination, testing, contract tracing
    - Local responses, local drivers of compliance and positive deviance
- Research gaps: Expand efforts to understand secondary impacts:
    - Underlying health conditions, health seeking behaviour
    - Childhood and routine vaccinations, including influenza,
    - Flexible education and 'back to school'
    - Gender-based violence, mental health
    - Basic health & nutrition, access to healthcare and social services, employment, social supports, unpaid labour & caring

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ADDITIONAL RESOURCES

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