KEY CONSIDERATIONS:
COVID-19 RCCE STRATEGIES FOR CROSS-BORDER MOVEMENT IN EASTERN AND SOUTHERN AFRICA

This brief focuses on cross-border movement in Eastern and Southern Africa (ESA) and its implications for development of risk communication and community engagement (RCCE) strategies aimed at preventing transmission of COVID-19 in the ESA region. Given the extensive risk of cross-border transmission of the virus and the imminent reopening of borders, such strategies are essential to containment efforts. The brief can be read in conjunction with previous SSHAP briefs on cross-border dynamics in the context of Ebola.[1–3] It was developed for the Social Science in Humanitarian Action Platform (SSHAP) by Anthrologica (led by Leslie Jones) and IDS (Megan Schmidt-Sane), and with reviews from International Federation of Red Cross and Red Crescent Societies (Petronella Mugoni), UNICEF (Charles Kakaire and Ida Marie Ameda) and IOM (Sandrine Martin). The brief is the responsibility of the SSHAP.

KEY CONSIDERATIONS

- **Cross-border transmission of COVID-19 is an increasing concern,** particularly as countries begin to ease travel restrictions and lift border closures. Cross-border travel is essential to the Eastern and Southern Africa region's economy and society. People on both sides of borders in this region often share culture, familial ties and economic activity, and movement across the borders is fluid regardless of formal closures.

- **Knowledge, attitudes, and practices influence COVID-19 control.** In some border populations, low levels of knowledge of the disease, low risk perception and negative attitudes toward movement restrictions may compromise COVID-19 control.

- **Evidence from past epidemics shows that stigma may prevent people from seeking treatment** for COVID-19 and other health concerns. Groups at high risk of stigma may include truck drivers, sex workers, migrants, returnees or displaced persons.

- **Structural factors can be a barrier to cross-border COVID-19 management.** Historically, few governments have invested in public health capacity at border crossings. Testing, processing and contact-tracing capability, shortages of personnel, PPE and other

necessary materials, and medical and social support for confirmed cases and those in quarantine remain a concern and should be addressed.

■ **Efforts to control cross-border COVID-19 transmission may be impeded by political and economic factors,** including regional non-cooperation, community resistance to lockdowns, and the devastating effect of border shutdowns on livelihoods in the region.

■ **RCCE efforts for COVID-19 prevention should aim to reach key populations at a broad variety of locations**, including formal and informal entry points and along transport routes. Engagement efforts should include truck and *boda boda* (motorcycle taxi) drivers, traders, migrant workers, fisherfolk and pastoralists, refugees and other displaced persons and other vulnerable groups, returnees, members of border communities, people seeking health care or other services and the contacts of these groups.

■ **Development and sharing of RCCE information should involve trusted community members,** including religious and cultural leaders, trusted authorities, leaders of relevant trade associations, and representatives of vulnerable and marginalised population groups.

■ **Due to the diversity of individuals at the border and along transport routes, a variety of online and offline communication channels should be used** in line with key populations' preferences and with the aim of sharing accurate and timely information about COVID-19 and how to minimise infection risks. Technology-based messaging may be suitable for some populations but are not uniformly accessible or trusted; other communication methods, like radio, public address, print materials and personal/peer-to-peer communication should also be used.

■ **Two-way community engagement should cover public health recommendations in local languages using common terminology**. Formats accessible to people with disabilities and those of lower literacy are essential. Communication should allow for information sharing from the community which can then be incorporated into revised RCCE.

■ **Experience with past epidemics, including Ebola, demonstrates the importance of regional cooperation and cross-border coordination**. Some local governments in border communities need capacity building, which national governments can organise with support from RCCE partners. RCCE implementers should also collaborate across borders and consider interventions for high-risk audiences. Cross-border population groups should be actively involved in joint risk analysis and developing actions to minimise infection risks.

BORDER CONTEXT

Cross-border traffic has been identified as a significant factor in COVID-19 transmission in Eastern and Southern Africa, and most countries in the region restricted entry to reduce importation of the virus – some even before the first local cases were identified.[4] However, the economy and the social fabric of the region are dependent on cross-border flow of goods and people, and there is increasing concern that the impact of border closures may be as severe as, or worse than, the impact of COVID-19. As a result, countries have begun to relax COVID-19 containment measures and lift border closures, which will increase the risk of international transmission of the virus. It is essential to understand cross-border transmission dynamics and movement patterns and the behaviour of cross-border actors so that effective, contextually appropriate RCCE strategies can be formulated to reduce risk from COVID-19 both now and as borders reopen.

ESSENTIAL CONTEXT: BORDERLANDS

Borderlands are characterised by an intersection of cultures, economic activity, and movement.[5,6] Present-day national borders in the ESA region are largely colonial creations that are arbitrary and do not necessarily reflect shared kinship and traditions.[7] Borderlands are often populated by more marginalised ethnicities with an historic tendency to mistrust central governments, as seen during recent Ebola epidemics.[8] Border communities are often strongly interconnected and residents travel frequently to visit family members[9] or engage in commercial pursuits on the other side of the border.[10]

CUSTOMARY AND CURRENT CROSS-BORDER MOVEMENT PATTERNS AND ACTORS

Under normal circumstances, a wide range of individuals cross national borders in the ESA region to engage in essential activities. These include truck and *boda-boda* (motorcycle taxi) drivers, small and large-scale traders, tourists, migrant workers, fisherfolk and pastoralists, refugees, returnees, members of border communities, and people travelling to seek health care and other social services.[2,10–17] These individuals, in turn, interact with the communities they encounter as they travel and on their return.[18] Border officials, security officers and support staff engage with travellers and return to their homes daily, increasing the risk of community spread. Although COVID-19-related border closures have reduced cross-border traffic, most of these measures exempt commercial truck drivers as well as citizens returning from abroad. According to IOM data, for example, over 63,000 migrants from Southern African Development Community (SADC) member states[a] returned to their country of origin between March and early June 2020.[12]

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In addition to individuals permitted to cross the border under current restrictions, there are widespread reports of individuals crossing national borders through unauthorised entry points, where they are not subject to screening and other transmission management measures. For example, Botswana has reported a large number of Zimbabweans entering at unauthorised crossing points,[19] and Lesotho has seen many of its nationals return home from South Africa via unauthorised crossing points during the latter's lockdown.[20] Individuals who are known to border officials because they cross frequently are not always required to submit to screening.[21] The WHO has noted that illicit movement through porous borders is a material driver of cross-border transmission of COVID-19.[22]

BORDER CLOSURES

As of July 28, 2020, nearly every country in the ESA region was still under some form of border closure.[23] Most had closed their airports, usually with exceptions for cargo and humanitarian flights. Land crossings remain closed to all except essential traffic in many countries. The status of border closures is fluid; several sources provide updates on current closure status.[4,23,24] On 23 June, the Africa CDC announced that it was working with stakeholders to develop recommendations to support resumption of travel across the continent using land, marine and air transport.[25] In early July, Rwanda announced plans to reopen its airports to passenger traffic on August 1.[26]

COVID-19 CASES IN EASTERN AND SOUTHERN AFRICA

Cases of COVID-19 have been confirmed in every Eastern and Southern African country.[27]. In the two months from May to July , the reported cases in the region rose from 22,000 to over 325,000, with the fastest increase and highest number of cases in South Africa.[4] South Africa is an important regional hub, with transport networks radiating outward to neighbouring countries and further into Africa; Lesotho, Malawi and Zimbabwe all attribute their increasing numbers of COVID-19 cases to citizens returning from South Africa.[20,28,29] However, there are wide variations in testing and reporting, and the high number of reported cases in South Africa is likely due in part to its testing rate (over 47000 tests/1MM population) being among the highest in the region.[30]

Cross-border transmission remains pervasive,[4,22] with high numbers of cases among truck drivers[22,31–33] as well as those with whom they have been in contact along their routes. Sex workers, border agents and service providers are at high risk.[4] Patterns of infection are constantly shifting: In Uganda, for example, most of the earliest reported cases were transmitted by returnees from abroad. By May and early June, confirmed cases shifted to trans-border truck drivers and their contacts in and near points of entry (PoEs).[34] By

mid-June, this had shifted again and new local transmissions, primarily along transport routes, outnumbered new cases among truck drivers.[34]

MEASURES FOR MANAGEMENT OF CROSS-BORDER TRANSMISSION

All countries in the region have intensified surveillance at POEs[35] and have implemented recommended measures for management of cross-border transmission.

Guidance and policies

The WHO regional office for Africa, the East African Community (EAC) and ESA COVID-19 regional technical working groups have developed a range of strategic recommendations and guidance on issues related to cross-border travel.[,18,36–38] Recommended measures for cross-border truck drivers include pre-departure testing and issuance of a certificate showing test results, enhanced hygiene requirements, and limits on who may travel (driver and assistant only). The EAC has also launched a digital platform to facilitate sharing of information on truck drivers and other travellers.[39] The African Union and Africa CDC have launched a programme entitled 'Test Trace and Treat: Partnership to Accelerate COVID-19 Testing (PACT) in Africa,' which has the stated goal of testing 10 million individuals by October 2020. It also sets out general guidance on testing, contact tracing and treatment of confirmed cases.[35]

Testing

Testing of returning migrants and truck drivers for COVID-19 is being conducted at border crossings in most countries in the region. Several EAC bloc states agreed in May to double testing and allow transit through EAC on testing negative; they also agreed to adopt a coordinated system to certify and share COVID-19 testing results and other information.[39,40] Under the EAC COVID-19 response plan,[36] mobile laboratories have been set up in each country of the EAC. The East Africa Public Health Laboratory Networking project has included establishment of 'state of the art' labs in cross-border areas with rapid processing capacity.[41]

Contact tracing

Countries in the region have implemented contact tracing measures in an effort to slow spread of COVID-19. For example, in Uganda, where testing is focused on borders, contacts and alerts,[b] as of 10 July 2020, 12,957 contacts had been identified for Uganda cases. Of those, 86% had completed 2-week follow-up; the remaining 14% were still under follow-up.[42] Kenya's national COVID-19 response strategy includes tracing contacts by phone or in person through community health volunteers, local leaders and security personnel.[43] In Zambia, sex workers are assisting government efforts at tracing the

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contacts of truck drivers.[44] South Africa has repurposed contact tracing mechanisms that had been developed for tuberculosis outbreaks [45] and has developed new mobile phone-based geomapping technology.[46] However, there have been criticisms that even where rates of testing and contact tracing are high, as in South Africa[47] and Zimbabwe,[48] inadequate arrangements to support self-isolation and state-mandated quarantine erode any gains from contact tracing.

FACTORS INFLUENCING COVID-19 MANAGEMENT AT BORDERS

A range of factors have influenced and will influence development and implementation of transmission management measures for cross-border actors. It will be crucial for RCCE specialists to understand and take into consideration the ways in which each of these factors may affect community uptake of RCCE.

CURRENT KNOWLEDGE, ATTITUDES AND PRACTICES

Available research into knowledge and perceptions related to COVID-19 in the region indicates a fairly high level of awareness about COVID-19 in countries surveyed; respondents reported generally being aware of and supportive of most prevention and control measures.[49–60] Perceptions of individual risk of infection and serious illness if infected vary by country, age and income.[49–56,59] Studies in Tanzania and Uganda included data regarding individual practices, and found high levels of adherence to public health recommendations,[61,62] though awareness and adherence were sometimes associated with education level and profession. A study in Uganda found knowledge of COVID-19 and attitudes towards and use of protective measures was lower among drivers and merchants;[62] another among cross-border drivers showed limited knowledge of the disease.[60]

Reports on current attitudes towards COVID-19 and containment measures have indicated that certain sectors of the community are very concerned about the negative impact of movement restrictions (especially border closures) on the region's economies and communities,[4,17,49] which may lead to efforts to circumvent cross-border movement restrictions and transmission management measures. There are accounts of negative attitudes towards groups with high rates of infection, including migrants, truck drivers and sex workers, due to concerns about transmission.[12,17,33,40] Sex workers and business owners along transport routes express concern with being exposed to truck drivers,

whom they perceive as at high risk.[43] In Lesotho, Malawi and Zimbabwe, there is increasing stigma associated with the term 'returnees', especially those from South Africa who are frequently portrayed in local media as vectors of COVID-19 and the sole causes of increasing community transmission.[63] IOM has noted that negative public perceptions and stigma may influence willingness among stigmatised groups to access health and other essential services.[12]

> **Effect of experience with past disease outbreaks: stigma and message exhaustion**
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> Research during HIV's spread in Africa showed that truck drivers tested positive for the virus at a rate double that of the general population, and there is concern that a similar pattern is emerging with COVID-19.[43,63] A higher prevalence may influence community perceptions of truck drivers and may contribute to the stigma many report experiencing.[43] Migrants and displaced persons have also been historically blamed for the spread of disease; developers of COVID-19 RCCE materials must be mindful of the stigma they have experienced.[64] There are also reports of public exhaustion with disease messaging: COVID-19 may be seen as the latest in a long series of health challenges, with risk communication about the pandemic coming at a time when Hepatitis B vaccination campaigns have not yet been completed, Ebola is still a concern for many[11] and tuberculosis, HIV and measles are killing significantly more people per week. However, lessons from SARS show the importance of early risk communication efforts with vulnerable groups.[64]

STRUCTURAL FACTORS

In order to be effective, RCCE should be backed up by efforts to ensure that measures to manage transmission have low impact on those at risk, including rapid testing and support for affected individuals. IOM, in collaboration with international partners and national governments, has conducted assessments of processing and testing capacity and availability of PPE and other necessary supplies (for handwashing, sanitising, etc.) at POEs throughout the region. Along with the EAC, it has provided COVID-19 training and supplies, including PPE, for staff at border crossings.[12,64] Supply and personnel shortages nonetheless remain a concern at borders and beyond and have caused lengthy delays in crossing.[65] The Africa CDC recently projected a "catastrophic shortage" of health care professionals' medical supplies because of border closures, price increases and restrictions on exports imposed during the pandemic.[66]

Few governments in the region have invested in the necessary infrastructure, supplies or personnel at border crossings and lack processing capacity, particularly in the context of a disease outbreak. In May, 400 Malawian returnees escaped quarantine at a stadium in South Africa, after reportedly having waited days for test results without adequate food, water or toilets.[4] Truck drivers at border crossings in east African countries have reported understaffed testing and screening facilities and waits as long as 5-10 days to receive clearance to cross. As of 25 June, truck drivers were still experiencing delays at the border between Kenya and Tanzania, and individuals reported walking freely back and forth

between the countries as they waited for clearance, allowing them the opportunity to mingle with local populations, merchants and sex workers. [32,33] Delays have similarly been reported at the borders between South Africa and neighbouring countries, where drivers waited up to 48 hours without food or handwashing facilities.[67]

POLITICAL/ECONOMIC FACTORS

Border regions have increasingly become areas of study for epidemic control, offering lessons applicable to COVID-19 RCCE strategies.[68–70] Cross-border HIV transmission and control efforts, including among truck drivers,[69,70] and efforts from cholera outbreaks in the Eastern and Southern Africa region, illuminate the importance of regional cooperation and cross-border coordinated prevention.[71]

Governments across the region have committed to cooperate to facilitate trade while protecting their populations from cross-border spread of COVID-19. The Common Market for East and Southern Africa (COMESA), EAC and SADC adopted guidelines to facilitate safe and efficient movement of goods across borders across the tripartite area.[72] However, there remain tensions, particularly between Tanzania and its neighbours.[40] Tests at the Zambia, Uganda and Kenya border crossings with Tanzania have shown high rates of infection among truck drivers and within border communities.[73] Tanzania claims that the tests are faulty[73] and that Kenya is inflating numbers to try to sabotage Tanzania's tourism industry.

There is also increasing community noncompliance in the region as lockdowns and other movement restrictions continue.[74] The African Union has warned that continued border closures may have a "devastating effect on the health, economy and social stability of many African states."[75] The need to travel for work may lead to attempts at avoiding border control measures, including not waiting to be tested.[43] Ugandan farm workers, for example, are increasingly frustrated as they are unable to cross the border to work their land in DRC. According to reports, harsh enforcement of border controls is not uncommon, with women being beaten with canes and fines imposed on those who try to cross.[11] These economic and social impacts may negatively influence community uptake of RCCE and preventive and risk reduction practices.

CONSIDERATIONS FOR RCCE

In addition to the factors highlighted above, it is important to understand which actors should be involved in formulating and implementing RCCE strategies for people engaged in cross-border movement, as well as the optimal locations and preferred

channels and approaches to RCCE in Eastern and Southern Africa. An understanding of current ongoing initiatives is also important to inform RCCE strategies. Where feasible, rapid research can allow a better understanding of these factors, both in border areas and along transit routes.

ONGOING COMMUNICATION INITIATIVES

There are a variety of ongoing communication initiatives that reach cross-border traffic in the region. IOM is working to raise awareness of COVID-19 among truck drivers, cross-border traders and host communities through a variety of means, including in-person communication at the border, radio programmes, and billboards at five POEs in Zimbabwe and two major POEs in Mozambique. They use tailored messaging on risk and prevention measures and provide Information, Education and Communication materials (IEC) for migrants during quarantine and on arrival in the host community.[12] Throughout the region, a variety of informational campaigns on COVID-19 prevention and services, targeting the population more generally, are running on radio, TV and online.[34] However, reports from Uganda indicate that health workers at the border do not provide sufficient, accessible information.[60] In South Sudan, it has been reported that rumours and misperceptions are widely circulating, and a systematic approach to rumours collection and countering has been incorporated in RCCE strategies.[76]

ENGAGEMENT LOCATIONS

RCCE efforts will need to engage with populations at a variety of locations to best reach cross-border travellers and those with whom they come in contact. Formal crossing points will provide the most direct and sustained access to those who are crossing the border legally, but it is equally important to reach those who might cross at informal crossing points, communities along transport routes and refugee communities within ESA countries. Border officers on motorcycles have been supported to monitor informal crossing points across eastern Africa and sensitise individuals crossing there and in border communities about COVID-19 IPC measures, and they may be able to provide useful information about where best to engage with people about COVID-19.[37] IOM's experience In Mozambique shows that local community leaders, community health workers and other community-based informants are best placed to Identify and sensitise returnees In their home communities.[77]

STAKEHOLDERS AND TRUSTED INTERLOCUTORS

Previous research on cross-border dynamics during Ebola outbreaks has highlighted the importance of engaging with trusted local authorities, particularly those with a role in

cross-border governance such as elders and clan leaders. [2] Cultural leaders such as kings and chiefs as well as religious leaders can be influential.[2,31] It is important to include associations and individuals who are directly involved in cross-border activity, such as representatives of truck, *boda-boda* driver and cross-border merchant associations, and representatives of service establishments (food, lodging and essential travel supplies) at border crossings and along trucking routes.[60] Representatives of often-overlooked and hard-to-reach groups, such as pastoralist and fisherfolk communities, refugee communities, migrant laborers and sex workers should be engaged.

TARGET POPULATIONS AND VULNERABLE GROUPS

There needs to be engagement and communication about COVID-19 with all those who are involved in or affected by cross-border travel, with particular emphasis on vulnerable segments of those populations and women. Many women are cross-border traders and informal and domestic workers in neighbouring countries, and they make up a disproportionate number of caregivers and health workers. Yet they often lack access to information and services. Other vulnerable populations on whom specially tailored efforts should be concentrated are children, people with disabilities, refugees, migrants, and the elderly.[78]

COMMUNICATION CHANNELS

Because a wide range of individuals pass through borders and along transit routes, a range of communication channels will be required. Research in a number of African Union countries showed that in general (not specifically related to border points) social media, TV and radio are the most common sources of information on COVID-19.[57,58,62] In Uganda, many people report having seen COVID-19 information on messaging apps (e.g., WhatsApp),[62,79] and truck drivers suggested using driver associations' WhatsApp groups to inform their members.[60] In Somalia, radio messages are received and trusted for information on COVID-19 by about 70% of study participants.[57]

However, pastoralists and refugees, in particular, may not have access to mobile phone technology or trust messages via those platforms, and a variety of channels (on and offline) should be used to communicate with those populations.[78,79] In Somalia, IDPs, refugees and returnees were less likely to trust radio as a source of COVID-19 information, and more likely to trust family and friends.[57] As possible, volunteers from migrant and refugee communities should be involved in developing and disseminating COVID-19 messaging, working in conformity with IPC protocols including wearing masks, maintaining physical distance and practicing hand hygiene,[78] or via public address systems as is done in refugee settlements in Uganda.[79] A small study among truck drivers

in Uganda found interest in messages delivered by peer educators or by well-known drivers and shared via animated screens and megaphones, as well as WhatsApp.[60]

COMMUNICATION CONTENT AND LANGUAGE

RCCE specialists should actively involve cross-border population groups and actors in joint risk analysis and in developing approaches to minimise infection risks. It is important to understand existing misconceptions about COVID-19 risks, prevention and treatment in each context. Two-way communication, via the same channels used to disseminate information, has been recognised as essential in the context of responses to infectious diseases outbreaks such as the COVID-19 pandemic[80] and community members must be afforded the opportunity to ask questions and provide information about their understandings of COVID-19 as well as about their specific concerns. They should also be encouraged to share advice and strategies that may be in use at the community level; this can help inform future risk reduction measures as well as messaging strategies.[81]

A broad variety of information sharing approaches and materials is required at border crossings and along transit routes, as individuals have a range of literacy skills and speak a range of languages and dialects. A language, format and communications assessment may be helpful in formulating information sharing strategies for cross-border use.[82] A total of 157 different languages are spoken in five ESA countries alone.[83] Literacy varies greatly throughout the region: Women's literacy lags behind men's in every country except Botswana, Eswatini and Lesotho, and older adults are less likely to be literate than younger people.[84] An emphasis on pictorial, audio and video dissemination of public health information on COVID-19 may be most effective, with translation of materials into accessible formats and languages when needed.[78,85] Posters in high-traffic areas may be preferable to leaflets and pamphlets, which may contribute to transmission as they are passed from hand to hand. Where possible, captions or sign language should be included on videos and TV productions and IEC materials should be translated into braille for people with visual impairments. Child-friendly message formats will be needed to reach this target group.

In the cross-border context, particular care should be taken to avoid language that will reinforce stigmatisation of certain groups, such as truck drivers and returnees. Stigmatisation and misinformation can prevent people from seeking care, and references to individuals or groups 'infecting' or 'spreading' to others should be avoided.[78]

LESSONS LEARNT FROM PRIOR OUTBREAKS

Prior infectious disease outbreaks have highlighted the importance of capacity strengthening, particularly at high-risk border areas, to enable local governments to implement RCCE work, and the real-time collection and inclusion of community feedback in RCCE development. RCCE implementers may be able to follow the example of immigration and customs officials and collaborate across points of entry. During the design of RCCE strategies, interventions should be considered for broader high-risk audiences, including health workers and support staff (e.g. border officials, cleaners, security guards, food handlers).[8] RCCE guidance developed for use in COVID-19 and other infectious disease outbreaks is a valuable source of information for the formulation of strategies in the present context.[78–81,86] A key first step in the development of RCCE should be to closely analyse the specific cross-border context to allow a tailored approach suitable to the particular populations.

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CONTACT

If you have a direct request concerning the response to COVID-19, regarding a brief, tools, additional technical expertise or remote analysis, or should you like to be considered for the network of advisers, please contact the Social Science in Humanitarian Action Platform by emailing Annie Lowden (a.lowden@ids.ac.uk) or (oliviatulloch@anthrologica.com). Key Platform liaison points include: UNICEF (nnaqvi@unicef.org); IFRC (ombretta.baggio@ifrc.org); and GOARN Research Social Science Group (nina.gobat@phc.ox.ac.uk).

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[a] SADC member states include Angola, Botswana, Comoros, Democratic Republic of Congo, Eswatini, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Tanzania, Zambia and Zimbabwe. All of these except DRC, Mauritius and Seychelles are also part of ESA.

[b] Alerts are suspected cases, pending verification.