



**COVID-19**

**RESOLVE**  
TO SAVE LIVES

**Vital  
Strategies**

# Responding to COVID-19 in African Countries: Analysis and Report of Survey Findings

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May 5<sup>th</sup>, 2020

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# Responding to COVID-19 in Africa: Survey Results

## Introduction

Public health social measures (PHSMs) are an important strategy to delay and reduce the magnitude of COVID-19. PHSMs, particularly those that restrict movement or entail the closure of services, can place a significant economic and social burden on populations and they may be difficult to follow in crowded or low-resource settings. Based on data from surveys in 20 African countries, conducted between 29 March and 17 April 2020,<sup>1</sup> we describe people's reactions to the pandemic, including their perceptions of personal risk, the burdens they will experience under community-wide PHSMs, and their confidence in the government response, and how this may be related to public acceptance of PHSMs and ultimately their effectiveness.

## Key Findings

### Awareness, Information and Misbelief

**Knowledge of COVID-19 – its symptoms and transmission – is high. But, gaps in knowledge persist. Some of these gaps are the reality of the scientific uncertainty around COVID-19: a lot is yet unknown.**

Awareness of COVID-19 is almost universal (over 98%) and basic knowledge is high: 91% across all 20 countries identified it as a disease, virus or respiratory illness; 97% accurately described its main symptoms to be either a fever, dry cough, shortness of breath, or a flu/cold like sickness. Most know that washing hands helps prevent getting COVID-19 (93%).

Yet, a significant minority does not know that infected people may not show symptoms for 5 -14 days (20% in the Central African region, 15 % in the East Africa region and 14% in the West Africa region.) There is uncertainty over how to respond to those who have recovered from COVID-19: over 50% of respondents think that people who have recovered from COVID-19 should be avoided to prevent spreading it. This perception ranges from 66% in the North African region to 45% in the East African region.

**There is evidence of misinformation, including some that could be potentially harmful. Misinformation is often a reflection of public anxieties and uncertainties and can be addressed carefully to ensure that it does not encourage non-compliance with public health guidance. Disinformation, or potentially harmful rumors that often tap into latent prejudices, can result in discrimination and violence.**

Misinformation of essentially three varieties persists.

There are beliefs about **genetic and climactic protections**. One in five (20%) believes that Africans cannot get COVID-19. This is as high as one in four (25%) in the West African region. One in two (54%) believes that hot climate can stop the spread; this belief is even higher in the Southern African region, with nearly two in three (61%) expressing this belief.

There is faith in **alternative remedies**. Over one in two (57%) thinks that you can prevent COVID-19 by drinking lemon and vitamin C. One in three believe you can cure COVID-19 with garlic (38% in the Central region and 35% in the West African region).

<sup>1</sup> See the technical note for further details on the methodology.

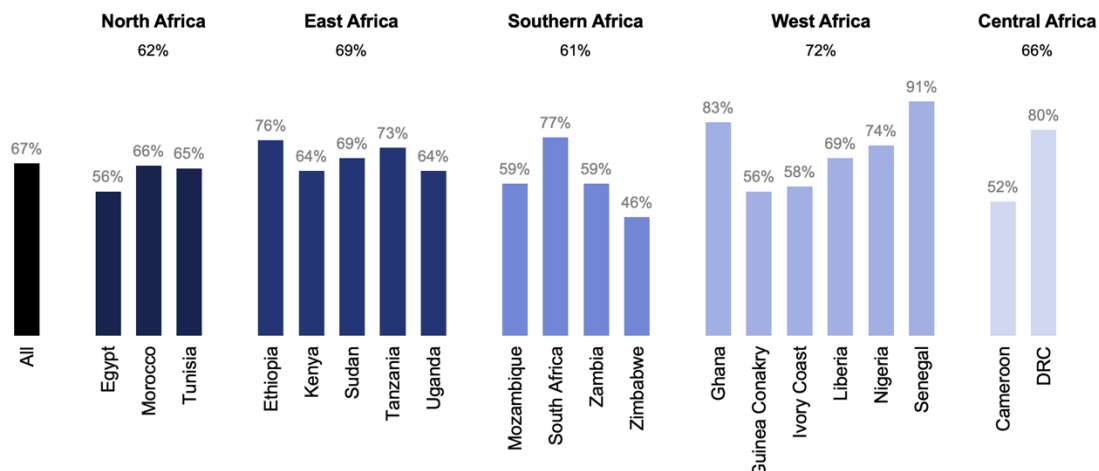
In some parts, potentially dangerous disinformation as **prejudice against the Chinese** persists. Three in ten think that they can get COVID-19 ‘from any Chinese person in their country;’ this was highest in North Africa (42%) and lowest in Central Africa (22%). One in three (37%) think that ‘Chinese-made hair weaves can be infected with coronavirus.’

Finally, Moroccans expressed **retributational** beliefs with 40% believing that COVID-19 is ‘a punishment from God’; and 20% believing it to be ‘a bioweapon/conspiracy.’

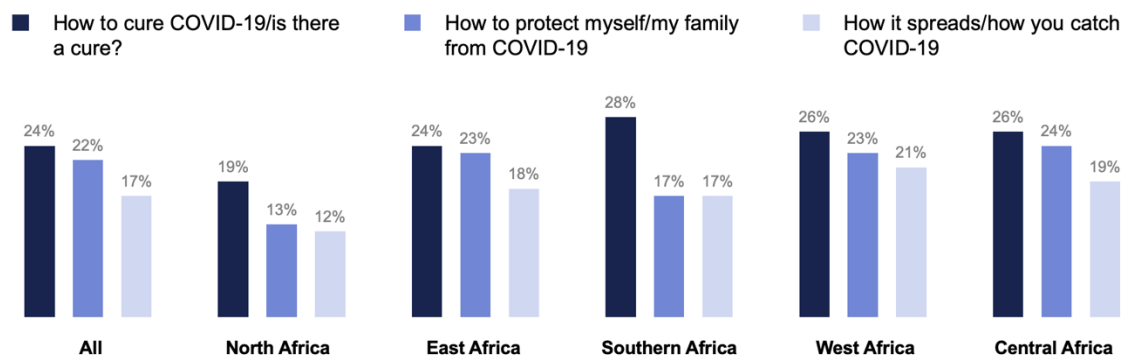
**There is a clear public call for more information, particularly around self-protection and treatment.**

One in three Africans says that they need more information about how the coronavirus spreads (33%), most commonly on how to protect themselves, and its treatment. Information needs are highest in Southern Africa and North Africa (37% and 36% respectively), and most concerning in Zimbabwe and Cameroon, with about half of respondents feeling they need more information. Hence, there is need for continued and tailored information around COVID-19.

### Q10. Do you feel you currently have enough information about the coronavirus/COVID-19 situation?



### Q11. What are the two things about it that you would like most to have more information about? [Top three mentions]





### Q14. I'm going to read things people have said about coronavirus or COVID-19. Please tell me if you think each is definitely true, probably true, probably false, or definitely false.

| Share who agree definitely/probably true  | All | North African |         |         | East African |       |       |          | Southern African |            |              |        | West African |       |                |             |         | Central African |         |          |     |
|---|-----|---------------|---------|---------|--------------|-------|-------|----------|------------------|------------|--------------|--------|--------------|-------|----------------|-------------|---------|-----------------|---------|----------|-----|
|   |     | Egypt         | Morocco | Tunisia | Ethiopia     | Kenya | Sudan | Tanzania | Uganda           | Mozambique | South Africa | Zambia | Zimbabwe     | Ghana | Guinea Conakry | Ivory Coast | Liberia | Nigeria         | Senegal | Cameroon | DRC |
| The virus can spread when an infected person touches someone's hand or face, kisses them, or sneezes or cough near them | 94% | 98%           | 99%     | 99%     | 97%          | 95%   | 95%   | 96%      | 96%              | 94%        | 96%          | 95%    | 96%          | 91%   | 89%            | 94%         | 96%     | 89%             | 93%     | 90%      | 87% |
| Washing hands helps prevent getting it  | 93% | 96%           | 99%     | 99%     | 95%          | 94%   | 95%   | 92%      | 93%              | 96%        | 95%          | 93%    | 94%          | 92%   | 90%            | 92%         | 95%     | 90%             | 91%     | 91%      | 86% |
| Infected people may not show symptoms for 5-14 days   | 81% | 87%           | 94%     | 91%     | 73%          | 80%   | 87%   | 76%      | 78%              | 88%        | 87%          | 75%    | 87%          | 81%   | 70%            | 76%         | 76%     | 82%             | 87%     | 71%      | 75% |
| People who have recovered from it should be avoided to prevent spreading it   | 56% | 76%           | 56%     | 64%     | 52%          | 56%   | 73%   | 38%      | 65%              | 66%        | 61%          | 49%    | 66%          | 62%   | 55%            | 33%         | 47%     | 61%             | 48%     | 49%      | 40% |

## Risk Perception

While the majority perceive COVID-19 as a big problem for their country, people's perception of their own risk of catching the disease is lower. Perception of personal risk tends to be an important predictor of whether or not people will comply with public health guidance; this data suggests that many Africans may not do so because they do not feel at personal risk of catching COVID-19.

**Three in five (62%) anticipate that the coronavirus will be a 'big problem' in their country**, which suggests that a significant minority has not accepted this pandemic as a major problem. By region, East Africans are most likely to anticipate 'a big problem' (70%, including 77% in Ethiopia and 72% in Kenya), while North Africans are less inclined to think so.

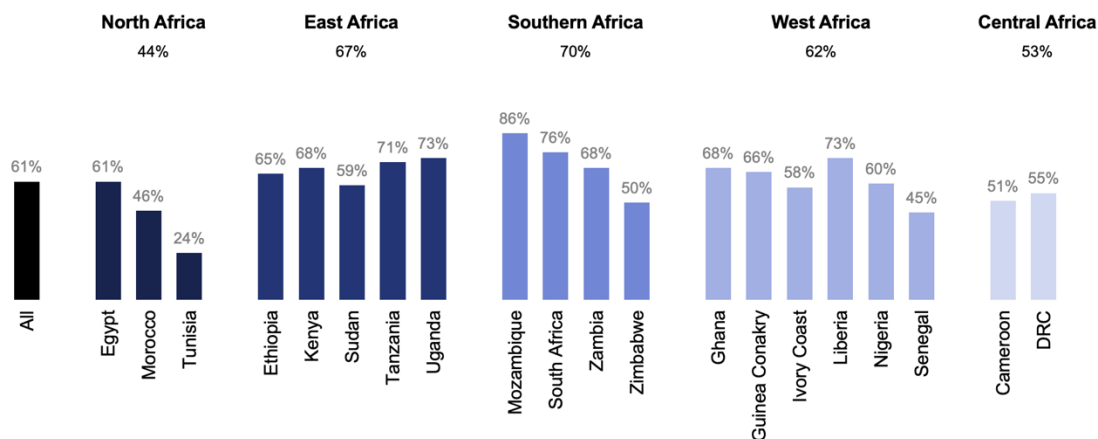
**Perceptions of personal risk of catching COVID-19 are lower: Two in five (44%) thinks that they would be at high risk of catching it.** The perception of risk as personal, likely and severe is crucial to achieving successful behavior change, suggesting that significant numbers of Africans have not recognized their personal susceptibility to COVID-19 and may therefore not act according to the PHSMs as indicated. Perceptions of high personal risk are particularly low in North Africa (27%); it is higher in the Southern & Western regions (49%). Across countries, Tunisia has the lowest risk perception (9%), followed by Morocco & Tanzania (33%) while it was highest in Mozambique (63%) followed by Liberia and DRC (55%).

**Three in five thinks 'coronavirus would be a serious health issue if they were to be infected' (61%).** These perceptions of severity are consistent with respondent's personal risk perception across regions and countries: lowest in North African region (44%) while highest in the Southern African region (70%). Among countries Tunisia (24%), followed by Morocco & Senegal (45-46%) show the lowest risk perception, with the highest levels in Mozambique (86%), South Africa (76%) and Uganda (73%).

The most commonly cited reason for thinking coronavirus could be a serious health issue if they were to be infected was a belief that 'it could kill or make very sick' (43%), followed by the perception that 'it is serious' (20%). Being strong/healthy/young is the most common rationale among those anticipating a less serious personal health impact, particularly among men.

There were some significant demographic differences in perceptions of personal risk. Risk perceptions were lower among younger adults, and perception of **personal risk increases with age, which is consistent with the epidemiological evidence on this pandemic**. Only four of ten 18-25 year-olds think they are at high risk, while almost 50% of those over 46 years perceive themselves at high risk. Risk perceptions were also associated with income: **they were lower among the higher-income groups, and tended to decrease with income status**. Only 39% of those with household incomes over \$500 a month perceive themselves at high risk, while almost half (47%) of households with less than US\$100 a month perceive themselves at high risk.

### Q6. If you were infected by coronavirus or COVID-19, how seriously do you think it would affect your health? [% who think their health would be very or extremely seriously impacted]



### Satisfaction, Trust and Confidence

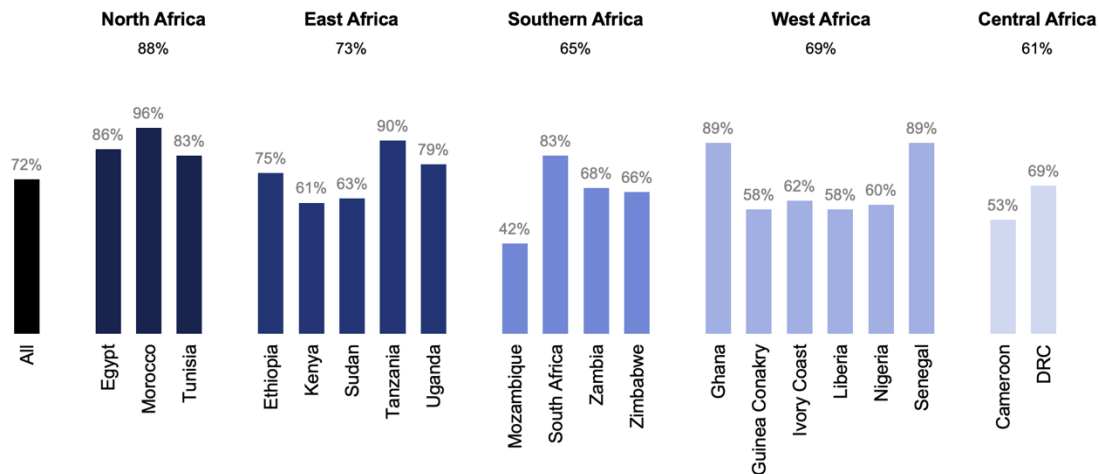
**The majority of Africans are satisfied with the government's response and they trust the information they are receiving. Most Africans are also confident that they will immediately get the help they need if they were to fall sick with COVID-19.**

Two in three Africans are confident about being able to immediately get the help they need if they were to become ill (67%). While there is little difference across age groups or income levels, there are large differences in confidence by region and country. Confidence is highest in the West Africa region (73%) and lowest in the South Africa region (61%). Confidence is highest in Senegal and Tanzania (81%), Morocco (80%) and in South Africa (78%). Confidence is less than 50% in Tunisia (44%), Zimbabwe (47%) and Mozambique (48%).

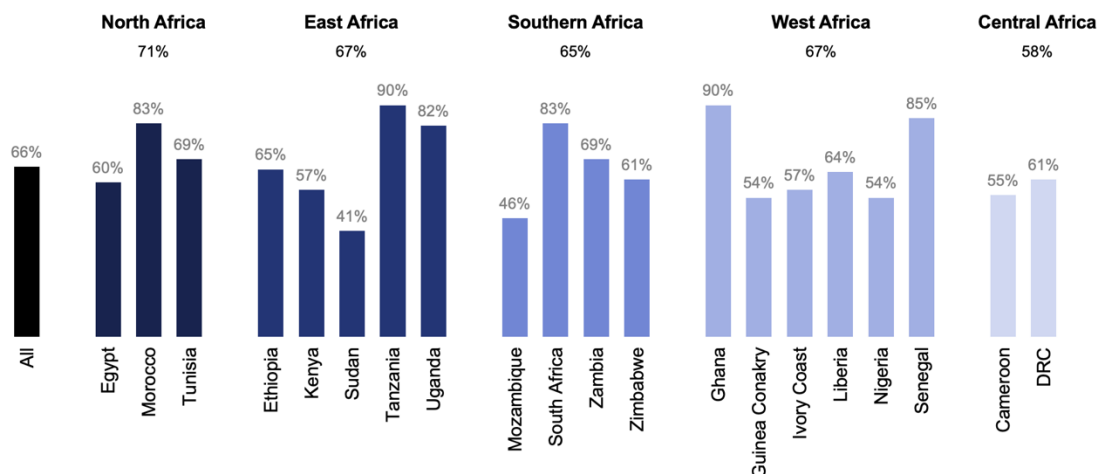
**There is a fairly high level of satisfaction with the government's response to COVID-19.** However, 27% are dissatisfied, including 14% 'very dissatisfied'. Satisfaction levels vary more by region than by socio-demographic factors, with the highest levels in North Africa and more modest levels in Central Africa. Mozambique has a higher level of dissatisfaction than satisfaction (55% vs. 42%).

**Two-thirds trust the information they receive from governments** However younger respondents have lower levels of trust (61% of those 18-25 versus 74% of those over 46 years). The eroding trust among younger adults is significant given the skew towards younger age groups in most African countries.

### Q12. How satisfied are you with the [COUNTRY] government's response to coronavirus or Covid-19? [% who are very or somewhat satisfied]



### Q13. How much do you trust information from the [COUNTRY] government about the coronavirus or COVID-19? [% who are completely or mostly trusting]

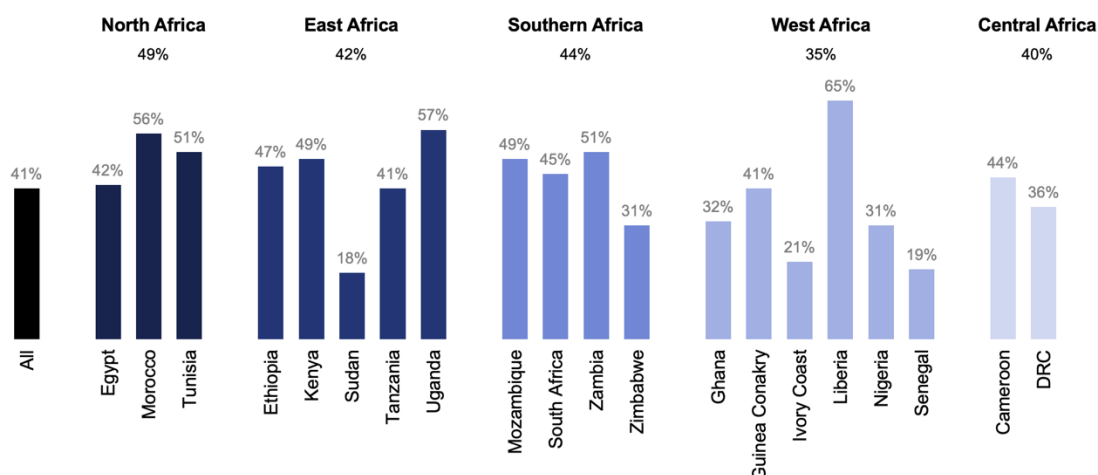


## Support for Public Health Social Measures

**Support for personal public health social measures (PHSMs) are strong; however, opposition levels rise for measures that require isolation in homes.**

There is almost universal support for personal social measures, such as stopping handshake/kiss greetings (95%). In line with the acknowledgment of the importance of hand washing overall, two in five (41%) stated they washed their hands with soap or use hand sterilizer 10+ times in the day prior to their interview. However, this varies considerably across and within region, from 65% in Liberia to one in five or fewer in Sudan, Senegal and Ivory Coast (18%, 19% and 21% respectively).

### Q40. Yesterday, how many times did you wash your hands with soap or use hand sanitizer? [% who washed their hands over ten times]



However, there is greater opposition to measures that require isolation or quarantine: One in five people oppose home isolation for infected people with significant regional and demographic variation. One-third of those in the Central Africa region (33%) oppose home isolation versus only 13% opposition in the North and South African regions. There is a similar pattern of opposition to requiring those who have contact with infected people to self-quarantine (16%, ranging from 30% in Central Africa region to 6% in the North African region). Opposition to home quarantine for infected people is higher among those with lower income levels. Twenty-two percent of those with income less than US\$100 per month oppose home quarantine compared to 17% of those with household income greater than US \$500 per month. Younger respondents are more likely to oppose home quarantine, with 22% of those 18-25 years old opposed to quarantine versus only 19% of those over 45 years.

**Africans support restricting public gatherings, including religious gathering. Nearly one in two supports remote means of accessing religious services.**

Support is almost universal for restricting public gatherings to help limit a COVID-19 outbreak by stopping music concerts (96%); closure of restaurants and nightclubs (92%); and sports fixtures (96%).



Support for closure of religious gatherings is also high: three-quarters support closing churches or mosques (77%), though at are slightly lower levels of support for stopping prayer gatherings (82%). Although this is consistent at the regional level, opposition to this runs as high as three in ten in three in Liberia and Sudan.

The most frequently cited solution to reduce the effect of restricting prayer or religious gatherings would be to offer services on TV or Internet (48% of all respondents support) followed by radio broadcasts (46% support).

**Support for closure of schools is near universal, but there is lower support for the closure of essential services.**

While only 5% oppose closure of schools, almost six times as many respondents oppose closing markets (30%), workplaces (29%), transport (29%), or their entire city (27%). Opposition to closure of markets, workplaces and transport varied across the regions and countries. Opposition was highest in the Central African region (34-37%) and lowest in the North African region (21-25%).

Opposition to closure of markets, workplaces, or transport was highest among those with lower income (31-35% for household incomes under US\$100) versus higher income (18-23% for households with more than \$500 monthly income). Church and mosque closures were opposed by one of five respondents. Opposition was higher among those with lower incomes (26% opposition among households with less than US\$100 per month) versus those higher incomes (only 17% opposition among households with monthly income above US\$500). Opposition to church and mosque closures were highest in the East, West and Central regions (26%, 25% and 23%) and lowest in the North region (15%) and South region (17%).

**Level of support for public health and social measures (PHSMs), by type of intervention**

|   | All | North Africa | East Africa | Southern Africa | West Africa | Central Africa |                          |
|---|-----|--------------|-------------|-----------------|-------------|----------------|--------------------------|
| Stopping greeting with handshakes or kisses                                 | 95% | 95%          | 96%         | 95%             | 95%         | 92%            | ■ Personal PHSMs         |
| Those people who have contact with infected people staying home for 14 days | 82% | 93%          | 84%         | 88%             | 77%         | 67%            | ■ Public gathering PHSMs |
| Requiring people with Covid19 to stay home until they are well              | 79% | 86%          | 78%         | 86%             | 76%         | 65%            | ■ Community PHSMs        |
| Stopping sport fixtures   | 96% | 95%          | 97%         | 96%             | 96%         | 94%            |                          |
| Stopping music concerts   | 96% | 96%          | 98%         | 96%             | 96%         | 94%            |                          |
| Stopping prayer gatherings  | 82% | 82%          | 82%         | 86%             | 80%         | 82%            |                          |
| Closing schools   | 95% | 96%          | 96%         | 94%             | 94%         | 92%            |                          |
| Closing restaurants and nightclubs  | 92% | 96%          | 93%         | 94%             | 90%         | 85%            |                          |
| Closing churches and mosques  | 77% | 84%          | 73%         | 82%             | 75%         | 77%            |                          |
| Closing transportation between cities                                       | 74% | 85%          | 71%         | 75%             | 73%         | 69%            |                          |
| Closing off a city for 2 weeks  | 72% | 83%          | 67%         | 73%             | 72%         | 63%            |                          |
| Closing transportation in and around cities                                 | 71% | 77%          | 73%         | 70%             | 69%         | 62%            |                          |
| Closing workplaces  | 70% | 74%          | 69%         | 71%             | 70%         | 64%            |                          |
| Shutting down markets   | 70% | 79%          | 71%         | 69%             | 67%         | 63%            |                          |

## Potential Burden

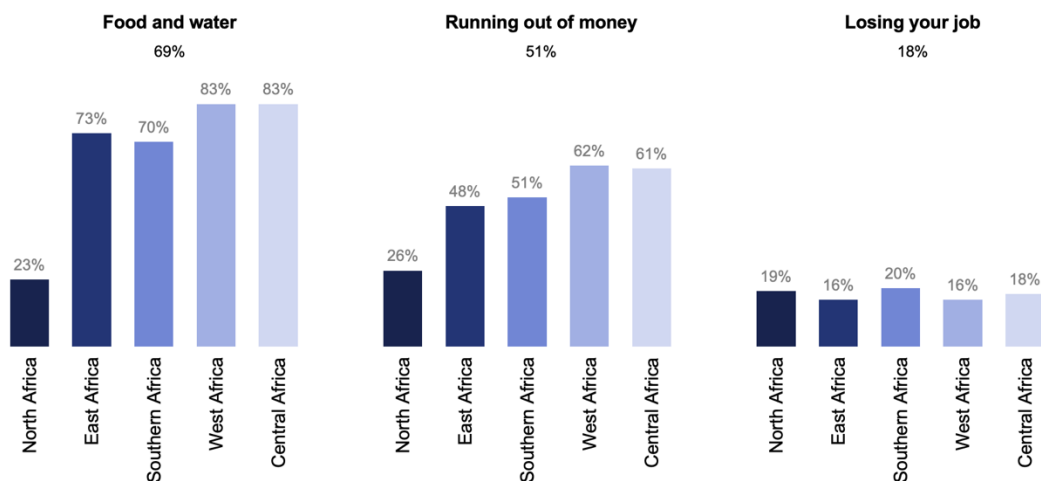
**Longer-term use of certain PHSMs will likely result in significant burdens.**

**Many Africans do not have the room to isolate the sick:** No more than two in five have a separate room to isolate someone who becomes sick (40%) and as the chart below shows, this varies considerably by region and country, with only 16% of Cameroonians having this facility.

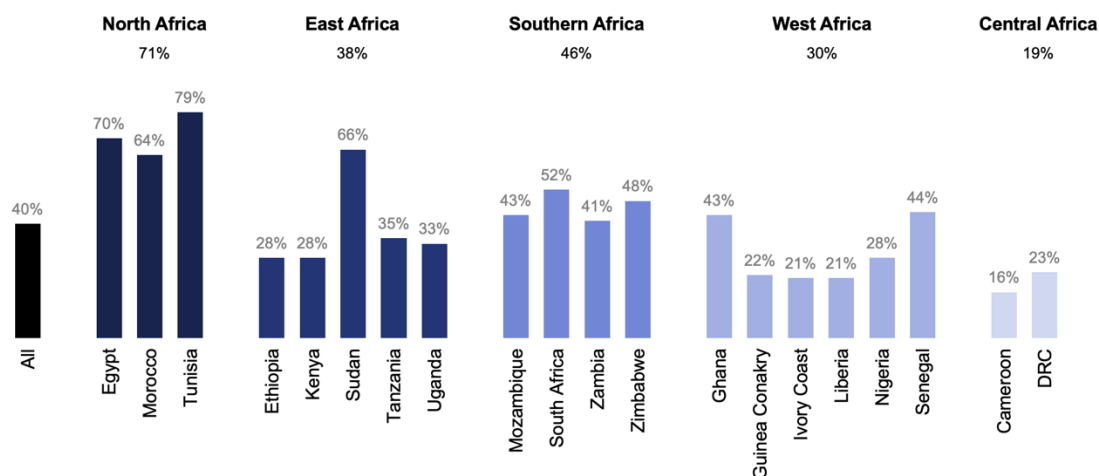
**Most Africans would run out of food, water, medicine and money quickly.** On average, most would run out of food in 10 days, prescription medicine in less than 9 days, and money in 12 days. The lowest income households (less than US\$100 per month) would run out of money and food in less than a week, while the higher income households could last about two weeks (over US\$500 a month). Regionally, food insecurity is highest in the Central region and lowest in the Southern region. Cameroon and Guinea (less than 7 days of food) and money insecurity is highest in Cameroon and Nigeria (less than 7 days in.)

**One in five might lose their job if asked to stay at home for 14 days (18%).** Almost four in ten work outside the home (39%), with higher levels of employment among older people (importantly, 63% of people 18-25 are not working). Outside employment is highest in Ethiopia (65%) and Tanzania (55%). Of those employed outside the home, only half (55%) indicate that their workplace could accommodate staggered shifts.

### Q17. What would be the biggest problems for people like you to stay at home for 14 days?



### Q38. Would you have a separate room in your home to keep someone isolated if they are sick? [% who have a separate room available]



### Variance by Income, Age and Gender

**There were some systematic differences in public reactions by age, income and gender. Lower income groups and older adults are the most concerned and likely to face the greatest burden of PHSMs. Women are more concerned than men about school and market closures.**

#### Income Status

Lower income Africans were more likely than those in higher-income brackets to have the highest risk perception (47% vs. 39% of the highest income group) and increased concern that COVID-19 as a serious health issue (65% vs. 56%). They are also less likely to think they have enough information (61% vs. 75% in the highest income group). Lower income respondents were more likely to believe misinformation about prevention (hot climates, drinking bleach, and garlic) and less likely to know it can spread asymptotically.

While there is little difference by income in levels of dissatisfaction with the government response, lower income people trust information from the government more (68% vs. 63% for highest income households). In addition, lower income respondents are less likely to think that COVID-19 is a “germ weapon created by a government” (35% vs. 38%).

Lower income people were the most likely to worry about running out of food and water (83% of households with less than US\$100 a month vs. only 53% of households above US\$500). Lower income people would run out of money in about a week while higher income people had a few more days. Respondents with lower incomes are more likely to oppose closing markets (35% lowest income vs 21% for highest income respondents), workplaces (34% vs. 23% highest income respondents) churches and mosques (26% lowest income vs. 17% highest income), and transport (32% lowest income vs 23% highest income respondents)

## Age

Older respondents have a higher risk perception (47% vs. 40% in the youngest group); the most concern that COVID-19 is a serious health issue (64% vs. 58%); and more confidence that they could get immediate help (69% vs. 64% for younger adults). However older adults are more likely to state that they have enough information. Older people were also more likely to believe misinformation about prevention (lemon and vitamin C and garlic) and more likely to know it can spread asymptotically.

Younger people are more likely to be dissatisfied with government response, and less likely to trust information from the government (61% vs 72% in the oldest group). Younger people are more likely to believe that COVID-19 is a “germ weapon created by a government” (38% vs. 32% of the oldest group).

Middle-age groups are most likely to anticipate running out of money (53% of those 26-45 years vs. 46% of those 18-25 and 47% of those over 46 years). All age groups were relatively equally worried about running out of food, with younger people more likely to run out of money sooner. Older people were slightly less likely to worry about losing their job. Opposition is relatively flat across age groups for closing markets, workplaces, churches and transport.

## Gender

Women have lower levels of personal risk than men (‘very high’ 24% for women versus 26% for men) but are equally concerned about COVID-19 as a serious health issue. For the one-third of all respondents that didn’t perceive COVID-19 to be a serious risk, men are more likely to offer that it is because they are “strong, healthy, or young” (40% men who don’t perceive COVID-19 to be a serious risk cite this reason vs only 29% of similar women). Men are slightly more likely to think they have enough information. There were few gender differences in misinformation.

Women are slightly less dissatisfied about government response than men (26% vs 28%) and less likely to distrust the government (31% vs. 33%). Women are less likely to believe COVID-19 is a ‘germ weapon created by a government’ (32% vs. 38% for men).

Men were more worried than women about running out of money (53% vs. 48%) or losing their job (19% vs. 16%). Women were significantly more likely to say that, if schools closed, there was no one to take care of the children (30% vs. 24% of men); Women were more likely to oppose shutting markets (31% vs 28% for men) and churches or mosques (23% vs. 21% for men).

## Media Use and Communication Channels

**Television is the most common media source relied on, but there is considerable variation by country with radio, friends and family and social media cited as frequent sources in several countries. The most trusted spokespersons for health information are medical authorities, including within the government, and religious leaders.**

**Traditional media are highly used continent-wide, though Whatsapp and Facebook are also commonly used.** The majority of respondents use national television as their main media source (53%) and three in five use it for national news (62%), with most respondents viewing TV more than four times a week. Radio was next most frequent (followed by radio (15% using it as the main source and 27% using it for national news), although only one-third of respondents listened more than three times a week. There is, however, considerable variation in media use for news by country with, for example, radio used by 74% in Liberia, Facebook Social media (Facebook, YouTube & Twitter) by 56% in Tunisia, and WhatsApp by 39% in Zimbabwe. WhatsApp and Facebook are used by about half of respondents more than four times a week.).

**The most trusted media sources** for health information are television (international 73% and local 73%), local radio (68%) and social media (42%).

**The most trusted spokespeople for health information** are medical authorities, including within the government, and religious leaders, and they are trusted more than political leaders. While the Presidency is trusted more than other political leaders (68% vs. 38%), local leaders are more trusted, such as doctors (88%), the national level Health Ministry (83%), community health workers (71%) and local health centers (71%). Religious leaders are more trusted (65%) than cultural leaders (33%).

## Technical Note

The fieldwork on this study was conducted by Ipsos with results based on 20,990 interviews with adults aged 18+ in 28 cities across 20 countries. Fieldwork was conducted by telephone (16 countries) and face-to-face interviews prior to PHSMs being introduced (4 countries: Cameroon, Côte d'Ivoire, Ethiopia and Mozambique). Respondents were sampled by random digit dial incorporating landline and mobile phones for telephone fieldwork and by random walk and in-household Kish-grid sampling methods for face-to-face fieldwork. Data are representative of the populations of the urban area (s) included and are unweighted. The original questionnaire was developed by Charney Associates LLC. Fieldwork took place between March 29 and April 17, 2020. All responders consented to join the study. Regional country groupings, survey coverage and field dates are summarized in the table below.

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

This summary report presents an overview of the findings across the 20 countries included in the survey. Individual country summary reports are also available. Further waves of the research are planned for the coming months.