RISK COMMUNICATION & COMMUNITY ENGAGEMENT (RCCE)

Somalia COVID19 Rapid Assessment Survey Report (April 2020)

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1. Background

The World Health Organization (WHO) Situation report #96 dated 25th of April indicated that nearly 3 million people are infected with COVID19 and the disease has claimed more than 200,000 lives across the globe. Somalia has reported 390 confirmed cases and 18 deaths with exponential increase in the last 2 weeks. However, the figures in Somalia might be underreported due to limited capacity of the country to identify and test cases. The outbreak is having visible negative impact on food security due to rising food prices and health system resource channeled to the outbreak containing effort.

COVID19 pandemic comes with catastrophic impact on education, health, nutrition, and protection for millions of children and their parents in Somalia. Communities at high risk of COVID19 are disproportionately impacted, especially those who live in refugee camps with limited access to health and sanitation services. In most vulnerable communities such as IDP (Internally Displaced People) centers, stopping the spread of the deadly virus becomes almost impossible. The pandemic brings apprehension for communities living under already staggering health and economic situation in Somalia. The negative effect is vividly touching the livelihoods of children. Several efforts are currently going on to communicate the danger posed by the pandemic, and to create awareness across the community.

The COVID19 global pandemic is an unprecedented situation, and as such requires an unprecedented response. COVID19 is unlike any disease outbreak we typically respond to in Somalia (AWD/cholera, measles), and business as usual will not suffice. Our current approach to community engagement and other Social Behavior Change Communications (SBCC) is typically very ‘one-way’, top-down, and often ‘spray and pray’, whereby we pump out untested messages through multiple channels and hope that it works. For that reason, to effectively prepare and respond to COVID19 pandemic, WHO and partners have developed the RCCE (Risk Communication and Community Engagement) guidelines based on experience from the Ebola outbreak.

RCCE promotes a two-way communication strategy between the population at high risk of COVID19 and the responding agencies including the government, NGOs/INGOs, UN and others actors working to contain the outbreak of the diseases by proactively asking, listening to and understanding the knowledge and perception gaps, and tailoring the communication messaging accordingly. Regular and proactive RCCE of at-risk populations not only enables people to prevent the infection of COVID19, but also helps to reduce fear and stigmatization (which can prompt social isolation of groups and contribute to a situation where the virus is more, not less, likely to spread); and increase social support for and access to basic social services.

Understanding the importance of measuring the gap in knowledge, perception, attitude, communication channels, and existing barriers is important to effectively design evidence based institutional communication and campaigning strategies. Save the Children conducted a Rapid Assessment covering the entire Somalia between 13th to 16th of April, 2020. The findings of the assessment will inform the defining and prioritizing of the RCCE strategy and key communication and community engagement plan; including contextualizing key messages tailored to circumstances of vulnerable communities, defining key actions/activities, and tailoring and testing materials. Ultimately, the exercise will increase the effectiveness of our communication activities and therefore the impact of the overall response. Furthermore, meaningful participatory engagement and adapting messages to the local context and audience is also proven to lead to stronger ownership, buy-in and commitment, as well as maintaining/increasing access, and strengthening the organization’s integrity and reputation.

2. Objectives

The general objective of this rapid assessment is to generate evidences on current gaps in knowledge, perception, attitudes, communication channels; and social, cultural and political barriers that hinders the proper flow of message about COVID19 among the most vulnerable communities in Somalia. Specifically, the assessment sought evidence on:

i. Knowledge gap of the communities about the COVID19, focusing on what the community know about the diseases, its symptoms, transmission mechanism and prevention measures practiced.

ii. Source of messages and the trusted source for COVID19 related information.

iii. How children and people with disability in the communities get information on COVID19.

iv. Understanding the misperception and stigma around the disease.
3. Methodology

This rapid assessment used phone interviews to conduct cross-sectional quantitative and qualitative survey through structured questionnaire designed using the WHO RCCE assess and analysis guide. The questions from WHO RCCE guideline were slightly modified by including children and disability specific questions. The questionnaire was then developed into Kobo xlx form. Trained enumerators then made calls to a contact randomly selected individual from the list of beneficiaries.

There were two type of surveys developed for quantitative and qualitative data collection. Enumerators were trained on data collection using phone calls undertook quantitative data collection. The phone calls were based on questions with pre-coded response, listening to responses and completing the questionnaire on kobo form. The second type of the survey used separate respondents, selected from the same districts as those in the quantitative survey. However, in qualitative survey the questionnaire remained open ended and by engaging a randomly selected Key Informants called to get responses on the questions.

The qualitative survey used the WHO which is the modified version of quantitative survey guideline, where the options for the responses were removed and discussion took place using open-ended guiding questions. There was lively discussions between the caller (enumerator), and the respondents using the guiding and probing questions to get in-depth understanding of the community perception and knowledge gap on COVID19. To facilitate the data collection and analysis process, the caller used voice recorder to capture the conversations (after getting the consent from the participants). When possible, the caller requested the respondent to invite people around him/her to discuss the questions and get additional insights from people living with the respondent.

Phone surveys are faster to conduct and process data for rapid utilization of the findings and therefore ideal to conduct rapid assessment under humanitarian context like COVID19 outbreak. However, it suffers from low response rate (about 29%), which can also lead to increased cost of conducting survey, and create biasness in the estimates (Lau et al., 2003; Rubin et al., 2009), because the sample will not be a random interview; as non-responding contact replaced with the next available respondents.

In this study, we assumed the highest response rate of 50% because the list is selected from the existing list of Save the Children beneficiary households who have been with the projects for a longer time and have a good relationship with Save the Children staff. The sampling frame was extracted from 100,000 plus registered beneficiary list in four larger multi-area projects implemented in Somalia. Sample size estimation assumed 50% response rate; 2% margin of error; 95% confidence interval; and total estimated population of Somalia at 15,000,000 to reach a total of 7,200 contacts to be called. This yields 3,600 individuals to successfully complete interview forms nationally. A total of 3,600 sample is further distributed to survey areas proportion to total number of beneficiaries. Accordingly, 1,680, 840, and 1,080, individuals were targeted to be interviewed in Southern States (SS), Puntland (PL), and Somaliland (SL) areas, respectively. To arrive at the required sample size in each area about 3,360, 1,680, and 2,160 individuals were targeted to be contacted, in SS, PL, and SL, respectively. Out of the total sample in each area 5% of the respondents were targeted to be interviewed for qualitative KII making 180 Key informant Interviews.

However, it is possible to reach the required sample size with fewer calls than 7,200 depending on actual response rate. The procedure is enumerators keep on calling until they reach the required sample size in each district. Finally, Data was collected from representative samples from 17 regions, and 43 districts, which covers almost 90% of the entire Somalia/Somaliland.
4. Findings of the Study

4.1. Respondents by Geographical Area, Demography, Settlement Type and Occupation

This finding is based on rapid assessment conducted on 3,510 (72% female, 19% internally displaced, 6% returnees, 5% refugees) individuals using phone interview survey. Surveyed respondents were selected from 43 districts, located in 17 regions, distributed in three areas: Puntland 24%, Somaliland 31%, and Southern States 45%. The average age of the respondents was 37.8 (sd. 12.8, min 13, and max 85) years; 17% were below 25 years, 35% between ages 25 to 35 years; 34% were 35 to 50 years old; and 15% above 50 years. On average females were 3 years younger than the male counterparts.

The major occupation of the respondents was farming or pastoralist, 51%, followed by small-scale business; 22%; and 24% without any kind of employment. About 70% of the respondents were without any formal education; 22% completed primary; and less than 10% have education above secondary school.
4. Findings of the Study

4.2. Knowledge about COVID19, What They Know, And Misperception

Regarding the knowledge about the COVID19, nine questions were posed to the respondents focusing on whether or not they heard about the COVID19 virus; what kind of information they received; what they know; source of information, and trusted sources; level of anxiety, and perceived likelihood of being infected. Ninety-four percent of the respondents had heard about the COVID19 by the time of the survey; only 6% didn’t receive any information; 14% of the older population aged 50 reported they didn’t receive any information about COVID19 (Figure 3).

![Figure 3: Knowledge about COVID19 by age category](image)

About 10% of people living in IDP settings (IDP, refugees, or returnees) reported not hearing about COVID19, against 5% of the residents. Even though 94% of the respondents heard about the COVID19, about 45% of those who heard of the disease don’t think they will be likely to become sick with the new coronavirus. Of 94%, those heard about the COVID19 disease; 26% (25% of females and 27% of males) reported “Not know anything about the virus”; furthermore, 42% believe its government campaign and 17% believe it’s a radio/TV campaign. Those who are at high risk of corona virus, 14% (18% females and 14% of males) aged 50 years and above never heard about the corona virus, and were less likely to get information about the diseases. Moreover, 48% have received information on how COVID19 virus is transmitted from sick person; 58% received information on the symptoms; and only 16% received information on what to do if someone in their family or themselves got sick with the disease (Figure 4).

![Figure 4: Type of information respondents received about corona virus](image)
Moreover, in response to if they have heard about COVID19 and what they know about the disease on Key Informants Interview, women living in pastoralist community responded as below.

“Yes, I have only heard about the disease this month; I really don’t know anything about the disease; I heard about the diseases from people speaking about it; I hear this disease is affecting other countries like Ethiopia”
A 60 years female pastoralist, in Shire village, Qardo district of Puntland.

“I haven’t received enough information about the disease except what I listen on the phone which is about awareness on washing hands thoroughly and keeping good sanitation.

I heard from the phone (Golis Telecom), when I make a call, I hear about this disease and it was where I first heard about it; No, I don’t know how to protect myself or the symptoms”

Female, 59, Pastoralist, Canbaar Sare village, Puntland.
4. Findings of the Study

Respondents heard about the coronavirus through several channels: Radio accounts for 72%; TV 21%, friends (16%), Social media 15%, community health workers (12%), community leaders (8%), religious leaders (7%), and Health unit/Health care worker 7% (Figure 5).

Figure 6: Trust source of information on covid19.
The most trusted source of information channels follows similar trend from where they heard about the COVID19. Radio is trusted by about 70% of the respondents; TV 18%; family members 17%; community health workers 16% (improved as trusted source eventhood only 7% heard about the diseases from community health workers); health units/Health care workers 12%; social media excluding WhatsApp 11%; community leaders by 10%; Religious leaders, 10%; and friends by 9% (Figure 6). Significant difference were observed regarding trusted source of information between females and males; females were 23% (p<0.002) more likely to trust TV, compared to males, while men were 8% (p<0.000) more likely to trust radio compared to females.

There is a difference between IDPs and the resident respondents regarding trusted channels, IDPs (IDPs, refugees, and returnees) were 5-percent point less likely to trust radio as a source of COVID19 information (p<0.003) while 36-percent point more likely to trust family or friends (p<0.000). IDPs more significantly trust information coming from the international society like Red Cross or Crescent while resident respondents more likely to trust community-based communication channels (religious leaders, traditional leaders, community workers, community leader).

Moreover, rural and urban residents differ in their trust source of information; rural residents were, 7% (p<0.000) more likely to trust radio then urban residents; 10% more likely to trust information from the religious leaders; and International NGOs compared to urban residents. While urban residents, 50% (p<0.000) more likely to trust TV, and 37% social media; rural community trust NGOs; and community leaders, and religious leaders.
4. Findings of the Study

4.4. Knowledge of Disease Spread, Symptoms, Prevention Mechanisms, What to Do In Case Someone Gets Sick with Coronavirus

About 70% (67% IDPs, and 75% residents) believe that the major spread of the disease is through direct contact with infected person; 58% airborne; 54% touching contaminated surface; and 49% droplet from infected people (Figure 7).

How Does Coronavirus Spread?

In response to prevention practices 95% reported hand washing regularly with water and soap; 60% indicated covering mouth and nose during coughing and sneezing; 37% avoiding contact with people sneezing and coughing and 20% by drinking only treated water. About 80% and 78% mentioned cough and fever respectively as the main symptoms of corona virus; 53% shortness of breath and breathing difficulty; 32% headache, 22% muscle pain, and about 10% don’t know the symptoms.

Even though only 16% of the respondent indicated that they have heard what to do if someone has symptoms of the disease; about 65% will be going to hospital if someone from their family has symptoms of the disease; 27% would stay in quarantine; 23% will consult more experienced members of the family; 8% will buy medicine; and 8% will go to the neighbor to seek advice (Figure 8).

“We usually give some traditional medicine like lemon juice, and also protect from the cold”

Female 37 years, Bari region
4. Findings of the Study

What To Do If You Or Someone From Your Family Has Symptoms Of This Disease?

- I will go to the hospital / health unit: 64%
- I would stay in quarantine: 27%
- I will look for a more experienced relative: 23%
- I will buy medicines at the market: 8%
- I will go to the neighborhood nurse: 8%
- I will look for the traditional healer: 7%
- Other: 4%

![Chart showing the percentage of responses to what to do if someone from the family has symptoms of the coronavirus.]

Figure 8: What to do if someone from the family has symptoms of the coronavirus

4.5. Prevention, Perceived Risk Level, What More Would You Like To Know About the Disease

Three-quarter believes it is important to act to prevent the spread of the coronavirus in their community; the rest 25% don’t know or do not believe in taking any action. Some of the participants in Key Informant interview believe that they can’t do anything and believe only Allah can protect, thus, they don’t believe in taking action to stop the disease.

More than 80% of the respondents think the new coronavirus is the most dangerous disease and has serious health consequences, about 10% believe it is more or less dangerous. About 60% and 21% respectively, think elderly, and adults are at highest risk of getting coronavirus; and about 10% mention children are at a high risk. More than 50% of the respondents believe they will be more likely to be infected by the disease; females perceive high risk than males.

“No, we didn’t do any actions to prevent the COVID19 because we are Muslim we believe in Allah, and it will not harm us” Male 30, in Bari Region. “Yes, I have heard the about the disease and it is nightmare to the community, everywhere you go people are talking about the virus, only Allah can protect us from the CORONA, if we keep repenting our sins and keep praying, Allah will relieve us from coronavirus”

Female, 22 years old.
4. Findings of the Study

4.6. Access to COVID19 Information, Risk of COVID19 for Children and People with Disability and Stigma

Children and people with disability have limited accessibility to COVID19 information. Thus, it critical to ensure children and people with disability are getting consistent, tailored and reliable information about the disease. A question is posed to the respondents asking if they have seen any communication materials about COVID19 using sign language or adapted specifically for children and people with disability.

About 65% of the surveyed respondents indicated they didn’t see any information provided on COVID19 to the community using sign language or other formats used by persons with disabilities. Nearly half of the respondents indicated children in their community went out to the market to buy or sell goods during COVID19 outbreak. About 27% of the respondents indicated coronavirus is generating stigma against specific people: 43%, 32%, and 12% indicated coronavirus induced stigma created against Chinese, all foreigners, and diaspora community, respectively.

![Figure 9: Does coronavirus generating stigma against people](image-url)
5. Conclusion

Most of the respondents have heard about the COVID19 virus, however, a significant number of respondents have limited knowledge about the disease; indicating that the general public information is not consistent and sufficient enough to bring confidence to the community to take required actions against the disease. There is mixed perception on the prevention mechanism, level of risk and vulnerability. Most people received information from the radio, followed by the community-based workers including community health workers, traditional leaders, religious leaders, families and friends; while social media is less likely to be trusted.

At the same time, traditional channels such as Radio are among the most trusted source of information, however, access to radio, and TV is limited and hinders accessibility of the information by people who are at high risk of COVID19. There is difference in the preferred and trusted source of information based on the demographic, and type of residence. Religious believes playing a significant misperception that the diseases can only be stopped by God, and prayer, and repentance to sin is solution.

Moreover, even though significant part of the community has knowledge about how the diseases is spread, symptoms, prevention approaches; and feel it is dangerous disease; the willingness to change practice is not promising.

It is clear that it is important to re-design our communication strategy to tailor it to different segments of the community. The findings further indicated that people who are at high risk of the disease that is the elderly women and adults were less likely to get the right information about the disease. This requires re-defining and structuring appropriate messaging with a combination of both the conventional approaches through radios, TVs and community based faced-to-face approach to reach people without access to radios, or TV, or unable to visit health centers.

There is need to customize the communication approaches, based on the finding, there is difference in trusted source of information between IDPs and the resident respondents. People living in IDPs were less likely to trust radio and more likely to trust family or friends; or community-based communication (religious leaders, traditional leaders, community workers, community leader).

Thus, it is important to design communication and campaigning strategies specifically addressing the challenges faced by IDPs, and channeling messaging through the community-based campaigning than the wider mass-media approach. Children and people with disability are left out from the COVID19 virus communication and more likely to remain in the risk of infection by the disease as they were going to market to buy or sell goods; and there is not enough sign language or disability sensitive information dissemination approaches.
6. Recommendations

- It is important to engage the community to understand the gaps in perception, knowledge, and attitudes on disease and respond to the barriers around the misperceptions and it is key to strengthen coordination for better preparedness and ensuring effectiveness in mitigation efforts.

- The findings from rapid assessment indicated that several channels were used as means of communication on coronavirus outbreak: different communities preferred different channels and there is still need for further information dissemination for the community; urban communities prefer Television and social media; while the rural communities trust radio and religious leaders, and community leaders.

- Therefore, it is important to identify, initiate and coordinate the existing community networks for better preparedness and response. Community leaders, religious leaders, and community-based workers should play central role to design and implement communication and advocacy strategies.

- Since there is a higher proportion of people over 50 years who haven’t heard of coronavirus; there should be assorted effort to target this group specifically; since global data shows that elderly, adults, and people with prior health issues are at high risk of having severe-critical symptoms of the diseases.

- Since smaller proportion (~15%) of people have received information and have knowledge about what to do if someone is sick with coronavirus; it is crucial to disseminate specific information focusing on “what to do if someone in the family or community is showing coronavirus symptoms” this is a key step to stop growing community transmission of the diseases and to foster positive health care seeking behavior in congested settlements like IDP centers.

- Children and people with disability were not accessing information on coronavirus, thus, it is important to increase availability of child-friendly messaging and explore trusted communication channels for children specifically. This is important even if children are not the most at risk of having severe-critical symptoms, but they are carriers/spreaders of the diseases. In addition, in Somalia context given the high level of malnutrition in children and other childhood diseases, especially pneumonia, children may be more at risk as they have already compromised health situation.

- The finding further indicated that there is stigma against people suspected of coronavirus; thus, it is important to disseminate accurate information to reduce the confusion and avoid misunderstandings.

- Proactive communication will reduce stigma among population at-risk, build trust and increase social support and access to basic needs. The language used in describing the outbreak, its origins, and prevention steps can reduce stigma.

- There should be proactive processes of generating evidence on risks related to perceptions, behavior changes, existing barriers, community specific needs and knowledge gaps as the pandemic outbreak evolves. Using the evidence generated, set a proper plan, a two-way communication to regularly transfer the findings and promote preventive measures recommended based on the findings and health authority recommendations. This will result in improving the coordination between the public, national and international partners working at the front line of prevention of the disease.

- The findings should be used to understand and provide identified communities/groups with accurate information tailored to their circumstances.

- Dialogue must be established with affected populations from the beginning; this needs to happen through diverse channels, at all levels and throughout the response.