

A cough that kills people:

Views on Covid-19 from Somalia's displacement-affected communities

Introduction

Prior to the compounding impact of Covid-19, Somalia represents one of the most complex and longstanding humanitarian crises in the world. A legacy of civil war and the protracted absence of functional government institutions have caused profound humanitarian and development challenges, while ongoing conflict and frequent, extreme climatic events continue to drive displacement and restrict humanitarian access to significant parts of the country.

An average of 928,000 people were displaced within Somalia each year since 2017,¹ 72 per cent due primarily to the impact of floods or drought, 25 per cent due primarily to conflict, and 3 per cent citing other reasons, including the lack of assistance in rural areas. An estimated 80 per cent of those displaced arrive to urban areas, causing the expansion of Somalia's cities and placing additional pressure on resources. IDPs in urban areas are typically transformed into the urban poor, integrated into chronically poor host communities or desolate settlements with limited access to water and sanitation facilities, few livelihoods opportunities and heightened vulnerability to protection concerns including gender-based violence, exploitative labour and forced evictions. A large number of those displaced rely on daily wage labour to meet their basic needs, contributing to a poverty rate of 74 per cent among displaced populations.²

As the Covid-19 pandemic takes hold in Somalia, government agencies, with support from humanitarian and development actors, have made considerable efforts to contain the risk of virus-spread in the country. Border closures, curfews, restrictions on gatherings and quarantine measures have all sought to limit movement while mass messaging by mobile phone, radio, social media and by way of influential community leaders has concentrated on handwashing, hygiene and social distancing. Notably however, while this official messaging reflects World Health Organisation (WHO) guidance and prevailing lessons from countries that have managed to contain an outbreak of Covid-19, it presents significant challenges for large populations with limited access to soap and water, highly congested and inadequate shelter, and reliance on daily wage labour to meet basic needs.

The Global Humanitarian Response Plan for COVID-19 recognises 2.6 million internally displaced people (IDPs) as among the most affected and at-risk populations in Somalia, noting that people have "limited access to quality essential health care and water and sanitation services and live in crowded urban and semi-urban areas."³ A consolidated effort is required from all authorities, humanitarian and development actors to help mitigate the direct and collateral impacts of the virus on these communities, the foundation for which depends on clear, two-way communication and partnerships to help understand how displacement-affected communities see risks and how they want to address them.

Somalia Snapshot

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| Total Population: 12.3 million | Adult literacy rate: 37.8 per cent (2018) |
| Internally Displaced People: 2.6 million | Radio access: 75 per cent listen on weekly basis |
| In need of basic WASH services: 2.7 million | Mobile phone ownership: 90 per cent |
| Displacement sites: 2,000+ | Health workers per 100,000 people: 2 (global average: 25) |

¹ UNHCR and NRC (2019) Protection and Return Monitoring Network: <https://unhcr.github.io/dataviz-somalia-prmn/index.html>

² Desai, R.M. (2 October 2019) Brookings Institute: Somali's Path to Stability: <https://www.brookings.edu/blog/future-development/2019/10/02/somalias-path-to-stability/>

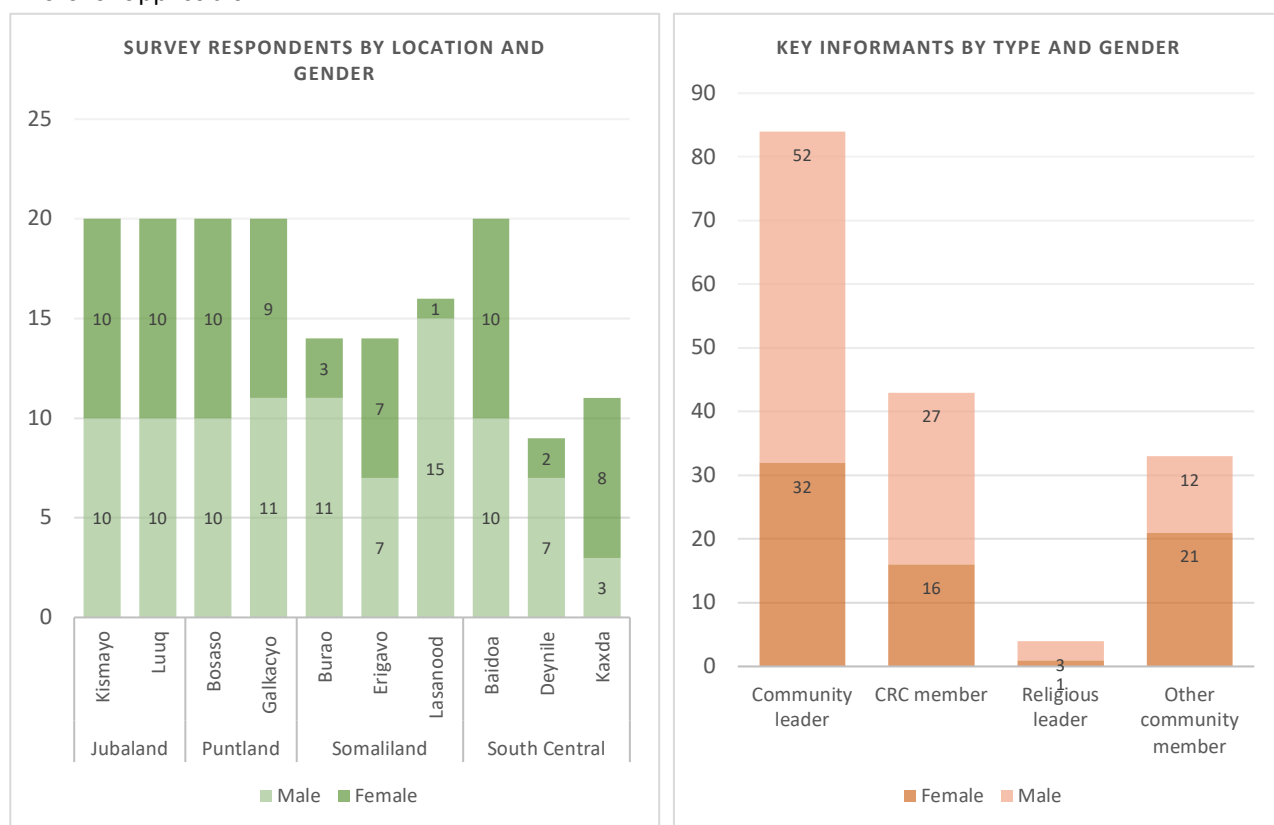
³ OCHA (25 March 2020) Global Humanitarian Response Plan for COVID-19: <https://www.unocha.org/sites/unocha/files/Global-Humanitarian-Response-Plan-COVID-19.pdf>

Rationale and methodology

As the Norwegian Refugee Council (NRC) embarks on efforts to mitigate the direct and indirect impacts of Covid-19 on displacement-affected people in Somalia, and in anticipation of more drastic restrictions on movement, we have sought to engage with communities to understand what they know about Covid-19, where they perceive risks, how they receive information and what they most need.

This survey was conducted with 164 key informants from 82 displacement sites across ten districts in Somalia. Key informants included community leaders (51.2%), community relief committee (CRC) members (26.2%), religious leaders (2.4%) and other community members (20.2%), 42.7 per cent of whom were women. Key informants represented internally displaced people (64%), host communities (26.2%) and people identifying as ‘other’ (9.8%), typically representing community members without a representative role. The key informants were contacted by phone between 1 and 5 April, over which time Somalia reported between five and seven confirmed cases of Covid-19.⁴

The survey was delivered as a questionnaire (annexe 1) in Somali, using a combination of quantitative and qualitative questions. In most cases, participants were asked open-ended questions, and responses were recorded against a pre-set list. As the purpose of the survey was to understand the full perspective and interests of respondents, no limits or parameters were set around responses, and multiple responses recorded wherever applicable.



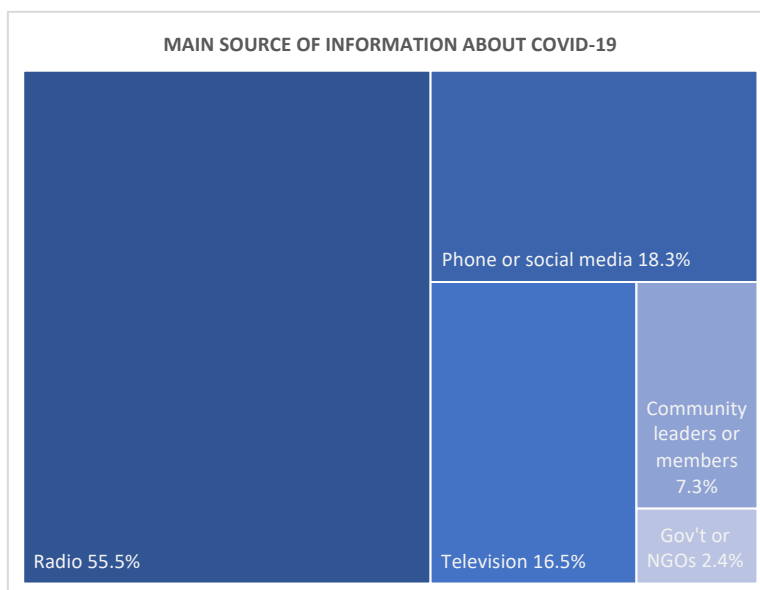
Seven survey questions solicited the views of respondents without a pre-set list for recording responses. Responses were recorded in English by survey enumerators and later grouped for the purpose of identifying key themes. While a small number of these responses indicate a misinterpretation of the question or possible mis-recording of the response (possibly owing to translation), the vast majority of responses are clear and demonstrate consistent themes. Where a response to these questions included multiple themes, all were recorded.

While this is a rapid analysis and has not sought to disaggregate findings according to gender, respondent type or location, it is reflective of key themes found in speaking with male and female representatives from a large number of displacement-affected communities in Somalia about Covid-19. It should be regarded as an overarching snapshot of perspectives from these communities during the very early stages of the outbreak in Somalia and used to inform both early response actions and ongoing dialogue with communities.

⁴ Worldometer, Total Coronavirus Cases in Somalia: <https://www.worldometers.info/coronavirus/country/somalia/>

Key Findings

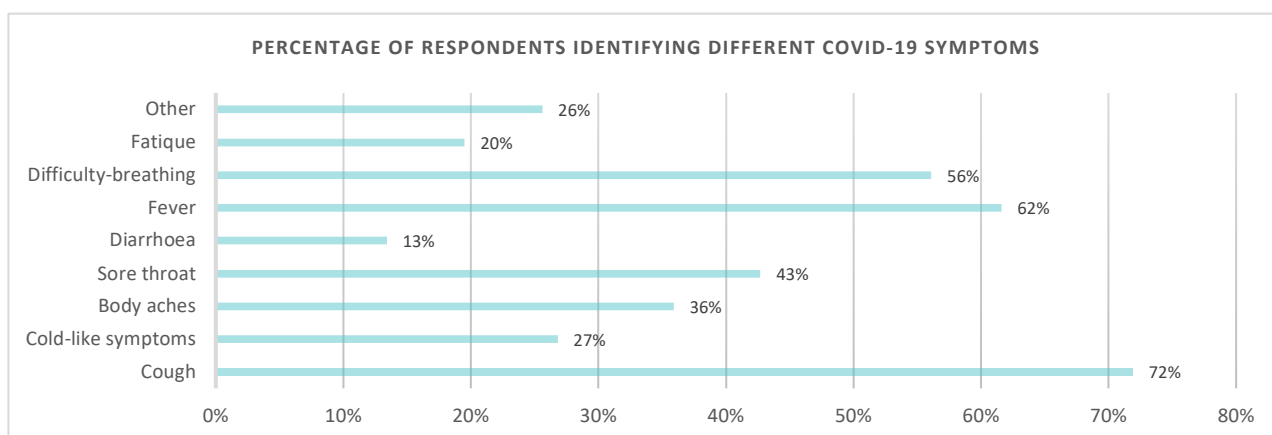
100 per cent of survey respondents stated that they had heard of Covid-19. 80.5 per cent described it as a dangerous and/or contagious virus or disease. Almost a third of all respondents (32.9%) referred to Covid-19 as fatal, 16.7% per cent referred to it being a global problem and a very small number (2.4%) stated that the disease only affects non-Muslims. More than half of all respondents (55.5%) identified radio as their primary source of information about Covid-19, followed by social media or phone (18.3%), or television (16.5%), with just under 10% identifying local authorities, community leaders, neighbours or other community members as their primary source of information about the virus.



Knowledge of Covid-19

When asked what they know about Covid-19, 58.5 per cent of all respondents stated that they had received information on how to prevent the virus, 91.6 per cent of whom identified handwashing as a means by which to prevent it from spreading. Notably however, none referred to the mode of transmission or demonstrated awareness of why these prevention measures are recommended. 26 per cent of those who had received information about symptoms referred to staying at home, avoiding crowds or social distancing, and 12.5 per cent cited the importance of prayer or other religious practices. A large number of respondents responded to this question with a request for more information about prevention, treatment or the availability of medicines.

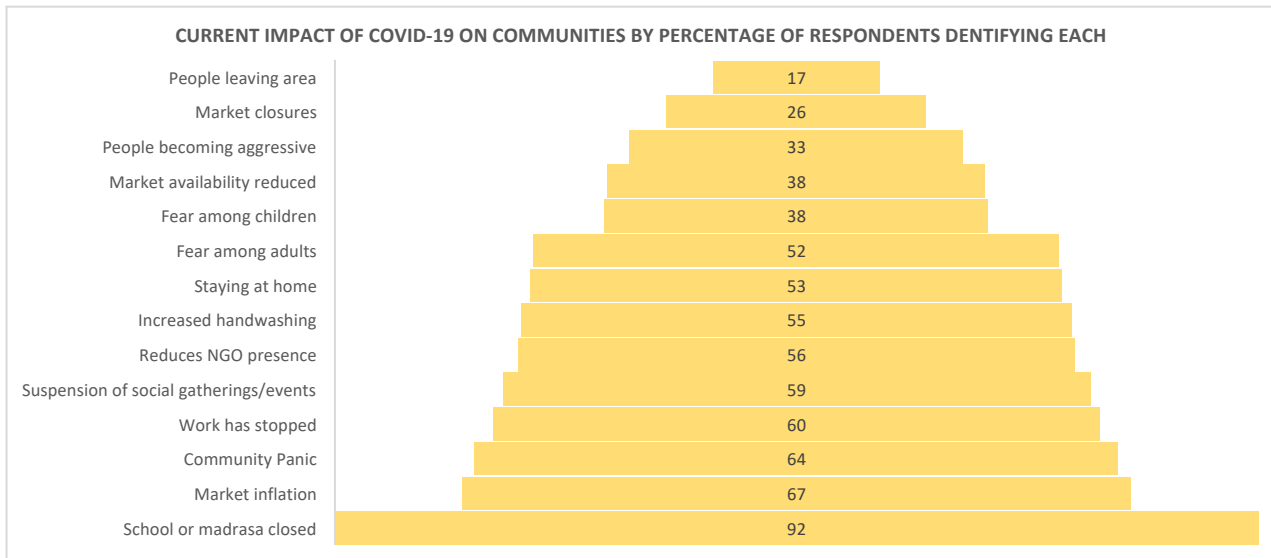
Three quarters of all respondents stated that they knew the symptoms of Covid-19; while the remaining 25 per cent said they did not. The symptoms identified by most respondents were coughing (72%), fever (61.6%) and difficulty breathing (56.1%), followed by a sore throat and body aches (42.7% and 36% respectively), cold-like symptoms (26.8%), fatigue (19.5%), diarrhoea (13.4%) and 'other' symptoms (25.6%), of which sneezing was the most prominently identified. The findings indicate a general sense of awareness about the virus but notable lack of certainty to distinguish it from other health issues affecting the community: very few respondents had confidence in their knowledge about how it is transmitted, how the virus presents or which symptoms are likely to be most prominent. Respondents spoke in general terms about prevention but only a small minority demonstrated a clear understanding of it beyond generalised concept of potentially fatal illness.



When asked to identify community members most at risk of becoming sick with Covid-19, 75.6 per cent of respondents identified the elderly, and 64 per cent specified people with pre-existing medical conditions. While these responses are largely consistent with data and messaging about those most at risk of severe illness from Covid-19, just under 60 per cent of respondents also identified babies and small children, or pregnant or breastfeeding mothers as among the most at-risk groups.

Current impact and primary concerns

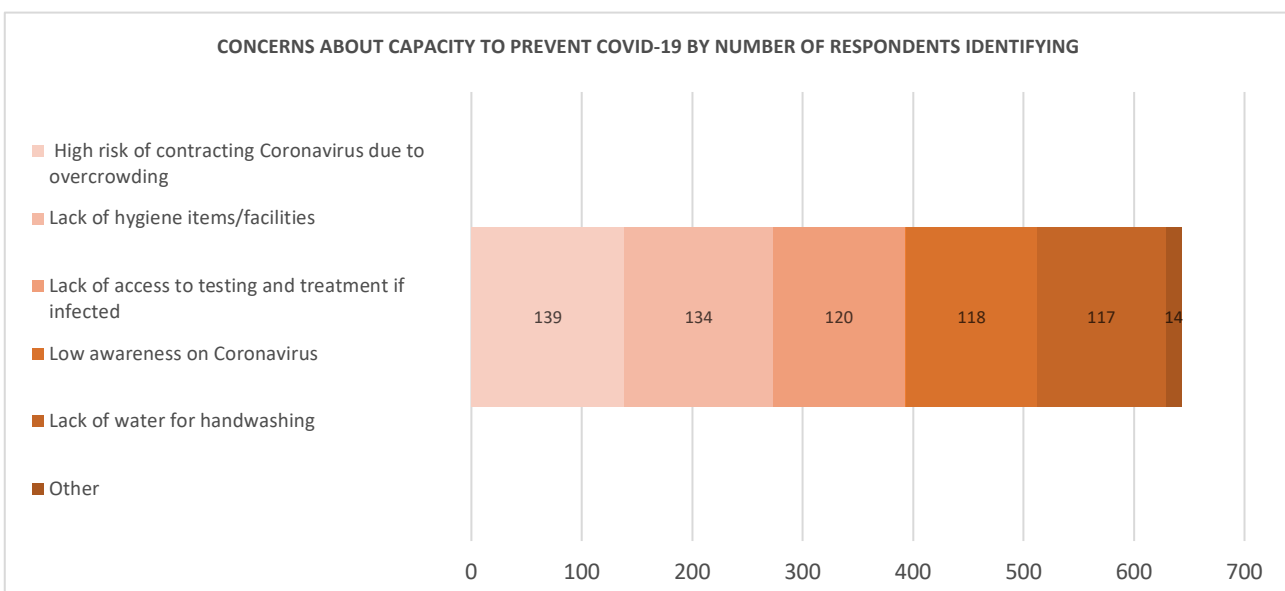
Respondents identified multiple ways in which news of or control measures for Covid-19 were affecting the daily life of their family or community, the most notable of which was the closure of schools and madrasas (identified by 92 % of respondents), market inflation (67%), community panic (64%) and work stoppages (60%). Notably, 56 per cent of respondents cited a reduced presence of NGOs and more than one third (38%) referred to reduced availability of market commodities.



When prompted, respondents identified multiple public health and hygiene considerations as being a “main concern” within their communities, and subsequently elaborated serious concerns about access to food and livelihoods when asked a more open-ended question on the same.

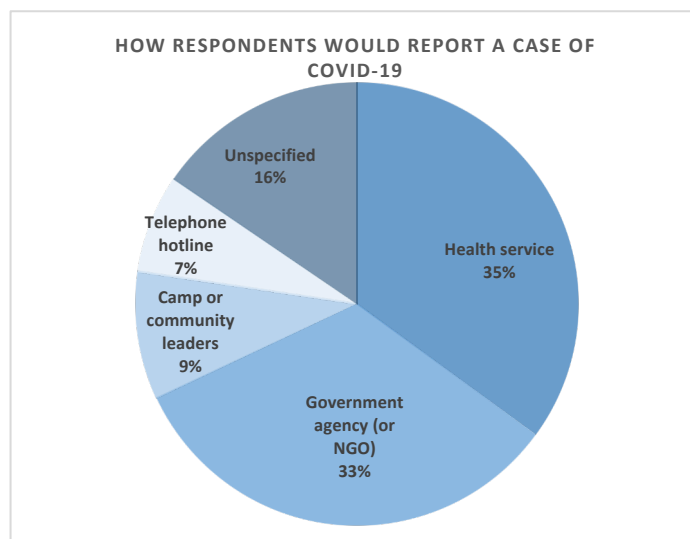
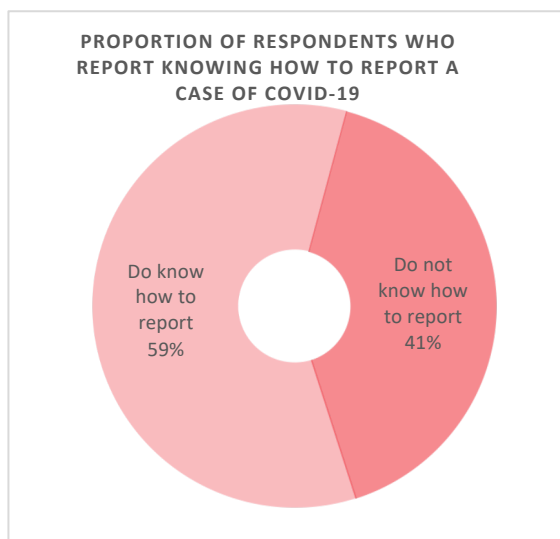
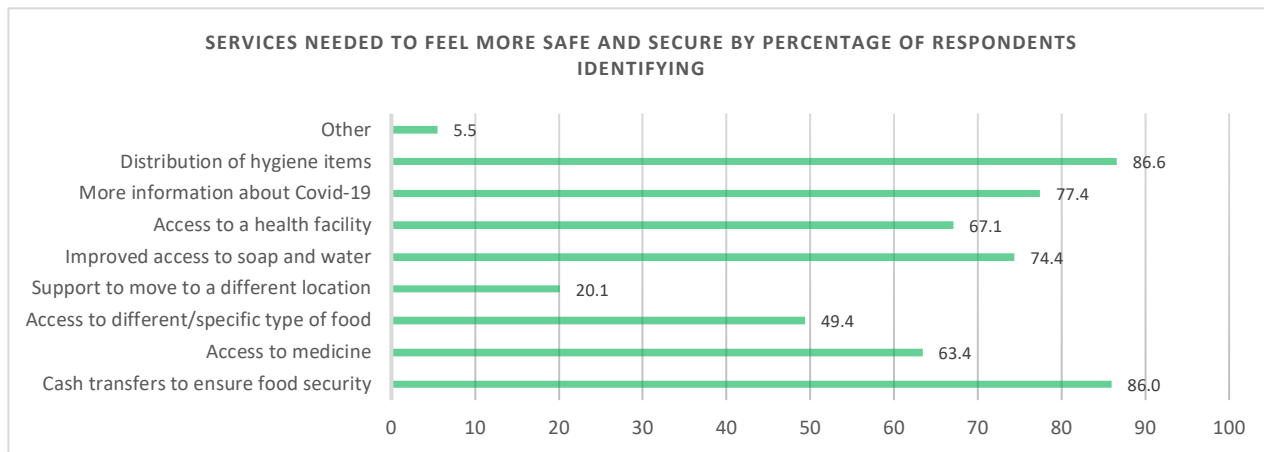
On issues relating to the capacity of communities to prevent the spread of Covid-19, congestion and overcrowding was identified most, by 84.8 per cent of respondents. A lack of hygiene items and facilities was the next most prevalent concern, identified by 81.7 per cent of respondents, followed by a lack of access to testing and treatment services (73.1%), low levels of awareness about the virus (72%) and a lack of water for handwashing (71.3%).

In elaborating further, close to a third of respondents (32.9%) identified issues relating to anticipated economic hardship, difficulties sustaining casual labour, inflation and inability to access basic needs as a principal concern. 10.4 per cent reiterated worries about a lack of access to testing facilities or related health services and 9.8 per cent articulated fears about a lack of awareness within their community, including a concern that the community did not understand the seriousness of the threat posed by the virus. One respondent identified the potential for stigma within the community.



Priority needs, plans and access to services

At 86.6 percent and 86 per cent respectively, cash transfers for the purpose of meeting basic needs, together with hygiene items, were the items/services most identified by respondents as those needed for communities to feel secure and supported in the current situation. More than three quarters of respondents (77.4%) likewise cited a need for more information about Covid-19, or access to soap and water (74.4%). 67 per cent of respondents expressed that they would feel more secure with improved access to a health facility and/or medicine.



On the latter, while 76.8 per cent of respondents reported an intention to seek assistance from a health facility if a member of their family became unwell, almost 60 per cent reported not having any access to a health centre, the most oft-cited barriers to which were distance (86.2%), medical fees (75.5%) a lack of medicine or trained personnel (51.1% and 47.9% respectively), or discrimination (21.3%). Among 9.6 per cent citing other factors, a handful of respondents stated that restrictions to movement created by armed actors prevented them from reaching facilities.

59.1 per cent of respondents said they knew where to report in the case of a suspected case of the virus, of which 35 per cent identified a healthcare provider or hospital, 32 per cent a government body or agency, 9.3 per cent identified the camp leadership, 7 per cent would use the Hormuud hotline⁵. 40.9 per cent of all respondents said they did not know how or to whom they should report.

Finally, while 72.6 per cent of respondents specified that Covid-19 would either not bear any weight on their decision to relocate, or would not cause them to leave their current location, 16 per cent of this group specified that this was due to a lack of options or alternative places to go. 15.2 per cent of respondents stated that they would consider leaving their current location because of the virus, and 10.3 per cent said they hadn't yet thought about it or discussed the matter with their family, presenting potential risk of returns to areas where ongoing violence may act as a buffer to the movement of the virus but expose people to other forms of risk.

⁵ Hormuud Telecom Somalia Inc. is a privately held telecommunications company through which 3-digit hotline has been established for reporting suspected cases of Covid-19

Summary remarks

While the key findings from this survey illustrate high levels of general awareness within surveyed communities about some of the direct and collateral *threats* posed by Covid-19, they also indicate critical knowledge gaps about the specifics of the virus, most notably how it is transmitted, why the cited prevention measures might help contain the virus, key symptoms, the groups most at risk of becoming severely unwell, ways to report suspected cases and available treatments (or lack thereof). An overwhelming majority of respondents indicated access to and reliance upon radio, mobile phone, social media and/or television for information about the virus, presenting opportunities for more contextualised mass media and two-way communication, with communities. The value in this messaging notwithstanding, many respondents demonstrated an awareness of the incongruity between prevention and control measures and local realities, where congestion, a lack of water and hygiene facilities and widespread dependence on daily wage labour significantly limit the capacity of communities to heed prevailing guidance. Such considerations must be taken into account in all humanitarian and development response planning in Somalia, where social isolation and handwashing messages alone are insufficient to meaningfully addressing community needs and concerns. A common thread through most responses was one of concern not about the impact of the virus itself, but how measures to control its spread might have an equal or more detrimental effect on livelihoods and survival.

As among the most vulnerable to the direct and indirect impacts of Covid-19, displacement-affected communities must be actively engaged in discussions about how related risks can be weighed and managed, the “cough that kills people” - as it was described by one respondent - is not the only threat to life.

Recommendations to humanitarian and development actors

- **Continue to push strong, coordinated, consistent, contextualised mass media messaging** about Covid-19 on radio, television, social media and by phone, including avenues through which communities can actively engage with and clarify information (call-back radio, hotlines, free text messaging service etc);
- **Utilise the pre-/early-outbreak period to work collaboratively with key community members or groups (religious leaders, representative forums, youth committees) to identify workable systems and strategies to reduce crowding** in key areas, share available resources and protect the most vulnerable people in a given site or community. Establish and implement sustainable communications mechanisms with communities now so that these can be sustained and information exchange continue in the event of increased movement restrictions;
- **Upscale shelter interventions and explore the workability of shielding practices or establishment of ‘green zones’⁶** to protect the most vulnerable people in a given site or community, ensuring communities have clear, comprehensive information about purpose and participate in all decision-making to determine the cultural suitability of these measures;
- **Take early action to ensure that WASH interventions can continue safely under all circumstances**, including in the event of strict lockdown measures. Governmental actors and other authorities should commit to modalities that will enable the ongoing provision of water (shallow wells, boreholes, water trucking), local production of soap and ongoing distribution of hygiene items, even where other restrictions are in place;
- **Dramatically expand cash and voucher assistance** to cushion highly-vulnerable people from the impact of economic slowdown, the loss of daily wage labour, challenges created by possible lockdown directives and a major reduction in remittances (which currently support an estimated 40 per cent of the Somali population).⁷ In the case that movement restrictions prevent NGOs from adhering to usual registration and verification processes, actors must institute the best possible alternative and take a “no regrets” approach to distributing assistance, ensuring peoples’ continued access to sufficient, nutritious food and other essential items.
- **Donors must show flexibility (in modality use) and all actors should engage in efforts to sustain supply chains (into and around Somalia), to manage inflation and to mitigate the risk of speculation.** Where necessary, humanitarian actors should work with commercial vendors to explore the possibility of mobile markets and ensure that assistance is as predictable as possible for those who need it.

⁶ See Favas, C (31 March 2020) *Guidance for the prevention of COVID-19 infections among high-risk individuals in camps and camp-like settings*, London School of Hygiene and Tropical Medicine.

⁷ Majid, N. and Hammond, L. (7 April 2020) *How will Remittances Affect the Somali Covid-19 Response?*, [Research and Evidence Facility, EU Emergency Trust Fund for Africa](#)