



## END LINE REVIEW FOR HBCC PROJECT: INCLUSIVE COMMUNITIES: CHANGING BEHAVIOURS TO RESPOND TO COVID-19



FINAL REPORT

HORN AFRICA CONSULTANTS FIRM

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## ACRONYMS

CHW	Community Hygiene Workers
COVID-19	Coronavirus Disease 2019
FGD	Focus group discussions
HBCC	Hygiene & Behavior Change Coalition
HF	Health Facility
IDP	Internally Displaced Person
KII	Key Informant Interviews
PHEIC	Public health emergency of International concern
WaSH	Water Sanitation and Hygiene
WHO	World Health Organization

## ACKNOWLEDGEMENT

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Thanks to you all

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## EXECUTIVE SUMMARY

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**Background:** The end line survey was commissioned by CARE International in Somalia to assess the overall change outcomes of the COVID-19 Hygiene Behaviour Change Campaign as per the project's theory of change and to identify key lessons learned for the campaign that could inform future strategies. The project was implemented through an extensive mass media, digital and interpersonal hygiene promotion information and messaging campaign in communities and institutions supported by the provision of water supply and handwashing kits and infrastructure as well as provision of relevant Personal Protective Equipment-PPE, as per context.

**Methodology:** A participatory mixed method approach was employed involving triangulation of both qualitative and quantitative approaches targeting beneficiaries of the HBCC project within its catchment areas; as well as other stakeholders in COVID-19 health service delivery. Quantitative data was obtained from household survey and assessments while qualitative data was collected through key informant interviews (KIIs) Focused Group Discussions (FGDs) and observations. WASH'Em was the main approach used in the qualitative assessment through Handwashing demonstrations using video records; Observations, and FGDs. A total of 1,258 households were surveyed across four regions (Somaliland, Puntland, Galmudug and Jubaland); including 14 FGDs and 27 KIIs. Assessment findings were supplemented with literature review to enhance their validity and reliability. Data collection was done using hand held devices (Android-enabled mobile phones) eliminating delays in data entry and also reducing data entry errors

**Findings:** Assessment findings give an average household size of 8 with female-headed households accounting for 77.5% compared to 22.5% male-headed households across the four regions. Key assessment findings are highlighted below:

- i. A vast majority of the respondents (99.3%) reported having heard of the new coronavirus disease with radio and community members being cited as the leading sources of this information at 71% and 69% respectively.
- ii. Various promotional messages on COVID-19 prevention and mitigation from CARE were received by 94.4% of respondents including COVID-19 transmission (92%), signs and symptoms (83%), prevention (79%), stigma (41%), where to seek early support in case of symptoms (36%) and isolation/quarantine (31%).
- iii. Observed levels of improved hygiene practices (correct hand washing with soap and water-74.6%, knowledge of critical handwashing times-73%, observance of social distancing-65%) clearly point to the project's efforts to improve on community's attitudes and practices around the transmission of coronavirus, while heightening the much-needed awareness around prevention and control.
- iv. Slightly more than half of the respondents (51%) cited specific elements of the messaging as difficult to practice due to several factors including lack of physical handwashing facilities (58%), low access to soap (50%) and limited affordability of facemasks.
- v. Assessment findings show Galmudug with the highest percentage (83.3%) of mothers/caregivers observed to wash hands with water and soap for 20 seconds before eating, before preparing food, before feeding young children, after using the toilet, after

cleaning child faeces followed by Jubaland (71.8%) while Somaliland and Puntland reported the least at 70.2% and 69% respectively.

- vi. Of concern is the low number of respondents (34%) reporting availability of handwashing facilities near the toilet and kitchen and where such are available, there is reported lack of soap/ash or their location is inconvenient and not easily accessible by either family members or others.
- vii. Contrary to observed elements of stigmatization at baseline, the end line survey findings point to improved levels of community treatment for individuals and households contracting COVID-19 disease with 82% of respondents showing acceptance and support. Notable observation is the perception that COVID-19 does not affect Muslims which served to fuel existing stigma on wearing of facemasks.
- viii. As such, urgent interventions are required to fully address underlying stigma and discrimination as 33% of respondents reported rejection and isolation, 29% of children from these households were refrained from learning institutions while 22% indicated stoppage of business engagements with victims and family members from affected households

**Figure 1: Summary of Findings Based on Theory of Change**

Objective Statements	Indicators	End Line value
<b>Goal: Contribute in reducing incidences of COVID -19 transmissions in Somalia</b>	R-0' value maintained below 1.0 between Jan and March 2021 in all HBCC targeted regions in Somalia	
<b>Outcome 1: Handwashing with water and soap practiced at key times for at least 20 seconds to interrupt the spread of covid19 transmission</b>	% of targeted population who demonstrate correct handwashing practice with water and soap for at least 20 seconds	74.6
	% of mothers/caregivers observed to wash hands with water and soap for 20 seconds before eating, before preparing food, before feeding young children, after using the toilet, after cleaning child faeces.	73
	% of targeted people who report being satisfied with the quality and quantity of hygiene kits distributed	Quality: 99 Quantity: 97
<b>Outcome 2: increased knowledge and information of the targeted people on COVID-19 prevention and mitigation</b>	% of targeted populations recalling three messages from the radio spots (billboards, posters etc.	60
	% of target populations recalling at least 3 key times for handwashing with soap and water	73
<b>Outcome 3: Social distancing and avoidance of public gatherings are practiced widely in all the targeted areas</b>	% of target populations who maintain social distancing while interacting with the community	65
	% of target population who avoid public gatherings in the last one month	15.3
	% of target population who are willing to get the COVID-19 vaccination	70

Objective Statements	Indicators	End Line value
<b>Outcome 4: more people accept the severity of COVID-19 and that it can affect everyone in the community</b>	% of target population who are confident to report if they are tested with COVID-19	93

**Recommendations:**

- i. In view of the reported higher numbers of female headed households (77.5%), future projects should seek to incorporate specific HBCC activities which would seek to encourage increased participation by women and girls.
- ii. Urgently address various forms of stigma and discrimination observed through biased treatment of families contracting coronavirus disease. Proven approaches include building trust in reliable health services and advice and messaging that show empathy to those affected.
- iii. Scale up of family-based handwashing practices through combined provision of hygiene kits and risk communication which serves as the starting point for communities to embrace COVID-19 preventive measures.
- iv. There is continued need to survey community’s attitude and practices on COVID-19 with a view to analyzing its ability to adapt to the rapidly evolving pandemic landscape and the people’s ability prevent and respond to the threat of this virus.
- v. Deliberate and sustained diversification of modalities for HBCC messaging around COVID-19 in view of the observed differences in information consumption habits to ensure communication approaches are centered around favoured information channels within different regions.
- vi. Initiate community dialogue using existing communication channels to generate more evidence on perceptions, behavior changes, existing barriers, other community specific needs and vaccine knowledge gaps as the pandemic outbreak evolves.
- vii. Tailor made HBCC innovative interventions such as community outreaches and mobile platforms to promote equity in HBCC messaging access by specific vulnerable groups such as the elderly, PLWD, pregnant and lactating mothers as well as children below 5 years of age.
- viii. An exit strategy is paramount to ensuring that the gains made by the project are not lost but harnessed for sustainability through established community structures for longer term benefit of the community post-pandemic.

## CHAPTER ONE: INTRODUCTION

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### 1.1. Contextual analysis of the COVID-19 situation in Somalia

Somalia confirmed its first case of the novel coronavirus (COVID-19) in Mogadishu on 16 March 2020. As of 13 of August 2021, there are 15,490 confirmed cases in Somalia with 812 confirmed death cases. While the official COVID-19 burden has remained relatively low in Somalia, the impact to people's daily lives, income and livelihoods due to public health responses, has been significant. Somalia received 300,000 doses of the Oxford-AstraZeneca vaccine in March 2021 and has reportedly inoculated close to 120,000 people with the first jab of a two-shot rollout. However, the vaccines delivered so far cover under 0.5 percent of the population. That means the wearing of masks and social distancing remain vital, but such measures are only being very loosely adhered to. In the first COVID-19 wave, from April to June last year, healthcare and funeral workers reported anecdotal evidence of an unprecedented spike in fatalities, especially in the capital, Mogadishu. The second wave, beginning in February this year, has been even more severe. According to the official data, more people have died in the past three months than during the entire March to December period in 2020. As with all humanitarian crises in Somalia, the COVID-19 response has largely fallen to the international aid community.

### 1.2 Background to the HBCC project

With funding from Unilever-DFID HBCC (Hygiene Behaviour Change Coalition) to drive hygiene behaviour change communication to the vulnerable communities living in rural, urban and IDP centers, across five countries: Zimbabwe, Rwanda, Somalia, Jordan and North Eastern Syria. The project was aimed at minimizing the transmission of and harmful impact of COVID-19 by delivering inclusive and interactive gender responsive mass media and digital communications, supported by product availability and community interventions that improve personal and environmental hygiene practices, and reduce stigma and discrimination

In Somalia, the HBCC project was implemented in Somaliland, Puntland, Galmudug and Jubaland. This was undertaken through an extensive mass media, digital and interpersonal hygiene promotion information and messaging campaign in communities and institutions supported by the provision of water supply and handwashing kits and infrastructure as well as provision of relevant Personal Protective Equipment-PPE, as per context. The project aimed at rapidly disseminating messaging in support of the government's actions for a wider reach of information coverage and to curb the COVID-19 pandemic. Additionally, the project worked with relevant government institutions and community-based organizations to engage vulnerable communities and institutions to promote effective hygiene with focus on COVID-19 preventive measures. Using a variety of delivery channels, the project focused on mass media, digital media and community level interpersonal campaigns (where possible due to lockdowns and travel restrictions) across all project areas. The messages were executed in line with the MoH and WHO Health Service approved guidelines as well as some of the Unilever Global assets like the PASSWORD Campaigns, Mums Magic Hands, School of 5 among others. Key issues covered included COVID-19 transmission, signs and symptoms, prevention, stigma, protection, safety, security and where to seek early support when showing signs and symptoms of COVID-19. Based on the baseline findings, these messages were tailored for specific audiences

### **1.3 Overall Purpose and Objectives of the End Line Survey**

#### **1.3.1 Purpose of Survey**

Primarily, the End Line survey sought to assess the overall change outcomes of the COVID-19 Hygiene Behaviour Change Campaign as per the projects Theory of Change and identify key lessons learned for the campaign that could inform future similar strategies.

#### **1.3.2 Objectives of the assessment**

Specifically, the end line assessment sought to:

- i. Measure the behavioral outcomes, and determine how the project has contributed to these changes; with a special focus on how the project has generated positive changes in the lives of targeted women, girls, boys, and men; including vulnerable groups such as those living in remote locations as well as the elderly and people with disabilities
- ii. Identify unintended consequences of the project, both positive and negative; for target groups and others impacted;
- iii. Document the enabling factors and challenges or barriers that influenced project implementation; and
- iv. Provide evidence-based recommendations for all stakeholders for future programming in light of the review findings, including specific recommendations in relation to gender equality/women's empowerment issues.

## CHAPTER TWO: METHODOLOGY

### 2.1 Assessment approach and study design

The End Line survey adopted a mix of participatory research approaches involving qualitative and quantitative methods of data collection. The approaches were descriptive, analytical, and consultative involving the triangulation of both qualitative and quantitative data to enhance validity and reliability of the research findings. Both primary and secondary data gathering methods were employed as described in various parts of this section.

The data collection team was supported by the lead consultant from HACOF Consultants with extensive experience developing research methodologies and conducting evaluations in conflict and volatile contexts including South Central Somalia, Somaliland and Puntland. An intensive training session was conducted for the enumerators in order to build a shared understanding on the objectives of the needs assessment and orientate them on the survey tools which they would be administering. Summarized data collection tools are presented in table 1 below:

**Table 1: Summary of data collection tools**

Tool	Description	Number
<b>Qualitative data</b>		
Literature Review	<ul style="list-style-type: none"> <li>➤ Somalia COVID-19 response plans</li> <li>➤ HBCC project quarterly reports</li> <li>➤ Routine programme data and reports</li> <li>➤ Project milestones &amp; baseline report</li> </ul>	
Key Informant Interviews (KIIs)	➤ MoH representatives	27
	➤ Local authority representatives	
	➤ Local media representatives	
	➤ International media representative: BBC Media Action	
	➤ CARE Staff	
	➤ Head teachers	
Focus Group Discussions (FGD) Guide	➤ Men	14
	➤ Women	
	➤ Youth groups	
Observation checklist	➤ Hand washing	8
<b>Quantitative data</b>		
Household questionnaire	➤ Somaliland, Puntland, Jubaland, Galmudug	1,258

### 2.2 Data Collection, analysis and management process

#### 2.2.1 Quantitative data

Quantitative data was collected using handheld devices (Android-enabled mobile phones) from eligible households where the survey questionnaire was programmed and administered electronically using KOBO collect. At the end of each day, the evaluation team debriefed on key issues related to the tools/instruments, review completed interviews and upload the day's surveys onto a remote server. The database was designed with data entry screens with skip patterns and data/value ranges programmed into it. This ensured that the data is consistent at the point of interview.

All data from the four program locations was merged into one Microsoft Access database. The merged data was then investigated using Structured Query Language (SQL) for validity and accuracy before being exported for statistical data analysis. A code book (reference manual of all variables) was generated. Proportionate to size sampling for household selection yielded the following samples for the four locations:

**Table 2: Household sample size distribution**

Location	Female respondents	Male respondents	Total (%)
Galmudug	199	61	260 (20.7)
Jubaland	257	44	301 (23.9)
Puntland	262	65	327 (26.0)
Somaliland	257	113	370 (29.4)
<b>Total</b>	<b>975</b>	<b>283</b>	<b>1,258</b>

### 2.2.2 Data Processing, Analysis and Interpretation

Data entry and analysis for the quantitative data was conducted using the statistical package for social sciences (SPSS) software version 26. Data was first cleaned by removing any cases that are outside the inclusion criteria and identifying responses that were improbable (outside the normally expected range) or impossible. This involved simple univariate frequencies of questions chosen to reflect desired analyses as per survey objectives.

Descriptive statistics was used to determine frequencies and percentages for different variables of interest. Results were then presented using graphs, tables and pie charts.

### 2.2.3 Management of Qualitative Data

Depending on the target respondent, qualitative interviews were conducted in both English and local Somali language, translated, transcribed and typed into Microsoft word. This is in addition to the WASH'Em tools/guides for demonstrable knowledge and practices on COVID-19 prevention and mitigation. Debriefing sessions were held between the consultants and the research team after each interview to provide an overview of issues raised. Informal preliminary analysis was conducted by way of summaries of the collected data made after each session for clarification or follow up.

Analysis for the qualitative data entailed open coding and progressive categorization of emerging issues into themes based on inductive (where analytical categories were derived gradually from the data) and deductive approaches (where ideas from the interview schedule shaped the coding scheme). Final analysis was organized around a description of the main issues identified relating to the HBCC project delivery.

### 2.2.4 Data Quality Assurance

The use of handheld devices for data collection eliminated the need for manual data entry; thereby reducing data entry errors. At field level the consultants facilitated daily data reviews with the M&E team for the filled questionnaires to ensure completeness, consistency and validity, upon which the research assistants concerned were involved in ensuring identified discrepancies are corrected. Additionally, close supervision was maintained at all times between consultants, supervisors and field teams. Considerable care was taken in trying to achieve the desired response rate and obtain complete and good quality data. At entry level, completed questionnaires were first examined for

possible inconsistencies before submission; which ensured 100% verification. Validity and rigor will be enhanced during the interpretative analysis through a series of feedback sessions with members of the evaluation team.

### 2.3 Ethical considerations

The implementation of the assessment was done in strict compliance with human subjects' ethical requirements thus:

- i. **Informed consent:** For all participants, the survey team implemented a policy of informed consent. This was either verbal or written for the KIIs, FGDs and household interviews
- ii. **Voluntary participation:** Respondents were informed of their rights to refuse participation or withdraw from the assessment at any point and that this will not affect the services provided by CARE in any way.
- iii. **Privacy and confidentiality:** The information provided as part of these interviews and discussions was not linked to any specific respondent in the final report and all information provided was kept confidential and used solely for limited purposes of the survey.
- iv. Only general identifying information (geographical unit, gender, and age if reported voluntarily) was utilized. Any information that could be directly linked to an individual was not used.
- v. Only members of the core survey team had access to the transcripts and raw data. Prior to the start of the survey, the research team led by the lead consultant committed to abide to the principle of confidentiality.
- vi. **In-country authorization:** Permission to carry out the research was obtained from the Ministry of Health and relevant regional authorities through CARE Somalia

### 2.4 Survey limitations due to COVID-19 pandemic

To minimize infection risks associated with the prevailing COVID-19 pandemic, all preventive measures, procedures and guidelines set by the Ministry of Health to curb disease spread (wearing of face masks for all study participants and research assistants; observing social distancing of 1.5 meters apart during interviews, handwashing and referrals of participants and research assistants who present symptoms of Covid-19 for testing) were exercised during data collection. The research teams were equipped with information on how and where to call in case of exposure or symptoms of COVID-19 or notice participants with symptoms requiring professional support for appropriate referral. The training included focused sessions and practical exercises on COVID-19 prevention. In addition, all enumerators were competent locals who could administer the tools in a language that is clear and comprehensible to the respondents

## CHAPTER THREE: FINDINGS

### 3.1 Socio-demographic characteristics of respondents

The assessment surveyed a total of 1,258 households across the four regions representing 94% response rate. Of these, majority 77.5% were female headed compared to 22.5% male headed households (HHs) with Puntland and Galmudug representing the highest and least proportion of female headed households at 20.8% and 15.8% respectively. Notably, 83.3% of respondents possess no formal education with the highest illiteracy levels reported in Puntland (23.4%). The average household size was 8 with a minimum of 1 and a maximum of 15 as illustrated in the summary table below:

**Table 3: Household Characteristics**

Region	Sex of the household head		HHs with no formal education	
	Female (%)	Male (%)	Female (%)	Male (%)
Galmudug	199 (15.8)	61 (4.8)	174 (13.8)	47 (3.7)
Jubaland	257 (20.4)	44 (3.5)	241 (19.2)	39 (3.1)
Puntland	262 (20.8)	65 (5.2)	237 (18.8)	57 (4.5)
Somaliland	257 (20.4)	113 (9.0)	189 (15.0)	64 (5.1)
Sub-total	975 (77.5)	283 (22.5)	841 (66.9)	207 (16.5)

### 3.2 Behavioural outcomes related to project activities

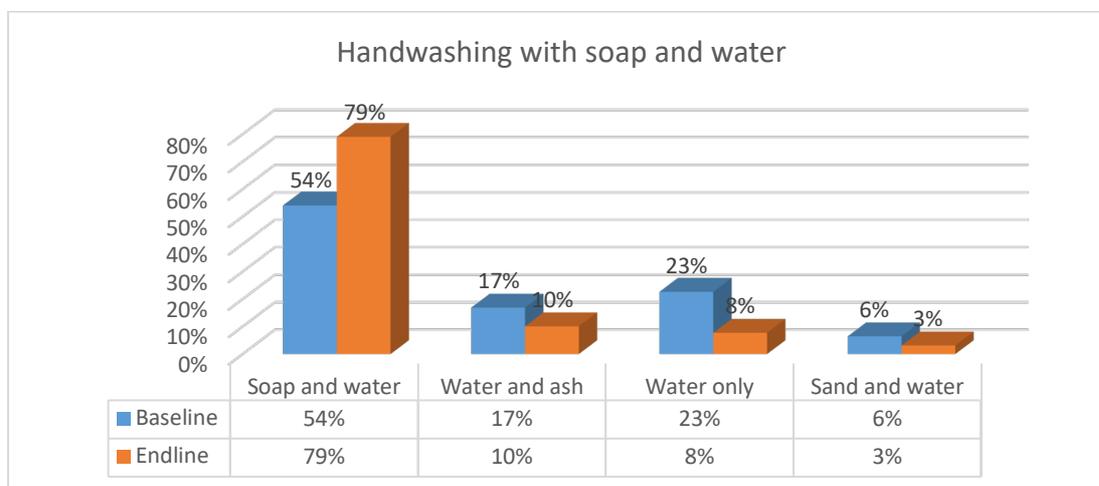
While survey findings under behavioral outcomes may give early community level indications of possible behaviour change, full impact-level assessment of behavioral changes may not be possible due to challenges in attribution.

#### 3.2.1 Hand washing behavior

**Handwashing with soap and water:** Because of its prominence in transmitting disease-causing pathogens including COVID-19 virus, proper hand washing with soap and water and/or ash has been recognized by the community as an important measure in decreasing the spread of infection within community settings. According to survey findings, 74.6% of respondents demonstrated correct handwashing practice with soap and water for at least 20 seconds compared to 54% reported at baseline representing 20.4% increase. This highlights the role played by the project's hygiene promotion activities in changing collective and individual handwashing practices for better hygiene towards reduced diseases transmission. For handwashing at household level, majority of respondents reported using soap and water (79%) or ash and water (10%) compared to 8% who use water only. The disseminated hygiene messages could be cited for the improved hand washing practices compared to baseline. According to a CHW from Somaliland;

*"..... we have seen a lot of people embrace frequent handwashing since the facilities are now readily available even in market places. All groups including small children and men, who were not taking hand washing seriously. We thank the people from CARE who have been supporting all these activities. When the facilities are available near us, using them is not a problem compared to before when we never had even water".*

There was general consensus that improved the observed hand hygiene practices were central in preventing rampant communicable diseases. This is illustrated in the figure below:



**Figure 2: Handwashing with soap and water**

With regard to messaging on hand hygiene, it is noted that 51.6% of respondents reported that some message components were difficult to understand which could hinder intended application of such messages in the fight against the pandemic. Such included components on physical handwashing facilities (58%), access to soap (50%), affordability of face masks (46%) and hand sanitizers (40%)

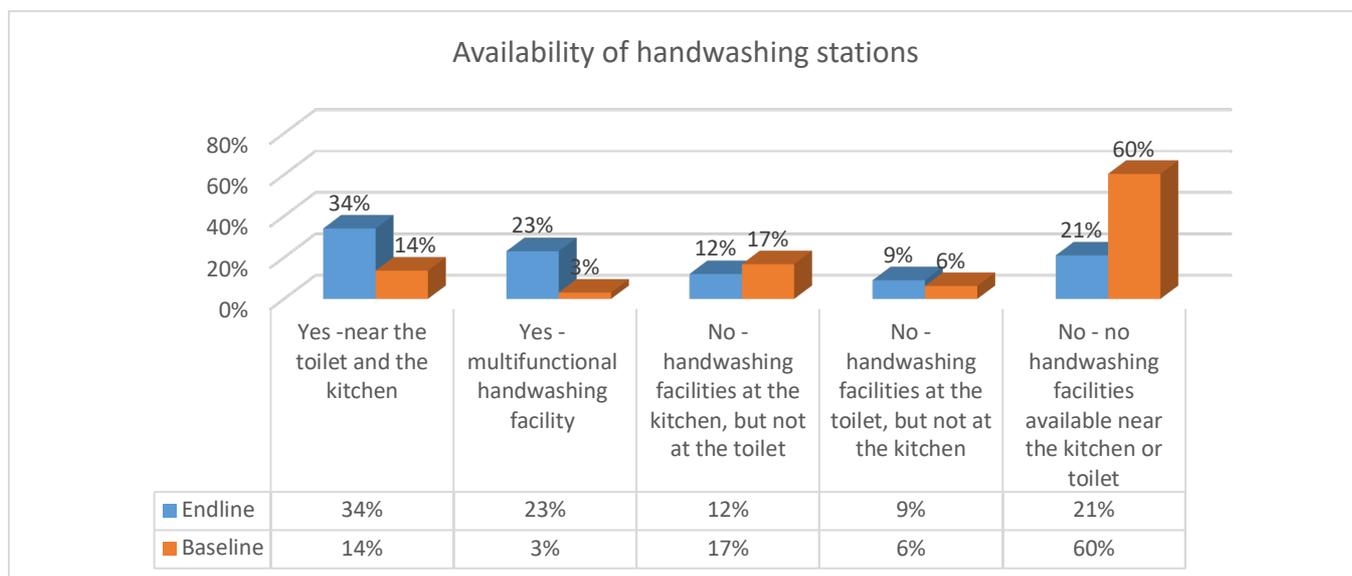
**Handwashing practices at critical times:** Survey findings indicate that 73% of mothers/caregivers were observed to wash hands with water and soap for 20 seconds at the recommended critical times i.e. before eating, before preparing food, before feeding young children, after using the toilet, after cleaning child faeces. The reported baseline proportion was 52% representing a 21% improvement. Hygiene messages disseminated through the project were cited as key contributors to the observed practices as explained by a key informant from Puntland:

*“.....the messages have reached far and wide, including to our learning centres that are not easily reachable. Including COVID-19 sessions in school timetable so that every students learns COVID-19 as part of normal lessons and make them understand basic elements such as prevention, transmission and symptoms. Even posters are available in Somali language and we can read”.*

Figure 3 below illustrates the reported availability and location of handwashing facilities among surveyed households:

**Figure 3: Availability of handwashing facilities at HH level**

This contribution from the project is expected to, in the long run, improve the unsanitary conditions and poor environmental indicators resulting from overcrowding and displacement



Overall, 34% of surveyed households surveyed from the quantitative data have a specific place for handwashing facilities near the toilet and the kitchen while 23% have a multifunctional handwashing facility (a basin or tap that is used for handwashing and is used for other things like laundry; with 69% of these facilities being located conveniently for others to see thereby increasing chances of utilization by both family members and visitors. The survey established that these households formed part of the targeted recipients for both hygiene related supplies as well as COVID-19/hygiene promotion awareness messages from CARE. This is in stark contradiction to the baseline situation where few households reported availability of conveniently located hand washing facilities. Availability of soap or ash either near the toilet/kitchen or anywhere within the household was reported by 87% of surveyed households and this could be cited as a major facilitator for the observed good hand washing practices in the community.

Commonest type of soap within the households included liquid/foaming soap (39%), bar soap designed for handwashing/bathing (37%). A further, 61.8% of surveyed households reported availability of water at the handwashing facilities compared to 38.2% who had to go elsewhere to get water before handwashing (for example, into the home to access stored water). Ensuring accessibility of water at hand washing facilities within homesteads is key in promoting handwashing behaviours towards reduced diseases transmission; and this was a key activity carried out by HBCC project

**Hygiene kits distribution and use:** The project distributed hygiene kits to visited households such as handwashing/laundry soaps, hand sanitizers, facemasks, water containers, aqua tabs as indicated by 94% of target population who confirmed receiving these supplies from CARE. Notably, 99% were satisfied with the quality while 97% were satisfied with the quantity of kits distributed. Among those dissatisfied with the quantity, large family sizes requiring the packages was cited as the main reason for dissatisfaction. The availability of the kits to the population was cited as key in bridging a major

accessibility and affordability gap while driving their utilization as quoted from a local authority representative from Galmudug during a men FGD:

*“.....we have started wearing face masks, improved sanitation and hygiene in our homes and also increased the number of times we wash our hands”*

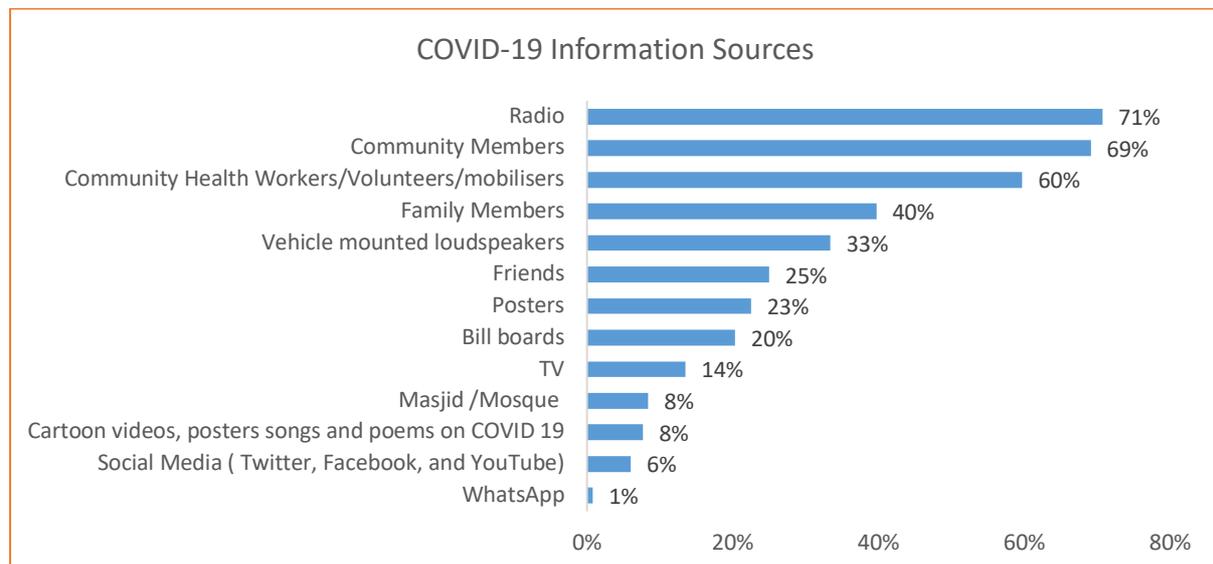
This is expected to go a long way in helping address poor hygiene and unsanitary conditions documented in these regions, resulting in preventable hygiene related diseases as the main causes of observed health conditions among children

### 3.1.2 Knowledge and understanding of COVID-19

**Knowledge and information on COVID-19 prevention and mitigation:** The end line survey established that at community level, the project focused on mass media, digital media and community level interpersonal campaigns across all project areas in Jubaland, Somaliland, Puntland and Galmudug.

As a result, a significant majority of the target population (99.3%) have heard about Coronavirus disease compared to the situation at baseline. Specific messages reported by the respondents from the HBCC project include COVID-19 transmission (92%), signs and symptoms (83%), prevention (79%), stigma (41%), where to seek support (36%) and isolation/quarantine (31%).

Qualitative information triangulated from key informants within local authorities and MoH staff confirm that CARE International executed the messaging in line with the MoH and WHO Health Service approved guidelines. Reported information sources are illustrated in the figure below:



**Figure 3: COVID-19 Information Sources**

Synthesis from survey respondents indicate that campaign consistency and access to preventive information in hard-to-reach audiences was key in influencing behavioural modification towards positive health seeking behaviour. Respondents were asked what key aspects of COVID-19 they know based on the information received from the project. From the available information sources, community members are more aware about COVID-19 as compared to the situation at baseline.

Reported information about the disease include protection steps, symptoms, transmission, self-care, risks/complications and government action as illustrated in the table below:

Type of information on COVID-19 people know	Baseline	End Line
Protection steps	61%	87%
Symptoms	79%	83%
Transmission	56%	70%
Self-care	41%	42%
Risks/complication	22%	25%
Government action	9%	15%

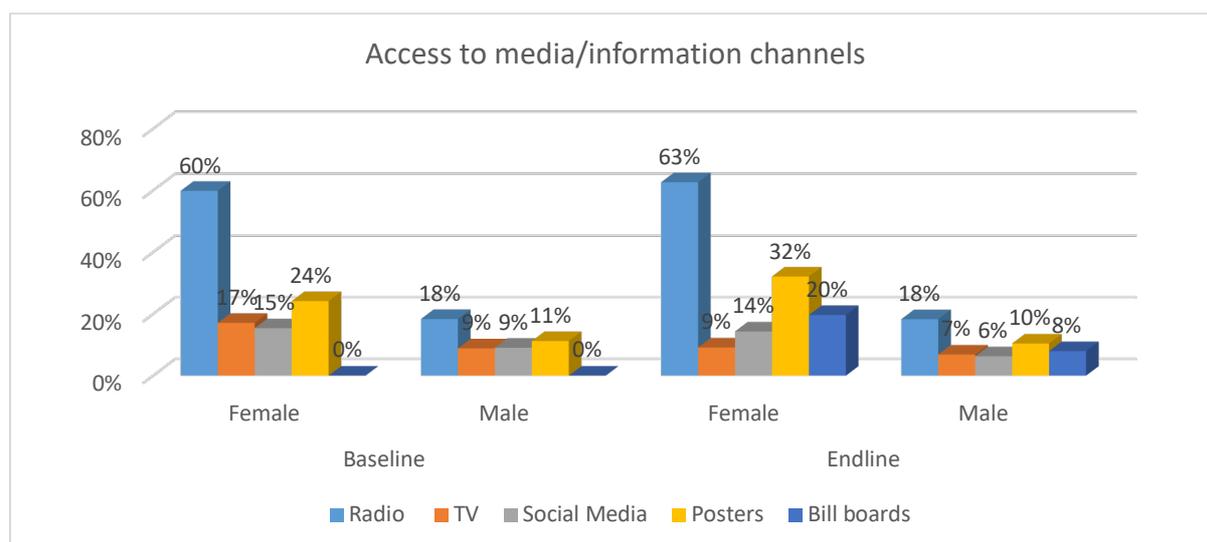
**Table 4: Type of information known to community members**

*“..... For the first few months it was difficult to convince the community that COVID-19 exists. Some components of the messages included wearing facemasks and social distance. Men specifically were not familiar on wearing mask.” KII from CARE Staff*

*“.....During the start of the project people were having a lot misinformation concerning religious dynamics on COVID-19. After implementation of this HBCC project by giving out hygiene messages and engaging community stakeholders; ordinary people, government and non-governmental organization the rumors and stigma about COVID-19 has reduced” KII from Jubaland*

Additionally, survey findings show a marked increase in access to media and information sharing channels including radio (81%), posters (43%), billboards (28%), social media (21%) (Facebook, Twitter and YouTube) and TV (16%). Improved access to crucial lifesaving preventive information on COVID-19 has contributed to the observed overall change outcomes of the COVID-19 Hygiene Behaviour Change Campaign in target regions; as illustrated in the figure below:

**Figure 4: Access To Media/Information Channels**



Some information sources/channels are however more trusted to give good information on Coronavirus disease than others. Perceived reliability alongside ready availability of radio (72%) in households was cited as the main reason for the trust levels while trust levels for community health workers (23%) was based on the fact that they are deemed as part of community members.

Reported trust levels are illustrated in the below table:

**Table 5: Trust levels on information sources/channels**

	Channel Preference Rates (%)		Trust Levels		
	Female	Male	High	Low	Medium
Radio	53	16	83%	4%	13%
TV	9	5	50%	16%	34%
Bill boards	16	6	62%	7%	31%
Community Members	50	14	54%	9%	37%
Family Members	30	10	60%	11%	29%
Friends	16	7	68%	9%	22%
Posters	18	6	75%	5%	20%
Community Health Workers	45	13	72%	9%	19%
Vehicle mounted loudspeakers	23	7	63%	9%	28%
Social Media	5	2	51%	15%	34%
WhatsApp	1	0	67%	11%	22%
Cartoon videos	4	1	51%	13%	36%
Masjid /Mosque	3	2	61%	3%	36%
Community leaders	12	3	66%	7%	27%
Religious leaders	4	2	71%	5%	23%
Health facilities	15	5	76%	3%	21%

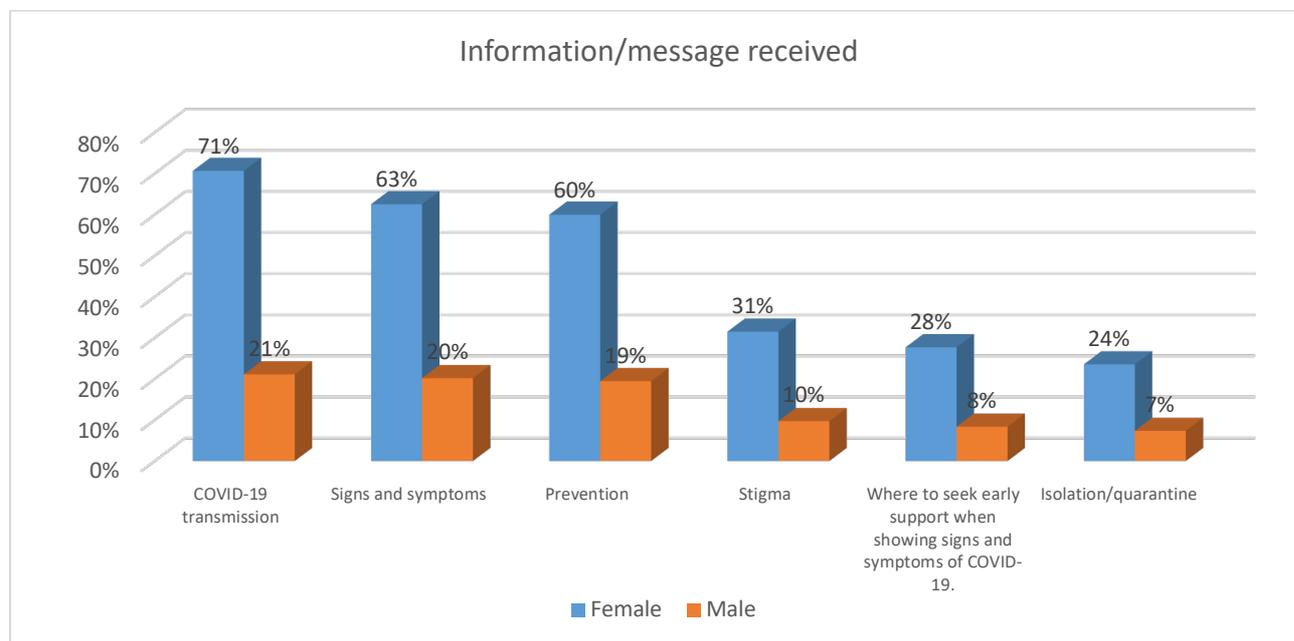
According to survey findings, 95.7% of respondents received hygiene promotional messages on hand washing information from various channels including radio (61%), community members (59%), CHWs/mobilisers (56%), vehicle mounted loudspeakers (30%), posters (23%), billboards (22%), TV (11%), social media (5%) among other channels. In addition, 94.4% received promotional messages on COVID-19 prevention and mitigation from various channels employed by the project.

This was done in a manner that was deemed inclusive, targeting specific people, such as persons with disabilities, marginalized groups and the elderly, leaving no one behind in the fight against the pandemic. In particular, public service announcements (PSA) through vehicle mounted speakers and call waiting messaging were cited as most efficient in reaching out to these groups attributed to the fact that beneficiaries can receive these messages from the comfort of their homes or directly to their mobile phones. These are not only low-income groups who generally face higher levels of risk, but also have less possibility of getting rapid and appropriate medical treatment if they fall ill as a result of some natural or man-made hazards. They can least afford treatment and medication or income loss while recovering from sickness or injury, and often undertake menial jobs that pre-dispose them to numerous health hazards.

As alluded to by a key informant from CARE staff; “.....messaging design considered difference profiles of the society, gender, literacy levels to ensure the messages are well understood. Different messages were developed for different groups”

Key messages received are illustrated in the figure below:

**Figure 5: Information/messages received**



### 3.3 Enabling factors and challenges influencing project implementation

Survey findings show that a number of factors directly and indirectly influenced project implementation and uptake of interventions among community members. These factors are not necessarily within the mandate of the implementers but will continue to have a bearing on similar interventions presently and in the future. They include both facilitating and constraining factors as elucidated here below:

#### Constraining factors/challenges

- Deeply rooted socio-cultural determinants of health access which have been amplified by social exclusion and discrimination of marginalized groups exacerbated by the prevailing pandemic condition. Assessment findings show that 77.5% of the sampled households were female headed apportioning parental responsibility solely on women and denying them other economic and growth opportunities
- Low literacy levels especially women which would impact negatively on the uptake of lifesaving health services including COVID-19 and immunizations
- Weak and disjointed health infrastructure characterized by low investment from government, poverty and insecurity. This is not supportive of equitable healthcare and continues to limit access and availability of lifesaving health services especially to women and children
- Surging numbers of infections (both reported and unreported) resulting in growing demand for COVID-19 response support; in addition to the already existing need for other health services

- e) Environmental hazards such as floods and continued displacement of populations as reported in various parts of the target regions
- f) Some messaging components were cited as difficult to understand; with the domino effect of inhibiting their adaption by community members
- g) Protracted conflict compounded by sporadic displacements due to insecurity have continued to suppress the penetration of public health services in target regions, which has a potential to hamper COVID-19 response activities
- h) Low participation of men who are critical decision makers and locus of power within the communities, including influence on uptake of healthcare services including COVID-19 messaging
- i) i. Living arrangements within target communities make it impossible for social distancing to be practiced, a significant drawback within households with reported cases of COVID-19 infection

#### **Enabling factors**

- i. Strong linkages between project implementation team, relevant MoH departments, local authorities, communities and other stakeholders which promoted a cordial working relationship among players. The good will from community was particularly central in promoting uptake of project activities
- ii. Adoption of digital media and community level interpersonal campaigns offered an effective means of delivering crucial lifesaving COVID-19 messages to rural and hard-to-reach areas
- iii. Beneficiary involvement at all stages of implementation which supported community buy-in as well as increasing their participation, which is key in promoting sustainability prospects
- iv. Delivering messages through diverse channels, innovatively linking the HBCC and WASH interventions while considering outreach, equal digital access, and capabilities based on gender and locations E.g. PSA and call waiting for marginalized groups, elderly and persons with disabilities; posters and radio for youth and young adults
- v. Information designed specifically to help different demographic groups understand recommended COVID-19 mitigation measures, including posters and other visual aids was key in facilitating information flow and acceptance at community level. Visual aids are (including animated cartoons and songs) notably efficient with vast majority who report low literacy levels while wording in specific local dialect resonates more effectively across the target regions and percolates differently across various target demographics

#### **3.4 Unintended consequences of project implementation**

- i. COVID-19 has been positive in terms of learning about handwashing; which according to CHWs has contributed to reduced cases of hygiene related disease conditions such as diarrheal among children under five
- ii. Since the HBCC's project started, there has been reported improvement in sanitation attitudes and routines particularly among men, as communities are taking personal and household sanitation more seriously by influencing each other's hand washing practices
- iii. Survey findings indicate that appropriate WASH practices have formed among families in project areas, providing an opportunity to create longer-term change to norms post-pandemic

- iv. Reported use of headscarf as face masks in instances where members could not afford to buy mandated face masks
- v. Attitude adjustment on religious perceptions that *“COVID-19 does not affect Muslims”*

### **3.5 Synthesis of project performance from qualitative data**

Summation of qualitative information obtained from key informant interviews focus group discussions and observations across the four regions covered by the HBCC project show that the project has generated positive changes in the lives of targeted women, girls, boys, and men; including vulnerable groups such as those living in remote locations as well as the elderly and people with disabilities. As explained by an FGD participant from Galmudug;

*“..... we have improved the cleanliness in our camps, we started wearing facemasks, social distance and changed the way we greeted each other. Everyone including children has been sensitized. The information is all over and people are listening. You can tell people are very careful with the disease”*

As explained by a MoH representative from Jubaland, the strengthening of community capacity to improve WASH practices in hard-to-reach areas of the vast region has contributed to improved response to COVID-19 pandemic leading to a more productive living in in the midst of pandemic. The rapid dissemination of messaging in support of the government’s efforts for a wider reach of information coverage in curbing COVID -19 pandemic was a significant contributor to the projects theory of change as espoused by another MoH representative from Somaliland *“...within a short time we had a lot of people already reached with messages on prevention and this was helpful since leaders cannot be everywhere at the same time to educate the community on COVID-19 issues”* . Overall, the project has contributed to increased recognition and assimilation of hygiene practices like handwashing at household level which in turn has contributed to a reduction in the incidence of preventable and treatable diseases such as diarrhea among children in these areas; as alluded to by a community health worker from Galmudug;

*“.....we have started wearing face masks, improved sanitation and hygiene in our homes and also increased the number of times we wash our hands, and we feel good because a lot of people are not reporting cases of the Coronavirus disease like before”*

Notably, key messaging channels particularly public service announcements were noted to contribute rapidly to improved knowledge on COVID-19 prevention and mitigation measures across different groups especially in marginalized and hard to reach areas where ordinary health promotion activities are a challenge. A head teacher in a local secondary school from Somaliland explains

*“.....the messages have reached far and wide, including to our learning centers that are not easily reachable. Including COVID-19 sessions in school timetable so that every student learns COVID-19 as part of normal lessons and make them understand basic elements such as prevention, transmission and symptoms. Even posters are available in Somali language and we can read”*.

In addition, various interest groups (including government institutions and community-based

organizations) intimated that the community participation approaches employed by the project were deemed appropriate as they involved real-time interaction with targeted audience.

## CHAPTER FOUR: CONCLUSION AND RECOMMENDATIONS

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### 4.1 Conclusion

It is noted that the HBCC project is directly contributing to the achievement of the Somalia's COVID-19 National Response Plan by prioritizing reduction in incidences of transmission, as well as bridging the crucial information gap to health materials targeting prevention and mitigation. Conclusively, the HBCC campaign has been instrumental in increase community's understanding of coronavirus disease transmission, that both washing hands with soap and water as well as motivating people to maintain physical distancing are critical to curtailing the virus's spread among communities. Evidently, from secondary data sources, comprehensive knowledge of the fundamentals of COVID-19 and what communities can do to mitigate transmission are statistically higher in regions that are receiving COVID-19 messages and reporting commensurate availability of handwashing facilities; as compared to neighboring regions that are not covered by the project; as deduced from indicators on WASH and health. This underscores the need to empower communities to ensure that such interventions are planned and adapted based on their feedback and local contexts. Critical functions employed by the HBCC project, such as community education, protecting vulnerable groups, equipping health workers with basic health promotion information, supply of hygiene kits and cooperation with physical distancing measures can only happen with the support of every part of affected communities. Trusted information sources for COVID-19 information include radio, community members, community healthcare workers, vehicle mounted loudspeakers, posters and friends. Stigma is still prevalent among surveyed communities where frequent forms include rejection and isolation, barring children from affected households in learning institutions as well as stoppage of business engagements with victims and family members. Synthesis of qualitative data indicate that several underlying socio-cultural and religious factors influence healthy handwashing practices at community level; namely family's economic status, access to resources and education level. It is also observed that knowledge and attitudinal factors also play an important role. Education, community level resources and social support are needed to achieve longer-term change to WASH practices at home. Besides COVID-19, additional social safety networks are necessary to cushion communities against dwindled livelihood prospects emanating from the raft of preventive measures instituted by local authorities. The newly formed handwashing practices as well as positive perceptions on COVID-19 prevention provide an opportunity for creative content leveraging on identified enablers in order to sustain these practices beyond the project's lifespan by utilizing lessons learned. Indications that certain groups could be stigmatized in the context of the pandemic requires close monitoring. As observed during the survey, parents often lack requisite knowledge of the correct handwashing methods and so struggle to encourage them among their children. Through the continuous health messaging on COVID-19, the project has empowered not just the community but also various cadres of healthcare workers who will cascade the training to others to sustainably manage and prioritize COVID-19 infection prevention and control. Synthesis from qualitative data indicate that improved outcomes for HBCC can be achieved more effectively through a holistic approach, combining interventions that address social, cultural and gender related barriers. The WASH'Em approach, though qualitative in application, provided an opportunity to understand key health characteristics of target communities as well as preferred touchpoints, which are useful in helping to adapt existing health messages and to design new ones

. This is especially so considering that majority of the communities served in affected regions are poor and can hardly afford alternative information sources and hygiene supplies. Inadequate hygiene and sanitation practices and lack of clean water have traditionally been identified as underlying causes of high mortality and morbidity rates

#### 4.2 Recommendations

Based on the survey findings, the following recommendations are made for improvement of current and future HBCC interventions within the surveyed regions and in similar contexts:

- i. **In view of the reported higher numbers of female headed households**, future projects should seek to incorporate specific HBCC activities which seek to encourage increased and equal participation by women, girls, men and boys within the intervention structures while addressing gender roles in health and hygiene promotion.
- ii. **Urgently address various forms of stigma and discrimination** observed through biased treatment of families contracting coronavirus disease. Risk communication and community engagement approach is helpful in identifying affected vulnerable groups for streamlined inclusion in remedial/corrective measures aimed at addressing identified stigma
- iii. **Scale up of family-based handwashing practices** through combined provision of hygiene kits and risk communication which serves as the starting point for communities to embrace COVID-19 preventive measures; specifically targeting women as agents of change at household level. It is noted that residents from neighboring regions struggle to observe ideal hygiene behaviours due to limited access to soap, water and proper sanitation facilities
- iv. **There is continued need to survey community's attitude and practices on COVID-19** with a view to analyzing its ability to adapt to the rapidly evolving pandemic landscape and the people's ability to prevent and respond to the threat of this virus
- v. **Initiate community dialogue using existing communication channels** to generate more evidence on perceptions, behavior changes, existing barriers, community specific needs and vaccine knowledge gaps as the pandemic outbreak evolves
- vi. **Tailor made HBCC innovative interventions such as community outreaches and mobile platforms** to promote equity in HBCC messaging accessed by specific vulnerable groups such as the elderly, PLWD, pregnant and lactating mothers as well as children
- vii. **Deliberate and sustained diversification of HBCC messaging around COVID-19** in view of the observed differences in information consumption habits to ensure communication approaches are centered around favored information channels within different regions
- viii. **An exit strategy is paramount to ensuring that the gains made by the project are not lost** but harnessed for sustainability through established community structures for longer term benefit of the community post-pandemic

## ANNEXES

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HBCC Endline  
Survey Individual To



HBCC Endline  
Survey- KII Guide\_Fir



HBCC Endline  
Survey- FGD Guide\_]



List of Key  
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