

WASH responses to COVID-19 in Ethiopia, Somalia and South Sudan

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In the face of COVID-19, adaptation, innovation and learning from experience have been key to responding adequately to the needs of displaced people.

The humanitarian community has had to learn about COVID-19 while responding to this new disease. From the start it was known that basic hygiene practices, such as proper handwashing, could help prevent its transmission. However, many displacement settings do not have the required facilities for implementing household and community-level Infection Prevention and Control (IPC) measures. They may also have weak governance systems for managing and maintaining water, sanitation and hygiene (WASH) services.

Some displacement settings, such as in Ethiopia, Somalia and South Sudan, host some of the hardest populations to reach, where communities are ill-equipped to protect themselves and respond to health threats. Overcrowding and limited access to adequate WASH facilities can increase vulnerability to diseases. Meanwhile, the fear around COVID-19 can lead to the spread of misinformation and increased xenophobia and stigma. IOM teams working in these settings had to adapt their Risk Communication and Community Engagement (RCCE) and IPC activities as new information emerged and as lessons were learned.

Adapting RCCE strategies

In typical WASH programming, surveys are conducted at the onset of an emergency to understand people's needs and enable effective and appropriate responses. In the case of COVID-19, localised lockdowns, access restrictions and the need to adhere to physical distancing guidelines impeded early data collection, and one-on-one interviews were prioritised over broad survey exercises. In Ethiopia, interviews were undertaken by people already implementing field activities in order to avoid additional

personnel movements and increased health risks. Lack of funding is a common barrier faced in all emergency response; while more innovative communication methods would have been preferred, the method used in Ethiopia to collect data during COVID-19 managed both to keep activities going – in the face of potential complete closure – and to keep data collection costs low. Interviewees included vulnerable groups such as persons with disabilities to understand their perception of COVID-19.

In all three countries it was recognised there was insufficient time for baseline surveys, so the initial response was to increase water supply and handwashing facilities, and use existing strategies to deliver hygiene promotion messages, fit for any humanitarian and public health emergency. As time evolved and more information emerged, hygiene promotion messages were adapted to incorporate physical distancing, respiratory hygiene and the use of face masks.

In Somalia, insecurity further constrains access to certain populations and hard-to-reach locations. Hence, updates on COVID-19 were disseminated through mobile phones to hygiene promoters within the community, and trainings became virtual. In other cases, door-to-door engagement methods were adopted to target vulnerable populations such as people with disabilities; access to these communities actually improved, due to use of virtual communications. In South Sudan, movement restrictions did not apply to water truckers as they delivered an essential service; they were therefore trained by IOM to disseminate COVID-19 preventive messages. In Ethiopia, as restrictions eased, hygiene promoters, WASH committee members, community and religious leaders and government health



IOM WASH teams monitor appropriate handwashing practices in Hai Referendum market, in Juba, South Sudan.

extension workers were provided with basic IPC materials (handwashing units and soap) in order to set up hand hygiene stations at water points, and were given appropriate training and encouraged to disseminate COVID-19 information. Child-friendly hygiene sessions were carried out in small groups outdoors, with tailored activities using puppets and colouring books. In general, COVID-19 information was paired with cholera prevention messaging, which proved effective as these communities were already accustomed to implementing cholera prevention practices.

In all countries, WASH teams used alternative communication strategies to reinforce COVID-19 messaging, such as radio broadcasts and broadcasting from vehicles with loudspeakers. In Ethiopia, culturally appropriate Information, Education and Communication (IEC) materials were printed in the early stages of the pandemic; later, to avoid unnecessary risks for staff distributing the flyers, these materials were re-designed as posters and banners, in collaboration with a local artist. Unfortunately, over-repetition of the same message resulted in decreased interest by the community in the messages; to address this, WASH teams mainstreamed

specific COVID-19 messaging within a wider range of hygiene-related themes, and this was seen to engage communities more effectively. In Somalia, audio-visual and printed materials were developed for different literacy levels, and radio programmes were translated into a variety of languages used by the displaced populations. In South Sudan the existing communication strategy that had been developed in response to the Ebola outbreak in the neighbouring Democratic Republic of the Congo was revised to reflect COVID-19. Short, easy-to-

remember messages were used in all cases.

At the beginning of the emergency, community stakeholder mapping was attempted in Ethiopia; however, as key staff were not able to travel to the field to train volunteers, the data collected was not sufficiently robust for use in planning. In addition, the WASH teams took into account the fact that in Ethiopia, where government presence is strong, communities often view government authorities as the main conduit for reaching communities, even at village level. Therefore, WASH teams used simple messaging in line with the widely accepted style of communication from government authorities, in particular the Ministry of Health.

Adapting IPC protocols

Given the access barriers imposed by travel restrictions, increased cooperation with other actors was essential for an effective response. In Ethiopia, the WASH team collaborated closely with Health Cluster partners and the government's health ministry to train the government-employed health extension workers. In South Sudan, WASH and Health Cluster partners developed joint standard operating procedures (SOPs)

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and held weekly coordination meetings. SOPs were also developed by IOM teams in Somalia and Ethiopia, where IOM's Hygiene Promotion Training Manual was adapted to include COVID-19 guidelines.

Protocols released by WHO recommended handwashing after touching common surfaces, which led IOM teams to promote no-touch technologies for handwashing. Foot-operated 'Tippy taps' were manufactured in South Sudan with local materials; IOM promoted their use and provided instructions to communities on how to use them. It was observed, however, that the more traditional, hand-operated handwashing stations were preferred. This prompted IOM to prioritise community preferences over the introduction of an alternative technology which, despite its advantages in terms of preventing infection, would be used less.

The adoption of face masks – in terms of materials and usage – was one aspect that was particularly characterised by misinformation and shifting guidance at different stages of the pandemic. In Somalia, when there was a global shortage of masks at the beginning of the emergency, masks were recommended only for health-care workers, people with COVID-19 and their caregivers. This persisted even with increased mask availability, leading to a widespread perception of mask use being limited solely to persons with symptoms, which in turn encouraged low rates of acceptance. In Ethiopia, since the government mandated their widespread use in public from the onset, adoption of masks was easier but was still challenging in remote areas with a weaker government presence. This highlighted the importance of community engagement as key to building acceptance and ownership by the community, particularly in areas characterised by mistrust of the government.

Adapting logistics

Restrictions and lockdowns caused delays in delivering WASH emergency items, while the increased demand generated shortages in the markets and a sudden increase of prices, which in turn triggered a focus on local procurement. As a result of COVID-19,

IOM missions in each country enhanced their stockpiling plans for emergency supplies in case of long-term closure of borders, while also prepositioning for other emergencies.

In South Sudan, donors supported the expansion of prepositioning to include Personal Protective Equipment (PPE) and additional WASH items; however, in Ethiopia – where prepositioning is not the norm – restricted donor funding only allowed for procurement of items for direct implementation, and therefore stockpiling remains a substantial challenge. To address the lack of standard items, household handwashing stations were establishing using plastic water containers and laundry soap, with masks produced by local suppliers. In Somalia, where there is also a lack of stock, new supply hubs are being planned, and prepositioning efforts dedicated to flood response are currently supporting COVID-19 preparedness.¹

Responding to evidence

Knowledge, Attitude and Practices (KAP) surveys were conducted in late 2020 and early 2021, after the initial roll-out of IOM's response. Surveys indicated that people with disabilities had relatively heightened concerns about COVID-19, believing that they are a burden on their families due to the need for help in implementing basic measures, such as frequent handwashing.² The WASH team therefore increased the frequency of household visits to vulnerable people such as those with disabilities and prioritised them during distributions. Qualitative surveys also highlighted myths around COVID-19, such as being able to prevent COVID-19 by drinking hot beverages or killing the virus through sunlight exposure. In some locations, COVID-19 was considered to be a fictional story disseminated by the ruling government party in order to delay elections. Hygiene promoters were trained to identify these misconceptions and provide simple, easy-to-understand counterinformation.

Conclusions

Humanitarians are often faced with disease outbreaks in humanitarian contexts, and

lessons must be captured and applied to ensure future outbreaks are acted upon with maximum efficacy. While some of these recommendations are not new, COVID-19 reinforced the importance of certain approaches while triggering new approaches to overcome new barriers. Recommendations and lessons learned from our experience in Ethiopia, Somalia and South Sudan include the following:

- While emergencies often present the challenge of lack of community engagement because of information fatigue, COVID-19 presented a new challenge, and this sparked innovative messaging methods that can be used in future disease outbreaks and other emergencies. IOM used a mix of traditional methods such as radio shows, posters and household visits and new methods such as signs on water trucks to convey hygiene promotion guidance at critical points.
- While reaching the most vulnerable is always a priority, COVID-19 demonstrated that with some relatively minor additional funding it was possible to use remote communication methods for hard-to-reach locations and segments of the population, such as people with disabilities. A combination of localising hygiene promotion and using remote communication methods was proven to work, suggesting a reduced need for on-the-ground international staff; this approach should be prioritised and written into future project designs.
- Similarly, assessing vulnerable populations in the early stages of programming should be reinforced as standard practice in order to be able to plan targeted assistance. COVID-19 has proved that measures such as household-level distribution, which was previously an uncommon method of distributing emergency supplies, is possible and allows agencies to more accurately target those who are unable to leave their home.
- Acknowledging that epidemics are likely to present a threat in the future, pre-positioning of emergency supplies such as IPC materials for disease outbreaks (face masks, portable handwashing stations, etc) should be common practice in humanitarian response plans, in addition to the emergency supply items commonly prioritised; this requires vigorous advocacy by humanitarian actors for dedicated funding by donors.
- COVID-19 showed that rapid dissemination of IEC material is critical at the early stage of a disease outbreak. Preparing ready-made, context-appropriate IEC materials that can be quickly adapted in the event of any outbreak with similar IPC requirements (such as Ebola) would enable rapid roll-out whenever required.
- Pairing new disease information with well-known information and delivery methods is important to facilitate acceptance by the community, while engaging community members in all strategies for behaviour change is key to ensuring culturally appropriate and context-relevant delivery of messages, and to gain trust and acceptance of new information and technologies.
- While investing in capacity building for hygiene promotion to empower local responses has always been part of any emergency response, COVID-19 forced further localisation due to the lack of international travel. It highlighted strong local capacity and willingness in some communities, demonstrating how supporting local structures can help consolidate hygiene promotion capabilities while negating the need for a high level of international assistance in the event of future outbreaks.

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1. WHO (2020) 'Rational use of personal protective equipment for coronavirus disease and considerations during severe shortages' bit.ly/WHO-2020-PPE-COVID-19
2. Nadia Kevlin, personal communication

