2020 COVID-19 KAP SURVEY REPORT

Assessing the *Knowledge, Attitudes & Practices (KAP)* of Jamaicans regarding the Novel Coronavirus & COVID-19

MINISTRY OF
**HEALTH &
WELLNESS**

**National COVID-19
Research Agenda**

**STATISTICAL INSTITUTE
OF JAMAICA**

2020 KAP Survey Report

Assessing the Knowledge, Attitudes and Practices of Jamaicans regarding the Novel Coronavirus and COVID-19

Statistical Institute of Jamaica (STATIN)

September 2020

Suggested citation:

STATIN. (2020). 2020 COVID-19 KAP Survey Report: Assessing the Knowledge, Attitudes and Practices of Jamaicans Regarding the Novel Coronavirus and COVID-19. Kingston Jamaica: Statistical Institute of Jamaica.

Preface

The 2020 COVID-19 Knowledge, Attitudes and Practices (KAP) Survey was undertaken as part of the National COVID-19 Research Agenda (NCRA). The NCRA is a collaborative effort aimed at providing vital information for evidence-based decision-making. The Ministry of Health and Wellness (MoHW) in partnership with the Statistical Institute of Jamaica (STATIN) co-chair the NCRA.

The KAP Survey is the first nationally representative telephone-survey executed by STATIN. It is an innovative response to unprecedented circumstances, as the Institute suspended in-person interviews due to the uncertainties associated with the coronavirus (SARS-Cov-2). As a resilient organization, STATIN adapted its approach to survey data collection, deploying the 2020 KAP Survey using Computer Assisted Telephone Interviews (CATI). To ensure methodological soundness, the Institute obtained technical support from the Statistics Division of the Economic Commission for Latin America and the Caribbean (ECLAC). The KAP survey has produced nationally representative estimates, that are statistically robust at the parish and regional levels.

The KAP Survey provides insights into the Knowledge, Attitudes and Practices of Jamaicans regarding the SARS-Cov-2 and COVID-19 during the months of April and June 2020. Additionally, data were collected on the economic impact of the pandemic, and certain health-related risk factors. STATIN conducted the 2020 KAP Survey during the months of April and June 2020.

The role of STATIN is to provide relevant and timely statistical information for informed decision making. We, therefore, hope that the findings contained in this report will inform decision-making in response to the pandemic.

Carol Coy
Director General
Statistical Institute of Jamaica

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1 Background

In December 2019, a cluster of pneumonia-like cases was discovered in Wuhan, China. According to the WHO, the pathogen associated with this cluster was subsequently identified as the novel Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2). By January 2020, the World Health Organization (WHO) declared the novel coronavirus outbreak a Public Health Emergency of International Concern (PHEIC) and in March 2020, it was declared a global pandemic. This represented a paradigm shift globally, as countries across the globe attempted to implement measures to control the outbreak, while simultaneously trying to understand the virus. As scientists worked to develop adequate testing and treatment protocols, the responses varied widely across countries, ranging from total lockdowns to no responses. In some countries, the death toll and infection rate increased rapidly, with millions of lives being adversely impacted by the virus.

In Jamaica, the Ministry of Health and Wellness (MoHW) launched a multipronged strategy in response to the pandemic. This included clinical and other research, expansion of the health system capacity, proactive communication and the development of guidelines and protocols. The 2020 COVID-19 Knowledge, Attitudes and Practices (KAP) Survey was designed to support the MoHW response to the pandemic in Jamaica.
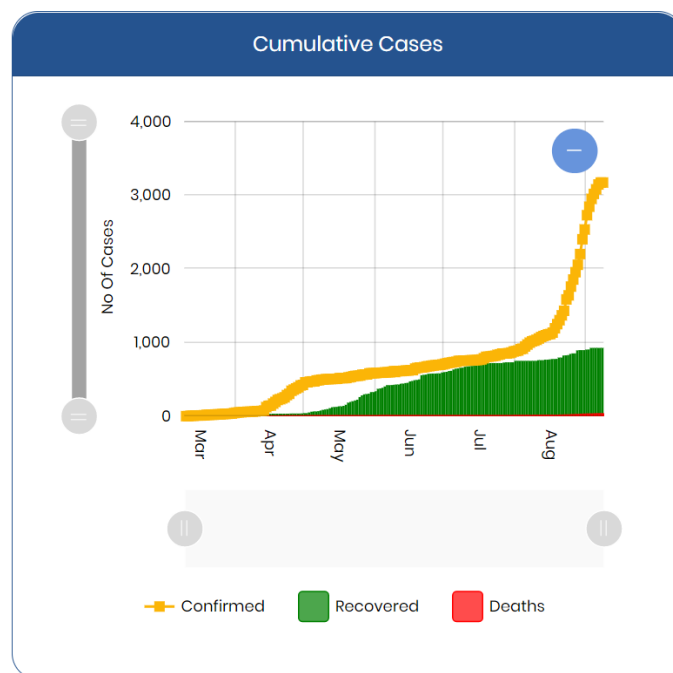
FIGURE 1-1: CONFIRMED CASES OF COVID-19 IN JAMAICA MARCH - AUGUST 2020

According to the Ministry of Health and Wellness (MoHW), "*[c]oronaviruses are a large family of viruses that are known to cause illness ranging from the common cold to more severe diseases such as Middle East Respiratory Syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS)*" (MoHW, 2020). The SARS-CoV-2 is a new strain of the coronavirus that had not been previously identified in humans.

It is not uncommon for viruses and the disease they cause to have different names. *"Viruses are named based on their genetic structure to facilitate the development of diagnostic tests, vaccines and medicines... Diseases are named to enable discussion on disease prevention, spread, transmissibility, severity and treatment"* (WHO, 2020). In this instance, the virus is called Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2), because the virus is genetically related to the coronavirus responsible for the SARS outbreak of 2003. On the other hand, the diseased caused by this virus is called COVID-19, because it is a coronavirus disease that was discovered in 2019.

1.1 National COVID-19 Research Agenda

In March 2020, as part of the response to the pandemic, the Essential National Health Research Committee (ENHRC) of the MoHW brought stakeholders together to discuss the formulation of a National COVID-19 Research Agenda. The ENHRC is chaired by Dr. Karen Webster-Kerr, Principal Medical Officer, National Epidemiologist and is a CMO[1]-appointed Committee which:

- has developed a National Health Research Agenda,
- is developing a National Policy on Research for Health,
- has already had collaboration with several research stakeholders across sectors in the execution of activities.

ENHRC membership is comprised of key stakeholders in research, including representatives from the MoHW, educational institutions, the Pan American Health Organization (PAHO), the Caribbean Public Health Agency (CARPHA), the Planning Institute of Jamaica (PIOJ), the Statistical Institute of Jamaica (STATIN), the Registrar General's Department (RGD), professional associations and non-governmental organizations. The National COVID-19 Research Agenda (NCRA) is an initiative of the ENHRC.

The NCRA is co-chaired by the MoHW and the STATIN. Membership of the NCRA Working Groups represents over seventy (70) individuals from fifteen (15) organizations. The Research Working Groups are structured as follows:

| Clinical and Laboratory | Epidemiological/ Surveillance: a.Case and Control b.Household and Community | Health Systems | Socioeconomic | Communication | Policy |

Cross-cutting: Data Management and Documentation

The purpose of the National COVID-19 Research Agenda is to provide an integrated framework to guide the coordination, implementation and utilization of research regarding COVID-19 to inform the national

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[1] Chief Medical Officer

response in the mitigation and/or management of the current outbreak and future activities. The objectives of the National COVID-19 Research Agenda are to:

- Support the generation of evidence needed to strengthen clinical management, public health guidance and actions essential for mitigating the impact of COVID-19 disease on the population of Jamaica
- Determine the impact of COVID-19 on various sectors in Jamaica to provide information for action
- Coordinate efforts across Government, academia, the private sector, development partners and other stakeholders to optimize research efforts and outcomes in a 'whole-of-society' response to producing data.
- Support the development of the research for health enterprise to be better prepared for the next emerging and re-emerging disease outbreak.

1.2 Health Regions in Jamaica

Jamaica has a decentralized health system with four health regions. Each health region has responsibility for discreet groups of parishes. They are:

Southern Regional Health Authority (SRHA)	Southeast Regional Health Authority (SERHA)	Northeast Regional Health Authority (NEHRA)	Western Regional Health Authority (WRHA)
St. Elizabeth	St. Catherine	Portland	Trelawny
Manchester	St. Andrew	St. Mary	St. James
	Kingston		Hanover
Clarendon	St. Thomas	St. Ann	Westmoreland
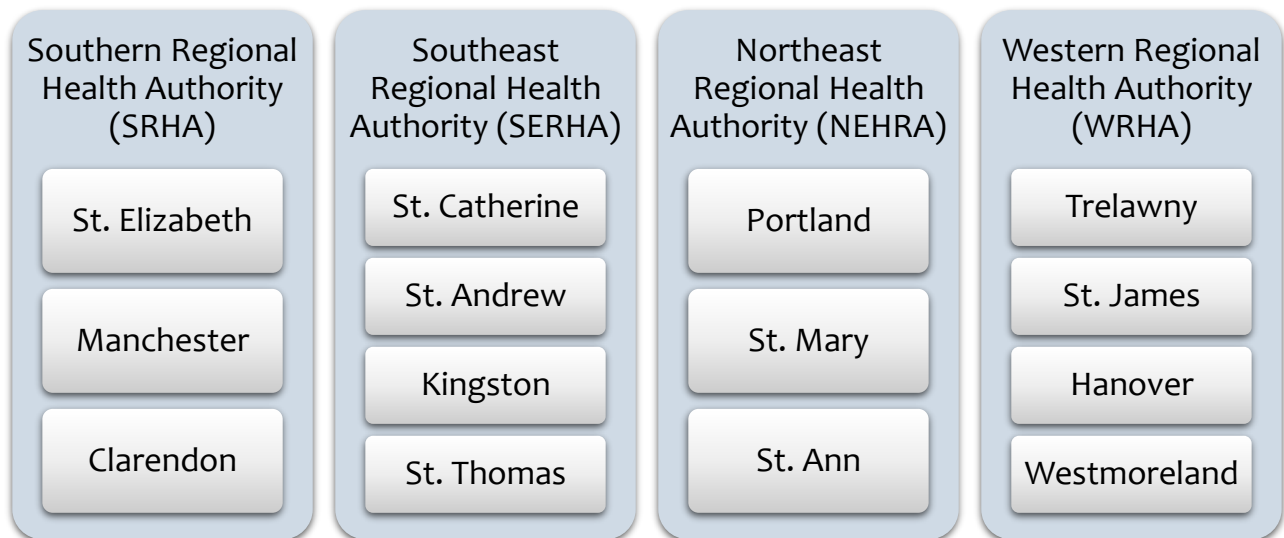
FIGURE 1-2: PARISHES PER HEALTH REGION

2 Survey Design

The 2020 COVID-19 Knowledge, Attitudes and Practices (KAP) Survey was the first of its kind to be executed by the Statistical Institute of Jamaica (STATIN). In light of the way the Coronavirus (SARS-CoV-2) is transmitted, and the urgency of the data collection, STATIN opted to do its first ever national survey using Computer Assisted Telephone Interviewing (CATI). The novelty of this data collection approach however required additional research and technical support, which was provided by the Economic Commission for Latin America and the Caribbean (ECLAC) through its Santiago, Chile Office.

The primary purpose of this survey was to assess the knowledge, attitudes and practices of Jamaicans regarding COVID-19 and the novel Coronavirus SARS-CoV-2. The survey was executed on the request of the Ministry of Health and Wellness (MoHW) and sought to provide nationally representative estimates.

This survey forms part of the output of the National COVID-19 Research Agenda. Specifically, this survey is an activity of the Epidemiological/Surveillance: Household and Community Working Group, which is chaired by Professor Affette McCaw-Binns, Epidemiologist.

STATIN implemented the 2020 COVID-19 KAP Survey project in two phases:

FIGURE 2-1: 2020 COVID-19 KAP SURVEY PROJECT PHASES

2.1 Scope and Coverage

The 2020 COVID-19 KAP Survey was a non-commercial telephone survey designed to produce reliable estimates at the national and parish levels. The target population for this survey was persons ten (10) years and older who were usual residents of Jamaica with active non-commercial mobile telephone subscriptions. Excluded from the sample were persons without a mobile phone. Approximately ninety per cent (90%)[2] of Jamaican residents are estimated to be current mobile phone users.

The survey targeted the primary user of the selected mobile phones. Where the primary user of the phone was under the age of eighteen (18) years, the consent of a responsible adult was obtained prior to the interview.

2.2 Survey Instrument

The survey instrument was developed based on consultation with key stakeholders including the MoHW, and other partners in the National COVID-19 Research Agenda. Additionally, survey instruments developed by the World Bank and other Development Partners for the rapid assessment of the pandemic were also

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[2] Source: Statistical Institute of Jamaica, ICT Indicators Report

reviewed. In developing the questionnaire, STATIN sought to balance the data needs of stakeholders, and the appropriateness of the survey instrument given the mode of collection.

The final 2020 COVID-19 KAP Survey questionnaire consisted of ninety (90) questions spread across six (6) sections. The survey instrument was divided as follows:

| Contact History | Knowledge | Attitudes | Practices | Demographics | Economic Activity |
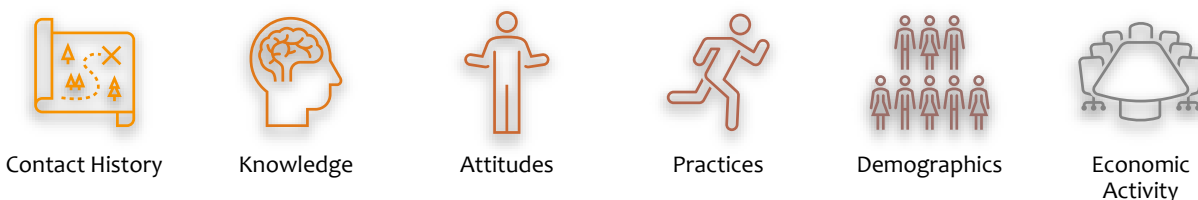
FIGURE 2-2: QUESTIONNAIRE SECTIONS

2.3 Data Collection and Interviewer Training

Cognitive testing was done to assess the clarity and appropriateness of the questions. This is important in ensuring that the questions adequately serve their intended purpose thereby facilitating the capture of good quality data.

Additionally, a pre-test was conducted by five Interviewers over three days. The primary aim of this pre-test was to assess several aspects of the questionnaire to include the wording of questions, relevance of response options, flow/skip instructions as well as the receptiveness and cooperation of respondents. The results from the cognitive assessments and pre-tests informed the final KAP survey instrument.

Data collection for the 2020 COVID-19 KAP Survey was between April and June 2020. Sixty-one Interviewers and 17 Supervisors participated in this process. The method of data collection was Computer Assisted Telephone Interviewing (CATI) using the World Bank developed Survey Solutions platform. A total of 9,379 persons were interviewed representing a response rate of 52.8 persons.

2.3.1 Interviewer Training

Training for the Interviewers and Supervisors was conducted virtually in April 2020 by way of a pre-recorded instruction video which was disseminated via the web. In addition to the video, each person received a copy of the KAP questionnaire and an Interviewer's Manual. This manual explained the concepts used in the survey, provided detailed instructions on how to complete the questionnaire as well as guidelines for general interviewing. After watching the video and perusing the documents, persons participated in practise sessions in which they explored the electronic questionnaire via Survey Solutions. Finally, the Interviewers and Supervisors attended a question and answer session, facilitated by the survey team, in which they had the opportunity to seek clarification on the video, information contained in the manual, the questionnaire or any other issue regarding the conduct of the survey.

2.4 Estimation

The data were analysed using SAS to estimate the parameters of interest. Survey responses have been weighted to population totals. Point estimates are rounded to the nearest hundred, and proportions to one decimal place. The variance estimation was based on the Taylor Series Linearization and accounted for the survey design. Both the final weight and the stratification defined as the mobile service provider were

accounted for in the estimation process. Estimates with coefficients of variation (CVs) above 20 per cent are not presented in this report. These values are represented by **'*'** in the tables.

Additional information on the sample design see Appendix I: Technical Notes.

3 Demographics

The data presented in this report is representative of the population in Jamaica that is 10 years or older. This subset of the population was relatively equitably distributed across sex, with females accounting for 50.7 per cent and males the remaining 49.3 per cent. Four out of every 10 (40.8%) of this population were between the ages of 10 and 29 years old. Persons 30 to 49 years old accounted for 31.7 per cent of the population, while those 50 to 69 years old accounted for 20.4 per cent. The elderly, those 70 years and older accounted for 7.1 per cent of the population.

Most of the population resided in St. Andrew (21.4%) and St. Catherine (18.8%). On the other hand, the parishes of Hanover (2.6%), Trelawny (2.8%) and Portland (3.1%) were among the least populated. Half of the target population was served by the Southeast Regional Health Authority (SERHA). The smallest proportion (13.7%) of the population is served by the Northeast Regional Health Authority (NERHA).

Just over a half of the population (50.9%) indicated that their highest level of education was between upper secondary and post-secondary, non-tertiary. This level of education allows for transition into tertiary level education, or entry into the world of work. There was however 26.3 per cent of the population who indicated that they did not obtain education beyond the lower secondary level (Grade 9). It is estimated that 332,400 or 14.1 per cent of persons in the target population have attained tertiary level education. In contrast 7.5 per cent had other levels of education not elsewhere classified. Just over one per cent refused to provide information on their level of education.

TABLE 3-1: DEMOGRAPHICS BY SEX, PARISH, AGE, HEALTH REGION AND EDUCATIONAL ATTAINMENT

	N	%
Sex		
Male	1,162,100	49.3
Female	1,195,000	50.7
Age Group		
Age 10 to 29	961,500	40.8
Age 30 to 49	747,000	31.7
Age 50 to 69	480,500	20.4
Age 70 plus	168,100	7.1
Parish of Residence		
Kingston	78,300	3.3
St. Andrew	504,700	21.4
St. Thomas	82,000	3.5
Portland	72,800	3.1
St. Mary	100,300	4.3
St. Ann	150,900	6.4
Trelawny	66,300	2.8
St. James	157,000	6.7
Hanover	61,200	2.6
Westmoreland	125,900	5.3
St. Elizabeth	134,100	5.7
Manchester	168,800	7.2
Clarendon	211,500	9.0
St. Catherine	443,400	18.8
Health Region		
Southern Regional Health Authority	514,500	21.8
Southeast Regional Health Authority	1,108,300	47.0
Northeast Regional Health Authority	324,000	13.7
Western Regional Health Authority	410,400	17.4
Educational Attainment		
Pre-school to Lower Secondary	620,400	26.3
Upper Secondary to Post-secondary	1,198,800	50.9
Tertiary	332,400	14.1
Other, not elsewhere classified	176,200	7.5
Refused	29,300	1.2
Total	**2,357,200**	**100.0**

4 Economic Activity

During the 2020 COVID-19 KAP Survey, respondents were asked to indicate what they were doing most of the time during a one-week reference period in March and April 2020. These two questions were used to determine their labour force status before the outbreak of COVID-19 in Jamaica and within the first month of the pandemic.

Consistent with the concepts in the Labour Force Survey, a person is considered employed if he/she worked for at least one hour during the reference week or if he/she was with a job but not working during the said reference week. It should be noted that the survey did not ask sufficient questions to produce an official unemployment rate, but instead presents a proxy of the level of employment during these two months.

> The number of persons employed declined by **19.3%** or **273,100 persons** between March and April 2020.

From the survey, it is estimated that six in every ten (61.2% or 1,418,600) persons were employed or had an attachment to a job during the first week of March 2020. This means that they were either full-time, part-time, self-employed, doing odd jobs, working in a family business or on leave from a job. In comparison, 49.4 per cent (1,145,500 persons) were employed in the first week of April 2020. This represents a decline of 19.3 per cent or 273,100 in the number of persons employed.

Persons are considered unemployed if at the reference week they were seeking, willing and available for work. On the other hand, those outside the labour force are non-seekers and tend to include persons who are full-time students, retired, disabled and persons not interested in finding employment. From the survey, it is estimated that 87,600 (3.8%) of the population was unemployed, and 813,200 (35.1%) was outside the labour force during the first week of March 2020. There was an increase in the number of persons unemployed to 135,600 (5.8%) and an increase in the number of persons outside the labour force to 1,038,300 (44.8%) as at the first week in April 2020.
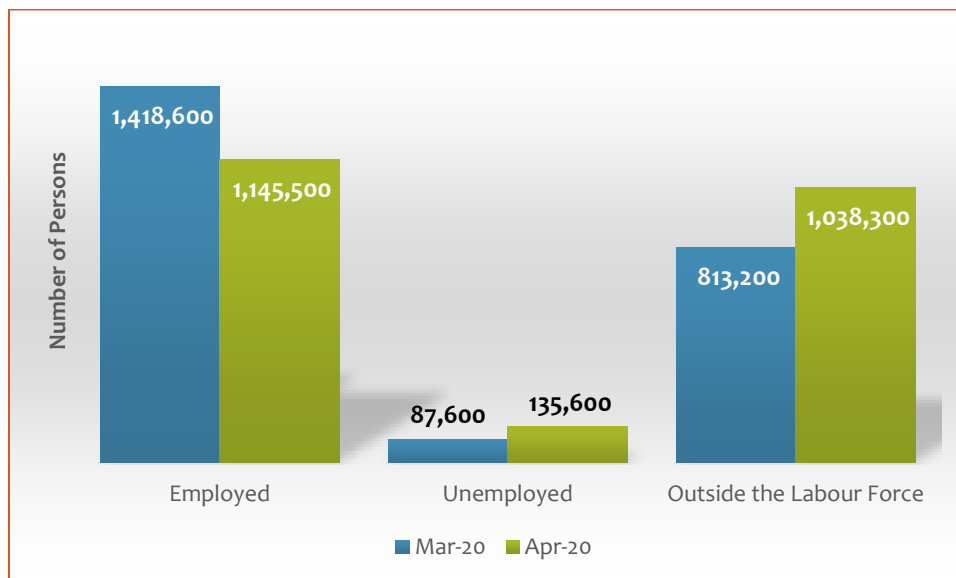
FIGURE 4-1: LABOUR FORCE STATUS, MARCH AND APRIL 2020

Persons who were employed or had an attachment to a job during the April 2020 reference period were asked about the impact of the measures implemented to curb the spread of the COVID-19 on their income. Approximately 47 per cent (539,300 persons) of the persons who responded to the question said that there was a reduction in their income and another 12.9 per cent (148,200) said they had a severe or complete loss of income. Four in every 10 (39.4% or 451,700) indicated that their income was "Not at all" impacted.
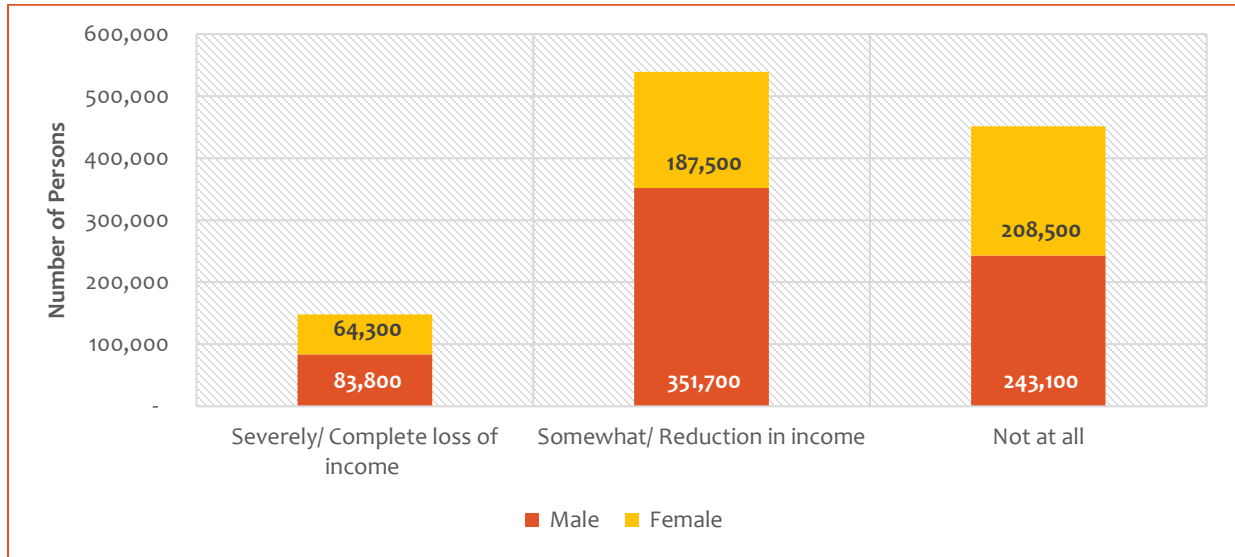
FIGURE 4-2: NUMBER OF PERSONS EXPERIENCING A CHANGE IN INCOME RELATED TO COVID-19 CONTROL MEASURES BY SEX

A greater number of males indicated that their income had been reduced, either completely or partially, because of COVID control measures. A total of 435,600 males, relative to their female counterparts (251,800) indicated that they had experienced some or complete reduction in their income. A greater proportion of females (45.0%) reported no change in their income compared to males (35.6%).
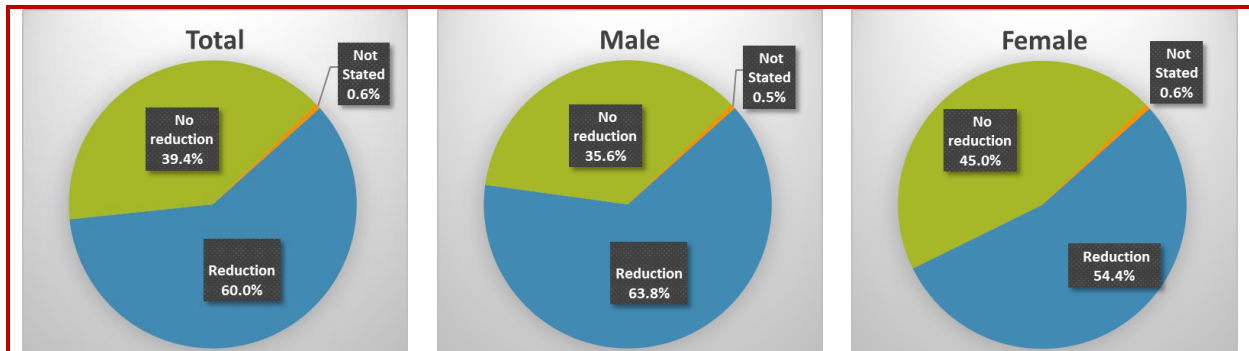
FIGURE 4-3: PROPORTION OF PERSONS EXPERIENCING A CHANGE IN INCOME RELATED TO COVID-19 CONTROL MEASURES BY SEX

5 Access to Non-COVID related Medical Services & Medicine

The maintenance of essential health services is of paramount importance especially given the risk factor associated with COVID-19. The prevention and treatment for non-communicable diseases such as cancer, diabetes, lupus and hypertension are services that many persons still require during the pandemic. During the survey, persons were asked if they had any chronic illnesses or underlying conditions. Among those who have been diagnosed with any such conditions the survey sought to determine if persons have experienced any disruption in care services or had any difficulty sourcing their medication. Most persons did not have any chronic illnesses or underlying conditions (1,812,500 or 77.6%).
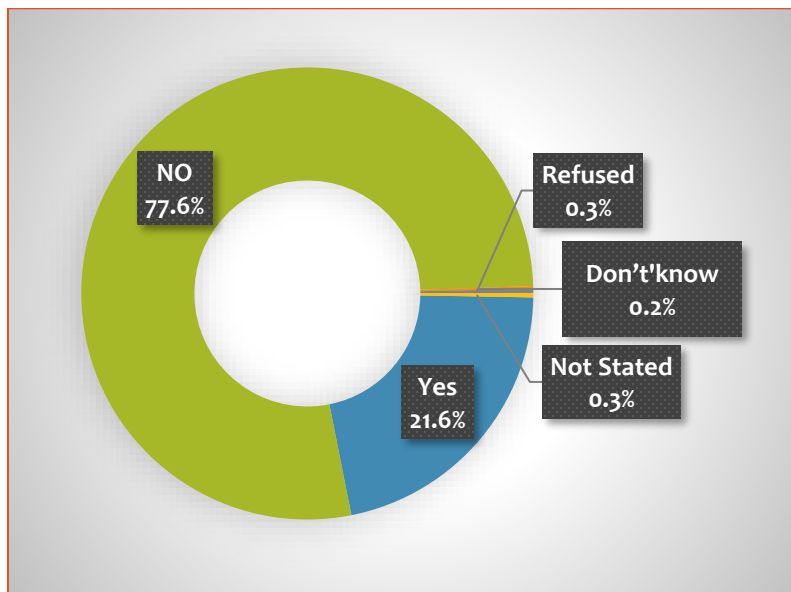
FIGURE 5-1: PROPORTION OF THE POPULATION REPORTING CHRONIC ILLNESSES OR UNDERLYING CONDITIONS

The data showed that a greater proportion of females (29.1%) than males (13.8%) had a chronic illness or underlying condition. The data also shows that the proportion of persons with comorbidities increases with age. It is estimated that one in two persons 70 years or older have an underlying condition as opposed to one in 10 among persons aged 10 to 29 years old.

At the parish level, one in five persons reported having a chronic illness or underlying condition. However, the parish of Manchester had the highest proportion (one in four) of persons with comorbidities, whereas Westmoreland had the lowest proportion (18.4%).

	Yes	
	N	% of Pop
Sex		
Male	159,500	13.8
Female	343,700	29.1
Age Group		
Age 10 - 29	104,100	10.9
Age 30 - 49	132,500	17.8
Age 50 - 69	179,100	37.6
Age 70 plus	87,500	53.3
Parish of Residence		
Kingston	15,000	19.3
St. Andrew	108,800	21.8
St. Thomas	19,300	23.6
Portland	14,700	20.4
St. Mary	22,100	22.2
St. Ann	33,400	22.3
Trelawny	13,300	20.3
St. James	32,700	21.3
Hanover	11,500	19.3
Westmoreland	23,000	18.4
St. Elizabeth	30,100	22.5
Manchester	41,800	25.0
Clarendon	45,400	21.8
St. Catherine	92,000	20.9
Jamaica	**503,300**	**21.6**

Of the 21.6 per cent or 503,300 persons who were estimated to have a chronic illness, approximately 270,500 had hypertension or other cardiovascular diseases and 139,900 had asthma. Additionally, approximately 117,100 Jamaicans were estimated to have diabetes. It is important to note that this was a multi-select question, and therefore persons may have multiple comorbidities. The data however shows that the median number of comorbidities was one with a maximum of four of the listed comorbidities reported. Other conditions mentioned were cancer and autoimmune diseases such as lupus.
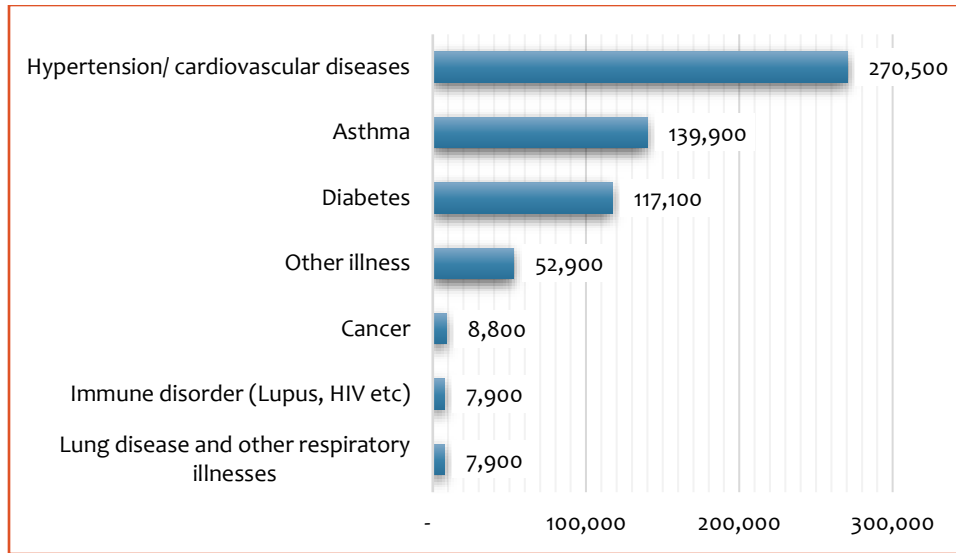
FIGURE 5-2: NUMBER OF PERSONS WHO REPORTED A CHRONIC ILLNESS BY CONDITION

A total of 270,500 or one in nine of the population is estimated to have hypertension or other cardiovascular diseases. More than twice as many females, relative to their male counterparts, are estimated to have this comorbidity. The data also shows that the proportion of the population with this underlying condition increased notably with age. One per cent of persons 10 to 29 years old is estimated to have hypertension or other cardiovascular diseases. However, this proportion increases to 36.9 per cent among persons 70 years or older. The data also shows that the proportion of the population with hypertension or other cardiovascular diseases was highest in the southeast region at 22.5 per cent. The proportion of the population with this condition was however lowest in the north eastern region at 7.8 per cent.

TABLE 5-2: TOP THREE COMORBIDITIES REPORTED BY SEX, AGE AND PARISH OF RESIDENCE[3]

	Hypertension and other cardiovascular diseases		Asthma		Diabetes	
	N	% of Pop	N	% of Pop	N	% of Pop
Sex						
Male	80,500	6.9	36,500	3.1	37,800	3.3
Female	190,100	15.9	103,400	8.7	79,300	6.6
Age Group						
Age 10 to 29	10,100	1.0	77,800	8.1	*	*
Age 30 to 49	66,000	8.8	39,500	5.3	22,700	3.0
Age 50 to 69	132,400	27.6	17,800	3.7	53,800	11.2
Age 70 plus	62,000	36.9	*	*	36,900	22.0
Region of Residence						
SRHA	67,600	13.4	29,300	5.8	26,300	5.2
SERHA	113,300	22.5	75,300	15.0	54,600	10.9
NERHA	39,400	7.8	15,900	3.2	17,000	3.4
WRHA	50,200	10.0	19,400	3.9	19,200	3.8
Total	**270,500**	**11.5**	**139,900**	**5.9**	**117,100**	**5.0**

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[3] '*****' value suppressed due to high standard error

Asthma was the second most common underlying condition, with approximately six per cent or 139,900 persons estimated to have this condition. A larger proportion of females (8.7%) than males (3.1%) are estimated to have asthma. The prevalence of the disease was higher among younger persons, declining as persons got older. A greater proportion of persons with asthma was recorded in the region with the highest level of urbanization, SERHA. In this region, the proportion of the population estimated to have asthma was 15.0 per cent.

The survey estimates that five per cent of the population is diabetic. More than twice as many females (79,300) are estimated to have this underlying condition, when compared to their male counterparts (37,800). The data also shows that the prevalence of this disease increases with age. The estimated proportion of the population with diabetes was lowest among persons aged 30 to 49 years old (3.0%) and highest among those 70 years and older (22.0%). Geographically, the proportion of the population who are estimated to have diabetes ranges from 3.8 per cent in the western region to 10.9 per cent in the south eastern region.

TABLE 5-3: PERCENTAGE OF PERSONS HAVING CHALLENGES ACCESSING MEDICAL CARE AND MEDICATION FOR A NON-COVID-19 ILLNESSES

	Access to Medical Care		Access to Medication	
	N	%	N	%
Yes	12,700	2.5	12,800	2.6
No	488,900	97.1	488,500	97.1
Don't Know	1,600	0.3	1,900	0.4
Total	503,300	100.0	503,300	100.0

The persons who indicated that they have a chronic illness were also asked during the survey if they experienced any difficulty in the three weeks before the survey accessing medical care services or medication for their chronic condition. Most persons who responded to the question indicated that they did not experience any difficulty accessing services (97.1 %) or medication (97.1 %). Of note however is the estimated 12,700 persons who had difficulty accessing medical care, and the 12,800 who experienced challenges accessing medication.

6 Knowledge

This survey assessed the knowledge of Jamaicans regarding the pandemic during the period April to June 2020. This was the early stages of the pandemic in Jamaica. It should be noted that the awareness of the population regarding the virus may change over time.

6.1 Source of information

Understanding the source from which persons get information about COVID-19 is a critical part of the strategy to prevent and curb the spread of COVID-19. Officials can publicize information through more popular channels and can target certain demographic groups through a specific medium. It is also important to know if the population is getting information through trusted sources as misinformation can have dire consequences. Most of the Jamaican population (82.8%) received their information about COVID-19 from local traditional media (television, radio, newspaper). Social media pages (Instagram, Facebook, and Twitter, etc.) was the second most popular source mentioned by 47.5 per cent of persons. Other sources of information included Family and Friends (18.2%), International traditional media such as TV, radio and newspaper (15.5%) and Official GOJ press conferences and social media (13.3%).
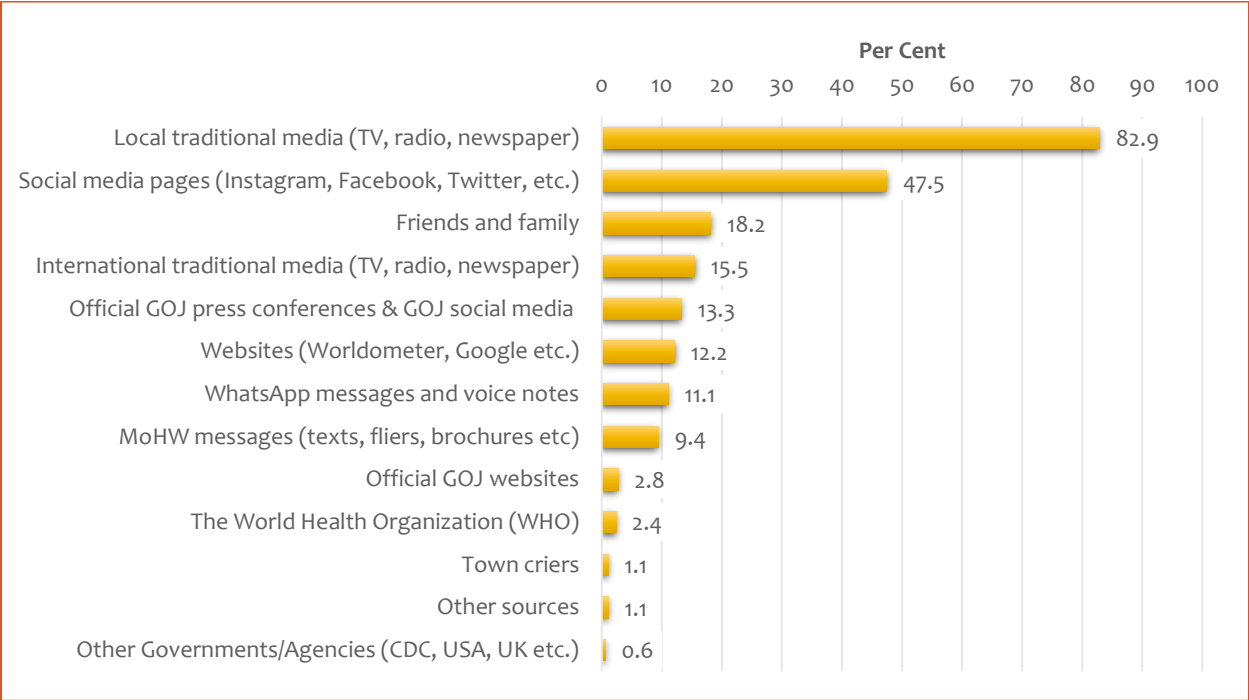

FIGURE 6-1: SOURCES OF INFORMATION ON CORONAVIRUS

The sources of information were grouped into Official sources, Traditional Media and Other Sources for the purpose of analysis. These are defined as follows:

- Official Sources
    - Official GOJ press conferences and GOJ social media accounts
    - MoHW messages (texts, fliers, brochures etc)
    - Official GOJ websites

- o Other Governments/Agencies (CDC, USA, UK etc.)
- o The World Health Organization (WHO)
- Traditional Media
  - o Local traditional media (television, radio, newspaper)
  - o International traditional media (television, radio, newspaper)
- Other Sources
  - o Friends and family
  - o Social media pages (Instagram, Facebook, Twitter, etc.)
  - o WhatsApp messages and voice notes
  - o Town criers
  - o Websites (Worldometer, Google etc.)
  - o Other

The data shows that people on average consulted two or more sources for information on COVID-19. The data also shows that women were more likely than men to consult multiple sources, and the number of sources consulted declines with age.

Official Sources
- **Age 10 to 29**
  - 23.1%
- **Age 30 to 49**
  - 24.3%
- **Age 50 to 69**
  - 22.2%
- **Age 70 and older**
  - 12.7%

Traditional Media
- **Age 10 to 29**
  - 81.0%
- **Age 30 to 49**
  - 87.6%
- **Age 50 to 69**
  - 95.8%
- **Age 70 and older**
  - 94.7%

Other Sources
- **Age 10 to 29**
  - 76.8%
- **Age 30 to 49**
  - 67.0%
- **Age 50 to 69**
  - 45.0%
- **Age 70 and older**
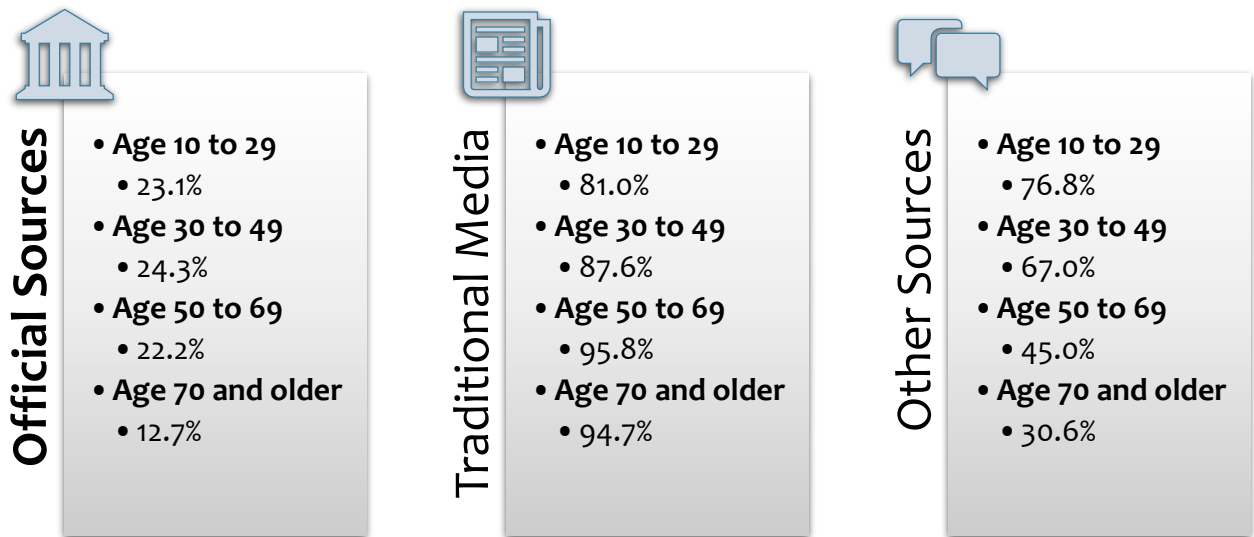 - 30.6%

FIGURE 6-2: SOURCES OF INFORMATION BY AGE

The data reveals that older persons were less likely to obtain information on COVID-19 from Official and Other Sources. They were more likely to get information regarding the virus from Traditional Sources. The use of other sources of information including WhatsApp and Social Media was more prevalent among younger persons than older persons.

TABLE 6-1: SOURCES OF INFORMATION BY HEALTH REGION AND EDUCATIONAL ATTAINMENT[4]

	Official Sources		Traditional Media		Other Sources	
	N	% of Pop	N	% of Pop	N	% of Pop
Health Region						
SRHA	100,200	19.5	458,400	89.2	314,100	61.1
SERHA	256,300	23.1	929,400	83.9	728,700	65.8
NERHA	66,100	20.4	288,200	89.0	210,000	64.8
WRHA	108,700	26.5	376,700	91.8	253,500	61.8
Educational Attainment						
Pre-school to Lower Secondary	75,600	12.2	575,900	92.9	276,700	44.6
Upper Secondary to Post-secondary, non-tertiary	264,600	22.1	1,020,600	85.1	842,000	70.2
Tertiary	142,700	42.9	278,000	83.6	239,100	71.9
Other	44,900	25.5	155,900	88.4	135,300	76.8
Refused	*	*	22,200	76.3	13,200	45.4
Total	**531,200**	**22.5**	**2,052,700**	**87.1**	**1,506,300**	**63.9**

The data also showed little disparity in information source across regions, with the use of other information sources being most prevalent in SERHA & NERHA. The use of Official Sources and Traditional media was most prevalent in the western end of the country (WRHA).

Persons with a higher level of educational attainment were more reliant on official sources of information. Just over one in 10 persons with *pre-school to lower secondary level education* used official sources, this number increased to four out of ten for persons with tertiary level education. The use of traditional media sources was highest among persons with *pre-school to lower secondary level education*. The use of other sources including social media and WhatsApp was lowest among this cohort at 44.6 per cent, and among those who *refused* to state their educational attainment. This proportion however increased to over 70 per cent, among persons with upper secondary or higher levels of education.

6.2 Knowledge of COVID-19 Symptoms and Infection Prevention and Control Measures

Respondents were asked a set of true and false questions to help assess the level of knowledge within the population about the COVID-19 disease, how it is spread and the symptoms. A little over one-half (54.0%) said it was true that only persons with symptoms can infect others. Four out of ten persons (40.3%) said it was true that only the elderly and those with underlying conditions will get sick from the virus. Approximately 38 per cent said it was true that a person who has a runny nose does not have the virus. One in ten persons (12.2%) believe that if you have not travelled, you are not at risk of contracting COVID-19. Most persons (82.0%) agreed that persons can recover with early treatment.

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[4] '*' value suppressed due to high standard error

TABLE 6-2: KNOWLEDGE OF THE SYMPTOMS AND SPREAD OF COVID-19

Statements	True	False	Don't Know
Only persons with symptoms of the COVID-19 are able to infect others.	54.0	43.1	2.9
Only the elderly and those with underlying conditions will get really sick from COVID-19.	40.3	56.9	2.8
Patients usually recover from COVID-19 if they get medical care early.	82.0	11.3	6.7
If I have a runny nose, I do not have COVID-19.	38.4	53.8	7.8
I did not travel recently, therefore I do not have COVID-19.	12.2	85.3	2.6

6.2.1 Knowledge of COVID-19 Symptoms

The Ministry of Health and Wellness (MoHW) advises that the most common symptoms of COVID-19 are fever, fatigue (tiredness), and dry cough. They also advise that some patients may have aches and pains, nasal congestion, runny nose, sore throat or diarrhoea. Understanding the perceptions of the symptoms within the population is a critical source of information that could inform the disease management communication strategies.

During the 2020 COVID-19 KAP Survey, respondents were asked to identify the symptoms of COVID-19. The three most mentioned symptoms were dry coughing (74.8%), fever, and other flu-like symptoms (66.9%), and sneezing (49.3%). Less than one-third of respondents (32.4%) mentioned shortness of breath/difficulty breathing and 19.1 per cent said that a cold is also a symptom of COVID-19. It is noted that some of the popular symptoms mentioned, such as sneezing, are not listed by the MoHW as a symptom of the disease. Additionally, some of the symptoms identified by the MoHW are unknown to much of the population.
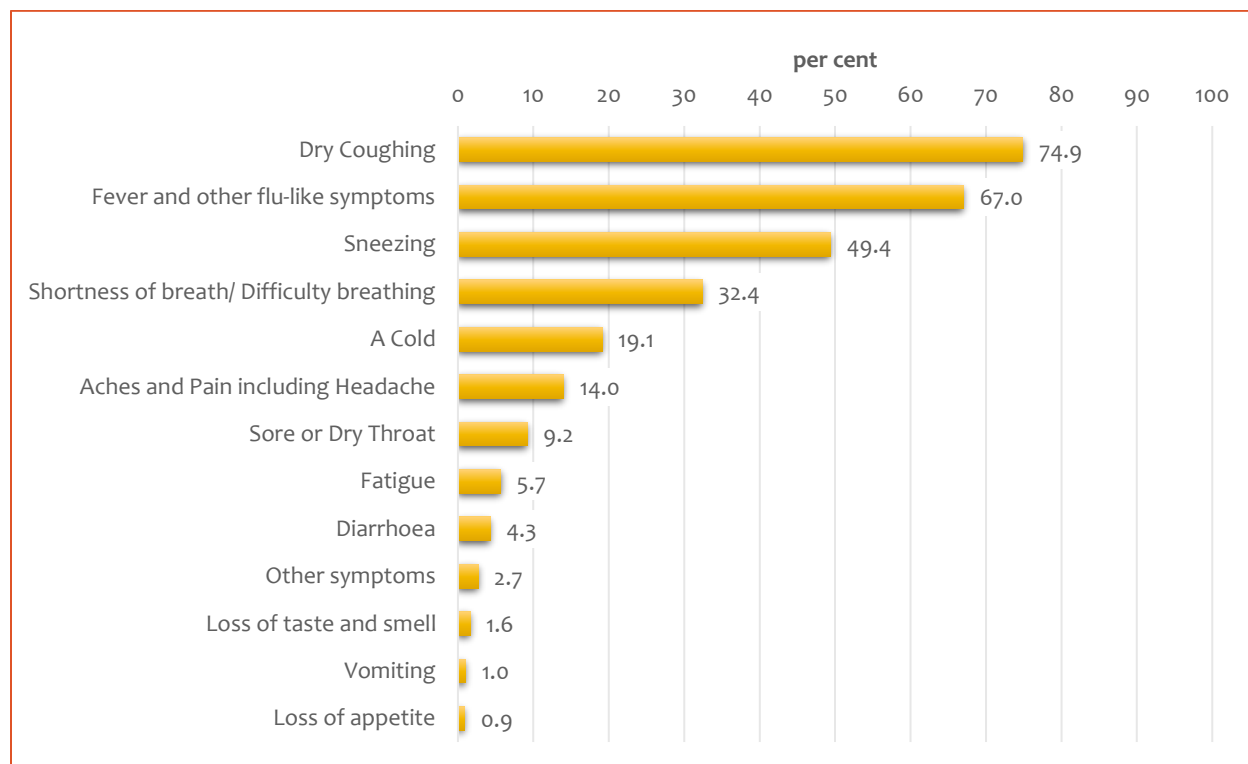

**FIGURE 6-3: KNOWLEDGE OF THE SYMPTOMS OF COVID-19, APRIL TO JUNE 2020**

Knowledge of the symptoms of COVID-19 was assessed by source of information. The data shows that the source of information did not have a notable impact on persons knowledge of the symptoms of COVID-19. This may be because persons on average obtained information from multiple sources.

TABLE 6-3: KNOWLEDGE OF THE SYMPTOMS OF COVID-19 BY SOURCE OF INFORMATION, APRIL TO JUNE 2020

	Official Source	Traditional Media	Other Source	Total
Dry Coughing	79.0	75.9	77.3	74.8
Fever and other flu-like symptoms	76.4	67.4	69.7	66.9
Sneezing	48.1	50.0	50.7	49.3
Shortness of breath/ Difficulty breathing	40.7	32.2	35.2	32.4
A Cold	22.0	19.6	20.4	19.1
Aches and Pain including Headache	16.6	14.3	15.0	14.0
Sore or Dry Throat	9.4	9.3	10.9	9.2
Fatigue (tiredness)	6.3	5.6	6.5	5.6
Diarrhoea	5.9	4.1	4.7	4.3
Other symptoms	2.8	2.3	3.0	2.7
Loss of taste and smell	3.2	1.4	1.8	1.6
Vomiting	0.8	1.0	1.2	1.0
Loss of appetite	2.1	0.9	0.9	0.9

6.2.2   Knowledge of COVID-19 Infection Prevention and Control Measures

Medical research shows that infectious diseases can be spread in three main ways: through the air, person to person contact and by touching contaminated objects or surfaces. The MoHW advises that "*some coronaviruses can be transmitted from person to person, usually after close contact with an infected patient*". According to the WHO "*Current evidence suggests that COVID-19 spreads between people through direct, indirect (through contaminated objects or surfaces), or close contact with infected people via mouth and nose secretions. These include saliva, respiratory secretions or secretion droplets. These are released from the mouth or nose when an infected person coughs, sneezes, speaks or sings, for example*" (WHO, 2020).
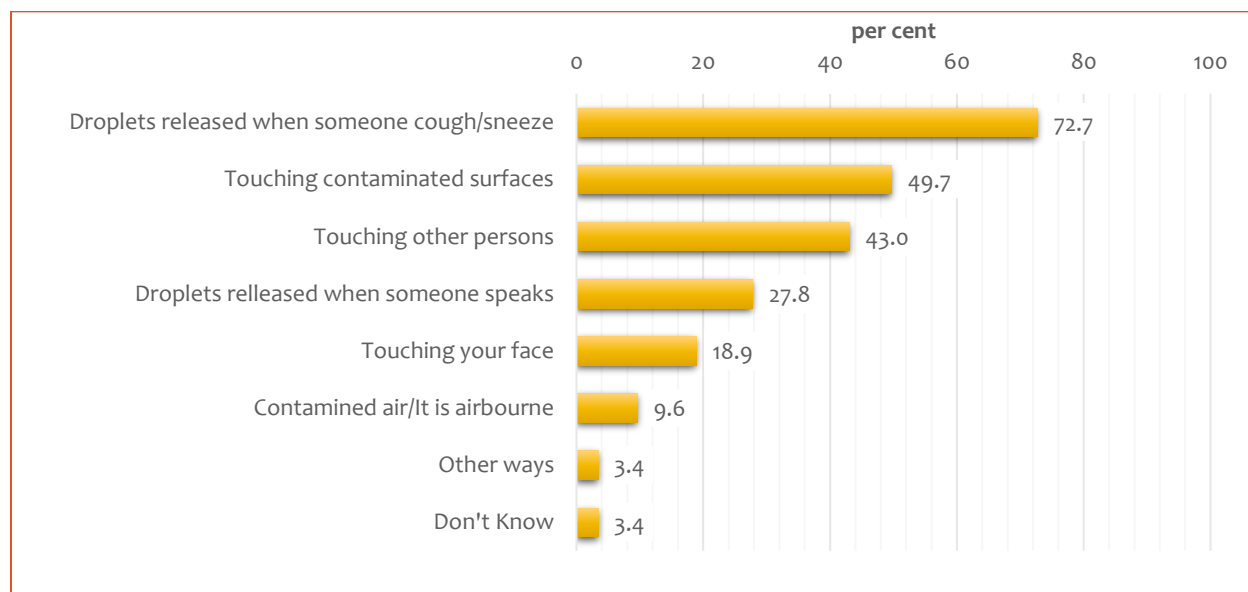
FIGURE 6-4: KNOWLEDGE OF THE SPREAD OF THE NOVEL CORONAVIRUS

During the survey, most persons (72.7%) indicated that the novel Coronavirus could be spread through droplets released when someone coughs or sneezes. Just about one-half (49.7%) of the population stated that touching contaminated surfaces is one way that the virus is spread. Forty-three per cent indicated that the virus can be spread through person to person contact. The data shows that approximately one in four persons acknowledge that the virus may be spread through droplets which are released when someone speaks.

When disaggregated by age, the data shows a difference in the knowledge about the transmission of the virus. The proportion of persons who acknowledge that the virus may be spread when someone coughs ranges from a high of 76.0 per cent among persons 30 to 49 years old to a low of 58.7 per cent among those who were 70 years or older. Just over one half of persons in the age groups 10 to 29 years old and those 30 to 49 years old acknowledge that the virus was spread through touching contaminated surfaces. This proportion declines to just over one third of persons 70 years or older.
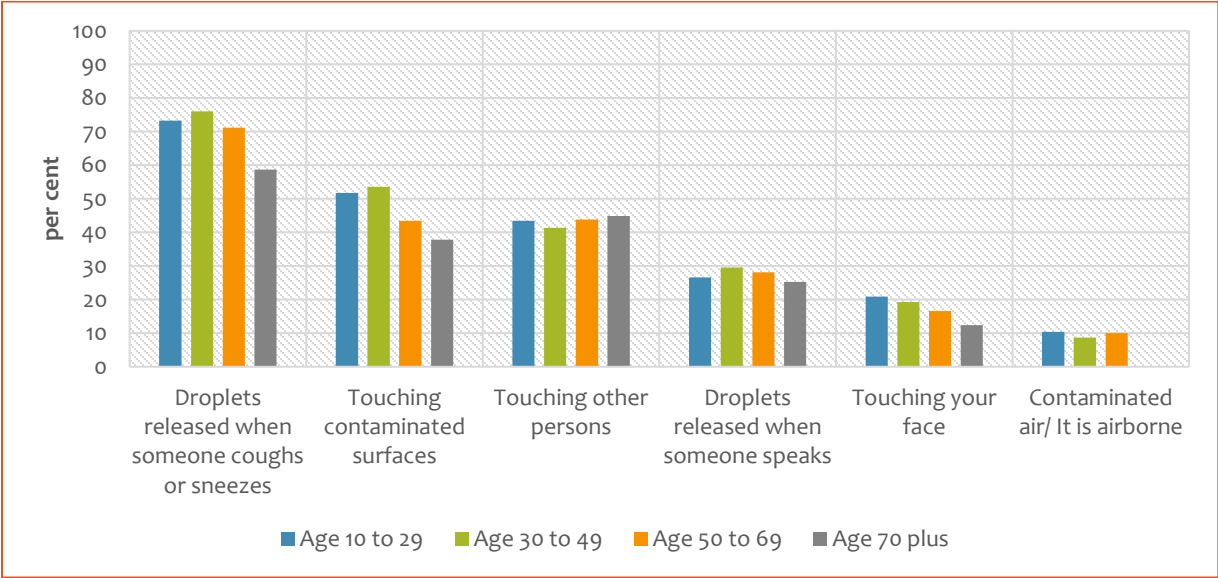

FIGURE 6-5: KNOWLEDGE OF THE SPREAD OF THE NOVEL CORONAVIRUS BY AGE

Respondents were asked what they should do if they encountered a person who tested positive for COVID-19. Multiple responses were allowed, and on average there were two actions mentioned. When asked, six out of every ten persons (59.7%) indicated that they would call the Ministry of Health and Wellness (COVID Hotline). Additionally, just over one-half (51.6%) would stay at home and self-isolate if they found out that they encountered a person who tested positive for COVID-19.
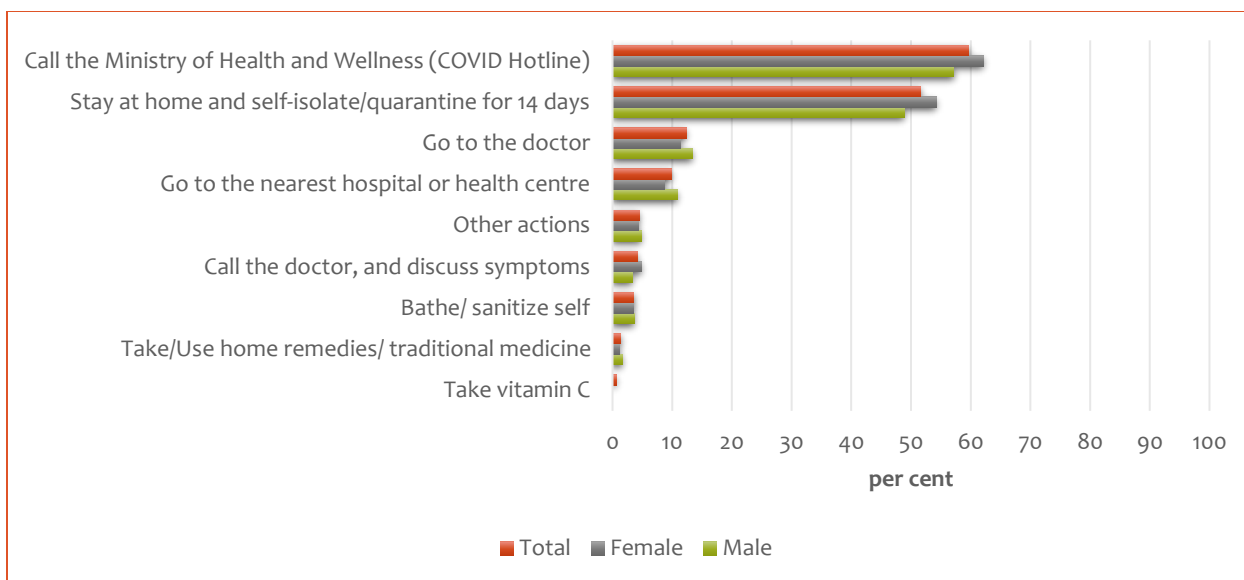
FIGURE 6-6: KNOWLEDGE OF STEPS THAT WOULD BE TAKEN IF A PERSON COMES IN CONTACT WITH A COVID-19 POSITIVE CASE

The survey revealed that the proportion of persons who indicated that they would call the COVID-19 hotline or self-isolate declines with age. On the other hand, the proportion of persons who indicated that they would visit the doctor increases with age. Going to the nearest hospital or health centre was largely consistent across age groups, with one in ten persons indicating this action.

TABLE 6-4: KNOWLEDGE OF STEPS TO BE TAKEN IF A PERSON COMES IN CONTACT WITH A COVID-19 POSITIVE CASE BY AGE[5]

	Age 10 to 29	Age 30 to 49	Age 50 to 69	Age 70 plus	Total
Call the Ministry of Health and Wellness (COVID Hotline)	61.0	63.1	56.9	45.1	59.7
Stay at home and self-isolate/quarantine for 14 days	56.1	54.3	44.3	35.5	51.6
Go to the doctor	9.1	10.9	15.8	27.3	12.4
Go to the nearest hospital or health centre	10.3	9.6	9.1	9.8	9.8
Other actions	4.9	3.8	5.2	*	4.5
Call the doctor, and discuss symptoms	3.9	3.8	4.3	*	4.1
Bathe/ sanitize self	4.2	3.5	3.0	*	3.6
Take/Use home remedies/ traditional medicine	*	1.5	1.9	*	1.4
Take vitamin C	*	*	*	*	0.6

Widespread knowledge about what to do if persons have symptoms of COVID-19 is necessary to help restrict the spread of the virus. The Ministry of Health and Wellness advises persons who are feeling sick to stay at home and avoid contact with others. The MoHW also advises that persons should call the JAMCOVID-19 Hotline, a doctor or health facility to inform them of their symptoms and follow the instructions provided. Persons are further advised to monitor their symptoms and follow all other protocols to prevent further spread. To assess awareness of the actions to take if a person presents with some common COVID-19 symptoms, persons were asked: *"What should you do if you have a respiratory tract*

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infection, such as cold, congestion or difficulty breathing?" It should be noted that this was a multiple response question as persons can take several actions in response to feeling ill.
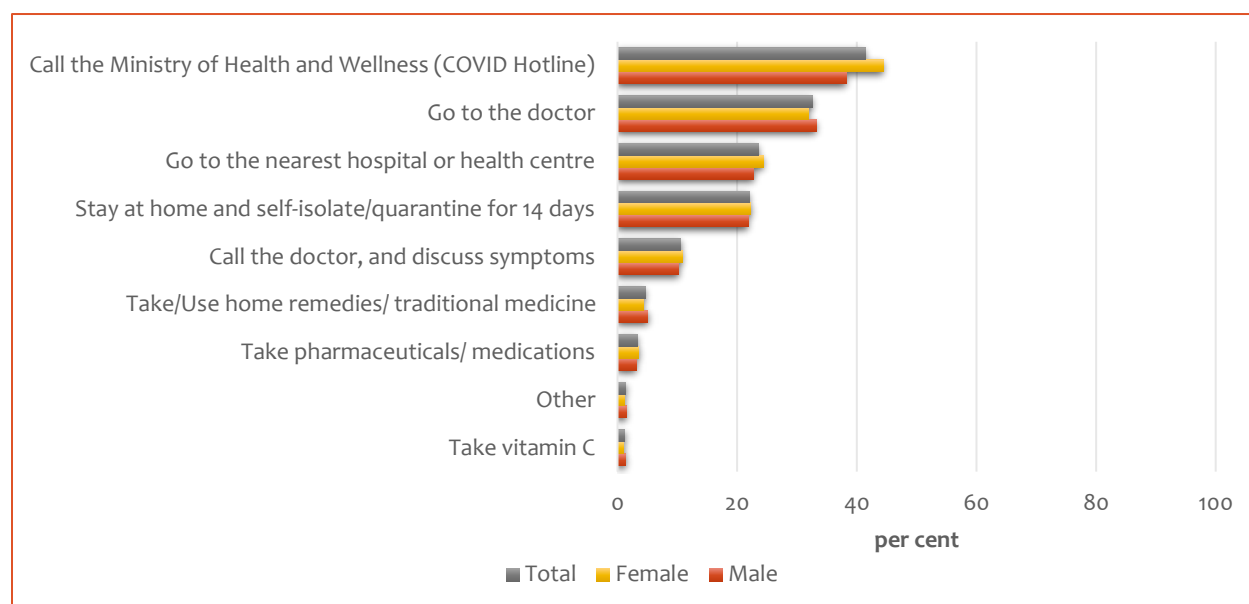

FIGURE 6-7: KNOWLEDGE OF STEPS THAT WOULD BE TAKEN IF A PERSON HAS A RESPIRATORY TRACT INFECTION

Four out of every 10 persons (41.4%) indicated that they would call the Ministry of Health and Wellness JAMCOVID-19 Hotline. Almost one-third of the population (32.6%) mentioned that they would go to the doctor and just under one-quarter (23.6%) said they would go to the nearest hospital or health centre. It should be noted that 22.1 per cent indicated that they would stay home and self-isolate for 14 days.

The data shows that a person's response to a respiratory tract infection varies by age. Relative to persons 70 years or older, a greater proportion of persons indicated that they would call the JAMCOVID hotline. A similar pattern was observed regarding visiting the nearest hospital or health centre, and self-isolation. On the other hand, persons 70 years or older were most likely to go to the doctor, if they had a respiratory tract infection.

TABLE 6-5: KNOWLEDGE OF STEPS THAT WOULD BE TAKEN IF A PERSON HAS A RESPIRATORY TRACT INFECTION BY AGE[6]

	Age 10 to 29	Age 30 to 49	Age 50 to 69	Age 70 plus	Total
Call the Ministry of Health and Wellness (COVID Hotline)	41.0	46.0	39.9	28.0	**41.4**
Go to the doctor	29.3	30.4	37.6	46.2	**32.6**
Go to the nearest hospital or health centre	26.6	23.1	20.9	16.3	**23.6**
Stay at home and self-isolate/quarantine for 14 days	25.7	23.7	15.9	12.0	**22.1**
Call the doctor, and discuss symptoms	9.7	10.7	11.8	11.5	**10.6**
Take/Use home remedies/ traditional medicine	3.9	4.8	6.0	*	**4.7**
Take pharmaceuticals/ medications	3.3	3.1	3.2	*	**3.3**
Other	1.8	1.2	*	*	**1.4**
Take vitamin C	1.4	1.2	*	*	**1.2**

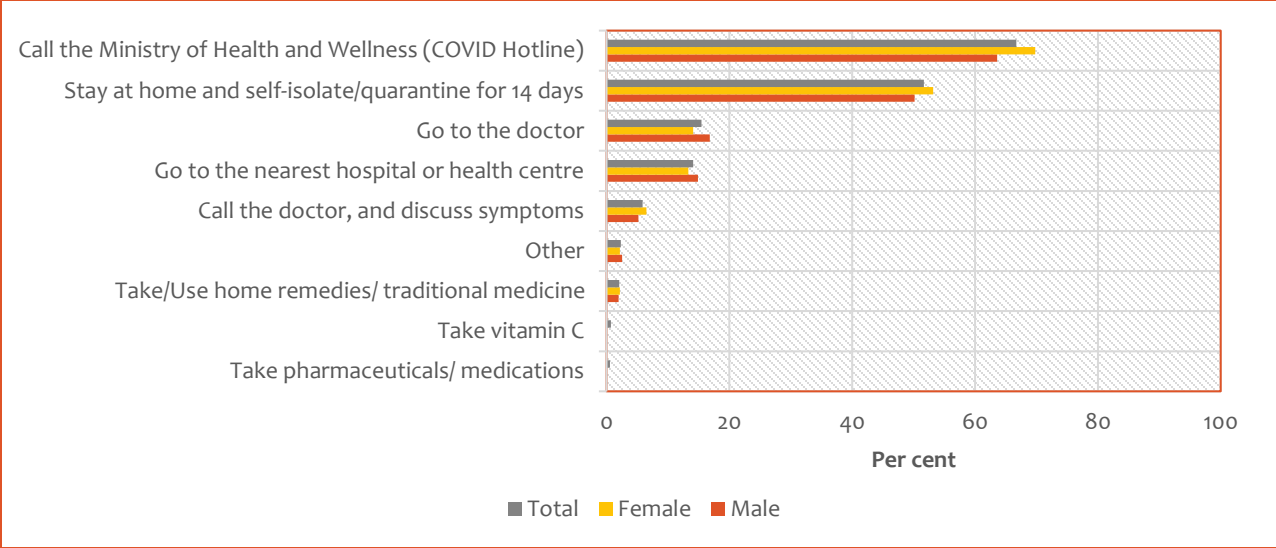[6] '*' value suppressed due to high standard error

FIGURE 6-8: KNOWLEDGE OF STEPS TO BE TAKEN IF A PERSON HAS SYMPTOMS OF COVID-19

In the event persons did not think of a respiratory tract infection as a symptom of COVID-19, they were explicitly asked what steps should be taken if they had symptoms of the virus. Two-thirds of the population (66.7%) indicated that they would call the Ministry of Health and Wellness (COVID Hotline). A little over one-half (51.7%) indicated that they would stay at home and self-isolate/quarantine for 14 days.

TABLE 6-6: KNOWLEDGE OF STEPS TO BE TAKEN IF A PERSON HAS SYMPTOMS OF COVID-19 BY AGE

	Age 10 to 29	Age 30 to 49	Age 50 to 69	Age 70 plus	Total
Call the Ministry of Health and Wellness (COVID Hotline)	69.2	70.7	62.9	46.1	**66.7**
Stay at home and self-isolate/quarantine for 14 days	55.8	55.0	45.1	32.0	**51.7**
Go to the doctor	11.5	13.5	20.4	33.1	**15.5**
Go to the nearest hospital or health centre	15.9	12.6	11.6	17.0	**14.1**
Call the doctor, and discuss symptoms	5.6	5.7	6.1	*	**5.9**
Other	2.8	2.0	1.9	*	**2.3**
Take/Use home remedies/ traditional medicine	*	2.2	3.2	*	**2.1**
Take vitamin C	*	*	*	*	**0.7**
Take pharmaceuticals/ medications	*	*	*	*	**0.5**

6.3   Knowledge of Treatment Options for COVID-19

There is currently no known treatment for COVID-19, but in some cultures, there is a traditional system of belief around the causes of the illness and how it can be cured. This may include homoeopathic remedies and the use of plants to treat certain ailments. In Jamaica, it is not uncommon for persons to use home remedies to treat illnesses. The survey data shows that there is a level of belief in Jamaica, that COVID-19 may be treated with traditional herbal medicines. Respondents were asked about the treatment options for COVID-19. Persons could indicate multiple responses, which were later grouped for analysis purposes. The response options were grouped as follows:

Nothing/ There is no treatment

Over-the-counter medication

- Paracetamol (Cetamol, Panadol etc.)
- Acetaminophen (Tylenol, Sudafed etc.)
- Ibuprofen (Brufen, Advil, Motrin etc.)

Home Remedies

- Vitamin C
- Garlic
- Ginger
- Lemon grass (fever grass)
- Other Home remedies/Traditional medicine

Other Treatment Options

Don't know

When asked what may be used to treat COVID-19, almost one-half of the population indicated that they did not know, (48.3%) and near one-quarter (23.8%) stated that there was no treatment. One in every five persons (20.0%) said that home remedies such as garlic, ginger and lemongrass could be used as treatment.

TABLE 6-7: KNOWLEDGE OF COVID-19 TREATMENT OPTIONS[7]

	Nothing/ There is no treatment	Over-the-counter Medication	Home remedies/ Traditional medicine	Other	Don't Know
Sex					
Male	24.7	3.1	19.7	5.9	48.8
Female	23.0	7.4	20.3	6.3	47.7
Age Group					
Age 10 to 29	22.7	4.3	18.6	6.7	50.7
Age 30 to 49	26.2	6.8	20.6	6.1	44.5
Age 50 to 69	23.2	5.5	22.3	5.3	47.4
Age 70 plus	20.9	3.5	18.8	*	53.6
Region					
SHRA	25.9	5.4	19.3	8.6	45.5
SERHA	22.4	5.2	19.5	5.2	51.1
NERHA	17.6	6.0	21.7	6.7	51.4
WRHA	29.9	4.6	20.8	4.9	41.7
Total	**23.8**	**5.3**	**20.0**	**6.1**	**48.3**

A large proportion of persons who think that COVID-19 can be treated with home remedies suggested herbal medicines including turmeric, lemon grass and bissy (kola nut). A notable number of persons also

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[7] '*****' value suppressed due to high standard error

indicated using various warm/ hot concoctions such as teas and steam and citrus based concoctions as treatment for COVID-19.
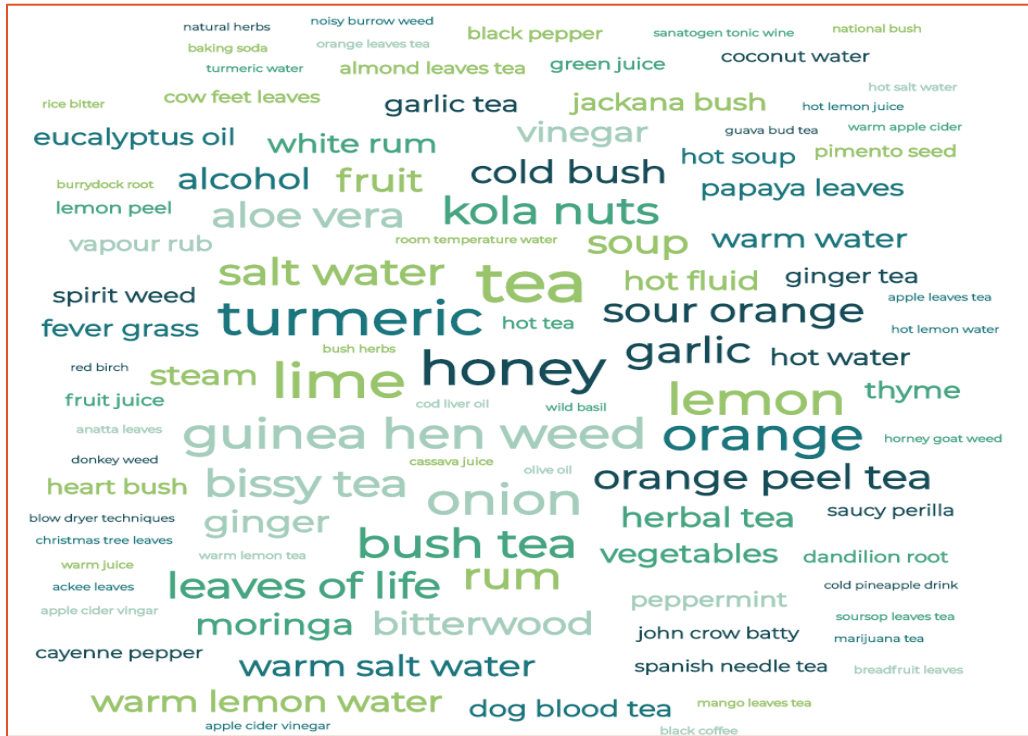
FIGURE 6-9: HOME REMEDIES BEING USED TO TREAT COVID-19

7 Attitudes

7.1 Perception of Individual Risk

An individual's perceived susceptibility to a particular risk is a critical aspect of health behaviour change programmes. Research has shown that there is an association between risk perception and behaviour. During the 2020 COVID-19 KAP Survey, respondents were asked who they believed was most at risk of contracting COVID-19; respondents could provide multiple responses. The survey shows that elderly persons 65 years and over were perceived to be most at risk. This was mentioned by 61.9 per cent of the respondents; another 34.3 per cent said persons with underlying conditions. The third most popular answer given by 23.1 per cent or respondents was children.

per cent

Category	Value
Elderly (65 years or older)	61.9
Persons with underlying conditions	34.3
Children (under 18 years old)	23.1
Everyone	9.7
Adults (25 – 64 years old)	9.1
Young people (18 - 24 years old)	7.6
Health care workers	7.3
Soldiers, police and other essential workers	6.4
Women	4.5
Persons with poor hygiene	4.5
Men	4.0
People not following the rules	3.4
Foreigners/persons who recently travelled overseas	3.2
Persons in contact with people who travelled overseas	3.2
The poor and persons living in inner city communities	2.7
Other	1.9
Service workers (taximen & supermarket workers)	1.5
Commuters	1.2

FIGURE 7-1: PERCEPTION OF WHO IS MOST AT RISK FOR CONTRACTING COVID-19

The data showed that there was some disparity in the perception of risk across sex, age and Health Regions. A greater proportion of females than males identified the top eight groups perceived to be at risk for contracting the virus. This was also true for persons living in the western region relative to the other health regions.

FIGURE 7-2: PERCEPTION OF WHO IS MOST AT RISK FOR CONTRACTING COVID-19 (TOP 8 REASONS) BY SEX, AGE AND HEALTH REGION

7.2   Perception of Community Risk

Perception of community risk of COVID-19 was also assessed in the survey. Persons were asked whether they thought their community was at risk of a COVID-19 outbreak. Most persons did not believe that their community was at risk of a COVID-19 outbreak (70.7%) while 17.9 per cent thought that their community was at risk of an outbreak.
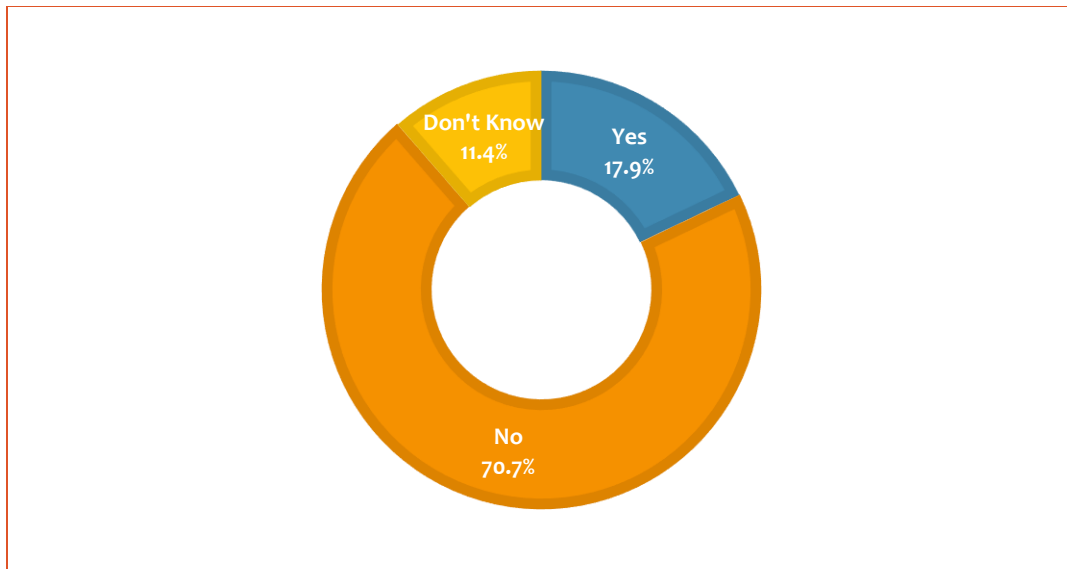
FIGURE 7-3: PERCEPTION OF COMMUNITY RISK OF COVID-19 OUTBREAK

The data shows a disparity in the perception of community risk across age group, health region and level of education. The proportion of males (17.5%) and females (18.3%) who perceived that their community was at risk was relatively equal. It is however observed that there was a lower proportion of older persons who perceived that their community was at risk for an outbreak of COVID-19. Additionally, those residing in the most populated health region (SERHA) had the highest perception of risk, while those who attained lower levels of education had the lowest perception of risk of a community outbreak.

TABLE 7-1: PERCEPTION OF COMMUNITY RISK OF COVID-19 OUTBREAK BY SEX, AGE, HEALTH REGION AND EDUCATIONAL ATTAINMENT[8]

	Yes	No	Don't Know
Sex			
Male	17.5	73.0	9.5
Female	18.3	68.4	13.3
Age Group			
Age 10 to 29	19.0	70.8	10.2
Age 30 to 49	20.5	67.8	11.8
Age 50 to 69	15.6	73.8	10.5
Age 70 and older	*	74.0	19.2
Health Region			
SHRA	13.3	77.2	9.6
SERHA	22.5	62.9	14.6
NERHA	19.2	71.5	9.4
WRHA	10.5	82.8	6.7
Educational Attainment			
Pre-school to Lower Secondary	12.5	75.3	12.2
Upper Secondary to Post-secondary	18.3	71.7	9.9
Tertiary	27.1	56.7	16.2
Other	18.6	73.0	8.4
Total	**17.9**	**70.7**	**11.4**

Among the reasons given by those persons who believed that their community was at risk of a COVID-19 outbreak were *'People are not taking it seriously'* (34.3%), *'We do not practice social distancing'* (30.4%) and *'People do not comply with curfews and other orders'* (19.7%). Non-compliance with the recommended risk reduction strategies was the main reason persons believed that there would be an outbreak in their community. Another 17.3 per cent of respondents thought that there was a likelihood of community outbreak of the virus because persons in the neighbourhood take public transportation.

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[8] '*** value suppressed due to high standard error

FIGURE 7-4: PROPORTION OF THE POPULATION BY REASONS FOR BELIEVING THAT THEIR COMMUNITY IS AT RISK, APRIL TO JUNE 2020

Approximately 70 per cent or 1,662,900 persons believed that their community was not at risk, the most popular reasons were 'No *one in my community has it'* (56.1%), *'People are taking it seriously/there has been a community response'* (30.2%), *'We practice social distancing'* (32.8%), *'People comply with the curfews, and other orders'* (22.1%) and *'Most persons wear masks when outside (20.9%).*

FIGURE 7-5: PROPORTION OF THE POPULATION BY REASONS FOR BELIEVING THAT THEIR COMMUNITY IS <u>NOT</u> AT RISK, APRIL TO JUNE 2020

For persons who indicated that they believed their community was at risk for an outbreak of COVID-19, respondents were asked whether they thought that persons with COVID-19 were present in their community. Many persons either did not think or did not know whether persons with COVID-19 were in their community.
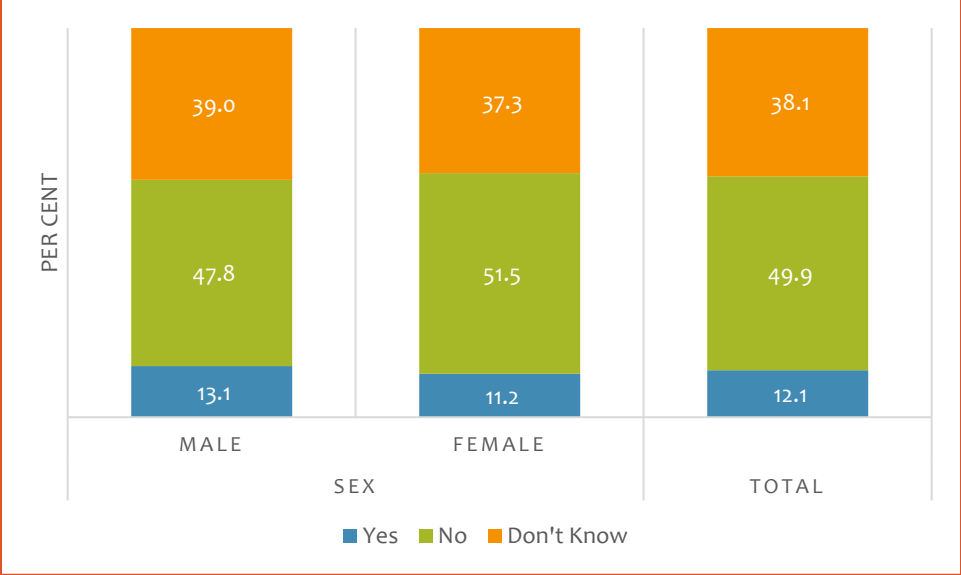
FIGURE 7-6: PERCEPTION OF THE PRESENCE OF COVID-19 IN COMMUNITIES BY SEX, APRIL TO JUNE 2020

7.3   Attitudes Towards the Management of COVID-19

Ten statements were included on the survey questionnaire in the form of five-point Likert scale questions with responses ranging from strongly agree to strongly disagree. These questions were aimed at gauging people's opinions about the novel Coronavirus and the response of the relevant authorities and the population to the virus. For this analysis, the response categories strongly agree and agree were combined, likewise disagree and strongly disagree.

Since the start of the pandemic, the Government of Jamaica and the Ministry of Health and Wellness (MoHW) have implemented several strategies to contain the spread of the virus. The strategies include localized and island-wide curfews, the restriction of some public events, development of a COVID-19 hotline, among other public education and communication strategies. Approximately 86 per cent of persons agreed that the public health authorities were doing enough to control the spread of the virus. In response to the statement concerning the cancellation of mass gatherings such as parties, sporting events, weddings, and funerals, 83.9 per cent of the population supported this strategy. Just about one-half (50.8%) of respondents supported the temporary closure of the workplace and businesses as a COVID-19 response. A little under one-quarter of the population (23.9%) supported a complete lockdown of the country.

In response to statements about the virus itself and the spread, 97.0 per cent agreed that the COVID-19 outbreak is dangerous. Six out of every ten persons (61.1%) felt that they were at risk. Approximately 94 per cent agreed that individuals should avoid contact with persons who have symptoms and another 87.0 per cent felt that people should avoid communities where infected persons live. Most persons (94.7%)

supported voluntary self-isolation of two weeks for persons who have been in contact with someone who received a positive test result for the virus.

TABLE 7-2: OPINIONS ABOUT COVID-19 AND THE STRATEGIES TO CURB THE SPREAD

Questions	Agree		Neutral		Disagree	
	N	%	N	%	N	%
The Public Health Authorities are doing enough to control the spread of the Coronavirus	2,013,700	85.6	149,500	6.4	190,100	8.1
The COVID-19 outbreak is dangerous	2,282,300	97.0	38,800	1.6	32,200	1.4
I am at risk for contracting the Coronavirus	1,437,600	61.1	252,800	10.7	662,900	28.2
People should avoid contact with persons who have symptoms of the COVID-19	2,218,100	94.3	58,500	2.5	76,500	3.2
People should avoid contact with communities where infected people live	2,048,000	87.0	137,600	5.8	167,500	7.1
There is nothing I can do to prevent myself and my family from contracting the Coronavirus	301,200	12.8	130,200	5.5	1,921,900	81.7
I support voluntary self-isolation/quarantine for up to 2 weeks for people who have been in contact with someone who has the COVID-19.	2,229,100	94.7	47,400	2.0	76,900	3.3
Mass gatherings such as parties, sporting events, weddings and funerals should be cancelled or postponed to limit the spread of the Coronavirus	1,974,000	83.9	183,300	7.8	196,000	8.3
Workplaces and businesses should close temporarily to reduce the risk of employees being infected by the Coronavirus	1,195,300	50.8	458,900	19.5	699,100	29.7
The entire country should shut down to reduce the spread of the Coronavirus	562,700	23.9	354,200	15.1	1,436,400	61.0

8 Practices

8.1 Personal Actions to Limit Risk

In the absence of a vaccine or a cure for COVID-19, the emphasis is on prevention. Prevention strategies include washing and sanitizing the hands, avoid touching the face, avoiding close contact with other persons, wearing a mask and disinfecting surfaces as often as possible. During the survey, persons were asked to indicate all they had done in the 14 days preceding the survey to limit their risk of contracting COVID-19.

Two-thirds (66.2%) mentioned that they were staying at home unless absolutely necessary to go out. Approximately 64 per cent indicated that they were wearing a mask when going outside and a little over one-half (55.1%) increased the use of sanitizer or rubbing alcohol to disinfect their hands. Approximately 44 per cent mentioned social distancing and 43.2 per cent washing of hands more frequently.
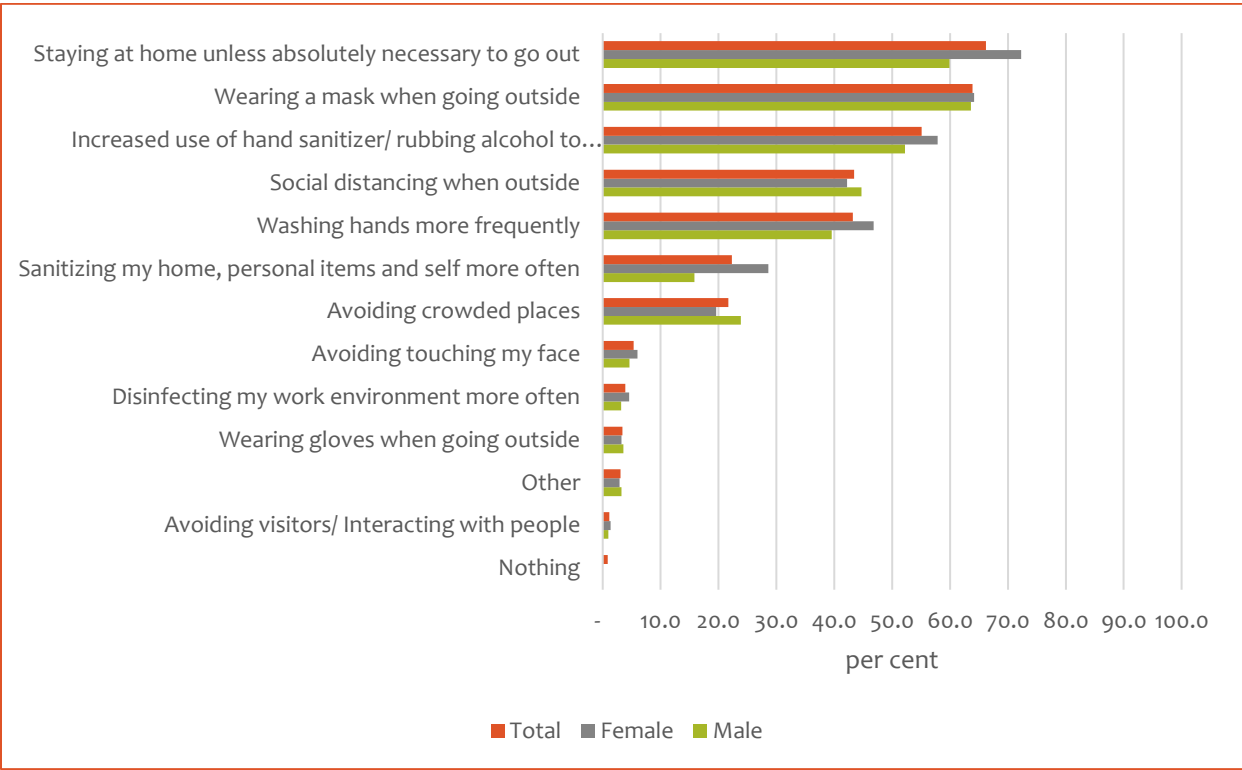
FIGURE 8-1: ACTIONS TAKEN TO LIMIT THE RISK OF CONTRACTING COVID-19 BY SEX

The data shows that a greater proportion of females than males were staying at home (72.3%); disinfecting their hands more often (57.8%); washing their hands more frequently (46.8%); and sanitizing their home, personal items and themselves more often (28.6%). On the other hand, a greater proportion of males were social distancing when outside (44.7%) and avoiding crowded places (23.9%). The proportion of persons who wore masks when going outside was relatively equal across sex.

Three out of every four elderly persons aged 70 or older indicated that they were staying home unless absolutely necessary, to limit their risk of contracting COVID-19. Among the other age groups, this was approximately two out of three persons.

	Age 10 to 29	Age 30 to 49	Age 50 to 69	Age 70 plus	Total
Staying at home unless absolutely necessary to go out	67.5	62.2	66.5	75.7	66.2
Wearing a mask when going outside	58.6	69.3	68.9	55.7	63.9
Increased use of hand sanitizer/ rubbing alcohol to disinfect my hands	55.5	59.1	53.0	40.5	55.1
Social distancing when outside	42.6	45.3	44.1	38.4	43.4
Washing hands more frequently	42.0	46.2	44.3	34.1	43.2
Sanitizing my home, personal items, and themself more often	20.0	27.2	21.7	15.4	22.3
Avoiding crowded places	17.9	23.9	26.4	20.1	21.7
Avoiding touching my face	6.0	5.7	4.3	*	5.3
Disinfecting my work environment more often	3.2	5.0	4.2	*	3.9
Wearing gloves when going outside	4.1	3.5	2.7	*	3.4
Other	3.3	3.0	2.5	*	3.1
Avoiding visitors/ Interacting with people	1.3	1.0	*	*	1.2
Nothing	*	*	*	*	0.8

The data on actions taken to limit the risk of contracting COVID-19 was analysed by educational attainment. The proportion of persons who were wearing masks, increasing their use of hand sanitizer, social distancing and washing hands more frequently all increased with educational attainment.
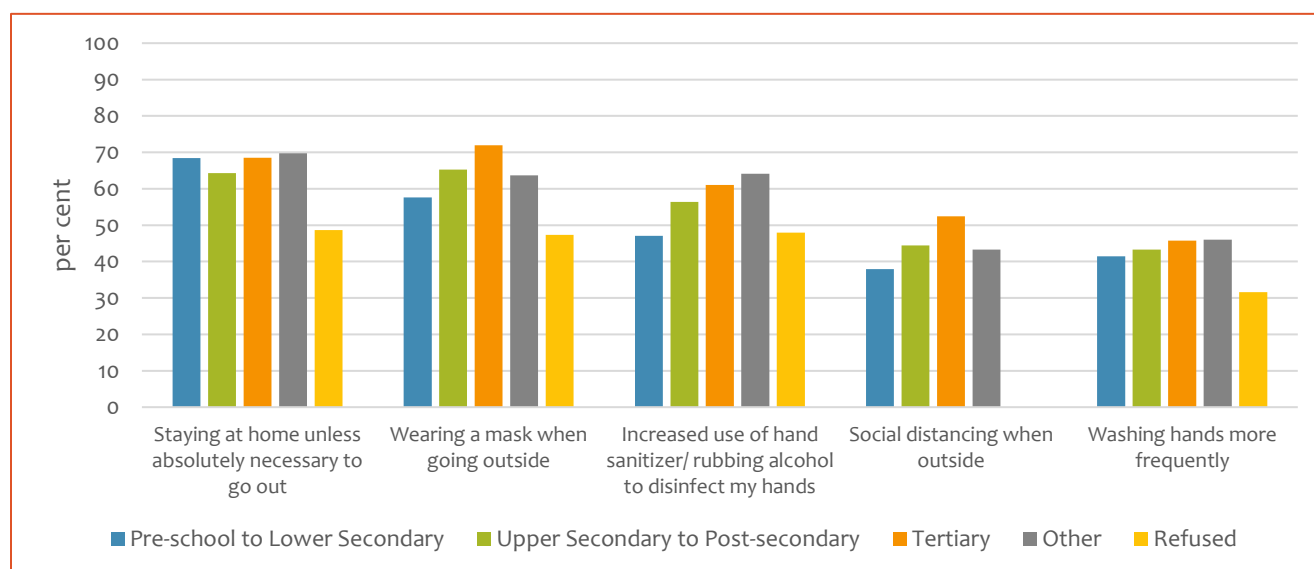
FIGURE 8-2: ACTIONS TAKEN (TOP 5) TO LIMIT THE RISK OF CONTRACTING COVID-19 BY EDUCATIONAL ATTAINMENT

When the respondents were asked whether they were complying with the recommendation to stay at least three feet away from the next person when standing in line, more than one-half (51.0%) indicated that they did so all the time. A little over one-quarter of the population (28.2%) said they did it most of the time. Notably, there was an estimated 209,500 persons (8.9%) who either never or occasionally stayed at least three feet away from the person in front of them when standing in line.

	Male		Female		Total	
	N	%	N	%	N	%
All the time	530,400	45.7	671,100	56.2	1,201,600	51.0
Most of the time	357,400	30.8	308,200	25.8	665,600	28.2
Occasionally	75,700	6.5	49,600	4.1	125,300	5.3
Not at all	45,000	3.9	39,200	3.3	84,200	3.6
I avoid lines	104,700	9.0	70,800	5.9	175,600	7.5
Does not go outside	31,000	2.7	40,300	3.4	71,400	3.0
Other	*	*	*	*	9,100	0.4

The data shows that a greater proportion of females (56.2%) than males (45.7%) complied with the requirement for social distancing at all times when standing in line. Conversely, a greater proportion of males either never or occasionally complied with social distancing when standing in line.

8.2 Workplace response

Persons who were employed or had a formal job attachment in the first week of April were asked what measures were implemented at their place of employment in response to COVID-19. The most popular answer was increased sanitization and cleaning (58.0%). This was followed by enhanced screening before entering the building (21.1%). Approximately 14 per cent said that the business did not implement any measures, and so it was business as usual. Approximately 14 per cent said that their place of employment implemented a work from home measure and the same proportion said their workplace had other safety measures or protocols.
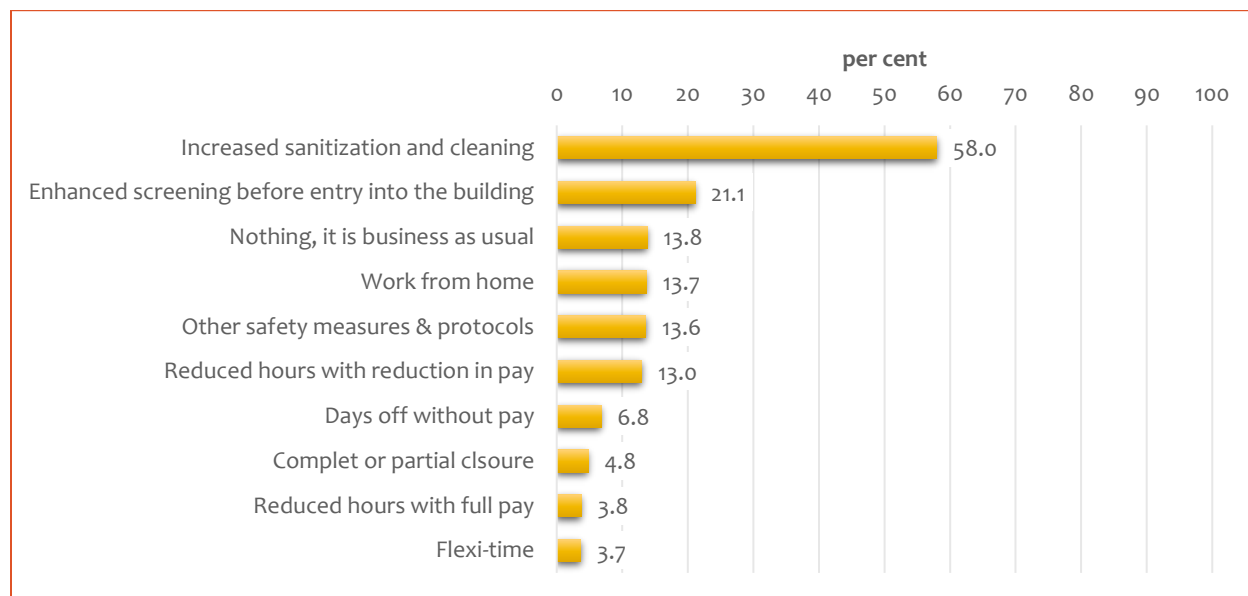
FIGURE 8-3: WORKPLACE RESPONSE TO THE CORONAVIRUS PANDEMIC, APRIL TO JUNE 2020

When analysed by health regions, the survey shows that a greater proportion of employees in SERHA (62.0%) and WRHA (61.1%) reported increased sanitization and cleaning at their place of work. Similarly,

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[9] '*' value suppressed due to high standard errors

these two regions saw the highest proportion of employees reporting enhanced screening at entry points for their workplace. On the other hand, the highest proportion of employees reporting business as usual (22.5%) were from the southern region (SRHA).

TABLE 8-3: WORKPLACE RESPONSE TO THE NOVEL CORONAVIRUS BY REGION, APRIL TO JUNE 2020[10]

	SHRA	SERHA	NERHA	WRHA	Total
Increased sanitization and cleaning	52.0	62.0	50.3	61.1	58.0
Enhanced screening before entry into the building	15.3	24.6	14.3	24.4	21.1
Nothing, it is business as usual	22.5	8.5	14.3	18.1	13.8
Work from home	6.8	19.6	7.1	10.5	13.7
Other safety measures and protocols implemented by employer	11.4	15.8	12.5	10.1	13.6
Reduced hours with reduction in pay	10.2	12.9	14.6	16.3	13.0
Days off without pay	*	8.6	10.6	*	6.7
Complete or partial closure of the business	4.6	3.5	10.5	4.1	4.8
Reduced hours with full pay	2.3	4.6	*	5.0	3.8
Flexitime	2.8	4.5	2.9	2.9	3.7
Days off with pay	*	2.6	*	*	2.0
Other initiatives	3.7	*	*	*	1.6
Customer screening and management	*	*	*	*	1.0

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[10] '*****' value suppressed due to high standard errors

9 Implications for action: Findings from the May-June COVID-19 KAP survey

Prof. Affette McCaw-Binns, *Epidemiologist,* University of the West Indies, Mona – chair of the Community and Household Working Group – National COVID-19 Research Agenda (NCRA)

This novel survey using telephone interview provides critical information on the effectiveness of health promotion and protection efforts to limit the spread of the SARS-COV2 virus in Jamaica, at May-June 2020. Then, more than 85 per cent of Jamaicans accessed COVID-19 information through traditional media (TV, radio, newspaper). Younger adults (<50 years) also consulted social media, while those with a tertiary education more often checked official sources (e.g. Ministry of Health and Wellness, the World Health Organization).
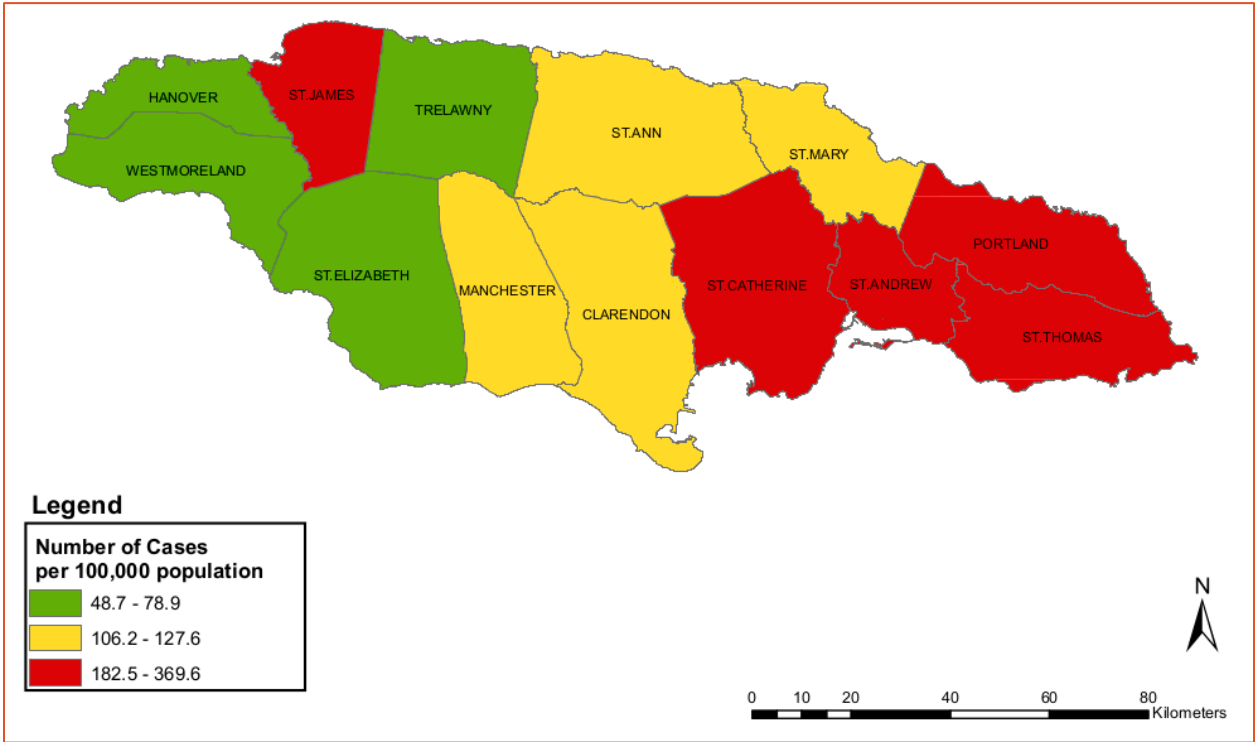
FIGURE 9-1: COVID-19 CUMULATIVE PREVALENCE RATE, BY PARISH, AS AT SEPTEMBER 22, 2020

Women and persons 30-49 years were the most informed. Knowledge was highest in the western region and may have contributed to relatively lower cumulative prevalence there (Figure 9-1). Lessons learnt should be shared. Also, of interest were the age variations in the potential response to a respiratory tract infection or possible COVID-19 exposure. While older persons would consult a health provider, younger persons were more willing to self-isolate and "wait it out" with implications for transmission if asymptomatic.

9.1   Potential policy and practice impact

We can now strategically target information by age and risk groups, utilizing how different demographic groups access information – using social media to reach younger persons, but relying on traditional media

for older adults. As a new disease, knowledge has evolved rapidly. When new information becomes available, communities need to be efficiently informed. For example, persons now recognize (compared to May-June) that loss of taste and smell and fatigue are important signs of possible COVID-19 infection.

Health promotion strategies must ensure **everyone** understands that anyone can get infected and advise persons on how and where to seek information and care if exposed. For communities now experiencing low exposure to the virus, messaging should focus on primary protection (wearing masks, hygiene) and understanding that asymptomatic persons can be unwitting vectors of disease, including children.

To support epidemic control measures, routine surveillance should generate rolling 14-day incidence rates (not numbers) by community; age-group and sex. Maps can communicate if community and parish rates are increasing, staying the same or declining. A traffic light approach could also show if areas have moved from a **high (red), average (yellow) or low (green)** prevalence category (Figure 9-1), with appropriate guidance for each level.

9.2   Implications for future research/analysis

Further surveys should document how knowledge, attitudes and practice evolve. More critically, we need to understand the epidemic's impact on households and families, especially on income, food security and education of children 5-17 years old. It would be useful to explore the specific challenges persons faced accessing non-COVID-19 related health care and treatment – were these due to resource constraints; physical access to a health provider or pharmacist; or fear of co-mingling with potentially infected persons?

9.3   Conclusion

COVID-19 has taught resilience and STATIN and MOHW have demonstrated their capacity to learn and grow and adapt to these changing global circumstances.

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Appendix I.   Technical Note

Sample Design and Weighting

The 2020 COVID-19 KAP Survey was a telephone-based household survey where respondents were selected using a simple random sampling design, stratified by parish. This survey used a list-aided dual frame approach representing active non-commercial mobile telephone subscribers as of March 2020.

According to the Office of Utilities Regulations (OUR)[11], the Mobile Subscription Penetration Rate exceeds 100 per cent. This rate implies that there are more mobile phone subscribers than persons residing in Jamaica. Therefore, there exists a non-zero probability of an overlap of the two frames.

Limitations of the Design

All surveys have associated limitations, which must be clearly understood to interpret the results appropriately. Telephone surveys such as the 2020 COVID-19 KAP Survey have the following inherent risks:

1.   Under-coverage:
   a. Individuals living in areas with low or no coverage may be underrepresented in the survey sample.
2.   Over-coverage:
   a. Groups of the population are more inclined to have access to mobile phones or are more likely to respond to calls from unknown numbers. This segment of the population may be overrepresented in the sample.
3.   Non-response:
   a. Telephone-based surveys typically have a higher level of non-response than in-person household surveys. In addition to the typical cadre of persons who do not respond to surveys, individuals who are busy or averse to answering calls from unknown numbers are less likely to participate in an interview, thereby increasing the non-response.

The first two limitations were mitigated through the weighting process, while the third limitation was mitigated through the public education campaign.

Sample Size

The sample size for the 2020 COVID-19 KAP Survey was calculated using the formula:

$$n = \frac{Z_{\alpha/2}^2 \times p(1-p) \times deff}{ME^2 \times rr} \times h = 17,920$$

Where:

- n sample size
- $Z_{\alpha/2}$ z-statistic for the two-tailed 95% confidence level
- p the estimated parameter of the key variable (0.4)
  - Proportion of the population who always stand at least 3 feet away from the person in front of them when standing in line (Practicing social distancing)

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[11] OUR, Telecommunications Market Information Report: July - September 2019

- $deff$ the design effect (2)
- ME the margin of error (0.5)
- h the number of domains (14)
- rr the expected response rate (0.6)

The sample was allocated, where possible, across the fourteen (14) parishes based on a Kish allocation with $\alpha = 0.5$. The distribution of the population by parish was used as the allocation variable, with a minimum allocation of 250 persons per domain.

The total sample size was distributed equally across both frames, given the approximately equal distribution. Telephone numbers were randomly selected within each domain from each frame.

Probability of Selection

Each sampling frame is comprised of a list of active non-commercial mobile phone numbers of size N from which a sample of size n is selected using a simple random sampling design. After the respondent is identified, we can compute the probability that a person k that has L active non-commercial mobile telephone lines, belongs to the sample s. This phenomenon follows a Hyper-geometric distribution (Gutiérrez, 2020):

$$\pi_k = \Pr(k \in s) = 1 - \frac{\binom{L}{0}\binom{N-L}{n}}{\binom{N}{n}} \approx 1 - (1-f)^L$$

If N and n are large, the sampling fraction is defined as $f = \frac{n}{N}$.

Weighting

The design weights are defined as the multiplicative inverse of the inclusion probability. Given that each sample was selected independently, the design weights also must be calculated independently. The design weight for each frame is given by:

$$d_k^i = \frac{1}{1 - (1-f)^L}$$

$$d_k \begin{cases} d_k^1 \ \ Provider \ 1 \\ d_k^2 \ \ Provider \ 2 \end{cases}$$

Not all persons selected in a survey will complete an interview; this is referred to as a non-response. For this survey, it was assumed that the non-respondents were randomly distributed across the sample, implying that there was no significant bias. Since we have no profile on the non-respondents, the level of bias cannot be computed. The non-response adjustment is given by:

$$NR_k = \frac{k_r + k_{nr}}{k_r}$$

Where k_r and k_{nr} represents the total number of effective respondents and non-respondents, respectively.

The post-stratification adjustment uses auxiliary information that reduces variance and corrects problems of coverage that could not be corrected in the previous steps. For this survey, the mid-year population estimates for 2018 was used in calibrating the weights. The application of post-stratification allows for estimates of population totals based on the responses from the sample.

The post-stratification adjustment for each group b is given by:

$$PS_k = \frac{b_{pop}}{b_{sam}}$$

For the 2020 COVID-19 KAP Survey, the following were used for calibration:
- Sex
- 20-year age group
- Parish of residence

Prior to applying the post-stratification adjustment, missing values for these variables were imputed using hot deck imputation.

The final weight for each respondent W_k was calculated as a composite of the design weight, non-response adjustment and post-stratification adjustment as follows:

$$W_k = d_k \times NR_k \times PS_k$$

Response Rate

The response rate for the survey is given by the number of complete and partial interviews divided by the number of eligible respondents in the sample.

Phone numbers that did not ring and those respondents that were deemed inadequate[12] are considered as ineligible, and as such were excluded from the response rate calculation. The rate of response was calculated using the formula:

$$RR = \frac{(I + P)}{(I + P) + (R) + (NC + O)}$$

Where:
- I = the number of completed interviews
- P = the number of partially completed interviews
- R = the number of persons that refused an interview
- NC = the number of persons with whom interviewers were unable to make contact
- O = the number of interviews with other outcomes

$$RR = \frac{9,379}{(9,379) + (4,427) + (3,528 + 361)} = 52.8\%$$

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[12] Includes unsupervised minors and persons with conditions that would hinder their participation in the survey.

The response rate for the survey was 52.8 per cent.

TABLE I-1: EFFECTIVE SAMPLE DISTRIBUTION BY SEX AND PARISH OF RESIDENCE

	Male	Female	Total
Kingston	305	364	669
St. Andrew	290	332	622
St. Thomas	255	400	655
Portland	242	293	535
St. Mary	289	322	611
St. Ann	291	352	643
Trelawny	160	213	373
St. James	208	258	466
Hanover	172	211	383
Westmoreland	361	492	853
St. Elizabeth	220	300	520
Manchester	309	463	772
Clarendon	429	570	999
St. Catherine	546	732	1,278
Total	**4,077**	**5,302**	**9,379**

Appendix II.   Survey Instrument

Jamaica Survey on Knowledge, Attitudes and Practices Regarding CORONAVIRUS/COVID-19

Parish ☐☐ **Network** ☐ **Phone Num.** ☐☐☐ - ☐☐☐ - ☐☐☐☐

Good day, my name is ……… I am calling from the Statistical Institute of Jamaica (STATIN). We are conducting a short survey on behalf of the Ministry of Health and Wellness (MoHW) to get information on the knowledge, attitudes and practices of Jamaicans regarding Coronavirus/COVID-19. Your participation will help the government to understand what is happening in the country to inform decision-making and guide planning. The information you provide will be kept str

A1. May I proceed with the questions?	☐ 01. Yes	☐ 02. No (End Interview)	
A2. Are you the primary user of this phone?	☐ 01. Yes (>>A4)	☐ 02. No	
A3. May I speak to the primary user of the phone?	☐ 01. Yes	☐ 02. No (End Interview)	
A4. May I have your name just for reference?	_____		
A5. What is your age group?	☐ 01. Under 10 years (End Interview)	☐ 02. 10-17 years	☐03. 18 yrs. and over (>>B1)
A6. For persons 10-17 years old, name of adult providing consent			

A. CONTACT HISTORY

Call Num	Date (dd/mm/yy)	Call Time (24hr Clock) Start	Call Time (24hr Clock) End	A3. Initial Contact Code	A4. Result Code	A5. Refusal Code	A6. Final Result Code
1		:	:				
2		:	:				
3		:	:				☐
4		:	:				
5		:	:				
6		:	:				

Response Codes

A3. Initial Contact Code	A4. Result Code	A5. Refusal Code	A6. Final Result Code
01. Contact made with individual 02. No Answer – Message left 03. No Answer – No message left 04. Non-contact (Does not ring) 96. Other (specify)	01. Completed interview 02. Partially completed interview 03. Call back scheduled 04. Unable to provide information 05. Refused 96. Other (specify)	01. Does not have the time 02. Questions too personal 03. Does not trust surveys 04. Doesn't get anything in exchange for answering 05. Is tired of answering surveys 06. Does not respond to surveys 07. Is prevented from answering 08. No reason given 96. Other (specify)	01. Completed interview 02. Partially completed interview 03. Unable to provide information 04. Non-contact 05. Refused 96. Other (Specify)

FOR INTERNAL USE ONLY

	Interviewer	Supervisor	Headquarters User
Name			
ID Num			
Signature			
Date			

Interviewer Comments:

B. KNOWLEDGE

These first set of questions seek to find out how well persons understand the Coronavirus/COVID-19.

QUESTIONS	RESPONSE OPTIONS
B1. Who do you think is most at risk of contracting the Coronavirus/COVID-19? (Tick all that apply)	☐ 01. Children (under 18 years old) ☐ 02. Young people (18-24 years old) ☐ 03. Adults (25 – 64 years old) ☐ 04. Elderly (65 years or older) ☐ 05. Men ☐ 06. Women ☐ 07. Persons with underlying conditions ☐ 08. Persons who have recently travelled overseas ☐ 09. Persons in contact with people who recently travelled overseas ☐ 10. Persons living in inner city communities ☐ 11. Persons with poor hygiene ☐ 12. Health care workers ☐ 13. Soldiers, police and other essential workers ☐ 96. Other (Specify) _____ ☐ 97. Don't Know ☐ 98. Refused ☐ 99. Not stated
B2. What are the symptoms of Coronavirus/COVID-19? (Tick all that apply)	☐ 01. Sneezing ☐ 02. Dry Coughing ☐ 03. Fever ☐ 04. A Cold ☐ 05. Diarrhoea ☐ 06. Loss of appetite ☐ 07. Fatigue ☐ 08. Loss of taste and smell ☐ 09. Shortness of breath/ Difficulty breathing ☐ 96. Other (specify) _____ ☐ 97. Don't Know ☐ 98. Refused ☐ 99. Not stated
B3. How is the Coronavirus/COVID-19 spread? (Tick all that apply)	☐ 01. Droplets released when someone coughs or sneezes ☐ 02. Droplets released when someone speaks ☐ 03. Touching your face ☐ 04. Touching other persons ☐ 05. Mosquitos ☐ 06. Polluted water ☐ 07. Contaminated air ☐ 08. Touching contaminated surfaces ☐ 09. Vaccinations ☐ 96. Other (specify) _____ ☐ 97. Don't Know ☐ 98. Refused ☐ 99. Not stated

Are the following statements true or false? (*READ STATEMENTS*)	True (01)	False (02)	Don't know (07)
B4. Only persons with symptoms of Coronavirus/COVID-19 are able to infect others.	☐	☐	☐
B5. Only the elderly and those with underlying conditions will get really sick from Coronavirus/COVID-19.	☐	☐	☐
B6. Patients usually recover from Coronavirus/COVID-19 if they get medical care early.	☐	☐	☐
B7. If I have a runny nose, I do not have Coronavirus/COVID-19.	☐	☐	☐
B8. I did not travel recently, therefore I do not have Coronavirus/COVID-19.	☐	☐	☐

QUESTIONS	RESPONSE OPTIONS
B9. What should you do if you have a respiratory tract infection, such as a cold, congestion, or difficulty breathing? (Tick all that apply)	☐ 01. Do nothing if you have no symptoms ☐ 02. Stay at home and self-isolate/quarantine for 14 days ☐ 03. Call the Ministry of Health and Wellness (COVID Hotline) ☐ 04. Go to the doctor ☐ 05. Call the doctor, and discuss symptoms ☐ 06. Go to the nearest hospital or health centre ☐ 07. Take pharmaceuticals/ medications ☐ 08. Take vitamin C ☐ 09. Take/Use home remedies/ traditional medicine ☐ 96. Other (specify) _____ ☐ 97. Don't Know ☐ 98. Refused ☐ 99. Not stated
B10. What should you do if you think you have Coronavirus/COVID-19? (Tick all that apply)	☐ 01. Do nothing if you have no symptoms ☐ 02. Stay at home and self-isolate/quarantine for 14 days ☐ 03. Call the Ministry of Health and Wellness (COVID Hotline) ☐ 04. Go to the doctor ☐ 05. Call the doctor, and discuss symptoms ☐ 06. Go to the nearest hospital or health centre ☐ 07. Take pharmaceuticals/ medications ☐ 08. Take vitamin C ☐ 09. Take/Use home remedies/ traditional medicine ☐ 96. Other (specify) _____ ☐ 97. Don't Know ☐ 98. Refused ☐ 99. Not stated
B11. What should you do if you come into contact with someone who has Coronavirus/COVID-19? (Tick all that apply)	☐ 01. Do nothing if you have no symptoms ☐ 02. Stay at home and self-isolate/quarantine for 14 days ☐ 03. Call the Ministry of Health and Wellness (COVID Hotline) ☐ 04. Go to the doctor ☐ 05. Call the doctor, and discuss symptoms ☐ 06. Go to the nearest hospital or health centre ☐ 07. Take pharmaceuticals/ medications ☐ 08. Take vitamin C ☐ 09. Take/Use home remedies/ traditional medicine ☐ 96. Other (specify) _____ ☐ 97. Don't Know ☐ 98. Refused ☐ 99. Not stated
B12. What may be used to treat Coronavirus/COVID-19? (Tick all that apply)	☐ 01. Nothing/ There is no treatment ☐ 02. Paracetamol (Cetamol, Panadol etc.) ☐ 03. Acetaminophen (Tylenol, Sudafed etc.) ☐ 04. Ibuprofen (Brufen, Advil, Motrin etc.) ☐ 05. Vitamin C ☐ 06. Garlic ☐ 07. Ginger ☐ 08. Lemon grass (fever grass) ☐ 09. Home remedies Traditional medicine (specify) _____ ☐ 96. Other (specify) _____ ☐ 97. Don't Know ☐ 98. Refused ☐ 99. Not stated

C. ATTITUDES

These questions seek to find out the attitudes of persons towards Coronavirus/COVID-19.

QUESTIONS	RESPONSE OPTIONS
C1. Is the community where you live at risk for an outbreak of Coronavirus/COVID-19?	☐ 01. Yes ☐ 02. No ☐ 07. Don't know
C2. Why do you think your community is/ is not at risk for an outbreak of Coronavirus/COVID-19? (Tick all that apply)	**If Yes at C1** ☐ 01. Living quarters are overcrowded ☐ 02. My community has a lot of elderly persons ☐ 03. We do not practice social distancing ☐ 04. People do not comply with curfews, and other orders ☐ 05. We do not have regular water supply ☐ 06. Health care worker(s) live in the community ☐ 07. Someone in my community has/had CORONAVIRUS/COVID-19 ☐ 08. There is someone who recently returned from abroad ☐ 09. People are not taking it seriously ☐ 10. Other reasons why (specify) _____ **If No at C1** *(Once answered, go to C4)* ☐ 11. Living quarters are spacious/ not crowded ☐ 10. My community does not have a lot of elderly persons ☐ 11. We practice social distancing ☐ 12. People comply with curfews, and other orders ☐ 13. Most persons wear masks when outside ☐ 14. No health care worker(s) live in the community ☐ 15. No one in my community has it ☐ 16. There is no one who recently returned from abroad ☐ 17. People are taking it seriously and are being responsible ☐ 96. Other reasons why not (specify) _____ ☐ 97. Don't Know ☐ 98. Refused ☐ 99. Not stated
C3. Do you think Coronavirus/COVID-19 is in your community now?	☐ 01. Yes ☐ 02. No ☐ 07. Don't know

Please indicate whether you strongly agree, agree, neutral, disagree or strongly disagree with the following statements.	Strongly Agree 1	Agree 2	Neutral 3	Disagree 4	Strongly Disagree 5
C4. The Public Health Authorities are doing enough to control the spread of the Coronavirus/COVID-19 disease.	☐	☐	☐	☐	☐
C5. The Coronavirus/COVID-19 outbreak is dangerous.	☐	☐	☐	☐	☐
C6. I am at risk for contracting Coronavirus/COVID-19.	☐	☐	☐	☐	☐
C7. People should avoid contact with persons who have symptoms.	☐	☐	☐	☐	☐
C8. People should avoid contact with communities where infected people live.	☐	☐	☐	☐	☐
C9. There is nothing I can do to prevent myself and my family from contracting Coronavirus/COVID-19.	☐	☐	☐	☐	☐
C10. I support voluntary self-isolation/quarantine for up to 2 weeks for people who have been in contact with someone who has Coronavirus/COVID-19.	☐	☐	☐	☐	☐
C11. Mass gatherings such as parties, sporting events, weddings and funerals should be cancelled or postponed to limit the spread of Coronavirus/COVID-19.	☐	☐	☐	☐	☐
C12. Workplaces and businesses should close temporarily to reduce the risk of employees being infected by the Coronavirus/COVID-19.	☐	☐	☐	☐	☐
C13. The entire country should shut down to reduce the spread of Coronavirus/COVID-19.	☐	☐	☐	☐	☐

These questions seek to find out the actions that persons have taken to prevent catching/spreading Coronavirus/COVID-19.

QUESTIONS	RESPONSE OPTIONS
D1. In the past 14 days, what have you been doing to limit your risk of contracting Coronavirus/COVID-19? (Tick all that apply)	☐ 01. Nothing ☐ 02. Avoiding crowded places ☐ 03. Wearing a mask when going outside ☐ 04. Wearing gloves when going outside ☐ 05. Washing hands more frequently ☐ 06. Increased use of hand sanitizer/ rubbing alcohol to disinfect my hands ☐ 07. Avoiding touching my face ☐ 08. Staying at home unless absolutely necessary to go out ☐ 09. Social distancing when outside ☐ 10. Disinfecting my home and personal items more often ☐ 11. Disinfecting my work environment more often ☐ 96. Other (specify) _____ ☐ 97. Don't Know ☐ 98. Refused ☐ 99. Not stated
D2. When standing in line, how often do you stand at least 3 feet away from the person in front of you? *Interviewer: READ RESPONSES*	☐ 01. All the time ☐ 02. Most of the time ☐ 03. Occasionally ☐ 04. Not at all ☐ 96. Other (specify) _____ ☐ 97. Don't Know ☐ 98. Refused ☐ 99. Not stated
D3. Where do you get information about Coronavirus/COVID-19? (Tick all that apply)	☐ 01. Official GOJ press conferences and social media accounts ☐ 02. MoHW messages (texts, fliers, brochures etc) ☐ 03. Friends and family ☐ 04. Social media pages (Instagram, Twitter, Facebook, etc.) ☐ 05. WhatsApp messages and voice notes ☐ 06. Official GOJ websites ☐ 07. Local traditional media (television, radio, newspaper) ☐ 08. Town criers ☐ 09. Other Governments/Agencies(CDC, USA, UK etc.) ☐ 10. The World Health Organization (WHO) ☐ 11. International traditional media (television, radio, newspaper) ☐ 12. Websites (Worldometer, Google, etc.) ☐ 96. Other (specify) _____ ☐ 97. Don't Know ☐ 98. Refused ☐ 99. Not stated

E. DEMOGRAPHICS

The next set of questions is designed to provide background information of persons.

QUESTIONS	RESPONSE OPTIONS
E1. What is your age?	_____ ☐ 09. Refused
E2. Are you male or female?	☐ 01. Male ☐ 02. Female ☐ 09. Refused

E3. Which parish do you currently reside in?

☐ 01. Kingston	☐ 06. St. Ann	☐ 11. St. Elizabeth
☐ 02. St. Andrew	☐ 07. Trelawny	☐ 12. Manchester
☐ 03. St. Thomas	☐ 08. St. James	☐ 13. Clarendon
☐ 04. Portland	☐ 09. Hanover	☐ 14. St. Catherine
☐ 05. St. Mary	☐ 10. Westmoreland	☐ 99. Refused

E4. What is the highest LEVEL of education/training/school that you have COMPLETED (i.e. not currently attending)?

☐ 01. Pre-school/Basic/Infant	☐ 08. Masters/ Graduate Degree or equivalent
☐ 02. Primary (Grades 1-6)	☐ 09. Doctorate/Ph.D. or equivalent
☐ 03. Lower Secondary (Grades 7-9) or equivalent	☐ 10. HEART (specify Level) _____
☐ 04. Upper Secondary (Grades 10-11) /CAP or equivalent	☐ 11. JFLL (Specify e.g. HDSE) _____
☐ 05. Grade 12-13/ Other Post-secondary, non-tertiary	☐ 96. Other (Specify) _____
☐ 06. Short Cycle Tertiary or equivalent	☐ 97. Don't Know
☐ 07. Undergraduate/First Degree or equivalent	☐ 98. Refused
	☐ 99. Not stated

E5. Do you have any chronic illnesses or underlying conditions?

- ☐ 01. No → Skip to next section
- ☐ 02. Yes, Asthma
- ☐ 03. Yes, Diabetes
- ☐ 04. Yes, Hypertension
- ☐ 05. Yes, Kidney disease
- ☐ 06. Yes, Liver disease
- ☐ 07. Yes, Cancer
- ☐ 08. Yes, Lung disease
- ☐ 09. Yes, Immune disorder (Lupus, HIV, etc.)
- ☐ 96. Yes, Other (specify) _____
- ☐ 97. Don't Know
- ☐ 98. Refused
- ☐ 99. Not stated

QUESTIONS	RESPONSE OPTIONS
E6. In the past three (3) weeks, have you experienced any difficulties accessing **MEDICAL CARE** for non-CORONAVIRUS/COVID-19 illnesses?	☐ 01. Yes ☐ 02. No ☐ 09. Refused
E7. In the past three (3) weeks, have you experienced any difficulties accessing **MEDICATION** for non-CORONAVIRUS/COVID-19 illnesses?	☐ 01. Yes ☐ 02. No ☐ 09. Refused

The next set of questions are designed to assess how Coronavirus/COVID-19 has affected your work and income.

QUESTIONS	RESPONSE OPTIONS
F1. What were you doing for most of the time during the first week of **March** 2020?	☐ 01. Working full-time for an employer ☐ 02. Working part-time for an employer ☐ 03. Working for myself/ in my own business ☐ 04. Working in Agriculture ☐ 05. Doing odd jobs, buying and selling or hustling ☐ 06. Working in a family business without pay ☐ 07. On leave from job (vacation, sick, other) ☐ 08. Seeking a job ☐ 09. Did not seek work but wanted work and was available ☐ 010. Attending school/ studying ☐ 11. Did home duties ☐ 12. Retired, did not work ☐ 13. Disabled, unable to work ☐ 14. Not interested in work ☐ 96. Other (specify) _____ ☐ 97. Don't Know ☐ 98. Refused ☐ 99. Not stated
F2. What were you doing for most of the time during the first week of **April** 2020?	☐ 01. Working full-time for an employer ☐ 02. Working part-time for an employer ☐ 03. Working for myself/ in my own business ☐ 04. Working in Agriculture ☐ 05. Doing odd jobs, buying and selling or hustling ☐ 06. Working in a family business without pay ☐ 07. On leave from job (vacation, sick, other) ☐ 08. Seeking a job ☐ 09. Did not seek work but wanted work and was available ☐ 010. Attending school/ studying ☐ 11. Did home duties ➔ Go to F7 ☐ 12. Retired, did not work ☐ 13. Disabled, unable to work ☐ 14. Not interested in work ☐ 96. Other (specify) _____ ☐ 97. Don't Know ☐ 98. Refused ☐ 99. Not stated
F3. What is your occupation?	_____ ☐ 09. Refused
F4. What industry do you work in?	_____ ☐ 09. Refused
F5. How has your income been impacted by the measures put in place to limit the spread of Coronavirus/COVID-19? ***Interviewer: READ RESPONSES***	☐ 01. Severely/ Complete loss of income ☐ 02. Somewhat/ Reduction in income ☐ 03. Not at all ☐ 96. Other (specify) _____ ☐ 97. Don't Know ☐ 98. Refused ☐ 99. Not stated

QUESTIONS	RESPONSE OPTIONS
F6. What measures has your place of employment implemented in response to Coronavirus/COVID-19?	☐ 01. Nothing, it is business as usual ☐ 02. Work from home ☐ 03. Flexi-time ☐ 04. Days off with pay ☐ 05. Days off without pay ☐ 06. Reduced hours with full pay ☐ 07. Reduced hours with reduction in pay ☐ 08. Increased sanitization and cleaning ☐ 09. Enhanced screening before entry into the building ☐ 96. Other (specify) _____ ☐ 97. Don't Know ☐ 98. Refused ☐ 99. Not stated
The next question is used to calibrate/adjust the sample post-data collection	
F7. How many mobile phones do you have on this or other networks? _____	☐ 09. Refused

End of Interview