BRCiS COVID-19 MONITORING

REPORT 4

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Key Messages

- The BRCiS COVID-19 Monitoring system has been collecting data from Safety Net cash beneficiaries to assess the impact of the COVID-19 pandemic on their health and livelihoods. Six rounds of data collection have been conducted covering June 2020 to November 2021.
- Due to the end of the BRCiS cash transfer programme in many areas, the results reported here come from a smaller sample of households (n=427) than in previous data collection rounds.
- A forth wave of infections impacted Somalia from July to December 2021. Results from round 6 show that the syndromic score case rate rose during this wave to 102 cases/1,000,000/day and exceed the estimate from the third wave but did not reach the peak seen during wave 1.
- The estimated COVID-19 death rate increased to 6.8 deaths/10,000/day but was only about half the peak level seen in wave 1. The crude and under-five death rates remained well below humanitarian thresholds.
- Behavioural indicators showed that adherence to preventative behaviours such as mask wearing and social distancing had decreased since the third wave.
- However, vaccine acceptance has increased with 76% reporting that they would accept vaccination if it was available.
- In contrast, the reported COVID-19 vaccine coverage was only 2.6%, indicating a large unmet demand.
- Following the completion of round 6 data collection a wave of infections, presumably due to the *omicron* variant, has started to impact Somalia. A steep rise in infections was reported by the WHO/MOH in late December. While there is evidence from other countries that the disease caused by this variant is less severe, its very high transmissibility means that the public health situation remains unpredictable.
- Continued behaviour change communication and monitoring of the situation is recommended during the ongoing wave of COVID-19 in Somalia.

Overview

The Building Resilient Communities in Somalia consortium (BRCiS) is comprised of eight partner NGOs and is led by the Norwegian Refugee Council (NRC). BRCiS has been monitoring the impact of COVID-19 on the beneficiaries of its Safety Net pilot cash transfer programme since June 2020. Evidence for

Change (e4c), a humanitarian research and learning generation organisation was contracted to provide technical support for this work. This is the forth report from the BRCiS COVID-19 Monitoring System in Somalia, and covers the period up to November 2021.

Methods

The BRCiS Safety Net pilot project has served 43 communities across 10 regions until the second half of 2021. However, the Safety Net project is now ending and the cash transfers are currently only conducted in Qardho and Iskushuban districts in Puntland, and Adaado, Dinsoor, and Luuq in southern Somalia. During the current data collection round, we included 427 households. Participant households had diverse livelihoods and included pastoralists, agro-pastoralists, and urban residents.

A team of enumerators, closely supported by consortium staff and supervised by e4c technical consultants, collected longitudinal data on households that were receiving Safety Net cash transfers. Household heads were interviewed by telephone and data was captured on mobile devices using ODK software. Data was collected on the prevalence of COVID-19 symptoms, the death of household members, as well as key indicators of preventative behaviour and attitudes towards vaccination. Deaths were monitored to determine the direct and indirect impact of the pandemic. To find out if a death is likely to have been caused by COVID-19, we used the COVID-19 Rapid Mortality Surveillance questionnaire and analysis software developed in association with WHO.[1]

To identify suspected cases of COVID-19, we used a similar symptom scoring approach to the one used in the mortality surveillance screening tool. We asked about the presence of a range of symptoms and used these to calculate a symptom score and classify a person as suspected case. The symptom scoring and case definition is described in more detail in the annex. This report describes findings from all six rounds of data collection, between June 2020 and November 2021.

Results

(a) Suspected Cases of COVID-19

Figure 1 summarises the of Suspected Symptomatic cases detected in the BRCiS monitoring system and laboratory confirmed cases reported by WHO/MoH. Data from all six rounds of collection are shown. *Table 1* contains information on the samples used in each round and the dates of data collection. The data shows that the rate of suspected infection in the population sample rose during round 6 to 102 cases/1,000,000/day, and exceeded the levels seen during wave 2 (Sep-Dec 2020) and wave 3 (Jan-Jun 2021). However, the increase observed in round 6 did not reach the levels seen at the beginning of the pandemic in wave 1. Care is needed in comparing the levels in rounds 5 and 6 directly, due to the fact that the recall period in round 6 more fully captured the peak of wave 4.

[1] http://www.byass.uk/interva/crms

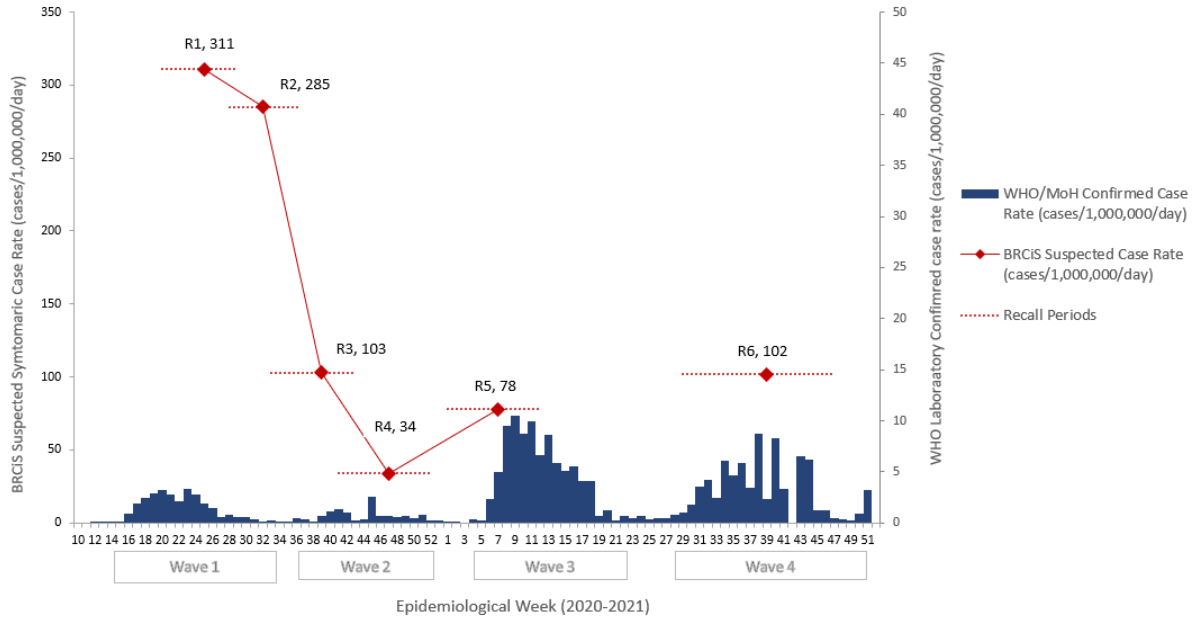

Figure 1: Summary of Suspected Symptomatic cases detected in the BRCiS monitoring system and laboratory confirmed cases reported by WHO/MoH

(b) Household Resources and Behaviours

To help assess the risk of infection and the impact of programme behavioural change communication activities, questions on behaviours and resource availability were asked at each data collection round. The resulting behavioural indicators are shown in table 3.

The perception that COVID-19 was a threat to their household had increased since round 5 with 82% of respondents now viewing it a major threat (Table 4). Despite this and the onset of the 4th wave of infections, there was a reduction in the use of face masks and an increase in hugging and handshaking compared to the previous data collection round. This change contrasts with the behaviours observed during the 3rd wave where a marked increase in preventative behaviours was observed.

Vaccine hesitancy was surprisingly low and had decreased further since round 5. Seventy-six percent of respondents reported that they would get vaccinated if it was made available. A slightly higher proportion would recommend their elderly relatives get vaccinated. In those that would decline vaccination the top three main reasons were not knowing enough about the vaccine and a belief that the will of Allah would determine whether they caught the disease, followed by concerns about side effects.

Eleven percent of respondents reported that a member of their household had received a vaccination against COVID-19. Coverage in the sampled population was 2.6%, which compares with the estimated national coverage of 5.4% reported by MoH/WHO.[2] The low coverage measured here indicates a large

[2] COVID19 Situation Report – Somalia, Issue 95 (26 DEC 2021 TO 1 JAN 2022), MoHSS, WHO

unmet demand and a long way to go if the WHO target for COVID-19 70% vaccination is to be met by mid-2022.[3]

(c) Mortality

As shown in Table 5 below, both the crude and under five death rates continued to be below emergency thresholds. However, the cause specific death rate attributable to suspected COVID-19 rose in round 6.

Conclusions

- The 6 rounds of data collection completed under this project has allowed for detailed monitoring of the impact of the pandemic, so far, on BRCiS beneficiaries. As the pandemic progressed and successive waves of infection impacted Somalia we observed fluctuating levels of suspected symptomatic infections, cause-specific, and crude death rates.
- The rises in mortality associated with the successive waves of infection underline the seriousness of COVID-19 for Somalia. However, to date, the public health impacts have not been as severe as was feared at the start of the pandemic.
- The inclusion of behavioural and perception indicators to look at attitudes and behaviours provided a valuable insight into how the population perceived the threat from COVID-19 and reacted to the national SBCC wave 2 campaign. Results showed a high level of awareness of key campaign slogans and a surprisingly low degree of vaccine hesitancy compared to anecdotal reports. Use of preventative behaviours such as mask wearing, avoiding physical contact, and hand washing varied over time and were related to the perceived level of risk.
- Unfortunately, the COVID-19 pandemic is not over and the emergence of the latest, highly infectious, omicron variant now poses a new potential threat to public health in Somalia. Continued efforts to engage communities with behaviour change communication and monitor the evolution of the situation are critical. It is also important to bear in mind that it is still possible that a more virulent variant will evolve and impact Somalia.

Recommendations

- The monitoring of the outbreak within Somalia should be continued by BRCiS as the wave of infections linked to the omicron variant progresses.
- SBBC activities should continue and stress the need for enhanced preventative behaviours if case numbers continue to increase.
- Support to clinical facilities to safely and effectively deal with any COVID-19 cases that present should be continued, and testing capacity should continue to be scaled up.
- The reported COVID-19 vaccine coverage was only 2.6%, indicating a large unmet demand. This is rather surprising given the reported low degree of vaccine hesitancy. Therefore, in order to minimize deaths, severe disease and overall disease burden; roll out of COVID-19 vaccines should be prioritised.

[3] Strategy to Achieve Global Covid-19 Vaccination by mid-2022 (WH0)
https://cdn.who.int/media/docs/default-source/immunization/covid-19/strategy-to-achieve-global-covid-19-vaccination-by-mid-2022.pdf

- Innovative ways such as participatory learning and action (PLA) approach that has shown potential to improve routine vaccination knowledge and coverage in Somalia should be considered in order to improve COVID-19 vaccine uptake.

Table 1: Incidence of suspected COVID-19 infections in Safety Net beneficiaries

Measurement period	Round 1[1] Interview respondents only	Round 2	Round 3	Round 4	Round 5	Round 6
		All household members				
Data Collection	Jun 22 - Jul 15 2020	Aug 10- Sep 3 2020	Oct 6-Oct 22 2020	Nov 30-Dec 20 2020	Mar 27-Apr 18 2021	Nov 7-Nov 24 2021
Households included in sample	1,117	1,046	1,115	1,565	1,550	427
Households interviewed	952	942	947	1,430	1,441	368
Household members included in symptom assessment[1]	952	7,381	6,916	7,418	11,541	2,894
Sex (% female)	61.0%	51.4%	51.5%	51.8%	52.2%	52.8%
HH members with symptomatic COVID-19 in recall period[2]	9	64	36	12	81	34
Period prevalence of symptomatic COVID-19	0.9%	0.9%	0.5%	0.2%	0.7%	1.2%
Symptomatic COVID-19 infection rate (cases/1,000,000/day)	311	285	103 ↓	34 ↓	78 ↑	102 ↑

[1] In round 1 only the household respondent was asked about symptoms; in round 2 onwards all household members were included
[2] In rounds 1 and 2 a one month recall period was used. In round 3 and 4 the recall period was the number of days since the previous interview. In round 5 and 6 a 3-4 month recall period was used due to the extended period since the last interview.
[3] Arrows indicate a rise or fall in the indicator since the previous data collection round.

Table 2: Prevalence of self-reported WASH resources and behaviours during previous 7 days

Data Collection Round	1[2]	2[3]		3		4		5		6	
Number of respondents[1]	952	942		872		1,430		1,380		368	
Households with adequate access to water	70 %	67 %	↓	64 %	↓	68%	↑	69%	↑	48%	↓
Households with adequate access to soap	52 %	39 %	↓	60 %	↑	50%	↓	60%	↑	36%	↓
Number of times hands washed per day	5.3	6.5	↑	7.8	↑	7.7	↓	8.2	↑	8.3	↑
Proportion of households reporting shortages of soap in the market	12 %	5 %	↓	5 %	–	23%	↑	29%	↑	21%	↓
Length of each hand washing episode (seconds)	27	n/m		45		50		n/m		n/m	

[1] Questions were asked to the respondent for each household, who was normally the head of household

[2] n/m = not measured

[3] Key protective behaviours are shown in italics and changes since the previous data collection round are indicated by red or green arrows. Red indicates a change in behaviours that is less protective against COVID-19 infection while a green arrow indicates a change that increases the protection of the population, and an orange bar signifies no change.

Table 3: Seven-day frequency of self-reported social distancing behaviours and facemask use

Data Collection Round	1	2	3	4	5	6
Number of respondents[1]	952	942	872	884	1,380	368
Key Behavioural Indicators[2]						
Average number of days they *kept a distance of at least two meters* (6 feet) from people outside of their household	1.4	1.0 ↓	0.8 ↓	0.6 ↓	n/m	n/m
Proportion who *covered their mouth and nose with a bent elbow* when coughing or sneezing (%)	65	61 ↓	61 –	70 ↑	n/m	n/m
Average number of days they *attended social gatherings* (e.g., visit family and friends, drink tea at a stall, etc.)	1.4	1.5 ↑	1.5 –	1.1 ↓	1.5 ↑	1.8 ↑
Proportion of respondents using *face masks* when outside of their home (%):				↑	↑	↓
Everyday			7 %	4%	20%	10%
Most of the days			8 %	9%	26%	13%
Some days			19 %	27%	18%	24%
Never			66 %	60%	35%	50%
Proportion of respondents who *shook hands* with people outside of their household (%):				↑	↓	↑
Everyday			5%	7%	3%	6%
Most of the days			14%	19%	10%	11%
Some days			36%	43%	33%	44%
Never			46%	31%	54%	35%

Proportion of respondents who *hugged* someone from outside their household (%):					↑	↓ ↑
Everyday			0%	0%	2%	0%
Most of the days			4%	6%	2%	2%
Some days			18%	25%	9%	21%
Never			78%	69%	87%	73%
Other behavioural indicators						
Proportion of men who attended Friday prayers at a mosque?	68 %	71 %	76 %	77	n/m	n/m
Average number of days Men and Women attended prayers at a mosque?	1.6	1.5	1.5	1.5	1.3	2.3
Proportion who left home to work	56 %	63 %	65 %	81	n/m	n/m
Average number of days they stayed at home all day, without going out at all and without receiving any visits	2.26	1.67	1.2	1.2	n/m	n/m

[1] Questions were asked to the respondent for each household, who was normally the head of household

2 Key protective behaviours are shown in italics and changes since the previous data collection round are indicated by red or green arrows. Red indicates a change in behaviours that is less protective against COVID-19 infection, a green arrow indicates a change that increases the protection of the population, and an orange bar signifies no change.

Table 4: Perceptions about COVID-19 and Vaccination

Data Collection Round	4	5	6
Number of respondents	884	1,412	368
How much of a threat, if any, is Covid-19 to your health and to the health of your family?			
Not a threat	7.9%	5.7%	2.2%
A minor threat	45.9%	24.8%	12.8%
A major threat	46.2%	69.6%	81.5%
Proportion who believe that Covid-19 is a disease that can affect only non-Muslims	6%	9%	10.1%
If a vaccine to protect against COVID-19 was offered to you now, would you take it?			
Yes	n/m	69.9%	77.5%
No	n/m	24.9%	18.2%
Not sure	n/m	5.3%	0.8%
If an elderly family member was offered the COVID-19 vaccine would you recommend they take it?			
Yes	n/m	67.7%	79.1%
No	n/m	26.4%	15.8%
Not sure	n/m	5.9%	1.6%
Main reason given for refusing vaccination (n=416):			
Don't know enough about it	n/m	33.9%	29.9%
Don't think it is safe	n/m	16.6%	6%
Worried about side effects	n/m	29.6%	20.9%
It won't stop COVID-19	n/m	2.2%	1.5%
I have already had COVID-19 and I am immune	n/m	0.5%	n/m
Would not know where to get it	n/m	0.7%	1.5%
My family would not allow me	n/m	0.5%	n/m
Would not be able to afford it	n/m	0.0%	n/m
Will of Allah	n/m	10.6%	29.9%
Other	n/m	5.5%	10.5%
Has anyone in your household received a vaccination against COVID-19?	n/m	n/m	11.4%
Vaccination coverage of household population	n/m	n/m	2.6%

Table 5: Crude Death Rate (CDR) and Cause Specific Death Rate in Households Covered by the COVID-19 Monitoring System

Data Collection Round	1	2	3	4	5	6
Persons under observation	7,618	7,395	6,917	7,418	11,541	2,680
Average recall period (days)	70	52	50	56	118	218
Person days of observation	528,664	349,942	348,870	350,982	1,281,809	584,736
Total deaths reported	16	12	17	10	23	12
Deaths in children <5 years	4	4	4	3	6	1
Deaths due to suspected COVID-19	5	4	5	4	8	4
COVID-19 death rate (deaths/million/day)	9.5	11.4 ↑	14.3 ↑	11.4 ↓	6.2 ↓	6.8 ↑
Crude Death Rate[2] (CDR) deaths/10,000/day	0.30	0.34	0.49	0.28	0.18	0.21
Under-5 Death Rate[3] (U5DR) deaths/10,000/day	_	0.61	0.61	0.46	0.25	0.09

[1] Recall periods/days of exposure are calculatd individually for each houshold member depending on the dates when they were interviewed.

[2] Threshold levels for CDR[2,3] are: 1/10,000,day = Emergency; 2/10,000/day = Out of control

[3] U5DR was not calculated for round 1. Threshold levels for U5DR are: 2/10,000,day = Emergency; 4/10,000/day = Out of control

Source: Humanitarian Charter and Minimum Standards in Humanitarian Response; Essential health services standard 1 http://www.spherehandbook.org/en/essential-health-services-standard-1-prioritising-health-services/

and Interpreting and using mortality data in humanitarian emergencies, Checchi and Roberts (2005) http://odihpn.org/wp-content/uploads/2005/09/networkpaper052.pdf

Annex 1

Symptom Score Case Definition for Suspected COVID-19

A provisional syndromic score case definition was developed by consultants working for BRCiS and has been utilised in the analysis reported here.

The symptoms, and the occurrence of a positive laboratory test, were recorded and then scored as listed in the table below. A suspected case of COVID-19 was defined as someone with a symptom score ≥ 2.0.

Table 1. Syndromic scoring system

Symptom or test	Scores
Loss or change in taste or smell	0.9
Cough	0.7
Fever	0.7
Shortness of breath or difficulty breathing	0.6
Fatigue	0.4
Sore throat	0
Headache	0
Diarrhoea or stomach pains	0
Body aches	0
Other	0
Positive laboratory test for COVID-19	2
Maximum possible score	**5.3**

A cut-off score of >= 2 was used to define a suspected case