BRCiS COVID-19 MONITORING

REPORT 3 | 24 May 2021

KEY MESSAGING

The BRCiS COVID-19 Monitoring system is continuing to collect data from Safety Net cash beneficiaries to assess the impact of the COVID-19 pandemic on their health and livelihoods. Five rounds of data collection have been conducted covering June 2020 to April 2021.

A second wave of infections has impacted Somalia from the start of 2021. Results show that the syndromic score case rate has risen in the BRCiS monitoring sites during the first 3 months of 2021.

The higher laboratory case rate reported during the 'second wave' may be partly due to the 7-fold increase in laboratory testing relative to the start of the pandemic.

Nonetheless, given the persistence of community transmission and the global circulation of highly transmissible SARS-CoV-2 variants, the public health situation remains serious and unpredictable.

Behavioural indicators show encouraging levels of awareness and increased adoption of preventative behaviours such as mask wearing in public places.

Vaccine hesitancy is lower than expected from other anecdotal reports.

The results reported here come from a sample of households that were not selected to be a nationally representative sample. The results, therefore, do not necessarily reflect the situation in the general population.

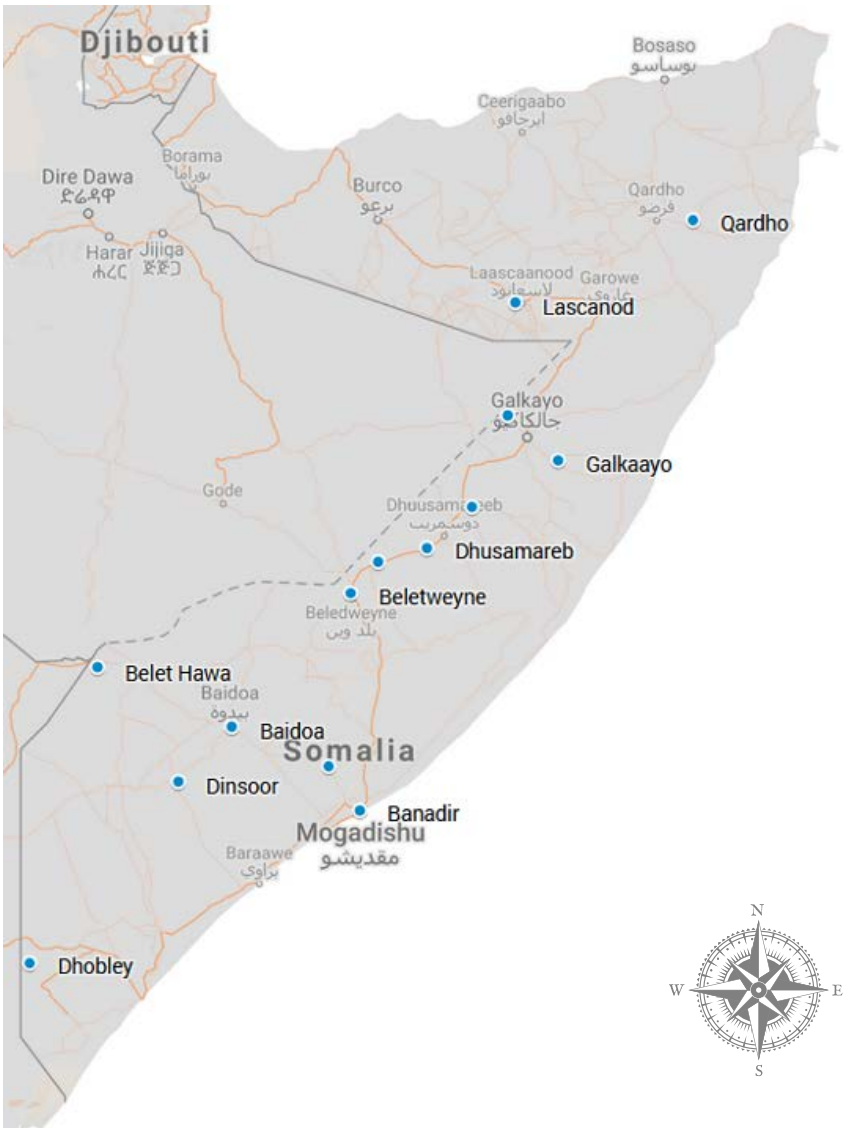
Overview

The Building Resilient Communities in Somalia consortium (BRCiS) is comprised of eight partner NGOs and is led by the Norwegian Refugee Council (NRC). BRCiS is monitoring the impact of COVID-19 on the beneficiaries of its Safety Net pilot cash transfer programme. This is the third report from the BRCiS COVID-19 Monitoring System in Somalia, and covers the period up to April 2021.

Methods

The BRCiS Safety Net pilot project serves 43 communities across ten regions: Banadir, Bari, Bay, Galgadud, Gedo, Hiran, Lower Juba, Lower Shabelle, Mudug, and Sool. It reaches 3,048 households in total. Participant households have diverse livelihoods and include pastoralists, agro-pastoralists, IDPs, and urban residents.

Map 1: The distribution of safety net participant households by district



The monitoring system uses a convenience sample of the households covered by the BRCiS Safety Net pilot project. A team of enumerators, closely supported and supervised by consortium technical staff, is collecting longitudinal data on households that are receiving Safety Net cash transfers. Household heads are interviewed by telephone and data is captured on mobile devices using ODK software. Data is collected on the prevalence of COVID-19 symptoms, impacts on food security, the way the cash transfers are used, and the death of household members, as well as key indicators of preventative behaviour and attitudes towards vaccination. Deaths are being monitored to determine the impact of the pandemic on the number of productive household members and the need for any additional support. To find out if a death is likely to have been caused by COVID-19, we are using the COVID-19 Rapid Mortality Surveillance questionnaire and analysis software developed in association with WHO.

To identify suspected cases of COVID-19, we are using a similar symptom scoring approach to the one used in the mortality surveillance screening tool. We ask about the presence of a range of symptoms and use 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. The initiative is being supported by external consultants. This report describes findings from the first five rounds of data collection, between June 2020 and April 2021.

Results

(a) Suspected Cases of COVID-19

Table 1 shows that the rate of suspected infection in the whole population sample fell markedly between rounds 2 and 3 and this fall continued through round 4. However, a marked rise in the case rate was seen during round 5, corresponding to the second wave of laboratory-confirmed cases of COVID-19 in Somalia.

(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 are being asked at each data collection round. Behavioural indicators for WASH and social distancing are described in tables 3 and 4 with key indicators given in italics.

There has been a small improvement in household WASH resources reported during round 5. The number of times hands were washed per day also increased. Questions on use of face masks, hugging and handshaking were introduced in round 3. There has been a large increase in the use of face masks during round 5, with respondents using them every day going up by 16 percentage points and the proportion never using them dropping by almost half. Hand shaking and hugging behaviours also fell during round 5. These data suggest that households sharply increased their COVID-19 precautions during the period since the start of the second wave.

This change in behaviour appears to agree with the increased concern about the seriousness of the COVID-19 threat, with nearly 70% of respondents seeing it as a major threat to their households. (table 4).

CONTRASTO/marcogualazzini/BRCiS

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
		All household members			
Data Collection	Jun 22–Jul 15	Aug 10–Sep 3	Oct 6–Oct 22	Nov 30–Dec 20	Mar 27–Apr 18
Households included in sample	1,117	1,046	1,115	1,565	1,550
Households interviewed	952	942	947	1,430	1,441
Household members included in symptom assessment1	952	7,381	6,916	7,418	11,541
Sex (% female)	61.0%	51.4%	51.5%	51.8%	52.2%
HH members with symptomatic COVID-19 in recall period[2]	9	64	36	12	81
Period prevalence of symptomatic COVID-19	0.9%	0.9%	0.5%	0.2%	0.7%
Symptomatic COVID-19 infection rate (cases/1,000,000/day)	311	285	103 ↓	34 ↓	78 ↑

[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 rounds 3 and 4 the recall period was the number of days since the previous interview. In round 5 a 3 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.

CONTRASTO/marcogualazzini/BRCiS

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

Data Collection Round	1[2]	2[3]	3	4	5
Number of respondents[1]	952	942	872	1,430	1,412
Households with adequate access to water	70 %	67 % ↓	64 % ↓	68% ↑	69% ↑
Households with adequate access to soap	52 %	39 % ↓	60 % ↑	50% ↓	60% ↑
Number of times hands washed per day	5.3	6.5 ↑	7.8 ↑	7.7 ↓	8.2 ↑
Proportion of households reporting shortages of soap in the market	12 %	5 % ↓	5 % —	23% ↑	29% ↑
Length of each hand washing episode (seconds)	27	n/m	45	50	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
Number of respondents[1]	**952**	**942**	**872**	**1,430**	**1,412**
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
Proportion who covered their mouth and nose with a bent elbow when coughing or sneezing (%)	65	61 ↓	61 —	70 ↑	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 ↑
Proportion of respondents using face masks when outside of their home (%):				↑	↑
Everyday			7%	4%	20%
Most of the days			8%	9%	26%
Some days			19%	27%	18%
Never			66%	60%	35%
Proportion of respondents who shook hands with people outside of their household (%):				↑	↓
Everyday			5%	7%	3%
Most of the days			14%	19%	10%
Some days			36%	43%	33%
Never			46%	31%	54%
Proportion of respondents who hugged someone from outside their household (%):				↑	↓
Everyday			0%	0%	2%
Most of the days			4%	6%	2%
Some days			18%	25%	9%
Never			78%	69%	87%
Other behavioural indicators					
Proportion of men who attended Friday prayers at a mosque?	68%	71%	76%	77%	n/m
Average number of days Men and Women attended prayers at a mosque?	1.6	1.5	1.5	1.5	1.3
Proportion who left home to work	56%	63%	65%	81	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
Households	1,117	1,046	1,115	1,565	1,550

[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[1]

Data Collection Round	4	5
Number of respondents	**884**	**1,412**
How much of a threat, if any, is Covid-19 to your health and to the health of your family?		
Not a threat	7.90%	5.70%
A minor threat	45.90%	24.80%
A major threat	46.20%	69.60%
Proportion who believe that Covid-19 is a disease that can affect only non-Muslims	6%	9%
If a vaccine to protect against COVID-19 was offered to you now, would you take it?		
Yes	n/m	69.90%
No	n/m	24.90%
Not sure	n/m	5.30%
If an elderly family member was offered the COVID-19 vaccine would you recommend they take it?		
Yes	n/m	67.70%
No	n/m	26.40%
Not sure	n/m	5.90%
Main reason given for refusing vaccination (n=416):		
Don't know enough about it	n/m	33.90%
Don't think it is safe	n/m	16.60%
Worried about side effects	n/m	29.60%
It won't stop COVID-19	n/m	2.20%
I have already had COVID-19 and I am immune	n/m	0.50%
Would not know where to get it	n/m	0.70%
My family would not allow me	n/m	0.50%
Would not be able to afford it	n/m	0.00%
Will of Allah	n/m	10.60%
Other	n/m	5.50%

[1] Trend indicators indicate when there has been an increase or decrease of 5 percentage points or more.

Vaccine hesitancy was surprisingly low (table 4), with 70% saying they would get vaccinated if it was made available. A slightly lower proportion would recommend their elderly relatives get vaccinated. This is perhaps related to the reasons given by people who would not currently take up vaccination. The top three main reasons were not knowing enough about the vaccine, followed by concerns about side effects or vaccine safety.

In round 5 we also asked if people had heard of key phrases used in the in the ongoing SBCC campaign on COVID-19 in Somalia (table 5). A high proportion of respondents reported hearing the three key phrases used. However, only slightly more than half reported that someone in their household had made their facemask, an approach that is recommended in the campaign.

Table 5: Trust in Information Sources and Awareness of BCC campaign[1]

Data Collection Round	4	5
Number of respondents	**884**	**1,412**
Have heard the phrase 'Hands face space'	n/m	87.5%
Have heard the phrase 'iMask up'	n/m	71.3%
Have heard the phrase 'I protect my flock'	n/m	67.8%
Someone in household has made their own facemask	n/m	53.1%
Proportion of respondents who mostly or strongly trust the following information sources about COVID-19:		
Religious Leaders/Mosque	94%	80% ↓
Community health workers or NGO workers	84%	81% ↓
Community Resilience Committees	82%	69% ↓
Women's group	70%	55% ↓
Government Sources	62%	65% ↑
Radio	59%	64% ↑

[1] n/m, not measured

Trust in different sources of information on COVID-19 are ranked in table 5, according to those reported in round 4. As indicated by the red and green arrows, trust in these sources has evolved with more people reporting trust in radio and government sources and a marked fall in trust in religious leaders, resilience committees, and women's groups. However, these 3 sources still remain the most trusted.

(c) Mortality

As shown in Table 5 below, both the crude and under five death rates continued to be below emergency thresholds during round 5. The cause specific death rate attributable to suspected COVID-19 rose also fell between round 4 and 5. As deaths lag behind infection by about 3 weeks, we may see an increase in suspected COVID-19 deaths during the next round of data collection, reflecting the increase in infections detected in round 5.

Shutterstock.com

Table 6: 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
Persons under observation	**7,618**	**7,395**	**6,917**	**7,418**	**11,541**
Average recall period (days)	70	52	50	56	118
Person days of observation	528,664	349,942	348,870	350,982	1,281,809
Total deaths reported	16	12	17	10	23
Deaths in children <5 years	4	4	4	3	6
Deaths due to suspected COVID-19	5	4	5	4	8
COVID-19 death rate (deaths/million/day)	9.5	11.4 ↑	14.3 ↑	11.4 ↓	6.2 ↓
Crude Death Rate2 (CDR) deaths/10,000/day	0.3	0.34	0.49	0.28	0.18
Under-5 Death Rate3 (U5DR) deaths/10,000/day	–	0.61	0.61	0.46	0.25

[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 CDR2,3 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 See: 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). See; http://odihpn.org/wp-content/uploads/2005/09/networkpaper052.pdf

Conclusions

- The first 5 rounds of data collection indicate that while infection levels had fallen by October there has been a renewed surge of infections in the early part of 2021, corresponding to the widely reported second wave.
- In round 5 we introduced additional behavioural and perception indicators to look at attitudes to vaccination against COVID-19 and awareness of the national SBCC campaign. Results show 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 also increased during round 5.
- This change in behaviours is associated with a marked increase in the proportion of respondents who see COVID-19 as a major threat to their households.

Results show a high level of awareness of key campaign slogans and a surprisingly low degree of vaccine hesitancy compared to anecdotal reports.

Recommendations

- The monitoring of the outbreak within Somalia should be continued as the case incidence is still significant and further increases in infections are possible. This includes the possibility of outbreaks with new variants, such as the Delta (B1.176.2) variant currently highly prevalent in India and rising in the UK and elsewhere.
- SBCC activities should continue and build on the relatively high awareness of COVID-19, tackle reasons for vaccine hesitancy, and stress the need for continued preventative behaviours while case numbers remain elevated.
- 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.

Annex 1

Symptom Score Case Definition for Suspected COVID-19

A provisional syndromic score case definition has been 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, are recorded and then scored as listed in the table below. A suspected case of COVID-19 is defined as someone with a symptom score of ≥ 2.0.

Table 1: Syndromic scoring system

Symptom or test	Score
Loss or change in taste 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
Ciarrhoea or stomach pains	0
Body aches	0
Other	0
Positive laboratory test for COVID-19	2
Maximim possible score	***5.3***

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