September 2020

COVID-19 information note 5

Preventing resurgence of COVID-19 in Somalia: proposed strategic interventions for the next phase of the epidemic

Epidemiological situation of COVID-19 in Somalia: low prevalence and unknowns

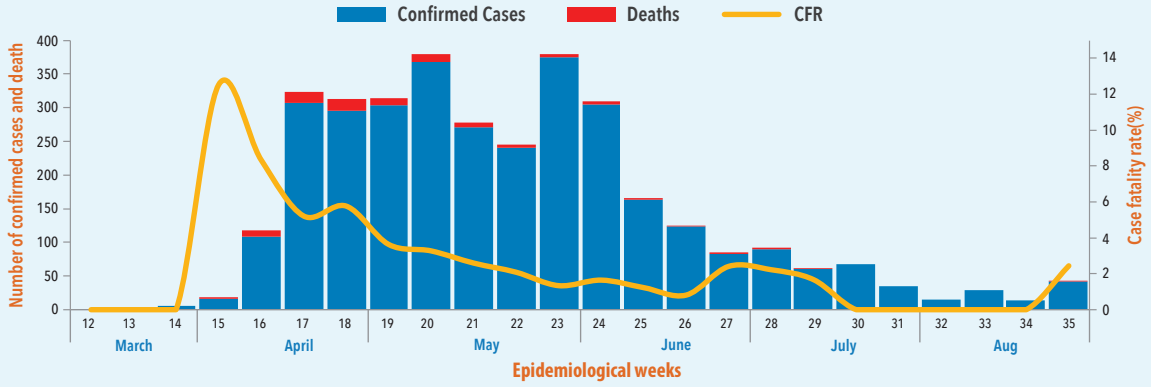
The Ministry of Health and Human Services of the Federal Government of Somalia reported that 3310 laboratory-confirmed cases of coronavirus disease-19 (COVID-19) including 97 associated deaths had been recorded in the country as of 31 August 2020. After the first confirmed case, reported on 16 March 2020, the country saw a rapid rise in cases during the months of May and June after community transmission of the virus causing COVID-19 (SARS-CoV-2) began in late March and April. The outbreak spread to all states of the country with varying degrees of community spread, but recently the laboratory-confirmed cases and deaths have been steadily decreasing (at a rate of between 60 and 90%) across all states since epidemiological week no. 26 (week ending 27 June). During week no. 31 (week ending 1 August), the overall positivity rate was 7% – a significant drop in positivity rate from over 50–60% reported in epidemiological week no. 24 (week ending 13 June). This too despite a relative increase in the number of samples tested during the same period.

Other epidemiological measures, such as the time-varying reproduction number, growth rate and doubling time, also indicate that the epidemic is not growing, transmission is confined to specific geographical areas and virus transmission has been slowing recently, 5 months after the virus was introduced in Somalia in March 2020. Many of the questions on this slowdown of epidemic growth remain unanswered.

Next phase of the epidemic: risk assessment

WHO's current epidemiological risk assessment shows that, to date, COVID-19 cases have been reported from 57 (48%) of the 118 districts in Somalia. Of the remaining 61 districts, samples from only three districts were tested for COVID-19 and none had positive cases. No samples have been collected from the remaining 58 districts. This means that there is no information on the epidemic or any ongoing circulation of COVID-19 virus in these 61 districts where an estimated 4.7 million people (30% of the population of Somalia) live. At least 17 of these districts are not accessible because of security concerns and poor communication

EPIDEMIC CURVE OF COVID-19 CASES AND DEATHS IN SOMALIA, 16 MARCH-29 AUGUST 2020



World Health Organization
Somalia

infrastructure. The media are also reporting that most people in the country are not strictly following the mitigation measures aimed at reducing infection among the susceptible population, such as physical distancing, wearing masks and avoiding public and mass gatherings. In addition, there are now confirmed cases among the 2.6 million internally displaced people, where standard measures such as self-isolation and quarantine practices are difficult to implement.

The country has recently lifted movement restrictions and lockdown measures; this move was more a political choice than one based on a risk-based approach. For example, domestic and international flights have resumed in Somalia. Given the porous borders between Somalia and its neighbouring countries, where cases and deaths have not yet shown any sign of stabilization, development partners are apprehensive that, because of the withdrawal of travel restrictions, the cross-border movement between these countries may lead to a reintroduction of the virus and an upsurge in COVID-19 cases, especially in the border districts.

Although the current epidemic of COVID-19 in Somalia is not showing any sign of growing exponentially, it has a non-linear pattern and different peaks have been seen at different times. These peaks probably correspond to the number of samples tested at that time and they do not necessarily represent a true increase in case numbers. Even though cases of COVID-19 have decreased recently, it is too early to predict how the epidemic will evolve in the coming months as it is not clear if this decrease represents a true decline given that few tests have been done in Somalia compared with neighbouring countries.

In view of this situation, development and humanitarian partners have some justifiable concerns that the current epidemic trajectory may not represent the true epidemiological situation in the country, and that a large number of cases may be undetected and community transmission may be continuing unnoticed in small geographic areas which is not being picked up by the country's weakened surveillance system. Given the fragile setting in Somalia, low levels of testing and a lack of a systematic strategy to test, track and trace, the COVID-19

position remains a public health concern. Therefore, a strategy was needed for the current situation in order to ensure that the epidemic risk of COVID-19 remains low among susceptible populations as indicated by recent surveillance data, and that concerns about silent community transmission of the virus in some isolated or inaccessible areas are properly addressed.

As the virus is more contagious than other respiratory viruses, there is urgent need to strengthen and possibly expand the epidemic response capacities of the health authorities for COVID-19. In addition, because the size and scale of the outbreak cannot be ascertained – because of the low levels of testing and limitations in the surveillance system – key public health actions that are already being implemented must be supported and expanded to prevent further spikes in COVID-19 cases, the re-establishment of community transmission and a resurgence of the epidemic. Such a resurgence has been observed in many countries where, following a period of low virus prevalence and a period of relaxation of active case finding, contact tracing and quarantine, the virus rebounded and triggered further community transmission. In many countries this rebound happened because of undetected community clusters either from ongoing slow levels of virus circulation or from reintroduction of the virus.

Strategy for the next phase of the COVID-19 epidemic

WHO's proposed strategy will have two overarching goals – containment and suppression. These goals will be achieved by building on current interventions to promote active case finding and case management using test, trace, track and treat. Under this strategy, WHO will partner with other agencies to support the federal and state health authorities with targeted interventions to:

- contain COVID-19 outbreaks within geographically limited areas wherever cases are detected,
- limit human-to-human transmission in order to prevent possible resurgence, and
- prevent reintroduction of the virus through importation.

Table-1: Strategies for enhancing epidemiological and virological surveillance for COVID-19, September to December 2020	
1	**Assess ongoing circulation**
	a. Monitor circulation of virus in all 'silent" districts
	b. Assess epidemiological signs of ongoing circulation
2	**Prevent reintroduction of virus**
	a. Enhance screening measures for incoming travellers at the designated points of entry
	b. Improve cross-border surveillance and information sharing
	c. Conduct regular epidemiological risk
3	**Monitor the circulation of COVID-19 and other respiratory viruses including influenza**
	a. Test all patients with pneumonia, pneumonia-like symptoms and unexplained fever for COVID-19
	b. Establish sentinel-based surveillance system for severe acute respiratory infection (SARI)
	c. Introduce sentinel-based surveillance system for influenza-like illness
	d. Expand the community-based surveillance for respiratory disease

The strategy and public health measures proposed are based on available evidence, proven effectiveness of interventions and lessons drawn from WHO's response to the COVID-19 outbreak in its first 100 days. The strategy provides a planned pathway to prevent and control of COVID-19 and other epidemic threats from acute respiratory infections.

To this end, the following essential activities will be further expanded and strengthened.

Enhance epidemiological and virological surveillance

The current surveillance system will be enhanced at the health-facility and community level to detect suspected COVID-19 cases in districts not reporting on COVID-19 and in the general population, and at points of entry into the country.

(i) Assess ongoing circulation of COVID-19

WHO will deploy a specialized team to the 44 accessible districts (out of 61 districts) where no epidemiological signs of circulation of COVID-19 are evident. The team will conduct a field investigation in September 2020 and carry out the following activities.

- Visit the main health facilities and look at the log or register of outpatient and/or inpatient departments and review the trend of outpatient visits of patients with fever and respiratory symptoms.
- Systematically collect nasopharyngeal swabs from each of these districts (at least 15–20 samples per district). All patients with a negative malaria test result who have a high-grade fever and respiratory difficulty will be swabbed.
- Ship these samples for testing to the Central Public Health Reference Laboratory in Mogadishu.

Both the epidemiological and virological data from these 44 districts will be collected digitally using the Open Data Kit platform and analysed separately in real time. Based on the epidemic risk and on evidence of ongoing circulation of COVID-19 in these districts, an interventional plan will be developed.

(ii) Prevent reintroduction of virus

WHO will work closely with the UN International Organization for Migration and the airport health authorities to prevent reintroduction of the virus. The following activities will be undertaken.

- Screening (temperature screening using either hand-held digital thermometers or thermal scanners) of all incoming travellers at the 21 designated points of entry.
- The government's policy for incoming travellers (either returning with a negative PCR result or quarantine for a certain duration) will be supported using an epidemiological risk-based approach.
- The state-based rapid response teams will be trained on enforcing implementation of government policies for incoming travellers, for example enforcing quarantine measures or getting a COVID-19 test result on arrival in the country.

In addition, WHO will put an emphasis on cross-border surveillance between Somalia and other neighbouring countries by facilitating information-sharing and continuous risk assessment.

(iii) Monitor the circulation of COVID-19 and other respiratory viruses, including influenza

Health-facility level

- All patients presenting with pneumonia, pneumonia-like symptoms or unexplained fever will be screened and tested for COVID-19. This action will be implemented in all high-volume health facilities across the country. Trained health workers will be required to take samples and ensure that these cases are isolated until the test results are known. The test result should be made available within 24 hours of sample collection.
- One sentinel site will be established immediately in each of the main cities of Banadir, Hargeisa and Garowe for virological surveillance of severe acute respiratory infection. These sites will be expanded to seven once the molecular testing laboratories are established in all state capitals. The sentinel sites will collect both epidemiological data and nasopharyngeal swabs from suspected cases that meet the case definition for severe acute respiratory infection. Samples from these sentinel sites will be tested for COVID-19, influenza and other respiratory viruses using multiplex pathogen detection. Both the epidemiological and virological data will be analysed every week using an online web-based and mobile phone platform especially developed for surveillance of severe acute respiratory infection (emflu.emro.who.int). The data for this surveillance will be accessible online in the public domain.
- In each of the state capital cities and in each of the 18 regional hospitals (at least 25 in the country), sentinel sites for influenza-like illnesses will be established at the outpatient departments for virological surveillance of influenza. Swabs from e patients with influenza-like illnesses will be tested for COVID-19 and influenza.

Community level

- Community health workers will continue to visit households of the 50 districts on a regular basis for case finding and contact identification.

- In particular, community health workers will monitor all newcomers to a community for at least 14 days to ensure that if any of these new arrivals develop signs and symptoms of COVID-19, they are quarantined and swabbed until the test result is available.
- The community health workers will also inform district-based rapid response teams using the Open Data Kit platform to investigate and verify any community clusters or any other situations that suggest the possible introduction or circulation of the virus.

Specific events

- The state-level rapid response teams will undertake rumour verification (preferably case investigation should be completed within 48 hours of notification) including collecting samples for proper verification.
- The community health workers will notify the district-based rapid response teams about any unexplained community deaths and unexplained clusters of illness among specific populations for further investigation

Public health measures

In line with the actions that have already been implemented on the ground, the following public health measures will be scaled up in support of this strategy.

- Active case search. Community health workers will visit households of geographically defined areas (at least 4000–5000 a week) and look for any suspected case with signs and symptoms of COVID-19.
- Alert investigation and sample collection. All alerts (100%) of suspected cases or clusters of cases will be investigated by the rapid response team within 24–48 hours of notification by the community health workers. All sporadic cases and all suspected cases in a cluster will be sampled (100%). In principle, 20–30 tests for each symptomatic laboratory-confirmed case will be done. The test result should be available within 24 hours

- Self-isolation at home and hospital isolation. All asymptomatic cases and cases with mild symptoms will be self-isolated while cases with chronic health conditions and elderly people will be isolated at any of the designated isolation centres.
- Proactive containment. At least 70–80% of close contacts of a laboratory-confirmed cases will be traced, followed up and quarantined.
- Accessible laboratory network. Additional PCR-based laboratories (6–7) will be established at the federal member states to increase the laboratory network and access to testing for COVID-19 and other viral respiratory diseases.

Epidemiological risk assessment

WHO will continue to conduct a joint epidemiological risk assessment with the federal and state health authorities on the epidemiological situation of COVID-19, how it is evolving and any other emerging health threats.

Expected outcome

Two outcomes of implementation of this strategy are expected.

- Suppression of the virus in geographically limited areas where signs of reintroduction or ongoing circulation of COVID-19 virus are evident.
- Prevention of the re-establishment of community transmission and further spread of the virus and a resurgence of the COVID-19 epidemic.

Funding gap and requirement

WHO will need approximately USD 10.87 million to implement these strategic interventions during this phase of the epidemic until March 2021.

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