COVID-19 and Sustainable Development in Somalia/Somaliland

Phase 2 Report

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COVIDEV

COVIDEV is a research and practice collaboration between the University of Bristol and Transparency Solutions on the protection and promotion of sustainable development in Somalia/Somaliland during, through and as a method of COVID-19 response.

In this work, sustainable development is the enhancement of lives, livelihoods and inclusion for current and future generations so that they can live the lives they value in ways that allow the natural world to flourish.

COVIDEV is part of the joint University of Bristol and Transparency Solutions Somali First initiative to promote Somali-led development in all sectors. Transparency Solutions is an official Strategic Partner of the University of Bristol.

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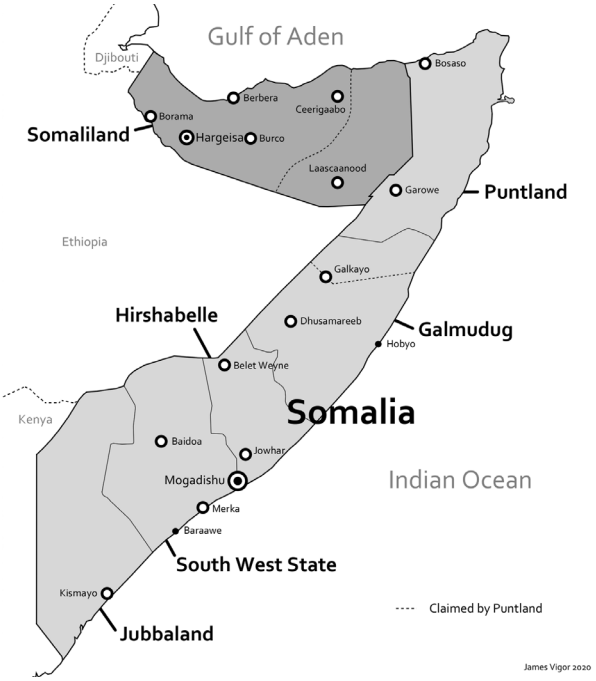
INTRODUCTION

Somalia/Somaliland is among the places of the world least able to cope with COVID-19 (coronavirus disease) due to numerous forms of poverty-related deprivation, low levels of access to health care and limited state capacity. Before this crisis struck it was already a long way from having sustainable development. COVID-19 and responses to it threaten to undermine what Somalia/Somaliland has achieved in development.

In this project we examined how sustainable development might be promoted during, through and as a method of COVID-19 response in Somalia/Somaliland. We did so though discussions with people in Mogadishu (capital of Somalia) and Hargeisa (capital of Somaliland). By sustainable development we mean the enhancement of lives, livelihoods and inclusion for current and future generations so that they can live the lives they value in ways that allow the natural world to flourish. In 1991, Somaliland unilaterally declared its independence from Somalia. It has been self-governing ever since but has not achieved international recognition as a sovereign state; this status is why we refer to Somalia/Somaliland where relevant.

The people we spoke with were mainly those who in some way are excluded from full participation in their society due to illiteracy, gender, youth, being a member of a minority clan or minority ethnic group, or being a low caste worker, rural pastoralist, informal small trader, internally displaced or a refugee from another country. Sometimes an aspect of exclusion such as gender is counterbalanced by an aspect of inclusion such as higher income. However, often aspects of exclusion intersect and reinforce each other, such as low income, internal displacement and illiteracy. We also discussed these issues with some



people in more privileged positions – government health, employment and inclusion (e.g. women's rights) officials and senior or middle ranking telecommunications company staff. The idea of talking with people from diverse backgrounds was to see the issues from many different perspectives and to provide a platform for those who usually are not listened to due to exclusion.

This report is based on the second phase of work for this project. For details of our overall methodology for Phase 1 and Phase 2 and for our Phase 1 findings please see our initial report on the Transparency Solutions website in English and Somali.

For Phase 2 we carried out a series of three interviews and focus group discussions with the forty participants (twenty in Mogadishu and twenty in Hargeisa) during July 2020. The health and safety of all researchers and participants in relation to COVID-19 was ensured by use of non-face-to-face methods only, i.e. telephone and online.

DISTRICT LEVEL RESPONSE TO COVID-19

We asked participants, 'In your district, what is your overall rating of the response to COVID-19?'. This was assessed on a scale from 'Excellent' down to 'Very poor'.

Table 1: District level response to COVID-19 – Mogadishu

Excellent	Good	Neither good nor poor	Poor	Very poor	Don't know / No answer
0	1	5	5	6	3

Table 2: District level response to COVID-19 – Hargeisa

Excellent	Good	Neither good nor poor	Poor	Very poor	Don't know / No answer
2	15	3	0	0	0

There were strongly divergent responses from Hargeisa and Mogadishu. The Mogadishu participants, spread across a number of different districts, perceived the district level responses to COVID-19 as more negative with over 50% of the respondents answering 'Poor' or 'Very poor'.

'We have never seen precautions in this district, we just heard about the coronavirus issues from the media and the official offices of the Government. Only schools have been closed, other aspects of life have been going well.' (P10 – Youth)

'The district officials initially seemed like they were responding to COVID-19. They came to the neighbourhoods and took pictures with the community members, but we didn't hear from them again.' (P17 – Low caste worker)

In Mogadishu, the perception of a lack of district level involvement to the COVID-19 response was tempered by opinions that the Federal Government of Somalia (FGS) was leading the response, rather than the district authorities.

'The response to COVID-19 was handled by the FGS and BRA [Benadir Regional Adminsitration – the Mogadishu area local government]; the local districts were just playing a supporting role.' (P20 – Disabled person)

'I have seen people raising awareness on COVID-19 but to my knowledge they were from the Mogadishu Municipality, not from the local district.' (P14 – IDP)

Participants with less representation in society reported that local government officials initially visited their areas, with minimal follow up.

'We were visited by people from the local government who provided us with hand-washing machines and some advice.' (P15 – Minority clan member)

Rural areas surrounding Mogadishu were re-

ported to have seen no response to the disease.

'COVID-19 responses didn't reach the small villages and the rural areas at all.' (P19 – Rural pastoralist)

The participants from Hargeisa had opposing views to Mogadishu, with 75% answering that the district level responses to COVID-19 were 'Good'.

'They have ensured distancing on public transportation.' (P30 – Youth)

'People were, and still are, taking the necessary actions by wearing face masks; I still do too.' (P36 – Minority ethnic group member)

One explicit and reoccurring reason for the positive opinions from Hargeisa participants was the increased levels of awareness raising facilitated within their districts, which enabled people to help themselves regarding hygiene and social distancing.

'I would explain that there were great efforts with the precaution methods; hand washing, face masks, social distancing, messages through cell phones, spreading out at grocery markets, improved hygiene from the local government, country-wide awareness raising, restrictions at mosques etc. Specifically, hand washing was a practice that people adopted widely. These were delivered well and people obtained skills and knowledge.' (P40 – Disabled person)

'They carried out good awareness raising across the different sub-districts; precaution practices, required standards and informing the individual people about COVID-19. This has been a continued effort that has been observed by many people. Of course, there were limitations on meeting the standards.' (P35 – Minority clan member)

'There were strong restrictions on public gatherings in the condensed settlements. Children were trained on basic hygiene practices such as hand washing, elbow coughing and sneezing, and maintaining these practices in the home. People adopted prevention practices and they maintained these regularly.' (P34 – IDP)

Two participants from Hargeisa suggested that it actually was the citizens of Hargeisa who drove and ensured COVID-19 precautions were adhered to, with little input form the local government.

'People themselves controlled their own movements; in particular not going to public gathering places. This is what I observed personally, which delighted me very much.' (P37 – Low caste worker)

'The local government should have played a bigger role in this response as they are the ones responsible for the districts. All they did was hire a few cars and place speakers on them, going around downtown telling people to social distance.' (P28 – Woman)

As in Mogadishu, not all participants received the same level of engagement; especially in those rural areas outside of Hargeisa.

'For us in the countryside, there was little awareness raising on COVID-19. Most of the support targeted urban areas like Gabiley. We observed that many programmes had been delivered to Gabiley, Tog-wajale, Alleybadey, and Kalabiadh towns in the Gabiley region. There was little on awareness raising for us as a rural community.' (P39 – Rural pastoralist)

ACCESS TO HEALTH CARE

Focusing on the accessibility of health care we asked participants, **'Which of these is closest to describing the situation of you and your family right now?'**

Table 3: Access to health care – Mogadishu

Usually able to access major health care	Sometimes able to access major health care	Usually able to access minor health care	Sometimes able to access minor health care	Nearly always unable to access even minor health care	Don't know / No answer
6	3	2	3	6	0

Table 4: Access to health care – Hargeisa

Usually able to access major health care	Sometimes able to access major health care	Usually able to access minor health care	Sometimes able to access minor health care	Nearly always unable to access even minor health care	Don't know / No answer
1	4	4	7	4	0

In Mogadishu, 45% of participants reported that they were able to access major health care at some level. However, 25% of participants still reported that they were nearly always unable to access even minor health care. The ability to access health care is often reportedly reliant on an individual's financial position.

'The healthcare is not free, but I am one of the few privileged who can have access to it. I am a health professional; I have worked in different hospitals and I know most of the doctors in Mogadishu. That makes it easy for my family and I to get access to the health care, but this is not true for everyone else.' (P1 – Government health official)

'I can access major health care. However, it is expensive and depends on my health situation.' (P4 – Telecoms employee)

'In Somalia, if you have money then you have access to the health facilities. We don't have free health care in the country; it depends on your income and situation. My family and I don't have access to health care because our income is too low.' (P6 – Small informal trader)

'Access to the health system, for me and my family, is dependent on our ability to pay. It's also dependent on what facility you need. In terms of having severe and high-level critical issues, you need a lot of money and we don't have that much money. There is no free access to the health care system.' (P12 – Illiterate person)

'We don't have facilities everywhere; we need health care in our area. It depends on your ability to afford it.' (P8 – Woman)

A government official from Mogadishu stated that, though limited in capacity, free health care was being introduced and therefore becoming more accessible for COVID-19 patients specifically.

'In Somalia, your access to health care depends on your ability to afford going to the hospitals. Generally we don't have free health care, but the government recently changed this for COVID-19 patients. Although

the capacity is below the required level, people are now admitted to Di Martino hospital free of charge.' (P2 – Government employment official)

The existence of free health care is reported by two participants, with the caveat that it is generally not effective or is for specific segments of society.

'It is available in our area and it's all your choice; if you have a high income and you can afford paying for your treatment, you can go to any hospital like Dikfer or other hospitals. Although there is free health care in our country, most of the people have a big problem with this issue.' (P10 – Youth)

'The hospital fees are expensive, and we often cannot afford it, but there are free Maternal & Child Health Centres which provide basic consultations.' (P15 – Minority clan member)

Only 25% of participants from Hargeisa stated that they could usually or sometimes access major healthcare. Most participants stated that they could either usually or sometimes access minor health care. 20% of participants reported that they were nearly always unable to access even minor health care. Major health care is reported as not accessible on a daily basis in Hargeisa, with minor health care services being the main facility that there is any possibility of accessing.

'If we take away the public healthcare, the big hospital, that's the only place open on a Friday or public holidays. If I break my leg or have a heart attack, there's nowhere for me to go until Saturday morning. Not even private healthcare is open on Fridays, nowhere is open.' (P23 – Government inclusion official)

'It is all minor health services, [paid] through your own pocket, because there is no relevant public health care that people can get! You need to finance your own family health from your pocket. This is the reality on the ground in Somaliland.' (P27 – Woman)

'I find it really necessary to go to the hospital or receive health care when I'm pregnant or nearly giving birth. Most of the time it is almost impossible to go to a hospital or seek medical assistance as it is very expensive, and we cannot afford that.' (P26 – Small informal trader)

The issue of financing health care that was prominent in Mogadishu was further reflected in Hargeisa.

'It is all beyond our capacity, financially, to get the necessary health care. There is no public health care available at all, and no relief schemes that would provide support to the majority of the poorer households.' (P35 – Minority clan member)

'To cover the health of my family, as well as my own, it is all from my own pocket. I have never seen any public health care schemes or donations.' (P37 – Low caste worker)

'Accessing health care depends on your financial capacity in Somaliland. You should not expect sufficient public health care.' (P22 – Government employment official)

'There is no free health care. Everything comes with a price.' (P24 – Telecoms employee)

'The health service is available, but we can't afford it. For both private and public health care, you must pay.' (P30 – Youth)

It is perceived that people with more money will travel abroad to address their medical issues, rather than accessing medical care at home.

'Most rich people go abroad for treatment.' (P35 – Minority clan member)

'There is no such thing as a free health care in Somaliland. If you have money you will go to the big hospitals or travel abroad. If you can't, like us, you will just stay inside your house whether you are ill or not.' (P33 – IDP)

The COVID-19 response was also reported to have damaged the general health care service in Hargeisa, with delays in treating medical problems deemed to be less urgent.

'It's affected our community, not just my family. People are afraid to go to hospital because COIVD patients are there. The government failed to nominate a specific area to treat COVID-19. They nominated one hospital, but the government hospital is for everything, for all regions of Somaliland, for every major disease. The people who wanted to go to the hospital have reduced because they know COVID patients are there; this is also where the people go to get tested. They made a big mistake announcing to the people that if it's not an emergency, they should hold on and not come to the hospital for check-ups or elective operations. Because of that, the people have been stigmatised when seeking help in the hospitals. This has majorly affected the people. Anyone with communicable diseases, they have postponed their appointments. It takes time to rectify, already people are stigmatised. Rather than seeking help in the hospital for their check-ups; they're too afraid to do so. Currently, the government hospital is trying to change this because they understand the number of non-COVID patients has reduced. They are now trying to focus COVID-19 into one hospital, including the testing of it.' (P21 – Government health official)

CONFIDENCE IN THE QUALITY OF HEALTH CARE

We asked participants, 'Which of these is closest to describing your view of the quality of the health care in your area (not just for COVID-19)?'.

Table 5: Confidence in the quality of health care – Mogadishu

High confidence	Moderate confidence	Low confidence	Don't know / No answer
1	7	9	3

Table 6: Confidence in the quality of health care – Hargeisa

High confidence	Moderate confidence	Low confidence	Don't know / No answer
0	5	15	0

The answers from both Mogadishu and Hargeisa were more aligned with regard to the respondents' confidence in the quality of health care. Only 1 participant, from the total sample of 40 participants, answered that they had high confidence in the quality of health care in their area. In Mogadishu, 7 participants had moderate confidence in the health care in their area compared to 5 from Hargeisa.

'There are a lot of hospitals in my area, including two government-run hospitals, Madina Hospital and Banadir Hospital. The hospitals have recently been rehabilitated with the help of the private sector.' (P1 – Government health official)

At least 10% of Mogadishu participants explicitly mentioned their fears and doubts surrounding the qualifications and professional conduct of people who claim to be doctors.

'The quality of both the medicine and the private medical staff need to be reviewed. At the moment, everybody can claim to be a doctor.' (P2 – Government employment official)

'I do not think the quality of the healthcare is good. There are a lot of people who claim to be doctors but only God knows if they are telling the truth or not.' (P18 – Minority ethnic group member)

One participant was even worried about becoming more ill by being prescribed the wrong medicine.

'I have low confidence in the medical care in my area. I normally go to small clinics and I worry about my health if they give me the wrong medication. At these clinics, they don't have professional doctors or nurses. We sometimes hear that someone has become sick because of the wrong drugs from the wrong prescription.' (P16 – Minority clan member)

Another fear regarding the quality of health care available in Mogadishu was related to the lack of sufficient and applicable resources and equipment.

'We are importing medicine from unreliable sources. Parliament has recently passed the medical practitioners' law and I hope it will be enforced to ensure people's lives and their health are not at risk.' (P2 – Government employment official)

The economic factor which drives private medical health care facilities in Mogadishu is also an issue; this was seen as leading to institutions sacrificing quality for profit.

'All the hospitals in this area are for profit; they prioritise income and they expect too much for the services they provide.' (P9 – Youth)

45% of participants from Hargeisa and 75% of participants from Mogadishu reported that they had low confidence in the quality of the health care. Overall, participants from Hargeisa were less confident in the quality of health care.

'I do not have the capacity to get relevant medical care with a suitable quality, at all. It is all dependent on your financial capacity.' (P35 – Minority clan member)

'To be honest, I do not have any confidence in the quality of the medical care in my area. You need to cover yourself and I do not see it improving. On the other hand, people are stable and have confidence in the COVID situation as they were provided with awareness raising.' (P37 – Low caste worker)

'I have low confidence in the quality of healthcare in my area because of the shortage of facilities and resources, and also the unskilled healthcare professionals.' (P28 – Woman)

The economic factor is again an influence regarding the quality of health care in Hargeisa.

'The quality depends on your income, to have the options.' (P33 – IDP)

Reported perceptions of medical professionals being unqualified in Mogadishu were also a feature of responses of some of the Hargeisa participants.

'There is not sufficient health care, so there is no issue to consider about the quality! Again, there are no qualified professionals in service.

We are concerned about the medical equipment which is either limited or does not meet the necessary qualitative standards.' (P22 – Government employment official)

'I have low confidence in the quality of healthcare in my area because of the shortage of facilities and resources, and also the unskilled healthcare professionals.' (P28 – Woman)

One participant indicated that they already know what is wrong with them and that hospital results do not uncover anything further.

'We get tired when we follow up and review the hospital tests and the result is something we already know.' (P38 – Minority ethnic group member)

Following on from this distrust of medical professionals, traditional remedies as a more effective alternative were proposed by a small informal trader and minority ethnic group member.

'I don't think hospitals are that bad, you will only know if they are bad when you go to them multiple times. Our case it is different, we prefer to use natural home remedies which we have found to be so effective for so many diseases. You can solve constipation with warm camel milk and use ginger, black seeds and honey for colds and allergies.' (P36 – Minority ethnic group member)

'I usually see the gynaecologist whenever I go to a hospital. When that happens, it is either expensive or they will give you a pack of medicine and sometimes I feel like that my body has got used to them because it is not making any difference. When that happens to me, I switch to natural home remedies like ginger, garlic and black seeds; they are effective.' (P26 – Small informal trader)

EVALUATION OF THE PHASE 1 REPORT

After having sufficient time to read or listen to a summary of the Phase 1 report, we asked participants to **'Please give the report an overall rating. Please be honest'**.

Table 7: Evaluation of the phase 1 report – Mogadishu

Excellent	Good	Neither good nor poor	Poor	Very poor	Don't know / No answer
19	1	0	0	0	0

Table 8: Evaluation of the phase 1 report – Hargeisa

Excellent	Good	Neither good nor poor	Poor	Very poor	Don't know / No answer
19	1	0	0	0	0

19 out of 20 of the Mogadishu participants rated the Phase 1 report as 'Excellent', with one participant rating the report as 'Good' overall.

The majority of Mogadishu participants stated that they had no suggested changes for the report. They told us that it had informed them much more than expected, all comments from participants had been included, it was the best research on COVID-19 that they had participated in and one of the best research projects completed in Somalia.

'Excellent. I have read the complete report and I wanted to tell you that your level of understanding of the situation on the ground is unmatched, honestly.' (P8 – Woman)

'This is not the only COVID-19 related research I have participated in, but it is definitely the best with its simple and inclusive approach.' (P14 – IDP)

'I went through your report and I can say it is one of the most amazing pieces of work done in Somalia. Well done to you.' (P2 – Government employment official)

'The report has given me more information on the impact of the virus than I thought. I mean, I already knew that it had financially affected many people, but the impact is far reaching according to the report. Also, the fear it has come with is very worrying.' (P11 – Illiterate person)

'I don't have much to add. I think since you have already included everyone's contribution to the report there are no further additions required.' (P8 – Woman)

'The report is very informative; it asked us our concerns and made them known to the rest of world.' (P12 – Illiterate person)

The participant who rated the report as 'Good' suggested talking directly with people we know to have been affected by coronavirus.

'You could have talked to those who recovered from the virus and see how they have been financially and psychologically affected. Did they pay for their treatment, for example? What about those who have a dead relative from the virus, how are they feeling?' (P7 – Woman)

Diverse participants from Mogadishu said that the report was an inclusive one. They recognised the intention to create a space where everybody's opinion would be heard equally, including ensuring that approximately half of the participants were women; engaging with people from groups of society who are not always recognised; and equally considering Somalia and Somaliland. The value of the financial support to participants was also endorsed.

'The inclusive reporting makes it perfect. Also, your financial help throughout the program has helped me and I want to thank you for it.' (P13 – IDP)

'The report is inclusive. It tried to include the voices of all the levels of the society, from government level to youth, women, IDPs and low-income individuals.' (P1 – Government health official)

'This is an inclusive report; it included the different levels of society. It has also tried to capture the perspectives of the people of southern Somalia and those in Somaliland, to find the perceptions of every group.' (P8 – Woman)

'I saw that about half of your respondents were women, which is a good thing. Women have a lot to face and have interesting personal accounts on the hardships that they face.' (P3 – Government inclusion official)

'The report gave a voice to members of society who are underrepresented in the research world. This fact alone deserves credit and praise.' (P20 – Disabled person)

'The report is inclusive and respectful to the

people who were interviewed. The report has covered the feelings of people like me. It was the first time somebody reached out to my community for input and I'm thrilled to see my contribution has made it into the report.' (P19 – Rural pastoralist)

A sense of wellbeing and pride was also reported by Mogadishu participants. They articulated a sense of a confidence, motivation to participate more widely and validation from being part of the COVIDEV research project.

'I think it is very good and I'm very proud to have been included in the selected group of respondents. I have nothing more to add. The report has helped me express my point confidently.' (P12 – Illiterate person)

'It is great and it was a good experience for me; it has helped me take part in something that I believed in.' (P14 – IDP)

'Taking part in this research and seeing the final report has given me confidence that I can contribute to things that can benefit society.' (P18 – Minority ethnic group member)

The participants from Mogadishu made a number of suggestions for further research. These included going into more depth about the health care system, engaging more with the traditional media to disseminate the report and writing a follow-up report.

'It is good as it is, but I would suggest the research team continue researching other areas such as access to health care in Somalia. This has been included in the report, but I mean I would like to see a dedicated report on this.' (P1 – Government health official)

'The report is good, but it would be great to know if you are planning to write a follow-up report; it doesn't mention this now.' (P7 – Woman)

'You have published the report on your website, social media and other digital communication channels. However, there are many people who do not have access to the internet or digital media. It would be great if a summary was broadcasted on the traditional media to reach more people; this is not a criticism, just a comment.' (P9 – Youth)

'Your next consideration should be making it reach as many people as possible including those who do not use the internet.' (P20 – Disabled person)

Mirroring Mogadishu, 95% of the Hargeisa participants rated the Phase 1 report as 'Excellent' with one participant giving the report an overall rating of 'Good'.

'The report is perfect.' (P28 – Woman)

'I do not have any improvements to mention here.' (P31 – Illiterate Person)

'It is an amazing report and looks good to me.' (P29 – Youth)

'It is was an excellent report because of how it was developed, prepared, the fact that different participants actively participated and that it was directed by you as researchers. All of these things combined.' (P25 – Small informal trader)

'It was the first of its kind. People were asking and talking about the disease and this was captured by the study at a relevant time. Academically, there is no other study of this level as far as I know. It will be very relevant to refer to when responding to the impact of COVID-19.' (P22 – Government employment official)

'I would rate it as excellent because it is the first of its kind, from my knowledge, on COVID-19 in the Somali region.' (P30 – Youth)

The main reason for the 'Good' rating was in relation to the format of the heat maps.

'Reading the tables was a bit tricky because you don't know who said what, and it was clumped together.' (P23 – Government inclu-

sion official)

A common theme noted by the Hargeisa participants was the diversity of the social groups who were part of the project, and the active inclusion which this fostered.

'It was an inclusive study with all social groups, which gave considerable attention to these different groups. We worked collectively and produced an excellent final report that would will benefit all Somalis. It was a good project that I very much liked being a part of it.' (P35 – Minority clan member)

'We were considered to be a part of the study and we have the report in place; it is a very good achievement collectively.' (P39 – Rural pastoralist)

'It is a recent product from a COVID-19 study in which Somalis participated. It will be a very useful resource for new researchers to refer to regarding the Somali territories. It demonstrates how people are tackling COVID-19.' (P30 – Youth)

'The diversity of the participants was unique, showing different experiences and different impacts.' (P38 – Minority ethnic group member)

'I appreciated that the report captured the prevention practices both in Mogadishu and in Hargeisa. I also appreciated the different views of Mogadishu and Hargeisa participants on the diaspora. You see, those in Mogadishu did not believe the diaspora would contribute to the virus spreading while those in Hargeisa had a negative view of the diaspora. It demonstrates the different contexts of the two major cities of Mogadishu and Hargeisa.' (P30 – Youth)

A diverse selection of Hargeisa participants including an IDP, a minority ethnic group member, a young person and a government health official expressed the view that having the profiles of all the participants was a very useful and positive feature.

'The report was very good; it was good to learn more about the people who took part in this project and learn about their stories.' (P29 – Youth)

'The fact that the report had profiles and stories, giving me the chance to learn more about the people who took part, was really useful. The data interpretation was excellent as well.' (P21 – Government health official)

'I think the report is perfect. I read it on my phone, and it was very interesting to read all the stories and how collecting all this data can then turn into a beautiful report like this one.' (P33 – IDP)

'To learn more about Somalis in general was very interesting; reading everyone's story – it really touched me. I liked how most of the text in the report came from the participants who took part in the process.' (P38 – Minority ethnic group member)

The consideration given to the participants was also referenced positively, with the project ensuring that the participants' voices were not only heard but were the main voices heard. Participants endorsed our creation of a space for everyone to be able to contribute based on their individual situation. Also endorsed was our inclusive practice of reading out the report to participants who cannot read.

'I really appreciate you taking the time to read the report to me, nobody has done that before.' (P31 – Illiterate Person)

'I have read so many reports on COVID-19 and I have never seen a report that is almost 95% of what the participants said, this is really positive.' (P28 – Woman)

Two Hargeisa participants emphasised that the report will be a useful reference point for future research, regarding both COVID-19 and the lives of Somalis.

'I have shared it with my acquaintances and

if some people need to know specifically what our lives were like during the pandemic, this would be a good reference for them.' (P33 – IDP)

'It will be a very useful resource for new researchers to refer to in regard to the Somali territories. It demonstrates how people are tackling COVID-19.' (P30 – Youth)

Various suggestions were made for further research, including increasing the number of participants, increasing the level of dissemination, further dividing the contexts of Somalia and Somaliland and comparing levels of education to responses.

'Also, I would love to have seen if the level of education made a difference to the opinion.' (P23 – Government inclusion official)

'I would suggest increasing the dissemination as much as possible. We should deliver the report to the maximum of number of people because it is very important.' (P30 – Youth)

'Yes, I would suggest that the different contexts of Somalia and Somaliland should be separated because the participants demonstrated very different perspectives. It is possible that in some areas people may not know very much about COVID-19, the precaution practices may be different. So, I would argue you separate the different, extreme contexts of the two territories.' (P34 – IDP)

'Increasing the number of the participants would have been good; there are only 40 at the moment.' (P21 – Government health official)

DISSEMINATION

We asked the participants to **tell people about our project**, but only if they were comfortable to do so. Suggestions we made included telling people about how the project was conducted, the report and the participants' role in it. It was completely up to the participants on how to do this, whether that was talking with family and friends only, posting on social media or talking with journalists. This approach is part of our co-production method in that it gave participants real control over the dissemination process. It is also part of our inductive method, that is, learning and research by gathering in observations of what participants choose to do or not to do. Finally, it underlines our commitment to inclusion; people who would otherwise have been excluded from learning about the report if only more formal and centralised dissemination methods were used were included.

The majority of Mogadishu participants was able to disseminate the report and discuss the project with friends, family and their wider networks. However, due to busy schedules a minority of participants was not able to do this. Other networks included housemates, co-workers and colleagues. Social media, specifically Facebook and WhatsApp, were the online tools used for this. The verbal summary which we gave over the phone to participants who were not able to read the report were also further utilised, with one participant recounting it over the phone to their grandmother.

'I shared the report with my WhatsApp contacts and with my Facebook friends.' (P1 Government health official)

'I forwarded the documents and the links to my friends, co-workers and relatives.' (P2 –

Government employment official)

'I forwarded the link to my housemates and colleagues.' (P4 – Telecoms employee)

'I told my family members about the report, but I did not have the time to tell anyone beyond that. I told them that I have contributed to this report and it was telling about our lives and situation.' (P6 – Small informal trader)

'I gave the [verbal] summary you told me to my sister in Dafet.' (P11 – Illiterate person)

'I am often busy these days, but I have managed to tell some small details about the report to a couple of relatives.' (P15 – Minority clan member)

'I was very busy so was not able to talk about it with people.' (P17 – Low caste worker)

'I told my grandmother about the report.' (P18 – Minority ethnic group member)

The Mogadishu responses from sharing the report with people outside of the project were very encouraging. A woman and rural pastoralist were congratulated for being a part of the project, both also citing positive feedback. It was reported that the people have continued to share the report with their wider networks as well, stating that they enjoyed reading the report; with one person making a further engaged response about the profile photos.

'They are positive about the report and they congratulated everyone who took part in it.' (P19 – Rural pastoralist)

'People were overwhelmingly positive and have congratulated me for my role in the report as a respondent.' (P8 – Woman)

'Every person who has seen the report has contacted me and told me they enjoyed reading the report. Someone asked about the rural photo of my profile and has jokingly asked me if I am planning to retire there.' (P9 – Youth)

'Engineers do not read a lot but some of them showed some interest.' (P4 – Telecoms employee)

'My family were aware that I was taking part in this project and that I was been paid every time. They love your project anyway.' (P5 – Small informal trader)

'People were supportive and positive.' (P20 – Disabled person)

'They have reshared it with their peers.' (P2 – Government employment official)

Asking the Mogadishu participants what they thought about being asked to tell people about the report and the project, as well as requesting feedback on how it was received, highlighted two main themes. The first was that the project was a collective and inclusive one, meaning the participants were involved in each stage. Secondly, the participants have different and far-reaching networks, including large social media followings, which should be utilised to disseminate the findings as far as possible.

'The feedback is important to you because the report is a collective work, and everybody has contributed to it.' (P18 – Minority ethnic group member)

'Because every one of us has taken part in the project you want to make sure every respondent also spreads the news of the report.' (P19 – Rural pastoralist)

'This is because the feedback is important to you and will give you more ideas to improve the report or other similar reports you make in the future.' (P20 – Disabled person)

'I think because you know that every one of us knows many people, you want to reach those people as well. Also, you want to know how these people responded.' (P15 – Minority

clan member)

'I have a large number of followers on social media, and I am glad to do what I can to make sure our efforts reach more people, including people who might have the resources to help the people.' (P10 – Youth)

'It is great to spread the news of the report, of the hard work you have put into it, and you have done good work by asking the respondents to share it. Every respondent has many friends and family members who can further promote this useful report.' (P8 – Woman)

'It is normal to ask friends for some help. If I were in your position, I would do the same.' (P3 – Government inclusion official)

The majority of Mogadishu participants were very happy with the project overall and did not have further suggestions for changes. However, there were some very useful points which included using analytical computer software to assess the performance of the report, translating the report into Arabic to facilitate further access and using traditional media outlets including print, TV and radio for further dissemination.

'You have done everything that I learned in communications by sharing the report on your organisation's social media, as well as asking friends and those who participated in the report to make the report known to more people. By the way, I would like to thank you and commend the excellent work you have done; I hope you will do more great reports like this on Somalia and Somaliland.' (P10 – Youth)

'Word of mouth is the best way to spread news and you have done a great job asking the participants to spread the news.' (P1 – Government health official)

'I think you can also translate the report into Arabic if possible.' (P18 – Minority ethnic group member)

'I would suggest that you use more channels such as print media to reach more people. Well done to you and congratulations for completing this wonderful work.' (P20 – Disabled person)

'It is worth sharing segments of the report or a summary of it on radios and TV if possible. There are people who do not have internet connection but who still have some interest in the report.' (P9 – Youth)

You could use analytical programs, such as Google Analytics, to see how the report is performing.' (P4 – Telecoms employee)

Most Hargeisa participants also shared the report with and described the project to their friends and family, as well as discussing it with people who were curious after having overheard the phone interviews that we had conducted. Social media including Twitter, Facebook and WhatsApp were all mentioned as methods of dissemination, with one young person also sharing soft copies. A minority ethnic group member described the project to both the Syrian and Yemeni communities in Hargeisa. Images of their own photos and profiles were also used by participants to circulate information on the project.

'I told all the Yemeni and Syrian community in Hargeisa about you. We have this WhatsApp group and I used it to send them all the text messages and news that we have exchanged. I have also shared the paper with them through WhatsApp and they were really happy thar I took part in this.' (P38 – Minority ethnic group member)

'I sent your report to a friend of mine who is actually researching this topic. He couldn't get enough data to read, he studies Public Health, and this will be very useful for him.' (P33 – IDP)

' I told my family members about what was written in the report and also the whole project; they were really happy for me that I was part of such a process.' (P29 – Youth)

'I told some friends about you and your programme. Also, I spoke with the people who sell vegetables next to me because they used to hear me whenever you and I were talking to each other, so I told them how helpful you were to me.' (P26 – Small informal trader)

'I shared the research report on social media platforms such as Twitter, Facebook and WhatsApp.' (P21 – Government health official)

'I talked with others in my communal cluster here in the rural area. It was amazing and good work.' (P39 – Rural pastoralist)

'I took a screenshot of my profile/picture and I have sent it to them.' (P31 – Illiterate person)

The responses to those the Hargeisa participants engaged with were wholly positive. A number of participants reported that some of the people who had been told about the project said that they then felt better informed about the COVID-19 situation in general, as well as stating that it was a very relevant time to be releasing the report. The dissemination process has created interest for people in Hargeisa, with at least two participants stating that other people wanted to be involved in future, similar projects.

'When I asked them about their feedback, they said that they learned many things from the report that they did not know. There was enough data about the disease, how to prevent it, its impacts on livelihoods and social perceptions.' (P30 – Youth)

'So far they all were positive, they said that it is a wonderful study.' (P22 – Government employment official)

'They responded positively, and they liked it. They said it was good work. They said that the COVID-19 project was good, and they appreciated it.' (P27 – Woman)

'Their feedback was positive, and they liked the project. They underlined the relevance of the project at this particular time.' (P37 – Low caste worker)

'They were delighted and appreciated it very much, as well as wishing they could be a part of it too.' (P39 – Rural pastoralist)

'They were very interested and asked to be included in the future. They liked getting to know about the project.' (P40 – Disabled person)

'Some readers were surprised and welcomed the fact that the participants represented different sections of the community. This is what makes it so inclusive and reflects the situation of the people living in Somalia and Somaliland. One reader was saddened by the plight of the poor due to the effect of COVID-19, while another liked hearing the voices of marginalised people.' (P21 – Government health official)

We asked the participants what they thought of us asking them to tell people about the report and the project, as well as requesting feedback on how it was received. The Hargeisa participants responded with great appreciation, stating that it demonstrated that the project team cared not only about the project but also the participants. It was also highlighted that not many other organisations approach their work in this way.

'I think that it is an amazing thing to do. I remember you mentioning it to me on our last call, but I think that this is really caring, it means you want us to be involved in the process.' (P38, Minority ethnic group member)

'I can understand you checking our feedback as I'm sure you want to feed this information into your report; this is a clever idea and most of the reports are lacking this aspect.' (P33 – IDP)

'I think it is a very nice thing of you to do; it shows that you care about people and you want to help them.' (P29 – Youth)

'There should always be these two sides,

even though most of the organisations who create publications don't do stuff the way you do; you did more engagement and had more interaction. The result is something that is going to benefit everyone.' (P28 – Woman)

'You haven't been taking up too much of my time and you are paying me; thank you so much for that.' (P26 – Small informal trader)

'I personally think that it's okay and reasonable for you to ask us to share the report, as the number of readers will increase, and more people will have access to it. It wouldn't make sense to just write a report and only have a set number of people read it – that would defeat the purpose of it.' (P23 – Government inclusion official)

'It is a good idea to ask for feedback and know the readers' points of view of the report. I believe it is the way of improving and moving forward.' (P21 – Government health official)

The Hargeisa participants made various excellent suggestions about how to approach any future extension of the project should it be possible. The ideas included, for when COVID-19 poses less of a risk, distributing soft copies of the report and then hosting an event where people can discuss the content in person. Other good ideas were focusing on the education and health of poorer families; widening the project to include more people, experts and a more global reach; and using billboard to publicise the work.

'I would suggest holding an event meeting for the report, giving copies out to the participants ahead of time and then having a forum. Discussions would take place with debates, feedback and face to face meetings. Some might present a comment that they do not want to write somewhere now, but that would be very suitable.' (P22 – Government employment official)

'I would suggest you extend the project, covering a larger area than we did now, and reach out to larger groups in society because it was very good work and you need to extend it.' (P25 – Small informal trader)

'Focus further into the issues of COVID-19, particularly the education and the health aspect, to which I would give special consideration. I emphasise that the education and health of poor families should be given consideration by actors.' (P27 – Woman)

'Develop the project into more of an open platform on COVID-19 and the Somali context. Have a more global level, engage as many experts as possible, address continuous programmes about COVID-19 where people will have equal access.' (P30 – Youth)

'Give consideration to the humanitarian aspect, for those suffering who do not even have something to cook for one meal a day. I would argue for supporting those people that need help.' (P32 – Illiterate person)

'Enhance the visibility of the project by installing billboards to increase the project's influence.' (P34 – IDP)

DISCUSSION

District level response to COVID-19

The participants' perceptions of district level responses to COVID-19 were different in Mogadishu and Hargeisa. The preponderance of Hargeisa participants viewing the response in a positive light compared to the majority of Mogadishu participants who reported that it was not good enough and often not visible at all.

Mogadishu participants reported that, rather than a localised district level response, the FGS was more prevalent in leading actions to combat the virus. It was stated that local officials did visit the districts in Mogadishu during the COVID-19 response, but their input was not particularly felt after the visits. This highlights an initial desire and push to combat COVID-19 on the part of local authorities, but a possible lack of resources or commitment to follow through.

Participants from Hargeisa had a more encouraging perception of the local district response. They highlighted the intensified awareness raising programmes that were instigated across the city. Participants felt that, through various awareness raising initiatives, they were in some respects well prepared for dealing with COVID-19. This was the case in relation to a deeper understanding of hygiene practices, the importance of social distancing or the use of face coverings. This facilitation of knowledge allowed people in Hargeisa to take ownership of their safety, fostering a sense and a reality that it was the citizens who were actively taking measures to prevent the disease. However, the less common perception that it was the people rather than the government promoting and adopting the required precautions did lead to responses suggesting that the local authorities in Hargeisa could have done more.

Perceptions of a COVID-19 response were those of urban participants for both Mogadishu and Hargeisa. The rural pastoralist participants from both locations reported that the COVID-19 response did not reach the more remote areas whatsoever. This suggests a targeted approach in the cities, where the highest concentration of people is found, coupled with a sense of neglect for those residents living in the countryside; areas with a lack of government support and health infrastructure to start with.

Access to health care

Regarding access to health care, the Hargeisa and Mogadishu participants tended to be aligned in their responses. Rural pastoralists and small informal traders found it particularly hard to access health care. Those in rural areas do not have available health care facilities close to them. This pattern is similar to the views expressed about district level responses to COVID-19. It underlines the point that medical care is focused in the more populous urban locations.

Participants reported lack of financial capacity as one of the biggest barriers to being able to access health care in Mogadishu. Whether going to a public or a private health facility, payment is expected for services. This means that people with very little means, and with incomes that have since been reduced further due to coronavirus measures, are often unable to access the health care that is available.

To pay for their required health care, a small number of participants reported relying on relatives abroad. However, this was dependent on the relatives' current situation and, as discovered in the Phase 1 report, with COVID-19 restrictions also in place in other countries, members of the diaspora are in less of a position to be able to support relatives back in Somalia and Somaliland.

To help people who have been affected by COVID-19 both economically and health-wise, a government health official, young person and minority clan member all stated that there had been a move toward providing free health care for patients specifically affected by COVID-19. Despite this positive step, it was reported that free health care was neither reliable or accessible, apart from in relation to a specialist unit focused on maternal and child-care unrelated to the coronavirus response.

Hargeisa participants reported less access to major health care services, with a similar number of participants to Mogadishu nearly always unable to access any health care. Finances were again a major barrier to being able to access health care in Hargeisa, with fees at almost every level of service. Initial registration fees were reported to take up a large amount of money, before patients are even able to get any tests, results or medication. Inequality was highlighted even further by a minority clan member and IDP stating that people with enough money would travel abroad for their health requirements, rather staying in Hargeisa to be treated.

The approach in tackling COVID-19 in Hargeisa was also reported as to be negatively affecting other health care services there. One of the measures introduced by the Somaliland Government, to reduce contact between carriers of the virus and the general population, was to announce that elective operations and minor surgeries and health issues should be postponed wherever possible. This has led to people with underlying health issues being neglected, as well as fostering a wider growth in fear about entering hospitals and a stigmatisation of those having, or suspected of having, COVID-19.

Confidence in the quality of health care

As with the access to medical care, the Mogadishu participants reported that a person's financial capability influences the quality of health care that they have available to them. This inability to access good quality health care due to financial barriers saw the majority of Mogadishu participants respond that they had either moderate or low confidence in the quality of health care.

Doubt surrounding the quality of health care was not only related to money. Participants suggested that often people claim to be doctors when they do not have the requisite qualifications, leading to a low-quality service even when paying. Such problems demonstrate the need for standardisation of medical practices, including medical boards that can provide benchmarking, accountability and transparency in relation to the quality of health care.

This doubt in medical professionals is also extended to medical resources and equipment in Mogadishu, with participants stating that the equipment and medicine is not sufficient. One participant even feared that they may in fact get more ill by taking the medicine prescribed to them. The doubt in quality intensifies these fears and reduces access to health care even further.

Hargeisa participants echoed these fears of unqualified doctors operating in the area. A small informal trader and minority ethnic group member both reported that they were more likely to use traditional medicines and remedies rather than trusting doctors in Hargeisa and the medicines that they prescribe. This was not only out of doubt surrounding the legitimacy of the doctors, but also out of the belief that traditional remedies are more effective than prescribed drugs. A financial incentive is also apparent for using traditional remedies, which are much cheaper than pharmaceuticals.

The belief that traditional remedies are more effective than drugs also links to the availability of resources. Phase 1 reported that Personal Protection Equipment (PPE), oxygen

and other medical supplies were often not available for health professionals for citizens in Hargeisa and Mogadishu. The resources that are available are not always of a high standard or in date, leading to the view that alternative therapies are better.

In Hargeisa and Mogadishu, it is clear that people do not trust the quality of health care that is available to them. Proper licensing and assessments of both health care professionals and the equipment which they use would work toward altering this for the better.

Evaluation of the Phase 1 report

95% of participants rated the Phase 1 report as 'Excellent' and the remaining 5% rated it as 'Good'. This demonstrates success in enabling representation of a wide range of people from different parts of society in Somalia and Somaliland.

Inclusivity and wellbeing were two prominent themes which were uncovered when discussing the Phase 1 report with the Mogadishu participants. The rural participant from near Mogadishu reported that this project was the first time that his community had been contacted to discuss its opinions – indicating the importance of including rural communities in research. One minority ethnic group member from Mogadishu told us that their participation in the project had given them the confidence and understanding that their views and opinions can benefit wider society. This demonstrates an extended benefit of working with people whose voices are often not heard.

Suggested ideas included a more targeted dissemination approach with traditional media outlets, rather than online ones. We knew that a minority of the participants did not have access to the internet; to address this initial barrier, we called them and read the report to them. It was an active decision to not provide hard copies at this juncture, due to the coronavirus risks which accompany physical contact.

The inclusion of different groups from Somali society, which was ensured through the diverse selection of people who are not necessarily part of the standard conversation, meant that the participants felt represented within the project. The interaction between participants, facilitated through focus group discussions during one of the later rounds of questions, created further relationships and the participants were very keen to hear the perspectives from other parts of society. This was enriched further when the participants recognised a lot of similarities in not only their opinions, but also their situations in dealing with coronavirus in the two different locations The participant profiles included at the beginning of the Phase 1 report underlined the human element which the Hargeisa participants related to well.

Specific participants, such as the Hargeisa rural pastoralist, emphasised how important to them it was to be invited onto the project; this echoed the sentiments of the Mogadishu rural pastoralist. The recognition of people living in these more rural areas, coupled with the reporting of a lack of government interaction there, was noted to be unique; they had never been offered a similar opportunity prior to our project. This was further recognised with the researchers contacting participants and reading the report to them when they were not able to read it themselves. Whether this was due to no internet access or being unable to read, the sense of inclusion reported highlighted that participants did not feel excluded during the process.

Two main suggestions made were to include more participants and disseminate the report further through traditional media. In future research we would like to include more participants, and the dissemination of both the Phase 1 report and this Phase 2 report will

continue in the meantime, including through traditional media. Another suggestion was to provide more disaggregation of responses, which is something we would be happy to do in future.

One Mogadishu participant suggested engaging with people ill with COVID-19, or those who have recovered. This is an excellent suggestion, and one we are keen to follow up on to explore COVID-19 journeys in terms of physical and mental health, livelihoods and inclusion. The issues of fear and stigma would require appropriate handling. In some cases, anonymisation would be required. However, some people in Mogadishu have been willing to be filmed talking about having had COVID-19 to try to reduce the fear and stigmatisation of those who have had the disease.

Dissemination

We asked the participants in both locations to disseminate the report amongst their networks. We did this deliberately to ensure a co-produced, inclusive approach to all stages of the project. This required us to be sure that everyone was involved in the process in whichever way they felt comfortable and to opt out if that was their preference. To engage with research participants on such an interactive level is an unusual method which promotes inclusivity and openness. It contrasts with the more common approach in which participants are excluded once data has been gathered. Our inclusive approach was developed to engage participants further, develop a genuine sense and reality of ownership, increase the number of people who can benefit from the research and subsequent findings, and engage with those who would usually be excluded from dissemination. As we are endorsing the concepts of sustainable development and building back better, we must ensure that research projects in Somalia and Somaliland do not have the flaw of communities that are supposed to benefit from research never seeing or having any means of influencing or feeding back on the research output.

The Mogadishu participants were very pleased to be asked to share their experiences of the project and the final report with their peers and relations. The networks which they mentioned included friends, family, co-workers, housemates and colleagues and the main methods of dissemination were through social media, word of mouth and phone calls. A few participants were not able to participate in our time frame due to prior commitments but can still choose to tell others about the project and the report when convenient for them. The fact that people from so many social categories were keen to share the report is indicative of its inclusivity and of the value of the information to many different social groups. When we asked the Mogadishu participants about what they thought of our approach to dissemination, one of the most common answers was that it was more evidence of the inclusiveness of the project; hence the participants verified that we had achieved this central goal in our work.

The feedback received from the participants' contacts in Mogadishu was congratulatory. This reinforces our view that research should aim for inclusive co-production of dissemination. Some of those contacted by participants stated that they had shared the report further, demonstrating again the value and reach of involving participants in dissemination.

We asked participants about how we could improve reporting in future. One suggestion was to also have a version in Arabic as well as Somali and English to cater for refugees to Somalia from Arab countries. This would make the report more accessible to some of the most marginal people in the country. Another useful suggestion was that we could use software such as Google Analytics to evaluate online accessing of the report. Further embracing technology in this manner would create a

new level of benchmarking for dissemination, allowing the project team to track the progress on a more granular level.

The Hargeisa dissemination was responded to positively by all participants in relation to the process, the response from others and the understanding of our approach. Some of the Hargeisa participants used their access to the internet and social media for dissemination, such as Facebook and Twitter. WhatsApp was also used to circulate the report and snippets of the report such as photos and participant profiles, to groups of people including the Syrian and Yemeni communities in Hargeisa. When participants were not able to share information online, they engaged with relatives, friends and neighbours to tell them about the project. One participant printed off soft copies of the report to distribute to his network. The small informal trader discussed the work with other vegetable traders who had overheard the phone interviews; this is a vivid of how our approach to dissemination touched the lives of people who would otherwise never have heard about the work. Such people are important audiences and yet are usually never even considered. This immediate and active engagement demonstrates pride and proprietorship from the participants; they wanted as many people as possible – within and beyond their social group – to know and understand the COVIDEV project, and to know that they as individuals had been integral to the process.

The response from the participants' networks in Hargeisa was again wholly positive, with participants reporting that other people would like to be involved in future projects like this. The encouraging reactions from wider networks reinforces the idea that engaging with communities directly and inclusively is beneficial and appreciated. The fact that people also said that the report had provided them with new knowledge on COVID-19, as well as a better understanding of other people's situations in Somalia and Somaliland, is a helpful and constructive result. The Hargeisa participants were very appreciative of being asked for feedback on both the report and on other people's responses. They reported that it showed a caring side of the project whilst ensuring as many people learned about the report as possible.

Further suggestions from the Hargeisa participants included a launch event of the report for community discussion and focusing further research on disadvantaged groups and how their health and education had been affected by COVID-19. This indicates the thoughtful and compassionate side of the Hargeisa participants, whilst also showing the importance that the project has for them and their desire to disseminate and explore the topic further through research using the approach we have implemented together.

CONCLUSION

Phase 2 of COVIDEV has highlighted various new findings which can be utilised in the future for more effective responses to health care emergencies in Somalia and Somaliland, whilst taking into account the concepts of sustainable development and building back better.

Key finding: *COVID-19 response at the urban district level in Mogadishu was mostly lacking but more effective in Hargeisa: this reversed the pattern found in our Phase 1 report.*

Key finding: *In rural areas for Mogadishu and Hargeisa there was almost no COVID-19 response: this was the same as the pattern found in our Phase 1 report.*

The participants saw district level COVID-19 response in Mogadishu during the Phase 2 reporting period of late July as distinctly lacking, with few actions taken. To encourage further confidence in the authorities, we recommend more active community-level engagement, and especially action to support disadvantaged groups such as IDPs and poorer families. In Hargeisa, the appreciation of raising awareness on precaution practices was high; continuation of this approach would be valuable but still needs to be supplemented by material support for incomes. Rural communities were neglected in both the Mogadishu and Hargeisa areas; any responses implemented in urban areas should also be implemented in more remote areas.

Key finding: *Access to medical care in Mogadishu and Hargeisa is fundamentally inadequate: being wealthier helps but is no guarantee, especially in Hargeisa.*

Key finding: *For most, access to minor health care is all they manage, and for a large minority access to even minor health care is nearly always impossible.*

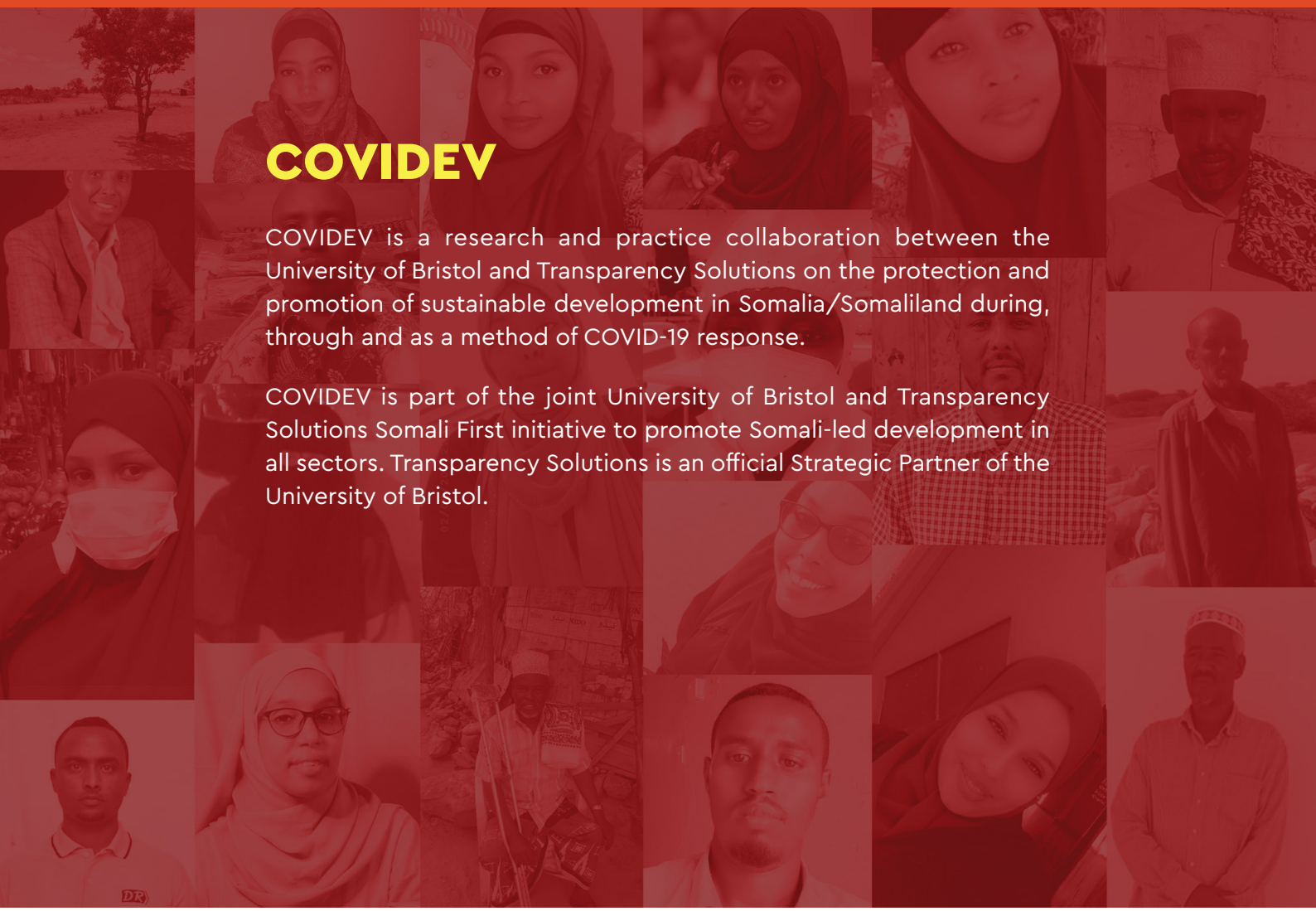
Key finding: *Confidence in the quality of health care in general in Mogadishu and Hargeisa is low, especially in Hargeisa: being wealthier helps a little rather than fundamentally.*

Access to health care in Mogadishu and Hargeisa was influenced by participants' financial resources. The requirement to pay for even the most limited health care often put people off using medical services. However, access to major health care is difficult, especially in Hargeisa, even when someone has the necessary funds due to sheer lack of facilities. Doubts about the ability of medical professionals and the resources available to them were also widespread; more investment in the health sector in both Somalia and Somaliland is an urgent necessity, as is proper regulation and assessment of ability to work as a medical professional. The COVID-19 response has deterred many people from using hospital facilities, even when advertised as free, and the the fear and stigma surrounding infection should also be addressed to help remedy this reaction. Again, rural residents outside of the cities had far less access to health care than anyone else.

Key finding: *Involving participants from socially excluded categories to work with researchers on all stages of research is desirable as well as practical – it improves the quality of the research, gathers insights that would otherwise have been missed, and embodies the inclusiveness necessary for sustainable development.*

Key finding: *The comprehensive success of our inclusive dissemination process demonstrates that it is not too difficult for even illiterate people who have never had any formal education to engage in dissemination of rigorous research. It also demonstrates that there is a great deal to be gained from inclusive dissemination.*

95% of all participants rated the COVIDEV project as 'Excellent', the highest possible rating, and the remaining 5% rated it as 'Good'. This very high level of satisfaction was due to the value participants attached to their active involvement at every stage of the project. The ownership that was provided through our methodology meant every participant responded positively. It also resulted in many participants offering constructive ideas for further work, including engaging with people who either currently have coronavirus or have recovered; this is a stream of research that the COVIDEV team intend to engage in. Participants often found that they were congratulated for being a part of the project when they told others about it and generated expressions of desire from the participants' networks to also want to be involved with similar projects in the future. The approach taken in the project suggests a way forward not only for research but for the inclusiveness that is vital for development to be sustainable.



COVIDEV

COVIDEV is a research and practice collaboration between the University of Bristol and Transparency Solutions on the protection and promotion of sustainable development in Somalia/Somaliland during, through and as a method of COVID-19 response.

COVIDEV is part of the joint University of Bristol and Transparency Solutions Somali First initiative to promote Somali-led development in all sectors. Transparency Solutions is an official Strategic Partner of the University of Bristol.

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