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COVID-19 and sustainable development in Somalia/Somaliland

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ABSTRACT

The research aimed to understand the impact of COVID-19 and responses to it on sustainable development in Somalia and its breakaway region Somaliland. It explored how sustainable development could be protected and promoted through, during and as a method of COVID-19 response. It explored the themes of lives, livelihoods and inclusion. Due to COVID-19, it used three non-face-to-face methods: desk-based analysis of literature and secondary data; 175 phone interviews; and five phone Focus Group Discussions. The research was co-produced with 40 participants, which ensured that the study was carried out with as well as for those who could potentially benefit from it. COVID-19 and responses to it have generated intense and multi-dimensional concerns and deprivation, especially among those on low incomes. Livelihoods are being destroyed but people are receiving little or no financial support. People are receiving too little help to cope with the many problems they face. Limited action to prevent COVID-19 infection is more due to structural and social factors than lack of information. Public health education is still necessary; it should include challenging stigmatisation, explaining that wearing a face covering does not mean a person is infectious, and explaining that those recovered from the virus are not still infectious. Health care is mostly unavailable, unaffordable and not trusted. There is broad and deep agreement across all major issues explored in the research, including the immediate actions needed and the fundamentals of what building back better would mean. Responses to COVID-19 have mainly had the effect of undermining the prospects for sustainable development in Somalia/Somaliland. Despite this, the existence of broad and deep agreement on the major issues explored in the research could form the basis of a new commitment to sustainable development.

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Sustainable development; COVID-19; Somalia; Somaliland

Introduction

Somalia/Somaliland is among the places of the world least able to cope with COVID-19 due to many forms of poverty-related deprivation, low levels of access to health care and limited state capacity. Somaliland unilaterally declared independence from Somalia in 1991; although internationally unrecognised, Somaliland has been self-governing ever since that declaration. This ambiguous status is why we refer to Somalia/Somaliland where relevant. Insufficient data availability (indicative of limited state capacity) means that Somalia is not ranked by the United Nations (UN) in comparison with other countries in its sustainable development reports. On specific UN Sustainable Development Goal (SDG) indicators, where there are data, Somalia is overwhelmingly rated as having 'significant challenges', which is bland language for the lowest rating (UN (United Nations), 2019, pp. 34, 58, 393–393). To illustrate the depth of multi-dimensional deprivation: around 30% of the population of Somalia do not have an improved drinking water source, 50% do not have access to improved sanitation and 90% of children 11–23 months old are not vaccinated against common diseases (FRS (Federal Republic of Somalia) and UNFPA (United Nations Population Fund), 2020). On the Global Health Security Index, Somalia scored 16.6 out of 100 in 2019, making it 194th out of 195 countries. Its health care barely registered, with a score of 0.3 out of 100 (NTI (Nuclear Threat Initiative) and JHCHS (Johns Hopkins Center for Health Security), 2019).

As of 9 July 2020, there were 3,038 confirmed cases of COVID-19 in Somalia, with 92 confirmed deaths (FRS (Federal Republic of Somalia) and UN OCHA (United Nations Office for the Coordination of Humanitarian Affairs), 2020). As of 6 July, Somalia was 100th in the world for confirmed cases and 88th for confirmed deaths (Worldometer, 2020). The relatively low numbers can in part be explained by low levels of testing and related under-reporting (Ahmed et al., 2020) but there is no evidence of massive under-reporting. Due to this

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pattern, during July the Federal Government of Somalia and Government of Somaliland lifted many infection control restrictions. They have an opportunity to act on public health and the economy without having to do so under the pressure of a large wave of infections. In the research, we explored the impact of the actions taken so far by all relevant actors.

There is a rapidly expanding body of scholarly literature on the impact of COVID-19 and responses to it in low-income countries. Some studies generalise across many low-income countries on various issues, such as the particular vulnerability of the poor in relation to food insecurity or difficulties in social distancing (e.g., Winskill et al., 2020), indirect harms to health (e.g., Robertson et al., 2020), the COVID-19 measures that are practical for low income and displaced populations (e.g., Dahab et al., 2020), and how COVID-19 response threatens sustainable development but could be harnessed to it (e.g., Filho et al., 2020). Others focus on single countries, regions or continents, including Africa (e.g., Badu et al., 2020). However, there is almost no scholarly literature on COVID-19 and Somalia/Somaliland or on its relationship to sustainable development there. Somalia/Somaliland is among the poorest countries in the world. With limited state functioning and high levels of environmental and conflict-related displacement, anything other than occasional minor health care is beyond the reach of most of the population (Herring et al., 2020). These considerations need to be borne in mind when comparing with or generalising to other contexts, even those elsewhere in East Africa such as Kenya and Ethiopia. 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 (Sen, 1999; Tikly, 2020, p. 57). There is some grey literature on COVID-19 and Somalia/Somaliland, usually in the form of short commentaries (e.g., Gele, 2020a, 2020b; Gele & Farah, 2020; Abdullahi, Sharif, 2020; Majid et al., 2020). The largest research project on COVID-19 in Somalia has been by Africa's Voices (no date). It focused only on public understanding of COVID-19, with data gathering via text message from self-selected respondents: our research was much wider in scope, used interviews and Focus Group Discussion (FGDs), and participants were selected by social category.

The research examined how sustainable development might be protected and promoted during, through and as a method of COVID-19 response in Somalia/Somaliland. The research addressed three related problems. Firstly, some COVID-19 interventions are having multifaceted negative impacts on lives, livelihoods and inclusion. This is through harm to other health interventions and the health impacts of economic contraction; loss of income and employment; and disproportionate effects on groups already disadvantaged in relation to opportunities, resources, voice and respect for rights. Secondly, while trade-offs – for example, between lives and livelihoods – could be part of the situation, COVID-19 interventions can be positive for other health interventions, livelihoods and inclusion. The actions generated by the pandemic should be channelled as positively as possible. Thirdly, in Somalia/Somaliland, the negative impacts of COVID-19 and related interventions are liable to be particularly acute due to the low levels of health care, near absence of a material safety net and pre-existing high levels of exclusion across multiple social categories. Understanding such inequalities is necessary if they are to be mitigated.

Methods

Study design

The study was co-produced qualitative descriptive research which combined desk-based secondary data and literature review, phone interviews of 40 individuals from selected social groups in Somalia/Somaliland and phone FGDs with twenty-five of the 40 individuals, as the basis of inductive thematic analysis.

Ethics, consent and inclusion

Ethics approval was obtained from the University of Bristol before the recruitment of participants and data collection began. The health and safety of all staff and participants in relation to COVID-19 was ensured by use of non-face-to-face methods only. Interviews, FGDs and dissemination were all conducted by phone. Due to Somali oral culture and the unfamiliarity of most participants with formal research methods, we obtained oral rather than written consent. We obtained, recorded and adhered to each participant's preferred degree of anonymity. We drew on the team's deep understanding of and embeddedness in the local contexts of Mogadishu and Hargeisa to manage cultural, political, social, physical, and psychological risks.

The research engaged with people from groups which are vulnerable due to their social exclusion. Inclusion is not just about the presence of people from different

social groups. It is also about the attitudes and behaviours of all concerned. Axes of exclusion and inclusion intersect and interact. These issues were considered in our research methods and analysis. We ensured participation across a range of excluded social categories; addressed poverty as an aspect of exclusion by providing payment for participation; addressed minimal access to technology by enabling participation with a basic phone; addressed illiteracy by having staff read or summarise materials pitched to the individual's level of understanding; engaged with participants in their preferred language and dialect (Somali, the Somali dialect Maay and Arabic as well as English); forestalled potential biases in FGD participation by establishing commitment to ground rules of inclusivity, active listening and trust; and analysed inclusion as one of the three main strands of the research (the others being lives and livelihoods). The population is for the most part comfortable with Somali, but some in the South predominantly speak Maay. As far as we know, this is the first time Maay has been used in scholarly research outside of linguistics. Arabic is an official language of Somalia and is the first language of the increasing number of refugees from Yemen. There are other linguistic minorities making up a small percentage of the population we were unable to include, such as speakers of Swahili dialects (LandInfo, 2011). We hope that this research will encourage increased linguistic inclusiveness in research in Somalia/Somaliland in future, including in our own work. Around 50% of the adult population of Somalia/Somaliland have at least a basic mobile phone and most payments are made by text on basic mobile phone rather than cash or into bank accounts. Use of a basic mobile phone did not prevent participation in the FGDs as we put incoming calls on speaker. Research such as this creates a relationship with participants. We managed expectations so that were clear about the benefits that we could and could not deliver.

The fact that none of the participants withdrew and all continued into the next phase of the research suggests a high level of satisfaction with our approach. This satisfaction was confirmed by 36 participants rating the project as 'Excellent' and four rating it as 'Good', and by their qualitative feedback. Participants said that their positive evaluation of the project was due to its social inclusiveness, its co-production methods, the respectful and emotionally supportive nature of our engagement, the substance of the issues explored, its educational value regarding COVID-19, and payment for participation. We considered but found no reason to conclude that the findings would be skewed by paying participants for their time. We made it clear to participants that we were not hoping for one finding rather than another (and in reality we were not); we engaged with participants in depth about their views and the reasons for them; and we went over many points again in subsequent interviews. The project demonstrated that it is possible to carry out such research with remote methods only. This success is also grounded in having research teams who are part of the societies which are being researched, with the full range of relevant language and cultural knowledge. Also vital is having highly developed and flexible skills capable of grasping policy agendas and connecting illiterate people and senior government officials alike to those agendas.

Co-production

The research was based on a 'with, not for' method and an understanding that we all have capacities to bring to bear, all lack certain capacities and all can learn from each other. Participants were not only sources of data; their insights were structured into the work through inductive revision of the project themes after each round of interviews; by obtaining their feedback on how we were conducting the research and on the preliminary findings; and by enabling their participation in the dissemination of the findings. Participants were invited to evaluate and rate the project, including feeding into ideas for follow on work.

Equitable partnership

The project had an equitable approach in terms of co-production (set out above) and funding. In using Official Development Assistance funding, money should, as far as possible, go to the low-income country and to those with low incomes in that country, to facilitate sustainable development. 100% of the funding for this research went to Somalia/Somaliland; payments for participation enabled participation for those on low incomes; and the substantive focus of the project is on sustainable development.

Desk-based review: preparation of themes and questions

We conducted a desk-based secondary data and literature review to inductively develop initial themes and questions for interviews. The review was based on the

expert knowledge of the team, key word searches, and materials from key academic and non-academic sources.

Sampling and recruitment of study participants

We recruited 40 participants with almost equal numbers of adult females and males – 20 living in or near Mogadishu, the capital of Somalia, and 20 living in or near Hargeisa, the capital of Somaliland (see Tables 1 and 2).

The sample of participants was stratified, that is, it comprised a range of social groups relevant to the context and themes in which we are interested. Thirty-two of the participants were people in social categories that experience social exclusion in terms of representation, resources, rights and/or voice in their society due to illiteracy, gender, being a youth (which for the research we define as age 18–23), being a member of a minority clan or minority ethnic group, or being a low caste worker, rural pastoralist, informal small trader, internally displaced person or refugee. 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. The participants also included eight people in more privileged positions – government health, employment and inclusion (e.g., women's rights) officials and senior telecommunications company staff. The mix of less and more privileged participants enabled comparison of and inclusive interaction between people from those different social categories. Within the social categories, we did not select the sample randomly. Instead, we recruited the participants using the Known Sponsor method, by which a reputable and trusted local interlocutor from the research team who knew or identified someone in a relevant category contacted the person and invited them to participate (Patton, 2002, pp. 312–313). By drawing on our local contacts and understanding we could be confident that participation would be low risk. The tables contain demographic information regarding gender, age range, years of education, income level, language(s) spoken and phone type. This provides more in-depth qualitative understanding of the individual participants and feeds into the discussion at numerous points in the paper on issues relating to those characteristics.

Table 1. Mogadishu sample.

Participant	Sample category	Male/ female	Age range	Years of formal education	Income level	Occupation	Language(s) spoken (main first)	Phone type
P1	Government health official	F	24–39	11 or more	Medium	Government health official (senior)	Somali/ English	Smart
P2	Government employment official	M	24–39	11 or more	High	Government employment official (senior)	Somali/ English	Smart
P3	Government inclusion official	F	24–39	11 or more	Medium	Government inclusion official (senior)	Somali/ English	Smart
P4	Telecoms employee	M	24–39	11 or more	Medium	Telecoms employee (senior)	Somali/ English	Smart
P5	Small informal trader	F	40–59	0	Very low	Small informal trader (milk)	Maay/Somali	Basic
P6	Small informal trader	M	60 or older	0	Low	Small informal trader (general)	Maay/Somali	Basic
P7	Woman	F	24–39	6–10	Low	Shop owner	Maay	Smart
P8	Woman	F	24–39	11 or more	Medium	INGO finance manager	Maay/Somali	Smart
P9	Youth	M	18–23	11 or more	Medium	Writer/Translator	Somali/ English	Smart
P10	Youth	F	18–23	11 or more	Medium	Secretary/Youth activist	Somali/ English	Smart
P11	Illiterate	M	24–39	0	Very low	Washing cars/Low wage jobs	Maay/Somali	Basic
P12	Illiterate	F	24–39	0	Very low	Domestic worker	Somali	Basic
P13	Internally displaced (rural Lower Shabelle)	F	24–29	0	Very low	Unemployed	Maay/Somali	Basic
P14	Internally displaced (Bay)	M	40–59	1–5	Low	Driver	Maay/Somali	Basic
P15	Minority clan (Ajuran)	F	60 or older	0	Very low	Domestic worker	Somali	Basic
P16	Minority clan (Jaarso)	F	40–59	1–5	Very low	Assistant cook	Maay/Somali	Basic
P17	Low caste worker (Gabooye)	M	24–39	0	Low	Steel worker	Somali	Basic
P18	Minority ethnic (Somali-Yemeni)	F	18–23	1–5	Low	Professional cook	Arabic/ Somali	Smart
P19	Rural pastoralist	M	60 or older	0	Low	Pastoralist	Somali	Basic
P20	Physically disabled (wheelchair user)	M	24–39	11 or more	Medium	Activist	Somali/ English	Smart

Table 2. Hargeisa sample.

Participant	Sample category	Male/ female	Age range	Years of formal education	Income level	Occupation	Language(s) spoken (main first)	Phone type
P21	Government health official	F	24–39	6–10	Medium	Government health official (middle)	Somali/English	Smart
P22	Government employment official	M	40–59	11 or more	Medium	Government employment official (middle)	Somali/English	Smart
P23	Government inclusion official	F	18–23	11 or more	Medium	Government inclusion official (junior)	Somali/English	Smart
P24	Telecoms employee	M	40–59	11 or more	Medium	Telecoms employee (senior)	Somali/English	Smart
P25	Small informal trader	M	24–39	11 or more	Medium	Small informal trader (soft drinks/sweets)	Somali/English	Basic
P26	Small informal trader	F	18–23	11 or more	Medium	Small informal trader (groceries)	Somali	Smart
P27	Woman	F	40–59	11 or more	Medium	Small informal trader (general)	Somali/Basic English	Smart
P28	Woman	F	24–39	11 or more	Medium	Researcher	Somali/English	Smart
P29	Youth	F	18–23	6–10	Medium	Hairdresser	Somali	Smart
P30	Youth	M	18–23	11 or more	Medium	Medical student/ unemployed	Somali/English	Smart
P31	Illiterate	F	18–23	1–5	Low	Cafeteria owner	Somali	Smart
P32	Illiterate	M	40–59	0	Very low	Salesperson used car parts	Somali	Basic
P33	Internally displaced (Somali Ethiopia)	F	24–39	11 or more	Very low	Teashop owner	Somali	Smart
P34	Internally displaced (rural Gabiley)	M	40–59	11 or more	Low	Headteacher, Government primary school	Somali/Some Arabic/ Broken English	Basic
P35	Minority clan (Madigan – Dir)	M	40–59	11 or more	Low	Headteacher, Government primary school	Somali/Arabic/Broken English	Basic
P36	Minority clan (Jaarso)	F	40–59	6–10	Medium	Shop owner	Somali	Basic
P37	Low caste worker (Gabooye)	M	24–39	6–10	Very low	Barber	Somali	Basic
P38	Minority ethnic (Yemeni)	F	40–59	11 or more	Very low	Homemaker	Arabic	Smart
P39	Rural pastoralist	M	40–59	0	Low	Agro-pastoralist	Somali	Basic
P40	Physically disabled (polio)	M	40–59	11 or more	Very low	Quranic Teacher	Somali/Arabic	Basic

Data collection

All researchers involved in data collection were native or fluent speakers of Somali, English or both languages; some were also fluent in Maay or Arabic. These language skills enhanced inclusiveness, encouraged participation and reduced misinterpretation. The interviews were conducted by mobile phone and audio recorded with the consent of the participants. Participants were offered the alternative of the interviewer taking notes and not audio recording; none took up this offer. Consent was obtained to use the data for this study. To encourage participation, we did not ask for consent for the audio recordings to be made public as a secondary data resource. All participants were allocated a participant number and were identified to the extent agreed. The data were gathered in May, June and early July 2020.

The interviews were semi-structured. They included a set of standardised questions and scoring scales for consistency of responses and reliability of findings. The questions were a mix of closed and open. The interviews allowed space for interviewees to go beyond the questions; the interviewers encouraged such expression of views as part of the inductive method. To enhance natural flow and authenticity the standard questions were not asked in a fixed order. The interviews were around 45 minutes in length with four interviews per participant, resulting in a total of 160 interviews before the FGDs.

The FGDs were semi-structured in the same way as the interviews. They included a mix of more and less privileged participants. Due to scheduling problems, 15 participants were unavailable for a FGD but were able to do a fifth individual interview. This resulted in a total of five FGDs with 25 participants overall plus a further 15 interviews in addition to the initial 160. We found no indication of any effects on the study findings from this when we compared the interviews and FGDs.

Data analysis

The data were analysed inductively for themes and sub-themes. The recordings of the interviews and FGDs were not transcribed. Instead, the relevant team members reviewed their audio recordings and entered quotes in English in a shared thematic document. Nearly all the interviews were not in English and so

generally the quotes were translated by the researcher. In addition, where qualitative and quantitative scores were elicited from participants, these were logged on a table to enable comparison. The team then generated a preliminary analysis of the patterns, which was discussed and refined within the team and through follow-up discussions with participants. We provided participants with a written draft of the analysis, including all quotes, in English or Somali, or we summarised the material over the phone in Somali, Maay or Arabic for those who were not literate or did not have internet access. We did not attempt to draw any conclusions about the statistical significance of our findings. This is because the objective was to produce inductive qualitative thematic findings based on a relatively small sample of people from different social categories in two locations but not in proportions representative of the population as a whole.

Results

In this section, we set out the results of the analysis with a view to identifying patterns that relate to the themes and sub-themes of the research.

We provide numerous quotes for two reasons. The first is to illustrate the patterns and exceptions to those patterns. The second, in the spirit of inclusiveness and co-production in our work, is to allow the individual voices, humanity and nuances of the participants to be heard. We have included quotes from a wide range of participants from both locations. Each quote is identified by participant number and primary sample (social category and location), such as 'P16: Minority clan member, Mogadishu'. Additional demographic details as set out in Tables 1 and 2 are not provided with each quote, as the analysis is concerned primarily with relating the focus of each section to overall patterns, the participants' social categories and their locations. Exploring the patterns of responses in relation to the secondary demographic characteristics would be valuable as further research.

In the tables the percentages indicate what proportions of participants agreed with a position put to them on a scale (e.g., that they were very worried, a bit worried or not worried about lack of access to basic necessities) or said that they did a particular thing (such as washed their hands). When a table refers to Mogadishu or Hargeisa, it means that the percentages are based on the 20 participants for that location. When a table refers to both locations it means that the percentages are based on all 40 participants.

Intense and multi-dimensional concerns and deprivation, especially among those on low incomes

People in Mogadishu and Hargeisa were deeply worried. Fear of what might happen over the next 3 months was intense and multi-dimensional, especially among those on low incomes (see Tables 3 and 4). COVID-19 was at the forefront of participants' minds but not far behind was worry about loss of income due to COVID-19 response measures.

> I have dependents in Lower Shabelle who I have been sending some of my earnings to, but my reduced income now means I have to work longer in order to earn more. I have been stressed by this thought recently and I don't know what to do. (P11: Illiterate person, Mogadishu)

Table 3. Main concerns about the next 3 months - Mogadishu.

Thinking about the next three months, please tell us **how worried** you and your family are and **what you are worried about**

	Very worried	A bit worried	Not worried	Don't know/ No answer
Illness due to COVID-19 infection	85%	10%	5%	0%
Physical health issues other than COVID-19	5%	55%	40%	0%
Mental illness	5%	30%	65%	5%
Loss of income due to COVID-19 control measures	70%	15%	10%	5%
Lack of access to basic necessities	45%	40%	15%	0%
Discrimination because of your social group	0%	65%	30%	5%
Violence	20%	45%	30%	5%
Other	10%	5%	5%	80%

Table 4. Main concerns about the next 3 months - Hargeisa.

Thinking about the next three months, please tell us **how worried** you and your family are and **what you are worried about**

	Very worried	A bit worried	Not worried	Don't know/ No answer
Illness due to COVID-19 infection	95%	0%	0%	5%
Physical health issues other than COVID-19	20%	10%	45%	25%
Mental illness	10%	40%	35%	15%
Loss of income due to COVID-19 control measures	85%	10%	5%	0%
Lack of access to basic necessities	65%	20%	10%	5%
Discrimination because of your social group	20%	20%	15%	45%
Violence	15%	30%	15%	40%
Other	25%	20%	15%	40%

We found extensive evidence of worry, mainly among participants on low incomes, about physical health issues other than COVID-19, discrimination because of their social group, violence due to crime, and the surge in Gender-Based Violence (GBV) and Female Genital Mutilation/Cutting (FGM/C).

> Domestic violence is increasing - specifically FGM - because mothers now have time to take their children or call the circumcisers to their home. Also, we have seen that little girls are now working a lot doing the housework where it should have been these little girls doing home schooling until going back to school. (P33: IDP, Hargeisa)

The fact that around one-third of participants reported being even a little bit worried about their own mental health or that of a family member is striking considering that fact that they live in a society where, like others, mental illness is to some degree stigmatised.

> When things get really tough and you tell the people to stay at home, some will have panic attacks, and this can lead to mental illness. Because we, as a Somali society, we are not people who can easily express their emotions; we just keep quiet. (P28: Woman, Hargeisa)

The most and least privileged generally had similar views, but with the least privileged experiencing the highest levels of worry due to loss of income and specific issues of exclusion. These included IDPs lacking representation without permanent habitation, women and girls facing GBV or FGM/C, small informal traders being extorted by corrupt police and physically disabled people lacking representation and losing employment.

> To be honest, nothing that much has changed. They just told us to work from home which we do and the responses didn't affect me that much, as much as it did for those ones who all their life and income depended on the market – those are the ones who are suffering the most. (P22: Government inclusion official, Hargeisa)

> There is a lot of people, including I and my family who want to have a secure livelihood, but because we live as IDPs that is almost impossible for us. People in our position need a permanent resettlement plan first, then we can think about secure jobs. (P14: IDP, Mogadishu)

> Gender based violence exists and is really common. The reason I think it is increasing is because the schools are shut now and all the students are in the house, parents are hiring the circumcisers and the circumcisers are making money out of it as the sources of income are very limited now; they can also be virus spreaders as they are going from house to house. (P28: Woman, Hargeisa)

> As a trader, I face violence every day. Government forces come and harass us. We pay tax to the local authorities but there are always uniformed individuals coming and asking money. Government has to stop these forces from harassing me and other small traders. (P5: Small trader, Mogadishu)

> People with disabilities face more challenges than any other social group that I can think of, and the COVID-19 response measures have made their situation worse. Many of them used to go out to do small tasks, or non-permanent jobs, but many of them have lost these and as a result are at risk of facing depression. They also feel excluded from any decision-making related to the COVID-19 responses. (P20: Physically disabled person, Mogadishu)

Livelihoods are being destroyed but people are receiving little or no financial support

We heard many times that measures to try to control COVID-19 have thrown families into crisis.

> The lockdown sounds easy for people on a good salary or those who have the skills to earn income while at home, but it is terrible for those whose lives depend on going out – for us it is either getting coronavirus or watching your family starve at home. (P12: Illiterate person, Mogadishu)

Few of the participants said they were in a financial position to take measures such as stockpiling food, paying off debts, saving money, borrowing money or items, taking on extra or different work or providing extra financial support to others (see Table 5).

Loss of income without any support means people are going hungry and running into fundamental financial difficulties. Some of the financial problems resulted from families choosing to no longer employ cleaners in their homes or visit tea shops to protect themselves from the virus. So understandable actions at family level are generating problems.

Table 5. Actions taken on livelihoods – Mogadishu and Hargeisa.

Have you and your family taken any of these actions due to the coronavirus or due to what is being done in responding to it?	
Found ways to still work or go out after curfew (if there is one)	55%
Stockpiled anything such as food	35%
Borrowed money or items	25%
Paid off debts or saved money	20%
Taken on extra or different work	20%
Joined a cash transfer programme	15%
Provided extra financial or other support to others	10%

People are receiving little help

Participants said that they were receiving little help in coping with the many problems they were facing (see Tables 6 and 7)

The diaspora plays an important role in sending funds to relatives in some cases. However, the diaspora is in most cases not making the situation at all better. In one case a participant was providing psychological support to the diaspora; this provides an exception to the usual picture of the diaspora being the ones providing (usually financial) support.

> We use videoconferencing at home too, especially with family in the diaspora. I feel they need us more; they need the contact. Lockdown in Europe and the US has been much harder than here. We have more freedom. It is important for them to feel they are not alone. (P24: Telecoms employee, Hargeisa)

The telecom companies are helping by having COVID-19 public health education ringtones but otherwise, people are hit by price rises by other businesses.

> Everyone is worried prices at the markets will be high. Somtel has reduced charges by half. Others have kept

Table 6. Impact of other people and organisations – Hargeisa.

What **overall impact are other people and organisations having** on you and your family at the moment?						
	Making the situation a lot better	Making the situation a little better	Having no impact	Making the situation a little worse	Making the situation a lot worse	Don't know/ No answer
Family, friends and relatives in the country	5%	15%	30%	5%	5%	40%
Family, friends and relatives in the diaspora	10%	30%	10%	10%	0%	40%
Your own community or social group	0%	25%	45%	10%	0%	20%
Another community or social group	0%	15%	30%	0%	0%	55%
The national government	0%	45%	15%	10%	10%	20%
The local government	0%	15%	50%	0%	5%	30%
Business	5%	15%	40%	10%	5%	25%
The mosque	5%	30%	35%	10%	0%	20%
Local NGOs	5%	30%	45%	0%	0%	20%
International organisations and NGOs	5%	10%	40%	0%	0%	45%
Foreign governments	0%	30%	30%	0%	0%	40%
Other	0%	5%	10%	0%	5%	80%

Table 7. Impact of other people and organisations – Mogadishu.

What **overall impact are other people and organisations having** on you and your family at the moment?						
	Making the situation a lot better	Making the situation a little better	Having no impact	Making the situation a little worse	Making the situation a lot worse	Don't know/ No answer
Family, friends and relatives in the country	10%	20%	50	10%	0 %	10%
Family, friends and relatives in the diaspora	25%	15%	40%	10%	0 %	10%
Your own community or social group	10%	20%	50%	5%	0%	15%
Another community or social group	0%	15%	60%	5%	0 %	20%
The national government	30%	30%	25%	10%	0 %	5%
The local government	30%	30%	25%	5%	5%	5%
Business	0%	20%	15%	60%	0 %	5%
The mosque	10%	10%	40%	25%	10%	5%
Local NGOs	5%	50%	35%	5%	0%	5%
International organisations and NGOs	5%	40%	40%	5%	5%	5%
Foreign governments	20%	30%	40%	5%	0%	5%
Other	0%	0%	15%	0%	0%	85%

Table 8. Actions taken on lives – Mogadishu and Hargeisa.

Have you and your family taken any of these actions due to the coronavirus or due to what is being done in responding to it?	
Washed your hands with soap more often	98%
Avoided large groups of people	75%
Covered your mouth with your elbow when you cough or sneeze	73%
Tried to avoid touching your eyes, nose or mouth	58%
Started wearing a face covering (anything that covers your mouth and nose e.g., mask, scarf, niqab)	55%
Started using hand sanitiser or used it more	53%
Tried to be healthier generally	45%
Disinfected or washed things with soap more	43%
Tried to stay at least 2 metres away from people when you are outside	40%
Avoided touching your face covering and kept it away from other things before washing it with soap	38%
Avoided or tried to prevent violence (e.g., from the police enforcing curfew)	23%
Brought relatives together in your home	13%
Tried to have old, unhealthy or ill family members live as separately as possible from everyone else	13%
Avoided touching the body of a relative who died	5%
Sent relatives to the countryside	0%

> prices the same and others have made donations including food to low income families and to IDPs. However, other businesses are making a market out of the situation and increasing prices. (P21: Government health official, Hargeisa)

> No contribution from the businesses. They increase available stock prices. (P32: Illiterate person, Hargeisa)

> We have learnt a lot from the ringtones [automated public health messages] that Telesom Company has facilitated, which tells us the guiding practices for avoiding infection. (P39: Rural pastoralist, Hargeisa)

Friends, relatives and family in the country, foreign governments, local NGOs, international organisations and international NGOS are helping, but only a little. The exception to the pattern of similarities was the more positive perception of the national and local governments in Mogadishu as opposed to Hargeisa. This may be due to an imbalance in resources available or differences in the use of those resources.

Limited action to prevent COVID-19 infection is more due to structural and social factors than lack of information

Nearly all participants showed that they understood the fundamentals of how to prevent COVID-19 infection and were taking various actions to protect their lives generally (see Table 8, which indicates the percentages of participants who indicated that they took the action specified). On this issue we were focused primarily on showing the overall pattern of actions and so did not disaggregate the results between the two locations; the results were similar in both.

Various forms of social exclusion usually did not prevent participants from learning about hand washing and social distancing.

In explaining their own limited compliance with actions to prevent infection, we often heard from participants that it was not practical for them – they lacked money to buy soap or hand sanitiser, had problems with accessing water, or could not avoid living and working in crowded places. Those who thought erroneously that COVID-19 was like bad flu or could be treated by special foods were a small minority of the participants (two out of forty); we do not know whether this is representative of the population as a whole; this would be worth researching further.

> It is difficult because often there is no soap on hand. (P16: Minority clan member, Mogadishu)

> I live in a rural area where crowds are not a concern for my wife and children. However, I go to the town market every day to sell our camels' milk and I meet a lot of people; many of them come close to me although I try to maintain social distancing. Since I go out to the market in Mogadishu and meet with people there, I could easily get the virus and also infect my family. There is no easy way to avoid the virus while also trying to earn a living. (P19: Rural pastoralist, Mogadishu)

> it is difficult as I work in a very congested environment. (P26; Small informal trader, Hargeisa)

This knowledge of what they need to do combined with lack of resources to put that into action generated feelings of helplessness (see Tables 9 and 10).

Table 9. Information about preventing infection: impact on feelings – Mogadishu.

When you hear about how to avoid catching or spreading the disease, which of these is closest to how you and your family feel?			
Better because you can make yourselves safer	No different from before	More frightened because there is so little you can do	Don't know/No answer
25%	25%	50%	0%

Table 10. Information about preventing infection: impact on feelings – Hargeisa.

When you hear about how to avoid catching or spreading the disease, which of these is closest to how you and your family feel?			
Better because you can make yourselves safer	No different from before	More frightened because there is so little you can do	Don't know/No answer
25%	10%	55%	10%

Table 11. Explaining limited action to prevent infection – Mogadishu.

Why do you think that other people are not doing more to protect themselves and others from COVID-19?			
Mainly lack of knowledge	A roughly equal mix of lack of knowledge and not having a choice (e.g., lack of money, lack of space, having to work close to others)	Mainly not having a choice (e.g., lack of money, lack of space, having to work close to others)	Don't know/ No answer
20%	50%	30%	0%

> We feel frightened because we cannot do anything against it. (P35: Minority clan member, Hargeisa)

Public health education is still necessary. It should include challenging stigmatisation, explaining that wearing a face covering does not mean a person is infectious, and explaining that those recovered from the virus are not still infectious.

Many participants reported their belief and concern that others lacked knowledge about how to prevent the spread of the disease or the means to act upon such knowledge, or a mix of the two (see Tables 11 and 12).

> The majority of our population do not have the relevant knowledge on COVID-19. They do not understand the serious health risks which can increase infection. They do not have the financial capacity to adopt the necessary precautions; social distancing, staying at home etc. They do not have sufficient income to tackle such disasters. (P35: Minority clan member, Hargeisa)

Participants reported the need to reduce fear and misunderstanding in relation to face coverings; they said that some people who are hostile to those wearing face coverings say they think that the wearer is infectious and therefore a danger to them. It can also be interpreted as a lack of faith in Islam (see Tables 13 and 14).

> I encourage people to wear masks when they are going shopping or to overpopulated areas, as it reduces the spread of the virus. Some people are hostile to this and I have seen people calling those wearing the mask "coronavirus." It is ignorance which can be addressed by mass mobilisation. (P2: Government employment official, Mogadishu)

> Since the Somali people are not familiar with this face mask, except the doctors, people think it is just showing off, or you have the virus already. (P3: Government inclusion official. Mogadishu)

> I wear a face mask literally every time I go out. I'm sure there is a perception that whoever wears a mask has COVID-19. When you walk on the streets downtown, there are men who mock you and call you names like "Miss Corona." Some of them will say, "Do you not trust your Creator? If you are meant to die, you will die

Table 12. Explaining limited action to prevent infection – Hargeisa.

Why do you think that other people are not doing more to protect themselves and others from COVID-19?			
Mainly lack of knowledge	A roughly equal mix of lack of knowledge and not having a choice (e.g., lack of money, lack of space, having to work close to others)	Mainly not having a choice (e.g., lack of money, lack of space, having to work close to others)	Don't know/ No answer
5%	90%	5%	0%

Table 13. Face masks and hostility – Mogadishu.

I feel hostile to people wearing face masks					
Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know/No answer
0%	20%	5%	35%	40%	0%

Table 14. Face masks and hostility – Hargeisa.

I feel hostile to people wearing face masks					
Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know/No answer
0%	10%	0%	40%	50%	0%

> one day. Do you think that face mask will protect you from death?" (P28: Woman, Hargeisa)

There was strong agreement among participants that people with COVID-19 had nothing to be ashamed about (see Tables 15 and 16).

The few who disagreed thought people would feel shame due to the attitudes of others, not because they should feel shame. There was extensive worry about being stigmatised.

> Those recovered from the virus will remain shamed because the rest of the society believe that these people are sick and need to be avoided. There is a need to teach people to accept these people. (P14: IDP, Mogadishu)

Participants were divided about whether they would keep it secret if they had COVID-19 symptoms, with a tendency towards a strong view that they would not keep it secret (see Tables 17 and 18).

Participants felt that it would be better not to keep it secret and said that they would only do so to avoid stigma, hostility, exclusion, loss of income or being forced into quarantine or poor standard health facilities. Some argued that those negative attitudes towards people with COVID-19 (including those who have recovered from it) were due to fear of the disease rather than necessarily thinking that having the disease is shameful, though that can also be the case. Some thought shaming was due to unfamiliarity with the disease and how it is spread. Participants were worried about being mocked, having their reputations permanently tarnished, being given an unpleasant nickname or being unable to have a proper Islamic burial.

> I don't agree with being ashamed about it, because if you hide something harmful from the people it is selfish. I think the rationale of hiding your identity or getting ashamed about it is that people are afraid because they will get nicknames and be laughed at. I think the most feared thing is if someone dies and he or she cannot be washed and buried in the Islamic way. There is a certain way of doing *Ghusl* [mandatory death purification ritual]; when someone dies from COVID-19 it means that person would be buried without *Ghusl*, or not be touched at all. (P33: IDP Hargeisa)

While participants tended to be willing to go to hospital with COVID-19 symptoms, over one-third said they would be reluctant (see Tables 19 and 20)

Participants reported being fearful of not being able to earn a living if they admitted to being or having been infected, being ostracised even after recovering due to a false belief that they are still infectious and being

Table 15. COVID-19 and shame – Mogadishu.

People who have COVID-19 have nothing to be ashamed about					
Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know/No answer
85%	10%	0%	5%	0%	0%

Table 16. COVID-19 and shame – Hargeisa.

People who have COVID-19 have nothing to be ashamed about					
Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know/No answer
45%	35%	0%	0%	15%	5%

Table 17. COVID-19 and secrecy – Mogadishu.

If I contracted COVID-19 I would try to keep it secret from other people (e.g., outside my family)					
Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know/No answer
10%	25%	5%	15%	45%	0%

Table 18. COVID-19 and secrecy – Hargeisa.

If I contracted COVID-19 I would try to keep it secret from other people (e.g., outside my family)					
Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know/No answer
0%	10%	0%	35%	55%	0%

Table 19. Unwillingness to go to hospital with COVID-19 symptoms – Mogadishu.

If I became unwell with COVID-19 symptoms (e.g., a fever and frequent new cough) I would be unwilling to go to hospital					
Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know/No answer
25%	15%	5%	15%	40%	0%

Table 20. Unwillingness to go to hospital with COVID-19 symptoms – Hargeisa.

If I became unwell with COVID-19 symptoms (e.g., a fever and frequent new cough) I would be unwilling to go to hospital					
Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know/No answer
10%	20%	0%	20%	50%	0%

stigmatised in the long term for having been infected. They also said they feared compulsory quarantine by the hospital.

> It is related to the community perception of the virus. Many people are not aware that the virus is not permanent and that it can be recovered from within weeks, so these people avoid interacting with those who have experienced COVID-19; due to fear, not discrimination. (P11: Illiterate person, Mogadishu)

> First, if somebody gets sick, they will feel isolated and abandoned. Second, those whose lives depended on working for other people will also feel like they are being avoided and they might lose their income as a result. (P14: IDP, Mogadishu)

Health care is mostly unavailable, unaffordable and not trusted

Health care is mostly unavailable or unaffordable, and where it does exist it is often not trusted (see Tables 21–24). Even minor health care is nearly always beyond the reach of a quarter of the participants. Major health care is always unavailable or unaffordable for well over half of the participants. The predominant feeling is of low confidence in what health care there is: only one out of 40 participants had high confidence in health care.

> I would go visit health centres or hospitals for treatment and care. This is my stand as Ahmed. (P25: Small informal trader, Hargeisa)

Table 21. Access to health care – Mogadishu.

Which of these is closest to describing the situation of you and your family right now?					
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
30%	15%	10%	15%	30%	0%

Table 22. Access to health care – Hargeisa.

Which of these is closest to describing the situation of you and your family right now?					
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
5%	20%	20%	35%	20%	0%

Table 23. Confidence in quality of health care – Mogadishu.

Which of these is closest to describing your view of the quality of the health care in your area (not just for COVID-19)?			
High confidence	Moderate confidence	Low confidence	Don't know/No answer
5%	35%	45%	15%

Table 24. Confidence in quality of health care – Hargeisa.

Which of these is closest to describing your view of the quality of the health care in your area (not just for COVID-19)?			
High confidence	Moderate confidence	Low confidence	Don't know/No answer
0%	25%	75%	0%

I don't have the money to go to hospital. I would rather use remedies such as ginger and garlic which are much cheaper than the medicine available at the hospitals. (P15: Minority clan member, Mogadishu)

There is more than one answer to this question. I wouldn't go to the hospital if I caught the virus because by going there, I could have already transmitted the disease to the hospital and the people there. Another reason I would fear going is the lack of attention and the negligence of the health workers who are treating the patients. Also, the quarantine places and beds in the hospitals cannot be relied upon; the healthcare here is poor, especially in the Hargeisa main hospital. All the death tolls they report every day are due to the negligence of the nurses and the lack of ventilators. I believe this is a very serious issue. At this stage, it is better you treat yourself. (P38: Minority ethnic group member, Hargeisa)

I would not go to hospital for COVID-19, I can treat myself because it is like a bad flu. I would take the traditional medicines like black seed, honey and lemon for a few days and I will be fine. I know some people who did that, and they are fine now. (P31: Illiterate person, Hargeisa)

I can understand most people;, they prefer to stay at home and keep hiding themselves because they don't have the confidence to go to the hospitals. They do not believe they will recover. (P1: Government health official, Mogadishu)

Most of the people don't believe they will get proper treatment from the hospitals, so they prefer to stay at home. They also hate quarantine. (P5: Small informal trader, Mogadishu)

Broad and deep agreement across all major issues examined in the research

We found broad and deep agreement across all major issues examined in the research, with similar patterns in Mogadishu and Hargeisa. Many of the similarities are set out above in the text and tables. The participant sample is not representative, that is, it is not weighted in proportion to the presence of the social categories in the overall population of Somalia/Somaliland. The fact that the findings are so similar across Mogadishu and Hargeisa and across the social categories – including rural pastoralists – suggests that further research could productively explore whether the findings have broad applicability across Somalia/Somaliland.

The depth and breadth of agreement across many major issues was high (see Tables 25 and 26). There was consensus or near consensus among the participants that they understood the threat posed by COVID-19, wanted more action backed by more financial help and more help to avoid crowds and wanted the police to be supportive rather than repressive. There was also near consensus that the poor felt fearful and helpless.

Table 25. Feedback of participants on preliminary findings – Mogadishu.

Do you agree or disagree with the following statements?	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know/No answer
You have a good understanding of the health threat from COVID-19	85%	15%	0%	0%	0%	0%
You want a lot more action to control the virus but need that to be matched with a lot of financial support (e.g., cash transfers, price controls and lower taxes)	70%	25%	5%	0%	0%	0%
You support current restrictions on mosque attendance, and praying at home, and would support more restrictions if they were agreed to in a proper way	55%	25%	5%	15%	0%	0%
People who have a low or very low income feel fearful and helpless	90%	10%	0%	0%	0%	0%
People need help to control the virus in terms of avoiding large groups	60%	35%	0%	0%	0%	5%
People have a mostly positive attitude towards cooperating with other social groups	20%	30%	10%	25%	15%	0%
People need the police to be supportive and protective not repressive	100%	0%	0%	0%	0%	0%

Table 26. Feedback of participants on preliminary findings – Hargeisa.

Do you agree or disagree with the following statements?	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know/No answer
You have a good understanding of the health threat from COVID-19	80%	15%	0%	5%	0%	0%
You want a lot more action to control the virus but need that to be matched with a lot of financial support (e.g., cash transfers, price controls and lower taxes)	80%	20%	0%	0%	0%	0%
You support current restrictions on mosque attendance, and praying at home, and would support more restrictions if they were agreed to in a proper way	90%	10%	0%	0%	0%	0%
People who have a low or very low income feel fearful and helpless	70%	20%	0%	10%	0%	0%
People need help to control the virus in terms of avoiding large groups	60%	35%	0%	0%	0%	5%
People have a mostly positive attitude towards cooperating with other social groups	25%	20%	5%	35%	15%	0%
People need the police to be supportive and protective not repressive	45%	40%	5%	10%	0%	0%

When we asked the participants whether they supported current restrictions on mosque attendance, and praying at home, and would support more restrictions if they were agreed to in a proper way, support was strong overall (see Tables 25 and 26). This, and the mild endorsement of the mosques in terms of their impact on the situation (see Tables 6 and 7), suggests that the COVID-19 response does not have to be framed mainly in terms of Islam, just compatible with it and supported by it. It contradicts the notion that the devotion of Somalis to Islam at the level of individual attitudes is a major barrier to action to preventing the spread of COVID-19, even if it is a barrier on occasion. Indeed, our participants overwhelmingly emphasised the value of Islam for sharing, inclusion, mutual support, strength and comfort. Our findings show that the COVID-19 response does not have to be channelled primarily through the mosque, but that the support of the mosque is important for legitimacy and compliance.

The consensus on the fundamentals of how to build back better was overwhelming across the elements of our definition of sustainable development; protecting and enhancing lives, livelihoods and inclusion; living the life that one values; providing for future as well as current generations; and allowing the natural world to flourish. The same points were repeated many times and the points that were made only by one or two participants were compatible with or added nuance to the more common ones.

In relation to protecting lives from health threats, participants proposed more education on preventing the spread of COVID-19; support so that people can do the things needed to prevent the spread of COVID-19; personal protective equipment (PPE) for those who must go out to work; care and support to infected people so that they can be quarantined; protection against other diseases; educating people to have an accurate understanding of COVID-19 so that people who have recovered are not shamed or avoided; free or affordable public health care for all rather than private health care; regulated health care to ensure quality; working out how to adapt to control the virus while returning to normal as much as possible; organisation and coordination at all levels; and a national strategy. On protecting lives from violence, participants proposed passing and enforcing laws and having education to protect women and girls from domestic violence, rape and FGM/C; jobs, incomes and education and reduce social inequality so that people have an alternative to violence; and measures to improve security.

On protecting livelihoods, participants proposed avoiding lockdowns or curfews unless there is emergency financial assistance (especially for those most in need); more equal sharing of resources; government and business cooperation; more support from business for the poorest; when government cuts taxes on business to help the poorest, businesses cutting their prices; cooperation between national and regional governments; working with religious leaders; sharing to help people survive; skills training for employment; prioritising those on lowest incomes; regulating food prices; promoting domestic food production; free or affordable education for all; health care to support livelihoods; reduced corruption so that the best use is made of the resources that are there; and international support.

On inclusion, participants urged the following:; promote unity; provide inclusive education and social justice; reduce inequalities; stop speaking negatively about minority groups; ensure that women and minorities have people representing them in senior government positions; do not discriminate against people based on any characteristic, such as clan or physical disability; and follow Islam as it instructs people to share and not to discriminate against anyone because we are all human.

On living the life that one values, participants recommended strong governance to provide the right context but also self-development and less reliance on aid; following the guidance of Islam on how to live a good life; health care, education, food security and secure employment; sharing and mutual support; being realistic and modest in what you seek; improving society; and ensuring enough prosperity for permanent accommodation and savings.

On taking care of this generation and future generations, participants recommended the following: create a better system with regulations, stability, security and all the main services; learn from past mistakes; ensure that everyone has education and is not just trying to survive now; educate the younger generation in how to live life well; learn from traditional ways but also adapt to the modern world; and work out how parents can guide their children.

On allowing the natural world to flourish, participants favoured waste management and recycling to create jobs, as well as to protect the environment; accountability and regulation of business; government efforts to protect nature (such as a ban on cutting down trees for charcoal); public education about the importance of the environment; renewable energy; government policy rather than relying on NGOs; and strong regional cooperation.

Disagreements can be expected over specific policies, priorities and allocation of resources. Nevertheless, the

participants universally chose to emphasise what they had in common rather than what they disagreed about.

Discussion

The many areas of common ground among the participants despite their diversity in terms of social category could provide a sound basis for policy on sustainable development. In making suggestions about how to protect and enhance lives, livelihoods and inclusion, the participants emphasised the importance of long-term structural and infrastructural investments as well as short-term and narrowly focused emergency measures. This was true across the board regarding COVID-19 health, general health, necessities, social inclusion, violence and other matters. The participants indicated that health care other than that relating to COVID-19 was needed – such as a proper health care system with free access and addressing the social inequalities that generate ill health. 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. It is not too difficult for people who are not literate or who have never had any formal education to participate in rigorous research.

We have structured the discussion of COVID-19 responses around three key themes of sustainable development, i.e. protecting and enhancing lives, livelihoods and inclusion.

Lives

Addressing the systemic facts that health care is mostly unavailable, unaffordable and not trusted needs to be at the heart of COVID-19 response and of laying the foundations for sustainable development. Related to that, while the COVID-19 prevention knowledge of participants had gaps and was occasionally inaccurate, acknowledging that should not detract attention from often more important structural barriers (e.g., having to go to crowded places to work, lack of access to water, lack of money to stay at home or go to hospital when infected) and social barriers (e.g., feeling the need to comply with close contact patterns of social interaction in order to fit in) to preventing infection. Inattention to structural and social factors can lead to the blaming of individuals or acting oppressively towards them for not absorbing and acting on public health messaging. In view of the value and low cost of face coverings for reducing the spread of the disease, informational barriers (misunderstandings), structural barriers (lack of free face masks or simple cloth coverings) and social barriers (stigma) to their widespread use should be addressed. Face coverings need to be seen as evidence of caring about others; wearers do not usually think they are infectious but are mainly trying to protect others in case they are wrong while also trying to protect themselves. Fear of violence is also a feature of the situation. Although Hargeisa has suffered no terrorist attacks since 2008 whereas Mogadishu remains very dangerous in that respect, we found similar levels of worry about violence in both. This seems to be due to habituation to different levels of violence and a shared fear of more crime due to scarcity of resources, increased unemployment leaving numerous males with time on their hands, and a surge in GBV and FGM/C during the partial lockdown and school closures.

Livelihoods

While many countries around the world have cushioned the public through furlough schemes and other social welfare mechanisms, this is unavailable to Somalis. Few of the participants said they had been enrolled into cash transfer schemes. The lack of financial options is a major danger sign. Most of all, loss of income combined with rising prices explains the widespread worry, especially among the lower income participants, about lack of access to necessities such as food, clean water and shelter. For some, access to food and clean water is even more intermittent than before. For many, access to health care is effectively non-existent and debt is accumulating. COVID-19 responses are failing the most vulnerable. Without an income or a welfare system, people will starve. The precarious livelihoods that people have created to support themselves are being swept away, with no confidence that those livelihoods can be rebuilt and with great suffering now. Schools were closed and many restrictions (included ineffective ones like the curfew in Mogadishu) were imposed on making a living and yet people still gathered in other social settings. There was a strong consensus around the need for the police to play a supportive rather than repressive role. There was an equally strong and reasonable rejection of the Mogadishu night-time curfew as ineffective in preventing the spread of

COVID-19. Based on this rational rejection and imperative of making a living, the participants in Mogadishu found ways to go out despite the curfew.

Inclusion

Despite the new hardships of COVID-19 and responses to it making previous hardships even greater, the participants communicated a powerful message of their dignity, understanding, rationality, compassion and commitment to inclusion. They expressed a desire for access to health care but with no expectation that this desire would be fulfilled. There was no evidence that the strong current of fear had taken the participants in the direction of hatred, stigmatisation or discriminatory practices. Indeed, they repeatedly spoke out against those things, worried about their existence and urged commitment to unity, common humanity and cooperation. When we asked questions intended to find out whether the participants had exclusionary attitudes or engaged in exclusionary practices, the participants usually reinterpreted our questions into positive ones about social distancing and anti-exclusionary practices. Illiterate people on very low incomes in one of the poorest countries in the world talked of their efforts to support each other (such as families sharing food when another does not have enough that day) and how bad they feel at not being able to do more. Some reported witnessing exclusionary practices and being targets of them. This was reflected in polarisation in responses to our question about whether other people have a mostly positive attitude towards other social groups (see Tables 23 and 24). Nevertheless, there was extensive and consistent evidence of inclusiveness in the views of the participants.

Conclusion

Somalia/Somaliland has not, at least so far, been hit by COVID-19 nearly as hard as many other places in the world. However, people suffering already from social exclusion in various respects have been pushed into a desperate situation by the current forms of COVID-19 response due to the lack of meaningful social welfare and especially income support. The situation for those people is deteriorating. If COVID-19 surges, their situation could rapidly become much worse. People, especially those on low incomes, are suffering and worried about many things – loss of income, physical health issues other than COVID-19, discrimination because of their social group, violence (due to crime and a surge in GBV and FGM/C) and their mental health. There should be no full or partial lockdown without income support, especially for the poorest: the focus needs to be on more sustainable measures such as hand washing, social distancing and wearing of face coverings. Public health education should be provided on what people can realistically do to protect themselves. Just as important, resources should be provided to enable those actions and those actions should be promoted as socially valuable, responsible and normal. The awareness raising should include explaining that those who have recovered from the virus are no longer infectious and include reducing hostility to use of face coverings. COVID-19 response and sustainable development are hampered by the fact that health care is mostly unavailable, unaffordable or untrustworthy. Establishing community-based health facilities that are trusted, regulated, safe and free should be a top priority for the authorities. There was broad and deep agreement across all major issues explored, including across Mogadishu and Hargeisa. This included agreement on many of the immediate actions that are needed and the fundamentals of what building back better would mean. Even with few resources, much more can be done. Across the board, we found that the participants had many shared views that could be a major resource for constructive individual and collective action for sustainable development during, through and as a method of COVID-19 response. In essence, the paper shows that COVID-19 responses are contributing to controlling COVID-19 while exacerbating inequalities and harming the most vulnerable. It suggests ways of aligning COVID-19 responses and the protection and enhancement of lives, livelihoods and inclusion as part of sustainable development. It does so by identifying perceptions, challenges and opportunities around these issues in the Somalia/Somaliland context in ways that are relevant to contexts with similar characteristics such as very low incomes, low levels of state capability and near absence of health care for most of the population.

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