



Republic of  
Somaliland

# COVID-19 Socio- Economic Impact Assessment

2021



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REPUBLIC OF SOMALILAND

# COVID-19 Socio-Economic Impact Assessment

2021

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## Foreword

The COVID-19 pandemic has no boundaries and presents an extreme threat to Somaliland and the world at large. WHO has reported new and more infectious strains of COVID-19 contributing to the rising number of new cases globally.

The Somaliland government stepped up its mitigation mechanisms, including nomination of a committee led by the Vice President, the implementation of lockdown measures, closure of airports and borders among others that have affected food value-chains, international trade, and Micro and Small Enterprises (MSMEs), which are the main source of livelihoods for the bulk of the Somaliland population. Mitigation measures such as lockdowns in other parts of the world have affected the remittances stream. The pandemic continues to challenge a vast number of communities, presenting a colossal test to the leadership and humanity. In addition, it has disturbed livelihoods, increased morbidity and mortality and overwhelmed Somaliland's health systems.

The COVID-19 Socio-Economic Assessment report is an effort to understand and document the socio-economic effects and impact that the COVID-19 pandemic has on urban households. The report shows that the pandemic negatively affected the population's economic, health and education sectors and the vulnerable population.

I hope that the in-depth analysis presented in this report will contribute to the efforts by the government and its partners to enhance the community's resilience and cooperation levels to mitigate the health, social and economic impact of the COVID-19 pandemic. It will also enable us to formulate appropriate policy options and strategies to reduce the impact that COVID-19 has had on people's lives in general.

I would like to extend my appreciation to the UNFPA for the technical expertise and financial support that made the assessment happen. Finally, the same appreciation goes to the survey team (CSD) and interviewers for their efforts in successfully completing this important exercise.



**Hon. Mr. Hassan Mohamed Ali (Gaafadhi)**

*Minister of Planning and National Development*

## Executive summary

The Ministry of Planning and National Development conducted a survey to establish the socio-economic impact of COVID-19 in November 2020. This survey, which was at the household level, randomly enumerated 640 households in 32 sampled Enumeration Areas (EAs) from four cities of four regions in Somaliland, specifically significant cities. The survey also included a short assessment of health facilities to check on the level of uptake of routine health services such as maternal and child health.

### Respondent background characteristics

The majority of the household survey respondents were women (91 percent) compared to male respondents at only 9 percent. Seventy-seven percent of the respondents were aged between 20 and 49 years; at 27 percent, those aged 20 to 29 years had the largest proportion. Over two-thirds of the respondents were married (69 percent), followed by unmarried or single respondents at 13 percent while divorced and widowed respondents constituted 11 and 8 percent respectively.

### Economic impact

Among urban households, 58 percent lost their income due to COVID-19, 35 percent reported a loss of business, while 13 percent reported a loss of income from remittances. Burao city has the largest proportion of households that reported at least one of its members lost their income during the pandemic at 83 percent. Hargeisa reported the least proportion of households, which had their income affected by the pandemic at 22 percent.

### Social impact

On 18 March, the government of Somaliland began a nationwide lockdown, forcing the closure of all kinds of schools throughout the country as part of the restrictions to contain the spread of COVID-19. Hence, the study showed that 92 percent of the respondents did not know any child who had not resumed schooling after the temporary closure of

schools whereas, 8 percent responded that they knew children who did not resume schooling after the temporary closure.

Respondents were also asked whether they or a member in their family experienced humiliation, insults, threats during the COVID-19 crisis compared to before. Fifty-three percent reported more GBV cases occurring during the COVID-19 pandemic. Thirty-seven percent of household respondents said GBV cases remained the same as before, while 10 percent said the GBV cases reduced.

### Health impact

The study found out that only 5 percent of the respondents had reported that at least one household member was tested for COVID-19. Borama had the largest proportion of tested household members (16 percent), while Berbera had the lowest proportion.

Households were asked whether a member of their households was hospitalized for COVID-19 or not. Among participating households, 95 percent responded that they had members not tested for COVID-19. Likewise, 3 percent of all households responded to have a member hospitalized for COVID-19. On the contrary, 3 percent responded that they did not have a member hospitalized for COVID-19.

The study assessed the effect of the COVID-19 pandemic on maternal and child health services by asking the respondents about their experience in accessing antenatal, delivery and child care services. The results showed that one-third of children's access to healthcare, almost half women's access to ANC and delivery services were affected by the pandemic.

### Resilience and household food security

Across all the surveyed cities, 56 percent of households reported not to have worried about food supply due to the COVID-19 crisis. In comparison, 44 percent indicated that they worried about food supply during the COVID-19 crisis.

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# 1

## Background



## 1. Background

### 1.1 Introduction

The COVID-19 pandemic is a serious global health threat that is affecting 219 countries and regions around the world. Coronavirus is a virus that causes severe acute respiratory syndrome - coronavirus 2 (SARS-CoV-2) or COVID-19. It was first identified in Wuhan, China in December 2019 (WHO, 2020b). COVID-19 is a serious illness and in some cases patients can develop difficulty in breathing leading to extreme complications. The severity of the risk posed by the disease increases steadily with age. Additionally, those of all ages with underlying medical conditions (including but not limited to heart disease, diabetes, or lung disease) appear to be at higher risk in developing severe COVID-19 compared to those without these conditions (CDC, 2020).

### 1.2 COVID-19 Global Context

A study conducted by Imperial College London in 2020 estimated that in the absence of interventions, COVID-19 would result in 7.0 billion infections and 40 million deaths globally in the year. Mitigation strategies focusing on shielding the elderly (60% reduction in social contacts) and slowing but not interrupting transmission (40% reduction in social contacts for wider population) could reduce this burden by half, saving 20 million lives, but we predict that even in this scenario, health systems in all countries will be quickly overwhelmed. This effect is likely to be most severe in lower income settings where capacity is lowest (Imperial College, 2020).

According to John Hopkins University's Coronavirus Resource Centre, as of April 6th 2021, there were 132,481,635 confirmed cases of COVID-19 and 2,875,670 deaths in 219 countries (Johns Hopkins University, 2021). Fortunately, after long research by international scientists, there are now clinically approved antiviral drugs or vaccines that are effective against COVID-19. After relentless efforts by the international scientists, the International Narcotics Control Board (INCB), the World Health Organization

(WHO) and the United Nations Office on Drugs and Crime (UNODC) as well as UK, USA and EU have given the green light on three treatment drugs against COVID-19 with varying degrees of efficacy. The pharma companies such as Pfizer, AstraZeneca, and Moderna have begun dispatching millions of doses across the globe (WHO, 2021).

Economically, the virus outbreak is severely disrupting the global trade, supply chains and employment. Despite the hard work and efforts that all the nations are putting in to control the transmission of the disease by testing & treating patients, quarantining suspected persons, contact tracing and restricting large gatherings, the pandemic is speedily spreading around the world. The economic and social disruption caused by the pandemic is devastating as tens of millions of people around the world are at risk of falling into extreme poverty. Also, under threat is the number of undernourished people, currently estimated at nearly 690 million, could increase to up to 132 million by the end of the year (WHO, ILO, FAO, 2020).

The COVID-19 outbreak affects all segments of the population and is particularly detrimental to members of those social groups in the most vulnerable situations, and continues to affect populations, including people living in poverty situations, older persons, persons with disabilities, youth, and indigenous peoples. If not properly addressed through policy the social crisis created by the COVID-19 pandemic may also increase inequality, exclusion, discrimination and global unemployment in the medium and long term. Comprehensive, universal social protection systems, when in place, play a much durable role in protecting workers and in reducing the prevalence of poverty, through provision of basic income security at all times, thereby enhancing people's capacity to manage and overcome shocks (UNHCR, 2020).

### 1.3 COVID-19 Situation in Somaliland

Somaliland is one of the least developed countries in the world with limited capacity to deal and manage the COVID-19 pandemic. This is due to a weak health system with poor structure and governance, appropriate human resource, weak information management system and deficiency in supplies. The situation is compounded by the extreme poverty-related deprivation. As of April 6th 2021, there were 3,320 confirmed cases and 184 deaths in Somaliland. The number of COVID-19 cases in Somaliland may be higher than the reported figures due to under reporting linked to a weak and poorly coordinated information system, limited capacity to test, as well as stigmatization towards Coronavirus.

Economically, the country has been hit hard by the global implications of COVID-19. Remittances from the diaspora, and livestock exports, which are the main source of revenue are affected by the global economic crisis caused by the pandemic. The economic crisis is unprecedented in its scale: the pandemic has created a demand shock, a supply shock, and a financial shock all at once (World Bank, 2020a).

In terms of government efforts, the president of Somaliland formed the national COVID-19 committee chaired by the vice-president consisting of ministries of Health, Interior, Education, Finance and Information and Culture. The committee is mandated to lead all COVID-19 efforts and guide all policy level agenda. There is a dedicated website for updating the public on COVID-19 issues as well as a technical committee chaired by the Director General of MOH tasked to deliberate on the technical aspects of COVID-19.

The Ministry of Health supported by other players, works to ensure that all medical facilities, equipment and personnel are well organised and trained to deliver a robust medical intervention. The Ministry of Interior coordinates the local and central government to enhance the preparedness and response by the municipalities and other relevant bodies in the regions. The private sector has provided the majority of health provisions including protective equipment, food and medicine supplies. In addition, the civil societies have also contributed in awareness raising and cascading messages on the dangers of COVID-19.

To contain the spread of the virus, schools and office-based businesses were closed, social events

and gatherings prohibited, and flights and travel restricted. The government issued guidelines effective for one month starting from 19 March 2020. Khat chewing establishments were ordered closed, and special guidance was issued for mosques. An initial government decision to close mosques for four weeks was rescinded after pressure from religious leaders. Initially, the entry was banned for flights and people from China, Iran, Italy, France. This was later extended to all the countries till June. However, the Ethiopian flights continued to operate but with strict adherence to COVID-19 protocols.

### 1.4 Rationale

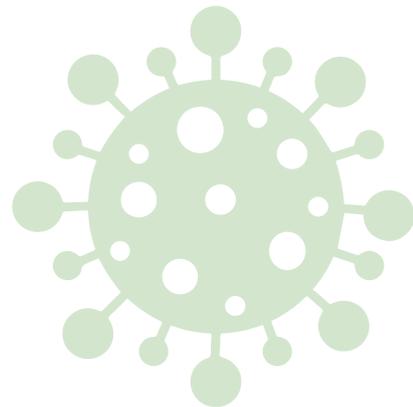
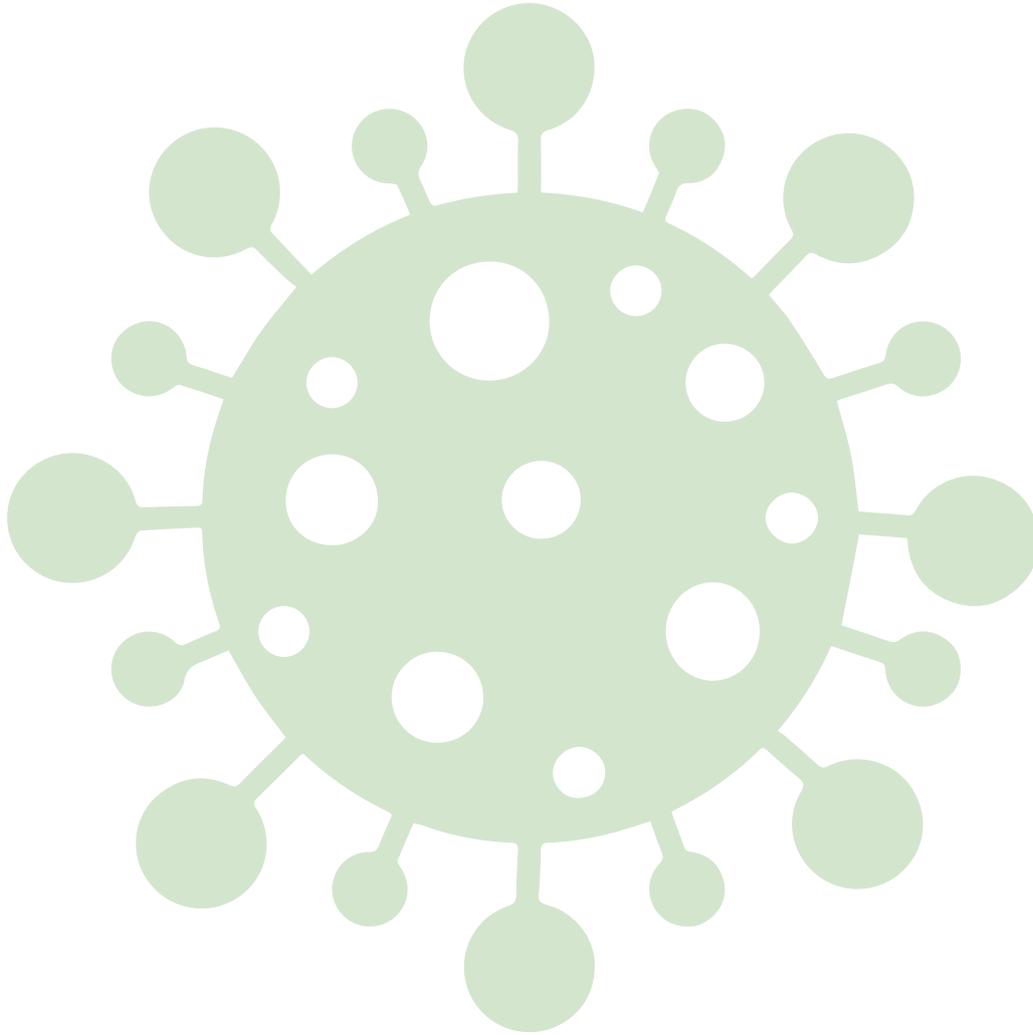
In order to plan and implement proactive measures to mitigate the impact on Somaliland citizens and the economy from the pandemic, the Ministry of Planning and National Development with the support of UNFPA carried out a COVID-19 impact assessment. The findings of the assessment provide information that could be used by government and other service providers, to better understand the impact of the pandemic and to devise interventions to assist the population. The assessment investigates the impact of the pandemic on income, expenditure, education, food security and resilience at household level, as well as gender-based violence and child marriages at household level. The findings will help decision makers to better plan and target mitigating interventions at household level.

### 1.5 Objective

The main objective of this assessment was to understand the socio-economic impact of COVID-19 in order to inform effective and appropriate strategies to minimize the social and economic consequences of the crisis.

The assessment specifically focused on effects of COVID-19 on:

- a. Access to maternal and child health care services.
- b. Household economic status
- c. Psycho-social status of the population
- d. Education attendance.
- e. Households resilience.
- f. GBV, FGM and early marriages.



# 2

## Research Methodology



## 2. Research Methodology

### 2.1 Sample design

COVID-19 pandemic has had a profound impact on Somaliland as whole, however, major cities were expected to face multifaceted socio-economic challenges, because they are the epicentres of the pandemic. This assessment covered four major cities - Hargeisa, Borama, Burao and Berbera. The assessment was designed to cover both households and health facilities in the selected cities to provide an indication on the effects of the pandemic on a range of topics including: income, household food security, education attendance, access to health services, GBV, and household resilience.

#### 2.1.1 Household sample

The main assessment was at household level. It was designed to cover 640 randomly selected households in 32 randomly sampled Enumeration Areas (EAs) in the four major cities. The samples were selected from the sampling frame developed during the Somaliland Health and Demographic Survey (SLHDS) of 2020. The number of dwelling structures in each selected city in the sampling frame was adjusted and converted into households based on findings from household listing exercise during SLHDS 2020. The adjustment factor, at the city level, was obtained by dividing the total number of listed households in the city by the total number of digitized dwelling structures in the city which formed the updated sampling frame for this assessment.

A two-stage cluster sampling design was applied for this assessment. In the first stage, a selection of 32 Primary Sampling units (PSUs) or Enumeration Areas (EAs) were carried out from selected four cities by using a probability proportionate to the number of COVID-19 infected cases reported from each city. Listing of households was conducted and hence the number of households in each of the sampled 32 PSUs were obtained. Finally, a systematic selection of the

Ultimate Sampling Units (USUs) was conducted by selecting 20 households from each of the 32 PSUs listed by using a random selection designed excel sheet template.

Before the actual enumeration, households in all sampled EAs were listed. Listing enables the use of probability sampling, which is a technique in which every household in the sampled EAs has a chance (non-zero probability) of being selected in the sample, and this chance can be accurately determined. At the end of the listing exercise, a total of 2,203 of residential households were listed from the selected cities. Thereafter, the number of residential households obtained from each of the sampled PSUs were used to carry out random selection of 20 households from each PSU.

#### 2.1.2 Health facilities

The assessment was designed to cover health facilities in the selected cities. The health facilities sample frame consisted of an updated list of public health facilities obtained from the Ministry of Health Development. There are 42 public health facilities in the four cities all of which were selected for interviews because of the small numbers.

### 2.2 Training

Prior to the training session, presentations and other necessary training materials were prepared including survey methodology, key definitions, interview guidelines and field staff responsibilities. Documents on selected EAs, list of health facilities, EAs for pre-testing, field work arrangements, data quality monitoring etc. were also made available to training of field staff.

A total of 12 enumerators and four supervisors (staff from the statistics department of the Ministry of Planning and National Development) were trained

for two days- 31st October and 1st November 2020 for the documents and presentation mentioned above. Specifically, it was focused on the field staff to comprehensively understand the data collection tools, sampling procedures and locating EAs by using GPS essentials.

Field testing was conducted to assess the understanding of the trainees, appropriateness of questionnaires, soundness of sampling procedures and the identification of EAs and households. Each team was assigned an EA from which they were supposed to list households and select 20 households randomly for interviews. At the end of the pretest, there was a debrief of all teams where all issues arising were addressed.

### 2.3 Data collection

Data collection was carried out simultaneously across the four cities. Apart from one team who travelled to Berbera one day before, teams started field work on the fourth day of November 2020. The fieldwork was carried out by four teams, each consisting of one supervisor, three enumerators, regional coordinator and a driver. An Android platform developed in CSPro was used for data collection. Prior to data collection, enumerators listed households in each of the sampled EAs from which 20 households per EA were sampled by the technical team and assigned to the field team for interviewing. The collected data was sent to the server on a daily basis. Uploaded data by teams was evaluated at the end of each day for completeness, errors, inconsistencies, percentage of skipping questions per team and per enumerator as well as percentage of missing and “don’t know” of some selected variables per team and per enumerator for key selected variables. Any issues identified were informed immediately to respective teams and enumerators to correct them.

In addition, data collection was continuously coordinated and supervised. Quality control teams made random visits to the field to enhance the quality of collected data and to ensure teams followed the right procedures of sampling households and conducting interviews.

The field work was completed successfully on the 16th November 2020 with all the teams reporting a complete coverage as planned except few health facilities that either refused or no longer existed.

### 2.4 Data processing and analysis

Processing transforms survey responses obtained during collection into a form that is suitable for tabulation and data analysis. The processing of COVID-19 Socio-Economic impact assessment data started after the fieldwork. Data processing was done by a core technical team from the Central Statistics Department of Ministry of Planning and National Development (MoNPD) supported by technical personnel from UNFPA. The tabulation plan, with detailed layout and specification of each table was developed in advance with reference to the assessment questionnaire. The electronic files were downloaded as CSPro files that were exported to SPSS for data processing.

### 2.5 Computation of Weight

Design weights which is the inverse of probability of selecting a household unit to be interviewed and survey weights which is the design weight corrected for non-response including other adjustments where necessary, were computed for every household selected to participate in the COVID19 impact assessment. Survey weight of a household was computed as shown in the following steps;

#### First Stage: Selection of EAs from the selected cities

let

$EA_h$  = number of EAs to be sampled in city  $h$ ;  
and

$HH_{hi}$  = number of households for EA  $i$  in city  $h$ .

The probability of selecting EA  $i$  in city  $h$  is

$$P_{hi} = EA_h \times HH_{hi} / \sum_{i \in E_h} HH_{hi}$$

Design Weight for 1<sup>st</sup> stage enumeration areas:

$$DW_{1ea} = 1/P_{hi}$$

**Second stage: Selection of 20 households from each EA using random excel sheet template,**

let

$d_h$  = total number of households to be sampled from EA;

$D_h$  = total number of households in the EA;

The probability of selecting households in EA<sub>i</sub> is

$$P_{h2i} = d_h / D_h$$

Then, the overall probability of selecting household in EA *i* of city *h* is

$$P_{hi} = P_{hi} \times P_{h2i}$$

The design weight for each household in EA<sub>i</sub> of city *h* is the inverse of its overall selection probability:

$$W_{hi} = 1 / P_{hi}$$

**Adjustment for non-response and computation of final survey weights**

There was no non-response at the EA level, hence, only non-response rate at the household level was calculated to adjust for non-response and to compute the final survey weight. Therefore, the following steps explain how the final survey weight was calculated.

Let  $k_{hj}$  be the number of households allocated in EA<sub>j</sub> of city *h*; let  $d_{hj}$  be the number of households interviewed in the EA<sub>j</sub>, then the household response rate in city *h* is calculated by;

$$R_{HH} = d_{hj} / k_{hj}$$

The household final survey weight of EA<sub>j</sub> in city *h* is calculated by dividing the household design weight by EA response rate for each of the sampling EA:

$$W_{hjf} = W_{hi} / R_{HH}$$

**Normalization of final Survey weight**

The final survey weights were normalized in order to give a total number of weighted cases that equals the total number of unweighted cases. Normalization was done by dividing the survey weight by the mean of the survey weight for the household weight.

# 3

## Respondents background characteristics



### 3. Respondents background characteristics

This chapter presents information on the demographic characteristics of respondents. Factors which were analyzed include age, sex, marital status, educational level and economic status. For this survey, the respondent was any household member above 15 years. Information on the demographic and socioeconomic characteristics of the respondents provides a context to interpret the impacts of COVID-19. It provides an approximate indication of the representativeness of the survey and sheds light on the living conditions of the population.

#### 3.1 Demographic characteristics

Sex, age and marital status are the basic characteristics of any demographic group. They affect not only demographic events but also the social, economic and political structure, for they influence birth and death rate, internal and international migration, manpower, the gross national product, planning regarding educational and medical services and housing. They are also the determinants of the types of social amenities that population will be given by the government like schools, hospitals, care homes and maternity services.

It has been proved that COVID-19 causes severe health issues for adults over the age of 60 with particularly fatal complications for those 80 years and older. Conditions like diabetes, heart disease, and other chronic illnesses can lead to more intense symptoms and complications in the disease. The infections are higher among men compared to women.

Figure 3.1 shows the percentage distribution of respondents by gender. Majority of the survey respondents were women at 91 percent compared to male respondents at only 9 percent. There was a slight difference in prevalence on women and men respondents in cities. The city with the highest proportion of male respondents is Borama at 11 percent while Berbera has the lowest proportion at 7 percent. The proportions of male respondents in Burao and Hargeisa are 10 percent and 9 percent respectively.

**Figure 3.1** Percentage distribution of respondents by gender

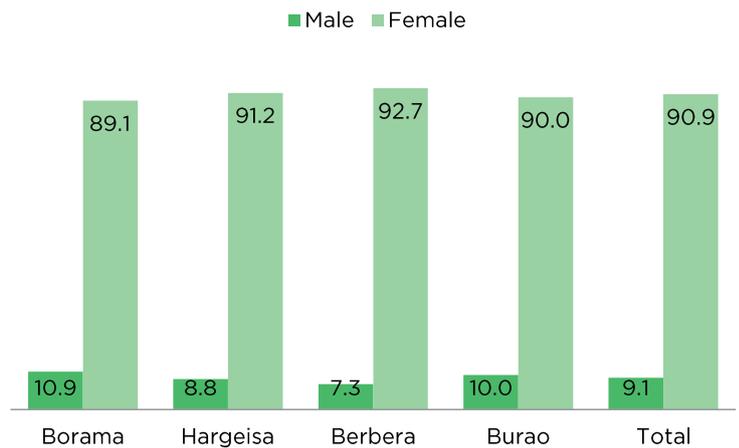


Figure 3.2 shows the percentage distribution of survey respondents categorized into ten-year age groups. Majority of respondents were aged between 20 and 49 years at 77 percent; those aged 20 to 29 years had the highest proportion at 27 percent. Five percent of respondents were aged 15 to 19 years, 11 percent were aged 50 to 59 while only 6 percent were 60 years and above.

**Figure 3.2** Percentage distribution of respondents by age

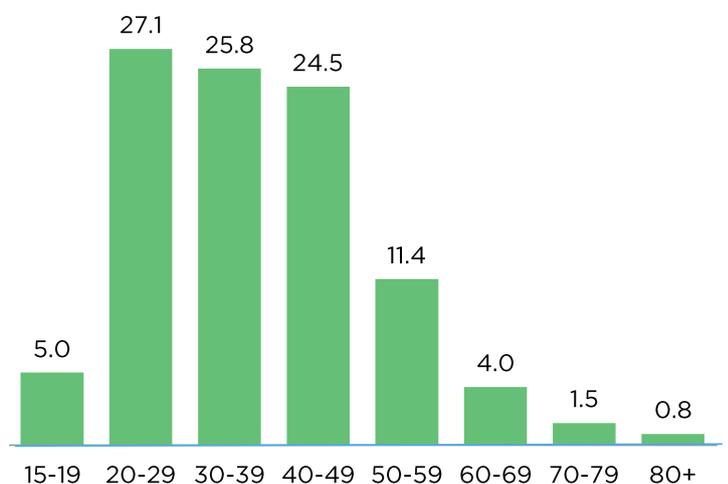


Figure 3.3 compares percentage age distribution of respondents by city. The proportions of respondents with different age categories varied between cities. Majority of respondents in Berbera and Borama were aged 30 to 39 years at 45 percent and 30 percent respectively. The highest proportions of

the respondents in Burao and Hargeisa were in the age category of 20 to 29 years at 34 percent and 28 percent respectively. Hargeisa has the highest proportion of respondents aged 15 to 19 years at 7 percent while Berbera has the highest proportion of respondents aged 60 years and above at 8 percent.

**Figure 3.3** Percentage distribution of respondents by age and town

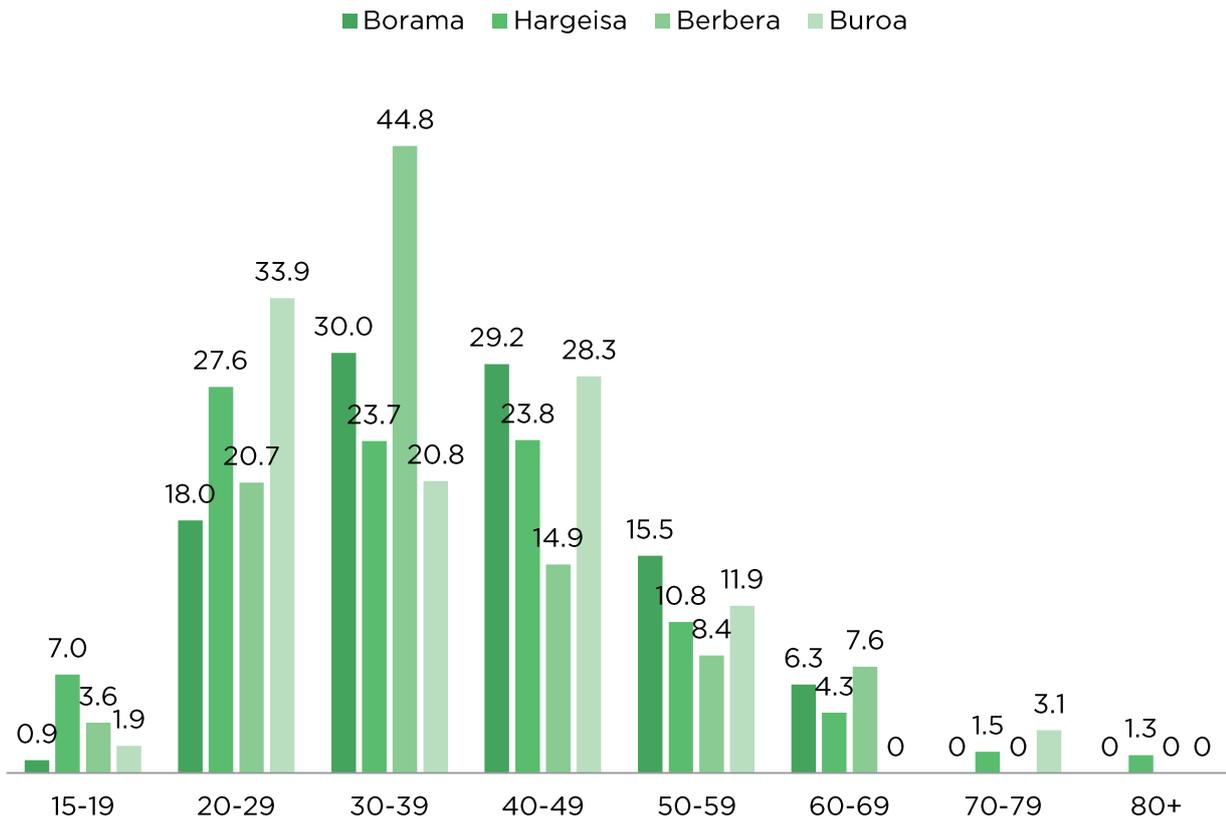
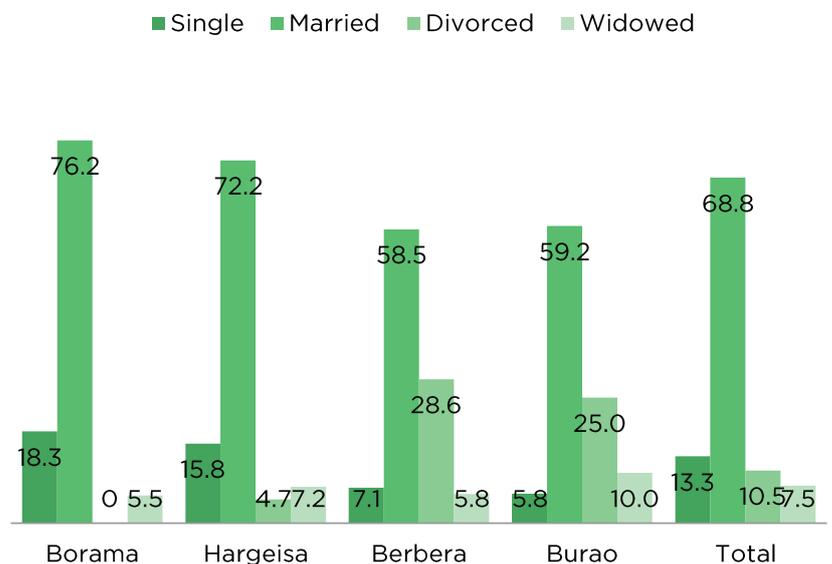


Figure 3.4 shows the percentage distribution of respondents by their marital status. Over half of the respondents were married at, 69 percent followed by unmarried or single respondents at 13 percent while divorced and widowed respondents constituted 11 percent and 8 percent respectively. There was not much variation in marital status between cities. Both proportions of married and single respondents were highest in Borama at 76 percent and 18 percent respectively followed by Hargeisa at 72 percent and 16 percent respectively. The proportion of divorced respondents is highest in Berbera at 29 percent followed by Burao at 25 percent while the proportion of widowed respondents are highest in Burao at 10 percent followed by Hargeisa at 7 percent.

**Figure 3.4** Percentage distribution of respondents by marital status



### 3.2 Education

Education is one of the most important aspects of social and economic development. Education improves capabilities and is strongly associated with various socioeconomic variables such as lifestyle, income, and fertility for both individuals and societies.

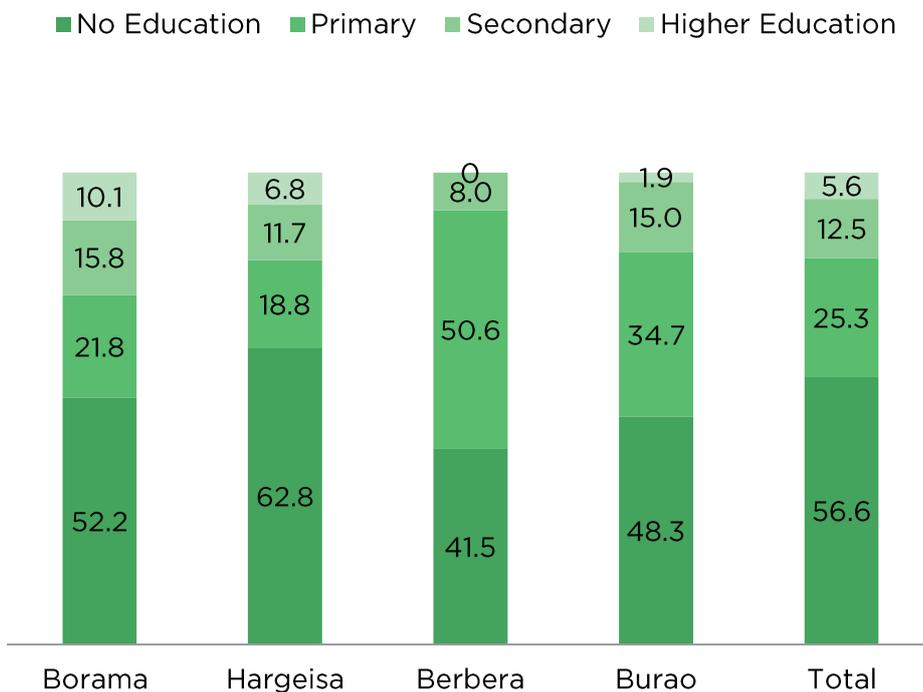
Level of education attained may influence social and health behavior, including uptake of health services such as choice of wearing a mask and preventive measures and hygiene promotion. It is one of the key national response tools to combat poverty and guarantee income generation and a determinant of success in life.

Information on the level of educational of the respondents according to their town of residence is presented in Figure 3.5. More than half; (57

percent) of the survey respondents did not attend any formal education, 25 percent have primary level of education, 13 percent completed secondary level of education while the remaining 6 percent have attained university level of education.

Comparing levels of formal education among different cities, the proportion of respondents with no education were highest in Hargeisa at 63 percent and lowest in Berbera at 42 percent. About half (51 percent) of respondents in Berbera attained primary level of education, however, no respondent in Berbera has attained university education. Respondents with higher education were highest in Borama at 10 percent, followed by Hargeisa at 7 percent.

**Figure 3.5** Percentage distribution of respondents by educational level



# 4 Economic Impact



## 4. Economic impact

### 4.1 Background of the economy

Somaliland has a GDP per capita of USD 566 in 2018, and a strong fiscal outlook with no outstanding debt. In the medium and the long term, Somaliland is in a relatively strong position to take advantage of its peace dividend and secure economic and human development. The economy is dominated by low-productivity sectors with livestock and retail trade making up over 50% of GDP. The livestock sector accounts for around 30% of GDP and most of its exports. The livestock sector is highly vulnerable for instance to drought and livestock bans which has led to macroeconomic volatility. The country requires critical reforms and investments to diversify its economy and reduce dependency on primary production. Other contributors to the GDP are wholesale and retail trade (21.9%), real estate activities (7.6%) and crops (7.0%). On the other hand, sectors that are key for economic growth such as energy (1.0%) and finance (0.3%) have meagre participation (Somaliland NDPII, 2017).

Although COVID-19 is a health problem it impacted other sectors including household income and food security. Measures put in place by the government to curb the spread of COVID-19 like imposition of movement restrictions, closure of schools and universities among others. These measures inevitably affected the economy, household income and employment.

The global economy was projected to contract sharply 5.2 % according to a UN report June 2020. The global economy is expected to lose nearly \$8.5 trillion in output over the next two years due to the COVID-19 pandemic. The pandemic is estimated to cause an estimated 34.3 million people to fall below the extreme poverty line in 2020, with 56% of this increase occurring in African countries. The world trade was forecasted to shrink by 15% in 2020 (Global economy prosperity, 2020). Somaliland being a part of the global economy is likely to suffer either the same or worse.

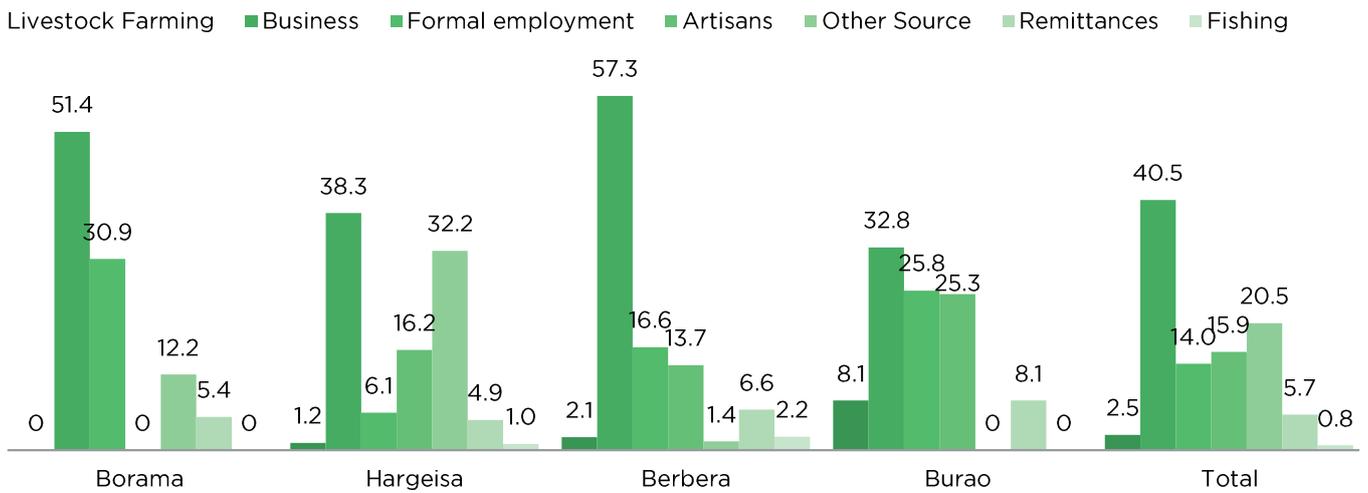
### 4.2 Household Economic Status

Information on economic status was collected from respondents aged 15 years and above from all the selected households by asking questions on the main source of households' income and whether households have secondary sources of income. The categories for sources of income included: business, paid jobs, artisans, remittances, livestock farming, fishing and other possible sources of income for households.

Figure 4.1 presents percentage distribution of respondents by primary source of household income. Vast majority of households obtain their primary source of income from business at 41 percent followed by other income sources not specified in the data collection tool at 21 percent, artisans at 16 percent and formal employment at 14 percent. The proportion of households with remittance as the main source of income constitutes 6 percent while respondents whose households receive their primary source of household income from livestock farming are the least proportion with only 3 percent.

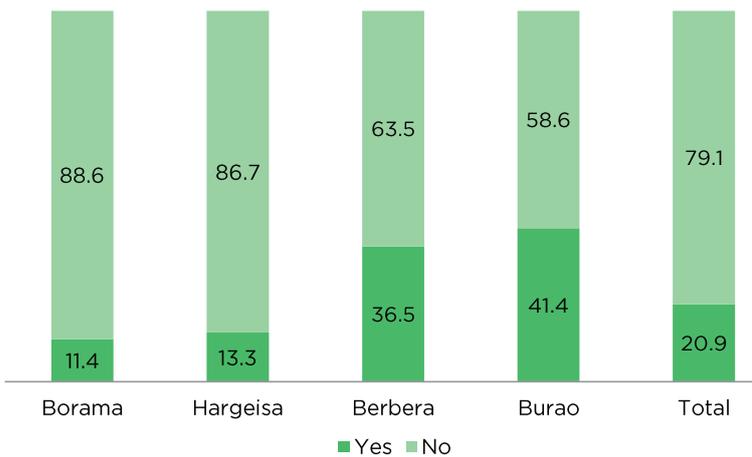
Fifty-seven percent of the households in Berbera obtain their main source of household income from business, while half of households (51 percent) in Borama receive their primary source of income from business. The percentage of households whose main source of income from formal employment is highest in Borama at 31 percent, followed by Burao at 25 percent while the least proportion is reported in Hargeisa at 6 percent only. Highest proportion of households that obtain their main income from artisans are in Burao at 25 percent. About 32 percent and 12 percent of households in Hargeisa and Borama respectively receive the main income from other sources. There is no much disparity of the proportion of households whose main income is from remittance across the selected cities as it varies between 8 percent in Burao, 7 percent in Berbera and 5 percent in both Borama and Hargeisa.

**Figure 4.1** Percentage distribution of households by primary source of income.



On the other hand, the survey sought to determine whether households receive secondary income and the results are presented in Figure 4.2. About 21 percent of households who participated in the survey have a secondary source of income. The proportion of households with a secondary source of income is highest in Burao at 41 percent, followed by Berbera at 37 percent and lowest in Borama at 11 percent. About 13 percent of interviewed households in Hargeisa receive secondary income.

**Figure 4.2** Percentage distribution of respondents by household's secondary source of income



Remittances from the diaspora contribute significantly to household income. Remittances provide sustenance including purchase of basic goods such as food, rent, education, and health services. The exact

volume of remittances entering Somaliland is hard to determine due to the absence of official data and statistics (Somaliland NDPII, 2017). According to World Bank (2016), it is estimated that between USD 500-900 million in remittances per year are received in the country, which is equivalent to 35-70% of Somaliland's 2012 GDP estimate. Due to the global nature of the pandemic, remittances to Somaliland are negatively affected. The decline in remittances places immediate pressure on household income and poses a challenge on the household livelihood.

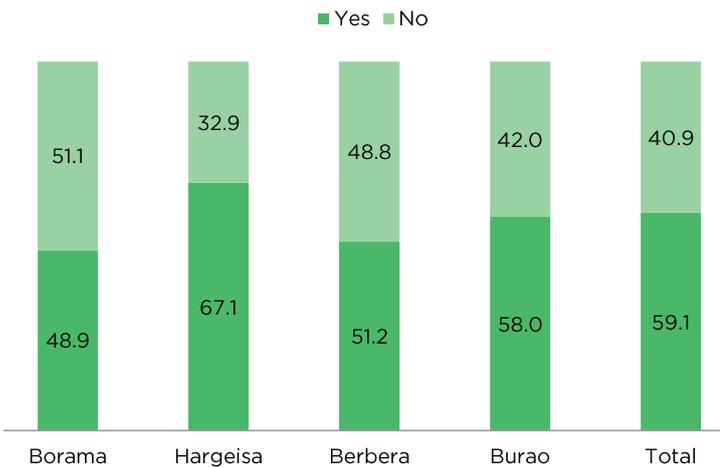
As the COVID-19 pandemic continues to spread, the amount of remittance that migrant workers send home was projected to decline by 14 percent by 2021 compared to the pre-COVID-19 levels in 2019 (World Bank 2020). Remittance which is a transfer of money, often by Somaliland diaspora to relatives, individuals or households in the country, was specifically considered by survey due to the possible impact of COVID-19 on the global economy. Remittances from the diaspora contribute significantly to household income.

If the primary or secondary source of income of households was remittance, the survey asked follow-up questions on whether households are still receiving remittance or whether it has ceased following the COVID-19 crisis. Among the interviewed households, only 9 percent indicated they receive remittances from the diaspora. The percentage distribution of households by whether they are still receiving remittance is presented in Figure 4.3. Among households that receive remittances from

the diaspora, 59 percent continue to receive while 41 percent no longer receive remittance after the COVID-19 outbreak. This shows that COVID-19 has a serious impact on households when remittance is the primary or secondary source of income.

The difference between households with remittance and those affected by COVID-19 on their remittance is not wide across the selected cities. COVID-19 impact on households with remittance is the highest in Borama as 51 percent of households don't receive remittance at the moment. About 49 percent of the households in Berbera and 42 percent of households in Burao are no longer receiving remittance after emergence of COVID-19 pandemic diseases, while least proportion was reported in Hargeisa at 32 percent are not still receiving any more.

**Figure 4.3** Percentage distribution of respondents by whether household still receiving remittance

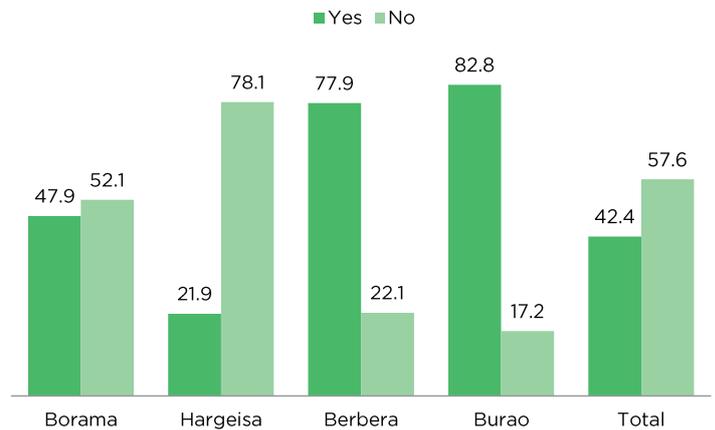


### 4.3 Impact of COVID-19 on household income

Urban households rely mainly on business and employment for income. In Somaliland, the government remains the major single employer with about 65,000 employees. Understanding the effect of the pandemic on household income is critical as household income is a critical indicator of household vulnerability. Loss of household income, partially or wholly has a great impact on the welfare of household members including health, nutrition, education of children, and the relationships in the households, among others. Figure 4.4 shows how household income was affected by the pandemic. Among urban households in Somaliland, 42 percent lost their income due to COVID-19. Burao has the

highest proportion of households that reported at least one of its members lost their income during the pandemic period at 83 percent. Hargeisa reported the least proportion of households which had their income affected by the pandemic at 22 percent.

**Figure 4.4** Percentage of household heads who lost income due to COVID-19



The ILO was quick to recognize that the COVID-19 pandemic is not just a health crisis, but equally an economic and labour market crisis. The lockdown measures adopted in most countries to prevent the spread of the pandemic restricted economic activities. Evidently, developing countries have faced disruptions in trade and supply chains, triggering negative growth. Somaliland NDPII acknowledges that the country faces key challenges to improve its employment and labor markets. Amongst these were lack of technical and managerial capacity; limited financial and physical resources; lack of labor market information; ineffective labor market; unskilled or poorly trained workforce; limited employment opportunities; and an informal economy that is hard to regulate.

Understanding the vulnerability of different sources of income is key in terms of future planning for the economy and the labour market. In the urban areas, business is the major source of income followed by formal employment and casual jobs (artisans). Figure 4.5 presents the distribution of households that reported loss of income by their main sources of income. In the urban, formal employment forms the most vulnerable source of income followed by business and remittances. Fifty nine percent of respondents reported loss of job due to COVID-19, 35 percent reported loss of business while 13 percent reported loss of income from remittance.

**Figure 4.5** Percentage of households who lost their source of income due to COVID-19 by source of income.

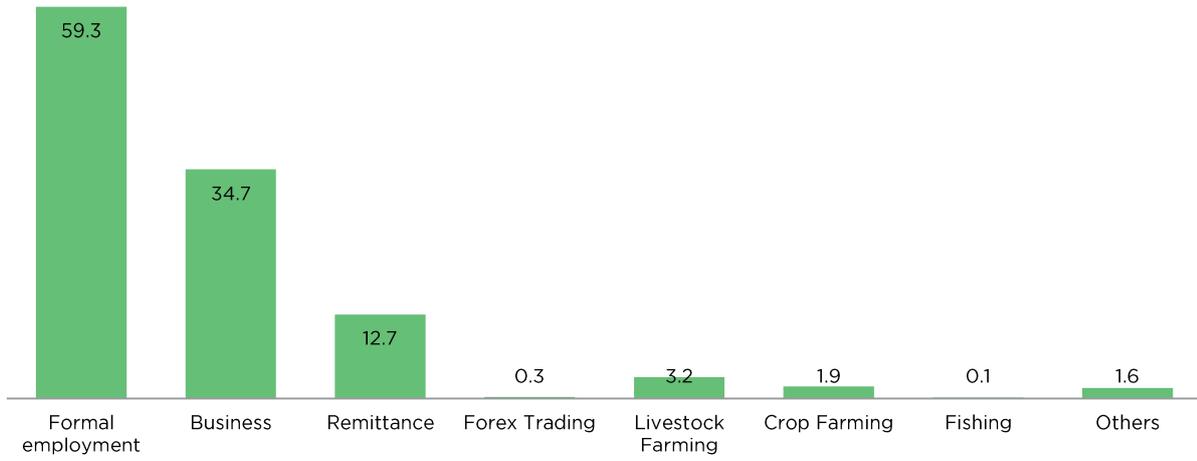


Figure 4.6 below summarizes the impact of COVID-19 on the household heads who lost their primary source of income by region. Most of the household heads who lost their primary source of income due to COVID-19 were from Berbera at 84 percent followed by Burao at 59 percent. While only 19 percent of Borama household heads reported they lost their primary source of income due to COVID-19.

**Figure 4.6** Percentage of household heads who lost their primary source of income due to COVID-19.

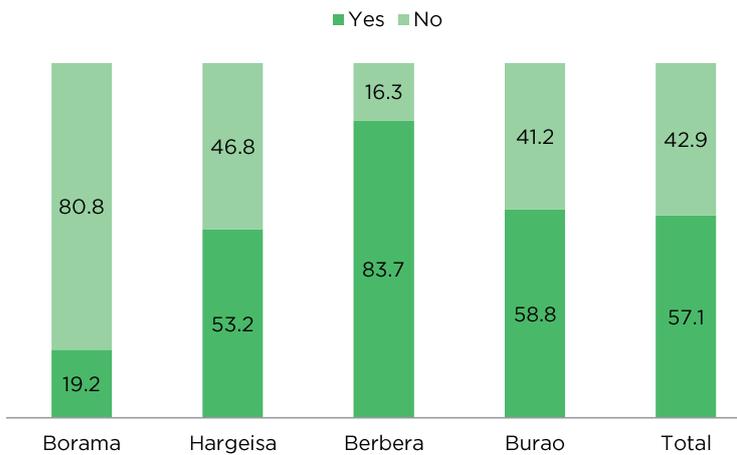
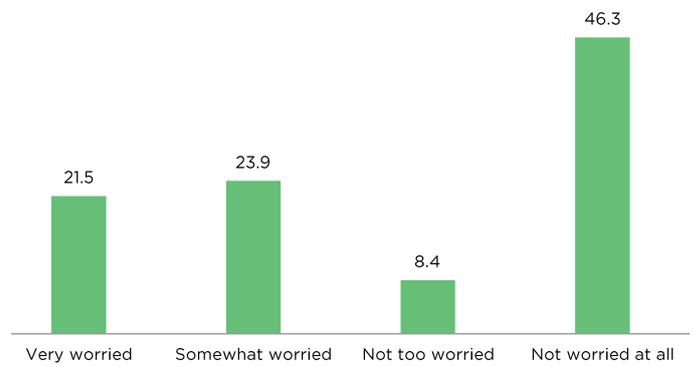


Figure 4.7 shows respondents who expressed worry about their income due to COVID-19. Forty-six percent of households are not worried at all about their income during this pandemic period, 24 percent are somewhat worried while 22 percent expressed that they are very worried about their income due to COVID-19.

**Figure 4.7** Percentage distribution of respondents expressing worry about household income due to COVID-19 crisis



# 5

## Social Impact



## 5. Social Impact

### 5.1 Introduction

The government started a nation-wide lockdown on 18th March, forcing closure of all learning institutions across the country, as part of restrictions to control the COVID-19 spread. Like other parts of the world, COVID-19 negatively impacted on education in Somaliland. The government used the national TV and radio to broadcast lessons to the students, while some of the private schools opted to deliver learning via internet platforms such as google. Many students from poor urban and rural households were unable to access virtual learning. On 24th June, 2020 the government officially lifted all COVID-19 restrictions-- physical learning resumed but with strict adherence to COVID-19 protocols.

“On April 5th, 2020, United Nations Secretary-General Antonio Guterres called attention to what he described as a “horrible surge in domestic violence” since the start of COVID-19, and advocated for all governments to “put women’s safety first as they respond to the pandemic.” Gender-based violence (GBV) has been associated with a host of negative health, psychosocial, and developmental outcomes in the lives of survivors—both in the short-term as well as the long-term. In light of these issues, GBV prevention, response, and risk mitigation represent essential and life-saving components of proposed interventions. Pre-existing toxic social norms and gender inequalities, economic and social stress caused by the pandemic, coupled with restricted movement and social isolation measures, have led to an increase in GBV globally and Somaliland is not exceptional. Many women are in lockdown at home with their abusers while being cut off from normal support services. On one hand, quarantine is necessary to reduce the community spread of the Coronavirus, but on the other hand, it has serious psychological and socially disruptive consequences.

Early marriage forces girls into adulthood before they are emotionally and physically matured, and it has harmful effects on their health, educational, economic

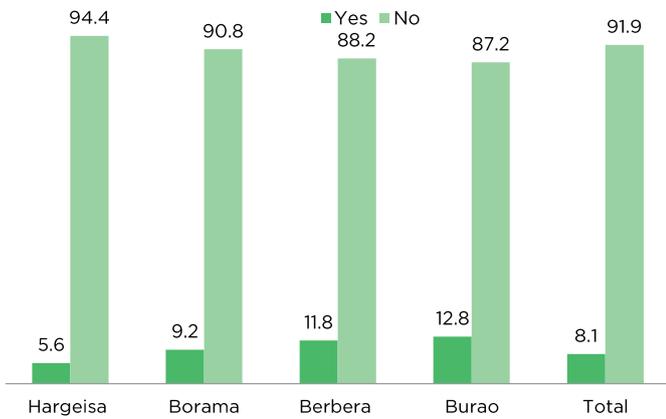
and social development. The consequence of early marriage is that they drop out of school. This means girls lose the opportunity to acquire knowledge and skills. Another is the loss of adolescence since most married individuals immediately take on adult roles and responsibilities which is stressful to young girls. Furthermore, there are severe reproductive and health risks, abuse of victims’ human rights and a high risk of contracting sexually transmitted diseases. Early marriage age is different from country to country but in this survey, we focused on girls less than 14 years old who have been married off during the COVID-19 crisis period. In addition, the research deeply investigates whether the early marriage increased, remained the same or reduced during the COVID-19 crisis period.

According to the SLHDS 2020 findings, 7 percent of women aged 15-19 have already had a live birth and 1 percent of them are pregnant with their first child while 9 percent have begun childbearing. Teenagers with no education tend to start childbearing earlier than their better educated peers. The level of teenage fertility is strongly associated with education. Twelve percent of teenagers who have never been to school have begun childbearing as compared with 2 percent who have a secondary school education and 3 percent who have higher education. Long periods of school closure and economic uncertainties during the COVID-19 pandemic period are likely to push families to marry off their under-age daughters.

### 5.2 Impact on education

The findings from the study show that by November, 8 percent of children in the four cities had not resumed learning following the re-opening of schools in June. Comparing the four cities, Burao and Berbera had the highest proportion of households with children who had not resumed school, at 13 and 12 percent respectively. As presented in Figure 5.1, Borama also indicated a high number of dropouts at 9 percent and Hargeisa had the least proportion at 6 percent.

**Figure 5.1** Percentage distribution of households with children who had not resumed school

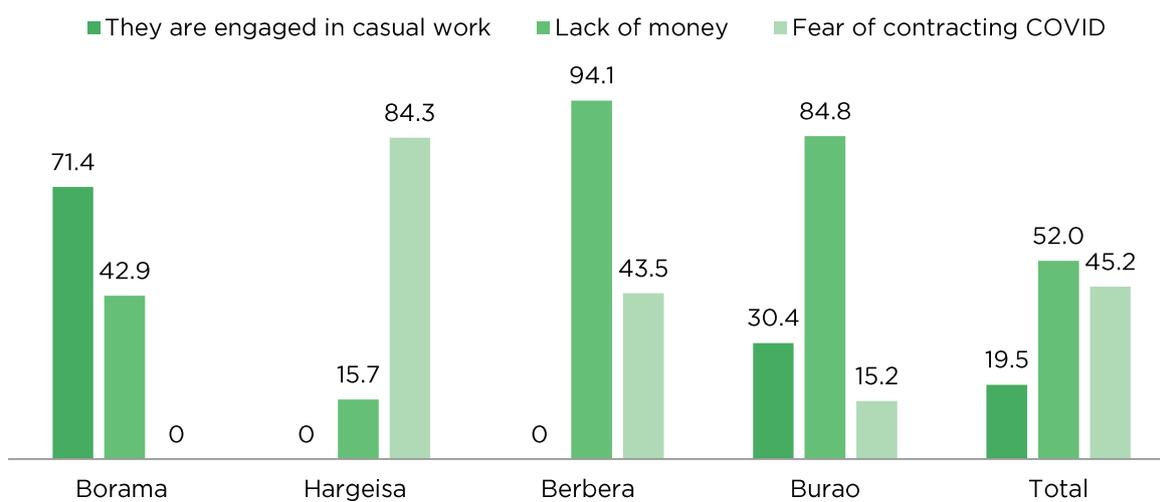


Further, for those who had not resumed school, the study investigated the reasons for not resuming.

Majority of households, 52 percent indicated lack of school fees as the reason for non-resumption. Twenty percent of households indicated that children had not resumed as they were engaged in casual work.

Forty five percent of households indicated that children had not resumed school due to fear of contracting COVID-19. Households in Hargeisa reported the highest proportion of children who had not resumed learning for fear of contracting the corona virus at 84 percent compared to 15 percent among households in Burao. Berbera and Burao had the highest proportion of households reporting students who had not resumed school due to financial reasons at 94 and 85 percent respectively (Figure 5.2).

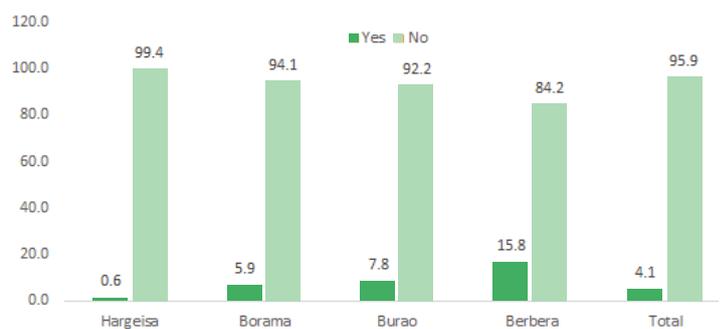
**Figure 5.2** Percentage distribution of respondents by reason for non-resumption of school since lifting of COVID-19 restrictions



### 5.3 Impact on GBV

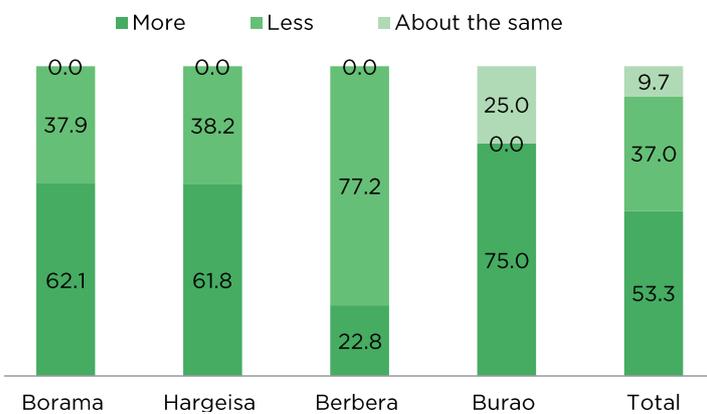
Figure 5.3 shows the percentage distribution of households by occurrence of violence to any household member during the COVID-19 pandemic period by city. The survey findings show that more than 4 percent of households reported that a member was either humiliated, insulted or threatened. Berbera has the highest proportion of households that reported violence of a member at 16 percent. Hargeisa which is the most populated city in Somaliland reported least violence at less than 1 percent. Around 8 percent of households in Burao reported violence which is half that reported by Berbera.

**Figure 5.3** Percentage distribution of households reporting violence of a household member



The household respondents were asked from their experience if cases of GBV increased, remained the same or reduced. Generally, 53 percent reported more GBV cases occurring during COVID-19 crisis. Thirty-seven percent of household respondents said GBV had reduced while 10 percent of respondents said the GBV cases are about the same as before COVID-19. Burao had the highest proportion of respondents who indicated the cases had increased while Berbera had the least (Figure 5.4).

**Figure 5.4** The percentage distribution of respondents by their perception of GBV cases



The survey asked respondents if they had been hit, slapped, kicked or beaten during the COVID-19 crisis. According to the survey 50 percent of respondents interviewed in Burao and 33 percent in Hargeisa indicated some physical violence which involved hitting, slapping, kicking or beating. No physical violence was reported from Borama and Berbera during COVID-19 crisis period. Further investigated is recommended for these two cities to identify this unique finding.

The households were also asked who were the perpetrators of GBV. In Hargeisa, GBV cases were committed by a partner/spouse, while in Burao the perpetrators of violence were mostly family members such as brothers and sisters at 86 percent.

### 5.4 Impact on FGM/C

The long period over which schools were closed presented an opportunity for FM/C which is usually practised during school holidays. In addition, with all focus shifted to COVID-19, there is likely to be a lapse in surveillance of FGM/C. Overall, 3 percent of respondents indicated they know a school age girl who had undergone FGM/C since the start of COVID-19. The results also indicate that Burao had the highest proportion of respondents who knew of a school aged girl that underwent FGM/C, at 11 percent, while Borama recorded 6 percent. In Berbera no respondent was aware of a girl who underwent FGM/C (Figure 5.5).

**Figure 5.5** Percentage distribution of respondents who reported knowledge of a school aged girl that underwent FGM/C since the start of the pandemic.

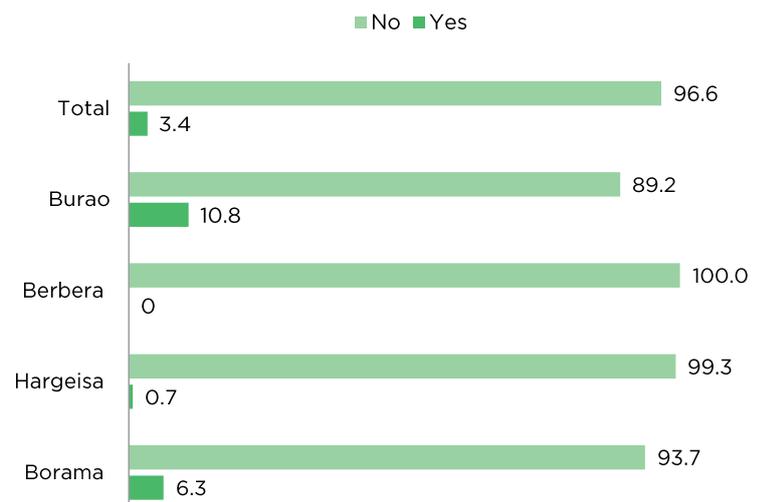
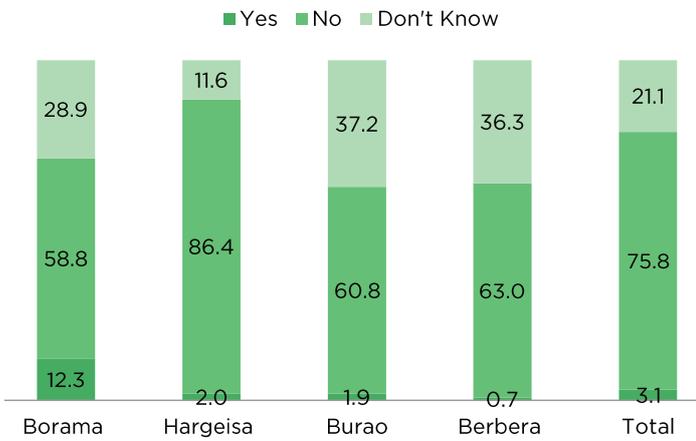


Figure 5.6 illustrates percentage distribution of households reporting girls under 14 years who had undergone FGM/C during the COVID-19 pandemic period. Overall, 3 percent of households reported they had a girl/s below age 14 who underwent FGM/C during COVID-19 crisis period. The proportion of households reporting a case of FGM/C during the pandemic was highest in Burao at 12 percent followed by Borama and Hargeisa at 2 percent each.

**Figure 5.6** Households reporting new cases of FGM/C among girls under 14 years since the onset of COVID-19 pandemic



**Figure 5.7** Percentage distribution of the respondents based on their opinion on cases of FGM among girls <14 since the onset of COVID-19 pandemic

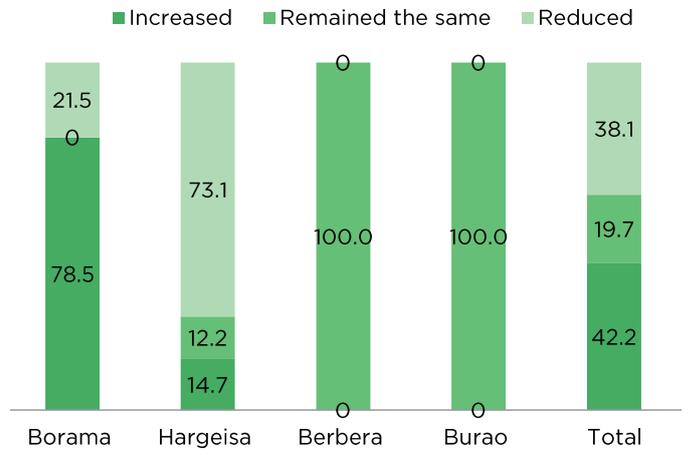


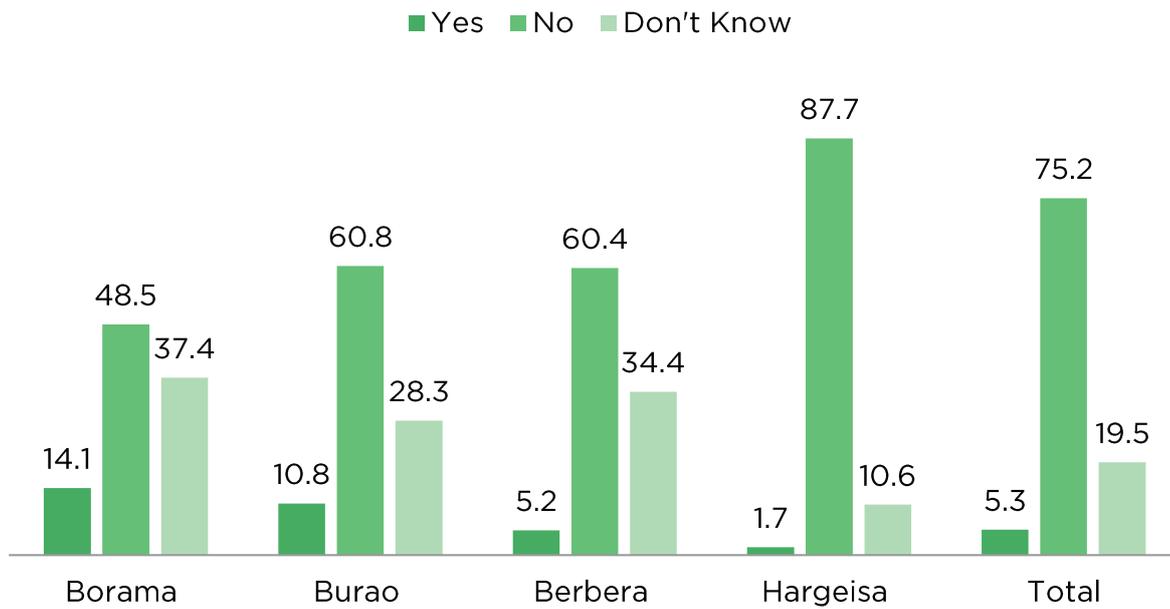
Figure 5.7 illustrate the respondents opinion on cases of FGM/C among girls under 14 years during the COVID-19 pandemic. The results indicate that respondents in Borama and Hargeisa reported an increase in FGM/C cases among girls of less than 14 years old at 79 percent and 15 percent respectively, while those in Berbera and Burao indicated there has not been any change in the cases of FGM/C. Furthermore, 73 percent of respondents in Hargeisa reported a decrease in FGM/C cases during the COVID-19 pandemic.

### 5.5 Impact on early marriages

The tough economic situation and uncertainty over schools resumption are factors likely to have led parents/guardians to marry off their under age girls. Overall, 5 percent of respondents indicated they know of girls under 14 years of age who got married since the onset of COVID-19. Fourteen percent of the respondents who indicated that they know of a girl below 14 years that had been married during this period were in Borama, while Burao had the second highest proportion at 11 percent, and Hargeisa had the least reported at 2 percent.



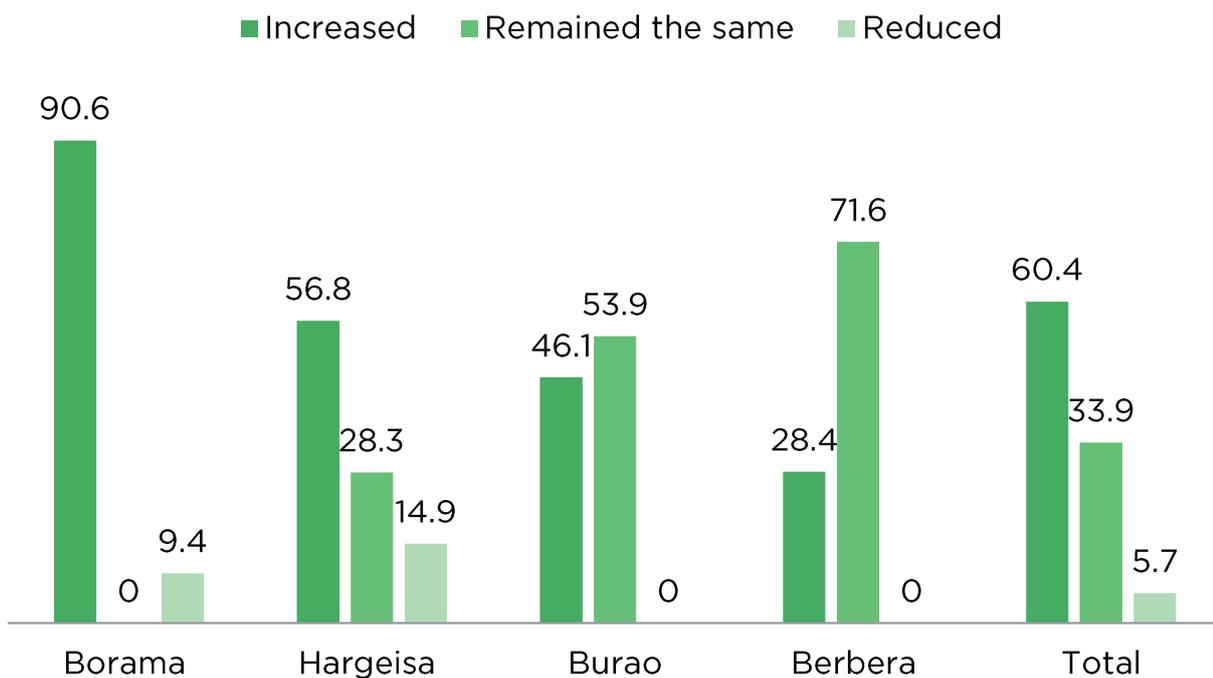
**Figure 5.8** Percentage distribution of respondents by their knowledge of early marriage cases during COVID-19 crisis.



The findings of the survey indicate that 60 percent of respondents indicated there has been an increase in cases of early marriage during the COVID-19 crisis period while 34 percent indicated there has been no change.

Borama has the highest proportion of respondents reporting an increase of new cases of marriage among girls <14 at 91 percent compared to Hargeisa and Burao at 57 percent and 46 percent respectively and Berbera the least at 28 percent.

**Figure 5.9** Percentage distribution of respondents by their opinion of early marriage cases during COVID-19 crisis



# 6

## Health Impact



## 6. Health impact

### 6.1 Introduction

Globally, COVID-19 has presented a serious threat, overwhelmed the health infrastructure and put poor countries like Somaliland in a difficult situation to balance between the need to respond to COVID-19 and to maintain the provision of other life-saving health services. Worldwide, during the pandemic, drop-in prenatal care visits, an increase in severe maternal and mental health issues and spike GBV cases were reported (Kotlar, et al., 2021). On the other hand, the situation was complicated by the lack of adequate training on COVID-19 and the limited availability of updated guidelines on service provision during the pandemic (Semaan et al., 2020).

So far, Somaliland has reported 3,320 confirmed cases of COVID-19 and 184 deaths as at 31st March, 2021. It is noteworthy, the vast majority of the people who are tested for COVID-19 are those that seek to travel outside the country thus it is possible that there is huge underreporting of cases and deaths due to lack of testing. Despite the difficulties in ascertaining the true prevalence of COVID-19 across Somaliland, Somaliland reported an increase in cases over the months of January and February. Figure 6.1 below shows, February had continuously higher COVID-19 positive cases as compared to the previous months.

**Figure 6.1** COVID-19 positive cases between October 2020 and February 2021

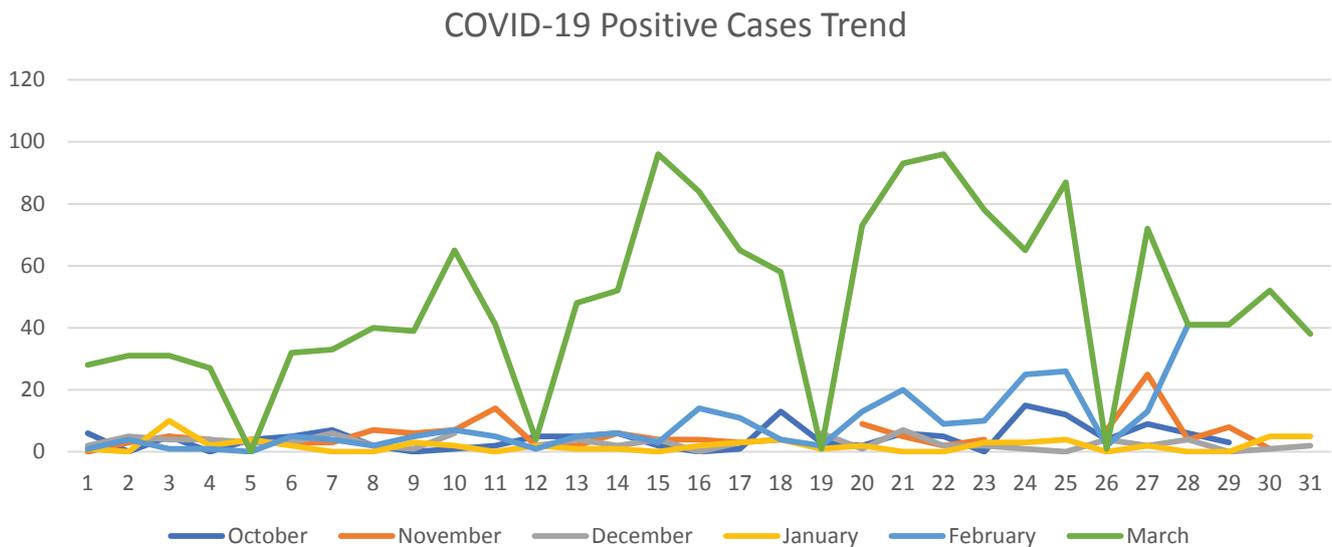
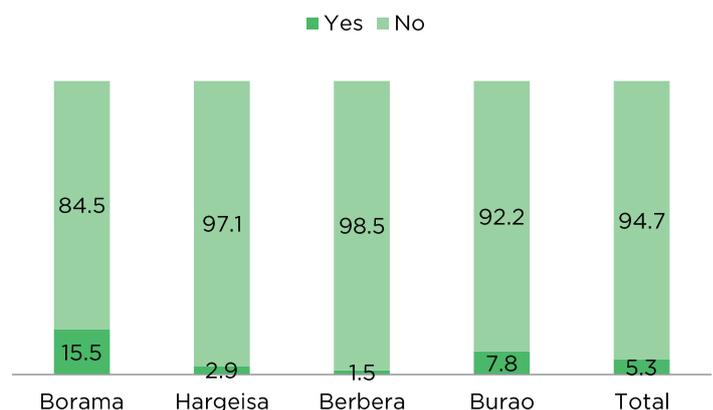


Figure 6.2 illustrates the percentage distribution of households by the test status for COVID-19 of their members. Only 5 percent of the households that participated in the study reported having a household member who tested for COVID-19.

Borama had the highest proportion of households reporting a member who took the COVID-19 test at 16 percent, Berbera had the least at 2 percent followed by Hargeisa at 3 percent.

**Figure 6.2** Percentage distribution of households who had a member that had taken the COVID-19



## 6.2 COVID-19 hospitalization rates

To estimate a population-based rate of laboratory-confirmed COVID-19-associated hospitalizations, respondents were asked if they have any household member hospitalized due to COVID-19.

The hospitalization rate is calculated as the number of residents of a defined area who are hospitalized with a positive COVID-19 laboratory test divided by the total sample covered. However, the study did not specify the number of household members who were hospitalized for the disease. Therefore, it is assumed that from households with confirmed cases, only one member was hospitalized.

Figure 6.3 shows the percentage distribution of respondents by household members tested positive for COVID-19 who are hospitalized. More than half (53 percent) of positively tested household members were hospitalized. All the household members tested positive for COVID-19 in Berbera were hospitalized. Least proportion of hospitalized household members due to COVID-19 were in Borama at 14 percent.

**Figure 6.3** Percentage distribution of households with a hospitalized member that tested positive for COVID-19

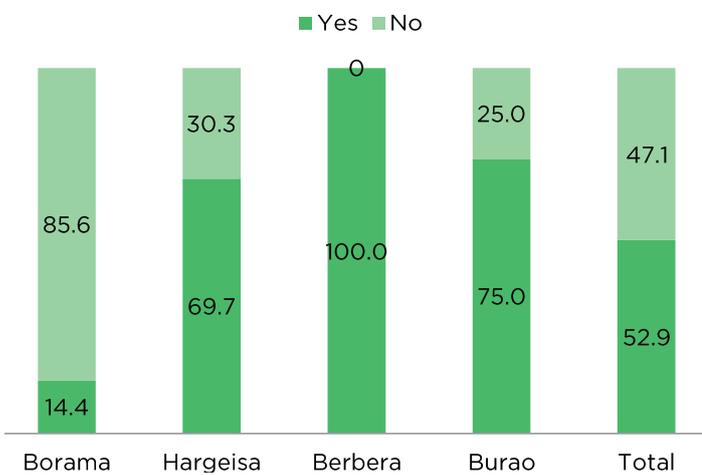
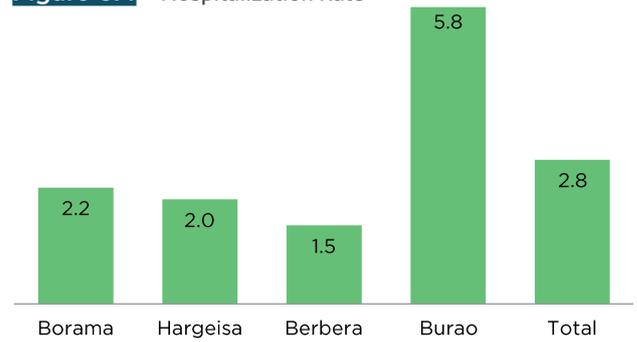


Figure 6.4 presents the hospitalization rate due to COVID-19. Overall hospitalized rate is around three percent. Hospitalization rate was highest in Burao at 6 percent while other three cities displayed the same hospitalization rate at two percent each.

**Figure 6.4** Hospitalization Rate



## 6.3 COVID-19 vulnerability for Mortality

Although, people of all ages can be infected by the COVID-19, there are at risk groups who are more vulnerable to die or to serious complications from the disease. It has been proved that COVID-19 causes severe health issues for adults over the age of 60 with more fatal complications for those 80 years and above. People with pre-existing medical conditions such as obesity, asthma, diabetes, heart disease, and other chronic illnesses are more likely to suffer more intense symptoms and complications from the disease, WHO (2020).

Information on COVID-19 vulnerability to mortality was collected from all the selected households by asking questions related to the presence of household members with chronic diseases, living with disability and elderly people of 60 years and above.

Figure 6.5 indicates the percentage distribution of households with chronically ill members. About 10 percent of households reported to have a member with a chronic disease. The proportion of households with chronically ill members are highest in Burao at 18 percent followed by Borama at 9 percent while least proportions are reported in Berbera and Hargeisa at 8 percent each.

**Figure 6.5** Percentage of households with a chronically ill member

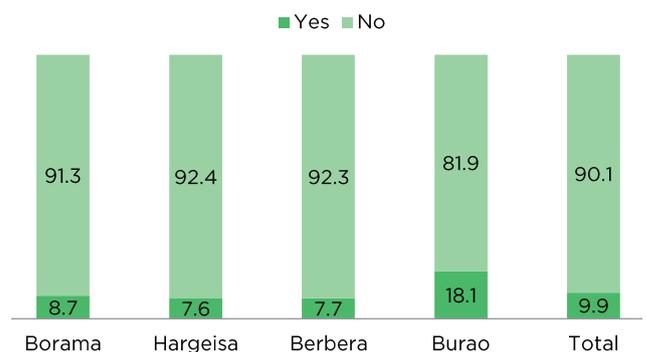
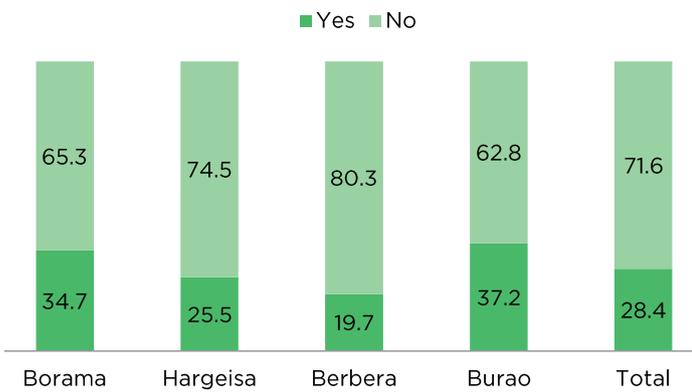


Figure 6.6 presents the percentage distribution of households with members above 60 years old. About 28 percent of interviewed households had a member aged 60 years and above. The proportion of the elderly population of 60 years above is highest in Burao at 37 percent followed by Borama and Hargeisa at 35 percent and 26 percent respectively. The least proportion of households with elderly population is reported in Berbera at 20 percent.

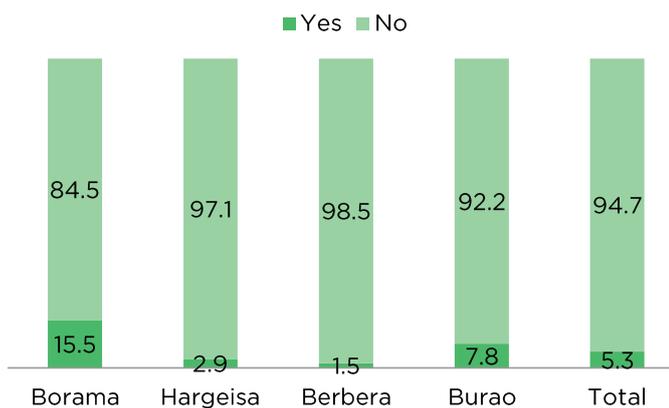
**Figure 6.6** Percentage of households with members above 60 years



### 6.4 COVID-19 Mortality rate

The survey sought to determine the level of mortality due to COVID-19 related complications. All the interviewed households were asked whether any household member died due to COVID-19 and the result is presented in Figure 6.7. About one percent of all interviewed households reported death of a household member due to COVID-19 related complications. which is almost similar to deaths reported in Hargeisa and Berbera.

**Figure 6.7** Percentage of households with a member who died of COVID-19 related complications



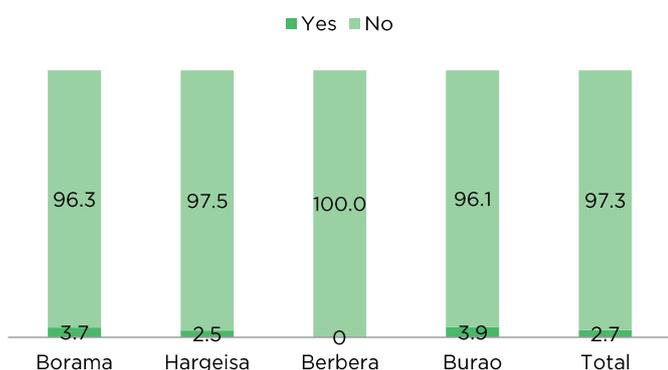
### 6.5 Disability vulnerability for COVID-19

It is important to note that there are certainly very legitimate COVID-related health concerns specific to persons with disabilities. People with disability may be at greater risk of contracting COVID-19 because of, barriers to implementing basic hygiene measures, such as handwashing (e.g., hand basins, sinks or water pumps may be physically inaccessible, or a person may have physical difficulty rubbing their hands together thoroughly). They may also encounter difficulty in practicing social distancing because of additional support needed or because they are institutionalized. In addition, they have barriers to accessing public health information (WHO, 2020).

Percentage distribution of households by whether a member living with disability is presented in Figure 6.8. Overall, 3 percent of interviewed households reported to have disabled members. The highest proportion of people living with disability were in Burao and Borama at 4 percent in each city while no disabled members were reported from Berbera. Around 3 percent of Hargeisa households reported to have members with disabilities.



**Figure 6.8** Percentage of households with a member living with disability

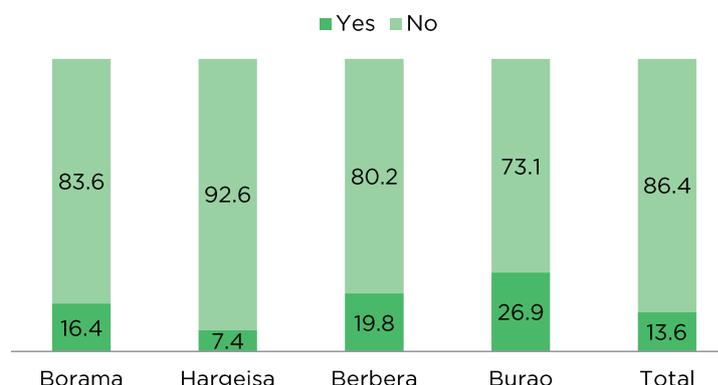


### 6.6 Impact on health service delivery during COVID-19 crisis

In Somaliland, people seek treatment from both public and private facilities. Across Somaliland, more than 250 public facilities deliver maternal and child health services. Some reports indicate at least 60 percent of the community seek their healthcare services from private health facilities. Somaliland is among the countries with high maternal and child mortality, low coverage of skilled birth attendance and antenatal care and childhood immunization services. Only 13 percent of the children between 12-23 months received all of the recommended vaccinations. Despite the global target of more than 90 percent skilled birth attendance coverage, only 40 percent of mothers delivered with the assistance of a skilled professional (SLHDS, 2020). Low rates of health seeking behavior for maternal and child health is due to lack of high-quality and timely maternal and child healthcare services are either unavailable, inaccessible, or unaffordable for a vast majority of women and children even before the pandemic.

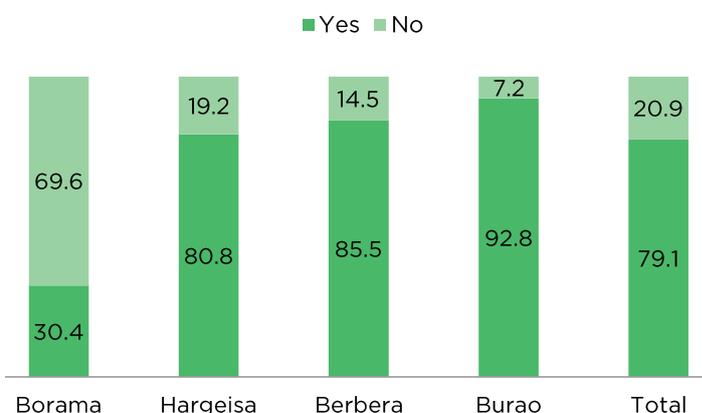
This study assessed the impact of COVID-19 on community health seeking behavior by asking whether any of the household members had become sick during the pandemic and whether they sought treatment for the illness. Fourteen percent of the total households across the surveyed cities and almost a third of the households in Burao had at least one member of their household, who had become sick during the pandemic period. The data indicates that Hargeisa had the lowest proportion of households at 7 percent that reported a sick household member during the pandemic period. On average 14 percent of the household reported a sick member (Figure 6.9).

**Figure 6.9** Percentage of households with a member who became sick during COVID-19 crisis



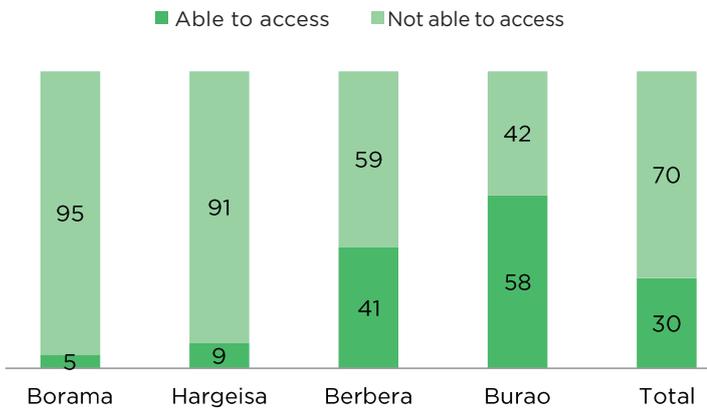
Among the households that reported a sick member, 79 percent indicated that the members sought treatment. Burao had the highest proportion of household members that sought treatment at 93 percent while Borama had the least at 30 percent (Figure 6.10).

**Figure 6.10** Percentage of households who sought treatment/advice for a sick member during COVID-19 crisis

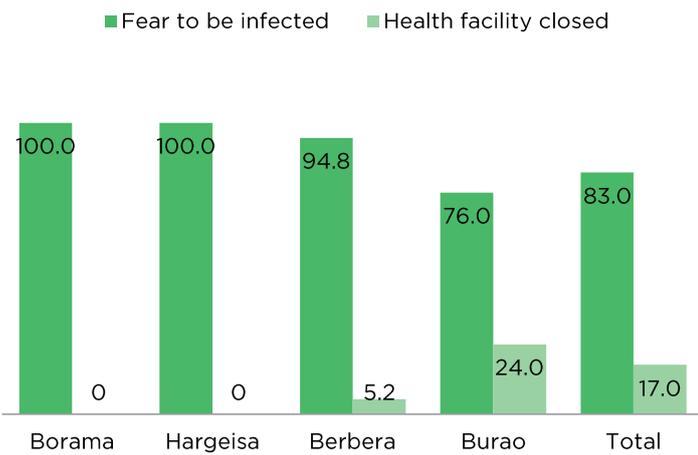


The study assessed the effect of COVID-19 on health seeking behavior of children and mothers by asking whether access to child health, antenatal care visits and health facility delivery services were interrupted. Around 21 percent of the surveyed households had at least one child under-five years of age. As presented in Figure 6.11, 30 percent of households reported that health services for their children below five years were interrupted. The effect on access to health care by under-five children was highest in Burao (58 percent) and lowest in Borama (5 percent). Fear of getting infected was the most quoted reason hampering children’s access to healthcare at 83 percent (Figure 6.12).

**Figure 6.11** Percentage of households with children under 5 years who were not able to access health services during COVID-19 crisis

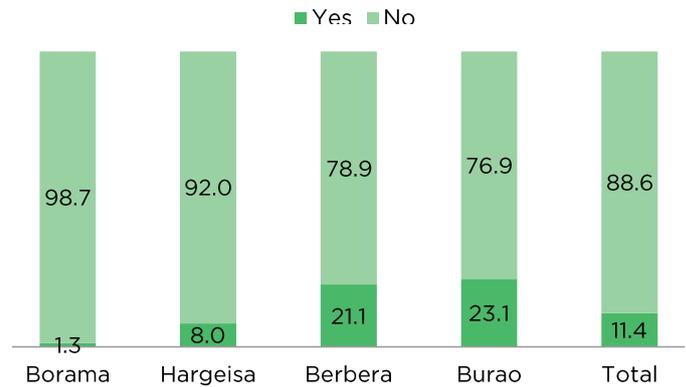


**Figure 6.12** Percentage of households with children under 5 by reasons for hampered access to health services during COVID-19 pandemic.



Across the surveyed households, we found out that 11 percent had at least one pregnant woman (Figure 6.13). As shown in Figure 6.14, slightly more than half (52 percent) of the households with a pregnant mother reported that their access to ANC services was disrupted. The ANC disruption was highest in Hargeisa (63 percent), while services were not disrupted in Borama. Likewise, 50 percent of the same households reported that access to delivery services was disrupted by COVID-19 crisis (Figure 6.15).

**Figure 6.13** Percentage of households reporting a pregnant mother during COVID-19 crisis.

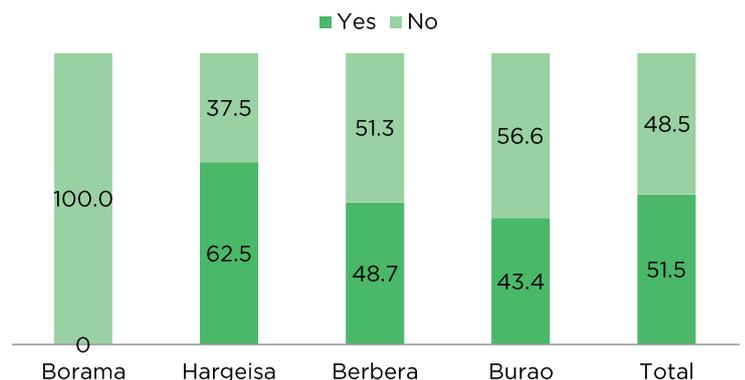


As shown in Figure 6.14, access to delivery services was interrupted for one in every two women. Women in Hargeisa suffered the most interruption with 63 percent reporting no access while 43 percent of women in Borama had access to delivery services interrupted. The obstacles to access of ANC services were fear of infection (67 percent) or the perception that the facility was closed (23 percent) as shown in Figure 6.16.

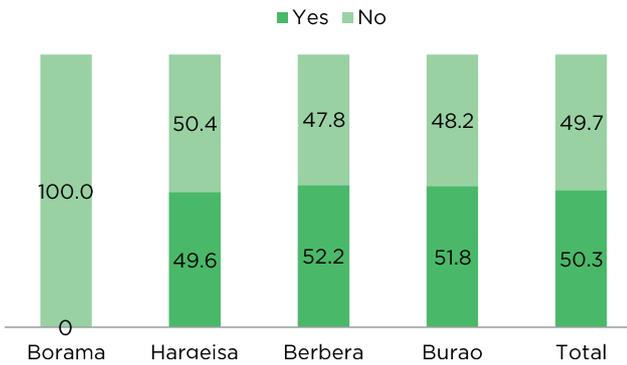
As presented in Figure 6.17, pregnant mothers were not able to access delivery services mainly because of the fear to be infected at 51 percent and closure of the facility at 22 percent. Fear of COVID-19 infection is the main reason why access to delivery services was affected in Berbera at 92 percent and Burao at 81 percent. However, access to delivery services was affected in Hargeisa mainly due to closure of health facilities during COVID-19 at 31 percent.

The disruption of access to maternal and child health care due to COVID-19 pandemic is likely to have detrimental effects on the health of mothers and children and may increase morbidity and mortality.

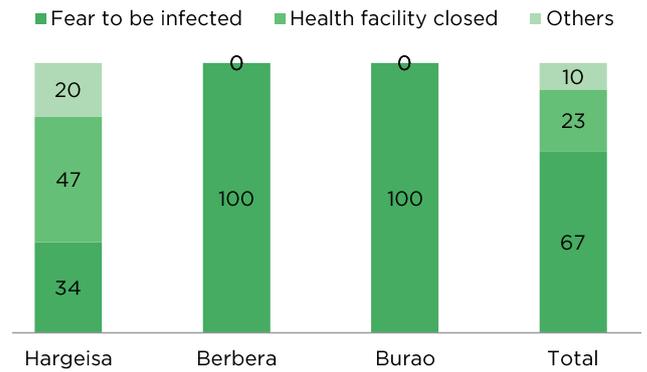
**Figure 6.14** Percentage distribution of women whose access to ANC services was affected by COVID-19 crisis



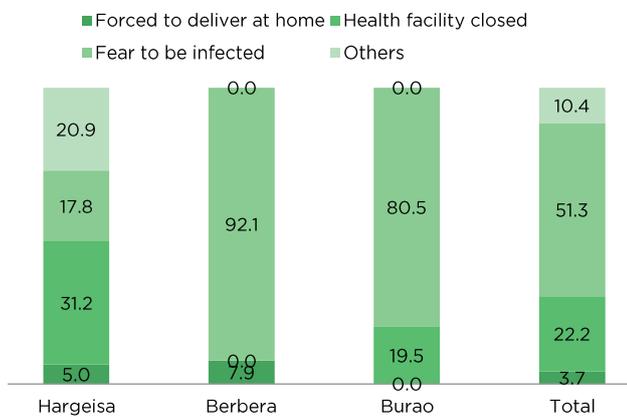
**Figure 6.15** Percentage of women whose access to delivery services was affected by COVID-19 crisis



**Figure 6.16** Percentage of households by reasons access to ANC services affected by COVID-19 crisis



**Figure 6.17** Percentage of households by reasons why access to delivery services was affected by COVID-19 crisis



The survey data was collected from both households and health centers in the selected cities. Data from the health facilities was collected from facility heads

focused on the level to which services provided by health facilities were disrupted by COVID-19 crisis and the reasons for the disruption of services. The results are displayed in Figure 6.17 and Figure 6.18. Whereas the health facilities have not been closed at any point during the COVID-19 pandemic, at different points there was a reduction in patients seeking services.

As shown by Figure 6.18, the highest proportions of completely disrupted services are in TB cases detection and treatment at 14 percent, Malaria diagnosis and treatment at 11 percent and not specified other services at 11 percent. Partially disrupted services with highest proportions are Antenatal Care, Management of moderate and severe malnutrition and NCD diagnosis and treatment at 30 percent at each.

**Figure 6.18** Percentage of health facilities disrupted by COVID-19 crisis

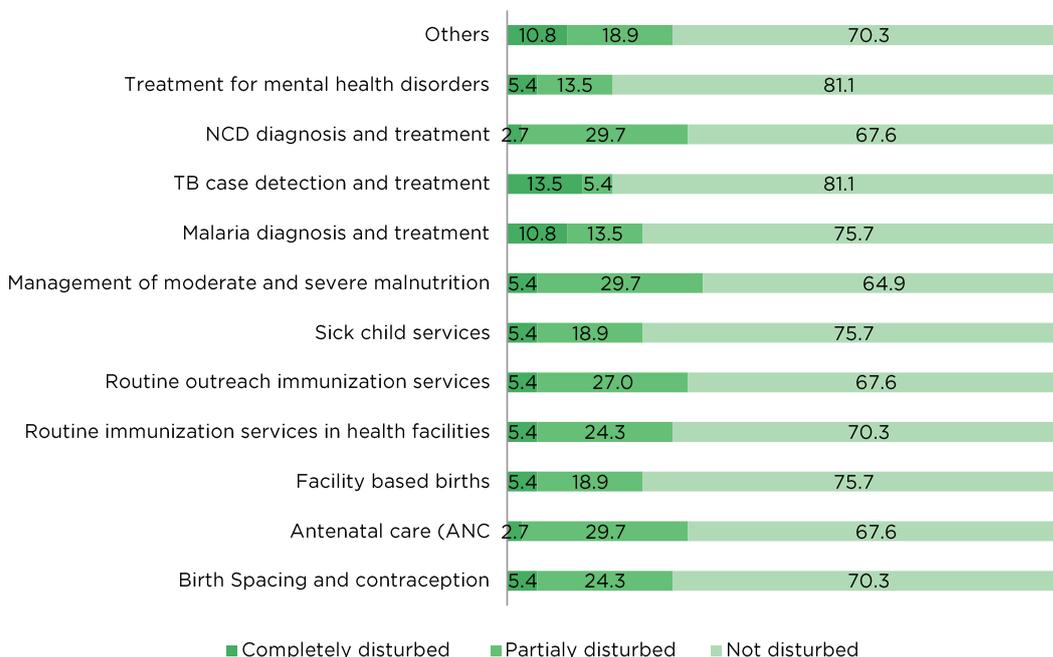
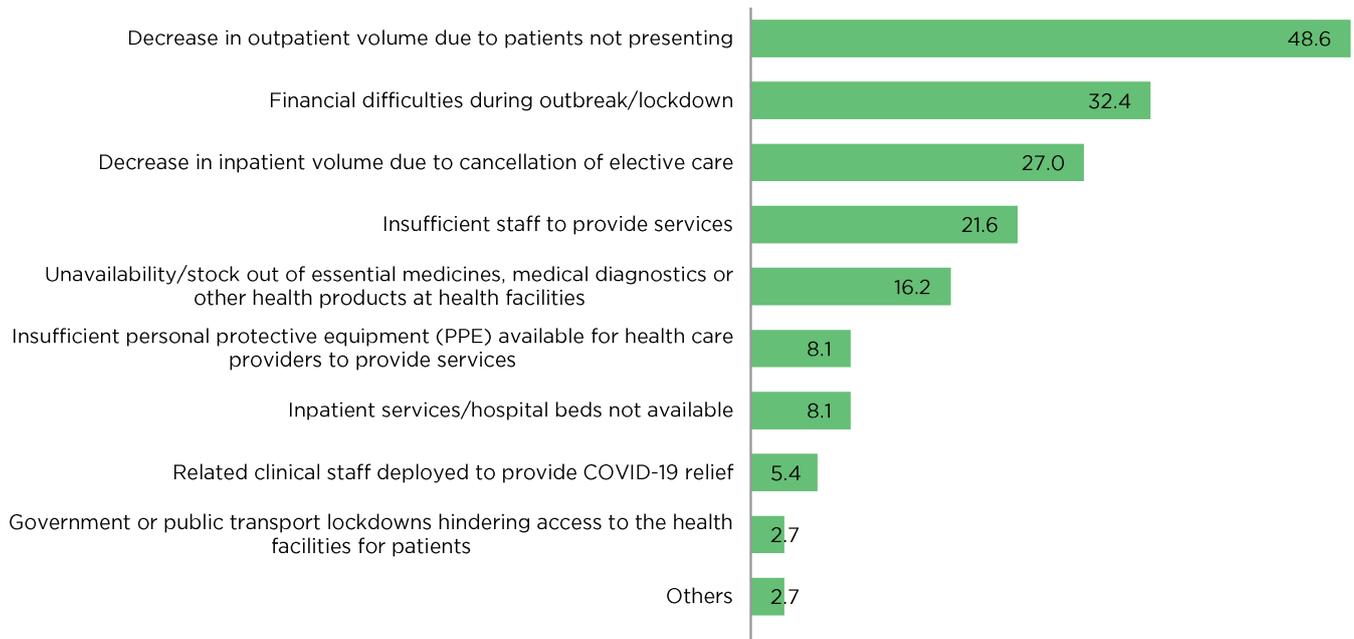


Figure 6.19 shows the percentage distribution of health service disruption reasons during COVID-19 crisis. The main reasons of health facilities disruption were decreased outpatient volumes due to patient not presenting and financial difficulties at 49 percent and

32 percent respectively. Other main reasons included the decreased inpatient volume due to cancellation of elective care and closure of outpatient service due to government directive at 27 percent at each.

**Figure 6.19** Percentage of health facilities by reason for health service disruption during COVID-19 crisis



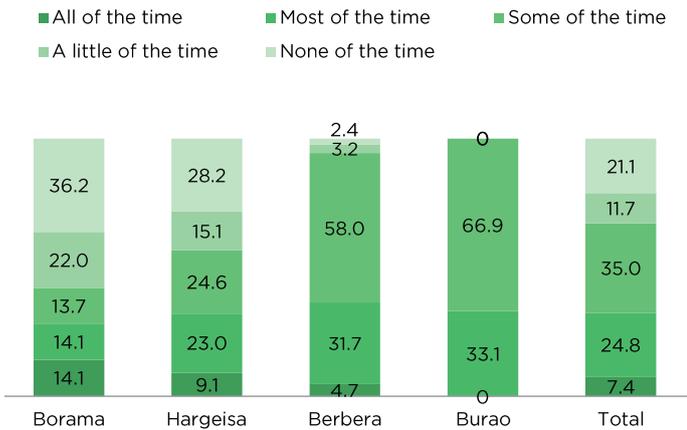
### 6.7 Mental health

Mental health is the foundation for the well-being and effective functioning of individuals. It is more than the absence of a mental disorder, mental health is a state of balance, both within and with the environment (Physical, psychological, social, cultural, spiritual) and other interrelated factors participate in producing this balance (WHO). Somaliland is among the countries with a high prevalence of mental health illness. At least one in two families has a member with some form of Mental Health Disability (GAVO, 2004). Somaliland Ministry of Health recognizes that mental health illness is one of the areas of negligence, which need intervening, improving and preventing. As stated in Somaliland Mental Health Policy 2014, the mental health services should be integrating into primary healthcare services. In recent years, the Ministry of Health has put great efforts in addressing the mental health problems by putting mental health component as one of the key priorities in the health sector.

COVID-19 has impacted not only physical health of the population but also has caused anxieties among households. According to the figure 6.20, 7 percent of the households from Hargeisa, Burao, Borama and Berbera cities have experienced anxiety all the time during COVID-19 while 25 percent of the households have experienced anxieties most of the time. Majority of the households from the four cities (35 percent) have experienced anxieties some of the time during COVID-19 crisis, whilst 21 percent of households have not experienced any anxiety during COVID-19 crisis.

Based on the findings of specific cities, the majority of households from Hargeisa and Borama (28 percent and 36 percent respectively) have experienced anxieties none of the time during COVID-19 crisis. Whereas the majority of the households from Burao and Berbera (67 percent and 58 percent respectively) have experienced anxieties some of the time.

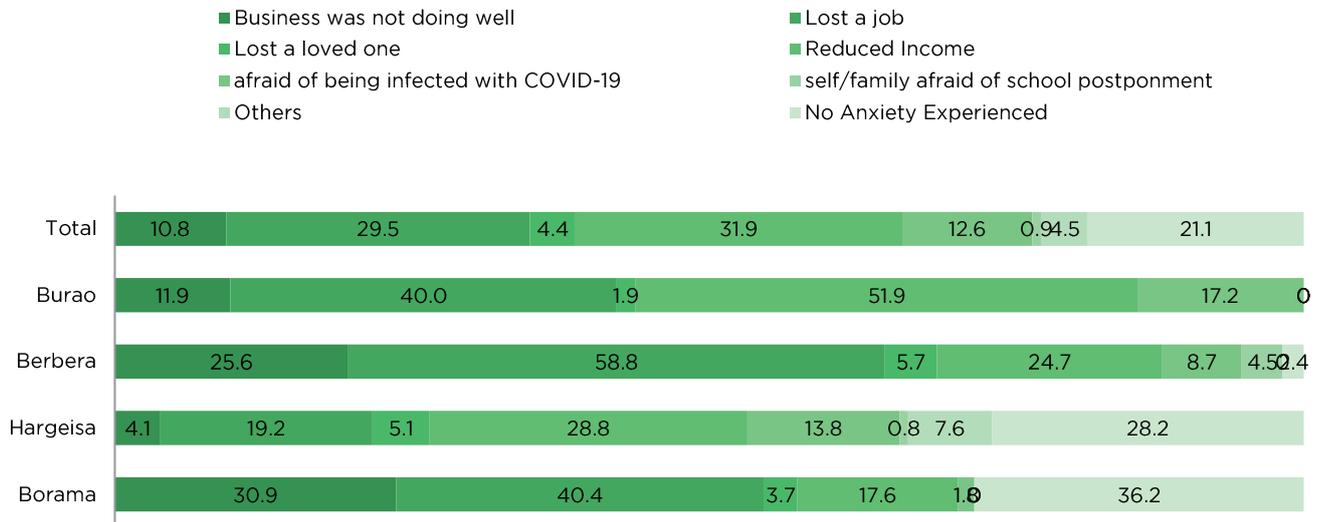
**Figure 6.20** Percentage distribution of household members by experience of anxiety during COVID-19 crisis



As shown in Figure 6.21, the majority of the households (32 percent) from the four cities cited reduced income as the source of anxieties whereas 30 percent of the households stated that loss of a job caused the anxiety. Thirteen percent of the households highlighted fear of being infected with COVID-19 as the source of anxiety.

According to the findings majority of households from Burao (52 percent) and Hargeisa (29 percent) stated that reduced income was the main source of anxiety, while in Berbera and Borama the loss of a job was highlighted as the main source of anxiety at 59 percent and 40 percent respectively.

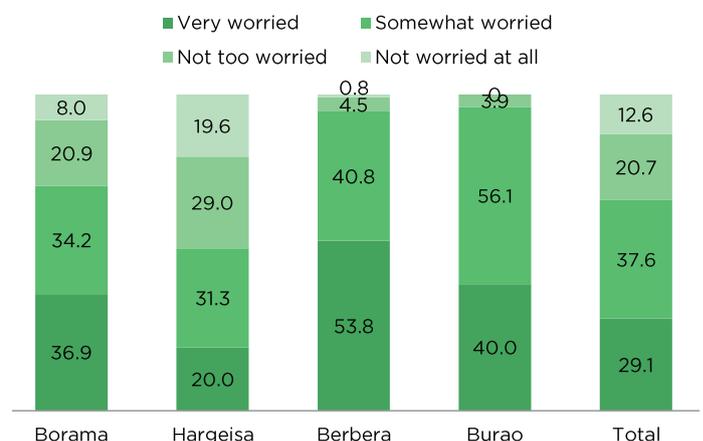
**Figure 6.21** Percentage of household by source of anxiety for household members during COVID-19 crisis



COVID-19 disease has made the majority of the world population to fear due to its high transmission and rapid spread. In this study households were asked to what extent they worry of being ill from COVID-19. Majority of the households (38 percent) stated that they were somewhat worried while 29 percent said they were very worried and 13 percent were not worried at all.

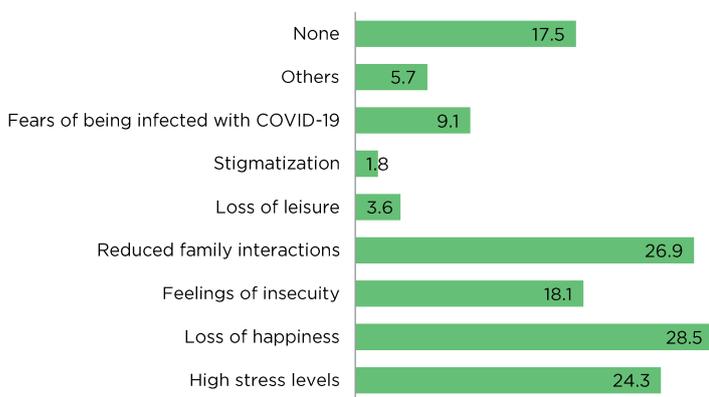
Based on findings from the study, the majority of households from Berbera and Borama were very worried at 54 and 37 percent respectively, whereas the majority of households from Burao and Hargeisa were somewhat worried of being ill from COVID-19 at 56 and 31 percent respectively.

**Figure 6.22** Percentage distribution of households by extent of worry of a member contracting COVID-19



COVID-19 disease not only causes fatal complications, but also brings other distresses to the person. As shown in Figure 6.23, 29 percent of households stated that COVID-19 has brought loss of happiness while 27 percent said that COVID-19 has caused reduced family interactions. Additionally, 24 percent of households had experienced high stress levels as a result of COVID-19 crisis, while 18 percent of the households had experienced no distress.

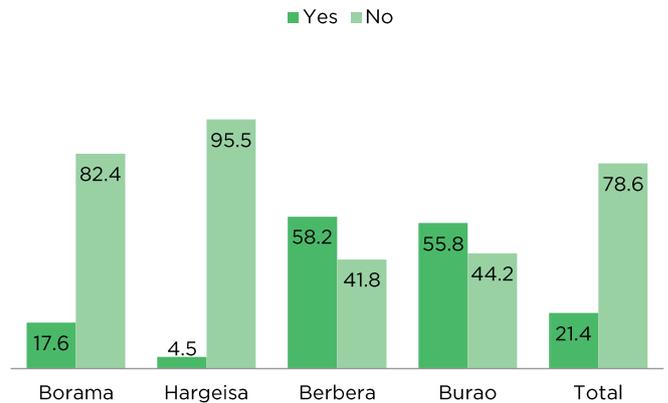
**Figure 6.23** Percentage of households by type of distress faced by household members as a result of COVID-19



### 6.8 Impact of COVID-19 on relationship of household members

The COVID-19 crisis has impacted the world economy and employment. Many business activities have been closed across the world due to lockdowns. This has had a direct impact on the lives of families and individuals as well. In this study, households were asked if COVID-19 has affected their relationship. According to the Figure 6.24, 79 percent of the households stated that COVID-19 has not affected their relationship, whereas 21 percent of households said COVID-19 has affected their relationship. Findings from the specific cities indicate that, majority of households from Hargeisa and Borama said that COVID-19 has not affected relationships between household members, with percentages of 96 and 82 respectively. However, more than half of the households from Berbera and Burao (58 percent and 56 percent respectively) indicated relationships among household members were affected.

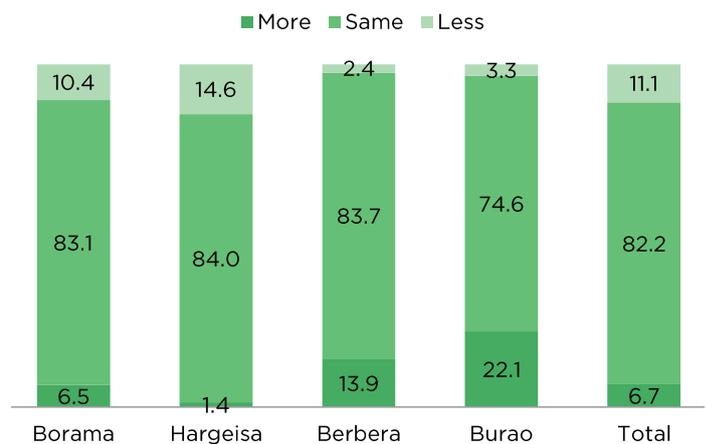
**Figure 6.24** Percentage of households with members whose relationship was affected by COVID-19.



### 6.9 Impact of COVID-19 on spousal relationship

Respondents were asked if the time they spent together with their spouses was affected by the pandemic. As shown in Figure 6.25, 82 percent indicated that they spent the same time together as before, while 7 percent said they spent more time now. According to the findings, couples from Burao and Berbera spent more time together during COVID-19 (22 percent 14 percent respectively) compared to those from Hargeisa and Borama at one and 7 percent respectively.

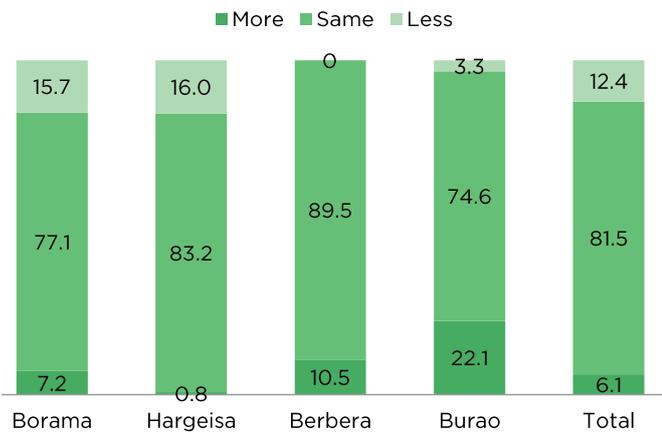
**Figure 6.25** Percentage of households by time spent with spouse during COVID-19-Crisis



During the study, spouses were asked the amount of tension that existed between them during COVID-19 crisis. As depicted in figure 6.26, the majority of respondents from households in the surveyed cities (82 percent) reported that tension existing during

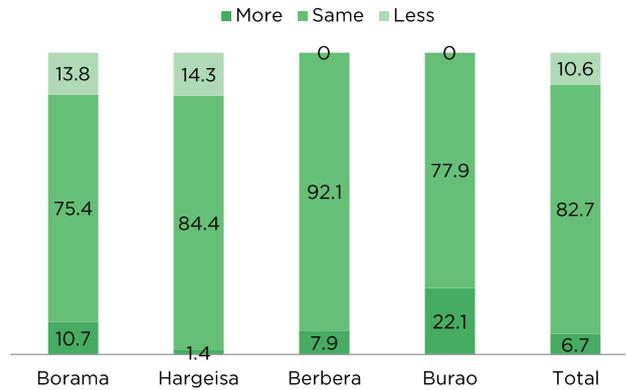
the COVID-19 was the same as previously while 6 percent said the tension existing with the spouse was more during COVID-19 crisis as compared to before. Spouses from Burao and Berbera had more tension (22 percent and 11 percent respectively) during COVID-19 crisis compared to those households from Hargeisa and Borama (1 percent and 7 percent respectively).

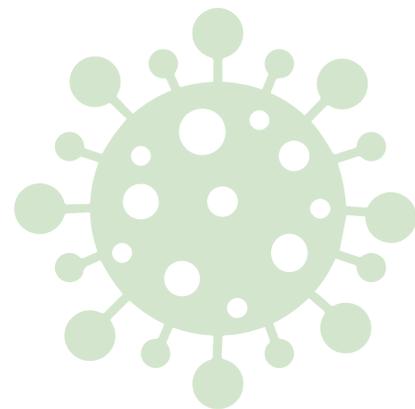
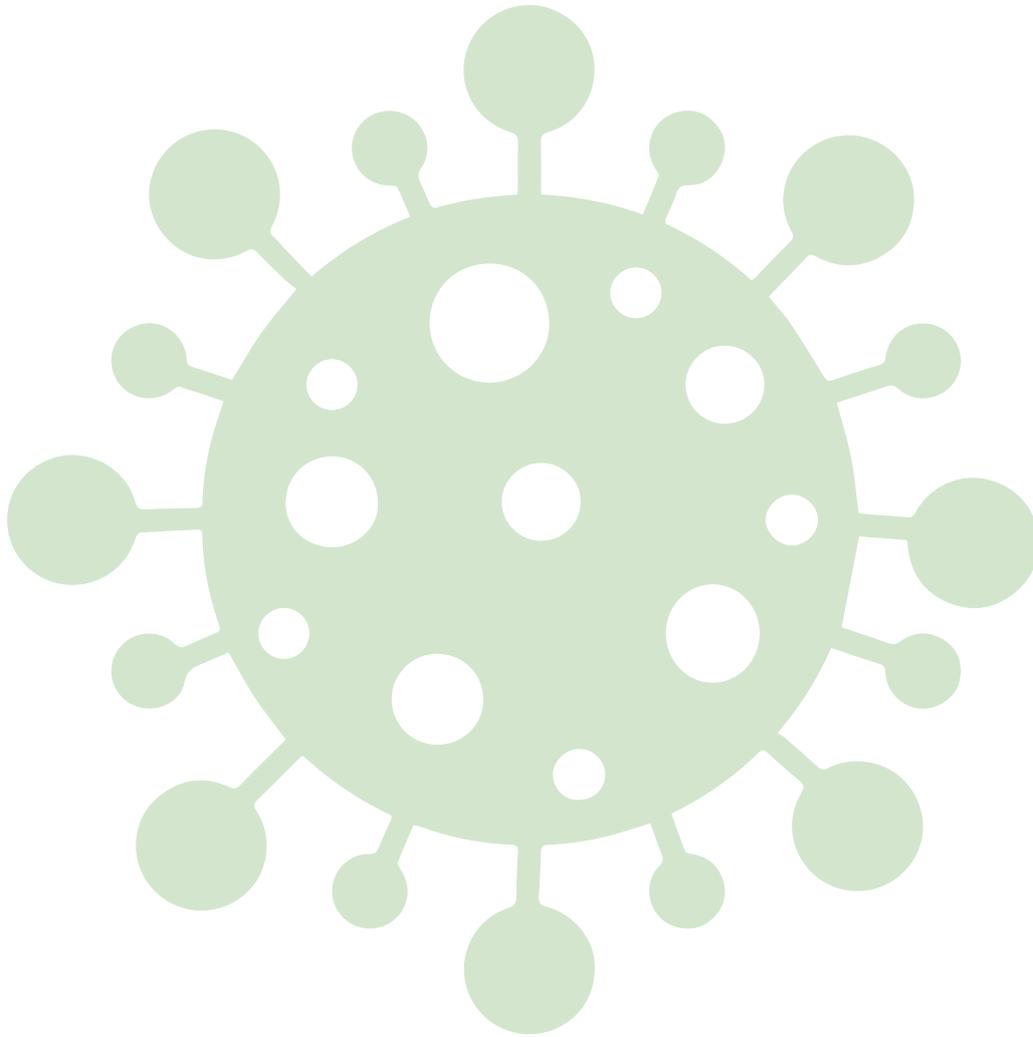
**Figure 6.26** Percentage of households by amount of tension existing with spouse during COVID-19 crisis



Married respondents were asked if the pandemic affected the emotional support received from their spouse during the COVID-19 pandemic. As shown in Figure 6.27, the majority of spouses (83 percent) said the amount of emotional support received from a spouse during COVID-19 was the same while 7 percent said they received more emotional support. Based on findings by cities, spouses from Burao received more emotional support at 22 percent) compared to spouses from Borama at 11 percent, Berbera at 8 percent and Hargeisa at one percent. Spousal support during times of shock is critical for the psychological well-being of not only the spouse but the entire household.

**Figure 6.27** Percentage of households by amount of emotional support from spouse during COVID-19 crisis





# 7

## Resilience and Household Food Security



## 7. Resilience and Household Food Security

### 7.1 Introduction

Since the first case of COVID-19 was reported in China in late 2019, the pandemic has spread quickly and widely across the globe. It has had profound repercussions for food security and nutrition. Through multiple dynamics, this emerging crisis has affected food systems and challenged people’s access to food. Lockdowns put in place to contain the spread of the virus have caused disruption to food supply chains, but also a major global economic downturn affecting people’s ability to purchase food due to reduced or loss in income and inflated prices for some food commodities. Like many other countries, Somaliland has had her fair share of disruptions in the economic and food systems as a result of measures put in place by the government to minimize the spread of the corona virus. Somaliland’s food security was once again under threat after a gradual recovery from food insecurity famine in 2011, and drought between 2016 and 2017. Around 2.7 million people were unable to meet their daily food needs and need urgent humanitarian assistance, with more than half a million on the verge of famine. To keep from sliding into crisis, another 2.7 million were in need of support for their livelihoods (WFP, May 2018).

### 7.2 Impact of COVID-19 on food security

Somaliland experienced her first case of COVID-19 in March 2020. Since then, the Somaliland government put in place strict measures to contain the spread of the disease to protect the lives of its people. These measures included isolation of suspected and confirmed cases, lockdowns and restricted movement within the country and in and out of the country. These restrictions in movement are deemed to have affected the food security at household level. Figure 7.1 illustrates the food situation at household level during the COVID-19 pandemic period. Across all the surveyed cities, 57 percent of households reported not to have worried about food supply due to the COVID-19 crisis, while 44 percent indicated that they worried about food supply during the COVID-19 crisis.

Berbera and Burao reported the highest proportions of households that worried about food supply due to COVID-19 pandemic at 98 and 95 percent, respectively. Conversely, Hargeisa and Borama have the least proportions of households that are worried about food supply at 17 percent and 47 percent, respectively.

**Figure 7.1** Percentage distribution of households feeling worried about household food supply due to COVID-19

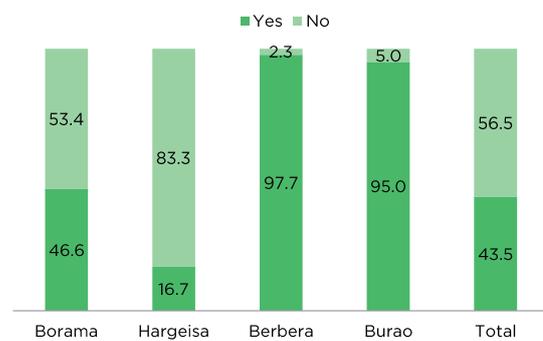


Figure 7.2 illustrates a household’s extent of worry about food supply. Twenty-two percent of households reported to have worried much about food supply while 18 percent were somewhat worried. On the other hand, 57 percent of households did not worry at all while 3 percent were not too worried about food supply.

**Figure 7.2** Percentage distribution of households with the extent of worry about household food supply due to COVID-19

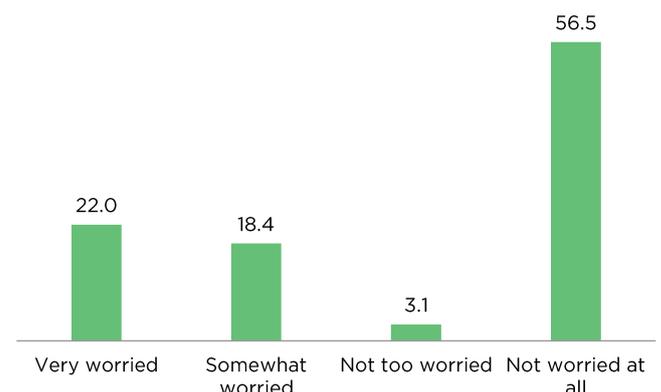


Figure 7.3 shows the change in household food situation during the pandemic period. Fifty-eight percent of households indicated that they have experienced an improved household food supply during the pandemic, 38 percent have seen no change while 4 percent indicated the food situation in their household has changed for the worse with the pandemic.

**Figure 7.3** Change in household food situation due to COVID 19 crisis

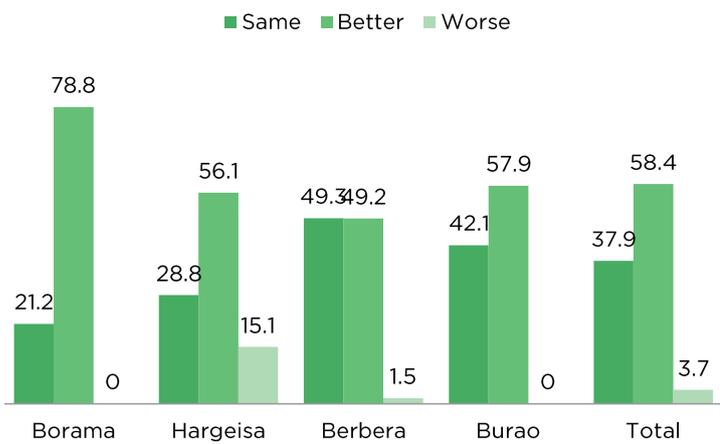


Figure 7.4: illustrates the percentage distribution of households that lost income and their worry about the expressing worry about household food supply during the pandemic. Berbera and Burao have the highest proportions of households responded to have worried about food supply and household members lost income due to COVID-19 at 100 percent and 94 percent respectively. Likewise, Hargeisa and Borama have the least proportions of households worried about food supply and their household members lost income during the pandemic period at 36 percent and 55 percent.

Forty five percent of the households surveyed, responded to have neither worried about food supply nor members of their households lost income due to COVID19 crisis. On the contrary, 31 percent of the households responded to have worried about food supply and members of their households lost income due to COVID19. Moreover, 13 percent of the households responded to worried about food supply, but members of households did not lose income due to COVID19 crisis. Conversely, 12 percent of them responded to have not worried about food supply, but members of their households lost income due to COVID19 crisis.

Berbera and Burao have the highest proportions of households responded to have worried about food supply and members of their households lost income due to COVID19 crisis at 78 percent. Conversely, Hargeisa and Borama have the least proportions of households, which have worried about food supply and members of their households lost income due to COVID19 crisis at 8 percent and 26 percent respectively.

Hargeisa and Borama have the highest proportions of households, which responded they have not worried about food supply and members of their households did not lose income due to COVID19 crisis at 69 percent and 32 percent respectively. In Contrast, Burao and Berbera have the least proportions of households, which responded they have not worried about food supply and members of their households did not lose income due to COVID19 crisis.

**Figure 7.4** Percentage distribution of respondents expressing worry about household food supply due to COVID-19 by loss of income

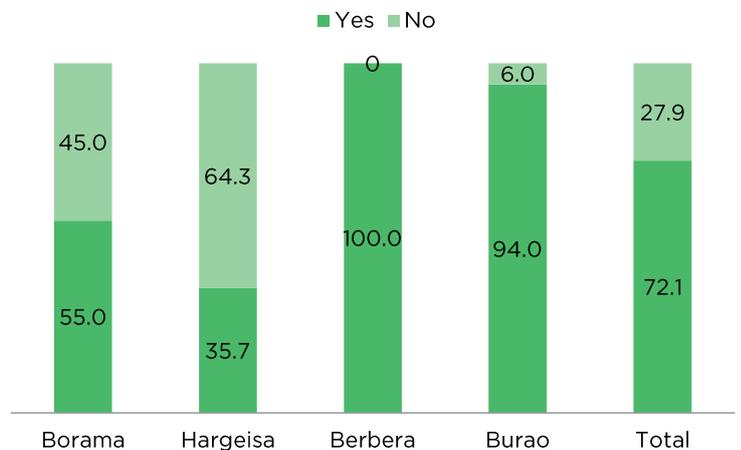
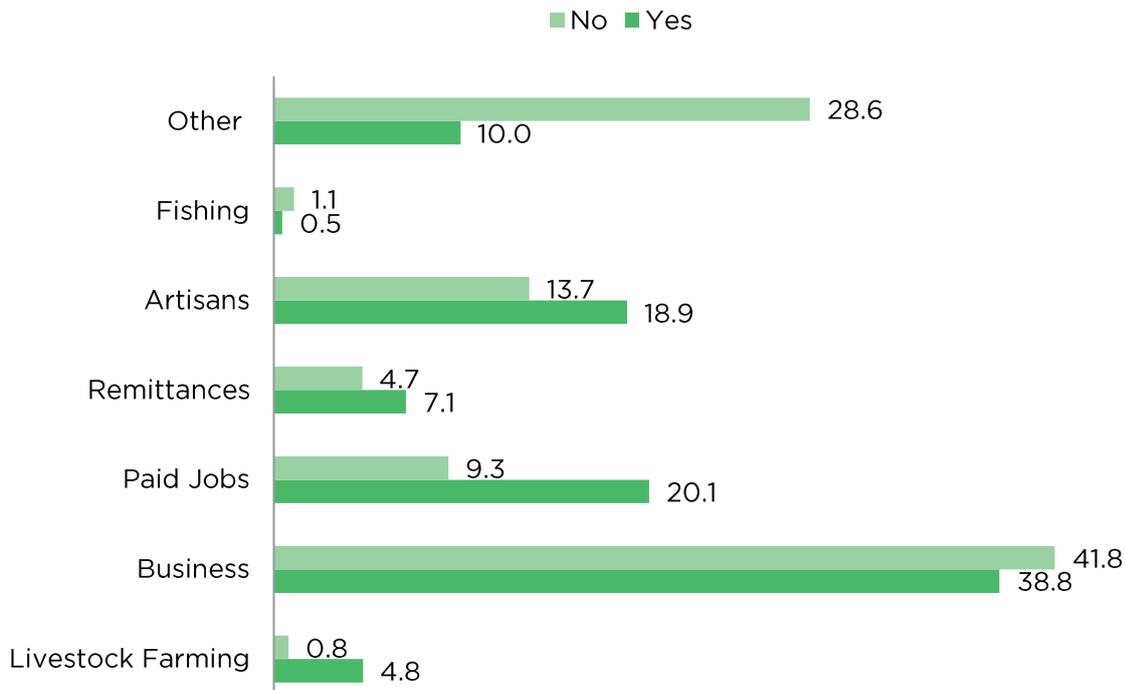


Figure 7.5 shows the percentage of households expressing worry about food supply during the pandemic by their primary source of income. The findings indicate that business is the most vulnerable primary source of income during the pandemic, followed by paid jobs and artisans. Household food security that is dependent on fishing and livestock farming was more resilient to the COVID-19 shock. Thirty-nine percent of households whose primary source of income was business worried about food supply, while 20 percent and 19 percent of

households whose primary source of income was either paid jobs or artisans worried about food supply during the pandemic. Five and one percent of the households depending on livestock farming and fishing respectively worried about food supply.

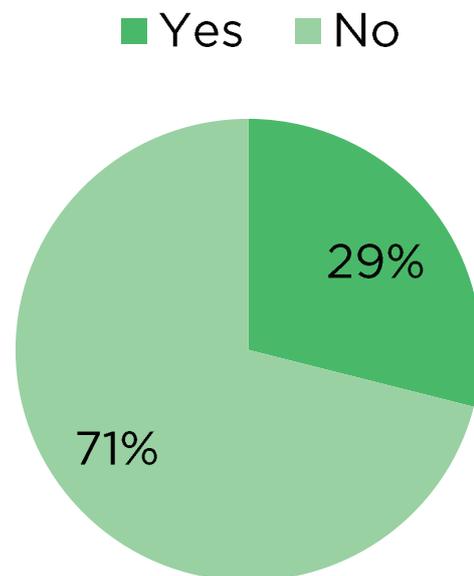
Due to the global nature of the pandemic, remittances which mostly come from the diaspora were also affected. Among households that depend on remittances as their main source of income, 7 percent indicated that they worried about food supply.

**Figure 7.5** Percentage of households expressing worry about food supply due to COVID-19



Livelihood diversification is one of the interventions advocated for by development experts to build household resilience and food security. Income diversification provides additional income that relaxes the financial constraint on households. Subsequently, households spend more on their basic needs including food, clothing, education, and healthcare. Thus, multiple sources of income with reliable amounts are essential to ensuring food for households (Sultana et al., 2016). As presented in Figure 7.6, 29 percent of households with more than one source of income worried about food supply compared to 71 percent that had only one source of income.

**Figure 7.6** Percentage of households worried about food supply due to COVID-19



### 7.3 Household coping strategies

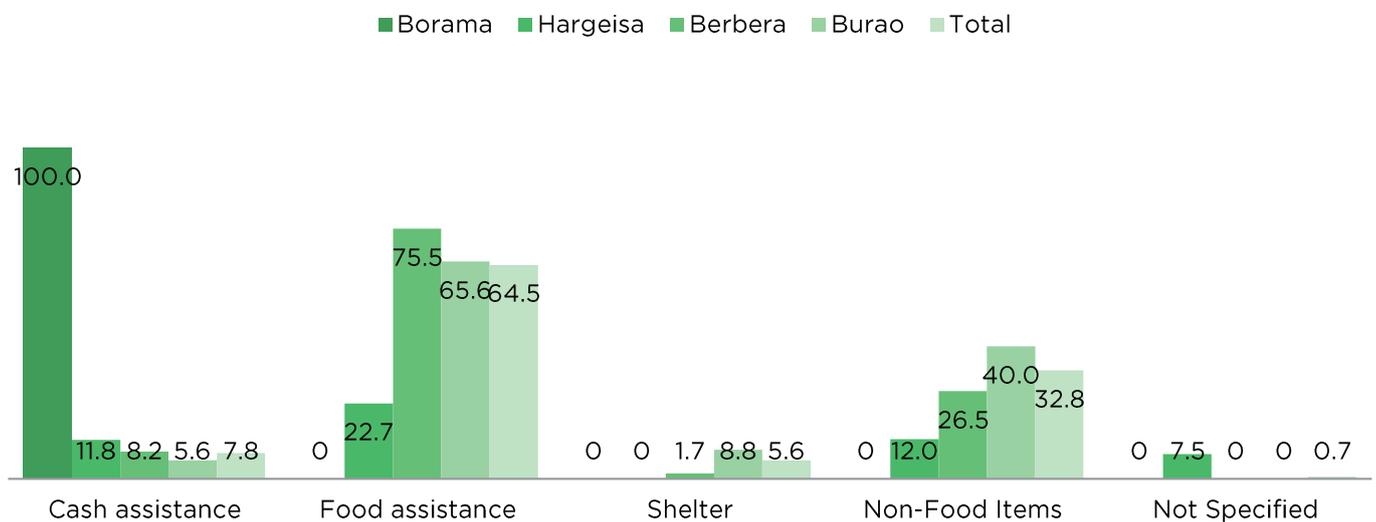
To mitigate shocks and stresses, households adopt various strategies to ensure their survival. The strategies can be internal (adjustments made within the household) or external (assistance received from other parties not living within the household). The strategy adopted to cope can either build a household’s resilience, make it dependent or increase its vulnerability. Figure 7.7 shows the percentage distribution of households worrying about food supply during the COVID-19 pandemic by the coping strategies they have adopted.

People need strategies to deal with stress, maintain their self-control and self-management. Across the four cities, households adopted different strategies to survive during the pandemic. Figure 7.7 illustrates the percentage of household coping strategies by city. In Burao, households mainly sold their assets (34percent) or reduced their food rations (34 percent) intake to survive the pandemic shock. In Berbera, the main coping strategy for households is reducing

the food rations reported by 33 percent followed by sale of assets at 32 percent. Among households in Borama they mainly received support from family and friends at 25 percent and accepting lower wages at 19 percent. In Hargeisa, households mainly sell their assets at 21 percent followed by accepting lower wages at 15 percent. Across the four cities, households are employing negative coping strategies which could increase poverty and hamper recovery. Households i had the largest proportion of households whose coping strategies during the COVID-19 crisis was “Support from family/friends” and “Sale of assets” at 34 percent and 33 percent respectively. Likewise, 25 percent of households in Borama city had “Support from family/friends” as their coping strategy, and 21 percent of households in Hargeisa had “Sale of assets” as their coping strategy.

On the other hand, Borama and Hargeisa cities had the largest proportion of households that did not have any coping strategy at 40 percent and 34 percent respectively.

**Figure 7.7** Percentage distribution of households by coping strategies during COVID-19 crisis



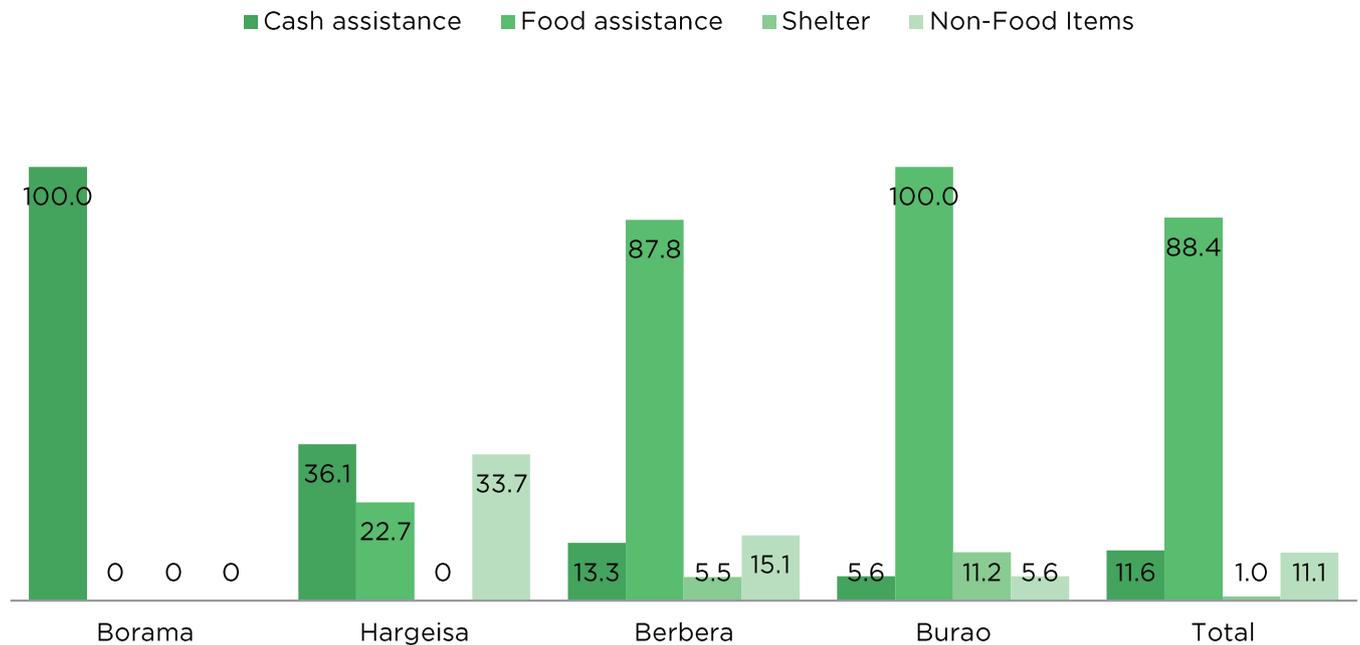
### 7.4 Government mitigation

Somaliland developed a Food and Water security strategy (FWSS) in 2011 to deal with water and food security challenges (NDPII). The primary objectives of the FWSS were to promote domestic food production capacity, improve food and water availability, increase domestic capacity to import adequate quantities of food supplies, increase food insecure households' participation in agricultural activities, and generate both forward and backward capacity.

Figure 7.8 indicates the distribution of households by the kind of assistance they received from the government during the pandemic. Most of the assistance to urban households from the government is through food donation reported by 88 percent 11 percent of households, were provided with non-food

items and 1 percent with shelter. In Borama only one household reported that it had received cash assistance from the government, compared to 36 percent of households in Hargeisa, 13 percent of the households in Berbera and 6 percent in Burao. Burao and Berbera had the largest percentage of households receiving food from the government, while Hargeisa had the least at 23 percent. Thirty four percent of the households in Hargeisa received non-food items, 15 percent of the households in Berbera received non-food items, 6 percent of the households in Burao received non-food items, while households in Borama received no non-food items assistance from the government. Unlike households in the other regions that got varied government assistance, in Borama, the government aid was only in the form of cash.

**Figure 7.8** Percentage distribution of households by type of assistance received



## 7.5 Non-state actor's (I/NGOs) mitigation

Table 7.9 illustrates percentage distribution of households received assistance from non-state actors by the form of assistance received. Most of the assistance to urban households from the non-state actors is through food donation reported by 65 percent while 33 percent of households, were provided with non-food items, 8 percent cash assistance, 6 percent with shelter and 1 percent with non specified. In Borama only one household reported that it had received cash assistance from the

Hundred percent of the households living in Borama city responded to have received cash assistance, 12 percent of the households in Hargeisa responded to have received cash assistance, 8 percent of the

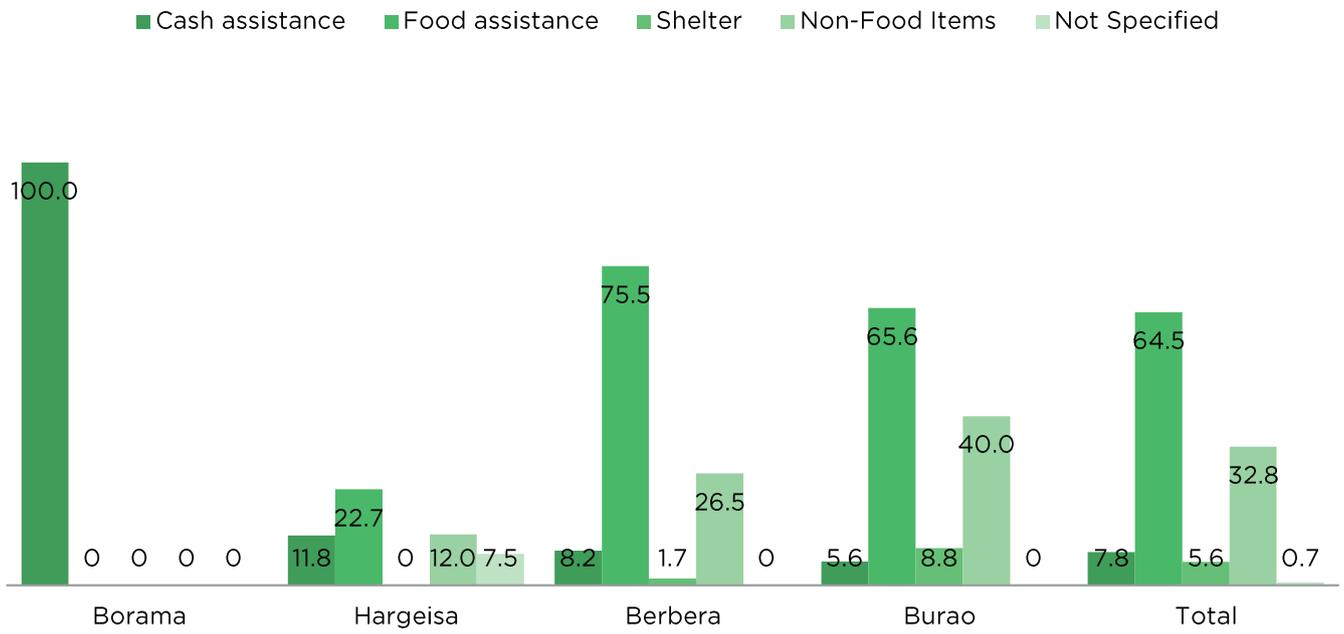
households in Berbera also received cash assistance and Burao households received the least proportion of cash assistance at 6 percent.

Seventy-six of the households in Berbera city received food assistance from the government, 66 percent of the households in Burao received food assistance, 23 percent of the households in Hargeisa received food assistance and none of the households in Borama received food assistance.

Twelve percent of the households in Hargeisa city received non-food items, 27 percent of the households in Berbera received non-food items, and 40 percent of the households in Burao received non-food items, while households in Borama received no assistance from non-state actors.



**Figure 7.9** Percentage distribution of households by type of assistance received



# 8

## Conclusion and Recommendation



## 8. Conclusion and Recommendation

### Conclusion

- COVID-19 has adverse effects on the health of household members, not only are they vulnerable to COVID infection and it's related complications including hospitalization and related mortality, but also it has affected their health seeking behavior. There is a decrease in the access to health services including routine check-ups, maternal and child health services and also consultation in the case of a.
- It is also shown that COVID-19 has impacted not only physical health of the population but also has caused anxieties, distresses and poor relationships among Somaliland household members.
- Household income is not immune to COVID-19 pandemic. Households reported loss of income particularly those relying on formal employment. Income from businesses and remittances was also affected with the most resilient income being from fishing, livestock and crop farming.
- COVID-19 crisis has affected the household food security, households that previously did not worry about their food security, are now worried. Whereas the food security of households with only one source of income was the most affected, a few of those with a secondary income were also affected. Households were forced either to sell their assets, accept lower wages, engage children in casual chores to supplement and even reduce food rations to meet their food needs.
- Children's education is not spared either. Some children have dropped out of school due to fear of contracting the corona virus, some have been engaged in casual work to supplement family income.
- The pandemic has seen a rise in cases of early marriage, FGM, GBV and violence in general.

### Recommendations

- There is need for aggressive awareness campaign interventions by government and key stakeholders to relay the fears, stigma and discrimination associated with COVID-19 a. It is also important to facilitate COVID-19 testing services to identify the exact situation of disease transmission.
- The government and the international partners need to support and expand health facilities with specific focus on maternal and child health services. It is important to provide preventive measure equipment like face masks and handwashing facilities in health centers to improve accessibility to health facilities and remove fear of people from health facilities.
- The government and development partners need to come up with socio- psychological and mental health support programs and centers to provide counselling to the population affected by COVID-19 crisis.
- The government and other partners need to support small business development programmes and income generating projects particularly for the most vulnerable households. It is also important to provide skills and entrepreneurship training to enable the small businesses to be able to bounce back from the pandemic.
- The government and stakeholders need to support job creation programs to reduce unemployment caused by the pandemic through among others provision of subsidies to employers.
- It is important to create and strengthen awareness programmes against early marriages, Gender Based Violence's (GBV) and school dropouts. Government with development partners to initiate education support programs specifically households who cannot afford to pay tuition fees.

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