BASELINE SURVEY FINAL REPORT

TITLE: IMPROVING LOCAL CAPACITY TO RESPOND TO COVID-19 AND WITHSTAND ITS SOCIO-ECONOMIC IMPACT IN SOMALIA

SUBMITTED TO:

CARE SOMALIA

SUBMITTED BY:

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Table of Contents

EXECUTIVE SUMMARY 5

1.0 INTRODUCTION 8

1.1 Background information 8

1.2 Rationale of the study 9

1.3 Purpose of the baseline survey 9

1.4 Baseline survey Implementation process 9

1.5 Study methodology 10

1.6 Organization of the report 12

2.0 SURVEY RESULTS 13

2.1 DEMOGRAPHIC CHARACTERISTICS 13

2.2 SURVEY FINDINGS 14

3.0 CONCLUSIONS AND RECOMMENDATIONS 23

3.1 CONCLUSIONS 23

3.2 RECOMMENDATIONS 23

4. ANNEXES 25

4.1. Annex I: Household questionnaire 25

Annex II: Key In-depth Interview for MOH 31

Annex III: Key In-depth Interview for health care personnel 33

Annex IV: Focused Group Discussions 35

Annex V: Observation checklist 36

Annex VI: Terms of Reference 37

LIST OF TABLES

Table 1: Summary of Baseline survey indicators 7

Table 2**:** Multi stage probability sampling 11

Table 3: Demographic variables 13

Table 4: Covid-19 awareness and source of information by socio-demographic variable 15

Table 5: Participant's main source of income 18

Table 6: Facility preparedness towards COVID-19 22

LIST OF FIGURES

Figure 1: Source of information by age 16

Figure 2: Source of information by level of education 16

Figure 3: Prevention measures taken to cope up with COVID-19 virus 17

Figure 4: Impact of COVID-19 on livelihood 20

ACROYNMS

ATLAS.ti:	Archiv für Technik, Lebenswelt und Alltagssprache (Archive for Technology, Lifeworld and Everyday Language.text interpretation)
CARE:	Cooperative for Assistance and Relief Everywhere
COVID-19:	Coronavirus Disease 2019
FGDs:	Focus Group Discussions
FSNAU:	Food Security and Nutrition Analysis Unit
HCFs:	Health Care Facilities
HCWs:	Health Care Workers
HH:	Household
IDPs:	Internally Displaced Persons
IGA:	Income Generating Activity
IPC:	Infection Prevention and Control
KAP:	Knowledge Attitude and Practices
KIIs:	Key In-depth Interviews
KOBO:	KOBO collect app
MOH:	Ministry of Health
NGO:	Non-Governmental Organization
ODK:	Open Data Kit
PPEs:	Personal Protective Equipment's
SomReP:	Somalia Resilience Program
SPSS:	Statistical Package for Social Sciences
STS:	Serving Together Social
TOR:	Terms of Reference
UN:	United Nations
VSLA:	Village Savings and Loan Association
WHO:	World Health Organization

EXECUTIVE SUMMARY

Baseline purpose and objectives: The baseline survey was conducted to establish the current status of COVID-19 prevention and response awareness and health services provision in Mogadishu and Afgoye districts in Banadir and Lower Shabelle regions respectively. Three main objectives covered include: a) to assess awareness level and skills of health care workers and communities in preventing and managing COVID-19 and related vulnerabilities; b) to assess the coverage, efficiency and quality of health services in target communities that will enable existing health facilities and its workers to cope with COVID-19 and related vulnerabilities; and c) to examine the economic resilience and adaptive capacity of target communities that will enable them withstand the socio-economic impact of COVID-19 and related vulnerabilities.

Methodology and Respondents Demographics: The baseline survey applied mixed method with both quantitative and qualitative approaches. Data collection methods included desk review, technical expert consultations, key in-depth interviews (KIIs), focus group discussions (FGDs) and quantitative household survey. Qualitative analysis was conducted using ATLAS.ti software on all KIIs and FGDs transcripts using a Grounded Theory Approach or thematic analysis. Quantitative analysis was conducted using SPSS version 23 where descriptive and inferential statistics were conducted on HH survey tool. Twelve health care workers (8 from Afgoye and 4 from Mogadishu) took part in the study. Both district medical officers were males. Among the 65 FGD respondents from VSLAs, women and youths, 45 were female while 20 were males. Approximately 79% of the respondents who took part in household survey were female as compared to 21% who were male. More than half, (51.8%, 155) lived in the urban areas whereas 48.2% lived in rural areas. Approximately 74.3% (n = 222) of the respondents have no education, followed by primary level of education (n = 40), secondary (n = 28) and post-secondary education (n = 9).

Survey findings: All the health care workers were aware of the COVID-19 virus spread, signs and symptoms, prevention and treatment. Most of them were able to state that Corona virus is viral infection that affects the respiratory system and has symptoms such as coughing, fever and difficulty in breathing. It is a pandemic that has affected the health, social and economic aspects of the human beings. Approximately 75% (n = 223) of the respondents who took part in the study were aware of COVID-19 virus. 76.2% of female respondents were aware of COVID-19 virus as compared to 69.8% male counterparts. Radio is the most trusted source of information. Other sources include social media, friends, door to door visits by MOH officials and through SMS.

Health care workers stated that most of the facilities are open but the number of the patients who seek health care services has reduced as result of fear of contracting the virus at the hospital, lack of awareness about continuity of health care services provided at the health facilities. Health care facilities still provide essential services and thus the quality of health care has not been affected. The above finding was supported by 45.8% respondents who stated that the essential health care services were always available. Approximately 66.2% respondents stated that their health situation had remained the same for the past three months while 16.0% stated an improvement in their health situation. Majority of the respondents 51.8% (n = 155) stated that the cost of health care since COVID-19 remained the same as compared to 40.7% who felt that the cost had increased. All Health care workers in Afgoye district have not been trained to handle COVID-19 patients as compared to their counterparts in Mogadishu who attended the training. Health care

workers in Afgoye also noted that they are very few in number and the health care facilities do not have adequate resources to support COVID-19 patients.
As a result of COVID-19 virus, Somalia imposed a total lockdown from March to September 2020 resulting in loss of jobs by 26% of the respondents followed by salary reduction (24%), limited mobility (22%), change of livelihood activity or sector (20%), increased demand of goods and services (14%) and 11% reported that livelihoods inputs such as seeds, fertilizer are too expensive or inaccessible among others. Approximately 23.2% (n = 69) of the respondents stated that the pandemic led to the reduction in their income by a margin of 50-75%; and 13.8% respondents reported an income reduction of less than 25% because they have more expenses as compared to before the crisis.
The organizations in the project area include Juba Foundation who work with the Afgoye General Hospital and STS International who work closely with the 21st October health facility. Other stakeholders in the project area include the European Union, Action Against Hunger, Caafimaad (Somalia Health Info) and World Health Organization.

Conclusions and recommendations: The baseline survey was able to achieve its study objectives and purpose of the study. Most of the respondents have heard about the COVID19 virus and have knowledge about the COVID-19 virus. Radio and or TV is the most trusted source of information among all age groups, gender and place of residence. Most of the health facilities were open to provide essential services. Somalia COVID-19 restriction measures and lockdown led to loss of jobs, salary cuts, limited mobility, change of livelihood activity or sector, increased demand of goods and services and livelihoods inputs such as seeds, fertilizer became too expensive or inaccessible.
The following are some of the recommendations:

- It is important to engage the community to understand the gaps in perception, knowledge, and attitudes on COVID-19 and it is key to strengthen coordination for better preparedness and ensuring effectiveness in mitigation efforts.
- The project can use Radio or television since it is the most preferred means of communication on coronavirus outbreak
- The project can engage community leaders, religious leaders, and community-based workers in designing and implementation of communication and advocacy strategies.
- The ministry of health and other partners such as Juba Foundation and STS International offering support to health facilities should equip the health care facilities with COVID-19 virus screening kits, in vitro diagnostics kits and PPEs.
- Health care workers should also be trained by the Ministry of health and other partners on rational use of Personal Protective Equipment's (PPEs), Infection Prevention and Control (IPC), health care waste management, and COVID-19 management protocols.
- The humanitarian partners and the government should improve the livelihood of the community through supporting income generating activities. This can be done through supporting existing VSLAs and promotion of vocation skills training for women and youths such.
- The humanitarian partners working closely with the government should also come up with the measures such as conditional and unconditional cash transfers to cushion families which have been hit hard by COVID-19 and have lost their jobs and income.

Table 1: Summary of Baseline survey indicators

Sno.	Objective	Indicators	Results
1	Awareness and skills	# of persons with knowledge of COVID-19 virus	All health care workers have knowledge of COVID-19 spread, prevention, symptoms and treatment 75% of respondents have knowledge of COVID-19 virus spread
		# of persons with skills on how to prevent and respond COVID-19 virus	All the health care workers in Afgoye do not have adequate skills on responding to COVID-19 No Training has been conducted in Afgoye by MOH
		# of persons who practice covid-19 prevention measures	Perform hand hygiene 64% Put on masks properly 37% Maintain social distance 35%
		# of sources of COVID-19 awareness information	Radio, TV and Social media, are the most trusted sources of information
2	Coverage, efficiency and quality of health services	# of persons especially women and girls who can access health facilities	Most women and girls who visited health facilities received care All health care facilities are open
		# of health facilities which offer COVID-19 related services	All three facilities offer COVID-19 related services
		# of health care personnel who offer COVID-19 related services	No health care worker has been trained on COVID-19 virus in Afgoye district
3	Economic resilience and adaptive capacity	# of persons affectively negatively by COVID-19 pandemic	Loss of jobs (26%) Salary reduction (24%) Limited mobility (22%) Change of activity or sector (20%) Increased demand or decreased supply of goods and services (14%) Livelihoods inputs are too expensive or inaccessible (11%)
		# of persons who lost livelihood as a result of COVID-19 pandemic	
		# of persons who lost jobs as a result of COVID-19 pandemic	

1.0 INTRODUCTION

Somalia and across the Horn of Africa has seen an increase in hazardous events such as droughts, flash floods and massive land degradation. Somalia is grappling with pre-existing challenges of conflict and climate change induced floods and drought impact, coupled with desert locust that worsen the impact of COVID-19 pandemic, these including poor health facilities, insufficient access to water and sanitation, malnutrition and cramped IDP camps, that can all exacerbate the spread of the Virus, at these times it has been observed that women and girls suffer the most.

On 16th March, 2020, Somalia recorded its first case of coronavirus, and as of 4th October 2020, there were 3,588 confirmed cases in Somalia with 99 confirmed death cases, in accordance with officially registered number of cases, although it has been reported that the real numbers are much more than the reported cases. This is partly because the governments don't have the capacity to conduct wide-scale testing and also, for many Somalis, there is no point in getting a COVID-19 test.

1.1 Background information

CARE Somalia is implementing various programs comprising food security and livelihoods, education, water and sanitation, governance and peace building and health across different regions in Somalia helping the most vulnerable households to cope with the different risks they face and achieve self-reliance. It has identified and selected two impact groups (Rural Women and Urban Youth) as its core programming focus/strategy and each program has a comprehensive Theory of Change spanning over 10-15 years of implementation period. In an effort to address the health and economic impact that COVID-19 placed on vulnerable Somali households and most notably women and children in IDP camps, rural and peri-urban areas in Benadir and Lower Shabelle, CARE received funds from Beiersdorf to implement a project entitled: 'Improving local capacity to respond to COVID-19 and withstand its socioeconomic impact'. The project aims to enhance the capacity of vulnerable women, youth, and service providers to cope with medium and long-term shadow effects of COVID-19 pandemic on economic, social and health wellbeing. As a member of the Somalia Resilience Program (SomReP) consortium, CARE has been implementing resilience building activities in Afgoye district and hence has built partnerships with communities and local authorities and thus the need to integrate this COVID-19 response in its already existing programing.[1]

Care Somalia sought Hornsom Consultants and Trading Company consultancy services to conduct baseline survey in order to establish the current status of COVID-19 prevention and response awareness and health services provision in project areas. This information provided a reference point for assessing changes and impact by establishing a basis for comparison before this intervention.

The project will be implemented in Afgoye district and Mogadishu. Afgoye is thirty kilometres from the capital city of Mogadishu and is a very strategic town that joins many regions to the city. Its population depends on agriculture and livestock for their livelihood. The district has hosted 15,000 internally displaced persons (IDPs) communities affected by the armed conflict that is currently affecting neighboring locations around Afgoye region. The complexity of displacement and drought and its impact on IDPs and host communities in Afgoye has increased

[1] Care Somalia (2021). Improving local capacity to respond to COVID-19 and withstand its socio-economic impact in Somalia. Project Proposal

the vulnerability of these people leading to a humanitarian crisis. Mogadishu is the capital city of Somalia and is a home to about 2.5 million people with nearly 200,000 IDPs living in crowded settlements. The capital is devastated by conflict and limited health facilities and personnel to tackle with disease outbreaks, most notably COVID-19 at the present time. The beneficiaries of project activities will be mainly urban and peri-urban communities in Mogadishu and farmers in Afgoi district.

1.2 Rationale of the study

CARE recognizes the efforts of governments and the United Nations (UN) system to minimize the human, health and socio-economic consequences of the unprecedented COVID-19 pandemic that is impacting individuals, communities and governments across the globe. However, the world is ill-prepared to face such a pandemic, particularly in countries with large numbers of poor and marginalized people already challenged to access basic health and other social services. COVID-19 is already amplifying inequalities and existing injustices. Women and girls are at high risk, along with the elderly, disabled people, those in poor health or malnourished, and groups such as marginalized ethnic groups, especially when they live in perpetually fragile contexts already affected by complex emergencies, with dilapidated health systems and no social protection. A strong commitment to maintain and scale up existing humanitarian operations is a critical element of the COVID-19 response to ensure that the most vulnerable do not become even more susceptible to the effects of the pandemic. At the same time, given the far-reaching impact of the crisis, support for critical social and economic development sectors that prioritize the furthest behind in developing countries and fragile contexts should be maintained, albeit with the necessary adaptations to avoid a further health, food and economic crisis on the heels of COVID-19.

1.3 Purpose of the baseline survey

The overall purpose of the survey was to establish the current status of COVID-19 prevention and response awareness and health services provision in project areas and understand the root causes and inherent complexity of vulnerability of target populations to the impact of COVID-19.[2]

1.3.1 Specific objectives

a) To assess awareness level and skills of health workers and communities in preventing and managing COVID-19 and related vulnerabilities
b) To assess the coverage, efficiency and quality of health services in target communities that will enable existing health facilities and its workers to cope with COVID-19 and related vulnerabilities
c) To examine the economic resilience and adaptive capacity of target communities that will enable them withstand the socio-economic impact of COVID-19 and related vulnerabilities

1.4 Baseline survey Implementation process

Hornsom Consultants and Trading Company conducted this baseline survey with close collaboration with the CARE's Somalia Team. The methodology and tools were developed by the Lead consultant and then reviewed by CARE Somalia team. The tools mainly comprised of

[2] Care Somalia (2021). Improving local capacity to respond to COVID-19 and withstand its socio-economic impact in Somalia. Logical Framework

the household survey questionnaires (Household heads in Afgoye), key informant interview (Health care workers in Mogadishu and Afgoye), focus group discussion questions (Youth, women and VSLA groups) and observation checklists (health care facilities). The baseline survey process started with desk reviews and training of the enumerators (4) Somalis with the local knowledge and experience of the project area. Pretesting of the questionnaire was conducted in Afgoye district to determine and strengthen usability, comprehensiveness and validity of the instruments among few respondents with the same characteristics as the project target population. The co-lead expert and enumerators were then deployed to the field for data collection from 24th July to 9th August 2021 with the guidance and logistic arrangements from the Care Somalia staff.

1.5 Study methodology

The baseline survey was carried out in two regions (Banadir and Lower Shabelle), two districts (Mogadishu and Afgoye districts) and three health facilities. The baseline study aimed to understand the current status of COVID-19 prevention and response awareness and health services provision in project areas. It used mixed methods to collect and analyze information about the current status of COVID-19 prevention and response awareness and health services provision. The study also examined the vulnerabilities, strengths, weaknesses, and risks of the target groups that is women and youths in the study area. A total of 299 household questionnaires were administered in Afgoye district only because the target facility in Mogadishu focused on passengers using the Airport and thus could not depict the true picture. Majority of the health care workers in Afgoye were males (5 out of 8) as compared to health care workers in Mogadishu where 3 out 4 key informants were females. Both the district medical officers were males. 6 FDGs in Afgoye with a total of 65 respondents was conducted. Out of 65 respondents 45 were female while 20 were males (Respondents were from VSLAs, women and youths).

1.5.1 Study design

The baseline survey used mixed methods i.e. quantitative and qualitative research methods to collect and analyze the data. The baseline survey involved participatory approach where key stakeholders were involved including MoH, selected beneficiaries' groups, CARE and NGO staff in Mogadishu and Afgoye districts.

The quantitative component generated baseline values of project indicators and measure awareness levels of COVID-19, capacity of existing health services in relation to COVID-19 management and prevention and economic resilience of beneficiary households in relation to coping with the socio-economic impact of COVID-19. On the other hand, the qualitative component aimed to establish in-depth understanding of COVID-19, its impact on livelihood, health care services and strategies put in place to adopt with the pandemic as well as to further illuminate quantitative results.

1.5.2 Data collection procedure

Data was collected using the following approaches:

- Desk review of project documents and other background documents like, project proposal, log frame, MoH data, COVID-19 impact assessment reports, among others.
- Household Survey tools to collect quantitative indicators that cannot be assessed through secondary data using KOBO collect digital platform.
- The key in-depth interviews (KIIs) and focus group discussions (FGDs) were used to collect the qualitative data. The KIIs were conducted with the MOH officials (district

medical officers) and health care personnel. This was conducted through face-to-face interviews.

- Observations from fieldwork (heath facilities): Observation checklists were used to collect information on the preparedness of the health facilities in terms of COVID-19 measures, communities' behavior and practices towards the laid COVID-19 measures such as wearing masks, performing hand hygiene, and social distance.

1.5.3 Sampling technique

Multi-stage probability sampling plan were used in addition to the full probability sampling to determine the study respondents. The target population came from Mogadishu and Afgoi districts. They are approximately 3,500 households which use the 3 facilities under the study area. To get the sample size we use Yamane's Formula.

$$n = \frac{N}{1 + N(e)^2}$$

$$n = \frac{3500}{1 + 3500(0.05)^2} = 359 = 359$$

Sample size = 359

A total of 299 (83.3% response rates) respondents took part in the household survey in Afgoye district. In addition, 2 MOH officials (2 district medical officers) and 8 health care workers (4 Afgoye and 4 in Mogadishu). A total of 6 FGDs were conducted with a total population of 65 respondents.

Table 2**:** Multi stage probability sampling

Stages	**Multi-stage sampling plan**	**Locations**
Stage 1	Clustering of the divisions in each location	Afgoye and Mogadishu districts
Stage 2	Clustering of vulnerable communities in Afgoye district	Afgoye district
Stage 3	Selection of households (359) (Simple random sampling were used to select the baseline survey respondents)	Afgoye (299 respondents) and Mogadishu (5 respondents) districts

1.5.4 Data management

Data was collected from 24th July to 9th August 2021 through mobile data collection systems (Kobo Collect Toolbox) thus helping in doing real-time quality checks as information was checked for completeness and quality and the field team briefed on the progress. Online data collection platform also helped in avoiding data entry and associated delays.

Collected data were analyzed using both qualitative and quantitative analysis methods. Quantitative analysis was analyzed using Excel Pivot Tables, an advanced data analysis tool within MS Excel and SPSS (Statistical Package for Social Science) version 23.0. Qualitative data collected using KIIs and FGDs transcripts was analyzed using thematic analysis. The team

conducted the analysis using a qualitative analysis software (ATLAS.ti)[3]. The analyzed data was crosschecked for consistency and presented in form of tables, graphs, charts and figures where appropriate. Data was organized into 4 sections including demographic characteristics, awareness of COVID-19; impact of COVID-19 on livelihood and economy; and impact on health care services.

1.5.5 Ethical considerations

Confidentiality and privacy were observed to all respondents during the study. All the information obtained was strictly confidential and the data protected using password, only accessed by the lead expert and other key staff from CARE Somalia. Respondents in the study were kept anonymous and verbal and written consent were sought.

1.5.6 Survey Limitation

Firstly, the language barrier: the survey questions were administered in English and yet localities/communities where the survey was carried out predominately speak Somali. Therefore, it is likely that cross-translation errors could have compromised the quality of the data collected. Secondly, in some instances, systematic random sampling was not consistently followed. This was due to the nature and pattern of those who sought health care services from the 2 health care facilities in Afgoye. The mitigation measures taken was to train the enumerators, pretesting the tools and give feedback on data collected.

1.6 Organization of the report

This section of the report briefly highlights an overview of the overall structure of the baseline report. Section one (1) gives a preview of introductory background information and the objectives of the survey, and methodology of the baseline survey. Key survey findings are discussed and summarized in section two (2). Finally, the last section (four 3) summarizes the conclusion on the report and provides recommendations based on the key findings of the survey.

[3]ATLAS.ti is a qualitative research tool that can be used for coding and analyzing transcripts & field notes, building literature reviews, creating network diagrams, and data visualization.

2.0 SURVEY RESULTS

2.1 DEMOGRAPHIC CHARACTERISTICS

More than half of the respondents (51.8%, 155) lived in the urban areas whereas 48.2% lived in rural areas. Approximately 43% (n = 130) of the respondents were head of households whereas 57% were not the head of the household. Majority of the respondents were aged 25-29 years (n = 68), followed by 30-34 years (n = 53), 40-44 years (n = 51), 35-39 years (n = 45); 18-24 years (n = 34), 45-49 years (n = 30), and only 14 respondents were aged above 50 years. Approximately 79% of the respondents were female as compared to 21% who were male. Seventy-four percent (n = 222) of the respondents had no education, followed by primary level of education (n = 40), secondary (n = 28) and post-secondary education (n = 9). Majority of the respondents are married and spouse present (n = 123), those who are married and spouse not present (n = 81), divorced (n = 28), single (n = 26), widowed (n = 23), and separated (n = 18). Seventy-one percent (n = 212) don't have any chronic illness, 12% (n = 36) have chronic illness, and 17% (n = 51) who don't know. Approximately 69% (n = 198) respondents live with children under 18 years, 19% (n = 55) live with people in a COVID-19 risk group (people above 65 yrs), and 5% (n = 14) live alone as shown by table 2 below.

Table 3: Demographic variables

Variables	**Frequency (n)**	**Percent (%)**
Residence of survey respondents		
Urban	155	51.8
Rural	144	48.2
Head of household		
Yes	130	43
No	169	57
Age of respondents		
18-24 years	34	11.5
25-29 years	68	22.7
30-34 years	53	18.0
35-39 years	45	16.0
40-44 years	51	17.1
45-49 years	30	10.0
Above 50 years	14	4.7
Gender		
Male	63	21
Female	236	79
Level of education		
None	222	74.2
Primary	40	13.4
Secondary	28	9.4
Post-secondary	9	3.0
Marital status		
Single	26	8.7
Married and spouse present	123	41.1

Married and spouse not present	81	27.1
Separated	18	6.0
Divorced	28	9.4
Widowed	23	7.7
Presence of chronic illness		
Yes	36	12
No	212	71
I don't know	51	17
Members of household		
I live alone	14	5
I live with children under 18 years	198	69
I live with people in a COVID-19 risk group (people above 65 years)	55	19
None of the above	19	7

2.2 SURVEY FINDINGS

2.2.1 Awareness of COVID-19 Virus

World Health Organization (2020) defined Coronavirus disease (COVID-19) as an infectious disease caused by the SARS-CoV-2 virus that mostly cause mild to moderate respiratory illness and recover without requiring special treatment while some will become seriously ill and require medical attention. [4] Seventy-five percent (75%) of the respondents who took part in the survey were aware of COVID-19 virus. 76.2% of female respondents were aware of COVID-19 virus as compared to 69.8% male counterparts. 53.3% of the persons aged over 50 years had knowledge of COVID-19 virus. In addition, all the health care workers were aware of the COVID-19 virus. Most of them were able to define and briefly describe COVID-19. They stated that Corona virus is viral infection that affects the respiratory system and has symptoms such as coughing, fever and difficulty in breathing. Furthermore, it is a pandemic that has affected the health, social and economic aspects of the human beings. The finding of the survey supports the above as highlighted by a nurse from Afgoye district who stated that "*Corona virus is a pandemic that affects the respiratory system of patients and spreads through droplets.*" A clinician from Mogadishu stated that "*Corona virus commonly known as COVID-19 is a severe pneumonia which affects the respiratory system and causes difficulty in breathing*."

The finding is supported by our results where majority of the respondents got the information from Radio and/or TV (68.6%, n = 153), social media (19.2%, n = 43), friends (9.7%, n = 25), and only one participant stated that they got the information from door to door visits by MOH officials and through SMS each. Radio is the most trusted source of information. Save the Children's COVID-19 assessment survey report reveals that the most trusted sources of

[4] World Health Organization (2020). Coronavirus disease (COVID-19). https://www.who.int/health-topics/coronavirus#tab=tab_1

information for COVID-19 are: Radio; TV; family members; community health workers, social media excluding WhatsApp; community leaders; Religious leaders and friends[5].

Table 4: Covid-19 awareness and source of information by socio-demographic variable

Variables	**COVID-19 awareness**		**If yes, where did you get the information?**				
	No	Yes	Radio or and TV	Friends	Social Media	Door to Door visit by MOH	SMS
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Residence							
Urban	49 (31.6)	106 (68.4)	49 (46.2)	20 (18.9)	36 (34.0)	0 (0.0)	1 (0.9)
Rural	26 (18.2)	117 (81.8)	104 (88.9)	5 (4.3)	7 (6.0)	1 (0.9)	0 (0.0)
Age							
18-24 years	8 (23.5)	26 (76.5)	15 (57.7)	3 (11.5)	8 (30.8)	0 (0.0)	0 (0.0)
25-29 years	11 (16.2)	57 (83.8)	35 (61.4)	5 (8.8)	16 (28.1)	1 (1.8)	0 (0.0)
30-34 years	11 (20.4)	43 (79.6)	25 (58.1)	10 (23.3)	8 (18.6)	0 (0.0)	0 (0.0)
35-39 years	12 (26.7)	33 (73.3)	26 (78.8)	3 (9.1)	3 (9.1)	0 (0.0)	1 (3.0)
40-44 years	13 (25.0)	39 (75.0)	32 (82.1)	1 (2.6)	6 (15.4)	0 (0.0)	0 (0.0)
45-49 years	13 (43.3)	17 (56.7)	12 (70.6)	3 (17.6)	2 (11.8)	0 (0.0)	0 (0.0)
Above 50 years	7 (46.7)	8 (53.3)	8 (100)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Gender							
Male	19 (30.2)	44 (69.8)	23 (52.3)	4 (9.1)	15 (34.1)	1 (2.3)	1 (2.3)
Female	56 (23.8)	179 (76.2)	130 (72.6)	21 (11.7)	28 (15.6)	0 (0.0)	0 (0.0)
Education							
None	50 (22.6)	171 (77.4)	135 (78.9)	15 (8.8)	21 (12.3)	0 (0.0)	0 (0.0)
Primary	17 (42.5)	23 (57.5)	10 (43.5)	5 (21.7)	7 (30.4)	0 (0.0)	1 (4.3)
Secondary	7 (25.0)	21 (75.0)	6 (28.6)	5 (23.8)	9 (42.9)	1 (4.8)	0 (0.0)
Post-secondary	1 (11.1)	8 (88.9)	2 (25.0)	0 (0.0)	6 (75.0)	0 (0.0)	0 (0.0)

[5] Save the Children (2020). Risk communication & community engagement (RCCE). Somalia COVID19 Rapid Assessment Survey Report (April 2020)

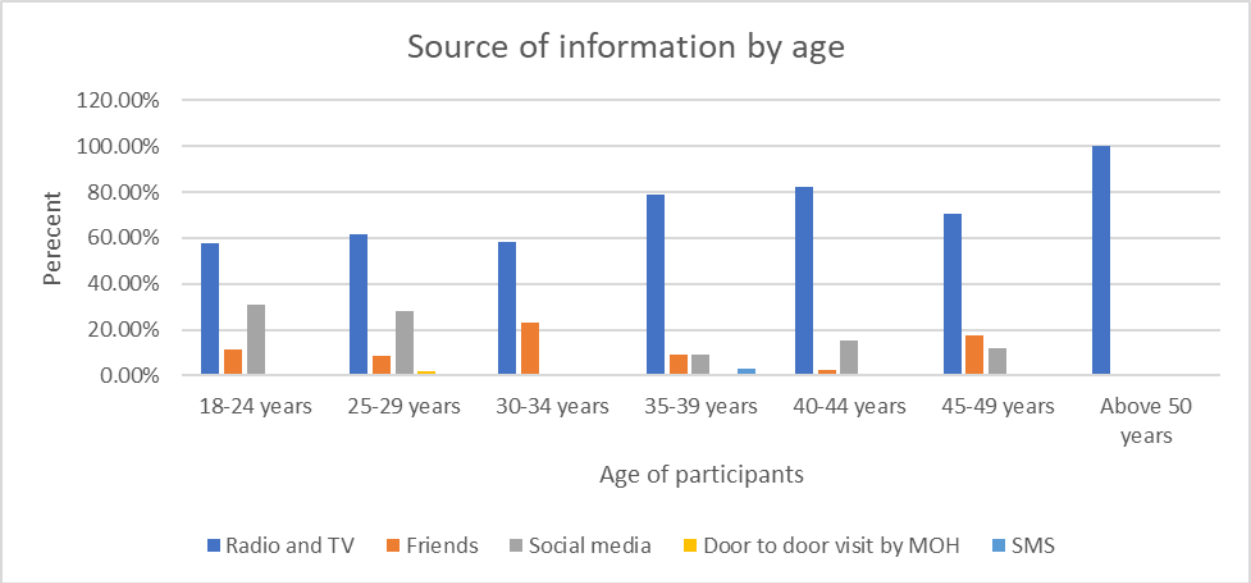

Figure 1: Source of information by age

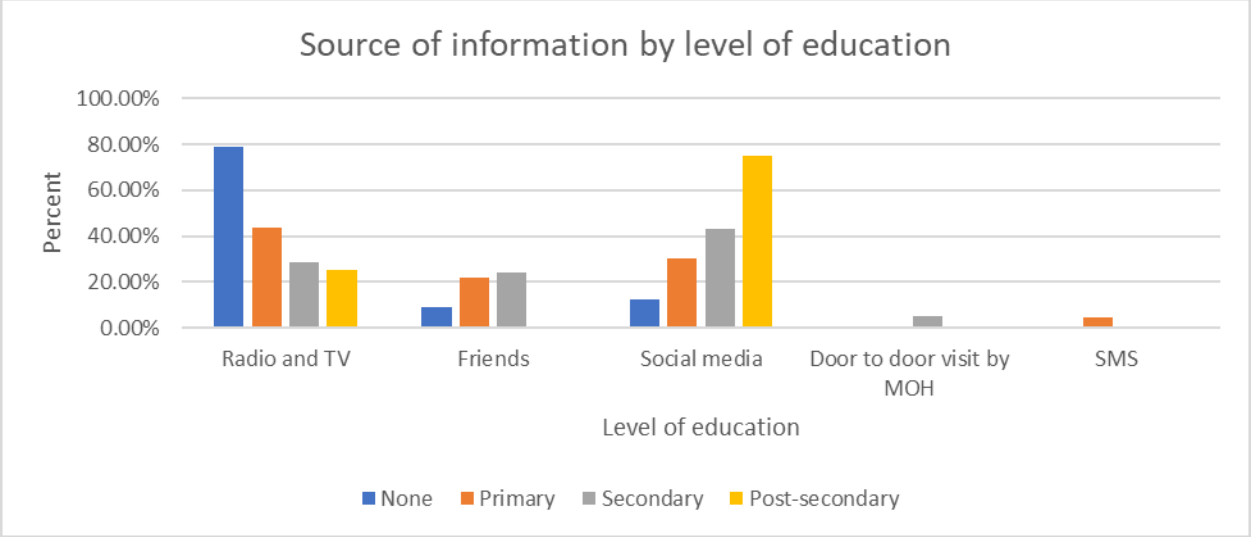

Figure 2: Source of information by level of education

All healthcare workers in Mogadishu and 50% in Afgoye stated that they know of the family members and friends who had confirmed COVID-19 virus. Only 5% (n = 16) of the respondents stated that they had the knowledge of being infected with COVID-19 virus. 14 out of 16 had mild symptoms and only 2 respondents had severe signs and symptoms. The patients at risk include older people and those with underlying medical conditions like cardiovascular disease, diabetes, chronic respiratory disease, or cancer are more likely to develop serious illness.[6] Sixteen percent (16%, n = 48) of the respondents know the risks associated to the COVID-19 virus. They reported that the risk includes age (the elderly), chronic illnesses such as cancer,

[6] World Health Organization (2020). Coronavirus disease (COVID-19). https://www.who.int/health-topics/coronavirus#tab=tab_1

diabetes, hypertension, asthmatic, and medical complications. In addition, 10% (n = 31) of the respondents stated that they are at risk of getting COVID-19 Virus because they are elderly, they have chronic illness such as diabeties, they are hypertensive, and most of the time they don't observe the government measures and advisories such as wearing mask and no hand shaking as a result of additional cost to purchase masks, and cultural issues like hand shaking as a sign of respect.

According to WHO (2020), COVID-19 virus can spread from an infected person's mouth or nose in small liquid particles when they cough, sneeze, speak, sing or breathe. These particles range from larger respiratory droplets to smaller aerosols. It is important to practice respiratory etiquette, for example by coughing into a flexed elbow, and to stay home and self-isolate until you recover if you feel unwell.[7] Fifty-three percent (53%) of the respondents who took part in the household survey reported the knowledge on signs and symptoms of COVID-19 and mentioned that high fever, coughing, headache, weakness and fatigue, difficulty in breathing, and loss of smell and taste are some of the signs and symptoms someone should be worried about.

The best way to prevent and slow down transmission is to be well informed about the disease and how the virus spreads. Protect yourself and others from infection by staying at least 1 metre apart from others, wearing a properly fitted mask, and washing your hands or using an alcohol-based rub frequently. Get vaccinated when it's your turn and follow local guidance.[8] Sixty-four percent of respondents reported that they perform hand hygiene, 37% put on masks properly, and 35% maintain social distance as a methods of preventing COVID-19. Urban respondents put on masks properly and maintain social or physical distance as compared to their rural counterparts who perform hand hygiene more frequently (Figure 3).

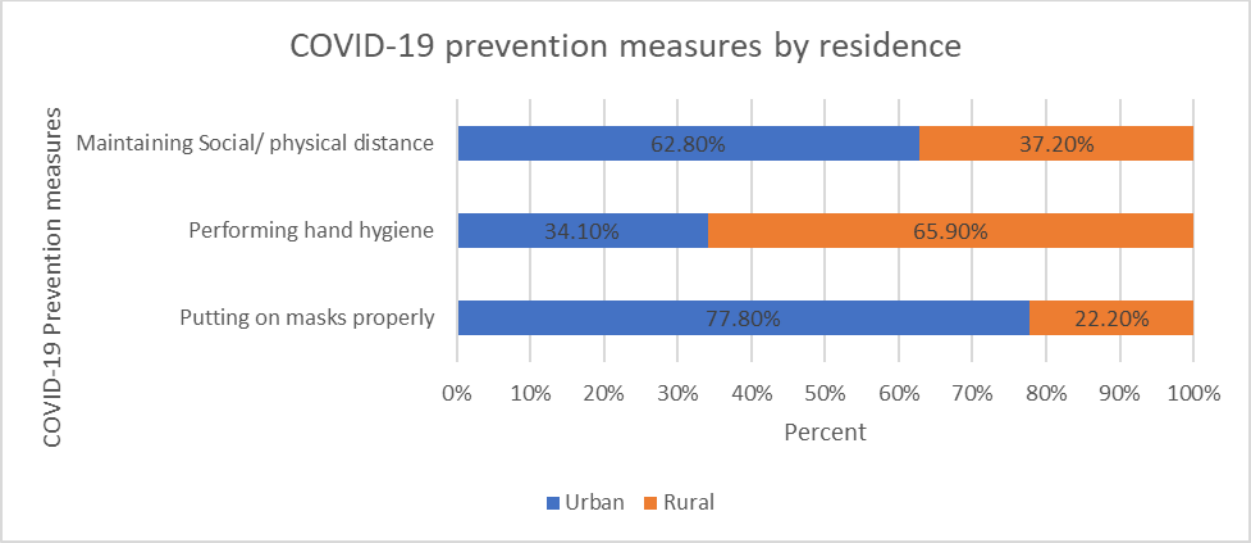

Figure 3: Prevention measures taken to cope up with COVID-19 virus

[7] World Health Organization (2020). Coronavirus disease (COVID-19). https://www.who.int/health-topics/coronavirus#tab=tab_1

[8] World Health Organization (2020). Coronavirus disease (COVID-19). https://www.who.int/health-topics/coronavirus#tab=tab_1

Coping mechanisms to prevent COVID-19 virus

The coping mechanisms which the community members are using include wearing of masks; social distance; handwashing; and avoiding public gathering. A participant from FGD in Afgoye stated that "*After we received the news of Corona in Somalia, I constantly teach my daughter how to wash hands in the recommended way. I do this to protect my family. Schools were closed and I encouraged my family not leave the house for a month because we were afraid. To keep myself updated about the virus, I listen to the radio and follow the advice of health officials*".

2.1.2: Impact of COVID-19 on Economic and livelihood

The baseline survey identified the sources of income and sector of economy among the respondents in Afgoye district. The survey found out that 26.4% of the respondents own small business/income generating activity, followed by 17.1% who have temporary or wage work, 12.4% have other sources of income, 12.4% currently have no source of income, 9.7% have informal work, 6.7% depend on remittances from abroad, 4.0% depend on the support from networks of friends, family and others, 3.7% have formal paid work in private sector, 3.01% rely on savings made in the past, 2% have formal paid work in public sector, 1.6% unemployment benefit or other subsidies, 0.7% depend on government aid program, humanitarian institutions or other programs, and 0.3% pension. Approximately 37.5%, (n = 112) keep livestock, followed by 26.4% (n = 79) agriculture, 19.1% (n = 45) small business (trade), 6.4% (n = 19) formal paid work, 5.3% (n = 16) other, 4.0% small business (services), and 1.3% small business (technical) as shown by table 3 below.

Table 5: Participant's main source of income

Main source of income	**Count**	**Percent**
Now we have no sources of income	37	12.4%
Own small business/Income Generating Activity	79	26.4%
Informal work of one or more household members (selling in the street)	29	9.7%
Temporary / wage work	51	17.1%
Formal paid work of one or more household members (employee) in private sector	11	3.7%
Formal paid work of one or more household members (employee) in public sector	6	2.0%
Government aid program, humanitarian institutions or others programs	2	0.7%
Savings made in the past	9	3.0%
Support from your networks of friends, family or others in your country of residence	12	4.0%
Remittances obtained from abroad	20	6.7%
Pension	1	0.3%
Unemployment benefit or other subsidies	5	1.6%
Other (livestock and agro-pastoralists)	37	12.4%
Sector of the economy		
Agriculture	79	26.4%
Livestock	112	37.5%

Formal paid work	19	6.4%
Small business/IGA (trade): grocery shop/Mini-market (house, drinks, food items), Coffee shop, Clothing/Accessories shop, Electronics shop, miscellaneous items shop.	57	19.1%
Small business/IGA (services): snack house/bar, restaurant, Transportation of people, Beauty parlor, hair salon, security, housework	12	4.0%
Small business/IGA (technical work): maintenance of equipment, tailor/garment, construction, blacksmith, carpentry, painting, welding	4	1.3%
Other (wage and manual works)	16	5.3%
	299	100

The COVID-19 crisis affected the livelihood of the Somalis as a result of the contagion and restrictions measures and disruption of both global and national supply chain levels. These posed a severe risk to the purchasing power of the households and increased the price of essential food items.[9] From the study, Forty-one percent (41%, n = 122) indicated that COVID-19 have affected their livelihood. They reported that COVID-19 has led to inflation and increased prices of commodities, movement restrictions, reduced income and salaries, loss of jobs, lack of ready market, high cost of transportation, inadequate credit facilities and stiff business. The baseline survey report identified loss of jobs (26%) as one of the biggest impact COVID-19 has on households followed by salary reduction (24%), transport limitation (22%), change of activity or sector (20%), increased demand of goods and services (14%) and 11% livelihoods inputs are too expensive or inaccessible among others. Thirty-seven percent (37%, n = 110) of the respondents stated that COVID-19 virus has affected the economy of the country. Majority mentioned that COVID-19 has led to loss of jobs, inflation, reduced income and high cost of transportation due to restrictions on movement. In addition, health care workers also agreed that the pandemic has increased inflation in the country; has led to delayed salaries; closure of business; loss of jobs; reduction in the export and imports of goods and services and closure of schools.

Respondents from Women FGD agreed that COVID-19 has led to the significant job loss and stated "*Before Coronavirus we were working and now we are at home because of job loss. Food items price also skyrocketed and feeding the family became a challenge in addition to the payment of the bills*."

[9] MERCY CORPS (June 2020). Assessment and Recommendations: Economic Impact of COVID-19 in the Somali Region

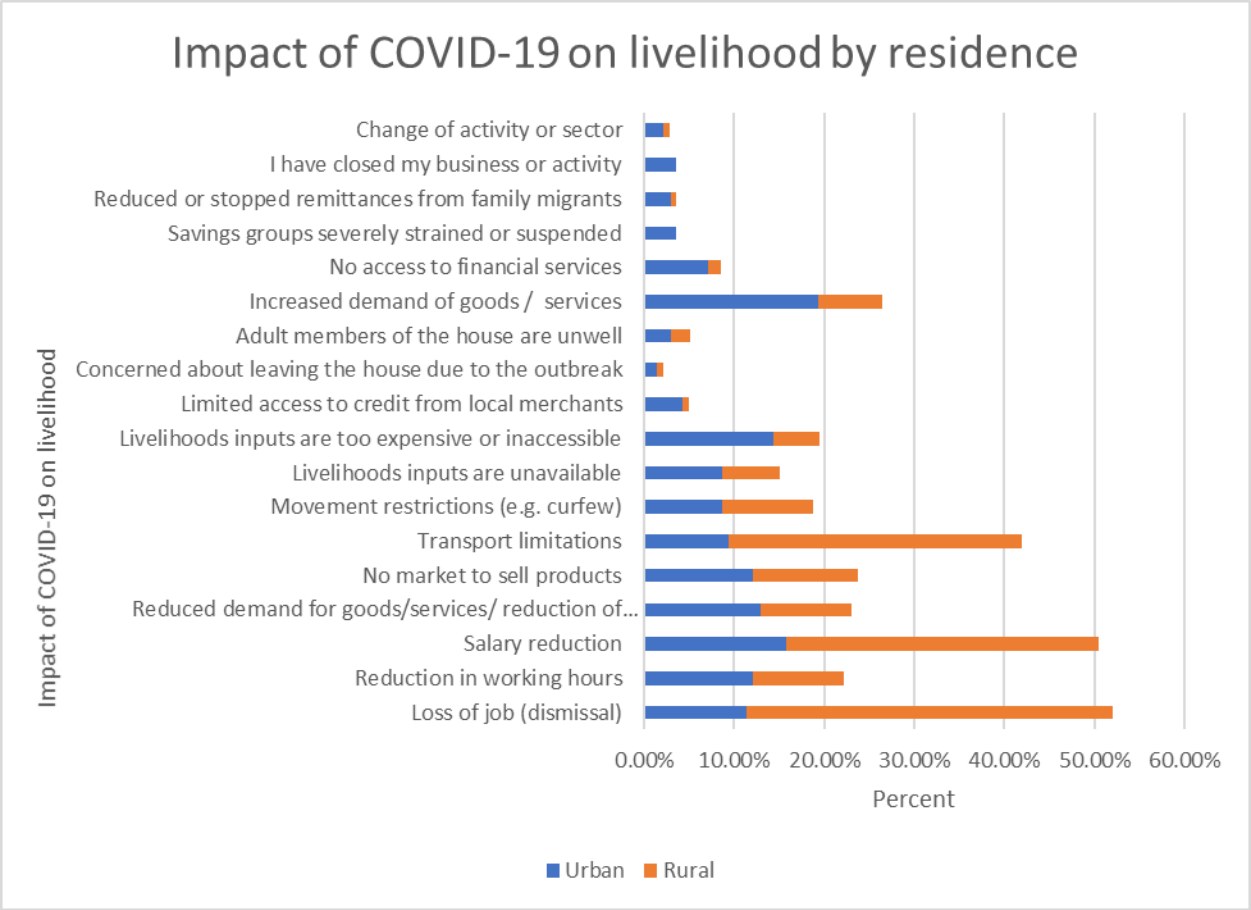

Figure 4: Impact of COVID-19 on livelihood

The results of the baseline indicated that 23.2% (n = 69) respondents agreed that the pandemic has led to the reduction of their income by a margin of 50-75%; followed by 13.8% respondents who said that COVID-19 has led to reduction of less than 25% of their income; 11.6% COVID-19 led to reduction of income by more than 76%; 9.4% respondents stated that there was a reduction of income between 25-49%; 4.0% stated that COVID-19 affected their situation because they have more expenses as compared to before the crisis. Participants stated that they have been forced to relocate to the village, some have closed up the business, and others have changed their lifestyle and reduced the meals they eat in a day.

A young male respondent from FGD reported that "*I lost my job and had to travel back to the village since I was unable to cope up with the life in the city. I could not afford buying commodities because the prices of commodities went up and life became unbearable.*"

Another woman respondent from FGD 4 stated that "*I could not provide three meals a day for my family because my business closed down. Currently we can only afford two meals and most of the time I depend on the neighbours and friends because even my savings have been finished.*"

2.1.3: Impact of COVID-19 on health

Somalia's capacities to prevent, detect and respond to any global health security threat scored six out of 100 as measured by the Health Emergency Preparedness Index in 2016. There are two healthcare workers per 100,000 people, compared to the global standard of 25 per 100,000.[10] The research conducted by Amnesty International finds out that access to health facilities for Covid-19 patients has been severely limited with just one hospital in the capital Mogadishu managing all Covid-19-related cases across the south-central region during the first wave of infections.[11] This shows that Somalia health care sector was not prepared and ready to handle outbreaks and pandemics. Although the findings reported that most of the facilities were open, the number of the patients who seek health care services has reduced, the quality of health care services has gone down because of fear and lack of adequate PPEs to handle COVID-19 patients.

A clinician from Afgoye stated that "*We don't have enough PPEs and equipment to help us assist the patients with COVID-19 signs and symptoms. We don't have adequate isolation wards. Sometimes we had to use a single nasal oxygen cannula for multiple patients. This is sad because it limits and affects the quality of health care services that we provide*."

A nurse from Afgoye reported that "*We have not been trained on how to handle COVID-19 patients and what to do in order to prevent the spread the COVID-19 especially in the health care facility. Areas of concern include Infection Prevention and Control measures, Waste management, COVID-19 management protocols among others. These trainings are key to protect and every patient who visits our facility*."

The baseline survey indicates that the majority of the respondents 45.8%, (n = 137) stated that essential health care services were always available, followed by 34.8% (n = 104) those who stated that the services were partially or sometimes available, those who don't know 16.4% (n = 49), and 0.3% (n = 9) respondents stated that the services were not available. Majority of the respondents 66.2% (n = 198) stated that their health situation had remained the same for the past three months, followed by 16.0% (n = 48) those who stated improved, 11.4% worsened (n = 34), and 6.4% (n = 19) respondents stated they don't know. Approximately 47% (n = 140) of the respondents stated that they can afford to access health care as usual since COVID-19 pandemic. Majority of the respondents 51.8% (n = 155) stated that the cost of health care since COVID-19 remained the same, followed by 40.7% (n = 121) who stated that the cost of health care increased, and 6 respondents stated that the cost had decreased.

The finding has been supported by health care workers who unanimously agreed that they still continue to provide health care services and thus the sector has not been adversely affected by COVID-19. A nurse from Afgoye stated that "*we still continue to provide essential health care services to our clients within our catchment area. The cost of services are still the same and the quality of the services have not been affected for the essential services*."

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[10] SOMALIA COUNTRY PREPAREDNESS AND RESPONSE PLAN (CPRP) COVID-19. UN and partners' support towards the immediate humanitarian and socio-economic consequences of COVID-19 August 2020(v2). https://reliefweb.int/sites/reliefweb.int/files/resources/CPRP%20Final%20Subow%2C%2026%20April%20%281%29.pdf

[11] Somalia: Wholly Inadequate Covid-19 Response Highlights Need to Use Debt Relief to Invest in Healthcare. https://www.africanews.com/2021/08/17/somalia-wholly-inadequate-covid-19-response-highlights-need-to-use-debt-relief-to-invest-in-healthcare/

A woman from FGD said that "*I have been attending my antenatal clinics in the hospital and when I visit, I am able to get the services that I require*." Another respondent stated that "*When my mum was sick, I was afraid and worried on whether we will be assisted at the hospital. When I reached Afgoye hospital we were attended and thank to the health care workers that my mum recovered as fast as possible*."

Majority (64%) of the respondents stated that facilities have hand sanitizer, 61% perform hand hygiene facilities, 51% have masks, 47% keep social and physical distance, 29% maintain cough etiquette and only 20% perform universal screening of all patients for fever and respiratory.

Table 6: Facility preparedness towards COVID-19

Do health care facilities have these facilities? Have you ever or seen them using them as instructed by WHO?	**Frequency**	**Percent**
Washing hands with soap for 60 seconds	182	61%
Have hand sanitizer	192	64%
Keep social and physical distances	141	47%
Maintain cold and cough time hygiene	85	29%
Universal screening of all patients for fever & respiratory	60	20%
Provided PPE	1	1%
Provided Mask	152	51%
All of these	4	1%
I don't know	37	12%
	854	287%

Key stakeholders in the survey areas

The ministry of health is working closely with the local organizations, communities and other partners in the project locations. The organizations in the project area include Juba foundation who work with the Afgoye general hospital and STS International who work closely with the 21st October health facility. Other stakeholders in the project area include the European Union, Action Against Hunger, Caafimaad and World Health Organization. A health care worker Afgoye stated that "*STS International work closely with us and they have been in the forefront in ensuring that we have the facilities such as Handwashing point at the health facility that is adequately sufficient and functional. They also play critical role in sensitizing the communities through providing key COVID-19 messages in banners*."

A clinician from Afgoye said that "*we work hand in hand with Juba foundation. They have been supporting our facility in the provision of essential health care services to the community. In terms COVID-19, Juba foundation has been able to support us by raising awareness of the virus to the community, supporting the health facilities with essential items such as gloves and handwashing points*."

3.0 CONCLUSIONS AND RECOMMENDATIONS

3.1 CONCLUSIONS

The baseline survey established the current status of COVID-19 prevention and response awareness and health services provision in project areas. Furthermore, it sought to understand the root causes and inherent complexity of vulnerability of target populations to the impact of COVID-19 so that project interventions are guided by critical analysis of social, economic and health factors surrounding capacity to respond to COVID-19.

Most of the respondents have heard about the COVID19 virus, however, a significant number of elderly respondents have limited knowledge about the COVID-19 virus. It is also evident that females were more aware of COVID-19 virus spread and prevention measures as compared to their male counterparts. Most people received information from the radio, followed by the friends, social media and SMS. Traditional channels such as Radio and or television is the most trusted source of information among all age groups, residence of the respondents and gender. Respondents with secondary and post-secondary level of education prefer social media as compared to Radio.

Most of the respondents were able to access the health care facilities and get the attention of the health care workers. Although the facilities are open the number of patients attended by health care workers have reduced. Lack of personal protective equipment (PPE) and inadequate water and sanitation in healthcare facilities (HCF) creates unsafe conditions for HCWs and patients; contributing to disruptions in essential services. Health care workers from Afgoye district stated that they do not have adequate capacity to handle COVID-19 patients because they don't have enough isolation wards and equipment such as oxygen cylinders and ventilators. In addition, the facilities have inadequate staff who have not been trained on handling COVID-19 patients. The essential health care services were always available, and most of the respondents stated that their health situation had remained the same for the past three months and improved.

Last but not least, Somalia COVID-19 restriction measures and lockdown from March 2020 had significant real and direct impact on livelihood of Somalis. Majority of the respondents were affected by movement restrictions and other COVID-19 related Government directives, disruptions to imports and domestic supply chains, and access challenges, the availability of basic commodities, as well as increase in prices. It was evident that majority of the respondents reported that COVID-19 has caused inflation, increased the price of commodities, lack of ready market for goods and services, loss of jobs, salary cuts or reduction, reduced demand of certain goods and services and business closure. In order to deal with the impact of COVID-19, majority of the respondents who lost jobs did manual work in order to earn an income, ate once or twice a day because of increased prices of commodities, migrated back to the village and survived from hand to mouth without saving anything.

The key stakeholders included Juba foundation who work with the Afgoye general hospital and STS International who work closely with the 21st October health facility. Other stakeholders in the project area include the European Union, Action Against Hunger, Caafimaad (Somalia Health Info) and World Health Organization.

3.2 RECOMMENDATIONS

The following are some of the recommendations:

- It is important to engage the community to understand the gaps in perception, knowledge, and attitudes on COVID-19 and it is key to strengthen coordination for better preparedness and ensuring effectiveness in mitigation efforts. This can also be done

through hygiene promotion and provision and supply of the hand hygiene facilities in schools, health care facilities and markets.

- The project should use Radio and or TV which is the most preferred and trusted media in disseminating information related to COVID-19 virus and prevention strategies.
- The project can engage the community leaders, religious leaders, and community-based workers in designing and implementation communication and advocacy strategies.
- Using the evidence generated, set a proper plan, a two-way communication to regularly transfer the findings and promote preventive measures recommended based on the findings and health authority recommendations. This will result in improving the coordination between the public, national and international partners working at the front line of prevention of the disease.
- The ministry of health and other partners such as Juba foundation and STS international who are supporting the facilities should equip the health care facilities with COVID-19 virus screening kits, in vitro diagnostics kits and PPEs.
- Health care workers should also be trained and equipped with necessary skills in order to effectively manage COVID-19 patients. It is necessary that they receive the following training rational use of PPEs, Infection Prevention and Control (IPC) training, Hospital cleaning and disinfection, Waste management, Advanced screening and triage skills, Advanced COVID-19 management protocols, Skills on using equipment's to deal with COVID-19, and Psychological and counselling training.
- Humanitarian partners in collaboration with government should improve the livelihood of the community through provision of income generating projects through the already established VSLAs and women and youths such as vocational training.
- Humanitarian partners in collaboration with government should also come up with the measures such as conditional and unconditional cash transfers to cushion families which have been hit hard by COVID-19 and have lost their jobs and income.

4. ANNEXES

4.1. Annex I: Household questionnaire

Dear Participant,

Thank you for taking part in this study to help improve actions taken in response to COVID-19 pandemic and to inform the response to similar future outbreaks.

This study will involve answering a 45-minute survey which will be asking you questions relating to the impact of coronavirus. Please do not start until you will have enough time to complete it in one go. This study is conducted by Hornsom Consultants and Trading Company and the data is collected by Mr. Isse.

By taking part, you are agreeing that you have read and understood the information about the study below. Please ensure you have read and understood this information before continuing.

The purpose of this household questionnaire is to establish the current status of COVID-19 prevention and response awareness and health services provision in Afgoye and Mogadishu districts.

Consent

I understand that:

- My participation is completely voluntary.
- All my answers will be used for scientific research to improve actions taken in response to the coronavirus pandemic and to inform the response to similar future outbreaks.
- My data will be stored securely, however, no personal data will be stored, and my answer will be completely anonymous.
- My data gathered in this study will be shared with relevant researchers and government agencies.
- Because I am submitting anonymous data, it will not be possible to withdraw my answers after they have been submitted.

Please note that you can stop the survey at any time. This will not entail any penalty, and it will not affect the services (health care services or others) that you receive.

By ticking the box, you are agreeing that you are at least 18 years old, that you have read the information about the study, and that you voluntarily agree to take part in it.

[ ] I agree to participate in this study

Questions

Basic information

1. Date of interview DD/MM/YYYY _____
2. Name of the Enumerator _____
3. Name of the consultancy firm _____
4. Location (Village, district, region) _____
5. GPS location _____
6. Is it urban or rural

a) Urban □
b) Rural □
c) Mixed between urban and rural □
d) Other, please specify _____

General information

7. Are you the "head of the household
   a) Yes □
   b) No □
8. What is your age?
a) 18-24 years □
b) 25-29 years □
c) 30-34 years □
d) 35-39 years □
e) 40-44 years □
f) 45-49 years □
g) Above 50 years □
9. What is your gender
a) Male □
b) Female □
10. What is level of education?
a) None □
b) Primary □
c) Secondary □
d) Post secondary □
11. What is your marital status?
a) Married and spouse present □
b) Married and spouse not present □
c) Divorced □
d) Widowed □
e) Separated □
f) Single □
g) Other _____
12. Do you have a chronic illness?
a) Yes □
b) No □
c) Don't know □
13. Who lives in your household besides yourself? Choose as many as apply
a) I live alone □
b) I live with children under 18 □
c) I live with people in a COVID-19 risk group (people over 65 years and/or with chronic disease) □
d) None of the above □
14. How many household members do you live with? _____

Awareness of COVID-19 virus

15. To your knowledge, are you, or have you been, infected with COVID-19?
a) No □
b) Yes □
16. If "yes": Was it:
a) Mild □
b) Severe □
17. Was it:
a) Confirmed by a test □
b) Not confirmed by a test □
18. Are you aware of COVID-19 virus?
a) Yes □
b) No □
19. If yes, where did you get the information?
a) Radio and/or TV □
b) Social media, □
c) SMS □
d) Door to door visits by the MOH officials □
e) Friends □
20. Do you know the risks associated to the COVID-19 visurs?
a) Yes □
b) No □
21. If yes, please specify? _____
22. Do you know any signs and symptoms of COVID-19 virus?
a) Yes □
b) No □
23. If yes, please specify? _____
24. Are you at risk of getting COVID-19 virus?
a) Yes □
b) No □
25. If yes, please specify _____
26. How can you protect yourself from COVID-19 virus?
a) Putting on masks properly □
b) Performing Hand hygiene □
c) Maintaining Social/physical distance □
d) Other please specify _____
27. Are you aware of the government directives?
a) Yes □
b) No □
28. If yes, please specify? _____

Economic impact

29. What is your main source of income? (Select one)
a) Now we have no sources of income
b) Own small business/Income Generating Activity

c) Informal work of one or more household members (selling in the street)
d) Temporary / wage work
e) Formal paid work of one or more household members (employee) in private sector
f) Formal paid work of one or more household members (employee) in public sector
g) Government aid program, humanitarian institutions or others programs
h) Bank loans or debts
i) Savings made in the past
j) Support from your networks of friends, family or others in your country of residence
k) Remittances obtained from abroad
l) Pension
m) Unemployment benefit or other subsidies
n) Other: _____

30. What sector does the main source of income belong to?
a) Agriculture
b) Livestock
c) Fishery
d) Formal paid work
e) Small business/IGA (trade): grocery shop/Mini-market (house, drinks, food items), Coffee shop, Clothing/Accessories shop, Electronics shop, miscellaneous items shop.
f) Small business/IGA (services): snack house/bar, restaurant, Transportation of people, Beauty parlor, hair salon, security, housework
g) Small business/IGA (technical work): maintenance of equipment, tailor/garment, construction, blacksmith, carpentry, painting, welding
h) Other: _____
31. Please assess your private financial situation since COVID-19 pandemic:
a) Improved □
b) Remains the same □
c) Worse □
d) Don't know □
32. Do you think COVID-19 affected the economy of the country?
a) Yes □
b) No □
33. If yes, please explain/give examples? _____
34. Has COVID-19 affected your livelihood?
a) Yes □
b) No □
35. If yes, please explain? _____
36. Have your sources of income changed from last year at the same period?
a) Yes
b) No
c) I don't know
d) Prefer not to answer
37. How has the COVID-19 crisis impacted on your sources of income of your household? (Select all that applies)
a) Loss of job (dismissal)

b) Reduction of working hours
c) Salary reduction
d) Reduced demand for goods/services/ reduction of clients
e) No market to sell products
f) Transport limitations
g) Movement restrictions (e.g. Curfew)
h) Livelihoods inputs are unavailable
i) Livelihoods inputs are too expensive or inaccessible
j) Limited access to credit from local merchants
k) Concerned about leaving the house do to the outbreak
l) Adults members of the house are unwell
m) Increased demand of good/services
n) No access to financial services
o) Savings groups severely strained or suspended
p) Reduced or stopped remittances from family migrants
q) I have closed my business or activity
r) Change of activity / sector
s) Other: _____

38. How has Covid-19 impacted on the economic situation of your household?
a) Completely affected because of reduction of 76% or more of our income
b) Very affected (reduction between 50% and 75% of our income)
c) Affected (reduction between 25% and 49% of our income)
d) Little affected (reduction of less than 25% of our income)
e) Affected because the prices of essential items and services have risen
f) Affected because now I have more expenses than before the crisis (masks, alcohol, cleaning, technology for distance education, etc.)
g) It has not been affected
h) It has been improved

Health impact

39. Do health care facilities have these facilities? Have you ever or seen them using them as instructed by WHO?
a) Washing Hands with soap for 20 seconds
b) Have hand sanitizer
c) Keep social and physical distances
d) Maintain cold and cough time hygiene
e) Universal screening of all patients for fever and respiratory symptoms and separating those possibly contagious from those who seem healthy
f) Provided PPE
g) Provided mask
h) All of these
i) I don't know

40. Are essential health care services available since COVID-19 pandemic?
a) Always available
b) Partially or sometimes available
c) Not available

d) I don't know

41. Please assess your health situation over the past three months:

a) Improved □
b) Remains the same □
c) Worse □
d) Don't know □

42. I can afford to access health care as usual since COVID-19 pandemic.

a) Yes □
b) No □

43. The cost of health care since COVID-19 has:

a) Increased □
b) Remains the same □
c) Decreased □
d) Don't know □

□ **I hereby give my consent to Hornsom Consultants and Trading Company to collect, handle and store my personal data.**

Household representative signature_____Date and place_____

Enumerator/interviewer signature_____Date and place_____

Thank you for participating

Annex II: Key In-depth Interview for MOH

Dear Participant,

Thank you for taking part in this study to help improve actions taken in response to COVID-19 pandemic and to inform the response to similar future outbreaks.

This study will involve answering a 30-minute survey which will be asking you questions relating to the impact of coronavirus. Please do not start until you will have enough time to complete it in one go. This study is conducted by Hornsom Consultants and Trading Company and the data is collected by Mr. Isse. By taking part, you are agreeing that you have read and understood the information about the study below. Please ensure you have read and understood this information before continuing.

The purpose of this household questionnaire is to establish the current status of COVID-19 prevention and response awareness and health services provision in Afgoye and Mogadishu districts.

Date (DD/MM/YYYY): _____ Location (Village/district/region): _____

GPS Location: _____

Name of the enumerator: _____

Questions

1. Name of the district you are in charge or overseeing?
2. Are you aware of COVID-19 virus? Briefly explain.
3. Have you, any of your family members or friends been affected by the COVID-19 virus?
4. Briefly explain what you understand about the impact of COVID-19 virus on health services?
5. Do your facility or facilities still open and readily accessible by the population? How many facilities in your district serve as COVID-19 isolation and treatment center?
6. Has the number of patients who access the facilities affected since COVID-19 pandemic?
7. Does the facility has enough facilities to handle COVID-19 patients such as wards and equipments?
8. Do you think the health care services offered are adequate in terms of enough staff, who are trained, have enough PPEs and comfortable to deal with COVID-19 pandemic? Which kind of training have you offered to health care workers?
9. What are the gaps in the health sector that can be enhanced to improve access to the health services? What have you done to improve the health care services?
10. Briefly explain what you understand about the impact of COVID-19 virus on economy?
11. What are the current coping mechanisms in the target communities in regard to COVID-19 and related vulnerabilities?
12. Do you think the current COVID-19 prevention and management practices improve the awareness, reduce the infection and burden to health care facilities?
13. What are the current NGO, government, local community coordination and information sharing systems/platforms as well as awareness raising activities and identify coordination and awareness raising gaps?
14. What are key recommendations to improve the economic and health issues in your area?

15. Any other suggestions on how to improve the awareness on COVID-19?

I hereby give my consent to Hornsom Consultants and Trading Company to collect, handle and store my personal data.

Name of the interviewee signature_____Date and place_____

Enumerator/interviewer signature_____Date and place_____

Thank you for participating

Annex III: Key In-depth Interview for health care personnel

Dear Participant,

Thank you for taking part in this study to help improve actions taken in response to COVID-19 pandemic and to inform the response to similar future outbreaks.

This study will involve answering a 30-minute survey which will be asking you questions relating to the impact of coronavirus. Please do not start until you will have enough time to complete it in one go. This study is conducted by Hornsom Consultants and Trading Company and the data is collected by Mr. Isse.

By taking part, you are agreeing that you have read and understood the information about the study below. Please ensure you have read and understood this information before continuing.

The purpose of this household questionnaire is to establish the current status of COVID-19 prevention and response awareness and health services provision in Afgoye and Mogadishu districts.

Date (DD/MM/YYYY): _____

Location (Village/district/region): _____

GPS Location: _____

Name of the enumerator: _____

Questions

1. Name of the facility you are in charge or overseeing?
2. Are you aware of COVID-19 virus? Briefly explain.
3. Have you, any of your family members or friends been affected by the COVID-19 virus?
4. Briefly explain what you understand about the impact of COVID-19 virus on health services?
5. Do your facility or facilities still open and readily accessible by the population?
6. Has the number of patients who access the facilities affected since COVID-19 pandemic?
7. Does the facility has enough facilities to handle COVID-19 patients such as wards and equipments?
8. Do you think the health care services offered are adequate in terms of enough staff, who are trained, have enough PPEs and comfortable to deal with COVID-19 pandemic?
9. What are the gaps in the health sector that can be enhanced to improve access to the health services?
10. Briefly explain what you understand about the impact of COVID-19 virus on economy?
11. What are the current coping mechanisms in the target communities in regard to COVID-19 and related vulnerabilities?
12. Do you think the current COVID-19 prevention and management practices improve the awareness, reduce the infection and burden to health care facilities?
13. What are the current NGO, government, local community coordination and information sharing systems/platforms as well as awareness raising activities and identify coordination and awareness raising gaps?
14. What are key recommendations to improve the economic and health issues in your area?

15. Any other suggestions on how to improve the awareness on COVID-19?

I hereby give my consent to Hornsom Consultants and Trading Company to collect, handle and store my personal data.

Household representative signature_____Date and place_____

Enumerator/interviewer signature_____Date and place_____

Thank you for participating

Annex IV: Focused Group Discussions

Dear Participant,

Thank you for taking part in this study to help improve actions taken in response to COVID-19 pandemic and to inform the response to similar future outbreaks.

This study will involve answering a 30-minute survey which will be asking you questions relating to the impact of coronavirus. Please do not start until you will have enough time to complete it in one go. This study is conducted by Hornsom Consultants and Trading Company and the data is collected by Mr. Isse.

By taking part, you are agreeing that you have read and understood the information about the study below. Please ensure you have read and understood this information before continuing.

The purpose of this household questionnaire is to establish the current status of COVID-19 prevention and response awareness and health services provision in Afgoye and Mogadishu districts.

Date (DD/MM/YYYY): _____

Location (Village/district/region): _____

GPS Location: _____

Name of the enumerator: _____

Questions

1. Name of the youth or women group?
2. Are you aware of COVID-19 virus? Briefly explain.
3. Have you, any of your family members or friends been affected by the COVID-19 virus?
4. Briefly explain what you understand about the impact of COVID-19 virus on health?
5. Briefly explain what you understand about the impact of COVID-19 virus on economy?
6. What are the current coping mechanisms in the target communities in regard to COVID-19 and related vulnerabilities?
7. Do you think the current COVID-19 prevention and management practices improve the awareness, reduce the infection and burden to health care facilities?
8. Can you access health care services easily at your facility since COVID-19 pandemic? Briefly explain?
9. What are key recommendations to improve the economic and health issues in your area?
10. Any other suggestions on how to improve the awareness on COVID-19?

Thank you for participating

Annex V: Observation checklist

The following checklist will be used to determine the behavior and practices among the community members on COVID-19

Date (DD/MM/YYYY): _____

Location (Village/district/region): _____

GPS Location: _____

Name of the Observer: _____

Sno.	Variables	Yes	No	Comments
	Community/market setups / health care facility			
1	The communities have provision for hand hygiene facilities			
2	Posters or IEC materials on putting on mask, hand hygiene and social distance are readily availabe			
3	No access to services without observing the COVID-19 measures			
4	Hand hygiene is practiced frequently			
5	People wear masks properly			
6	People wear masks all the time			
7	Social distance is practiced at the community or facilities			
8	Universal screening is done at the health care facilities			
7	Health services are readily available to the population			

Annex VI: Terms of Reference

TERMS OF REFERENCE FOR BASELINE SURVEY IMPROVING LOCAL CAPACITY TO RESPOND TO COVID-19 AND WITHSTAND ITS SOCIO-ECONOMIC IMPACT IN SOMALIA

Background

On 16th of March 2020, Somalia recorded its first case of corona virus and since then morbidity and mortality rates have been growing although it is assumed that the actual number of cases is substantially higher than the officially recorded figures. To some extent, this is due to the government's limited testing capacity, yet many people feel that testing is not worthwhile due to a lack of treatment options and limited access to health care. This situation has happening when Somalia is already grappling with cyclic climatic shocks, conflicts, natural disasters, poverty, insecurity, and locust infestation that continue to devastate most parts of the country. According to the Food Security and Nutrition Analysis (4th February 2021), up to 2.7 million people across Somalia are expected to face food consumption gaps or depletion of livelihood assets indicative of Crisis (IPC Phase 3 or worse outcomes through mid-2021 in the absence of humanitarian assistance. The drivers of acute food insecurity in Somalia include the compounding effects of poor and erratic rainfall distribution, flooding, desert locust infestation, socioeconomic impacts of COVID-19, and conflict.

CARE Somalia implements various programs comprising food security and livelihoods, education, water and sanitation, governance and peace building and health across different regions in Somalia helping the most vulnerable households to cope with the different risks they face and achieve self-reliance. It has identified and selected two impact groups (Rural Women and Urban Youth) as its core programming focus/strategy and each program has a comprehensive Theory of Change spanning over 10-15 years of implementation period. In an effort to address the health and economic impact that COVID-19 placed on vulnerable Somali households and most notably women and children in IDP camps, rural and peri-urban areas in Benadir and Lower Shabelle, CARE received funds a multi-national company to implement a project entitled: 'Improving local capacity to respond to COVID-19 and withstand its socio-economic impact'. The project aims to enhance the capacity of vulnerable women, youth, and service providers to cope with medium and long-term shadow effects of COVID-19 pandemic on economic, social and health wellbeing. As a member of the Somalia Resilience Program (SomReP) consortium, CARE has been implementing resilience building activities in Afgoye district and hence has built partnerships with communities and local authorities there and there will integrate this COVID-19 response in its already existing programing. The project has three main focus areas – a) awareness raising; b) health services and c) economic resilience.

It will partner with civil society organizations, government authorities and service providers to effectively contribute to the prevention of the spread of COVID-19 and mitigate its negative impact on the most vulnerable communities in Somalia.

The project's specific objective and outcomes are:

Specific objective: Enhance the capacity of vulnerable women, youth, and service providers to cope with medium and long-term shadow effects of COVID-19 pandemic on economic, social and health wellbeing

Outcome 1: Increased safety, knowledge, skills and practices to prevent and respond to Covid-19 and related vulnerabilities

Outcome 2: Improved access to equitable and qualitative health services with a focus of vulnerable women and girls
Outcome 3: Increased economic resilience of vulnerable groups against the social and economic impacts of Covid-19

Profile of project target areas and beneficiaries

The project will be implemented in Afgoye district and Mogadishu. Afgoye is thirty kilometers from the capital city of Mogadishu and is a very strategic town that joins many regions to the city. Its population depends on agriculture and livestock for their livelihood. The district has hosted 15,000 internally displaced persons (IDPs) communities affected by the armed conflict that is currently affecting neighboring locations around Afgoye region. The complexity of displacement and drought and its impact on IDPs and host communities in Afgoye has increased the vulnerability of these people leading to a humanitarian crisis. Mogadishu is the capital city of Somalia and is a home to about 2.5 million people with nearly 200,000 IDPs living in crowded settlements. The capital is devastated by conflict and limited health facilities and personnel to tackle with disease outbreaks, most notably COVID-19 at the present time. The beneficiaries of project activities will be mainly urban and peri-urban communities in Mogadishu and farmers in Afgoye district.

Baseline survey purpose and objectives

The overall purpose of the survey is to establish the current status of COVID-19 prevention and response awareness and health services provision in project areas. This will provide a reference point for assessing changes and impact by establishing a basis for comparison before this intervention. Furthermore, it will seek to understand the root causes and inherent complexity of vulnerability of target populations to the impact of COVID-19 so that project interventions are guided by critical analysis of social, economic and health factors surrounding capacity to respond to COVID-19. In other words, the baseline survey aims to understand the current social, economic and health environment by which the project is determined in the target areas while measuring the current status of the project indicators and establishing base values.

Specific objectives

1. To assess awareness level and skills of health workers and communities in preventing and managing COVID-19 and related vulnerabilities
2. To assess the coverage, efficiency and quality of health services in target communities that will enable existing health facilities and its workers to cope with COVID-19 and related vulnerabilities
3. To examine the economic resilience and adaptive capacity of target communities that will enable them withstand the socio-economic impact of COVID-19 and related vulnerabilities

Baseline survey methodology

The survey will adopt a participatory approach, and use mixed methods i.e. quantitative and qualitative research methods to collect and analyze the data. The focus will be to obtain an in-depth understanding of vulnerability to COVID-19 project in the two districts from the perspectives of the relevant stakeholders including MoH, selected beneficiaries' groups, CARE implementing staff and other sector-relevant actors in the concerned districts. The quantitative component will generate baseline estimates of project indicators and measure awareness levels of COVID-19, capacity of existing health services in relation to COVID-19 management and prevention and economic resilience of beneficiary households in relation to coping with the socio-economic impact of COVID-19. On the other hand, the qualitative component will aim to

examine the factors that assist target households to withstand the impact of COVID-19 reasons for adopting particular strategies as well as to further illuminate quantitative results. Mush as we expect the consultant to propose an appropriate and detailed methodology for delivering this assignment, below are the possible strategies to be used for collecting the baseline information:

1. Desk review of project documents and other background documents like, project proposal, log frame, MoH data, COVID-19 impact assessment reports, etc.
2. Survey to collect quantitative indicators that cannot be assessed through secondary data.
3. In-depth interviews with key informants
4. Observations from fieldwork (heath facilities)

Key lines of inquiry

1. What evidence can be drawn for establishing project base values that demonstrate the current awareness, health services and economic resilience status of the target households and communities (urban, peri-urban and farmers) in line with the project logical framework?
2. What are the current coping mechanisms in the target communities in regards to COVID-19 and related vulnerabilities?
3. What evidence and conclusion can be drawn from the existing COVID-19 prevention and management practices at household and community levels as well as in target health facilities in order to improve COVID-19 awareness, bolster health services and strengthen the economic resilience of the target communities?
4. What are the current NGO, government, local community coordination and information sharing systems/platforms as well as awareness raising activities and identify coordination and awareness raising gaps?
5. What are key recommendations for quality project implementation in the project areas?

Time-line

The expected time-frame of this review is 30 working days, and the draft report will be submitted within two months of signing contract. CARE Project Manager will collate feedback from stakeholders (CARE Germany, donor and government), and share with the consultant within two weeks of receiving the draft. The final report must be submitted after one week of receiving the feedback

Work plan

The detailed work plan for the baseline survey will be finalized by 31st March 2021 in consultation with the program team after a consultant is identified to undertake this survey. The roles and responsibilities to execute the process will be determined based on consultation with CARE Germany.

Ethical considerations

The survey's objectives will be clearly explained to all the respondents prior to gathering any form of information from them. Written consent of the respondents will be taken before collecting information where possible. The team will further be required to follow the CARE 'Policy on Protection from Sexual Exploitation and Abuse' throughout the baseline survey process.

Key deliverables

1. An inception report outlining the approach and methodology including the sampling approach of the baseline survey
2. A draft report that addresses the expectations stipulated in the objectives and key questions of the survey

3. A debriefing presentation for CARE Somalia, where the overview of the findings and the recommendations will be discussed
4. Final evidence based report as per objectives and evaluation questions stipulated in the ToR and following the reporting outline incorporating all feedback, suggestions and recommendations from CARE and other key stakeholders.
5. All datasets and tools are submitted with the baseline survey.
6. All necessary permissions, approvals, etc. required prior to data collection

Report outline

1. The final report will contain the following elements:
2. Title Page
3. Table of Contents and Other Sections That Preface the Report
4. Executive Summary
5. Introduction and Background description
6. Rationale: (scope and purpose of the survey)
7. Methodology
8. Results Chapters or Key Findings.
9. Conclusion and Recommendations
10. References and Appendices
11. List of references

Expected Qualification and Experience

1. Bachelor's degree in public health, data management, monitoring & evaluation or relevant disciplines
2. 5 years of experience in similar evaluation/survey in context of or similar to Somalia
3. Knowledge and demonstrated experience of designing and leading baseline and mid-line surveys and project evaluations
4. Strong knowledge of qualitative and quantitative research methods and sampling strategies
5. Statistical analysis skills and strong proficiency with data analysis packages such as SPSS or STATA and qualitative data analysis software including ODK
6. Fluency (verbal and written) in English and Somali is essential and presence of the key survey team in Somalia
7. The proposal may include a team instead of an individual. If a team is proposed, their roles should be clearly specified

Expression of Interest

Applications should contain:

1. A brief cover letter (not exceeding one page), clearly indicating experience in the area of planning, designing and conducting baseline surveys and similar research activities
2. Technical proposal, financial proposal and Up to date curriculum Vitae (CV), copy of Bachelor's degree of the consultants that will be involved in the baseline study. A profile of the consulting firm, Specific roles and responsibilities of the team leader, supervisory chain and other core members of the evaluation team. A technical proposal including: Research methodology, study design, sampling technique, sample size, data collection instruments, data collection and analysis plan
3. Detailed work plan showing the different activities the baseline survey process will comprise – training of enumerators, data collection, reporting, etc.

4. Financial proposal covering all costs – fees of the key team, transport costs, cost of enumerators, stationery, etc.

How to apply

The consultant from/individuals is expected to send a technical proposal including updated CVs, copy Bachelor's Degree and financial proposal, the financial proposal should be included every cost to som.consultant@care.org with the subject line baseline survey covid 19 project". Applications should be submitted no later than (29-May-2021)

Note: Submitting the financial proposal is a key requirement and if missing, your application will not be considered for further processing.