

Now and the Future

Gender Equality, Peace and Security in a COVID-19 World¹

Somalia

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¹ This report was finalised in December 2020 and was updated in March 2021. It was written by Mohamed Ali Gure, research consultant for SWDC, and Julia Poch Figueras from Saferworld, with the support of Amina Arale from SWDC, who also conducted the data collection, and Diana Trimiño Mora from Saferworld. Hannah Bond and Eva Tabbasam from GAPS reviewed the report. We are particularly grateful to Shukria Dini (SWSC) who conducted a thorough review and editing of the report.

1. Introduction

Background

The impact of COVID-19 is deeply gendered. Gender-sensitive conflict analysis is crucial to understand how COVID-19 is interacting with conflict dynamics and to assess the virus' disproportionate impact on people and communities in fragile and conflict-affected contexts, and based on their intersecting identities (including gender, race, ethnicity, disability, class, age and social-economic status). It is also needed to understand how women's and girls' needs and rights can be at the centre of short- and long-term global response and recovery and advance the women, peace and security (WPS) agenda.

In April 2020, Gender Action for Peace and Security (GAPS) launched its '[Call to Action: Now and the Future: COVID-19, Gender Equality, Peace and Security](#)' which assesses the immediate and long-term impacts of COVID-19 on women's and girls' rights and on peace and security. Through this multi-country project, GAPS and partners aim to ensure COVID-19 preparedness and response policy and practice are context-specific, gendered and conflict sensitive,² and to explore cross-context parallels and distinctions.

Using the [Beyond Consultations tool](#), project partners consulted with women's rights and civil society organisations (WROs and CSOs) to produce context-specific gender analysis of COVID-19. In Somalia, the Somali Women Development Centre (SWDC) and Saferworld worked together, consulting a total of 20 organisations (11 WROs and nine CSOs) across different federal member states: four in South West, five in Banadir, two in Hirshabelle, two in Galmudug, three in Puntland and four in Jubaland. Once the responses were analysed, and a first draft had been written, a validation was conducted with all participants, including KIIs with six of the organisations. While most of these organisations work in multiple states in Somalia, none of them cover all states. In addition, 19 out of the 20 CSOs/WROs are registered as organisations, while only one is registered as a network.³

² Saferworld (2020) 'COVID-19 in Somalia: A conflict-sensitive response to overlapping crises', April (<https://www.saferworld.org.uk/resources/news-and-analysis/post/866-covid-19-in-somalia-a-conflict-sensitive-response-to-overlapping-crises>)

³ For safety reasons the participant organisations are not named in this report, but project partners are grateful for their time, knowledge and expertise.

COVID-19 in Somalia

Somalia announced its first confirmed case on March 16th 2020. The government put in place prevention measures including: the establishment of COVID-19 response committees and an incident management system; border-closures; suspension of local and international flights; movement restrictions; and suspensions of services including education. It also restricted mass gatherings and advised social distancing and curfews, which were eased for the holy month of Ramadan.

The Federal Ministry of Health and Human Services' 'National Preparedness and Response Plan for Corona Virus Disease, March-August 2020'⁴ appealed to international support. The plan had 10 pillars, none of which focused on risk mitigation of the gendered impacts of the pandemic or ensured women's and girls' rights. Only two pillars made a reference to gender-related or women- and girl-specific needs, namely lifesaving maternal and neonatal services in the Health pillar and gender-based violence (GBV) referral mechanisms in the Psychosocial Care pillar. COVID-19 responses are yet to address the specific health needs of women and girls in Somalia.

Following this plan, the UN and partners launched a 'Country Preparedness and Response Plan (CPRP) COVID-19' in April 2020, to respond to the humanitarian and socio-economic consequences of the pandemic.⁵ In contrast to previous emergency response plans, including the Ebola response which side-lined gender,⁶ this plan integrates gender comprehensively. It acknowledges the increase of GBV against women and girls during the COVID-19 pandemic and calls for the reduction of GBV and provision of comprehensive support to survivors. In addition, it rightly points out that women and girls, together with other marginalised groups, are at a greater risk of vulnerability to the COVID-19 pandemic due to their gender and socio-economic status. Furthermore, the plan acknowledges that women and girls are expected to take on more responsibilities as caregivers in their families, even in the case of employed women. The plan called for a total of \$527 million: \$256 million for the humanitarian component and \$271 million for the socio-economic component. As of September 11th 2020, only \$56.6 million (25 per cent) of the \$256 million had been received to support humanitarian interventions related to the pandemic.

In addition, the 2020 annual 'Humanitarian Response Plan for Somalia' (released by OCHA in January) sought \$1.01 billion to deliver aid and protection to three million people out of the 5.2 million persons in need. In December 2020, this was 82 per cent funded (\$827

³ Ministry of Health and Human Services, Federal Government of Somalia (2020) 'National Preparedness and Response Plan for Corona Virus Disease 2019 (COVID-19)', August (<https://documentcloud.adobe.com/link/review?uri=urn%3Aaaid%3Aascds%3AUS%3Adb05da55-9c12-4a92-a98d-43cd78c9fe2e>) and Federal Government Of Somalia and OCHA (n/d) 'COVID-19 in Somalia: A conflict-sensitive response to overlapping crises' (<https://covid19som-ochasom.hub.arcgis.com/>)

⁴ UN (2020) 'Somalia Country Preparedness and Response Plan (CPRP)', August (<https://reliefweb.int/sites/reliefweb.int/files/resources/CPRP%20Final%20Subow%2C%2026%20April%20%281%29.pdf>) and Federal Government of Somalia and OCHA (n/d) 'COVID-19 in Somalia: A conflict-sensitive response to overlapping crises' (<https://covid19som-ochasom.hub.arcgis.com/>)

⁵ International Rescue Committee (2015) 'Are we there yet?', September (<https://www.rescue.org/sites/default/files/document/664/ircarewethereyetwebfinalukspell.pdf>)

million). Clusters including protection, health and shelter (which are particularly important for women, girls and marginalised groups) remain underfunded at 21 per cent, 33 per cent and 36 per cent respectively.⁷

Somalia has limited capacity for case management and establishing well-equipped COVID-19 treatment facilities to effectively respond to this pandemic. These challenges are more severe in newly established federal member states, such as Galmudug and Hirshabelle. Due to weak health and social systems, such states have difficulties in community engagement, health promotion and in enforcing preventive measures.⁸

Moreover, the country faces a looming food security and humanitarian crisis which can be attributed to severe flood, desert locust infestation, protracted conflict, stability risks posed by an impending election, the socio-economic impact of COVID-19, and cumulative impacts of previous shocks.⁹ The Federal Ministry of Agriculture declared a national emergency in February 2020.¹⁰ Although COVID-19 related data is hard to gather in Somalia, up to now the rate of hospitalisation and deaths is still low.¹¹ The fear is that the disease is spreading undetected and the impacts could be devastating. There are already difficulties in accessing basic services, such as health, justice and livelihoods programmes in Somalia. This is because the global threat placed by COVID-19 forces humanitarian organisations providing such services to re-prioritise and focus their efforts on pandemic response and preparedness, to mitigate its impact on marginalised populations in an already underfunded humanitarian response.

In a country in which only half of the population is economically active, the socio-economic impact of COVID-19 also plays an important role: a decline in remittances and in livestock export; increased food prices; and a decline in employment and other income earning opportunities for the urban poor and internally displaced persons (IDPs).¹² Despite representing 36.6 per cent of the economically active population, women make up to 70 per cent of the informal sector and have been particularly affected by this situation.¹³

⁷ OCHA (2020) 'Somalia: Humanitarian Dashboard - September 2020', October (<https://reliefweb.int/report/somalia/somalia-humanitarian-dashboard-september-2020-28-october-2020>)

⁸ MoPIED (2020) 'Socio-Economic Impact Analysis of COVID-19 in Galmudug State, Somalia', unpublished document

⁹ FSNAU-FEWS NET (2020) 'Post Gu Technical Release - Up to 2.1 million people in Somalia face acute food insecurity Crisis (IPC Phase 3) or worse outcomes in late 2020', September

¹⁰ Arab News (2020) 'Somalia declares locusts a 'national emergency,' says ministry', February (<https://www.arabnews.com/node/1622011/world>)

¹¹ UNICEF Somalia (2020) 'COVID-19 situation reports', October-November (<https://www.unicef.org/somalia/reports/covid-19-situation-reports>)

¹² FSNAU-FEWS NET (2020) 'Post Gu Technical Release - Up to 2.1 million people in Somalia face acute food insecurity Crisis (IPC Phase 3) or worse outcomes in late 2020', September 2020; FSNAU-FEWS NET (2020) 'Post Gu Technical Release', September 30th 2020; and Mogadishu/Washington and Africa Renewal (2020) 'Using innovation to deliver in Somalia despite COVID-19', June (<https://www.un.org/africarenewal/news/coronavirus/using-innovation-deliver-somalia-despite-covid-19>)

¹³ International Labour Organization (2020) 'Sectoral Assessment of Women's Entrepreneurship Development in the Agriculture and Renewable Energy Sectors in Somalia', June (https://www.ilo.org/empent/areas/womens-entrepreneurship-development-wed/facet/WCMS_757371/lang--en/index.htm)

Most of them sell tea, milk and khat, and deal with currency exchange and fuel trade – activities that have been negatively impacted by restrictions and lockdowns.

As a result of this situation, there is a risk that socio-political tensions could deepen in an already unstable context marked by natural disasters (such as locusts and flooding), social inequalities and political tensions between federal and regional governments. COVID-19 is also exacerbating GBV cases,¹⁴ robberies and crimes in urban areas, tensions between citizens and security forces as a result of the curfew, and tensions among political leaders due to the up-coming parliamentary and presidential elections.¹⁵ Conflict resolution processes have been delayed and hindered by this pandemic.¹⁶ It is paramount that aid is provided in a gender and conflict-sensitive manner, and in consultation and partnership with WROs and CSOs. If that does not happen, it could complicate the situation: ‘by [aid] being diverted towards those involved in violence, by being seen to go to one group more than another, or by being distributed in a way that reinforces the marginalization of particular communities or groups’, including women and girls.¹⁷

Consultation findings

Somalia is a patriarchal and militarised society with deeply entrenched gender norms and roles. GBV prevalence is high including: female genital mutilation (FGM); child, early and forced marriages (CEFM); and domestic violence (DV). Women are excluded from all levels and spheres of formal and informal decision-making processes and are enduring structural socio-economic inequalities. This situation is even worse in the case of young women, women refugees and IDPs, and women from other marginalised groups.

The impacts of the COVID-19 pandemic are huge on Somali women and girls. Through interviews, women and women’s rights organisations (WROs) have shown concerns about how the COVID-19 pandemic can erode some of the gains that they have made for gender equality and women’s and girls’ protection, including meaningful access to justice and protection. In the response to COVID-19, women’s and girls’ rights and needs are not being prioritised and women activists and organisations remain excluded from the design and implementation of official responses. As a result, during the pandemic, as with many other crises, women’s and girls’ discrimination and marginalisation in all existing social, economic and political structures has increased.

¹⁴ During interviews, stakeholders reported increased GBV cases including domestic violence, forced marriages, FGM/C and rape and pointed out that the COVID-19 pandemic has perpetuated violence against women and girls, and diminished social protection.

¹⁵ International Crisis Group (2020) ‘Staving off Violence around Somalia’s Elections’, November (<https://www.crisisgroup.org/africa/horn-africa/somalia/b163-staving-violence-around-somalias-elections>)

¹⁶ International Crisis Group (2020) ‘Ending the Dangerous Standoff in Southern Somalia’, July (<https://www.crisisgroup.org/africa/horn-africa/somalia/b158-ending-dangerous-standoff-southern-somalia>)

¹⁷ Saferworld (2020) ‘COVID-19 in Somalia: A conflict-sensitive response to overlapping crises’, April (<https://www.saferworld.org.uk/resources/news-and-analysis/post/866-covid-19-in-somalia-a-conflict-sensitive-response-to-overlapping-crises>)

Global evidence shows that women and girls are disproportionately affected by economic shocks and crises, and find difficulties in fulfilling their expected roles in terms of contribution to the food security and nutrition of their families. Somalia is no different, and women and girls are bearing the brunt of this pandemic: they are maintaining communities' safety, distributing food for people in isolation, taking care of the sick and distributing protective equipment, including to local mother and child health (MCH) clinics. They also have additional caring responsibilities linked to an increase in people needing care and more people being at home due to movement restriction measures.

In Somalia, at least 20 per cent of households are headed by women who bring in on average 70 per cent of households' incomes, the majority of which comes from activities in the informal sector. The COVID-19 pandemic has seriously impacted women's income due to mobility restrictions, lockdowns and increased work at home. For example, measures to contain COVID-19 have imposed restrictions on international and local flights, affecting imports of goods including khat, vegetables, fruits, candies and clothes, most of which are sold by women in Somalia. Night curfews have negatively affected small businesses belonging to women, such as teashops, restaurants and milk shops, who could not open their businesses at night which is the peak time. As a result, many businesses belonging to women have been hit hard and experienced loss of incomes and customers, negatively impacting the wellbeing of their families and overall communities. In addition, the COVID-19 pandemic has led to a reduction of remittances and aid programmes that focus on strengthening women's economic initiatives, leaving women and their families without income or any safety nets.

Economic hardships, suspension of schools and movement restriction measures have led to UN and Somali organisations reporting an increase in DV and other forms of GBV against women and girls, including sexual exploitation and abuse. Teenage girls have been subjected to increased CEFM and FGM, as families are facing economic hardships and the closure of schools has provided the traditional cutters with the opportunity to resume and increase their practice. This is a setback to many decades of awareness-raising on the negative effects of harmful cultural practices on women and girls. Mobility restrictions and cuts in funding for GBV prevention and response mean that survivors are struggling to access essential GBV response services from women's organisations and have less options to rebuild their lives and livelihoods. Furthermore, sexual and reproductive health and rights (SRHR) services have been more limited because the health sector focus has shifted to responding and averting the pandemic. Due to the scale-back in supplies of antibiotics, personal protective equipment (PPE) and other medicines, many people (including pregnant and lactating women, people in need of treatment for sexually transmitted infections, and GBV survivors) have been unable to get adequate, even life-saving treatments.

WROs are having to respond to a decrease in funds and an increase in the need and demand for their services and programmes. Despite this, they continue to be at the forefront of the COVID-19 pandemic and other emergency responses such as droughts, floods and locust invasions. WROs continue to carry out critical interventions that support women and their families to access livelihoods and resources and provide legal aid and other life-saving services to an increasing number of GBV survivors. They continue to advocate for gender

equality and ending gender discrimination, abuse and GBV in their respective communities, as well as for increased women's participation in political processes (particularly in the upcoming 2021 elections) and fighting to enshrine the women's 30 per cent quota in the Provisional Constitution. WROs have also been instrumental in enabling access to accurate information on COVID-19 for all (and countering misinformation), particularly for those in rural areas or from marginalised groups. Despite the crucial roles women's organisations play, they have noted that they have neither been consulted on COVID-19 responses in Somalia, nor been provided with the required resources to work in recovery and protection.

WROs are best placed to lead the changes needed: they possess in-depth knowledge of the context and the social and gender norms that lead to deep inequalities and power imbalances, as well as ways to transform these. They understand the differential impacts of crises within communities and can effectively respond to communities' needs, including women's and girls' needs. They are experts in working with diverse community stakeholders and effectively preventing conflict. Through their interventions, WROs are also contributing to gender equality and peace. In order for WROs' work to continue to be sustainable and relevant in Somalia (saving lives and advancing long-standing agendas on WPS), they must be fully supported to acquire financial stability, enough human resources, strong governance and good administration systems. Donors and INGOs should increase their financial and technical support and understand that their role is to facilitate CSOs'/WROs' work and leadership in a sustainable and long-term manner.

2. Recommendations

2.1. Recommendation 1: Increase women's and girls' meaningful participation and representation in formal decision-making processes

Government and UN agencies should consult women, girls, WROs and networks in all decision-making intended to effectively respond to and prevent COVID-19. It is also critical to include women and WROs in emergency preparedness and response bodies and processes, and promote their meaningful and sustainable participation in all stages of decision-making spheres – including private, public and political spheres and at all levels (domestic, community, federal member state and national).

Through diplomacy with the Somali government and federal member states, donors and INGOs should advocate for an increase in women's participation in pandemic responses and preparedness (such as by ensuring that there is a gender balance in all teams making decisions on national and regional COVID-19 responses). In addition, CSOs/WROs should also be included in recovery planning and monitoring, as they are best positioned to identify their communities' most pressing immediate needs.

Donors and INGOs should invest in WROs' access to funding to continue programmes as well as invest in strengthening their capacities on advocacy and movement building (networks). Donors and INGOs should also support WROs' advocacy efforts more broadly during this pivotal moment around the women's quota in the upcoming election, adopting the quota in the Provisional Constitution and passing the Sexual Offences Bill (SOB) in Parliament in replacement of the Law on Sexual Intercourse Related Crimes. They should also support WROs' advocacy towards the Federal Government of Somalia to develop a National Action Plan on WPS, crystallising the participation of women and WROs in decision-making processes at all public levels and in relation to all topics, not only those that affect women and girls.

Recommendation for: donors, government, UN and INGOs.

2.2. Recommendation 2: Address the causes of gender-based violence (GBV)

Donors, the UN and INGOs should adopt and fund integrated approaches to addressing GBV across the humanitarian, development and peacebuilding sectors. Such a holistic approach should include GBV prevention, protection and response, and consider GBV services as life-saving and essential, including during the COVID-19 pandemic and any other crises. WROs should be granted direct funding, including core and unrestricted funding, to ensure they continue delivering GBV services (particularly in emergency crises) while tackling root causes and preventing GBV through integrated and holistic approaches at home, community and higher levels. This approach will foster a reduction in stigmatisation and violence against GBV survivors and their families, and address all root causes of GBV at the same time – strengthening the links between these interventions and those seeking to transform harmful gender and

social norms, strengthening women's access to livelihoods, and increasing women's meaningful participation in decision-making.

Donors, UN agencies and coordination bodies should increase support to the protection sector within the COVID-19 pandemic and other emergency response funds, especially towards GBV and child protection. They should support all levels of government in ensuring that GBV services and responses are made available during lockdown and other movement restriction measures, and ensure that women and girls in all communities are aware of the existence of such services, and can easily access them.

Recommendation for: donors, government, UN and INGOs.

2.3. Recommendation 3: Improve women's access to sexual reproductive health and rights services (SRHR)

The UN and government should prioritise access to SRHR services in emergency response and preparedness plans and resource allocation (including those for COVID-19). This should include strengthening the health sectors, both in systems and capacity, to ensure that women and girls from all backgrounds and groups have full access to timely and quality services, as well as ensuring that services are able to respond to trends such as the reported increase in FGM and CEFM. Funding the Minimum Initial Service Package (MISP) within first-phase emergency response is crucial and financial resources should be earmarked for SRHR programmes and not diverted to COVID-19 response.

Recommendation for: government, UN, donors and INGOs.

2.4. Recommendation 4: Strengthen women's access to justice, social protection, safety nets and support networks

The government should design and strengthen women's access to justice, social protection policies and systems that meet women's and girls' specific needs. This should be done with the support of donors and the UN, and in consultation with civil society and WROs.

Donors and INGOs should increase their support to WROs advocating for women's access to justice and social protection policies and programmes, as well as the inclusion of women in the justice system. Donors should fund CSOs and WROs through core funding and emergency funding to ensure they can continue working on some of these previous activities and commitments, while at the same time supporting a specific COVID-19 response.

Recommendation for: donors, government, multilateral institutions, INGOs and civil society.

2.5. Recommendation 5: Improve women's access to socio-economic resources and strengthen women's businesses

Donors, the UN and INGOs should support initiatives to increase women's access to economic resources and promote women's economic rights and independence – particularly for women from low socio-economic backgrounds and internally displaced persons (IDP). Donors, UN agencies and INGOs should work with the government to enhance women's access to resources, skills training and information for their businesses.

They should all promote women's participation in long-term development programmes, addressing root causes of poverty and women's exclusion, including challenging harmful gender norms. This requires a long-term investment to ensure that women's work and owned businesses are not predominantly in the informal sector.

Donors should invest more in short-term responses that provide immediate safety nets to women and their businesses, as well as programmes to ensure household incomes.

Recommendation for: donors, government, multilateral institutions and INGOs.

2.6. Recommendation 6: Strengthen and support women's rights organisations and networks

Donors and INGOs should ensure that WROs and women's rights networks can survive the current economic crisis, address the exclusionary funding trends which affect CSOs and WROs in particular, and enable WROs to lead the change that their communities want to see. Donors should support WROs and women's rights networks with direct funding for long-term projects, as well as core funding which will ensure organisational development and capacity strengthening in core functions (such as MEL, fundraising, governance, management and operations).

When working with WROs, INGOs should: establish equal and long-term partnerships which go beyond specific projects; co-design all programmes and budgets; share overhead and administrative costs equally; provide financial resources for national NGOs' organisational development and facilitate their access to direct funding; and ensure that programmes respond to the changes they themselves have identified as being necessary.

Recommendation for: donors, government, multilateral institutions and INGOs.

2.7. Recommendation 7: Increase investment in the healthcare sector and address health disparities

The government, donors, the UN and INGOs should invest in strengthening Somalia's health system. The public health system is weak and unable to cope with people's needs, particularly in the midst of a pandemic. There should be increased efforts in providing information on COVID-19 and countering misinformation to prevent the spread of the virus. Health equipment, medical supplies and highly-trained health professionals for public hospitals should be provided at all times, and reinforced in times of crisis. In particular, they should invest in building and improving health facilities

in rural areas which are particularly lacking, as well as in newly-established federal member states, such as Galmudug and Hirshabelle.

Donors, UN agencies, INGOs and the government should create equal opportunities for women and men to access healthcare skills development trainings and recruitment in the health sector and ensure equal representation of women in healthcare decision-making processes.

Recommendation for: donors, INGOs, all levels of government and CSOs.

2.8. Recommendation 8: Engage with men and boys to promote gender equality and protection

In Somalia, men hold most power positions, both at home and at the public and political levels, such as policy makers and traditional and religious leaders. Due to their power and influence, it is crucial to engage them in the fight for gender equality and women's and girls' rights. They also need to be engaged to respond to the negative effects of the COVID-19 pandemic on women and girls and design and implement a gender-sensitive pandemic response.

Donors and INGOs should support programmes that facilitate the engagement of men and boys as champions to address harmful social, cultural and religious practices, and to promote gender equality and women's and girls' social and political representation. Programmes should raise awareness among men and boys on women's and girls' rights, gender equality, harmful gender norms and the importance of women's participation in formal decision-making spaces. This work should supplement efforts on gender equality and not replace existing work with women and girls as it is essential that work with men and boys does not reinforce unequal gender power relationships, but addresses them.

Recommendation for: donors and INGOs.

3. Recommendations and Evidence

3.1. Recommendation 1:

Increase women's and girls' meaningful participation and representation in formal decision-making processes

Government and UN agencies should consult women, girls, WROs and networks in all decision-making intended to effectively respond to and prevent COVID-19. It is also critical to include women and WROs in emergency preparedness and response bodies and processes, and promote their meaningful and sustainable participation in all stages of decision-making spheres – including private, public and political spheres and at all levels (domestic, community, federal member state and national).

Through diplomacy with the Somali government and federal member states, donors and INGOs should advocate for an increase in women's participation in pandemic responses and preparedness (such as by ensuring that there is a gender balance in all teams making decisions on national and regional COVID-19 responses). In addition, CSOs/WROs should also be included in recovery planning and monitoring, as they are best positioned to identify their communities' most pressing immediate needs.

Donors and INGOs should invest in WROs' access to funding to continue programmes as well as invest in strengthening their capacities on advocacy and movement building (networks). Donors and INGOs should also support WROs' advocacy efforts more broadly during this pivotal moment around the women's quota in the upcoming election, adopting the quota in the Provisional Constitution and passing the Sexual Offences Bill (SOB) in Parliament in replacement of the Law on Sexual Intercourse Related Crimes. They should also support WROs' advocacy towards the Federal Government of Somalia to develop a National Action Plan on WPS, crystallising the participation of women and WROs in decision-making processes at all public levels and in relation to all topics, not only those that affect women and girls.

Recommendation for: donors, government, UN and INGOs.

Donors, the government and INGOs should recognise girls' and women's rights to take part in decisions that affect their lives, and acknowledge women's organisations' and networks' in-depth context knowledge and expertise in working with communities. They should consult, partner with, and support them, as well as call for their meaningful and sustainable participation in private, public and political spheres and at all levels (domestic, community and beyond), including emergency preparedness and response.

They should also increase funding to programmes that will promote women's and girls' participation, and continue to support programmes during the pandemic; and provide women's organisations with the necessary direct, flexible and core funding to undertake the activities they consider necessary. Pandemic-related participation should include meaningfully consulting women and WROs in COVID-19 responses, and ensuring there is gender balance in all decision-making teams, including at leadership level.

They should support WROs and networks in their advocacy efforts and work with them, through diplomacy, to push the Somali government and federal member states to include women in pandemic response and preparedness.

Evidence:

Somali women and girls have long been marginalised from political participation due to gender norms in cultural, religious and clan related traditions that designate the public sphere as a male territory. This has been reinforced by the protracted conflict. Despite the dedicated efforts of many Somali women activists and organisations, women continue to be significantly underrepresented in decision-making bodies at all levels, particularly in official institutions but also at the community and household levels. Girls continue to have no say in the face of decisions around traditions and practices that affect them directly, such as FGM and CEFM.

In the face of global pandemics like COVID-19, women and women's organisations are the first responders at the forefront of providing basic needs and services to their families, taking care of sick relatives, and supporting their communities. In Somalia, WROs have contributed to: maintaining communities' safety; providing assistance to GBV survivors; informing communities of COVID19-related issues and counterbalancing misinformation; distributing food for people in isolation; and distributing protective equipment to local MCH services. They take on these additional responsibilities despite a lack of resources and being particularly affected by the COVID-19 pandemic, through an increase in GBV, FGM, CEFM, intimate partner violence (IPV), caring duties, and loss of incomes. Despite these crucial contributions, Somali women, activists, WROs and CSOs have been underrepresented and not consulted in decision-making spaces linked to the COVID-19 response.

In addition, due to patriarchal norms and measures to respond to COVID-19, women have lost access to public and women-only spaces, eroding WROs' efforts towards the achievement of women's representation and participation in the upcoming 2021 election and their push for inclusive political and electoral processes in Somalia. Despite there being a 30% quota agreed in government, only 24 per cent of parliamentarians and 6.7 per cent of ministers are women – and the quota has still not been enshrined in the constitution despite advocacy efforts by WROs and networks. Alongside this, the high registration fees for candidates to both Lower and Upper houses, dramatically limit women's participation. Election and representation-related advocacy efforts have been drastically reduced due to the pandemic. Public officers are much more difficult to reach and many donors have stopped or reduced the funding to these types of projects, particularly those not directly linked to the health emergency.

Participants in **Southwest** state noted that women and girls were not actively involved in participation and decision-making for the COVID-19 pandemic. They also highlighted that women's and girls' economic and security situation has worsened due to response measures such as lockdown, which limit their involvement in activities to improve women's and girls' rights, usually conducted by activists, informal groups or CSOs.

In **Banadir**, the CSOs/WROs noted a lack of inclusivity in both preventing and responding to the COVID-19 pandemic and in the political spaces in preparation of the upcoming national election. This is due to gender norms, cultural barriers, skewed economic empowerment, and lack of legislations that advocate for more involvement of women and girls in participation and decision-making processes. For example, during the last National Leadership Forum (NLF), which brought together all the 'top' national organisations and stakeholders, women had no stake and were not represented. However, during the COVID-19 response, women and girls played a pivotal role as active volunteers, with women responding immediately to community needs, including in IDP settlements.

In **Puntland** state, most of the CSOs/WROs noted that poor participation of women in decision-making and political participation is caused by a range of factors that include structural and systemic gender inequalities, poor economy, social norms and cultural barriers. For example, participants noted that intermarriages and political rivalries among clans in Somalia affect women's chances to be elected as a political representative both by her clan and by her husband's clan.

In **Jubaland** state, women were also not included in COVID-19 related decision-making processes, despite women's businesses and activities being affected by restrictions and an increase in DV and GBV cases. It is also worth noting how the tension between the federal government and the Jubaland government has restricted Jubaland women and WROs in carrying out advocacy work with women and WROs in other regions. This is due to the flight suspension and the military build-up of federal government and Jubaland forces in Gedo region (particularly in Belet Hawo and Dolow). One of the CSOs noted that due to the economic crisis, fathers in Belet Hawo town married their daughters to men to gain some money without the consent of the mother or daughter; a practice common in other regions in Somalia. It was also noted that before COVID-19, women used to gather and discuss issues related to their rights amongst themselves. However, for fear of contracting the virus, they no longer take part in these activities.

3.2. Recommendation 2:

Address the causes of gender-based violence (GBV)

Donors, the UN and INGOs should adopt and fund integrated approaches to addressing GBV across the humanitarian, development and peacebuilding sectors. Such a holistic approach should include GBV prevention, protection and response, and consider GBV services as life-saving and essential, including during the COVID-19 pandemic and any other crises. WROs should be granted direct funding, including core and unrestricted funding, to ensure they continue delivering GBV services (particularly in emergency crises) while tackling root causes and preventing GBV through integrated and holistic approaches at home, community and higher levels. This approach will foster a reduction in stigmatisation and violence against GBV survivors and their families, and address all root causes of GBV at the same time – strengthening the links between these interventions and those seeking to transform harmful gender and social norms, strengthening women’s access to livelihoods, and increasing women’s meaningful participation in decision-making.

Donors, UN agencies and coordination bodies should increase support to the protection sector within the COVID-19 pandemic and other emergency response funds, especially towards GBV and child protection. They should support all levels of government in ensuring that GBV services and responses are made available during lockdown and other movement restriction measures, and ensure that women and girls in all communities are aware of the existence of such services, and can easily access them.

Recommendation for: donors, government, UN and INGOs.

Donors need to sustain and increase their funding to GBV during this pandemic and other emergencies (such as droughts, floods and new conflicts and displacements). Despite the new challenges created by the COVID-19 pandemic, the protection sector continues to be underfunded. Furthermore, to promote holistic, effective and sustainable response to, and prevention of, GBV beyond immediate life-saving service provision, donors should encourage and fund gender transformative programming and integrated approaches which reinforce GBV response and prevention. This should be done by tackling root causes of violence and increasing women’s participation at domestic and public levels through peacebuilding approaches, while investing in health assistance and awareness raising, as well as in programmes to support women’s and girls’ access to economic resources and long term livelihood.¹⁸ Transforming harmful gender norms and behaviours that sustain gender inequality is essential to reduce GBV in the long-term, but also to ensure women’s and girls’ access to basic services – therefore it should be done alongside humanitarian response. As noted by one of the participants in the research, GBV response services need to be strengthened by investing in awareness raising of: gender norms and GBV; health and psychosocial assistance; and livelihoods programmes that should provide unconditional

¹⁸ What works to prevent violent (2018) ‘Intersections of violence against women and girls with state-building and peace-building: Lessons from Nepal, Sierra Leone and South Sudan’, September (<https://www.whatworks.co.za/resources/reports/item/465-intersections-of-violence-against-women-and-girls-with-state-building-and-peace-building-lessons-from-nepal-sierra-leone-and-south-sudan>)

cash transfers during times of acute crisis. In addition, there should be emergency funding allocated to ensure that these efforts can be taken forward and even enhanced during crisis, when the recurrence of GBV cases usually increases.

Evidence:

According to the GBV/FGM AoR survey,¹⁹ 38 per cent of respondents indicated an increase in GBV incidents compared to the period before the COVID-19 pandemic. Most reported cases are of physical violence, both in and outside the house (34 per cent), sexual abuse and harassment (20 per cent), IPV (18 per cent), rape (18 per cent) and CEFM (nine per cent). Thirty-one per cent of respondents reported an increase in FGM during the COVID-19 period. Other sources have also reported an increase in FGM, with circumcisers going door-to-door offering to cut girls stuck at home during the pandemic, thereby undermining efforts to eradicate the practice in Somalia.²⁰ The increase in FGM has been linked to: schools being closed and girls being at home, which practitioners see as an opportunity to increase their practice; the economic crisis which may drive families to increase CEFM; and that awareness raising programmes with communities on the dangers of FGM were stopped. This in essence presented a huge challenge to the elimination of FGM in Somalia, thus making the attainment of the SDG 5 indicators and targets difficult.²¹

WROs have been at the frontline of providing GBV response services.²² Despite the noted increase in GBV during the pandemic, up to 36 per cent of GBV service providers have reported that COVID-19 has had a high effect on GBV service provision, making it difficult for survivors to get support (such as health and psychosocial assistance and legal aid). This has also come at a time when advocacy to revoke the Law on Sexual Intercourse Related Crimes and pass the Sexual Offences Bill (developed in consultation with women, civil society, and the international community) is being met with a huge backlash and rejection in the federal parliament. CSOs, WROs and international organisations argue that the Law on Sexual Intercourse Related Crimes breaches international and regional provisions against rape and sexual violence.²³

In **Southwest** state, participants outlined that there was an increase in DV such as physical assaults and sexual abuse.

¹⁹ GBV AoR Somalia (2020) 'GBV/FGM Rapid Assessment Report: In the Context of COVID-19 Pandemic', July

²⁰ *The Guardian* (2020) 'Huge FGM rise recorded in Somalia during coronavirus lockdown', May (<https://www.theguardian.com/world/2020/may/18/fgm-risk-in-somalia-heightened-by-coronavirus-crisis>)

²¹ Sustainable Development Goal 5 seeks to achieve gender equality and empower all women and girls.

²² Saferworld (2020) 'Gender and COVID-19: responding to violence against women and children in Somalia', June (<https://www.saferworld.org.uk/resources/news-and-analysis/post/884-gender-and-covid-19-responding-to-violence-against-women-and-children-in-somalia>)

²³ Reuters (2020) 'Outrage as Somali parliament drafts law permitting child, forced marriages', August (<https://uk.reuters.com/article/us-somalia-women-rights/outrage-as-somali-parliament-drafts-law-permitting-child-forced-marriages-idUSKCN257200>); UN News (2020) 'Somalia: Draft law a 'major setback' for victims of sexual violence', August (<https://news.un.org/en/story/2020/08/1070022>)

CSOs and WROs from **Banadir** noted that there was an increase in cases related to DV, sexual exploitation and abuse, rape, FGM and CEFM. Some women residing in IDP camps have reported that they have been forced into prostitution and forced marriage.

In **Hirshabelle** state, CSOs/WROs outlined that there was an increase in DV as a result of violent masculinities linked to the decrease in, or lack of, income for women who earned their livings in the informal sector. Rape cases also increased, as many poor and IDP women and girls were forced to work as casual labourers in far and insecure areas to earn an income.

The CSOs/WROs from **Puntland** state, stated that there were increased cases of DV due to unemployment and difficulties in bringing an income home (including among IDPs). Violence perpetrated by men who were abusing drugs also increased.

In **Jubaland** state, the lockdown resulted in an increase in GBV cases. This was partly due to an increase in unemployment and lower household incomes which, due to social norms and masculinities, caused IPV, divorce and family separation. Participants stated that funding for livelihood and GBV programmes, including psychosocial support and unconditional cash transfers, would have been effective mechanisms to support women and girls who are being affected by GBV and the COVID-19 pandemic. In addition, most IDP camps in Kismayo reported an increase in cases related to DV and FGM during the school closures, when most girls were at home during the lockdowns.

3.3. Recommendation 3:

Improve women's access to sexual reproductive health and rights services (SRHR)

The UN and government should prioritise access to SRHR services in emergency response and preparedness plans and resource allocation (including those for COVID-19). This should include strengthening the health sectors, both in systems and capacity, to ensure that women and girls from all backgrounds and groups have full access to timely and quality services, as well as ensuring that services are able to respond to trends such as the reported increase in FGM and CEFM. Funding the Minimum Initial Service Package (MISP) within first-phase emergency response is crucial and financial resources should be earmarked for SRHR programmes and not diverted to COVID-19 response.

Recommendation for: government, UN, donors and INGOs.

The government, UN and donors should ensure that services dealing with SRHR are continued and reinforced during emergencies, and that women and girls in need (including IDPs, those in rural areas and in regions affected by conflict) have access to them. Measures to contain the virus (such as restricted mobility) should not affect women's access to SRHR services. The government, UN and donors should work with community groups and leaders to ensure a good spread of information of how and where to access SRHR services and disseminate this information through different communication channels.

During COVID-19 and other crises, the UN and donors should invest more in preventing shortages of antibiotics and other health supplies necessary to treat cases of SRH, including post-exposure prophylaxis (PEP). They should do this by ensuring different clusters are coordinated (mainly the Protection cluster in which the GBV working group sits and the Health cluster). This will help to prevent and mitigate difficulties in importation and distribution. They should ensure that SRH assistance providers and doctors have a sufficient supply of PPE to be able to continue their work safely. The UN, government and donors should also support the training of more doctors in SRH, so they can effectively respond to critical FGM cases and provide much needed SRH services to women residing in remote areas.

Donors should ensure that specific funding for SRHR is maintained in humanitarian responses during emergency crisis. They should also support the implementation of the MISPP²⁴ in COVID-19 responses, particularly in rural areas and in areas affected by conflict.

Evidence:

Participants reported that during the COVID-19 pandemic, SRHR services were reduced as more focus shifted to responding to and averting the pandemic. The Somali health system is dominated by private hospitals and clinics with an irregular service provision, particularly in rural areas. During COVID-19, most of the services have either been provided minimally or not at all, as many private hospitals decided to stop admitting patients during the pandemic. This has made it hard for pregnant and lactating women to access health services, as well as people in need of treatment for sexually transmitted infections, GBV survivors (including FGM), and women seeking family planning services. The COVID-19 pandemic affected MCH services-delivery as there were reduced maternal and reproductive health services and inadequate supplies, including antibiotics (partly resulting from the shutdown of local and international flights). As in previous health emergencies, such as Ebola in Liberia and Sierra Leone, the COVID-19 pandemic endangers the lives of many women and girls seeking critical services in health facilities. Furthermore, given that FGM cases are increasing all over Somalia, many hospitals and their health professionals need further training in dealing with complications in FGM-related cases and other GBV cases.

In **Southwest** state, participants noted that during the pandemic, medical supplies at different health facilities had dwindled (especially in MCH services, areas with a high density of IDP population, and urban poor areas. As a result, unsterilised tools may have been shared, endangering women's and girls' lives. In addition, MCH facilities reduced working time because of social distancing measures, reducing family planning services, drug distribution and health assistance to pregnant and lactating women. A shortage in PEP kits to save women and girls from having STI diseases was also reported.

In **Banadir**, participants stated that road blocks restricted pregnant women from accessing emergency maternal services. One interviewee witnessed a woman, who was attempting to go to a nearby hospital, giving birth at a checkpoint which had been placed to restrict

²⁴ UNFPA (2020) 'Minimum Initial Service Package (MISP) for SRH in Crisis Situations', November (<https://www.unfpa.org/resources/minimum-initial-service-package-misp-srh-crisis-situations>)

movement. Also, a reduction in the provision of pre- and post-natal MCHs care was noted, allegedly due to pregnant and lactating women being afraid of contracting the virus at the facility.

In **Galmudug** state, WROs reported that sexual abuse and FGM practices increased during the lockdown period but there was a shortage of PEP kits to prevent women and girls contracting STIs. In addition, there were poor medical supplies at the MCH services and fewer women attended the facility due to movement restrictions and fear of contracting the virus. It was also reported that essential services such as counselling for survivors of GBV were not available in main hospital.

In **Puntland** state, health services such as health education shifted to COVID-19 response action, and family planning decreased as MCH services reduced their activities. In addition, there were inadequate medical supplies in MCH services, and because women were afraid of contracting the virus, fewer sought these services.

In **Hirshabelle, Jubaland** and **Southwest** state, women have faced difficulties in accessing reproductive health services during the COVID-19 pandemic. Health centres that provided free services ran out of supplies due to budget cuts and the lockdown. Most private hospitals that had the capacity to test and admit COVID-19 patients closed their doors because their staff feared the virus. Reproductive health services were not considered a priority and some health centres temporarily suspended them and laid off their staff.

3.4. Recommendation 4:

Strengthen women's access to justice, social protection, safety nets and support networks

The government should design and strengthen women's access to justice, social protection policies and systems that meet women's and girls' specific needs. This should be done with the support of donors and the UN, and in consultation with civil society and WROs.

Donors and INGOs should increase their support to WROs advocating for women's access to justice and social protection policies and programmes, as well as the inclusion of women in the justice system. Donors should fund CSOs and WROs through core funding and emergency funding to ensure they can continue working on some of these previous activities and commitments, while at the same time supporting a specific COVID-19 response.

Recommendation for: donors, government, multilateral institutions, INGOs and civil society.

Social protection policies need to become a priority within COVID-19 preparedness and response. Civil society and WROs should be consulted on them, and the policies should meet women's and girls' specific needs. Many organisations suggested that funds dedicated to women's and girls' programmes, as well as gender equality, should be at least partially secured and that gendered safety nets that meet women's and girls' needs should be designed. This could be done by: ensuring core funding for CSOs and WROs; earmarking funds for protection and GBV within pooled humanitarian funds; and increasing flexible and emergency funds to CSOs and WROs.

Donors and INGOs should continue to support WROs to push for the inclusion of women in the justice system and improve women's and girls' access to justice. The efforts to reform the justice system in Somalia should continue even in the midst of responding to the COVID-19 pandemic.

Evidence:

The COVID-19 pandemic has forced CSOs and WROs, as well as social services, to prioritise a preparedness and response to this specific crisis over the work they were committed to previously. This is due to a number of factors: community needs paired with weak public institutions that cannot fulfil needs or provide safety nets (thus leaving CSOs and WROs to fill in the gaps); and the lack of core and flexible funding for WROs and CSOs (who depend on donor priorities and do not have core funding or staff to diversify their work during an emergency).

Women's economic rights and women's social and political participation projects shifted their focus to respond to the pandemic. Women who were part of support networks provided through previous programmes (including safe spaces to share needs and concerns, or who were part of activities that promoted women's public participation) were unable to access those spaces anymore. Participants called for the need to sustain safe spaces for women and girls and to ensure that social distancing measures allow access to them.

Many families lost their main sources of income, including remittances from overseas. These remittances play a pivotal role in the Somali economy and have provided lifelines to people affected by disasters and shocks, with many households in urban, semi-urban and some rural towns dependent on them to meet their basic household needs.²⁵

In addition, many participants pointed out that before COVID-19 Somali women were underrepresented in the judicial system and many struggled to have access to justice. Responses to COVID-19, including the lockdown and a priority to invest in averting the pandemic, have exacerbated this situation. Many GBV survivors who faced violence across the country during the early months of the pandemic did not get the legal redress and attention that they are entitled to. The COVID-19 pandemic weakened both the government's response to, and social protection systems for, women and girls. WROs' advocacy for women's access

²⁵ MoPIED (2020) 'Socio-economic Impact Analysis of COVID-19 in Galmudug State of Somalia', Unpublished document

to justice and representation has decreased due to the pandemic and the national elections. Improving women's and girls' state protection and access to justice is urgently needed.

In **Southwest** state, WROs outlined that the pandemic has impacted social protection, safety nets, support networks and participation of the people. This is due to restrictions that made women's economic rights projects difficult to implement, such as the Bahnano (read as '*Baxnaano*'²⁶ in Somali) project which gave women with low incomes, and their spouses, small grants. In addition, the pandemic also delayed the implementation of any other project activities outside the core response. Furthermore, the pandemic affected support from women's associations who used to distribute sanitary kits but had their operations suspended due to restrictions, such as social distancing.

Also, in **Southwest** state cases of GBV were reported against women by people distributing food. In moments of shortages, women depending on lifesaving assistance might be more exposed to violence and abuse. In addition, it was reported that IDP women and poor women were unable to raise the required fee to hire lawyers and launch their legal actions against perpetrators of DV and other forms of GBV.

Some of the participants in **Banadir** stated that lockdown caused resources and attention to be shifted to respond to COVID-19. As a result, women's participation diminished and social protection was reduced. It also affected access to justice and many capacity building activities. Humanitarian assistance has also been affected by COVID-19 as most resources are channelled into responding to the pandemic. Protection and prevention programmes for women and girls, including refugees and IDPs, have been overlooked and become underfunded, thereby deepening gender and social inequalities.

In **Banadir** and **Galmudug**, the COVID-19 pandemic has affected women's access to life-saving services. For instance, women in IDP camps who rely on free services provided by local and international organisations (like food vouchers) were hit hard due to the reduced food rations.

In **Jubaland** state, CSOs/WROs stated that movement restriction, such as the international flight shutdown and movement restrictions between countries, caused some women to suspend their income-generating activities. This particularly affected those selling perishable goods that were mostly imported from neighbouring countries like Kenya. There were also delays of payments of cash relief to beneficiaries, as organisations had to prioritise responding to the pandemic. Activities of women's and girls' support networks diminished as a result of lockdown as they had no funds to continue them.

²⁶ Shock Responsive Safety Net for Human Capital Project, a national cash transfer project aimed at supporting poor and vulnerable households through income support. See: The Federal Government of Somalia, Ministry of Labour and Social Affairs (2019) 'Somalia: Shock Responsive Safety Net for Human Capital Project (SNHCP)', October (<http://molgov.so/wp-content/uploads/2019/11/Shock-Responsive-safety-Net-for-Human-Capital-BAXNAANO-Project-Operations-Manual..pdf>)

3.5. Recommendation 5:

Improve women's access to socio-economic resources and strengthen women's businesses

Donors, the UN and INGOs should support initiatives to increase women's access to economic resources and promote women's economic rights and independence – particularly for women from low socio-economic backgrounds and internally displaced persons (IDP). Donors, UN agencies and INGOs should work with the government to enhance women's access to resources, skills training and information for their businesses.

They should all promote women's participation in long-term development programmes, addressing root causes of poverty and women's exclusion, including challenging harmful gender norms. This requires a long-term investment to ensure that women's work and owned businesses are not predominantly in the informal sector.

Donors should invest more in short-term responses that provide immediate safety nets to women and their businesses, as well as programmes to ensure household incomes.

Recommendation for: donors, government, multilateral institutions and INGOs.

More support for women and women's organisations is needed to enhance women's economic rights and independence, particularly for women from low socio-economic backgrounds and IDPs. Women's participation should be ensured in long-term development programmes, addressing root causes of poverty and women's exclusion, such as social norms that prioritise men being the breadwinners and that lead to a double burden for women working outside the house (as they also undertake increased household work and care for family members). This requires a long-term change to ensure that 'women's work' is not predominantly in the informal sector, and that short-term responses provide immediate safety net programmes to ensure household incomes are sustained (see Recommendation 4). Addressing gendered root causes of poverty, risk and marginalisation, is expected to impact risk mitigation at the individual and household levels and contribute to poverty reduction, social cohesion and inclusion.

Evidence:

The COVID-19 pandemic has affected many businesses that provided the sole source of income to people in Somalia. Measures put in place (such as the suspension of both domestic and international flights, curfews, partial lockdowns and cessation of freedom of movement) have contributed hugely to the collapse of small businesses such as those related to the sale of flight tickets, tea or khat, as well as others which are dominated by women.

Women, who usually have more precarious and informal jobs, have been particularly affected. They are the ones looking for solutions to bring an income home, sometimes being forced, or having to resort to exploitative jobs and situations, with one organisation mentioning an increase in forced marriages and prostitution in IDP camps as means of survival. Women in poor host communities and IDPs were mostly affected as they are the primary breadwinners for their families and could not get casual jobs such as cleaning, washing and doing other household chores. IDP women and girls who worked as domestic workers and temporary cleaners faced abuse and exploitation from the families they worked for, some being intimidated by their employers and unpaid for months.

This situation has been further worsened as the Somali diaspora, who have also been affected by the crisis, have been unable to transfer money to their relatives in Somalia. As the pandemic is global it has equally affected the diaspora community who have to deal with restrictions and use the little they have to meet their own needs. The most comprehensive household survey of remittance flows conducted to date before the pandemic (conducted only in Somaliland and Puntland), identified 41 per cent of the survey sample as households that receive at least some remittances (51 per cent in urban and 29 per cent in rural settings, with urban households accounting for a much larger share of remittance value).²⁷

In addition, women and girls continue to do the majority of unpaid care work in households, and tend to carry out most of the care for the sick relatives, household chores and childcare responsibilities, which increases their own risk of infection.²⁸

In **Banadir**, participants outlined that the COVID-19 pandemic affected women's business activities, such as selling khat, tea, milk, and washing clothes. This led to an increase in unemployment in informal and domestic work. In addition, import and export activities reduced (as the airport and the port were shut down), small scale businesses (particularly in low income families) collapsed and their few savings were used to provide for their families during this hard time. Furthermore, women with low incomes businesses involved in micro-finance projects found it difficult to meet their obligations – most failed to repay the loans on a monthly basis because the curfew had suspended their business activities.

Many small scale businesswomen in the districts in **Banadir** and **Southwest** states noted having lost their businesses during the outbreak and indicated that, had they received immediate loans or cash transfers and food aid, they would have coped well during COVID-19 pandemic.

In **Southwest** state and **Jubaland**, women's increased roles in caring for relatives and children (due to school closures) and time spent visiting patients in hospitals exposed women to the virus, doubled their domestic work and limited the time devoted to their businesses, particularly in the case of single mothers.

²⁷ FSNAU (2013) Remittances and Livelihoods Support in Somaliland and Puntland

²⁸ Saferworld (2020) 'COVID-19 in Somalia: A conflict-sensitive response to overlapping crises', April (<https://www.saferworld.org.uk/resources/news-and-analysis/post/866-covid-19-in-somalia-a-conflict-sensitive-response-to-overlapping-crises>)

In **Hirshabelle** state, participants indicated that micro-finance programmes provided by private banks and local NGOs were suspended due to COVID-19-related restrictions and lockdowns. This caused a decrease in income and further raised the level of unemployment among women. They also outlined that the pandemic, closure of schools and the lockdown increased women's and girls' work in domestic tasks and childcare in their homes.

In **Galmudug** state, participants noted that most of the people affected economically by the COVID-19 pandemic were women who washed clothes, or sold tea or khat, and had lost their incomes and livelihoods. In addition, ongoing projects that support women and girls were restricted, and working women were also at home doing the vast majority of unpaid work. This loss in income and work insecurity forced some women, particularly IDP women, to search for alternative and sometimes abusive jobs.

In **Puntland** state, participants outlined that at the onset of the pandemic, clothes sellers were the first affected as their imports were cancelled for fear of spreading the disease and this adversely affected the income of women in this industry. In addition, small scale businesses, that were mostly owned and run by women, collapsed due to the restriction measures and their savings diminished as they had to use them to feed their families.

In **Jubaland** state, participants indicated that the COVID-19 pandemic affected livelihoods and women's economic rights. This was due to restrictions on business activities, particularly informal ones, which resulted in loss of income and unemployment, especially in IDP and marginalised households. Alongside doing unpaid care work, some women started searching for extra work (such as washing clothes) to meet their families' needs. This made the situation difficult for women who had to balance new paid work with their usual domestic work.

3.6. Recommendation 6:

Strengthen and support women's rights organisations and networks

Donors and INGOs should ensure that WROs and women's rights networks can survive the current economic crisis, address the exclusionary funding trends which affect CSOs and WROs in particular, and enable WROs to lead the change that their communities want to see. Donors should support WROs and women's rights networks with direct funding for long-term projects, as well as core funding which will ensure organisational development and capacity strengthening in core functions (such as MEL, fundraising, governance, management and operations).

When working with WROs, INGOs should: establish equal and long-term partnerships which go beyond specific projects; co-design all programmes and budgets; share overhead and administrative costs equally; provide financial resources for national NGOs' organisational development and facilitate their access to direct funding; and ensure that programmes respond to the changes they themselves have identified as being necessary.

Recommendation for: donors, government and INGOs.

WRO and CSO participants outlined the need for capacity strengthening in key core organisational areas including: MEL, governance, fundraising, proposal development, financial and narrative reporting, donor requirements, due diligence processes and procurement management. To achieve this, donors should provide core flexible funding to enable WROs to go beyond project implementation and into organisational capacity strengthening and sustainability. They should also prioritise long-term funding, as short-term funding is an obstacle in strengthening organisational capacity, sustainability, programme quality and overall long-term impacts on targeted communities. Donors should also make it easier for CSOs/WROs to access such funding by: simplifying their due diligence processes; investing in their core capacities; and tailoring application processes and budgets to the capacities of CSOs and the needs of communities.

INGOs have an important role to play in supporting WROs and CSOs. They should prioritise equal and long-term partnerships when working with WROs and CSOs, co-designing programmes and budgets, and ensuring that CSOs and WROs have equal access to overhead and administration costs to secure their own sustainability. They should also support CSOs' and WROs' advocacy initiatives and establish links between them and governments. Tools, activities and methodologies put forward by CSOs/WROs should be prioritised over those developed by INGOs. Participants also outlined that funding CSOs' and WROs' coalitions and networks working on different WPS thematic areas allows for collaboration in advocacy to advance WPS policies at local and national levels.

In addition, INGOs should ensure that funds towards capacity strengthening respond to WROs' and CSOs' needs and priorities, instead of focusing on training to deliver a specific INGO priority, approach or methodology. Ultimately, CSOs and WROs should be able to decide if they wish to develop and conduct all programmes without a partner, or if they prefer to establish an international partnership because it reinforces the change they seek to see.

Evidence:

CSOs, WROs and networks understand the needs of the communities they work with, and the gender norms and inequalities that hinder women's and girls' safety and participation. In addition, they have the flexibility to adapt and provide services in a way that government entities often cannot, allowing them to fill critical gaps during both crisis and recovery. They complement this emergency response work with comprehensive programmes and advocacy for structural change at local and national level. In order to ensure women's and girls' rights and participation, they need to be able to provide long-term sustainable and regular work with the targeted communities, based on the communities' needs.

During the COVID-19 crisis, CSOs and WROs have been active and flexible in responding to the needs of the communities they work with. But they have also had to navigate the difficulties that have surfaced due to the lockdown and mobility restrictions, as well as material and funding shortages. WROs/CSOs have changed their previous activities in order to: raise awareness of the pandemic; fill in the gaps where there is a lack of information (particularly in rural areas); and reduce the prevalence of misinformation. For example, they engaged

with doctors, religious leaders and young people who created video clips in order to reach as many people as possible.

WROs have also intensified their work in strengthening women's economic opportunities and supporting women's businesses that are on the verge of collapse due to the crisis. Unfortunately, projects in support of women's participation in elections and political processes have seen a reduction in funds, as well as activities. This is because authorities are less available to meet, and leadership skills training for potential women candidates is difficult to conduct remotely.

In **Banadir**, some participants indicated that the specific areas to be funded usually depend on the donor's interest and areas of opportunities, as opposed to the actual needs of the beneficiaries. They also outlined that donors tend to fund individual thematic areas instead of a combination of them in line with an integrated approach, which is not reflective of people's lives and needs, and limits the provision of comprehensive service packages or holistic programmes.

In **Galmudug** state, WROs noted that funding is usually project-based and therefore they cannot invest in organisational development and core functions (such as MEL, fundraising or proposal development) to strengthen and expand their work. They outlined that they understand and know better the situation of the communities they work with, but have to accept donor priorities and partner with INGOs who, in many cases, end up taking the lead.

In **Southwest** state, participants identified proposal writing, financial management, report writing, MEL, financial systems, due diligence requirements, advocacy, fundraising and procurement as areas in which they need funds and capacity strengthening. In addition, one of the participants identified gaps in coordination between the CSOs and recommended establishing coordination networks, which would better enable them to respond to future crises and emergencies.

3.7. Recommendation 7:

Increase investment in the healthcare sector and address health disparities

The government, donors, the UN and INGOs should invest in strengthening Somalia's health system. The public health system is weak and unable to cope with people's needs, particularly in the midst of a pandemic. There should be increased efforts in providing information on COVID-19 and countering misinformation to prevent the spread of the virus. Health equipment, medical supplies and highly-trained health professionals for public hospitals should be provided at all times, and reinforced in times of crisis. In particular, they should invest in building and improving health facilities in rural areas which are particularly lacking, as well as in newly-established federal member states, such as Galmudug and Hirshabelle.

Donors, UN agencies, INGOs and the government should create equal opportunities for women and men to access healthcare skills development training and recruitment in the health sector and ensure equal representation of women in healthcare decision-making processes. In addition, health services should take into account the differential needs of women and girls in terms of treatment and services, ensure accessibility and information to women and girls on where and how to access these services, and train healthcare providers to support women and girls.

Recommendation for: donors, government and INGOs.

Most of the health facilities and services in Somalia are located in cities and towns and this leaves large numbers of the population underserved, particularly in rural areas and nomadic populations. In addition, most of the public hospitals need more health equipment, medical supplies and highly-trained health professionals. Donors, UN agencies and INGOs should invest more in the health sector to address the root causes of existing health disparities and ensure access to life-saving healthcare services for all, including people in remote areas or from marginalised groups.

COVID-19 is putting a strain on an already weak healthcare system. There have been efforts to establish specific COVID-19 units,²⁹ but many feel that other health services have been left aside, putting many non-COVID-19 patients in danger. In addition, more awareness raising and information on COVID-19 is needed to dispel false beliefs and counter misinformation. For this, donors, the government and INGOs should work with WROs, CSOs, and religious and traditional leaders who have already been making efforts to bring accurate information to the communities they work with and that need support to continue this work.

²⁹ A number of health facilities have been either re-equipped or established to respond to the COVID-19 pandemic. For example, in Banadir, De Martino Hospital and Kesaney Hospital are the only public facilities set up to treat COVID-19 patients. Laanseleti Hospital also offers minimal services. Private hospitals such as Shaafi Hospital, Kalkaal Hospital, Digfeer Hospital (currently known as Erdogan Hospital) and Yardameeri Hospital also have limited capacity to provide comprehensive COVID-19 mitigation. In Southwest state, Bay Regional Hospital and Baidoa District Hospital established isolation centres for COVID-19 patients. Kismayu General Hospital in Jubaland created an isolation unit with basic services.

Participants also highlighted the unequal representation of women in healthcare decision-making processes, which results in a men-led and men-centric perspective of health needs and a potential lack of women's and girls' concerns being responded to. As seen above, SHRH and GBV services need to be strengthened, particularly in times of crisis. Donors, UN agencies, INGOs and the government should invest in gender-sensitive health programmes tailored to women's and girls' needs. They should also ensure equal opportunities for women to access skills training and have a better inclusion of women in recruitment processes in the health sector. They should also promote women's participation in leadership roles and health-related decision-making spaces.

Evidence:

Donors, UN agencies and INGOs have been filling the funding gaps in Somalia, working closely with line Ministries of Health in all regions of Somalia. They have provided much needed services through their activities, including WASH, health, nutrition and access to livelihoods in various communities. Despite this support, there are still health disparities in Somalia and many people continue to struggle in accessing basic healthcare services. The fact that the fund requirements of the Global Humanitarian Response Plan response have not been fully met complicates the situation. In 2020, only 33 per cent of the UN funds for the health cluster was met, and only 37 per cent in the case of funds to health responses directly related to COVID-19.³⁰

Although COVID-19 has increased the demand of people needing healthcare services, many privately owned health facilities have reduced their working hours or stopped admitting patients. Others have prioritised mitigating the pandemic, limiting the services available to patients with other needs. This has exposed the severity and risk to communities (in particular women and girls, and people living in rural and remote areas) of an underfunded and weak public health system.

In all regions of Somalia, the majority of hospitals are privately owned and anyone who wants to use them must pay. Many people, particularly the urban poor, IDPs and rural population are unable to afford these fees. Public hospitals are located in the capitals of all states and are under-funded, under-equipped, under-staffed and unable to meet the healthcare needs of the population comprehensively. As a result, many people turn to traditional healers for treatments.

In addition, a fair amount of misinformation has been spread since the pandemic started, which has led some people to believe in facts that put their health at risk and hinder efforts to mitigate the propagation. There are rumours that deny the existence of the virus, while others refer to the virus attacking only a certain social or religious group. Some people also think that health facilities are a focus of contagion and avoid visiting them for any other treatment. A COVID-19 mitigation committee has been established, aimed at collecting data, tracking incidents, and documenting and reporting cases. However, misinformation is spreading, resulting in people not taking the publicly suggested prevention actions or refraining from seeking help in fear of putting themselves at high risk.

³⁰ Financial Tracking Service, UN OCHA, 'Somalia 2020' (<https://fts.unocha.org/appeals/831/summary>)

Furthermore, despite women representing more than 75 per cent of the workforce in the health sector, only 10 per cent of them sit in leadership roles at all levels (national, regional and local), including in INGOs operating in the country.³¹ This reinforces gender inequalities and establishes a health system where women's and girls' needs and concerns are underrepresented and therefore not integrated in health services and responses. There is a need to address this and ensure that all health programmes are gender-sensitive. This should be achieved by: facilitating the access to equal education; addressing the gender pay gap; increasing the participation of women in decision-making spaces; meaningfully consulting women and girls and conducting regular gender analysis; and putting an end to discrimination and abuse against women in the workplace.

COVID-19, as well as previous crises, has brought to the surface all the weakness, inequalities and discriminations of the Somali health system, aggravating the negative effects of the pandemic for the country and its population. It is evident that the government, the UN and INGOs in Somalia need to increase their investment in programmes aimed at strengthening the health system and promoting healthcare services that are effective, non-discriminatory, widely accessible and gender-sensitive.

3.8. Recommendation 8:

Engage with men and boys to promote gender equality and protection

In Somalia, men hold most power positions, both at home and at the public and political levels, such as policy makers and traditional and religious leaders. Due to their power and influence, it is crucial to engage them in the fight for gender equality and women's and girls' rights. They also need to be engaged to respond to the negative effects of the COVID-19 pandemic on women and girls and design and implement a gender-sensitive pandemic response.

Donors and INGOs should support programmes that facilitate the engagement of men and boys as champions to address harmful social, cultural and religious practices, and to promote gender equality and women's and girls' social and political representation. Programmes should raise awareness among men and boys on women's and girls' rights, gender equality, harmful gender norms and the importance of women's participation in formal decision-making spaces. This work should supplement efforts on gender equality and not replace existing work with women and girls as it is essential that work with men and boys does not reinforce unequal gender power relationships, but addresses them.

Recommendation for: donors and INGOs.

Donors should support activities designed by women and WROs that facilitate the engagement of men and boys who can support in addressing harmful cultural practices. These practices include gender norms that fuel gender inequality and women's and girls' social exclusion and hinder the integration of gender-sensitive approaches into COVID-19 responses.

Donors should invest in WROs' activities which raise awareness among men and boys in their respective communities of women's and girls' rights, GBV, and gender equality. Such programmes should sensitise men and boys about their roles in: ending harmful cultural practices and gender norms; strengthening social protection networks for women and girls, and supporting women's and girls' participation in economic, social, and political spheres, as well as in peace processes.

However, these efforts should supplement (or be part of) and not replace programmes that respond to women's and girls' specific needs and rights, and that enable them to take leadership positions and meaningfully participate in decision-making. Priority should be given to such programmes, while investing in those that also target the root causes of gender discrimination, including engaging men and boys in a common effort to challenge gender inequality and conflict.

Evidence:

In a patriarchal society, power and decision-making spaces are dominated by men – at domestic, socio-economic, political and judiciary levels. They make up and represent the vast majority of those in leadership positions in the judiciary system, education, the health sector, military and security bodies, and political institutions. They also make up most of the informal and religious leaders, as well as those in INGOs and UN bodies. They have prominent positions in conflict resolution and negotiations, leading on drafting policies, agreements and legal provisions. Their views and actions affect women, girls and boys substantially, who on the contrary, have little to no say in these decisions that affect their lives.

Efforts must be undertaken to challenge harmful gender norms, practices and systems of power that are at the basis of these inequalities – while putting an end to GBV and promoting women's and girls' rights and their meaningful participation at all levels. This work needs to be done for, and by, women and girls and as a way of facilitating them to take the space they are denied.

Including men and boys to accompany women and girls' protection and rights work might increase the chances of success. It might also foster a change in men's negative attitudes and beliefs to women and girls, as well as in the systems they are part of and perpetuate. Men can promote women's participation in decision-making around: conflict prevention and peace-building; access to healthcare services (including reproductive health); access to justice; and girls' education, protection, resources and information. Moreover, in the midst of a pandemic that has steeply increased the prevalence of GBV, and particularly IPV, men should be approached to take an active part in awareness raising campaigns that must be women-led. They should also attend workshops, designed by women and girls, on women's and girls' rights, GBV and gender inequalities.

4. Partners

Somali Women Development Centre (SWDC) is a non-governmental and non-profit making organisation that was established mid-2000. Since then, SWDC has worked with a range of partners, donors and governments (including UN agencies and INGO grantees) to implement programmes and activities that promote equal rights for women – to ensure they have an active role in the Somali community through enhancing their social, political, economic and cultural participation.

SWDC works to improve the situation of women in Somalia. Its guiding vision is the belief that, with support, women can become empowered to make positive changes in their lives. It strives to minimise the number of women who are subjected to violence by empowering them through access to knowledge and greater economic independence. It also works to prevent and respond to GBV, providing survivors of GBV with social and psychological counselling, legal assistance and case management, and advocating for increased women's legal protection.

SWDC has facilitated a variety of training and workshops within ministries and communities, and worked with religious leaders, judges and police officers in an effort to provide information and secure community members' support for enhancing women's rights and protection.

Saferworld is an independent international organisation working to prevent violent conflict and build safer lives. We work with people affected by conflict to improve their safety and sense of security, and conduct wider research and analysis. We use this evidence and learning to improve local, national and international policies and practices that can help build lasting peace. Our priority is people – we believe in a world where everyone can lead peaceful, fulfilling lives, free from fear and insecurity. We are a not-for-profit organisation working in 12 countries and territories across Africa, Asia and the Middle East.

Saferworld has been working to promote peace, democratisation and good governance in Somalia and Somaliland since 2004. We support civil society's involvement, particularly women's and youth groups, in crucial decision-making processes on peace, security and development. With partners, we help community groups to identify and address their safety concerns, work to improve police services and make recommendations on security policy. We also work with democratic institutions such as electoral management bodies and political parties to help improve the quality of elections and civic and voter education.

Gender Action for Peace and Security (GAPS) is the UK's women, peace and security (WPS) civil society network. We are a membership organisation of NGOs in the fields of development, human rights, humanitarian assistance and peacebuilding. We were founded to promote WPS including United Nations Security Council Resolution (UNSCR) 1325. GAPS promotes and holds the UK government to account on its international commitments to women and girls in conflict areas worldwide.

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