

# The effect of COVID-19 and government response measures on poor and vulnerable groups in urban areas in Ethiopia

Research report: Results from the second round of a mixed method panel study in urban areas in 10 cities in Ethiopia

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## About the BRE programme

BRE is a three-year (2019–2022) technical assistance programme co-funded FCDO and the United States Agency for International Development (USAID). It is being implemented by Oxford Policy Management (OPM) and operates under a memorandum of understanding that was signed by the Ethiopian Ministry of Finance and FCDO in June 2019. The main aim of BRE is to support Ethiopia's drive towards becoming a middle-income country, by strengthening nationally owned and led systems that better anticipate and respond to recurrent shocks and resulting acute needs. The BRE vision is in line with the National Disaster Risk Management Policy and will support the Government of Ethiopia to lead and deliver an effective, gradually self-financed, and accountable response to climate and humanitarian shocks. BRE works in collaboration with other international development assistance partners, such as the US Centers for Disease Control, the World Health Organization, and Public Health England.

## About Maintains

This five-year (2018–2023) operational research programme is building a strong evidence base on how health, education, nutrition, and social protection systems can respond more quickly, reliably, and effectively to changing needs during and after shocks, while also maintaining existing services. Maintains is working in six focal countries—Bangladesh, Ethiopia, Kenya, Pakistan, Sierra Leone, and Uganda—undertaking research to build evidence and providing technical assistance to support practical implementation. Lessons from this work will be used to inform policy and practice at both national and global levels.

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## Preface

This study aims to understand the impact of COVID-19 and government response measures on poor and vulnerable groups in urban areas in Ethiopia. COVID-19 has had significant initial effects in urban areas, where population densities are extremely high, public services – including health and water, sanitation, and hygiene (WASH) – are often poor, livelihoods are precarious, and a range of other factors often have a negative impact on people’s lives (e.g. high levels of crime, gender-based violence, uncertainty for migrants/undocumented people). Pre-existing health conditions associated with poverty, such as malnutrition and TB are also likely to increase COVID-19-related morbidity and mortality. There is also a suspicion that air pollution may exacerbate vulnerability to COVID-19 infection, and such pollution is of course much more severe in urban areas, particularly large fast-growing cities. One particular control measure being widely used is physical distancing and movement restrictions, which have been introduced to huge sections of the global population in ways not experienced before. There are particular challenges in applying lockdown measures in low-income urban areas. The high density of informal and low-income settlements means administering physical distancing is a problem and other impacts as a result of distancing can exacerbate transmission (e.g. crowding, increased social mixing in crowded conditions, indoor pollution, etc.): few houses have their own water source or toilets, so shared water posts, if there are water posts, and community toilets increase transmission risk for the people using these services. Above all, for the urban poor there is a fundamental conflict between economic survival and compliance with stay-at-home physical distancing policies.

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## List of abbreviations

ANC	Antenatal care
BRE	Building Resilience in Ethiopia
CSO	Civil society organisation
ETB	Ethiopian Birr
FCDO	Foreign, Commonwealth and Development Office
IFPRI	International Food Policy Research Institute
KII	Key informant interview
NGO	Non-governmental organisation
OPM	Oxford Policy Management
PPE	Personal protective equipment
RT PCR	Reverse Transcription Polymerase Chain Reaction
SD	Standard deviation
SSB	Small-scale business
UNHCR	United Nations High Commissioner for Refugees
UPSNP	Urban Productive Safety Net Project
USAID	United States Agency for International Development
WASH	Water, sanitation, and hygiene

## Introduction

Unintended consequences of COVID-19 responses are becoming visible across sub-Saharan Africa. As at 15 October 2020, the number of people infected with COVID-19 in Ethiopia had reached 87,169, of whom 40,988 had recovered and 1,325 had died.<sup>1</sup> On 6 October, after lifting the state of emergency, the Government of Ethiopia issued a detailed COVID-19 pandemic prevention guideline that covers a wide range of issues, including the requirements for foreign travellers entering the country. According to the guideline, any foreign traveller above the age of 10 coming through the country's international airports needs to bring a certificate showing a negative RT PCR test result from the country of origin; the test must be done up to 120 hours, or five days, before arriving in Ethiopia. Any traveller who does not bring a certificate showing a negative RT PCR test result from the country of origin has a duty to give a RT PCR test sample, to have their address registered, and to self-quarantine at home until the result of the test is known. It is prohibited for any person to be found without a mask anywhere outside his or her residence, or to move from one place to another within the country. According to the directive, it is allowed to have a meeting of up to 50 individuals, by taking the precautionary measures. Moreover, all cross-country or inter-city transport service providers have a duty to carry passengers in accordance with the law setting the maximum carrying capacity, to deny service to individuals who are not wearing masks, to open windows to allow sufficient air circulation in the vehicle, and to provide their service by implementing other necessary precautions.<sup>2</sup>

The report on the results of the first round of our survey indicated that COVID-19 had significantly affected vulnerable groups and had differential impacts related to structural inequalities, such as gender, age, ability, and people marginalised for other reasons (e.g. internally displaced persons (IDPs)). Daily wage earners, people with jobs in the informal sector, vendors, petty merchants, and labourers were found to be the most likely to be impacted due to loss of jobs and livelihoods. Migrants and people living with no social safety nets were also found to be particularly vulnerable to the disease, and it was found that they may not have received sufficient aid and support. A similar study conducted by the World Bank Group highlighted concerns about the impact of COVID-19 on the health and livelihoods of the community, and found that food insecurity was prevalent among the participants.

This report presents the results from the second round of our mixed methods phone survey (using semi-structured and qualitative diary-style interviews, in which respondents led the discussion with gentle guiding by the interviewers across the main themes). The same households/individuals have been tracked for six months, with the focus on selected respondents, typically household heads. This round of the survey focused on the households (selected from Urban Productive Safety Net Project (UPSNP) beneficiaries, small business owners, and IDPs/refugees/returnees) and individual day labourers (petty traders and others, who we refer to as a 'special population segment' that could be especially vulnerable to the effects of the COVID-19 pandemic, and who were interviewed at length) who participated in the first round. This study aims to assess the effects of COVID-19 and government responses on their lives and changes in food security, livelihoods,

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<sup>1</sup> <https://covid19.ephi.gov.et/covid-19/>

<sup>2</sup> Federal Ministry of Health: a directive issued for the prevention and control of COVID-19 pandemic. Directive No 30/2020.

education for their children, and access to and use of health services over the past month.<sup>3</sup> It also aims to assess knowledge of, and practising of, preventive measures related to COVID-19, as well as stigma and discrimination against vulnerable groups as a result of COVID-19. The phone surveys were conducted in 10 selected cities in Ethiopia: Addis Ababa, Mekelle, Dire Dawa, Adama, Gambela, Bahir Dar, Jigjiga, Bulehora, Logia, and Semera. These were selected based on the size of the population of urban poor and vulnerable groups, including IDPs and refugees. We have worked closely with the Federal Ministry of Health and the National Disaster Risk Management Commission (NDRMC), in order to ensure that the findings of this study will help the government design social policies and interventions to curb the further spread of the pandemic and to reduce its impacts.

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<sup>3</sup> The first round of the phone interviews was carried out between 22 June 2020 and 22 July 2020 and in the first round we also interviewed local government officials, non-governmental organisations (NGOs)/civil society organisations (CSOs), and healthcare professions. However, we only interview these groups every two rounds. The main focus of our study is on the dynamics of the impact of COVID-19 and government measures on households and day labourers. The key informant interviews (KIIs) with local government officials, NGOs/CSOs, and healthcare professions help provide the context for our study, but they are not the main focus.

## Methodology – Round 2 (September 2020)

The study uses a mixed methods design, employing both qualitative and quantitative data collection methods. Semi-structured and qualitative diary-style interviews were conducted over the phone to explore the effects of COVID-19 and government measures on the following themes:

- knowledge and practices for preventing the transmission of COVID-19;
- urban poor households' economy (i.e. their income, expenditures, and means of livelihood);
- food security, and strategies for coping with the effects of the pandemic;
- access to health services and health-seeking behaviour;
- access to education during school closures;
- access to WASH facilities;
- mental health status;
- aid and support from the government, NGOs, and other organisations.

### Cities covered

The study was conducted from 23 August to 13 September 2020 in 10 cities/towns located in different regions of Ethiopia. The cities included were: Addis Ababa, Mekelle, Dire Dawa, Adama, Gambela, Bahir Dar, Jijjiga, Bule Hora, Logia, and Semera. This selection of cities is intended to include different regional states, different geographic locations, and different sizes, and to capture the impact of the different measures taken by the regions. Additionally, differences in the local economies, level of access to basic services, and the effects of internal displacement were also considered during the selection of the cities. The ten cities were thus selected to produce findings that are relevant across Ethiopia, and to allow for some comparison between different cities.

### Quantitative interview sample

The quantitative interviews were conducted among UPSNP beneficiaries, households who own a small-scale business (SSB), and refugees/IDPs/returnees. The UPSNP is designed to improve the income of targeted poor households and to establish urban safety net mechanisms. UPSNP beneficiaries are households who are identified as 'the poorest of the poor' based on their ability to generate income, their ownership of valuable assets, and their living conditions. The UPSNP beneficiary households receive a monthly payment from the government as direct beneficiaries (those working on city beautification and cleaning) and indirect beneficiaries (those not engaged in any work due to health problems, old age, and/or disability). Similarly, households in the IDP/refugee category are among the most vulnerable groups, and will be highly affected by COVID-19 and the associated government responses as their socio-economic status and livelihoods are already compromised due to displacement from their original location. In this study, the term 'refugee' refers to individuals who are under international protection living out of camps in the cities and are mainly from Logia, Semera, and Gambela. According to the *United Nations Guiding Principles on*

*Internal Displacement*, IDPs are ‘persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalised violence, violations of human rights or natural or human-made disasters, and who have not crossed an internally recognised state border’.<sup>4</sup> By contrast, there is no universally accepted definition of return migration. Return is ‘in a general sense, the act or process of going back or being taken back to the point of departure. This could be within the territorial boundaries of a country, as in the case of returning internally displaced persons (IDPs) and demobilised combatants; or between a country of destination or transit and a country of origin, as in the case of migrant workers, refugees, or asylum seekers’.<sup>5</sup>

It is worth noting that the sample sizes for IDPs, refugees, and returnees are small (76, 31, and 14, respectively),<sup>6</sup> and thus for most of the presentation of the results we group them together (the total sample size across the three groups is 123). However, we do acknowledge that these are very different groups of people, facing different types of challenges. Therefore, in the subsequent rounds, we aim to increase the sample size, particularly of refugees and returnees.

The third category – SSB households – are those engaged in a small local business to support their livelihood. The SSB households were included because of the possibility that their business or income would be significantly affected by the pandemic, given that economic activities are greatly impacted due to movement restrictions/lockdown.

The quantitative household interviews were conducted among the same participants involved in the first-round data collection. A simple random sampling method was used to select household survey participants within each of the three categories. Independent sampling frames were used for each group in each city. Lists of UPSNP beneficiaries were obtained from city-level UPSNP coordination offices, lists of SSBs were obtained from small-scale and micro enterprise offices, and lists of IDPs and refugees were obtained from local government authorities (social affairs, city administrations, and the Administration for Refugee and Returnee Affairs (ARRA)). The total targeted sample size (450, or 45 respondents per city) was equally allocated for the three categories, giving 15 respondents per category per city. A separate sampling frame containing lists of individuals and their telephone numbers, as obtained from the above-mentioned authorities and offices, was used to randomly select the allocated sample for each stratum.

Of the 436 sample of households included in the quantitative survey (Round 1), we were able to interview 407 participants during the second round, a response rate of 93.3%. Of

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<sup>4</sup> <https://emergency.unhcr.org/entry/44826/idp-definition> This, however, is a descriptive definition, which does not confer a special legal status because IDPs, being inside their country, remain entitled to all the rights and guarantees as citizens and other habitual residents of their country. As such, national authorities have the primary responsibility for preventing forced displacement and for protecting IDPs (UNHCR).

<sup>5</sup> IOM Glossary on Migration, 2019. There are two main types of return migration according to the IOM Glossary on Migration: (i) voluntary return, which is ‘the assisted or independent return to the country of origin, transit or another country based on the voluntary decision of the returnee’; and (ii) forced return, which is ‘a migratory movement which, although the drivers can be diverse, involves force, compulsion, or coercion’.  
[https://publications.iom.int/system/files/pdf/iml\\_34\\_glossary.pdf](https://publications.iom.int/system/files/pdf/iml_34_glossary.pdf)

<sup>6</sup> Since the sample size for returnees is very small, we refer to this category as ‘IDP/refugee’, in the interest of space.

these, 143 were UPSNP beneficiaries, 142 were SSB owners, and 122 were IDPs (76), refugees (31), or returnees (14).

## Qualitative interview sample

Diary-style interviews were conducted with the same participants from the first round of data collection. A total of 50 diary-style interviews (an average of five per city) were conducted with 10 UPSNP beneficiaries, nine SSB owner respondents, 17 IDPs and refugees, and 17 participants from the 'special population group' (i.e. daily labourers, shoeshines, waiters, porters, and commercial sex workers). These were slightly less than the first round (57 participants) as some of the respondents had changed their phone numbers and some refused to take the calls.

The qualitative data collectors also conducted weekly observation sessions to provide contextual insights into the communities' behaviour regarding the prevention of COVID-19 and level of compliance with the restrictions or measures set by national and local authorities. We used a semi-structured checklist to guide the observation. The information gathered from the 10 cities was summarised to see the changes between the observation sessions and to describe the overall context of the cities. The qualitative interviews in this round focused on the diary-style interviews with households only. No key informant interviews (KIIs) were carried out with local government officials, NGOs/CSOs, or health workers in this round. These KIIs are included every two rounds and will be included in Round 3.

## Interview approach

All interviews were conducted using a two-step approach: an introductory call made by the city coordinator (who is a part of the research team from MERQ) to introduce the study, obtain consent, and schedule interviews with potential participants, and then the actual interviews, conducted by the data collectors. The average duration of each interview for the quantitative semi-structured interview was 35 minutes, with 41 minutes for the diary-style interviews. The number of call attempts ranged from one to 10, in order to reach each respondent for the actual interview. Debriefings with the field-based data collectors and the study team were conducted at the conclusion of the interviews.

## Data analysis

Quantitative data were analysed using STATA Version 14. Descriptive statistical methods, including frequency tables and proportions (percentages), were used to analyse the quantitative data. We used tables and graphs to present the results. Chi-square and paired t-tests were used to test statistical differences in selected variables between the UPSNP beneficiaries, SSB, and IDP/refugee groups, and McNemar chi-square and paired t-tests were used to test statistical differences in selected variables across the two rounds. The data processing and analysis were concurrent with the data collection. All qualitative interviews were imported and coded using NVivo 14 qualitative analysis software. The interviews were coded independently using an inductive approach by members of the research team and differences and emerging codes were discussed. Framework analysis

was used to allow the identification of common variable patterns by themes/topic guides within and across different groups: UPSNP beneficiaries, SSB owners, refugees, IDPs, returnees, and the special groups, relating to their experience of the impact of COVID-19 and associated government measures. Salient quotes (translated into English) were used to express the experiences and perceptions of the informants, and for the case studies.

## **Limitations of the study**

Due to the nature of the subject under study (i.e. COVID-19 and compliance with government response measures), the findings of the study could be influenced by social desirability bias. However, we carefully designed the data collection tools in order to take this potential bias and other confounds into account. For example, the data collectors were not allowed to read the options out to the respondents (i.e. spontaneous responses to questions were captured, rather than respondents choosing from a fixed set of options). In addition, the study participants were clearly informed about the purpose of the study in the consent form.

We also faced multiple challenges during the data collection period. The phone numbers of some participants used during the first-round data collection did not work, which affected our data management process. The team had to apply adaptive means to increase the response rate, including using more days to reach out to participants whose phones were not working and asking field coordinators to trace those respondents and to find alternative phone numbers.

The attrition rate of the qualitative diary interview participants was very high in one city in particular, Gambella (five out of six participants). Half (three out of six) of the respondents no longer wanted to be involved in the study, and the phone numbers of the remaining participants did not work. Consequently, the research team decided to enrol new diary interview respondents selected from the main household survey.

## Context during Round 2

This section reports the contextual information as reported by the data collectors, based on their field observations. Like in the first round, the restriction measures imposed by the Ethiopian Government appeared to be implemented at varying levels across the ten cities. The major incidents/events observed by the data collectors during this round are summarised in the paragraphs below.

On 7 September 2020 (i.e. in the middle of Round 2), the federal government officially lifted the state of emergency, which had been declared in April 2020. Consequently, the restrictions imposed on public transport service providers to accommodate only 50% of their capacity was lifted. Moreover, the transport tariff, which had been double the normal price, was restored to the original price. Despite the above changes, the obligation for everyone on board (passenger, driver, and driver's assistant or cashier) to wear a facemask remained intact. The Ministry of Transport has declared a 1,000 Ethiopian Birr (ETB) penalty for drivers and drivers' assistants/cashiers who fail to wear a mask.

Tigray regional state (the capital city of which is Mekelle) conducted regional elections during this round of data collection. According to the regional state government, more than 2.5 million people participated in the election. People were observed to be wearing facemasks at the election centres. However, there was a lack of physical distancing.

Following the assassination of the well-known Ethiopian singer Hacalu Hundesa, there were riots and public demonstrations in most of the study areas in the Oromiya regional states (Adama and Bulehora), Addis Ababa, and in Dire Dawa city administration. A large number of protesters were observed to not be wearing any facemask while being in close contact with others. The protesters also blocked the roads from all directions to Addis Ababa, which appeared to create problems in public and goods transportation among different cities, and from those cities to Addis Ababa.

Based on the weekly observations by our data collectors, compliance with the COVID-19 measures, in terms of wearing a facemask in public places (banks, government offices, and marketplaces), washing hands or practising hand rubbing with sanitiser or alcohol-based solutions before entering service-providing institutions such as banks, has decreased in the past month. Moreover, the level of compliance with the restrictions greatly varied across the weekly observations conducted from 23 July to 13 September 2020, and appeared to fluctuate from time to time. As observed in Round 1, inappropriate use of a facemask was also common in all the cities. Some people only wore facemasks to cover their mouth, while others only used them to avoid being held accountable by the police for not wearing a mask in public places (but quickly took off their masks when they could not be seen by the authorities). Similar to Round 1, children were seen playing in the street without any face mask and not practising social distancing.

It was very common to see public gatherings without proper protections (i.e. wearing a facemask and physical distancing) at marketplaces, religious places, cafés, restaurants, etc. However, banks and some government offices (like Ethio Telecom) located in Addis Ababa, Mekelle, Bahirdar, and Adama were still forcing their customers to wear masks and to use hand sanitiser prior to entering the institutions/offices.

The team also observed food shortages, particularly of fruits and vegetables in Addis Ababa, which was perceived to be due to interruptions to the supply chain caused by road closures. It is worth noting that our team observed very minimal activity (by the government and NGOs) in terms of mobilising resources to support poor and vulnerable segments of the population. Finally, awareness-raising activities, which were very common during Round 1, were rarely observed in this round.

## Summary of household characteristics

The quantitative phone survey included a total of 407 households: 143 UPSNP beneficiaries, 142 SSB owners, and 122 refugees and IDPs – 29 fewer respondents than in Round 1, due to dropout (i.e. refusal to participate, phone switched off, or unable to pick up their phone). Female respondents account for 49.6% of the total respondents. The average age of respondents is 32, with a range between 20 and 68. The average family size is 5.2 (standard deviation (SD): 2.5), and the average household income is ETB 2,086 (SD: 1,880), compared to ETB 2,277 (SD: 4,814) in Round 1. Among the households in our sample, only 8% include lactating and/or pregnant women, while 50.5% have at least one child under five. Forty-two percent of the households live in accommodation that is rented from private owners and 27% own their homes. About 34% of households have recently moved to their current place of residence, and the remaining households have always lived in their neighbourhood.

For the qualitative study, a total of 50 diary-style interviews were conducted (compared to 57 in the first round) with nine UPSNP beneficiaries, eight respondents from the SSB group, 10 IDPs, seven refugees, and 17 participants from the special population group (i.e. daily labourers, shoeshines, waiters, porters, and commercial sex workers).

**Table 1: Characteristics of households and respondents, urban poor in selected 10 cities in Ethiopia, September 2020 (total n=403<sup>7</sup>, UPSNP = 142, SSB = 141, IDPs/refugees = 120)**

Household characteristics (n=403)		UPSNP (%)	SSB (%)	IDP/refugee (%)	Total (%)
<b>Gender of the respondent</b>	Male	27.3	69.0	55.7	50.4
	Female	72.7	31.0	44.3	49.6
<b>Family size</b>	Less than three	15.7	15.7	8.5	13.5
	Three to five	50.3	48.4	50.8	49.8
	Above five	34.0	35.9	40.8	36.7
<b>Number of children under five</b>	None	54.2	51.0	42.3	49.5
	One	27.5	32.0	33.8	31.0
	Two	12.4	15.0	18.5	15.1
	Three or more	5.9	2.0	5.4	4.4
<b>Residence status</b>	Permanent/long-term resident	90.2	84.3	17.7	66.5
	Moved recently to this neighbourhood	9.8	15.7	82.3	33.5
	Private accommodation (own)	33.3	37.3	6.2	26.6

<sup>7</sup> The sample size is reduced due to missing data for some of the variables for five respondents. All of the analyses in this report use the total sample of 403.

<b>Type of accommodation/ housing</b>	Rented from individual owner	39.9	49.0	36.9	42.2
	Rented from government	16.3	8.5	13.1	12.6
	Cohabit with relatives	5.9	4.6	4.6	5.0
	Cohabit with non-relatives	2.0	0.0	1.5	1.1
	Temporary-built accommodation	2.0	0.0	37.7	11.9
<b>Study sites/cities</b>	Addis Ababa	9.8	11.3	12.3	11.1
	Adama	9.8	9.2	9.8	9.6
	Bule Hora	14.7	12.7	0.0	9.6
	Dire Dawa	10.5	10.6	9.0	10.1
	Jigjiga	9.1	10.6	12.3	10.6
	Semera	10.5	9.2	13.1	10.9
	Logia	10.5	10.6	12.3	11.1
	Bahir Dar	10.5	9.9	11.5	10.6
	Mekelle	9.8	8.5	12.3	10.1
	Gambela	4.9	7.7	7.4	6.7

## Highlights of the results – Round 2

- Although the respondents reported that they regularly practised preventive measures, avoidance of crowded places has slightly decreased from 93% in Round 1 to 88% in Round 2 (not statistically significant). There also appeared to be misconceptions related to COVID-19, particularly in terms of the severity of its effects and even its existence. From our observational exercise (carried out by data collectors), compared to Round 1, **in this round in all cities we were less likely to observe wearing a facemask, keeping physical distance, and avoiding public gatherings.**
- Despite the improvement in access to water, participants seemed to be struggling with the economic costs associated with purchasing water and transporting it from the area where it was available to their own homes.
- Only 60 respondents reported that they needed medical treatment, of which 18% said that they were not able to access medical treatment when needed (compared to 12% in Round 1). The most common reason (23%) for this was reported to be **the cost of treatment**. In our qualitative interviews, however, **the fear of being infected with COVID-19 and being sent to quarantine centres** were most repeatedly mentioned as the reason not to attend health facilities.
- No change was observed in terms of access to educational platforms. About 72% and 66.7% of participants reported that their children helped them with routine/daily activities and played around the neighbourhood, respectively. Mothers were still bearing the greatest (if not all of the) childcare burden. 44% of the participants reported that their children had spent their time doing some reading since school closure. About 63% of the total households had at least one child attending primary or secondary education before the schools were closed due to COVID-19. **Fourteen girls were reported to have been married following the school closure and the median age at marriage was 15 years** (257 respondents/households reported that there was at least one child in the family attending school before the COVID-19 pandemic).
- The proportion of households who consumed an average of three or more meals appeared to have increased from 66% during Round 1 to 74% in this round. However, most respondents still struggled with increased food prices and **even though they managed to consume three meals a day, these usually consisted of basic food, such as rice and white flour** (not meat, fruit, or vegetables).
- The proportion of respondents who reported feeling stressed due to COVID-19 and government measures declined from 68% in Round 1 to 55% in Round 2. However, **there was a statistically significant increase in probable symptoms of depression among respondents (from 16% in Round 1 to 18% in Round 2).**
- On average, 40% of households reported to have received assistance from the government or NGOs in this round, which is comparable to Round 1 (39%). The largest proportion of the assistance provided was in the form of free food (74%), followed by cash (56%). However, the support was perceived by the participants to be inadequate and the process around the selection of beneficiaries was not seen as transparent.

## Results by theme<sup>8</sup>

### Behaviour relating to COVID-19

#### Key findings:

- Practising handwashing and using hand sanitiser appeared to be common among the participants. However, the use of a facemask was found to be less common among the UPSNP beneficiaries group compared to the SSB and IDP/refugee groups. The difference could partially be attributed to these groups' living arrangements and the differences in the nature of their daily activities.
- There was no significant difference in reported practising of the preventive measures between Rounds 1 and 2. However, respondents reported to be less likely to avoid crowded places in this round compared to Round 1.
- Misconceptions about the severity of COVID-19 seemed to have contributed to the limited practising of preventive measures.

We asked the participants if they were still practising measures to reduce their exposure to COVID-19. In this round, 99%, 88%, and 98% reported that they were still practising handwashing, hand rubbing with sanitiser or alcohol-based solution, and using a facemask, respectively. **The findings from the qualitative interviews indicated a declining practice of the preventive methods over the past month (since the first round interview was completed on the 23<sup>rd</sup> of July).** According to our respondents, some people were not using facemasks and the enforcement by the authority was becoming weaker. The field observations data also indicated that compliance with the government restrictions was decreasing.

*Several people do not use masks in the city. When we compare the habit of wearing a mask, it is getting reduced. There is no punishment for not wearing a facemask. Anyone who is not interested can stop wearing a facemask. (IDP, Logiya)*

The decrease in the practising of preventive methods was partially associated with misperceptions of the severity of the disease and its existence, and a decline in awareness-raising activities:

*They [the community] were taking precautions at the beginning of the pandemic. Now, they are not taking precautions that much. People became used to coronavirus and have become careless. (IDP, Dire Dawa)*

*If you say there is Corona, why don't you wear facemask? Why don't you maintain a physical distance? They reply, 'Corona is "yesew sim hunual", meaning [It is just like*

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<sup>8</sup> Note that we present the results for IDPs, refugees, and returnees as one group in the tables and graphs but wherever possible we highlight significant differences between these groups in terms of the impacts, acknowledging that they are defined very differently. The breakdown of the results for IDPs, refugees, and returnees for all themes can be found in **Error! Reference source not found.C**, and a summary of the qualitative results for these groups can be found in **Error! Reference source not found.**

*name of somebody] joking. There is no one to question why people fail to wash hands and maintain physical distance. (Member of special group, Addis Ababa)*

*Last month, when the pandemic began, health professionals, community leaders, and other responsible bodies were creating awareness related to COVID-19 among the community. As a result, people were practising all the preventive measures such as washing hands frequently with soap, social distancing, wearing mask etc. But later, all those awareness creation activities from the government decreased. So, some people are back to their normal life and give less attention to COVID-19. (Refugee, Semera)*

Similarly to Round 1, a few respondents from our qualitative interviews explained that some people practised the preventive measures only so as not to be held accountable by the authorities for ignoring government restrictions. According to the respondents, people even questioned the existence of COVID-19 and considered it not to be a reality. This finding indicates that some people may not be well-informed about why they need to wear a facemask or to practise social distancing:

*Some people make a joke of people who wear facemask it. They say, 'Do you think corona exists? How can you do that?' Some of them wear just because they are forced to do it by the government and fearing not to be seen without wearing it by the police. Some people wear it until they enter into the taxi, then they remove it. (Returnee, Bahir Dar)*

A few respondents had misconceptions regarding their vulnerability to COVID-19: they believed that people who go to churches were protected:

*I do not wear facemask when I go to church as I believe God will protect me once I go there. Others have the same belief. (Special group member from Bahir Dara)*

*I don't think going to religious gathering prevent this pandemic. People, however, believe that God protect them when they go to religious gathering. You seldom see people wearing facemask in a mosque. Some people consider you as lacking faith if you are worried about COVID-19 while you are in the mosque. Now all religious places are reopened, and it is free as if there is no COVID-19. (IDP from Jijjiga)*

There was no significant difference in regard to practising handwashing (chi-square: 4.815; p-value: 0.090) or using sanitiser (chi-square: 3.207; p-value: 0.201) among the UPSNP beneficiaries, SSB, and refugee/IDP groups. However, there was a significant difference in using a facemask (chi-square: 10.017; p-value: 0.007) among the UPSNP beneficiaries, SSB, and refugee/IDP groups. Using a facemask was found to be more common among the SSB and refugee/IDP groups, but not the UPSNP beneficiaries group. The discrepancy could be due to difference in the living condition of UPSNPs, characterised by less movement compared to the SSBs. Overall, there were no significant differences in practising the major methods to reduce exposure to coronavirus across the cities included in this study. However, it was found to be difficult for participants from Gambella to avoid overcrowded places. According to the qualitative findings, living arrangements posed a challenge in terms of physical distancing, particularly among IDPs, which also created anxiety among them. An IDP from Mekelle described the situation as follows:

*Our living condition is worse; we are living in a single crowded room. There are five sub-cities in the village where I am living in. For instance, when I come back to the room, I drop the mask and join a group of 36 women. We stay in the room and eat food and drink coffee together. If any one of us is infected by the virus, obviously we could all contract it. (IDP, Mekelle)*

The percentage of respondents who reported drinking hot tea as a means of reducing exposure to COVID-19 has dropped significantly, from 94% in Round 1 to 77% in Round 2 (chi-square: 11.267; p-value: 0.001). This finding could partially be explained by improved community awareness about the correct COVID-19 preventive measures.

The level of avoidance of crowded places in Round 2 was slightly lower compared to Round 1 (chi-square: 3.903, p-value: 0.071) and there was no significant difference in the practising of methods to reduce exposure to coronavirus between male-headed and female-headed households, except for handwashing (chi-square: 4.043, p-value: 0.044).

**Table 2: Compliance with government restrictions among the urban poor in selected 10 cities in Ethiopia, September 2020 (total n=403, UPSNP = 142, SSB = 141, IDPs/refugees = 120)**

Characteristics	Respondent category			Round 2 Total	Round 1 Total	Chi-2 [p-value]
	UPSNP (%)	SSB (%)	IDP/Ref. (%)			
<b>Compliance with movement restrictions</b>						
A lot	62.0	50.7	54.5	55.8	55.3	<b>59.36</b> [<0.000]
Somewhat	23.9	30.7	29.8	28.0	23.3	
Not very much	2.8	4.3	3.3	3.5	8.8	
Not at all	11.3	14.3	12.4	12.7	12.5	
<b>Compliance with wearing a facemask</b>						
A lot	80.3	85.0	78.5	81.4	74.2	<b>21.32</b> [0.001]
Somewhat	16.9	14.3	19.0	16.6	28.7	
Not very much	1.4	0	0.8	0.7	2.5	
Not at all	1.4	0.7	1.7	1.2	12.5	
<b>Compliance with social distancing</b>						
A lot	73.2	64.3	65.3	67.7	65.4	<b>30.99</b> [<0.000]
Somewhat	25.4	26.4	31.4	27.5	20.9	
Not very much	0.7	2.9	1.7	1.7	3.9	
Not at all	0.7	6.4	1.7	3.0	9.8	

Note: Null hypothesis for the first chi-2 test: there is no difference among the three categories. Null hypothesis for the second chi-2 test: there is no difference in Round 1 and Round 2. We used the McNemar chi-square test for dichotomous variables and the Stuart-Maxwell test for other categorical variables.

We also asked participants if they met people other than their family members. About 42% reported having met with people outside their households, and more than half of these meetings (53%) happened **at a religious gathering**.

We are aware that self-reported data may be affected by social desirability bias and therefore we also asked about compliance with different preventive measures by

respondents' family members and friends. Similar to Round 1, the reported compliance rates among family members were significantly lower compared to the self-reported rates of own behaviour set out above. Only 56% and 68% reported that all of their family members complied with the movement restrictions and wore a facemask, respectively. About 62% said that all of their family members practised social distancing. In Round 2, there was no significant difference in the level of family compliance with movement restrictions (chi-square: 3.697; p-value: 0.449) and the use of facemasks (chi-square: 0.039; p-value: 1.000) between UPSNP beneficiaries, SSB, and IDP/refugee groups (Table 3).

**Table 3: Family compliance with government restrictions among the urban poor in selected 10 cities in Ethiopia, September 2020 (total n = 403; UPSNP = 142, SSB = 140, IDPs/refugees = 121)**

Restrictions	UPSNP (%)	IDPs/refugees (%)	SSB (%)	Round 2 Total (%)	Chi-2 [p-value]
<b>Compliance by family members with movement restrictions</b>					
None of them	11.3	15.7	10.7	12.4	3.697 [0.449]
Some of them	26.8	31.4	35.7	31.3	
All of them	62.0	56.2	50.7	56.3	
<b>Compliance by family members with wearing a facemask</b>					
None of them	1.4	1.7	1.4	1.5	0.039 [1.000]
Some of them	30.3	30.6	30.7	30.5	
All of them	68.3	67.8	67.9	68.0	
<b>Compliance by family members with social distancing</b>					
None of them	2.1	2.5	7.9	4.2	11.375 [0.023]
Some of them	28.2	38.0	36.4	34.0	
All of them	69.7	59.5	55.7	61.8	

Note: Null hypothesis for chi-2 test: there is no difference in the level of family compliance with movement restrictions, wearing a facemask, and social distancing among the three sampling categories.

## WASH

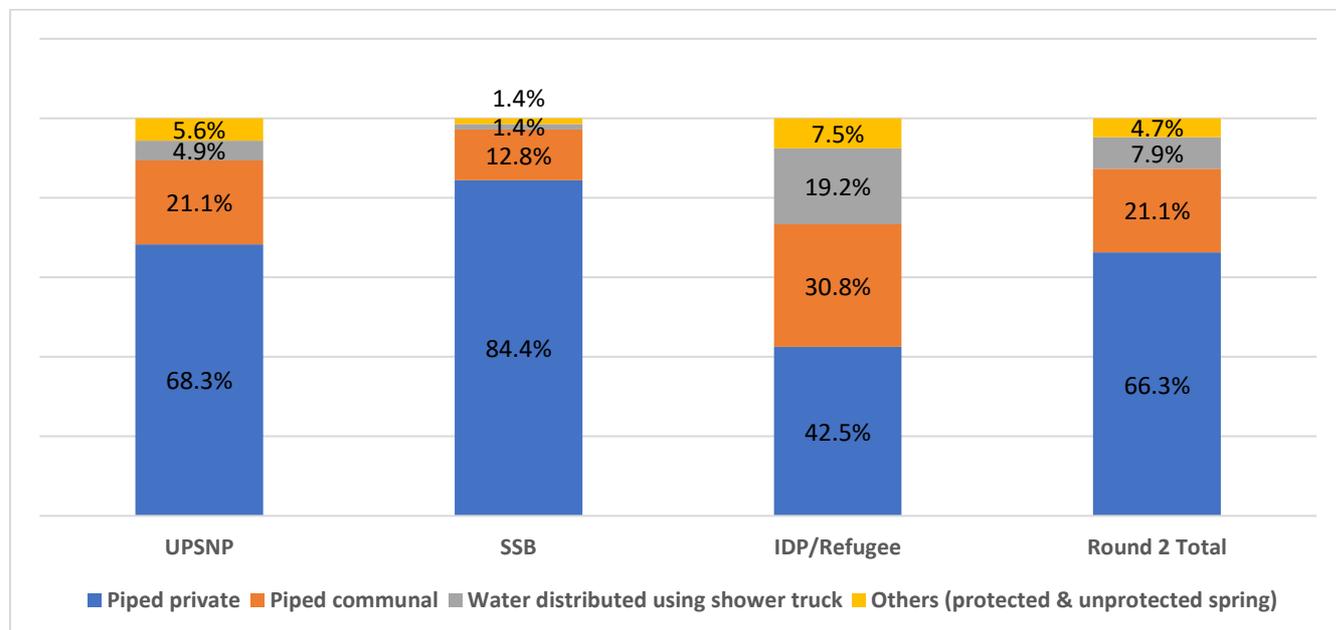
### Key findings:

- The proportion of households who had everyday access to water supply has significantly increased from 52% in Round 1 to 60% in Round 2 (Chi square value of 26.0 at P = 0.000).
- Despite the improvement in access to water, participants widely mentioned the economic burden associated with purchasing water and transporting it from the area where it was available to their homes.

Private piped water supply was the main source of water for the majority of households from the UPSNP beneficiaries (68%) and SSB (84%) groups. IDP/refugee respondents obtained

water through a mixture of sources, including private and communal piped water and shower truck and spring (protected and unprotected) (Figure 1).

**Figure 1: Source of water for the urban poor in selected 10 cities in Ethiopia, September 2020 (total n = 403; UPSNP = 142, SSB = 140, IDPs/refugees = 121)**



The proportion of households who had everyday access to a water supply increased from 52% in Round 1 to 60% in Round 2. There was no statistically significant difference among the three categories of respondents in terms of the frequency and the level of difficulty of accessing water (Table 4).

The average number of days of water shortage in the past month was six days (SD = 6.2) in this round. This finding showed a slight improvement compared to the first round, where the result was 7.5 days (SD= 7.6). However, the change is not statistically significant.

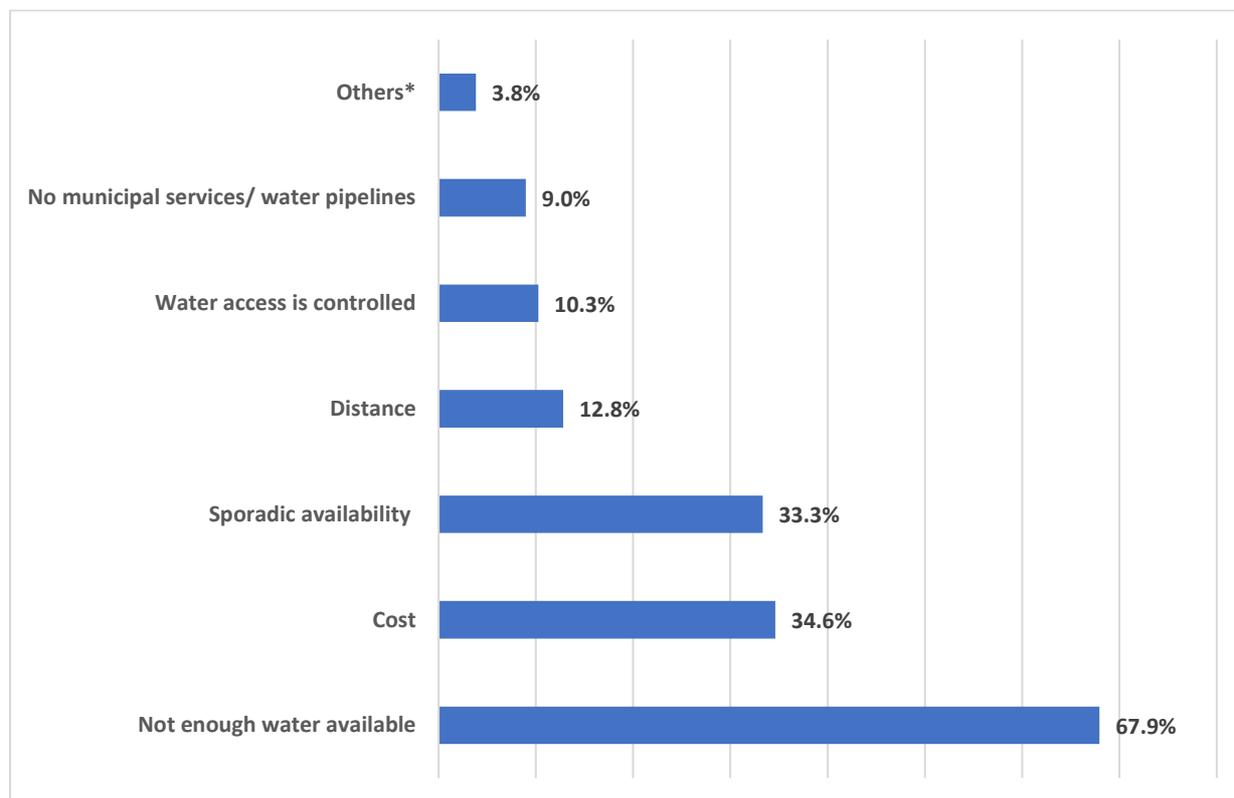
**Table 4: Access to adequate water supply among urban poor households in selected 10 cities in Ethiopia, September 2020 (total n = 403; UPSNP = 142, SSB = 140, IDPs/refugees = 121)**

Characteristics/variables		Respondent category			Chi-2 [p-value]	Round 1 total (%)	Round 2 total (%)	Chi-2, p-value
		UPSNP (%)	SSB (%)	Refugee/ IDP (%)				
<b>Shortage of water in the last one month</b>	Yes	34.5	22.7	36.7	7.1 [0.028]	32.7	31.0	<b>3.2</b> [0.725]
	No	65.5	77.3	63.3		67.3	69.0	
<b>Frequency of access to water supply</b>	Every day	57.7	56.0	67.5	10.3 [0.113]	51.6	60.0	<b>26.1</b> [0.000]
	Once in a week	24.6	29.8	26.7		25.1	27.0	
	Once in two weeks	2.8	2.1	0.0		4.4	1.7	
	Other **	14.8	12.1	5.8		18.9	11.2	
<b>Level of difficulty accessing water since COVID-19 outbreak</b>	Much more difficult	4.2	3.5	4.2	9.3 [0.155]	9.1	4.0	<b>19.4</b> [0.003]
	Slightly more difficult	16.2	11.3	19.2		17.7	15.4	
	Nothing changed	64.8	78.0	63.3		55.8	69.0	
	Easier than before	14.8	7.1	13.3		17.4	11.7	

Note: Null hypothesis for the first chi-2 test: there is no difference among the three categories. Null hypothesis for the second chi-2 test: no difference in Round 1 and Round 2. We used the McNemar chi-square test for dichotomous variables and the Stuart-Maxwell test for other categorical variables.

For those who reported having experienced water shortage, absence of adequate water, higher prices and transportation costs, and sporadic availability of water were among the main reasons for difficulty in accessing water reported by the quantitative household survey participants (Figure 2).

**Figure 2: Major reasons for difficulty accessing water since the COVID-19 outbreak among the urban poor in selected 10 cities in Ethiopia, September 2020**



Some participants of the qualitative diary-interviews frequently mentioned shortages and interruptions of piped water supply (both private and communal). They also reported the use of alternative water sources, such as spring and rainwater.

*There is shortage of water and we have no access to clean water here. We are using rainwater for drinking and cooking. (IDP, Gambella)*

*At this time there is no problem because there is rainwater. We are collecting rainwater from our roof to the handwashing tanks where we regularly wash our hands. Thanks for God, the summer is very nice. (Special group member, Mekelle)*

Participants widely mentioned the economic burden associated with purchasing water and transporting it from the area where it was available to their homes. They also stated that there had been an increase in the price of water since the onset of the COVID-19 pandemic.

*There is no adequate water supply. So, we buy water from tanker truck and cart... After COVID-19 the price of one jerrican [21-litre plastic container] water increased from 6 to 10 birr. There is shortage of water, it is difficult to access and the cost is also high. (IDP, Jijjiga)*

Participants from all three groups described the shortage of water as a major challenge in relation to proper handwashing practice, which they recognised one of the most important COVID-19 prevention measures.

*My family members couldn't wash their hand frequently due to the unavailability of water. Washing hand frequently could help them to keep their hygiene, and it can protect them from different diseases. (UPSNP beneficiary from Bule Hora)*

By contrast, a few participants from Addis Ababa, Bahirdar, Mekelle, Bulehora, and Adama mentioned improvements in access to water supply compared to the previous month (Round 1). Increased capacity of municipal water supply during the rainy season is one of the reasons for improved availability of water in the cities.

*Availability of water is better than the previous month. Previously, we had access to pipe water only once in a week, but now there is improvement...the frequency has increased. (SSB owner from Addis Ababa)*

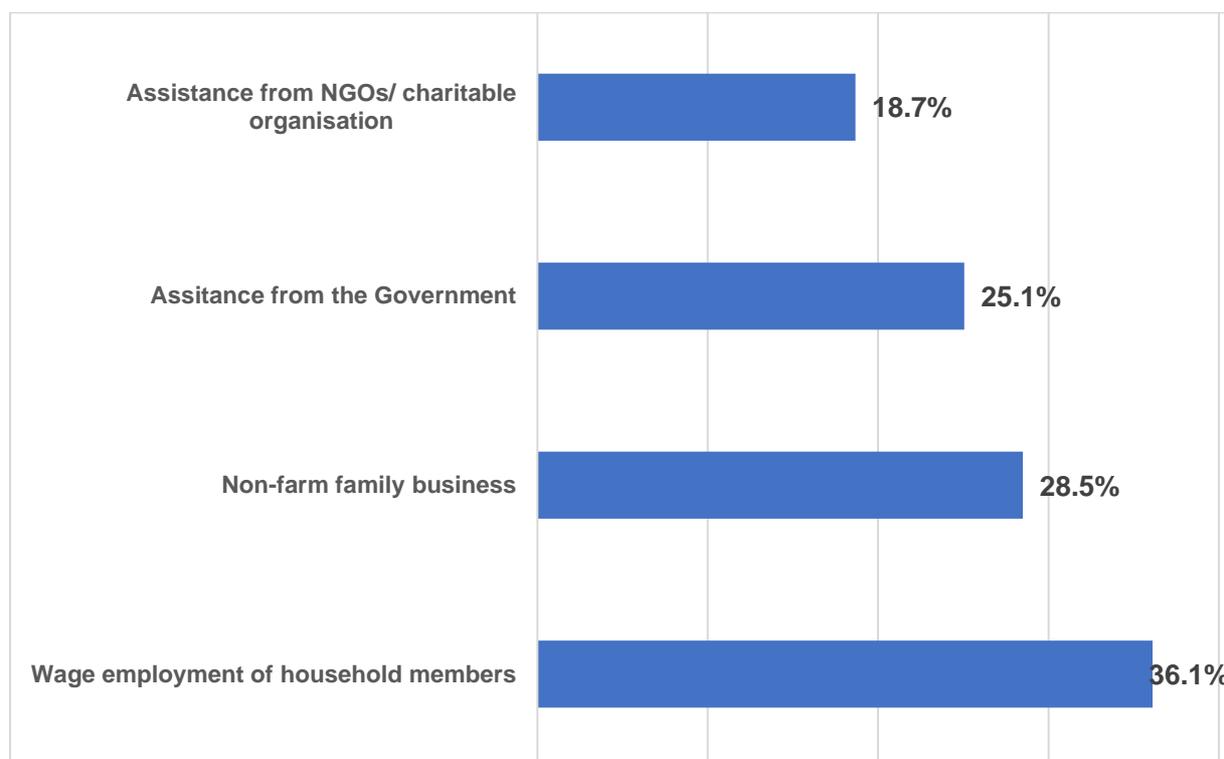
## Income and expenditure

### Key findings:

- The average monthly income of households has declined from ETB 2,410 during Round 1 to ETB 2,086 in Round 2; but this change is not statistically significant.
- The ability of households to earn income as they did before COVID-19 has significantly **increased** from 67% in Round 1 to 83% in Round 2.
- Major strategies used to cope for those with reduced income during this survey period (Round 2) included using up savings, getting help from family members, and humanitarian assistance.

Among our sample, wage employment was the major means of livelihood (36%), followed by non-farming family businesses (28%), and assistance from government (25%) (Figure 3). However, the average monthly income of households has reportedly declined from ETB 2,410 during Round 1 to ETB 2,086 during Round 2, although this change in the income is not statistically significant.

**Figure 3: Means of livelihood among the urban poor in selected 10 cities in Ethiopia, September 2020 (total n=403, UPSNP = 142, SSB = 141, IDPs/refugees = 120)**



Some households reported to be able to earn the same income as pre-COVID period has significantly **increased** from 67% in Round 1 to 83% in Round 2. The SSB group had the highest proportion of households who were able to earn the same income as they did before COVID-19. This result is supplemented by the qualitative findings, in which respondents, particularly from the SSB and special groups, mentioned improvement in their income during Round 2. Factors that were mentioned as contributing to improvement in their income were: being able to open their shops; availability of transport services due to the easing of government restrictions; and improved availability of goods (such as food materials) . However, with increased food prices, some respondents said that they did not feel better off than last month:

*There has been change in my income but no significant betterment. After deducting food and transport expenses, I would be left with about 30 birr a day. I earn about 250 to 300 birr a week. (Special group member, Adama)*

Another respondent from Dire Dawa reported an improvement in her income as follows:

*Last time [Round 1] I was in a great worry...I was in difficult situation to pay house rent. I did not pay for the past two consecutive months. I feared to get evicted from the house. But now, I have paid the house rent and all my debts. I have no such kind of worries.... the situation of my job is getting better, I am getting better income. (Special group member, Dire Dawa)*

The perceived risk of eviction from participants' houses due to loss of income has sharply declined from 45% in Round 1 to 14% in Round 2. Compared to the UPSNP beneficiaries and IDP/refugees, the SSB households faced a lower risk of eviction from their house due to loss of income (Table 5) since they were able to resume their business again. It is worth noting that about 3% of respondents (i.e. 13 households) reported having been evicted from their house in past month. Of these, 4% and 6% were from the UPSNP beneficiaries and IDP/refugee groups, respectively, with none from the SSB group. Male-headed households reported a higher proportion (seven out of 10) of evictions from their homes compared to female-headed households (Table 5).

There was no statistically significant difference between male- and female-headed households in terms of reduced working hours and current ability to earn income (Annex B). There were disparities among the 10 cities, however. Higher proportions of respondents from Mekele, Adama, and Logiya reported cutting down their working hours and/or the amount of work in Round 2. The proportions of households who reported to be at risk of eviction were higher in Bulehora, Jigjiga, and Mekele, and were lowest in Dire Dawa, Semera, and Bahirdar (Annex A).

**Table 5: Income and employment among the urban poor in selected 10 cities in Ethiopia, September 2020 (total n=403, UPSNP = 142, SSB = 141, IDPs/refugees = 120)**

Characteristics/variables		Respondent category			Chi-2[p-value]	Round 1 total (%)	Round 2 total (%)	Chi-2 [p-value]
		UPSNP (%)	SSB (%)	Refugee/ IDP (%)				
<b>Cut down hours or amount of work since COVID-19</b>	Yes	62.0	59.6	58.3	<b>0.37</b> [0.827]	61.2	60.0	<b>2.57</b> [0.740]
	No	38.0	40.4	41.7		38.8	40.0	
<b>Current ability to earn income like normal work before COVID-19</b>	Yes	80.3	87.9	80.0	<b>3.9</b> [0.140]	66.8	82.9	<b>6.45</b> [0.000]
	No	19.7	12.1	20.0		33.2	17.1	
<b>Risk of eviction from their house due to loss of income</b>	Yes	16.9	8.5	15.8	<b>4.9</b> [0.08]	44.7	13.6	<b>0.58</b> [0.001]
	No	83.1	91.5	84.2		55.3	86.4	

Note: Null hypothesis for the first chi-2 test: there is no difference among the three categories. Null hypothesis for the second chi-2 test: no difference in Round 1 and Round 2. We used the McNemar chi-square test for dichotomous variables and the Stuart-Maxwell test for other categorical variables.

The qualitative findings are in line with the quantitative results. Respondents reported that the relaxation in government restrictions on transportation and marketplaces created an opportunity to engage in income-generating activities. However, **due to the persistent increase in the price of food, the economic and affordability issues remained the same – and even worsened in some cases:**

*My income is now better than it was when we spoke last time. This does not mean that my current income is comparable to my income before the advent of the Coronavirus; however. Nevertheless, since I am now back to my work, I am able to make from 200 to 300 birr per day these days. (IDP, Adama)*

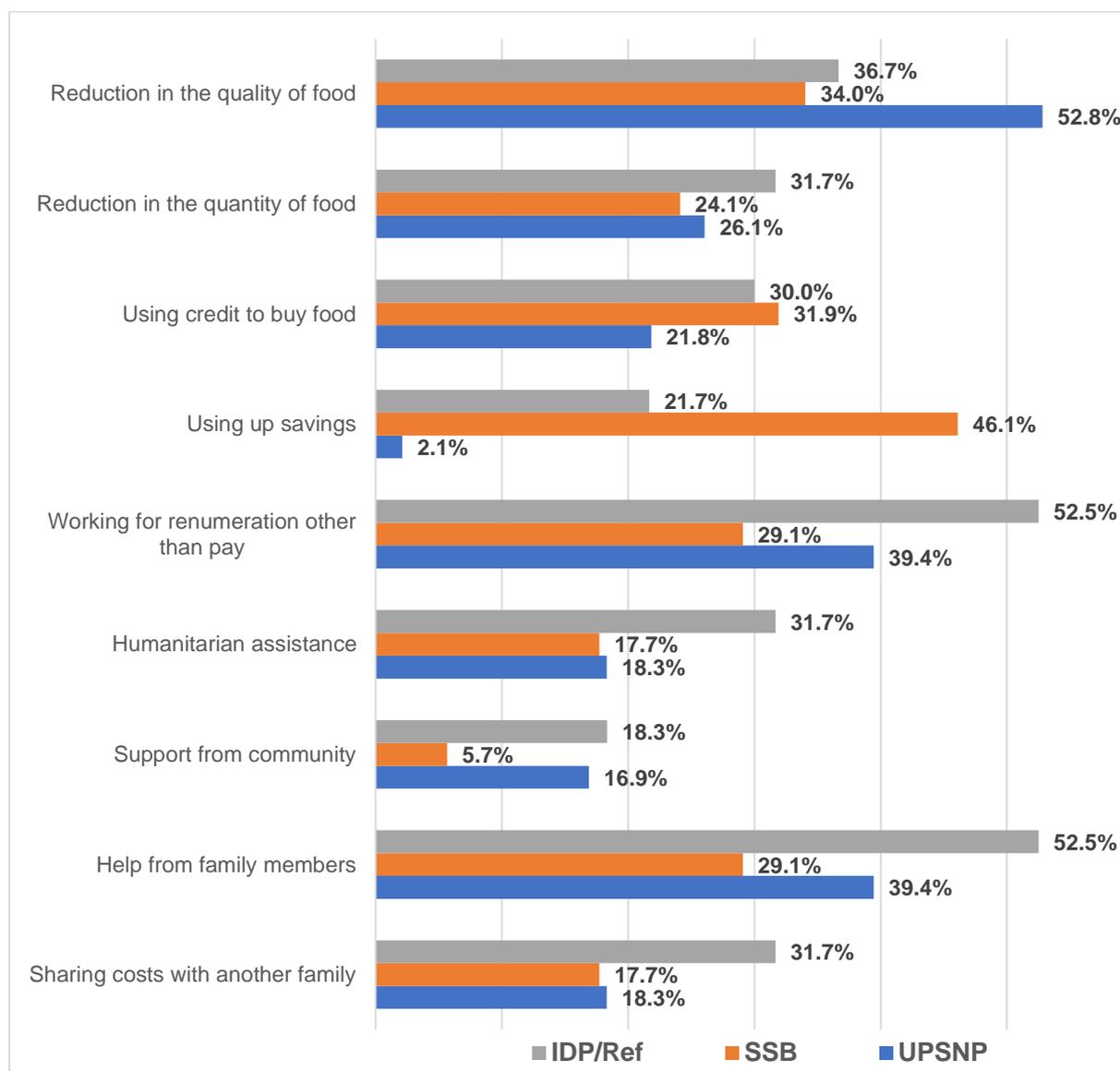
*I have started working but it is not going well even if it is better than last time. I had no work previously, but now I am working twice a week. (Special group member, Bahirdar)*

On the other hand, some IDPs/refugees mentioned a decrease in their income and a lack of job opportunities. One of the IDP respondents described the situation as follows:

*I went to my previous customers for washing clothes, but they ignored me because they said 'it is corona time; we can wash ourselves'. So, there is no work, I could not find any work because of the virus. Before corona, I was washing their clothes and they pay me 300 birrs. (IDP from Mekelle)*

Similar to Round 1, the strategies used to cope with reduced income included reducing the quantity and quality of food, using up savings, obtaining help from family members, and receiving humanitarian assistance (Figure 4). However, the proportion of respondents who mentioned working for enumeration, i.e. to earn additional/supplement income, as a coping strategy sharply increased from 7% in the first round to 40% in this round. Similarly, the proportion of respondents who used their savings to cope with economic challenges also increased more than twofold (Figure 4). There was no significant difference between male- and female-headed households in regard to coping strategies.

**Figure 4: Coping mechanisms for reduced income one month before the survey among the urban poor in selected 10 cities in Ethiopia, September 2020 (total n=403, UPSNP = 142, SSB = 141, IDPs/refugees = 120)**

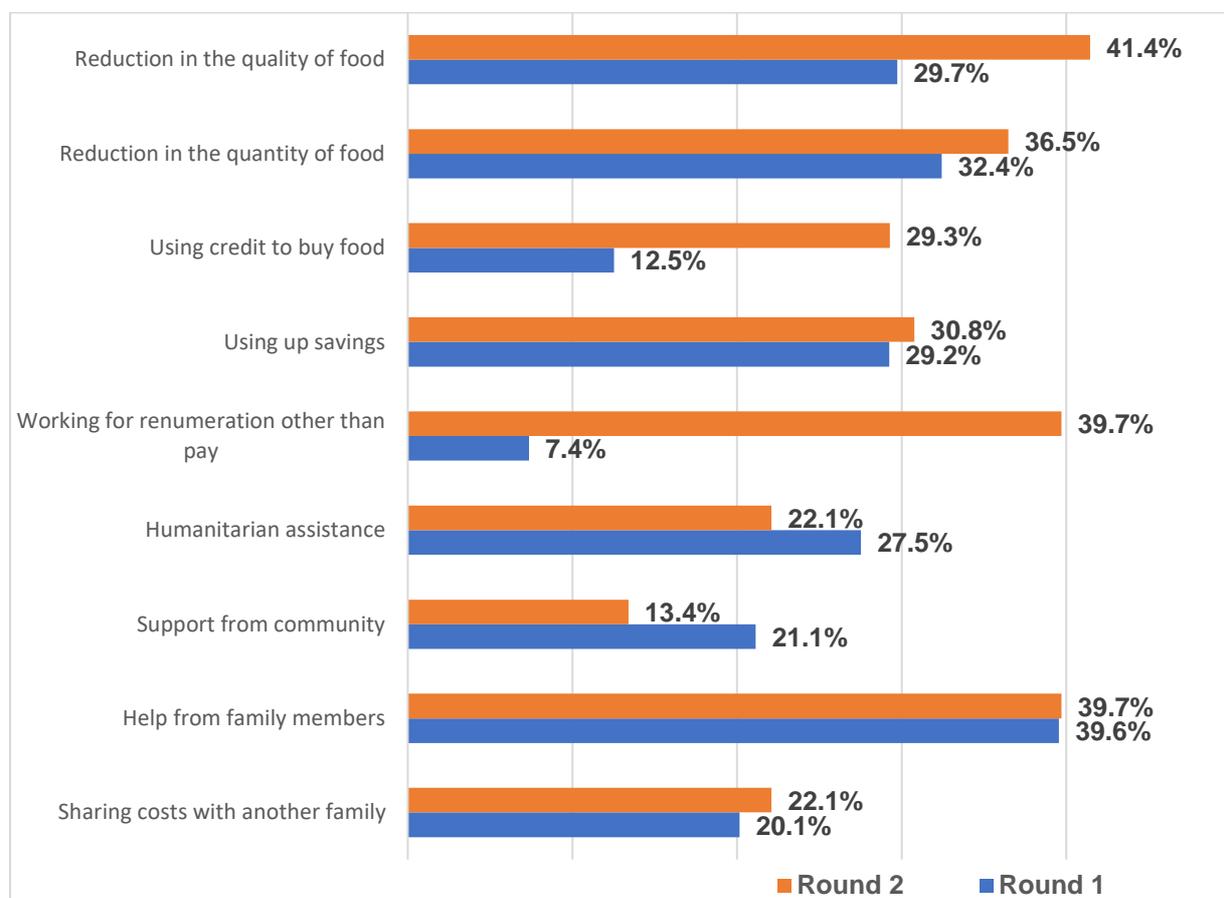


Asking for support from relatives, reductions in the quality and quantity of food consumed, purchasing less preferred and cheaper food items, and using up savings were broadly mentioned as coping mechanisms by the qualitative study participants.

*Currently, I am covering my expenses using the financial support I get from my relatives. In this month, house rent and other expenses were covered by my relatives. I can't tell you what will happen in the future. I am very ashamed of asking help from my relatives, while I am physically fit and healthy to do job and earn income. (UPSNP beneficiary, Logiya)*

*I cope with this challenge by taking credits from local shops. It is by borrowing that I cope. We would tell them that we will pay them back when we get our salaries. (UPSNP beneficiary from Adama)*

**Figure 5: Mechanisms for coping with reduced income during Rounds 1 and 2 among the urban poor in selected 10 cities in Ethiopia, September 2020 (total n=403, UPSNP = 142, SSB = 141, IDPs/refugees = 120)**



## Food security

### Key findings:

- The proportion of households who consumed an average of three or more meals per day increased from 66% in Round 1 to 74% in Round 2. However, most respondents still struggled with increased food prices and **even though they managed to consume three meals a day, these usually consisted of basic food, such as rice and white flour** (not meat or vegetables).
- Availability of food reserves for future use has also increased, from 72% to 94% in Round 2.

The proportion of households who consumed an average of three or more meals per day increased from 65.8% during Round 1 to 74% in Round 2. However, most respondents still struggled with increased food prices, and **even though they managed to consume three meals a day, these usually consisted of basic food, such as rice and white flour** (not meat or vegetables).

The proportion of households who reported consuming three or more meals per day was highest among the SSB households and there is a statistically significant difference among

the three categories, and between Round 1 and Round 2. However, there was no statistically significant difference between male- and female-headed households regarding the consumption of food (Annex B).

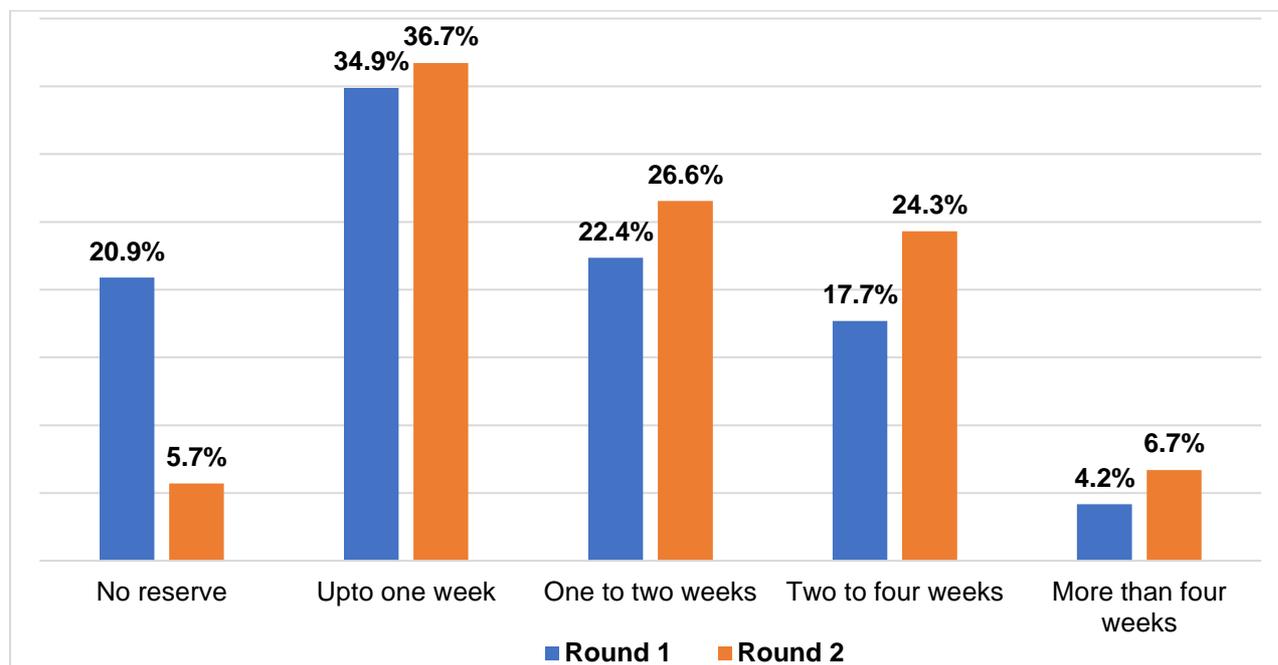
Availability of food reserves for future use has statistically significant increased during Round 2. For instance, the proportion of households with no food reserves declined from 21% in Round 1 to only 6% in Round 2 (Figure 6). The proportion of households with no food reserves was lower for SSB households as compared to UPSNP beneficiaries and refugees/IDPs. Incidence of food shortages was highest (56%) among UPSNP beneficiary households, followed by IDP/refugees (47%). The proportion of households who reported having to reduce the number of meals per day also decreased from Round 1 (32%) to Round 2 (23%) (Table 6).

**Table 6: Household food access, by respondent category and rounds, among the urban poor in selected 10 cities in Ethiopia, September 2020 (total n=403, UPSNP = 142, SSB = 141, IDPs/refugees = 120)**

Characteristics/variables		Respondent category			Chi-2[p-value]	Round 1 total (%)	Round 2 total (%)	Chi-2 [p-value]
		UPSNP (%)	SSB (%)	Refugee/IDP (%)				
<b>Average frequency of meals per day consumed by household members during the last month</b>	Two or less	37.3	12.1	29.2	<b>24.3</b> [0.000]	34.2	26.1	<b>6.7</b> [0.000]
	Three and above	62.7	87.9	70.8		65.8	73.9	
<b>Availability of food reserves</b>	No reserve	6.3	2.1	9.2	<b>49.5</b> [0.000]	20.9	5.7	<b>72.0</b> [0.000]
	Up to one week	50.7	28.4	30.0		34.9	36.7	
	One to two weeks	26.1	22.7	31.7		22.4	26.6	
	Two to four weeks	16.2	31.9	25.0		17.7	24.3	
	More than four weeks	0.7	14.9	4.2		4.2	6.7	
<b>Incidence of food shortage in the last one month</b>	Yes	56.3	28.4	46.7	<b>29.8</b> [0.000]	54.1	43.7	<b>2.8</b> [0.000]
	No	43.7	71.6	53.3		45.9	56.3	
<b>Reduction in number of meals per day after COVID-19</b>	Yes	12.8	25.0	22.6	<b>29.7</b> [0.000]	32.2	22.6	<b>4.7</b> [0.001]
	No	87.2	75.0	77.4		67.8	77.4	

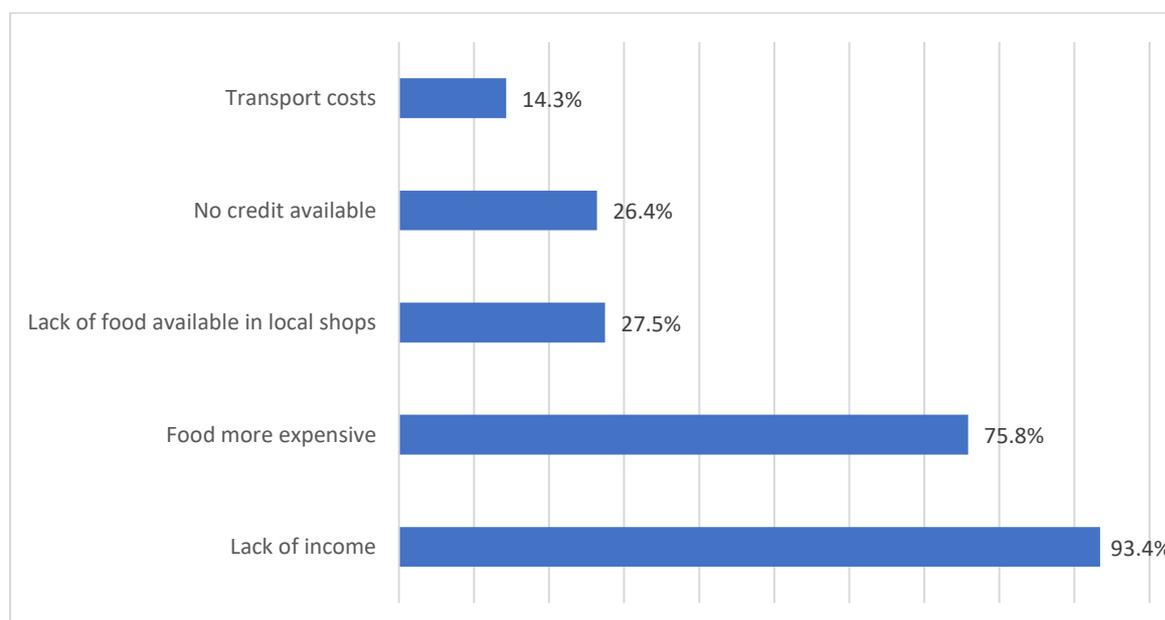
Note: Null hypothesis for the first chi-2 test: there is no difference among the three categories. Null hypothesis for the second chi-2 test: there is no difference in Round 1 and Round 2. We used the McNemar chi-square test for dichotomous variables and the Stuart-Maxwell test for other categorical variables.

**Figure 6: Availability of food reserves in the household among the urban poor in selected 10 cities in Ethiopia, September 2020 (total n=403, UPSNP = 142, SSB = 141, IDPs/refugees = 120)**



Among households that reported a reduction in the number of meals per day, we also explored the major reasons for the reduced food consumption. Lack of income and increased prices of food items were found to be the most predominant reasons (Figure 7). The qualitative findings were in line with the quantitative survey results, where higher food prices, lack of income, and an increase in the cost of transportation were mentioned as the major reasons for food insecurity in general.

**Figure 7: Reasons for reducing food consumption among the urban poor in selected 10 cities in Ethiopia, September 2020 (total n=403, UPSNP = 142, SSB = 141, IDPs/refugees = 120)**



In qualitative interviews, participants described an increase in the price of certain crops, such as Teff, which is one of the main staple food items:

*At this time, it is aggravated, the price of Teff has increased to more than 4,000 birr per quintal and subsequently the price of one Enjera became 15 birr. ... maybe only rich people can overcome this problem...but for us (the poor) it is too scary and even difficult to survive...The good thing is I have experience to handle hunger....I have seen even worse than this. (IDP from Mekelle)*

This result is in line with the findings from a recent review of a phone survey produced by the International Food Policy Research Institute (Hirvonen, 2020).<sup>9</sup> Evidence from their case study in the vegetable sector suggests that price dynamics are highly context- and crop-specific. Their study calls for more comprehensive price monitoring to identify food value chains and areas where food price increases may have been unusually rapid. Contrary to Round 1, inadequacy, scarcity, and unavailability of food/food items in the market were not mentioned as reasons for reduced consumption and food insecurity. The current season (i.e. Ethiopian summer) is typically known for surplus availability of fruits and vegetables in the market. However, participants mentioned the high price of food resulting in the consumption of less preferred food items, which are considered to have poor nutritional value.

*Currently, there is no shortage of food like last month. You can get everything if you have money, but it is too expensive. (UPSNP beneficiary from Semera)*

*Currently, shops and markets are open, and all food items are available. There is no shortage of food in the market, but food price is still rising (Special group member from Logiya)*

*We are eating only maize [the cheapest and less preferred food item]. We couldn't afford buying other foods like meat, bread, and Teff even if we have a desire for them. (UPSNP beneficiary from Bule Hora)*

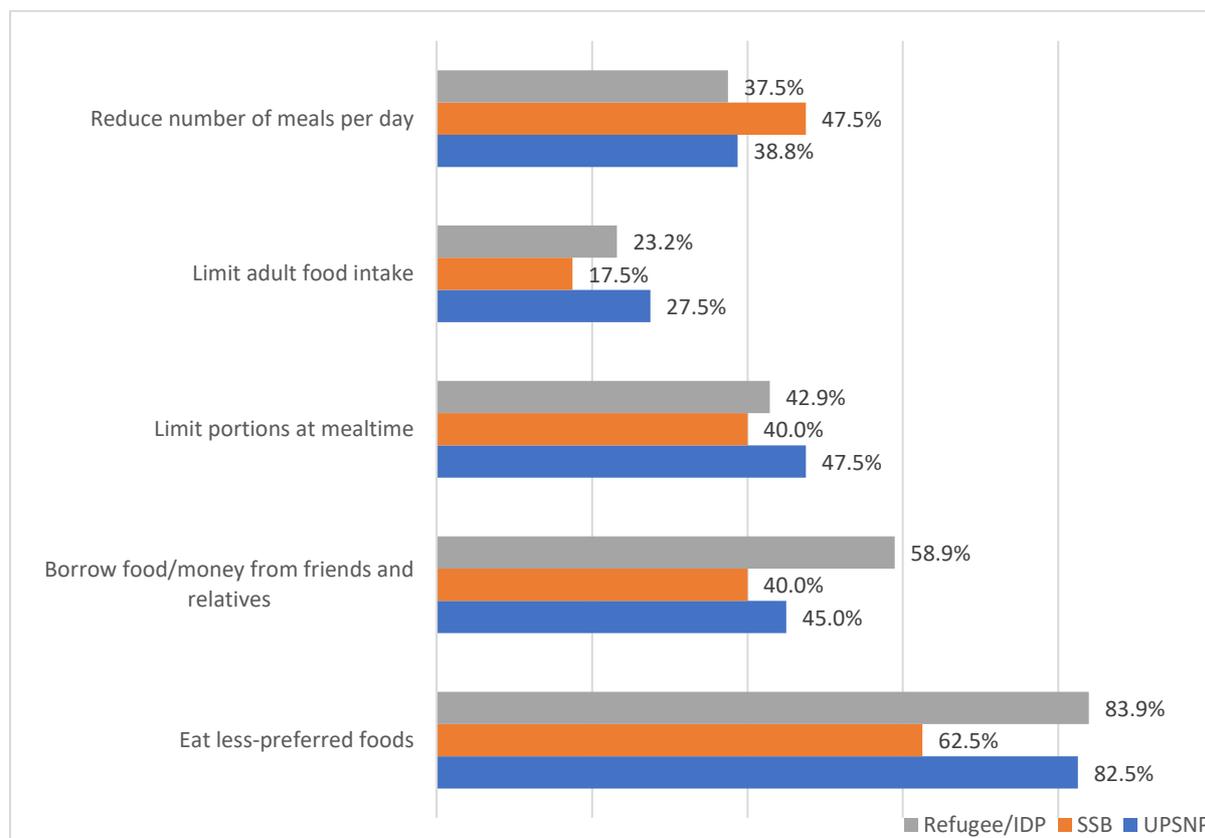
Participants also mentioned road closures due to riots during August and September as a cause of interruptions of food supply chains (from the sources to the markets or customers), which could have contributed to increased food prices. Some of the participants also mentioned that the increased price of food is attributed to an increase in the demand for food items for the holiday celebration ceremony (relating to the Ethiopian New Year).

Eating less preferred foods and reducing the number of meals per day remained the predominant strategies for coping with food insecurity (unaffordability) during the past month. There was a slight variation in coping strategies among the UPSNP beneficiaries, SSB, and IDP/refugee groups (Figure 8).

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<sup>9</sup> [www.ifpri.org/publication/economic-impacts-covid-19-pandemic-ethiopia-review-phone-survey-evidence](http://www.ifpri.org/publication/economic-impacts-covid-19-pandemic-ethiopia-review-phone-survey-evidence)

**Figure 8: Strategies for coping with reduced access to food among the urban poor in selected 10 cities in Ethiopia, September 2020 (total n=403, UPSNP = 142, SSB = 141, IDPs/refugees = 120)**



Similar coping strategies were also mentioned by participants in the qualitative interviews.

*We are having three meals per day, but we reduced the amount of food we eat. Mostly rice and white flour are the main staple food of the household. (Refugee, Semera)*

*Sometimes it is difficult to eat food three times a day, when there is no money or food at home. As we know, food price is going up. Sometimes I can't afford to buy food and member of the family eat two times a day, except children who eat more. (Special group member, Bulehora)*

## Health

### Key findings:

- Most respondents or members of their families who needed medical attention reported having been able to access medical treatment. However, some people still chose not to visit health facilities due to fear of exposure to COVID-19, or of being sent to a quarantine centre.
- Overall, the results suggest that maternal health service utilisation has not been significantly impacted by COVID-19.

In this round, only 60 respondents (14.7%) reported that they had needed medical treatment in the 30 days preceding the survey. Of these 60, the most common reason for needing medical attention was **fever with persistent cough or difficulty breathing (26.7%), followed by diarrheal diseases**. Of this group, 18.3% said that they were not able to access medical treatment when needed and the most common (23.5%) reason for this was the cost of the treatment. In Round 1, the fear of being infected by COVID-19 was the most common reason (23.5%) for not accessing treatment.

Our qualitative interviews indicated that the fear of being infected by COVID-19 and the fear of being sent to a quarantine centre still remained barriers to treatment-seeking:

*Everyone just goes to pharmacies and buys any medicine for their illness. They avoid going to health facilities. There is dengue fever outbreak here in our village and people just go to pharmacies ask them medication for fever. When we ask them why they don't go to health facility for treatment, they reply they may be tested and quarantined there. They may not return to their home if they go to healthcare centres. (Special group member, Dire Dawa)*

*Last month when I got common cold, I was scared of going to a health facility because I thought they would quarantine me. As a result, I treated myself at home using herbal medications like steam and other hot drinks. The first reason is that once you go to a health facility with the above symptoms, they immediately consider it as COVID-19 and throw you in quarantine. (SSB owner, Semera)*

Some respondents had a different view with regard to the fear of being infected by COVID-19 and health-seeking behaviour. A refugee from Semera explained:

*The reason that I did not visit a health centre was that I didn't feel sick. It was not the fear of being infected with COVID-19. (Refugee, Semera)*

Respondents from the SSB group reported that the COVID-19 pandemic had not affected their access to healthcare. This group appeared to be better off in terms of the reported access to health services, compared to the other groups. This could be due to the fact that businesses were reopening. As indicated elsewhere in this report, the SSB group has a higher proportion of households who are able to earn the same income as they did before COVID-19.

*I needed a health service, because of renal infection not for COVID-19. COVID-19 did not affect my ability to get health services last month. There is no problem in this regard. The situation in health facility is far better than previous. (SSB owner, Jijjiga)*

In terms of awareness of people who are more vulnerable to COVID-19, 63%, 61%, and 22% of the respondents believed that older people, people with chronic diseases, and children are more vulnerable to COVID-19 compared to other groups, respectively. About 16% of respondents believed that there is no difference in the level of vulnerability to COVID-19 across different groups. **Only 29 respondents (34.1%) reported that they were aware of any measures in place to protect vulnerable people from COVID-19.**

The qualitative findings indicated that respondents were well-informed that people with chronic diseases like hypertension and diabetes mellitus are at increased risk from COVID-19.

*Mostly it is indicated that individuals who are more at risk for coronavirus are the elders and those co-diseased with other diseases like hypertension and diabetes mellitus. It is due to the virus will have the opportunity to damage internal organs of such people easily. (IDP, Logiya)*

Respondents were asked if any children under five in their family had been sick in the 30 days prior to the Round 2 interview. Only 30 respondents (13.5%) reported that there was at least one child under five who was sick, and 24 respondents reported taking their children to a health facility for treatment.

Respondents were also asked if any of their children under five were diagnosed as malnourished. Only 29 participants reported that their children were reported to have been diagnosed with malnutrition by health workers. Of the 55 children eligible for vaccination, almost all (53) were reported to have been vaccinated. The qualitative findings also suggested no or a small effect of COVID-19 on caregivers' treatment-seeking behaviour for children under five and for child vaccinations in their community.

*There are many pregnant and lactating women in our area. I have observed that they are taking their children to a health facility to get them immunised. Moreover, COVID-19 did not prevent pregnant women and family planning users visiting health facilities. They are accessing health services. They are educated and excellent mothers; they have no problem attending maternal and child health services. (IDP, Mekelle)*

*This month I took two of my children to the health facility. I am not scared of going to health centre for any treatment needed. (Refugee, Semera)*

*There is a neighbour who has a child less than one year. I know the child was immunised twice since COVID-19 was reported in our country. I myself accompanied them once when they immunised the child. (Special group member, Jigjiga)*

However, some caregivers reported having felt scared of taking their children to health facilities due to the fear of exposure to COVID-19:

*Nobody has been taking their child for immunisation because of the fear of corona infection. (UPSNP beneficiary, Bule Hora)*

Only 6% of the total household sample included pregnant women (25 households), of which 76% had access to antenatal care (ANC). About 23% of our household sample included lactating women (91 households), of which 75% had accessed postnatal care. There was no significant difference in the access to ANC and postnatal care between Round 1 and Round 2. In Round 1, 70% and 76% of pregnant and lactating women were able to access ANC and postnatal care, respectively.

About 92% of the total household sample in this round included women of reproductive age, of whom 37% and 36% were reported to have been using a method to avoid or delay

pregnancy before and after the COVID-19 pandemic. The qualitative findings also indicated that maternal health service utilisation has not been significantly impacted by COVID-19.

*There was a pregnant woman who gave birth after we moved to this camp recently. She was attending antenatal care and gave birth at the hospital without any interference by the pandemic. Still, we didn't go with them, they went alone to the hospital. (IDP, Mekelle)*

Some respondents did report that some pregnant women preferred not to visit health facilities for ANC and delivery services due to fear of contracting COVID-19.

*There are many pregnant women among our relative, friends, and neighbours. They were going to the health facility for ANC visit but after COVID-19, these pregnant women are not visiting health facilities as before because they are scared of being infected and prefer to stay at home. (Special group member, Semera)*

## Education

### Key findings:

- Children mostly spent their time playing around the neighbourhood, helping their family, and watching TV. Only a small proportion spent their time studying.
- The most alarming finding is that some of the young girls in our sample got married following school closure and the median age at marriage was 15 years.

Over 60% of the total households (257) had at least one child attending primary or secondary education before schools were closed due to COVID-19. Of these, only 28.4% had access to an educational platform, including TV and radio, to help them learn from home. Respondents felt that nothing was done to help children learn from home. Some participants explained that educational programmes transmitted through radio and television had been interrupted and children were just left with textbooks.

*There has been no change in this regard [availability of educational materials]. Our children have their previous textbooks only and nothing more... There is no platform prepared concerning young children. (IDP, Jigjiga)*

*As we discussed with you last time [in Round 1], children were following their education through TV program, which has stopped currently. (SSB owner, Dire Dawa)*

We asked about how children were spending their time during the COVID-19 pandemic. About 72% and 66.7% of participants reported that their children helped them with routine/daily activities and played around the neighbourhood, respectively. Only 44.3% of participants reported that their children spent their time reading since the closure of schools (Table 7). There was no significant difference in how children spent their time after school closure between the UPSNP beneficiaries, SSB, and IDP/refugee groups.

*The school is closed and there is no one to help them while they are teaching themselves at home. Hence, in the past month they were spending their time playing*

*with other children outside. It is very difficult to keep them at home day and night. So, we let them play and refresh themselves. (SSB owner, Addis Ababa)*

A few participants mentioned that their children had continued studying at home:

*I bought books immediately after the school was closed. I bought books for four of them among the 12 children. Those attending second and third grade learn only the Quran, whereas those attending 11th and 12th grade read the books I bought for them. I also bought books for those attending eighth and ninth grade. (IDP from Dire Dawa)*

**Table 7: Time use among children from the urban poor in 10 cities in Ethiopia, September 2020 (total n=403, UPSNP = 142, SSB = 141, IDPs/refugees = 120)**

Characteristics	Respondent category			Round 2 total
	UPSNP (%)	SSB (%)	IDP/Ref. (%)	
<b>Time use among children</b>				
Help their family	72.4	73.1	68.8	71.8
Study	37.5	51.6	46.9	44.3
Play around the neighbourhood	65.3	68.8	65.6	66.7
Stay at home, watch TV/movies, and play games	41.8	49.5	34.4	42.7
Engaged in income-generating activities	16.3	15.1	18.8	16.5

As shown in Table 8, most of the respondents (78%) reported that mothers were the primary caregivers during the school closure, which was similar to the finding from Round 1. The qualitative findings are in line with the quantitative results. However, some participants mentioned that other family members supported mothers in taking care of children.

*When I am not at home, his father takes care of our child. When we both go out of home for any purpose, he goes with us. We didn't allow him to stay at home alone...(SSB owner, Addis Ababa)*

**Table 8: Childcare responsibility among the urban poor in 10 cities in Ethiopia, September 2020 (total n=403, UPSNP = 142, SSB = 141, IDPs/refugees = 120)**

Characteristics	Respondent category			Round 2 total	Round 1 total
	UPSNP (%)	SSB (%)	IDP/Ref. (%)		
<b>Person responsible for looking after the children during school closure</b>					
Mother	70.4	81.7	85.9	78.4	78.3
Father	9.2	4.3	0	5.1	5.1
Grandparents	1.0	0	0	0	0.4
Siblings	6.1	8.6	7.8	7.5	7.5
Relatives	8.2	2.2	6.2	5.5	5.5

About 63% of the total households had at least one child attending primary or secondary education before schools were closed due to COVID-19. In this round, we asked if there were any school-aged girls who got married following the COVID-19 pandemic. **Fourteen girls were reported to have been married following the school closure, at the median age of 15 years.** Of these, seven, four, and three were from UPSNP beneficiaries, SSB, and IDP/refugee families, respectively. School closure has caused confusion for participants as to what to do if schools remain closed for a long period of time. A few qualitative respondents would have preferred to send their children to private schools if there were no financial constraints:

*Currently schools are closed. But there is a rumour that registration is about to begin. I am planning to send my children to government schools. I would love to send my children to private school, but I don't have the capacity to pay for private school at this time.* (Special group member, Logia)

## Mental health

### Key findings:

- The proportion of respondents who reported feeling stressed due to COVID-19, and the response measures, have significantly declined from 68% in Round 1 to 55% in Round 2.
- By contrast, there was a statistically significant increase in probable symptoms of depression among respondents (from 15.6% in Round 1 to 18% in Round 2).

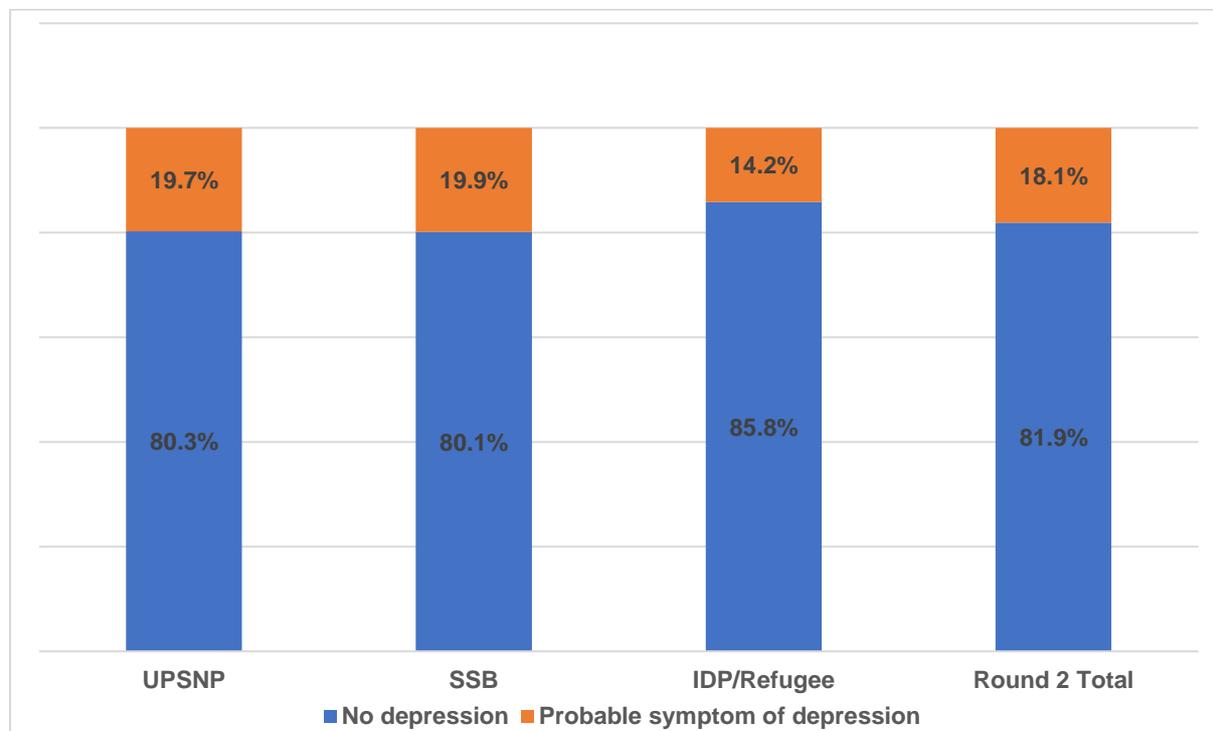
More than 55% of respondents reported that they had had feelings of being stressed, scared, and frustrated in the past month. This finding is significantly lower than the first round (68.2%) (chi-square value = 66.9, p-value = 0.000). Similarly, the proportion of respondents who perceived there to have been a negative effect of COVID-19 and associated government responses significantly declined from 18.% in Round 1 to 11.4% in Round 2 (chi-square value = 25.1, p-value = 0.001). There was no statistically significant difference regarding the feeling of being stressed, scared, and frustrated among the three categories.

The study evaluated the mental health status of respondents using a standard tool called the Patient Health Questionnaire (PHQ-9). The tool contains nine questions that measure indications of probable depression using a three-point scale, ranging from 0 (not at all) to 3 (nearly every day). The results of a reliability test indicated that the instrument has acceptable consistency, with a Cronbach's alpha value of 0.93. The mental health status was measured against a total of 27 points, in which 10 was considered as a cut-off point. Respondents who scored 10 points and above were categorised as having 'probable symptoms of depression', and those with a total score below or equal to 10 were grouped as having 'no mental health problem'. In this round, about 18% of respondents exhibited probable symptoms of depression. This was found to be slightly lower among refugees/IDPs (14%) than other categories (Figure 9). There was no statistically significant difference between male and female respondents in terms of exhibiting probable symptoms of depression (chi-square value = 0.131, p-value = 0.717). The proportion of respondents with

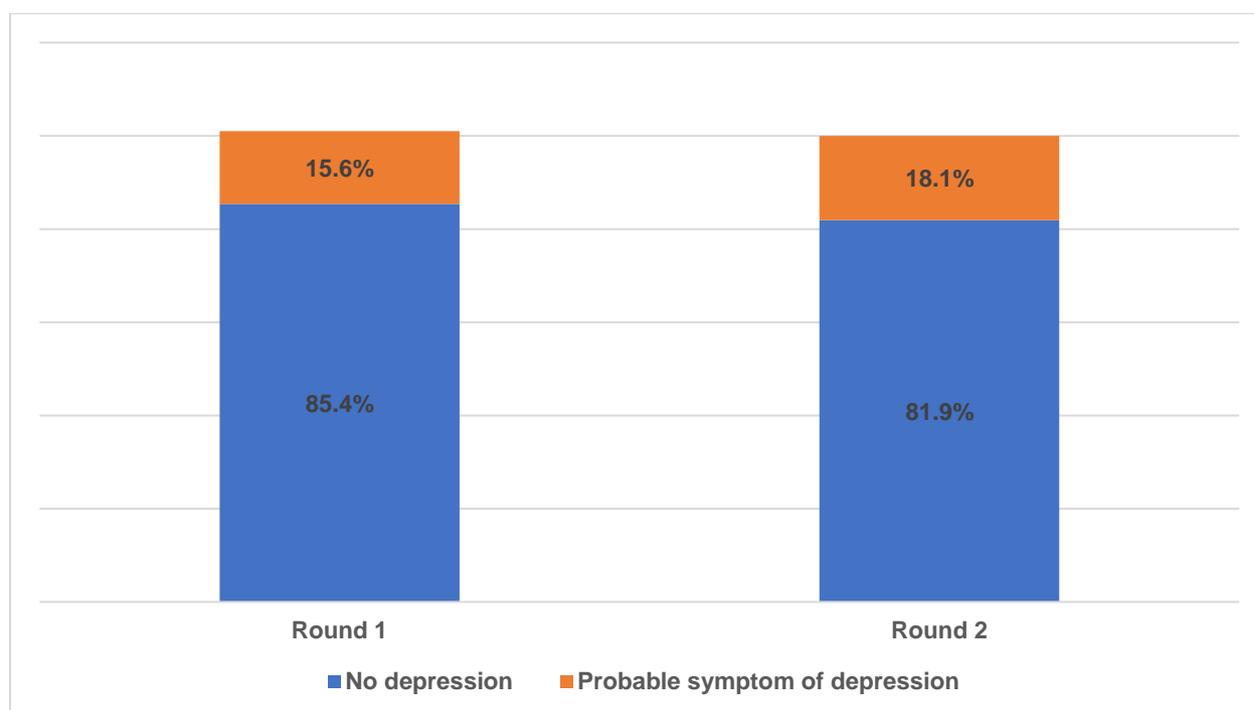
probable symptoms of depression significantly increased from 16% (in Round 1) to 18% in this round (chi-square value = 230.1, p-value = 0.000) (

Figure 10).

**Figure 9: Overall mental health status (PHQ-9 scale index) by category, among the urban poor in selected 10 cities in Ethiopia, by respondent categories, September 2020 (total n=403, UPSNP = 142, SSB = 141, IDPs/refugees = 120)**



**Figure 10: Overall mental health status (PHQ-9 scale index) in Round 1 and Round 2, among the urban poor in selected 10 cities in Ethiopia, by respondent categories, September 2020 (total n=403, UPSNP = 142, SSB = 141, IDPs/refugees = 120)**



In the qualitative interviews, most participants mentioned some level stress due to lack of a job, economic problems, and fear of contracting COVID-19:

*To tell you the truth, currently I am stressed. That's because I do not have any job, and nobody wants to help me. I'm in a serious economic problem where I cannot feed my children. Due to this, I'm under a lot of stress. (Special group member, Logia)*

Another participant from the IDP group stated:

*Mostly I am concerned about being unemployed...I am educated/certified, and I can help my family if employed. I have applied to several companies. But I could not get a job as a result, I am very worried. (Refugee, Semera)*

Some IDPs mentioned that being displaced and the lack of a job were the causes of their feeling distress.

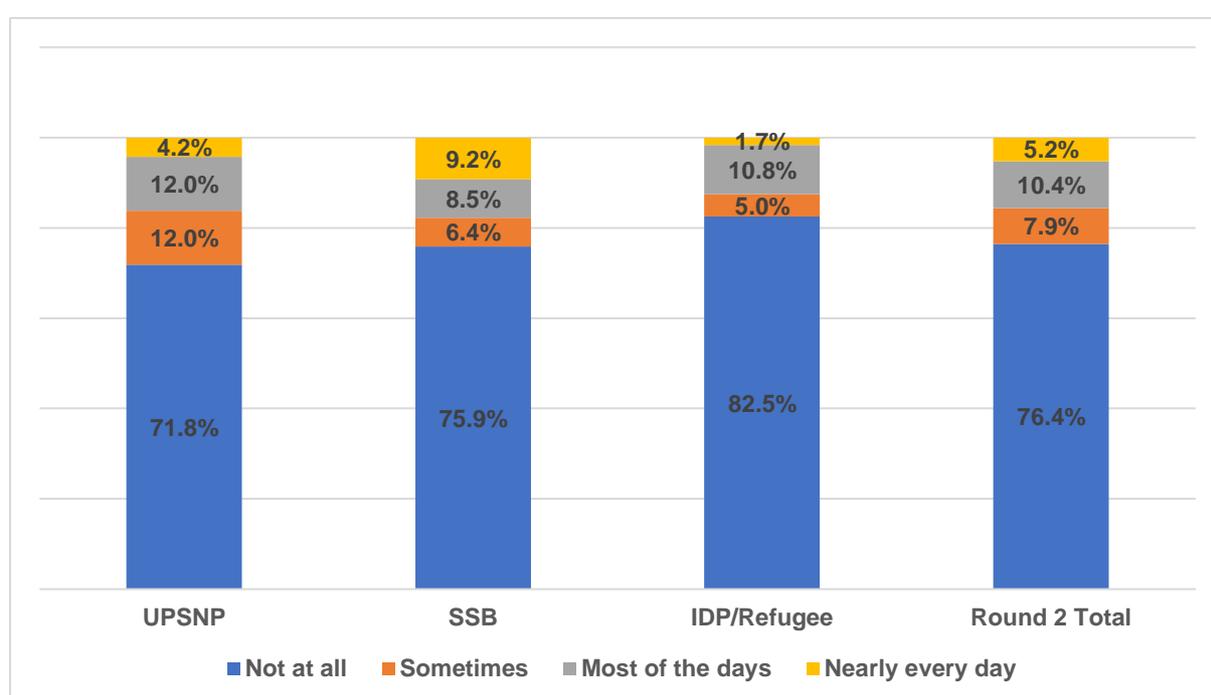
*I feel distressed ever since we get displaced from our home, because it is just depressing sitting without work. Some of my families also feel depressed or stressed. It is really difficult to be a displaced family. Their mood is affected. We want to live our independent life by leaving this detention camp. (IDP, Dire Dawa)*

Feeling very hopeless and/or having thoughts of hurting oneself in some way is one of the nine PHQ-9 items that can be used to monitor mental health status. About 25% of the respondents reported this feeling with varying degrees/frequency of occurrence in the 15 days prior to the interview. A higher proportion of respondents from the UPSNP beneficiaries group

(28%) had thought about hurting themselves than those in other categories, and the differences among the three categories were found to be statistically significant (with chi-square value of 16.4, at p-value=0.01). (Figure 11). This finding is also supported by the qualitative results, where respondents from the UPSNP beneficiaries category repeatedly reported frustration at being unable to cope with the increasing cost of food and the absence of job opportunities to earn additional income.

Moreover, there was no statistically significant difference among male and female respondents in relation to feeling very hopeless and/or having thoughts of hurting oneself (with chi-square value of 0.86, at p-value=0.739).

**Figure 11: Feeling very hopeless and/or having thoughts of hurting oneself among the urban poor in selected 10 cities in Ethiopia, September 2020 (total n=403, UPSNP = 142, SSB = 141, IDPs/refugees = 120)**



Qualitative diary interview participants were asked about their coping strategies to overcome depression or the feeling of being stressed. Respondents in all groups (IDPs, refugees, special group, SSB owners, and UPSNP beneficiaries) frequently mentioned similar coping mechanisms, such as having a rest, sleeping, and convincing themselves to be ready to accept any challenge.

*When I am concerned and worried, I would like to forget my anxious feelings by being alone and take rest. I simply sleep and try to forget my concerns in these manners. (Refugee, Logiya)*

Another participant managed to convince himself to accept any challenges:

*Personally, if I respect the rules and apply the recommendations forwarded by WHO, FMOH, Tigray Regional Health Bureau, I can protect myself, I could be stable psychologically. If I am infected, I could not consider it much challenging than I am*

*living currently. Because military life taught me a lot of problem-handling mechanisms. (IDP, Mekelle)*

One participant from the SSB group mentioned that avoiding situations that increase the risk of being infected, such as keeping physical distance from people, helped them cope with the level of stress and anxiety:

*I was able to avoid this [fear and anxiety associated with fear of being infected] by keeping physical distance and trying to prevent/protect myself from the disease. Recently I have tested and found out that I am free from the virus. (SSB owner, Semera)*

## Aid and support

### Key findings:

- Overall, support was reported to be available during the COVID-19 pandemic, but was perceived to be inadequate.
- Support was mainly provided in the forms of food and cash.
- The pandemic had negatively affected daily interactions within the community, and thus the culture of the community in regard to supporting each other.
- There was a concern regarding how beneficiaries are selected for possible support and there was a feeling of being excluded.

In this round, 58% of participants (160) reported awareness of the availability of assistance from the government, NGOs, CSOs, and other groups (e.g. religious groups). However, of these, only 40%—35% of UPSNP beneficiaries (including those registered but not yet receiving the support), 69% of IDPs, and 2% of SSB owners—had received assistance through one of these means. This support included food, cooking oil, soap, and other sanitary materials.

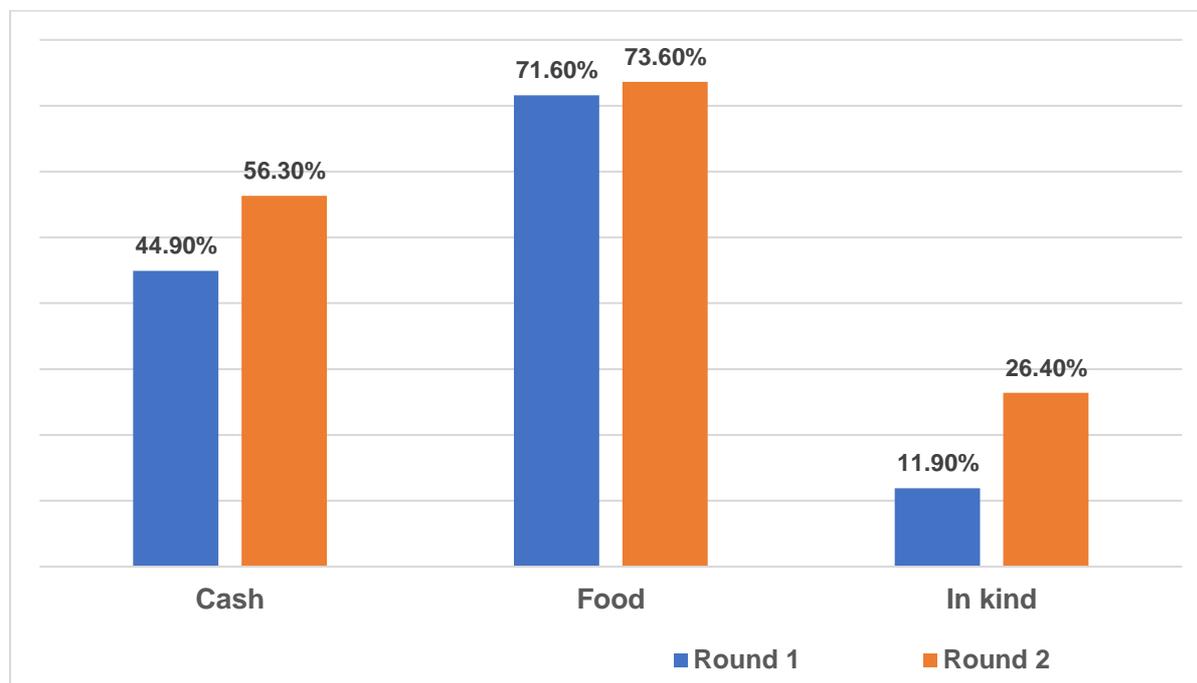
Similarly, in the qualitative interviews we asked respondents about the availability and adequacy of the support provided to the most vulnerable segments of the population. The support was reported to be inadequate and it was perceived as not targeting the ones who were most in need:

*Until now, we haven't got any support for equipment/material to keep our sanitation. But, since all the personal protective equipment is available on the market, we use them buying from the market. (Refugee, Semera)*

*Currently, there is no such support...recently there was registration in kebele to support poor people who lost their job due to corona. But, for your surprise, a large number of people who are not poor were registered rather than the actual poor people. (Refugee, Bahir Dar)*

The largest proportion of the assistance provided was in the form of free food (74%), followed by direct cash transfers (56%). A similar finding was found in Round 1, where 70% of the assistance was reported to be in the form of free food.

**Figure 12: Type of aid received from institutions among the urban poor in selected 10 cities in Ethiopia, July and September 2020 (total n=403, UPSNP = 142, SSB = 141, IDPs/refugees = 120)**



Only 2.5% of participants reported having an awareness of any other sorts of support from the community, including religious institutions. In addition, the pandemic was reported to negatively affect daily interactions and social events, with weddings, funerals, religious practices, and other events all having been restricted. Respondents explained that people used to support each other and there were strong social interactions, but since COVID-19 this had changed and the respondents felt that there was inadequate support among community members, due to the reduction in incomes and due to social distancing.

*...The community cannot further support us, because the pandemic has affected their life now. No one gets closer to us now (i.e. intimate). They used to help us, but now no one is helping us, and our economic crisis is getting worse... (IDP, Dire Dawa)*

## Conclusion

The easing and lifting of restrictions seems to have increased employment and work opportunities for our respondents. However, our results indicate that this might have disproportionately benefited certain groups of the population, such as SSB owners, while leaving others behind (day labourers, IDPs, and UPSNP beneficiaries). Also, due to variations in the easing of restrictions across the 10 cities included in our sample, residents of some cities appear to have benefited more than others. It is, therefore, unsurprising that the average household income for the total sample has declined, compared to Round 1. Affordability problem also seems to be getting worse due to the persistent increase in the prices of certain food items and crops. Our findings are in line with those of the World Bank, which reported that affordability was a concern for over 90% of its sample, which included both urban and rural households (3,058).<sup>10</sup> The International Food Policy Research Institute (IFPRI) has also highlighted in its recent study that price dynamics are highly context- and crop-specific. This is in line with our finding which suggests that even though more respondents reported being able to consume three meals a day, most were not able to consume meat, fruit, or vegetables due to their high prices. Feelings of stress and anxiety are still prevalent among some of our respondents, particularly those who have not been able to find work and earn income.

Although most of our respondents reported practising handwashing, hand rubbing with a sanitiser, and social distancing, we found that for some respondents these practices have declined significantly. In particular, respondents reported being less likely to avoid crowded places, only wearing their masks when being observed by the police or in public places, and not wearing masks at religious gatherings. Moreover, in our qualitative interviews it was reported that there were increasing misconceptions regarding COVID-19, particularly regarding the severity of its effects, and some people even questioned its existence. These findings indicate that there is a need to increase awareness-raising activities and to consider more tailored interventions for certain groups of the population, to avoid laxness in applying the appropriate behaviours in response to the virus, and to reduce misconceptions about COVID-19.

The costs associated with purchasing and transporting water are one of the main challenges in accessing water and practising handwashing. Despite the fact that respondents reported an improvement in water access, disruptions in water supply seem to occur regularly, resulting in some respondents having to source water from protected and unprotected springs.

For respondents and family members who needed medical treatment, most were able to access health services. However, there were also people who avoided visiting health facilities due to the fear that they could be forced to quarantine. Similar to Round 1, the fear of being infected with the virus still appears to have influenced some of our respondents' health-seeking behaviour. Maternal health service utilisation does not seem to be

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<sup>10</sup> <http://documents1.worldbank.org/curated/en/5111101597307914033/pdf/Results-from-a-High-Frequency-Phone-Survey-of-Households.pdf>

significantly impacted, although our sample for this group was small, and thus the results need to be interpreted with caution.

According to the participants, no change has been observed with regards to access to educational platforms, which remains low. Most children spend much of their time playing or helping their family with chores, rather than engaging in educational activities. It is very concerning that 14 girls in our sample got married following school closures, and that the median age at marriage was 15 years.

Government and NGOs are the main sources of support, in the form of food and cash. However, the support is reported to have decreased compared to Round 1. It is also felt that it is not targeting those who are the most in need.

Our results suggest that the pandemic has now significantly affected social interactions and the culture of support within the communities. This was felt much more strongly during this round of data collection compared to the first round – most respondents cited reduced income and social distancing as the main reasons for a decline in community support. Most respondents are also not aware of how they can help the most vulnerable segments of the population, despite knowing who they are. It is of paramount importance in policy design to ensure that the most vulnerable are benefited by the support provided by the government and other organisations, and that the process of targeting the support is transparent. There is a clear need to continue to use education and information campaigns to raise awareness of the severity of the pandemic, to reduce misconceptions about COVID-19. Finally, the lack of access to education materials for poor and vulnerable is likely to exacerbate gender and income inequalities even more, and needs urgent attention.

## Case studies

### Case Study 1 (continued from Round 1)

Mrs Lelo (not her real name) is a 31-year-old mother of four children. She was displaced from the Somali Region of Ethiopia following a conflict that happened in 2017, in which she lost her husband, so she is shouldering the entire burden of supporting the children. Currently, Mrs Lelo is living in a temporary shelter in Adama City.

Mrs Lelo is well aware of COVID-19. She is still practising COVID-19 prevention measures. Last time she explained how the COVID-19 pandemic and the government restrictions had affected her daily life. A key impact she mentioned was reduced work opportunities. Mrs Lelo works selling 'Khat' as a means of obtaining income to support her life and to feed her family. However, due to the pandemic, she was not able to sell chat on a daily basis. During Round 1, income was significantly affected and she lost the capacity to feed her family. However, she believes that her business is getting better and her income has improved in the last month, though not comparable to pre-COVID-19 pandemic times: *'My income is now is better than how much it has been when we spoke last time. This does not mean that my current income is comparable to my income before the advent of the Coronavirus, however. Nevertheless, since I am now back to my work, I am able to make from 200 to 300 birr per day these days.'* Mrs Lelo explained that there is no change in the supply and prices of food items. Water shortage is the most difficult thing that she and other IDPs are facing, which affects their handwashing practices: *'You know what; even now, it has been three days since we had access to water. Last night, I have even been waiting for the water to come till 5:00 A.M. in the late evening but to no avail.'* Mrs Lelo reported that there are no pregnant women in her family, and no one has been using a family planning method. However, she knows a neighbour who is pregnant. According to Mrs Lelo, this pregnant woman is not attending ANC due to a bad experience she faced when she took her child to a health facility for immunisation: *'There is my neighbour who is pregnant. She also has a child who is a little more than a year. I do not think she goes to the health centre for check-ups. I think she is not going to the health centre because she had an unfavourable experience when she visited the health centre for the immunisation of her one-year-old child.'*

As reported during Round 1, government rations are the only support that Mrs Lelo's family is getting, which is often not provided on a regular basis: *'Except for the monthly governmental food ration of wheat, that is often delayed, I have received no support or assistance from anyone else for the last month. There has been none other than the support that I received from our religious group and the like that I told you about back then [during the first-round interview].'*

### Case Study 2 (continued from Round 1)

Mr Goitom (not his real name) is a 32-year-old man from Mekelle, Tigray, who has completed high school. He is married and is the father of one four-year-old boy. He is a junkman who collects used materials – such as metals, plastics, and glass bottles – for recycling purposes for a living. His wife sells traditional clothes at the 'Adihaki' market.

Last month, due to the pandemic, his expenditures were much higher than his income; as a result, his savings were depleted. This time, he reported that he has managed to save 500 birr a month by working extra hard and by compromising the quality of his daily life. Mr Goitom stated that the price of food and other materials in the market is still inflated and is even higher than last month, giving an example of how the price of one quintal of Teff has risen to 4,700 birr (200–300 birr more than the previous month).

Ashenda is a yearly cultural festival that is mostly celebrated in Tigray and Amhara regions. The festival is celebrated by women and girls, who wear cultural clothes that are made specially for the event. The celebration is attended by tourists and pilgrims all over the country. This is the time when sales skyrocket for traders like Mr Goitom's wife. This year was not a good business year for Mr Goitom's wife and others as Ashenda was not celebrated in Mekele due to the pandemic. The

overall business activities have been severely affected; accordingly, his wife could not sell her traditional clothes, as the price has significantly dropped – by almost half the original price. As of last month, even though the government restrictions have been relaxed to some extent, the cost of transportation is still double what it used to be. Regardless of the social gathering restrictions (still being enforced) for social interactions such as funerals and marriage ceremonies, it is now common to see close to 400 individuals attending funeral ceremonies. More positively, all people wear masks and keep their distance (1 to 1.5 metres) while attending funerals. Before, Mr Goitom was not able to educate and stabilise his child, but currently his child is fine and stable because he provides him with children’s films and he teaches him moral lessons and raises his hopes for the future.

As Mr Goitom’s work requires going around multiple households to gather used materials, he is perceived as a potential spreader of the virus. Hence, people are reluctant to interact with him, which threatens his job. He is afraid it may eventually render him jobless. Despite the highly contagious nature of his work, he claims that he usually uses appropriate PPE materials and applies alcohol and uses sanitiser after each contact. He also said that there is adequate rainwater for handwashing, though there is a shortage of drinking water. Mr Goitom explained that the majority of the community does not apply the prevention measures properly – in particular, he observed that many people move about without keeping physical distance and considering transmission of the virus.

### Case Study 3 (new from Round 2)

Mrs Mame (not her real name) is a 38-year-old HIV-positive woman, a high school graduate who works as a freelancer at the Addis Ababa city Women’s Affairs office. She lives with her two children, her husband, and her sister. Her husband is an HIV-positive man that has additional health problems, including diabetes and hypertension; thus, he visits the healthcare facility for regular check-ups. She has had to temporarily send her two nephews who were living with her to a relative because she could not take care of them anymore.

Mrs Mame has been diagnosed with left lung pneumonia since the COVID-19 outbreak, and that has been stressful for her as she is worried that she might have low resistance due to her health status. She worries that she might be exposed to COVID-19 because some community members are not applying the preventive measures diligently. Though she is grateful for the sufficient water supply in her residential area, she is concerned that she may not be able to sustain the balanced diet she needs through this difficult time. She has stopped buying processed food supplies as she has started preparing her own food. Her monthly salary is ETB 800 net after tax. She cannot afford to buy food materials. The staggering inflation in the price of food items has made it difficult for her and her family to maintain their usual diet, as a result of which they have minimised their consumption. There are times where she might just drink a soft drink when she feels hungry. She further stated that milk is an essential part of her diet because of her health condition but recently it has become difficult for her to get a regular supply of milk.

Mrs Mame uses fabric facemasks regularly and washes them with salt and water every night. She instructs her family members to do the same so that they do not bring the virus into their home. The ever-increasing number of coronavirus patients and related deaths had stressed her to the point where she became hysteric and showed chest pain and fever symptoms and had to go to a health facility for a check-up. After she received the necessary advice from health professionals everything went back to normal.

Because of the inflation, economic challenges, health problems, and the additional fear of getting infected by coronavirus (which requires extra cleaning), life has become more challenging for Mrs Mame and her family. She also disclosed that her children might be stressed by the extended stay at home if the schools remain closed for a few more months. She is planning to ask for book donations to keep her children entertained and occupied in the meantime.

Mrs Mame is not using family planning because of the side-effects she has experienced. She also complained about the shortage of vaccines, related to the medical supply shortage.

Concerning the crime rate and safety issues in her community, she says that they have organised community policing, for which she serves as head. They are keeping their community safe with the support of shop owners and other residents.

Mrs Mame believes that coronavirus can be eliminated from the throat area using hot beverages and states that they (she and her family members) mostly drink hot beverages with garlic, rather than cold drinks. She also uses other homemade remedies, like lemon and sugar mix, coffee with garlic etc. She says she visits churches but with proper precautions. She even advises people who regularly go to church to be extra careful and to worship with caution [i.e. to avoid contact with others and surfaces].

All in all, she thinks that coronavirus affects people who are living with HIV, people who are malnourished, people who have an extremely poor lifestyle, and people who carry out domestic work like her. She believes that is where the necessity of protection becomes more prominent. Finally, she mentioned receiving powdered milk as a form of support from a certain Korean office, because she had a cough. She also received support for the Ethiopian New Year holiday, in the form of eggs, from a good Samaritan who works with her.

## Case Study 4 (new from Round 2):

Mr Amin (not his real name) is a 30-year-old father from Semera. He is married and a father of four children. He used to work as a daily labourer to lead his life and feed his family. Mr Amin explained how the COVID-19 pandemic and the government restrictions have affected his life. He lost work opportunities following the pandemic. Lack of job opportunities and the difficulty in getting something to eat are the main challenges that he and his family are struggling with:

*'I am most worried about the loss of job. The most difficult thing I faced last month was lack of food to eat.'*

Mr Amin is not sure what to do if the pandemic persists and explained how he is coping with the loss of job and income by selling his assets: *'I am selling my goats to feed my family. I am so worried of what would happen in the future.'* He added that it has become difficult to make rental payments for the house he is living in:

*'Regarding the house I am living, I pay the rent by selling my goats. Sometimes if I don't have money, they give me time and wait till I pay them.'*

On top of the loss of job opportunities, Mr Amin is struggling with the food price escalation. He explained that his family is forced to reduce the amount of food he and his family eat: *'We, the adults, are eating two meals/day. We serve meals to children three times a day because they don't understand what the shortage and absence of food means, so we feed them in small amount.'*

Mr Amin explained that COVID-19 is still a public concern and that he and his family members are still practising the preventive measures to reduce the risk of contracting the virus:

*'We did not stop doing/practising handwashing with soap and water, avoiding overcrowded areas, and using mask. I did not hear that the disease has disappeared, rather the government is warning us every day that the disease is increasing. So, I and my family take care of ourselves.'*

Mr Amin also discussed utilisation of maternal health services since COVID-19 was reported in Ethiopia. He believes that some women prefer not visit health facilities to seek health services due to the fear of contracting the coronavirus: *'There are many pregnant women in our relative, friends, and neighbours. They were going to health facility for ANC visit according to the appointment given but after COVID-19 these pregnant women are not visiting health facilities as before because they are scared of being infected and prefer to stay at home.'*

## Annex A: Disparities in key variables by city

Key indicators/variables	Addis Ababa	Adama	Bule Hora	Dire Dawa	Jigjiga	Semera	Logia	Bahir Dar	Mekelle	Gambela	Total
<b>Behaviour in response to COVID-19 (all figures are percentages): Round 2</b>											
Proportion of respondents who reported practising washing hands frequently with soap and water	98.9	100.0	100.0	97.6	100.0	100.0	100.0	100.0	100.0	90.0	98.9
Proportion of respondents who reported practising hand rubbing with sanitiser or alcohol-based solution	97.1	100.0	77.3	97.5	18.2	53.3	100.0	90.0	95.7	82.4	87.8
Proportion of respondents who reported wearing a facemask	100.0	100.0	97.0	100.0	100.0	88.9	100.0	100.0	100.0	95.2	98.5
Proportion of respondents who reported avoiding overcrowded places	61.5	80.0	100.0	100.0	100.0	100.0	100.0	90.0	92.3	26.7	88.1
Proportion of respondents who reported all their friends or family members wear a facemask all the time	77.8	100.0	89.7	9.8	0.0	45.5	91.1	60.5	97.6	65.2	63.3
<b>Behaviour in response to COVID-19 (all figures are percentages): Round 1</b>											
Proportion of respondents who reported practising washing hands frequently with soap and water	92.5	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	95.7	99.0
Proportion of respondents who reported practising hand rubbing with sanitiser or an alcohol-based solution	94.3	94.9	77.3	95.0	100.0	73.3	100.0	85.0	100.0	95.0	92.1
Proportion of respondents who reported practising wearing a facemask	100.0	94.9	97.0	100.0	100.0	100.0	97.1	93.5	96.4	100.0	97.9
Proportion of respondents who reported avoiding overcrowded places	88.5	76.7	100.0	100.0	100.0	90.0	95.8	87.5	100.0	93.8	93.3
Proportion of respondents who reported friends or family members wear a facemask all the time	55.6	7.7	94.9	78.0	51.2	40.9	77.8	69.8	97.6	33.3	61.7
<b>WASH (all figures are percentages): Round 2</b>											
Proportion of households who have piped private water supply	62.2	82.1	33.3	63.4	18.6	88.6	100.0	81.4	68.3	56.5	66.3
Proportion of households who have access to water supply every day/daily	46.7	100.0	17.9	56.1	14.0	86.4	88.9	95.3	24.4	73.9	60.0
Proportion of households reported shortage of water since COVID-19 outbreak	15.6	74.4	74.4	34.1	9.3	2.3	20.0	32.6	22.0	39.1	31.0
Proportion of households who reported difficulty in accessing water supply	62.2	174.4	92.3	90.2	23.3	88.6	108.9	127.9	46.3	113.0	91.1

<b>Food security (all figures are percentages): Round 2</b>											
Proportion of households relying on food assistance from government/NGOs/United Nations/local charity	0.0	43.6	10.3	26.8	16.3	36.4	53.3	2.3	12.2	4.3	21.3
Proportion of households having difficulty going to places to access food/food materials	0.0	0.0	0.0	0.0	7.0	0.0	0.0	0.0	2.4	13.0	1.7
Proportion of households who have reduced number/frequency of meals consumed per day since the outbreak of COVID-19 and associated impacts	28.9	38.5	64.1	9.8	9.3	2.3	35.6	0.0	19.5	21.7	22.6
Proportion of households having three or more meals per day	28.9	38.5	64.1	9.8	16.3	2.3	35.6	0.0	22.0	34.8	73.9
<b>Income, expenditure, and employment (all figures are percentages): Round 2</b>											
Proportion of respondents reported cutting down hours or amount of work since COVID-19	42.2	92.3	84.6	19.5	25.6	15.9	91.1	93.0	85.4	52.2	60.0
Proportion of households who are currently able to earn income similar to their normal work before lockdown/physical restrictions	88.9	92.3	25.6	80.5	95.3	79.5	97.8	100.0	82.9	78.3	82.9
Proportion of households facing risk of eviction from their house due to loss of income	8.9	10.3	46.2	2.4	34.9	0.0	6.7	2.3	19.5	4.3	13.6
<b>Health (all figures are percentages): Round 2</b>											
Proportion of participants who needed any medical treatment since the COVID-19 outbreak	4.4	2.6	33.3	12.2	4.7	4.5	48.9	9.3	9.8	18.5	14.7
Proportion of participants who needed medical treatment and have had access to health services	100.0	0.0	53.8	100.0	100.0	50.0	100.0	100.0	75.0	60.0	81.7
Proportion of households whose member(s) needed any medical treatment since the COVID-19 outbreak	4.4	2.0	23.1	4.9	25.6	9.1	2.2	2.3	4.9	8.7	8.7
Proportion of households whose member(s) needed medical treatment and have had access to health services	50.0	0.0	66.7	100.0	100.0	100.0	100.0	0.0	50.0	50.0	77.1
<b>Health (all figures are percentages): Round 1</b>											
Proportion of respondents/households whose member(s) needed any medical treatment since the COVID-19 outbreak	31.1	20.5	38.5	17.1	14.0	31.8	24.4	9.3	24.4	22.2	23.3
Proportion of respondents/households whose member(s) needed medical treatment and have had access to health services	75.6	35.9	30.8	92.7	100.0	86.4	100.0	14.0	19.5	44.4	61.4
<b>Mental health (all figures are percentages): Round 2</b>											

Proportion of respondents who perceived there to be a negative impact of COVID-19 and associated responses on mental health	0.0	20.5	66.7	4.9	4.7	6.8	0.0	2.3	0.0	17.4	11.4
Proportion of respondents feeling stressed, scared, or/and worried during the past month	0.0	100.0	79.5	100.0	74.4	29.5	93.3	0.0	31.7	60.9	55.8
Proportion of respondents with probable symptoms of depression (cut-off point = 10 out of 27 points on a Patient Health Questionnaire)	0.0	92.3	5.1	0.0	0.0	0.0	0.0	0.0	0.0	43.5	11.9
<b>Aid and support (all figures are percentages): Round 2</b>											
Proportion of respondents who are aware of any relief being provided to address the impacts of COVID-19	11.1	66.7	20.5	43.9	58.1	97.7	97.8	23.3	100.0	52.2	57.6
Proportion of households/household members who received aid from any institution after the COVID-19 pandemic	0.0	100.0	25.0	61.1	48.0	41.9	31.8	0.0	17.1	16.7	39.7
<b>Aid and support (all figures are percentages): Round 1</b>											
Proportion of respondents who are aware of any relief being provided to address the impacts of COVID-19	80.0	87.2	25.6	90.2	25.6	88.6	86.7	60.5	95.1	37.0	69.0
Proportion of households/household members who received aid from any institution after the COVID-19 pandemic	53.3	61.5	33.3	12.2	32.6	47.7	64.4	11.6	68.3	3.7	40.3
<b>Total sample/observations (in number)</b>	<b>45</b>	<b>39</b>	<b>39</b>	<b>41</b>	<b>43</b>	<b>44</b>	<b>45</b>	<b>43</b>	<b>41</b>	<b>23</b>	<b>403</b>

## Annex B: Disparities in key variables by gender

Key indicators/variables	Male (%)	Female (%)	Total (%)	Chi-square [p-value]
<b>Behaviour in response to COVID-19: Round 2</b>				
Proportion of respondents who reported practising washing hands frequently with soap and water	97.9	100.0	98.9	<b>4.043 [0.044]</b>
Proportion of respondents who reported practising hand rubbing with sanitiser or alcohol-based solution	86.8	89.0	87.8	0.260 [0.610]
Proportion of respondents who reported wearing a facemask	99.4	97.4	98.5	2.064 [0.151]
Proportion of respondents who reported avoiding overcrowded places	89.6	86.4	88.1	0.647 [0.421]
Proportion of respondents who reported all their friends or family members wearing a facemask all the time	62.6	64.0	63.3	2.009 [0.366]
<b>WASH: Round 2</b>				
Proportion of households who have piped private water supply	58.1	74.5	66.3	17.1 [0.004]
Proportion of households who have access to water supply every day/daily	54.7	65.5	60.0	4.9 [0.173]
Proportion of households reported a shortage of water since COVID-19 outbreak	31.0	31.0	31.0	0.01 [0.994]
Proportion of households who reported difficulty in accessing water supply	22.7	16.0	19.4	7.1 [0.049]
Proportion of households who store water for later use (water storage practice at household level)	76.4	75.0	75.7	0.1 [0.751]
<b>Food security: Round 2</b>				
Proportion of households relying on food assistance from government/NGOs/United Nations/ local charity	20.7	22.0	21.3	0.10 [0.748]
Proportion of households having difficulty going to places to access food/food materials	1.5	2.0	1.7	
Proportion of households who have reduced number/frequency of meals consumed per day since the outbreak of COVID-19 and associated impacts	25.1	20.0	22.6	1.51 [0.219]
Proportion of households having three or more meals per day	72.4	75.5	73.9	0.49 [0.480]
Proportion of households who have no food reserves for future consumption (no food reserves at all)	5.4	6.0	5.7	1.10 [0.901]
<b>Income, expenditure, and employment: Round 2</b>				

Proportion of respondents reported cutting down hours or amount of work since COVID-19	58.6	61.5	60.0	0.348 [0.555]
Proportion of households who are currently able to earn income similar to the normal work before lockdown/physical restrictions	82.8	83.0	82.9	0.004 [0.949]
Proportion of households with a risk of eviction from their house due to loss of income	16.3	11.0	13.6	2.36 [0.124]
Proportion of households who were evicted from their house due to loss of income	4.9	1.5	3.2	3.78 [0.052]
<b>Health: Round 2</b>				
Proportion of participants who needed any medical treatment since the COVID-19 outbreak	14.1	15.3	14.7	0.117 [0.733]
Proportion of participants members who needed medical treatment and have had access to health services	96.6	67.7	81.7	8.306 [0.004]
Proportion of households whose member(s) needed any medical treatment since the COVID-19 outbreak	9.4	8.0	8.7	0.235 [0.628]
Proportion of households whose member(s) needed medical treatment and have had access to health services	89.5	62.5	77.1	3.584 [0.058]
<b>Mental health: Round 2</b>				
Proportion of respondents who perceived there to be a negative impact of COVID-19 and associated responses on mental health	13.8	9.0	11.4	2.2 [0.130]
Proportion of respondents feeling stressed, scared, or/and worried during the past month	59.1	52.5	55.8	1.78 [0.181]
Proportion of respondents with probable symptoms of depression (cut-off point = 10)	11.3	12.5	11.9	0.13 [0.717]
<b>Aid and support: Round 2</b>				
Proportion of respondents who are aware of any relief being provided to address the impacts of COVID-19	52.3	62.0	57.6	3.192 [0.074]
Proportion of households/household members who received aid from any institution after the COVID-19 pandemic	37.0	41.9	39.7	0.579 [0.447]
<b>Total sample/observations (in number)</b>	<b>205</b>	<b>202</b>	<b>407</b>	

## Annex C: Key variables broken down by IDPs, refugees, and returnees

Compliance with government restrictions among IDPs, refugees, and returnees in selected 10 cities in Ethiopia, September 2020

	IDPs (%)	Refugees (%)	Returnees (%)	Total (%)
<b>Compliance with movement restrictions</b>				
A lot	34.2	93.5	78.6	54.5
Somewhat	42.1	3.2	14.3	28.9
Not very much	5.3	0.0	0.0	3.3
Not at all	18.4	3.2	7.1	13.2
<b>Compliance with wearing a facemask</b>				
A lot	71.1	96.8	78.6	78.5
Somewhat	27.6	0.0	14.3	19.0
Not very much	1.3	0.0	0.0%	0.8
Not at all	0.0	3.2	7.1	1.7
<b>Compliance with social distancing</b>				
A lot	48.7	96.8	78.6	64.5
Somewhat	48.7	0.0	14.3	32.2
Not very much	2.6	0.0	0.0	1.7
Not at all	0.0	3.2	7.1	1.7

**Family compliance with government restrictions among IDPs, refugees, and returnees in selected 10 cities in Ethiopia, September 2020**

<b>Restrictions</b>	<b>IDPs (%)</b>	<b>Refugees (%)</b>	<b>Returnees (%)</b>	<b>Total (%)</b>
<b>Compliance of family members with movement restrictions</b>				
None of them	18.4	3.2	0.0	12.4
Some of them	47.4	3.2	14.3	32.2
All of them	34.2	93.5	85.7	55.4
<b>Compliance of family members with wearing a facemask</b>				
None of them	0.0	6.5	0.0	1.7
Some of them	40.8	12.9	14.3	30.6
All of them	59.2	80.6	85.7	67.8
<b>Compliance of family members with social distancing</b>				
None of them	3.9	3.2	0.0	3.3
Some of them	53.9	6.5	21.4	38.0
All of them	42.1	90.3	78.6	58.7

**Access to adequate water supply among IDPs, refugees, and returnees in selected 10 cities in Ethiopia, September 2020**

Characteristics/variables	Respondent specific category			Round 2 total (%)	
	IDP (%)	Refugee (%)	Returnee (%)		
<b>Household source of water</b>	Piped private	18	87	79	43
	Private communal	41	13	14	31
	Water distributed using shower truck	30	0	0	19
	Others (protected and unprotected)	11	0	7	7
<b>Shortage of water in the last one month</b>	Yes	41	19	57	37
	No	59	81	43	63
<b>Frequency of access to water supply</b>	Every day	57	81	100	68
	Once in a week	34	19	0	26
	Other **	9	0	0	6
<b>Level of difficulty accessing water since COVID-19 outbreak</b>	Much more difficult	7	0	0	4
	Slightly more difficult	24	16	0	19
	Nothing changed	57	65	100	64
	Easier than before	13	19	0	13

**Income and employment among IDPs, refugees, and returnees in selected 10 cities in Ethiopia, September 2020**

Characteristics/variables		Respondent specific category			Round 2 total (%)
		IDP (%)	Refugee (%)	Returnee (%)	
<b>Cut down the hours or amount of work since COVID-19</b>	Yes	51	58	100	59
	No	49	42	0	41
<b>Current ability to earn income like normal work before COVID-19</b>	Yes	72	87	100	79
	No	28	13	0	21
<b>Risk of eviction from house due to loss of income</b>	Yes	25	0	0	16
	No	75	100	100	84
<b>Were you evicted from your home in the past one month?</b>	Yes	9%	0%	0%	6%
	No	91%	100%	100%	94%

**Household food access, by respondent category, among IDPs, refugees, and returnees in selected 10 cities in Ethiopia, September 2020**

Characteristics/variables	Respondent specific category			Round 2 total (%)	
	IDP (%)	Refugee (%)	Returnee (%)		
<b>Average frequency of meals per day consumed by household members during the last month</b>	Two or less	45	3	0	29
	Three and above	55	97	100	71
<b>Availability of food reserves</b>	No reserve	14	0	0	9
	Up to one week	16	65	29	30
	One to two weeks	38	32	0	32
	Two to four weeks	26	3	64	25
	More than four weeks	5	0	7	4
<b>Incidence of food shortage in the last one month</b>	Yes	49	65	0	47
	No	51	35	100	53
<b>Reduction in number of meals per day after COVID-19</b>	Yes	36	13	0	26
	No	64	87	100	74

**Access to and utilisation of health services among IDPs, refugees, and returnees in selected 10 cities in Ethiopia, September 2020**

<b>Variables/characteristics</b>		<b>Refugees (%)</b>	<b>IDPs (%)</b>	<b>Returnees (%)</b>	<b>Total (%)</b>
<b>Proportion of household heads/participants that needed any medical treatment since the COVID-19 outbreak</b>	Yes	11.5	32.3	7.1	16.3
	No	88.5	67.7	92.9	83.7
<b>Access to health services by household member who sought health services</b>	Yes	77.8	100.0	100.0	90.0
	No	22.2	0.0	0.0	10.0
<b>Proportion of households whose member(s) needed any medical treatment since the COVID-19 outbreak</b>	Yes	7.9	3.2	0.0	5.8
	No	92.1	96.8	100.0	94.2
<b>Proportion of households whose member(s) needed medical treatment and have had access to health services</b>	Yes	83.3	100.0	85.7	83.3
	No	16.7	0.0	14.3	16.7
<b>People vulnerable to COVID-19</b>	Old people	67.1	67.7	7.1	60.3
	People with chronic diseases	69.7	64.5	0.0	60.3
	Children	35.5	9.7	0.0	24.8
	Young adults	2.6	19.4	0.0	6.6
<b>Pregnant women were able to see a health provider (ANC) since COVID-19</b>	Yes	-	100	-	100
	No	-	0	-	0
<b>Lactating women were able to see a health provider (postnatal care) since COVID-19</b>	Yes	80.0	100.0	100.0	86.5
	No	20.0	0.0	0.0	13.5

## Annex D: Summary of the qualitative interviews (diary-style) with IDPs, refugees, and returnees

### Behaviour relating to COVID-19

Most of the IDPs, refugees, and returnees explained that they are still able to practise handwashing. However, some IDPs explained that the lack of an adequate water supply is affecting their handwashing practices as regards protecting themselves from COVID-19 and other diseases. On the other hand, some IDPs explained that it is difficult to avoid overcrowded places, given their living arrangements.

*People are not keeping their physical distancing in most cases. The living conditions and social interaction has returned to normal way of living as before corona pandemic occurrence. (IDP)*

Moreover, respondents acknowledged that some people have started perceiving that COVID-19 is less severe and have stopped practising the measures to protect themselves from the disease:

*They were taking precaution at the beginning of the pandemic. They are now not taking precautions that much. People have become careless now, because of being familiar with the coronavirus. (IDP)*

Some refugees attributed decreased practising of preventive measures to limited community awareness activities and control systems.

*Last month, when the pandemic begun, health professionals, community leaders and other responsible bodies were creating awareness related to COVID-19 among the community and the people were practising all the preventive measures such as washing hands frequently with soap, social distancing, wearing mask etc. But later on, all those awareness creation activities from the government side decreased and as a result some people are back to their normal life and give less attention to COVID-19. (Refugee)*

*Several people don't use masks in the city. When we compare the habit of wearing mask, it is getting reduced, especially in the last month. There will be no punishment for not wearing of facemask. Any person who is not interested to wear facemask can leave it. (Refugee)*

### Availability and adequacy of water supply (WASH)

Participants widely mentioned the economic burden associated with purchasing water and transporting it from the area where it is available to their homes. They also stated that there has been an increase in the price of water since the outbreak of the COVID-19 pandemic.

Shortage and inadequacy of the water supply is one of the major challenges exacerbating the effects of COVID-19 and associated government restrictions on households' economy

and health, as described by respondents from the IDP, refugee, and returnee categories. IDPs who took part in the qualitative diary-interviews frequently mentioned shortages of and interruptions to the piped water supply (both private and communal).

*There is shortage of water and we have no access to clean water here. We are using rainwater for drinking and cooking. (IDP)*

Another IDP from Dire Dawa described the effect of the inadequate water supply on the household economy as follows:

*There are no adequate water supplies. So we buy water from tanker truck and cart... After COVID-19 the price of one jerrican [21-litre plastic container] water increase from six to 10 birr. There is shortage of water, it is difficult to access and it is cost is also high. (IDP)*

Some of the participants from the three categories (IDPs, returnees, and refugees) mentioned using alternative water sources to cope with shortages and the high cost of water.

*Last month it rained well, but without it we would have severe shortage of water... (IDP)*

*There is also one area in our vicinity that draws water from ground which is unclean and not suitable for drink. We go to that water source every morning and our women fetch that unclean water.... (IDP)*

Participants from all three groups described the shortage of water as a major challenge to proper handwashing practices, which they recognised as the most important COVID-19 prevention measure. One of the IDPs described the problem as follows:

*They told us to prevent corona virus infection by washing our hands and keeping our body clean. But they are not giving us adequate water for this purpose. We search water in city and buy with money we earn from our work (IDP).*

## **Effect of COVID-19 on income and employment**

The negative effects of COVID-19 were widely mentioned by all categories of respondent (IDPs, refugees, and returnees). Participants reported a decrease in their income and employment opportunities due to the decrease in economic activities after COVID-19 and associated restrictions. However, the recent easing of restrictions on transport services was reported to have improved their mobility and opportunity to work and to earn a better income, compared to Round 1.

*Unlike the previous time [i.e. unlike the period covered by Round 1 interview], I now go outside and work. ... I go to my workplace at 7 a.m. in the morning and return home from there at about 2 p.m. in the afternoon. (IDP)*

*My income is now better than how much it has been when we spoke last time. This does not mean that my current income is comparable to my income before the advent of the Coronavirus, however. Nevertheless, since I am now back to my work, I am able to make from 200 to 300 birr per day these days. (IDP)*

Despite improvements in their income and job opportunities, respondents mentioned a worsening of their economic problems from Round 1 to Round 2, due to the persistent increase in the price of food.

*Currently, the living expense is becoming very difficult. The work situation and the living expense are not comparable. (Returnee)*

On the other hand, some of the respondents from the IDPs and refugees categories reported a decrease in their income or having the same income as that in the previous month (i.e. Round 1). One of the IDPs described the situation as follows:

*I went to my previous customers for washing clothes, but they ignored me because they said 'it is corona time, we can wash ourselves'. So, there is no work, I could not find any work because of the virus. Before corona, I was washing their clothes and they pay me 300 birrs. (IDP)*

## **Effect of COVID-19 on food security**

Unlike in Round 1, inadequacy, scarcity, and unavailability of food/food items in the market was not mentioned as a reason for reduced consumption and food insecurity. Good availability of food items was mentioned by most respondents in all three categories. However, respondents reported the unaffordability of food/food items due to the increase in prices. As a result, households are being forced to consume less preferred and cheap food items, which are considered to have poor nutritional value.

Participants from all categories described the inflation of food/food materials and food insecurity as follows:

*At this time, it is aggravated, the price of Teff has increased to more than 4,000 birr per quintal and subsequently the price of one Enjera became 15 birr. ... maybe only rich people can overcome this problem...but for us (the poor) it is too scary and even difficult to survive...The good thing is I have experience to handle hunger...I have seen even worse than this. (IDP)*

Refugees also reported an increase in the availability of food/food items:

*Still there is no problem of food supply. However, the food price inflation is still the challenge. Especially, currently it's very expensive. (Refugee)*

*The price of food is increasing and it is reaching to the level that we cannot afford buying foods like vegetables, especially onion and tomato. (Refugee)*

Another returnee from Bahirdar said:

*The price of food items is getting higher and higher. A kilo of onion, which was 30 birr, is being sold with 45 birr now.... (Returnee)*

## Effect on healthcare visits

Like the UPSNP beneficiaries and SSB owners group, health-seeking behaviour was not found to be highly affected by COVID-19 among refugees, IDPs, and returnees. Most respondents explained that women are using maternal health services as usual. A few respondents reported the unavailability of drugs at government pharmacies, which exposes them to more expenses. One respondent also reported that IDPs are not able to access health services free of charge:

*Unless we get free card as we are displaced family, they will treat us like ordinary citizen. They will not give you free service unless you show them some ID that indicates you are internally displaced. The city is big, they don't identify you are displaced family. (IDP)*

## Effect of COVID-19 on education

Because of COVID-19, schools have been closed and students have been forced to stay at home without education for a long period of time. Regarding children's time use, both IDPs and refugee groups reported similar things regarding how children spend their time after the closure of the schools.

Some participants from the IDP and refugee groups have been trying to provide their children with educational books and other religious books (including the Quran), movies, and alphabets at home. Most of the younger students spend their time playing in the compound. Refugees reported that they want schools to be reopened and have the desire to take their children to school during the pandemic. One IDP participant said:

*...if the school opens; I will take all of them to school tomorrow morning if the school opens. I don't have any fear. (IDP)*

Some participants from the refugee group mentioned that they had heard a rumour that the schools will be opened within a short period of time and they are preparing their children to read books and get ready for class. Their children have been registered at governmental schools because they cannot afford to pay for private schools currently. One participant from the refugee group said:

*...at the moment, I have registered three of them at government/public schools. That is because I don't have the capacity to pay 400 birr per month. Private schools are much better in terms of educational quality. The students do not leave the school compound after they enter the compound. As well as, they learn at least two or three subjects per day since they have sufficient teachers. (Refugee)*

## Effect of Covid-19 on mental health

COVID-19 is a global problem (for both developed and developing countries) and people are experiencing stress in relation to their worries about its impact on people's life and on the economy. All of the IDP, refugee, and returnee participants have experienced stress about the impact of the virus on their life, due to lack of jobs, economic problems, and fear of contracting COVID-19.

*Mostly I am concerned about being unemployed...I am educated/certified, and I can help my family if employed. I have applied to several companies. But I could not get a job as a result, I am very worried. (Refugee)*

The participants worry about how to lead their families as their economy has been devastated by the pandemic. Participants from the IDP group experience a high level of stress as they are living in a camp without work and cannot generate income for their family. With regard to this, one IDP participant said:

*...because we need to work to support our family. We feel depressed in a country where the government does not establish us in permanent house and I feel stressed when I sit without job... (IDP)*

However, some participants from the IDP group reported that although they are scared about COVID-19 infection, they hope to hear good news, particularly when they see many people have recovered from the disease. One IDP participant said:

*Although the number of cases is increasing, many individuals are recovering (which is good news, and we have the hopes to be become free). (IDP)*

On the other hand, participants from the refugee group feel stressed when they hear that people living in developed countries have died, and they usually protect themselves by practising prevention measures and praying.

Some IDPs use coping mechanisms, including supplicating their creator (Allah or God), and they do not consider the burden on their personal economy too much because they feel that wealth is worldly; they can get money if they work hard during the post-COVID-19 era. Moreover, some IDP participants handle their stress by applying the rules and recommendations of the World Health Organization (WHO). The following idea was mentioned by one IDP participant:

*Personally, if I respect the rules and apply the recommendations forwarded by WHO, FMOH, Tigray Regional Health Bureau, I can protect myself, I could be stable psychologically. If I am infected, I could not consider it much challenging than I am living currently. Because the military life taught me a lot of problem-handling mechanisms. (IDP)*

## **Effect of COVID-19 on social support and safety**

It is known that the impact of COVID-19 on the livelihood of poor individuals is enormous. At the beginning of the pandemic, social support was good and a number of poor people got help as a campaign, but this activity has not been continued aggressively. Most of the IDPs, refugees, and returnees said that they did not get any support in kind or in cash during the month prior to the survey. A refugee participant said:

*Until now, we haven't got any support for equipment/material to keep our sanitation. But, since all the personal protective equipment is available on the market, we use them buying from the market. (Refugee)*

The government has been supporting IDPs by providing them with rations, but they have not received these for the last two months. Moreover, some NGOs, like the United Nations Children's Fund (UNICEF), have recorded IDPs' data but have not started to provide aid yet. The following quote was taken from one IDP participant:

*There is no change. You know the government assists us with a ration of 15 kilograms of rice or wheat and a litre of food oil per month per household. We have not received this support for the past two months, however. (IDP)*

Moreover, other IDP participants raised similar problems:

*There is no support of any sanitary or other material after we moved to this camp, it is about 20 days since moved to this camp. We are using the soap that we got from the regional health bureau before. There is no support given recently, when we were at Elshaday, one child from each family was selected to be supported by a safety net, but we haven't received it yet. Because we were considered as we were living in a big problem. (IDP)*

Starting from last month, aid and support from governmental and non-governmental organisations has been decreasing, at this this there is no support. Other participants reported that they are still getting support from the government and NGOs but they mentioned delays in receiving support as a main challenge.

*...I am a refugee, there is a donation provided for me from UNHCR. For example, rice, edible oil, flour, and a limited amount of money were granted for us... (Refugee)*

*...I receive food and other material from the refugee camp but the problem is that they don't give us on time and this makes my life difficult... (Refugee)*

## Community support

Regarding support from the community, participants from the IDPs, refugees, and returnees groups said that people are generous and have been helping each other; however, some participants reported that the community support is declining.

*...The community cannot further support us, because the pandemic has affected their life now. No one gets closer to us now (i.e. intimate). They used to help us, but now no one is helping us and our economic crisis is getting worse... (IDP, Dire Dawa)*

One refugee said:

*The afar community has the culture of helping one another and sharing for others. We used to live in this kind of support one another. For instance, in this town there are several individuals who get benefits from the government. Thus, we also obtain support and help from them. However, now it's possible to say that they also don't get anything and community support is also reducing. (Participant from refugee group)*

## Safety and security

With regard to social safety and security, some home robberies and thefts of domestic animals were reported by both IDPs and refugees. Some disputes were reported in specific areas of the country, which may not be caused by the pandemic. One participant from the refugee group said:

*There is a high degree of robbery in this region. Most people have goats. So, there is high degree of goat stealing. They steal during the day time using Bajaj. At night, they jump over the fence and take the goats. Whenever they steal goats from Logia they will sell in Dubti while they steal from Dubti they will sell in Logia. Generally, there are several people who leads their life with stealing. (Refugee)*

Some IDP participants raised the fact that there have been security problems, particularly for women and children, such that one cannot go out at night alone, but the refugees and returnees did not report similar problems. One IDP mentioned this problem:

*...as I told you earlier there is a concern of the so-called China group, this puts people's security at risk, no one can go out alone at night. It is more concerning for women and children, because women can't go out to buy something from neighbourhood shop even at 1 pm fearing physical abuse and sexual harassment by this so-called China group. (IDP)*