

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

Results from **the sixth round** of a mixed method panel study in urban areas in nine cities in Ethiopia

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About the BRE programme

BRE is a three-year (2019–2022) technical assistance programme co-funded by FCDO and the United States Agency for International Development. 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 and Prevention, the World Health Organization, and Public Health England.

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Abbreviations

| | |
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| ANC | Antenatal care |
| BRE | Building Resilience in Ethiopia |
| COVID-19 | Coronavirus Disease 2019 |
| CSO | Civil society organisation |
| ETB | Ethiopian Birr |
| FCDO | UK Foreign, Commonwealth and Development Office |
| IDP | Internally displaced person |
| NGO | Non-governmental organisation |
| OPM | Oxford Policy Management |
| PNC | Postnatal care |
| SSB | Small-scale business |
| TPLF | Tigray People's Liberation Front |
| UNHCR | United Nations High Commissioner for Refugees |
| UPSNP | Urban Productive Safety Net Project |
| WASH | Water, sanitation, and hygiene |

Introduction

This report presents the results from **the sixth round (final round)** of a mixed methods phone survey which aims to assess the effects of COVID-19 and government responses to it on the lives of urban poor Ethiopians, including changes in their food security and livelihoods, as well as education for their children, and their access to and use of health services. It also aims to assess people's knowledge of, and practising of, preventive measures related to COVID-19, as well as stigma and discrimination against vulnerable groups because of COVID-19. Phone surveys were conducted in nine selected cities in Ethiopia: Addis Ababa, Dire Dawa, Adama, Gambela, Bahir Dar, Jijjiga, Bule Hora, Logia, and Semera. These were selected based on the size of the population of urban poor and vulnerable groups, including internally displaced persons (IDPs) and refugees.

The same households/individuals (typically household heads) have been surveyed over six rounds.¹ We focus on the types of respondents who may not be included in nationally representative surveys (namely beneficiaries of the Urban Productive Safety Net Project (UPSNP), small business owners, and IDPs and refugees) and individual day labourers (petty traders and others, who we refer to as a 'special population segment' (or 'special group') that could be especially vulnerable to the effects of the COVID-19 pandemic). We have worked closely with the Federal Ministry of Health and the National Disaster Risk Management Commission in order to ensure that the findings of this study will help the government to design social policies and interventions to curb the further spread of the pandemic, and to reduce its impacts.

Our findings from all rounds indicate that COVID-19 has significantly affected poor and vulnerable groups, and has had, to some extent, differential impacts related to structural inequalities, such as gender and ability, and on people who are marginalised for other reasons (e.g. IDPs). Access to food and water remain major challenges for the urban poor. In addition to the problems associated with low income, the increased price of food items was mentioned as the primary factor that is exacerbating food insecurity among the urban poor in this round, despite the fact that income for some respondents has returned to almost the same level as in the pre-pandemic period. By contrast, daily wage earners, people with jobs in the informal sector, vendors, petty merchants, labourers, and women are found to be the most impacted due to loss of jobs and reduced income, and due to the disproportionate childcare burden for women. IDPs and refugees, and people living with no social safety nets, are also found to be particularly vulnerable to the pandemic. Moreover, there is a significant decline in the practising of, and compliance with, the COVID-19 preventive measures.

¹ The first round of the phone interviews was carried out between 22 June and 22 July 2020, the second round from 23 August to 13 September 2020, the third round from 28 October to 13 November 2020, the fourth round from 26 February to 13 March 2021, and the fifth round from 15 July to 15 August 2021. In the first, third, and sixth rounds we also interviewed local government officials, non-governmental organisations (NGOs)/civil society organisations (CSOs), and healthcare professions. However, we only interviewed these groups every two rounds (the third round also included interviews with these groups and in the fifth round we interviewed healthcare professionals). 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 with local government officials, NGOs/CSOs, and healthcare professions help provide the context for our study, although they are not the main focus.

Additionally, in this round, security issues originating from political turmoil and conflicts in some parts of the country (mainly in Tigray, Amhara, and Afar regions) have had a severe impact on economic activity, resulting in a rise in food prices. In particular, the respondents from Semera and Logia (in Afar region, which is most affected by the conflict) widely mentioned a severe shortage of water due to the disruption of the municipal water supply which has resulted from an absence of electric power used to operate water pumps and distribute water to residents. In addition, respondents from the same areas were also faced with a negative effect of the conflict on their income, and on household food security. The increased difficulty in terms of access to water, sanitation, and hygiene (WASH) services appears to be related to an inability to pay for services, and to disrupted supply chains as a result of reduced transportation.² Therefore it seems that even though people are able to work more now (compared to the beginning of the COVID-19 pandemic), affordability is still a major problem due to price increases for items which are necessities, such as food and water. Irregular income and affordability issues have also led to the increased mental health problems observed in this round.

² www.worldbank.org/en/news/feature/2020/05/11/in-ethiopia-keeping-water-flowing-during-the-covid-19-coronavirus-response

Methodology – Round 6 (December 2021)

The study uses a mixed method design, employing both qualitative and quantitative data collection methods. A phone survey, using an interviewer-administered quantitative questionnaire and a respondent-led qualitative interviews, was conducted 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; and
- aid and support from the government, NGOs, and other organisations.

Cities covered

The current round of the study was conducted from **15 November to 15 December 2021** in nine cities/towns located in different regions of Ethiopia. In each round it took an average of 30 days (a month) to collect data. However, due to delays related to various causes (mainly the conflict in northern Ethiopia and unrest in Oromia region, which resulted in interruption of telecommunication services), the time intervals between rounds was not constant. The cities included in this round were Addis Ababa, Dire Dawa, Adama, Gambela, Bahir Dar, Jijjiga, Bule Hora, Logia, and Semera. This selection of cities was intended to include different regional states, geographic locations, and sizes, and to capture the impact of the different measures taken by the regions. Additionally, differences in the local economies, the level of access to basic services, and the effects of internal displacement were also considered during the selection of the cities. Initially, 10 cities were selected, but due to the telecommunication service blackout and the conflict between the Tigray People's Liberation Front (TPLF) and the Ethiopian Federal Government we excluded Mekelle in Rounds 4, 5, and 6.

Quantitative interview sample

The quantitative interviews were conducted among UPSNP beneficiaries,³ households that own a small-scale business (SSB), and refugees and IDPs.

- The UPSNP is designed to increase the income of targeted poor households and to establish urban safety net mechanisms. UPSNP beneficiaries are households that are identified as 'the poorest of the poor' based on their ability to generate income, their

³ Respondents included under the UPSNP category include: beneficiaries who receive direct support in cash or in kind; those engaged in street cleaning jobs and receiving a monthly salary; and individuals who are identified as eligible to be enrolled in the programme but who are not receiving any support, since UPSNP is not operating in some cities (i.e. Bahir Dar, Bule Hora). Our findings also showed that UPSNP respondents (those registered/eligible and those receiving support) are in the lowest income quintile (their income is even below that of IDPs/refugees). Therefore, we can assume that they are still eligible for UPSNP.

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).

- 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 have been greatly impacted due to movement restrictions/lockdown.
- Households in the IDP/refugee category are among the most vulnerable groups and are being highly affected by COVID-19⁴ as their socioeconomic status and livelihoods are already compromised due to displacement from their original location. The term 'refugee' refers to individuals who 'have fled war, violence, conflict or persecution and have crossed an international border to find safety in another country' and who are under international protection.⁵ The sample for this study is restricted to refugees who are living outside of camps in rented accommodation in the cities, primarily in 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'.⁶ 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 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'.⁷ Our respondents self-identified as one of these three categories (IDP, refugee, or returnee) based on the definitions outlined above.

The quantitative household interviews were conducted among the same respondents who were involved in the previous five rounds of data collection. Before the first round, a simple random sampling method was used to select household survey respondents 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; for Bahir Dar and Bule Hora (cities in which the programme has not started) a list of potential candidates registered for the UPSNP was obtained from the city/sub-city or kebele administration. Lists of SSBs were obtained from small-scale and micro enterprise offices. Lists of IDPs and refugees were obtained from local government authorities (Social Affairs

⁴ www.internal-displacement.org/crises/coronavirus

⁵ www.unhcr.org/uk/what-is-a-refugee.html

⁶ <https://emergency.unhcr.org/entry/44826/idp-definition> However, this is a descriptive definition, which does not confer a special legal status because IDPs, being inside their own country, remain entitled to the same rights and guarantees as other citizens and habitual residents of the country. As such, national authorities have the primary responsibility for preventing forced displacement and for protecting IDPs (UNHCR).

⁷ International Organization for Migration (2018) *IOM Glossary on Migration*. 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

Office, City Administrations, and the Administration for Refugee and Returnee Affairs). The total targeted sample size (450, or 45 respondents per city) was equally allocated across 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 sample of 436 households included in the quantitative survey (Round 1), we were able to interview **303 respondents during this round** (309 in Round 5), **a response rate of 69.5%**. Of these, 107 were UPSNP beneficiaries (108 in Round 5), 106 were SSB owners (108 in Round 5), and 90 were IDPs/refugees/returnees (93 in Round 5).⁸ We faced multiple challenges during the data collection period in this round. In Round 6, a total of six respondents were lost as compared to the previous round, due to being unreachable using the phone numbers we had obtained, and due to refusal to take our calls. The team spent several days trying to reach out to these respondents through field coordinators, who tried to trace these respondents and to find alternative phone numbers. The average length of the quantitative household survey interviews was 33 minutes. Given the telecom service outage following the conflict between the TPLF and the Federal Government of Ethiopia, and the subsequent potential psychosocial impact, we excluded 25 respondents (who were also excluded in Rounds 4, 5, and 6) from Mekelle. To avoid systematic bias due to dropout of respondents having particular characteristics (social, economic, health, behaviour, etc.) the sample size in each round is adjusted by including only those interviewed in all preceding rounds (i.e. respondents who dropped out in Rounds 1, 2, 3, 4, or 5 were excluded from Round 6).

Qualitative interview sample

A total of 32 qualitative interviews were conducted in this round: 21 diary interviews and 11 key informant interviews with government offices and NGOs. The diary interviews were conducted with a separate set of respondents who were purposively selected from among the Round 1 respondents. The total of 21 diary interview respondents (an average of around three respondents per city) were from four categories: UPSNP beneficiaries (4); SSB owner respondents (4); IDPs/refugees/returnees (8); and respondents from the 'special population group' (i.e. daily labourers, shoeshines, waiters, and porters) (5). The number of diary interview respondents for Round 6 was less than in the previous five rounds (57, 50, 35, 30 and 24 respondents in Round 1, Round 2, Round 3, Round 4, and Round 5 respectively). The major reasons for dropout were that some of the respondents had changed their phone numbers, some refused to take the calls, and some of them were inaccessible as their phone was switched off or out of service (mainly because of network and electric power issues). In addition, we were not able to reach out to any of the respondents from Mekelle in Rounds 4, 5, and 6, due to the network shutdown and security concerns, as mentioned above.

In this round, we conducted an additional 11 key informant interviews with representatives of government offices (Women's and Children's Affairs offices, and City Health Offices) and

⁸ In Round 4, our sample was 336 participants (and thus we lost 27 participants overall in this round). Of these, 113 were UPSNP beneficiaries, 120 were SSB owners, and 103 were IDPs/refugees/returnees.

NGOs or civil society organisations (CSOs), to explore the effect of COVID 19 on the livelihoods (i.e. health, food security, behaviour, and social and economic effects) of the urban poor. We planned to conduct three key informant interviews per city, but we were only able to conduct 11 interviews in total, with respondents from Addis Ababa (1), Adama (2), Bulehora (1), Dire Dawa (1), Jijjiga (2), Bahirdar (2), and Gambela (2). We were not able to conduct any key informant interviews in Semera or Logia, as the offices were closed due to the security problem associated with the conflict in northern Ethiopia.

Interview approach

All interviews were conducted using a two-step approach: the city coordinator (who is a part of the research team from MERQ) made an introductory call to introduce the study, obtain consent, and schedule interviews with potential respondents; and then the actual interviews were conducted by the data collectors. The average duration of the qualitative interviews was 36 minutes. The number of call attempts made ranged from one to 12, in order to reach each respondent for the actual interview. Daily debriefings were conducted between the study team and the field-based data collectors.

Field observation by data collectors

The qualitative data collectors also conducted weekly observation sessions to provide contextual insights into the communities' behaviour regarding the prevention of COVID-19 and the level of compliance with the restrictions or measures set by national and local authorities. We used a checklist to guide the observations. The information gathered from the nine cities is summarised in the 'Context' section below, where we identify the changes between the observation sessions and describe the overall context of the cities with regard to compliance with COVID-19-related measures, including using a facemask and maintaining physical distancing, as well as food prices.

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 between the rounds (Round 6 versus Round 5 or Round 4 or Round 3 or Round 2 or Round 1).⁹

All qualitative interviews were transcribed and coded using NVivo 14 qualitative analysis software. Two members of the team independently coded the interviews using an inductive approach, and differences and emerging codes were discussed. Framework analysis was used to allow for the identification of common variable patterns by themes/topic guides within and across different groups. Salient quotes (i.e. quotes that reflected strong patterns in the

⁹ Primarily, we tested the difference between Round 6 and Round 5, but we sometimes also tried to compare the differences between Round 6 and Round 1, Round 2, Round 3, and Round 4 – mostly in regard to mental health.

data and that were succinct when translated into English) were used to express the experiences and perceptions of the respondents, and for the case studies.

Limitations of the study

This study has some limitations that should be considered. First, the study was unable to explore other factors that may have influenced the respondents' answers to the survey questions that were not observable or relevant to COVID-19. Since the interviews were conducted over the phone, we were not able to connect and establish as much of a rapport as we could have done with face-to-face interviews. The duration of the calls was also short and network disruption was also an issue. Secondly, the data presented, including on compliance with COVID-19 response measures, the level of malnutrition, and the psychological impacts of COVID-19, are based on respondents' self-reports, which may be affected by social desirability bias. We carefully designed the data collection tools in order to take social desirability bias and other confounding factors 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). For questions around the knowledge and practising of preventive methods against COVID-19, we also asked respondents about what 'others' (family members and friends) do, in addition to their own behaviour: we found significant differences between own (self-reported) behaviour and the behaviour of others as reported by the respondents. Finally, the attrition rate is a problem in this round, as mentioned above, which could bias our results in a systematic way, depending on who has been dropped from the sample. We explore this further in the 'Summary of household characteristics' section below.

Context and field observation findings during Round 6

This section reports information on the context of the study, nationally and in each city, based on a document review and field observations by the data collectors.

As at 10 January 2022, a total of 4,198,175 COVID-19 laboratory tests had been conducted since the start of the pandemic. 446,268 infections and 7,042 coronavirus-related deaths have been reported in the country since the pandemic began.¹⁰ Ethiopia has administered a COVID-19 vaccine to 9,363,216 people and has provided at least 10,956,131 doses of COVID-19 vaccines so far. Assuming every person needs two doses, this is enough to have vaccinated about 4.9% of the country's population. There was a significant increase in the level of COVID-19 infection during this round, compared to Round 5. In Round 5 (as at 10 July 2021), the number of people infected with COVID-19 reached 289,962, of whom 206,870 had recovered and 3,840 had died.¹¹ A total of 1,287,801 people in the priority group had been vaccinated.¹² In the previous rounds, COVID 19 vaccination was being given to health workers, people over 65, and those with comorbidities, and vaccination rates were higher in Addis than in other cities. However, in this round, there has been an improvement in vaccination coverage as people over 35 years old are also included in the priority group to receive the vaccine.

The COVID-19 prevention and control guideline issued on 6 October 2020 by the Government of Ethiopia is still in place. The guideline sets out the following measures:

- service-providing individuals and customers must wear a facemask except when eating and drinking;
- it is prohibited to enter the premises of any religious institution without wearing a facemask;
- any person attending a funeral is expected to wear a facemask and to maintain a distance of two adult strides; and
- service-providing facilities must take necessary measures to control the spread of the virus by preparing required tools at the entrance and exit and other areas, ensuring that rooms have adequate air ventilation, and providing employees with the necessary personal protective equipment.

Given the rapidly accelerating transmission of COVID-19 and declining practices relating to, and compliance with, the preventive measures, on 28 March 2021 the Ministry of Health and the Ethiopia Federal Attorney General Office announced the legal framework for, and enforcement of, the COVID-19 prevention guideline and control directive (Directive-30/2020).¹³ Since then, there has been no new or updated guideline, though there is

¹⁰ <https://covid19.who.int/region/afro/country/et>

¹¹ <https://reliefweb.int/report/ethiopia/unhcr-ethiopia-covid-19-and-operational-update-8-may-2021>

¹² <https://graphics.reuters.com/world-coronavirus-tracker-and-maps/countries-and-territories/ethiopia/>

¹³ Federal Ministry of Health (2020) 'A directive issued for the prevention and control of COVID-19 pandemic', Directive No. 30/2020. Directive No. 30/2020, which came into effect on 5 October 2020, laid down a set of requirements for those international travellers who wished to enter the country through its international airports. Beyond requiring travellers to provide a negative RTPCR test conducted up to five days before arrival, the directive also requires international travellers to quarantine at home for seven days. The directive continues the

evidence of widespread and accelerating community transmission of COVID-19 in the country.

The major incidents and events observed by the data collectors during this round are summarised in the paragraphs below.

- In all of the cities, data collectors observed that most drivers and their assistants providing public transport services were not wearing a facemask. In addition, passengers using public transport were rarely seen wearing facemasks.
- In most service-providing institutions, including bars and restaurants, waitresses were not wearing a facemask when serving customers.
- As was reported in Round 5, there was limited compliance with the government's directive that everyone visiting churches and mosques should wear a facemask. It was observed that most people did not wear a facemask when going into churches and mosques, though better compliance was observed in Addis Ababa.
- The data collectors observed that most students did not wear a facemask in the school compound or in classrooms. Compliance with physical distancing was also found to be poor in all of the cities. Moreover, the data collectors also observed that most people had started shaking hands again in all of the cities. The data collectors observed better use of a facemask in Addis Ababa and Adama, which was also documented in Round 5.
- Enforcement of the law and regulations regarding COVID-19 was observed to be weak and inconsistent. According to the observational reports, people were not complying with the COVID-19-related laws and regulations, and were not held accountable for this. A lack of compliance with the restriction measures – including using a facemask and social distancing – was prevalent in all of the study cities, although with slight differences in the degree of compliance with wearing a facemask. It was also common to see public gatherings without proper protections (i.e. wearing a facemask and maintaining physical distancing) at marketplaces, religious places, cafés, restaurants, etc. Enforcement of the law and regulations regarding COVID-19 was observed to be relatively better at banks and government offices like Ethio Telecom, though it remained weak and inconsistent.

In Ethiopian academic year 2013 (2020/21GC), school classes were held in two different shifts for three days a week, based on directives provided by the Ethiopian Public Health Institute. Shift were introduced to control and prevent the spread of the COVID pandemic. In Ethiopian academic year 2014 (2021/22 GC), however, the students have returned to normal schooling (five days a week).

policy of temporary isolation for international travellers that display any of the symptoms associated with COVID-19. The directive also regulates how private enterprises should interact with their employees, as well as their customers. For example, the directive obligates employers to not only provide precautionary materials to their employees but to also make information about COVID-19 readily available, as well as to ensure that employees are able to work while maintaining a safe distance between each other.

Summary of household characteristics

In this round the quantitative phone survey included 303 households: 107 UPSNP beneficiaries, 106 SSB owners, and 90 refugees and IDPs – six fewer respondents than in Round 5, due to dropouts (i.e. due to network problems, refusal to participate, phone being switched off, or unavailability). Females accounted for 51.5% of the respondents. The average age of the respondents was 34, with a range between 20 and 65. The average family size was 5.43 (standard deviation (SD): 2.8). Among the households in our sample, 49.8% of them had at least one child under five (see Table 1).

Out the total of 436 respondents enrolled in the beginning of the study (Round 1), 133 (30.6%) dropped out before or in Round 6. The dropout rate among quantitative survey respondents was highest among respondents from Mekelle (100%), Gambela (58.0%), and Addis Ababa (48.1%). On the other hand, relatively low dropout rates were recorded in Jigjiga (8.7%), Logia (9.2%), and Dire Dawa (9.6%) (Table 2). The proportion of dropouts was comparable across the three categories: 30% (46 out of 153 respondents in Round 1) of UPSNP beneficiaries, 31% (47 out of 153 respondents in Round 1) of SSB owners, and 31% (40 out of 130 respondents in Round 1) of IDPs/refugees discontinued before or in Round 6 (see Table 1).

For the qualitative study, we conducted a total of 32 interviews in this round (21 diary interviews and 11 key informant interviews with representatives of government offices and NGOs). There was a high dropout rate among diary interview respondents: the number of respondents declined from 57 in Round 1 to 21 in Round 6. The diary interviews were conducted with four UPSNP beneficiaries, four SSB owner respondents, eight IDPs/refugees/returnees, and five respondents from the 'special population group' (i.e. day labourers, shoeshines, waiters, porters). In addition, 11 key informant interviews were conducted with representatives of selected government offices (nine key informant interviews) and NGOs (two key informant interviews). As stated earlier, we were not able to conduct any key informant interviews in Semera or Logia, as the offices were closed due to the security problem associated with the conflict in northern Ethiopia.

Table 1: Characteristics of quantitative household survey respondents for all rounds of the study, urban poor in selected nine cities in Ethiopia, December 2021

| Variables/ characteristics | Round 1 (n=436) | | Round 2 (403) | | Round 3 (380) | | Round 4 (336) | | Round 5 (309) | | Round 6 (303) | |
|---|--------------------|------|------------------|------|------------------|------|------------------|------|------------------|------|------------------|------|
| | N | % | N | % | N | % | N | % | N | % | N | % |
| Gender of the respondent | | | | | | | | | | | | |
| Male | 225 | 51.6 | 203 | 50.4 | 201 | 53.0 | 168 | 50.0 | 158 | 51.1 | 156 | 51.5 |
| Female | 211 | 48.4 | 200 | 49.6 | 179 | 47.0 | 168 | 50.0 | 151 | 48.9 | 147 | 48.5 |
| Family size | | | | | | | | | | | | |
| Less than three | 59 | 13.5 | 54 | 13.5 | 38 | 10.0 | 37 | 11.0 | 25 | 8.1 | 19 | 6.3 |
| Three to five | 217 | 49.8 | 201 | 49.8 | 198 | 52.0 | 165 | 49.0 | 151 | 48.9 | 145 | 47.9 |
| Above five | 160 | 36.7 | 148 | 36.7 | 144 | 38.0 | 131 | 39.0 | 133 | 43.0 | 139 | 45.9 |
| Number of children under five | | | | | | | | | | | | |
| None | 216 | 49.5 | 199 | 49.5 | 182 | 48.0 | 168 | 50.0 | 156 | 50.5 | 151 | 49.8 |
| One | 135 | 31.0 | 125 | 31.0 | 129 | 34.0 | 101 | 30.0 | 90 | 29.1 | 91 | 30.0 |
| Two | 66 | 15.1 | 61 | 15.1 | 61 | 16.0 | 50 | 15.0 | 49 | 15.9 | 49 | 16.2 |
| Three and above | 19 | 4.4 | 18 | 4.4 | 11 | 3.0 | 13 | 4.0 | 14 | 4.5 | 12 | 4.0 |
| Respondent category | | | | | | | | | | | | |
| UPSNP | 153 | 35.1 | 142 | 35.2 | 121 | 31.8 | 113 | 33.6 | 108 | 35.0 | 107 | 35.3 |
| SSB | 153 | 35.1 | 141 | 35.0 | 137 | 36.1 | 120 | 35.7 | 108 | 35.0 | 106 | 35.0 |
| IDP/refugee | 130 | 29.8 | 120 | 29.8 | 122 | 32.1 | 103 | 30.7 | 93 | 30.1 | 90 | 29.7 |
| Mean age of respondents | 32 | | 32 | | 33 | | 33 | | 35 | | 34 | |
| Average monthly income in Ethiopian Birr (ETB) | 2,277 | | 2,086 | | 2,785 | | 3,069 | | 3,045 | | 3,458 | |

Table 2: Dropout rate of quantitative household survey respondents across the six rounds, urban poor in selected nine cities in Ethiopia, December 2021

| Cities | Round 1 (n=436) | | Round 2 (n=403) | | Round 3 (n=380) | | Round 4 (n=336) | | Round 5 (n=309) | | Round 6 (n=303) | | Dropout rate R1 to R6 | |
|--|--------------------|------|--------------------|------|--------------------|------|--------------------|------|--------------------|------|--------------------|------|--------------------------|-------------|
| | N | % | N | % | N | % | N | % | N | % | N | % | N | % |
| Addis Ababa | 46 | 10.6 | 45 | 11.1 | 42 | 11.0 | 37 | 11.0 | 30 | 9.7 | 24 | 7.9 | 22 | 48.1 |
| Adama | 46 | 10.6 | 39 | 9.6 | 42 | 11.0 | 40 | 12.0 | 40 | 12.9 | 39 | 12.9 | 7 | 15.6 |
| Bule Hora | 45 | 10.3 | 39 | 9.6 | 38 | 10.0 | 34 | 10.0 | 28 | 9.1 | 32 | 10.6 | 13 | 28.7 |
| Dire Dawa | 43 | 9.9 | 41 | 10.1 | 42 | 11.0 | 40 | 12.0 | 41 | 13.3 | 39 | 12.9 | 4 | 9.6 |
| Jigjiga | 45 | 10.3 | 43 | 10.6 | 42 | 11.0 | 44 | 13.0 | 43 | 13.9 | 41 | 13.5 | 4 | 8.7 |
| Semera | 45 | 10.3 | 44 | 10.9 | 46 | 12.0 | 44 | 13.0 | 41 | 13.3 | 39 | 12.9 | 6 | 13.2 |
| Logia | 44 | 10.1 | 45 | 11.1 | 46 | 12.0 | 44 | 13.0 | 40 | 12.9 | 40 | 13.2 | 4 | 9.2 |
| Bahir Dar | 46 | 10.6 | 43 | 10.6 | 42 | 11.0 | 40 | 12.0 | 37 | 12.0 | 36 | 11.9 | 10 | 22.1 |
| Mekelle | 45 | 10.3 | 41 | 10.1 | 27 | 7.0 | - | - | - | - | - | - | 45 | 100.0 |
| Gambela | 31 | 7.1 | 27 | 6.7 | 23 | 6.0 | 13 | 4.0 | 9 | 2.9 | 13 | 4.3 | 18 | 58.0 |
| Total dropout between Round 1 and Round 6 | | | | | | | | | | | | | 133 | 30.6 |

Highlights of the results – Round 6

- A considerable number of respondents believed that they were no longer at risk of contracting COVID-19. **The self-reported practising of, and compliance with, the COVID-19 preventive measures were limited** and had significantly decreased compared to the previous rounds. According to the qualitative findings, perceived low susceptibility to and perceived low severity of the disease, political instability, and weak and inconsistent enforcement of COVID-19-related law and regulations seem to have contributed to the decline in the practising of preventive measures.
- Reported willingness to receive COVID-19 vaccine was high. The majority of respondents (92.1%) said that they would accept the vaccine for themselves. Most respondents agreed that it was important, safe, effective, and compatible with their religious beliefs or personal values to get the COVID-19 vaccine if it was offered to them. However, only 19.1% of the respondents reported having been vaccinated. Moreover, the findings from qualitative interviews with the diary interview respondents indicated that there was still a concern that the vaccine could cause some side-effects.
- **Shortages of water and limited accessibility remained a major problem** for the urban households. The proportion of households that reported experiencing shortages in the municipal water supply increased from 40.3% in Round 5 to 58.1% in Round 6. There was disparity across the respondents from the nine cities in terms of experiencing water shortages and the level of difficulty in accessing water. In this round, IDPs/refugees were more affected in terms of experiencing water shortages, and difficulty in accessing water.
- **The average monthly income of households has increased across the six rounds**, from ETB 2,456 in Round 1 to ETB 3,458 in Round 6. The SSB group had the highest average monthly income (ETB 5,608) as compared to the UPSNP and IDP/refugee groups. Despite the increasing trend in regard to household incomes, 61.7% of respondents reported that their income was inadequate to cover basic expenses (food, paying for shelter/house rent, and buying clothes). Likewise, most of the qualitative study respondents mentioned the inadequacy of their income to cover their basic expenses, mainly because of **the increase in the price of food (inflation)**.
- **The incidence of food shortages remained one of the major challenges for the urban poor**, although the proportion of households that reported food shortages decreased from 58.70% in Round 1 to 49.5% in Round 6. Like in previous rounds, the increase in the price of food items and the lack/inadequacy of income were the major factors resulting in a shortage of food and decreased meal frequency among the urban poor. In Round 6, respondents mentioned that eating less preferred foods and reducing the number of meals per day remained the predominant strategies for coping with food insecurity (unaffordability).
- Only 51 respondents (16.8% of the total sample) reported that they needed medical treatment over the past month, and all of whom were able to access medical treatment when needed.
- In this round, feelings of distress had increased, and it appeared that inflation in the cost of living and conflicts, rather than COVID-19, were the reasons for the stress.
- There was no significant change in regard to receiving better support compared to the previous round. The main sources of support were the government and NGOs. Support from community and religious institutions was very minimal in this round.

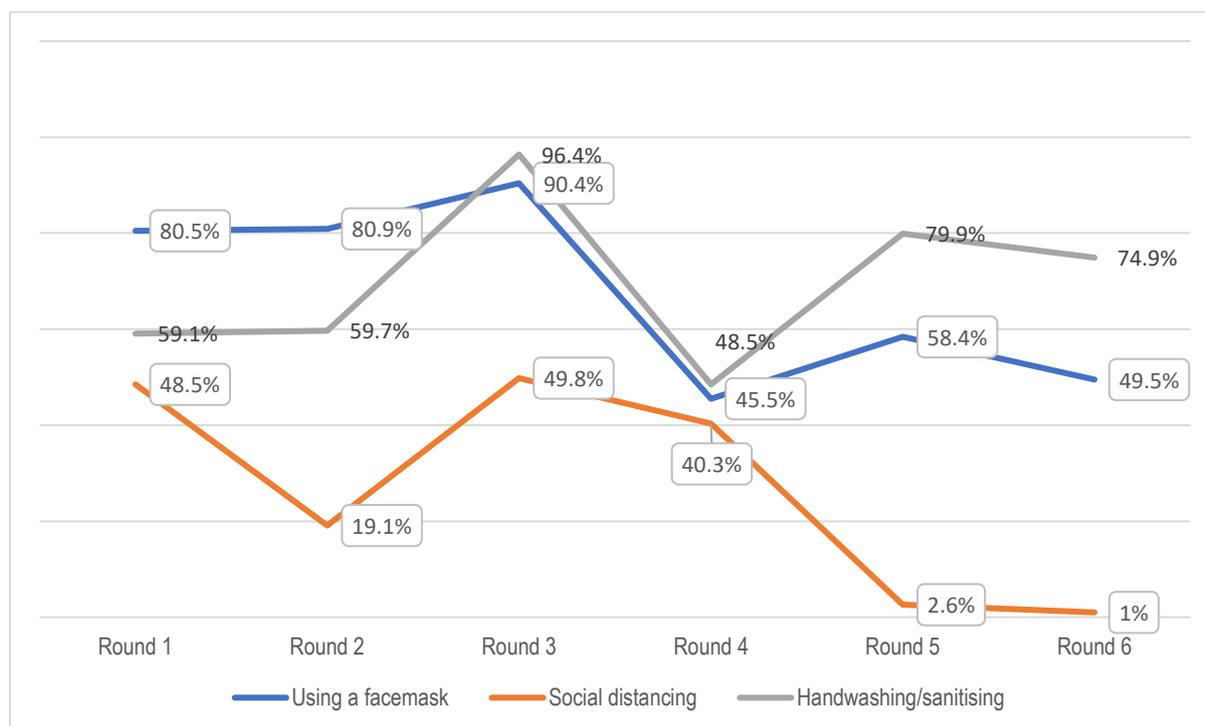
Results by theme

Behaviour relating to COVID-19 prevention

Key findings:

- Most respondents believe that COVID-19 still exists, but a considerable number believe that they are no longer at risk of contracting the disease.
- The practising of COVID-19 preventive measures declined significantly in this round, and was also found to vary across the cities. According to the qualitative findings, perceived low susceptibility to and severity of the disease, political instability, and weak and inconsistent enforcement of COVID-19-related law and regulations seemed to have contributed to a decline in the practising of preventative measures.
- The reported willingness to receive a COVID-19 vaccine was high. Most respondents agreed that it is important, safe, effective, and compatible with their religious beliefs or personal values to get the COVID-19 vaccine if it is offered to them. However, only 19.1% of the respondents reported having been vaccinated so far.
- Only 22.1% (67 respondents) reported having been offered the COVID-19 vaccine, most (86.6%) of whom had received the vaccine. Fear of vaccine-related side-effects, waiting for someone to get vaccinated first, perceived low susceptibility, and limited access to the vaccine itself were the major factors for low coverage of the COVID-19 vaccine.

Most (76.9%) of the respondents believe that COVID-19 still exists. However, 32.7% of the total sample believe that they are no longer at risk of contracting the disease, which is slightly higher compared to the 28.1% in Round 5. Overall, the practising of COVID-19 preventive methods was found to be more limited. In this round, 74.9%, and 49.5% reported that they were still practising handwashing and/or sanitising, and using facemasks, respectively. Practising of physical distancing significantly dropped in Rounds 5 (2.6%) and 6 (1%), compared to 49.5% in Round 3 and 40.3% in Round 4. The use of a facemask also decreased from 58.4% in Round 5 to 49.5% in this round (chi-square: 13.25; p-value: <0.001) (see Figure 1), but was higher compared to the 45.5% in Round 4. A significant increase in the practising of handwashing/sanitising and using a facemask observed in Rounds 5 and 6 could partially be attributed to the arrival of the third wave of the pandemic in the country.

Figure 1: Practising using a facemask and social distancing among the urban poor in selected nine cities in Ethiopia (n=303), December 2021

We found no statistically significant difference in terms of practising handwashing and/or hand-sanitising (chi-square: 5.399; p-value: 0.067) and wearing a facemask (chi-square: 5.013; p-value: 0.082) between the UPSNP beneficiaries, SSB group, and refugee/IDP group. Moreover, the differences in the practising of COVID-19 preventative measures between male and female respondents were not statistically significant.

We asked the respondents to rate their compliance with preventative measures on a scale of one to five.¹⁴ The self-reported compliance of the respondents with the COVID-19 preventative measures significantly decreased in this round. The proportion of respondents who described their compliance with handwashing/sanitising either as 'a lot' or 'somewhat' had dropped from 90.1% in Round 5 to 78.9% in this round. Like in the previous rounds, we asked respondents to rate family members' level of compliance with preventative measures on a scale of one to four.¹⁵ The respondents reported low compliance with the preventative measures among family members. Only 35.3, 20.8%, and 2% reported that all of their family members complied with handwashing and/or sanitising, wearing a facemask, and physical distancing, respectively. The level of compliance by all family members with the COVID-19 preventative measures, including wearing a facemask and physical distancing, reported in this round was similar to that in Round 5. In Round 5, 38.6%, 21.5%, and 2% of respondents

¹⁴ How much do you comply with handwashing/sanitising, wearing a facemask, and social distancing as COVID-19 prevention measures? (A lot, somewhat, not very much, not at all, no longer in place).

¹⁵ How much do other family members comply with handwashing/sanitising, wearing a facemask, and social distancing as COVID-19 prevention measures? (No longer in place, none of them, some of them, all of them).

reported that all their family members complied with handwashing and/or sanitising, wearing a facemask, and physical distancing, respectively.

There was a statistically significant difference in the level of family compliance with handwashing and/or sanitising (chi-square: 11.092; p-value: 0.029) and wearing a facemask (chi-square: 15.691; p-value: 0.016) between UPSNP beneficiaries, the SSB group, and the IDP/refugee group (Table 3).

Table 3: Family compliance with government restrictions among the urban poor in selected nine cities in Ethiopia, December 2021 (total n = 303; UPSNP = 107, SSB = 106, IDPs/refugees = 90)

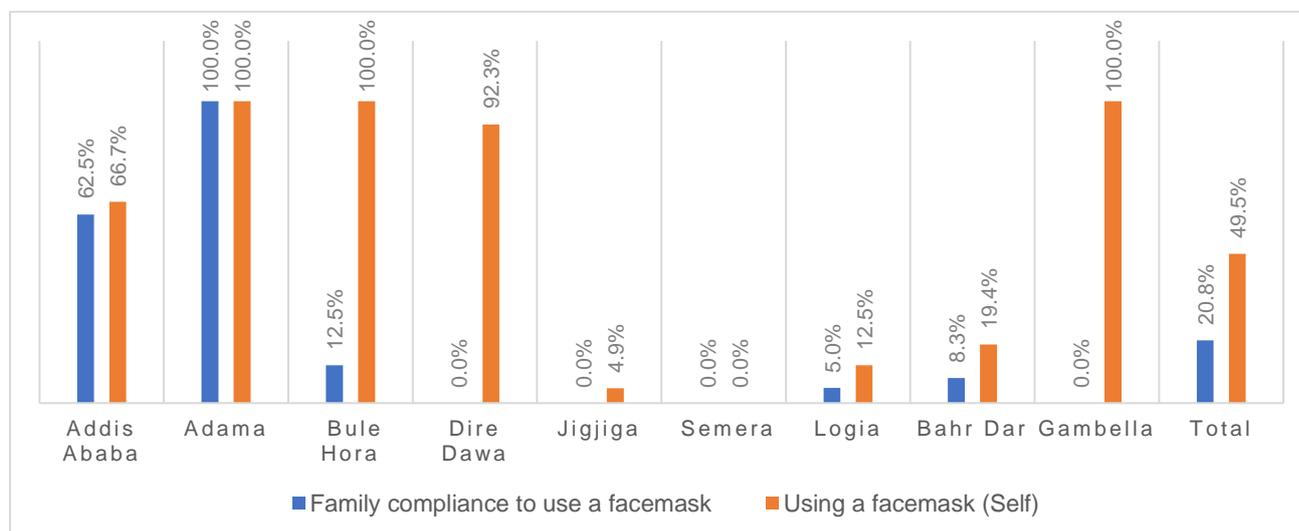
| Restrictions | UPSNP (%) | IDPs/refugees (%) | SSB (%) | Round 6 total (%) | Chi-2 [p-value] |
|---|-----------|-------------------|---------|-------------------|-------------------|
| Compliance by family members with handwashing/sanitising | | | | | |
| None of them | 0 | 1.1 | 0 | 0.3 | 11.092 [0.029] |
| Some of them | 53.3 | 33.3 | 49.1 | 45.9 | |
| All of them | 30.8 | 37.8 | 37.7 | 35.3 | |
| No longer in place | 15.9 | 27.8 | 13.2 | 18.5 | |
| Compliance by family members with wearing a facemask | | | | | |
| None of them | 6.5 | 1.1 | 8.5 | 5.6 | 15.691 [0.016] |
| Some of them | 32.7 | 18.9 | 35.8 | 29.7 | |
| All of them | 19.6 | 23.3 | 19.8 | 20.8 | |
| No longer in place | 41.1 | 56.7 | 35.8 | 43.9 | |
| Compliance by family members with social distancing | | | | | |
| None of them | 48.6 | 31.1 | 55.7 | 45.9 | 20.709 [0.002] |
| Some of them | 4.7 | 1.1 | 0.0 | 2.0 | |
| All of them | 2.8 | 1.1 | 1.9 | 2.0 | |
| No longer in place | 43.9 | 66.7 | 42.5 | 50.2 | |

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

There was a significant difference in respondents' reported practising of the COVID-19 preventive measures and level of family compliance with the COVID-19 prevention methods **between the cities**. In this round, a lower level of compliance with wearing a facemask among family members was reported in all of the cities except Addis Ababa and Adama (Figure 2). A higher level of compliance with wearing a facemask among family members was also reported in these two cities in Round 5. The better practising of the preventive measures in these two cities could partially be attributed to relatively good enforcement of the COVID-19 rules and regulations, which is supported by our qualitative findings. It is also possible that residents of big cities like Addis Ababa and Adama have better access to COVID-19-related information. The practising of the preventive measures was found to be

significantly low in Jigjiga, Semera, and Logia. Only seven (5.8%) out of 120 respondents (39.6% of the sample size) from these cities reported that they were using a facemask.

Figure 2: Self-reported use of a facemask and family compliance with using a facemask all the time among family members of the urban poor in selected nine cities in Ethiopia, December 2021 (total n = 303)



We also asked the respondents what their main concerns were at the moment and the majority said that market price inflation (95%) and political instability (94.4%) were their major source of worries, while 72.3% of the respondents reported that they were worried about COVID-19.

The decline in the practising of preventive methods was also reflected in the qualitative interviews. Respondents reported that they were no longer worried about COVID-19, and that the practising of preventative measures was limited:

You do not observe many people wearing facemasks or those who kept a distance, which was not the case during the previous time. When you walk along the street in Adama, you only see a few people wearing a facemask. You wonder if the virus has totally disappeared. (IDP, Adama)

Currently, COVID-19 is not a big issue for us and no one talks about it. People are not keeping their physical distance and not wearing a facemask. No one, including the government, is worried about COVID-19 because there is a big concern related to the conflict. (UPSNP, Semera)

According to the qualitative findings, limited activities related to COVID-19 prevention and control by the government have led to a perception that the disease is not real and has contributed to the limited practising of the preventive measures. Moreover, a lack of, and inconsistent enforcement, of the COVID-19 preventive measures was also found to be contributing to declining practising of COVID-19 preventive methods.

Previously, we used to wear facemasks and wash our hands before we enter banks but now such practices are not there. I am not hearing about COVID-19 and we never thought it exists. Personally, I never thought it exists. (Special group, Bahir Dar)

No one is commanding people to wear a facemask on taxis and I have not seen policemen who take measures on taxi drivers if found serving passengers not using facemasks. (IDP, Dire Dawa)

Limited and inconsistent enforcement of the COVID-19 preventative measures was also corroborated by respondents from the government offices and NGOs. A lack of facilities like water taps and a lack of supplies of soap and hand sanitiser were reported to be common and as contributing to the limited practising of handwashing at offices and other official spaces:

Previously, drivers used to be punished if found not wearing a facemask while providing a transportation service. You don't see any driver wearing a facemask. Since drivers do not wear a facemask, passengers are not wearing it. (NGO)

We used to wear a facemask and wash our hands. These practices were good previously, but recently there have been some gaps as there is no water and soap placed within the office compound. (NGO, Adama)

As was reported in the previous rounds, there are still people who have misconceptions regarding susceptibility to and the severity of COVID-19. Some people believe that the pandemic has disappeared and they questioned its existence. Others believe that the disease results in a serious health problem only among old people and people who have some form of chronic disease.

I am not concerned about being infected because it is like a common cold. I saw many people who recovered from it. I believe that I have good immunity too. (IDP, Jigjiga)

People lack awareness. They believe that it happened by the will of God, thus they do not practise the preventive methods. (Government official, Jigjiga)

In addition, respondents explained the difficulty of wearing a facemask and questioned the effectiveness of wearing a facemask as well as of practising other preventative measures when others are not doing the same.

There are a few people who tease you when they see you wearing a facemask. They say, 'this piece of cloth may not save you from the infection if it is a will of Allah for you to be infected'. (IDP, Jigjiga)

We heard that the risk of being infected is the same for those who practise and those who do not practise the preventive methods (SSB, Dire Dawa)

People think that you are a health professional if you are wearing a facemask. Some will look at you in amazement. I made it a habit to always wear a face mask. My friends tell me to remove it as they believe that it is useless. (UPSNP, Jigjiga)

The vast majority (92.1%) said they would accept the vaccine for themselves. Similarly, 92.1% reported that they would accept the vaccine if it would help protect friends, family, and/or at-risk groups. These figures are similar to the figures reported in Round 5 but lower when compared to those in Round 3. In Round 5, 92.1% of the respondents reported that they would

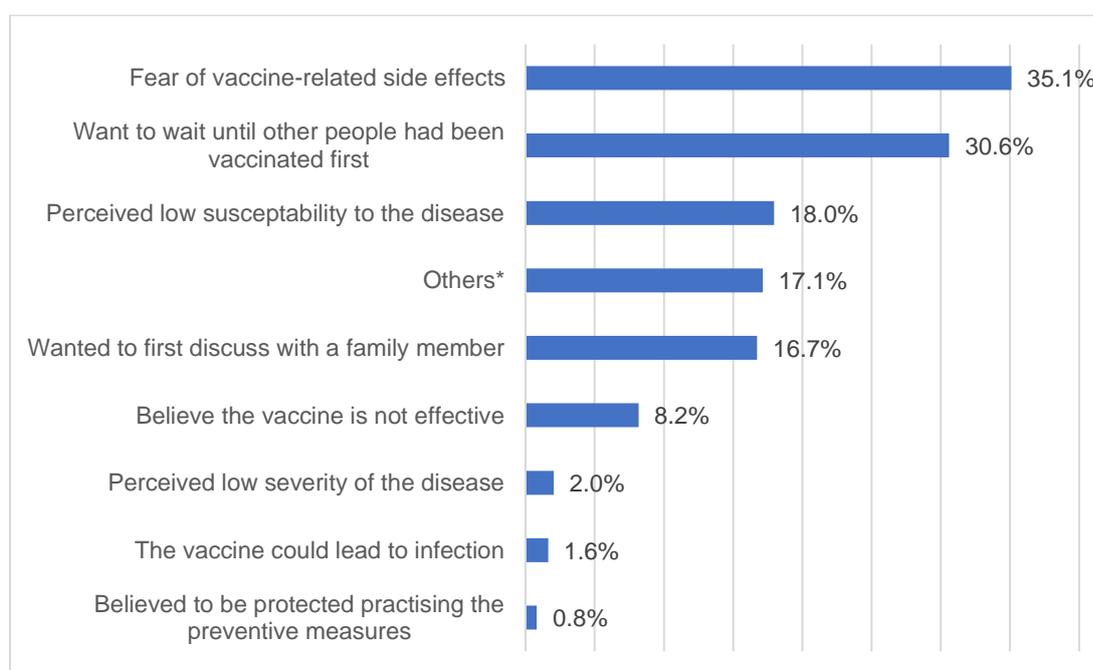
accept the vaccine for themselves, and 92.7% reported that they would accept the vaccine if it would help protect friends, family, and/or at-risk groups.

In this round, we asked the respondents if they had ever been offered the COVID-19 vaccine. Only 22.1% (67 respondents) reported having been offered the vaccine, and 86.6% (58 respondents) had received it. Overall, 19.1% of the respondents reported having been vaccinated, which is a slight increase compared to the 11.6% in Round 5, but is still low. About 60.3% (35 out of 58) of respondents who reported having received the vaccine were male. However, we found no statistically significant difference in terms of vaccination status between female and male respondents (chi-square: 2.254; p-value: 0.1333). Moreover, there was no statistically significant difference in regard to vaccination status between the UPSNP beneficiaries, SSB group, and refugee/IDP group.

Most respondents agreed that the vaccine is important (82.8%), safe (76.6%), and effective (77.9%). However, only 43.9% of respondents agreed that the vaccine is compatible with their religious or personal values. These figures are lower when compared to those in Round 5. In Round 5, 89.1%, 79.9%, 78.9%, and 74.3% of the respondents agreed that the vaccine is important, safe, effective, and compatible with their religious or personal values, respectively.

According to the quantitative findings, fear of vaccine-related side-effects (35%), waiting for someone to get vaccinated first (30.6%), perceived low susceptibility (18%), a need to discuss it with family members first (16.7%), and limited access to the vaccine itself were the major factors leading to not receiving the COVID-19 vaccine (Figure 3). Some of the respondents did not know whether they were eligible to take the vaccine and had no access to the vaccine.

Figure 3: Reported reasons of never receiving COVID-19 vaccine among the urban poor in selected nine cities in Ethiopia, December 2021 (total n = 245)



*Others: Limited access to the vaccine, lack of awareness regarding eligibility, never been offered

These findings are corroborated by the qualitative findings. As reported in Round 5, there are still concerns related to vaccine-related side-effects. Fear of vaccine-related side-effects is explained to be the main reason for people not receiving the vaccine.

I do not want to receive the vaccine because I was worried that my blood pressure would get worse. Most people in this area do not want to get vaccinated because they think the vaccine has side-effects like blood clotting. (Refugee, Semera)

Moreover, it seems that knowing someone who has been infected with the coronavirus is not only related to the practising of preventive methods, but is also related to acceptance of the COVID-19 vaccine.

Most people do not want to be vaccinated because they believe the virus does not exist. (Refugee, Logia)

The community does not want to receive the vaccine because the COVID-19 virus did not cause any harm. In general, they are curious what the vaccine does in the absence of the virus. (SSB, Logia)

There is a need to provide health education to reduce misconceptions, and to improve acceptance of the COVID-19 vaccine in communities.

I was told in the community that the vaccine causes severe pain and discomfort. Then I decided not to receive it. However, I changed my mind and received the vaccine after health workers educated us. (UPNSP, Dire Dawa)

Overall, some respondents reported believing that COVID-19 still exists, but a considerable number of respondents believe that they are not at risk of contracting the disease. The practising of preventative measures has continued to decline in this round, with a relatively better level of handwashing/sanitising. However, these practices were found to vary across the cities. Limited practising of preventative measures was supported by the qualitative findings, particularly around weak enforcement and the political environment. The vaccine seems to be accepted by most people and is perceived to be important, safe, effective, and (to an extent) compatible with the respondents' religious beliefs or personal values. However, the qualitative findings indicate that there is still a need to work on awareness creation regarding perceptions of vaccine-related side-effects, in addition to knowledge around COVID-19 in general.

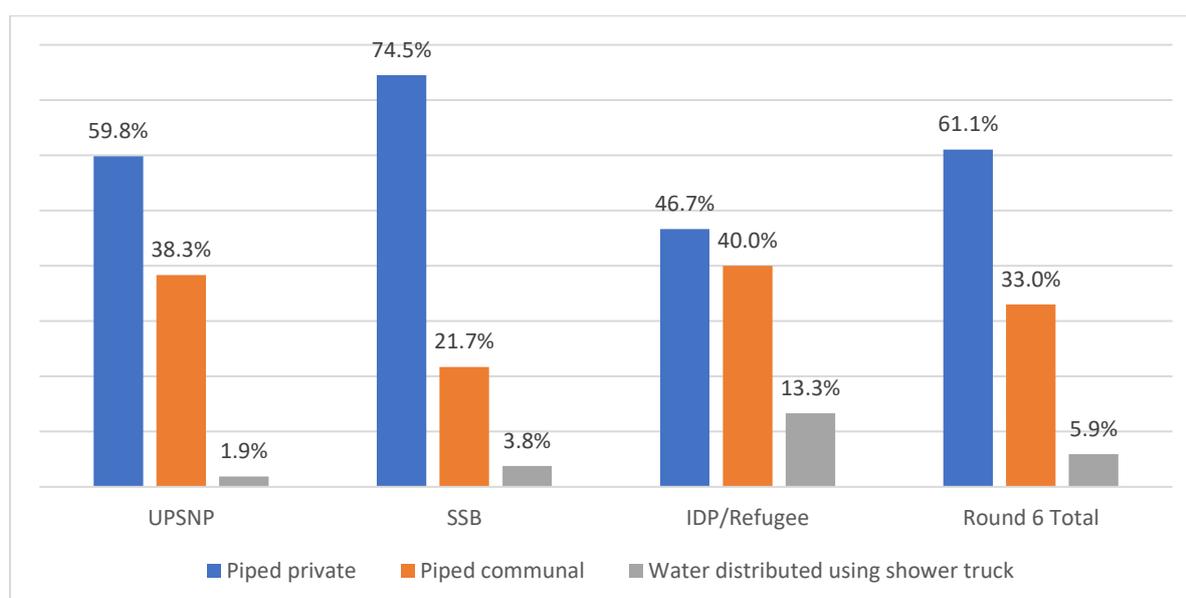
WASH

Key findings:

- The proportion of households that reported a shortage of the municipal water supply increased from 40.3% in Round 5 to 58.1% in Round 6.
- There was disparity across the respondents from the nine cities in terms of the respondents' experience of water shortages and the level of difficulty in accessing water. All respondents from Semera (39 respondents) and Logia (40 respondents) reported a shortage of water and difficulty accessing it during Round 6.
- Similarly, findings from the qualitative study reveal severe shortages and more difficulty in accessing water in Semera and Logia because of municipal water supply interruptions in this round, which is mainly due to electric power blackouts because of the conflict in northern Ethiopia.
- In this round IDP/refugees are more affected in terms of experiencing water shortages, and difficulty in accessing water.

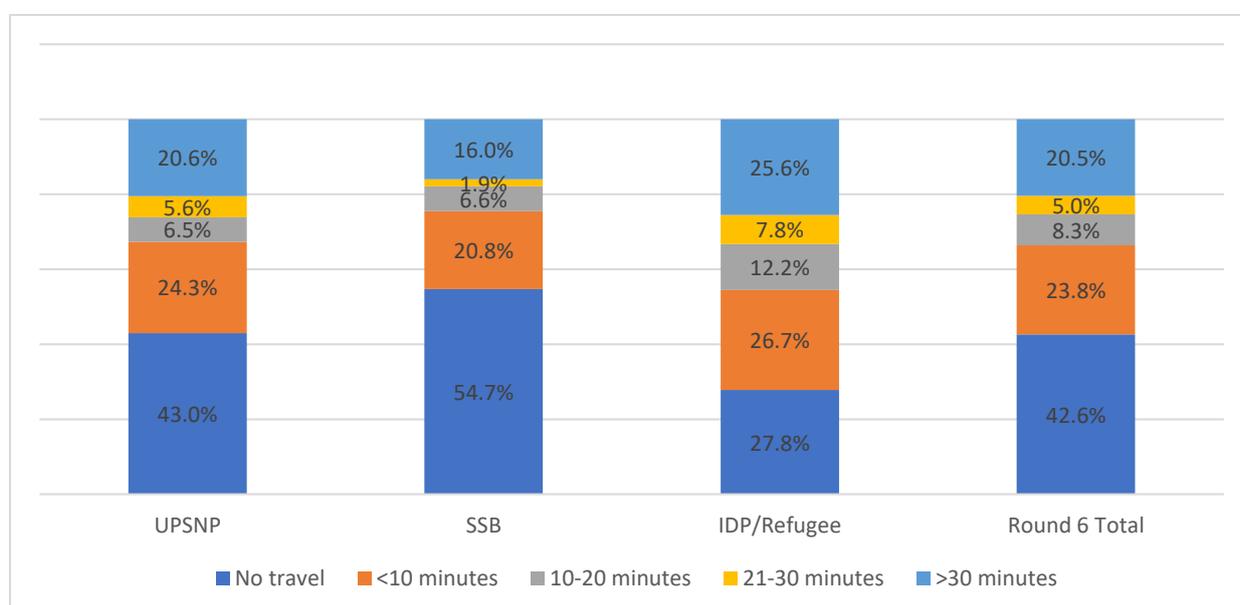
Most households (94.1%) had access to a municipal water supply pipeline near to or inside their residence (61.1% of households used a private piped water supply, i.e. located in their house or within their compound and 33.0% used the communal water supply). This result is slightly higher than that in Round 5, in which 89.1% had access to a municipal water supply, although a slightly smaller proportion used a private water supply compared to Round 5 (62.7%), while more people reported using a communal water supply compared to Round 5 (26.4%). A significantly higher proportion (74.5%) of households from the SSB group had access to a private piped water supply, followed by UPSNP households (59.8%). Households from the IDP/refugee group had relatively lower access to a private piped municipal water supply (46.7%). The difference among the three categories was statistically significant (chi-square value = 24.69, p-value = 0.000) (Figure 4).

Figure 4: The major sources of household water supply in selected nine cities in Ethiopia, December 2021 (total n = 303, UPSNP = 107, SSB = 106, IDPs/refugees = 90)



Similarly, there was a significant variation in the distance travelled to access a water supply among the three categories, during Round 6. A relatively higher proportion (25.6%) of households from the IDPs/refugee group reported having to travel more than 30 minutes (round trip) to fetch water, compared to the UPSNP (20.6%) and SSB group (16.0%). Moreover, 54.7% of households from the SSB group reported that they did not need to travel to access a water supply, while only 27.8% of IDP/refugees were able to access a water supply without travelling. There was a statistically significant difference in the distance travelled to access a water supply among the three groups (chi-square value = 17.20, p-value = 0.028) (Figure 5). In general, the IDPs/refugee households had poor access to piped municipal water supply/pipe connections at or near their residence, and an additional burden of travelling to access a water supply.

Figure 5: Distance travelled to access a water supply/water point by households in selected nine cities in Ethiopia, December 2021 (total n = 303, UPSNP = 107, SSB = 106, IDPs/refugees = 90)



The average number of days of water shortages in Round 6 was 5.8 days (SD=3.6). This result was higher than that in Round 5 (4.5 days (SD = 4.0)); however, the change between Rounds 6 and 5 was not statistically significant. The highest average number of days of water shortages was recorded in Round 1 (7.0 days); this declined in Round 2 (5.4 days), in Round 3 (5.5 days), in Round 4 (6.3 days), and in Round 5 (4.5 days).

In line with the above result, the proportion of households that reported water shortages¹⁶ has increased from 40.3% in Round 5 to 58.1% in Round 6. This result is also higher than that in all previous rounds: Round 1 (32.3%), Round 2 (32.7%), Round 3 (37.0%), and Round 4 (51.2%). The difference between Rounds 5 (40.3%) and Round 6 (58.1%) was statistically significant (chi-square value = 54.63, p-value = 0.000) (Figure 6) (Table 4). There was no notable difference in the proportion of households that reported water shortages

¹⁶ Water shortages refers to a lack of water due to interruption to the water supply or unavailability of water at the source.

among the UPSNP (58.9%), the SSB (59.4%), and the IDP/refugee (55.6%) households. The difference among the three categories was not statistically significant.

Similarly, the proportion of households that reported difficulty accessing water¹⁷ increased from 29.4% in Round 5 to 36.6% in Round 6, and the change was statistically significant (chi-square value = 36.86, p-value = 0.000). It is worth noting that the proportion of people who reported having difficulty accessing water was highest in Round 4 (43.6%) (Figure 6) (Table 4). This was because Round 4 data collection took place during the driest season, which is likely to have resulted in increased difficulty in accessing water. On the other hand, Round 5 was conducted during the rainy season, during which most households use rainwater as an alternative source.

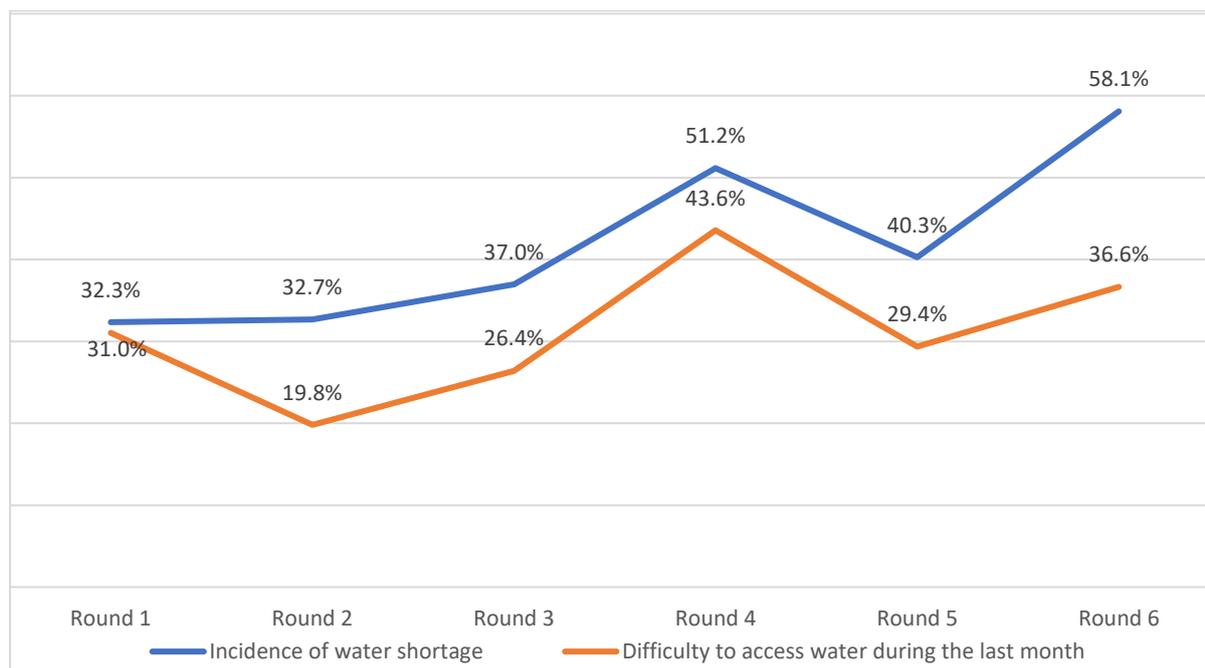
A slightly higher proportion of UPSNP beneficiaries (42.1%) reported more difficulty in accessing a water supply compared to the IDPs/refugees (37.8%) and the SSB group (30.2%). However, the difference among the three groups was not statistically significant (Table 4).

Despite the availability of the municipal water supply system, the UPSNP beneficiaries suffered interruptions of the municipal water supply. This is because the availability of a pipeline does not guarantee access to water. In some cities/areas, the pipeline might be dry for two weeks (i.e. the water is only available once every two weeks, or even once a month). In this case, households have to travel to another area where water is available, in order to get water. This sometimes requires travelling long distances, purchasing water, and paying for transportation. We consider this as constituting difficulty in accessing water.

In the case of IDPs/refugees who live in camps, the municipal water supply is not connected to their houses, but there are water points (public standpipes or tankers/reservoirs) located within a distance of 500 metres. There is a regular communal water supply at the IDP/refugee camps.

¹⁷ Difficulty in accessing water refers to the degree to which the households face a problem in getting water, despite its availability. Difficulty in accessing water is mainly related to distance, interruption of the water municipal supply, cost to buy and transport water, and the time spent on travel and queuing.

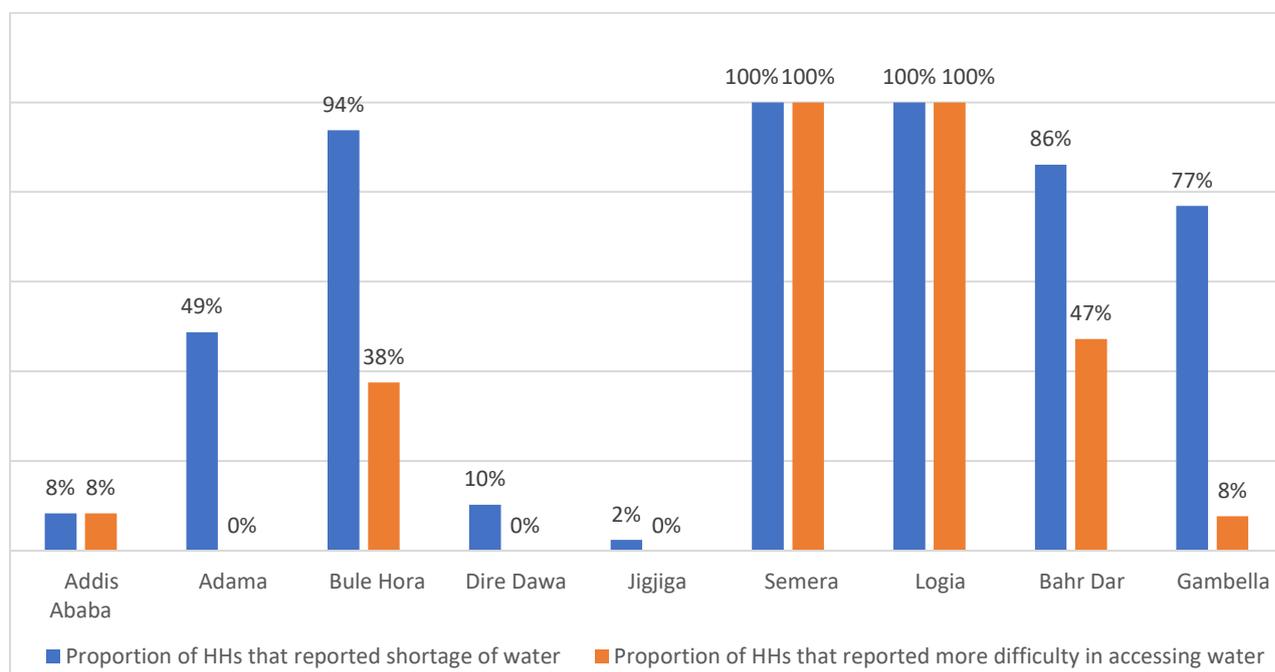
Figure 6: Incidence of water shortages and difficulty in accessing a water supply among the urban poor in selected nine cities in Ethiopia, December 2021 (total n = 303, UPSNP = 107, SSB = 106, IDPs/refugees = 90)



There was disparity across the respondents from the nine cities in terms of experiencing water shortages and the level difficulty in accessing water: more respondents from Semera, Logia, Bulehora, Bahir Dar, and Gabella appeared to suffer compared to those from other cities¹⁸ (Figure 7).

¹⁸ We have data for Jigjiga and Dire Dawa, but none of the survey respondents there reported a shortage of water.

Figure 7: Proportion of households that reported a shortage of water, and more difficulty in accessing it, among the urban poor in nine cities in Ethiopia during Round 5, December 2021 (n = 309)



The survey respondents who reported having difficulty accessing a water supply in this round (58.1% of the total respondents) were asked about the reasons for the difficulty in accessing water. About 48% mentioned water access being controlled and the inadequacy of the municipal water supply (40.5%) as a major reason. Respondents also mentioned the absence of a municipal water service, the higher cost of purchasing and transporting water, distance, and the sporadic availability of water as reasons for experiencing difficulty in accessing water (Figure 8).

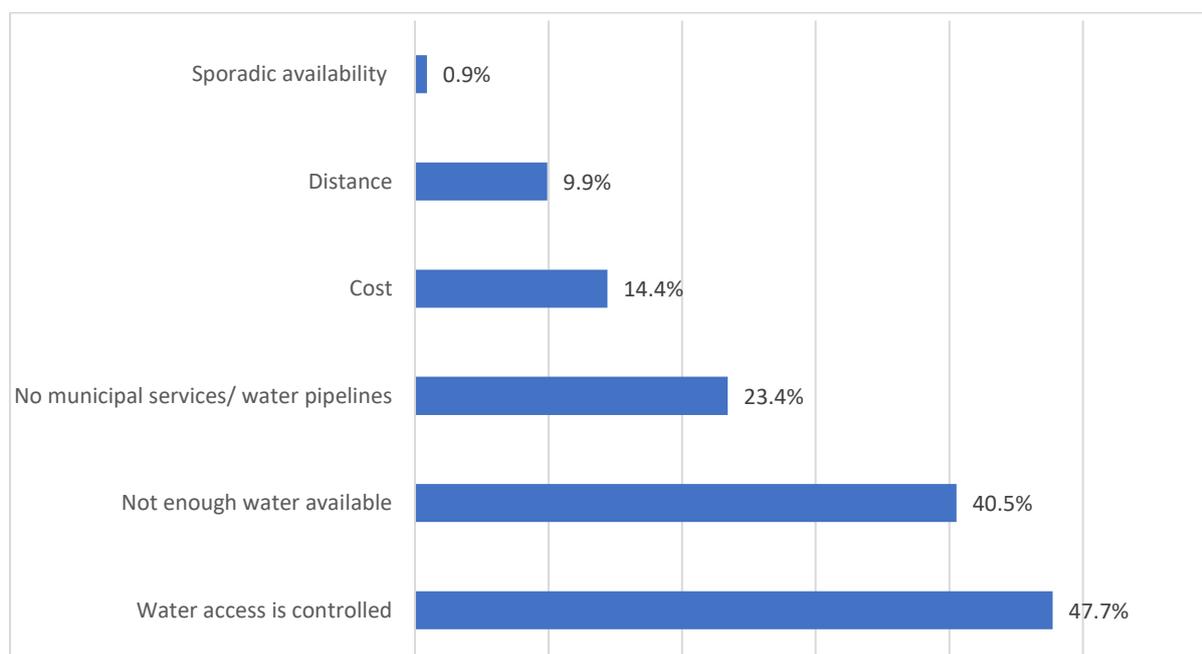
The qualitative results are in line with the findings of the quantitative survey. Poor access to a safe water supply due to inadequate infrastructure, and irregular availability of, or interruption to, the municipal water supply were mentioned as the main reasons for experiencing difficulty in accessing water. There were disparities in terms of the accessibility of a water supply across the nine cities. Respondents from Jigjiga, Logia, Semera, and Bahir Dar frequently mentioned high water shortages because of low coverage (absence of infrastructure) and inadequate distribution (because of interruption) of the municipal or piped water supply.

Even though the government is installing tap water in many neighbourhoods, the coverage is very low. (UPSNP, Jigjiga)

There are times that we do not get water for one week up to 10 days, which affects the lives of women and children. There is no water accessibility. (IDP, Dire Dawa)

Shortage of water is a major problem...even we get water only for two days in a week and we do have serious water problem. Tuesday and Friday are the days we get water in a week. (Special group respondent, Bahir Dar)

Figure 8: Major reasons for experiencing difficulty accessing water since the COVID-19 outbreak among the urban poor in selected nine cities in Ethiopia, December 2021 (n = 11)



The respondents were also asked what actions they took in the case of a municipal water supply interruption or a lack of water for an extended period. Most of them mentioned purchasing and transporting water from other areas (even from adjacent towns) and fetching water from a spring or river (unsafe water sources).

The results of the qualitative study also indicate increased shortages of water, and more difficulty in accessing water, during this round compared to Round 5, in which the interviews took place during the rainy season. Most of the respondents mentioned the use of rainwater as an alternative that was used to overcome water shortages in Round 5. However, this was not the case in this round.

In the past few months, there was rainwater that eased the water problems to some extent. However, there is no rain [during last month], and tap water [municipal water supply] is not adequate; so, there is a shortage of water. (UPSNP, Jigjiga)

It [shortage of water] is worsening. Starting from last summer we are not getting adequate water. In the summer we were getting better access because we were using rainwater but now there is no rain. (Special group, Bahirdar)

Moreover, respondents from Semera and Logia (in Afar region, which is affected by the current conflict) widely mentioned severe shortages of water due to disruption of the municipal water supply during this round. The major reason given for the disruption of the water supply was the absence of electric power, which is used to operate the water pumps and to distribute water to the residents.

...we could not get water due to absence of electric power because of the current conflict. In general, we have a water supply problem because of the power interruption. (UPSNP, Logia)

A female refugee from Logia described the severity of water shortages as follows:

Right now, our biggest problem is shortage of water. We have a severe water shortage... Due to this, we are drinking river water. (Refugee, Logia)

The respondents for the qualitative study reported various coping mechanisms to overcome water shortages and inaccessibility of the water supply. Storing water using containers, fetching water from nearby villages, fetching water from a river, and buying water were the most frequently mentioned mechanisms.

There is a water shortage. We get water twice a week (Tuesday and Friday). When it [municipal water supply] is not available, we fetch from other areas. ... We fill containers and store water. (Special group, Bahirdar)

When there is no water in this area, we fetch water from the Awash River, at which time we charge up to 10 birr per water jar. (Refugee, Logia)

We bring water from the river to keep our clothes and personal hygiene clean. (Special group, Logia)

Overall, shortages in the municipal water supply remained a major challenge for the study respondents in this round. Water shortages were reported to mainly be caused by the mismatch between the capacity of the existing water supply infrastructure and the demand or population size, interruption of the municipal water supply, lack of coverage (i.e. absence of a municipal water supply system) in some parts of the cities, and disruption of a water supply system in conflict-affected areas (Logia and Semera) because of electricity blackouts.

Table 4: Access to an adequate water supply among urban poor households in selected nine cities in Ethiopia, December 2021 (total n = 303, UPSNP = 107, SSB = 106, IDPs/refugees = 90)

| Characteristics/variables | | Respondent category | | | Chi-2 [p-value] | R 1 (%) | R 2 (%) | R 3 (%) | R 4 (%) | R 5 (%) | R6 (%) | Chi-2, p-value |
|--|---------------------------------------|---------------------|------------|------------------------|-------------------------|------------|------------|------------|------------|------------|-----------|-------------------------|
| | | UPSNP (%) | SSB (%) | Refugee/ IDP (%) | | | | | | | | |
| Shortage of water in the last one month | Yes | 58.9 | 59.4 | 55.6 | 0.343 [0.842] | 32.3 | 32.7 | 37.0 | 51.2 | 40.3 | 58.1 | 54.63 [0.000] |
| | No | 41.1 | 40.6 | 44.4 | | 67.7 | 67.3 | 63.0 | 48.8 | 59.7 | 41.9 | |
| Frequency of access to water supply | Every day | 57.9 | 59.4 | 43.3 | 18.54 [0.005] | 55.4 | 66.7 | 54.1 | 55.4 | 61.4 | 54.1 | - |
| | Once a week | 40.2 | 36.8 | 43.3 | | 23.4 | 25.7 | 34.3 | 27.7 | 28.1 | 39.9 | |
| | Once in two weeks | 0.0 | 2.8 | 3.3 | | 4.3 | 0.3 | 2.0 | 5.9 | 2.6 | 2.0 | |
| | Other** | 1.9 | 0.9 | 10.0 | | 16.8 | 7.3 | 9.6 | 10.9 | 7.9 | 4.0 | |
| Level of difficulty accessing water since COVID-19 outbreak | Much more or slightly more difficult | 42.1 | 30.2 | 37.8 | 10.84 [0.093] | 31.0 | 19.8 | 26.4 | 43.6 | 29.4 | 36.6 | 36.86 [0.000] |
| | Nothing changed or easier than before | 57.9 | 69.8 | 62.2 | | 69.0 | 80.2 | 73.6 | 56.4 | 70.6 | 63.4 | |

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 5 and Round 6. We used the McNemar chi-square test for dichotomous variables and the Stuart-Maxwell test for other categorical variables.

** Others refers to households that have a very limited access to a water supply (i.e. once in three weeks, once in a month, or even longer).

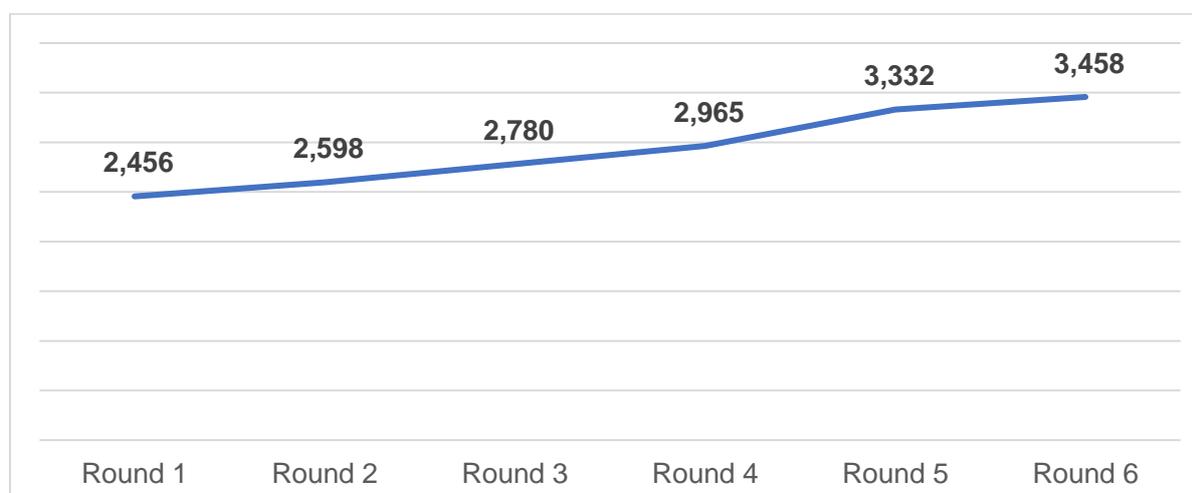
Income and expenditure

Key findings:

- The average monthly income of households has increased across the six rounds, from ETB 2,456 in Round 1 to ETB 3,458 in Round 6. The SSB group had the highest average monthly income (ETB 5,608) as compared to the UPSNPs and IDP/refugees in this round.
- The proportion of households that reported the ability to earn the same income as in the pre-COVID period has increased across all rounds. However, 61.7% of respondents reported inadequacy of their income to cover basic expenses (like buying food, paying for shelter/house rent, and buying clothes).
- Similarly, most of the qualitative interview respondents mentioned the inadequacy of their income to cover basic expenses, mainly due to inflation (particularly the increase in the price of food items).
- In addition, in this round, respondents from Semera and Logia (which are in Afar region, which is affected by the conflict in northern Ethiopia), widely described the significant effect of the conflict on their incomes and expenditures.
- Coping mechanisms include reductions in the quantity and quality of food, using up savings, and obtaining help from family members. Similar coping mechanisms were also mentioned by the qualitative study respondents.

The quantitative survey findings reveal a consistent increase in the average monthly income (this includes earned income and aid and support received) of households across the six rounds, from ETB 2,456 in Round 1 to ETB 3,458 in Round 6. The change in the income of respondents between Rounds 1 and 6 was statistically significant (with $t = -3.46$ and $p\text{-value} = 0.001$) (Figure 9). The average monthly income varies across the three categories. The SSB group had the highest average monthly income (ETB 5,608), followed by the IDPs/refugees (ETBs 2,498 ETB), and the UPSNP group, who had the lowest income (ETB 2,017) in this round.

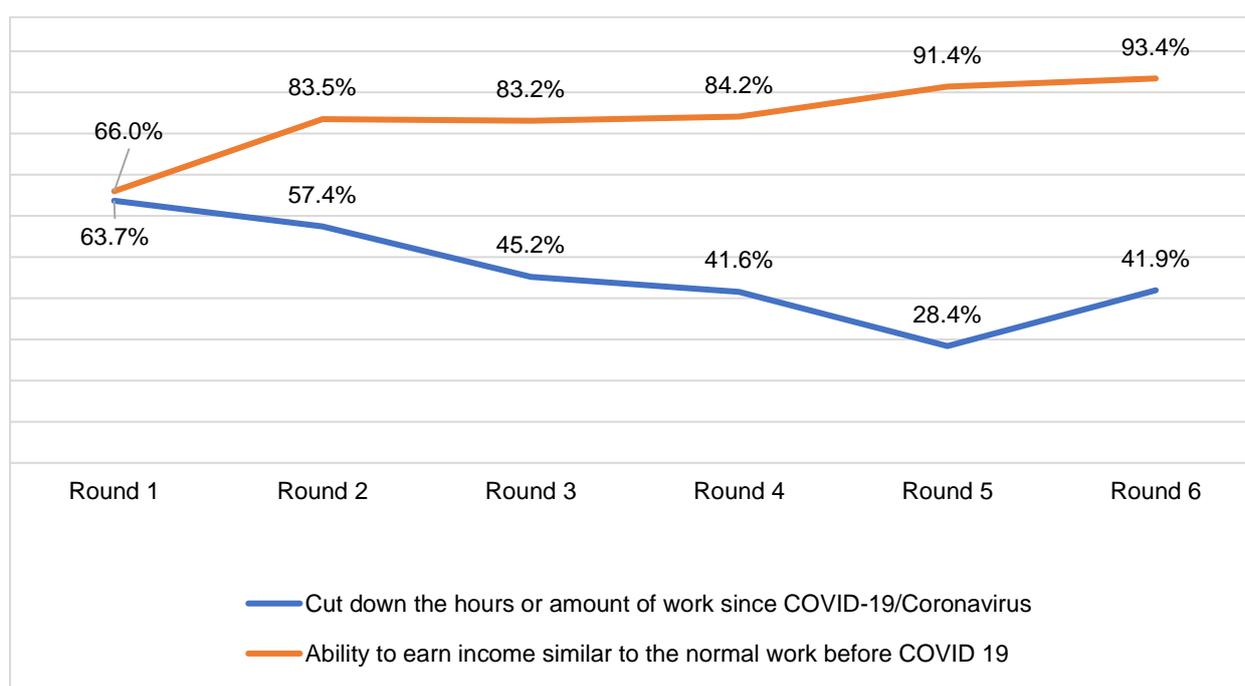
Figure 9: Average household monthly income (in ETB) of the urban poor in selected nine cities in Ethiopia, December 2021 (total n = 303)



The proportion of respondents who reported having the ability to earn the same income as in the pre-COVID period increased from 66% in Round 1 to 93.4% in this round. This result is

slightly higher than that in Round 5 (91.4%). The change between Round 5 and Round 6 was statistically significant (chi-square value = 36.2 and p-value = 0.000) (Figure 10). Moreover, during this round the proportion of respondents that reported having the ability to earn the same income as they did before COVID-19 slightly differed across respondent groups: UPSNP (93.5%), SSB (98.1%), and IDP/refugee (87.8%). The difference among the three categories was statistically significant (chi-square value = 8.4 and p-value = 0.015).

Figure 10: Proportion of respondents who reported being able to earn a comparable income to that earned before COVID-19 and a cut in their working hours during Rounds 1, 2,3,4,5, and 6, in selected nine cities in Ethiopia (total n = 303)



Respondents were asked if the income they earned was adequate to cover their basic expenses (like buying food, paying for shelter/house rent, and buying clothes). In this round, only 38.3% (116 out of 303 respondents) reported that their income was adequate. A higher proportion of respondents from the SSB group (53.8%) reported the adequacy of their income to cover basic expenses of their family, whereas the proportion was much lower for UPSNP (37.4%) and IDP/refugees (21.1%) respondents. There was also a statistically significant difference among the three categories (chi-square value = 22.0 and p-value = 0.000).

Respondents were also asked about their pattern of expenditure for health, food, and shelter. All respondents (100%) reported spending most on food during the last month, and about 26.7% and 17.8% reported spending a significant portion of their income on house rent and health (diagnosis and treatment), respectively. In terms of expenditure patterns, there was no significant difference among the three categories.

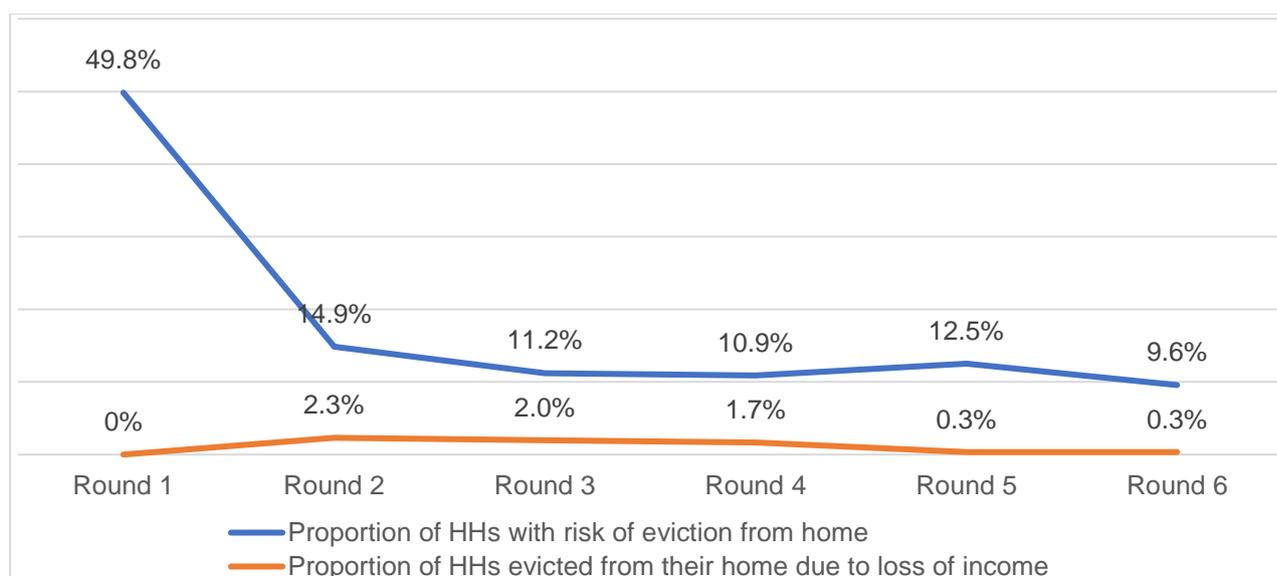
According to the results from the quantitative survey, the number of respondents who reported a perceived risk of eviction from their house due to loss of income has significantly declined, from 49.8% in Round 1 to 9.6% in Round 6. This result is slightly lower compared to Round 2 (14.9%), Round 3 (11.2%), Round 4 (10.9%), and Round 5 (12.5%) (Figure 11).

The decrease in the risk of eviction between Round 5 and Round 6 was statistically significant (chi-square value = 30.5 and p-value = 0.000).

The perceived risk of eviction was relatively higher for the UPSNP category (11.2%), and IDPs/refugees (11.1%), as compared to the SSB group (6.6%). The difference among the three categories was not statistically significant. In this round, only one respondent, in the UPSNP category, from Bahirdar, reported being evicted from his house due to loss of income (i.e. being unable to pay the house rent). The SSB households appeared to have relatively better income and ability to cover their basic expenses as compared to the UPSNP and IDP/refugee households.

Cross-city comparisons showed variations in terms of respondents' risk of eviction from their home due to loss of income. The proportions of households who reported being at risk of eviction were higher in Jigjiga (28.1%) and Adama (44.4%), whereas only a few or none of the respondents from other cities reported any risk of eviction.

Figure 11: Incidence of eviction and perceived risk of eviction from respondents' houses in the future due to loss of income among the urban poor in selected nine cities in Ethiopia, December 2021 (total n = 303)



Despite the trend of increased income among respondents of the quantitative survey, most of the qualitative study respondents (from all groups) mentioned having the same income or a decrease in their income during the last month (Round 6).¹⁹ Respondents mentioned a lack of job opportunities, a cut in the amount of work available, and a decline in economic activities.

I used to go house to house and wash clothes. Currently, no one invites me to wash their clothes. ... because they are using washing machines. I am not getting any job

¹⁹ The quantitative respondents were asked 'how much was your income during the last month (the amount in birr)?', while the qualitative diary interview respondents were asked if their income had increased or decreased during the past month (i.e. a yes or no type of question).

opportunities. I am trying to get support from the kebele. ... but there is nothing I received from the kebele office. (UPSNP, Dire Dawa)

Another UPSNP beneficiary from Dire Dawa mentioned a decrease in her income because of the fact that she had to cut down her working hours/days.

The salary [monthly payment from UPSNP] is reduced ... Now we are receiving 400 birrs per month. It is reduced because the project is near to phaseout. Currently, we are working 15 days per month. It was 20 days per month before. You get paid for the day you work only. Thus, if the number of days is reduced the salary will too. (UPSNP, Dire Dawa)

In addition, respondents from Semera and Logia (Afar region, which is affected by the conflict in northern Ethiopia), widely described the significant effect of the conflict on their income and pattern of expenditure.

...now our situation is much worse than before. If you already have the money, you can buy whatever you want. But now we have no money [income]. Given the current conflict and the high cost of living, many are concerned about the future. (SSB, Logia)

In general, because of the ongoing conflict, work [income] is not like before. ...everyone is going to conflict front. As a result, the number of customers is decreasing and my income is also decreasing. (Refugee, Logia)

The existing conflict has had a significant impact on food prices. Everything became more expensive after COVID-19 and the conflict, especially after the last interview. As a result, the cost of living is rising from time to time. ... most people are in trouble and are not able to afford to buy the foods they normally eat. (SSB, Semera)

Moreover, like in the previous round, most of the respondents mentioned the inadequacy of their income to cover their basic expenses, mainly because of the increase in the price of food, and the increased cost of living in general. The qualitative study respondents also mentioned the risk and incidence of eviction from their home due to being unable to pay the house rent, because of their inadequate income.

I am suffering to pay [house rent] at the end of the month. The money I receive from the safety net is not adequate to pay the rent. ...you feel ashamed to even get back home. (UPSNP, Dire Dawa)

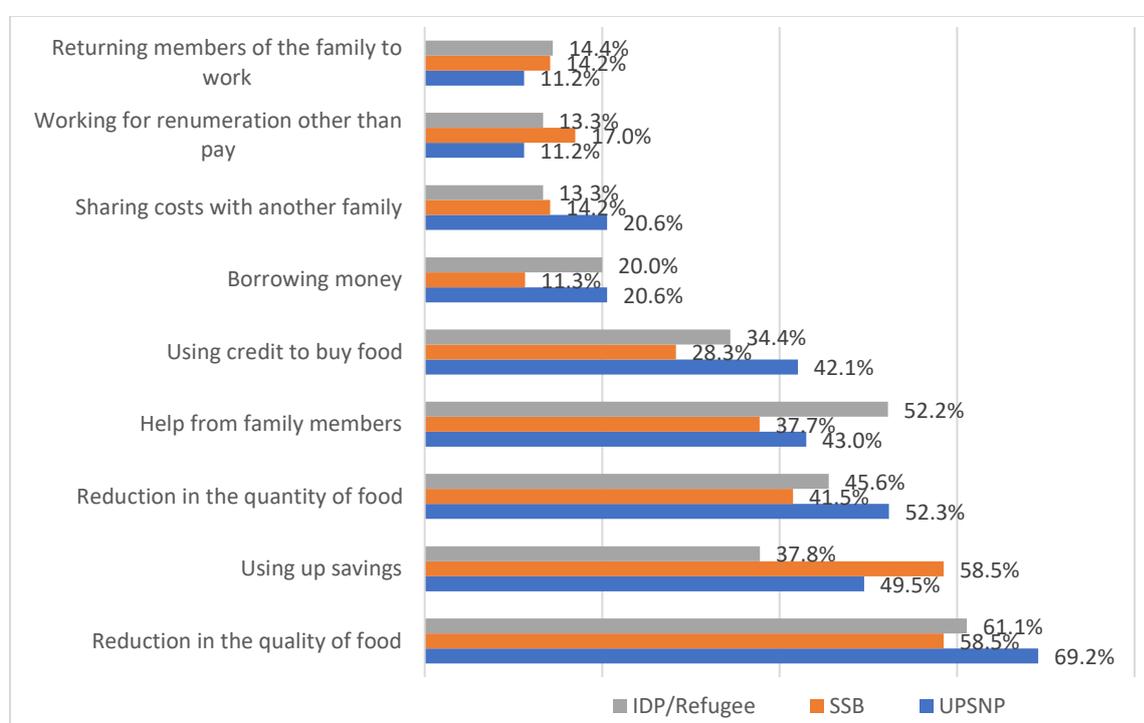
I moved to a new home, I changed it, because the owner increase the rent that I couldn't afford. (IDP, Jigjiga)

As explained above in regard to the quantitative results, the average monthly income is measured in the amount of money earned by a household. The survey results show an increasing trend in household income, yet the majority (62%) of households reported the inadequacy of their monthly income to cover their basic expenses. In the qualitative study, respondents were asked to describe income in terms of its adequacy or ability to cover household expenses, which is more contextual and is affected by inflation (the purchasing power of money). Despite the difference in the way household income was assessed, both the qualitative and quantitative studies yielded consistent results: the majority of respondents

reported the inadequacy of their monthly income to cover their basic expenses (like food, shelter, and buying clothes).

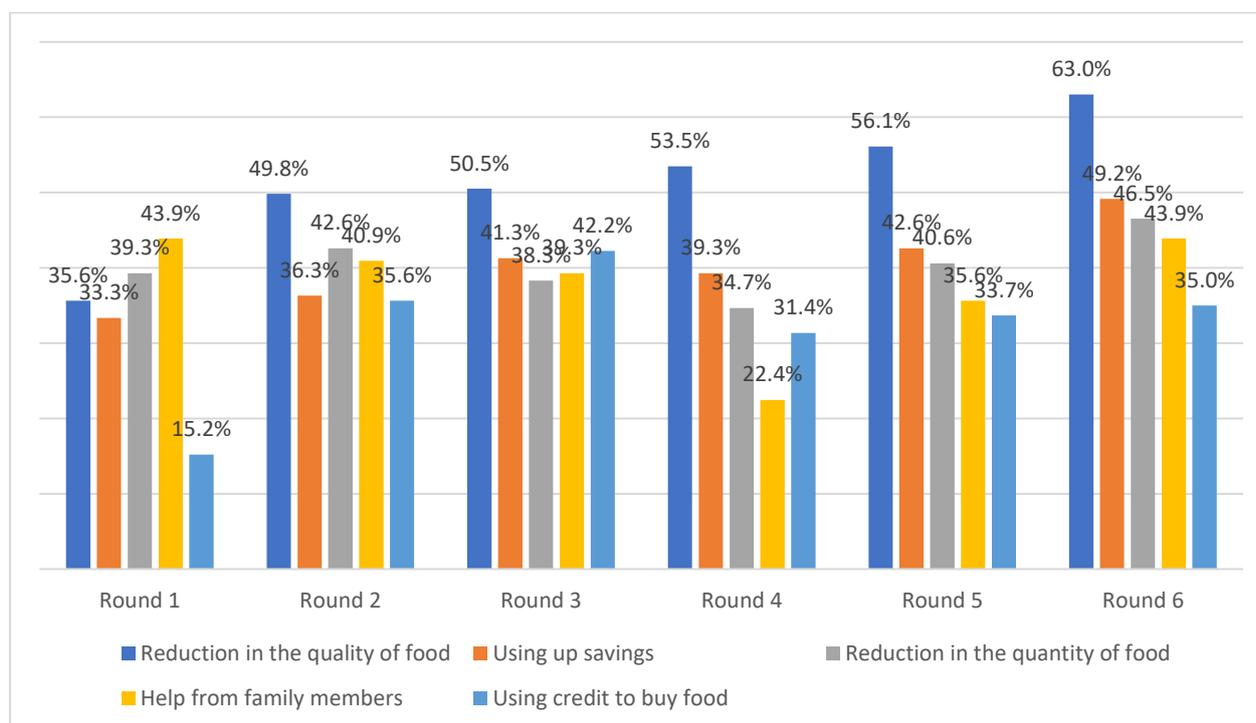
Respondents were asked what coping mechanisms they used to overcome the reduced affordability of basic items. Reducing the quantity and quality of food, using up savings, using credit to buy food, and obtaining help from family members were mentioned in this round as the main coping mechanisms. Reducing the quality of food was the predominant coping strategy across the three categories of respondents. There was a slight difference among the three categories in terms of coping mechanisms: for instance, a relatively higher proportion of respondents from the IDP/refugee group and UPSNP beneficiaries mentioned using credit to buy food as a coping mechanism (Figure 12).

Figure 12: Coping mechanisms mentioned by all three groups of respondents in nine cities in Ethiopia, December 2021 (total n = 303, UPSNP = 107, SSB = 106, IDPs/refugees = 90)



Reductions in the quantity and quality of food, using up savings, and obtaining help from family members were widely mentioned coping mechanisms across the six rounds (Figure 13). For instance, the proportion of respondents that mentioned reducing the quality of food consumed increased across the rounds (from 36.6% in Round 1 to 49.8% in Round 2, 50.5% in Round 3, 53.5% in Round 4, 56.1% in Round 5, and 63.0% in Round 6).

Figure 13: Mechanisms for coping with reduced income during all rounds among the urban poor in selected nine cities in Ethiopia, December 2021 (total n = 303, UPSNP = 107, SSB = 106, IDPs/refugees = 90)



As in the previous round, the coping mechanisms mentioned by the qualitative interview respondents were in line with the quantitative survey findings. Reducing the quantity and quality of food, skipping regular meals, purchasing less preferred and cheaper food items, using credit to buy food, and using up savings were predominantly mentioned as the coping strategies for decreased income and/or the increased cost of living.

Since the cost of every food item has increased, we have reduced the amount and diversity of food that we normally consume. For instance, we have stopped drinking tea in the morning. (Special group, Adama)

As a family, we are coping with the problem by skipping breakfast, sometimes lunch [reduced frequency of meal] to overcome the economic inflation. (IDP, Jigjiga)

To cope up with increased in the price of food items, we are forced to cut some meals [reduce meal frequency] for adults and we must eat cheaper foods like wheat flour. (UPSNP, Semera)

.... we have decreased the amount and type of food. For example, we reduced the amount [frequency] of meat and rice [most preferred food in the area] per week from two times a week to once and sometimes we don't eat meat at all. (Refugee, Semera)

Overall, the quantitative household survey findings reveal an increase in the household average monthly income across the six rounds. Likewise, the proportion of households that reported the ability to earn the same income as in the pre-COVID period has increased across the six rounds. However, the majority (62%) of quantitative survey respondents still reported the inadequacy of their income to cover their basic expenses. At the same time, the

results of the qualitative study show a worsening of the economic burden due to the significant increase in the price of food and the cost of living in general. The food price increase is a serious problem; while it may not be related to COVID-19, it significantly affects the urban poor's standard of living.

Food security

Key findings:

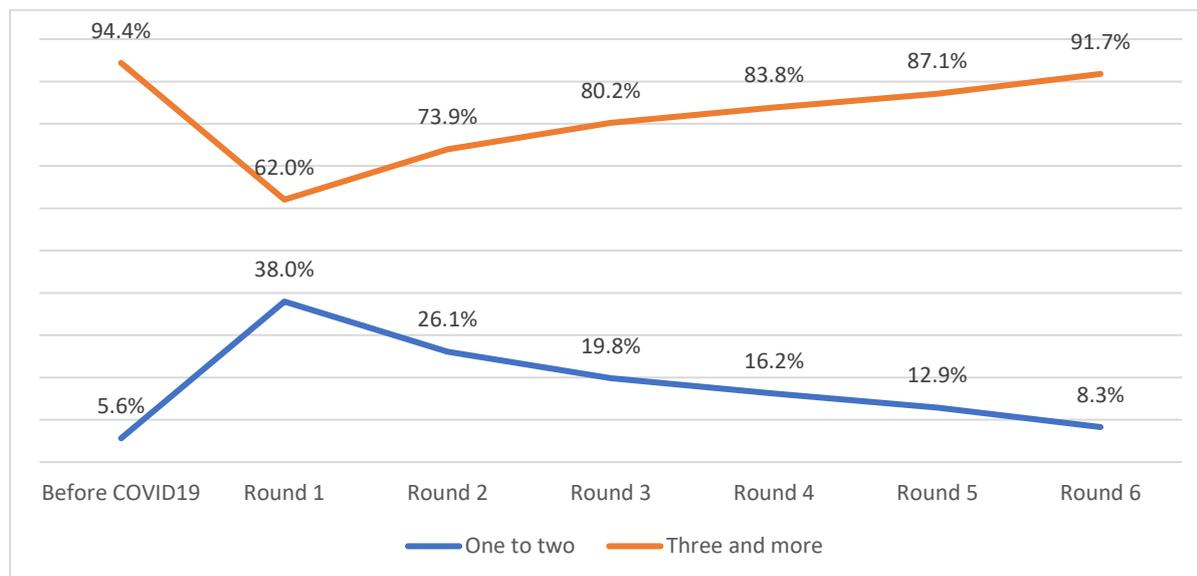
- The proportion of households who consume an average of three or more meals per day has gradually increased from 62.5% in Round 1 to 91.7% in Round 6. Despite this increase, the type of food they consume is found to be of a low quality. For instance, only 9.2% and 27.7% of households reported consuming meat and eggs in this round, respectively.
- The incidence of food shortages among the households has varied across the six rounds, from 58.70% in Round 1 to 49.5% in Round 6. The incidence of food shortages in this round was highest among UPSNP households. The proportion of households experiencing a food shortage was high in Semera, Bule Hora, and Gambela, Addis Ababa, and Jigjiga.
- Similar coping mechanisms were mentioned in Round 5 and Round 6. Eating less preferred foods and reducing the number of meals per day have remained the predominant strategies for coping with food insecurity (unaffordability) during the past month. Respondents also mentioned avoiding or stopping buying expensive food altogether as a major coping mechanism.
- Like in the previous rounds, the increase in the price of food items and the lack/inadequacy of income remained the major challenges resulting in a shortage of food and decreased meal frequency among the urban poor. Furthermore, respondents from Logia and Semera highlighted the impact of the conflict in northern Ethiopia on their income, food availability, and affordability.

The proportion of households who consume an average of three or more meals per day has gradually increased from 62.5% in Round 1 to 91.7% in Round 6 (Figure 14). The difference between Rounds 5 and 6 was statistically significant (chi-square value = 84.9, p-value = 0.000). However, despite, the gradual improvement across the six rounds, the result is slightly below the pre-COVID-19 period, when 94.4% of households consumed an average of three or more meals per day.

The proportion of households who reported consuming three or more meals per day was highest among the SSB respondents (96.2%), followed by the UPSNP beneficiaries (93.5%), and slightly lower for the IDPs/refugees (84.4%). The difference in the frequency of meal consumption among the three categories was statistically significant (chi-square value of 9.58 at p-value = 0.008).

Figure 14: Average frequency of meals per day consumed by household members during the last month among the urban poor in selected nine cities in

Ethiopia, December 2021 (total n = 303, UPSNP = 107, SSB = 106, IDPs/refugees = 90)



The incidence of food shortages among the households has varied across the six rounds, from 58.70% in Round 1 to 49.5% in Round 6. The change between Rounds 5 and 6 was statistically significant (chi-square value of 61.2, with p-value = 0.000) (Figure 15).

The proportion of households who reported a food shortage during the last month was highest for the UPSNP category (60.7%), followed by IDPs/refugees (54.4%), and was lowest among the SSB respondents (34.0%). The difference among the three categories was statistically significant (chi-square value of 16.5, with p-value = 0.000).

Across the nine cities, the proportion of households experiencing a food shortage was highest in Semera, Bule Hora, Gambela, Addis Ababa, and Jigjiga, and lower in Bahirdar and Logia. Similarly, a higher proportion of respondents from Bule Hora, and Gambela reported reducing the number/frequency of meals they or their household members consumed per day (Figure 16). The observed difference across the nine cities could be due to variation in economic activities, a discrepancy in the price of food/food items, and/or access to food items (availability in the market).

Figure 15: Incidence of food shortages and reduction of number of meals in Rounds 1, 2, 3, 4, 5, and 6 among the urban poor in selected nine cities in Ethiopia, December 2021 (total n = 303, UPSNP = 107, SSB = 106, IDPs/refugees = 90)

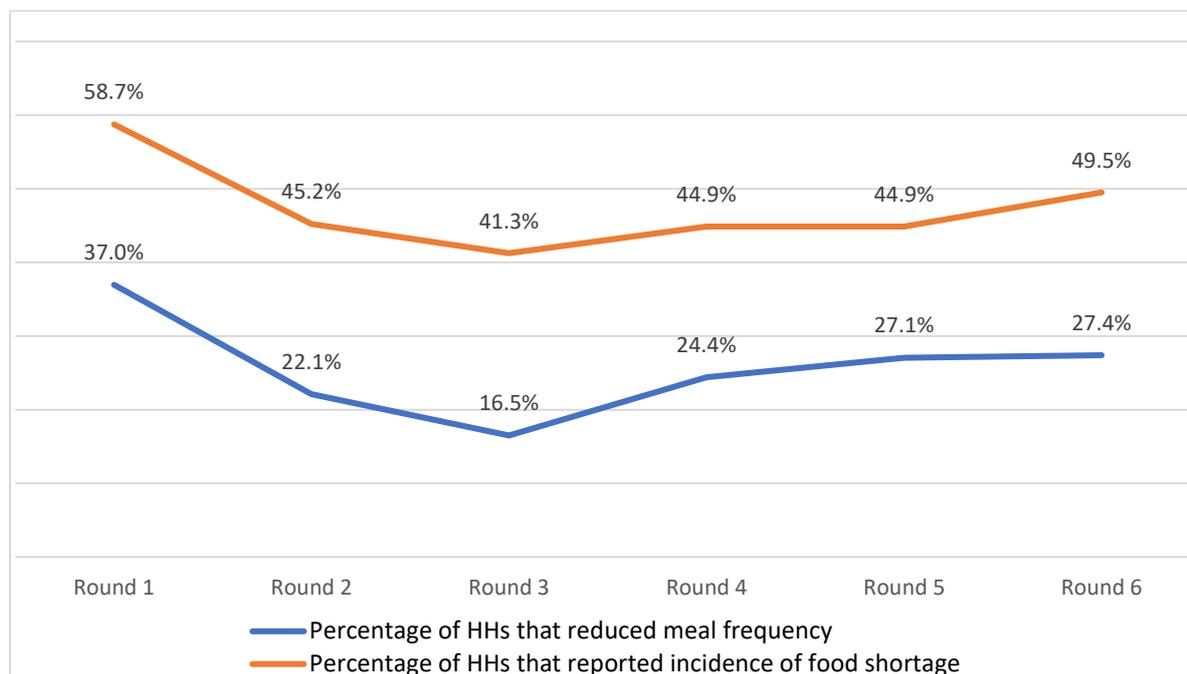
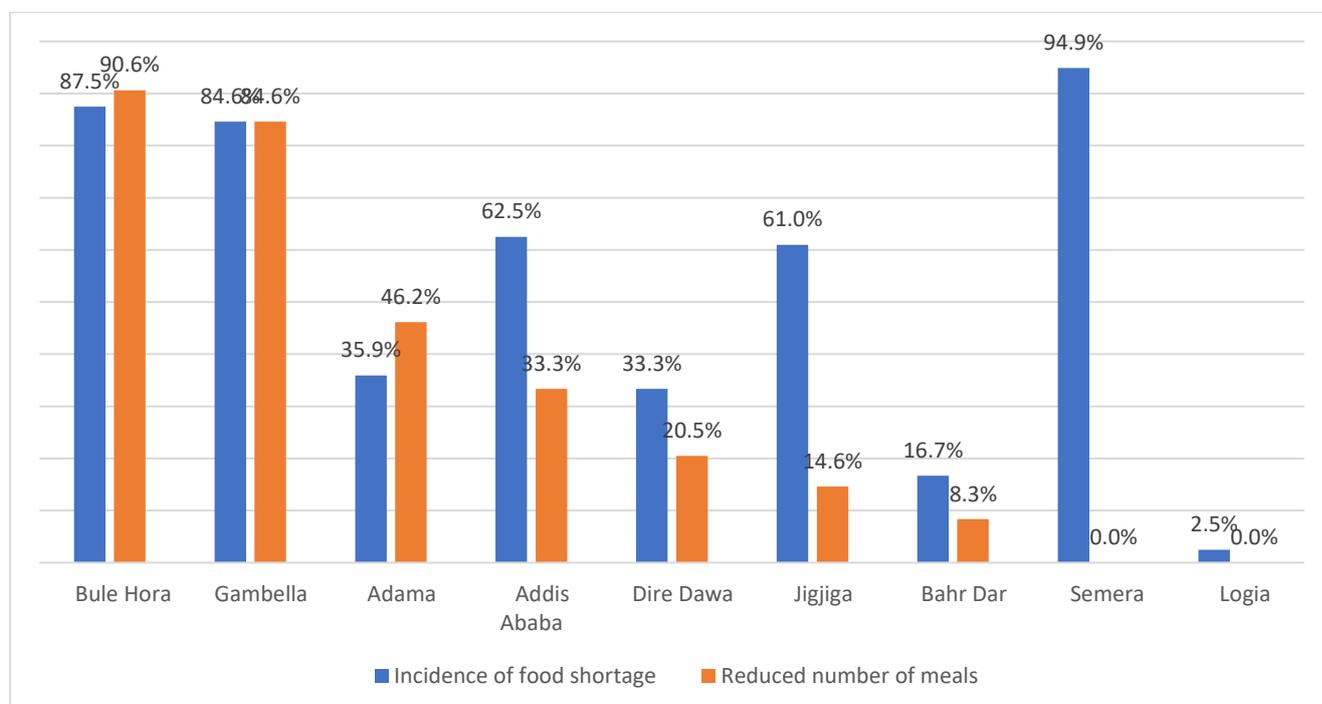
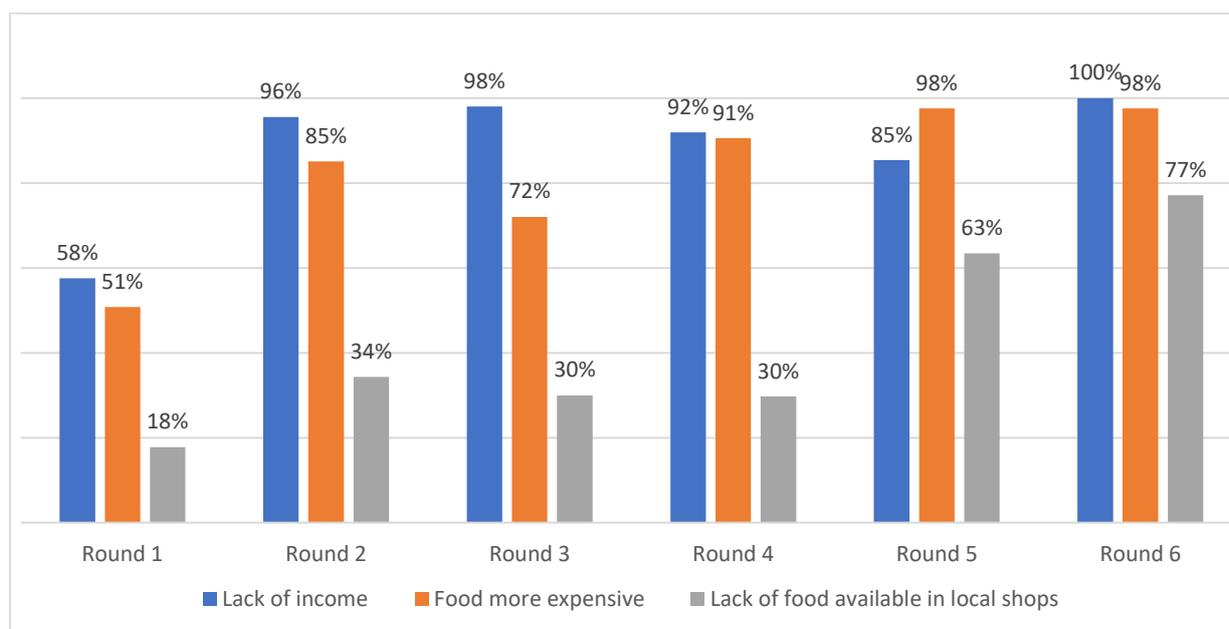


Figure 16: Incidence of food shortages and reduction of number of meals over the past month among the urban poor in selected nine cities in Ethiopia, December 2021 (total n = 303, UPSNP = 107, SSB = 106, IDPs/refugees = 90)



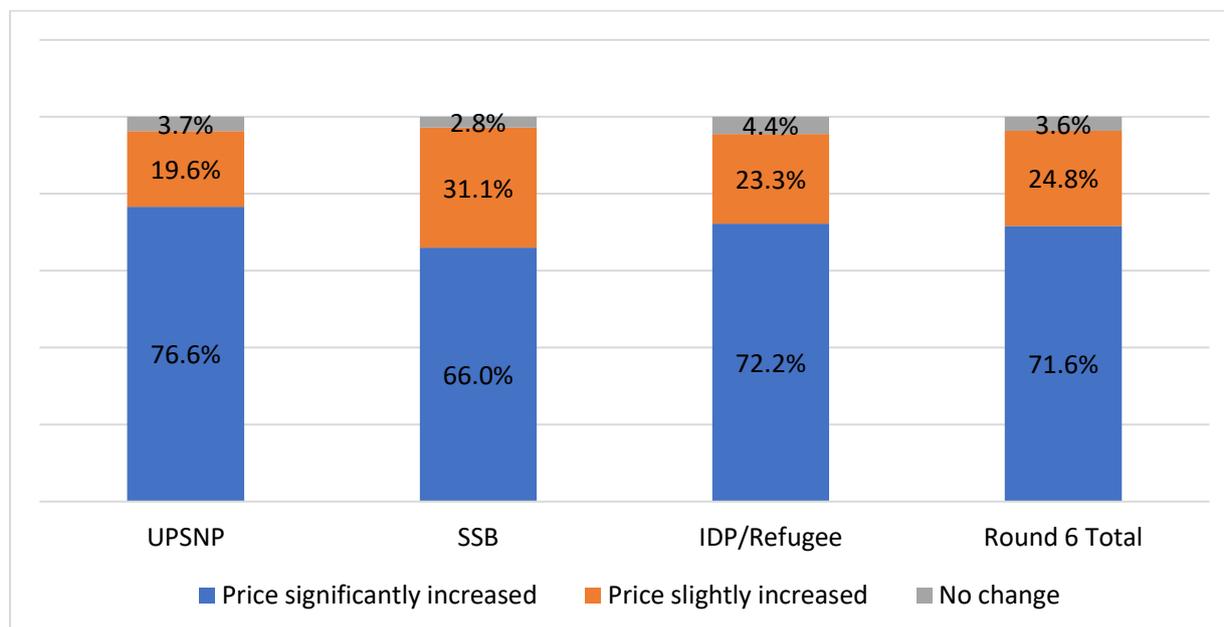
The respondents who reported consuming fewer meals per day were asked the reasons for their reduced food consumption. Increased prices of food items and lack of income were found to be the most commonly reported reasons across the six rounds. For instance, the proportion of respondents that reported lack of income (i.e. inadequacy of household income to buy sufficient food) increased from 58% in Round 1 to 96% in Round 2, 98% in Round 3, 92% in Round 4, 85% in Round 5, and 100% in Round 6 (Figure 17).

Figure 17: Major reasons for reducing food consumption among the urban poor in selected nine cities in Ethiopia: December 2021 (total n=83)



In this round, respondents were asked whether they thought food prices had increased in this month compared to the previous month. The majority of household survey respondents (71.6%) reported that they believed there had been a significant increase in food prices in the current month, compared to that in the previous month. The proportion was highest among the UPSNP (76.6%) and IDP/refugee (72.2%) groups (Figure 18).

Figure 18: Respondents' perceptions of an increase in food prices compared to the previous month among the urban poor in selected nine cities in Ethiopia, December 2021 (total n = 303, UPSNP = 107, SSB = 106, IDPs/refugees = 90)



The qualitative findings are in line with the quantitative survey results. Most of the respondents mentioned that the prices of most food items were twice as high as they had been in the previous round.

Twenty-five kilograms of white flour used to cost 900 birr, but now it sells for 1,200 birr. It costs 4,500 birr per quintal. We are buying every item twice as much as before. In addition, we can never find any vegetables. (SSB, Logia)

The price of a KG of teff is now 53 Birr. ... The price of Shiro increased from 50 to 60 birr. (UPSNP, Adama)

...the price of food items has increased. Everything has risen in price, including wheat flour. We're purchasing 1 kilogram of wheat flour for 50/60 Birr, 1 kilogram of macaroni for 40 Birr, and spaghetti for 35 Birr. (Special group, Bahirdar)

The qualitative diary interview respondents pointed to various explanations for the rise in food prices. Most of them felt that the price increases could be attributable to increases in costs across the supply chain (from production to transportation, to wholesalers/distributors, and finally to retail and local markets). Furthermore, respondents from Logia and Semera highlighted the impact of the conflict in northern Ethiopian on their income, food availability, and affordability.

Life becomes more difficult because everything was shutdown, including electricity, internet, water supply, transportation, and so on. As a result, many economic crises are occurring, such as an increase in food prices, and limited availability of food items. It was more difficult for the poor. (Semera SSB)

Food price increased mainly because of inflation. The second reason is the current situation of our country... the price of all food items has increased. (UPSNP, Jigjiga)

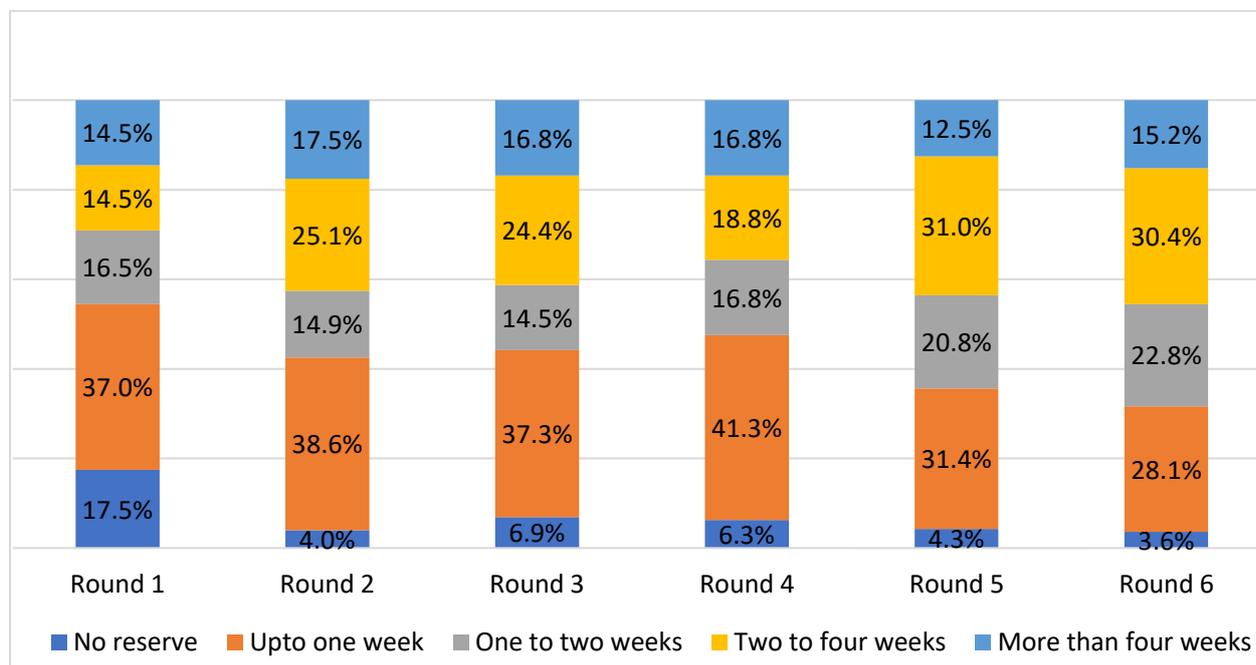
We are currently in a very bad situation because of the conflict. ... As a result, our way of life is in jeopardy, and our living expenses are rise steeply. For example, during our last interview, the price of 50 kg flour was 2000 birr, but it is now around 2500 birr/50 kg, a kg rice is 60 birr...and the price of a single injera [the most commonly consumed food item in Ethiopia] is 15 birr. (Semera, UPSNP)

The availability of food reserves within households significantly improved between Round 1 (82.5%) and Round 6 (96.4%). However, the proportion of households having food reserves that can feed their family for a month or more was very small and had increased only slightly, from 14.5% in Round 1 to 15.2% in Round 6 (Figure 19). It is well known that most households in Ethiopia have a culture of holding food reserves (mainly non-perishable food items like teff, wheat or maize flour, cooking oil, shiro, berbere, etc.) that can serve their family for at least one month. In most cases, the households purchase these items on a monthly basis, unless they have a shortage of income.

The proportion of households with food reserves was slightly higher for SSB households (97.2%) as compared to the UPSNP beneficiaries (96.3%) and IDPs/refugees (96.4%). Similarly, the proportion of households having enough food to feed their family for one month or more was significantly higher for the SSB group (27.4%), and was lowest for the UPSNP beneficiaries (6.5%) and IDPs/refugees (11.1%).

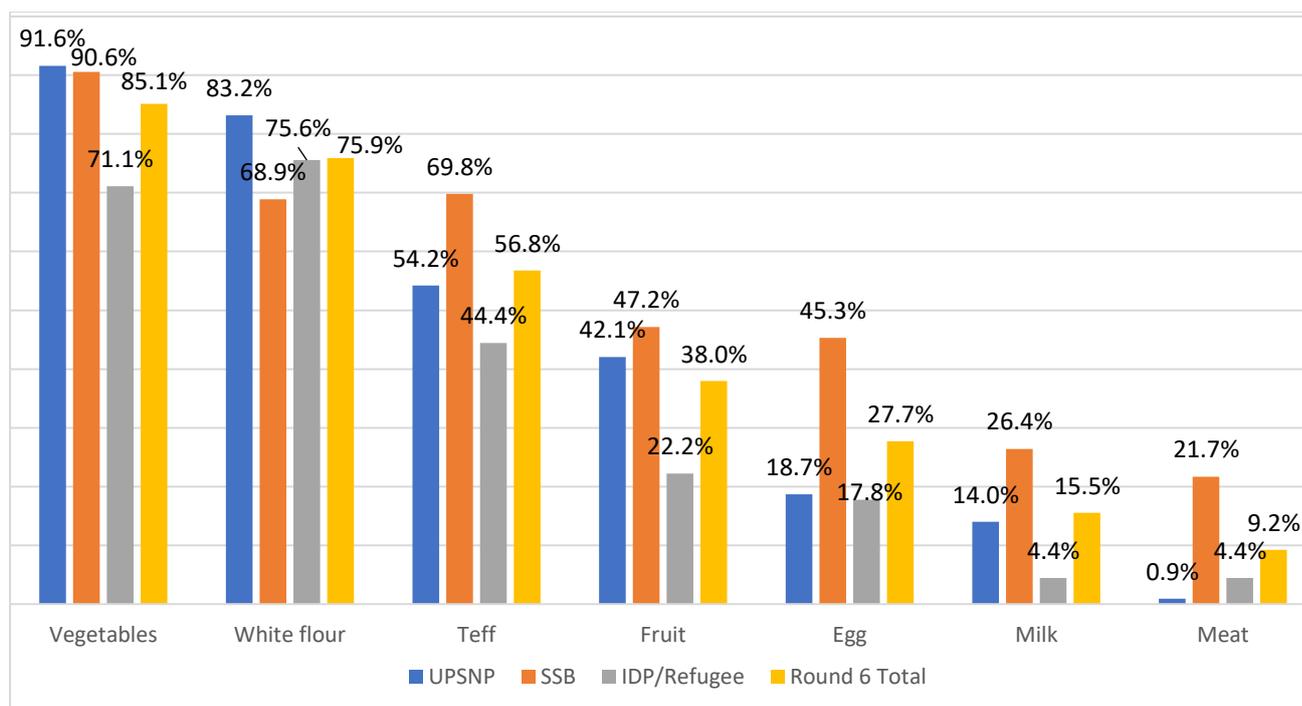
It is worth noting that the circumstances of the three categories are very different. The SSB group consists of people who own small businesses and who earn a better income even than some government employees. The UPSNP beneficiaries are a very poor segment of the population who are enrolled in the programme due to their lower economic status and their inability to generate income (either due to old age or health conditions). Finally, IDPs/refugees are not native to their current location and thus they are in an economically disadvantageous position due to their displacement. Most depend on aid and support provided by the government or United Nations agencies.

Figure 19: Availability of food reserves in the household among the urban poor in selected nine cities in Ethiopia, December 2021 (total n = 303, UPSNP = 107, SSB = 106, IDPs/refugees = 90)



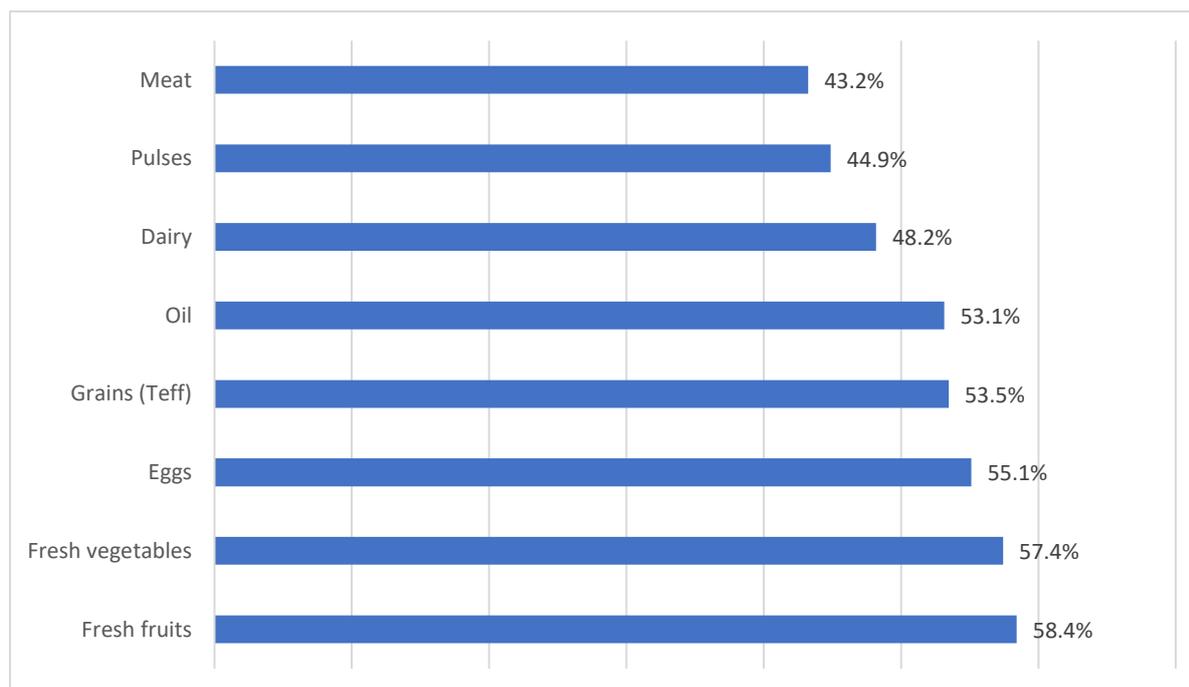
Despite the increase in the proportion of households consuming three or more meals per day, the type of food they consume was found to be of low quality. For instance, only 9.2% and 27.7% of households reported consuming meat and eggs in this round, respectively.

Figure 20: Types of food items most frequently consumed by urban poor households in selected nine cities in Ethiopia, December 2021 (total n = 303, UPSNP = 107, SSB = 106, IDPs/refugees = 90)



Respondents in the quantitative survey were also asked about the types of food items they bought less of or had stopped buying entirely during this round. Teff (53.5%), eggs (55.1%), dairy products (48.2%), and meat (43.2%) were among the food items that households reported not buying or buying less frequently and/or in smaller quantities. These items are relatively expensive and are becoming unaffordable for the urban poor due to increased prices (Figure 21).

Figure 21: Types of food items purchased less or not at all because of the impact of COVID-19 during Round 6 among households of the urban poor in selected nine cities in Ethiopia, December 2021 (total n=303)



Overall, similarly to the previous rounds, food shortages remain one of the biggest issues confronting the urban poor in Round 6. The continual rise in food prices (inflation) and the inability of household incomes to cover basic expenses, including food, are the main causes of this problem. Security issues relating to political turmoil and conflicts in some parts of the country (mainly in Tigray, Amhara, and Afar regions) have had a severe impact on economic activity, resulting in a rise in food prices. To deal with this issue, the study respondents have been forced to employ a variety of coping techniques, which include avoiding or stopping buying more expensive foods, consuming low-quality/less preferred foods, and reducing the quantity and frequency of meals.

Health

Key findings:

- In this round, all of the respondents and their family members who needed medical attention reported being able to access medical treatment.
- All sick children under five were reported to have been taken to a health facility for treatment. All children who had an appointment and were eligible for childhood vaccines were reported to have been vaccinated.
- About 37% of the respondents who had at least one child under five reported that their children had been diagnosed with malnutrition by health workers, constituting **a significant increase** compared to previous rounds.
- Utilisation of maternal and child health services has not been significantly impacted by COVID-19 and increased significantly in this round. Fear of COVID-19 did not seem to prevent people from accessing healthcare services.

In this round, only 16.8% (51 out of 303 respondents) reported that they had needed medical treatment in the period since the last survey. Among these 51, the most common reason reported for needing medical attention was fever with a persistent cough or difficulty breathing (40 respondents), 36 of whom were tested for COVID-19. All of those who needed medical treatment reported that they were able to access it. The majority (98.7%) of the survey respondents reported that they would definitely go to a health facility if they needed to in the future.

Of the total quantitative interview respondents, 50.2% (158 households) had at least one child under five years of age. Respondents were asked if any children under five in their family had been sick since the last survey. Only 14 respondents (9.1%) reported that there was at least one child under five who had been sick, and all of them reported taking their child to a health facility for treatment. All 31 children who had an appointment and were eligible for childhood vaccines were reported to have been vaccinated.

As in the previous rounds, respondents were also asked if any of their children under five years old had been diagnosed as malnourished. In this round, 37.3% (59 of the 158 respondents) reported that their children had been diagnosed with malnutrition by health workers, which is higher than the 30.9% in Round 5, 18.6% in Round 4, and 9.3% in Round 3. This figure is much higher than the 5.7% national average of acute malnutrition in urban areas in Ethiopia,²⁰ which could be attributed to the fact that this study is being conducted among the most disadvantaged segments of the urban population. The higher reported prevalence of malnutrition could partially be attributed to the consumption of low-quality food over a long period of time. Since the first round of this study, avoiding or stopping buying more expensive foods, consumption of low-quality/less preferred foods, and reducing the quantity and frequency of meals have been reported as the major coping mechanisms in the presence of food shortages and market price inflation.

All of the pregnant women in the sample households reported attending their antenatal care (ANC) appointments (n = 19). The level of access to ANC has increased in each round except for Round 4 (Figure 22). About 20.7% of our respondent sample included lactating

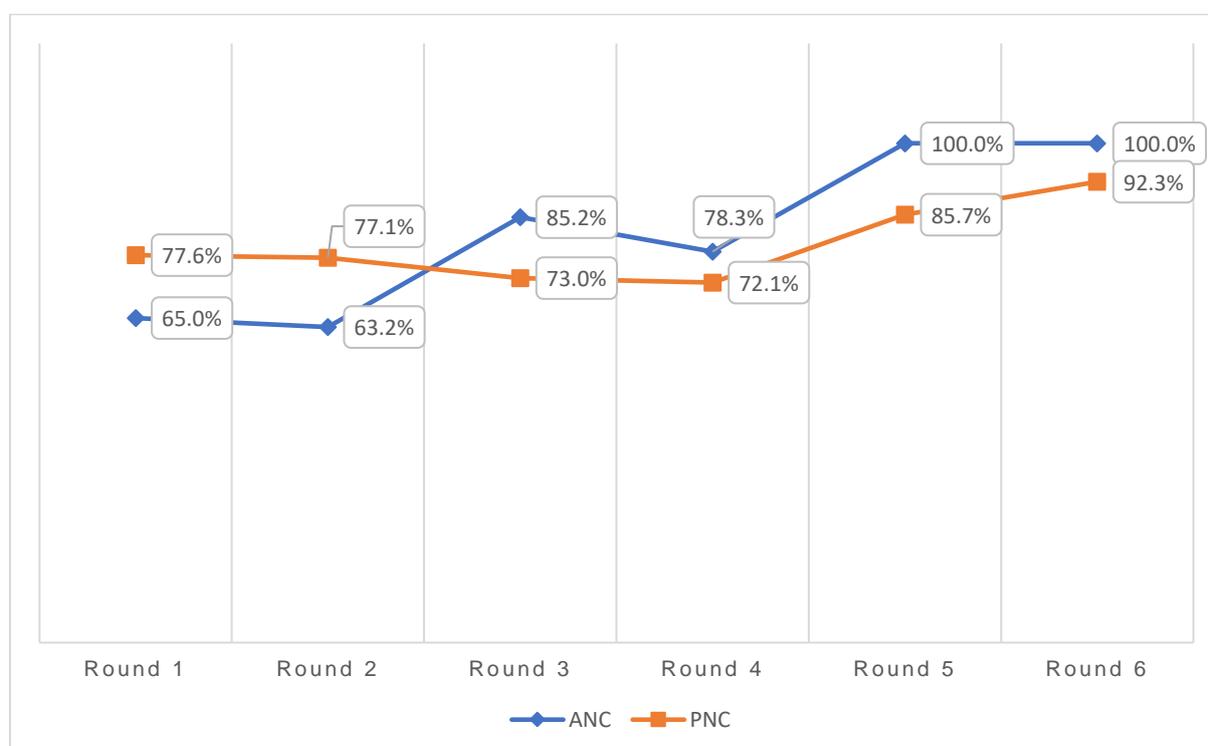
²⁰ <https://dhsprogram.com/pubs/pdf/PR120/PR120.pdf>

women (n = 64), of which 92.3% had accessed postnatal care (PNC), which seems to have increased across the rounds.

The qualitative findings are in line with the quantitative results in this area. The provision and utilisation of reproductive, maternal, and child health services did not seem to be significantly impacted by COVID-19. In the first two rounds, our qualitative interviews indicated a fear of being infected with COVID-19 and a fear of being quarantined as the major barriers to accessing medical care in the community. In this round (as was the case in Round 5), this was no longer the case.

We were at the hospital when my sister got sick. The hospital compound was full of people. Some of them were seeking vaccinations, family planning services, and others for medical treatment. There is no one stays at home due to the fear of this virus. People are using these services. (UPSNP, Adama)

Figure 22: Uptake of ANC and PNC among the urban poor in nine cities in Ethiopia, August 2021 (n pregnant = 19; n lactating = 52)



Overall, in this round, all of the respondents and their family members who needed medical attention reported having been able to access medical treatment. The most common reason reported for needing medical attention was fever with a persistent cough or difficulty breathing (40 respondents), all of whom were tested for COVID-19, except four respondents. The proportion of respondents who reported that their children had been diagnosed with malnutrition by health workers has increased significantly in this round. Utilisation of maternal and child health services also increased significantly in this round. However, our sample sizes for these groups are small, and thus the results need to be interpreted with caution.

Education

Key findings:

- In all cities, the schools were open and had returned to their normal schedule.
- All students except five had returned to their school in this round.
- Students were reported to spend more time studying and playing with their friends compared to previous rounds, while less time was spent helping their families at home.
- About 80% of all respondents indicated that their child–parent relationship had improved, while 20% reported that their child–parent relationship had worsened.
- No child marriage was reported.

Of the total respondents, 175 (52%) reported having at least one child. Among the total 137 female children and 145 male children who were in school before COVID-19 (n = 303), three (2.2%) females and two (1.4%) males were not in school in this round. However, no child marriages were reported in this round.

In the qualitative study, two respondents from Bahredar and Logia reported that their children had dropped out of school because they were unable to afford the school fee.

My older child is attending class because there is no school fee. But my younger five-year-old child dropped out of school because I can't afford the school fee. (SSB respondent, Bahredar)

Two of my children have dropped out of school. It is difficult when you teach children right now. Because they need notebooks, pens, and shoes, which I can't afford for all. So I didn't send two of my children because a dozen notebooks for one child sell for 600 birrs. (Refugee, Logia)

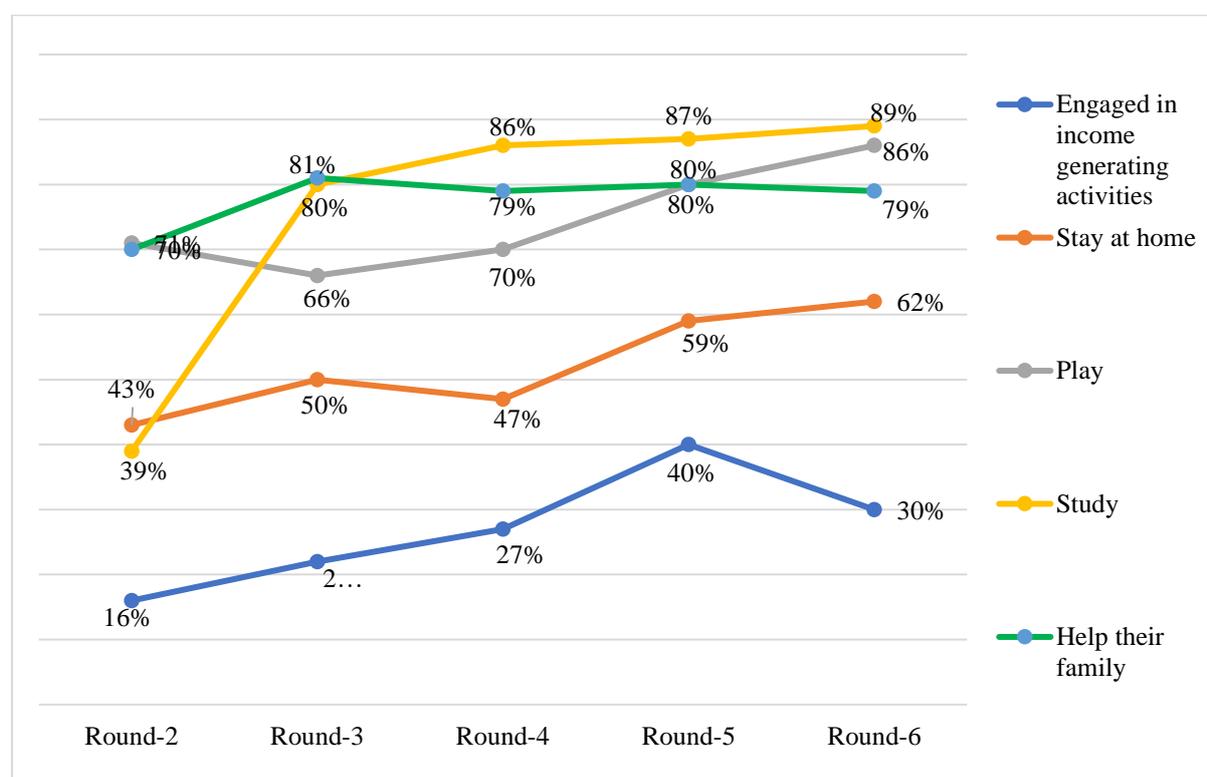
Increased school fees in the new academic year added an additional burden for parents wishing to send their children to school.

The private schools have increased the fees, we used to pay around 300, then they increased to 500 first and then to 820 birrs. So, I couldn't afford to pay the private school fee. The government has declared not to increase school fees in public schools, so I just transferred my kid to a public school. (UPSNP, Adama)

The percentage of time children were reported to spend on different activities is presented in the figure below. From Rounds 3 to 6, the percentages of time that children spend on studying and playing outside of their homes with other children has increased, while the percentage of time spend helping their families at home has decreased. This could be because, in this round, all children are back to school, which encourages them to study and to interact with other children. The percentage of time that children spend playing and staying at home watching TV has also slightly increased compared to previous rounds. This could be because, as reported in Figure 1, the practising of COVID-19 prevention measures like physical distancing has significantly declined and children are back to their previous social life. However, children's engagement in income-generating activities, which was

previously increasing from 16% in Round 2 to 40% in Round 4), has declined to 30% (Figure 23). In the previous rounds children had to attend school in a shift programme, in order to reduce the number of students per class and to maintain social distancing. However, in Round 6 they were back to the full-day class schedule, which means that they had less time to engage in income-generating activities (Figure 23).

Figure 23: Children's time use among the urban poor in nine cities in Ethiopia, during COVID-19 pandemic, December 2021 (total n=183)



In addition to spending their whole day in school, respondents also mentioned that their children spend their time playing with other children.

The schools are open and our children are going to school every day. Children's use of time is very good because they spend full time at school. They also spend time playing with friends on days off from school and studying Quran. My children are registered to attend school in this academic year, but the fee has increased. (UPSNP, Semera)

Social distancing was not reported to be in place in schools, but facemasks were given to students and wearing them remained mandatory.

They do not keep physical distance. They use a facemask in a class. The number of students in a class is not limited to 20 as it has been in the past. There are so many students in a class. (UPSNP, Dire Dawa)

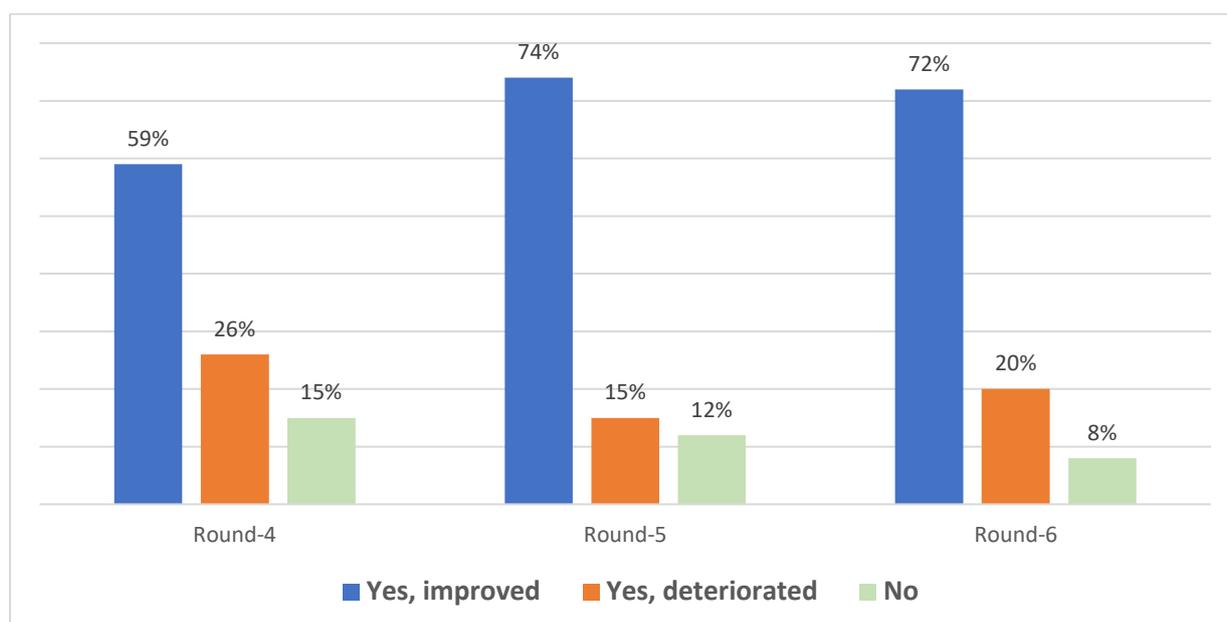
Respondents were asked about any change in their relationship with their children after the COVID-19 pandemic. In this round, more than 80% of the respondents reported that they

spent the same amount of time or more time with their children compared to before the COVID-19 pandemic (Table 5), with a statistically significant difference across respondent groups (chi-square: 13.3; p-value<0.04). Likewise, about three-quarters also reported that the relationship with their children had improved over the course of the pandemic. By contrast, 20% of all respondents reported that their relationship with their children had deteriorated over the course of the pandemic, with no significant difference across the study groups (Table 5).

Table 5: Parents' time spent with their children among the urban poor in nine cities in Ethiopia, December 2021 (N=183)

| | UPSNP (%) | SSB (%) | IDP/Ref. (%) | R-V total | Chi-2-test (P-value) |
|---|-----------|---------|--------------|-----------|----------------------|
| How much time do you spend with your children now compared to before the pandemic? | | | | | |
| Less | 23.8 | 16.9 | 10.2 | 17.5 | 13.3 (0.04) |
| About the same | 25.4 | 25.3 | 42.9 | 30.0 | |
| More | 50.8 | 57.8 | 42.9 | 51.4 | |
| Much more | 0.0 | 0.0 | 4.0 | 1.09 | |
| Before the pandemic, how close was your relationship with your children? | | | | | |
| Not at all | 0 | 0 | 0 | 0 | 4.5 (0.35) |
| Not very close | 23.8 | 18.3 | 16.3 | 19.7 | |
| Somewhat close | 68.2 | 66.2 | 77.5 | 69.9 | |
| Very close | 7.9 | 15.5 | 6.1 | 10.4 | |
| Has your relationship with your children changed over the course of the pandemic? | | | | | |
| Yes, improved | 68.2 | 74.6 | 73.5 | 72.1 | 2.1 (0.71) |
| Yes, deteriorated | 25.4 | 18.3 | 16.3 | 20.2 | |
| No | 6.3 | 7.0 | 10.2 | 7.6 | |

As shown in Figure 24, in this round about 72% of respondents reported that their relationship with their children had improved compared to before the COVID-19, which is similar to Round 5. 20% mentioned a deterioration in their relationship with their children in this round, which is higher than in the previous two rounds.

Figure 24: Parents' time spent with their children among the urban poor in nine cities in Ethiopia, December 2021 (n = 183)

About 95% of the respondents reported that they valued spending time with their children. About 60% of the respondents said that they felt that men should spend more time with their children, and about 50% of the respondents stated that they believed that men did not value caring for children as much as they should. The majority (86%) of the respondents reported that they felt confident in their ability to care for their children and three-fourths felt confident in their ability to provide economic support to their children (Table 6).

Table 6: Perceptions of parents regarding the value of spending time with their children and their confidence in their ability to care for their children among the urban poor in nine cities in Ethiopia, December 2021 (n = 175)

| | UPSNP N(%) | SSB N(%) | IDP/Ref. N(%) | Total N(%) | Chi-2 test (P-value) |
|--|---------------|-------------|------------------|---------------|-------------------------|
| Spending time with children provides value in my life | | | | | |
| Strongly disagree | 2 (3) | 5 (7) | 1 (2) | 8 (4) | 8.3 (0.4) |
| Disagree | 0 | 0 | 1 (2) | 1 (0.5) | |
| Neither agree nor disagree | 0 | 0 | 1 (2) | 1 (0.5) | |
| Agree | 46 (73) | 51 (72) | 38 (78) | 135 (74) | |
| Strongly agree | 15 (24) | 15 (21) | 8 (16) | 38 (21) | |
| Men should spend time with their children | | | | | |
| Strongly disagree | 16 (25) | 12 (17) | 9 (18) | 37 (20) | 5.4 (0.7) |
| Disagree | 8 (13) | 11 (15) | 10 (20) | 29 (16) | |
| Neither agree nor disagree | 7 (11) | 4 (6) | 3 (6) | 14 (8) | |
| Agree | 26 (41) | 32 (45) | 20 (41) | 78 (43) | |
| Strongly agree | 6 (9) | 12 (17) | 7 (14) | 25 (14) | |
| Men do not value caring for children as much as they should | | | | | |

| | | | | | |
|--|---------|----------|---------|----------|-------------|
| Strongly disagree | 16 (25) | 14 (18) | 7 (12) | 30 (14) | |
| Disagree | 25 (34) | 18 (23) | 9 (15) | 52 (25) | 15.1 |
| Neither agree nor disagree | 6 (8) | 12 (16) | 6 (10) | 24 (11) | (0.05) |
| Agree | 27 (36) | 20 (26) | 30 (50) | 79 (37) | |
| Strongly agree | 7 (10) | 13 (17) | 8 (13) | 28 (13) | |
| I feel confident about my ability to care for my children | | | | | |
| Strongly disagree | 0 (0) | 1 (1) | 0 (0) | 1 (0.5) | |
| Disagree | 1 (1.6) | 6 (8) | 4 (8) | 11 (6) | 14.2 (0.07) |
| Neither agree nor disagree | 6 (10) | 2 (3) | 6 (12) | 14 (8) | |
| Agree | 42 (67) | 43 (61) | 35 (71) | 120 (66) | |
| Strongly agree | 14 (22) | 19 (27) | 4 (8) | 37 (20) | |
| I feel confident about my ability to provide (economically/financially) | | | | | |
| Strongly disagree | 0.0 | 0.0 | 0.0 | 0.0 | |
| Disagree | 11 (18) | 7 (10) | 11 (22) | 29 (16) | 12.4 |
| Neither agree nor disagree | 7 (11) | 2 (3) | 5 (10) | 14 (8) | (0.05) |
| Agree | 28 (44) | 363 (51) | 26 (53) | 90 (49) | |
| Strongly agree | 17 (27) | 26 (37) | 7 (14) | 50 (27) | |

In summary, schools were open and had resumed their normal full class schedule during this round. Respondents mentioned that their children spent their time studying and playing more than helping their families. There were five children who had dropped out of school but no child marriage was reported. Children's engagement in income-generating activities had slightly reduced compared to the previous rounds, although this might be expected since they were back at school full time. Regarding the parent-child relationship, most respondents believed in the positive effect of spending time with their children and mentioned that their relationship with their children had improved after COVID-19.

Mental health

Key findings:

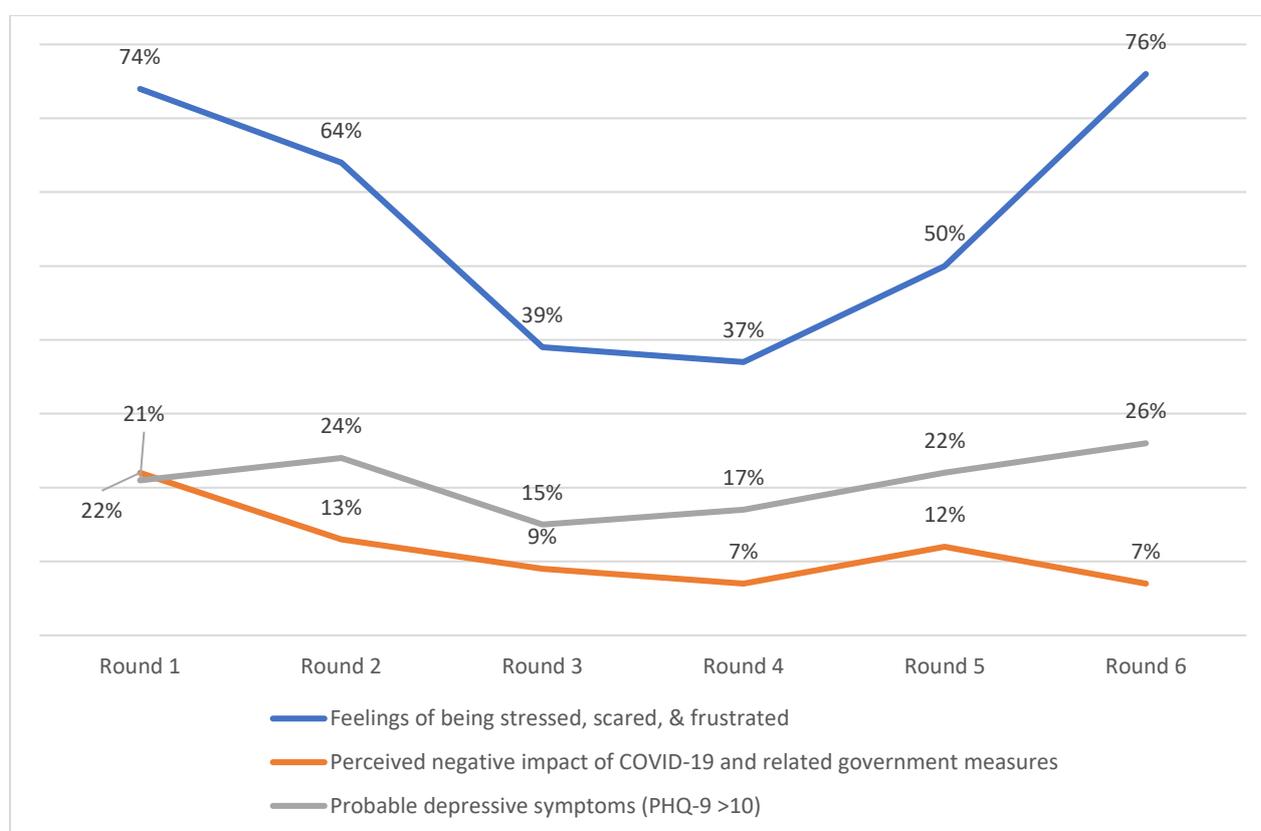
- From Rounds 3 to 6, the proportion of respondents with symptoms of probable depression and feelings of stress has been increasing.
- The main reason for depression/stress provided by respondents in the current round was the inflation in the cost of living, and conflicts, rather than COVID-19.

In this round, 76% of the respondents reported being stressed, scared, or frustrated, without a significant difference among the three groups (chi-square = 0.04; P-value = 0.9). Of the total respondents, 7.7% had had a feeling of hopelessness and/or had had thoughts of hurting themselves most of the day or nearly every day within the last 14 days (Table 7).

Table 7: Mental health measures for the urban poor in nine cities in Ethiopia, December 2021 (n = 303)

| Measured outcome | Respondent category | | | Total N (%) | Chi2-test (P-value) |
|--|---------------------|--------------|------------------|----------------|------------------------|
| | UPSNP N (%) | SSB N (%) | IDP/Ref N (%) | | |
| Feelings of being stressed, scared, or frustrated | 82 (36) | 80 (35) | 68 (30) | 230 (76) | 0.04 (0.9) |
| Feeling hopeless and/or having thoughts of hurting themselves | | | | | |
| Not at all | 83 (77.6) | 86 (81.1) | 69 (76.7) | 238 (78.5) | 7.2 (0.3) |
| Sometimes | 17 (15.9) | 13(12.3) | 12(13.3) | 42(13.9) | |
| Most of the day | 3 (2.8) | 4(3.8) | 6(6.7) | 13 (4.3) | |
| Nearly every day | 4 (3.7) | 3(2.8) | 3(3.3) | 10 (3.3) | |

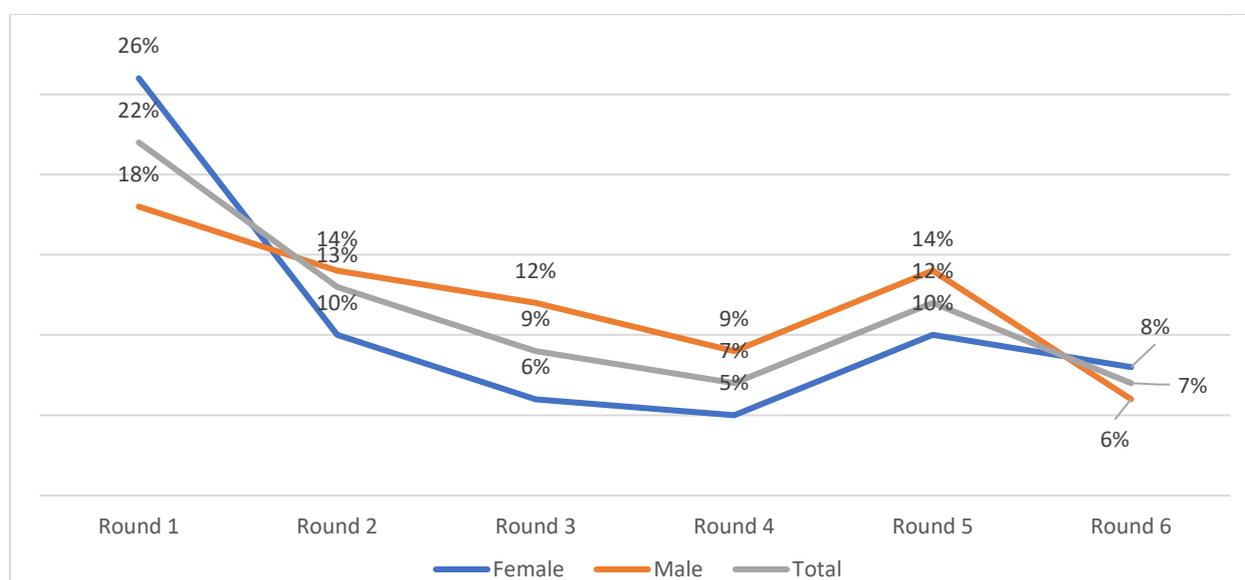
The feeling of being stressed or scared decreased from 74% in Round 1 to 37% in Round 4. However, the proportion increased from 37% in Round 4 to 76% in Round 6. Similarly, the magnitude of probable symptoms of depression increased from 15% in Round 3 to 28% in Round 6 (Figure 25).

Figure 25: Feelings of being stressed, scared, or frustrated among respondent categories among the urban poor in selected nine cities in Ethiopia, December 2021 (total n= 303, UPSNP = 107, SSB = 108, IDPs/refugees = 90)

Only 7% of the respondents perceived that COVID-19 and related government measures had had a negative impact on their lives, and this perception was lower among the refugee group, although the difference among the three groups was not statistically significant (chi-square: 0.2; p-value = 0.9). In this round, the proportion of respondents with probable symptoms of depression was 26% (Figure 26). There was no significant difference across cities in the proportion of respondents with probable symptoms of depression.

When looking at the perceived impact by gender in this round, the proportion of respondents that perceived that COVID-19 and the related government measures had had a negative impact was higher among females (8%) compared to males (6%), but the difference was not statistically significant (chi-square = 0.7; p-value 0.4) (Figure 26).

Figure 26: Percentage of respondents perceiving a negative impact of COVID-19 and related government measures by gender among the urban poor in selected nine cities in Ethiopia, December 2021 (total n = 303)



In the qualitative study, respondents were asked about feelings of stress related to the COVID-19 pandemic and the response measures. Most respondents reported that they were more worried about the crisis happening due to the conflict with the TPLF in the country and the reduced work opportunities than they were about getting infected or ill with COVID-19.

I get worried about the existing lack of peace in our country following the conflict. In addition, people are getting careless about COVID-19, including me, while the virus is killing many people. The other is about the decline in job opportunities and the rise in the cost of living on the other hand. (Special group, Adama)

A respondent from Logia also mentioned that they were more worried about the instability due to the conflict than about COVID-19:

What is bothering us right now is the conflict with TPLF than COVID-19. We are facing a lot of problems due to this ongoing conflict. For example, many people are being displaced, we are not able to move as we want, the cost of living has increased in a

way we have never seen before, and there is a shortage of supplies. So, the current conflict is what worries us the most (Special group, Logia)

In summary, the proportion of respondents reporting symptoms of stress and probable symptoms of depression has increased since Round 3. Respondents mentioned the inflation in the cost of living and the conflict taking place in the country as causes of these feelings. On the other hand, the proportion of respondents perceiving a negative impact of COVID-19 and related government measures declined in this round.

Aid and support

Key findings:

- Overall, there was no significant change in regard to whether respondents reported receiving better support, compared to the previous round.
- The government and NGOs remained the main sources of support, followed by NGOs. Support from community and religious institutions was very minimal in this round.
- The support provided was mainly in-kind, such as food items.

In this round, 49% (n=109) of the respondents reported being aware of the availability of support from the government, NGOs, CSOs, or other groups (e.g. religious institutions). The proportion of respondents who were aware of the availability of support was lower among SSB respondents (15%) compared to those in the UPSNP category (43%), followed by IDPs/refugees (42%). The difference among the three categories was statistically significant (chi-square value of 32; p-value>0.001).

The proportion of respondents who were aware of the availability of support (49%) was lower compared to the previous rounds, when it was at least 50%. Among respondents who were aware of support, 45% (49) of them reported that the support was unrelated to COVID-19 or its related impacts. Likewise, 25% (76) of the total respondents reported that they or members of their household received support from one or more organisations within the two months before the data collection began.

Among the 76 respondents who received support in this round, 41% (31) of them received support through the UPSNP. The proportion of households who received support was higher among refugees (55%), followed by UPSNP beneficiaries (43%). Only one respondent from the SSB group received support, although this was to be expected since the first two groups are beneficiaries of aid and support. The difference among the three respondent groups was statistically significant (chi-square = 56; P-value< 0.001). Regarding the type of support received, 41% reported cash, 64% reported food items, and 17% reported in-kind support (more than one type of support).

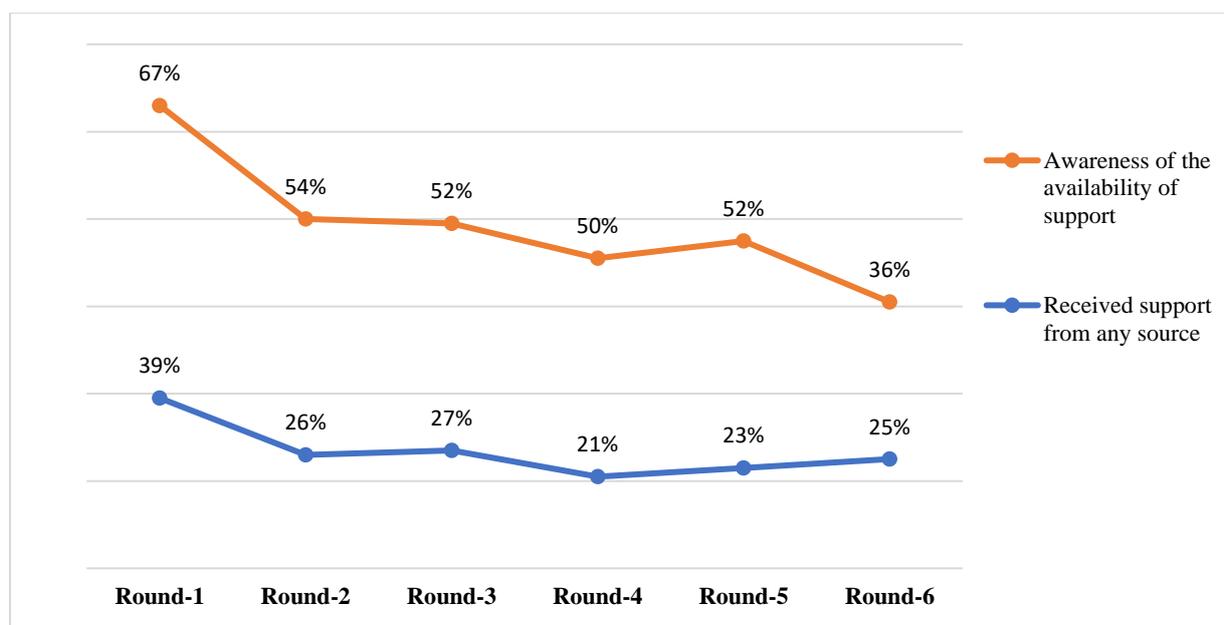
In the qualitative study, UPSNP beneficiaries also reported that they received support last month, but that it was inadequate.

I'm not living with my family. I know that my family has received support with different food items like edible oil, beans, rice, and flour through UPSNP, but it has never been adequate. It has been given every month and has been helpful for some basic needs, though it was adequate. (UPSNP, Jigjiga)

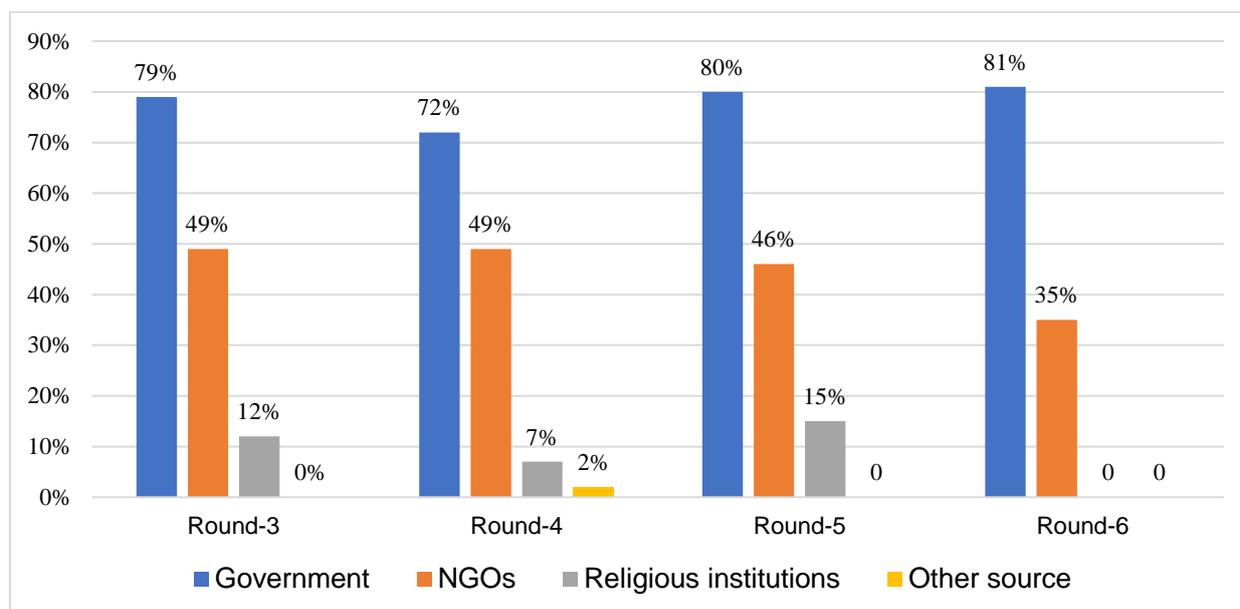
Regarding the support provided before COVID-19 and its continuity, 30% (90) of all respondents were receiving support before COVID-19. Among them, 61 (68%) are still receiving such support and 52% (47) reported a significant reduction in the support they receive compared to before COVID-19.

There has been a decreasing trend over the study rounds in the proportion of respondents who have received aid and support. In general, respondents' knowledge about the availability of support and the proportion of those who actually received the support has declined over time (Figure 27).

Figure 27: Percentage of respondents who were aware of the availability of support, or who received it, from any source, among the urban poor in selected nine cities in Ethiopia, December 2021 (total n=303)



Regarding the source of support, similarly to the previous round, government support was the main source of support reported, followed by NGOs. However, the amount of support from NGOs reported in this round has declined significantly compared to Round 5 (P-value= 0.006), whereas support from the government remains the same as in the last round. In this round, none of the respondents reported support being received from religious institutions, whereas in the last three rounds respondents reported that religious institutions were a source of support. Likewise, support from other sources, like the community, was not reported in this round (Figure 28).

Figure 28: Source of support among urban poor in nine cities in Ethiopia, August 2022 (total n = 303)

In the qualitative study, refugee respondents described that the support from their government or community had declined in this round. However, they mentioned that they were still getting the support from the United Nations High Commissioner for Refugees (UNHCR) that they had received before the COVID-19 pandemic.

I have not received any help from community or government this month. But as I told you before, we are getting support from UNHCR as usual. For example, they have given us wheat, oil, soap, money, Fafa, and so on. (Refugee, Logia)

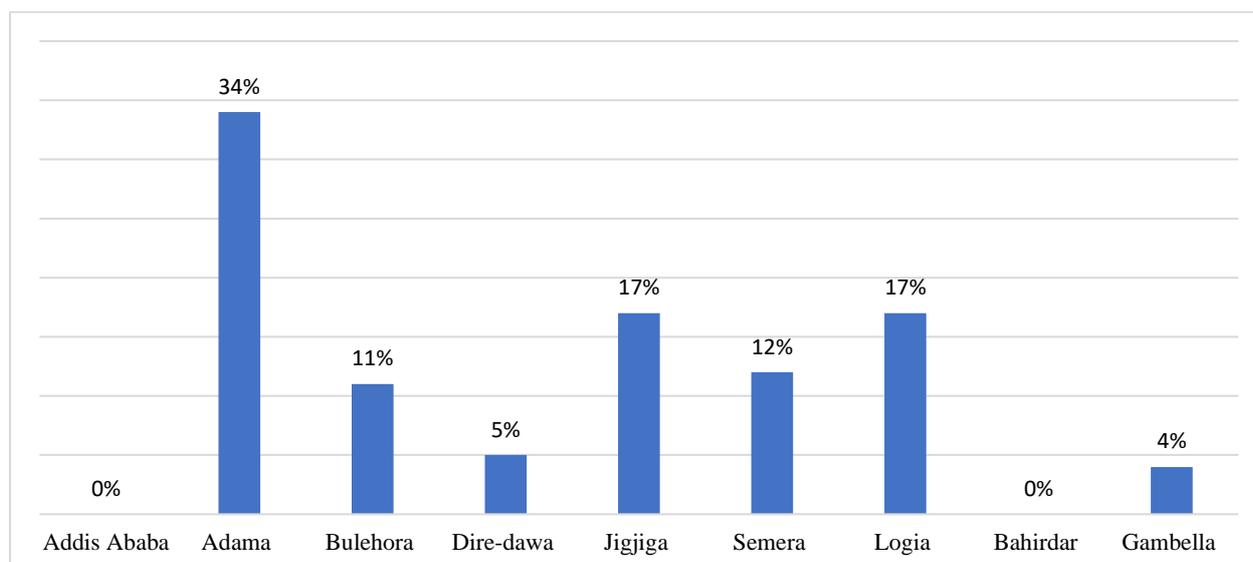
A government official from Jigjiga and also said:

We provide food, clothes, and COVID-19 prevention materials to the community who can afford, but the support is not adequate. Even though the support is inadequate, something is better than nothing. (Government official, Jigjiga)

Other respondents from Semera and Bahredar also reported that there was no organised community or government support related to COVID-19, but that in Logia and Semera the government was supporting people who have been newly displaced due to the conflict in Afar.

There is support for people who have been displaced by the current conflict. The government provides food and shelter for the IDPs. (SSB, Logia)

There was also a significant difference in the degree of support received, across the nine cities (chi-square value = 72, p-value < 0.001). In Adama, a higher proportion of respondents reported having received support, followed by Jigjig and Logia, whereas none of the respondents from Addis Ababa and Bahir Dar reported having received support in this round (Figure 29).

Figure 29: Support received, by study cities, among the urban poor in selected nine cities in Ethiopia, December 2021 (total n = 303)

In this round, the total amount of money that the respondents received in cash ranged from ETB 500 to ETB 1,000 (mean = ETB 750 and SD = 353), equivalent to US\$ 10.1–20.2. The estimated cost of the food support that they received ranged from ETB 350 to ETB 750 (mean = 445 and SD = 168), which is around US\$ 7.14 – 15.3 (Table 8).

Table 8: Estimated value in ETB of support received in the form of cash, food items, and in-kind support among the urban poor in nine cities in Ethiopia, December 2021

| | | Round 1 | Round 2 | Round 3 | Round 4 | Round 5 | Round 6 |
|-------------|---------|---------|---------|---------|---------|---------|---------|
| Cash | Minimum | 250 | 300 | 200 | 600 | 520 | 500 |
| | Maximum | 500 | 450 | 700 | 600 | 1980 | 1000 |
| | Mean | 375 | 375 | 446 | 600 | 881 | 750 |
| | SD | 176 | 106 | 252 | | 284 | 353 |
| Food | Minimum | 25 | 240 | 150 | 200 | 350 | 300 |
| | Maximum | 1600 | 480 | 500 | 500 | 1200 | 750 |
| | Mean | 425 | 354 | 296 | 383 | 683 | 445 |
| | SD | 346 | 92 | 112 | 160 | 453 | 168 |

In summary, overall, there was a significantly lower level of awareness of the availability of support in this round. However, the proportion of respondents who received support was not significantly different compared to the previous round. The government and NGOs remained the main sources of support for the urban poor over the past month. The support provided was mainly in cash and food items. There was also a significant difference in the degree of support received across the nine cities, being highest in Adama, followed by Jigjiga and Logia.

Conclusion

Throughout the six rounds of this study we have reported the social and economic impacts of the COVID-19 pandemic on the urban poor living in nine cities in Ethiopia. The situation in the country has changed over the period of our study: in the last two rounds the respondents were more concerned about the rise in food prices and the ongoing political conflict than they were about COVID-19. Nevertheless, COVID-19 is still very much prevalent in Ethiopia, with a record number of 56,706 new cases reported from 1 December to 31 December 2021. According to the Ethiopian Public Health Institute, 35 out of every 100 people that tested for COVID-19 during this period were positive.

Despite evidence indicating that community transmission of COVID-19 is widespread and accelerating rapidly, a significant number of the respondents still believe that they are not at risk of contracting the virus and the practising of preventative measures had significantly declined in this round. Greater adoption of social distancing and COVID-19 preventive practices were reported among government employees in Addis Ababa than in other cities.²¹

Political instability meant that government offices were busy engaging in the coordination of various activities and interventions related to the conflict in this round, and thus COVID-19 prevention and promotion activities were neglected. COVID-19 was found to be less of a priority, particularly in Afar, Tigray, and Amhara regions. As a result, misconceptions about the existence of the disease, perceived low susceptibility to it, and limited and inconsistent enforcement of the government restrictions were prevalent. This is extremely alarming since such misconceptions are likely to contribute to the accelerating community transmission of the virus across the country. Previous studies have indicated that knowledge about the transmission and prevention of COVID-19 are significantly associated with the practising of preventative measures.²² Regulations imposed by the government should be enforced and more rigorous information interventions and education campaigns are still of importance to enhance the practising of, and compliance with, preventive measures as part a comprehensive package of COVID-19 prevention and control strategies.

Despite these beliefs regarding the disease, the willingness to accept a COVID-19 vaccine was found to be high – although only 19.1% of respondents reported having received the vaccine. Some respondents were concerned about vaccine safety and vaccine-related side-effects. Our findings indicate a need to address concerns related to the safety of the vaccine and its side-effects.

Shortages of water and irregular availability of the municipal water supply remain among the biggest challenges for the urban poor and were significantly more common this round than in previous rounds. The reasons for this problem include the inadequacy of the municipal water supply or sporadic availability of water, the absence of a municipal water service (poor coverage), and the higher cost of purchasing and transporting water. The increase in water shortages could be attributed to seasonal variations (i.e. Round 5 was conducted during the rainy season, but Round 6 was conducted during a dry season). In the previous round (which was the rainy season) the use of rainwater to overcome shortages of municipal water was widely mentioned by the qualitative study respondents.

²¹ <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0257112>

²² <https://pubmed.ncbi.nlm.nih.gov/33705480/>

There were disparities across the respondents from the nine cities in terms of experiencing water shortages and the level of difficulty in accessing water. All respondents from Semera and Logia reported a shortage of water and difficulty accessing water due to interruptions to the municipal water supply (mainly due to the electric power blackout in those cities as a result of the conflict in northern Ethiopia). The economic burden associated with the cost of purchasing and transporting water, as well as travelling distances to get water, presented additional challenges to the urban poor included in our study, as reported in the previous rounds.

Despite an improvement in the frequency of meal consumption across the six rounds and a slight reduction in the incidence of food shortages, the type of food respondents reported consuming was still found to be of low quality.

There were disparities across the nine cities in terms of experiencing food shortages. The incidence of food shortages was highest among respondents from Semera, Bule Hora, Gambela, Addis Ababa, and Jigjiga. Similarly, there were variations across the three categories: the UPSNP and IDP/refugee respondents seemed to be more affected by food shortages. The main reasons given for these shortages were a lack of income and the increase in the prices of food items.

The main reported coping strategies for both a lack of income and food insecurity included reducing the quantity and quality of food, using up savings, and obtaining help from family members. Food items that are assumed to be more nutritious (eggs, meat, milk) were less often consumed as households were purchasing less or had stopped buying them altogether because of the increase in prices. The decreased consumption and the reduction in the consumption of nutritious food items over a long period of time is a major concern and calls for urgent interventions.

The uptake of health services seems to have increased across all rounds. Maternal health service utilisation and treatment for children under five did not seem to have been significantly impacted by COVID-19. However, there is an alarming increase in the proportion of malnourished children in this round, which is likely to be linked to rising food insecurity.

In this round, schools were open and had resumed the normal full class schedule. Children were reported to spend their time studying and playing, more than helping their families. There were five children who had dropped out of school, but no child marriage was reported. Regarding the parent–child relationship, most respondents reported believing in the positive effect of spending time with their children and mentioned that their relationship with their children had improved after COVID-19.

The proportion of respondents who reported symptoms of stress and probable symptoms of depression (according to the Patient Health Questionnaire 9 (PHQ-9) index) has increased since Round 3. This appears to be due to concerns about the rise in the cost of living and the ongoing conflicts in the country, rather than COVID-19.

Overall, there were significantly lower levels of awareness about the availability of aid and support in this round. However, the proportion of respondents who reported having received support was not significantly different from the previous round. The government and NGOs remained the main sources of support for the urban poor over the past month. The support provided was mainly in the form of cash and in food items. There were significant differences

in the provision of support across the nine cities, being highest in Adama, followed by Jigjig and Logia.

Overall, the findings of this study indicate that the urban poor are still struggling to cope with multiple challenges, which may no longer necessarily primarily relate to COVID-19. These include the inadequacy of their income to cover their basic needs, the persistent increase in food prices, which has exacerbated food insecurity, and the lack of access to a clean and adequate water supply. Malnourishment has increased significantly in this round and requires urgent attention. At the same time, mental health problems (i.e. increased levels of stress and depression) are getting worse for the urban poor due to concerns about the high food prices, the decline in economic activity, and affordability, which increase stress, anxiety, and depression.

Case study

Case Study 1 (continued from Round 1 to Round 6)

Mrs Lelo (her name has been changed for privacy) is a 31-year-old mother of four. She was displaced from Somali Region following a conflict that happened in 2017, in which she lost her husband. She currently lives in a temporary shelter in Adama City. She is the sole caretaker of her children.

Mrs Lelo reported a decline in the practising of COVID-19 preventive measures in Adama City: *'You do not observe many people wearing masks or keeping a physical distance, which was not the case in the previous time. It looks as if the virus has disappeared.'* According to Mrs Lelo, lack of awareness creation campaigns and limited law enforcement are among the reasons for the limited practising of COVID-19 preventive measures. *'There is no restriction on taxis as in previous times. You rarely observe people wearing facemasks except in a few places like banks. There is no awareness creation through the media as in the previous period.'* Moreover, she believes that the ongoing conflict in the country and market price inflation has contributed to declining practising of preventive measures, as less attention is paid to COVID-19. *'Now people are getting careless. I think it is due to the ongoing conflict in the country. The cost of living is also rising.'*

Throughout the rounds, Mrs Lelo has consistently mentioned a shortage of water supply. She is now hopeful that the community is going have access to adequate water: *'To be honest, we have a challenge accessing water. We have been collecting a jar of water for 15 or 14 birrs for a long time. Now the government is constructing a new water project. We hope we will get it [water access] very soon.'* According to Mrs Lelo, lack of an adequate water supply has negatively affected the community's handwashing practices: *'How can you wash your hands and clothes when there is no water? You couldn't afford to pay. You know that water is life.'*

In Round 5, Mrs Lelo had explained that there had been no support from the government or other sources even though life had become increasingly difficult for her family and the IDPs in the area. *'I have not seen or observed any support in the last two months. Wallahi [I swear], I didn't see people supporting each other.'*

In the previous rounds, Mrs Lelo had explained how the COVID-19 pandemic and the government restrictions following the pandemic had affected her daily life and her ability to feed her family. In Round 5, Mrs Lelo reported having stopped selling chat/khat due to increasing prices, and that her income had decreased as a result. In this round, however, she said she believes that her income has increased, relatively speaking. Nonetheless, she said it is not sufficient to support her family and it would have been difficult without the support she is getting from her family: *'My income has improved but not sufficient. My family and people who know me sometimes provide me supports.'*

Through the rounds, escalating food prices have been the main challenge for Mrs Lelo and other IDPs in the area. In this round, however, she reported that food prices have declined, relatively speaking, except for some food items: *'I think it [food price] has shown a decline*

compared to the previous time. The prices of other food items have declined from the previous month except for some cereals that have shown a slight increase.'

In the previous rounds, Mrs Lelo had explained that the community has limited access to health facilities and patients are expected to travel long distances to get health services. As explained in the last round, fear of being infected with the coronavirus has not prevented women from visiting health facilities for maternal health services, including family planning and ANC. *'There is no one who avoids going to a health facility due to the fear of the virus. Both pregnant women and those who attend family planning classes visit health facilities regularly.'*

According to Mrs Lelo, the community's perception of the COVID-19 vaccine is good and people are willing to take it. *'People like this vaccine and have the hope of taking this vaccine. Other than this, there is no such negative attitude towards this vaccine.'*

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 |
|---|-------------|-------|-----------|-----------|---------|--------|-------|-----------|---------|---------|-------|
| Behaviour in response to COVID-19: Round 6 (all figures are percentages) | | | | | | | | | | | |
| Proportion of respondents who reported practising washing hands frequently with soap and water and/or hand-rubbing with a sanitiser or alcohol-based solution | 8.3 | 92.3 | 100.0 | 61.5 | 14.6 | 100.0 | 97.5 | 100 | NA | 100 | 74.9 |
| Proportion of respondents who reported practising wearing a facemask | 66.7 | 100.0 | 100.0 | 92.3 | 4.9 | 0 | 12.5 | 19.4 | NA | 100 | 49.5 |
| Proportion of respondents who reported practising physical distancing | 0 | 0 | 3.1 | 0 | 0 | 0 | 5 | 0 | NA | 0 | 1 |
| Proportion of respondents who reported all family members wearing a facemask all the time | 62.5 | 100 | 12.5 | 0 | 0 | 0 | 5 | 8.3 | NA | 0.0 | 20.8 |
| Proportion of respondents who reported that they believe that they could still be infected with the coronavirus | 41.7 | 100 | 100 | 89.7 | 22 | 94 | 30 | 47.2 | NA | 100.0 | 67.3 |
| Health (all figures are percentages): Round 6 | | | | | | | | | | | |
| Proportion of participants that needed any medical treatment since the last round of the survey | 16.7 | 43.6 | 50 | 7.7 | 0.0 | 2.6 | 10 | 0 | NA | 46.2 | 16.8 |
| Proportion of participants/members that needed medical treatment and have had access to health services | 100 | 100 | 100 | 100 | NA | 100.0 | 100.0 | NA | NA | 100 | 100 |
| Proportion of households whose member(s) needed any medical treatment since the COVID-19 outbreak | 0 | 10.3 | 12.5 | 15.4 | 7.3 | 5.1 | 7.5 | 0.0 | NA | 0.0 | 7.3 |
| Proportion of households whose member(s) needed medical treatment and have had access to health services | NA | 100 | 100 | 100 | 100.0 | 100 | 100 | NA | NA | NA | 100 |
| Mental health: Round 6 (all figures are percentages) | | | | | | | | | | | |

| | | | | | | | | | | | |
|--|------|------|------|------|------|------|------|------|----|------|------|
| Proportion of respondents feeling stressed, scared, or/and worried during the past month | 79.2 | 100 | 100 | 61.5 | 90.2 | 92.3 | 97.5 | 2.8 | NA | 100 | 75.9 |
| Proportion of respondents with probable symptoms of depression (cut-off point =10) | 33.3 | 33.3 | 25 | 15.4 | 24.4 | 25.6 | 25.0 | 30.6 | NA | 15.4 | 26.0 |
| Aid and support: Round 6 | | | | | | | | | | | |
| Proportion of respondents who are aware of any relief being provided to address the impacts of COVID-19 | 0 | 59.0 | 34.4 | 15.4 | 34.1 | 94.9 | 35.0 | 2.8 | NA | 23.1 | 36.0 |
| Proportion of households/household members who received aid from any institution after the COVID-19 pandemic | 0 | 66.7 | 25 | 10.3 | 31.7 | 23.0 | 32.5 | 0 | NA | 23.1 | 25.1 |
| Total sample/observations (in number) | 24 | 39 | 32 | 39 | 41 | 39 | 40 | 36 | NA | 13 | 303 |

