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BRE BUILDING RESILIENCE IN ETHIOPIA

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

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

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About the BRE programme

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

About Maintains

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

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Preface

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

Table of contents

List of tables and figures

List of abbreviations

ANC	Antenatal care
BRE	Building Resilience in Ethiopia
CSO	Civil society organisation
ETB	Ethiopian birr
FCDO	Foreign, Commonwealth and Development Office
IDPs	Internally displaced persons
KII	Key informant interview
NGO	Non-governmental organisation
OPM	Oxford Policy Management
PHQ-9	Patient Health Questionnaire
PPE	Personal protective equipment
SD	Standard deviation
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

The unintended consequences of COVID-19 responses are becoming visible across sub-Saharan Africa. As at 8 December 2020, the number of people infected with COVID-19 in Ethiopia had reached 114,266, of whom 84,948 had recovered and 1,766 had died.[1] Following the lifting of the state of emergency, the Government of Ethiopia issued a detailed COVID-19 pandemic prevention guideline on 6 October, 2020, which is still in force. The guideline covers a wide range of issues, including the requirements for foreign travellers entering the country. According to the guideline, service-providing individuals and customers must wear a facemask except when eating and drinking. It is also prohibited to enter the premises of any religious institution without wearing a facemask. Moreover, any person attending a funeral is expected to wear a facemask and to maintain a distance of two adult strides. According to the guideline, 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 (PPE).[2]

This current round of the study aims to assess the effects of COVID-19 and government responses on the lives of Ethiopians, on changes in their food security and livelihoods, as well as on education for their children, in addition to their access to and use of health services, over the past month.[3] 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 as a result of COVID-19. Phone surveys were conducted in 10 selected cities in Ethiopia: Addis Ababa, Mekelle, Dire Dawa, Adama, Gambela, Bahir Dar, Jigjiga, 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.

This report presents the results from **the third round** of our mixed methods phone survey (using semi-structured quantitative and diary-style qualitative interviews, in which respondents led the discussion, with gentle guiding by the interviewers across the main themes). The same households/individuals have been tracked for six months, with the focus being on selected respondents (typically household heads). This round of the survey focused on the households (selected from among the Urban Productive Safety Net Project (UPSNP) beneficiaries, small business owners, and IDPs/refugees/returnees) and individual day labourers (petty traders and others who we refer to as a 'special population segment' that could be especially vulnerable to the effects of the COVID-19 pandemic and who were interviewed at length) who participated in the first round. We have worked closely with the Federal Ministry of Health and the National Disaster Risk Management Commission in order

[1] https://covid19.ephi.gov.et/covid-19/
[2] Federal Ministry of Health (2020) 'A directive issued for the prevention and control of COVID-19 pandemic', Directive No 30/2020.
[3] The first round of the phone interviews was carried out between 22 June 2020 and 22 July 2020, and in the first round we also interviewed local government officials, non-governmental organisations (NGOs)/civil society organisations (CSOs), and healthcare professions. However, we only interview these groups every two rounds (this round – Round 3 – also includes interviews with these groups). The main focus of our study is on the dynamics of the impact of COVID-19 and government measures on households and day labourers. The key informant interviews (KIIs) with local government officials, NGOs/CSOs, and healthcare professions help provide the context for our study, but they are not the main focus.

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 results 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, ability, and people who are marginalised for other reasons (e.g. IDPs). The situation remains the same in this round as in the previous two rounds. Daily wage earners, people with jobs in the informal sector, vendors, petty merchants, labourers, and women were found to be the most likely to be impacted due to loss of jobs and livelihoods, and a disproportionate childcare burden. Migrants and people living with no social safety nets were also found to be particularly vulnerable to the pandemic, and it was found that they might not have received sufficient aid and support. Our results are in line with a study conducted by the World Bank Group, which highlighted concerns about the impact of COVID-19 on the health and livelihoods of a representative sample of respondents, and found that food insecurity and loss of income have been prevalent during the pandemic.

Methodology – Round 3 (Nov-Dec 2020)

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

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

Cities covered

The study was conducted from **28 October to 13 November 2020** in 10 cities/towns located in different regions of Ethiopia. The cities included were Addis Ababa, Mekelle, Dire Dawa, Adama, Gambela, Bahir Dar, Jigjiga, 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, level of access to basic services, and the effects of internal displacement were also considered during the selection of the cities. The 10 cities were thus selected to produce findings that are relevant across Ethiopia, and to allow for some comparison between different cities.

Quantitative interview sample

The quantitative interviews were conducted among UPSNP beneficiaries,[4] households that own a small-scale business (SSB), and refugees/IDPs/returnees. 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 ownership of valuable assets, and their living conditions. The UPSNP beneficiary households receive a monthly payment from the government as direct beneficiaries (those working on city beautification and cleaning) and indirect beneficiaries (those not engaged in any work due to health problems, old age, and/or disability). Similarly, households in the IDP/refugee category are among the most vulnerable groups and are being highly affected by COVID-19 and the associated government

[4] Respondents included under the UPSNP category include: beneficiaries who receive direct support in cash or in kind; those engaged in street cleaning jobs and receive a monthly salary; and individuals who are identified as eligible to be enrolled in the programme but not receiving any support since UPSNP is not operating in some cities (i.e. Bahirdar, Bulehora).

responses as their socioeconomic status and livelihoods are already compromised due to displacement from their original location. In this study, the term 'refugee' refers to individuals who are under international protection and are living out of camps in the cities, who are mainly from Logia, Semera, and Gambela. According to the *United Nations Guiding Principles on Internal Displacement*, IDPs are 'persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalised violence, violations of human rights or natural or human-made disasters, and who have not crossed an internally recognised state border'.[5] 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'.[6] Our respondents self-identified as one of these three categories (IDP, refugee, or returnee) based on the definitions outlined above.

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

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

Of the sample of 436 households included in the quantitative survey (Round 1), we were able to interview **380 participants during the third round**, a response rate of 87.2%. Of these, 121 were UPSNP beneficiaries, 137 were SSB owners, and 122 were IDPs (73), refugees (30), or returnees (17). This compares to the sample of 436 households included in Round 1, where 153 were UPSNP beneficiaries, 153 were SSB owners, and 130 were IDPs (88), refugees (30), or returnees (11).

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

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

Qualitative interview sample

Diary-style interviews were conducted with the same participants from the first round of data collection. A total of 35 diary-style interviews (an average of around four participants per city) were conducted with: six UPSNP beneficiaries; five SSB owner respondents; 12 IDPs/refugees/returnees (IDPs (six), returnees (four), and refugees (two)); and 12 participants from the 'special population group' (i.e. daily labourers, shoeshines, waiters, porters, and commercial sex workers). These were slightly less than the previous two rounds (57 and 50 respondents in Round 1 and Round 2, respectively) as some of the respondents had changed their phone numbers and some refused to take the calls. The qualitative interviews were conducted in all the cities targeted by the study except Mekelle. We were not able to reach out to any of the respondents from Mekelle due to the network shutdown following the conflict between the Tigray regional government and the federal government.

The qualitative data collectors also conducted weekly observation sessions to provide contextual insights into the communities' behaviour regarding the prevention of COVID-19 and level of compliance with the restrictions or measures set by national and local authorities. We used a semi-structured checklist to guide the observation. The information gathered from the nine cities was summarised to identify the changes between the observation sessions and to describe the overall context of the cities. The qualitative interviews in this round focused on both the diary-style interview participants and key government officials. In this round, 22 key informant interviews (KIIs) were carried out: with 11 local government officials, five NGOs/CSOs, and six health workers. These KIIs are included every two rounds. The total number of KIIs conducted in this round is less than in Round 1 (when 35 were conducted).

Interview approach

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

Data analysis

Quantitative data were analysed using Stata Version 14. Descriptive statistical methods, including frequency tables and proportions (percentages), were used to analyse the quantitative data. We used tables and graphs to present the results. Chi-square and paired t-tests were used to test statistical differences in selected variables between the UPSNP beneficiaries, SSB, and IDP/refugee groups, and McNemar chi-square and paired t-tests were used to test statistical differences in selected variables between the rounds (Round 3 versus Round 2 or Round 1). The data processing and analysis were concurrent with the data collection. All qualitative interviews were imported and coded using NVivo 14 qualitative analysis software. The interviews were coded independently, using an inductive approach,

by members of the research team, and differences and emerging codes were discussed. Framework analysis was used to allow the identification of common variable patterns by themes/topic guides within and across different groups – UPSNP beneficiaries, SSB owners, refugees, IDPs, returnees, and the special groups – relating to their experience of the impact of COVID-19 and associated government measures. Salient quotes (i.e. quotes that reflected strong patterns in the data and that were succinct when translated into English) were used to express the experiences and perceptions of the informants and for the case studies.

Limitations of the study

This study has some limitations that should be considered. First, this study was unable to explore causal relationships because there may be other factors that influence the respondents' answers to the survey questions which are not observable or relevant to COVID-19. Secondly, the data presented are based on participants' self-reports, which may be associated with a social desirability bias. We carefully designed the data collection tools in order to take social desirability bias and other confounds into account. For example, the data collectors were not allowed to read the options out to the respondents (i.e. spontaneous responses to questions were captured, rather than respondents choosing from a fixed set of options). For questions around the knowledge and practice 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 also faced multiple challenges during the data collection period for this round. The phone numbers of some participants used during the first-round data collection did not work, which affected our data management process. The team had to apply adaptive means, including using more days to reach out to participants whose phones were not working and asking field coordinators to trace those respondents and to find alternative phone numbers, to increase the response rate.

Given the connection shutdown following the conflict between the Tigray People's Liberation Front (TPLF) and the Federal Government of Ethiopia, we were only able to interview 25 of the expected 41 survey participants from Mekelle city. Moreover, we could not conduct any of the diary interviews and KIIs in the city.

Context during Round 3

This section reports information on the context of the study, as reported by the data collectors (based on their field observations). Like the previous rounds, the restriction measures imposed by the Ethiopian Government appeared to be implemented at varying levels across the 10 study cities. The major incidents/events observed by the data collectors during this round are summarised in the paragraphs below. All the government restrictions are supposed to be implemented and enforced in all the cities across the country.

As will be recalled from our Round 2 report, the federal government officially lifted the state of emergency in September, which had been declared in April 2020. Consequently, the restrictions imposed on public transport service providers to accommodate only 50% of their capacity were lifted. Moreover, the transport tariff, which had been raised to double the normal price, was restored to the original price. Despite the above changes, the obligation for everyone on board (passenger, driver, and driver's assistant or cashier) to wear a facemask remained intact. The Ministry of Transport also announced a penalty for drivers and drivers' assistants/cashiers who fail to wear a mask. However, drivers and their assistants were commonly observed by the data collectors without facemasks while providing public transport services. In addition, most passengers using public transport were also observed by the data collectors to not be wearing facemasks. The data collectors reported their observation that law enforcement has become weak and that people are not complying with the government restrictions, and are not held accountable. According to the observational findings, 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 (for instance, people living in Addis Ababa were more likely to use facemask than in other cities). There was mixed compliance with the government's directive that everyone visiting churches and mosques should wear a facemask. It was observed that some people did not wear a facemask when going into churches and mosques, but the compliance appeared to be better in Addis Ababa. On the other hand, compliance with physical distancing was found to be poor in all of the cities. The data collectors also observed that some people had started shaking hands again.

As in Round 2, there were riots and road closures in some of the study areas in Oromia regional state (Adama and Bule Hora), and in the Dire Dawa city administration. The road closures created problems in the transportation of goods (mainly food items) across the cities in the study. In addition, there was conflict between the federal government and the TPLF. This conflict has caused social, humanitarian, and economic crises in the country, particularly in Amhara and Tigray regional states.

Similar to our observation findings during Rounds 1 and 2, inappropriate use of a face mask was also found by the data collectors to be common in all of the study cities. Some people were seen to only wear face masks to cover their mouth, while others only used them to avoid being held accountable by the police for not wearing a mask in public places (but quickly took off their masks when they could not be seen by the authorities).

It was also common for the data collectors to see public gatherings without proper protections (i.e. wearing a face mask and physical distancing) at marketplaces, religious

places, cafés, restaurants, etc. However, banks and some government offices (like Ethio Telecom) located in Addis Ababa were still found to be forcing their customers to wear masks and to use hand sanitiser prior to entering the institutions/offices.

At the end of the Round 3 data collection, the government announced the re-opening of schools and dates for sub-national exams (eight grade) and national exams (12th grade). Accordingly, schools started to open in all cities. However, some of the schools in Amhara region, and all schools in Tigray region, remain closed, following the conflict. Private universities are now able to open. Public universities opened for 45 days for graduate students, and then closed again in November due to rising COVID-19 cases. It was announced that public universities would be opening again in person from mid-November, and a number of universities have indeed opened. Many students are also living on campus at the time of this round of data collection.

Summary of household characteristics

The quantitative phone survey included a total of 380 households: 121 UPSNP beneficiaries, 137 SSB owners, and 122 refugees and IDPs – 27 fewer respondents than in Round 2 due to dropout (i.e. refusal to participate, phone switched off, or unable to pick up their phone). Female respondents accounted for 47% of the total respondents. The average age of respondents was 33, with a range between 20 and 68. The average family size was 5.4 (standard deviation (SD): 2.8). Among the households in our sample, 19.5% had breast-feeding/lactating women and 7.6% had pregnant women, while 52% had at least one child under five. Forty percent of the households lived in accommodation rented from private owners, and 28% owned their homes.

For the qualitative study, a total of 35 diary-style interviews were conducted with six UPSNP beneficiaries, five respondents from the SSB group, 12 IDPs/refugees, and 12 participants from the special population group (i.e. daily labourers, shoeshines, waiters, porters). In addition, we conducted 22 KIIs with respondents from government offices (11), health workers (six) and NGOs/CSOs (five). The qualitative study was conducted in nine cities (Mekelle was not included due to instability and the communication blackout).

Table 1: Characteristics of quantitative household survey respondents, urban poor in selected 10 cities in Ethiopia, Oct/Nov 2020 (total n = 380, UPSNP = 121, SSB = 137, IDPs/refugees = 122)

Household characteristics (n = 380)		UPSNP (%)	SSB (%)	IDP/ refugee (%)	Total (%)
Gender of the respondent	**Male**	31	69	57	53
	Female	69	31	43	47
Family size	**Less than three**	15	9	6	10
	Three to five	51	54	51	52
	Above five	34	36	43	38
Number of children under five	**None**	57	50	36	48
	One	27	21	37	34
	Two	13	11	23	16
	Three or more	2	2	4	3
Type of accommodation/ housing	**Private accommodation (own)**	38	40	5	28
	Rented from individual owner	34	47	39	40
	Rented from government	20	9	9	12
	Cohabit with relatives	4	4	7	5
	Cohabit with non-relatives	2	0	2	1

	Temporary-built accommodation	2	0	38	13
Study sites/cities	**Addis Ababa**	11	11	11	11
	Adama	11	10	11	11
	Bule Hora	17	12	1	10
	Dire Dawa	12	11	9	11
	Jigjiga	11	11	12	11
	Semera	12	10	13	12
	Logia	12	11	12	12
	Bahir Dar	11	9	11	11
	Mekelle	0	7	12	7
	Gambela	3	7	7	6

Highlights of the results – Round 3

- Overall, there has been a decline in the practising of preventive methods. There appears to be fatigue with respect to the disease, and there are misconceptions related to COVID-19, particularly in terms of the severity of its effects – and even its existence (and regarding people who are asymptomatic) – which seems to have contributed to the limited practising of preventive measures. From our observational exercise (carried out by data collectors), compared to Round 2 and Round 1, it is less common to observe people wearing a facemask, maintaining a physical distance, and avoiding public gatherings in all of the cities.
- In this round, we also asked questions about the perceptions and acceptance of the COVID-19 vaccine among the participants. The vast majority (93.2%) said that they would accept the vaccine for themselves when it is available. Most participants strongly agreed or tended to agree that the vaccine is important, safe, effective, and compatible with their religious or personal values.
- Respondents without access to clean water nearby are struggling to wash their hands and to keep up with the required level of hygiene. The additional costs of accessing water compounds the economic impacts of COVID-19 on the urban poor.
- Healthcare workers reported that the absence of an adequate water supply is a major problem that hinders health service provision, and hygiene and sanitation practices in the health facilities (i.e. among patients and providers).
- The average monthly income of households significantly has increased from Ethiopian Birr (ETB) 2,301 in Round 2 to ETB 2,785 in Round 3, and the perceived risk of eviction due to loss of income has significantly declined from 46% in Round 1 to 12% in Round 3 (it was 14% in Round 2).
- The proportion of households who consume an average of three or more meals per day has significantly increased from 64% in Round 1 to 79% in Round 3 (it was 73% in Round 2). Similarly, the incidence of food shortage among households has improved in this round. However, despite improvements in the availability of food and the frequency of meal consumption, the qualitative diary interview respondents widely mentioned the poor quality of food and the absence of fresh fruit or vegetables.
- Only 55 respondents reported that they needed medical treatment, and of these, only 11.9% (six participants) said that they were not able to access medical treatment when needed (compared to 17.2% in Round 2 and 8.9% in Round 1).
- The proportion of respondents who reported feeling stressed due to COVID-19 and the response measures had significantly reduced from 58% in Round 2 to 36% in Round 3.
- Similarly, the proportion of respondents with symptoms of probable depression had reduced from 19.6% in Round 2 to 12.6% in Round 3.
- Only 27% of respondents had received COVID-19 assistance/aid during our data collection period for Round 3. The proportion of respondents who received support was higher Adama and Logia, and was lowest in Bahir Dar, Addis Ababa and Jigjiga. The provision of aid and support was found to be very low in Round 3, compared to that of Round 1 and 2.

Results by theme

Behaviour relating to COVID-19

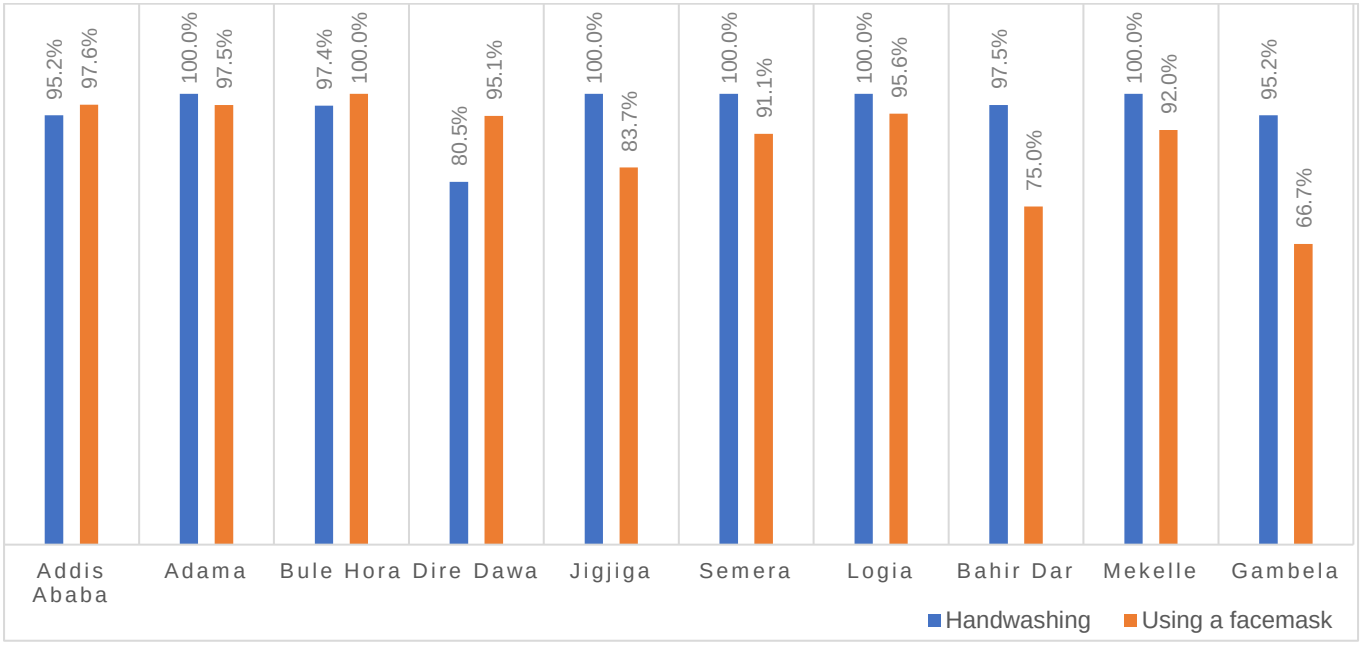
Key findings:

- Nearly half of the participants believe that they are no longer at risk of contracting COVID-19. Fatigue with the disease and the government regulations, misperceptions of the severity of the disease and its existence, limited enforcement of the government restrictions, and the lifting of the state of emergency seem to have contributed to the limited practising of preventive measures. Moreover, a lack of signs and symptoms among some COVID-19 cases has contributed to negligence relating to, and limited practising of, the preventive measures.
- Most participants agree that it is important, safe, effective, and compatible with their religious beliefs or personal values to get the vaccine if a new COVID-19 vaccine becomes available.

Only 50.5% of the participants believe that they could still be infected with COVID-19, and reported use of preventive measures was mixed, with increases in facemask usage and decreases in handwashing. Using facemasks and social distancing were the most common measures that our respondents reported to still be in place in their surroundings. In this round, 79.7%, 61.3%, and 90.5% reported that they were still practising handwashing, hand-rubbing with a sanitiser or alcohol-based solution, and using a facemask, respectively. The percentage of participants who are practising handwashing has significantly declined from 91.3% in Round 2 to 79.7% in Round 3. On the other hand, the use of facemasks has significantly increased from 79.2% in Round 1 and 78.8% in Round 2 to 90.5% in Round 3. These findings should be interpreted carefully as behaviours could be over-reported and influenced by social desirability bias. This is evidenced when respondents were asked about the preventive measures among family members: in this round, only 35.8% and 55% reported that all their family members complied with the movement restrictions and wearing a facemask, respectively; and only 44.5% said that all their family members practised social distancing.

Respondents from Addis Ababa and Adama were less likely to avoid crowded places compared to those from the other cities. Using hand sanitiser was found to be less common among respondents from Jigjiga, Semera, and Gambela (Figure 1). Moreover, avoidance of crowded places (chi-square = 7.238; p-value = 0.007) and social distancing (chi-square = 8.279; p-value = 0.004) were significantly associated with the gender of the participants.

Figure 1: Implementation of COVID-19 prevention methods among the urban poor in selected 10 cities in Ethiopia (n=380), Oct/Nov 2020



The decline in the practising of preventive methods was also reflected in the qualitative interviews. The decline in the practising of preventive methods appeared to be associated with fatigue with the disease, misperceptions of the severity of the disease and its existence, and limited enforcement of the authority. People also reported that they did not believe COVID-19 exists, or that its voracity had been overestimated:

> *People do not wear face masks. In addition to this, keeping social distance and chewing 'Khat' as well as gathering in different places are other examples. Also, church ritual programmes have begun where several people attend in one place. Previously restricted activities are now being exercised. For instance, burial and wedding ceremonies are being celebrated in communal. I have attended a burial ceremony after my friend's mother passed away. They [community] have forgotten the disease.* (Refugee, Semera)

> *... I was sitting with my mother in a taxi. The taxi attendant asked us to add one more person on our chair. I said, 'No, the chair is for two people and on top of that there is corona'. The taxi attendant didn't listen to us and he made us get out of the taxi. The passengers did not really mind being congested as much. If you disagree to add beyond its normal capacity, people even scorn you saying, 'Why are you so hard for this five min trip!'. The precautions I was taking in the early times have changed now, I have become reluctant these days.* (Returnee, Bahir Dar)

Similarly, key informants explained that the reduction in prevention practices was linked to the perception that the disease was not as severe as expected, and to a lack of trust in public communications about COVID-19:

> *The number of people who believe that the virus is disappearing is increasing. Some people who were previously diagnosed with the virus had no symptoms. As a result, the community believes that the disease is a lie and that the government is using it*

> *for a political gain. They also believe that the virus will not survive in tropical hot areas. As a result, no one is cautious now.* (Government official, Logia)

> *Since our last discussion, 44 people were diagnosed with corona and none of them showed signs and symptoms. As a result, many people started to develop an attitude that there is no disease called corona. Our people become reluctant on prevention measures. Currently, majority of the people are not using facemasks and wash their hands.* (Government official, Bule Hora)

> *What was done* [awareness creation] *to prevent corona was very good. Stopping it after the restriction was over, is wrong. Most people are saying it [COVID-19] does not exist anymore. When someone wears a mask, they say corona does not any more why would you wear a facemask?* (Government official, Bahir Dar)

> *I think negligence and mistrust are the reasons for not wearing facemasks. What else would it be! If we do believe in the existence of the disease* [COVID-19], *we would at least be careful for ourselves if not for other people. Nowadays, most people are saying that there is no corona; it is a lie and there is no corona disease at all. The public even mock on you when they see you wearing facemasks or try to protect yourself.* (Returnee, Bahir Dar)

In most of the interviews, it was repeatedly explained that awareness creation activities have been reduced and that they are limited to health facilities. A key informant from Gambela reported that the health bureau has acknowledged the problem and is working on strengthening activities intended to improve community awareness about COVID-19.

> *It* [practising of preventive methods] *is not like before, it has decreased. There may be negligence among the society about corona after different offices are opened. In my opinion the community lacks awareness, they are not wearing facemasks even in urban places. Health bureau of the region is working on awareness creation. Awareness creation began because there is a perception in the community that corona virus is gone.* (Government official, Gambela)

Moreover, some respondents associated compliance with preventive methods with the state of emergency. These respondents believe that the practising of preventive methods started to decline after the lifting of the state of emergency. In other words, the perception was that as the state of emergency had been lifted, the issue is no longer of concern:

> *People are not respecting government rules anymore. After the restriction stopped, everybody started going to recreational areas. Nobody keeps their social distance, neither wears their masks except for a few individuals. However, some places, such as banks and health facilities, people still follow the rules.* (Returnee, Bahir Dar)

> *To be honest, no one is afraid of the disease right now. Because of the government lifted the state of emergency restrictions, most people have completely stopped worrying and fearing the disease.* (Health worker, Addis Ababa)

> *The practice was good and community awareness was better. But now, I can say that more than 70% of the community is not taking preventive actions. Following lifting of the state of emergency, people have stopped it* [practising of preventive

> methods]. *No one is wearing masks in taxis, nor in the city. They are only wearing it if they are forced to. For example, if they are asked to wear a mask in a meeting, then they eventually wear it. People hold their masks in their pocket. No one is using sanitisers. People have already went back to the normal life.* (Government official, Bahir Dar)

It was mentioned that people use facemasks and wash their hands when entering banks and some government offices, like Ethio Telecom. The field observation data also show relatively good compliance at these facilities.

The above findings indicate that some people practise the preventive measures only so as not to be held accountable by the authorities for ignoring government restrictions. This finding was documented in the previous two rounds.

> *You know our people, they will practise things if you enforce it to them and if you don't, they won't do anything. The community is aware about the corona pandemic, but like I said, they only follow the measures if you build adequate trust and understanding. No one is following the measures and it might be due to the life situation.* (Government official, Bahir Dar)

A few respondents expressed some misperceptions regarding COVID-19. A respondent from Jigjiga reported that the COVID-19 pandemic is considered a punishment from God for the sins that the people have committed.

> *There are also some people who believe this pandemic is a curse from God and yet it does not exist in our country.* (IDP, Jigjiga)

In this round, we found no statistically significant difference in regard to practising handwashing (chi-square: 0.042; p-value: 0.979) using sanitiser (chi-square: 5.031; p-value: 0. 081), and wearing a facemask (chi-square: 3.470; p-value: 0.176) between the UPSNP beneficiaries, SSB group, and refugee/IDP groups. However, avoidance of crowded places was found to be more common among the UPSNP compared to the SSB and refugee/IDP groups. The discrepancy could partially be attributed to the gender of the participants. Most (69.4%) of the UPSNP beneficiaries are women. This finding is supported by a statistically significant association between the gender of the participants and the level of practising of some COVID-19 prevention methods.

The participants' level of compliance with movement restrictions (chi-square: 56.863; p-value: <0.00), wearing a facemask (chi-square: 31.452; p-value: <0.00), and social distancing (chi-square: 60.554; p-value: <0.00) were also all significantly lower in Round 3 than in Round 2.

We observed differences in the level of compliance with the COVID-19 prevention methods between the cities included in the study. A higher level of reported compliance with using a facemask and maintaining social distancing was found among participants from Addis Ababa, Bule Hora, Semera, and Logiya. None of the participants from Jigjiga reported using a facemask (Figure 2).

Figure 2: Compliance with COVID-19 prevention methods among the urban poor in selected 10 cities in Ethiopia (n=380), Oct/Nov 2020

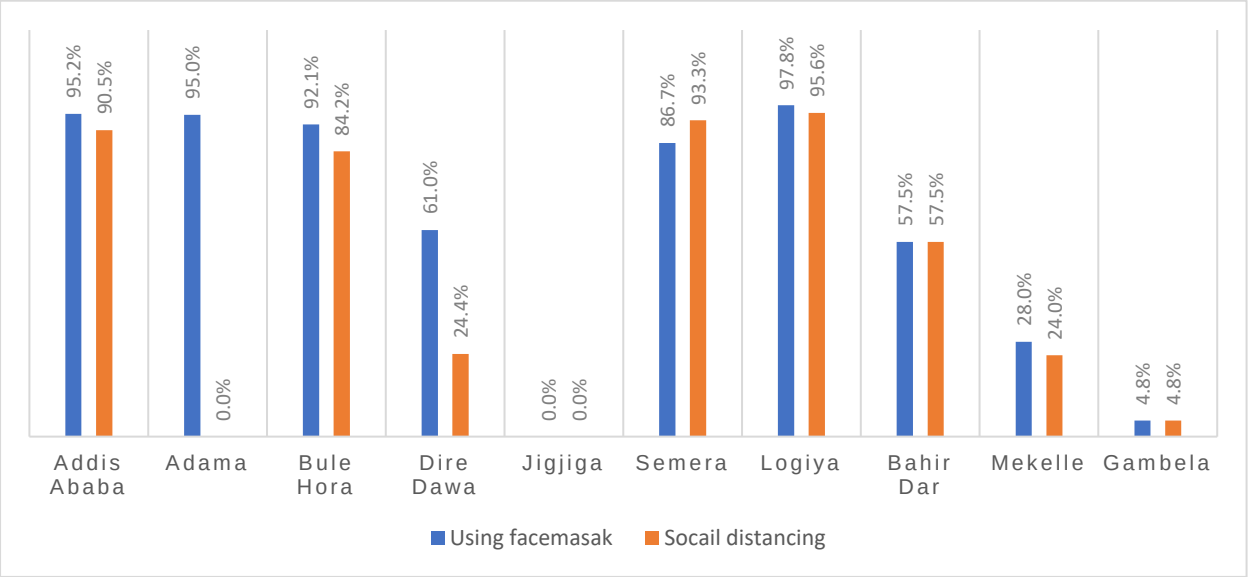


Table 2: The level of compliance with government restrictions among the urban poor in selected 10 cities in Ethiopia, Oct/Nov 2020 (total n = 380, UPSNP = 121, SSB = 137, IDPs/refugees = 122)

Characteristics	Respondent category			Round 3 total	Round 2 total	Chi-2 [p-value]
	UPSNP (%)	SSB (%)	IDP/Ref. (%)			
Compliance with movement restrictions						
A lot	51.2	35.0	42.6	42.6	54.8	56.86 [0.000]
Somewhat	35.5	43.1	34.4	37.9	29.9	
Not very much	8.3	9.5	7.4	8.4	3.5	
Not at all	5.0	12.4	15.6	11.1	11.8	
Compliance with wearing a facemask						
A lot	69.4	65.0	64.8	66.3	80.2	31.45 [0.001]
Somewhat	24.0	25.5	25.4	25.0	17.9	
Not very much	2.5	5.1	3.3	3.7	0.8	
Not at all	4.1	4.4	6.6	5.0	1.1	
Compliance with social distancing						
A lot	57.9	47.4	49.2	51.3	66.6	60.55 [0.000]
Somewhat	31.4	25.5	33.6	30.0	28.6	
Not very much	5.8	21.9	9.0	12.6	1.9	
Not at all	5.0	5.1	8.2	6.1	2.9	

Note: Null hypothesis for the chi-2 test: there is no difference in Round 2 and Round 3. We used the McNemar chi-square test for dichotomous variables and the Stuart-Maxwell test for other categorical variables. Bold: statistically significant at P-value <0.05

We are aware that self-reported data may be affected by social desirability bias, and therefore we also asked about compliance with different preventive measures by the respondents' family members and friends. Like the previous two rounds, the reported compliance rates among family members were significantly lower compared to the self-reported rates of their own behaviour set out above. Only 35.8% and 55% reported that all their family members complied with the movement restrictions and wore a facemask, respectively. Moreover, only 44.5% said that all their family members practised social distancing. There was also a statistically significant difference in the level of family compliance with movement restrictions (chi-square: 14.829; p-value: 0.005) between UPSNP beneficiaries, the SSB group, and IDP/refugee groups. The higher level of compliance with movement restrictions was found to be more common among the UPSNP group. Moreover, there was a slight difference in the family members' level of family compliance with the use of facemasks and social distancing between the three groups (

Table 2).

There was a significant difference in the level of family compliance with the COVID-prevention methods between the cities. A lower level of compliance with wearing a facemask among their family members was found among participants from Jigjiga, Gambela, and Bahir Dar.

Figure 3: Family compliance with using facemask all the time among family members of the urban poor in selected 10 cities in Ethiopia, Oct/Nov 2020 (total n = 380)

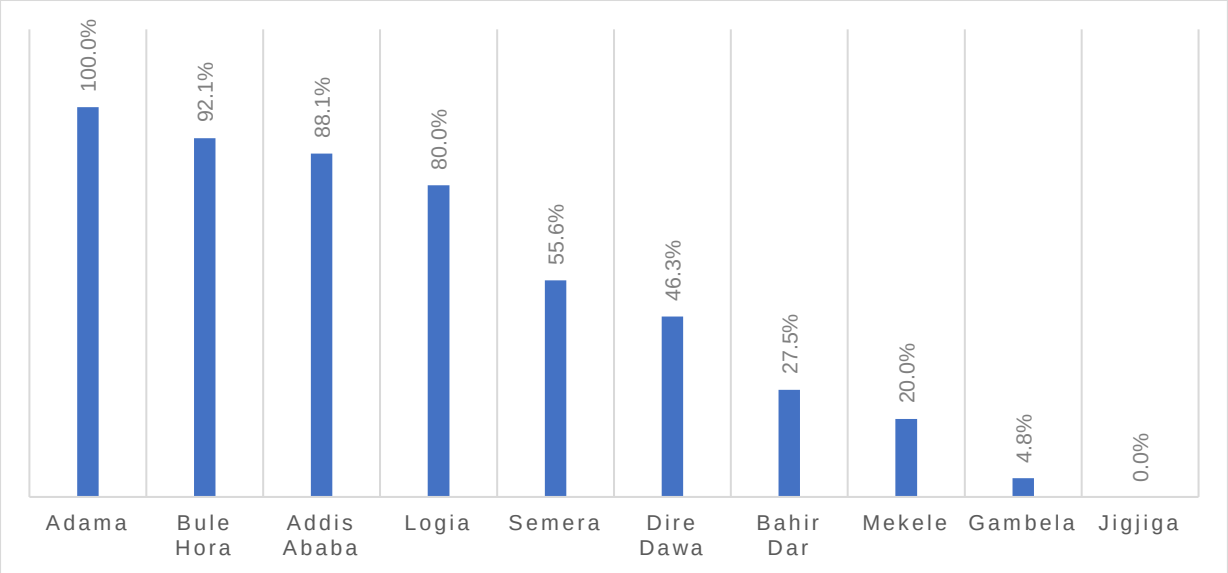


Table 3: Family compliance with government restrictions among the urban poor in selected 10 cities in Ethiopia, Oct/Nov 2020 (total n = 380; UPSNP = 121, SSB = 137, IDPs/refugees = 122)

Restrictions	UPSNP (%)	IDPs/refugees (%)	SSB (%)	Round 3 total (%)	Chi-2 [p-value]
Compliance by family members with movement restrictions					
None of them	11.6	19.0	22.1	17.6	14.829 **[0.005]**
Some of them	39.7	52.6	46.7	46.6	
All of them	48.8	28.5	31.1	35.8	
Compliance by family members with wearing a facemask					
None of them	5.0	6.6	7.4	6.3	8.650 [0.070]
Some of them	31.4	37.2	47.5	38.7	
All of them	63.6	56.2	45.1	55.0	
Compliance by family members with social distancing					
None of them	14.0	20.4	21.3	18.7	9.281 [0.054]
Some of them	30.6	38.0	41.8	36.8	
All of them	55.4	41.6	36.9	44.5	

Note: Null hypothesis for chi-2 test: there is no difference in the level of family compliance with movement restrictions, wearing a face mask, and social distancing among the three sampling categories. Bold: statistically significant at P-value <0.05

We also asked participants if they gathered with people other than their family members. About 42% reported having met with people outside their households, and more than half of these meetings (51.6%) were reported to happen at a religious gathering. This finding is similar to the finding from Round 1, where 53% reported meeting someone at a religious gathering.

In this round, we also asked participants about their **acceptance of a vaccine** that it is believed can protect them from COVID-19. **The vast majority (93.2%) said they would accept the vaccine for themselves,** and 92.3% reported they would accept the vaccine if it protected friends, family, and/or at-risk groups. Most participants strongly agreed or tended to agree that the vaccine is important, safe, effective, and compatible with their religious or personal values.

Table 4: Perceptions regarding COVID-19 vaccine among the urban poor in selected 10 cities in Ethiopia, Oct/Nov 2020 (total n = 380, UPSNP = 121, SSB = 137, IDPs/refugees = 122)

Restrictions	UPSNP (%)	IDPs/refugees (%)	SSB (%)	Total (%)	Chi-2 [p-value]
COVID-19 vaccine would be important					

Strongly agree	60.3	58.2	61.3	60.0	5.492 [0.704]
Tend to agree	35.5	40.2	100.0	36.1	
Tend to disagree	0.8	0.0	2.2	1.1	
Strongly disagree	0.8	0.8	1.5	1.1	
Do not know	2.5	0.8	2.2	1.8	
COVID-19 vaccine would be safe					
Strongly agree	38.8	45.9	48.2	44.5	**19.060 [0.015]**
Tend to agree	49.6	52.5	36.5	45.8	
Tend to disagree	4.1	0.0	5.1	3.2	
Strongly disagree	1.7	0.8	2.2	1.6	
Do not know	5.8	0.8	8.0	5.0	
COVID-19 vaccine would be effective					
Strongly agree	37.2	45.9	45.3	42.9	9.281 [0.054]
Tend to agree	50.4	51.6	38.7	46.6	
Tend to disagree	3.3	0.0	4.4	2.6	
Strongly disagree	1.7	0.8	2.2	1.6	
Do not know	5.8	1.6	9.5	5.8	
COVID-19 vaccine would be compatible with my religious or personal belief					
Strongly agree	47.1	52.5	54.7	51.6	9.155 [0.329]
Tend to agree	38.0	41.8	35.0	38.2	
Tend to disagree	6.6	4.1	5.1	5.3	
Strongly disagree	1.7	0.8	2.2	1.6	
Do not know	6.6	0.8	2.9	3.4	

Note: Null hypothesis for chi-2 test: there is no difference in the level of perceptions of the COVID-19 vaccine among the three sampling categories. Bold: statistically significant at P-value <0.05

WASH

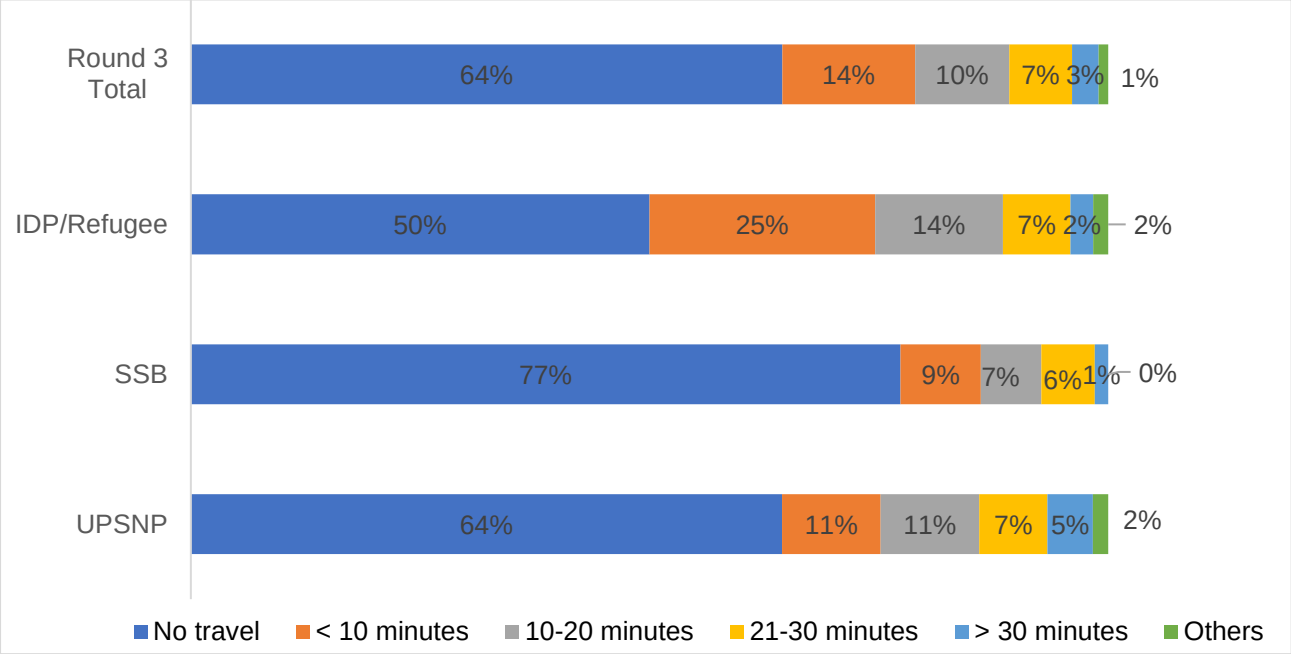
Key findings:

- The majority of respondents (64%) have access to a water supply from near to or inside their residence; however, 10% of respondents access a water supply at more than 20 minutes walking distance. Compared to the UPSNP and SSB groups, a higher proportion of respondents from the IDP/refugee category travel for more than 20 minutes to access a water supply.
- The economic burden associated with purchasing water and transporting it from the area where it is available to their homes remains a major challenge for the urban poor.
- Healthcare providers also mentioned the absence of an adequate water supply as a major problem that hinders health service provision.

Private piped water supply was found to be the main source of water for the majority of households from the UPSNP beneficiaries (61%) and SSB (81%) groups. IDP/refugee respondents obtained water through a mixture of sources, including private and communal piped water and a shower truck and spring (protected and unprotected).

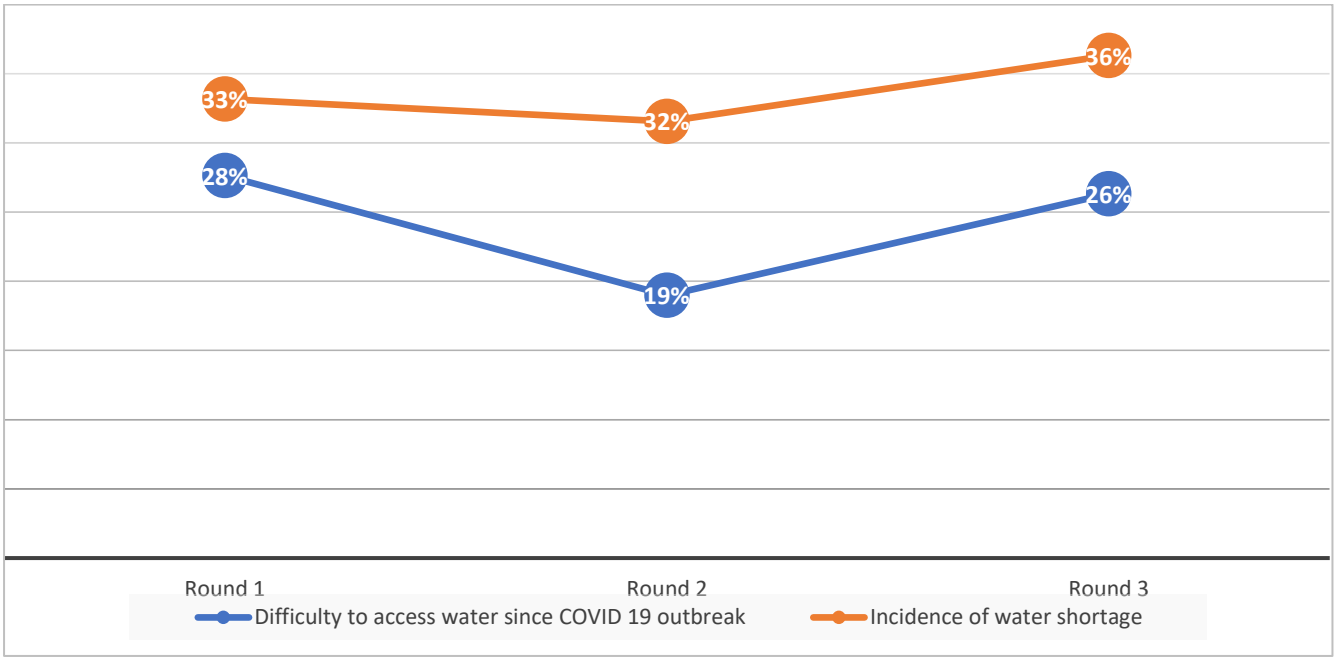
Most of the respondents (64%) had access to a water supply from near to or inside their residence. There was a statistically significant difference among the three categories regarding the level of access to a water supply (chi-square value = 29.2, p-value = 0.000). Compared to other categories, a higher proportion (50%) of respondents from IDP/refugees reported needing to travel to access a water supply (Figure 4). The results also showed disparity among the 10 cities. In Jigjiga, Bule Hora, and Dire Dawa a higher proportion of respondents were required to travel to access water supply. On the other hand, only a few respondents from Addis Ababa, Bahir Dar, and Logiya reported needing to travel to access a water supply (Annex A).

Figure 4: Distance travelled to access water supply/water point by households in selected 10 cities in Ethiopia, Oct/Nov 2020 (total n=380, UPSNP = 121, SSB = 137, IDPs/refugees = 122)



About 36% of respondents reported a shortage of water in the past one month (i.e. during Round 3), and there was no statistically different variation among the UPSNP group, the SSB group, and IDPs/refugees. Similarly, there was no statistically significant variation between Round 2 and Round 3 regarding the proportion of respondents who reported a shortage of water (Table 4). The average number of days of water shortage in the past month was 6.5 days (SD = 5.6) in Round 3, and 6.68 (SD = 5.2) in Round 2. This finding shows that there was no statistically significant difference between Round 2 and Round 3 (Figure 5).

Figure 5: Incidence of water shortage and difficulty of accessing a water supply among the urban poor in selected 10 cities in Ethiopia, Oct/Nov 2020 (total n=380, UPSNP = 121, SSB = 137, IDPs/refugees = 122)



Some of the qualitative diary interview participants mentioned inadequacy and interruption of the water supply during this round.

> *We have tap water in our yard, but the water comes once in a week, and only during the night-time. I can say that water shortage is a major problem in our village.* (Returnee from Bahirdar)

Some of the respondents, mainly IDPs and UPSNP beneficiaries, explained the problems related to price, inadequacy/shortage, and lack of cleanliness of the water supply as follows:

> *We don't have adequate water supply. The water we have is not for drinking. It is collected from a well and not suitable for drinking. We are in a great trouble as usual. It is not only this month, but also throughout the year... since the water distributed from the tanker is not clean and safe we are forced to buy from other sources.* (IDP, Dire Dawa)

> *The water distributed by the government using water tankers has been stopped. We do buy water from far away and get it delivered on donkeys' back. The payment for this has increased by two birr compared to the previous month* [Round 2]. (IDP, Adama)

Respondents also explained the burden and difficulty of accessing water due to interruptions of the water supply. They also mentioned the presence of a water pipe in their compound or nearby, but that the water supply remained irregular.

> *There is still shortage of water in our area…. We have water pipe in our compound, but the water supply is highly interrupted. Therefore, I fetch water from other places*

> *where water is available and bring the water by carrying on my shoulder. Nevertheless, the water we drink is cleaner than the previous times* [Round 1 and 2]… (UPSNP beneficiary, Logiya)

> *The water problem is worse than the previous month, because in the past, we have been using rain water, but now it is dry. Last time, we pay 10 birr for a jerican* [20 litre container]*, the cost is still the same.* (IDP, Jigjiga)

Similarly, some of the health professionals included in the KIIs described a shortage or absence of an adequate water supply as a major problem that hindered health service provision – mainly hygiene and sanitation practices in the health facilities (i.e. among patients and providers).

> *We have running water problem because the taps are not functional, so we can't get a water from a tap but we fill the containers we have because it is difficult to work without water in my department. Even mothers can't get water to take shower after delivery.*

On the other hand, the proportion of households who reported everyday access to a water supply had significantly decreased from 61% in Round 2 to 49% in Round 3. The frequency of access to water supply also showed a statistically significant reduction between Round 2 and Round 3 (chi-square value = 27.4, p-value = 0.000). There was also a statistically significant difference among the three categories of respondents in terms of the frequency of accessing a water supply (chi-square value = 26.9, p-value = 0.000). Similarly, a higher proportion (32%) of IDPs/refugees reported more difficulty in accessing a water supply compared to the SSB group (23%) and UPSNP beneficiaries (24%). The difference was significantly different across the three categories (chi-square value = 22.5, p-value = 0.000) (Table 5).

Among 36% of the main household survey respondents who reported a shortage of water during the past one month, 74% of them mentioned the inadequacy of the water supply as a major reason for difficultly in accessing water. Moreover, a considerable proportion of respondents also mentioned higher prices and transportation costs, water access being controlled, and sporadic availability of water as the main reasons for experiencing difficulty in accessing water (Figure 6).

There was also disparity in the level of water supply, and difficulty in accessing a water supply, among the 10 cities. A higher proportion of respondents from Adama, Gambella, Mekelle, Bule Hora, and Jigjiga reported difficulty accessing a water supply in the past one month (Figure 7). Similarly, qualitative diary interview participants from Adama, Jigjiga, Bule Hora, and Dire Dawa more frequently mentioned inadequacy of the water supply and higher prices and transportation costs of water as major reasons for experiencing difficulty in accessing water.

Figure 6: Proportion of households who reported difficulty accessing water among the urban poor 10 cities of Ethiopia during Rounds 1, 2, and 3 (n = 138).

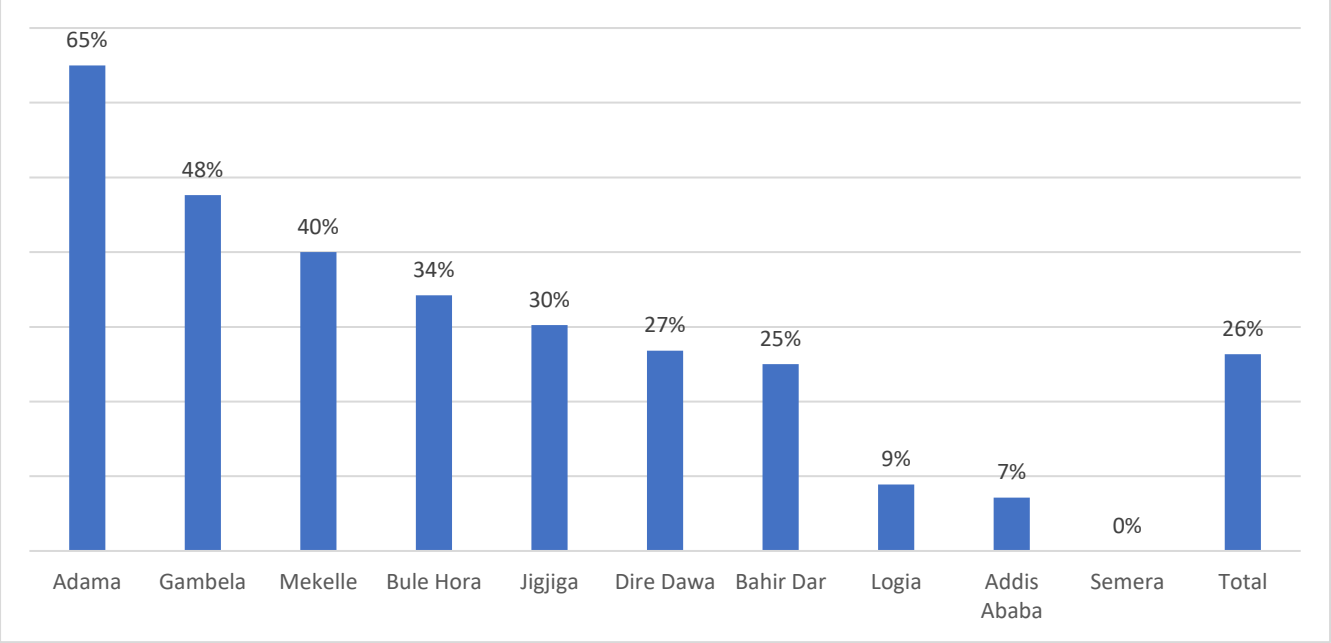
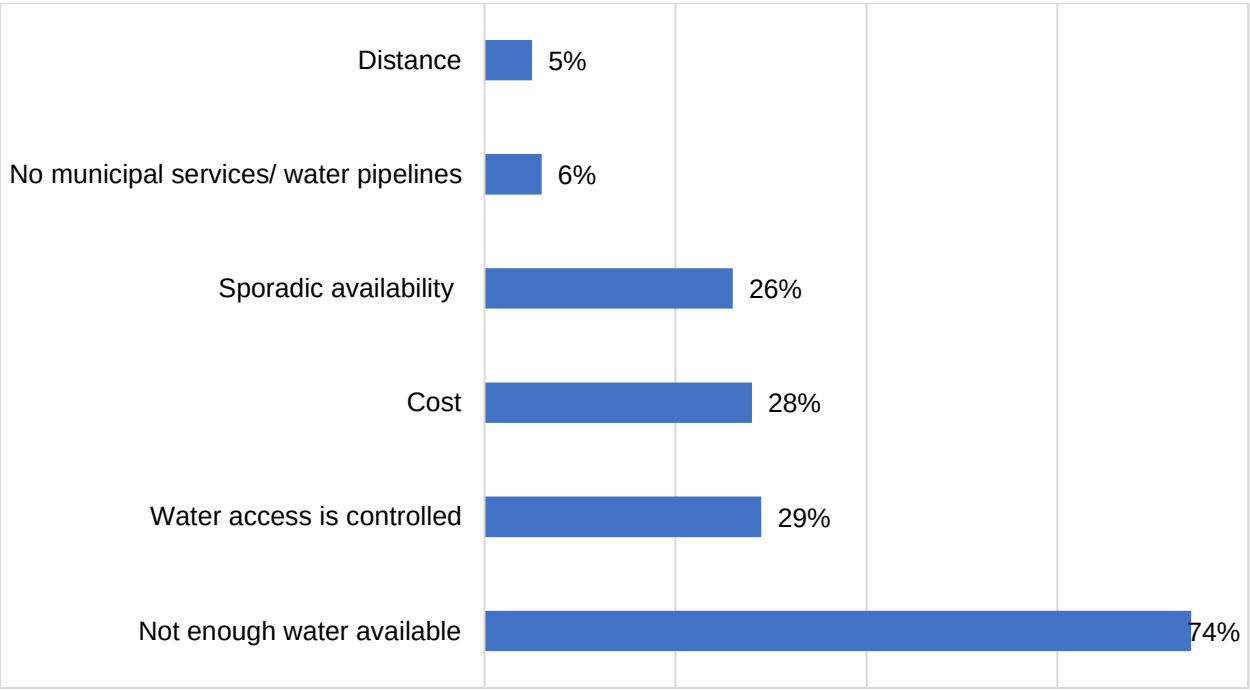


Figure 7: Major reasons for experiencing difficulty accessing water since the COVID-19 outbreak among the urban poor in selected 10 cities in Ethiopia, Oct/Nov 2020 (n = 138).



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

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

Table 5: Access to adequate water supply among urban poor households in selected 10 cities in Ethiopia, Oct/Nov 2020 (total n=380, UPSNP = 121, SSB = 137, IDPs/refugees = 122)

Characteristics/variables		Respondent category			Chi-2 [p-value]	Round 1 total (%)	Round 2 total (%)	Round 3 total (%)	Chi-2, p-value
		UPSNP (%)	SSB (%)	Refugee/ IDP (%)					
Shortage of water in the last one month	Yes	36	37	36	**0.08** [0.958]	33	32	36	**2.1** [0.147]
	No	64	63	64		67	68	64	
Frequency of access to water supply	Every day	50	46	51	**26.9*** [0.000]	52	61	49	**27.4*** [0.000]
	Once in a week	33	45	32		24	28	37	
	Once in two weeks	2	0	10		4	1	4	
	Other **	15	9	7		19	10	10	
Level of difficulty accessing water since COVID-19 outbreak	Much more difficult	7	5	21	**22.5*** [0.000]	10	3	11	**23.0*** [0.000]
	Slightly more difficult	17	18	11		18	16	15	
	Nothing changed	60	66	57		55	69	61	
	Easier than before	16	11	11		17	12	12	

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 2 and Round 3. We used the McNemar chi-square test for dichotomous variables and the Stuart-Maxwell test for other categorical variables.

Income and expenditure

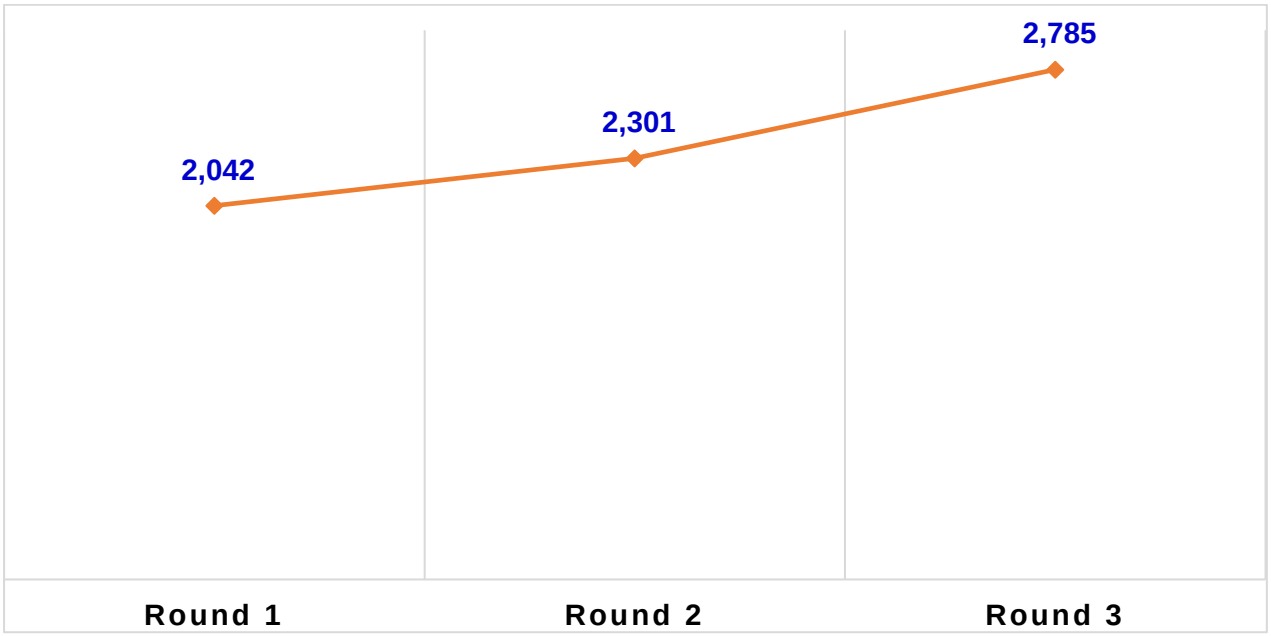
Key findings:

- The average monthly income of households has significantly increased from ETB 2,301 in Round 2 to ETB 2,785 in Round 3.
- The ability of households to earn income as they did before COVID-19 has significantly increased across the three rounds (64% in Round 1, 82% in Round 2, and 84% in Round 3).
- The perceived risk of eviction from their houses due to loss of income has significantly declined from 46% in Round 1 to 14% in Round 2, and to 12% in Round 3.

The average monthly income of households increased across the three rounds from ETB 2,042 in Round 1 to ETB 2,301 and ETB 2,785 in Round 2 and Round 3, respectively. The increase in income was statistically significant between Rounds 2 and 3 (with t = -3 and p-

value = 0.001) (Figure 8). The average monthly income varied across the three categories. The SSB group had the highest average monthly income (ETB 4,792), and the UPSNP beneficiaries had the lowest (ETB 1,600).

Figure 8: Average household monthly income of the urban poor in selected 10 cities in Ethiopia, Oct/Nov 2020 (total n = 380)



Similarly, the proportion of households that reported the ability to earn the same income as in the pre-COVID period increased across the three rounds (64% in Round 1, 82% in Round 2, and 84% in Round 3). The change between Round 2 and Round 3 is statistically significant, with a chi-square value = 57.6 and p-value = 0.000. However, there was no statistically significant difference among the UPSNP, SSB, and IDP/refugee groups in terms of their ability to earn the same income as they did before COVID-19.

The above result is supplemented by the qualitative findings, in which most of the diary interview respondents, particularly those from the IDPs and special groups, reported improvement in work opportunities and income during Round 3. Participants frequently mentioned that people's mobility had greatly improved following the lifting of restrictions on transportation and marketplaces (public gatherings), which enhanced economic activities.

Respondents also explained how a reduction in transport tariffs and the lifting of the restrictions positively contributed to their ability to move from place to place and to generate more income.

> *Compared to the previous months, it's much better now because we have begun to move from places to places freely. I have begun working for my former customers. … Glory to God!! The bad time has passed.* (Special group, Logia)

Another respondent, who sustains her life by working as a housemaid and washing clothes, said:

> *My work condition is now better. So is my income. My part-time housemaid work is better these days. Thanks to God. I have also started to work by going to people's*

> *houses. I wash clothes, carry out household chores and make/cook injera.* (Special group, Dire Dawa)

One of the respondents, whose income depends on her daily coffee sales, described the improvement as follows:

> *After the restriction are lifted our business is good. Previously only few people were coming. Now, almost all of our previous customers are coming to drink coffee. My coffee shop is open until 7:00 PM in the evening.* (Special group, Bahir Dar)

Like in Round 2, an increase in food item prices remained the major challenge to the urban poor in Round 3. Most of the participants described the impact of increased food prices and a higher cost of living as a threat to their family wellbeing. Some of the respondents mentioned the inadequacy of their income to cover their basic needs, such as house rent and food.

> *The price of food items is increasing every day. For instance, the price of one-unit* [amount that can serve a family for a day] *kocho/inset* [local food item which is used to make bread] *has increased from 25 Birr to 35 Birr in the past one month.* (UPSNP beneficiary, Bule Hora)

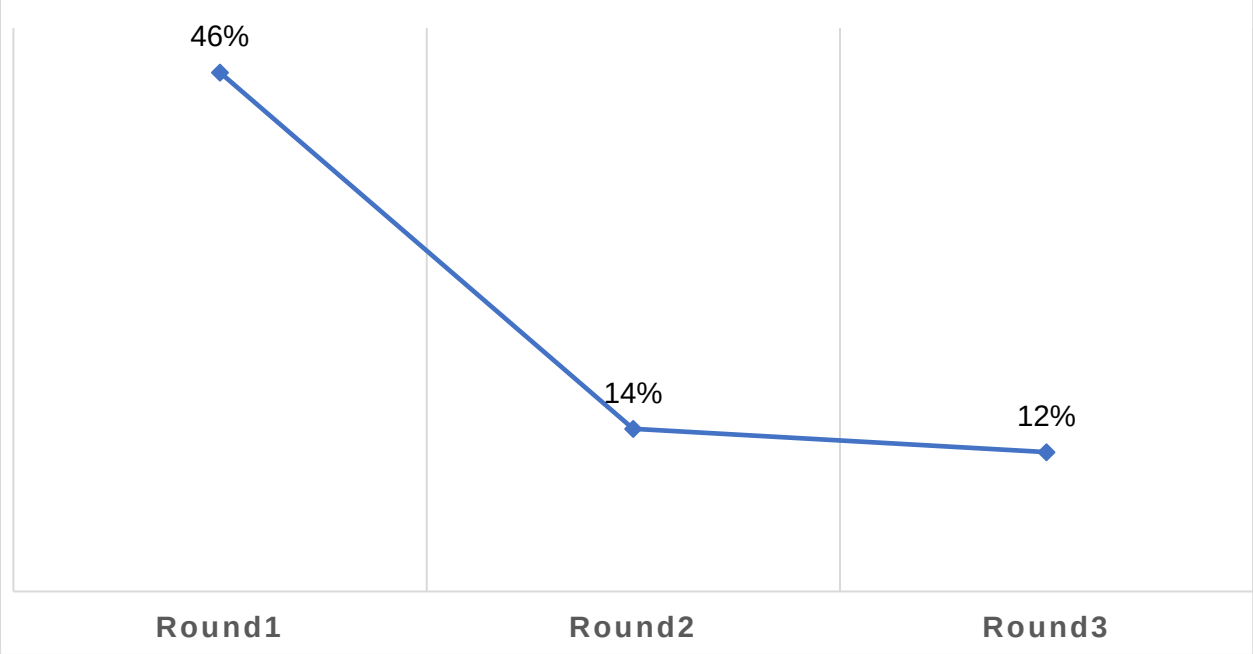
> *I was not able to pay the house rent during the past months, and I decided to rent small house with lower price…I searched for two months and I couldn`t find. The price of house rent is getting higher and higher in our area.* (Special group, Dire Dawa)

> *Everything is becoming more expensive. The price of food items has increasing from time to time. The price of fruits and vegetables gets higher when the road that connects Dire Dawa and nearby towns is closed by protesters around Aweday. Even today the roads are closed. My business is not profitable like that of the previous time.* (SSB group, Dire Dawa)

The perceived risk of eviction from their house due to loss of income had significantly declined from 46% in Round 1 to 14% and 12% in Round 2 and Round 3, respectively (Figure 9). The decrease in the risk of eviction between Round 2 and Round 3 is statistically significant, with a chi-square value = 88.6 and p-value = 0.000. The difference in the risk of eviction from home was not statistically significant among the UPSNP beneficiaries, IDP/refugees, and the SSB respondents.

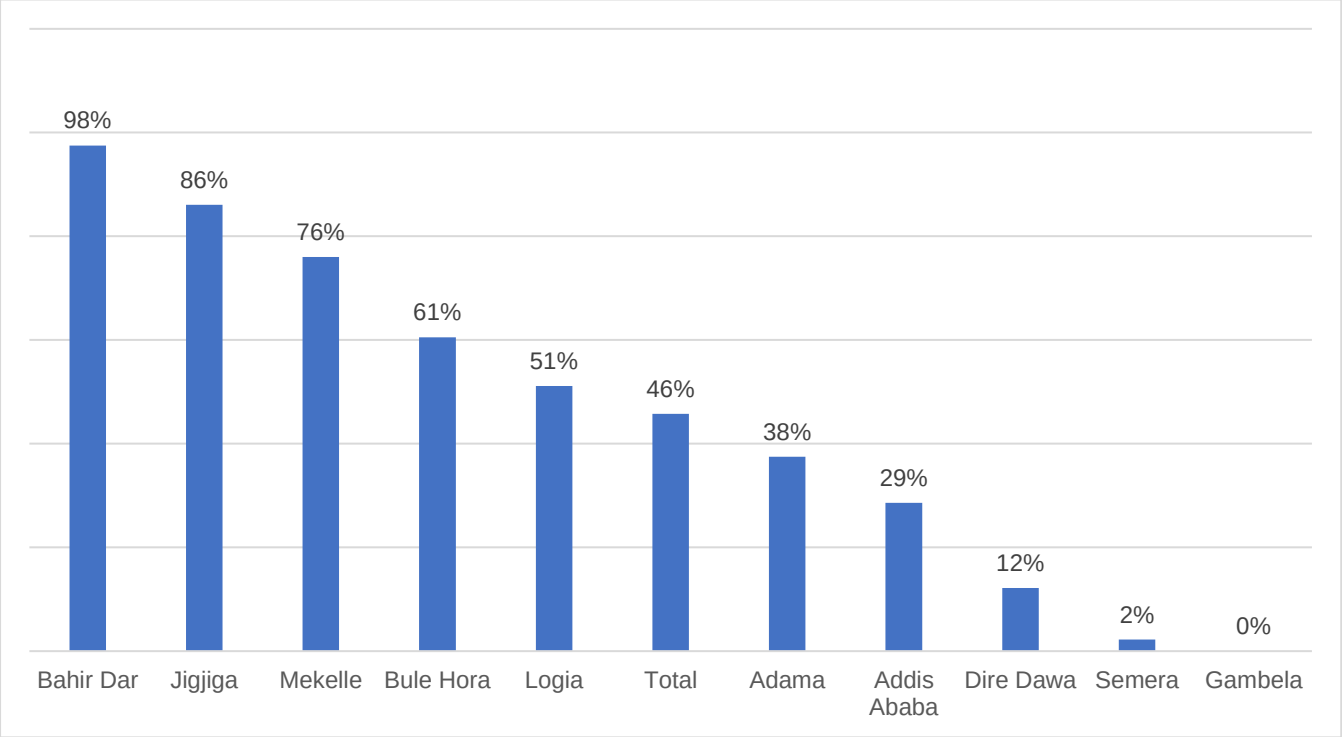
Only 2% of respondents (i.e. seven households from the three categories, SSB (three), IDP/refugee (three), and UPSNP (one)) reported being evicted from their house due to a loss of income (i.e. unable to pay the house rent) in the past month. Male-headed households reported a higher proportion (six out of seven) of evictions from their homes compared to female-headed households.

Figure 9: Risk of eviction from their house due to loss of income among the urban poor in selected 10 cities in Ethiopia, Nov/Dec 2020 (total n = 380)



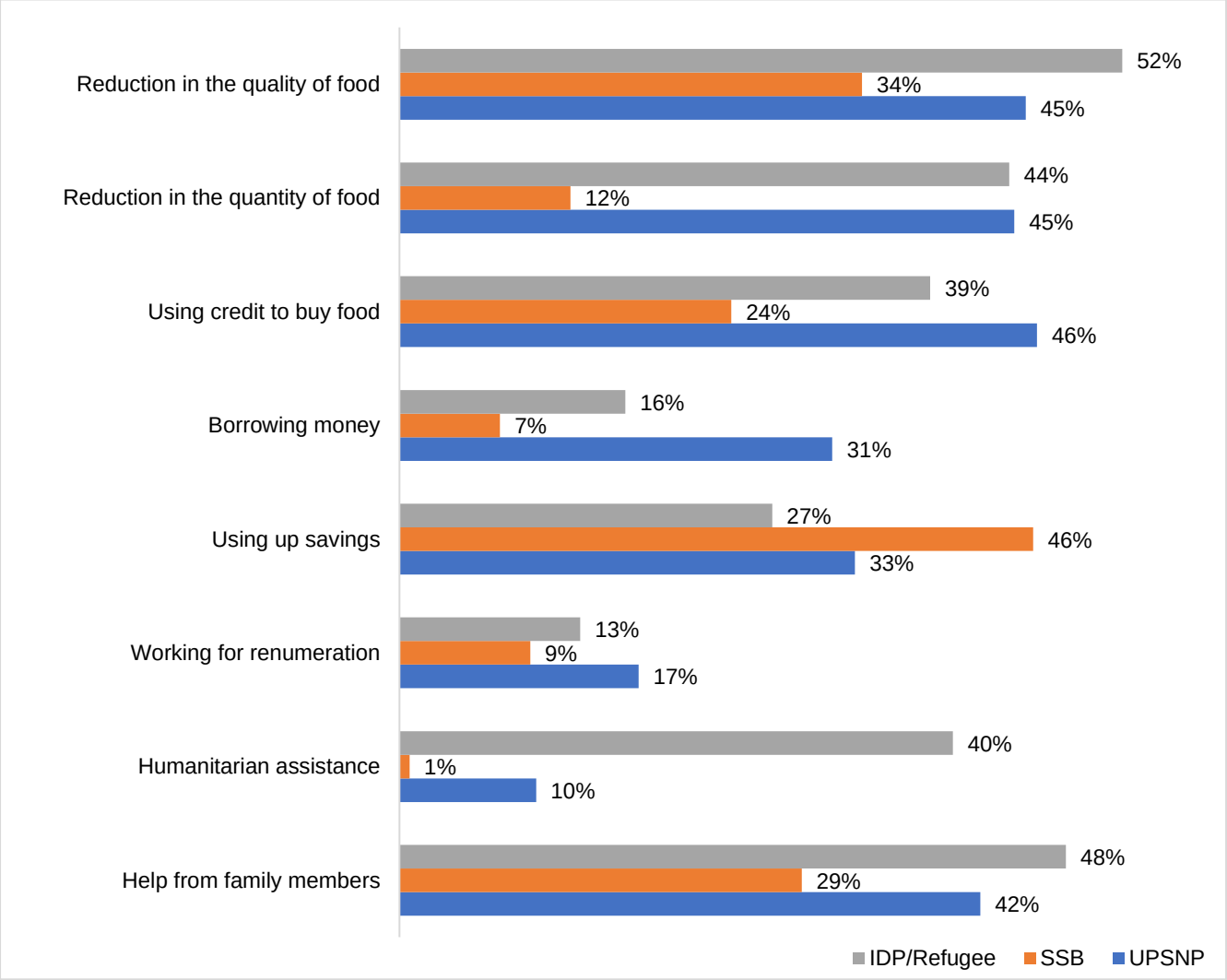
There was no statistically significant difference between male- and female-headed households in terms of reduced working hours and current ability to earn income in Round 3 (Annex B). There were disparities among the 10 cities, however. In Round 3, a higher proportion of respondents from Bahir Dar, Jigjiga, Bule Hora, and Logia reported cutting down their working hours and/or the amount of work. The proportion of households who reported being at risk of eviction was higher in Bule Hora, Jigjiga, and Mekelle, and was lowest in Dire Dawa, Semera, and Gambela (Annex A).

Figure 10: Proportion of respondents who reported having cut down their working hours since the onset of COVID-19 in selected 10 cities in Ethiopia, Oct/Nov 2020 (total n = 380)



Reducing the quantity and quality of food, using up savings, working for renumeration (i.e. *ad hoc* job/temporary work to earn additional income), and obtaining help from family members were widely mentioned coping mechanisms in Round 3 (Figure 11). The proportion of respondents who mentioned members of the family returning to work as a coping strategy increased from 7% in Round 2 to 20% in Round 3. On the other hand, the proportion of respondents who mentioned getting support from the community as a coping mechanism decreased from 22% in Round 1 to 13% and 9% in Rounds 2 and 3, respectively (Figure 12).

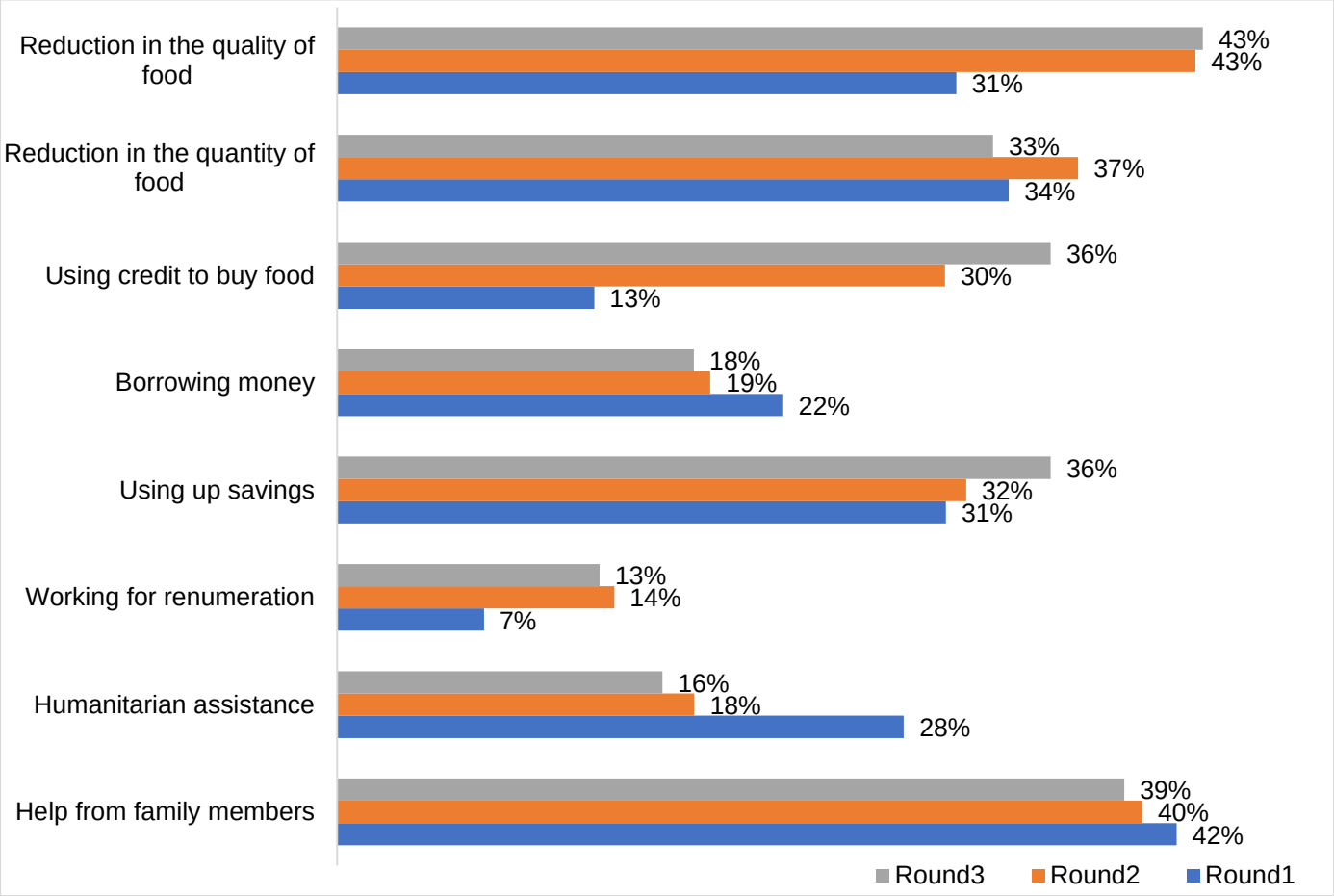
Figure 11: Coping mechanisms for reduced income one month before the survey among the urban poor in selected 10 cities in Ethiopia, Oct/Nov 2020 (total n=380, UPSNP = 121, SSB = 137, IDPs/refugees = 122)



Similarly to the previous round, diary interview participants mentioned several strategies to cope with the challenges of reduced income and inflation. The coping mechanisms broadly mentioned included asking for support from relatives, reductions in the quantity and quality of food consumed, purchasing less-preferred and cheaper food items, and using up savings.

> *We had to cut back on food. Except for our children, if we eat our breakfast, we skip our lunch and have dinner. And if we have our lunch late, we skip our dinner. This is a must to cope up with the situation we are in.* (IDP, Adama)

Figure 12: Mechanisms for coping with reduced income during Rounds 1, 2, and 3 among the urban poor in selected 10 cities in Ethiopia, Oct/Nov 2020 (total n=380, UPSNP = 121, SSB = 137, IDPs/refugees = 122)



Food security

Key findings:

- The proportion of households who consume an average of three or more meals per day has significantly increased from 64% in Round 1 to 73% in Round 2 and 79% in Round 3. Similarly, the incidence of food shortages among households has declined across the three rounds.
- Despite improvements in the availability and frequency of meal consumption, respondents widely mentioned the consumption of poor quality of food that are assumed to have poor nutritional value.
- The majority of respondents (75%) reported consuming teff, and white flour (63%). A small proportion of respondents reported the consumption of meat (14%), milk (12%), and eggs (9%), which are assumed to be highly nutritious and the most preferred foods items.

The proportion of households who consumed an average of three or more meals per day increased from 64% during Round 1 to 73% in Round 2 and to 79% Round 3. The change in the average frequency of meals consumed between Round 2 and Round 3 was also statistically significant, with a chi-square value of 72.2 at p-value = 0.000. The incidence of food shortages in households has declined from 54% in Round 1 to 43% in Round 2 and

38% in Round 3. The difference between Round 2 and Round 3 is statistically significant, with a chi-square value of 47.4 at p-value = 0.000 (Figure 13 and

Table 6).

The proportion of households who reported consuming three or more meals per day was highest among the SSB households, but the difference among the three categories was not statistically significant. A higher proportion of female-headed households (85%), compared to male-headed households, reported average consumption of three or more meals per day, nevertheless the difference is not statistically significant (Annex B).

The proportion of households who reported incidence of food shortages has declined from 33% during Round 1 to 23% in Round 2 and to 17% Round 3. The change between the current round and Round 2 was statistically significant, with a chi-square value of 49.9 at p-value = 0.000 (

Table 6). A relatively lower proportion of SSB households (9%) reported incidence of food shortages during the last month. However, there was no statistically significant difference among the three categories (

Table 6).

The incidence of food shortages was higher among respondents from Semera, Jigjiga, and Bule Hora (Figure 13). There was no difference between male- and female-headed households regarding the incidence of food shortages during last month (Annex B).

Figure 13: Incidence of food shortages during the last month among the urban poor in selected 10 cities in Ethiopia, Oct/Nov 2020 (total n=380, UPSNP = 121, SSB = 137, IDPs/refugees = 122)

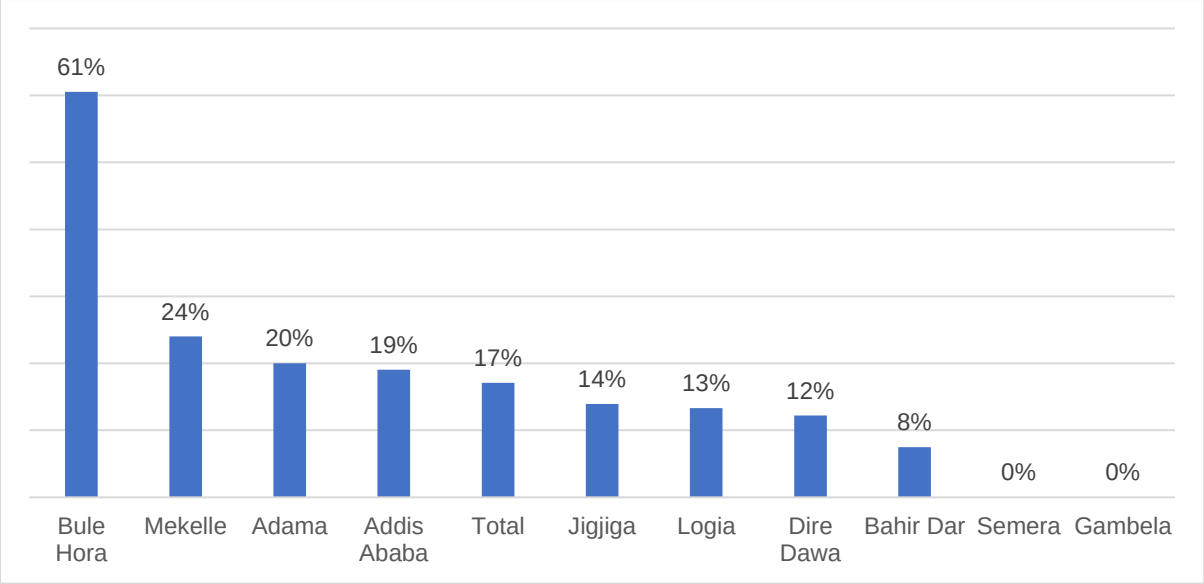
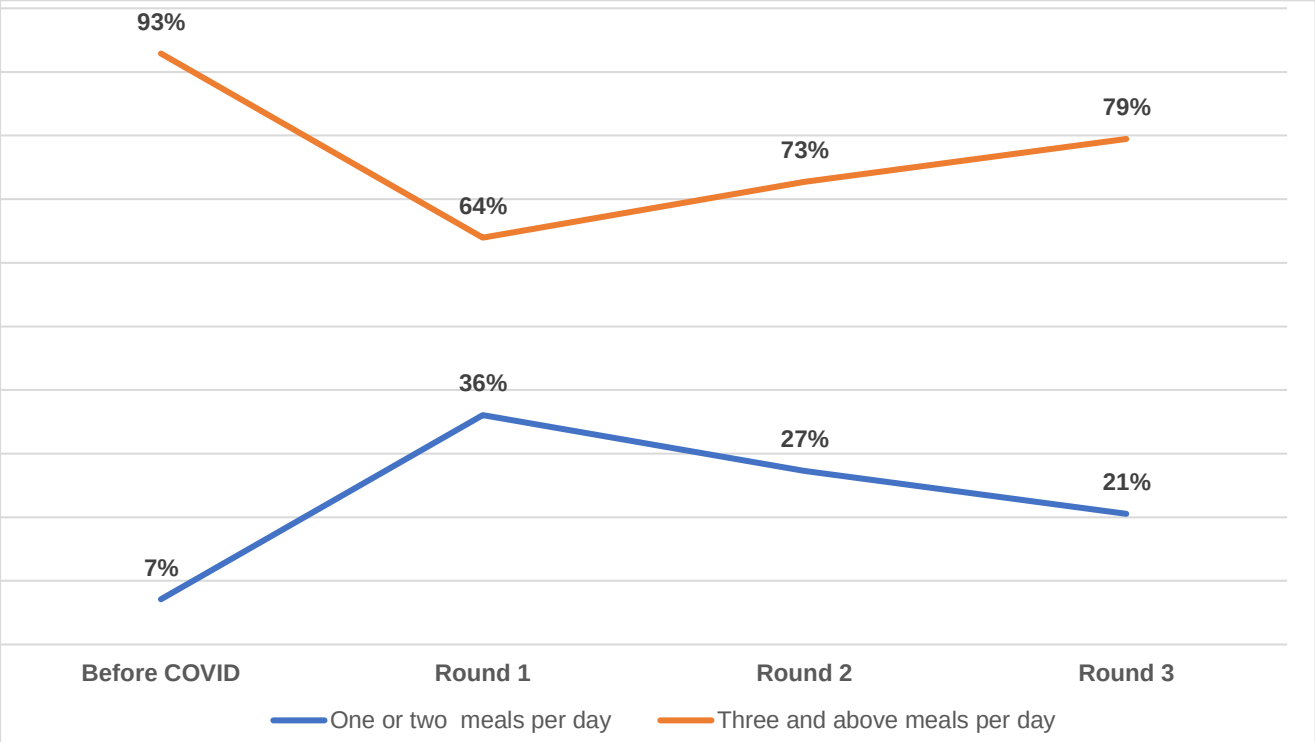


Figure 14: Average frequency of meals per day consumed by household members during the last month among the urban poor in selected 10 cities in Ethiopia, Oct/Nov 2020 (total n=380, UPSNP = 121, SSB = 137, IDPs/refugees = 122)

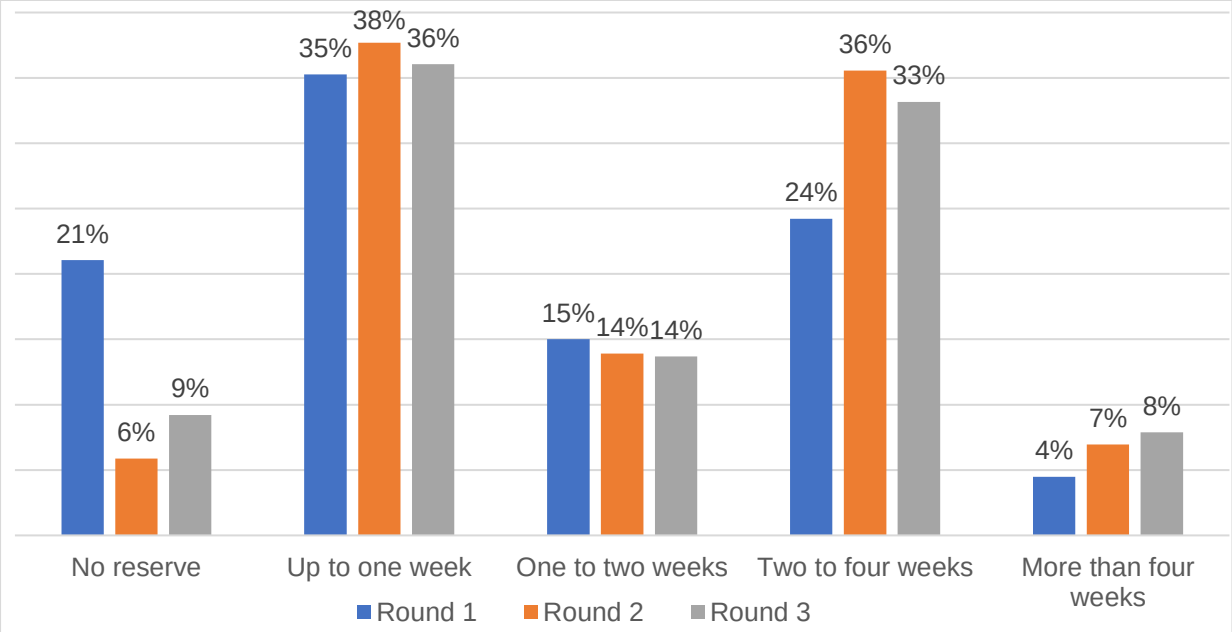


The availability of food reserves for future use has slightly decreased from 94% in Round 2 to 91% in Round 3 (see Figure 15); however, the difference is not statistically significant (Chi-square value of 16.6 with p-value = 0.083). The proportion of households with no food reserves was lower for SSB households as compared to UPSNP beneficiaries and refugees/IDPs. The incidence of food shortages was highest (61%) among IDP/refugee households, and lowest (17%) among households from the SSB category. The difference among the three categories was also statistically significant, with a chi-square value = 52.8 and p-value = 0.000 (

Table 6). It is worth noting that the circumstances of the three categories are very different. The SSB group are people who own small businesses and earn 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). This group earns a very small income (not adequate to cover their basic needs). 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.

In Round 3 there was no disparity among the 10 cities in terms of average frequency of meals consumed per day, incidence of food shortages, access to food in marketplaces, and availability of reserve food for future use (Annex A).

Figure 15: Availability of food reserves in the household among the urban poor in selected 10 cities in Ethiopia, Oct/Nov 2020 (total n=380, UPSNP = 121, SSB = 137, IDPs/refugees = 122)



Among 146 households that reported a reduction in the number of meals per day, we also explored the major reasons for the reduced food consumption. Lack of income and increased prices of food items were found to be the most predominant reasons (Figure 16).

The qualitative findings were in line with the quantitative survey results, where higher food prices, lack of income, and an increase in the cost of transportation were mentioned as the major reasons for food insecurity in general.

Figure 16: Reasons for reducing food consumption among the urban poor in selected 10 cities in Ethiopia, Round 3: Oct/Nov 2020 (total n=380, UPSNP = 121, SSB = 137, IDPs/refugees = 122)

In line with the quantitative results, some of the diary interview respondents from all categories described a shortage of food in their household due to unaffordable prices.

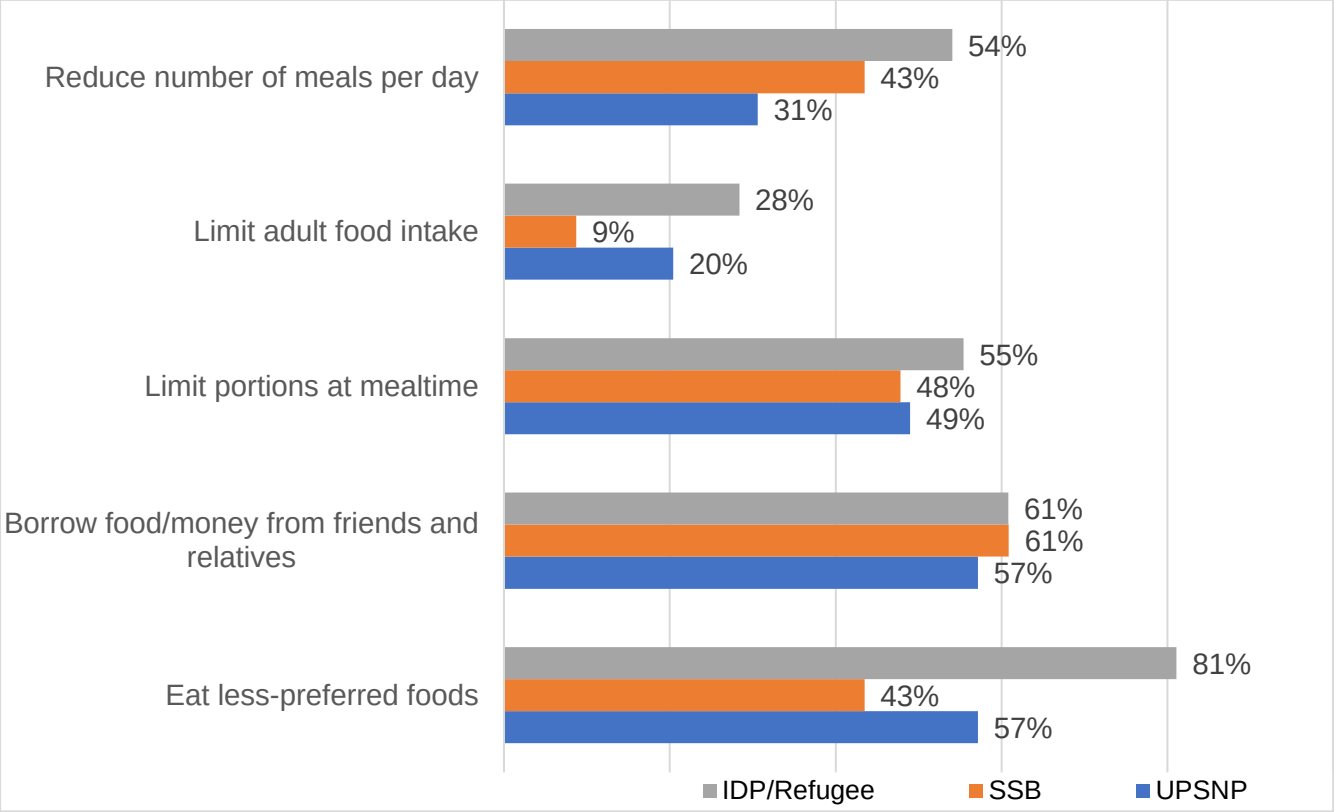
> *Sometimes it is difficult to eat three times a day due to lack of money to buy adequate food. There are circumstances when there is nothing to eat in our house…. the price of food getting more expensive, at the level which I can't afford. In our home, adult members of the family eat twice a day, and we provide food for children more frequently.* (Special group member, Semera)

> *We are suffering with shortage of food… the children cannot tolerate hunger… we keep leftovers and bread and give them when they cry.* (UPSNP beneficiary, Bule Hora)

> *There is no shortage of food in the market, but the price of food is still high. It is becoming to the extent which poor people can't afford. I am using white flour and rarely rice. I have almost stopped buying main staple food, or at least decreased buying the quantity of our staple food since we last spoke.* (Special group member, Semera)

Eating less-preferred foods and reducing the number of meals per day remained the predominant strategies for coping with food insecurity (unaffordability) during the past month. There was a slight variation in coping strategies among the UPSNP beneficiaries, SSB group, and IDP/refugee group (Figure 17).

Figure 17: Strategies for coping with reduced access to food among the urban poor in selected 10 cities in Ethiopia, December 2020 (total n=380, UPSNP = 121, SSB = 137, IDPs/refugees = 122)



Like the survey participants, the qualitative diary interview respondents predominantly mentioned **reducing the quality of food** (i.e. eating foods with less nutritional value and cheaper), reducing frequency of meals, and limiting adult food intake to cope with the shortage of food (food insecurity) due to unaffordability. The majority of respondents (75%) reported consuming teff, and white flour (63%). A small proportion of respondents reported consumption of meat (14%), milk (12%), and eggs (9%), which are assumed to be highly nutritious, and the most preferred foods items.

Table 6: Household food access, by respondent category and rounds, among the urban poor in selected 10 cities in Ethiopia, Oct/Nov 2020 (total n=380, UPSNP = 121, SSB = 137, IDPs/refugees = 122)

Characteristics/variables		Respondent category			Chi-2 [p-value]	R 1 (%)	R 2 (%)	R 3 (%)	Chi-2 [p-value] (R2 Vs R3)
		UPSNP (%)	SSB (%)	Refuge/ IDP (%)					
Average frequency of meals per day consumed by household members during the last month	Two or less	26	11	26	**16.0** [0.014]	36	27	21	**72.2** [0.000]
	Three and more	74	89	74		64	73	79	
Availability of food reserves	No reserve	10	8	10	**70.0** [0.008]	21	6	9	**16.6** [0.083]
	Up to one week	45	31	34		35	38	36	
	One to two weeks	12	11	18		15	14	14	
	Two to four weeks	31	32	36		24	36	33	
	More than four weeks	2	18	2		4	7	8	
Incidence of food shortages in the last one month	Yes	40	17	61	**52.8** [0.000]	54	43	38	**47.4** [0.000]
	No	60	83	39		46	57	62	
Reduction in number of meals per day after COVID-19	Yes	21	9	23	**6.9** [0.008]	33	23	17	**49.9** [0.000]
	No	79	91	77		67	77	83	

Note: Null hypothesis for the first chi-2 test: there is no difference among the three categories. Null hypothesis for the second chi-2 test: there is no difference in Round 2 and Round 3. We used the McNemar chi-square test for dichotomous variables and the Stuart-Maxwell test for other categorical variables.

Health

Key findings:

- In this round, the majority of participants or members of their families who needed medical attention reported having been able to access medical treatment. The fear of being infected with COVID-19 and being sent to quarantine centres was not the major reason for not attending health facilities.
- Overall, the results suggest that maternal and child health services utilisation has not been significantly impacted by COVID-19.
- Most participants are aware that people with underlying diseases like diabetes mellitus and hypertension are at increased risk of contracting the COVID-19. However, most of them are not aware of any measures in place to protect them from the pandemic.

In this round, only 55 respondents (14.5%) reported that they had needed medical treatment in the 30 days preceding the survey. Of these 55, the most common reason reported for needing medical attention was fever with a persistent cough or difficulty breathing (38.2%). Of this group, most (89.1%) said that they were able to access medical treatment when needed. The majority (93.2%) reported that they would definitely go to a health facility when needed in the future. In this round, only six participants reported that they were not able to access treatment when needed, and four of them reported financial constraints as the major reason for not accessing treatment.

In the previous two rounds, our qualitative interviews indicated fear of being infected by COVID-19 as the major barrier to health-seeking behaviour in the community. Health workers believe that fear of being infected by COVID-19 is no longer a barrier to health-seeking behaviour, and that most people in need of any medical attention go to their health facilities for treatment.

> *In the beginning there was fear of being infected and that's why they were not coming to health facilities, but currently there is no fear of being infected.* (Health worker, Semera)

> *The number of people coming to the health centre decreased following the COVID-19 pandemic. This was because people were somehow afraid of coming here due to fear of getting infected. But this has been completely changed ever since. …* (Health worker, Adama)

A few respondents, however, reported that there are still people who fail to visit health facilities when they think the symptoms they have are similar to those of COVID-19. It is possible that these people fear being quarantined if they are suspected of being infected with COVID-19. A relatively low level of the community awareness and weaker healthcare could partially explain the difference in health-seeking behaviour between the cities. One respondent from Gambela believed that the fear of being quarantined had resulted in decreased health-seeking behaviour.

> *I know many people who are afraid of visiting health facilities when they notice signs and symptoms of malaria, like fever, coughing, and the like. They say health centres focus on measuring our temperature level to diagnose corona.* (Returnee, Bahir Dar)

> *Number of outpatient care-seekers has decreased, because if they saw some symptoms of resembling to corona, such as cough and fever, they fear to come to health institutions. They fear not to get into isolation centres. Because of this reason, number of outpatient care case has decreased.* (Health worker, Gambela)

In terms of awareness of people who are more vulnerable to COVID-19, 67.6%, 60.3%, and 27.9% of the respondents believe that older people, people with chronic diseases, and children, respectively, are more vulnerable to COVID-19 compared to other groups. About 21% of respondents believe that there is no difference in the level of vulnerability to COVID-19 across different groups. About 22% (70 participants) believe that there they have at least one family member vulnerable to COVID-19.

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

> *People with chronic illnesses like diabetes, blood pressure, asthma, and old people etc. are more vulnerable to COVID-19. My mother is hypertensive and have heart problem. She is more vulnerable to the pandemic. Therefore, she practises preventive measures like frequent hand washing with soap, not shaking hands, using facemask, and stay at home. She also has drugs at home, which she uses when needed.* (Refugee, Semera)

Only 17 participants (24.3%) reported that they were aware of any measures in place to protect vulnerable people from COVID-19. On the other hand, health workers explained that necessary measures are being taken to protect people with chronic diseases from being infected with COVID-19.

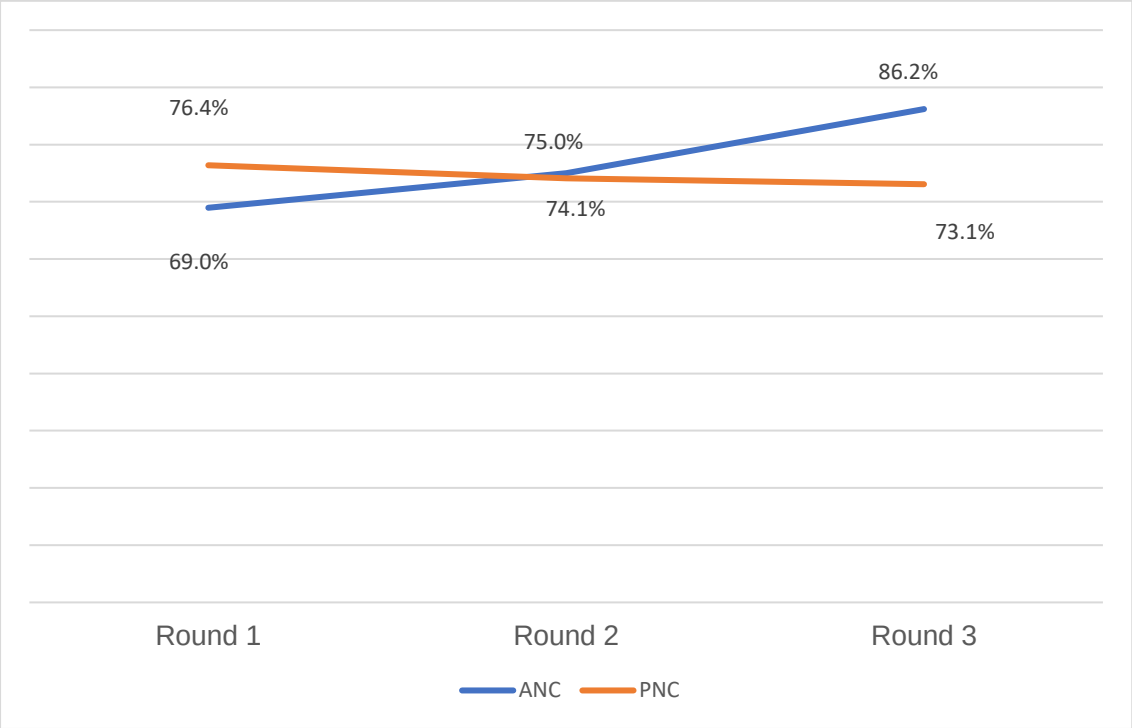
> *There is a separate outpatient department for clients with chronic illness. Though they are vulnerable to COVID-19, we are working on awareness creation to protect them. We advise them to wear facemasks always and to take care of themselves. The hospital is working on providing services with better quality and minimum waiting time, there is no time to waste in this case.* (Health worker, Gambela)

Only 49% (191 households) of the total household sample had children under five years old. Respondents were asked if any children under five in their family had been sick in the 30 days prior to the Round 3 interview. Only 17 respondents (8.6%) reported that there was at least one child under five who was sick, and almost all (16) respondents reported taking their child to a health facility for treatment.

Respondents were also asked if any of their children under five years old were diagnosed as malnourished. In this round, only 15 (7.6%) participants reported that their children were reported to have been diagnosed with malnutrition by health workers, which is lower than the 12.2% found in Round 2. This figure is slightly higher compared to the 5.7 national average of the prevalence of acute malnutrition in urban areas in Ethiopia, which could be attributed to the fact that this study is being conducted among the most disadvantaged segment of the urban population. All 39 children who had an appointment and were eligible for vaccination were reported to have been vaccinated.

There was no statistically significant difference in the access to antenatal care (ANC) and postnatal care between Round 2 and Round 3. The level of access to ANC increased from 69% in Round 1 and 75% in Round 2 to 86.2% in Round 3, and the difference was statistically significant. About 20.5% of our household sample included lactating women (78 households), of which 73.1% had accessed postnatal care. About 29% of the total household sample in this round included women of reproductive age reported to be using a method to avoid or delay pregnancy a month before this round, which is slightly lower than Round 2 (36.6%).

Figure 18: Uptake of ANC and postnatal care among the urban poor in 10 cities in Ethiopia, Oct/Nov 2020



The qualitative findings also suggested no – or only a small – effect of COVID-19 on caregivers' treatment-seeking behaviour for children under five, for child vaccinations in their community, and for maternal health service uptake, including ANC, postnatal care, and family planning.

> *Services of antenatal and postnatal are going as usual. Children who got birth here are getting vaccines.* (Health worker, Gambela)

> *There are four pregnant women around my residence. No they didn't face any problem. They come and served by the health extension worker by keeping their own distance. They get the service at a separate place. At the backyard of the health centre.* (Special group, Addis Ababa)

> *My neighbour is using family planning method. She was advised not to get pregnant in a short period of time. I see her going to the health facility and receive the medication.* (SSB group, Semera)

Education

Key findings:

- Parents and caregivers want children to be in school and are committed to children's learning, but are unable to provide them with home schooling due to their economic condition or their own illiteracy.
- Children mostly spend their time playing and helping their family. Only a small proportion spend their time studying.
- There is less educational materials and PPE support for students.
- Mothers are the primary caregivers of children during school closures.

Over 60% of the total households (230) had at least one child attending primary or secondary education before schools were closed due to COVID-19. Of these, 61.3% and 69.6% of the households reported their female and male children, respectively, had been attending elementary school. Thirty-eight of 230 participants (16.5%) reported that there were girls who were attending secondary school in their household, and, of those, nine participants reported more than one girl. Similarly, 42 (18.2%) participants reported the presence of one or more boys who were attending secondary school before COVID-19 in the household. In previous rounds 14 early child marriages were reported. In this round no child marriages were reported.

Like the previous rounds, we asked about how children were spending their time during the COVID-19 pandemic. Most (77%) and 65.2% of participants reported that their children helped them with routine/daily activities and played around the neighbourhood, respectively. Overall, there was no statistically significant difference in students' time use between the three groups of participants (UPSNP group, SSB group, and IDPs/refugees). However, school-children from the IDP/refugee group were reported to be more likely to spend their time playing around their neighbourhood (chi-square: 6.67; p-value 0.036) compared to students from the other two groups. The percentage of participants who reported that their children spent their time reading books for the last month significantly increased from 35% in Round 2 to 77.8% in Round 3 (chi-square 41.09: p-value <0.001). This finding is partially explained by the re-opening of schools in some cities (Bahirdar, Logiya, and Semera).

In line with the quantitative findings, most diary participants in all categories also frequently mentioned that their children spend their time playing with other children, watching TV, and helping their families.

> *I have one son and two daughters. My son is 13-year-old, the girls are 17 and 15. My children were used to play and watch movies for the last month due to school closure.* (Special group, Jigjiga)

Regarding engagement of children in income-generating activities, only a few participants from the special group reported that their children worked on household activities in their relatives' houses – not to receive money but to receive meals like breakfast and lunch.

> *In the last month, my children have spent their time playing tennis and work home activities in relative house in order to secure their meal* (Special group, Addis Ababa)

In the qualitative study, none of the diary participants reported having observed an early/child marriage in their families or in a setting they were living in, due to the school closure. Likewise, key informants from NGOs also reported that they had not heard about early marriage due to school closure in the settings they were working on. However, they reported some government reports on early/child marriage. Only one key informant interviewee from a government organisation in Gambela reported increased early marriage due to school closure:

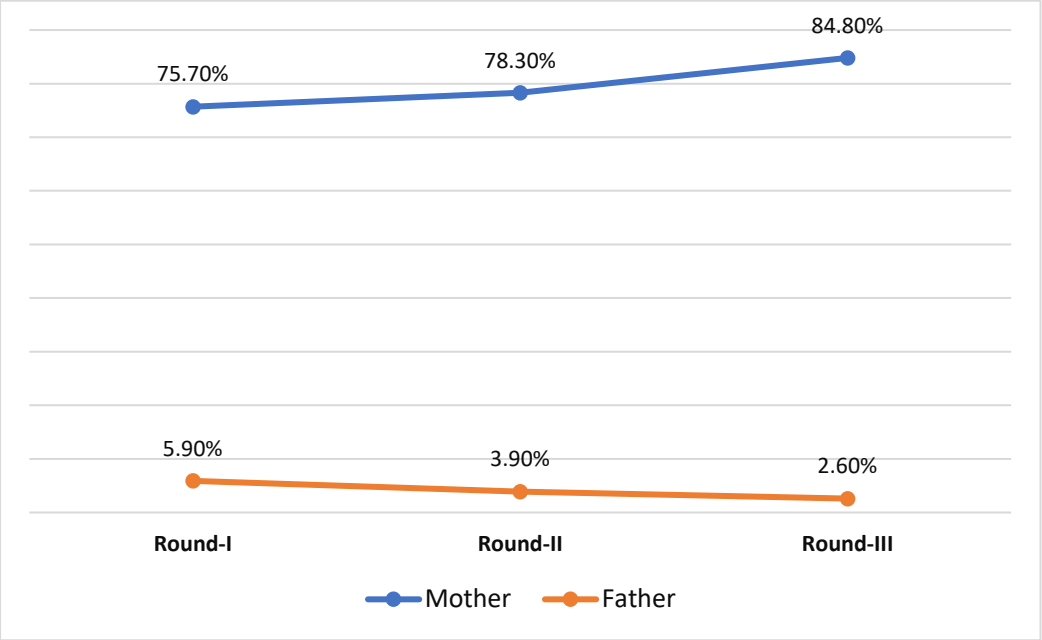
> *Regarding education, a school around where I reside was closed as a result there was large number of early marriages. Students staying at home resulted economic burdens. Because of economic problems families let their kids to marry at early ages.* (Government official, Gambela)

Table 7: Time use among children from the urban poor in 10 cities in Ethiopia, Oct/Nov 2020 (total n=230, UPSNP = 77, SSB = 85, IDPs/refugees = 68)

Characteristics	Respondent category			Round 3 total	Round 2 total
	UPSNP (%)	SSB (%)	IDP/Ref. (%)		
Time use among children					
Help their family	77.9	74.1	79.4	77.0	76.9
Study	77.9	77.6	77.9	77.8	35.0
Play around the neighbourhood	64.9	56.5	76.5	65.2	64.5
Stay at home, watch TV/movies, and play games	45.5	57.6	39.7	48.3	38.2
Engaged in income-generating activities	18.2	17.6	23.5	19.6	13.5

As shown in Figure 19, most of the respondents (84.8%) reported that mothers were the primary caregivers during the school closure, which was similar to the findings from Round 1 and Round 2. The responsibility of mothers to take care of the children has increased in each round, while the responsibility of fathers and siblings has decreased. In general, the difference was statistically significant (Pearson chi-square: 22.7549; p-value = 0.012). In Round 3, there was no difference among the three categories (UPSNP beneficiaries, SSB group, and refugees/IDPs).

Figure 19: Childcare responsibility among the urban poor in 10 cities in Ethiopia, Oct/Nov 2020 (total n=230)



Similar to the quantitative findings, most participants in the diary interviews reported that mothers are the persons with primary responsible for looking after their children. A few others reported that fathers and relatives also engaged in taking care of the children. A few diary participants from the special group (day labourers) reported that siblings helped care for the children, and that parents let the children stay at home alone when the parents went to work.

> *I prepare their food and water and leave them alone at home. They can stay alone without any other person. They also keep the house. I have no worry to leave them alone.* (Special group, Dire Dawa)

In the qualitative study, we also asked the diary interview participants about school re-opening and support for educational materials. Most participants reported that the schools had not opened yet, but they had got information about the re-opening of schools in the near future from the media and schools. One participant from the IDP group mentioned the schools re-openings as follows:

> *We have registered our two sons to school. But the school have not yet began providing education, thus we are waiting on them to start education. At times I am feeling okay, I try to help my sons study some basic literacy lessons.* (IDP, Adama)

A few participants described how their children were just sitting at home without schooling, hearing about the COVID-19 pandemic, some internal political situations, and economic problems. This may be psychologically traumatising for children. Therefore, they mentioned their hope for an early school re-opening. One participant from a special group in Addis said:

> *I am sad when I heard the extension of school re-opening by television. It darkens your day. Once we suffer from Corona and then lack of peace and security comes. Everything is worrying… I am praying to God to have school opening as early as*

> *possible. Their mind [her children] might not be good if they stay at home without schooling. I urge to open the school as early as possible.* (Special group, Addis Ababa)

A few participants from the special group and UPSNP group who sent their children to a private school before the COVID-19 pandemic mentioned the unaffordability of private schools, and their limited capacity to fulfil what was needed for their children in terms of schooling:

> *We pay 400 birr per month even though the children go to school only 12 days in a month. Since I can't afford to pay 400 birr per child this time, my children are not going to private school as before. So, I want them to switch from private to public school.* (Special group, Logia)

> *There are things that worry me very much, like school payment; they also need to take lunch and supper to school [private school]. This is what worries me very much. Thus, I can't send them now.* (UPSNP, Bule Hora)

Regarding support for educational materials, with the exception of some IDPs/refugees, most SSB and UPSNP diary interview participants reported a lack of educational materials support.

> *I went to school and told them that we heard from TV that students at government schools will receive educational materials, masks, and sanitisers, but my child did not receive any of these materials. But they didn't give us, I had to buy both exercise books and masks by myself.* (Special group, Dire Dawa)

However, a few refugees reported support for PPE for school-children.

> *I have two daughters attending school in the house. Recently, they have registered in school, and they have received facemasks but they haven't started school yet. The school system has been set to be given in shifts; therefore, they are waiting until the shift schedules are posted.* (Refugee, Logia)

Some key informants from government offices mentioned that they had distributed educational materials only for orphans but that they will now distribute masks for all as per the government direction.

> *The government sectors at district level are working in collaboration with associations and we are distributing education materials like exercise books, pen and pencil etc… for 320 orphans.* (Government official, Semera)

In conclusion, education for urban poor children has been neglected but schools are finally re-opening, although several measures and trainings need to be put in place first, in order to ensure that schools can be opened safely. This has caused some delays and parents are getting more and more desperate for their children to go back to school.

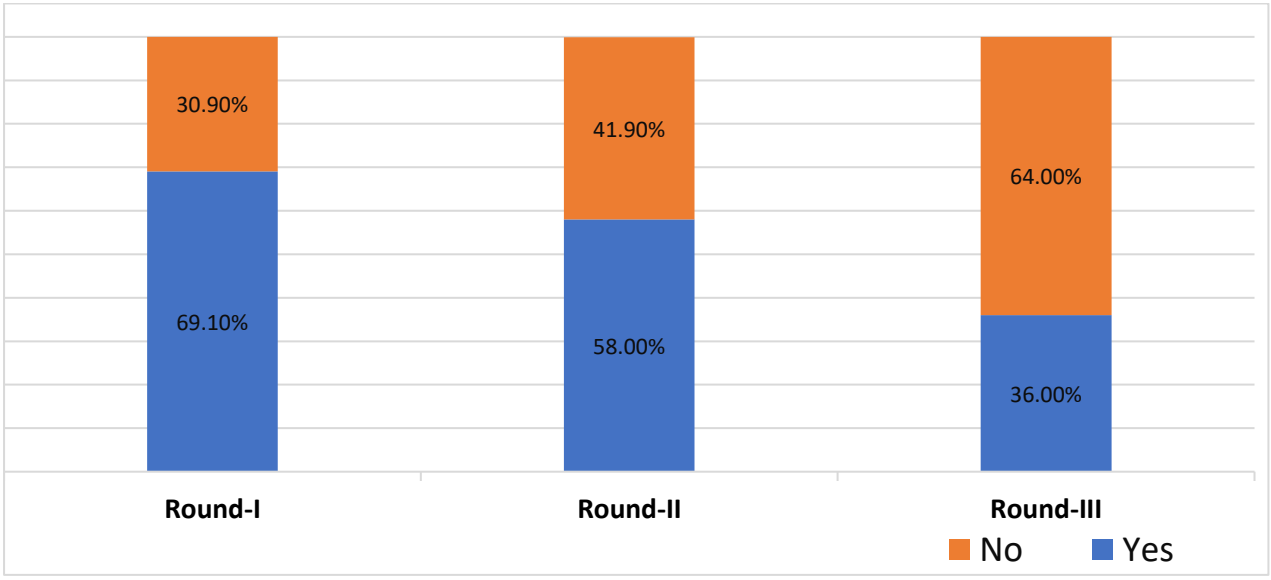
Mental health

Key findings:

- The proportion of respondents who reported feeling stressed due to COVID-19 and the response measures has significantly declined, from 58% in Round 2 to 36% in Round 3.
- Similarly, the proportion of respondents with symptoms of probable depression has declined from 19.6% in Round 2 to 12.6% in Round 3.

About 36% of respondents reported that they had had feelings of being stressed, scared, and frustrated in the past one month: this finding is much lower than in Round 2 (58%) and Round 1 (69%) (Figure 20). The difference between Round 3 and Round 2 is statistically significant, with the chi-square value of 66.9 at P=0.001. However, there was no statistically significant difference among respondents from the UPSNP, SSB, and refugees/IDPs categories.

Figure 20: Feelings of being stressed, scared, and frustrated among respondent categories among the urban poor in selected 10 cities in Ethiopia, Oct/Nov 2020 (total n=380, UPSNP = 121, SSB = 137, IDPs/refugees = 122)

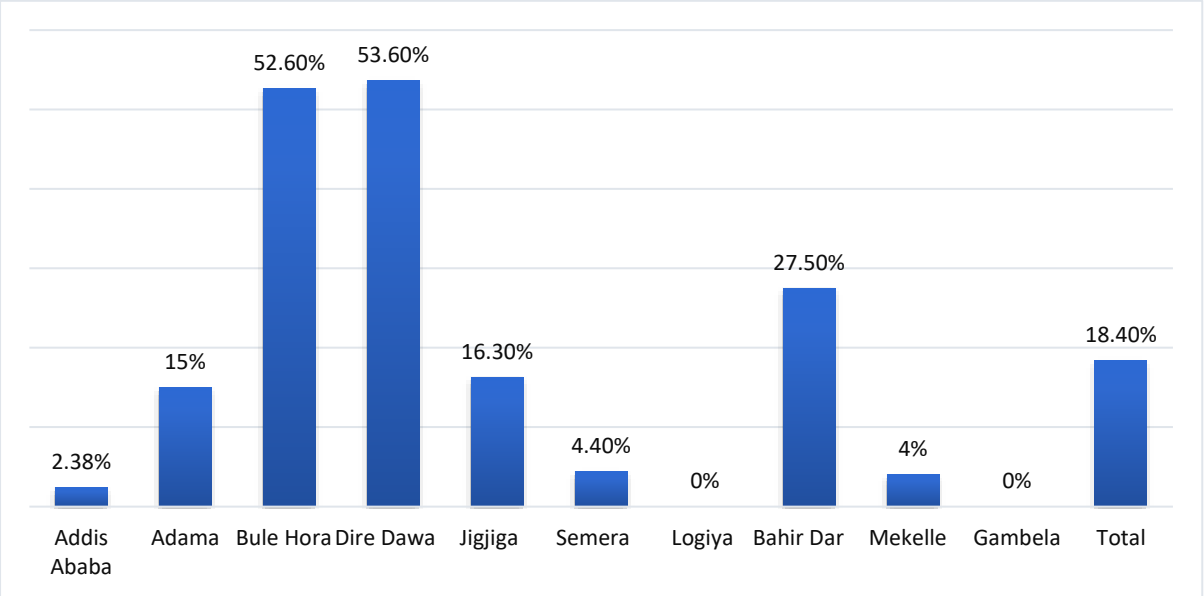


As shown in Figure 21, the findings indicate an ongoing significant reduction in the perceived negative impact of COVID-19 and related government measures in the three rounds (chi-square = 19.7; p-value <0.001). Additionally, regarding perceived negative impact, in this round, UPSNP beneficiaries perceived a more negative impact compared to the SSB and refugees/IDP participants, and less than refugees/IDPs. The difference was statistically significant (chi-square = 15.7; p-value <0.001). In the third round, the proportion of respondents who exhibited probable depressive symptoms was 12.6%, with no statistical difference among the three groups (p = 0.45)

There was also a significant difference in the perceived negative impact of COVID-19 and related measures across the 10 study cities (chi-square = 97.5; p-value <0.001). A higher proportion of respondents from Bule Hora, Dire Dawa, Adama, Jigjiga, and Bahir Dar perceived there to be a less negative impact of COVID-19 and related restrictions than

participants from other cities. But there was no difference in the perceived negative impact between male and female participants (chi-square = 2.55; p-value 0.12).

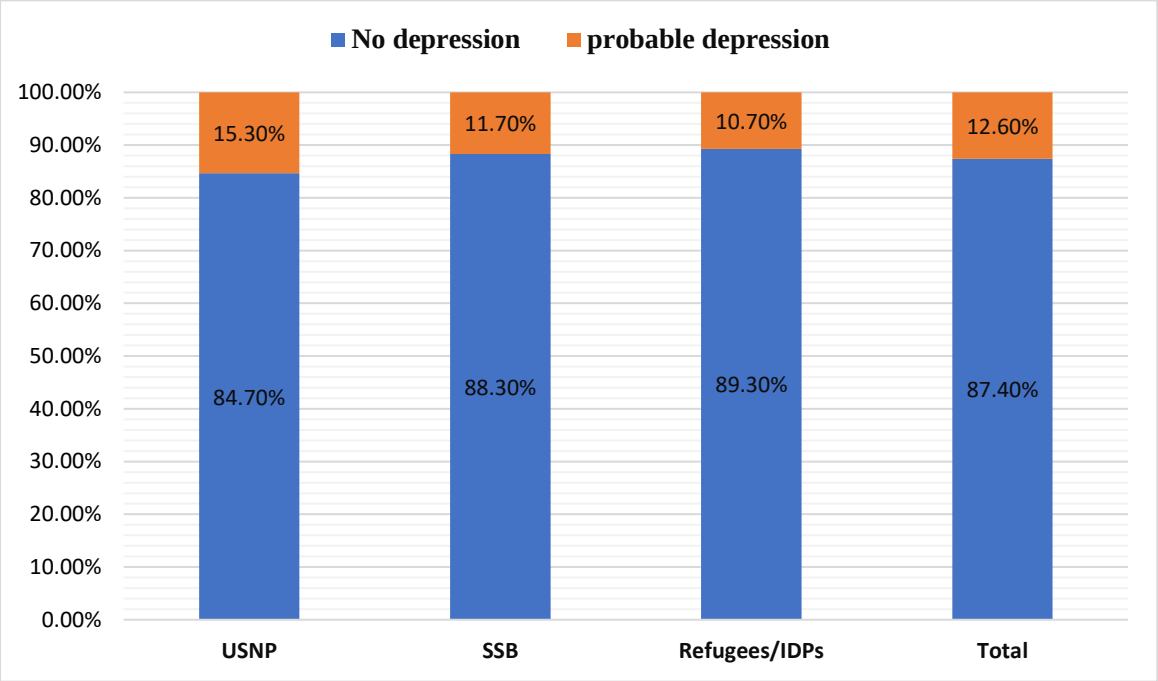
Figure 21: Perceived negative impact of COVID-19 and related government measures by study cities among the urban poor in selected 10 cities in Ethiopia, Oct/Nov 2020 (total n=380)



We used the Patient Health Questionnaire (PHQ-9) to assess probable symptoms of depression. The PHQ-9 has nine items, with a four-point scale, ranging from 0 (not at all) to 3 (nearly every day). The results of a reliability test indicate that the instrument has acceptable consistency, with a Cronbach's alpha value of 0.93. We used 10 as a cut-off point for symptoms of depression. In this round, the overall magnitude of probable depressive symptoms was 12.6%. The proportion of probable depressive symptoms was higher among UPSNP beneficiaries than the SSB and refugees/IDPs categories; however, the difference was not statistically significant (chi-square = 1.58; p-value = 0.45) (

Figure 22).

Figure 22: Round 3 overall mental health status (PHQ-9 scale with cut-off of 10) by respondent categories among the urban poor in selected 10 cities in Ethiopia, Oct/Nov 2020 (total n=380, UPSNP = 121, SSB = 137, IDPs/refugees = 122)



Additionally, the magnitude of probable depressive symptoms was significantly lower in this round – by more than one-third – compared to the previous two rounds (chi-square = 7.12; p-value = 0.03). There were also differences among the 10 cities in the proportion of probable depression: in Adama and Bule Hora a higher proportion of participants scored higher in PHQ-9.

In this round, 24.2% of the participants reported feeling hopeless and/or having thoughts of hurting themselves in various degrees in the past two weeks before the interview. Moreover, 2.8% reported feeling hopeless and/or having thoughts of hurting themselves nearly every day. The proportion was higher among UPSNP beneficiaries (19%) compared to the other two categories (SSB and refugees/IDPs), but the difference between the three categories was not statistically significant (chi-square = 6.27; p-value = 0.39).

The results also show a disparity among the 10 cities. In Adama, Bule Hora, Dire Dawa, and Gambella, participants reported feeling hopeless and/or having thoughts of hurting themselves to a greater degree (chi-square = 367.4; p-value <0.001).

In the qualitative study, we asked participants if they experienced stress related to the COVID-19 pandemic, and about their related responses. Most participants reported that they were feeling less worried about getting infected or ill with COVID-19. Additionally, they mentioned more improvements in social interactions (observing COVID-19 prevention methods) than in previous months, which they reported made them worry less and made them less stressed.

> *In the past, I had some stress and I was worried about the spread of COVID-19 and its related problems. Due to COVID-19, social interaction was limited, but now there*

is no problem, it is ok. People started practising social life with taking precautions. No one in our family has stress, due to improved social interaction. (IDP, Jigjiga)

On the other hand, some participants reported that they were more worried about food insecurity and the current political situation in the country in general than they were about COVID-19.

Now, I am much worried about the current situation of our country than the COVID-19 pandemic. The peace of our country is making us worried. (Special group, Bahir Dar)

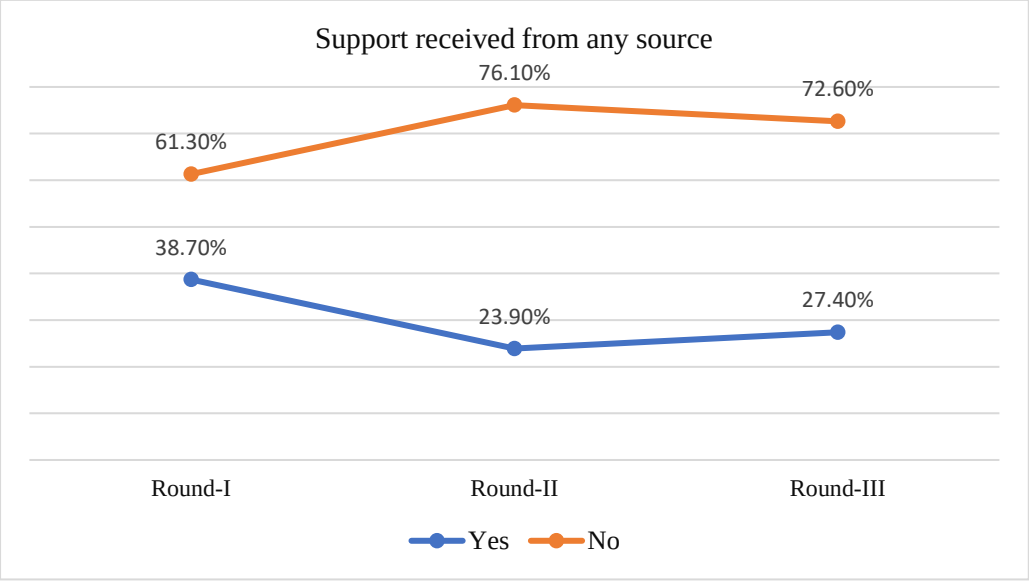
Aid and support

Key findings:

- Overall, there has been inadequate support for the urban poor in the last month.
- Support from the government and NGOs has mainly been provided in cash and in kind.
- Women and those who do not have any support are the categories that are the most supported by the government.

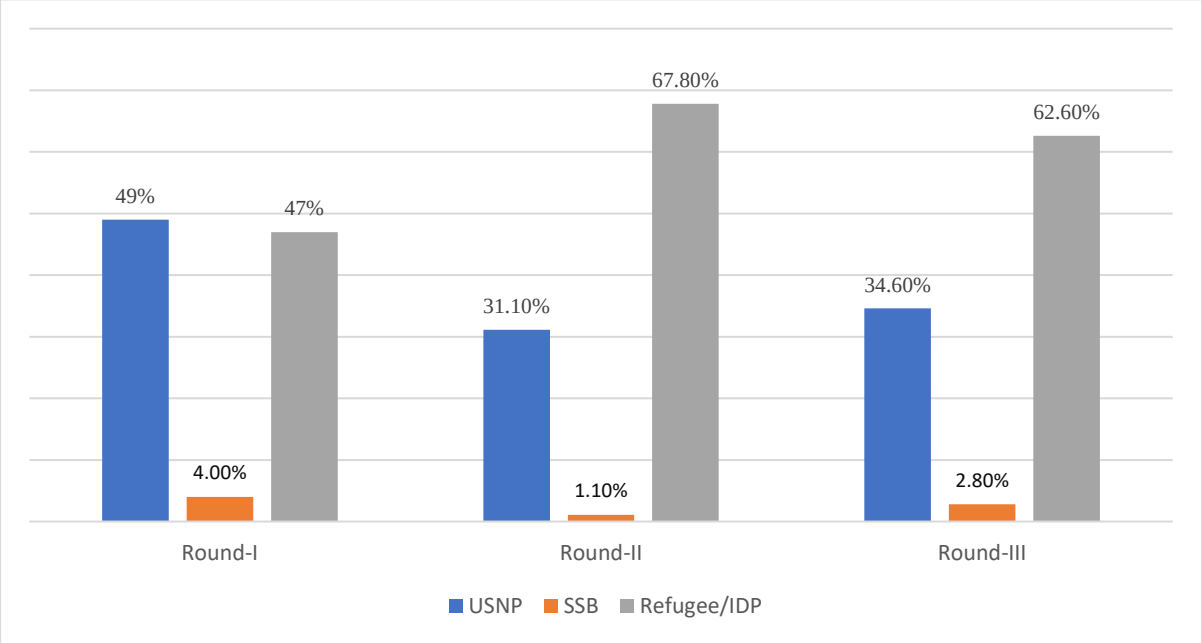
In this round, 53.4% of participants (160) reported awareness of the availability of assistance from the government, NGOs, CSOs, or other groups (e.g. religious institutions), with no significant difference among the three categories (UPSNP beneficiaries, the SSB group, and refugees/IDPs) (chi-square = 5.67; p-value = 0.06). However, only 104 (27.4%) of the participants had received support, which is better than the second round (23.9%) There is a significant difference in regard to receiving support across the three rounds (chi-square = 21.8; p-value <0.001). Among participants that had received support, 79.8% received support from the government, 46.2% from NGOs/CSO, and 9.6% from religious institutions.

Figure 23: Support received from any source among the urban poor in selected 10 cities in Ethiopia, Oct/Nov 2020 (total n=380)



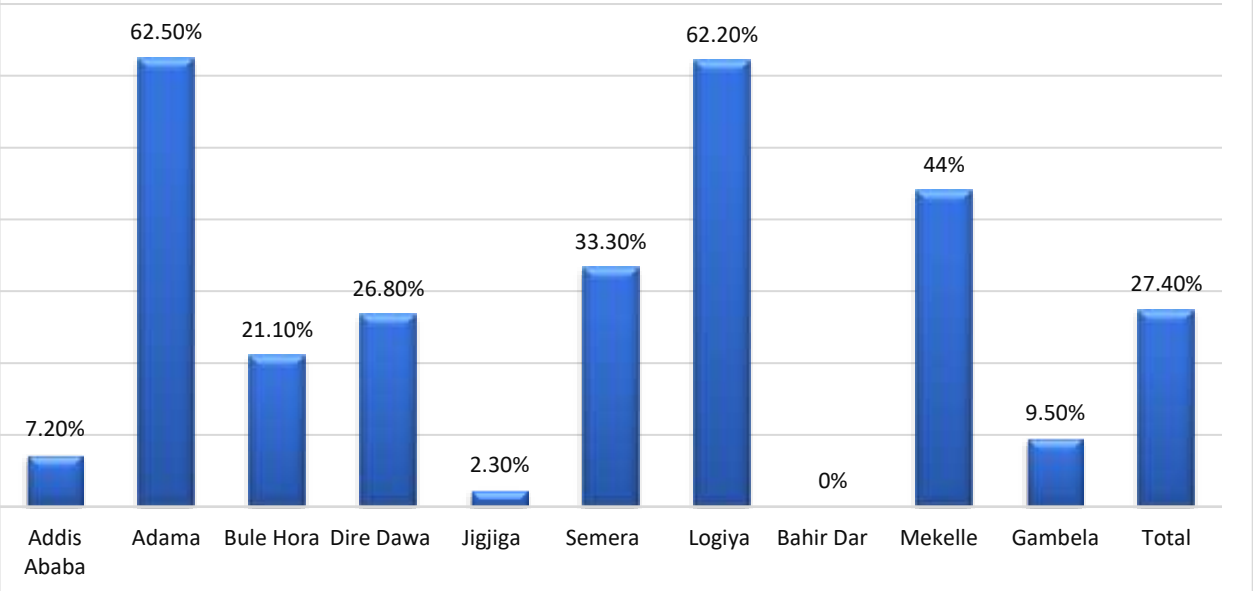
Regarding the support received, there was insufficient support for the UPSNP and SSB groups. There was a statistical difference among the three categories in all kinds of support: chi-square = 6.5; p-value = 0.03 for support in cash, chi-square = 50.5; p-value <0.001 for support in food items, and chi-square = 17.3; p-value <0.001 for other items.

Figure 24: Support received from any source by respondent categories among the urban poor in selected 10 cities in Ethiopia, Oct/Nov 2020 (total n=380, UPSNP = 121, SSB = 137, IDPs/refugees = 122)



There was also a significant difference in the support received across the 10 cities. In Adama and Logia, a higher proportion of participants received support, whereas the proportion of respondents who received support was lower in Addis Ababa (7%), Jigjiga (2%), and Bahir Dar (0%) (Figure 25). In Bahirdar, all participants are returnees and they are living with their families.

Figure 25: Support received by study cities among the urban poor in selected 10 cities in Ethiopia, Oct/Nov 2020 (total n = 380)



In the qualitative study, the key informant from the Women and Children's Affairs Office reported that they were working in collaboration with different government and non-government organisations, and were prioritising people who need special attention or support.

> *If you see the data, more than 70% we have helped are women. As sectors, we identified and address those single mothers and who live alone, those who have no economic capacity. We identified with the Woreda officials. Then we categorise as temporary and permanent support seekers. For instance, one organisation has helped 75 of them for three months. Likewise, other organisation had also helped about 50 of them for three months. Others supported [with] money and helped them to generate income…* (Government official, Addis Ababa)

Moreover, a diary participant also reported that not all urban poor have economic support: it is mostly women who are raising children alone that have received government support.

> *Mostly women who gave birth and are raising their child alone are getting aid and support. But I don't know the criteria for others. I just heard they are being provided 2,000 birr each month.* (Returnee, Bahir Dar)

Unlike other diary participants, refugees from Semera and Logia town who live in the community (out of the refugee camp) reported that they are getting regular aid and support from the refugee camp – specifically from the United Nations High Commissioner for Refugees (UNHCR), and sometimes from the community.

> *As I have told you before, we are refugees residing in a city so we are receiving support from UNHCR. In addition to this, recently my neighbour has bought me two packs of exercise books for school. Each pack costs around 250 Ethiopian birrs…* (Refugee, Logia)

A few IDPs and UPSNP beneficiaries also reported that they had received some support from NGOs.

> *Save the Children has given each one of us (IDPs) 2,000 birr a month. We have received this financial assistance for two consecutive months...* (IDP, Adama)

Another UPSNP beneficiary said:

> *There is some support from NGOs, such as UNICEF, OWDA [Organization for Welfare and Development in Action] and DANISH [Danish Refugee Council]. It has helped my family a lot. They provide us most necessary materials and food. We have not seen any other community support so far….* (UPSNP, Jigjiga)

However, none of the participants from small-scale businesses and returnees reported getting support in the last month.

> *Currently, I only work on my shop business. As I told you, the shop business is poor, and my family's and my household rely on this small business. I don't have another source of income other than the shop; I didn't get any support from any source so far.* (Returnee, Bahir Dar)

It seems that aid and support come from different sources and are given to different groups.

Safety and security

In the qualitative study, we asked participants about safely and security issues for children, women, and the whole community, and activities that have been conducted to ensure the safety of the community. All diary participants reported that there were no problems they had observed or heard regarding the safety of women and children, and no instances of abuse, violence, or child marriage. However, they reported the destruction of farms in some parts of the country, by locusts and flood. In addition, they mentioned the following problems in some urban communities:

> *I can say all problem like health, economic, security, hygiene, and sanitation problems, including food insecurity, are problems of the urban poor. During the last two months, in addition to COVID-19, there was flooding which destroyed acres of crops, homes etc.* (Government office, Semera)

Another participant from Semera reported destruction of farms by locusts:

> *There was locust outbreak in my area last month. Though it disappeared immediately, a lot of damage on agricultural lands and normal trees happened in a short time…* (SSB participant, Semera)

Conclusion

In this round, there were mixed reports of the practising of COVID-19 preventive measures, with reported increases in facemask usage and hand sanitiser but a decrease in handwashing compared to the previous two rounds. Practising of, and the level of compliance with, some of the preventive measures was found to be higher in some cities, and differed between the UPSNP, SSB, and refugee/IDP groups. The gender of the participants was also found to be associated with avoidance of overcrowded places (with more female participants reported to have avoided crowded places). Moreover, it is alarming that nearly half of the participants reported believing that they are not at risk of contracting COVID-19. Fatigue with the disease, misperceptions of the severity of the disease and its existence, and limited enforcement of the government restrictions seem to have contributed to the limited practising of preventive measures. These misconceptions about COVID-19, and compliance with restrictions, must be addressed with awareness-raising activities and more tailored interventions for certain groups. The majority of participants stated that they believe the COVID-19 vaccine is important, safe, effective, and compatible with their religious or personal beliefs. These findings indicate that the vaccine would be acceptable if proven to protect against infection with COVID-19.

Most respondents reported having access to a water supply from nearby or inside their residence; however, sporadic availability of a water supply remains a major challenge to accessing water for household use, and to practising proper handwashing. Compared to Round 2, the proportion of households that reported everyday access to a water supply has significantly decreased in Round 3. Moreover, the economic burden associated with purchasing water and transporting it from the area where it is available to their homes remains a major challenge for the urban poor.

The findings of this study indicate improvement in the availability and consumption of food. For instance, the proportion of households that consume three or more meals per day has significantly increased in Round 3. Similarly, the incidence of food shortages among households has declined across the three rounds. However, despite improvements in the availability and frequency of meal consumption, respondents widely mentioned the consumption of poor-quality foods that are assumed to have poor nutritional value.

Most of the respondents and family members who needed medical treatment reported being able to access health services. Only four people reported avoiding visiting health facilities due to the cost of treatment. In Rounds 1 and 2, the fear of being infected with the virus was the major factor that influenced some of our respondents' health-seeking behaviour. Maternal health service utilisation does not seem to have been significantly impacted, although our sample for this group was small, and thus the results need to be interpreted with caution.

Like the previous two rounds, mothers are the primary caregivers of children. It is concerning that most children are still spending much of their time playing or helping their family with chores, rather than engaging in educational activities, even after the re-opening of many of the schools. Moreover, according to the participants, no change has been observed with regards to access to educational platforms.

Mental health problems, such as feelings of being stressed and the prevalence of probable depression, have significantly declined in the current round. Most qualitative diary interview participants reported feeling less stress/worry about getting infected or ill with COVID-19, and reported improvements in social interactions due to the easing of government restrictions.

Only 27% of respondents had received assistance/aid during the past month (in Round 3). The proportion of respondents who received support was higher in Adama and Logia, and lowest in Bahirdar, Addis Ababa, and Jigjiga. The provision of aid and support reported in Round 3 is very low, compared to that reported in Rounds 1 and 2.

Case studies

Case Study 1 (continued from Round 1)

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

Mrs Lelo explained that she is still practising the COVID-19 preventive measures, but water supply shortages are challenging: *'I do practise the preventive measures. For example, I wear my facemask, keep my physical distance from my customers. Although the shortage of water has posed a challenge to regularly and properly wash our hands, we are doing our best and trying to wash our hands with the water we managed to get somehow.'* She also explained that misconceptions regarding how COVID-19 is perceived, and that compliance with the government measures has declined in the area where she is living: *'People say that coronavirus is a hoax. Most people do not practise preventive measures. It is only some who wear facemasks and keep physical distancing.'* She added that it is only in places where there is enforcement that some people practise washing their hands and wearing facemasks: *'It is not in all places that the preventive rules are not practised. There are some places, like governmental workplaces and banks, where people are still required to wear their facemasks and keep their physical distances.'*

In the previous two rounds, Mrs Lelo had explained how the COVID-19 pandemic and the government restrictions had affected her daily life. A key impact she mentioned was reduced work opportunities. Mrs Lelo sells 'khat' as a means of obtaining income to support herself and to feed her family. During Round 1, her income was significantly reduced, and she lost the capacity to feed her family. However, she said that her business got better and her income improved during Round 2, though not comparable to pre-COVID-19 pandemic times. In Round 3, she believes that her income has decreased again, due to a limited supply of chat/khat, which was attributed to a change in the weather: *'My income decreased because of the nature of the business I do. There has not been rainfall in areas that cultivate/produce chat/khat over the past month. And that affected the supply of chat/khat, which in turn made my income to decline.'*

Water shortages are still the most difficult thing that she and other IDPs are facing, which affects their handwashing practices. In the previous two rounds, she reported that the ration provided by the government was the only assistance she was getting. In Round 3, Mrs Lelo explained that she has not received the support lately: *'Have I told you that the food ration that we (IDPs) used to receive as assistance has been stopped? They have stopped food ration distribution to IDPs. They once provided us wheat flour. However, this has been stopped.'* She explained the burden of the food price inflation on top of her reduced income and the lack of assistance: '*Food prices have been increased within the past month. For example, 25 kilograms of rice that we used to buy for 600 birr has been sold from 730 birr to 750 birr.'*

Mrs Lelo reported that neither she nor any member of her family had been sick. She explained that she would visit a health facility if she needed any medical attention, and that she has no fear of getting infected with COVID-19 and quarantined if she visits a health facility: *'I am neither afraid of contracting the virus at a healthcare centre nor am I afraid of getting admitted to a quarantine centre had I happen to have coronavirus. I would even like to get tested and know my status*.' There are no pregnant women in her family, and no one has been using a family planning method. However, she knows a neighbour who is pregnant. Mrs Lelo said that the woman gave birth at home: *'There is a pregnant woman which I have told you about last time. She is my neighbour. She gave birth at home before 15 days.'* In our last interview, Mrs Lelo said this woman had not attended ANC due to a bad experience she faced when she took her child to a health facility for immunisation. Mrs Lelo said there is no nearby health facility and she believes that it would be good if health extension workers were assigned to her location: *'The healthcare centre is not found nearby our site. It would have been good if we at least have health extension workers at our locality.'*

Case Study 2 (continued from Round 2)

Mrs Mame (not her real name) is a 38-year-old HIV-positive woman, a high school graduate who works as a freelancer at the Addis Ababa city women's affairs office. Since the last interview, she has witnessed a 40- or 50-year-old neighbour who has been infected by the coronavirus. She says the corona infection rate is increasing, especially among those with HIV, diabetes, and hypertension, because people are not implementing the proper preventive measures. She says the elders are the most careful ones when it comes to prevention, while younger adults and youth are careless. She has faced certain illnesses, like a severe headache and a morning cough, because of pneumonia. This worries her, but the health centre is near her living area, and she goes there for treatment and to receive multi vitamins. She is still very fearful of the corona pandemic and, as such, follows proper preventive methods. Different awareness activities have been carried out in her community, like discussion of the advantages of handwashing, as well as how to use bleach as a disinfectant.

She says the culture of helping each other still exists in her community, even though the economy is challenging. They share whatever they have. The water supply in their area is as reported last time: it is available every Tuesday and Thursday. She said the water cost is not that much exaggerated but she complains about the reduced pensions that reduced her salary from 1,000 to 800, and that this is not enough for all her family expenses, not to mention her health expenses. In terms of spending, her priorities are shiro, oil, and injera, because her salary is inadequate. Just 1 kg of teff is ETB 40 and she says she needs to buy 5–10 kg of teff.

When she was asked about her fear of being evicted from her home, Mrs Mame said that she has no worries on that subject because she lives in a house that belongs to the kebele. She has also been a beneficiary of health insurance and because of that she has no health cost since it is covered by the government. She has no chance for savings because of the inadequacy of her salary, as well as the health condition of her husband, who used to be a taxi driver, but she wishes to save for the future of her children if possible.

She says house staples are available in the market but the problem is their cost. She has trained in handicrafts and could have work opportunities here and there, but because of her fear of being infected by the coronavirus, her movement is limited. Because of her limited earnings, she has sent two of her nieces to a relative's home so that they can secure their meal there. She never fails to buy textbooks for her children, even though she is hungry most of the time. She is planning to train them on how to make masks using her sewing machine if she gets a donor for the purchase of the fabric. She was asked if there are any girls she knows that were married after quitting school due to corona and she said that she has witnessed one neighbour that got married.

She explained further about the religious impact of the virus, stating that priests might let many individuals kiss their crosses and that has scared her a lot because she heard that the virus might stay on the metal for a long period of time. There are also crowds in the churches so she goes to church only around mid-day. However, she said that there are also churches that have advised people to keep their distance while they are in the compound.

Since she is a worker at the women's association, she advises people about family planning, and even accompanies some women to the health centre. She also distributes condoms she gets from the health centre. According to her, ANC services are also being provided by health extension workers, while keeping the necessary distance. Concerning immunisation, she says people are still reluctant to do this because of the fear of the pandemic. As a result, awareness campaigns were necessary and were conducted. The immunisation was also given in a hurry because the World Health Organization urged for it to be finished in four days, and so she and her colleagues were overloaded with work, since there are around 16,000 households in every woreda.

There are patrolling at night and three times a week to make sure that people are wearing their masks.. She and her family members are still stressed about the pandemic, as well as being anxious about the recent turmoil.

Last but not least, she mentioned receiving around 4 kg of rice and 5 kg of flour as aid from the government (Woreda). She is thankful for that and she wishes for the mercy of God as regards the pandemic, so that all will be normal again.

Case Study 3 (continued from Round 2):

Mr Amin (not his real name) is a 30-year-old father from Semera. He is married and a father of four children. He used to work as a daily labourer, to support himself and his family.

Mr Amin explained that he is still practising preventive measures to reduce the risk of contracting COVID-19, and fears have reduced as they have got used to the disease. However, he admitted that he has become less compliant with the practices in Round 3: 'I am still practising preventive measure by wearing a mask, but not like before because I became familiar with the disease.'

In the previous round, Mr Amin explained how the COVID-19 pandemic and the government restrictions affected his life. He lost work opportunities following the pandemic. Similarly, during Round 3 he explained that he was struggling with the food price escalation, on top of the loss of job opportunities. Mr Amin is still concerned about food price inflation: 'If we talk about the price of food, it is still increasing every day.' He explained the cause of the food price escalation: he believes that the food price escalation is not due to a price increase on the part of the farmers but rather is one imposed by the merchants because of the pandemic. As a result, he explained that his family was forced to reduce the amount of food they eat*: 'It [food] is available in every shop and we shouldn't travel far to get food items. There is no change in the price of food rather it is increasing from time to time by shop owners because of COVID-19 and we are eating two meals a day.'*

In the previous round, Mr Amin explained that he was coping with the lack of job opportunities and income by selling his assets to cover his cost of living, including house rental. In Round 3, he explained how he was coping with the loss of job opportunities and decreased income. He explained that he was not at risk of eviction, given the culture of the community supporting each other: *'I am not at risk of being evicted, because we Afar people are so patient when someone faces a problem*.*'*

Mr Amin said that his children are back at school, but the costs of uniforms and exercise books have become challenging. He explained that the school was providing facemasks to the students: *'There is no educational material provided by the school. I managed to buy exercise books and a uniform. The exercise book is expensive. What the school provides facemask only*.*'*

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 (all figures are percentages): Round 3											
Proportion of respondents who reported practising washing hands frequently with soap and water	7	100	95	22	100	100	100	98	92	95	80
Proportion of respondents who reported practising hand-rubbing with a sanitiser or alcohol-based solution	93	95	74	73	0	18	67	95	80	10	61
Proportion of respondents who reported practising wearing a facemask	98	98	100	95	84	91	96	75	92	67	91
Proportion of respondents who reported avoiding overcrowded places	7	25	84	95	72	100	78	80	12	19	62
Proportion of respondents who reported friends or family members wearing a facemask all the time	88	100	92	46	0	56	80	28	20	5	55
WASH (all figures are percentages): Round 3											
Proportion of households who have piped private water supply	60	68	26	68	14	87	84	93	76	48	63
Proportion of households who have access to a water supply every day/daily	52	80	11	78	2	60	56	88	16	19	49
Proportion of households who reported a shortage of water since COVID-19 outbreak	90	25	34	68	86	96	76	48	68	14	64
Proportion of households who reported difficulty in accessing water supply	7	65	34	27	30	0	9	25	40	48	26
Food security (all figures are percentages): Round 3											

Proportion of household relying on food assistance from government/ NGO/United Nations/ local charity	0	0	0	0	0	0	2	0	0	29	2
Proportion of households facing difficulty going to places to access food/food materials	0	33	13	27	0	33	33	3	48	0	19
Proportion of households with reduced number/frequency of meals consumed per day since the outbreak of COVID-19 and associated impacts	19	20	61	12	14	0	13	8	24	0	17
Proportion of households having three or more meals per day	67	100	37	76	58	100	91	100	72	95	79
Income, expenditure, and employment (all figures are percentages): Round 3											
Proportion of respondents who reported cutting down hours or amount of work since COVID-19	29	38	61	12	86	2	51	98	76	0	46
Proportion of households who are currently able to earn income similar to the normal work before lockdown/physical restrictions	98	100	37	54	95	100	89	100	80	71	84
Proportion of households with a risk of eviction from their house due to loss of income	10	0	45	0	30	0	4	5	36	0	12
Health (all figures are percentages): Round 2											
Proportion of participants that needed any medical treatment since the COVID-19/coronavirus outbreak	4.4	2.6	33.3	12.2	4.7	4.5	48.9	9.3	9.8	18.5	14.7
Proportion of participants/ members that needed medical treatment and have had access to health services	100.0	0.0	53.8	100.0	100.0	50.0	100.0	100.0	75.0	60.0	81.7
Proportion of households whose member(s) needed any medical treatment since the COVID-19/coronavirus outbreak	4.4	2.0	23.1	4.9	25.6	9.1	2.2	2.3	4.9	8.7	8.7

Proportion of households whose member(s) needed medical treatment and have had access to health services	50.0	0.0	66.7	100.0	100.0	100.0	100.0	0.0	50.0	50.0	77.1
Health (Round 3)											
Proportion of respondents/households whose member(s) needed any medical treatment since the COVID-19/coronavirus outbreak	31.1	20.5	38.5	17.1	14.0	31.8	24.4	9.3	24.4	22.2	23.3
Proportion of respondents/households whose member(s) needed medical treatment and have had access to health services	75.6	35.9	30.8	92.7	100.0	86.4	100.0	14.0	19.5	44.4	61.4
Mental health (all figures are percentages): Round 3											
Proportion of respondents who perceived a negative impact of COVID-19 and associated responses on mental health	0	47.5	26.3	0.0	0	0	0	5.0	0	0	8.1
Proportion of respondents felling stressed, scared, or/and worried during the past month	0	100	65.8	2.4	46.5	6.7	77.8	0	52.0	0	36.0
Proportion of respondents with probable symptoms of depression (cut-off point =10)	0	100	21.0	0	0	0	0	0	0	0	12.6
Aid and support (Round 3)											
Proportion of respondents who are aware of any relief being provided to address the impacts of COVID-19/coronavirus	4.8	65.0	50.0	75.6	39.5	97.8	11.1	35.0	100	95.2	53.4
Proportion of households/household members who received aid from any institution after the COVID-19/coronavirus pandemic	7.1	62.5	21.0	26.8	2.3	33.3	62.2	0.0	44.0	9.5	27.4
Total sample/observations (in number)	42	40	38	41	43	45	45	40	25	21	380

Annex B: Disparities in key variables by gender

Key indicators/variables	Male (%)	Female (%)	Total (%)	Chi-square [p-value]
Behaviour in response to COVID-19: Round 3				
Proportion of respondents who reported practising washing hands frequently with soap and water	79	81	79.7	0.337 [0.561]
Proportion of respondents who reported practising hand-rubbing with a sanitiser or alcohol-based solution	64	58	61.3	1.475 [0.225]
Proportion of respondents who reported practising wearing a facemask	91	90	90.5	0.134 [0.715]
Proportion of respondents who reported avoiding overcrowded places	55	69	61.6	7.238 [0.007]
Proportion of respondents who reported all their friends or family members wearing a facemask all the time	55	55	55	0.526 [0.769]
WASH: Round 3				
Proportion of households who have piped private water supply	54	73	63	22.6 [0.000]
Proportion of households who have access to a water supply every day/daily	47	51	49	9.4 [0.023]
Proportion of households who reported a shortage of water since COVID-19 outbreak	35	38	36	0.41 [0.522]
Proportion of households who reported difficulty in accessing a water supply	30	22	26	4.9 [0.179]
Food security: Round 3				
Proportion of households relying on food assistance from government/NGO/United Nations/local charity	17	21	19	1.10 [0.288]
Proportion of households facing difficulty to go to places to access food/food materials	2	2	2	-
Proportion of households with reduced number/frequency of meals consumed per day since the outbreak of COVID-19 and associated impacts	18	16	17	0.19 [0.659]
Proportion of households having three or more meals per day	84	75	53	4.9 [0.026]
Proportion of households who have no food reserves for future consumption (no food reserves at all)	9	9	9	4.10 [0.389]
Income, expenditure, and employment: Round 3				
Proportion of respondents that reported cutting down hours or amount of work since COVID-19/coronavirus	48	44	46	0.67 [0.041]
Proportion of households who are currently able to earn income similar to the normal work before lockdown/physical restrictions	82	85	84	0.079 [0.373]
Proportion of households with a risk of eviction from their house due to loss of income	15	9	12	2.57 [0.109]
Proportion of households who were evicted from their house due to loss of income	3	1	2	-
Health: Round 3				
Proportion of participants that needed any medical treatment since the COVID-19/coronavirus outbreak	18	11	15	4.071 [0.044]

Proportion of participants/ members that needed medical treatment and have had access to health services	92	84	89	0.711 [0.399]
Proportion of households whose member(s) needed any medical treatment since the COVID-19/coronavirus outbreak	10	7	8	0.589 [0.443]
Proportion of households whose member(s) needed medical treatment and have had access to health services	84	92	88	0.463 [0.496]
Mental health: Round 3				
Proportion of respondents who perceived a negative impact of COVID-19 and associated responses on mental health	41	31	36	4.2 [0.041]
Proportion of respondents felling stressed, scared, or/and worried during the past month	11	5	8	4.42 [0.035]
Proportion of respondents with probable symptoms of depression (cut-off point =10)	14	10	12	0.33 [0.248]
Aid and support: Round 2				
Proportion of respondents who are aware of any relief being provided to address the impacts of COVID-19/coronavirus	50	58	53	2.31 [0.129]
Proportion of households/household members who received aid from any institution after the COVID-19/coronavirus pandemic	23	32	27	3.41 [0.061]
Total sample/observations (in number)	**201**	**179**	**380**	