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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 fourth round** of a mixed method panel study in urban areas in nine cities in Ethiopia

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About the BRE programme

BRE is a three-year (2019–2022) technical assistance programme co-funded by FCDO and the United States Agency for International Development (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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Abbreviations

ANC	Antenatal care
BRE	Building Resilience in Ethiopia
ETB	Ethiopian birr
FCDO	UK Foreign, Commonwealth and Development Office
IDP	Internally displaced person
IOM	International Organization for Migration
NDRMC	National Disaster Risk Management Commission
NGO	Non-governmental organisation
OPM	Oxford Policy Management
PNC	Postnatal care
SSB	Small-scale business
UNHCR	United Nations High Commissioner for Refugees
UPSNP	Urban Productive Safety Net Project
USAID	United States Agency for International Development
WASH	Water, sanitation and hygiene

Introduction

This report presents the results from **the fourth round** of six-round mixed methods phone survey, which aims to assess the effects of COVID-19 and government responses to it on the lives of urban poor Ethiopians, on changes in their food security and livelihoods, as well as on education for their children, and access to and use of health services. It also aims to assess people's knowledge of, and practising of, preventive measures related to COVID-19, as well as stigma and discrimination against vulnerable groups because of COVID-19. Phone surveys were conducted in nine selected cities in Ethiopia: Addis Ababa, Dire Dawa, Adama, Gambela, Bahir Dar, 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.

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

Our results so far indicate that COVID-19 has significantly affected poor and vulnerable groups, and has had, to some extent, differential impacts related to structural inequalities, such as gender and ability, and on people who are marginalised for other reasons (e.g. IDPs). Access to food and water remain major challenges for the urban poor. In addition to the problems associated with low income and the increased price of food items, devaluation of the Ethiopian birr (ETB) was mentioned as an additional burden that is exacerbating food insecurity among the urban poor in this round. Daily wage earners, people with jobs in the informal sector, vendors, petty merchants, labourers, and women are found to be the most likely to be impacted due to loss of jobs and reduced income, and due to the disproportionate childcare burden for women. IDPs and refugees, and people living with no social safety nets, are also found to be particularly vulnerable to the pandemic due to insufficient aid and support. Moreover, there is seen to be a significant decline in the practice of and compliance with the COVID-19 preventive measures. These results are in line with a study conducted by the World Bank Group, which highlighted concerns about the impact of COVID-19 on the livelihoods of a representative sample of respondents. In particular, food insecurity remains a serious problem in Ethiopia due to higher prices and/or less regular

[1] The first round of the phone interviews was carried out between 22 June and 22 July 2020; the second round was caried out between 23 August and 13 September 2020; and the third round was carried out between 28 October and 13 November 2020. 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 (Round 3 also included interviews with these groups and the next round we will also include these interviews). The main focus of our study is on the dynamics of the impact of COVID-19 and government measures on households and day labourers. The key informant interviews with local government officials, NGOs/CSOs, and healthcare professions help provide the context for our study, although they are not the main focus.

income.[2] The increased difficulty in terms of access to water, sanitation and hygiene (WASH) services appears to be related to an inability to pay for services and to disrupted supply chains as a result of reduced transportation.[3] Therefore it seems that even though people are able to work more now (compared to the beginning of the COVID-19 pandemic), affordability is still a major problem due to price increases for items which are necessities, such as food and water. Irregular income and affordability issues have also led to the increased mental health problems observed in this round.

[2] http://documents1.worldbank.org/curated/en/678511608616662907/pdf/Monitoring-COVID-19-Impacts-on-Households-in-Ethiopia-Results-from-Six-Rounds-of-High-Frequency-Household-Phone-Surveys.pdf
[3] https://www.worldbank.org/en/news/feature/2020/05/11/in-ethiopia-keeping-water-flowing-during-the-covid-19-coronavirus-response

Methodology – Round 4 (March 2021)

The study uses a mixed method design, employing both qualitative and quantitative data collection methods. A phone survey, using interviewer administered quantitative questionnaire and qualitative interviews, was conducted to explore the effects of COVID-19 and government measures on the following themes:

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

Cities covered

The current round of the study was conducted from **26 February to 13 March 2021** in nine cities/towns located in different regions of Ethiopia. The cities included in this round were Addis Ababa, 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. Initially, 10 cities were selected, but due to the internet blackout and the conflict between the Tigray People's Liberation Front and the Ethiopian Federal Government we excluded Mekelle in this round.

Quantitative interview sample

The quantitative interviews were conducted among UPSNP beneficiaries,[4] households that own a small-scale business (SSB), and refugees and IDPs.

- The UPSNP is designed to increase the income of targeted poor households and to establish urban safety net mechanisms. UPSNP beneficiaries are households that are identified as 'the poorest of the poor' based on their ability to generate income, their ownership of valuable assets, and their living conditions. The UPSNP beneficiary households receive a monthly payment from the government as direct beneficiaries

[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 who are not receiving any support since UPSNP is not operating in some cities (i.e. Bahirdar, Bule Hora).

(those working on city beautification and cleaning) and indirect beneficiaries (those not engaged in any work due to health problems, old age, and/or disability).

- SSB households are those engaged in a small local business to support their livelihood. The SSB households were included because of the possibility that their business or income would be significantly affected by the pandemic, given that economic activities are greatly impacted due to movement restrictions/lockdown.
- Households in the IDP/refugee category are among the most vulnerable groups and are being highly affected by COVID-19[5] 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'.[6] By contrast, there is no universally accepted definition of return migration. Return is 'in a general sense, the act or process of going back or being taken back to the point of departure. This could be within the territorial boundaries of a country, as in the case of returning IDPs and demobilised combatants; or between a country of destination or transit and a country of origin, as in the case of migrant workers, refugees, or asylum seekers'.[7] Our respondents self-identified as one of these three categories (IDP, refugee, or returnee) based on the definitions outlined above.

The quantitative household interviews were conducted among the same participants who were involved in the previous three rounds of data collection. Before the first round, 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 **336 participants during this round**, **a response rate of 77.1%.** Of these, 113 were UPSNP beneficiaries, 120 were SSB owners, and 103 were

[5] www.internal-displacement.org/crises/coronavirus
[6] 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 the same rights and guarantees as other citizens and habitual residents of their country. As such, national authorities have the primary responsibility for preventing forced displacement and for protecting IDPs (UNHCR).
[7] 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

IDPs/refugees/returnees. We faced multiple challenges during the data collection period in this round. Forty-four participants were lost due to being unreachable using the phone numbers we had obtained. The team spent several days trying to reach out to these participants through field coordinators, who tried to trace those respondents and find alternative phone numbers. Given the internet outage following the conflict between the Tigray People's Liberation Front and the Federal Government of Ethiopia, and the subsequent potential psychosocial impact, we excluded participants from Mekelle. Given that we have lost 100 participants in this round compared to Round 1, the results need to be interpreted with caution as there may be systematic bias due to particular types of respondents having dropped out.

Qualitative interview sample

Qualitative interviews were conducted with a separate set of respondents who were randomly selected from among Round 1 participants. Thirty respondents (an average of around four respondents per city) were interviewed in this round: five UPSNP beneficiaries; six SSB owner respondents; nine IDPs/refugees/returnees (IDPs (six), returnees (four), and refugees (two)); and 10 participants from the 'special population group' (i.e. daily labourers, shoeshines, waiters, and porters). These were less than in the previous two rounds (57, 50 and 35 respondents in Round 1, Round 2, and Round 3, respectively) as some of the respondents had changed their phone numbers and some refused to take the calls. In addition, we were not able to reach out to any of the respondents from Mekelle due to the network shutdown there.

Interview approach

All interviews were conducted using a two-step approach: the city coordinator (who is a part of the research team from MERQ) made an introductory call to introduce the study, obtain consent, and schedule interviews with potential participants; and then the actual interviews were conducted by the data collectors. The average duration of the qualitative interviews was 30 minutes. The number of call attempts ranged from one to nine, in order to reach each respondent for the actual interview. Daily debriefings were conducted between the study team and the field-based data collectors.

Field observation by data collectors

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

Data analysis

Quantitative data were analysed using Stata Version 14. Descriptive statistical methods, including frequency tables and proportions (percentages), were used to analyse the quantitative data. We used tables and graphs to present the results. Chi-square and paired t-tests were used to test statistical differences in selected variables between the UPSNP beneficiaries, SSB, and IDP/refugee groups, and McNamara chi-square and paired t-tests were used to test statistical differences in selected variables between the rounds (Round 4 versus Round 3 or Round 2 or Round 1).

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

Limitations of the study

This study has some limitations that should be considered. First, this study was unable to explore causal relationships because there may be other factors that influence the respondents' answers to the survey questions that were not observable or relevant to COVID-19. Since the interviews were conducted over the phone, we were not able to connect and establish as much of a rapport as we could have done with face-to-face interviews. The duration of the calls was also short and network disruption was also an issue. Secondly, the data presented, including compliance with COVID-19 response measures, the level of malnutrition, and the psychological impacts of COVID-19, are based on respondents' self-reports, which may be 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 found significant differences between own (self-reported) behaviour and the behaviour of others as reported by the respondents. Finally, the attrition rate is a problem in this round, as mentioned above, which could bias our results in a systematic way, depending on who has been dropped from the sample. We explore this further in the 'Summary of household characteristics' section below.

Context and field observation findings during Round 4

This section reports information on the context of the study and observations by the data collectors (based on their field observations). As at 7 May 2021, the number of people infected with COVID-19 in Ethiopia had reached 261,580, of whom 206,870 had recovered and 3,840 had died.[8] A total of 1,287,801 people in the priority group had been vaccinated, including 1,218 refugees. On average, 815 positive cases have been reported over the last seven days (as at 7 May 2021).

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 being enforced. This guideline covers a wide range of issues, including the requirements for foreign travellers entering the country. The guideline sets out the following measures:

- service-providing individuals and customers must wear a facemask except when eating and drinking;
- it is prohibited to enter the premises of any religious institution without wearing a facemask;
- any person attending a funeral is expected to wear a facemask and to maintain a distance of two adult strides; and
- service-providing facilities must take necessary measures to control the spread of the virus by preparing required tools at the entrance and exit and other areas, ensuring that rooms have adequate air ventilation, and providing employees with the necessary personal protective equipment.[9]

Given the rate of the spread of the COVID-19 and declining practices relating to, and compliance with, the preventive measures, on 28 March 2021 the Federal Ministry of Health and the Ethiopia Federal Attorney General Office announced the legal framework for, and enforcement of, the COVID-19 prevention guideline and control directive (Directive-30/2020).[10] It is worth noting, however, that this did not prevent bars and restaurants from opening.

Up to 7 March 2021, **Ethiopia** had received 2.184 million doses of the Astra Zeneca COVID-19 vaccine via the COVAX Facility.[11] Later, Ethiopia received an additional 300,000 doses of the coronavirus vaccine developed by Sinopharm.[12] Health workers and government officials were prioritised for the first phase of vaccination.[13]

[8] https://reliefweb.int/report/ethiopia/unhcr-ethiopia-covid-19-and-operational-update-8-may-2021
[9] Federal Ministry of Health (2020) 'A directive issued for the prevention and control of COVID-19 pandemic', Directive No 30/2020.
[10] www.ephi.gov.et/images/novel_coronavirus/EPHI_PHEOC_COVID-19_Weekly_Bulletin_48_English_04022021.pdf
[11] www.afro.who.int/news/22-million-covid-19-vaccines-allocated-covax-facility-arrive-ethiopia-marking-start-countrys
[12] www.aa.com.tr/en/africa/ethiopia-gets-300-000-virus-vaccine-doses-from-china/2192681
[13] www.afro.who.int/news/ethiopia-introduces-covid-19-vaccine-national-launching-ceremony

All government restrictions are supposed to be implemented and enforced in all cities across the country. However, the restriction measures continue to be implemented to varying degrees across the nine cities included in our study. The major incidents and events observed by the data collectors during this round are summarised in the paragraphs below.

Except for Addis Ababa, data collectors observed most drivers and their assistants providing public transport services without wearing a facemask. In addition, most passengers using public transport were also observed to be not 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 for this. 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 and Adama were more likely to use facemask than those 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. Moreover, the data collectors also observed that most people had started shaking hands again in all of the cities.

In most service-providing institutions, including bars and restaurants, waitresses were not wearing a facemask when serving customers. Similar to our observations during the previous rounds, the inappropriate use of facemasks was also found to be common in all of the study cities. Enforcement of the COVID-19 direction released in October was found to be weak in most of the cities. As in Round 3, it was also common to see public gatherings without proper protections (i.e. wearing a facemask and maintaining physical distancing) at marketplaces, religious places, cafés, restaurants, etc. In this round, most of the banks and some government offices (like Ethio Telecom) were found to be no longer forcing their customers to wear masks and to use hand sanitiser before entering the institutions/offices.

Summary of household characteristics

The quantitative phone survey included 336 households: 113 UPSNP beneficiaries, 120 SSB owners, and 103 refugees and IDPs – 44 fewer respondents than in Round 3 due to dropout (i.e., network and psychosocial problems following the conflict in the Tigray region, refusal to participate, phone switched off, or unavailability). Female respondents accounted for 50%. 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 50% of them had at least one child under five.

For the qualitative study, 30 interviews (compared to 35 in Round 3) were conducted with five UPSNP beneficiaries, six respondents from the SSB group, nine IDPs/refugees, and 10 participants from the special population group (i.e. day labourers, shoeshines, waiters, porters).

Table 1: Characteristics of quantitative household survey respondents, urban poor in selected nine cities in Ethiopia, March 2021 (total n = 336, UPSNP = 113, SSB = 120, IDPs/refugees = 103)

Study sites/cities (n = 336)	UPSNP		SSB		IDP/ refugee		Total	
	N	%	N	%	N	%	N	%
Gender of the respondent								
Female	75	66	44	37	48	47	167	50
Male	38	34	76	63	55	53	169	50
Family size								
Less than three	17	15	17	14	4	4	38	11
Three to five	57	50	56	47	53	51	166	49
Above five	39	35	47	39	46	45	132	39
Number of children under five								
None	64	57	60	50	45	44	169	50
One	27	24	40	33	33	32	100	30
Two	16	14	17	14	19	18	52	15
Three or more	6	5	3	3	6	6	15	4
City								
Addis Ababa	12	32	13	35	12	32	37	11
Adama	13	33	14	35	13	33	40	12
Bule Hora	16	47	17	50	1	3	34	10
Dire Dawa	15	37	15	37	11	27	41	12

Jigjiga	13	30	15	35	15	35	43	13
Semera	15	34	14	32	15	34	44	13
Logia	15	33	15	33	15	33	45	13
Bahir Dar	12	31	13	33	14	36	39	12
Gambela	2	15	4	31	7	54	13	4
Total	**113**	**34**	**120**	**36**	**103**	31	**336**	100

Note: Changes from Round 3 in brackets. Mekelle sample was 0 UPSNP, 7 SSB, and 12 IDPs/refugees.

Highlights of the results – Round 4

- Overall, self-reported **practice of, and compliance with, the COVID-19 preventive measures was limited and had significantly decreased compared to the previous rounds**. Perceptions regarding the severity of COVID-19 and the low perceived susceptibility to the disease seem to have contributed to a decline in the practising of preventive measures. Compared to the previous rounds, it was less common to observe people wearing a facemask, maintaining a physical distance, and avoiding public gatherings in seven of the nine cities included in this study, the exceptions being Addis Ababa and Adama.
- **Shortage of water, and a difficulty to access it, remained a major problem** for the urban households. The proportion of households that reported having experienced a water shortage continued to increase, from 34% in Round 1 to 50% in this round. Similarly, difficulty in accessing a water sharply has increased, from 18% in Round 1 to 43% in this round. The major reasons given for this were inadequacy of the water supply, sporadic availability of water, and the absence of a municipal water service. This problem was most prevalent in **Gambella, Jigjiga, Adama, and Bule Hora**.
- Despite the increasing average monthly income of households, from ETB 2,477 in Round 1 to ETB 3,069 in this round, the respondents mentioned experiencing a **double economic burden due to the increased cost of living**, particularly **a sharp increase in the price of food items.**
- Eating less preferred foods and reducing the number of meals per day remained the predominant strategies for coping with food insecurity (unaffordability) in this round. Respondents also mentioned avoiding or stopping buying expensive foods as a major coping mechanism. The incidence of food shortages was higher among respondents from **Semera, Jigjiga, and Bule Hora**, compared to the other cities.
- Only 51 respondents (15% of the total sample) reported that they had needed medical treatment over the past month, and, of these, only one said that they were not able to access medical treatment when needed. Fear of being infected by COVID-19 did not seem to be a barrier to treatment-seeking behaviour, including maternal and child health services.
- In all cities, schools were open, but the students only attended school every other day due to the social distancing requirement. About 5% of girls and 2.4% boys were not attending school.
- The proportion of respondents who reported feeling stressed due to COVID-19 has not changed compared to the previous round. However**, the proportion of respondents with symptoms of probable depression (according to the Patient Health Questionnaire (PHQ)-9 index) has increased**, from 13% in Round 3 to 15% in this round.
- Finally, **there has been a decline in the proportion of households who reported having received aid and support** during this round (from 26% in Round 3 to 20% in this round). Government and NGOs were still reported to be the main sources of support for the urban poor.

Results by theme

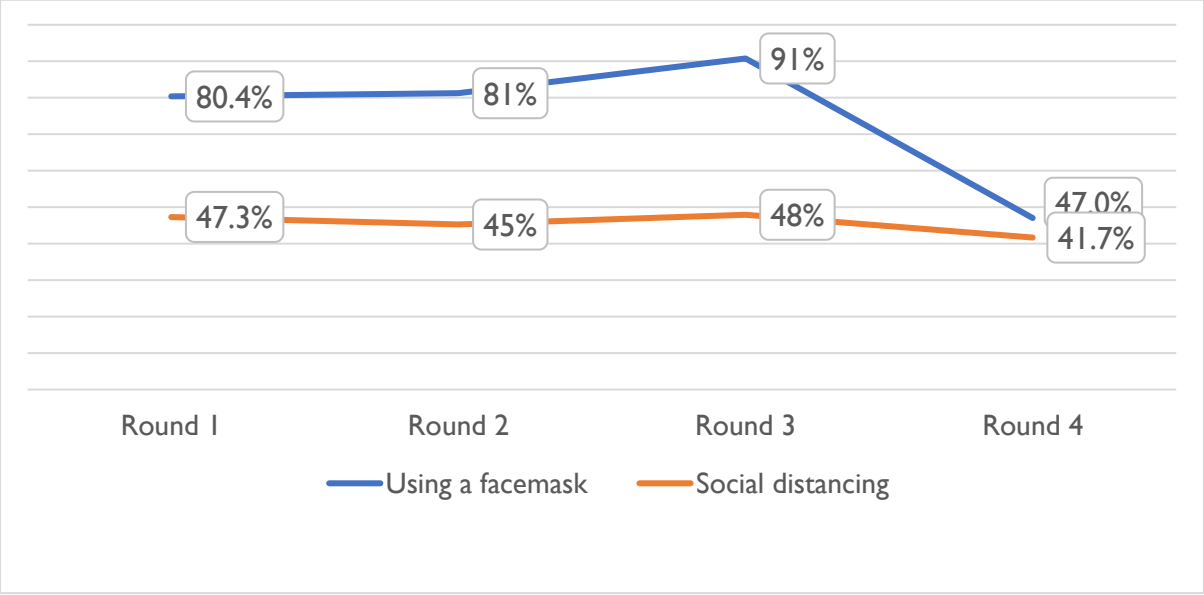
Behaviour relating to COVID-19 prevention

Key findings:

- Most respondents believe that COVID-19 still exists, but that they are no longer at risk of contracting the disease.
- The practising of COVID-19 preventive measures has declined significantly in this round and was also found to vary across the cities. Relatively better practices of handwashing/hand-rubbing and using a facemask were observed in Adama and Addis Ababa compared to other cities.

Most (80%) of the participants believe that COVID-19 still exists. However, 28% of the total sample also believe that they are no longer at risk of contracting the disease. **Overall, the practising of COVID-19 preventive methods was found to be limited**. In this round, only 47%, 41.7%, and 47% reported that they were still practising handwashing and using hand sanitiser, keeping a physical distance, and using facemasks, respectively. These figures were much lower than those in previous rounds. The use of facemasks had significantly decreased, from 80% in Round 1, 81% in Round 2, and 90.8% in Round 3 to 47% in this round, with a significant drop between Round 3 and this round (see Figure 1).

Figure 1: Practising using a facemask and social distancing among the urban poor in selected nine cities in Ethiopia, (n=336), March 2021



We found no statistically significant difference in terms of practising handwashing and hand-sanitising (chi-square: 0.107; p-value: 0.948), physical distancing (chi-square: 1.973; p-value: 0. 373), and wearing a facemask (chi-square: 2.169; p-value: 0.338) between the UPSNP beneficiaries, SSB, and refugee/IDP groups. Moreover, the differences in the practising of COVID-19 preventive measures were not statistically significant between male and female respondents.

The respondents also reported low compliance with the preventive measures among family members. Only 37.8% and 18% reported that all their family members complied with wearing a facemask and physical distancing, respectively, which was significantly less compared to Round 3 (58.3% and 45.8%, respectively). There was also a statistically significant difference in the level of family compliance with wearing a facemask between UPSNP beneficiaries, the SSB group, and the IDP/refugee group (chi-square: 13.768; p-value: 0.032). A higher level of compliance with wearing a facemask was found among the SSB group (Table 2). The discrepancy could be due to the nature of SSB owners' work: they have to interact with people more than the other groups.

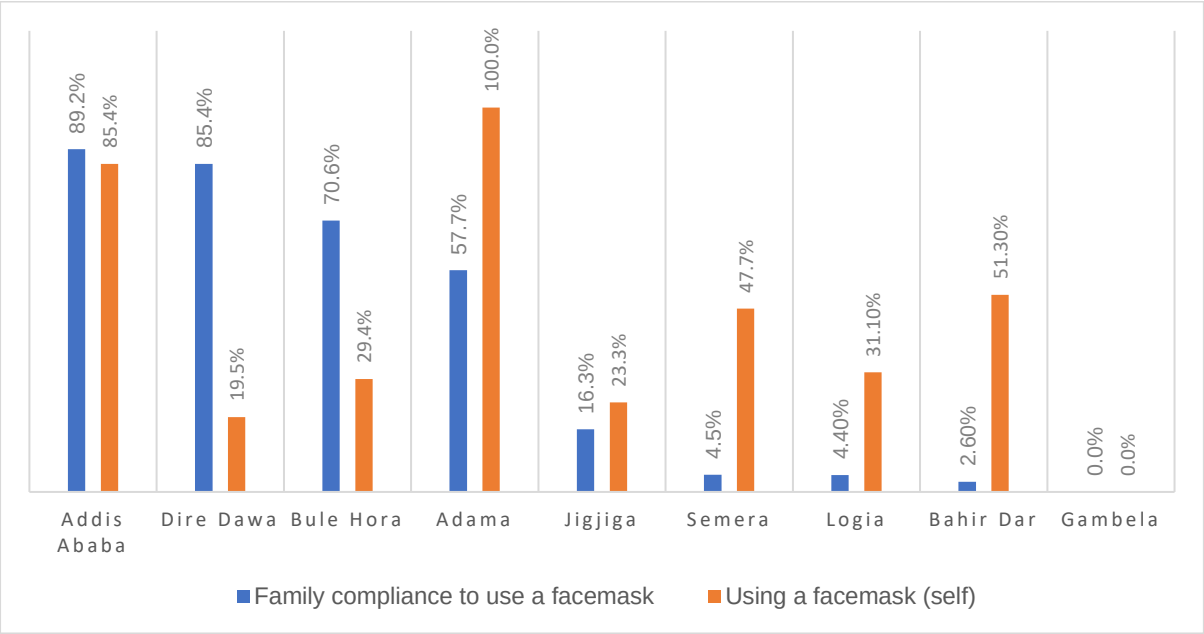
Table 2: Family compliance with government restrictions among the urban poor in selected nine cities in Ethiopia, March 2021 (total n = 336; UPSNP = 113, SSB = 120, IDPs/refugees = 103)

Restrictions	UPSNP (%)	IDPs/refugees (%)	SSB (%)	Round 4 total (%)	Chi-2 [p-value]
Compliance by family members with handwashing/sanitising					
None of them	*4.4*	*13.6*	*10.0*	*9.2*	6.328 [0.387]
Some of them	*38.1*	*33.0*	*38.3*	*36.6*	
All of them	*45.1*	*39.8*	*40.8*	*42.0*	
No longer in place	*12.4*	*13.6*	*10.8*	*12.2*	
Compliance by family members with wearing a facemask					
None of them	*15.9*	*27.2*	*13.3*	*18.5*	13.768, **[0.032]**
Some of them	*25.7*	*24.3*	*35.8*	*28.9*	
All of them	*44.2*	*30.1*	*38.3*	*37.8*	
No longer in place	*14.2*	*18.4*	*12.5*	*14.9*	
Compliance by family members with social distancing					
None of them	*38.9*	*51.5*	*49.2*	*46.4*	9.394 [0.153]
Some of them	*15.9*	*16.5*	*17.5*	*16.7*	
All of them	*26.5*	*11.7*	*15.8*	*18.2*	
No longer in place	*18.6*	*20.4*	*15.8*	*18.2*	

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

There was a significant difference in the level of family compliance with the COVID-prevention methods among family members **between the cities.** A lower level of compliance with wearing a facemask among their family members was reported in Jigjiga, Semera, Logia, Gambela, and Bahir Dar (Figure 2).

Figure 2: Self-reported use of a facemask and family compliance with using a facemask all the time among family members of the urban poor in selected nine cities in Ethiopia, March 2021 (total n = 336)



The decline in the practising of preventive methods was also reflected in the qualitative interviews. According to the qualitative findings, knowing someone infected with the COVID-19 encouraged preventive measures and increased perceptions of the disease as real and severe.

However, for some respondents the pandemic was believed to be a curse and punishment from God:

> *What matters is the perception of the people. Some people believe this virus is a curse from God. Others believe there is no way to escape from this virus, and the virus might attack a person everywhere if it is the will of God.* (UPSNP beneficiary, Adama)

> *The community believes that God has sent the disease and the solution is God.* (UPSNP beneficiary, Addis Ababa)

In addition, the misuse of facemasks and the lack of precautions by public figures led people to believe that COVID-19 does not exist:

> *You see public figures like ministers while they put their mask on their hand or under their neck when they are in a meeting hall. After watching these behaviours on television, the community concluded that there is no corona disease and they conclusively say these are all propagandas of the government to extend their political life span.* (SSB group, Bule Hora)

Enforcement of the COVID-19 preventive measures was also found to be inconsistent and to vary between the cities. A respondent from Logia explained that it was not compulsory to wear a facemask to get services from offices, whereas in the past it was mandatory for customers to wear a facemask to receive services.

Previously, if you go to a bank and some government offices for a service, they would not let you in unless you put on a mask. Now, even if you do not have a mask, you can get the service at the bank or anywhere else, you can get services without wearing a mask. (Refugee, Logia)

WASH

Key findings:

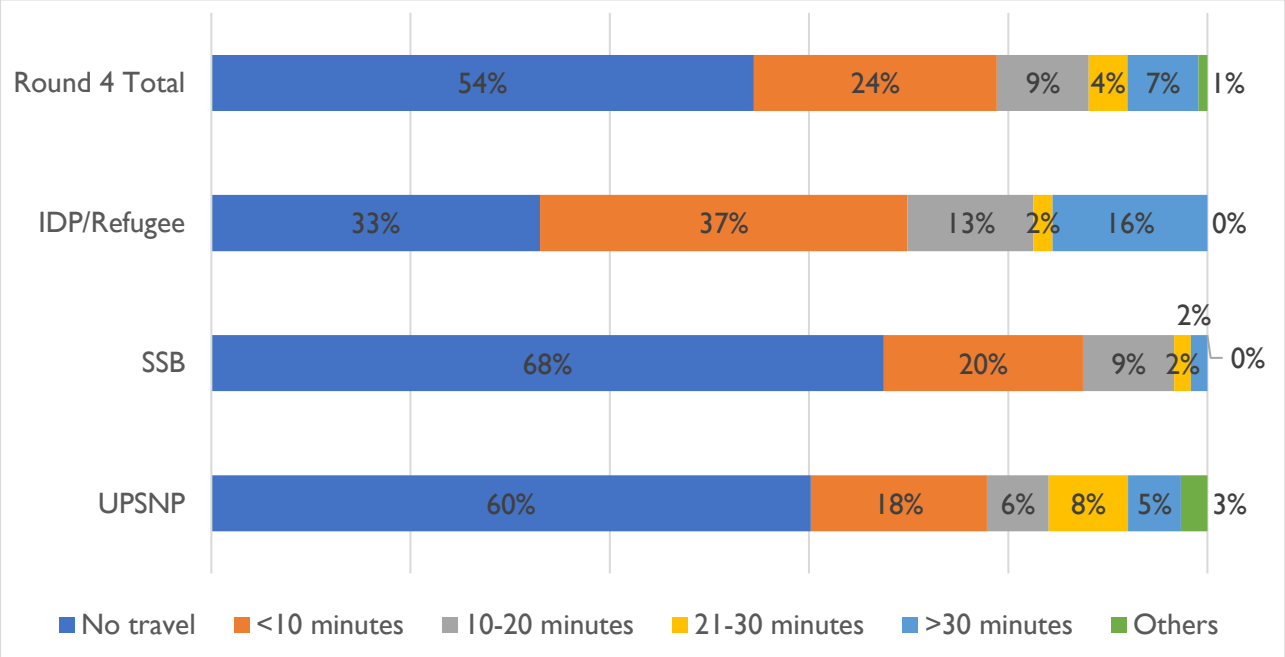
- About 50% of respondents reported a shortage of water in this round. The proportion of households that reported an incident of water shortage increased across the four rounds (34% in Round 1, 32% in Round 2, 36% in Round 3, and 50% in Round 4).
- More than 70% of respondents who reported experiencing a water shortage mentioned the inadequacy of the water supply as a major reason for this. Similarly, qualitative study participants mentioned the balance between demand and supply as one of the reasons for the shortage of water.
- The economic burden associated with purchasing water and transporting it to their homes remains a major challenge for the urban poor.

Some of the respondents (54%) had access to a water supply from near to or inside their residence (i.e. they did not need to travel to get water) but there were disparities among the three groups of respondents. Only 33% of respondents from the IDP/refugee group reported accessing a water supply from near to or inside their residence, much lower than the SSB group (68%) and UPSNP group (60%) (Figure 3).

Moreover, there was a significant variation in the level of distance travelled to access a water supply among the three categories. For instance, a notably higher proportion of respondents from the IDPs/refugees group (16%) reported having to travel more than 30 minutes (round trip) to fetch water, compared to the SSB group (2%) and UPSNP group (5%) (Figure 3).

There was also found to be a disparity across the cities in terms of access to a water supply. A relatively higher proportion of respondents from Jigjiga, Bule Hora, and Logia were required to travel to access a water supply (Annex A).

Figure 3: Distance travelled to access a water supply/water point by households in selected nine cities in Ethiopia, March 2021 (total n = 336, UPSNP = 113, SSB = 120, IDPs/refugees = 103)



Half of the respondents (50%) reported experiencing a water shortage[14] during this round. This was much higher than in the previous rounds (34% in Round 1, 36% in Round 2, and 36% in Round 3). The changes between Round 3 and Round 4 were statistically significant (chi-square value = 6.3, p-value = 0.012) (

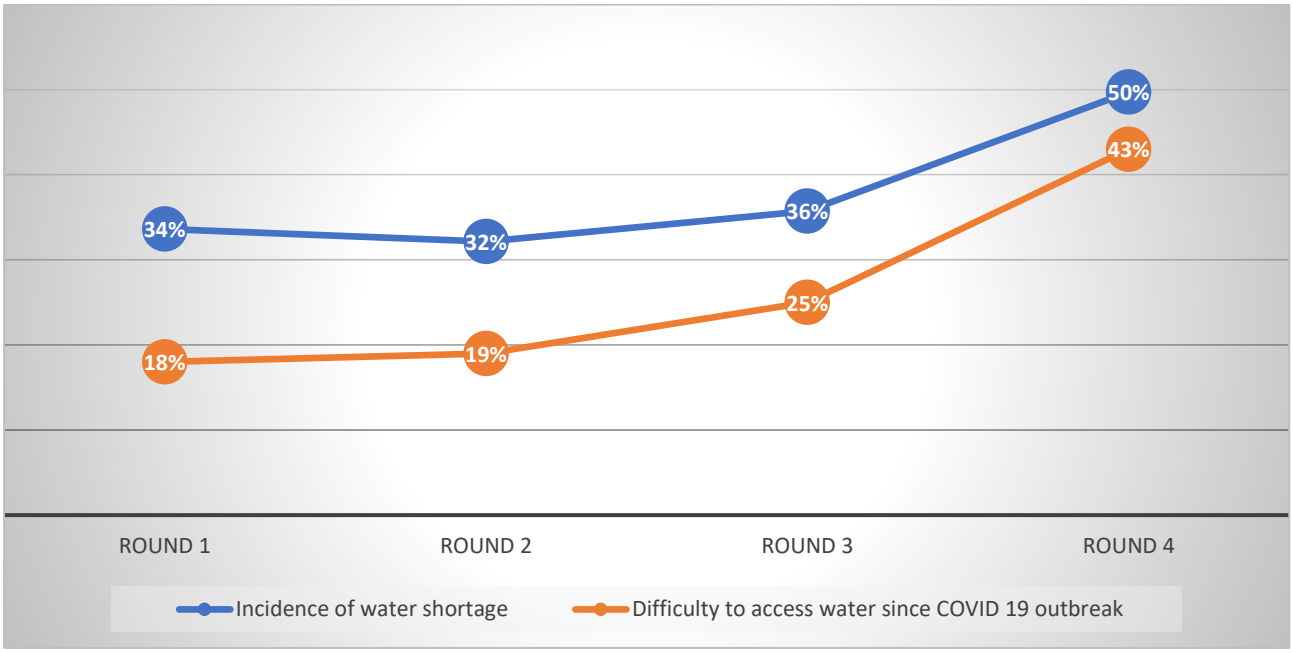
Table 3). The average number of days of water shortage during Round 3 was 5.3 days (SD = 4.5): there was a slight increase in this round, to 6.2 days (SD = 8.2), but the change was not statistically significant (Figure 4).

Similarly, the proportion of households that reported difficulty accessing water[15] has increased across the four rounds. The difference was statistically significant between Round 3 (25%) and Round 4 (43%) (chi-square value = 27.4, p-value = 0.000) (Figure 4). Compared to other categories, a higher proportion of IDPs/refugees (61%) reported more difficulty in accessing a water supply compared to the UPSNP beneficiaries (32%) and SSB group (38%). The difference among the three groups was statistically significant (chi-square value = 28.5, p-value = 0.000) (

Table 3).

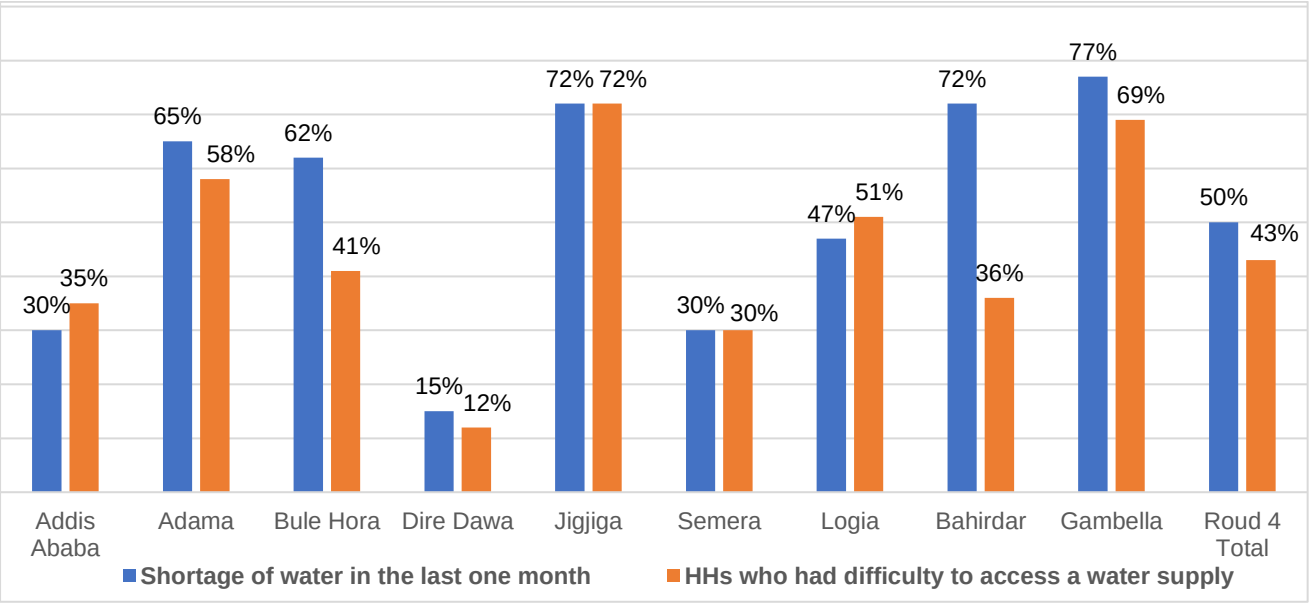
[14] Incidence of water shortage refers to a lack of water due to interruption of the water supply or unavailability of water at the source.
[15] Difficulty in accessing water refers to the degree to which the households faced a problem in getting water, despite its availability. Difficulty in accessing water is mainly related to distance, cost to buy and transport water, and the time spent on travel and queuing.

Figure 4: Incidence of water shortage and difficulty in accessing a water supply among the urban poor in selected nine cities in Ethiopia, March 2021 (total n = 336, UPSNP = 113, SSB = 120, IDPs/refugees = 103)



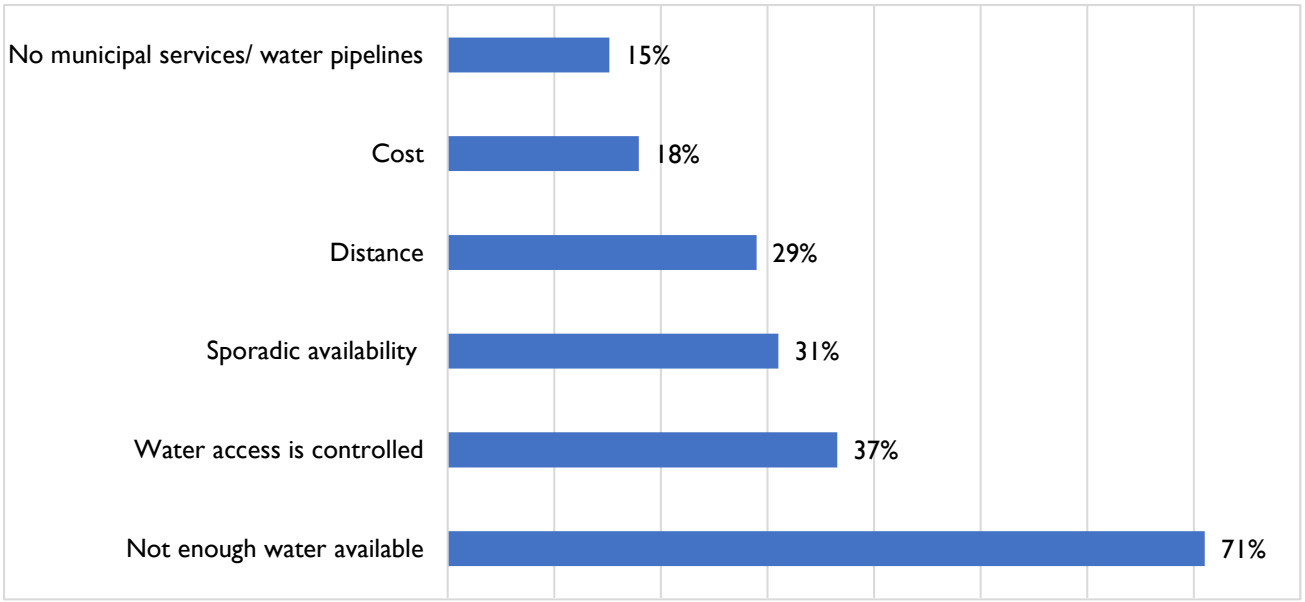
There was found to be a disparity in water shortages and the level difficulty in accessing a water supply among the nine cities. A higher proportion of respondents from **Gambella, Jigjiga, Adama, and Bule Hora reported experiencing a shortage of water and more difficulty accessing a water supply during this round** (Figure 5).

Figure 5: Proportion of households who reported a shortage of water and difficulty accessing it among the urban poor in nine cities in Ethiopia during Round 4, March 2021 (n = 336).



Those who reported having difficulty accessing a water supply in the past month (43% of the total respondents) were asked about the reasons for the difficultly in accessing water. About **71% mentioned the inadequacy of the water supply as a major reason**, while others also mentioned the sporadic availability of water, water access being controlled, the absence of a municipal water service, and higher prices/transportation costs as the main reasons for experiencing difficulty in accessing water (Figure 6).

Figure 6: Major reasons for experiencing difficulty accessing water since the COVID-19 outbreak among the urban poor in selected nine cities in Ethiopia, March 2021 (n = 138).



The qualitative interview respondents mentioned having poor access to a water supply due to inadequate infrastructure and water sources, and the perceived unfair distribution of water, as the reasons for their inability to access water. The problem seemed to be more severe among IDP/refugees.

> *I can say there is no water at all now. People are using well water [unprotected and unsafe for drinking]. Pipeline water is coming rarely now.* (IDP, Bule Hora)

> *There is still a problem with the availability of water, we do not always get it. For example, the pipe water once a week and there are also times that we get water once every two weeks. Still, our area is better than it was. We used to get water once every two weeks, but now we get it at least once a week.* (Refugee, Logia)

Another IDP from Dire Dawa mentioned the absence of safe water for drinking purposes in the camp.

> *We have no water! They are providing water that is not purified. It is not used for drinking purpose I told you last time. It is only used for shower, making food, and hygiene. For drinking purpose, we are begging from other. We have a huge problem related to a water supply.* (IDP, Dire Dawa)

Respondents from Jigjiga, Bahirdar, and Dire Dawa mentioned the perceived uneven and unfair distribution of the water supply by the city municipality, whereby water is usually available in some parts of the city but is highly interrupted in some of the villages.

> *Due to discrimination, usually, water scarcity is common in kebele 04, 05 and 06.* (Special Group, Jigjiga)

Some respondents from Adama, Jigjiga, and Dire Dawa mentioned interruptions to water distribution by the government and the shortage of water being due to an inadequate number of water points to serve the large number of households in the area.

The qualitative interview respondents mentioned the economic burden associated with the higher cost of purchasing and transporting water. Some of the respondents also mentioned being forced to buy and drink packed water, which they said they could not afford.

> *I pay 150 birr (ETB) for one cart of water. One cart holds 15 jerrican (20-litre plastic bottle) which is 10 birr per jerrican. This is enough for only three days.* (IDP, Gambella)

It was also mentioned that the current dry season has made the water shortage worse than in the previous months. During the rainy season, respondents could collect rainwater, but during the dry season there is a significant increase in their expenditure on water. Respondents also mentioned the negative effect of the water shortage on their adherence to COVID-19 prevention practices, particularly handwashing:

> *We do not have even water for drinking let alone for handwashing. Since water is not easily accessible near our area, we can't get water for drinking.* (IDP, Adama)

Table 3: Access to an adequate water supply among urban poor households in selected nine cities in Ethiopia, March 2021 (total n = 336, UPSNP = 113, SSB = 120, IDPs/refugees = 103)

Characteristics/variables		Respondent category			Chi-2 [p-value]	R 1 (%)	R 2 (%)	R 3 (%)	R 4 (%)	Chi-2, p-value
		UPSNP (%)	SSB (%)	Refugee/ IDP (%)						
Shortage of water in the last one month	Yes	42	48	61	**8.6*** [0.013]	34	32	36	**50**	**6.3** [0.0123]
	No	58	53	39		66	68	64	50	
Frequency of access to water supply	Every day	56	55	52	**7.6** [0.269]	54	64	53	54	-
	Once a week	24	26	32		24	27	36	27	
	Once in two weeks	10	4	3		5	0	2	6	
	Other **	11	15	13		18	9	10	13	
Level of difficulty accessing water since COVID-19 outbreak	Much more difficult	20	13	33	**28.5*** [0.000]	10	2	9	**22**	
	Slightly more difficult	12	25	28		18	17	16	**21**	
	Nothing changed	43	43	29		54	70	63	39	
	Easier than before	25	19	10		17	11	12	18	

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 3 and Round 4. We used the McNemar chi-square test for dichotomous variables and the Stuart-Maxwell test for other categorical variables.

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

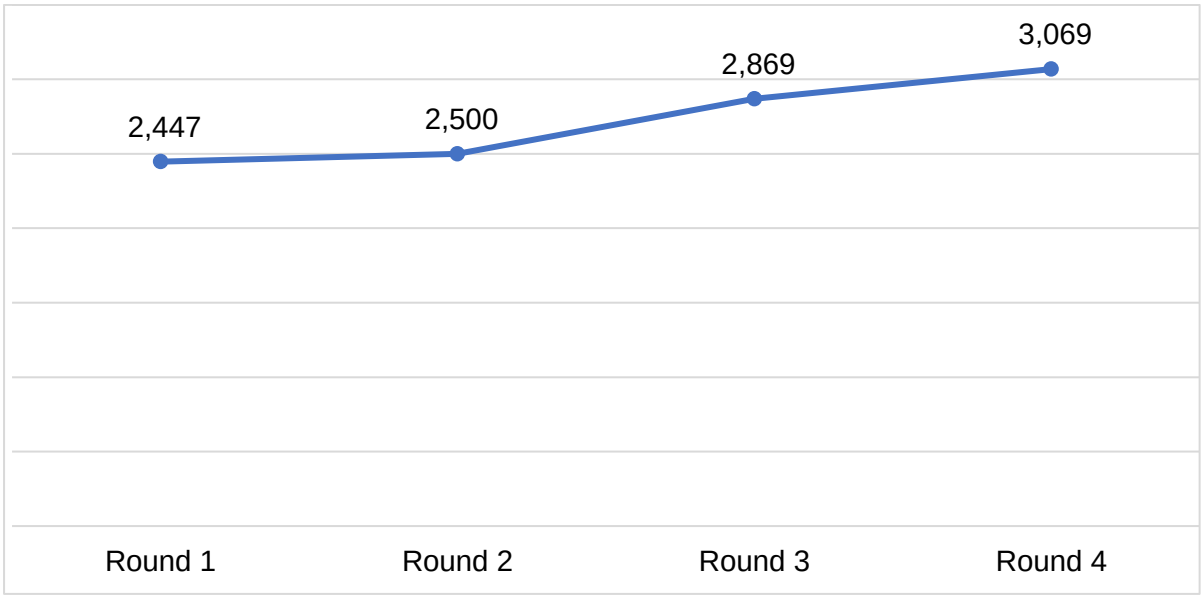
Income and expenditure

Key findings:

- The average monthly income of households has increased across the four rounds, from ETB 2,477 in Round 1 to ETB 3,069 in this round.
- The proportion of households that reported the ability to earn the same income as in the pre-COVID period has increased across the four rounds (64% in Round 1 to 84% in Round 4).
- However, most of the qualitative interview respondents referred to having the same income or having a decreased income compared to the previous month.
- There is a double economic burden due to income remaining the same or a reduction in their income, and the increased cost of living (particularly the sharp increase in the price of food items).

The average monthly income of households has increased across the four rounds according to the quantitative respondents, from ETB 2,477 in Round 1 to ETB 3,069 in Round 4. This is statistically significant (with t = -2.3 and p-value = 0.019) (Figure 7).

Figure 7: Average household monthly income of the urban poor in selected nine cities in Ethiopia, March 2021 (total n = 336)



The proportion of quantitative respondents that reported having the ability to earn the same income as in the pre-COVID period also increased from 64% in Round 1 to 84% in Round 2, but has remained unchanged in Round 3 (85%) and Round 4 (84%). The change between Round 1 and Round 4 was statistically significant (with a chi-square value = 75.9 and p-value = 0.000).

Moreover, during this round 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.

In contrast to the quantitative result, most of **the qualitative interview respondents** referred to **having the same income or seeing a decrease in their income compared to the previous month**. Some of the IDPs and refugees also reported a decrease and/or interruption to the aid they received from the government.

> *Previously, we used to get 2,000 birr from donors. But this has now stopped and also the support that we get from the government. In addition, we are not even engaging in the work activities that we used to do. Therefore, our income has significantly reduced.* (IDP, Adama)

Another respondent from the UPSNP beneficiary category described the inadequacy of the monthly payment that they received in terms of fulfilling their basic needs:

> *Nothing has changed. Safetynet* [the amount of monthly payment for beneficiaries] *is just insignificant. I am earning 315 ETB every month. What is the use?...It is not even enough to cover my transport expense. It is not enough to cover my living cost. In general, don't consider it as an income.* (UPSNP beneficiary, Addis Ababa)

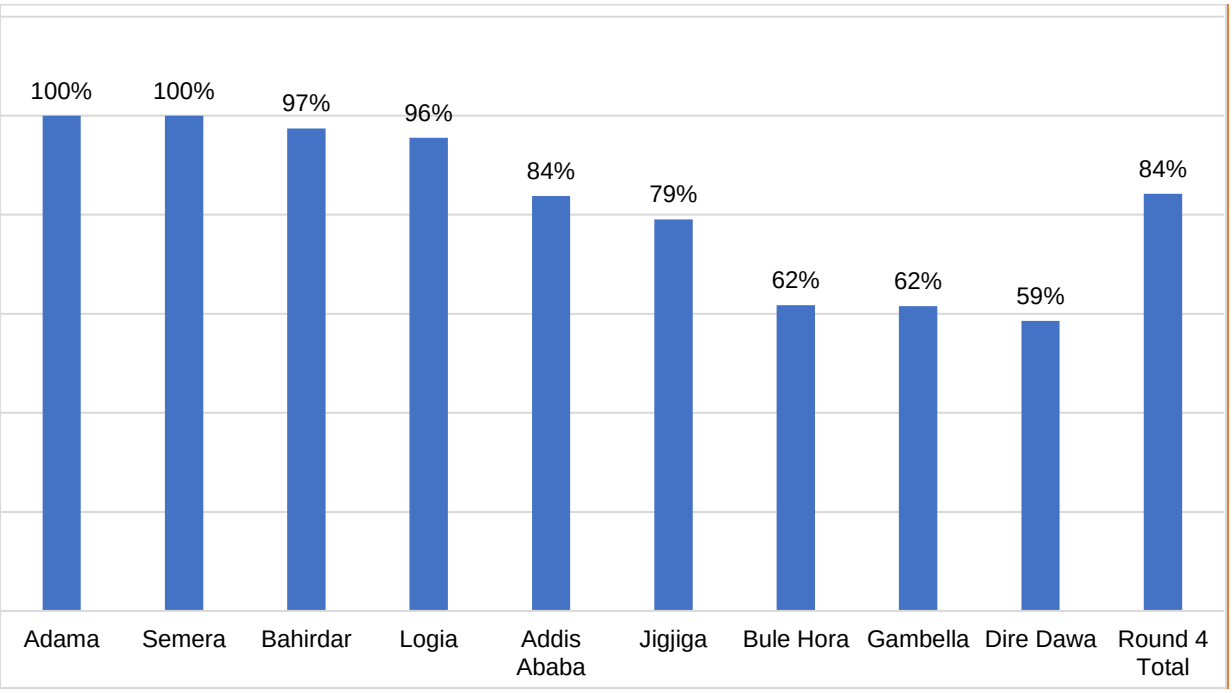
One of the respondents from Bule Hora explained the effect of the decline in economic activity in the community on the income of SSB owners as follows:

> *It's the same as what I earn before. It is well known that the majority of the population has seen a significant decline in income due to the COVID-19 pandemic. Our income rises only if we run a business and when the community buy from us. However, the income of the society has reduced, so does our income.* (SSB group, Bule Hora)

Like in the previous rounds, **an increase in the price of food items remained the major challenge to the urban poor in this round**. Most of the respondents described the impact of increased food prices and a higher cost of living as a threat to their family's well-being. Some of the respondents mentioned that they struggled to properly feed their family.

There were also disparities across cities. Respondents from Adama and Semera reported that they were able to earn the same income that they used to make before the pandemic. On the other hand, a significant proportion of respondents from Bule Hora, Gambella, and Dire Dawa said that they were not able to earn the same income as in the pre-COVID 19 period (Figure 8).

Figure 8: Proportion of respondents during Round 4 who reported being able to earn a comparable income to that earned before COVID-19 in selected nine cities in Ethiopia (total n = 336)



The qualitative interview respondents also mentioned the decreased purchasing power of the local currency because of the adjustment in the exchange rate: this was widely mentioned as a contributing factor to the increase in the price of imported goods, such as clothes and food items. In general, a decrease in household income and an increase in expenditure because of inflation were mentioned as the prominent economic challenges facing the urban poor.

> *….I am in trouble. My income is very small but my expenditure has increased. The price of everything has significantly increased. Last week I was very depressed, and I was looking for a psychiatrist....* (SSB group, Bule Hora)

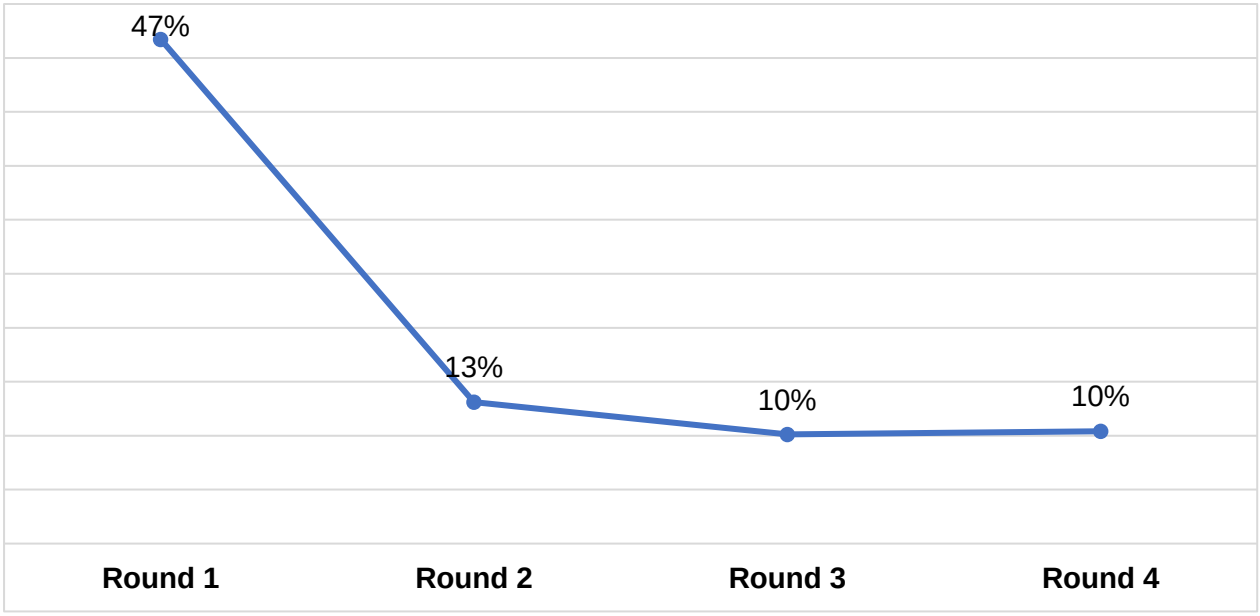
Some respondents in the qualitative interviews suspected that suppliers had made unreasonable price increases, and urged immediate action by the government to stabilise the market by controlling illegal and unfair price increases.

Respondents' **perceived risk of eviction** from their house due to loss of income has significantly declined, from 47% in Round 1 to 10% in this round (Figure 9). The decrease in the risk of eviction between Round 1 and Round 4 was statistically significant (chi-square value = 96.9 and p-value = 0.000). Respondents from the UPSNP category reported a relatively higher (17%) risk of eviction from their home, as compared to the SSB group (8%) and IDP/refugees (7%). The difference between the three categories was statistically significant (chi-square value = 96.9 and p-value = 0.000). In this round, a total of five respondents (i.e. three from the UPSNP group and two from the SSB group) reported being evicted from their house due to a loss of income (i.e. unable to pay the house rent).

A cross-city comparison shows variations across cities in regard to the risk of eviction. The proportions of households who reported being at risk of eviction were higher in Bule Hora,

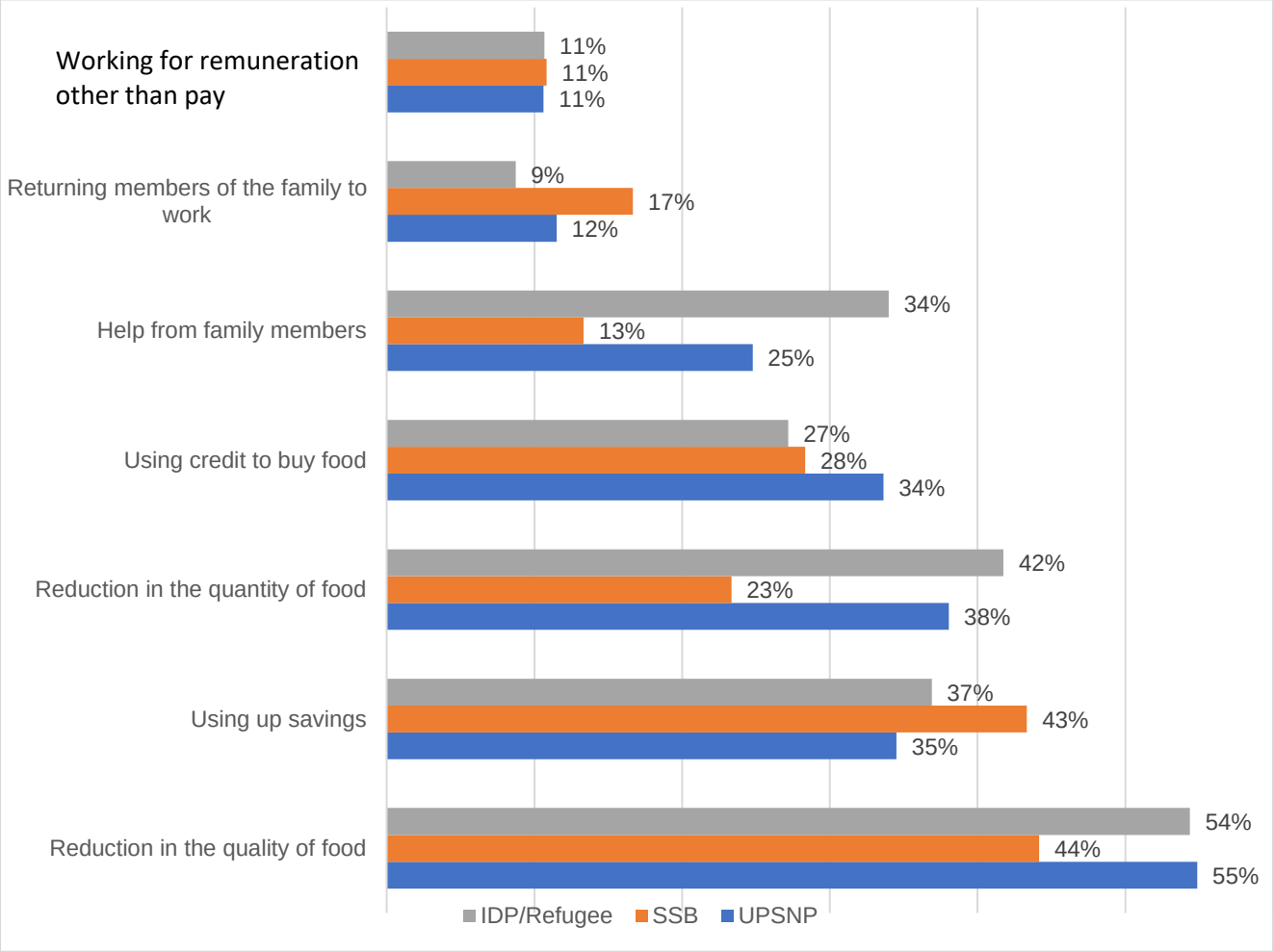
Jigjiga, and Addis Ababa, whereas none of the respondents from Bahirdar and Semera reported any risk of eviction (Annex A).

Figure 9: Risk of eviction from their house due to loss of income among the urban poor in selected nine cities in Ethiopia, March 2021 (total n = 336)



Reducing the quantity and quality of food, using up savings, using credit to buy food, and obtaining help from family members were mentioned in this round as the main coping mechanisms for reduced income. Reducing the quality of food was mentioned as the predominant coping strategy across the three categories of respondents. A relatively higher proportion of respondents from the SSB group mentioned using up savings as a coping mechanism (Figure 10).

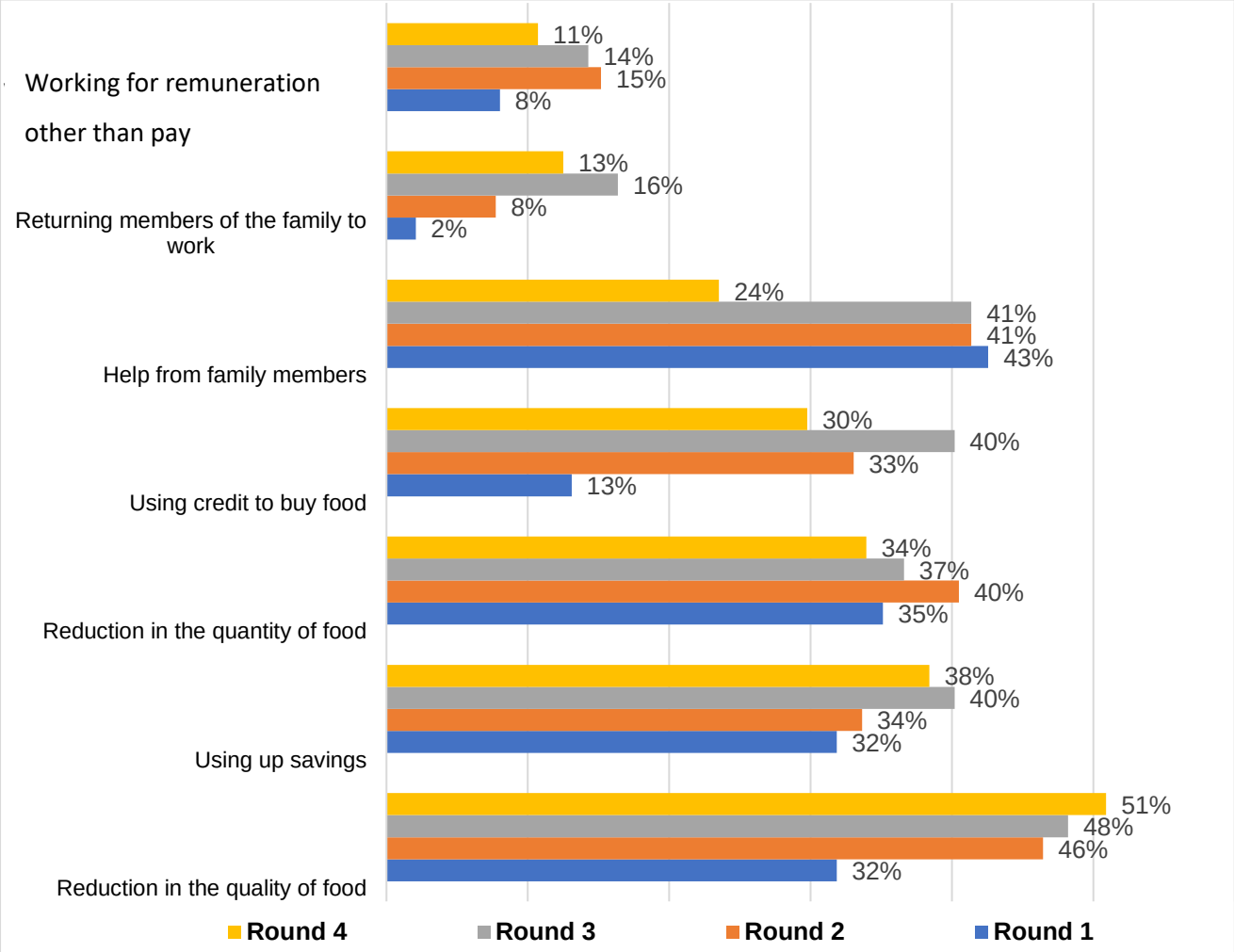
Figure 10: Coping mechanisms mentioned by all three groups of respondents in nine cities in Ethiopia, March 2021 (total n = 336, UPSNP = 113, SSB = 120, IDPs/refugees = 103)



The figure below shows trends in coping mechanisms across the four rounds. Reductions in the quantity and quality of food, using up savings, and obtaining help from family members were widely mentioned coping mechanisms across the four rounds. The proportion of respondents who mentioned reduction the quality of food has increased consistently across the rounds (from 32% in Round 1 to 46% in Round 2, 48% in Round 3, and 51% in Round 4). On the other hand, the proportion of respondents who obtained help from other family members to cope with the reduction in their income declined from 43% in Round 1 to 41% in Round 2 and 3, and to 24% in Round 4 (Figure 11).

The coping mechanisms mentioned by the qualitative interview participants were in line with the quantitative survey findings. Reducing the quantity and quality of food, purchasing less preferred and cheaper food items, and using up savings were predominantly mentioned as coping strategies for decreased income and/or the increased cost of living.

Figure 11: Mechanisms for coping with reduced income during Rounds 1, 2, 3, and 4 among the urban poor in selected nine cities in Ethiopia, March 2021 (total n = 336, UPSNP = 113, SSB = 120, IDPs/refugees = 103)



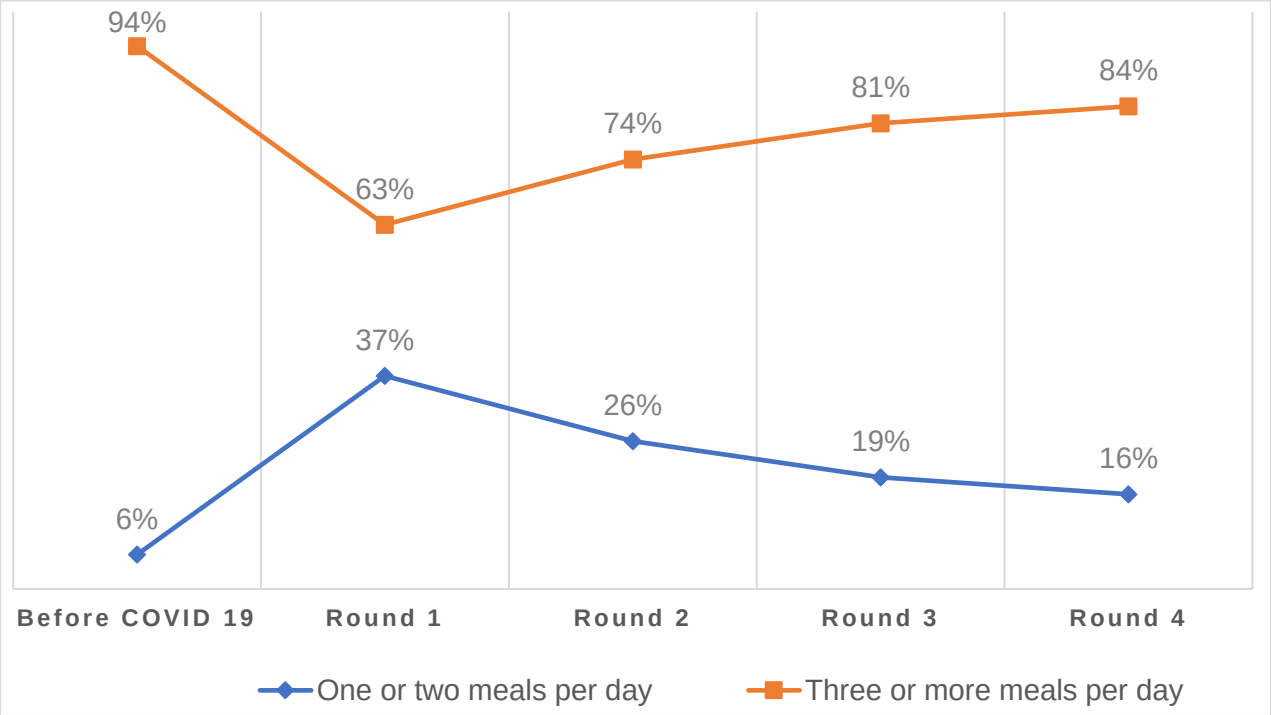
Food security

Key findings:

- The incidence of food shortage is higher among respondents from **Semera, Jigjiga, and Bule Hora,** compared to other cities.
- **Eating less preferred foods and reducing the number of meals per day have remained the predominant strategies for coping with food insecurity (unaffordability)** during the past month. Respondents also mentioned avoiding or stopping buying expensive food as a major coping mechanism.
- Egg (47%), meat (46%), and dairy products (44%) are among the food items that households had not bought or had bought less frequently and/or in a lower quantity in the past one month (i.e. during Round 4).

The proportion of households who consume an average of three or more meals per day has gradually increased from 64% in Round 1 to 74% in Round 2, to 81% in Round 3 and to 84% during Round 4 (Figure 12). The proportion of households who reported consuming three or more meals per day was highest among the SSB households (93%) and lowest for UPSNP beneficiaries (77%). The difference in the frequency of meal consumption among the three categories was statistically significant (chi-square value of 13.1 at p-value = 0.001).

Figure 12: Average frequency of meals per day consumed by household members during the last month among the urban poor in selected nine cities in Ethiopia, March 2021 (total n = 336, UPSNP = 113, SSB = 120, IDPs/refugees = 103)



The incidence of food shortages among the households appears to have declined from 56% in Round 1 to 23% in Round 4 (Chi-square value of 22.9 with p-value = 0.000). The change

between Round 3 and 4 was statistically significant (Chi-square value of 51.7 with p-value = 0.000).

The proportion of respondents who stated that they had some food reserves has increased from 81% in Round 1 to 93% in Round 4 (Chi-square value of 41.7 with p-value = 0.000). However, these reserves are only for a short period. The proportion of households having food reserves that can feed their family for more than a month is very small and has increased only slightly from 5% to 9% between Round 1 and 4 (Figure 13).

Across the respondent groups, reported experiences of food shortages was higher among the IDP/refugee (27%) and UPSNP (27%) households, while it was lower among households from the SSB category (17%). The difference among the three categories was also statistically significant (chi-square value = 18.4 and p-value = 0.000). Similarly, the proportion of households with no food reserves was lower for SSB households as compared to UPSNP beneficiaries and refugees/IDPs. 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 a better income even than some government employees. The UPSNP beneficiaries are a very poor segment of the population who are enrolled in the programme due to their lower economic status, and their inability to generate income (either due to old age or health conditions). Finally, IDPs/refugees are not native to their current location and thus they are in an economically disadvantageous position due to their displacement. Most depend on aid and support provided by the government or United Nations agencies.

Across the nine cities, **the proportion of households with a reduced number/frequency of meals consumed per day was highest in Bule Hora, Addis Ababa, and Logia**, and was lower in Bahirdar, Semera, and Dire Dawa (Annex A). Similarly, experiencing food shortages was more common among respondents from Semera, Jigjiga, and Bule Hora (Figure 14).

Figure 13: Availability of food reserves in the household among the urban poor in selected nine cities in Ethiopia, March 2021 (total n = 336, UPSNP = 113, SSB = 120, IDPs/refugees = 103)

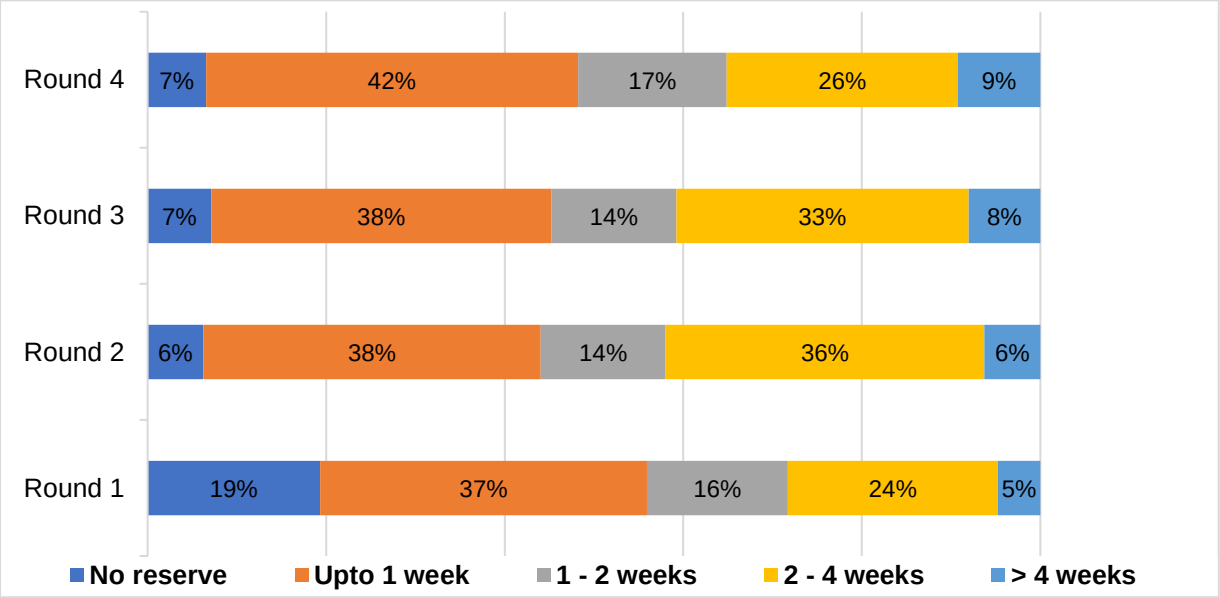
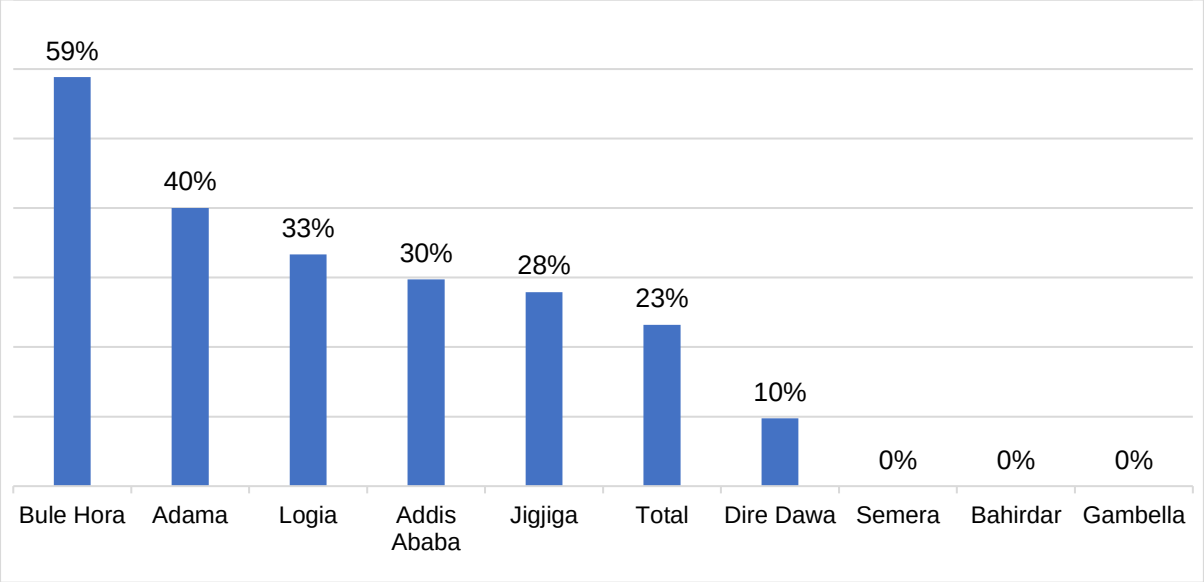


Figure 14: Incidence of food shortages over the past month among the urban poor in selected nine cities in Ethiopia, March 2021 (total n = 336, UPSNP = 113, SSB = 120, IDPs/refugees = 103)



Despite the increase in the proportion of households consuming three or more meals per day, **the quality of food was found to be low in Round 4**. For instance, only 11% and 15% of households reported consuming meat and egg in this round, respectively. Vegetables were reported as the most commonly consumed food items by the vast majority of respondents (79%) (Figure 15). Compared to IDPs/refugees and UPSNP beneficiaries, a higher proportion of households from the SSB category reported consuming meat, eggs, milk, and fruit (Figure 15). The difference in their incomes (i.e. SSB owners earn a better income than UPSNP beneficiaries, and IDP/refugees) could be contributing to the observed disparity.

Quantitative survey participants were also asked about the types of food items that they purchased less or that they had stopped buying altogether because of the COVID-19 impact during this round. Eggs (47%), meat (46%), and dairy products (44%) were among the food items that households were not buying or were buying less frequently and/or in lower quantity. These items are relatively expensive and are becoming unaffordable to the urban poor due to increased prices (Figure 16).

Figure 15: Types of food items most consumed by urban poor households in selected nine cities in Ethiopia, March 2021 (total n = 336, UPSNP = 113, SSB = 120, IDPs/refugees = 103)

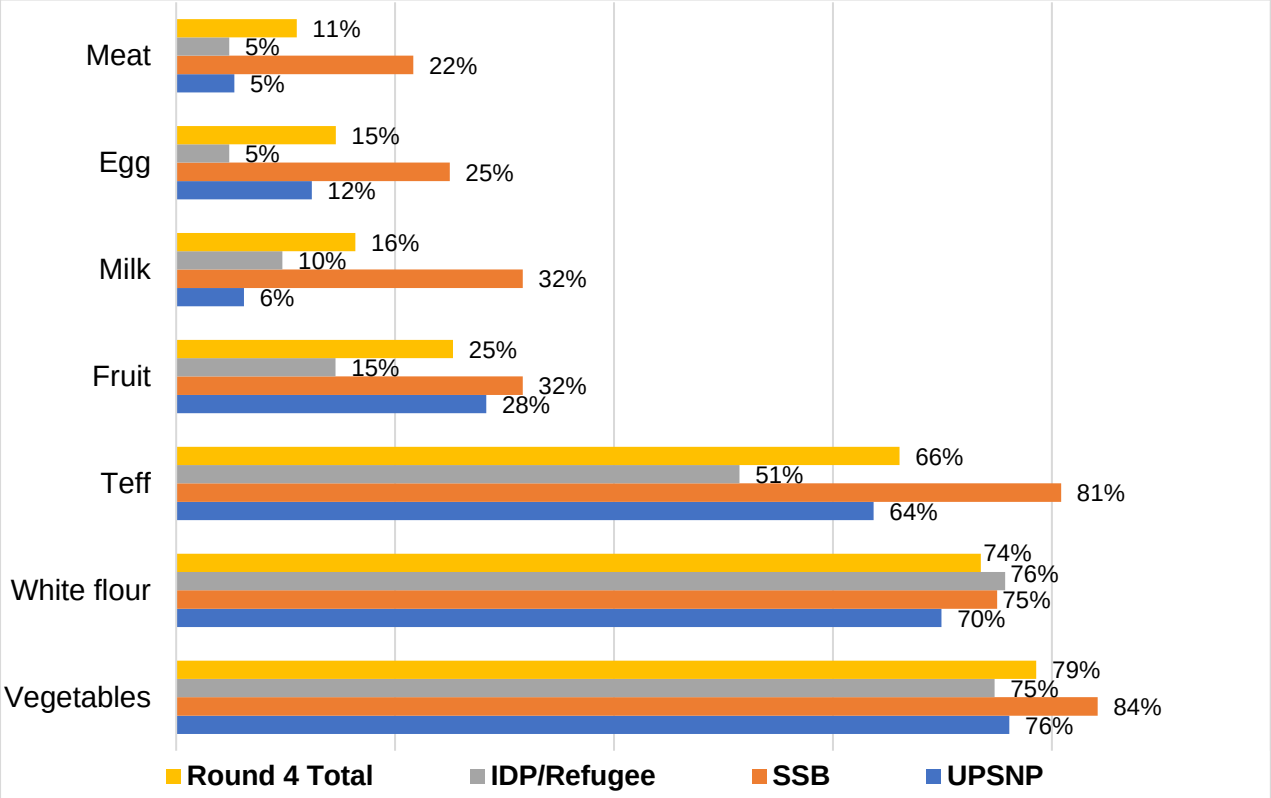
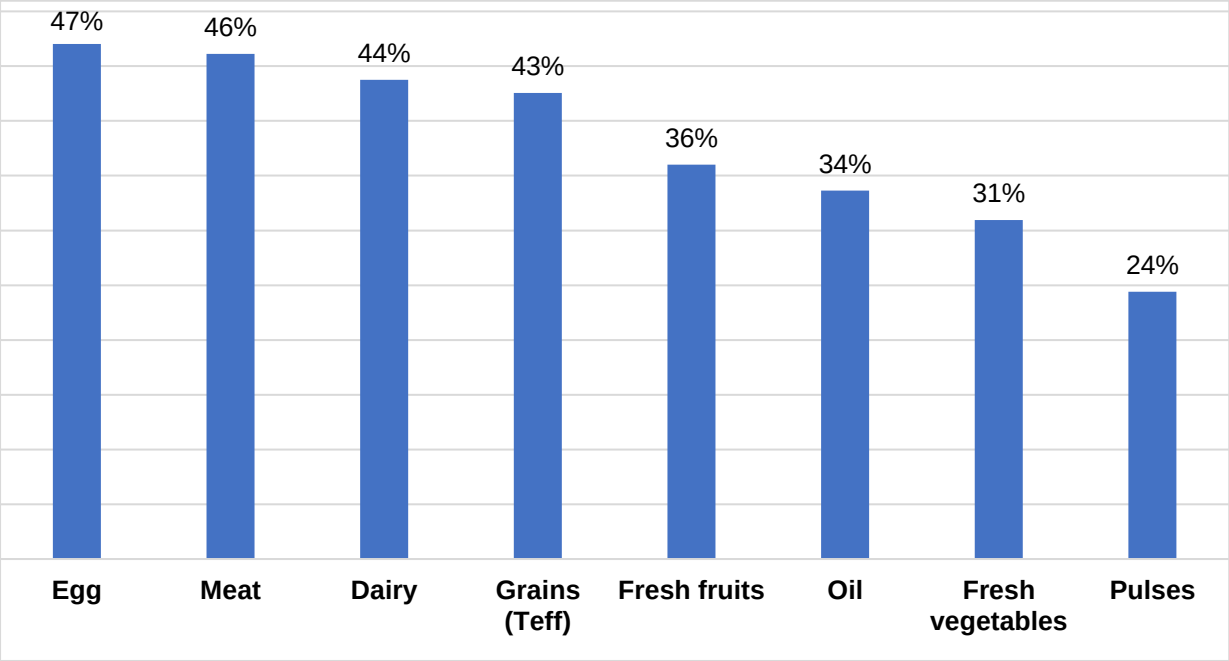
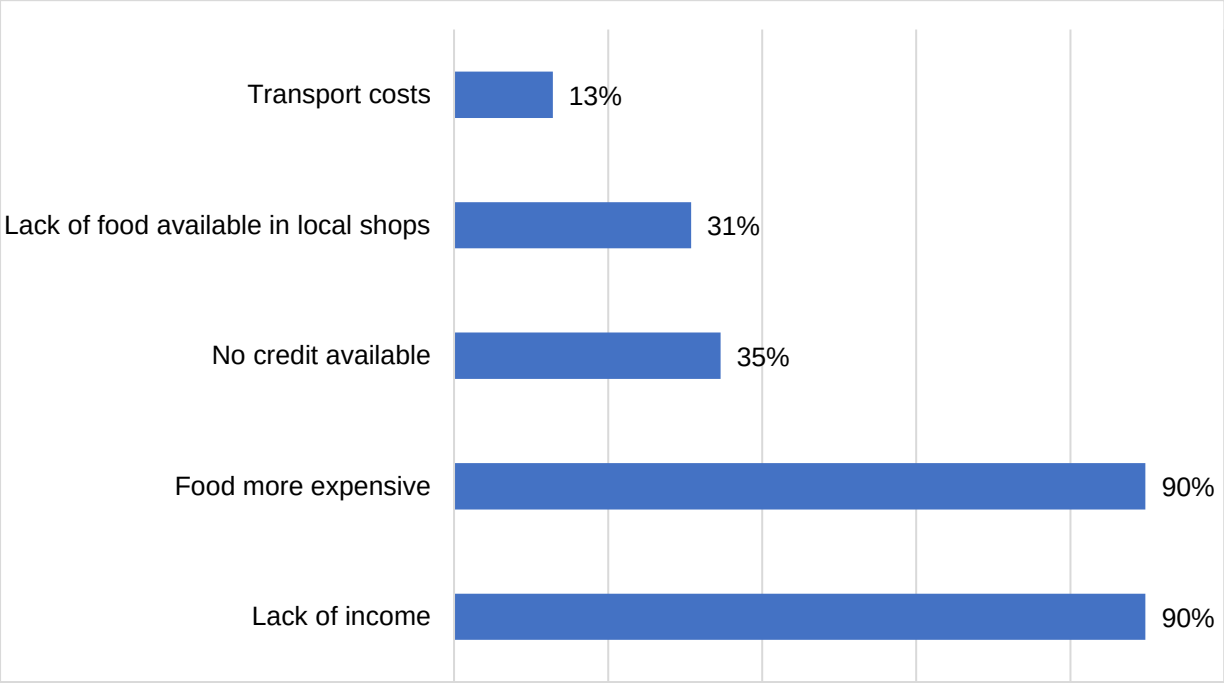


Figure 16: Types of food items purchased less or not at all because of COVID-19 impact during Round 4 among households of the urban poor in selected nine cities in Ethiopia, March 2021 (total n=336)



The 78 respondents (23% of the total sample) who reported consuming less meals per day were asked for the reasons for their reduced food consumption. Lack of income and increased prices of food items were found to be the most common reasons (Figure 17).

Figure 17: Reasons for reducing food consumption among the urban poor in selected nine cities in Ethiopia, Round 4: March 2021 (total n=78)



The qualitative findings are in line with the quantitative survey results in this area: higher food prices and a decline in household income were mentioned as the major reasons for food insecurity in general. According to the respondents, price increases were common for both imported (e.g. cooking oil, pasta, etc) and locally available food items:

> *The price of food oil and macaroni and pasta is increased. Previously it was around 20 birr, but now it is around 40 birr per kilogram. The price of wheat powder has also increased.* (Returnee, Bahirdar)

> *Food items are getting more expensive. For example, during our last interview, the price of white flour was 1,250 birr/50 kg and today it is about 1,700 birr/50 kg. So life is becoming difficult and hard to survive….* (Refugee, Semera)

> *The price increment is more than two folds…. The maize we buy for 8 birr previously is now 20 birr; 12 birr addition. Chilli (red pepper) we buy for 25 birr previously is now 50 birr; it added 25 birr. It increases too much at a time. For instance, the soap that comes through Moyale was 30 birr and now 50 birr; it added 20 birr upon us. In this situation, we may not purchase soap at all.* (SSB group, Bule Hora)

We explored the causes for the increase in the price of food items during this round. Respondents mentioned the increased exchange rate of foreign currency to birr as one of the possible reasons for the significant increase in the price of food items.

> *Even shortly after the outbreak of COVID-19 the price of food was lower. But since two or three months onward, there has been an increase due to the increase in the exchange rate (dollar), as we have heard from the media.* (IDP, Adama)

Some respondents also cited delays in the transportation of imported products due to movement restrictions in some countries as another possible reason for the increased price of imported food items like cooking oil and pasta.

> *Since our country is importing a huge amount of food from abroad, there is a shortage of currency (dollar), which is why the price of food is rising. Pasta, oil, and infants' milk are among the common food items [mainly imported from abroad] that their prices have increased.* (IDP, Jigjiga)

In addition to the above reasons, some respondents from Jigjiga, Semera, and Dire Dawa stated that there were extremely tight control measures at the border areas to prevent the entry of illegal items (contraband), which could be one of the reasons for the food price increases. They also mentioned that the control measures had resulted in decreased accessibility of, and the increased price of, food items that used to be very cheap in those cities located around the Djibouti border.

Three respondents from Logia, Jigjiga, and Bahirdar reported a slight decrease in the price of tomatoes and onions compared to the previous month. The major reason was an over-supply of those items as they are harvested in the current season.

Most of the respondents mentioned a worsening of the situation among the urban poor (mainly the IDPs and refugees) and unemployed people with no or limited income.

> *The issue [inflation] is not similar to all households: it's harder for the poor, elderly, refugees, people with economic problems and people who do not have work.* (Refugee, Semera)

> *It is most challenging for IDPs… those who can't speak Somali languages are not even getting a job, so they might not get money to buy food.* (Special group, Jigjiga)

Health

Key findings:

- Fear of COVID-19 is no longer preventing people from accessing healthcare services.
- In this round, almost all of the participants or members of their families who needed medical attention reported having been able to access medical treatment.
- Utilisation of maternal and child health services has not been significantly impacted by COVID-19.
- Most respondents are aware that people with underlying diseases like diabetes mellitus and hypertension are at increased risk of contracting COVID-19. However, they are not aware of any measures in place to protect them from the pandemic.

In this round, only 51 respondents (15.2%) reported that they had needed medical treatment in the period since the last survey. Among these 51 the most common reason reported for needing medical attention was fever with a persistent cough or difficulty breathing (23 participants), 14 of whom had been tested for COVID-19. All of those who had needed medical treatment reported that they were able to access it, except one person. The majority (95%) of the survey participants reported that they would definitely go to a health facility if they need to in the future.

In the first two rounds, our qualitative interviews indicated fear of being infected by COVID-19 as the major barrier to accessing medical care in the community. In this round, **it seems that the fear of being infected by COVID-19 was no longer a barrier to accessing medical care**.

> *It is different from the previous time. Previously, people feared to go to health facilities due to fear of being infected by this virus. Now, they are going to health centres and getting the service by keeping their distance and every other preventive measure. It is not as in the previous time.* (IDP, Adama)

However, the availability of medicines at government health facilities seemed to be an issue for some of the respondents:

> *I caught a common cold and had typhoid. Then I went to the hospital for treatment. However, there was no medication at the hospital. Thus, I bought the medications from outside [private facility] and it was expensive, about 400 ETB.* (Special group, Semera)

Respondents appeared to be well-informed regarding the fact that people with chronic diseases like hypertension and diabetes mellitus are at increased risk of COVID-19.

> *No one is vulnerable for COVID-19 in our family, because no one had a chronic disease so far and there are no old people*. (UPSNP beneficiary, Jigjiga)

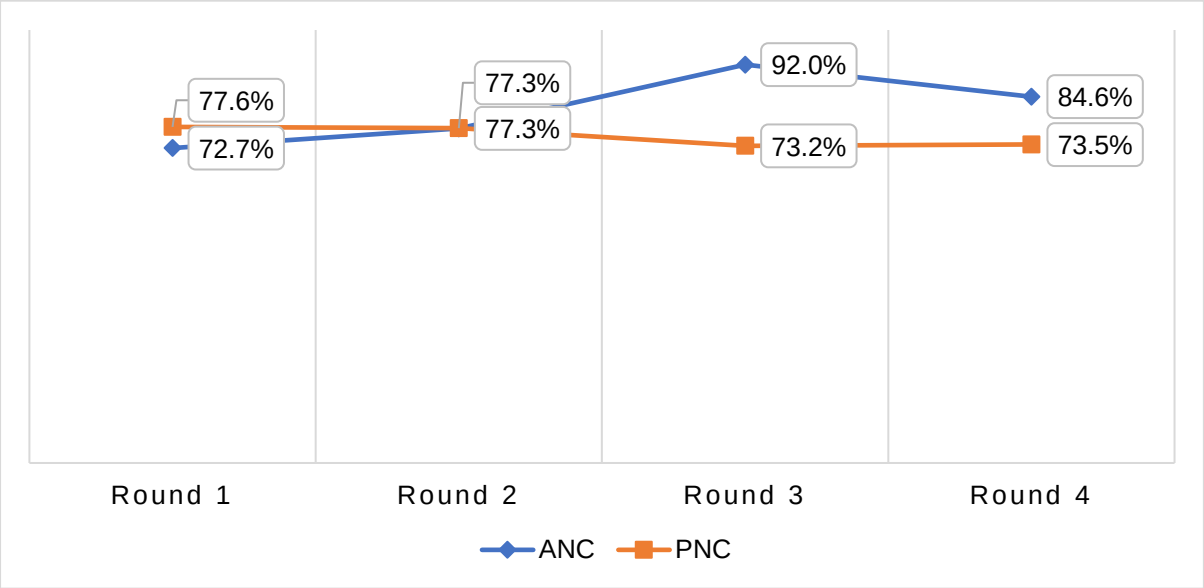
Of the total quantitative interview respondents, 49% (165 households) of the total household sample had children under five years old. Respondents were asked if any children under five in their family had been sick since the last survey. Only 19 respondents (11.5%) reported that there was at least one child under five who had been sick, and all of those respondents reported taking their child to a health facility for treatment. Respondents were also asked if any of their children under five years old had been diagnosed as malnourished. In this round, 28 (17% of the 165 respondents) reported that their children had been diagnosed with malnutrition by health workers, which is higher than the 8% found in Round 3. This figure is also higher compared to the 5.7% national average prevalence of acute malnutrition in urban areas in Ethiopia,[16] which could be attributed to the fact that this study is being conducted among the most disadvantaged segment of the urban population. All 45 children who had an appointment and were eligible for childhood vaccines were reported to have been vaccinated.

Most of the pregnant women in the sample households were reported to have attended their antenatal care (ANC) appointment (n = 21). The level of access to ANC increased from

[16] https://dhsprogram.com/pubs/pdf/PR120/PR120.pdf

Rounds 1 to 2 but has decreased from Rounds 3 to 4 (**Figure 18**). About 20.2% of our respondents sample included lactating women (n = 68), of which 73.5% had accessed postnatal care (PNC), which seems to have remained unchanged across the rounds.

Figure 18: Uptake of ANC and PNC among the urban poor in nine cities in Ethiopia, March 2021 (n pregnant = 21; n lactating = 68)



The qualitative findings are in line with the quantitative results in this area.

The practising of COVID-19 preventive measures during visits to health facilities was also mentioned by the respondents:

> *When we go to the health centre to vaccinate the child, we find many mothers who came there to vaccinate their children. They use masks, sit by keeping their distance, and get the service [vaccination] turn by turn. There is no fear of contracting the virus [COVID-19] when taking children to a health facility for vaccination. No leaves his or her child unvaccinated.* (UPSNP, Adama)

Education

Key findings:

- In all cities, the schools are open but the students only attend school every other day due to social distancing measures within each classroom.
- Among a total 316 children who were attending school before COVID-19, 12 (3.8%) are not attending their school now that it has re-opened.
- Children have started spending more of their time on studying compared to previous rounds.
- Mothers are the primary caregivers of children during off-school days.
- More than half of all respondents reported that their child–parent relationship had improved, while a quarter reported that their child–parent relationship had worsened.
- Almost all study participants believe that spending time with their children is important while half believe that men do not value taking care of their children as much as they should.

Of the total respondents, 175 (52%) reported having at least one child. Among the total 152 female children and 164 male children who were in school before COVID-19 (n = 316), eight (5%) females and four (2.4%) males were not in school in this round. A 16-year-old boy was found to have married in this round, which was acknowledged as an early marriage, without reasons being given for why it happened.

In the qualitative interviews, none of the respondents mentioned the incidence of child marriage in their families or their community. However, it was reported that a few students had not gone back to school:

> *Most children are now back to school while some of the students didn't. I think some of these students want to work and generate an income to help their family. This is because it is difficult to continue learning while your family are facing economic problem.* (SSB group, Sumera)

The quantitative results show that around three-quarters of the respondents with at least one child in their family reported that their children had been spending their time studying and helping their families, with no significant difference across the three study groups (UPSNP group, SSB group, and IDPs/refugees). The only exception was children's time spent playing around the neighbourhood: children whose parents are IDPs/refugees were more likely to spend their time playing around their neighbourhood (chi-square: 14.6; P-value =0.001) compared to those from the other two groups. Additionally, 25% of the children were reported to spend their time on income-generating activities and about 44% were reported to stay at home watching TV (

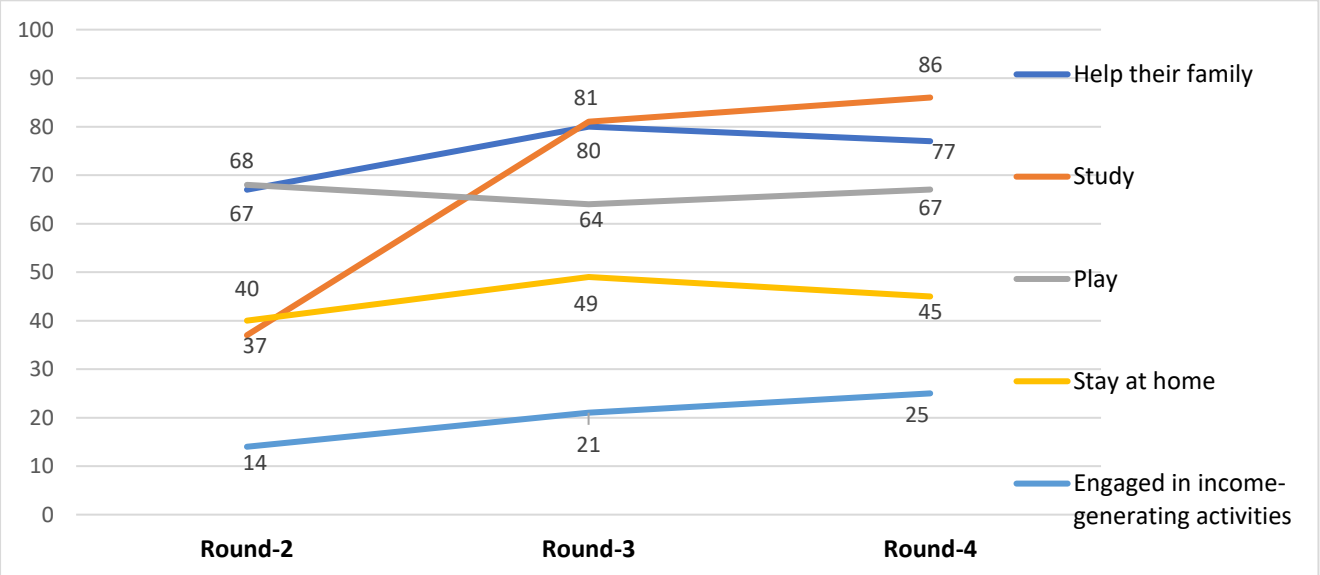
Table 4).

Table 4: Time use among children from the urban poor in nine cities in Ethiopia, March 2021 (n = 316)

Children's time use	Respondent category			Chi2-test (P-value)	Total
	UPSNP (%)	SSB (%)	IDP/Ref. (%)		
Help their family	74	74.	85	3 (0.24)	77
Study	88	88	82	1.4 (0.47)	86
Play around the neighbourhood	61	58	87	14 (0.001)	67
Stay at home, watch TV/movies, and play games	45	49	38	1.4 (0.48)	45
Engaged in income-generating activities	22	27	27	0.6 (0.74)	25

The percentage of time that children spent studying has increased from 36% in Round 2[17] to 86% in this round. The proportions of children helping their families with household activities and staying at home and watching TV/movies or playing games have declined compared to the previous rounds. On the other hand, children's engagement in income-generating activities has also consistently increased across the rounds (Figure 19).

Figure 19: Children's time use among the urban poor in nine cities in Ethiopia, during COVID-19 pandemic (total n= 316)



Although the schools were open, class sizes were reduced by half and thus the number of school days for each student had been reduced from five to three days a week. Having a small number of students in class allows students to avoid physical contact, as part of COVID-19 prevention measures.

> *The new thing in this round is that the schools are opened. They [students] are attending school only three days a week. When we ask their teachers, the number of*

[17] We did not collect these data in Round 1.

> *school days are reduced hoping this will help to reduced COVID-19 transmission. For example, if the class holds 50 students previously, now the class size is reduced to 25.* (IDP, Dire Dawa)

Some parents reported trying to help their children to study, while others mentioned that the new schedule affected their children's time use and that they ended up spending their time playing with their friends:

> *Since they are attending school three days a week…they use their free time [the remaining days] to study and to do their homework. I am also helping them with their assignments. I encourage them to read as if they are in their class. I repeatedly urge them to read.* (SSB group, Dire Dawa)

> *Our children go to school every other day. Their time management is very poor because they don't spend full time at school. I think it has affected the learning process and students' ability to remember what they have learned. They spend their time outside school playing with their friends.* (SSB group, Sumera, Afar)

Regarding personal protective equipment, almost all participants mentioned that the students wear facemasks when travelling to school. Some also mentioned that the facemasks were given to the students using the school budget. In addition, some schools provided COVID-19-related information and facemasks to their students. However, there was reported to be a lack of educational materials:

> *Schools are opened and our children are now going to school according to their schedule. They wear a facemask which is given to them from school. One thing which I want to tell you is that the school didn't give us exercise books, pens etc…this is the time we need support but we are managing it by ourselves* (Special group, Sumera)

In the previous rounds, the schools were not open and around 80% of mothers were the primary caregivers. In this round, the quantitative data show that only six respondents reported having children out of school. Interestingly, fathers were the primary caregivers for four of these out-of-school children and other relatives were responsible for caring for the remaining two children.

In the qualitative interviews, however, most respondents mentioned that mothers were still the primary carers for their children. Fathers, grandparents, and other relatives were responsible for looking after the children on the days they did not go to school. A male respondent from Logia said:

> *For some time, I have tried to take care of them [children]. But mostly, their mother looked after them. Because I go to work most of the time, and I can't spend much time with them* (Refugee, Logia)

A female respondent from the special group in Bahirdar city also said that she was the primary responsible person to look after the children

> *I spend the whole day with my little boy. The older one spends the morning time at school and home in the afternoon. I am responsible to look after them.* (Special group, Bahir Dar)

Additionally, respondents who had children in different grades mentioned that they faced difficulty looking after their children because they were in different programmes and in school at different times.

> *The class schedule is a major challenge for us. In the past, all our children used to go to school in the same time. Now, when one of the children go to school, the other children stay at home because they belong to a different shift. This is difficult for us because it makes us to look after them the whole week. So, this shift programme of schooling is very difficult for us. We could not control the children. When we ask the child why he does not go to school, he/she would say 'it's not my shift today'*
> (Refugee, Logia)

In this round, parents were asked to report the amount of time they spent with their children and their perception of their relationship with their children. About 70% reported that they spent the same amount of time or more time with their children compared to their pre-COVID-19 pandemic practice, with no statistically significant difference across participant groups (chi-square: 9.1; p-value = 0.33). About 16% reported having a very close relationship with their children before the pandemic and more than 50% reported that the relationship with their children had improved during the COVID-19 school closure. By contrast, 25% of all respondents said that their relationship with their children had deteriorated during the school closure, with no significant difference across the study groups (Table 4).

Table 5: Parents' time spent with their children among the urban poor in nine cities in Ethiopia, March 2021 (n = 175)

	UPSNP (%)	SSB (%)	IDP/ Ref. (%)	R-IV total	Chi2-test (P-value)
How much time do you spend with your children now compared to before the pandemic?					
Much less	12	8	7	9.	9.1 (0.33)
Less	19	18	20	19	
About the same	45	35	48	42	
More	24	34	23	27	
Much more	0.0	5	2	2	
Before the pandemic, how close was your relationship with your children?					
Not at all	5	4	2	4	15.9 (0.01)
Not very much close	20	27	32	26	
Somewhat close	53	48	65	54	
Very much close	22	22	2	16	
Has your relationship with your children changed over the course of the pandemic?					3.5 (0.47)
Yes, improved	54	56	65	58	
Yes, deteriorated	24	30	20	25	

No	22	14	15	17	

Almost all respondents (who had children, n = 178) valued spending time with their children. They agreed that men should spend more time with their children and about 50% of the respondents stated that they believed that men did not value caring for children as much as they should. Of the total respondents, 90% felt confident in their ability to care for their children and about 67% felt confident in their ability to provide economic support to their children (Table 6).

In line with these findings, respondents from the qualitative interviews stated that they believed that parents had a responsibility to spend time with their children. They said that children could learn from their parents.

> *I believe that spending time with children is beneficial. I'm a social worker and I have a lot of child-related work to do. It is good for the whole family to spend time with their children because it makes things easier for their children. During childhood, they can learn anything that we try to teach them and help their children to be successful. I would also love if I could spend more time with my son but I don't have time to do that right now. I only have one free day in a week.* (SSB, Logia)

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

	UPSNP N(%)	SSB N(%)	IDP/Ref. N(%)	Total N(%)	Chi2-test (P-value)
Spending time with children provides value in my life					
Strongly disagree	1 (1)	0	3 (5.0)	4 (2)	23.9 (<0.001)
Disagree	0	0	0	0	
Neither agree nor disagree	0	0	0	0	
Agree	40 (54)	30 (39)	44 (73)	114 54)	
Strongly agree	33 (45)	57 (61)	13 (22)	93 (44)	
Men should spend time with their children					9.2(0.32)
Strongly disagree	1 (1)	0.0	3 (5)	4 (2)	
Disagree	0.0	1 (1)	1(2)	2 (1)	
Neither agree nor disagree	1 (1)	1 (1)	0.0	2 (1)	
Agree	43 (58)	39 (51)	37 (62)	119 (56)	
Strongly agree	29 (39)	36 (47)	19 (32)	84 (40)	
Men do not value caring for children as much as they should					
Strongly disagree	9 (12)	14 (18)	7 (12)	30 (14)	15.1 (0.05)
Disagree	25 (34)	18 (23)	9 (15)	52 (25)	
Neither agree nor disagree	6 (8)	12 (16)	6 (10)	24 (11)	

Agree	27 (36)	20 (26)	30 (50)	79 (37)	
Strongly agree	7 (10)	13 (17)	8 (13)	28 (13)	
I feel confident about my ability to care for my children					
Strongly disagree	1 (1)	1 (1)	1 (2)	3 (1)	
Disagree	4 (5)	3 (4)	1 (2)	8 (4)	
Neither agree nor disagree	3(4)	1 (1)	4 (7)	8 (4)	8.79
Agree	48 (65)	53 (64)	45 (75)	142 (67)	(0.46)
Strongly agree	18 (24)	23 (30)	9 (15)	50 (24)	
I feel confident about my ability to provide (economically/financially)					
Strongly disagree	14 (19)	7 (9)	5 (8)	26 (12)	
Disagree	12 (16)	12 (16)	10 (17)	34 (16)	
Neither agree nor disagree	2 (3)	3 (4)	3 (5)	8 (4)	7.31
Agree	37 (50)	42 (55)	37 (62)	116 (55)	(0.51)
Strongly agree	9 (12)	13 (17)	5 (8)	27 (3)	

Mental health

Key findings:

- The proportion of respondents who report feeling stressed due to COVID-19 and the response measures has not changed.
- **The proportion of respondents with symptoms of probable depression has increased** from 13% in Round 3 to 15% in Round 4.

In this round, more than a third of respondents reported being stressed, scared, and frustrated. These proportions were higher among the UPSNP group and were lowest among the IDPs/refugees group. We also observed the same pattern across study groups in terms of probable symptoms of depression. Of the total respondents, 14% had had a feeling of hopelessness and/or had had thoughts of hurting themselves within the last 14 days.

About 7% of the respondents perceived that COVID-19 and related government measures had had a negative impact on their lives, and this perception was significantly pronounced among the SSBs group (chi-square: 9.8; p-value = 0.01) (Table 7).

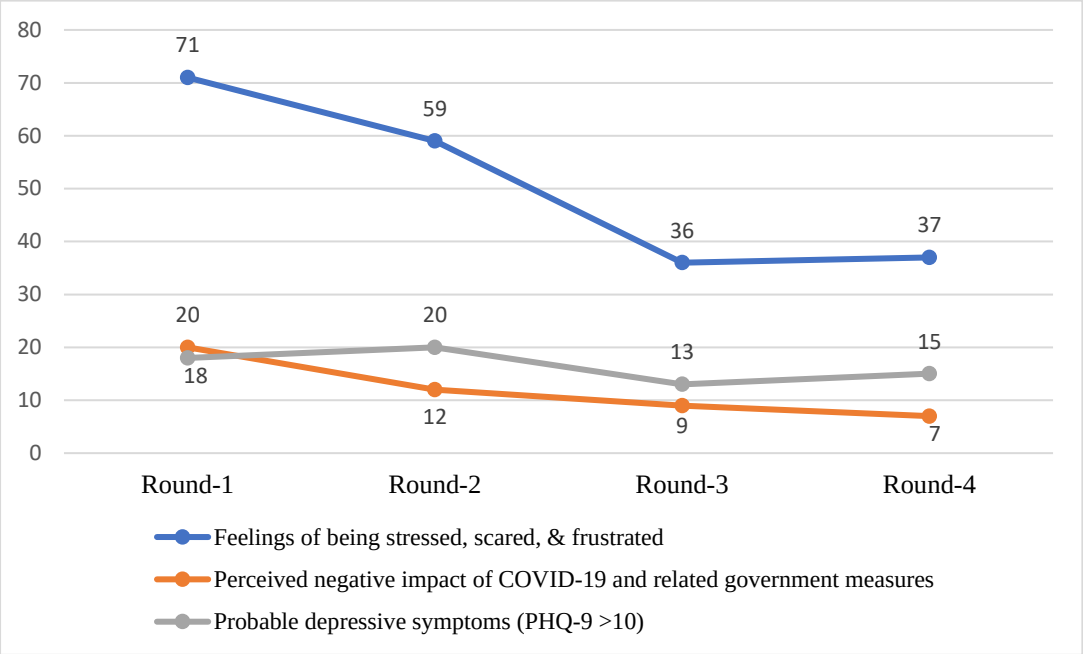
Table 7: Mental health measures for the urban poor in nine cities in Ethiopia, March 2021 (n = 336)

Measured outcome	Respondent category			Total N (%)	Chi2-test (P-value)
	UPSNP N (%)	SSB N (%)	IDP/Ref N (%)		
Feelings of being stressed, scared, and frustrated	52 (42)	38 (30)	35 (28)	125 (37)	5.5 (0.06)
Probable depressive symptoms (PHQ-9 >10)	20 (38)	18 (35)	14 (27)	52 (15)	0.7 (0.69)
Feeling hopeless and/or having thoughts of hurting themselves					
Not at all	95 (33)	105 (36)	90 (30)	290 (86)	4.3 (0.64)
Sometimes	5 (38)	4 (31)	4 (31)	14 (4)	
Most of the day	11 (35)	11(35)	9 (29)	31 (9)	
Nearly every day	2 (100)	0.00	0.0	2 (1)	
Perceived negative impact of COVID-19 and related government measures	3 (13)	15 (66)	5 (22)	23 (7)	9.8 (0.01)

The feeling of being stressed or scared decreased from Round 1 (71%) to Round 3 (35%) and remained almost unchanged in this round (37%). However, the magnitude of probable symptoms of depression in this round (15%) was higher compared to Round 3 (13%) (chi-square value = 5.44, p-value =0.02) (Figure 20).

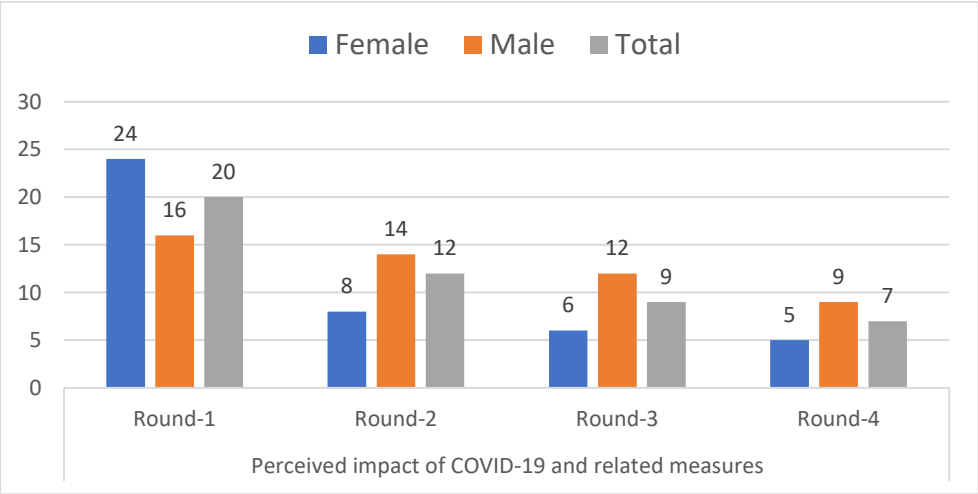
There were also differences across cities in the proportion of respondents with probable symptoms of depression: **in Adama and Bule Hora, higher proportions of respondents scored higher on the PHQ-9 index** (chi-square value = 264, p-value <0.001).

Figure 20: Feelings of being stressed, scared, and frustrated among respondent categories among the urban poor in selected nine cities in Ethiopia, March 2021 (total n= 336, UPSNP = 113, SSB = 120, IDPs/refugees = 103)



There was a slightly higher percentage of respondents perceiving a negative impact of COVID-19 among male respondents (9%) compared to females (5%), but with no statistically significant difference (chi-square = 2.63; p-value 0.10) (Figure 21). The respondents who reported a negative impact of COVID-19 were from Adama (70%) and Bule Hora (30%).

Figure 21: Percentage of respondents perceiving a negative impact of COVID-19 and related government measures by gender among the urban poor in selected nine cities in Ethiopia, March 2021 (total n = 336)



In line with the above findings, respondents who participated in the qualitative interviews also mentioned that they experienced some level of stress. Most of them mentioned that their stress was related to the lack of a job, an inability to pay their rent, and increased food prices:

> *Being unable to pay the house rent was most stressful. I feel bad when I am not able to pay for it on time. Other expenses can wait for some time if there is no money at hand.* (Special group, Dire Dawa)

Another respondent also commented on how the lack of a job and economic problems made him worried:

> *If you may feel overwhelmed with a different reason, for example when you think about payment for the rented house, unable to access care due to lack of money if you are not able to buy the things you need, and if you do not have a job to do, you are likely to be overwhelmed and stressed. These are the biggest problems that makes me worried.* (Special group, Logia)

The cost of food items and other materials, such as soap and cleaning products, had increased in this round. These price increases were reported to be an additional source of stress:

> *Currently, I am not working, my friends shared with me what they have. Our income is very small but the price of everything has increased very much. Last week I was very stressed because of the inflation. it is just a month since a gave birth. I need to go out and search for a job but I get worried about the societal norm. If I return to work just after a month of giving birth, it will not be acceptable for the society.* (SSB, Bule Hora)

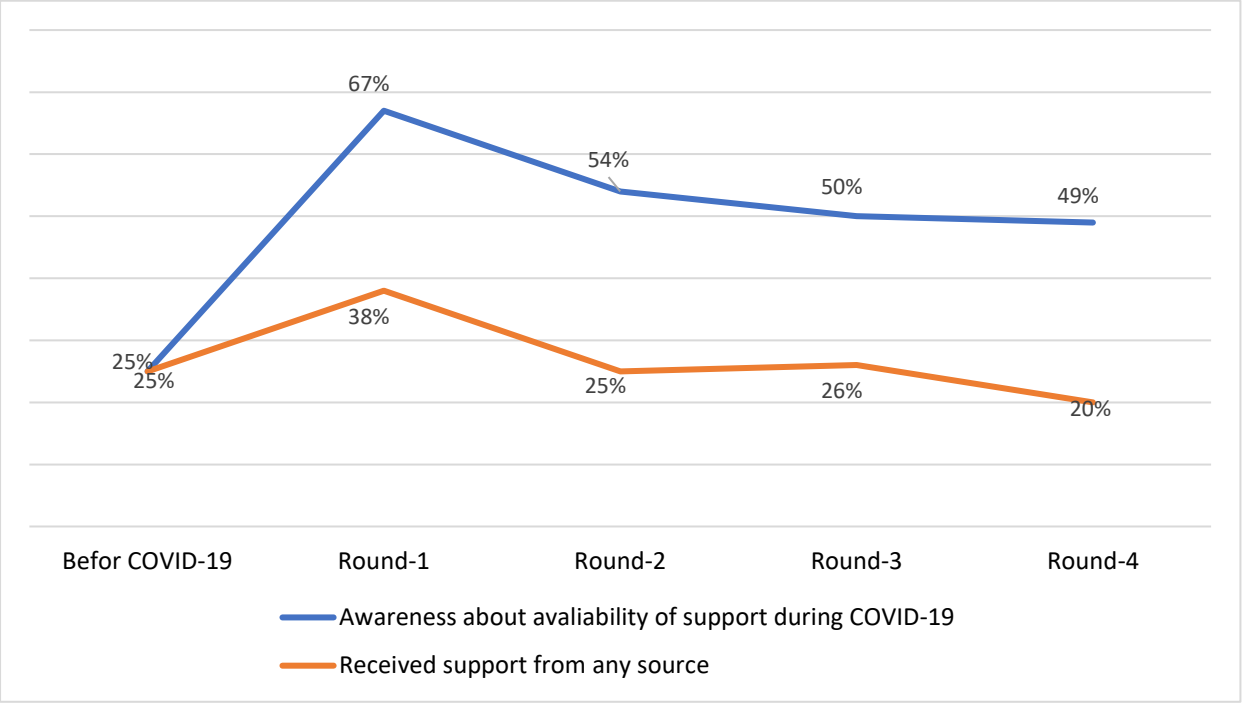
Aid and support

Key findings:

- Overall, respondents reported experiencing a decline in aid/support during this round (from 26% in Round 3 to 20% in Round 4).
- Government and NGOs have remained the main sources of support for the urban poor over the past month.
- The support provided is mainly in cash and food items.

In this round, 49% (n=163) of the respondents reported having an awareness about the availability of support from the government, NGOs, civil society organisations (CSOs), or other groups (e.g. religious institutions). Among those who had such an awareness, only 20% actually received support. There has been a decreasing trend over the study rounds in the proportion of respondents who have received aid and support. In general, respondents' knowledge about the availability of support and the proportion of those who actually received the support has declined over time (Figure 22).

Figure 22: Percentage of respondents who were aware of the availability of support, or who received it, from any source among the urban poor in selected nine cities in Ethiopia, March 2021 (total n=336)



In line with the quantitative findings, some of the qualitative interview respondents mentioned that they did not have information about aid and support and that they had not observed any support being received in their community.

> *Previously, support had been provided at the kebele level. For example, people who are poor, older, and have no support were receiving support. But now there is no such type of support in the area. There are blind and disabled people who are our neighbours. These people were receiving flour and macaroni before. However, there*

> *is support for them this time. I did not see people receiving anything. I don't know whether they are providing it around, but I did not see it.* (Special group, Bahirdar)

Others also mentioned that the support they were receiving had been reduced over time because many of the NGOs who were supporting them had phased their support out:

> *We are receiving some sort of support from NGOs, but I'm not sure whether all UPSNP is involved or not, they are providing us with some basic needs like ration, every month. The support is not adequate, but it covers some of our basic requirements. As of now, many NGOs have left, because their projects are phased out, as a result, the amount of support we had is reduced.* (UPSNP beneficiary, Jigjiga)

One IDP from Adama also said the following:

> *For anyone who has been displaced from other areas, it would be very difficult to survive if the government does not support them by creating job opportunities in different factories. This is because everyone needs food, cloth, and shelter. If you have no income, how could you cover all those expenses? The government has been supporting us previously. But those supports have now stopped for six or seven months* (IDP, Adama)

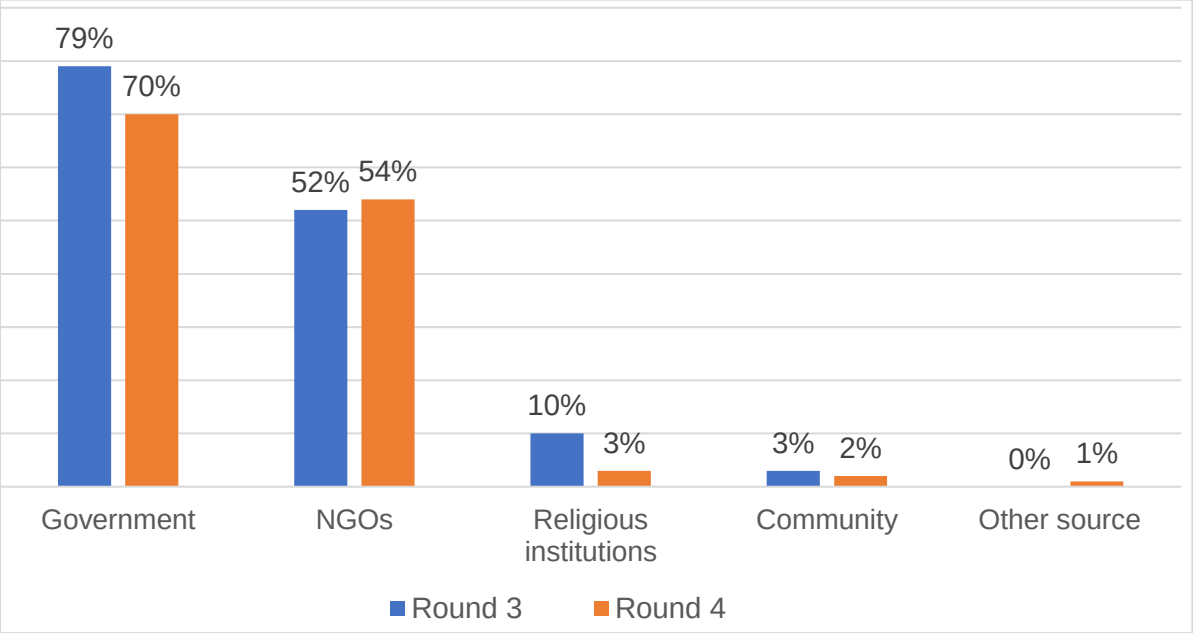
Another IDP from the same study setting said that the support they were getting was inadequate. Additionally, they said that work opportunities were also minimal. As a result, people were selling their assets:

> *The majority of our people have no job as in the previous time. Additionally, there is no adequate support. As a result, they are even selling their houses and this problem is getting even worse. This situation is even more difficult for those who have many children. That is why I feel sad and angry.* (IDP, Adama)

Similar to the previous round, for those who received support, the government was the main source of support, followed by NGOs. However, the reported amount of support from the government in this round has declined significantly compared to the previous round (P-value= 0.047). In this round, among the total participants who had received support, the support received from religious institutions (3%) was significantly lower compared to the previous round (Chi2 = 13.8; p-value < 0.001). Likewise, support from the community (2%) was also lower (

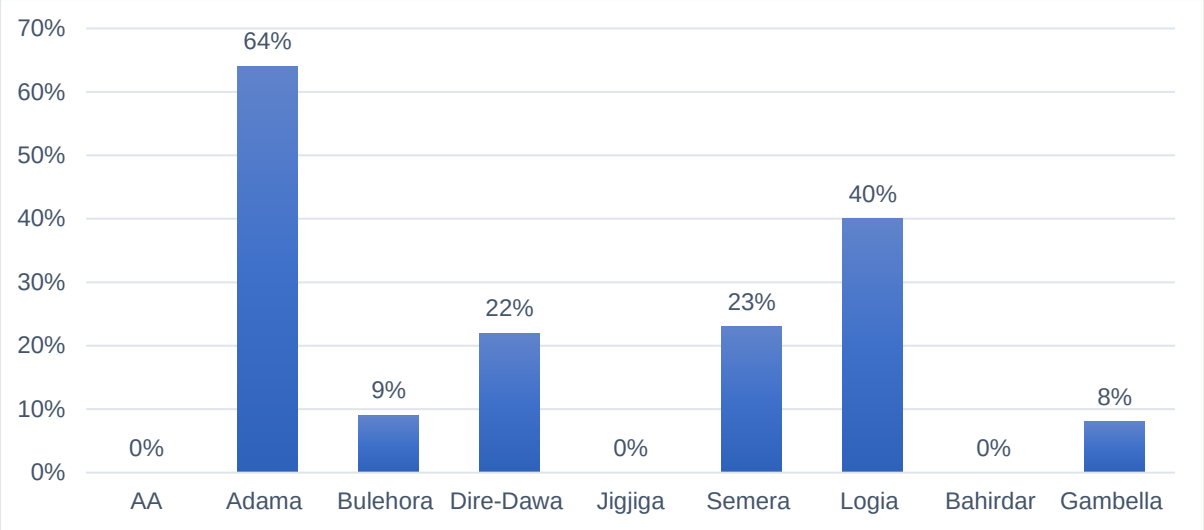
Figure 23).

Figure 23: Availability of aid and support among urban poor in nine cities in Ethiopia, March 2021 (total n = 336, UPSNP = 113, SSB = 120, IDPs/refugees = 103)



There was also a significant difference in the support received, across the nine cities (chi-square value = 93, p-value <0.001). In Adama and Logia, a higher proportion of respondents reported having received support, whereas none of the respondents from Addis Ababa, Jigjiga, and Bahir Dar reported having received support in this round. In Bahirdar, all respondents were returnees and were living with their families and thus they did not report requiring any support from the government or NGOs (**Figure 24**).

Figure 24: Support received, by study cities, among the urban poor in selected nine cities in Ethiopia, March 2021 (total n = 336)



The total amount of money the respondents reported receiving in cash ranged from ETB 360 to ETB 3,600 (US$ 9.7–97) (mean = ETB 1,103.2 and SD = 808.2). The estimated cost of the food support that they received ranged from ETB 160 to ETB 1,200 (USD$ 4.3–32) (mean = 585.6 and SD = 268.4), and the estimated cost of the support they received in kind (e.g. detergents and other cleaning products, such as soap) ranged from ETB 3 to ETB 200 (US$ 0.10–5.4).

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

		Round 1	Round 2	Round 3	Round 4
Cash	**Minimum**	150	200	200	360
	Maximum	1,650	2,160	3,600	3,600
	mean	726	944	1,073	970
	SD	322	475	721	662
Food	**Minimum**	10	50	200	160
	Maximum	3,500	3,000	1,200	1,200
	mean	638	887	557	580
	SD	505	652	233	230
In kind	**Minimum**	3	35	15	4
	Maximum	200	500	400	400
	mean	67	148	199	223
	SD	63	130	123	106

Among the qualitative interview respondents, refugees from Semera and Logia reported that they were receiving regular aid and support from the refugee camp, specifically from UNHCR.

> *To be honest, nothing changed in terms of support from religious group or anyone else. As I mentioned before, everyone is busy of his own problems. Except the support I get from the refugee camp, I haven't received any support from anyone/organisation.* (Refugee, Semera)

Respondents from Adama mentioned that support had been given for the first three or four months after COVID-19 was first reported in Ethiopia, but it had then stopped:

> *The first three to four months after COVID-19 was reported, there was support at the national level as you might have seen on TV. Then, they stopped the support when the number of people who get infected with the virus was declined.* (Special group, Adama)

In the qualitative study, respondents were asked about safety and security issues for children, women, and the whole community. Most said there was no problem that they had heard of, especially with respect to women and children. However, some respondents said that the community was anxious:

> *We hear almost every day the sound of a gunshot in the night but I do not know who did it. We have reported this to the government but there is no solution for this. However, we are sure it is not the government's gunshots every night. Due to this, our women and children stay in fear every night.* (IDP, Adama)

Conclusion

Overall, the results from this round of data collection point to a bleaker picture than in the previous round (October to November 2020), as the country is grappling with the second wave of COVID-19, the conflict in Tigray region, the dry season, and high food prices.

Despite the rising number of COVID-19 cases, a significant number of the respondents still believe that they are not at risk of contracting the virus. As a result, they are less likely to practise preventive measures. Our results are also in line with those reported in other studies.[18,19,20] Only 47% of the respondents reported that they were frequently washing/rubbing their hands with hand sanitiser. This is extremely alarming since such misconceptions are likely to facilitate the spread of the virus across the country. Our findings indicate that more rigorous information interventions and education campaigns are needed to address these misconceptions regarding COVID-19, particularly among the urban poor, in order to enhance practices and compliance with preventive methods and reduce the spread of the virus.

Shortages of water and difficulty in accessing it have become a major problem for our respondents. The proportion of respondents who reported a shortage of water and experiencing difficulty in accessing water have sharply increased in this round. The reported reasons for water shortages and inaccessibility were the inadequacy of the water supply, sporadic availability of water, the absence of municipal water services, inadequate infrastructure, perceived unfair distribution of water within the city, and the current dry season. The economic burden associated with the cost of purchasing and transporting water, as well as travelling distances to get water, present additional challenges to the urban poor included in our study, particularly IDPs and refugees.

There is a conflicting picture between the quantitative respondents and qualitative interview respondents with respect to incomes. While the quantitative respondents have seen their income increasing over the four rounds, the qualitative interview respondents reported that their income has not changed, and some had less income than before COVID-19. Some groups are also doing better than others. SSB owners seem to be able to improve their earnings, while UPSNP beneficiaries and IDPs/refugees' economic situation seems to have deteriorated. The increased cost of living, mainly due to the significant increase in the price of food items, is the main economic challenge for these groups.

We observe some improvement in the availability and consumption of food in terms of the number of meals consumed per day, but the quality of food is poor due to the increase in the price of food items. For instance, eggs, meat, milk, and fruits are among food items that were reported to be less consumed or not consumed at all. The main coping strategies for both a lack of income and food insecurity include reducing the quantity and quality of food, using up savings, and obtaining help from family members. There are a number of factors that have contributed to food insecurity in Ethiopia, including flash floods during the rainy season, which damaged infrastructure and crops. The abundant rainfall also contributed to

[18] Amsalu *et al*. (2021) 'Practice of COVID-19 Prevention Measures and Associated Factors Among Residents of Dire Dawa City, Eastern Ethiopia: Community-Based Study', *Journal of Multidisciplinary Healthcare* 14.
[19] http://documents1.worldbank.org/curated/en/678511608616662907/pdf/Monitoring-COVID-19-Impacts-on-Households-in-Ethiopia-Results-from-Six-Rounds-of-High-Frequency-Household-Phone-Surveys.pdf.
[20] www.ncbi.nlm.nih.gov/pmc/articles/PMC7956895/

the desert locust outbreak, which caused additional losses to the agricultural sector. Our findings in this area are in line with those from the World Bank and the International Food Policy Research Institute,[21] which reported no deterioration in consumption in terms of number of meals consumed per day, but a change in consumption patterns in terms of food consumed. The Young Lives study[22] reported a significant increase in the proportion of households who had run out of food in the previous 12 months, and that food shortages were most likely to affect the poorest households and those in rural areas.

In this round, only a small number of respondents reported needing medical treatment and most reported being able to access health services. The fear of being infected with the coronavirus no longer seems to influence our respondents' health-seeking behaviour. Maternal health service utilisation and treatment for children under five do not seem to have been significantly impacted. However, our sample sizes for these groups are small, and thus the results need to be interpreted with caution.

Schools were open in all cities in this round and the children in the households interviewed attend school every other day, due to the social distancing requirement. About 8% of respondents reported that they did not send their children to school after it was re-opened. Mothers are still the primary caregivers of children during this round, although fathers and relatives are also helping out when the children are not in school. According to a study by Gender & Adolescence: Global Evidence, girls who are out of school face a greater risk of early child marriage.[23] In this round, however, no incident of child marriage was reported, except for a 16-year-old boy, for whom the reason for his marriage was not given.

The proportion of respondents who reported feeling stressed due to COVID-19 has not changed since the previous round. However, the proportion of respondents with symptoms of probable depression (according to the PHQ-9 index) has slightly increased, from 13% in Round 3 to 15% in this round. Our respondents also reported that aid and support has declined during this round, especially IDPs and refugees, who reported that NGOs have phased out their support.

Overall, our results indicate that the urban poor are still struggling to cope with multiple challenges, in addition to COVID-19, particularly food insecurity and lack of access to clean water. While most restaurants and businesses are open to the public, the practising of preventive measures has significantly reduced. False beliefs, misinformation, and the lack of an advocacy campaign seem to have contributed to this change in behaviour. As mentioned in the previous round, there is an urgent need for the government to provide correct information about the pandemic and why it is important to practise handwashing, social distancing, and the wearing of a facemasks. Mental health is getting worse for the urban poor due to the loss of jobs and income, which increases stress and anxiety. The economic and social impacts of the pandemic are also unevenly felt among the urban poor. SSB owners seem to be faring better than UPSNP beneficiaries, IDPs/refugees, and day labourers, who have seen their aid and support reduced.

[21] www.ifpri.org/publication/economic-impacts-covid-19-pandemic-ethiopia-review-phone-survey-evidence
[22] www.younglives.org.uk/content/ethiopia
[23] www.gage.odi.org/research/countries/ethiopia/

Case studies

Case Study 1 (continued from Round 1 to Round 4)

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. Currently, Mrs Lelo lives in a temporary shelter in Adama City and she is the sole carer of her children.

In the previous rounds, Mrs Lelo had explained how the COVID-19 pandemic and the government restrictions had affected her daily life and her ability to feed her family. A key impact she mentioned was reduced work opportunities. She said that her business got better and her income improved during Round 2, though it was not comparable to pre-COVID-19 pandemic times. She believes that her income has decreased in this round, due to the limited supply of chat/khat, which she sells. The escalating food prices are becoming the main challenge to Mrs Lelo and other IDPs in the area.

The income that she earns from selling chat is now inadequate to cover the cost of living:

'*My expenditure has increased because of the rise in the cost of all food and non-food items. Therefore, our income and expenditure are not balanced*.'

According to Mrs Lelo, the increase in food prices is not related to the COVID-19 pandemic:

'*There is an increase in the price of all food items like maize, wheat, sorghum, spaghetti, macaroni, and food oil. The price of all food items has increased from the previous time. Even shortly after the outbreak of COVID-19, the price of food was lower. But over the past few months, there has been an increase due to the increase in the exchange rate (dollar), as we have heard from the media*.'

Life is becoming difficult for her family and the IDPs in the area as they have received no support from the government lately:

'For anyone who has been displaced from other areas, it would be very difficult to survive if the government does not support them. This is because everyone needs food, cloth, and shelter. If you have no income, how could you cover all those expenses? The government has been supporting us previously. However, those supports have now stopped for six or seven months now. The government was providing us rice. However, they have stopped.'

Mrs Lelo said that the community has limited access to health facilities: patients are expected to travel a long distance to get health services, which affects access to essential health services. She knows women who have given birth at home.

'*We could not easily access health centres. The health centres are very difficult for transport services. Due to this problem, many women are giving birth at home. We are not getting medication since we could not afford to pay for transportation*.'

Case Study 2 (continued from Round 1 to Round 4):

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

For Mr Amin and his family, the COVID-19 pandemic is still a concern. Mr Amin explained that he was aware that the disease was spreading. He reported that he is still practising COVID-19 preventive methods, including frequent handwashing and wearing a facemask:

'*The COVID-19 situation is still concerning us because we heard that it comes again. I heard that it is transmitted very fast. Thus, I am trying to protect myself by washing hand, keeping distance, and by wearing masks*.'

He observed that the practising of COVID-19 prevention methods is limited in his community. He also added that there are no community awareness creation activities and there is poor enforcement of the preventive measures:

'*In my area, I see a few people wearing facemasks in transportation and offices. Regarding handwashing, there is no handwashing at different facilities. Now you can enter banks without washing your hands, which was impossible in the past. Keeping distance is completely forgotten. No one uses facemasks during transportation.'*

Access to a water supply is challenging and has become a barrier for him and his family in regard to frequently washing their hands.

'There is shortage of water and it is very difficult for us to conduct all activities at home like washing clothes and our hands every time because we are getting water from the market.'

In the previous rounds, Mr Amin had explained that he was struggling with the food price escalation, on top of the loss of job opportunities. In this round, he mentioned that he had not managed to get a job, which makes it difficult for him to support his life and his family:

'*Honestly speaking, I don't have a job and nothing changed. I think this is because there is no budget and the disease is appearing again.'*

Mr Amin explained that he is coping with the lack of job opportunities and income by taking loans and selling assets.

'*My life depends on the intermittent job that I get. I take loans from a shop. My last option in my hand is to sell my goats. Even I could not sell them at a good price because they are emaciated.'*

The food price escalation has become a burden for Mr Amin, on top of the lack of job opportunities. Food items are available in the market, but are not affordable:

'Food items are available in every shop but the main issue is the price is very high or expensive for us. I think you may notice it because it knocks on everyone's door. For example, during our last interview, the price of white flour was 1,250 birr/50 kg, and today it is about 1,800 birr/50 kg. Life is becoming difficult and hard to survive. If the rate of price escalation continues this way, I am not going to afford it. Because I don't have a permanent job.'

Mr Amin is glad that his children are back in school and that they are provided with facemasks. However, it is difficult to get exercise books for his children and he does not get support when he needs it the most:

'It is good now relating to education, schools are opened and our children are going to school wearing a facemask supplied by the school itself. One thing I would like to tell you is that the school didn't give us exercise books, pens, etc. This is the time we need support.'

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 4											
Proportion of respondents who reported practising washing hands frequently with soap and water or hand-rubbing with a sanitiser or alcohol-based solution	83.8	97.5	23.5	31.7	14.0	2.3	77.8	64.1	NA	0.	47.0
Proportion of respondents who reported practising wearing a facemask	94.6	100.0	29.4	19.5	23.3	47.7	31.1	51.3	NA	0.0	47.0
Proportion of respondents who reported practising physical distancing	70.3	0.0	20.6	78.0	93.0	59.1	4.4	17.9	NA	0.0	41.7
Proportion of respondents who reported family members wearing a facemask all the time	89.2	57.5	70.6	85.4	16.3	4.5	4.4	2.6	NA	0.0	37.8
Proportion of respondents who reported that they believe that they could still be infected with the coronavirus	100.0	72.5	80.0	35.3	97.6	80.0	56.8	33.3	NA	72.5	100.0
WASH (all figures are percentages): Round 4											
Proportion of households who have a piped private water supply	54	68	35	73	0	98	96	87	NA	69	65
Proportion of households who have access to a water supply every day/daily	46	100	9	71	5	59	60	90	NA	31	54
Proportion of households who reported a shortage of water since the COVID-19 outbreak	30	65	62	15	72	30	47	72	NA	77	50

Proportion of households who reported difficulty in accessing a water supply	35	58	41	12	72	30	51	36	NA	69	43
Food security (all figures are percentages): Round 4											
Proportion of household relying on food assistance from government/an NGO/United Nations/a local charity	0	23	0	27	0	34	31	3	NA	8	15
Proportion of households who reported eating less preferred food due to lack of enough food or money to buy food over the past month	44	100	87	100	91	7	100	100	NA	100	64
Proportion of households with reduced number/frequency of meals consumed per day since the outbreak of COVID-19 and associated impacts	30	40	59	10	28	0	33	0	NA	0	23
Proportion of households having three or more meals per day	43	0	44	12	33	0	0	0	NA	38	16
Proportion of households buying less or who stopped buying cooking oil during the past month	0	100	59	2	5	70	9	31	NA	23	34
Proportion of households buying less or who stopped buying fresh fruits during the past month	0	90	6	44	21	9	33	69	NA	77	36
Income, expenditure, and employment (all figures are percentages): Round 4											
Proportion of respondents who reported cutting down hours or amount of work since COVID-19	46	73	76	12	49	0	9	100	NA	0	42

Proportion of households who are currently able to earn income similar to the normal work before lockdown/physical restrictions	84	100	62	59	79	100	96	97	NA	62	84
Proportion of households with a risk of eviction from their house due to loss of income	16	8	44	2	19	0	4	0	NA	0	10
Health (all figures are percentages): Round 4											
Proportion of participants that needed any medical treatment since the last round of the survey	18.9	35.0	35.3	17.1	2.3	2.3	11.1	7.7	NA	7.7	15.2
Proportion of participants/ members that needed medical treatment and have had access to health services	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	NA	0.0	98.0
Proportion of households whose member(s) needed any medical treatment since the COVID-19 outbreak	16.2	2.5	58.8	0.0	4.7	2.3	2.2	0.0	NA	0.0	9.2
Proportion of households whose member(s) needed medical treatment and have had access to health services	100	100	100	NA	100.0	100	100	NA	NA	NA	100
Mental health (all figures are percentages): Round 4											
Proportion of respondents who perceived a negative impact of COVID-19 and associated responses on mental health	0	38.5	20.6	0	0	0	0	0	NA	0	6.7
Proportion of respondents felling stressed, scared, or/and worried during the past month	54.0	100	67.6	2.4	37.2	0	55.6	0	NA	0	37
Proportion of respondents with probable symptoms of depression (cut-off point =10)	0	100	29.4	2.4	0	0	0	0	NA	8.3	15.3

Aid and support (Round 4)											
Proportion of respondents who are aware of any relief being provided to address the impacts of COVID-19	0	64.1	14.7	17.1	41.9	95.4	93.3	35.9	NA	83.3	48.8
Proportion of households/household members who received aid from any institution after the COVID-19 pandemic	0	64.1	8.8	23.0	0	22.7	40.0	0.0	NA	8.3	19.8
Total sample/observations (in number)	2	2	0	2	2	2	2	2	NA	2	16