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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 first round of a mixed method panel study in urban areas in 10 cities in Ethiopia

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About the Building Resilience in Ethiopia (BRE) programme

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

About Maintains

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

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Preface

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

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List of abbreviations

ANC	Antenatal care
BRE	Building Resilience in Ethiopia
CSO	Civil society organisation
DFID	UK Department for International Development
IFPRI	International Food Policy Research Institute
KII	Key informant interview
NGO	Non-governmental organisation
PPE	Personal protective equipment
SSB	Small-scale business
UPSNP	Urban Productive Safety Net Project
USAID	US Agency for International Development
WASH	Water, sanitation, and hygiene

Introduction

Unintended consequences of COVID-19 responses are becoming visible across sub-Saharan Africa. The Ethiopian government declared a state of emergency on 8 April 2020 to curb the spread of the novel coronavirus disease (COVID-19). As at 11th August, there are 23,591 cases in Ethiopia and there have been 420 deaths (Coronavirus Resource Centre, Johns Hopkins University)[1]. According to the rules governing the state of emergency, public gatherings of more than four people and greetings using a handshake are banned. Moreover, the state of emergency bans all movement at land borders, except for the flow of cargo and essential goods, and orders transportation service providers to reduce passenger loads by 50%. Although implementation of the restrictions set by the government varies across cities, food security is being threatened by restrictions in activities and movements.

It is anticipated that COVID-19 will affect more vulnerable groups disproportionately and has differential impacts related to structural inequalities such as gender, age, ability, and people marginalised for other reasons (such as ethnicity, sexual orientation, or socio-economic status). Daily wage earners, people with jobs in the informal sector, vendors, petty merchants, and labourers are likely to be most impacted due to loss of jobs and livelihoods. Migrants and people living in unauthorised areas with no social safety nets are also particularly vulnerable to the disease and may not receive sufficient aid and support.

There is still a lack of understanding of how the COVID-19 pandemic and government responses have affected the lives of the urban poor, and is the main contribution of the current study. We conduct a monthly mixed methods phone survey (using semi-structured and qualitative diary-style interviews, in which respondents lead the discussion with gentle guiding by the interviewers across the main themes) with households and individual day labourers (petty traders and others were interviewed at length, which we refer to as a 'special population segment' that could be especially vulnerable to the effects of the COVID-19 pandemic), as well as key informant interviews (KIIs) with non-governmental organisations (NGOs), civil society organisations (CSOs), local government officials, and health professionals. This is being done in order to document the effects of COVID-19 and government responses on food security, livelihoods, and access to and use of health services among the urban poor and vulnerable groups over six months from July to December 2020. The phone surveys were conducted in 10 selected cities in Ethiopia: Addis Ababa, Mekelle, Dire Dawa, Adama, Gambela, Bahir Dar, Jigjiga, Bulehora, Logia, and Semera. These were selected based on the size of the population of urban poor and vulnerable groups, including internally displaced persons (IDPs) and refugees. This study assesses the level of knowledge and, more importantly, practising of preventative measures related to COVID-19, as well as stigma and discrimination against vulnerable groups as a result of COVID-19. The findings of this study will help the government design social policies and interventions to curb further spread of the pandemic and reduce its impacts.

[1] https://coronavirus.jhu.edu/map.html

Methodology – Round 1 (July 2020)

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

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

KIIs were also conducted with local government officials (women and child affairs, health offices, healthcare providers, and social affairs offices) and different NGOs and CSOs that are working on health and other social issues.

The study was conducted in 10 cities/towns located in different regions of Ethiopia from 22 June 2020 to 22 July 2020. The cities included were Addis Ababa, Mekelle, Dire Dawa, Adama, Gambela, Bahir Dar, Jigjiga, Bule Hora, Logia, and Semera. This selection of cities is intended to include different regional states, different geographic locations, and different sizes, and to capture the impact of the different measures taken by the regions. Additionally, differences in the local economies, level of access to basic services, and the effects of internal displacement that entail the urban poor may face specific challenges were also considered during the selection of the cities. Fundamentally, these 10 cities were thus selected to produce findings that are relevant across Ethiopia and to allow for some comparison between different cities. The intention was to produce results that will help inform appropriate policy responses, specifically for poor and vulnerable groups in urban areas.

The study was conducted among Urban Productive Safety Net Project (UPSNP) beneficiaries, households who own a small-scale business (SSB), and refugees/IDPs/returnees. The UPSNP is designed to improve the income of targeted poor households and to establish urban safety net mechanisms. UPSNP beneficiaries are households who are identified as 'the poorest of the poor' based on their ability to generate income, their ownership of valuable assets, and living conditions. The UPSNP households receive a monthly payment from the government as direct (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). In this study, we include both groups as well as those registered to be enrolled in the programme for cities where the UPSNP has not yet started. Similarly, households under the IDP/refugee category are among the most vulnerable groups, which will be highly affected by COVID-19 and the associated

government responses as their socio-economic status and livelihood are already compromised due to displacement from their original location. In this study, the term 'refugee' refers to individuals who are under international protection living out of camps in the cities and are mainly from Logia, Semera, and Gambela. It is worth noting that the sample sizes for IDPs, refugees, and returnees are small in this round (88, 30, and 12 respectively)[2]; thus, for most of the presentation of the results, we group them together (the total sample across the three groups is 130). We do acknowledge, however, that these are very different groups of people, facing different types of challenges. Therefore, in the subsequent rounds, we are looking to increase the sample size, particularly of refugees and returnees. The third category – SSB households – are those engaged in a small local business to support their livelihood. The SSBs were included because of the possibility that their business or income will be significantly affected by the pandemic, given that economic activities are greatly impacted due to movement restrictions/lockdown in response to COVID-19.

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 Administration for Refugee & 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.

A total sample of 436 households was included in the quantitative survey, for a response rate of 96.9%. Of these, 153 were UPSNP beneficiaries, 153 were SSBs, and 130 were IDPs, refugees, or returnees. Since people in the IDP/refugee category were not available in Bule Hora, the 15 IDP/refugee households allocated for the city were added to the sample size for the UPSNP and SSB categories.

Purposive sampling was used to select qualitative study participants (i.e. for the diary-style interviews and KIIs). For the KIIs, we selected participants who have in-depth knowledge and direct involvement or exposure to the subject matter under study. A total of 57 diary-style interviews (an average of six per city) was conducted with 10 UPSNP beneficiaries, 10 respondents from the SSB, 17 IDPs and refugees, and 20 participants from the special population group (i.e. daily labourers, shoeshines, waiters, porters, and commercial sex workers). With the exception of the special population group, all diary-style interview participants were selected from the household survey respondents who were found to be talkative and open and therefore suitable for a more in-depth interview. A total of 35 KIIs (an average of 3–4 interviews per city) was conducted with representatives from government offices (one interview from each city with healthcare providers, women's and children's affairs offices, and city health offices) and NGOs and CSOs. The qualitative data collectors

[2] Since the sample size for returnees is very small, we refer to this category as 'IDP/Refugee' in the interest of space.

also conducted weekly observation sessions to provide contextual insights into the community's behaviour regarding the prevention of COVID-19 and level of compliance with the restrictions or measures set by national and local authorities.

All interviews were conducted using a two-step approach: an introductory call made by city coordinators to introduce the study, obtain consent, and schedule interviews with potential participants, and then the actual interviews as conducted by the data collectors. The average duration of each interview for the quantitative semi-structured interview was 35 minutes, with 41 minutes for the diary-style interview and KIIs. The number of call attempts ranged from one to eight in order to reach each respondent for the actual interview.

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 t-tests were used to test statistical differences in selected variables between the UPSNP, SSB, and IDP/refugee groups, as well as variations across gender. The data processing and analysis were concurrent with the data collection. Debriefings with the field-based data collectors and the study team were conducted at the conclusion of interviews. All qualitative interviews were imported and coded using NVivo 14 qualitative analysis software. The interviews were coded independently using an inductive approach by members of the research team and differences and emerging codes were discussed. Framework analysis was used to allow the identification of common variable patterns by themes/topic guides within and across different groups: UPSNP, SSB, refugees, IDPs, returnees, and the special groups, relating to their experience of the impact of COVID-19 and associated government measures. Salient quotes (translated to English) were used to express the experiences and perceptions of the informants.

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

Challenges: we faced multiple challenges during the data collection period. The political unrest, which happened in the middle of our data collection in July, and the disruption of the internet throughout the country both affected our data management process. Data collectors were not able to synchronise and email the data and, thus, the team had to opt for creative means to transfer the data, including using postal services and private messengers to bring the data from the field to the central team for analysis.

Context during Round 1

The restriction measures imposed by Ethiopian government are being implemented at a varying level in the cities included in this study. Based on the weekly observations of our data collectors, in most of the cities people comply with the mandatory wearing of a facemask in public places (bank, government offices, and marketplaces), washing hands or practising hand rubbing with sanitiser or alcohol-based solutions before entering service-providing institutions. However, the level of compliance with the restrictions varies greatly across the four weekly observations conducted from 22 June to 22 July 2020, declining from time to time.

The current State of Emergency regulations mandate that nightclubs and bars are closed. Restaurants and cafes are allowed to open with a seating arrangement that ensure physical distancing of the customers. Compliance is mixed. In some places, security guards are employed to make sure that customers wear facemask and wash their hands before entering service providing institutions in Adama city.

Inappropriate use of a facemask is common in all the cities. Some people only wear a facemask to cover their mouth, whilst others only use to avoid being accountable for not wearing in public places. It is commonly observed that street children do not wear facemasks, exposing themselves to virus and contributing to its spread.

Public transport service providers (taxi, bus, *bajaj* and light city train in Addis) are accommodating only 50% of their capacity. Service providers who violate the restriction are being penalised up to 5,000 Ethiopian birr (ETB). Additionally, everyone onboard (passenger, driver and driver assistant or cashier) is obliged to wear mask. Restrictions on attending religious places have been loosened in some places.

In addition to the above restrictions, at the start of the pandemic the Tigray regional state declared that anyone entering the borders of the region had to be in quarantine for two weeks, but this has now been reduced to one week. Those in quarantine are tested for COVID-19 if they develop any symptom of the disease during the quarantine period. In addition, the region has restricted any travel across *zonal* administrations[3] and from rural to urban areas. However, more recently these travel restrictions have been lifted.

City administrations, NGOs, charitable associations, youth groups, private for-profit organisations, and individuals are all mobilising their resources to support poor and vulnerable segments of the population, which include our sampled groups. Support is provided in the form of food items (rice, pasta, oil, baking powder, etc.), sanitary materials (soap, sanitiser/alcohol), and cash. Moreover, food banks have been established by the Addis Ababa city administration where donations of non-perishable food items are stored and distributed to vulnerable segments of the population.

[3] A ‘zone’ is a sub-regional administration unit that contains multiple districts and has clearly demarcated borders.

Summary of household characteristics

The quantitative survey included a total of 436 households: 153 UPSNP beneficiaries, 153 SSB owners, and 130 refugees and IDPs. Female respondents account for 51.6% of the total respondents. The average family size is 5.2 (SD: 2.5) and the average income is ETB 2,277 (SD: 4,814). Among all households, only 8% include lactating and/or pregnant women, while 50.5% have at least one child under five. Only 26.7% of the respondents live in private accommodation (home ownership); 42.2% live in accommodation that is rented from private owners. About 34% of households have recently moved to their current place of residence, and the remaining households have always lived in their neighbourhood.

For the qualitative study, a total of 35 KIIs and 57 (31 male and 26 female) diary-style interviews were conducted with 10 UPSNP beneficiaries, 10 respondents from the SSB, 17 IDPs and refugees, and 20 participants from the special population group (i.e. daily labourers, shoeshines, waiters, porters, and commercial sex workers). The mean age of respondents was 32, with a range between 20 and 68.

Table 1: Characteristics of households and respondents, urban poor in selected 10 cities, Ethiopia, July 2020 (total n=436, UPSNP = 153, SSB = 153, IDPs/refugees = 130)

Household characteristics		UPSNP (%)	SSB (%)	IDP/ Refugee (%)	Total (%)
Gender of the respondent	Male	29.4	69.3	56.9	51.6
	Female	70.6	30.7	43.1	48.4
Family size	Less than three	15.7	15.7	8.5	13.5
	Three to five	50.3	48.4	50.8	49.8
	Above five	34.0	35.9	40.8	36.7
Number of children under five	None	54.2	51.0	42.3	49.5
	One	27.5	32.0	33.8	31.0
	Two	12.4	15.0	18.5	15.1
	Three or more	5.9	2.0	5.4	4.4
Residence status	Permanent/long-term resident	90.2	84.3	17.7	66.5
	Moved recently to this neighbourhood	9.8	15.7	82.3	33.5
Type of accommodation/ housing	Private accommodation (own)	33.3	37.3	6.2	26.6
	Rented from individual owner	39.9	49.0	36.9	42.2
	Rented from government	16.3	8.5	13.1	12.6
	Cohabit with relatives	5.9	4.6	4.6	5.0
	Cohabit with non-relatives	2.0	0.0	1.5	1.1

	Temporary-built accommodation	2.0	0.0	37.7	11.9
Study sites/cities	Addis Ababa	9.2	11.1	11.5	10.6
	Adama	10.5	9.8	11.5	10.6
	Bule Hora	15.0	13.7	0.0	10.3
	Dire Dawa	9.8	9.8	10.8	9.9
	Jigjiga	9.2	10.5	11.5	10.3
	Semera	9.8	9.2	12.3	10.3
	Logia	9.8	9.8	10.8	10.1
	Bahir Dar	10.5	9.8	11.5	10.6
	Mekelle	9.8	9.8	11.5	10.3
	Gambela	6.5	6.5	8.5	7.1

Highlights of the results – Round 1

- Awareness about COVID-19 was prevalent; all respondents had heard about COVID-19 and most of them knew that asymptomatic people could transmit the virus.
- About three-quarters of survey respondents reported compliance with wearing facemasks in crowded public places. Respondents, however, explained that some people only practised preventative measures so as not to be held accountable for bypassing government restrictions.
- Only half of the households in our sample reported having access to a water supply every day, and 28% of households reported having more difficulty accessing water since the COVID-19 pandemic and associated restrictions began in March 2020.
- The average monthly income of households has reduced due to restrictions associated with COVID-19 from ETB 2,580 to ETB 2,277 (not statistically significant). About 62% of households have reduced their work hours or their amount of work since the start of COVID-19, with SSB households, refugees, and day labourers being highly affected.
- The proportion of households who consume an average of three meals a day has reduced significantly since the pandemic began, from 87.6% before COVID-19 to 62.2% at the time of the interview. Loss of income, increased food prices, and lack of access to food or food materials were all cited as major reasons for the reduction in food consumption.
- The effect of the COVID-19 pandemic on food access was worse for daily labourers, petty traders, and waitresses, whose survival depends on their daily income. Restrictions and lockdowns led to the loss of jobs for these groups of people.
- Only 22.5% of households reported that any member of their families had needed medical treatment since the COVID-19 outbreak. Of these, only 12.2% said that they were not able to access medical treatment when needed. The most common reason why people had needed medical attention was childhood illnesses (31.6%), followed by non-communicable diseases (25.5%).
- A significant proportion of households with children (66%) had no access to education materials from home, with the level of lack of access to an education platform highest among refugees (81%). Most respondents had limited access to electronic platforms, including educational programmes transmitted through radio and TV. Respondents reported that the absence of education had psychological and social implications for children as well as other family members.
- About 16% of respondents had probable symptoms of depression. Mental health problems were lower among refugees/IDPs (13.2%) compared to other categories. A quarter of respondents expressed feelings of hopelessness and/or having thoughts of hurting themselves. Respondents from the refugee/IDP group (40%) reported stronger feelings of stress than those in the UPSNP (27%) or SSB groups (29%). Female-headed households had a higher level of stress (68%) than their counterparts.
- On average, 39.5% of households had received assistance through government, NGOs, or religious institutions since the outbreak started. The largest proportion of the assistance provided was in the form of free food (70%), followed by cash (43%).

Results by theme[4]

Knowledge and behaviour relating to COVID-19

Key findings:

- Awareness about COVID-19 was prevalent: all respondents had heard of COVID-19 either through TV or radio.
- Most knew about the transmission, the major signs and symptoms, and actions to reduce exposure to the coronavirus. Most knew that asymptomatic people could transmit the virus, but a slight difference was observed between cities in this regard.
- A few respondents had a misperception regarding susceptibility to and the severity of COVID-19.
- Practices of preventative measures were widely reported. However, these results may be affected by social desirability bias. When asked about practices of these measures among family members and friends, the compliance rates dropped significantly. Compliance in relation to movement restrictions, wearing a facemask, and social distancing varied between cities.

All respondents included in this survey had heard about COVID-19, and most (77.3%) knew that a person could acquire the virus from asymptomatic individuals. However, differences were found between the cities included in this study. Most (77.8%) respondents from Jigjiga were not aware that asymptomatic persons could still be a source of infection for others. Television (86.5%), neighbours (67.7%), and friends (59.4%) were the most common sources of respondents' awareness about COVID-19. A relatively higher number of IDPs reported radio as a major source of information about COVID-19 compared to refugees (Annex B).

Likewise, the findings from the qualitative data indicate widespread awareness and access to information about COVID-19. However, a few qualitative respondents suggested low awareness and barriers to obtaining information. There were also misconceptions about susceptibility to and the severity of COVID-19 in the community:

> *Most people in our community are aware of COVID-19, but we do not know its symptoms, how it is transmitted, or actions for prevention measures against the virus because we do not have access to information about this within our community.* (IDP, Gambela)

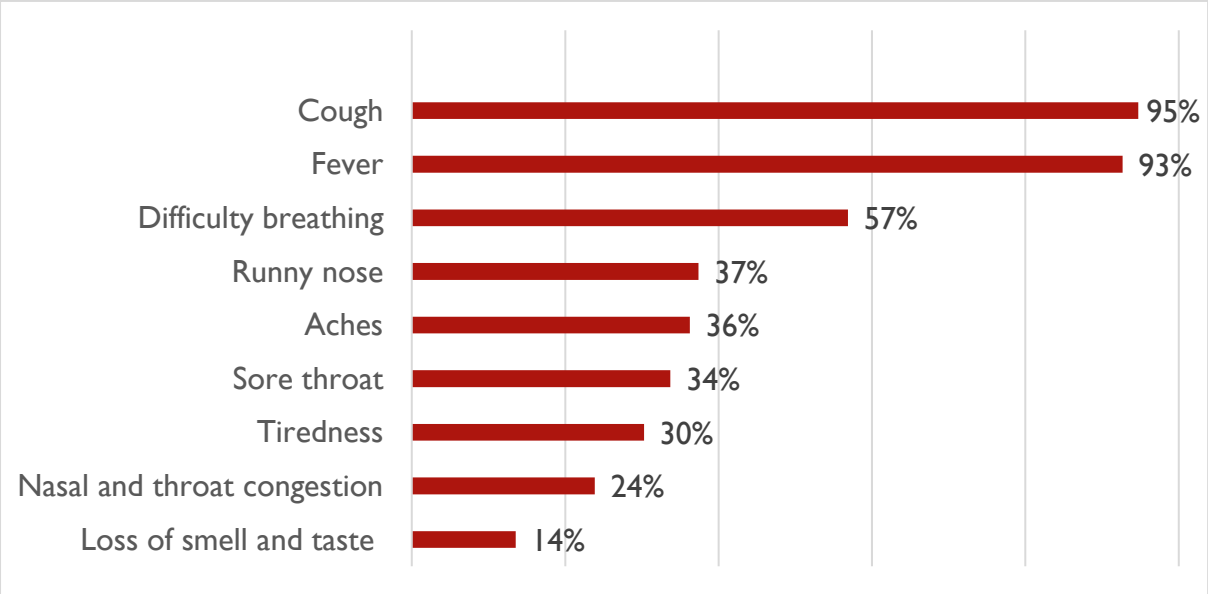
> *People residing in rural areas believe that they are not susceptible to the coronavirus.* (SSB, Bule Hora)

We also assessed respondents' knowledge about the major signs and symptoms of COVID-19. In general, both the quantitative and qualitative data indicated that respondents were

[4] Note that we present the results for IDPs, refugees, and returnees as one group in the tables and graphs but wherever possible highlight significant differences in terms of the impacts between these groups, acknowledging that they are defined very differently. The breakdown of the results for IDPs, refugees, and returnees for all themes can be found in Annex B and a summary of qualitative results for these groups can be found in Annex C.

well informed about the signs and symptoms of COVID-19. Almost everyone involved in the quantitative survey knew that cough and fever were among the major manifestations of COVID-19 (Figure 1). Difficulty breathing, a runny nose, a sore throat, and aches were also mentioned as signs and symptoms of COVID-19. A slightly lower number of respondents from Mekelle mentioned coughs (34 out of 45) and fevers (34 out of 45) as among the major symptoms of COVID-19 compared to respondents from other cities. Differences between refugees and IDPs are relatively small in terms of the knowledge of signs and symptoms.

Figure 1: Knowledge of signs and symptoms of COVID-19 among the urban poor in selected 10 cities, Ethiopia, July 2020 (n=436)



Regarding preventative methods, both the quantitative and qualitative findings indicated that respondents were well informed on how to reduce the spread of COVID-19. Overall, the majority (93.8%) knew that handwashing for 20 seconds and the use of a facemask (80.5%) are among the actions that can be taken to reduce the disease's spread. Moreover, 66.3% and 61.2% reported avoiding overcrowded places and rubbing their hands with sanitiser or alcohol-based solutions to reduce their exposure to COVID-19, respectively. A small proportion believe that drinking hot tea (21.1%) and eating garlic and ginger (25%) could reduce their exposure to COVID-19 (Table 2).

Table 2: Knowledge of actions to reduce exposure to COVID-19 among the urban poor in selected 10 cities, Ethiopia, July 2020 (total n = 436; UPSNP = 153, SSB = 153, IDPs/refugees = 130)

	UPSNP (%)	IDPs/ refugees (%)	SSB (%)	Total (%)
Avoid spitting in public	20.3	16.9	25.5	21.1
Drink hot tea	22.2	13.8	26.8	21.3
Cover nose and mouth while coughing or sneezing	54.2	45.4	53.6	51.4

Clean hands with sanitiser or alcohol hand rub	51.6	49.2	81.0	61.2
Wear a facemask	77.8	79.2	84.3	80.5
Avoid crowded places	68.0	56.9	72.5	66.3
Wash hands frequently with soap for 20 seconds	94.1	87.7	98.7	93.8

Note: Multiple selections per participant were allowed for these questions.

The qualitative findings also indicated that respondents were aware of how to reduce exposure to COVID-19. We also asked if they actually practised the actions needed to reduce their exposure. Overall, respondents reported having practised the most common measures to combat the spread of the coronavirus. Of the 409, 267, and 351 (multiple options could be chosen for this question) respondents who reported handwashing, hand rubbing with a sanitiser or alcohol-based solution, and the use of a facemask as methods to prevent exposure to coronavirus, 99%, 91%, and 97.7% reported that they actually practise them to reduce exposure to COVID-19, respectively. There was no significant difference in practising handwashing (chi-square: 0.32; p-value: 0.853), using a facemask (chi-square: 3.22; p-value: 0.200), and using sanitiser (chi-square: 1.69; p-value: 0.430) among the UPSNP, SSB, and refugee/IDP groups. There was also no significant difference in practices of the major methods to reduce exposure to coronavirus among the cities included in this study (Annex A). Moreover, differences in handwashing, wearing a facemask, and avoidance of overcrowded places between refugees and IDPs were also relatively small (Annex B).

In the qualitative study, a few respondents reported the perception that facemasks were used only by those who were infected with the coronavirus. An SSB owner from Bule Hora expressed concern about losing customers if they used a facemask. **This finding indicates a fear of stigma could negatively affect the use of a facemask,** which is one of the main ways to reduce exposure to coronavirus:

> *If we serve them while wearing a facemask, they will not be happy. They think that we are using a facemask because we are infected with the virus.* (30-year, SSB, Bule Hora)

Moreover, in our KIIs, some healthcare providers reported their observation of inappropriate use of a facemask:

> *I usually notice when people partially cover their mouths while their noses are left uncovered.* (Healthcare provider, Addis Ababa)

These findings indicate that there are people who lacks adequate knowledge about why and how to use a facemask.

We asked participants to rate their compliance with the restrictions put in place by the government. Most (78.4%) said they always complied with movement restrictions. About 91.8% and 86.2% reported that they wore a facemask and practised social distancing all the time or somewhat, respectively. Compliance with social distancing was higher among the

UPSNP beneficiary group compared to the SSB and IDP/refugee groups (Table 3). However, we did not find a significant difference in compliance with movement restrictions (chi-square: 2.7; p-value: 0.257), wearing a facemask (chi-square: 0.68; p-value: 0.712), or social distancing (chi-square: 3.3; p-value: 0.190) among male and female participants. We found that almost half of participants from Addis Ababa did not practise social distancing (19 out of 46) or wear a facemask (18 out of 46). Respondents from Adama also reported less compliance with movement restrictions and wearing a facemask (Annex A).

Table 3: Compliance with government restrictions among the urban poor in selected 10 cities, Ethiopia, July 2020 (total n = 436; UPSNP = 153, SSB = 153, IDPs/refugees = 130)

Restrictions	UPSNP (%)	IDP/ Refugee(%)	SSB (%)	Total (%)	Chi-2, p-value
Compliance with movement restrictions					
A lot	59.5	53.1	49.0	53.9	12.84, 0.040*
Somewhat	25.5	26.2	22.2	24.5	
Not very much	8.5	5.4	11.8	8.7	
Not at all	6.5	15.4	17.0	12.8	
Compliance with wearing a facemask					
A lot	76.5	70.8	71.2	72.9	3.68, 0.720
Somewhat	15.7	22.3	19.0	18.8	
Not very much	0.7	1.5	2.0	1.4	
Not at all	7.2	5.4	7.8	6.9	
Compliance with social distancing					
A lot	71.9	60.8	59.5	64.4	21.72, 0.001*
Somewhat	19.0	30.0	17.6	21.8	
Not very much	2.0	3.1	7.2	4.1	
Not at all	7.2	6.2	15.7	9.9	

Note: * statistically significant at p<0.05; Null hypothesis for Chi-2 test: there is no difference in the level of compliance with movement restrictions, wearing a facemask, and social distancing among the three sampling categories.

We are, however, aware that self-reported data may be affected by social desirability bias and therefore we also asked about compliance with different preventative measures on the part of respondents' family members and friends.

The reported compliance rates among family members were significantly lower compared to the self-reported rates above. Only 55.5% and 60.1% reported that all of their family members complied with the movement restrictions and wore a facemask, respectively. About 60.8% said that all of their family members practised social distancing. Compliance of families with the use of facemasks was higher among the UPSNP group compared to the SSB and IDP/refugee groups (Table 4). There was no significant difference in compliance to

movement restrictions (chi-square: 1.75; p-value: 0.416), use of facemasks (chi-square: 0.99; p-value: 0.609), and social distancing (chi-square: 1.22; p-value: 0.542) among male- and female-headed households in terms of reporting of other family members' behaviour.

Table 4: Family compliance with government restrictions among the urban poor in selected 10 cities, Ethiopia, July 2020 (total n = 436; UPSNP = 153, SSB = 153, IDPs/refugees = 130)

Restrictions	UPSNP (%)	IDPs/refugees (%)	SSB (%)	Total (%)	Chi-2, p-value
Compliance of family members with movement restrictions					
None of them	8.5	12.3	6.5	8.9	6.36, 0.174
Some of them	31.4	33.1	41.8	35.6	
All of them	60.1	54.6	51.6	55.5	
Compliance of family members with wearing a facemask					
None of them	5.9	9.2	3.3	6.0	10.83, 0.029*
Some of them	25.5	42.3	35.3	33.9	
All of them	68.6	53.8	56.9	60.1	
Compliance of family members with social distancing					
None of them	5.9	16.2	6.5	9.2	8.38, 0.079
Some of them	26.8	32.3	31.4	30.0	
All of them	67.3	60.0	54.9	60.8	

Note: * statistically significant at p<0.05; Null hypothesis for Chi-2 test: there is no difference in the level of family compliance with movement restrictions, wearing a facemask, and social distancing among the three sampling categories.

A few respondents from our qualitative interviews explained that some people practised the restriction measures so as not to be held accountable for bypassing government restrictions. This finding indicates that some people do not want to use a facemask or are not well informed on why they need to wear a facemask:

> *There are people who use a facemask only because they see police around. They use a mask not because they trust the information about its benefit in preventing exposure to COVID-19 but due to fear of pressure from security officers. The government proclamation and fear forced them to use them.* (Healthcare provider, Addis Ababa)

We asked participants if they met people other than their family members. One-fifth reported having met with people outside their households, and most of these meetings (70%) happened in their own homes. The respondents were asked what they would do if they had symptoms of COVID-19. Most (75.6%) reported that they would self-isolate, and 16.8% said they would take paracetamol to help ease the symptoms. Others reported drinking plenty of water (16.4%), taking a spoon of honey (15.8%), and opening windows (15.6%) to increase ventilation.

WASH

Key findings:

- Shortage of water supply was one of the major challenges that hindered implementation of COVID-19 prevention measures, mainly handwashing practices.
- Around 50% of households reported having daily access to a water supply, and 34% of households reported having more difficulty accessing water since the COVID-19 pandemic and associated restrictions began.
- Refugees and IDPs had much more difficulty than others accessing water since the outbreak.

Access to an adequate water supply and hygiene and sanitation facilities is the most important facilitator of proper practising of COVID-19 prevention and control measures. Individuals need water and soap, or their substitutes (e.g. hand sanitiser or alcohol rub), to practise frequent handwashing at critical times (after going to the toilet, before eating, after interacting with other people or being in a crowded place, and before touching their faces or mouths). Most households (81%) perceived that they have access to an adequate water supply (i.e. enough water for drinking, cooking, personal hygiene, and washing clothes). Only 50% of households, however, reported that they were able to access a water supply on a daily basis, and around 20% reported having access to water only once in more than three weeks (Table 5). Compared to IDPs, refugees reported better access to water supply (Annex B).

About 34% of households reported having experienced a shortage of water since the COVID-19 pandemic, and about 10% of households reported having *much more* difficulty accessing water since the outbreak (Table 5). The mean number of days with a shortage of water since the COVID-19 outbreak was 7.7 (with a standard deviation of 10.8 days), i.e. more than a week. Refugees/IDPs (as a combined group) reported having had much more difficulty than others accessing water since the outbreak. The findings of our qualitative study are in line with the above result. IDPs from Addis Ababa and Adama repeatedly mentioned the lack of piped water system in their village, stating that they had to rely on water distributed by the government using water trucks. They also mentioned interruptions to their water supply and its general inadequacy.

There were disparities in terms of access to water supply among the 10 cities. The proportion of households reporting a shortage of water since the pandemic was highest in Bule Hora (68.9%), followed by Gambela (48.4%) and Addis Ababa (45.7%) (Annex A).

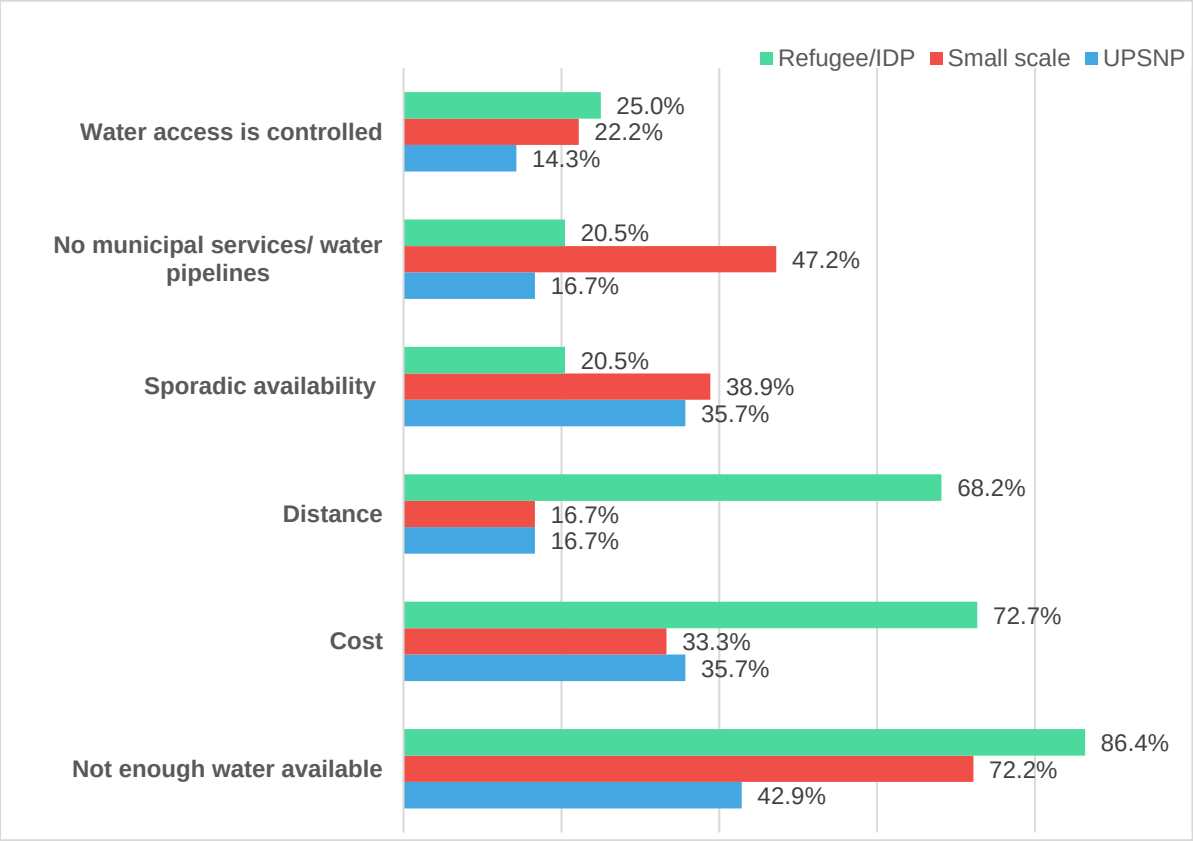
Table 5: Access to adequate water supply among urban poor households in selected 10 cities, Ethiopia, July 2020 (total n = 436; UPSNP = 153, SSB = 153, IDPs/refugees = 130)

		Respondent category				Gender of HH head			Chi-2, p-value
		UPSNP (%)	SSB (%)	IDP/Ref. (%)	Chi-2, p-value	Male (%)	Female (%)	Total (%)	
Access to an adequate water supply	Yes	83	78.4	81.5	1.08, 0.583	76.9	85.3	81	5.00. 0.025*
	No	17	21.6	18.5		23.1	14.7	19	
Frequency of access to water supply	Every day	52.9	47.7	51.5	10.86, 0.093	45.8	55.9	50.7	11.69, 0.009*
	Once in a week	28.8	24.2	22.3		23.6	27	25.2	
	Once in two weeks	3.9	7.2	1.5		6.2	2.4	4.4	
	Other **	14.4	20.9	24.6		24.4	14.7	19.7	
Shortage of water since COVID-19	Yes	35.9	35.9	30.8	1.08, 0.582	38.2	30.3	34.4	3.00, 0.083
	No	64.1	64.1	69.2		61.8	69.7	65.6	
Level of difficulty accessing water since COVID-19 outbreak	Much more difficult	6.5	8.5	15.4	19.43, 0.003*	13.3	6.2	9.9	6.52, 0.089
	Slightly more difficult	20.9	15	18.5		17.3	19	18.1	
	Nothing changed	62.1	58.8	43.1		52.4	58.3	55.3	
	Easier than before	10.5	17.6	23.1		16.9	16.6	16.7	

Note: * statistically significant at p<0.05; Null hypothesis for Chi-2 test: there is no difference in the level of access to water among the three sampling categories and between male- and female-headed households. ** access to water supply once in three or more weeks

The absence of adequate water, higher prices, and the absence of a municipal service or pipeline were among the major impediments to accessing water by the urban poor (Figure 2).

Figure 2: Major reasons for difficulty accessing water since the COVID-19 outbreak among the urban poor in selected 10 cities, Ethiopia, July 2020 (n=150)



Food security

Key findings:

- COVID-19 and associated government responses posed challenges regarding food security for the urban poor. People whose survival depended on a daily income were the most vulnerable to food insecurity.
- Lack of income and increased prices of food/food items were the major reasons for reduction in the quality and quantity/frequency of food among the urban poor.

The proportion of households who consumed an average of three meals per day fell from 87.6% before the pandemic to 62.2% with the COVID-19 pandemic and its movement restrictions. A significant reduction was recorded across all categories of respondents, but less severe for the SSB group. The majority reported that it has become difficult to access food since the pandemic (Table 6). According to the qualitative study, **the effect of the pandemic on food access was worse for daily labourers and petty traders** whose survival depended on their daily income. Restrictions and lockdowns led to the loss of jobs for these groups.

Before the corona outbreak, I earned a lot of money and paid the house rent on the due date. But after the corona outbreak, I am challenged to get even daily bread.…There are no jobs. I am just fighting to earn daily food. (35-year-old male, Dire Dawa)

Since the occurrence of the pandemic, my working hours have been reduced, which has decreased my income. On the other hand, the cost of everything fundamental for life is increased. For instance, I used to eat breakfast for ETB 25, but currently I'm paying ETB 35 for a similar dish. Some things that we used to buy for ETB 50 are currently ETB 70 or more. (21-year-old male, Jigjiga)

Table 6: Household food access, by respondent category and gender of household head, among the urban poor in selected 10 cities, Ethiopia, July 2020 (total n = 436; UPSNP = 153, SSB = 153, IDPs/refugees = 130)

		Respondent category				Gender of HH head		Total	
		UPSNP (%)	SSB (%)	Refugee/ IDP (%)	Chi-2, p-value	Male (%)	Female (%)	(%)	Chi-2, p-value
Frequency of meal before COVID-19 outbreak	Two or less	11.1	3.9	6.9	16.78, 0.010*	8.4	6.2	7.3	4.82, 0.232
	Three	84.3	86.9	92.3		88	87.2	87.6	
Frequency of meal after COVID-19 outbreak/currently	Two or less	47.1	16.3	41.5	52.38, 0.000*	35.6	33.6	34.6	0.59, 0.897
	Three	52.9	75.2	57.7		61.3	63	62.2	
Difficulty in accessing food after COVID-19	Yes	92.2	98	90.8	7.50, 0.024*	92.4	95.3	93.8	1.48, 0.223
	No	7.8	2	9.2		7.6	4.7	6.2	
Incidence of food shortage after COVID-19	Yes	67.3	40.5	54.6	22.1, 0.000*	54.2	54	54.1	0.01, 0.968
	No	32.7	59.5	45.4		45.8	46	45.9	
Reduction in number of meals per day after COVID-19	Yes	47.7	18.3	26.8	30.22, 0.000*	31.6	33.6	32.6	0.22, 0.641
	No	52.3	81.7	58.2		68.4	66.4	67.4	

Note: * statistically significant at p<0.05, Null hypothesis for Chi-2 test: there is no difference in the frequency of meals, food shortage, and reduction in number of meals among the three sampling categories and between male- and female-headed households; Participants were allowed to choose multiple options for these questions.

There was disparity in food security and access to food/food materials among the 10 cities. For instance, the proportion of households relying on food assistance from government, NGOs, UN agencies, and local charities was highest in Logia (59.1%), followed by Mekelle (57.8%), whereas the lowest was in Bahir Dar (6.5%), followed by Addis Ababa (10.9%). Most households (70%) from Adama and from Logia (69.6%) reported a reduction in their number of meals per day since COVID-19. On the contrary, only 6.7% from Semera and none of the households from Jigjiga reported a reduction in the number of meals per day (Annex A).

There was a slightly higher reduction in the number of meals among refugees compared to IDPs. The proportion of refugee households who consumed an average of three meals per day before was lowered from 96.7% to 63.3% after the pandemic. Similarly, households experiencing incidences of food shortage after COVID-19 were higher among refugees than IDPs (Annex B).

In this study, we also assessed the reasons for food insecurity since the COVID-19 pandemic. Both the quantitative (see Figure 3) and qualitative data show some of the reasons for increased food insecurity during the crisis. Lack of income, increased prices of food items like teff, cooking oil, and onions, and unavailability of food items in the market were among the major reasons for reduced food consumption. Increased demand among some people who can afford to buy food for backup stores has also resulted in a rise in prices and a shortage of supply of food in the market.

> *There is no adequate supply in the market at this time; its availability is not as before.…I think people have developed fear due to COVID-19 and have started buying and storing supplies as a reserve. There is also the issue of this market price inflation, in addition to this supply scarcity. For example, previously, you buy after selecting a better product among the other available options, but at this time you do not have options or preferences. You are just expected to buy what is available.* (26-year-old female, IDP, Addis Ababa)

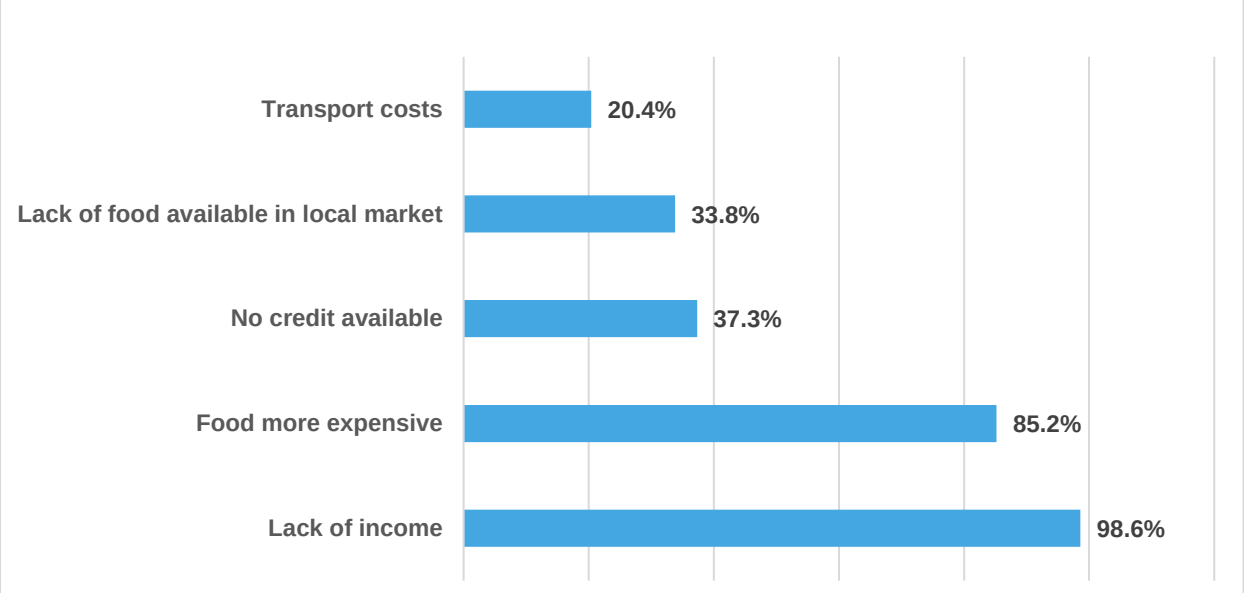
> *After the government response or restriction, there is no food availability problem, but there are increased prices of food items. For example, the price of onions increased from ETB 18 to ETB 42. Formerly, our staple foods were injera and souse, but now we cannot buy injera because the price of one injera inflated from ETB 6 to ETB 12. For these reasons, we turned to eat bread and souse always after corona started. In addition to this, my wife is pregnant and she needs a variety of foods. But I cannot fulfil her needs due to a lack of money.* (35-year-old male, Logia)

> *Food items are available, but they are not as common as previously. You will not find some food items as easily as before unless you visit several places.* (24-year-old female, returnee, Bahir Dar)

Another IDP from Gambela shared this view:

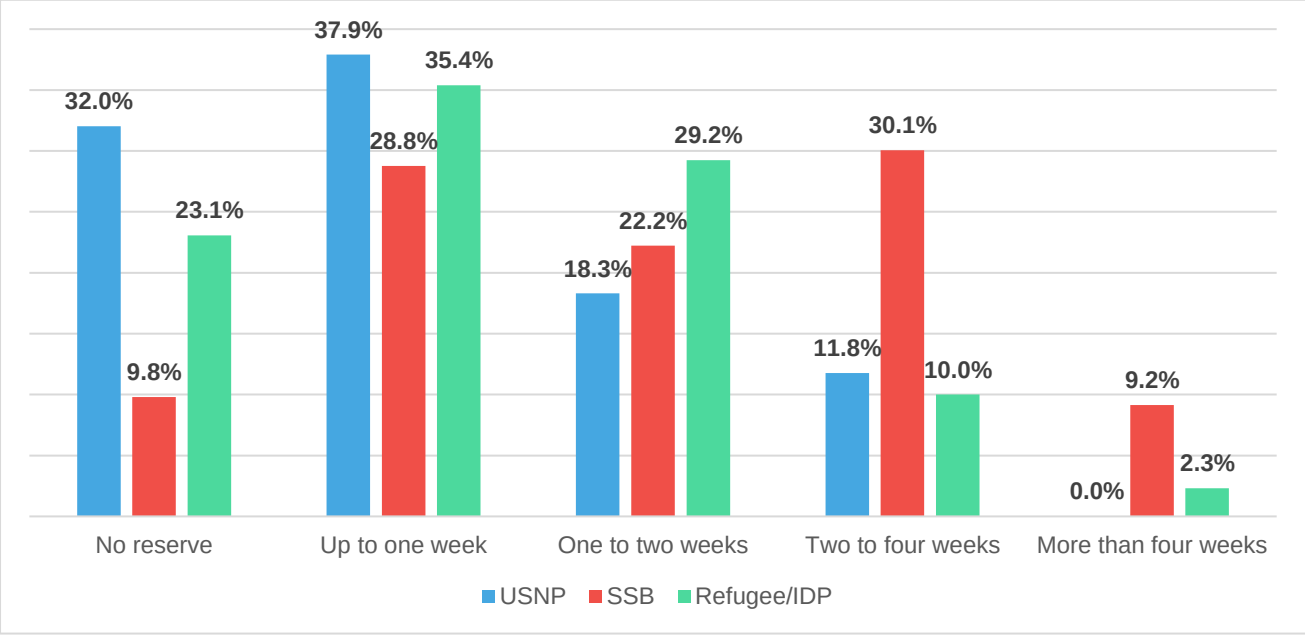
> *Some foods are available in the market with a high inflation rate that could be above ETB 200 per day, but other foods have not been accessible recently.* (28-year-old male, IDP, Gambela)

Figure 3: Reasons for reducing food consumption among the urban poor in selected 10 cities, Ethiopia, July 2020



We also asked people about their capacity to store food in reserve. The results suggest that about 20% of households had no food reserves for future consumption and 34% of them had a food reserve that would last one week or less. In general, SSB households appeared to have relatively better food reserves than other groups (Figure 4). There is no significant difference in the availability of food reserves between male- and female-headed households.

Figure 4: Availability of food reserves among the urban poor in selected 10 cities, Ethiopia, July 2020



In terms of strategies used to cope with food shortages, reductions of both the quantity and quality of food were reported among most of the respondents so as to cope with the inaccessibility and unaffordability of food items. Replacing common food items with other

perceived low-quality or less-preferred foods, reducing food consumption, and compromising on essential needs were repeatedly mentioned as coping strategies.

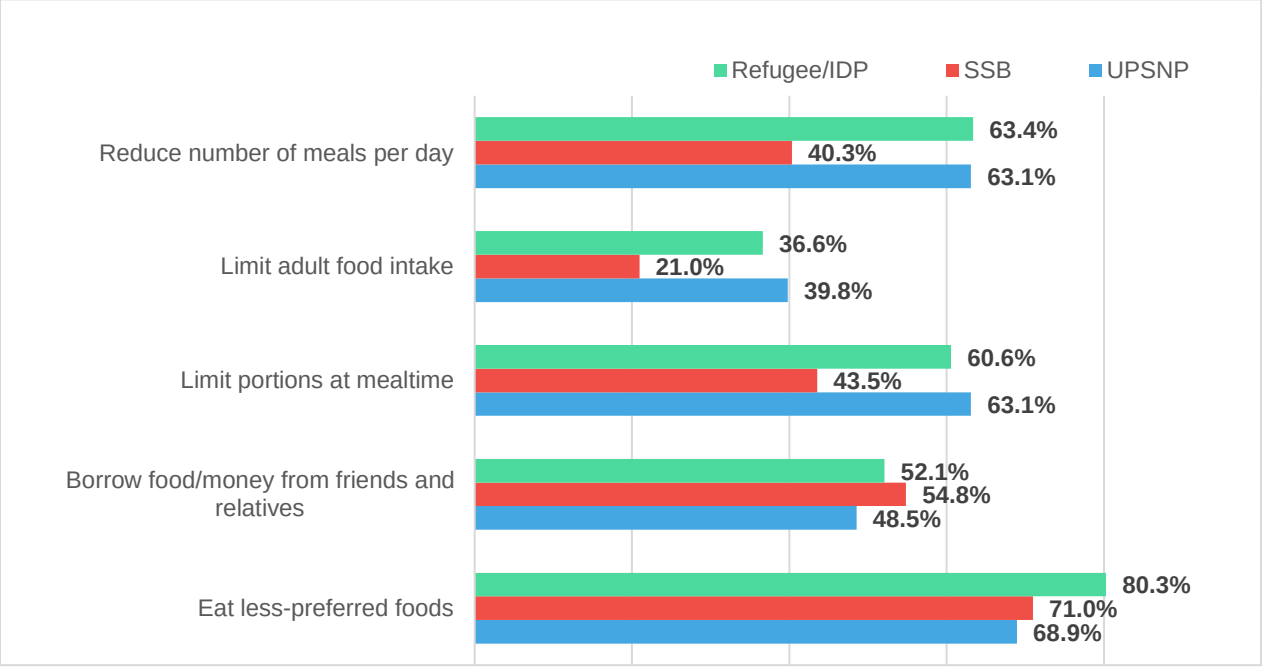
> *Now I am buying only one kilogram of onion and tomato while I had been buying three kilograms; we are reducing the amount we use. We stopped eating foods like meat, eggs, and vegetables. The quality of the food we eat has decreased.* (24-year-old female, returnee, Bahir Dar)

> *All of my children are older than six years. My child who is female and six years old has had a little bit of lunch, but all the rest of my children are above six years old and have had to cut down lunch.* (42-year, Small scale, Bule Hora)

> *Most of the time, we skip breakfast and usually eat two meals a day. We used to eat meat sometimes, but now we have ceased to use it.* (21-year-old male, Jigjiga, daily labourer)

Reducing the number of meals and eating less-preferred foods appeared to be the predominant strategies for coping with food shortages due to the pandemic. There is a slight variation in coping strategies among the UPSNP, SSB, and IDP/refugee groups (Figure 5).

Figure 5: Strategies for coping with reduced access to food among the urban poor in selected 10 cities, Ethiopia, July 2020



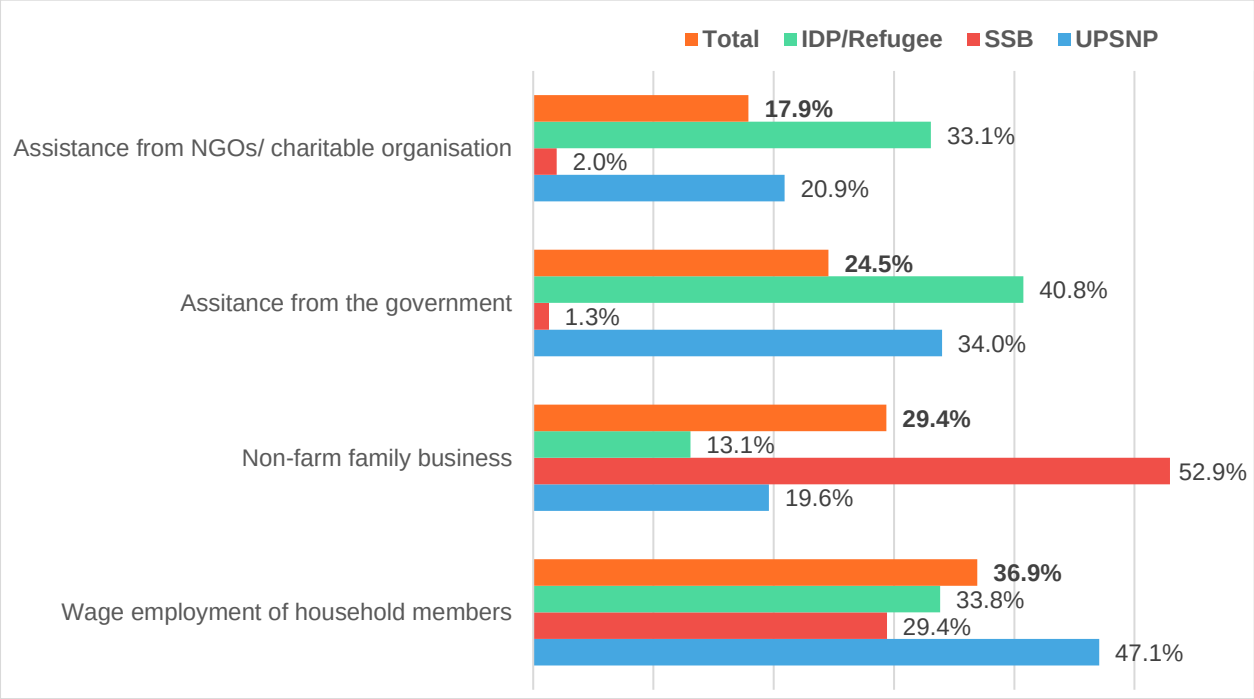
Income and expenditure

Key findings:

- Household income has been reduced due to COVID-19.
- About 62% of households have reduced their work hours or their amount of work since the start of COVID-19, with SSB households, refugees, and day labourers being highly affected.

Among our sample, wage employment is the major means of livelihood (37%), followed by non-farming family businesses (29%) and assistance from government (24.5%) (Figure 6). The mean monthly income of households has reduced from ETB 2,580 before COVID-19 to ETB 2,277 since, although this reduction is not statistically significant. Compared to IDPs, a higher proportion of refugees reported a reduction in the amount of work since COVID-19.

Figure 6: Means of livelihood among the urban poor in selected 10 cities, Ethiopia, July 2020



About 62% of households had reduced their work hours or their amount of work since the start of COVID-19. SSB households were highly affected (74%) by the reduction in their working hours and amount of work, with 25% of such households reporting an inability to earn the same income as they did before COVID-19. About 47% of households reported that they were worried about being evicted from their homes due to their loss of income.

Table 7: Income and employment among the urban poor in selected 10 cities, Ethiopia, July 2020 (total n = 436; UPSNP = 153, SSB = 153, IDPs/refugees = 130)

		UPSNP (%)	SSB (%)	IDPs/ refugees (%)	Total (%)	Chi-2, p-value
Reduced work hours or amount of work since COVID-19	Yes	58.8	73.9	51.2	61.8	16.18, 0.000*
	No	41.2	26.1	48.8	38.2	
Current ability to earn income is similar to ability before COVID-19	Yes	63.4	74.5	58.1	65.7	8.97, 0.012*
	No	36.6	25.5	41.9	34.3	
Risk of eviction from their homes due to loss of income	Yes	51.6	44.4	44.2	46.9	2.13, 0.345
	No	48.4	55.6	55.8	53.1	

Note: * statistically significant at p<0.05; Null hypothesis for Chi-2 test: there is no difference in the amount of work, earning ability, and risk of eviction among the three sampling categories.

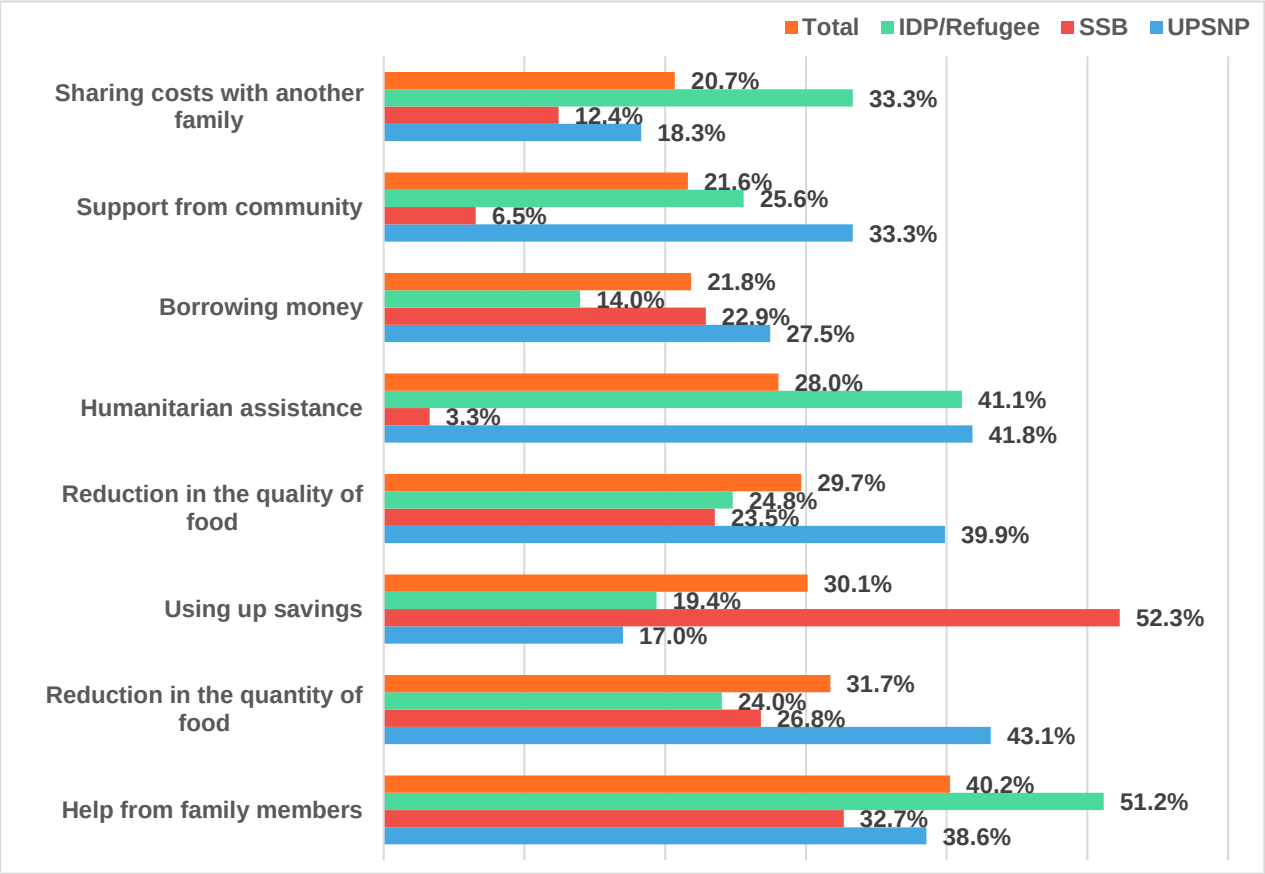
The qualitative results are consistent with the household survey findings, with respondents reporting a reduced income and loss of job opportunities due to the pandemic. One refugee described the problems related to the lack of jobs:

> *Before the coronavirus pandemic, I was doing various daily labour works like carrying different things and slaughtering goats and sheep* during the wedding ceremony *. Now everything is changed. For example, there is no weeding and daily labour work because everybody is at home so we could not get work as before. Now we are living by UNHCR* [United Nations High Commissioner for Refugees] *support only.* (30-year-old male, refugee, Logia)

There were variations in the effects of COVID-19 and associated government restrictions on household income among the 10 cities. The proportion of households who were able to earn a similar income to the level they had earned before the pandemic was high in Logia (100%), Gambela (90.3%), and Bahir Dar (86.7%), while it was lower in Bule Hora (22.0%) and Dire Dawa (44.2%). On the other hand, about 97% of Adama households (highest) and 17.8% of Jigjiga (lowest) households reported a fear of being evicted from their house due to the loss of income (Annex A).

As mentioned in the above section (food security), loss of income appeared to be the major reason for reduced accessibility and affordability of food/food materials. Therefore, there was a significant overlap between coping strategies for food security and for the loss of income. As shown in Figure 7, seeking help from family members and reducing the quality of food were the most common mechanisms used to cope with reduced income during the survey period. The majority (52.3%) of SSB households reported having used their savings as a coping strategy.

Figure 7: Coping mechanisms for reduced income one month before the survey among the urban poor in selected 10 cities, Ethiopia, July 2020



Similar coping strategies such as asking for support, loans, and selling assets were reported in the qualitative interviews. Respondents also expressed concerns and frustration that they would not be able cope with economic challenges if the pandemic continued for a long period of time.

> *We get assistance from our relatives who live in rural areas. The owners of the house also provided us with a house rent waiver for a few months. That is how we are leading our lives.* (special group, Bule Hora)

> *…the credit I took from the shop [i.e. borrowing food materials to be paid later] is getting higher and higher, for example, I take onion, tomato and chillies and the like that I used to prepare sauce.* (37-year-old female, IDPs, Semera)

Some respondents from the SSB group reported selling of goods and domestic animals to cope with reduced income:

> *I have been dealing or coping with this* [i.e. reduced income] *for the last two months by selling the goats we have at home one by one because we didn't have any savings… I will also try to get a loan from someone.* (30-year-old male, special group, Semera)

Regarding the expenditures of our respondents since the COVID-19 pandemic, some reported that they had reduced their expenses by compromising on their needs. There were also respondents who mentioned that their overall expenses had increased because of the additional expense of buying facemasks and hand sanitisers, as well as the increased cost of food items, transportation, and other materials.

> *The Bajaj tariff for one person was ETB 5. Now one person is paying ETB 10. If we use three or four trips, we are expected to pay ETB 30 or 40 or 50, which exposed us to extra costs. There is also cost for buying facemasks that will be ruined after being used for only a few days; thus, we are expected to buy facemasks again and again. We also need to buy sanitiser daily. These are all additional costs compared to before.* (42-year, Small scale, Bule Hora)

A physically disabled respondent from Bule Hora said that:

> *Currently, I am at the bus station. Sometimes, I beg from the drivers. I stop in front of them and ask for coffee. I ask for hand sanitiser, and once I get the money I go in my wheelchair and send somebody who buys sanitiser for me. I got a difficulty to practice physical distancing because I stand in a place where there are a lot of people* (34-year, Male UPSNP, Bule Hora)

Some respondents reported a change in priorities regarding their expenses, while others reported food items and house rental costs as their priorities rather than buying clothes, as they used to do before the COVID-19 pandemic. In general, the income loss among households resulted in changes their priority. A respondent from Bule Hora said that:

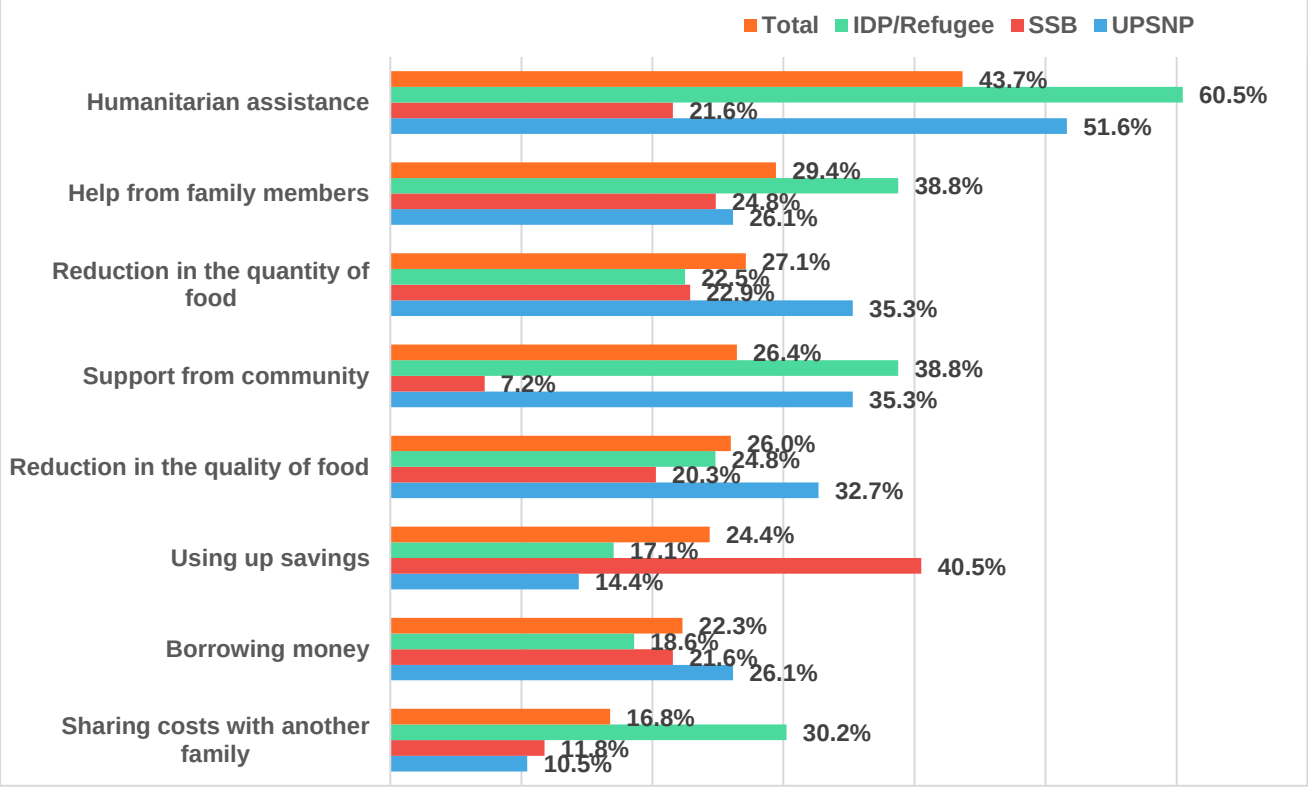
> *I used to buy clothes and fruit for the children before, but I have stopped purchasing such items because our income decreased significantly. Thus, currently, we have been prioritising purchasing food, buying water, and house rent.* (28-year, Female, UPSNP, Bule Hora)

A few other respondents reported that they had stopped saving money and used their money to buy food and food materials instead:

> *Previously, I spent on family food. If I got some extra money, I used to save for medication and other services in the form of* Ekub [traditional money saving]. *Now there is no* Ekub*; we stopped it totally. Now we are spending for the family's food consumption.* (33-year-old male, SSB, Bahir Dar)

As shown in figure below, humanitarian assistance, help from family members, and reductions in the quality and quantity of food were the major planned mechanisms for coping with reduced income for the next month.

Figure 8: Planned mechanisms for coping with reduced income for the next month among the urban poor in selected 10 cities, Ethiopia, July 2020



Health

Key findings:

- Respondents or members of their families, who needed medical attention, reported to have some accessed a medical treatment. However, health managers and healthcare providers observed a decrease in the number of people seeking health services from health facilities since the COVID-19 pandemic began.
- Perceived risk of exposure to coronavirus was the main reason affecting health-seeking behaviour.
- Healthcare providers were concerned about their safety and risk of exposure to coronavirus given the inadequate supply of personal protective equipment (PPE).

Only 98 respondents (22.5%) reported that they or any member of their families had needed medical treatment since the COVID-19 outbreak. Of these 98, the most common reason they had needed medical attention was childhood illnesses (31.6%), followed by non-communicable diseases (25.5%). Of this group that needed medical attention, 12.2% said that they were not able to access medical treatment when it was needed. The most common (23.5%) reason for this was reported as the fear of being infected with the coronavirus.

This finding was supported by the qualitative study. A few respondents expressed their concerns about the risk of exposure to the coronavirus when visiting health facilities – although only a small proportion (7.1%) reported having skipped routine services (e.g. vaccination). The majority (91%) said they would still go to health facilities if they needed

medical treatment in the future (note, however, that social desirability bias may influence this type of answer). Only 8% of the total household sample included pregnant women, of whom 74.3% had access to antenatal care (ANC). In our qualitative interviews, healthcare providers reported that some pregnant women prefer not to visit health facilities for ANC and delivery services. A similar finding was found in the qualitative interviews with households. About 20% of our household samples included lactating women, of which 75.3% had accessed postnatal care (PNC).

> *Pregnant women especially are not going to a health facility. Previously, pregnant women were having follow-up at a clinic, but now due to fear* [of being infected with the coronavirus] *they are not having follow-up. Currently, there are home delivery reports. For example, we have found two women who gave birth at home.* (Government official, Bahir Dar)

Both health officials and health care providers reported a decreased number of people seeking health services. This was particularly noticeable among women and people with HIV/AIDS. According to respondents, the fear of being infected with the coronavirus was the major reason for the decrease in health-seeking behaviour. Moreover, healthcare providers acknowledged that the COVID-19 pandemic has affected the supply of essential supplies including vaccines:

> *Around 80 women with HIV/AIDS have stopped taking their drugs, and some stopped going to health facilities to take their drugs because they perceived that they would contract COVID-19.* (Government official, Gambela)

> *There is a situation in which mothers are coming to the health facilities but get back home without receiving the TT* [tetanus toxoid] *vaccine because it is not available. Mothers are bringing their children during this pandemic and return home without getting them vaccinated due to the shortage of vaccines.* (Healthcare provider, Bahir Dar)

Other than the fear of being infected with the coronavirus, lack of money was reported to be the reason for not seeking care for sick children under five among refugees. One of the main reasons was the increase in transport costs, which were reported to have doubled following government restrictions. Moreover, caregivers were worried that anyone having symptoms similar to COVID-19 would be kept in quarantine. As a result, they tried to treat their sick children at home instead of taking them to a health facility.

> *The only problem is if you have symptoms that are similar to the symptoms of coronavirus like a fever or cough, they will admit you to the quarantine centre. So, we fear going to the health centre even if our children have a fever. We will not take them to a health facility because of this fear. We treat them with a cold compress to reduce the fever at home. Generally, we have a fear of this disease because there are many people in the health centre.* (35-year, Female, Refugee, Logia)

> *The transportation tariff has doubled. It is not allowed for two people to use one Bajaj. The person who is ill and the attendant should travel by two different Bajaj when going to a health facility. That adds another expense. This contributes a little to the rise in the cost of accessing healthcare, but I have not felt any change in the cost of medicine or healthcare.* (30-year, Male, IDP, Jigjiga)

On the supply side, some healthcare providers had concerns about the impact of COVID-19 on their working lives. They described the inadequacy of PPE and their concerns and worries about their risk of exposure to coronavirus. Some healthcare providers stated that they had been provided with training on COVID-19, but they considered it inadequate:

> *At the facility, since a number of healthcare workers have been infected by COVID-19 and taken to an isolation centre for follow-up, health professionals are to some extent worried at this time about COVID-19. Because a patient may be asymptomatic, but he/she is able to transmit the virus.* (Healthcare provider, Gambela)

> *Heath workers were very terrified, because we are on the frontlines and easily exposed where there is no adequate PPE or other prevention mechanisms. Our families are scared of infection transmission from us. Therefore, in the first months, there was a bit of stigmatising of health workers.* (Healthcare provider, Mekelle)

> *Our great disappointment is the lack of adequate PPE, including aprons, shoe covers, gowns, and eye shields.* (Healthcare provider, Dire Dawa)

Education

Key findings:

- The absence and unaffordability of education platforms to help students learn from home is challenging for the urban poor.
- This absence of platforms or mechanisms has psychological and social implications for children and families in the urban poor.

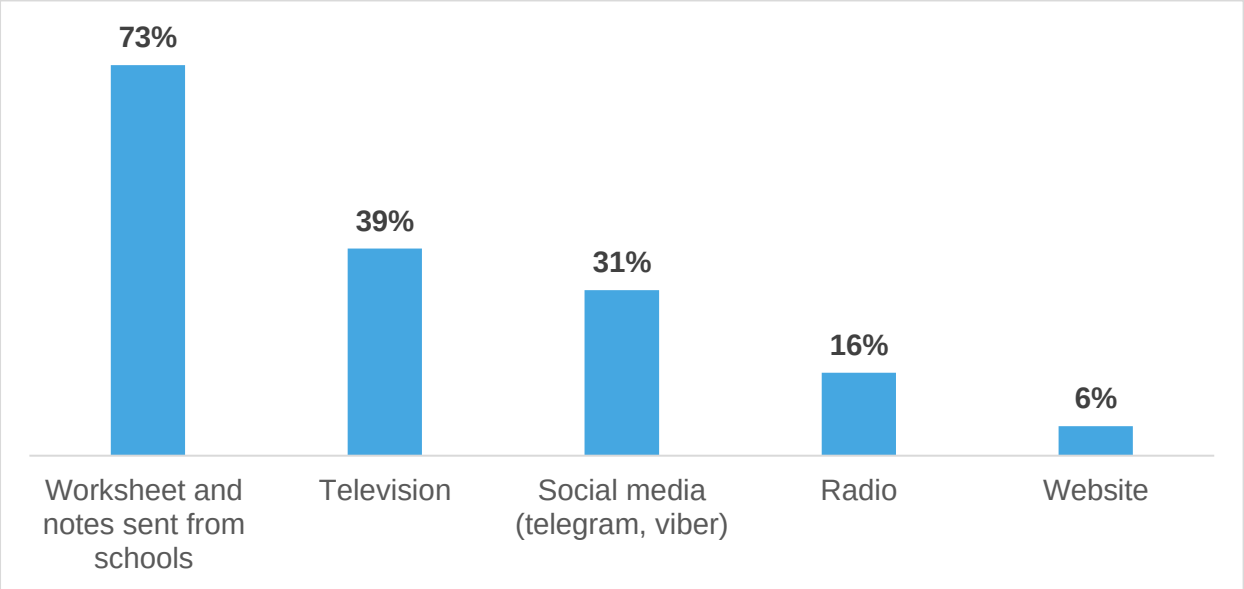
Over 60% of the total households had at least one child attending primary or secondary education before schools were closed due to COVID-19, and about half of refugee/IDP households had children attending school. Around 66% of households had no way for their children to learn from home, with the lack of access to home-learning platforms highest among refugees (81%) (Table 8).

Table 8: Availability of platforms or mechanisms for students to learn from home among the urban poor in selected 10 cities, Ethiopia, July 2020

		Respondent category				
		UPSNP (%)	SSB (%)	IDP/Ref. (%)	Total (%)	Chi-2, p-value
Households with children who go to primary or secondary school	Yes	66.7	65.4	50.4	61.4	9.40, 0.009*
	No	33.3	34.6	49.6	38.6	
Number of school-aged children	One	32.4	31	26.2	30.3	14.22, 0.582
	Two	27.5	33	38.5	32.2	
	Three	17.6	14	20	16.9	
	Four and above	22.5	22	15.4	20.6	
Platform or mechanism for students to learn from home	Available	28.4	49	18.5	33.7	18.50, 0.000*
	Not available	71.6	51	81.5	66.3	

Among the 90 households (28.4%) who reported having access to the home-learning platform, worksheets or notes provided by schools were the major mechanisms. The results suggest that the urban poor have limited access to other electronic platforms, including educational programmes transmitted through radio and television (Figure 9).

Figure 9: Available educational platforms among the urban poor in selected 10 cities, Ethiopia, July 2020



The result of the qualitative study is in line with the quantitative finding. Most of the diary interview respondents mentioned the absence of platforms or mechanisms to help their

children learn from home during the school closure. Even if they were aware that educational programmes were being transmitted on television, most respondents reported that they were unable to watch the programmes due to the absence of a TV apparatus in their house. On the contrary, a few respondents whose children were enrolled in private schools reported having access to books, worksheets, and reading materials provided by the schools. Only two people mentioned having access to an educational programme transmitted through television and radio.

> *I heard that there are educational programmes on TV and radio, but my children are not able to access them. I am planning to send my children to our neighbour to watch the educational transmission through the television.* (30-year male, Day labourer, Semera)

Our results suggest that the school closure has resulted in a huge burden on children, parents, and the community in general, widening the gap between children who go to public and those who go to private schools. According to participants in our study, for the poor community, schools are seen as more than a place for education. Spending their time at schools, their children have opportunities to engage in physical exercise, refresh themselves with games and sports, and interact with their friends. A majority of respondents stated that, since the school closure, their children had been idle and wasting their time playing in their neighbourhoods and in places that were inappropriate for children. It was reported that lack of materials and learning opportunities had increased exposure to the virus as children often played closely together rather than staying at home.

> *At this time, these students* [children and youth] *are playing mobile application games in close contact, which will increase the risk of exposure to the virus.* (68-year, Male, IDP, Mekelle)

We asked about childcare responsibilities during the COVID-19 pandemic. Most of the respondents (77%) reported that mothers are the primary caregivers during the school closure because of the pandemic. Once again, the qualitative finding is in line with the quantitative result. The respondents reported increased burden on mothers to look after their children while working on their daily obligations. Some respondents who are mothers reported being forced to take their children to their workplaces during the pandemic, as there was no one at home to look after them. This has increased the burden and stress on women.

Mental health

Key findings:

- COVID-19 and associated government responses have had an effect on the mental health status of the urban poor.
- About 25% reported feeling very hopeless and/or having thoughts of hurting oneself in some way, which is a response that requires mental health intervention.
- About 16% of respondents had probable depression.

About 68% of quantitative survey respondents reported feeling stressed, scared, and worried. The main reasons include a decline in income due to restrictions, the absence of work or unemployment, an inability to pay their rent, food insecurity (both in terms of access to and the affordability of food), the school closure and its impact on children, and the fear of being infected with coronavirus. Respondents from the refugee/IDP group (40%) reported stronger feelings of stress than those in the UPSNP (27%) or SSB groups (29%). Female-headed households had a higher level of stress (68%) than their counterparts.

There was some variation in the mental health status of respondents across the 10 cities. More than 95% of respondents from Adama, Jigjiga, and Bule Hora reported feeling stressed during the past month. This was much higher than Bahir Dar (31.1%) and Addis Ababa (39.1%) (Annex A).

The qualitative findings from the diary-style interviews strongly support the quantitative result. IDPs reported a feeling of stress related to various social, economic, and psychological problems as a result of the pandemic. They reported that the problems were more worrisome to them because of the double stress of being displaced from their living environment and home or their return from other countries due to COVID-19, as well as the fear of stigma in addition to the socio-economic problems:

> *The COVID-19 pandemic changed a lot of things. The price of materials has inflated, and many people have also lost their jobs, so many people are in stress. Previously, we were working as daily labourers, but now it is very difficult to find a job. I am worried. We lost our property and were evicted from our home. We are thinking over and over about our fate. How could we continue in such a way? We need to resettle and restart our lives.* (40-year-old male, IDP, Dire Dawa)

Likewise, most respondents whose livelihood is based on a daily income also reported a fear of getting infected, unemployment, an inability to cover basic necessities, and housing problems, anticipating the future worsening of their situations as their main source of stress. One respondent reflected that:

> *I'm having the most troublesome time due to the coronavirus and the cost of living. One of the things that worries me is being unable to cover the rent for my house because I have stopped working.* (36-year-old male, day labourer, Logia)

Moreover, some respondents expressed fear and feelings of stress because of the infectious nature of COVID-19, which affects not only a person but also their family members:

> *I fear and get frustrated whenever I start thinking about the disease because I may not die alone if I get infected, but there are also my children behind me. This is why I prefer to believe that COVID does not exist ever.* (38 year-old female, IDP, Mekelle)

Respondents also mentioned the negative effect of school closures as a coronavirus response measure on their children's psychological well-being:

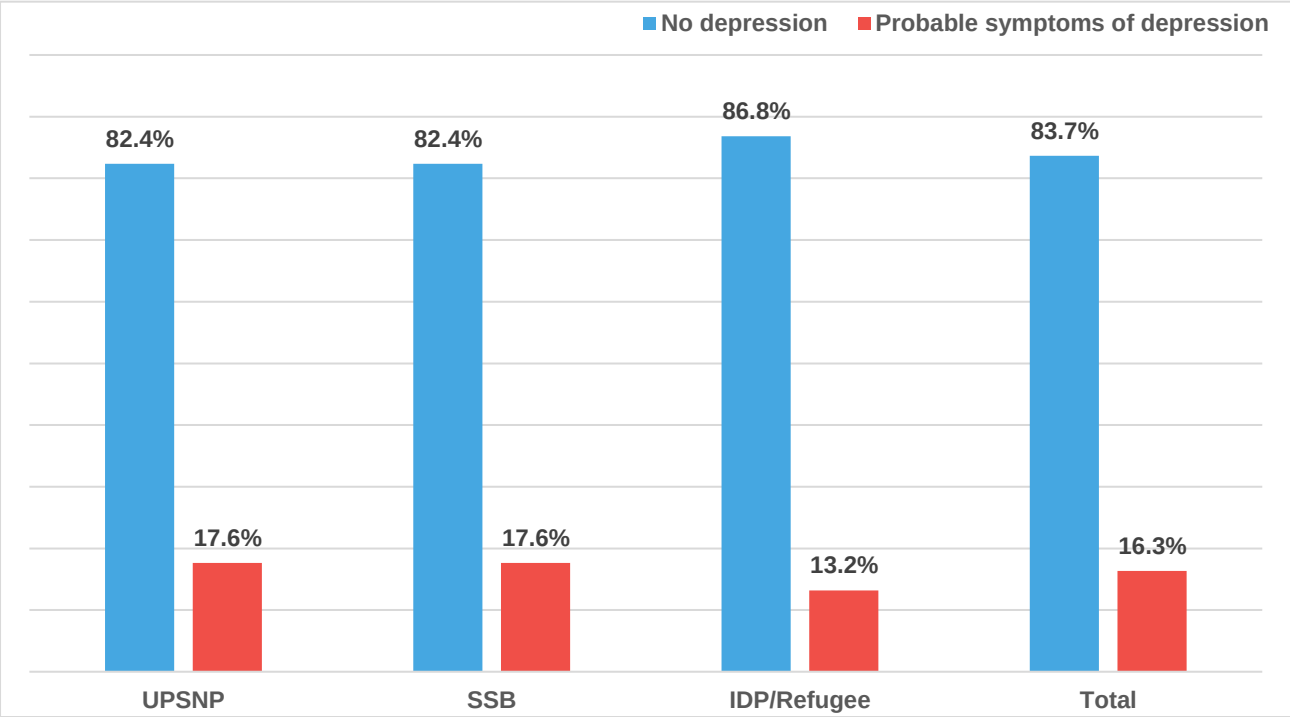
> *My child was active before the school closure, but currently he has developed dizziness. I don't know the reason, but he started keeping silent when I talk to him. When I ask him what happened to him, he responds to me by saying, 'Nothing'.* (29-year-old female, special group)

Most respondents in the SSB and UPSNP groups also reported a fear of further lockdown and its social and economic consequences and a fear of getting the infection rather than their current problems in relation to the current situation:

> *I am worried the most about what would happen to my sisters and daughter if I got infected and could not work. What if I die without preparing the livelihoods of my daughter and sisters? It is not my own death that worries me; rather, I am worried about my daughter's and sisters' lives.* (23-year-old female, UPSNP, Adama)

The study evaluated the mental health status of respondents using a standard tool called the Patient Health Questionnaire (PHQ-9). The tool contains nine questions that measure the level of depression with three-point scales, ranging from 0 (not at all) to 3 (nearly every day). According to the reliability test result, the instrument has acceptable consistency with a Cronbach alpha value of 0.93. The mental health status was measured from a total of 27 points, in which 15 was considered as a cut-off point. Accordingly, individuals who scored 10 and above points were categorised as "probable symptom of depression", and those with total score below or equal to 10 were grouped as "no mental health problem". About 16% of respondents had probable symptoms of depression. The incidence of mental health problems was found to be slightly lower among refugees/IDPs (13.2%) than other categories. However, there was no significant difference in mental health status between male-headed and female-headed households (Figure 10).

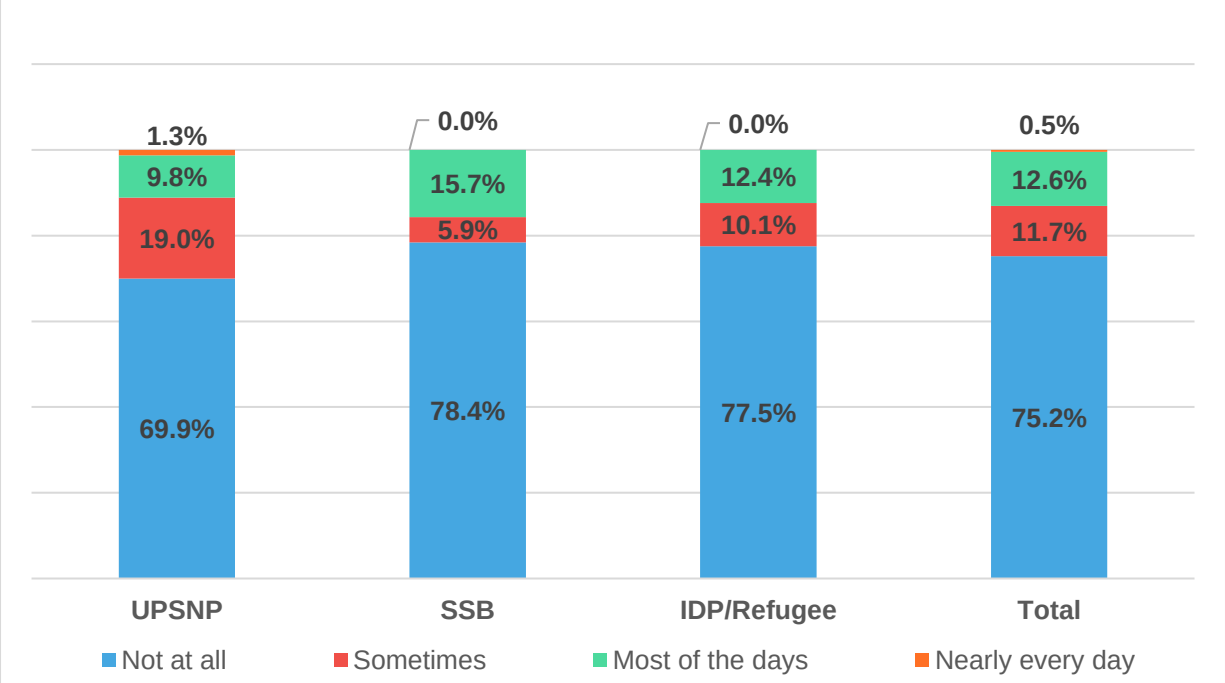
Figure 10: Overall mental health status (PHQ-9 scale index) among the urban poor in selected 10 cities, Ethiopia, July 2020



Feeling very hopeless and/or having thoughts of hurting oneself in some way is one the nine PHQ-9 items that can be used to monitor mental health status. About **25% reported this feeling to varying degrees**. A higher proportion of respondents from the UPSNP group (30%) had thought about hurting themselves than in other categories (Figure 11).[5]

[5] As part of the interview protocol, all data collectors were trained to provide information about mental health support within a particular city (the consent form is available upon request).

Figure 11: Feeling very hopeless and/or having thoughts of hurting oneself among the urban poor in selected 10 cities, Ethiopia, July 2020



Aid and support

Key findings:

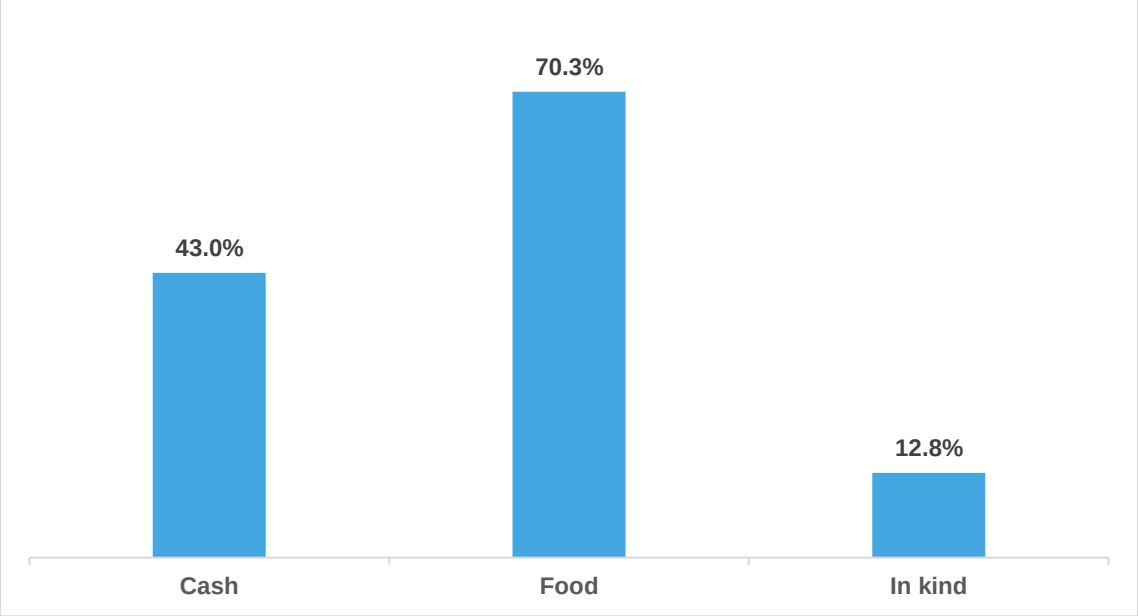
- Overall, support was reported to be available during the COVID-19 pandemic but inadequate.
- Government, NGOs, CSOs, and the community were all sources of support. Support was provided predominantly in the forms of food and cash.
- The pandemic has negatively affected daily interactions and social events and the culture of the community supporting each other.

Most (68%) respondents reported awareness about the availability of assistance from the government, NGOs, CSOs, and other groups (e.g. religious groups) since the outbreak. About 39.5% of households – 60.8% of UPSNP beneficiaries (including those registered but not yet receiving the support), 56.6% of IDPs, and 3.9% of SSB owners – had received assistance through one of these means (government, NGOs, or religious institutions) since the outbreak. Similarly, we asked respondents about the availability and adequacy of support to the most vulnerable segment of the population in the qualitative study. Street children, women, and commercial sex workers have been given priority in the provision of support during the pandemic. Most respondents reported that there was support from the government, NGOs, and the community. However, the support was reported to be inadequate given the high number of people in need. This support included food, cooking oil, and soap and other sanitary materials.

> *For instance, there are commercial sex workers who are being supported by our office. These commercial sex workers have stopped their work since all hotels and nightclubs are already closed. So, based on their level of vulnerability that is identified at the kebele* [the lowest administrative unit] *level, we are providing them support. For example, we are providing them with teff, flour, kinche, shiro, and other important 'asbeza'. Additionally, we are providing soap and other materials for their hygiene. We are providing support for those who are identified as vulnerable and who have lost their jobs due to this.* (Government official, Bahir Dar)

The largest proportion of the assistance provided was in the form of free food (70.3%), followed by direct cash transfers (43%).

Figure 12: Type of aid received from institutions among the urban poor in selected 10 cities, Ethiopia, July 2020



The pandemic has negatively affected daily interactions and social events, with weddings, funerals, religious practices, and other events all having been restricted. People used to support each other and there was strong social interactions in all the cities included in the study. Several respondents mentioned that there was inadequate support among community members since the COVID-19 pandemic due to fear of exposure to the virus.

> *There is no support between communities because everyone has a fear of this disease (COVID-19). In addition to this, they spend their time at their home and visiting relatives has reduced …* (22-year-old female, Logia)

There were also respondents who explained that the closure of mosques and churches had reduced their social interactions, which they used as a means of getting support.

> *The movement restriction, to some extent, affected the ability to support each other inside the community. Because everyone fear to visit other which in turn reduced social support . In addition, we are currently unable to get assistance from the mosque that previously provided for us for every Ramadan fasting period because the mosque is closed due to the COVID-19 pandemic…* (35-year-old female, Logia)

Case studies

Case Study 1:

Mr Goitom (not his real name) is a 32-year-old man from Mekelle, Tigray, who has completed high school. He is married and is the father of a four-year-old boy. He collects used materials, such as metals, plastics, and glass bottles, for recycling purposes for a living.

Before the beginning of COVID-19, Mr Goitom was so busy at his work that he used to do home-to-home rounds to collect used materials 10 times per day without a break; resultantly, he had been earning a lot of money. He used to save money (ETB 200 per day), procured food for his family at an affordable cost, and sent his child to a fee-charging kindergarten. Since the pandemic, however, his work has stopped and his livelihood has worsened dramatically. He has only expenditures now but no significant income, and his savings have been depleted. The price of food and other materials in the market has inflated; for instance, the price of one quintal of teff has risen from ETB 3,000 to ETB 4,200. Additionally, as a result of government measures (i.e. restrictions), his transport costs have doubled, and social interactions like funerals and marriage ceremonies are prohibited, which has also negatively affected his normal life. Consequently, he cannot procure food or other basic necessities for his family as before. He is not able to educate his child (who has an emotional disorder) as before. To address these challenges, he has tried to live by compromising the quality of his daily life and prioritising his expenditures. For example, he has reduced the number of meals from three to two, as well as his amount of food. He has also reduced the frequency with which he purchases new clothes and shoes by half. Overall, he has been making decisions for the sake of survival. As his work area is highly exposed to communicable diseases, he usually wears a mask, washes his hands regularly, and applies alcohol and sanitiser. He has never lost hope;, instead he is praying to God for help when problems grow beyond his capacity to address.

Case Study 2:

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

Mrs Lelo is well aware of COVID-19. She heard about the pandemic from mass media like TV and radio and public announcements. She is well informed about how the disease is transmitted, its signs and symptoms, and how to reduce exposure to coronavirus. Mrs Lelo explained that she is adherent to government restrictions including social distancing and the use of facemasks in public. She is aware that staying at home could help her and her children reduce the risk of exposure to the coronavirus. Furthermore, she explained that she and her children frequently wash their hands with water and soap. On the other hand, she highlighted low adherence to the restrictions included in the state of emergency. The community's adherence to the restrictions including the use of facemasks and physical distancing is low. According to Mrs Lelo, adherence to the recommended measures to reduce exposure to COVID-19 is widely because of the fear of being apprehended: '*Most people do not seem to actually follow the recommended measures. It is not allowed to get into bajaj without wearing facemasks, for instance. People use facemasks for such purposes only. They hold it in their pockets, and wear it only out of fear of being apprehended*.'

Mrs Lelo explained how the COVID-19 pandemic and the government restrictions have affected her daily life. A key impact she mentioned was reduced work opportunity. She used to work as a social worker on a project implemented by an NGO, which was phased out a year back. Following the project phase-out, she chose to work on selling 'chat' as a means of income to support her life and feed her family. However, due to the pandemic, she was not able to sell chat on a daily basis. Thus, her income was significantly affected and she lost the capacity to feed her family: '*I lost my source of income since the pandemic started. I could not go out and work. Consequently, what has been the most difficult thing for me and my family is food—there is a shortage of food in our house.*' It has

not been easy to cope with the reduced income. Mrs Lelo and her family have been forced to cut the number of meals they used to have daily: '*We have cut down on food. Because we stay at home, I make the family wake up late in the morning, thereby avoiding breakfast.*' She explains how difficult it would have been for her to feed her family if it was not for the support she got from her friends and close relatives. The monthly ration of 15kg of wheat or rice was reported to be inadequate. Moreover, Mrs Lelo suggested that provision of soap should be considered to be included in the support package.

The occurrence of the COVID-19 pandemic has not changed her health-seeking behaviour. Mrs Lelo explained that she has no fear of contracting coronavirus if she makes a visit to a health facility: '*If I happen to seek healthcare service, I am not scared at all to go to health facilities. I am not scared to contract the virus from there.*'

The closure of schools following the declaration of the state of emergency became a source of stress for Mrs Lelo. She explains that her children spend their time playing mobile-based games. She believes they are not properly using their time but that there is nothing she can do about it.

Conclusion

Our first round of phone interviews took place four months after the first case of COVID-19 was recorded in Ethiopia. During these months, the government has put in place a number of response measures and measures to raise awareness of COVID-19. The intensity of these measures has varied across the 10 cities included in our sample. Overall, our findings are consistent with the results of a high-frequency phone survey of nationally representative sample of households conducted by the World Bank in all regions of Ethiopia[6] and the study of the impact of COVID-19 on food security by the International Food Policy Research Institute (IFPRI).[7] In terms of knowledge and practices of preventative measures, our respondents reported having acquired knowledge about the pandemic and most reported practising hand washing, hand rubbing with a sanitiser, and social distancing to reduce exposure to the virus. However, one needs to be cautious in interpreting these results as they are likely to be influenced by social desirability bias. In order to deal with such bias, we also asked questions about the practices of friends and family members and found that the compliance rates were much lower when respondents were asked about what other people did. Furthermore, through our qualitative interviews, it was reported that some people only practised COVID-19-related restriction measures to avoid being apprehended. These findings indicate the need to consider a more tailored intervention to avoid negligence, improve misconceptions about COVID-19, and better contain the pandemic.

Although most respondents reported that they had the access to health services that they or a household member needed, fear of being infected with the coronavirus appeared to affect their health-seeking behaviour, at least for some of our respondents. Maternal health service utilisation including facility-based deliveries and missing of medical appointments among people infected with HIV/AIDS were among the healthcare services affected during this pandemic, although our sample for this group was small and, thus, the results need to be interpreted with caution. Nevertheless, our results raise a need for further rigorous research that focuses on assessing the health service coverage of highly affected areas during the COVID-19 pandemic. The inadequacy of PPE needs attention to protect the safety of healthcare providers and patients as well as the psychological and physical well-being of health professionals, who reported feeling stressed and worried. Having adequate PPE for health workers would also signal that health facilities are safe to visit, which will reduce the fear of being infected by COVID-19 among patients.

Our results suggest that an unneglectable proportion of households has experienced a shortage of water since the COVID-19 outbreak, which has negatively affected handwashing practices. The shortage was partially attributable to the movement restrictions and reduced supply by the municipality, and it affected some cities more than others. The findings of this study suggest the need for a timely effort to ensure that communities have adequate water supplies to ensure that hygiene and the preventative measure of handwashing can continue to be practised in order to contain the spread of COVID-19.

[6] www.worldbank.org/en/country/ethiopia/brief/phone-survey-data-monitoring-covid-19-impact-on-firms-and-households-in-ethiopia
[7] www.ifpri.org/publication/food-and-nutrition-security-addis-ababa-ethiopia-during-covid-19-pandemic-july-2020

Our respondents reported having limited access to educational platforms and, despite there being awareness of educational programmes on television, most children do not have access to these platforms due to the absence of a TV. The lack of activities for children also exposes them to greater risks of infection and psychological problems.

A significant number of households experienced reduced income attributed to the loss of work opportunities and reduced work hours due to the restrictions in place to combat the spread of COVID-19. Prices of food and food items have risen to a level that the urban poor cannot afford. Reduced income and market price inflation have thus led to food insecurity among the urban poor. Our results in terms of food security are much starker compared to the World Bank's survey but are in line with those of IFPRI and high-frequency phone surveys conducted with female garment workers in Hawassa, particularly in terms of the strong effects on women.[8] As a result, a considerable number of people have been forced to reduce the number of meals they eat per day and also the quality and variety of the food they consume. Government, NGOs, and the community were the main sources of support, which has been provided predominantly in the forms of food and cash. The support was reported to be available but so far has not been sufficient to meet the overwhelming needs of the poor and vulnerable groups. Since the pandemic has also negatively affected the community interaction and social support that used to exist before the pandemic, the number of households dependent on aid and support has increased. Thus, community mobilisation to strengthen support networks is of paramount importance (while ensuring health safety). The involvement of more local NGOs and timely tailored interventions to reduce the effect of reduced food security are urgently needed, particularly for women, day labourers, and IDPs.

[8] www.poverty-action.org/recovr-study/impact-covid-19-lives-women-garment-industry-evidence-ethiopia

Upcoming activities

Round 2 data collection is planned for 17 August. We will revise the interview tools slightly to adjust to the constantly changing nature of this pandemic and policy responses. We will place a stronger emphasis on IDPs and refugees and examine the results separately for these two categories. We will also look to add more refugee respondents to our sample in the subsequent rounds. As we expect the rate of the spread of the virus to continue to increase, we will place a stronger emphasis on collecting data on health-seeking behaviour and access to health services in parallel with mental health symptoms and access to mental health support. The report of the second-round results will be accompanied by a blog post that will kickstart our three-blog series. The blog post will summarise our findings from rounds 1 and 2 as well as challenges and lessons learned from our data collection exercises, both qualitative and quantitative.

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
Knowledge and behaviour in response to COVID-19 (all figures are in percentage)											
Proportion of respondents who were aware that asymptomatic people could be a source of coronavirus infection	76.1	100.0	64.4	95.2	22.2	88.9	66.7	80.4	95.6	87.1	77.3
Proportion of respondents who mentioned coughs as a sign and symptom of COVID-19	100.0	100.0	100.0	100.0	100.0	100.0	97.8	80.4	75.6	93.5	94.7
Proportion of respondents who mentioned fevers as a sign and symptom of COVID-19	97.8	100.0	86.7	100.0	100.0	88.9	100.0	87.0	75.6	90.3	92.7
Proportion of respondents who mentioned shortness of breath as a sign and symptom of COVID-19	17.4	100.0	51.1	90.5	33.3	48.9	82.2	45.7	44.4	58.1	56.9
Proportion of respondents who reported practising washing hands frequently with soap and water	92.7	100.0	100.0	100.0	100.0	100.0	100.	100.	100.	96.2	99.0
Proportion of respondents who reported practising hand rubbing with a sanitiser or alcohol-based solution	94.4	89.1	77.8	95.1	100.0	75.0	100.0	86.4	100.	92.3	91.0
Proportion of respondents who reported practising wearing a facemask	100.0	93.5	97.4	100.0	100.0	100.0	97.1	93.9	96.6	100.0	97.7
Proportion of respondents who reported avoiding overcrowded places	88.9	79.4	100.0	100.0	100.0	90.0	95.8	87.8	100.	95.2	93.8
Proportion of respondents who reported friends or family members wearing a facemask	58.7	95.7	97.8	100.0	100.0	100.0	86.7	93.5	100.	83.9	91.7
WASH											
Proportion of households who reported access to an adequate water supply	89.1	73.9	62.2	76.7	73.3	91.1	95.5	91.3	84.4	67.7	81.0
Proportion of households who had access to a water supply every day/daily	17.4	71.7	15.6	58.1	28.9	80.0	84.1	56.5	33.3	67.7	50.7

Proportion of households reporting a shortage of water since the COVID-19 outbreak	45.7	34.8	68.9	27.9	35.6	11.1	18.2	26.1	31.1	48.4	34.4
Proportion of respondents practising proper handwashing/cleaning to prevent transmission of COVID-19	93.5	78.3	97.8	83.3	2.2	97.8	68.3	24.4	100.	93.5	73.3
Food security											
Proportion of households relying on food assistance from government/ NGOs/UN/local charities	10.9	34.8	28.9	30.2	28.9	40.0	59.1	6.5	57.8	12.9	31.4
Proportion of households having difficulty going to places to access food/food materials	2.2	10.9	2.2	0.0	24.4	0.0	2.3	6.5	6.7	6.5	6.2
Proportion of households reducing the number/frequency of meals consumed per day since the outbreak of COVID-19 and associated impacts	17.4	69.6	64.4	30.2	0.0	6.7	61.4	28.3	8.9	41.9	32.6
Proportion of households depending on humanitarian aid as a coping strategy because of the outbreak of COVID-19 and associated impacts	13.0	34.8	44.4	39.5	97.8	93.3	43.2	6.7	20.0	45.2	43.7
Proportion of households planning (next month) to depend on humanitarian aid as coping strategy	6.5	45.7	35.6	9.3	22.2	44.4	54.5	20.0	4.4	41.9	28.0
Income, expenditure, and employment											
Proportion of respondents reporting cutting down hours or amount of work since COVID-19/coronavirus	37.0	76.1	51.1	48.8	75.6	35.6	79.5	88.9	57.8	71.0	61.8
Proportion of households currently able to earn an income similar to normal work before lockdown/physical restrictions	78.3	67.4	20.0	44.2	62.2	60.0	100.0	86.7	55.6	90.3	65.7
Proportion of households with a risk of eviction from their house due to loss of income	28.3	95.7	55.6	32.6	17.8	64.4	50.0	37.8	31.1	58.1	46.9
Health											
Proportion of households whose member(s) needed any medical treatment since the COVID-19/coronavirus outbreak	30.4	21.7	37.8	16.7	13.3	31.1	24.4	8.9	24.4	12.9	22.5
Proportion of households/household members needed medical treatment and have had access to health services	92.9	70.0	82.4	100.0	100.0	92.9	100.	100.	72.7	75.0	87.8

Proportion of respondents who perceived the possibility of seeking healthcare if needed (i.e. who would definitely go to a health facility)	97.8	97.8	86.7	100.0	68.9	93.3	82.2	100.	97.8	83.9	91.0
Education											
Proportion of households who reported the availability of any platform or mechanism for students to help them learn from home	53.3	31.4	44.4	46.2	9.4	2.9	10.3	80.0	61.9	33.3	33.7
Mental health											
Proportion of respondents who perceived a negative impact of COVID-19 and associated responses on mental health	2.2	15.2	53.3	51.2	17.8	4.4	0.0	24.4	6.7	6.5	18.4
Proportion of respondents feeling stressed, scared, and/or worried during the past month	39.1	97.8	95.6	79.1	97.8	55.6	77.3	31.1	48.9	58.1	68.3
Proportion of respondents with probable symptoms of depression (cut-off point =10)	0.0	97.8	15.6	11.6	4.4	0.0	2.3	0.0	2.2	32.3	16.3
Aid and support											
Proportion of respondents who are aware of any relief being provided to address the impacts of COVID-19/coronavirus	80.4	84.8	26.7	90.7	24.4	88.9	86.4	57.8	95.6	35.5	68.0
Proportion of households/household members who received aid from any institution after the COVID-19/coronavirus pandemic	52.2	60.9	31.1	14.0	33.3	48.9	63.6	11.1	64.4	3.2	39.5
Total sample/observations (no.)	**46**	**46**	**45**	**44**	**45**	**45**	**43**	**46**	**45**	**31**	**436**

Annex B Key variables broken down by IDPs, refugees, and returnees

Table 9: Sources of information about COVID-19 among the IDPs, refugees, and returnees in selected 10 cities, Ethiopia, July 2020

Sources of information about COVID-19	Refugees (%)	IDPs (%)	Returnees (%)	Total (%)
Radio	30.0	64.8	16.7	52.3
TV	76.7	84.1	91.7	83.1
Neighbours	83.3	63.6	75.0	69.2
Friends	50.0	52.3	91.7	55.4
Family	66.7	48.9	100.0	57.7
Leaflet/poster	16.7	30.7	0.0	24.6
Other sources	30.0	64.8	16.7	52.3

Table 10: Knowledge of actions to reduce exposure to COVID-19 among the IDPs, refugees, and returnees in selected 10 cities, Ethiopia, July 2020

	Refugees (%)	IDPs (%)	Returnees (%)	Total (%)
Avoid spitting in public	63.3	85.2	75.0	79.2
Drink hot tea	0.0	20.5	0.0	13.8
Avoid touching eyes, nose, or mouth	36.7	36.4	16.7	34.6
Keep physical distance	63.3	56.8	50.0	57.7

Cover nose and mouth while coughing or sneezing	70.0	42.0	8.3	45.4
Clean hands with sanitiser or alcohol hand rub	33.3	54.5	50.0	49.2

Table 11: Compliance with government restrictions among the IDPs, refugees, and returnees in selected 10 cities, Ethiopia, July 2020

	Refugees (%)	IDPs (%)	Returnees (%)	Total (%)
Compliance with movement restrictions				
A lot	63.3	45.5	83.3	53.1
Somewhat	20.0	29.5	16.7	26.2
Not very much	3.3	6.8	0.0	5.4
Not at all	13.3	18.2	0.0	15.4
Compliance with wearing a facemask				
A lot	70.0	69.3	83.3	70.8
Somewhat	20.0	23.9	16.7	22.3
Not very much	0.0	2.3	0.0	1.5
Not at all	10.0	4.5	0.0	5.4
Compliance with social distancing				
A lot	70.0	54.5	83.3	60.8
Somewhat	23.3	34.1	16.7	30.0

Not very much	0.0	4.5	0.0	3.1
Not at all	6.7	6.8	0.0	6.2

Table 12: Family compliance with government restrictions among the IDPs, refugees, and returnees in selected 10 cities, Ethiopia, July 2020

Restrictions	Refugees (%)	IDPs (%)	Returnees (%)	Total (%)
Compliance of family members with movement restrictions				
None of them	0.0	18.2	0.0	12.3
Some of them	50.0	28.4	25.0	33.1
All of them	50.0	53.4	75.0	54.6
Compliance of family members with wearing facemasks				
None of them	0.0	5.7	0.0	3.8
Some of them	63.3	36.4	33.3	42.3
All of them	36.7	58.0	66.7	53.8
Compliance of family members with social distancing				
None of them	10.0	8.0	0.0	7.7
Some of them	23.3	35.2	33.3	32.3
All of them	66.7	56.8	66.7	60.0

Table 13: Access to adequate water supply among the IDPs, refugees, and returnees in selected 10 cities, Ethiopia, July 2020

		Respondent category			Gender of HH head		Total (%)
		Refugee (%)	IDP (%)	Returnee (%)	Male (%)	Female (%)	
Household access to an adequate water supply	Yes	83.3	78.4	100.0	77.0	87.5	81.5
	No	16.7	21.6	0.0	23.0	12.5	18.5
Frequency of access to water supply	Every day	66.7	43.2	75.0	45.9	58.9	51.5
	Every week	16.7	23.9	25.0	24.3	19.6	22.3
	Every two weeks	0.0	2.3	0.0	1.4	1.8	1.5
	Other	16.7	30.7	0.0	28.4	19.6	24.6
Shortage of water since COVID-19 pandemic	Yes	30.0	34.1	8.3	32.4	28.6	30.8
	No	70.0	65.9	91.7	67.6	71.4	69.2
Level of difficulty accessing water since COVID-19 outbreak	Much more difficult	10.0	18.2	8.3	17.6	12.5	15.4
	Slightly more difficult	16.7	20.5	8.3	17.6	19.6	18.5
	Nothing changed	40.0	38.6	83.3	39.2	48.2	43.1
	Easier than before	33.3	22.7	0.0	25.7	19.6	23.1

Table 14: Household food access, by respondent category and gender of household head among the IDPs, refugees, and returnees in selected 10 cities, Ethiopia, July 2020

		Respondent category				Gender of HH head		Total (%)
		SNP (%)	SSB (%)	Refugee/ IDP (%)		Male (%)	Female (%)	
Before COVID-19 outbreak	Two or less	3.3	9.1	0.0	9	4	6.9	3.3
	Three	96.7	89.8	100.0	91	95	92.3	96.7
	Four	0.0	1.1	0.0	0	2	0.8	0.0
After COVID-19 outbreak/currently	Two or less	36.7	45.5	25.0	46	36	41.5	36.7
	Three	63.3	53.4	75.0	54	63	57.7	63.3
	Four	0.0	1.1	0.0	0	2	0.8	0.0
Difficulty accessing food after COVID-19	Yes	100.0	86.4	100.0	86	96	90.8	100.0
	No	0.0	13.6	0.0	14	4	9.2	0.0
Incidence of food shortage after COVID-19	Yes	83.3	51.1	8.3	55	54	54.6	83.3
	No	16.7	48.9	91.7	45	46	45.4	16.7
Reduction in number of meals per day after COVID-19	Yes	43.3	29.5	16.7	28	36	31.5	43.3
	No	56.7	70.5	83.3	72	64	68.5	56.7

Table 15: Income and employment among the IDPs, refugees, and returnees in selected 10 cities, Ethiopia, July 2020

		Respondent category			Gender of HH head		Total (%)
		Refugee (%)	IDP (%)	Returnee (%)	Male (%)	Female (%)	
Reduced work hours or amount of work since COVID-19	Yes	70.0	39.8	90.9	39.2	67.3	51.2
	No	30.0	60.2	9.1	60.8	32.7	48.8
Current ability to earn income is similar to ability before COVID-19	Yes	80.0	47.7	81.8	48.6	70.9	58.1
	No	20.0	52.3	18.2	51.4	29.1	41.9
Risk of eviction from their homes due to loss of income	Yes	63.3	37.5	45.5	35.1	56.4	44.2
	No	36.7	62.5	54.5	64.9	43.6	55.8

Table 16: Availability of platform or mechanism for students to learn from home among the IDPs, refugees, and returnees in selected 10 cities, Ethiopia, July 2020

		Respondent category			Total (%)
		Refugee (%)	IDP (%)	Returnee (%)	
Households with children of primary or secondary school age	Yes	53.3	50	45.5	50.4
	No	46.7	50	54.5	49.6
Number of school-aged children	One	18.8	29.5	20	26.2
	Two	37.5	34.1	80	38.5
	Three	31.3	18.2	0	20
	Four and above	12.5	18.2	0	15.4

Platform or mechanism for students to learn from home	Available	100	84.1	0	81.5
	Not available	0	15.9	100	18.5

Table 17: Access to and utilisation of health services among the IDPs, refugees, and returnees in selected 10 cities, Ethiopia, July 2020

Variables/characteristics		Refugees (%)	IDPs (%)	Returnees (%)	Total (%)
Proportion of households whose member needed any medical treatment since the COVID-19/Coronavirus outbreak	Yes	13	22	9	18.6
	No	87	78	91	81.4
Type of illness or healthcare service sought	Family planning	0	10.5	0	8.3
	Malaria/Dengue	25.0	5.3	100	12.5
	Maternal health (ANC, PNC)	0	21.1	0	16.7
	Common childhood illnesses	50	31.6	100	37.5
	Child immunisation	0	5.3	0	4.2
	Malnourished children/nutritional services	0	5.3	0	4.2
	Other non-communicable diseases	25	31.6	100	33.3
	Other (accident, mental health, gastitus, etc.)	0	5.3	100	8.3
Access to health services by household member who sought health services	Yes	75.0	68.4	100	70.8
	No	25.0	31.6	0	29.2
	Yes	13.3	5.7	27.3	9.3

Household member or respondent skipped a routine health service appointment due to COVID-19 outbreak	No	86.7	94.3	72.7	90.7
Perceived possibility of seeking healthcare if needed	I will not go/never	3.3	0	0	0.8
	I might go but less likely	13.3	11	0	10.9
	I will definitely go	80.0	89	100	87.6
	Can't tell/don't know	3.3	0	0	0.8
Have you or any member of your household skipped a routine appointment?	Yes	7.2	5.2	9	7.1
	No	92.8	94.8	91	92.9
Pregnant women were able to see a health provider (ANC) since COVID-19	Yes	100.0	66.7	100	76.9
	No	0.0	33.3	0	23.1
Lactating women were able to see a health provider (PNC) since COVID-19	Yes	88.9	88.2	100	90.0
	No	11.1	11.8	0	10.0

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

Knowledge and behaviour relating to COVID-19

All participants in the returnees, refugees, and IDPs groups reported that they had heard about COVID-19 signs and symptoms, transmission, and prevention methods from different sources. The media, government organisations, and NGOs were mentioned as common sources of COVID-19-related information among the three groups.

Effect of COVID-19 on access to food

IDPs, refugees, and returnees are among the most vulnerable groups during the pandemic. In the qualitative study, all groups of participants repeatedly referred to an increase in the cost of food items.

Unlike other groups of participants (UPSNP, SSB, and special group), IDPs and refugees reported food items like pasta and macaroni to be their main staple food. Due to fear of long-term lockdown, the demand for and cost of such types of food items, which can be stored for a long period of time, have increased. As a result, there was a shortage of food in the market and people were forced to buy what was on the market regardless of their product preferences.

> *There is not an adequate supply in the market at this time; its availability is not as before.…**previously, few people were buying pasta and macaroni but now I think people have developed frustration due to COVID-19 and have started buying and storing such supplies as a reserve**. There is also the issue of this market price inflation, in addition to this supply scarcity. For example, previously you buy after selecting a better product among the other available options, but at this time you don't have options or preferences. You are just expected to buy what is available*. (26-year-old female, IDP, Addis Ababa)

Coping mechanisms

Participants in all groups (IDPs, refugees, special group, SSB, and UPSNP) reported similar coping mechanisms, such as reducing the quality and quantity of food they consume. Replacing common food items with other perceived low-quality or less-preferred foods, reducing food consumption, and compromising on essential needs were repeatedly mentioned strategies.

> *I cannot afford some food items and I have had to cut back on food and eat twice daily. In our family older people are more likely to have to cut back on foods than children.* (28-year-old male, IDP, Gambela)

> *….. we are not getting food support like before so we have changed our eating habits. Before this pandemic, we used to eat three times a day but now we eat only once a day.* (30-year-old male, refugee, Logia)

Effect on income

Respondents mentioned lack of a job and an increase in the cost of materials as the major reasons for economic problems. One refugee described the problems related to the lack of a job as follows:

> *Before the corona pandemic I did many works, like carrying different things [i.e. porter] and butchering cattle for weeding ceremonies. Now everything is changed. For example, there is no weeding and daily work because everybody is staying at home so we could not get job as we did before. Now we are living by UNHCR support only.* (30-year-old male, refugee, Logia)

Unlike returnees and refugees, IDPs reported that being displaced from their living environment and home made life more challenging, in addition to economic problems:

> *The COVID-19 pandemic changed a lot of things. The price of materials has inflated and many people have also lost their jobs so many people are in stress. Previously, we were working as daily labourers but now it is very difficult to find a job. I am worried. We also lost our property and were evicted from our home. We are thinking over and over about our fate. How could we continue in such a way?* (40-year-old male, IDP, Dire Dawa)

Effect on expenditure

Unlike returnees, IDPs and refugees mentioned increased expenditure after the COVID-19 pandemic due to increased cost of items, transport, and payment for rented houses.

> *We are living in a private rental home but we don't have fear of being evicted. The payment, however, increased by ETB 100. Now we are paying 800.* (22-year-old female, refugee, Logia)

Effect on healthcare visits

Health-seeking behaviour has decreased due to the COVID-19 pandemic among refugees and IDPs. In our qualitative interviews, respondents explained that caregivers' treatment-seeking behaviour for sick children under five had been affected. Lack of money and fear of being infected with coronavirus were the major reasons for not seeking healthcare for sick children under five. The respondents expressed fear that they would be kept in a quarantine centre if they brought their children who had a cough and/or fever to a health facility, which are among the major symptoms of COVID-19. Thus, they tried to treat their sick children at home instead of taking them to a health facility. The cost of transportation, which doubled following the movement restrictions, was also reported to have affected the community's health-seeking behaviour.

> *The only problem is that if you have symptoms that are similar to the symptoms of coronavirus, like a fever or cough, they will admit you to a quarantine centre. So we*

> *fear going to a health centre even if our children have a fever. We are not bringing them to a health facility because of this fear. We treat them with cold compress to reduce the fever at home. Generally, we have fear of this disease because there are many people at health centres.* (30-year-old male, refugee, Logia)

> *The transportation tariff has doubled. It is not allowed for two people to use one Bajaj. The person who is ill and the attendant should travel by two different Bajaj when going to a health facility. That adds another expense. This contributes a little to the rise in cost of accessing healthcare, but I have not felt any change in the cost of medicine or healthcare.* (30-year-old male, IDP, Jigjiga)

The respondents were happy that healthcare providers were taking all measures they could, including using PPE to protect themselves and their clients from being infected with the coronavirus. However, the respondents had a feeling that some patients cannot access a close follow-up when needed.

> *I had a follow-up at Ayder hospital. I went there for an appointment and wore a facemask and gloves. I had a health problem related to my bones and joints, and I went to the orthopaedic department. The physician also wore preventative mechanisms. They told me to have physiotherapy but as this health service requires physical contact, I was told to stay home and do some recommended exercises. I am not getting adequate support because of the pandemic.* (Health professional, Bahir Dar)

Effect on education

The refugees, IDPs, and returnees also mentioned a lack of access to mechanisms or platforms to help their children learn from home, as well as the effect of school closures. An IDP from Adama explained the burden of school closures as follows:

> *Children could not go to school. That is a problem. When they stay at home, it is really hard. They ask you for several things, which you cannot afford. It is a relief for the family when they spend the day there in their schools.* (30-year-old male, IDP, Adama)

Effect on mental health

Stress and fear of getting infected, loss of loved ones, and inflated cost of basic necessities were reported among returnees, refugees, and IDPs. Refugees, however, reported more feelings of stress due to the lack of jobs and the fact that their life had become fully dependent on donors during the COVID-19 pandemic. On the other hand, IDPs were more stressed because of being displaced from their previous environment and home and living in a rented house, in addition to other problems.

Social support

Unlike returnees, IDPs and refugees reported that they received some social support during religious holidays and other events from religious institutions, NGOs, and government. However, they reported that social support among the community was reduced because of the reduction in social life due to fear of COVID-19.