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

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About the BRE programme

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

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Abbreviations

ANC	Antenatal care
BRE	Building Resilience in Ethiopia
CSO	Civil society organisation
ETB	Ethiopian Birr
FCDO	UK Foreign, Commonwealth and Development Office
IDP	Internally displaced person
IOM	International Organization for Migration
NGO	Non-governmental organisation
OPM	Oxford Policy Management
PHQ	Patient Health Questionnaire
PNC	Postnatal care
SSB	Small-scale business
UNHCR	United Nations High Commissioner for Refugees
UPSNP	Urban Productive Safety Net Project
WASH	Water, sanitation and hygiene

Introduction

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

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

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

These results are mostly in line with a study conducted by the World Bank Group that highlighted concerns about the impact of COVID-19 on the livelihoods of a representative

[1] The first round of the phone interviews was carried out between 22 June and 22 July 2020; the second round was carried out between 23 August and 13 September 2020; and the third round was carried out between 28 October and 13 November 2020. In the first round we also interviewed local government officials, non-governmental organisations (NGOs)/civil society organisations (CSOs), and healthcare professions. However, we only interview these groups every two rounds (Round 3 also included interviews with these groups and in this round we interviewed the healthcare professionals; the NGOs/CSOs will be interviewed in Round 6)). The main focus of our study is on the dynamics of the impact of COVID-19 and government measures on households and day labourers. The key informant interviews with local government officials, NGOs/CSOs, and healthcare professions help provide the context for our study, although they are not the main focus.

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

[2] http://documents1.worldbank.org/curated/en/678511608616662907/pdf/Monitoring-COVID-19-Impacts-on-Households-in-Ethiopia-Results-from-Six-Rounds-of-High-Frequency-Household-Phone-Surveys.pdf; https://www.worldbank.org/en/topic/poverty/brief/high-frequency-monitoring-surveys; and https://www.worldbank.org/en/data/interactive/2020/11/11/covid-19-high-frequency-monitoring-dashboard

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

Methodology – Round 5 (August 2021)

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

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

Cities covered

The current round of the study was conducted from **15 July to 15 August 2021** in nine cities/towns located in different regions of Ethiopia. The cities included in this round were Addis Ababa, Dire Dawa, Adama, Gambela, Bahir Dar, Jigjiga, Bule Hora, Logia, and Semera. This selection of cities was intended to include different regional states, geographic locations, and sizes, and to capture the impact of the different measures taken by the regions. Additionally, differences in the local economies, level of access to basic services, and the effects of internal displacement were also considered during the selection of the cities. Initially, 10 cities were selected, but due to the internet blackout and the conflict between the Tigray People's Liberation Front and the Ethiopian Federal Government we excluded Mekelle in Round 4 and 5.

Quantitative interview sample

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

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

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

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

- SSB households are those engaged in a small local business to support their livelihood. The SSB households were included because of the possibility that their business or income would be significantly affected by the pandemic, given that economic activities have been greatly impacted due to movement restrictions/lockdown.
- Households in the IDP/refugee category are among the most vulnerable groups and are being highly affected by COVID-19[5] as their socioeconomic status and livelihoods are already compromised due to displacement from their original location. The term 'refugee' refers to individuals who 'have fled war, violence, conflict or persecution and have crossed an international border to find safety in another country' and who are under international protection.[6] The sample for this study is restricted to refugees who are living outside of camps in rented accommodation in the cities, primarily in Logia, Semera, and Gambela. According to the *United Nations Guiding Principles on Internal Displacement*, IDPs are 'persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalised violence, violations of human rights or natural or human-made disasters, and who have not crossed an internally recognised state border'.[7] By contrast, there is no universally accepted definition of return migration. Return is 'in a general sense, the act or process of going back or being taken back to the point of departure. This could be within the territorial boundaries of a country, as in the case of returning IDPs and demobilised combatants; or between a country of destination or transit and a country of origin, as in the case of migrant workers, refugees, or asylum seekers'.[8] Our respondents self-identified as one of these three categories (IDP, refugee, or returnee) based on the definitions outlined above.

The quantitative household interviews were conducted among the same participants who were involved in the previous four rounds of data collection. Before the first round, a simple random sampling method was used to select household survey participants within each of the three categories. Independent sampling frames were used for each group in each city. Lists of UPSNP beneficiaries were obtained from city-level UPSNP coordination offices; lists of SSBs were obtained from small-scale and micro enterprise offices; and lists of IDPs and refugees were obtained from local government authorities (social affairs, city administrations, and the Administration for Refugee and Returnee Affairs). 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

[5] www.internal-displacement.org/crises/coronavirus
[6] www.unhcr.org/uk/what-is-a-refugee.html
[7] https://emergency.unhcr.org/entry/44826/idp-definition This, however, is a descriptive definition, which does not confer a special legal status because IDPs, being inside their country, remain entitled to the same rights and guarantees as other citizens and habitual residents of their country. As such, national authorities have the primary responsibility for preventing forced displacement and for protecting IDPs (UNHCR).
[8] *IOM Glossary on Migration*, 2019. There are two main types of return migration according to *the IOM Glossary on Migration*: (i) voluntary return, which is 'the assisted or independent return to the country of origin, transit or another country based on the voluntary decision of the returnee'; and (ii) forced return, which is 'a migratory movement which, although the drivers can be diverse, involves force, compulsion, or coercion'. https://publications.iom.int/system/files/pdf/iml_34_glossary.pdf

and their telephone numbers, as obtained from the above-mentioned authorities and offices, was used to randomly select the allocated sample for each stratum.

Of the sample of 436 households included in the quantitative survey (Round 1), we were able to interview **309 participants during this round** (336 in Round 4), **a response rate of 71%.** Of these, 108 were UPSNP beneficiaries (113 in Round 4), 108 were SSB owners (120 in Round 4), and 93 were IDPs/refugees/returnees (103 in Round 4).[9] We faced multiple challenges during the data collection period in this round. In Round 5, a total of 27 participants were lost as compared to the previous round, due to being unreachable using the phone numbers we had obtained, and call refusals. The team spent several days trying to reach out to these participants through field coordinators, who tried to trace these respondents and to find alternative phone numbers. The average length of the quantitative household survey interviews was 33 minutes. Given the telecom service outage following the conflict between the Tigray People's Liberation Front and the Federal Government of Ethiopia, and the subsequent potential psychosocial impact, we excluded 25 participants (excluded in Rounds 4 and 5) from Mekelle. Given that we have lost 127 participants in this round compared to Round 1, the results need to be interpreted with caution as there may be systematic bias due to particular types of respondents having dropped out.

Qualitative interview sample

A total of 29 qualitative interviews were conducted in this round: 24 diary interviews and five key informant interviews with health workers. The diary interviews were conducted with a separate set of respondents who were purposively selected from among the Round 1 participants. The total of 24 diary interview respondents (an average of around three respondents per city) were from four categories: UPSNP beneficiaries (3); SSB owner respondents (4); IDPs/refugees/returnees (10); and participants from the 'special population group' (i.e. daily labourers, shoeshines, waiters, and porters) (7). The number of diary interview respondents for Round 5 was less than in the previous four rounds (57, 50, 35, and 30 respondents in Round 1, Round 2, Round 3, and Round 4, respectively). The major reasons for dropout were: some of the respondents had changed their phone numbers, some refused to take the calls, and some of them were inaccessible as their phone was switched off or out of service (mainly because of network and electric power issues). In addition, we were not able to reach out to any of the respondents from Mekelle in Rounds 4 and 5, due to the network shutdown there.

In this round, we conducted an additional nine key informant interviews with health workers (i.e. one per city) to explore the effect of COVID 19 on health service utilisation and service provision. However, we were only able to interview five health workers, one each from Addis Ababa, Adama, Bahir Dar, Jigjiga, and Logia. We could not include health workers from the other cities because of dropout (i.e. data collectors were unable to reach them, or because they refused to participate).

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

Interview approach

All interviews were conducted using a two-step approach: the city coordinator (who is a part of the research team from MERQ) made an introductory call to introduce the study, obtain consent, and schedule interviews with potential participants; and then the actual interviews were conducted by the data collectors. The average duration of the qualitative interviews was 36 minutes. The number of call attempts made ranged from one to 16, in order to reach each respondent for the actual interview. Daily debriefings were conducted between the study team and the field-based data collectors.

Field observation by data collectors

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

Data analysis

Quantitative data were analysed using Stata Version 14. Descriptive statistical methods, including frequency tables and proportions (percentages), were used to analyse the quantitative data. We used tables and graphs to present the results. Chi-square and paired t-tests were used to test statistical differences in selected variables between the UPSNP beneficiaries, SSB, and IDP/refugee groups, and McNemar chi-square and paired t-tests were used to test statistical differences in selected variables between the rounds (Round 5 versus Round 4 or Round 3 or Round 2 or Round 1).

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

Limitations of the study

This study has some limitations that should be considered. First, the study was unable to explore other factors that may have influenced the respondents' answers to the survey questions that were not observable or relevant to COVID-19. Since the interviews were conducted over the phone, we were not able to connect and establish as much of a rapport as we could have done with face-to-face interviews. The duration of the calls was also short and network disruption was also an issue. Secondly, the data presented, including on compliance with COVID-19 response measures, the level of malnutrition, and the

psychological impacts of COVID-19, are based on respondents' self-reports, which may be affected by social desirability bias. We carefully designed the data collection tools in order to take social desirability bias and other confounding factors into account. For example, the data collectors were not allowed to read the options out to the respondents (i.e. spontaneous responses to questions were captured, rather than respondents choosing from a fixed set of options). For questions around the knowledge and practising of preventive methods against COVID-19, we also asked respondents about what 'others' (family members and friends) do, in addition to their own behaviour: we found significant differences between own (self-reported) behaviour and the behaviour of others as reported by the respondents. Finally, the attrition rate is a problem in this round, as mentioned above, which could bias our results in a systematic way, depending on who has been dropped from the sample. We explore this further in the 'Summary of household characteristics' section below.

Context and field observation findings during Round 5

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

As at 16 July 2021[10] a total of 3,120,043 COVID-19 laboratory tests had been conducted since the start of the pandemic, there were 19,882 active cases, there had been 289,962 total cases, 265,589 people had recovered, there had been 4,489 total deaths, and 2,314,394 people were vaccinated against COVID-19. There was a significant increase in the level of COVID-19 infection during this round, compared to Round 4. In Round 4 (as at 7 May 2021), the number of people infected with COVID-19 reached 261,580, of whom 206,870 had recovered and 3,840 had died.[11] A total of 1,287,801 people in the priority group had been vaccinated. In the previous rounds, COVID 19 vaccination was being given to health workers, people over 65, and those with comorbidities, and vaccination rates were higher in Addis than in other cities. However, in this round, there has been an improvement in vaccination coverage as people over 35 years old are also included in the priority group to receive the vaccine.

Following the lifting of the state of emergency, the Government of Ethiopia issued a detailed COVID-19 pandemic prevention guideline on 6 October 2020, which is still being enforced. This guideline covers a wide range of issues, including the requirements for foreign travellers entering the country. The guideline sets out the following measures:

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

Given the rate of the spread of COVID-19 and declining practices relating to, and compliance with, the preventive measures, on 28 March 2021 the Federal Ministry of Health and the Ethiopia Federal Attorney General Office announced the legal framework for, and enforcement of, the COVID-19 prevention guideline and control directive (Directive-30/2020).[12]

[10] www.africanews.com/2021/08/16/coronavirus-ethiopia-covid-19-reported-cases-16-august-2021//
[11] https://reliefweb.int/report/ethiopia/unhcr-ethiopia-covid-19-and-operational-update-8-may-2021
[12] Federal Ministry of Health (2020) 'A directive issued for the prevention and control of COVID-19 pandemic', Directive No. 30/2020. Coming into effect on 5 October 2020, Directive No. 30/2020 lays down a set of new requirements for those international travellers that wish to enter the country through its international airports. Beyond requiring travellers to provide a negative RTPCR test conducted up to five days before arrival, the

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

- Except for Addis Ababa, data collectors observed that most drivers and their assistants providing public transport services were not wearing a facemask. In addition, most passengers using public transport were also observed to be not wearing facemasks.
- The data collectors reported their observation that law enforcement regarding COVID-19 measures has become weak and that people are not complying with the government restrictions, and are not held accountable for this. According to the observational findings, a lack of compliance with the restriction measures – including using a facemask and social distancing – was prevalent in all of the study cities, although with slight differences in the degree of compliance with wearing a facemask (for instance, people living in Addis Ababa and Adama were more likely to use a facemask than those in other cities).
- There was mixed compliance with the government's directive that everyone visiting churches and mosques should wear a facemask. It was observed that some people did not wear a facemask when going into churches and mosques, but the compliance appeared to be better in Addis Ababa.
- On the other hand, compliance with physical distancing was found to be poor in all of the cities. Moreover, the data collectors also observed that most people had started shaking hands again in all of the cities.

Like in the previous round, there was found to be poor implementation of COVID-19 prevention measures. In most service-providing institutions, including bars and restaurants, waitresses were not wearing a facemask when serving customers. Similar to our observations during the previous rounds, the inappropriate use of facemasks (not covering the nose) was also found to be common in all of the study cities. Enforcement of the COVID-19 direction released in October was found to be weak in most of the cities. As in Rounds 3 and 4, it was also common to see public gatherings without proper protections (i.e. wearing a facemask and maintaining physical distancing) at marketplaces, religious places, cafés, restaurants, etc. In this round, most of the banks and some government offices (like Ethio Telecom) were found to be no longer forcing their customers to wear masks and to use hand sanitiser before entering their institutions/offices.

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

Summary of household characteristics

The quantitative phone survey included 309 households: 108 UPSNP beneficiaries, 108 SSB owners, and 93 refugees and IDPs – 27 fewer respondents than in Round 4, due to dropout (i.e. due to network problems, refusal to participate, phone being switched off, or unavailability). Female respondents accounted for 48.9% of respondents. The average age of respondents was 35, with a range between 20 and 65. The average family size was 5.5 (standard deviation (SD): 2.8). Among the households in our sample, 50% of them had at least one child under five (see Table 1).

Out the total of 436 participants enrolled in the beginning of the study (Round 1), 127 (29.2%) dropped out before or in Round 5. The dropout rate among quantitative survey participants was highest among respondents from Mekelle (100%), Gambela (70.9%), Addis Ababa (35.1%), and Bule Hora (37.7%). On the other hand, relatively low dropout rates were recorded in Jigjiga (4.2%), Dire Dawa (5.0%), Semera (8.7%), and Logia (9.2%) (Table 2). The proportion of dropouts was comparable across the three categories: 29% (45 out of 153 participants in Round 1) of UPSNP beneficiaries, 29% (45 out of 153 participants in Round 1) of SSB owners, and 28% (37 out of 130 participants in Round 1) of IDPs/refugees discontinued before or in Round 5.

For the qualitative study, 24 diary interviews (compared to 30 in Round 4) were conducted with three UPSNP beneficiaries, four SSB owner respondents, 10 IDPs/refugees/returnees, and seven participants from the 'special population group' (i.e. day labourers, shoeshines, waiters, porters). In addition, five key informant interviews were conducted with health professionals (i.e. those providing diagnosis and treatment to patients/clients at health facilities) working in health centres or hospitals located in Addis Ababa, Adama, Bahir Dar, Jigjiga, and Logia.

Table 1: Characteristics of quantitative household survey respondents, urban poor in selected nine cities in Ethiopia, August 2021 (total n = 309, UPSNP = 108, SSB = 108, IDPs/refugees = 93)

Study sites/cities (n = 336)	UPSNP		SSB		IDP/ refugee		Total	
	N	%	N	%	N	%	N	%
Gender of the respondent								
Male	31	28.7%	75	69.4%	52	55.9%	158	51.1%
Female	77	71.3%	33	30.6%	41	44.1%	151	48.9%
Family size								
Less than three	11	10.2%	8	7.4%	6	6.5%	25	8.1%
Three to five	48	44.4%	59	54.6%	44	47.3%	151	48.9%
Above five	49	45.4%	41	38.0%	43	46.2%	133	43.0%
Number of children under five								

None	60	55.6%	51	47.2%	45	48.4%	156	50.5%
One	26	24.1%	36	33.3%	28	30.1%	90	29.1%
Two	15	13.9%	18	16.7%	16	17.2%	49	15.9%
Three or more	7	6.5%	3	2.8%	4	4.3%	14	4.5%
City								
Addis Ababa	11	10.2%	8	7.4%	11	11.8%	30	9.7%
Adama	13	12.0%	13	12.0%	14	15.1%	40	12.9%
Bule Hora	16	14.8%	12	11.1%	0	0.0%	28	9.1%
Dire Dawa	14	13.0%	16	14.8%	11	11.8%	41	13.3%
Jigjiga	14	13.0%	14	13.0%	15	16.1%	43	13.9%
Semera	15	13.9%	15	13.9%	11	11.8%	41	13.3%
Logia	12	11.1%	15	13.9%	13	14.0%	40	12.9%
Bahr Dar	9	8.3%	12	11.1%	16	17.2%	37	12.0%
Gambela	4	3.7%	3	2.8%	2	2.2%	9	2.9%
Total	**108**	**35%**	**108**	**35%**	**93**	**30%**	**309**	**100%**

Table 2: Dropout rate of quantitative household survey respondents, urban poor in selected nine cities in Ethiopia, August 2021

City	Total number of respondents in Round 1	Total number of respondents in Round 5	Dropout in number	Dropout in %
Addis Ababa	46	30	16	35.1%
Adama	46	40	6	13.4%
Bule Hora	45	28	17	37.7%
Dire Dawa	43	41	2	5.0%
Jigjiga	45	43	2	4.2%
Semera	45	41	4	8.7%
Logia	44	40	4	9.2%
Bahir Dar	46	37	9	19.9%
Mekelle	45	0	45	100.0%
Gambela	31	9	22	70.9%
Total	**436**	**309**	**127**	**29.2%**

Highlights of the results – Round 5

- Overall, **the self-reported practising of, and compliance with, the COVID-19 preventive measures was limited** and had significantly decreased compared to the previous rounds. According to the qualitative findings, perceived low prevalence of COVID-19 and the perceived low susceptibility to the disease seem to have contributed to a decline in the practising of preventive measures
- The majority of respondents (93.2%) said that they would accept the vaccine for themselves. However, the findings from qualitative interviews with health workers and diary interview participants indicated that there was a concern that the vaccine could cause some side effects.
- **Shortages of water and limited accessibility remained a major problem** for the urban households; however, there has been slight improvement in this round. The proportion of households that reported water shortages has also decreased from 49% in Round 4 to 39% in Round 5. The use of rainwater as an alternative source was widely mentioned as a coping mechanism to overcome the inadequate municipal water supply.
- **The average monthly income of households has increased across the five rounds**, from Ethiopian Birr (ETB) 2,016 in Round 1 to ETB 3,045 in this round. However, there is variation among the three respondent categories, with the SSB group having the highest average monthly income (ETB 4,838), followed by the IDPs/refugees (ETB 2,269), with the lowest income for the UPSNP group (ETB 2,039). Despite the increase in incomes that has taken place, most of the qualitative study participants mentioned the inadequacy of their income to cover their basic expenses, mainly because of **the increase in the price of food,** which has resulted in a **decline in the purchasing power and increased cost of living.**
- **The incidence of food shortages remained unchanged during Round 5** (45%). About 13.6% (42 households) that had no shortage of food in Round 4 reported food shortage in this round. On the other hand, 14.2% (44 households) who had shortage of food in the previous round didn't face shortage in Round 5. The proportion of households that reported food shortage was higher among respondents fromin Semera, Jigjiga, and Bule Hora, and Gambella compared to other cities.
- Similarly to the previous rounds, **eating less preferred foods and reducing the number of meals per day remained the predominant strategies for coping with food insecurity** (unaffordability) during the past month.
- Only 55 respondents (17.8% of the total sample) reported that they had needed medical treatment over the past month, and, of these, only one said that they were not able to access medical treatment when needed.
- In almost all cities, the schools were closed due to the annual break and the students were spending their time helping their parents, staying at home watching TV, and playing with their friends (which would have happened anyway during the school holiday).
- **The proportion of respondents who reported feeling stressed has increased** from 37% in Round 4 to 50% in this round. Similarly, the proportion of respondents with symptoms of probable depression (according to the Patient Health Questionnaire (PHQ)-9 index) has increased, from 16% in Round 4 to 21% in this round. The difference between Round 4 and 5 is statistically significant. The reported reason for feeling depressed was mainly the inflation in the cost of living, rather than COVID-19.
- Finally, **there has been a slight increase in the proportion of households who reported having received aid and support** during this round (from 21% in Round 4 to 24% in this round). The proportion of households that received aid and support is highest for IDP/refugees (46.2%), followed by UPSNP (29.6%), while none of respondents from SSB group reported receiving aid and support during Round 5. The government and NGOs were still reported to be the main sources of support for the urban poor.

Results by theme

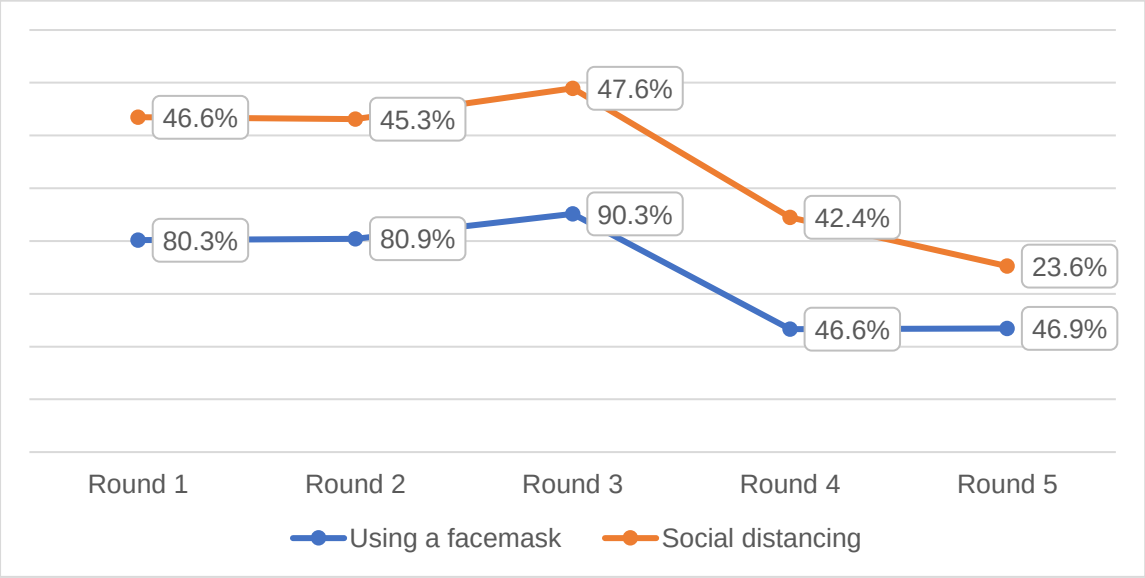
Behaviour relating to COVID-19 prevention

Key findings:

- Most respondents believe that COVID-19 still exists, but a considerable number believe that they are no longer at risk of contracting the disease. The practising of COVID-19 preventive measures has therefore declined significantly in this round, and was also found to vary across the cities. According to the qualitative findings, perceived low prevalence of COVID-19 and the low perceived susceptibility to the disease seem to have contributed to a decline in the practising of preventive measures.
- Most participants agree that it is important, safe, effective, and compatible with their religious beliefs or personal values to get the COVID-19 vaccine if it is offered to them. More than one-tenth (12%) of the participants reported that they have received the vaccine.

Most (81.6%) of the participants believe that COVID-19 still exists. However, 28.5% of the total sample believe that they are no longer at risk of contracting the disease. **Overall, the practising of COVID-19 preventive methods was found to be limited**. In this round, only 19.4%, 23.3%, and 46.9% reported that they were still practising handwashing and/or sanitising, keeping a physical distance, and using facemasks, respectively. These figures are much lower than those in the first three rounds. The use of facemasks has significantly decreased, from 80.3% in Round 1, 80.9% in Round 2, and 90.3% in Round 3, to 46.9% in this round (see Figure 1).

Figure 1: Practising using a facemask and social distancing among the urban poor in selected nine cities in Ethiopia, (n=309), August 2021



We found no statistically significant difference in terms of practising handwashing and/or hand-sanitising (chi-square: 6.043; p-value: 0.049), physical distancing (chi-square: 1.392; p-value: 0.498), and wearing a facemask (chi-square: 0.062; p-value: 0.969) between the UPSNP beneficiaries, SSB group, and refugee/IDP group. Moreover, the differences in the

practising of COVID-19 preventive measures between male and female respondents were not statistically significant.

The respondents also reported low compliance with the preventive measures among family members. Only 39.8, 23.3%, and 1.9% reported that all of their family members complied with handwashing and/or sanitising, wearing a facemask, and physical distancing, respectively. The level of compliance by all family members with the COVID-19 preventive measures, including wearing a facemask and physical distancing, reported in this round was lower compared to the previous rounds. There was no statistically significant difference in the level of family compliance with handwashing and/or sanitising (chi-square: 4.435; p-value: 0.618) and wearing a facemask (chi-square: 6.436; p-value: 0.376) between UPSNP beneficiaries, the SSB group, and the IDP/refugee group (**Error! Reference source not found.**).

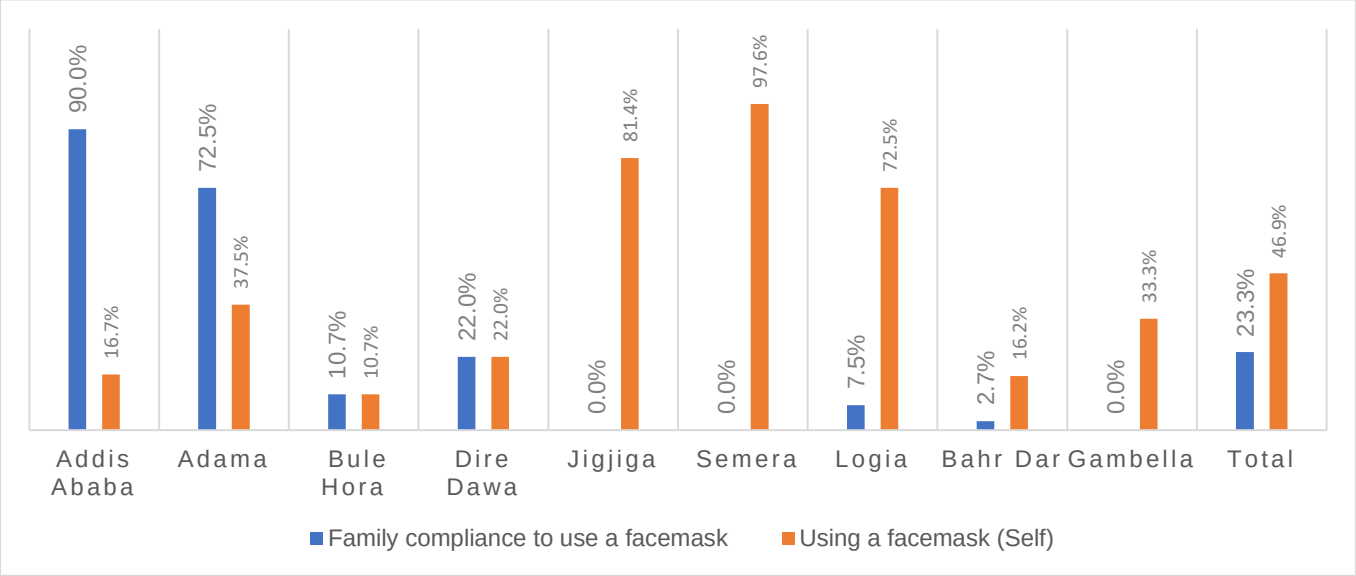
Table 3: Family compliance with government restrictions among the urban poor in selected nine cities in Ethiopia, August 2021 (total n = 309; UPSNP = 108, SSB = 108, IDPs/refugees = 93)

Restrictions	UPSNP (%)	IDPs/refugees (%)	SSB (%)	Round 5 total (%)	Chi-2 [p-value]
Compliance by family members with handwashing/sanitising					
None of them	*1.9*	*1.1*	*2.8*	*1.9*	4.435 [0.618]
Some of them	*47.2*	*49.5*	*47.2*	*47.9*	
All of them	*39.8*	*35.5*	*43.5*	*39.8*	
No longer in place	*11.1*	*14.0*	*6.5*	*10.4*	
Compliance by family members with wearing a facemask					
None of them	*22.2*	*19.4*	*27.8*	*23.3*	6.436, [0.376]
Some of them	*38.9*	*30.1*	*28.7*	*32.7*	
All of them	*19.4*	*24.7*	*25.9*	*23.3*	
No longer in place	*19.4*	*25.8*	*17.6*	*20.7*	
Compliance by family members with social distancing					
None of them	*49.1*	*35.5*	*43.5*	*43.0*	7.002 [0.321]
Some of them	*9.3*	*10.8*	*7.4*	*9.1*	
All of them	*0.9*	*1.1*	*3.7*	*1.9*	
No longer in place	*40.7*	*52.7*	*45.4*	*46.0*	

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

There was a significant difference in the reported level of family compliance with the COVID-prevention methods among family members **between the cities.** In this round, a lower level of compliance with wearing a facemask among family members was reported in all of the cities except Addis Ababa and Adama (Figure 2).

Figure 2: Self-reported use of a facemask and family compliance with using a facemask all the time among family members of the urban poor in selected nine cities in Ethiopia, August 2021 (total n = 309)



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

> *Our social life continue like before. We are together like before in mourning and other social interactions. We visit hospital if someone is ill but no one thinks about COVID-19 preventive measures and we don't fear it.* (SSB respondent, Bahir Dar)

> *In general, no one implements COVID-19 prevention methods. Previously, people used prevention methods, both individually and in groups, but now almost no one practises these prevention methods.* (Refugee, Logia)

According to the qualitative findings, the perceived low prevalence of COVID-19 and the low severity of the disease have contributed to limited practising of the preventive measures, and to a perception that the disease is not real.

> *The spread of the virus is not too much. Additionally, there are not many people infected with COVID-19. As a result, they believe that the virus is prevented or does not exist. People living in this area do not care much about the coronavirus. So, they live a communal life where they eat, drink, and live together.* (Refugee, Logia)

> *I may probably get infected if I get in contact with infected person when I'm not protected. However, I do not believe that I will be seriously ill or die of the disease. I know that this infection does not hurt those who have intact immunity and young people except old and people who have other concomitant diseases.* (IDP, Jigjiga)

As was reported in the previous rounds, some respondents still believe the pandemic to be a curse and a punishment from God:

> *This disease comes from abroad because of the Allah's punishment due to their homosexuality, pornography, and other evil acts. They may bring it to us so, I don't*

> *believe it and I never accept it. That is the result of their sin. I have strongly believed that it could not happen on me and my relatives.* (IDP, Dire Dawa)

In addition, respondents explained how difficult it is to use a facemask when most people are not wearing it.

> *Most people are doing what they want, and don't wear face masks. Even if few people wear masks, most people look at them as if they are doing some odd things and, therefore, you feel something. As a result, you won't even want to do it because you are afraid of doing it when most people are not doing it.* (Refugee. Logia)

Enforcement of the COVID-19 preventive measures was also found to be inconsistent, and to vary between the cities. Respondents explained that the use of a facemask was no longer mandatory to access services like transportation and other government services.

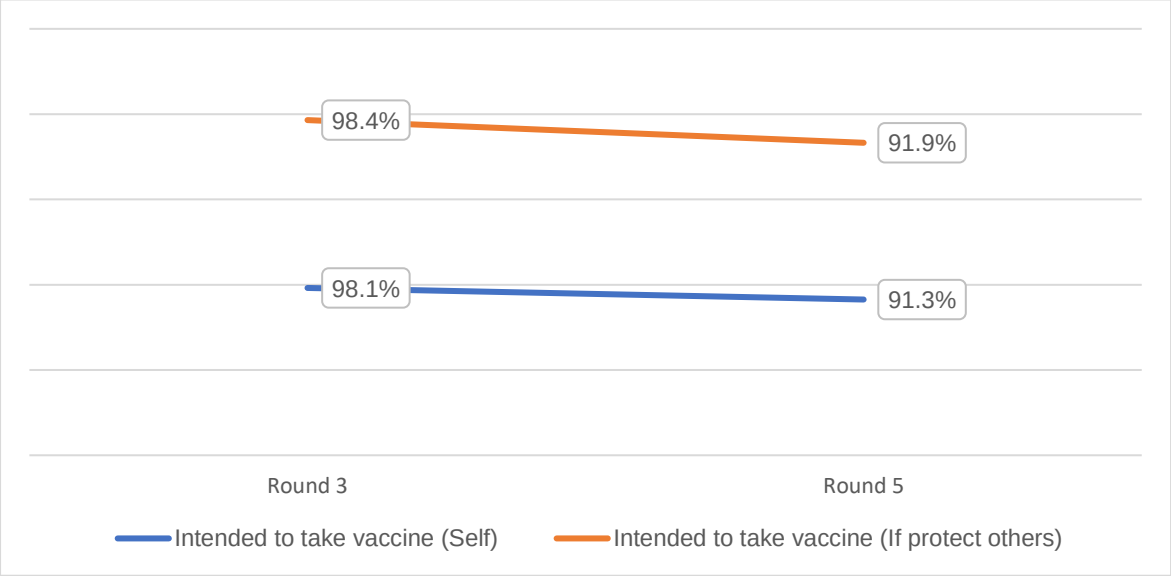
> *In the past, the government used to put a restriction to control the pandemic. People were prevented from gathering. Wearing a facemask was mandatory. Now, none of these are in place. Thus, people don't bother about it, and that they don't practise the prevention measures.* (UPSNP beneficiary, Jigjiga)

> *No one use a facemask in the city and in the taxi. No one forces you to wear the mask at every places. No one wears it.* (Special group respondent, Dire Dawa)

> *In the past, there was a rigid rule that it was impossible to travel with Bajaj without wearing a facemask. Currently, there is none who forces people to use a facemask. Only a few workers who work in banks and health facilities wear a facemask.* (Special group respondent, Dire Dawa)

In this round, we also asked participants about their **acceptance of a vaccine** that it is believed will protect them from COVID-19. **The vast majority (91.3%) said they would accept the vaccine for themselves,** and 91.9% reported that they would accept the vaccine if it would help protect friends, family, and/or at-risk groups. These figures were slightly lower when compared to those in Round 3. In Round 3, 98.1% and 98.4% of the participants reported that **they would accept the vaccine for themselves,** and 91.9% reported that they would accept the vaccine if it would help protect friends, family, and/or at-risk groups, respectively.

Figure 3: Reported willingness to accept COVID-19 vaccine among the urban poor in selected nine cities in Ethiopia, August 2020 (total n = 309, UPSNP = 108, SSB = 108, IDPs/refugees = 93)



Most participants strongly agreed or tended to agree that the vaccine is important, safe, effective, and compatible with their religious or personal values (Table 4). More than one-tenth (12%) of the participants reported that they had received the vaccine.

More than half (54.1%) of participants who reported having received the vaccine were female. We found no statistically significant difference in terms of vaccination status between female and male participants. Moreover, there was no statistically significant difference in regard to vaccination status between the UPSNP beneficiaries, SSB group, and refugee/IDP group.

Table 4: Perceptions regarding COVID-19 vaccine among the urban poor in selected nine cities in Ethiopia, August 2020 (total n = 309, UPSNP = 108, SSB = 108, IDPs/refugees = 93)

Restrictions	UPSNP (%)	IDPs/refugees (%)	SSB (%)	Total (%)	Chi-2 [p-value]
COVID-19 vaccine would be important					
Strongly agree	44.4	45.2	42.6	44.0	15.498 [0. 050]
Tend to agree	44.4	50.5	37.0	43.7	
Tend to disagree	1.9	1.1	7.4	3.6	
Strongly disagree	1.9	1.1	4.6	2.6	
Do not know	7.4	2.2	8.3	6.1	
COVID-19 vaccine would be safe					
Strongly agree	24.1	35.5	25.9	28.2	13.718 [0.089]
Tend to agree	54.6	53.8	45.4	51.1	
Tend to disagree	4.6	4.3	7.4	5.5	

Strongly disagree	2.8	1.1	6.5	3.6	
Do not know	13.9	5.4	14.8	11.7	
COVID-19 vaccine would be effective					
Strongly agree	34.3	29.0	26.9	30.1	15.628 **[0.048]**
Tend to agree	44.4	57.0	42.6	47.6	
Tend to disagree	3.7	5.4	8.3	5.8	
Strongly disagree	1.9	1.1	7.4	3.6	
Do not know	15.7	7.5	14.8	12.9	
COVID-19 vaccine would be compatible with my religious or personal belief					
Strongly agree	32.4	39.8	39.8	37.2	14.969 [0.060]
Tend to agree	41.7	39.8	25.9	35.6	
Tend to disagree	7.4	8.6	18.5	11.7	
Strongly disagree	2.8	2.2	4.6	3.2	
Do not know	15.7	9.7	11.1	12.3	

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

Some health workers explained that fear of vaccine-related side-effects is common and that they wanted to wait until other people had been vaccinated first. Fear of vaccine-related side-effects was also reported to be common in the community.

> *The COVID-19 vaccine is said to cause a variety of health problems, so most of the community including me are afraid to get vaccinated.* (Refugee, Logia)

> *I would not get vaccinated even if I get the access, because I'm afraid. As I heard from the world media, it has side-effects that may either be seen in a short time or the long run. I think that there is something unclear about the vaccine. There is also a rumour that the vaccine is a side effect of blood clotting. There is a rumour that the government officials are being injected placebo not the real vaccine as they think that vaccine is not safe.* (IDP, Jigjiga)

A respondent from Bahir Dar reported the rumour that the vaccine could even cause death among people who get vaccinated, which the respondent believed had contributed to the lack of acceptance of the vaccine among the community.

> *There was one doctor in Bahir Dar and this doctor received the vaccine then he died, people are dying after they receive the vaccine, because of this I don't think people love this vaccine. It is not accepted by the community, after the doctor died because of the vaccine no one is interested. Two in three individuals died because of this. I don't think people accept the vaccine.* (Returnee, Bahir Dar)

A few respondents explained that they would not receive the vaccine as they believed that they were not at risk of contracting the virus.

> *I always use all the precautions; I don't fear that I might get COVID-19. So, I don't need to receive it.* (Special group respondent, Dire Dawa)

Overall, COVID-19 is believed to still exist, but a considerable number of participants believe that they are no longer at risk of contracting the disease. The practising of COVID-19 preventive measures has declined significantly in this round and was also found to vary across the cities. Likewise, the qualitative findings indicate limited practising of preventive measures. According to the qualitative data, the perceived low prevalence of COVID-19 and the low perceived susceptibility to the disease seem to have contributed to a decline in the practising of preventive measures. Overall, the COVID-19 vaccine seems to be accepted and is believed to be important, safe, effective, and compatible with respondents' religious beliefs or personal values. However, the qualitative findings indicate concerns regarding the side-effects of the vaccine among health workers and the community.

WASH

Key findings:

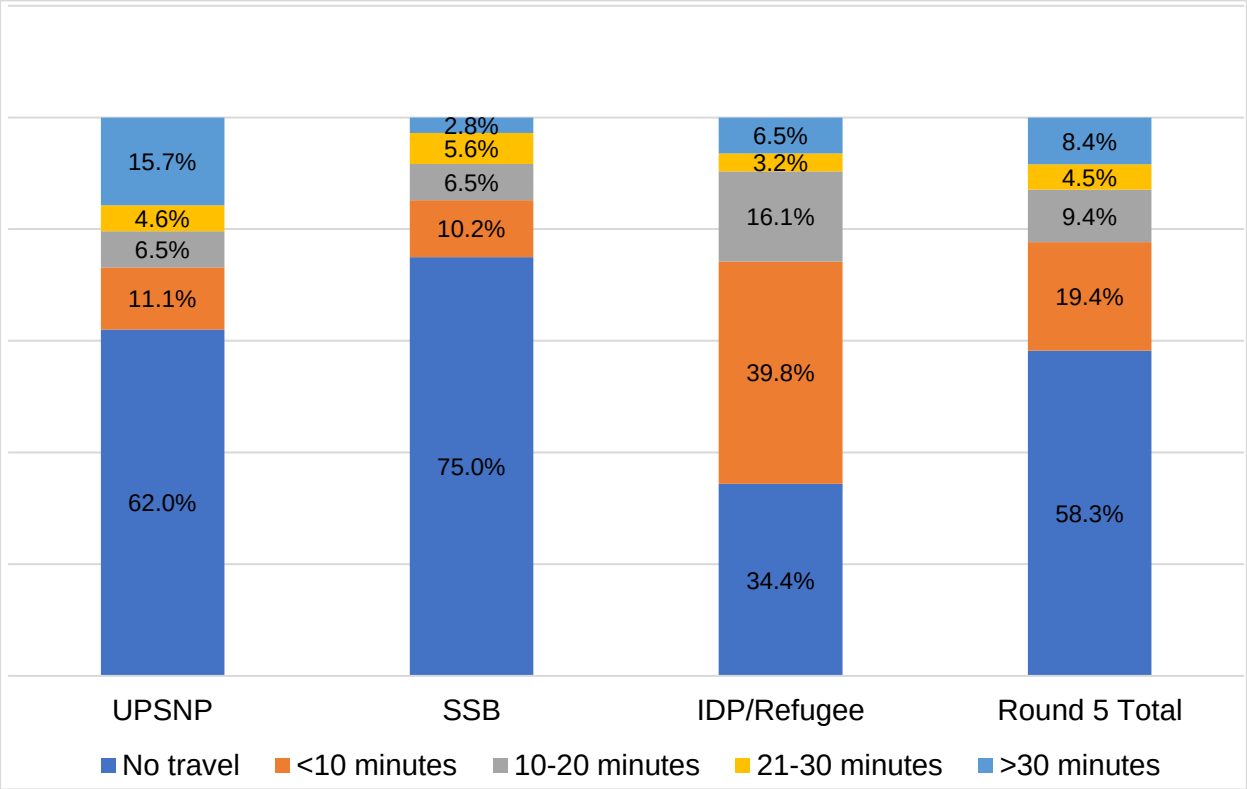
- The proportion of households that reported a shortage of the municipal water supply has fallen from 49% in Round 4 to 39% in this round. Most of the qualitative diary interview respondents also mentioned a shortage of, and interruption to, the municipal water supply. The use of rainwater as an alternative source was widely mentioned as a coping mechanism to overcome the inadequate municipal water supply.
- More than 80% of survey respondents who reported experiencing a water shortage mentioned the inadequacy of the water supply as a major reason for the shortage. Similarly, qualitative study participants mentioned the mismatch between the capacity of existing water supply infrastructure and the demand or population size, as well as frequent breakdown of pipelines, as reasons for the shortage of water.
- There was disparity across the respondents from the nine cities in terms of experiencing water shortages and the level of difficulty in accessing water. A higher proportion of respondents from Bahir Dar, Bule Hora, Gambela, and Logia reported a shortage of water in Round 5, compared to respondents from other cities.
- The economic burden associated with purchasing water and transporting it to their homes remains a major challenge for the urban poor.

Most of the respondents (58.3%) had access to the municipal water supply pipeline from near to or inside their residence (i.e. they did not need to travel to get water when the municipal water supply was not interrupted). The Round 5 results show disparities among the three respondent groups. Only 34.4% of respondents from the IDP/refugee group reported accessing a water supply from near to or inside their residence, which is much lower than the SSB group (75.0%) and UPSNP beneficiaries group (62.0%). The difference among the three categories was statistically significant (chi-square value = 61.4, p-value = 0.000) (Figure 4). The SSB and UPSNP households have better access to a municipal water supply/pipe connection at or near their residence. Unlike those two groups, most of the IDPs/refugees live in a camp, where the water distribution points are located in selected spots, which might be far away from them but are still easily accessible (i.e. at less than 30 minutes' walking distance).

Furthermore, there was a significant variation in the reported distance travelled to access a water supply among the three categories, during Round 5. For instance, a notably higher

proportion of respondents from the UPSNP group (15.7%) reported having to travel more than 30 minutes (round trip) to fetch water, compared to the SSB group (2.8%) and IDP/refugee group (6.5%) (Figure 4). Despite poor access to municipal water supply/pipe connections at or near their residence, the proportion of IDPs/refugees that reported travelling more than 30 minutes was lower than that of the UPSNP beneficiaries. This could be due to the availability of water points near to the residence of the IDPs/refugees. According to the *Sphere Handbook*[13] for minimum standards in humanitarian responses, water points/sources should be located less than 500 metres from the residence of IDP and refugee households.

Figure 4: Distance travelled to access a water supply/water point by households in selected nine cities in Ethiopia, August 2021 (total n = 309, UPSNP = 108, SSB = 108, IDPs/refugees = 93)



The average number of days of water shortage in this round was 4.7 days (SD=4.1). This result is lower than that in Round 4, 6.3 days (SD = 8.4); however, the change between Rounds 5 and 4 was not statistically significant.

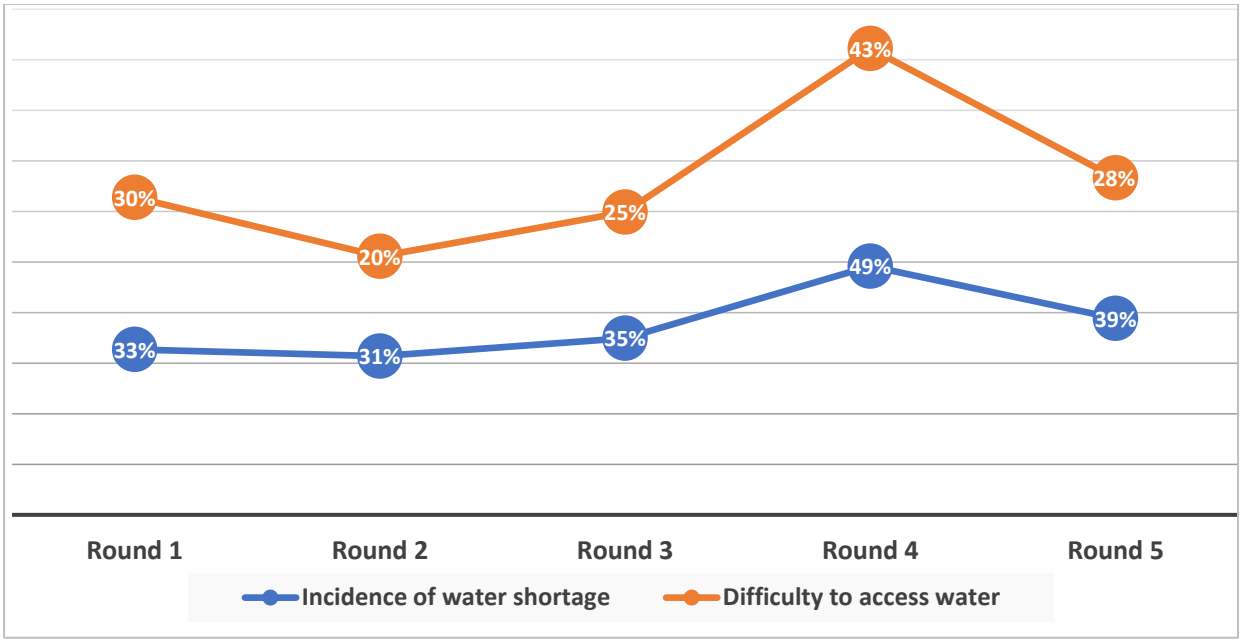
The proportion of households that reported water shortages[14] has also decreased from 49% in Round 4 to 39% in Round 5, but is slightly higher than it was in Round 3 (35%), Round 2 (31.4%), and Round 1 (32.7%). The difference between Rounds 4 and 5 was statistically significant (chi-square value = 19.6, p-value = 0.000). Similarly, the proportion of households

[13] Sphere Association (2018) *The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response*, fourth edition, Geneva, Switzerland, www.spherestandards.org/handbook
[14] Water shortages refers to a lack of water due to interruption to the water supply or unavailability of water at the source.

that reported difficulty accessing water[15] has decreased from 43% in Round 4 to 28% in Round 5, and the change was statistically significant (chi-square value = 7.92, p-value = 0.005) (Figure 5).

The proportion of households that reported water shortages was slightly lower for the IDP/refugee category (35%), compared to the UPSNP (41%) and SSB (40%) categories. However, the difference among the three categories was not statistically significant. Likewise, a higher proportion of UPSNP beneficiaries (34.3%) reported more difficulty in accessing a water supply compared to the IDPs/refugees (21.5%) and the SSB group (26.9%).[16] The difference among the three groups was statistically significant (chi-square value = 12.1, p-value = 0.006).

Figure 5: Incidence of water shortages and difficulty in accessing a water supply among the urban poor in selected nine cities in Ethiopia, August 2021 (total n = 309, UPSNP = 108, SSB = 108, IDPs/refugees = 93)



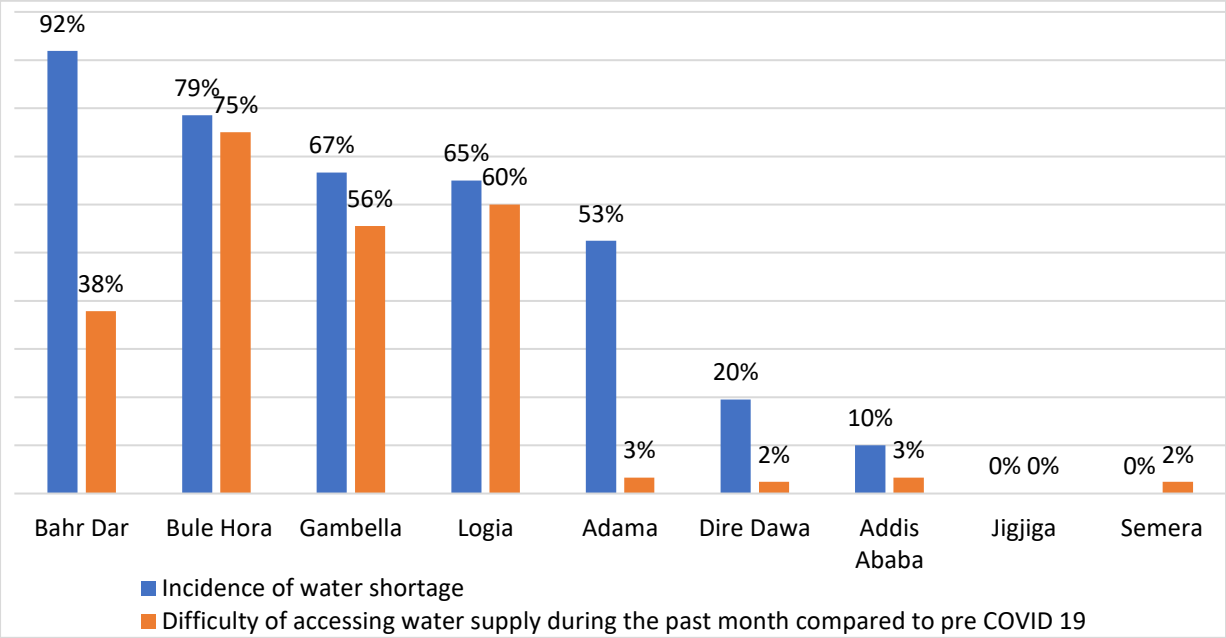
There was disparity across the respondents from the nine cities in terms of experiencing water shortages, and the level difficulty in accessing water. For instance, a higher proportion of respondents from Bahir Dar (34 out of 37 respondents), Bule Hora (22 out of 28 respondents), Gambela (6 out of 9 respondents), and Logia (26 out of 40 respondents)

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

[16] Despite the availability of the municipal water supply system, the UPSNP beneficiaries suffer due to interruptions of the municipal water supply. This makes accessing water more difficult. The availability of pipelines does not guarantee access to water. In some cities/areas, the pipeline might be dry for two weeks (i.e. the water is only available once every two weeks, or even once in a month). Because of this, households will go to another area where water is available, in order to get water. This requires travelling long distances, purchasing water, and paying for transportation. This is what we consider as difficulty in accessing water. In the case of IDPs/refugees who live in camps, the municipal water supply is not connected to their house, but there are water points (public standpipes or tankers/reservoirs) located within 500 metres' distance. There is a regular water supply at the IDP/refugee camps.

reported experiencing a shortage of water during Round 5.[17] Nevertheless, none of the survey participants from Jigjiga and Semera reported a shortage of water (Figure 6).

Figure 6: Proportion of households that reported a shortage of water, and more difficulty in accessing it, among the urban poor in nine cities in Ethiopia during Round 5, August 2021 (n = 309)



The qualitative findings are in line with the quantitative survey findings, which find that a shortage of, and difficulty in accessing, the municipal water supply remained a problem for most of the respondents in this round. By contrast, some of the diary interview participants mentioned an improvement in the availability of the municipal water supply.

Most of the qualitative study participants mentioned having poor access to a safe water supply due to inadequate infrastructure, and irregular availability of, or interruption to, the municipal water supply. However, there was disparity in terms of water supply problems in the nine cities. Participants from Jigjiga,[18] Logia, and Bahir Dar frequently mentioned high water shortages and inadequate distribution of the municipal or piped water supply.

> *There is serious water problem here. Now people are using pond water, there is shortage of water… it is getting worse. Previously, tap water was available on daily basis but now you may not get even once in a week.* (Returnee, Bahir Dar)

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

[17] We have data for Jigjiga and Semera, but none of the survey respondents reported a shortage of water.
[18] We have contradicting results for this variable for Jigjiga. The qualitative study participants mostly mentioned shortage of, and poor access to, the municipal water supply, but none (0%) of the quantitative survey participants reported a shortage in this round. The discrepancy could be related to the way the questions were designed: in the qualitative interviews, the question was asked in regard to their access to the municipal water supply, with probing questions to explore alternative water supplies, and the level of shortage; in the quantitative interviews, these just asked about the incidence of water shortages in the household. The difference in the number of respondents (few qualitative and many quantitative respondents) may result in the extent.

Another respondent from Logia said:

> *One of the problems we have now is the lack of water [municipal water supply]. Because there are times when we do not even get water once a month. It was even better before; we had been getting it at least once a week. For example, it has been a month since we got water and we have a serious water problem.* (Refugee, Logia)

On the other hand, some of the qualitative study participants mentioned an improvement in access to a water supply during this round. Respondents from Semera and Logia reported an improvement in the water supply after broken pipelines were repaired. Participants also mentioned the use of rainwater as an alternative to overcome water shortages.

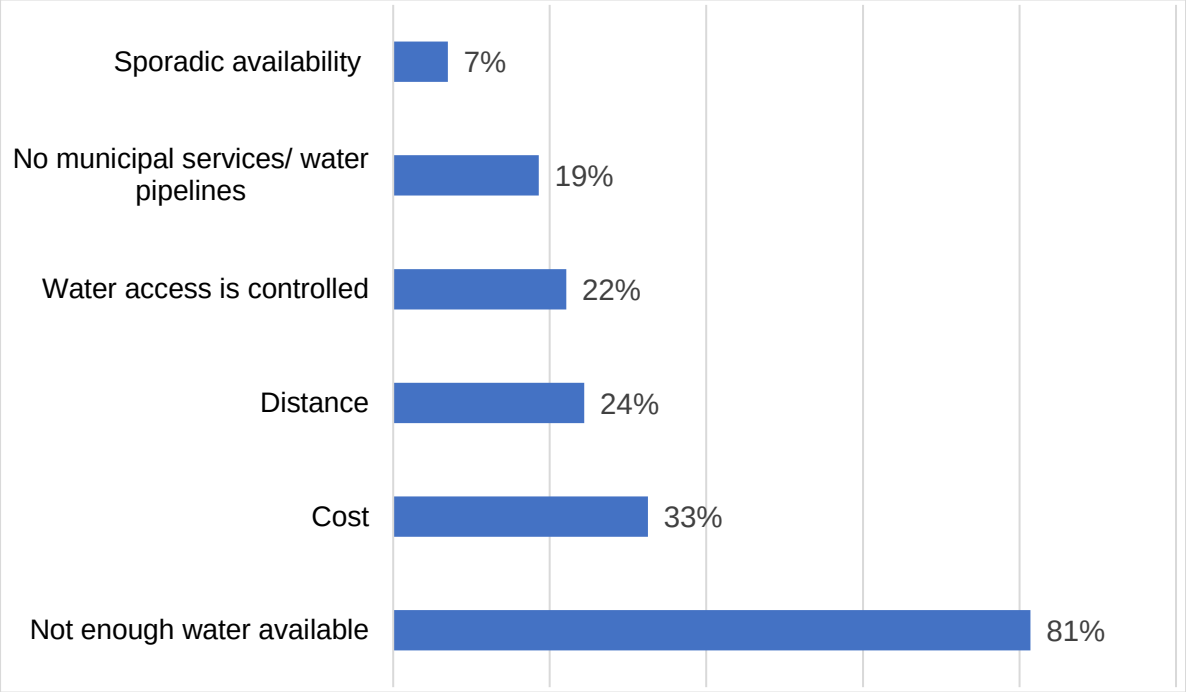
> *…. last month there was a problem with some water supply because the water line was broken. But now, after repairing the water line, we are getting enough water. … have no water problems.* (Special population respondent, Logia)

> *The availability of water supply is getting better from last time because they maintained the pipe, which was broken and also because of the weather condition is changed.* (Refugee, Semera)

We explored the major reasons for shortages of the municipal water supply and difficulty in accessing water. The qualitative and quantitative studies yielded consistent results.

The survey participants who reported having difficulty accessing a water supply in the past month (28% of the total respondents) were asked about the reasons for the difficultly in accessing water. About 81% mentioned the inadequacy of the municipal water supply as a major reason, while others also mentioned the higher cost of purchasing and transporting water, distance, water access being controlled, the absence of a municipal water service, and sporadic availability of water as reasons for experiencing difficulty in accessing water (Figure 7).

Figure 7: Major reasons for experiencing difficulty accessing water since the COVID-19 outbreak among the urban poor in selected nine cities in Ethiopia, August 2021 (n = 86).



Similarly, the qualitative study participants mentioned the following reasons for water shortages: inadequate water production by the municipality, mismatch between the capacity of existing water supply infrastructure and the demand or population size, frequent breakdown of pipelines (water supply system), failure to maintain the system, and absence of a municipal water supply system (water pipes) in some villages.

Additionally, the qualitative study participants from Bahir Dar and Jigjiga complained about poor-quality municipal water supply during the previous month.

> *…following the breakage of the water tunnel, there were a great problem with the quality of water which has a great effect on our health. We have even seen parasites in the water and since we don't have the capacity to treat the water, we used to boil the water before we drink it.* (SSB respondent, Jigjiga)

As in previous rounds, the qualitative interview respondents frequently mentioned the economic burden associated with the higher cost of purchasing and transporting water.

> *There was a high shortage of water once since we last spoke, we even bought a 20 litre of water with a cost of 20 birrs.* (IDP, Jigjiga)

Overall, shortages in the municipal water supply remained a challenge to the study participants. Compared to the previous round, in this round there has been a slight decrease in the proportion of households that reported a shortage of the municipal water supply. However, in this round, unlike in the previous rounds, which were conducted during the dry season, the use of rainwater as an alternative source helped the households to overcome the shortage of, or inadequate, municipal water supply. Water shortages were reported to mainly be caused by the mismatch between the capacity of the existing water supply

infrastructure and the demand or population size, interruption of the municipal water supply because of frequent breakdown of pipelines, and lack of coverage (i.e. absence of municipal water supply system) in some parts of the cities.

Table 5: Access to an adequate water supply among urban poor households in selected nine cities in Ethiopia, August 2021 (total n = 309, UPSNP = 108, SSB = 108, IDPs/refugees = 93)

Characteristics/variables		Respondent category			Chi-2 [p-value]	R 1 (%)	R 2 (%)	R 3 (%)	R 4 (%)	R 5 (%)	Chi-2, p-value
		UPSNP (%)	SSB (%)	Refugee/ IDP (%)							
Shortage of water in the last one month	Yes	40.7	39.8	35.5	**0.648** [0.723]	32.7	31.4	35.0	49.2	38.8	**19.6** [0.000]
	No	59.3	60.2	64.5		67.3	68.6	65.0	50.8	61.2	
Frequency of access to water supply	Every day	57.4	63.0	58.1	**6.69** [0.350]	55.0	65.0	55.0	56.3	59.5	-
	Once a week	34.3	26.9	25.8		23.6	27.8	34.0	25.9	29.1	
	Once in two weeks	0.9	1.9	5.4		4.9	0.3	1.9	6.1	2.6	
	Other**	7.4	8.3	10.8		16.5	6.8	9.1	11.7	8.7	
Level of difficulty accessing water since COVID-19 outbreak	Much more or slightly more difficult	34.2	26.8	21.5	**12.06** [0.060]	30.1	19.7	25.0	43.0	27.8	**7.92** [0.005]
	Nothing changed or easier than before	65.7	73.2	78.5		69.9	80.3	75.1	56.9	72.2	

Note: Null hypothesis for the first chi-2 test: there is no difference among the three categories. Null hypothesis for the second chi-2 test: no difference in Round 4 and Round 5. We used the McNemar chi-square test for dichotomous variables and the Stuart-Maxwell test for other categorical variables.

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

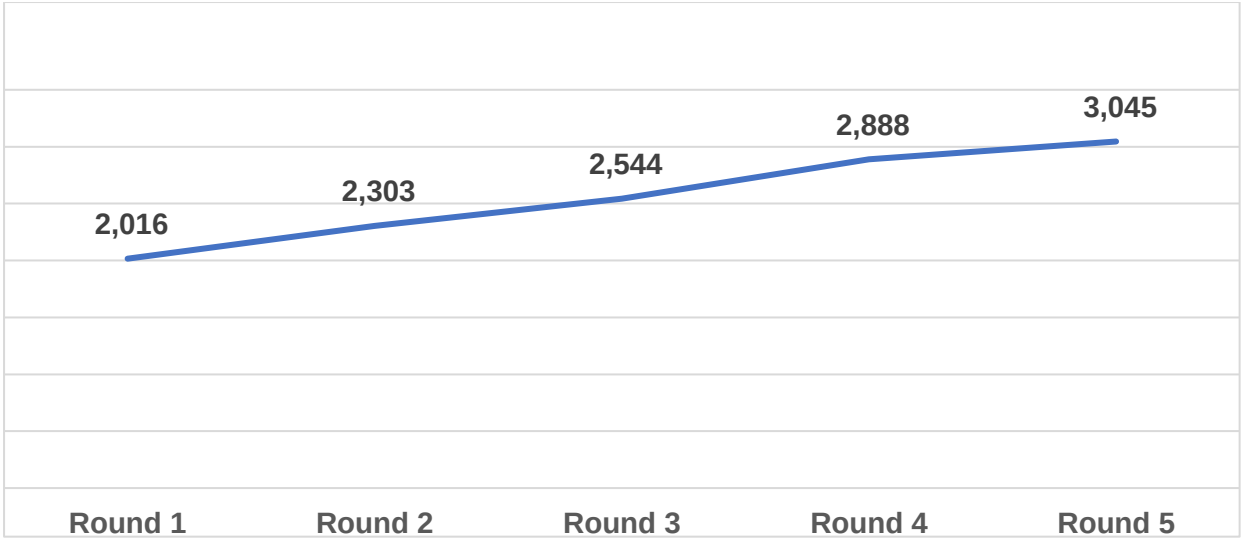
Income and expenditure

Key findings:

- The average monthly income of households has increased across the five rounds, from ETB 2,016 in Round 1 to ETB 3,045 in this round.
- The proportion of households that reported the ability to earn the same income as in the pre-COVID period has increased across the five rounds (from 66% in Round 1 to 91% in Round 5). However, most of the qualitative interview respondents referred to having the same income, or having a decreased income, compared to the previous month. The difference in qualitative and quantitative results could be due to variation in the respondents. In addition to UPSNPs, SSBS and IDP/refugees who are part of the qualitative and quantitative interviews, the daily wage earners (people that seems to struggle more than others) are included in the qualitative interview.
- Despite the increasing trend for monthly income reported by the quantitative household survey participants, the qualitative study participants widely mentioned a double economic burden due to income remaining the same or a reduction in their income, and the increased cost of living (particularly the sharp increase in the price of food items). Inflation has resulted in a decline in the purchasing power of the Birr, which in turn has resulted in the inadequacy of respondents' monthly income to cover basic expenses for food and shelter. This finding is consistent with the results from the previous round.

The quantitative survey findings reveal a consistent increase in the average monthly income of households across the five rounds, from ETB 2,016 in Round 1 to ETB 3,045 in Round 5. The change in the income of respondents between Rounds 1 and 5 was statistically significant (with t = 2.2 and p-value = 0.012) (Figure 8). The average monthly income varies across the three categories. The SSB group has the highest average monthly income (ETB 4,838), followed by the IDPs/refugees (ETBs 2,269 ETB), and the UPSNP group, who have the lowest (ETB 2,039).

Figure 8: Average household monthly income (in ETB) of the urban poor in selected nine cities in Ethiopia, August 2021 (total n = 309)

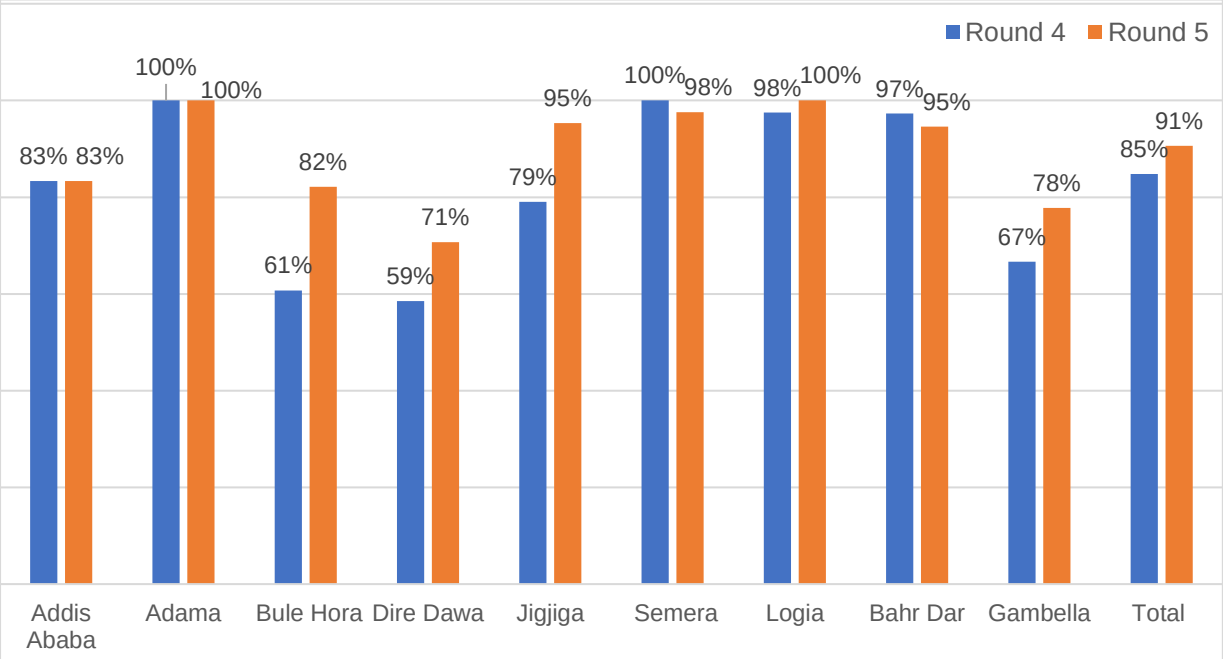


The proportion of quantitative respondents that reported having the ability to earn the same income as in the pre-COVID period increased from 66% in Round 1 to 91% in Round 5, but remained unchanged in Round 2 (85%), Round 3 (84%), and Round 4 (85%). The change

between Round 1 and Round 5 was statistically significant (chi-square value = 14.6 and p-value = 0.000). Similarly, the change between Round 4 and Round 5 was statistically significant (chi-square value = 54.5 and p-value = 0.000). Moreover, during this round the proportion of respondents that reported having the ability to earn the same income as they did before COVID-19 differed slightly across the UPSNP (95.4%), SSB (92.6%), and IDP/refugee (82.8%) groups. The difference among the three categories was not statistically significant.

Across the nine cities, the proportion of respondents that reported the ability to earn the same income as they used to make before the pandemic was highest in Adama, Semera, Logia, and Bahr Dar. In Round 5, respondents from most of the cities reported an improvement in their ability to earn the same income as they earned before the pandemic, as compared to Round 4 (9).

Figure 9: Proportion of respondents who reported being able to earn a comparable income to that earned before COVID-19 during Round 4 and Round 5 in selected nine cities in Ethiopia (total n = 309)



Unlike the quantitative results, most of the qualitative study participants (who are mostly daily wage earners) mentioned having the same income or having seen a decrease in their income compared to the previous month. When asked to name the major reason for a reduction in their income the participants mentioned the lack of job opportunities, limited economic transactions due to the decline in imports, and a lack of foreign exchange. Despite the improvement in their income, most mentioned the inadequacy of their income to cover their basic expenses, mainly because of the increase in the price of food, which has resulted in a decline in the purchasing power of money.

> *Previously I had relatively better income, but now price of everything has increased… the income I earn can only feed my children.* (Special group respondent, Bahir Dar)

> *Now, the cost of materials and food items is very high. As a result, most people find it difficult to live. For example, people who are employed in government organisations also face difficulty covering their expenses.* (Special group respondent, Logia)

Participants also mentioned a significant change in the pattern of their expenditure because of the increase in the price of basic life-sustaining items, mainly food. Some of them reported a doubling of their monthly expenses.

> *If previously 3,000 Birr can cover all our monthly expenses, but now, we spend 6,000 Birr to cover our [household] basic needs. For example, oil was 300 Birr previously but now it costs 600 ETB.* (SSB respondent, Dire Dawa)

Another respondent from Logia said:

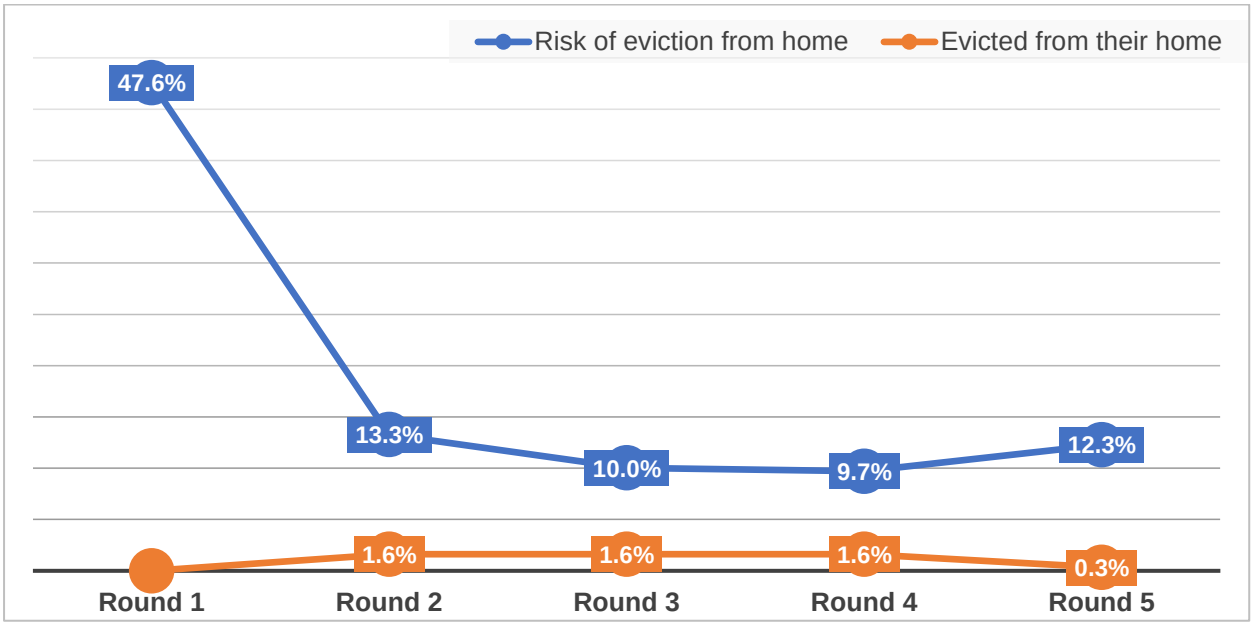
> *Our biggest problem is increase in the prices of food items. Although we have started working, the rise in the cost of food prices is higher. ... the current price of food is much higher than before. For example, 1 kg of white flour costs 50 birrs. 5 litres of edible oil is 600 birrs. In general, everything has increased.* (Refugee, Logia)

The number of respondents who reported a perceived risk of eviction from their house due to loss of income has significantly declined, from 47.6% in Round 1 to 12.3% in Round 5. However, the proportion has slightly increased during this round compared to Round 3 (10%) and Round 4 (9.7%) (Figure 10). The decrease in the risk of eviction between Round 4 and Round 5 was statistically significant (chi-square value = 9.6 and p-value = 0.002). Similarly, there has been a statistically significant change between Round 1 and Round 5 (chi-square value = 4.2 and p-value = 0.040).

The perceived risk of eviction was highest for the UPSNP category (22.2%), followed by IDPs/refugees (7%), and was lowest for respondents from the SSB group (3.7%). The difference among the three categories was statistically significant (chi-square value = 17.5 and p-value = 0.000). In this round, only one respondent, in the SSB category, from Bule Hora, reported being evicted from his house due to a loss of income (i.e. unable to pay the house rent). As mentioned above, SSB households have relatively better income and ability to cover their basic expenses as compared to the UPSNP and IDP/refugee households. Moreover, the lower risk of eviction among the IDPs/refugees could be because of their access to free shelter provided in camps or settlement sites.

A cross-city comparison shows variations across cities in terms of respondents' risk of eviction from their home due to loss of income. The proportions of households who reported being at risk of eviction were higher in Jigjiga, and Adama, whereas none of the respondents from Dire Dawa and Semera reported any risk of eviction (Annex A).

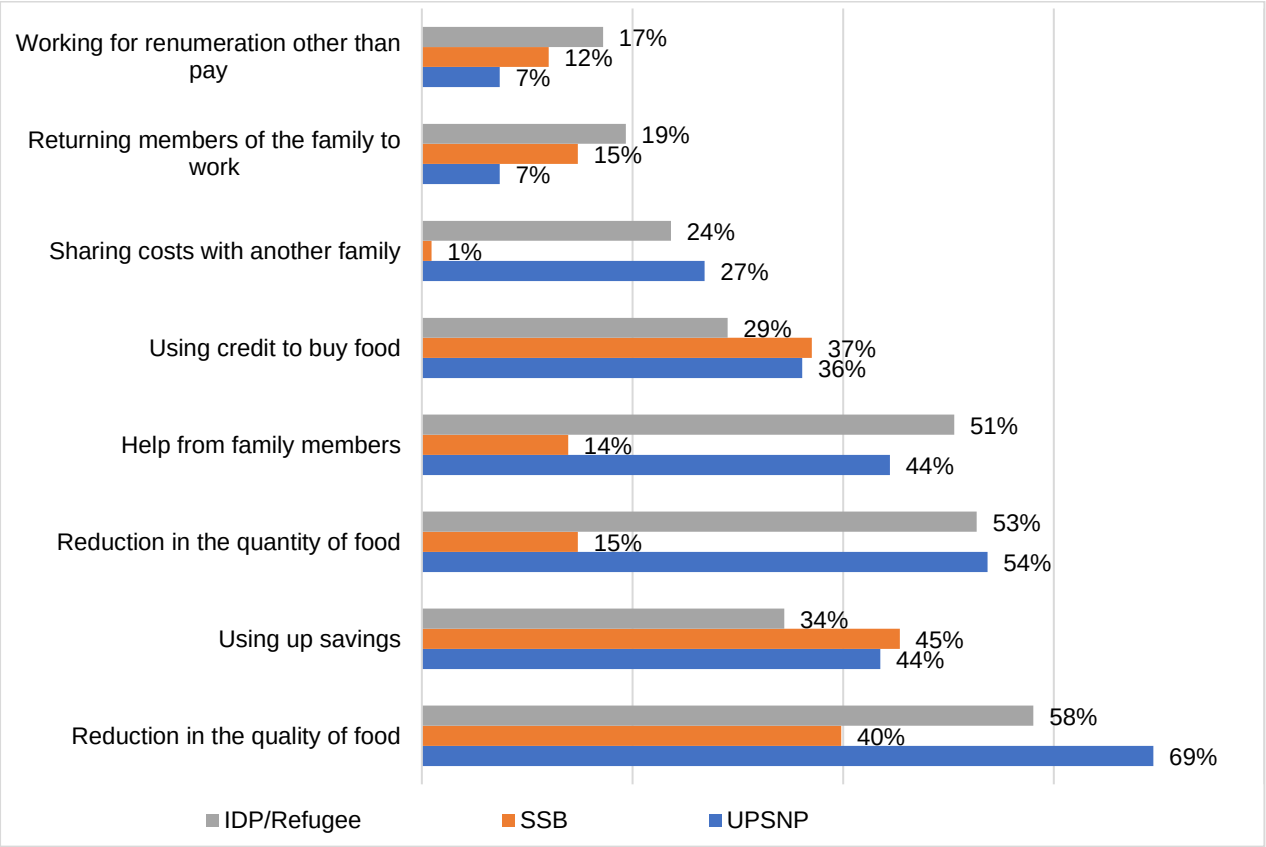
Figure 10: Incidence of eviction and perceived risk of eviction from respondents' houses in the future due to loss of income among the urban poor in selected nine cities in Ethiopia, August 2021 (total n = 309)



Reducing the quantity and quality of food, using up savings, using credit to buy food, and obtaining help from family members were mentioned in this round as the main coping mechanisms for reduced income. Reducing the quality of food was the predominant coping strategy across the three categories of respondents. A relatively higher proportion of respondents from the SSB group and UPSNP beneficiaries mentioned using up savings as a coping mechanism (Figure 11).

The coping mechanisms have remained consistent across the five rounds. Reductions in the quantity and quality of food, using up savings, and obtaining help from family members were widely mentioned coping mechanisms across the five rounds. For instance, the proportion of respondents that mentioned reducing the quality of food consumed has increased across the rounds (from 33% in Round 1 to 49% in Round 2, 51% in Round 3, and 54% in Round 4, with a slight decrease to 46% in Round 5). On the other hand, the proportion of respondents reporting obtaining help from other family members to cope with the reduction in their income has declined from 43% in Round 1 to 15% in Round 2, 10% in Round 3, and 7% in Round 4, but increased to 15% in Round 5 (Figure 12).

Figure 11: Coping mechanisms mentioned by all three groups of respondents in nine cities in Ethiopia, August 2021 (total n = 309, UPSNP = 108, SSB = 108, IDPs/refugees = 93)



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

> *During the past month, I couldn't afford to buy food for my family. As a result, we borrowed food from a shop. ... But now I started to repay my debts with the income I get.* (Refugee, Semera)

> *We skip some meals for adults and eating cheaper foods. Since a while we did not eat rice because it's so expensive for me.* (UPSNP beneficiary respondent, Semera)

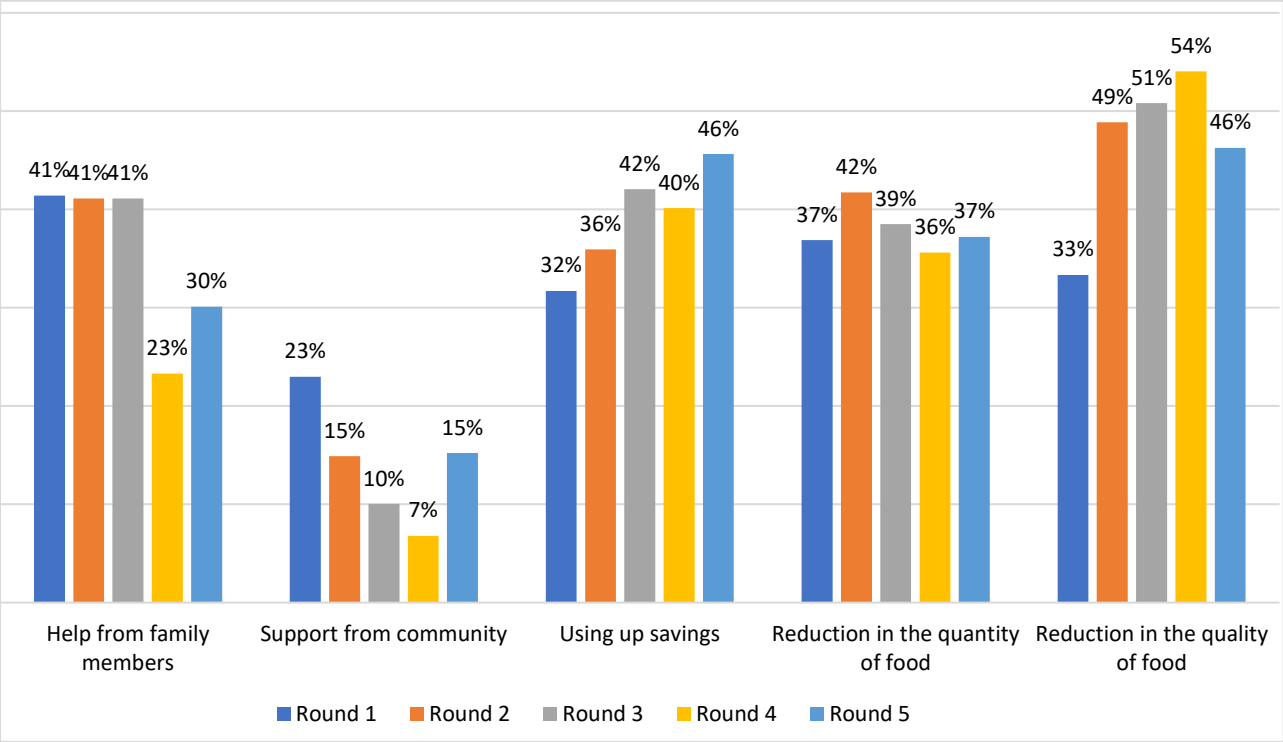
> *We have reduced our meal frequency. ...if we eat our breakfast, we do not eat our lunch.* (UPSNP beneficiary respondent, Adama)

> *If we eat our breakfast, we don't eat our lunch, only children eat [three meals per day]. ... adults do not eat lunch and dinner once they eat their breakfast.* (IDP, Adama)

> *We always eat shiro [the most common food perceived to be less nutritious, less preferred, and mostly consumed by people with low income], previously I feed my*

children potato and other food types but now I only feed them shiro. (Special group respondent, Bahir Dar)

Figure 12: Mechanisms for coping with reduced income during Rounds 1, 2, 3, 4, and 5 among the urban poor in selected nine cities in Ethiopia, August 2021 (total n = 309, UPSNP = 108, SSB = 108, IDPs/refugees = 93)



The quantitative household survey findings reveal an increase in the household average monthly income across the five rounds, from ETB 2,016 in Round 1 to ETB 3,045 in this round. Similarly, the proportion of households that reported the ability to earn the same income as in the pre-COVID period has increased across the five rounds (66% in Round 1 to 91% in Round 5). However, the results from the qualitative study show a worsening of the economic burden due to the significant increase in the cost of living (particularly the sharp increase in the price of food items) and the decline in the purchasing power of the Birr, resulting in the inadequacy of respondents' income to cover their basic expenses for food and shelter. The food price increase is a serious problem; while it may not be related to COVID-19, it significantly affects the urban poor's standard of living.

Food security

Key findings:

- The incidence of food shortages remain unchanged during Round 5 (45.3% in Round 4 and 45% in Round 5). The proportion was higher among respondents from Semera, Jigjiga, and Bule Hora, compared to other cities.
- Similar coping mechanisms were mentioned in Round 5 and Round 4. Eating less preferred foods and reducing the number of meals per day have remained the predominant strategies for coping with food insecurity (unaffordability) during the past month. Respondents also mentioned avoiding or stopping buying expensive food altogether as a major coping mechanism.
- The increase in the price of food items has remained the major challenge to the urban poor across the five rounds.

The proportion of households who consume an average of three or more meals per day has gradually increased from 62.5% in Round 1 to 74.4% in Round 2, to 79.9% in Round 3, to 83.8% in Round 4, and to 85.4% during Round 5 (Figure 13). The difference between Rounds 4 and 5 was statistically significant (chi-square value = 93.1, p-value = 0.000). Similarly, the change between Round 1 and Round 5 was statistically significant (chi-square value = 13.7, p-value = 0.000). However, despite, the gradual improvement across the five rounds, the result is still well below the pre-COVID-19 period, when 94.2% of households consumed an average of three or more meals per day.

The proportion of households who reported consuming three or more meals per day was highest among the SSB participants (96.3%), and was slightly lower for the UPSNP beneficiaries (86.1%) and IDPs/refugees (72.0%). The difference in the frequency of meal consumption among the three categories was statistically significant (chi-square value of 23.7 at p-value = 0.000) (Figure 14).

Figure 13: Average frequency of meals per day consumed by household members during the last month among the urban poor in selected nine cities in

Ethiopia, August 2021 (total n = 309, UPSNP = 108, SSB = 108, IDPs/refugees = 93)

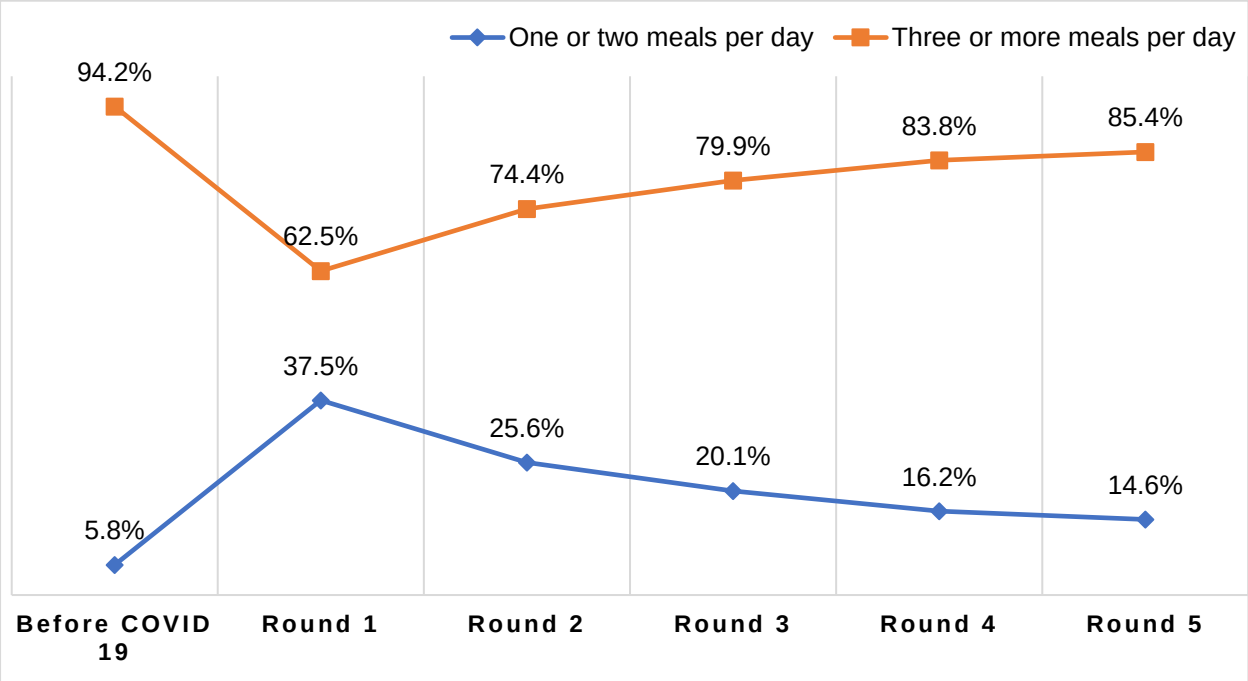
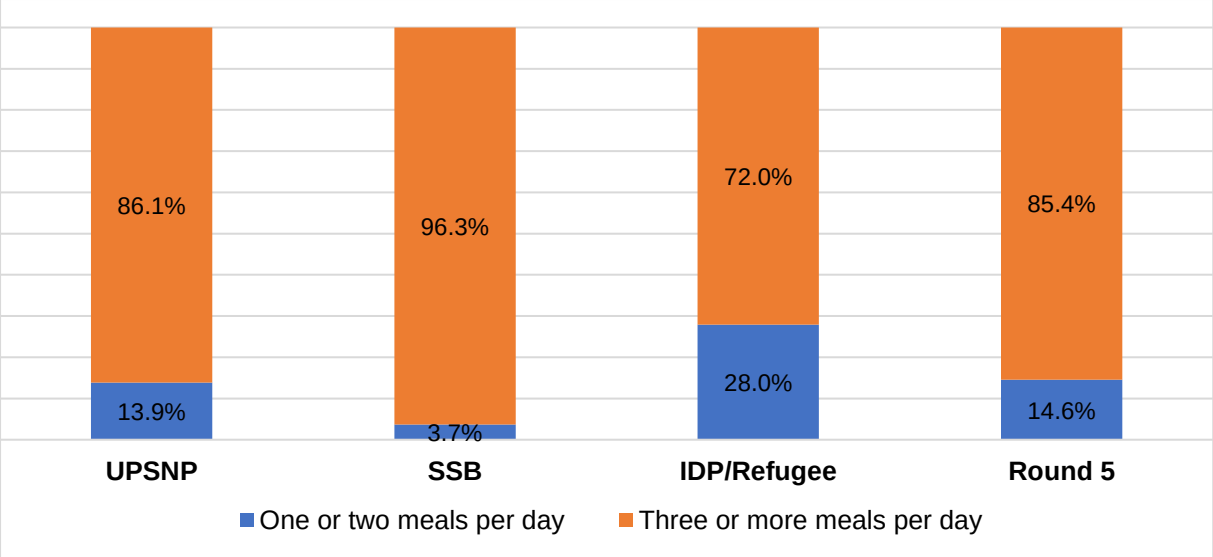


Figure 14: Average frequency of meals per day consumed by household members during the last month among the urban poor in selected nine cities in Ethiopia, August 2021 (total n = 309, UPSNP = 108, SSB = 108, IDPs/refugees = 93)



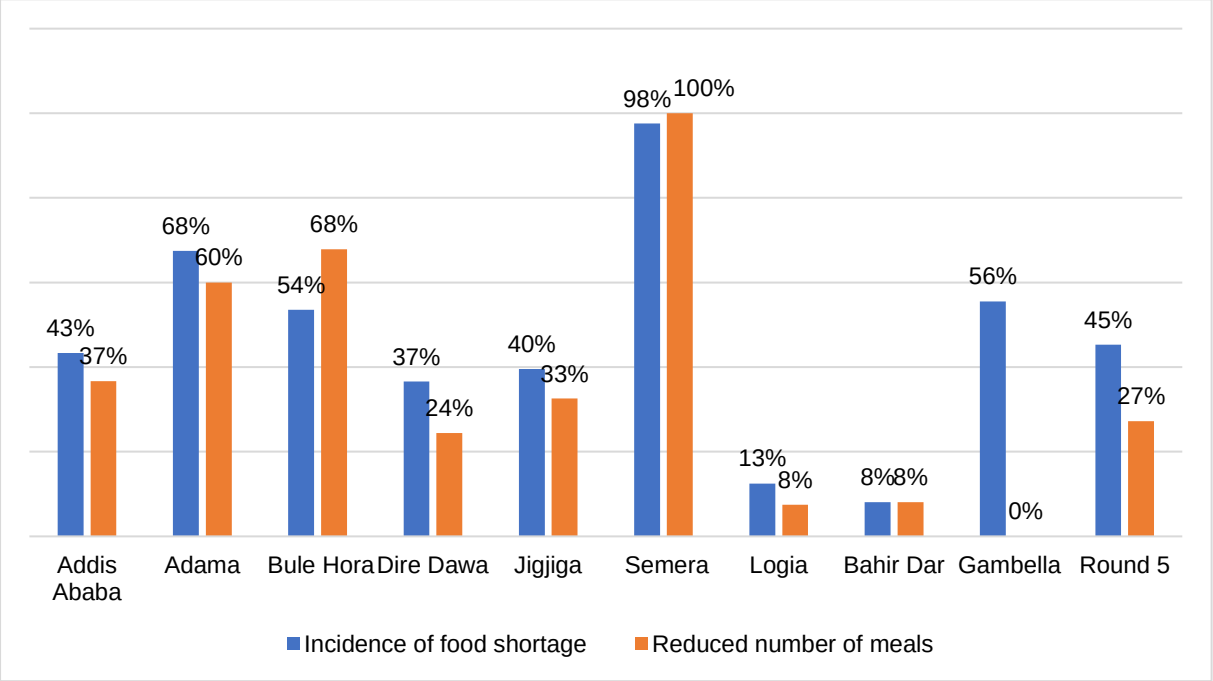
The incidence of food shortages among the households has varied across the five rounds, from 57.0% in Round 1 to 45.3% in Round 2, to 40.8% in Round 3, to 45.0% in Round 4, and to 45.3% in Round 5. The change between Rounds 1 and 5 was statistically significant (chi-square value of 24.1, with p-value = 0.000).

The proportion of households who reported a food shortage during the last month (140 out of the total 309 households) was highest for the UPSNP category (65.7%, 71 out of 108

households), followed by IDPs/refugees (51.6%, 48 out of households), and was lowest among the SSB participants (19.4%, 21 out of 108 households). The difference among the three categories was statistically significant (chi-square value of 48.8, with p-value = 0.000).

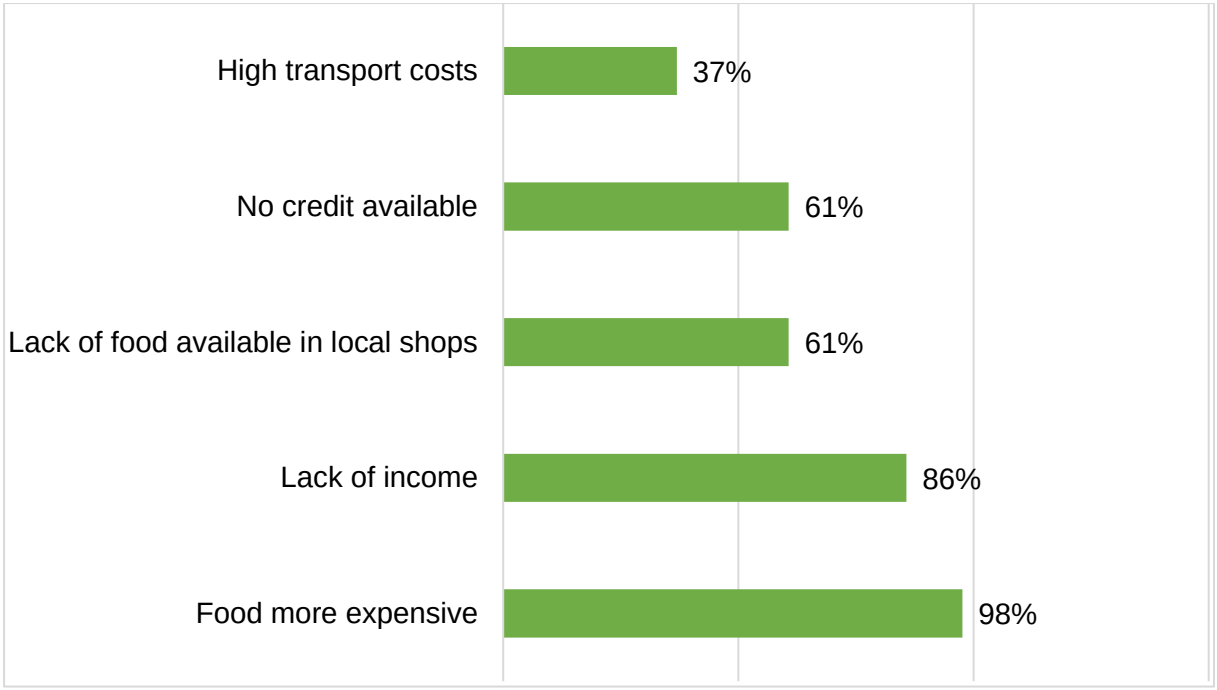
Across the nine cities, the proportion of households experiencing a food shortage was highest in Semera, Bule Hora, and Adama, and was lower in Bahir Dar, Logia, and Dire Dawa. Similarly, respondents from the same cities (Semera, Bule Hora, and Adama) were those who most commonly reported reducing the number/frequency of meals they or their household members consume per day (Figure 15).

Figure 15: Incidence of food shortages and reduction of number of meals over the past month among the urban poor in selected nine cities in Ethiopia, August 2021 (total n = 309, UPSNP = 108, SSB = 108, IDPs/refugees = 93)



The 78 respondents (23% of the total sample) who reported consuming less meals per day were asked the reasons for their reduced food consumption. Increased prices of food items and lack of income were found to be the most common reasons (Figure 16).

Figure 16: Reasons for reducing food consumption among the urban poor in selected nine cities in Ethiopia, Round 5: August 2021 (total n=78)



The qualitative findings are in line with the quantitative survey results. As in previous rounds, the incessant increases in the price of food remained the most important challenge facing the urban poor. Many participants reported that the decline in the purchasing power of the Birr affected their ability to cover their basic expenses (food, shelter, and clothes). They specifically mentioned the unaffordability of food items due to the significant and frequent price increases.

> *The cost of living is getting higher and higher. When we compare it to the previous price there are some foods that have increased by 100%, 200%... For example, the price of 1 kilogram pepper has increased from 100 Birr [in the previous month] to 320 Birr [in this month]…* (SSB respondent, Logia)

Most of the qualitative study participants agreed that inflation, and mainly the dramatic increase in food prices, affects every segment of the population (rich and poor), but that the problem is worse for the poor. The participants also mentioned the devastating effect of the increase in food prices on people with disability, who are not able to work, old people, and unemployed people.

> *... regarding the price it's not affordable by me and other people who are poor with many children, elders, and sick people who are not able to work.* (UPSNP beneficiary respondent, Semera)

The qualitative diary interview respondents mentioned various possible reasons for the increase in food prices. Most believe that the price increase is due to cost increases throughout the supply chain (i.e. starting from production and moving on to transportation, at the wholesalers/distributers, and up to the retail and local market level). Moreover, some of them mentioned the limited imports of goods (such as pasta, macaroni, edible oil, sugar, etc)

due to the lack of foreign currency, which has resulted in shortages (unbalanced demand and supply) and has increased the price of food items.

Some of the qualitative study participants mentioned the catalytic effect of the conflict, security problems, and political unrest in some parts of the country (mainly in Tigray, Amhara, Oromiya, and Afar regions). They also mentioned the effect of the conflict on the country`s economic activity, which has resulted in interruptions to supply chains (the movement of goods from production to the market), and consequently increases in prices.

> *Honestly speaking, there are a lot of changes [due to political conflict] and life became harder because everything has increased in price. So it is not only COVID-19 but also the unrest of the country especially the region that affects everything and has a major impact on food price.* (SSB group respondent, Semera)

Some of the participants explained that the increase in food prices is not associated with the effect of COVID-19:

> *Despite working and getting money there is inflation and the food price is increasing from time to time, but I don't believe this is related to impact of COVID-19 ... it could be related to other factors, such as dollar value increment and lack of government control.* (UPSNP beneficiary respondent, Jigjiga)

> *The food price has risen sharply in the past month, but it has nothing to do with COVID-19.* (Refugee, Logia)

Almost all of the qualitative study participants believed that there is no problem related to the availability of food items in the market. Some mentioned that there was even greater availability of and access to food in the market, compared to previous months.

> *…food item is available, but the problem is on its price, supply is available everywhere… you can get whatever you need in market. But the price increases from time to time. You cannot find something tomorrow with the same price as today.* (Returnee, Bahir Dar)

> *It is different from when the corona came first, at that time all people were returned to their home. It was difficult to get everything. But now you can get everything from the market.* (IDP, Dire Dawa)

Another respondent from Dire Dawa described the availability of food items as follows:

> *…everything is available. If you have the money at hand, you can get what you want. The issue is only the increment in price, not the availability.* (Special group respondent, Dire Dawa)

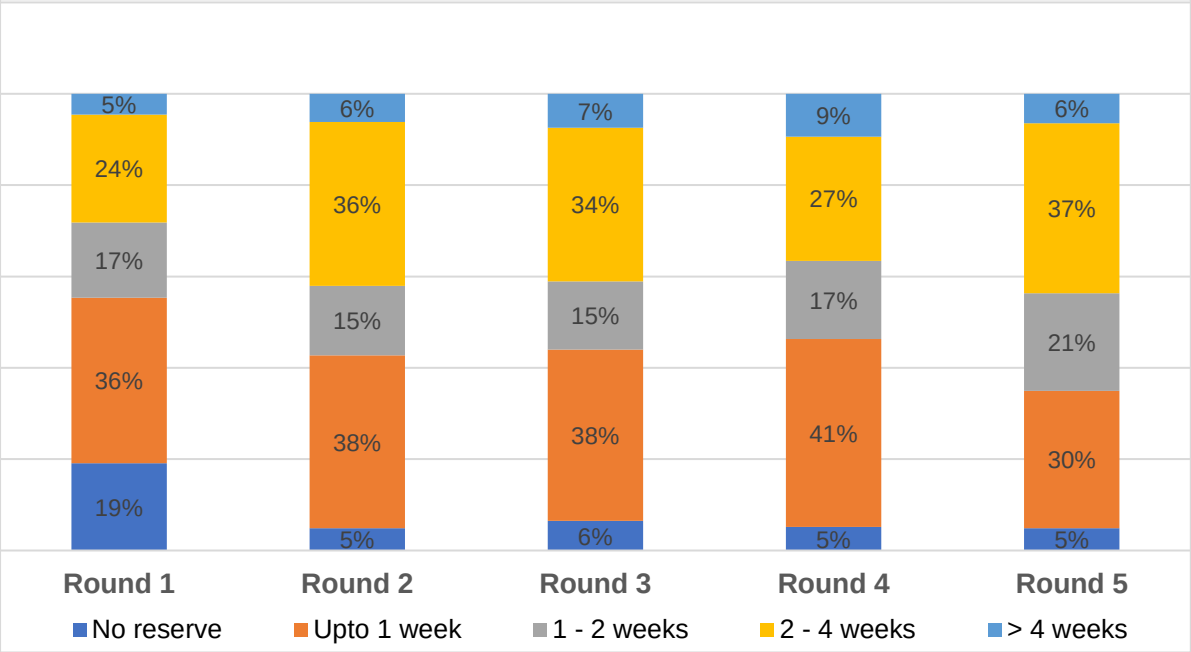
The availability of food reserves within households significantly improved between Round 1 (81%) and Round 2 (95%) but has remained steady thereafter (94% in Round 3, 95% in Round 4, and 95% in Round 5). However, **these reserves are only suitable for a short period**. The proportion of households having food reserves that can feed their family for a month or more is very small and has increased only slightly, from 5% in Round 1 to 6% in Round 5 (a slight decrease compared to Round 4, which was 9%) (Figure 17). It is well known that most households in Ethiopia have a culture of holding food reserves (mainly non-

perishable food items like teff, wheat or maize flour, cocking oil, shiro, berbere, etc.) that can serve their family for at least one month. In most cases, the households purchase those items on a monthly basis, unless they have a shortage of income.

The proportion of households having food reserves was the highest for SSB households (96.3%) and IDPs/refugees (95.7%) as compared to the UPSNP beneficiaries (93.5%). Moreover, the proportion of households having enough food to feed their family for one month or more was highest for the SSB group (17.6%). However, none of the IDPs/refugees and only 1% of UPSNP beneficiaries reported having food reserves for at least one month.

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

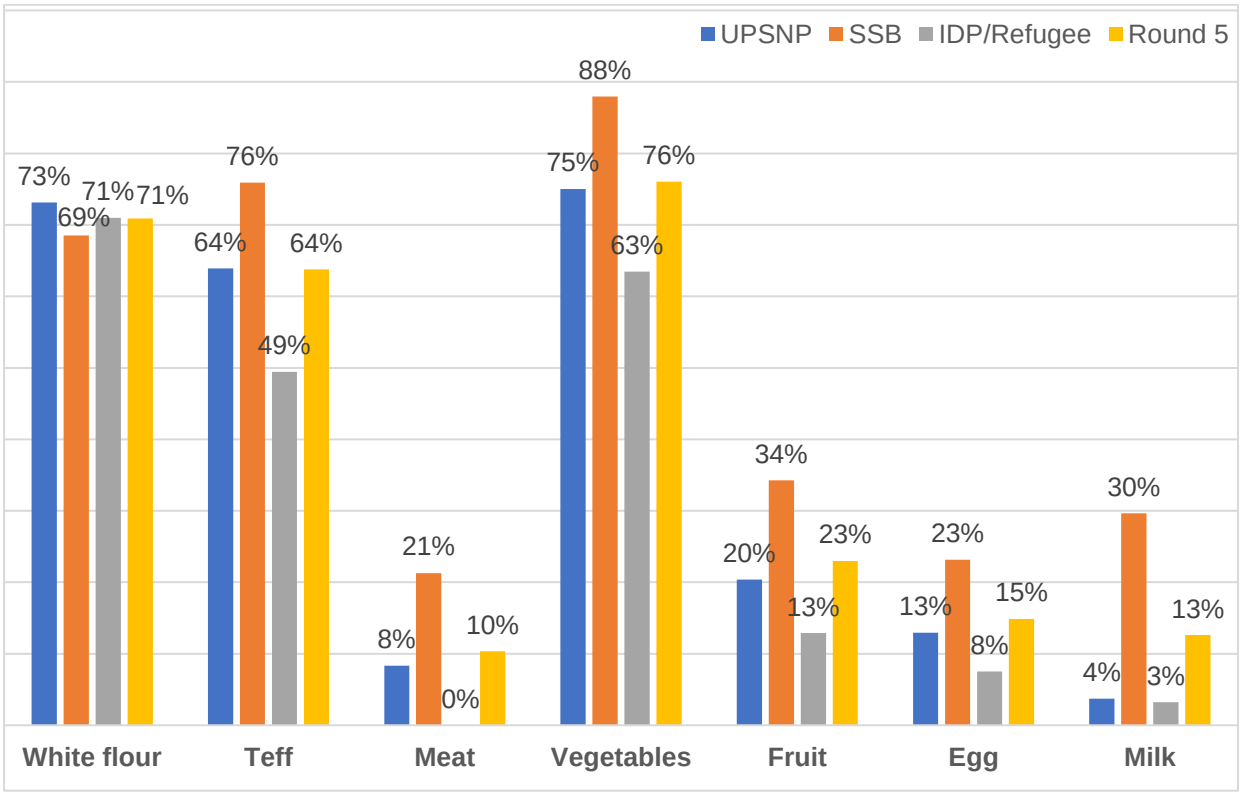
Figure 17: Availability of food reserves in the household among the urban poor in selected nine cities in Ethiopia, August 2021 (total n = 309, UPSNP = 108, SSB = 108, IDPs/refugees = 93)



Despite the increase in the proportion of households consuming three or more meals per day, the type of food they consume was found to be of low quality. For instance, only 10% and 15% of households reported consuming meat and eggs in this round, respectively. Vegetables were reported to be the food items most frequently consumed by the vast majority of respondents (76%). Compared to IDPs/refugees and UPSNP beneficiaries, a higher proportion of households from the SSB category reported consuming meat, eggs, milk, and fruit (Figure 18). The difference in their incomes (i.e. SSB owners earn a better

income than UPSNP beneficiaries, and IDPs/refugees) could be contributing to the observed disparity.

Figure 18: Types of food items most frequently consumed by urban poor households in selected nine cities in Ethiopia, August 2021 (total n = 309, UPSNP = 108, SSB = 108, IDPs/refugees = 93)

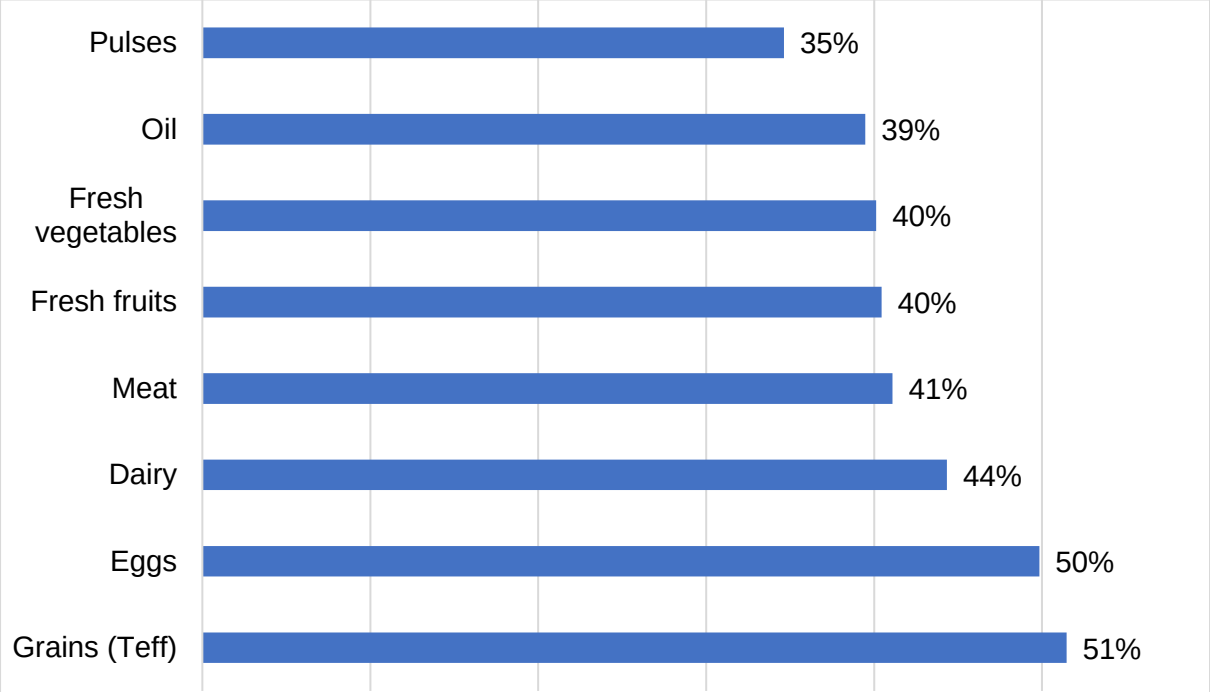


Quantitative survey participants were also asked about the types of food items that they purchased less of, or that they had stopped buying altogether, because of the COVID-19 impact during this round. Teff (51%), eggs (50%), dairy products (44%), and meat (41%) were among the food items that households were not buying or were buying less frequently and/or in lower quantity. These items are relatively expensive and are becoming unaffordable for the urban poor due to increased prices (Figure 19).

Regarding coping mechanisms for dealing with shortages of food, the qualitative findings supplement the quantitative survey results. The respondents widely mentioned avoiding or stopping buying more expensive foods, consuming low-quality/less preferred foods, and reducing the quantity and frequency of meals as major coping mechanisms.

> *I am eating garasulla [a low-quality, cheap wheat flour] because the price of garasulla is cheaper than the white flour. For example, the price of white flour became 2,000 Birr which is beyond my salary payment.* (UPSNP beneficiary, Semera)

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



In general, shortages of food and food insecurity have remained one of the major problems affecting the urban poor throughout the five rounds of our study. The problem is mainly caused by the persistent increase in food prices (inflation), and the inadequacy of households' income to cover their basic expenses, including food. Security problems caused by the political unrest and conflict in some parts of the country have negatively affected economic activities, resulting in an increase in the price of food items. To overcome this problem the study participants have been forced to apply various coping strategies, which include avoiding or stopping buying more expensive foods, consuming low-quality/less preferred foods, and reducing the quantity and frequency of meals.

Health

Key findings:

- In this round, all of the participants who needed medical attention reported having been able to access medical treatment, except one person.
- About 29% of the respondents who had at least one child under five reported that their children had been diagnosed with malnutrition by health workers, constituting a significant increase compared to previous rounds.
- Utilisation of maternal and child health services has not been significantly impacted by COVID-19 and has increased significantly in this round. Fear of COVID-19 is no longer preventing people from accessing healthcare services.

In this round, only 55 respondents (17.8%) reported that they had needed medical treatment in the period since the last survey. Among these 55 the most common reason reported for needing medical attention was fever with a persistent cough or difficulty breathing (41

participants), 31 of whom were tested for COVID-19. All of those who needed medical treatment reported that they were able to access it, except one person. The majority (97.1%) of the survey participants reported that they would definitely go to a health facility if they needed to in the future.

In the first two rounds, our qualitative interviews indicated a fear of being infected by COVID-19 and a fear of being quarantined as the major barriers to accessing medical care in the community. In this round (as was the case in Round 4), **it seems that a fear of being infected by COVID-19 is no longer a barrier to accessing medical care**.

> *There was low patient flow during the first few months following the COVID-19 pandemic. People in need of medical care/service were not coming to health facilities because they had a fear that they would be quarantined if they are suspected of being infected with the coronavirus. But now this is changing, people are visiting health facilities to get treatment.* (Health worker, Gambela)

Of the total quantitative interview respondents, 49.8% (154 households) had children under five years old. Respondents were asked if any children under five in their family had been sick since the last survey. Only 14 respondents (9.1%) reported that there was at least one child under five who had been sick, and most (11) of those respondents reported taking their child to a health facility for treatment. Three respondents reported financial constraints as the major barrier to seeking medical attention for their sick child. All 29 children who had an appointment and were eligible for childhood vaccines were reported to have been vaccinated. As in the previous rounds, respondents were also asked if any of their children under five years old had been diagnosed as malnourished. In this round, 45 (29.2% of the 154 respondents) reported that their children had been diagnosed with malnutrition by health workers, which is higher than the 8.8% found in Round 3 and the 19% found in Round 4. This figure is also higher compared to the 5.7% national average prevalence of acute malnutrition in urban areas in Ethiopia,[19] which could be attributed to the fact that this study is being conducted among the most disadvantaged segment of the urban population. The higher reported prevalence of malnutrition could partially be attributed to the consumption of low-quality food. In this round, avoiding or stopping buying more expensive foods, consumption of low-quality/less preferred foods, and reducing the quantity and frequency of meals were reported to be the major coping mechanisms in the presence of food shortages. The higher prevalence of malnutrition found in this round could also be related to seasonal variation. Previous studies have documented how wasting is very sensitive to seasonal changes, particularly towards the end of the dry season.[20]

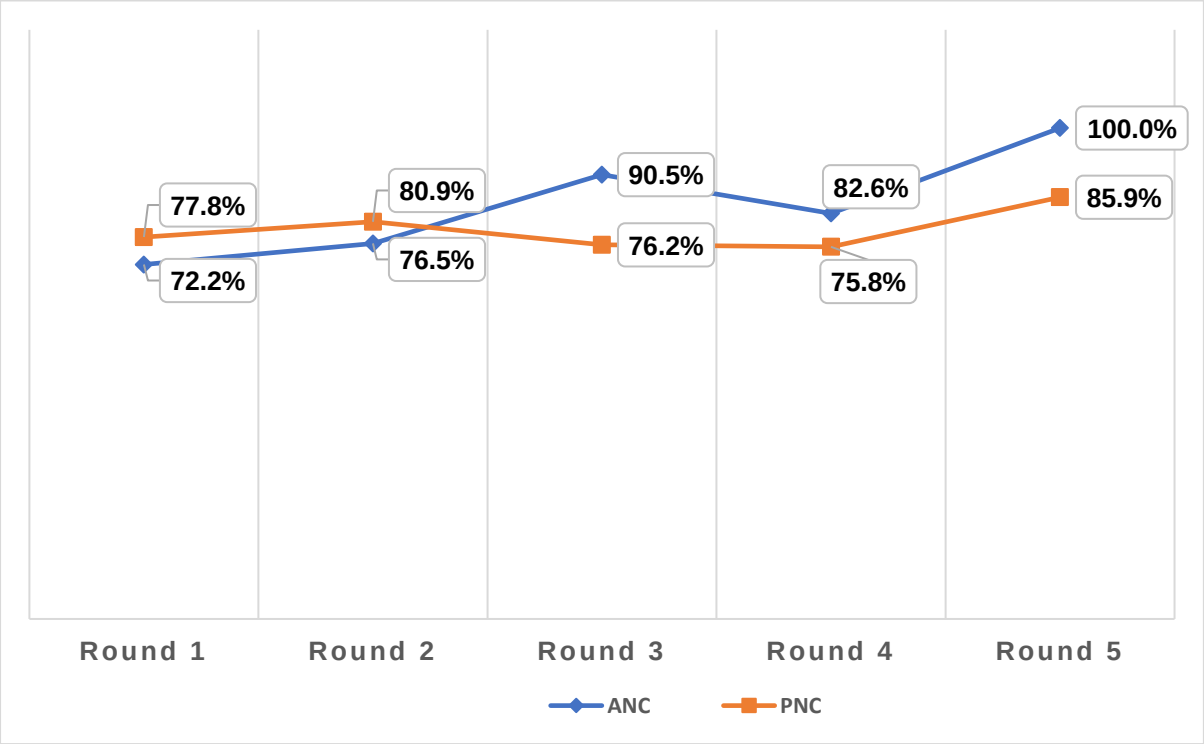
All of the pregnant women in the sample households were reported to have attended their antenatal care (ANC) appointments (n = 23). The level of access to ANC increased in each round except for Round 4 (Figure 20). About 20.7% of our respondent sample included lactating women (n = 64), of which 85.9% had accessed postnatal care (PNC), which seems to have increased across the rounds.

[19] https://dhsprogram.com/pubs/pdf/PR120/PR120.pdf
[20] Talley, L., Boyd, E., Sharief, F., Blanton, C., Omer, A.M., Omer, A. M. M. (2012) 'Prevention of acute malnutrition during the lean season: comparison of a lipid-based nutrient supplement and an improved dry ration, South Darfur, Sudan. A quasi-experimental study', *Journal of Nutrition Disorders & Therapy*, p. 117. 104172/2161-05091000117 2012.

The qualitative findings are in line with the quantitative results in this area. The provision and utilisation of maternal and child health services has not been significantly impacted by COVID-19, as also reflected in the qualitative interviews.

> *My oldest sister is pregnant and she visits the health centre according to her appointment and she is also vaccinated. They get antenatal care and medications for free. To be honest, the services around maternal and child health services are very good. Health facilities are open, and staff and medication are available as well.* (UPSNP beneficiary, Semera)

Figure 20: Uptake of ANC and PNC among the urban poor in nine cities in Ethiopia, August 2021 (n pregnant = 23; n lactating = 64)



The increase in the uptake of health services was also reflected in the qualitative interviews. Both the health workers and community members reported that that the fear of being infected by COVID-19 was no longer a barrier to accessing medical care. However, a health worker from Gambela explained that the provision of health services was challenged by an inadequate supply of essential drugs:

> *Most of the time we cannot get adequate drugs including essential drugs from EPSA [Ethiopian Pharmaceuticals Supply Agency] Gambela branch. I am not sure if it is possible to get from other EPSA branches. We cannot get the drugs we need at this branch.* (Health worker, Gambela)

It seems that fear of COVID-19 is not deterring people from accessing healthcare services. In this round, all of the participants who needed medical attention reported having been able to access medical treatment, except one person. The most common reason reported for needing medical attention was fever with a persistent cough or difficulty breathing (41 participants), most of whom were tested for COVID-19. The proportion of respondents who reported that their children had been diagnosed with malnutrition by health workers has

increased significantly in this round. Utilisation of maternal and child health services has also increased significantly in this round. However, our sample sizes for these groups are small, and thus the results need to be interpreted with caution.

Education

Key findings:

- In almost all cities, during survey Round 5, the schools were closed due to the annual break, and the students spent their time helping their parents, staying at home watching TV, and playing with their friends.
- Siblings and relatives are the primary caregivers of children during off-school days.
- About three-quarters of all respondents indicated that their child–parent relationship had improved, while 15% reported that their child–parent relationship had worsened.
- About 90% of the study participants believe that spending time with their children is important, while half of them believe that men do not value taking care of their children as much as they should.

Since the data collection began in July, schools were closed during the data collection period; however, some schools were open within the one-month period preceding data collection. Of the total respondents, 175 (52%) reported having at least one child. Among the total of 137 female children and 145 male children who were in school before COVID-19 (n = 309), three (2.2%) females and two (1.7%) males were not in school in this round. In the fourth round, one early child marriage was reported; in this round, however, no child marriages were reported.

Likewise, in the qualitative interviews, none of the participants reported witnessing or hearing about a child marriage in their families or their community. However, it was reported that a few students had not gone back to school:

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

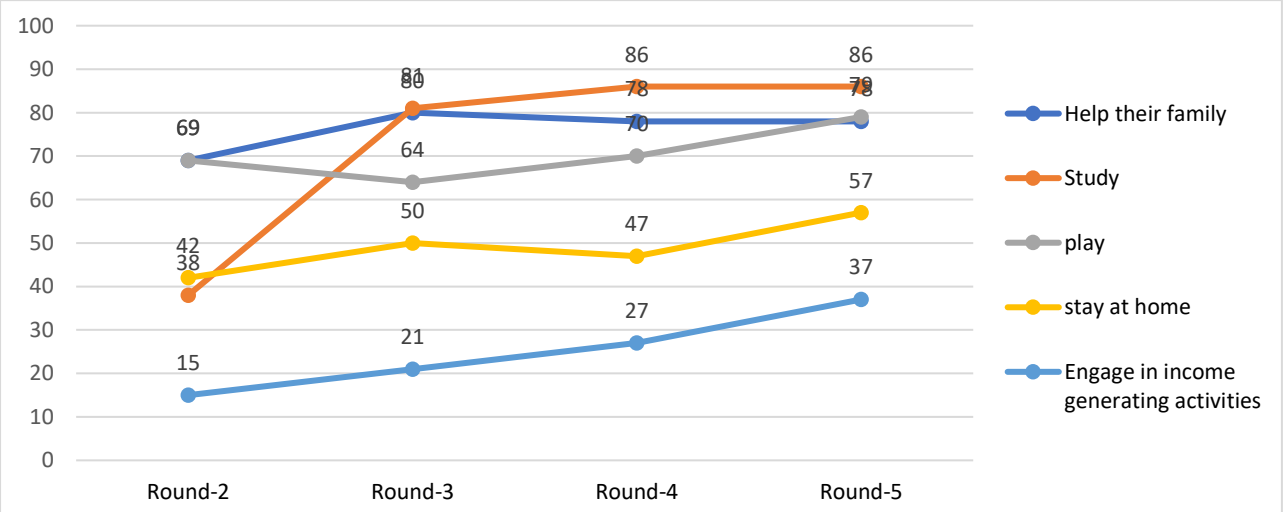
The quantitative results show that three-quarters of the respondents with at least one child in their family reported that their children had been spending their time helping their families, with no significant difference across the three study groups (UPSNP group, SSB group, and IDPs/refugees). The children's time spent playing around the neighbourhood and studying were significantly different across the three groups: children whose parents were UPSNP beneficiaries were less likely to spend their time studying compared to those from the other two groups. Children whose parents were IDPs/refugees were more likely to play around their neighbourhood compared to those from the other two groups. In this round, 36% of the children were reported to spend their time on income-generating activities, with no significant difference across the three study groups. However, this figure is higher compared to the previous round (25%). This could be because the data in this round (Round 5) were collected in July, when schools were closed in most of the areas. Thus, children may engage in income-generating activities in their free time.

Table 6: Time use among children from the urban poor in nine cities in Ethiopia, August 2021

Children's time use	Respondent category			Chi-2-test (P-value)	Total (%)
	UPSNP (%)	SSB (%)	IDP/refugee(%)		
Help their family	80	80	73	0.5 (0.76)	77.8
Study	80	92	90	6.8 (0.03) *	86.5
Play around the neighbourhood	75	70	96	13 (0.001) *	78.9
Stay at home, watch TV/movies, and play games	60	53	57	0.7 (0.69)	56.7
Engaged in income-generating activities	44	34	29	2.8 (0.23)	36.7

The percentage of time that children spend studying and helping their families has increased from Round 2 to Round 4, but has not changed in this round compared to Round 4. The percentage of time that children spend playing and staying at home watching TV has also increased compared to previous rounds (though this is likely to increase anyway during the school holidays). Children's engagement in income-generating activities has consistently increased across the rounds: from 15% in Round 2 to 37% in this round (Figure 21).

Figure 21: Children's time use among the urban poor in nine cities in Ethiopia, during COVID-19 pandemic



In this round, with the exception of a few participants, all parents indicated that their children attended school in a shift programme throughout the year. However, during the data collection period, the schools were closed and their children were spending their time playing, staying at home watching TV, and helping their parents.

> *In this area, now the school is closed so children have no education. So, they spend time at home watching TV and helping us. However, in the past, children spent most of their time by learning and studying their education.* [SSB respondent, Afar, Logia]

In the qualitative interviews, participants mentioned that their relatives watched after their children while they went to work. Some others also indicated that the children themselves took responsibility, by taking care of each other:

> *The school is closed currently and, therefore, they spend their time at home watching television [laughing]. They have nothing to do. I don't spend the entire day with my children because I spend my day at work. I don't also look after them, because they are not too young and I just gave all the responsibility to them to look after each other.* [Special group respondent, Bahir-Dar]

In this round, parents were asked to report the amount of time they spent with their children, and their perception of their relationship with their children. About 90% reported that they spent the same amount of time or more time with their children compared to their pre-COVID-19 pandemic practice, with no statistically significant difference across participant groups (chi-square: 12.5; p-value = 0.13). About three-quarters reported having a somewhat close relationship with their children before the pandemic, while a quarter were not close at all or not very close to their children before the pandemic. About 73% also reported that the relationship with their children had improved during the COVID-19 school closure. By contrast, 15% of all respondents reported that their relationship with their children had deteriorated over the course of the pandemic, with no significant difference across the study groups (Table 7).

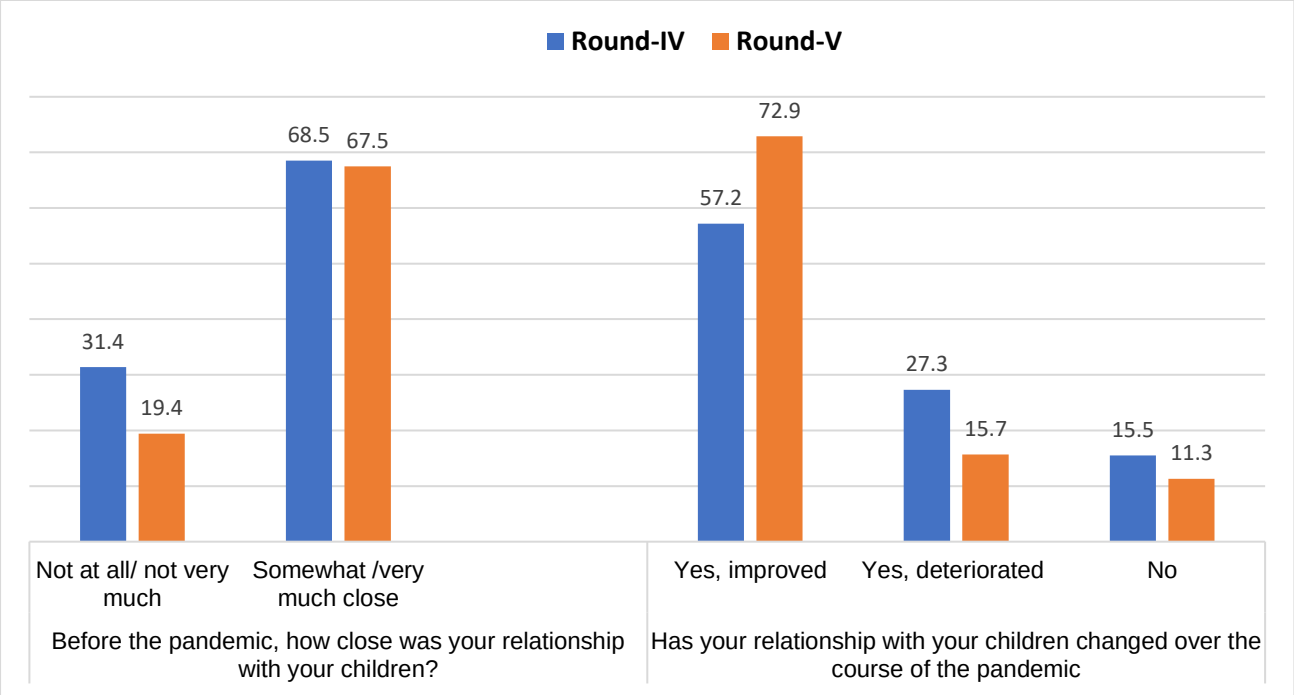
Table 7: Parents' time spent with their children among the urban poor in nine cities in Ethiopia, August 2021 (n = 175)

	UPSNP (%)	SSB (%)	IDP/ ref. (%)	Round 5 total	Chi-2-test (P-value)
How much time do you spend with your children now compared to before the pandemic?					
Much less	3.0	4.5	4.0	3.8	12.5 (0.13)
Less	4.4	16.7	3.9	8.6	
About the same	53.0	36.4	43.1	44.3	
More	38.0	40.0	49.0	41.6	
Much more	1.5	3.0	0.0	1.6	
Before the pandemic, how close was your relationship with your children?					
Not at all	1.5	3.0	4.0	2.7	4.8 (0.56)
Not very much close	16.2	15.2	19.6	16.7	
Somewhat close	73.5	65.1	70.6	569.7	
Very much close	8.8	16.7	5.9	10.8	
Has your relationship with your children changed over the course of the pandemic?					
Yes, improved	73.5	72.7	72.5	72.9	0.14 (0.99)
Yes, deteriorated	14.7	16.7	15.7	15.7	
No	11.8	10.6	11.8	11.3	

As shown in Figure 22, in this round, about 70% of participants reported that their relationship with their children had improved during the course of the COVID-19 pandemic, which is higher compared to the previous round (57%). At the same time, a lower proportion

of participants reported that their relationship with their children had deteriorated over the course of the pandemic in this round (15%) compared to the previous round (27%).

Figure 22: Parents' time spent with their children among the urban poor in nine cities in Ethiopia, August 2021 (n = 175)



Almost all respondents valued spending time with their children. About 88% of the participants also agreed that men should spend more time with their children, and more than half of them reported that they believed that men did not value caring for children as much as they should. Of the total sample of respondents, 80% felt confident in their ability to care for their children and about three-quarters felt confident in their ability to provide economic support to their children (Table 8).

Table 8: Perception of parents regarding the value of spending time with their children and their confidence in their ability to care for their children among the urban poor in nine cities in Ethiopia, August 2021

	UPSNP N(%)	SSB N(%)	IDP/ref. N(%)	Total N(%)	Chi-2-test (P-value)
Spending time with children provides value in my life					
Strongly disagree	2 (2.9)	3 (4.5)	1 (1.9)	6 (3.2)	6.1 (0.64)
Disagree	0	1 (1.5)	1 (1.9)	2 (1.08)	
Neither agree nor disagree	4(5.9)	3 (4.5)	1 (1.9)	8(4.3)	
Agree	47 (69.1)	36 (54.5)	34 (66.7)	117 (63.2)	
Strongly agree	15 (22.0)	23 (34.8)	14 (27.4)	52 (28.1)	
Total					
Men should spend time with their children					16.3 (0.04)
Strongly disagree	0 (0)	2 (3)	1 (2)	3 (1.6)	
Disagree	1 (1.5)	5 (8)	0.0	6 (3.2)	
Neither agree nor disagree	7 (10.3)	4 (6)	0.0	11 (6)	
Agree	36 (53)	28 (42)	23 (45)	87 (47)	
Strongly agree	24 (35.2)	27 (41)	27 (53)	78 (42)	
Total	68 (100)	66 (100)	51 (100)	185 (100)	
Men do not value caring for children as much as they should					
Strongly disagree	9 (13)	10 (15)	12 (24)	31 (17)	5.7 (0.7)
Disagree	13 (19)	16 (24)	11 (22)	40 (22)	
Neither agree nor disagree	7 (10)	6 (9)	3 (6)	16 (9)	
Agree	32 (47)	23 (35)	18 (35)	73 (39)	

Strongly agree	7 (10)	11 (16)	7 (14)	25 (13)	
Total	68 (100)	66 (100)	51(100)	185 (100)	
I feel confident about my ability to care for my children					
Strongly disagree	0.0	1 (1.5)	0.0	1 (0.5)	11.0 (0.2)
Disagree	7 (10.3)	1 (1.5)	4 (8)	12 (6.5)	
Neither agree nor disagree	5 (7.3)	11 (17)	4 (8)	20 (11)	
Agree	38 (56)	35 (53)	24 (47)	97 (52)	
Strongly agree	18 (26)	18 (27)	19 (37)	55 (30)	
Total	68 (100)	66 (100)	51 (100)	185 (100)	
I feel confident about my ability to provide (economically/financially)					
Strongly disagree	1 (1.5)	0.0	2 (4)	3 (1.6)	4.0 (0.86)
Disagree	12 (18)	14 (21)	9 (18)	35 (19)	
Neither agree nor disagree	5 (7)	5 (8)	4 (8)	14 (8)	
Agree	28 (41)	23 (35)	21 (41)	72 (39)	
Strongly agree	22 (32)	24 (36)	15 (29)	61 (33)	
Total	68 (100)	66 (100)	51(100)	185 (100)	

In summary, schools were closed during the data collection period. However, some schools had been open during the one-month period leading up to the data collection. Participants mentioned that their children spent their time helping them, staying at home watching TV, playing with their friends, and studying. Participants also reported that older siblings were the individuals with primary responsibility for looking after their younger siblings after schools closed. Regarding the parent–child relationship, most participants believed in the positive effect of spending time with children and mentioned that their relationship with their children had improved after COVID-19. Unlike in the previous round, no child marriage was reported. However, children's engagement in income-generating activities had slightly increased compared to the previous rounds, although this might be expected during the school holidays.

Mental health

Key findings:

- There is an increasing trend in the proportion of respondents with symptoms of probable depression and feelings of stress starting from Round 3 up to the current round (Round 5).
- The main reason for depression/stress provided by respondents in the current round was inflation in the cost of living, rather than COVID-19.

In this round, half of the respondents reported being stressed, scared, and frustrated, with significant differences across the three study groups (UPSNP beneficiaries, SSB owners, and IDPs/refugees). A fifth of the participants reported probable depressive symptoms, which were higher among UPSNP beneficiaries and lower among IDPs/refugees. However, the difference was not statistically significant. Of the total respondents, 20% had had a feeling of hopelessness and/or had had thoughts of hurting themselves within the last 14 days.

About 11% of the respondents perceived that COVID-19 and related government measures had had a negative impact on their lives, with no significant difference across participant groups (Table 9).

Table 9: Mental health measures for the urban poor in nine cities in Ethiopia, August 2021 (n = 309)

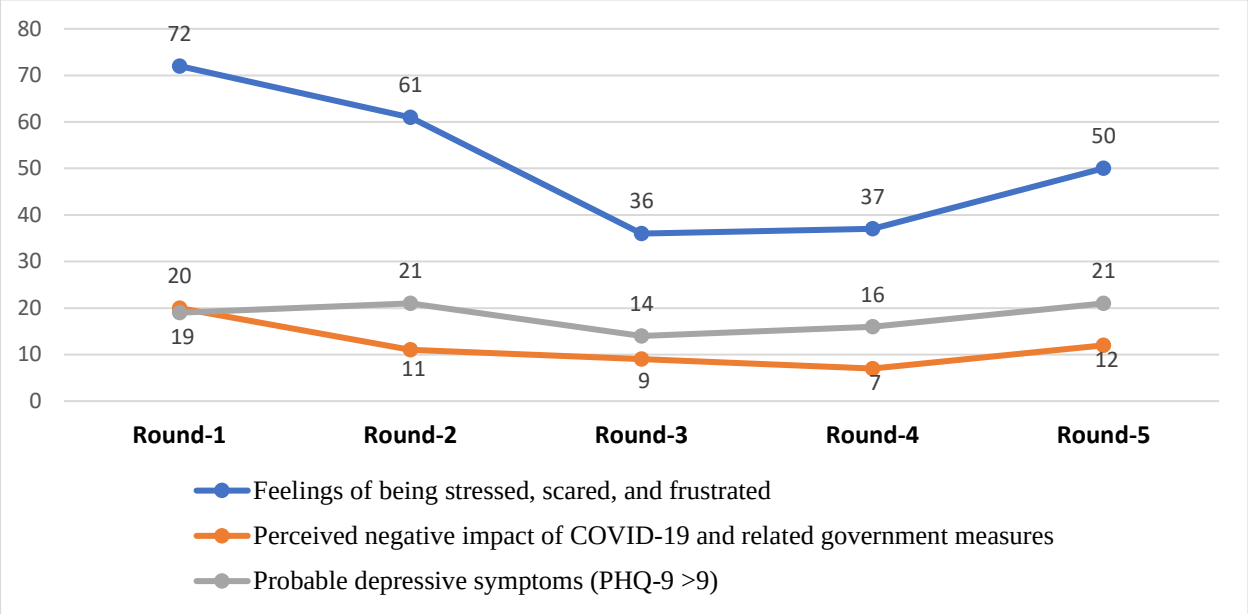
Measured outcome	Respondent category			Total N (%)	Chi-2-test (P-value)
	UPSNP N (%)	SSB N (%)	IDP/refugee N (%)		
Feelings of being stressed, scared, and frustrated	59 (38)	44 (28)	51 (33)	154 (50)	5.5 (0.06)
Probable depressive	29 (45)	20 (31)	15 (23)	64 (21)	3.9 (0.14)

symptoms (PHQ-9 >10)					
Feeling hopeless and/or having thoughts of hurting themselves					
Not at all	69 (64)	83 (77)	63 (67)	215 (70)	8.2 (0.22)
Sometimes	15 (14)	6 (5.2)	12 (13)	33 (11)	
Most of the day	23 (21)	17(16)	18 (19)	58 (19)	
Nearly every day	1 (1)	2 (1.8)	0.0	3 (1)	
Total	108 (100)	108(100)	93 (100)	309 (100)	
Perceived negative impact of COVID-19 and related government measures	14 (39)	9 (25)	135 (36)	36 (11.6)	1.8 (0.4)

The proportion of respondents reporting feeling stressed or scared decreased from Round 1 (72%) to Round 3 (36%), remained almost unchanged in Round 4 (37%) and has increased in the current round (50%). Likewise, the magnitude of probable symptoms of depression and the perceived negative impact of COVID-19 and related government measures has increased in the current round compared to previous rounds (Figure 23).

In this round, the proportion of respondents reporting probable symptoms of depression on the PHQ-9 index was significantly higher among participants from Adama and Bule Hora compared to participants from other sites (chi-square value = 268, p-value =<0.001), which is similar to the previous round.

Figure 23: Feelings of being stressed, scared, and frustrated among respondent categories among the urban poor in selected nine cities in Ethiopia, August 2021 (total n= 309)

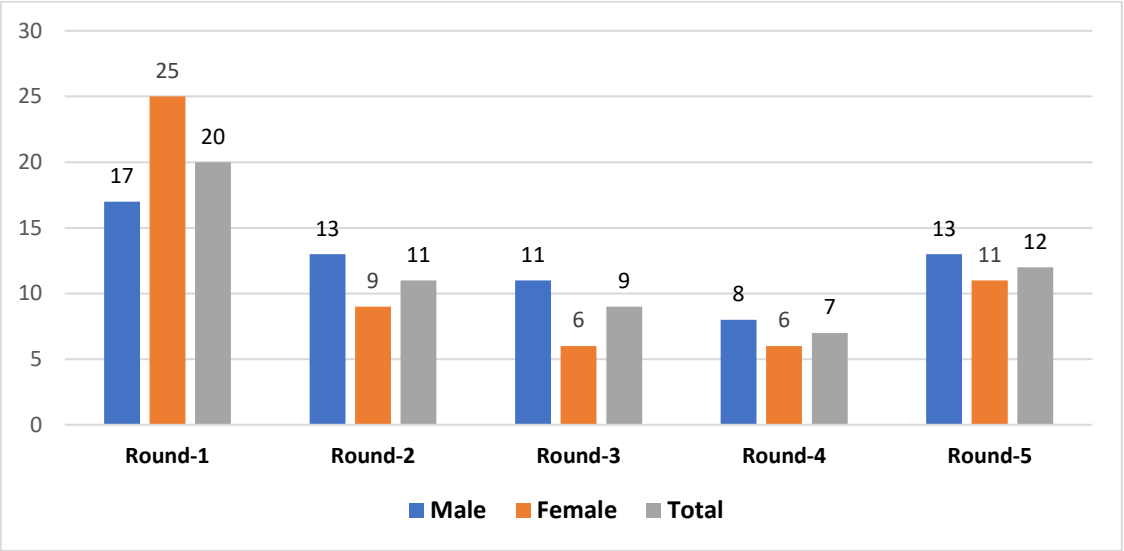


In this round, there was a slightly higher percentage of male respondents (13%) perceiving a negative impact of COVID-19, compared to female respondents (11%), but with no statistically significant difference (chi-square = 0.26; p-value 0.6) (Figure 24). The proportion of respondents reporting a perceived negative impact of COVID-19 and related government measures was significantly higher among respondents from Adama (70%) and Bule Hora (30%) compared to participants from other cities (chi-square = 113; p-value < 0.001), which is similar to the previous round.

In the qualitative study, participants from Adama mentioned various reasons for the perceived negative impact of COVID-19, such as the absence of work opportunities after COVID-19. One UPSNP beneficiary said:

> *Just, the cost of living is rising. Unlike the previous time, employers do not allow you to work rather they do it by themselves. In addition, there is no economic activity when compared to the previous time, which is so worrisome.* [UPSNP beneficiary, Adama]

Figure 24: Percentage of respondents perceiving a negative impact of COVID-19 and related government measures by gender among the urban poor in selected nine cities in Ethiopia, August 2021 (total n = 309)



Similar to the previous round, participants in the current survey round mentioned that they were not worrying too much about COVID-19, rather they were worried about job insecurity and lack of income:

> *I have not felt any stress related to COVID-19. The main thing is health and I am in good condition physically. What worried me is only the issue of job. There is no adequate job opportunity. I have worried about the lack of job and lack of income. That is the main thing that stressed me more.* [Special group respondent, Dire Dawa]

Another respondent, from Logia, also described how the inflation in the cost of items made him more worried than COVID-19 did:

> *I feel stressed right now because of the inflation and the high cost of living. Everything has increased, more than COVID-19. For example, I have to pay for food as well as rent, school fees, and other expenses. So, I wonder how I can cover these expenses. I'm also so worried about how we will live in the future.* [Special group respondent, Logia]

In the qualitative study, respondents were asked about safety and security issues for children, women, and the whole community. Most of them mentioned the conflict between the Ethiopian Government and the Tigray People's Liberation Front, which worried them in general. Participants from Afar mentioned conflict on the Tigray and Afar border and in a few places in Afar.

> *Actually, there is no specific public security problem in the place where I live. However, there are security problems all over the country, such as Amhara region, Afar region zone 4 and Tigray. So, we see a large number of defence forces in our area and the regional special police are also active. There are a lot of Afar communities which are displaced from their home because of the war in zone 4 and most of them come to Semera and Logia and the government is supporting them.* [SSB group respondent, Afar, Semera]

In summary, there is an increasing trend in the proportion of respondents reporting symptoms of stress starting after Round 1. Participants mentioned inflation in the cost of living and reduced work opportunities as causes of these feelings. The proportion of respondents reporting a perceived negative impact of COVID-19 and related government measures was significantly higher among respondents from Adama and Bule Hora compared to participants from other cities.

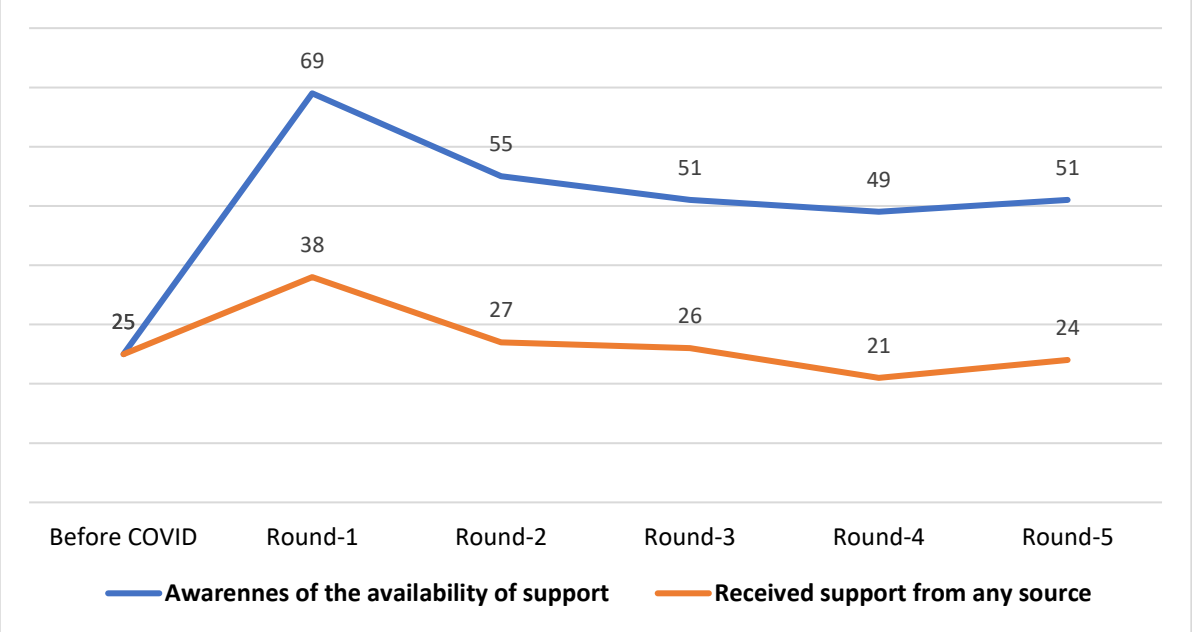
Aid and support

Key findings:

- Overall, there is no significant change in awareness about the availability of support, and respondents also reported receiving better support compared to the previous round.
- The government and NGOs remained the main sources of support for the urban poor over the past month.
- The support provided is mainly in-kind, such as food items.

In this round, about half (n=158) of the respondents reported having an awareness of the availability of support from the government, NGOs, CSOs, and other groups (e.g. religious institutions). Among those who had such awareness, only 24% actually received support. There had been a decreasing trend over the study rounds until Round 4 in the proportion of respondents who had received aid and support, but there has been a very slight increase in Round 5. In general, respondents' knowledge of the availability of support, and the proportion of those who actually received the support, has declined over time (Figure 25).

Figure 25: Percentage of respondents who were aware of the availability of support, or who received it, from any source among the urban poor in selected nine cities in Ethiopia, August 2021 (total n=309)



In line with the quantitative findings, most participants mentioned that they or their families had received support from government organisations, NGOs, or religious institutions in the

past month. The refugees mentioned that they received support mainly from NGOs like the United Nations High Commissioner for Refugees (UNHCR), whereas IDPs and UPSNP beneficiaries reported that they received support mostly from government or religious institutions

> *Currently, I don't have income or job except the support I received from UNHCR. I get support in kind like food items.* [Refugee, Afar, Logia]

Most participants in all groups (IDPs/refugees, UPSNP beneficiaries, and SSB households) received support in kind.

> *We have received support from religious institutions. They provided us food items like maize, meat, edible oil, rice, and sugar. In the past, they used to provide every 15 days, but they are now providing on monthly basis.* [UPSNP beneficiary, Somali, Jigjiga]

In Afar, participants mentioned that there were humanitarian organisations that supported vulnerable people and orphans who had lost their parents due to various causes:

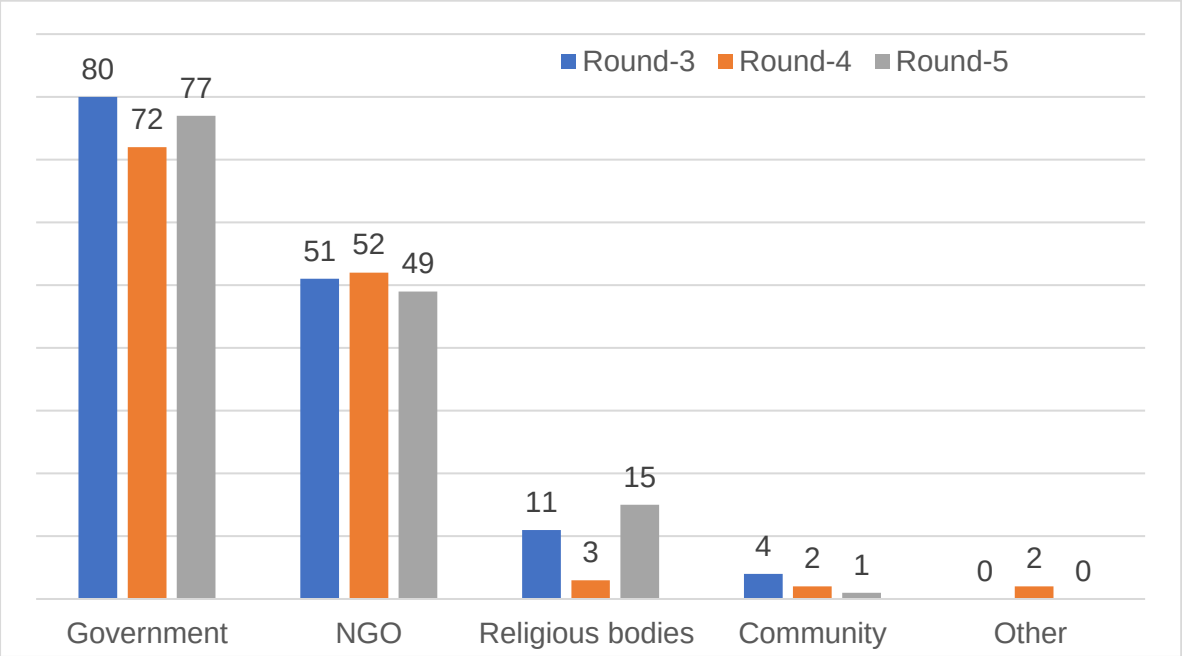
> *I don't know much about support given to disabled people. But there is an organisation that helps orphans called 'YETIM'. In addition, there are religious institutions that provide support for the vulnerable people.* [SSB group respondent, Afar, Logia]

Though most participants mentioned that they received support mostly in kind, they also indicated that the support they were getting was inadequate and inconsistent.

> *Support of government was cereals that was given us once per month and even sometimes per two or three months. There is no regular and permanent support that is provided for us and therefore we get it randomly. We have been receiving the aid regularly every month during the first months of corona outbreak. But it has slowly changed and we are not getting the aid regularly.* [IDP, Dire Dawa]

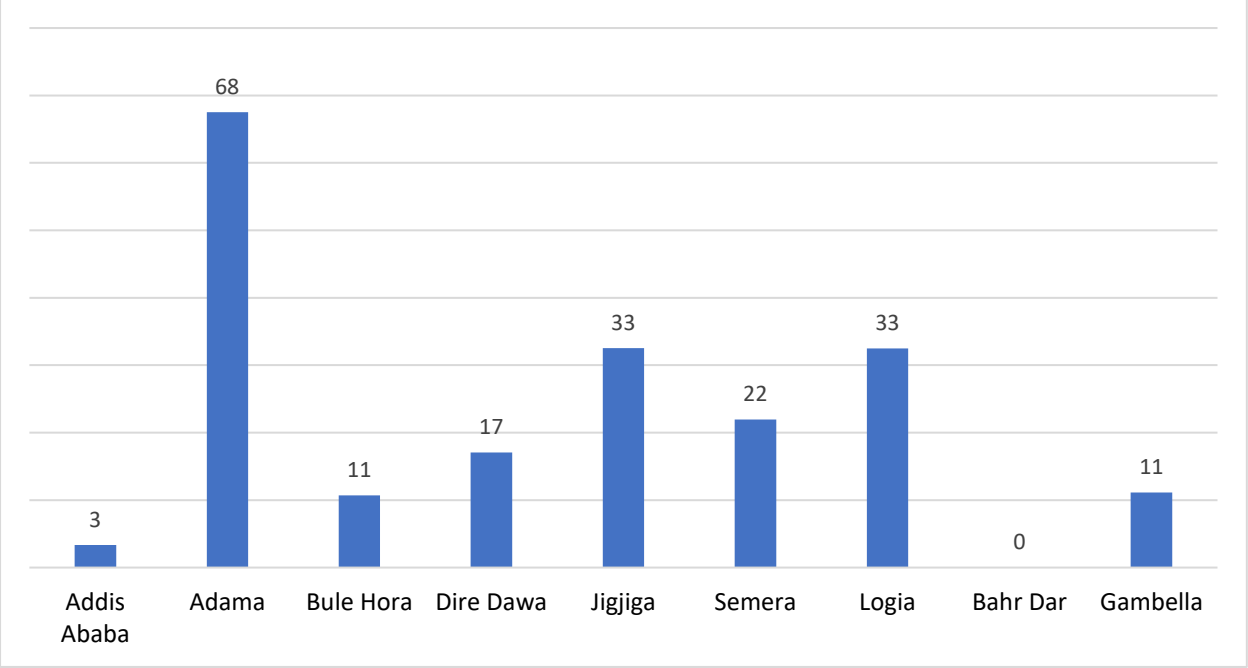
Similar to the previous round, for those who received support, the government was the main source of support, followed by NGOs. However, the amount of support received from the government in this round increased by 5 percentage points compared to the previous round. In this round, among the total participants who had received support, the support received from religious institutions (15%) was significantly higher compared to the last round (Round 4), with a 12 percentage point increase. By contrast, support from the community has declined continuously from Round 3 (4%) to Round 5 (1%).

Figure 26: Availability of aid and support among urban poor in nine cities in Ethiopia, August 2021 (total n = 309)



There were significant differences in the support received, across the nine cities (chi-square value = 67, p-value < 0.001). Similarly to the previous round, in Adama and Logia, a higher proportion of respondents reported having received support. In this round, none of the participants from Bahir Dar reported having received support. However, in the last round participants from Addis Ababa and Jigjiga also reported not receiving any support. 33% of participants from Jigjiga mentioned that they received support from different sources (Figure 27).

Figure 27: Support received, by study cities, among the urban poor in selected nine cities in Ethiopia, August 2021 (total n = 309)



In line with the quantitative findings, in the qualitative study, participants from Bahr Dar mentioned that the support that had been provided to poor during the time of COVID-19 pandemic had totally stopped

> *During the first few months after the pandemic, poor community members were also receiving support but now there is no such kind of activity, everything has stopped.* [Bahr Dar, returnee]

The total amount of money the respondents reported receiving in cash ranged from ETB 520 to ETB 1,980 (US$ 12–45) (mean = 881 and SD = 284). The estimated cost of the food support that they received ranged from ETB 200 to ETB 1,500 (US$ 4.5–34.1) (mean = 675 and SD = 245), and the estimated cost of the support they received in kind (e.g. detergents and other cleaning products, such as soap) ranged from ETB 100 to ETB 300 (US$ 2.27–6.82).

Table 10: Estimated value in ETB of support received in the form of cash, food items, and in-kind support among the urban poor in nine cities in Ethiopia, August 2021

		Round 1	Round 2	Round 3	Round 4	Round 5
Cash	Minimum	0	0	200	360	520
	Maximum	1,650	2,160	3,600	3,600	1,980
	Mean	726	976	1,071	925	881
	SD	314	466	663	562	284
Food	Minimum	0	50	200	0	200
	Maximum	3,500	3,000	1,200	1,200	1,500

	Mean	636	867	563	582	675
	SD	517	645	228	228	245
Kind	Minimum	3	35	15	0	100
	Maximum	200	500	400	400	300
	Mean	51	125	188	209	179
	SD	45	119	120	101	73

In summary, overall, there has been no significant change in awareness about the availability of support. Participants also reported receiving better support compared to the previous round. The government and NGOs remained the main sources of support for the urban poor over the past month. The support provided was mainly in-kind, such as food items. There was also a significant difference in the support received, across the nine cities, which was higher in Adama and Logia and lower in Addis Ababa and Bahir-Dar.

Conclusion

This study has assessed changes in patterns of behaviour and practices of respondents towards COVID 19 prevention measures; access to water supply; food security (availability and access); patterns in household income and expenditure; health service utilisation; education and school attendance; mental health status of respondents; and access to aid and support.

Despite the rising number of COVID-19 cases in Ethiopia, a significant number of the respondents still believe that they are not at risk of contracting the virus. The practising of COVID-19 preventive measures was found to be limited, declining significantly in this round. Only 19.4% and 46.9% of respondents reported that they were still practising handwashing and/or sanitising and using facemasks, respectively. Our results in this regard are in line with those reported in other studies.[21,22,23] Misconceptions about the existence of the disease, perceived low susceptibility, and limited enforcement of the government restrictions seem to have contributed to the limited practising of preventive measures. This is extremely alarming since such misconceptions are likely to facilitate the spread of the virus across the country. Previous studies have indicated that knowledge on the transmission and prevention of COVID-19 are significantly associated with the practising of preventive measures.[24] Our findings indicate that more rigorous information interventions and education campaigns are still of importance to address these misconceptions regarding COVID-19, particularly among the urban poor, in order to enhance practices and compliance with preventive methods and reduce the spread of the virus.

The reported willingness to accept a COVID-19 vaccine was high. A previous study conducted in Ethiopia has also documented a high intention to accept a COVID-19 vaccine.[25] Despite positive perceptions of the importance and efficacy of a COVID-19 vaccine, however, health workers and community members were concerned about vaccine safety and vaccine-related side-effects.

Shortage of water and irregular availability of the municipal water supply remain challenges for the urban poor. Households have relatively better access to water during rainy seasons (in Round 5) compared to the dry seasons. The use of rainwater as an alternative was a widely mentioned coping mechanism to overcome the problem associated with shortage in, and irregular availability of, the municipal water supply. There was disparity across the respondents from the nine cities in terms of experiencing water shortages, and the level difficulty in accessing it. The majority of respondents from Bahir Dar, Bule Hora, and Logia reported experiencing a shortage of the municipal water supply during Round 5. However, in this round, unlike the previous rounds, which took place during the dry season, the use of rainwater as an alternative water source to overcome the shortage or inadequate municipal

[21] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0249853
[22] Amsalu *et al*. (2021) 'Practice of COVID-19 Prevention Measures and Associated Factors Among Residents of Dire Dawa City, Eastern Ethiopia: Community-Based Study', *Journal of Multidisciplinary Healthcare* 14. http://documents1.worldbank.org/curated/en/678511608616662907/pdf/Monitoring-COVID-19-Impacts-on-Households-in-Ethiopia-Results-from-Six-Rounds-of-High-Frequency-Household-Phone-Surveys.pdf.
[23] http://documents1.worldbank.org/curated/en/678511608616662907/pdf/Monitoring-COVID-19-Impacts-on-Households-in-Ethiopia-Results-from-Six-Rounds-of-High-Frequency-Household-Phone-Surveys.pdf. www.ncbi.nlm.nih.gov/pmc/articles/PMC7956895/
[24] https://pubmed.ncbi.nlm.nih.gov/33705480/
[25] https://africacdc.org/download/covid-19-vaccine-perceptions-a-15-country-study/

water supply was mentioned by the qualitative study participants from all cities. The economic burden associated with the cost of purchasing and transporting water, as well as travelling distances to get water, present additional challenges to the urban poor included in our study, as reported in all five rounds.

There has been a significant improvement in the respondents' ability to work and earn income comparable with that of the pre-pandemic period. In this round, most of the respondents reported earning a comparable income to that gained during the pre-COVID-19 pandemic. At the same time, the average monthly income of households has increased across the five rounds. However, there is a conflicting picture between the quantitative respondents and qualitative interview respondents with respect to incomes. While the quantitative respondents reported seeing their income increase over the five rounds, the qualitative interview respondents reported that their income has not changed, and some reported having less income than before COVID-19. More importantly, the qualitative study participants widely mentioned the inadequacy of their income to cover basic expenses for food and shelter due to the decline in the purchasing power of the Birr as a result of significant increases in the price of food items.

Despite the general improvement in the pattern of income, the majority of households are suffering because of the inadequacy of their income to cover their basic expenses, mainly due to the increase in the price of food. The qualitative study participants revealed significant changes in the pattern of their expenditure because of the significant increase in the price of basic life-sustaining items, mainly food. The purchasing power of money (Birr) has declined because of inflation, which has resulted in a doubling of household monthly expenses. In general, the economic problems (income and expenditure) are believed to be the result of inflation (the rise in food prices) and the decline in the purchasing power of the Birr, as well as the decline in economic activities and transactions because of the war. The effect of COVID-19 and associated restrictions on income/expenditure were less emphasised by respondents in this round.

There has been no improvement in the availability and consumption of food in terms of the number of meals consumed per day, compared to the previous round. The major reasons given for the incidence of food shortages and decreased consumption of food were lack of income and the increase in the price of food items. The main reported coping strategies for both the lack of income and food insecurity included reducing the quantity and quality of food, using up savings, and obtaining help from family members. Food items that are assumed to be more nutritious (eggs, meat, milk) were less often consumed as households were purchasing less or had stopped buying them altogether because of the increase in their price. Overall, the decreased consumption and the reduction in the purchase of nutritious food items can be considered a proxy indicator for the existence of food insecurity.

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

In this round, schools were closed in all cities for the annual break (the Ethiopian summer season break), and the students spent their time helping their parents, staying at home watching TV, and playing with their friends. The majority of the respondents indicated that their child–parent relationship had improved because of spending more time with their children during Round 5. No child marriages were reported during this round.

The proportion of respondents who reported feeling stressed due to COVID-19 has increased during Round 5. The proportion had declined across the previous four rounds (Round 1 to Round 4), but has sharply increased in the current round. Similarly, the magnitude of probable symptoms of depression (according to the PHQ-9 index) has significantly increased in this round, compared to previous rounds. In line with the previous round, most of the qualitative study participants mentioned a lack of income, and inflation (increased food prices), as major contributing factors resulting in stress and depression. The effect of COVID-19 and associated restrictions on the observed level of stress or depression was not highlighted by the respondents during the current round.

The proportion of respondents that reported receiving aid and support has slightly increased in the current round. Like in previous rounds, governmental organisations, NGOs and religious institutions are the major sources from which respondents receive aid and support. The refugees mainly receive support from NGOs like UNHCR, whereas IDPs and UPSNP beneficiaries mostly receive support from government or religious institutions. The proportion of respondents who reported receiving support was highest in Adama, whereas none of the respondents from Bahir Dar reported receiving support during Round 5.

Overall, the findings of this study indicate that the urban poor are still struggling to cope with multiple challenges, particularly the inadequacy of their income to cover their basic needs, the increase in food prices, and the lack of access to clean and adequate water. At the same time, the mental health problem (i.e. increased levels of stress and depression) is getting worse for the urban poor due to high food prices, the decline in economic activity, and the inadequacy of household income to buy food, which increases stress, anxiety, and depression. Despite the rising number of COVID-19 cases and deaths, the practising of COVID-19 preventive measures has declined significantly across the five rounds. Most of the respondents do not perceive themselves to be at risk of contracting the virus. Moreover, the enforcement of COVID-19 prevention measures (i.e. the obligation to wear a facemask and handwashing or using sanitiser) in public places (marketplaces, restaurants, on transportation) and before entering public institutions (such as banks) seems to be neglected or required less during this round. False beliefs, misinformation, and the lack of an advocacy campaign seem to have contributed to this change in behaviour. As mentioned in the previous round report, there is an urgent need for the government to provide the correct information about the pandemic and why it is important to practise handwashing, social distancing, and the wearing of facemasks.

Case studies

Case Study 1 (continued from Round 1 to Round 5)

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

Mrs. Lelo believes that the spread of COVID-19 is decreasing. She explains that awareness campaigns about COVID-19 are not active anymore as it is believed that the community has adequate information about it. *'About a few months back, we have heard that there were some individuals who were infected by this virus. But now, we have no information if there are people infected with the virus. They used to create awareness using 'Bajaj'. The reason why they are not doing this now is that people have already got awareness.'*

Mrs. Lelo shares her observation that COVID-19 prevention methods are limited in her community. *'To be honest, they are not doing these [waring a facemask, frequent handwashing] right now, which they used to practice when COVID-19 outbreak was first reported in Ethiopia.'*

Throughout the rounds, Mrs. Lelo has consistently mentioned a shortage of water supply. *'We have been continuously reporting that we do not have water from the very beginning. But we have not seen anyone who listened to us. We do not have water and we are paying 10 Birr, for the larger 'Jerrycan' to collect water using horse from distant places.'*

In the previous rounds, Mrs Lelo explained how the COVID-19 pandemic and the government restrictions following the pandemic had affected her daily life and her ability to feed her family. A key impact she mentioned was reduced work opportunities. Although she reported an increase in her income in Round 2, her income decreased in Round 4 due to the limited supply of chat/khat, which she sells. In round 5, Mrs. Lelo has stopped selling chat/khat due to increasing price and is planning to start a new business: '*Since the price of Chat/khat increased this summer and it is not profitable, I have not been working for the past 2 months and now I am thinking on how to shift to other jobs.'* She explains that because her income has reduced, she is forced to use her savings and to also reduce her expenditure.

Similar to previous rounds, the escalating food prices is the main challenge for Mrs. Lelo and other IDPs in the area. *'It [food price] has increased. We used to buy 5 litters of Food Oil for around 300 birr. But now, its price is around 600 Birr.'*

According to Mrs Lelo, the increase in food prices is not related to COVID-19: *'I do not think it is related with COVID-19. Whenever you ask the reason for the rise in commodity prices, they tell you it is due to the increase in the exchange rate (forex)*.'

Mrs. Lelo explains that life is becoming increasingly difficult for her family and the IDPs in the area as they have not received any support from the government: *'There are many refugees who came from Somali region to the place where I am living right now. If truth can be told, there is no one who provides any support for anyone either from the government or from community members. People are just handling the situation by themselves.'*

According to Mrs Lelo, the community has limited access to health facilities and patients are expected to travel long distances to get health services, which affects access to essential health services. She explains that fear of being infected with the coronavirus has not prevented women from visiting health facilities for maternal health services including family planning, however. Mrs. Lelo is currently working as a volunteer with the Ethiopian Family Guidance Association. *'I provide voluntary service to the family guidance [association]. We advise them [women] that they should not hesitate to use family planning due to fear of COVID-19. We advise them to use these services [family planning] by taking appropriate care. Thus, there is no one who failed to use this service due to fear of COVID-19.'*

Annex A: Disparities in key variables by city

Key indicators/variables	Addis Ababa	Adama	Bule Hora	Dire Dawa	Jigjiga	Semera	Logia	Bahir Dar	Mekelle	Gambela	Total
Behaviour in response to COVID-19: Round 5 (all figures are percentages)											
Proportion of respondents who reported practising washing hands frequently with soap and water and/or hand-rubbing with a sanitiser or alcohol-based solution	36.7	35.0	14.3	19.5	11.6	2.4	12.5	21.6	NA	44.4	19.4
Proportion of respondents who reported practising wearing a facemask	16.7	37.5	10.7	22.0	81.4	97.6	72.5	16.2	NA	33.3	46.9
Proportion of respondents who reported practising physical distancing	3.3	2.5	7.1	0.0	0.0	0.0	0.0	10.8	NA	0.0	2.6
Proportion of respondents who reported all family members wearing a facemask all the time	90.0	72.5	10.7	22.0	0.0	0.0	7.5	2.7	NA	0.0	23.3
Proportion of respondents who reported that they believe that they could still be infected with the coronavirus	86.7	100.0	85.7	100.0	27.9	95.1	32.5	48.6	NA	88.9	71.5
Health (all figures are percentages): Round 5											
Proportion of participants that needed any medical treatment since the last round of the survey	20.0	45.0	50.0	17.1	2.3	2.4	17.5	0.0	NA	11.1	17.8
Proportion of participants/members that needed medical treatment and have had access to health services	100.0	100.0	100.0	100.0	100.0	100.0	100.0	NA	100.0	0.0	98.2
Proportion of households whose member(s) needed any medical treatment since the COVID-19 outbreak	16.7	5.0	10.7	2.4	2.3	29.3	12.5	0.0	NA	0.0	9.4
Proportion of households whose member(s) needed medical treatment and have had access to health services	100	100	100	100	100.0	100	100	NA	NA	NA	100
Mental health: Round 5 (all figures are percentages)											

Proportion of respondents who perceived a negative impact of COVID-19 and associated responses on mental health	0.0	55.0	35.7	0.00	2.33	0.0	2.5	5.4	NA	0.0	11.6
Proportion of respondents feeling stressed, scared, or/and worried during the past month	43.3	100	89.2	34.1	74.4	2.4	72.5	0	NA	0	49.8
Proportion of respondents with probable symptoms of depression (cut-off point =10)	100.00	78.5	20.6	2.44	0	0	0	0	NA	11.1	20.7
Aid and support: Round 5											
Proportion of respondents who are aware of any relief being provided to address the impacts of COVID-19	0.0	95.0	25.0	36.5	65.1	100.0	50.00	2.7	NA	88.8	51.1
Proportion of households/household members who received aid from any institution after the COVID-19 pandemic	3.3	67.5	10.7	17.0	32.5	21.9	32.5	0.0	NA	11.1	24.2
Total sample/observations (in number)	30	40	28	41	43	41	40	37	NA	9	309