Monitoring COVID-19 Impacts on Households in Ethiopia

REPORT NO. 9
30 / April / 2021
WORLD BANK GROUP

How COVID-19 is affecting households in Ethiopia:

Results from the High-Frequency Phone Surveys of Households from April 2020 through January 2021

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INTRODUCTION

The Ethiopia High Frequency Phone Survey of Households (HFPS-HH) is conducted by the World Bank every four weeks to collect timely data to help monitor the economic and social effects of COVID-19 on households, relieve the impacts, and protect the welfare of the least-well-off Ethiopians. The HFPS-HH is a subsample of the national longitudinal Ethiopia Socioeconomic Survey (ESS), which the Central Statistical Agency (CSA) and the World Bank carried out in 2019, that was representative of households with access to a working phone. The same households are being tracked over 12 months, with selected respondents, typically the household head, completing phone-based interviews every three to four weeks. Frequent follow-up allows for better understanding of the household effects to the pandemic in near real time to support prompt, evidence-based responses. This brief summarizes the survey findings as of January 2021 with emphasis on the three rounds fielded between October 2020 and January 2021 (Box 1).[2] The 15–20-minute questionnaires for these three rounds covered topics such as access to basic staple food items and medicines, educational activities of children after schools reopened in Ethiopia, access to health care services, employment dynamics, household debt, post-harvest agricultural activities, water and sanitation, and assistance received.

SUMMARY OF KEY FINDINGS

- The survey monitored household access to basic food items and essential medicine during the pandemic. Between October 2020 and January 2021, 70–75 percent of households were able to buy enough of most basic items; the rest were not able to do so due to higher prices or less regular income.
- As in previous rounds, in January 2021 about 27 percent of households were in need of health services, but about 90 percent of those households were able to access them. The remaining 10 percent were not able to receive the services, mainly due to lack of money, facility closures, or supply shortages in health care facilities.
- In-person classes resumed for the majority of children in October 2020, with schools reopening in phases starting from rural areas then moving on first to small towns and then to large urban areas. About 59 percent of households with school-age children that had attended school before the pandemic reported that their children were attending in-person classes at the time of the interview.
- More households have taken out loans since the outbreak of COVID-19. Nationally, 40 percent of households reported taking out loans from any source since the outbreak began, compared to 10 percent pre-COVID. Households most often borrow from relatives and friends and most often to buy food and household supplies.
- The COVID-19 pandemic had only small effects on farmers in Ethiopia; most farming households were able to continue normal farming activities. The few farmers that were affected by the pandemic reported mobility restrictions at the outset as the main reason. Over time, however, COVID-19 related restrictions on movement eased, though other factors, such as weather, affected farming activities.
- At the onset of the pandemic, 8 percent of respondents had lost jobs but employment recovered quickly. By September 2020, employment rates reached pre-COVID levels. However, the quality of employment seemed to have been affected, with respondents working in more vulnerable jobs than previously.

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Acknowledgements: Laterite BV Ltd. Collected the data. Anne Grant provided editorial assistance.

In April 2020, only about 8 percent of households reported receiving any assistance from either government or nongovernment sources. By November 2020, even fewer households (3.1 percent) received assistance but that rebounded to 5.3 percent in January 2021. For households that received assistance, food aid was the main source and until November 2020 the government was the most important provider of assistance.

ACCESS TO BASIC NEEDS

Respondents were asked whether their household was able to buy enough medicine and enough of the most important food items during the seven days preceding the interview.[3] When they were not, they were asked for the main reasons. From April to November 2020, most households were able to buy the items they needed. Of the five items that the HFPS monitored (Figure 1), teff was the scarcest: one-third of households reported not being able to buy enough. Fewer households (by 9 percentage points) were able to buy maize in November than in April. All other staple food items maintained their baseline profiles. On the other hand, the ability to buy medicine increased from 71 percent of households in April to 94 percent in November 2020.

Figure 1: Ability of Households to Buy Certain Items, R1-R7, Percent

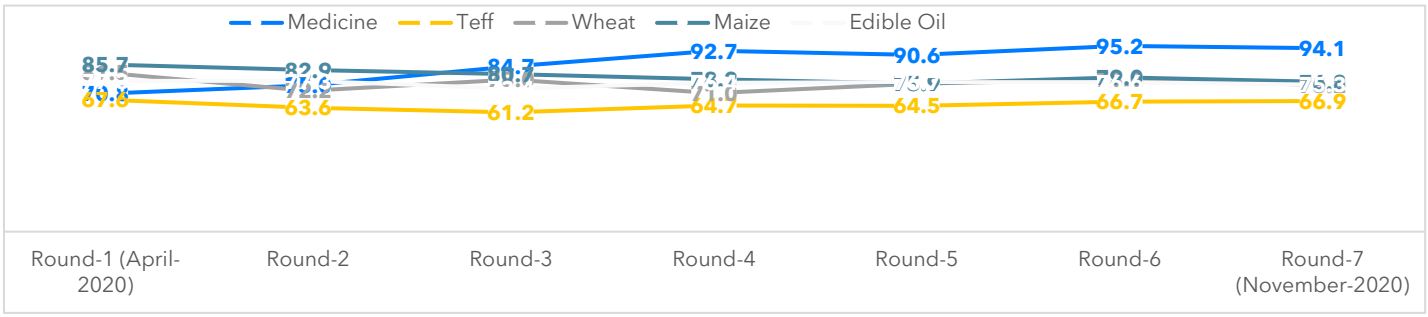
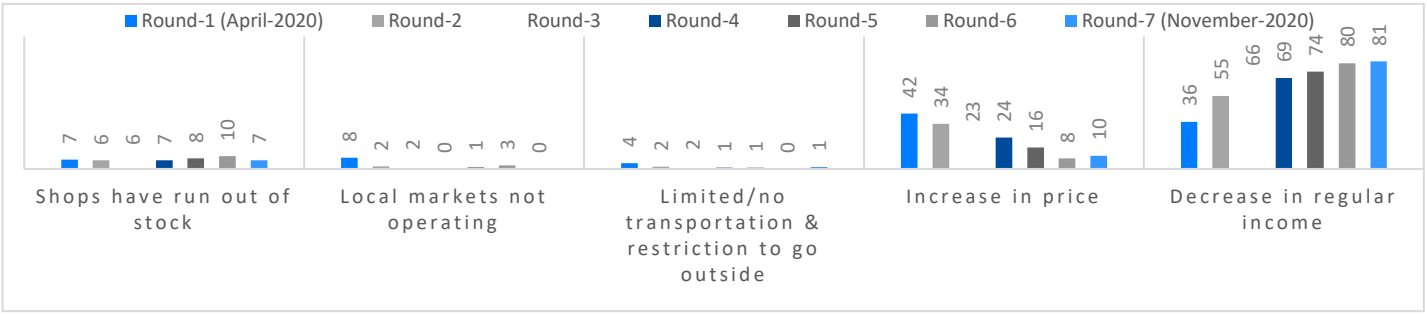


Figure 2 shows why households were not able to buy enough of basic items. Among the reasons were less regular income, higher item prices, stores running out of stock, and market and transport restrictions. Lack of affordability, due to higher prices or less regular income, was a concern for over 90 percent of households that were not able to buy enough food. However, over time, changes in item prices lost importance and lower income gained.

Figure 2: Reasons for Inability to Buy Certain Items, R1-R6, Percent



ACCESS TO HEALTH SERVICES

Respondents were asked whether they needed medical treatment or needed to visit health facilities for consultations during the four weeks preceding the interview.[4] If they needed health care, they were asked if they were able to access it. Between April 2020 and January 2021 (figure 3), less than one-third of the households were in need of either treatment or consultation, and for most of these access was not a problem. While the percentage of households needing medical attention remained below 40 percent, it fluctuated over time, with the lowest share in April (17 percent) and the highest in December (38 percent). Among the 10 percent of households that were not able to access medical services or consultation, the main reasons were lack of money, facility closures, and supply shortages in the facilities (Table 1). Respondents were also asked to identify the type of health services they were seeking; adult and child health services were the most common (Table 1).

[3] According to the 2018–19 ESS, the four most important food items are edible oil, teff, wheat, and maize as grain or as flour or cooked.
[4] The recall period for the first round was from the date of the outbreak of COVID 19 to the date of interview instead of 4 weeks.

Figure 3: Needing and Accessing Medical Treatment and Consultation, R1-R9, Percent

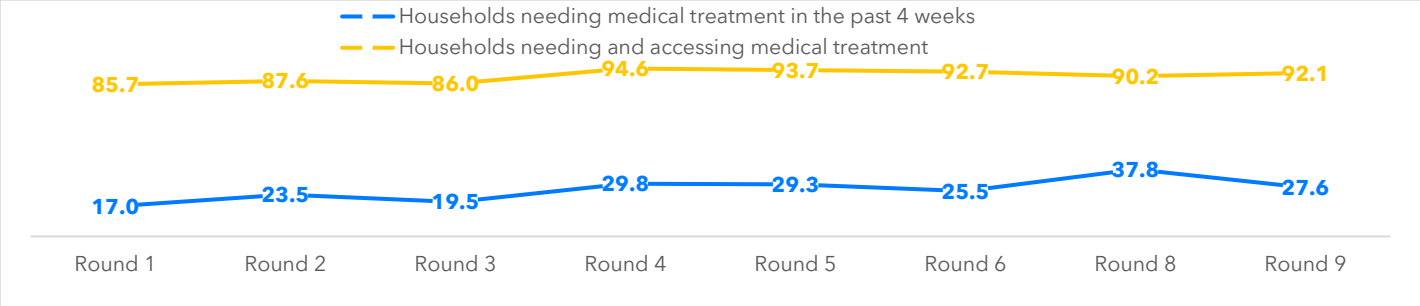


Table 1. Household Access to Health Services During COVID-19, R8 and R9, Percent

	R8 (Dec 2020)	R9 (Jan 2021)
Could not access	10.1	8.1
Could not access: Rural	11.6	9.6
Could not access: Urban	7.3	5.2
Reason for inability to access		
Lack of money	28.4	25.1
No medical personnel available	17.1	6.7
Turned away because facility was full	0.0	0.0
Turned away because facility was closed	37.1	15.3
Hospital/clinic not having enough supplies or tests	17.3	40.5
Health facility too far	0.0	12.4
Restrictions on going outside	0.1	0.0
Type of health services in demand		
Family planning	0.3	0.5
Vaccination	3.2	2.5
Maternal health	4.1	7.1
Child health	25.0	34.4
Adult health	63.5	50.8
Emergency care	10.1	12.8
Pharmacy	4.6	11.6

SCHOOLS

On March 16th, 2020, Ethiopia closed all primary and secondary schools; for more than seven months, children were out of the classroom. Over 26 million students were affected, and more than 700,000 teachers and school management employees were out of work. Although some children were able to access distance learning, many, especially those in remote rural areas, were unable to do so.

In-person classes resumed for the majority of children in October 2020, with schools reopening in phases, starting with rural areas, then small towns, and then large urban areas. In R8, the HFPS collected information on education at individual child level[5] to monitor school reopening, registration and attendance for each school age child in the household . The results are presented in Tables 2 and 3.

Only 59 percent of households with school-aged children reported that their children who had attended school before the outbreak attended in-person classes once schools reopened; there were few differences between urban and rural areas. Most children whose schools had reopened (94 percent) attended in-person classes (with more girls than boys), which suggests high willingness to return to school.

About 67 percent of children aged 3 to 22 (inclusive) were registered to attend classes for the 2020/21 school year. There were no significant differences between rural and urban children with respect to school registration but about one quarter of urban children were in private schools and almost all rural children in public schools. For households that did not register their children for school, the main reasons were the delayed registration process, the need to participate in income-generating activities, and children dropping out because they had missed too much schooling to catch up.

Table 2: Registration and School Continuation during the 2020/21 school year, R8, Percent

	Rural	Urban	National
Children who had attended before COVID-19 that were attending at time of interview	58.1	61.4	58.9
Children who had attended before COVID-19 that did not attend at time of interview	41.9	38.6	41.1
Attendance by gender			

[5] Previous survey rounds collected information only for the entire household and the results were at household level.

Girls among those attending	51.4	52.5	51.7
Girls that attended (among all girls in the sample)	60.7	62.2	61.1
Boys that attended (among all boys in the sample)	55.5	60.4	56.7
Children registered in school	66.4	68.1	66.8
Children registered in government schools	97.5	76.6	92.6
Children registered in non-government schools	2.5	23.4	7.4
Reasons for not registering			
School did not reopen	23.6	23.3	23.6
Must contribute to household finances	18.0	19.2	18.2
Married/pregnant	5.4	7.7	5.9
Cannot afford school	1.2	11.8	3.5
Has missed too much schooling to catch up	12.0	4.1	10.3

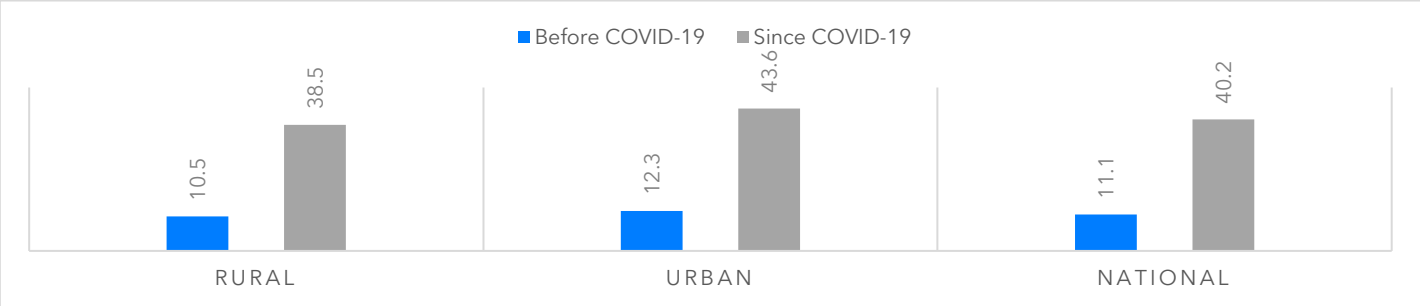
Notes: Children are defined as individuals between ages 3 and 22 (inclusive). In R8 the education module was answered by individual members in contrast to previous rounds where one respondent answered yes/no to account for the whole household.

HOUSEHOLD DEBT

Following the onset of the pandemic, the survey monitored losses in household income and copping strategies to mitigate the loss. One of the strategies that the households used is loan from formal and informal sources. In December 2020, about 8 months into the pandemic, the survey included a credit module: Respondents were asked if they had borrowed ETB 150 or more from any source since the outbreak began. If they had, they were asked the reasons for borrowing money and the payment arrangements.

Figure 4 shows borrowing behavior before and since-COVID-19. More households, both rural and urban, reported taking loans during the pandemic than they had pre-COVID. Nationally, 4 out of 10 households reported taking a loan from any source since COVID-19 compared to 1 in 10 households pre-COVID-19.

Figure 4: Household Taking Out Loans Before and Since COVID-19, R8, Percent



The most important reason for taking out a loan both before and since COVID-19 was to buy food, followed by purchasing agricultural inputs (Table 3), but taking out loans to cover household food consumption and healthcare costs increased as a result of the pandemic.

Table 3. Reasons for Borrowing, R8, Percent

	Before COVID-19	Since COVID-19
Household food and supplies	44.4	62.8
Purchase of agric. inputs (food crops)	17.5	11.3
Hospital visits, health care	2.8	11.3
Purchase of agric. inputs (other crops)	7.6	8.5
Other reasons	41.9	17.7

Most households reported informal borrowing from friends, neighbors, and relatives (Table 4); formal financial institutions had a limited role. Formal sources did not finance purchases for consumption purposes and for medical expenses.

Table 4. Source of Loans since-COVID, R8, Percent

	Rural	Urban	National
Friend	19.8	39.8	26.9
Neighbor	36.0	21.6	30.9
Relative	19.1	18.2	18.8
Grocery/ local merchant	11.7	15.0	12.9
Microfinance institution	10.2	5.8	8.6
SACCOs	6.3	4.6	5.7
Other sources*	6.4	1.6	4.7

ASSISTANCE AND SUPPORT

Although households were hit hard by the COVID-19 pandemic and experienced serious losses of income, few reported receiving assistance from institutions. Table 6 shows assistance provided to households by both government and nongovernment sources. In April 2020 about 8 percent of households reported receiving

assistance. Results from subsequent rounds show fluctuations in the proportion of households reporting assistance, with substantial changes in the types and sources of assistance received: Households receiving free food assistance doubled from April to December. Direct cash support was the second most common assistance type reported but this type declined substantially between April and December. At the beginning of the pandemic government was the main source of assistance and contributed about 71 percent of total assistance. However, the role of government providing assistance declined in December with assistance from non-governmental organizations becoming more prominent (Table 5).

Table 5: Assistance to Households since the COVID-19 Outbreak, Type and Source, Percent

	Round 1	Round 2	Round 3	Round 4	Round 5	Round 6	Round 7	Round 9
Household received assistance: Any source	7.8	5.7	3.8	6.9	4.0	3.4	3.1	5.3
Assistance type: Free food	47.2	39.3	66.9	60.2	64.0	74.5	68.2	75.9
Assistance type: Food or cash for work	15.7	16.8	2.5	8.0	22.2	6.4	0.5	9.1
Assistance type: Direct cash transfer	38.6	39.9	31.8	32.6	17.6	19.2	33.3	15.1
Assistance source: Government	76.9	70.9	72.4	70.6	75.2	57.1	59.2	44.2
Assistance source: NGO	11.8	16.9	5.6	12.0	17.8	38.2	30.3	48.6
Assistance source: Religious organization	4.2	5.7	10.4	12.7	6.3	1.6	6.2	5.8
Assistance source: Volunteer or youth organization	7.0	2.1	3.4	2.4	2.6	2.5	2.3	0.1

Notes: In round 1, the question asks for assistance received since the outbreak. In rounds 2 to 7, the question asks for assistance received in the last month. Assistance source and type conditional on household receiving assistance.

EMPLOYMENT AND MIGRATION

At the onset of the pandemic in April 2020, 8 percent of respondents lost their jobs; of these 63 percent cited COVID-19 as the main reason. Job loss was more severe in urban (20 percent) than in rural (3 percent) areas. Yet employment recovered quickly; by October 2020 (R6), employment rates were similar to pre-COVID rates (Figure 5). However, although jobs were recovering, respondents moved from more stable to more vulnerable types of jobs, such as self-employment, casual employment, and family work (Figure 6). Moreover, nonfarm household businesses have still not recovered to pre-COVID levels. In April 2020, 23 percent of households surveyed owned a business but in September that was down to 19 percent.

Figure 5: Respondents who Worked in the 7 Days Preceding the Interview, R1-R9, Percent

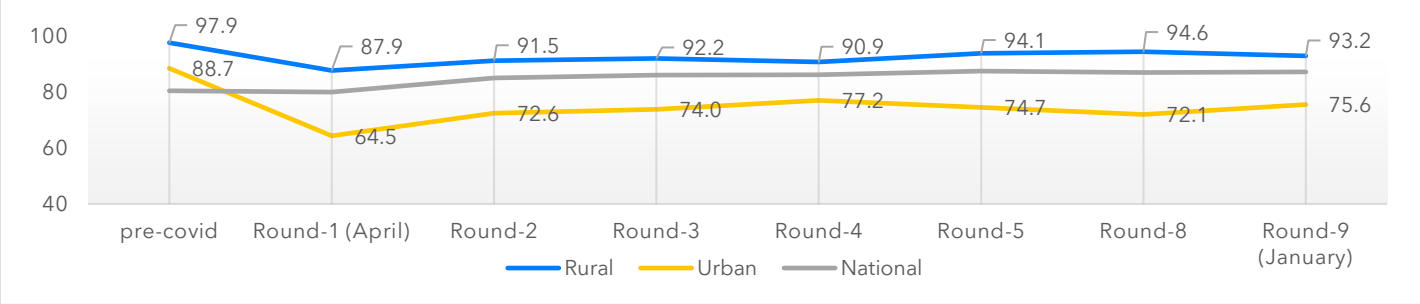
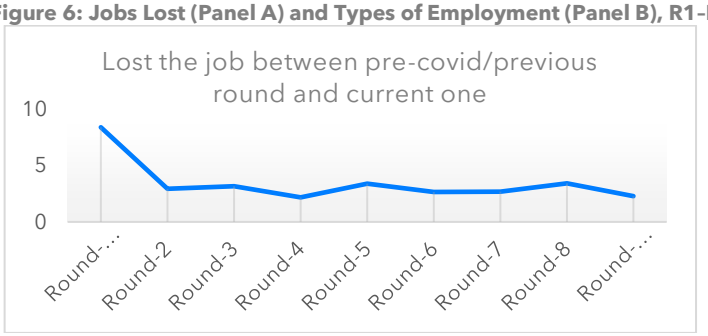
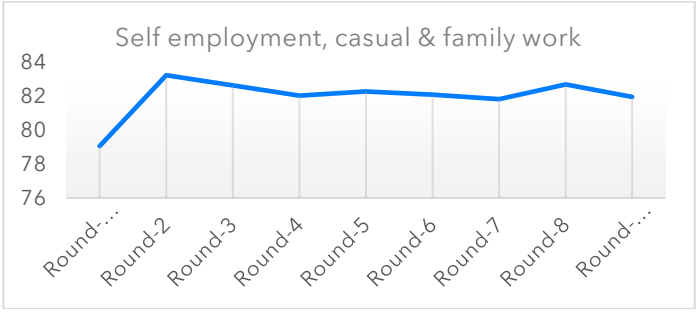


Figure 6: Jobs Lost (Panel A) and Types of Employment (Panel B), R1-R9, Percent





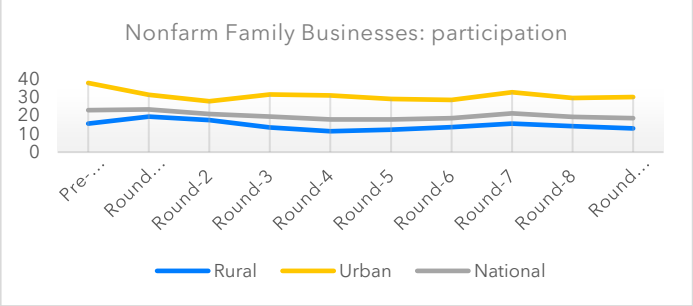
NONFARM FAMILY BUSINESS

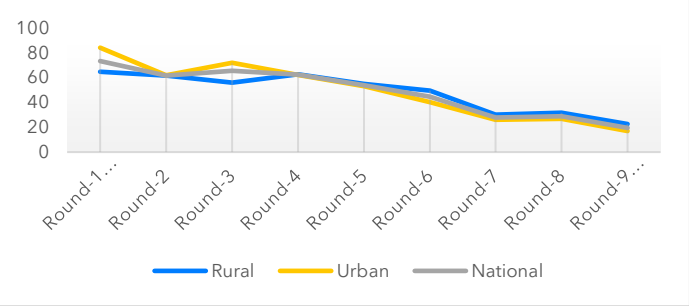
Before the COVID-19 pandemic, almost 25 percent of households in Ethiopia owned a nonfarm business—16 percent in rural and 38 percent in urban areas. Many such businesses closed early in the pandemic and in April 2020, only about 23 percent of households owned a business. That share remained relatively stable except for the November 2020 round (R7) when fewer households reported owning a business (Figure 7).

For those households still operating a nonfarm business at the time of the first survey round in April 2020, over two-thirds indicated that business income was lower than had been usual. To some extent income improved over

time but in January 2021, about 20 percent of households with a family business reported a decline in income (Figure 7).

Figure 7: Nonfarm Family Businesses (Panel A) and Loss of Business Income (Panel B), R1 and R9, Percent





COMING ACTIVITIES

This survey brief is the ninth in a series reporting on the findings of the HFPS-HH. It reports results from round 1 to round 9 on the effects of and responses to the COVID-19 pandemic in Ethiopia. Data collection will continue by following up with the same households in February, April, and May 2021. For each round, the survey brief, table of indicators, and microdata will be available at https://www.worldbank.org/en/country/ethiopia/brief/phone-survey-data-monitoring-covid-19-impact-on-firms-and-households-in-ethiopia.

BOX: SURVEY METHODOLOGY

The HFPS-HH sample is a subsample—households with access to a phone—of those interviewed in 2019 for the Ethiopia Socioeconomic Survey (ESS), which covers urban and rural areas in all regions of Ethiopia. Phone penetration in rural Ethiopia is low; about 40 percent of rural households have access to a phone compared to over 90 percent of urban households. This not only means that the rural sample is smaller but there is also a systematic difference between households that have access to a phone and those that have not. Phone-owning households are better off in terms of total consumption, educational attainment, access to improved water and sanitation, access to assets, and access to electricity. The sample of the HFMP-HH is therefore representative only of households that have access to phones in urban and rural Ethiopia. The respondent is typically the household head and due to this individual-level results such as employment are only representative of this group.

In Round 1, in April 2020, the HFPS-HH called all the 5,374 households that in the ESS had provided a valid phone number; of these, 3,249 households consented to be interviewed. The subsequent rounds attempted to reach the same 3,249 households. Table 6 shows the number of interviews completed in rural and urban areas and modules as of Round 9. There has been some attrition starting from the second round of the survey in May/June 2020. However, the drop in Round 8 was higher than the trend due to internet and telephone network interruptions as the security situation worsened in some parts of the country.

Table 6: Number of Completed Interviews by Round

	Round 1 (Apr 22-May 13, 2020)	Round 2 (May 14-June 3, 2020)	Round 3 (June 4-26, 2020)	Round 4 (July 27-Aug14, 2020)	Round 5 (Aug 24-Sep 17, 2020)	Round 6 (Sep 21- Oct 13, 2020)	Round 7 (Oct 19-Nov 10, 2020)	Round 8 (Dec1-21, 2020)	Round 9 (Dec. 28, 2020- Jan 22, 2021)
Rural	978	940	934	838	775	760	716	576	553
Urban	2,271	2,167	2,124	2,040	1,995	1,944	1,821	1,646	1,524
National	3,249	3,107	3,058	2,878	2,770	2,704	2,537	2,222	2,074