THE SOCIO-ECONOMIC IMPACT OF COVID-19 ON YOUNG PEOPLE IN ETHIOPIA

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COVID-19 and the Youth Question in Africa: Impact, Response and Protection Measures in the IGAD Region Project

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The SOCIO-ECONOMIC IMPACT OF COVID-19 ON YOUNG PEOPLE IN ETHIOPIA

Consortium of Christian Relief and Development Association

In collaboration with

Organization for Social Science Research in Eastern and Southern Africa

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Acronyms

APA - American Psychological Association

CCRDA- Consortium of Christian Relief and Development Association

CSO – Civil Society Organization

EPHI - Ethiopian Public Health Institute

GDP - Gross Domestic Product

ICU - Intensive Care Unit

IRB - Institutional Review Board

IVR - Interactive voice response

OSSREA - Organization for Social Science Research in Eastern and Southern Africa

SDGs - Sustainable Development Goals

SoE - State of Emergency

SSA - Sub-Saharan Africa

SPSS - Statistical Package for Social Science

WASH - Water, Sanitation and Hygiene

Key Findings

- Almost all (96%) of the respondents have reported that they have received information on local distancing and self-isolation as a preventive measure against the coronavirus.
- About one third (31%) of the respondents were not satisfied by the government's response to the coronavirus crisis. Among the reasons for not being satisfied with the national or regional government's response, are existence of no financial assistance by the government, shortage of medical material, late response by government and limited testing points.
- About 40% of the participants reported that a member of their family has needed medical service since the pandemic. But among those who needed the service, more than one third (35%) were not able to access the services due to lack of money (41%), unavailability of medical personnel (31%), afraid of going out and getting the virus (23%), and turned away because facility was full (21%).
- More than half (55%) of participants did not do any work for pay during the pandemic; of which 39% had work before the pandemic. Higher proportion of female respondents (61%) did not do any work for pay compared to their counterpart male respondents (50%). Compared by regions, it was 71% for Jigjiga, (which is about twice that of Addis Ababa), 57% for Hawassa and 38% for Addis Ababa.
- About two third of the respondents (i.e. 64%) have reported that their household's income has reduced since the pandemic; and only 29% reported that it stayed the same.
- More than two third (69%) of participants have reported that their households have been affected by the pandemic situation. Region wise, 85% of Hawassa, 71% of Addis Ababa and 50% of Jigjiga households have been affected. The major effects of the pandemic were job loss; increase in price of major food items; non-farm business closure; and illness, injury or death of income earning family member.
- Overall pooled prevalence of food insecurity was 25%. Among the three regions, Hawassa has the highest prevalence (49%) while Jigjiga has the lowest (6%).
- More than three-fourth (76%) of participants' households did not receive any assistance from the government in the form of cash, in kind, payment relief for public services or free food during the pandemic. Similarly, 90% of respondents did not receive any assistance from NGOs during the pandemic.

1. Introduction

The world is in the most severe pandemic in living memory caused by Severe Acute Respiratory Syndrome Coronavirus-2 (SARS-CoV-2), which is more commonly referred to by the label assigned the disease it causes: coronavirus disease 2019 “COVID-19”. (1)

Since the COVID-19 pandemic first broke out at Wuhan, China in December, 2019, it has caused more than 413 million cases and more than 5.8 million deaths globally; more than 11.3 million cases and more than 244 thousand deaths in Africa; and more than 467 thousand cases and more than 7.4 thousand deaths in Ethiopia as of mid-February, 2022. (2, 3)

The pandemic has triggered simultaneous financial, supply, demand, health, etc. shocks to the world economy by forcing governments to implement partial and full closure of businesses and human movement in response to contain the pandemic. (4) These restrictions severely affected business and social interactions worldwide. Even though, the full impact of the pandemic is not yet fully understood, it became more visible and riskier to developing economies. (1)

The effect of the pandemic on the economic activities of different countries varied across geographical locations, economic status, and demographic compositions. Generally, it has resulted in increased unemployment, decreased income for daily labour, increased food insecurity, depletion of saving and relief measures. (5)

The pandemic significantly heightens all existing inequalities which severely affect vulnerable segments of the societies particularly the developing economies like Ethiopia. The emergent of the pandemic in Ethiopia, where the condition of life for the majority of the population is already precarious, has multiplied the risk of the vulnerable groups. The magnitude of poverty in Ethiopia is the highest even before the COVID-19 pandemic outbreak.(1, 6)

The government of Ethiopia, in response to the pandemic, has declared a State of Emergency (SoE) in April 2020 that stayed for 6 months with restrictions on economic activities, including international and local movement, banning gatherings of more than four people, and halting the operation of restaurants. And this might most affected youth population, since they suffer from lower employment quality and a higher percentage of working poor, compared to adults. (7)

Youths accounting for one-third of the global population are specially disadvantaged with the socio-economic impact of the pandemic. The word “Socioeconomic” refers to societal and economic factors. The American Psychological Association (APA) define it as the social standing or class of an individual or group. It covers a variety of ways that explains occupation, household income, access to basic needs and resources, as well as issues related to privilege, power and control. (8, 9)

In an attempt to understand the societal and economic effect of COVID-19 on youths and their households, this study assessed the effect of the pandemic on individual aspects of livelihood, employment, food security, access to basic services, etc.

2. Statement of the problem

The COVID-19 pandemic has caused more than 413 million cases and more than 5.8 million deaths globally as of February, 2022. (3) Besides health related effects, it has resulted in the fourth most severe global recession of the past 150 years by causing the global activity to have contracted 4.3 percent in 2020. (10) The pandemic has triggered simultaneous financial, supply, demand, health, etc. shocks to the world economy by forcing governments to implement partial and full closure of businesses in response to contain the pandemic. (4)

In low- and middle-income countries, the pandemic has brought devastating economic impacts. The illness and containment measures implemented by the governments have resulted in employment and income loss, especially, among people with limited coping strategies. As a result, the number of global extreme poor is projected to have increased for the first time during the last two decades. (11, 12)

The world economy has started to recover markedly since 2021. The recovery is helped by the gradual deployment of effective vaccines, announcements of additional fiscal support in some countries, and economies are coping better with measures in response to contain the pandemic. Economic activities moved even above pre-pandemic levels in China, India and Turkey. (13)

However, the recovery of Sub-Saharan Africa (SSA) economy remains fragile. Economic growth in the SSA reached an estimated 3.5 percent in 2021, supported by a rebound in commodity prices and a gradual easing of social restrictions. Nevertheless, recurrent virus flare-ups in several countries and low vaccination rates slowed the pace of the recovery. The economic growth is forecasted to firm to 3.7 percent a year on average in 2022 for the region. As of end of December, 2021, the number of fully vaccinated people was only 6.2 percent of SSA's population. In some of the region's most populous countries, such as Nigeria, Ethiopia, Democratic Republic of Congo, and Tanzania - only about 2 percent or less of the population have been fully vaccinated. Amplified by the pandemic, previous weaknesses, such as vulnerabilities to climate change, poverty, food insecurity, and violence, weigh heavily on recoveries across the region as well. (14)

Ethiopia's economy, that has been growing 9.4% a year on average for a decade since 2010, has decelerated from 8.4% in 2019 to 6.1 percent in the 2020, to 2.4 percent in 2021 and, forecasted to stand at 4.3 percent in 2022, largely because of the COVID–19 pandemic. (14-16)

The pandemic does not affect every social group in the same way. It has exacerbated existing inequalities along gender and socioeconomic lines. Those who were disadvantaged before the pandemic, such as women, youth and low-skilled workers are experiencing even greater challenges. Moreover, the impacts of the pandemic on household incomes and welfare have been geographically uneven with more severe effect resulted on urban households—many of whom are informal, self-employed, or casual workers—in many low- and medium-income countries. (11, 17)

The COVID-19 crisis has severely affected the socio-economic aspects of young people more than other age groups. For example, youth employment fell by 8.7 per cent in 2020 compared with 3.7 per cent for adults, globally. (18)

In Ethiopia, the pandemic has affected youth employment and earnings, with a more significant fall among self-employed workers, particularly in transportation, manufacturing, and other services, including restaurants. It has also increased the gender wage gap by causing a more considerable fall in earnings to female workers than male workers, it has augmented uncertainty and pessimistic attitude among young workers about their future life. (7)

The lockdown and social distancing has mostly affected the participation of young people in social, civic, political and economic activities. With high rates of unemployment, and closure of school and informal sector activities, youth are bearing the brunt of this disease in more ways than the public health impact. (1, 7)

It is against this background that the insights, experiences, perspectives of youth are important in COVID-19 responses. Focusing on young women and men from different socio-economic, political and cultural backgrounds, and from both urban and rural areas, high school and university students as well as youth living in streets and informal settlements, the research will generate evidence for policies and actions.

3. Literature Review

3.1. Country Profile

Ethiopia is located in the center of the Horn of Africa. It covers an area of 1.14 million square kilometres (944,000 square miles). (19) The country has population size of more than 117 million people and population growth rate of 2.6% (2021 estimate). It is the second most populous nation in Africa after Nigeria; and the 12th in the world rank. (20-22)

About 78% of Ethiopia's population is rural based with 22% residing in urban settings. (23) Ethiopia, is a country of young where 70% of its population is less than 35 years of age and about 30% is classified as youth. (20-22, 24) The country has a total of about 21.5 million pupils enrolled in primary and secondary education. Of these pupils, about 16.2 million (76%) are enrolled in primary education. Approximately 16% of youth have no formal education and 54% of youth have attained at most incomplete primary education. Nearly 55% of female youth of secondary school age are out of school and 46% of male youth of the same age. (25)

The country has three tier health system structure with the primary level consisting of primary healthcare units (health posts and health centers) and primary hospitals; secondary level services are provided by general hospitals; and tertiary level services by specialized hospitals. The health system of the country is characterized by serious scarcity of basic equipment, trained health professionals, essential medicines and infrastructure. Overall, there are 144,731 health care workers (medical and paramedical), 410 public and private hospital of different category across the country with 29748 beds in total which are equipped with 341 ICUs and 173 functional ventilators. Most of the 67 functional ventilators and 87 Intensive Care Unit (ICUs) are located in the capital, Addis Ababa. (26)

Response Measures

The corona virus pandemic remains to be a major global health threat up until now. The World Health Organization has declared the pandemic as a public health emergency of global concern calling for concerted efforts from across all nations to stop the spread of the virus. Most African countries face an enormous mission to contain the rapidly spreading pandemic due to poor healthcare and limited resources. Higher transmissibility is expected in such countries due to a larger household sizes, overcrowding and insufficient water and sanitation, which will affect the

implementation of the recommended preventive measures. Ethiopia being an African country is also vulnerable to the pandemic due to its relatively fragile health systems, poor infrastructure, population mobility, and exposure to social and political unrest. Thus, it becomes a priority for the nation to implement effective intervention strategies to contain the rapidly transmitting virus. (27)

The Ethiopian government has adopted different measures endorsed by the World Health Organization after experiencing the first COVID-19 case on 13 March 2020. Informing the public about regular hand washing with water and soap, physical distancing, contact tracing, self-isolation and quarantine measures were some of the measures implemented. Also, the government has announced school and workplace closures, limited public gatherings and establishing COVID-19 task forces at different levels. (27)

The Ethiopia COVID-19 Emergency Response Project has been at the front of implementing efforts and mobilizing critical resources to rapidly strengthen preparedness and response to the pandemic. The project was prepared during a 10-day period in the early March of 2020. The objective was filling the critical gaps in implementing the EPRP and strengthening the prevention activities, rapid detection, preparedness and response to the COVID-19 outbreak. The emergency response depend the country's prevention-based primary public health-care infrastructure and the health extension system made during the last two decades, community mobilization, and public-awareness campaigns. (28)

Since June 2020, the number of identified COVID-19 cases has increased substantially in Ethiopia, due to both expansion of community transmission, as well as significant enhancements in testing capacity for detection. The government has a new and innovative approach, the Enhanced Community Mobilization Activities and Testing, tailored to address the immediate needs of the current phase of the epidemic in the country, while continuing to apply an integrated Whole of Government Approach in response to the above situations. The introduction of community/self-isolation sites within households, with health professionals closely following up to mitigate socioeconomic consequences of COVID-19 on vulnerable groups was one of the key strategic shifts in the new approach. (28)

3.2. The Socio-Economic Context

The immediate requirement to tolerate in times of COVID-19 are troublingly low in Ethiopia. The larger segment of the population lives on a daily starving income level. A sizable portion of the population struggles with limited access to food, water and housing provisions. 58% of the population lack access to clean water, 89% live without safe toilets, and 55.7% survive without electricity and 48 million people live further than 2Kmfrom all-weather road. Furthermore, the country's health care system is too basic and fragile to cope up with the preventive methods prescribed by the World Health Organization. With the existing poor socio-economic status of the people, it would be unbelievable for Ethiopia to withstand tremendous shocks posed by the pandemic. (29)

The COVID-19 pandemic has bought a highly negative impacts in almost every sectors of the country. The socio-economic impacts has spread in every corner of the country's economy including governance (Regional response, case investigation, surveillance, coordination and communication), economy (immigration, employment, logistics, border of entry), peace & security (gender based violence, mental health, limited civic space, misinformation), environment (infection, WASH programs, prevention, control) and social wellbeing (Health, Education, social support, food security, External communication).

3.3. Governance

2.2.1 Political Impact of COVID-19 in Ethiopia

While the country experience several challenges, the dramatic political reforms that have taken place since the beginning of 2018 have sparked hopes that the country can bring about an end to decades of authoritarian rule. Though, the response to COVID-19, in addition to raising concerns about overreach under the vague new state of emergency, also brings forward concerning questions about how the lawfulness of the government can be maintained in the absence of planned elections. (30)

The National Electoral Board of Ethiopia (NEBE) on March 31st announced that due to the virus, it was terminating the electoral calendar published in February which had set national elections for August and was suspending all election-related operations. This announcement caused extensive

assumption as to what it would mean for Ethiopia's uptight efforts to move away from decades of authoritarian rule and build a democratic system of government. (30)

2.2.2 Risk Communication and Coordination

Zikargae M H. (2020), did study on assessment of how the Ethiopian Government has executed administrative actions and managed risk communications and community engagement. The study implemented a qualitative approach of data collections and thematic analysis. The outcomes of the study indicate that COVID-19 situations gain the highest momentum by increasing alarmingly and shows a significant differences after two months since March 2020 reporting the first case in Ethiopia. The government took several measures ranging from public health emergency response to the state of emergency. The communication strategy and state of emergency are in place to reduce the prospective risks of COVID-19. The strategy segmented the population by tailoring activities of risk communication and community engagement at all levels. The government has strongly obtained various measures like lockdown and a state of emergency even though it was not handled seriously. (31)

3.4. Economy

2.3.1 Immigration

A numbers of Ethiopian migrant workers from the Middle East deported to their home country following the coronavirus disease outbreak. Returnees who came back to Ethiopia during the early stages of COVID-19 went through difficult experiences of unplanned return and unfamiliar quarantine. (32)

News Global, (2020) states that The International Organization for Migration, signed a Memorandum of Understanding (MoU) with the Ethiopian Government to strengthen return and rehabilitation assist to thousands of Ethiopian migrants returning home due to the pandemic. The project will provide cash grants and other forms of support to over 8,000 returning migrants. Nearly 34,000 migrants have returned to Ethiopia since the outbreak of COVID-19. Many have arrived with nothing other than the clothes on their backs, and were in need of medical attention, and basic humanitarian items. Others were also in need of psychosocial support after having gone through traumatic experiences during their journeys. The vulnerable migrants we given priorities

these migrants include victims of trafficking, those disabled, people with medical conditions, and single-headed households. (33)

Demiessie.H.G, (2020) did a study on the impact of COVID-19 pandemic uncertainty shock on the macroeconomic stability in Ethiopia in the short run period. The result of the study tells that the Ethiopian economy heavily depend on import to supply the majority of its consumption and investment goods, the pandemic's uncertainty effect starts as supply chain shock, whose effect transmitted into the domestic economy via international trade channel. (29)

2.3.2 Employment

The Ethiopian youth contribute more than 60% of the country's total population, the demographic dividend is turning into a misery to create adequate jobs. More than 25 million students are joined in primary, secondary schools and different universities and about 2 million educated young people enter the labor market. According to the World Bank over the last 12 years, Ethiopia's witnessed 9.4% growth annually from 2010-2019. But over the past two years due to COVID-19, the growth has slowed down 6.1%. (34)

At the arrival of the COVID-19 pandemic, in the manufacturing sector alone, 11% of total employment mostly involving temporary low-skilled workers was at risk over the next quarter, if no actions were taken. Similarly expected to be one of the hardest hit sectors which employs more than 1.5 million people was tourism. Large-scale job losses are a real and increasingly likely prospect. (35)

3.5. Social Wellbeing

The COVID-19 pandemic has significantly affected poor and vulnerable groups, to some extent has differential impacts related to structural inequalities, such as gender and ability, and on people who are marginalized for other reasons. Access to basic human needs remain to be a most important challenges for the urban poor. Devaluation of the Ethiopian birr was mentioned as an additional burden that is exacerbating food insecurity among the urban poor in this round. Daily wage earners, people with jobs in the informal sector, vendors, petty merchants, labourers, and women are found to be the most likely to be impacted due to loss of jobs and reduced income, and due to the disproportionate childcare burden for women. IDPs and refugees, and people living with no social safety nets, are also found to be particularly vulnerable to the pandemic due to insufficient

aid and support. Furthermore, there is seen to be a significant weakening in the practice and obedience of the COVID-19 preventive measures. These results are in line with a study conducted by the World Bank Group, which highlighted concerns about the impact of COVID-19 on the livelihoods of a representative sample of respondents. In particular, food insecurity remains a serious problem in Ethiopia due to higher prices and/or less regular income. (36)

2.4.1 Education

A report of BRE (2021) program states a negative impacts of the pandemic on access to education. It mentions that the pandemic has widened existing inequalities, with unequal access to distance learning opportunities during school closure, particularly between rural and urban populations, higher- and lower-income households, and girls and boys. Also an enlarged pressure on girls to help with family chores and care for other siblings is likely to have reduced the time they have available for distant learning. Children with disabilities saw the most limited access to education opportunities during school closures, as captured by GAGE and supported by findings in other studies. Upon schools re-opening the World Bank study found that, girls were more likely to go back to school compared to boys. The Young Lives study found that by the end of 2020, around two in five of 19-year-olds still in education had not engaged in any form of learning including online learning since school closures began, with those from the poorest households and rural areas affected most. (37)

The significant increase in the use of online learning throughout the COVID-19 pandemic presents an opportunity to further invest in digital technologies and increase internet access particularly in rural areas. This is vital to address the huge digital divide which has been exposed and exacerbated between urban and rural communities and girls and boys. (37)

2.4.2 Health

The ongoing pandemic poses an indirect health risks to children. It also has secondary impacts on children and households as a result of government-enacted policies for managing the pandemic. Policy responses and financing measures are crucial to protect children from the worst primary and secondary impacts of the pandemic in the short- and long-term. They are also needed to prevent long-term adverse impacts on their wellbeing, as well as the reversal of hard-earned progress made towards fulfilling the Sustainable Development Goals (SDGs) for children. (38)

Elezaj E et al, (2020) conducted a study on the effect that the Covid-19 pandemic had bought to children. It was done considering only children in Addis Ababa. The study mentions that children are highly vulnerable to the indirect secondary effects of the pandemic which is due to household financial shocks and the disruption of social services and care networks, educational progress and essential health services. Before the hit of the pandemic, two in three children in Ethiopia, and almost one in four children in Addis Ababa, lacked access to essential goods and services. More than 1.2 million children in Ethiopia are monetarily poor, living in households that lack the minimum financial resources necessary for survival. In the capital city, nearly 1 in 3 children are monetarily poor. A current analysis by Save the Children and UNICEF anticipated that the economic impact of the pandemic may push up to 24 million additional children living in Sub-Saharan Africa into poverty by the end of 2020, from 250 million children living in poor households to around 274 million children. (38)

2.4.3 Food Security

Kibrom A et al, (2020) showed a study on the impact of Ethiopia's flagship social protection program, the Productive Safety Net Program on the adverse impacts of the COVID-19 pandemic on the food and nutrition security of households, mothers, and children. The analysis uses pre-pandemic, in-person household survey data and a post-pandemic phone survey. The study shows that two-thirds of the respondents reported that their incomes had fallen after the pandemic began, and almost half reported that their ability to satisfy their food needs had worsened. The study finds that household food insecurity increased by 11.7 percentage points and the size of the food gap by 0.47 months in the aftermath of the onset of the pandemic. Participation in the Productive Safety Net Program offsets virtually all of this adverse change -- the likelihood of becoming food insecure increased by only 2.4 percentage points for Productive Safety Net Program households and the duration of the food gap increased by only 0.13 month. The protective role of the program is greater for poorer households and those living in remote areas. (39)

2.4.5 Mental and Psychological Well-being

Khodr.A, (2020) states that the impact of COVID-19 pandemic will be measured not only in the number of deaths or the scale of job losses but also in how it is affecting our mental and emotional wellbeing. In Ethiopia where mental health and psychology support services are already limited, these may be devastating especially for children and young people. Anecdotal reports from

healthcare facilities in Addis Ababa, including some mental health clinics, suggest that people are staying at home rather than seeking treatment for fear of being infected with the virus or being taken into isolation. (40)

3.6. Environment

Harris.D et al. (2021) states 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. Therefore it seems that even though people are able to work more now compared to the beginning of the pandemic, affordability is still a major problem due to price increases for items which are necessities. Irregular income and affordability issues have also led to the increased mental health problems observed in this round. (37)

3.7. Peace and Security

2.6.1 Gender Based Violence

World Health Organization defines IPV as a physical, sexual, or emotional abuse by an intimate partner or ex-partner or spouse to a woman. Shitu.S, Yeshaneh.A & Abebe.H, (2021) did a community based study that employed reproductive-age women to assess IPV and associated factor during COVID-19 pandemic. The result shows that two in five women undergo one type of violence in their lifetime and the occurrence of the COVID-19 pandemic also impacted these women on violence. (41, 42)

2.6.2 Stigma and Discrimination

As new coronavirus cases are confirmed each day, the fear and misinformation continue to spread more rapidly than COVID-19 itself. False or misleading claims in the media, lifted by harmful labels, have fuelled discrimination and violence that wake up painful histories of attributing disease outbreaks to marginalized groups. Health officials have taken note of the disturbing trend, cautioning that stigma and discrimination could undermine efforts to contain the outbreak. (43)

Assefa.N et al. (2021) showed a study among healthcare workers in sub-Saharan African countries. The study was conducted to assess knowledge, perceptions, COVID-19 prevention measures, stigma, and mental health of health care providers. The finding show that majority of the health care providers reported to have a self-perceived social stigma. (44)

Despite of the high levels of knowledge among health care providers in sub-Saharan Africa, there is a need to improve the COVID-19 perceptions and compliance with prevention measures as well as address social stigma toward healthcare providers to be better ensure their safety and prepare them to deliver health services. (44)

2.6.3 Misinformation

Although knowledge about COVID-19 in Ethiopia is nearly common, as the Ohio State university study shows, misinformation is extensive. Only one in four respondents believed they were at personal risk of being infected: more than half believed that the corona virus could be treated with the use of garlic and nearly 80 percent said it could be treated with lemon and vitamins. (40)

4. Objective of the study

4.1. General Objective

The objective of the study was to to assess the gendered socio-economic impact of COVID-19 on youths in Addis Ababa, Somali region and Sidama regions of Ethiopia from 18th, October, 2021 to 6th, November, 2021.

4.2. Specific objectives

- To assess the impact of COVID-19 on the livelihood of youths
- To assess the impact of COVID-19 on access to social services on youths
- To assess the impact of COVID-19 on food security of youths and their households
- To assess the level of government and NGOs support to manage the impact of COVID-19 on youths

5. Methods and Materials

A mixed research approach involving both quantitative and qualitative methods was employed to assess the Socio-economic impact of COVID-19 on youths from 18th, October 2021 to 6th, November 2021.

5.1. Methods and Materials: Quantitative Study

5.1.1. Study Setting

The study was conducted in three regions of Ethiopia, namely Addis Ababa city administration, Somali region and Sidama regions of Ethiopia. It was carried out in 9 randomly selected areas (i.e. 3 per region) located in the three regions.

5.1.2. Study Design and Study Population

Quantitative: A community based cross-sectional study was employed among youths aged from 15 to 35 years in Addis Ababa city administration, Somali region and Sidama regions of Ethiopia. We included youths who were permanent resident of the respective study areas and volunteer to participate in this study.

Qualitative: qualitative approaches such as transcription, interpretation and triangulation method was used to explore the socio-economic impact of COVID-19 on youths; which was used to triangulate the quantitative finding.

5.1.3. Sample Size and Sampling Procedure

Quantitative: The sample size for the quantitative study was calculated based on one population proportion formula using Epi-info software assuming 95% CI, 5% margin of error, and a 23% for the level of economic impact of COVID-19 taken from a previous study. Accordingly, the minimum sample size for this survey is determined to be 272 for each of the three regions (816 for all the three regions). Participants were selected using a non-probability quota sampling methods to ensure adequate number of representatives from both males and females. We included youths who were walking through streets of the selected area until we complete our sample size.

Qualitative: For the qualitative study, from all the three regions, individuals who believed to bring any additional insights and context specific inputs to the study were included until the level of saturation or redundancy of information. With regard to this, youth association leaders, government authorities, CSO direcotrs and experts from the three regions were included in this

study. In addition, 45 youths from each of the regions who believed to bring different experiences were included.

5.1.4. Variables of the Study.

Dependent Variable

- Youths socio-economic status as a result of the COVID-19 pandemic

Independent Variables

- Variables related to socio-demographic characteristics such as age, sex, educational status, etc.
- Variables related to youths perceived barriers and facilitators related to
    - Government response to control COVID-19 spread
    - Citizen's satisfaction toward government response
    - Shock coping mechanisms
    - Support mechanism

5.1.5. Operational Definition

Youth – individuals aged between 15-35 years

5.1.6. Data Collection Methods and Data Quality Assurance

The data was collected using structured interviewer administered questionnaire administered through SurveyCTO software. The questionnaire includes background information; knowledge of youths on COVID-19 prevention methods; attitude of youths toward government measures in the COVID-19 response; impact of COVID-19 on youths and their household livelihood, access to basic services, food security, etc.

The quality of quantitative data were assured by properly designing and pre-testing the questionnaire, training of data collectors and supervisors, proper coding and categorization of variables. Every day, electronic questionnaires were reviewed for completeness by supervisors and investigators and necessary feedbacks were provided for data collectors in the next morning before data collection.

5.1.7. Data Processing and Analysis

Quantitative data were transferred from the SurveyCTO software to the Statistical Package for Social Science (SPSS) version 23 software for data management and analysis. Descriptive findings

were generated and summarized in terms of mean, frequencies, and percentage and presented using tables and appropriate statistical diagrams. Analytic statistics using logistic regression was carried out to measure the level of association among relevant variables.

5.2. Methods and Materials: Qualitative Study

We conducted qualitative study to understand the socio-economic impact of COVID-19 among youths in Ethiopia. Accordingly, nine focus group discussions (FGDs)– three in each region (AA, Hawasa, Jigjiga) and 24 key informant interviews (KIIs) - 9 in AA, 6 in Hawassa, and 9 in Jigjiga) were conducted.

The number of participants in each FGD were 12. Almost all of the participants were in their late adolescent stage/age. The FGDs were arranged for males and females separately and one composed of both male and female in each region. The average time spent for FGD was one hour and participants were selected based on their involvement in youth-based activities. Similarly, we purposely selected the Key Informants from public youth centers, youth-based NGOs/CSOs, and other public organizations working on youths, thinking that they could have better experience on our research questions.

5.2.1. Data collection methods

The data collection method was an in-depth interview and focus group discussion. Interviews and group discussions were carried out by investigators from 18th, October, 2021 to 6th, November, 2021. All participants were interviewed face-to-face on one occasion only. All in-depth interviews and group discussion were audio recorded and notes were taken during interviews/discussions to capture emotions expressed verbally or non-verbally. Both in-depth interview and FGD guides prepared in local language (Amharic and Somali) were used to guide the interview process. All the interviews/discussions were conducted in Amharic and Somali languages. While data collection was on progress, preliminary analysis of the early interviews provided a means to adapt questions and to refine probes considering the important issues emerged. The process of data collection was considered saturated when consecutive in-depth interviews did not bring new information. We concluded data collection after 9 in-depth-interviews from Addis Ababa and Somali regions and 6 in-depth-interviews from Sidama region.

5.2.2. Data processing and analysis

Each FGD and KII was transcribed verbatim by two research team members and reviewed by one investigator for accuracy. Transcripts were first to read several times to get an overall picture and then the information was coded from the data. Then, meaningful concepts were condensed and categorized into broad themes using thematic analysis approach. Participant quotations from KIIs and summary points of FGDs were selected to illustrate particular issues raised.

5.2.3. Techniques to enhance trustworthiness

We tried to improve the rigor of the data through prolonged engagement and member checking. Furthermore, we tried to solicit feedback for the transcripts from few participants, who supported the validity of our transcripts.

5.3. Ethical Issue

Ethical clearance was obtained from the Institutional Review Board (IRB) of Ethiopian Public Health Association. Necessary communication was made with all concerned bodies and permission was secured before the data collection process. The purpose of the study was explained to the study participants and participation in the study was completely voluntary. An informed oral consent was obtained from each study participant before data collection.

6. Result and Findings of quantitative study

6.1. Socio-demographic characteristics of the respondents

Overall, 844 youths in the age group 18-35 from three regions of Ethiopia, namely Addis Ababa city administration, Somali and Sidama regions, have participated in this study giving a response rate of 100%. The ratio of male to female respondents was equivalent (51% male to 49% female) which was also same across regions. Mean age of the respondents was 25.5 years (SD = 4.9).

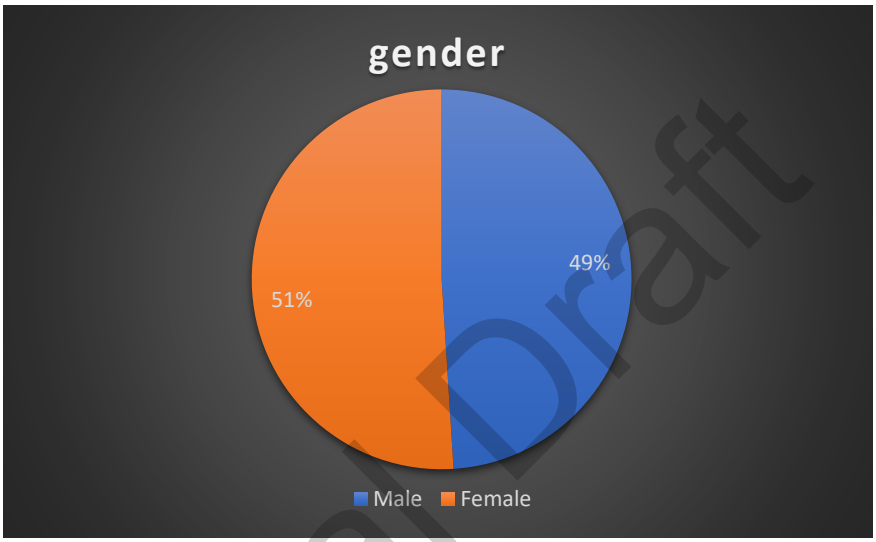

Figure 1 Pie chart showing proportion of study participants by Sex

Regarding educational level of the respondents, about 92% of the participants had attended some level of formal of education. Moreover, a quarter (25%) of the participants are secondary complete; 21% bachelor complete or higher; 14% bachelor incomplete; and 13% secondary incomplete. The characteristics of the respondents related to educational level was relatively similar among the regions except that the proportion of respondents with no education was higher for Somali region (18%) compared with Hawassa (5%) and Addis Ababa (3%)

Table 1 Demographic characteristics of participants by region (n=843)

Variable	Category	Addis Ababa		Hawassa		Jigjiga		Total	
		Frequency	Percentage	Frequency	Percentage	Frequency	Percentage	Frequency	Percentage
Gender	Male	138	48.6%	148	52.1%	144	52.4%	430	51%
	Female	146	51.4%	136	47.9%	131	47.6%	413	49%
Age group	18-23	108	38%	111	39%	103	37%	322	38%
	24-29	121	43%	101	36%	98	36%	320	38%
	30-35	55	19%	72	25%	74	27%	201	24%
Educational Status	None	8	2.8%	14	4.9%	49	17.8%	71	8.4%
	Primary incomplete	15	5.3%	36	12.7%	7	2.5%	58	6.9%
	Primary complete	25	8.8%	34	12.0%	26	9.5%	85	10.1%
	Secondary incomplete	36	12.7%	46	16.2%	27	9.8%	109	12.9%
	Secondary complete	71	25.0%	69	24.3%	71	25.8%	211	25.0%
	Bachelor incomplete	51	18.0%	25	8.8%	38	13.8%	114	13.5%
	Bachelor complete/ higher	71	25.0%	48	16.9%	55	20.0%	174	20.6%
	Other	7	2.5%	12	4.2%	2	0.7%	21	2.5%

6.2. Knowledge Regarding the Spread of COVID-19

To assess the knowledge of youths towards the spread of COVID-19, study participants were asked questions on measures that can reduce the risk of contracting COVID-19. Accordingly, the measures most identified by the respondents were using face mask (identified by 87% of the respondents), hand washing (by 81% of the respondents) and use of sanitizer (by 66% of the respondents). Among the rest of the respondents who did not agree, 59% were from Addis Ababa.

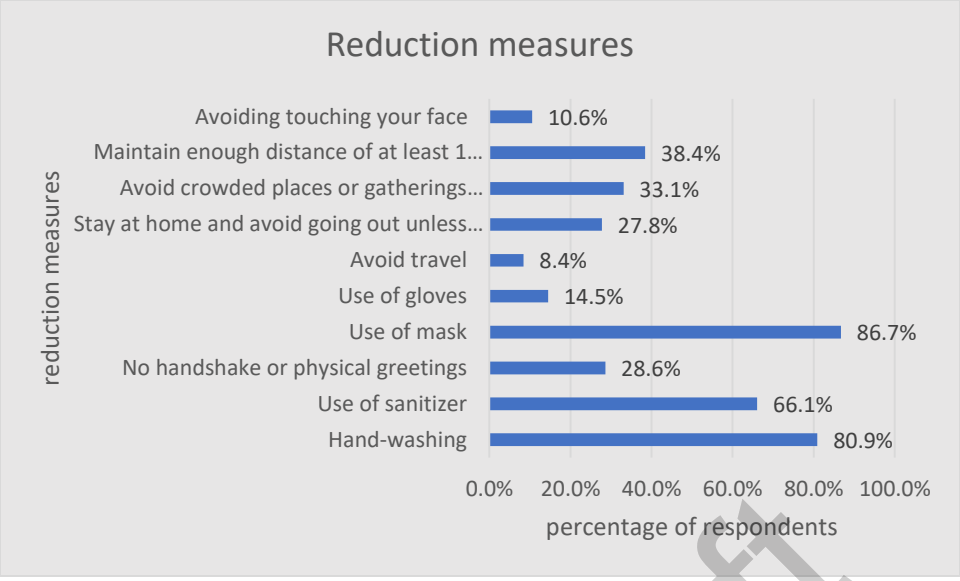

Figure 2 Bar chart showing knowledge of participants on measures than can reduce the risk of contracting COVID-19

Regarding the steps taken by the government or local authorities to curb the spread of the corona virus, the steps most identified by the participants were "advised citizens to stay at home" (79%), "closure of schools and universities" (54%), "restricted travel within country/area" (34%), and "disseminate knowledge about the virus" (30%).

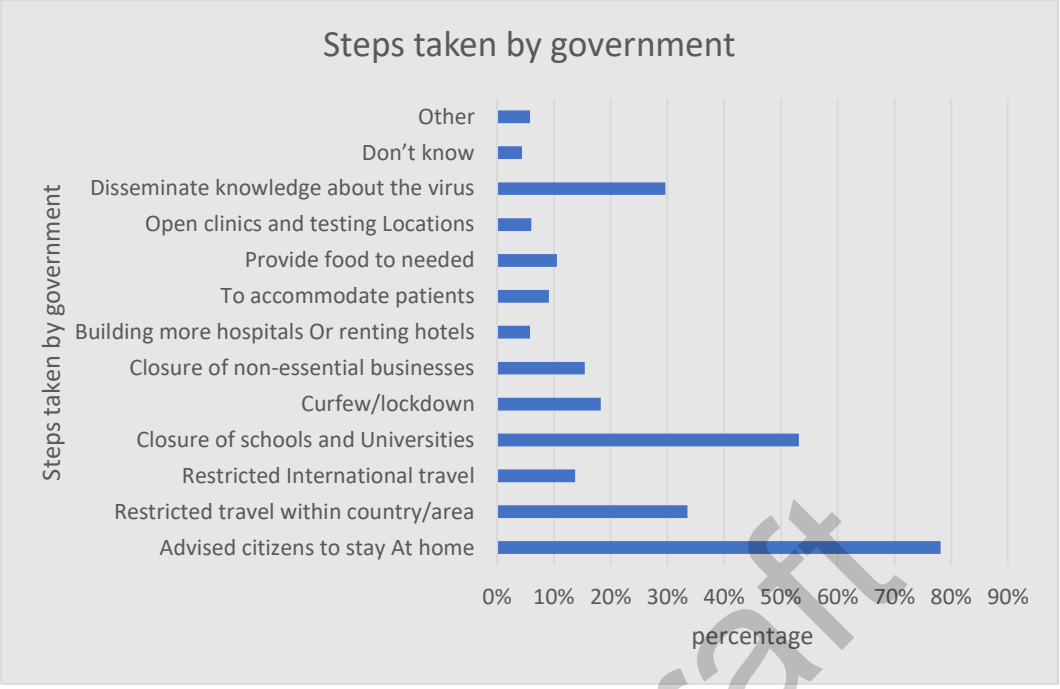

Figure 3 Bar chart showing steps taken by the government or local authorities to curb the spread of the corona virus

Regarding access to information on local distancing and self-isolation as a preventive measure against the coronavirus, almost all (96%) of the respondents have reported that they have received information on the issue. The most common sources of information reported by the participants were television (87%), radio (61%), social media such as twitter or Facebook (45%), phone (37%) and healthcare worker (33%). Whereas, traditional healer/pastor/faith based healer was the least reported sources of information.

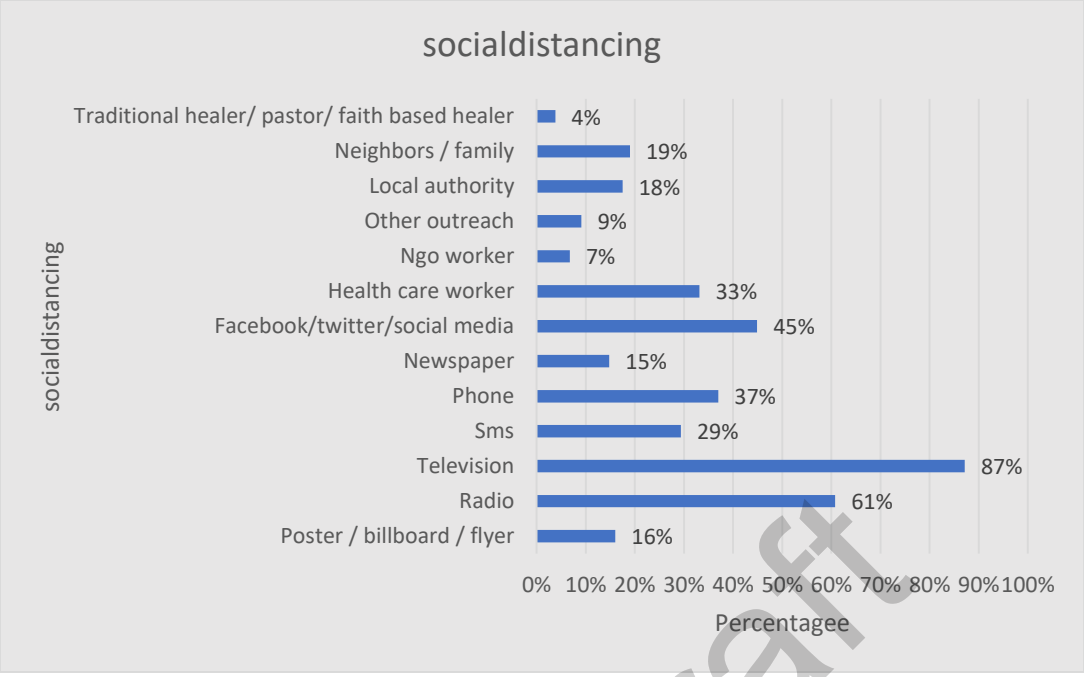

Figure 4 Bar chart showing households access to information on local distancing and self-isolation as a preventive measure against the coronavirus

About one third (31%) of the respondents were not satisfied by the government's response to the coronavirus crisis. The disaggregated result among the study areas shows that 31%, 38% and 22% of the respondents from Addis Ababa, Hawassa and Jigjiga areas respectively, were not satisfied by the government's response to the coronavirus crisis. Overall, no major variation was found by gender or study area of participants toward level of satisfaction by the government's response.

Among the reasons for not being satisfied with the national or regional government's response, existence of no financial assistance by the government was reported by 46% of the participants followed by shortage of medical materials (43%), late response by government (37%), limited testing points (31%) and others (21%).

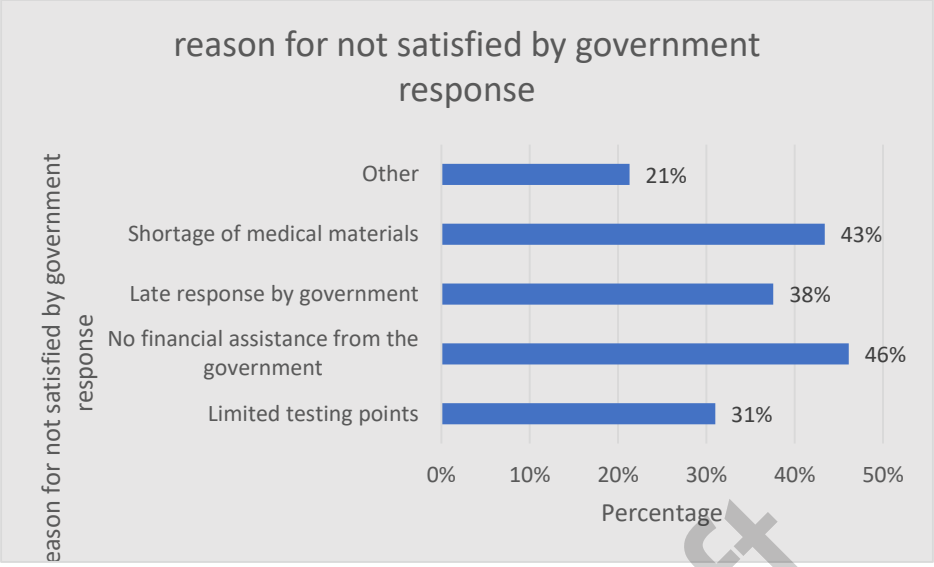

Figure 5 Bar chart showing reasons for not being satisfied with the national or regional government's response to COVID-19 pandemic

Majority of the participants expressed neutrality regarding local authorities / government trustworthiness, fairly treating all citizens when providing health care and ability to provide health care to address the Coronavirus crisis.

The mean score of the participants attitude toward the local authorities / government trustworthiness in the way they manage the Coronavirus crisis was 3.07; fairly treating all citizens (regardless of age, gender and origin) when providing health care related to the Coronavirus crisis was 3.23; and ability to provide health care to address the Coronavirus crisis was 3.0.

However, majority of the participants agree that they intend to follow the government's guidelines to mitigate the spread of the coronavirus as indicated by the mean score of 3.57. The overall mean for the aforementioned variables was 3.2 indicating that majority of the participants expressed neutrality toward the issues.

Table 2 Participants' intension to follow guidelines and their attitude toward government's trustworthiness, fairness and ability in managing the COVID crisis. (n=843)

S.No	Variables	N	Minimum	Maximum	Mean	Std. Deviation
1	Trust Local Authorities	843	1	4	3.07	1.023
2	Equal Treatment	843	1	4	3.23	1.009
3	Government Ability Provide Health Service	843	1	4	3	0.998
4	Follow Government Guidelines	843	1	4	3.57	0.835
5	Overall mean score	843	1	4	3.21	0.77376

6.3. Access

6.3.1. Access to medicine

Regarding access to medicine, majority (i.e. 62%) of the participants reported that their household have not tried to buy medicine since the COVID19 outbreak; while about a quarter of respondents (24%) reported that they have been unable to buy medicine. The remaining 19% reported that they were able to buy medicine. Among those who reported that they have been unable to buy medicine, 37% were from Addis Ababa, 38% from Hawassa and 25% from Jigjiga.

About two third (63%) of male respondents reported that their households have not tried to buy medicine since the COVID19 outbreak; while a quarter of them (25%) reported that they have been unable to buy medicine. Similarly, among female respondents, about two third of them reported that their households have not tried to buy medicine since the COVID19 outbreak; while about a quarter (23%) reported that they have been unable to buy medicine.

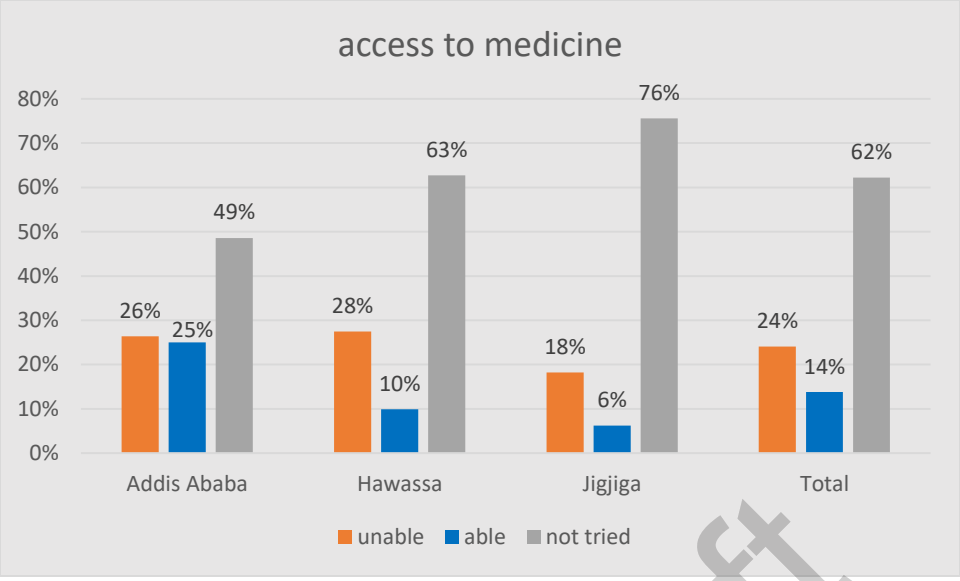

Figure 6 Bar chart showing level of access to medicine during the pandemic

6.3.2. Access to basic food items

Regarding access to basic food items, more than one third (35%) of the participants have reported that their households were unable to buy basic food items during the pandemic. However, the majority of the participants (64%) have reported that their households were not unable to buy basic food items during the pandemic.

Among the regions, two third of respondents (62%) form Hawassa reported that their households were unable to buy basic food items during the pandemic. On the contrary, majority of respondents form Jigjiga and Addis Ababa, 83% and 71% respectively, reported that their households were not unable to buy basic food items during the pandemic.

No major variation in the response of participants was observed by gender. Generally, about two third of respondents of either sexes (62% male, 66% female) reported that their households were not unable to buy basic food items during the pandemic; while the other (remaining) one third (38% male, 32% female) reported that they were unable to buy basic food items.

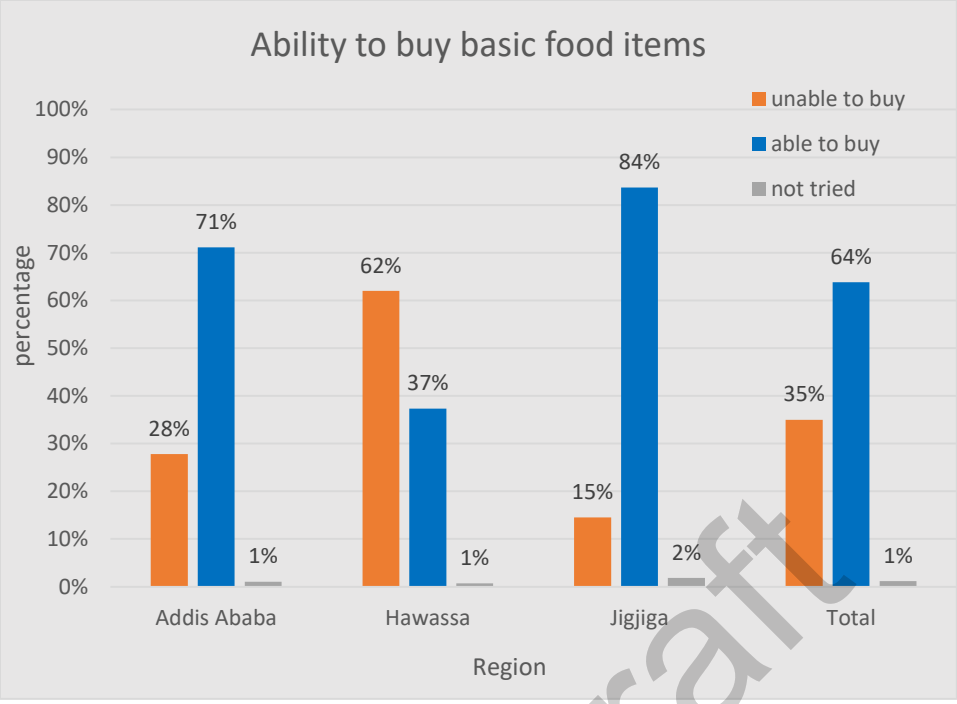

Figure 7 Bar chart showing households access to buy basic food items during the pandemic

Out of the 295 respondents who reported their households were unable to buy basic food items during the pandemic, increase in price was identified by 203 (69%) of them as a reason. Similarly, 141 respondents (48%) reported local markets not operating / closed, 112 respondents (38%) reported shops have run out of stock, 101 respondents (34%) reported restriction to go outside, 98 respondents (33%) reported cannot afford it and 90 respondents (31%) reported limited / no transportation as the reasons why their households were unable to buy basic food items during the pandemic.

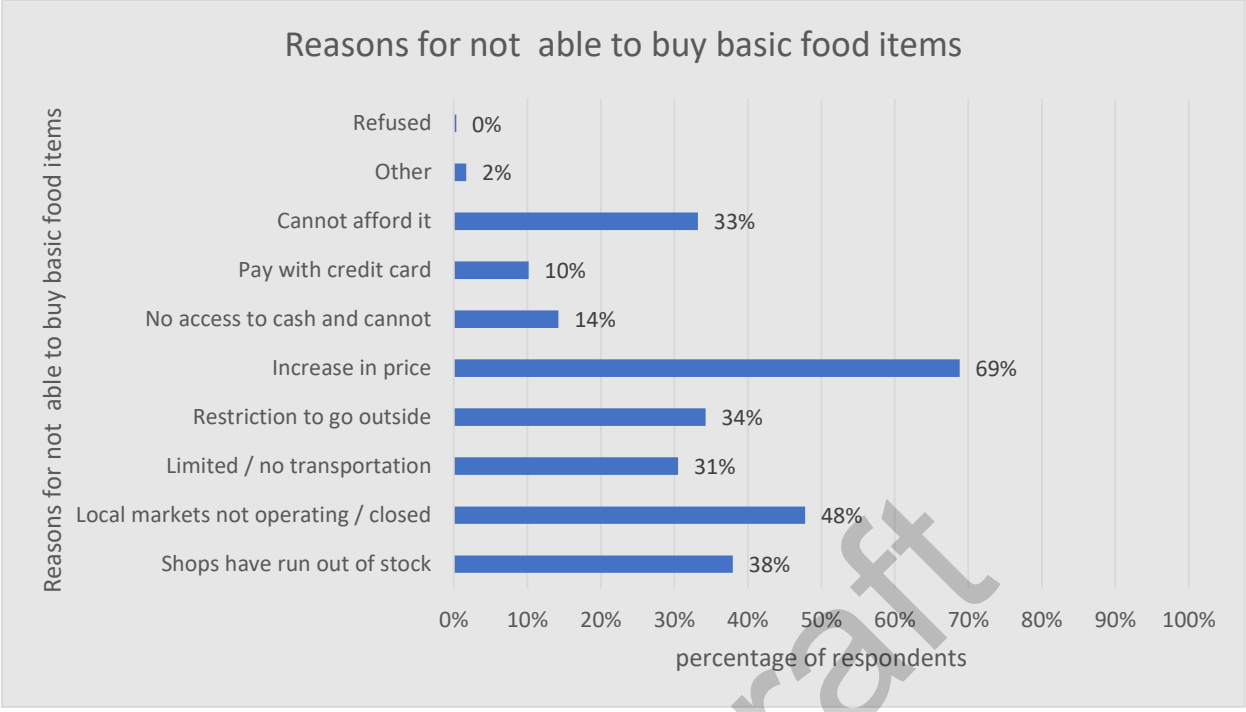

Figure 8 Bar chart showing households reasons for not able to buy basic food items (n=295)

Table 3 Frequency of the ability to buy basic food items …… (n=843)

Variables		Response			
		Unable to buy basic food		Able to buy or not tried to buy basic food	
		Frequency	Percentage	Frequency	Percentage
Region	Addis Ababa	79	27.8%	205	72.2%
	Hawassa	176	62.0%	108	38.0%
	Jigjiga	40	14.5%	235	85.5%
Gender	Male	164	38.1%	266	61.9%
	Female	131	31.7%	282	68.3%
Education Level	Never attended school	27	38.0%	44	62.0%
	Primary incomplete	31	53.4%	27	46.6%
	Primary complete	38	44.7%	47	55.3%
	Secondary incomplete	49	45.0%	60	55.0%
	Secondary complete	72	34.1%	139	65.9%

	Bachelor incomplete	24	21.1%	90	78.9%
	Bachelor completed or higher	45	25.9%	129	74.1%
	Other	9	42.9%	12	57.1%
Follow Government Guidelines	Strongly disagree	29	69.0%	13	31.0%
	Disagree	20	31.3%	44	68.8%
	Neutral	28	25.0%	84	75.0%
	Agree	218	34.9%	407	65.1%

6.3.3. Access to other food items

Among the total 843 study participants from the three regions, 327 (39%) have reported that their households have been unable to buy other food items during the pandemic; whereas a little higher than half of the participants (54%) reported the opposite.

There is a regional variation towards accessing other food items. A little lower than two third (62%) of the participants from Hawassa have reported that their households have been unable to buy other food items during the pandemic; whereas a little higher than one third (37%) of the participants from Addis Ababa and only 17% of the participants from Jigjiga reported the same.

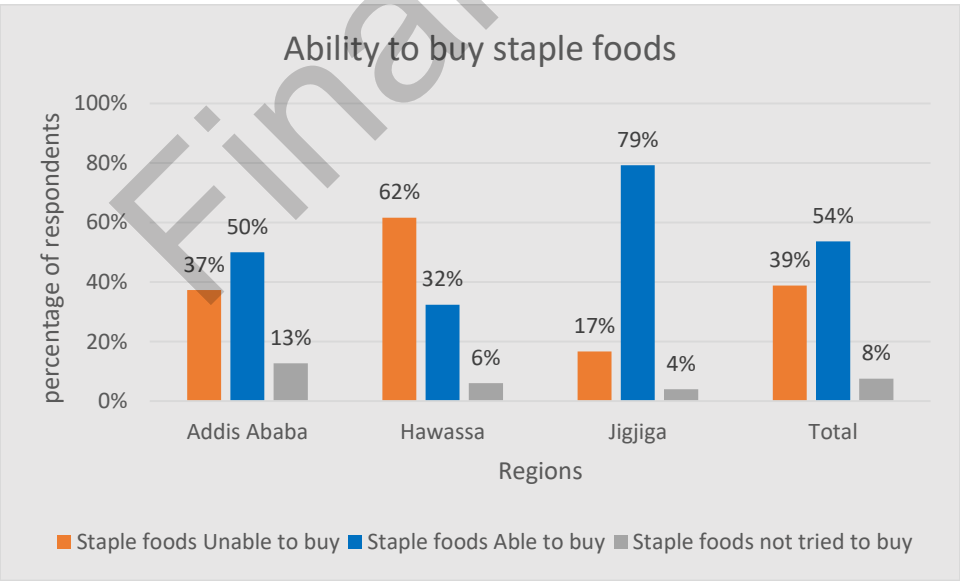

Figure 9 Bar chart showing households access to buy staple foods during the pandemic

Out of the 327 respondents who reported their households were unable to buy other food items during the pandemic, increase in price was identified by 206 (63%) of them as a reason. Similarly,

122 respondents (37%) reported local markets not operating / closed, 87 respondents (27%) reported shops have run out of stock, 95 respondents (29%) reported restriction to go outside, 117 respondents (36%) reported cannot afford it and 89 respondents (27%) reported limited / no transportation as the reasons why their households were unable to buy other food items during the pandemic. The result is highly consistent with the magnitude and reasons identified by the respondents for basic food items.

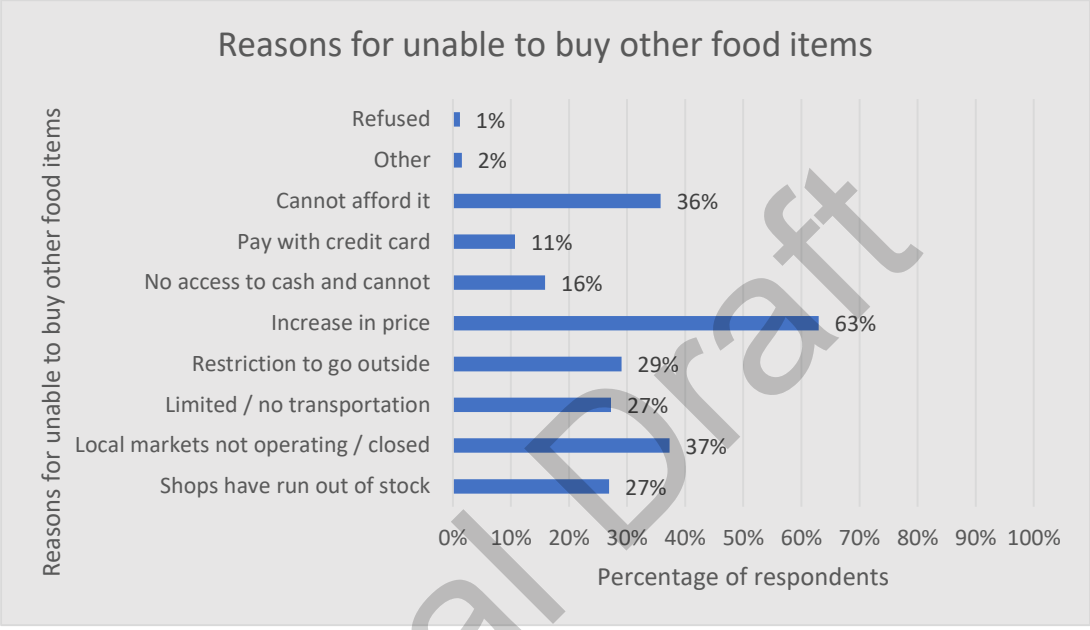

Figure 10 Bar chart showing households reason for being unable to buy staple foods during the pandemic (n=327)

6.3.4. Access to water

Regarding access to water, among 843 respondents from the three regions, almost half of them (49%) have reported that, there was at least one time that they did not have sufficient drinking water to meet household needs during the outbreak of COVID19; while the rest half (49%) of the respondents reported it was always sufficient.

There is a regional variation in participants' response on access to water during the pandemic. More than two third (65%) of the participants from Jigjiga, one third (35%) of the participants from Hawassa and almost half (50%) of the participants from Addis Ababa reported that there was at least one time that they did not have sufficient drinking water to meet household needs during the outbreak of COVID19. No major variation in the response of participants was observed by gender.

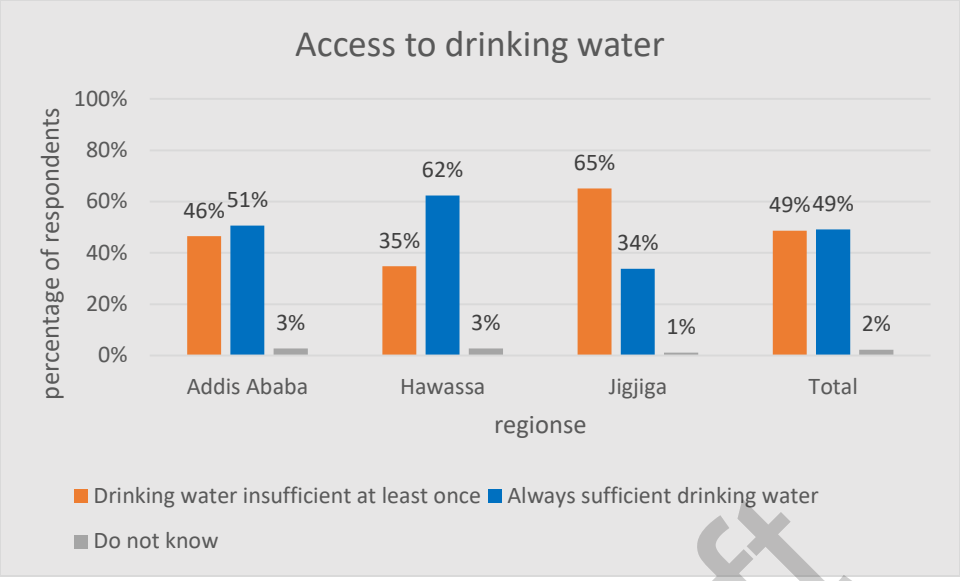

Figure 11 Bar chart showing households access to sufficient drinking water to meet hosehold needs during the pandemic

Among the 410 participants who reported that there was at least one time that they did not have sufficient drinking water to meet household needs during the outbreak of COVID19, 234 (57%) respondents reported no longer available water supply, 217 (53%) reported reduced water supply and 78 (18.5%) reported increase in price as the main reason their households were unable to access sufficient drinking water.

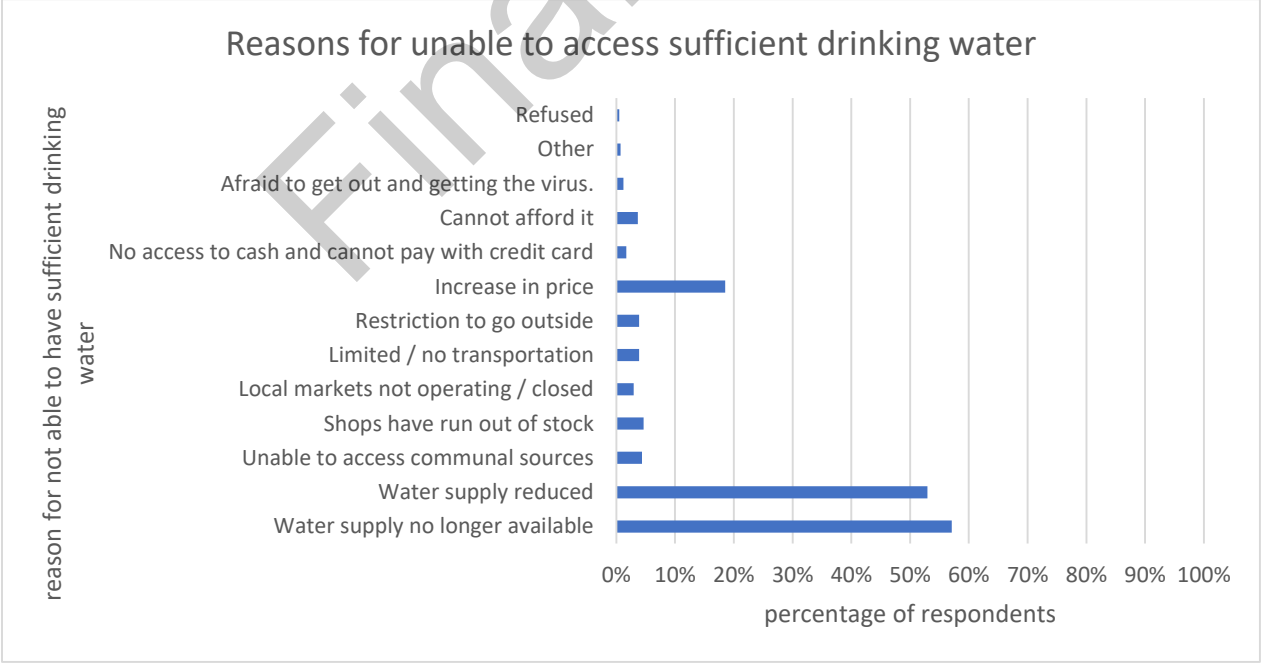

Figure 12 Bar chart showing households reason for not being able to access sufficient drinking water during the pandemic (n=410)

Table 4 Frequency of sufficient drinking water to meet household needs during the pandemic (n=843)

Variables		Drinking water			
		Insufficient at least once		Always sufficient	
		Frequency	Percentage	Frequency	Percentage
Research sites	Addis Ababa	132	46.5%	152	53.5%
	Hawassa	99	34.9%	185	65.1%
	Jigjiga	179	65.1%	96	34.9%
Gender	Male	198	46.0%	232	54.0%
	Female	212	51.3%	201	48.7%
Education level	Never attended school	43	60.6%	28	39.4%
	Primary incomplete	21	36.2%	37	63.8%
	Primary complete	42	49.4%	43	50.6%
	Secondary incomplete	50	45.9%	59	54.1%
	Secondary complete	115	54.5%	96	45.5%
	Bachelor incomplete	50	43.9%	64	56.1%
	Bachelor completed or higher	75	43.1%	99	56.9%
	Other	14	66.7%	7	33.3%
Follow government guidelines	Strongly disagree	33	78.6%	9	21.4%
	Disagree	43	67.2%	21	32.8%
	Neutral	73	65.2%	39	34.8%
	Agree	261	41.8%	364	58.2%

6.3.5. Sufficient water

Among 843 respondents from the three regions, 255 (30%) have reported that they did not have sufficient water to wash their hands when needed during the pandemic. The region wise proportion of respondents who reported water insufficiency for hand washing was, 48%, 23% and 20% for Jigjiga, Addis Ababa and Hawassa respectively.

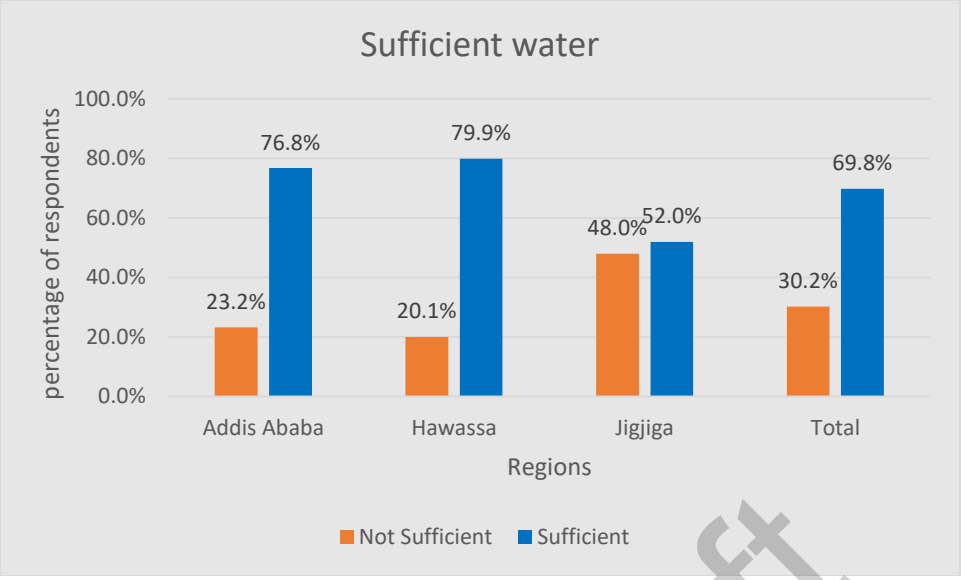

Figure 13 Bar chart showing households access to sufficient water to meet household needs during the pandemic

Among the 255 participants who reported that they did not have sufficient water to wash their hands when needed during the pandemic, 160 (i.e. 63% or nearly two third) of them identified that the main reason that their households were unable to access water to wash their hands was because water supply was not available. Similarly, reduced water supply and increase in price were also identified as reasons by 138 (54%) and 36 (14%) of the participants.

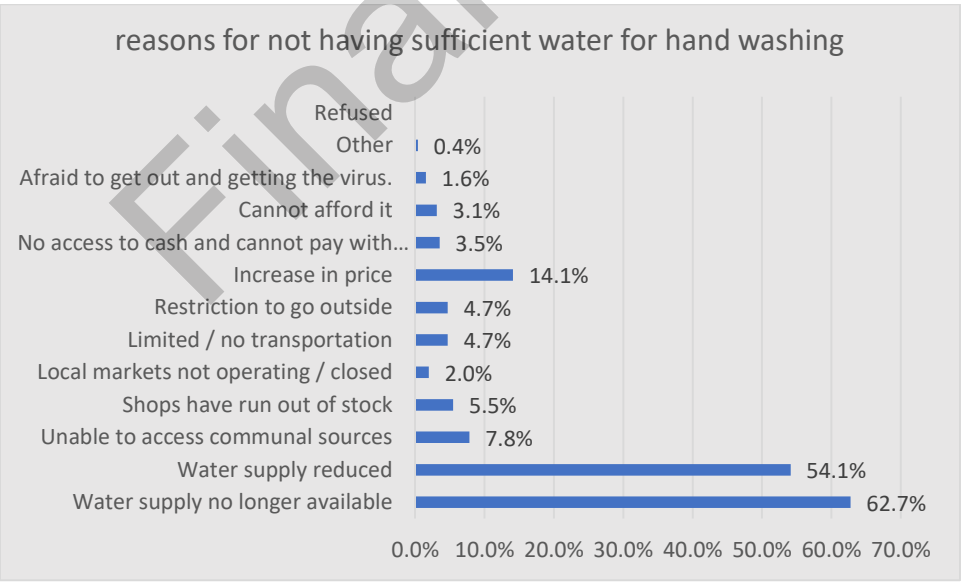

Figure 14 Bar chart showing households reasons for not being able to access sufficient water for hand washing during the pandemic (n=225)

6.3.6. Hand Washing

Among 843 study participants 210 (25%) of them reported that they did not have sufficient soap to wash their hands when needed during the pandemic. When compared among regions, 31% of participants from Jigjiga, 28% of participants from Hawassa and 19% of participants from Addis Ababa reported soap insufficiency.

Increase in price, reported by (54%) of participants; shops have run out of stock (39%); local markets not operating / closed reported by (23%); and cannot afford it (23%) were the main reasons identified by participants who reported that they did not have sufficient soap to wash their hands when needed during the pandemic respectively.

6.3.7. Electricity

Among the 843 respondents almost all (98%) have reported that national grid connection was the primary source of electricity at their home during the pandemic. Regarding access to electricity, 640 (76%) of the participants have reported that, during the pandemic, their households' access to electricity was same as before while 148 (18%) participants reported that it was worse than before.

6.3.8. Access to health service

Among the 843 respondents, 340 (40%) have reported that a member of their family has needed medical service since the pandemic. Of the 340 participants who reported that their family has needed medical service, 119 (35%) of them has indicated that their households were not able to access the medical services.

Among the regions, Hawassa, was the region with the highest proportion of participants (i.e. 42%) who reported that their households were not able to access medical services, followed by Jigiga (30%) and Addis Ababa (27%). The most common reasons reported by the participants why their households were not able to access the medical services were lack of money (reported by 41%), no medical personnel available (31%), afraid of going out and getting the virus (23%), and turned away because facility was full (21%).

Table 5 Frequency distribution of socio-economic variables in relation to access to health service (n=843)

Variables		Health service			
		Needed service		Not needed service	
		Frequency	Percentage	Frequency	Percentage
Region	Addis Ababa	120	42.3%	164	57.7%
	Hawassa	130	45.8%	154	54.2%
	Jigjiga	90	32.7%	185	67.3%
Gender	Male	173	40.2%	257	59.8%
	Female	167	40.4%	246	59.6%
Education level	Never attended school	27	38.0%	44	62.0%
	Primary incomplete	28	48.3%	30	51.7%
	Primary complete	36	42.4%	49	57.6%
	Secondary incomplete	39	35.8%	70	64.2%
	Secondary complete	75	35.5%	136	64.5%
	Bachelor incomplete	53	46.5%	61	53.5%
	Bachelor completed or higher	72	41.4%	102	58.6%
	Other	10	47.6%	11	52.4%
Follow government guidelines	Strongly disagree	25	59.5%	17	40.5%
	Disagree	20	31.3%	44	68.8%
	Neutral	37	33.0%	75	67.0%
	Agree	258	41.3%	367	58.7%

The most common reason for Addis Ababa were “afraid to go out and caught the virus”, “lack of money” and “turned away because facility was full” which were identified by 41%, 28% and 25% of those respondents who reported that households were not able to access the medical services

respectively. Likewise, the most common reason for Hawassa were "no medical personnel available", "lack of money" and "turned away because facility was full" which were identified by 48%, 45% and 27% of those respondents who reported that households were not able to access the medical services respectively. However, the most common reasons for Jigjiga were "lack of money" and limited transportation" which were identified by 48% and 26% of those respondents who reported that households were not able to access the medical services respectively

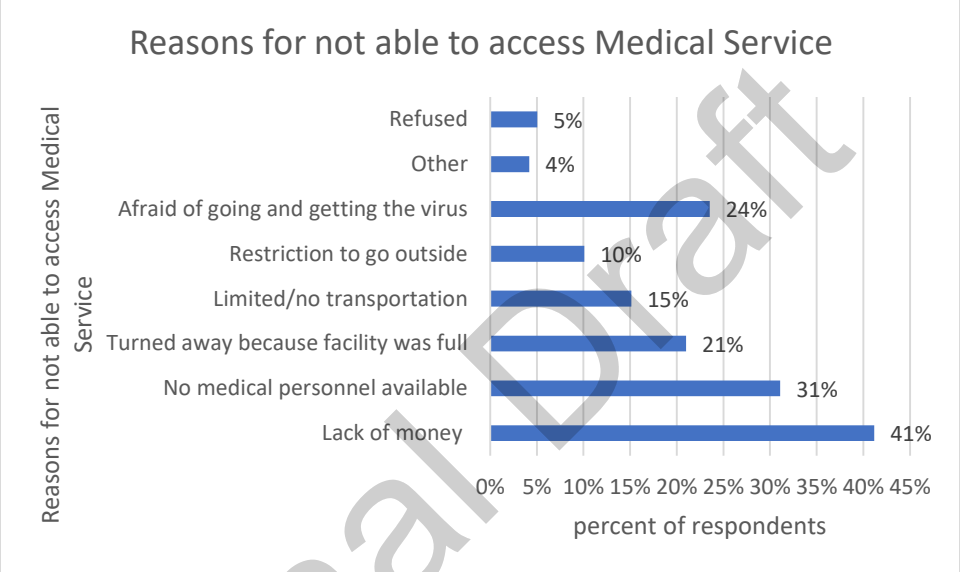

Figure 15 Bar chart showing households reasons for not being able to access medical service during the pandemic

6.3.9. Public transport

Among 843 participants, 679 of them (81%) reported that, during the pandemic, either any member of their households needed to make use of public transportation services. Among the three regions, the result was almost similar for Addis Ababa (86%) and Hawassa (85%) but a little lower for Jigjiga (71%).

Among the 679 respondents who reported that their households needed to make use of public transportation services during the pandemic, 119 (16%) were able to successfully access transportation service without difficulty while equivalent proportion of respondents (i.e. 101 participants or 15%) reported that they were not able to access the service at all. However, majority of the respondents (69%) reported that they were able to access the service but with reduced frequency. Among the regions, the proportion of respondents that reported the level of access to

transportation service were corresponding with that of the overall result except for Hawassa where nearly one third (32%) of the participants reported that they were not able to access the service at all, which is about five times higher than that of Addis Ababa and Jigjiga. Furthermore, there was no significant variation in access to transportation service during the pandemic by gender.

The main reasons for not being able to access transport service were movement restriction, identified by 62% of the participants who reported that they were not able to access the service at all, cessation of service identified by 41% and fear to go outside because of the corona virus identified by 33% of them. Compared by regions, cessation of service was the main reason for Addis Ababa, whereas, movement restriction for Hawassa and Jigjiga.

Table 6 Frequency distribution on public transport usage during the pandemic (n=843)

Variables		Use public transport			
		Yes		No	
		Frequency	Percentage	Frequency	Percentage
Research sites	Addis ababa	39	13.7%	245	86.3%
	Hawassa	44	15.5%	240	84.5%
	Jigjiga	81	29.5%	194	70.5%
Gender	Male	79	18.4%	351	81.6%
	Female	85	20.6%	328	79.4%
Education level	Never attended school	35	49.3%	36	50.7%
	Primary incomplete	13	22.4%	45	77.6%
	Primary complete	17	20.0%	68	80.0%
	Secondary incomplete	16	14.7%	93	85.3%
	Secondary complete	30	14.2%	181	85.8%
	Bachelor incomplete	16	14.0%	98	86.0%
	Bachelor completed or higher	33	19.0%	141	81.0%
	Other	4	19.0%	17	81.0%

Follow government guidelines	Strongly disagree	4	9.5%	38	90.5%
	Disagree	21	32.8%	43	67.2%
	Neutral	42	37.5%	70	62.5%
	Agree	97	15.5%	528	84.5%

6.4. Income

6.4.1. Paid work

In response to the question inquiring if participants have done any work for pay, any kind of business, farming or other activity to generate income, even if only for one hour, during the pandemic, 463 (55%) reported that they did not. It was also found that higher proportion of female respondents (61%) did not do any work for pay compared to their counterpart male respondents (50%). Compared by regions, the proportion of respondents who did not do any work for pay during the pandemic was 71% for Jigjiga, which is twice that of Addis Ababa, 57% for Hawassa and 38% for Addis Ababa.

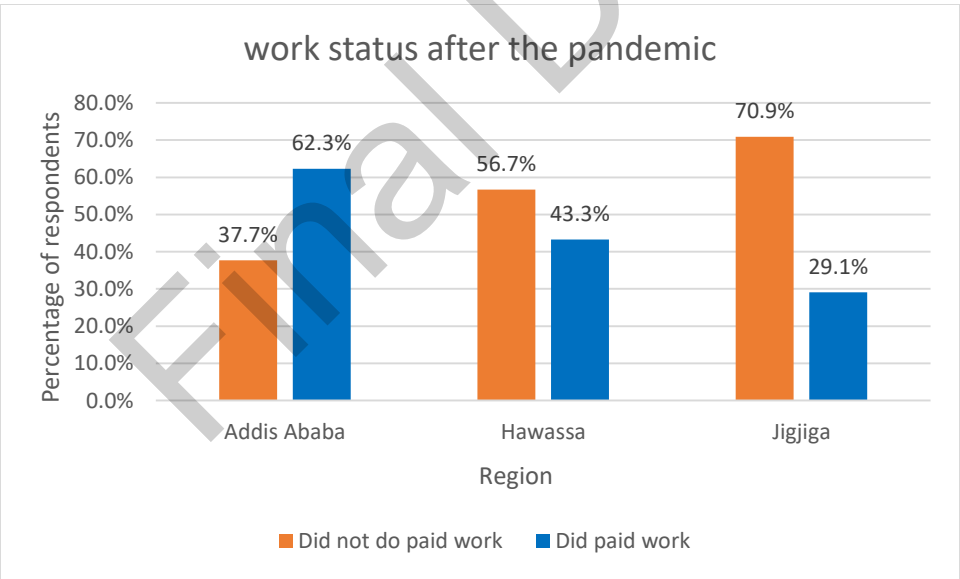

Figure 16 Bar chart showing participants work status after the pandemic

A logistic regression analysis to investigate the association of paid work with gender and region (residence of participants) was conducted. Accordingly, it was found that youths living in Addis Ababa, have 4 times greater chance of having a paid work compared to those in Jigjiga. Similarly, youths living in Hawassa, have 1.8 times ($p<0.05$) greater chance of having a paid work compared

to those in Jigjiga. In addition, males have about 1.7 times ($p<0.05$) greater chance of having a paid work compared to females.

Table 7 : Regression analysis output on the the association of paid work with gender and region

Paid work							
		B	S.E.	Wald	df	Sig.	Exp(B)
Step 1a	Jigjiga			62.593	2	0.000	
	Addis Ababa	1.437	0.183	61.738	1	0.000	4.208
	Hawassa	0.633	0.180	12.323	1	0.000	1.883
	Gender (Male)	0.524	0.146	12.875	1	0.000	1.688
	Constant	-1.180	0.158	55.630	1	0.000	0.307
a. Variable(s) entered on step 1: reseach sites, gender.							

Among those who 463 participants who reported that they did not do any paid work during the pandemic, 182 (39%) had work before the pandemic. The proportion of respondents who had work before the pandemic was highest for Hawassa (67%), followed by Addis Ababa (44%) and least for Jigjiga (14%). The main reason was closure of business / government due to coronavirus legal restrictions as identified by almost half (48%) of them. In addition, other reasons – identified by 16% of them, closure of business / government for another reason - identified by 12% of them, respondents' fear of exposure to the virus - identified by 10% of them, and laid off while business continues - identified by 10% of them were also among the main reasons.

Among the 182 respondents who reported that they had work before the pandemic, 32% were working in business organization focusing on buying & selling goods, repair of goods, hotels & restaurants; and 29% business organization focusing on personal services, education, health, culture, sport, domestic work, other.

The proportion of respondents who did some work for pay during the pandemic were higher in Addis Ababa compared to the other two regions. Accordingly, 62%, 43% and 29% of respondents from Addis Ababa, Hawassa and Jigjiga respectively have done some work for pay during the pandemic. Among them, 30% were working in organizations whose main activity were buying & selling goods, repair of goods, hotels & restaurants; 27% in organizations whose main activity were personal services, education, health, culture, sport, domestic work, other; and 15%

organizations whose main activity were government/public sector. In addition, 62% of them have reported that their employers do not provide them with benefits.

Table 8 Frequency distribution of participants based on paid work status during the pandemic (n=843)

Variables		Paid work			
		Did not do paid work		Did paid work	
		Frequency	Percentage	Frequency	Percentage
Research sites	Addis Ababa	107	37.7%	177	62.3%
	Hawassa	161	56.7%	123	43.3%
	Jigjiga	195	70.9%	80	29.1%
Gender	Male	213	49.5%	217	50.5%
	Female	250	60.5%	163	39.5%
Education level	Never attended school	49	69.0%	22	31.0%
	Primary incomplete	30	51.7%	28	48.3%
	Primary complete	51	60.0%	34	40.0%
	Secondary incomplete	66	60.6%	43	39.4%
	Secondary complete	124	58.8%	87	41.2%
	Bachelor incomplete	69	60.5%	45	39.5%
	Bachelor completed or higher	63	36.2%	111	63.8%
	Other	11	52.4%	10	47.6%
Follow government guidelines	Strongly disagree	19	45.2%	23	54.8%
	Disagree	38	59.4%	26	40.6%
	Neutral	78	69.6%	34	30.4%
	Agree	328	52.5%	297	47.5%

6.4.2. Livelihood

Among 843 participants who were asked what their households' source of livelihood were in the past 12 months, 41% reported wage employment of household members; 28% reported non-farm family business; 16% reported family farming, livestock or fishing; and 13% reported income from

properties, investments or savings. No major variation was observed by gender or study area. Moreover, about two third of the respondents (i.e. 64%) have reported that their household's income has reduced since the pandemic; and only 29% reported that it stayed the same. No major variation was observed by gender or study area.

Table 9 Frequency distribution of participants based on income status

Variables		Income status			
		Increased or stayed same		Reduced or no income	
		Frequency	Percentage	Frequency	Percentage
Research sites	Addis Ababa	91	32.0%	193	68.0%
	Hawassa	98	34.5%	186	65.5%
	Jigjiga	87	31.6%	188	68.4%
Gender	Male	152	35.3%	278	64.7%
	Female	124	30.0%	289	70.0%
Education level	Never attended school	22	31.0%	49	69.0%
	Primary incomplete	12	20.7%	46	79.3%
	Primary complete	21	24.7%	64	75.3%
	Secondary incomplete	30	27.5%	79	72.5%
	Secondary complete	58	27.5%	153	72.5%
	Bachelor incomplete	45	39.5%	69	60.5%
	Bachelor completed or higher	80	46.0%	94	54.0%
	Other	8	38.1%	13	61.9%
Follow government guidelines	Strongly disagree	8	19.0%	34	81.0%
	Disagree	20	31.3%	44	68.8%
	Neutral	20	17.9%	92	82.1%

	Agree	228	36.5%	397	63.5%

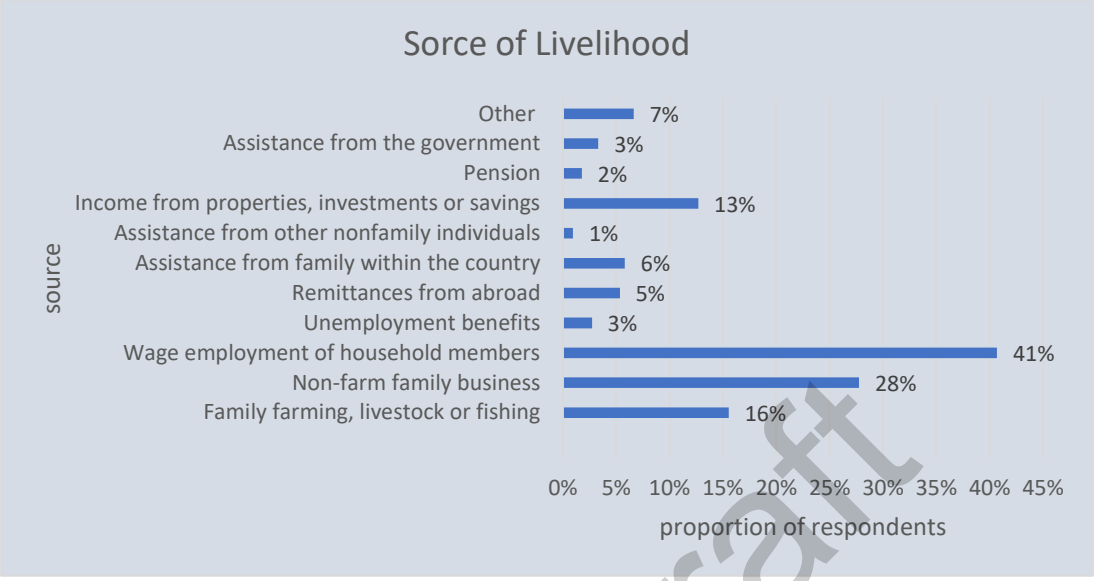

Figure 17 Bar chart showing households source of livelihood during the pandemic

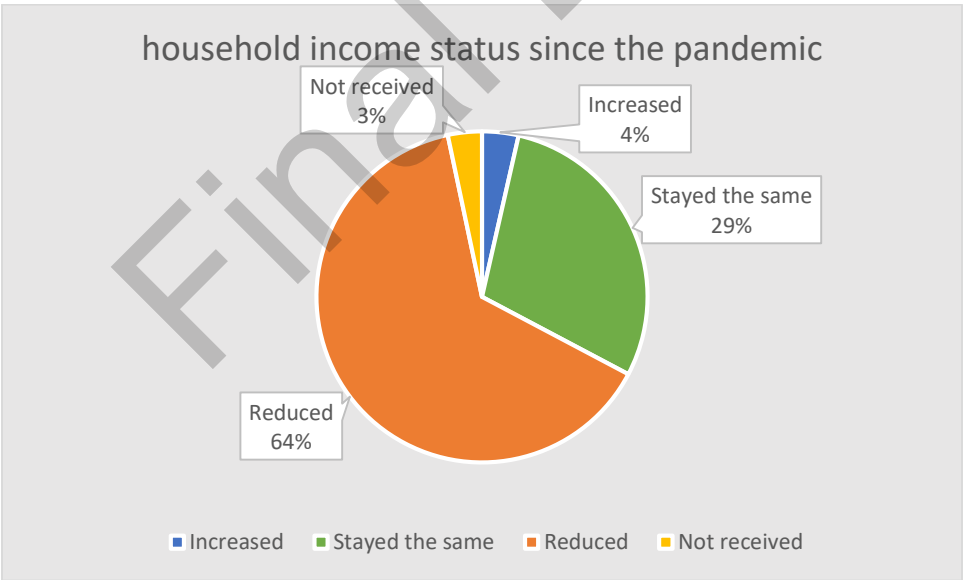

Figure 18 Pie chart showing households income status since the pandemic

6.5. Food Security

Among 843 participants, 345 (41%) reported that, during the last 30 days prior to the data collection time, there was a time when they or any other adult in their household were worried

about not having enough food to eat because of lack of money or other resources. The response has variation among the three study areas. More than three fourth (76%) of participants from Hawassa; one third (34%) of participants from Addis Ababa; and only 12% from Jigjiga reported there was time when they were worried about food shortage during the indicated time period. However, there was no significant version in response based on gender of participants.

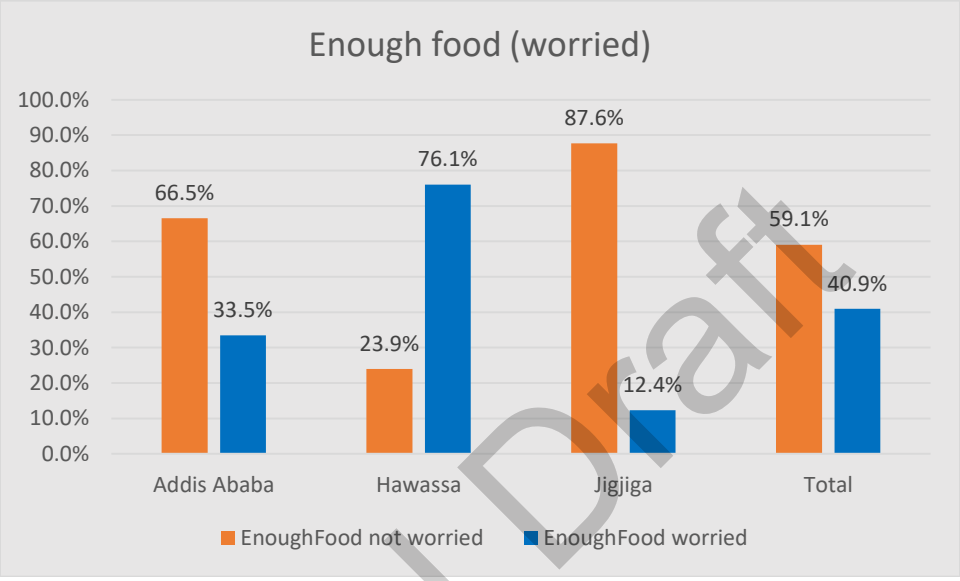

Figure 19 Bar chart showing households concern for enough food during the pandemic

Among 843 participants, 337 (40%) reported that, during the last 30 days prior to the data collection time, there was a time when they or any other adult in their household were unable to eat healthy and nutritious/preferred foods because of lack of money or other resources. The response has significant variation among the three study areas. More than two third (71%) of participants from Hawassa; more than one third (36%) of participants from Addis Ababa; and only 12% from Jigjiga reported there was time when they were unable to eat healthy and nutritious/preferred foods because of lack of money or other resources during the indicated time period. However, there was no significant version in response based on gender of participants.

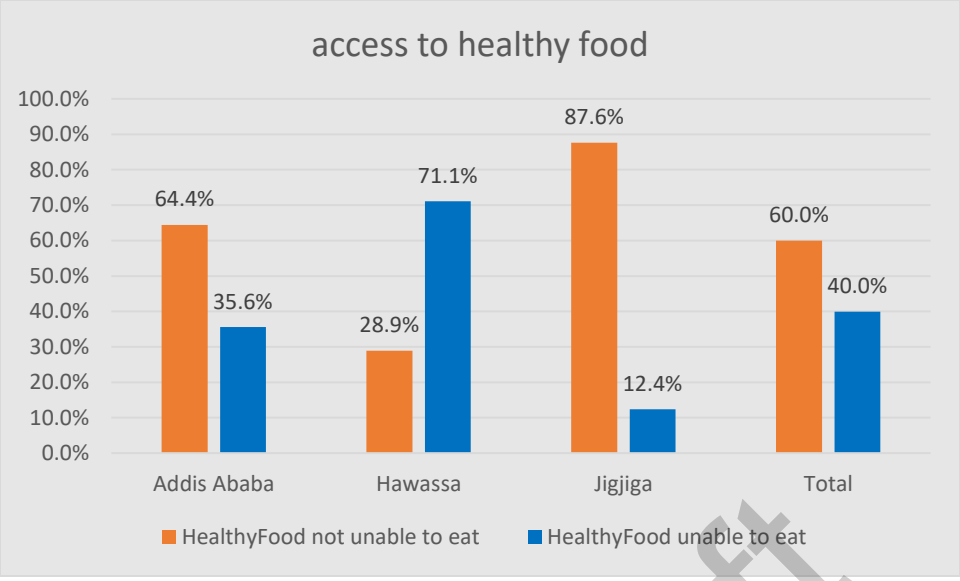

Figure 20 Bar chart showing households access to healthy food during the pandemic

Among 843 participants, 313 (37%) reported that, during the last 30 days prior to the data collection time, there was a time when they or any other adult in their household ate only a few kinds of foods because of lack of money or other resources. The response has significant variation among the three study areas. About three fourth (74%) of participants from Hawassa; more than a quarter (27%) of participants from Addis Ababa; and only 10% from Jigjiga reported there was time that they ate only a few kinds of foods because of lack of money or other resources during the indicated time period. However, there was no significant version in response based on gender of participants.

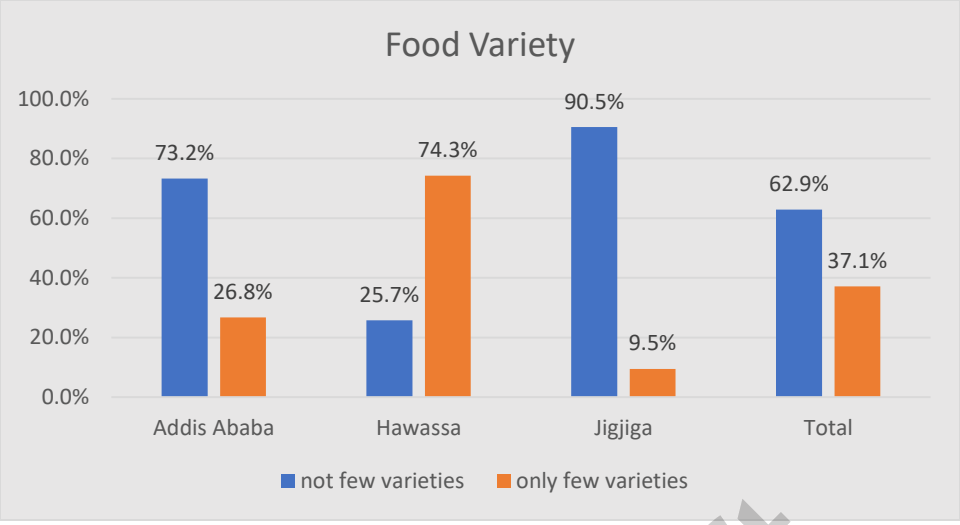

Figure 21 Bar chart showing households access to variety food items during the pandemic

Among 843 participants, 205 (24%) reported that, during the last 30 days prior to the data collection time, there was a time when they or any other adult in their household had to skip a meal because of lack of money or other resources. The response has significant variation among the three study areas. About half (49%) of participants from Hawassa; 19% of participants from Addis Ababa; and only 5 % from Jigjiga reported there was time that they had to skip a meal because of lack of money or other resources during the indicated time period. However, there was no significant variation in response based on gender of participants.

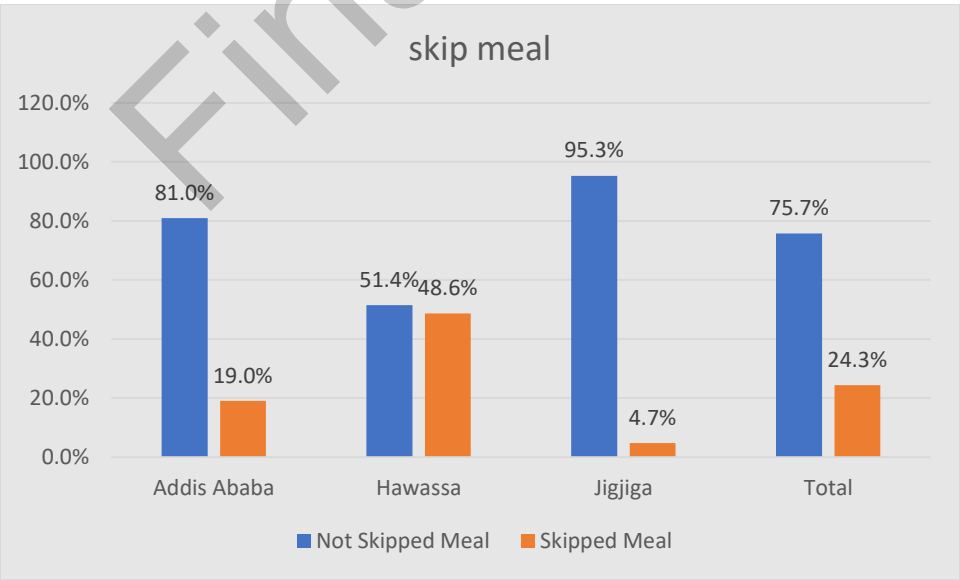

Figure 22 Bar chart showing food quantity of households during the pandemic

Among 843 participants, 261 (31%) reported that, during the last 30 days prior to the data collection time, there was a time when they or any other adult in their household ate less than you thought you should because of lack of money or other resources. The response has significant variation among the three study areas. About two third (62%) of participants from Hawassa; about one fourth (23%) of participants from Addis Ababa; and only 8 % from Jigjiga reported there was time that they ate less than you thought you should because of lack of money or other resources during the indicated time period. However, there was no significant variation in response based on gender of participants.

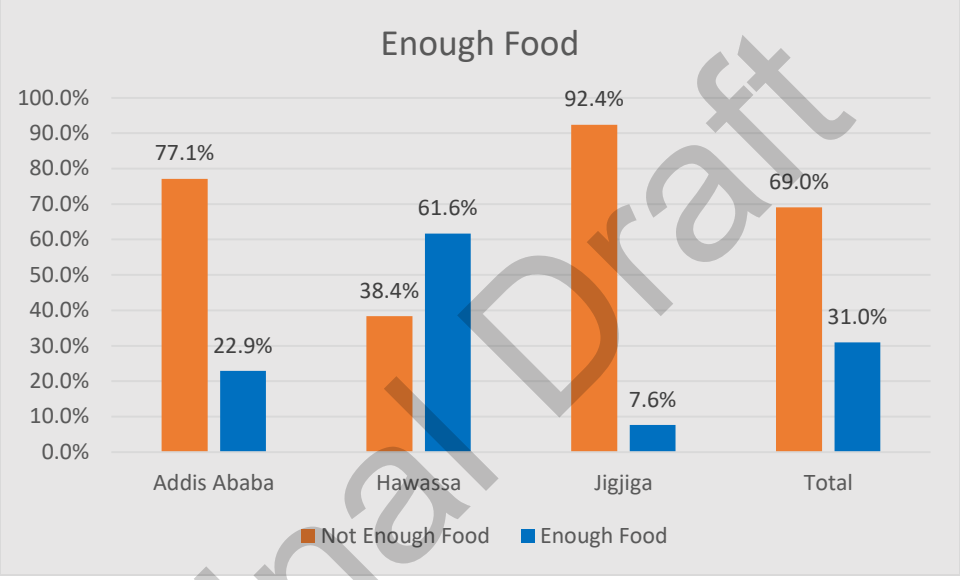

Figure 23 Bar chart showing food quantity of households during the pandemic

Among 843 participants, 169 (20%) reported that, during the last 30 days prior to the data collection time, there was a time when their household ran out of food because of lack of money or other resources. The response has significant variation among the three study areas. More than one third (36%) of participants from Hawassa; 17% of participants from Addis Ababa; and only 6% from Jigjiga reported there was time that their households ran out of food because of lack of money or other resources during the indicated time period. However, there was no significant variation in response based on gender of participants.

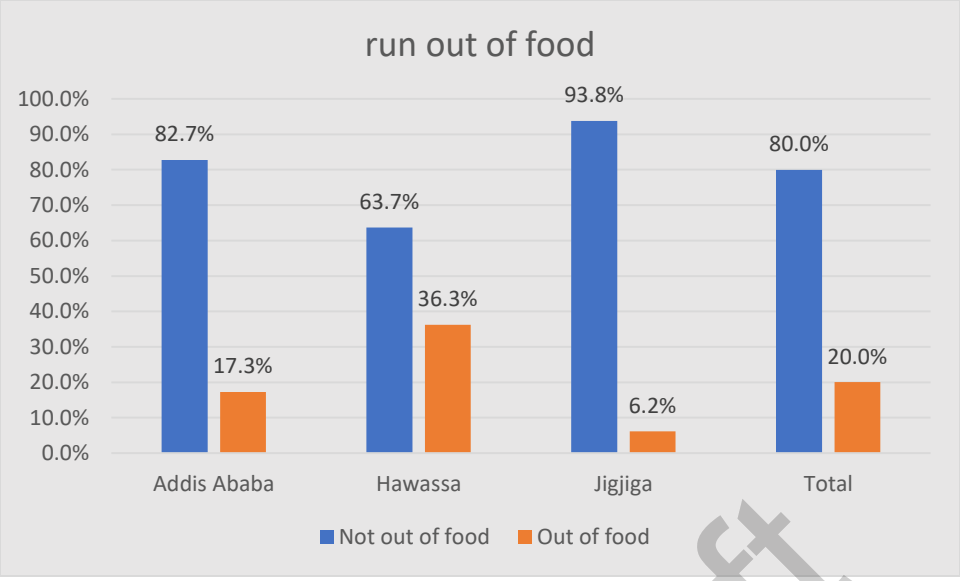

Figure 24 Bar chart showing food quantity of households during the pandemic

Among 843 participants, 140 (17%) reported that, during the last 30 days prior to the data collection time, there was a time when they or any other adult in their household were hungry but did not eat because of lack of money or other resources. The response has significant variation among the three study areas. More than a quarter (27%) of participants from Hawassa; 17% of participants from Addis Ababa; and only 6% from Jigjiga reported there was time that they were hungry but did not eat because of lack of money or other resources during the indicated time period. However, there was no significant variation in response based on gender of participants.

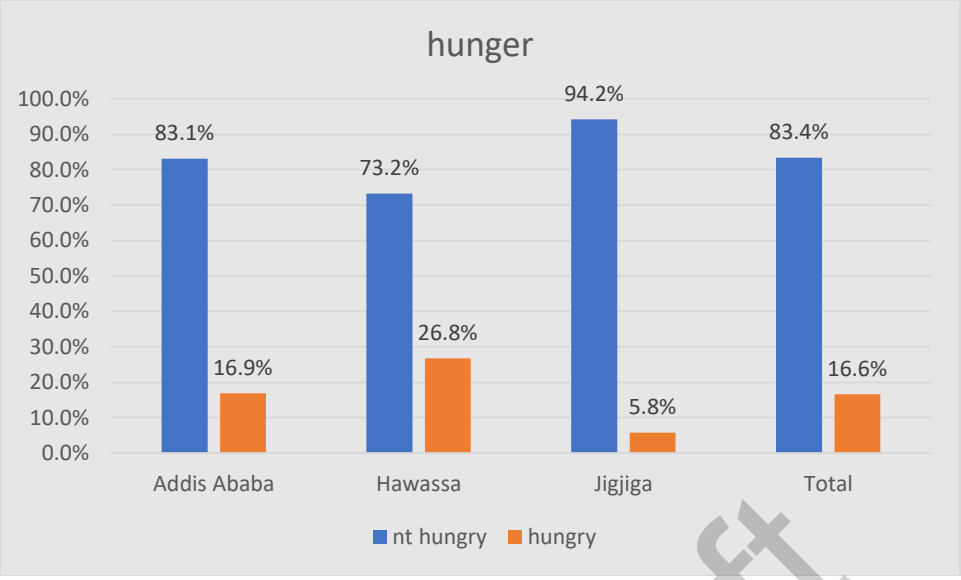

Figure 25 Bar chart showing households access to adequate food during the pandemic

Among 843 participants, 104 (12%) reported that, during the last 30 days prior to the data collection time, there was a time when they or any other adult in their household went without eating for a whole day because of lack of money or other resources. The response has significant variation among the three study areas. Nearly a quarter (22%) of participants from Hawassa; 11% of participants from Addis Ababa; and only 4% from Jigjiga reported there was time that they went without eating for a whole day because of lack of money or other resources during the indicated time period. However, there was no significant variation in response based on gender of participants.

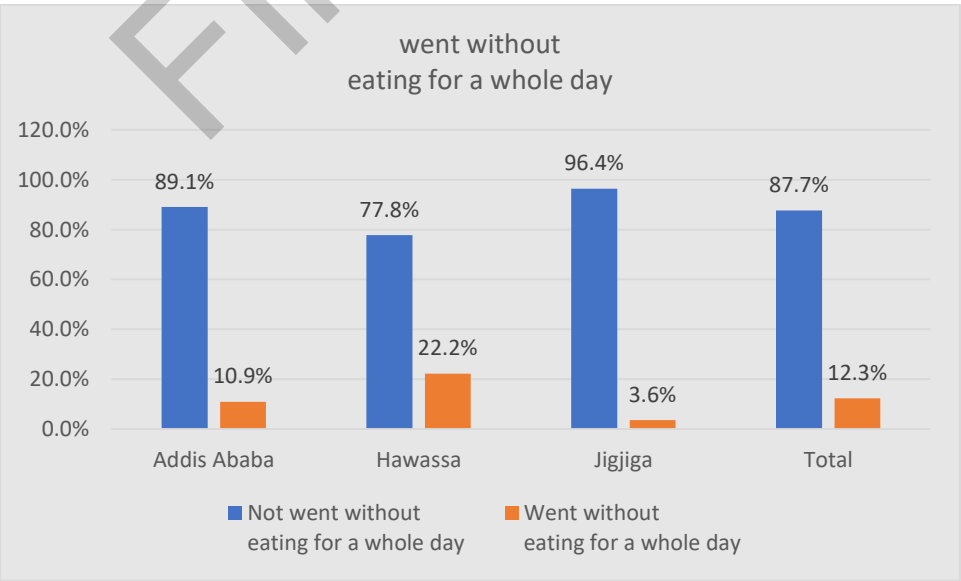

Figure 26 Bar chart showing households access to adequate food during the pandemic

Table 10 Frequency distribution of participants experience on food security

Food Security variables	Response	Overall		Addis Ababa		Hawassa		Jigjiga	
		Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Worried about Enough Food	no	498	59%	189	67%	68	24%	241	88%
	yes	345	41%	95	33%	216	76%	34	12%
	total	843	100%	284	100%	284	100%	275	100%
Healthy Food	no	506	60%	183	64%	82	29%	241	88%
	yes	337	40%	101	36%	202	71%	34	12%
	total	843	100%	284	100%	284	100%	275	100%
Food Variety	no	530	63%	208	73%	73	26%	249	91%
	yes	313	37%	76	27%	211	74%	26	9%
	total	843	100%	284	100%	284	100%	275	100%
Skip Meal	no	638	76%	230	81%	146	51%	262	95%
	yes	205	24%	54	19%	138	49%	13	5%
	total	843	100%	284	100%	284	100%	275	100%
Not Enough Food	no	582	69%	219	77%	109	38%	254	92%
	yes	261	31%	65	23%	175	62%	21	8%
	total	843	100%	284	100%	284	100%	275	100%
Out fFood	no	674	80%	235	83%	181	64%	258	94%
	yes	169	20%	49	17%	103	36%	17	6%
	total	843	100%	284	100%	284	100%	275	100%
Hunger	no	703	83%	236	83%	208	73%	259	94%
	yes	140	17%	48	17%	76	27%	16	6%
	total	843	100%	284	100%	284	100%	275	100%
Starvation	no	739	88%	253	89%	221	78%	265	96%
	yes	104	12%	31	11%	63	22%	10	4%
	total	843	100%	284	100%	284	100%	275	100%

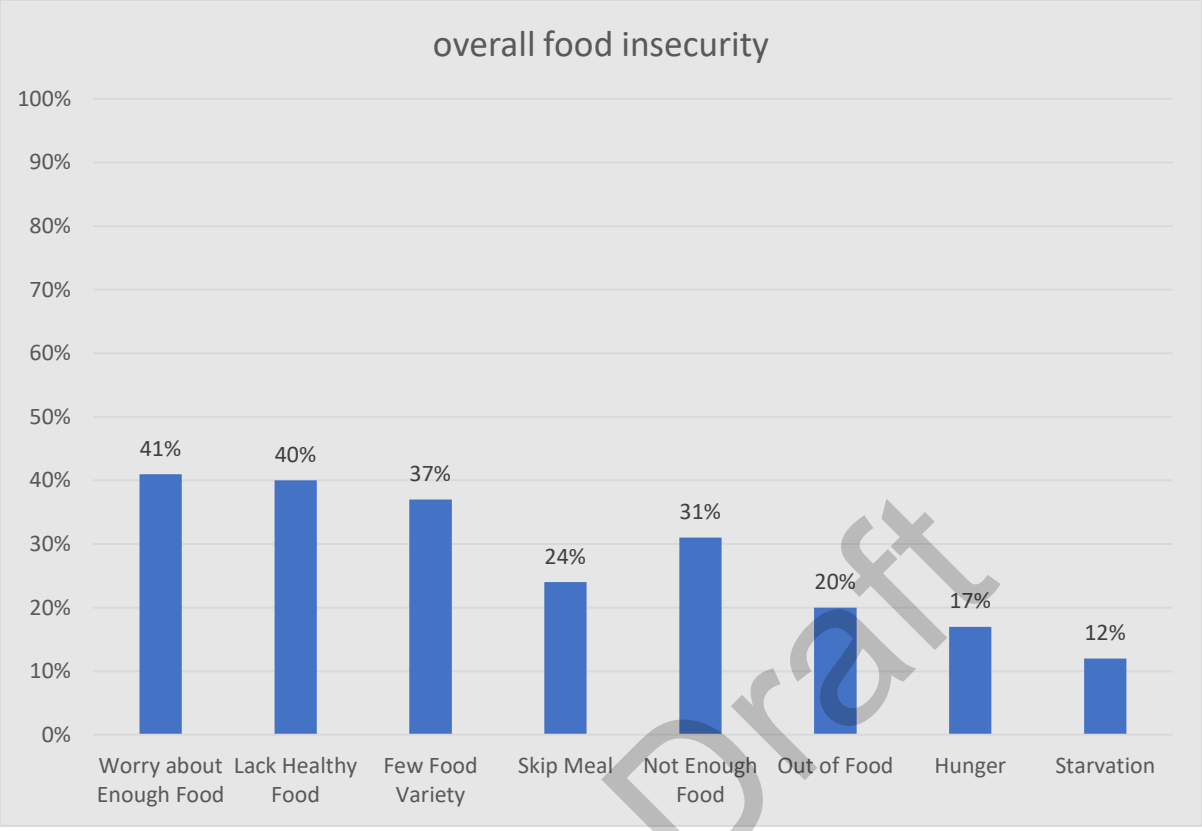

Figure 27 Bar chart showing households level of overall food security during the pandemic

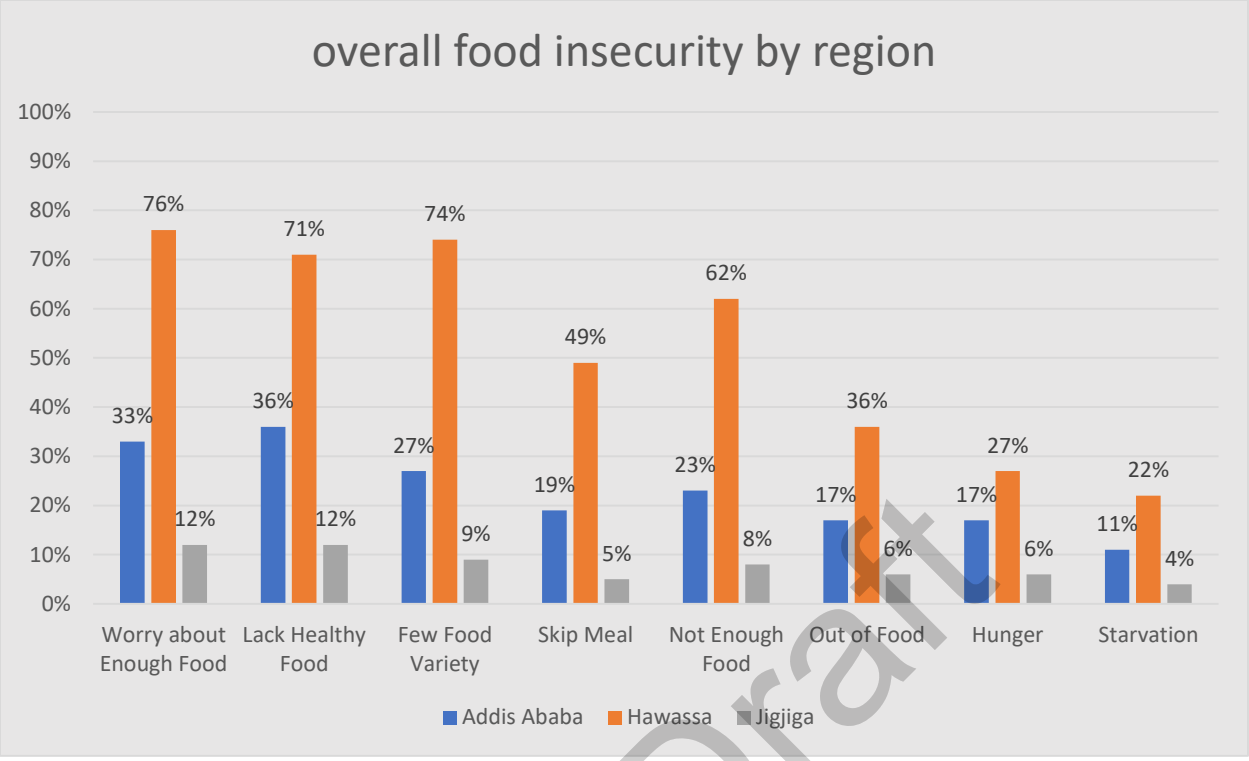

Figure 28 Bar chart showing households level of overall food security by region during the pandemic

To create a pooled prevalence of food insecurity, we computed the above eight variables on food security of households and generated a single variable; and classified those respondents who reported insecurity for five or more of the variables (more than half of the variables) as food insecured; and those respondents who reported insecurity for four or less of the variables as food secured. Accordingly, the pooled prevalence of food insecurity was found to be 25%.

Table 11 Frequency distribution of food security status

Food security status	Frequency	Percentage
Secure	633	75.1%
Insecure	210	24.9%
Total	843	100.0%

Among the three regions, Hawassa has the highest food insecurity prevalence (49%) while Jigjiga has the lowest (6%).

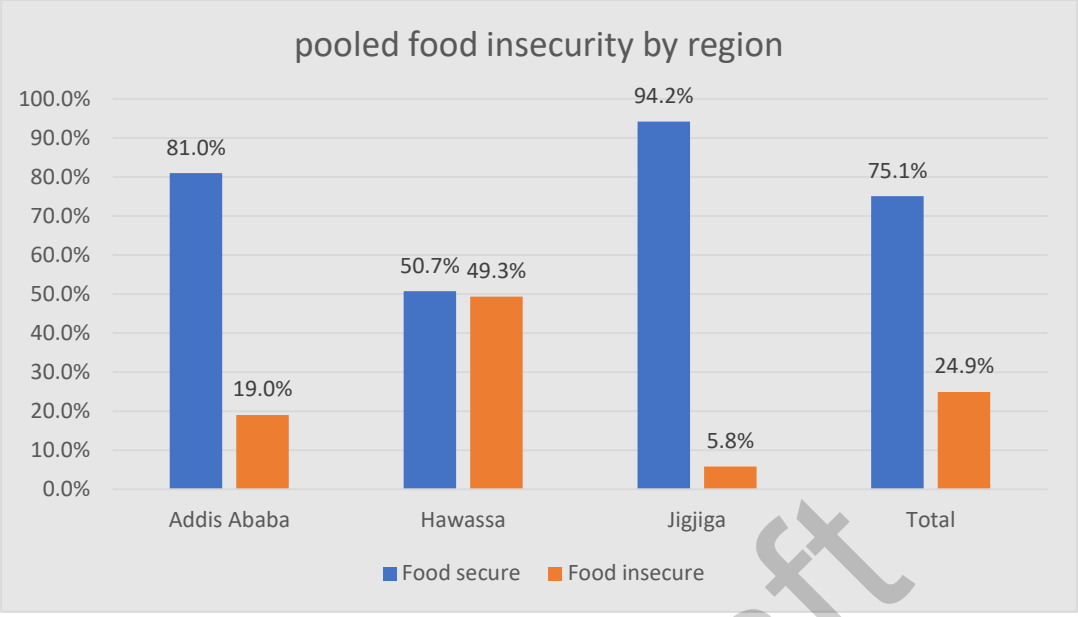

Figure 29 Bar chart showing pooled prevalence of household food security during the pandemic

A logistic regression analysis to investigate the association between gender and region (residence of participants) with household food insecurity was conducted. Accordingly, it was found that households in Addis Ababa, have 5.3 times ($p<0.05$) greater chance of being food insecure compared to those in Jigjiga. Similarly, households living in Hawassa, have more than 19 times ($p<0.05$) greater chance of being food insecure compared to those in Jigjiga. In addition, males have about 1.4 times ($p<0.05$) greater chance of being food insecure compared to females. The odds of being food insecure is 75% lower for those who are secondary school complete, 88% lower for those who are bachelor incomplete and 85% lower for those who are bachelor complete or higher compared to those who never attended school.

6.6. Affected

Among 843 participants, 580 (69%) have reported that their households have been affected by the pandemic situation. Region wise, majority (85%) of participants from Hawassa, more than two-third (71%) of participants from Addis Ababa and half (50%) of participants from Jigjiga affirmed that their households have been affected. No difference was observed in the experience of male and female participants.

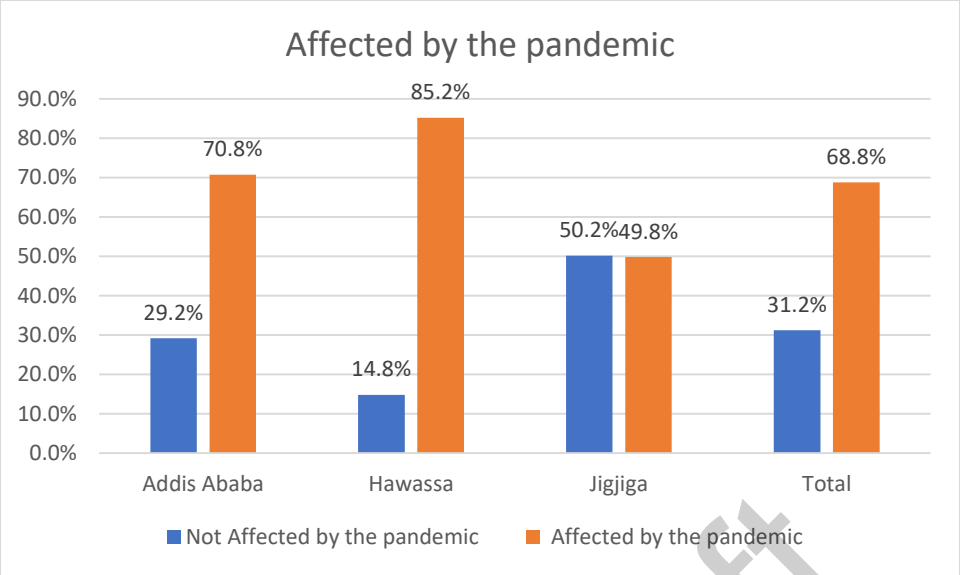

Figure 30 Bar chart showing proportion of youths affected by the pandemic

Among the 580 participants who reported that their households have been affected by the pandemic situation, 319 (55%) identified job loss; 315 (54%) identified increase in price of major food items; 83 (14%) identified non-farm business closure; 65 (11%) identified illness, injury or death of income earning family member; and 105 (18%) identified other causes as the major issues that have been affected their households.

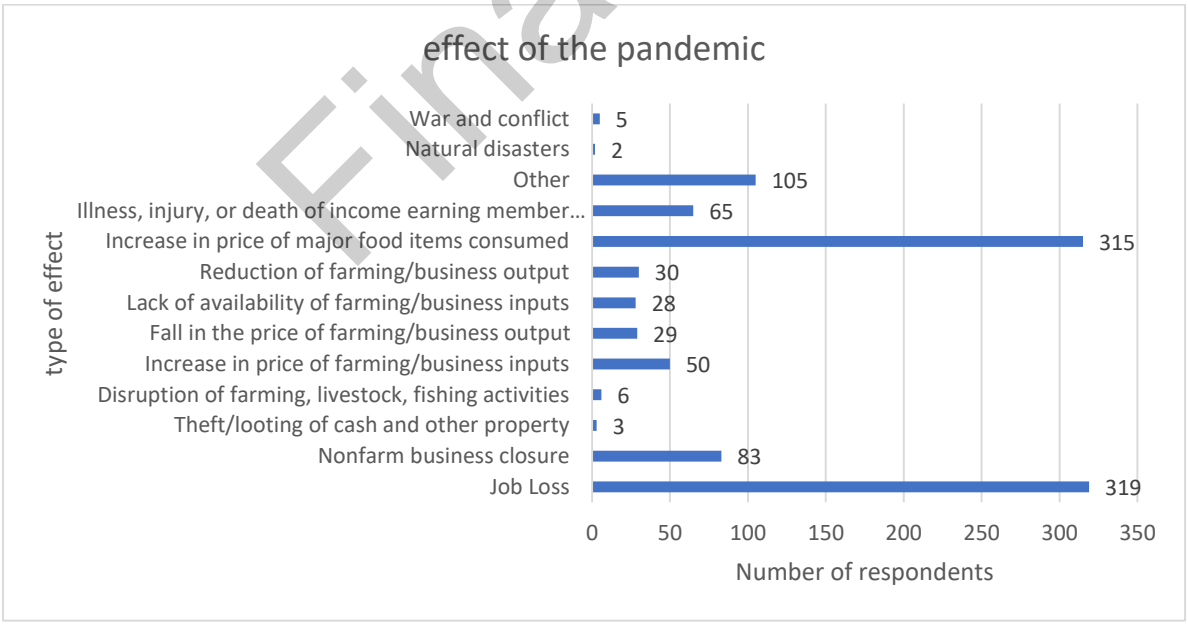

Figure 31 Bar chart showing major effects of the pandemic

Coping

All the participants from the three regions (i.e. 842) were asked what coping mechanisms were implemented by their households toward the COVID-19 situation. Accordingly, the coping mechanisms most reported by the participants were relied on savings, borrowed from family and friends, did nothing, received assistance from family and friends, engaged in additional income generating activities, reduced food consumptions and sell of assets.

No major variation among the study areas and gender of respondents in identifying the type of coping mechanisms implemented by households.

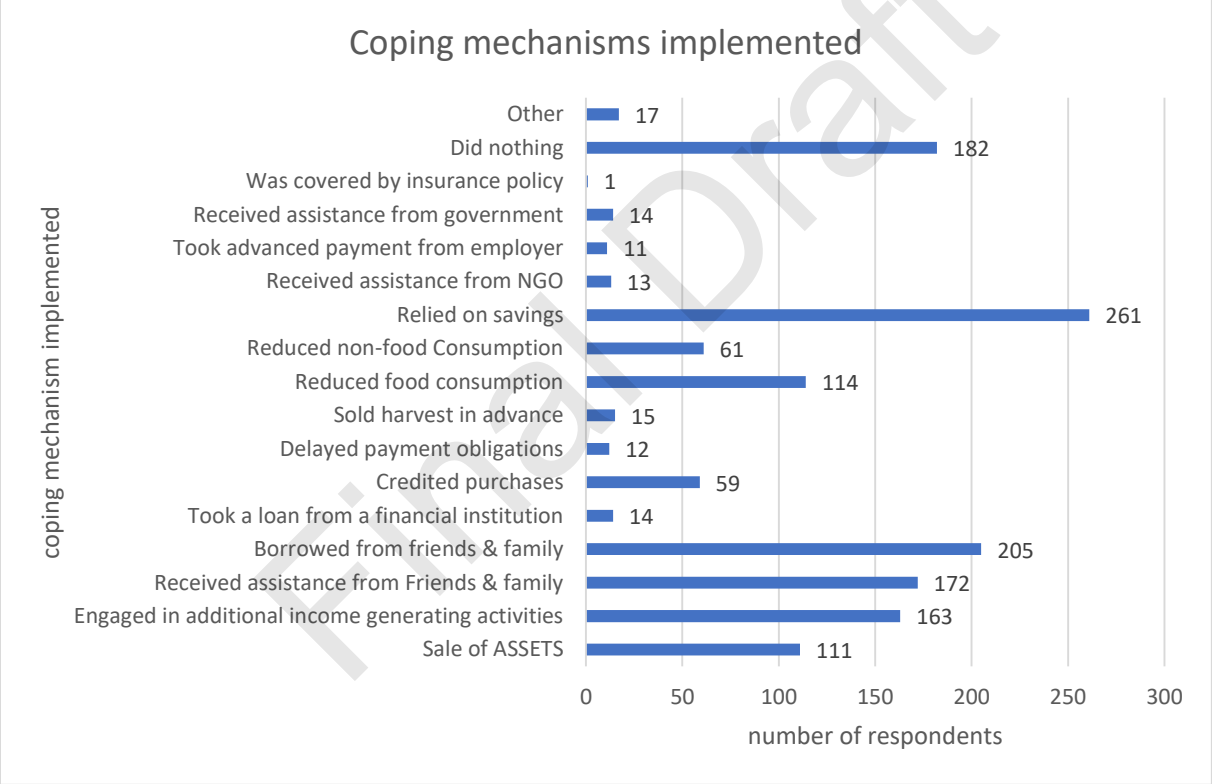

Figure 32 Bar chart showing type of coping mechanisms implemented by youths and thier households during the pandemic

6.7. Support

Safety net

Among the 842 respondents, 592 (76%) reported that they did not receive any assistance from the government in the form of cash, in kind, payment relief for public services or free food during the

pandemic. Similarly, 90% of respondents have reported that they did not receive any assistance from NGOs.

Almost all (95%) reported that any member of their household haven't received assistance from the government in the form of cash transfer. Similarly, the proportion of respondents who reported that any member of their household haven't received assistance from the government in the form of food assistance, payment relief of public services and other in kind transfers were 93%, 92% and 78% respectively. No major difference in the respondents experience was observed by study site or gender.

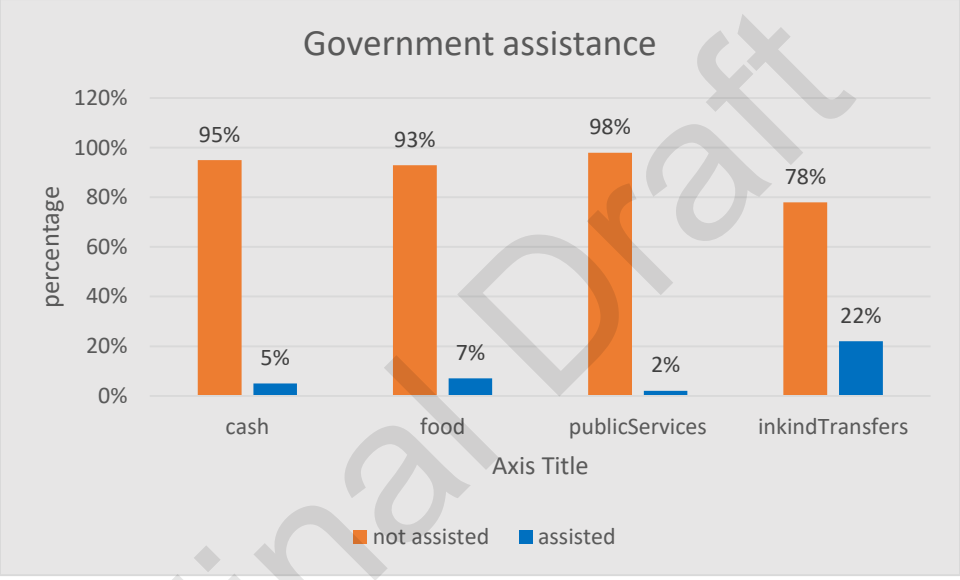

Figure 33 Bar chart showing type and level of government assistance to youths and their households during the pandemic

Likewise, among the 842 respondents, 96% reported that any member of their household haven't received assistance from NGOs in the form of cash transfer. Similarly, the proportion of respondents who reported that any member of their household haven't received assistance from NGOs in the form of food assistance, payment relief of public services and other in-kind transfers were 93%, 97% and 85% respectively. No major difference in the respondents experience was observed by study site or gender.

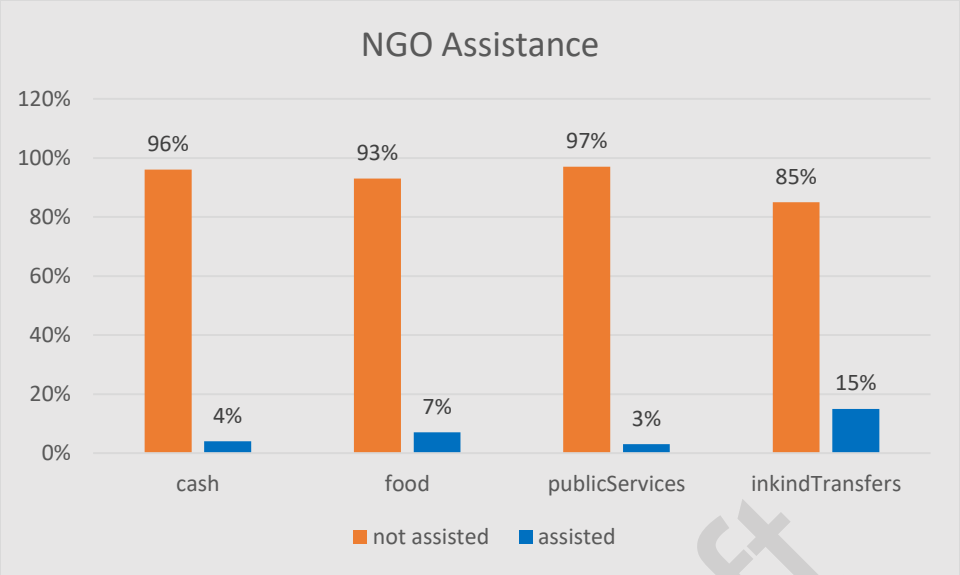

Figure 34 Bar chart showing type and level of NGO assistance to youths and their households during the pandemic

Among the total 842 respondents, 139 (16%) have reported that their households had experienced challenges while accessing the aforementioned assistances. The major challenges to access assistance identified by the participants were lack of adequate information to access befit, mobility constraint due to lockdown, bribe was requested, incomplete or delayed payment and others. However, the major challenge reported by the respondents from Addis Ababa and Hawassa were "lack of adequate information" as reported by 76% of respondents from Addis Ababa and 62% from Hawassa; whereas, 90% of respondents from Jigjiga identified "mobility constraint due to lockdown" as the major challenge to access benefits.

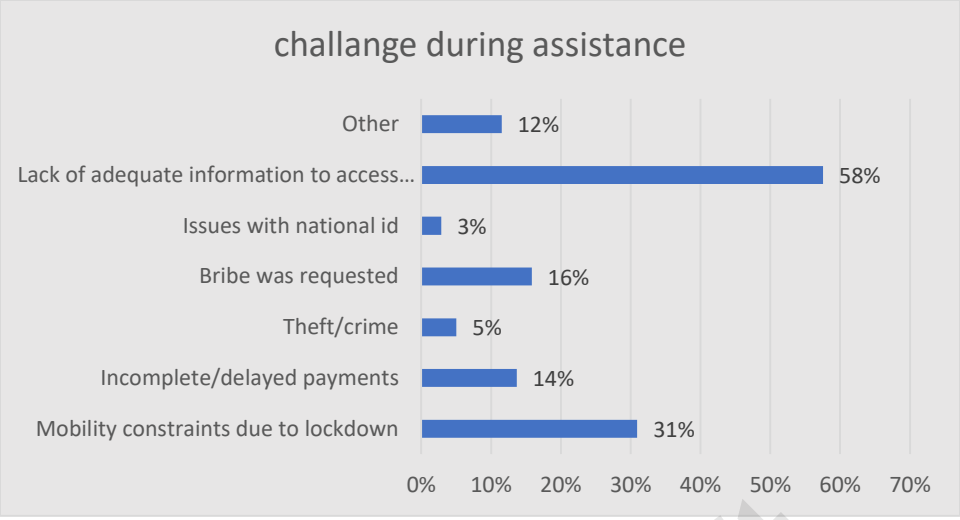

Figure 35 Bar chart showing type of challanges faced by youths and their households to demand assistance during the pandemic

Among 841 study participants, 90 (11%) have reported that they or someone in their household sought assistance from the government or the municipality and has been turned down. The major reasons identified by them for being turned down were giving priority to other people who know the officials better; told funding for the program had temporarily run out, asked to pay a bribe and refused to; and told additional documents would be required. The major challenges reported by respondents from Hawassa was other people who know the officials better; whereas for Addis Ababa - told funding for the program had temporarily run out and other people who know the officials better; and for Jigjiga - told additional documents would be required asked to pay a bribe and refused to.

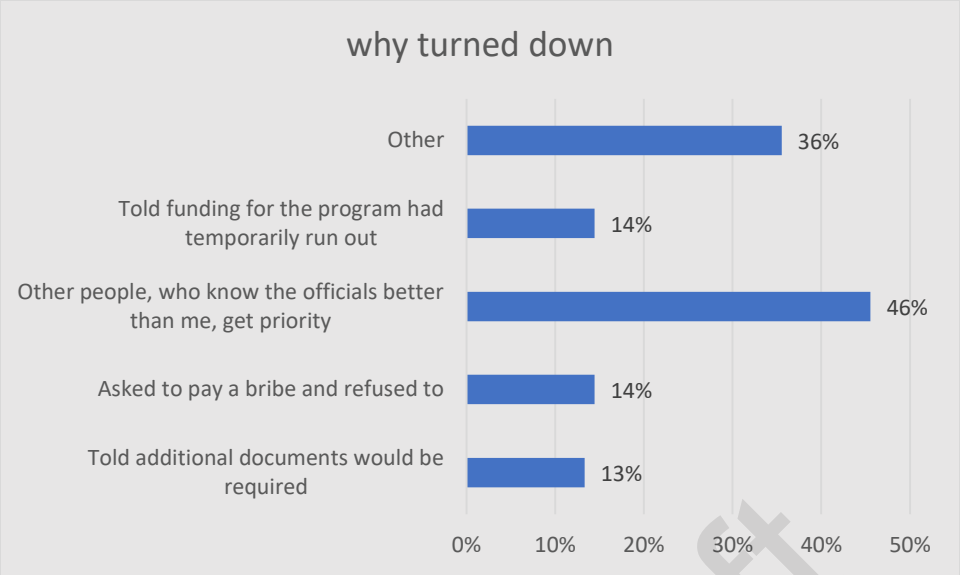

Figure 36 Bar chart showing reasons for being turned down by the govenent while demanding assistance during the pandemic

7. Findings of Qualitative study

7.1. Qualitative study findings

We combined findings from key informant interviews (KIIs) and focus group discussions (FDGs) and presented in six themes including: Good governance, access to public service, economy, peace and security, environment and social wellbeing.

7.1.1. Good Governance

Most FGD and KII participants reported that COVID-19 pandemic has adversely affected the operations of many public institutions. Regular public service was changed to work from home, working by rotation, which raises a major challenge of ensuring quality service. COVID-19 has created a good opportunity for poor governance and corruption. As participants point out, several institutions reason out COVID-19 for not giving timely and quality service for their customers. However, if you can approach them differently (i.e. if you can pay money) you get whatever you want. That was raised by participants as the only mechanism to pass COVID related restrictions. However, from one FGDs at Hawassa we understand the reason behind poor governance may be due to shortage of COVID prevention materials for service providers, like PPEs, that may limit service providers to give appropriate service for their customers, which may lower customer satisfaction towards public services. The following quotation proved these findings:

Around Kebele, woreda, or Municipal, no one wanted to talk to you, they said no service due to COVID. In some office you may be asked money to get service (corruption) -if you pay you can get the service or otherwise not. (KI Hawassa)

Poor customer satisfaction, public institutions were not working with their full potential. They reduced number of workers and office time. There was a problem in distributing collected food items and other supplies on time and to the appropriate beneficiary, as a result several food items were spoiled and expired (KII, Saris Youth center)

During COVID all youth centers were closed, for example we had distributed over 50,000 condoms, which means this much unprotected or unsafe sex occurred. No access to emergency pills. Peoples with disability were also most affected because they are easily vulnerable. Health facilities shifted their focus to COVID, other essential services were interrupted (KII AA Youth Coordination office)

In fact, our offices are not comfortable to provide service by implementing COVID precautions, so the only option was total closure. Using the state of emergency and some covid containment measures as an opportunity there are government employees engaged in corruption (KII, AA Redeem the Generation)

Almost all public facilities were totally closed or reduced their working potential by 50%, or working by rotation, these all reduced the quality of service and there were several complaints from customers. Creates good opportunity for corruption and poor governance. (FGD, Korem Sefere Youth Centre, Hawasa)

7.1.2. Access to Public Service

7.1.2.1. Health

As reported by our FGD and KII participants non COVID-19 health services were almost collapsed due to diversion of resources towards COVID -19. In these regards several Heath Care Professional (HCPs) were mobilized for COVID-19 prevention and control activity, several Health Facilities (HFs) were dedicated for COVID isolation and treatment center which resulted in ignorance of other essential health services. The following quotations demonstrated these finding:

Due to travel restrictions, critically ill patients who need advanced medical care aboard were died. Health facilities were not working in full time and shifted their focus to COVID, ignoring other essential and chronic health service. Especially Ear Nose Throat (ENT) health services had completely isolated by HCPs because no one is willing to touch this site. Loss of essential drugs for HIV, TB, DM, HTN, they were only available at private pharmacies with expensive cost. Disruption of the referral system had affected patients who need medical care at referral hospitals (Women FGD, Saris Woreda 6)

During COVID all youth centers were closed, for example we had distributed over 50,000 condoms, which means this much unprotected or unsafe sex occurred. No access to emergency pills. (KII,AA Youth Coordination office)

Only Elective and emergency health services were given. Chronic disease follows up interrupted. But COVID teach us how much our health system is resilient to cope up such type of disasters/emergencies and made huge improvements in terms of testing, and treating COVID-19.

Health service cost, particularly at private HFs were really very expensive. You may be asked in hundred thousand to get medical support for your COVID illness (KII, AAHB,-EOC)

Peoples were affected by several psycho-social problems, like depression, anxiety. Community based activities through the health development army (HAD) were interrupted because group meeting was not allowed. Health extension workers (HEWs) were highly stigmatized by the community thinking that HCPs were carriers of COVID 19. Shortage and or Inflated cost of drugs for common health problems (DM, HTN, Goiter, Seizure disorders etc…) (KII, Hawsa Millennium H/C)

Converting HFs to COVID isolation and treatment center, ignorance of other chronic and inpatient health services. For example, my friend was admitted at ALERT hospital with chronic illness. When COVID happens, the Hospital changed to quarantine center and all patients were discharged without treatment or cure. There are also nurse who resign from their work thinking they are more exposed. (KII, CCRDA, AA)

No youth reproductive health service, which means no access to condom, and STI/STD health services. Difficult to get health service if you don't have COVID test result. You are requested to bring COVID test result, for which you need at least one-week period from public facilities or 1 or 2 days from private laboratories. Until you do that you may be died with the existing health problem you have. (KII, Temsalet charity Asso. Hawassa)

HCPs were not respectful and compassionate. They stigmatize and discriminate COVID patients or any one with respiratory complaints. Quotations supporting these findings include:

COVID-19 affected compassionate and respectful care at health facilities. HCPs were not friendly, they stigmatize patients, they give you care at distance. They were not working at their full potential. They give more attention to their personal welfare not the patient. Because of that to get service you have to hide your respiratory complaints not to be like a COVID patient (KII, Tikurwuha Youth Center Hawassa)

"HSPs at public health facilities were disrespectful, stigmatizing. Because of that patients were enforced to go to private health facilities which are again very expensive. They charged you for everting they do in relation to COVID-19, including for risk allowance.

It was extra burden for our unprepared health system. Communities health seeking behavior decreased. HCPs were not comfortable to treat COVID patients. I think we had good lesson form this pandemic, if we can use to strengthen our disaster response systems for the future. COVID was almost a national as well as global agenda a priority. We have to use this opportunity to build a strong EOC center. (KII, AAHB-EOC)

7.1.2.2. Education

The study revealed that education sector is another extremely affected area by COVID-19 pandemic. Because of interruption of education and school closure enforced students to stay longer at home, which caused a lot of consequences to them including psycho-social problems like extreme panic, depression and anxiety; gender-based violence (GBV); exposure to substance use and addiction.

Most schools were used as COVID patient's isolation center. When students stay home they were exposed to substance use and GBV. We noted high school absenteeism and dropouts, due to fear of acquiring infection (female FGD, Saris Youth center)

Participants strongly reflected on the disparity in access to education in relation to home schooling, distance and virtual/online learning between the lower and higher socio-economic groups, between the rural and urban, between private and public schools. The following quotations are few examples supporting these findings:

There was disparity between private and public schools. Some private schools were giving virtual education. When school stared again courses were covered in short period of time. All students promoted (free promotion) from one grade to the next whether or not they are competent or not (KII, Jekdo-Hawassa).

Access to education was highly affected, online/virtual learning was not accessible to all, that creates disparity. When students stay long at home, they started watching Adult movies. COVID-19 extends duration of academic year by a year and more. It also affected the quality of education. (Male FGD, AA Redeem the generation)

Disparity in access to education among the poor and wealthy, some students were learning online because they have access to internet and able to afford that, but not others in the rural area and poor families. (FGD-Hawassa)

Several participants reported that school dropouts have increased because some families were not interested to send their children to school when school restarted not to get COVID from school. They also reported poor quality education after re-opening because of shortage of time to cover courses and free promotion from grade to grade as shown by the following quotation.

"Families were tensioned of their children not to acquire COVID from school, due to that dropout rate increased. In our village (village-Ferensay), there are several youths smoking tobacco and taking substances in group regularly." (KII, AA Youth Association)

7.1.2.3. Public Transport

Participants both in the FGDs and KIIs raised poor access to public transport to travel within or across cities. Furthermore, passengers were required to pay two or three times higher from the usual tariff. The problem is very exacerbated for peoples with disability since they need someone who can assist them to use public transport. On the other hand, workers in the transport sector, and those who had private vehicles were also complaining the negative effect they suffered because of restriction imposed by the government like reducing seat occupancy to half, road rotation system and restriction of transport service across regions. We presented the following summary points and quotations from FGDs and KIIs, respectively.

Containment measures like restriction of movement, reduction of seat size, road rotation, banning of motor cycles have been associated with extra economic burden for the community- for example passengers were requested to pay double in public transport. (Male FGD Arada W10, AA)

Due to unavailability of transport. We were exposed to looting especially in the eventing. Passengers were forced to pay double for public transport and long waiting time to get public transport (female FGD, Tikurwuha Hawassa)

"To use public transport visually disabled individuals were required to pay quadruple (i.e two times for themselves and two times for their supporter." (KII, Hawassa Asso. Of PWD)

7.1.3. Economy

Participants reported that extreme household food insecurity due to loss of job and lack of income particularly among the poorest families which are attributed to restriction of movement, lockdowns, unable to work freely and lack of job opportunities.

Participants mentioned the import and export has decreased and this affected many small and private businesses. The prices of foods and other goods doubled and many families started to buy half of what they used to buy before Covid-19 pandemic. Individuals working at private sectors lost their jobs due to closure of the businesses. All these combined, have further deepened the existing poverty and the socio-economic problems in the community. The following are a sample of quotations to exemplify these findings.

"…. *Loss of job, unemployment. Especially in the area of small enterprises, the impact was significant. Youth Revolving Fund Program was highly affected – Youths who got financial support from this program were unable to pay their credit/loan due to COVID-19. Several small enterprises were collapsed and sent out of business. Several organizations reduced their employees resulting in loss of job and loss of income…" (male FGD, Arada W10)*

"COVID-19 results in loss of job, and unemployment, particularly it affected daily laborers. Higher living cost, to the extent that some families start begging on the street and become homeless. Now a days Mask and Sanitizer becomes basic needs for human being, but there are several people who cannot afford to buy these things." (Male FGD, Redeem the Generation)

"The rate of national growth was decreased by 3 or 4% from the expected growth rate. Inflation rate on food items is around 30%, over all cost of living is extremely inflated. Several small enterprises have diminished because they can't pay their credit. The tourism sector is almost died, which was one means of foreign currency." (KII, AA Youth Coordination Bureau)

The COVID-19 pandemic is reported to have higher adverse effects on the manufacturing and construction sector followed by transport, hotel and tourism. Small enterprises working on metal work and fishery were reported to have had the sever effect, in relation to the wrong community perception of high transmission of COVID-19 through metallic substance and water animals.

"Loss of job and loss of income, there was perception that COVID highly transmitted by metallic materials, related to that general metal work and aluminum workers were more affected." (KII, Saris Youth center)

Loss of job and loss of income. Several workers were fired from their job especially those working in manufacturing (general metal work, fishery)-these jobs were associated with higher risk for COVID_19 at that time. (KII, Tikurwuha Youth center, Hawassa)

On the other hand, few respondents mentioned job opportunities in relation to COVID Pandemic

"…. I think, because of COVID there are some job opportunities created. In the health sector we employed several contractual workers for COVID prevention and control activity. Mask production factories, sanitizer production and sell…" (KII, AAHB-EOC)

7.1.4. Peace and security

Some of the group mentioned the peace and security improved as a result of restrictions and decreased social gatherings. Others mentioned the peace and security deteriorated due to increased poverty as a result of joblessness and many opted to theft. Due to increased school dropouts' juvenile delinquencies increased, many violent groups formed and many of school dropouts resorted to drugs and harmful behaviors. The following FGDs summary points and KII quotations confirmed these findings.

Fraud and theft: The thieves use home disinfection, hand washing and sanitizing activities as an opportunity to steal peoples. In relation to avoiding large gathering around religious institutions peoples were abused by security forces. Miss treatment of peoples by police (slam, beat up) without any reason, they also loot mobile phone from the community. Corruption – they used the opportunity to collect money from hotels, bar and restaurants and conference organizing organizations (FGD, Arada W10, AA)

"Several youths were displaced or returned to their region because they can't afford living in big towns. I saw conflict between police and food and drinking establishments, when police tried to shutdown these facilities because of violation of COVID containment measures such as social distancing and social gathering. Theft and fraud, looting has become increased during and after COVID. Thief's spay something dirty on your trouser and then they said you sorry and attempted to wiped and disinfect with sanitizer, they are preparing you for pocket picking. Previously, looting was in the night, now a days it become a common practice in days. The economic crisis resulted in social crisis-resulted in peace and security problem." (KII, Youth coordination office, AA)

"Extreme Food insecurity due to Job cut, reduction of labor and working hour etc. resulted loss of job and loss of income for many peoples. The national economy is also reduced because of loss of foreign exchange and international lockdowns." (KII, Arada W10, AA)

"…emergency situations are enabling environment for thieves; the economic crisis may be associated with the increasing rate of theft and fraud. High number of deportees from middle east countries." (KII, CCRDA, AA)

Creates good opportunity for theft, fraud and looting. Several households were looted by home disinfectant workers. They asked you to stay outdoor until they disinfect your home during that time they do what they want (stole your property. High cost of living exposed youths to engage in illegal activities like, looting mobiles and pickpocket." (FGD, Korem Sefer, Hawassa)

Participants also reported measures taken as part of the response to COVID-19 have resulted violation of human right such as the right to work, the right to freedom of movement, the right to freedom of assembly. Some groups mentioned, the government sometimes randomly forced people to be quarantined without their will or without even confirming their Covid-19 status. Other groups mentioned unbalanced use of force to enforce Covid-19 preventive measures such as wearing masks by security forces. Rights to access basic services such as health services were hindered to restrictions and some of the groups mentioned as one of the human rights violations.

I saw security forces abuse or batter the community in relation to enforcing mask use, social distancing and social gathering restrictions. Initially face mask was not available and it was very expensive, but polices would not understand you. They gather several peoples in one room or quarantine in an open filed for several hours that expose peoples for COVID. (Female FGD, Saris Youth center, AA

7.1.5. Environment

There are reports about the positive impacts of COVID-19 on the environment. Mostly connected to improved personal hygiene and environmental sanitation. Proper hand washing and use of sanitizers was becoming a culture in our community. Moreover, the practice of home gardening and tree planting has become increasing. However, a strong concern was raised with regarding to COVID-19 related infectious management practices, including poor and hazardous disposal of face masks and wastes from quarantine areas. Face masks were thrown here and there, waste from quarantine areas were disposed together with other domestic solid wastes. There was also speculation on the negative effect of home disinfectants and poor-quality sanitizer and chemical. These findings were supported by the following FGD summaries and KII quotations.

"…Creates a culture of good personal hygiene and environmental sanitation. Poor Solid waste disposal system …masks were thrown everywhere, I saw children were playing with used masks-that is a hazardous." (Mixed FGD, Korem Sefer, Hawassa)

"I think, it has a positive impact on the environment related to reduction in emission of carbon dioxide as a result of restriction in vehicle movement and closure of factories. Improvement of personal hygiene in the community. For example, common cold had decreased during COVID because of masking, sanitizing or no hand shaking etc." (KII, Redeem the generation, AA)

7.1.6. Social Well Being

7.1.6.1. Domestic labor division

Regarding domestic labor division there are reports showing that girls and women were seen to bear the greatest burden of increased household responsibilities and care for children/siblings or ill relatives during the pandemic as demonstrated by the following quotations:

"a culture of househusband is positive impact by which husbands share household duties traditionally carried by women. But, later when staying home becomes extended there are conflicts like domestic violence due to the economic and psychological burden. "KII, CCRDA, AA)

"In some family Covid improves family intimacy – it helped couples to understand and support each other each other. Husband got the opportunity to realize how much women's house hold role is difficult, how much burden they carry. Children also get adequate time to stay with their parents for good parenting. However, some other families it has a negative impact. Conflict between couples due to economic burden resulting in disruption of family." (KII, JKDO, Hawassa)

7.1.6.2. Social Solidarity and Support mechanisms

Participants reveled and agreed that several social values and social support mechanisms we had as Ethiopians including Edir, Equip, Buna Tetu, were eroded. They mentioned that they social values were the means we support with each other psychologically or financially during grief and delight. The following quotations have presented to show these findings.

"We lost our social integrity, because peoples were panic not to get COVID from others. "Edir" during loss and grief had several social values, we were unable to bury our beloved ones. He was buried by municipal/hospital…" (KII, Temsalet Charity Asso. President, Hawassa)

"Our social values have eroded. Several social support mechanisms were disrupted including; edir, equip, coffee ceremony. Coffee ceremony (Buna Tetu) has a big social value apart from the talk and means of get-together. In our project (JKDO) we had discussion with our beneficiaries aimed to do a form of need assessment, what we understand from one family is that the value of Buna Tetu ceremony, by which families used Buna Tetu to feed their children from the piece of food served during coffee ceremony. At COVID time, there was no BUNA TETU, which expose these families to lose this golden opportunity to feed their children. Edir has both psychological, social and economic value. By means of Edir families support each other during "Hazen and Desta" by sharing house hold utensils, financial support, human labour support. COVID breakdown all these social supporting mechanisms." (KII, JKDO, Hawassa)

"Dead body handling arose serios social crises. Dead body was not given to their relatives, it was buried by hospitals or the municipal, and there was a strong social resistance in these regards. Social stigma and withdrawal of COVID patients." (KII, AAHB-EOC)

"Unable to have funeral ceremony, you are not allowed to burry dead body or no one can support you that complicates your grief. Closure of religious facilities extremely affect and resulted in several spiritual and psychological problems. Our Edirs were sundered, weeding program canceled." (KII, AA Youth Asso.)

7.1.6.3. Gender Based Violence (GBV)

There are reports of increased GBV due to prolonged confinement of peoples in a single house hold. In these regards, housemaids and female school children were the most widely affected population groups. That problem is associated with school closure and home drinking. Adults bring alcohol to home because hotels, bars and restaurants were closed. Participants reported a chain of problems in relation to GBV (Figure 37) as demonstrated by quotations that followed.

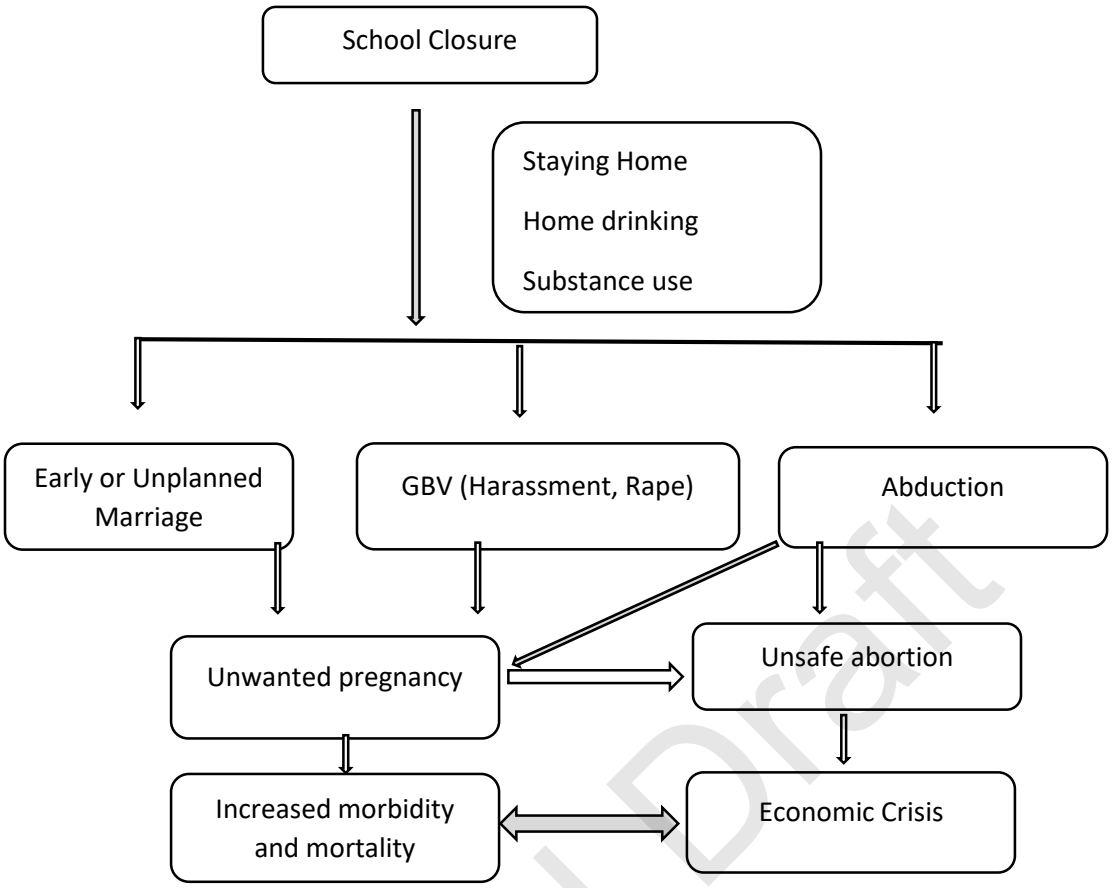

Figure 37: Conceptual relationships between several consequences of COVID-19 related school closure among Youths.

In these regards it has both positive and negative effect: Positively some husbands/males share women's house hold role. Negatively, staying home crates a good opportunity for couples to understand each other and uncover hidden behaviors, because of that several domestic violence, conflicts happened. Some of them ended with divorce. (KII, Saris Youth center, AA)

Due to closure of school a house made dropped school, raped by her employer and exposed to unwanted pregnancy, unsafe abortion and finally she turned to street. There is also a tendency to get in to unplanned marriage, which costs the family a lot and finally resulted in divorce (female FGD, Tikurwuha, Hawassa)

We are hearing increasing rate of rape, that may be due to extended stay at home, which are resulting in unwanted pregnancy and unplanned marriage, domestic violence and conflict between couples ((female FGD, Saris Youth enter AA)

8. Conclusion

The study found out high level of socio-economic impact of COVID-19 on Ethiopian youths and their households. The major social and economic dimensions affected by the pandemic were food security; income; livelihood; and access to basic services of education, health, drinking water and transportation. In addition, the pandemic, by adversely affecting the operations of many public institutions including regular public service, has created a good opportunity for poor governance and corruption.

The major causes for the resulted impact were increased price of food and transportation service, unavailability and unwillingness of public service providers, reduced opportunity of job and restriction of movement with varying degree on geography, gender, educational status and other demographic variables. It was also found that government and NGOs have not made enough effort to reduce the impact of the pandemic. The satisfaction of youths towards the government's response to the coronavirus crisis is low. On the other hand, access to information on local distancing and self-isolation as a preventive measure against the coronavirus was good.

Education sector is one of the extremely affected services by the COVID-19 pandemic due to disparity in access to education in relation to home schooling, distance and virtual/online learning between the lower and higher socio-economic groups, between the rural and urban, and between private and public schools. Besides, increased school dropouts because families were not willing to send their children to school from fear of getting COVID-19 from school; and poor quality education after re-opening because of shortage of time to cover courses and free promotion from grade to grade has also negatively affected the sector. In addition, school closure enforced students to stay longer at home, which caused adverse consequences to them including psycho-social problems like extreme panic, depression and anxiety; gender-based violence (GBV); and exposure to substance use and addiction.

The response measures against the pandemic has resulted dual effect on peace and security. While the restrictions on social gatherings contributed to improve peace and security; poverty as a result of joblessness and juvenile delinquencies as a result of increased school dropouts' and increased substance use caused the peace and security to deteriorate.

The pandemic has contributed to improve personal hygiene, environmental sanitation, home gardening and tree planting practice. However, the management practices of COVID-19 related infectious wastes is a concern.

Girls and women, besides sharing all the negative impacts of the pandemic like the rest of the community, were particularly affected by bearing the greatest burden of increased household responsibilities and care for children/siblings or ill relatives during the pandemic, and increased GBV due to prolonged confinement of peoples in a single house hold.

Our finding supports the evidences from literatures that, the restriction measures and other related COVID-19 response measures taken by the government to control the pandemic have severely disrupted the socio-economy of youths and their households in Ethiopia. Overall, the COVID-19 pandemic has exacerbated existing inequalities along gender and socioeconomic lines.

9. Recommendation

In recommendation, the government need to address the limitations affecting access, quality and timely public service provisions; design policies and program targeted at improving job access and livelihood of youths; stimulate the economy and strive to resume economic activities at least to the Pre-COVID level; regularly assess the socio-economic impact of response measures imposed against the pandemic and make timely and relevant adjustments and re-evaluate related policies and regulations.

Civil society organizations need to design evidence based, unique and innovative support mechanisms to address the gendered socio-economic impact of the pandemic on youths and their households.

Integration and mainstreaming of COVID-19 with other service like youth reproductive health service, school health services, etc. for sustained and resilient COVID-19 prevention and control program.

All concerned bodies need to engage youths in all phases of their project, starting from designing, planning, and implementation to monitoring and evaluation.

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