SITUATION AND ACCESS TO SERVICES OF PEOPLE WITH DISABILITIES AND HOMELESS PEOPLE IN TWO SUB-CITIES OF ADDIS ABABA

Prepared by Development Pathways on behalf of UNICEF Ethiopia and the Ministry of Labour and Social Affairs

2019
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## Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ARV</td>
<td>antiretroviral treatment</td>
</tr>
<tr>
<td>BoE</td>
<td>Bureau of Education</td>
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<tr>
<td>BoH</td>
<td>Bureau of Health</td>
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<tr>
<td>BoLSA</td>
<td>Bureau of Labour and Social Affairs</td>
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<tr>
<td>BoWCA</td>
<td>Bureau of Women and Children's Affairs</td>
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<tr>
<td>CBHI</td>
<td>community-based health insurance</td>
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<tr>
<td>CCC</td>
<td>community care coalitions</td>
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<td>DP</td>
<td>Development Pathways</td>
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<tr>
<td>FGD</td>
<td>focus group discussion</td>
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<tr>
<td>HEW</td>
<td>health extension worker</td>
</tr>
<tr>
<td>KII</td>
<td>key informant interview</td>
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<tr>
<td>MoLSA</td>
<td>Ministry of Labour and Social Affairs</td>
</tr>
<tr>
<td>NSPP</td>
<td>National Social Protection Policy</td>
</tr>
<tr>
<td>Sida</td>
<td>Swedish International Development Cooperation Agency</td>
</tr>
<tr>
<td>SNNPR</td>
<td>Southern Nations, Nationalities, and Peoples' Region</td>
</tr>
<tr>
<td>SSI</td>
<td>semi-structured individual interview</td>
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<td>UPSNP</td>
<td>Urban Productive Safety Net Programme</td>
</tr>
<tr>
<td>UJCFSA</td>
<td>Urban Job Creation and Food Security Agency</td>
</tr>
<tr>
<td>WDA</td>
<td>Women Development Army</td>
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</table>
Acknowledgements

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The findings and recommendations expressed in this report are those of the authors alone and do not necessarily reflect the views of UNICEF and/or the Government of Ethiopia.
Executive summary

This report presents evidence from a mixed-method study on the living conditions and needs of people with disabilities and homeless people in two sub-cities within Addis Ababa: Addis Ketema and Arada. The purpose of the study is to inform the design of a pilot programme to deliver integrated social services in the two sub-cities; and the design of the destitution component of the government-run Urban Productive Safety Net Programme (UPSNP). The study uses three main methodologies: an in-depth literature review, secondary analysis of survey datasets, and qualitative field research that took place in August 2018 in Addis Ketema and Arada.

Needs of people with disabilities and homeless people

The vast majority of people interviewed – whether people with disabilities or homeless people – mentioned lack of access to adequate housing as the main issue they face, followed by access to employment or income-generating activities.

A number of barriers to accessing services cut across sectors. For people with disabilities, a main barrier is the general lack of an enabling environment for people with disabilities in Ethiopia. While relevant legislation exists, implementation has so far been limited. The reasons for this include both lack of supply-side and demand-side pressure: there is a lack of coordination and limited capacity among disabled people’s organisations (DPOs) in Ethiopia, and insufficient inclusion of DPOs in decision-making processes. In addition, there is no high-level government entity with the mandate to mainstream inclusion of people with disabilities across sectors, and there is generally limited awareness of disability issues among government officials and other stakeholders.

For homeless people, the lack of permanent residence and the resulting lack of formal identification (a Kebele ID) is a main barrier to accessing many services, as well as employment. In addition, we found high levels of social exclusion, stigma and discrimination against homeless people who are not included in employment and community organisations such as iddirs (traditional associations engaging in informal insurance arrangements).

In order to improve the living conditions of people with disabilities and homeless people, it is necessary to work on improving the capacity of individuals to demand increased inclusion in mainstream services across sectors as well as the supply of services tailored specifically to the needs of these groups.

1. A kebele is the smallest administrative unit of Ethiopia, similar to a ward or a neighbourhood.
2. Iddirs are indigenous financial institutions often used in both rural and urban areas of Ethiopia to cover such risks and expenses as those that arise from “funeral ceremonies, death of major productive assets (such as draft oxen), medical expenses and food shortages.” (Aredo, 2010). Characteristics of the iddir are: “reciprocity; regular payments to a pool in cash; payments of fixed compensation for pre-defined shocks; ex-ante arrangements; and a high degree of institutional permanency and sustainability.” (Dejene 2003; 2002; 1993 cited in Aredo, 2010).
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Income and employment

Most of the families interviewed reported insufficient income to cover their basic needs. Many do not have any regular income. Those who do have regular employment often reported earning approximately ETB 2,000 per month (compared to national average monthly per capita revenues of ETB 3,498). Several homeless people working for waste collection associations earned such revenues. The many respondents who rely on irregular income from activities such as selling items on the streets, generally reported incomes of between ETB 500 and 1,000 per month. Women often reported earning an income from daily labour such as washing clothes or baking injera. Many homeless people earn an income from selling items on the streets such as gum, candy, cigarettes, tea and coffee. Others resort to begging. Children may also contribute to household revenues, but they often earn very little. Homeless boys may work as day labourers in construction, or as shoeshine boys if they have money for the materials. Both homeless boys and girls also obtain money by begging or stealing.

Families taking care of children with disabilities face additional costs as a result of the disability. People with disabilities face much higher transportation costs than those without disabilities, as many cannot use public transportation and taxis are expensive in Addis Ababa. People with disabilities also have much higher health expenses than others and face several barriers to improving income generation:
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- Widespread prejudice that people with disabilities are not able to work, and a lack of awareness about how to include people with disabilities in both private and public sector employment.
- Most buildings and the general environment are inaccessible, including most woreda offices.
- Lack of access to education contributes to limiting the employment opportunities of people with disabilities.
- Multiple additional barriers exist for female caregivers of children with disabilities and females with disabilities. Income-generating activities are often added to domestic responsibilities for women with disabilities. Care activities are usually the responsibility of women caregivers. Caring for a child with a disability often limits time and opportunities for engaging in livelihood activities and earning an income. There are no childcare facilities available and not enough inclusive schools with the capacity to care for children with disabilities.

Homeless people face other barriers to improving income generation:

- Lack of education: Many of the homeless people interviewed had originally come from rural areas and had dropped out of school at a young age or had few education opportunities where they grew up. This is especially the case for women, many of whom are illiterate, which contributes to limiting their economic opportunities.
- Discrimination and stigma: Most people are reluctant to hire homeless people, as they are perceived to be unreliable, unclean and/or dishonest.
- Lack of formal identification: A lack of Kebele ID cards is a barrier to employment, as many employers require them.
- Lack of guarantors: Many employers require guarantors, which many homeless people are not able to provide.
- Lack of childcare and secure housing: Single parents are unable to look for work with children in tow.

Limited services are available to help people overcome these barriers. There are government-run business centres that provide space for people operating small businesses; and within woreda offices of the Bureau of Labour and Social Affairs (BoLSA) there is a service available that registers unemployed people and refers them to available jobs. Similarly, woreda Bureaus of Women and Children’s Affairs (BoWCA) also provide some services linking women with job opportunities, but the scope seems to be limited. Additionally, there is very limited access to credit from banks for low-income families and only very small-scale loans available from village savings and loans associations (VSLAs). BoLSA implements a programme to support small and micro-enterprises with start-up capital and microcredit, but the scope is very limited.

The UPSNP is the only systematic and substantial income support programme available to low-income families in Addis Ababa. Providing essential income support for many families, it is sometimes the main income source, at times the only one. It is therefore essential that the programme be sustained and expanded to cover all families in need, including the homeless. The main barrier to access to the programme is that it operates within a set quota for each woreda, which means that
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most households in need of support are not able to benefit. In addition, very little has been done to ensure that the programme takes into concern the needs of people with disabilities. Further, most homeless people are excluded as a matter of policy, although there are no insurmountable practical reasons for their exclusion.

Food security

Most families interviewed that include people with disabilities have insufficient incomes that impact their access to a nutritious diet. Most respondents mentioned food as a primary unfulfilled need. Most families interviewed reported eating two to three times a day, but usually consumed the same or similar food every day, often injera with shiro (traditional Ethiopian bread with sauce). Foods like meat, milk, eggs and vegetables are only eaten on special occasions, and parents face challenges ensuring a balanced diet for their children. In severe cases, families reported eating only once a day, with parents often foregoing meals to prioritise food for the youngest children.

Many homeless people depend on leftovers from hotels and restaurants that often constitute a health hazard. While some people living under plastic shelters in a semi-permanent location are able to purchase raw ingredients and cook their own food, others do not have this option. People therefore have to rely either on donated food, or on relatively more expensive food from small food stalls. Many of the homeless people living around churches or mosques rely on food donated by passers-by.

There are limited services provided to ensure food security of low-income families and the homeless. Important support for school-age children is provided by two school feeding programmes that provide breakfast and lunch. However, these programmes are targeted to only the poorest households rather than provided on a universal basis, which means that many children in need are excluded. Various NGOs also implement nutrition and food security programmes, but they are limited in scope.

Housing

Access to adequate housing or shelter is the main need for people with disabilities and homeless people. Women with children living on the streets are in urgent need of safe shelter facilities. Unfortunately, services are limited. There is insufficient government housing available to meet demand, and what does exist is typically in poor condition and not accessible to people with disabilities. While the sub-city and woreda Bureau of Health have initiated a sanitation programme supporting the construction of septic tanks as well as public toilets, efforts to maintain and improve housing conditions are limited. There are several NGO-run shelters for homeless people in Addis Ababa, but the number of beds is inadequate to meet demand. The lack of housing is a main cause of every other issue that homeless people face, and should be addressed as the first priority, in keeping with international best practice following a ‘Housing First’ policy. However, as noted by the World Bank (2015), between 70 and 80 percent of housing is of low quality in Addis Ababa.
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Healthcare

Good access to quality healthcare is provided through a combination of Health Extension workers, woreda health centres, government hospitals and healthcare services provided by NGOs. However, there are still some barriers to access. For people with disabilities, it can be difficult to physically access health centres, medicine is often unaffordable and there are no rehabilitation services. For people with disabilities and homeless people, free healthcare through the health fee waiver programme is essential but most homeless people are not able to access the programme because they do not have a Kebele ID. There is a severe lack of access to assistive devices, including wheelchairs, crutches, braille, and hearing aids. In addition, several people mentioned the need to pay more attention to mental health and intellectual disabilities, as most support is currently focused on people with physical disabilities. Health Extension workers also indicate that the lack of sanitation facilities in areas dominated by public kebele housing, poor hygiene practices and overcrowding are contributing causes to diarrhoea, typhoid fever and other diseases.

Education

We encountered very few out-of-school children, and both key informants and households described good access to primary schools. This is a result of a concerted effort by government to increase enrolment, including through annual home-to-home sensitisation campaigns prior to commencement of the school year in September to ensure that all children are enrolled. However, there is a lack of initiatives to make mainstream schools accessible for children with disabilities and insufficient quality and quantity of special needs schools. Homeless children are able to enrol in school without birth certificates or IDs as long as they have caretakers, but often face challenges in staying in school because of work commitments and other challenges resulting from their lack of a home.

Protection

Both homeless people and people with disabilities are vulnerable to violence and abuse, and homeless women are especially vulnerable. There is very limited access to protection services, as a result of both supply and demand side barriers. The limited services available are provided mainly by the police, woreda Bureaus of Women and Children, and community associations such as women development armies and NGOs. For homeless people, the police can be a source of protection but also of insecurity. While community care coalitions (CCC) are envisioned to play a key role in Ethiopia's child protection case management system and are very active in some parts of the country, we did not find evidence of CCC activity in the two sub-cities studied.
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Integrated case management systems

A number of actors collect comprehensive information about all households in Arada and Addis Ketema sub-cities. However, a lack of coordination leads to unnecessary use of resources on extensive house-to-house registration exercises. At the same time, there is very limited data available on the homeless population, with no systematic data collection currently taking place. There is a need for an integrated case management information system (MIS), which can make the existing data operational. Such a system should also enable the flagging of child protection cases to BoWCA by anyone who raises a concern (e.g. Health Extension workers, Women Development Army members, UPSNP officers, teachers). A shared MIS could also ensure that all UPSNP direct support beneficiaries and all homeless people have automatic access to free health care (currently provided through the fee waiver programme and through fee-exempted participation in community-based health insurance or CBHI) and that all UPSNP Public Works beneficiaries are enrolled automatically in the CBHI.

Several different actors are in a good position to provide identification of vulnerable groups. However, there is a lack of systematic approaches and tools for needs assessment at the community level, and insufficient training on how to identify vulnerable groups and carry out an initial interview and screening. There is a need for better training of frontline workers and community volunteers on how to identify and refer vulnerable individuals and households, including people with disabilities.

There are currently very limited efforts by the government to identify and screen the needs of homeless people. The main actors currently working on identification of homeless people and referrals to services are Health Extension workers (in Addis Ketema) and the police, as well as outreach workers employed by NGOs. The various community committees and associations generally do not work with the homeless population. There is a need to sensitise many of the existing actors on how to work with homeless people, as well as introducing specialised outreach teams that can identify particularly vulnerable groups – including homeless children – carry out a preliminary screening and refer them to the necessary services.

In addition, there is a large unmet need for training on disability assessment for everybody involved in identification and referrals, including both government and non-governmental actors such as Health Extension workers and Ketena Committee members. In general, assessment tools are not of sufficient quality to effectively assess the needs of vulnerable groups. A comprehensive review is recommended of procedures and tools used for needs assessments.

With the exception of the health sector, there is currently no functioning case management system – understood as a system with systematic monitoring and follow-up of individual or household case plans. As a result, woreda offices have very limited possibilities for providing follow-up, which is also hindered by the fact that social services in Addis Ababa are significantly underfunded. Indeed, most bureaus in the social service sector are not able to fulfil their mandates because of lack of funding. There is an urgent need to strengthen both budgets and equipment available for social service provision, as well as to develop a plan for improving recruitment and retention of qualified staff.
1. Introduction

This report presents evidence from a mixed-method study on the living conditions and needs of people with disabilities and homeless families in the sub-cities of Addis Ketema and Arada in Addis Ababa. The purpose of the study is to inform the designs of (i) a pilot programme to deliver integrated social services in the two sub-cities and (ii) the destitution component of the Urban Productive Safety Net Programme (UPSNP).

The study uses three main methodologies: an in-depth literature review, secondary analysis of survey datasets, and qualitative field research in two sub-cities. Field research took place in August 2018 in the two sub-cities of Addis Ketema and Arada. The research was carried out by Development Pathways on behalf of UNICEF Ethiopia, in partnership with the Ethiopian Ministry of Labour and Social Affairs and with funding from the Swedish International Development Cooperation Agency (Sida).

The study complements a recent, largely quantitative, study on destitution in Ethiopia commissioned by the Ministry of Labour and Social Affairs and carried out by the local consultancy Soberland. The current study complements this previous work with more in-depth qualitative research, which enables a deeper understanding of the situation of homeless people and the causes of and interlinkages between the different challenges they face.

In addition, the current study includes a distinct focus on the situation of people with disabilities in Addis Ababa. We provide a detailed analysis of the services available to people with disabilities and homeless people, and the barriers they face in accessing such services. Finally, we provide an analysis of existing case management and coordination mechanisms among service providers, and how these might be improved as a part of the development of an integrated case management system.
2. Methodology

The study uses three main methodologies: an in-depth literature review, qualitative field research in two sub-cities, and secondary analysis of survey datasets.

a. Prior to the field research, an in-depth, comprehensive literature review was carried out. A total of 368 resources were reviewed in full. Whilst substantial literature exists on different aspects of poverty in Ethiopia, including in urban areas, the literature review showed that there is limited evidence available specifically regarding the situation and needs of people with disabilities and of homeless people in urban areas, including their access to services.

b. Qualitative field work took place in Addis Ababa from 17 July to 1 August 2018, with participation from three international researchers, six Ethiopian researchers and three interpreters (including sign language interpretation). The findings from the literature review informed the focus of this field work, carried out by Development Pathways researchers in cooperation with researchers from the Africa Disability Alliance (ADA) and independent Ethiopian researchers. A total of 192 participants were involved in 112 research activities including:

i. 43 semi-structured individual interviews (SSIs) with people with disabilities taking care of children; parents or caregivers of children with disabilities; and people living on the streets.

ii. 15 focus group discussions (FGDs) with community-based organisations, disabled people’s organisations (DPOs) and frontline social service workers, with a total of 83 participants.

iii. 54 key informant interviews (KIIs) with 66 officials at city, sub-city and woreda levels, as well as NGOs/DPOs, frontline workers and community leaders.

Throughout the report, references are provided to interviews using the above acronyms (SSI, FGD and KII) along with a numbering system that refers specifically to interviews that took place (see Annex 2).

c. Quantitative analysis has been carried out on national household survey datasets, including the Ethiopia Socioeconomic Survey (ESS), 2015/16; The Household Consumption and Expenditure (HCE)/Welfare Monitoring Survey (WMS), 2015/16; Ethiopia Demographic Health Survey (EDHS), 2015/16 and the Census, 2007 and the Census (10% sample).

Research questions and how they have been addressed

The main research questions to be answered are:

a. What is the current situation of destitute households and households with disabled family members in Addis Ababa in terms of basic and disability-specific needs?
b. To what extent are households with disabled family members and homeless people able to access social services in Addis Ababa?

c. Which processes and systems exist that can form the basis for an integrated case management pilot programme in Addis Ketema and Arada sub-cities?

Table 1 shows how each research question was broken down by sub-topic. The methodologies used for data collection are classified as: quantitative analysis (quant), qualitative analysis (qual), or literature review (lit review), or a combination of these.

Table 1: Overview of Methodologies for Data Collection

<table>
<thead>
<tr>
<th>Research question</th>
<th>Main topics covered</th>
<th>Methodology</th>
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<tr>
<td>Sector</td>
<td>Poverty and income</td>
<td>Quant + qual + lit review</td>
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<td>Sector</td>
<td>Education</td>
<td>Quant</td>
</tr>
<tr>
<td>Sector</td>
<td>Health</td>
<td>Quant + qual + lit review</td>
</tr>
<tr>
<td>Sector</td>
<td>WASH</td>
<td>Quant + qual + lit review</td>
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<tr>
<td>Sector</td>
<td>Protection</td>
<td>Quant + qual + lit review</td>
</tr>
<tr>
<td>Sector</td>
<td>Gender</td>
<td>Quant + qual + lit review</td>
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<td>Social services access</td>
<td>Access to income support</td>
<td>Qual</td>
</tr>
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<td>Social services access</td>
<td>Access to education</td>
<td>Qual + quant + lit review</td>
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<tr>
<td>Social services access</td>
<td>Access to healthcare</td>
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<td>Social services access</td>
<td>Access to services to assist with food security and nutrition</td>
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<td>Social services access</td>
<td>Access to protection services</td>
<td>Qual + lit review</td>
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<tr>
<td>Social services access</td>
<td>Access issues related to gender</td>
<td>Qual + lit review</td>
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<tr>
<td>Processes and mechanisms</td>
<td>Availability of data on vulnerable groups</td>
<td>Qual</td>
</tr>
<tr>
<td>Processes and mechanisms</td>
<td>Identification of vulnerable individuals and families</td>
<td>Qual</td>
</tr>
<tr>
<td>Processes and mechanisms</td>
<td>Case management</td>
<td>Qual</td>
</tr>
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<td>Processes and mechanisms</td>
<td>Coordination and cooperation</td>
<td>Qual</td>
</tr>
<tr>
<td>Processes and mechanisms</td>
<td>Follow-up and monitoring</td>
<td>Qual</td>
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<tr>
<td>Processes and mechanisms</td>
<td>Human resources</td>
<td>Qual</td>
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</tbody>
</table>
Research populations

The study focuses on two primary target groups: families living on the street and households with a family member with a disability (either a child or a caregiver). To be included in the study, participants fell into one of the two groups:

a. **Families living on the street**: Often referred to as ‘pavement dwellers’, this group includes families with children (below the age of 18) who reside permanently or predominantly in an open space, or in makeshift shelters which are not suitable for dignified and safe human habitation. This includes shelters constructed out of tarpaulins or tin sheets. Besides the primary target group, we also interviewed a number of single people living on the streets. A total of 25 homeless people were interviewed, including 14 females and 11 males.

a. **Households with a family member with a disability**: This group includes low-income households with either a child with a disability or a caregiver with a disability. There was not a fixed income threshold for inclusion as it was not possible to access reliable information on income. Instead, we included households residing in low-income areas of the two sub-cities, mainly in government housing. A total of 18 people with disabilities were interviewed, including nine females and nine males.

A third target group consists of children living on the streets. It was agreed with UNICEF prior to the field research not to directly interview children living on the streets. This was mainly due to the ethical and procedural challenges of conducting research with children on the streets, including obtaining informed consent and ensuring that minor respondents trust in and are comfortable with the researchers. The existing literature on research with street children shows that establishing the necessary trust with street children requires engaging with them for several months, which was not possible within the timeframe of the study. Instead, in order to gather information about the needs and access to services of street children, we carried out interviews with people and organisations that work with street children. In addition, we were able to draw on information from the sizeable existing literature on street children in Ethiopia that we reviewed and summarised in the literature review, as well as the recent study carried out by Soberland that included interviews with street children.

Key informants included officials from city, sub-city and woreda administrations, representatives of NGOs and DPOs and frontline workers such as community police officers and Health Extension workers. We originally intended to interview other frontline workers such as teachers and health professionals, however, since the research was carried out during school holidays, we were not able to interview teachers. And in the health sector, we instead decided to focus on Health Extension workers and officials from the bureau of health at sub-city and woreda level, and did not have time to include doctors and nurses working in clinics, health centres or hospitals. Interviews with key informants served two purposes: firstly, to draw on their knowledge of the situation of vulnerable groups and to assess their awareness of the issues facing people with disabilities and homeless people, and secondly, to assess existing processes and mechanisms of case management.
Finally, members of community-based organisations were included to draw on their knowledge of the situation in their local areas, but also to gauge their levels of awareness about the issues facing vulnerable groups, and their role in case management processes. Groups included the Women Development Army, iddirs (community funeral associations) and ketena committees (including permanent ketena committees and the targeting committees established for the identification of UPSNP beneficiaries). We had originally intended to carry out focus group discussions with community care coalitions (CCCs) as well, but found that these were not very active in our focus areas.

**BOX 1: A NOTE ON TERMINOLOGY AND KEY CONCEPTS**

**Destitution:** Destitution is generally used in the global literature to refer to either homelessness or extreme poverty. In the first instance, destitution is seen as qualitatively different from other forms of poverty, whereas in the second case, it is a matter of degree.

**Homelessness and the homeless:** Homelessness is a complex phenomenon, and in practice there is a fine line between homeless people living in the street and squatters. The physical living conditions in many squatter settlements are little better than those experienced by some roadside dwellers. Accordingly, definitions of homelessness vary: some definitions only include people who are literally homeless, i.e. sleeping in public spaces or in homeless shelters, while others also include those who may have a permanent private residence, but where the quality of housing is inadequate. In the Ethiopian context, a narrow conceptualisation is most suitable that includes only those people sleeping in places not intended for human habitation. An important sub-category in many low- and middle-income countries is so-called ‘pavement dwellers’ who live on the street in a specific location, usually with some form of makeshift cover. Sometimes the sleeping place may be just a mat or cardboard box, but in many cases, people use tarpaulin sheets or other scavenged materials to construct a simple shelter. Contrary to the majority of people sleeping rough in public places, who are often single men, pavement dwellers may also include families (Busch-Geertsema et al., 2016). As this group is understudied, the field work focused particularly on families living on the street in two sub-cities of Addis Ababa.
**Disability:** The second primary target group of the research is people with disabilities, in particular families with children with disabilities. Disability is a complex issue, with many different types of disability, including physical, mental and intellectual, and with high variety within each. There is no single agreed-upon definition of disability (Mitra, 2006, p. 236). The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD, 2006) does not offer an explicit definition of disability, although it does state in Article 1 that ‘Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others’ (UNCRPD, 2006, p. 4). Following this conceptualization, disability is not the same as impairment, which is an injury, illness, or congenital condition that causes or is likely to cause a loss or difference of physiological or psychological function. The extent to which an impairment translates into disability varies according to the environment and situation of individuals, the resources available to the individual and the extent to which the environment is accessible (Mitra, 2006, p. 235-247).

**Research locations**

Under the current administrative structure, Addis Ababa is divided into ten sub-cities which are further divided into 116 woredas (formerly known as kebeles) with an average population of about 25,000 people each. The woreda level is the lowest formal administrative unit in Addis Ababa, but many volunteers and community committees are active at the ketena (community) level. In general, each woreda is divided into ten ketenas, which therefore have an average population of about 2,500 people across the city. Two sub-cities of Addis Ababa were the focus of the study. Addis Ketema and Arada were selected by UNICEF as the administrative units for piloting an integrated approach to social protection and social service delivery. This Integrated Safety Net Programme (ISNP) in collaboration with the Ministry of Labour and Social Affairs is funded by the Swedish International Development Cooperation Agency (Sida).

These two sub-cities were selected out of four sub-cities proposed by the Addis Ababa city government following a rapid assessment of their characteristics and capacity for service delivery by UNICEF\(^3\). The key selection criteria included: the number of UPSNP participants, the size of the destitute population, administrative capacity, interest in improving service delivery and coordination, existing coordination efforts and linkages between UPSNP and other services, and planned urban re-development in the near future. The rapid assessment found that the two selected sub-cities provided a good variation across the majority of the key selection criteria, which means that they are likely to be more representative for a variation of sub-cities in Addis Ababa and beyond. For the purpose of the qualitative research, two woredas in each sub-city were selected (four in total), based on the areas with the highest prevalence of homelessness and low-income households (primarily those living in government housing).

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BOX 2: THE TWO RESEARCH LOCATIONS

**Addis Ketema:** Addis Ketema is located in the north-western part of the city and borders Gullele in the north, Arada in the east, Lideta in the south and Kolfe Keraniyo in the west. The sub-city has an estimated population of around 270,000 people and a very high population density of more than 36,000 people per square kilometre due to its relatively small area (7.4 km²). Addis Ketema has a significant migrant population, largely due to having the largest bus station and open-air market in the country. The sub-city is struggling to cater to the needs of a growing number of people classified as destitute. Currently, some 55,000 people in Addis Ketema are enrolled in the Urban Productive Safety Net Programme, but administrative capacity to implement the programme is constrained. Within Addis Ketema, we focused on Woredas 4 and 8.

**Arada:** The second research location is the Arada sub-city located in the northern part of Addis Ababa and bordering the sub-cities of Gullele, Yeka, Kirkos, Lideta and Addis Ketema. Arada has a population of around 212,000 people and a population density of over 22,300 persons per square kilometre. Arada is one of the oldest parts of Addis Ababa but is likely to undergo significant transformation due to urban redevelopment in the next few years, which may lead to the displacement of vulnerable groups. Within Arada sub-city we focused on Woredas 4 and 6.

<table>
<thead>
<tr>
<th></th>
<th>Addis Ketema</th>
<th>Arada</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population</strong></td>
<td>271,644</td>
<td>225,999</td>
</tr>
<tr>
<td><strong>Male</strong></td>
<td>132,825</td>
<td>105,963</td>
</tr>
<tr>
<td><strong>Female</strong></td>
<td>138,819</td>
<td>120,036</td>
</tr>
<tr>
<td><strong>Area</strong></td>
<td>7.41 sq. km.</td>
<td>9.9 sq. km.</td>
</tr>
<tr>
<td><strong>Population density per sq. km.</strong></td>
<td>36,660</td>
<td>22,805</td>
</tr>
<tr>
<td><strong>No. of woredas</strong></td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td><strong>Average population per woreda</strong></td>
<td>27,164</td>
<td>22,600</td>
</tr>
<tr>
<td><strong>Number of ketenas</strong></td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td><strong>Average population per ketena</strong></td>
<td>2,716</td>
<td>2,281</td>
</tr>
</tbody>
</table>
Research ethics

Research protocols were approved by the Scientific and Ethical Review Committee of the Ethiopian Public Health Institute. All researchers and interpreters were trained in how to carry out qualitative research with vulnerable populations before the commencement of the field research. This included training on ethical principles, including “do no harm”; ensuring protection of respondents; ensuring participation (including obtaining consent and ensuring that respondents are aware that they do not have to participate and have the right to opt out of research at any time); and empowerment (carrying out research without judgement and with patience and respect). Written consent was obtained before all interviews through consent forms. In order to protect the privacy of participants, no names have been included in this report and no photos were taken of participants. During the research, researchers held frequent debriefings to ensure that all researchers adhered to the ethical principles.

Study limitations

As described above, the scope of the study is to assess the needs and access to services of two very different and heterogeneous population groups – people with disabilities and homeless people. The study also spans a broad range of sectors, including income, food security and nutrition, housing and shelter, education and skills development, healthcare, and protection. In addition, the study also aims to assess a broad range of aspects of case management and local governance. This broad scope means that the study can only provide an overview of these topics, not an in-depth analysis of any one sector. More in-depth sector-specific research is needed to provide a more detailed analysis of barriers to specific services for people with disabilities and homeless people. More specifically, there is a need for in-depth research and comprehensive analysis of the following:

- **Procedures and tools currently being used for needs assessments:** This should inform a plan for improving such assessments. The procedures and tools used by both NGOs and government offices should be included.
- **Mental illness:** Interviews with people with mental illness or service providers working with people with mental illness. This is also a gap in the existing literature. There is therefore a need for more research on mental illness in Addis Ababa, including services available for people with mental illnesses and the connection between homelessness and mental illness.
- **Capacity of disabled people’s organisations at local, national, regional and levels:** This can provide a basis for future support to these organisations.
- **Gaps in the data available on disability at sub-city and woreda level:** The quality of the tools and processes that are used to collect this data should also be considered. Only a preliminary assessment of the data is included here.
- **Data collection methods for the homeless population:** In order to effectively gather information and data on the homeless population in Addis Ababa, methods need to be further developed.
3. People with disabilities: Situation

Key Messages

- People with disabilities face even more difficulties in accessing employment than others. There is a widespread preconception, including among government officials, that people with disabilities cannot or should not work. Buildings, roads and transport are not accessible. People with disabilities are more vulnerable to being taken advantage of by others. Street vendors with disabilities are often harassed by police and others.

- Lack of employment means that most people have very low incomes, which results in an inability to afford adequate food for themselves and their children.

- Lack of care options means carers of children with disabilities (and carers of adults with severe disabilities) face difficulties engaging in work outside the home.

- While there is still prejudice and discrimination, in particular in relation to employment, the stigma associated with disability has to some extent dissipated. People with disabilities did not describe many issues of stigma or discrimination, and on the contrary, some described a supportive attitude by communities.

3.1. Income, employment and food security

Most of the families interviewed reported having insufficient incomes to cover their basic needs, many do not have any regular income. Most respondents do not have salaried employment and those that do include nurses, guards and people working with waste collection. All of the salaried employees interviewed mentioned receiving a monthly salary of ETB 2,000. The many respondents who rely on unstable income from other income sources, such as selling items on the streets, reported incomes of between ETB 500 and 1,000 per month. Women often reported earning income from day labour such as washing clothes or baking injera. Others reported selling lottery tickets. Children may also contribute to household revenues – for example by working as shoeshine boys – but they often earn very little. Based on longitudinal survey and qualitative data from Young Lives, Tafere (2014) found that most children contributed to family income, but that they did not necessarily benefit from their work themselves. The research also highlighted how quantitative data tends to overlook the contributions of children to their households, and that mixed methods approaches are therefore necessary (Tafere, 2014).
Most people interviewed in the qualitative research reported owing small amounts of money to local shops for purchase of food or various household items. Some have small savings, including in local savings groups.

Traditionally, men are responsible for income generation, while women are responsible for household activities, including childcare and food preparation. However, in many low-income families today, women have to participate in income-generating activities, which then come on top of their domestic responsibilities (SSI21.1). In addition, caring for a child with a disability often means limited opportunities for engaging in livelihood activities and earning income (SSI19.1; SSI27.2). This is especially the case as there are few childcare facilities and not enough inclusive schools available with the capacity to care for children with disabilities (SSI19.1). Caring for a child with a disability can also inhibit the ability of parents, in particular mothers, to take part in community activities (SSI19.1).

While most job opportunities are in the private sector, this is also where people with disabilities face the most barriers in the form of lack of awareness and stigma (KII19.1). In practice, private sector employment is not available for most people with disabilities, which leaves self-employment, including various small-scale businesses, and government employment. For the latter, people with disabilities are supposed to be given preference for public sector jobs in theory, but there are issues of discrimination in practice, with people without disabilities often preferred (KII19.1). In addition, most government offices are not accessible. Lack of access to education also contributes to limiting the employment opportunities of people with disabilities, in particular for women.

Because of limited income opportunities, some people with disabilities have to resort to begging. Groce et al. (2014), in their study on people with disabilities who engage in begging in Addis Ababa, found four distinct groups of people coming to the city for the purpose of begging: people with pre-existing disabilities coming from rural areas, people with pre-existing disabilities coming to the city for medical treatment, people with pre-existing disabilities coming to the city for education, and people coming to Addis Ababa for work from rural areas who have had an accident and now have a disability. The types of disabilities among street beggars in Addis Ababa are varied. Most of those surveyed (80 per cent) were either blind/visually impaired (28 per cent), physically disabled (40 per cent), or identified themselves as “multiply disabled” including physical disability 12 per cent). The other 20 per cent were made up of persons with epilepsy, ex-leprosy patients and individuals with multiple disabilities. Few or no individuals with intellectual disabilities or deafness were observed begging in this study (Groce et al. 2014, p. 30). While about 59 per cent of those begging with a disability had no former employment, 41 had worked before and 55 per cent had at least some education. Based on their findings, Groce, et al. (2014) recommend piloting and implementing social protection programmes for people with disabilities in both rural and urban areas in order to avoid people having to resort to begging.

Most of the families interviewed during the qualitative research reported that their insufficient incomes impacted access to a nutritious diet. Birhane et al. (2014) found that 75 per cent of households were food insecure and 23 per cent were in a state of hunger in a survey of 550 households in three sub-cities of Addis Ababa. Reduction in meal size and shifting to poor quality/less expensive food types were among the common coping strategies used by households.
Families interviewed in Addis Ketema and Arada sub-cities reported eating two to three times a day, but usually the same or similar food every day, often consisting of injera with shiro (traditional bread with sauce). For most families, foods like meat, milk, egg and vegetables are only eaten on special occasions, and parents face challenges ensuring a balanced diet for their children. In some severe cases, families reported eating only once a day, with parents often foregoing meals to prioritise food for the youngest children.

My priority is my daughter’s meals. I make sure that she eats well every day, even if the nutrition content is often not good enough. She also gets food at school from the National School Children Feeding Program. That helps a lot because I don’t need to provide food to my child three times a day on weekdays. She gets her breakfast and lunch at school (Woman with a disability, SSI28.1).

Main expenses besides food include: electricity, water and children’s education-related expenses. Families taking care of children with disabilities face additional costs, including for items such as diapers, as well as for transport and health expenses.

### 3.2. Social relations

Much of the literature on urban poverty in Ethiopia describes relatively strong social networks even in urban communities, including through traditional mutual support associations such as the iddir. Respondents interviewed by Zemebe (2002) stated that support from family and friends in the community was essential for meeting their basic needs, and people reported that relatives and neighbours were supporting people living in poverty, including small children, older people and people with disabilities. Several people also emphasised not only the material support from relatives and friends, but also the emotional support. Similarly, Pankhurst and Tiumelissan (2013) found that children and their caregivers valued cohesive social relations despite the conditions of material deprivation in those areas of Addis Ababa selected for re-development. Relations with family and friends are important for children, and they liked living close to their friends, schools, markets, cafés and religious institutions (Pankhurst and Tiumelissan, 2013).

People with disabilities did not describe many issues of stigma or discrimination. A common sentiment expressed by both people with disabilities and key informants is that previously prevalent attitudes that disability is a curse and punishment from God are changing, even if they have not yet been eliminated altogether. However, people with disabilities are generally considered by society, government and stakeholders as unable to work.

I live because of the people around me. I live because of my neighbours. Although they are poor themselves, whenever I ask for support, even money, not once did I ever face rejection. If they don’t have money to lend, they tell me so and instead they give me something in kind, such as injera, bread, sugar, etc. I am also a member of the community iddir but cannot afford the equb. (Woman with a disability, SSI28.1)
Disabilities do not have to act as barriers to participation in the social life of the community. However, for some carers, the work involved in caring for people with disabilities can significantly hinder their own ability to participate in social activities in the community. Further, because of the additional expenses related to having a disability, and the barriers that people with disabilities and carers face in engaging in employment, some families reported not being able to participate in iddirs because of lack of sufficient income (SSI19.2; SSI23.1).

Our neighbourhood does not exclude us and has a good integration with us. The only reason I do not actively participate in social events is because I am too preoccupied taking care of the sisters with disabilities and I get very exhausted. I have no assistance in the house. For a 60-year old woman, this is beyond manageable. (Older woman caring for three nieces with disabilities, SSI24.2)

3.3. Hopes and aspirations

Because of the barriers to formal employment, people with disabilities expressed a wish to establish small businesses as a way to improve their situation. The main barrier to this is access to capital, which most people do not have, as well as a space to conduct business, which people wish to be provided by the government.

I desperately want to be provided with training to do home-based income-generating activities. I am very capable of using my hands and if given training and a workspace, I can support myself and my family. That is not what is happening now. Sometimes I get very discouraged, but have a belief deep within me that this too shall pass. (Woman with a disability who is confined to her house, SSI30.2)
4. Homeless people: Situation

Key Messages

- Most homeless people are working as day labourers, for example with waste management, as porters, or with petty trading, washing clothes, while others beg. Most subsist on very low incomes.

- Lack of housing is a barrier for engaging in employment, in particular for women who need to protect their children. In addition, people are also often unwilling to hire homeless people.

- Homeless people face challenges in accessing safe food. Many people eat leftovers from hotels and restaurants that are often of low quality and mixed with waste such as paper tissues, creating a health hazard. People may sometimes buy food, but this is expensive. The lack of shelter makes storing and cooking food difficult, and access to safe drinking water is a challenge.

- Social relations are extremely important, and closely interlinked with poverty and homelessness, and homeless people are heavily stigmatised and excluded from social relations with other people. However, in some cases, homeless people have strong relationships with other people living on the streets, who can be sources of support.

4.1. Extent and causes of homelessness in Addis Ababa

There is a significant population of homeless people in Addis Ababa. Although it is difficult to obtain precise numbers, the city administration estimates the number of homeless individuals to be around 50,000 (Soberland, 2018). The majority of the destitute are male (77.2 per cent) and between 18 and 35 years old (62.2 per cent), with approximately 10.5 per cent below 18, and 13 per cent above 45. Of the adult population of homeless individuals, only 7 per cent are married, which reveals a striking difference between the surveyed population and the general population (Ibid). Another study in 2010 by the NGO StreetInvest estimated that there were 11,830 street children as well as an estimated 9,000 children in residential care in Addis Ababa (StreetInvest 2011). Homelessness is predominantly caused by a combination of unsafe migration, lack of support from social networks, lack of access to employment and income-generating opportunities, lack of access to affordable housing and lack of access to an effective social protection system.
These findings are in line with international research on child and youth homelessness. A meta-analysis of causes of child and youth homelessness published in 2016 reviewed 49 studies, with a total of 13,559 participants from 24 countries, including 21 developing countries. The study found that the most commonly reported reason for homelessness was poverty (39 per cent pooled prevalence), followed by family conflict (32 per cent) and abuse (26 per cent). Delinquency was the least frequently cited reason (10 per cent) (Embleton et al. 2016).

Most of the homeless people interviewed are migrants from rural areas, although some have resided in Addis Ababa for a long time (Ayano et al., 2017; Soberland, 2018). Soberland found that 62 per cent of the destitute people surveyed had been born in a rural area. However, the situation varies between locations. Whereas in some locations of the study more than 80 per cent of respondents reported being born in a rural location, in Addis Ketema, it was 48 per cent, and in Arada about 60 per cent. Origins of migrants also varies by study location: in both Arada and Addis Ketema, the largest group is migrants from Amhara (44.5 and 50 per cent respectively, with large groups from Oromia (24.0 and 23.0 per cent) and SNNPR (26.7 and 23.0 per cent) (Soberland, 2018).

Similarly, Abebe (2008) found that most of the street children who participated in his research were either first- or second-generation migrants, and that more than half had been born outside Addis Ababa (Adebe, 2008). Children come to Addis Ababa for various reasons: sometimes their family may send them away if they find it difficult to provide for them, other times they flee the home because of domestic conflicts, for example, in the case of the death of a parent and conflict with new step-parents. In other cases, children migrate to the city in search of better opportunities of education and income, similar to the reasons for adult migration (KII27.6; KII31.7). Girls often do not live on the street and are usually initially engaged in domestic work. However, they are often abused by employers and often end up on the street, sometimes engaging in sex work (KII27.6). Domestic workers are hard to reach, the girls often only come into contact with the authorities – usually the police – if they flee their occupation and household and find themselves in Addis Ababa without support (KII27.6). Children and their families are also sometimes promised work in Addis Ababa by brokers but are then abandoned at the city’s bus stations (KII27.6).

According to the literature, the underlying reason for migration is often the loss of assets and livelihoods in people’s places of origin. Migration to urban areas in itself may also lead to further loss of social support networks. In the Soberland (2018) survey, 61 per cent of respondents said that the main reason for migrating to the city was poverty, while 23 per cent said that it was in order to earn a better income. On average, respondents stated that they had left their homes about 5.5 years ago and had been living on the streets for the last four years. Significantly, the majority of survey respondents stated that they no longer visited relatives in their places of origin, and when asked to prioritise various types of support, assistance to go back to their place of origin and re-unite with families was the last priority. Support with housing, food and employment were the highest priorities. The exception to this was among the youngest group where there was higher demand for reunification with family.
Tadele et al. (2018) show linkages between urban destitution and the combination of migration from rural areas and the resulting lack of support from social networks, which makes young women less resilient to coping with births and health problems, including HIV/AIDS (Tadele, et al., 2018). Sebrato (2016) similarly describes how migrant children who come to Addis Ababa both from rural and other urban areas become highly vulnerable to destitution, homelessness and exploitation as soon as they reach their destination (Sebrat, 2016).

People often describe moving in and out of homelessness as their situations change. For example, women’s situations change when they have small children, no job and the father cannot provide for them. However, once people lose their homes, they become vulnerable to vicious circles of homelessness leading to exclusion from employment, social support and social services, which makes it even more difficult to again afford a home.
4.2. Income, employment and food security

Many homeless people earn an income from selling items on the streets such as gum, candy, cigarettes or tea and coffee. Others resort to begging. The survey by Soberland (2018) showed that begging was a main source of income for the destitute people surveyed, although it was still only a minority that engaged in begging: 28 per cent of men and 44 per cent of women. Most men reported engaging in whichever casual labour they could get, while 41 per cent of women reported that they engage in commercial sex work to earn a living (though this was partly a result of deliberate oversampling of commercial sex workers in the study). Another common occupation is waste collection. Several homeless people interviewed during the qualitative research worked for waste collection associations, where they are paid a salary of ETB 2000 per month (SSI19.4). Homeless boys may also work as day labourers in construction, or as shoeshine boys if they have money for materials. Both boys and girls obtain money from begging or stealing, which they commonly describe as their “occupation” (SSI28.2; SSI28.3).

Low levels of education are a barrier for many homeless people to improve their situation. Many of the homeless people interviewed dropped out of school at a young age or had few education opportunities where they grew up. This is especially true for women, many of whom are illiterate (SSI23.4). Soberland (2018) found low levels of education among the destitute people surveyed, with 26.3 per cent unable to read and write and only about 28 per cent having gone to school beyond lower primary education (Grade 4). There are large differences between the study areas: Addis Ketema is among the places with the worst education status among the destitute, with only 6 per cent having attended Grade 5 and above. Arada fares much better, with more than 20 per cent having attended Grade 5 and above. Qualitative research findings point out that there is a cultural preference for supporting boys’ education over girls’ education and that girls’ domestic obligations may get in the way of their studies (Zemebe, 2002).

Homelessness in itself also presents a barrier to income and employment in several ways. Due to the stigma attached to being homeless, many people are not willing to hire people living on the streets. For mothers with children, the lack of secure accommodation or any creche facilities means that they cannot move far from home to look for income opportunities (SSI19.1; SSI21.2). In addition, it is often difficult to get a job without having a Kebele ID and someone to guarantee for you, both requirements that are very difficult to manage for homeless people without social networks in Addis Ababa (SSI26.1; SSI27.4; SSI24.6).

One day, I started giving tutorial classes to young children in one household. I taught them for two months. Then the mother heard that I was homeless and live on the street. She insulted me and told me to get out of her house. (Young homeless man with a BSc, SSI24.1).
Homeless people face challenges in accessing sufficient and safe food. While some people living under plastic shelters in a semi-permanent location are able to purchase raw ingredients and cook their own food, others do not have this option. People therefore have to rely either on donated food, or on relatively more expensive food from small food stalls (SSI19.4; SSI25.3). In many cases, people reported relying on leftover food (referred to as bullie) donated by local restaurants and hotels. In some cases, there are middlemen who sell this leftover food to homeless people for ETB 5-10 per meal. In the survey by Soberland (2018), 7 per cent of respondents reported that they cook their own food, whereas most are begging leftover food from hotels, cafes or restaurants and a minority reported buying food from street vendors or being given food from religious institutions.

Several homeless people interviewed reported that leftover food is often hard to identify and comes with waste in it, such as tissues. This constitutes a health hazard and several people reported having become sick from eating leftover food, and therefore having stopped eating it (SSI25.1; SSI23.4; SSI24.1).

We had paper, soft tissue and other dirty materials. I felt disgusted and nauseous during the first days. But now it is normal for me. (Homeless young man, SSI24.1)

Many of the homeless people living around churches or mosques rely on food donated by passers-by. Some report being able to eat three times a day, while others eat only once or twice a day, with adults often having to forego meals to put the children first. Soberland (2018) found that 60 per cent of the destitute respondents reported eating only two times a day and about 4 per cent only once a day. More than half said that they had spent a night without food in the last week, while 37 per cent reported that they went to bed without food for two nights and 33 per cent that they spent three nights or more without food in the last week.

BOX 3: HOW HOMELESSNESS PRESENTS A BARRIER TO EMPLOYMENT (SSI27.4)

A 40-year old man became homeless when he lost his job in Addis Ababa. He was previously a hotel manager in Gondar but has not been able to find a job in Addis Ababa despite looking for any type of work: “They requested someone who can be a guarantor. I do not know anyone here in Addis whom I may approach for this purpose. Moreover, they also requested my Kebele ID, which I don’t have.”

He described looking for any kind of work, including as day labourer in construction sites and as a waiter in café and hotels. But, as he said, “these days, if you do not have a good social network or relative, you can’t get any job.” He described how society has a negative attitude towards people living on the street: “They think that we cannot work, that we are not responsible. So, no one wants to hire a person from the street regardless of their potential.”
Common meals are bread with tea for breakfast and injera with shiro, or bullie (which is often a mix of different things) for lunch and dinner. Meat, eggs, vegetables and milk are very rare. In addition to food expenditures, purchasing drinking water and soap are the other main expenses for many homeless people.

4.3. Social relations

Based on the qualitative research, poverty and social relations are interlinked. Domestic conflicts are often a cause of poverty and homelessness, and poverty and homelessness can lead, in turn, to social exclusion. Many of the homeless people interviewed described difficult relations with family members as part of the reason for their homelessness, and conflict with family members was often what had originally led people to migrate to Addis Ababa – at a very young age for many.

My father’s wife is too bad to live with. She used to beat me when I was a child. I couldn’t tolerate her, so I finally stole some money from her and came to Addis Ababa. (15 year old homeless girl, SSI28.2)

Once in Addis Ababa, people often rely on other family members for support, but if these relations sour they are left on their own (SSI23.4; SSI25.4; SSI26.1; SSI26.2; SSI21.2). Divorce, death or departure of husbands is also often a trigger of homelessness for women. Many are then left on their own with children and are unable to earn enough income to pay rent. Shame is an important aspect of homelessness, often contributing to keeping people on the streets. For example, one young man said that he has relatives in Addis Ababa, but that he is too ashamed to even visit them, let alone ask for their help. In most other cases, people have relatives in their places of origin, but are too ashamed of their situation to return home or ask them for support.

I don’t want to go there looking like this, I feel ashamed of the way I dress now. I will visit them once my life is better. (SSI27.6)

Previous research with children in low-income households in the Kolfe area of Addis Ababa by Gebru (2009) has similarly found that negative relationships were a major factor adversely affecting a sense of wellbeing. This included conflict between and with parents or caregivers and conflicts with friends, peers and neighbours. In fact, most children perceived negative relations, not poverty, to have the greatest effect upon their well-being – only children from single-parent families who did not mention any other major risk to their well-being saw poverty as a direct risk to well-being. This does not mean that poverty does not affect children’s well-being, but that the relationship is often indirect – for example with poverty leading to more conflicts in families. Good relations with family members and neighbours also emerged as a key determinant of children’s ability to cope effectively with adversity (Gebru, 2009).
The interviews with key informants, community members and homeless people themselves showed mixed results about the inclusion of homeless people in communities. In some cases, families who have lived in the same location for many years are well-known in the communities and community members provide assistance to some extent (SSI21.2). However, at the same time there is still stigma attached to being homeless as a result of the poor living conditions homeless people endure.

It is difficult to even consider them as human beings, looking at the current state they are in.

(UPSNP targeting committee member, FGD23.1)

As mentioned above, most people are also unwilling to hire homeless people, and the social exclusion they experience therefore has a direct bearing on their income. Homeless people are also excluded from iddirs, as people do not trust them to pay the monthly fees. In the qualitative research, we found no examples of a homeless person being part of an iddir (SSI23.4; SSI24.1; SSI27.4). This discrimination and social exclusion was also described by some – both the homeless themselves and key informants – as having a psychological impact on homeless people, as they feel disrespected and demoralised.

They are discriminated against and segregated by society. There are problems with the public attitudes about people living on the street. Many people do not consider them as human beings.

(Police officer, KII31.8).

Like other groups, people living on the streets have differing social networks. While some homeless people live in places with no other homeless people around, others stay in areas where many others sleep as well. Staying in an area with many people living on the street, such as around churches, can have both positive and negative effects. Some people reported experiencing harassment and violence, while others described a sense of community and mutual support in case of crisis. Teenage girls interviewed described a particularly close relationship with other children and adolescents living on the streets, something that has also been described in the existing literature on the lives of street children in Addis Ababa (SSI28.2; Sebrato, 2016; Fikre, 2016).

Previous qualitative research with 16 children aged 15 to 18 involved in commercial sexual exploitation in Addis Ketema sub-city also highlighted the social exclusion of this group of vulnerable children. This social exclusion was related to the stigma attached to commercial sex work, which led community members to regard these children as apart from the community, with passers-by or police exposing them to verbal and physical abuse. Stigma connected with commercial sex work is related both to the stigma of sexually transmitted infections such as HIV/AIDS and to the view that commercial sex workers are immoral and may exert a negative influence on other children. This social exclusion means that the children are completely dependent on support from each other, which makes it more difficult to get out of commercial sexual exploitation (Melaku, 2014).
4.4. Hopes and aspirations

The common approach to homelessness in Addis Ababa, so far, has been to relocate homeless people to their places of origin, or simply to centres outside of Addis Ababa. While some homeless people want to be supported to return home, the majority of those interviewed do not wish to return home but instead seek housing and employment in Addis Ababa.

In many cases, people described being too ashamed of their situation to return home. Shame may come for some women from the fact that they have had children outside of marriage, or simply from having married without the permission of their families. These women all stated that they can never return home (SSI24.4; SSI25.4; SSI26.1). Women with children are desperate for some kind of safe accommodation for themselves and their children, and secondarily need support to earn an income.

For men, the nature of the shame they feel is slightly different. They usually came to Addis Ababa to earn money and are ashamed of their failure to succeed. Often, their relatives do not know about their situation in the city. Many of these men expressed a desire to eventually return home, but not before they have been able to improve their lives, at least to the extent of having a good set of clothes and a bit of savings to bring home. What they are mainly interested in is the ability to earn an income (SSI27.4; SSI30.4). Children are often in a similar situation to adults and may find it difficult to return home because of the shame of not having been successful in the endeavour to earn money to bring home to their families. The shame is even greater for children who have been subjected to abuse while in the city.

There are also some people for whom homelessness is a choice to some degree. These are usually young men who come to Addis Ababa to work, and who send most of their income home. Since our main target group is families living on the street, we only interviewed a few single men, and therefore did not encounter many from this group of the homeless. Finally, there are people who are homeless as a result of mental illness. However, we were not able to include this group as primary respondents, and since mental health services are very limited, we were not able to gather much information about this group from service providers.
5. Access to social services: Barriers, bottlenecks and enabling factors

This chapter reviews access to services for people with disabilities and homeless people in Addis Ababa. Before moving to the assessment of access to services by sector, we briefly describe the main cross-cutting barriers that people with disabilities and homeless people are facing in Addis Ababa.

When it comes to disability, Ethiopia generally has a well-developed legal and policy framework articulated in the National Plan of Action for the Inclusion of Persons with Disabilities (2012-2021), as well as other legislation and policies, but implementation has so far been limited (Sida, 2014). In practice, there is therefore not an enabling environment for people with disabilities to access services and in order to create one, it is necessary to improve both demand and supply for mainstreaming of disability-inclusion across sectors and specific services for people with disabilities. Currently, there is no strong network of civil society organisations working with and for people with disabilities to embody this demand, and there is no centrally placed, empowered actor within government to push for mainstreaming of disability across ministries. In addition, there is a general lack of awareness of disability issues among staff at all levels of government, NGOs and community-based organisations.

A key barrier for homeless people is the lack of a permanent address and the resulting lack of national ID (Kebele ID). The government officials interviewed often expressed that they are unable to provide services to people who do not have a Kebele ID. This is because services are provided by woreda offices to people who can prove that they are residents of a particular woreda. In some cases, officials said that they think they ought to provide services to homeless people, and that they have the capacity to do so, but that they are not able to because homeless people do not have ID cards. The Kebele ID is issued by the woreda civil registration and vital statistics office and is difficult to obtain for homeless people. However, there are other types of ID which can and do provide access to services for homeless people. BoWCA can issue an ID card, and the UPSNP also issues its own ID card that can, for example, then be used to access the health fee waiver programme.
5.1. Access to the Urban Productive Safety Net Programme (UPSNP)

Recommendations

• Carry out more research on how to create an enabling environment for disability inclusion in Ethiopia, including assessment of civil society strengths and weaknesses. Support establishment of empowered disability champions within government at all levels.

• Support a comprehensive programme of awareness raising and training on disability for government officials at all levels.

• Support the development of processes and guidelines for assessing the needs of people with disabilities – either as a cross-cutting national disability assessment mechanism, or as mechanisms specific to sectors or programmes.

• Review access to identification for homeless people, with the aim of developing a uniform process of providing an ID card which grants access to the necessary services – either by adjusting requirements for obtaining the national identification card, or by issuing a separate or temporary ID card for people who do not have proof of address.

Key Messages

• There have been no efforts to ensure that the UPSNP Public Works component is accessible for people with disabilities.

• The UPSNP implementation manual reflects a prejudice that people with disabilities cannot work. Locally, officials and community committee members recognise that this is not the case, and therefore apply a test of work capacity rather than disability as such.

• There are no guidelines or training provided for targeting committee members on how to assess the work capacity of people with disabilities.

• The current targeting criteria, which includes an assessment of belongings, are not an accurate proxy for current income or food security.

• Homeless people are excluded from the UPSNP as a matter of policy, more than practical barriers.

• There is no functional grievance redress mechanism after the initial targeting process has been completed since the grievance redress committee is only operational for 15 days following targeting and only deals with complaints related to targeting.
The UPSNP is the only systematic and substantial income support programme available to low-income families in Addis Ababa. Providing essential income support for many families, it is sometimes the main income source, at times the only one. It is therefore essential that the programme be sustained and expanded to cover all families in need. The main barrier to access to the programme is that it operates with a set quota for each woreda instead of by need alone, which means that most households in need of support are not able to benefit from the programme. In addition, very little has been done to ensure that the programme takes into concern the needs of people with disabilities. Further, most homeless people are excluded as a matter of policy.

Besides the quotas, there are other barriers to accessing the programme. Communication efforts have not been sufficient to ensure that all community members are aware of the programme, and there seem to have been no particular efforts to ensure that communication reaches people with disabilities. The targeting mechanism is somewhat subjective, and guidelines and training provided to the members of community targeting committees are inadequate to ensure a predictable and unbiased targeting process. As a result, many people interviewed did not perceive the targeting process to be fair and effective in selecting the most vulnerable people.

**BOX 4: THE UPSNP TARGETING PROCESS**

Beneficiaries of the UPSNP are selected using a combination of geographical targeting, with quotas for each woreda, and community-based targeting. A proxy means test is used for spot checks of the accuracy of the community-based targeting. Selection of beneficiaries happens through ketena targeting committees, with members elected by the communities. Members of targeting committees are provided with a three-day training on how to gather data for the selection of beneficiaries. They then carry out house-to-house visits to gather data on people’s income and living conditions, which is used to divide all households in the ketena into four categories. The UPSNP aims to include only the lowest category, the ‘poorest of the poor’.

While the main barrier to accessing the UPSNP is the limited supply caused by the quota in place, there are also potential demand-side barriers. The term ‘the poorest of the poor’ (‘yediha diha’ in Amharic) is perceived to be derogatory, which has meant that, according to some focus group participants, people do not provide correct information about their living conditions and the problems they have because they do not want to be considered poor.
Once the beneficiaries have been selected, the ketena targeting committee is also responsible for identifying people for the sub-components of UPSNP: Direct Support and Public Works. According to the programme implementation manual, Direct Support beneficiaries include people with disabilities, people above 60, people with chronic illness and orphans. However, there are no guidelines for identifying people with disabilities, and the programme implementation manual conflates issues of reduced work capacity and disability. While the guidelines seem to imply that people with disabilities are by definition unable to work, and should therefore receive Direct Support (which was also the viewpoint expressed by UPSNP team leaders in the sub-city administrations), targeting committees in practice apply a test of capacity to work. Only those people with disabilities who are deemed unable to work and who do not have anybody else in the household who can provide for them are admitted into Direct Support (FGD27.4).

The criteria used for UPSNP Direct Support is whether someone can work – not whether they have a disability or not – and whether they have someone who can support them. Sometimes you can see on a person’s disability that they cannot work, but other times people need to have letters from doctors ascertaining that they have a health issue which means that they cannot work. (KII24.2)

As a result of the conflation in the programme implementation manual of disability and reduced capacity to work, the UPSNP does not include any initiatives to make the Public Works component accessible for people with disabilities, as it is implicitly assumed that people with disabilities should not benefit from it. This is a clear case of discrimination and violation of the principle that people with disabilities should be able to participate in society on an equal basis with others. It is also problematic because the potential benefit from the programme is higher for Public Works than for Direct Support.

Homeless people are generally excluded from the UPSNP as a matter of policy, as officials are waiting for the destitution component to be implemented. This is despite the fact that many homeless people would benefit greatly from inclusion in the UPSNP and that there are no insurmountable practical barriers to their participation. Despite the official policy, we found that several homeless people have in fact been included in the UPSNP. This is the case for those who live in one location permanently and are therefore known by the community members in the targeting committee, even if they live in a temporary shelter and do not have a Kebele ID. These households are included in the house-to-house registration undertaken by the ketena targeting committees and are classified as belonging to the wealth category of ‘the poorest of the poor’ (FGD27.5; FGD28.2). Others who are more transient and are not residents in one location have not been included, and the requirement of the programme for beneficiaries to have stayed at least six months in the same area remains a barrier to their participation.

Payments can be difficult to access for people with disabilities who cannot travel to banks to open accounts, and homeless people included in the programme face difficulties in opening bank accounts without Kebele IDs. Benefit levels do not take into account the additional costs faced by people with disabilities.
The **work requirement** of the programme can be a challenge for carers of children with disabilities. The UPSNP provides quite flexible work, but it can still be difficult for carers to manage both taking care of children with disabilities, working on the UPSNP, and taking care of domestic work (SSI19.1). Some targeting committees stated that they recognised this and that people with heavy care burdens were therefore also eligible for Direct Support. However, this seems to depend on the targeting committee involved. There is no functional **complaints and grievance mechanism** after the first 15 days following the selection process.

### Recommendations

- Strengthen communication about the UPSNP, including eligibility criteria and rights of beneficiaries, as we found several households who were not aware of the programme.

- Ensure that the UPSNP is disability-friendly:
  - Payments should be accessible for people with disabilities.
  - Households with people with disabilities should receive a higher benefit than others to compensate for the additional cost of disability.
  - The Public Works component, including skills training and livelihoods support, should be made accessible for those people with disabilities who are able to work.
  - The selection into Direct Support and Public Works respectively needs to take place based on an assessment of work capacity – not disability – based on comprehensive guidelines, with adequate training of committee members.
  - People taking care of children with disabilities or adults with severe disabilities, and without any other adults in the household, should qualify for Direct Support.

- Ensure that all homeless people can participate in the UPSNP on an equal basis with others, and resolve issues of opening bank accounts for homeless people.

- Make sure that Public Works beneficiaries with children can access childcare services.

- Establish a permanent grievance redress mechanism and other social accountability mechanisms, as envisioned in the UPSNP citizen engagement component, and ensure that these are accessible for people with disabilities.
Outside of the Public Works arm of the UPSNP, there are limited initiatives to provide employment and income support services. There are, however, government-run business centres that provide space for people operating small businesses, for example in the Rimo area. The provision of space for small businesses is something that many people with disabilities requested. They complained that they are not given preferential access to the existing spaces, which is supposed to be the case. The fact that it is illegal to sell goods on the side of the road in many places is a barrier to people with disabilities who make a living from petty trading.

Within woreda BoLSA offices, there is a service available that registers unemployed people and refers them to available jobs. Similarly, BoWCA also provides some services linking women with job opportunities, but the scope seems to be limited (KII23.2). A major barrier to starting small businesses mentioned by many of the people interviewed is the limited access to capital. There is very limited access to credit from banks for low-income families. However small-scale loans are available from village savings and loans associations. There are attitudinal barriers to access to credit – while women and young people are able to get credit from the government, people with disabilities are perceived to be ‘unproductive’ and are therefore often barred from receiving loans (KII19.1). BoLSA implements a programme to support small and micro enterprises with start-up capital and microcredit, but the scope is limited, and the programme requires recipients to form groups, which means that projects often fail when groups do not keep together (KII25.7).

Two different school feeding programmes provide important access to food for many low-income families. The public schools child feeding programme was initiated by former first lady Roman Tesfaye and is now run by the Office of the Prime Minister through a foundation called ‘Ye Enat Wog Bego Adragot’ (‘Charity of the Mother Foundation’). The programme provides breakfast and lunch for school-going children from low-income households. The programme has a limited scope, covering

5.2. Access to other income, food and employment support programmes

Key findings

- Programmes providing income, food and employment support are fragmented and have insufficient scope.
- School feeding programmes provide essential support to many low-income families but are targeted at the ‘poorest of the poor’ and depend partly on the contributions of volunteers and local donors.
- Iddirs are an important source of community-based support. While people with disabilities are likely to be included, there has been no particular initiatives by Iddirs to make their services more disability-friendly. Homeless people are generally excluded from Iddirs.
only 942 students in Addis Ketema and 1,713 in Arada at the time of the research (July 2018). The programme is targeted at the ‘poorest of the poor’ and prioritises the homeless, as well as students whose parents have a chronic illness (KII30.4). In addition, a community-run informal feeding programme also provides breakfast and lunch to children from low-income households enrolled in government schools. In Addis Ketema, the programme covered 2,030 students at the time of the research (KII30.4). BoWCA is responsible for identifying children for support from the programme and also recruits volunteers to cook (KII23.2). The fact that the school feeding programmes are targeted at the poorest households, rather than provided on a universal basis, means that many children in need are excluded. Various NGOs also provide limited food distribution to vulnerable people.

Iddirs, traditional funeral associations, including other associations based on ethnic, clan, religious, wealth, location, gender, and occupation are increasingly engaged in subsidiary activities, and many people are members of more than one iddir. They provide loans for medical treatment, help provide guarantees for members who take loans from micro-credit institutions, distribute money for members on holidays and iddir leaders may also be involved in dispute settlement on behalf of members (Bevan et al., 2006). However, one can only be part of an iddir if one has the money to add to the saving scheme regularly, which excludes those with little or unstable sources of income. Homeless people are usually excluded because community members do not trust them to pay the membership fees.

### Recommendations

- Expand access to school feeding programmes, ideally by making school feeding programmes universal in all schools.
- Look at options for improving existing income sources of homeless people, for example by supporting waste collection associations, which provide incomes for many homeless people.
- Review and strengthen existing employment and income-generating support programmes implemented by BoLSA, for example by providing credit to individuals rather than groups and strengthening technical advice on entrepreneurship.
- Provide space for vulnerable groups to conduct small businesses and make it legal to carry out petty trading on streets. Generally improving conditions for street vendors is likely to benefit low-income people with disabilities and the homeless in particular.
- Look at options for incentivising and potentially subsidising iddirs to improve their provision of income support to vulnerable households who have not been included in the UPSNP.
- Provide awareness raising for iddir management on the needs of people with disabilities and the homeless.
5.3. Access to housing, shelter, alternative care and re-integration

Key findings

- The main need expressed by people with disabilities and homeless people is for adequate housing.
- Most of the people with disabilities interviewed live in crowded government housing, without access to proper sanitation and usually in one-room houses. Toilets and baths are communal, sometimes with ten households sharing one latrine that is not accessible for people with disabilities.
- The broader environment is not accessible, often trapping people with disabilities inside their homes.
- The main need for most homeless people, especially couples or single parents with children, is housing, or at least safe shelter of some form. Lack of shelter is a key cause of every other need expressed by homeless people.
- There is very limited government service provision in housing and shelter. Access to government housing is through a waiting list, with referral through ketena committees. There is limited transparency in the process of accessing government housing and people report often waiting for many years to get access.
- A number of NGOs run shelters for the homeless, but the number of beds is not sufficient to meet demand.

Between 70 and 80 per cent of housing in Addis Ababa is estimated to be of low quality, only 44 per cent of the population has access to a safe water supply and only 10 per cent have piped sewage (World Bank, 2015). Access to adequate housing was cited as the main need by the vast majority of respondents in the qualitative research, both people with disabilities and homeless people. Despite the importance of access to shelters and housing, there is very limited service provision. The main government service in housing is the provision of government housing for rent at very low rates and government-owned condominiums for sale through government mortgages. For low-income households, only government housing is relevant, as condominiums are not affordable. The supply of government housing is substantial, but nevertheless inadequate for demand.

I think housing is the most critical issue. You’re not going to solve anything else effectively if […] the people don’t have stable, safe housing. If we can get people into stable housing that they own, we solve 99 per cent of their problems. (Ethiopia ACT director, KII31.11)
Access to housing for people with disabilities

Most of the people with disabilities interviewed lived in one-room dilapidated housing, sometimes with as many as eight family members (SSI19.2). In addition, many respondents lacked basic household items such as beds, mattresses and blankets (SSI21.1). The houses are not comfortable during the rainy season, and many areas are prone to flooding. These findings are in keeping with previous research in Addis Ababa (Bevan, 2006; Pankhurst and Tiunelissan, 2013; Zemebe, 2002). Poor conditions lead to issues with diarrhoea, typhoid fever and other types of fever, made worse because of the overcrowding of the houses (KII27.4). In addition, houses and surroundings are not accessible for people with disabilities, leading some to be confined to their home their entire lives (SSI19.2). This is particularly an issue regarding toilet facilities in government housing, which are generally communal and shared by eight to ten families (SSI19.2; SSI21.1; SSI23.2; SSI27.1). The lack of accessibility is exacerbated by the severe lack of access to assistive devices. However, even those who have assistive devices, such as wheelchairs, may find the physical environment inaccessible, and in practice still end up being confined to their homes (SSI19.1; SSI24.7).

Access to housing and shelter for homeless people

The respondents in the Soberland study (2018) mentioned a range of different sleeping places, with 35 per cent sleeping on the street, 20 per cent sleeping in a church or mosque, 18 per cent in plastic tents or under canvas, and the remaining sleeping under bridges, in parks, at railway stations, in abandoned houses or cars or in rented houses (kesha houses). However, the majority (81 per cent) have permanent sleeping places.

The main need expressed by homeless people, both in our qualitative research and in the Soberland survey, is access to safe accommodation. It is clear from the interviews that the lack of access to accommodation underlines all the other needs that homeless people have. Families often live in makeshift plastic shelters, usually in the same location for years (what has sometimes been termed ‘pavement dwelling’), while single men seemed more likely to describe sleeping rough in different places and being chased away by police.

In both sub-cities, but in Addis Ketema in particular, large numbers of homeless people sleep rough or under plastic shelters near churches (SSI25.4; SSI26.1). Some homeless people, in particular children and young people, sometimes rent beds by night from private landlords to get out of the cold and rain. We found that there is very limited access to shelters for homeless people in the two sub-cities, as was also documented by Soberland (2018). Although a number of NGOs operate shelters, the number of beds is inadequate.
BOX 5: THE ‘HOUSING FIRST’ APPROACH TO SERVICE PROVISION FOR THE HOMELESS

Services for the homeless in OECD countries have progressed from provision of food and emergency accommodation, and permanent supported housing and transitional services to more effective ‘housing first’ and case-management service models. These differ from older service models in five key respects:

1. The services use a combination of permanent accommodation, support workers and case management services; they are an integrated response combining housing and support services to meet the needs of homeless people.

2. There is no requirement to undertake a series of steps to be made ‘housing ready’ prior to accessing permanent accommodation. Permanent accommodation is provided immediately, or as rapidly as possible, and homeless people are moved in as quickly as possible.

3. Access to accommodation is not conditional on abstinence from drugs and alcohol and there is no requirement to comply with treatment for mental or physical health problems. Service users choose for themselves whether or not to use these services without affecting their access to accommodation and being allowed to remain in accommodation.

4. Services follow a harm-reduction approach with a recovery orientation.

5. There is an explicit emphasis on treating homeless people with compassion, warmth and respect and on recognising that access to suitable housing is a human right.

Even though ‘Housing First’ is increasingly recognised as international best practice, and has shown results in OECD countries, it is important to note that services should still be provided based on what is in the best interest of the homeless person, based on an individual assessment of need. As mentioned above, housing is not necessarily the greatest need of all homeless people. In addition, some homeless people may not be able or interested in holding onto permanent accommodation, or permanent accommodation may simply not be available. In that case, the lack of accommodation should not prevent the provision of other forms of support to people without permanent accommodation.
Access to alternative care and reintegration

As with other social services, alternative care and reunification is mainly implemented by various NGOs, while BoWCA, in cooperation with the Women’s Development Army and the police, plays a role in identification and assessment of homeless adults and children in need of support. Woreda BoWCA officials will identify children and complete a form requesting support, which is submitted to the city government that will then contact NGOs running shelters. Woreda BoWCA officials are not empowered to provide referrals directly. The NGOs working with street children follow broadly similar models, at least on paper, based on provision of temporary shelter where psychosocial support and other training is potentially provided, followed by efforts to reunify children with their families, usually in other parts of Ethiopia. In some cases, where adolescents or young people do not wish to be reunified with their families, they are instead provided with various types of skills development and employment support (KII27:2).

Previous research of NGOs delivering services to orphans and vulnerable children in Arada sub-city revealed major challenges, including: lack of coordination among organisations; frequent interruptions in funding; lack of ownership on behalf of participants and local communities; lack of data on orphans and vulnerable children; and insufficient resources to provide services to all identified children in a sustainable manner, including to foster parents, with the result that support is often interrupted with adverse consequences for the children (Bekele, 2013).

**Recommendations**

- Set aside budgets for improving living conditions in government housing, and for making houses and surroundings accessible for people with disabilities. A particularly urgent need is to improve access to toilets, but also public roads and government buildings. Schools in particular need to be made accessible.

- Work with housing offices to improve feedback regarding access to government housing and transparency in the decision-making process to ensure that the most vulnerable people are provided with access to housing and that people are made aware of the status of their applications.

- Urgently provide support to NGOs to expand access to shelters for homeless people, including facilities specialising in supporting children who are on their own as well as families/single women with children. Shelter facilities for working-age people, including single women with children, should include childcare services and be located centrally to allow income-generating activities.

- Advocate for the sub-city administrations to make land available for homeless people where they can legally establish makeshift shelters.

- Establish trained outreach teams of social workers focusing specifically on homeless people, including children.
5.4. Access to education and skills development

**Key findings**

- School enrolment is generally high, but there are challenges of quality and retention.
- There has, so far, been insufficient attention and resources allocated to providing quality education to children with disabilities – both in terms of making mainstream schools accessible and ensuring availability of special needs education.
- Homeless children are able to enrol in school, but retention is a challenge.

Ethiopia has achieved unprecedented increases in enrolment in primary education over the last 15 years, as a result of free primary education and large-scale public awareness campaigns to promote school attendance. According to the Ministry of Education, net enrolment in grades 1-8 increased from 54 per cent in 2002/2003 to 94 per cent in 2014/2015 (Young Lives, 2017). During the qualitative research we encountered very few children not in school, and both key informants and households described good access to primary schools. This is a result of a concerted effort by government to increase enrolment, including through annual home-to-home sensitisation campaigns two months prior to commencement of the school year in September to ensure that all children are enrolled in education. This campaign happens through a cooperation between BoWCA, Bureau of Education, Bureau of Health and other bureaus in close cooperation with ketena committees. According to key informants, the school feeding programmes have also contributed to increasing enrolment. However, the quality of learning has not necessarily improved, and many children in early grades are not learning as expected (Woodhead et al., 2017 in Young Lives, 2017). Many respondents complained about the quality of the education that children receive in government schools (SSI21.1; SSI28.4).

Urban children have much better access to education than rural children and it is easier to combine work with school in urban areas, where there are night classes available (Tafere and Camfield, 2009). However, while education is free in Ethiopia, households on low incomes are unable to afford uniforms, books and other expenses related to education (Zemebe, 2002). Access to pre-schooling is an important factor in later school success. Those children in Ethiopia in urban areas who went to pre-school were 26 per cent more likely to complete secondary education at the appropriate age than children without pre-school, including control variables (Woldehanna and Araya, 2017). That is problematic, as poorer children are much less likely to attend pre-school than their richer counterparts, as one would expect (Woldehanna, 2016).
There is no government support for the provision of school materials. However, BoWCA works with woreda child rights committees to raise funds from individual donors (KII23.2). Many children in the families interviewed were receiving school materials such as exercise books and stationary, and in some cases school uniforms from various NGOs, churches or individuals (SSI21.1; SSI26.1). Some organisations support many children with school uniforms and materials – for example Abebech Gobena provides support to 1,747 children with funding from Plan International’s sponsorship programme (KII23.5).

Access to education for children with disabilities

Children with disabilities are benefitting from the improved access to mainstream education available to everyone in Ethiopia. However, the lack of attention to the specific needs of children with disabilities creates barriers for learning. This includes a lack of teaching materials for people with disabilities and a lack of teacher training on how to treat people with disabilities (SSI19.1). Often, mainstream schools have only one teacher who has been trained in special needs education, and even these teachers have not received comprehensive training and may not have any relevant practical experience in working with children with disabilities. To address this, some schools recruit sign-language interpreters on a temporary basis to assist deaf students (KII25.6).
In addition, school buildings are not accessible. There are insufficient numbers of specialised education schools available, usually only one per sub-city, whereas one in each woreda would be more appropriate (FGD27.4). In addition, the existing special needs school building and the surrounding areas are not accessible (FGD29.2). There is a limited number of DPOs and NGOs providing training and skills development for people with disabilities. There are also demand-side barriers to education, including a misconception that children with disabilities should not go to school. According to most respondents, this view is declining rapidly in Addis Ababa, but may still be a significant factor for some groups, in particular children with intellectual disabilities (KII30.1). In addition, the significant shortage of assistive devices constitutes a barrier for many children in accessing education.

The government’s own report says that during the last Education Sector Development Plan only ‘poor progress’ towards supporting children with special education needs has been made (Government of Ethiopia, 2015). Abebe (2011) carried out qualitative research with 160 children with intellectual disabilities in Addis Ababa and found that schools with special or inclusive classes for children with intellectual disability are not generally available while there is a conducive policy framework for inclusive education. As a result, the vast majority of children with intellectual disabilities are not able to access education. The few schools that do have special or inclusive education classes are not equipped with relevant learning materials and teaching aids, and the learning environment is not convenient and comfortable for children with intellectual disabilities (Abebe, 2011).

A significant number of children with disabilities reportedly drop out by Grade 5 because their schools would not allow them to progress further due to their disability (ACPF, 2011 in Sida, 2014). There are also many barriers preventing students with disabilities from participating in training and vocational education (Malle, 2017).

Access to education for homeless children

We found that children living on the streets with their parents are generally able to access education. However, homelessness affects their ability to study, as children have difficulties doing homework without access to electric light (SSI23.4). This is partly because they have to work in order to support their families and/or cover the cost of education (for uniforms, education materials etc.), but also because of various other social and psychological problems resulting from malnutrition, poor hygiene and sanitation, poor health condition, drug use, etc.
### Recommendations

- Focus on improving quality and retention, in particular for children with disabilities and homeless children, as enrolment is not the main challenge.
- Make school buildings accessible – both special needs education schools and mainstream schools.
- Encourage the creation of more special needs schools.
- Train and hire more special needs teachers, and acquire more materials for children with disabilities.
- Improve disability assessment of children’s needs.
- Expand the school feeding programme and, ideally, make it universal.
- Provide homeless children with additional support to improve retention in school. This needs to be based on an individual needs assessment and case management, which would address the multiple needs that they and their families are facing.

### 5.5. Access to healthcare (including child and maternal care and nutrition interventions)

### Key findings

- There is generally good access to healthcare through Health Extension workers, woreda health centres, public hospitals and NGO-run clinics and hospitals.
- The Health Fee Waiver Programme provides essential support for low-income families to access healthcare. For those not part of the fee waiver programme, cost is a main barrier.
- Most homeless people are excluded from the fee waiver programme, as they do not have a Kebele ID.
- Even for those enrolled in the fee waiver programme, the cost of medicine is often prohibitively high.
- There is a severe lack of access to rehabilitation services and assistive devices for people with disabilities.
As with education, the general improvements in access to healthcare in Ethiopia, in particular through the Health Extension Programme, has also benefitted vulnerable groups such as people with disabilities and the homeless, even if there are still many barriers to access. Woreda health centres provide promotive, preventive, curative and rehabilitative outpatient care, including basic laboratory and pharmacy services. Most respondents interviewed had a positive experience of the healthcare they had received at woreda health centres. Woreda health centres are close enough to people to be generally accessible, and together with private for-profit and NGO-run hospitals, health centres and clinics they provide a reasonably high level of access to health services. However, buildings are not accessible for people with disabilities, and even though the health centres are close by, they can still be difficult to reach for people with disabilities, because most roads are not accessible – both for people with physical disabilities and for those with visual impairments (SSI28.4).

In addition, medicine often has to be purchased from private pharmacies and can be prohibitively expensive (Bevan et al., 2006; Government of Ethiopia, 2017). We found high prevalence of HIV/AIDS among the people interviewed, which means that many people need frequent medical attention. Most HIV-positive people described having access to ARVs free of charge through Woreda health centres. For some low-income households and homeless people, various NGOs provide essential healthcare services. The two largest non-profit providers in Arada and Addis Ketema sub-cities include Abebech Gobena, which runs several healthcare facilities in Arada sub-city, and Mother Teresa (Missionaries of Charity), which provides essential healthcare for homeless people.
Health Extension workers play an important role in prevention and awareness raising on health-related topics, although they do not provide treatment. There are ten Health Extension workers and two supervisors in each woreda. They are based at woreda health centres or woreda offices but spend most of their time carrying out family visits. Each Health Extension worker is assigned approximately 500 households. They focus mainly on awareness raising, prevention and referrals to Woreda Health Centres. While they do not provide treatment, they do deliver a range of services directly to families, including:

- Vaccination (including polio vaccine), provision of vitamin A and de-worming treatments to children under the age of five.

**BOX 6: ACCESS TO FREE OR SUBSIDISED HEALTHCARE SERVICES FOR VULNERABLE GROUPS**

The ‘Indigent Fee Waiver Programme’ provides an essential means of support for poor people, older people and people with disabilities to access healthcare in Ethiopia. Applications are taken through the woreda BoLSA office, which provides a letter of support. Eligibility is determined by ketena committees, based on an assessment of income, work capacity and employment status. Each woreda has a fixed budget allocation to pay for the services provided under the fee waiver programme. Eligibility is assessed on an annual basis.

Based on our field research, the programme seems to be generally accessible for those who need it, although we did find a few examples of eligible people who were not aware of the programme (SSI21.1). Generally, we found that public healthcare facilities are free or affordable for low-income households, with the exception of homeless people (FGD24.1). However, other national-level research has found that the fee-waiver programme has low coverage, reaching only 6 per cent of people below the poverty line (UNICEF, 2016; Government of Ethiopia, 2017).

For slightly more well-off people, community-based health insurance (CBHI) provides access to free health services for a fee of ETB 350 per year. The CBHI is currently being implemented in one woreda in each sub-city, with the intention to expand access to one additional woreda each year. As the programme has only recently been introduced, we did not encounter anybody benefitting from it, and have not been able to evaluate its importance and accessibility. Previous studies have found that only 7.4 per cent of the population in the country are covered and that the poorest wealth quintile has a much lower participation rate than the average (Government of Ethiopia, 2017).
Situation and access to services of people with disabilities and homeless people in two sub-cities of Addis Ababa

Access to social services: Barriers, bottlenecks and enabling factors

- Follow-up guidance for pregnant women and new mothers, including referral to antenatal and postnatal services at healthcare centres.
- Health education to communities on sanitation, waste management etc.
- HIV/AIDS counselling and referral to health facilities.
- Tuberculosis screening and follow up, as well as information about non-communicable diseases and communicable diseases such as HIV/AIDS and other sexually transmitted infections.
- Nutrition status and blood pressure screening.
- Guidance on personal hygiene, family planning and child health.

Ante-natal and post-natal care is available for free from government health centres. Most respondents, including the homeless, expressed satisfaction with the service, although several mentioned that ultra-sound scanning was not available to them (SSI26.1). As noted above, Health Extension workers also provide ante-natal and post-natal care, including regularly checking on pregnant women and providing them with vitamin and iron supplements. After birth, infants are provided with vaccinations, immunizations, growth monitoring (using the arm circumference measurement method), and information on breast-feeding practice and family planning (‘child spacing’) is provided. Again, they have responsibility for following all the pregnant women in their 500 households. Whenever a woman passes 37 weeks, the Health Extension worker will follow up to ensure delivery at a woreda health centre, and almost all women now give birth in health centres according to those health professionals and community members interviewed (KII27.4).

Access to healthcare for people with disabilities

While people with disabilities are benefitting from mainstream health services, there are limited disability-specific services and specialised services. Woreda health centres are generally not accessible and there is no training of health professionals on disability. Information is not available in braille and sign language at healthcare centres, which means that there is a high risk of miscommunication about important medical information for people with hearing or visual impairments (SSI23.2).

Access to rehabilitation for people with disabilities is extremely limited. In 2011, there were 13 physical rehabilitation centres in all of Ethiopia, out of which six were run by non-governmental organisations (Ministry of Labour and Social Affairs, 2011). No respondents in the qualitative research mentioned accessing rehabilitation services, and in fact many people with disabilities, and carers of people with disabilities, are not even aware that rehabilitation services should be available, nor are they informed about the value of accessing rehabilitation services. Access to assistive devices is recognised as a key need by people with disabilities and carers of people with disabilities, however supply is extremely limited. There are no government services provided in this area, and only a few NGOs provide assistive devices.
Health Extension workers do not have the necessary skills on early identification and provision of home-based rehabilitation case management for persons with disabilities. They do not have information about how to refer people with disabilities to rehabilitation and assistive devices (KII31.10). In order to provide treatment for people in their homes, health outreach teams are currently being piloted in Woredas 4 and 6 of Arada sub-city (KII25.1). This initiative could potentially be very important for improving access to healthcare for people with disabilities who face difficulties getting to the health centres.

While the Ethiopian government has taken initiatives to combat HIV/AIDS in the country, people with disabilities have generally been excluded from these efforts, as they are considered not to be sexually active, and therefore not at risk. However, qualitative research in Addis Ababa found that people with disabilities are in fact at high risk of infection, as a result of factors like poverty, lack of information, inaccessibility of HIV educational materials and social exclusion and stigma (Gunjefo, 2007).

**Access to healthcare for homeless people**

Homeless people face difficulties accessing healthcare mainly because they often do not have a Kebele ID and are therefore not accessing the Health Fee Waiver Programme. Among the destitute homeless surveyed by Soberland (2018), 22 per cent reported having an episode of illness during the three months prior to the survey. About 47 per cent among those who became sick or injured consulted someone for treatment. Among the respondents who did not consult someone to get treatment for their sickness or injury, 65 cited lack of money as the reason.

Health Extension workers are generally focusing on the families within their portfolio, which are households with permanent addresses. They therefore only provide limited services to the homeless, including counselling and testing for HIV, as well as vaccinations of children under five years of age during vaccination campaigns (FGD27.1).

The revised Health Extension manual does include provisions for Health Extension workers to start providing more services to homeless people, but this service has not yet started in all areas (FGD27.1). In Arada sub-city, Health Extension workers are not reaching out to the homeless (KII25.1), whereas in Addis Ketema Health Extension workers have been providing the training package to homeless people in the last year. In Addis Ketema, many homeless people have also been enrolled in the Health Fee Waiver Programme. However, based on interviews with homeless people themselves, the main barrier to accessing healthcare is cost. Even though homeless people should be eligible for the Health Fee Waiver Programme, and some are accessing it, the majority of the homeless people we interviewed reported having to pay for healthcare at government health centres.
As for all low-income households, medicine is often unaffordable for homeless people who generally do not have regular income. Many of the homeless people interviewed are HIV positive and most are receiving free antiretroviral treatment from public hospitals (SSI21.2). HIV/AIDS tests are available in various locations across Addis Ababa, and if people are found to be HIV/AIDS positive, Health Extension workers will refer them to free antiretroviral therapy services.

Because many homeless people are not included in the Health Fee Waiver Programme, and are unable to afford paying for healthcare at government health centres, almost all of the homeless people interviewed described being treated at Mother Teresa’s Missionaries of Charity Center (SSI21.2). There are other NGOs providing healthcare services in the two sub-cities, including the Macedonians Humanitarian Association shelter, which also includes a clinic. Several homeless young women described receiving antenatal care and giving birth in government health centres, and then subsequently receiving post-natal care at the Mother Teresa health centre, based on referral from their woreda health centre (SSI24.4; SSI25.5; SSI30.3).

Previous research has found very high rates of mental and alcohol disorders among the homeless in Addis Ababa. In a recent study involving 217 homeless adults in Addis Ababa, about 90 per cent of the respondents had experienced some form of mental or alcohol use or disorder: 41 per cent had experienced psychosis, 60 percent had hazardous or dependent alcohol use, and 14.8 percent reported attempting suicide in the previous month (Fekadu et al., 2014). However, even with such evident need there are very limited mental healthcare services available in the two sub-cities.

Recommendations

• Take measures to improve access to affordable medicine, by ensuring that medicine is available at woreda health centre pharmacies, and/or potentially including subsidies for medicine as part of the health fee waiver programme.

• Monitor progress on piloting and rolling out health outreach teams, and make sure that people with disabilities and homeless people are able to benefit from the services they provide, and that health professionals in the teams are trained on assessing the needs of people with disabilities, and in establishing positive relations with homeless people.

People with disabilities

• Improve accessibility of government healthcare centres for people with disabilities by installing elevators and improving accessibility of surroundings.

• Consider providing support to cover the cost of transportation to and from health care centres for people with disabilities.
• Address severe supply-side shortages in the case of rehabilitation and assistive devices. In addition, the UPSNP should work with disability experts to strengthen processes of needs assessment to refer people to services.

• Health Extension workers need training in community-based rehabilitation to equip them with the necessary skills for early identification, assessment, referrals and home-based physical rehabilitation of children with disabilities and post-intervention follow-up techniques.

Homeless people

• Review service provision to homeless people included in the revised Health Extension Manual and carry out an analysis of how the UPSNP destitution component can draw on and complement work of health extension workers with homeless people. Any cooperation would require MoUs to be signed between BoLSA and the Bureau of Health at the city level.

• Better prepare Health Extension workers for working with homeless families, potentially by providing additional specialised teams of Health Extension workers, where at least two people move together to provide services to homeless people.

• Ensure that guidelines for the fee waiver programme specify that homeless people are eligible for the programme, even without a Kebele ID. Ensure that all homeless people are issued UPSNP ID cards, are automatically enrolled in the Health Fee Waiver Programme and are provided with information about their rights under the programme.

• Make sure that all children under five years of age living on the street are included in all vaccination programmes.

5.6. Access to protection

Key findings

• Both homeless people and people with disabilities are vulnerable to violence and abuse, and homeless women are especially vulnerable.

• The main actors providing protection are the police and the woreda-level Bureau of Women and Children’s Affairs.

• However, protection services are generally not easily accessible, and most cases of abuse and violence are unlikely to be reported.
Homeless people are exposed to serious protection risks as a result of their lack of secure accommodation. Women live in constant fear of sexual abuse, harassment and theft (SSI19.1), and many homeless women and girls experience rape and have children outside of marriage as a result.

It is a must to get married when you are on the street. Otherwise, you will have children without father by losing your dignity. *(Young homeless woman, SSI26.1)*

Based on data from Young Lives, Pankhurst et al. (2016) provide a comprehensive account of violence against children in Ethiopia. The study finds that many types of violence against children are widespread and normalised in Ethiopian society. Corporal punishment is the most prevalent form of violence, both at school and at home, whereas in communities, emotional violence in the form of insults and harassment is more common. Children’s experience of violence varies along lines of age and gender. Violence against children is also influenced by contextual factors such as the quality of family relationships, family composition/structure, families’ social connections in their communities, community social norms, the commitment to child protection and the quality of formal institutions such as schools, social services, the police and the judiciary (Pankhurst et al., 2016).

Children with disabilities are more vulnerable to violence than other children. The effect is not direct, but disabilities can put children in situations where they are more vulnerable to violence. For example, they may not be able to move around independently, or to communicate with family members, which creates frustrations. Parents’ lack of knowledge about their child’s situation may also make the child more vulnerable to violence. Poverty can also add to negative relationships between children and caregivers, because there are no resources to provide children with the assistance they need, which can affect their behaviour. Lack of money for assistance may force parents to either lock their child in the house, or leave them on their own in the street where they are vulnerable to abuse (Boersma, 2008).

Children living on the streets are at high risk of abuse and sexual harassment, and homeless people interviewed, both men and women, described sexual abuse and harassment of girls and women as very common (SSI24.1; SSI26.1). There is very limited access to protection services, as a result of barriers in both supply and demand. The limited services available are provided mainly by the police, by woreda Bureaus of Women and Children, as well as community associations such as members of the Women's Development Army and NGOs.

The policemen are always against the homeless people. They do not allow staying in one place for long. They consider the homeless to be thieves and criminals, though they are not all involved in these activities. *(KII31.8)*
Women report different forms of harassment and abuse to BoWCA, which is the main government office responsible for these cases. BoWCA also provides support to homeless women, including health check-ups, re-connection with family members or referrals to institutions as well as following up to ensure that perpetrators of abuse are prosecuted. However, as with most other bureaus, woreda BoWCAs are often severely understaffed and all the homeless women interviewed described access to first response referral systems for survivors of gender-based violence as very difficult (SSI19.4;SSI23.4;SSI26.1). This is corroborated by quantitative evidence. According to the 2016 Ethiopia Demographic and Health Survey 2016, only 23 per cent of women aged 15-49 who experienced physical or sexual violence sought help.

**BOX 7: COMMUNITY CARE COALITIONS**

Community care coalitions (CCC), community-based organisations that raise funds to support those who are worst off in the community, are envisioned to play an important role in the strengthening of the social protection system in the National Social Protection Policy (NSPP) (UNICEF, 2016). The involvement of CCCs in the social protection system was tested in Tigray as part of the UNICEF-supported social cash transfer pilot programme. The evaluation of the role of CCCs in the pilot project was largely positive: the CCCs were found to be able to raise significant funds in support of vulnerable people in the communities.

However, it was also recognised that there are limitations to relying on volunteers, who are often busy with other activities, and that the funds collected by CCCs are not sufficient to provide adequate support. The CCCs should therefore be seen as a valuable complementary service, not as a replacement for government social protection services (FAO, 2014; Birhane, 2014). It is also worth noting that some of the challenges experienced by CCC members in the Tigray pilot may be more pronounced in an urban context – in urban areas, people have both more expenses and better access to income-earning opportunities than in rural areas. This means that the opportunity cost of engaging in voluntary work is likely to be much higher in an urban context. The NSPP envisages a further expansion of the CCCs, that can also play a crucial role in promoting child protection measures within communities if supported by accredited social workers.
In Addis Ketema, we did find some examples of active CCCs functioning as forums of collaboration between government and non-government stakeholders and mobilising resources from communities for vulnerable households, but in general we did not find CCCs to play a significant role in the two sub-cities as of yet. According to the respondents that were aware of the CCCs in Addis Ketema, their main focus is mobilising local resources, including for food distribution to homeless people and vulnerable families during holidays in collaboration with hotels and other volunteers. They also collect used clothes and shoes from the community and redistribute them to people in need. However, no respondents mentioned CCCs as an important factor in relation to child protection. Instead, this role is fulfilled by members of the Women’s Development Army.

**Recommendations**

- Work with BoWCA and the police to strengthen protection response and referral systems.
- Provide training for police to increase their understanding and ability to work with homeless people.
- Strengthen cooperation between police and BoWCA to ensure that the police refer unaccompanied minors to BoWCA.
- Deploy community social workers who can identify and refer protection cases.
6. Destitution as a targeting criterion for service delivery

6.1. Conceptualising destitution

A thorough literature review established the lack of a universal definition for destitution at present. This is a qualitative concept that is understood and operationalised on the basis of particular socio-economic and cultural contexts. Narrower definitions focus on specific characteristics or manifestations associated with extreme deprivation and/or long-term poverty, such as homelessness (Speak, 2004; Tipple and Speak, 2003; Fajemilehin, 2007; Carter 2011; ASAP 2016; Kissoon, 2010; Ghafur, 2006; Shoma 2010). Broader definitions incorporate the factors for and consequences of destitution, such as lack of income and assets, and multi-dimensionality of poverty such as social exclusion and lack of access to services (Crawley et al. 2011; Cuthill et al., 2013; Fitzpatrick et al., 2015; Devereux, 2003; Sharp et al., 2003; Dreze, 2000; Dasgupta, 1993; Harriss-White 2002 and 2005; Brown, 2008; Alkire et al, 2014; Santos and Barrett, 2005; Stephen, 2000; Heinonen, 2000; Green, 2006).

There are further caveats within these definitions of destitution that are based on fluid frameworks of extreme poverty or homelessness. Extreme poverty is in itself a relative concept, with ‘destitution’ signifying a layer or degree of multi-dimensional deprivation and the lack of ability to cover one’s basic needs (Devereux, 2003). Homelessness, on the other hand, is considered a tangible and visible indicator of extreme poverty; one’s inability to cover the basic need for shelter or the extreme point of deprivation of the right to adequate housing (OHCHR, n.d). However, homelessness is still a relative measure in the urban context of low and middle-income countries, where homeless populations are much larger and more diverse than in developed countries. The degree of homelessness, apart from the conditions of housing that one is able to access, is related to individual choice and economic stability in the place of origin and location. There is often little difference in the degree of vulnerability between ‘pavement dwellers’, i.e. persons living on the street in makeshift tent homes, and squatters in abandoned homes. While the physical living conditions of the latter are marginally better than that of pavement dwellers, the quality of housing is grossly inadequate and they are faced with a similar constant threat of eviction. Furthermore, inadequacy of housing conditions is difficult to assess where the majority of the population are residing in poor quality or unsafe housing.

Adequate housing has been defined by the United Nations Committee on Economic, Social and Cultural Rights (UNCESCR) in the following terms: ‘Adequate shelter means adequate privacy, adequate space, adequate security, adequate lighting and ventilation, adequate basic infrastructure and adequate location with regard to work and basic facilities—all at reasonable cost.’ Article 11 (1) (UNCESCR, 1991).
While housing conditions are a fundamental aspect of homelessness, there are other aspects to consider such as income and assets below a productive threshold, social exclusion and lack of access to essential services and protection. Such aspects of destitution are closely linked to the conditions under which one may become homeless *(driving factors)*. The livelihood of any household comprises an eco-system built around productive assets, income-generating activities as well as the management of both assets and money through savings, re-investments and informal insurance mechanisms. Much of the literature points to the loss of livelihood or an economic shock that drives individuals into ‘unsustainable livelihoods’ as a driving factor for destitution.

Sen (1981) was one of the first to outline the continuum of destitution, starting with steady and irreversible asset depletion that leads to a state of extreme deprivation. This can be observed through increased frequency of drought affecting farmers and pastoralists, eviction of tenants, livestock sales by smallholders, large-scale economic migration, increased begging and mass displacement to relief camps. Destitution can therefore be understood as a multi-faceted concept that begins at a point of crisis and culminates into unsustainable livelihoods (with assets and income falling below a certain threshold), inability to cover basic needs, exclusion from social and political spaces and, at times, homelessness. Destitution should be conceptualised as cyclical or ‘in sequence’ (Sen, 1981), with one form of deprivation perpetuating the other, with no scope for recovery or escape in the absence of social capital and access to services *(consequences and impacts)*.

### 6.2. Destitution in social protection: Lessons learned from other countries

Globally, the use of the concept of destitution is limited in social protection policy and programming. Destitution as a targeting criterion is most often narrowed down to specific categories of vulnerable populations, where the parameters are articulated for each category. In the *United Kingdom (UK)*, destitution is defined with homelessness, inability to meet basic needs and social exclusion for the purposes of targeting of social services and benefits. The UK’s Housing Act 1996 articulates the parameters of homelessness that focus on inadequate accommodation and inability to meet basic needs. Fitzpatrick et al. (2015) integrate the element of choice into the contextual definition of destitute groups in the UK, as those that ‘*suffer an enforced lack of the following minimum material necessities: shelter, food, heating, lighting, clothing and basic toiletries OR have an income level so low that they are unable to provide these minimum material necessities for themselves*’. For the ‘Asylum Support’ benefit, the UK government assesses destitution of asylum seekers on the degree of social integration (or social exclusion) that they experience, with inadequate accommodation and ability to meet basic needs used as proxy criteria (ASAP, 2016).
In **India**, destitution is closely associated with social exclusion, and demographic categories that are at risk of being marginalised and stigmatised. The state of Tamil Nadu uses the concept to identify categories of persons for the provision of social assistance. To qualify for both the Destitute Widow Pension Scheme and the Destitute Physically Handicapped Pension Scheme for example, one must have no income and not possess property with a value above Rs 5,000\(^4\). The broad definition of destitution and ill-defined parameters for identifying categories of the destitute translates into high exclusion errors in targeting of the benefits (Kidd, Wapling, Schjoedt et al, 2019). The national ‘Destitute Women and Widows Welfare Bill, 2009’ associates destitution with gender and marital status, and defines a ‘destitute woman and widow’ as ‘any female citizen of India who is a widow or divorcee and has no independent source of income or livelihood to support herself or is not being looked after by any family member’\(^5\).

In **Bangladesh**, destitution is understood as a consequence of climate-affected loss of livelihoods. The Addressing Climate Change Related Destitution (ACCD) programme was set up as part of the Challenging the Frontiers of Poverty Reduction Programme – Targeting the Ultra Poor (CFPR –TUP), to address the impact of climate change on livelihoods and socio-economic contexts in the coastal regions. However, eligibility to participate in the programme is based on level of risk exposure or vulnerability to climate change, rather than income levels or other indicators.

Finally, in **Botswana**, destitution is associated with labour capacity. The Destitute Persons Programme (DPP) was established in the 1980s as cash and in-kind assistance for persons identified as ‘destitute’, and families that take care of orphans. The Government of Botswana provides allowances on the basis of whether someone is assessed as ‘permanent destitute’ or ‘temporary destitute’, and both categories are vided accommodation if assessed to be living in inadequate housing conditions. The ‘permanent destitute’ are those unable to engage in economic activities due to disability, chronic health conditions and insufficient assets and income sources. The latter are persons temporarily incapacitated as a result of floods, fire, motor-vehicle accidents, and/or ill-health etc. (GoB/MLB, 2018). In 2012/13, the DPP reached 30,516 persons or 1.5% of the total population but its scope and effectiveness was found to be limited by poor administration and a lack of coordination with other social assistance programmes. The criteria utilised by a social worker to assess eligibility are listed below (see Table 2).

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5. http://164.100.47.4/billstexts/lsbilltexts/AsIntroduced/23631s-6.pdf
**Table 2: Definitions of Destitution Used in the Botswana Destitute Allowance**

<table>
<thead>
<tr>
<th>Definition</th>
<th>Permanent</th>
<th>Temporary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition</td>
<td>An individual who is unable to engage in sustainable economic activities due to:</td>
<td>They are usually able-bodied people who are encouraged to engage in the rehabilitation programmes so as to exit the destitution programme.</td>
</tr>
<tr>
<td></td>
<td>■ Disability</td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ Chronic health condition</td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ Insufficient assets and income sources.</td>
<td></td>
</tr>
<tr>
<td>Assessment indicators</td>
<td>An individual who is:</td>
<td>A person who is temporarily incapacitated, until he/she can support him/herself, due to:</td>
</tr>
<tr>
<td></td>
<td>■ Possessing not more than four livestock units.</td>
<td>■ Floods</td>
</tr>
<tr>
<td></td>
<td>■ Earning or receiving an income of less than P120.00 per month without dependents or less than P150.00 per month with dependents.</td>
<td>■ Fire</td>
</tr>
<tr>
<td></td>
<td>A dependent is someone who is under 18 years of age, who depends on an adult for more than half of his or her subsistence.</td>
<td>■ Motor vehicle accidents</td>
</tr>
<tr>
<td></td>
<td></td>
<td>■ Ill-health, etc.</td>
</tr>
</tbody>
</table>

*Source: Government of Botswana/MLB (2018)*

In conclusion, destitution is a complex qualitative concept with no consensus definition, rendering it difficult to use as a standardised measure of poverty and thus as an effective targeting criterion. The use of such an arbitrary concept for targeting increases the risk of high exclusion errors as it most often comes down to the subjective understanding and judgement of the assessor. The implementation of the criterion has therefore been fraught with challenges unless project design integrates well-developed and broad parameters, such as in the United Kingdom. However, targeting narrowly defined categories of ‘destitute’ persons in a low-income country context can prove to be difficult where the majority exist in deprived conditions that are indistinguishable across socio-economic strata. It is likely to exclude persons that are only marginally better off than the designated ‘destitute’, who equally require services such as income or employment support, health care and counselling, improved housing and other specific services.*
6.3. Identifying the urban destitute in Ethiopia

In Ethiopia, the contextual manifestations of destitution have been explored by a number of studies (Sharp et al. 2003, Tadele et al. 2018, Devereaux 2003, Demewozu, 2005). Sharp et al. (2003) identify three dimensions of destitution in the Wollo region of Ethiopia: inability to meet basic needs, lack of access to productive assets and access to social capital. The framework has consequently been adopted by the scoping study on urban destitution commissioned by MoLSA and conducted in 2017 by Soberland (2018). Devereaux (2003) focuses on the third dimension by expanding the definition of assets or capital in the context of Ethiopia, where the lack of social capital is a critical aspect of destitution within a context of widespread poverty. In particular, for social networks to become an asset would predicate the need for networks with the community elite, which act as a critical resource that protect families and individuals from becoming destitute, contrary to having peer networks that may be equally weakened and impoverished (Huda, et al., 2008). Gemtessa et al. (2007) observe that in rural Ethiopia, pastoralists become destitute when they have no animals, a source of both income and social status.

Other studies explore categorical destitution, such as “land poor” and “labour poor” (such as people with disabilities, older persons living alone, widows and orphans) who would be identified as categories of destitute persons in rural Ethiopia. In the urban context, Tadele et al. (2018) identify the destitute as: homeless adults or families (21%), destitute prostitutes (19%), street children (18%), older people without family support (17%), beggars (15%) and people with disabilities or mental illness (10%). Demewozu (2005) describes the urban destitute as including but not limited to: ‘resource-poor urban-dwellers; people under conditions of contingency, including orphans, people with different disabilities and disaster victims; and policy-related displacees, such as the retrenched, demobilized soldiers, and war-affected people.’ On the basis of existing literature and our research, the key characteristics of people living in urban destitution in Addis Ababa can be summarised as:

- Rural-urban migrants due to loss of livelihoods in the place of origin,
- Homeless people using a broader definition of people with very poor housing/makeshift homes or street dwellings, with the commonality being the high risk of eviction and extremely poor hygiene and sanitation standards,
- People who lack access to services due to lack of kebele registration,
- People with precarious livelihoods such as those engaged in sex work and begging when there is lack of choice (Harriss-White, 2002), and
- Persons with disabilities, in particular people with mental disability and severe physical disability.

Among the urban destitute, there is the sub-typology of street children with particular characteristics and risks. Children engage in street life mainly due to poverty, neglect, violence and other crises faced at home. UNICEF (1996) identified three types of street children based on two variables: the degree of participation in street activities and the degree of contact/ties with their families:
■ **Children on the Street**: Children working on the street but maintaining more or less regular ties with their families. Their focus is home to which they return at the end of the day and they have a sense of belonging to the local community.

■ **Children of the Street**: Children who maintain only tenuous relations with their families, visiting them only occasionally. They see the street as their home where they seek shelter, food and companionship. Sometimes this group of children is called ‘hard-core’ street children, or children who live and habitually sleep on the street.

■ **Abandoned Children**: Children of the street but differentiated from the broader category by the fact that they have cut off all ties with their biological families and are completely on their own. They have no home to go to. This may be because of the death of, or the rejection by, their parents and/or the unavailability of or rejection by their extended family.

The Operations Manual and the ‘Project Appraisal Document for an Urban Productive Safety Net Project’ (World Bank, 2015) describes destitute individuals as ‘the poor that live on the street, and comprise street children, the homeless and beggars’. The documents also refer to the destitute as those ‘who do not have access to a sustainable livelihood and often resort to begging or illicit activities to make a living.’ The document states that these are ‘people who need housing, healthcare, counselling and often reunification with their family, in addition to financial support’.

The Soberland study (2018) was commissioned by MoLSA and carried out in 11 cities across Ethiopia. The estimated urban destitute population covered was 88,690 individuals (1.6 per cent of the total urban population), including older persons with no support and destitute commercial sex workers. The majority were men (72.2 per cent), who were predominantly single (65.5 per cent), belonging to Orthodox Christianity (75.8 per cent) and from rural areas (62.2 per cent), although there were significant variations in place of origin across the research sites. The level of education was lower among the urban destitute, with 26.3 per cent unable to read or write and approximately 28 per cent having completed Grade 5 and above. A limitation of the study is that it potentially underestimates the population of street children in Ethiopia, partly due to the purposeful oversampling of sex workers. According to MoLSA (2002) there are approximately 150,000 street children in Ethiopia, of which 60,000 reside in Addis Ababa. UNICEF Ethiopia estimates a staggering 600,000 street children countrywide, with over 100,000 in Addis Ababa alone.

The Soberland study adapts the three-dimensional framework developed by Sharp et al. (2003) for conceptualising destitution: inability to meet basic needs, lack of access to multiple types of assets/resources, and dependence on the goodwill of others. The experience of urban destitute persons is conceived as a state of deprivation from the “social fabric” of society, rendering them invisible and trapped in a cycle of ‘poverty, homelessness, powerlessness, stigmatization, discrimination, exclusion and material deprivation, all of which mutually reinforce each other’. On the basis of this framework, a typology of the urban destitute including the destitute homeless is identified on the basis of the surveyed sample in Table 3 below:
The majority of the urban destitute that were surveyed reported inadequate income/poverty (61 per cent) as the main reason for migrating to urban centres, followed by death of parents or guardians, domestic violence and eviction due to armed conflict. Once in the city, begging is the main source of income with more women engaged in begging (44 per cent) than men (28 per cent). Men also relied on casual labour, while 41 per cent of women engaged in commercial sex work since the income is substantially higher than the average income of ETB 1,200 (USD 43).
The vast majority of the urban destitute live with friends or alone, and only a small proportion live with family members. The study found that only 7 per cent of the adult urban destitute population are married; a striking difference between the surveyed population and the general population. The surveyed population reported a range of different sleeping places, with 35 per cent sleeping on the street, 20 per cent sleeping in a church or mosque, 18 per cent in plastic tents or under canvas, and the remaining 27 per cent sleeping under bridges, in parks, at railway stations, in abandoned houses or cars or in rented houses (kesha houses). However, the majority (81 per cent) have permanent sleeping places.

The Soberland study also puts forward guidelines for the design and implementation of the UPSNP pilot; the Urban Destitute-People with Special Needs Support Programme. The study outlines the goal for the programme: ‘To provide comprehensive and inclusive urban social safety nets for people with special needs that reduces destitution, promotes access to services and stimulates social stability.’ The programme aims to reach 22,000 urban destitute persons that are not enlisted in the National Population and Household Census (2007).

The guidelines push for a rights-based approach that prioritises community-based interventions for the urban destitute as opposed to institutional solutions, creating hierarchies of support structures while improving collaboration and integration of existing social services, and strengthening the learning systems for programmes. The need for partnerships and coordination between stakeholders is emphasised. Key principles with actionable guidelines are proposed (see Table 4):

<table>
<thead>
<tr>
<th>Key principle</th>
<th>Actionable guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needs and evidence-based</td>
<td>Establish a simplified Data Base and Information Management System on the profile of the destitute and their distribution.</td>
</tr>
<tr>
<td>Participation of beneficiaries</td>
<td>Develop beneficiaries’ engagement strategy/ action plan.</td>
</tr>
<tr>
<td>Gender equality and diversity</td>
<td>Develop a gender and other social-inclusion strategy to ensure a gender-sensitive and socially inclusive destitute support program at all its cycles, e.g. targeting committee, grievance-hearing committee, etc.</td>
</tr>
</tbody>
</table>

The guidelines outline the need to establish the key components of an effective social transfer programme that would include: adequate long-term financing; procedure harmonisation; timely, predictable and appropriate transfers; and transparent accountability structures and appeals mechanisms. The study aligns the programme’s theory of change with the World Bank’s graduation approach (PEI, 2018) with a range of support services ranging from psycho-social and healthcare services, livelihood interventions, and financial inclusion envisioned to create a linear pathway out of urban destitution. International development organisations are identified as important actors for financing and providing technical assistance but also to participate in joint appraisals and MEL activities. Finally, the steps for capacity building at the various organisational levels are outlined, and the roles and responsibilities of the key actors of the programme are envisioned (see Figure 1).
Figure 1: Actors, Roles and Responsibilities for the Urban Destitute Pilot Programme

**Ministry of Labour and Social Affairs (MoLSA)**
- Providing oversight to Pre-DSTC
- Facilitating stakeholder coordination
- Technical support and capacity building
- Coordinating planning in 9 state and two sub-cities
- Preparing national plan of UTC

**City Bureau of Labour and Social Affairs (BoLSA)**
- Planning and implementation of Direct Support Programme
- Facilitating integration with social protection strategy
- Stakeholder Coordination for targeting
- Supports Pre-DSTC

**City Bureau of Health (BoH)**
- Focal office for identification of destitute affected by substance abuse
- Providing health and nutrition training

**Sub-city BoLSA**
- Technical support and capacity building of KTC
- Assisting Woreda level Steering Committee
- Coordinating M&E
- Forming Pre-DSTC and follow up of implementation progress
- Strengthening coordination between lower level actors

**Sub-city BoH**
- Providing data on DS beneficiaries
- Linking DS beneficiaries to HEWS
- Member of Pre-DSTC

**Social workers/Urban Committee/CCCs**
- Identification and targeting
- Verification of eligibility of services
- Supports social workers and HEWs
- Mobilise resources
- Raising awareness

**NGOs, CBOs and faith-based organisations**
- Delivery of services in partnership during the pilot phase; psychological, medical, vocational, social and economic rehabilitation programmes

Source: Pre-Direct Support Technical Committee
7. Readiness for an integrated case management system

Key findings

- There are already linkages between UPSNP and other services, and BoLSA acts as a gateway for some health and education services.
- A lot of data is being collected by different actors, but it is not used optimally and no common MIS exists for storing this data and making it operational. There is a lack of data on the homeless population.
- Existing community structures provide a good basis for identification and referrals but need better training and assistance in streamlining coordination and cooperation, with clear roles and responsibilities.
- Needs assessment is happening, but better training and guidelines, including training on disability assessment should take place.
- There is currently no proper case management system and no social workers with capacity to do home visits or outreach work to homeless people.

Most people living on the streets or in extreme poverty have needs in addition to income support. For example, the homeless need shelter and access to health care, and children need support to stay in school. Because a child or family often has more than one problem that needs to be addressed, time-bound interventions focusing on just one aspect of concern are unlikely to be effective. UNICEF recognises that the "rights and needs of children who face multiple risks are best addressed within a coordinated and integrated approach" (UNICEF, 2017).

Integration of social services can provide benefits to both citizens and service providers, in particular for vulnerable populations with multiple disadvantages. Establishing a strong social work system is essential for providing services, including social protection, to vulnerable populations. This is especially the case for groups such as people with disabilities or the homeless, who require various services. In the context of Ethiopia, a key concern should be to improve access to services for vulnerable groups. Integrated services can facilitate this, in particular if they involve case management and outreach and home-based services.
Based on the experience of OECD countries, OECD (2015) outlines the key steps necessary for successfully integrating social-service delivery:

1. **Better identification of vulnerable groups and monitoring of their service use.** Improving data collection on vulnerable populations is an essential element in the design of innovative service-delivery methods that target these individuals.

2. **Information sharing across providers and sectors.** Efficient information-sharing agreements facilitate identifying gaps in services provision and reducing duplication of services.

3. **Citizen-centred approaches** to integration of services are most efficient. Services should be integrated from the perspective of the citizen, not the provider, as this allows people to make informed choices about their own care.

4. A citizen-centric approach also helps in the adoption of a **non-stigmatising approach** to providing services for the homeless, or people with mental health concerns.

5. Integration of services delivery needs to be accompanied with **financial integration.**

6. Greater investment and focus on **early intervention and prevention** is warranted when integrating and delivering social services for vulnerable populations.

This chapter examines the existing structures and resources available in Arada and Addis Ketema sub-cities for integrated case management. This includes an assessment of the extent of necessary data collection; processes of identification of vulnerable individuals and households; systems being used for case management (including processes and tools for needs assessment, referrals and service provision and follow up and review); and the resources available within local administrations and existing mechanisms and practices of coordination, including existing linkages between the UPSNP and other social services.

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**BOX 8: CASE MANAGEMENT**

Case management can be defined as ‘a collaborative process to identify individuals vulnerable to certain risks, assess their needs and strengths to ensure that their rights are being met, set goals in a participatory manner with the client, provide direct or referral services, follow up, evaluate progress, and terminate the case when the goals have been met’. A case management process involves the following key steps:

1. Identification of vulnerable individuals.
2. Interview and assessment to decide whether a case management process should be initiated.
3. Development of an individual case plan.
4. Provision of direct support and/or referral to other services.
While the literature on integrated case management systems in sub-Saharan Africa is limited, there are some examples of this approach, including one-stop centres used in several countries, as well as South Africa’s Thuthuzela Care Centres and Zambia’s Coordinated Response Centres (UNICEF, 2017). One model of integrated services and case management is shown below.

![Diagram of integrated case management services]

7.1. Data availability

A number of actors collect quite comprehensive information about all households in Arada and Addis Ketema sub-cities, including the UPSNP, the Bureau of Education and the Bureau of Health. BoLSA collects data on people with disabilities in the sub-city, but the prevalence rates seem to indicate that the data collection process and tools are not very effective at identifying all residents with disabilities. There is very limited data available on the homeless population, with no systematic data collection currently taking place.
7.2. Identification of vulnerable groups and initial interview and assessment

Several different actors are in a good position to provide identification of vulnerable groups. However, systematic approaches and tools for needs assessment at the community level are lacking, and training on how to identify vulnerable groups and carry out an initial interview and screening is insufficient. These first screenings have to happen at the community (ketena) level in order to decide whether something is a cause of concern or not, and consequently whether the case needs to be reported to the authorities. There is a need for more training of frontline workers and community volunteers on how to identify and refer vulnerable individuals and households. The UPSNP eligibility criteria and targeting process is not and is not meant to be an effective mechanism for identifying these vulnerable groups. In addition, because of the quota imposed on the UPSNP, the programme does not reach all of its target group. A case management system limited to UPSNP beneficiaries will therefore exclude most of the vulnerable children in need of support.

A number of actors have the ability to identify vulnerable groups, including: community care committees (in particular ketena coordination committees), BoLSA UPSNP Departments, Women's Development Army groups, Health Extension workers, community police, school teachers, woreda officials with responsibilities for specific ketenas, DPOs, NGOs and community members.

The rehabilitation and prevention team in BoLSA is the main actor responsible for identifying vulnerable individuals such as people with disabilities. In some cases, woreda BoLSA offices carry out regular data collection to identify people with disabilities, but, as described above, this is not always the case, and the tools used are not necessarily suitable for identifying all people with disabilities. There is therefore a need to review the processes and mechanisms for collecting data about people with disabilities. In addition, there is a large unmet need for training on disability assessment for everybody involved, including both governmental and non-governmental actors such as Health Extension workers and ketena committee members.

There are currently very limited efforts by the government to identify and screen the needs of homeless people. The main actors currently working on identification of homeless people and referrals to services are Health Extension workers (in Addis Ketema), the police and outreach workers employed by NGOs. On the contrary, the various community committees and associations generally do not work with the homeless population. There is a need to sensitise many of the existing actors on how to work with homeless people, as well as to introduce specialised outreach teams that can identify particularly vulnerable groups, including children, carry out a preliminary screening and refer people to the necessary services.

7.3. Case management

Procedures and tools used for needs assessments should have a comprehensive review in order to strengthen them. Often, tools are not of sufficient quality to be able to effectively assess the needs of vulnerable groups. With the exception of the health sector, there are currently no case management systems, understood as systems with individual or household case plans, monitoring and follow-up.
As described above, the first identification and screening of needs for many services happens by ketena committees, potentially with involvement of representatives from the local disability association. We did not encounter any evidence that ketena committees have been trained on assessing the needs of people with disabilities. Following recommendation from the ketena committees, people are referred to woreda offices, including the BoLSA office, which completes a needs assessment form. BoLSA officials verify that the person is indeed among those most in need of assistance and prepare a letter of support for access to assistive devices from NGOs. However, there are no specific guidelines for assessing the needs of people with disabilities – this is determined simply based on observation. BoLSA social workers do not have the capacity to carry out home visits.

UPSNP teams have started using needs assessment forms. However, these are not adequate for capturing information on people with disabilities or issues such as chronic illness or malnutrition, and UPSNP officers do not have the resources and training to carry out needs assessments.

The Bureau of Education has a robust form for registration of students with disabilities, disaggregated in terms of age, gender, disability type and level/extent, category of education enrolled (primary, secondary, tertiary, extension or vocational), category of study placement and a form for students with disabilities who repeat and/or drop out of classes. Three such forms are in place, focusing respectively on: 1) regular/non-extension students with disabilities; 2) extension/vocational students with disabilities; and 3) students with disabilities repeating and/or dropping out of classes. While this tool is substantially better than others in use, it was not clear whether the people completing these surveys are adequately trained to actually assess these disabilities and their severity.

Health Extension workers keep a file on the approximately 500 households for which they are responsible, including how many are pregnant, how many are breastfeeding, how many children are under 5 years etc. This data is updated on an annual basis. The extension workers will follow up with the households once every 15 days. If there is a critical issue, some extension workers follow up on a daily basis. However, this will depend on the dedication and availability of the Health Extension worker in question. Health Extension workers are in a good position to provide needs assessment of people with disabilities, but they have not been trained on disability assessment and have no guidelines for carrying out such assessments. In addition, there are severe supply side gaps in the services available to which they could potentially refer people with disabilities, even if they have the ability to provide proper needs assessments.

As there is no case management system as such, there are very limited possibilities for woreda offices to provide follow-up. The only government actors that systematically trace the same household over time are the Health Extension workers who are responsible for 500 families, who they visit regularly and follow up on. In addition, NGOs have their own systems of monitoring and following up on the situation of certain groups, such street children, who have been re-united with their families.

The main identification and referral mechanisms, eligibility tests and provision of services for each of the sectors are listed here (see Table 5).
### Table 5: Identification And Referral Mechanisms Per Sector

<table>
<thead>
<tr>
<th>Sector</th>
<th>Identification and referrals</th>
<th>Eligibility test</th>
<th>Provision of services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Education</strong></td>
<td>BoE, with ketena committees, carries out annual house-to-house registration</td>
<td>N/A</td>
<td>Schools, including special needs schools</td>
</tr>
<tr>
<td></td>
<td>Ketena committees refer children to school feeding programmes</td>
<td>BoLSA approves eligibility for school feeding programmes</td>
<td>Schools</td>
</tr>
<tr>
<td></td>
<td>Ketena committees Women’s Development Army groups</td>
<td>Ketena committees Women’s Development Army Groups</td>
<td>BoLSA and BoWCA provide support through NGOs</td>
</tr>
<tr>
<td><strong>Healthcare</strong></td>
<td>House visits by Health Extension workers, referrals to health centres</td>
<td></td>
<td>Woreda health centre (Referral to hospitals)</td>
</tr>
<tr>
<td></td>
<td>Ketena committees refer households to fee waiver programme</td>
<td>BoLSA approves eligibility for health fee waiver programme</td>
<td>Woreda Bureau of Health issues fee waiver ID</td>
</tr>
<tr>
<td><strong>Income support (UPSNP)</strong></td>
<td>Ketena targeting committees carry out household survey</td>
<td>Ketena targeting committees select beneficiaries, with PMT spot checks</td>
<td>Payment service provider Direct Support: BoLSA Public Works: UJCFSA</td>
</tr>
<tr>
<td><strong>Protection</strong></td>
<td>Women’s Development Army groups refer protection cases to BoWCA</td>
<td>BoWCA assesses needs, refers to healthcare and police</td>
<td>Woreda health centre Police</td>
</tr>
<tr>
<td><strong>Shelter &amp; alternative care</strong></td>
<td>Community police or BoWCA refer street children to NGOs NGO outreach workers identify vulnerable children on the streets</td>
<td>Police BoWCA NGOs</td>
<td>NGOs</td>
</tr>
<tr>
<td><strong>Housing</strong></td>
<td>Ketena committees refer households to government housing</td>
<td>Woreda Bureau of Housing compiles list of eligible households</td>
<td>Sub-city Bureau of Housing makes the final selection</td>
</tr>
</tbody>
</table>

While many actors are potentially able to identify and refer vulnerable people to services, they do not necessarily have accurate information about the services available and who is eligible to receive them. As the agency mandated to provide support to low-income households, BoLSA acts as the gatekeeper to services for low-income households. As described above, eligibility is usually determined by Ketena committees, which refer people to BoLSA, which then refers to the relevant bureau or NGO services.
Education: The main referral to education happens through the annual survey carried out by the Bureau of Education in cooperation with Ketena committees. In addition, BoLSA has links directly with schools and can refer children from low-income households to the school feeding programmes once their eligibility has been determined by ketena committees. The support letter for free higher education is also provided by BoLSA. Both BoLSA and BoWCA work with NGOs to provide school uniforms and stationary to school-age children, with identification done by ketena committees or Women's Development Army groups.

Health: Health Extension workers are the main actors referring people to health services at woreda health centres (which will then refer relevant cases onwards to hospitals as needed). However, access to the health fee waiver programme is controlled by BoLSA. Ketena committee leaders provide a letter of support to the woreda BoLSA asserting eligibility for the programme. The woreda BoLSA provides a letter of support to the woreda health office, which issues the ID for access to free health care.

Income support: The UPSNP operates its own targeting process. UPSNP Direct Support teams are also in the process of developing needs assessment mechanisms for UPSNP Direct Support beneficiaries but are not yet providing referral services to other social services.

**BOX 8: EXAMPLE OF LINKING SOCIAL PROTECTION TO SERVICES FOR THE HOMELESS**

One example of a national social protection programme where efforts have been made to adapt to an urban context and link with other services is the Philippines’ Pantawid Pamilya programme. In order to extend coverage to those who were excluded from the mainstream programme, for example because of inability to provide proof of address, a modified programme was piloted, targeting specific groups that were likely to be left out. This included homeless families identified by civil society organisations. These organisations fill out a pre-screening form, which acts as the basis for a case management assessment. Beneficiaries are offered additional services, including housing grants, alternative family homes, cash for work programmes, training, psychological counselling, livelihood assistance and referral services (Gentilini, 2015). The case management process consists of the following steps:

1. Intake or psychosocial assessment
2. Goal setting and treatment planning
3. Implementation/accessing services
4. Progress monitoring and evaluation, and transition, follow-through, or mainstreaming
Protection: BoWCA is the main actor when it comes to child protection and violence against women. They mainly receive referrals from the Women's Development Army, but Health Extension workers also refer cases of violence and sexual abuse to BoWCA.

Shelter and alternative care: Identification happens mainly through NGO outreach workers or police officers, who then refer children on the streets to NGO-run shelters.

Housing: Eligibility for access to government housing is determined by ketena committees, which provide a letter of support to the woreda housing office. The woreda office then compiles a waiting list for the sub-city housing office, which makes the final decision on granting access to government housing.

7.4. Resources

In general, the social service area in Addis Ababa is significantly underfunded and most bureaus working in the social services are not able to fulfil their mandates because of lack of funding. There is a recognition among BoLSA staff that they do not have the resources to fulfil their mandate, including when it comes to providing people with disabilities with rehabilitation services.

In practice there is no support. We are only addressing these issues [rehabilitation] on paper. We do not have any resources to do anything. There is a huge gap between the needs and the services we can provide. The NGOs providing support are very few. (KII21.1)

We found that all departments at woreda and sub-city levels are severely understaffed. Departments commonly have only half of the staff that they should have. The exception is the Bureau of Health, which seems to be better resourced, at least at the sub-city level. The low salaries also mean that there is high staff turnover, which again, according to key informants, leads to a lack of professionalism amongst BoLSA staff, as most people move to better paid positions with other bureaus or NGOs when they have the opportunity (KII19.1; KII21.1).

The UPSNP departments are still relatively new and lack clear job descriptions. UPSNP officials in Addis Ketema complained of not having received training in implementation of the programme, having just been given the programme implementation manual that does not include any guidance or criteria for selection of people with disabilities for UPSNP Direct Support (KII24.5).

There is an insufficient quantity of social workers to carry out outreach work and house visits, which means that they are unable to serve as a bridge between vulnerable households and the authorities. Because of the understaffing of government offices, the social sector relies substantially on volunteer members of community-based organisations and on NGOs. There is a need to ensure much better training of these volunteers for them to carry out their expected roles in terms of identification, screening and referrals. A 2014 assessment of the capacity of the government social workforce by MoLSA recognised the need to expand the workforce at all levels, and a National Joint Plan of Action has been developed to guide this work (UNICEF, 2016).
Woreda offices provide insufficient space and equipment. Sub-city administrations have better conditions, as new large modern office buildings have recently been constructed in all sub-cities. In Arada sub-city, the new building is currently being finalised and the sub-city administration is at the moment still spread across various buildings of poor quality. While the new sub-city office buildings are accessible, with ramps and elevators, none of the woreda office buildings we visited were accessible. There is a lack of equipment, including computers. Most staff use desktop model computers, with no access to laptops, and there are frequent power cuts, which makes desktop computers inconvenient. In woreda offices, many people have to share the same desk, and not all have access to their own work computer (KII24.3).

7.5. Programme coordination

Coordination across sectors

Government administrations in the two sub-cities tend to be more tightly integrated vertically within sectors rather than horizontally across sectors. Heads of bureaus report primarily upwards to their superiors at sub-city and city level, not to woreda or sub-city chief executive officers. For example, even within BoLSA, we found limited coordination at the sub-city level in Arada sub-city between the UPSNP team and the other BoLSA departments including the Social Problem Prevention Department, despite being physically placed just across the corridor from one another (KII19.1). At the woreda level, the different departments seemed better integrated, but even here some UPSNP staff stated that they work quite separately from the other departments as they have their own tasks and standards to follow (KII23.4).

The main coordination mechanisms across sectors for the UPSNP are the BoLSA Management Coordination Committee and the Technical Coordination Committee, which exist at both woreda and sub-city levels. However, in practice, they face challenges in organising meetings. The emphasis on vertical lines of reporting also means that any coordination between sectors needs to be based on formalised agreements between sector bureaus at the city level and even with formalised agreements, it is important to consider whether employees from different sectors have incentives to work together. For example, it is not clear that the health sector has incentives for cooperation with the UPSNP.

Coordination between woreda offices and community structures

BOLSA has close relations with key community structures such as the iddirs, disability associations and older people’s associations. Officially, BoLSA should meet with these organisations monthly, but in practice key informants related that they may meet once every three months, or otherwise ad hoc in connection with the awareness raising and training activities of BoLSA in the communities (KII21.1).
While there is cooperation between some NGOs and woreda offices, cooperation and coordination is not always as close as might be expected. Since monitoring of NGO activities happens at the national level, woreda offices do not necessarily have an overview of the activities of the NGOs working in their area. For example, BoLSA in Woreda 4 of Arada sub-city described how NGOs would contact the office and ask for cooperation when they start implementing activities, but there did not seem to be ongoing coordination. BoLSA did not even have the contact information of local programme managers from some of the main NGOs working in their woreda (KII21.1). On the contrary, the sub-city offices have detailed data on NGOs they work with. Some NGOs work closely with BoLSA and BoWCA to select beneficiaries for their programmes. This is the case for Abebech Gobena in Arada sub-city, which receive referrals from the woreda BoLSA, BoWCA and St. Paul’s Hospital (KII23.5). Children benefitting from the organisation’s sponsorship programme are identified by the Woreda BoWCA office, through Women’s Development Army groups. We found generally good working relations and coordination between community committees and the different woreda bureaus.

Linkages between UPSNP and other services

At the time of the field research, UPSNP woreda officials were waiting to receive training on carrying out needs assessments of Direct Support beneficiaries through family visits, in order to link them to other services (KII23.4). However, there are already some linkages between the UPSNP and other social services:

- BoLSA already provides additional services to UPSNP Direct Support beneficiaries, including school uniforms and educational materials (through NGOs) (KII21.1, Arada Woreda 4 BoLSA; KII24.5, UPSNP Addis Ketema sub-city)

- UPSNP Direct Support beneficiaries are automatically enrolled in the Health Fee Waiver Programme (KII21.1, Arada Woreda 4 BoLSA)

- There are plans to automatically include UPSNP Public Works beneficiaries in the CBHI (KII21.1, Arada Woreda 4 BoLSA).

- There are plans to provide free public transport to UPSNP direct support beneficiaries, using the same ID system that provides free transport to government workers. However, this is pending an agreement with the relevant ministry at the city level (KII21.1, Arada Woreda 4 BoLSA).

In addition, the programme is hoping to create linkages with maternal and child health and nutrition services, including antenatal and postnatal care, and the school feeding programmes. There are currently no formalised processes of referring UPSNP beneficiaries with disabilities to other services, for example to access assistive devices, even though this is the mandate of BoLSA (KII28.3).
In general, we found that BoWCA officials expressed a strong commitment and interest in working more closely together with the UPSNP. This is potentially important for strengthening linkages between the UPSNP and protection services. It will be important for any new community social workers (even if reporting to BoLSA) refer child protection cases to the child protection expert at BoWCA. In relation to protection services, the system primarily needs to strengthen its ability to identify and refer cases, for example by improved training of community volunteers and frontline workers. Community social workers could provide support in this regard and function as local frontline workers for protection. In relation to homeless people in particular, it is important that social workers are able to establish trust with people in order to make them confident enough to report cases of abuse.

Health and nutrition is clearly the mandate of Health Extension workers, however, additional BoLSA community social workers could potentially help identify pregnant and breastfeeding women and infants who may have been missed by the health system, or who may require services beyond the standard package offered by Health Extension workers. They could focus on monitoring access to health by people with disabilities and the homeless, who are particularly vulnerable and more at risk of being missed by Health Extension workers.

In relation to school enrolment and attendance, the Bureau of Education carries out annual household visits to register children who need to be in school. If a social registry would be developed that registers all children, these household visits would no longer be necessary. In addition, the Bureau of Education does not have a presence at ketena level, and social workers can therefore provide valuable support by following up on cases of children who are missing from schools. This would require them to work closely together with schools, with teachers able to raise concerns with social workers to trigger family visits.

7.6. Management Information Systems (MIS) for integrated case management

A critical component that brings the elements of an integrated case management system together is an appropriate Management Information System (MIS). Such systems, in general, underpin effective social protection schemes, ensuring effective delivery of the key operational processes, such as registration, enrolment, payments, and grievances. MIS also play an important role in facilitating and supporting programme monitoring. For the broader operations of the PSNP programme, in both urban and rural areas, the PSNP-specific MIS will incorporate the different key functions: registration and targeting, beneficiary management (updates and exits), complaints and grievances, payments and disbursements, and monitoring and reporting.
The Social Cash Transfer (SCT) MIS however, will be included as a module for case management of Direct Support beneficiaries, such as linkages to social services and tracking compliance with health, child protection and education indicators. SCT MIS offers an example of an automated web-based system that is built to consolidate information across five main processes including: i) household profile capture for the PSNP PDS beneficiaries; (ii) co-responsibility assignment; (iii) managing compliance with co-responsibilities; (iv) case management; and (v) re-certification. The SCT MIS runs off a database platform (SQL Server 2016 relational database) with the web application running backend processes to automatically create forms that would otherwise require days to be completed manually. The system is also designed to allow social workers to put forward queries, access reports and view the overall SCT programme indicators through interactive dashboards at the woreda and the federal level.
The design and implementation of SCT MIS has evolved over time in line with changing programme requirements of the MIS pilot in Oromia, SNNPR and at the federal level in Addis Ababa. In fact, the MIS has been enhanced a number of times based on operational changes to the pilot programme, such as the introduction of a re-certification function and upgrades to the dashboards. At the woreda level, the MIS operates in an offline mode to overcome the challenges of erratic Internet connections, but the data can still be exported to regional and federal levels.

An effective MIS has to be accompanied with two elements: a broader strategy of capacity building within UPSNP staff, and stakeholder coordination. First, the training of MIS officers and social workers that are recruited by the woreda and sub-city level governments should ensure that they are able to sufficiently support and maintain the SCT MIS. Second, the MIS should be hosted by a government data centre so that it is available and accessible by all stakeholders over the Internet to improve coordination of and access to the data collected on beneficiaries.
8. Conclusions and key recommendations

Based on our research and previous evaluations of Cash Plus programmes in Ethiopia and other countries, the concluding remarks relate to four themes: 1) availability and quality of services; 2) targeting of and access to services; 3) appropriateness and relevance of services offered; and, finally, 4) a rights-based approach.

First of all, the availability of quality services requires adequate commitment to investing in the development of further service enhancements and improved infrastructure. While we have identified barriers to accessing services for people with disabilities and homeless people in Addis Ababa, on both the supply and demand side, it is clear that focusing mainly on increasing demands for services is not going to lead to significant results. In some sectors where hardly any services are available, such as rehabilitation and assistive devices, the primary focus needs to be on improving service provision. In other sectors, such as education and health, there may be a need for linking people with services, but at the same time there is a need to maintain a strong focus on improving the quality of the services offered.

Second, targeting existing services of insufficient quality to a select few on the basis of an arbitrary criterion is problematic. As part of the UPSNP for example, the concept of destitution is mainly operationalised as homelessness, despite a categorical reference to ‘beggars’ who are not necessarily homeless. On the other hand, the condition of housing is not a useful indicator in Addis Ababa, where 70-80 per cent of the population live in inadequate housing situations (World Bank, 2015). The Soberland study guidelines interchangeably utilise two very distinct concepts of ‘destitution’ and ‘people with special needs’. Similarly, local CSOs and NGOs that are potential partners in an integrated case management system currently use the term ‘destitution’ for targeting services, but without any precise definition. All of these examples indicate an implementation challenge, whereby sufficient confusion is generated by various stakeholders in the use of a highly subjective and contextual concept.

‘Homeless populations’ as a category of destitution would be cumbersome to identify due to the general lack of data on pavement dwellers that include persons living on the street under plastic sheets or illegally renting kebele homes. In general, the urban destitute are harder to systematically identify and register for services than rural destitute populations, due to issues of ‘visibility’, high mobility, and lack of social cohesion that does not allow for coherent information gathering and monitoring.

Third, interventions need to respond to need in an appropriate way. Previous research shows how interventions to improve nutrition in rural Ethiopia have focused on changing the behaviour of vulnerable people, whereas the real issue was access to essential services such as clean drinking water (Roelen et al., 2017). The support provided should instead be based on the assessed need of vulnerable individuals and households. This means, for example, that interventions to support homeless people in Addis Ababa have to start by improving access to housing and shelter, whose lack is a key cause of all other challenges faced by homeless people.
Finally, the Soberland study (2018) pre-supposes a linear trajectory for the urban destitute with adequate, intensive and sequenced support. Graduation-based exit strategies are inappropriate for high-risk vulnerable populations that need monitoring and support services in the long term to be able to cover basic needs. Graduation benchmarks at best offer short-term objectives or goals, which may not be sustained in the absence of an appropriate social-protection system. It is also contrary to a rights-based approach argued for by the study, wherein access to social security is a human right in recognition of the fact that a person’s life trajectory is not linear, that each and every individual is vulnerable to shocks over their lifetime on the basis of their age, gender, work capacity and disability status. The premise for designing service delivery should be universal entitlement for all, and not time-bound poor relief.

8.1. Improve access to services for people with disabilities

The Ethiopian government should be supported to strengthen efforts to implement the existing legal and policy framework for inclusion of people with disabilities. More research on how to create an enabling environment for disability inclusion in Ethiopia, including an assessment of civil society strengths and weaknesses needs to be conducted. Disability champions within government at all levels, who can push the inclusion agenda within their sectors, need to be identified and empowered. A comprehensive programme of awareness raising and training on disability for all staff and volunteers involved in the delivery of services to people with disabilities needs to be undertaken since there is a low level of awareness of disability among government officials at all levels. Better processes and guidelines for assessing the needs of people with disabilities should be developed – either as a cross-cutting national disability assessment mechanism, or as mechanisms specific to sectors or programmes.

Improve access to the UPSNP for people with disabilities

The main issue with the UPSNP is that quotas restrict access to the programme and exclude most households in need of support. The programme should therefore be expanded. In addition, the programme is currently not disability friendly. The following steps are recommended to make the UPSNP more accessible for people with disabilities.

- Strengthen communication about the UPSNP, including eligibility criteria and rights of beneficiaries – we found several households who were not aware of the programme. Communication activities should take the needs of people with disabilities into account.

- Ensure that the UPSNP is disability friendly:
  - Payments should be accessible for people with disabilities.
  - Households with people with disabilities should receive a higher benefit than others to compensate for the additional cost of disability.
  - The Public Works component, including skills training and livelihoods support should be made accessible for those people with disabilities who are able to work.
The selection into Direct Support and Public Works, respectively, needs to take place based on an assessment of work capacity – not disability – based on comprehensive guidelines, with adequate training of committee members.

People taking care of children with disabilities or adults with severe disabilities without any other adults in the household, should qualify for Direct Support.

Ensure that all homeless people can participate in the UPSNP on an equal basis with the general population, and resolve issues of opening bank accounts for homeless people.

Make sure that Public Works beneficiaries with children can access childcare services.

Establish a permanent grievance redress mechanism and other social accountability mechanisms, as envisioned in the UPSNP citizen engagement component, and ensure that these are accessible for people with disabilities.

**Improve access to income and food security support programmes for people with disabilities**

There are limited services available to ensure income and food security of vulnerable individuals and households in Addis Ababa. The long-term vision should be to establish a more comprehensive social protection system that can ensure income security across the life cycle. In the short term, the following initiatives could be considered in order to improve the existing programmes:

- Expand access to school feeding programmes, ideally by making them universal in all schools.
- Look at options for improving existing income sources of homeless people, for example by supporting waste collection associations, which provide incomes for many homeless people.
- Review and strengthen existing employment and income-generating support programmes implemented by BoLSA, for example by providing credit to individuals rather than groups and strengthening technical advice on entrepreneurship.
- Provide space for vulnerable groups to conduct small businesses and make it legal to carry out petty trading on streets. Generally improving conditions for street vendors is likely to benefit low-income people with disabilities and the homeless in particular.
- Look at options for incentivising and potentially subsidising iddirs to improve their provision of income support to vulnerable households who have not been included in the UPSNP.
- Provide awareness raising for iddir management on the needs of people with disabilities and the homeless.
- Strengthen efforts to support private companies and public employers to provide jobs for people with disabilities.
Improve access to housing for people with disabilities

The main need in Addis Ababa is for better access to low-cost housing. While this objective is difficult to achieve, the existing government housing could be improved and made more accessible for people with disabilities. The process of accessing government housing could also be improved.

- Set aside budgets for improving living conditions in government housing, and for making houses and their surroundings accessible for people with disabilities. A particularly urgent need is to improve access to toilets and to include gender specific facilities and clean water, but also public roads and government buildings, including schools need to be made accessible.
- Work with housing offices to improve feedback regarding access to government housing and transparency in the decision-making process to ensure that the most vulnerable people are provided with access to housing and that people are made aware of the status of their application.

Improve access to education for people with disabilities

While most children are able to access education, there have been limited initiatives to enable children with disabilities to learn.

- Make school buildings accessible – both special needs education schools and mainstream schools.
- Encourage the creation of more special needs schools.
- Train and hire more special needs teachers, and acquire more materials for children with disabilities.
- Improve disability assessment of children needs.

Improve access to healthcare for people with disabilities

While there is access to healthcare in general, medicine is often unavailable or unaffordable, and health centres are inaccessible for people with disabilities. In addition, there are very limited rehabilitation services and assistive devices available for people with disabilities.

- Take measures to improve access to affordable medicine, by ensuring that medicine is available at woreda health centre pharmacies, and/or potentially include subsidies for medicine as part of the Health Fee Waiver Programme.
- Monitor progress on piloting and rolling out health outreach teams, and make sure that people with disabilities and homeless people are able to benefit from the services they provide, and that health professionals in the teams are trained on assessing the needs of people with disabilities, and in establishing positive relations with homeless people.
Conclusions and key recommendations

- Improve accessibility of government healthcare centres for people with disabilities, by installing elevators and improving accessibility of surroundings.
- Look at providing support to cover the cost of transportation to and from health care centres for people with disabilities.
- Address severe supply-side shortages in the case of rehabilitation and assistive devices. In addition, the UPSNP should work with disability experts to strengthen processes of needs assessment to refer people to services.
- Health Extension workers need training in community-based rehabilitation to equip them with the necessary skills for early identification, assessment, referrals and home-based physical rehabilitation of children with disabilities and post-intervention follow-up techniques.

Improve access to protection for people with disabilities

While there are protection procedures in place, they are currently ineffective in identifying and responding to cases. There is a need to work with the relevant government actors and community volunteers to strengthen systems and processes to ensure access to protection services.

- Work with BoWCA and the police to strengthen protection response and referral systems
- Deploy community social workers who can identify and refer protection cases.

8.2. Improve access to services for homeless people

A key issue for homeless people is their lack of permanent residence and the resulting lack of access to identification, which is a barrier to accessing many services.

- Review access to identification for homeless people, with the aim of developing a uniform process of providing an ID card which grants access to the necessary services – either by adjusting requirements for obtaining the national identification card, or by issuing a separate or temporary ID card for people who do not have proof of address.

Improve access to the UPSNP for homeless people

Most homeless people are excluded from the UPSNP as a matter of policy, even though there are no insurmountable practical barriers to their participation. This policy should be changed to allow homeless people to participate in the UPSNP on an equal basis with others. In addition, the destitution component of the UPSNP should focus on providing income support to homeless people who are not able to participate in the regular UPSNP programme, as well as prioritising provision of access to housing or shelter.

- Ensure that all homeless people can participate in the UPSNP on an equal basis with others.
- Resolve issues of opening bank accounts for homeless people.
Utilise the UPSNP destitution component to provide access to housing or shelter, following a Housing First approach.

Improve access to income support for homeless people

Develop a strategy for supporting income-generating activities based on research on the current occupations and income sources of homeless people. This could mean strengthening waste collection associations or providing better conditions for people selling items on the streets. In addition, iddirs generally do not include the homeless, but could potentially play a role in providing support.

- Look at options for improving existing income sources of homeless people, for example by supporting waste collection associations, which provide incomes for many homeless people.
- Make it legal to carry out petty trading on streets. Generally improving conditions for street vendors is likely to benefit the homeless in particular.
- Look at options for incentivising and potentially subsidising iddirs to improve their provision of income support to the homeless.

Improve access to housing for homeless people

Housing is the most pressing need for homeless people, but very limited services are currently available. There is an urgent need to improve access to low-cost housing, and in the short run to expand access to shelters for the homeless, including for women with children.

- Work with housing offices to improve feedback regarding access to government housing and transparency in the decision-making process to ensure that the most vulnerable people are provided with access to housing and that people are made aware of the status of their application.
- Urgently provide support to NGOs to expand access to shelters for homeless people, including facilities specialising in supporting children who are on their own as well as families or single women with children. Shelter facilities for working-age people, including single women with children, should include childcare services and be located centrally to allow income-generating activities.
- Advocate for the sub-city administrations to make land available for homeless people where they can legally establish makeshift shelters.

Improve access to education for homeless people

Homeless children need to be provided with additional support to improve retention in school. This needs to be based on an individual needs assessment and case management that addresses the multiple needs that they and their families are facing.
Improve access to healthcare for homeless people

Many homeless people are not able to access healthcare because they are not enrolled in the Health Fee Waiver Programme. Enrolling them in the programme should therefore be a priority.

- Monitor progress on piloting and rolling out health outreach teams, and make sure that homeless people are able to benefit from the services they provide, and that health professionals in the teams are trained on assessing the needs of people with disabilities, and in establishing positive relations with homeless people.
- Review service provision to homeless people included in the revised Health Extension manual and carry out an analysis of how the UPSNP destitution component can draw on and complement work of Health Extension Workers with homeless people. Any cooperation would require MoUs to be signed between BoLSA and the Bureau of Health at the city level.
- Better prepare Health Extension workers for working with homeless families, potentially by providing additional specialised teams of Health Extension workers, where at least two people travel together to provide services to homeless people.
- Ensure that guidelines for the fee waiver programme specify that homeless people are eligible for the programme, even without a Kebele ID. Ensure that all homeless people are issued UPSNP ID cards, are automatically enrolled in the Health Fee Waiver Programme and are provided with information about their rights under the programme.
- Make sure that all children under five years of age living on the street are included in all vaccination programmes.

Improve access to protection for homeless people

Homeless people are very vulnerable to abuse and violence but are currently not able to access protection services. Protection services should be improved in cooperation with the police and BoWCA. Outreach teams of social workers who are able to establish trusting relationships with homeless people would be able to facilitate better access to protection services.

- Provide training for police to increase their understanding and ability to work with homeless people.
- Strengthen cooperation between police and BoWCA to ensure that the police refer unaccompanied minors to BoWCA.

8.3. Move towards an integrated case management system

Based on our research as well as recommendations from previous evaluations of Cash Plus programmes in Ethiopia and other countries, and the Integrated Nutrition and Social Cash Transfer (IN-SCT) pilot programme in Ethiopia (Roelen et al., 2017), we make the following recommendations to guide efforts to develop an integrated case management system in the two sub-cities.
Recommendation: Establish clear referral mechanisms through city-level MoUs.

First of all, previous evaluations highlight the importance of political commitment and formal agreements as a necessary foundation for operationalising cross-sectoral linkages. Key informants interviewed at sub-city and woreda level also consistently mentioned that they depend on city-level formal agreements of cooperation to establish linkages with other sectors. Protocols that enable relevant sharing of data, while protecting the privacy of vulnerable individuals, thus need to be established.

Awareness and engagement of all stakeholders is imperative for coordination. In Addis Ketema and Arada sub-cities, this requires not only more staff training, but also sector bureaus that are properly resourced to ensure that staff have time to participate in coordination activities. A digital MIS could potentially free up time currently spent on data collection and entry. Other sectors do not necessarily have any incentive to work together with BoLSA. In addition, the current BoLSA coordination mechanisms related to the UPSNP – the technical steering committee and management committee – does not seem to be configured in a way that enables them to function as effective coordination mechanisms.

Recommendation: Focus on enabling better information sharing between professionals within specific geographical areas.

This would ensure incentives for participating and avoiding organisational inertia. Such initial activities to improve coordination can be very specific to professionals within specific geographical areas such as those working with street children or children with disabilities.

Effective case management requires investment in a skilled and qualified cadre of social service workers. At the same time, administrative processes of application and transfer payments can be implemented by administrative staff so that trained social workers can focus on social work, rather than administrative tasks. Currently, there is often too heavy reliance on community volunteers as a cheaper way of filling capacity gaps.

Recommendation: Make it a priority to strengthen the social service workforce.

This should include both hiring additional trained social workers and ensuring that woreda bureaus are able to attract and retain qualified staff for the many vacancies they currently experience. Social workers need to have the capacity to carry out home visits if they are to serve as links between vulnerable individuals and social services. This means that they should be placed at the ketena level. Social workers operating as specialised outreach teams would be particularly relevant for assisting the homeless, including identifying street children, carrying out preliminary screenings and referring them to relevant services. Given the current low capacity of the social service workforce in Ethiopia,
it seems inevitable to continue depending to a large extent on community volunteers to carry out many essential tasks. These volunteers should receive comprehensive training on identification, screening and referral mechanisms, how to work with homeless people and how to carry out disability assessments.

An effective case management system is essential for facilitating access to services. This requires a focal point with clear responsibility and oversight over individual cases with a mandate to ensure support from across sectoral services. An MIS is important for achieving this.

**Recommendation:** Improve coordination of data collection, including harmonisation of tools and joint data collection exercises.

This should include improving data collection processes and tools for collecting data on people with disabilities and homeless people. A case management MIS should be developed, where data can be continuously added in order to make the collected data operational and accessible across sectors. Frontline workers and volunteers should be trained on identification, screening and referral mechanisms, and the procedures and tools used for needs assessments should be reviewed with a view to strengthening them. The case management function itself – i.e. the system for establishing individual or household case files, as well as ensuring follow-up and monitoring – may rest with dedicated social workers hired by BoLSA or be a function of the MIS. It should be noted that many woreda offices currently do not have the necessary access to computers, electricity and Internet connections to be able to make effective use of a digital MIS. To overcome this, options for tablet or smartphone-based systems could be explored.

There are many community-based organisations active in social work in Addis Ababa (see Annex 2 for a list of those active in Arada and Addis Ketema). New interventions should build on these organisations and work to ensure that they operate according to clearly defined roles and responsibilities, including clear referral pathways, and that all staff and volunteers have the necessary knowledge and tools to identify vulnerable individuals and households, carry out preliminary needs assessments and refer to relevant social service workers and/or service providers. Additional social workers at the ketena level would be able to assist with these activities.

**8.4. Strengthen stakeholder coordination**

A well-coordinated case management system and service delivery is the cornerstone necessary to effectively address the needs of homeless populations and of persons with disabilities. Case management is defined as: ‘a collaborative process to identify individuals vulnerable to certain risks, assess their needs and strengths to ensure that their rights are being met, set goals in a participatory manner with the client, provide direct or referral services, follow up, evaluate progress, and terminate the case when the goals have been met’ (OECD, 2015). As discussed earlier, there are number of systems and procedures already in place in Addis Ababa that can be made more effective with improved coordination.
Recommendation: Invest in standardising existing ad-hoc case management systems.

In Addis Ababa, there are already a number of informal and ad hoc systems that are operated by various stakeholders, especially in the lower levels of administration, leading to duplication of identification processes. Effective coordination for referrals to appropriate services that vulnerable individuals and families require is not in place. For example, the Women’s Development Army (WDA) has over 10,000 members in each of the two sub-cities and has the capacity to carry out household visits, thus playing an important role in needs assessment and referral systems. At present, the WDA works closely with Health Extension workers to provide access to healthcare services, and with woreda BoWCA offices to refer women and children affected by violence to protection services. WDA members also issue ID cards, which have in some cases been used as an alternative to the ID cards issued by the UPSNP, if too few UPSNP cards had been sent to a Ketena. Similarly, the community police have local presence and know their communities well. One police officer is responsible for each Ketena. However, they work mainly with NGOs rather than woreda or sub-city departments.

This existing level of informal coordination can be strengthened if clear guidelines are established for community-based organisations to carry out identification and referral procedures for child protection and other services. This includes appointing the WDA to serve as a bridge between ordinary citizens, ketena leaders and the woreda administration, as WDA members are often the first point of contact for many people in need of support (FGD27). Systems can become more formalised with increased contact and communication. Therefore, frequent coordination meetings between active community-based organisations and woreda departments can facilitate communication and speed up referrals. The ‘People’s Wing’ that includes the iddirs, disability associations and older people’s associations reportedly have an active relationship with BoLSA. However, the BoLSA only meets with them once every three months despite the official requirement for monthly meetings. It is especially difficult to meet the People’s Wing as they prefer to meet on weekends.

Moreover, coordination between NGOs and woreda officials must be prioritised and integrated into the case management system. NGO activities are regularly monitored, and individual woreda and sub-city departments regularly forward cases to NGOs, especially of street children and sex workers. This is due to limited internal capacity to offer necessary services. However, this is not standard procedure, and is left to the discretion to the woreda/sub-city department. There are cases of woreda offices, as observed in Addis Ketema, where officials are not aware of the NGOs working in their area.
Recommendation: Invest in grassroots coordination mechanisms.

At present, several different actors provide identification services and conduct needs assessments, but without any training or systematic approaches nor assessment tools. The Ketena Coordination Committees for example, consisting of community leaders, have the mandate to sign letters of support for access to services and therefore play a crucial role for identification and referral to services. The committee however receives no support from the government, and the members are all volunteers, though they can raise funds independently from the community, including from local NGOs, business owners and individual residents. However, Ketena Coordination Committee members said that they are rarely able to raise sufficient funds. Similarly, the activities of the Women’s Development Army are curtailed by the absence of any official support, and therefore lack certainty of funds.

Recommendation: Strengthen horizontal and cross-departmental/sectoral coordination at the sub-city level and the woreda level for UPSNP and other departments.

In contrast to a strong coherent vertical system of intra-departmental coordination from the city to the woreda level, the horizontal coordination system between departments at each tier of governance is especially lacking. The woreda and sub-city heads of bureaus engage primarily with their immediate lines of management, i.e. departmental superiors at sub-city and city level respectively, and not with other woreda or sub-city chief executive officers. There is, for example, very limited coordination between the UPSNP and the Social Problem Prevention Department within the BoLSA at Arada sub-city level (KII19.1). Although there is relatively more interaction between departments at the woreda level, the new UPSNP staff are not fully integrated into cross-departmental activities as they have specific standard operating procedures to follow (KII23.4). Given the pressure to adhere to the vertical lines of management, cross-departmental/sectoral coordination must be formalised through MoUs between departments with the same bureaus, and sectors at the city level (KII19.1). According to key informants, it is challenging to create linkages with other sectors without having MoUs signed at the city level. Moreover, coordination within the UPSNP is yet to be institutionalised both at the woreda and sub-city levels. The sub-city Management Coordination Committee (MCC) and the Technical Coordination Committee (TCC), struggle to hold coordination meetings amongst their members that cut across departments and sectors.

Such cross-departmental coordination efforts are in their infancy and require particular attention. Incentives for promoting inter-departmental/sectoral coordination should be considered. A silver lining is an explicit commitment and interest expressed by BoWCA officials to work closely together with the UPSNP. This is a critical relationship to prioritise, to strengthen linkages between the UPSNP and existing child protection mechanisms.
8.5. Suggestions for further research

More in-depth sector-specific research is needed to provide a more detailed analysis of barriers to specific services for people with disabilities and homeless people (see Annex 3 for a table of barriers and recommendations). More specifically, in-depth research and comprehensive analysis should be undertaken on the following:

- **Procedures and tools currently being used for needs assessments**: This should inform a plan for improving such assessments. The procedures and tools used by both NGOs and government offices should be included.

- **Mental illness**: Interviews with people with mental illness or service providers working with people with mental illness. This is also a gap in the existing literature. There is therefore a need for more research on mental illness in Addis Ababa, including services available for people with mental illnesses and the connection between homelessness and mental illness.

- **Capacity of disabled people’s organisations at local, national, regional and levels**: This can provide a basis for future support to these organisations.

- **Gaps in the data available on disability at sub-city and woreda level**: The quality of the tools and processes that are used to collect this data should also be considered. Only a preliminary assessment of the data is included here.

- **Data collection methods for the homeless population**: In order to effectively gather information and data on the homeless population in Addis Ababa, methods need to be further developed.


References


Situation and access to services of people with disabilities and homeless people in two sub-cities of Addis Ababa

References


References


United Nations Children’s Fund. (2016). Linking safety net clients to basic social services - Focusing on access to basic health services.


Annex 1: Qualitative research tools and interviews

Overview of research tools

Four different research tools were used for data collection: key informant interviews (KII), focus group discussions (FGD), semi-structured interviews (SSI) with people with disabilities or caregivers and semi-structured interviews with homeless people.

Table 6: Research Tools: Locations and Participants

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<thead>
<tr>
<th>Tools</th>
<th>City level</th>
<th>Arada</th>
<th>Addis Ketema</th>
<th>All</th>
<th>Tools</th>
<th>Participants</th>
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<tr>
<td>SSIs (homeless people)</td>
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<tr>
<td>SSIs (people with disabilities)</td>
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Note: M = Male; F = Female; All = Both female and male

Focus group discussions (FGDs)

Focus group discussions (FGDs) were facilitated by two national researchers working together. FGDs were used to collect data from community-based organisations such as Women’s Development Army, Ketena committees, DPOs and iddirs, as well as health extension workers. A total of six focus group discussions were carried out in Arada and 9 in Addis Ketema, for a total of 15 discussions with 83 participants.

Table 7: Focus Group Discussions: Locations and Participants

<table>
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<th>Location</th>
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Table 8: Focus Group Discussion Reference Numbers, Dates, Participating Organisations and Locations

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Key informant interviews (KII)

A comprehensive key informant interview tool, covering all the various sectors were used to guide key informant interviews. The three international researchers carried out only key informant interviews, and most key informant interviews were carried out by the international researchers accompanied by an interpreter, although some KIIIs were done by national researchers in order to complete the necessary number of interviews within the time available. The choice for international researchers to focus on key informant interviews were made based on an expectation that the presence of foreigners during interviews with households would significantly affect the answers of participants and not create a constructive interview situation. The key informant tool included three parts: Perceptions of the needs of vulnerable groups and access to services; readiness for case management; and document review. A total of 54 key informant interviews were carried out with officials from city, sub-city and woreda administrations, representatives of NGOs and DPOs, frontline workers (community police officers and Health Extension workers and community leaders).
Annexes
Annex 1. Qualitative research tools and interviews

Table 9: Key Information Interviews: Participants and Locations

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Individual interviews

Semi-structured interviews with people with disabilities and caregivers

Semi-structured interviews were carried out based on a comprehensive tool covering all the relevant sectors for the needs assessment. Topics included: background information about household members; overview of most important needs; caregiving and employment; income and expenses; food security; housing situation and physical environment; social dynamics and access to informal safety nets; access to basic and disability specific services; hopes and aspirations. The interviews also included a ranking exercise, ranking accessibility of various services. In addition, researchers observed the living conditions of the participants.

Semi-structured interviews with homeless people

Semi-structured interviews were carried out based on a comprehensive tool covering all the relevant sectors for the needs assessment. Topics included: background information about household members; overview of most important needs; income, expenses and employment; food security; housing situation and physical environment; social dynamics and access to informal safety nets; access to basic services; hopes and aspirations. The interviews also included a ranking exercise, ranking accessibility of various services. In addition, researchers observed the living conditions of the participants.

A total of 43 semi-structured interviews were carried out with the primary target groups. These included 25 interviews in Arada sub-city and 18 in Addis Ketema, and 18 interviews with people with disabilities or caregivers of children with disabilities and 25 interviews with people living on the streets.

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## Annexes

### Annex 1. Qualitative research tools and interviews

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<td>27</td>
<td>Homeless</td>
<td>Addis Ketema</td>
<td>4</td>
</tr>
<tr>
<td>SSI27.5</td>
<td>27</td>
<td>Homeless</td>
<td>Addis Ketema</td>
<td>4</td>
</tr>
<tr>
<td>SSI27.6</td>
<td>27</td>
<td>Homeless</td>
<td>Addis Ketema</td>
<td>4</td>
</tr>
<tr>
<td>SSI27.7</td>
<td>27</td>
<td>Homeless</td>
<td>Addis Ketema</td>
<td>4</td>
</tr>
<tr>
<td>SSI28.1</td>
<td>28</td>
<td>Disability</td>
<td>Addis Ketema</td>
<td>4</td>
</tr>
<tr>
<td>SSI28.2</td>
<td>28</td>
<td>Homeless</td>
<td>Addis Ketema</td>
<td>8</td>
</tr>
<tr>
<td>SSI28.3</td>
<td>28</td>
<td>Homeless</td>
<td>Addis Ketema</td>
<td>4</td>
</tr>
<tr>
<td>SSI28.4</td>
<td>28</td>
<td>Disability</td>
<td>Addis Ketema</td>
<td>8</td>
</tr>
<tr>
<td>SSI30.1</td>
<td>30</td>
<td>Disability</td>
<td>Addis Ketema</td>
<td>8</td>
</tr>
<tr>
<td>SSI30.2</td>
<td>30</td>
<td>Disability</td>
<td>Addis Ketema</td>
<td>8</td>
</tr>
<tr>
<td>SSI30.3</td>
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<td>SSI30.6</td>
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</tr>
<tr>
<td>SSI30.7</td>
<td>30</td>
<td>Homeless</td>
<td>Addis Ketema</td>
<td>8</td>
</tr>
</tbody>
</table>
## Annex 2: Mapping of services in Arada and Addis Ketema sub-cities

<table>
<thead>
<tr>
<th>Sector</th>
<th>Government</th>
<th>NGO/private</th>
<th>Community based</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income support and credit</td>
<td>Addis Micro-finance savings cooperative</td>
<td>Abebech Gobena supports women’s village savings and loans</td>
<td>Iddirs sometimes provide a small amount to people with nobody to support them.</td>
</tr>
<tr>
<td></td>
<td>Some hotels in Addis Ketema provide cash or in-kind support for orphans through BoWCA and BoLSA</td>
<td>Some hotels in Addis Ketema provide cash or in-kind support for orphans through BoWCA and BoLSA</td>
<td>Iddirs exist for the blind and members of the iddir provide small loans.</td>
</tr>
</tbody>
</table>

### Education and skills training

<table>
<thead>
<tr>
<th>Arada</th>
<th>Addis Ketema</th>
<th>Addis Ketema, 1 Special Needs School</th>
</tr>
</thead>
<tbody>
<tr>
<td>One inclusive education school for both disabled and non-disabled students, both primary and secondary.</td>
<td>One inclusive education school (for both disabled and non-disabled students, both primary and secondary).</td>
<td></td>
</tr>
<tr>
<td>The school feeding programme (Ye Ebat Weg) of Zenashe Tarekegn, the former First Lady.</td>
<td>The school feeding programme (Ye Ebat Weg) of Zenashe Tarekegn, the former First Lady.</td>
<td></td>
</tr>
<tr>
<td>Vocational training: 10+3 (but not market relevant)</td>
<td>Vocational training: 10+3 (but not market relevant)</td>
<td></td>
</tr>
<tr>
<td>Siddharta – provides uniforms, stationary materials, and educational support.</td>
<td>Siddharta – provides uniforms, stationary materials, and educational support.</td>
<td></td>
</tr>
<tr>
<td>Forum on Sustainable Child Empowerment (formerly Forum on Street Children) – provides training for street children</td>
<td>Forum on Sustainable Child Empowerment (formerly Forum on Street Children) – provides training for street children</td>
<td></td>
</tr>
<tr>
<td>El Shaddai provides an employment programme</td>
<td>El Shaddai provides an employment programme</td>
<td></td>
</tr>
<tr>
<td>FTP – provides training for street children</td>
<td>FTP – provides training for street children</td>
<td></td>
</tr>
<tr>
<td>German pilot project is providing bread and milk to primary schools in Arada 6</td>
<td>German pilot project is providing bread and milk to primary schools in Arada 6</td>
<td></td>
</tr>
<tr>
<td>Future Hope Integrated Development provides uniforms, stationary materials, and educational support.</td>
<td>Future Hope Integrated Development provides uniforms, stationary materials, and educational support.</td>
<td></td>
</tr>
<tr>
<td>Islamic Relief</td>
<td>Islamic Relief</td>
<td></td>
</tr>
<tr>
<td>The Organisation for Child Development and Transformation provides school materials</td>
<td>The Organisation for Child Development and Transformation provides school materials</td>
<td></td>
</tr>
<tr>
<td>The Organization for Prevention, Rehabilitation and Integration of Female Street Children (OPRIFS) supports around 600 school children to stay in school by providing them stationary materials.</td>
<td>The Organization for Prevention, Rehabilitation and Integration of Female Street Children (OPRIFS) supports around 600 school children to stay in school by providing them stationary materials.</td>
<td></td>
</tr>
<tr>
<td>Sector</td>
<td>Government</td>
<td>NGO/private</td>
</tr>
<tr>
<td>--------</td>
<td>------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Healthcare</td>
<td>Woreda Health Centres (primary healthcare, maternal care, prenatal and postnatal care, minor surgery, emergency, ARVs) Hospitals (under city administration) Health extension workers (HEW) Vaccination campaigns (through HEW, Health Centres, schools) Outreach teams (currently piloting) Community-based health insurance (currently being gradually rolled out in Addis Ababa) Health Fee Waiver programme Emmanuel Mental Hospital Screenings in schools</td>
<td>Mother Teresa Marie Stopes Wegen Aden used to provide services for HIV/AIDS patients Abebech Gobena operates health care centres for low-income women and children and has a re-imbursement scheme for healthcare expenses Macedonia clinic serves 4,000 people, including 450 with mental illness</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>Some physiotherapy at hospitals</td>
<td></td>
</tr>
<tr>
<td>Assistive devices</td>
<td>Prosthetic Orthosis Centre (not affordable however)</td>
<td>Help For Persons with Disabilities (HPDO) provides assistive devices Cheshire Services Ethiopia</td>
</tr>
<tr>
<td>Protection</td>
<td>Woreda Bureau of Women’s and Children’s Affairs Community police City and Federal Police</td>
<td>FSCE contacts community police to report protection issues</td>
</tr>
</tbody>
</table>
### Annex 2: Mapping of services in Arada and Addis Ketema sub-cities

<table>
<thead>
<tr>
<th>Sector</th>
<th>Government</th>
<th>NGO/private</th>
<th>Community based</th>
</tr>
</thead>
</table>
| **Shelter and alternative care** | Kolfe Boys’ Home  
Kechene Girls’ Home  
Ledata Youth Home  
(none of these are based in the two sub-cities, but children and youth are referred to these institutions across Addis Ababa) | Mission for Community Development Programme (MCDP) – temporary shelter for homeless, focusing on returnees from the Middle East  
FSCE – 40 beds in Addis Ketema for street children  
Sacro – 120 beds, mainly for women with children, in Addis Ketema  
Macedonians – over 1000 beds  
Retrack – 30 beds in Addis Ketema (two other shelters in other areas of Addis Ababa)  
Organisation for Prevention, Rehabilitation and Integration of Female Street Children – shelters in Addis and Bahir Dar (also currently focusing on returnees from Saudi)  
Macedonia provide shelter for 1,700 people  
El Shaddai (outside Addis) | Private landlords rent out slum housing on a nightly basis |
| **Food and nutrition**         | Government discount shops provide access to subsidised basic food stuff  
School feeding programmes provide breakfast and lunch for children from low-income households | Abebech Gobena operates a feeding programme for pregnant and lactating women and infants below 3 years at risk of malnutrition  
Mother Teresa – cooked food distribution  
Hotels and restaurants provide left-over food to the homeless | Iddir Councils distribute teff and oil  
Community food distribution during holidays |
| **Street children**            | Technical Working Group on Street Children  
Organisation for Prevention, Rehabilitation and Integration of Female Street Children | | CCCs work with community police to re-connect street children with their families |
## Annex 3: Barriers to services and recommendations: An Overview

### Cross-sector barriers and recommendations

<table>
<thead>
<tr>
<th>Barriers for people with disabilities</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>No centrally placed government agency with responsibility for mainstreaming inclusion of people with disabilities across sectors</td>
<td>Advocate for the establishment of an empowered, centrally placed, actor with a strong mandate to mainstream inclusion of people with disabilities across sectors.</td>
</tr>
<tr>
<td>Lack of awareness of disability issues among government officials</td>
<td>Establish and train disability focal points within each sector agency at city, sub-city and woreda level.</td>
</tr>
<tr>
<td>Lack of awareness of disability issues among all stakeholders</td>
<td>Provide comprehensive training on disability for all relevant stakeholders. Start a process of developing disability assessment processes and guidelines.</td>
</tr>
<tr>
<td>Lack of Kebele ID</td>
<td>Review access to identification for homeless people, with the aim of developing a uniform process of providing an ID card which grants access to the necessary services – either by adjusting requirements for obtaining the national identification card, or by issuing a separate or temporary ID card for people who do not have proof of address.</td>
</tr>
</tbody>
</table>

### Barriers to income, employment and food security sector access and recommendations

<table>
<thead>
<tr>
<th>Barriers for people with disabilities</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prejudice that people with disabilities cannot work</td>
<td>Provide intensive awareness raising activities for government officials, community volunteers and employers.</td>
</tr>
<tr>
<td>Lack of accessibility of buildings and general environment</td>
<td>Strengthen enforcement of legislation on accessibility.</td>
</tr>
<tr>
<td>Low levels of education</td>
<td>See below.</td>
</tr>
<tr>
<td>Lack of day care services</td>
<td>Improve access to daycare services, including childcare, care facilities within special needs schools and day care for adults with severe disability.</td>
</tr>
<tr>
<td>Lack of access to capital for small or micro businesses</td>
<td>Improve access to start-up grants and microfinance.</td>
</tr>
<tr>
<td>Lack of access to market stalls</td>
<td>Improve access to small stalls or sheds and legal access to sell items on the streets for people with disabilities.</td>
</tr>
</tbody>
</table>

### Barriers for homeless people

<table>
<thead>
<tr>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited capacity and inclusion of DPOs</td>
</tr>
<tr>
<td>Barriers for homeless people</td>
</tr>
<tr>
<td>Discrimination and stigma</td>
</tr>
<tr>
<td>Lack of Kebele ID</td>
</tr>
</tbody>
</table>
### Lack of guarantors
Work with employers to improve access to employment for homeless people and with communities to counter social exclusion. Explore options for strengthening work through waste collectors associations.

### Lack of secure housing
See Housing

### Low levels of education
See Education

### Inability to afford nutritious food for children
Expand access to school feeding programmes, ideally making them universal, or as a first step ensure that homeless children are prioritised for participation.

### Barriers to access housing and recommendations

<table>
<thead>
<tr>
<th>Barriers for people with disabilities</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>No access to proper sanitation</td>
<td>Improve sanitation in government housing</td>
</tr>
<tr>
<td>Inaccessible housing and general environment</td>
<td>Set aside budgets for improving living conditions in government housing and for making houses and surroundings accessible for people with disabilities. A particularly urgent need is to improve access to toilets, but public roads and government buildings, including schools need to be made accessible as well.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Barriers for homeless people</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insufficient supply of shelter facilities</td>
<td>Urgently provide support to NGOs to expand access to shelters for homeless people, including facilities specialising in supporting children who are on their own as well as families/single women with children. Shelter facilities for working-age people, including single women with children, should include child-care services and be located centrally to allow income generating activities</td>
</tr>
<tr>
<td>Insufficient supply of adequate and affordable housing</td>
<td>Make sure homeless people are prioritised for access to government housing. Work with housing offices to improve feedback regarding access to government housing and transparency in the decision making process.</td>
</tr>
</tbody>
</table>

### Barriers to access social protection (UPSNP) and recommendations

<table>
<thead>
<tr>
<th>Barriers for people with disabilities</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of appropriate communication</td>
<td>Strengthen communication about the programme, ensuring communication is appropriate for reaching people with disabilities.</td>
</tr>
<tr>
<td>Inability to travel to bank branches</td>
<td>Ensure that bank officials travel to the homes of beneficiaries to facilitate opening of bank accounts, and that beneficiaries are able to nominate proxies to collect payments.</td>
</tr>
<tr>
<td>No additional payment to compensate for the cost of disability</td>
<td>Introduce a higher benefit level for people with disabilities</td>
</tr>
<tr>
<td>No established disability assessment mechanism</td>
<td>Develop comprehensive guidelines on how to carry out assessment of work capacity, which should guide the selection into the Direct Support and Public Works components of UPSNP respectively. Provide training on how to carry out the assessment for targeting committee members.</td>
</tr>
<tr>
<td>Limited number of beneficiaries admitted into the programme, based on quotas</td>
<td>Expand coverage of the programme to include more people in each woreda.</td>
</tr>
</tbody>
</table>
### Barriers to services and recommendations: An Overview

<table>
<thead>
<tr>
<th>People facing heavy care burdens are not consistently considered eligible for UPSNP direct support</th>
<th>Ensure that people with heavy care burdens are considered eligible for UPSNP direct support.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barriers for homeless people</td>
<td>Recommendations</td>
</tr>
<tr>
<td>Exclusion from the UPSNP public works and direct support programmes as a matter of policy</td>
<td>Ensure that homeless people can participate in the Public Works and Direct Support programmes on an equal basis with others. In most cases, homeless people should be eligible for Direct Support because of their lack of secure housing.</td>
</tr>
<tr>
<td>Inability to leave their children as a result of lack of secure housing</td>
<td>Ensure that all Public Works participants have access to childcare.</td>
</tr>
<tr>
<td>Inability to open bank accounts because of lack of Kebele ID</td>
<td>Work with banks to ensure that homeless people are able to open bank accounts using the UPSNP ID, or facilitate the issuing of Kebele IDs to homeless people.</td>
</tr>
</tbody>
</table>

### Barriers to access education and recommendations

<table>
<thead>
<tr>
<th>Barriers for people with disabilities</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insufficient special needs teachers and teaching materials in mainstream schools</td>
<td>Strengthen training of teachers in the needs of children with disabilities and make more materials available.</td>
</tr>
<tr>
<td>Insufficient number of special needs schools</td>
<td>Increase the number of special needs schools.</td>
</tr>
<tr>
<td>Lack of accessibility of school buildings</td>
<td>Ensure that all school buildings are accessible.</td>
</tr>
<tr>
<td>Barriers for homeless people</td>
<td>Recommendations</td>
</tr>
<tr>
<td>Lack of space for homeless children to study</td>
<td>Improve access to shelters and homes. Improve access to space for studying and mentoring of homeless children at schools.</td>
</tr>
<tr>
<td>Multiple challenges related to homelessness</td>
<td>Provide support to improve retention of homeless children in school, based on individual assessment of needs.</td>
</tr>
</tbody>
</table>

### Barriers to healthcare access and recommendations

<table>
<thead>
<tr>
<th>Barriers for people with disabilities</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>High cost of medicine</td>
<td>Ensure that medicine is available at woreda health centre pharmacies, and/or potentially include subsidies for medicine as part of the health fee waiver programme.</td>
</tr>
<tr>
<td>No access to rehabilitation and assistive devices</td>
<td>Strengthen supply of rehabilitation services at health centres and production of and access to assistive devices.</td>
</tr>
<tr>
<td>Difficulties traveling to health centres and limited accessibility of health centres.</td>
<td>Monitor progress on piloting and rolling out health outreach teams, and make sure that people with disabilities are able to benefit from these services, and that health professionals in the teams are trained on assessing the needs of people with disabilities. Improve accessibility of government healthcare centres for people with disabilities, by installing elevators and improving accessibility of surroundings. Look at providing support to cover the cost of transportation to and from health care centres for people with disabilities.</td>
</tr>
</tbody>
</table>

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**Situation and access to services of people with disabilities and homeless people in two sub-cities of Addis Ababa**
<table>
<thead>
<tr>
<th>Barriers for homeless people</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited awareness of disability among Health Extension workers</td>
<td>Provide Health Extension workers with training on community-based rehabilitation to equip them with the necessary skills of early identification, assessment, referrals, home-based physical rehabilitations of children with disabilities and post-intervention follow-up.</td>
</tr>
<tr>
<td>Exclusion from the health fee waiver programme, due to lack of information and lack of Kebele ID</td>
<td>Ensure that guidelines for the fee waiver programme specify that homeless people are eligible for the programme even without a Kebele ID. Ensure that all homeless people are issued with UPSNP ID cards, are automatically enrolled in the health fee waiver programme and provided with information about their rights under the fee waiver programme.</td>
</tr>
<tr>
<td>High cost of medicine</td>
<td>Ensure that medicine is available at woreda health centre pharmacies, and/or potentially include subsidies for medicine as part of the health fee waiver programme.</td>
</tr>
<tr>
<td>Limited knowledge about healthcare services available and hesitancy to seek healthcare</td>
<td>Review provisions for access to service for homeless people in the revised health extension manual, and carry out an analysis of how the UPSNP destitution component can draw on and complement work of Health Extension workers with homeless people. Any cooperation would require MoUs to be signed between BoLSA and BoH at the city level. Prepare Health Extension workers better for working with homeless families – possibly by providing additional special teams of Health Extension workers, where at least two travel together to provide services to homeless people.</td>
</tr>
<tr>
<td>Risk of exclusion from health programmes such as vaccinations</td>
<td>Make sure that all children under age five living on the street are included in all vaccination programmes.</td>
</tr>
</tbody>
</table>

### Barriers to access protection and recommendations

<table>
<thead>
<tr>
<th>Barriers for people with disabilities</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited awareness of the risks of abuse faced by people with disabilities. Tendency by families to hide cases of abuse</td>
<td>Increase awareness about the risks of abuse that people with disabilities face, and the importance of families reporting cases of abuse.</td>
</tr>
<tr>
<td>Lack of access to protection services</td>
<td>Ensure that all stakeholders are aware of when and how to report cases, and that there are clear referral pathways. Work with BoWCA and police to strengthen protection response and referral systems.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Barriers for homeless people</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antagonistic relationship between homeless people and police officers</td>
<td>Provide training for police to increase their understanding and ability to work with homeless people.</td>
</tr>
<tr>
<td>Limited cooperation between BoWCA and police</td>
<td>Strengthen cooperation between police and BoWCA to ensure that the police refer unaccompanied minors to BoWCA.</td>
</tr>
<tr>
<td>Lack of resources to build trustful relations between homeless people and the authorities</td>
<td>Deploy community social workers who can identify and refer protection cases and establish trust with homeless people.</td>
</tr>
</tbody>
</table>