# Child Poverty and Access to Basic Services Qualitative Research Brief: Amhara Region

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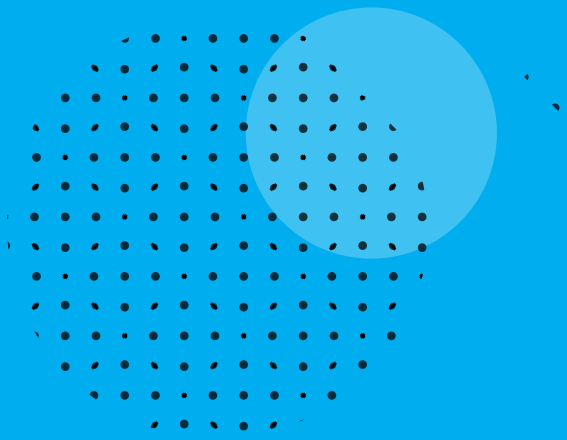

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## Introduction

Ethiopia's economic growth over the last decade has been remarkable: 9.8 percent yearly between 2008/09 and 2018/19[i]. However, these gains have yet to translate into considerable improvements in wellbeing, especially among children. According to the latest analysis for the report "Faces of poverty: Studying the overlap between monetary and multidimensional child poverty in Ethiopia" (2020), 28 percent of children under 18 are both monetarily poor and multidimensionally deprived . In other words, more than 11 million children in Ethiopia live in households that lack the minimum financial resources necessary for survival. They are also simultaneously deprived of fulfillment of three or more basic needs or rights, like access to adequate nutrition, education, healthcare services, water, sanitation, housing and protection. Nearly nine in ten children, or 36.5 million, are multidimensionally poor, and nearly one in three, or 12 million, are monetarily poor (UNICEF Ethiopia & CSA, 2020, pp. vii-viii). The effect of economic growth on reducing inequality has been equally meager. While more than one in three children in Amhara and Afar experience monetary and multidimensional poverty at the same time, in Addis Ababa and Harari this is the case for one in ten children (UNICEF Ethiopia & CSA, 2020, pp. vii-viii).

One positive development in enhancing children's wellbeing in recent years has been the government's approval of the Sustainable Development Agenda and its goals (SDGs), and their integration into the second Growth and Transformation Plan (GTP-II[vi]. Different child rights – and respective SDGs – are mainstreamed in the sectors of health and education, and the wellbeing of children, youth and women is considered a cross-cutting issue. There have also been numerous efforts to gain a comprehensive understanding of child wellbeing and inform related policies and strategies. The results of the multidimensional child poverty report in 2019[v] were followed by a study of the relationship between women's empowerment and child wellbeing[vi] , children's perceptions of urban child poverty [vii], while the latest poverty research investigates the relationship between monetary and multidimensional child poverty (UNICEF Ethiopia & CSA, 2020). The latter also examined the relationship between deprivation and monetary poverty and other factors and served as a basis for research in this brief.

The 2020 UNICEF Ethiopia & CSA report found that children living in monetarily poor households are more likely to be multidimensionally poor and deprived of health, nutrition, and education. The study also finds that proxies of financial wellbeing, such as income sources of the household, employment status of household members, and households' economic activity, are associated with multidimensional poverty and deprivation. Among children's characteristics, the report finds that girls are more likely to be deprived of education, protection, and to be multidimensionally poor compared to boys, and that children with disabilities are significantly more likely to be deprived of education and multidimensionally poor compared to their peers. The lack of access and availability of public services and

public infrastructure are also associated with poverty and deprivation. Children living in communities too far from primary schools, health facilities, tarmac roads, and public transportation are more likely to be multidimensionally poor and to be deprived of health and education.

Gaining an in-depth understanding of issues with basic service accessibility and availability was therefore an imperative component of the research exercise. The topic became increasingly important[viii] with the outbreak of the coronavirus pandemic, which resulted in major disruptions in basic service delivery and markets and had multiple (potential) effects on children's wellbeing.

This research brief presents a summary of findings from quantitative data analysis from the report "Faces of poverty: Studying the overlap between monetary and multidimensional child poverty in Ethiopia" (2020) and qualitative research findings from Key Informant Interviews (KIIs) with service providers in the sectors of health, nutrition, education, WASH, and child protection in the Amhara region.

# Methodology

The qualitative research was carried out in two woredas in Amhara Region, Enebse Sarmidir and Libo Kemkem, and two woredas in Somali Region, Kebri Beyah and Shinile. The selection of the regions followed a two-step procedure using results from the quantitative research analysis of the UNICEF Ethiopia and CSA (2020) report: Step 1: Ranking of regions in descending order using the multidimensional poverty rate, and Step 2: Ranking of regions in descending order using deprivation incidence across wellbeing dimensions used in the analysis (see Annex I). Regions ranking as most deprived and multidimensionally poorest were selected for further qualitative research. The selection of woredas attempted to ensure representation of several characteristics of the regions, including i) urban-rural areas, ii) central/dense rural areas and remote/hard-to-reach areas, iii) pastoralist communities, and iv) geographical characteristics (arid, semi-arid, mountainous, planes) (see Annex II).

This component of the study attempted to answer the following research questions:

1. What factors are associated with deprivation of basic services like healthcare, education, nutrition, protection and WASH?

2. To what extent is deprivation of basic services related to bottlenecks in service provision?

[1] UNICEF Ethiopia & CSA, (2020), Faces of poverty: studying the overlap between monetary and multidimensional poverty

The qualitative research consisted of KIIs with service providers in the sectors of health, nutrition, education, WASH, and child protection. Key informants included respondents from different levels of service provision, including woreda offices for health, education, water and electricity; primary and secondary school head teachers/principals and teachers; health centre medical staff and managers; and social workers/Community service workers/Community care coalition officers (see Annex II for a list of respondents by type) (see Annex III).

Due to the coronavirus outbreak, lockdown measures instated in Ethiopia and precautionary measures against the spread of COVID-19, the interviews were administered via mobile phones. Considering limited mobile phone ownership and access to electricity in Amhara and especially Somali Region, caregivers and children could not be covered by this research. A final criterion for selection of the two regions was feasibility and accessibility for carrying out fieldwork.

Although the conditions of research have changed due to the outbreak of the COVID-19 pandemic, limiting the data collection to remote mobile phone interviews, the selection of these two regions reflects the underlying conditions during the early stages of research design.

## Ethical considerations

The implementation of this research was facilitated by the Amhara Regional Office of UNICEF Ethiopia and approved by the respective Woreda Offices. The training of interviewees included sessions on ethical data collection and informed consent. The introduction module of the interviews included the following ethical considerations: a) Scope, objectives, and topics of the study; b) Confidentiality of information; c) Voluntary participation; d) Communication that the interview is being recorded; and e) The right to speak off the record about certain issues or topics.

# Health

The 2020 UNICEF Ethiopia and CSA report on multidimensional and monetary child poverty in Ethiopia shows that Amhara Region has the third-highest incidence of deprivation on the health dimension among children under five years, representing 76 per cent of children whose mothers did not receive skilled birth attendance.

## Common illnesses and risk factors

Interview respondents in the Enebse Sarmidir and Libo Kemkem woredas reported that the most common risk factors to health are climate-related factors (such as drought), poverty, poor access to clean drinking water and adequate sanitation facilities, and poor hygiene practices. These issues were most concentrated in lowland areas and were associated with higher risks of food insecurity and malnutrition, as well as chronically poor health and illness. Living in rural and lowland areas, in addition to climate-related factors, food insecurity and poor WASH conditions, was reported to be associated with higher risks of illness including diarrhoea (especially among young children), malaria, scabies, anaemia among pregnant women and upper respiratory tract infections among adolescents and adults. Poor coverage of clean drinking water and no

improved toilet facilities in lowland and rural areas were repeatedly cited as a risk factor to child and adult health. Key informants in both selected woredas singled out children aged under five years as being particularly prone to health risks.

## Healthcare system overview

In Enebse Sarmidir woreda, three layers of health facilities (one primary hospital, 8 health centers and 37 health posts) serve a population of around 170,308 inhabitants. However, the distribution of health posts across health centers is not uniform, and most health centers were stated to have a catchment below the national standard. All kebeles have a health post, with a minimum of two Health Extension Workers (HEWs). The medical staff at the primary hospital consists of 15 General Practitioners (GP), 4 health officers, 12 pharmacists, 14 laboratory technicians, 12 midwives, 16 nurses and 35 other medical staff. At the 8 health centers, there are 19 health officers, 49 nurses, 29 midwives, 24 pharmacists, and 11 laboratory technicians. The 37 health posts are staffed with 88 HEWs. Staffing at health posts depends on the catchment population of the kebele; two HEWs are assigned per kebele with an average population of 5,000 inhabitants, with one additional HEW assigned if the population is above this average. At the community level, below the health posts, the HEWs organize groups of women that assist in outreach activities. Private clinics and pharmacies regulated by the Woreda Health Office also serve the woreda population.

In Libo Kemkem woreda, one primary hospital, 9 health centers and 42 health posts serve a population of over 270,000 inhabitants. The total woreda medical staff includes 3 specialists, 14 GPs, 6 health officers, 139 nurses, 42 midwives, and 34 pharmacists. The health coverage for the woreda is 82 percent, and the catchment population for the HEWs is the population of one kebele; two HEWs are assigned per kebele with an average population of 5,000 inhabitants, with one additional HEW assigned if the population is above this average. At the community level, below the health posts, the HEWs organize groups of women that assist in outreach activities.

## Healthcare services

Health centers commonly provide **general primary health services,** including service for outpatient and in-patient care, reproductive health, pediatric and adolescent health, emergency care, laboratory services, immunization, tuberculosis treatment, HIV testing and counselling, maternal and child healthcare, nutrition, and outreach. Most **immunization services** are carried out at the health post level in Enebse Sarmidir, and at the health center and health post levels in Libo Kemkem. In Libo Kemkem, vaccination coverage reaches at least 98 percent. While there were no **internally displaced persons or refugees** in Libo Kemkem, health services in Enebse Sarmidir are provided free of charge to internally displaced persons in the area.

Health centers and health posts both carry out regular **outreach services** and support HEWs during outreach activities. Health posts and HEWs in Enebse Sarmidir, as well as health centers, HEWs and health promotion officers in Libo Kemkem, regularly provide outreach activities to promote community awareness and demand for routine services such as antenatal care, immunization, family planning, nutrition and hygiene practices. HEWs are responsible for reaching all communities in assigned clusters in a kebele.

Youth-friendly, adolescent **health and reproductive health services** are provided at health facilities, while adolescent health education services are additionally provided at youth centers and schools. Health centers provide both out and in-patient services, as well as counselling, family planning and reproductive health services sensitive to gender and privacy concerns. In Libo Kemkem, youth leaders participated in outreach and counselling services in schools to facilitate discussions and promote awareness on youth reproductive health issues.

## Bottlenecks in Service Delivery

### Shortage of medicine and medical supplies

The shortage of medicine and medical supplies was the most frequently cited bottleneck in service delivery in both woredas. Shortages of both basic and prescription medicines were reported for all health facilities, in some cases for more than six months. As the sole supplier for public health facilities is the government Pharmaceutical Supply Agency, lack of coordination or supply here is cited as a common bottleneck. Patients are often referred to purchase medicines from private vendors and pharmacies. In Libo Kemkem, some health facilities lacked cold chain fridges for vaccination storage, leading to vaccine shortages.

### Shortage of funds

Budget shortages were the second most frequently cited bottleneck by key informants. They were cited as the source of other service bottlenecks including inadequate infrastructure and reparations, poor access to electricity and water, staff shortages and lack of medical equipment. Health facility budgets, which were reported to have decreased over time, are derived from two main sources: government treasury budget and internal revenue budgets to cover facility needs. Insufficient funds were reported for both sources. In Libo Kemkem, the introduction of the Community Based Health Insurance Scheme (CBHIS) was noted as a recurring source of budgetary issues in the health sector of both woredas, due to poor management and failure to reimburse service charges owed to facilities.

*"The reimbursement of CBHI service money is not paid properly. Lately they are not reimbursed at all, especially in the past year. Once allocated, the government grant budget is received on time, but it is too small to cover all costs of the health centre."*

**– Health Center Officer, Libo Kemkem**

### Staffing, qualifications and remuneration

In Enebse Sarmidir, a shortage of key health professionals was noted because of budget shortages. While the number of staff was below standards in this woreda, it was deemed enough in certain health facilities relative to the patient load. In Libo Kemkem, while no shortage of staff was cited as a concern, lack of motivation and commitment among HEWs was noted as a problem. HEWs are commonly unsatisfied by rural assignments and salaries, and therefore frequently do not show up at health posts. HEWs are also predominantly female and may miss their posts due to marriage or maternity leave. This results in unavailability of services.

*"The challenge with HEWs sustainability is that most of them request to be transferred to*

*urban areas after serving in rural areas for a while. However, as there are limited spaces in these health posts, it is difficult to address their request… and their frustrations are reflected in their work. They are not found at health posts on most occasions; they skip work. The other challenge is, as all HEWs in the wereda are female, they get married and leave work for maternity leave. It is very seldom that all two or three HEWs assigned to one kebele are found at the health posts."*

**– Woreda Health Officer, Libo Kemkem**

### Inadequate infrastructure and equipment

Facilities at different levels of provision face numerous challenges with infrastructure. Many are old and need maintenance and repairs, and some lack access to water, sanitation and a reliable electricity supply. In Libo Kemkem, two health centres do not have their own water sources. In Enebse Sarmidir, lack of road infrastructure makes it difficult for some kebeles and lowland area woredas to be adequately covered.

### Factors hindering access to health service utilization

In addition to poor health-seeking behaviour and cultural norms, **barriers with accessibility and affordability** hinder health service utilisation in both woredas. Access to health centres and health posts is constrained by their remote location, the lack of transportation options and lack of infrastructure. In addition to remote locations, poverty was cited as a common reason for the lack of uptake; even though public health facilities are cheaper than private facilities, many families cannot afford the cost of health services. Spiritual healing and home remedies, both associated **with cultural norms and poor health-seeking behaviour,** were suggested to be common coping mechanisms for families unable to afford public health services. Due to a lack of knowledge or a lack of funds, parents frequently exhibited poor health-seeking behaviour with regards to preventive healthcare and acute malnutrition treatment, leading to recurrent health issues among children.

*"In rural areas, there is tendency to prefer spiritual healing. They go to churches to get solutions for their health problems. They do this also for cost reasons."*

**– Health Center Officer, Libo Kemkem**

## Healthcare services since the outbreak of COVID-19

### Provision of healthcare services

In health centres in both woredas, no disruptions to service provision caused by COVID-19 were reported. The only suspended activities were those related to health education and outreach, especially those involving community guidelines, in line with COVID-19 prevention. House-to-house visits by HEWs were discontinued, and in Enebse Sarmidir, remote outreach activities (such as through community loudspeakers) compensated for group activity suspensions. Health professionals were encouraged to minimise absences, and their annual leaves were suspended to prioritise health care service provision.

Medical shortages, previously reported as a major bottleneck before the pandemic, persisted and even worsened in both woredas, due to shifting priorities of suppliers or other supply-related bottlenecks. In both woredas, health sector financing shifted to prioritise the supply of PPE to medical staff and promote health education on COVID-19 prevention. In both woredas, health professionals and patients strictly adhered to COVID-19 prevention activities such as wearing masks and PPE, handwashing or providing hand sanitizers and soaps. However, in Enebse Sarmidir, as the woreda is located far from urban centres and few positive cases were reported, community adherence was not sustained.

### Utilisation of healthcare services

Both woredas reported significantly reduced patient flows, including among internally displaced persons. In Libo Kemkem, patient flows to health posts were less affected than flows to health centres; patients avoided health centres due to the fear of contracting the disease and of being quarantined. In Enebse Sarmidir, although the fear of contracting the virus was not a factor, patient flows to health facilities reduced for the first two months of the pandemic due to fear of being quarantined. In both woredas, utilisation has returned to levels close to before the outbreak.

# Nutrition

The 2020 UNICEF Ethiopia and CSA report[2] on multidimensional and monetary child poverty in Ethiopia shows that in Amhara Region, 43 percent of children aged 0-4 years, 45 percent of children aged 5-14 years, and 43 percent of children aged 15-17 years were deprived on the nutrition dimension in 2016.[3] This compared to 18, 16, and 23 percent of children in each of these age groups being deprived of nutrition in Addis Ababa. Further, Amhara was the region with the third-highest share of stunting: 42 percent of children under age 5 years. This is twice the share of stunted children in Addis Ababa, the region with the lowest incidence of stunting nationally.

## Common nutrition-related issues and risk factors

Interview respondents in the Enebse Sarmidir and Libo Kemkem woredas reported malnutrition to be among the most common adverse health conditions, due to 1) high food insecurity (associated with poverty, poor access and climate-related factors); 2) inadequate food diversity; and 3) poor feeding practices. Frequent drought and climate change were the most cited sources of malnutrition in these woredas, as they led to frequent food shortages and food insecurity. These factors were especially concentrated in lowland areas and a selection of kebeles.

[2] UNICEF Ethiopia & CSA, (2020), Faces of poverty: studying the overlap between monetary and multidimensional poverty

[3] Among children aged 0-4 years, deprivation was measured in terms of deprivation in the indicators assessing exclusive breastfeeding (0-5 months), Vitamin-A rich food consumption (6-59 months), wasting (3-59 months) and underweight (3-59 months). For children aged 5-14 years, deprivation in nutrition was measured in terms of deprivation in the indicators assessing meal frequency and diversity, food shortages, and iodised salt consumption at the household level.

Both food insecurity resulting from frequent drought, as well as poor dietary practices and traditional feeding practices, were associated with a lack of diversity in nutritional intakes, especially among young children. Cross-sectoral risk factors to stunting among children include poor access to improved water, poor sanitation and hygiene coverage and the associated risk of chronic disease, especially in rural and lowland areas.

*"People always eat eat the same kind of foods. There is no tradition of eating diversified food; not even when other kinds of food are cheaper and accessible."*

**– Woreda Health Officer, Libo Kemkem**

## Nutrition services

Maternal and child health and nutrition services, including education, outreach, growth monitoring, supplementation and acute malnutrition treatment, are provided under the mandate of the woreda health systems. As such, HEWs provide health and nutrition education services to communities, including on child feeding and exclusive breastfeeding. Child feeding education is promoted to mothers by health facilities and health offices in coordination with the agricultural office. Acute and therapeutic malnutrition treatments are provided at health centres for mild and severe cases. HEWs screen malnutrition cases at the community level, provide nutrition supplementation in mild cases, and refer severe cases to health centres. No systematic growth monitoring is performed at health centers in Enebse Sarmidir, but children under five years are measured for height and MUAC (Mid Upper Arm Circumference) when visiting health centers for any other reason. Regional health bureaus, as well as organisations like UNICEF, support nutrition programmes and distribute nutritional supplements to woreda health facilities. Malnutrition treatment and nutrition supplement supplies were noted to usually be adequate and sufficient, with some instances of delay or unavailability.

## Bottlenecks in service delivery

Bottlenecks in nutrition service delivery are like those of health services in terms of budgetary, infrastructure, staff and medical supply shortages. However, key informants did not explicitly cite nutrition-specific bottlenecks. In Libo Kemkem, key informants reported that nutritional supplements are provided by regional support programmes, but they are sometimes delayed in reaching the woreda, leading to shortages. Acute malnutrition therapeutic treatments such as Plumpy'Nut are frequently noted as being widely available and at times supplied in excess.

### Factors hindering access to nutrition service utilization

As with healthcare service uptake, affordability, distance, poor health-seeking behaviour, cultural norms and lack of awareness were common hindrances to nutrition service utilisation. Key informants reported cases of parents not seeking regular check-ups or follow-up treatments for children who have been treated for nutrient deficiencies, leading to chronic malnutrition even with prior treatment.

*"There is poor follow up. After they are treated and recover, they go back to being malnourished again. Parents do not properly follow up and additionally provide them with home cooked foods."*

**– Health Center Officer, Libo Kemkem**

### Nutrition services since the outbreak of COVID-19

As with healthcare service provision, the pandemic had no major impact on nutrition service provision; both nutrition programmes and case treatments were carried out as before in both woredas. For the same reasons as in the case of healthcare service utilisation, the pandemic led to a significant reduction in patient flow, including those that might have sought nutrition services or treatment for mild or severe cases of malnutrition. However, service utilisation has returned to levels close to before the outbreak.

# Education

According to the 2020 UNICEF Ethiopia and CSA report[4] on multidimensional and monetary child poverty in Ethiopia, almost half (46 percent) of children aged 5 to 14 years in Amhara are deprived of education, either by not attending school or being two or more years behind in their schooling. Deprivation in education, measured in terms of school attendance, grade-for-age, and literacy, is even higher among children aged 15 to 17 years, at 69 percent. By comparison, deprivation in education for these two age groups stands at 16 and 42 percent, respectively, for children living in Addis Ababa. Deprivation in education among children age 15 to 17 in Amhara is ranked fourth highest of all regions.

## Education system overview

In Libo Kemkem, there are 6 secondary schools and 98 primary schools. All these schools are public. There are also 5 nursery schools, two of which are private and three are faith organisations. All education is equally accessible for all children regardless of gender or other characteristics. There are 1,761 teachers serving over 40,000 students, averaging one teacher per 36 students.

In Enebse Sarmidir, there are 76 primary schools, 53 of which are in lowland areas where access to services such as water, roads, and electricity is limited. These areas are also frequented by drought. Additionally, there are five secondary schools, and two private kindergartens. All primary and secondary schools are public schools and are not separated by gender.

Education is widely perceived in communities in both woredas as a pathway to economic development. Entry requirements are based on age and verification of birth certificates, or alternative means of verification such as verifying the child's physical appearance or aptitude tests. In one secondary school in Libo Kemkem, which was noted as possibly above the national average in terms of facilities, service quality and teacher-student ratio, a registration fee of Birr 300 was required.

## Non-education services provided

None of the schools in the two woredas provided school feeding services. Health education and counselling, including campaigns for vaccination, deworming and

[4] UNICEF Ethiopia & CSA, (2020), Faces of poverty: studying the overlap between monetary and multidimensional poverty

nutrition supplementation, adolescent and reproductive health, WASH and safety, have been provided at the schools in collaboration with non-governmental organisations and Woreda Health Offices. In Libo Kemkem, there are also activities aimed at mitigating harmful practices such as early marriage and gender-based violence. Menstrual hygiene education and materials are provided in Libo Kemkem for adolescent girls to prevent stigma and school absence. However, this service is not provided regularly.

Bottlenecks in the provision of non-education services revolved around shortages of funds, irregular provision and limited coordination across key multisectoral actors, such as in the health and water sectors. This affected both the quality and the sustainability of delivered services, such as in the case of the school-feeding programme in Enebse Sarmidir, which was discontinued after one year. In Enebse Sarmidir, key informants listed trachoma as a key health issue among children. However, medical supplies to treat this illness were provided only once a year, meaning that children must wait until the following year to receive this crucial health treatment if they miss distribution in schools.

Only 14 primary schools in Enebse Sarmidir have toilet facilities, while only 26 primary schools have clean water, and few have handwashing stations. Among schools in both woredas that have access to clean drinking water, service can be irregular. Among schools in remote areas, lack of access to safe drinking water and lack of adequate sanitation, including separate facilities for boys and girls and menstrual hygiene management, were noted as issues.

## Services for vulnerable groups

In both woredas, Woreda Education Offices, the community or non-governmental organisations provide children of poor families with necessary school materials to ensure these can attend school. Systems, including allotted budgets, are in place in the school and in the local community to support children in disadvantaged or humanitarian situations, as well as orphans. However, in Enebse Sarmidir, inclusive education for children with disabilities is limited. While disability is a problem, budget and resource shortages meant that little was done to address their educational needs.

## School attendance and dropout

In Libo Kemkem, school attendance and dropout issues were not reported as common, being limited to 2-5 percent. Primary enrolment at the woreda level lies at 89 percent, thanks to outreach and awareness campaigns. Provisions for children of disadvantaged backgrounds, in addition to intersectoral collaborative efforts and student monitoring of attendance, helped to reduce dropouts drastically. However, it was acknowledged that some dropouts occur due to children's lack of interest in education, child marriage or employment (such as helping parents with farm activities). Boys were more likely to drop out than girls. School attendance and dropout may also be affected by the lack of public schools in remote areas, the lack of transportation, the lack of access to adequate sanitation for boys and girls, disability, orphan hood, or not speaking the language taught in schools.

In Enebse Sarmidir, key informants cited several factors strongly associated with higher dropout rates. These were: girls' early marriage and pregnancy, boys and girls seeking economic opportunities, gender perceptions and domestic chores. Poverty was an underlying reason accounting for all these factors, especially among children living in rural and lowland areas. Early marriage among girls was recognised as a serious problem, as girls often face pressure by families to marry for reasons of social status, or due to pregnancy. In one primary school, the school liaises with girls' families, kebele officials and legal offices to ensure girls' consent to marriage. The school also attempts to resume her education in case the marriage is successfully invalidated. During times of income shortage, the education of boys in the household is prioritised over that of girls. School interventions in cases of dropout are limited. However, efforts are made for raising community awareness, including support for disadvantaged students.

## Bottlenecks in service provision

### Poor infrastructure and school materials

Poor infrastructure, such as road access, sanitation and hygiene facilities, or the lack of textbooks and learning materials such as laboratory equipment and ICT infrastructure are an issue in both woredas. In both woredas, most schools are ranked in the lowest two standard levels, assessing qualities such as teacher-student ratio, student-textbook ratio and student-desk ratios. WASH shortages are an issue in both woredas. 50 percent of schools in Libo Kemkem struggle with providing adequate sanitation facilities for boys and girls, as well as drinking water and handwashing stations. Access to electricity is also unstable in schools; in Enebse Sarmidir, only 5 out of 76 primary schools and 3 out of 5 high schools have access to an electric power source. The inadequate number and size of classrooms hinders learning quality and teachers' ability to manage students and classes effectively in both woredas.

*"There have been problems with accommodating students of different learning capabilities due to differences in age and sex. In relation to the first, students of diverse ages, for instance 9 years old children and 13 years old children, often learn together. Older children appeared to have better learning capability and outcomes than their younger counterparts"*

**– Primary school teacher, Libo Kemkem**

*"Phenomena such as poor awareness, low economic status, malnutrition, shortage of water or the early marriage of girls due to cultural factors, are widely prevalent in these lowland areas. The quality of education is also poor in these areas because of the high turnover of teachers arising from limited availability of infrastructure, such as water, roads and electricity."*

**– Woreda Education officer,**

In Enebse Sarmidir, there are 76 primary schools, 53 of which are in lowland areas where access to services such as water, roads, and electricity is limited. Living in these areas is also associated with higher rates of child marriage, poverty, malnutrition and service shortages. As a result, there is a higher turnover rate of teachers for schools in these areas, as well as a shortage of appropriately trained teachers to serve children in these disadvantaged communities, leading to poor quality of education provided to children.

### Shortages of textbooks and school supplies

A shortage of textbooks and teaching materials was one of the most common bottlenecks reported by key informants. Although textbooks are provided freely to all students, they are often in short or delayed supply, leading to the need to share textbooks between multiple students. Infrastructure limitations leading to shortages of ICT equipment and learning materials such as laboratory equipment limit learning quality.

*"Textbooks and other teaching materials are freely available to all students. However, some texts like English and Maths are in short supply. In extreme cases, there are times when a teacher could not find a copy for teaching, let alone copies for students. In contrast, other textbooks such as civics, social science, and physics are in excess supply."*

**– Primary school officer, Libo Kemkem**

### Poor coordination among stakeholders and inadequate budgets

Budgetary shortages and poor coordination among stakeholders were frequently reported to be overarching bottlenecks in education service delivery and quality. Budgetary shortages were noted as the main reason behind poor staffing (lack of teachers across certain subjects, laboratory technicians) as well as teaching quality and teacher commitment due to dissatisfaction with remuneration and inadequate training.

Government funding and support was noted to be highly insufficient and inadequate for improving infrastructure, teaching quality, or acquiring necessary learning materials. The most cited reasons for this were the lack of coordination between different levels of government, as well as the lack of consultation in the budgeting process with respect to schools' actual needs.; schools are not consulted in the budgeting process and plans for raising educator salaries have been suspended. The Woreda Education Office only receives information on the number of planned enrolments, and assigns a recurrent budget based on a per student allotment of Birr 10-20 depending on the schooling level. Additional sources of funding from government subsidies and non-governmental organisation grants cannot be used for recurrent expenditures and do not adequately evaluate and address the actual needs of schools.

*"With regards to shortages of some textbooks… we always make our appeals to the concerned department of the school, which in turn would forward to higher level officials. Unfortunately, we never had our voices heard and requests answered. Most of our requests remain on paper."*

**– Primary school officer, Libo Kemkem**

## Bottlenecks to education service utilisation

Students' poor perceptions of future employment prospects and lack of interest in education, alongside cultural practices such as early marriage of girls and normal acceptance of child labour (including economic activity and household chores) were reported by key informants to be the main bottlenecks in the utilisation of education services. Especially among adolescent girls, poor WASH infrastructure and shortage of menstrual hygiene management facilities was a hindrance to utilisation.

*"Some girls drop out from school to support their families with domestic chores and income generating activities. This is despite an increase in girls' enrolment these days due to better employment opportunities for educated women in the community, as well as reduced early marriage due to improved community awareness."*

**– Woreda Education Officer, Enebse Sarmidir**

# Education services since COVID-19

## Education service provision and uptake

In both woredas, limited effort was made to continue learning during lockdown, due to a lack of preparedness, a lack of training and budgetary support for distance learning and a lack of distance learning infrastructure, especially for disadvantaged children and children living in rural areas. Although TV-based and radio-based learning programmes existed, only a limited population of families with children had access to the necessary infrastructure to access them. Overall, education was largely suspended for children during the school closure period. A limited number of paper-based learning materials were provided for children in secondary school to prepare them for sitting national exams. All these factors had a negative impact on children's interest in learning, quality of learning at home, without parental support or support from teachers, and on learning outcomes.

*"There was a worksheet prepared and distributed to students attending grade 8 and grade 12. This was because these students are sitting for national exams. However, such worksheets were not provided for students attending other grades (1-7 and 9-11). The worksheets provided for grade 8 and 12 students are also not adequate due to budget shortages."*

**– Woreda Education Officer, Enebse Sarmidir**

*"To be honest, we did nothing at the time [since the start of the pandemic], because nobody anticipated the school would remain closed that long. We did not give students any materials after they were told to stay at home."*

**– Primary school officer, Libo Kemkem**

Since the re-opening of schools, some remedial classes were instituted for children to catch up in their learning. However, many children chose not to participate, as they perceived it was not necessary. Not all children returned to regular schooling, due to 1) having left school to pursue economic activities or household chores; 2) the fear of contracting the virus, in part due to a lack of preventive materials such as masks, or lack of income to purchase preventive materials; 3) child marriage or pregnancy, especially among girls. Upon reopening, schools made renovations to WASH facilities, provided preventive materials to students and staff, and engaged in some reorganisation of class structures. Limited awareness of COVID-19 by families and students, or the lack of taking the disease seriously, inhibited full adherence to preventive measures inside and outside of classrooms.

*"Students had fully abandoned any thoughts of education. Most were left without any hope for education or their future. Female students were deeply engaged in domestic chores, with no spare time left for education"*

**– Secondary school officer, Libo Kemkem**

# Child Protection

According to the 2020 UNICEF Ethiopia and CSA report[5] on multidimensional and monetary child poverty in Ethiopia, 32 percent of children aged 0-4 years, 55 percent of children aged 5-14 years and 9 percent of children aged 15-17 years are deprived of child protection.[6] Among children aged 5-14 years, Amhara ranks the highest of all regions in terms of the share of children deprived of their rights to protection. Among children aged 10-17 years, the share is 41.8 percent across Ethiopia and 7.3 percent in Addis Ababa.

## Key risk factors affecting children

Child protection services are available in the two studied woredas, but are limited in scope, adequacy and effectiveness. Social workers in both Enebse Sarmidir and Libo Kemkem reported the following main risk factors affecting children's protection: violent discipline at home; gender-based violence against girls, including sexual violence and trafficking; child marriage and pregnancy, especially among girls aged 10 years and older; harmful traditional practices including FGM (only in Libo Kemkem); stigma against and lack of support for orphans and children with disabilities; and child labour among both boys and girls in the woredas. Rape and abduction were singled out as problems affecting girls in Libo Kemkem.

Children who were orphaned and those with disabilities faced numerous intersecting risks of social exclusion, and have a compounded risk of all forms of violence in combination with poverty, due to limited specialised services for these children across all sectors, as well as due to cultural norms, which adversely affect both provision and uptake of protection services.

*"Orphans and children with disabilities are more vulnerable to all forms of violence. These children are often perceived as a misfortune to a family. Many believe God gives a child with disability when he wants to punish that family."*

**– Social Worker, Libo Kemkem**

*"Children with disabilities are facing several problems – limited access to social supports and exclusion (i.e. these disabilities are often considered bad luck to their families and hence the children are forced to be excluded from social networks and public life – school and others). Similarly, orphans are also considered a misfortune to their families. In local terms, these children are sometimes called 'Gafi', meaning 'Mother/father repellent'."*

**– Social Worker, Libo Kemkem**

## Bottlenecks in service provision and uptake

HEWs, as well as social workers, contribute to addressing protection issues in the community. In Enebse Sarmidir, HEWs contribute to the prevention of child marriage through raising community awareness, while social workers work closely together with the kebele to support children at risk, including orphans and children with disabilities.

[5] UNICEF Ethiopia & CSA, (2020), Faces of poverty: studying the overlap between monetary and multidimensional poverty

[6] Measured in terms of circumcision (of girls) for children aged 0-4 years, and using the indicators circumcision (of girls), child marriage (10-14 years), and child labour (10-14 years) for children aged 5-14 years, and child marriage for children 15-17 years.

The reluctance to diverge from cultural norms was the key underlying bottleneck at both levels of supply and demand for protection services, especially in terms of curbing instances of child labour, child marriage and pregnancy, as well as social exclusion of orphans and children with disabilities. Cultural acceptance of protection violations, especially for practices such as child labour and child marriage for both girls and boys, was perceived to be a major factor among both service providers and inhabitants, and undermining the quality of services, budgeting and resources devoted to curbing harmful practices against children. Domestic violence in the home, and violence against girls in the streets, is rarely reported or linked to legal repercussions, due to stigma and cultural pressure.

*"Cultural norms and values are the key factors underlying the practices. According to the local culture, girls are expected to get married as early as possible. A girl or woman who remains unmarried for an extended period is undermined and subjected to social exclusion. In local terms, this is called "Komo Keri", meaning "an unmarried woman is an unwanted woman"*

**– Social Worker, Enebse Sarmidir**

*"Cultural values and norms are a key challenge underlying early marriage and other problems affecting girls in the community. The limited access to means of transportation and the inadequate budget for subsistence has also prevented government agents from providing adequate support to communities."*

**– Social Worker, Enebse Sarmidir**

*"Early marriage is also often caused by families that want to establish strong social ties with other families. In local terms, this is called "LijenLelijih", meaning "my child for your child" … The law enforcement bodies at woreda level lack the courage and commitment to penalize the perpetrators of such practices because they fear not respecting cultural norms and values".*

**– Social Worker, Enebse Sarmidir**

Although some effort was made between woreda administrators and local law enforcement bodies to curb child marriage and abduction, especially in Libo Kemkem, these efforts have been limited in both implementation and effectiveness. The limited coordination and commitment of relevant actors at the governing, administrative and community levels (including religious institutions, traditional community-based organizations and woreda-level government structures such as the Woreda Women Affairs Office, Police, administration and courts) hamper efforts to effectively deal with protection violations against children. Even where access to legal services is provided, it is rarely adequate. Support for orphans and children with disabilities is rarely systematic, and often relies on contributions in the form of cash or schooling resources from development partners, local administration and communities.

*"Efforts to protect children from violence and risks are not well planned and resourced, and hence rarely implemented."*

**– Social Worker, Enebse Sarmidir**

The most common points of contact for families and children were schools, the kebele administration, health facilities, and elders and religious leaders. Less frequently referenced were law enforcement bodies. However, children and families minimally take up contact with law enforcement institutions due to fear, lack of awareness and stigma. The already limited access and provision of protection services lead to limited awareness

of first points of contact for both children and members of the community when seeking help for children at risk. In general, children have only limited awareness on how and where to seek help in cases of protection violations. Awareness of first points of contact is also especially limited among disadvantaged groups such as rural families and children. Even among those with higher levels of awareness, cultural factors and mistrust of local institutions are hindrances to taking up legal and institutional protection services. Limited uptake of services has also been linked to poverty, as families lack income to cover potential legal expenses.

While schools may be the first points of contact for children and families in cases of protection violations, schools may also not be adequately addressing instances of violence within their own institution. In Enebse Sarmidir, violence in schools is often suppressed and not communicated to legal protection offices.

While birth registration services are generally provided and taken up according to the governmental decree for registering births within the first 30-90 days after birth, cultural practices limit birth registration to an extent, especially for first-born children. HEWs and social workers raise awareness for birth registration at community meetings and during field visits. Mothers generally register children's births with the kebele manager, who passes this information to the Main Events Registration Office. However, in Enebse Sarmidir, cultural value is placed upon a mother's first birth carried out at her maternal home, which may delay or prevent the birth from being registered in the kebele where the woman commonly lives. This may lead to underrepresentation of children officially registered in the kebele or woreda. In Libo Kemkem, displaced people from outside of Ethiopia may not be able to register their children with the woreda, and therefore may not be eligible for social services.

## Child protection services provision, uptake and issues since COVID-19

Key informants reported an increase in children's risks of protection violations of all forms as a result of the pandemic. They especially reported a surge in child marriage, child labour, and gender-based violence. No new measures related to social and protection services were introduced, and activities such as community visits and counselling in schools have been reduced or suspended due to the pandemic. In both woredas, there were reports of girls and boys seeking economic opportunities or migrating to nearby towns to earn additional income for their families, exposing themselves to added risks of violence, exploitation and early marriage and pregnancy. This has been linked to increased poverty due to the pandemic. For boys, increased consumption of alcohol and other toxic substances has been reported during school closures. An increase in child marriage among both boys and girls was also linked to school closures during the pandemic period, implying a permanent exit from education, especially among girls.

Social distancing during the pandemic period also disrupted birth registration services, as woreda governments suspended these services to reduce vulnerability to infection. In Libo Kemkem, birth registration was suspended for 4-5 months, which might have adverse implications for children born during this period in terms of their eligibility to social services and support, especially in the pandemic context where many families lost vital sources of income.

*There was a risk of exposure to violence, such as early marriage, beatings, rape and other bad practices affecting children. For instance, several girls have left home in search of casual labour to earn some income during the pandemic. Some of these were exposed to violence on the road and at their working places.*

**– Social Worker, Enebse Sarmidir**

The stigma against children with disabilities and orphans intensified during the pandemic, as the fear of infection intersected with existing prejudices against these groups. This is likely to have led to increased vulnerabilities and risks faced by these groups.

# Water, Sanitation and Hygiene (WASH)

Around half of all children in Amhara are deprived of an improved drinking water source, and nearly all children lack adequate sanitation, according to the 2020 UNICEF Ethiopia and CSA report[7] on multidimensional and monetary child poverty in Ethiopia. This is in comparison with the rate in which almost none of the children are deprived in improved water source in Addis Ababa. much higher. Deprivation of Sanitation is nearly universal in Amhara, compared to around 45 percent in Addis Ababa. Nationwide, access to improved sanitation is a universal issue, with 98-99 percent of children being deprived.

## Water supply system at the woreda level

The WASH steering committee governs the WASH programmes that operate in the woreda. At the woreda level, the committee implements and coordinates WASH activities, and includes multisectoral members from the sectors of water, health, education, agriculture, women & children affairs, administration and finance. This committee decides on the WASH programme budget and its allocation to steering committee members. The woreda council allocates budgets, which are distributed to sector offices based on their activity plan. Similarly, WASH committee members are also established at regional and zonal levels to support the work of the woreda level WASH committee. At the kebele level, WASH committees comprising of kebele administration, HEWs, teachers, kebele managers, youth representatives and others were also established to implement WASH activities in their respective kebeles. At all levels, the WASH programme is governed by woreda WASH steering committees led by the Woreda administration. In Libo Kemkem, 63 percent of the population has access to a safe water supply. IDPs in Enebse Sarmidir were relocated to areas where safe water was accessible but were not provided specialised access to WASH services.

The main activities in the previous five years in both woredas included the maintenance of WASH facilities in schools, health facilities and public spaces, the provision of safe water to communities and the promotion of biogas technology, solar energy and energy saving stoves. The Woreda Health Office carries out education and outreach activities related to sanitation and hygiene practices, in collaboration with the Woreda Education Office.

[7] UNICEF Ethiopia & CSA, (2020), Faces of poverty: studying the overlap between monetary and multidimensional poverty

## Bottlenecks in the access and uptake of WASH services

In both woredas, distance and the settlement patterns of communities lead to limited water service provision and limited community access to safe water and sanitation, especially for those living in lowland areas where there are no water sources that can be developed. In four kebeles/communities in Enebse Sarmidir, there is zero water coverage due to this issue, and community members must travel long distances to access potable water, while other sources of water are deemed unsafe. For the same reasons, in Libo Kemkem, access to safe water in highland and midland areas is better, with coverage of over 70 per cent, while access is extremely limited in lowland areas, at 32 per cent. These lowland area communities rely on water sources that are hard to access and unsafe. The potential for developing water sources in lowland areas was deemed too costly in the context of existing budget shortages.

The budget allocation and administrative commitment for WASH programmes as managed by the WASH steering committee were often noted as being insufficient in relation to community needs. The lack of coordination and commitment among stakeholders and implementing partners was also a common bottleneck to service provision and extension of coverage, especially given the capital and labour-intensive needs of this sector. In addition, many kebeles lack road access and WASH offices lack adequate means of transportation to reach out to these communities. In terms of service uptake, no problems were reported, and beneficiaries of WASH services were reported to be happy to contribute to local development projects.

*"In highland and midland areas, some households are far from existing safe water sources and rely on unsafe water sources. Also, in some cases, people avoid travelling long distance to fetch water from safe sources due to limited awareness. However, paying for water is not a hindering factor because water fees are very small or non-existent for all available water sources."*

**– Woreda Water and Energy Officer, Libo Kemkem**

*"Here, the WASH programme is considered a sector on its own and allocated a budget managed by the woreda WASH steering committee. However, the allocated budget is not in line with local needs. For instance, less than 1% of the total woreda budget was allocated to WASH last year. As a result, we were not able to provide safe water in many communities in the woreda."*

**– Woreda Water and Energy Officer, Enebse Sarmidir**

## Service provision and uptake since COVID-19

During the early months of the pandemic period, WASH service providers worked on ensuring the functionality of existing water sources, and supported schools and health facilities with the maintenance and disinfection of water sources. Intersectoral collaborations with Woreda Health and Education offices took place to promote education and community awareness of hygiene and prevention guidelines considering the pandemic. These activities increased the availability of safe water in some areas.

However, as time passed, the limited financial allocations, waning interest and commitment, as well as perceptions of the virus as a

"common flu" by both government staff and community members, including children, have hindered the sustainability of these interventions. Budget shortages in Enebse Sarmidir meant that efforts to continue developing water sources in schools were not sustained. This especially applied to lowland areas where many kebeles and rural communities continue to lack access to safe water sources and have limited potential for future development, hence also limiting their potential for COVID-19 prevention. Limited community awareness, or warped perceptions of risks, have led to the continuation of public gatherings in the later months of the pandemic, and existing poor hygiene practices, including open defecation and lack of awareness on proper sanitation, were continued. This was also linked to the lack of public toilets under the jurisdiction of the Woreda Health Office.

Budget and administrative shortages hindered the expansion of existing WASH infrastructure such as public handwashing facilities in communities. The lack of behavioural change on both the demand and supply side was a major hurdle for public health interventions to prevent and manage COVID-19, in addition to limited buy-in for protective measures (personal hygiene, improved sanitation and PPE).

*"We worked on ensuring the functionality of existing water sources so that people have access to safe water for consumption and washing. To this end, we maintained and disinfected several water sources. We also supported schools and health facilities with the maintenance and disinfection of water sources. However, we didn't provide hand washing facilities to communities."*

**–Woreda Water and Energy Officer, Libo Kemkem**

*"There is limited commitment of woreda stakeholders, including the administration, to pandemic management nowadays. Many of these are downplaying its impact and are reluctant to cooperate and contribute. For instance, the COVID committee used to meet every day in the past to discuss progress, but now this is not even happening once every two weeks."*

**– Woreda Water and Energy Officer, Libo Kemkem**

*"Currently, COVID-19 is not getting adequate attention, neither from the local government, nor from communities. We were rarely involved in school reopenings. The COVID committees on both woreda and kebele levels are weak and not meeting frequently to discuss progress. … Due to budget shortages, our office couldn't continue developing water sources in schools to ensure improved access to safe water for the school community."*

**–Woreda Water and Energy Officer, Enebse Sarmidir**

# Recommendations

## Overarching recommendations

The shortage of funds is an overarching bottleneck in service provision across all sectors paramount to children's wellbeing. While the scope of the study did not cover public finance analysis, the results suggest that the existing financing models in all sectors, especially health, WASH and education, should consider the volume and type of services provided by frontline facilities[8], as well as their needs for staffing and remuneration, expanding the network and type of frontline facilities, access to basic facilities like water, sanitation and electricity, maintenance and reparations, and other operational costs. Service providers such as schools and WASH offices should be actively engaged in budgeting processes to account for specialised local needs.

Poverty was an overarching theme undermining access and uptake of key services across all sectors. Poverty additionally led to negative coping mechanisms that put children at risk, including taking up traditional healing practices in lieu of seeking professional healthcare, engaging children in labour and marriage, and continued exposure of children to violence and harmful practices. Especially in the context of the pandemic where many households have lost or reduced income, these risks are likely to be aggravated, and existing inequities exacerbated. Expanding coverage and adequacy of the Ethiopian Productive Safety Net Programme (PSNP), by lowering barriers to access and eligibility requirements, would benefit populations who were already vulnerable, as well as those who became vulnerable or whose poverty deepened due to the pandemic. PSNP would therefore provide cross-cutting assistance for cushioning social and financial shocks and expanding access to basic services. Coordinated efforts across administrative levels, and adapted disbursement mechanisms, are necessary to reach the most vulnerable populations, including those living in rural and lowland communities. These programme expansions should include regular monitoring, and evaluation of coverage, adequacy and effectiveness in relation to the actual needs of households.

Both the provision of services in all sectors and subsequent service utilization would greatly benefit from investments in public roads infrastructure in the region and availability of public transportation. Distance to health facilities and schools was reported to be a major barrier in access to services, especially due to the associated costs in absence of public transportation. Water treatment supply distribution, expansion of the water supply network, community engagement in WASH, and outreach health services in remote areas were reported to be often unavailable in remote areas because of a lack of roads and transportation.

[8] For example, in the sector of health the level of services provision, number of patients, number of service; in the sector of education, the number of student; etc.

## Thematic recommendations

### Health and Nutrition

In the health sector, interventions aimed at improving coverage of the population should consider options for adapting service provision to the needs and characteristics of the community. KIIs indicated that there are major bottlenecks in outreach and service availability at the level of health posts, especially in rural and lowland areas, due to a shortage of staff (HEWs), high turnover, high absenteeism, issues with remuneration, lack of facilities (e.g., WASH and medical equipment) that are essential for service provision, and lack of vehicles.

Considering the issues of service provision sustainability in terms of staffing in remote locations, adequate remuneration and other financial incentives should be put in place to attract qualified HEWs and retain the existing staff. This is particularly critical in the pandemic context, where ensuring service continuity for routine interventions such as vaccinations and maternal and child health care services is crucial to prevent the escalation of an existing public health crisis.

Shortages of medicine and medical supplies were a substantial barrier in accessing medical services. Procurement and disbursement procedures of medicine and medical supplies might need reviewing to enhance efficiency and expand access. This may include public provision and subsidies for medicines and medical supplies, as well as expanding the public supply of medicine to avoid shortages and delays in delivery. In parallel, investments should be made in cold chain infrastructure to optimize the provision of immunization services.

Malnutrition due to food shortages during periods of droughts was underscored as one of the key risks to the wellbeing of children and pregnant women in the region. The risk of malnutrition also increased due to the pandemic and related income shocks. Since the PSNP is the only source of income and nutrition for many households, especially during periods of drought induced livelihood losses, expanding its coverage should be considered as a first step towards a holistic approach to tackling the malnutrition issue in the region. Other efforts should include ensuring the sustainability of malnutrition screening and monitoring services at the community level, linking the patients to healthcare providers for treating cases of moderate and severe malnutrition, and ensuring the sustainability of regular micronutrient supplements (vitamin A, iron tablets, deworming) provision campaigns.

To improve health-seeking behaviour in cases of malnutrition, particularly for younger children, health and nutrition education activities should include dedicated modules for caretakers on the identification of malnutrition and importance of early treatment, as well as the importance of regular screening and check-ups.

To tackle malnutrition among school-age children, a regional multisectoral strategy consisting of the following components is essential: i) Implementing a school feeding programme in all pre-tertiary institutions (with spill-over effects on school enrolment and attendance, as stated by key informants), ii) providing regular growth monitoring services at schools and micronutrient supplements such as iron tablets, vitamin A and deworming, iii) incorporating modules on feeding practices, including on meal diversity (along with hygiene, sanitation and health) into school

curricula or non-education activities and iv) making such activities systematic and sustainable. Establishing a clear institutional framework and financing model of the nutrition sector is imperative to ensure the sustainability of programmes and coordination with other sectors. This is particularly relevant in schools, as school-feeding programmes in Amhara were either not active, or, in some cases, discontinued due to a lack of funding and commitment.

To compensate for disruptions in health service utilization during the lockdown period, especially in MCHN services, it is urgent to organize more frequent outreach, screening, immunization and nutrition supplement provision activities and campaigns, prioritizing more severely affected areas. Such activities should also include awareness raising about COVID-19 prevention and protection, as well as safety in the utilization of healthcare services in case of lockdowns in the near future.

# Education

In the education sector, substantial resources are required to increase school enrolment and attendance and improve the quality of learning. The COVID-19 pandemic and the likelihood of future shocks, including climate-related disasters and drought, also incentivised seeking opportunities for long-term reforms that innovate existing learning methods and expand access to education to all children, to prevent learning setbacks in cases of school closure and to close the digital divide. This requires substantial commitment from governmental and development partners to invest in the necessary infrastructure, including digital infrastructure, as well as in the training and re-training of staff and educators to provide specialised education services for vulnerable children and children learning from home.

The Woreda Education Office should also consider financial incentives for students of secondary schools to pursue a career in teaching in the region, as well as for generally improving staffing and teaching quality in schools.

Substantial investment is necessary to improve infrastructure and quality of learning in schools, including WASH facilities for girls and boys, textbooks and learning materials, desks and classrooms, as well as learning equipment and adequately trained staff. The financing model of schools should incorporate a budget line for the provision of menstrual hygiene products to girls, rather than relying on donor and NGO funds. Investments should also be made for school infrastructure to cater to the needs of children with disabilities, including via the provision of wheelchairs and other assistive devices, learning material, and trainings for teachers. Enhancing the provision of inclusive education for all also requires integrating existing schools/centres providing education for children with disabilities into "mainstream" schools.

Sustainable school feeding programmes are paramount for increasing school attendance and enhancing learning outcomes. Setting an institutional basis at the woreda (and/or kebele) level, and financing models that rely on governmental revenues rather than donors, would contribute to the continuity of such programmes.

The provision of non-education services in schools, like psycho-social support, health and nutrition education, family planning education, etc., needs a "formalization" of administrative structures, with clearly defined roles and responsibilities of the woreda, kebele, schools, teaching staff and students in order to manage the provision of non-educational services . Also, a clear definition roles and responsibilities of frontline facilities and institutions in sectors (such as health, sanitation, and social services) in terms of implementation and monitoring of activities; and capacity building and financing modalities is needed.

*"One way to improve budget allocation is to include other budget allocation criteria, other than those listed above. For instance, school activities such as the establishment of clubs, supporting students from poor families, student awareness creation on various issues (gender, nutrition, HIV/AIDs, etc.) should be considered. Also, the plans of woreda education offices and schools should be considered during the budget allocation process, which is not the case now. For instance, last year, we were even missing a staff salary because our plan was not considered during budget allocation. Moreover, the budget we received this year is 800,000birr lower than that of last year. This means our schools are less likely to implement some of their important activities that support teaching quality and and improved learning environment."*

**–Woreda Education Officer, Enebse Sarmidir**

The disruption in learning and teaching activities in both woredas at the onset of the COVID-19 pandemic raises serious concerns about educational losses affecting children's future learning and earning outcomes. The woredas should consider arrangements to compensate for such losses before the start of the next academic year and make participation in remedial learning programmes mandatory.

Arrangements should also be made to provide psychosocial support to children given the increased risks that they faced since the outbreak of the pandemic and especially during the lockdown period.

# Child Protection

Every reform and policy measure promoting child protection in Amhara requires behavioural change and shifting cultural norms away from harmful practices against children, away from stigma and taboos (especially against children with disabilities and orphans), and towards reforms that prioritise child wellbeing and protection from violence, exploitation, or abuse at home and in schools. These cultural shifts are required at the household and community levels, as well as at the levels of service provision, administration and governance. Close coordination and commitment from all relevant stakeholders, including religious institutions, schools, legal protection offices and community and health offices, is crucial for effectively shifting these norms. Expanding the PSNP and other social protection and assistance measures targeting vulnerable families and families economically impacted by the pandemic can also contribute to shifting cultural norms away from negative coping mechanisms, such as child labour and child marriage, while compensating for the lost income of families no longer engaging in these practices.

Harmful practices like child marriage, FGM (in Libo Kemkem), and teenage pregnancy remain strongly embedded in cultural norms and traditions, and often hinder support seeking. The effectiveness of interventions

is also hampered by (informal and hidden) biases of community leaders, elders, and even governmental officials towards the preservation of such values. The latter is especially discouraging for those exposed to these risks due to trust issues. In addition to awareness-raising campaigns targeted at the entire community, monitoring and accountability mechanisms should be established to ensure that governmental institutions (including the kebele and woreda administration) are providing the mandated services effectively.

*"Changing cultural norms and values requires comprehensive action supported by evidence, and collaboration among actors. Interventions are rarely well designed; actions taken so far to prevent harmful practices were limited in scope and fragmented, while relevant actors were often reluctant to get involved and contribute."*

**– Social Worker, Libo Kemkem**

*"Forge collaboration between kebele and woreda structures; release the support and commitment of kebele structures to improve the well-being of children; work with community elders and religious leaders to address the cultural norms and values undermining children's well-being."*

**– Social Worker, Libo Kemkem**

Providing child protection services first and foremost requires a clear institutional framework of service provision, including the appointment of a leading government agency/institution, a well-defined range and type of social services that this institution provides, a definition of procedures and standards for social service provision, and clear roles and responsibilities of institutions and stakeholders involved in each link of the service provision chain, including frontline health facilities, health extension workers, school teachers, law enforcement institutions (courts and police) and community leaders. Such interventions will together contribute to enhance coordination among stakeholders, the lack of which was frequently mentioned as hampering service effectiveness. Capacity building and development should be provided to all the above-mentioned stakeholders to ensure that teachers, as well as other "first contact" persons can easily identify risks and react/follow-up timely with related institutions.

Awareness raising for the availability of social services should be provided in schools by teachers and through outreach activities by HEWs and social workers to ensure extensive coverage.

# WASH

It is essential to prioritize the budgetary allocation for the WASH sector at the woreda level, as well as mobilize resources for the construction of new water sources and the expansion of the distribution network. Capacity building and ensuring sustainability in the functionality of administrative and operational structures is also essential for improving access to safe drinking water in the region. Ensuring that health facilities and schools have access to safe drinking water would not only enhance service provision in these sectors, but also contribute to improved health and nutrition outcomes, and even to school attendance rates. The financial allocation for expanding WASH services in schools, health facilities, homes, and public spaces should be adapted considering the possibility of future public health crises.

## *Annex I Ranking of regions using multidimensional poverty rate and deprivation rates across dimensions of wellbeing*

| Multidimensional poverty (k=3) | Physical development (stunting) | Health (children<1 year) | Nutrition (children under 5) | Education (5-14 years) | Information (5-17 years) | Child protection (5-14 years) | Water (5-14 years) | Sanitation | Housing (5-17 years) |
|---|---|---|---|---|---|---|---|---|---|
| Somali (97.5%) | Afar (54.7%) | Somali (88.5%) | Somali (85.9%) | Somali (71.4%) | Somali (52.5%) | Afar (60.0%) | Somali (65.6%) | Benishangul-Gumuz (99.4%) | Benishangul-Gumuz (99.7%) |
| Afar (93.6%) | Tigray (47.6%) | Afar (80.3%) | Afar (73.9%) | Oromia (64.4%) | Amhara (41.2%) | Amhara (54.8%) | Afar (64.6%) | Oromia (98.8%) | SNNPR (99.4%) |
| Oromia (90.7%) | Amhara (42.3%) | Amhara (75.5%) | Benishangul-Gumuz (64.5%) | SNNPR (60.3%) | SNNPR (40.5%) | Somali (46.4%) | SNNPR (60.8%) | Amhara (98.1%) | Amhara (99.4%) |
| SNNPR (90.2%) | Somali (41.9%) | SNNPR (70.8%) | SNNPR (49. 2%) | Afar (58. 2%) | Gambella (35.3%) | Tigray (40.2%) | Oromia (58.8%) | Afar (98%) | Afar (99%) |
| Amhara (89.8%) | SNNPR (40.9%) | Oromia (68.1%) | Dire Dawa (45.4%) | Benishangul-Gumuz (49.8%) | Afar (32.7%) | Oromia (39.2%) | Amhara (48.9%) | Somali (97.8%) | Somali (98.8%) |
| Benishangul-Gumuz (89.7%) | Benishangul-Gumuz (36.1%) | Benishangul-Gumuz (67.3%) | Tigray (44.6%) | Amhara (46.1%) | Oromia (31%) | SNNPR (35.5%) | Tigray (43.1%) | Gambella (97.3%) | Oromia (98.8%) |
| Tigray (77.6%) | Oromia (35. 2%) | Gambella (59.1%) | Amhara (42.7%) | Dire Dawa (43.5%) | Tigray (26. 2%) | Benishangul-Gumuz (32.9%) | Harari (31.9%) | SNNPR (96.9%) | Gambella (98.4%) |
| Gambella (76.8%) | Harari (31.7%) | Tigray (44.9%) | Oromia (38.7%) | Gambella (42.2%) | Benishangul-Gumuz (24.8%) | Dire Dawa (29.1%) | Gambella (26. 2%) | Tigray (86.0%) | Tigray (92.6%) |
| Harari (69.8%) | Gambella (22.9%) | Harari (41.1%) | Harari (33.0%) | Tigray (36.9%) | Dire Dawa (21.6%) | Harari (21.8%) | Benishangul-Gumuz (25.3%) | Harari (85.5%) | Harari (85.1%) |
| Dire Dawa (66.7%) | Dire Dawa (23.6%) | Dire Dawa (39.1%) | Gambella (28.1%) | Harari (34.1%) | Harari (8%) | Gambella (10. 2%) | Dire Dawa (21.6%) | Dire Dawa (80.1%) | Addis Ababa (82.9%) |
| Addis Ababa (22.5%) | Addis Ababa (21.1%) | Addis Ababa (4.3%) | Addis Ababa (17.6%) | Addis Ababa (15.9%) | Addis Ababa (0.6%) | Addis Ababa (7.3%) | Addis Ababa (0. 2%) | Addis Ababa (44.7%) | Dire Dawa (72.9%) |

***Source: UNICEF Ethiopia and CSA, 2020: Faces of poverty: Studying the overlap between monetary and multidimensional poverty in Ethiopia.***

## Annex II Characteristics of the selected woredas

| Region | Woreda | Characteristics |
|---|---|---|
| Amhara | Libo Kemkem | Rural, central/densely populated, sedentary farming community, midland, UNICEF presence |
| | Enebse Sarmidir | Rural, highland, sedentary farming community, sparsely populated, UNICEF presence |
| Somali | Shinile | Rural, pastoral and agro-pastoral communities, remote, arid and sparsely populated |
| | Kebri Beyah | Rural, purely pastoralist community, semi-arid and plain area, sparsely populated, UNICEF presence |

## Annex III Respondents and number of interviews per geographical locality

| | | Amhara, 2 woredas | Somali, 2 woredas | Total number of interviews |
|---|---|---|---|---|
| Structured interviews | Woreda Office of Health, Education, and Water and Electricity | 6 structured interviews | 6 structured interviews | 12 structured interviews |
| | Healthcare providers | 2 structured interviews | 2 structured interviews | 4 structured interviews |
| | Primary schools | 2 structured interviews | 2 structured interviews | 4 structured interviews |
| | Secondary schools | 2 structured interviews | 2 structured interviews | 4 structured interviews |
| | Social workers/Community service workers/Community care coalition officers | 2 structured interviews | 2 structured interviews | 4 structured interviews |

# Acknowledgments

This brief presents a summary of findings from quantitative data analysis from the report “Faces of poverty: Studying the overlap between monetary and multidimensional child poverty in Ethiopia” (2020) and qualitative research findings from Key Informant Interviews (KIIs) with service providers in the sectors of health, nutrition, education, WASH, and child protection in the Amhara Region. The study was commissioned by UNICEF Ethiopia under the Social Policy Section and implemented in partnership with Central Statistical Agency. It was undertaken by the Social Policy Research Institute (SPRI) in partnership with the Economic Policy Research Institute (EPRI). The interviews were carried out by Rebret Business and Consultancy PLC under the leadership of Dereje Kebede.

The brief was prepared by EPRI and SPRI consultants, Julia Karpati and Erëblina Elezaj, and reviewed by Vincenzo Vinci and Martha Kibur, and edited by Tom Garner.

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[i] World Bank, 2020: https://www.worldbank.org/en/country/ethiopia/overview#:~:text=Ethiopia's%20economy%20experienced%20strong%2C%20broad,for%20most%20of%20the%20growth.

[ii] Monetary poverty was measured using the 2015/16 poverty line of Birr 7,184 per adult equivalent per year set by the National Planning and Development Commission of Ethiopia.

[iii] Multidimensional child poverty was measured using UNICEF's Multiple Overlapping Deprivation Analysis (MODA) methodology as detailed in de Neubourg, C., Chai, J., de Miliano, M., Plavgo, I., and Wei, Z. (2012). For children five, indicators across dimensions of development, health, nutrition, information, child protection, water, sanitation, and housing were used in the analysis, whereas for children age 5-17 years,indicators in dimensions of nutrition, education, information, child protection, water, sanitation, and housing were used.

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[vii] UNICEF, PSI and ODI (2019): Ethiopian children's voices and views on urban child poverty. Available at: https://www.unicef.org/ethiopia/media/2981/file/Report%20.pdf

[viii] During project implementation.

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