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CATI COVID-19 RAPID GENDER ASSESSMENT

Highlights

ETHIOPIA | 2020

UNITED NATIONS HUMAN RIGHTS OFFICE OF THE HIGH COMMISSIONER

ETHIOPIA

Highlights of COVID-19 Rapid Gender Assessment

BACKGROUND AND CONTEXT

In February 2020, the World Health Organization (WHO) declared COVID-19 a public health emergency of international concern. The first confirmed case in Ethiopia was reported in March 2020 and a state of emergency declared in April. This led to a ban of inter-regional public transport and public gatherings, countrywide school closures, and the introduction of public health measures to reduce person-to-person transmission of the novel coronavirus.

By mid-November, 103,928 positive cases had been identified in Ethiopia with 1,601 deaths reported[1]. During this time, Ethiopia was also dealing with social unrest and internal political conflicts, a relatively high internally displaced population, deportation of Ethiopian migrants from countries in the middle East and elsewhere, floods, and a locust plague that adversely affected food security in the region.

Since the expiry of the state of emergency in September, parts of the economy and education sector have gradually reopened; approximately 30% of schools reopened at the end of October.

From early in the pandemic, signs of the differential impacts on women and men began to emerge. UN Women, in partnership with the Office of the High Commissioner of Human Rights (OHCHR), commissioned IPSOS to execute a survey in the period 10th September to 7th November 2020.

Due to movement restrictions, traditional in-person surveys and other forms of social research were limited, and the rapid gender assessment was designed as a Computer Assisted Telephone Interview (CATI) survey for the period September 10th to November 7th, 2020. Highlights of the emerging report are presented in this publication.

Goals and expected outcomes

The overall goal of the assessment was to produce disaggregated data on the impacts of COVID-19 on women and men in Ethiopia. Specifically, the survey was aimed at collecting data on the impact of COVID-19 on several sectors including economic, food security, health, and education.

[1] WHO/John Hopkins data on 18 November 2020.

The study also aimed to produce data disaggregated by sex, age and location of residence (rural, semi-urban, and urban) on the impact of COVID-19; to test a core set of questions that can potentially be used in a global survey on the impact of COVID-19 on gender-based violence (GBV); identify appropriate program interventions to improve the well-being of women and men, including robust recovery and resilience efforts; and identify messages for advocacy purposes to improve the well-being of women and men.

The expected outcome is that the evidence collected will help to ensure gender-responsive national response, advocacy, recovery and resilience plans and institutional interventions. Replicating several standard questions will also enable UN Women and partners to produce an Eastern and Southern Africa regional analysis that will increase the understanding of differences between countries and provide opportunities for regional interventions.

Overview of methodology

Given the nature of the pandemic and difficulties associated with collecting quality statistical data, using typical statistically sound methodologies, UN Women Eastern and Southern Africa Regional Office (ESARO) has conceptualized a uniform data collection methodology for Rapid Gender Assessments (RGAs) across the region. Developed in partnership with the UN Women Kenya Country Office (CO), UNFPA, and other partners, the omnibus of generic questions was used for the Ethiopia CATI RGA on COVID-19. The UN Women Ethiopia CO provided expertise in refining the tools and updates to accurately reflect the local context.

The Ethiopia survey covers a broad range of topics using two generic questionnaires to fit the 20-minute interview time limit and minimize respondent fatigue. The questionnaires covered: demographics, economic activities, agriculture, and education; and demographics, contextual questions on GBV[2], and GBV. The questionnaires, which comprised only multiple-choice and scale-based answers, were adapted as necessary to better reflect the local context.

A sample of 2400 women and men aged 18 years and above were selected through a process of random direct dialing (RDD). An existing database was applied to fill gaps in the quota framework, for example, for older women based in rural areas when RDD no longer yielded sufficient respondents. Where possible, the same respondent was interviewed for both questionnaires. If not available for the second interview, the respondent was replaced with someone of similar demographic characteristics. Soft quotas were applied after data collection by rural/urban and average household month expenditure prior to COVID-19. The margin of error is +/-2.0% at 95 percent confidence level for reporting at national level.

Study focus, limitations, and ethical considerations

Research analysis and recommendations highlighted the needs of the identified population with special focus on disadvantaged groups of women, i.e., women living in rural areas, and women of different age groups based on the identified impact of the pandemic on them. Unfortunately, the sample size was too small to properly measure and disaggregate data by disability status.

The study was executed with high sensitivity to confidentiality and anonymity considerations with ethical and safety principles followed to ensure that no harm, risk, or distress were imposed on women and men who participated in the remote exercise. Informed consent was obtained from each participant and the safety of interviewers was ensured in line with COVID-19 protocols.

[2] These included questions on issues such as changes in economic activities and income, health, human rights, safety, and security from a GBV perspective.

RESULTS OF THE GENDER RAPID ASSESSMENT SURVEY

The study produced disaggregated data on the topics of economic activities, food security, education, safety and security, access to information, access to water and sanitation, and effects on GBV since the start of the pandemic. Highlights of the findings are presented below.

Economic activities, household income, and other resources

A quarter of the Ethiopian population aged 15 years and older is estimated to be living in extreme poverty in 2020, with estimates of 25.7% for women and 26.4% for men. This represents an increase of approximately 2 percentage points from 2019 estimates[3].

The gender rapid assessment finds that the economic activities of approximately 7 out of 10 respondents changed due to COVID-19 with women and men in a worse position as a result of the pandemic and associated measures.

Employment status: The percentage of women who worked for someone for pay decreased from 38.2% in March 2020 to 29.4% while the same data for men showed a similar drop from 45.1% prior to COVID to 35.9% during the pandemic. The number of women who went into business/freelance work with no employees rose from 14.8% prior to the onset of COVID-19 to 16.6% at the time of the survey. The same was observed for men, albeit with a negligible rise from 19.4% to 19.5%. The proportion of women in business/freelance engagements with employees decreased from 11.7% to 10.6% and from 11.3% to 10.1% for men.

Engagement in non-agricultural casual work/odd jobs rose for women (3.7% to 4.4%) and men (5.8 to 7.7%) between March and September 2020. These changes can possibly be attributed to the loss of formal jobs, which caused employees to migrate to this sector.

[3] UN Women Covid-19 gender monitor, *https://data.unwomen.org/resources/covid-19-and-gender-monitor, accessed 19/11/2020*

Around **80%**

Women and men who were in paid fixed-term employment prior to COVID-19, remained in paid fixed employment.

There was an overall decline in the number of paid economic activities that the respondents reported engaging in.

Women, previously in paid employment, were more likely than men to transition into unemployment or into the 'not employed' category (i.e. not available to work, busy with unpaid care work, etc.).

Of those who lost their jobs;

7%

Of **women** managed to transition to other economic activities.

13%

Of **men** managed to transition to other economic activities.

Changes in individual income and levels of financial difficulty: Women and men were nearly equally affected by declines in personal incomes, as approximately 6 out of 10 individuals experienced individual declines and 7 out of 10 reported declines in combined household incomes. A total 37.4% (women) 35.7% (men) reported no changes in income since the onset of COVID-19.

Respondents over the age of 55 years were the least affected by individual changes in income levels. Nearly two-thirds (63.9%) of women aged 35-54 years reported a decrease/downsize while men aged 18-34 years were similarly affected negatively (64%).

Women respondents residing in semi-urban areas reported the highest level of financial difficulty during COVID-19 while the lowest reports (43.9%) were recorded from women residing in rural areas. By contrast, the highest proportion of respondents who reported "no difficulty" during COVID-19 were rural women (39.0%) and men aged above 55 years (32.1%).

Other related difficulties: Women residing in semi-urban areas also reported the highest occurrence of family separation due to cessation of movement/quarantine (15.3%) in contrast with women aged over 55 years and men in rural areas who reported approximately half that occurrence at 7.6% and 8.1% respectively.

The eating habits of women aged 18-34 years were more likely to be negatively impacted than men of the same age, with 11.1% reporting that they had to eat less or skip a meal because of lack of money or other resources during the pandemic compared to 5.3% of the men.

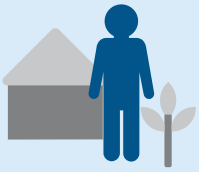
Food security

Nearly 9 out of 10 respondents indicated that the prices of the food they normally buy increased during COVID-19. Women and men were equally likely to experience problems with increases in food prices, but those living in rural areas were the least likely to say that food prices increased. Men aged 35-54 years and men in semi-urban areas (90.3% and 89.3% respectively) reported being most heavily affected by increases in prices of food they usually bought at the local market/shops since the onset of COVID-19. On the other hand, women in rural areas reported the highest incidence of prices remaining the same (25.9%). Women and men in rural areas and women aged over 55 years were moderately affected by increases in food prices at 80.7% and 79.8% respectively.

Nearly 9 out of 10

87% Women and **men** indicated that the prices of the food they normally buy increased during COVID-19.

Women and men were equally likely to experience problems with increases in food prices, but those living in rural areas were the least likely to say that food prices increased.



80%

Men in rural areas

Were moderately affected by increases in food prices.

81%

Women aged **over 55 Years**

Were moderately affected by increases in food prices.

Education

TV (38%), print media (34%) and WhatsApp (21%) were the dominant mechanisms used by girls and boys aged 7-14 years and residing in urban areas to study during COVID-19 in stark contrast to their rural-based peers, majority of whom applied no study measures (44%), or used print media (39%) and radio (16%) to study. Urban-based girls and boys were more likely than their semi-urban and rural peers (13%, 4% and 1% respectively) to use online learning platforms. The distribution of use of the various mechanisms between sexes was relatively even with the greatest disparities registering at 4% for online learning platforms (girls at 7% and boys at 11%) and 3% for TV (girls at 36% and boys at 33%).

Lack of a skilled instructor/adult in the house (girls 18% and boys 22%) and lack of a conducive environment (girls 18% and boys 23%) were considered significantly more of a challenge than increased household chores for the learners (girls 12% and boys 11%) and multiple roles of the parent/guardian (girls 7% and boys 8%).

40% Girls **39%** Boys

Lack of electricity/source of lighting was the most frequently cited challenge to continued learning.

29% Girls **31%** Boys

Experienced limited access to the Internet.

27% Girls **20%** Boys

More girls than **boys** cited limited access to learning materials (e.g. books) as a challenge.

Burden of care and unpaid care work

Before the onset of COVID-19, women respondents were responsible for the majority of domestic tasks namely: food and meal management and food preparation (65.3%); cleaning (59.8%); shopping for own household/family members (62.7%); collecting water/firewood/fuel (51.4%); minding children without doing something specific for them (43.7%); playing with, talking to and reading to children (41.1%); instructing, teaching, training children (41.0%); and caring for children, including feeding, cleaning, and physical care (41.4%).

Little external help for house chores

Only a small number of women and men rely on external help (domestic worker, nanny or nurse) to carry out chores in the house.

47% Women **52%** Men

Majority of women and men indicate that they have not been receiving any additional help since the onset of COVID-19.

Women also did the lion's share of other domestic work such as: assisting elderly/sick/disabled adults with medical care, feeding, cleaning, physical care (19.8% compared with 6.4% of men); assisting elderly/sick/disabled adults with administration and accounts (20.5% compared with 7.5% of men); and affective/emotional support for adult family members (29.9% compared with 22.5% of men).

During this time, both women and men reported spending an increased amount of time on domestic chores related to cleaning (women 54.3% and men 51.6%) Both sexes also reported significant increases in responsibilities related to minding children without doing something specific for them (42.6% and 45.1%), playing with, talking to and reading to children (45.5% and 46.0%), instructing, teaching, training children (42.2% and 44.2%) and caring for children, including feeding, cleaning, and physical care (44.8% and 46.5%).

More women (40.4%) than men (31.9%) reported increased food and meal management and food preparation responsibilities and more than 2 in every 5 women (42.9%) indicated that their responsibilities in food and meal management and food preparation remained unchanged since the onset of COVID-19. An equally high proportion was observed for men, approximately half of whom responded similarly. This can possibly be attributed to the fact that women were largely responsible for cooking and preparing family meals before the pandemic, which still remains the case. However, a significant number of women (36.2%) and men (32.1%) indicated that the time they devoted to helping/supporting non-household members in the community/neighborhood has decreased since the onset of COVID-19.

Women reported that their daughters were nearly twice as likely to help them with household chores (24.7%) than their sons (12.5%). A similar number of men respondents (10.7%) reported that their sons assist with household chores while 27.6% of men indicated that their partners help them with household chores.

Water and Sanitation

Since the COVID-19 virus is highly contagious, one of the preventative measures is frequent handwashing and improved general hygiene. With most citizens more housebound during the period of movement restrictions, the demand for water also increased.

In general, the majority of women surveyed (74.8%) indicated that they had access to clean and safe water while only 6.2% flagged this as a challenge. However, rural women experienced the greatest challenge in accessing clean and safe water (29.7% reported they had no access), while 19.0% confirmed that they had some access to clean and safe water. Urban-based women and men had the highest access to clean and safe water (78.3% and 69.1% respectively). More than half (51.6%) of the respondents blamed their limited or altogether lack of access on the water supply schedule which only makes piped water available on certain days of the week. Only a small proportion (0.3%) cited fear of COVID-19 and water sources being closed due to the pandemic (0.6%) as reasons for limited or no access to water.

Access to clean, safe water

15% Respondents said that access to clean and safe water has always been a challenge.

15% Respondents identified the long distance to the source as the reason for limited or no access to water.

Sources of and access to information about COVID-19

The potential rapid spread of the disease made civic education and access to information about the modes of transmission and preventative measures critical.

A whopping 99.9% of all respondents confirmed that they have received information about COVID-19 prior to the survey. Whereas a large majority (94.2%) pointed to mass media (radio, television and newspapers) as their source of information about the pandemic, a moderate proportion pointed to community health workers (20.4%) and phone calls and text messages (19.4%) as their sources of this information. The internet as well as community (family and friends) also played a big role in providing information about the pandemic (43.9% and 26.7% respectively).

Health and health-seeking behavior

While more than 60% of all respondents reported that their own mental or emotional health[4] had been negatively affected since the onset of COVID-19, women respondents in general and women aged 18-34 years in particular reported the highest negative impact (63.6% and 64.8% respectively) on their mental and emotional wellbeing during this time. In general, men were moderately less affected than women with less than 60% of men in all age groups reporting that the pandemic had affected their mental and emotional health. The incidence was recorded at 55.9% for men aged 18-54 years (the lowest across sex and age), and at 56.8% for men aged 55 years and above.

[4] Mental or emotional health was categorized as issues relating to stress, anxiety, confidence, etc. for this survey.

Women in general reported being more anxious about getting COVID-19 than men across the board with the incidence recorded at 61.0% and 56.2% respectively. Most of their anxiety has been around fears about contracting COVID-19. The highest incidence of worry about contracting the disease (63.9%) was recorded both among women aged 18-34 years and men residing in urban areas followed by women in semi-urban areas (63.1%), women aged 55 years and above (62.9%), men in rural areas (62.9%) and women in urban areas (62.0%). Women in rural areas were least concerned about contracting the disease (44.4%).

Worries about death (30.5%), access to food (23.2%) and access to medicine (23.3%) also came up frequently as did concerns about

61%

Women were anxious about getting COVID-19 compared to **56%** of men

32%

Respondents cited missing school as the next major concern after fears of contracting COVID-19.

17%

Respondents indicated they have not been worried about any issue since the onset of the pandemic.

other health issues (22.6%) and safety related to the crisis (17.6%). The assessment found that overall, only 18% of the respondents have some form of health insurance with only 14.4% of women respondents and their households covered by health insurance compared to 23% of men.

In terms of health-seeking behavior, the majority of respondents (55.1%) did not seek or need medical care during the period (women 52.3% and men 58.1%). A small proportion of respondents polled (3%) indicated that they opted to self-medicate for fear of contracting the illness at a healthcare facility. The study also found that women were more than twice as likely as men to self-medicate during this period than men (4.0% of women polled compared to 1.9% of men). Most of those who needed to access healthcare services were able to access it.

Of those who were unable to access healthcare services, respondents seeking child healthcare services seem to have been hardest hit with 26.1% indicating that they could not access the services. Respondents seeking healthcare services for chronic illnesses (15.0%) and maternal healthcare services (12.1%) also indicated that they could not access these.

Safety and security

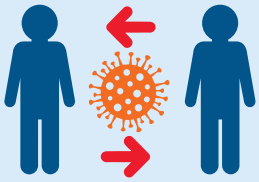
Majority of respondents (58.7%) reported no changes in feelings of safety in the community from threat of violence or violence itself since the onset of COVID-19. Hardly any difference was noted in the feelings of safety reported by women (57.4%) and men (59.9%). An equal number of women and men (31.2%) reported feeling less safe since the onset of COVID-19 with 10.2% of all respondents reporting that they felt safer from threat of violence or from violence itself.

Among those who felt less safe, women residents of semi-urban areas reported the highest percentage (40.4%) while 74.7% of women aged 55 years and above registered the highest proportion of respondents who felt the same level of safety as before the pandemic. Men in semi-urban areas recorded the highest proportion of respondents who reported feeling safer (14.2%).

A large majority of respondents (92.0%) reported that they had not personally experienced violence or threats of violence by the police or security agents during the pandemic. Women aged 55 years and above reported the lowest incidence of violence or threats of violence by police or security agents during this time (1.2%) while men aged 18-34 years reported the highest at 13.6%. The assessment found that in general, women were least likely to encounter this kind of violence or threats of violence.

59%

Majority of respondents reported no changes in feelings of safety in the community from threat of violence or violence itself since the onset of COVID-19.



41%

Proportion of those feeling unsafe in their homes during this time. The main reason given for this is the **high risk of transmission of the disease**, especially due to the movement of children in high-density neighborhoods, thus making it a top concern. **Women (44%)** were more concerned about this issue than **men (37%)**.

On the issue of discrimination[5] since the onset of COVID-19, the assessment found that 8.3% of the respondents indicated that they experienced discrimination during the pandemic. Men aged 18-34 years were most likely to experience discrimination (10.2%) while men over 55 years were the least likely (4.0%).

When questioned on their perception about changes in discrimination, prejudice or racism in their areas of residence since the onset of COVID-19, most respondents (59.5%) noticed "no change" while men aged 35-54 years reported the largest perceived increase in discrimination. Conversely, a significant proportion of women aged 18-34 years (31.8%) and men in the same demographic (27.5%) reported a decrease in the incidence of discrimination.

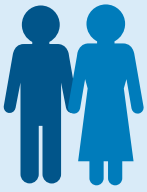
[5] This study defined discrimination as 'anything that happens that makes you feel that you were treated less favorably compared to others or harassed because of your sex, age, disability, socio-economic status, or any other characteristic'.

Most respondents (53.9%) indicated that they were feeling just as safe at home as they did before the pandemic with women registering a slightly higher percentage (54.2%). While 30.7% of respondents felt less safe at home than they did before the pandemic, the number of women with this perception registered slightly higher at 31.9% indicating that women felt slightly less safe at home than men during this time. Indeed, less women (13.9%) than men (16.9%) reported feeling safer.

When probed on the reasons for feeling unsafe in their homes during this time, a high proportion of respondents (40.6%) pointed to the high risk of transmission of the disease, especially due to the movement of children in high-density neighborhoods, thus making it a top concern. Women (43.6%) were more concerned about this issue than men (37.4%). Increase in crime was also a significant concern with 24.2% of respondents saying that this made them feel unsafe at home since the onset of the pandemic. Stigma about having been infected with the disease was the least of respondents' concerns (2.2%), although men were slightly more affected by stigma, which they reported at 2.5%.

Gender-based violence

Regarding the frequency of GBV in Ethiopia, only a small portion of respondents (men in rural areas, 0.9%) reported that it "never happens". Women in urban areas and some men in rural areas held divergent views; a majority of urban women (59.7%) indicated that GBV "happens very often" and a large proportion of rural men (56.1%) indicated that it "happens sometimes". Only 2.6% of total respondents reported not knowing the frequency of GBV in Ethiopia. Regarding potential changes in the occurrence of GBV since the onset of COVID-19, six out of ten respondents felt that the incidence of GBV has increased with more women (68.4%) holding this perception than men (57.7%). Urban-based women (70.2%) and men



57% Women **42%** Men

More women think that GBV happens very often compared to men.

Sensitivities on GBV questions

To reduce the likelihood of potential harm to the respondents, no direct questions about personal victimization experiences were asked. Instead, the assessment sought to establish whether respondents know of anyone who has been a victim of the most common types of GBV presented in a list of since the onset of COVID-19.

(60.5%) were more likely to feel that GBV has increased during the pandemic than rural women (51.6%) and men (52.3%).

The majority of respondents (62%) indicated that they do not know anyone who has been a victim of GBV, with women (62.6%) and men (61.5%) registering nearly identical views. The most common types of GBV that respondents admitted to knowing victims of were sexual harassment (including jokes and suggestive comments) victims of which 17.4% of women and 16.5% of men said that they knew, and emotional abuse including through verbal attacks (both women and men reported this equally at 14.6%). Knowledge of victims of GBV in the form of female genital mutilation (FGM) had the lowest incidence at 2.6% (women) and 2.7% (men).

When queried about perpetrators of GBV, most blame was apportioned to neighbors (28.6% of women blamed neighbors compared to 33.2% of men). According to respondents, spouses and partners ranked fifth on the list of perpetrators (cited by 10.4%) after other members of the community (29.9%), friends (24.3%), and other family members (15.2%). A moderate number of respondents (7.2%) said that they did not know who the perpetrators of the most recent cases of GBV were, while a small number (0.8%) blamed religious leaders, and 0.5% refused to say who they thought the perpetrators were.

Most respondents (29.6%) indicated that victims of GBV were most likely to seek help from the police with 24.5% reporting "no, did not seek help" in reference to the victims. Respondents (14.3%) also identified health facilities as a source of help and mentioned the Women's Affairs office and a family member (approximately 10.0% for each), a helpline (2.1%) and online platforms (0.8%). A small number (0.4%) declined to respond on the health-seeking behavior of victims.

When asked whether they or someone they know would seek help if they experienced gender-based violence or harmful practices, 84% of those surveyed responded in the affirmative and only 12.4% responded in the negative. Slightly more women (85.1%) were of the view that someone they know would seek help if they experienced gender-based violence or harmful practices. According to respondents, the kinds of GBV support most required are legal support (68.8%), medical support (68.6%), psychosocial support (56.8%) and financial support (54.0%).

As to the source and kind of help required if the respondent becomes a GBV victim, most respondents said that they would call or go to the police (81.6%) as the preferred course of action. Going to a health facility was the next favored option (51.9%) followed by seeking support from family (44.3%) and talking with friends (37.3%). Only a relatively small proportion would seek access to friendly spaces for children in the community (15.9%), while a slightly larger proportion would be more likely to seek help and support from community leaders (28.5%), a helpline (25.7%), access centers for women/men (22.7%), or seek out a religious leader (21.4%).

CONCLUSIONS AND RECOMMENDATIONS

Based on the study, it is evident that the COVID-19 pandemic has had diverse and potentially far-reaching effects on the lives of women and men in Ethiopia. Women and men of all ages and in various places of residence have recorded declines in personal and household incomes, forcing many individuals to fall back onto familial and other social support networks.

Wide-ranging effects of COVID-19

The pandemic has affected multiple spheres of life including economic and agricultural activities, food security, the burden of care and unpaid care work, education, and GBV.

While an analysis of the mechanisms used by girls and boys to study from home during COVID-19-related school closures did not show significant differences between the sexes, it exposed fault-lines by location of residence. Children in rural areas were the least likely to have any measures in place to continue learning during this period. Even though some children continued learning, the disruptions across the education system will continue to be felt in the coming years. Catch-up support to children in rural settings and those from disadvantaged families will be particularly important.

Even though the study did not specifically measure the incidence of teenage pregnancy, anecdotal evidence suggests that this may have increased during the pandemic. Special programs aimed at ensuring that affected girls are re-absorbed into the education system to continue their learning should be made.

Prior to COVID-19, women overwhelmingly bore the brunt of unpaid domestic and care work. This changed during COVID-19 as both women and men reported increases in the amount of time they were spending on unpaid domestic and care work. It is quite significant that the support received by women from their partners and other household members for unpaid domestic and care work increased during the pandemic and that nearly half of the men reported spending more time on unpaid domestic and care work. This could be the seed for more targeted campaigns to build on this positive outcome of the movement restrictions to further encourage men, girls, and boys maintain the momentum and help reduce women's unpaid domestic and care work burden.

In as much as nearly all respondents attested to receiving information about COVID-19 prior to the survey, the way women and men sourced information during the pandemic reflects the general gap in ICT use between women and men. Efforts to bridge this gap across all spheres of life need to be strengthened and expanded.

From a mental and emotional health perspective, the pandemic and its associated movement and social distancing restrictions as well as economic consequences have placed a lot of strain on individuals and households. Women reported a higher incidence of negatively affected mental and emotional health during the pandemic. In addition, even though problems related to child healthcare services were flagged by slightly less than one in five respondents, it was a problem experienced by more than a third of women who had problems compared to 18.6% of the men, again possibly pointing to the burden of care.

There has been some increase in feelings of unsafety due to violence or threats of violence during the with women living in semi-urban areas seeming to be more vulnerable than other groups. This needs further investigation using police and other records so that location-specific advocacy and communication programs can be developed.

GBV is complex and difficult to measure. Given the dynamics of remote interviewing using CATI, GBV questions mostly focused on perceptions or an account of GBV experiences of someone that is known to the respondent rather than the respondent's own experience. Women were significantly more likely than men to think that GBV is a big problem in Ethiopia and that its incidence has increased since the onset of the pandemic.

Even though the study steered clear of trying to measure direct victimization, perceptions about the seriousness of GBV as well as third-party reported incidences suggest that this area needs continued programmatic support and interventions aimed at increasing advocacy, awareness of and access to helplines, and providing shelters as well as economic alternatives especially to women affected by violence.

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