Cash transfers and COVID-19: Experiences from Kiryandongo, Uganda

Mini-report- Round 3 of 3

December 2020

Scenes from Kiryandongo refugee settlement, Uganda.
Photo Credits: Heather E Lanthorn, January 2020

SUMMARY[1]

This report reflects an October 2020 snapshot of our work in the Kiryandongo Refugee Settlement in Uganda, exploring the effect of cash transfers on health and household welfare outcomes during the COVID-19 pandemic. In this last of three rounds of ~35-minute structured phone interviews, we interviewed 652 refugee respondents between 19 and 30 October 2020. We conducted Round 1 data collection from 6 to 28 July 2020 and Round 2 from 18 August to 14 September 2020. These phone surveys are layered onto an on-going randomized evaluation of a 1000 USD cash transfer to households registered in the settlement. The treatment group has already received their transfers, while the control group will receive a transfer in 2021. Some of the key findings in this third round include:

Perception of COVID-19 and compliance with COVID-19 public health measures
Perceived likelihood of contracting COVID-19 and mask wearing stayed steady over time (at 60% and 85% respectively in October 2020). However, recognition of asymptomatic transmission and self-reported social distancing dropped since July 2020, from 47% for both asymptomatic transmission and self-reported social distancing to 33% and 32%, respectively, in October 2020.
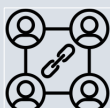
Food security
Households that received cash transfers reported being less food insecure compared to households that are yet to receive cash transfers. However, most households across groups reported cutting down the size of meals or skipping meals in the last seven days.

Alcohol consumption
Overall, respondents had mixed opinions on whether and how alcohol consumption had changed since baseline or since lockdown. **More male respondents (28%) reported consuming alcohol in the last month compared to female respondents (16%).** There was no statistically significant differences in drinking behavior among treatment and control households.

Social cohesion
Respondents reported that they **felt good about inter-refugee and refugee-host relations. Compared to October 2019, refugees reported that inter-refugee and refugee-host relations have improved.** However, most respondents noted that overall, the host community treated refugees unfairly with the pricing of goods in markets run by Ugandans.

CONTEXT
KIRYANDONGO REFUGEE SETTLEMENT

Uganda is one of the world's leading refugee-hosting countries. This study focuses on households registered in the Kiryandongo refugee settlement, initially established in the 1970s and located in Uganda's Western Region. This ~10,000-household settlement is situated on formerly cleared ranch land, adjacent to Kiryandongo district's commercial centre, Bweyale. According to the United Nations High Commissioner for Refugees' (UNHCR) Kiryandongo settlement profile, most households (99%) are from South Sudan and are predominantly ethnically Nuer, Dinka, or Acholi/Luo, though over ten languages are spoken. Most refugees arrived after 2014, which marked South Sudanese independence and the ensuing civil war.

As of late-2019 (when we collected baseline data for the on-going randomized evaluation), many people in the settlement were making a living through casual labour, running small enterprises, or depending on remittances from abroad and food rations from organizations like the World Food Programme (WFP). At the time of this round of data collection, GiveDirectly operations had been paused by the Ugandan government and no cash transfers were taking place. In terms of other sources of food and aid, respondents had received WFP food or cash in September 2020, which was intended to last two months. Maize was harvested in July and August 2020, with a second harvest expected in November and December 2020.

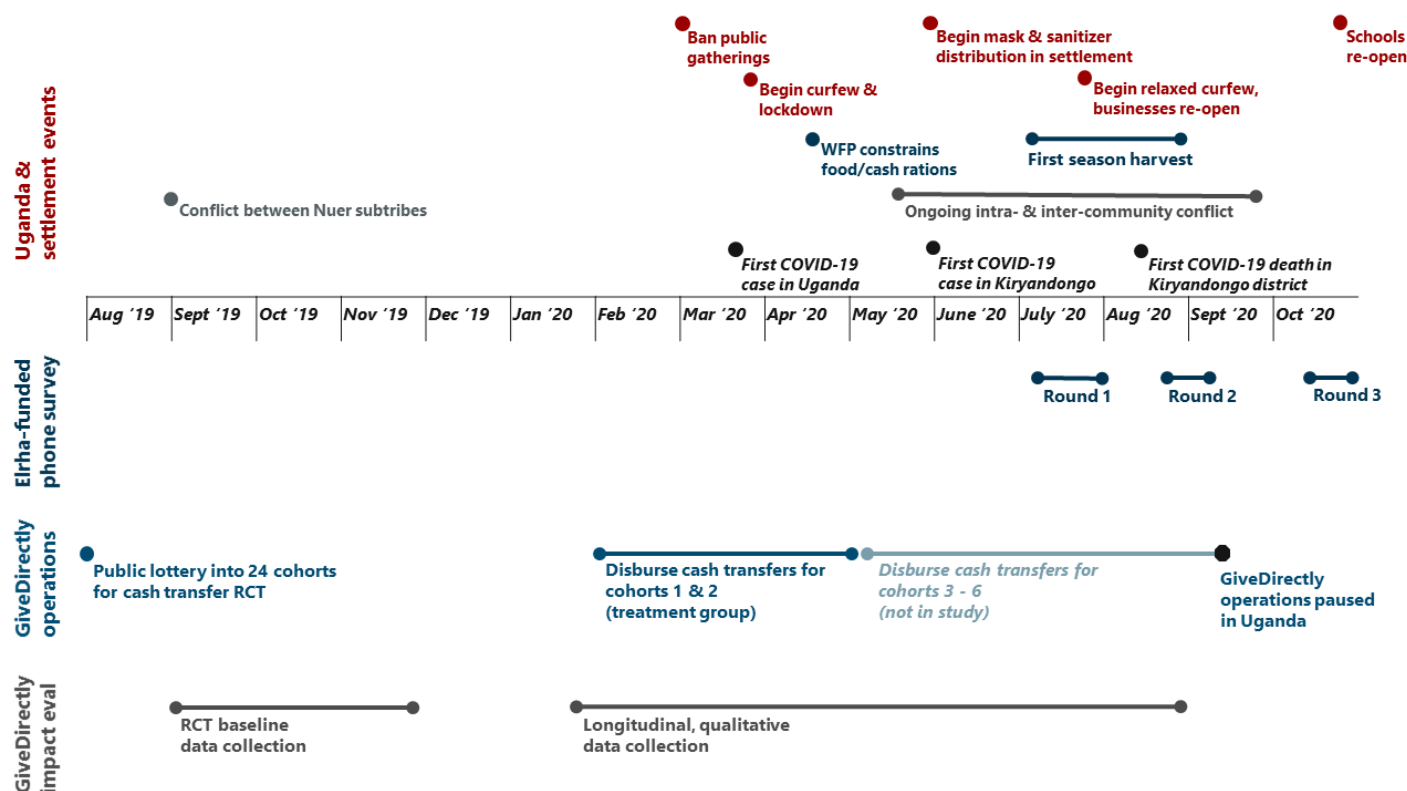*A house in Kiryandongo.Photo credit: Heather E Lanthorn, February 2020*

COVID-19 IN THE SETTLEMENT

On 30 March 2020 — as shown in Figure 1 — Uganda entered a nationwide lockdown to prevent COVID-19 spread, restricting almost all movement and commerce within the country, as well as across international borders. In June, the Government of Uganda, the United Nations High Commissioner for Refugees (UNHCR), and some NGOs also started issuing masks and small bottles of sanitizers to people in the settlement. By October 2020 — the time of our last round of phone surveying — the government had announced a phased reopening of schools, starting with students in final-year classes and finalists in tertiary institutions and universities from 15 October.

Additionally, in October, non-essential businesses, such as hair salons and shopping arcades, were allowed to open, and motorcycle taxis (boda bodas) could operate again. The government had also allowed religious gatherings to take place, with a maximum number of 70 people per gathering. By October 2020, only one COVID-19 related death had been reported in Kiryandongo.

A COVID-19 inter-agency rumor tracking report, based on staff observations by Ground Truth Solutions, highlighted that a majority of people in refugee settlements in Uganda downplayed the risks associated with COVID-19. The report noted that most people were convinced that the government is exaggerating the risk of COVID-19 for political gain, that the virus does not exist at all, and that it only affects older persons.

Figure 1: Timeline of studies and COVID-19 related events

ABOUT THIS STUDY

The goal of this set of phone-based surveys is to understand the current state of welfare and health outcomes among households registered in the Kiryandongo refugee settlement and to explore the impact of having received a large cash transfer on each of these parameters.[1]

ROUND 3 DATA COLLECTION

In this third and final of three rounds of short[2], structured phone interviews, we focused on COVID-19 attitudes and behaviour, food security, alcohol consumption, and social cohesion.

We hypothesized that households who have received large cash transfers (treatment) before the March lockdown would, relative to control:

- Show higher adherence to public health directives
- Report higher food security outcomes

In addition, we explored social cohesion and alcohol consumption. We took some measure of both of these at baseline and we decided to explore them again as they came up regularly in our longitudinal qualitative work. For the most part, we asked about respondent understandings of what was happening in the settlement at large — this allows for triangulation with our qualitative work but not for treatment-control comparisons. In some cases, we can explore differences between baseline and this survey. From qualitative interviews, alcohol consumption came up when we asked about negative consequence of the transfer, and we wanted to quantitatively understand how widespread alcohol consumption actually is, and understand better if the cash transfer could be driving higher alcohol consumption.

Data collection for this round took place from 19 to 30 October. A team of eleven enumerators conducted these interviews, covering Acholi, Dinka, Juba-Arabic, Nuer, and Bari languages. Eight of our eleven enumerators are South Sudanese refugees living in or near the settlement.

FOUNDATIONAL STUDY

From February to September 2020, GiveDirectly rolled out 1000 USD unconditional cash transfers to all refugee households using mobile money. Transfers were delivered to the registered head of household; in our sample, 75% of households are headed by a woman. Our treatment group consists of those who received their transfers starting from February 2020 (see Figure 1); control households will receive transfers in 2021.[3]

The on-going impact evaluation also includes a longitudinal qualitative component. For this report, we complement our phone survey data with both the RCT baseline data (Sept - Nov 2019) and this qualitative data (January - August 2020). Further data collection details are in Appendix 2.

SAMPLE

Our phone survey sample (n=652 for Round 3) was drawn from a larger, on-going randomized control trial (RCT) with GiveDirectly; this larger study (n=1,264 at baseline) was randomly sampled from the ~9,000 households that did not have Persons with Specific Needs (PSN), registered in Kiryandongo settlement. More specifically, we attempted to reach 1,060 baseline households for whom we had a phone number. Out of these households, 652 consented to participate; five declined to participate and 403 did not pick up or were unavailable on the phone in Round 3.

We reached a different mix of households during Round 3 compared to Round 1 and Round 2, detailed in Table 1 below, but maintained balance between treatment and control households on key baseline characteristics such as gender of household head and ethnicity of respondents.

In Round 3, 76% of our sample households were female-headed.[4] Households have spent an average of 6 years in the settlement and have an average of 9 members per household. Respondents represent the main ethnic groups in the settlement: Acholi/Luo (21%), Bari (13%), Dinka (25%), and Nuer (19%).

Table 1: Number of respondents in the treatment and control groups called during Round 1, 2 & 3 of phone surveys

Description	Treatment	Control	
Responded during Round 3 (total)	340	312	652
Responded during Round 2 (total)	330	303	633
Responded during Round 1 (total)	322	308	630
Responded during 3 but not Round 1 and Round 2	113	102	225
Responded during at least two of three rounds	342	311	653
Responded during at least one of three rounds	485	456	941
Responded in all three rounds	165	156	321

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3 Cash transfers were paused in September and at the time of this Round 3 survey in October 2020, 25% of the households across the settlement had received their transfer. The rest of the households will continue to receive transfers contingent on the government's decision to allow GiveDirectly to resume operations.
4 During phone calls, we spoke to household heads when possible and if the household head was absent, we spoke to an alternate adult member of the household.
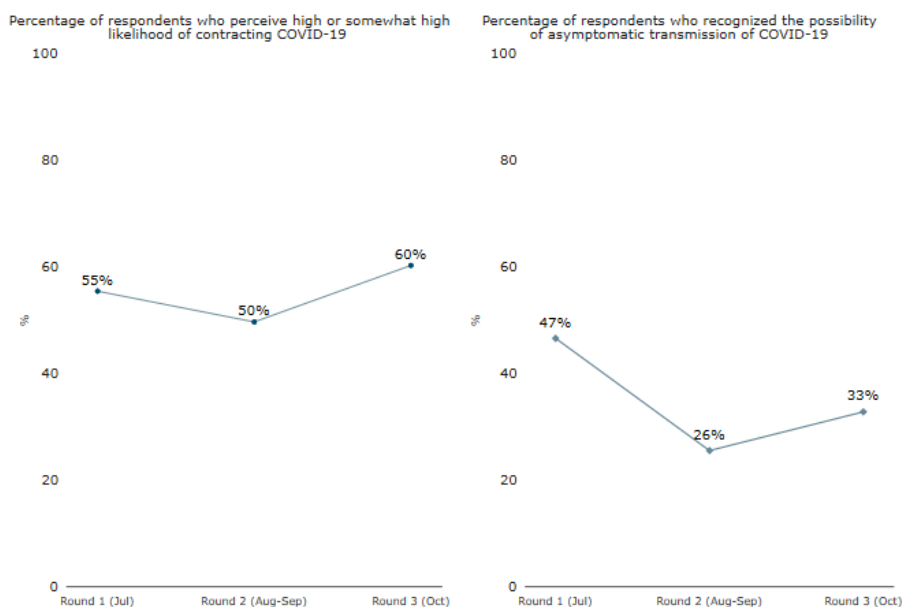
FINDINGS

In this section, we present brief findings for each of our areas of inquiry. For notes on the analysis, please see Appendix 2. For many findings, we report the sample average and then disaggregate most by both respondent's sex and the respondent's ethnic group (for COVID-19 knowledge and practices, food security, and social cohesion). We include this disaggregation because we hypothesize that these groups may have different experiences, including the ability to access COVID information and other services in their preferred language. We also provide information on differences in outcomes for our treatment and control groups, representing the impact of having received a large cash transfer before the lockdown. Please note that for this rapid mini-report, we have not corrected for multiple hypothesis testing, so results should be taken as preliminary.

PERCEPTIONS OF RESPONDENTS ON COVID-19

In Round 3, 60% of respondents perceived their likelihood to contract COVID-19 to be highly or somewhat likely. While there have not been large changes over time, this perception is the highest we have measured since July 2020.

Figure 2: COVID-19 perceptions on the likelihood of contraction and asymptomatic transmission over time
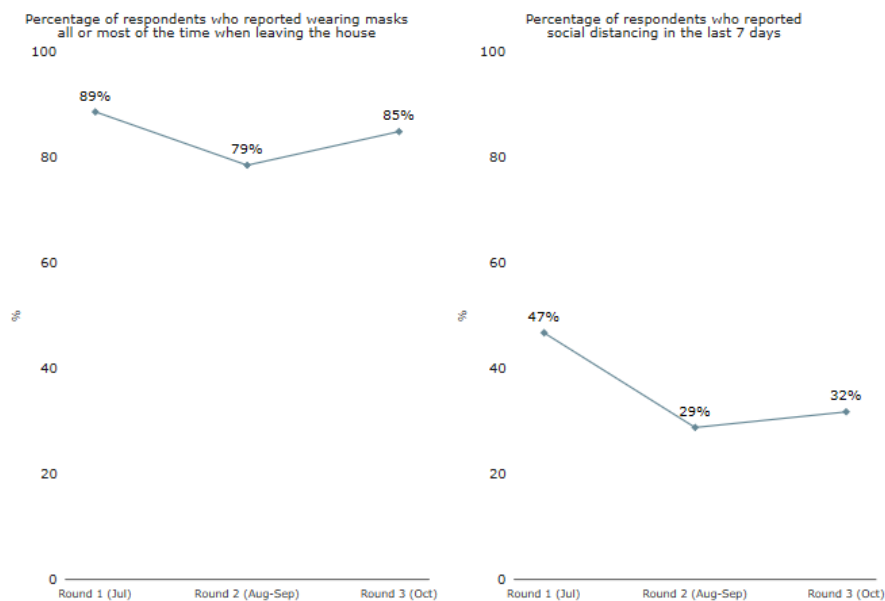
In Round 3, **most respondents felt highly (39%) or somewhat likely (22%) to contract the virus.** On the other side, one-third of respondents felt relatively protected from the virus: 15% felt a little bit likely, and 20% felt not at all likely to contract COVID-19. As we show on the left in Figure 2, this number has been fairly consistent, with people feeling slightly more vulnerable to the virus now than in previous rounds. Slightly more treated respondents (64%) felt vulnerable to the virus relative to control (56%) (p=0.1). There were no notable differences in risk perception by gender or ethnic group.

To assess knowledge of asymptomatic transmission, we asked whether someone infected with COVID-19 would have symptoms that could be heard or seen. As we show on the right in Figure 2, **less than half of the respondents recognized the possibility for asymptomatic transmission in each round.** This could lead people to not take preventative measures when they are actually needed. As we show on the right in Figure 2, this number seems to have declined since July 2020. In Round 3, one-third of respondents said that people infected with COVID-19 sometimes have observable symptoms; an additional 41% noted that people with COVID-19 always have observable symptoms, and 20% of the respondents reported they never have observable symptoms. There were no notable differences by treatment group, ethnic group, or the sex of respondent or household head.

COMPLIANCE WITH COVID-19 PUBLIC HEALTH MEASURES

Across survey rounds, three-quarters (or more) of respondents reported always or mostly wearing masks when they go out. In October 2020, 85% of respondents who reported going outside also reported wearing masks over their noses and mouths on all or most of the days when leaving their homes — but report lower numbers for others' behavior. In October 2020, respondents reported leaving their house and grounds three days a week on average. About 30% of respondents who mentioned that they left the house reported maintaining social distancing while out, down from nearly half doing so in July 2020.

Figure 3: COVID-19 mask-wearing and social distancing behaviour over time

Self-reported mask-wearing has been high across survey rounds, with 85%of respondents wearing masks all or most of the time when leaving their house and grounds. We show this trend in the left-hand graph in Figure 3. In October 2020, over half (59%) of respondents reported always wearing masks when stepping out in the past seven days; another quarter (26%) reported mostly wearing a mask when out. Only 2% of the respondents reported that they never wore masks when going out. There were no notable differences in reported mask-wearing by treatment group, sex of the respondent or household head, or ethnic group.

While most respondents said they always or mostly wore a mask when going out, **only 11% of the respondents noted that all the people with whom they had interacted outside in the past week wore masks covering both their mouth and nose.** About half (47%) of respondents indicated that most (55%-99%) people wore masks, while 18% noted that about half of the people they interacted with wore masks. These data may be closer to true mask usage than the self-reported data.

Mask wearing is imperfect. **Most respondents (71%) noted that most other people who wore masks did not keep them on all the time.** Fifty-seven percent of respondents said that most people pulled down their masks sometimes; 14% noted that most people pulled down their masks all the time.

In Round 3, most respondents (85%) reported leaving their house and grounds at least once in the past week. On average, respondents reported leaving their house/compound 3.2 of the last seven days, and 21% reported going out each day in the past week. More male respondents (90%) reported leaving the house at least once in the past week compared to female respondents (84%) (p=0.01). There were no notable differences by treatment group or ethnic group.

In October 2020, 32% of those who left the house in the past week were able to maintain social distancing each time they went out. More treated respondents (35%) reported being able to maintain social distancing compared to the control group (29%) (p=0.08). There were no notable differences by sex of the respondent or household head or ethnic group. In the right-hand graph in Figure 3, we show that about half of respondents were socially distancing in July, but this has declined over time since. This may in part reflect the official lifting of many movement restrictions in September 2020.

FOOD INSECURITY

Overall, households that already received cash transfers reported being less food insecure compared to households that are yet to receive cash transfers. However, food security index scores for most households across groups were very low and most households reported cutting down the size of meals or skipping meals in the last seven days.

Most households report being food insecure in October 2020. Low food security is signaled both through adults and children skipping or cutting meals, or going entire days without food. As we show in Table 2, both adults (76%) and children (53%) — under the age of 14 — report cutting or skipping meals in the previous week. Echoing this pattern of consideration toward children, respondents report 43% of household adults and one-quarter of children report skipping at least one whole day of eating in the previous week. In the bottom two rows of Table 2, we show responses related to the consumption of animal protein.[5] On average, households report eating animal protein less than once a week.

Table 2: Percentage of respondents who reported experiencing different food security components and the average number of days a component was experienced.

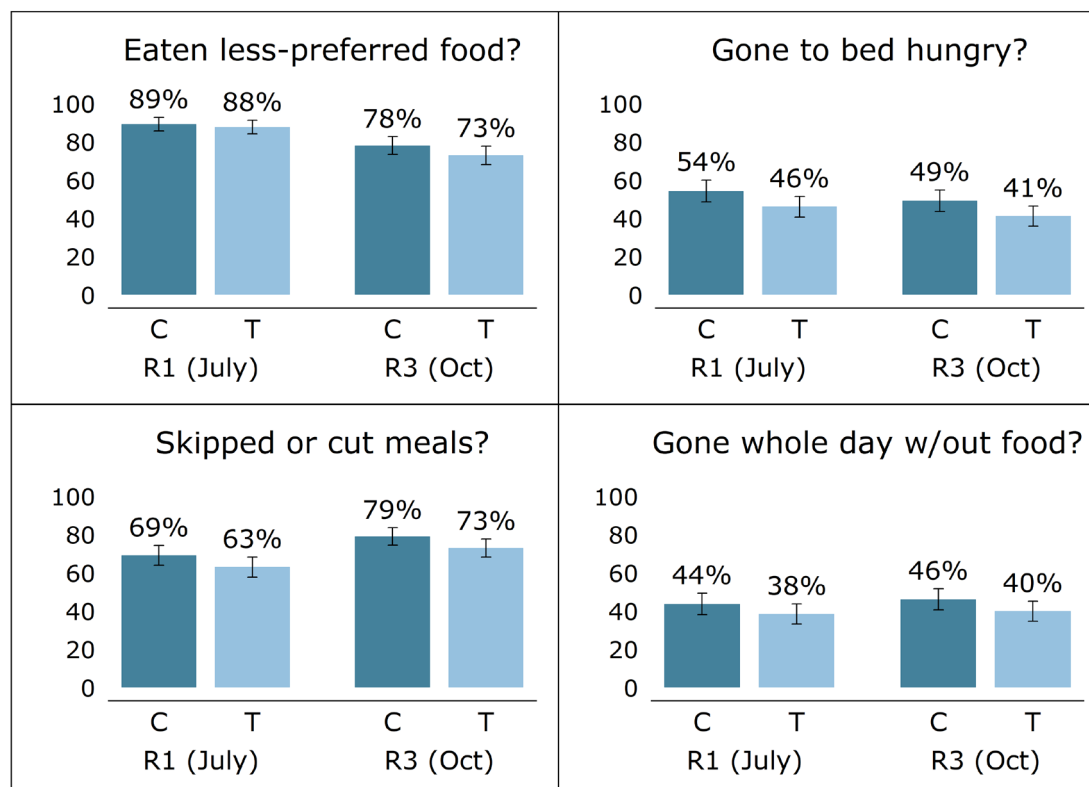|	Percent of respondents reporting experience in the past seven days	The average number of days respondent had experience in the past seven days
Reported food security components		
Adults in the household went a whole day without food	43%	2.5 days
Children under 14 years old went a whole day without meals	25%	2.1 days
Adults in the household that skipped or cut the size of meals	76%	4.1 days
Children under 14 years old cut the size of meals or skipped meals	53%	3.6 days
Dietary diversity		
Household did not eat meat (beef, chicken, goat, pork, etc.), eggs, or fish	61%	6.2 days
Children under 14 years old did not eat meat, eggs, or fish	60%	Not asked

Treatment households were less food insecure than control households and consumed more animal protein. In both Round 1 and Round 3, treatment households had higher scores on our food security index (by 0.19 standard deviations, p=0.02.). In Figure 4 below, we compare elements of the food security scores between households that had already received cash transfers (treatment group) and households that are yet to receive cash transfers (control group) in Round 1 and Round 3. We see that treatment households are less likely to skip meals, go to bed hungry, go whole days without food, or eat less preferred food.

We should note, however, that in Round 2 we did not detect a difference in the total value of food consumed between the treatment and control group. We hypothesize that this is because Round 2 was right after harvest, where there are fewer food shortages.

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5 To allow comparability across GiveDirectly projects, the index is taken from Egger, D, Haushofer, J., Miguel, E., Niehaus, P., and M. Walker. 2019. "General equilibrium effects of cash transfers: experimental evidence from Kenya". Available at https://www.givedirectly.org/wp-content/uploads/2019/11/General-Equilibrium-Effects-of-Cash-Transfers.pdf.

Figure 4: Example components of food security index scores by treatment group during Round 1 and Round 3 of phone surveys

ALCOHOL CONSUMPTION

Respondents had mixed opinions on whether and how alcohol consumption had changed since baseline or since lockdown. Male respondents self-report higher alcohol consumption behavior.

We wanted to better understand drinking behaviour in the settlement — in part because the use of 'temptation goods' is always a point of interest in cash transfer studies but also because alcohol consumption, especially given COVID-19, has come up regularly in our qualitative interviews. Specifically, we wanted to understand drinking behaviour in general, changes due to COVID-19, and whether the transfer seems to change behaviour.

At baseline and during Round 2 phone surveys, refugee households reported consuming very minimal alcohol.[6] We asked respondents how many people among their immediate neighbours regularly drunk alcohol, with 'regular' being at least once a week. **Almost half (42%) of the respondents thought that the majority of the people in their neighbourhood had consumed some alcohol regularly in the last seven days.**

In contrast, **19% of the respondents noted that they or someone in their household had consumed alcohol in the last month.** This contrast also played out in our qualitative data, in which respondents discussed drinking among others but none reported drinking in their own households. **Significantly more male respondents (28%) reported consuming alcohol in the last month compared to female respondents (16%) (p=0.00).**

Nine percent of the respondents reported that they had engaged in binge drinking since October 2019, defined as drinking to a point where it "made you feel sick and you woke up feeling unwell or with a headache." Additionally, **8% of the respondents reported that since October 2019, they or someone in their household had spent more money on alcohol than you/they wish you/they had.**

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6 At baseline, the average amount of money respondents reported spending on alcohol was 2 USD at PPP (Purchasing Power Parity), and accounted for only 0.2% of total consumption. During Round 2 surveys, respondents reported spending an average of 0.4 USD PPP on alcoholic beverages.

More male respondents reported engaging in binge drinking (15%) and spending more money than they wished (13%) on alcohol compared to female respondents who reported binge drinking (7%) or spending more money than they wished (7%). (p=0.01 & p=0.02, respectively). There were no notable differences by ethnic group.

Drawing on both our quantitative and qualitative data, respondents had mixed opinions on how drinking behaviour had changed since our baseline. Roughly a third of respondents held each of the possible positions: 39% thought the proportion of settlement adults consuming alcohol had increased, 32% thought it had decreased, and 28% thought it had stayed the same. Our qualitative respondents paint a similarly mixed picture. While some assert that alcohol consumption stayed the same or increased (particularly at home due to the lockdown), most respondents said that it has decreased due to lack of money or bar closures.

Among those (39%) who noted that alcohol consumption had increased, most attributed the increase in alcohol consumption to increased idleness due to lack of work (55%) and lack of school activities (52%). One man articulated idleness as boredom: "*According to my observation, [drinking] has increased because people are all home and people are bored so people look for ways to kill boredom, so they go onto alcohol.*" Another forty percent also attributed the increase to worries or stress. A woman highlighted the link between limited work opportunities, stress, and alcohol: "*There are those who have finished education but no work, so they take on drinking... The youth are drinking out of job disappointments.*" Finally, 10% noted that people thought drinking alcohol prevents COVID-19.

One woman explained a variety of issues relating to increased alcohol consumption to us: "I think it [drinking] is even more problematic than corona, because the issue of violence has increased during this same period because they are now living together, they see each other more often, so people are taking alcohol more than before. There was even a rumor that it was the cure for corona. They use it as hand sanitizer. So, you hear all sorts of words."
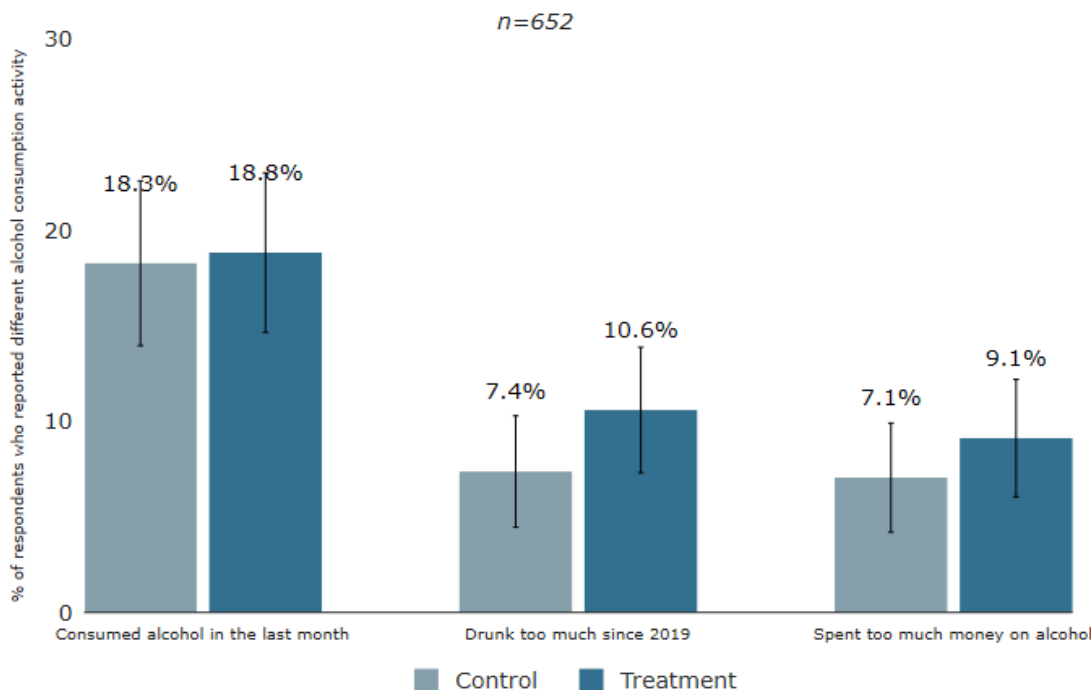
Respondents (32%) who noted that alcohol consumption had decreased largely (69%) attributed the decrease to less money being available to purchase alcoholic drinks. Additionally, 15% of respondents noted COVID-19 restrictions and bar closures led to decreased consumption; this reasoning is reflected by most of our qualitative respondents. One woman explained that "*Before coronavirus, people were allowed to gather in one place and they take alcohol. But the lockdown stopped all that, bars closed, people stay at home.*"

Finally, we wanted to understand the extent to which respondents attributed drinking trends to the cash transfer and whether we see any impacts of the cash transfer on different household drinking behaviours. When we ask explicitly about the large cash transfer and drinking behaviour; **very few (7%) refugees believe the GiveDirectly cash transfer has led to increased alcohol consumption.**

One man explains why the GiveDirectly transfer has not resulted in increased alcohol consumption: "You know money is controlled by women. The majority of the people in the settlement are women. It is very hard for women to take alcohol. Women are the ones controlling the GiveDirectly money in most homes and they know it is the only means of survival they have."

Turning to self-reported behaviour, we considered household drinking behaviour in three ways: any household consumption (in the past month), binge drinking (in the past year), and spending more than desired on drinking (in the past year). In Figure 5 below, we show the percentage of respondents in the treatment and control groups that reported that they or someone in their household had: consumed alcohol, engaged in binge drinking in the last year, or spent too much money on alcohol in the last year. Reported alcohol consumption in the last month was almost identical across those who had received cash and those who had not. Households that had received cash transfers reported directionally higher rates on the other two measures of alcohol consumption, but none of the differences were statistically significant.

Figure 5: Percentage of respondents that reported to have consumed alcohol in the past month, consumed too much alcohol, or spent more money than they wished since October 2019, by treatment group.

Notes: The numbers above error bars represent the means of each group.
Error bars represent the 95% confidence interval (CI) of the means.

SOCIAL COHESION

Overall, respondents reported that they felt good about inter-refugee and refugee-Ugandan relations. Compared to October 2019, refugees reported that both inter-refugee and refugee-host relations have improved. However, most respondents noted that overall, the Ugandan host community treated refugees unfairly with the pricing of goods in the market.

The majority (68%) of refugee survey respondents felt good about current inter-refugee relations in October 2020. On average, respondents reported interacting with at least one person of a different tribe on 2.6 out of the last 7 days, suggesting moderate inter-refugee interaction even during COVID-19.

Over the last 12 months, the majority of respondents (43%) reported the trends of these relations between refugees improved, while 41% noted that the relations had stayed the same. Only 16% of the respondents felt that inter-refugee relations had worsened. However, our qualitative data, which span a longer time period including a time of intense unrest in the settlement, suggest a more complicated picture of those relations.[7] **In our open-ended conversations, the vast majority of refugee respondents reported challenges, tensions, and conflicts between different South Sudanese ethnic groups,** with some "*staying well together*" but others "*quarrelling*" with each other.

While some respondents adopted the rhetoric of "*now we are all one tribe*" in the settlement, others assert that "*the same conflicts that occurred back home in South Sudan, they have still brought them here.*" These can include conflicts between tribes and within sub-clans of the same tribe. In particular, respondents tell us that neighbors use squabbles between children to channel their grievances, that romantic relations between youth of different tribes and sub-clans have caused serious conflicts, and that football matches regularly escalate. One woman explains, "*If [Tribe X] defeats [Tribe Y] in football, that night no sleeping at night. You need to transfer that night and sleep elsewhere. Like for me, if my child has gone to play football and defeats [Tribe Y], immediately they will fill this place, they just want to kill the child, so what is the use?*"

Three quarters (74%) of refugee survey respondents felt good about current refugee-host relations, with mixed opinions on whether they have changed over the past 12 months. Interactions between refugees and Ugandans are limited, with many respondents highlighting that "*here, there are no refugees*" (male host respondent) or "*I haven't met any national*" (female refugee respondent).
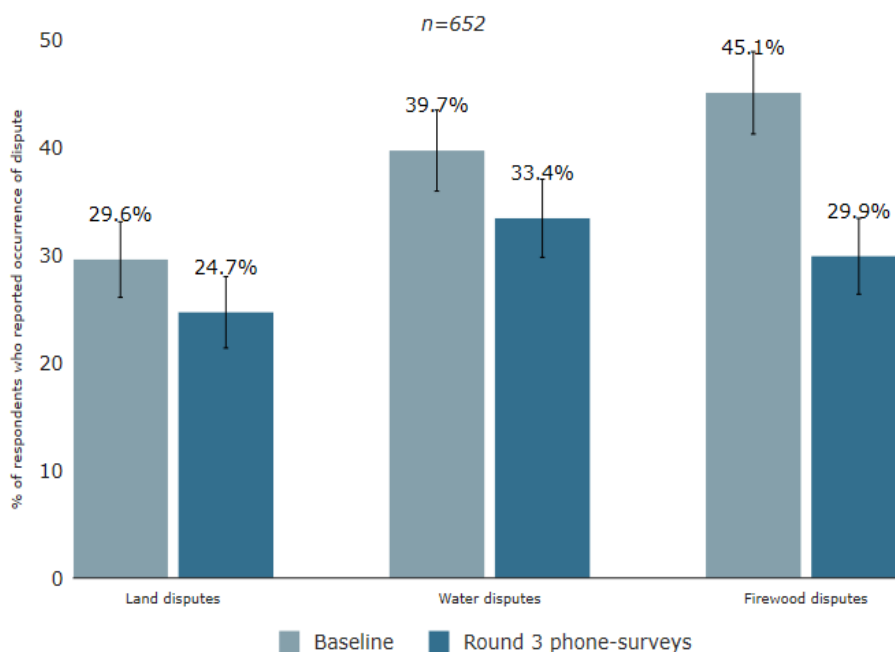
7 See Figure 1 above for the timeline of intra- and inter-household conflicts that had just ended in September 2020.

Within the context of limited interaction, our qualitative findings support the general picture of positive or fair relationships. When speaking in generalities, refugees and Ugandans report that they are "*staying well together*," although some reveal that there are "*some little misunderstandings*."

To dig deeper, we asked about three particular points of potential conflict common in the literature on Kiryandongo: water, firewood, and land. **Over the past twelve months, 65% of the respondents reported witnessing or hearing about different host-refugee conflicts.** Knowing about water disputes was most common (33%), while 30% had heard about or witnessed firewood disputes and 25% about land disputes. One woman explained that "*Ugandans… sometimes grab land from the refugees. You know, they own land, so you hire from them, and sometimes you have agreed to use it for a year, and then when you dig the land for just one season, they come and grab it from you.*"

Half (50%) of respondents reported relations between Ugandans and refugees stayed the same over the past 12 months, while 25% noted that relations had worsened, and another 25% noted that relations had improved. When we ask about specific points of conflict, reported disputes are significantly lower in October 2020 than they were in October 2019, with an especially large drop in firewood disputes. We show this comparison of water, land, and firewood refugee-host disputes reported during baseline (October 2019) and this third round (October 2020) in Figure 6 below.

Figure 6: Percentage of respondents that reported different forms of refugee-host disputes in October 2019 and October 2020.

Notes: The numbers above error bars represent the means of each group.
Error bars represent the 95% confidence interval (CI) of the means.

Another place for conflict, or at least a perception of unfairness, is at a regular site for Ugandan-refugee interaction: the market. **Most respondents (63%) noted that overall, Ugandans treated refugees unfairly with the pricing of goods in the market.** The issue of differential pricing at the market has come up repeatedly in our qualitative interviews with respondents asserting that Ugandans are "*overcharging*" them. Respondents attribute this to two main factors: (1) they point out that many refugees do not bargain, and (2) they stress that Ugandans believe "*that refugees have money.*" Quantitatively, this perception of unfair treatment was stronger among female respondents (66%) compared to male respondents (57%) (p=0.04). There were no differences in perception of unfair treatment by treatment group or ethnic group.

"I think it is because they think the refugees have money. Maybe they got the money from somewhere. Even NGOs are giving them money, and others also took advantage of the sickness [COVID-19] so they hiked their prices. So we don't know which one is which here, because they think we have a lot of money, NGOs are pumping them with money so they hike the prices. Others hike prices because of disease because they know whether people have money or not, they will buy so they hike the price."

APPENDIX 1: HOUSEHOLD CHARACTERISTICS

Table 3: Key characteristics of our phone survey sample (n=652)

Characteristics	Mean	Standard deviation
Household size	9 members	3.40
Time in settlement (years)	6 years	5.52
Male head of households	0.23	0.42
Female head of households	0.77	0.42
Ethnicity-Acholi / Luo	0.21	0.41
Ethnicity-Dinka	0.25	0.43
Ethnicity- Nuer	0.19	0.39
Ethnicity- Bari	0.13	0.34
Other ethnicities	0.21	0.41

APPENDIX 2: METHODS NOTE

RESEARCH OVERVIEW

METHODOLOGY

In May 2020, IDinsight added a phone-based COVID-19 study component to an on-going impact evaluation of GiveDirectly's unconditional cash transfer program in the Kiryandongo refugee settlement, Uganda. This COVID-19 component, funded by Elrha, explored the refugees' current experiences, knowledge, attitudes, and behaviour. It further compared refugee households who have already received their GiveDirectly cash transfer with refugee households who will receive their cash transfer in the near future in order to understand how unconditional cash transfers impact a variety of relevant outcomes, such as health behaviour, health access, and food security.

For the primary impact evaluation of GiveDirectly's programming, around 10,000 refugee households in Kiryandongo were randomized into 24 cohorts using a public lottery. Each group has received (or will receive) cash transfers (worth around USD 1000 per household) via mobile money sometime over the next 24 months, beginning in March 2020. The treatment group comprises cohorts 1 and 2, and the control group comprises cohorts 17-20, which provides a baseline sample of 1,264 households (1,060 with phone numbers).

The phone-based component involves three rounds of structured rapid phone surveys with a random subset of the baseline sample; we conducted 633 phone interviews for Round 1, based on a sample size calculation for an MDE 0.2[1] standard deviations and a p-value of $p<0.1$[2].

Initially, we had planned to focus on three broad outcomes of interest: (i) Knowledge of COVID-19 and preventative measures; (ii) Propensity to adhere to public health directives, such as social distancing; and (iii) access and use of medical services. At the time, the first case of COVID-19 in Uganda had just been announced, and the situation in the settlement seemed to be changing rapidly, such that there were different rules and regulations affecting livelihoods in the settlement every week. However, based on findings from the first round of data collection and co-current qualitative research we are conducting, we do not anticipate changes to responses to similar questions between rounds. Instead, we decided to ask about some different outcomes that are of interest to us as researchers and GiveDirectly.

In this round, we explored four main COVID-19 topics: 1) COVID-19 perceptions and public health behaviour, 2) Food security, 3) Alcohol consumption and, 4) Social cohesion. By layering this work onto the on-going impact evaluation, we can provide precise estimates of treatment effects in each of these areas.

DATA COLLECTION

IDinsight's enumerator team included eleven experienced enumerators who worked with us during our baseline survey and predominantly resided in the settlement. These enumerators had previously attended our in-person training during baseline. Additionally, we conducted remote training using Google Meets and WhatsApp. Due to poor network connectivity in Kiryandongo, we also provided the enumerators with written and pre-recorded training materials. Finally, enumerators also completed quizzes and survey pilots, which they submitted to IDinsight for feedback. With training and enumeration being conducted by phone, our data collection limited the risk of COVID-19 transmission due to our work.

Enumerators administered and captured the surveys using the SurveyCTO advanced case management Computer Assisted Telephone Interviewing (CATI) system. We reached 652 households, calling over ten days, from 19th October to 30th October 2020, and interviews lasted 36 minutes on average. We called 1060 potential respondents and achieved a 59% response rate overall. To improve our response rates, we implemented a callback protocol whereby 1) Respondents were called seven times on different days and at various times of the day, 2) Enumerators sent text messages to respondents whose phones were off or who did not pick phone calls during the first attempt to notify them about the survey and enquire when they could call back, 3) Respondents were able to schedule calls at a time that was convenient to their schedule, and 4) Enumerators recorded why households did not answer calls and set up appointments for callbacks. Additionally, we offered a small incentive to respondents to participate in the survey (approximately 1 USD mobile money transfer). This incentive was to cover phone-charging costs since electricity is not available to most households in the settlement data analysis.

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1 This is a common effect size to use in a study such as this where there is little data to inform a possible effect size.
2 We suggest this p-value is appropriate for a rapid response study such as this one, in which we are trying to achieve rigour while accounting for the significant constraints the study faces.

RISK MITIGATION AND ETHICAL APPROVAL

We ensured that informed consent was administered at the start of all surveys to ascertain that respondents understood their rights and risks. Respondents were able to refuse to answer any questions and end the survey at any time.

We used strict data security protocols. All data were collected via SurveyCTO, encrypted, and uploaded to a secure central database. We stored back-ups on password-protected computers and folders to ensure the confidentiality of the data. The encrypted raw data was not accessible to anyone without the decryption key, which was only available to the research management team.

As per Ugandan government regulations, we obtained ethical approval for this study in a two-stage process:

- First, our research protocol was reviewed and approved by the Research Ethics Committee (REC) of Mildmay Uganda. Mildmay is a Uganda-based non-profit that focuses on health research and programming. Mildmay has been accredited by the Ugandan Government, which allows them to function as a REC to protect the rights and welfare of research participants in Uganda.

- Second, the Uganda National Council for Science and Technology (UNCST) reviewed the Mildmay-approved research protocol and provided final government approval.

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ABOUT IDINSIGHT

IDinsight uses data and evidence to help leaders combat poverty worldwide. Our collaborations deploy a large analytical toolkit to help clients design better policies, rigorously test what works, and use evidence to implement effectively at scale. We place special emphasis on using the right tool for the right question and tailor our rigorous methods to the real-world constraints of decision-makers.

IDinsight works with governments, foundations, NGOs, multi-laterals, and businesses across Africa and Asia. We work in all major sectors, including health, education, agriculture, governance, digital ID, financial access, and sanitation.

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