HUMANITARIAN RESPONSE PLAN
ETHIOPIA

MID YEAR REVIEW

HUMANITARIAN PROGRAMME CYCLE
2020

ISSUED AUGUST 2020

About

This document reflects the Ethiopia humanitarian response that is the result of a close partnership of the Government of Ethiopia, in its leadership role, and the international humanitarian community.

PHOTO ON COVER

Birzaf Akelew, 20 and her 5 years old daughter Fire
Chekole Sekota Zuria woreda, Amhara Regional State.
Photo: UNICEF Ethiopia/Meklit Mersha

Table of Contents

HARANA BULUK *WOREDA*/OROMIA REGION, ETHIOPIA
Students at Shawe primary school, Photo: UNICEF Ethiopia/2019/Mersha

Foreword by the Deputy Commissioner

Like many countries around the world, Ethiopia has been dealing with the unforeseen threat paused by the COVID-19 pandemic since March 2020. The Government of Ethiopia has been taking the necessary measures to prevent further spread of the virus and boost mitigation and preparedness measures.

COVID-19 pandemic is not only a health threat; its impact spans across all sectors and society. I, on behalf of the Government of Ethiopia, am overseeing the multi-sector COVID-19 response coordination. Together with our partners, we will continue to respond to needs and labor to fill identified gaps.

COVID-19 is our immediate focus. However, we will not lose sight of the multi-faceted and simultaneous humanitarian challenges across the country, including food insecurity, desert locust, floods and displacement. All these are further compounded by the pandemic.

The mid-year review of the 2020 Humanitarian Response Plan captures additional needs due to COVID-19, desert locust infestation and other natural and man-made disasters. At least 15.1 million people require urgent food and non-food assistance, requiring an outstanding US$930 million.

As always, I, on behalf of my Government, would like to thank the unwavering support of our international partners. We recognize that your countries are facing similar challenges due to the pandemic. This makes your continued support a stronger testament to your partnership and your commitment to support the Government and people of Ethiopia during these challenging times.

The world can only overcome this global challenge by standing in solidarity.

H.E. Mr. Damene Darota,
National Disaster Risk Management Commission,
Deputy Commissioner

Foreword by the Humanitarian Coordinator

COVID-19 pandemic is equally ravaging developed and developing countries. However, its impact will disproportionately be suffered by developing countries whose systems are already unable to deal with existing natural and man-made disasters.

Before the pandemic hit the country in March 2020, the major drivers of humanitarian need in Ethiopia were, and continue to be today, food insecurity, displacement, disease outbreaks, drought in some parts of the country and seasonal floods in others. In addition, the worst desert locust infestation reported in 25 years hit Ethiopia and neighboring countries in late 2019 and continues to affect many communities to date, leading to livelihood loss and food insecurity. COVID-19 deepened these already existing vulnerabilities.

The response to the virus has stretched weak health systems beyond capacity, with reports of shortages of oxygen and of beds. The six-fold increase in cases between June and August, as well as the first cases detected in Internally displaced people (IDP) settings are cause for concern. Internally displaced people/people in camp-like settings, along with women/female-headed households, children, the youths, persons with disabilities, older people and the homeless are amongst the most vulnerable groups requiring special focus in the response and post-pandemic interventions. Other health outbreaks such as cholera, measles, yellow fever and polio should also not be overlooked.

Although it started as a health crisis, the pandemic evolved into a series of other co-pandemics. The necessary Government measures taken to prevent and control the spread of the virus disrupted schooling and economic activities, and limited movements and access to services. Many will continue to suffer from the long tail of social and economic disruptions even after the pandemic. For example, income losses as a result of limited economic activities and unemployment threatened the livelihoods of millions. Similarly, COVID-19 interrupted the learning of more than 26 million school-aged children across the country. We should continue to collectively work to mitigate its long-term impact, including ensuring alternative learning modalities reach and benefit all children equally such as poor families, IDP and refugee children as well as children with special needs. The psychological impact from the fear of the pandemic, the stress from income loss and the changes in family dynamics should also not be overlooked.

Today, more than ever, the Government and people of Ethiopia need the steadfast support from international partners. The country needs urgent additional financing to not only control the various co-pandemics before they further spread across the country, but to also mitigate the adverse long-term impact on the humanitarian context.

The mid-year review of the 2020 Humanitarian Response Plan seeks US$1.44 billion to assist 15.2 million people in the year 2020. The additional needs are mainly due to the impact of COVID-19, desert locust infestation, new displacement and wide spreading flooding. As I write today, the requirement is only 35 per cent funded, which is at its lowest in the last ten years.

Understanding the very difficult circumstances that all countries face, this is one time when shared responsibility and global solidarity is called for. Today, I call on all the friends and partners of Ethiopia to continue to affirm their support to the Government and people of Ethiopia during this context of greatest need. As always, I would like to take this opportunity to covey that the United Nations and dozens of non-governmental organizations are committed to support all people in Ethiopia during this crisis as we all strive to ensure that no one is left behind.

Dr Catherine Sozi
Humanitarian Coordinator in Ethiopia

Response Plan Overview
at a glance

REVISED PEOPLE IN NEED
19.2M

REVISED PEOPLE TARGETED
15.1M

REVISED REQUIREMENTS (US$)
1.44B

OUT OF WHICH PRIORITIZED (US$)
866M

61% **21%** **9%**

REVISED TARGET BY CLUSTER	Original Jan 2020	Non COVID/COVID May	Non COVID/COVID August
Agriculture	1.4 M	1.9 M	1.8 M
Education	1.3 M	6.3 M	7.9 M
ES/NFI	1.9 M	2.4 M	2.0 M
Food	5.9 M	15.0 M	11.8 M
Health	3.2 M	6.5 M	6.5 M
Nutrition	3.6 M	4.4 M	4.4 M
Protection	2.0 M	4.6 M	3.9 M
WASH	5.3 M	7.8 M	10.5 M

	ORIGINAL REQUIREMENTS (US$ MILLION)	NON-COVID-19 MAY (US$ MILLION)	COVID-19 MAY (US$ MILLION)	REVISED NON-COVID-19 REQUIREMENTS (US$ MILLION)	REVISED COVID-19 REQUIREMENTS (US$ MILLION)	GOVERNMENT OF ETHIOPIA CONTRIBUTIONS (US$ MILLION)	INTERNATIONAL CONTRIBUTIONS (US$ MILLION)	GAP (US$ MILLION)
Agriculture	54.0 M	45.2 M	28.5 M	73.7 M ↑	0.3 M ↓		5.9 M	68.1 M
Education	30.0 M	20.3 M	15.1 M	19.6 M ↓	15.7 M ↑		2.8 M	32.5 M
ES/NFI	95.8 M	81.5 M	24.3 M	77.7 M ↓	23.4 M ↓		5.0 M	96.1 M
Food	399.5 M	488.7 M	284.7 M	434.4 M ↓	159.0M ↓	83.1 M	208.8 M	301.6 M
Health	94.3 M	95.0 M	100.0 M	95.0 M =	100.0 M =		15.1 M	179.9 M
Logistics	-	59.7 M		4.7 M ↓	18.7 M ↑		3.8 M	19.6 M
Nutrition	193.4 M	226.8 M	25.8 M	226.8 M =	25.8 M =		65.5 M	187.1 M
Protection	42.4 M	33.7 M	14.0 M	33.7 M =	14.0 M =		3.4 M	44.2 M
WaSH	79.7 M	81.8 M	13.7 M	86.0 M ↑	17.4 M ↑		14.2 M	89.1 M
Coordination	12.0 M	12.0 M		12.0 M =	-		4.5 M	7.5 M
Multi-sector or sector not specified							*96.2M*	*-96.2 M*
Total	**1.00 B**	**1.14 B**	**506.0 M**	**1.06 B**	**374.2 M**	**83.1 M**	**425.1 M**	**929.6 M**

Changes in context

WEST GUJI ZONE/OROMIA REGION, ETHIOPIA

Dawa Bicho kevele of Melka Soda woreda, where 500 HHs are displaced and currently they are settled in this new site. Photo: UNOCHA Ethiopia/2019/Nahimi Feyissa

The drastic changes in the humanitarian context since the release of the 2020 Humanitarian Response Plan (HRP) on 28 January 2020 warranted an immediate revision of the HRP requirements, which was released on 9 June 2020. At the time, the humanitarian caseload considerably increased to 16.5 million people (up from 7 million) and the financial requirement to US$1.65 billion (up from $1 billion).

The additional humanitarian needs mainly emanated from the multi-sector impact of the COVID-19 pandemic since March 2020, which disproportionately impacts crisis-affected communities. Sluggish economic activities and job losses, as well as restrictions in movement, including border closures disrupting markets, are some of the economic impacts of COVID-19.

Ethiopia saw a six-fold increase in confirmed COVID-19 cases between June and August, with 5,689 cases by end June compared to 34,058 cases as of 19 August. Ethiopia also registered more than 13,000 recoveries and more than 600 deaths. As of the last week of August, Ethiopia was leading eastern African countries with the highest number of cases.

The daily testing capacity has exponentially increased with an average of 4,000 daily testing as of 30 June to some 21,000 daily testing as of 19 August. Meanwhile, the confirmation of the first corona cases amongst internally displaced people (IDPs) in late July raised alarm. Their living and health conditions, as well their lack of adequate access to basic services make IDPs amongst the most vulnerable people for the virus. A recent analysis using WaSH, health, and shelter indicators highlighted that IDPs in 56 sites live in overcrowded settings making physical distancing nearly impossible and with inadequate hygiene facilities and lack of access to health services. As of mid-August, there were 17 cases detected amongst IDPs in Qoloji sites (Somali region) where 12,532 households reside in overcrowded conditions. Qoloji site is one of the 26 IDP sites in the country prioritized for decongestion and scaled-up response by regional authorities and humanitarian actors. Overall, there are some 953,000 IDPs living in a camp-like settings in Afar, Benishangul Gumuz, Oromia and Somali regions.

Concern over the likelihood of further spike is high given that at least 63 per cent of recent cases resulted through community transmission. Weak health systems are already stretched beyond capacity, with shortages of oxygen and beds for COVID-19 patients being reported.

The pandemic also threatens gains made on other health threats. At present, a cholera outbreak is reported in at least 17 zones across three regions. According to the Ethiopian Public Health Institute (EPHI), 6,789 cholera cases were reported between January and August 2020 across SNNP (4,819 cases), Somali (1,319) and Oromia (651) regions. Measles and other endemic diseases are equally demanding sustained attention of the Government system and health partners.

Coupled with the pandemic, the desert locust infestation has contributed to food insecurity. More than 1 million people were affected by the infestation in the first quarter of the year alone and made dependent to food assistance. There are indications that crop damage by desert locusts have contributed to below normal harvests during the 2020 belg/spring season in some areas, further impacting food security of vulnerable households. Of greater concern is the significant overlap between areas affected by desert locust and chronically food-insecure woredas in Afar, Amhara, Oromia, SNNP and Somali regions. More breading is expected during the 2020 summer (June-September) rainy season in parts of Afar, Oromia and Somali, and possibly in south eastern Amhara and eastern Tigray regions due to favourable weather conditions. Adding to this, new swarms have been arriving from Yemen in Afar region since early August 2020, while active movement of immature swarms is ongoing between Somalia and eastern Ethiopia. Meanwhile, the situation in SNNP is calm, although the risk for residual swarms in Kenya to make their way northward into southern Ethiopia is high. Ground and aerial control operations are ongoing in Afar, Oromia and eastern Somali regions as of August 2020.

Heavy 2020 spring rains caused flooding, affecting more than 250,000 people, of whom 140,056 were displaced. Heavy 2020 summer rainfall and discharge of filled dams have also caused flooding and landslides, displacing people in several parts of the country. As of 18 August, at least 159,557 people were affected by floods in July and August, including 133,576 people displaced (40,131 people displaced in Afar, 45,557 people in Somali, 3,321 people in Oromia, 20,066 people in SNNP, 20,892 people in Gambella and 3,609 people in Amhara). Houses were destroyed, livelihoods were lost and WaSH and other public infrastructures damaged. The risk of further flooding is high during the remainder of the summer rainy season according to the National Meteorological Agency, including in areas where the cholera outbreak is currently spreading. More than 2 million people are projected to be affected and 435,000 people to be displaced during the season.

Meanwhile, localised insecurity and violence is ongoing in several regions. The July unrest in Oromia region displaced more than 9,000 people, resulted in destruction of property, and impacted humanitarian operations such as relief food deliveries. Testing for COVID-19 dramatically decreased during the unrest, and contact tracing was disrupted.

Similarly, the mass return of IDPs in several regions (e.g. at least 67,888 households returned within Somali region, 18,000 individuals returned to Metekel zone (Benishangul Gumuz) and 42,000 individuals returned within Oromia region (Chinaksen woreda alone), has altered the displacement dynamic and humanitarian needs in these locations since the release of the 2020 HRP.

In addition to the above-mentioned changes in the humanitarian context, humanitarian partners' operational capacity will be affected in the second half of 2020 due to a reduction in the number of UN, NGO and Government partners involved in humanitarian response in Ethiopia (drop from 88 in December 2019 to 67 partners by the end of May 2020). Lack of funding and operational restrictions due to COVID-19 are the main reasons for this decrease.

Part 1

Response priorities

BALE ZONE,OROMIA REGION, ETHIOPIA

Shega Husen studnet at Level 1 on her way back home in Berak IDP site, Colomena woreda, Bale zone. Photo: UNICEF/2019/Mulugeta Ayene

The prevention of COVID-19 pandemic and the mitigation of its impact remains a high priority in IDP camps and camp-like settings. Assessments conducted in Somali region and in Borena zone of Oromia region revealed that the living space per person is 1.3m², while the internationally recommended standard is 3.5m², making physical distancing difficult or near impossible. A joint analysis using WaSH, health, and shelter indicators identified 56 sites where IDPs live in overcrowded settings. Access to potable water, basic hygiene and sanitation facilities is also below the sphere standards. Through an integrated WaSH, health, ES/NFI, nutrition and protection intervention however, impacts of COVID-19 could either be prevented or mitigated. To this end, site decongestion , risk awareness communication, active community surveillance, and expansion of water and sanitation facilities must be undertaken immediately. The Inter-Cluster Coordination Group (ICCG) intends to apply a phased intervention approach to these 56 sites. The ICCG has identified 10 high-risk IDP sites in Afar, Oromia and Somali in need of immediate intervention. An additional 16 sites will require similar intervention in phase two.

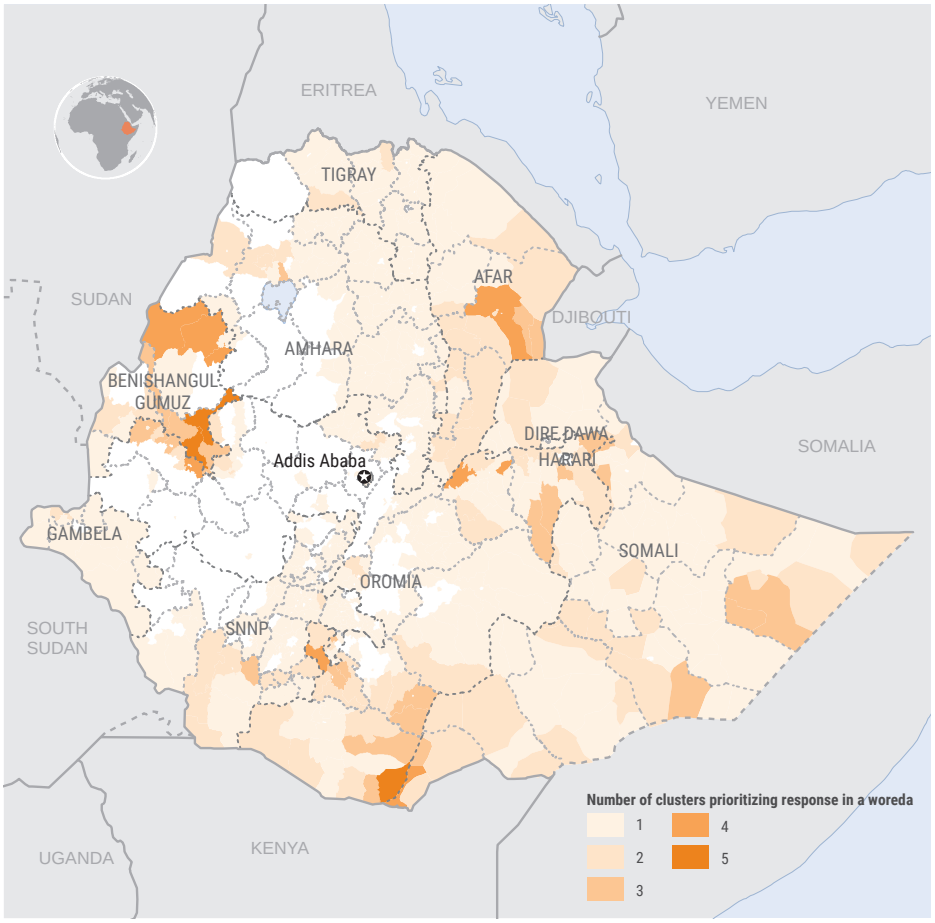
As of August, funding towards the 2020 HRP was the lowest recorded in a decade. In addition to advocacy and resource mobilization efforts, targeted and further prioritised response will be essential. Targeting areas where there is convergence of multiple needs is one key prioritization strategy to reach the most vulnerable.

In Oromia region, Borena, Guji, East Hararge, West Hararge and West Wollega zones are amongst the prioritized areas for multi-sector intervention. In East Hararge, agricultural and nutrition interventions are required mainly due to the prevalence of food insecurity, while ES/NFI, health and protection interventions are needed for conflict IDPs and returnees. Similarly, conflict IDPs and returnees in Borena urgently require nutrition, ES/NFI, education, protection and WaSH support. In West Hararge, health, nutrition and protection needs are identified. In West Wollega, protection monitoring, community-based protection mechanisms and structures for case identification and referral must be strengthened, while HLP interventions, integrated with cash-for-rent interventions are recommended to address the needs of secondary displaced IDPs. Conflict IDPs and returnees in the area should also be prioritized for ES/NFI, health and nutrition interventions. Meanwhile, nutrition and education are prioritized interventions for onflict IDPs and returnees in Guji.

In Afar region, several woredas in Zone 1 require nutrition, education and WaSH support; while in Somali region child protection, sexual and gender-based violence (SGBV), general protection, nutrition services and agricultural support are priorities identified particularly in Shabelle zone. In addition to hosting IDPs, Shabelle zone is projected to receive thousands of relocated IDPs as part of the durable solution program.

In Amhara region, conflict IDPs and returnees in Central Gondar zone require nutrition and protection needs; while in Kamashi zone of Benishangul Gumuz region, conflict IDPs identified education, health, nutrition and protection as their priority needs.

In addition to the above-mentioned geographic areas, pressing needs in the nutrition sector were identified in Sidama zone of SNNPR, Sout Wollo and North Showa zones of Amhara region and Bale and Arsi zones of Oromia region.



1.2 Use of Multi-Purpose Cash

The proven positive impact of cash and voucher assistance (CVA) has led to an increase in cash-based interventions in Ethiopia. In 2019, members of the Ethiopia Cash Working Group (ECWG[1]) distributed cash or vouchers to 1,062,279 households. Stand-alone cash provision for food is provided through the Productive Safety Net Programme (PSNP).

Findings from cash feasibility assessments indicate CVA is feasible in most parts of Ethiopia and is the most preferred modality by beneficiaries in areas where markets are functioning and security is reliable. Assessments also show that in-kind assistance is preferred in some areas where the right type commodity and the desired quality is not available in the market. In-kind assistance is also preferred where there is poor community cash management practices and lack of previous experience with CVA-based projects.

Desert locust and COVID-19-affected households, as well as IDPs/returnees/relocated have multi-sector needs. The MPG TWG identified Gedeo/Guji, East and West Hararge and East and West Wollega as areas where multi-purpose cash assistance can be implemented. Some partners have already started implementing MPC assistance in communities affected by desert locust infestation in Oromia and Somali regions. Cities and towns whose population are affected by a high prevalence of COVID-19 can also be targeted for multipurpose cash (MPC) assistance.

The CVA interventions are generally informed by cash feasibility assessments that advise on the best approach to meet identified needs. Feasibility assessments examine markets, beneficiary preference, political acceptance, and protection and security concerns to ensure that cash is the most appropriate response modality. Deeper gender analysis needs to be included in CVA assessments, including analysis of SGBV risks related to CVA distribution to women. Differences of opinions within the household can put further pressure on women and present a risk for GBV. Emphasizing and addressing gender-specific needs and gaps highlighted in assessments is a move towards greater gender equality.

Community engagement and accountability to affected populations throughout the project cycle is key to ensure the efficiency of CVA. Protection risks related to SEA, child safeguarding and persons with specific needs, such as age, ability and chronic illness, will also be considered. Measures will be taken to ensure that cash transfers will be feasible country-wide and will provide access to the same nutritional components as in-kind transfers. Each cash program has its own set of standards to analyse risks and develop mitigation measures.

The Government of Ethiopia, ECWG members, including INGOs, UN agencies, donors, sub-national cash working groups, and federal, regional and lower-level Government structures are key partners in the coordinated use of multi-purpose cash.

[1]The ECWG leads crisis-specific initiatives related to CVA, develops suggested transfer values based on local market assessments, ensures uniformity of standards, and provides technical and strategic guidance to implementing partners. The ECWG works with clusters and advocates a cash-first modality where suitable to address the needs of crisis affected areas. A Multi-Purpose Cash Grant Technical Working Group (MPG TWG) was established in 2019 to put in place a basic needs approach through multi-sector needs assessments. The aim of the group is to support people-centred and evidence-based response options and support cash programming. The Transfer Value Working Group, also part of the ECWG, strives to harmonize the transfer value with the existing PSNP program. The ECWG is working to roll out a joint market monitor initiative in 2020. Coordination efforts are aligned with clusters, the Collaborative Cash Delivery (CCD) Network, sub-national cash working groups, the Refugee Cash Task Force, and the Agency for Refugee and Returnee Affairs (ARRA). Representatives of the ECWG have participated in the NDRMC-led Prioritization Committee, which focuses on cash for food. e ECWG leads crisis-specific initiatives related to CVA, develops suggested transfer values based on local market assessments, ensures uniformity of standards, and provides technical and strategic guidance to implementing partners. The ECWG works with clusters and advocates a cash-first modality where suitable to address the needs of crisis affected areas. A Multi-Purpose Cash Grant Technical Working Group (MPG TWG) was established in 2019 to put in place a basic needs approach through multi-sector needs assessments. The aim of the group is to support people-centred and evidence-based response options and support cash programming. The Transfer Value Working Group, also part of the ECWG, strives to harmonize the transfer value with the existing PSNP program. The ECWG is working to roll out a joint market monitor initiative in 2020. Coordination efforts are aligned with clusters, the Collaborative Cash Delivery (CCD) Network, sub-national cash working groups, the Refugee Cash Task Force, and the Agency for Refugee and Returnee Affairs (ARRA). Representatives of the ECWG have participated in the NDRMC-led Prioritization Committee, which focuses on cash for food.

1.3

Operational Capacity

The number of UN, NGO and Government partners involved in humanitarian response in Ethiopia dropped from 88 in December 2019 to 67 partners by the end of May 2020. These partners are operating in 614 woredas across 88 zones. The reduction in the number of humanitarian partners is mainly attributed to decreased humanitarian funding, prioritization of COVID-19 response over regular programming, as well as COVID-19-related operational concerns and restrictions, as well as precarious security in parts of the country. The changes in the humanitarian context and the lack of funding will affect the overall operational capacity in the second half of 2020.

The risk of COVID-19 has dominated the operational environment since March. In a period of six weeks the number of COVID-19 cases quadrupled (from 5,850 cases by the end of June to the 22,800 cases in early August). By mid-year, seven of the eight humanitarian clusters estimated that the impact of the COVID-19 pandemic caused their planned response and activities to decrease by seven per cent in 81 woredas. The impact of COVID-19 on partner activities has been slowly increasing since April-May, yet the Education Cluster remains the most affected by delayed/suspended activities. Protection coverage is currently limited to a few hotspot zones, leaving emerging protection needs in other regions largely unaddressed. The flood response in Afar for example recorded a high incidence of SGBV and female genital mutilation (FGM) in Tigray and Somali regions. In addition, complex HLP and civil documentation issues in western Oromia (West Wellega, East Wellega and Metekel zones; child protection (child marriage, abuse and labour) and documentation issues in Somali region; mental health and psycho-social support nation-wide.

To counter COVID-19, the Government of Ethiopia has established new coordination structures, including the federal Emergency Operations Centre (EOC) and Emergency Coordination Centre (ECC) that are being replicated, to various degrees and forms, at sub-national levels. While conducting an impressive response in many critical areas of the country, the GoE has faced compounded challenges in implementing national, regional and zonal COVID-19 plans that have affected coordination, technical, human, logistical, material and financial resources at all governance levels. The brunt of on-the-ground emergency response has been put on zonal and woreda health authorities that need focused guidance and other support to better action multi-sectoral coordination and best practices. The UN has deployed focused on-the-job support to federal authorities and introduced COVID-19 regional emergency coordination forums to ensure coordinated, systematic and comprehensive support of sub-national government efforts. Humanitarian clusters continued to support within their sometimes-fluctuating capacities, especially at zonal level, due to sporadic lack of dedicated leadership (e.g. Guji, Bale and East Bale zones in southern Oromia), COVID-19- and security-related coordination and communications challenges.

Multi-agency assessments on quarantine centres and point of entries were conducted in seven regions and one city council (Afar, Amhara, Benishangul Gumuz, Gambela, Oromia, Somali and Dire Dawa), identifying critical gaps in food, shelter/NFI, WASH and personal protective equipment (PPE). Incoming cross-border movements (62 per cent of all cross-border movements) remain a concern due to lack of government capacity to control the potential disease spread, while partners have limited coverage in these areas. Congested spontaneous and collective settlements of IDPs, returnees and refugees have been particularly at risk due to the communities' heightened density, vulnerability, needs and lack of adequate support.

Recurrent security incidents in Oromia have

Partners by Sector

SECTOR	NO. PARTNERS
WASH	43
ESNFI	33
Protection	25
Agriculture	19
Nutrition	18
Health	14
Education	5
Food	3*

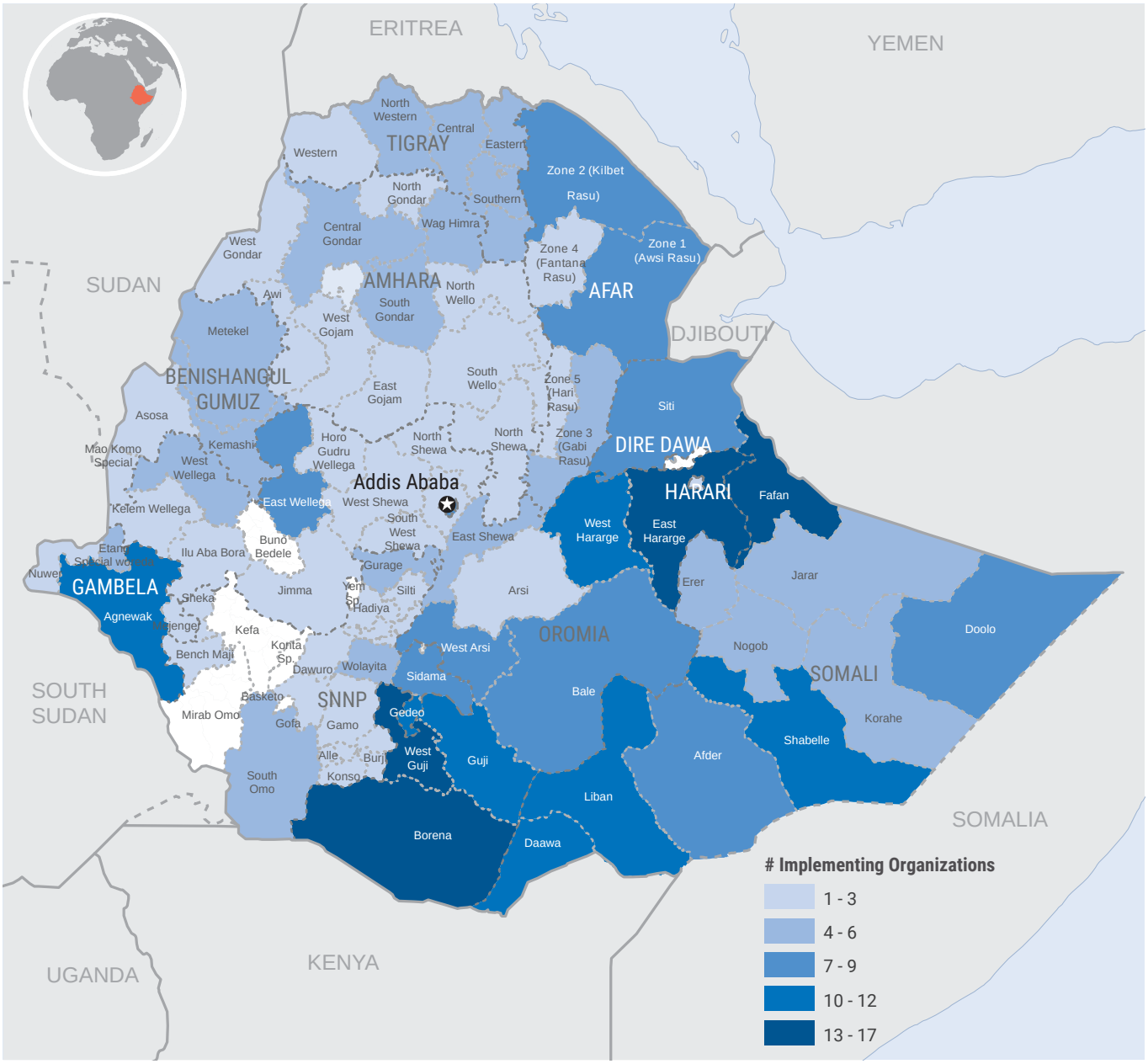
Partners by Type

TYPE	NO. PARTNERS
INGO	43
NNGO	13
UN	5
Government	6

reliefweb

For the latest operational updates, visit:
reliefweb.int/country/eth

* The number of partners under the food sector refers to the three operators in Ethiopia, i.e. NDRMC, JEOP and WFP. JEOP is a consortium with international and local NGOs as members. Please note that number of partners is not representative of the sector as the sector reached 8 million people in 2019- see page 36



had a severe impact on humanitarian operations in and around the region. The violent protests in June-July 2020, following the killing of a local socially influential and politically active Oromo artist in Addis Ababa, resulted in the loss of lives, population displacement (an estimated 9,000 people), destruction of property (including humanitarian assets), road blockades and movement restrictions. To mitigate the effects of the socio-political unrest, the GoE shut down internet access across the country for weeks, disrupting practically all communications and coordination efforts. The situation has significantly affected humanitarian operations in terms of partial suspension or delays in the provision of life-saving assistance within Oromia as well as adjacent regions with affected cross-regional supply routes.

Humanitarian and government partners continue to jointly and on-the-ground address the immediate impact of COVID-19 on healthcare while also addressing regular hazards and risks. Recurrent internal conflicts/tensions and floods have put communities at high risk of waterborne diseases like cholera (especially in West Omo and South Omo zones of SNNP and West Guji zone of Oromia), acute watery diarrhoea, as well as malaria.

More than 908,100 people (primarily IDPs and returnee) in need across Ethiopia have been partly or fully out of reach/assistance. In northern Ethiopia, an estimated 350,000 of people in Tigray (Raya Azebo, Alamata, Enda Mehoni, and Maichev zones), Amhara (West Gondar, North/South Wello and Oromo zones) and Afar east cross-boundary corridor (toward Somali region) are unassisted mainly due to bad terrain, tensions and frequent population movements. In Somali region, an estimated 162,100 people Dawa and Shabelle zones are off limit due to rough terrain and inter-clan conflict. In southern Oromia, 165,000 people in Borena, West Guji, Guji and East Bale zones

are hard to reach due to poor infrastructure, distance and precarious security situation. In western Oromia, an estimated 49,000 people (mostly secondarily displaced) in West Wellega and Metekel zones are hard to reach due to security operations against unidentified armed groups (UAGs) and inter-clan tensions. In SNNP region, at least 17,000 people in South Omo, West Omo and Surma are somewhat inaccessible due to poor (often flood-affected) infrastructure, security operations and inter-community tensions.

The lack of partners' presence in reachable areas similarly renders people in need effectively neglected.

One of the solutions towards reaching affected yet unassisted populations is increased mobilization of national/local NGOs (beyond the current 19 per cent of registered partners), as well as engagement of zonal DRMOs. This is conditional upon their presence, outreach, coordination capacities, management stability, reliability, compliance with humanitarian principles (exceptionally pragmatically interpreted under the cardinally changed realities on the ground) and adequate funding. Among many locally available NGOs, the Ethiopian Red Cross Society (ERCS) remains the one with the highest overall coverage, experience and credibility to channel humanitarian response to neglected people in need. Sub-contracting arrangements with UN and INGOs still remain a strong guarantee of effective programming and oversight, conscious of relatively sub-optimal organizational capacities of many NNGO and government entities, including persistent and overwhelming communication and coordination challenges due to lack of ICT hardware, software and know-how.

The overall capacity of aid partners (with focus on guided NNGOs) to absorb and effectively action much needed funding is considered high; their capacity to do so in a coordinated and effective manner could significantly improve through key donors' commitment to condition as a matter of principle all funding by partners' active participation in relevant clusters and similar applicable humanitarian coordination mechanisms.

The combination of multiple, simultaneous and compounding shocks, including the "triple threat" of COVID-19, floods and desert locust upsurge as well as sporadic droughts and related displacements have and will likely continue to affect many, mostly densely populated areas, such as urban and IDP settings, as well as pastoral areas, generating new and significant needs that will require additional resources.

The Ethiopia HRP, which targets 16.5 million people with life-saving humanitarian interventions, has been at its lowest mid-year funding in the past eleven years with under 25 per cent funding (USD 435 million). The Ethiopian Humanitarian Fund (EHF) allocated some USD 24.5 million by mid-year to support the response related to returnees and IDP, droughts, COVID-19 and other situations of humanitarian concern, and the CERF Rapid Response allocated USD 8 million to mitigate the impact of floods in the spread of cholera across the country. While this will help fill some gaps, significant and critical needs are expected to remain largely unaddressed until the end of the year.

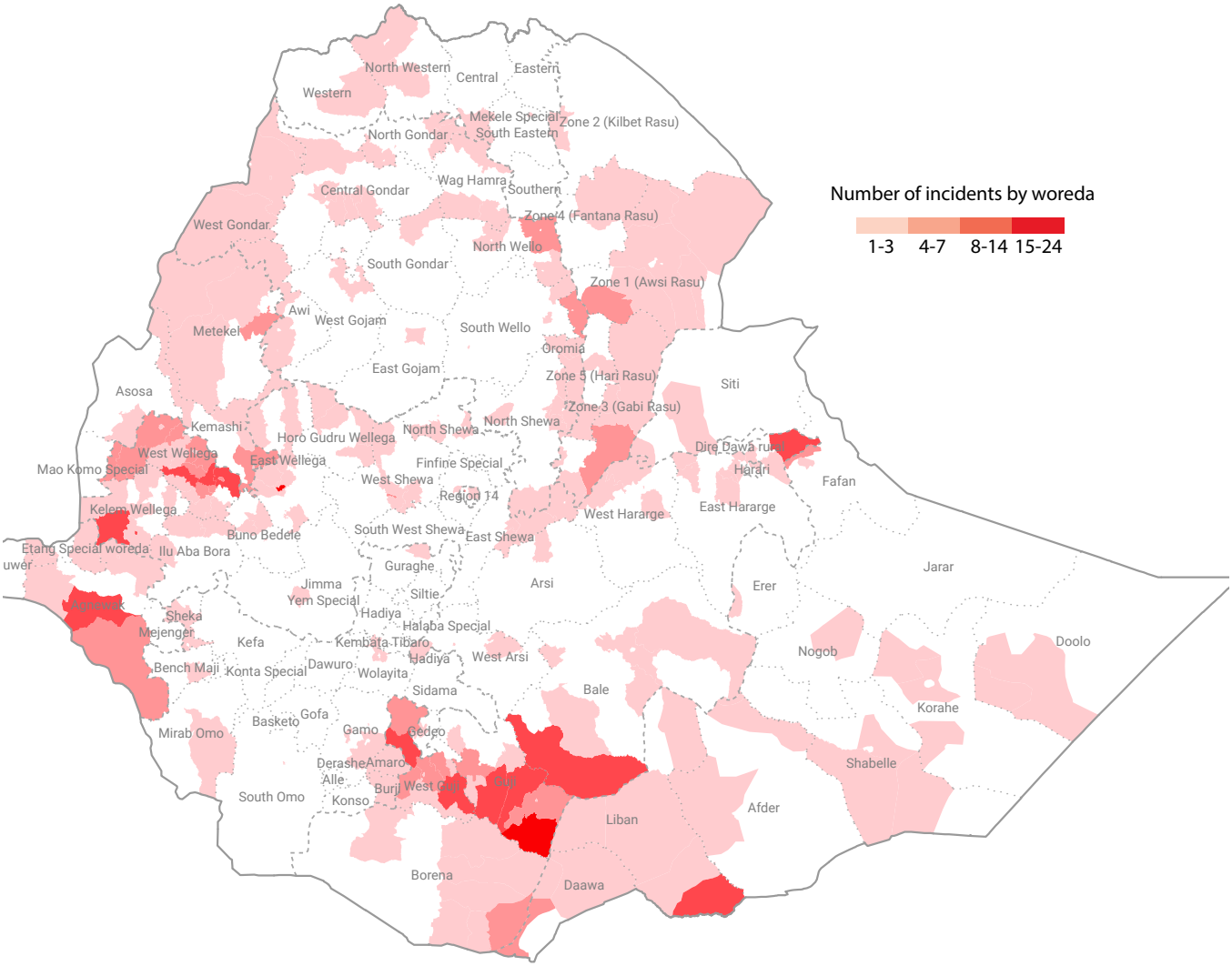
1.4

Access Constraints

Generally, the operational environment to relief operations remained permissive through the first half of 2020. Partners were able to deliver assistance, including in hotspot areas, though often only on an intermittent basis (as of the end of June, partners have reported over 650 access incidents). Most of the reported access impediments were related to hostilities, intra-communal conflicts, and social unrest, which hindered the quality of the humanitarian response and the scale at which partners were able to deliver goods and services to people in need.

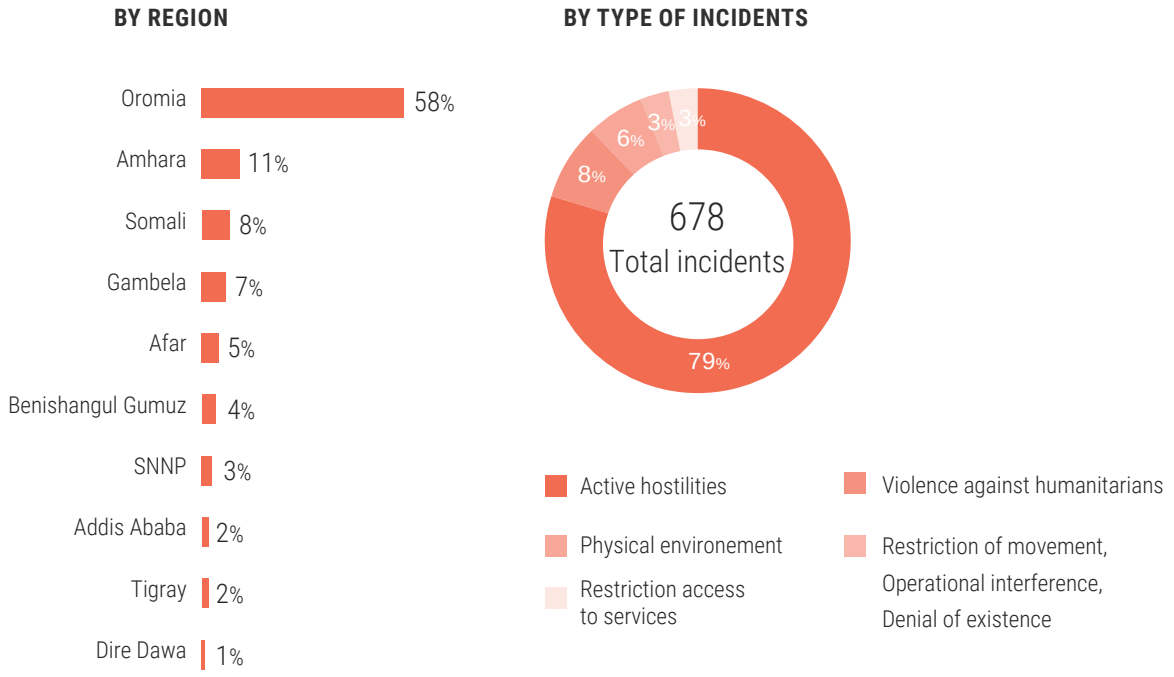
The violence related to security operations against UAGs in western and southern Oromia continues unabated. The population is trapped in the violence and suffering as a result of insecurity, limitations to movement (confinement), and lack of access to services and livelihoods. Humanitarian operations are often suspended leaving thousands of people without much-needed aid. An estimated 37,000 secondary IDPs in West Wollega and some 15,000 in East Wollega, have not received assistance for almost one year. In Western Oromia, the Government imposed a communication blackout that lasted for three months, and significantly affected operations. In Guji, as of the end of June, close to 18,000 IDPs remain out of reach and an additional 37,000 remain in areas that are only partially accessible, meaning on an intermittent basis.

Whilst the UN and NGO partners have not been directly targeted in the violence, operations are conducted in high-risk environments and the likelihood of suffering collateral damage is high during road movements and/or programme delivery. In Western and Southern Oromia, partners continue to operate in a highly insecure and volatile environment. OCHA in constant communication with Government



The designations employed and the presentation of material in the report do not imply the expression of any opinion whatsoever on the part of the Secretariat of the United Nations concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

Humanitarian access incidents January - June 2020



and security counterparts at all levels to improve adherence to humanitarian principles, including through the provision of training on the humanitarian principles and Humanitarian Civil – Military coordination (CMCoord).

In Gambella, there is limited improvement of security since the killing of two INGO aid workers in September 2019 by unidentified armed men. Ensuring the safety of aid workers and the arrest and prosecution of those responsible for that attack is still work in progress.

By the end of June, close to 80,000 IDPs were returned by the Goverenment to areas of origin in Metekel (Benishangul Gumuz), Awi (Amhara), Fafan (Somali), and East Hararge (Oromia) zones. There is a significant gap in ensuring the voluntariness of the return process and adherence to humanitarian and durable solution principles given the dire situation returnees are facing in areas of return. The humanitarian community has advised to pause the return of IDPs until conditions in areas of return are fully conducive for the resumption of livelihoods in a safe, secure, and dignified manner.

Access to people in need has improved in West Guji (Oromia), and North and West Gonder (Amhara) zones as a result of enhanced community-level security and peace and reconciliation efforts. Further, SNNPR authorities have authorized the rollout of the Displacement Tracking Monitoring (DTM) system in the region.

In the first half of 2020, OCHA conducted field missions and access workshops to all conflict hotspots in the country, and developed access analyses to support the humanitarian response, made available as well to the Ethiopian and international community (https://www.humanitarianresponse.info/en/operations/ethiopia/humanitarian-access). The approach to improve humanitarian access is field-driven in support to aid partners – including monitoring of access constraints and humanitarian negotiations - complemented with sustained advocacy at all levels. In the second half of 2020, OCHA– through the Ethiopia Access working group - will develop an 'Access strategy for Ethiopia' outlining the strategic approach to improve humanitarian access and including roles and responsibilities.

The arrival of COVID-19 in Ethiopia caused another layer of complexity to relief operations. At the start of the pandemic, federal and regional authorities put in place restrictions that affected the movement of humanitarian personnel and supplies. Delay of activities promoted new ways of working, such as distributing various rounds of food aid in one go or resorting to remote protection monitoring. Activities entailing direct contact with beneficiaries largely stopped/significantly reduced. Physical coordination services interrupted, forcing partners to resort to virtual meetings whenever possible. COVID-19-related restrictions gradually eased paving the way for humanitarian partners to operate freely within international and local COVID-19 guidelines. International borders have remained open for humanitarian personnel and supplies. In June, WFP and the newly established Logistics Cluster in Ethiopia put in a place a system to monitor road and border constraints.

Part 2

Monitoring and Accountability

AFDERA, AFAR, ETHIOPIA

These mulit-village schemes are part of a long term strategy to build climate-resilient infrastructure that reduces vulnerability to shocks and provides improved water service levels to the communities. .

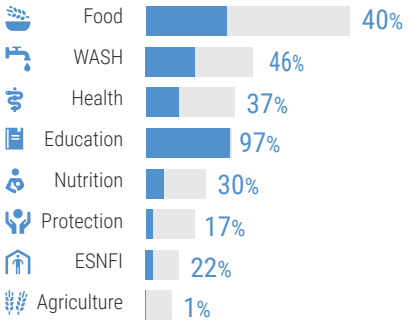
Photo: UNICEF ETHIOPIA/2019/Mulugeta Ayene

2.1

Review of Response and Achievements

After the additional annex for the COVID-19 response to the HRP 2020 was added in May 2020, the original target of 7 million was revised to 16.5 million. By June 2020, humanitarian partners had reached 8.7 million people (53 per cent of the revised target). The food sector reached 5.9 million people and the non-food sectors reached 7.1 million people with at least one type of humanitarian intervention. The assistance was provided by the 67 operational partners, including the Government of Ethiopia, INGOs, NNGOs, and UN agencies. Since March, humanitarian partners have continuously adjusted ongoing programs to included COVID-19 response components where possible. Even if the response was overall dominated by COVID-19 management and impact mitigation, the need to continue to address other humanitarian needs was recognized and address as much as resources allowed, including flood response, alternative education support and national measles campaign in June 2020 reaching 14.3 million children of 9 -59 months of age.

SECTORAL RESPONSE



Agriculture

1.4M Original Target | 1.9M Revised Target | 17K Reached | 1%

SELECTED RESPONSE ACTIVITY	ORIGINAL	REVISED	REACHED
# of people that received animal health interventions	502K	777K	167K 22%
# of people that received animal feed interventions	53K	139K	46K 33%

Education

1.3M Original Target | 6.3M Revised Target | 6.1M Reached | 97%

SELECTED RESPONSE ACTIVITY	ORIGINAL	REVISED	REACHED
# of emergency-affected school age boys and girls benefiting from emergency school feeding	1.1M	1.3M	11K 0.8%
# of children reached with radio and television broadcasting lessons	94K	6.3M	6.1M 97%

ESNFI

2.0M Original Target | 2.4M Revised Target | 536K Reached | 22%

SELECTED RESPONSE ACTIVITY	ORIGINAL	REVISED	REACHED
# of displaced people receiving emergency shelter and NFI assistance	885K	354K	285K 80%
# of displaced people receiving core relief items (Non-food items)	217K	405K	101K 25%

Food

5.9M Original Target | 14.9M Revised Target | 5.9M Reached | 40%

SELECTED RESPONSE ACTIVITY	ORIGINAL	REVISED	REACHED
# of targeted beneficiaries receiving food and/or cash	5.9M	14.9M	5.9M 40%

Health

3.2M Original Target | 6.5M Revised Target | 2.4M Reached | 37%

SELECTED RESPONSE ACTIVITY	ORIGINAL	REVISED	REACHED
# of total OPD consultations	1.2M	1.5M	959K 64%
# of community members receiving health IEC messages	3.2M	6.4M	2.4M 37%

Nutrition

3.6M Original Target | 4.4M Revised Target | 1.3M Reached | 30%

SELECTED RESPONSE ACTIVITY	ORIGINAL	REVISED	REACHED
# of new admissions for SAM treatment	444K	550K	160K 29%
# of new admissions for MAM treatment	3.1M	3.8M	1.2M 30%

Protection

2.0M Original Target | 3.6M Revised Target | 629K Reached | 17%

SELECTED RESPONSE ACTIVITY	ORIGINAL	REVISED	REACHED
# of people with specific needs identified through protection monitoring services	990K	410K	289K 70%
# of boys & girls receiving child protection services including PSS, FTR, etc.	150K	90K	32K 36%

WASH

5.3M Original Target | 7.8M Revised Target | 3.6M Reached | 46%

SELECTED RESPONSE ACTIVITY	ORIGINAL	REVISED	REACHED
# of people accessing safe drinking water (water trucking)	2.0M	2.0M	770K 38%
# of people provided with life-saving WASH NFI	4.2M	4.1M	1.7M 41%

2.2

Review of funding

FUNDING REQUIREMENTS MAY HRP REVISION
1.65B

FUNDING RECEIVED INTERNATIONAL DONORS
425.1M

FUNDING RECEIVED INTERNATIONAL DONORS
83.1M

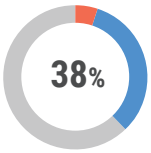
UNMET REQUIREMENTS HRP
1.14B

The Ethiopian Humanitarian Response plan, which targets 16.5 million people with life –saving humanitarian interventions, is significantly underfunded. Out of the required US$ 1.65 billion, only 31.2 per cent has been funded to date (5.0 per cent by the Government of Ethiopia, and 26.2 per cent by international humanitarian donors), leaving a gap of US$ 1.14 billion unmet requirements.

By mid-year, the HRP was at its lowest funding level of the past eleven years. The unmet requirements have never been so high before in Ethiopia at mid-year, and never before exceeded US$ 1 billion. Particularly the non-food clusters are severely underfunded, with only 26 per cent of the yearly requirements being met so far. The non-food funding level has similarly not been so low since 2012. By July the funding on the food sector level was only 38 per cent, the lowest it has been in the last 5 years.

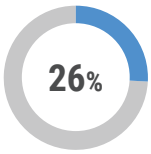
Sector/Cluster	Funding Received (in million US$)	% Overall Covered	Requirements (in million US$)
Food	291.9	38%	773.4
Nutrition	65.5	26%	252.6
Health	15.1	8%	195.0
ESNFI	5.0	5%	105.4
WASH	14.2	15%	95.5
Agriculture	5.9	8%	73.7
Logistics	3.8	6%	59.7
Protection	3.4	7%	47.6
Education	2.8	8%	35.4
Coordination	4.5	38%	12.0
Sector not specified	39.8	-	-
Multiple sectors (breakdown not specified)	56.4	-	-

FOOD



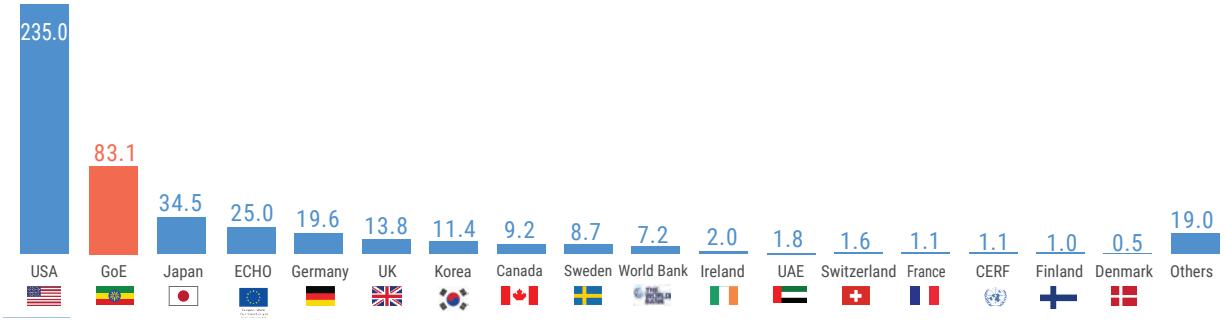
$481.5M
Unmet requirements

NON-FOOD SECTORS



$653.2M
Unmet requirements

FUNDING PROVIDED BY DONOR
(in million US$)



2.3 Review of needs

Impact of belg/spring rains on food security and livelihoods

Following the belg/spring rains, the impact of the rains on food security was analyzed using the Household Economy Analysis (HEA[1]) method, complemented with the Livelihood Impact Analysis Sheet tool (LIAS) and the Livelihoods, Early Assessment and Protection (LEAP) satellite-based crop yield monitoring system, together with early warning monitoring data from regions.

According to the satellite imagery, overall the belg/spring rains were better than in recent years, and in some areas were very good. This should have increased yields. Unfortunately, in the north of the country (Tigray and North Wollo in Amhara), the expectations from the satellite imagery were contradicted by field reports, which indicated that the rains started late resulting in much reduced yields.

COVID-19 restrictions also reduced availability of key inputs and increased prices. This reportedly reduced the area planted with belg crops by 69 per cent in Tigray, 42 per cent in Oromia, 19 per cent in SNNPR and 16 per cent in Amhara.

In addition, the desert locust infestations impacted lowlands in north eastern and south eastern Ethiopia. Overall losses of greater than 20 per cent in belg production were reported in parts of Oromia (Arsi, Borena, Guji, West Guji and East Hararge). Greater losses were reported in Somali region, with a total or near-total loss of crops in many areas. Meanwhile in northern Ethiopia (Tigray, Amhara and north-east Oromia) satellite imagery indicated an increase in yields of between 25 to 50 per cent compared to those recorded in recent year (the HEA reference year). However, these expectations were contradicted by ground reports from belg-growing areas of southern Tigray and North Wollo (Amhara). Although belg is a secondary crop for communities in southern Tigray, the crop loss worsened food security nonetheless. In North Wollo, the yield by less than 25 per cent compared to a normal year. Belg is the main crop in these areas.

SNNPR also heavily depends on belg production. The satellite data indicated yields between 90 to 130 per cent compared to recent typical years, this would have been largely offset by the reported 19 per cent reduction in area planted, leading to significant yield reductions in a number of areas (to 75-80 per cent of recent production).

In Oromia, belg production is generally of secondary importance. In many of the areas where belg is grown, yields were expected to be between 20 to 50 per cent higher than in a typical recent year. However, these increases were more than offset by the reduction in area planted, with total production in the range of 60 to 80 of that in recent years.

Gu/spring rainfall is also very important for the pastoralist and agro-pastoralist areas in the south (SNNP, Oromia and Somali region). The satellite imagery indicated that these rains were also good in 2020.

In Somali region, overall, there was about twice as much rain compared to a typical recent season. The rains were less exceptional in other pastoralist areas, but still relatively good. The positive effects of these rains were however offset in some areas by the damage done by locusts to pasture and browse. There were two waves of locust infestation, one in February (affecting pasture/browse from the previous kremt/deyr rains) and another in May/June (affecting pasture/browse from the belg/gu rains).

In many areas, pastoralists will have been able to migrate away from the areas affected by locusts to other areas where good belg grazing could be found, and the overall impact on milk production will have been limited. There should also have been relatively limited effects on mortality. In Somali region however, locusts were reported to have destroyed pasture and grazing across large swathes of the region. This made it much more difficult to mitigate the problem through migration, and very substantial reductions in milk production for all types of animal were reported. Herd sizes were also reported to have fallen significantly, presumably as a result of increased mortality.

Floods

In total, floods affected 470,163 people, of whom some 301,284 people were displaced during the belg season. Flood incidences were reported in 26 woredas in SNNP region, eight woredas in Oromia, eight woredas in Afar, 25 woredas in Somali, and in Dire Dawa city council. The highest number of people affected and displaced were in Somali region, followed by Oromia and SNNP. Moreover, landslides occurred in Amhara, Oromia, and SNNP regions.

In June 2020, the National Flood Task Force issued a Flood Alert indicating a very high probability of a wetter kiremt season in the south-west, western, and central parts of the country, especially in July and August. Predominantly normal rain is anticipated in half of the eastern part of the country. The onset of the kiremt rains was on time and are expected to benefit agriculture activities, pasture regeneration, and water replenishment. On the other hand, dry spells and erratic rainfall will likely occur in some areas from June to September.

Heavy rainfall will likely cause flooding and landslides in flood-prone areas, especially during July and August. It is estimated that some 2,066,683 people will be affected by river and flash floods during the 2020 kiremt season, of which, 434,154 people (21 per cent of the total at-risk population) across the country are likely to be displaced. In addition, there are high risks of landslides for the 2020 kiremt season in several areas in Oromia, Amhara, SNNP, and Tigray regions as well as in Dire Dawa city council.

Floods can severely damage or destroy productive assets (resulting in loss of livelihoods), destroy infrastructure (impacting affected communities' access to services/assistance), or result in displacement

of a significant proportion of the community (generating multiple other needs and protection risks). As a result, they may turn to negative coping mechanisms, leading to increased discrimination, greater exclusion, and disproportionate risks for women, children and other vulnerable groups. Moreover, displaced people will be at higher risk, as they will be exposed to different elements and protection risks without shelter and household items. Cholera and other water-borne diseases are more likely to spread during flooding due to deteriorated sanitary conditions, use of contaminated water sources, and mass movements.

Children and pregnant and lactating women (PLW) are at increased risk of malnutrition during flooding and displacement caused by limited food supplies, damage to stored food, and disease outbreaks. If nutrition-sensitive and nutrition-specific malnutrition prevention interventions like IYCF, food, WASH, and health are not adequately available and accessible, 19,508 and 77, 367 children are expected to be severely and moderately malnourished respectively, and a further 60,741 PLW will be acutely malnourished.

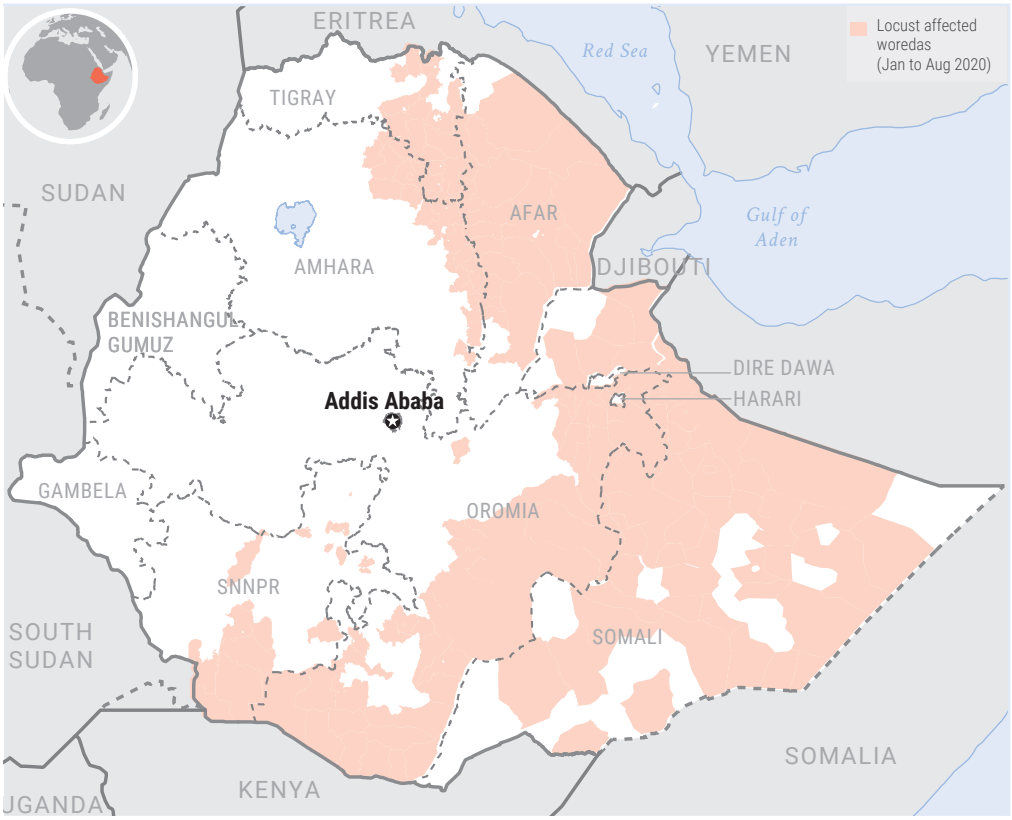
Flood-affected communities, particularly at-risk groups such as women, girls, older persons, persons with disabilities, children, and IDPs, face heightened exposure to protection risk, such as GVB and child protection (CP) risks and increased reliance on negative coping mechanisms (e.g. child labour, child abduction, transactional sex, and child marriage) while also combatting psychosocial distress/trauma. In addition, safety threats such as theft, harassment, and inter-communal violence are often reported in flood-affected communities.

Desert Locust Infestation

The unprecedented desert locust threat to food security and livelihoods persists in the Horn of Africa including in Ethiopia. Cross-border movements of immature swarms along the borders of Kenya and Somalia are ongoing. Second-generation spring swarms have formed in eastern Ethiopia while breeding started in the Ethiopian highlands. Hopper bands and a new generation of immature swarms have formed in the Oromia and SNNP regions, including the Rift Valley. Since the beginning of August mature swarms are crossing from Yemen, reaching Afar. Ground and aerial control operations continue mainly against immature swarms in the northern Rift Valley and in the Harar Highlands in the east.

More than a million people are estimated to have become food insecure due to the desert locust infestation. Women and girls continue to be particularly vulnerable on all dimensions of food security: availability, access, utilization and stability. Within the household, because of weaker bargaining position, women and girls may eat least, last and least well. Women and girls in Ethiopia continue to suffer the most from macro- and micronutrient deficiencies, with long-term negative development impacts for society as a whole. Agricultural gender inequalities remain strong, whereby women farmers are particularly at risk of hunger -especially in crises. Patriarchal norms create disadvantages for women farmers, specifically in land rights, productive resources, unpaid work, insecure employment and exclusion from decision-making.

An increase in the proportion of households using emergency livelihood coping strategies was assessed in February. The number of households using such coping strategies, including the increased sale of animals, expenditure reduction on livestock and agricultural inputs, consumption of seed stocks, and selling breed animals, increased from 22% in August 2019 to 49% in February 2020, with households in Oromia, Somali, Amhara, and Afar regions being particularly affected. Protection concerns arise from negative coping mechanisms putting at risk the most vulnerable, particularly children and women. In the same regions,



apart from Amhara, the Terms of Trade were negative as a result of very high cereal prices. Households are faced with decreasing cereal stocks and falling livestock prices. This is worrying as 25% of assessed households are dependent on markets for food and disproportionality affects market-dependent pastoralist households. Furthermore, the majority of households reported that they had limited or no cereal stocks a month after the Meher harvest.

COVID-19

COVID-19 has dominated the humanitarian landscape since the first confirmed case in Ethiopia on 13 March. COVID-19 is a health crisis but has far reaching impacts on many aspects of society such as the economy, food security, education, and protection risks. It has exposed the vulnerabilities of the country and led to an increase in humanitarian multi-sectoral needs throughout Ethiopia. Emerging data and reports have shown that all types of violence against women and girls, particularly domestic violence, has intensified (i.e. 'shadow pandemic'). COVID-19 exacerbates and magnifies existing intersectional inequalities related to gender, age, class and ability; thus, placing women, children, IDPs, migrants, and other vulnerable populations at increased risk for SGBV and IPV.

The number of confirmed COVID-19 cases have rapidly increased over the past few weeks. As of 21 August, a total of 35,836 COVID-19 confirmed cases and 620 deaths have been reported in Ethiopia. It is highly likely that the cases will continue to increase in the coming months with 59 per cent of the cases now due to community transmission[1]. COVID-19 cases have been confirmed in all regions in Ethiopia with the majority of cases in Addis Ababa.

The increase of cases will continue to put a strain on the already overstretched healthcare system and will see resources being shifted to the COVID-19 response. Regular essential primary healthcare and nutrition services are hampered or suspended and this will disproportionately affect women. Fewer mothers, women, adolescents and children under five will be able to access routine EPI, treatment for common illnesses, nutrition services, other Mother and Child Health (MCH) services, sexual and reproductive health services (including for GBV survivors), mental health and psychosocial support are also being affected. Major response gaps have already been reported in addressing the effects of the pandemic on the population's mental health while psychosocial support is underfunded across the country, with only a quarter of government health facilities offering any kind of MHPSS service. At the same time, continued services may become underutilized as people fear contamination in health facilities. Moreover, acute malnutrition, affecting children and pregnant and lactating women, is expected to increase with approximately 30 per cent during June/ July/ August due to secondary impacts of COVID-19.

The forex crunch has constrained the purchase of routine medicines and medical supplies for health system pipelines, leading to shortages. As a result, people suffering from other health conditions, including preventable communicable diseases and non-communicable diseases, may not be able to access services and receive the treatment and support they require, which could lead to an increase in other morbidities and mortality. Throughout the response and in order not to perpetuate inequalities, it is critical that gender norms, roles, and relations influencing men and women's differential vulnerability to infection, exposure to pathogens, and treatment received are addressed.

Frontline health workers, of whom a large part are women, remain one of the most at-risk groups to contract COVID-19 infection, both at the health facility and at community levels. The shortage of personal protective equipment, hygiene supplies and water further aggravate the risk. This can have several effects and impacts such as infected health workers potentially infecting health care seekers, and once diagnosed having to take time off work when they are most needed in the response, demotivating and creating fear among colleagues, and further undermining regular essential healthcare services. There is a significant shortage of qualified healthcare workers to implement the COVID-19 response in emergency-affected locations and recruitment to fill those gaps is proving difficult.

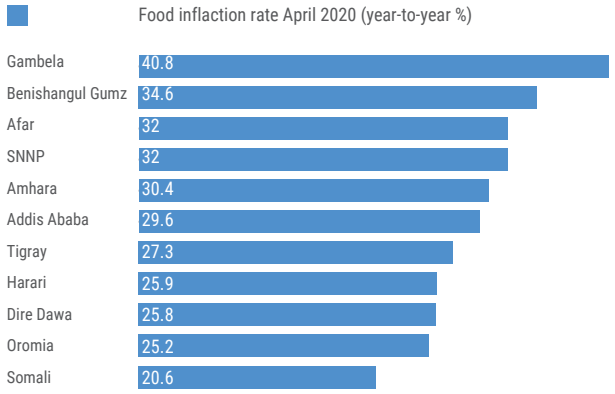
COVID-19 prevention measures have contributed to delays in the movement of commercial goods throughout the country, causing shortages of food items and price increases, and resulting in pockets of food insecurity. The urban poor, destitute, homeless and those working in informal sectors of the economy have been the most affected. As women make up 65% of the informal workforce, they are severely impacted. In rural communities, food insecurity has increased mostly among households that rely on market purchases. While food insecurity has not been severely affected so far and Addis Ababa as well as the majority of urban areas remain in IPC Phase 1, more urban areas than usual face IPC Phase 2 and 3 outcomes. Some 16 per cent of urban households reported reduced food consumption as a result of COVID-19 which has affected the affordability of food. The outbreak has a negative impact on food, cash, and in-kind distribution processes, including on beneficiary verifications at distribution sites, post-distribution monitoring, and on-site distribution monitoring exercises. Furthermore, the Government and humanitarian partners are ensuring social distancing and hygiene standards at distribution sites which increases the time required to complete distributions. As a result of movement restrictions there are also delays in moving in-kind commodities from warehouses to final distribution points.

Food supply chains have not yet been severely disrupted, but transportation difficulties have led to increased food prices, causing concern about business closures among retailers and wholesalers. This has led to increased food insecurity, especially in communities where there are existing challenges with physical and economic access to food. These supply chain disruptions is affecting pastoralist households with limited access to staple foods and vulnerable people in urban communities, such as poor households dependent on market purchases, and children and people living on the street who are currently not receiving humanitarian assistance.

Furthermore, the COVID-19 pandemic adds a layer of complexity to agricultural production in Ethiopia. Movement restrictions, enacted as prevention and mitigation controls, limit the availability of agricultural inputs, contribute to labour shortages during harvesting season and impede access to both livelihoods and markets, which in turn add to food insecurity levels in the country. Subsequently, due to compromised

access to markets, high food prices, and limited access to health care, as well as the effects of the desert locust and climate change, severe acute malnutrition is expected to increase and will represent a significant additional burden to the existing malnutrition situation in Ethiopia. With households increasingly unable to meet their basic needs, they will increasingly rely on negative coping mechanisms such as exploitive labour (including child labour) and dangerous migration, as well as transactional sex, child marriage.

Food inflation rate April 2020 (year to year %)



Source: WFP Ethiopia Market Watch May 2020

While the COVID-19 impact on the food security sector is significant, other sectors are also impacted. In March 2020, the Government announced the closure of pre-primary, primary, and secondary schools. This has interrupted the education of 26 million children, suspended school-feeding programmes to one million children, and hindered services delivered through education in emergencies programmes. The longer children are kept out of school, the higher the risk of malnutrition, school dropouts, child protection issues, and psychosocial distress becomes. Children from poor families, IDP families, girls, and children living with a disability are particularly at risk, with the disruption to their learning denying them their basic right and leading to a loss of equity gains in education and society at large. Loss of education will take away these children's only chance to transform their lives and reach their potential, which will have long-term socio-economic impacts. School closures in combination with the loss of family livelihoods could also increase the risk of reliance on negative coping mechanisms such as child labour, early marriage, or transactional sex. While the Government is working hard to provide educational services through innovative means, i.e. TV and radio broadcasting. However, the most vulnerable children are not benefitting from these services or alternative home-school methods. Particularly children in rural households, where only 12 per cent of children are engaged in any form of distance learning while engagement with distance learning of children in urban households is more than three times higher. It is estimated that 2.79 million school-aged children have access to TV, of whom approximately 300,000 are enrolled in secondary education. The Government has secured eight satellite TV channels until the end of the year to amplify reach and access to TV learning.

The COVID-19 pandemic is adversely impacting the protection situation of all vulnerable groups already in need of protection support identified in the 2020 HNO and HRP. Moreover, social distancing measures and the diversion of resources towards the COVID-19 response result in the suspension of essential protection services and humanitarian response for at-risk persons already identified as in need in the 2020 HNO, leaving these needs unmet. The suspension of social events and practices and overstretched resources in host communities, may rupture social cohesion, increasing distrust and tensions between communities (including between host and IDP communities).

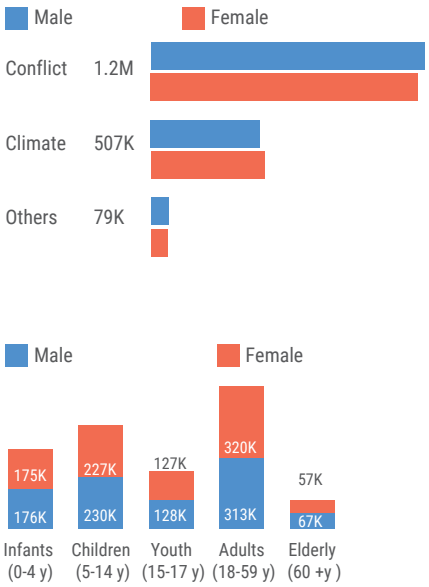
People living in densely populated areas, such as IDPs and refugees living in camps, planned sites, spontaneous settlements, collective centres and within dense urban spaces, are highly vulnerable to COVID-19. Key concerns include overcrowding as families are forced to live together in small non-partitioned spaces with shared toilet, bathing, and cooking facilities – if they have access to these at all. In July 2020, 17 cases of COVID-19 were detected among IDPs in Qoloji site, where 12,532 HHs reside in overcrowded conditions. Qoloji site is one of the 26 IDP sites in the country prioritized for decongestion by humanitarian actors and regional authorities plan to scale up response, highlighting the criticality of risk mitigation measures, and risk communication in these sites. Displaced people generally have difficulty accessing essential services such as adequate shelter, WASH, and healthcare. These challenges in combination with the likelihood of displaced persons tendency to have a higher rate of malnutrition and other underlying health conditions place them at a very high risk of COVID-19 morbidity and mortality. Another challenge for IDPs and refugees is limited access to reliable information, which will complicate their efforts to protect themselves appropriately. The absence of communication networks, language barriers, and low literacy levels can prevent accurate and timely messages reaching these groups. As only 44% of women and girls in Ethiopia are literate, this will affect them in particular. Without critical information about COVID-19, these groups may not only risk spreading the virus but also find themselves in violation of government-imposed restrictions. Protection actors' provision of information on the rights of IDPs will be essential.

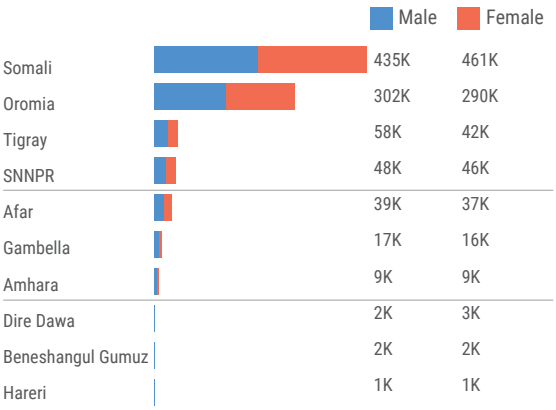
Experiences and lessons-learned from previous outbreaks, suggest that the COVID-19 pandemic may increase the risk of sexual exploitation and abuse (SEA) by humanitarian staff, state officials and armed guards. In Ethiopia, the surge in responders, combined with stringent movement restrictions and unequal access to resources, may lead to a concentration of power, wielding to the detriment of vulnerable people. This can lead to negative coping strategies for affected populations, thereby increasing the risk of SEA. Moreover, the use of isolation-measures limit access to information, reporting channels, and sexual and reproductive health services in Ethiopia. As such, the COVID-19 pandemic exacerbates and magnifies existing intersectional inequalities related to gender, age, sexuality and ability; thus, placing women, children, IDPs, migrants, and other vulnerable populations at increased SEA risk.

Vulnerable groups

While the pandemic will affect all of society, certain at-risk groups identified in the HNO 2020 such as women, children, persons with disabilities, older persons, IDPs, people to be relocated, returnees and refugees will be disproportionately affected. In addition, the pandemic

Number of IDPs by cause of displacement, sex, age and region





will also affect new groups who have not previously been targeted for humanitarian assistance, such as the urban poor, persons (including children) living and working on the street, returning migrants, refugees and persons with deprived liberties or in institutions. These vulnerable groups are at more immediate risk of contracting COVID-19 or indirect impacts because of their age, living conditions, lack of civil documentation (required to access health services), displacement status, or reduced capacity to access health services. The coping capacities of these vulnerable groups are already stretched and another shock such as the COVID-19 pandemic could increase their vulnerability and heighten the risk of turning to negative coping mechanisms.

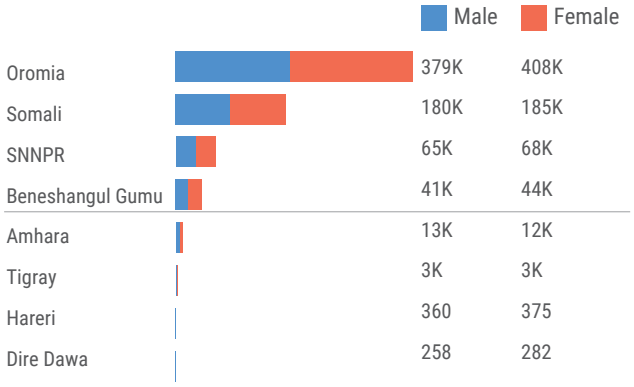
Refugees and their hosting communities: Some 760,000 refugees and members of their hosting communities are at heightened risk from the immediate health impact of the pandemic as well as the longer-term socio-economic implications. Although an Out of Camp Policy (OCP) is in place, the majority of refugees continue to live in camp settings with their host communities, in areas characterized by harsh weather conditions, poor infrastructure, low administrative capacity, a high level of poverty and poor development indicators, leaving people particularly at risk from COVID-19. Within such conditions, pre-requisite measures to limit the spread of the virus remain challenging, including maintaining health capacity, provision of basic services including soap and water and the ability to comprehensively transmit sensitization messages to combat the virus.

IDP and returnee situation

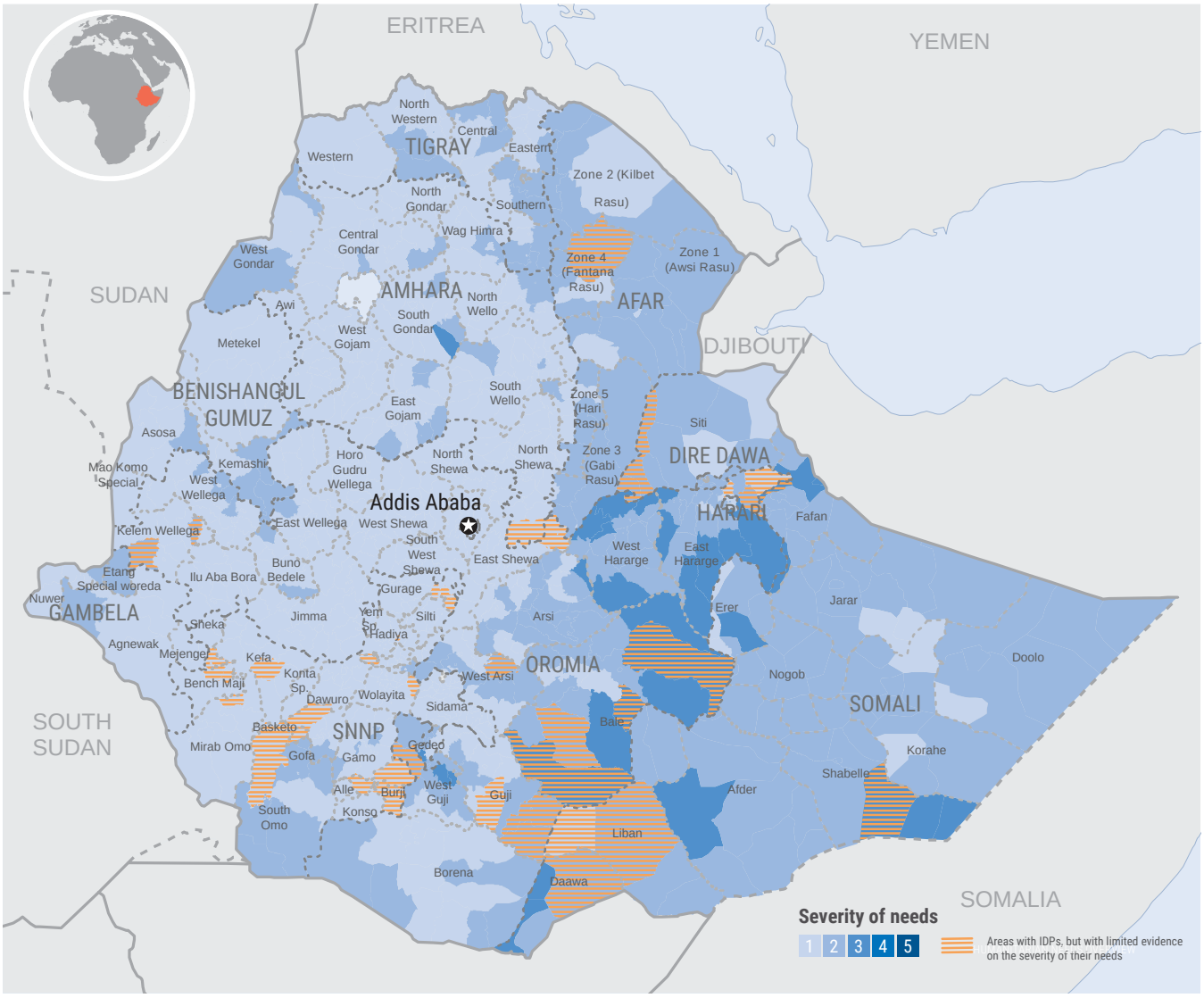
Since the beginning of the year, there have been changes to the IDPs and returnees' landscape. Overall, the number of IDPs currently stands at 1.8 million (50 per cent female IDPs) (source: draft/unendorsed results from IOM DTM round 22), and there are currently 1.4 million (48 per cent male and 52 per cent female) returnees identified through the Village Assessment Survey (draft/unendorsed result from IOM VAS round 5).

During DTM's Site Assessment round 22, it was found that there were 1,820,811 IDPs across 1,297 sites throughout the country. This data was collected from 1 June to 5 July 2020 and observed a +4.92 per cent increase since the previous round 21 which was carried out from 1 February to 12 March 2020. This increase was mainly due to the new coverage of SNNPR and Sidama which collectively had 93,982 IDPs (49 per cent female and 51 per cent male IDPs). In assessed locations, 1,233,557 IDPs (49 per cent female and 51 per cent male IDPs) were displaced due to conflict (68 per cent of caseload), 351,062 IDPs (19 per cent) were displaced due to drought and 104,696 IDPs (51 per cent female and 41 per cent male) were displaced due to seasonal floods (6 per cent).

IDP returnee by region and sex



DTM's Village Assessment Survey round 5, collected in June-July 2020, found 1,400,672 (52 per cent female and 48 per cent male) returning IDPs across 1,205 villages. There was a modest increase of +0.28 per cent since the previous round. A majority of returning IDPs (94.8 per cent or 1,328,432 returning IDPs) were initially displaced by conflict. This is followed by 37,336 returning IDPs (2.7 per cent) who were initially displaced due to seasonal floods and 33,659 returning IDPs (2.4 per cent) who were initially displaced due to drought.



Severity of needs

The severity of needs analysis at woreda level has changed since the 2020 HNO as result of changes in the humanitarian situation. The severity of needs analysis has been updated with data from the IOM Displacement Tracking Matrix, IOM Village Assessment Survey, cholera and measles incidences, SAM and MAM admissions, and the desert locust impact assessment carried out by the Ministry of Agriculture, FAO and partners.

There is no woreda in the very high or severe category.

Most woredas in the high severity category are in Bale and East Hararghe (6 woredas in each of these zones) and West Hararghe (5 woredas) in Oromia, and Fafan (4 woredas) in Somali region.

In terms of the geographical change of the severity of needs, most notable increases are in Goljano and Wajale city (Fafan, Somali), Doba, Goba Koricha and Gumbi Bordede (West Hararghe, Oromia), Shanan Kolu (Arsi, Oromia), Rayitu and Dawe Ketchen (Bale, Oromia), and Bibirsa Kojowa (West Guji).

Most notable improvements in the severity of needs, compared to January, are found in Marsin (Korahe, Somali), Lehel-Yucub (Doolo, Somali), Liben (Guji, Oromia) and Gelealo (Zone 3 – Gabi Rasu, Afar).

	Low	Medium	High	Very High	Severe
Addis Ababa	10				
Afar	7	28			
Amhara	162	20	1		
Benishangul Gumz	16	4			
Dire Dawa		13			
Gambela	12				
Harari	4	5			
Oromia	229	86	20		
SNNP	189	22	1		
Somali	12	76	11		
Tigray	31	21			

People in need

Changes in the humanitarian situation, most notably due to the desert locust infestation, increases in food security and malnutrition rates, and diseases outbreaks in the country, have impacted the number of People in Need (PIN). The number of food insecure people have been determined through the Integrated Phase Classification (IPC) and the HEA. This has resulted in an increase in the non-COVID PIN from 8.4 million (2020 HNO) to 9.8 million currently.

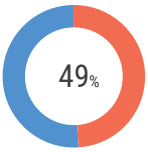
The impacts of COVID-19 and related restrictions have caused an additional 9.4 million people to have humanitarian needs, ranging from food insecurity, disadvantaged children out of school, protection needs, water, sanitation and hygiene needs, and health care.

TOTAL PEOPLE IN NEED

19.2 MILLION

PEOPLE IN NEED DUE TO COVID-19

9.4 MILLION



NON-COVID-19 PEOPLE IN NEED

9.8M

BY POPULATION GROUP

General non-displaced	16.4M
Returnees to home	660K
Conflict idps in host communities	626K
Conflict idps in sites	608K
Climate induced idps	587K
Returnees to area of origin (Not home)	311K

BY REGION

Oromia	7.1M
Amhara	4.0M
SNNP	3.4M
Somali	2.2M
Tigray	1.1M
Addis Ababa	545K
Afar	387K
Benishangul Gumz	230K
Dire Dawa	123K
Gambela	99K
Harari	90K

FARO HEALTH POST,AFAR ETHIOPIA

Fatuma Yayo holds her neighbour, nine-month-old Fatuma Ibrahim, at Faro health post in Afar region. Photo: UNICEF/2018/Demissew Bizuwerk

2.3

Summary of Needs, Targets and Requirements

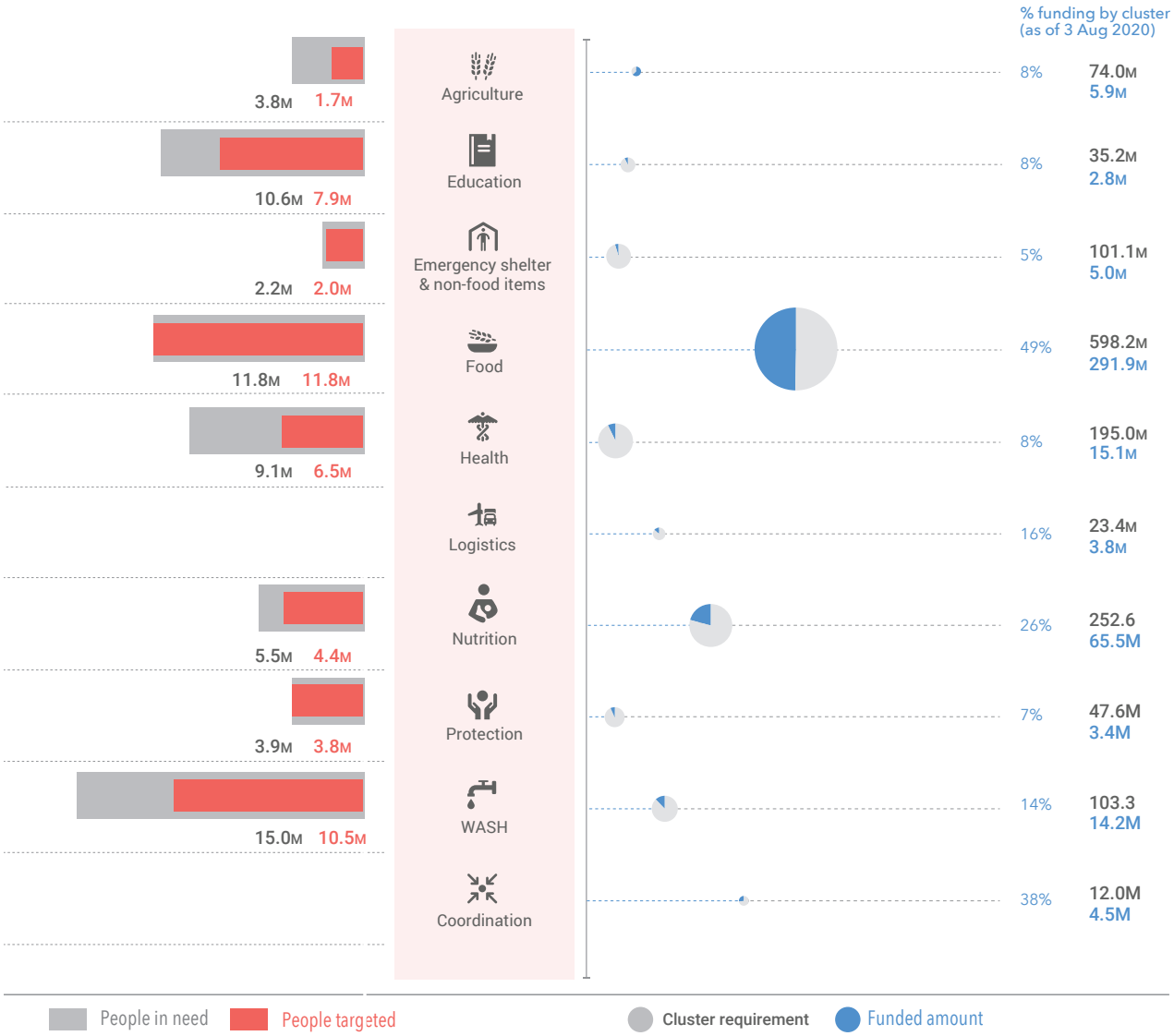
People in need 19.2M

People targeted 15.1M

35.3% funded

Requirement 1.44B

Funded 508.2M



2.4

Inter-Agency Accountability to Affected Populations and Protection from Sexual Exploitation and Abuse

Accountability to Affected Populations (AAP) and Protection from Sexual Exploitation and Abuse (PSEA) are an integral component of the 2020 HRP and will continue to be mainstreamed throughout the Humanitarian Programme Cycle (HPC). In the second semester of 2020 the Government and the humanitarian community will continue to actively promote and support efforts to fulfil Commitments on AAP and the Core Principles Relating to PSEA, as outlined by the IASC, as well as the Grand Bargain Participation revolution: include people receiving aid in making decisions that affect their lives.

SEA will be recognized as a form of GBV and a serious breach of accountability resulting in adequate investigation and victim assistance. Coherence will be ensured with the IASC Results Group 2 on Accountability and Inclusion, and IASC plan for accelerating PSEA in humanitarian response at country-level. The Government and the humanitarian community will support the use of standards and benchmarks for overall quality, including AAP and PSEA, in order to measure and verify joint achievements at national- level and/or response-level. The results will be shared locally and globally and will be used throughout the HPC.

The Government and the humanitarian community will promote the collective use of relevant standards such as the Core Humanitarian Standard on Quality and Accountability and the Humanitarian Standards Partnership - with Sphere Standards -, to strengthen system-wide humanitarian action in Ethiopia.

An Inter-Agency Multi Sector AAP and PSEA Framework will be designed as a reference for the 2021 HRP. It would be the common reference for all accountability and PSEA-related activities falling into a national inter-agency work plan for 2021.

The Inter-Agency Accountability Working Group (IAAWG) and the Ethiopia PSEA Network in Ethiopia will work jointly to ensure inter-connections. They will contribute to the design of the Inter-Agency Multi Sector AAP and PSEA Framework and of a work plan for 2020 in a participatory manner. The IAAWG and the PSEA Network will reinforce coordination with the Government, the EHCT and the ICCG and clusters. The EHCT will provide the IAAWG in Ethiopia with support and specific resources to be defined – i.e. advisory, coordination-oriented, capacity building, technical and/or financial. Clusters will incorporate and mainstream AAP and PSEA within their sectoral plan and implementation. Preparation of indicators and allocation of specific resources for AAP/PSEA will be key. Agencies will name Focal Points and monitor jointly AAP/PSEA implementation as per the indicators identified.

A people-centred approach: Proposed priority areas on AAP and PSEA for 2020

The EHCT and the UNCT will adopt a PSEA strategy and disseminate collective messaging on humanitarian principles and people's rights through appropriate channels and styles. Government and the EHCT will promote a people-centred approach throughout the HPC and the Clusters by having strategies and tools relating to cross-cutting and transversal themes such as the inclusion of most vulnerable people, community engagement, etc.

Human rights-based approach (HRBA) in humanitarian and protection response creating the fundamental legal relation between the right holders and duty bearers as per international human right standards is important. The EHCT will promote meaningful and appropriate Communication and Community Engagement (CCE), information to, the participation of and leadership of affected populations and communities across the HPC, in an inclusive manner and at both national-local level and response level.

Mechanisms to ensure two-way communication

Key to this people centered approach are the mechanisms for feedback and complaints. Government and the EHCT will support the development of a reliable inter-agency Community-Based Complaint Mechanism (CBCM) which will enable to map agency/organisations -specific complaints and feedback mechanisms (CFMs). It will also allow to complement those mechanisms with collective mixed tools for the affected populations and communities to share feedback and raise complaints. The IA CBCM will specifically allow to prevent, respond to and investigate incidents of SEA in a safe manner. It will build on best practices and consider relevant languages, format, cultural style and channels.

Complaints coming from communities will be sorted out and appropriate linkages will be done with respective government structures at different levels, based on their relevance and on the type of complaint. Their proper handling and response will be monitored. Wherever possible the IAAWG will also work through its members on establishing joint mechanism for complaint handling systems, especially at grass-roots level where government stakeholders will be involved.

Feedback and complaints' analysis will feed into the HPC and allow for adjustments to be made. This analysis will contribute to guiding the cluster approach and implementation.

The EHCT will support a thorough inter-agency learning strategy and

capacity building to enhance Quality and AAP as well as PSEA in collaboration with appropriate Government structures. An official and standardized PSEA curriculum is in the process of being developed and the trainings will target the PSEA Network members, focal points, cluster/sector task forces, partners and Government staff.

Finally, the EHCT will support a collective inter-agency measurement and verification process – self or externally-led - taking people and communities' perceptions into account and will share results.

Implications for AAP/PSEA during COVID-19 Response

Against the backdrop of the COVID-19 pandemic, it has become globally increasingly evident that the measures held necessary to control the spread of the virus, also increase the risk of GBV/SEA and limit the affected persons' ability to access external support. As such, it is critical that all actors – across all sectors – involved in global and in local efforts to respond to the COVID-19 health emergency, accentuate PSEA in humanitarian programme, planning and implementation.

The COVID-19 health emergency exacerbates and magnifies existing intersectional inequalities related to gender, age, sexuality, race, class and ability; thus, placing women, children, IDPs, migrants, and other vulnerable populations at increased risk of SEA by humanitarian and development actors, implementing partners and government partners. Moreover, the use of isolation measures limits access to information, reporting channels, and sexual and reproductive health services in Ethiopia.

While the pandemic does not in any way create new responsibilities for humanitarian actors, it does highlight the importance of actions that protect against SEA, which can only be achieved by strengthening existing inter-agency PSEA commitments and effective communication with communities.

Within this context, the inter-agency Ethiopia PSEA Network follows the IASC guidance and recommended actions on PSEA during Covid-19.

Inter-agency AAP/PSEA main activities through the first half of 2020

The IAAWG and he PSEA Network have closely liaised to ensure cross learning and joint advocacy, together with the with GBV AoR and through other related topics such as Community Engagement.

Community consultation through regional missions and joint assessment in Quarantine Centers had led to specific AAP/PSEA collective planning and launch of initiatives.

A PSEA Working Group on CBCM is led jointly with the IAAWG to allow for single inter-agency mechanisms, complement and avoid confusion and duplications for communities. This working group has designed a data collection tool which will be tested in quarantine centers. Engagement with national authorities through the ECC and MoWCA has been very concrete. NDRMC and MoWCA are now part of the PSEA Network and the ECC has delegated MoWCA as the technical Ministry to lead the implementation of CFMs in quarantine centers with support from the PSEA Network and the IAAWG.

Finally, global guidance such as the CHS Commitments and the PSEA principles have been contextualized, translated and disseminated through both the IAAWG, the PSEA Network and the Protection Cluster. Capacity strengthening initiatives through trainings and guidance are ongoing and are a key component of the revised 2020 PSEA Strategy and inter-agency work plan.

Inter-agency AAP/PSEA priority activities through the second half of 2020

The mapping of efforts to ensure PSEA (baseline assessment) will be complemented to ensure evidence-based analysis. A key joint AAP/PSEA activity will enable to map the CFMs and GBV services in at least three regions and initiate the design of a comprehensive approach to an IA CBCM, encompassing AAP and PSEA/GBV with specific SoPs ensuring specific attention to immediate victim assistance and referral pathways. The PSEA regional networks will be involved and supported through this initiative. This will also be closely linked to clarifying reporting mechanisms – including investigations' follow up - and exploring the setting of a Sexual Misconduct Disclosure Scheme, as a key component falling under the 'Do no Harm' principle. Capacity strengthening of member agencies on AAP and PSEA will be conducted in a systematic manner with appropriate tools and pace. Alongside the PSEA Network and the IAAWG will promote access to reliable, accurate and timely information through training and information campaigns to ensure continuous and strong two-way intersectional communication with partners, stakeholders and affected populations. Overall linkages with the centrality of protection and the Gender-Based Violence (GBV) and Child Protection (CP) AoR will be reinforced to ensure a system-wide people-centred approach.

Gendered Response

Intersectionality continues to be an essential component of the 2020 HRP, ensuring the continuum of equitable, effective and participatory humanitarian action that responds to specific needs and priorities of crisis-affected people of different gender, age, class, and ability. By ensuring and safeguarding evidence-based assistance that targets individuals and groups most in need, as well as by monitoring the impact on those assisted, the humanitarian community in Ethiopia aims to dismantle barriers and discrimination in humanitarian programming.

This will be achieved by fully integrating the concept of gender mainstreaming throughout the humanitarian program cycle (HPC), reinforcing a human rights-based approach to humanitarian action; thus, also presenting opportunities for new and for more progressive gender roles and relationships to emerge in preparedness, response and recovery.

As such, the humanitarian community in Ethiopia recognises that – whereas equality is about choice – empowerment is about the agency required to achieve this choice. Women, girls, men, and boys from (different intersectional backgrounds) must not only have equal access to resources and opportunities but must also have the agency to use these rights, capabilities, resources and opportunities to make strategic decisions. Focusing on transforming the systems that perpetuate gender inequality in Ethiopia is thus a key to the 2020 HRP.

The Gender Technical Working Group (GTWG), through its inter-agency coordination role, will support this process, providing technical expertise, capacity-building, as well as evidence-based response and advocacy. More specifically, online training on the use of sex- and age-disaggregated data (SADD) and gender analysis will be facilitated by the working group in order to promote gender-responsive programming. This is important, as - so far - the absence of intersectional baseline data in Ethiopia has restricted access to gendered evaluation methods.

2.5 Centrality of Protection

Protection demands meaningful engagement with affected persons during all phases of a response in a manner that recognizes and is sensitive to age, gender and diversity. A meaningful engagement that goes beyond dialogue and risk assessment should enable humanitarian actors to respond to the priorities of affected persons and determine the impact of humanitarian action (or inaction) on them and, in turn, to design, implement and adapt activities that address or prevent patterns of violence, abuse, coercion and deprivation and assist people to claim their rights. Protection mainstreaming, an imperative for all humanitarian actors engaged in humanitarian response, ensures a protection lens is incorporated into operations. It is a way of designing and implementing all programmes so that protection risks and potential violations are taken into account (IASC Policy on Protection in Humanitarian Action, 2016).

The Centrality of Protection in the Humanitarian Response

Crisis, such as climate shocks, inter-communal violence, political violence, and resultant internal displacement heightens protection risks for affected populations. Protection risks have further increased post-COVID-19 pandemic. Risks to those already marginalized in society and affected by multiple other shocks — including women, children, older persons, persons with disabilities, ethnic minorities, internally displaced persons, those with chronic medical conditions, persons deprived of their liberties, persons living or working on the streets amongst others – are exacerbated. Many of these persons are already living in precarious conditions lacking adequate access to livelihoods, income, education and protection, increasing their exposure to violence, abuse, coercion, and discrimination. On top of these deprivations, the lack adequate water, sanitation, health care and overcrowded or inadequate shelter further increases their vulnerability to diseases – and in particular to COVID-19. If exposed to the virus, those who recover and their families may also encounter additional social stigmatization and discrimination creating further protection concerns and potential exclusion from programmes and services. Due to misinformation and the overall climate of fear, there is a clear risk of stigmatization and related discrimination against displaced groups and their alleged connection to the spread of COVID-19. Disseminating clear and accurate information on how COVID-19 does and does not spread is key in this respect and effective communication with communities at the grassroots as well as complaints and feedback mechanisms is necessary to protect these individuals, and to improve access to programmes and services for those most at-risk.

Desert locust infestations are exacerbating food insecurity, affecting livelihoods, and potentially leading individuals to negative coping mechanisms, as families struggle to survive. Recurrent floods and drought also add to increased vulnerabilities through mass displacements, loss of livelihoods, homes, and lives. Movements of IDPs in Government-led return and relocation has also led to humanitarian need, on top of the on-going shocks.

While the focus on health, adequate shelter and water for COVID-19 response are critical, food security and livelihoods for desert locusts response, shelter/NFI and food for returns/relocations are equally important. Ignoring protection or failure to mainstream protection in the response could also do harm, lead to exclusion, intra-communal violence, and further compound vulnerabilities

Ensuring safe, equitable, dignified, and accessible and inclusive assistance to all affected persons in Ethiopia is essential, even more so with the on-going shocks deeply affecting communities and exacerbating vulnerabilities and marginalization. Therefore, all humanitarian actors must, at a minimum, prioritize safety and dignity and avoid causing harm, and incorporate meaningful access and inclusion, accountability, and participation and empowerment into their activities.

Clusters will continue to identify potential protection risks and barriers to accessing services and facilities in relation to their interventions and suggest mitigation measures to address them, as well as promote access for persons with specific needs and hard-to-reach groups. In addition, they will monitor and check if these measures are effective to reduce the access-to-service barriers that the most at-risk groups face. Consulting all affected population and receiving feedback is essential in this regard. Moreover, providing information to affected communities about their rights and services available should be provided in multiple formats and local/relevant languages to address literacy, language and disability barriers.

Part 3

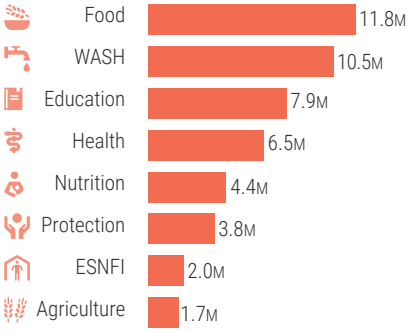
Sectoral Objectives and Response

Overview of Response

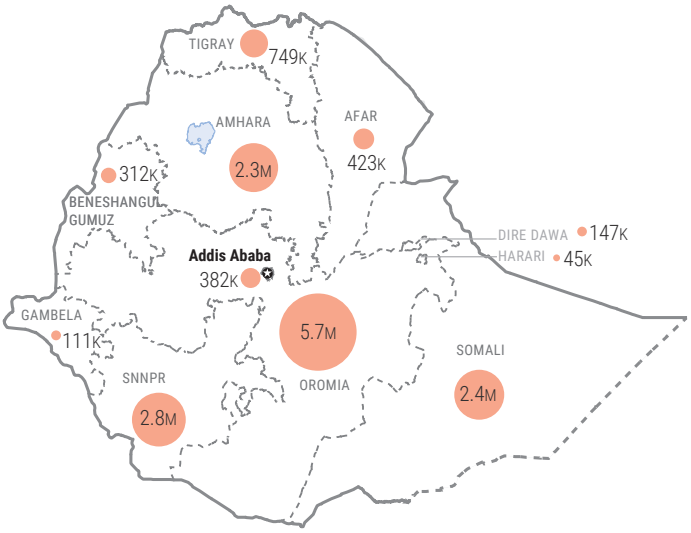
TOTAL PEOPLE TARGETED

15.1 MILLION

PEOPLE TARGETED BY CLUSTER



PEOPLE TARGETED BY REGION



PEOPLE TARGETED BY REGION AND CLUSTER

	Agriculture	Education	ESNFI	Food	Health	Nutrition	Protection	WASH
Addis Ababa	-	-	37K	95K	-	-	-	382K
Afar	47K	85K	68K	421K	295K	289K	121K	301K
Amhara	61K	2.1M	14K	1.2M	368K	532K	490K	1.4M
Benishangul Gumz	16K	144K	78K	312K	79K	24K	40K	82K
Dire Dawa	7K	56K	7K	147K	6K	-	1K	77K
Gambela	1K	71K	20K	111K	15K	2K	32K	19K
Harari	1K	36K	-	45K	2K	-	18K	20K
Oromia	706K	2.5M	880K	4.4M	3.2M	1.4M	1.8M	3.9M
SNNP	39K	2.0M	37K	2.6M	372K	579K	188K	691K
Somali	762K	218K	870K	1.9M	2.1M	1.3M	676K	2.4M
Tigray	81K	726K	-	512K	180K	211K	426K	507K

3.1

Agriculture

ORIGINAL TARGET	REVISED TARGETED	ORIGINAL REQUIREMENTS (US$)	REVISED REQUIREMENTS (US$)
1.4M	1.71M	$54.0M	$74.0M
COVID-19 RELATED	0.1M		$0.3M
NON COVID-19 RELATED	1.6M		$73.7M

PRIORITIZED REQUIREMENTS

$22.0M

% CHILDREN	% WOMEN	% PEOPLE WITH DISABILITIES
53%	23%	17%

Change in context

The Agriculture Sector in Ethiopia is facing unprecedented, complex and overlapping threats. COVID-19 pandemic and the desert locust upsurge erode food security and livelihoods assets of vulnerable communities. The sector objective remains to address the importance of access to livelihood support and protection of productive assets for crises affected households - contributing to mitigate the impact of food price inflation, reduced food availability and limited food access. Limited access to markets, reduced crop production, diminished livestock body conditions and its implications on market prices and food availability are some of the consequences desert locust and COVID-19 have on livelihoods of vulnerable households. Whilst humanitarian needs and vulnerabilities triggered by drought and displacement remain a priority, responding to the needs that arose due to desert locust and COVID-19 are key to prevent further deterioration of an already fragile food security situation and mitigate humanitarian consequences of the overlapped shocks. Lastly, due to COVID-19 pandemic and mitigation measures, the response capacity of cluster partners has been altered but not decreased. Operational presence of partners throughout areas with high severity of need remains.

Objectives

For 2020 mid-year review, the Agriculture Cluster continues to aim for support and sustain core agriculture livelihoods of vulnerable households to strengthen their coping capacities, mitigate food insecurity and restore livelihoods of the most vulnerable. Moreover, protection of core-livelihood assets and enhancing access to a productive life contributes to the mitigation of negative coping strategies that households usually face to deal with crises.

To reduce the double burden caused by restriction measures and drastic loss of income as well as access to nutritious food who depend on agriculture as a primary livelihood, the agriculture cluster will adjust the target to 1.71 million people targeted with protection and sustainment of their core agriculture livelihoods.

Revised cluster strategy and response priorities

The Agriculture Cluster with the Ministry of Agriculture will remain working in partnership with NGOs to ensure the needs of the affected population are being addressed. The Cluster will continue to provide livelihood assistance and protection to 1.71[1]

[1] For the Agriculture sector, PiN and targets represent heads of household.

million people in areas of high severity of need. The agriculture interventions aim to protect and sustain livelihoods of vulnerable households comprising the overlap of desert locust affected households and other shocks, female headed households, people with disabilities, child headed households and displacement affected households living with host communities, that returned to their places of origin or relocated elsewhere and have access to land and/or own livestock. Given the interventions of the agriculture cluster focus on protecting and sustaining livelihood of affected and most vulnerable population, livelihood interventions benefit households.[1]

[1] idem

At the same time, ensuring women and groups with specific needs are targeted in the agriculture response, the cluster advocates for community-based targeting including consulting women of different ages, as well as persons with disabilities. For the response, voucher or cash modalities, one-time distributions and sanitation measures at marketplaces will be encouraged among partners. Distributions

through in-kind, cash and voucher modalities will depend on market access and COVID-19 sensitive measures as well as protection and gender considerations.

These cluster response priorities comprise areas with high levels of food insecurity according to IPC phase 3 and focuses on the targeting of geographic areas that overlap with the needs and woredas that have been affected by the desert locust upsurge. Agricultural production in pocket areas of Somali, Oromia, SNNP, Afar, Tigray and Amhara have been damaged by the upsurge and threats of a second wave of invasion remain.

Response plan

As desert locust invasions will lead to considerable drop in agricultural production, livestock feed and forest cover, targeting desert locust affected areas with livelihood support is pivotal to compensate damages in crop and livestock production. Given the substantial overlap of desert locust affected woredas and already food insecure and vulnerable woredas, affected areas of Somali, Oromia, SNNP, Afar, Tigray and Amhara will be prioritized.

The impact of COVID-19 in food security and nutrition through the reduced agricultural activities in already chronic food insecure areas represent a double burden for populations facing critical health conditions and unsteady access to nutritious and diversified sources of food. The sector will expand its priority to vulnerable pastoralist and agro- pastoralists that have access to land. These are mostly in pocket areas of Oromia and Amhara, Somali region, Afar and the corresponding bordering areas of Southern and Eastern Tigray.

On the other hand, displacement affected households remain part of the sector targets in both scenarios. Compounding displacement affected people that returned, relocated or remain among host communities, with access to land and/or own livestock assets in areas of high severity of need. These areas are mostly in East and West Wollega, East and West Haraghe, Guji and West Guji in Oromia, Kamashi in Benishangul Gumuz and Sitti and Fafan zones in Somali region.

For the response, the Agriculture Cluster will prioritize the activities that protect, maintain and restore productive assets of vulnerable households. Food insecurity and malnutrition of the most vulnerable households shall be tackled through provision of emergency crop, vegetable and forage seed for households with significant harvest reduction, distribution of essential farm tools and equipment, and provision of animal feed and health interventions mainly to protect core-breeding livestock and consequently protecting milk production and reproduction success rates.

Cost of response

The Cluster will require an estimated amount of $74 million to address the needs of the 1.71 million people targeted through humanitarian and resilience interventions in 2020. Costing established based on the input requirements and the operational expenses to provide a standardized response. Minimum standard packages for livestock interventions and agriculture inputs are considered when developing the response. The cluster response plan is in line with selected activities under each strategic objective. Activities were selected according to the needs and requirements of targeted population based on previous assessments including Food Security and Nutrition Monitoring Survey (FSNMS), Integrated Phase Classification (IPC) analysis results, agriculture partner's consultation and projections of COVID-19 on food supply chains and food security.

Monitoring

The Agriculture Cluster partners will provide monthly reports through the 5Ws, with situation update for the implementation sites, targeted population, and implemented activities. The Cluster 5Ws reporting and monitoring tool will comprise COVID specific interventions. Additionally, monitoring will comprise ad-hoc partner reporting, assessments and post-distribution monitoring. The Cluster will monitor desert locust specific interventions within the HRP and partners' contributions to survey and control operations that do not comprehend HRP targets.

As a result of the 5Ws reports, information management derivative products like dashboards that summarizes the work at the sector against the HRP targets, partner's operational presence, gap analysis used for highlighting gaps and overlaps on monthly basis as well as the Cluster newsletter. This information will be shared with donors for increasing funding and support to the Agriculture Cluster and with OCHA for inter-cluster coordination.

Objectives, Indicators and Targets

		JAN		REVISED MYR	
OBJECTIVE	INDICATOR	IN NEED	TARGETED	REVISED PIN	REVISED TARGET
Cluster Objective 1: To enable 1.25 million target population to maintain and restore their basic needs by December		**2.8 M**	**1.4 M**	**3.8 M**	**1.7 M**
	1.1 Number of people that received animal health interventions	1 M	502 k	1.8 M	1M
	1.2 Number of people that received animal feed interventions	92 k	53 k	243 k	60 k
	1.3 Number of people that received agricultural inputs	1.6 M	431 k	1.9 M	792 k
	1.4 Number people that received restocking intervention	43 k	18 k	43 k	18 k
	1.5 Number people that received destocking intervention	2 k	2 k	2 k	2 k
Cluster Objective 2: Contribute to the recovery and resilience of crisis affected people through humanitarian interventions in 2020				**0.9 M**	**0.7 M**
	2.1 Number of people benefited with established or rehabilitated water harvesting structures	599 k	445 k	599 k	445 k
	2.2 Number of people benefited with rangeland management interventions	140 k	132 k	130 k	59 k
	2.3 Number of people that received forage seed provision	244 k	154 k	244 M	154 k
	2.4 Number of people benefited with established feed and seed banks	86 k	34 k	86 k	34 k
	2.5 Number of people that received short maturing seed provision	130 k	59 k	130 k	59 k
	2.6 Number of people benefited from livelihood diversification interventions	244 k	154 k	244 k	154 k

3.2

Education

ORIGINAL TARGET	REVISED TARGETED	ORIGINAL REQUIREMENTS (US$)	REVISED REQUIREMENTS (US$)	
1.3M	7.9M	$30.0M	$35.2M	
COVID-19 RELATED	7.5M		$15.7M	PRIORITIZED REQUIREMENTS $11.5M
NON COVID-19 RELATED	1.1M		$19.6M	

% CHILDREN	% WOMEN	% PEOPLE WITH DISABILITIES
100%	0%	12%

Change in context

After the first case of COVID-19 was confirmed in March 2020, the Government decided to close schools and other education institutions, halting the learning of more 26 million school aged children (3 -18 years). Education Cluster partners have since then worked closely with the Ministry of Education to deliver learning opportunities through distance learning modalities. Remote learning methods had not previously been applied in public education, and new challenges were therefore encountered, including high cost of delivery (radio and television broadcasting), the need to address households without radio sets (particularly for displaced populations), language of delivery and community engagement. The Education Cluster targeted 6.2 million school aged children for the combined HRP 2020 and COVID-19 EiE response from May 2020. As of the end of July 2020, more than 6 million children had been reached through radio and television broadcasting. but it critical to record that the learning was time bound based on the resources spent on broadcasting the radio and television-based lessons. Without additional resources, the distance learning initiatives will not continue. Therefore, the target for learners has increased to 9,486,291 million children, although the amount requested by the Education Cluster will remain at $35.4 million. By the end of July 2020, the Education Cluster received $2.8 million for the COVID-19 and HRP 2020 response which amount to only 8 per cent of the total requirement of $35.3 million according to Financial Tracking Service (FTS). The high reach of learners was necessitated by reprogrammed education funding that went to COVID-19 response activities from other priorities like school feeding which could not be implemented with closure of schools.

Education partners indicate that less than 20 per cent of children are reached through radio and television lesson broadcasting and other online platforms. Children in pastoralist areas, IDPs in camps and camp like settings and in far remote areas are disadvantaged as the areas lack infrastructure such as electricity and households lack radios and television sets. The cluster will focus more on the marginalized and most vulnerable children, including girls, who based on lessons learned from previous outbreaks are more prone to child marriage and other forms of violence. The Education Cluster has increased the target of the school aged children to be reached with distance learning. There have been plans to reopen schools, however, as of early August 2020, the actual timing has not been announced by the Ministry of Education. The Education Cluster partners, and the Ministry of Education have recognized that even with schools reopening, a blended learning approach of a mix between distance and face to face lesson delivery modes, will needed. This is based on that some learners will continue to learn remotely either continuously or at intervals.

Cluster objectives

1) increase access in provision of learning opportunities to COVID-19 and other emergency affected school aged boys and girls through distance and remote learning

2) ensure safe and inclusive school environments for children and communities

3) maintain the continuity of learning through acceleration, improvement and resilience building of leaners and communities.

REVISED CLUSTER STRATEGY AND RESPONSE PRIORITIES

In the June 2020 HRP revision, the Education Cluster adjusted the cluster plan to incorporate COVID-19 needs and responses in order to ensure the safety of school children and communities. The response is focused on addressing education needs of children and communities before schools reopen, during school reopening, and supporting education continuity. Professional technical guidance by

the Ministry of Health and other sectors such as WASH, protection and WASH is required if schools will reopen during the pandemic. The cluster will collaborate with protection sector in entrenching community based protection mechanisms to protect school children from the increased risks occasioned by the pandemic. Parents-Teacher Associations will be empowered through knowledge and orientation to referral pathways to especially address the causes and possible solutions in protecting adolescent girls from early marriages. Community protection mechanisms are acceptable from cultural and religious perspectives of communities since the representatives are critical community influencers.

Surveys carried out by education partners and humanitarian actors on the impact of COVID-19 on communities, indicate various adverse effects on people's livelihoods, social protection and basic human rights. Teenage pregnancies, gender-based violence and abuse and exploitation of children have increased. School children, particularly girls, have been disproportionately affected and are at risk of not returning to school. Thereby, the children are denied their basic right and halting improving equity in education and the society in general. The cluster has prioritized education intervention to displaced people, girls, children with disabilities and children in pastoralist communities.

Response plan

The Education Cluster is focused on delivering education services to emergency affected children and communities. This is achieved by targeting the most vulnerable, namely children in emergency affected pastoralist areas, IDPs, returnees, girls, adolescents and children with disabilities. The cluster work in synergy with the Ministry of Education at federal and regional levels and in collaboration with communities. Centrality of protection principles will be implemented through training teachers in MHPSS, School Related SGBV, Teachers Code of Conduct in emergencies, Child protection principles and orientation of child-friendly schools.

All education in emergencies assessments will include children with disabilities and advocate for provision of learning opportunities to teenage mothers.

Service delivery modality for education response:

When schools reopen, distance learning modalities and Ministry of Health approved presential lessons will be delivered. Cash based programming for education is targeted for female and child headed households. This cluster strategy is already being implemented by the education refugee partners for EiE.

The education response has a critical protection function. Schools provide a safe environment for children away from the risks of exploitation, abuse, neglect and gross violations of their rights. Girls in school are less likely to become pregnant and married off. Children from poor households get an opportunity to have school meals which are at times the only food they may have. The school have linkages with health and sanitation actors who easily make referrals when related challenges arise. The cluster response includes these considerations during the implementation of education projects.

Cost of response

The Education Cluster has raised the number of targeted children from 1.3 million to 6.2 million. The increase reflects the great need to reach out to children with distance learning modalities during COVID-19 school closures. The Cluster is striving to ensure continuity of education is upheld which is a basic right to children and becomes a protection

function of education through parental/caretaker empowerment. The total financial request for COVID-19 and non-COVID-19 response is $35.3 million. Provision of learning spaces has been deprioritized owing to the possibility of prolonged closure of schools due to the pandemic. With decreased and lost livelihoods due to economic effects of the COVID-19 pandemic, malnutrition and food insecurity, especially in rural areas, are bound to increase. Lack of school feeding to deprived children affects their attendance, learner retention, and learning capacity. The key beneficiaries will be IDPs and returnees who are intended to receive first line of response services. Improvement of learning outcomes and support to learners, teachers and the community in adopting better coping mechanisms will be part of the approaches employed to reach the major outcomes of enhanced school retention, transition and completion rates. The education response targets the whole education continuum – from pre-primary to primary, and to secondary school learners – to ensure no learner is left behind in accessing education because of the crisis. The response has been costed per activity which varies with type and location. The cost per child for the response is under $10 US dollars due to the high target for radio and TV reach.

Monitoring

In order to successfully coordinate and implement the planned response, the Education Cluster will collaborate with education partners and stakeholders: MoE EMIS, IOM on displacement data and OCHA among others for information sharing and exchange. The Cluster will maintain an updated Education Cluster Monitoring Tool (ECMT) for partners which captures the key aspects of implementation and provides basis for analysis of education sector response. Partners will report monthly on their outputs. The 6.3 million target is specifically for the radio and television delivery of learning content and monitoring will be supported through the media companies that are contracted to broadcast as well as education officers at the woreda levels. Activities targeting schools in the second phase of COVID-19 response will be monitored by the implementing agencies as well as MoE and REBs. AAP (Accountability to Affected Populations (AAP) and PSEA (Protection Against Sexual Exploitation and Abuse) mechanisms will be put in place to ensure that the activities being carried out are relevant and meaningful to the beneficiaries. The ECMT will be used to generate information products that reflect gaps analysis and inform the creation of advocacy messages. The tool will also be utilized in ensuring there is no duplication or overlap of activities and assist partners in their operational planning.

Objectives, Indicators and Targets

		JAN		REVISED MYR	
OBJECTIVE	**INDICATOR**	**IN NEED**	**TARGETED**	**IN NEED**	**TAR-GET**
Cluster Objective 1: Increase access in provision of quality education to crisis affected school aged boys and girls through an inclusive, safe and protective learning environment					
	1.1 Develop and broadcast Radio/TV lessons, RC	7.2 M	6.3 M	10.6 M	7.9 M
	1.2 Number of emergency-affected school age girls and boys benefited in emergency school feeding	1.4 M	1.1 M	1.4 M	1.3 M
	1.3 Provide radio sets in hard to reach areas	1.0 M	500 k	1.0 M	500 k
	1.4. Number of emergency-affected school age girls and boys learning in safe learning environment through TLC	542 k	92 k	542 M	92 k
Cluster Objective 2: Enhance the quality of formal and non-formal learning opportunities for emergency affected boys and girls in areas of displacement, areas of return and in host communities bearing the burden of displaced persons					
	Number of displaced primary school age girls and boys received learning opportunities through ALP	542 k	223 k	542 k	223 k
	Number of girls and boys benefiting from learning materials or related cash interventions	1.4 M	910 k	1.4 M	910 k
	Distribute learner workbooks	500 k	300 k	500 k	300 k
	Number of male and female teachers trained on how to provide PSS or SEL to children	9 k	4 k	8 k	4 k
	Distribute School Thermometers	500 k	250 k	500 k	250 k
	Safe Schools Operation – Provides handwashing kits, disinfectants, water tanks	1.0 M	500 k	1.0 M	500 k
Cluster Objective 3: Empower and facilitate crisis affected children and communities in the restoration and protection of learning facilities and promoting peace through school platform					
	Back to School Campaign	2.0 M	1.0 M	2.0 M	1.0 M
	Number of displaced and returnees pre-primary school age girls and boys received learning opportunities through ASR	542 k	23 k	542 k	23 k
	Train teachers and education supervisors on SRGBV, positive discipline.	200 k	85 k	200 k	85 k
	Train primary school children and adolescents from IDP settings with life skills and peacebuilding programmes	200 k	85 k	200 k	85 k

3.3

ES/NFI

ORIGINAL TARGET	REVISED TARGETED	ORIGINAL REQUIREMENTS (US$)	REVISED REQUIREMENTS (US$)	
1.9M	2.0M	$95.8M	$101.1M	
COVID-19 RELATED	0.53M		$23.4M	PRIORITIZED REQUIREMENTS $33.7M
NON COVID-19 RELATED	1.94M		$77.7M	

% CHILDREN	% WOMEN	% PEOPLE WITH DISABILITIES
17%	53%	17%

Change in context

With a surge in displacements trends (an increase of 5 per cent between DTM21 and DTM22) and many IDPs not having access to shelter and forced to sleep in overcrowded spaces or inadequate living conditions leaving vulnerable groups not only more susceptible to disease but also at heightened risk of protection and health concerns.

More than 50 IDPs sites across five regions mainly Afar, Somali, Gambella, Oromia and Benishangul have a high population density. IDPs are living in crowded conditions in emergency shelters or in communal sites, sharing household items, and with limited or no possibility to quarantine safely, creating a higher risk of COVID-19 spreading in IDPs sites.

IDPs are categorized as a highly affected population group, however, there are more intersectional vulnerabilities among the IDP group, such as secondary displaced people, older persons, women, girls with specific needs, children, people with disabilities, and those with underlying illnesses. Furthermore, a higher percentage of IDPs are living in heavily congested and deplorable conditions.

Heavy rains and high winds in May have destroyed infrastructure, houses, and livelihood leading to displacements in multiple locations across the country. The Flood Task Force has projected that during the kiremt season (July – September), around 2 million people will be affected and 450,000 in danger of displacement.

As of 30 June, the Shelter/NFI cluster had received $15 million against its total HRP requirement of $105 million. The cluster reached 21 per cent of the revised target of $2.4 million, including COVID-19 related activities. As such, the Shelter/NFI sector is only 14 per cent funded to its overall HRP revised requirements for 2020. The Cluster requires US 101 million up to the end of the year.

Cluster objectives

The Shelter/NFI Cluster continues to prioritize the protection, safety, and health of the most vulnerable displaced households through the provision of timely, targeted, and appropriate shelter assistance and relief items. Assistance gaps range from lack of household items to lack of privacy, exposure to harsh weather conditions, and overcrowded shelters, the latter being particularly severe in the current COVID-19 pandemic.

The cluster ensures that services are proportionate to needs, and all people, regardless of gender, age, disability, ethnicity, or any other diversities, have equitable access to impartial assistance. Partners will map and address barriers to access that could influence the people's gendered and intersectional ability to participate in Shelter/NFI interventions. Additionally, cluster responses will ensure that Shelter/NFI services are within safe and easy to reach locations for the affected population. In order to ensure quality programming and ownership, it is crucial to include and have the participation of the community in all phases of the project cycle.

Revised cluster strategy and response priorities

While the overall 2020 response plan remains relevant to addressing the Shelter/NFI Cluster's strategic priorities, bearing in mind the shortfall in shelter sector funding at mid-year, the focus of some interventions will be recalibrated to what is critically needed for the remainder of 2020. The primary focus will be on COVID-19 mitigation activities for IDPs in sites, distribution of lifesaving ESNFIs to IDPs in cluster severity 4 and 5, and Emergency Shelter Repair kits for those returned to completely damaged houses. As the cluster's HRP response is currently underfunded (although a significant portion of the funding remains under 'sector not-reported' on FTS), mobilization of resources to fill significant funding gaps is an outstanding priority for the Cluster.

Noting the impact of the COVID-19 outbreak on vulnerable populations and the disruption to humanitarian response implementation, cluster partners will ensure that the most vulnerable populations have their needs met through programming that is gender, age, and disability sensitive.

Response plan

The Shelter/NFI Cluster targets 2 million IDPs, returnees, affected host communities, deportees and migrants with emphasis on child and female-headed households, older persons, separated children, people with disabilities and households at higher risk of illness. In the COVID-19 context, the Cluster prioritizes collective, spontaneous, and planned sites where people are at high risk of morbidity because of overcrowding, limited access to healthcare, hygiene and sanitation facilities, and reliance upon distributions that may involve large gatherings.

The Cluster's first-tire response follows a two-pronged strategy: (1) a provision of lifesaving activities to IDPs living in overcrowded and (2) improving the living conditions of IDPs and returnees living without adequate protection from the environment.

The most effective way to avoid getting infected with Coronavirus is a combination of social distancing and personal hygiene practices, decongestion of high-risk living situations, and provision of essential household items to vulnerable populations to reduce transmissions. This will be the cluster priority activities. The provision of core relief items to displaced households mitigates the sharing of kitchenware and hygiene items, reducing the risk of transmission from contaminated items. Essential household items target not only high-risk populations but also people in quarantine centers who need support to adopt COVID-19 prevention practices.

Similarly, the Cluster will tailor its activities with a focus on emergency packages such as Emergency Shelter Repair Kits to returnees whose houses are entirely damaged complimented with HLP, and Emergency Shelter and NFI kits to IDPs in displacement location categorized as severity3, 4 and 5 within the Cluster.

For second-tier response, the Cluster aims to reach IDPs that fall under severity 3 with Emergency Shelter and NFI kits and rental support to secondary IDPs that settled within the host community. Using multiple data sources to map damage and living conditions in return and displacement areas, the Cluster will provide Emergency Shelter and NFI kits and Emergency Shelter Repair Kits, while supporting durable solutions wherever feasible.

Prepositioning of materials at strategic locations throughout the country is key to being able to respond promptly as markets are not always accessible in the immediately after a conflict or flooding. Cash can also be "prepositioned" with agreements being established in advance.

Both cash and in-kind assistance are encouraged based on market and protection risk assessments. Cluster partners will continue to do protection analysis and mainstream protection principles in the response. The Cluster promotes integrated programming with HLP, SMS, and WASH so that interventions are comprehensive and sustainable. The Cluster encourages multisectoral assessments for more comprehensive analyses and coordinates collective site activities with SMS.

Cost of response

The Cluster has estimated $101million will be needed to provide emergency shelter and NFI assistance to 2 million people identified as the most in need. Costing for the Cluster is activity-based, and in close consultation with the SAG members, an average unit costs for the operational and administrative cost is established. Consideration has also been taken to access constraints and the impact of COVID-19. Primary cost drivers beyond the costs of the interventions are warehousing, transport, and transfer costs for cash-based programs.

Among the different prioritized interventions, around 23 per cent is planned for activities related to COVID-19. At the same time, 71 per cent is planned for an emergency response to IDPs and returnees and aligned to the Sectoral Objective 1 and 2. The remaining percentage will fall under resilience to support return and integration for returnees.

In terms of response modalities, around 70 per cent of the assistance is planned to be provided in-kind, in the form of ESNFI, and Emergency Shelter repair packages while the remaining is planned to be provided through cash-based assistance. The cost of the different type kits are developed through regional TWiGs (Technical Working Groups) and following a market monitoring costs have been adjusted, the member of SAG sets the support and operational cost.

Monitoring

Shelter/NFI Cluster partners are committed to monitoring the quality of shelter interventions and reporting unintended outcomes to ensure that activities are appropriate and effective, with adaptations made promptly where necessary. The fluidity of contexts in Ethiopia is aggravated by COVID-19 and requires increased monitoring to track evolving needs and inform changes to the response. Monthly cluster monitoring data is published on the HumanitarianResponse.info website, as well as on the Ethiopia Shelter/NFI Cluster website with complementing visual products (maps, interactive dashboards). This includes monthly RPM (Response Planning and Monitoring) reports that highlight progress against cluster targets. Additionally, the Cluster publishes quarterly reports that include data and analyses on the Global Shelter/NFI Cluster website.

The Shelter Monitoring and Evaluation Framework was revised in 2020 and included objectives, outputs, indicators, and means of verification. Indicator data is aggregated from partner projects to provide an overview of core sector outputs and remaining gaps, as well as advocate for resource allocation to identified priority activities and areas.

		JAN		REVISED MYR	
OBJECTIVE	INDICATOR	IN NEED	TARGETED	IN NEED	TARGETED
Cluster Objective 1: Ensure on-time contextualized and inclusive access to live-saving shelter & NFIs for 244,428 crises affected people to safeguard their health, security, privacy and dignity		**5.0 M**	**5.7 M**		
	1.1 Number of displacement affected population whose health safety and security is improved through the provision Emergency Shelter and NFIs	244 k	244 k	378 k	313 k
	1.2 Number of IDPs that receive in-kind or cash emergency shelter assistance for physical protection and to reduce overcrowding.			463 k	374 k
	1.3 Increase preparedness efforts through pre-positioning of ES/NFI stocks to support newly displaced households either in-kind or through cash		24 k		12 k
	1.4 Number of IDPs that received Core Relief items to reduce the likelihood of health and protection consequences			462 k	373 k
	1.5 Number of individuals who benefited from NFIs in a quarantine center			25 k	23 k
	1.6 Number of HHs whose houses are completely damaged receiving emergency shelter repair kits that consider the needs of women, children, people with disabilities, and the safety of beneficiaries.				
Cluster Objective 2: Improve the living conditions of 1,863,760 displaced affected population and basic humanitarian needs in a timely manner through provision of Shelter and NFI					
	2.1 Number of displacement affected population receiving emergency shelter and NFI assistance that considers the needs of women, children, people with disabilities and the safety of beneficiaries.	1.0 M	885 k	1.0 M	745 k
	2.2 Number of IDPs that receive in-kind or cash emergency shelter assistance for physical protection and to reduce overcrowding.			167 k	78 k
	2.3 Number of displacement affected population receiving emergency shelter repair kits that consider the needs of women, children, people with disabilities, and the safety of beneficiaries.	723 k k	723 k	499 k	325 k
	2.4 Number of displacement affected population that have received core relief items (COVID-19+Non-COVID-19) that consider the needs of women, children, people with disabilities, and the safety of beneficiaries.	217 k	217 k	685 k	343 k
	2.5 Number of individuals who benefited from NFIs in a quarantine center			50 k	47 k
	2.6 Number of HHs covered by pre-positioned ES/NFI stocks				6 k

3.4 Food

ORIGINAL TARGET	REVISED TARGETED	ORIGINAL REQUIREMENTS (US$)	REVISED REQUIREMENTS (US$)
5.9M	11.8M	$399.5M	$593.4M

COVID-19 RELATED	4.9M		$159.0M	PRIORITIZED REQUIREMENTS $593.4M
NON COVID-19 RELATED	6.9M		$434.4M	

% CHILDREN	% WOMEN	% PEOPLE WITH DISABILITIES
54%	22%	10%

Change in context

COVID-19, the negative impact of desert locust on crops and pastures and extreme weather variability are the main drivers of food insecurity in Ethiopia, in both urban and rural communities. In urban communities, there are indications of growing food insecurity due to disruption of livelihoods, particularly for households that rely on informal income sources. A survey by World Bank[1] already indicates job losses due to COVID-19, in both urban and rural communities, which suggest that the pandemic is having negative impact on livelihoods, including on access to food in both urban and rural communities. Access to nutrition rich food items is likely to be affected in the coming months, due to reduced disposal incomes among poor and ultra-poor households – especially the female and child headed households. World Bank survey also shows an increase in percent of households that have reduced food consumption as a coping strategy from 13 in round 1 to 19 percent in round 2. Findings from IFPRI's phone survey[2], which was conducted in May 2020 in Addis Ababa noted that "households are reducing food expenditures by substituting away from more nutrient-dense foods to cheaper, less-nutrient dense foods". COVID-19 will also contribute to increased food insecurity in rural communities, where there are existing high food insecurity levels due to other hazards, such as flooding, lack of sustainable livelihoods and localized conflicts.

The projected good performance of the kiremt rains will be beneficial to agricultural activities, pasture regeneration and water replenishment in kiremt rain-receiving areas. However, these above normal rains are also projected to contribute to displacements in low-lying areas of Afar, Amhara, Gambella, Oromia, Somali and SNNP regions. There also are indications that the desert locust has contributed to below normal harvests during the belg season in some areas, and the meher season will also be affected if desert locusts are not fully controlled. In areas of Afar, Oromia, and Somali to an extent the south-eastern Amhara and eastern Tigray, the weather conditions including current heavy rainfall remains favourable for DL multiplication and spreading.

Conflict affected people, including displaced and returnees, are among the highly food insecure people to be prioritized for cash and food distributions. There are some changes in number of displaced people in areas where some of the households have returned to places of origin from displacement sites. In addition, partners have reported increased food insecurity in return communities due to limited access to sustainable livelihoods sources.

The overall people in need of food assistance is estimated to have doubled from 5.9million to 11.8 million, when compared to beginning of the year. COVID-19, flooding and desert locust infestation are the main drivers of food insecurity.

Seven rounds of cash/food assistance were planned in 2020, including the bridging round between the 2020 and 2021 response plans. As of August 2020, four rounds of cash/food assistance were already implemented, to cover March, April, May and June food requirements. The mid-year review will therefore consider the remaining three rounds of assistance.

Response capacity

The Food Cluster will maintain the existing response capacity in all the targeted locations. This includes implementation of one operator per woreda principle, which is being applied to avoid duplication of assistance to targeted beneficiaries. Regional level coordination structures will continue to support the response at field level and guide the overall implementation of the response at woreda level. In the context of COVID-19, the cash/food distribution guidelines that were developed in the second quarter of 2020, will continue to employ protection measures that minimize the risk of spread of COVID-19, in line with the do no harm approach. This includes distribution of double rations, in order to reduce the number of

visits to distribution sites, minimize crowding at distribution points by having markings for entry and exit areas, and provision of good hygiene facilities. Food operators have also established cash/ food distribution points in areas that are close to beneficiaries, in areas that are accessible by vulnerable population groups. In some regions, partners have provided cash top-ups to cover transportation.

The mid-year review is highlighting additional areas where no partners were providing cash/food assistance in previous years, and these are areas that are vulnerable to COVID-19 related shocks. There are mechanisms that have been considered to ensure that all locations with food needs are covered during the second half of the year.

In urban communities, the sector will also monitor implementation of cash/food response conducted through various actors, including the Urban Productive Safety Net (UPSNP), private sectors and NGOs. This information will provide evidence that will allow for adjustments and prioritization of the Food Cluster activities.

Support to food insecure people from the PSNP public works clients will be included in the second half of the year to cover short-term food needs in some of the vulnerable households. This will be coordinated through the existing PSNP structures at woreda level.

IDPs and returnees will be prioritized in cash/food distributions, due to their limited access to food or incomes to buy food. The Food Cluster will utilize information from various sources including the DTM, village assessments and regional reports, to ensure that most vulnerable households are included in the distribution registers.

Cluster objectives

Cluster Objective: To provide emergency in-kind food and cash assistance to meet food needs of acute food insecure people.

The negative impact of COVID-19, desert locust infestation and other natural hazards will contribute to reduced access to food or incomes by the most vulnerable households. From the household survey, In Oromia out of about 35% that were involved in farming activities, 10% reported that more than half of their cropped land (50-100%) were infested by DL. In Afar, out of 25% involved in some crop production 6% reported that 50-100% of their land was infested by DL while in Somali, out of 20% involved in crop production, 20% reported 50-100% of their land was infested by DL this year. However, the understanding is that in rural areas, COVID 19 impacts are more in the context of reduced remittances and reduced availability of food in markets because traders are afraid to catch the virus. In all regions, movement of food and operation of markets are allowed as a government priority. These food insecure households will have access to food through the planned cash/food distributions. The cash assistance will be implemented and prioritized in areas where there are functioning markets and sustainable payments systems including in urban areas where COVID-19 will likely contribute to increased food needs. In-kind food items will also enable households to have access to food items through a standard food basket of cereals, pulses/CSB and vegetable oil. The Food Cluster is projecting an increase in food insecurity among households that rely on informal income sources in both urban and rural communities, including for the displaced and returnees. Flood affected people in low-lying areas will also receive cash/food rations to reduce the impact of flooding on households' food needs.

Revised cluster strategy and response priorities

The overall strategy is not expected to change in the second half of 2020. The Food Cluster is projecting an increase in food needs among urban communities due to the COVID-19 related shocks, including disruption in food systems and supply chains. It is projected that 5.5 million people will be food insecure due to COVID-19 related shocks, and these comprise of 3.4million individuals in urban communities and 2.1 million in rural areas. Some of the food insecure people will be assisted through the UPSNP productive safety-net activities, which has a plan to support vulnerable households in 27 urban cities.

Flood affected communities are also facing food insecurity, particularly communities in low-lying areas of Afar, Gambella, Oromia and Somali regions. The National Flood Alert[3] has indicated that areas in the western, south western and central parts of Ethiopia will receive heavy rains during the meher season. The Government also issued a flood contingency plan[4] in June 2020, which estimates that 2 million people will likely be affected by flooding and 430,000 will be displaced during 2020 kiremt season. The response to flood affected communities will be based on evidence from the Flood Taskforce, which is provided by regions from various assessments that are conducted at regional level. Food Cluster partners will work with partners to ensure timely distribution of humanitarian assistance to food insecure people in flood prone areas.

People displaced by conflict and climatic conditions will be prioritized in the response. There are nearly 1.8million displaced people and 938,000 returns who will be assisted through cash/food distributions. Regular verifications of distribution registers will be conducted to update the number of people to be assisted, mainly in areas where there are movements of displaced/ returns. There is an indication of movement of displaced people from Chinaksen woreda in Oromia, Tuluguled woreda in Somali and Metekel woreda in Amhara region.

Cash/food assistance will also be provided to returns in quarantine centers and at points of entry (PoE). It is estimated that 90,000 migrant returnees, are expected to arrive from middle East and neighbouring countries, from now up-to December 2020. The food cluster is also projecting that 120,000 individuals will require food assistance in isolation centers, in areas that are affected by COVID-19.

Support through cash transfers will be prioritized in areas where there are functioning markets, and where households have access to these markets. Cash transfers will also be considered in woredas where PSNP clients were assisted through cash from January to June. The feasibility of cash transfers will also be informed by evidence from regular monitoring and assessments that will be conducted by partners, to provide updated information on market functionality. Partners will utilize the PSNP systems, in processing of cash transfers, in areas where these systems are already functional and where appropriate.

Response plan

The Food Cluster is targeting to assist 11.8 million food insecure people from conflict and flood affected communities, households

facing food needs due to COVID-19 related shocks and communities that are likely to have below normal harvest due to negative impact of desert locust. The targeting process will ensure inclusion of the most vulnerable population groups including the female headed households with disabled members, child headed and the older persons. Partners will continue with implementation of various complaints and feedback mechanisms (CFMs) including call centers that will provide information from the communities on how the targeting and response is implemented. Feedback collected by some partners indicates the need to strengthen information provision, especially in instances of delayed distributions and targeting criteria. A recommendation highlighted was to strengthen capacities of all partners engaged in food assistance on accountability to affected populations.

The national cash-food integrated planning will continue to provide guidance on modalities that will be implemented in the woredas. Cash will be considered in urban communities, where there are functional markets and predictable prices of commodities including in areas where the rural PSNP is being provided through cash transfers. 4.5 million targeted people are in woredas where cash transfers are feasible, including in 225 rural woredas where there are PSNP systems to support cash transfers. The cash transfer values will be determined using available evidence on market prices and supply of commodities in the markets. In-kind food commodities will be provided based on a standard food basket of cereals, pulses/CSB and Vegetable Oil. It is estimated that 357,159MT and US$139.8million will be distributed in the second half of the year, to cover the remaining three rounds.

Cooked meals will be provided to people who are returning from the Middle East and neighbouring countries. The support will be provided at the points of entry and during the mandatory quarantine period. This will be coordinated through multi-sectoral mechanisms that are led by the Government of Ethiopia and supported by humanitarian partners through the Emergency Coordination Centers (ECC), at national and regional level. The ECC will ensure multi-sectoral coordination of the support to the returns, which will ensure timely provision of humanitarian assistance to these individuals, including access to WASH and Protection services.

NDRMC will continue with implementation of coordination mechanisms through the Prioritization Committee (PC) and the National Cash-Food Integrated Committee, that provides guidance to partners on the response. At regional level, partners will contribute to the multi-sectoral coordination planning of humanitarian response. Safeguarding measures will continue to be put in place to enhance protection from sexual exploitation and abuse, and the cluster will work closely with the Protection Cluster and the PSEA Network to maximize protection outcomes in targeted communities.

Partners will continue to implement measures that prevent the spread of COVID-19, including provision of hygiene facilities at distribution sites, consider double allocation of cash/food rations and coordinating with health authorities in planning distributions and monitoring of cluster activities.

Cost of response

The revised cost for the Food Cluster is US$593.4million, which includes US$159million for COVID-19 response and US$434.4 million for non-COVID-19 related needs. The evidence-based analysis of COVID-19 needs indicates that the impact of COVID-19 on food insecurity is not as initially projected in June 2020. This is mainly due to government's measures which ensured sustained supply of food items in the markets including imported commodities, and continued access to income opportunities in both urban and rural communities. Implementation of measures that prevent the spread of COVID-19 will also contribute to increase in overall costs of the response. It's also estimated that about 500,000 food insecure people from the PSNP-public works clients will request two round of food assistance.

Monitoring

The post distribution monitoring (PDMs), rapid assessments and regular monitoring will be the main sources of evidence to inform on implementation of cash/food response in the country. There are initiatives that are implemented to remotely monitor the response, including the household food security monitoring surveys and regional food security monitoring reports. The analysis from the Household Economy Approach (HEA), World Bank Surveys and updated Integrated Food Security Phase Classification (IPC) will also provide information on changes in food needs in the country. Food cluster partners will continue to support the multi-sectoral response to flood affected communities and provide regular updates on cash/food distributions through the flood taskforces at federal and regional level. Remote monitoring will be implemented in all areas, as a measure to avoid the spread of COVID-19. According to the cash/food distribution guidelines in the context of COVID-19, partners will waive any activities that require contact with beneficiaries including households visits for post distribution monitoring or beneficiary contact monitoring at distribution sites. Monitoring of arrivals at points of entry will be coordinated through the ECC coordination structures to ensure timely provision of cooked meals. The Displacement Tracking Matrix (DTM) and Villages surveys are expected to continue providing updates on number of displaced people and returns.

		JAN		REVISED MYR	
OBJECTIVE	**INDICATOR**	**IN NEED**	**TARGETED**	**IN NEED**	**TARGETED**
Cluster Objective 1: Distribution of in-kind and cash to food insecure people					
	1.1 Number of targeted beneficiaries receiving food and/or cash transfers	6.5 M	5.9 M	11.8 M	11.8 M
	1.2 Quantity of cash distributed (USD)		141.1 M	164.7 M	164.7 M
	1.3 Quanity of food distribited (MT)		410.6 M	712 k	712 k

3.5 Health

ORIGINAL TARGET	REVISED TARGETED	ORIGINAL REQUIREMENTS (US$)	REVISED REQUIREMENTS (US$)	
3.2M	6.5M	$94.3M	$195.0M	
COVID-19 RELATED	3.3M		$100.0M	PRIORITIZED REQUIREMENTS
NON COVID-19 RELATED	3.2M		$95.0M	$64.4M

% CHILDREN	% WOMEN	% PEOPLE WITH DISABILITIES
54%	23%	6%

Objectives

1. To provide accessible essential health services to targeted populations, focusing on main causes of morbidity and sexual and reproductive health. Accessible primary healthcare will pay attention to geographical distances for targeted populations to reach the services. The availability of a variety of services will be key, including outpatient consultations and treatment, health education, routine vaccination for children under five, antenatal care, delivery services, postnatal care, family planning, communicable diseases, non-communicable diseases and referrals to higher services. Deliberate measures will be taken to ensure that response to the COVID-19 pandemic does not divert focus from essential health services. Instead an integrated approach will be promoted to maintain essential services and benefit from the interventions to the outbreak including infection prevention and control at health facilities. All services will be provided to users free of charge.

2. To provide quality care for people with physical injuries, disabilities and mental health needs. Casualties of all forms of conflict and violence will be treated for physical and mental injuries and referred for additional care as necessary. Patients with pre-existing and new physical and mental disabilities will receive care and linked to other related services in the continuum of care. Additional efforts will be made to look out for these groups of people as they are more vulnerable during the COVID-19 pandemic.

3. To prepare for, detect and respond to epidemic prone disease outbreaks, including COVID-19. The early warning system for disease outbreaks will be strengthened, based on the existing integrated disease surveillance and response system. Minimum preparedness actions will be undertaken in hotspot and displacement locations to mitigate the impact of outbreaks when they occur. Ongoing response to the COVID-19 pandemic will be enhanced to contribute to minimization of caseloads, deaths and the impact on the health system.

Response

Supporting multi-cluster response.

The Health Cluster will work with all other clusters through the inter-cluster coordination group to ensure joint assessments are conducted for new emergency events including COVID-19. The cluster will contribute to the quantification of needs and action planning and coordinate the response with other clusters and government departments through the Emergency Operation Centre (EOC) for COVID-19, other EOCs whenever activated or other coordination platforms. Additionally, the cluster will participate in joint inter-sectorial prioritization exercises to ensure the most vulnerable get help first. Importantly, the cluster will adopt commonly agreed upon tools for joint response monitoring and accountability to affected populations.

In 2020, the Health, Nutrition and WASH technical working group will lead the integrated approach. Within this mechanism, the three clusters intend to pilot integrated projects that will be prioritized based on needs and response capacity. The projects will be either between two or all the three clusters, with coordination and co-location as enablers. Whenever possible each project will be implemented by one partner. Standard criteria for selecting priorities and a minimum package for each of the three clusters will be utilized. Some of the areas of convergence will include severe acute malnutrition, disease outbreaks, and WASH in health facilities.

Response modalities.

Ethiopia has a good network of health facilities including health posts, health centres, primary hospitals and referral and teaching hospitals. The Health Cluster will prioritize emergency response

through these facilities where they exist. Partners will provide surge capacity in the form of health workers, medicines, medical supplies, laboratory supplies and logistics to cover increased caseloads and disease surveillance during crises. For people within the catchment population not accessing facilities, outreach health services linked to the facilities will take care to them. Referral mechanisms will be strengthened or established to ensure that deserving patients are transferred to higher and specialized services.

Mobile health and nutrition teams will remain an option for locations that lack functional and accessible health facilities. They will be supported to provide essential health services to targeted populations while dialogue and efforts to rehabilitate the local health system continue, or until a durable solution to the crisis is found. A similar mechanism is the rapid response teams that will be deployed by partners and the Government during acute events of a limited duration. Such events include COVID-19 pandemic, mass gatherings and mass casualties. Mass vaccination campaigns will require a combination approach through health facilities, mobile and rapid response teams.

People-centred approaches.

Health projects will be designed to respond to specific populations and needs, with the most applicable response modalities being utilized. The target populations will include, but not limited to those affected by disease outbreaks, severe malnutrition, IDPs, returnees, returning migrants, migrants and host communities. The services will be availed as close to the target population as possible, ensuring sensitivity to specific vulnerable groups and variations in local cultures. High levels of flexibility will be exercised both geographically and within the service areas to ensure users are accessing services with least constraints. Minimum health standards, norms and guidelines will be adhered to in order to deliver high quality services. Health workers will enhance the attitude of inclusion by listening more to patients, clients and families for their own care. It is critical to consider the continuation of health services unique to the well-being of women and girls including pre- and post-natal healthcare, access to quality sexual and reproductive health services, and life-saving care and support for survivors of gender-based violence. If these services are unavailable or inaccessible, the health impacts can be catastrophic, especially in rural, marginalized, and low-literacy communities.

Cost of response

At a unit cost of $30 per beneficiary, the Health Cluster will require $195 million to reach the 6.5 million targeted people with essential health services for one year. It is projected that 30 per cent of these funds will go into procurement, shipment and distribution of emergency health kits. 40 per cent of the funds will be utilized to support the health workforce that ensures that the services are available at different points of delivery. Another 30 per cent will pay for support services like logistics and overhead costs. The general assumption is that the Government incurs a similar complimentary cost for the same population.

Monitoring

Health Cluster partners will submit monthly reports in three parts including 4W matrix, short narrative and the cluster's HRP indicators. These will be compiled into one 4W matrix and bulletin. The 4W matrix will show what projects each partner is implementing, locations, activities, duration and target populations. The bulletin will summarize the achievements of the cluster for the month against the HRP targets, and shared with partners, donors and government. Partners also directly report to the health information management system and integrated disease surveillance and response through local health authorities. Project managers, cluster coordination team, and health authorities will conduct regular support supervision and monitoring visits to observe service delivery and quality of care.

		JAN		REVISED MYR	
OBJECTIVE	**INDICATOR**	**IN NEED**	**TARGETED**	**IN NEED**	**TARGETED**
Cluster Objective 1: The physical and mental well-being of 5.7 million crisis-affected people is improved					
	1.1 Number of health facilities including COVID-19 isolation facilities and mobile teams supported in crises affected locations	927	500	1 k	713
	1. 2. Number of total OPD consultations	2.2 M	1.2 M	3.4 M	1.7 M
	1.3. Number of normal deliveries attended by skilled birth attendants	11 k	6 k	17 k	9 k
	1.4. Number of women in child bearing age receiving modern contraceptives	67 k	36 k	102 k	51 k

1.5. Number of community members receiving health IEC messages including COVID-19	5.9 M	3.2 M	9.1 M	4.6 M
Cluster Objective 2: To provide quality care for people with physical injuries, disabilities and mental health needs				
2.1. Number of assorted emergency medical kits and COVID-19 PPE kits distributed in crises affected locations	2 k	1 k	3 k	2 k
2.2. Number of cases with injuries and disabilities treated and referred for further care	185 k	100 k	284 k	143 k
2.3. Number of cases receiving mental health and psychosocial support services	22 k	12 k	34 k	17 k
2.4. Number of survivors of SGBV receiving clinical care for rape	1 k	600	2 k	1 k
Cluster Objective 3: prepare for, detect and respond to epidemic prone disease outbreaks				
3.1. Number of epidemic prone disease alerts including COVID-19 verified and responded to within 48 hours	445	240	682	342
3.2. Number of children 6 months to 15 years receiving emergency measles vaccination	3.7 M	2.0 M	5.7 M	2.9 M

3.6 Logistics

ORIGINAL TARGET	REVISED TARGETED	ORIGINAL REQUIREMENTS (US$)	REVISED REQUIREMENTS (US$)
			$23.4M

COVID-19 RELATED			$18.7M	PRIORITIZED REQUIREMENTS $7.8M
NON COVID-19 RELATED			$4.7M	

Change in context

COVID-19 is expected to cause an additional strain on the logistics sector with the current high increase of cases in-country and regionally. Disruptions in supply chains put the continuation of critical services and programs in jeopardy and complicate efforts to adequately scale-up and respond to increasing needs, especially in view of the logarithmic expansion of COVID-19 cases, desert locust migration and changes to the IDP and returnee landscape, on top of physical access challenges as seen in Oromia or in flood affected areas.

Cluster objectives

COVID-19 will cause an additional strain on the logistics sector with the current high increase of cases in-country and regionally. Disruptions in supply chains put the continuation of critical services and programmes in jeopardy and complicate efforts to adequately scale-up and respond to increasing needs. Given the logarithmic expansion of COVID-19 cases, desert locust migration and changes to the IDP and returnee landscape, on top of physical access challenges.

Air and land operations will thus be critical in delivering life-saving assistance to main hubs and remote areas with impacted access, providing rapidly critical COVID-19 medical items and other life-saving supplies.

To address the ongoing logistics challenges faced by the humanitarian community in Ethiopia, the Logistics Cluster co-led with NDRMC in Ethiopia, will coordinate, facilitate and streamline logistics services, coordination, increase operational efficiencies and information to ensure the delivery of life-saving cargo in Ethiopia.

The role of the Logistics Cluster is of utmost importance to maximize capacity, avoid duplication of efforts and speed up the humanitarian response through coordination, information management, capacity strengthening support, advocacy to increase operational capacities of partners.

REVISED CLUSTER STRATEGY AND RESPONSE PRIORITIES

Logistics support to the humanitarian community has become more crucial due to an increase of community transmission of COVID-19, combined with physical access challenges in some regions, adding to the existing humanitarian needs.

The Logistics Cluster continues to collect gaps and needs from partners to reflect the current changes in the logistics landscape. Due to the seasonal import period for Ethiopia, the transport capacities are overstretched, exacerbated by the reluctance of transporters to operate in some areas impacted by a high number of COVID-19 cases or physical access constraints. As a result of the change in the humanitarian landscape, partners have increased needs for storage capacities and logistics support equipment to be placed for critical shelter items, waiting areas for truck drivers, screening centers and quarantine centers in key locations and point of entries such as in Djibouti, being the main entry corridor for supply.

While the Logistics Cluster supports the entire humanitarian community, prioritization of activities is done based on funding available and priority areas targeted by relevant clusters.

As part of its COVID-19 response, the Logistics Cluster aims to support entry and exit points, providing logistics solutions for gaps observed in food, shelter, NFIs, WASH and health, amongst others, including implementing screening centres and areas for border crossing trucks.

Preparedness actions need to be activated through pre-positioning of critical logistics support equipment given potential future humanitarian impacts, including the increase of COVID-19 supplies.

Response plan

Based on the needs expressed and identified by the humanitarian community, the Government of Ethiopia, the Humanitarian Country Team and the Inter-Cluster Coordination

Group, the Logistics Cluster aims to continue to facilitate access to sufficient and reliable information sharing, coordination mechanisms and logistics services, in particular, storage and overland & air transport for humanitarian organizations within Ethiopia.

The Logistics Cluster activities listed below are crucial to ensure access to relief cargo and humanitarian staff within Ethiopia; they are all carried out depending on the needs of the humanitarian community, and if funding allows.

Activities and response will be co-led with NDRMC and will be provided for both COVID-19 and non-COVID-19 response based on prioritization, needs and funding availability

A. Contracted Services (Air and Road Transport) and Logistics Support Equipment (Storage)

- The Logistics Cluster facilitates transport for humanitarian cargo from/to strategic locations and provide coordinated services for the consolidation of cargo within Ethiopia as per critical humanitarian needs
- Air services for delivery of critical items will be provided through already existing network to domestic airports for fast dispatch of critical supplies
- The storage capacity is being increased through Mobile Storage Units for common storage for partners. Adequate logistics support equipment is being provided to increase operational capacities of partners. The logistics support equipment will also come with the required engineering services and rehabilitation as and when required.
  In addition, as and when required logistics support equipment will be provided for entry and exit border or other areas for screening of drivers for trucks and cargo moving from neighbouring countries or with in the regions.

Note: The services facilitated by the Logistics Cluster are not intended to replace the logistics capacities of partner agencies or organisations, but rather to supplement them through the access to common services.

B. Information Management, Coordination, Capacity Strengthening and Advocacy

- To support operational decision making and improve the efficiency of the logistics response, the Logistics Cluster collects, analyse and disseminate information through dedicated tools and products
- The Logistics Cluster provides essential information management support, including Geographic Information Systems (GIS) mapping, to enable a smooth and coherent flow of relevant information to all partners, from Government to NGOs.
- The Logistics Cluster provides the fundamental link to overall logistics efforts across the country through enhanced coordination activities between relevant authorities from the Government of Ethiopia and humanitarian partners, to minimize duplications of efforts and streamline logistics activities and ensure efficient utilization of existing assets
- Through its information management and coordination activities, WFP will advocate for the continued access to the country via pre-existing humanitarian corridors and the prioritization of essential humanitarian cargo and critical supply
- Increase of logistics staffing will be provided based on needs to also support and increase the Government's response together with capacity strengthening activities as and when required.

Important note: The Logistics Cluster does not target nor reach beneficiaries directly, as it aims to provide enabling support to organisations rather than individuals. For this reason, figures of direct beneficiaries are not available. The Logistics Cluster aims to augment the existing logistics structure where gaps are identified to facilitate transport and storage of humanitarian cargo on behalf of humanitarian organisations to provide assistance to the population where partners have programmes and activities. The Logistics Cluster will support the movement of cargo, provide storage facilities, refurbish existing structures where gaps are identified.

Cost of response

The cluster requirements have been revised based on the timeframe of the activation of the Logistics Cluster, approved for 6 months, starting 29th April. For the remaining 3 months, most of the Logistics Cluster activities will focus on supporting urgent needs and gaps of humanitarian partners, currently prioritizing the COVID-19 response and activate a preparedness plan for pre-positioning of logistics support equipment. The rest of the activities are focusing on non-COVID-19 response and support on-going humanitarian needs from partners in Ethiopia through the clusters.

The Logistics Cluster will provide efficiencies by consolidating logistics needs from partners through consolidation of cargo, storage space strategically positioned based on analysis of activities, operations and pipelines of partners.

Monitoring

The Logistics Cluster monitors its cargo transport and storage services through the Relief Item Tracking Application (RITA). In addition, regular coordination meetings are held not only to coordinate logistics activities, but also to evaluate the services and adjust them as necessary. The Logistics Cluster conducts user surveys to receive feedback from service users, identify gaps, and to re-assess if the current operational set-up is responding properly to the changing needs of the humanitarian organizations operating in the response. All the organizations engaged with the Logistics Cluster are offered and encouraged to provide feedback through bilateral surveys and meetings.

In addition, the Logistics Cluster will issue a monthly Situation Update, providing an overview of current achievements, challenges and needs pertaining to Logistics Cluster operation in Ethiopia.

3.6 Nutrition

ORIGINAL TARGET	REVISED TARGETED	ORIGINAL REQUIREMENTS (US$)	REVISED REQUIREMENTS (US$)
3.6M	4.4M	$193.4M	$252.6M

COVID-19 RELATED	0.3M		$25.8M	PRIORITIZED REQUIREMENTS $83.4M
NON COVID-19 RELATED	4.1M		$226.8M	

% CHILDREN	% WOMEN	% PEOPLE WITH DISABILITIES
62%	38%	0%

CHANGE IN CONTEXT

The overall number of children affected by severe acute malnutrition (SAM) and who were admitted for treatment from January to May 2020 was 10.3 per cent higher than what it was during the same period of last year and this represent 75.7 per cent of the 2020 revised HRP target estimated at the of May and 29.1 per cent of the annual target. Higher admissions in 2020 in almost all regions except SNNPR with for example Amhara (more than double) SNNPR (by 17.8 per cent), Oromia (by 0.4 per cent), Tigray (by 33.5 per cent), Somali (by 1.9 per cent), Afar (by 6.7 per cent) and Gambella (by 6.3 per cent).

From January to June 2020, a total of 588,549 children and 575,266 pregnant and lactating women (PLW) affected by moderate acute malnutrition were reached by the TSF Program (46.0 per cent and 58 per cent of the revised annual targets respectively). The revised guideline with a new cut-off for admissions has been implementing widely and the SAM and MAM admissions are expected to increase slightly in the second half of the year.

Cluster objectives

The Emergency Nutrition Coordination Unit (ENCU/Nutrition Cluster) and its partners' main goal is to ensure life-saving nutrition services continue to be delivered during the COVID-19 pandemic. Nutrition partners will contribute to the COVID-19 response through the following main objectives:

- To ensure continued provision of timely access to life-saving quality treatment of acute malnutrition among children under five years of age and pregnant and lactating women (with immediate adoption of necessary adjustments in service delivery)
- To strengthen lifesaving preventive Infant and Young Child Feeding (IYCF-E) activities during the emergencies and integrate IYCF-E program in all components of the response
- To support the dissemination of key messages including FMoH /EPHI COVID-19 specific IEC materials, messages on adequate maternal and child nutrition, hygiene practices (hand WaSHing), and inclusion of adequate childcare practices in the Risk Communication and Community Engagement (RCCE) part of the response
- To support and contribute to strong coordination mechanisms jointly with NDRMC, FMoH and EPHI at national and sub-national levels that strengthens emergency response capacities

Acute malnutrition is expected to rise due to secondary impact of the COVID-19 crisis and the associated deteriorating food security situation (compromised access to markets, high food prices), access to health and nutrition services may be compromised and health seeking behaviors affected. The planning assumption is that acute malnutrition will increase country wide - in urban and rural areas - and affect all population categories (general and displaced population). Most of the acute malnutrition caseload will be among the general population living in rural areas. The large-scale emergency nutrition response will continue to focus on malnourished children and pregnant and lactating women.

Response plan

Children under five years of age and pregnant and lactating women affected by acute malnutrition are at an increased risk of contracting infectious diseases and their immune system tends to weaken. ENCU/Nutrition partners will support the Government of Ethiopia's COVID-19 response to reduce morbidity and mortality while ensuring the continuity of equitable lifesaving nutrition service delivery. The EPHI/WHO recommended precautions to limit the spread of the COVID-19 (social distancing, hand hygiene, contribution to infection prevention and control) are integrated in the nutrition services. The priority will be to support the health system for the continuation of

lifesaving Community-based Management of Acute Malnutrition (CMAM) services and technical support will be provided to the health work force to roll-out the recently revised National Acute Malnutrition guidelines. The adoption of the revised guidelines during the COVID-19 pandemic will be supported through on-the-job coaching and via remote support while classroom trainings are temporarily suspended, and the necessary programmatic adjustments are adopted as per the ENCU COVID-19 and Nutrition Task Force recommendations. Efforts will be made to sustain activities that focus on early identification and referral of malnourished children. The feasibility of introducing a new approach called Mother-MUAC to empower mothers in monitoring the nutritional status of their children, will be explored. This approach could be instrumental during the COVID-19 crisis when mass MUAC screening exercises may not take place and/or Health Extension Workers (HEWs) will be limited in their door-to-door / active case finding activities. Surge support will be provided to enhance access to Nutrition services in remote and hard-to-reach communities, including IDP/returnee sites through technical and operational support to static and mobile health and nutrition services. Nutrition stakeholders from MoH and EPHI, with the support of humanitarian and development Nutrition partners, will prioritize the protection, promotion and support adequate maternal, infant and young child feeding (MIYCF) practices. MIYCF activities will be integrated across all interventions. Particular attention will be put on monitoring, reporting and addressing any unsolicited donations of Breast Milk Substitute (BMS) and other violations of the International Code on the marketing of BMS.

In close collaboration with the Health and WASH Clusters, a multisectoral response (minimum integrated package) will be implemented in most at-risk woredas (with high acute malnutrition, high incidence of infectious disease and high WASH needs).

Nutrition partners will continue to mainstream protection principles in the Nutrition response. Where partners have already identified referral mechanisms for Gender Based Violence (GBV), efforts will be made to use them / to maintain referral pathways for GBV survivors, including specific procedures for Sexual Exploitation and Abuse (SEA) complaints' management. Also, partners will adjust training modalities of staff, government officials and health care practitioners on protection from SEA so that sensitization and orientation on PSEA continue to be reinforced.

Finally, the ENCU will continue to support emergency coordination mechanisms at national/ federal and sub-national levels as well as emergency preparedness and response planning for timely and effective nutrition response. This includes efforts made for the pre-positioning of nutrition supplies and medicines. Close monitoring of the pipeline through remote means will be used to anticipate and respond to nutrition supply needs through timely dispatch to avoid gaps in provision of CMAM services.

The initial 2020 target still aims at reaching 443,565 children affected by severe acute malnutrition to be admitted across the country, more than 1.7 million children aged 6-59 months affected by moderate acute malnutrition benefiting from targeted supplementary feeding program and over 1.3 million malnourished PLW will also be projected to receive support in priority woredas. As acute malnutrition is expected to rise over the next nine months due to deteriorating food security situation (harvest losses, desert locust infestation, high market prices, etc.), occurrence of infectious diseases (cholera, measles), inadequate WASH and poor access to health care, etc., the initial targets have increased by about 20 per cent. Hence, non-COVID-19 related, 539,791 additional malnourished individuals are expected to be reached for treatment. Moreover, acute malnutrition is expected to increase further due to secondary impact of the COVID-19 crisis, forecasted to lead to a peak of SAM and MAM cases during June/July/Aug (during the lean season in cropping areas) with an estimated 30 per cent increase. Therefore, it is anticipated that 271,646 additional individuals will fall into acute malnutrition (see table 1 below). In summary, all shocks combined, there will be 811,437 SAM and MAM cases in addition to the 3.5 million target initially estimated (overall 23 per cent increase of the 2020 nutrition targets).

Cost of response

In addition to the initial annual requirements of 193.4 million USD, it is estimated that a total $59,195,070 will be needed for the additional nutrition response needs hence making it a total of 252.5 million USD in 2020 (see table 2 below). The biggest proportion of the budget forecast (71 per cent) is for therapeutic foods such as RUTF, therapeutic milks (F75 and F100), for specialized nutritious foods (SNFs) such as RUSF and Super Cereal Plus, and medicines. Nutrition supplies costs include logistics costs for their shipment, storage and distribution/ dispatch.

28 per cent of the budget factors technical support from Nutrition NGO partners in 150 priority woredas. IEC materials and key messages dissemination including through mass media costs represent about 1 per cent of the total budget. About $90,000 was factored for remote support and monitoring through mobile technology and $120,000 (0.2 per cent of total budget) is allocated for surge staffing of Nutrition Experts support.

In a scenario whereby only part of the funding requirements is mobilized, the geographical coverage of the targeted supplementary feeding program (MAM treatment) will have to be reduced and instead of aiming at targeting all woredas of most severe concern (Priority 1 woredas according to the NDRMC Hotspot woredas classification + IDP affected woredas) only about 200 woredas will be prioritized. In addition to the reduced geographical coverage of the targeted supplementary feeding program, the number of woredas where technical support is provided to the health system will be reduced to 50 woredas only in the immediate term (instead of 100 woredas) and additional staffing not mobilized. Hence, the additional budget requirement will be in that scenario of 118.5 million USD.

Monitoring

ENCU jointly with Nutrition partners and FMoH and EPHI will continue to monitor the nutrition situation through routine nutrition program data. SAM admissions and MAM beneficiaries will continue to be monitored on monthly basis, reflecting also the continuation of the

CMAM services. CMAM program performance indicators (as per SPHERE standards and national Acute Malnutrition guidelines cure, defaulter and death rates) will continue to be monitored on a monthly basis. New partnerships have been identified in collaboration with FMoH to support remote program implementation, facilitation of remote training and technical support to health care practitioners, and supplies monitoring through mobile enabled technology. Efforts will be made toward ensuring these nutrition data and information include sex and age disaggregated data.

Mechanisms will be put in place to also collect indicators reflecting the integration of the COVID-19 response in the Nutrition response, for example monitoring the number of HWs/HEWs sensitized / oriented on basic COVID-19 key messages (as per FMoH and EPHI guide) and the number of caregivers counselled on adequate IYCF practices.

		JAN		REVISED MYR	
OBJECTIVE	**INDICATOR**	**IN NEED**	**TARGETED**	**IN NEED**	**TARGETED**
Cluster Objective 1: To ensure continued provision of timely access to life-saving quality treatment of acute malnutrition among children under five years of age and pregnant and lactating women (with immediate adoption of necessary adjustments in service delivery)					
	1.1 # of children U5 newly admitted for SAM treatment	554 k	444 k	687 k	550 k
	1.2 # of children 6-59m and PLW newly admitted for MAM treatment	3.9 M	3.1 M	4.8 M	3.8 M

3.7

Protection

ORIGINAL TARGET	REVISED TARGETED	ORIGINAL REQUIREMENTS (US$)	REVISED REQUIREMENTS (US$)
2.0M	3.8M	$42.4M	$47.6M
COVID-19 RELATED	3.3M		$14.0M
NON COVID-19 RELATED	1.3M		$33.7M

PRIORITIZED REQUIREMENTS

$15.7M

% CHILDREN	% WOMEN	% PEOPLE WITH DISABILITIES
49%	22%	10%

Objectives

Cluster Objective 1: The protection needs of crisis-affected persons are identified, advocated for, and addressed by government, humanitarian and development actors.

Cluster Objective 2: Crisis-affected communities, in particular women (including women with disabilities and older persons) and children, are protected from violence, exploitation, abuse and harmful practices, receive quality and timely response services and benefit from risk reduction and prevention measures.

Cluster Objective 3: Accountable, safe, accessible, and coordinated service delivery for crisis-affected persons (IDPs and returnees/relocatees and affected host communities) is improved.

Response

The planned response to 3.9 million people (including for more than 1.9 million IDPs) identified as in need of protection in 2020, has been hindered by the COVID-19 pandemic. In recognition of the criticality of protection, the Protection Cluster will prioritize the adaptation of core protection activities identified in the 2020 HRP to ensure their continuity (wherever possible), while also concentrating on the identification and mitigation of new protection risks resulting from the outbreak.

To that end, the Protection Cluster will conduct rapid assessments and protection monitoring to collect, verify and analyse information in order to identify violations of rights and protection risks faced by IDPs, returnees/relocatees, and other crisis-affected populations for the purpose of informing an effective response that does not exacerbate risks or reinforce patterns of violation. The protection situation of already vulnerable groups (particularly women, girls, older persons and persons with disabilities) will be further exacerbated by the pandemic, while new risks will emerge, therefore monitoring and referral activities will continue to target crisis affected communities (including those newly at risk) but with additional data collection on pandemic-associated risks. The modality of these activities will be adapted to mitigate the risk of doing harm to targeted populations or to service providers, while also ensuring continued participation and feedback of the affected population on access to assistance.

Safe and equitable access to basic services (including health services) will be enhanced through strengthened referral pathways, advocacy by protection monitors, and supported for those with specific needs through cash stipends (e.g. persons with disabilities requiring referrals for COVID-19), and individualized protection assistance (IPA). In IDP sites, especially, coordination of COVID-19 mitigation and response measures will be supported by the SMS WG and/or SMS actors, using evolving best practice guidance from global and national levels. Non-specialized mental health and psychosocial support (MHPSS) will be required at the community level to address the psychological needs of those affected either by conflict, climate or the pandemic. Cognizant of the fact that social distancing and other containment measures will require adaption of community-based protection activities, protection actors will continue to support community protection structures and engage them in the identification of needs and awareness raising on services available, rights as well as local conflict resolution. Through these activities, protection actors will mobilize and capacitate affected communities to prevent, mitigate and respond to protection risks identified in their own communities thereby enabling individuals' access to their rights.

Protection and peacebuilding actors must also prevent, anticipate and address the risks of violence, discrimination, stigmatization and marginalization towards at-risk population groups of concern by enhancing awareness and understanding of the COVID-19 pandemic and conflict dynamics at community level and through social cohesion interventions. Continued communication with communities on risks protection risks/rights and access to services/referrals associated with the both conflict and the COVID-19 outbreak (including containment measures) will mitigate the increased risk of inter-communal and inter-ethnic tensions which could give rise to further political violence and displacement. These awareness raising activities must be complemented with advocacy towards authorities/communities to address stigmatization, abuse, exploitation, and discrimination in accessing health and other essential services. While capacity building on IDP rights to community members, government authorities, law enforcement and court authorities, is likewise essential to enable their response, these actions have been scaled-down and will adopt modified modalities as necessitated by COVID-19 containment measures. However, capacity building of IDP site management actors to mitigate and respond to COVID-19 will be stepped up, albeit through remote support modalities.

Disputes over Housing, Land and Property Rights (HLP), are both fundamental causes and consequences of conflicts. Moreover, HLP violations hinder the exercise of rights of IDPs and remain a barrier to durable solutions. The response will address HLP issues through the provision of information, counselling and technical assistance as well as through the provision of civil documentation - essential for freedom of movement and accessing health services. In light of COVID-19, the response also includes rent support to 2,000 families at-risk of eviction. Child Protection (CP) and Gender-based Violence (GBV) risks (including sexual exploitation and abuse (SEA) risks, are exacerbated in all emergency situations (e.g. displacement and pandemics) and will be addressed through a systems strengthening approach to ensure specialized protection services are adapted in the context of COVID-19 and provide continuum of care.

While ensuring the continuity of protection services (Objectives 1 & 2), the protection response will also work to ensure that the inter-sectoral humanitarian response takes into account the different needs and vulnerabilities of women, girls, boys, and men, especially persons with disabilities, older persons and those who have long-term chronic illness to be more effective and accountable to all affected populations. Support for protection mainstreaming, including other cross-cutting issues such as AAP/PSEA, will therefore be provided through the cluster, as well as through IDP site management support (SMS) activities under objective 3. Additionally, coordination of COVID-19 mitigation and response measures will be supported by SMS actors, using evolving best practice guidance from global and national levels.

Cost of response

In line with global best practices, the Protection Cluster advocates for a comprehensive approach to protection programming which addresses the protection needs of men, women, boys, and girls, persons with disabilities, older persons and persons with specific needs in crisis-affected communities. Protection activities which identify, respond to, and advocate for, the different needs of these groups should be implemented together rather than as standalone activities. (For example, protection monitoring should not be implemented as a standalone activity without response capacity, while case management for at-risk children should be implemented as a package with psychological support activities for children, caregiver support to promote child well-being, child protection response and prevention activities.) Therefore, the tiered allocation above does not represent a prioritization of individual activities, but rather largely, a complementary package of activities, scaled up to reach more beneficiaries as funding allows.

The total cost for Objective 1 is 12,212,000 USD

The total cost for Objective 2 is 25,434,286 USD

The total cost for Objective 3 is 9,975,000 USD

Child Protection / Gender-Based Violence Areas of Responsibility (AoR)

The CP/GBV AoR will continue to provide support for systems strengthening to ensure that critical community (less formal) and more formal and specialized protection services are available and meet global standards of care in emergency affected locations. This will include the deployment of qualified personnel and case management services in places affected by displacement (including in areas of return and relocation) and in areas affected by COVID-19 outbreak. Additionally, existing services – such as for mental health and psychosocial support, Gender-Based Violence (GBV) risk mitigation, prevention and response (including case management and referral services) and support for GBV survivors (including men and boys), child protection (i.e. for prevention/response to violence, identification, registration and referrals for health, justice, social welfare), alternative care, family tracing and reunification of unaccompanied and separated children (UASC), will be scaled-up and monitored. Child protection and GBV case management, including the management of SEA cases, is considered a vital service, which will be adapted in context of COVID-19 to ensure continuum of care and support. The AoRs will ensure the active participation of the different categories of the population at all stages of programming, with functional women and child friendly complaint and feedback mechanisms established. Survivors of sexual exploitation and abuse will be linked with and receive GBV response services in line with the survivor-centred approach, using existing and

newly to be developed GBV referral pathways at national and sub-national level and ensuring integration of GBV referral pathways into Community-Based Feedback and Complaint Mechanisms.

Evidence shows that child protection risks and GBV are exacerbated in all emergencies (including pandemics), while GBV in particular remains grossly underreported due to social norms and stigma associated especially with sexual violence and rape. Likewise, rapid assessments and DTM (Displacement Tracking Matrix) data have noted a critical shortage of response services for survivors, in addition to poor quality of services, despite high prevalence of intimate partner violence, sexual violence, rape, and physical assault in crisis-affected communities. These risks of abuse, along with identified negative coping mechanisms such as child labour, child marriage and transactional sex due to reduced livelihood opportunities and impacts on school closure, are only expected to increase as a result of the COVID-19 pandemic. Some categories of children, including children living and working on the street may be particularly vulnerable while access to services for at risk women and children may be hampered. Hence, the need for establishing and/or scaling up prevention and response programming.

To complement the services, the CP/GBV AoR will support community sensitization and awareness raising to mitigate risks and build resilience among communities on sensitive topics– including on harmful practices, which continue at alarming rates in host and displaced communities. COVID-19 awareness (e.g. hygiene) will be integrated with key messages on the right to/availability of services, positive parenting, and other CP and GBV protection issues. These awareness raising and community outreach activities are envisaged to continue in smaller groups and using different tools and modalities including loudspeakers, radio and new technologies, adapting to national guidance of group gathering and social distancing.

The CP/GBV AoR will also address psychological distress and trauma as communities continue to be exposed to violence and experience stress due to displacement and conflict, which may be further exacerbated by the social and economic impacts of COVID-19. Evidence shows, for example, that children may be stressed due to school closures, the disruption of daily routines, while women will face reduced mobility, loss of livelihood opportunities and increased domestic tension. The MHPSS interventions are therefore needed to mitigate the harmful mental health and psychosocial consequences (of both pandemic and conflict) and support individual and community resilience to recover and rebuild. These activities are envisaged to be adapted in light of COVID-19, with focused direct MHPSS intervention for women and children with high priority needs and adhering to national guidance related to group gathering and social distancing, including using new communication tools and modalities.

Capacity support and sensitization to multi-sectoral service providers is also needed to prevent and minimize unintended negative effects of sectoral interventions, ensure safe access to services and facilities and child protection and GBV risk mitigation for vulnerable groups including but not limited to: adolescent girls, female headed households, women in polygamous marriages, child headed households, UASC and persons with disabilities. Especially in light of the COVID-19 pandemic when health resources are likely to be diverted, it will be a priority to ensure the continuum of care for children at risk and GBV survivors by supporting frontline staff through the provision of personal protective equipment, information, and specific items in line with international and national guidance. The CP/GBV AoR will work with the other sectors (especially health) to help ensure gender-based violence and child protection considerations are integrated in their areas of work, as per global standards. For example:

- Psychosocial First Aid (PFA) trainings and GBV sensitization for safe and ethical referral for frontline workers will be provided to facilitate and enhance access to response services, including for service providers working on COVID-19 response.
- The interface between the health response and the social services workforce will be strengthened by deploying social service workers to COVID-19 isolation and treatment centres and by increasing the capacity of health service providers on psycho-social support and CP and GBV referrals.
- Technical support for inclusion of SEA/GBV referral pathways in complaints and feedback mechanisms.

Housing Land and Property Working Group

The HLP Working Group (HLP WG) provides a forum for coordination of interventions, consensus-building, creation of partnerships and linkages to foster a strategic and consensual approach to address HLP concerns. Reflective of the cross-cutting nature of HLP issues, the HLP WG is an inter-sectoral working group, with a dedicated advisory role to the Protection and ES/NFI Clusters, while the group also provides an advisory role and technical expertise – as requested – to other UN and I/NGO coordination structures, such as the Durable Solution Initiative. This advisory role supports protection mainstreaming of HLP issues in these various fora and sectors.

HLP violations hinder the exercise of rights of IDPs, generate tensions within and across communities (resulting in further conflict) and remain a barrier to sustainable peace and stability. As identified by the IASC Framework on Durable Solutions for IDPs, unresolved HLP issues are among the key obstacles to durable solutions for displacement-affected populations. Improper determination, registration, administration and overall management of HLP issues may also have negative impact on humanitarian and development

activities and investments, including women's empowerment. Women's socio-culturally conditioned lack of access to HLP rights reduces their participation in household decision-making, undermines their coping capacities and often deprives them of basic security and protection. Focusing on gender perspectives while implementing HLP related projects should therefore be seen as a priority.

The current COVID-19 pandemic highlights the importance of security of tenure as it places many households at risk of eviction due to unpaid rent or stigmatization or development projects. Meanwhile legal assistance to obtain civil documentation is also a priority to facilitate access to health, shelter and other basic services at this time. While women are less likely to have civil documentation (impacting access to services), men are reportedly facing higher risks of harassment or arrest at movement checkpoints if lacking civil documentation. Thus, if HLP concerns are not addressed as part of the humanitarian response, they are likely to impede containment of the pandemic as well as the sustainability of durable solutions.

The HLP WG facilitates effective preventive, responsive and remedial action on HLP matters, through (1) strengthening the capacity of government, other stakeholders (traditional leaders, religious leaders, members of civil society) and humanitarian actors to identify and address HLP issues; (2) analysing the national HLP framework and relevant legislative and administrative provisions (foundation work); (3) contributing to the identification and to the resolution of HLP issues in Ethiopia, with initial particular attention to those issues stemming directly from the implementation of the HLP sector plans and projects; (4) providing technical guidance and expert advice on HLP matters to national and international actors in Ethiopia; (5) enhancing awareness on specific issues related to HLP to different stakeholders; (6) enhancing accountability, predictability and effectiveness of HLP-related activities; (7) increasing the security of tenure for affected populations; (7) develop a countrywide strategy on HLP and harmonize HLP assessment tools. As of April 2020, several objectives of the HLP WG are impacted due to COVID-19 outbreak and preventive measures taken by the Government of Ethiopia and Humanitarian agencies to mitigate transmission of the virus. All activities representing a risk for humanitarian workers and persons of concerns, involving international, inter-regional travel or group/public gathering, are scaling-down. Activities related to capacity building are being replaced by one-to-one coaching visits; assessments are either postponed or conducted with limited field work, qualitative group information sessions are replaced by one-to-one information sessions.

In response to COVID-19 outbreak, HLP WG is focusing on vulnerable groups at immediate risk of contracting COVID-19 and facing direct impacts because of their living conditions (e.g. displaced populations living in congested settings and those lacking civil documentation). Legal assistance to obtain civil documentation and information provision on access to services and COVID-19 prevention measures (via radio, information boards) is prioritized, along with one-to-one information and counselling sessions. In order to prevent risks of eviction and ensure that the most vulnerable persons have shelters, cash assistance is provided to households at risk of eviction. Advocacy messages will target local authorities and communities on the risks faced by displacement affected population on access to housing, eviction, forced eviction, forced relocation or forced returns.

Site Management Support Working Group

The goal of Site Management Support (SMS) working group (WG) is to provide a coordinated and timely response to the humanitarian needs of displacement-affected persons in both IDP sites and out of displacement sites. In 2020, SMS services are also be required in areas of return or relocation, where emergency needs are still present. The SMS approach is consistent, in both displacement and return contexts, as it applies the same methodologies as site management, on an area (e.g. kebele or woreda) basis, in out-of-site contexts, with the exception of site planning and decommissioning. In 2020, SMS services will continue to improve living standards of crisis-affected persons.

Ensuring a healthy, safe and dignified living environment in affected sites across the country will entail coordinating with and between Site Management (local authorities) and service providers across all sectors, to enhance service quality and efficiency. In the ongoing context of COVID-19, IDP sites, especially collective centres and spontaneous settlements, where households frequently share communal living, cooking and WASH facilities, and where water availability for sanitation is often well below the Sphere standard, will be of primary concern to mitigate the spread of COVID-19. Virus containment efforts in sites will require close collaboration between SMS actors and the Shelter, WASH and Health sectors, especially in the identification of high-risk locations and in the efforts to decongest them and increase hygiene conditions.

Site Management authorities will continue to be supported through capacity building, including on preparedness and durable solutions' pre-requisites for site closure, both particularly relevant in the context. In the pandemic context, capacity building will take the form of on-the job mentoring of government Site Managers, including remotely if necessary, and production of self-study (e.g. digital/audio-visual) training materials and corresponding tools that can be used by Site Managers and other relevant stakeholders.

Accountability to Affected Population (AAP) is central in all SMS activities, and is catalyzed through key activities such as Communicating with Communities (CwC), community participation and governance, as well as the provision of Community Feedback Mechanisms (CFMs). The SMS actors

will adapt their standard community participation activities to include Risk Communication, in coordination with Health and WASH actors. This includes mobilization of already trained Site or Kebele Committees and intensive messaging and awareness raising for both displacement-affected groups and their wider communities. Protection will be further mainstreamed throughout SMS implementation, including GBV risk mitigation and prevention, in line with the IASC Guidelines for Integrating GBV Interventions in Humanitarian Action, and undertaking actions for the protection against Sexual Exploitation and Abuse. All SMS activities will continue to prioritize displacement-affected persons, especially those in and around IDP sites and in areas of return.

Monitoring

The Protection Cluster, including the CP/GBV AoR, the HLP WG and SMS WG, will monitor the progress of the Protection Cluster activities against targets through monthly 5Ws (Who do What, Where, When and for Whom) reporting. Additionally, protection monitoring, partner reports, and assessments will be used to collect, verify and analyse trends emerging to ensure response capacities are adequate and meet the minimum standards in place. While protection mainstreaming efforts by individual actors and through Clusters have been made, there remain gaps and a lack of systemic efforts to examine and mitigate protection risks to affected communities. There are physical safety and security issues, risks of sexual exploitation and gender-based violence, child protection risks (including but not limited to child labour, child marriage, exclusion of child-headed households), a lack of information and communication with beneficiaries as well as mechanisms to allow PSEA reporting (in line with AAP/PSEA frameworks), risks of inaccessibility of programming (particularly for the persons with disabilities), the potential for inter-communal violence and tensions, amongst other serious protection risks.

To address such concerns, the Protection Cluster plans to roll-out the Protection Risk Analysis (PRA) tool to all Clusters over the course of 2020-2021, to promote and support "do no harm" programming across the response and increases opportunities for a multi-sectoral approach to addressing protection threats and risks experienced by affected communities (the period required for this initiative has extended into 2021 due to COVID-related delays). Once implemented this approach will be in line with, and adheres to, the four protection mainstreaming principles:

1. Prioritize Safety & Dignity and Avoid Causing Harm: Prevent and minimize as much as possible any unintended negative effects of your intervention which can increase people's vulnerability to both physical and psychosocial risks.

2. Meaningful Access: Arrange for people's access to assistance and services - in proportion to need and without any barriers (e.g. discrimination). Pay special attention to individuals and groups who may be particularly vulnerable or have difficulty accessing assistance and services.

3. Accountability: Set-up appropriate mechanisms through which affected populations can measure the adequacy of interventions, and address concerns and complaints.

4. Participation and empowerment: support the development of self-protection, capacities and assist people to claim their rights, including -not exclusively -the rights to shelter, food, water and sanitation, health, and education.

In addition to this cluster initiative, the Protection Cluster will continue to encourage partner participation in the PSEA network and IAAWG, as well as other strategic linkages in response planning, to uphold overarching commitments in this regard.

Cluster Objective 1: The protection needs of crisis-affected persons are identified, advocated for, and addressed by government, humanitarian and development actors			Jan HRP		Revised	
			PIN	Target	revised PIN	revised Target
Indicator 1.1:	Number of persons with specific needs identified through protection monitoring and referred for assistance (by sex, age and disability)	Activity 1.1. Protection risks, human rights violations and gaps in available service, are identified and addressed through protection monitoring and analysis and rapid protection assessment; access to basic services is enhanced through strengthened referral pathways (including transport for COVID cases) and advocacy by protection monitors.	133,320	1,999,800	18,332	441,623
Indicator 1.2:	Number of individuals receiving information on HLP (by sex, age and disability)	Activity 1.2 Individuals receive information on HLP	500	74,993		
Indicator 1.3	Number of individuals receiving counselling on HLP (by sex, age and disability)	Activity 1.3 Individuals receive counselling on HLP	333	99,990		
Indicator 1.4	Number of individuals receiving technical assistance on HLP (by sex, age and disability)	Activity 1.4 Individuals receive technical assistance on HLP	67	66,660		
Indicator 1.5	Number of individuals receiving information on civil and legal identity (by sex, age and disability)	Activity 1.5 Individuals receive information on civil and legal identity documents	667	99,990		
Indicator 1.6	Number of individuals receiving counselling on civil and legal identity (by sex, age and disability)	Activity 1.6 Individuals receive counseling on civil and legal identity documents	333	99,990		
Indicator 1.7	Number of individuals receiving technical assistance on civil and legal identity (by sex, age and disability)	Activity 1.7 Individuals receive technical assistance on civil and legal identity documents	67	66,660		
Indicator 1.8	Number of individuals benefiting from supported dispute resolution mechanisms (by sex, age and disability)	Activity 1.8 Support to collaborative dispute resolution mechanisms, including mediation, negotiation, arbitration or reconciliation, to resolve disputes	67	16,665		
Indicator 1.9	Number of persons that receive information or training on IDP rights provided to community members, local government authorities including law enforcement and court authorities (by sex, age and disability)	Activity 1.9 Information and training on IDP rights (including civil documentation and HLP right) provided to community members, local government authorities including law enforcement and court authorities.	1,667	33,330	4,000	71,993
Indicator 1.10	Number of assessments conducted	Activity 1.10 Research, studies, assessments and analysis are conducted to inform better protection programming	1	49,995	1 assessment	5,000
Indicator 1.11	Number of people reached through social cohesion / community-based protection structures supported (by sex, age and disability)	Activity 1.11Community-based protection structures and implement social cohesion strengthening/peacebuilding interventions which promote community engagement in response decision-making	3,333	25,331	10,000	161,667
Indicator 1.12	Number of individuals receiving information, counselling, technical assistance on access to basic services, with respect to HLP, legal identity documents and human rights (by sex, age and disability)	Activity 1.12 Individuals receive one to one information, counselling and technical/legal assistance and are supported through referrals to access to basic services (with focus on health services), HLP rights and legal identity documents			1,835	400,000
Indicator 1.13	Number of individuals supported against risks of eviction (by sex, age and disability)	Activity 1.13 Eviction montioring, facilitation of rent support to ensure security of tenture and avoid homelessness			667	240,000
Indicator 1.14	Number of advocacy messages on access to housing, forced evictions or relocations (by sex, age and disability)	Activity 1.14 Advocacy messages targeting local authorities and communities on the risks faced by displacement affected population on access to housing, eviction, forced eviction, forced relocation or forced returns			167	16,667
Indicator 1.15	Number of people reached with communication materials on protection risks associated with COVID (by sex, age and disability)	Activity 1.15 Communication with at-risk groups on protection risks/rights and access to services/referrals associated with COVID outbreak			100,000	100,000

Crisis-affected communities, women (including women with disabilities and older persons), adolescent girls and children, are protected from violence, exploitation, abuse and harmful practices, receive quality and timely response services and benefit from risk reduction and prevention measures.			Jan HRP		Revised	
			PIN	Target	revised PIN	revised Target
Indicator 2.1:	Number of at risk children provided with case management support (by sex, age and disability)	Activity 2.1.1 Identification and case management support provided to children at risk, including unaccompanied and separated children	10,000	10,000	10,000	10,000
Indicator 2.2	Number of children provided with MHPSS (by sex, age and disability)	Activity 2.1.2 Mental health and psychosocial support services (MHPSS) provided to children at protection risk including through safe spaces with intersectoral programming interventions	90,000	90,000	90,000	43,831
Indicator 2.3	Number of parents supported with positive parenting (by sex, age and disability)	Activity 2.1.3 Sensitisation and parenting support for caregivers to promote children's wellbeing and to protect them from maltreatment and other negative effects of adversity	143,101	10,000	143,101	10,000
Indicator 2.4	Number of individuals reached with messaging and outreach activities on child protection (by sex, age and disability)	Activity 2.1.4 Prevention activities such as awareness raising about child protection (including child protection in emergencies) to children and community members	1,860,309	130,000	1,860,309	100,000
Indicator 2.5	Number of individuals reached by capacity building support on child protection (by sex, age and disability)	Activity 2.1.5 Provision of chid protection response services enhanced though capacity development of service providers including providers of humanitarian assistance	143,101	10,000	143,101	5,000
Indicator 2.6	Number of individuals reached with GBV risk mitgation messaging (by sex, age and disability)	Activity 2.2.1: Risk mitigation activities and awareness raising is provided to affected populations, including women and adolescent girls, on sexual violence and other types of GBV	591,334	170,000	591,334	170,000
Indicator 2.7	Number of GBV survivors referred for comprehensive care (by sex, age and disability)	Activity 2.2.2 Survivors of GBV, including survivors of sexual exploitation and abuse (SEA), are supported, receive case management services and referred for multi-sectoral response services, as required	5,000	5,000	5,000	5,000
Indicator 2.8	Number of Women and adolescent girls provided with mental health and psychosocial support (MHPSS) services (age and disability)	Activity 2.2.3 Women and adolescent girls are provided with mental health and psychosocial support (MHPSS) services through women friendly spaces and community-based support.	20,000	20,000	20,000	20,000
Indicator 2.9	Number of individuals reached by capacity building support (by sex, age and disability)	Activity 2.2.4 GBV response service provision and access to services enhanced through capacity development and dissemination of referral pathways	52,177	10,000	52,177	10,000
Indicator 2.10	Number of dignity kits distributed (by age and disability)	Activity 2.2.5 Women, and adolescent girls of reproductive age provided with dignity kits	278,275	80,000	278,275	150,000
Indicator 2.11	Number of individuals provided with non-specialized psychosocial support (by sex, age and disability)	Activity 2.3.1 Non-specialized MHPSS interventions for crisis-affected communities (including in quarantine sites)			324,785	71,000
Indicator 2.12	Number of individuals reached with IEC messaging and outreach activities on positive parenting, hygien promotion, well-being and CP & GBV risk mitigation in context of COVID-19 (by sex, age and disability)	Activity 2.4.1 Development and distribution of IEC materials and undertake outreach on hygiene promotion, positive parenting, well-being, and specific protection issues related to COVID 19 (e.g. prevention of child separation, GBV, child labour (due to livelihood impact), intimate partner violence, etc.)			3,728,856	3,226,000
Indicator 2.13	Number of cases reported and referred by type of services # of UASC referred and accessing family based care or alternative care (by sex, age and disability)	Activity 2.4.2 Identification, case management services (including alternative care) and referral support to women and children affected directly or indirectly by COVID-19, including women and children in quarantine.			4,975	2,500
Indicator 2.14	Number of social workers supported with materials for selt-care and messages on life saving / behaviroual change on COVID 19 (by sex and age)	Activity 2.4.3 Support frontline staff including social service workforce with personal protective equipment, information, capacity support, and specific items (e.g. phones for remote case management and follow-up) to ensure continuum of case management work for CP and GBV			4,574	1,000

Indicator 2.15	Number of health service providers trained (by sex and age)	Activity 2.4.4 Provide capacity building support to health service providers to integrate basic PSS services at health facilities (PFA, and GBV guiding principles), child safeguaring, CMR, and on CP and GBV prevention and mitigation, and identification and referral of cases.			2,287	500
Indicator 2.16	Number of woredas assessed and with availability of post rape treatment kits	Activity 2.4.5 Regularly assess availabiity of heath response services for GBV survivors, in collaboration with health cluster, and procurement and distribution of post rape treatment kits.			983	50
Indicator 2.17	Number of social workers deployed (by sex and age)	Activity 2.4.6Strengthen the interface between the health system and the social welfare (including child protection system) with social workers, for follow-up and case management support of children and women affected by COVID-19			500	100
Indicator 2.18	Number of individuals provided with psychosocial support and benefiting from targetted COVID 19 messaging on MHPSS (by sex, age and disability)	Activity 2.4.7 Provide targeted MHPSS support to children, women and GBV survivors and caregivers that have been affected (directly or indirectly) from the COVID-19, including women and children in quarantine.			36,595	8,000
			Jan HRP		Revised	
Accountable, safe, accessible, and coordinated service delivery for crisis-affected persons (IDPs and returnees/relocatees and affected host communities) is improved			PIN	Target	revised PIN	revised Target
Indicator 3.1:	Number of IDPs and host community members with access to functional Community Feedback Mechanism (by sex, age and disability)	Activity 3.1.1 Strengthen community self-management and access to information for displaced populations through support to community governance structures, information and awareness campaigns, and complaint and feedback mechanisms	554,033	246,391	554,033	400,000
Indicator 3.2	Number of individuals benefiting from site improvement works completed (by sex, age and disability)	Activity 3.1.2 Improve living conditions of displaced people through site development, care and maintenance and decommissioning/restoration of facilities in displacement hosting	336,723	149,746	336,723	100,000
Indicator 3.3	% of people living in sites with SMS presence reporting access to multi-sectoral services (by sex, age and disability)	Activity 3.1.3 Strengthen safe access to multi sectorial services at site level through improved site management and coordination	505,160	224,657	505,160	175,000
Indicator 3.4	Number of stakeholders reached with SMS and protection mainstreaming capacity building (by sex, age and disability)	Activity 3.1.4 Capacity development on Site Management and protection for stakeholders	984,940	438,027	984,940	1,588,000
Indicator 3.5	Number of individuals trained in protection mainstreaming (by sex and age)	Activity 3.2. 1 Protection mainstreaming initiatives (including capacity building of clusters, local authorities and service providers)			49,150	50
Indicator 3.6	Number of IDPs and host community members reached through SMS-supported RCCE/CwC (by sex, age and disability)	Activity 3.3.1 Mitigate health and hygiene risks for displaced people through Risk Communication and Community Engagement			1,719,852	766,667

3.8 WASH

ORIGINAL TARGET	REVISED TARGETED	ORIGINAL REQUIREMENTS (US$)	REVISED REQUIREMENTS (US$)	
5.3M	10.5M	$79.7M	$103.4M	
COVID-19 RELATED	5.2M		$17.4M	PRIORITIZED REQUIREMENTS $34.1M
NON COVID-19 RELATED	5.3M		$86M	

% CHILDREN	% WOMEN	% PEOPLE WITH DISABILITIES
53%	23%	17%

Change in context

Due to the wide spread of COVID-19 pandemic in the country, needs in sustainable solution increased significantly to improve water supply in many areas. Though WASH Cluster had prioritized responses to COVID-19 pandemic at Healthcare Facilities (HCFs) when HRP was revised in May 2020, additional water supply and hygiene facility needs are identified in many towns and host-communities. The people in need analysis also revealed that WASH response needs among conflict IDPs in host community, returnees but not at home and other general non-displaced population, have increased. As a result, the COVID-19 related target population increased from 2.7 million to 5.19 million.

Although WASH Cluster partners are generally underfunded, the response capacity to extend WASH responses to larger group of the target population, is quite strong. Several national NGOs have been actively contributing cluster coordination and exhibiting adequate response capacity. Though some national NGOs had started accessing humanitarian funding from Rapid Response Mechanisms and EHF, further increase in funding for WASH response enables full utilization of the response capacity of WASH partners in the country.

CLUSTER OBJECTIVES

Lack of access to protected water and improved sanitation increases the risk of disease outbreaks and malnutrition, which significantly affect physical and mental well-being. As such, minimum WASH services are recognized as minimum living standard to be met for the affected population. In addition, sub-standard WASH services and facilities have the potential to become a root cause of protection risks, such as SEA and GBV, and barriers to vulnerable groups like people with disabilities and older persons. Therefore, the cluster objectives aim to meet the minimum WASH standards to save lives of the target population, by providing the following WASH responses:

1. Provide safe drinking water by water trucking and/or rehabilitation of non-functioning water schemes, extension of pipe network from the existing scheme, or construction of new water schemes
2. Provide hygiene and sanitation facilities by constructing differently types of latrines and deliver essential sanitation and hygiene messages through hygiene promotion
3. Provide life-saving essential NFIs, such as water collecting and storage items, household water treatment chemicals, hygiene and dignity kits, etc.

Revised cluster strategy and response priorities

Due to the increased response needs among non-displaced general population, WASH Cluster has prioritized sustainable solution activities (rehabilitation of non-functioning water scheme, expansion of pipe network) at host-communities. Major target groups are IDPs at host-communities, returnees and non-displaced population who are not accessing minimum standard of WASH services. This is prioritized to improve IPC at communities by providing reliable WASH service, especially water supply for hand hygiene and hygienic practices.

Following the findings and recommendation by the Multi-Sectoral Assessment at the points of entry and Quarantine Centers conducted in June 2020, 11 points of entry and 9 HCFs were added as additional target institutions. In total, targeted HCFs increased from 416 to 427.

All types of humanitarian WASH responses for the target groups will be integrated with COVID-19 preparedness and

ITANG TOWN, GAMBELLA REGION, ETHIOPIA

Nyarech Galuech, 30, serving the community at strategically constructed water kiosk at itang Town. Photo: UNICEF Ethiopia/2019/Nahom Tesfaye

response activities with additional hygiene items and RCCE measures. This is to strengthen community IPC through improvement of hygiene facilities and hygienic practices among vulnerable target groups, such as among IDPs, cholera affected, floods affected, drought affected and especially women and girls and people with disabilities.

Response plan

Depending on the context, water supply will be provided by emergency water trucking, sustainable solutions, or a combination of both. Since long-term water trucking operation is not cost-efficient, sustainable solutions will be preferred for protracted displacement as well as COVID-19 response for general affected population. Sustainable solutions will be applied especially at treatment, isolation and quarantine centers and communities. Improvement in sanitation will be addressed by construction of different types of latrines, such as VIP latrine, semi-permanent latrine and emergency trench latrines accordingly to the needs and context. Design and style of latrines should be inclusive and gender, age and protection sensitive. Hygiene promotion and distribution of essential lifesaving NFIs would be widely provided for different target groups, including people affected by disease outbreak. In preparedness to COVID-19 pandemic, additional hygiene items and handWaSHing basins need to be provided to the target population.

In order to incorporate actual needs and protection perspective of the target groups, technical specifications/design of WASH facilities would be agreed upon with the affected population. The Humanitarian WASH response would be flexibly implemented as per the actual needs of the target population in consideration of natural environment while also considering protection risks such as SEA and GVB. Response monitoring and post-distribution monitoring would be done accordingly to meet the minimum commitment of Accountability to Affected Population, which also incorporate CRM and other monitoring tools.

In response to COVID-19 pandemic, the WASH Cluster will align to the 3 Strategic Priorities of the Global Humanitarian Response Plan that are 1) Contain the spread of the COVID-19 pandemic and decrease morbidity and mortality, 2) Decrease the deterioration of human assets and rights, social cohesion and livelihoods and 3) Protect, assist and advocate for refugees, IDPs, migrants and host communities particularly vulnerable to the pandemic and integrate existing response plans and activities with more emphasis on community engagement.

Most of the WASH target population falls under the third strategic priority. Comprehensive WASH responses will be delivered to the affected population with additional items and messages of the COVID-19 pandemic, which also includes protection mainstreaming, assistance and advocacy for IDPs, migrants and host communities particularly vulnerable to the pandemic. IPC measures will be adopted at water supply and

NFI distribution sites including social distancing.

Cost of response

Due to increase in target population from 7.8 to 10.5 million people and targeted HCFs, total cost requirement has increased from $95.5 million to $10.3 million. Targeted HCFs increased from 416 to 427, while 11 points of entry are newly targeted as a result of Multi-Sectoral Assessment. Requirement for Non-COVID target has increased from $81.8 million to $86 million, while COVID-19 related requirement also increased from $13.7 million to $17.3 million.

The predominant cost driver in the response is the poor WASH coverage in the country as well as the large number of affected population due to sever natural environment, limited availability of water sources especially in lowland areas of the country and COVID-19 pandemic.

Water trucking is a means to deliver safe drinking water to affected population, areas and HCFs for disease outbreak and COVID-19. A long-term water trucking operation is more costly than rehabilitation of non-functioning water schemes or extension of water supply pipe scheme. According to an assessment done in 2017, the cost of rehabilitation and extension of existing water scheme is the same as provision of water trucking for 9-month in Oromia and for 6-month in Somali regions. Therefore, selection of water supply activities should be made based on the assessment and overall response plan to that particular emergency occurrence.

Monitoring

The WASH Cluster will monitor the response and its progress through monthly updates by partners through 4W which would be supported by ad-hoc updates at monthly Cluster meetings. WASH emergency response activities are important for preparedness and response to COVID-19. Besides, the cluster has slightly revised its regular reporting matrix (4W) to accommodate COVID-19 as an emergency, its corresponding preparedness and response activities and outputs at treatment, isolation and quarantine centers.

Gap analysis and progress monitoring on WASH responses at isolation and quarantine centers need to be jointly conducted with the federal and regional ECC and sub-national cluster platforms through multi-sectoral coordination, especially with the Health Cluster. This response monitoring will capture the achievement of the collective response as well as effectiveness of preparedness actions to respond to new occurrences or rapid deterioration.

Impact on operation will be monitored at monthly coordination platforms at the federal and sub-national levels in close coordination with OCHA and ICCG. This focuses on logistical aspects of WASH NFIs, especially cross-border transport between regions, as well as response delivery at IDP sites, community and health facilities.

Accessibility to WASH services among the target population will be done through tools such as DTM (Displacement Tracking Matrix) and VAS, and regular updates by cluster partners at coordination meetings. Availability of WASH facilities and services at isolation and quarantine centers would be updated by ECC following the national coordination mechanism for COVID-19.

		JAN		REVISED MYR	
OBJECTIVE	**INDICATOR**	**IN NEED**	**TARGETED**	**IN NEED**	**TARGETED**
Cluster Objective 1: To provide safe drinking water					
	1.1 % of/ Number of people having access to safe drinking water through emergency Water trucking	3.9 M	1.9 M	4.4 M	2.2 M
	1.2 % of/ Number of people having access to safe drinking water through sustainable solution	5.3 M	1.7 M	5.3 M	1.8 M
Cluster Objective 2: To provide sanitation and hygiene facilities (latrine & bathing/hand washing facilities)					
	2.1 % of/Number of people accessing sanitation facility (latrines & bathing/hand washing facilities)	971 k	583 k	5.3 M	3.9 M
	2.2 % of/Number of people reached through essential sanitation and hygiene message	5.3 M	5.3 M	10.5 M	10.5 M
Cluster Objective 3: To provide life-saving WASH NFIs					
	3.1 % of/Number of people provided with life-saving WASH NFI	5.3 M	4.7 M	10.5 M	9.5 M

3.9 Coordination

ORIGINAL TARGET	REVISED TARGETED	ORIGINAL REQUIREMENTS (US$)	REVISED REQUIREMENTS (US$)
		$12.0M	$12.0M
COVID-19 RELATED			
NON COVID-19 RELATED			$12.0M

Coordination will aim to facilitate coordinated and principled evidence-based humanitarian planning, action, and advocacy. The Government of Ethiopia and the humanitarian community coordinate the humanitarian response using the existing coordination mechanism and creating or revitalizing additional platforms. The overall coordination strategy focuses on strengthening leadership and coordination of preparedness and response operations at national and sub-national levels, strengthen early warning systems for the identification and confirmation of hazards, reinforcing capacity to rapidly respond to sudden-onset emergencies, and increase risk communication and community engagement among relevant stakeholders.

At the national level, key joint Government-humanitarian partners' strategic forums such as the multi-sectorial Emergency Coordination Center (ECC), the Health Emergency Operation Center (EOC) and the Disaster Risk Management Technical Working Group (DRMTWG) play a key role in the coordination of humanitarian response to the COVID-19 Pandemic and other hazards.

The Government of Ethiopia activated a national Emergency Coordination Center (ECC) to coordinate the multi-sectoral response to COVID-19 and other hazards. The ECC, chaired by the Commissioner of the National Disaster Risk Management Commission (NDRMC), is composed of various Government ministries, cluster coordinators, UN agencies, and NGOs. OCHA supports ECC management and has a liaison role in bridging the ECC and the wider humanitarian community. IOM, UNICEF, WFP and Plan International Ethiopia also support the ECC through the secondment of staff to the ECC. So far, the ECC has been instrumental in COVID-19 multi-sectoral coordination. However, rolling out similar structures in the regions yielded limited results. Therefore, the national ECC is providing technical support to regions to activate and effectively run regional ECCs. So far, Amhara and Somali regions have received training and technical support from a team sent from the national ECC. Before the end of the third quarter of the year, the national ECC plans to provide similar support to Afar, Gambella and Oromia regions. OCHA supports both the Federal and regional governments in establishing and operating effective regional ECCs.

Coordination of COVID-19 response also requires enhanced coordination and inter-linkage among the various coordination models and forums such as the refugee coordination model. In areas hosting refugees such as Gambella, COVID-19 prevention and response efforts require a joined-up approach. OCHA and UNHCR will work closely to design linkage between the different coordination forums.

The Ethiopia Humanitarian Country Team (EHCT), led by the RC/HC, will continue to provide overall strategic guidance and key advocacy channel. The EHCT convenes fortnightly with the participation of representatives from UN agencies, donors, and representatives of National and International NGOs.

Inter-Cluster Coordination Groups (ICCG) both at the national and subnational levels will continue to steer operational coordination. Due to low levels of humanitarian funding, ICCGs will focus on prioritization of needs among other things. During the second half of the year, ICCGs will also work to coordinate anticipatory action, preparedness, and rapid response. A decentralized coordination structure will also enable effective coordination of response and advocacy at sub-national levels with respective humanitarian coordination structures established by regional, zonal, and district administrations. Such humanitarian coordination mechanism will ensure an effective, agile, and principled multi-sectoral response to address the protection and assistance needs of the affected population. Moreover, it will also aid in promoting the integration of gender into humanitarian action in order to ensure that the particular needs, capacities and priorities of women, girls, men and boys in regard to pre-existing intersectional gender roles and inequalities, along with the specific impacts of a crisis, are recognized and addressed both at national and subnational levels.

Coordinated assessment and analysis of the situation will ensure a regular, common, and deep understanding of needs and severity of needs across population groups. This will be achieved by coordinating joint assessments; facilitate IDP and returnee tracking and data analysis; and information management on behalf of the humanitarian community. These activities will support the Humanitarian

Programme Cycle including a combined evidence-based needs assessment, Humanitarian Needs Overview (HNO), and Humanitarian Response Plan (HRP).

Coordination services will facilitate inter-agency and inter-sectoral vulnerability and need analysis to ensure evidence-based and context-specific responses. Based on the needs of humanitarian partners, coordination services will focus on improving agility to address operational challenges on the ground. This will also provide effective tools to streamline data collection and information management – particularly on access constraints to facilitate real-time solutions to access challenges. In terms of strengthening Accountability to Affected Population (AAP) in humanitarian decision-making, concrete steps will be identified and promoted that will ensure community level communication and engagement. Durable solutions to returns, resettlement, and reintegration will be realized through strong coordination, mainstreaming of community communication and engagement, and enhanced information sharing and communication. Humanitarian partners will be provided with all possible support to expand access and create an enabling operational environment which also includes humanitarian negotiations & civil-military liaison.

The Ethiopia Humanitarian Fund, a country based pooled fund will continue to strategically support humanitarian partners in delivering assistance to collectively prioritized needs, in line with response parameters and programmatic priorities set out in the 2020 HRP.

Part 4

Annexes

BAMBASI REFUGEE CAMP/BENISHANGUL-GUMUZ, ETHIOPIA

Bambasi Refugee camp primary school. Photo: UNICEF 2019/Ethiopia

4.1 **Total and Prioritized Targets and Requirements, by Cluster Activity**

Agriculture

		Cluster Objective 1: Most vulnerable crisis affected people are supported with basic services						**Cluster Objective 2:** Contribute to strengthening recovery and resilience of crisis affected people and system					
		Activity 1: Number of people that received animal health interventions	Activity 2:Number of people that received animal feed interventions	Activity 3:Number of people that received agricultural inputs	Activity 4:Number people that received restocking intervention	Activity 5: Number people that received destocking intervention	De-stocking interventions	Activity 1: Number of people benefited with established or rehabilitated water harvesting structures	Activity 2: Number of people benefited with rangeland management interventions	Activity 3: Number of people that received forage seed provision	Activity 4: Number of people benefited with established feed and seed banks	Activity 5: Number of people that received short maturing seed provision	Activity 5: Number of people benefited from livelihood diversification interventions
Original (January 2020)	In Need	964,575	92,921	1,562,825	43,112	2,175	2,175	598586	140,311	243,527	85,934	129597	243,527
	Target	501,943	53,337	431,351	18,245	1,791	1,791	445,140	132,489	153,937	33,750	58,580	153,937
	Requirements	8,883,023	36,195,697	16,583,822			316,059	12,000					
Revised (August 2020)	**Tier 1**												
	Non-COVID-19 Target	286,190	19,233	238,589	6,021	591		146,896				19,331	50,799
	Non-COVID-19 Requirements	3,676,230	13,054,223	7,596,504				3,960					
	COVID-19 Target	12,928	868	22,802									
	COVID-19 Requirements	25,344	36,300	31,416									
	Total												
	Non-COVID-19 Target	867,241	58,283	722,995	18,245	1,791		445,140				58,580	153,937
	Non-COVID-19 Requirements	11,140,090	39,558,251	23,019,710				12,000					
	COVID-19 Target	39,177	2,632	69,098									
	COVID-19 Requirements	76,800	110,000	95,200									

Education

		Cluster Objective 1 Increase access in provision of learning opportunities to COVID-19 and other emergency affected school aged boys and girls through distance and remote learning "				**Cluster Objective 2** Ensure safe and inclusive school environments for children and communities"					**Cluster Objective 3** Maintain the continuity of learning through acceleration, improvement and resilience building of leaners and communities"				
		Develop and broadcast Radio/TV lessons, RC	Number of emergency affected school age girls and boys benefited in emergency school feeding	Provide radio sets in hard to reach areas	Number of emergency-affected school age girls and boys learning in safe learning environment through TLC	Number of displaced primary school age girls and boys received learning opportunities through ALP	Number of girls and boys benefiting from learning materials or related cash interventions	Distribute learner workbooks	Number of male and female teachers trained on how to provide PSS or SEL to children	Distribute School Thermometers	Safe Schools Operation – Provides handwashing kits, disinfectants, water tanks	Back to School Campaign	Number of displaced and returnees pre-primary school age girls and boys received learning opportunities through ASR	Train teachers and education supervisors on SRGBV, positive discipline.	Train primary school children and adolescents from IDP settings with life skills and peacebuilding programmes
Original (January 2020)	In Need	10,598,003	1,400,000	1,000,000	542,000	542,000	1,400,000	500,000	9,000	500,000	1,000,000	2,000,000	542,000	200,000	200,000
	Target	7,886,139	1,289,000	500,000	92,000	222,750	910,000	300,000	4,000	250,000	500,000	1,000,000	23,000	84,969	84,969
	Requirements	2,980,000	8,008,749	1,000,000	3,475,000	7,614,000	4,934,698	0	1,300,000	500,000	1,000,000	2,000,000	2,000,000	1,169,938	1,169,938
Revised (August 2020)	**Priority 1**														
	Non-COVID-19 Target	0	542,000				555,000			0					
	Non-COVID-19 Requirements	0	1,500,000				3,000,000			0					
	COVID-19 Target	2,602,426	169,000	500,000			355,000			250,000	500,000				
	COVID-19 Requirements	980,000	1,500,000	1,000,000			2,000,000			500,000	1,000,000				
	Total														
	Non-COVID-19 Target		578,000		41,000	94,000		0	2,000				0	84,969	84,969
	Non-COVID-19 Requirements		5,008,749		3,475,000	5,614,000		0	650,000				0	169,938	169,938
	COVID-19 Target	5,283,713				128,750		300,000	2,000			1,000,000	23,000	220,000	220,000
	COVID-19 Requirements	2,000,000				2,000,000		0	650,000			0	2,000,000	1,000,000	1,000,000

ES/NFI

		Cluster Objective 1: Ensure contextualized access to lifesaving shelter and NFIs for displacement affected people, to safeguard their health security, privacy and dignity						Cluster Objective 2: Improve the living conditions of 1,846,655 displaced affected population and basic humanitarian needs in a timely manner through provision of Shelter and NFI					
		Activity 1: Provision of Emergency Shelter and NFI that consider the needs of women, children, people with disablities and and improve the beneficaries safety and security	Activity 2: Provision of in-kind or cash emergency shelter assistance for physical protection and to reduce overcrowding	Activity 3: Provision of core relief items to reduce the likelihood of health and protection consequences	Activity 4: provision of NFIs in a quarantine center	Activity 5: Pre-positioning of ES/NFI stocks	Activity 6: Provision of Emergency Shelter Repair Kit to HHs whose houses are completely damaged that consider the needs of women, children, people with disabilities, and the safety of beneficiaries.	Activity 1: Provision of Emergency Shelter and NFI that consider the needs of women, children, people with disablities and and improve HH safety and security	Activity 2: Provision of in-kind or cash emergency shelter assistance for physical protection and to reduce overcrowding	Activity 3: Provision of Emergency Shelter Repair Kit to HHs whose houses are completely damaged that consider the needs of women, children, people with disabilities, and the safety of beneficiaries.	Activity 4: Provide appropriate live-saving Non-food/ core relief items to safeguard the health and protection of displaced people affected people	Activity 5: provision of NFIs in a quarantine center	Activity 6: Pre-positioning of ES/NFI stocks
Original (January 2020)	In Need	244,430						1,022,700		722,940	216,880		
	Target	244,430				24,140		885,060		722,940	216,880		
	Requirements	1,060,700				4,224,140		25,304,620		46,005,110	3,943,300		
Revised (August 2020)	**Tier 1**												
	Non-COVID-19 Target	312,000				12,000	15,000						
	Non-COVID-19 Requirements	11,477,090				2,460,000	5,377,905						
	COVID-19 Target		373,460	373,460	22,950	70,000*							
	COVID-19 Requirements		4,413,590	8,148,170	1,836,230	5,600,000							
	Total												
	Non-COVID-19 Target	312,000			49,500	12,000	15,000	745,000	78,000	325,000	217,000		6,000
	Non-COVID-19 Requirements	11,477,090			1,800,000	2,460,000	5,377,905	31,728,970	2,610,300	20,658,500	1,843,850		1,212,000
	COVID-19 Target		373,460	373,460							259,000	47,000	
	COVID-19 Requirements		4,413,590	8,148,170							5,645,400	3,727,600	

Health

		Cluster Objective 1 To provide accessible essential health services to targeted populations, focusing on main causes of morbidity and sexual and reproductive health						Cluster Objective 2 To provide quality care for people with physical injuries, disabilities and mental health needs			Cluster Objective 3 To prepare for, detect and respond to epidemic prone disease outbreaks including COVID-19	
		Supporting health facilities including COVID-19 isolation facilities and mobile teams in crises affected locations	OPD consultations	Assist for normal deliveries attended by skilled birth attendants	Provide modern contraceptives for women in child bearing age	Provide community members with health IEC messages including COVID-19	Distribution of assorted emergency medical kits and COVID-19 PPE kits in crises affected locations	Treat/refer for future care cases with injuries and disabilities	Provide mental health and psychosocial support services including COVID-19	Provide clinical care for survivors of SGBV/ rape	Responding and verifying to epidemic prone disease alerts including COVID-19 within 48 hours	Measles vaccination to children 6 months to 15 years
Original (January 2020)	In Need	1,000	5,900,000	236,000	1,475,000	5,900,000	1,000	200,000	445,000	2,000	1,000	2,360,000
	Target	500	1,200,000	6,000	36,000	3,200,000	1,200,000	100,000	12,000	600	240	2,000,000
	Requirements	15,000,000	9,000,000	1,000,000	1,000,000	1,000,000	29,000,000	12,000,000	8,000,000	1,000,000	12,000,000	6,000,000
Revised (August 2020)	**Priority 1**											
	Non-COVID-19 Target	83	247,500	990	11,880	1,056,000	248	33,000	1,980	99	330	330,000
	Non-COVID-19 Requirements	4,950,000	2,970,000	330,000	330,000	330,000	9,570,000	3,960,000	2,640,000	330,000	3,960,000	1,980,000
	COVID-19 Target	83	247,500	990	11,880	1,089,000	248	33,000	1,980	99	330	330,000
	COVID-19 Requirements	3,300,000	1,980,000	330,000	330,000	330,000	8,250,000	2,640,000	1,320,000	330,000	13,200,000	990,000
	Total											
	Non-COVID-19 Target	250	750,000	3,000	36,000	3,200,000	750	100,000	6,000	300	1,000	1,000,000
	Non-COVID-19 Requirements	15,000,000	9,000,000	1,000,000	1,000,000	1,000,000	29,000,000	12,000,000	8,000,000	1,000,000	12,000,000	6,000,000
	COVID-19 Target	250	750,000	3,000	36,000	3,300,000	750	100,000	6,000	300	1,000	1,000,000
	COVID-19 Requirements	10,000,000	6,000,000	1,000,000	1,000,000	1,000,000	25,000,000	8,000,000	4,000,000	1,000,000	40,000,000	3,000,000

Logistics

Revised (August 2020)

	Cluster Objective 1: Provide transportation for the dispatch and delivery of life saving humanitarian cargo					Cluster Objective 2: Provide adequate storage services and logistics support equipment for the pre-positioning of critical supply					Cluster Objective 3: Provide capacity strengthening to the humanitarian community related to supply chain and augment operational coordination and support				
	Activity 1: Transport Services by land requested fulfilled	Activity 2: Transport services by air requested fulfilled	Activity 3: xxx	Activity 4: xxx	Activity 5: xxx	Activity 1: Total storage services requested fulfilled	Activity 2:Total logistics support equipment requested fulfilled	Activity 3: xxx	Activity 4: xxx	Activity 5: xxx	Activity 1: Increase logistics cluster staffing capacity across regions	Activity 2: Augmentation of staffing, logistics sytems and provision of trainings to the humanitarian community	Activity 3: xxx	Activity 4: xxx	Activity 5: xxx
Tier 1															
Non-COVID-19 Target	80%	80%				80%	80%				3	5			
Non-COVID-19 Requirements	132,000	198,000				671,880	264,000				132,000	146,520			
COVID-19 Target	80%	80%				80%	80%				3	5			
COVID-19 Requirements	528,000	792,000				2,687,520	1,056,000				528,000	586,080			
Total															
Non-COVID-19 Target	80%	80%				80%	80%				6	10			
Non-COVID-19 Requirements	400,000	600,000				2,036,000	800,000				400,000	444,000			
COVID-19 Target	80%	80%				80%	80%				6	10			
COVID-19 Requirements	1,600,000	2,400,000				8,144,000	3,200,000				1,600,000	1,776,000			

Nutrition

		Cluster Objective 1 To provide enhanced access to treatment services to children under five years of age and pregnant and nursing women affected by acute malnutrition			**Cluster Objective 2** To support preventive nutrition services for vulnerable populations focusing on protection of adequate Infant and Young Children Feeding (IYCF) practices and promoting multi-sectoral responses		**Cluster Objective 3** To strengthen local health system capacities including on coordination mechanisms, early warning, Nutrition situation monitoring and Nutrition emergency preparedness and response planning		
		SAM treatment	TSFP -U5	TSFP -PLW	IYCF-E counseling	RCCE	HWs/HEWs support	NGO's support to the health system for the delivery of Nutrition services	Surge support of Expert for Coordination and/or IYCF
Original (January 2020)	In Need								
	Target	443,565	1,772,761	1,360,784			3,000	100	
	Requirements	31,049,550	49,637,308	103,419,584			490,000	8,500,000	
Revised (August 2020)	**Tier 1**								
	Non-COVID-19 Target	256,662	1,085,816	833,481				25	
	Non-COVID-19 Requirements	17,748,390	30,402,848	63,344,518				2,750,000	
	COVID-19 Target	18,315	66,479	51,030	21,237		1,500	50	1
	COVID-19 Requirements	1,282,050	1,861,398	3,878,242		300,000	45,000	5,500,000	45,000
	Total								
	Non-COVID-19 Target	513,324	2,171,632	1,666,961				50	1
	Non-COVID-19 Requirements	35,496,780	60,805,696	126,689,036				5,500,000	60,000
	COVID-19 Target	36,630	132,957	102,059	42,474	15-20 million individuals	3,000	100	1
	COVID-19 Requirements	2,564,100	3,722,796	7,756,484	Captured/integrated in other budget lines	600,000	90,000	11,000,000	90,000

Protection

		Prioritized (August 2020)				Total			
		Non-COVID-19 Target	Non-COVID-19 Require-ments	COVID-19 Target	COVID-19 Require-ments	Non-COVID-19 Target	Non-COVID-19 Require-ments	COVID-19 Target	COVID-19 Require-ments
Cluster Objective 1: The protection needs of crisis-affected persons are identified, advocated for, and addressed by government, humanitarian and development actors	Activity 1.1. Protection risks, human rights violations and gaps in available service, are identified and addressed through protection monitoring and analysis and rapid protection assessment; access to basic services is enhanced through strengthened referral pathways (including transport for COVID cases) and advocacy by protection monitors.	133,320	1,999,800	18,332	441,623	400,000	6,000,000	55,000	1,325,000
	Activity 1.2 Individuals receive information on HLP	500	74,993			1,500	225,000		
	Activity 1.3 Individuals receive counselling on HLP	333	99,990			1,000	300,000		
	Activity 1.4 Individuals receive technical assistance on HLP	67	66,660			200	200,000		
	Activity 1.5 Individuals receive information on civil and legal identity documents	667	99,990			2,000	300,000		
	Activity 1.6 Individuals receive counseling on civil and legal identity documents	333	99,990			1,000	300,000		
	Activity 1.7 Individuals receive technical assistance on civil and legal identity documents	67	66,660			200	200,000		
	Activity 1.8 Support to collaborative dispute resolution mechanisms, including mediation, negotiation, arbitration or reconciliation, to resolve disputes	67	16,665			200	50,000		
	Activity 1.9 Information and training on IDP rights (including civil documentation and HLP right) provided to community members, local government authorities including law enforcement and court authorities.	1,667	33,330	4,000	71,993	5,000	100,000	12,000	216,000
	Activity 1.10 Research, studies, assessments and analysis are conducted to inform better protection programming	1	49,995	1 assess-ment	5,000	3	150,000	1 assess-ment	15,000
	Activity 1.11Community-based protection structures and implement social cohesion strengthening/peacebuilding interventions which promote community engagement in response decision-making	3,333	25,331	10,000	161,667	10,000	76,000	30,000	485,000
	Activity 1.12 Individuals receive one to one information, counselling and technical/legal assistance and are supported through referrals to access to basic services (with focus on health services), HLP rights and legal identity documents			1,835	400,000			5,505	1,200,000
	Activity 1.13 Eviction montioring, facilitation of rent support to ensure security of tenture and avoid homelessness			667	240,000			2,000	720,000
	Activity 1.14 Advocacy messages targeting local authorities and communities on the risks faced by displacement affected population on access to housing, eviction, forced eviction, forced relocation or forced returns			167	16,667			500	50,000
	Activity 1.15 Communication with at-risk groups on protection risks/ rights and access to services/referrals associated with COVID outbreak			100,000	100,000			300,000	300,000
	Activity 2.1.1 Identification and case management support provided to children at risk, including unaccompanied and separated children	3,333	573,333			10,000	1,720,000		
	Activity 2.1.2 Mental health and psychosocial support services (MHPSS) provided to children at protection risk including through safe spaces with intersectoral programming interventions	26,667	880,000			80,000	2,640,000		
	Activity 2.1.3 Sensitisation and parenting support for caregivers to promote children's wellbeing and to protect them from maltreatment and other negative effects of adversity	3,333	666,667			10,000	2,000,000		
	Activity 2.1.4 Prevention activities such as awareness raising about child protection (including child protection in emergencies) to children and community members	33,333	771,429			100,000	2,314,286		
	Activity 1.15 Communication with at-risk groups on protection risks/ rights and access to services/referrals associated with COVID outbreak	1,667	200,000			5,000	600,000		
	Activity 2.2.1: Risk mitigation activities and awareness raising is provided to affected populations, including women and adolescent girls, on sexual violence and other types of GBV	56,667	1,416,667			170,000	4,250,000		
	Activity 2.2.2 Mental health and psychosocial support services (MHPSS) provided to children at protection risk including through safe spaces with intersectoral programming interventions	1,667	416,667			5,000	1,250,000		

Cluster Objective 2: Crisis-affected communities, women (including women with disabilities and older persons), adolescent girls and children, are protected from violence, exploitation, abuse and harmful practices, receive quality and timely response services and benefit from risk reduction and prevention measures.	Activity 2.2.3 Women and adolescent girls are provided with mental health and psychosocial support (MHPSS) services through women friendly spaces and community-based support.	6,667	266,667			20,000	800,000		
	Activity 2.2.4 GBV response service provision and access to services enhanced through capacity development and dissemination of referral pathways	3,333	500,000			10,000	1,500,000		
	Activity 2.2.5 Women, and adolescent girls of reproductive age provided with dignity kits	26,667	533,333	23,333	583,333	80,000	1,600,000	70,000	1,750,000
	Activity 2.3.1 Non-specialized MHPSS interventions for crisis-affected communities (including in quarantine sites)	1,667	33,333	22,000	220,000	5,000	100,000	66,000	660,000
	Activity 2.4.1 Development and distribution of IEC materials and undertake outreach on hygiene promotion, positive parenting, well-being, and specific protection issues related to COVID 19 (e.g. prevention of child separation, GBV, child labour (due to livelihood impact), intimate partner violence, etc.)			1,075,333	537,667			3,226,000	1,613,000
	Activity 2.4.2 Identification, case management services (including alternative care) and referral support to women and children affected directly or indirectly by COVID-19, including women and children in quarantine.			833	143,333			2,500	430,000
	Activity 2.4.3 Support frontline staff including social service workforce with personal protective equipment, information, capacity support, and specific items (e.g. phones for remote case management and follow-up) to ensure continuum of case management work for CP and GBV			333	266,667			1,000	800,000
	Activity 2.4.4 Provide capacity building support to health service providers to integrate basic PSS services at health facilities (PFA, and GBV guiding principles), child safeguarding, CMR, and on CP and GBV prevention and mitigation, and identification and referral of cases.			167	66,667			500	200,000
	Activity 2.4.5 Regularly assess availabiity of heath response services for GBV survivors, in collaboration with health cluster, and procurement and distribution of post rape treatment kits.			17	39,000			50	117,000
	Activity 2.4.6Strengthen the interface between the health system and the social welfare (including child protection system) with social workers, for follow-up and case management support of children and women affected by COVID-19			33	150,000			100	450,000
	Activity 2.4.7 Provide targeted MHPSS support to children, women and GBV survivors and caregivers that have been affected (directly or indirectly) from the COVID-19, including women and children in quarantine.			2,667	213,333	200,000	1,200,000	200,000	500,000
Cluster Objective 3: Accountable, safe, accessible, and coordinated service delivery for crisis-affected persons (IDPs and returnees/ relocatees and affected host communities) is improved	Activity 3.1.1 Community services to establish and support community governance structures, community awareness campaigns and community complaint and feedback mechanisms	66,667	400,000	66,667	166,667	100,000	1,200,000		
	Activity 3.1.2 Site improvement works such as communal facilities construction, maintenance, partitioning and drainage, as well as decommissioning/restoration of facilities in displacement hosting	33,333	400,000			175,000	4,200,000		
	Activity 3.1.3 Site operations through deployment of site management support teams and monitoring services provided at the site/area level; disseminate information to local authorities and partners; and facilitate regular site/area-level coordination meetings as required	58,333	1,400,000			438,000	275,000	1,150,000	250,000
	Activity 3.1.4 Capacity development on Site Management and protection for stakeholders	146,000	91,667	383,333	83,333	50	100,000		
	Activity 3.2. 1Protection mainstreaming initiatives (including capacity building of clusters, local authorities and service providers)	17	33,333					766,667	1,000,000
	Activity 3.3.1 Mitigate health and hygiene risks for displaced people through Risk Communication and Community Engagement			255,556	333,333			450,000	1,250,000
	Activity 3.3.2 National and Sub-National Coordination Structures and local Site Management are supported in the mitigation of and response to COVID-19, through inter-sectoral coordination, development, dissemination, application of guidelines and SOPs for site decongestion, social distancing, and case management and referral in site settings, etc.			150,000	416,667				

WASH

		Cluster Objective 1 To provide safe drinking water		**Cluster Objective 2** To provide sanitation and hygiene facilities (latrine & bathing/hand washing facilities)		**Cluster Objective 3** To provide life-saving WASH NFIs
		Water trucking/tankering	Rehabilitation and maintenance of water schemes and Pipe-line expansion	construction of Emergency latrine and bathing/hand washing facilities	Sanitation and hygiene promotion	Provision/distribution of essential life-saving WASH NFIs including water treatment chemicals
Original (January 2020)	In Need	3,993,270	5,258,581	970,877	5,258,581	5,258,581
	Target	1,996,635	1,726,008	582,526	5,258,581	4,705,967
	Requirements	26,954,573	25,469,777	10,485,472	6,310,297	10,517,162
Revised (August 2020)	**Priority 1**					
	Non-COVID-19 Target	727,772	581,517	1,411,506	1,764,382	1,411,506
	Non-COVID-19 Requirements	9,824,916	8,673,759	4,231,250	2,117,259	3,528,765
	COVID-19 Target	37 facilities	110 facilities	98 facilities	1,714,899	141 facilities & 2,137,172
	COVID-19 Requirements	1,053,459	1,008,493	1,102,675	428,725	2,137,172
	Total					
	Non-COVID-19 Target	2,205,368	1,762,173	3,851,369	5,346,613	4,277,291
	Non-COVID-19 Requirements	29,772,473	26,284,119	12,821,971	6,415,936	10,693,227
	COVID-19 Target	111 facilities	333 facilities	296 facilities	5,196,665	427 facilities & 4,339,107
	COVID-19 Requirements	3,192,300	3,056,040	3,341,438	1,299,166	6,476,279

4.2 Refugees

SOMALI REGION, ETHIOPIA

Saabirim Barre Hassan, 16, who attends Grade 9 at the host community secondary school. Photo: UNICEF 2019/Ethiopia/Mulugeta Ayene

Ethiopia has a long-standing history of hosting refugees, maintaining an open-door policy for humanitarian access and protection to those seeking asylum on its territory. Ethiopia's parliament adopted revisions to its existing national refugee law in 2019, providing refugees with the right to work and reside out of camps, access social and financial services, and register life events, including births and marriages. Refugee protection is provided within the framework of international and national refugee laws as well as the core international human rights treaties that have been ratified by the country. At the start of the year, Ethiopia hosted 735,204 refugees from 26 countries who were forced to flee their homes as a result of insecurity, political instability, military conscription, conflict, famine and other problems in their countries of origin. Principal displacement factors are predominantly the conflict in South Sudan, the prevailing political environment in Eritrea, together with conflict and food insecurity in Somalia. The majority of refugees in Ethiopia are located in Tigray Regional State and the four Emerging Regions of Ethiopia: Afar, Benishangul-Gumuz, Gambella and the Somali Regional State.

Grounded in the Global Compact on Refugees (GCR), the roll out of the Comprehensive Refugee Response Framework (CRRF) in Ethiopia and contributing to the ten-year National Comprehensive Refugee Response Strategy, the Ethiopia Country Refugee Response Plan outlines the collective response of 54 humanitarian and development agencies over the next two years in support of refugee population groups in the country. It aims to increase coherence and alignment of all planned interventions supporting refugees against common sectorial objectives and performance targets, and to

improve coordination in the delivery of protection and solutions. In light of the COVID-19 pandemic, UNHCR has developed its business and operational continuity plans, while contributing to inter-agency efforts and support to the Government's COVID-19 preparedness and response plans.

Response

A comprehensive protection and solutions strategy has been developed for refugees in the country, with core objectives including: preserving and enhancing the protection environment and living conditions for refugees and the promotion of peaceful coexistence; strengthening refugee protection through the expansion of improved community-based and multi-sectorial child protection and SGBV programmes; strengthening access to basic services; supporting the implementation of the Government's Pledges to expand access to rights, services, and self-reliance opportunities in the longer-term; contributing to the development of linkages to local and national development interventions; and expanding access to solutions when feasible and legal migration pathways. The majority of refugees in Ethiopia have no immediate prospect or intention of voluntary return, with the advent of the COVID pandemic further complicating the establishment of conditions necessary for the facilitation of returns for some groups. Similarly, the closure of international borders has also stymied the smaller numbers of spontaneous returns from the country.

Refugee camps and surrounding hosting areas require enhanced coordination and management to ensure provision of services respecting recommended precautionary and hygiene measures for COVID-19, adapt monitoring mechanisms, as well as to mitigate against collateral impact of public health measures on families and high-risk individuals. Critical elements in successfully preventing, containing or mitigating the spread and impact of COVID-19—physical distancing, quarantine and/or isolation facilities, adequate technical support regional government authorities' capacity to test, trace and isolate, as well as adequate provision of soap, water and shelter—remain difficult to achieve or are in short supply in many camps. To effectively manage large-scale outbreaks in such conditions, the right level of preparedness is needed through a multi-sector camp or area-based approach to holistically consider existing conditions and plan interventions to reduce COVID-19 risks. The continued provision of essential health and other services is of utmost importance to reduce incidences of death, long-term negative health and social consequences. This includes community sensitization and ensuring that persons of concern particularly vulnerable to the pandemic receive assistance in the form of core relief items, cash-assistance, mental-health and psychosocial support.

Coordination and partnerships

Ethiopia has well-established refugee response and coordination processes in place, based on the Refugee Coordination Model, anchored in a solid framework of refugee law and procedures. The refugee response in Ethiopia brings together 54 partners, including the Government's Agency for Refugees and Returnees Affairs (ARRA), supported by UNHCR – the UN Refugee Agency, in coordination with UN agencies, international and national NGOs. Active sector working groups include Protection, Health, Education, WASH, Shelter, Energy and the Environment, together with a Child Protection/ SGBV sub-working group. The UN Country Team also forms part of the broader consultation forum on supporting Ethiopia to deliver Sustainable Development Goals and national development priorities within the framework of refugee protection and assistance.

Within the context of COVID-19, the Ministry of Health and its UN partners have adopted a coordinated approach to working in the areas of contact tracing, case investigation, case management, infection prevention and control/quarantine, laboratory and risk communication. Refugees are included within Government national and regional COVID-19 response plans, and the COVID-19 Multi-Sectoral Preparedness and Response Plan also includes provision of key services to refugees and displaced persons. In the Regional States where most of the refugees are hosted, UNHCR is part of the response efforts led by the Regional Health Bureaus. Under this overarching umbrella, ARRA, WFP and UNHCR have also jointly prepared the Ethiopia Refugee Preparedness and Response Plan (ERPRP) for COVID-19 with corresponding detailed workplans under development in collaboration with partners in each region. These are aligned to respective Regional Government response plans, and ongoing efforts are being made to ensure that partners involved in refugee response are included within wider COVID response coordination.

4.3 Costing Methodology

Agriculture

Costing methodology was determined through cluster's partner consultation and other programmes in place to harmonize and enhance response.

1. Animal health is determined by multiplying 3 animals per household by $12 for treatment and covering the operational cost (excluding cost of vaccines).

2. Animal feed is determined by providing 3.5kg of fodder (bale of hay at $4) and 2.5 kg of concentrate (1 quintal at $20) for 90 days for 3 core breeding animals.

3. Emergency seeds is determined by multiplying total targeted people by an average of 0.75 hectares with the unit price of different seeds varieties (price differs per type) and farming tools at total cost of $20.

4. Animal restocking is determined based on types of animals recommended during the assessment (price differs per type) for households at risk. Restocking is recommended for 5 shoats at a cost of $98.

5. Animal destocking is determined based on types of animals recommended in the seasonal assessment (price differs per type) for households at risk during a drought period. Its recommended to destock 2 animals at $88.

Education

School feeding: Total targeted children* $0.19 per child/day (WFP study estimation) *22 days per month * 6 months in a year. Learning stationary: Total target * $ 6 per child (8 exercise, 4 pen, 2 pencil, 1 eraser and pencil). ASR: Total target * $ 40 per child. ALP: Total target * $ 60 per child. Temporarily learning Centers: $14,000 per TLC. The recent engineering cost is estimated. Training for teachers (venue for training, per diems, materials etc.): $100 per teacher

ESNFI

The methodology for the present costing considers regular and COVID-19-related market inflation, as well as other cost drivers. The cost of the different type kits is developed through regional TWiGs (Technical Working Groups) and following a market monitoring costs have been adjusted, the member of SAG sets the support and operational cost.

Emergency Shelter and Non-Food Items (emergency shelter kit, bedding set, mosquito net, kitchen set, and partial hygiene kit): Procurement, transportation, storage, distribution, and other operational expenses. Cost: Average of $202/HH.

[COVID-19 response] Non-Food Items/ Core Relief Items (bedding set, mosquito net, and partial hygiene kit): Procurement, transportation, storage, distribution, and other operational expenses. Cost: Average of $120/HH.

[COVID-19 response] Emergency Shelter Kit (plastic sheets, rope, wooden poles, roofing nails, wire nails, and metal strap): Procurement, transportation, storage, distribution, and other operational expenses. Cost: Average of $110/HH.

[COVID-19 response] Non-Food items for Quarantine Centers (Bedsheets, clothes, personal eating utensils, soap): Procurement, transportation, storage, distribution, and other operational expenses. Cost: Average $100/HH

Emergency Shelter Repair Kit: The Shelter Repair Kit contains essential construction materials and tools that can be used to subsidize households in the reconstruction of basic houses or to repair partially damaged shelters (rebuild or repair). The kit is designed to be versatile enough to serve the needs of families whose houses have either been partially or fully damaged. The kit includes cash for construction materials that are locally available and culturally appropriate and should be accompanied by technical construction and Housing, Land and Property support. Emergency Shelter Repair Kit (CGI sheets, fixtures, and cash to subsidize the cost for labour and construction materials): Procurement, transportation, storage, distribution, technical support, and other operational expenses. Cost: $350/HH.

[Both COVID-19 and non-COVID-19 response] Cash for Rent for an average HHs of 2 rooms (around 21 m2): Including distribution, HLP support for tenancy agreements, and operational costs estimated at $30/month for six months is $180/HH.

Training of locally recruited carpenters for monitoring as a way of skills transfer and support for Housing, Land, and Property issues: Cost $10/HH.

Food

The cost of response is calculated using the national cash-food principle - for in-kind food items, the cost per MT is estimated to be US$602.11 which is then multiplied with total in-kind food requirement. The cash requirements are estimated based on the revised PSNP wage rates. The cost to support returns in quarantine and at points of entry (PoE) is based on the estimated cost of meals in various regions and the estimated number of returns who are expected to arrive during the second half of the year.

Health

The various emergency health kits are

estimated by population or caseloads as each kit is designed to reach a certain number of people or cases. Total cost of the kits was worked out using known international prices. Knowing that essential supplies constitute about 30% of the overall cost of emergency healthcare, the total cost for the response was calculated. For the target population of 3.2 million, it is possible to compute the quantity of kits required by type amounting to $28.8 million. With this figure worked out, the average cost of availing medicines to patients for 12 months is $9. The cost of a mobile team or surge team for health facility is about $4,000 per month. Therefore $24 million will be required to support 500 units for 12 months. To facilitate work for the teams, renting a car account for $3,000 per month, totalling $18 million. For 21 Health Cluster implementing partners, on average $55,000 is required monthly for project management and core staff, with significant variations. This amounts to $14 million for one year. An additional $10 million is required for travel, support supervision and monitoring, at an average cost of $40,000 per partner per month.

Logistics

The initial budget plan for the Logistics Cluster activities was accounted for a period of 8 months amounting to $59.7 million. This amount was included in the initial HRP before the activation of the Logistics Cluster. Once the Logistics Cluster was officially activated, the activation was approved for six-months period reducing the budget to $46.7 million.

The revision of the budget for the MYR has been done for a period of three months, i.e. until the approved end of the activation of the Logistics Cluster, thus reducing the budget to $23.4 million. This budget for the next three months aims to support the humanitarian community through the following activities:

1. Increase of storage capacities and earthworks
2. Cold storage for forwards hubs
3. Air transport operation
4. Capacity Strengthening of the Government
5. Augmentation of in-land transport capacity
6. Logistics Support Equipment
7. Staffing capacity.

The increase of storage capacity include the purchase of 200 Mobile Storage Units in order to increase storage for humanitarian community in remote areas or in areas where storage is not available at a cost 30,000 USD each including the earthworks required for the erection of those MSUs. Some of these Mobile Storage Units are already being used also to support the COVID-19 response in the point of entry/ exits of Ethiopia by using them as temporary isolation or testing units. Those costs include the shipment from UNHRD Dubai to Djibouti and transport to Adama.

The cold storage requirements include the purchase of refrigerated containers and prefabricated to be positioned in each regions and support both the response of COVID-19 but also trigger a preparedness plan for the future vaccination. This will allow to increase capacities in each region for both storage of cold-chain COVID-19 supplies and workspace for skilled staff supporting the COVID-19 response. There are 100 prefabs/refrigerated containers budgeted to be distributed across regions with a cost of 22,000 USD per container/ prefab including the shipping costs from UNHRD Dubai to Djibouti to then be transported into Ethiopia. Generators were also included with a total cost of 45,000 USD each for location.

The air transport operation plan comprises of 54 trips within country with consolidated cargo of partners for a total cost of 3 million USD. The air transport operations allows to rapidly transport COVID-19 supplies or emergency assistance between national airports and link it to forward hubs to manage the storage of cold chain requirements including the prefabricated for temporary office and generators as logistics support equipment adding 4M on the budget.

Augmentation of in-land transport Capacity plan to have rented commercial transported for the humanitarian community to increase their COVID-19 response or emergency assistance and consolidate cargo to make it more cost efficient with a total cost of 2 M USD.

Capacity strengthening activities for the Government and partners include augmentation of staffing capacity in critical areas to manage the logistics of the operations, cargo tracking for the humanitarian community through the WFP corporate system and Government's supply , and trainings as required in supply chain management.

Nutrition

The biggest proportion of the Nutrition response budget (95 per cent) is for therapeutic foods such as RUTF, therapeutic milks (F75 and F100), specialized nutritious foods such as RUSF and Super Cereal Plus, and medicines. Nutrition supplies costs include logistics costs for their shipment, storage and distribution/ dispatch. It is estimated that the treatment of a SAM child roughly costs $70, a MAM child treatment costs $26 and it amounts to $76 per malnourished women. 4.4 per cent of the budget factors for 6-month surge support from Nutrition partners in 100 priority woredas (with an average amount of $85,000 per woreda). Capacity building events and training cost represent about 0.3 per cent of the total budget and cater for trainings of Health care personnel on the revised acute malnutrition guidelines (targeting 3,000 participants), NiE training and Nutrition Preparedness and response planning workshops (targeting 75 participants). About $270,000 (0.1 per cent of total budget) is allocated for Nutrition related assessments (with the tentative plan to undertake 15 Nutrition surveys in 2020 at an average amount of $18,000 per survey). Finally, it is estimated that the support to Nutrition coordination mechanisms at subnational level provide by ENCU in 6 Regions cost about $24,000 a month, i.e., $288,000 are forecasted for Nutrition coordination support.

Protection

The unit costs for protection monitoring activities in 2020 have been calculated based on the cost per individual beneficiary for protection monitoring activities that were implemented in 2019, now adjusted for additional costs to mitigate for COVID-19

during implementation. Each protection monitoring unit consisting of a driver, vehicle, fuel costs, three protection staff and a government official that can accompany the unit when available and DSA charges may apply. The cost of each Protection monitoring is $15 per person reached. An additional sum has been added to this activity under the COVID-19 appeal to cover transport costs to facilitate referrals to services (e.g. health) for persons with specific needs. The associated costs for CP and GBV activities are calculated based on the cost per individual beneficiary for activities in 2019. Case management and GBV response costs may include costs associated with the social service workforce providing case management and support for medical, social welfare, justice/legal, and MHPSS/ psychological services, transport for the beneficiary to and from referral appointments, or the costs associated with a community service worker or social worker reunifying an unaccompanied child with family members. However, developing child protection case management capacity, including for an information management system contributes to strengthening the social service workforce system in Ethiopia and improving the quality of services for all children in emergency affected locations. The cost for dignity kits and other supplies such as recreational kits and tents include the items, as well as delivery and distribution The unit costs for information, counselling, technical assistance with respect to HLP and legal identity documents is calculated based on staff costs for the same activities that were implemented in 2019. The costs for HLP services include salary for Project Coordinators, Legal Officers, Paralegals, vehicles, and incidental costs such as traveling and small costs for facilitating group information sessions. The cost for legal identity document services include salary for three Project Coordinators, eight officers, vehicles and incidental costs such as traveling and small costs for facilitating group information sessions. Research studies and assessments have been budgeted at the unit cost of 15,000 per study. The cost of providing IEC materials and messaging for communication with at-risk groups on protection risks/rights and access to services/referrals associated with COVID outbreak, has been budgeted at $1/person as it will be integrated into other activities (such as protection monitoring above). SMS costs are calculated based on an average of both sites and return area needs, including related staff, material costs. In 2020, SMS plans to target 80 sites/kebeles, with an average of 6,250 beneficiaries per site/kebele. However, due to COVID, the cost per beneficiary of "Community services to establish and support community governance structures, community awareness campaigns and community complaint and feedback mechanisms" has increased from $4.8/person to $6/person due to increased costs of reaching beneficiaries (vehicle restrictions) etc. Meanwhile the cost of capacity development for site management actors has declined to $0.6/ indirect beneficiary due to a move towards pre-recorded self-study training modules. It is noted that costs vary substantially depending on the context of the site or kebele of implementation.

WASH

The cost of activities is calculated using sphere standard and current costs of items in the market. Unit cost per person is calculated based on average cost of activities for a certain number of people in different areas.

1. Unit cost of latrine construction is at $18/person with coverage of 100 persons per latrine stance, assuming 1 block consists of 7 stances.
2. Unit cost of water trucking is at $13.5/ person/6-month to provide 5litre/c/d. with the assumption that water trucking will be done for 6 months only with an exit strategy
3. Unit cost of NFIs including water treatment chemicals was calculated at the rate of $2.5/person based on cost of average NFIs kit.
4. Unit cost of hygiene promotion is $ 1.2/ person
5. Unit cost for rehabilitation and maintenance of a water scheme is $ 14/person
6. Unit cost for pipeline expansion of a water scheme is $ 21/person
7. Unit cost for construction of new water scheme is $ 50/person
8. Unit cost per person is calculated based on average cost of activities for a certain number of people in different areas.

4.4 What if We Fail to Respond?

Education

Education in emergencies response is life saving and life sustaining. Where education sector partners are not able to implement the projects for the children affected by emergencies, several negative effects are bound to happen;

- Children at home without dedicated support for learning are at risk of losing all that they had learnt before and subsequently less likely to want to return to school to continue learning
- The net effect is a drastic drop-in completion rate of basic education that subsequently results in worsened human development indices.
- Children are at higher risk of physical, emotional, sexual exploitation and abuse when not in school. They are more vulnerable especially when they lack basic needs leading to child marriage, teenage pregnancies and child labour.
- Schools are platforms for various essential services including health, hygiene promotion, food and nutrition and protection. Supporting schools when they reopen will support communities in reducing the spread of the COVID-19 virus when adequate protocols are instituted and followed

ESNFI

Failing to meet the critical needs for shelter and NFI means a population already vulnerable on many levels will be left without one of the most important basic needs that allow them to start rebuilding their lives. The importance of shelter is reflected in the multi assessment reports with shelter and food often the top priorities of affected communities.

In addition, shelter and provision of essential household items are pivotal for rebuilding resilience towards future shocks and the lives of affected families. Without adequate shelter, people will be left exposed to the elements, secondary displacement and increased incidents of gender-based violence. Women and children are particularly susceptible to external hazards from the surrounding environment. If the humanitarian needs are not met, there will be a risk of households employing negative coping strategies that could have a longer-term impact.

Food

The compounding negative impact of multiple hazards on household food insecurity will likely be contributed to increased malnutrition among the most vulnerable population group if there are inadequate resources to response to food needs in the country. Food insecure people are likely to employ negative coping strategies, some that will have long-term impact of livelihoods. Gaps in responding to food needs in quarantine and points of entry will result in some of the returns deserting these centers and contribute to risks of COVID-19 transmission in the country.

Logistics

The main challenges for the Logistic Cluster are to provide transport and storage capacity for relief items in areas where partners are facing difficulties either because of physical constraints, lack of infrastructures or because of a sudden increase of the needs also most of the time partners ask for the Logistics Cluster support in emergency situations where they don't have the capacity to give a quick response and cover all the needs (floods, earthquakes, typhons etc..). The result of a failure in providing an adequate and intime response to humanitarian crisis ends up with a delay in the delivery of relief items to beneficiaries or insufficient response. Such failure may have consequences on the capacity of the affected population to recover from a crisis as their situation may deteriorate and require additional efforts from the humanitarian community.

Health

Without adequate timely response to the health and medical needs of people in crises, it is expected that excess morbidity and mortality will abound. The first five years of life can be the riskiest if children are not vaccinated. Lack of access to routine and emergency vaccination will reduce the likelihood of any child celebrating their fifth birthday. Preventable diseases and deaths from common treatable causes like diarrhoea, pneumonia, malaria and measles especially affecting children under five should not be allowed. Uncontrolled disease outbreaks result in high attack rates, case fatality rates and increased burden to the health system. If trauma care is not available, casualties of conflict will die from direct and indirect causes or live with long term complications of their injuries. Similarly, pregnant women unable to reach emergency obstetric care will end up losing their life and that of the baby or live with long term complications. Survivors of sexual and gender-based violence suffer both physical and mental harm, including post-traumatic stress disorder, infectious diseases and unplanned pregnancy, which if left unattended to will have lifetime consequences. All health interventions are directly or indirectly affected by the COVID-19 pandemic. So, failure to mount an adequate response to the pandemic will have devastating consequences for all population groups.

Nutrition

Failure to respond will mean that people's food and nutrition needs will not be met and underfunding of the response will have significant negative impact on the food security of targeted households. The nutrition response directly contributes to reducing infant and child mortality and sustains Ethiopia's success in gradually decreasing the mortality rate of children under five years of age. Failure to support the management of acute malnutrition and/or withdrawal of humanitarian funds allocated for these life-saving nutrition interventions would lead to a deterioration of the nutritional status of the population, including pronounced increase in the prevalence of wasting and child mortality. This impact will be felt in no more than one year after the nutrition program phase-out. Nutrition status of pregnant and lactating women, children, households with disabled members and female-headed households will be compromised if there are no adequate resources to respond to the food needs of the targeted beneficiaries.

Protection

The Ethiopian population continues to struggle against the concurrent shocks of conflict, disaster, locusts and pandemic. Failure to respond means that the affected population's ability to cope with these shocks will continue to erode, placing even larger number of people at even greater risk from the continued cycle of shocks and without access to their rights or protection services.

As a result of COVID-19 (movement restrictions) access to livelihoods and ability of IDP households to meet basic needs in the face of higher market costs is declining. Without support, households will thus increasingly rely on negative coping mechanisms including decrease in caloric intake (particularly for women and girls), increased engagement in transactional sex, child labour and child marriage, while vulnerable members of families (older persons and persons with disabilities) may also be at greater risk of both financial and physical exploitation. In short, lack of access to adequate housing, HLP rights, health services and livelihood opportunities will increase the risk of exposure to sexual and gender-based violence, family separation and other human rights violations. Inadequate provision of basic services, lack of information, and coordination gaps may expose affected populations to life-threatening risks.

Survivors of sexual and gender-based violence suffer both physical and mental harm, including post-traumatic stress disorder, infectious diseases and unplanned pregnancy, which if left unattended to will have lifetime consequences and can furthermore serve as a continued source of intra-communal tensions and a driver of conflict.

Disputes over Housing, Land and Property Rights (HLP), are both fundamental causes and consequences of conflicts. Moreover, HLP violations hinder the exercise of rights of IDPs and remain a barrier to durable solutions. (For example, thousands of IDPs who attempted to return home in the first half of 2020 were unable to gain access to their original properties and land (some due to fear, some due to secondary possession) and therefore were forced back into displacement.) Therefore, lack of funding for HLP issues, means that pattern of displacements will only continue in the long-term.

Finally, while gaps in basic needs (including food, protection and WASH) place lives at immediate risk, they also perpetuate and exacerbate the effects of conflict. As displaced families are unable to meet their basic needs and exhaust the overstretched capacity of host communities, there are already several warning signs of increased intra and inter-communal tensions with reports of stigmatization and denial of services for IDPs. Exclusion and perception of inequality of access to services and assistance will fuel further violence in those communities and rigidify communal divisions along ethnic lines. These vulnerable and fragile communities may be thus be prone to increased risk of wide-spread inter-ethnic violence and conflict which could undermine recent socio-political reforms in Ethiopia and destabilize the East Africa region.

WASH

If we fail to provide minimum WASH service to the targeted population, there will be a huge risk of physical well-being such as disease outbreak and malnutrition, especially among vulnerable groups such as displace population. If WASH responses fail to meet required standard, there will be higher protection risks among vulnerable groups, especially among girls and women, children, and the physically disabled. It may also severely affect mental well-being of the affected population as access to basic WASH services is recognized as the human rights and life of all. As long as COVID-19 pandemic continues, failure to provide minimum WASH service will lead to wider community infection due to inadequate infection prevention as hand hygiene and hygienic practices would be limited. Poor WASH service at Healthcare Facilities may exacerbate the environment for healthcare staff and patients and IPC WASH measures at facilities will be inadequate, which in the worst case may lead to healthcare-acquired infection.

4.5

How to Contribute

Contribute through the Central Emergency Response Fund

The CERF provides rapid initial funding for life-saving actions at the onset of emergencies and for poorly funded, essential humanitarian operations in protracted crises. The OCHA-managed CERF receives contributions from various donors – mainly governments, but also private companies, foundations, charities and individuals – which are combined into a single fund. This is used for crises anywhere in the world.

cerf.un.org/donate

Contribute through the Ethiopia Humanitarian Fund

The Ethiopia Humanitarian Fund (EHF) is a country-based pooled fund (CBPF). CBPFs are a multi-donor humanitarian financing instruments established by the Emergency Relief Coordinator (ERC)and managed by OCHA at the country level under the leadership of the Humanitarian Coordinator (HC).

www.unocha.org/ethiopia

Registering and recognising your contributions

OCHA manages the Financial Tracking Service (FTS), which records all reported humanitarian contributions (cash, in-kind, multilateral and bilateral) to emergencies. Its purpose is to give credit and visibility to donors for their generosity, to show the total amount of funding, and to expose gaps in humanitarian plans. Please report yours to FTS, either by email to fts@un.org or through the online contribution report form:

fts.unocha.org

GEDEO ZONE/SNNP, ETHIOPIA

Students smiling for the camera at Gotiti primary school, Gotti kebele, Gedewo zone, SNNP
Photo: UNICEF Ethiopia/2019/MershaMichael Tsegaye

4.6 Acronyms

AAP	Accountability to affected people
ARRA	Agency for refugee and returnee affairs
AoR	Areas of responsibility
BMS	Breast milk substitute
CBCM	Community -based complaint mechanism
CCD	Collaborative cash delivery
CE	Community engagement
CFM	Complaints and feedback mechanism
CHS	Core humanitarian standard
CMAM	Community-based management of acute malnutrition
CP	Child protection
CVA	Cash Voucher assistance
CWC	Communication with community
CWG	Cash working Group
DRMTWG	Disaster risk management technical working group
DSA	Daily subsistence allowance
DTM	Displacement Matrix
ECC	Emergency coordination center
ECMT	Education cluster monitoring tool
ECWG	Ethiopia cash working groups
EHCT	Ethiopia humanitarian country team
EHF	Ethiopian Humanitarian Fund
EIE	Education in emergency
ENCU	Emergency nutrition coordination unit
EPHI	Ethiopia public health institute
EOC	Emergency operation center
ESNFI	Emergency shelter and nonfood items
FMOH	Federal ministry of health
FSNMS	Food security and nutrition monitoring survey
FTS	Financial tracking service
GBV	Gender based violence
GCR	Global compact on refugees
GIS	Geographic information system
GOE	Government of Ethiopia
HC	Humanitarian coordinator
HCF	Health care facilities
HEA	Household economy approach
HEW	Health extension workers
HLP	Housing, land and property rights
HNO	Humanitarian needs overview
HPC	Humanitarian program cycle
HRBA	Human right based approach
HRP	Humanitarian response plan
IAAWG	Inter-agency accountability working group
IA CBCM	Inter-agency community-based complaints mechanism
ICCG	Inter-cluster coordination group
IDP	Internally displaced people
IEC	Information, Education, Communication
INGOS	International non-government organizations
IPA	Individualized protection assistance
IPC	Integrated phase classification
IPV	Intimate partner violence
IYCF	Infant and Young child feeding
MAM	Moderate acute malnutrition
MCH	Mother and child health
MEB	Minimum expenditure basket
MHPSS	Mental health and psychological support
MIYCF	Maternal, infant and young child feeding
MOWCYA	Ministry of women and youth affairs
MPC	Multi purpose cash
MPG	Multi purpose cash grant
MPG TWG	Multi purpose cash grant technical working group
MSU	Mobile storage unit
MT	Metric tone
NDRMC	National disaster risk management commission
NiE	Nutrition in emergencies
PC	Prioritization committee
PDM	Post distribution monitoring
PFA	Psychosocial first aid
PLW	Pregnant and lactating women
PRA	Protection risk analysis
PSEA	Protection from sexual exploitation and abuse
PSNP	Productive safety net program
POE	Points of entry
RCCE	Risk communication and community engagement
RITA	Relief item tracking application
SAM	Severe acute malnutrition
SEA	Sexual exploitation and abuse
SGBV	Sexual and gender-based violence
SMS WG	Site management support working group
SNF	Specialized nutritious foods
SNNP	Southern nations, nationalities and people
TSF	Targeted supplementary food
UASC	Unaccompanied and separated children
UPSNP	Urban Productive safety net project
WG	Working group

Get the latest updates

Humanitarian RESPONSE

Humanitarian Response aims to be the central website for Information Management tools and services, enabling information exchange between clusters and IASC members operating within a protracted or sudden onset crisis.

humanitarianresponse.info/en/operations/ethiopia

Humanitarian InSight

Humanitarian InSight supports decision-makers by giving them access to key humanitarian data. It provides the latest verified information on needs and delivery of the humanitarian response as well as financial contributions.

hum-insight.info/plan/936

fts Financial Tracking Service

The Financial Tracking Service (FTS) is the primary provider of continuously updated data on global humanitarian funding, and is a major contributor to strategic decision making by highlighting gaps and priorities, thus contributing to effective, efficient and principled humanitarian assistance.

fts.unocha.org

MID-YEAR REVISED
HUMANITARIAN RESPONSE PLAN
ETHIOPIA

ISSUED August 2020