UPDATE TO THE 2020 ETHIOPIA HUMANITARIAN RESPONSE PLAN

This Annex presents revisions due to the recent changes to the humanitarian context, and should be read as part of the 2020 HRP. Only the Needs and Risk Analysis and the Cluster Plans of the annual HRP have been updated.

ISSUED MAY 2020

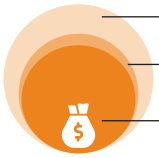
ANNEX

AT A GLANCE

REVISED TARGET (# people)
16.5M

REVISED REQUIREMENTS (US$)
1.65B

PRIORITIZATION OF REVISED REQUIREMENTS (US$)



PRIORITY 3 **1.65B**
PRIORITY 2 **1.16M**
PRIORITY 1 **1.08B**

NON COVID-19 TARGET (# people)
6.7M

NON-COVID-19 REQUIREMENTS (US$)
1.14B

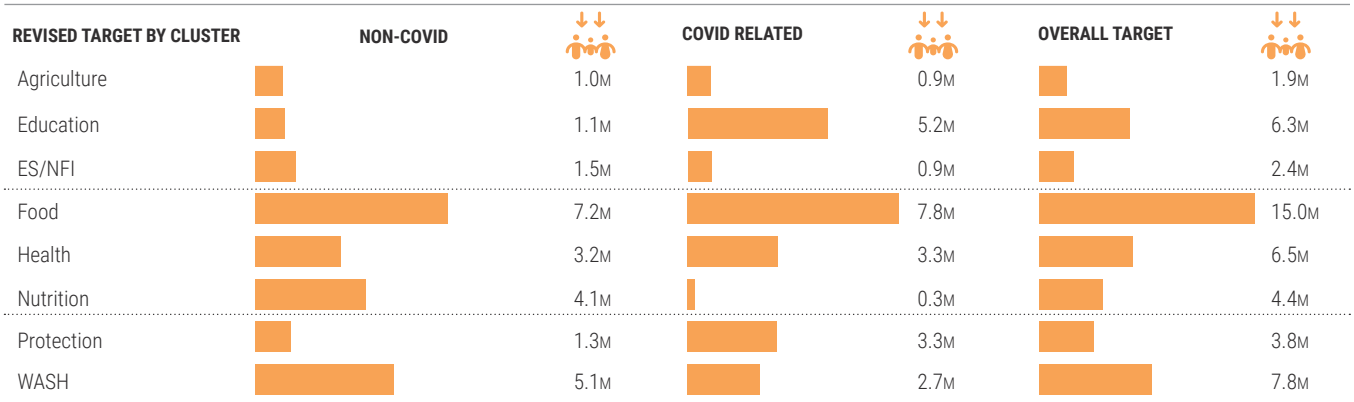
% COVID TARGET (# people)
9.8M

COVID REQUIREMENTS (US$)
506M

% CHILDREN
61%

% WOMEN
21%

% PEOPLE WITH DISABILITIES
9%



	ORIGINAL REQUIREMENTS (US$ MILLION)	REVISED NON-COVID REQUIREMENTS (US$ MILLION)	COVID REQUIREMENTS (US$ MILLION)	INTERNATIONAL CONTRIBUTIONS (US$ MILLION)	GAP (US$ MILLION)
Agriculture	54.0 M	45.2 M ↓	28.5 M	5.8 M	67.9 M
Education	30.0 M	20.3 M ↓	15.1 M	1.0 M	34.4 M
ES/NFI	95.8 M	81.5 M ↓	24.3 M	-	105.8 M
Food	399.5 M	488.7 M ↑	284.7 M	123.6M	649.8 M
Health	94.3 M	95.0 M ↑	100.0 M	7.2 M	187.8 M
Logistics	-	59.7 M ↑	-	-	59.7 M
Nutrition	193.4 M	226.8 M ↑	25.8 M	50.9 M	201.7 M
Protection	42.4 M	33.7 M ↓	14.0 M	1.1 M	46.6 M
WASH	79.7 M	81.8 M ↑	13.7 M	9.4 M	86.1 M
Coordination	12.0 M	12.0 M =	-	2.8 M	9.2 M
Multi-sector or sector not specified				*86.4 M*	*-86.4 M*
Total	**1.00 B**	**1.14 B**	**506.0 M**	**288.3 M**	**1.36 b**

Updated Needs Analysis

Since the release of the 2020 Humanitarian Needs Overview (HNO), there have been some changes to the humanitarian situation in Ethiopia. In this chapter we will analyze the changes in humanitarian needs based on events that have already occurred, most notably the impact of the desert locust infestation and changes to the IDP and returnee landscape, and conduct a risk analysis to project the anticipated needs due to the COVID-19 pandemic.

Impact of the desert locust infestation

Since January 2020, 180 *woredas* in seven regions have been impacted by the desert locust infestation. While desert locusts are mainly in the east and south of Ethiopia, changing weather conditions have caused swarms to move westwards from Somali region towards Oromia and SNNP regions. There are also reports of new swarms in the southern and western parts of the country, which could contribute to reduced crop harvest in 2020.

A joint assessment into the impact of the desert locust on household livelihoods and food security was conducted in February 2020. Assessed households reported pasture damage of 50 per cent on average and cereal losses totaled 356,286 MT affecting around 806,400 farming households, 197,163 ha of cropland and 1,350,000 ha of pasture and browse areas. The desert locust infestation has damaged different types of crops. The worst affected cereal was sorghum (113,639 ha affected), followed by maize (41,341 ha) and wheat (36,188 ha). Oromia was the worst affected region with a total cereal loss of 122,835 MT on 41,051 ha of cropland, followed by Somali region which experienced cereal crop losses of 102,613 MT on 90,076 ha of cropland.

The proportion of households reporting poor food consumption has increased, indicating heightened food and nutrition insecurity. The Food Consumption Score has deteriorated from 37 per cent in August 2019 to 41 per cent in March 2020, while the average Coping Strategies Index showed an increase from August 2019, demonstrating a more frequent use of consumption coping strategies, an indicative of the worsening food security situation. In addition, the quality of household diets has worsened as indicated by the Dietary Diversity Score which decreased from 3.45 in August 2019 to 3.07 in February 2020. Finally, the Household Economy Analysis, using LEAP-LIAS projections, shows that approximately 1 million additional people will be in need of emergency food assistance as a result of the desert locust infestation. The highest number of additional people requiring food assistance is located in Somali and Oromia regions, which is consistent with the areas that experienced the highest crop losses according to the Ministry of Agriculture.

To measure the impact of the desert locust infestation on livelihoods, the proportion of households using emergency livelihood coping strategies we assessed. Results showed an overall increase in the sale of animals, reduction of expenditure on livestock and agricultural inputs a consumption of seed stocks, and increased selling of breed animals from 22 per cent in August 2019 to 49 per cent in February 2020, with households in Oromia, Somali, Amhara, and Afar regions being particularly affected. In the same regions, apart from Amhara, the Terms of Trade were negative as a result of very high cereal prices. This is a sign of lower cereal stocks against stagnant or falling livestock prices. This is of concern since 25 per cent of assessed households are dependent on markets for food, in particular pastoralist households. A month after the ***Meher*** harvest, the majority of households reported that they had limited or no cereal stocks, indicating a high vulnerability of households to food insecurity. Moreover, an estimated 800,000 households will need additional livelihood support, mainly located in Somali and Oromia regions.

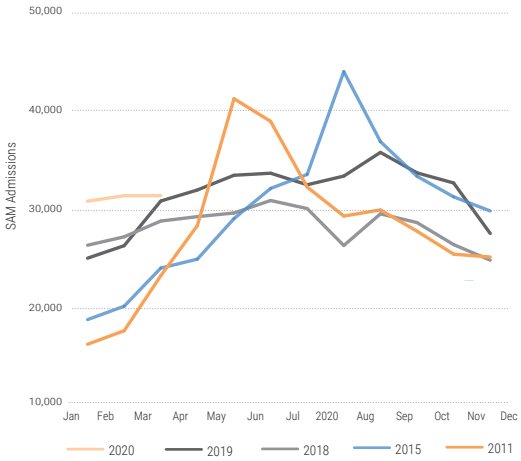
The rapid incursion of desert locusts across many regions in Ethiopia has resulted in significant cropland losses and jeopardized the livelihoods of smallholder farmers who depend on crops. By the start of the school year in September 2020, the infestation will have likely led to a considerable drop in agricultural production, which will further exacerbate the existing food insecurity situation and malnutrition in the regions. Furthermore, WFP and the Government school-feeding programmes in some regions such as SNNP and Oromia are entirely reliant on home-grown crops, whereby food is purchased from smallholder farmers.

Although it is very difficult to specifically attribute the desert locust infestation to the deterioration of the nutrition situation, it is worth noting that the overall number of children affected by severe acute malnutrition (SAM) and who were admitted for treatment during the first quarter of the year was significantly higher than what it was during quarter one last year. As end of March 2020, nationwide SAM admissions were 13.6 per cent higher compared to quarter one 2019 and higher in almost all regions with for example 41.1 per cent increase in Tigray, 23.1 per cent in Amhara, 18.2 per cent in Afar, and 15.6 per cent in Oromia region (Figure 1). Further increases are anticipated as the food security situation continues to deteriorate.

IDP and returnee situation

Since the release of the 2020 HNO, there have been changes in the IDP and returnee situation throughout the country. Between December 2019 and January 2020, persons were newly displaced in all regions

Figure 1. Ethiopia Annual SAM Admission trends



(except Benishangul-Gumuz), mostly as a result of conflict. Seasonal floods and drought were the other main drivers of new displacements. The total number of displaced persons is currently 1.8 million[1] .

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 DTM, VAS and the desert locust impact assessment carried out by the Ministry of Agriculture, FAO and partners.

Moyale *woreda* in Daawa zone, Somali region, shows a very high severity of needs and is currently the only *woreda* remaining in this category (Figure 2)

In terms of the geographical change of the severity of needs, most notable increases are in Goljano (Fafan, Somali), Kobo Town and Woldiya Town (North Wello, Amhara), Dodola Town (West Arsi, Oromia), Anfilo and Dale Sadi (Kelem Wellega, Oromia), Gololcha Bale (Bale, Oromia), Doba (West Hararghe, Oromia), Amibara (Zone 3, Afar) and Kombolcha Town (South Wello, Amhara).

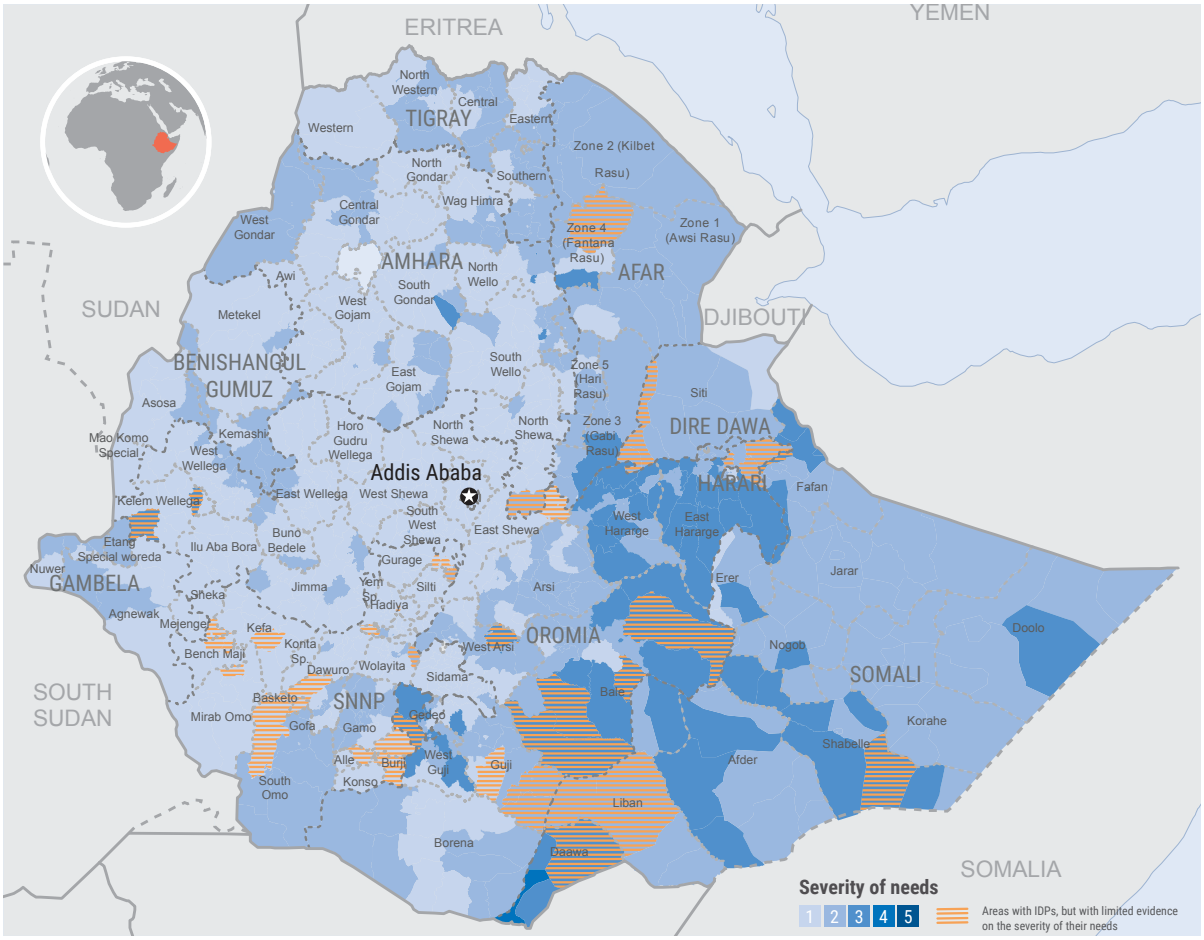
People in need

Changes in the humanitarian situation (non-COVID 19 related) have impacted the number of People in Need (PIN). Available data indicates that the PIN has increased from 8.4 million (2020 HNO) to an estimated 10.6 million currently, disaggregated by population group, as indicated below.

POPULATION GROUP	UPDATED PIN
Conflict IDPs in sites	678 k
Conflict IDPs in host communities	1.0 m
Returnees to areas of origin but not home	125 k
Returnees to home	815 k
Climate induced IDPs	602 k
General population	7.3 m
Total	**10.6 million**

	Low	Medium	High	Very High	Severe
Addis Ababa	10				
Afar	5	28	2		
Amhara	145	36	4		
Benishangul Gumz	14	6			
Dire Dawa		12	1		
Gambela	9	6			
Harari	4	5			
Oromia	208	82	45		
SNNP	170	40	2		
Somali	5	69	24	1	
Tigray	21	31			

Figure 2. Updated inter-sectoral severity of needs (at *woreda* level)



[1] Source: draft DTM Round 21 results (pending endorsement). This is the number of IDPs that were assessed by IOM-DTM in February-March. This however excludes IDPs in SNNP region, to which DTM teams do not have access.

Risk Analysis and Projected Evolution of Needs

Since the first confirmed case of COVID-19 was reported on 13 March, the Government of Ethiopia has been implementing a series of control and prevention measures in an attempt to slow down virus transmission. As cases continued to increase, the Government announced a State of Emergency on 8 April for a period of five months, although depending on the development of the pandemic this may be extended.

Health impacts of COVID-19

COVID-19 will directly impact the health of those infected with the virus. Two months into the 1st case, on 13 May, there were 265 confirmed cases in Ethiopia. The Ethiopia Public Health Institute (EPHI) estimates 102,000 people will be infected with the virus in the next three months, with over 39 million people at risk of becoming infected on the basis of no mitigation measures in place. Should these previsions materialize, the current health care system will not be able to cope with such a surge of COVID-19 cases in need of specialized medical treatment, which could lead to a high fatality rate. 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.

This anticipated increase of cases will also have an indirect health impact as resources are shifted to the COVID-19 response and the healthcare system becomes overwhelmed with COVID 19 cases. Health workers, health facilities, medical supplies, and water will be repurposed to the COVID-19 response, causing additional stress to an already struggling health care system. Regular essential primary healthcare services will be hampered or suspended and will disproportionately affect women. It is likely that fewer mothers, women, adolescents and children under five will be able to access routine EPI, treatment for common illnesses, other Mother and Child health (MCH) services, reproductive health services, and mental health and psychosocial support. At the same time, continued services may become underutilized as people fear contamination in health facilities. Physical and financial access to healthcare is also likely to decrease as morehouseholds fall into poverty, healthcare services become stretched, and movement restrictions are reinforced. 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.

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 community levels. The shortage of personal protective equipment, hygiene supplies and water further aggravate the risk. Data from other countries shows that an important proportion of health workers were infected. 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.

Indirect humanitarian effects of COVID-19

COVID-19 is expected to have an indirect but serious impact on the food security situation throughout Ethiopia. COVID-19 prevention measures will likely contribute to delays in 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 are likely to be highly affected. As women make up 65% of the informal workforce, they will be most severely impacted. In rural communities, food insecurity will increase mostly among households that rely on market purchases. The outbreak will have 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 will have to ensure social distancing and hygiene standards at distribution sites which will increase the time required to complete distributions. It is also anticipated that as a result of movement restrictions there will be delays in moving in-kind commodities from warehouses to final distribution points.

The pandemic will also negatively impact supply chains including food supplies to markets in areas where cash transfers are implemented. This will likely lead to increased food insecurity, especially in communities where there are existing challenges with physical and economic access to food. These supply chain disruptions will affect 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 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, acute malnutrition is expected to increase and will represent a significant additional burden to the existing large-scale malnutrition problem in Ethiopia.

While the COVID-19 impact on the food security sector is paramount, other sectors will also be impacted. In March 2020, the Government announced the closure of pre-primary, primary, and secondary schools throughout the country. 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. Girls and children living with disability are particularly at risk, with the disruption to their learning denying them the only chance to transform their lives and reach their potential. 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 technology, the risk remains that the most vulnerable children will not benefit from these services or alternative home-school methods, thereby further widening the learning gap between the lowest and highest quantiles.

COVID-19 pandemic is expected to adversely impact the protection situation of all vulnerable groups already in need of protection support identified in the 2020 HNO and HRP. Existing vulnerabilities are likely to be exacerbated, while new ones may develop (not least driven by the socio-economic consequences of COVID-19 mentioned above). Moreover, social distancing measures and the diversion of resources towards the COVID-19 response, may 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 COVID-19 pandemic may also contribute to the further deterioration of inter-communal trust and result in an escalation of regional conflict. Ethiopia is already rife with inter-ethnic discrimination and violence. The suspension of social events and practices may rupture social cohesion, increasing distrust and tensions between communities (including between host and IDP communities). This divide could be further augmented if one particular group becomes associated with the disease. Additionally, there is the risk that armed groups capitalize on these perceptions to incite political or ethnic violence, resulting in new waves of conflict or displacement.

People living in densely populated areas, such as IDPs and refugees living in camps, planned sites, spontaneous settlements, collective centers 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. Furthermore, 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, places 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 respond appropriately. The absence of communication networks and language barriers can prevent accurate and timely messages reaching these groups. 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.

Vulnerable groups

While the pandemic will affect all of society, certain vulnerable groups will be at greater risk, such as women , children, persons with disabilities, older persons, IDPs, returnees and refugees, as identified in the 2020 HNO, but also 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, and persons with deprived liberties or in institutions, and elders. 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.

Although data suggests that the physical illness affects more men than women (as per 1 June 2020, 67.4% of confirmed cases were men), the secondary effects of the outbreak disproportionally impacts women and girls. They are at increased risk of GBV, IPV, and SEA as well as at increased risk of exposure to the virus due to their predominant roles as caregivers within families and as front-line healthcare workers.

A full breakdown of vulnerable groups requiring extra support during the pandemic are listed below:

People living on the streets, there are an estimated 88,000 – 150,000 persons living on the streets in Ethiopia with a large number of women, children and youth, of which approximately 52,000 are in Addis Ababa[2] and include a large sum of children, youth, and women. Persons living on the streets generally have poor health, which could enable the virus to progress to more severe morbidity requiring medical care which they struggle to access. They are also less likely to be reached by awareness campaigns or information materials on prevention measures. As this group may be perceived as transmitters of the virus, they may become increasingly vulnerable to social exclusion and discrimination.

Older persons over 60, persons with disabilities, and those with chronic medical conditions, (including mental health) will likely experience increased challenges in accessing basic, critical healthcare services due to lack of accessibility to the physical environment (i.e. mobility constraints), lack of accessible information, as well as increased discriminatory behaviours, neglect, and exclusion. Moreover, COVID-19 presents specific risks for older people

[2] The Federal Ministry of Women, Children and Youth – An Emergency Plan to Protect People Living and Working on the Streets from Corona Virus Disease 2019 (COVID-19), March 2020

given that initial research showed a mortality rate of 2.3 per cent for the general population, rising to 8 per cent in those aged 70-79 and nearly 15 per cent in those 80 and over.

People deprived of their liberties or living in closed facilities, (e.g. residential care homes, prisons, psychiatric hospitals) may have excess risk of transmission due to their limited ability to apply social distancing and limited access to appropriate response measures. There is also potential risk of increased abuse and neglect.

People who lack identity documents, including migrants, displaced persons and others, may face challenges in accessing medical services, particularly testing and treatment for COVID-19. There is also potential risk of increased abuse and neglect.

Women and girls are particularly vulnerable for several reasons:

1. They are at heightened risk of exposure to the virus due to their common roles as front-line workers or health facility service staff and as caretakers of the family (e.g. to care for sick household members).
2. Overwhelmed healthcare services and reduction of financial resources will likely hamper women's access to other services including sexual and reproductive healthcare, exacerbating preventable maternal deaths and leading to a rise in unwanted / unplanned pregnancies and the social economic impact they have on individuals, households, and communities.
3. In line with global trends, women and girls may also be increasingly exposed to gender-based violence (GBV) and intimate partner violence due to movement restrictions and social distancing measures while facing multiple barriers to seek support and access services for SGBV, IPV, and SEA.
4. Single female-headed households will be at increased risk of SEA.
5. Women and girls are not fully incorporated in health security surveillance, detection, and prevention mechanisms.
6. Women's voices are rarely incorporated to protect and support the economic empowerment of women.
7. Limited access to adequate and correct information on COVID-19 as a result of low literacy rates and low media access, internet penetration, and language barriers. This will affect women in the informal sector, women with disabilities, migrants, refugees, and IDPs in particular. .

Children may face multiple risks during a pandemic like COVID-19 including:

1. Family separation due to hospitalization, treatment, or death as a result of the virus.
2. Increased psychosocial distress or trauma caused by fear related to COVID-19, stigmatization and social exclusion when family members contract the disease, and the disruption of schools and daily routines.
3. Increased violence and abuse at home due to caregivers becoming increasingly distressed and turning to dysfunctional coping mechanisms (alcohol, substance abuse, etc.). Adolescent girls may be at particular risk to gender-based violence as a result of reduced family and community care protection and a breakdown of social protection structures. School closures and reduced family livelihoods also increase the risk of children dropping out of school and turning to negative coping mechanisms such as child marriage, child labour, or sex work.
4. Restricted access to adequate food as a result of a breakdown in the food supply chain and household mitigation measures.
5. Reduced access to services, in particular for already vulnerable children such as children living on the street, unaccompanied and separated children, child-headed households, and Children with disabilities.

IDPs, the majority of whom are women, will be at heightened risk of immediate and longer-term effects of the pandemic, as their social support networks are often fragmented, and coping mechanisms already stretched. They may experience difficulties accessing care and medical services, including testing for COVID-19 due to lack of documentation, safe transportation, and service. Many depend on the informal economy for survival and lack personal resources to tolerate market price fluctuations, making them more vulnerable to restrictions or emergency regulations. Distribution delays may negatively impact the nutritional status of IDPs and adjusted distributions, including the suspension or limitation of accountability mechanisms, may place some IDPs at risk of exclusion or impede distribution access to IDPs with specific needs. Gender protection safeguarding evidence indicates that female IDPs in particular will be at an increased risk of exposure to GBV and SEA. As one of the main sources of transmission is through respiratory droplets transmitted by an infected person or contaminated surfaces, IDPs living in informal settlements / sites, have a higher risk of exposure to Covid-19 due to overcrowded living conditions, shared WASH/ cooking facilities, and insufficient access to safe water and hygiene. While this has been raised as a serious concern by the Government and several clusters, resource and capacity shortages will make it difficult to decongest sites and relocate IDPs and refugees.

Migrants, may lack access to basic services, - including access to dignity kits to ensure menstrual health for female migrants as highlighted in a recent assessment of quarantine facilities, face linguistic barriers with respect to access to information, experience discrimination and exclusion from services, and be trapped by travel restrictions, lack of legal status or documentation. At least 2,700 Ethiopian irregular migrants have been deported from the Kingdom of Saudi Arabia in recent weeks and an additional 2,000 from Djibouti, Kenya, and Somalia. Although quarantined, forced returns of irregular migrants increases the risk of cross-border transmission of the virus. Unaccompanied minors are among these migrant returnees who will be requiring specialized protection support.

Urban poor, often live in congested conditions with limited WASH facilities and access to safe water. Considering the virus spreads through contact, this group is at high risk of transmitting the disease once infected. Furthermore, as this group often depend on daily labour and market purchases, they will be disproportionately affected

Figure 3. COVID-19 vulnerability analysis (at *woreda* level)

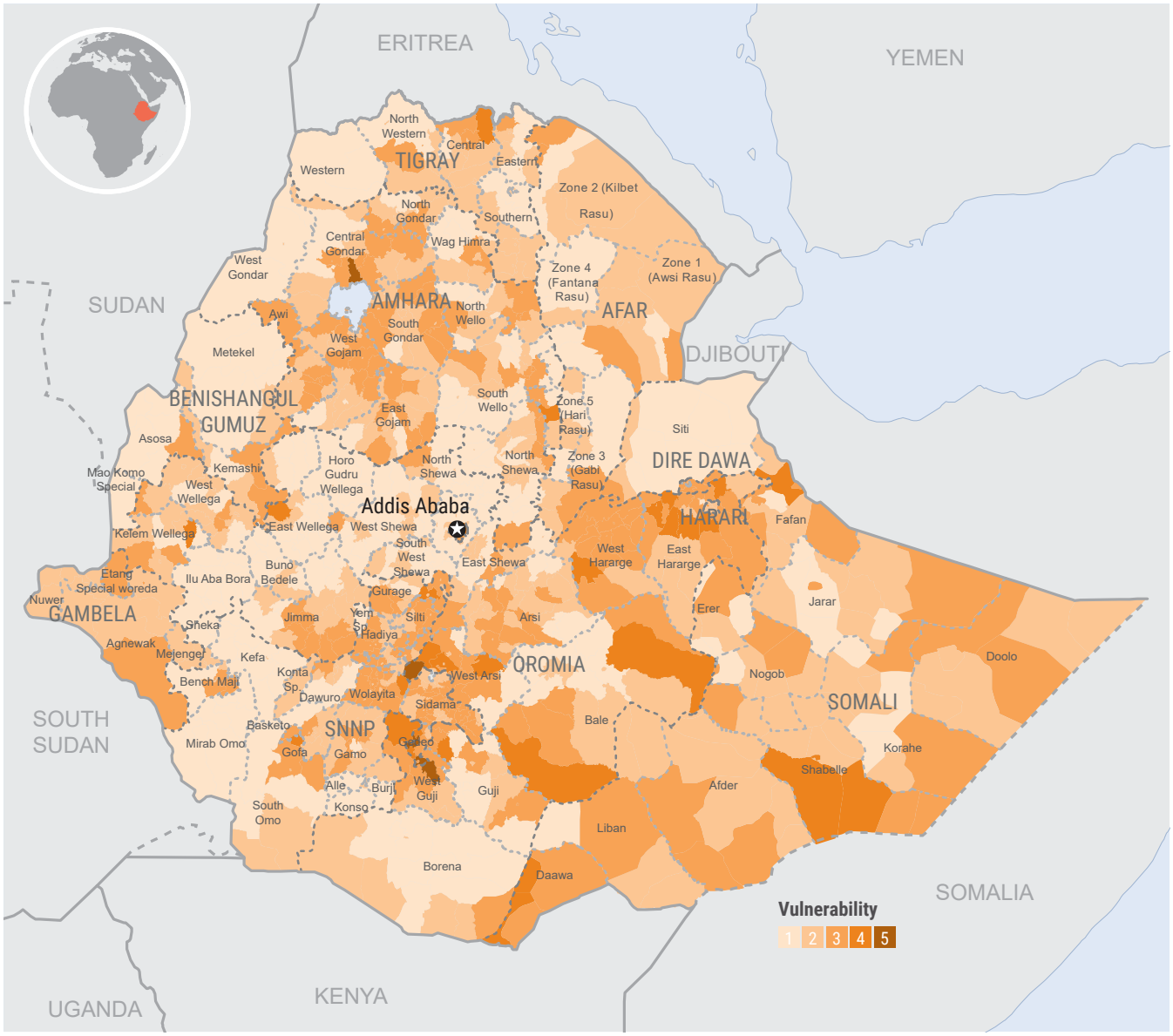


Figure 4. Number of *woredas* in each COVID-19 vulnerability category, by region

	Low	Medium	High	Very High	Severe
Addis Ababa			2	8	
Afar	15	15	5		
Amhara	46	79	56	1	1
Benishangul Gumz	14	3	3		
Dire Dawa			12	1	
Gambela		12	3		
Harari		8	1		
Oromia	136	111	70	16	2
SNNP	39	92	74	5	2
Somali	24	42	27	6	
Tigray	13	32	6	1	

by job losses and market price increases of staple goods.

Nomadic pastoralists depend on moving for their livelihood, which may be hindered by the movement restrictions put in place throughout the country. In addition, they are unlikely to have access to safe water supply – which for the overall country stands at 30 per cent – and struggle to follow COVID-19 preventative hygiene measures.

Labourers in COVID-19 impacted industries, including sectors which have already felt the economic impact of the pandemic such as the tourism industry, hospitality, bus and taxi drivers, are at high risk of losing their livelihoods leading to a loss of income which can result in increased food insecurity, limited access to services, and turning to negative coping mechanisms.

Projection of health-related needs due to COVID-19

The projection done by EPHI on the number of COVID-19 cases

requiring medical attention in Ethiopia is 102,000 persons/patients over the next 3 months. When looking at the current trend on the continent which seems to be less advanced than in other countries globally. However it is likely to spread over a longer period, with the humanitarian consequences of the outbreak being felt for an even longer period of time. It should however be noted that the global demand for testing kits has made it difficult for African countries to acquire enough kits to get a clear picture of the extent of the spread of transmission.

As we have discussed previously, the pandemic will lead to many health related humanitarian needs due to factors including the overburdening of the health system, loss of health care workers, delay of immunizations, lack of medical supplies, limited access to health services, etc.

The EPHI estimates that 66.6 million people are at risk of COVID-19: all urban population and half of the rural population. Out of these people at risk, approximately 39.9 million people are estimated to become infected.

To estimate the resulting humanitarian needs for the remainder of the year, the following assumptions have been made:

- The 39.9 million people which are estimated to become infected by EPHI at national level is for the remainder of the year
- The risk level is the same in each region
- Out of these 39.9 million people, approximately 30 per cent will require humanitarian assistance (12 million people)
- People's vulnerability will determine whether they require humanitarian assistance

To start estimating the distribution of humanitarian needs based on these assumptions, a vulnerability analysis for COVID-19 was conducted at *woreda* level. The analysis used a series of indicators to map the potential vulnerability. The indicators used in this analysis include access to sanitation, availability of improved water sources, availability of sufficient water, population density, estimates of urban poverty, concentration of displacement, HIV and TB prevalence, SAM and MAM burden, and humanitarian access constraints.

Five (5) *woreda**s*** are in highest vulnerability category (category 5). These *woreda**s*** are located in three regions: Amhara (East Dembia), Oromia (Kercha, Siraro), and SNNP (Gedeb, Yirgachefe). These highly vulnerable *woredas* face a combination of issues ranging from a high SAM burden, above average levels of extreme poverty, humanitarian access issues, and lack of access to sanitation and improved water sources. Some of these *woredas* also host a large number of IDPs, and all of them have a high population density.

In terms of urban areas, 32 per cent of the urban areas are in vulnerability category 3 and 4. The rest are in category 2. The main factors contributing to the vulnerability are the density and the absolute number of poor people in these dense centers. Usually urban areas have a higher access to sanitation and water and are generally accessible to humanitarians. Most sub-cities in Addis Ababa have a severity of 4.

The people projected to require humanitarian assistance is distributed at *woreda* level in accordance with this vulnerability analysis: the more vulnerable a *woreda is*, the higher their share of the projected COVID-19 health-related PIN.

REGION	UPDATED PEOPLE IN NEED (NON COVID-19 RELATED)	PROJECTED TOTAL NEEDS DUE TO COVID-19	TOTAL PIN (CURRENT AND PROJECTED)
Addis Ababa	567	1,239,059	1,239,059
Afar	574,521	182,661	587,688
Amhara	1,212,701	2,894,337	3,455,273
Benishangul Gumuz	232,888	156,183	321,116
Dire Dawa	51,471	130,990	171,965
Gambela	81,758	76,013	119,162
Harari	34,708	42,034	65,370
Oromia	3,516,999	5,500,838	7,346,821
SNNP	1,071,193	2,890,134	3,354,699
Somali	3,183,842	856,652	3,265,094
Tigray	625,544	602,339	930,790
Total	**10,586,191**	**14,571,240**	**20,857,035**

Projection of food related needs due to COVID-19

The expectation is that the indirect impacts of COVID-19 will be significant. The various types of vulnerable groups in the country, as outlined above, will immediately experience the negative impact of the COVID-19 situation on the food security pillars. It is projected that additional people will require food assistance, including people in urban areas.

The HICE survey of 2015/16 found that the food poverty head count index was 24.8 per cent at the national level, but with a marked disparity between urban and rural areas (27.1 per cent in rural versus 15.2 per cent in urban areas).

Due to limited information and evidence on food insecurity in urban communities, the Food Cluster's projected needs are based on the below assumptions:

- Population of 99 million people in the country is estimated for this analysis - 22 per cent in urban communities and 78 per cent in rural communities

- Using the food poverty index, it is assumed that 15.2 per cent of the urban population and 27.1 per cent of rural population will be at risk of food insecurity (based on the HICE survey referenced above).
- The Government led national emergency response plan assumed that "50 per cent of the rural population is at risk given the sparse population distribution", it is projected that 50 per cent of the vulnerable food insecure people in rural communities will require emergency food assistance.
- In urban communities, the assumption is that all the 15.2 per cent will require emergency food assistance.
- People already part of the social safety net programme have been deducted from this analysis

Taking these assumptions into account, it is estimated that 10.9 million people will have food needs because of COVID-19, out of which 9.4 million people are currently not targeted for emergency food assistance. 36 per cent of this additional caseload are people in urban areas.

As outlined in the risk analysis and projected evolution of needs section, COVID-19 will also negatively impact other sectors. Considering the food sector looks at the people in society most vulnerable to shocks, it can be assumed that these people will also have other sectoral needs.

Total People in Need

When combining the food and health related projected needs due to COVID-19, and ensuring there is no double counting at *woreda* level, the total projected people in need due to COVID-19 is currently estimated at 14.6 million, of which 34 per cent are in urban areas.

On the other hand, the updated number of People in Need (PIN) due to non-Covid-19 related crises (including new displacements and desert locust affected people) is now 10.6 million persons.

Between these two groups there is an overlap of approximately 4 million people. This is because some of the people projected to be in need of food or health assistance due to COVID-19, are currently already facing critical problems related to physical and mental wellbeing, living standards and/or protection and hence are already included in the updated people in need.

Therefore, it is estimated that the multi-sectoral PIN will increase to a total of 20.9 million people. A breakdown by region is given above.

Planning assumptions

Health outlook

According to Ethiopia Public Health Institute (EPHI) 39.9 million people are expected to be infected with COVID-19 in the next three months. Due to limited testing capacity, only 102,000 cases are expected to be confirmed in this period. Although this is a three-months projection, it is assumed that this applies until the end of the year considering the current trend of infection in the country which spreads over a longer period. Out of these additional 39.9m COVID-19 affected people, approximately 30 per cent (12 million people) will likely require humanitarian assistance.

The current health care system will be challenged to cope with a high number of moderate to severe COVID-19 cases, that in the absence of adequate treatment may lead to a high fatality rate. Government capacity for testing and treatment of new infections by COVID-19 will diminish. Consequently, the model being used by responding partners will be expanded to increase to offset limitation and to ensure robust preparation and response. Due to the likely shift of resources to COVID-19 response and likely overwhelming of health care systems, resources will be re-directed to COVID-19 response. Hence, morbidity and mortality will increase during the rest of 2020 as a result of insufficient treatment to other heath conditions and routine treatment including communicable and non-communicable diseases.

Food outlook

The Food Cluster projection estimates that, using the food poverty index, 15.2 per cent of the urban population and 27.1 per cent of the rural population will be at risk of food insecurity. This is lower than the estimations made by the Government-led national emergency response plan (estimated 50 per cent of the rural population to be at risk). Using the food poverty index, an estimated additional 10.9m people will require food assistance, and 9.4 m of them are not targeted for emergency food assistance by the HRP, nor by the social safety net programmes (the PSNP or the UPSNP).

Increased cereal prices and the disproportionate decrease in livestock prices mainly in Oromia, Somali, Afar and Amhara regions will further exacerbate the reported negative terms of trade affecting vulnerable market-dependent households. Similarly, the vulnerability of households to food insecurity will deepen as households deplete cereal stocks in the coming lean months.

Operational outlook

COVID-19 prevention measures will likely disrupt movement/access and the supply chain contributing in shortage and increased price of commodities resulting in localized food insecurity. The urban poor, destitute, the homeless and those working in informal sectors of the economy are likely to be highly affected. In rural communities, food insecurity will increase among vulnerable households that rely on market purchases.

Increased vulnerability

Internally Displaced People (IDPs) and others who live in cramped conditions and informal settlements will likely be highly susceptible to COVID-19. Additionally, IDPs' difficulty to access essential services such as adequate shelter, WASH and health care will further be limited.

COVID-19 will also exacerbate the protection situation of vulnerable groups including those that were already identified in 2020 HRP. Women and adolescent girls are at higher risk of gender-based violence and child protection issues such as violence, abuse and exploitation.

COVID-19 will likely spread quickly among people living on the streets (where the large proportion of this group are women, children and youth), old persons, and persons with disabilities. Sectoral interventions will aim to incorporate response planning of these cross-cutting groups.

Due to the impact of desert locust and COVID-19 on livelihoods, increase in communities' resort to negative coping mechanisms will increase in the coming months including sale of household assets, consumption of seed stocks, selling breed animals, early marriage, transactional sex and child labor.

Scope

This revised HRP focuses on the risks influencing the humanitarian caseload posed by COVID-19 in the remainder of 2020. As it is too early to fully understand and analyze, other risks such as the impact of desert locust on *meher* and *belg* production and the seasonal *belg* (February to May) rain performance on food and nutritional situations are outside the scope of this revision exercise.

Targeting and Prioritization parameters

- Focus on humanitarian, time-critical and/or high impact life-saving actions.
- Three-stage scenarios/Prioritys: 1. Time-critical, 1st priority activities; (first line activity doesn't exceed one third of the full requirement) 2. Less critical activities; (It is suggested not to exceed half of the full requirement) 3. Full Cluster activities
- Ongoing and planned intervention and redirection of resources by development actors and government while targeting. E.g. scale up of urban safety net program, development programmes/funds repurposed, etc.
- Target the most Vulnerable (incl. among Urban Poor)
- Target only priority 2 and above both for COVID-19 and non-COVID-19 severity of needs
- Geographic prioritization for non-health response will be informed by areas where COVID-19 and non-COVID-19 needs are converging overlaid with the most vulnerable
- Response to IDPs (especially for decongestion) will use the List

of IDP Sites Prioritized by Risk of Community Transmission of COVID-19[2].

- Deprioritize protracted caseload with recovery and resilience actions for later resource mobilization sequencing.
- FOCUS on reducing RISK to VIOLENCE / EXPLOITATION
- FOCUS on mitigating conflict (Equitable Access – host / IDP communities for example)

Financial requirement

The same costing methodology is used as the existing HRP. Financial requirement distinguishes between additional COVID-19 related requirements and non-COVID-19 requirements.

3.1

Agriculture

ORIGINAL TARGET	REVISED TARGETED	ORIGINAL REQUIREMENTS (US$)	REVISED REQUIREMENTS (US$)
1.4M	1.87M	$54.0M	$73.7M
COVID-19 RELATED	0.9M		$28.5M
NON COVID-19 RELATED	1.0M		$45.2M

% CHILDREN	% WOMEN	% PEOPLE WITH DISABILITIES
51%	24%	16%

Objectives

The agriculture sector in Ethiopia is facing complex and overlapping threats. The COVID-19 pandemic and the desert locust upsurge have direct negative impact on food security and livelihoods of the most vulnerable communities, particularly women and female-headed households who's main source of income depend on agriculture livelihoods. The sector objective remains to address the importance of access to livelihood support and protection of productive assets of crises-affected households.

The Agriculture Cluster aims to support and sustain core agriculture livelihoods of vulnerable households to strengthen their coping capacities, mitigate food insecurity and restore their livelihoods. Moreover, protection of core-livelihood assets and enhancing access to a productive life contributes to the mitigation of negative coping strategies that households may face to deal with crises.

Whilst prevailing humanitarian needs and vulnerabilities triggered by drought and displacement remain a priority, responding to the expanded needs that arose due to desert locust invasions and COVID-19 will be key to prevent further deterioration of an already fragile food security situation. To reduce the double burden caused by restriction measures and drastic loss of income as well as reduced access to nutritious food of those who depend on agriculture as a primary livelihood, the Agriculture Cluster will target 1.87 million people with protection and sustainment of their core agriculture livelihoods.

Response

The Agriculture Cluster with the Ministry of Agriculture will continue to work in partnership with NGOs providing livelihood assistance and protection to 1.87 million people in areas of high severity of needs.

The agriculture interventions aim to protect and sustain livelihoods of vulnerable households comprising desert locust-affected households, 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.

To maximize the impact of the response and provide an integrated approach, coordination with other Clusters remain a priority, particularly with Food, Nutrition and Protection. 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 market places 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. Additionally, to ensure women and groups with specific needs are targeted the cluster will advocate for gender responsive needs assessment and analysis for and community based targeting including consulting women of different ages, as well as persons with disabilities.

Scenario 1 - 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 woredas invaded by desert locust and woredas with high severity of needs, the Cluster will prioritize 719,451 people in overlapped affected areas in Afar, Amhara, Oromia, SNNP, Somali and Tigray regions.

Scenario 2 - 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 target an additional 959,268 vulnerable pastoralists and agro-pastoralists that have access to land in pocket areas of Afar, Amhara, Oromia and Somali regions 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 people that returned, relocated or remain among host communities and have access to land or own livestock assets in areas of high severity of needs, particularly in East and West Wollega, East and West Hararghe, 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 activities that protect, maintain and restore productive assets. 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, cash based interventions and provision of animal feed and health interventions to protect core breeding livestock and consequently protecting milk production and reproduction success rates.

Scenario 3 - The Cluster will target additional 191,281 people with resilience mainstreaming interventions through livelihood diversification, rehabilitation and reconstruction of water points, feed and fodder production and rangeland management activities.

Cost of Response

The Cluster will require an estimated $74 million to address the needs of the 1.87 million people targeted through humanitarian and resilience interventions for the remaining months of 2020. Costing was established based on the agricultural input requirements and the operational expenses to provide a standardized response. Minimum standard packages for livestock interventions and agricultural 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, consultation with agriculture partners 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 implementation sites, targeted population, and implemented activities. The 5Ws reporting and monitoring tool will comprise COVID-19 specific interventions. Additionally, the Cluster will monitor desert locust specific interventions. Based on the 5Ws reports, information management derivative products like dashboards that summarize 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 will be produced. This information will be shared with donors for increasing funding and support to agriculture and with OCHA for inter-cluster coordination purposes.

	COVID RELATED		NON COVID RELATED		
	Targeted	**Requirement ($)**	**Targeted**	**Requirement ($)**	**Total Requirement ($)**
Priority 1 (<33%)	163,034	5.08 M	556,417	19.90 M	719,451
Priority 2 (<50%)	181,538	6.92 M	777,730	24.82 M	959,268
Priority 3 (Full req.)	858,678	28.48 M	1,018,147	45.19 M	1.87 M

3.2 Education

ORIGINAL TARGET	REVISED TARGETED	ORIGINAL REQUIREMENTS (US$)	REVISED REQUIREMENTS (US$)
1.3M	6.3M	$30.0M	$35.4M
COVID-19 RELATED	5.2M		$15.1M
NON COVID-19 RELATED	1.1M		$20.3M

% CHILDREN	% WOMEN	% PEOPLE WITH DISABILITIES
100%	0%	10%

Objectives

The Education Cluster aims to support children and youth affected by various emergencies in Ethiopia during 2020, including conflict, seasonal flooding, drought, locust infestation and COVID-19. The three main Cluster objectives are 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 and; 3) maintain the continuity of learning through acceleration, improvement and resilience building of leaners and communities.

These objectives directly contribute to strategic objectives SO2, SO3 and SO4 of the 2020 HRP as well as strategic priorities SP1, SP2 and SP3 of the Global Humanitarian Response Plan for COVID-19. To deliver timely and quality education in emergency responses, evidence-based and innovative approaches will be instituted to expand access to learning opportunities for emergency-affected children and youth. The Cluster will further seek to facilitate resilience mechanisms of the education system, communities, the schools and the learners to enhance preparedness and mitigate risks and vulnerabilities for future crises.

Response

Education Cluster partners aim to reach the most vulnerable crisis-affected children and teachers in different regions of Ethiopia through enhanced coordination and strengthened leadership of the education response by the Ministry of Education (MoE) at the federal level and the Regional Education Bureaus (REBs).

To minimize children's risks and vulnerabilities to COVID-19 pandemic and to ensure their social, economic and psychosocial well-being, Cluster members are disseminating information on prevention measures of the pandemic. Prolonged closure of schools and restrictions on social interactions mean that many children will not receive essential education in emergency services as scheduled which could lead to an increase in school dropouts, protection risks, including child labour, sexual exploitation and abuse, early pregnancy and early marriage. School aged girls and children living with disabilities are at a higher risk of their education being halted, ultimately impacting on their opportunity to transform their lives and reach their potential. Many families have faced reduced incomes or lost livelihoods due to COVID-19- related movement restrictions and business closures thereby straining food availability which affects the nutrition levels of children. The risk of domestic violence is increasing due to stress induced by socio-economic situations.

The Education Cluster will take a three phased approach to support at least 6.3 million girls and boys within three and eighteen years of age to access quality, inclusive and protecting learning opportunities in collaboration with MoE and REBs. To support school-aged children cope with the crisis, prevent learning loss and dropout, the first phase will support the continuity of learning through provision of distance education using various modes and platforms including radio and television to reach children and communities in masses. The phase will concurrently disseminate COVID-19 prevention messages and actions to communities to avoid and prevent disease transmission. The second phase will focus on safe and inclusive schools upon reopening with an aim to ensure that the lives of children and school communities are protected through safe schools' guidelines implementation. This will include enhanced school sanitation, hygiene and health protocols, contact reduction measures and enhancing counselling for students, teachers and families affected by the COVID-19. Learners and teachers in vulnerable locations such as IDPs and refugees will be supported with teaching and learning materials. The third phase will support the continuity of learning through improvement and accelerating access to and quality of education. In this regard, the Cluster will support 'Back to School campaigns', creation of accelerated learning programmes, provision of school feeding and supporting teachers to identify at most risk learners. Geographic priority areas for both IDP and returnees include: Afar, Amhara, Benishangul Gumuz, Dire Dawa, Gambella, Harari, Oromia, SNNP, Somali, and Tigray.

The Education Cluster will approach COVID-19 response with a three-pronged strategy:

Education continuity through distance learning during COVID-19 pandemic

1. Provision of distance learning modalities through radio and TV broadcasting, distribution of learner packs and distribution of radio sets with recorded curriculum-based lessons
2. Support teachers, learners and school communities to prevent the transmission and spread of COVID-19 through diverse communication channels (Risk Communication, RC)

Reopening of schools during COVID-19 pandemic

3. Safe Schools Operation kits – provision of handwashing kits, disinfectants, water tanks, thermometers
4. Training teachers on Safe Schools Guidelines, implementation and referral pathways; Mental Health and Psychosocial Support (MHPSS)

Maintain continuity of learning post COVID-19

5. Back to School Campaigns
6. Delivery of Accelerated Learning Programmes for IDP children and catch up classes
7. Provision of emergency school feeding in locations with high food insecurity
8. Deliver peace building and life skills to children and adolescents within IDPs, returnees and the hosting communities to enhance their resilience

Education Cluster partners will closely collaborate with other sectors to benefit from complementarity and value addition. Protection, WASH, Nutrition, Food GBV Clusters and sub Clusters will seek convergence points to improve response equality and effectiveness. The Cluster will explore creative community-based approaches together with affected people to infuse peace building within response activities.

Cost of Response

The Education Cluster has raised the number of targeted children from 1.3 million to 6.2 million. The increase is a reflection of 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. Accountability to Affected Population (AAP) 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 also assist partners in their operational planning.

	COVID RELATED		NON COVID RELATED		
	Targeted	**Requirement ($)**	**Targeted**	**Requirement ($)**	**Total Requirement ($)**
Priority 1 (<33%)	1.0 M	4.5 M	0.5 M	6.98 M	11.48 M
Priority 2 (<50%)	1.7 M	10.0 M	0.6 M	8.18M	18.18 M
Priority 3 (Full req.)	5.2 M	15.1 M	1.1 M	20.25 M	35.35 M

3.3 ES/NFI

ORIGINAL TARGET	REVISED TARGETED	ORIGINAL REQUIREMENTS (US$)	REVISED REQUIREMENTS (US$)
1.9M	2.4M	$95.8M	$105.7M
COVID-19 RELATED	0.9M		$24.3M
NON COVID-19 RELATED	1.5M		$81.1M

% CHILDREN	% WOMEN	% PEOPLE WITH DISABILITIES
53%	29%	0%

Objectives

The Shelter/NFI sector continues to prioritize the safety and health of the most vulnerable households through the provision of timely, targeted and appropriate shelter assistance, including 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 with a disproportionate impact on women and girls who also experience protection risks.

IDPs living in congested and unsanitary collective centers, spontaneous and planned sites, rental accommodations or shared shelters with relatives in host communities are particularly vulnerable to COVID-19. Migrants and deportees who have recently arrived in Ethiopia currently confined to underserviced Quarantine Centers without basic NFIs, are similarly at higher risk of transmission.

To mitigate COVID-19 transmission and provide privacy and safety, the Shelter/NFI response includes emergency shelter kits and rental support to build partitions in communal spaces, expand structures and protect households renting in host communities from eviction. Distributions of core relief items to newly displaced households and shelter repair materials to households who have returned to destroyed shelters are designed to enable vulnerable groups to adopt COVID-19 prevention practices. The sector promotes people-centered programming through community-based implementation and decision-making to ensure that activities are inclusive as well as culturally and climactically appropriate. Direct life-saving assistance and protection remain at the core of the Shelter/NFI response. As part of the Cluster's commitment to durable solutions in areas of return, local cohesion integration, and resettlement, growing attention is given to early recovery and livelihoods.

Response

The Shelter/NFI Cluster targets 2.3 million IDPs, returnees, affected host communities, deportees and migrants with emphasis on a child and female-headed households, the elderly, separated children, people with disabilities and households at greater risk of illness. In the COVID-19 context, the Cluster prioritizes collective, spontaneous and planned sites where people are at high risk of morbidity due to overcrowding, limited access to healthcare, hygiene and sanitation facilities, poor nutrition, limited access to public health communications and reliance upon distributions that may involve large gatherings.

The Cluster's first-line response follows a two-pronged COVID-19 strategy: decongestion of high-risk living situations and provision of essential household items, either in-kind or through cash to vulnerable populations, to reduce transmissions from shared everyday items.

Decongestion activities target expanding spontanoues/planned sites, overcrowded shelters and non-partitioned communal living spaces re-erecting and establishing emergency shelters, refurbishing collective centers, constructing partitions in single-room shelters shared by multiple families, and providing rental support so that displaced populations can move out of shared shelters or crowded rental houses. These activities reduce transmission risks posed by high-density conditions, enabling vulnerable groups to practice recommended public health measures.

The provision of core relief items to displaced households mitigates sharing of kitchenware and hygiene items and reduces the risk of transmission from contaminated items. Provision of essential

household items targets not only high-risk populations but also people in quarantine centers who need support to adopt COVID-19 prevention practices. Provision of shelter materials and essential household items for 870,000 people with acute and life-saving needs will require $35 million.

The Cluster's second-line response draws upon multiple data sources to map damage and living conditions in return and displacement areas. Using these findings, the Cluster tailors activities to all displacement phases with a focus on emergency packages such as Emergency Shelter and NFI kits and Emergency Shelter Repair Kits, while supporting durable solutions wherever feasible. To improve the living conditions of 1.1 million IDPs and returnees, $58.7 million is required.

Where possible, the Cluster advocates pre-positioning of in-kind materials or cash and voucher distribution. Contingency planning includes mapping local markets and regional supply chains to ensure that resources can be rapidly mobilized in the face of sudden displacements.

The full Cluster response includes shelter reconstruction and cash for shelter, which build upon the positive coping mechanisms of displacement-affected populations through community engagement and empowerment. Assistance to 391,000 people in the return, reintegration and relocation phase costs $11.7 million.

Both cash and in-kind assistance is encouraged based on market and protection risk assessments. Shelter activities are diverse and tailored to local contexts with the guiding principle that a community-led response is most sustainable. Partners are encouraged to build community resilience through grassroots engagement. Direct implementation is most appropriate in some areas, while cash for households to repair shelters is more efficient and empowering in others. Some displaced populations benefit from cash for ESNFIs, while others prefer receiving cash for rent and HLP support.

The Cluster promotes integrated programming with HLP, SMS and WASH so that interventions are comprehensive and sustainable. Where feasible, ESNFIs are incorporated into multi-sectoral kits with hygiene and dignity items and distributed jointly with the WASH Cluster to reduce operational costs. The Cluster encourages multi-sectoral assessments for more comprehensive analyses and coordinates collective site activities with SMS. In addition to training staff in PSEA and safe GBV referrals, Shelter partners also mainstream protection principles across processes and activities.. The Cluster encourages the inclusion of HLP support in shelter programming to ensure that interventions are ethical and sustainable.

Cost of Response

The methodology used to calculate the cost of the response takes regular and COVID-19-related market inflation, as well as other cost drivers into consideration

1. 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: on average $202/HH.
2. [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: on average $120/HH.
3. [COVID-19 response] Emergency Shelter Kit (plastic sheets, rope, wooden poles, roofing nails, wire nails, metal strap, and IEC materials): Procurement, transportation, storage, distribution and other operational expenses. Cost: on average $100/HH.
4. [COVID-19 response] Non-Food items for Quarantine Centers (bedsheets, clothes, personal eating utensils, soap): Procurement, transportation, storage, distribution and other operational expenses. Cost: on average $100/HH.
5. 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 HLP 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.
6. [Both COVID-19 and non-COVID-19 response] Cash for Rent for 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.
7. Training of locally recruited carpenters for monitoring as a way of skills transfer and support for HLP issues: Cost $10/HH.

Monitoring

Shelter/NFI Cluster partners are committed to monitor 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 exacerbated 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.

Developed in 2019, 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. For partners, the Shelter Cluster has developed standardized post-distribution and post-construction monitoring tools that allow for data comparison and aggregation of results. In addition, the Cluster promotes the inclusion of accountability mechanisms in partner projects to capture and respond to beneficiary feedback in a timely and safe manner. Where complaints are raised at inter-sectoral levels, the Cluster is committed to verification of the complaints and advocating for remedies with partners as well as donors.

	COVID RELATED		NON COVID RELATED		
	Targeted	**Requirement ($)**	**Targeted**	**Requirement ($)**	**Total Requirement ($)**
Priority 1 (<33%)	525,200	18.37 M	342,200	16.87 M	35.24 M
Priority 2 (<50%)	899,300	24.25 M	621,300	28.59 M	52.85 M
Priority 3 (Full req.)	899,300	24.25 M	1,488,700	81.09 M	105.35 M

3.4 Food

ORIGINAL TARGET	REVISED TARGETED	ORIGINAL REQUIREMENTS (US$)	REVISED REQUIREMENTS (US$)
5.9M	15.0M	$399.5M	$773.4M
COVID-19 RELATED	7.8M		$284.7M
NON COVID-19 RELATED	7.2M		$488.7M

% CHILDREN	% WOMEN	% PEOPLE WITH DISABILITIES
53%	23%	13%

Objectives

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

Approximately 7 million people are currently receiving food assistance in ten regions, a 19 per cent increase from 5.9 million people estimated in December 2019 and initially targeted in the 2020 Humanitarian Response Plan (HRP). The increase is due to deteriorating food security situation following localized below-normal rains and unseasonal increase in food prices. The negative impact of desert locust infestation which began in 2019 is also contributing to worsening food insecurity in northern, southern and western parts of the country.

The COVID-19 pandemic will likely deepen the food and nutrition insecurity in the country. The food prices which are already unseasonably high, is particularly concerning, as it is now more important than ever to boost, the immunological systems of the most vulnerable and that people are healthy. The most vulnerable people who normally rely on food hand-outs, including the homeless and street dwellers, predominantly women, elderly and children, with or without signs of acute malnutrition, chronically ill (HIV, TB, non-communicable diseases , elderly), will face significant food shortage as movement restrictions impact support from the streets and leftover food from restaurants and hotels. In rural communities, the most vulnerable households from both agro-pastoral and pastoralist communities will also face challenges in accessing food from markets.

The Food Cluster's objectives are centered around the following areas:

- Food availability and stability: movement of food commodities from surplus producing areas to deficit areas will be heavily affected by COVID-19 mitigation measures, including restrictions in movement of people and goods. This will negatively impact availability of staple and fresh food items at household level, particularly in communities where households rely on market purchases. Continued breeding of desert locust poses a severe threat to food security and livelihoods due to likely destruction of pastures and croplands, including in traditionally food secure parts of the country.

- Food access: The outbreak of COVID-19 will adversely impact both physical and economic access to food. Physical access will be hampered by movement restrictions and market closures. Economic access will be challenged for households, especially in urban areas, that are dependent on the informal sectors of the economy. These households are extra vulnerable as they will experience constrained incomes while also having little savings and reduced diversity of consumed food items. Factors contributing to a reduced household purchasing power will include: a) decreased incomes from cash crops, such as coffee and khat / qat in case of decline in exports – affecting not only cash crop producers, but also workers in these sectors who risk losing their jobs, b) reduction in foreign incomes through remittances, and c) reduced income earning opportunities for urban informal sector workers for example, street traders, shoe shiners, coffee stall operators and those in the service sector. Moreover, as food prices are already unseasonably high, further increases will exacerbate the food security situation.

- Utilization: Households will have additional needs, including

costs for water and cooking fuel for items that require food preparation. Some items in the food basket or purchased from markets will also require pre-processing steps including milling, which will add an additional cost for the targeted beneficiaries.

ESTIMATED FOOD INSECURE PEOPLE	NUMBER OF PEOPLE
In urban communities	3.3M
In rural *woredas* where there are no HRP/ PSNP interventions	4.6M
In rural *woredas* where there are HRP/ PSNP interventions	16.3M
Total projected food insecure people	24.2M

Response

The unfavorable impact of COVID-19 on the food security pillars will result in an increase in the number of people who require emergency food and nutrition assistance in both rural and urban communities. The projected needs are based on the following assumptions:

- Using the food poverty index , it is assumed that about 15.2 per cent of the urban population and 27.1 per cent of the rural population will experience severe food and nutrition insecurity. These are people who are already unable to meet the recommended food needs .
- In addition to the above 24.2 million projected food insecure people, it is estimated that 5 million people in urban cities are at risk of food insecurity if there is severe disruption in food systems.These are mainly people from households relying on informal sectors of the economy and low paying jobs.
- The analysis recognizes the ongoing food/cash assistance activities through the HRP, rural productive safety-net programme (RPSNP) and urban productive safety-net programme (UPSNP), assuming that these programs and transfers are adapted to the COVID-19 context in all targeted regions.
- In rural areas where there are on-going HRP and RPSNP interventions, it is estimated that 8.7 million food insecure people are already receiving food/cash assistance. This implies that 12.2 million people in rural communities will have to be added to food/cash responses.
- It is projected that only 50 per cent of the above vulnerable, food and nutrition insecure people in rural communities will require emergency food and nutrition assistance. In urban communities, the assumption is that all of the 15.2 per cent will require emergency food assistance.

Based on above assumptions, it is estimated that additional 9.4 million people will require emergency food and nutrition assistance. This initial analysis of food insecure people will be updated through regular monitoring and detailed needs analysis, given that there is insufficient evidence and parameters to inform on projections of COVID-19 related food needs. This will include through a mid-year multi-sectoral assessment and analysis of humanitarian needs, and ongoing monitoring of market related indicators - food prices and supply-chain analysis in the country.

In addition, food assistance will be provided to returnees at various quarantine centers. Ethiopia has recorded an increase in number of citizens returning from the Middle East , Djibouti, Kenya, Somalia and Sudan. Implementation of various measures including the 14-day mandatory quarantine to prevent the spread of COVID-19, has contributed to the need for multi-sectoral and coordinated humanitarian response to meet the needs of returnees, including food assistance. It is estimated that 220,000 people will return to Ethiopia by end of the year, and while in quarantine, they will require food assistance for the 14-days period.

It is also estimated that the 102,204 individuals projected to be infected with COVID-19 in a period of three months, will require humanitarian assistance while in isolation or treatment centers through nutrition dense food rations.

The design of food assistance will facilitate safe and equitable access to men, women, boys and girls. This has the potential to facilitate gender-transformative relations by reducing gender inequality and enhancing positive masculinity at household and community levels, necessary to bridge the gender gap in nutrition and food security.

In terms of response planning:

- The HRP will follow a cash first principle as consistent with the Grand Bargain. Cash will be the appropriate modality in areas where there are functioning markets and financial service providers. The urban safety net is established in 11 cities and there is potential to scale up the support within and beyond these cities. In-kind food commodities will be considered if there is significant disruption in flow of food to local markets and increase in food prices. In order to inform on functionality of market/ retail capacity and timing to shift between in-kind and cash modalities, the government and partners will conduct regular monitoring of market prices and availability of commodities,
- The food basket will be used where appropriate and will consist of cereals, pulses and vegetable oil.
- The Food Cluster will coordinate with relevant government

departments and ministries, NGOs and UN agencies to ensure good hygiene practices at food/cash distribution points. This will include implementation of food and cash distribution guidelines that were prepared to facilitate the distribution process in context of COVID-19. Partners are required to put in place the correct measures and necessary precautions during food/cash distributions and sensitize beneficiaries on social distancing and to provide hand washing facilities at distribution points with adequate water and soap supplies.

- In addition, the Food Cluster will continue to support an enhanced coordination between the safety-net interventions and assistance to acute food needs in the country. Where possible, the existing mechanism will be used to provide additional top-ups to existing beneficiaries (vertical expansion) or increase in number of beneficiaries (horizontal expansion).

- In exceptional circumstances, there will be a need for pre-cooked food items that will be provided to individuals who have no access to cooking facilities – e.g. individuals in isolation, quarantine or treatment facilities or people deported from other countries and those individuals from the streets who do not have the capacity to prepare their own meals. The Cluster will work with relevant Government Ministries, Community Based Organizations (CBOs), Faith Based Organizations (FBOs) and Non-Governmental Organization (NGOs) to identify suitable locations for institutional feeding programmes, where these individuals will receive regular cooked meals.

Targeting of beneficiaries

Targeting of beneficiaries will be informed by vulnerabilities resulting from age, gender and diversity. Gender responsive food assistance is critical to ensure that affected populations, predominantly women and children, are less vulnerable to negative coping strategies and provide safeguards against risks of sexual exploitation and abuse. In urban communities, the existing/adapted UPSNP targeting criteria, which includes a combination of community-based targeting and a self-selection process, will be utilized. The most food insecure people will comprise of urban poor households with no employed members / no regular income source, households headed by elderly, chronically ill or disabled person, households relying on informal income sources, street dwellers including children and homeless, and beggars. In rural communities, the existing targeting systems applied to identify food insecure people for emergency response plans will be followed. However, some of the activities that involve crowd gathering including verification of beneficiaries during targeting and registration, will be waived to avoid the spread of COVID-19.

Distribution of food/ cash to targeted beneficiaries

The above targeting processes for UPSNP generates registration lists at kebele level and is consolidated at the national level. However, lack of identity documents is likely to be a challenge for some of the population groups – particularly the street dwellers and the homeless, and urban migrants. Issuing of client ID Cards to register beneficiaries will be considered for households / individuals who can safely keep these IDs. Individuals with no / limited capacity to safely keep client IDs or provided resources (cash/food) should be registered and assisted through cooked meals at identified institutions. Additional food insecure people in rural communities will be registered in existing lists that are used by government and partners in distribution of food / cash. Cash and food distributions are currently being implemented with various measures that prevent the spread of COVID-19 at food distribution points. This includes in-kind food deliveries/ cash transfers and distributions to cover two rounds (round 1 and round 2) and provision of soap and water for hand-washing at distribution points. These measures will be considered in coming rounds, until there is no threat to COVID-19 transmission.

In isolation, quarantine and treatment centers, the registration lists will be used to distribute daily meals three-times a day. The food items in these centers will include nutrition dense food items. The Cluster will advocate for partners/ authorities to integrate individuals from quarantine sites in ongoing food assistance

response, based on the food security/ vulnerability status of the households in places of origin.

Accountability to Affected Populations, Protection, Gender and disability

The Food Cluster is committed to ensuring accountability to affected populations through the adoption of the Inter-Agency Standing Committee's (IASC) Commitments to Accountability to Affected Populations (CAAP). Enhance meaningful participation of stakeholders using channels that do not pose risks in COVID-19 transmission such as call centres for complaints and feedback, will be a key consideration for the Food Cluster in close collaboration with the Inter-Agency Accountability Working Group. Grievance mechanisms, which are part of the safety net programmes, will also provide evidence to further enhance accountability.

Rural communities have in the past experienced barriers and delays in accessing food assistance due to insecurity and poor road access during the rainy seasons, resulting in food shortages in some households. From these lessons learned, systems will be put in place to maximize safe and dignified access to assistance. Furthermore, studies have shown that incidents of gender-based violence, including sexual exploitation and abuse, tend to increase during periods of crisis like the COVID-19 outbreak. Safeguarding measures will 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 for targeted communities.

In its commitment to facilitate inclusive access to assistance and leave no one behind, especially the people with highest needs, the Cluster will promote the rights of persons with disabilities and has

targeted interventions to meet the specific needs of special interest groups such as the elderly, displaced people, persons with chronic illness, separated and orphaned children, amongst others.

Cost of Response $773.4million

i. Support to COVID -19 related needs for three rounds

- The three rounds of food distribution are projected to start in June 2020 through a staggered approach depending on the COVID-19 impact on the food security status of vulnerable household. The cost of the response in areas supported through in-kind commodities is calculated based on the cost per ton of the standard food basket – cereals, pulses and vegetable oil, which is estimated at $602.11/MT in 2020 HRP. In areas that are projected to have food insecure people due to COVID-19, it is projected that 254,581 MT of food will be required to assist 5 million people with in-kind commodities, and the cost is estimated to be $153.3 million.

- In urban communities, it is expected that cash transfers will be feasible due to functioning markets, including constant supply of food items and availability of financial service providers. A total of $134.4 million will be required to assist 3.4 million food insecure people in urban communities – this is estimated based on $53 per household per month. Assistance through the UPSNP is planned for $100 million to assist approximately 555,000 households for three months in 27 cities. Out of the 3.4 million projected food insecure people in urban communities, it is projected that 1.6 million individuals will be assisted through the UPSNP in the 27 cities. The cost to assist the remaining 1.8 million people is estimated at $71.7 million, mainly in small urban communities. There are also initiatives by the Government to implement food banks in urban cities, which will support some of the most food insecure people, with resources from the Government, donors, the private sector and the communities. The Cluster will support this initiative and ensure that this response is included in the response planning and implementation, including understanding of operational areas, response modality and timing on transfers.

- In rural communities, cash transfers will be provided in locations where there is existing PSNP infrastructure to support the cash transfers and functioning markets. It is therefore estimated that $26.5 million will be required to assist 1 million individuals who are projected to face food shortages in rural areas where it will be feasible to provide assistance through cash transfers. In both rural and urban communities, the Cluster will continue to advocate for cash transfer values that will enable households to purchase an equivalent of in-kind food basket. This will involve regular monitoring of prices in local markets, having a mechanism to adjust the cash transfer values on regular basis and technical guidance from the Cash Working Group (CWG) as well as regular updates of the minimum expenditure basket (MEB) values.

- In addition, Food Cluster partners will provide food assistance to returnees from the Middle East and neighboring countries, during their mandatory 14 days of quarantine. It is estimated that an individual will require $5.4 per day. An estimated $16.6 million will be required to assist the projected 220,000 individuals returning to Ethiopia in 2020.

- It is also estimated that $16.6 million will be required to assist 102,204 individuals who will be in isolation or treatment centers.

The Food Cluster will advocate for the food supply chains and livelihood sources to remain open, as this will provide incomes and access to food by households that are at risk of facing food gaps.

ii. Support to non-COVID -19 related needs for seven rounds

After the review by the regions, the number of people being assisted by the food operators increased from 5.9 million to 7 million in March 2020.. This could be attributed to the deteriorating food security situation in areas that received below normal rains and where there are reports of unseasonal increases in food prices. The overall requirements have therefore increased from $399.5 million to approximately $488.7 million – $118.9 million for cash transfers and $369.8 million for in-kind commodities. An assessment conducted in March 2020 indicates that nearly one million people will also require food assistance due to desert locust infestation. It is also projected that some of the areas will experience multiple hazards, particularly COVID-19 and desert locus infestation. The number of beneficiaries will be reviewed after the *belg* assessment / analysis of the food security situation. This will also include consideration of the transitory support to be provided to PSNP public works clients and the number of food distribution rounds to be provided to food insecure beneficiaries in the country.

Monitoring

Remote post distribution monitoring surveys will be undertaken to assess the extent of access to, utilization of, and satisfaction with food/cash assistance. This will help in understanding whether the assistance is likely to lead to the desired outcomes thus providing guide to the response implementation. In addition, by incorporating questions regarding the use of cash/food, feedback on double distributions, meal frequency and dietary diversity and coping strategies into the monthly PDM, the survey will also generate results which can be used to measure the intended outcomes. Partners will continue to provide information and updates on Food Cluster response activities, including a review of double food deliveries/ cash transfers and distributions for a decision on subsequent rounds.

The Food Cluster will utilize analysis from the Household Economy Approach (HEA), World Bank Surveys and the Integrated Food Security Phase Classification (IPC) to prioritize areas that require food / cash assistance and update the food requirements. The HEA will support prioritization of needs based on the scale and severity of food insecurity. The scale of the problem is measured by assessing the number of beneficiaries across the different regions and *woredas*. The severity of the problem is measured by assessing the size of the

survival and livelihood protection deficits - in terms of the amount and duration of assistance required. These two metrics combined, will provide prioritization criteria based on the number of beneficiaries and the amount and duration of assistance required. WFP's remote monitoring mechanism - the mVAM system, will also collect information through phone surveys (live calls), to update the food security indicators such as food consumption score, coping strategies, household hunger score, livelihood coping and access to water.

Information from early warning monitoring systems including government systems, FEWS NET and WFP price analysis will provide evidence for adjustment of the response plan parameters, including informing on economic access to food by vulnerable households and availability of food items in markets. Analysis from socioeconomic surveys including the Living Standards Measurement Study (LSMS) which is being implemented by the World Bank and Central Statistical Agency (CSA) and surveys from International Food Policy Research Institute (IFPRI), will also inform response adjustments including the prioritizations, geographical areas and population groups.

The Food Cluster will advocate partners to continue remote monitoring of outcome level indicators, which will inform of changes in the food and nutrition situation of assisted households. This information will provide evidence for both geographic and household targeting. Response monitoring for COVID-19 will adopt a harmonized approach – (on monitoring tools, methodologies and data collection calendar) to the extent possible with the government entities and other partners. This is with the objective of maximizing utilization of resources through value added complementarities thus ensuring increased monitoring coverage, transparency of the monitoring findings and most importantly reducing beneficiary interview fatigue. Monitoring capacity of the Government and partners will be enhanced through regular trainings and mentoring, to be conducted remotely.

	COVID RELATED		NON COVID RELATED		
	Targeted	**Requirement ($)**	**Targeted**	**Requirement ($)**	**Total Requirement ($)**
Priority 1-3 (Full req.)	7 .8 M*	284.7 M	7.2 M	488.7 M	773.4 M

* Out of the 9.4 million food insecure people, it is estimated that 1.6 million will be supported through safety-net programmes in some urban centers.

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
NON COVID-19 RELATED	3.2M		$95.0M

% CHILDREN	% WOMEN	% PEOPLE WITH DISABILITIES
54%	23%	9%

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. 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

1. 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, and other coordination platforms. Additionally, the Cluster will participate in joint inter-sectorial prioritization exercises to ensure the most vulnerable receive 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.

2. 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 of 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 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.

3. 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, internally displaced people, 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.

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. A total of 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.

CLUSTER OBJECTIVE	INDICATORS	TARGETS
1. To provide accessible essential health services to targeted populations, focusing on main causes of morbidity and sexual and reproductive health	1. Number of health facilities including COVID-19 isolation facilities and mobile teams supported in crises affected locations	500
	2. Number of total OPD consultations	1,500,000
	3. Number of normal deliveries attended by skilled birth attendants	6,000
	4. Number of women in child bearing age receiving modern contraceptives	72,000
	5. Number of community members receiving health IEC messages including COVID-19	6,500,000
	6. Number of assorted emergency medical kits and COVID-19 PPE kits distributed in crises affected locations	1,500
2. To provide quality care for people with physical injuries, disabilities and mental health needs	7. Number of cases with injuries and disabilities treated and referred for further care	200,000
	8. Number of cases receiving mental health and psychosocial support services including COVID-19	12,000
	9. Number of survivors of SGBV receiving clinical care for rape	600
3. To prepare for, detect and respond to epidemic prone disease outbreaks, including COVID-19	10. Number of epidemic prone disease alerts including COVID-19 verified and responded to within 48 hours	2000
	11. Number of children 6 months to 15 years receiving emergency measles vaccination	2,000,000

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.

	COVID RELATED		NON COVID RELATED		
	Targeted	**Requirement ($)**	**Targeted**	**Requirement ($)**	**Total Requirement ($)**
Priority 1 (<33%)	1.09 M	33.0 M	1.06 M	31.35 M	64.35 M
Priority 2 (<50%)	1.65 M	50.0 M	1.60 M	47.5 M	97.5 M
Priority 3 (Full req.)	3.30 M	100.0 M	3.20 M	95.0 M	195.0 M

3.6 Logistics

ORIGINAL TARGET	REVISED TARGETED[1]	ORIGINAL REQUIREMENTS (US$)	REVISED REQUIREMENTS (US$)
			$59.7M
COVID-19 RELATED			
NON COVID-19 RELATED			

1 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 facilitate transport and storage of humanitarian cargo on behalf of humanitarian organisations to provide assistance to the population where partners have programmes and activities.

Objectives

COVID-19 outbreak is happening at a time in Ethiopia when seven million people remain in need of humanitarian assistance (HRP 2020). Internally Displaced People (IDPs), returnees and resident population all remain vulnerable. They require support from the Government and the international community to meet their life-saving needs. Seven hundred thousand refugees are residing in Ethiopia supported under refugee response plan.

COVID-19 is expected to cause an additional strain on the logistics sector. Movement restrictions have resulted in border closures, import/export and port restrictions, reduced commercial aviation and shipping operations, and restrictions on movement to/from various countries or within a country. In effect, the movement restrictions result in direct consequences for the humanitarian community including on the availability of humanitarian items and other essential needs. Disruptions in supply chains put the continuation of critical services and programmes in jeopardy and complicate efforts to adequately scale-up and respond to the potentially exponentially increasing needs.

Air and land operations will thus be critical in delivering life-saving assistance to main hubs and remote areas where access is impacted but also by delivering rapidly critical COVID-19 supplies and other life-saving assistance.

With the goal of addressing 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 and increase operational capacities of partners.

Response

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 with in 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 planned to be increased by purchasing Mobile Storage Units and Refrigerated containers for common storage for partners in main hubs and provide adequate logistics support equipment to increase capacities, refurbish existing stores for COVID-19 supplies and response. 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 will collect, analyse and disseminate information through dedicated tools and products
- The Logistics Cluster will provide 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 will provide the fundamental link to overall logistics efforts across the country through enhanced coordination activities between relevant authorities from the Govern¬ment 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.

PRIORITY ACTIVITIES	BUDGET
Logistics Support Equipment	US$ 20m
Contractual Services (transport & storage)	US$ 30.7m
Staffing capacity	US$9m
Total	US$59.7m

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

Through the pre-existing air network structures, the Logistics Cluster will use a network of domestic airports as the forward hubs of response, facilitating airlifts of essential cargo to these destinations for onward transport in-country along with the provision of storage services in the form of mobile storage units (MSUs) and mobile cold storage units.

Through contracted services, the Logistics Cluster will provide urgent land and air transport capacities for humanitarian partners. Through this project, the Logistics Cluster aims to increase its readiness to respond to sudden crises in Ethiopia by ensuring the necessary capacity to carry out cargo transport, and by making available additional temporary storage capacity deployable for prepositioning as well as refurbishment as required for suitable storage. Both activities aim to ensure that humanitarian organizations can access the necessary capacity and resources to respond quickly to sudden crises in Ethiopia and reach the affected population. Critical staffing will be positioned to support the coordination, information management and advocacy pillars of the Logistics Cluster strategy. This may include capacity strengthening of the Government when required and depending on the criticality of the needs.

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 of the organizations engaged with the Logistics Cluster are offered and encouraged to provide feedback through bilateral surveys and meetings.

All Standard Project Reports (SPRs) for the Logistics Cluster are published on the dedicated WFP website at the beginning of each year. Any contribution received is reported officially in that year's SPR, which are usually published around the end of March of the following year. The SPR is the principle means through which the Logistics Cluster informs donors on how resources for given projects were obtained, used, and accounted for during the preceding year. 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.

3.7 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
NON COVID-19 RELATED	4.1M		$226.8M

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

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 life-saving 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 (PLW).

Response

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 life-saving 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 multi-sectoral response (minimum integrated package) will be implemented in most at-risk *woreda*s (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 Nutrition 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 continued 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 (SAM) to be admitted across the country, more than 1.7 million children aged 6-59 months affected by moderate acute malnutrition (MAM) benefiting from targeted supplementaty feeding program and over 1.3 million malnourished PLW will also be projected to receive support in priority *woreda*s. 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 *woreda*s. 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 *woreda*s of most severe concern (Priority 1 *woreda*s according to the NDRMC Hotspot *woreda*s classification + IDP affected *woreda*s) only about 200 *woreda*s will be prioritized. In addition to the reduced geographical coverage of the targeted supplementary feeding program, the number of *woreda*s where a technical support is provided to the health system will be reduced to 50 *woreda*s only in the immediate term (instead of 100 *woreda*s) 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 a 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.

	COVID RELATED		NON COVID RELATED		
	Targeted	**Requirement ($)**	**Targeted**	**Requirement ($)**	**Total Requirement ($)**
Priority 1-2 (<50%)	0.1 M	8.5 M	2M	110 M	118.5 M
Priority 3 (Full req.)	0.3 M	25.7 M	4.1 M	226.8 M	252.5 M

3.8 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

% 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, 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 and girls) 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.

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. Community-based MHPSS (Mental Health and Psycho-Social Support) will be required 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.

Protection and peacebuilding actors must also prevent, anticipate and address the risks of violence, discrimination, stigmatization and marginalization towards vulnerable/at-risk population groups of concern by enhancing awareness and understanding of the COVID-19 pandemic and conflict dynamics at community level. Continued communication with communities on risks and containment measures, social cohesion and peacebuilding interventions, will mitigate the increased risk of inter-communal and inter-ethnic tensions which could give rise to further political violence and

displacement. While capacity building on IDP rights to community members, government authorities, law enforcement and court authorities, is likewise an essential 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. Finally, communication with at-risk groups on protection risks/rights and access to services/referrals associated with COVID-19 outbreak and conflict is included, complemented with advocacy towards authorities/communities to address stigmatization, abuse, exploitation, and discrimination in accessing health and other essential services.

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

Scenarios:

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

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 is considered a vital service, which will be adapted in context of COVID-19 to ensure continuum of care and support.

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, 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/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 WG.

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. Meanwhile legal assistance to obtain civil documentation is also a priority to facilitate access to health, shelter and other basic services at this time. 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 prioritised, 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 may 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 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 their water supply.

Site Management authorities will also 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 catalysed through key activities such as Communicating with Communities (CwC) and community participation, as well as the provision of Community Feedback Mechanisms (CFMs). The SMS actors will replace or adapt their standard community participation activities to focus on Risk Communication, in coordination with Health and WASH actors. This includes mobilisation of already trained Site or Kebele Committees and intensive messaging and awareness raising for both displacement-affected groups and their wider communities. Meanwhile, the running of CFMs normally relies on regular staff presence in the field which may be impacted by COVID-19 restrictions, but alternatives such as toll-free hotlines are slated to help continue this critical service. 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.

All SMS COVID-19-specific activities will continue to prioritise displacement-affected persons, especially those in and around IDP sites (notably collective centres and spontaneous settlements where infection prevention and control are weakest). Additional partners will ideally be required to reinforce support to Site Management in emerging hotspot locations related to the pandemic.

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, 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. This approach is 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.

	COVID RELATED		NON COVID RELATED		
	Targeted	**Requirement ($)**	**Targeted**	**Requirement ($)**	**Total Requirement ($)**
Priority 1 (<33%)	1.09 M	4.61 M	449,385	11.10 M	15.72 M
Priority 2 (<50%)	1.65 M	6.99 M	674,077	16.83 M	23.81 M
Priority 3 (Full req.)	3.31 M	13.97 M	1,348,154	33.65 M	47.62 M

3.9

WASH

ORIGINAL TARGET	REVISED TARGETED	ORIGINAL REQUIREMENTS (US$)	REVISED REQUIREMENTS (US$)
5.3M	7.8M	$79.7M	$95.5M
COVID-19 RELATED	2.7M		$13.7M
NON COVID-19 RELATED	5.1M		$81.8M

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

Objectives

Lack of access to adequate and safe water and proper sanitation increases the risk of disease outbreaks and malnutrition which significantly affect physical and mental well-being. The Minimum WASH services are recognized as minimum living standards to be met to support the affected population. In addition, sub-standard WASH services and facilities are potential root causes of protection risks, such as SEA (Sexual Exploitation and Abuse) and GBV (Gender-Based Violence), and barriers to vulnerable groups like physically disabled and elderly persons. Water is not available at most health facilities, including COVID-19 treatment, isolation and quarantine centers. Additionally, hygiene facilities, such as latrines and handwashing stations, are not available to the extent needed, this is of particular concerning the regions. Securing adequate WASH services, including equipment for solid waste management for quarantine centers is minimum requirement to address COVID-19 IPC measures, preparedness and response. The WASH Cluster aims to meet the minimum WASH standards to save lives of the target population and prevent disease outbreak by providing the following WASH responses;

1. Provide safe drinking water by water trucking, rehabilitation of non-functioning water schemes, extension of pipe network from the existing scheme or construction of new water scheme. Adequate water for hand hygiene and sanitation should be supplied especially to vulnerable communities, such as IDP collective sites and treatment and quarantine centers.

2. Provide hygiene and sanitation facilities by constructing different types of latrines and handwashing stations at IDP sites and quarantine centers. Deliver essential sanitation and hygiene messages through hygiene promotion for all target population, including prevention and mitigation of COVID-19 pandemic.

3. Provide life-saving essential NFIs, such as water collecting and storage items, household water treatment chemicals, flashlights and hygiene and dignity kits. Provision of PPE (Personal Protective Equipment) and items for solid waste management at isolation and quarantine centers for COVID-19 pandemic should also be considered.

Response

Depending on the context, water supply will be provided by emergency water trucking, durable solutions, or a combination of both. Since long-term water trucking operation is not cost-efficient, durable solutions will be preferred for protracted displacement as well as general affected population. Durable solutions will be applied especially at treatment, isolation and quarantine centers. 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 life- saving 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 taking into account 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 GHRP (Global Humanitarian Response Plan)

and integrate existing response plans and activities with more emphasis on community engagement.

In order to contain the spread of COVID-19 under the strategic priority 1, the WASH Cluster's responses will be extended to isolation and quarantine centers. This will strengthen IPC and operational support through provision of water for hand hygiene and sanitation facilities together with distribution of non-food items for hygiene and for solid waste management. WASH preparedness activities will be extended to areas affected by other disease outbreaks such as cholera.

Under the strategic priority 2, the WASH Cluster will secure necessary WASH NFIs and hygiene items to decrease the deterioration of living standards, which in turn affects the hygienic environment and practices among vulnerable people. It also includes provision of dignity kits for women and girls, and maintaining facility standards and accessibility to physically disabled people and the elderly. Additional NFI items are required to support IPC and hand hygiene, both in communities and at health facilities.

The majority of the people the WASH Cluster targets fall 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

The total cost of the WASH response is $95.5 million. A total of 5.14 million people are targeted through non-COVID interventions and 2.69 million people are targeted via COVID-19 activities. A total of 416 health facilities are identified as either isolation, quarantine or treatment centers for COVID-19. The requirement for non-COVID-19 response activities is $81.8 million which is slightly higher than the original requirement of $79.7 million, while the requirement for COVID-19 is $13.7 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 and limited availability of water sources, especially in lowland areas of the country. In situations where reliable surface water is available, protected spring or shallow wells would be utilized for safe drinking water supply. However, in the majority of the cases, the affected population is in the semi-arid and drought-prone areas where securing reliable water sources is extremely difficult. In such environments, provision of safe drinking water highly depends on expensive water trucking operations. Even when durable solutions are applicable, such interventions usually require larger funds and longer implementation periods.

Water trucking is a means to deliver safe drinking water to those affected by acute onset emergency due to conflict and climatic reasons. A long-term water trucking operation is costlier 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 exercise 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 ECC (Emergency Coordination Center), Regional EOCs (Emergency Operation Centers) 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 EOC or ECC following the national coordination mechanism for COVID-19.

	COVID RELATED		NON COVID RELATED		
	Targeted	**Requirement ($)**	**Targeted**	**Requirement ($)**	**Total Requirement ($)**
Priority 1 (<33%)	889,022	4.5 M	1.73 M	27.0 M	31.56 M
Priority 2 (<50%)	1.35 M	6.9 M	2.63 M	40.2 M	47.08 M
Priority 3 (Full req.)	2.69 M	13.7M	5.14 M	81.8 M	95.54 M

Limitations

Humanitarian risks not included in current projections

Besides COVID-19, there are other risks that might influence the humanitarian caseload in the remainder of 2020. The impact of these factors on the humanitarian caseload will be further analyzed in the Mid-Year Review of the HRP following the *belg* rains.

Desert Locust Infestation

For the past months, parts of Ethiopia and the wider region have been affected by desert locust swarms. COVID-19 has already caused delays to the desert locust response, which if not controlled quickly could increase food insecurity and impact livelihoods among the 17.8 million people living in 180 affected *woredas*.

According to FAO, the desert locust situation remains extremely concerning as more swarms form and mature in southern Ethiopia. This poses an unprecedented threat to food security and livelihoods as it coincides with the beginning of the long rains and planting season. Although ground and aerial control operations are in progress, widespread rains that fell in late March will allow new swarms to stay in place, mature, and lay eggs while a few new swarms could move into Ethiopia from Kenya. In May, the eggs will hatch into hopper bands that will form new swarms in late June and July, coinciding with the start of the harvesting season. It was also noted that while hopper bands and an increasing number of swarms are maturing in the south of the country, mainly in Oromia and SNNP regions, new swarms have appeared in northern and southern Somali region. The North Gondar Agricultural Office also reported that, as of mid-March 2020, desert locusts have spread to some north-western areas of the country, including isolated *woredas* in Amhara. The desert locusts are expected to have localized impacts on *Meher* and *Belg* crop, producing areas.

Belg Harvest

According to FEWSNET, the February to May 2020 *Belg* rains in part of SNNP region and *Genna* rains in part of Oromia had a timely start with average rainfall. However, central Oromia, Rift Valley areas of SNNP region, eastern Amhara, and southern Tigray received below-average rainfalls at the start of the rainy season. The below-average rainfall in these areas slightly delayed the start of the *Belg* season and planting for *Belg* crops. *Gu* rainfall over south-eastern pastoral areas has yet to start, however, rainfall is forecast to start in late-March and April and predicted to be average throughout the season.

Challenges and constraints

In light of the COVID-19 pandemic, this HRP is being reviewed prior to the regular post-*Belg* mid-year review. Because of the tight turnaround time, this has been a light review of the humanitarian needs incorporating only key changes since the beginning of the year as a result of a changing IDP/returnee situation, the desert locust infestation, and COVID-19. Hence, for the updating of the current People in Need and the Severity of Needs analysis, only the most relevant indicators have been updated.

COVID-19 is a new type of crisis facing Ethiopia and the world. Not much is known yet on how the virus will spread in Ethiopia. Hence, detailed planning figures based on more sophisticated epidemiological models were not available. Only national level estimates were available to project where the humanitarian needs are to be expected due to COVID-19, for both health-related and food-related needs.

There has been a lack of baseline data when developing this analysis. Besides the regular data challenges related to outdated population baseline data and lack of clarity on the administrative divisions in the country, there is also important baseline data missing on health facilities in the country and the health system capacity at lower administrative levels. A countrywide HeRAMS exercise that commenced early this year to mitigate this lack of reliable health data has been interrupted due to the current situation.

Finally, there is lack of reliable data on many vulnerable groups in the country. The urban poor, homeless people, and street children for example, are some of the high-risk groups for contracting COVID-19 and transmitting the virus to others, and to face humanitarian consequences. However, there is limited available data on these groups which hinders this analysis. While it is estimated that 800,000 households will be in need of livelihood support as a result of the desert locust infestation, the *woreda* level breakdown of needs was not yet available. Therefore this will be incorporated in the Mid-Year Review.

Objectives, Indicators and Targets

Agriculture

		Cluster Objective 1 To enable 1.7 M target population to maintain and restore their basic needs by December 2020"						**Cluster Objective 2** Contribute to the recovery and resilience of crisis affected people through humanitarian interventions in 2020"					
		Animal health interventions	Animal feed interventions	Agricultural inputs	Cash based interventions	Restocking interventions	Destocking interventions	Established or rehabilitated water harvesting structures	Short maturing seed provision	Forage seed provision and production	Established feed and seed banks	Livelihood diversification intervention	Rangeland management interventions
Original (January 2020)	In Need	964,575	92,921	1,562,825		43,112	2,175	598,586	129,597	243,527	85,934	243,522	140,311
	Target	501,943	53,337	431,351		18,245	1,791	445,140	58,580	153,937	33,750	153,937	132,489
	Requirements	5,817,138	15,830,183	6,749,013		8,943,627	316,059	12,000,000					
Revised (May 2020)	**Priority 1**												
	Non-COVID-19 Target	323,021	45,542	233,396	36,861								
	Non-COVID-19 Requirements	3,494,230	13,292,450	3,118,208	3,980,978								
	COVID-19 Target	70,689	11,760	92,345	9,400								
	COVID-19 Requirements	778,402	4,158,220	139,110	1,015,146								
	Priority 2												
	Non-COVID-19 Target	386,639	49,861	391,091	45,971								
	Non-COVID-19 Requirements	4,422,409	14,506,700	5,895,230	4,964,868								
	COVID-19 Target	79,234	12,340	102,304	12,809								
	COVID-19 Requirements	906,340	4,468,203	1,542,209	1,383,350								
	Priority 3												
	Non-COVID-19 Target	456,700	76,646	561,447	61,458			443,080	42,500	137,420	33,750	120,650	
	Non-COVID-19 Requirements	5,223,693	19,500,482	8,462,988	6,637,433			12,000,000					
	COVID-19 Target	319,930	62,001	538,748	52,732								
	COVID-19 Requirements	3,659,330	16,695,215	8,120,834	5,695,076								

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	Provide radio sets in hard to reach areas	Distribute learner workbooks	Train Teachers– MHPSS, Safe Schools Guidelines	Distribute School Thermometers	Safe Schools Operation – Provides handwashing kits, disinfectants, water tanks	Emergency school feeding	Provide Learning materials for Boys/ Girls	Back to School Campaign	ASR for pre-primary children	Rehabilitate TLS and classrooms with adequate WASH facilities (schools)	Train teachers and education supervisors on SRGBV, positive discipline.	Train primary school children and adolescents from IDP settings with life skills and peacebuilding programmes	Develop contextualized ALP for IDP children, catchup classes
Original (January 2020)	In Need	7,467,679	1,000,000	500,000	9,000	500,000	1,000,000	1,400,000	1,400,000	2,000,000	542,000	3,000	9,000	200,000	542,000
	Target	6,200,000	500,000	300,000	8,000	250,000	500,000	1,320,000	910,000	1,000,000	40,500	92	24,496	84,969	222,750
	Requirements	3,000,000	1,000,000		1,300,000	500,000	2,000,000	7,868,749	4,934,698	0	2,000,000	3,475,000	489,938	1,169,938	7,614,000
Revised (May 2020)	**Priority 1**														
	Non-COVID-19 Target	0				0		542,000							94,000
	Non-COVID-19 Requirements	0				0		1,368,749							5,614,000
	COVID-19 Target	1,000,000				250,000		169,749							128,750
	COVID-19 Requirements	500,000				500,000		1,500,000							2,000,000
	Priority 2														
	Non-COVID-19 Target				5,000		0	542,000	355,000		17,500				94,000
	Non-COVID-19 Requirements				500,000		0	1,368,749	2,934,698		700,000				5,614,000
	COVID-19 Target	1,700,000	500,000		3,000	250,000	500,000	169,749	200,000		23,000	0	0		128,750
	COVID-19 Requirements	900,000	1,000,000		800,000	500,000	2,000,000	1,500,000	1,333,333		1,300,000	0	0		2,000,000
	Priority 3														
	Non-COVID-19 Target				3,000			1,120,000	555,000		17,500	92	24,496	84,969	94,000
	Non-COVID-19 Requirements				500,000			6,368,749	2,934,698		700,000	3,475,000	489,938	169,938	5,614,000
	COVID-19 Target	6,200,000	500,000	300,000	5,000	250,000	500,000	200,000	355,000	1,000,000	23,000			220,000	128,750
	COVID-19 Requirements	3,000,000	1,000,000	0	800,000	500,000	2,000,000	1,500,000	2,000,000	0	1,300,000			1,000,000	2,000,000

ES/NFI

		Cluster Objective 1 Ensure contextualized access to life-saving shelter and NFIs for displacement affected people, to safeguard their health security, privacy, and dignity					Cluster Objective 2 Improved living conditions of IDPs and basic humanitarian needs promptly through the provision of Shelter and NFI				Cluster Objective 3 Enhance resilience through shelter support in recovery, reintegration, and relocation
		Provision of shelter responses to improve HH safety and security	Provision of in-kind or cash emergency shelter assistance for physical protection and to reduce overcrowding	Provision of core relief items to reduce the likelihood of health and protection consequences	Pre-positioning of ES/NFI stocks	provision of NFIs in a quarantine center	Provision of in-kind or cash for emergency shelter assistance for displacement-affected people that considers the needs of women, children, people with disabilities, and the safety of beneficiaries	Provision of emergency shelter and NFI assistance for displacement-affected people that considers the needs of women, children, people with disabilities, and the safety of beneficiaries	Provision of safe, appropriate life-saving Emergency Shelter Repair Kits to returnees	Provide appropriate live-saving Non-food/ core relief items to safeguard the health and protection of displaced people affected people	Provide support livelihood and reintegration/ return/resettlement by improving shelter
Original (January 2020)	In Need	44,500					147,300	1,022,700	722,900	216,900	136,700
	Target	44,500			24,200		134,600	885,000	722,900	216,900	73,700
	Requirements	3,347,438			4,224,141		3,705,700	25,305,000	46,005,100	3,943,300	9,171,700
Revised (May 2020)	**Priority 1**										
	Non-COVID-19 Target	305,800			49,500						
	Non-COVID-19 Requirements	15,067,500			1,800,000						
	COVID-19 Target		256,850	495,000		70,000*					
	COVID-19 Requirements		2,794,500	9,980,000		5,600,000					
	Priority 2										
	Non-COVID-19 Target	305,800			49,500		104,930	78,640	98,160	49,080	
	Non-COVID-19 Requirements	15,067,500			1,800,000		2,032,970	2,891,900	6,265,250	535,800	
	COVID-19 Target		256,850	495,000		70,000*				269,500	
	COVID-19 Requirements		2,794,500	9,980,000		5,600,000				5,878,700	
	Priority 3										
	Non-COVID-19 Target	305,800			49,500		472,670	354,480	442,930	135,160	391,600
	Non-COVID-19 Requirements	15,067,500			1,800,000		9,157,450	13,026,940	28,242,530	2,413,560	11,390,700
	COVID-19 Target		256,850	495,000		70,000*				269,500	
	COVID-19 Requirements		2,794,500	9,980,000		5,600,000				5,878,700	

Food

		Cluster Objective 1 To provide emergency in-kind food and cash assistance to meet food needs of acute food insecure people
		Distribution of food and/or cash transfers for targeted beneficiaries
Original (January 2020)	In Need	5,100,000
	Target	5,900,000
	Requirements	399,500,000
Revised (May 2020)	**Priority 1-3**	
	Non-COVID-19 Target	7,200,000
	Non-COVID-19 Requirements	488,700,000
	COVID-19 Target	7,800,000
	COVID-19 Requirements	284,700,000

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 (May 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
	Priority 2											
	Non-COVID-19 Target	125	375,000	1,500	18,000	1,600,000	375	50,000	3,000	150	500	500,000
	Non-COVID-19 Requirements	7,500,000	4,500,000	500,000	500,000	500,000	14,500,000	6,000,000	4,000,000	500,000	6,000,000	3,000,000
	COVID-19 Target	125	375,000	1,500	18,000	1,650,000	375	50,000	3,000	150	500	500,000
	COVID-19 Requirements	5,000,000	3,000,000	500,000	500,000	500,000	12,500,000	4,000,000	2,000,000	500,000	20,000,000	1,500,000
	Priority 3											
	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

		Cluster Objective 1 Critical supplies distributed in sufficient quantity and quality and in a timely manner to targeted beneficiaries	Cluster Objective 2 Increased deployable storage capacity for prepositioning humanitarian cargo in field locations and furnishing existing central hubs at different locations in Ethiopia	Cluster Objective 3 Humanitarian partners and Government receiving reliable information for better coordination and response
		Provide transportation for the dispatch and delivery of life saving humanitarian cargo including food and non-food products	Provide storage services for the pre-positioning of critical supply	Provide information sharing to the humanitarian community related to supply chain
Original (January 2020)	In Need			
	Target			
	Requirements			
Revised (May 2020)	**Priority 1**			
	Non-COVID-19 Target			
	Non-COVID-19 Requirements			
	COVID-19 Target			
	COVID-19 Requirements			
	Priority 2			
	Non-COVID-19 Target			
	Non-COVID-19 Requirements			
	COVID-19 Target			
	COVID-19 Requirements			
	Priority 3			
	Non-COVID-19 Target			
	Non-COVID-19 Requirements			
	COVID-19 Target			
	COVID-19 Requirements			

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				3,000	100		
	Requirements	31,049,550	49,637,308				490,000	8,500,000		
Revised (May 2020)	**Priority 1-2**									
	Non-COVID-19 Target									
	Non-COVID-19 Requirements									
	COVID-19 Target									
	COVID-19 Requirements									
	Priority 3									
	Non-COVID-19 Target	69,759	265,914	204,118				50	1	
	Non-COVID-19 Requirements	4,883,130	7,445,592	15,512,968				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	60,000	

Protection

		Original (January 2020)			Revised (May 2020), Priority 3			
		In Need	Target	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.		832,000	8,320,000	400,000	6,000,000	55,000	1,325,000
	Activity 1.2 Individuals receive information on HLP	115,000	4,000	600,000	1,500	225,000		
	Activity 1.3 Individuals receive counselling on HLP	22,000	1,000	300,000	1,000	300,000		
	Activity 1.4 Individuals receive technical assistance on HLP	9,000	300	300,000	200	200,000		
	Activity 1.5 Individuals receive information on civil and legal identity documents	142,000	5,000	600,000	2,000	300,000		
	Activity 1.6 Individuals receive counseling on civil and legal identity documents	28,000	1,000	300,000	1,000	300,000		
	Activity 1.7 Individuals receive technical assistance on civil and legal identity documents	9,000	300	300,000	200	200,000		
	Activity 1.8 Support to collaborative dispute resolution mechanisms, including mediation, negotiation, arbitration or reconciliation, to resolve disputes	413,000	14,000	150,000	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.	354,000	12,000	216,000	5,000	100,000	12,000	216,000
	Activity 1.10 Research, studies, assessments and analysis are conducted to inform better protection programming		10AS	500,000	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	528,000	158,000	1,200,000	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						5,505	1,200,000
	Activity 1.13 Eviction montioring, facilitation of rent support to ensure security of tenture and avoid homelessness						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						500	50,000
	Activity 1.15 Communication with at-risk groups on protection risks/rights and access to services/referrals associated with COVID outbreak						300,000	300,000
	Activity 2.1.1 Identification and case management support provided to children at risk, including unaccompanied and separated children	47,000	10,000	1,720,000	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	110,000	110,000	3,770,000	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	143,000	10,000	2,000,000	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	1,900,000	130,000	3,008,572	100,000	2,314,286		
	Activity 2.1.5 Provision of chid protection response services enhanced though capacity development of service providers including providers of humanitarian assistance	143,000	10,000	1,200,000	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	743,000	170,000	4,250,000	170,000	4,250,000		
	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	1,250,000	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.				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	66,000	15,000	2,250,000	10,000	1,500,000		
	Activity 2.2.5 Women, and adolescent girls of reproductive age provided with dignity kits	350,000	80,000	1,600,000	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)	10,000	10,000	200,000	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.)						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.						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						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 safeguaring, CMR, and on CP and GBV prevention and mitigation, and identification and referral of cases.						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.						50	117,000
	Activity 2.4.6 Strengthen 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						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.						8,000	640,000
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	554,000	246,000	1,200,000	200,000	1,200,000	200,000	500,000
	Activity 3.1.2 Site improvement works such as communal facilities construction, maintenance, partitioning and drainage, as well as decom- missioning/ restoration of facilities in displacement hosting	337,000	150,000	1,500,000	100,000	1,200,000		
	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	505,000	225,000	5,200,000	175,000	4,200,000		
	Activity 3.1.4 Capacity development on Site Management and Site Management Support and protection for the different actors, including adaptation of training materials to Ethiopian context; including capacity building on best practice in Site Management in the epidemic context (ICP, RCCE, protection mainstreaming, etc.).	985,000	438,000	500,000	438,000	275,000	1,150,000	250,000
	Activity 3.2. 1Protection mainstreaming initiatives (including capacity building of clusters, local authorities and service providers)	NA			50	100,000		
	Activity 3.3.1 RCCE/CwC to IDP Site populations and host communities on public health, incl. through Site Management Committees.						766,667	1,000,000
	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, especially in IDP Sites, 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.						450,000	1,250,000

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	1,726,009	582,526	5,258,581	4,206,865
	Requirements	26,954,573	25,469,777	10,485,472	6,310,297	10,517,162
Revised (May 2020)	**Priority 1**					
	Non-COVID-19 Target	516,242	606,643	1,381,376	1,726,720	1,381,376
	Non-COVID-19 Requirements	6,969,267	9,166,685	5,372,418	2,072,064	3,453,440
	COVID-19 Target	33 health facilities	108 health facilities	98health facilities	889,022	889,022
	COVID-19 Requirements	890,109	985,559	1,063,216	222,255	1,369,665
	Priority 2					
	Non-COVID-19 Target	866,181	898,498	2,101,558	2,626,947	2,101,558
	Non-COVID-19 Requirements	11,693,437	13,417,421	6,693,455	3,152,336	5,253,894
	COVID-19 Target	50 health facilities	163 health facilities	148 health facilities	1,347,002	1,347,002
	COVID-19 Requirements	1,348,650	1,493,271	1,610,934	336,751	2,075,250
	Priority 3					
	Non-COVID-19 Target	2,041,636	1,729,667	4,115,852	5,141,815	4,115,852
	Non-COVID-19 Requirements	27,562,080	25,731,934	12,054,953	6,173,778	10,289,631
	COVID-19 Target	100 health facilities	326 health facilities	296 health facilities	2,694,005	2,694,005
	COVID-19 Requirements	2,697,300	2,986,542	3,221,868	673,501	4,150,501