2020

COVID-19 MULTI SECTORIAL PREPAREDNESS AND RESPONSE PLAN

DRAFT

MARCH



Source: WHO, 2020

ETHIOPIA

Financial Requirements (US$)	People Targeted	Period Covered
$1.43 Billion	10 Million	April-June 2020

Summary

People Targeted and Financial Requirements by Sector

SECTOR / MULTI-SECTOR RESPONSE	PEOPLE TARGETED	REQUIREMENTS (US$)
Agriculture	1.2 M	23.1 M
Education	1.1 M	7.2 M
ESNFI	2.5 M	282.0 M
SMS	1.2 M	2.0 M
Food	10.0 M	423.3 M
Health	39.0 M	430.0 M
Logistics	10 M	59.7 M
Nutrition	0.3M	17.0 M
Protection	3.9 M	15.3 M
Refugees	0.7 M	16.0M
WASH	10.0 M	152.3 M
Total	**10 M**	**$1.43 B**

Background

The Covid-19 virus was first identified in the Chinese city of Wuhan in December 2019. Following its rapid spread across the globe, the virus was recognized as a pandemic by the World Health Organization (WHO) on 11 March 2020. According to WHO COVID-19 Sitrep, as of 31 March 2020, 750,890 confirmed COVID-19 (in accordance with the applied case definitions and testing strategies in the affected countries) have been reported, including 36,405 deaths. On 13 March, the WHO announced that the epi-center of the pandemic had shifted from China to Europe.

On 13 March 2020, the first case was confirmed, and as of 1 April, there were 29 confirmed cases reported across Addis Ababa, Amhara region (Bahir Dar and Injibira), Oromia region (Adama) and Dire Dawa City Administration. Two of the confirmed cases are under treatment in the designated treatment center in Bahir Dar, Amhara regional state and one is in Dire Dawa city administration. Two of the patients are in a critical condition in the ICU and the remaining cases are on medical care in stable condition. So far, no deaths have been reported. Given the evolving nature of COVID-19 epidemiology, these figures are subject to change drastically in coming days. As a hub in East-Africa and the high level of travel and trade with China, Ethiopia is at high risk of further infections.

Potential Impacts

If the COVID-19 virus continues to spread in Ethiopia it will have far-reaching health, economic, social, and security impacts. The already overstretched healthcare system will not be able to cope with many Covid-19 cases. Due to lack of medical facilities, supplies, and access, patients infected with the virus might not be able to receive quality and timely treatment. At the same time, existing limited resources are likely to shift to the Covid-19 response, resulting in patients suffering from other diseases not being able to access the support they need.

As can be seen across the globe, the pandemic is already causing negative economic impacts and is likely to lead to a global recession. For Ethiopia, this will cause macro-economic disruptions and impact people's livelihoods. Interruptions in supply chains will cause supply shortages, and travel bans and border closures will have a further impact on many industries and trade. As a result, this could lead to price increases, job losses and food insecurity and malnutrition which in turn could lead to increased humanitarian needs. If the health and economic impacts in Ethiopia are not contained, it could lead to a breakdown of social systems and civil unrest. Furthermore, the Covid-19 pandemic has led to the postponement of the national elections, which were scheduled for 29 August 2020.

Government measures

The Government of Ethiopia has taken active prevention and control measures to curb the further spread of Covid-19 in the country. These measures impact all sectors and society at large as they focus on restricting travel, movement, and physical interaction. An extensive list of specific measures taken can be found in the Situation and Risk Analysis section.

On 26 March, the Tigray Regional State declared a state of emergency to prevent the spread of the virus. The regional government has banned all travel within the region for 15 days as well as social activities and mass gatherings. Tigray is the first region in the country to declare such measures. Similarly, Amhara, Oromia and SNNP regional governments banned travels into and out of their regions.

To prevent disruption orderly market transactions, the Ministry of Trade and Industry will continue to distribute imported wheat, sugar, oil and fuel to lower and middle income households with a subsidized price, Provide market stabilization on major staple crops such as teff, wheat, corn and sorghum and provide to the population in a competitive price.

The Ministry of Transport is ready to mobilize public transport operators and associations as well as government mass transport service providers to support the COVID-19 treatment effort, as required.

Ministry of Urban development and construction will establish urban focused EOC for the COVID-19 response. The establishment of the EOC will help to coordinate volunteers and donations. Food and non-food items will be stock piled for identified vulnerable groups in urban areas. The Ministry will also work to ensure proper hygiene practices and observance of recommended measures such as social distancing in residential areas such as condominiums.

As more and more states are closing boarders, a strong relationship with the Republic of Djibouti is essential. A team for negotiation with Djibouti will be established in order to ensure logistics and freight transport operations (all food and other non-food items as well as medical supplies). The Ministry of Transport will constantly monitor and regularly evaluate the COVID-19 situation and adjust its activities accordingly.

Planning Scenarios

The Ethiopian Public Health Institute developed three scenarios around the COVID-19, i.e.;

1. **Scenario 1**: (low impact) there will be no confirmed case of COVID-19 in Ethiopia (which is no longer relevant);
2. **Scenario 2**: (moderate impact) Ethiopia confirms an outbreak of COVID-19, however, the index case is identified early, and transmission is limited to no more than two Regions;
3. **Scenario 3**: (Severe impact) Ethiopia confirms an outbreak of COVID-19, cases reported in more than two Regions with high morbidity and mortality.

As of 31 March, scenarios 1 and 2 are no longer relevant. Therefore, this multisector plan is framed around scenario 3.

COVID-19 Scenario Three: Worst Case Scenario

According to EPHI, the number of expected cases for the response was calculated to be **34,068** confirmed cases per month for the next three months. The assumptions taken were:

- 21 per cent of the population is an urban population of whom are all considered at risk;
- 50 per cent of the rural population was at risk given the sparse population distribution;
- About 20 per cent testing capacity

It was then assumed that 39 million people will be infected with COVID 19. However, for the purpose of this plan, it is estimated that 10 million people will require multi-sector assistance.

COVID-19 is expected to cause a strain on the economy as well as slow down economic development, impact livelihoods, increase social stigma, and disrupt supply chains and the overall health system. It will also lead to a lack of capacity to maintain regular services and keep children out of school for a prolonged period of time. There will be a significant increase in the number of people in need of education, health, food, nutrition, and protection assistance. It is also expected to cause a slowdown and diversion of humanitarian responses due to limited movement of relief commodities and humanitarian actors as well as the diversion of resources and strategic focus. The security situation will likely worsen in affected regions, increasing the likelihood of civil unrest and testing the low administrative capacity to manage large-scale crises. The combination of these risks and economic impacts of COVID -19 is likely to lead to increased poverty in the short and medium-term and will make poverty reduction much harder.

2020 Humanitarian Response Plan

In addition to the 7 million people targeted in the Humanitarian Response Plan (HRP), an estimated 10 million people will require humanitarian assistance at least for the next three months until June. Assistance to the existing 7 million vulnerable people mayl be disrupted due to the emergence of new needs and/or access constraints. It is also expected that basic services will be disrupted due to the widespread closure of public facilities and the potential of staff exposure to COVID-19. While human lives are threatned by COVID-19, farmers and pastoralists are also risking their crops and pasture to desert locust in the upcoming agricultural seasons, and there is an increased risk of animal diseases. COVID-19 has hampered the control operation of the desert locust. Especially travel bans and delayed procurement as a result of strain on supply chain challenged the control operation. Due to restriction on gatherings planned workshop and trainings have been cancelled. In rural areas, it is expected that cumulative effect of COVID-19 and desert locust may lead to reduction of production and productivity due to limited availability of labor, limited availability and increase in price of agricultural produce and inputs. Increased livestock diseases is also expected as a result of disruption of vaccination and treatment.

Operations

Higher operational costs due to rising fuel prices, higher transport fees due to restriction of movements as well as inadequate financial or human resources to manage the scale of the crisis are expected. Huge supply chain interruptions are anticipated in the country. Humanitarian commodities- both food and non-food are transported mainly through the Port of Djibouti. Closure or operation scale down of the port will have a huge implication on humanitarian work in Ethiopia.

Situation and Risk analysis

Ethiopia is at a critical juncture. The population faces uncertainty over political transition, ongoing regional conflict and displacement, climate shocks (droughts/floods) as well as a severe locust invasion which may result in loss of livelihood and food security.

The compounded political, security and economic factors have severely affected the abilities of families to ensure their basic welfare and withstand the impacts of new shocks. If not contained, the COVID-19 pandemic, may prove to be the tipping point for further deterioration of the humanitarian crisis in Ethiopia.

COVID-19 Outbreak

Ever since the official announcement of confirmed cases of COVID-19 in Ethiopia on 13 March, the Government has taken several preventive and control measures to contain the spread of the disease in the country. These include, but are not limited to, screening of incoming passengers at international entry points, temporary flight suspensions to 30 countries, border closures, compulsory 14-day quarantine for arriving passengers, the establishment of isolation and quarantine centers for suspected and confirmed cases, laboratory diagnosis of COVID-19, procurement of medical supplies, community engagement and risk awareness campaigns, resource mobilization, the activation of the Federal Emergency Operation Center, market control, disinfection of public transportation, temporary closure of schools and higher education institutions, establishing alternative working modalities for public servants, and the suspension of mass gatherings.

Despite the ongoing preventative and control measures, containing the spread of the virus could be challenging in light of the underlying social and infrastructural settings of the country. Additionally, in Ethiopia, inherent cultural norms such as ritualistic greetings and strong social ties challenge key prevention methods such as social distancing. The quite dense settlement patterns of the society at large, and collective settlements of IDPs and refugees in particular, also contribute to the challenges for controlling the spread.

Public Health Impact

If the number of cases significantly increase, given the prevailing health system and level of preparedness in-country, the health system will be overwhelmed to cope with the daily caseloads and treatment needs. The COVID-19 outbreak will likely divert attention, resources, and response capacity from regular and pre-existing health needs in the country, which could lead to non-COVID-19 patients being neglected from accessing the services and receiving the treatment they need. Medical resources may be diverted to respond to the pandemic, leaving other essential services, including reproductive health services for women and girls (e.g. pre and post-natal health services), clinical response for GBV, treatment of malnutrition, and for people with disabilities, heavily underserviced and dysfunctional. Other ongoing infectious disease outbreaks such as cholera and measles may also intensify. This could result in an increase in mortality (including of preventable maternal mortality). This reality, therefore, necessitates all actors and sector interventions to work in tandem to flatten the curve.

Furthermore, Ethiopia's safe water supply is estimated to be around 30 per cent which will make the spread of the virus to regions and rural areas difficult to prevent. Stud¬ies show that some 60 to 80 per cent of communicable diseases in the country are attributable to poor access to safe water. People living in informal settlements such as IDPs, pastoralists, and refugees, particularly in remote, water-poor areas are most vulnerable in this regard. Persons with deprived liberties (e.g. detainees) as well as persons with disabilities (who may lack sufficient personnel support to ensure adequate hygiene due to the overwhelming family/community situation), will also be at risk due to inadequate sanitation facilities.

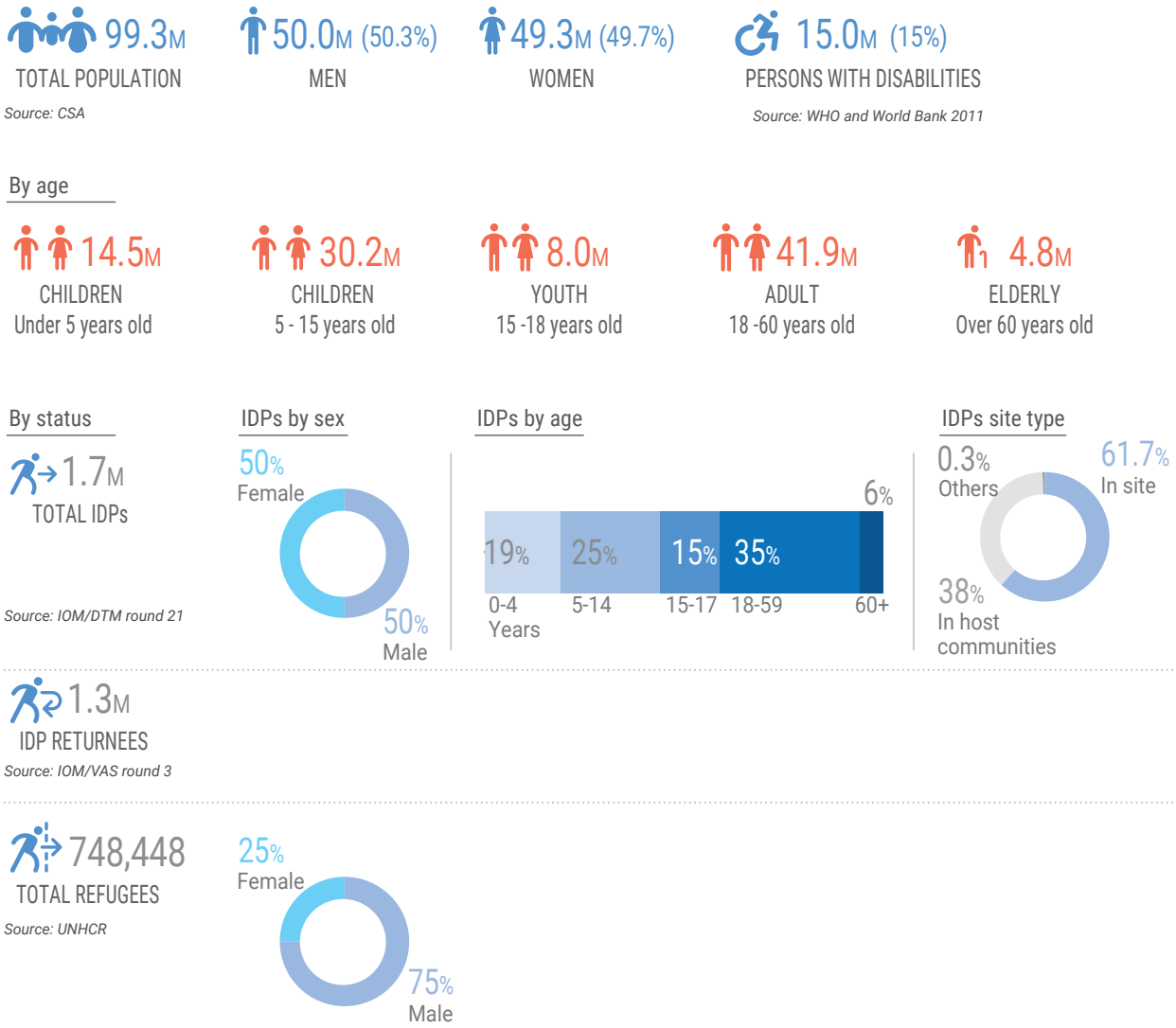
Impact on people

The 2020 Humanitarian Needs Overview (HNO) identified a to¬tal of 8.4 million people in need, out of which 74 per cent have acute needs. These people in need are among the most vulnerable in the country to cope with disruptions due to COVID-19, and include severely food insecure people, acutely malnourished women and children, and people without access to safe water.

The COVID-19 outbreak will exacerbate risks for groups already identified in the HNO as particularly vulnerable, while causing new vulnerabilities for others. Some of these vulner¬able groups are at more immediate risk of contracting the coronavirus or facing direct impacts because of their age, living condition, status, or the reduced capacity of health services, including people with disabilities, older persons without caregivers, pregnant

women and girls facing life threatening complications, GBV survivors, IDPs living in sites, returning migrants, and refugees. Other vulnerable groups are particularly at risk of facing indirect shocks caused by a COVID-19 outbreak, includ¬ing IDPs in host communities, child- and female-headed households, unaccompanied and separated children, people without legal documentation, people experiencing mental distress and trauma, and recently returned IDPs.

Baseline population in Ethiopia, disaggregated by sex, age, disability and displacement status



Socio-economic Impact

The Economic Commission for Africa (ECA) warned that Africa may lose half of its GDP with growth falling from 3.2 per cent to about 2 per cent due to, amongst others, the disruption of global supply chains due to the COVID-19 outbreak in Africa's major trading partner, China. COVID-19 has already proven to have a significant negative impact on the global economy since the outbreak. The stock market has fallen below a historic low. Many industries and manufacturers are directly or indirectly affected due to supply shortages, including for preventive and personal hygiene items and daily consumables, stemming from increased use of equipment to fight the outbreak globally. Panic buying and disruption of production and logistics systems have led to increased prices of items and their shortage in the market. Ethiopia is not exempt from this. The alarm caused by the confirmation of the COVID-19 outbreak in Ethiopia has seen a drastic increase in prices of basic commodities in the market, with the doubling of prices on some staple food items.

It is anticipated that travel bans and restrictions, border closures, and reduced productivity will increase their grip on the manufacturing and import sectors affecting availability and prices of essential consumer goods, hygiene and prevention materials, essential drugs, and basic services. Reduced productivity and production along with disruptions to logistics systems are likely to also impact the Ethiopian export market. A reduction of international demand could, in turn, lead to an increase in local market prices.

The service sector is also feeling the impact with the ban on public gathering and social events, while tourism has drastically decreased following Government measures on restricting travel, the closing of public places and tourist attractions.

In all this, the livelihoods of many poor Ethiopians who earn daily wages from vending, labour works, and service delivery will be further disrupted leading to deeper destitution. Furthermore, reduced income and purchasing power due to loss of jobs and work opportunities, restricted mobility, loss of access to productive inputs and markets, decreased productivity because of illness, and increased health expenditures will weaken the economic situation of the middle-income population.

The impacts on social cohesion will also be far-reaching. As mentioned above, social distancing measures will disrupt social gatherings and cultural events. In this outbreak, people may be labeled, stereotyped, discriminated against, treated separately, and experience loss of status because of a perceived link with a disease. Stigma can not only drive people to hide the illness to avoid discrimination, or prevent people from seeking health care immediately, but it can also undermine trust and community cohesion. Moreover, the trauma of displacement from homes and communities, and hopelessness created by protracted displacement are psychological stressors which may be further compounded by stress related to the disease outbreak. As Ethiopia is already experiencing political and regional conflict, the COVID-19 outbreak could therefore exacerbate inter-ethnic and inter-regional tensions to result in heightened violence. Conflict-sensitive social cohesion and peace-building activities will therefore continue to be of importance in the response.

Vulnerable Groups

COVID-19 affects the whole Ethiopian society and population. However, certain population groups will be put under further stress and their abilities to cope with both the disease itself as well as with the short and long-term consequences of it are limited. It is therefore of our highest concern, to especially give attention to these groups and support and provide assistance to meet their needs and to reduce the risk of transmission.

Main Vulnerable and At Risk Groups

Older persons, homeless persons, persons with disabilities and those with chronic medical conditions (including mental health) will likely experience increased challenges in accessing basic, critical health care 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 given that initial research (based on over 44,000 cases), showed a mortality rate of 2.3% for the general population, rising to 8% in those aged 70-79 and nearly 15% 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 limited access to appropriate prevention and response measures and there is a potential risk of increased abuse and neglect.

People who lack identity documents, including migrants, displaced persons and others (homeless populations for example), may face challenges in accessing medical services, particularly testing and treatment of COVID-19.

Women and girls are at heightened risk of exposure to the virus due to their common roles as front-line health workers or health facility service-staff (e.g. cleaners, laundry etc.), and as caretakers of the family (e.g. to care for sick household members).

Movement restrictions, coupled with increased tensions and stress in the home, can also increase women and girls' exposure to gender-based violence (GBV) and intimate partner violence, which are already prevalent in Ethiopia. Globally, domestic violence organizations have observed that extended quarantine and other social distancing measures have increased reports of domestic violence in COVID-19 affected areas. Yet, despite overlapping vulnerabilities and increased risks, evidence has shown that specialized services for GBV survivors remained limited in availability and funding was often deprioritized.

Overwhelmed health services will likely hamper women's access to sexual and reproductive healthcare, especially attended childbirth and other natal services, exacerbating preventable maternal deaths and potentially leading to a rise in unwanted or unplanned pregnancies and the social economic impact that they have to individuals, households and communities.

Children may be particularly vulnerable to COVID-19 in different ways: children may be separated from their parents and families due to hospitalization, treatment or death of their caregivers as a result of COVID-19. The loss of parental/guardian supervision as well as structured learning environments (due to school closures) may leave children exposed to dangers including child labour, exploitation and abuse.

Children may be at risk of psychosocial distress or trauma, due to fears related to COVID-19 impacting them and / or their families. Stigmatization and social exclusion due a family member having contracted the disease, and the disruption of schools, of daily routines and recreational activities are additional sources of psychosocial distress. At home, children may be increasingly vulnerable to violence, including sexual violence, physical and emotional abuse as a result of caregivers and / or other adult members becoming increasingly distressed and using dysfunctional coping mechanisms (alcohol, substance abuse, etc.) to deal with the challenging environment.

Adolescent girls may be particularly vulnerable to gender-based violence as a result of reduced family and community care protection and a breakdown of social protection structures. With school closures and reduced livelihood within the families, girls are less likely to return to school and are at further risk of negative coping mechanisms such as child/forced marriage, or sex work.

Already vulnerable children such as children living and working on the street, unaccompanied and separated children, child headed households, and children with disabilities may be particularly impacted due to reduced access to services. Children living and working on the street may be regarded as greater risk of source of transmission and diffusion of the virus, and thus particularly vulnerable to social exclusion and discrimination.

IDPs, who have been forced to flee their homes because of violence and human rights violations, will also 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. Displaced populations may experience difficulties in access to care and medical services, including testing

for covid-19, due to lack of transportation, lack of service availability in remote informal settlements, and unsafe travel conditions to health services. They might be more seriously affected by restrictions (e.g. imposed on movements) or emergency regulations as a result of their circumstances.

IDPs living in informal settlements/sites, especially spontaneous settlements and collective centres have a higher risk of exposure because of multiple factors including:

- Overcrowding, especially in collective sites, where large numbers of households share one living and sleeping area. Ensuring that their housing meets minimum habitability standards including access to water to comply with sanitary/hygiene requirements to prevent further spread of Covid-19 and to allow them to give adequate care to sick family members is vital to help control the further spread of the virus.
- Poor nutritional status due to delayed food/cash distributions or sale of food for other goods;
- Shared WASH/cooking facilities, and insufficient water and hygiene items for regular hand washing and maintenance of a clean living space.

In addition, food and cash distributions at IDP sites often entail mass gatherings of people, including both staff and beneficiaries. While it is essential to continue delivering humanitarian assistance to people in need, the distribution process must be adjusted in order to ensure social and physical distancing.

Migrants may lack access to basic services and could face linguistic barriers especially with respect to access to information, and experience discrimination and exclusion from services. They may be trapped by travel restrictions, caught in a limbo without legal status or documentation, thereby lacking certain rights/access to services. This could also lead to negative coping mechanisms, risky work, transactional sex, housing in crowded conditions, or arrest and detention.

Vulnerable Groups by Sector

In this preparedness and response plan, sectors/clusters are specifically targeting the following groups of vulnerable and at risk population (table to the right):

Sector/ Cluster	Most vulnerable and at risk groups targeted
Agriculture	Pastoral and agro-pastoral households
Education	Children in emergencies
	Children benefitting from school-feeding programmes
	Children living in rural areas who will not be able to access learning
ES/NFI	IDPs living in collective centers, planned and spontaneous settlements
	Returnees and host communities
	Vulnerable urban populations
Food	IDP communities
	Very poor and poor pastoralist and agro-pastoralist households
	Households with elderly members
	Pregnant and lactating women
	Children
	Poor urban households that rely on market purchases
	Cash crop producers
	Labourers
Nutrition	Children under five
	Pregnant and lactating women
Protection	Women and girls
	IDPs
	Refugees
	Persons with chronic health conditions
	Persons with disabilities
	Older persons
	Children
	Adolescents and young people
	Detainees
	Homeless people
	People with diverse gender and sexual identities
SMS	IDPs living in collective centers, planned and spontaneous settlements
	Families of isolated patients (especially if this person is the household head)
	Children who lose their primary caregiver
	Surrounding communities
WASH	People who have already been affected by emergencies
	General population who do not have regular access to water and hygiene facilities
Refugees	Persons above 60 years old
	People living with chronic illnesses such as diabetes, asthma, HIV
	Children under five

Monitoring

The overall monitoring of the implementation of the activities outlined in the Covid-19 Humanitarian Response Plan will be led by the Emergency Coordination Center (ECC). Response monitoring will be done through sectoral and cluster response monitoring systems. Each sector and cluster have defined their objectives along with priority activities. For each of the priority activities, a series of indicators has been determined with needs and targets.

Sectors and clusters will be responsible for reporting on their overall and indicator-specific progress on a monthly basis. Reporting will be done at woreda level and financial tracking will be conducted through the online Financial Tracking System (FTS). As a result of the sector and cluster monthly reporting, a response and funding dashboard will be published.



Inter-Agency Accountability to Affected Populations and Prevention of Sexual Exploitation and Abuse

Accountability to Affected Populations (AAP) and Protection from Sexual Exploitation and Abuse (PSEA) are an integral component of the 2020 HRP and will be mainstreamed during the preparedness and response to the COVID-19 crisis.

The Government and the humanitarian community will actively promote and support efforts to fulfill Commitments on AAP and the Core Principles Relating to PSEA, as outlined by the IASC, as well as the Grand Bargain Participation revolution: include people receiving aid in making the decisions which affect their lives.

AAP will be strongly and meaningfully connected with PSEA. SEA will be recognized as a form of GBV and a serious breach of accountability implying adequate referral mechanisms, investigation and victim assistance.

AAP will be at the core of this response and SEA is identified as an area of higher risk in a disrupted situation. Therefore, meeting our Commitment to AAP and PSEA is critical and especially relevant from the preparedness stage through the response.

This will be achieved through joint application and verification of common commitments, standards and tools such as the Core Humanitarian Standard (CHS) on Quality and Accountability – including a PSEA Index - and the Humanitarian Standards Partnership - with Sphere Standards, to strengthen system-wide humanitarian response to the COVID-19 crisis in Ethiopia.

By strengthening their engagement with communities and promoting a joint and harmonized response system, humanitarian actors in Ethiopia will (re)affirm collectively their commitments towards Quality and AAP as well as PSEA during the preparedness and response to the COVID-19 crisis.

Proposed core activities contributing to the 3 Global HRP COVID-19 Strategic Priorities:

A Collective Multi Sector Accountability and PSEA Framework will be designed and endorsed.

It will serve as an overarching Framework to enable a global mainstreaming of AAP and PSEA and will therefore reinforce and support all actors involved in the response and coordination mechanisms. This Framework will adopt an inclusive approach and promote resilience by linking Humanitarian – Development – Peace Building actors and activities.

Awareness raising and advocacy to all actors involved in the response

Human Rights Based approach (HRBA) through the humanitarian and protection response as per International Human Right Standards is key while addressing the needs of affected populations.

- Advocate for AAP/PSEA and a Rights Based Approach in all coordination bodies; Promote a Do No Harm approach.
- Remind all humanitarian actors of their Commitments and principles on AAP/PSEA.
- Draft key messages on AAP/PSEA and dispatch through various means and formats
    - Translate and share tools such as the video 'No Excuse for Abuse'
- Share lessons learned and global updates on AAP/PSEA

Communication and Community Engagement

Government and the EHCT will promote a people-centered approach throughout the HPC and the Clusters by having strategies and tools ensuring the inclusion of most vulnerable people.

The EHCT will promote meaningful and appropriate communication with communities (CWC), community engagement (CE), information to, participation of and leadership of affected populations and communities across the HPC, in an inclusive manner and at both national-regional-local levels.

- Promote and support community participation throughout all plans and activities
- Ensure and/or strengthen information to and 2-way communication with communities in appropriate formats, languages and channels in order to reach the most at risk groups.
    - Identify existing channels, local mechanisms and networks to reach the groups at risk, i.e. women, girls, boys, and men, especially persons with disabilities, detainees and homeless populations, older persons and those who have long-term chronic illness
    - Identify groups at risk preferences for information sharing and communications, including safe ways to report SEA cases.

Inter-Agency Feedback and Complaints Mechanisms

Government and the EHCT will support the development of a reliable inter-agency feedback and complaints mechanism for affected populations and communities to assess and comment on humanitarian performance. This mechanism will allow to prevent, respond to and specifically investigate incidents of SEA in a safe manner, with an integrated community-based complaint system that is linked to agency-specific mechanisms.

- Initiate, pursue and/or strengthen regional/local joint functional feedback and complaints mechanisms with a component for SEA cases ensuring the safety of the complainants.
- Ensure proper management, analysis of feedbacks and complaints received, including specifically SEA cases.
- Humanitarian decision making will echo peoples' voices. Feedback and complaints' analysis will feed into the HPC and allow for adjustments to be made.
- Finalise and share the SOPs for Inter-Agency PSEA CBCM
- Prepare an update on Agencies' resources for AAP/PSEA CBCM such as Focal Points, Messaging, etc.

Technical support on AAP/PSEA

- Support the PSEA Network and the IAAWG, which is the Sphere Focal Point in Ethiopia.
- Initiate a joint Help Desk on AAP/PSEA to support actors during the response.
- Deploy a remote surge capacity to support the implementation of AAP/PSEA activities through the coordination bodies.
- Liaise and coordinate with relevant actors and Networks such as OCHA, the EHCT and the ICCG and clusters, the RCO, the Inter-Agency Accountability Working Group (IAAWG) and the PSEA Network to strengthen and support the Government led coordination in Ethiopia.

Capacity-Building

- Promote on the job learning.
- Explore joint AAP/PSEA learning and cascading training strategies.
- Select and translate remote training materials for all staff.
- Provide ongoing mentoring and coaching and link with available technical support.

Verification/Evaluation

- Contribute to joint assessments and monitoring design and missions
- The EHCT will support a collective inter-agency measurement and verification process – self or externally-led - taking people and communities' perceptions into account and will share results locally and globally.
- The analysis will contribute to guiding the cluster approach and implementation.
- The clusters will monitor AAP/PSEA implementation as per common indicators.

This set of activities will be implemented with the support from:

- All actors involved in the response: Government, humanitarian, development and peace building actors.
- Networks such as the IAAWG, the PSEA Network.
- The PSEA Coordinator based at the RCO.
- Additional resources in-country.
- A remote surge capacity for AAP/PSEA deployed at the coordination level to boost the implementation of specific activities such as community engagement and CBCMs.

Budget:

AAP and PSEA will be mainstreamed throughout the preparedness and response to the COVID-19 crisis through technical support and activities that require specific resources.

Centrality of Protection

The Inter Agency Standing Committee (IASC) reaffirmed the importance of protection in the humanitarian response in two key documents:

- The IASC Principals' Statement, The Centrality of Protection in Humanitarian Action, (2013), stating: "Protection of all persons affected and at-risk must inform humanitarian decision-making and response"
- IASC Policy on Protection in Humanitarian Action, (2016), which requires that all sectors address protection issues that intersect with their formal mandates and sector-specific responsibilities.

These documents are complemented by sector specific documents, including:

- The IASC Guidelines for Integrating Gender-Based Violence (GBV) Interventions in Humanitarian Action (2015) to ensure all humanitarian actors consider and mitigate the risks of GBV in planning their activities; and
- The Minimum Standards for Child Protection in Humanitarian Action, (2019) to ensure the response considers child protection and considers the very specific risks and needs of children.
- The IASC Guidelines, Inclusion of Persons with Disabilities in Humanitarian Action, 2019

In crisis-affected areas, in particular during a pandemic like COVID-19, protection risks in humanitarian programming increase exponentially. Risks to those already potentially marginalized in society — including women, children, older persons, persons with disabilities, ethnic minorities, internally displaced persons, those with chronic medical conditions, persons deprived of their liberties, homeless persons amongst others – are exacerbated. Those who recover from COVID-19 and their families could face social stigmatization and discrimination. Particular social or ethnic groups could also be negatively associated with the virus and suffer similar social stigmatization. Effective communication with communities at the grassroots as well as complaints and feedback mechanisms will be necessary to protect these individuals.

The risk of evictions during the Covid-19 crisis is high because Regional States measures affecting livelihoods may render households without means to pay rent and/or utilities, and right to shelter for the vulnerable must be ensured without forced evictions.

There will likely be increased challenges for persons with disabilities, older persons and those with chronic medical conditions, person with deprived of their liberties, and homeless persons amongst others, in accessing basic, critical health care 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.

Traumatic events, as well as stress and fear during the pandemic, will likely **increase mental health challenges for the affected population, especially children and persons with disabilities**

Children may experience loss of parental care, when their caregivers die, are hospitalized, fall ill, or are quarantined. Children, who are hospitalized or quarantined, may also be deprived of parental care. Traditional cares support systems (extended family, community members) that would usually step in may be disrupted. As a result of school closure, and disruption of family and community support and reduced livelihood opportunities at household level, children may particularly be vulnerable to negative coping mechanism such as child labour, child and force marriage and transactional sex. Lastly, children may be particularly vulnerable psychosocial distress, abuse and exploitation, including domestic violence at homes.

Historical evidence demonstrates **the risks women and girls encounter during pandemics.** Women are more likely to be front-line health workers or health facility service-staff (e.g. cleaners, laundry etc.) and as such they are more likely to be exposed to the virus. Additionally, in many instances, norms and customs dictate that women and girls play the role of caretakers of the family. This can mean giving up work to care for children out-of-school and sick household members; the latter heightening the risk of exposure to the virus. Yet, despite overlapping vulnerabilities and increased risks, evidence has shown that specialized services for GBV survivors remained limited in availability and funding was often deprioritized

Overwhelmed health services will likely hamper women's access to sexual and reproductive health, especially attended childbirth and other natal services, exacerbating preventable maternal deaths. In addition, given that pregnant women are more likely to have contact with health services (antenatal care, delivery, and postnatal care), they experience greater exposure to infections in health facilities. Overwhelmed health services may also limit access to family planning, potentially leading to a rise in unwanted or unplanned pregnancies and the social economic impact that they have to individuals, households and communities. Access to life-saving nutrition services will also be compromised and will hinder early identification and referral of acutely malnourished children and pregnant and lactating women.

Humanitarian settings already **increase women and girls' exposure to gender-based violence (GBV)** and intimate partner violence, already prevalent in Ethiopia. With directives such as "stay home" and other movement restrictions, combined with fear, tension and stress

related to the COVID-19 outbreak, it is likely risk levels will increase. Globally, domestic violence organizations have observed that extended quarantine and other social distancing measures have increased the reports of domestic violence in COVID-19 affected areas

IDPs, who have been forced to flee their homes because of violence and human rights violations, will also 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. IDPs living in informal settlements/sites, especially spontaneous settlements and collective centres have a higher risk of exposure because of multiple factors including:

- Overcrowding, especially in collective sites, where large numbers of households share one living and sleeping area; ensuring that their housing meets minimum habitability standards including access to water to comply with sanitary/hygiene requirements to prevent further spread of Covid-19 and to allow them to give adequate care to sick family members is vital.
- Poor nutritional status due to delayed food/cash distributions or sale of food for other goods;
- Shared WASH/cooking facilities, and insufficient water and hygiene items for regular hand washing and maintenance of a clean living space.

Displaced populations may experience difficulties in access to care and medical services, including testing for covid-19. They might be more seriously affected by restrictions or emergency regulations even when these are supposed to be of general nature and not targeted against specific groups.

Ensuring safe, equitable, dignified, and accessible and inclusive assistance to all affected persons in Ethiopia is essential. All humanitarian actors must, at a minimum, prioritize safety and dignity and avoid causing harm, and incorporate meaningful access and inclusion, accountability, and participation and empowerment into their activities. In particular, information must be provided in multiple formats and local/relevant languages to address literacy, language and disability barriers. Due to misinformation and the overall climate of fear, there is a clear risk of stigmatization and related discrimination against displaced groups their alleged connection to the spread of Covid-19. Disseminating true, accurate, clear, adaptable, and available information on how Covid-19 does and does not spread is key in this respect.

Clusters and their members will therefore identify potential protection risks and barriers to accessing services and facilities in relation to their interventions and suggest mitigation measures to address them, as well as promote access for persons with critical specific needs and hard-to-reach groups including persons with disabilities and older persons. In addition, they will monitor and check, if these measures are effective to reduce the barriers that the most at risk groups face in accessing those essential services. Consulting the whole affected population, including men, women, boys, and girls, and receiving their inputs and feedback is essential in this regard.

Clusters are taking the following steps to mainstream protection in the Ethiopia response:

Clusters to fill in (suggestions from protection cluster below)

Education: National level partnerships, including the Education Technical Working Group and the Education Cluster, have been leveraged to develop a system-wide education preparedness and response plan for children affected by the risks associated with COVID-19. The Federal Ministry of Education Response Plan developed in collaboration with the education cluster aims to:

1. Ensure teachers, communities, students and parents understand basic information on COVID19.
2. Provide continuity of learning while schools are closed with academic content broadcasted alongside key life-saving messages on proper hygiene practices as well as life skills targeting girls. Messages to parents and girls on prevention of early marriages and promoting gender equity to be infused in lessons.
3. Introduce innovative technology where possible to improve learning outcomes through open learning sources, accessing complimentary and creative content through applications and free learning platforms.
4. Ensure students, teachers and staff help stop the spread of the disease through advocacy and best practices when schools resume.
5. Work collaboratively with other social service systems including child protection, health, GBV, WASH and Mental Health & Psychosocial Support (MHPSS) to ensure continuity of critical services for vulnerable children.
6. Target the most vulnerable populations affected by the COVID19 emergency including IDPs, Returnees and Refugees with education activities to ensure the vulnerability of school children in not worsened.

Food security: At community and household levels, the cluster will support partners in identifying indicators that will allow for a needs-based distribution of assistance to food insecure people, including female and child-headed households, persons with disabilities, older persons without caregivers – especially in quarantined locations - are specifically identified and targeted in all food and/or cash interventions. Women, (especially pregnant and lactating) will be targeted to prevent increase in malnourishment. These indicators will be included in beneficiary registers and will allow for prioritization of resources to the most food insecure households, as well as in the identification of people who require priority at food distributions points. In conjunction with the protection cluster, continuous guidance will be provided to enhance access to food assistance in a safe and dignified manner. In addition,

equal access to impartial assistance will be guided by need and without discrimination of those affected by the Covid-19. The cluster will also work with the IAAWG to facilitate accurate and inclusive information provision to affected populations, sharing messages produced by the government and relevant health authorities. Participation, inclusion and empowerment of different segments of communities - based on age, gender, disability and diversity - will be enhanced by opening up feedback systems and gender responsive monitoring. In coordination with the PSEA network, relevant information and resources will be availed to food security actors and partners, to minimise the inherent risk of sexual exploitation and abuse.

The food distribution process will follow the guidelines that were developed, with the aim of avoiding the transmission of COVID-19 during food distribution. The measures include provision of facilities for good hygiene practices and sensitization on social/ physical distancing.

Communities will be informed about the targeting criteria, registration process and how to engage with the government and partners at national and sub-national level. This will include use of print and electronic media, television, awareness through Non-Governmental Organization/ Faith Based Organizations and Community based organizations or health centres.

If there is an interruption in the flow of food to local markets, there will be consideration to respond using in-kind assistance while switching to a cash-based approaches at the earliest available opportunity in order to provide incentives for traders to resume their normal trade practices. This will ensure that the response is not doing harm to non-food beneficiaries. The food cluster will therefore work with partners to strengthen market monitoring systems, that will inform on functionality of market/ retail capacity and timing to switch modalities.

As food security and malnutrition levels are already witnessesed to be at concernning levels in the country, their further deterioritation as a result of the COVID-10 outbreak (driven by loss of income/livelihoods, high market prices, and crop production losses) should be monitored to prevent resulting exposure to critical protection risks and loss of life.

Health: Health actors will ensure equality of access to screening and health care without discrimination. In COVID-19 affected communities and quarantined areas, women should be prioritized in the provision of medical supplies, food, care, social protection measures and psychosocial services. Particular attention should be paid to pregnant and nursing women. All healthcare workers should be trained handling disclosures of GBV and be familiar with existing support mechanisms to be able to refer those in need to the right pathway for psychosocial support, health and legal support, and case management. Health workers should also pay special attending to children, particularly avoiding separation of children from caregivers due to quarantine, and be able to refer cases to child protection social service workforce. The health care system must ensure the continuity of care for reproductive health services in both non-COVID 19 affected areas, as well as affected areas, as most health care workers have been pulled into the COVID-19 response and many health services/facilities have been abandoned.

NFIs: All levels of healthcare providers, regardless of seniority or role, should have access to personal protective equipment as required. Dignity kits and sanitary materials must be made available to populations under quarantine or self-isolation strategies. They should also be made available to women and girls currently under-going treatment and in recovery. Any changes in times or locations of distribution of NFIs to accommodate social distancing requirements, should be implemented only after consultation with the community.

Nutrition: Young children, pregnant women, and nursing mothers affected by acute malnutrition are at an increased risk of contracting infectious disease and their immune systems are weakened. ENCU/Nutrition partners will support the Government of Ethiopia Covid-19 response while ensuring the continuity of equitable life-saving nutrition services delivery. Health care providers will be supported through on-the-job coaching to protect the nutritional status of children and pregnant and lactating women, to promote, and support adequate Infant and Young Child Feeding (IYCF) practices. Particular attention will be put in monitoring, reporting and addressing any unsolicited donations of Breast Milk Substitute (BMS) and other violation of the International Code on the marketing of BMS.

Where nutrition partners have already identified referral mechanisms for GBV, efforts will be made to strengthen their use.

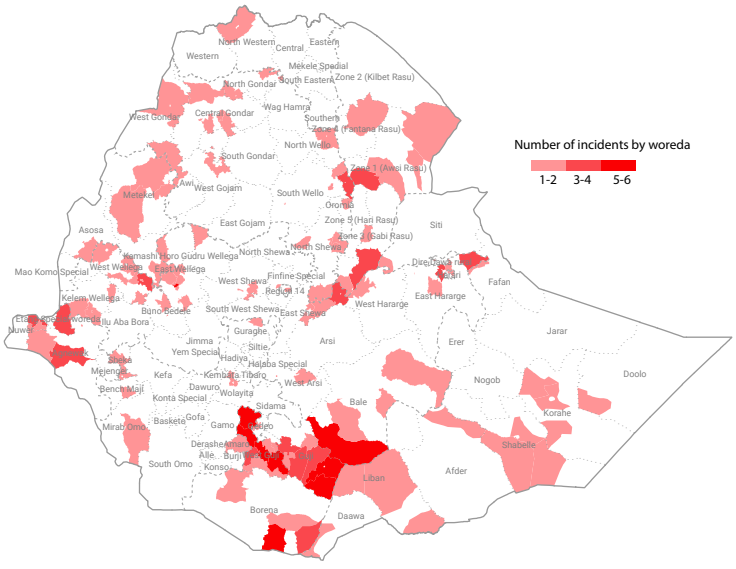
Shelter: The priority is to decongest living spaces with a focus on those populations with the most at risk due to limited space and tight living quarters, such as IDPs living in collective centers, planned, and spontaneous settlements as well as those in overcrowded areas in the host community. Reduction in overcrowding can reduce risk of violence against women and children. Coordination and planning efforts by the government and local authorities to prepare and respond to COVID-19, including risk communication, must include representation from men and women residents, including older persons, youth, persons with disabilities.

WASH: Good food and personal hygiene (including hand-washing) is central to controlling the spread of CONVID-19, but not everywhere has readily available water. The creation of any new facilities to promote hygiene in the community will be developed in consultation with women, men, girls, and boys in the community. Locations must be accessible to all especially to women (ensuring that they are not at any heightened risk of GBV in accessing these facilities and have adequate lighting), children, persons with disabilities, older persons, taking into account risks of safety, especially for vulnerable groups.

Access Analysis

- The operational environment to relief operations in Ethiopia remains permissive. This notwithstanding, ongoing security operations in Western Oromia (West Wellega and Kelem Wellega in particular) and Southern Oromia (Guji, West Guji as well as Bale and Borena) as well as in Amhara, are impacting the ability of humanitarian partners to deliver assistance to people in need, including to respond to COVID-19.
- In 2020, intra-community violence has escalated between ethnic Gumuz and Amhara in Benishangul Gumuz, Gambella, and between Afar and neighboring Somali, Amhara and Oromo communities, prompting new displacements and limiting access to the population. Elsewhere in Ethiopia, localized violence and generalized social unrest challenged relief operations on an intermittent basis.
- Whilst UN and NGO partners in Ethiopia are not directly targeted in the violence, the likelihood of suffering collateral damage is high, either during road movements or programme delivery. Partners have reported an increase of incidents with security forces, including cases of intimidation at check points and forceful commandeering of their vehicles. These incidents are worrying as they risk impacting the perception of humanitarian actors as "neutral", impacting the security of aid personnel and operations.
- Prevailing access obstacles in Ethiopia have an effect upon the quality of the humanitarian response, and will further impact the response to COVID-19. Humanitarian partners in Ethiopia are committed to support the government response to COVID-19 and ensuring that critical humanitarian activities are sustained. To this end, partners are actively implementing precautionary measures to ensure the safety of aid personnel as well as the population.
- While Government entities - at all levels – have stated their commitment to continue enabling the provision of assistance to people in need, humanitarian partners are concerned on the impact that measures meant to avoid the spread of the disease may have on the conduct of relief operations. The humanitarian community has requested government counterparts to ensure that an exemption is provided to humanitarian partners to enable them to continue their movements and operations, including COVID-19, throughout the country.

Access incidents in Ethiopia (January - March 2020)


Number of incidents by woreda
1-2
3-4
5-6
Tigray
Afar
Amhara
Oromia
Somali
Benishangul Gumuz
SNNP
Gambela
Dire Dawa
Harari
Addis Ababa
Dire Dawa
Mekele Special
Zone 2 (Kilbet Rasu)
Zone 3 (Fantana Rasu)
Zone 1 (Awsi Rasu)
Zone 5 (Hari Rasu)
Zone 4 (Gabi Rasu)
Finfine Special
Region 14
Bench Maji
Konta Special
Yem Special
Basketo
Mirab Omo
South Omo
Alle
Konso
Burji
Dasenech
Liban
Borena
Dawa
Afder
Shabelle
Korahe
Nogob
Doolo
Jarar
Erer
Fafan
Siti
Siltie
Hadiya
Halaba Special
Kembata Tibdro
Sidama
Gamo
Gofa
Wolayita
Dawuro
Kefa
Mejenger
Jimma
Guraghe
Arsi
Bale
West Arsi
East Arsi
West Harargе
East Harargе
East Shewa
North Shewa
West Shewa
South West Shewa
Buno Bedele
Kelem Wellega
West Wellega
East Wellega
Mao Komo Special
Asosa
East Gojam
West Gojam
Awi
Metekel
South Gondar
North Gondar
West Gonder
Central Gondar
Wag Hamra
North Wello
South Wello
Oromia
Meketo
Western
Central
Eastern
North Western
South Eastern
Southern
Ilu Aba Bora
Jimma
Hamashi Horo Gudru Wellega
Mirab Arsi
Mirab Shewa
Misraq Shewa
Misraq Harargе
Misraq Arsi
Misraq Gojam
Mirab Gojam
Misraq Gondar
Mirab Gondar
Misraq Wello
Mirab Wello

SECTOR PLANS

AGRICULTURE

People targeted
1.2M

Financial requirements (USD)
23.1M

Impact of COVID-19 on the sector

Desert Locust (DL) upsurge remains a priority to the Government of Ethiopia. A delay or stoppage in control operations of DL would heavily impact agricultural production, representing an additional shock to food security. At the same time, livelihood response to desert locust-affected households is crucial to mitigate further food insecurity. COVID-19 adds a layer of complexity to the response, given the need to continue operating while contributing to reduce the spread of the COVID-19. Additionally, COVID-19 will have an effect on food insecurity as restrictions on movement leads both to labor shortages at harvest time and constraints to access market.The potential impact of the pandemic in the Agriculture sector is:

- DL response: Delayed procurement of pesticides and other essential items, unavailability of inputs (PPE), impossibility for spraying/surveillance aircraft to arrive
- Reduced availability of agricultural inputs.
- Reduction of production and productivity of crops due to limited availability of labor and inputs.
- Disruption of markets - post-harvest losses and price inflation on inputs and production.
- Increase in livestock disease due to disruption of vaccination and treatment.
- Need to increase number PSNP clients.

Projected sector needs

Desert Locust response

Desert Locust remains a threat to agricultural livelihoods in Ethiopia, affecting crop production in Belg areas of the country. In the process of controlling DL and mitigating the spread of COVID-19, there will be the following problems;

- Delays in procurement and supplies;
- Delays in the field trip operations;
- Reduced professional presence in the field;
- Reduction of productivity in crops;
- Market challenges in agricultural products;
- Increased animal mortality and morbidity due to lack of health services available;

Ensure agricultural input supplies

Operational restrictions will impact availability of agricultural inputs, particularly fertilizer and seeds that are imported through Djibouti port. Delayed seed availability and distribution will reduce crop production, conservation and cultivation for the coming seasonal harvests.

Reduce food supply shortage

Food security will be severely affected in the case of restrictions and/or lockdown due to COVID-19. If smallholder farmers can't reach markets to sale their products, food availability and accessibility will be in dire scarcity. Food supply chains will be affected, compromising farmers' income and affecting access to food due to higher prices and limited purchasing power.

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Response strategy

The Agriculture sector is facing complex and multiple shocks; the desert locust invasion poses a direct threat to productive assets of pastoral and agropastoral households. Agricultural production can significantly reduce if control operations fail. At the same time, COVID-19 outbreak represents an unprecedented threat beyond health. The socio-economic implications of COVID-19 will impact food security and the agriculture sector in Ethiopia. The Agriculture sector response strategy will focus on continuing the effective and efficient DL control operations and livelihood response. The sectoral response will include prepositioning of agriculture inputs to ensure agriculture production is affected to a minimum and preventing further deterioration of food availability and food access by protecting core productive assets of the most vulnerable pastoralist and agro pastoralist households.

Activities

Prevention and control of desert locusts

- Procurement of material and inputs in advance
- Provide precautionary measures and safe operation procedures for the DL response at all levels

Fertilizer and Seeds Supply

- Ensure sanitation and safe operation procedures for distribution
- Ensure that control professionals maintain quality of supply
- Agreement with Djibouti Port to ensure import of inputs

Food insecurity mitigation through livelihood protection

- **Safe procedures for agricultural inputs and distribution adjustments through:**
  - Increase in number of distribution sites/frequency to avoid large gatherings
  - Provide all users and staff at distribution sites: handwashing, hand sanitizer, PPE (wrist, mouth mask).
  - Staggering of distribution cycles and loading procedures to reduce frequency of gatherings
  - If applicable, changes in packaging procedures to reduce time on site and contact between beneficiaries for redistribution;
  - Adjustment of SOPs to minimize the risk of exposure of personnel, service providers and beneficiaries during implementation of various activities.
  - Reducing congestion and market volatility by identifying and dividing alternative markets, while separating, monitoring, and supporting them.
- Pre-positioning of agricultural inputs stocks
  - Pre-positioning agricultural inputs closer to distribution points in order to anticipate/mitigate potential supply chain disruptions
- **Assistance modalities adapted**
  - Cash and voucher modalities or in-kind depending on market access

Priority activities	Target	Budget – USD $
Desert Locust response support		2,000,000
Ensure agricultural inputs		100,000
Provision of fast-cycle crop seeds (vegetables, tubers, legumes) including Cash+ if applicable	420,000	$7,000,000
Animal health campaigns and provision of animal feed to core-breeding livestock including Cash+	780,000	13,000,000
Support Ministry of Agriculture and partners at federal, regional and zonal level to implement an enhanced distribution process for the DL response		800,000
Support Ministry of Agriculture and Regional Bureaus on SOPs for markets, food safety and post-harvest reduction.		200,000
Total		**23.1 M**

EDUCATION

People targeted

1.1M

Financial requirements (USD)

7.2M

Impact of COVID-19 on the sector

- The government of Ethiopia announced the closure of schools and all learning institutions in March 2020 affecting more than 26 million learners in pre-primary, primary and secondary levels of education
- National examinations for candidate in grades 8 and 12 interrupted
- School feeding programmes targeting more than 1 million children affected by emergencies halted increasing vulnerability to hunger and dropping out of school when learning resumes
- Increased risk to exploitation and abuse of children when not attending school due to inadequate protective measures in the communities
- More than 120,000 children target with education in emergencies interventions will not receive the services as scheduled creating negative effects such drop outs andearly marriage

Projected sector needs

Ethiopia announced the first case confirmed with COVID-19 in mid-March 2020 and two days later the Prime Minister announced the closure of all schools and learning institutions affecting over 26 million students in pre-primary, ABE Centres, primary and secondary schools. This emergency comes while the country is responding to the effects of displacements and drought experienced in 2019 where 2.2 million people were displaced (70 per cent internally). Key education indices which were already dismal prior to the COVID-19 pandemic emergency are at risk of being worsened by the current crisis which have kept children out of school to avoid infection and spreading the disease. There are 4 million primary school aged children who are out of school according to UNESCO while education statistics from Ministry of Education show that the net enrolment rate for primary school nationally is an average of 86 per cent while the transition rate to secondary schools is even lower at 25 per cent. Humanitarian Needs Overview for (NHO) 2020 projected that 2.3million children are in need of emergency response. It is estimated that 80 per cent of the country's population lives in the rural areas which means that many children have no opportunity to access learning through technology based platforms due to low digital technology penetration and inadequate communication infrastructure. These factors have compounded the situation and put millions of children at the risk of dropping out of school as well as getting exposed to various forms of exploitation and abuse including early marriage, child labour and conscription into unnamed organized armed groups. Girls and disabled children face increased vulnerability risks than other children due to their special needs and disruption to learning could deny them their only chance to transform their lives and achieve their potential. In emergency affected regions including Somali, Oromia, Afar and SNNP, more than 50 per cent of the girls that were enrolled in early grades drop out in the second cycle (grades 5-8). While education will bring normality especially to children affected by the multiple emergencies, it is also critical in empowering them and their communities with coping and risk reduction mechanisms. The restrictions associated with avoiding infection and curbing the spread of COVID-19 have left the children with only the option of utilizing radio and television for learning.

Response strategy

The Ministry of Education will lead the response to ensure that children continue learning both during and after the pandemic. It has therefore employed two scenarios where schools open after a few weeks of closure and in another scenario, schools resume after few months to outbreak. The activities are designed to address the needs of learners, teachers and parents during and after the emergency. The strategy has three key focus areas:

1. Enhanced education system-level response to the pandemic
2. Support the planning and implementation of safe school operation and risk communication

3. Enhanced knowledge sharing and capacity building for the current response and future pandemics

Activities

- Accelerate the quick implementation of the Digital Technology and Innovations initiatives to support the Teaching- Learning Practice virtually and to encourage self -study (e-leaning approach) at least for upcoming months(need to implement phase by phase-like G11 & 12, G9 &10 approach).
- Digitalizing/ converting Primary Education Textbooks in to audio and visual format, distributing memory sticks and radio when necessary radio.
- The assumptions are at least our community have radio (70 per cent) or television (40per cent), so student who accessed the stick can use it in the home schooling
- Develop Radio based Parental Education program to enhance the practices of parents and care givers to exercise home schooling, play based learning, positive disciplining and also key messages for parents on COVID19.
- Develop radio content for continuous remote Early Childhood Education (ECE) through Parental Support.
- Develop psychosocial support training programme for children affected by the crisis and disseminate by using national and local media channels
- Support the Regional Education Bureaus to redesign the school calendar in response to the crisis - exam dates, strategy to compensate lost instructional time
- Commence a national back to school campaign to maximize retention after the school closures
- Establish procedures that can support schools to disinfect and ensure the sanitation and safe operation before a school re-open.
- Support the implementation of safe school guidelines through the provision of School WaSH materials (Water tanker, Water Supply whenever necessary, sanitizer, soaps and others)
- Train teachers on a simplified case definition and alert notification procedures including registration and reporting about the symptoms of COVID-19.
- Translate and disseminate key information on COVID-19 e.g. the brochures and posters for schools and the COVID-19 school guideline.
- Train teachers on PSS in the geographic areas affected by the virus
- Establish School Feeding Program where needed: Community based homegrown school feeding such as Hot Meal and High Energy Biscuits

Priority activities	Target	Budget – USD $	Remark
Curriculum based lessons delivered through radio and TV media; Provision of self-learner packs	1.1 million children (98%) and teachers; (80,000 learners get packs)	2,000,000	Use the MoE owned radio and TV as well as renting time in mainstream media
Disseminating COVID-19 prevention messages to school children, parents and teachers	1.1 million	200,000	The messages will aired in radio and TV and some printed
Establish school feeding programme	300 schools	2,000,000	Pre-primary, Primary and Secondary
Safe schools operation: WASH utilities and items for schools	1000 schools in areas with IDPs, hosting communities, refuges, and returnees	3,000,000	Disinfect schools and provide clean drinking water, rehabilitate sanitation facilities, provide tanks, detergents for cleaning and hand washing kits.

ES/NFI

People targeted

2.5M

Financial requirements (USD)

$282.0M

The Shelter and NFI (S/NFI) Cluster in Ethiopia strives to improve the living condition of vulnerable conflict- and climate-affected populations through the provision of life-saving emergency shelter and non-food items (NFIs). With the primary objective of coordinating appropriate, adequate, efficient, relevant, and timely services to displaced, host, and returnee populations living under substandard shelter situations. As COVID-19 continues to spread in an unpredictable manner it presents a growing risk to partners and beneficiaries, particularly during distributions. The COVID-19 virus could see a rapid transmission in IDP collective sites, formal sites, and informal sites due to overcrowding and lack of essential hygiene facilities and items. COVID-19 outbreak will also have a negative impact on supply chains including Shelter and Non-Food Items supplies to markets in areas where cash transfers are implemented. I addition to this, there is likely to be delays in movement of ES/NFI from the warehouses to the final distribution points and there will be prolonged distribution period due to minimal gathering to reduce contact between beneficiaries.

Projected sector needs

The latest DTM report indicates that there are 1,735,481 IDPs across 1,237 sites in Ethiopia. Of these, 95,396 live in collective centers, 116,916 in dispersed settlements, 659,672 in host communities, 100,924 in planned sites/camps, 756,059 in spontaneous sites/camps, 1,285 in transit centers and 5,229 in other types of settlements. IDPs have settled in 310 woredas across Afar, Amhara, Benishangul Gumuz, Dire Dawa, Harari, Gambella Oromia, Somali and Tigray regions.

Overall, 2 sites, hosting 3,217 individuals reported 51-75% of the population living in overcrowded shelters, while 54 sites, hosting 93,599 individuals, reported 25-50% of the population living in overcrowded shelters.

According to the WHO, one of the main ways of transmission of COVID-19 is close contact between people. To this end, and to further disaggregate and decongest the numbers IDPs living in collective centers, planned, and spontaneous settlements, 595,000 IDPs are identified with the greatest risk for close contact.

In addition to the above impact on the current IDPs it is also projected that additional 2 million people will require ES/NFI assistance, including in urban areas for the following critical activities that can be implemented in the three months.

- Provide essential core relief items or cash for families and people at higher risk of being affected by COVID-19;
- Provide ES/NFIs, such as bedding and cleaning materials kitchen utensil, to quarantine facilities;
- Improve hygiene conditions for families lacking basic facilities, such as kitchens items, by providing appropriate hygiene materials and cleaning supplies
- Providing additional shelter materials such as Rabhall and Tent for isolation centers;

Response strategy

The cluster has a twofold response strategy, primarily to in reducing congestions and providing partitions and core relief items to IDPs living in informal, formal and Collective Center; the main focus areas include

- Conduct a mapping to identify the areas most at risk such as areas where people are living in particularly overcrowded conditions, with higher densities, and with less space for expansion.
- IDPs living in individual accommodation below minimum shelter standards should be supported to improve those standards, particularly by increasing the living space coverage in cases of overcrowding.

- When communal / individual shelters do not meet the minimum requirement in terms of space, IDPs should be moved to the identified collective center.
- In places where several households are sharing latrines or cooking facilities, other facilities should be built to reduce the number of households using the same basic facilities.

Activities

Formal and informal settlements

- Map the existing IDP formal and informal sites to determine if IDPs are living in communal or individual shelters.
- Identification of public infrastructure available for shelter (schools and other) and ensuring the availability of WASH and other essential services to reduce overcrowding.
- Whenever the communal shelters/individual shelters do not meet the minimum requirement in terms of space, IDPs should be moved to the identified collective center
- Provision of core relief items
- Construction of partitions for each family for IDPs in communal shelter
- In places where several households are sharing latrines or cooking facilities, additional facilities should be built to reduce the number of households using the same basic facilities.

Collective centers

- Identification of public infrastructure available for shelter (schools and other) and ensuring the availability of WASH and other essential services-to reduce overcrowding
- Collective centers in which households are sharing the same shelter should be upgraded as much as possible to achieve minimum shelter standard for personal covered living space and household partitions
- Negotiation for additional land
- Whenever a collective center do not meet the minimum requirement in terms of space, IDPs should be moved to the identified collective center
- Reducing the number of HHs based on international standards on spaces per person.
- Transporting/ moving the IDPs to the new collective sites
- Erecting partitions for each family
- Distribution of core relief items
- In places where several households are sharing latrines or cooking facilities, additional facilities should be built to reduce the number of households using the same basic facilities.

Priority activities	Budget – USD $	Remark
Distribution of Core relief Item	242,348,485	Blanket, Mattress, Bed sheet, Kitchen utensil, Jeri can , Water tanker
Distribution of Shelter material	38,636,363	Tent, Plastic sheet, and Rab-hall
Transportation and other costs to move the IDPs in an overcrowded situation to other location	74,768	
Partition/Decongestion	840,027	For Decongestion Purpose
Transportation and other maintenance cost	481,618	
Total	**282,381,261**	

SMS

People targeted

1.2M

Financial requirements (USD)

2.0M

Impact of COVID-19 on the sector

Background: though Site Management Support (SMS) in Ethiopia has been actively responding to humanitarian needs in out-of-site settings as well as IDP Sites in 2019 and 2020, this response plan focuses primarily on the response in IDP sites and surrounding communities, for the following reasons:

- Residents of IDP Sites, including Collective Centers, Spontaneous Settlements and Planned Sites, Transit Sites, etc. are in most cases living in overcrowded conditions. For example, residents of collective centers often share non-partitioned spaces between large numbers of families.
- Such sites face problems across all sectors, with delays or insufficiencies in food distribution, little or no access to health services, below-Sphere standard levels of water supply and sanitation, etc.
- IDP Site populations may have higher rates of malnutrition than the surrounding community, which poses a risk in terms of reduced immunity to infectious disease.
- Residents of sites also share communal facilities such as communal kitchens and latrines.
- As a result, the populations of these sites may be at higher risk of contracting, and experiencing complications from, a virus such as COVID 19-19. This also puts the local community at an increased risk.

Projected sector needs

Site Management Support (SMS) actors will require human resources first and foremost, to support the cross-sectoral implementation of life-saving mitigation and response activities in IDP sites and their surrounding communities. Other sectoral needs are outlined in the budget table under Activities below.

It should be noted that at the time of writing, the SMS Working Group has only two members. The activities and costing outlined here are therefore designed primarily as support measures to the national authorities. However, as the hotspot locations emerging in preliminary analysis for COVID-19 planning, differ from those where SMS actors currently have presence, additional partners would be required, to reinforce support to Site Management.

Response strategy

All preparedness and response measures outlined below must aim to strike a balance – e.g. by improving living conditions (and thereby reducing beneficiaries' level of day-to-day exposure), while trying to mitigate the risk of exposure of and by humanitarian/government workers, in the course of implementation.

Site Management Support actors will support Site Management in these activities wherever possible, within the limits of public health measures which have reduced staff presence on the ground and pose an obstacle to scaling up/extending presence to new areas of intervention.

As a member of the SMS Working Group, UNHCR will act as a liaison to ensure that best practice measures being developed for IDP Sites are also being coherently applied to refugee camps.

1. Site/Area Coordination, including Information Management

Given the cross-cutting nature of COVID-19 mitigation and response in IDP Sites and their surrounding communities, Site Management Support's primary contribution will be through the provision of guidance and coordination support to National, Regional, Zonal and Woreda authorities, including by linking these with the key relevant humanitarian clusters, such as WASH, Shelter and Health.

This includes the identification and prioritization of highest-risk locations (according to IDP presence, and gaps in shelter and WASH coverage, etc.), and planning of mitigation and interventions based on this prioritization.

Activities:

Working closely with WASH, Shelter/NFI and Health line Ministries and actors, support Site Management authorities to reassess the hotspot locations for risk of disease spread and whether IPC measures can be improved, including:

- Sharing of health referral protocols to all Government offices and agencies working in the site to ensure immediate reporting of suspected cases and referral where necessary to the designated Isolation Facility corresponding to that site, as well as dead body management protocols, taking into consideration the limited space in many IDP sites.
- Support the families of those isolated to receive necessary food in case the isolated person is the household head – this will require coordination with the line ministry and distribution actors for food.
- Family childcare – though children are thus far not observed to be at highest risk of severe infection or death, parents and grandparents may be affected and Sites may need to upgrade their capacity to care for children left at home if parents are sick. This may include community support through neighbors.
- Education – current school closures in Ethiopia may be extended – input from Education and Child Protection line Ministries and actors will be required on how to address large numbers of children without daily activities, who may spread the disease if movement is not restricted.

2. Site Planning & Upgrading

Site Management of IDP Sites has the responsibility to ensure that living conditions meet minimum standards, including in the areas of WASH, Health, and Shelter. SMS will work closely with local authorities and Shelter actors to identify locations in need of decongestion and/or partitioning (e.g. sites where IDPs reside in communal spaces).

Activities:

- **Supporting National authorities and local Site Management on:**
- Flow patterns – where possible, introduce "one way" systems for pedestrians to reduce congestion and contact (allowing people to move in a single direction to and from a market, clinic, WASH facilities, etc. in sites).
- Timing of use of areas – consider whether scheduling of use of communal facilities (e.g. kitchens, WASH facilities, etc., needs to be introduced by block/zone, to limit numbers of people present at the same time.
- Decongestion – ideally at least at family level, 1-meter minimum distance between the families' shelters or living spaces. Introduce separation tools (barriers) in collective sites, and advocate for more space wherever possible. This may require the support of Shelter and/or SMS actors.
- **Coordination with WASH line Ministries and actors to ensure:**
- Rapidly increasing hand washing stations, at all possible points of concern (e.g. 1 per communal shelter/block of individual shelters; 1 per communal kitchen; 1 or more at the site entrance, etc.)
- Hand washing and WASH committees dedicated to training and monitoring and peer pressure to other camp residents to ensure regular handwashing and regular high-touch surface cleaning, disinfection, etc.

3. Community Participation, including Communication with Communities (CwC)

Site Management is also responsible for disseminating crucial humanitarian information (Communication with Communities/CwC). SMS actors will support the authorities to disseminate information where possible, including through liaison with the Risk Communication TWG, using the latest, approved, official public health and hygiene promotion messages, and within the limits of social distancing measures.

Activities:

- Clear information dissemination at all levels on the risks and prevention measures, including social distancing –NB: avoid attracting crowds when awareness raising; instead broadcast official public health messages by PA system (e.g. mounted on a vehicle).
- If feasible, this may include remotely mobilizing already trained Site/Community Committees by telephone, to be prepared to correctly answer community questions on COVID-19 and public health measures.

4. Capacity Building (for staff, authorities, partners and other stakeholders)

Traditional Site Management training takes place in person, in groups. In the COVID-19 context, SMS will instead provide on-the job coaching and support to key national stakeholders, remotely and in-person (where feasible/permitted), sharing lessons learned on COVID-19 mitigation and response from the other country operations and the Global CCCM Cluster.

Activities

Detailed activities are outlined until the four Pillars above. Priority activities are highlighted as follows:

Priority activities	Target	Budget – USD $
Coordination and support to/between key national and sub-national stakeholders, including authorities and humanitarian actors.	1,150,000	1.75M
Dissemination of public health/HP message, including through partners, using IEC materials, vehicle-mounted PA systems, etc.	1,150,000	250,000

FOOD

People targeted

10.0M

Financial requirements (USD)

423.3M

Impact of COVID-19 on the sector

The food sector is currently responding to food needs of 5.9 million people through the 2020 Humanitarian Response Plan (HRP), including to some of the most vulnerable groups such as IDP communities. The outbreak of COVID-19 will have a negative impact on both cash and food distribution processes.. Some of the necessary steps that are usually involved in the food sector response will have to be suspended, including beneficiary verifications at distribution sites, post-distribution monitoring, and on-site distribution monitoring exercises.

In addition, Food Cluster partners will adjust the distribution process to ensure social/ physical distancing when collecting food rations. This will increase the time required to complete food distributions. The Food Cluster and partners will also involve health officials during the food distribution process to ensure that good hygiene practices are implemented at food distribution sites. In collaboration with health officials, a coordinated approach will be applied on raising community awareness on how to prevent the spread of COVID-19. It is likely that there will be delays in moving in-kind commodities from warehouses to final distribution points as a result of additional measures that partners and the government will have to take in order to prevent the spread of COVID-19.

Cash distributions will also need to be reviewed. It is possible E-payments will start being implemented to replace the current distribution through envelopes. The COVID-19 outbreak will also have a negative impact on supply chains including food supplies to markets in areas where cash transfers are implemented. Partners will have to enhance their monitoring of market prices and availability of basic commodities in markets, and provide evidence for potential adjustments to cash transfer values or switch of modality to in-kind distributions.

Projected sector needs

The COVID-19 outbreak will likely contribute to increased food insecurity, especially in communities where there are existing challenges with physical and economic/ financial access to food. In certain urban communities, it is projected that disruption in supply chains of food and non-food commodities will contribute to reduced food availability. Urban households that depend on market purchases will be the worst affected if there is significant disruption in movement of commodities to markets. In rural communities, pastoralists households will also have limited access to staple foods since the majority of these households rely on purchases from the local markets. The COVID-19 outbreak will therefore affect the three pillars of food security:

- Food availability: movement of food commodities from surplus producing to deficit areas will be heavily affected. This will negatively impact access to both staple foods and fresh food items, particularly in communities where households rely on market purchases. This includes poor households in urban communities where informal income sources will be reduced in the context of the COVID-19 outbreak. In rural communities, very poor and poor households from both agro-pastoral and pastoralist communities will also face challenges in accessing food from markets.
- Food access: The outbreak of COVID-19 will negatively impact physical access to food in areas where households are already facing deficits due to other factors such asbelow normal rains and displacements. Non-beneficiaries will not have access to adequate supplies of food in markets, which will reduce the diversity of food items consumed by households. Incomes for households in informal sectors will likely be reduced during the COVID-19 period, worsening the food security situation in affected households. Income from cash crops such as coffee and khat/qat could also decrease significantly if there is a decline in exports. This will affect not only cash crop producers, but also workers in the these sectors who risk losing their jobs. A reduction in foreign income will impact both rural and urban households. Food prices are already unseasonably high, further increases will therefore worsen the food security situation.

- Utilization: Households will have additional needs for items required for food preparation, such as water and fuel. Some of the food items in the basket will also require pre-processing steps including milling, which will add an additional cost for the targeted beneficiaries.

Based on the above impact on the food security pillars, it is projected that additional people will require food assistance, including people 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:

- The national food poverty index is estimated to be 24 per cent which indicates that 24 million people will be vulnerable to food insecurity.
- 8 million people are already included in the PSNP plan and the transfers are being implemented in all targeted regions.
- The HRP is targeting 5.9 million food insecure people and resources are being transferred for the first two distribution rounds. The Government and partners are also expected to moblize resources to respond to identified HRP requirements.
- Therefore an additional 10 million food insecure people will require emergency food assistance.

Response strategy

- The most highly affected people will include some of vulnerable people in urban communities, where there are no ongoing humanitarian activities. The Food Cluster will therefore work with relevant government departments and urban municipalities in targeting of food insecure people.
- In exceptional circumstances, there will be a need for pre-cooked food items that will be provided to households that have no access to cooking facilities.This includes individuals in quarantine or isolation facilities or those deported from other countries. NDRMC will coordinate with relevant government department to ensure the provision of nutritious food baskets.
- The food basket will consist of the standard food basket of cereals, pulses and vegetable oil. Additional food items (CSB, biscuits) will be provided to the most vulnerable individuals including households with elderly members, pregnant and lactating women and children.
- In addition to the food basket items, the Food Cluster will also consider providing support for milling and cooking costs (utensils, fuel) in areas where there is limited access to these items.
- The Food Cluster will also coordinate with relevant government departments and ministries to ensure good hygiene practices at distribution points. This will also include the implementation of food distribution guidelines that were developed as a result of the COVID-19 outbreak for distributions to beneficiaries targeted in the HRP. These guidelines advocate for partners to sensitize beneficiaries on social distancing and to provide hand washing facilities at distribution points with adequate water and soap supplies.

Activities

- Mobilization of resources by the Government and international partners to respond to additional food needs.
- Identification of partners to support with implementation of response activities, particularly in urban communities.
- Procurement of food items.
- Geographic and beneficiary targeting of beneficiaries.
- Distribution of food to targeted beneficiaries.

Priority activities	Budget – USD $	Remark
Food distribution in targeted areas	USD388.3 million	Cost for food response to 10M people, who are projected to be food insecure due to the COVID-19 outbreak. This is in addition to food insecure targeted through the HRP.
Food distribution to people in isolation or quarantine centers	US$26.5 million	
Enhancing food distribution process and activities.	US$8.5 million	Activities will include good hygiene practices and awareness of beneficiaries to prevent the spread of COVID-19.

HEALTH

People targeted

39.0M*

Financial requirements (USD)

430M

Impact of COVID-19 on the sector

In Ethiopia, the healthcare system is already over-stretched. If there is a rapid and exponential increase in the number of confirmed COVID-19 cases in the country, similar to what we have seen in China, Europe, and the United States, then the healthcare system will become totally overwhelmed. The lack of healthcare facilities, supplies, and access to timely and quality healthcare could lead to a high mortality rate among infected people in the case of a full COVID-19 outbreak. At the same time, as most health resources in the country will shift to the COVID-19 response, patients with other illnesses and health issues are less likely to receive the treatment and care they need which could lead to an increase in severity and mortality. This highlights the need to flatter the COVID-19 curve through timely and coordinated health and non-health interventions.

Projected sector needs

Since 13th of march when the first Covid-19 case was announced in Ethiopia, several cases have been identified, most of which were imported, and the rest linked to imported cases (clusters). Ethiopia has also been classified as one of the high-risk countries. All neighboring countries have also reported confirmed cases.

The number of expected cases for the response was calculated to be 34,068 confirmed cases per month. The following assumptions were made:

- 21% of the population lives in urban areas and are considered at risk;
- 50% of the rural population was at risk given the sparse population distribution;
- About 20% testing capacity nationally.

Based on these assumptions, it was thencalculated that a total of 66.5 million people would be at risk. Taking into account the herd immunity (R0 – 1)/R0 is 60%, 39m people were expected to become infected with COVID 19.

In addition to this, according to a lancet publication, the risk of infection decreases by 60% if measures including social distancing are put in place. Ethiopia has implemented a series of measures including avoidance of mass gatherings, social distancing, and risk communication including the advocacy for hand washing, reducing the risk to 60%. However, since the measures are not stringent it was assumed that the risk was 30%. With the current non-health measures of social distancing, the peak of the epidemic may be delayed and reduced.

This plan was developed assuming that the expected number of COVID-19 cases will amount to approximately 102,000 cases within the next three months.

* The health sector targets 39 M people. However, the multi-setor plan targets 10 million people who are expected to have multi-sector needs.



Source: WHO, 2020

1. Coordination and leadership pillars

S/No.	Proposed Intervention	Activities
1	Strengthen national coordination	Revise stakeholders mapping
		Conduct biweekly meeting with stakeholder
		Conduct EOC inter-pillar weekly meeting
		Complete and disseminate operation plan
		Disseminate national guidelines and SOPs
		Conduct regular risk analysis (venerability
		Interface with NDRMC EOC
3	Support regional coordination	Conduct regional capacity assessment
		Review and support the preparation of regional EPRP and operational plan
		Conduct simulation exercise
		Support reginal EPRP activation/operationalization/ sub- regional PHEM structure
3	Strengthen resource mobilization	Conduct gap analysis internes of resource/forecasting
		Develop strategy for resource mobilization and disseminate it
4	Health workers capacity building	Map trained health workforce
		Develop a surge roster
		Conduct training
		Deploy health workforce
5	M&E framework	Develop KPIs strategy/plan
	Develop KPIs strategy/plan	Disseminate KPI plan to relevant stakeholder
		Develop and monitor reporting dashboard
		Prepare and disseminates periodic reports to relevant stakeholder
		Conduct need assessment for ICT interventions
		Help coordinate the selection of relevant technology and implement elaborate on it

2. IPC case management and facilities readiness

S/No.	Proposed Intervention	Activities
1	Expand isolation, treatment and quarantine sites	Establish and support 300 Isolation centers with bed capacity of 200 for each
	Train and deploy adequate number of IPC and clinical team	Establish and support 34 Treatment centers with bed capacity of 400 for each
	Develop and share IPC,CM and Facility Readiness support plan to regions and key stakeholders	Establish and support 100 quarantine centers with bed capacity of 500 for each
		Train and deploy adequate number of physicians (1,360), critical care specialists (204), and nurses (2,720)
		Train and deploy adequate number of IPC experts (10,000)
		Develop costed plan with indicators
		Share the plan with all relevant stakeholders
2	Develop and implement M&E framework including digitization	Support and monitor the implementation
		Develop and implement standardized data capturing and reporting formats
		Procure and distribute computers with database
		Develop and implement electronic data registration, monitoring and reporting system
3	Support the ME and Supplies forecasting, procurement and distribution task of the EOC	Support forecasting, distribution, and management of medical supplies and medical equipment
		Monitor and report consumption of medical supplies and medical equipment
4	Provide the required medical equipment, supplies and IPC materials	Distribute all the procured supplies and equipment based on need
	Provide biomedical technical supports	Improve efficiency of supply utilization and management
		Provide emergency biomedical technical supports through deploying a team of biomedical experts
		Conduct ambulance need assessment and develop plan of action
5	Strengthen ambulance management	Procure and deploy 300 ambulances equipped with basic life support materials
	Develop and implement health professional safety and support protocol	Distribute procured ambulance for regions based on their need
		Strengthen ambulance management system
		Hire, train and deploy personnel (sprayers (300), nurses (600)) working in ambulances
		Develop health professional safety and support protocol
		Support and monitor implementation of health professional safety and support protocol

3. Surveillance and laboratory Pillars

S/No.	Proposed Intervention	Activities	Time line
1	Have trained contact tracing team	Establish 33,334 contact tracing teams (each team with 2 people)	April, 2020
		Training for 66,668 contact tracing experts	April, 2020
	Avail logistics and PPEs for contact tracing team	Avail vehicles for each contact tracing team (33,334)	April, 2020
		Face mask for contact tracing team	April, 2020
		Hand sanitizer for contact tracing team and driver (600,012 bottle)	April, 2020
2	Expand laboratory to peripheral level	Expanding the testing capacity to 19 sites throughout the country (adding Hospitals both Referral and teaching Hospitals consider the new GeneXpert)	April, 2020
	Capacity building to facilitate sample collection and transportation	Establishing sample transportation system at each woreda level	April, 2020
		Training for laboratory technicians/technologists at least one from each woreda	April, 2020
3	Expanding call centers to regional level	Establish call center for 11 regions and city administration at least with a capacity of 20 lines	May, 2020
		Avail 1320 call center experts for 11 regions and City Administrations	May, 2020
	Enhance the capacity of EPHI's call center	Avail additional 24 call center lines in EPHI	April, 2020
		Avail total of 288 experts for call center (EPHI level)	April, 2020
4	Have trained rapid response team	Establish 24000 rapid response team? For 4000 RRT per health facilities and 2000 RRT per/10000 woredas	May, 2020
		Training for 28,000 RRTs (16,000RRT members in health facilities, 4000 RRT supervisor recruited per facilities and, 8000 RRT members per woreda)	May, 2020
	Avail logistics and PPEs for RRTs	Avail 2000 Ambulances and accompanying vehicles	April, 2020
		Avail all PPEs used to manage 100,000 cases	April, 2020
6	Use electronic reporting system	xxxx tablets/smart phone for RRTs and contact tracing and follow up trams	April, 2020
		Avail one server at each region and one additional at EPHI (a total of 12)	April, 2020
	Improve data management system	Avail 1182 computers for woredas and zones	May, 2020
		Assign 1116 data managers	April, 2020
		Supportive supervision	May, 2020
		Regular data analysis and feedback	Routine

POE

S/No.	Proposed Intervention	Activities	Time line
1	Engagement of regional higher administrative organs to give attention on the regional PoEs screening activities	Notify regional PHEM office via official letter to strength screening activities at land crossing POE	May 30,2020
		Give orientation/training for 68 land crossing POEs screeners & 18 domestic airports	May 30,2020
		Give training/orientation for all stake holders at POEs	Until May 30,2020
		Conduct supportive supervision for all POEs weekly	Until May 30,2020
2	Engagement of Telecommunication higher administrative Official to solve the problem	Design a reporting mechanism from POEs to EPHI using ODK(avail tablet which can take Sim card) or using Wifi modem	Until May 30,2020
3	Enforcement of the establishing of TIU and screening post at all PoEs (at Togo wuchale,Dawale, Lugdi, Moyale,& kumruk) on the 1st phase	Establish 05Temporary isolation center at POE using fiber material as per design	Until May 30,2020
		Equip established temporary isolation unit with necessary supplies and equipment	
4	Arrangement of the Ambulance linkage between PoEs and Treatment Units through discussion with Regional Heath Bureau	Assign at least 2- ambulance at international airports per shift for 24hrs POEs & 1-per domestic airport	Until May 30,2020
		Assign at least 2- ambulance at international airports per shift for 24hrs POEs & 1-per domestic airports	Until May 30,2020
5	Assessing the gap and assignment of required man power at all PoEs & Gate/entrance of Regions, Industrial park, refugee camp, major cities & domestic airports	Assign a minimum of 2-screeners at each land crossing POEs, Gate/entrance of Regions, Industrial park, refugee camp, Gate/Entrances of major cities & 4-at domestic airports	Until May 30,2020
		Assign min of 30 staffs at BIA per shift	Until May 30,2020
6	Procurement of more infrared thermometer for land crossing and thermal camera for all International airports	Procure 286 infrared thermometer	Until May 30,2020
		Procure 20 thermal camera for airports	Until May 30,2020
7	Strengthen filling of traveler's health declaration form by passengers on board	Strictly follow the implementation of filling traveler's health declaration form on board	Until May 30,2020
8	Engagement of Ethiopian Airports enterprise higher officials & other stake holders at POEs to solve weak coordination between POEs and other stakeholders at all POEs	Continue virtual meeting with COVID-19 BIA command post members to solve all issues related with screening activities and implement mandatory quarantine at hotel for passengers coming from abroad	Until May 30,2020
		Activate command meeting with stake holders at land crossing POEs stake holders	Until May 30,2020
9	Identification of illegal PoEs and establishing of new PoEs by setting priority based on its potential risks.	Work with legal enforcement bodies (Federal police/ army) to prevent illegal arrivals	Until May 30,2020
10	Strengthen screening and establishing TIU activities different place	Establish 4-screening sites and TIU at Addis Ababa main Gate /entrance in four direction of AA	Until May 30,2020
		Establish Entry and exit screening and site at all regions	Until May 30,2020
		Establish screening sites and TIU at major industrial parks	Until May 30,2020
		Establish screening site and TIU at all domestic airports	Until May 30,2020
		Establish screening site and TIU at refugee's camp	
		Establish screening site and Tiu at Major farms	Until May 30,2020

S/No.	Proposed Intervention	Activities	Time line
1	Train volunteers and link them to health and social services	Map community volunteers for training and deploy them to reach	March 30
		Map key stakeholders working with volunteers to reach key population (vulnerable and at-risk communities)	April 1-4
		To customize BCC materials to target the key population	March 26 – April 24
		Adapt RCCE strategy for scenario 3 to reach key population	April 6-16
		mobilize communication aids such as megaphones, mobile vans, etc.	March 30
2	Engaging and supporting regional health bureaus with a multi-sectoral approach	Partner with key stakeholders at zonal and woreda level to sensitize their existing networks	
		Provide RCCE guide orientation for various sectors and regional leaders	
		All developed guides should be signed and officially communicated	
3	Have a regional visit to promote trust and information sharing	Establish a telegram group communication platform with regional RCCE to increase collaboration	
		Conduct support supervision/ field visit to regional RCCE	
4	Communicate ground feedback to government for strict action	Communicate ground feedback to government for strict action	
		Revision of community engagement guide to reflect the current COVID-19 situation	
		Revision of COVID-19 Government, Non-pharmaceutical intervention (NPI) community guide	
5	Intensify public awareness and campaigns to various group	Customize, produce and disseminate NPI messages to target audience	
6	Customize messages for targeted communities to engage them	Undertake perception assessment among the public	
		Develop short educational messages to reach communities	
7	Empower community volunteer with information on how to reach targeted community groups	train volunteers to reach targeted community groups	
		Mobilize communication aids such as megaphones, mobile vans, etc	
		Equip volunteers with job guides/aids	

Priority activities	Target	Budget – USD $	% Contribution
Coordination and Leadership	214,286,960	6,533,139	2%
Surveillance and contacting tracing	5,887,513,272	179,497,356	42%
Laboratory	714,489,755	21,783,224	5%
Case management and IPC	6,104,335,558	186,107,791	43%
Points of Entry (POEs)	174,314,436	5,314,465	1%
Risk Communication and Community Mobilisation	895,242,000	27,293,963	6%
Evidence generation and operational research (1% of total budget)	139,901,820	4,265,299	1%
Total	**14,130,083,802**	**430,795,238**	

LOGISTICS

People targeted

10M

Financial requirements (USD)

59.7M

Impact of COVID-19 on the sector

The outbreak of COVID-19 presents an unprecedented challenge across the world and to the African continent, especially in countries where fragile security contexts or weak health infrastructures further complicate prevention and response efforts. Efforts to adequately prevent or respond to the crisis are further exacerbated by global logistical constraints imposed by movement restrictions on people and goods. At present, more than 107 countries have enacted nationwide travel restrictions and border closures, disrupting the free flow of goods and persons across the world.

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, etc. In effect, the movement restrictions result in direct consequences for the humanitarian community including on the availability of humanitarian items, fuel, and other essential needs. Disruptions in humanitarian supply chains put the continuation of services, projects, and programmes in jeopardy and complicate efforts to adequately scale-up and respond to the potentially exponentially increasing needs.

With access to essential logistics services limited in this context, including air support, warehousing, etc. preexisting humanitarian operations are significantly threatened and with the potential for an exponential increase in humanitarian needs related to COVID-19, additional humanitarian response to COVID-19 may be compromised should restrictions on movement remain in place.

In Ethiopia, where the logistics sector was already defined by congestion at the port of Djibouti, affecting timely delivery to Ethiopia, limited availability of transporters and inadequate contracting procedures, limited availability of adequate storage capacity, limited logistics supply chain coordination, and limited information sharing, the impact of COVID-19 will be significant on logistics operations. Humanitarian commodities are transported mainly through the Port of Djibouti and closure or scale-down of the port will impact humanitarianassistance. Any import or export restrictions of emergency shelter, food, and non-food items supplies from China and other countries will adversely impact the response and local procurement will not be feasible given that most supplies originate from China and other parts of the world.

Projected sector needs

As part of the overall Global Response Plan for COVID-19, logistics is at the forefront of response serving the entire humanitarian community, including the UN and NGOs, providing essential support to supply chains and the movement of humanitarian actors. Given the movement constraints and the potential for a significant increase in humanitarian requirements related to COVID-19, the Logistics Cluster expects a similar rise in need for logistics services from the UN, humanitarian and other partners to facilitate quick and timely response.

In Ethiopia, where logistics infrastructure is already weak, the coordination and leadership of the Logistics Cluster will enable a coherent response to the outbreak.

Response strategy

In accordance with the WFP COVID-19 Global Operational Plan, WFP has identified three priority objectives:

- Objective 1: Sustain WFP Operations
- Objective 2: Enable the Global Health and Humanitarian Response
- Objective 3: Track Impacts and Inform Decision-making

The re-activation of the Logistics Cluster in Ethiopia is aligned to Objective 2, wherein WFP will reinforce its supply chain and logistics network at the request of UN and NGO community and will extend

its supply chain infrastructure, assets, and partnerships to serve the wider humanitarian and health community.

The logistics response will focus on air assistance to the continent, and in line with previous recommendations from the last activation of the Logistics Cluster in Ethiopia, will focus on information management, coordination, and augmenting operational capacity.

Amidst disruptions to commercial air and sea traffic, port restrictions, and border closures, WFP through the Logistics Cluster, will support the effective and efficient delivery of the health and humanitarian response through the establishment of a humanitarian hub at Bole International Airport to provide onward logistics (including storage, handling, etc.) and air services to the rest of the continent.

Activities

1. Information Management (including GIS): The Logistics Cluster will provide essential information management support, including GIS mapping, to enable a smooth and coherent flow of relevant information to all partners, from Government to NGOs. To bolster information management and provide clear cargo tracking, the Logistics Cluster will use its system for cargo tracking along and reinforce Government's humanitarian tracking.

2. Coordination: The Logistics Cluster will provide the fundamental link to overall logistics efforts across the country and the continent, through enhanced coordination activities and technical support provided to enhance collaboration between relevant authorities from the Government of Ethiopia and humanitarian partners, to minimize duplications of efforts and streamline logistics activities and ensure efficient utilization of existing assets. Moreover, the Logistics Cluster will facilitate regular meetings with key representatives to identify logistics challenges and propose mitigating activities

3. Augmenting Operational Capacity: The Logistics Cluster will augment surface and air transport to facilitate timely and potentially quickly changing support to the Government and humanitarian partners. Surface transport will be capacitated through supply chain capacity strengthening services including training and strengthening existing partnerships with the Ethiopian Maritime Affairs Authority (EMAA), the Federal Transport Authority (FTA), and the Ministry of Transport.

As the existing transport capacity may prove to be insufficient to facilitate a response to high humanitarian demands, truck capacity may be augmented.

Through the preexisting air network structures of Ethiopian Airlines and UNHAS Ethiopia, 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, along with the provision of storage services in the form of mobile storage units (MSUs) and mobile cold storage units. Forward hubs structures will serve to increase operational capacity for staffs and comprise of prefabs equipped with generator and other equipment which can easily be moved in case of urgent outbreaks or reprioritization of emergency response and easily shifted between domestic airports, relying on Ethiopian Airlines and UNHAS Ethiopia.

4. Advocacy: Through its information management and coordination activities, WFP will advocate for the continued access to the country via preexisting humanitarian corridors, i.e. Djibouti and Berbera, and the prioritization of essential humanitarian cargo. WFP will reinforce upstream supply chain planning coordination with key stakeholders to ensure timely clearance and delivery of cargo. In the event that the Djibouti port is cut-off or movement is denied, the Logistics Cluster will advocate for access to and from other corridors including Sudan, Kenya, Uganda, etc.

Priority activities	Budget – USD $
Increase storage capacity	US$ 10m
Cold storage	US$ 4m
Air transport operation	US$7.1m
Staffing capacity	US$9m
Cargo tracking	US$3m
Capacity Strengthening	US$5m
Forward hubs	US$3m
Augmentation of transport capacity	US$12.6m
Logistics support equipment	US$6m
Total	US$59.7m

NUTRITION

People targeted

280k

Financial requirements (USD)

17.0M

Impact of COVID-19 on the sector

Acute malnutrition is expected to increase due to a deteriorating food security situation (compromised access to markets, high food prices), and access to health and nutrition services are/will be compromised.

The delivery of the ongoing Nutrition response is already becoming complex notably due to the following:

- Coordination mechanisms are not fully functional especially at sub-national level, e.g., Health and Nutrition Task force meetings in some regions and Zones are no longer taking place.
- The regular monitoring of the nutrition situation is weakened as Rapid Nutrition Assessments (RNAs) and Nutrition surveys are temporally suspended.
- Campaigns such as CHD may not take place anymore hence, halting mass MUAC screening exercise may lead to late identification and referral of acutely malnourished children
- Training on acute malnutrition management are suspended (cascade training for the roll-out of the revised guidelines on the management of acute malnutrition) as well as a Nutrition in Emergencies (NiE) training is postponed.
- Components of Nutrition program monitoring is halted (Review meetings suspended, CMAM program coverage evaluation suspended).
- The delivery of CMAM services (both for SAM and MAM treatment) are hindered by new COVID-19 measures such as the banning of large gatherings and implementation of social distancing. This is having an impact at health facilities and TSFP sites. The adoption of EPHI/WHO recommended precautions and necessary program adjustments are complex to implement and have financial implications that were not forecasted in the budget of ongoing responses.

Projected sector needs

The numbers of SAM and MAM cases (additional to 2020 HRP targets) due to consequences of the COVID-19outbreak and its multifaceted consequences are estimated to revolve around 35,000 SAM children admitted for treatment and 245,000 MAM cases (children and PLW) benefiting from TSFP. To note that these estimated figures are reflecting an anticipated increase in acute malnutrition that will span through a longer period than this 3-month response plan and might be subject to change as the situation evolves. Also, the timeliness and outcome of Belg rains will also be an important driver of the food and nutrition security situation in the short future. If Belg rains performances were to be sub-optimal acute malnutrition will further increase and the above estimates increase as well.

Response strategy

The priority is the continuation of life-saving CMAM services and roll-out of the recently revised National Acute Malnutrition guidelines. Efforts will be made to ensure and sustain activities that aim at early identification and referral of malnourished individuals. Surge support will be provided to enhance access to Nutrition services in remote and hard to reach communities including IDP/returnee sites through support to static and mobile health and nutrition services. . A priority will be put to protect, promote and support adequate infant and young child feeding (IYCF) practices and to integrate IYCF activities across all interventions. In close collaboration with the Health and WASH Clusters, a multi-sectoral response (minimum integrated package) will be implemented is most at risk woredas (with high acute malnutrition, high incidence of infectious disease and high WASH needs).

The nutrition response strategy will be to ensure continuity of the delivery nutrition services and will focus on the following specific objectives:

- To ensure continued provision of timely access to live-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 IYCF-Emergencies (IYCF-E) and integrated IYCF-E in all component of the response.
- To support the disseminate key messages including EPHI Covid19 messages and messages on adequate family practices, hygiene practices (hand washing), and adequate childcare practices to be included in the Risk Communication and Community Engagement part of the response.
- To support and to contribute to coordination mechanisms jointly with NDRMC, FMoH and EPHI at national and sub-national levels to strengthen the health system and its response capacities.

Activities

- To immediately adopt necessary program adjustments to limit the propagation of the Covid-19 and contribute to the ongoing Health response;
- To contribute to support the EPHI-led technical EOC and their thematic TWG at Federal and regional levels;
- To collaborate and coordinate with NDRMC, FMoH and EPHI to harmonized and integrate the dissemination of official recommendations and guidance notably on:
  - Temporary suspension of large gathering at the health facilities (HFs), MHNT sites, TSFP sites and to ensure better crowd control measures
  - Temporary suspension of nutrition surveys and nutrition-related assessments.
  - Temporary suspension of classroom training/ workshop/review meetings.
  - Support the adoption of WHO recommended precautions related to hygiene and social / physical distancing at the HFs, MHNT sites, food distribution and community mobilization sites – in all components of the CMAM and IYCF programs.
  - Replicate and disseminate existing EPHI Covid-19 IEC materials (jointly with local health authorities support any required translation; and other means of conveying key messages)
  - To intensify and integrate hygiene promotion (hand washing) in all Nutrition activities
- To support preparedness and response planning for the worst-case scenario / most critical phase of the outbreak including for the pre-positioning of nutrition supplies and medicines and to anticipate on nutrition supplies dispatch arrangements to avoid gaps in provision of CMAM services.

Table 1. Estimated targets (country-wide, additional to 2020 HRP targets)

	Targets
SAM admissions U5	35,212
MAM admissions U5	138,498
MAM admissions PLW	106,313
Total	**280,023**

Table 2. Financial requirements

	Targets
SAM treatment supplies	2,464,840
MAM management supplies	11,957,738
NGO surge support in 30 woredas (6 months)	2,550,000
Surge staffing and Social mobilization	60,000
Total (USD)	**17,032,578**

Priority activities	Target	Budget – USD $	Remark
To ensure continued provision of timely access to live-saving quality treatment of acute malnutrition	35,212 SAM and 244,811MAM cases	$17,032,578	Children under five and pregnant and nursing mothers among the general population and displaced population
To protect, promote and support adequate IYCF-E practices.			
To disseminate key messages on adequate family practices, hygiene practices (hand washing), and adequate childcare practices.			
To support and to contribute to coordination mechanisms jointly with NDRMC, FMoH and EPHI, to strengthen the health system and its response capacities.			

PROTECTION

People targeted

3.9M

Financial requirements (USD)

15.3M

Impact of COVID-19 on the sector

Historical evidence (including the Ebola outbreak in East Africa) suggests that the COVID-19 situation will directly or indirectly adversely impact the protection situation of vulnerable populations groups, including for IDPs, older persons, persons with disabilities, detainees and homeless populations, persons with long-term chronic illnesses, women and girls, and vulnerable children. In the most serious scenario of widespread community transmission of COVID-19 in Ethiopia (scenario 3#), there will be a range of protection issues, not least driven by the social-economic consequences of COVID-19, which will impact different groups. Existing vulnerabilities are likely to be exacerbated, while new vulnerabilities are likely to arise and these need to be carefully monitored by all responders (Government Ministries, agencies and NGOs) and prioritized in preparedness and response. Some protection risks are as follows:

- Increased socioeconomic vulnerability due to loss of livelihoods, resulting in higher reliance on negative coping mechanisms such as early marriage, and child labour, and potentially transactional sex, increasing protection and transmission risks.
- Increased social tensions and stigma of persons perceived to be affiliated with, or affected by the disease, resulting in discrimination in the provision of services and social exclusion;
- Potential growth of inter-ethnic distrust and political violence over the response;
- Increased levels of stress and anxiety; Psychosocial distress may increase with fear around the virus, particularly for families already under stress from displacement and conflict, and children whose routines have been disrupted.
- Increased level of difficulty faced by persons with disabilities, older persons and those who are suffering from chronic illness in accessing basic-critical health care services due to increased discriminatory behaviours, neglect, and exclusion;
- Increased risk of eviction linked to socioeconomic vulnerability resulting from the loss of livelihoods or linked to discrimination against persons who have contracted the virus;
- Child protection risks including possible separation of children from primary caregiver, physical violence and neglect;
- Increased risk for women and girls of domestic violence, workplace violence in the health sector, racial and sexual harassment, and abuse and exploitation; Humanitarian settings already increase women and girls exposure to GBV and intimate partner violence. With strategies such as 'shelter-in-place' and other movement restrictions, combined with the fear, tension, and stress related to the COVID-19 outbreak, it is likely the risk levels will be exacerbated.

At-risk groups:

Women and girls: Women and girls are particularly vulnerable to exposure as the most-likely first-line health workers, health facility service staff (e.g. cleaners, laundry) and as primary care providers in the home. In Ethiopia, social norms and customs largely dictate that women and girls play the role of caretakers of the family. This can mean giving up work to care for children out of school and/or persons with disabilities and family members who are sick or have long-term chronic illnesses, increasing exposure to the virus, as well as causing economic hardship-leading to potential negative coping mechanisms. Pregnant women are also more susceptible and may lack access to health care as health services get overwhelmed. Gender-based intimate partner violence is also expected to increase due to the containment measures (women having to live in isolation with little recourse to access resources and services), compounded by the disruption of support services.

Overwhelmed health services may hamper women's access to sexual and reproductive health, especially natal services and access to family planning, potentially leading to a rise in unwanted pregnan-

cies and exacerbating preventable maternal deaths.

Internally displaced people and refugees: IDPs and refugees who have been forced to flee their homes to due violence and human rights violations will also be at higher risk of immediate and longer-term effects of the pandemic as their social support networks are often fragmented and coping mechanisms already stretched. IDPs living in informal settlements/site have a higher risk of exposure due to overcrowding, which can exacerbate infection rates. Access to basic services and humanitarian assistance may also be limited as the focus shifts to COVID-19 response

Persons with chronic health conditions: COVID-19 may strain other medical services, and the reduced availability of medical resources can worsen different types of health conditions, such as high blood pressure, heart conditions, asthma, and other health and mental disorders. Some people with conditions such as HIV/AIDs may face discrimination which prevents them from accessing health assistance.

Persons with disabilities and older persons: On average 17.06% of the population has some type of disability(ies) in Ethiopia and they are among the most marginalized people in crisis affected communities and will be disproportionately affected at risk from COVID-19. Overwhelmed health services and persistent discriminatory behaviours and attitudes in the community may limit access to essential health care services, for persons with disabilities.

Persons with disabilities with mobility issues, those who have difficulty in seeing and hearing, as well as those with mental illness and learning difficulties may face obstacles accessing basic and essential health services due mobility issues, and the lack of accessible information.

Poor hygiene practice, lack of awareness and lack of personnel support due to an overwhelming family/community situation will further increase the risk of being contaminated by COVID –19 or receive medical care for persons with disabilities and others. Persons with disabilities and older persons will therefore need reasonable accommodation and necessary support and health care, and to take necessary steps in taking care of their need and protecting themselves from the outbreak.

Detainees and Homeless population: People who are detained in detention and prison facilities are vulnerable for the outbreak due to the congested living conditions. People who are living in street and does not have home are another category of people vulnerable to the COVID outbreak. Due to poor health and sanitation conditions, special attention should be given towards this population to prevent outbreak.

Children, Adolescents and Young People: Children may lose parental care when their caregivers die, are hospitalized, fall ill, or are quarantined; Children who are themselves hospitalized or quarantined may also be deprived of parental care; Children may also be sent by parents to stay with other family members of people in non- virus affected areas; Traditional cares support systems that would step in in the absence of parental care (extended family, community members) may be disrupted. These situations may lead children's increased exposure to neglect, violence and exploitation (including child labour).

Psychosocial distress, trauma and fear: Children may feel fearful as their families get sick and hospitalized. They may also feel insecure due to disruption to their familiar world, including the people, places and routines, such as restriction on mobility and closure of schools and churches. Children may experience stigmatization and social exclusion due to them or a family member having contracted the disease.

Exposure to violence, exploitation and abuse: Children may experience increased exposure to violence, including sexual violence, physical and emotional abuse as a result of caregivers and/or other adult members becoming increasingly distressed and using dysfunctional coping mechanisms (alcohol, substance misuse, etc.) to deal with the challenging environment;

People with diverse gender and sexual identities: Due to stigma and discrimination, people with diverse gender and sexual identities may have reduced access to information and health services.

Projected sector needs

As mentioned above, the outbreak of COVID-19 will adversely impact the protection situation of vulnerable and at-risk groups, exacerbating existing vulnerabilities and creating new ones. Due to the expected diversion of assistance towards the health response, social distancing measures and regional movement restrictions, critical protection needs highlighted under the 2020 HRP are not being addressed. The Protection Cluster estimates that around 148,000 individuals (and an additional 200,000 SMS beneficiaries) per month are no longer receiving protection services due to suspended activities/staff movements.

To be effective and accountable to all affected populations, the COVID humanitarian response plan (HRP) must:

1. Ensure continuity (and safety from risks of infection) of essential protection services provided for the most at risk population groups with specific needs;
2. Consider not only consider the different needs of women, girls, boys, and men, especially persons with disabilities, detainees and homeless populations, older persons and those who have long-term chronic illness but also that ensure containment measures do not result in additional risks/harm. Therefore all Government, UN, and NGO responders have the responsibility of ensuring protection mainstreaming, including mechanisms for complaints and feedback, throughout the COVID response plan.

Response strategy

In recognition of the criticality of protection, the response will prioritize adapting core protection services (see 2020 HRP) to ensure their continuity (wherever possible), while also concentrating on the identification of new protection risks resulting from the outbreak, and ensuring protection mainstreaming within the inter-sectoral response.

Protection actors recognize that limited information is currently available on protection risks associated with the COVID outbreak in the Ethiopian context; also, the fact that social distancing and other containment measures may require adaptation of core protection activities in which community interactions are usually a core component. Therefore phase 1 (3 months) of the response will prioritize the identification of key protection risks, mitigation of community tensions through information sharing and social cohesion interventions, and the adaptation of core protection services/activities (to ensure continuity). Phase 2 (subsequent 3 months) will include additional scale-up of activities (not in below budget) in response to identified protection risks and population groups/areas most at risk.

The protection response strategy will focus on the following specific objectives:

1. Ensure that the fundamental rights of population groups of concern (e.g. IDPs, host communities) who are particularly vulnerable to the pandemic are safeguarded; have access to information and assistance (including health services).
2. Ensure impartial, needs-based access to services (including health) and humanitarian assistance for the most at-risk, affected people; ensure accountable, participatory, and coordinated service delivery for affected persons.
3. 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 at community level.
4. Ensure the continuity (and safety from risks of infection) of essential protection services provided for the most at risk/vulnerable population groups with specific needs (see above) by government, humanitarian and development actors. The identification of protection needs and provision of these core services will ensure that affected communities, including women, adolescent girls, persons with disabilities and older persons, detainees and homeless populations, and children, are protected from violence, exploitation and abuse, receive response services, and benefit from risk reduction measures.

Priority activities	Target	Budget USD $
Protection risks, human rights violations and gaps in available service, are identified and addressed through protection monitoring established in affected regions to mitigate potential protection risks for people of concern; analysis and rapid protection assessment; access to basic services is enhanced through strengthened referral pathways and advocacy by protection monitors. Individuals receive information, counselling and technical/legal assistance on access to basic services, HLP and legal identity documents Protection actors and local authorities to monitor eviction cases, particularly among vulnerable groups, and facilitate rent support (see Shelter and advocate for measures to protect security of tenure and safe shelter to federal government/regional states Individuals of particularly vulnerable groups at risk of discrimination and exclusion receive information on rights, legal and justice services provided to community members, local government authorities including law enforcement and court authorities.	221,505 individuals	5,388,000
Protection cluster in coordination with humanitarian actors, to ensure the mainstreaming of protection across the multi-sectoral COVID-19 response. All actors to disaggregate data related to the outbreak by sex, age, and disability in order to understand the gender, age and other differences in exposure and treatment. Conduct gender and protection-analyses to identify inequalities, gaps, and capacities that should subsequently inform the response plan and implementation. All humanitarian actors to: ensure that testing and treatment should be available to all without discrimination, and measures should be taken to ensure that no one is denied for the lack of means, or because of their status. Community services to establish and support existing community governance structures, community awareness campaigns and community complaint and feedback mechanisms through which affected populations can measure the adequacy of interventions, and address concerns and complaints, including in isolation centres where possible.	Service providers, clusters, at-risk communities (20 woredas)	495,000
Enhance community-based protection structures and implement social cohesion strengthening interventions which promote community engagement in response decision-making. Conflict-sensitive community assessments and peacebuilding initiatives which prevent outbreaks of violence and conflict. In coordination with Ministry of Health, all clusters to develop communication material and distribute at the community level protection-sensitive awareness raising materials which is accurate, relevant and accessible on health risks associated with the COVID pandemic. In addition to health and hygiene promotion messaging, develop specific communication messaging on specific protection risks and mitigation measures, including related to gender based violence or separation of children and older persons. Messaging about COVID-19 will be translated into the languages spoken in targeted areas and should also ensure the use of different mediums (child and disability-friendly) which are accessible for those with hearing, seeing, mental illness and learning difficulties, in order to be easily accessible and understood by all.	575,228	1,282,074

Development and distribution of IEC materials targeting caregivers and children (including children with disabilities) on hygiene promotion, positive parenting, and specific protection issues related to COVID 19 (eg. prevention of child separation, GBV, child labour (due to livelihood impact), intimate partner violence, etc.) Continuum of case management work for CP and GBV and support in context of COVID 19 incl support to social workers with protective/hygiene items and remote case management work Case management support to children affected by COVID 19, including,-as a last resort (as all efforts are to be undertaken to keep families together) alternative care/family based care to children who are separated from their caregivers and families Together with Health sector, implement standard operating procedure for preventing/mitigating separation and including case management (social service focal point at health facilities, capacity building on PFA and CP referral, communication mechanism between children and caregivers who are temporarily separated due to quarantine, isolation, etc.) Support health service providers to integrate basic PSS services at health facilities (PFA, and GBV guiding principles) Regularly assess and update CP and GBV referral pathways and print and disseminate them. Regularly assess availability of heath response services for GBV survivors, in collaboration with health cluster, and procurement and distribution of post rape treatment kits Procurement and distribution of dignity kits for women and girls of reproductive age. Provide targeted MHPSS support to children women and GBV survivors and caregivers that have been affected (directly or indirectly) from the COVID-19, including children in quarantine, children out of school etc. Targeted psychosocial support interventions for at-risk communities Government and humanitarian agencies to ensure service providers at all levels (regional to woreda level) are supplied with adequate personal protective equipment, and/or remote working equipment to continue service provision while ensuring no risk of infection to staff or clients.	3,133,500	8,140,000 USD

WASH

People targeted

10.0M

Financial requirements (USD)

152.3M

Impact of COVID-19 on the sector

- Due to limited social gathering, distribution of WASH supplies at IDP collective sites and affected community and mass mobilization on hygiene practice needs to be reconsidered;
- Negative impact is expected on limited mobility of humanitarian WASH staff and logistics;
- Not only 5.2 WASH target population, general public who do not have regular access to water and hygiene facilities (handwashing) are negatively affected.
- Hospitals as isolation centers and its WASH service conditions may affect people diagnosed as positive cases during isolation
- Poor hygiene facility and lack of hygiene materials might severely affect frontline health workers
- Coordination needs between development sector and humanitarian cluster is significantly observed as WASH preparedness and response to Covid-19 would require not only short-term life-saving response but also sustainable improvement on access to WASH services among general public as well as at institutions like schools and health centers

Projected sector needs

To strengthen preventive measures among general public, stable and reliable water supply service together with handwashing facilities and hygiene kit are necessary in the entire country. However, limited access to basic WASH services poses a big challenge for all, especially for those who have been already affected by emergency occurrences such as displacement due to conflict, drought, flood or disease outbreak. Target population in the HRP is generally targeted under preparedness and response activities for COVID-19 with additional risk communication and community engagement messages. Besides, significant WASH needs are identified at Health Care Facilities. Due to intermittent water supply at most health facilities, inpatients may not be able to maintain hygienic practices which would also increase risks among frontline health workers.

Coordinated efforts between development programs (One WASH National Program) and humanitarian responses also need to be strengthened as preparedness and response needs are too big to be addressed by only humanitarian partners. To make timely preparedness and response possible, reprograming of ongoing development interventions as well as humanitarian responses need to be immediately considered. Further, integrated coordination between development and emergency needs to be strengthened.

Response strategy

The MOWIE response is aligned with the 2020 WHO Global Strategic Response Plan (WHO-SRP). With the dynamic epidemiology of COVID-19, the targets for the different WASH interventions will be based on the planning best and most-likely case scenarios of the country CPRP and will be guided by the periodic risk assessments and adjusted accordingly.

The following are the proposed WASH Responses which will contribute to limiting human-to-human transmission, protect individuals from exposure to COVID-19 and strengthen the capacity of Health facilities to treat COVID-19 cases.

1. Infection Prevention and Control (IPC)

- Procure and distribute critical hygiene and prevention items (including soap, hand-sanitizer, disinfectant for use in schools, health facilities, holy water sites and public spaces);
- Ensure good WASH in health care settings, including implementing regular cleaning and disinfection of surfaces;
- Provision of safe water supply services, chlorine disinfection and storage facilities;

- Provision of safe sanitation services in communities and support to solid and liquid waste management;
- Water trucking / storage, disinfection services and handwashing facilities;
- Rehabilitation and repairs of existing community and institutional water supply schemes; and
- Work jointly with EOC, MOH, EPHI and WHO to identify high risk locations and health facilities to prioritize water and sanitation supplies and support;

2. Risk communication & community engagement (RCCE)

- With the MoH, lead and support the development/ adaptation and implementation of the national risk-communication and community engagement COVID-19 strategy and plan;
- Support the preparation of accurate, culturally and gender appropriate messages and pre-test through a participatory process, specifically targeting key stakeholders and at-risk groups;
- Through regional Water Bureaus, work with key influencers, WASHCOS, women and youth groups, health workers and community volunteers to build their capacity for awareness raising and promoting healthy practices through participatory interventions;
- Engage with the existing community networks, media, NGOs, schools, traditional and community structures; and other relevant platforms to broadcast messaging and information on COVID-19;
- Support handwashing and safe sanitation campaigns in public facilities including schools, health facilities, child-friendly spaces and public spaces to improve preventive practices among children, at-risk groups, and the general public. Ensure that schools, churches, mosques and holy water sites are targeted;
- Broadcast COVID-19 prevention and control messages through local media channels (TV stations, Radio) in local languages.
- Coordinate with MoH, EPHI and other relevant stakeholders and identify barriers to effective communication channels around hygiene and sanitation;

Activities

1. Sensitization communication with Regional Water Bureaus and utilities and advocate for an immediate needs assessment to ensure water supply for health centers in general and COVID-19 isolation centres in particular. Also, make sure regional Water Bureaus closely work with regional COVID-19 Task Force.

2. In collaboration with AWSSA, look for sustainable water supply sources for the COVID-19 isolation centers in Addis Ababa and the regional capitals (priority will be given to Yeka-Kotebe, and Bole Chafa).

- Urgent technical assessment to look for alternative water supply sources;
- Provide water trucking when needed; and
- Increase storage capacity in all the isolation centres.

3. Look for ways of mass production of handwashing facilities as per the WHO design standards. Contact potential workshops that can produce the facilities in short time frame.

4. Commence procurement of water storage tanks and water treatment chemicals stock and identify potential suppliers.

5. Procure and stock water pumps, generators and basic fast-moving spare parts to support the regional COVID-19 response.

6. Conduct consultative meeting with relevant water sector private sectors actors (drillers, water bottling companies, contractors and consultants) for possible technical support to the COVID-19 WASH sector Emergency Preparedness and Response Plan.

7. Finalize long term water trucking procurement for any emergency needs in Addis Ababa and around Addis Ababa.

8. Establish a support mechanism for regional water bureaus and special line of communication on COVID-19. Establish an emergency technical task force within MoWIE/WDC who can provide technical support to regions.

9. Launch media action and public awareness on handwashing and water treatment. Establish communication team that will closely work with the EOC.

10. Avail a special COVID-19 emergency fund at MoWIE/ WDC to support regional water bureaus in their effort to ensure sustainable water supply for the fight against COVID 19.

Priority activities	Budget – USD $
Alcohol (500ml)	3,632,400
Aqua Tabs	117,600,000
Calcium Hypochlorite HTH)	6,684,000
Detoil	715,860
Jerrican	300,000
Sanitizer	457,500
Soap (liquid, laundry)	3,345,180
Water purification and disinfection	9,600,000
Water Tankers (10,000L)	2,112,000
Water Tankers(15000L)	646,000
Water Tankers(25000L)	160,000
Water Tankers(5000L)	1,240,000
Water Trucking (15 days)	5,355,000
posters	120,000
leaflets	300,000
Handwashing Facilities	6,000
Infectious waste bins	2,400
Total	152,276,340

REFUGEES

People targeted

700k

Financial requirements (USD)

16.0M

Impact of COVID-19 on the sector

With over 700,000 refugees in 26 camps across the country, UNHCR has embarked on several activities including the development of a Contingency Plan (CP) in line with the federal and regional plans. Whether in camps or settlements, refugees are living in extremely precarious conditions and there is steady flow of new arrivals among the various population groups, increasing the risk of exposure to COVID-19. 1,087 South Sudanese; 97 Sudanese; 3,004 Eritrean; 1,370 Somali new arrivals have been registered since the beginning of this year. The risk is also high for the 38,370 urban refugee population, thus the need for heightened alertness to the COVID-19 situation and for updating the CP as a dynamic document on regular basis as the situation evolves.

Major challenges are the immediate availability of adequate personal protective equipment (PPE) for health personnel, equipment necessary to resuscitate severe cases and adequate facilities for isolation. Some isolation facilities designated by the Regional Health Bureaus (RHB) are far from camps and alternatives need to be agreed upon. In the event of an outbreak, some non-emergency services will need to be discontinued (e.g. vaccination, ante-natal/post-natal care, etc.) which will have longer-term negative health consequences.

Protocols on COVID-19 have been shared with camp-based health staff and will continue to be updated and circulated to cover all staff. Case definitions for surveillance have been shared with all health facilities and will be updated and circulated if amended by WHO/MOH. Guidelines on sample collection, storage and transportation will be displayed in all health facilities as soon as this is finalized by RHB, and all laboratory staff will be trained on sample collection. A high index of suspicion is being introduced among health workers in keeping with the case definition during training and implemented at health facilities.

Relevant case reporting forms as per WHO/MOH template will be provided to all health facilities. Registration of all outpatient and in-patient cases will be ensured to enable trend analysis and contact tracing when necessary. As part of preparedness, a stockpile of necessary specimen collection materials will be assured and provided to all camps. A specimen transportation pathway will be established with respective RHB as will the feedback mechanism for results.

Ongoing border surveillance including COVID 19 has been scaled up in line with MOH guidance and are being introduced in locations not done previously (e.g. along Eritrean border). Screening of all new arrivals for symptoms specific to COVID-19 will be conducted in addition to the routine screening currently carried out in reception centers. Ad hoc COVID steering committee meetings systems have been activated including tele response systems given need for limiting contact.

Most affected population groups

Analysis of age profiles of the refugee population, their vulnerabilities and pre-existing medical conditions, health systems capacities, cross-border movements and UNHCR's engagement with regional as well as local health authorities across these locations have demonstrated that the general refugee population remains at high risk. Crowded living conditions in reception facilities and camps and official and unofficial cross-border movements are additional risk factors. Persons above 60 years old, in addition to those living with chronic illnesses such as diabetes, asthma, HIV, Tuberculosis have been identified as being at much higher risk than others.

Population age Profile and Select Vulnerabilities

Location	Vulnerability	Number	% of total population
Melkadida (Somali; 159,556)	60+ years and older persons at risk	6,113	4%
	Children under 5years	34,524	22%
	Serious medical condition	1,535	1%
Gambella (SSD; 318,218)	60+ years and older persons at risk	7,479	2%
	Children under 5years	60,962	19%
	Serious medical condition	2,089	1%
Assosa (Sudan & SSD; 62,820)	60+ years and older persons at risk	1,238	2%
	Children under 5years	13972	22%
	Serious medical condition	310	0.5%
Shire (Eritrean;183,383)	60+ years and older persons at risk	3,106	2%
	Children under 5years	15,363	8%
	Serious medical condition	2,168	1%
Jigjiga (Somali; 39,065)	60+ years and older persons at risk	633	2%
	Children under 5years	3,716	10%
	Serious medical condition	2,143	6%
Total (763,042)		155,351	20%

Projected sector needs

Three scenarios are envisioned to exist throughout the year in case of outbreak including the best case, most likely and worst-case scenarios.

Best case scenario - This scenario looks at a confirmed case outside the camp but with little impact on the refugee population or persons of concern. Persons of Concern most at risk are urban refugees or those in settlements. It is estimated that 5% of this population (1700) would be at risk and 1% (17) PoCs will develop a mild infection. The MOH or health authorities will place the case in isolation and trace contacts to the case in order to be placed under quarantine. Potential interaction with PoC in camps is limited as this case is reported out of camp but could encounter urban refugees or those in settlement. Key actions to be undertaken as summarized in the table below.

Most likely scenario - This scenario relates to a confirmed case in a camp or reception center. The impact is critical, and seriousness of risk is high, and it is estimated that 15% of the camp population (102,700) would be at risk and 3% (3000) of PoCs will develop severe infection and need treatment. Due to the human to human mode of transmission of the disease, in the event of a confirmed case within the camps or reception centers, service provision will be limited to essential lifesaving activities and activities that impact the livelihoods of the persons of concern. The cases will be isolated for management as well as the contacts will be isolated. An isolation area would be identified in camps/reception center as per MOH/WHO guidance or protocols. Key actions will continue with the same guidance as in the "best case scenario" in below table.

Worst-case scenario – For the third scenario, a confirmed case of UNHCR/Partner or UN/NGO agency staff working with persons of concern in the field, urban setting or Representation (Addis) level. While the impact on the PoCs could be critical, the seriousness of risk is medium, and the likelihood is very minimal. Estimates are that 20% (143,600) of the refugee population in urban, settlement and field settings will be exposed and 5% (7000) will develop a critical condition and will need intensive care. The concerned staff will be isolated and placed on management, contacts will be traced and quarantined. This will include staff from other agencies, PoCs, relatives of staff who may have interacted with the case in the weeks preceding onset of symptoms and beneficiaries that may have been accessed by the contact.

Response strategy

To mitigate the risk of outbreak, reinforce preparedness and further guide the response in case of an outbreak, UNHCR is currently taking the below measures:

Community Mobilization- community outreach agents are continuing house to house information dissemination in the community focusing on hand washing, respiratory etiquette, social distancing and early seeking of treatment. Mass information campaigns will continue to be carried out at public places such as mosques, churches and markets. Camp based coordination teams or focal points are engaging with opinion and religious leaders in the community as an avenue of information dissemination and further engagement with the community.

Capacity Building- training materials are being developed based on WHO & MOH guidance. The training materials target Health, Nutrition and WASH staff and will further build capacity to camp based staff.

Communication- communication on refugee movements in and out of camp has been prioritized as essential to reduction of transmission. Printed Information, Education and Communication (IEC) materials in suitable local languages are being demonstrated and distributed in public places.

Water, Sanitation and Hygiene- handwashing stations, soap and hand sanitizer are provided within the UNHCR compound and partner staff advised to provide the same within their compounds. Increased ration of soap is being distributed for the PoCs in all locations. Efforts are being made to increase the water production and distribution in camps where the supply is currently inadequate.

Food and Nutrition – measure are being taken to reduced sale of GFD.. Information dissemination on food handling and consumption of specialized nutrition products will continue through the community outreach workforce. WFP and ARRA in collaboration with UNHCR to provide at least two months GFD for all camps and BSFP beneficiaries. These will prevent crowding and congestion at the GFD sites in case of outbreak.

Response Gap and Challenges

UNHCR has identified the below points as major gaps and challenges in addressing needs that arise due to COVID19:

Coordination- the remoteness of the location and the distance from camps or field offices to the Regional health authorities creates a gap in effective MOH-led coordination.

Communication- poor communication infrastructure, with camp-based staff lacking access to internet communication and in some camps lack of strong mobile phone network leads to slow flow of information.

Community Mobilization- the operation has a good number of community outreach agents, however, there is limited availability of IEC materials to be provided to the community. While templates have been provided by WHO & MOH, it has not been possible to produce them in required quantities for use by the entire population, especially in the appropriate languages.

Water, Sanitation and Hygiene- the water system in some field operations is resource intensive and need heavy operational maintenance. Insufficient containers to use as handwashing facilities are affecting all the households. Jerrycans for handwashing are not available in some of the field warehouses.

Soap availability at household level is limited, thus making hygiene promotion messaging difficult for the recipients to implement. There is need to procure and stock more soap in order to achieve additional soap distribution.

In order to be able to adequately prepare there is need to increase the soap balance to be sufficient for at least 3 monthly distributions at 500g/person/month. Requirements for each of the sub-offices will be included their respective CP budgets.

Health Facility & WASH Infrastructure- health facility infrastructure is way below standard, with most camp health facilities lacking running water in patient consultation rooms. The availability of hand washing stations is not uniform and will need to be amplified.

The current power system in some of the health facilities supports a limited number of hours. Therefore, a power back up will be necessary to support case management of severe cases in need of oxygen.

Infection Prevention and Control in Health Facilities- implementation of infection prevention protocols at health facility is very poor due to unavailability of pre-requisite materials and supplies. The health facilities and health workers have almost no personal protective equipment against COVID-19, including N95 masks, goggles, clean gloves and gowns.

Disinfection materials at the health facilities are inadequate to meet the required level of disinfection to prevent disease transmission, regardless of the heat instability of the pathogen.

Case management – most camp health facilities do no have adequate means including enough parenteral antibiotics and oxygen therapy to treat serious COVID-19 cases, especially if the numbers escalate. Isolation facility is inadequate and not equipped to isolate highly infectious cases like COVID-19. The referral hospitals don't have capacity to treat critical cases needing ventilation support.

Water Sanitation and Hygiene in Schools- schools do not have handwashing facilities or possibility of soap utilization. A large majority of the school-going population will encounter more vulnerable members of the community, hence the need to limit transmission among this population.

WASH facilities in schools are insufficient and in poor conditions. An assessment has been planned on this for proper intervention.

Financial requirement

Priority activities	Target	Budget – USD $	Remark
Health status of the population improved		3,800,000	
Nutritional well-being improved		1,000,000	
Population lives in satisfactory conditions of sanitation and hygiene		4,600,000	
Supply of potable water increased or maintained		5,200,000	
Coordination and partnership		500,000	
6.5% overhead		981,500	
Total		**16,081,500**	

COORDINATION & MANAGEMENT ARRANGEMENTS

1. EPHI EOC

The Ethiopian Public Health Institute (EPHI) activated a Public Health Emergency Operation Center (PHEOC) on 27 January 2020. Since then, the PHEOC has been coordinating the COVID-19 response based on eight key pillars. These are Surveillance and laboratory capacity; Points of entry screening; Risk communication and community engagement; Case management and infection prevention and control; Operations support and logistics; Planning and capacity building; and Leadership and coordination support. The PHEOC will continue to coordinate the public health-related responses.

2. Multi-Sectorial Emergency Coordination Center

Based on the potential social, economic, and political impact of the current global pandemic, there is an urgent need to improve coordination with line ministries in support of the Ministry of Health's (MoH) COVID-19 response. In light of this, on 25 March, the National Disaster Risk Management Commission activated a Multi-Sectorial ECC/EOC at the federal level in order to facilitate coordination across sectoral offices and humanitarian partners to manage the social, economic, and political impacts of the CoViD-19 crisis. In line with the National DRM Policy and Strategy, the Federal ECC authority comes from the DRM Council through the NDRMC Secretariat.

Due to the nature and complexity of the COVID-19 Pandemic, the Federal ECC wasl activated for a minimum of 4 weeks (25 March – April 24, 2020), at which time the DRM Council, NDRMC, and MoH leadership will assess the situation to determine the timeframe for demobilization. Based on the COVID-19 situation and the potential impact on the social, economic, and political system, the duration of activation is unknown at the time of activation.

3. Other coordination arrangements

Depending on NDRMC's decision, the Strategic Multi-Agency Coordination (SMAC) forum, and Regional COVID-19 Emergency Operation Centers (EOCs) could be activated to mobilize and prioritize scarce resources and coordinate emergency incident status information and resources as required.

In addition, the Ethiopia Humanitarian Country Team (EHCT), which is currently led by the Humanitarian Coordinator (HC), convenes fortnightly. During these meetings, Country Representatives of UN agencies, representatives of NGOs, and donors, deliberate on setting out the joint humanitarian response strategy and take policy decisions on the direction of humanitarian operations. The frequency of EHCT meetings might be required to increase should the situation deteriorate.

Similarly, the Inter-Cluster Coordination Group (ICCG) is an operational coordination structure which brings cluster coordinators together fortnightly to confer on operational issues. Chaired by OCHA, the ICCG will continue to play an important role by providing operational support to line ministries and cluster partners at the federal level. Clusters should activate sub-national coordination mechanisms as appropriate and strengthen linkages with federal-level coordination mechanisms. Clusters will also designate sub-national focal points who could support sub-national coordination through the designated EOCs.

For the refugee operation, measures have been taken in field locations as well as in Addis Ababa (Representation) as UNHCR engages with the federal and regional health authorities, partner agencies, the refugee population and host communities in preparation for eventual outbreak of COVID-19. These include among others, inter-agency coordination and partnership arrangements, communication and community mobilization, health surveillance and capacity building, stockpiling of medical and WASH supplies.

UNHCR is represented in various coordination platforms that have been established including regional preparedness and response task forces, camp-based coordination teams, steering committees and sub-committees. UNHCR and ARRA have established interagency, sector, camp coordination forum that channels information; coordination of the refugee operations and systems including the current COVID 19 preparedness. In Gambella, WHO and RHB are the lead for the steering committee for COVID 19 which has active participation and representation of UNHCR and partners engaged in refugees operation.

In addition, regarding UNHCR's engagement with the health authorities, the public health units in Addis Ababa and in the field maintain an active engagement with authorities at the federal and regional levels including the MOH and regional health bureaus. More so, engagements with WHO and UNICEF have been maintained specifically in relation to vaccine preventable diseases.

It is to be noted that considering the specific nature of the potential situation and the need to reduce social interactions and reduce crowded spaces, UNHCR is envisioning together with partners innovative ways of distributing life-saving assistance while reducing crowds that increase the risk of COVID-19 transmission.

