

# REVISION OF THE NORTHERN ETHIOPIA RESPONSE PLAN

May to December 2021



**PHOTO ON COVER**

*Zinabu Temesgen, 19, holds her daughter, Meseret Birhau, 1 year and 8 months old.*

*Photo: UNICEF Ethiopia 2010/Mulugeta Ayene*

# Table of Contents

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05	Executive Summary
06	Access overview
07	Change in Humanitarian Needs and Response
10	Accountability to Affected People
11	Protection from Sexual Exploitation and Abuse
12	Gender equality
13	Agriculture cluster
17	CCCM cluster
21	Education cluster
25	ES/NFI cluster
28	Emergency telecommunications cluster
30	Food cluster
33	Health cluster
41	Logistics cluster
43	Nutrition cluster
46	Protection cluster
52	WASH cluster
55	Refugee
58	Coordination
60	Tigray Rapid Response Mechanism
61	How to Contribute
63	Acronyms
64	End Notes

# Overview


## PEOPLE IN NEED

 **PIN**  
**5.2M**


## PEOPLE TARGETED

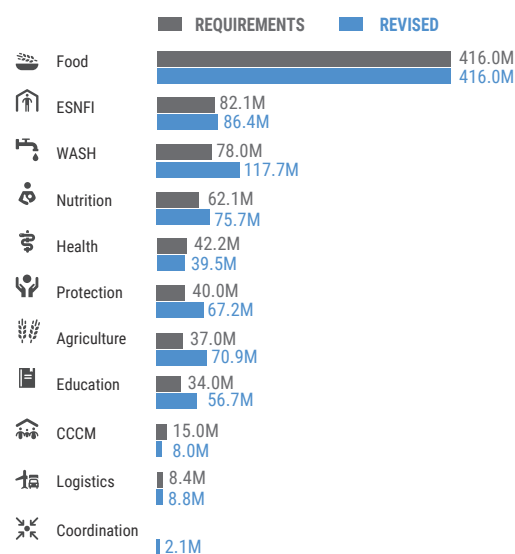
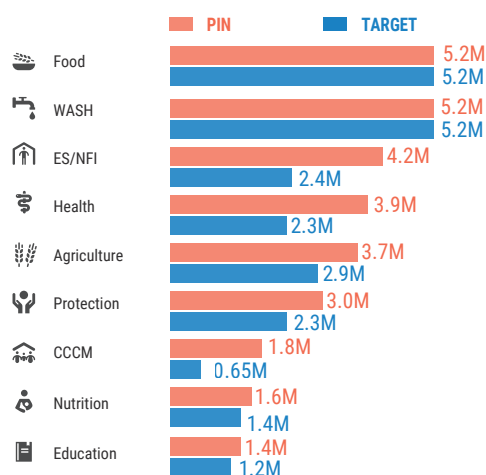
 **TARGET**  
**5.2M**

## FINANCIAL REQUIREMENTS

 **ORIGINAL**  
**REQUIREMENT**  
**\$853.4M**

 **REVISED**  
**REQUIREMENT**  
**\$957.0M**

 **GAP**  
**\$373.6M**



	PEOPLE IN NEED		PEOPLE TARGETED		FUNDING REQUIREMENT (US\$)					FUNDING GAP
	ORIGINAL	REVISED	ORIGINAL	REVISED	ORIGINAL	REVISED	CHANGE	FUNDING RECIEVED		
Agriculture	2.5 M	3.7 M	1.2 M	2.9 M	37.9 M	70.9 M	↑	+33 M	11.1 M	59.8 M
CCCM	1.8 M	1.8 M	1.2 M	0.65 M	15.0 M	8.0 M	↓	-7 M	2.6 M	5.4 M
Coordination	N/A	N/A	N/A	N/A	30.0 M	4.4 M	↓	-25.6 M	3.8 M	0.6 M
Education	1.4 M	1.4 M	420 K	1.2 M	34.0 M	56.7 M	↑	+22.7 M	1.0 M	55.7 M
ES/NFI	3.2 M	4.2 M	2.9M	2.4 M	82.1 M	86.4M	↑	+4.3 M	15.8 M	70.6 M
ETC	N/A	N/A	N/A	N/A	1.2 M	1.2 M	=	-	0.5 M	0.7 M
Food	5.2 M	5.2 M	5.2 M	5.2 M	416.4 M	416.4 M	=	-	298.3 M	127.1 M
Health	3.8M	3.9M	2.3 M	2.3 M	48.2 M	48.2 M	=	-	18.5 M	29.7 M
Logistics	N/A	N/A	N/A	N/A	8.8 M	8.8 M	↑	+0.4 M	4.1 M	4.7 M
Nutrition	1.6 M	1.6 M	1.4 M	1.4 M	62.1 M	75.7 M	↑	+13.6 M	18.2 M	57.5 M
Protection	2.7 M	3.0 M	1.4 M	2.3 M	67.3 M	67.3 M	↑	+27.3 M	20.4 M	46.9 M
WASH	4.5 M	5.2 M	3.2 M	5.2 M	112.0 M	112.0 M	↑	+33.7 M	23.5 M	88.5 M
RRM	N/A	N/A	N/A	N/A	0.95 M	0.95 M	--	-	-	0.9 M

# Executive Summary

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The first Northern Ethiopia Response Plan was released in May 2021 to address the increased humanitarian needs which arose in the Tigray region after conflict broke out on 4 November 2020 between Tigray Regional Forces and Ethiopia National Defence Forces (ENDF). This updated Response Plan is based on the changes in context and increased humanitarian needs since May 2021, and to ensure the ongoing response is adapted to meet the evolving needs. This revised Northern Ethiopia Response Plan covers the clusters' actual and planned response in the Tigray region, including the Western zone, for the months May to December 2021.

As the conflict has entered its eleventh month, the estimated number of people in need of assistance is 5.2 million people, all of which are targeted in this Response Plan.

On 28 April 2021, the Inter-Agency Standing Committee (IASC) Principals designated a humanitarian system-wide scale-up for northern Ethiopia, designed to enhance the humanitarian response in relation to increasing humanitarian needs and to ensure that resources and capacity are available to rapidly respond to the emerging situation and level of needs within the conflict affected population. As part of the IASC system-wide scale-up, an Operational Peer Review mission was conducted in September 2021 to assess the challenges and opportunities to further strengthen the coordination of the humanitarian response.

In the beginning of July 2021, fighting expanded into the neighbouring Amhara and Afar regions. Humanitarian partners are scaling up their response to support thousands of displaced people in these regions and efforts are underway to reach people behind the frontlines and in hard-to-reach areas within the Tigray region. Since the Northern Ethi-

opia Response Plan was released in May 2021, it has served as the guiding document for partners in responding to the growing humanitarian needs within Tigray region, tracking delivery against targets and as the benchmark against which emerging needs are determined. The current revised Response Plan continues to cover the needs in Tigray region, including Western zone. The Mid-Year Review of the 2021 Humanitarian Response Plan for Ethiopia covers the rest of Ethiopia (outside Tigray) as of early August 2021. As such, some of the growing needs in Afar and Amhara regions as a result of the spill-over of the Tigray conflict are reflected in the Mid-Year Review of the Humanitarian Response Plan for Ethiopia for 2021, although the extent of those needs are still being determined in view of ongoing fighting and insecurity in some of those areas.



# Access overview

Humanitarian access is defined both by the ability of humanitarians to access affected populations with the necessary relief support and services and the affected populations' access to humanitarian support and essential services. As the conflict has evolved both avenues of access have increasingly been challenged by the conditions on the ground.

Civilians lack access to basic infrastructure, face disrupted social and protection services, including health services, schools, water supply, shelter and other essential services. Health facilities have been attacked, occupied, rendered dysfunctional and looted, severely hampering access to life-saving health and nutrition care, including support for victims of sexual and gender-based violence.

Telecommunications, and banking services remain offline throughout Tigray, while commercial cargo and flights into the region remain suspended. However, since July, the United Nations Humanitarian Air Services (UNHAS) has operated flights to Mekelle twice a week. Electricity has resumed in the main cities/towns of each zone, however, outside of Mekelle the electricity is inconsistent and rural kebeles are still cut off.

While humanitarian access within the Tigray Region has improved considerably since the cessation of active fighting within Tigray region, access to the region has severely decreased over the same period due to the restriction on the flow of humanitarian supplies, fuel, cash and personnel into the region. As a result, partners have been forced to drastically scale down operations and reduce movements. For instance,

fuel shortages have forced partners to suspend mobile health clinics and water trucking services leaving thousands of people without access to basic healthcare and safe water, raising concerns for the spread of communicable diseases. The Afar "humanitarian corridor" (Semera – Abala – Mekelle) remains the only available route to move relief supplies into Tigray. However, insecurity and bureaucratic delays are impacting the logistics operation. Medicines, information and communications technology (ICT) equipment, fuel tankers, generators, and office supplies are all being denied transit into Tigray. Between 12 July and 19 October, a mere 1,111 trucks have made it into Tigray through this route, which constitutes a fraction of the 100 relief trucks a day required to meet the humanitarian needs of the people of Tigray. The most recent fuel tanker entered Tigray on 29 July 2021.

Since commercial traffic has been restricted, food prices have skyrocketed and a critical shortage of essential supplies, including medicines, has resulted. The lack of essential commodities in local markets in Tigray is severely affecting the ability of the population to meet their most basic needs. Meanwhile, reported attacks on public infrastructure and essential services have eroded access to essential services of the affected populations.

Aid workers continue to work in a highly complex and risky environment. Since the start of the conflict, 23 humanitarian workers were killed, making Tigray one of the most dangerous places to work globally.

# Change in Humanitarian Needs and Response

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## Changes in needs

Of the total population in Tigray of 5.7 million, it is estimated that 91 per cent or 5.2 million are in need of urgent food assistance out of which 2,572,291 (50%) are children. According to the Integrated Food Security Phase Classification (IPC) from June 2021<sup>1</sup>, over 400,000 people in Tigray region were suffering from catastrophic levels of hunger (IPC 5) between July and September 2021 and the risk of wide-spread famine increases daily if the food security needs of the affected population are not met and if they are not able to harvest their crops.

An increasing number of children and pregnant and lactating women (PLW) are suffering from acute malnutrition due to shortages of food, limited access to safe water and the lack of health services. A rapid analysis released by the nutrition cluster in September 2021 indicated proxy global acute malnutrition (GAM) levels amongst children under 5 (U5) in Tigray has increased from 17.1 per cent based on screenings in February, to 22.7 per cent from the first two weeks of September. GAM levels amongst pregnant and lactating women for the same period was 50.3 per cent. As such, the whole of Tigray has been targeted for the nutrition response through targeted and blanket supplementary feeding. Some 56,000 children are additionally expected to require treatment for severe acute malnutrition in 2021 and may die if treatment is not provided. Only limited medical supplies have been allowed to enter Tigray since August of 2021 and the availability of essential medication in the pharmacies has been seriously depleted with the cost of available medications rising exponentially. The increasing levels of food insecurity coupled with the lack of medication leads to lower immunity and increased risk of contracting diseases which, if unaddressed due to the limited diagnostics and treatment capacity, will result

in an increase in the overall mortality rate amongst the population, which will disproportionately impact children and women.

Prior to the conflict, agriculture was the main source of food and livelihood for over 80 per cent of the population in Tigray. The main rainy season ended in September in most parts of Tigray. The security situation prevailing at the start of the season affected agricultural activities, with farmers shifting from high yielding long cycle crops to short cycle crops. In addition, the expected harvest is at risk due to the presence of desert locusts in Tigray and neighbouring areas of Afar and Amhara.

Partners report people resorting to extreme negative coping mechanisms to secure access to food. As people move from rural to urban areas in search of security and assistance, there has been a notable increase in begging, child labor and women engaging in survival sex for food in both urban and rural settings. Additional coping mechanisms include reduction in meal sizes and/or of numbers of meals per day and in some cases not eating at all on a given day. This coping mechanism has especially affected adults, and particularly women, who have provided the little food available to children first. As a substitute for food, families consume qolo, cactus, leaves, wild vegetables and unknown plants. As a result, many people reportedly suffer from diarrhea and vomiting.

In addition, pastoralists and agro-pastoralists have lost livestock because of looting, displacement, and diseases or because they have been forced to eat or sell the livestock for other food items. The Meher harvest (November-December 2021) is projected to be between 30-40 per cent of the normal quantity and is further jeopardized by the presence of desert locust in

23 woredas. While the regional government is making efforts to ensure that agricultural inputs are available for the upcoming season, these efforts require consistent support by partners.

The rapid deterioration of the humanitarian situation has resulted in more than 63,110 people (as of end of September) having fled across the border to seek international asylum and protection in Sudan, albeit most displaced people have remained in the Tigray region.

With the depletion of services and limited access to food, the situation for Internally Displaced Persons (IDPs) is even more precarious now as compared to May 2021. At the time of writing, there were an estimated 2.1 million IDPs in Tigray<sup>2</sup>, with several sheltering in school facilities. In some cases, up to 60 individuals are sharing one classroom, with no separation of men, women, boys and girls. Many of these IDPs have no change of clothes. There is limited attention to the specific needs of women and girls, and other persons with specific needs. In some sites, there are no latrines nor access to water. Limited access to water, no privacy to change or wash clothes, unavailability of soap for washing and limited access to latrines are all causing women and girls of reproductive age struggling with personal hygiene and health issues. IDPs living in school facilities would need to be relocated or to return to other areas or places of origin to allow for school reopenings. In addition, IDPs living in congested and unsanitary collective centres, spontaneous and planned sites, or shared shelters are particularly vulnerable to COVID-19 infection. While most IDP families are separated, separated elderly men face particular challenges, including the inability to prepare food and care for themselves given their lack of knowledge and skills needed to prepare their own food due to the fact that social norms dictate that men are not socialized to prepare food.

An intention survey conducted by the Camp Coordination and Camp Management (CCCM) Cluster at the end of July showed that 62 per cent of the IDPs in Mekelle had been displaced for the last 6-12 months and that the majority of the IDPs wished to return to their places of origin when the security situation

permits. The intention survey showed that the IDPs identified food needs as the highest sectoral need (96 per cent), followed by Non-Food Items (NFI) (65 per cent) and shelter (58 per cent).

The conflict continues to take its toll on IDPs, leading to a significant increase in Mental Health and Psychosocial Support (MHPSS) needs which continue to be largely unmet, suggesting further deterioration of IDPs' ability to cope. They often have horrible stories to tell and living in large, crowded collective sites for a prolonged period increases their distress levels and exposure to additional traumas. The conflict has also driven a dramatic rise in reported Gender-Based Violence (GBV) cases, which is believed to represent a small proportion of the actual GBV incidents, given the lack of access to medical facilities in many parts of the region, as well as social stigma around reporting. There has, similarly, been a sharp rise in the number of reported cases of family separation and of Unaccompanied and Separated Children (UASC). The information about the humanitarian needs in Western zone remains limited due to restricted access and insecurity. The few partners present in the zone are based in the eastern woredas towards the North Western zone. However, there continues to be an influx of IDPs from Western zone into the rest of Tigray, indicating the continued worsening of the humanitarian situation within the Western zone.

## Changes in response

Partners' ability to provide assistance is heavily impacted by the insufficient volume of humanitarian supplies reaching the region (both humanitarian and commercial), limited fuel to transport the aid and provide services, restricted telecommunications and a lack of cash to sustain operations on the ground. To the extent possible, the response has been adapted operationally, however it is being critically impacted by these issues which require sustained advocacy and negotiation to resolve. Partners have largely scaled down operations, and are reducing their operational footprint, while some activities have had to be suspended due to these operational constraints.



A multi-sectoral response is crucial to effectively address the growing food insecurity among the population and looming threat of famine. Without proper health, nutrition, WASH, agriculture and protection assistance and services, food insecure people risk falling further into famine like conditions and become more likely to use negative coping mechanisms to survive.

Surveillance reports have shown the drastic increase of malaria, acute respiratory tract infections, diarrheal diseases and severe acute malnutrition cases. The population's ability to cope with these diseases and health conditions is highly dependent of their access to food, water and health care. To restore, maintain and strengthen the resilience of affected communities all factors need to be addressed simultaneously.

The national Technical Working Group to strengthen multi-sectoral response was reactivated in June 2021. This Working Group will help inform the planning for integrated responses among clusters, particularly Food, Agriculture, Nutrition, Health and WASH Clusters. There are plans for sub-national Clusters in Tigray to take this work forward and develop a three-month inter-cluster action plan to address the malnutrition situation and help prevent potential famine in the region.

Additionally, practical challenges around the relocation and return of IDPs in Tigray persist. The interest of some IDPs to return to their place of origin, coupled with the drive to reopen schools following almost 18 months of closure due to COVID-19 and the subsequent conflict, need to be balanced against the feasibility of safe, dignified and sustainable returns (or other durable solutions), especially as many areas of origin are still affected by armed hostilities. In June 2021, a Tigray IDP and host community strategy was developed to provide an integrated framework to guide and tailor the humanitarian response to the needs of IDPs and the host communities in different settings across the Tigray region, both in terms of safe returns or relocations.

Cash based programming would in theory be ideal to address needs of IDPs and host communities such as

cash for rent, NFIs and food. Cash based programming has also been recommended globally as a key strategy in addressing protection needs. However, this highly effective assistance mechanism is heavily restricted in the Tigray context by the lack of cash in the region. As of September, humanitarian partners are only allowed to bring 2 million Ethiopian birr (ETB) (US\$43,000) per UNHAS flight, operating twice a week between Addis Ababa and Mekelle. Humanitarian partners continue to advocate for this amount to be increased as it is insufficient to both maintain operations or provide cash assistance to beneficiaries. At the same time, due to the lack of commercial supplies entering the region, prices of commodities in the markets are highly volatile<sup>3</sup> further complicating the feasibility of scaling up cash based programming.

# Accountability to affected people

Accountability to affected people (AAP) is an active commitment by humanitarian actors and organizations to use power responsibly to take account of, give account to, and be held to account by the people they seek to assist. In Tigray some mechanisms for the community to share feedback with humanitarian partners are currently constrained due to internet and telephone outages. Nevertheless, an OCHA supported AAP surge team operating from Addis and Mekelle has been supporting efforts to adapt the AAP aspects of the response to the operational realities on the ground. They have facilitated an AAP training for 35 partner staff in Mekelle, developed a Terms of Reference for a regional APP Technical Working Group (AAP TWG) now meeting bi-weekly and with a sub national work plan to mainstream AAP in the response. The regional AAP/TWG will promote collective, systematic and coordinated community engagement to ensure that the humanitarian response is accountable to affected people and that AAP is mainstreamed throughout the response. In terms of participation, the regional AAP TWG will primarily target Clusters and the Inter-Cluster Coordination Group (ICCG) to ensure that AAP is mainstreamed response-wide. The AAP TWG will also support interagency and multisector needs assessments including promoting shared guidance and tools to ensure AAP questions are incorporated in all assessments to minimize duplication of assessments and community assessment fatigue. In terms of information sharing, the response will also promote strengthening linkages with an existing Communication with Communities (CwC) initiatives and will promote shared guidance on best practices for effective community engagement in this difficult operational environment characterized by information

and communication blackouts and promote using face-to-face interactions with strict adherence to COVID-19 protocols. The AAP TWG will continue to ensure that community voices are at the centre of the response by promoting a collective platform for community engagement. Evidence collated through this joint collective platform will be used to track and respond to community feedback and complaints in nearly real-time across the response. Clusters will use this information as their collective community feedback trackers and help to make it easier for all the community feedback received to become integral to response planning at a strategic level thereby guiding the response.

The AAP TWG will also encourage all partners to promote AAP capacity building initiatives with a view to establishing and expanding the AAP capacity in Tigray. A variety of tools will be developed to support the AAP processes and resources to roll out the plan, particularly on community engagement. Context based AAP Information, Education, and Communication (IEC) materials will also be developed and disseminated to raise awareness amongst communities about the response, their rights and available mechanisms engage with and shape the humanitarian response.

# Protection from Sexual Exploitation and Abuse

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The Ethiopia PSEA Network established regional networks in Mekelle and Shire in March 2021, aimed at supporting the EHCT and the Area Humanitarian Team (AHT) to prevent, mitigate and respond to sexual exploitation and abuse (SEA) in the region. As such, with close support and guidance from the national-level network, the mandate of the Tigray sub-networks includes the identification of SEA risks through assessments and coordinated referrals. It also includes close collaboration with the national and regional level Gender-based Violence Area of Responsibility, Child Protection Area of Responsibility, all Clusters, and the Inter-Agency Accountability Working Group to develop and strengthen accessible, confidential, and efficient systems that allow incidents to be reported in a safe manner. The regional networks in Tigray abide by the principles enshrined in the Secretary General's Bulletin on special measures for protection from sexual exploitation and abuse (ST/SGB/2003/13<sup>4</sup>), and reflects the strong commitments made by the EHCT and AHT to actively engage on PSEA preparedness and response.

Since the start of the conflict, the surge in new responders, combined with unequal access to information, resources and supplies, has increased the risk of SEA. Robust and informed responses that integrate gender considerations are therefore the main focus of the PSEA Networks in Shire and Mekelle to strengthen meaningful access to PSEA activities and services to meet the intersectional needs of at-risk populations. Building on the national-level Ethiopia PSEA Network strategy<sup>5</sup> and workplan<sup>6</sup>, and in line with the survivor-centred, gender-specific, and intersectional approach, the sub-networks in Tigray have agreed on a joint action plan. In order to implement this action plan, the regional networks in Shire and Mekelle, with close support from the PSEA Coordinator, report directly to its national-level counterparts. To date, the endorsement of Inter-Agency (IA) Standard Operating Proce-

dures (SOPs) for Community-Based Complaint Mechanisms (CBCMs), information campaigns (for both stakeholders and affected populations) with linked IEC materials, distribution of GBV pocket guides, and trainings on PSEA Training of Trainers, survivor support, and UN victim assistance have been ensured by the interagency Network. Going forward, the networks will build on these preparedness initiatives to safeguard the provision of timely support to SEA survivors, as well as multi-sectoral service provision, to address their intersectional needs.

During establishment of IA CBCMs in Tigray, a community-based approach will be taken by the Ethiopia PSEA Network. This will ensure accountability by incorporating meaningful participation by the affected populations into the overall system. The reporting mechanisms in Ethiopia will then be designed based on community consultations to ensure maximum accessibility, acceptability, and confidentiality amongst the affected populations, especially women and children. Moreover, the reporting mechanisms are designed to have multiple entry points, including embedded within existing services by the GBV/CP AoR and reporting lines by IAAWG-E. It is important to stress that humanitarian actors in Ethiopia must always assume that SEA may be occurring despite the absence of data or lack of evidence. Indeed, data is not needed to justify the implementation of PSEA services and activities by the Ethiopia PSEA Network. A reduction in the numbers of survivors who report SEA may only be an indicator of challenges in accessing services or other threats to safety, including retaliation or stigma, rather than an improving situation. As such, any data must only be collected by the PSEA Coordinator through confidential and standardized information management systems, and only shared in line with the endorsed IA SOPs of the Ethiopia PSEA Network.

# Gender equality

The ongoing conflict has impacted the lives of all people in Tigray, although to varying degrees and in different ways for women, girls, boys, and men. Young men largely bore the direct physical consequences of joining or being conscripted into armed forces or groups. Meanwhile, young women and girls experienced the majority of the sexual violence during the conflict. A primary source of psychological stress for women is sexual violence and fear for their children and family members, while men's stress is primarily associated with loss of livelihood and limited mobility. Gender roles changed during the conflict. Female-headed households have increased, women are taking up more roles to provide for their families, while men and boys migrating to work. Among the most vulnerable and most impacted by the humanitarian crisis are children under age 5, unaccompanied girls and boys, pregnant women, lactating mothers, separated older men, and persons with specific needs. The loss of assets, lack of labour opportunities and limited access to humanitarian assistance led women and children in particular to adapt coping mechanisms (such as survival sex and begging) which expose them to exploitative relations and Sexual and Gender-Based Violence (SGBV). When humanitarian actors do not recognize gender and age differences in needs, vulnerabilities and capacities, they run the risk of delivering inequitable assistance and might reinforce or perpetuate pre-existing inequalities.

The IASC policy (and Accountability Framework) on Gender Equality and the Empowerment of Women and Girls in Humanitarian Action (2017) emphasizes the centrality of gender equality and the empowerment of women and girls in humanitarian action, requiring humanitarian response to be grounded in a comprehensive gender analysis to inform gender equality programming that takes into account the intersection of the multiple gender factors (sex, age, disability and other diversity backgrounds). To operationalize these

accountability commitments and improve its engagement with affected populations, the AHT and ICCG defined minimum gender equality commitments for the response to integrate gender equality as follows:

- A gender analysis including sex, age, disability, and diversity disaggregated data informs clusters' programme planning, implementation, evaluation and participation;
- Clusters strengthen the integration of gender equality considerations into assessments, design, monitoring, reporting and review of clusters' response in line with the 2018 Gender Handbook for Humanitarian Action;
- Clusters will apply the IASC Gender with Age Marker tool to the design and monitoring phase.

The process of setting up an IASC Gender Equality in Humanitarian Action coordination group (Cluster gender focal points) has begun and the objective is to support the ICCG and AHT in the implementation of the minimum gender equality commitments, ensuring humanitarian programming is sensitive to gender needs and responsive to gender inequality.

# Agriculture



ORIGINAL PEOPLE IN NEED	REVISED PEOPLE IN NEED	ORIGINAL PEOPLE TARGETED	REVISED PEOPLE TARGET	ORIGINAL REQUIREMENTS (US\$)	REVISED REQUIREMENTS (US\$)	CURRENT FUNDING GAP (US\$)
2.5M	3.7M	1.2M	2.9M	\$37.9M	\$70.9M	\$59.8M

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% CHILDREN	% WOMEN	% MEN	% WITH DISABILITIES
49%	27%	24%	18%

## Response till September 2021

Farmers were not able to take full advantage of the Meher season due to a combination of factors, which include late cessation of hostilities in some areas, the late start and erratic rainfall season, limited access to agricultural inputs. There are reports of outbreaks of Foot and Mouth Disease, Peste des Petits Ruminants, Sheep and Goat Pox, Lumpy Skin Disease, Bovine Pasteurellosis and Ovine Pasteurellosis and blackleg in 22 woredas. A metabolic disorder disease has been observed in 241 animals in Central Zone which resulted in the death of all the infected animals. Investigations to establish the cause of death are underway. The breakdown of animal health delivery system poses a serious risk of further losses of livestock assets. While the regional authorities are making efforts to ensure that agricultural inputs are available for the upcoming season, these efforts require consistent support by partners. The major challenge facing the agricultural sector, like other humanitarian sectors is getting agricultural inputs into Tigray.

As part of the agriculture emergency seed assistance, at least 80 per cent of the population reported in IPC phase 3 and Phase 4 are targeted<sup>7</sup> for response. By the end of the Meher planting season in July 2021, the Agriculture Task Force (ATF) partners had provided cereal seeds to more than 197,000 households (HH) (78 per cent) of the set target of 250,000 HH. However, a combination of resource and access

limitations constrained the capacity of partners to deliver at scale.

## Change in humanitarian needs

The Agriculture Cluster targets 2.9 million people until the end of 2021. This is a significant increase of the 1.25 million people targeted in the previous Response Plan. However, the previous target was set at the time when most rural areas were inaccessible for humanitarian actors. Targeting is guided by the identification and definition of vulnerabilities, availability of financial resources as well as operational capacity of partners based on the prevailing situation in Tigray, which itself was informed by IPC projections and IOM's Displacement Tracking Matrix (DTM). Priority is given to people assessed to be in IPC phase 3, 4 and 5 according to the categorization provided by the IPC exercise, referring to the period July to September 2021 projections<sup>8</sup>.

Initial information from the CCCM Cluster on IDP intentions shows that a majority of the IDPs are willing to return to their original homes once secure to do so. Both Tigray regional and federal government authorities have expressed their interest to support quick return of the displaced to their original homes. A majority of IDPs did not previously have formal employment and depend fully on agriculture for their livelihoods. There is a need to support these IDPs to



get back to farming as soon as possible when they return to their places of origin.

Actions developed by agriculture partners will focus on improving access to basic crops and livestock by restoring the productive capacity of conflict-affected smallholder farmers and contributing to enhancing their resilience to recover. Now that the Meher season is over and active conflict has subsided, the agricultural sector is focusing on scaling up animal health services to protect remaining livestock assets, maximizing dry season vegetable production, seed multiplication and supporting farmers to properly save seed. Given distribution problems, post-harvest storage is even more important. There is an urgent need to provide farmers with post-harvest management technologies. The agriculture sector will also support aggregation and redistribution of Meher produce within Tigray, so that what is produced is actually consumed and not lost to waste.

The response also includes repair and equipping of emergency agriculture facilities (irrigation, vet clinics and cold chain systems) and other urgently needed interventions designed to mitigate the effects of a disrupted season and reduce the food gaps.

The following will be the priorities of the Agriculture Cluster:

- Agricultural inputs (cereal, legumes and vegetable seeds, fertilizers, agro-chemicals) support to the farming population to resume dry period agricultural activities. The technical deadline is the end of October;
- Provision of critical livestock support activities (vaccines, drugs, and vet equipment and supplies) by end of October;
- Rehabilitation and/or restoration of 100 partially damaged veterinary clinics across the region;
- Draught power support (hiring tractors/oxen) for irrigation cropping by the third week of October at the latest;
- Provide emergency seed pack (cereals, legumes, vegetables and maize) and fertilizer for 323,000 farm households (1.62 million people);

- Animal feed provision and seed support to 88,000 farmers (440,000 people);
- Multi-purpose cash to 205,000 vulnerable households;
- Income-generating activities targeting 101 021 youths (exploring potential livelihood opportunities in the IDP centers, cash modalities shall be deployed where feasible);

Capacity Building (Bureau of Agriculture experts and farmers) to 202,000 farmers, Bureau of Agriculture (BOA) experts and extension field officers.

### Change in the response

The proposed interventions will be implemented in close collaboration with UN agencies, International Non-Governmental Organizations (NGOs), and local NGOs. The ATF led by the Regional Bureau of Agriculture (BOA) and co-chaired by FAO has developed a guideline for the agricultural input distribution through the crop and livestock technical working groups.

This guideline will guide partners on the crop kits to be distributed, quantities, seed types and varieties across the 79 prioritized woredas and ensure well-coordinated and standardized emergency input support for the region.

The Agriculture Cluster's revised response plan requires \$70.9 million to implement and achieve its expected results until December 2021. This takes into account the short belg season in early 2022, whose preparation commences in December 2021. Approximately 90 per cent of the overall budget will ensure dry season crop varieties and livelihood restoration activities of host communities and IDPs. Vulnerable population groups such as IDPs, women, children, older people and people living with disabilities face serious protection concerns, including GBV, rape and sexual violence, and child marriage. The Cluster will ensure that through its response the communities are not placed in elevated risk of GBV, PSEA and child abuse. The partners through trainings, meetings and field visits will be encouraged to include the critical elements of protection in all their projects. The AAP core themes are expected to be part of the planning, implementation, monitoring and reporting of all ATF partners to ensure that Communication with Communities/ good community entry/ participatory





approaches etc. are employed and that inclusive approaches of engagement consider the needs of the children, youth and elderly; of people with varying degrees of disability and of women and girls, men and boys (gender).

The key identified challenges to implement the response under the Agriculture Cluster are as follows:

- Access constraints posed a challenge to the Cluster as initial planning for the Northern Ethiopia response included only 40 accessible woredas at the time. However, after June 28 access within Tigray was much less of a problem and most parts became accessible with a huge number of food insecure households and urgent food gaps to fill;
- The conflict decimated the agricultural input supply system. As a result cooperatives, which are normally the major source of inputs, played a limited role in the provision of inputs;
- The limited performance of the market is likely to result in high post-harvest losses;
- Tigray did not have a seed enterprise before the conflict, therefore inputs for dry season crop production and next year's Meher season is going to be a challenge given the constraints of getting agricultural inputs into Tigray. Although the regional authorities have already established a seed enterprise, there is a need to support local seed production;
- The crisis negatively impacted the annual performance of livestock services, such as vaccinations and treatment services, which present a huge gap on livestock populations demanding emergency service. Destruction of existing vet clinics (183 out of 198 vet clinics were destroyed and require immediate restoration and/ or rehabilitation to avoid additional disease outbreaks putting the remaining livestock (both goats and cattle) at risk of dying.

Key activity	Indicator (if Applicable)	PIN (#)	Target (#)	Original Total requirements (USD\$)	Revised Total requirements (USD\$)
Agricultural input provision (seed, fertilizer, and agrochemicals)	Number of people that received Agricultural inputs (pulses, cereals and vegetable)	2,823,664	1,616,331	\$12,500,000	\$18,607,814
Livestock vaccination, drugs and vet supplies	Number of people that received animal health intervention	2,300,000	995,566	\$1,000,000	\$4,747,763
Animal feed provision and forage seed	Number of people that received animal feed	2,300,000	439,220	\$1,440,000	\$5,424,497
Draught power support and asset restoration	Number of people that benefited from draught power support and livestock asset restoration	1,600 000	310,382	\$5,000,000	\$8,996,021
	Rehabilitation and/or restoration of vet clinics / damaged vet clinics	198	100	\$0	\$10,581,395
Multipurpose cash &Vegetable seeds	Number of people that received a multi-purpose cash-based interventions and vegetable seeds	1,600,000	204,970	\$6,000,000	\$8,920,024
Income generating activities (IGA)	Number of people who profited from IGA activities	1,600,000	101,021	\$10,000,000	\$10,102,071
Capacity Building (BoA experts and farmer)	Number of people that benefited from capacity building activities	1,600,000	202,041	\$2,000,000	\$3,520,414
<b>Total</b>				<b>\$37,940,000</b>	<b>\$70,900,000</b>



ORIGINAL PEOPLE IN NEED	REVISED PEOPLE IN NEED	ORIGINAL PEOPLE TARGETED	REVISED TARGETED	ORIGINAL REQUIREMENTS (US\$)	REVISED REQUIREMENTS (US\$)	CURRENT FUNDING GAP (US\$)
1.8M	1.8M	1.2M	651k	\$15.0M	\$8.0M	\$5.4M
<hr/>						
% CHILDREN		% WOMEN		% MEN		% WITH DISABILITIES
43% 		28% 		28% 		5% 

## Response till September 2021

The CCCM Cluster was activated in April 2021, and despite the challenges encountered in the response, the CCCM Cluster managed to reach over 307,000 individuals in 89 IDP sites / collective centres where CCCM partners have presence. The CCCM Cluster has increased its capacity with the addition of three NNGOs as CCCM actors in Tigray allowing it to expand its activities to cover more displacement locations in the region. The Cluster delivered six basic CCCM trainings to 145 individuals, in particular those who are mandated to manage the IDP sites and collective centres as well as key INGO and NNGO partners. The Cluster has also formed Relocation Taskforce in coordination with the authorities and co-led with protection Cluster. New sites were identified and over 8,000 IDPs are being supported by CCCM in the planned sites in the region. The Cluster in collaboration with the authorities has also identified additional 14 potential alternative structures and locations for the relocation of IDPs from schools which are being used as collective sites to facilitate re-opening of schools for classes. To ensure the meaningful participation of the affected and displaced population, 89 IDP self-governance committees have been formed. In collaboration with the Protection and Emergency Shelter/ Non-Food Items (ESNFI) Clusters and with support from DTM, the CCCM Cluster managed to carry out a household Level Intention Survey in July which informs the ongoing relocation exercises.

## Change in humanitarian needs

The majority of the displaced population in Tigray sought shelter with relatives and friends but many also had no other option but to live in congested and sub-standard collective centres/IDP sites, including, among others, schools, warehouses and churches. Recent intention surveys in July and in September 2021 showed that in some sites, up to 60 individuals were living together in one small 30 sqm classroom. Due to lack of space, IDPs are living in highly congested areas breaching minimum sphere standards for living space of 3.5sqm per person. With the recent instructions of the regional authorities to re-open schools, the CCCM cluster is collaborating with the relevant Clusters ES/NFI and WASH, to identify alternative shelter solutions other than, as a last resort, establishing formal camps. Discussions with the local authorities are ongoing to explore available options in the form of facilities and public premises for example the use of tertiary learning dormitories to relocate and shelter IDPs in the short and medium term so schools can reopen. An assessment led by the ESNFI cluster to review the potential use of unfinished buildings in various housing development estates in the region, yielded positive indicators in terms of potential additional intake capacity across the region. There is a collective recognition of the need to find solutions that are affordable, relevant, and applicable in the different zones.

While access to hard to reach IDP locations has improved over time, CCCM cluster partners experienced other challenges due to the fast-changing dynamics in the region. These challenges are not unique to CCCM cluster but are collectively faced by the other Clusters and service providers alike. Challenges such as the lack of access to cash, fuel, basic food and non-food items vital to providing life-saving assistance and sustaining a dignified life whilst in displacement are now severely impacting the mobility and functionality of the cluster partners to regularly deliver their activities, to monitor the needs and gaps in various life-saving sectors and the over-all situation of the emergency response by the various service providers in the IDP sites. Given the push to reopen schools, these challenges are exacerbated by the pressure to swiftly find options for sheltering the IDPs and address the capacity deficit for shelters.

The host communities have been providing unparalleled social and moral support to the displaced population, however, the current challenges confronting the whole of the region is also heavily impacting their ability to continue helping the IDPs. Of particular concern to the CCCM Cluster, is how to equally assist the host communities given that their resources are dwindling, and their reserves now depleted. IDP representatives have likewise indicated a rise in negative coping mechanisms amongst IDPs such as survival sex, alcohol and substance abuse further fraying the social fabric amongst displaced communities.

The CCCM Cluster seeks to continue assisting 651,000 IDPs in the collective and planned sites across the Tigray region. The rationale behind the reduction of the targeted individuals is based in the primary mandate of CCCM Cluster which is IDPs living in camps, camp like settings, collective centers and to reach out to a certain percentage of IDPs living with the host community as indirect beneficiaries and as resources permit. Parallel to on-going relocation exercises, the prospect of voluntary and phased return for those who are willing to do so is also being examined by CCCM in collaboration with Protection and other relevant Clusters, the return working group, and based on evidence (intention surveys, enrolment, loss and damage

assessments through a systemic evaluation of the supporting infrastructure in places of origin). While the Cluster is cognizant of the spontaneous returns that have already slowly taken place, it will continue to work with Protection and other Clusters, local authorities and IDPs towards a more comprehensive and durable solution. Based on the recent intention survey, the CCCM Cluster recognizes that of the 89 per cent IDPs who expressed a wish to return, 53.5 per cent of them are originally from the western part of the region and are still unable to return due to ongoing security dynamics in that particular area.

The Cluster also recognizes the continuing risks of COVID- 19 as well as that of other communicable diseases. The CCCM Cluster will continue its collaboration with ESNFI, WASH as well Health Clusters to ensure appropriate response and mitigation measures that are in place across IDP sites and collective centres.

### **Change in the response**

The CCCM Cluster's continuing strategic response will focus on its four pillars namely:

**Site Improvement / Development:** This includes site feasibility assessments and the establishment of formal sites in consultation with authorities, the displaced community, Protection and other key service for relocation as a last resort. It also includes physical improvements of existing IDP sites through drainage, privacy partitions, construction of communal facilities such as communal kitchens, temporary learning centres, Women and Girls safe spaces, child friendly spaces, among others consistent to camp management standards and practices.

**Coordination and Information Management:** Supporting the camp management agencies and camp administrators, CCCM provides vital support to ensuring regular, and predictable site level coordination mechanism, gathering and sharing of site level data to various stakeholders and ensuring that needs and gaps in the IDP site are flagged to service providers in a timely manner for response.



Community Participation: Including, among others, the formation and mobilization of Self-Governance IDP committees, ensuring equal and meaningful participation of the affected population. A practical capacity building program will be developed and tailored for the IDP committee representatives. The CCCM Cluster promotes and advocates for a representative and inclusive engagement of the affected population in the daily care and maintenance of the residents and infrastructure in the sites / collective centres. AAP will be mainstreamed in all interventions ensuring that Complaints and Feedback Mechanisms (CFM) and referral systems are effectively functional.

Capacity Building: Capacity building efforts will be scaled up prioritizing local stakeholders from institutions mandated to manage sites. COVID-19 protocols and mitigation measures will be mainstreamed throughout the responses.

Protection will be further mainstreamed throughout CCCM implementation, including GBV risk mitigation and prevention through referral from protection desk in every IDP sites and PSEA, in line with the IASC Guidelines for Integrating GBV Interventions in Humanitarian Action.

Possible Returns: In preparation for possible returns, a review of the social economic infrastructures in areas of origin through damage and loss assessment needs to be incorporated in the response plan. This will allow expanded discussions touching on durable solutions to commence. More community driven IDP solutions will be incorporated in the response plan and will be developed together with IDPs, authorities, as well as the Protection and other clusters.

CCCM will likewise collaborate with agencies that have cash-based interventions and programming particularly in line with the current pressure to address the shelter needs, to the extent possible.





Key activity	Indicator (if Applicable)	PIN (#)	Target (#)	Total reviewed financial requirements (USD\$)
# Camp maintenance & Improvement, decommissioning, including rehabilitation	# of people benefiting from site improvement projects	1.8M	651K	2,400,000
# Camp maintenance & Improvement, decommissioning, including rehabilitation	# of sites receiving care and maintenance support	116	90 sites	2,400,000
# Camp/area coordination, including Information Management	# of site verifications and site monitoring activities conducted or supported	90 IM products	90 IM products	533,333
# Camp/area coordination, including Information Management	# of coordination meetings conducted and recorded at various platforms	4,500	4,000 meetings	533,333
# Camp/area coordination, including Information Management	# of sites with information on availability of services	116	90 sites	533,333
# Community participation, mobilization/self- governance	# of sites with established CCCM mechanisms	116	90 sites	200,000
# Community participation, mobilization/self- governance	# of sites with established IDP community participation structures	116	90 sites	200,000
# Capacity building of stakeholders, including Government camp management focal points	# of individuals trained on basic CCCM standards, principles and practices.	600	600	600,000
# Capacity building of stakeholders, including Government camp management focal points	# of camp management committees formed and trained/capacitated	116	90	600,000
<b>Total</b>				<b>8 000 000</b>

# EDUCATION



ORIGINAL PEOPLE IN NEED	REVISED PEOPLE IN NEED	ORIGINAL PEOPLE TARGETED	REVISED TARGETED	ORIGINAL REQUIREMENTS (US\$)	REVISED REQUIREMENTS (US\$)	CURRENT FUNDING GAP (US\$)
1.4M	1.4M	0.4M	1.2M	\$34.0M	\$56.7M	\$55.7M

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% CHILDREN	% WOMEN	% MEN	% WITH DISABILITIES
96% 	2% 	2% 	14% 

## Response till September 2021

Due to the current crisis in the Tigray region and the COVID-19 outbreak, essential education services have been interrupted. As of September 2021, there are 1.4 million children in need of education support, and it is critical to ensure children of Tigray do not miss yet another school year. Any further extended period of school closures seriously threatens to destroy children's opportunity to gain sufficient knowledge and skills to survive, earn a livelihood and re-enter any further formal education in the future. The increased financial target is due to devastating effects of the conflict including property, school equipment and teaching materials damage, the need for UXOs removal and mine awareness actions, as well substantial remedial and informal education programs to bridge the loss of education for nearly two years. Considerable resources are also needed to fund school feeding, robust counselling, protection and intervention mechanisms with respect to mental health and psychosocial support (MHPSS), GBV, CP and PSEA.

During the ongoing conflict and the COVID-19 pandemic, the sub-national Education Cluster in Tigray provided minimal level of education through the partner Civil Society Organizations (CSO) by offering the Accelerated School Readiness (ASR) programs to 6,880 children, Accelerated Learning Programs to 5,332 children, Early Childhood Care and Development (ECCD) to 3,600 children and radio lesson programs

to help 140,00 children to learn at home during the lockdown. In total, 155,812 children were reached in Tigray through these flexible learning modalities delivered by partners.

Temporary Learning Spaces (TLS) were also provided in tents or adapted buildings targeting IDPs and host communities. In total, 957 students in Shire and Mekelle IDPs sites completed different learning programs. Furthermore, 34,000 exercise books were provided to priority woredas by UNICEF to support return to learning and an additional 100,000 children in Adigrat, Adwa, Axum, Enderta, Asgede and Tsimbla received exercise books. Children in the Western zone were able to receive radio lessons during lock down before the conflict. Due to access constraints, no other forms of education reached these zones.

## Change of humanitarian needs

By August 2021, significant school property damage was recorded due to the conflict. The damage assessment of 2,056 schools reported that 5,700 classrooms suffered 60-100 per cent damage. In the remaining schools, which were not structurally damaged, 1,879 classrooms were partially damaged. The rehabilitation needs differ from school to school; however, a significant number of classrooms require some repairs, painting and thorough cleaning. Some schools' laboratories have spillages of hazardous chemicals and require industrial cleaning to avoid poisoning or

other serious health and environmental risks to the school community. On top of the damages and looting during the conflict, the condition of schools used as collective centres also deteriorated with the high level of usage by large number of IDPs. The data from the report are still being processed, however, initial findings indicate that the most severely damaged classrooms were reported in the North Western zone (42 per cent), Eastern zone (38 per cent) and Central zone (32 per cent).

Until recently, access issues along with challenges relating to cash, fuel and lack of supplies impeded a number of planned education interventions. Since August, the Education Cluster has been working with the Regional Education Bureau (REB) on a concerted Back to Learning Action. This continues to be a priority for the Education Cluster in close collaboration with the REB, CSOs and other Clusters, mainly CCCM, WaSH, Food and Protection. A working group will support the REB in coordinating the process and scheduling of the schools' rehabilitation and cleaning process to ensure effective and timely management of school rehabilitation projects. Community leaders and volunteers in Tigray have pledged their support and contribution to schools' rehabilitation and have already commenced mobilization of internal resources.

### Change in the response

Detailed plans to resume education in all primary level schools are currently being prepared by the REB, taking into consideration the level of school damage, school rehabilitation priorities, partner capacity and availability of school furniture, equipment and learning resources. Consideration is given to safety and security aspects, as well as the need to assist with school feeding, wash and Psychosocial Support (PSS), for which the demand is expected to be high due to projected returns and relocations.

The Back-to-School Action in Tigray will be initially limited to primary age children (grade 1-6). The Education Cluster will be focusing on ensuring safety and security of the school environment including clearing schools from explosives, supporting Mine Aware-

ness action and implementing COVID-19 protocols; collaborating with other clusters on IDPs relocation from schools; rehabilitating damaged school facilities including WASH facilities in stages of priority (least to most damaged) and providing schools with basic education supplies that have been looted/damaged and providing scholastic materials to students.

As the teachers will be working with children who experienced trauma and had prolonged out of school experience, there is a need to train teachers in PSS, social emotional learning and accelerated learning methodologies. Workshops will be offered to teachers in formative assessments of students returning to schools to test their numeracy, literacy and subject knowledge levels (minimum learning competencies). Any children presenting with psycho-social issues will be referred for MHPSS support offered through professional networks coordinated by the Protection Cluster, the REB at the local school level in collaboration with health and community support structures. Similarly, PSS support will be made available to teachers and parents through services offered by partners in school communities. All teacher and facilitator training as well as student orientation sessions will include awareness on MHPSS, CP and PSEA services and referral networks.

As food shortages and low nutrition levels among children of Tigray are of particular concern in bringing children back to schools, school feeding programs will be implemented through partners in areas where the needs are the greatest. Schools will also be involved in interagency health and nutrition programs including awareness raising and delivery of vaccines.





The CSO partners will continue to offer accelerated school readiness and accelerated learning programs to children needing support with the formal school curriculum. Education in Emergency Project is planned for the Sebacare4 camp, to offer a safe learning and recreation space for educational activities targeting IDP children and youth residing in the camp.

Key activity	Indicator	PIN (#)	Target (#) (Individuals)	Revised Total requirements (USD\$) May to December
<b>E1: Effective leadership and coordination are established and functional</b>				
Education coordination established at zonal level	# zonal cluster	2	2	6,000
Education coordination members got capacity building training	# participants	40	40	4,200
Education cluster has well established data through IM	quality of data	1	1	16,000
Access to pre primary and primary education				
Children age 7 accessing ASR program	# of children	150,000	50,000	1,000,000
Children aged 9-14 accessing Accelerated school readiness	# of children	100,000	50,000	1,000,000
Children access primary education to be supported with item of clothing (school pride)	# of children	900,000	500,000	10,000,000
Children receiving distance learning for content development and air time on radio station	# of children	100,000	30,000	300,000
Children receiving catch up support for the most disadvantaged children incentive for facilitators /Tutors/	# of students	30,000	30,000	600,000
Children receiving scholastic materials with minimum package	# of children	1,100,000	50,000	500,000
E4: Mental Health and Psychosocial support for students, teachers and other education personnel is available in learning environment				
Capacity building on back to learning and pedagogical skill on learning assessment	# of teachers	26,400	11,000	1,100,000
teachers receiving psycho-social support training	# of teachers	26,400	4,400	880,000
students receiving psycho-social support through drama, poetry, music, drawing, story telling, role modeling, mini media entertainment at schools	# of students	1,150,000	550,000	1,750,000
schools receiving recreational materials	# of students	1,100,000	550,000	2,750,000



children receiving referral support	# of students	1,000	1,000	100,000
E6: Community engagement for behavior and social change				
Community mobilization on back to learning	# of people	33,600	33,600	168,000
Community mobilization on landmine awareness	# of people	33,600	33,600	168,000
E7 creating safe learning environment				
schools receiving black boards	# of blackboards	13,200	6,600	66,000
schools receiving combined desks	# of combined desks	165,000	41,250	4,125,000
schools receiving PPE to adhere to the safe school reopening	# of people	1,100,000	770,000	3,850,000
Schools receiving text books to be reprinted due to damage and content adjustment	# of printed text books	1,100,000	550,000	2,750,000
schools receiving rehabilitation support	# of schools	1,000	1,000	10,000,000
schools receiving temporary learning spaces	# TLS	500	500	5,000,000
schools receiving IT materials	# schools	2,200	550	11,105
Industrial cleaning of laboratory rooms	# of schools	500	500	250,000
school feeding service	# of children	1,150,000	345,000	10,350,000
<b>Total</b>				<b>56,744,305.00</b>



ORIGINAL PEOPLE IN NEED	REVISED PEOPLE IN NEED	ORIGINAL PEOPLE TARGETED	REVISED TARGETED	ORIGINAL REQUIREMENTS (US\$)	REVISED REQUIREMENTS (US\$)	CURRENT FUNDING GAP (US\$)
3.2M	3.0M	2.8M	2.4M	\$82.1M	\$86.4M	\$70.6M
% CHILDREN		% WOMEN		% MEN		% WITH DISABILITIES
42% 		28% 		31% 		17% 

## Response till September 2021

Between January and August 30, 2021, the ESNFI Cluster reached 707,980 beneficiaries with different emergency shelter and NFI solutions. As of September 2021, the ESNFI Cluster has received (committed, ongoing, and completed) \$36.8 million to address humanitarian needs in Tigray, out of the \$86.4 million required in the plan.

The emergency shelter responses are heavily underfunded while NFI coverage is considerably low. Due to this limited funding compounded with the overall lack of access and essential services, the Cluster has been continuously struggling to respond to its high priority needs. The Cluster has adopted different approaches to cope with the operational constraints, including revising the content of kits, and conducting prioritization in an attempt to make the limited available resources stretch further across the population in need.

## Change in Overview of Needs

The conflict in Tigray, now in its eleventh month, continues to affect millions of people, particularly women and children, subjecting them to displacement (new or continued), impoverishment, and the threat of violence. There are 2.1 million IDPs in Tigray. The majority of the IDPs were settled within host communities, while the rest are settled in 136 collective sites across the Tigray region. More than 100 IDP sites have a high population density; many IDPs are forced

to sleep in overcrowded spaces or inadequate living conditions, leaving vulnerable groups more susceptible to heightened risk of protection and health concerns. Amidst poor and overcrowded living condition of IDPs, COVID-19 cases were reported within the IDP sites in Mekelle where there are no sufficient isolation centers for contact cases.

IDPs often flee with little more than their clothes, meaning they lack the basic NFIs required to survive. In collective sites, people are observed sleeping without bedding sets which exposes them to pneumonia and other related diseases, particularly for old and other vulnerable groups. People also share cooking utensils and, in some sites, due to lack of jerrycans, IDPs are not able to collect or store water. So far, the Cluster has only reached 23 per cent of the IDPs in the collective sites with NFIs to address these needs.

While many of the displaced are settled in the collective sites, large numbers of IDPs are living within host communities. There is insufficient information on their situation and coping mechanisms; however, the host population has become as vulnerable as the displaced population as a result of having shared the few resources they had with the IDPs. No access to cash or income in the past few months has further aggravated the situation. Hence, the non-displaced general population has reportedly been affected by the loss of household assets and infrastructure damages.

However, as of September, the ESNFI Cluster provided very little support in terms of NFIs or shelter to the IDPs living within the host communities due to limited funding and operational constraints. Similarly, the IDPs in host community who pay rent have reportedly been joining the nearby collective sites due to lack of money to continue to pay rent which further strained the already stretched cluster response capacity.

Following the withdrawal of the ENDF in June, the prospects for displaced people's safe return to their areas of origin looked promising, however, very little return has taken place. With the exception of some zones, other areas of origin are conducive for return or could be made conducive by availing the required humanitarian return assistance. The recent Intention Survey indicated that the IDPs are willing to return to their places of origin, although IDPs are very cautious to return without the much-needed assistance. Many of the returnees may find their home partially damaged or fully destroyed and looted. As such, they would be forced to stay in inadequate housing without proper physical protection against harsh weather conditions. The Cluster assumes that with the exclusion of IDPs from the Western zone, 15 per cent of the IDPs can return to their place of origin

Children in Tigray have been out of school for close to two years due to COVID-19 and the ongoing conflict. There are plans to reopen schools in October 2021, however, many of these are currently used as shelters for displaced people. There is an urgent need to identify and ensure adequate living conditions in alternative shelters for these individuals. However, the Cluster does not have sufficient stocks to provide the resources for the provision of new alternative shelters and immediate return assistance, resulting from limited availability of funding as well as the absence of required environment to mobilize supplies into the region with available funding.

### Change in Response

To align with the changing context in Tigray, the Cluster has readjusted geographic and programmatic priorities and expanded its focus from IDPs in urban areas to IDPs, returnees, and the general affected

population in rural areas, which were inaccessible since the beginning of 2021 due to the security and access constraints.

The Cluster will continue providing a more fitted support tailored towards the targeted population's specific needs, considering displacement status (IDPs, returnees, and affected population), potential vulnerability, and type of settlement (collective sites, host communities, place of return). Emphasis will be made on sustainability, including benefit to local economies by sourcing and using locally available materials and labor. Cash or vouchers will be used wherever appropriate and possible. The Cluster continues applying a people-centered approach, with community participation through its active TWG in Mekelle and Shire. The ESNFI response considers cultural appropriateness, privacy for women and children, as well as climatic conditionality and cost-effectiveness.

Through the TWGs in Tigray (Mekelle and Shire), the Cluster is exploring and piloting different shelter options such as using available institutions, unfinished buildings, neighborhood approaches, cash for rent, and the provision of emergency shelter kits and ESNFI kits for IDPs settled in urban, semi-urban, and rural areas.

For returnees, the Cluster developed a First Line Response kit to ensure that the returnees have access to the minimum emergency shelter and NFI items that will serve as a transitional solution while the Cluster mobilizes resources for Shelter Repair kits. In addition, the Cluster advocates for an in-depth loss and damage assessment to inform the type of shelter solutions appropriate to the level of damage.

Based on the level of damage to houses and the loss of household assets, the affected community will be provided with NFI kits or cash-based support to repair houses or to facilitate recovery. In addition, the Cluster intends to strengthen its engagement in promoting and supporting durable solutions by providing shelter and cash for work assistance in areas of return, promoting local integration through social cohesion. In addition, the ESNFI Cluster will work closely with the Housing Land and Property (HLP) Working Group

under the Protection Cluster to support with proper documentation of land and property and to minimize risks of future evictions.





The ESNFI Cluster responses ensure that services are proportional to needs and all people regardless of gender, age, disability, ethnicity or any other diversities, have equitable access to impartial assistance. Furthermore, the Cluster will continue providing training to partners to ensure protection, GBV, AAP, CwC, and PSEA are mainstreamed in overall programming.

With this response, the ESNFI Cluster seeks to reach 2.4 million people for which 49.6 million dollars of financial support would be required from now (October) until the end of the year, 2021. The target has been reduced to 2.4 million. Despite the reduction in the number of target beneficiaries, the financial requirement increased by 5 per cent. This is because the returnee response packages which includes CGI sheet, poles, and nails are expensive compared with IDP response package which is mostly plastic sheet and NFIs.

Indicator	PIN (#)	TOTAL TARGET (#)	REVISED TOTAL REQUIREMENTS (USD\$)
Number of the displacement-affected population receiving emergency shelter and NFI assistance either in kind or through cash that considers the needs of women, children, people with disabilities and beneficiaries' safety.	438,837	393,655	16,168,923
Number of displacements affected populations that have received Non-food items either in-kind or through Cash that considers the most vulnerable or at risk and beneficiaries' safety	941,708	760,409	19,770,631
Number of displacements affected population that received in-kind or cash for emergency shelter assistance to improve physical protection and to reduce overcrowding	915,285	821,051	37,685,873
Number of displacements affected population that received in-kind or cash for Repairing their houses, disaggregated per gender and age	224,050	114,790	10,166,124
Number of Returnees whose houses are partially damaged and supported with cash or a repair kit	167,167	87,489	2,640,999
<b>Total</b>			<b>86,403,468</b>

# EMERGENCY TELECOMMUNICATIONS



ORIGINAL PEOPLE IN NEED	REVISED PEOPLE IN NEED	ORIGINAL PEOPLE TARGETED	REVISED TARGETED	ORIGINAL REQUIREMENTS (US\$)	REVISED REQUIREMENTS (US\$)	CURRENT FUNDING GAP (US\$)
N/A	N/A	N/A	N/A	\$1.2M	\$1.2M	\$0.7M
% CHILDREN		% WOMEN		% MEN		% WITH DISABILITIES
N/A 		N/A 		N/A 		N/A 

## Response till September 2021

The Cluster was activated on May 28 to provide emergency telecommunications services, and capacity building for the response community in three common operational areas (COAs) in the Tigray region. Since May, the Cluster, along with its partners and in support of UNDSS has set up emergency communications backbone network for the humanitarian community in Mekelle and Shire and provided capacity building session to support users in accessing the services.

## Change in Overview of Needs

With the evolving situation in the Tigray region, including the establishment of humanitarian hubs while local infrastructure is unavailable, the need for emergency ICT services and capacity building is critical and is required to adapt. In addition, with the increase in the number of staff participating in life-saving humanitarian activities, there is a need to ensure training on the use of communication tools is provided. Some of the prevailing operational challenges in the Tigray region include limited cash and fuel, obtaining visas as well as restrictions on moving critical telecommunication equipment into the region among others. A number of adopted strategies have been put in place to try to mitigate the prevailing operational challenges in the Tigray region, including fuel rationing and local sourcing of equipment.

## Change in Response

Based on these developments, a change to the initial response plan for the Tigray region has been made, to address additional requirements in the region. This plan will focus on emergency communications services and capacity building activities for the humanitarian community operating in the Tigray region. The Emergency Telecommunications Cluster will work closely with UNDSS to provide technical assistance to UNDSS in managing and maintaining the services which are critical in ensuring humanitarian staff's safety and security in the field. ETC will be focusing on strengthening its capacity to delivering more training to humanitarian staff on the use of communication devices.





Due to nonexistence of local services and internet service providers, this has directly impacted the access to internet for humanitarian community at designated locations. As the circumstance evolved, the resources allocated for that activity was redirected to further strengthen emergency communication lead by UNDSS and training humanitarian staff.



Key activity Indicator	Key activity Indicator	TOTAL TARGET (#)	TOTAL REQUIREMENTS (USD\$)
Coordination and Information Management	Platform and forum established to promote Collaboration and exchange of information	1	
Emergency Communications backbone network	# of common operational areas provided with security communications services	3	1,150,000
Capacity building activities	Platform and forum established to promote	3	

# FOOD



ORIGINAL PEOPLE IN NEED	REVISED PEOPLE IN NEED	ORIGINAL PEOPLE TARGETED	REVISED TARGETED	ORIGINAL REQUIREMENTS (US\$)	REVISED REQUIREMENTS (US\$)	CURRENT FUNDING GAP (US\$)
5.2M	5.2M	5.2M	5.2M	\$416.4M	\$416.4M	\$127.1M
<div> <div>% CHILDREN</div> <div>50% </div> </div> <div> <div>% WOMEN</div> <div>28% </div> </div> <div> <div>% MEN</div> <div>22% </div> </div> <div> <div>% WITH DISABILITIES</div> <div>18% </div> </div>						

## Response till September 2021

Access and security challenges within Tigray have greatly hindered partners' ability to reach and assist affected populations and delayed the first two rounds of food distribution within Tigray prior to late June. While Round 1 distribution has been completed, Round 2 distribution is ongoing in some locations.

Partners have completed Round 1 distribution as of 25 August, assisting 5,692,161 people with 96,144 MT of food across Mekelle town (416,813), Eastern (1,003,122), Western (61,771), Central (1,462,316), North-western (1,666,079), Southern (543,789) and South-eastern (538,271) zones of Tigray.

For Round 2 distribution which was launched in mid-May, 3,394,781 people have been assisted with 56,906 MT of food in Central (564,096), Southern (682,610), North-western (1,228,851), Eastern (475,760), and South-eastern (443,464) zones as of 01 September.

No partner has been able to start Round 3 distribution even though the launch was revised to early August instead of early July as originally planned. The significant delay continues due to supply shortage and inter-regional insecurity and operational challenges.

Between April and September 2021, food partners have distributed the agreed common food basket, meant to cover 63 per cent of the minimum caloric

needs (2,100 kcal per person per day) of the population, when stock was available. However, as rounds have stretched longer than expected (up to 4-5 months instead of 6 weeks), it is understood that the distributed assistance covered much less than the minimum caloric needs.

## Change in Overview of Needs

Available assessments are indicating that the number of people experiencing the most severe level of acute food insecurity in Tigray are the highest in the world since the 2011 Somalia famine<sup>9</sup>. According to the latest food security analysis, over 400,000 people in Tigray region are suffering from catastrophic levels of hunger (IPC 5) through the lean season; and across the region, more than 4 million people - 70 per cent of the population – are experiencing high levels of acute food insecurity (IPC 3 or above).

Based on qualitative information from the field, the number of food insecure people is increasing. Particularly, families with pregnant and lactating women, and/or with children under five are among the most vulnerable. Food prices have skyrocketed in disrupted markets in Tigray accompanied by significantly reduced purchasing power among vulnerable households. Even if the conflict does not intensify further, if humanitarian and commercial supply continues to be sporadic and insufficient, the evolution of the risk

factors of famine continues pointing towards the worst scenarios, particularly for October to December 2021.

The agricultural planting season has been missed in some parts of Tigray. There is no available food stock as many people were prevented from planting for months earlier this year. It is expected that food assistance will be required at least up to next year's harvest season during last quarter of 2022.

At least 5.2 million people are targeted for emergency food assistance in Tigray. In view of the deteriorating food security and nutrition situation, partners are revising their operational planning figures upwards to include additional needs identified on the ground. This has proven very challenging due to the increasing needs on the ground, which is often greater than the approved caseload allocation, the fluid population movement, turnover in the local administrative structure, and lack of documentation among the affected population.

During the first two rounds of food assistance under the 2021 response plan, partners are working to fine tune the planning figures and address inclusion and exclusion errors, with the hope that from Round 3 onwards, we will together have better understanding and more clarity regarding the population figures and the number of people in need of food assistance per location.

### **Change in Response**

Partners have been dispatching food and conducting distributions in prioritized woredas, especially targeting the areas that used to be hard to reach due to access/security and those that would be difficult to access during the rainy season. It has been a very difficult prioritization exercise for all food partners as the food requirements are significantly higher than the amount of available food commodities in Tigray.

To better understand the food security situation and improve the quality of assistance, partners are conducting process monitoring and post-distribution surveys as well as strengthening community-based complaint and feedback mechanism. Market price monitoring and household-level food security surveys

in accessible areas across the region will also be rolled out in September and October 2021. The Cluster is also working with the Tigray PSEA Network to enhance partners' capacities in PSEA preparedness and response.

Efforts to reach areas that were previously inaccessible by food partners and conduct food distribution closer to the target communities is being strengthened. Partners are also working to improve the timing of distribution as well as looking into the possibility of adding super cereal to the common food basket in selected hotspot locations to mitigate further deterioration in nutrition amongst the most vulnerable households.

The flexibility for timely inclusion of verified and vulnerable new caseloads for food assistance without allocation limitation is increasingly needed. Partners are working with the local administration to resolve the delays and inclusion/exclusion errors in local authority beneficiary registration and targeting, particularly for IDP populations.

The Cluster urgently calls for concrete assurance and actionable support in ensuring that free and unimpeded humanitarian access is respected by all parties; movement of humanitarian cargo into Northern Ethiopia is facilitated to assist vulnerable populations; and no humanitarian actor, including cargo drivers, is harmed for humanitarian efforts in Tigray region.





Lack of cooking energy and milling support remains a concern hindering food utilization and increasing protection risks. The Cluster is working with other Clusters and partners on the possibility of including transportation and food preparation associated costs in the food assistance package in prioritized locations.

The Cluster is working on a more comprehensive Northern Ethiopia Response approach, looking into how to address the emergency food needs in Tigray as well as the Amhara and Afar regions where it relates to the conflict and spill-over of the conflict, in a more systematic way.

Key activity	Indicator	PIN (#) (Individuals)	TARGET (#) (Individuals)	TOTAL REQUIREMENTS (USD\$)
Food assistance	Number of people assisted with food assistance	5,195,427	5,195,427	416.4M

# HEALTH



ORIGINAL PEOPLE IN NEED	REVISED PEOPLE IN NEED	ORIGINAL PEOPLE TARGETED	REVISED TARGETED	ORIGINAL REQUIREMENTS (US\$)	REVISED REQUIREMENTS (US\$)	CURRENT FUNDING GAP (US\$)
3.8M	3.9M	2.3M	2.3M	\$48.2M	\$48.2M	\$29.7M
% CHILDREN		% WOMEN		% MEN		% WITH DISABILITIES
49% 		28% 		23% 		18% 

## Response till September 2021

There are 24 Health Cluster partners in Tigray, of which 20 are direct implementing partners. The remaining four partners provide technical and material support. From January to July, the Health Cluster was focussed on providing the maximum access to health care through Mobile Health and Nutrition Teams (MHNT). There were 56 operational teams moving to many hard-to-reach areas, each with a coverage of 10,000 people covering 67 woredas in 7 zones of the Tigray region. This represented a catchment population of over approximately 560,000 people. As of July 2021, when access to most regions improved, the MHNT continue to operate and move to hard-to-reach areas and IDP camps, but many now provide support and capacity to previously non-functioning health facilities. The key focus for the health sector is building back the non-functional health facilities. In line with PSEA, an exploration will be done to distribute PSEA awareness material in collaboration with the local health authorities. There is a plan to train all these partners on PSEA and for them to sign the Code of Conduct.

The Health Cluster partners distributed medical equipment such as 24 Solar Derived Fridges for immunization and supplies, including Emergency Drug Kits, and Midwifery kits to health facilities to ensure that affected population have easy access to life saving health services in different parts of the region. Through partners like WHO, UNICEF and UNFPA the

Cluster supported Regional Health Bureau (RHB) to preposition appropriate medical kits in hospitals and health centres—for essential services, nutrition and water, sanitation and personal hygiene and sexual and reproductive health to health facilities in woredas prone to different conditions.

In late June 2021, the first round of the Oral Cholera Vaccination (OCV) Campaign provided cholera vaccination to almost 1.5 million IDPs and host communities in high-risk areas. In complement to this campaign, the Cluster partners promoted dissemination of different health messages that would encourage behavioral change and prevent the spread of diseases like scabies, cholera, malaria, and COVID-19, hypertension, diabetes, and tuberculosis. The partners also continued to train pregnant women and lactating mothers on danger signs in pregnancy, benefits of antenatal and postnatal care, infant and young child feeding practices, benefits of breast feeding, personal hygiene, and nutrition. The cluster also supported the RHB in introduction and roll out of COVID 19 vaccination where 94,826 people received first dose of Astra Zeneca vaccine. The Cluster partners also continue to ensure that young children and newly born children receive their required immunization against the six killer diseases. In health facilities and through the MHNTs the partners continued to provide routine immunization of children.

With the continually growing number of malnourished children in the region, the Cluster partners continued to support the establishment, strengthening and maintenance of stabilization centers and units within health facilities across the region to provide requisite therapeutical support to children and pregnant and lactating women with nutritional problems. Through the MHNTs the partners have been performing nutrition screening on children and pregnant and lactating women in health facilities and IDP sites to identify the cases for medical attention.

### Change in humanitarian needs

Healthcare services in Tigray are alarmingly limited, leaving hundreds of thousands of people, including those injured during the fighting, internally displaced people, children, pregnant and lactating women and survivors of sexual violence without adequate access to essential medicines and basic health care. Health facilities have been targeted, attacked and looted over the course of the conflict, and less than half of the referral hospitals of the region are now operative.

The Tigray RHB conducted assessments of 200 health facilities in July 2021, exposing additional destruction and looting to health and other strategic public facilities, further reducing the population's access to health services. The assessment revealed that 65 per cent of hospitals and 87 per cent of health centers have been looted, damaged and vandalized. Currently there are inadequate or no essential drugs, medical equipment, or supplies. The health supply chain into Tigray has been totally interrupted since May 2021, and health partners, including WHO, are about to completely run out of supplies. Since May 2021, the Health Cluster has been able to receive supplies on only two convoys and the quantities have been largely unable to serve the cluster partners. At the moment, drugs and medical supplies remain blocked at Semera as humanitarian community continues to call for unfettered access for the movement of the supplies into Tigray.

The surveillance reports have shown the drastic increase of malaria, acute respiratory tract infections, diarrheal diseases and severe acute malnutri-

tion cases. The morbidity and the burden of those diseases/ health conditions are the lingering difficult status of the communities (no water, no food, no access to health care). Therefore, the response strategy must be adapted to tackle and correctly answer those challenges.

There is an increased risk of diseases outbreaks due to displacement of populations who are currently sheltered in crowded conditions without adequate access to safe water and sanitation. Adding to those conditions, the unreliable and limited telecommunications affect and weaken the surveillance, data management and reporting system. Similarly, there is a clear disruption in the service organization, the delivery of services and the sharing of information and reports. The region is known to be malaria-prone; the rainy season will increase the number of cases and the limited access to prevention, tests and treatment could aggravate the situation. The risk of a measles outbreak is high due to a range of issues such as overcrowding IDP camps but is mainly due to the disruption of the health services and in particular the mother newborn and child health services and in particular the interruption of routine immunization resulting in a low measles vaccination coverage for the first and second dose. The weakness of the existing surveillance system otherwise capable of early warning and rapid detection of the disease could result in an outbreak.

These adverse events have led to a pronounced rise in acute malnutrition and translated in alarming rates of severe acute malnutrition SAM admissions in the region. The number of both Moderate Acute Malnutrition (MAM) and Severe acute malnutrition (SAM) admissions in 2021 continues to rise in proportions higher than the previous years of 2019 and 2020. There is need for enhanced nutrition screening to identify cases in the community and therapeutic feeding programs to treat SAM.

The breakdown of social infrastructure, the disintegration of families and communities and the disruption of humanitarian responses heighten the risk of GBV, particularly for women and girls, including



in the form of SEA. Up until June 2021 there were alarming increase in reports of sexual violence in Tigray region, including rape cases. Since, June, the number of reported cases continues to increase due to both new cases and to many survivors who had previous not reported coming forward. The ongoing COVID-19 pandemic and high level of conflict driven displacement worsens the health outcomes of groups that face significant barriers in accessing health care including women, girls, boys and older persons.

The average worldwide estimates for the proportion of people suffering from mental health conditions (anxiety, depression, and psychiatric conditions) is 15 per cent. In areas of conflict, WHO estimates that the prevalence of mental disorders (depression, anxiety, post-traumatic stress disorder, bipolar disorder, and schizophrenia) was 22.1 per cent at any point in time in the conflict-affected populations assessed.

COVID-19 response and prevention measures remain a priority public health concern with reports of increasing number of cases reported by the Public Health Emergency Management program. Hospitalizations are reported and recently, reporting of cases of COVID-19 has ceased, due to lack of testing and due to outages of testing materials. There is also limited awareness, adherence to preventive measures, coupled with limited testing and weak capacity for treatment due to the looting of equipment from hospital intensive care units and previously designated COVID-19 treatment centers.

Health partners need urgent funding and access to replenish facilities across the entire region with medicines, consumables and medical equipment to enable health workers to continue and expand life-saving health activities. Although health care providers are returning to work, there are still challenges in remuneration, as last salaries were received in May 2021. The limited cash flow due to banking restrictions and availability of cash is affecting the implementation of response activities by health partners.

The referral system is completely disrupted/halted and it is not clear where the patients could potentially

get access to alternative and appropriate health care to manage their conditions. The ambulance system is also no longer functional since when fuel became unavailable in the entire region.

### **Change in the response**

The crisis in Tigray region has increased the vulnerability of women, girls and boys, their access to basic services is severely curtailed. Improved access to the various zones in Tigray region has revealed the increased scale of needs to be met. As a result of the RHB Health Facility Assessment and information from health partners, 200 health facilities (HF) have been classified into 3 priority groups. Priority I (116 HF), Priority II (39 HF) and Priority 3 (45 HF) distributed across 6 of the 7 zones of the region. Although the Western zone of Tigray was inaccessible during the assessment, health cluster partners will also ensure maximum response in the Western zone, when access permits through MHNTs.

Since July 2021, access across Tigray has improved with over 75 per cent of the region accessible which prompted the change in the response strategy from heavy reliance on MHNTs that operated in hard to reach areas and IDP camps to nearly half of the 56 MHNTs now providing direct support, ensuring the rehabilitation, capacity building and restoring functionality to the non-functioning static health care centres. The suspension of 2 key health care partners operating in Tigray in July and August left a gap in service provision in over 20 facilities and IDP camps which has meant stretching limited partner resources to fill the gaps.

Another top priority is the urgent need to strengthen the surveillance systems and outbreak response measures. Less than 25 per cent of the health facilities provide regular weekly reports. All partners are working to support the RHB to ensure strengthened health surveillance systems. The risk of a cholera outbreak remains high in the region due to the volume of displaced people sheltering in crowded conditions without adequate sanitation. The region has consistently reported cholera outbreaks annually over the last five years. The rainy season could aggravate

cholera transmission due to increased contamination of water sources by waste. There is a need to accelerate cholera preparedness activities including prepositioning of supplies and the implementation of the second round of the Oral Cholera Vaccination campaign.

Routine immunization has been fully disrupted for over 10 months since the beginning of the conflict in Tigray. Health cluster partners will support the RHB in the implementation of Supplementary Immunization Activities targeting over 750,000 children between 0 and 59 months (including measles, polio, vitamin A, deworming). In addition, the cluster will support resumption of routine immunization services in health facilities.

To achieve these priorities, the five core objectives of the health cluster response will remain:

1. To institute measures to prevent, promptly detect, and ensure a multisectoral response to a potential disease outbreak;
2. To ensure affected populations can access integrated essential health services and address priority health conditions including reliable referral systems;
3. To support Treatment of Acute Malnutrition;
4. To strengthen service readiness and availability for clinical care of GBV survivors and MHPSS services;
5. To strengthen multisector coordination to prepare, plan and respond to the ongoing and emerging humanitarian health and outbreak needs.

Although the number of people in need of humanitarian health interventions has increased from 3.8 Million to 3.9 million due to the increase in IPDs and the number of non-functional health facilities, the target population of at least 2.3 million IDPs, returnees and host communities remains an achievable goal if resources become available.

Key activity	Indicator	Target (#)	Original Requirements (US\$)	Total requirements (US\$)
		2.3 million		
Outbreak coordination (technical task teams and EOC at regional and zonal levels)	# Coordination hubs established	7 hubs		400,000
Surveillance				
Support the re-establishment of Early warning and notification including rumours on outbreak alerts and timely analysis through the PHEM mechanism.	% of functioning facilities reporting on a regular basis	50% of functioning facilities reporting on a regular basis		800,000
Support regular reporting, analysis and distribution of data on disease outbreaks including training on data collection (registers or electronic formats) for data sharing				
Prompt rapid response deployment to investigate and respond to disease outbreak alerts	% of alert responded to within 48-72 hours	70% of alert responded to within 48-72 hours		200,000
Capacitating Regional, Woreda and Zonal Hospitals Lab technologist on sample collection and transportation				
Case management	Cholera case fatality rate (CFR)	CFR less than 2%		800,000
Capacitating Health workers in case management				
Capacity building, including IPC, for support staff and CHW				
Deploying a team for case management from higher hospitals				
WASH				
Capacitate woreda health offices on water quality monitoring, testing and water treatment	# of woredas capacitated	20 woreda health offices		100,000
Strengthen IPC/WASH at health facilities by constructing and rehabilitating WASH infrastructures and capacitating human workforce	# of health facility WASH facilities supported	10		100,000

Risk communication and community engagement			
Train health care and community health care workers on outbreak prevention and control, early detection, and referral	# of Health workers and CHW trained on health promotion and disease prevention	1000 Health workers and CHW trained on health promotion and disease prevention	800,000
Health prevention and promotion			
Produce and distribute IEC/ BCC/PSEA materials and media messages to at risk and Woredas			
Strengthen community level hygiene and sanitation activities in risk Woredas			
Second round of OVC Campaign	Number of people vaccinated with oral cholera vaccination	1.5 million IDPs and host communities vaccinated with oral cholera vaccination	1,480,000
Support the delivery of essential health and nutrition services through the MHNTs in all the zones where health facilities are severely damaged.	# MHNT in underserved and crisis affected locations	50 MHNT	8,000,000
Reinforcing of existing health facilities in areas of high vulnerability.	number of health facilities rehabilitated	90 health facilities	4,000,000
Strengthening the referral systems for promotive, preventative and emergency services	number of functioning ambulances	80 ambulances	4,000,000
Prevention of COVID-19 transmission	# of single dose COVID-19 vaccine administered	190,000 single doses of the COVID-19 vaccination administered to priority populations	700,000
COVID-19 Response measures: Case Management; IPC Isolation; Contact tracing; Risk Communication; Covax-19 Vaccination			
	# of HFs that started COVID RDT testing.	14 Hospitals and 30 HC will provide RDT for COVID	300,000
Child Health			
Revitalize and /or strengthen Neonatal Corners	Number of HF Neonatal corners	120 mHF	120,000
Revitalize and /or strengthen IMNCI in selected HFs	Number of HF providing IMNCI services	120 HFs	100,000





Revitalize/ strengthen Neonatal ICUs in selected HF	Number of HF with Functional NICU	40 Hospitals	500,000
Strengthen routine immunization: Start catch up immunization in all facilities			
Undertake Regional Supplementary			
Immunization Activities for children 6 months to 59 months	# of children 6 – 59 months that received measles vaccination	750,000 children 6 – 59 months	3,000,000
Trauma care and mass casualty preparedness			
Strengthen routine immunization: Undertake Regional Supplementary Immunization Activities for children 6 months to 59 months	# of 750,000 children 6 months – 59 months that received measles vaccination	750,000 children 6 months – 59 months	1,100,000
Strengthen existing HIV services, and support the resumption of screening, detection and treatment (including PMTCT and PEP)	# of health facilities with HIV screening, detection and treatment capacity	34 health facilities with HIV screening, detection and treatment capacity	750,000
Enhance access to maternal health services, including service provision by skilled birth attendants	% of facility-based deliveries		1,500,000
Malaria prevention, response coordination	% increase of malaria cases compared to 2020		650,000
Provision of core pipeline for essential medical supplier			
Emergency health kits and supplies to respond to life-threatening conditions related to essential health care. (Including Cholera Kits, IEHKs, Malaria case management medicines, SAM Kits, RH kits, and outbreak response)	# and types of emergency health kits prepositioned and distributed to partners		11,000,000
Logistics and warehousing, including strengthening of cold chain			
Strengthen capacity of health workers on SAM management	# of functional stabilization centres	25 stabilization centres	900,000

Strengthen referral linkage among health facilities for SAM with or without medical complications			
Ensure availability of essential clinical care services for GBV survivors	# of health facilities with capacity for clinical management of rape	40 health facilities with capacity for clinical management of rape	250,000
Train health workers on appropriate, confidential, and timely care for GBV survivors			
Coordinate and or provide referral mechanisms between primary, secondary and tertiary health care services			
Establish a crosscutting SGBV Technical Working Group through a collaboration between Health, Protection Clusters together with AORs			
Train of health workers using WHO mhGAP Humanitarian Intervention Guide on management of priority mental health conditions and essential psychosocial skills			250,000
Establish a crosscutting MHPSS Technical Working Group through a collaboration between Health, Protection Clusters together with AORs			
Ensure strong health cluster coordination in Mekelle and Shire	# of implementing health partners	27 partners	400,000
Conduct health and multi-sector assessments			
Establish SRH TWG to coordinate the provision of clinical reproductive health services across the region			
<b>Total</b>			<b>48,200,000</b>



# LOGISTICS



ORIGINAL PEOPLE IN NEED	REVISED PEOPLE IN NEED	ORIGINAL PEOPLE TARGETED	REVISED TARGETED	ORIGINAL REQUIREMENTS (US\$)	REVISED REQUIREMENTS (US\$)	CURRENT FUNDING GAP (US\$)
N/A	N/A	N/A	N/A	\$8.4M	\$8.8M	\$4.7M
% CHILDREN		% WOMEN		% MEN		% WITH DISABILITIES
49% 		28% 		23% 		18% 

## Response till September 2021

The establishment of the two Logistics Cluster hubs in Tigray in 2021 has allowed the dispatch and storage of life-saving humanitarian cargo on behalf of the humanitarian community in the region. This has improved the efficiency of the response by bringing together the requests, consolidating supplies from different actors in the same convoys and making available storage capacity in strategic locations for the response, such as Semera, Mekelle and Shire. The presence of the different hubs facilitates the rapid leverage and scale-up of the response if needed.

The Logistics Cluster engaged with 91 partners (UN Agencies, International NGOs and NNGOs) in 2021. This engagement came from participation in coordination meetings held in Addis Ababa, Semera, Shire and Mekelle, their access to Logistics Cluster-facilitated transport and storage services or their attendance at Logistics Cluster training sessions. During the first semester of 2021, the Logistics Cluster made available 10,700 m2 of storage capacity in 7 hubs. At the hubs, partners were also able to access transport services to dispatch supplies to other hubs or woredas.

Regarding usage of logistics services, as of 31 August, 37 humanitarian organisations had requested transport or storage services to mobilise cargo into Tigray. This represents a total of 14,406 m3 of cargo transported and 7,365 m3 stored in the different

hubs destined for Tigray. More specifically and within Tigray, the Logistics Cluster provided warehouse capacity in Mekelle and Shire (a total of 2,160 m2) to the humanitarian community to facilitate the distribution of life-saving supplies to the woredas in Tigray. In these warehouses, 3,563 m3 of humanitarian cargo were received, and a total of 13,698 m3 were transported to 34 different locations in Tigray. Additionally, during 2021, 17 convoys were coordinated to deliver supplies to Tigray.

## Change in Overview of Needs

Disruptions in supply chains in Tigray have worsened in the last few months as a result of conflict, the rainy season impact and access constraints. Recent assessments indicate increased food insecurity, the potential for famine, high levels of SAMs and potential IDP returns and relocations, which would imply a scale-up of the humanitarian response in the region.

Since early July, the only accessible route to move cargo into Tigray has been the corridor from Semera to Mekelle through Abala. In response to this situation, the Logistics Cluster has strengthened the hubs in Semera and Mekelle to support the coordination and organisation of humanitarian convoys. In addition, transport has also been facilitated from Adama and Addis Ababa to Semera to consolidate the cargo dispatched in the convoys in the warehouse in Semera.

The main logistics challenges faced in Northern Ethiopia are the access constraints, lack of fuel and cash as well as transport availability and capacities. The security concerns and the existence of only one route to move cargo into Tigray (from Semera to Mekelle) are additional factors jeopardizing the timely delivery of life-saving humanitarian items into Tigray and in turn the availability of logistics capacities.

Due to the unpredictability of the access constraints in the following months, the Logistics Cluster is ready to strengthen its hubs in Gondar in Kombolcha if new road routes become available as well as to continue the support within Tigray through its two hubs (Mekelle and Shire).





### Change in Response

The Logistics Cluster is planning to organise airlifts from Addis Ababa to Mekelle. This is a response to the challenges faced to mobilise cargo into Tigray due to the availability of only one land route, the limited number of transporters, and the difficulties to transport and store cold chain cargo. These airlifts will allow the delivery of medicines and complement the transport services offered by road. The initial ten rotations of the 5mt aircraft will dispatch essential medicines to Tigray, ensuring proper handling and timely delivery. The Logistics Cluster will continue to facilitate road transport and storage services as needed.

Key activity	Indicator	PIN (#) (Individuals)	TARGET (#) (Individuals)	TOTAL REQUIREMENTS (USD\$)
Storage capacity available for partners		NA	2,160	8.8M
Cargo storage and transported (m3)		NA	25,500	
Number of humanitarian organizations accessing storage and transport		NA	45	

# NUTRITION



ORIGINAL PEOPLE IN NEED	REVISED PEOPLE IN NEED	ORIGINAL PEOPLE TARGETED	REVISED TARGETED	ORIGINAL REQUIREMENTS (US\$)	REVISED REQUIREMENTS (US\$)	CURRENT FUNDING GAP (US\$)
1.6M	1.6M	1.4M	1.4M	\$62.1M	\$75.7M	\$57.5M
% CHILDREN 66% 		% WOMEN 34% 		% MEN 0% 		% WITH DISABILITIES 0% 

## Response till September 2021

The nutrition cluster response prioritized the affected population based on need and delivered a package of nutrition interventions which included a combination of activities to prevent malnutrition and identifying malnourished children, as well as PLW to offer appropriate treatment. Most children aged 6-59 months, and PLW in areas where partners are operating were regularly screened and appropriately referred to therapeutic feeding and targeted supplementary feeding as well as blanket supplementary food.

By mid-August 2021, a total of 759,872 screenings were conducted for children aged between 6-59 months from 86 rural woredas, towns and IDP sites were screened in Tigray region. Since the beginning of February 2021, a total of 1,006,614 screening of children under the age of five have been conducted. On average 2.0 per cent (20,175) have been identified as SAM and 15.1 per cent (151,941) were identified as moderately acute malnourished (MAM). Out-patient therapeutic treatment for those without medical complications and in-patient-treatment (stabilization centre) for those with medical complications were offered as required. All those identified with moderate acute malnutrition, 15.1 per cent (151,941) were put through supplementary feeding programme to manage malnutrition by using Specialized Nutrition Foods/products.

## Change in humanitarian needs

Nutrition programme interventions data since January 2021 has shown a steady increase in the number of children and pregnant and lactating women who are malnourished. Over a half (50.3 per cent) of 184,227 PLW screened between February and mid-August 2021 were found to be malnourished. At the same time, out of all children screened, on average, 2 per cent were identified with severe acute malnutrition while 14.5 per cent were identified with MAM. This showed persistent presence of malnutrition within the population, a situation that is potentially deteriorating with decreased access to food, limited availability of nutrition supplies for management of malnutrition as a result of logistic constraints and limited or no access to health services by the general population.

Considering the current constraints on nutrition programme interventions that include lack of access to food distribution points as well as lack of access to cash by Nutrition partners, lack of fuel and essential Nutrition supplies, the situation is expected to deteriorate. A total of 1,667,807 children aged under five and pregnant and lactating women will need nutrition interventions by the end of the year. The Western zone of the region has remained largely inaccessible in terms of implementing nutrition activities. A large majority of the population in Western zone has experienced displacement, with little or no access to adequate food and health services. Over 400,000 people in Western zone remain in need of humani-

tarian services with food and nutrition services the urgent priorities.

### Change in response

The Nutrition Cluster will continue prioritizing woredas that were classified under IPC 4-5 food insecurity, high concentration of displaced populations (in camps and withing the host community) and linkage to other services that would potentially help curb increasing cases of malnutrition among children and pregnant and lactating women. Priority woredas include Asgede, Seyemti Adyabo, Maekel Adyabo, Tsimbila, Endabaguna and Zana in the North Western zone; Tanka Milashin Central zone; Gerealta in the Eastern zone; Wejerat In South-Eastern zone and Neksege in Southern zone. The Cluster will have an increased focus on prevention of malnutrition with intensified activities on community engagement, support to optimal infant and young child-feeding practices and micronutrient supplementation for the children aged 6-59 months and pregnant women, along with more coordinate work with the food cluster coordination for more nutrition-sensitive targeting and programming.

Nutrition partners conduct routine community activities and engage directly with the communities during the screening of children under five for malnutrition. These interactions will be used to mainstream protection activities. The community workers will be sensitized on issues related to gender-based violence, and negative coping mechanisms to deal with food insecurity and will be able to direct those affected to the referral pathways to access assistance. Working closely with the Food Cluster, vulnerable households

will be targeted ensuring female headed households and those households with malnourished children are reached with food distribution to minimize their vulnerability to negative coping mechanisms.





Establishment of IYCF corners (safe spaces) in the IDPs centres and sites will also be used to provide safe spaces for dialogue with the affected mothers on the sensitive issues that affect them, including some of the cultural practices that could be discriminatory in regards to food consumption and access to reproductive health services. While undertaking nutrition assessments and surveillance efforts will be made to collect and analyze protection related concerns and data collected from these assessments will be disaggregated by sex age and disability.

Estimation of the nutrition response financial requirements is activity based and includes both prevention and treatment of acute malnutrition for the treatment of SAM the target doubled from 23,000 to 56,000 in the revised plan. Most of the nutrition prevention activities are population based and target women and children for activities such as supplementation and deworming. Therefore, the overall target does not change significantly unless there are significant changes in the population demographics or total numbers. The total beneficiaries to be reached is not the sum of each indicator rather its adjusted to avoid double counting.

Key activity	Indicator (if Applicable)	PIN (#)	Target (#)	Revised Total requirements (USD\$)
Treatment of SAM	# of children 6-59 months with SAM admitted for treatment	56,208	56,208	5,452,176
Targeted Supplementary Feeding	# children and PLW receiving supplementary food	768,080	537 656	49,867,480
BSFP (children/PLW)	# of children and PLW receiving SNF	841,620	841,620	
Vitamin A supplementation	# of children 6-59 month receiving vitamin A supplementation every 6 months	598,553	598,553	425,278
Infant and Young Child Feeding	# of primary caregivers of children 0-23 months receiving IYCF counselling	274,727	274,727	200,000
	# of children 6-23 months receiving SQ-LNS as part of complementary feeding	283,519	283,519	6,379,178
	# of PLW receiving SQ-LNS for appropriate nutrition	274,727	164,836	5,563,215
	# of Pregnant and Lactating Women receiving High Energy Biscuits	274,727	164,836	5,791,684
Assessment (SMART/ RNA)	# of assessments/surveys conducted	12	12	240,000
Coordination	# of coordination meetings conducted	42	42	482,581
Training/Capacity Building	# of personnel trained in Nutrition intervention areas	940	940	54,000
Iron and Folic Acid supplementation	# of pregnant women receiving Iron and folic acid supplementation	160,000	160,000	43,200
Screening/case-finding	# screening for children 6-59 months screened for acute malnutrition	708,796	708,796	1,152,672
Community awareness	# people reached with key information on nutrition services	1,013,096	1,013,096	21,000
<b>Total</b>				<b>75,672,464</b>

# PROTECTION



ORIGINAL PEOPLE IN NEED	REVISED PEOPLE IN NEED	ORIGINAL PEOPLE TARGETED	REVISED TARGETED	ORIGINAL REQUIREMENTS (US\$)	REVISED REQUIREMENTS (US\$)	CURRENT FUNDING GAP (US\$)
2.7M	3.0M	1.4M	2.3M	\$40.0M	\$67.3M	\$46.9M
% CHILDREN	% WOMEN		% MEN	% WITH DISABILITIES		
32% 	52% 		14% 	3% 		

## Response till September 2021

Protection partners rolled out a network of 57 protection desks in Mekelle, Shire, Axum, Adigrat, Abi Adi, Maichew to provide information to IDPs, identify vulnerable households and persons with specific needs, and to refer individuals in need to available service providers. Efforts are ongoing to strengthen the capacity of these protection desks and to roll-out new data collection and inter-agency referrals tools in order to identify response gaps and trend analysis of protection needs. Protection partners complemented protection desk activities with protection outreach and monitoring missions in areas outside formal IDP sites. Currently, a more robust protection monitoring framework is being developed, this includes daily visits to and reporting from IDP sites and host communities where IDPs are living, based on agreed questionnaire. Individuals in need for NFI distribution will be also identified and referred to the right assistance during these protection activities, monitoring field visits and meetings with IDPs during counselling at protection desks.

To increase the capacity of protection partners, government counterparts and other Clusters, protection trainings have been rolled out in the Tigray region, focusing on general protection, GBV, CP and Explosive Ordnance Risk Education, reaching 500 individuals since May 2021. Additionally, the Protection Cluster increased its efforts to conduct protection main-

streaming sessions for partners of non-protection Cluster like Shelter, WASH and CCCM.

Child Protection and GBV partners have prioritized the safety and dignity of IDPs, while avoiding causing harm, through identification of vulnerable cases including unaccompanied and separated children, emergency case management and referrals to life-saving services. This includes providing alternative care arrangements, family tracing and reunification for unaccompanied and separated children, as well as specialized services for GBV survivors and MHPSS and dignity kits distribution for women and adolescent girls of reproductive age. Additionally, partners work closely together with the IDPs on community-based engagement through establishment of youth and female community-structures such as community-based child protection mechanisms and information provision and awareness-raising activities on IDPs rights, child protection, sexual violence, PSEA and GBV.

With increasing access within the Tigray region, protection partners have been exploring options for thematic and geographical expansion of current protection programming, with a focus on GBV, CP, HLP and protection monitoring, protection desks and community-based protection.



When Regional Authorities announced that schools will be reopened at the end of September and the vast majority of IDP sites will be vacated, protection partners have been part of the Relocation Task Force (co-lead by CCCM and Protection Cluster) to identify and assess relocation sites, and prepare them to receive relocating IDPs. By identifying community safety nets and alternative arrangements for child-care to minimize the separation and UASC, partners will work to ensure further family separation. In Mekelle, Sabacare4 is being prepared for 3,450 HH (approximately 17,250 individuals) and additional sites are being identified. Similar exercises have been conducted in other locations in Tigray. Spontaneous returns of IDPs to their areas of origin started to increase in mid-July 2021. It is expected that the opening of schools and inability to meet basic needs in areas of displacement will be additional push factors for returns. To prepare for an increased return, the Protection Cluster provided support to Regional Authorities to develop a Return Plan, which will be further coordinated, and implemented by all Clusters.

### **Change in humanitarian needs**

IDPs continue to be displaced by the conflict in Tigray region, with increased movement into Central and Eastern Tigray zones and neighbouring regions of Amhara and Afar. Access improved during July and August with more informal IDP sites requiring assistance in remote areas that were previously inaccessible.

The inability to get supplies and food into Tigray, combined with the inability to cultivate lands resulted in a situation in which the lifeline provided by host communities to the IDP population is slowly being depleted. IDPs are facing increasing difficulties in meeting their basic needs and humanitarian actors do not have the supplies available to provide the much-needed assistance. The inability to meet basic needs has resulted in increased reports of survival sex, begging, child labour and affiliation with armed groups since July. These trends will require specific protection interventions above and beyond those incurred during the conflict itself.

Conflict-affected communities continue to see a breakdown in pre-existing social structures and justice mechanisms including lack of civil documentation, which has resulted in safety threats such as the destruction of housing and property, theft, harassment, GBV, and family separation. Women, girls, at-risk children, UASC, older persons, and persons living with disabilities are disproportionately impacted by the risks presented by the conflict and by the absence of community support structures.

There has been a sharp rise in the number of reported cases of family separation and UASC. At least 7,000<sup>10</sup> UASC, out of which 40 per cent girls, are believed to be living in Tigray and family tracing is increasingly challenging without internet and phone connectivity. The majority of unaccompanied/separated children, and child headed households have not received assistance. There has also been an increase in reported GBV cases, which is believed to represent only a small proportion of the actual number GBV incidents that have taken place since the beginning of the conflict. Due the lack of access to medical facilities in many parts of the region, as well as due to social stigma as well as fear for retaliation, there is underreporting in the number of GBV incidents.

There are wide ranging disability support needs across Tigray, which might increase due to unexploded ordnances yet to be cleared. A shortage of walking and other assistive aids is leaving many persons with specific needs immobile and unable to participate properly in community life.

The overall inability to meet basic needs and the lack of humanitarian assistance provided in the Tigray region is resulting in low morale and wellbeing among the IDP population, leading to a significant increase in MHPSS needs, which continue to be largely unmet. Widespread and mainstreamed MHPSS interventions are critical, not only to respond to existing trauma, but to assist communities to cope with ongoing hardship and change.

The Regional Authorities have announced the reopening of schools in October 2021, meaning that

the majority of collective IDP sites will need to be vacated. This will require most IDPs to relocate to new sites some may be unsafe or lack basic services necessary for persons to sustain themselves. In addition, IDPs might return to areas of origin if the provision of basic needs assistance, such as food, shelter, and water, in the areas of displacement is insufficient. From a protection point of view, one of the main concerns is HLP and lack of documentation issues, especially in the context of return as part of durable solutions. For example, IDPs losing their land and property, proof of ownership documentation in the areas of origin.

### Change in response

As the majority of collective sites hosting IDPs are schools that will reopen in November, a shift in protection programming from current IDP sites to places of relocation, host communities and return areas will be needed. Protection partners will be closely involved in the preparation of the relocation to ensure that community support networks are not broken during the process and relocation takes place in a protection-sensitive manner (also voluntary), ensuring the safety and wellbeing of the affected persons. In the relocation sites, protection services will be established, and protection partners will be part of the assessment identifying new potential relocation sites.

Given the limited protection capacity of and the high number of new staff within local partners, a further expansion of capacity building of both partners and the new regional government across all of Tigray is needed to ensure local partners and government officials can meet the variety of needs present in accordance with best practice standards, especially in the context of increased protection concerns.

The expansion of the Protection Desks network and establishment of continuous protection monitoring in the entire Tigray region will strengthen the identification of persons with specific needs and disability and enhance referrals to specialized service providers.

As conflict-affected communities continue to see a breakdown of their pre-existing social structures, a significant investment in Community-Based Protection activities is needed to capacitate the existing

structures and establish new structures where needed. Especially in the context of relocation and return planning it is a priority to ensure any transition takes place in a safe and dignified manner and proper two-way communication is established between the IDP communities and humanitarian actors.

With these considerations in mind, child protection partners CP AoR plan to reach 1,561,527 children and caregivers in total for the remainder of the year. To respond to the increasing number of increase in reported unaccompanied and separated children, as well as reported negative coping mechanisms such as child labour and child recruitment, CP actors will continue to strengthen the identification of children-at-risk, emergency case management and referrals to multi-sectoral life-saving services, community-based engagement, information provision on available services and reporting mechanisms as well as MHPSS and psychological first aid in IDPs sites and in host communities.

Similarly, to respond to the increased needs, GBV partners will expand case management activities, mental health and psychosocial support services, dignity kits distribution to women and girls of reproductive age, prevention, and risk mitigation through safe spaces and safe reporting channels. At community level, strengthening medical management of sexual violence, integrated sexual reproductive health services through one stop centres, functional health facilities, urgent provision of clinical management of rape and provision of reproductive health kits is needed.

Furthermore, various assessments conducted by GBV partners on non-medical GBV services, highlighted a dire need for GBV response, prevention, and risk mitigation services in the newly accessible areas. The assessments by the Regional Health Bureau identified about 71 health facilities including Primary health care, health centres and hospitals as severely affected and completely non-functional, and therefore in need of complete restoration of infrastructure, human

resources and services, including clinical management of rape and Sexual and Reproductive health capacity.

Protection partners will scale up Mine Action activities in Tigray region. The delivery of explosive ordnance risk education (EORE) messages to humanitarian personnel and populations at risk, threat assessment and victim assistance are becoming increasingly important in an environment with a potential high number of explosive remnants of war and unexploded ordnances. Housing, Land and Property (HLP) issues are expected to rise in the context of increased spontaneous return to areas of origin. Efforts are being made to ensure services are responsive, and available to address the needs of the children returning from armed groups activities.

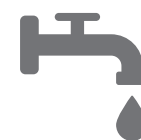
The Protection Cluster, together with its partners, will continue to support survivors of violence and grave human rights violations and their families. This includes referrals to medical care, MPHSS, emergency cash support and advocacy for the effective investigations and accountability measures as part of the survivors' right to effective remedy and in an effort to prevent further abuses.





Ongoing access restrictions into and from Tigray are expected to exacerbate the protection risks described above, as well as significantly limit the ability of cluster partners to deploy specialized equipment and personnel to those areas where the most vulnerable people are in need of critical assistance.

Key activity	Indicator (if Applicable)	PIN (#)	Target (#)	Revised Total requirements (USD\$)
GBV : Information provision awareness raising activities on child protection, sexual violence and GBV including HP risk mitigation, prevention, response and IDP rights including available services to affected population	# women, men, girls, and boys access awareness services CP and GBV risk mitigation, prevention, and response services in IDP camps and in host communities	1,030,000	804,649	20,116,225
GBV : Capacity building (including refresher training) for service providers, community leader, and humanitarian staff	# of service providers, community leaders and humanitarian staff trained on GBV issues	9,600	7,500	1,125,000
GBV/CP: Identification emergency case management and referrals to life saving services for women, men, and children including basic child protection case management family tracing and reunification, and alternative care arrangements for unaccompanied and separated children persons with disabilities and survivor of GBV through protection monitoring and community structure	1. # of people (including women, men, girls and boys) in IDP camps and host communities who have experienced violence reached by health, social work or justice/law enforcement services	21,700	16,982	3,396,450
CP : Identification emergency case management and referrals to life saving services to children including basic child protection case management family tracing and reunification, and alternative care arrangements for unaccompanied and separated children persons with disabilities and survivor of GBV through protection monitoring and community structure	2. # unaccompanied and separated children accessing family-based care or a suitable alternative care arrangement	7,200	5,661	1,132,150
CP : Information provision awareness raising activities on child protection, sexual violence and GBV including HP risk mitigation, prevention, response and IDP rights including available services to affected population	# women, men, girls, and boys accessing CP and GBV risk mitigation, prevention, and response services in IDP camps and in host communities	1,106,000	864,051	17,281,020
Protection : Tailored assistance for persons with specific needs and referrals	# of individuals with specific needs identified and referred for assistance	34,100	26,400	400,000
Protection : Information and training on IDP rights (including civil documentation and HLP rights) provided to community members, local government authorities including law enforcement and court authorities	# of experts from local government authorities, including law enforcement bodies, and community members provided with training	100	100	3,000

GBV : Psychological first aid and focused mental health and psychosocial support (MHPSS) provide to persons in need (including children at protection risk and women and adolescent girls	#of women, men, girls and boys accessing PFA and MHPSS in IDPs camps and host communities	154,845	120,697	7,241,820
CP : Psychological first aid and focused mental health and psychosocial support (MHPSS) provide to persons in need (including children at protection risk and women and adolescent girls	#of women, men, girls and boys accessing PFA and MHPSS in IDPs camps and host communities	189,255	148,148	7,037,030
Women, adolescent girls and girls with specific needs of reproductive age provided with dignity kits	#of women and girls of reproductive age provided with dignity kits in IDPs camps and in host communities	449,000	350,802	9, 518,250
<b>Total</b>				<b>67,250,945</b>

# WASH



ORIGINAL PEOPLE IN NEED	REVISED PEOPLE IN NEED	ORIGINAL PEOPLE TARGETED	REVISED TARGETED	ORIGINAL REQUIREMENTS (US\$)	REVISED REQUIREMENTS (US\$)	CURRENT FUNDING GAP (US\$)
4.5M	5.2M	3.2M	5.2M	\$78.3M	\$112.0M	\$88.5M
% CHILDREN	% WOMEN		% MEN		% WITH DISABILITIES	
50% 	28% 		22% 		18% 	

## Response till September 2021

**Water:** WASH partners have delivered 496,555 m<sup>3</sup> water through water trucking to approximately 1.47 million people by the end of September 2021. Most were displaced people. Further, 911,000 people have access to safe drinking water through durable solutions. WASH partners will also prioritise the rehabilitation of existing water systems to ensure sustainable and durable water source to communities as well as reduce the high costs of water trucking. From a target of 1.84 million, set in May, approximately 1.47 million people have been reached with water supply with on an average 1.87 LPCD.

**Sanitation:** Constructing communal latrines, hand-washing, and bathing facilities within IDP sites for people to access sanitation facilities has been a main priority. Over 400,000 IDPs have access to sanitation facilities of which over 31,191 have been constructed or rehabilitated by WASH Cluster partners. In addition, 739,000 people have been reached through the distribution of WASH NFIs, including NFI Kits, Hygiene Kits, Dignity Kits, bathing & laundry soap etc. The WASH NFI need for host communities is high and the response to address this need has been limited. The harmonization of NFI items and their delivery has been undertaken by the Hygiene Promotion Technical Working Group.

Hygiene promotion remains a priority for the WASH response in IDP sites and in woredas with high risk of disease outbreak e.g. Cholera, AWD, Dysentery etc. To ensure that the hygiene promotion activities are effective, the WASH Cluster has emphasized the deployment of two outreach workers per 1,000 beneficiaries. WASH partners have reached almost 400,000 people with ongoing and completed hygiene promotion messaging activities. However, a massive scale-up of the hygiene promotion activities is still required in the coming months to reach more beneficiaries.

WASH Cluster partners work closely with Regional Water Bureau (RWB) and Zonal/Woreda Water Offices to ensure coordination of service delivery. The main operational challenge during the period was access. Except for Western zone, access has improved significantly across the region, however, access to resource the response in the form of cash, fuel, and WASH supplies, has severely declined and limited the WASH response capacity.

## Change in response

WASH partners aim to prioritise the provision of the safe drinking water through water trucking for the displaced population and hotspot sites identified based on public health risks. Currently, IDPs are mainly hosted in schools and other public collective sites. As the plans to re-open schools, IDPs will be transferred to relocation sites in seven towns.



WASH partners will engage in the relocation strategy and return strategy to ensure IDPs have access to adequate and appropriate WASH services. The relocation strategy for the IDPs will start with Mekelle, Abiadi, Axum, Sheraro, Adwa, Adigrat and Shire Indaslassie towns. The target population of IDPs to be relocated is approximately 472,000 people. The implementation of WASH facilities within relocation sites will follow shelter construction.

It is important to note that the WATER trucking capacity in the region is decreasing. By end of September, 39 water trucks were engaged in emergency water supply. Towards beginning of October, the capacity has reduced to 24 due to shortage of fuel, cash and supplies for water point rehabilitation.

To enhance the efficiency of the response, the WASH Cluster is activating the coordination mechanism at five sub-Zonal locations in Sheraro, Axum, Adigrat, Mai Chew and Abi Adi. A focal point from the RWB and an active WASH Cluster NGO partner will lead the coordination. Weekly meetings will be held to aid in minimising gaps and overlaps, promote the efficient use of limited resources and improve response monitoring. For the Western Zone, the WASH Cluster has also engaged a rapid response mechanism through CARE, targeting over 120,000 people across nine woredas with water, sanitation, and hygiene promotion activities.

As the situation stabilizes, the sanitation approach will be focused on improved household sanitation facilities over the provision of communal facilities. The design and construction of the sanitation facilities considers durability aspects, privacy, user acceptance and gender segregation. The sanitation designs are validated through the WASH Cluster.

The rehabilitation of water schemes will support host community and will aim to reduce water trucking. 75 per cent of people in Tigray live in rural areas and most of the IDPs are coming from these rural areas. According to Functionality assessment conducted by Regional Water Bureau, 7.1 per cent of 19,251 water points in 6 zones were non-functional in 2019. During 2021, out of 19,251 water points, 17,080 water points in 5 Zones were assessed. 54.35 per cent of 17,080 water points are non-functional. A total 3,570,682 people are not having safe drinking water access due to the non – functional water point. Repairs and rehabilitation costs are estimated to 3,292,708,088 Birr or 73,171,290.85 USD.

The rehabilitation of rural water points is a priority to foresee IDP returns. WASH Cluster will work with RWB and town water utilities to reinforce the management of water schemes through capacity building of water utilities technicians and managers and support with fuel and tools to start running the system. This Functionality assessment finding will guide the water provisions and rehabilitation / maintenance needs to improve water access for selected sites, the population around the sites and in the villages of return.

Key activity	Indicator (if Applicable)	PIN (#)	Target (#)	Revised Total requirements (USD\$)
Emergency water supply through water trucking	# of people having access to safe drinking water through water trucking	2,036,398	2,036,398	28,509,572
Rehabilitation and maintenance of existing water schemes including expansion	# of people having access to safe drinking water through durable solutions	3,163,602	2,372,702	52,199,433
Construction and maintenance of emergency latrine, bathing space and handwashing facilities	# of people accessing sanitation facility (latrine, bathing space and handwashing facilities)	2,036,398	2,036,398	25,454,975
Provision and distribution of life saving WASH NFIs including Water treatment chemicals	# of people provided with lifesaving WASH NFIs	1,018,199	1,018,199	12,218,388
Hygiene promotions with essential NFI provisions	# of people reached through hygiene promotions and essential WASH NFIs	3,163,602	3,163,602	22,145,214
				<b>112,018,010</b>

# REFUGEE

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## Response till September 2021

The refugee response in Tigray is part of the Ethiopia Refugee Response Plan, under the leadership of the Agency for Refugees and Returnees Affairs (ARRA) and UNHCR at national level. For more information, please read the updated version of the 2021 Ethiopia Refugee Response Plan.

After the easing of access restrictions in late February 2021, UNHCR and partners scaled up presence with emergency teams and expanded its office in Mekelle. Since July, UNHCR has permanent presence in Mekelle, Shire, Mai Tsebri, Sheraro, Adwa, Axum, Embamadrie, Dansha (remote), Adigrat, Maychew in the Tigray region, and scaled up its presence in Debark and Semera as well. This upscaling will further enable the humanitarian community to have better information about refugees and asylum-seekers outside Mekelle, Shire and the refugee camps to build programming and advocacy.

The support to refugees relocated to and residing in Mai Aini and Adi Harush camps continued, even though access and provision of assistance remained challenging due to the security situation. Depending on the timeline for the relocation, continued efforts were made to install, repair and improve water supply networks and storage facilities. Water trucking is required until the water systems are fully operational. Additional communal latrines and bathing facilities need to be installed to improve sanitation and hygiene conditions that deteriorated due to overuse and overcrowding. To directly respond to the deteriorated overall protection situation for refugees, both inside and outside camps, UNHCR and partners have been upscaling and strengthening protection services and basic needs assistance within the Tigray region. WFP provided in-kind assistance for about 26,000 refugees in Adi-Harush and Mai-Ayni refugee camps till August 2021 replacing the hybrid food and cash assistance as markets and banks are not functional in the area.

WFP is trying to deliver food through Abala (Afar) - Mekele - Shire route to resume the food distribution that stopped due to the conflict near the refugee camps.

The finalization of the new site Alemwach, where approximately 25,000 refugees are to be relocated, is being expedited and remains a priority to the refugee response. Of utmost priority is readying the new site across all sectors to receive refugees. However, due to the worsened security situation, the relocation of refugees to Alemwach is on hold. In the meantime, some 250 refugees were accommodated in interim emergency communal shelters in Dabat town, with electricity and water connected. Relocated refugees have received basic relief items as an interim measure. For vulnerable refugee families inside Tigray, possibilities are being explored to relocate to Afar region with approval of ARRA (Agency for Refugee and Returnee Affairs) and the Tigray Regional Authorities. In August, 53 Eritrean refugees were relocated from Shire to Aysaita, in Afar region. Awaiting the possibility for relocation to Alemwach, UNHCR will continue advocating for and looking into options to relocate vulnerable refugees to other locations outside Tigray.

In collaboration with ARRA, the verification of refugees displaced from Shimelba and Hitsats camps to other locations due to the conflict continued. In August, around 8,500 Eritrean refugees who fled the two camps destroyed at the onset of the conflict were issued temporary identification documents in Addis Ababa. The three-year documents will enable refugees to access assistance, services, and protection. A total of 9,000 individuals are expected to be registered throughout this activity. Refugee and asylum-seeker communities residing in Addis Ababa continue to receive support in collaboration with ARRA.

Since the de facto Tigray Regional Authorities took over the control of the Tigray region in June, the number of Eritrean asylum seekers who have not had the opportunity to apply for asylum, and who remain undocumented and unregistered has increased due to lack of presence of ARRA. UNHCR continues to advocate with ARRA for screening, verification, and registration of unverified asylum seekers. In addition, advocacy continues to provide refugees residing among the host communities in urban areas access to humanitarian services and temporary and longer-term solutions.

### **Change in humanitarian needs**

As of August 2021, 3,056 asylum seekers were monitored in the Tigray region. The number of Eritrean asylum seekers without access to asylum increased since Tigray Regional Authorities took over control of the Tigray region in June. As ARRA has no longer presence in the Tigray region, Eritrean asylum seekers no longer have the opportunity to seek asylum and remain undocumented and unregistered. As long as there is no presence of ARRA, being the Ethiopian government body mandated to screen and register refugees, the number of asylum seekers without access to asylum will continue to increase.

UNHCR verified some 1,500 registered refugees in out-of-camp locations in the Tigray, who reside among the host communities. Most individuals are residing in Mekelle, Shire, Sheraro and Adigrat. Overall, there are still 10,041 refugees unaccounted in connection with the Tigray situation. From refugees who resided in Hitsats and Shimelba, 7,643 refugees are still unaccounted for. Due to the lack of access to basic needs assistance and protection services, refugees residing outside camp settings face increasingly difficulties to meet their basic needs, such as access to shelter, water and food.

There is an increased negative attitude of host community members towards Eritrean nationals in the Tigray region, including refugees and asylum-seekers, due to the nature of the conflict and involvement of the Eritrean military in the conflict. This has been leading to increased levels of harassment and feelings of insecurity among the refugee and asylum-seeker popula-

tion, especially with those individuals that are residing among the host communities.

Due to lack of access to Alemwach, as a result of insecurity and ongoing fighting, the relocation plan for refugees residing in Mai Aini and Adi Harush to Alemwach has been put on hold. Mai Aini and Adi Harush residents are facing increasingly insecurity and physical safety concerns due to the vicinity of the ongoing conflict. Additionally, humanitarian access to Mai Aini and Adi Harush has also been challenging at times, resulting decreased humanitarian presence on the ground, delays in food distributions and continuity of protection and basic needs services. Alternative relocation options continuously need to be explored for vulnerable refugee households in the Tigray region.

As the conflict spilled over to Afar region, there was no access to Barhale Camp hosting 21,000 refugees and the three sites Aynedeb, Erebt and Adigua hosting 13,000 refugees due to security reason since end of June and July 2021, only ARRA staff are on the ground to do limited activities like Health and food distribution.

### **Change in response**

Between September and December, UNHCR, ARRA HQ in Addis, Regional Authorities and partners will continue to strengthen and upscale protection services and basic needs assistance inside the Tigray region inside the refugee camps and explore short-term solutions for asylum seekers and registered refugees residing outside camps, who currently face difficulties to access assistance due to the lack of ARRA presence in the Tigray region. Inside Mai Aini and Adi Harush water trucking is required, additional communal latrines and bathing facilities will be installed, food distributions will no longer be delayed or interrupted and child protection, GBV and protection monitoring services will continue. Outside refugee camps, the priority is to identify shelter options and provide basic needs assistance to the most vulnerable.

In Barhale Camp, food distribution for in September 2021 will be done by ARRA but there is no partner on the ground. UNHCR is in discussion with ARRA how to continue the basic services.

In the meanwhile, UNHCR will continue to advocate for access and humanitarian corridors to the areas where beneficiaries in need of assistance reside, for access to asylum for asylum seekers and resumption of verification and registration of asylum seekers, and for improved access to protection services and basic needs assistance for refugees residing outside camp settings.

UNHCR, in collaboration with ARRA, will continue and upscale the verification (through biometrics) of registered refugees in the Tigray region as many pre-conflict residents of the Hitsats and Shimelba camps after still unaccounted for and relocated elsewhere inside or outside the Tigray region. In order to ensure that refugees come forward for verification, UNHCR will use the refugee community to communicate and to encourage people to come forward for verification. The biometric verification of registered refugees will be a continuous exercise and areas outside Mekelle and Shire will be targeted with mobile verification missions.

Finally, awaiting the preparation of and relocation to Alemwach, UNHCR will, in collaboration with ARRA and the Regional Authorities, explore and advocate for other relocation alternatives for vulnerable families who are willing to be relocated elsewhere outside the Tigray Region. UNHCR will also continue to explore resettlement options and complementary pathways for refugees residing in Tigray region.

## COORDINATION



The humanitarian situation and context in Tigray is rapidly evolving. In order to effectively respond to the growing needs of the population, coordination of partners is crucial.

In February and March 2021, two inter-cluster coordination groups (ICCGs) were created in Mekelle and Shire to coordinate the humanitarian response among Clusters. Besides the coordination structures in Mekelle and Shire, Satellite Hubs have been established in Sheraro, Axum/Adwa, Adigrat, Abi Adi, Maichew, and Dansha. Humanitarian partners have committed to relocate staff to these areas and establish coordination structures there. In addition, there is need to strengthen capacity with authorities on humanitarian coordination and mechanisms in order to improve the humanitarian coordination from the satellite hubs.

Seven months into the conflict and humanitarian crisis in Tigray, an Area Humanitarian Team (AHT) coordination body was established / formalized for effective strategic guidance and response tracking, accountability and coordination amongst all responding partners. The AHT is comprised of regional Heads of Agencies / Heads of Organizations or their appointed OIC to enable decision making. The AHT's terms of reference highlights that the forum will provide strategic guidance and decision making to the ICCG for active implementation and to produce advocacy messaging, Tigray-level inputs and response monitoring and progress tracking to the EHCT.

Since August 2021, EHCT / AHT and national ICCG / sub-national ICCG in Mekelle have held joint meetings on a monthly basis focusing on strategic and operational priorities and thereby strengthening coordination between the national and regional levels.

The Tigray Response Plan is a document developed by the humanitarian community, however, the linkages

to the de facto authority counterparts is important. Clusters are co-led by regional authority line ministries and cluster lead agencies from humanitarian partners and partners will continue to engage with the Tigray Emergency Coordination Centre (ECC) in Mekelle.

All Clusters have dedicated sub-national Cluster Coordinators in Mekelle to support the response and coordination of Cluster partners on the ground in Tigray. Since the release of the Northern Ethiopia Response Plan in May 2021, Clusters have further strengthened their presence in Shire. In addition, the majority of Clusters have dedicated Information Management Officers, either covering both Mekelle and Shire or dedicated to each area. To ensure linkages between national and sub-national level, Sub-national Clusters are in close collaboration with national Clusters. Regional PSEA Networks have been established in both Mekelle and Shire.

Key activity	Indicator (if Applicable)	Target (#)	Revised Total requirements (USD\$)
Strengthen mechanism to ensure coordinated approach to PSEA	# of regular bi-weekly network meetings and ad-hoc meetings organised	16	
92 250	# of people having access to safe drinking water through durable solutions	2,372,702	52,199,433
Capacity building on PSEA and CBCM (ToT modality + direct training provision)	# of capacity development sessions held for PSEA focal points and providers of humanitarian assistance	8	
Implement information campaigns, using the already developed IEC materials	# of individuals within the affected population and stakeholders reached with IEC materials on PSEA	7,900	
Train PSEA focal points, humanitarian staff, and healthcare providers on providing survivor-centered support	# of capacity development sessions held for PSEA focal points and providers of humanitarian assistance, based on GBV Pocket Guide	6	92,250
Training for community feedback committees	# of committee members that have been trained	80	800
Community Consultations to design interagency CE/AAP system	# of community meetings with Communities	2,000	5,000
Purchase of tablets/phones (to collect information during community consultations)	#of tablets purchases # of phone sets purchased	30	3,600
Data collection for AAP	# of data collection exercises	30	6,000
Establishment and maintenance of Feedback Channels for AAP	# of people reached through the feedback channel established and complains and feedback recorded.	40,000	5,000
Partner Training on AAP at sub- National level and Regional level	# of people trained on AAP at Sub-national and Regional level	400	6,000
IEC materials production	#of people reached with materials produced and disseminated	3,000	5,000
Communication materials purchased for communicating with Communities	# of people reached with radio airtime /TV purchased	50,000	15,000
House to House visits - outreach on AAP to hard-to-reach populations	# of communities reached through house to house visits	2,000	3,000
Conduct Community Perception Surveys and	# of people reached through survey conducted	1,000	10,000
Coordination and Common Services	Security and Duty of Care		2,043,480
OCHA	OCHA Tigray Office		2,190,407
<b>Total</b>			<b>4,390,137</b>



# ANNEX CLUSTER TABLES

## CCCM

Key activity	Indicator	Total P/N (# - revised)										Total Target (#) (Individuals)										Total reviewed financial requirements			
		P/N by Population group										Target by Population group													
		IDP	Returnee	General Non Displaced	Boys	Children Girls	Male Adult	Female Adult	Adults	Male Elderly	Female Elderly	Elderly People with disability	IDP	Returnee	General Non Displaced	Boys	Children Girls	Male Adult	Female Adult	Adults	Male Elderly	Female Elderly	Elderly People with disability	Total	
# Camp maintenance & improvement, including decommissioning, including rehabilitation	# of IDPs benefiting from site development/ improvement inputs	18,000,000	18,000,000	3,960,000	3,960,000	3,960,000	4,860,000	4,860,000	4,860,000	180,000	180,000	900,000	651,377	651,377	136,584	145,375	174,724	176,612	176,612	91,65	8,918	32,569	240,000		
# Camp maintenance & improvement, including decommissioning, including rehabilitation	# of sites receiving care and maintenance support	116 sites	18,000,000	3,960,000	3,960,000	3,960,000	4,860,000	4,860,000	4,860,000	180,000	180,000	900,000	90 sites	651,377	136,584	145,375	174,724	176,612	176,612	91,65	8,918	32,569	240,000		
# Camp area coordination, including information Management	# of site level verifications and site monitoring activities conducted	90 IM products	18,000,000	3,960,000	3,960,000	3,960,000	4,860,000	4,860,000	4,860,000	180,000	180,000	900,000	90 IM products	651,377	136,584	145,375	174,724	176,612	176,612	91,65	8,918	32,569	583,333		
# Camp area coordination, including information Management	# of coordination meetings conducted and recorded at various platforms	4,500 meeting	18,000,000	3,960,000	3,960,000	3,960,000	4,860,000	4,860,000	4,860,000	180,000	180,000	900,000	4000 meeting	651,377	136,584	145,375	174,724	176,612	176,612	91,65	8,918	32,569	583,333		
# Camp area coordination, including information Management	# of sites covered with service mapping activities	116 sites	18,000,000	3,960,000	3,960,000	3,960,000	4,860,000	4,860,000	4,860,000	180,000	180,000	900,000	90 sites	651,377	136,584	145,375	174,724	176,612	176,612	91,65	8,918	32,569	583,333		
# Community participation/ self-governance	# of sites with established CCIM mechanisms	116 sites	18,000,000	3,960,000	3,960,000	3,960,000	4,860,000	4,860,000	4,860,000	180,000	180,000	900,000	90 sites	651,377	136,584	145,375	174,724	176,612	176,612	91,65	8,918	32,569	200,000		
# Community participation/ self-governance	# of sites with established IDP community self-governance structures	116 sites	18,000,000	3,960,000	3,960,000	3,960,000	4,860,000	4,860,000	4,860,000	180,000	180,000	900,000	90 sites	651,377	136,584	145,375	174,724	176,612	176,612	91,65	8,918	32,569	200,000		
# Capacity building of stakeholders, including government camp management	# of individuals trained on Basic CCIM standards, principles and practices.	600 individuals trained	18,000,000	3,960,000	3,960,000	3,960,000	4,860,000	4,860,000	4,860,000	180,000	180,000	900,000	600 individuals trained	651,377	136,584	145,375	174,724	176,612	176,612	91,65	8,918	32,569	600,000		
# Capacity building of stakeholders, including Government camp management	# of camp management committees formed and trained/capacitated	24 trainings	18,000,000	3,960,000	3,960,000	3,960,000	4,860,000	4,860,000	4,860,000	180,000	180,000	900,000	24 trainings	651,377	136,584	145,375	174,724	176,612	176,612	91,65	8,918	32,569	600,000		
																						8,000,000			



# ES/NFI

Key activity	Indicator	Total PN (#) revised	PN by Population group					PN by sex and age					Total Target (#) (individuals)			Target by Population group			PN by sex and age					Target by Target by age and sex	Total reviewed financial requirements (USD) May to December	Requirements until the end of the year (Sep-Dec)	Funding utilized
			IDP	Returnee	General Non Displaced	Children Boys	Girls	Male Adult	Female Adult	Elderly Male Elderly	Elderly People with disability	IDP	Returnee	General Non Displaced	Children Boys	Girls	Male Adult	Female Adult	Male Elderly	Female Elderly	By disability People with disability						
Distribution of Emergency Shelter and NFI (ES/NFI) Kits either in kind or through Cash	Number of displacement affected population receiving emergency shelter and NFI assistance either in kind or through cash that considers the needs of women, children, people with disabilities and the safety of beneficiaries.	438,837	438,837	-	-	89,523	92,595	128,579	117,608	5,705	4,827	74,602	393,655	393,655	-	80,306	83,061	115,341	105,499	5,118	4,330	66,921	16,139,841	13,907,498			
Provision of NFIs Kits either in-kind or through Cash	Number of displace- ments affected popula- tions that have received Non-food items either in-kind or through Cash that consider the most vulnerable or at risk and beneficiaries safety	941,708	710,495	124,472	106,741	192,108	198,700	275,920	252,378	12,242	10,359	160,090	760,409	637,346	63,772	59,291	155,123	160,446	222,800	203,790	9,885	8,364	129,270	19,770,631	15,742,870		
In-kind or cash for emergency shelter	Number of displacements affected population that received in-kind or cash for emergency shelter assistance to improve physical protection and to reduce overcrowding	915,285	915,285	-	-	186,718	193,125	268,178	245,296	11,899	10,068	155,598	821,051	821,051	-	167,494	173,242	240,568	220,042	10,674	9,032	139,579	37,685,873	7,123,040			
In-kind or cash for Repairing houses	Number of displacement affected population that reslved in-kind or cash for Repairing their houses, disaggregated per gender and age	224,050	-	224,050	-	45,706	47,275	65,647	60,045	2,913	2,465	38,089	114,790	-	114,790	-	23,417	24,221	33,634	30,764	1,492	1,263	19,514	10,166,124			
Supporting the restore- tion of durable, safe and appropriate shelter to returnees through cash related activities	Number of Returnees whose houses are partialy damaged and supported with cash or a repair kits	167,167	-	124,472	42,695	34,102	35,272	48,980	44,801	2,173	1,839	28,418	87,489	-	63,772	23,716	17,848	18,460	25,634	23,447	1,137	962	14,873	2,640,999			

# FOOD

Total FN (#) - re-used	Total Target (#) (millions)													By disability	Total re-used financial requirements			
	Children						Adults						Elderly					
	Returnee			IDP	Returnee			IDP	Returnee			IDP						
	General Non-Dis-abled	Boys	Girls		General Non-Dis-abled	Boys	Girls		General Non-Dis-abled	Boys	Girls					Male-Adult	Female-Adult	
5,195,427	4,563,652	1,249,685	1,302,607	1,025,165	1,249,735	16,339	16,687	912,395	5,195,427	4,563,652	1,249,685	1,302,607	1,025,165	1,249,735	16,339	16,687	914,395	416,400,000

## HEALTH

Health Cluster	Key activity	Indicator	Target (t)	Total requirements (US\$)
Strengthen service readiness to detect, promptly respond to and ensure a multi-sectoral response to a potential disease outbreaks, including Cholera, Covid-19	Outbreak coordination (technical task teams and ECC at regional and zonal levels)	# Coordination hubs established	2.5 million	400,000
	Surveillance	% of functioning facilities reporting on a regular basis	50%	800,000
	Support the establishment of early warning and notification including rumours on outbreak alerts and timely analysis through the IPHEM mechanism	% of alert responded to within 48-72 hours	70%	200,000
	Support regular monitoring, analysis and distribution of data on disease outbreaks including training on data collection (registers or electronic formats) for data sharing	Cholera case fatality rate (CFR)	CFR less than 2%	800,000
Prompt rapid response deployment to investigate and report to disease outbreak alerts	Capacitating Regional, Woreda and Zonal Hospitals Lab technologist on sample collection and transportation	# of woredas capacitated	20 woredas health offices	100,000
	Case management	# of health facility WASH facilities supported	10	100,000
	Capacitating Health workers in case management	# of Health workers and CHW trained on health promotion and disease prevention	1,000	800,000
	Capacity building, including IPC, for support staff and CHW			
WASH	Deploying a team for case management from higher hospitals	Number of people vaccinated with oral cholera vaccine	1.5 million (IPs and host communities vaccinated with oral cholera vaccination)	800,000
	Water treatment	# MHNT in underserved and crisis affected locations	50 MHNT	800,000
	Strengthen IPC WASH at health facilities by constructing and rehabilitating WASH infrastructure and capacitating human workforce	number of health facilities rehabilitated	90 health facilities	4,000,000
	Risk communication and community engagement	number of functioning ambulances	80 ambulances	2,000,000
Train health care and community health care workers on outbreak prevention and control, early detection and referral	Health prevention and promotion	# of single dose covid-19 vaccine administered	190,000 single doses of the covid-19 vaccination administered to priority populations	700,000
	Produce and distribute E2/BCC materials and media messages to at risk and Woredas	# of HF that started COVID RDT testing	14 Hospitals and 30 HC will provide RDT for COVID	300,000
	Strengthen community level hygiene and sanitation activities in risk Woredas	Number of HF Neonatal corners	120 mHF	120,000
	Support the delivery of essential health and nutrition services through the MNHTs in all the zones where health facilities are severely damaged	Number of HF providing IMNCI services	120 HF	100,000
Reinforcing of existing health facilities in areas of high vulnerability	Reinforcing the referral systems for promotive, preventative and emergency services	Number of HF with Functional IMCI	40 Hospitals	500,000
	Prevention of COVID-19 transmission	750,000 children 6 - 59 months		
	Covid-19 Response measures: Case Management, IPC Isolation, Contact tracing, Risk Communication, Covid-19 Vaccination			
Provision of essential health care services and priority health conditions	<b>Child health</b>			
	Revitalize and/or strengthen Neonatal Corners			
	Revitalize and/or strengthen IMNCI in selected HF			
	Revitalize strengthen Neonatal ICUs in selected HF			
Under-take Regional Supplementary Immunization Activities for children 6 months to 59 months	Strengthen routine immunization: Start catch up immunization in all facilities			
	# of children 6 - 59 months that received measles vaccination			
	Trauma care and mass casualty preparedness			
	Strengthen routine immunization			
Under-take Regional Supplementary Immunization Activities for children 6 months to 59 months	# of 750,000 children 6 months - 59 months that received measles vaccination			
	Strengthen existing HIV services, and support the resumption of screening, detection and treatment (including PMCT and PEP)			
	Enhance access to maternal health services, including service provision by skilled birth attendants			
	Malaria prevention, response coordination			
To support the Treatment of Acute Malnutrition	Provision of core pipeline for essential medical supplies			
	Emergency health kits and supplies to respond to life-threatening conditions related to malnutrition			
	Logistics and warehousing, including strengthening of cold chain			
	Strengthen capacity of health workers on SAM management			
To strengthen service readiness and availability for critical care of GBV survivors and MHPS services	Strengthen referral linkage among health facilities for SAM with or without medical complications			
	Ensure availability of essential clinical care services for GBV survivors			
	Train health workers on appropriate, confidential, and timely care for GBV survivors			
	Coordinate and/or provide referral mechanisms between primary, secondary and tertiary health care services			
To strengthen multi-sector coordination to prepare, plan and respond to the ongoing and potential health and nutrition crisis and maintain health and outbreak needs.	Establish a crosscutting SGBV Technical Working Group through a collaboration between Health, Protection Clusters together with ADRs			
	Train of health workers using WHO mhGAP-Humanitarian Intervention Guide on management of priority mental health conditions and essential psychosocial skills			
	Establish a crosscutting MAPSS Technical Working Group through a collaboration between Health, Protection Clusters together with ADRs			
	Ensure strong health cluster coordination in Miskelle and Shire			
	Conduct health and multi-sector assessments			
	Establish SBH TWG to coordinate the provision of clinical reproductive health services across the region			

# NUTRITION

Key activity	Indicator	Total PIN (#) - revised	PIN by Population group						Target by age and sex						PIN by disability People with disability	Total Target (#) (Individuals)	by Population group			PIN by sex and age				Target by disability	Total reviewed financial requirements (US\$) (May to December) year (Sept-Dec)	Requirements until the end of the year (Nov-April)		
			IDP	Returnee	General Non Displaced	Children Boys	Girls	Male Adult	Female Adult	Adults	Male Elderly	Female Elderly	By disability People with disability	IDP			Returnee	General Non Displaced	Children Boys	Girls	Male Adult	Female Adult	Male Elderly				Female Elderly	People with disability
Treatment of SAM	# of children with SAM admitted for treatment	56,208				27,542	28,666	0	0	0				56,208					27,542	28,666	0	0	0	0	0	0	5,482,176	0
Targeted Supple- mentary Feeding	# children and adolescents receiving supplementary food	768,080				222,743	238,105	0	307,232					412,159					116,289	111,729	0	184,141	0	0	0	0	36,522,393	9,000,000
BSPF (children/PIW)	# of children and adolescents receiving SNF	841,620				244,970	256,902	0	336,648					556,925					223,828	214,858	0	118,039						
Vitamin A supplementation	# of children 6-59 months receiving vitamin A	598,553												598,553					293,291	305,262						425,278	283,319	
Infant and Young Child Feeding	# of primary caregivers of children 0-23 months receiving IYCF counselling	274,727				134,616	140,111	0	274,727					274,727					0	0	0	274,727				200,000		
	# of children 6-23 months receiving SNF as part of complementary feeding	283,519				138,924	144,595	0	0					283,519					138,924	144,595	0	0	0	0	0	0	6,379,178	6,379,178
	# of PLW receiving SQ-LNS for appropriate nutrition	274,727				0	0	0	274,727					164,836					0	0	0	164,836	0	0	0	0	5,583,215	5,583,215
	# of Pregnant and Lactating Women receiving High Energy Baecuts	274,727				0	0	0	274,727					164,836					0	0	0	164,836	0	0	0	0	5,791,684	1,930,561
Coordination	# of coordinators assigned to conduct meetings	42												42					0	0	0	461	479	0	0	0	482,381	-
Training/ Capacity Building	# of personnel trained in Nutrition intervention areas	940				0	0	461	479					940					0	0	461	479	0	0	0	0	54,000	54,000
Iron and Folic-Acid supplementation	# of pregnant women receiving iron and folic acid supplementation	160,000				0	0	0	160,000					160,000					0	0	0	160,000	0	0	0	0	43,200	-
Screening/case-finding	# children 6-59 months screened for acute malnutrition	708,796				347,210	361,486	0	0					708,796					347,210	361,486	0	0	0	0	0	0	1,152,672	-
Community awareness	# people reached with key information on nutrition services	1,013,096				0	0	496,417	516,679					1,013,096					0	0	496,417	516,679				21,000	-	
						466,813	499,007	461	644,839					1,380,695.4					339,917	326,587	461	303,139	-	-	-	-	75,672,464	23,210,473
																											52,461,990.91	

# PROTECTION

Cluster	Key activity	Indicator	Total IDP (referred)	PH by Population group			PH by sex and age			Target by Population group			Target by age and sex			Total cost reviewed financial requirements	Total disability by age and sex												
				IDP	Returnee	General Non Displaced	Boys	Girls	Adults	Male Adult	Female Adult	Children	IDP	Returnee	General Non Displaced			Male Elderly	Female Elderly	People with disability									
GBV	Informational provision awareness raising activities on child protection, sexual violence and GBV including IPF risk mitigation, prevention, response and IDP rights including available services to affected population	#women, men, girls and boys accessing CP and GBV risk mitigation, prevention, response services in IDP2, camps and in host communities	1,030,000	889,700	-	240,300	226,600	286,900	Children Boys	Girls	Adults	Male Adult	Female Adult	Children Boys	Girls	Adults	Male Adult	Female Adult	Children Boys	Girls	Adults	Male Elderly	Female Elderly	People with disability	25	20,116,225			
GBV	Capacity building (including refresher training) for service providers, community leader, and humanitarian staff	# of service providers, community leaders and humanitarian staff trained on GBV issues	9,600	7,400	-	2,200	-	4,800	4,800	578,100	67,800	578,100	103,600	Male Elderly	Female Elderly	103,600	10,300	13,500	804,449	627,626	177,023	48,279	160,950	40,232	547,101	4,023	150	1,125,000	
CP	Identification emergency case management and protection services to children including basic child protection case management family tracing and reunification services native case arrangements for unaccompanied and separated children persons with disabilities and GBV (CP and GBV) through protection monitoring and community structure	1. # of people (including women, men, girls and boys) accessing CP and GBV risk mitigation, prevention, response services in IDP2, camps and in host communities who have experienced violence related by health, social work or justice/law enforcement services	21,700	16,600	-	5,100	10,600	11,100	10,600	3,600	3,600	11,100	300	16,982	13,586	-	3,396	6,616	10,987	-	-	-	-	-	255	-	3,396,450		
CP	Identification emergency case management and protection services to adolescents including basic child protection case management family tracing and reunification services native case arrangements for unaccompanied and separated children persons with disabilities and GBV (CP and GBV) through protection monitoring and community structure	2. # unaccompanied and separated children referred to family-based care arrangements alternative care arrangement	7,200	5,500	-	1,700	3,600	3,600	3,600	3,600	3,600	3,600	100	5,561	4,529	-	1,132	2,205	3,456	-	-	-	-	-	85	-	1,132,150		
CP	Information provision awareness raising activities on child, violence and GBV including IPF risk mitigation, prevention, response and IDP rights including available services	#women, men, girls, and boys accessing CP and GBV risk mitigation, prevention, response services in IDP camps and in host communities	1,106,000	847,900	-	238,100	243,300	254,400	243,300	254,400	257,600	248,600	41,100	16,600	864,051	691,241	172,810	172,810	172,810	233,294	233,294	25,922	25,922	12,961	17,281,020	12,961	17,281,020	17,281,020	
Protection	Tailored assistance for persons with specific needs and referrals	# of individuals with specific needs identified and referred for assistance	34,100	26,100	-	8,000	-	10,400	10,000	6,300	7,400	4,000	26,400	24,000	24,000	24,000	2,400	-	-	-	50	50	-	-	-	-	-	3,000	400,000
Protection	Information and training on IDP rights (including IDP camps and HLP gpts) provided to community members, local government authorities including law enforcement and court authorities	# of experts from local government authorities, IDP camps and HLP gpts provided to community members, local government authorities	100	100	-	-	50	50	50	50	-	100	100	-	-	-	50	50	-	-	-	-	-	-	-	-	-	3,000	400,000
GBV	Psychological first aid and focused mental health support (MHRS) provided to persons in need (including women and adolescent girls)	# of women, men, girls and boys accessing PFA and MHRS in IDPs camps and host communities	154,845	118,710	-	36,135	34,065	31,095	26,475	50,885	6,030	6,030	2,340	120,697	94,144	26,553	7,242	24,139	6,035	82,074	603	603	603	60	7,241,820	60	7,241,820	7,241,820	
CP	Psychological first aid and focused mental health support (MHRS) provided to persons in need (including children at protection risk and women and adolescent girls)	# of women, men, girls and boys accessing PFA and MHRS in IDPs camps and host communities	189,255	145,090	-	44,165	41,635	38,005	32,725	62,095	7,370	7,370	2,860	148,148	118,518	29,630	37,037	37,037	29,630	29,630	7,407	7,407	2,222	7,037,030	2,222	7,037,030	7,037,030		
GBV	Psychological first aid and focused mental health support (MHRS) provided to persons in need (including children at protection risk and women and adolescent girls)	# of women, men, girls and boys accessing PFA and MHRS in IDPs camps and host communities	255,930	196,194	-	59,736	-	58,197	-	192,603	-	51,300	3,819	201,162	156,066	44,256	60,349	140,813	140,813	140,813	140,813	140,813	140,813	25	5,029,050	25	5,029,050	5,029,050	
CP	Psychological first aid and focused mental health support (MHRS) provided to persons in need (including children at protection risk and women and adolescent girls)	# of women, men, girls and boys accessing PFA and MHRS in IDPs camps and host communities	195,070	148,006	-	45,064	-	43,903	-	145,297	-	3,870	2,881	149,440	119,712	29,928	7,482	142,158	142,158	142,158	142,158	142,158	142,158	2,245	4,489,200	2,245	4,489,200	4,489,200	
Total																	67,250,945							67,250,945					



# WASH

Key activity	Indicator	Total PIN (#) reviewed	PIN by Population group				PIN by sex and age				PIN by sex and age				PIN by disability	Total Target (# Individuals)	Target by Population group				PIN by sex and age				Target by disability and sex	Total reviewed financial requirements	Remaining unmet
			IDP	Returnee	General Non Displaced	Children Boys	Girls	Male Adult	Female Adult	Adults	Male Elderly	Female Elderly	By disability People with disability	General Non Displaced			Children Boys	Girls	Male Adult	Female Adult	Elderly Male Elderly	Female Elderly					
Access to safe drinking water for IDPs and host communities around the DIP sites through water trucking	# of people having access to adequate & safe drinking water through emergency water trucking	2,036,398	2,036,398			428,552	499,180	534,116	556,232	29,084	29,084	10,182	2,086,398	2,036,398	428,552	459,180	534,116	556,232	29,234	29,084	10,182	12,218,388	6,109,194				
Water quality Monitoring (at least residual chlorine level at source and delivery points for water trucking)																						260,000	260,000				
Restoration (Rehabilitation and maintenance/ expansion) of non-functional water supply schemes in urban areas including construction of water scheme for the 8 new IDP relocations sites/camps.	# of people having access to sufficient & safe drinking water through durable solution	5,200,000																				9,923,530	8,536,530				
Support water utilities offices to re-function (provision of start-up capital and technical assistance for procurement of basic O&M tools)	Restoration (Rehabilitation and maintenance/ expansion) of non-functional water supply schemes in Health centers 249	2,036,398	2,036,398			3,163,602	1,094,319	1,172,530	1,363,881	1,363,881	74,650	74,266	74,650	26,000.0	1,772,059	472,059	1,300,000	372,027.7	254,923.7	25,308.54	196	8,860,095	2,879,062				
Support water utilities offices to conduct damaged infra structures assessment	Restoration (Rehabilitation and maintenance/ expansion) of non-functional hand pump/spring in rural areas.	2,036,398	2,036,398			3,163,602	1,094,319	1,172,530	1,363,881	1,363,881	74,650	74,266	74,650	-	3,427,941	1,564,339	1,863,602	721,397	772,955	936,325	49,211	48,558	17,140	2,399,5587	1,949,6470		
Restoration (Rehabilitation and maintenance/ expansion) of non-functional water supply schemes in schools.	# of institutions ( schools having access to sufficient & safe drinking water through durable solution)	2,266,850	884,072			1,382,779	1,094,319	1,172,530							592,113	205,786	386,327	284,214	304,899				200,000	200,000			
Restoration (Rehabilitation and maintenance/ expansion) of non-functional water supply schemes in Health centers 249	# of institutions ( health centers & CTC) having access to sufficient & safe drinking water	5,140,132	2,036,398			3,103,734	1,081,720	1,159,031	1,348,178	1,404,001	73,790	73,412	73,790	25,700.7	2,720,597	1,061,033	1,659,564	572,339	613,498	713,571	743,117	39,056	38,856	13,603	2,550,000	2,550,000	
Access sanitation facilities (latrines, showers and solid waste) for the IDPs in new sites	# of people accessing sanitation facility (latrines, showers and solid waste) for the IDPs in new sites	2,266,850	884,072			1,382,779	1,094,319	1,172,530							592,113	205,786	386,327	284,214	304,899				2,070,000	2,070,000			
Access sanitation facilities (latrines, solid waste) for students in school (rehabilitation & decommissioning of wash infrastructures and improve the general environment)	# of schools accessing sanitation facility (latrines & bathing/hand washing facilities)	2,266,850	884,072			1,382,779	1,094,319	1,172,530							592,113	205,786	386,327	284,214	304,899				2,070,000	2,070,000			
Access sanitation facilities (latrines, solid waste) for Health centers & CTC (yellow flag) and wash infrastructures and improve the general environment	# of institutions ( health centers & CTC) accessing sanitation facility (latrines & bathing/hand washing facilities)	5,140,132	2,036,398			3,103,734	1,081,720	1,159,031	1,348,178	1,404,001	73,790	73,412	73,790	25,700.7	2,720,597	1,061,033	1,659,564	572,339	613,498	713,571	743,117	39,056	38,856	13,603	2,720,000	2,720,000	
Ensure availability of sufficient water supply for CTCs/CTUs	# of institutions (CTC & CTU) having access to adequate & safe drinking water	95,000	38,000			57,000	19,992	21,421	24,917	25,949	1,364	1,357	1,364	475											2,000,000	2,000,000	
Provision of emergency water supply through water trucking for cholera affected populations 632,700 for 2 months	# of cholera affected people having access to adequate & safe drinking water through emergency water trucking	1,500,000	600,000			900,000	316,690	318,018			21,534	21,423	21,534	7,500	632,700	253,080	379,620	133,149	142,665	165,948	172,819	9,083	9,036	1,898,100	1,898,100		
Promotion of key/hygen messages including Covid 19 and Cholera preventive messages through different mechanisms for affected population including IDPs.	# of people reached through essential sanitation and hygiene message	5,200,000	2,036,398			3,163,602	1,094,319	1,172,530	1,363,881	1,363,881	74,650	74,266	74,650	26,000	2,721,495	2,036,398	687,797	573,296	614,269	714,515	744,100	39,108	38,907	13,621	5,175,971	4,761,892.9	
Provision of wash NFI and water treatment chemicals to IDPs	# of people having access to safe drinking water through distribution of emergency water treatment supplies	5,200,000	2,036,398			3,163,602	1,094,319	1,172,530	1,363,881	1,363,881	74,650	74,266	74,650	26,000	2,721,495	2,036,398	687,797	573,296	614,269	714,515	744,100	39,108	38,907	13,621	20,431,463	15,323,597	
Provision of critical WASH supply including hygiene items, NFI and water treatment chemicals to IDPs	# of cholera affected people provided with the emergency water treatment supplies	1,500,000	315,669			1,184,331	315,669	338,230	393,427	409,717	21,534	21,423	21,534	7,500	632,700	253,080	379,620	133,149	142,665	165,948	172,819	9,083	9,036	3,164	4,745,250	1,898,100	
Procure and distribute wash kits to health centers including CTCs/142 health centers and 20 CTC/CTU	# of institutions accessing Wash Kits	5,140,132	2,036,398			3,103,734	1,081,720	1,159,031	1,348,178	1,404,001	73,790	73,412	73,790	25,700.7	2,720,597	1,061,033	1,659,564	573,539	613,458	713,571	743,117	39,056	38,856	13,603	1,040,040	1,040,040	
Provide laundry and body soap for IDPs and host communities at collection sites to improve hand hygiene (2 bars of soap/person/month) for 5 months	# of people provided with leaving WASH NFI	5,200,000	315,669			4,884,331	315,669	338,230	393,427	409,717	21,534	21,423	21,534	26,000	2,721,495	2,036,398	687,797	573,296	614,269	714,515	744,100	39,108	38,907	13,621	10,896,780	7,264,520	
<b>Total</b>																								<b>117,421,822</b>	<b>93,425,157</b>		

## Tigray Rapid Response Mechanism

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Since the release of the Northern Ethiopia Response Plan in May 2021, a Tigray Rapid Response Mechanism (RRM) has been created to ensure effective and timely first line response in the hard-to-reach areas and provide lifesaving multisectoral assistance to the most vulnerable populations within 96 hours of activation. Through the Tigray RRM, multisectoral assessments are conducted while prepositioned emergency stocks for a response is prepared, such as distribution of essential non-food items, sanitation and hygiene kits, nutrition commodities and health kits. To have a mechanism that is fit for purpose and which is able to move assistance with the speed required, is crucial.

As of September 2021, the Tigray RRM has been activated five times, reaching 3,600 beneficiaries in the eastern zone and south eastern central zone. However, the RRM has faced significant challenges due to shortage of supplies in the region. Future RRM responses will be prioritized based on needs and available resources.

Sub-national Clusters have agreed on a composition of the response kit, which is meant to provide the affected population with a first response.

## What if we fail to respond?

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The conflict in Tigray is now in its eleventh month, and the humanitarian needs, and protection risks have heavily increased as a result of the changing context.

Prior to the conflict, the food system (production, transportation, processing, packaging, storage, retail, consumption, loss and waste) fed and supported the livelihoods of a vast majority of Tigray's population. Even though households in Tigray were repeatedly exposed to multiple shocks, such as drought, desert locust infestations, most of them were able to cope. This is however not the case at moment. After failing to harvest in 2020, the consequences of late planting in the 2021 main season is dire, as most households depend on their own production for food and income. If support is not provided immediately, we expect a further deterioration in food security. If we fail to respond, an estimated 580 000 households will be in need of continuous food support, including with seeds, livestock and fertilizers.

At least 3,600 MT of food commodities (or 90 trucks, equivalent to common food basket for around 210,000 people) are required to move into Tigray every day in order to sustain food assistance for at least 5.2 million people and avert the risk of famine. Food partners have been running very low on stocks for the common food basket within the region since 20 August, and some are forced to cease distribution. At least 5.2 million people are in need of emergency food assistance in Tigray to avert the risk of famine. If food assistance is not rapidly scaled up, people currently suffering from acute food insecurity could slide into catastrophic level of hunger and further into famine-like conditions. Any delay or hindrance on nutrition interventions as planned will put the health of over 400,000 children under five and 370,000 pregnant and lactating women in unprecedented jeopardy leading to increased child and maternal mortality rates. In addition, the acute malnutrition of PLWs will lead to poor pregnancy outcomes, low-birth weight, stunting in children and

increased child and maternal mortality rates and an estimated 214,000 U5 children may be in need of treatment for SAM, should the humanitarian situation remain unchanged or further deteriorate due to conflict. The increased application of negative coping practices will severely deplete agriculture, livestock and household assets risking plunging people in long term poverty.

All implementing health cluster partners have reported critically low levels of essential health kit supplies. Health Cluster partners have the capacity to operate 56 Mobile Health and Nutrition Teams in 69 woredas in all 7 zones of Tigray. This represented a catchment population of over 560,000 women, men, girls and boys. If partners do not receive medical supplies, access to cash and fuel, partners will not be able to provide basic services in the MHNTs and hospitals will not be able to continue to function, further increasing the number of people that do not have access to life-saving health care. Over 1.5 million IDPs and host communities received the first dose of the Oral Cholera Vaccination in high risk areas. If the second round of the OCV does not take place before the end of the year, and the Cluster does not implement the Supplementary Immunization Activities (including measles, OPV, vitamin A, and deworming) that targets over 750,000 children between birth and the age of 59 months this will lead to a large increase of preventable deaths among the most vulnerable populations. If the partners are facing regular issues in regards to access to essential medical supplies, equipment, cash and fuel they will be obliged to reduce their activities and 2.3 million people will not have access to life-saving health interventions. Maternal and newborn deaths are likely to increase to alarming proportions due to lack of medicines, skilled deliveries, referrals and good antenatal care. People with chronic diseases will die from lack of specialized medicines, testing capacity and prevention (vaccination) from COVID-19 and more people will die from communicable diseases e.g.

malaria, diarrheal diseases, acute respiratory tract infections and complications of SAM.

Furthermore, left unaddressed, collective trauma can have a significant impact upon the capacity of the displaced population to recover from their displacement. This includes decreased productivity levels even as livelihood opportunities resume, learning difficulties among children and students, family breakdown and long-term reliance upon already depleted health and social welfare services. Thousands of persons with specific needs/disabilities would remain on the margins of their communities, and may become stigmatized and left behind. Communities will be compelled to act on no information or misinformation as the situation develops, potentially resulting in harmful activities and risks i.e. from explosive ordinances or secondary displacement (needing to return to an IDP site once again for want of services or support in their place of origin). Community cohesion would rapidly deteriorate, which in and of itself, can result in increased conflict over resources, abuse of power and crime among other issues (as is beginning to show), as well as conflicts with host communities. A greater number of children and youth may be found in forced labour as a means of survival. The long-term impacts of this phenomenon can be costly and would require significant investment in rehabilitation efforts. Partners and local authorities will lack the capacity to respond to these mounting and complex needs and be required to limit their interventions to life saving measures only. In addition, the risk of protection concerns remains heightened considering the sub-standard living conditions of IDPs.

Additionally, if we fail to respond, 1.4 million children will be out of school for more than 2 years. Keeping children out of school increases the risk of child labour and child abuse. Any further extended period of school closures seriously threatens to destroy their opportunity to gain sufficient knowledge and skills to survive, earn a livelihood not to mention re-enter any further formal education in the future.

# Acronyms

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AAP – Accountability to Affected Populations  
AAP TWG – Accountability to Affected Populations  
Technical Working Group  
AHT – Area Humanitarian Team  
AoR – Area of Responsibility  
ARRA – Agency for Refugee and Returnee Affairs  
ATF – Agriculture Task Force  
BoA – Bureau of Agriculture  
CBCM – Community Based Complaint Mechanism  
CCCM – Camp Coordination and Camp Management  
CFM – Complain Feedback mechanism  
CP – Child Protection  
CSO – Civil Society Organization  
CTC – Cholera Treatment Centre  
CTU – Cholera Treatment Units  
CwC – Communication with Communities  
DTM - Displacement Tracking Monitoring  
ECC – Emergency Coordination Centre  
ECCD - Early Childhood Care and Development  
EHCT – Ethiopia Humanitarian Country Team  
ErDF – Eritrean Defence Forces  
ENDF – Ethiopian Defence Forces  
ESNFI - Emergency Shelter/ Non-Food Items  
ETB - Ethiopian birr  
ETC – Emergency Telecommunications Cluster  
GAM – Global Acute Malnutrition  
GBV – Gender-Based Violence  
HF – Health Facility  
HH – Households  
HINGO – Humanitarian International Non-Governmental Organizations  
HLP – Housing Land and Property  
IA - Inter-Agency  
IAAWG - E – Inter-Agency Accountability Working  
Group - Ethiopia

IASC – Inter-Agency Standing Committee  
ICCG – Inter-Cluster Coordination Group  
IDP – Internal Displaced Person  
IEC - Information, Education, and Communication  
INGO – International Non-Governmental Organization  
IPC – Integrated Food security Phase Classification  
ITC - information and communications technology  
MAM – Moderate Acute Malnutrition  
MHNT - Mobile Health and Nutrition Team  
MHPSS - Mental health and psychosocial support  
NFI – Non-Food Items  
NGO – Non-Governmental Organization  
OCV – Oral Cholera Vaccination  
ORP – Oral Rehydration Points  
PLW – Pregnant and lactating women  
PSEA – Prevention of Sexual Exploitation and Abuse  
PSS – Psychosocial support  
REB – Regional Education Bureau  
RRM – Rapid Response Mechanism  
RWB - Regional Water Bureau  
RHB – Regional Health Bureau  
SAM – Severe acute malnutrition  
SEA – Sexual Exploitation and Abuse  
SOP – Standard Operating Procedure  
SGBV – Sexual Gender-Based Violence  
TDF - Tigray Defence Forces  
TF – Tigray Forces  
TLS - Temporary Learning Spaces  
TWG – Technical Working Group  
UASC - Unaccompanied and separated children  
UNHAS - United Nations Humanitarian Air Services  
WASH - Water, Sanitation and Hygiene

# End Notes

- 1 IPC\_Ethiopia\_Acute\_Food\_Insecurity\_2021MaySept\_national.pdf (ipcinfo.org)
- 2 DTM Ethiopia Emergency Site Assessment Round 7 Report (June 2021).pdf (iom.int)<?>
- 3 Since June 2021, the price of cooking oil has increased by 400 per cent; salt by 300 per cent; rice by 100 per cent; and teff by 90 per cent.
- 4 ST/SGB/2003/13 - E - ST/SGB/2003/13 -Desktop (undocs.org)
- 5 Microsoft Word - Ethiopia PSEA Strategy and Workplan for 2021-2022, Endorsed July 30.docx (interagencystanding-committee.org)
- 6 Microsoft Word - Ethiopia PSEA Network 2021-22 Work Plan - endorsed July 28 .docx (interagencystandingcommittee.org)
- 7 Integrated Food security Phase Classification (May- June and July to September) Projections
- 8 IPC\_Ethiopia\_Acute\_Food\_Insecurity\_2021MaySept\_national.pdf (ipcinfo.org)
- 9 IPC Acute Food Insecurity Analysis
- 10 Administrative data collected by Child Protection Partners.

**REVISION**  
**NORTHERN ETHIOPIA**  
**RESPONSE PLAN**

ISSUED OCTOBER 2021