Report

Response options analysis and planning for Fafan zone (Somali region, Ethiopia)

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Contents

Introduction

Overview of the ERC-MPG consortium pilot in Ethiopia

Aim

As part of the ECHO Enhanced Response Capacity (ERC) funded Consortium for the uptake of quality, collaborative multi-purpose grants (MPGs) a pilot was conducted in Ethiopia. Between October 2017 and March 2018 the Consortium ran the pilot in Ethiopia with the aim of providing technical and strategic support to country-based humanitarian organisations, enabling them to engage in collaborative assessments and decision making. Whilst the Consortium was not conceived to provide direct assistance to crisis-affected populations, it was intended to have an indirect, positive impact on their lives, by means of influencing humanitarian actors to design better quality and more collaborative and contextually appropriate MPG programmes. As such, it supported and was line with the commitments made by donors and humanitarian partners as part of the Grand Bargain.

The pilot project provided information and analysis for selected woredas Fafan Zone in the Somali Region. It should be noted here that due to the varied nature of the Ethiopian context the findings of the pilot activities - which focused on Babile, Hereshen, Kabribeyah, and Tuliguled woredas in Fafan Zone, Somali Region - are not generalisable beyond these woredas. However, for the woredas assessed the Consortium provided information on:

- Basic needs of crisis-affected people, through the Basic Needs Assessment (BNA)
- Minimum expenditure basket (MEB) - defined as what a household needs, on a regular or seasonal basis, and its average cost over time
- Market functionality and related feasibility of cash transfer programming (CTP), through the Multi-Sector Market Assessment (MSMA)
- Availability of payment mechanisms and financial service providers
- Partners' and government's capacity to implement CTP
- Effectiveness of MPG based on existing experiences (M&E of existing programmes)
- SOPs for MPGs

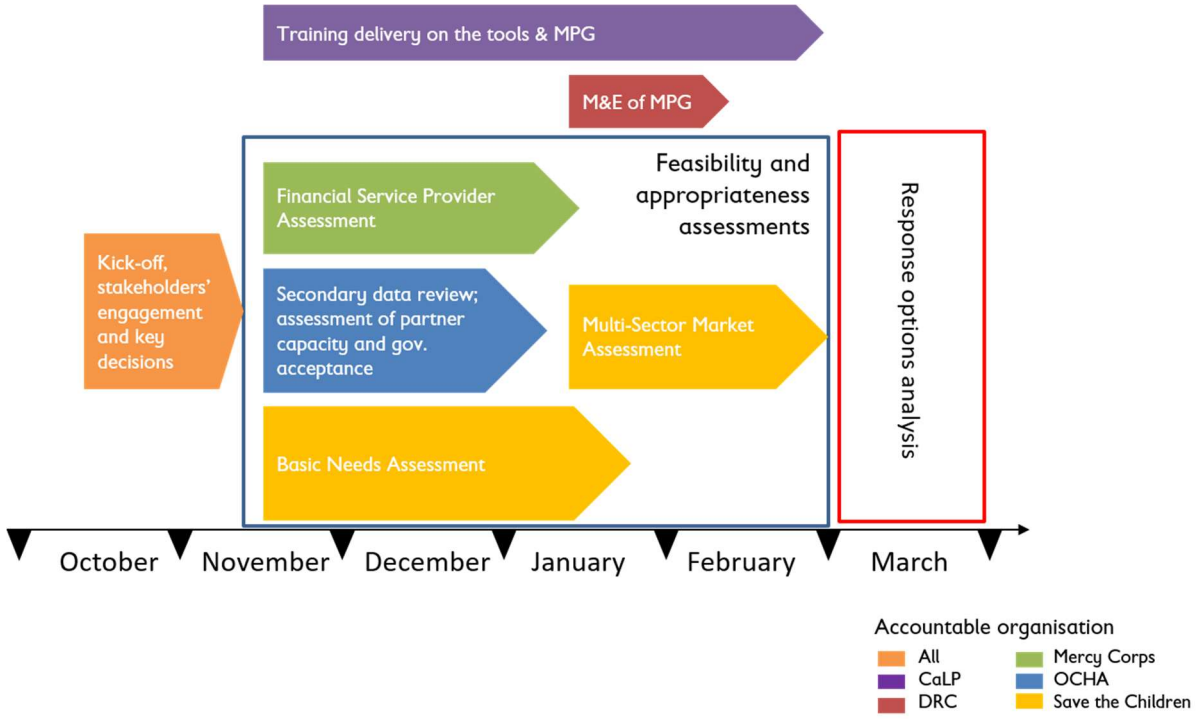
Assessment and decision-making tools, their findings (including the recommendations resulting from the response analysis workshop) and learning on the efficiency and effectiveness of collaborative MPGs will be shared with the country-level members of the Consortium, relevant IASC Clusters/Sectors, Cash Working Groups in country, and Cash Consortia (if any), as well as other key stakeholders in the pilot context. The pilot will help the humanitarian community in Ethiopia make more effective and wider use of MPGs, if and when appropriate and feasible.

A brief note on terms: according to the CaLP Glossary multi-purpose grants (MPGs), also sometimes known as multi-purpose cash assistance (MCAs), are defined as a transfer (either regular or one-off) corresponding to the amount of money a household needs to cover, fully or partially, a set of basic and/or recovery needs. They are by definition unrestricted cash transfers. The MPG can contribute to meeting a Minimum Expenditure Basket (MEB) or other calculation of the amount required to cover basic needs, but can also include other one-off or recovery needs.

Who it includes

Save the Children leads the Consortium which consists of the Cash Learning Platform (CaLP), the Danish Refugee Council (DRC), Mercy Corps, and the UN Office for the Coordination of Humanitarian Affairs (OCHA).

Time frame



Overview of the ROAP process

Too often response analysis is weak and inconsistently conducted with responses primarily designed on the basis of traditional ways of doing things i.e. what organisations are used to or good at. The Save the Children developed Facilitator's Guide for the Basic Needs-Based Response Options Analysis and Planning (ROAP) aims to address this challenge by providing a structured process that brings together sector and cash experts to develop response analysis that is more robust, transparent, and people-centred. It provides a framework for considering cash (in its various forms), other modalities (in-kind, services, technical assistance) or a combination of these from the start.

The first stage of the ROAP is undertaken at the sector level and results in the identification of population groups to be prioritised; the definition of response objectives; and the selection of the most appropriate response option for the selected groups and geographic areas. The second stage of the ROAP sees sectors coming together to create an integrated inter-sector response plan, including: the sequencing and frequency of transfers; the type and amount of sector assistance to be provided; and the cumulative effect that this may have on recipients.

In Ethiopia, March 2018, the ROAP process was facilitated by Save the Children's Cash & Markets Advisor who is a technical expert for the Consortium. They were joined in the ROAP process by members of the Task Team.

The Task Team

In November 2017 – the start of the pilot - a Task Team for Response Analysis (known as the Task Team) was established to provide in-county support, guidance, and engagement with the Consortium's work and with the ROAP process in particular. The Task Team's aim was to oversee and draw together all the various elements of the Consortium's work, analysing the information generated by the Consortium's assessments and complementing these with their expert knowledge of their sectors and the Fafan context.

This Task Team was not limited to members of the Consortium but consisted of technical experts drawn from those sectors identified as key priorities for beneficiaries in the BNA - the Emergency Shelter / Non-food Item (ES/NFI), Food Security, Health, and WASH clusters - as well as protection and cash experts. The formation of this group was designed to ensure that it was possible to conduct cross-sector response analysis and planning that mainstreams protection concerns and considers cash as a response modality. It should be noted that to develop a completely holistic approach to response analysis and planning all sectors should be involved in the process. However, due to time constraints this was not possible within the frame of the pilot.

For example, participants from the education cluster were involved in preliminary meetings but did not participate in the full ROAP process.

The Task Team was formed in November 2017, revitalised in January 2018, and was active between January to March 2018. During this period Task Team members participated in the activities outlined in the table below.

When	Action	Deliverable (relating to the ROAP)	Focal point
29 Jan- 2 Feb	One-on-one sessions with sector representatives in Task Team (TT) to understand the TT TORs, commitments, and calendar (in Addis Ababa)	• All TT members are clear about commitments and dates	Hannah Hames (Consortium Coordinator)
January	Validation of BNA with sector experts in Ethiopia. (part remote, part in Addis Ababa)	• Assessment findings validated by each sector (implausible ones discarded, and complementary information added); specific markets chosen for MSMA	Aaron Thegeya (Save the Children, BNA Consultant)
12 – 28 Feb	MSMA training and data collection (in Jijiga, Somali region)	• Data collected for selected markets	Jo Zaremba (Save the Children, MSMA Consultant)
28 Feb – 2 March	CaLP training on response analysis and the ROAP (in Addis Ababa)	• Profile and size of groups in need • Assistance objectives by group	Francesca Battistin (Save the Children, Technical Lead)
March	TT review (read) MSMA	• Good grasp of all assessment findings • Questions and observations	Jo Zaremba (Save the Children, MSMA Consultant)
19 – 27 March	Single-sector working sessions with clusters involved in the TT for identification of response options (in Addis Ababa)	• Response options for each sector objective • Comparative analysis of response options (operational risks, programmatic risks, costs, market feasibility, FSP, etc.)	Francesca Battistin (Save the Children, Technical Lead)
28 – 29 March	Inter-sector response planning workshop (in Addis Ababa)	• Integrated response plan (any linkages among sectors) • Composition of MPG and tentative value(s)	Francesca Battistin (Save the Children)

Report structure

This report details the discussions held and decisions made during the ROAP process between the 19th and 29th March. It covers both the single-sector working sessions – for Food Security, WASH, Health, and ES/NFI – and the inter-sector working sessions. As the ROAP was new to all participants and the workshops were limited to a total of three days per sector (one day of single-sector and 2 days of inter-sector work) not all elements of the process were finalised, and the below report does not produce

complete response plans for each sector or the sectors collectively. However, it does illustrate what the ROAP process can produce and is a useful point from which future interventions in Fafan Zone can be built.

Section 1 details some overarching background information that informs all the sectors work; section 2 provides a detailed report of each sector's decision-making process; section 3 reports on the inter-sector working-session and how analysis an planning were influenced by cross-sectoral discussions and awareness; and section 4 outlines the next steps of the ROAP.

Overarching situation analysis in Fafan zone

Demographic profile of the population

The table below shows the demographics of the four woredas where the assessments were piloted and on which the ROAP will focus. All four woredas are in Fafan Zone in the Somali Region of Ethiopia.

Population statistics

	Hareshen	Kebribayah	Tuliguled	Babile	Total
	Households				
Residents	17,279	35,736	60,756	16,595	130,366
IDPs in formal settlements	85	1,320	-	7,293	8,698
IDPs in spontaneous camps	-	-	1,265	2,425	617
IDPs in host families	-	-	360	-	-
Total IDP households	85	1,320	1,625	9,718	12,748
Total Residents + IDP	17,364	37,056	62,381	26,313	143,114
	Individuals				
Residents	103,675	214,417	364,533	99,572	782,197
IDPs in formal settlements	639	9,504	-	51,269	61,412
IDPs in spontaneous camps	-	-	10,090	15,274	3,482
IDPs in host families	-	-	2,160	-	-
Total IDP population	639	9,504	12,250	66,543	88,936
Total Residents + IDP	104,314	223,921	376,783	166,115	871,133

Cross-cutting protection issues and vulnerabilities

In the BNA certain groups with vulnerabilities and heightened exposure to risks were identified as being members of the communities within the assessed areas. For example, 20% of IDP and 5% of resident households include separated minors, and one in four IDP and one in three resident households include people with chronic diseases and/or permanent disabilities. Members of these vulnerable groups are recognised as having special needs and all sectors, lead by protection experts, discussed these issues during the working sessions and the following points were highlighted as important considerations to be born in mind when determining response options.

- The effects of vulnerabilities on households' ability to meet their basic needs can be compounded when people suffer from multiple special needs. For example, female headed-households are more likely to be economically and socially disadvantaged and so if they have a high number of dependants or people with chronic illnesses they are less likely to be able to cope.
- Displaced people are more likely to be vulnerable.
    - For example, in some contexts where healthcare is nominally provided free to the resident population internally displaced people (IDPs) may not be eligible for the same free service as they are not originally from the catchment area. It was noted in conversation that this could increase the importance of cash as a means of securing access to health services for IDPs.
    - Distribution sites, even those targeting IDPs, may not be close to where IDPs are living – especially when populations are regularly on the move. This means that IDPs are less likely to be included in distributions or able to access distributions.
    - The needs of IDPs with additional special needs (such as a physical disability or pregnant or lactating women (PLW)) are not well addressed.
- Protection issues are often themselves manifestations of the vulnerabilities and therefore there is a need to address the underlying cause of the vulnerability. For example, if a household's main wage earner is unable to work due to a disability (a vulnerability) then the household may adapt to the consequent lack of purchasing power by sending a child out to work (i.e. adopting a negative coping mechanism that creates protection concerns).

- Vulnerable groups might require distributions to be conducted in a particular way or at a particular time. For example, separated minors or child-headed households would benefit from evening distributions that do not interfere with their school attendance (although it was noted that evening distributions raise their own protection concerns).
  There is a need to ensure that the prioritisation of beneficiaries does not trigger households to adopt negative coping strategies. For example, if assistance targets 'separated minors' efforts should be made to ensure families don't send off their children just so they can then be classified as 'separated minors'.
- Child labour is a concern, especially in those locations where a high percentage of the population is under 18 (52% of working people are below 18 in some areas).

Single sector report: Food security

Profiling of the population with severe food security needs

The first step in the response analysis process is the profiling of the target beneficiary groups. The BNA asked people to assess the severity of their own food needs. From this could be calculated the percentages and absolute number of those most severely deprived of food. This is shown in the table 1 in Annex 2. The FS cluster determined to target those households that were severely deprived of food[1] by the total population of interest in each woreda[2] and the distribution of female- or male-headed household in Ethiopia.[3]

In total, according to the below estimates, there are around 6,300 IDP households and 36,944 resident households with severe food needs in the four target woredas. Babile and Tuliguled are the woredas with the highest absolute numbers of food deprived people, among both IDP and resident communities; Babile is the woreda with the highest relative figures among IDPs whereas Tuliguled has the highest prevalence of severe food deprivation among resident households. Hareshen is the woreda with the lowest number of severely food deprived households.

Based on the available estimates working session participants prioritised the woredas in the following order: Babile, Tuliguled, Kabribeyah, and Harshen.

The food security cluster representatives suggested the following targeting criteria for food assistance:

Group 1		Group 2	
Criteria	# household	Criteria	# household
• Female headed households • polygamous • have special needs • have PLW and children under 5 • are more than an hour from a food source • have not previously received food assistance (using this as a proxy of vulnerability)		• household that are in pastoral zones • have low levels of / no livestock or other assets • low income / expenditures • high dependency ratio • fewer and more seasonable sources of income • have been displaced multiple times	

Further analysis of the BNA raw data will provide information around the socio-demographic features that are correlated to food insecurity and/or income poverty, using expenditure as a proxy. However, this work was not done during the FS workshop.

To support protection sensitive programming protection participants recommended that information (either from the Consortium's BNA or external assessments) on the following topics would be useful:

- Specific protection needs of separated children
- Numbers of child headed household
- A gender analysis

Causal pathways to food insecurity

To determine the most appropriate humanitarian response option it is necessary to identify, as a minimum, both the first and second order causes determining the problem at stake. The BNA provides the causes of unmet food needs as identified by the beneficiaries themselves; they qualify as second-order causes. During the workshop FS experts discussed the first and third order causes of food insecurity to develop a fuller picture of the underlying causes of food insecurity. This information is illustrated in the diagram below.

[1] Source: BNA report, 2018.
[2] DTM round VII for IDP, and 2017 census for resident population.
[3] Source: the WB, 2016.

Further analysis could provide insights around the causes behind the reported low purchasing power. Fourth order causes may include livelihoods-related matters, such as loss of productive assets (e.g. sale of livestock for pastoralists), loss of income generating activity, unavailability of (casual) labour opportunities, etc. In turn, these may be a consequence of displacement or drought, which would be fifth order causes of food insecurity. -Nb. The green box shows the outcome or main issue being tackled, i.e. food insecurity; blue boxes show the top four most frequently cited causes in the BNA; and red boxes show the causes added during the workshop.

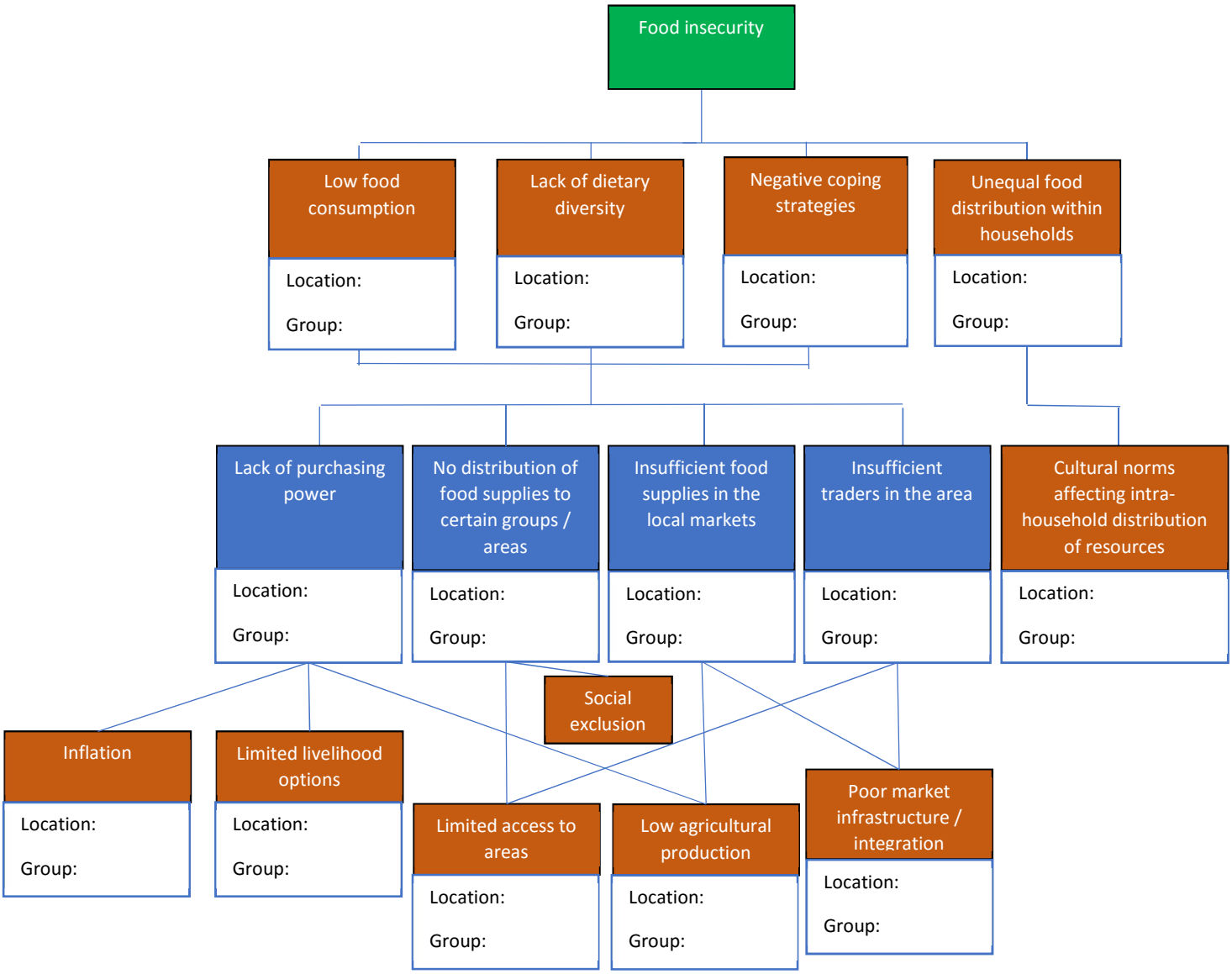


Figure 1 Causal pathways of food insecurity [the workshop participants did not complete the process of mapping of underlying causes for specific groups or localities]

Definition of food assistance objectives

In this section participants defined their sector objectives based on the strategic aims of the 2018 Humanitarian Disaster Resilience Plan (HDRP) the beneficiaries' needs, and their underlying causes. The HDRP set out the following three strategic, nation-wide food security objectives:

- To save lives and protect livelihoods of food insecure household through the provision of food assistance.
- To prepare for and effectively respond to humanitarian shock related food needs.
- To ensure that adequate food needs for the most affected people are met to improve food consumption, dietary diversity and reduce the number of people adopting negative coping mechanisms.

During the workshop, the sector experts developed programmatic objectives that fit within the first strategic objective above:

- Ensure severely food insecure IDP and resident households in Tuliguled, Babile, and Kebribeyah have access to minimum required quantity and quality food.
- To increase access to foods with micro-nutrients for PLW and under-fives who are suffering from MAM in severely food affected IDP and resident households in Tuliguled, Babile, and Kebribeyah.

Comparative analysis of food security response options with a focus on suitability

The BNA provides information on how beneficiaries usually meet their food needs and how long this takes (see table 2 in Annex 2). It also provides information on target groups' preferred assistance modalities: for food needs cash is the preferred assistance and in-kind the second preference across all woredas. In terms of how households get access to food, local markets and assistance from NGOs and community account for nearly 100% of the responses in Kabribayah and Hareshen whereas in Tuliguled and Babile, households also source their food needs through their own supply (presumably meaning they grow crops or keep animals). However, in these latter two woredas this source is only the third most common way of meeting needs (after purchase at local markets and provision by NGOs).

Response options for objective 1

The group identified in-kind transfers, cash transfers, as well as food vouchers, as appropriate response options to ensure that severely food insecure IDP and resident households in the prioritised woredas (Tuliguled, Babile, and Kabribayah) have access to minimum required quantity and quality food (objective 1).

All these assistance modalities appear to be accepted by the Government, which, in fact, is now encouraging and piloting a shift from in-kind food distributions to cash transfers in the Somali region. It should be noted that most (if not all) food distributed by WFP (the largest food distributor and government partner) is imported. As such, replacing in-kind food distributions with cash transfers would advantage Ethiopian producers and traders as people would likely purchase more locally grown goods.

The first response option, an in-kind food package, would consist of a monthly distribution (currently it is done every six weeks) of oil, cereal, pulses, and vegetables. From a suitability-to-objective point of view, this response option has several advantages: experts perceive that there would be high chances that the food is consumed by the household and that sector objectives would therefore be achieved; it is possible for the implementing agencies to control the continuity of the supply chain and to avoid disruptions in assistance; it allows food sharing, which in turn has positive effects on households' social capital within their communities and may benefit those that have been (wrongly) excluded from assistance. However, food sharing also reduces the food intake of intended households, which ultimately jeopardise the effectiveness of the response. Additional disadvantages of in-kind assistance are that it does not allow households to choose their preferred food and the timing when they need it; the package is also very limited in terms of variety of food groups and would not ensure much-needed dietary diversity.

The second response option of a cash transfer would be distributed monthly and would be of an amount equivalent to the cost of the diet including cereal (wheat), pulses (haricot beans), oil, fresh food (vegetables, dairy and eggs), and sugar as well as a small stipend to cover milling costs. The positive aspects of such a response relate to the flexibility for recipients; giving them diversity of choice and allowing them to procure the preferred food at the preferred time. In comparison to in-kind food distribution, a cash transfer would lead to higher dietary diversity, a very important element of food security. On the other hand, cash transfers can potentially be used for purposes that are outside of the scope of the programme - although this seems to be a negligible challenge for food, given that food expenditure is prioritised by households, who would allocate it as much as 1,800 ETB should they be given a cash transfer of 4,000 ETB.[4]

Food vouchers were the third considered option and was proposed as a monthly distribution/activation. The proposed approach was to use a commodity or value voucher that covered the following food items: cereal (wheat), pulses (haricot beans), oil, fresh food (vegetables, dairy and eggs), and sugar as well as a small stipend to cover milling costs. In comparison to cash transfers, food vouchers give greater control over the achievement of the programme objective as there is a greater chance that the voucher will be used to procure the intended food items in the desired quantity. And compared to in-kind food assistance, food vouchers offer an increased variety of food options and therefore greater dietary diversity (assuming the local market is able to provide a greater range of products). Yet, their flexibility is lower than cash transfers in terms of both goods

[4] Source: Basic Needs Assessment report.

and timing, as they must be redeemed within a certain window. Finally, compared to in-kind, the implementing agency does not have control over the quality of food that local trader partners provide to beneficiaries.

Response options for objective 2

The second objective was to increase access to foods with micro-nutrients for PLW and under-fives who are suffering from MAM in severely food affected IDP and resident households in Tuliguled, Babile, and Kebribeyah (objective 2). Targeting for this intervention would be done through referrals i.e. those PLW and under-five diagnosed by a medical professional as being MAM. Recipients would be a sub-set of the households that already receive food assistance as per objective 1. As such, the basic food needs of most household members would already be met and the additional foods with specific micronutrients would be intended to be consumed by those members of the household who particularly require them.

The group considered all the same modality options as above (in-kind, cash, and vouchers) as well as an additional option combining conditional cash transfers and case management for households with SAM and MAM.

The in-kind option would consist of a quarterly provision of micro-nutrient rich supplements. This guarantees that the required micro-nutrients are consumed. However, the supplements, in the form of PlumpyNut or equivalents, would need to be imported as therapeutic food is not commonly available locally.

The second option was for cash transfers that consist of a top-up to the monthly transfer for food (as part of objective 1) for an amount equivalent to the cost of micro-nutrient rich supplements. However, if this cash is given without labelling or restrictions, the food cluster believe this would be the weakest response option for this specific objective, as there is a high chance that the cash would not be used to buy micro-nutrient rich supplements. To increase the likelihood that cash is used for the intended purpose it was recommended that conditions are to the cash transfer, or the transfers are labelled and peer pressure from community members and/or other recipients of the same intervention is leveraged. One clear disadvantage of this response option is that micro-nutrient rich supplements may not be available in the local market and may be expensive. Finally, cash transfers may trigger intra-household's conflicts, due to competing priorities around how money is used, especially if the special needs of certain members of the household are not adequately considered and prioritised.

Vouchers, a third response option, are more likely than cash to be used to buy micro-nutrient rich supplements; yet, like cash, they require these commodities to be available on the local market.

The fourth response option considered by the food experts is a combination of conditional cash transfers and case management for PLW and children under 5 at risk of malnutrition or with SAM or MAM. The recommended condition would be that beneficiaries attend nutrition orientation and sensitisation activities. Compared to cash alone, this combination would give greater assurance that the desired micro-nutrients will be consumed and that the households adopt better nutritional practices, in a sustainable way.

Setting the transfer value for food needs

Since both cash transfers and vouchers response options are considered suitable to achieve food security objectives, the recurrent or one-off costs of key food items had to be estimated.

The first step taken by the group was to define the food basket, based on the dietary requirements and food preferences in Fafan zone/Somali region. The basket would include: cereal (wheat), pulses (haricot beans), oil, fresh food (vegetables, dairy and eggs), and sugar as well as a small stipend to cover milling costs. In addition, for PLW and children under five, the food basket would include food rich in particular micro-nutrients. It should be noted that maize is the most consumed staple food in Fafan zone and in its absence, households opt for rice and pasta; although these are imported from Somaliland so more expensive.[5]

In table 5 in Annex 2, is an overview of these costs. According to estimations made by the group, the cost of the diet would amount at 2,870 ETB. This includes a 20% margin for potential increases in cost when locally produced food has to be substituted by more expensive imported foods.[6]

The following step was to estimate the expenditure gap, by subtracting the actual average food expenditures according to BNA findings from the previously estimated cost of the diet. On this basis it was estimated that there was an expenditure gap of 1,558 ETB for resident households (who currently spend 1,312 ETB on food) and 1,965 ETB for IDP households (who currently spend 905 ETB on food). This would be a proxy of the amount to be transferred to achieve the first objective. However, the

[5] It is not clear why the FS experts opted to base their food basket calculations on the cost of wheat.

[6] This estimation was completed at the Response Analysis training workshop that the group attended from 27th February to 1st March 2018, in Addis Ababa.

food cluster experts suggest transferring the full basket costs of 2,870 ETB to IDP households on the basis that they have fewer resources overall.

During discussions it was noted that since the HDRP was released there have been discussions within the Ethiopian humanitarian community about how the food response can be more effectively split between cash and in-kind responses. The CWG has proposed what they believe to be a more realistic food basket broken down by region and based on preferences and which is worth approximately 1,500 ETB (which is similar to the expenditure gap of resident households reached above). However, this figure is substantially larger than that given by under the Government run Productive Safety Net Programme (PSNP), which is approximately 1,000 ETB and therefore the newly proposed figure has not yet been agreed. From this it is clear that the value of minimum expenditure baskets depend not only on needs and the costs of meeting these, but also on political considerations.

Overall comparative analysis of the food response options

In this step workshop participants further reviewed the possible response options and weighed them against each other, considering their possible advantages and disadvantages for all criteria relating to programmatic aims and approaches. In addition to the arguments around whether response options will meet the objectives (considered above) participants also weighed the impact an intervention would have on the public and private markets, the implementing agencies capacity, risks, and costs.

A summary of this information is in the tables 6 & 7 in Annex 2 (one table per response objective).

For objective 1 both cash and voucher transfers were considered as having more positive impacts on the local market than in-kind assistance as they would encourage the expansion of businesses, and in areas where there are liquidity issues (which includes many rural areas) cash injections would be particularly advantageous. Vouchers are somewhat less advantageous to the local markets as they disproportionately benefit those traders with whom the implementing agency build relationships. In-kind assistance would suppress local trade by reducing demand and there are issues around logistics of transferring food, particularly to remote or insecure areas.

All humanitarian organisations that meet food needs have experience in providing in-kind assistance, although an increasing number are also familiar with cash as a modality. However, some organisations have concerns around the possible risk of fraud and diversion associated with cash (and to a lesser extent) vouchers. Theft is considered a risk for both in-kind and cash for food interventions. In-kind food distributions are expensive for implementors to deliver (they require substantial transportation, warehousing, and distribution costs) and cash interventions have fewer logistical requirements particularly if done electronically) but have high start-up costs. Beneficiaries may incur costs (in terms of time and transport) in accessing both in-kind or cash transfers (although for the latter the cost is associated with having to go and purchase the goods if the transfer is electronic).

Cash is also considered more likely than in-kind to create intra-household tensions.

For objective two, many of the considerations are the same as above. However, in addition to these considerations there is a need to consider that micro-nutrient rich food (such a PlumpyNut) is not available on the local market and so whilst in-kind provision relies on international importing (and therefore high transportation costs and a time lag) it does not undermine local providers. And cash transfers or vouchers would not result in access to these goods for beneficiaries.

The combination of in-kind transfer of micro-nutrient rich foods and conditional cash transfer based on attendance at awareness sessions is seen as requiring higher manpower than the other options but as more likely to result in the intended outcome than cash alone. Implementing partners also have high levels of familiarity with providing orientation and sensitisation activities around nutrition.

Recommended food security response option for Fafan zone

[The FSL participants did not complete the ROAP process. To conclusively determine responses more work would be required on: the specifics of the response options i.e. the exact assistance package provided by each option; the cost of the preferred option; the number of target beneficiaries that fall under the second objective; mitigation measures that would be applied.]

Based on the weighted scoring the preferred options are:

For objective 1: Ensure severely food insecure IDP and resident households in Tuliguled, Babile, and Kebribeyah have access to minimum required quantity and quality food.

Over the next 9 months the food security sector will provide assistance to food insecure IDP and resident households in Tuliguled, Babile, and Kebribeyah. 278,659 individuals across 43,027 households will benefit from this assistance. This is 30% of total households living in these areas. This assistance will help ensure severely food insecure IDP and resident households in Tuliguled, Babile, and Kebribeyah have access to minimum required quantity and quality food. The food insecure IDP and resident households in Tuliguled, Babile, and Kebribeyah will receive a monthly unconditional cash transfer of 1,558 ETB for resident households and 2,870 ETB for IDP households in nine instalment(s) or rounds.

It should be noted that if the process was completed the sector would have also been able to complete the following information:

This assistance package will be delivered over nine months. Risks will be considered in the following way:

a) _____ (mitigation(s) of programmatic risk(s) including protection risks)
b) _____ (mitigation(s) of operational risk(s))
c) _____ (mitigation(s) of contextual risk(s))
d) _____ (mitigation(s) of institutional risk(s))

The total funding required will be [value of funding].

For objective 2: To increase access to foods with micro-nutrients for PLW and under-fives who are suffering from MAM in severely food affected IDP and resident households in Tuliguled, Babile, and Kebribeyah.

(It should be noted that not all the information is available here as the process was not completed as not all the relevant data – such as prevalence of MAM cases in the target areas and populations – was available in the BNA and the analysis of alternative options was not completed.)

Over the next nine months the food security sector will provide assistance to MAM-affected PLW and under-fives in severely food affected IDP and resident households in Tuliguled, Babile, and Kebribeyah. [estimated number of individuals] across [number of households] households will benefit from this assistance. This is [percentage] % of total households living in these areas. This assistance will help them to increase their access to foods with micro-nutrients. MAM-affected PLW and under-fives in severely food affected IDP and resident households in Tuliguled, Babile, and Kebribeyah will receive [type of cash-based transfer and frequency] of [amount / quantity] in [number of instalments] instalment(s) or rounds, [on the condition to …, as applicable].

This assistance package will be delivered over nine months. Risks will be considered in the following way:

a) _____ (mitigation(s) of programmatic risk(s) including protection risks)
b) _____ (mitigation(s) of operational risk(s))
c) _____ (mitigation(s) of contextual risk(s))
d) _____ (mitigation(s) of institutional risk(s))

The total funding required will be [value of funding].

Single sector report: WASH

Note on terms

WASH needs in the BNA were categorised into three distinct groups:

- Sanitation facilities and services (toilets, shower, bath, sewage system, repair and construction services, etc.). It has been noted by WASH sector experts that this should also have included vector control.
- Hygiene commodities (clothing, cleaning products, soap, toothbrush, pads, diapers, etc.)
- Potable water (treatment, water points, etc.)

Profiling of the population with WASH needs

The first step in the response analysis process is the profiling of the target beneficiary groups. The BNA asked people to assess the severity of their own WASH needs and the percentages and consequent absolute numbers of those most severely deprived of the sanitation facilities, hygiene commodities, and potable water are shown in tables 8 -10 in Annex 2. They have been estimated by multiplying the prevalence of households with severe WASH needs[7] by the total population of interest in each woreda[8] and the prevalence of female or male headed household in Ethiopia.[9]

In total, according to these estimates, there are around 5,316 IDP households and 51,374 resident households with severe water needs in the four woredas. In absolute figures, there are significantly more households in severe need for water than for food (i.e. nearly 57,000 households vs. 43,000). Tuliguled is the woredas with the highest relative and absolute numbers of water deprived people, among both IDP and resident communities, followed by Babile. Hareshen is the woreda with the lowest number of severely WASH deprived households. Female-headed households are comparatively more water deprived than male-headed households; the disparity is relatively most significant among residents in Kebribeyah, where the proportion of women-headed households in severe need for water is four times larger than that among male-headed households (35% vs. 9%). In Tuliguled, three quarters of resident female-headed households report severe unmet water needs.

The level of deprivation in sanitation infrastructures and services is almost as high as water deprivation. It is highest for resident households in Kebribeyah and Tuliguled, whereas the opposite is true for Babile where IDPs are relatively more affected. Regarding hygiene, relative and absolute figures of severely deprived households are lower across the board, if compared to the water and sanitation deprived. Hygiene needs are mostly felt among IDPs and women, in all woredas, and are the highest among resident in Tuliguled.

Based on the available estimates, working session participants prioritised the woredas in this order: Babile, Tuliguled, Kebribeyah, and Harshen, which is aligned with that for food security. The WASH cluster representatives suggested two combinations of targeted groups.

Overall, sector experts recommended that the different types of WASH interventions are not considered separately (i.e. water vs. sanitation vs. hygiene) as they are closely interrelated and mutually reinforce each other's effectiveness and feasibility in many ways. Targeting-wise, it is therefore strongly recommended to align the approaches. The consistency of findings of severely deprived people across the three components allows for that; geographically, the three priority woredas for WASH are Tuliguled, Babile, and Kebribeyah.

For hygiene and sanitation needs ranked groups in order of priority:

- First priority: households in Tuliguled, Babile, and Kebribeyah that are severely deprived of sanitation needs (according to the BNA and assuming that the hygiene commodity deprived would be fully included in this group), and who fall into one of the following criteria: female-headed IDP households, male-headed IDP households, female-headed resident households. This amount to approximately 19,900 households (130,000 individuals).
- Second priority: the resident male-headed households in Tuliguled, Babile, and Kebribeyah (not covered above) that are severely deprived, i.e. around 29,200 households, or 187,200 individuals.
- Third priority: households in Hareshen that are in severe need for sanitation (i.e. 535 households or 3,440 individuals according to estimates in Table 9).

It was noted that further information gathering to support additional disaggregation of target groups (beyond kebele, household head, and severity of deprivation) would add an unnecessary layer of complexity and disproportionately slow the provision of assistance. However, estimates of the percentages of households containing people with special needs (pregnant and lactating women, children under 5, those with chronic illnesses or physical disabilities etc.) are available for the population as a whole and could be applied if a smaller target group was required due to funding constraints.

In addition, if funds are limited and therefore the project is not able to reach all desired beneficiaries, then smaller target groups will be selected from within these above-mentioned groups, prioritising geographic areas with the largest populations of the most severely affected (e.g. Babile, with a focus on IDPs) and donor's own priorities (e.g. focus on conflict-affected IDPs or drought-affected populations).

[7] Source: BNA report, 2018.
[8] DTM round VII for IDP, and 2017 census for resident population.
[9] Source: the WB, 2016.

Finally, it is important to note that the BNA analysis presents an analysis at woredas level, whereas WASH actors are conducting analysis at the community level, which raises issues of comparison. IDP populations are concentrated in the contested zones between Somali and Oromia – due to government policies.

Causal pathways to unmet WASH needs

To determine the most appropriate humanitarian response option it is necessary to identify both the first and second order causes determining the problem at stake. The BNA provides the causes of unmet hygiene and water needs, as identified by the beneficiaries themselves; they qualify as second order causes as shown in Figure 2.

During the workshop WASH experts discussed the underlying causes of sanitation and hygiene needs and the underlying causes and outcomes of unmet water needs to develop a fuller picture of the causes that drive challenges in the WASH sector. This information is illustrated in the diagrams below.

Nb. The green box shows the outcome; blue boxes show the top four most frequently cited causes in the BNA; and red boxes show the causes added during the workshop.

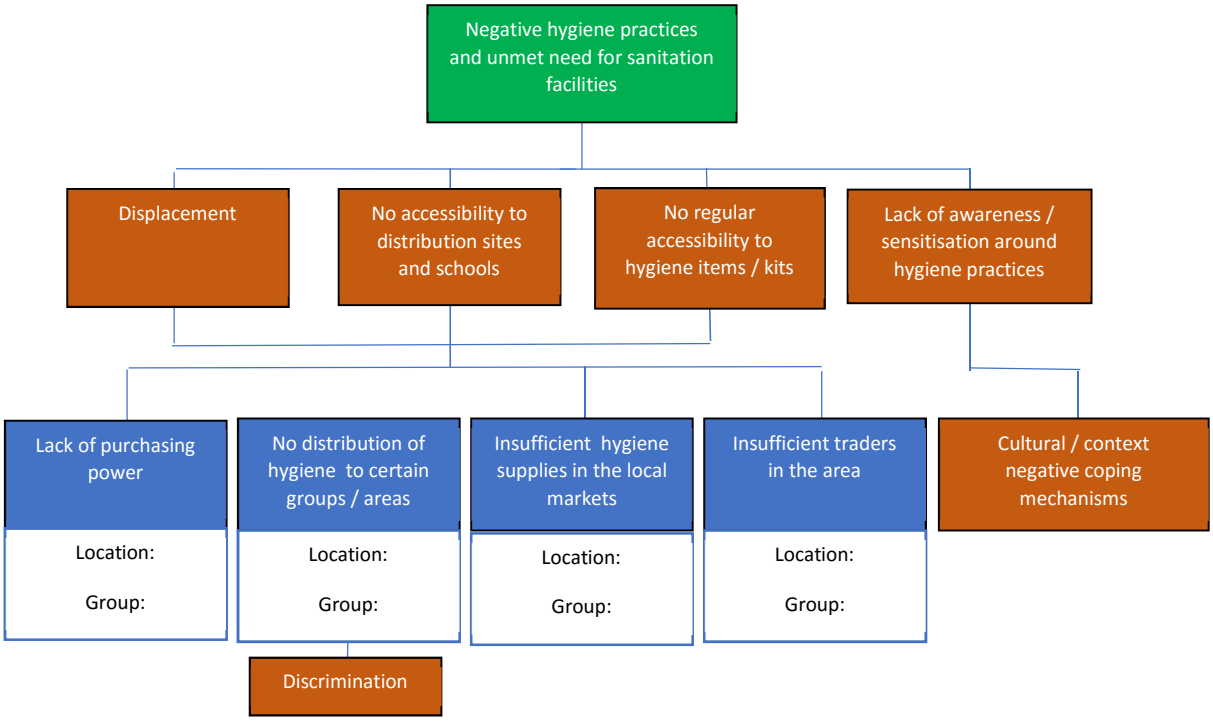


Figure 2: Hygiene practices and sanitation facilities causal pathways [the workshop participants did not complete the process of mapping of underlying causes for specific groups or localities]

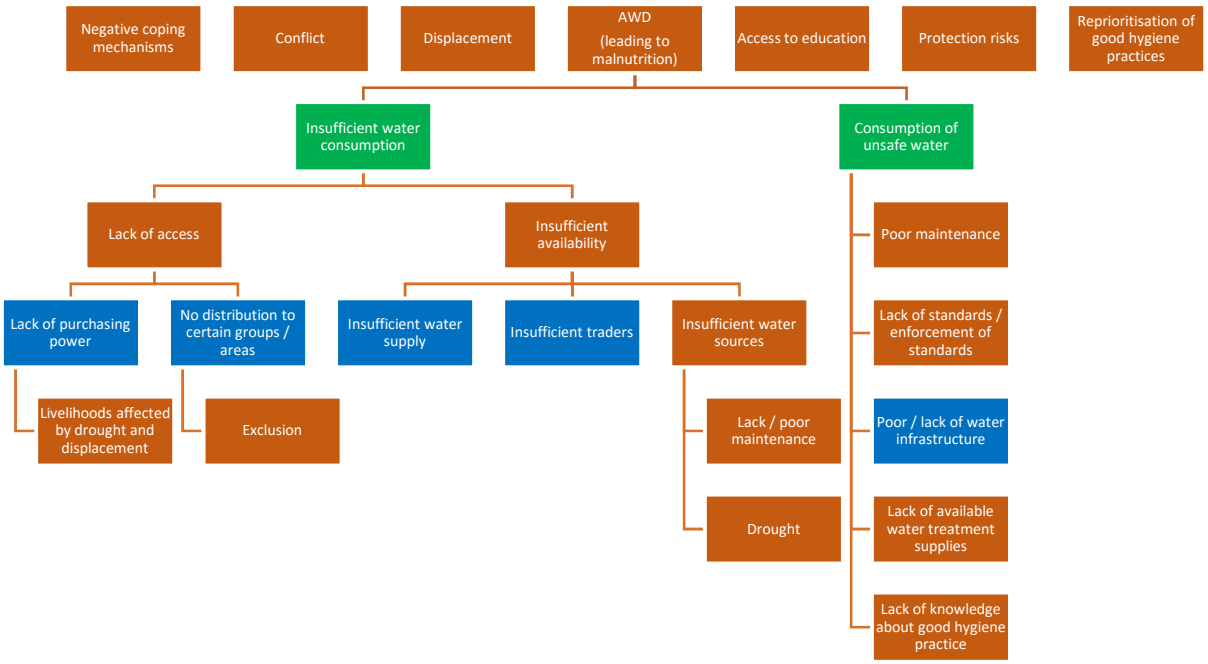


Figure 3 Potable water causal pathways [the workshop participants did not complete the process of mapping of underlying causes for specific groups or localities]

It should also be considered that when water is extremely scarce, communities usually consider access more important than quality.

Reviewing the information above on the most severely affected groups in light of the causal pathways identified here, WASH experts were able to begin to identify which causal pathways are particularly influential for particular groups (and therefore which potential responses would be best able to meet specific groups' needs). For example, the fact that in Kebribeyah female-

headed resident and IDP households are so significantly more deprived than their male counterparts (74% vs 59% severely deprived for IDPs and 68% vs 46% severely deprived for resident households) suggests that the underlying causes are likely ones of access not availability. The reasons why women-headed households are significantly more deprived should be investigated. Had this been completed the diagrams would be more contextualised and each box would contain information about where and for which groups this particular cause is a particular issue.

Definition of WASH assistance objectives

In this section participants defined their sector objectives. The following three objectives are drawn from the 2018 HDRP:

- Improved coordination in for emergencies to deliver water, sanitation, and hygiene promotion assistance to affected populations
- Prepare for humanitarian shocks and be well-positioned to provide WASH services during the response phase of an emergency
- Assist the recovery process of affected population by rehabilitating non-functional WASH infrastructure

During the workshop the sector experts further developed the first objective, adding detail and breaking it down into a water- and a hygiene-based objective. These are:

- Ensure 55,700 severely water deprived households in Babile, Tuliguled, and Kebribeyah have access to safe water to the minimum survival Sphere quantity standards for three months (5 litres per capita per day).
- Ensure accessibility and awareness to sanitation facilities and services for the most severely affected population and specific vulnerable groups (women and girls) in IDPs camps and resident population (19,900 households), during 12 months
    - Severely affected as defined in the BNA and including female-headed displaced households, male-headed displaced households, female-headed resident household.

Comparative analysis of WASH response options with focus on suitability

The BNA provides information on how beneficiaries usually meet their WASH-related needs and how long this takes (see the tables 11 & 12 in Annex 2). It also provides information on beneficiaries preferred assistance modalities: for water, hygiene, and sanitation needs cash is the preferred assistance modality across woredas, in-kind the second preference in Babile, Hareshen, and Kebribeyah and direct service provision the second preferred option in Tuliguled.

WASH experts used this information to weigh response options for objective 1 (water objective) and 2 (the sanitation facilities and services objective). This analysis can be found in tables 14 and 15 in Annex 2 respectively and is elaborated in the 'overall comparative analysis' section below.

Setting the transfer value

Since both cash transfers and vouchers response options are considered suitable to achieve WASH objectives - including those focused on sanitation and hygiene items and water needs - the recurrent or one-off costs of key food items had to be estimated.

The first step taken by the WASH group was to define the WASH basket, based on the sanitary and water requirements in Fafan zone/Somali region. The basket would include some items that are only required once a year (two jerrycans (a 20L and 10L), safety pins, a standard bucket, a washing basin, a nail cutter), others that are required twice a year (female underwear, women's fabric, fabric sanitary pads) and those that are required more regularly on a quarterly or monthly basis (bath soap, shampoo, laundry soap, glycerine/cream, buffer hygiene commodity, general cotton fabric roll, and water vouchers during the dry season).

In table x in Annex 2, is an overview of these costs. According to estimations made by the group, the cost of hygiene basket would be 10,168 ETB per year. 8,824 ETB would be split into quarterly grants for those items that need to be regularly replenished (including water), an additional 774 ETB would be split into two traches for less used items, and an additional transfer of 600 ETB would be given at the start of the programme for those commodities that only need to be purchased once.

The following step was to estimate the expenditure gap, by subtracting the actual average WASH expenditures (including hygiene commodities, sanitation facilities, and potable water) according to BNA findings from the previously estimated cost of the WASH basket. On this basis and assuming the hygiene basket costs were split evenly across the 12 months of a programme

(which is not realistic but a useful starting point) it was estimated that there was an expenditure gap of 481 ETB for resident households (who currently spend 366 ETB on WASH) and 629 ETB for IDP households (who currently spend 218 ETB on WASH needs). This would be a proxy of the amount to be transferred to achieve the two objectives.

Overall comparative analysis of the WASH response options

In this step workshop participants reviewed the possible response options and weighed them against each other, considering their possible advantages and disadvantages for all criteria relating to programmatic aims and approaches. A summary of this information is in the tables 14 and 15 in Annex 2, one for each response objective.

To ensure water access, the following response options were considered: cash transfers to cover the costs of water (the exact details of this were not specified); water trucking in Tuliguled and Babile; fixing non-functioning boreholes, pipeline extension, digging new boreholes in Tuliguled and Babile; and water vouchers for income-poor households in Kebribeyah.

The first approach – cash transfers – was seen as advantageous as it is flexible and could therefore adapt to changing water prices. However, crucially, there is no water market in Babile and Tuliguled and cash would not solve the availability issue. On this basis cash-based responses were rejected. Vouchers face the same issues.

Water trucking was then considered. This is a tried and tested method that all the organisations dealing with WASH issues are familiar with. Water trucking allows NGOs to have the greatest control over the quantity and quality of water people receive and can reduce protection issues connected with having to travel to collect water. However, the disadvantages of water trucking are that it is expensive, does not contribute to or build the local economy, and ultimately still depends on the availability of ground water that can be pumped. In addition, there are complications to this approach based on the government's engagement with the work: NGOs fear that the government may not agree with the vulnerability targeting criteria and instead insist on blanket coverage, which would reduce the number of communities that NGOs could afford to target. In addition, in the Somali Region the government has purchased 120 trucks but the method of running them, whether directly or through partners etc. has still not been agreed.

The third option considered to meet water-based needs was to repair and construct infrastructure such boreholes and pipelines. This is a widely accepted approach and the Somali region government already owns a number of drilling rigs. On the other hand, if targeting IDPs (as this intervention planned) the government's IDP resettlement policies would need to be considered so that infrastructure work is concentrated in areas where the government doesn't intend to move on the IDPs soon. A limitation of this approach is that it is time consuming and cannot address emergency-based needs. In addition, infrastructure in inherently not mobile so for some this may not address access issues or protection issues that occur during the journey to or from the water collection point.

Under the second objective - to ensure awareness and access to hygiene commodities and sanitation - the group proposed three alternatives: distribution of cash transfers to cover the costs of hygiene kits; direct provision of toilets and handwashing facilities complemented by hygiene promotion to ensure clear and standardised hygiene messages reach the target population; and a combination of service provision and cash transfer. It should be noted that these are not necessary alternatives but approaches that could be potentially complementary as they address different causes and seek to meet slightly different needs. Cash transfers deal with the need for hygiene kit items and the provision of infrastructure deals with a lack of infrastructure.

Cash is a well-established response option on the Somali region but not typically used for WASH interventions. As such partners are unlikely to have the necessary expertise in-house. However, the items that make up a hygiene kit (except for water) are reliably available in local markets. Quality of the goods cannot be guaranteed – although this is less important for the key items than it is for water.

The second response option of facilities and hygiene education provision is very well accepted by the WASH cluster. In addition, the physical infrastructure provides a relatively sustainable solution to the issue and this is complemented education element. However, construction takes time to complete so it will not meet immediate needs.

A combined response of service provision and cash transfers was also considered although the details were not fleshed out.

Recommended WASH response options for Fafan zone

[The WASH participants did not complete their analysis of response options due to time constraints and their limited knowledge of the local context. However, if they had completed the process they would have been able to complete the following paragraph for each response objective - currently there is only a partially completed section for the second objective.]

Based on the weighted scoring the following is the preferred option for the hygiene- and sanitation-based objective of ensuring accessibility and awareness to sanitation facilities and services for most severely affected population and specific vulnerable groups (women and girls) in IDPs camps and hosting communities.

Over the next 12 months the WASH sector will provide assistance to severely affected people and specific vulnerable groups (women and girls) in IDPs camps and within the resident population in Tuliguled, Kebribeyah, and Babile. [estimated number of individuals] across [number of households] households will benefit from this assistance. This is [percentage] % of total households living in these areas. This assistance will help them to access and be aware of the importance of sanitation facilities and services. Vulnerable groups (women and girls) in IDPs camps and within the resident population in Tuliguled, Kebribeyah, and Babile will receive quarterly unconditional cash transfer for hygiene and dignity kit items (to vary by quarter) as well as hygiene promotion services and whole communities within these areas will benefit from the construction of community latrines and handwashing facilities.

This assistance package will be delivered over [timeframe]. Risks will be considered in the following way:

a) _____ (mitigation(s) of programmatic risk(s) including protection risks)
b) _____ (mitigation(s) of operational risk(s))
c) _____ (mitigation(s) of contextual risk(s))
d) _____ (mitigation(s) of institutional risk(s))

The total funding require will be [value of funding].

Single sector report: Health

Profiling of the population with severe health needs

The first step in the response analysis process is the profiling of the target beneficiary groups. The BNA asked people to assess the severity of their own health commodity and health service needs and the percentages and consequent absolute numbers of those most severely deprived of health care are shown in the tables 15 & 16 in Annex 1. They have been estimated by multiplying the prevalence of households with severe needs[10] by the total population of interest in each woreda[11] and the prevalence of female or male headed household in Ethiopia.[12]

In total, according to the below estimates, there are around 4,849 IDP households and 37,535 resident households who are severely deprived of health commodities, and 5,355 IDP and 41,121 resident households that are severely deprived of health services in the four woredas. Tuliguled and Kebribeyah are the woredas with the highest absolute numbers of health deprived resident people; Babile is the woreda with highest absolute numbers of severely deprived IDPs. Hareshen is the woreda with the lowest number of severely health deprived people across all groups.

However, the information provided in the BNA was insufficient to gain a full picture of the health situation and there were unfortunately no additional assessment reports available on the Fafan region that would allow an adequate analysis of health needs, capacities, and risks.

It was noted by workshop participants that targeting should be the same for health service and health commodity needs, as medicines should only be obtained after having seen a qualified health worker who made an appropriate diagnoses and prescription, and that support to service provision would be the most appropriate given such high levels of needs. It was also noted that for epidemics and other public health risks there is a need to target areas where there are high vulnerabilities and that this is for example based on risk mapping of epidemics. The subsequent preventative and risk reduction activities are related to the identified potential risks. This part of the response analysis was not included in the ROAP. The type of mapping and consequent targeting criteria varies depending on the epidemics.

Therefore, during the workshop the health cluster developed two alternate approaches to targeting, focusing on access to essential services, including medication and other commodities that promote health.

The target groups and areas for interventions were classified as follows.

Target approach one focused on:

- Geographic areas where services are not available (a mapping has been done by many NGOs, unfortunately data from the Health Resource Availability and Mapping System was not yet available).
- Geographic areas where services are available, but with regular stock-outs and/or that charge user fees without being able to scale up exemption schemes
- the poorest households as identified by a triangulation of data from:
    - the PSNP programme
    - those who are eligible for a waiver in their contribution to the community based health insurance (CBHI) scheme, whether one is operational or not. Although it should be noted that the budget for waiving fees is usually limited to 10% of the population and those eligible are a significantly larger group. Therefore, using details of those with waived fees will only capture some of this eligible group.
    - those most suffering severe needs / deprivation according to the BNA
- household with special needs (as identified via BNA)
- Everyone who requires referral to secondary care should be targeted (approx. 10% of all patients), with the assumption that hospital care is available and able to address increased numbers of referrals.

In all Woredas, IDPs are targeted, as the BNA confirmed that they have significant financial barriers to access services and/or obtain medication.

[10] Source: BNA report, 2018.
[11] DTM round VII for IDP, and 2017 census for resident population.
[12] Source: the WB, 2016.

To avoid creating inequities between IDP and resident population, that may also be affected directly and/or indirectly by the crisis, resident households and female headed households that comply with the criteria for waiving of user fees or CBHI premiums will be targeted.

Protection concerns for the target groups

There is a high need for addressing child protection, especially in IDP households where one out of five households include at least one separated minor.

Gender based violence (GBV) is frequent in crises settings both within households and externally, especially when people are on-the-move. However, in all contexts there is very little data. In aid settings female-headed households are particularly exposed to the threat of sexual exploitation, regardless of the type of assistance and this increases the prevalence of unintended pregnancies. In the Somali Region early marriage is (anecdotally) particularly frequent among IDPs (and largely attributed to cultural traditions and low education levels) and is seen as a way to reduce the financial burden on a family and protect girls, particularly in times of crisis.

Reproductive health services are particularly limited and there are no clinical management of rape services and healthcare providers have limited skills in dealing with rape cases.

Important notes for targeting

The poorest households suffer the most. It could be argued that IDPs are the poorest, but response activities will equally benefit poor resident households.

IDPs sometimes do not have access to health services if they are settled far from health infrastructure. In areas where there is inadequate availability of primary care services, Mobile Health and Nutrition Teams will be established. However, if there are clinics and medicines, then IDPs and residents are equally able to access these – neither is discriminated against on the basis of their origins. In camps there is already a humanitarian response that involves provision of clinics directly to IDPs.

In areas where the community-based insurance schemes are implemented, only local poor residents are eligible for the local government to pay their insurance premium (the insurance also reimburses private pharmacies for medicines when the public clinics have stock-outs). In areas that are affected by the drought or that receive significant numbers of IDPs, and therefore have a much higher proportion of poor/indigent households than average, the local governments and/or the CBHI agency do not have sufficient buffer funds to compensate for the increased loss of revenue if they apply their criteria for waiving of fees or premiums to all who are eligible. In addition, in Ministry of Health (MoH) facilities, there are regular stock-outs of medication. This means that both IDPs and resident households then must purchase medications from private pharmacies where they often face difficulties securing the necessary medications due to lack of purchasing power. In addition to this, the private systems also often face stock-outs, particularly in poorer areas where ability to buy medicines is very low (so providers have limited incentives to stock medicines) and this affects all those using private clinics and pharmacies.

There is a need to distinguish the barriers for accessing primary and secondary care. Furthermore, there is a need to look at the performance of the community outreach component of primary care, that provides health promotion, prevention, and selected curative services, through the Health Extension Programme with Health Extension Workers and the Health Development Army. While there was no data on this available for the Fafan area, it is generally considered that this programme does not function adequately in the Somali region.

Health needs and subsequent expenditures cannot be averaged between households, so insurance policies make a lot of sense as they are based on risk sharing. Where the CBHI is not yet implemented, the waiving of user fees for the target population is the next best option to reduce financial barriers. Both these options are based on provider payment mechanisms, whereby the provider is reimbursed for services delivered to patients that are covered under either of these two schemes. If a cash transfers is used it needs to be linked to the time when the people are actually ill (not a standard value distributed over time) and the actual costs of obtaining the care they need (both at primary and secondary care levels, as well as indirect costs) and with the assurance of adequate quality. Therefore, contracting providers complemented with voucher mechanism is the best approach. The health sector NGOs already support MoH health facilities by paying the service provider directly when the clinics they support waive the user fees and when they issue referral slips for treatments or admission to hospital, after the service / items are provided (both the MoH health facilities and private pharmacies). In some cases, indirect costs incurred by people / households accessing the care are addressed (e.g. transport, accommodation, food, etc, for patients and/or caretakers).

Causal pathways to unmet health needs

To determine the most appropriate response option it is necessary to identify immediate and underlying causes of the problems at stake. The BNA provides the causes of health needs as identified by the beneficiaries themselves, but this needs to be complemented by a mapping by health sector experts of the availability and performance of services, an analysis of health system capacities and bottlenecks, and an analysis of health risks. During the workshop health experts discussed causes of health deprivation to develop a fuller picture of the underlying causes of health deprivations. (Note. commodities and services were considered in one joint framework as access to medicines needs to be seen as part of a process that also involves consultations, diagnosis and prescriptions from qualified health workers).

For example, further analysis by experts provided insights around the causes behind the reported low purchasing power. Causes suggested included livelihoods-related matters, such as loss of productive assets (e.g. sale of livestock for pastoralists), loss of income generating activity, unavailability of (casual) labour opportunities, etc. In turn, these may be a consequence of displacement or drought. However, to determine the details of the underlying causes there is a need – as with the causal analysis done for all sectors – to include inputs from local experts, which was not possible during the ROAP workshop.

This information is illustrated in the diagram below. Note, the green box shows the outcome or main issue being tackled, i.e. health deprivation or unmet health service needs, blue boxes show the top four most frequently cited causes in the BNA; and red boxes show the causes added during the workshop.

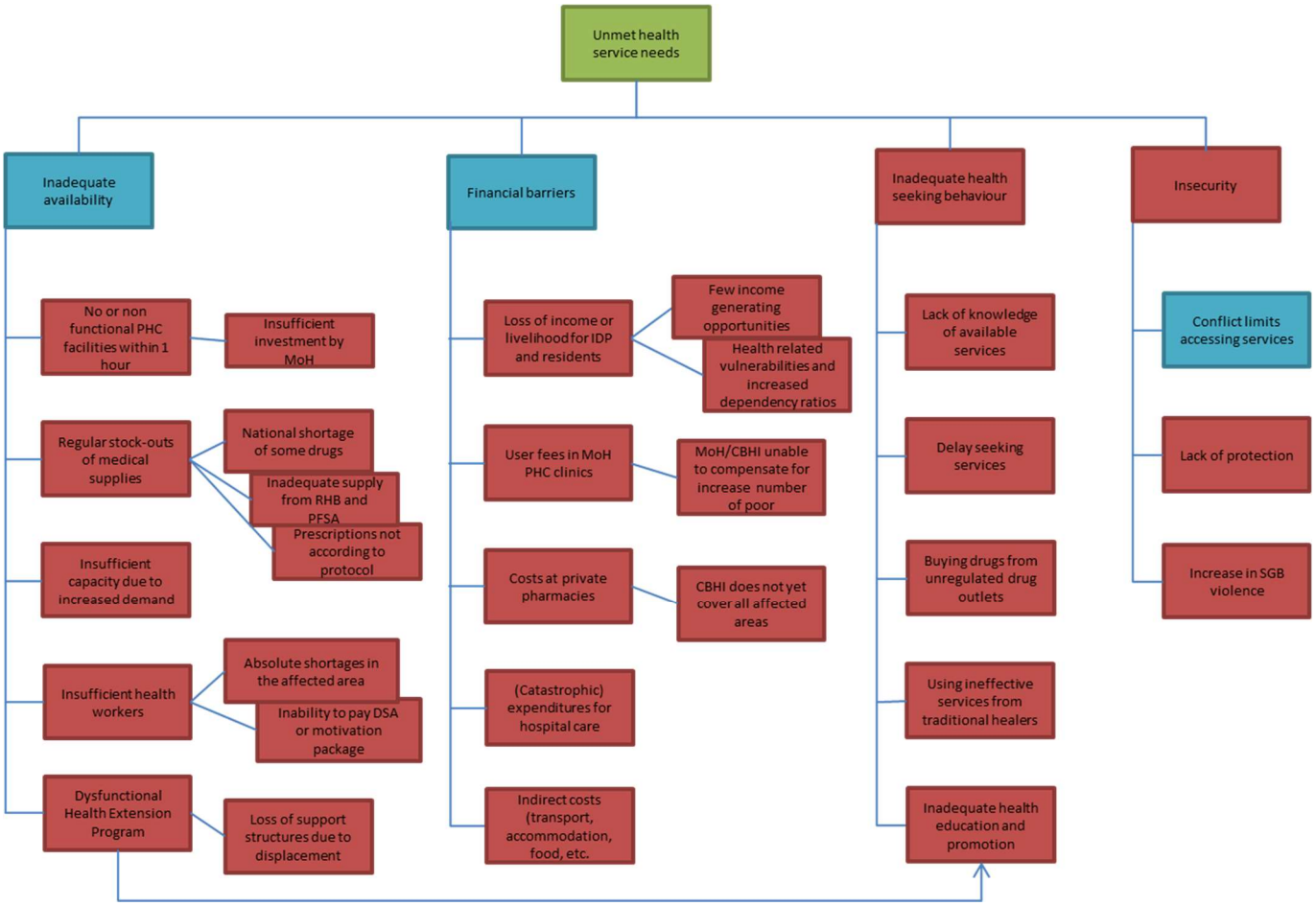


Figure 4 Health service causal pathways [the workshop participants did not complete the process of mapping of underlying causes for specific groups or localities]

Definition of health assistance objectives

In this section participants defined their sector objectives based on the needs and their underlying causes. The following three objectives are drawn from the 2018 Humanitarian Disaster Resilience Plan:

- Access to integrated Primary Health Care (including reproductive health) for 2.6 million drought and conflict affected population (including IDPs), promoting complementarity relationship with the nutrition, WASH, food and protection sectors to save lives and reduce morbidity.
- Protect around 6 million people at risk from communicable diseases outbreaks (focus on AWD) through effective early warning, flexible rapid response mechanisms, and timely access to appropriate case management to support FMOH and RHBs.
- Strengthen coordination and incident command mechanisms at all levels (Federal to *woredas*) including preparedness and surge delivery capacity for natural and manmade disasters.

During the workshop the sector experts developed more specific objectives in support of the first objective on access to Primary Health Care:

- Increase access to a package of essential quality primary healthcare services (preventive, promotive, curative and rehabilitative) at community, primary and secondary care levels without suffering financial hardship for the most vulnerable populations in Babile, Tuliguled (mostly resident) and Kebribeyah (mostly female-headed households) over the next 12 months. An essential service includes consultation, diagnosis, prescription, and health education delivered by a qualified health worker, and then obtaining quality medicines as per the prescription.
- Ensure that health commodities that support prevention and promotion are readily, safely, available to IDP and vulnerable host populations (based on the criteria above) without financial hardship.
    - This includes reproductive, sanitary, and baby kits, condoms, bed nets, water chlorination, soap, clean fuel, nutritional supplements and divers diet, etc.

Comparative analysis of health response options with a focus on suitability

The BNA provides information on how beneficiaries usually meet their health commodity and health service needs and how long this takes (see the tables below in Annex 2, table 18). For healthcare services government is the largest provider across all woredas although sector experts added that this is complemented by a network of private providers and pharmacies. In Kebribeyah a large proportion of the population buys healthcare services from private providers (42%), which sector experts interpreted as an indication of the regular stock-outs at MoH facilities and/or levels of self- medication, while in Babile after the government (which provides needs to 53% of people), NGOs provide most of the remaining healthcare (34%) and private healthcare providers (11%). In Tuliguled government provision amounts to 75%, while private healthcare providers meet the majority of the remainder (22%), leaving only 2% to be covered by NGOs. These statistics indicate that people are mostly reliant on public healthcare providers. During the ROAP workshop experts noted that most humanitarian health organisations provide support to MoH health facilities, rather than running their own clinics (except for in underserved areas, where for example NGOs run mobile health and nutrition teams) so community members may believe the assistance is provided uniquely via the government.

The BNA also provides information on beneficiaries' preferred assistance modalities: for both health commodity and service needs cash is the preferred assistance and in-kind the second preference across all woredas. However, ROAP participants felt it was important to note that given the specific characteristics of the health sector, the fact that health needs and related costs for treatment are not average, and that there is a need to assure the quality of services and medication, giving unrestricted average amounts of cash to households is not the the most appropriate, effective and/or efficient way to address household health expenditures. As indicated above, the desired response option (from the perspective of the health sector professionals) is through provider payment mechanisms, i.e. contracting of health service providers and reimbursing them for services (consultation, diagnosis and prescription for treatment, delivery of quality medication and medical supplies) to patients within the target population identified as in need of healthcare. Vouchers or cash transfers can complement this to cover indirect costs.

It is important to note at this stage that the health sector's prioritisations and plans are not reflected here as they cannot be as neatly reported based on the limited information available in the workshop. The nature of health and health responses means that there are a diverse and more specific range of considerations that need to be considered to build a health response. These include, but are not limited to, considerations around:

- Health expenditures are related to individual needs and linked to that individual's specific medical conditions or requirements rather than the household average which the BNA looked at. Illness is not an average occurrence for individuals or households, but rather a risk that can unpredictably happen to everyone, with some people more at risk than others.
- Sudden requirements for extreme expenditure can result from acute illnesses of catastrophic events which cannot be predicted. As such, the related extraordinary one-off health expenditures (e.g. emergency services and hospitalisation) do not lend themselves to the estimation of an average recurrent minimum expenditure basket.
- The quality of services and medical supplies is critical to users' health and survival but this cannot be readily controlled on the open market.
- The total average indirect plus direct household health expenditures can and should be reflected in the MEB calculations. However, this amount, even when there are providers that deliver services or medicines for a cost, cannot be translated in an equivalent amount of unrestricted cash in an MPG. This is because many health needs are not monetizable. See the diagram below for further explanation.

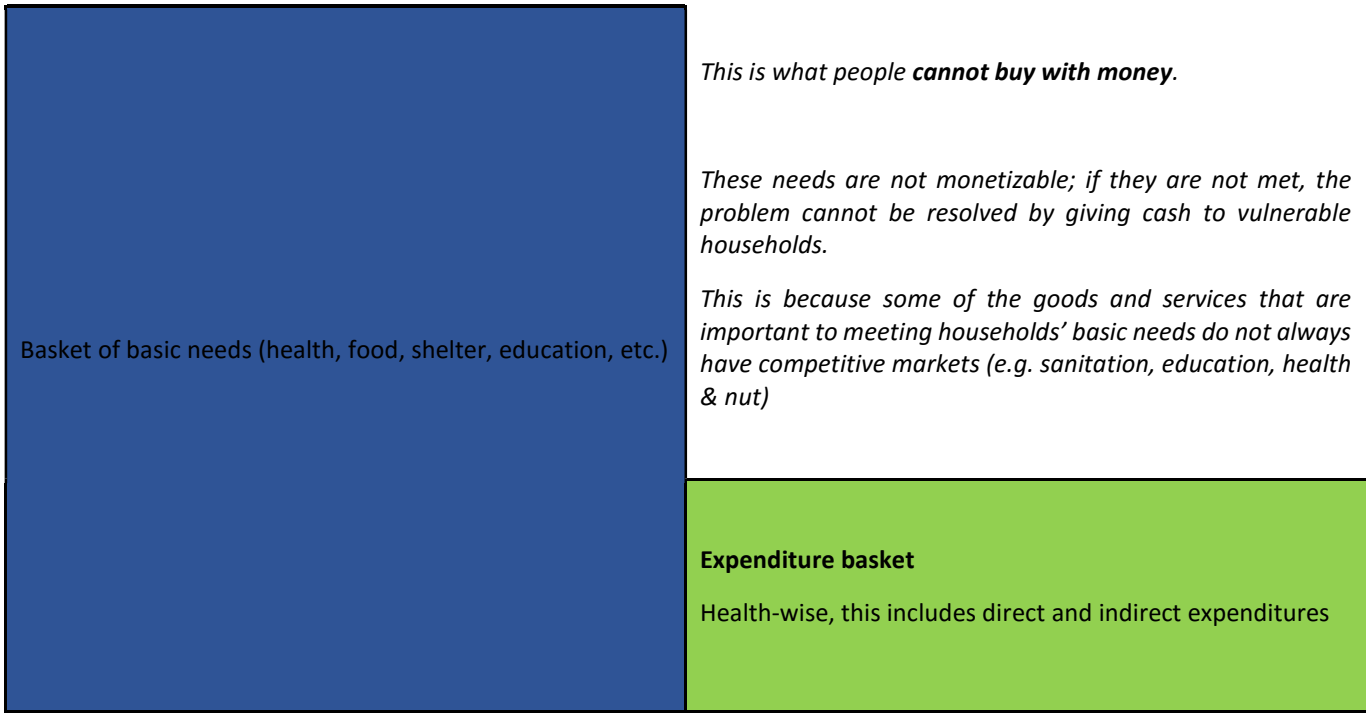


Figure 5 Not all health needs can be addressed with money

Taking these caveats into account, and not having more detailed information from additional health sector assessments, it is possible to develop some health-based scenario planning to address the underlying causes that lead to unmet health needs as in the diagram above. However, these are response options are highly context specific and during the ROAP sufficient contextual information was not available. Possible scenarios include:

- If a full range of health services are available and accessible to the affected population, and there is a functional community-based health insurance scheme (CBHI), then a possible health response would be to cover the insurance premiums for all severely affected people that are unable to pay themselves (using the same criteria as set by the CBHI).
- If a full range of health services are available and accessible but there is no functioning CBHI scheme, where the MoH implements the Indigent Health Fee Waiver programme (which provides the poorest free access to health services), then a viable response would be to reimburse the healthcare costs, covering the increased proportion of indigents for which the MOH is unable to do so.

For primary care services specifically, scenarios include:

- If no primary care services are available within a reasonable distance of the target population then direct service provision can be provided through mobile health and nutrition teams. Alternatively, if primary health care facilities have fallen out of use they can be made PHCU functional again.

- If primary health care facilities are available but of inadequate capacity due to increased demand then there is the option of hiring extra staff or repurposing existing staff to increase service delivery capacity in existing centres.
- If public health facilities face stockouts then a range of options would be possible depending the reason for this issue. These could include: contracts with private pharmacies to reimburse costs of medicines for prescribed drugs to referred patients; supplying drugs directly to the public health facilities; improving the rational use of antibiotics; improving stock management and forecasting of needs for supplies.

For secondary care (assuming they are available and able to address increased needs):L

- When user fees are charged then secondary service providers could be contracted for referred cases and user fees waived and other direct costs reimbursed.
- When there are stockouts of medicines and/or medical supplies then a contract could be established to reimburse cost of drugs/supplies from selected private pharmacies.
- When in addition to the above there are considerable indirect costs for food, transport, accommodation cash, vouchers, or in-kind support can be given directly to patients and/or their caretakers/

For community-based services (e.g. the Health Extension Programme or the Health or Health Development Army (HEP/HAD)):

- If available but inadequate or disrupted then should aim to revitalize and strengthen HEP/HAD through training, supplies, supervision, etc.
- When needs increase active prevention measures should be taken. For example, active screening and referral for malnutrition; health promotion for preventive programs; integrated community case management of selected diseases; and referral for morbidity and alerts for epidemic diseases.

Other:

- If services are available and accessible, then incentives or soft conditions / nudging can be used to support utilisation of services.
- Cash or vouchers could also be used to enable patients to put into practice health promotion advise given through other arms of the programme. For example, for buying products for a diverse diet when children are at risk becoming malnourished
- MPGs (covering other sectoral needs) could be complemented with a cash top-up targeted to households with health vulnerabilities (such as pregnant and lactating women or people with HIV/AIDS, non-communicable diseases, or chronic mental health), to compensate relatively higher dependency ratios and lower income generating opportunities

Overall comparative analysis of the health response options

In this step workshop participants reviewed the possible response options and weighed them against each other, considering their possible advantages and disadvantages for all criteria relating to programmatic aims and approaches.

To select the best response options health experts, need to know which interventions are relevant and appropriate in a specific area, based on the more detailed health sector assessment, so they can decide on a mix of the options outlined above. This could not be done during the workshop due to a lack of detailed data for the Fafan area. The proposed response options above are mostly complementary and not a matter of one or the other, as no proposed response by itself can fully address the underlying problem(s). Sector experts did however believe that going through the criteria was a useful exercise though, to start considering operational consequences and feasibility, and mechanisms for accountability.

The Humanitarian Development Nexus: The New Way of Working in practise

Furthermore, it was identified that most of the underlying causes of the unmet health needs were related to longer term underdevelopment of the affected areas, and geographic inequities that are aggravated by the drought and crisis. The current Health Sector Transformation Plan (HSTP) 2015/16-2019/20, described how the Federal MoH aims to address these inequities, and related challenges such as ensuring financial protection for those accessing health services. Further discussion and analysis is required to see how the emergency response interventions considered above and below (in Annex 2, Table 20 – 24) can be done in a way that supports planned or ongoing health system strengthening approaches as outlined in the HSTP. Furthermore,

based on the problem analysis, ROAP health participants formulated a number of questions that should now be discussed in the health development partner coordination platform (HPN), to see how they can prioritise the affected areas in an operational manner alongside the humanitarian interventions, so that they mutually reinforce each other.

This will make significant contribution to strengthening the resilience of the health system and communities for the current and future crisis, and make progress jointly toward achieving universal health coverage, including preparedness for epidemics and other public health risks.

Setting the transfer value for health needs

As indicated above, the average household health expenditure as would be calculated with an MEB cannot be used to translate in an average transfer amount of unrestricted cash to all households, as health needs are mostly unpredictable, expenditures are not average and health services and medicines should only be obtained from providers that meet minimum quality standards. CTP to purchase health services should in principle be targeted to patients when they need to use a priority service, the amount of the transfer should cover the direct and indirect costs of the health service (consultation, diagnostics and medicines), and only be obtained from pre-selected providers that meet minimum standards for effectiveness and quality.

Health prevention and promotion interventions such as antenatal and postnatal care, immunisation and growth monitoring, and other public health functions such as preparedness and response to epidemics, cannot be assured through demand side financing and should always be provided for free. Nonetheless, there may be indirect and/or opportunity costs related to such programs, for which a cash transfer could be useful to improve utilisation and follow up to health promotion instructions (such as transport, obtaining a diverse diet for malnourished children, or sleeping under a bed net).

However, work was done to define the most common health interventions that have associated costs for patients, which can be used as starting point to determine costs and the timing of the transfer. See Annex 2, table 19.

Recommended health response options for Fafan zone

[The Health participants did not complete the ROAP process. To conclusively determine responses more context information would be required.]

Despite limitations on information, based on the analysis above, the likely key interventions for meeting health needs include:

- Mobile health and nutrition teams in underserved areas
- Contracts with the MoH and/or the health insurance agency for reimbursing them for the additional number of people who became unable to pay the user fees or insurance premium due to the crisis (IDP and vulnerable households in resident/host population).
- Support MoH primary care level health facilities with medical supplies and medicines, based on an agreed list of essential life-saving medicines and supported by technical assistance for stock management and improved prescription practices in accordance to national treatment protocols.
- Vouchers and contracting with selected private pharmacies to reimburse costs for medication and medical supplies for patients referred to hospital, and for whom there are no medicines at the MoH facility
- Strengthening of the health extension programme, and support to the health development army, with a focus on community based screening, case management and referral, health promotion interventions, and community based surveillance.
- Support to the early warning systems for epidemics.

Single sector report: Emergency Shelter & Non-food Items

Profiling of the population with severe ES/NFI needs

The first step in the response analysis process is the profiling of the target beneficiary groups. The BNA asked people to assess the severity of their own shelter commodity and NFI needs and the percentages and consequent absolute numbers of those most severely deprived of shelter and NFI goods are shown in Annex 2, Tables 26 – 28. They have been estimated by multiplying the prevalence of households with severe needs[13] by the total population of interest in each woreda[14] and the prevalence of female or male headed household in Ethiopia.[15]

Across the four woredas, according to the estimates in the BNA, there are a total of approximately: 5,069 IDP households and 46,335 resident households who are severely deprived of shelter structures; 4,826 IDP and 46,565 resident households that are severely deprived of shelter commodities; and 4,165 IDP and 36,198 resident households that are severely deprived of household items.

Tuliguled is the woreda with the highest percentages and highest absolute numbers of IDP and resident people deprived of all ES/NFI needs. Female-headed households are more severely affected than male-headed households in almost all woredas and across all needs. Hareshen is the woreda with the lowest number of severely shelter structure deprived residents and amongst if not the actual lowest number of IDPs with ES/NFI needs.

On the basis of this information and the ES/NFI cluster's existing prioritisation categories, workshop participants selected the following targeting criteria.

Geographic location

Babile and Tuliguled were selected as the target areas. This was because: there are IDP settlements situated within the woredas; IDPs in these woredas have the highest percentage of severe needs and when combined with population numbers this leads to the largest absolute numbers of those in severe need; and Babile and Tuliguled have the highest proportion of people with special needs. Babile is also prioritised by the shelter cluster more broadly, although Tuliguled is not.

Harshen is not included as IDPs in this woreda are living in formal settlements and it is assumed that local authorities will take care about them, so they should have more access to services.

Population groups

IDPs are the ES/NFI cluster's focus group (for all ES/NFI responses) and so residents are not considered for assistance. Within the IDP population groups with special needs would be selected based on the standard vulnerability criteria used by the ES/NFI cluster. This includes female-headed household, child-headed household, household with more than 5 under-5s, and recently displaced households.

This identification process would follow these steps: geographical mapping of needs in liaison with government, community is informed how much assistance is available; local authorities select the households to receive assistance based on the criteria list; NGOs / assistance would then verify this selection.

Target group numbers

To determine the number of households and individuals severely in need of shelter and NFI needs workshop participants used the percentage of IDPs in Babile who report being severely deprived of shelter structure needs (27% of female-headed households and 44% of male-headed households) and the percentage of IDPs in Tuliguled who report being severely deprived of shelter commodity needs (42% of female-headed households and 54% of male-headed households). These different need groups were selected as they represent the highest proportion of IDPs in severe need (from amongst the various shelter deprivations) and therefore likely include all those in need of other shelter related goods and support.

This amounts to a target group of 3,856 household (all severely shelter structure deprived IDP households) in Babile and 1,051 household (all severely shelter commodity deprived IDP households) in Tuliguled – a total of 4,907 households. When broken down by individuals (using the average household sizes reported in the BNA) this amounts to 34,328 individuals (the 26,406 individuals in Babile and the 7,922 individuals in Tuliguled).

[13] Source: BNA report, 2018.
[14] DTM round VII for IDP, and 2017 census for resident population.
[15] Source: the WB, 2016.

Protection concerns for the target groups

The ES/NFI experts noted that when targeting and delivering assistance the following issues should be considered:

- Crowded living environments increase exposure to contagious diseases
- Men and women sharing toilets, with no lights during night, can expose women to violence
- Women are exposed to violence whilst going to collect wood for shelter construction
- People with disabilities need more attention and a targeted response to make sure they have the same opportunities as the other groups

What else is important to note about these groups?

Land is not necessarily a concern in humanitarian contexts as the government provides land for IDPs to temporarily settle. However, in longer-term development access to land is more of an issue. During displacement clan members tend to gravitate to areas where other members of their clan are located and whilst they may settle in other areas, being near their clans is likely to improve access to livelihood opportunities. However, drought displaced IDPs who moved over a long period have more ability to choose where they settle compared to conflict displaced IDPs who had move suddenly, and sometimes organised by the government, due to sudden-onset crisis. The government provides land for drought displaced people but often places conflict-displaced in collective centres.

Causal pathways to unmet ES/NFI needs

To determine the most appropriate response option it is necessary to identify, as a bare minimum, both the first and second order causes determining the problem at stake. The BNA provides the causes of shelter structure and shelter commodity needs as identified by the beneficiaries themselves; they qualify as second-order causes. During the workshop ES/NFI experts discussed the first and third order causes of ES/NFI deprivation (in terms structures, and shelter and household commodities) to develop a fuller picture of the underlying causes of ES/NFI deprivations. This information is illustrated in the diagram below.

Further analysis could provide insights around the causes behind the reported low purchasing power. Fourth order causes may include livelihoods-related matters, such as loss of productive assets (e.g. sale of livestock for pastoralists), loss of income generating activity, unavailability of (casual) labour opportunities, etc. In turn, these may be a consequence of displacement or drought, which would be fifth order causes of shelter insecurity.

Note, the green box shows the outcome or main issue being tackled, i.e. ES/NFI deprivation; blue boxes show the top four most frequently cited causes in the BNA; and red boxes show the causes added during the workshop.

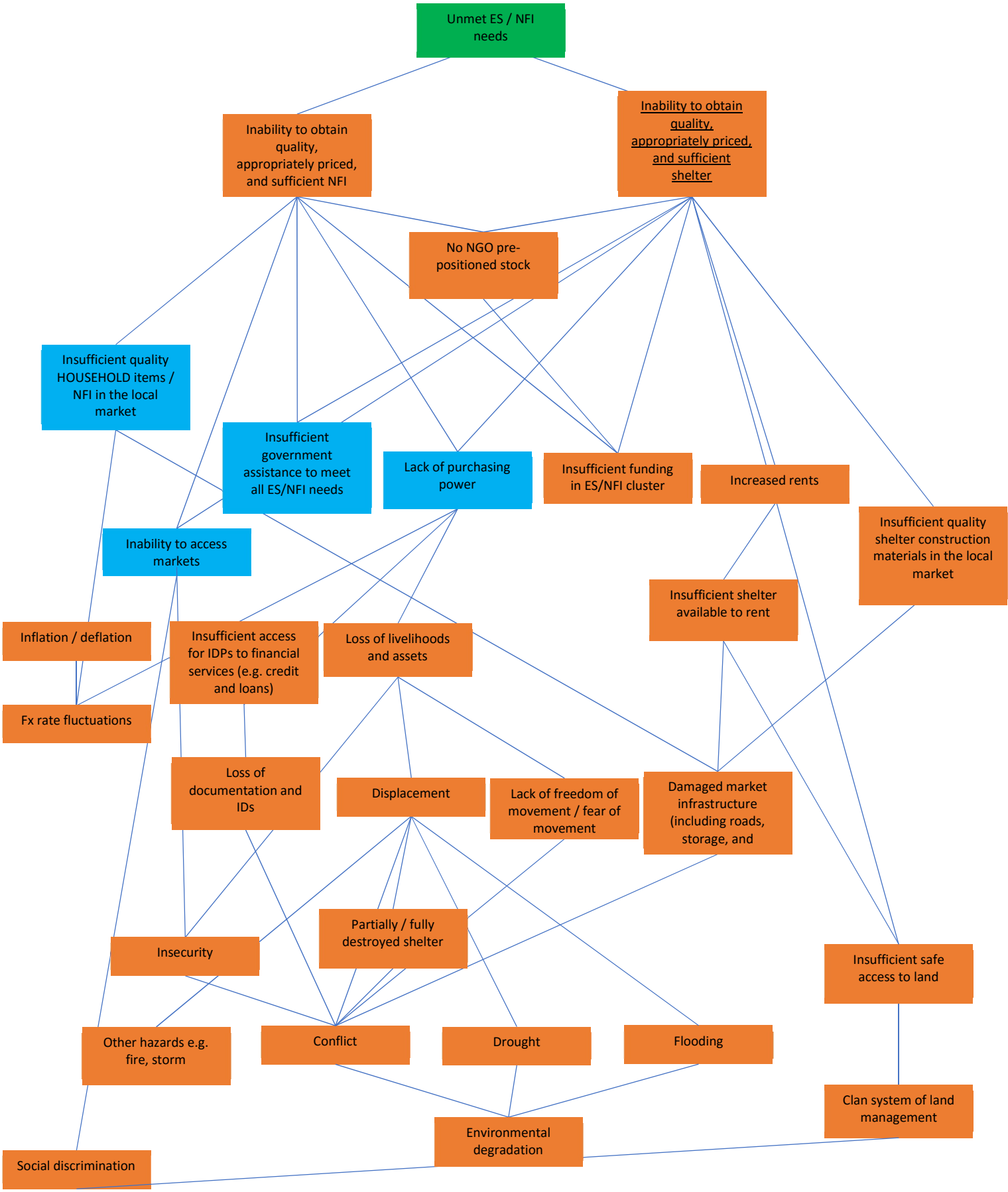


Figure 6 ES / NFI causal pathways [the workshop participants did not complete the process of mapping of underlying causes for specific groups or localities]

Definition of ES/NFI assistance objectives

In this section participants defined their sector objectives based on the needs and their underlying causes. The following three objectives are drawn from the 2018 Humanitarian Disaster Resilience Plan:

- Provide immediate life-saving assistance to displaced and affected households through different modalities
- Reinforce disaster risk mitigation, safe building practices and rehabilitation and recovery efforts for disaster affected households

During the workshop the sector experts developed their own objectives that fit within these:

- Ensure access to lifesaving NFI for 75% of the vulnerable IDPs in Babile and Tuliguled within six months from the time of displacement
- Support voluntary return and reintegration for 30% of displaced households through durable shelter solutions in Babile and Tuliguled.

Comparative analysis of ES/NFI response options with a focus on suitability

The BNA provides information on how beneficiaries usually meet their shelter structure and shelter commodity needs and how long this takes (see Annex 2, table 26). However, as data on how groups meet their needs is not disaggregated by IDPs and residents and as the latter are by far the largest group, it is not clear how IDPs specifically meet their needs. It is important to note that for IDPs the main source of shelter structure materials (e.g. tarpaulins) is NGOs.

The BNA also provides information on beneficiaries preferred assistance modalities: for both shelter structure and shelter commodity / household item needs cash is the preferred assistance and in-kind the second preference across all woredas. Although again, it should be noted that data is not disaggregated by resident and IDP responses.

In order to achieve the first objective, relating to the provision of NFI, the working session participants considered response options including a one-off unconditional cash transfer equivalent to the local costs of the NFI items, provision of services (which relates to construction of latrines and other infrastructure - although what exactly is not specified), a one-off distribution of the materials covered by the ES/NFI basket, and a combination of cash and in-kind assistance (again, the exact details were not specified). All of these options are accepted by government.

In terms of which response options would most effectively meet the objectives a cash transfer is seen as the most suitable as it is quickest, goods are readily available where there are functioning markets, and it is in line with beneficiary preferences. However, service provision (which is not directly comparable as it addresses the need for infrastructure not basic NFI items) is considered a better guarantor of quality infrastructure that protects the environment and IDPs from disease, while a combination of in-kind and cash has the advantages of being able to meet specific needs in environments where the market may not be fully functioning. For special needs groups cash empowers them to prioritise their own needs but may lead to challenge in moving to and from markets. Direct service provision can be tailored to meet special needs and there are no additional costs for beneficiaries to access the services, although the approach limits the numbers of IDPs who benefit (as it is more resource intensive).

In order to achieve the second objective, relating to the provision of durable shelter solutions, the working session participants considered response options including: a restricted commodity voucher for tools and a transitional shelter kit; restricted cash for tools and transitional shelter kit; unrestricted cash for tools and transitional shelter kits; in-kind distribution of tools and transitional shelter kits; service provision for transitional shelter materials and labour; conditional cash for transitional kits (dependent on attending training). All of these options are accepted by government.

When weighed to determine which approach would best meet needs and is the most appropriate for beneficiaries the restricted vouchers, in-kind, and service provision have the advantage of ensuring quality goods are purchased (which the unrestricted voucher or cash lacks). On the other hand, cash-based approaches allow beneficiaries greater flexibility of choice which is particularly important for those with special needs.

See Annex 2, Tables 29 - 30 for full details.

Setting the transfer value for ES/NFI needs

Since both cash transfers and vouchers response options are considered suitable to achieve ES/NFI objectives - including both those focused on meeting shelter construction and NFIs / household item needs - the costs of key ES/NFI items had to be estimated.

The first step taken by the ES/NFI group was to define the ES/NFI basket, based on the shelter and NFI requirements of IDPs in Fafan zone/Somali region. The resulting basket for objective 1 includes NFI / household items (a jerry can, cooking pots, a ladle, a kettle, drinking cups, plates, bowls, sleeping mats, blankets, mosquito nets, soap, a solar lamp, a bag, cooking fuel[16], plastic sheeting, rope) and the cost of transportation. In Annex 2, Table 28 is an overview of these costs. According to estimations made by the group, the cost of the NFI / household item basket would amount at 3,016 ETB.

A separate basket including costs related to construction materials and labour costs (to support construction) needs be developed for the second objective but there was insufficient data available to the ROAP participants to complete this during the workshop.

The following step was to estimate the expenditure gap, by subtracting the actual average ES/NFI expenditures (including shelter and household items) according to BNA findings from the previously estimated cost of the ES/NFI basket. As many shelter related costs are one-offs it is difficult to calculate the exact expenditure basket on a monthly a basis. However, some rough calculations have been made and are available in Annex 2, Table 27.

Overall comparative analysis of the ES/NFI response options

In this step workshop participants reviewed the possible response options and weighed them against each other, considering their possible advantages and disadvantages for all criteria relating to programmatic aims and approaches. In addition to the arguments around whether response options will meet the objectives (considered above) participants also weighed the impact an intervention would have on the public and private markets, the implementing agencies capacity, risks, and costs for objective 1 (the process was not completed for objective 2)

A summary of this information is in the Annex 2, Tables 29 & 30 (one table per response objective).

For objective one and cash-based interventions the success of the intervention would be limited by the availability of market suppliers providing quality items at a reasonable price. However, cash interventions have the capacity to boost the local market by increasing demand and improve relationships between IDPs and local providers (whereas service delivery and in-kind assistance do nothing to build such relationships). In a similar vein, provision of services will provide well-paid employment for skilled local labourers (including among IDPs) and in-kind assistance provides employment form transporters, labourers, and the larger wholesalers from whom implementing agencies purchase the materials. On the other side, there are also negative market consequences for all interventions although of varying degrees of severity with cash being the least troublesome. All interventions interact with the market at some level and so have the protentional to create a multiplier effect.

Implementing partners are more familiar and have greater capacity to deliver in-kind and service provision but the ES/NFI cluster have growing capacity and experience with cash-based shelter responses. The costs incurred by the implementor are higher for cash if they are not already familiar with it or don't have systems set up. However, service provision and in-kind assistance require higher levels of skilled staff and can take longer procure / sign contracts.

Recommended ES/NFI response options for Fafan zone

Based on the weighted scoring and knowledge of the working sessions participants the preferred options are

For objective one: Ensure access to lifesaving NFI for 75% of the vulnerable IDPs in Babile and Tuliguled within six months from the time of displacement

Over the next 12 months the ES/NFI sector will provide assistance to 75% of severely shelter deprived IDPs in Babile and Tuliguled. 34,328 individuals across 4,907 households will benefit from this assistance. This is 43% of total IDP households living in these areas. This assistance will help ensure access to lifesaving NFI for 75% of the severely shelter deprived IDPs in Babile

[16] Even though charcoal is widely used in some areas it provision and use is not supported by the ES/NFI cluster due to its contribution to environmental degradation.

and Tuliguled within six months from the time of displacement. This group will receive one-off unconditional cash transfer for NFI, clothing and emergency shelter within 6 months from displacement.

Note, during the ROAP workshop participants did not have time to complete the section of the process that looks at how risks would be considered and addressed. Likewise, due to above mentioned lack of information about construction costs they did not complete a forecasted budget.

For objective two: Support voluntary return and reintegration for 30% of displaced households through durable shelter solutions in Babile and Tuliguled.

Over the next 12 months the ES/NFI sector will provide assistance to 30% of severely shelter deprived IDPs in Babile and Tuliguled. 34,328 individuals across 4,907 households will benefit from this assistance. This is 43% of total IDP households living in these areas. This assistance will help them to voluntarily return and reintegrate. Average shelter deprived IDP households will receive a one-off commodity voucher to cover the costs of shelter materials and a one-off value voucher to cover the costs of shelter construction (labour) within 12 months of start of the project. IDP households with special needs will receive direct service provision (labour and materials) within 12 months of start of the project.

Note, during the ROAP workshop participants did not have time to complete the section of the process that looks at how risks would be considered and addressed. Likewise, they did not complete a forecasted budget.

Inter-cluster ROAP report

Linkages between the HDRP and the ROAP

The outputs of the ROAP process are intended as complement to the Humanitarian Disaster Resilience Plan (HDRP) which was released in March 2018. While the HDRP sets national objectives, priority geographic areas (hotspot woredas), numbers of people to be targeted, and funding requirements – working at a strategic level – the ROAP aims to define programmatic details, by selecting response options that will lead to the achievement of (some of) the objectives set out in the HDRP within the selected woredas of Fafan Zone.

Hotspot priority woredas

In Ethiopia a Hotspot prioritisation exercise led by the nutrition cluster and seeking to identify where there are fewer resources than required to meet all the needs identified in the HRDP, was completed in late 2017. Information from this can be used to support the ROAP's geographic targeting which was largely based on information from the BNA. To a certain degree, the BNA prioritisation differs from the Hotspot Woreda Classification. For example, the BNA ranked woredas by severity of needs in this order: Tuliguled, Babile, and Kebribayah with Hareshen excluded due to low levels of severe needs whereas the Hotspot Woreda Classification found Hareshen to be a first priority for nutrition needs, and the other three woredas of secondary priority. The Hotspot Classification, along with the Woreda Capacity Matrix, are used to prioritise where additional NGO support is needed to manage spikes in malnutrition treated by the Government CMAM and TSFP.[17] The Hotspot Woreda Classification is derived from expert judgment using six multi-sector indicators that are agreed upon at zonal, regional, and federal levels. The difference in methodology and sector prioritisation explains the different ranking produced by the BNA and the Hotspot Woreda Classification.

Of the sectors who participated in the ROAP process ES/NFI, food security, and WASH all use information from the HotSpot woreda prioritisation to inform their programming, although it is always complemented by other sources of information. It is only for the nutrition cluster (which did not engage in the ROAP process) that the HotSpot prioritisation list is binding. Other sectors have their own prioritisations. For example, ES/NFI largely target IDPs and conduct their own joint cluster-focused assessments; and for health the current epidemiological situation is also considered.

Most partners and donors will not restrict their focus to just those woredas classified as priority one but also consider priority two woredas (this includes all the woredas covered by the ERC Consortium). As such, the HotSpot prioritisation exercise is a useful source of data to inform the ROAP process but not a restricting one.

Inter-cluster causal analysis

During the workshop each cluster (with the support of protection experts) mapped the causal pathways that lead to unmet needs in their respective sectors, building on the causal analysis trees above. A world café exercise followed in which a sector representative presented their sector's mapping to rotating groups from the other sectors and the rotating sector actors noted where the causal factors overlapped with those of their own sectors. This exercise helped sectors identify shared underlying causes and triggered discussions around how shared challenges can lead to different outcomes for different sectors.

Participants were encouraged to consider how achieving one sectoral objective may need actors to address multiple causes, some of which may be core to other sector responses, and how the impact(s) that their sector's interventions, usually conceived of in isolation, can have on other sectors – their commonalities, complementarities, and cause-effect links across causal pathways. And to note how addressing some shared causes may serve to benefit multiple sectors.

However, it was also noted that while some causes, such as insufficient purchasing power, are common to multiple sectors, they are still just part of a larger picture of factors contributing to unmet needs which includes factors as diverse as (in order of importance according to the BNA) inadequate purchasing power, insufficient assistance, insufficient local infrastructure and facilities, lack of trade, and physical constraints to market access. And to be effective the response should be holistic and tackle these multiple causes – some of which will be unique to specific sectors. In particular, a multi-modality approach to meeting people's basic needs was suggested as the analysis of causal pathways related to the main basic needs (food, healthcare, housing, water, hygiene and sanitation) taken individually and collectively, showed that there are multiple factors at play,

[17] Ethiopia Government and Humanitarian Partners. *2018 Ethiopia Humanitarian and Disaster Resilience Plan* (Addis Ababa, 2018).

mostly related to physical and financial access as well as availability of facilities, infrastructures and services. And so multiple response options are required.

Cross-sector risks for special groups and for cash programming

During the inter-sector working session participants identified the special needs and vulnerabilities of some groups. This built on the earlier conversations around protection concerns that took place within the single-sector workshops.

The following groups were identified by the inter-sector group as being of particular concern when developing interventions: people with disabilities, victims / survivors of gender-based violence, pregnant and lactating women (of which there are a very high prevalence in the target woredas), children under 5, unaccompanied children (within the target woredas 20% of IDP households and 5% of resident households include separated minors), culturally marginalised people (which in the Somali Region includes those from minority clans), those with chronic diseases or physical disabilities, and those who don't speak the local language (the rates of which are increased as a result of displacement). The 'income poor' were also suggested as a key demographic and a broadly useful basis for targeting as lack of purchasing power is an underlying cause of so many problems regardless of sector.

In addition, it was noted that some groups face particular issues when it comes to cash transfer. While it is not always easy to identify protection risks, as social taboos can hide them, it is important to ensure that those with special vulnerabilities of needs are considered. Issues that affect these groups are varied but there are some cross-cutting issues that should be considered for all programming. The working session participants noted several practical examples of risks associated with cash transfers and how they can be mitigated, drawing on examples from within the Somali Region. From this they discussed mitigation measure that could be used in the interventions proposed as a result of the ROAP. These are outlined below *[with, it should be noted, some additional work done by the Save the Children's Cash & Markets Advisor to flesh out some of the mitigation measures, especially for the last three risks].*

- **Risk:** Unintended exclusion of households who meet the targeting criteria, due to difficulty in identifying them or making them aware of the opportunity to receive the assistance. **Mitigation measures**: (1) Map the presence of IDPs or resident households belonging to minority linguistic group or clan, in all targeted locations; (2) Boost community outreach ahead of the kick-off of the targeting process, with dedicated community outreach staff hired for the required period of time; outreach staff should be representative of minorities present in the area/be part of their communities; the team composition should be gender balanced; (3) With the community outreach staff, launch an information campaign to inform the population about the forthcoming programme, incorporating participatory processes when feasible (e.g. developing aspects of the targeting methodology with community groups); (4) Set-up a feedback and appeal mechanism that is accessible to the most vulnerable groups, e.g. those with disabilities.
- **Risk**: Safety and security concerns for IDPs residing in secluded areas or at risk of violence. **Mitigation measure**: Organising in-kind/cash/vouchers distributions to IDPs in or near the sites where they live.
- **Risk**: Lack of transportation, and/or high costs related to accessing markets for households living in remote areas. **Mitigation measure**: Top up the transfer with estimated amount of transportation costs. To simplify the administration of the assistance, the top-up could be done on a blanket basis (to all), as opposed to targeting only those who live in remote locations.
- **Risks**: Non-cost related challenges in accessing markets or sites where assistance is delivered (e.g. due to old age, disability, risk of GBV, other). **Mitigation measure**: An alternate person can be registered to actually receive the aid on behalf of the intended recipient, with a sort of "power of attorney arrangement" that must be formalised at enrolment stage between the aid agency, the intended beneficiary, and the alternate. This needs to be monitored to ensure that the benefits accrue to intended individuals.
- **Risk**: Limited ability to access cash when not delivered in hand through physical cash distribution, especially in the face of old age, low literacy levels or basic awareness of relevant technologies (such as mobile phones), unavailability of mobile phone within the household. **Mitigation measure**: same as previous. In addition, deliver training to both beneficiaries and agents before and during disbursements and provide customer assistance. The training would focus on the basics of mobile money and how to use the mobile money menu; may also need to explore providing either phones or SIM cards to beneficiaries (according to the FSP assessment Ethio Telecom is theoretically a willing partner).
- **Risk**: cash transfers may generate intra-household conflicts between husbands and wives / male and female adults, over the use of the money. Women may not be part of the spending decisions. It is assumed that cash transfers are more prone to this kind of risk, since husbands may not be comfortable in asking their wives to sell the in-kind assistance they personally received. **Mitigation measure**: conduct a participatory gender analysis to inform cash

transfers, as well as the other interventions. The assessment will look at acceptance of cash by adult men and women within targeted households, and at who controls cash within a household from both men and women's perspectives. It is important to bear in mind that answers to sensitive questions may not be accurate, and that specific questioning techniques will have to be applied. In some programmes cash transfers can accrue to specific individuals rather than the entire household.

- **Risk**: Environmental issues related to cash, as households may spend the money in purchasing non-environmental friendly commodities (e.g. charcoal, plastic bottles, nappies). **Mitigation measure**: include related awareness raising messages in the enrolment information package.
- **Risk**: Lack of identity documents (ID) which may be required for transfers via bank accounts as well as for certain in-kind transfers or service delivery. **Mitigation measures**: Work with local authorities to provide temporary IDs for targeted household heads that they can use to collect aid. For cash transfers specifically, and wherever feasible, recommend using Somali Micro-Finance Institute's (SMFI) alternate form of ID for those who don't have official ID.
- **Risk**: Since SMFI and HelloCash are, respectively, the only MFI and mobile money platforms operating in the region, the lack of competition may impact service delivery and agent penetration in the target area. In particular, the FSP assessment found issues with customer service including PIN resets and SIM replacement, which require a trip to Jijiga. **Mitigation measures**: (1) specific service level conditions must be set out in the contract with SMFI, including guarantee that agents will be set in each of the targeted kebeles, with a maximum number of recipients to be catered for by each agent; (2) feedback and grievance mechanism (through hotline) to assist beneficiaries when they lose/forget PIN, mobile phone/SIM card.
- **Risk**: Liquidity issue observed with HelloCash agents. **Mitigation measure**: this should be tackled in the service level agreement and by giving sufficient lead time to SMFI with regard to the transfers schedule.
- **Risk**: lack of protocols governing information security and customer privacy with SMFI. **Mitigation measure**: TBD.

Some of the above-mentioned risk mitigation measures will have an associated cost (e.g. additional community outreach staff; assessments; trainings; feedback, grievance and response mechanism). All costs arising from them have been accounted for in the project budget. And it was noted by workshop participants that while plans for mitigation are sometimes discussed and planned for at the design phase they are not always implemented in fact due to either a lack of awareness around their importance or budget limitations.

Integrating sector plans, forging synergies

Following on from the session on interlinked causal pathways participants mapped their chosen response options based on the target location and beneficiary group. This exercise resulted in the table below which helped participants think about where their sector's intended interventions would overlap and where potential synergies could be identified. It was noted that it is the aggregate effect of all the interventions that is important to beneficiaries and that overarching aim of an inter-sector project would be to address the basic needs of drought and conflict-affected resident and displaced people in Kebrybayah, Babile, and Tuliguled during a period of 12 months, ultimately with a view to protecting them from using negative coping strategies.

Participants identified a number of areas where collaborative cash transfer programming could result in efficiency gains. For example, the Food and WASH sectors noted that if they provided a joint monthly cash transfer that covered the costs of both the basic food basket and recurrent WASH needs (e.g. small hygiene kit items) to their overlapping beneficiaries then this could reduce administrative and logistic costs for both the implementing organisations and the beneficiaries.

In addition, there are other areas where due to the currently separate nature of sector interventions but overlapping needs there are redundancies in the goods beneficiaries receive. For example, standard NFI and WASH hygiene kits both contain soap, meaning that beneficiaries receiving items from both sectors may have excess soap. If a joint intervention was conducted then the sectors would need to determine: which sectors were providing overlapping goods, such as soap; in what quantity and quality they were to be provided and how frequently; and, if conducting and cash-based intervention, how much would need to be transferred to cover the cost of these goods. There is a great potential here for developing mutually supporting interventions, or at the very least, avoiding waste.

	IDPs (average household)	**IDPs with special needs**	**Residents (average household)**	**Residents with special needs**
Babile	Food: Monthly unconditional cash transfer to income-poor to cover cost of the diet for 9 months Shelter: One-off unconditional cash transfer for NFI, clothing and emergency shelter within 6 months from displacement Shelter: One-off commodity voucher to cover the costs of shelter materials and one-off value voucher to cover the costs of shelter construction (labour) within 12 months of start of the project WASH: Quarterly unconditional cash transfer for hygiene and	Food: Monthly unconditional cash transfer to income-poor to cover cost of the diet for 9 months Food: In-kind CSB to PLW and children <5 diagnosed with MAM until no longer MAM Shelter: Direct service provision to improve longer-term shelter solutions (labour + materials)	Food: Monthly unconditional cash transfer to income-poor to cover cost of the diet for 9 months WASH: Direct service to provide community latrines and handwashing facilities	Food: Monthly unconditional cash transfer to income-poor to cover cost of the diet for 9 months Food: In-kind CSB to PLW and children <5 diagnosed with MAM until no longer MAM

	dignity kit items (to vary by quarter) + hygiene promotion WASH: Direct service to provide community latrines and handwashing facilities			
Tuliguled	Food: Monthly unconditional cash transfer to income-poor to cover cost of the diet for 9 months Shelter: One-off unconditional cash transfer for NFI, clothing and emergency shelter within 6 months from displacement Shelter: One-off commodity voucher to cover the costs of shelter materials and one-off value voucher to cover the costs of shelter construction (labour) within 12 months of start of the project WASH: Quarterly unconditional cash transfer for hygiene and dignity kit items (to vary by quarter) + hygiene promotion WASH: Direct service to provide community latrines and handwashing facilities	Food: Monthly unconditional cash transfer to income-poor to cover cost of the diet for 9 months Food: In-kind CSB to PLW and children <5 diagnosed with MAM until no longer MAM Shelter: Direct service provision to improve longer-term shelter solutions (labour + materials) WASH: Quarterly unconditional cash transfer for hygiene and dignity kit items (to vary by quarter) + hygiene promotion	Food: Monthly unconditional cash transfer to income-poor to cover cost of the diet for 9 months WASH: Quarterly unconditional cash transfer for hygiene and dignity kit items (to vary by quarter) + hygiene promotion WASH: Direct service to provide community latrines and handwashing facilities	Food: Monthly unconditional cash transfer to income-poor to cover cost of the diet for 9 months Food: In-kind CSB to PLW and children <5 diagnosed with MAM until no longer MAM WASH: Quarterly unconditional cash transfer for hygiene and dignity kit items (to vary by quarter) + hygiene promotion

Kabribayah	Food: Monthly unconditional cash transfer to income-poor to cover cost of the diet for 9 months WASH: Monthly commodity voucher equivalent to the cost of 5 litres of safe water per person per day during rainy season WASH: Quarterly unconditional cash transfer for hygiene and dignity kit items (to vary by quarter) + hygiene promotion WASH: Direct service to provide community latrines and handwashing facilities	Food: Monthly unconditional cash transfer to income-poor to cover cost of the diet for 9 months Food: In-kind CSB to PLW and children <5 diagnosed with MAM until no longer MAM WASH: Quarterly unconditional cash transfer for hygiene and dignity kit items (to vary by quarter) + hygiene promotion	Food: Monthly unconditional cash transfer to income-poor to cover cost of the diet for 9 months WASH: Monthly commodity voucher equivalent to the cost of 5 litres of safe water per person per day during rainy season WASH: Quarterly unconditional cash transfer for hygiene and dignity kit items (to vary by quarter) + hygiene promotion WASH: Direct service to provide community latrines and handwashing facilities	Food: Monthly unconditional cash transfer to income-poor to cover cost of the diet for 9 months Food: In-kind CSB to PLW and children <5 diagnosed with MAM until no longer MAM WASH: Quarterly unconditional cash transfer for hygiene and dignity kit items (to vary by quarter) + hygiene promotion

As can be seen from the above, workshop participants agreed to target both IDP and resident households. These will be selected on the basis of the most severely in need, based on a categorical targeting approach that will prioritise households matching the criteria in the matrix below. The estimated number of IDP households to be targeted is 6,500, and the estimated number of resident households is 20,000.

The targeting approach will be categorical, with a three-stage identification approach that mixes community- or IDP-site based long-listing, a short-listing based on matching criteria, and a household-level verification to be completed by community outreach staff hired by the project for the first quarter.

Targeting criteria (1st priority)	**FOOD**	**WASH**	**HEALTH**	**SHELTER**
Babile Female-headed IDP HH	X	X	X	X
Babile Male-headed IDP HH	X	X	X	X
Babile Female-headed resident HH	X	X		
Babile Male-headed resident HH	X			
Tuliguled Female-headed IDP households	X	X	X	X
Tuliguled Male-headed IDP HH	X	X	X	X
Tuliguled Female-headed resident HH	X	X	X	
Tuliguled Male-headed resident HH	X		X	
Kebribayah Female-headed IDP households	X	X	X	
Kebribayah Male-headed IDP HH	X	X		
Kebribayah Female-headed resident HH	X	X	X	
Kebribayah Male-headed resident HH	X			
High-dependency ratio	X			
Child-headed households				X
Households with PLW	X		X	
HH with children with MAM (In-kind distribution of Corn Soya Blend (CSB))	X		X	
Households with children <5 (prioritising HH with the highest number)	X			
Households with disabilities & chronic diseases			X	
Income poor, expenditure as proxy and/or those granted a waiver in the community-based insurance scheme	X	X	X	
All households requiring referral to secondary healthcare			X	

Estimation of the value of an MPG and of other transfers

The inter-sector group worked to estimate the costs of all the cash transfers across sectors. Below is an estimate but there will be alterations based on sectors finalising costs; if beneficiaries turn out to have more or less existing resources than the BNA showed; if sectors decide to work together and therefore remove items that are duplicate; and if the actual costs in the region at the time of the transfer have substantially changed. In fact, it was suggested by some that each quarter 10% should be added to the estimation of the costs to account for inflation.

Estimated transfer values required to meet specified objectives for each sector:

- Monthly distribution of multipurpose grant for 9 months to IDP households in Babile, Tuliguled, and Kebribayah, for an amount equivalent to 3,153 ETB.
- Monthly distribution of multipurpose grant for 9 months to resident households, for an amount equivalent to 1,843 ETB.
- One-off unconditional cash transfer of the value of 5,700 ETB for NFI, clothing and emergency shelter to IDPs within 6 months from displacement.
- One-off commodity voucher of the amount of 8,200 ETB to cover the costs of shelter materials and one-off value voucher of 1,600 ETB to hire labour for shelter construction to IDP households in Babile and Tuliguled.
- Direct service provision to improve longer-term shelter solutions, including labour and materials, to female-headed IDP household, child-headed IDP household, IDP households headed by mentally or physically disabled person, IDP household with more than 5 under-5s; this assistance will be provided in Babile and Tuliguled.
- Monthly water (commodity) voucher equivalent to the cost of 5 litres of safe water per person per day during rainy season. Targeted households in Kebribayah only, and during dry season, will receive a voucher of 525 ETB for water.

- Unconditional cash transfers to cover the costs of hygiene and dignity items will be made at quarterly intervals with amounts varying to meet the needs of repeat and one-off costs. This will include a quarterly transfer of 346 ETC, topped up every six months by an additional 236 ETB, which is further complemented with an annual transfer of an additional 340 ETB. However, it should be noted that standard kits are not appropriate for people with special needs so individual case management will be required in addition to this.

In addition to cash transfers the following items and services were proposed and therefore their cost needs to be considered in project budgeting:

- In-kind CSB to IDP and resident households with pregnant and lactating women (PLW) and children <5 diagnosed with MAM until no longer MAM
- Direct services to provide community latrines and handwashing facilities.
- The health package still needs to be defined. Costings for health are not easily done and including an amount earmarked for health needs in the MEB requires an averaging of household costs, which is not practicable for health needs that vary significantly and unpredictably between households.

In light of the importance of harmonising cash transfers across all humanitarian actors, any project emerging from the ROAP workshop will need to coordinate with the multi-agency Task Force established within the Ethiopia Cash Working Group in early 2018 to estimate national and regional Minimum Expenditure Baskets (MEB) based on a shared agreement of what is covered by each sectors core minimum expenditure basket and how much these goods cost. The transfer amounts will be established accordingly, depending on the expenditure gap existing between the MEB and the average households' actual

As of April 2018 the CWG has followed this process: discussions started in earnest in Jan 2018 with mapping of cash transfer programmes and understanding what different clusters were implementing including what values they were using; there was an agreement about what the MEB should respond to (i.e. the objective was set as meeting people's emergency needs and, separately, their food needs); the proposed approach was presented to the Inter Cluster Working Group and sector representative were asked to provide the required information for their respective sectors; in March the food basket value was developed while the other sectors' baskets are still under negotiation. Ultimately, the MEB is intended to be a live document and the CWG are currently discussing how this can be done and what roles organisations will take in this process. . Because the Task Force's food MEB (1,500 ETB) is higher than that given by the PSNP (1,000 ETB), consensus with the government has not been found yet.

Considerations for an inter-sector and / or cash-based response package

Throughout the inter-sector workshop participants raised issues relating to inter-sector responses and cash-based responses. These do not fit neatly within the structure of the ROAP process, but the most pertinent issues are noted here for reference and as a record of how participants are conceiving of and approaching the topics:

- Collaborative programming raises issues of how data is collected, stored, and shared. In particular, participants began to discuss how registration and post-distribution monitoring (PDM) data should be accessed and used. This is a highly political discussion and although there is currently no law on data in Ethiopia it still needs to be carefully managed to protect members target groups and avoid conflict. IOM stated that it is planning to conduct a pilot IDP registration and learnings form this will be available afterwards.
- On a related note, if a shared beneficiary platform is used the targeting criteria used for transfers needs to be the same across organisations. Then once a common registry for beneficiaries is developed then it will be possible to do more nuanced targeting.
- Cash transfer programming raises the possibility of creating and / or exacerbating unequal intra-household relationships i.e. there is a fear that men will take control of the cash and use it for purposes other than intended by the humanitarian actors. Although it was recognised that this is an issue for many types of assistance participants felt that it is more pressing for cash transfers as with in-kind assistance men may be too proud to tell their wives to sell unwanted items whereas it was believed that they would have fewer qualms in taking a cash transfer. In order to address these issues it was recommended that a thorough gender analysis is conducted before and during cash transfer programming.
- In order to ensure that cash programming (and all other types of programming) improves over time and is responsive to the needs and challenges of its beneficiaries all programmes should have an in-built grievance and response mechanism. This should be done in a contextually appropriate manner.

Next steps

Following the ROAP workshops Save the Children's Cash & Markets Advisor used the outputs from the ROAP workshops to develop a concept note for a project.

On the 27th of April a core group of the most active members of the ROAP process met with donors to informally discuss implementing a project based on the outputs of the ROAP workshop. Members of this group, which represented all sectors involved in the ROAP process and a range of NGO and UN actors, will now take the process forward and refine a proposal that will hopefully then be implemented. Lessons from this process can then be used to refine the ROAP for future use.

Annex 1: workshop agendas and participant lists

All workshops (single- and inter-sector) were facilitated by Francesca Battistin Project Manager for the Consortium and Cash & Markets Advisor at Save the Children UK. Hannah Hames Consortium Coordinator provided support at all workshops.

Food Security ROAP workshop

Date: 19th March 2018

Participants list

Name	Title	Organisation	Email
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WASH ROAP workshop

Date: 21st March 2018

Agenda

Time	Session title
09:00 – 09:30	Introductions and agenda
09:30 – 09:50	Presentation of key BNA findings (refresher)
09:50 – 10:40	ROAP step: Profiling of the groups most in need for WASH assistance
10:40 – 10:50	Coffee break (short, as we have early lunch)
10:50 – 11:30	ROAP step: Causal analysis
11:30 – 12:15	ROAP step: Setting programmatic WASH objectives for Fafan in line with HDRP WASH objectives
12:15 – 13:15	Lunch break
13:15 – 14:30	ROAP step: Identification and comparison of response options based on causal analysis for each objective (excluding those not allowed by authorities)
14:30 – 15:00	ROAP step: Setting the cash transfer amount (if cash)
15:15 – 15:30	Coffee break
15:30 – 17:00	ROAP step: Selection of most operationally feasible and appropriate response options

Participants list

Name	Title	Organisation	Email

Boris Aristin	Emergency Specialist (Assessment, Measurement and Evidence). Rapid Response Team | Global Child Protection Area of Responsibility (CP AoR)	United Nations Children's Fund	baristingonzalez@unicef.org
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Health ROAP workshop

Date: 26th March 2018

Agenda

Time	Session title
09:00 – 09:30	Introductions and agenda
09:30 – 09:50	Presentation of key BNA findings (refresher)
09:50 – 10:40	ROAP step: Profiling of the groups most in need for Health assistance
10:40 – 10:50	Coffee break (short, as we have early lunch)
10:50 – 11:30	ROAP step: Causal analysis
11:30 – 12:15	ROAP step: Setting programmatic Health objectives for Fafan in line with HDRP Health objectives
12:15 – 13:15	Lunch break
13:15 – 14:30	ROAP step: Identification and comparison of response options based on causal analysis for each objective (excluding those not allowed by authorities)
14:30 – 15:00	ROAP step: Setting the cash transfer amount (if cash)
15:15 – 15:30	Coffee break
15:30 – 17:00	ROAP step: Selection of most operationally feasible and appropriate response options

Participants

Name	Title	Organisation	Email
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Shelter/NFI ROAP workshop

Date: 27th March 2018

Agenda

Time	Session title
09:00 – 09:30	Introductions and agenda
09:30 – 09:50	Presentation of key BNA findings (refresher)
09:50 – 10:40	ROAP step: Profiling of the groups most in need for ES/NFI assistance
10:40 – 10:50	Coffee break (short, as we have early lunch)
10:50 – 11:30	ROAP step: Causal analysis
11:30 – 12:15	ROAP step: Setting programmatic ES/NFI objectives for Fafan in line with HDRP ES/NFI objectives
12:15 – 13:15	Lunch break
13:15 – 14:30	ROAP step: Identification and comparison of response options based on causal analysis for each objective (excluding those not allowed by authorities)
14:30 – 15:00	ROAP step: Setting the cash transfer amount (if cash)
15:15 – 15:30	Coffee break
15:30 – 17:00	ROAP step: Selection of most operationally feasible and appropriate response options

Participants

Name	Title	Organisation	Email
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Inter-cluster ROAP

Agenda

DAY 1: 28TH March 2018

Time	Session title	Method / output
09:00 – 09:30	Introductions, agenda, and objectives	
09:30 – 10:30	The process so far: how it links with the HDRP? Who owns it and what are the next steps?	Group work
10:30 – 11:00	Brief review of the BNA overall findings. How can we reconcile them with the hotspot priority woredas?	Presentation and discussion
11:15 – 11:30	Coffee break	
11:30 – 13:15	Finalisation of target group definition, causal analysis, objectives, and response options, by the four sectors	Group work and presentation through flip charts
13:15 – 14:15	Lunch break	
14:15– 15:15	Presentation of single-sector response options. Q&A	Presentation and discussion

15:15 – 16:00	Building an inter-cluster causal analysis	Re-organisation of single-sector causal analyses to link them
16:00 - 16:15	Coffee break	
16:15 – 17:00	Integrating plans and identifying synergies: target groups, locations, interventions	Re-organisation of response options in a unified matrix

DAY 2: 29TH March 2018

Time	Session title	Method / Output
09:00 – 09:15	Opening	
09:15 – 10:30	Integrating plans and identifying synergies: target groups, locations, interventions	Group work on comparative response option analysis
10:30 – 10:45	Coffee break	
10:45 – 11:30	Additional considerations for vulnerable groups (e.g. gender, age, special vulnerabilities, environmental sustainability)	Plenary discussion
11:30 – 13:00	Estimation of sectoral transfer value	Presentation and plenary discussion
13:00 – 14:00	Lunch break	
14:00 – 15:00	Is multipurpose grant appropriate given the sectoral plans?	Plenary discussion
15:00 – 15:30	Adjustment of response options (including sectoral transfers) based on addition of MPG	
15:30 – 15:45	Coffee break	
15:45 – 16:30	Final recommendations on inter-sector assistance packages, quantity and timing for targeted groups and locations	Group work to determine sectors' response statement for Fafan

Participants

With a few exceptions all participants attended both days of the inter-sector workshop.

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Annex 2: Tables of the Cluster and Inter-cluster working sessions

Food Security cluster tables

Table 1: Population in severe need for food

		IDPs			RESIDENT			
	Location	female-headed HH	male-headed HH		female-headed HH	male-headed HH		
% of HH severly food affected	Babile	56%	57%		35%	39%		
	Hareshen	4%	12%		2%	1%		
	Kebribeyah	24%	15%		40%	8%		
	Tuliguled	21%	29%	TOTAL	57%	35%	TOTAL	GRAND TOT
Number of HHs severely affected?	Babile	1,382	4,132	**5,515**	1,475	4,828	**6,303**	**11,818**
	Hareshen	1	8	**8**	88	129	**217**	**225**
	Kebribeyah	80	148	**228**	3,631	2,133	**5,764**	**5,992**
	Tuliguled	87	471	**558**	8,796	15,863	**24,660**	**25,218**
	Total	**1,550**	**4,759**	**6,309**	**13,990**	**22,953**	**36,943**	**43,252**
Number of individuals severely affected?	Babile	9,465	28,295	**37,760**	9,442	30,900	**40,342**	**78,103**
	Hareshen	6	57	**64**	562	825	**1,387**	**1,450**
	Kebribeyah	579	1,063	**1,643**	23,237	13,649	**36,886**	**38,529**
	Tuliguled	653	3,553	**4,206**	56,296	101,526	**157,822**	**162,028**
	Total	**10,704**	**32,969**	**43,673**	**89,537**	**146,900**	**236,437**	**280,110**

Table 2: How target groups meet their needs and why they cannot currently do so (from BNA)

CAUSES AND SITUATION		
Immediate causes (including quality)	1, 2, 3 (order of frequency) (Source BNA)	1. insufficient purchasing power 2. insufficient assistance 3. insufficient supplies in the local market
How affected groups typically meet the need	1, 2, 3 (order of frequency) (Source BNA)	1. Local traders 2. NGOs / local support 3. Own supply (only in Tuliguled and Babile. In other woredas top two sources cover 100% / nearly 100%)
How far do they need to travel to procure the relevant commodity / use the relevant service?	Average time for most popular source (Source BNA)	For the vast majority of people, the distance from their source of food supplies is less than one hour In Tuliguled it's mostly more than two hours)

Table 3: target groups preferred assistance modalities and summary of potential response options

Criteria	Possible answers	**RESPONSE OPTIONS FOR OBJECTIVE 1:** Ensure severely food insecure IDP and resident HOUSEHOLDs in Tuliguled, Babile, and Kebribeyah have access to minimum required quantity and quality food.		
		In-kind transfer Direct service provision (if applicable)	**Cash Transfers**	**Vouchers**
Affected groups' preference	1, 2, 3 (order of preference)	2	1	
Suitability to objectives, target groups and groups with special needs / vulnerabilities *According to sector and protection experts, is the response option appropriate to achieve the objectives for ALL intended groups (including vulnerable groups) in ALL targeted geographic areas?* *Consider: quality, access, availability, groups with special needs / vulnerabilities*	Description	Monthly distribution of food: oil, cereal, pulses, vegetables	Monthly CT of an amount equivalent to the cost of the diet	Monthly voucher including the following food items
	Positive	High chance that assistance is used as intended Continuity of supply chain Food sharing	Flexibility to HOUSEHOLD- diversity of choice Flexibility for household as cash can be spent to buy food when needed Diverse diet	Increased likelihood (over CT) that aim of programme (i.e. access to minimum required quantity and quality of food) will be achieved – more control Increased choice of food items (over in-kind)
	Negative	Lack of choice Lack of dietary diversity Food sharing (not reach programme objectives), which may lead to consumption of lower quantities of food than required	Lower chance (than with in-kind) that assistance is used for intended purposes – a smaller challenge for food, since it is the main current and desired household expenditure (source: BNA)	Less choice than CT Limited control over quality of food that is given to voucher beneficiaries

Table 4: Comparative analysis of food-assistance response options based on suitability to objective 2

Criteria	Possible answers	**RESPONSE OPTIONS FOR OBJECTIVE 2:** Increase access to foods with micro-nutrients for severely food affected IDP and resident HOUSEHOLDs including those with special needs in Tuliguled, Babile, and Kebribeyah.				
		In-kind transfer	**Direct service provision (if applicable)**	**Cash Transfers**	**Vouchers**	**Combination**
Affected groups' preference	1, 2, 3 (order of preference)					
Suitability to objectives, target groups and groups with special needs / vulnerabilities	Description	Quarterly provision of micro-nutrient rich supplements	NA	*Suggestion for the group to consider and amend as necessary:* Top-up to the monthly transfer (only to targeted	For the group to describe the type of voucher (commodity or value), the list of items that it would	Conditional Cash Transfer combined with case management. Recommended condition: attend orientation / sensitisation activities

According to sector and protection experts, is the response option appropriate to achieve the objectives for ALL intended groups (including vulnerable groups) in ALL targeted geographic areas? *Consider: quality, access, availability, groups with special needs / vulnerabilities*				group) for an amount equivalent to the cost of micro-nutrient rich supplements	cover, the frequency it would be distributed.	
	Positive	More certain micro-nutrients are being consumed **PlumpyNut (or equivalents) must be distributed in-kind**		Peer pressure, restrictions on CT, and conditional CT can ensure cash is used as intended	More certain micro-nutrients will be consumed (than cash)	More certain micro-nutrients will be consumed (than with cash alone)
	Negative			Hard to control – could be spent on other needs Food with micro-nutrients may not be available Can create household conflicts	Food with micro-nutrients may not be available	

Table 52: Minimum expenditure basket for food needs

Item	Frequency	Quantity 7/HOUSEHOLD	Unit	Price /unit (ETB)	Total price (ETB)
Cereal (Wheat)	monthly	105	kg	14	1470
Pulses (Haricot Bean)	monthly	10.5	kg	40	420
Oil	monthly	3.15	kg	38	120
Fresh Food (veg, dairy, eggs)	monthly	1	household	550	550
Sugar	monthly	5	kg	20	100
Milling cost	monthly	105	kg	2	210
					2870

Table 6: Overall comparative analysis of food response options (objective 1)

OBJECTIVE Ensure severely food insecure IDP and resident households in Tuliguled, Babile, and Kebribeyah have access to minimum required quantity and quality food				
CRITERIA	**Considerations**	**Response options**		
		Monthly distribution of vegetable oil, cereal, pulses, vegetables	Monthly cash transfers of an amount equivalent to the cost of the diet	Monthly voucher including the following food items
ACCEPTANCE BY LOCAL AND NATIONAL AUTHORITIES				
Criterion # 1: Acceptance by authorities **(Weight: 3)** **If no, then option is vetoed and removed** *Is the response option acceptable for the local and national authorities in all the targeted locations? What concerns do / may they have?*	Yes	Broad acceptance of IK.	Broad acceptance of cash from national and Somali regional government PSNP is based on 'cash first' principle (for residents) Gov has used CT for refugees in Dollo	Acceptance of vouchers but not utilized widely.
	Actual/Anticipated Possible concerns	- Decision not based on evidence - Inclusion of vegetable as a new item requires dialogue with stakeholders. - Food basket composition may be reduced to match the PSNP level. - Dilution	- Transfer value might be lower due to current PSNP transfer rates and will not address the full food MEB and beneficiary needs. - CT might make beneficiaries more unwilling to move (and the government is aiming to resettle IDPS in some places) - Decision not based on evidence. - Dilution	- Decision not based on evidence. - Dilution
	score	2	3	2
APPROPRIATENESS (TAKEN FROM QUESTION 1)				
Criterion # 2: Suitability to objectives and target groups, according to beneficiaries **(Weight: 3)** *Is the response option appropriate to achieve the objectives? Is it the case for all intended groups? In all targeted locations?* *Are the target groups in the position to use and benefit from the response option, considering distance from providers, possible discrimination, cost incurred, security and protection risks?*	Advantages / pros	High chance that assistance is used as intended Continuity of supply chain Food sharing (positive for social capital) Reduces conflict at HOUSEHOLDs level especially if target group is women In Tuliguled markets are distant and access is an issue so in-kind is better for them Stocks are pre-positioned so for first distributions this is the faster option	Flexibility to HOUSEHOLD- diversity of choice Cash transfers, but only if electronic, could meet needs faster (especially once set up). If done through the government it would be slow, hence needs would remain unmet for a period of time If population are mobile then electronic cash circumnavigates access issues and it would not be necessary to locate beneficiaries' households at each distribution Flexibility for households as cash can be spent to buy food when needed	Increased likelihood (over CT) that aim of programme (i.e. access to minimum required quantity and quality of food) will be achieved – more control Increased choice of food items (over in-kind)

			Diverse diet	
	Disadvantages / cons	Lack of choice Lack of dietary diversity Food sharing (not reach programme objectives), which may lead to consumption of lower quantities of food than required	Lower chance (than with in-kind) that assistance is used for intended purposes – a smaller challenge for food, since it is the main current and desired household expenditure (source: BNA) Cash sharing	Less choice than CT Limited control over quality of food that is given to voucher beneficiaries sharing
	Score	2	2	1
Criterion # 3: Suitability to meet the objectives for target groups with special needs **(Weight: 3)** *Is the response option appropriate to achieve the objectives for people with special needs / vulnerabilities in all targeted locations?* *Are the identified groups with special needs in the position to use and benefit from the response option, considering distance from providers, possible discrimination, cost incurred, security and protection risks?*	Advantages / pros	Readily available	Get money and then go to markets Choice	As above
	Disadvantages / cons	Limited choice	Access to markets might be limited for groups with limited mobility	Limited choice
	Score	2	2	1
Criterion # 4: Programme quality (quality standards, including Sphere standards) **(Weight: 3)** *Which response option offers the best chance of achieving: the minimum quality and quantity of commodities and services that target groups should get access to / consume according to humanitarian standards?*	Advantages / pros	Standards of food basket more likely to reach 2,100kc		Reduced risk of selling assistance (vs in-kind) Standards of food basket more likely to reach 2,100kc
	Disadvantages / cons		Transfer value might not equal 2,100Kc	
	Score	3	2	3
PUBLIC SERVICES AND MARKETS				
Criterion # 5: Capacity of existing public service systems (e.g. education, health, public water system, other essential services) **(Weight:)** *Do the local public services, facilities, and infrastructure have the capacity to support and respond positively, timely and at scale to the proposed response options?* *If not, how easily and efficiently can they be enabled?*	Advantages / pros	NOT APPLICABLE FOR FOOD ASSISTANCE		
	Disadvantages / cons			
	score			

Criterion # 6: Consequences for the public service systems **(Weight:)** *Will the public service system and its facilities and infrastructure be damaged or supported by the proposed response option?*	Advantages / pros Disadvantages / cons score			
Criterion # 7: Capacity of market actors and private sector services **(Weight: 3)** *Do the relevant markets and private sector services have the capacity to respond positively, timely and at scale to the proposed response option?* *If not, how easily and efficiently can they be enabled?*	Advantages / pros	- Distribution points could be closer to beneficiaries	- Market capacity to respond - There is a the SMFI (bank) and HelloCash (mobile money).	- Support local markets and production Incentive for medium to large traders
	Disadvantages / cons	- Increased cost in transportation due to border conflicts. Border closure may impact supply chain	- If level of need is very high then smaller market traders may not be able to respond to the increased demand so may need support - Limited technology service providers with high costs and banks/agents may have liquidity issues.	- Voucher payments to traders are delayed therefore impacting their income.
	score	1	3	3
Criterion # 8: Consequences for relevant market actors and private sector services **(Weight: 3)** *Will the market actors (or other parts of the system) be damaged or supported by the proposed response option? Examples of unintended negative effects on markets: reduced competition, reduced demand, higher prices.*	Advantages / pros		- Support local markets and production - - - Incentive to small, informal and large traders. Multiplier effect (create new business opportunities) - In rural markets there are almost always liquidity issues which a cash injection would help	
	Disadvantages / cons	Shrinks the business volume of local traders and their earnings; it discourages them Beneficiaries selling on the goods may distort the market (more of a problem if food that is unsuitable / not preferred is distributed) - Negative impact, it might discourage local production and markets		A small number of traders benefit disproportionally and at the cost of other traders Disadvantages smaller traders who cannot qualify for the bids
	score	2	3	3
IMPLEMENTING AGENCIES' CAPACITY TO OPERATE AT SCALE AND IN A TIMELY MANNER				
Criterion # 9: Sector members' familiarity with the modality **(Weight: 2)**	Advantages / pros	In-kind has experience and expertise Infrastructure exists		

In the targeted geographic areas, what portion of the sector members are familiar with the response option (# of experienced organisations out of total # of members)?		Organizations might be risk averse to cash and vouchers		
	Disadvantages / cons		- Perceived to be more at risk of fraud and diversion (cash in envelope) - Limited expertise and HR resources for cash	- Limited expertise and HR resources for cash
	score	3	2	1
Criterion # 10: Capacity to start and go to scale (caseload size) in a short timeframe **(Weight: 3)** *In the targeted locations, which of the response options has the shortest start-up time for the sector partners, and the capacity to go to scale in the shortest timeframe?*	Advantages / pros	In-kind has experience and expertise Infrastructure exists Organizations might be risk averse to cash and vouchers		
	Disadvantages / cons	Dependant on a limited SC	Limited capacity	Limited capacity
	score	3	2	2
RISKS				
Criterion # 11: Protection **(Weight: 3)** *Which response option offers fewer and more manageable intra-household and community protection risks for beneficiaries, with specific attention to those with special needs and vulnerabilities?*	Advantages / pros	Perceived as less prone intra HOUSEHOLDs conflict		
	Disadvantages / cons	Distance from distribution site	Prog that focus on female HOUSEHOLD may cause intra-household conflict	
	Score	3	2	3
Criterion # 12: Operational, financial, and institutional risks **(Weight: 3)** *Which response option offers fewer and more manageable operational and institutional risks?*	Advantages / pros	More organizational experience		
	Disadvantages / cons	Risk of theft Easy to sell / divert Expensive logistics	Risk of theft Risk of internal fraud Lack of CT experience	Possibilities for fraud and selling of vouchers If paper vouchers, they can be counterfeited
	Score	3	2	2
Criterion # 13: Contextual risks **(Weight: 3)**	Advantages / pros			
	Disadvantages / cons	Fund shortage	Fund shortage	Fund shortage

Which response option is more vulnerable to external factors and changing conditions?		Transport access due to conflict	Subject to volatility of market prices (due to exchange rate)	
	Score	2	2	2
COSTS				
Criterion # 14: Costs and efforts for the organisation **(Weight: 2)** *Which of the response options has lower costs for the organisation?*	Observations and envisaged costs (list and estimated total)	Time consuming and expensive to monthly distribute Transportation Warehousing Distribution	If cash in envelop, it is time consuming and logistically expensive and risky to distribute it monthly Less logistical requirements (for org and HOUSEHOLD), in case it is distributed electronically	
	score	1	3	2
Criterion # 15: Costs and efforts for the beneficiaries **(Weight: 3)** *Which of the response options is most convenient for the beneficiaries (in terms of costs incurred to benefit)?*	Observations and envisaged costs (list and estimated total)	Expensive and cumbersome for HOUSEHOLDs to collect; perhaps no storage place at home Transportation to distribution point and back	Beneficiaries incur costs (financial and time) in spending the money – especially when markets are distant	
	Score	1	3	2
Overall score **(WEIGHTED: maximum = 37)** **(UNWEIGHTED: maximum = 45)**		**28**	**31**	**27**

Table 7: Overall comparative analysis of food response options (objective 2)

OBJECTIVE Increase access to foods with micro-nutrients for severely food affected IDP and resident households including those with special needs in Tuliguled, Babile, and Kebribeyah.					
		Response options			
CRITERIA	**Considerations**	Quarterly provision of micro-nutrient rich supplements (Plumpy nut)	*Suggestion for the group to consider and amend as necessary:* Top-up to the monthly transfer (only to targeted group) for an amount equivalent to the cost of micro-nutrient rich supplements	For the group to describe the type of voucher (commodity or voucher), the list of items that it would cover, the frequency it would be distributed.	**COMBINATION:** Conditional Cash Transfer combined with in-kind (nutrition supplement). Recommended condition: attend orientation / sensitisation activities

ACCEPTANCE BY LOCAL AND NATIONAL AUTHORITIES					
Criterion # 1: Acceptance by authorities **(Weight: 3)** **If no, then option is vetoed and removed** *Is the response option acceptable for the local and national authorities in all the targeted locations? What concerns do / may they have?*	Yes		Broad acceptance of cash from national and Somali regional government PSNP is based on 'cash first' principle (for residents) Gov has used CT for refugees in Dollo		
	Possible concerns (actual or anticipated)		Would require conversations and alignment with the government (which would take time and range of responses) CT might make beneficiaries more unwilling to move (and the government is aiming to resettle IDPS in some places)		
	score	3	1	3	3
APPROPRIATENESS (TAKEN FROM QUESTION 1)					
Criterion # 2: Suitability to objectives and target groups, according to beneficiaries **(Weight: 3)** *Is the response option appropriate to achieve the objectives? Is it the case for all intended groups? In all targeted locations?* *Are the target groups in the position to use and benefit from the response option, considering distance from providers, possible discrimination, cost incurred, security and protection risks?*	Advantages / pros	More certain micro-nutrients are being consumed PlumpyNut (or equivalents) has to be distributed in-kind Better for those who are far from markets Stocks are pre-positioned so for first distributions this is the faster option	Peer pressure, restrictions on CT, and conditional CT can ensure cash is used as intended Electronic transfers could meet needs faster (especially once set up) If population are on-the-move then electronic cash circumnavigates access issues and it would not be necessary to locate beneficiaries' households at each distribution	More certain micro-nutrients will be consumed (than cash)	More certain micro-nutrients will be consumed (than with cash alone) Lower costs that in-kind; more expensive than cash alone
	Disadvantages / cons	Can take time to import PlumpyNut (all internationally sourced)	Micro-nutrient rich food may not be available on the local market		
	Score	3	1	3	3
Criterion # 3: Suitability to meet the objectives for target groups with special needs **(Weight: 3)** *Is the response option appropriate to achieve the objectives for people with special needs / vulnerabilities in all targeted locations?*	Advantages / pros	More certain micro-nutrients are being consumed PlumpyNut (or equivalents) has to be distributed in-kind Better for those who are far from markets	As above	As above	As above

Are the identified groups with special needs in the position to use and benefit from the response option, considering distance from providers, possible discrimination, cost incurred, security and protection risks?		Stocks are pre-positioned so for first distributions this is the faster option			
	Disadvantages / cons	Can take time to import PlumpyNut (all internationally sourced)	Some groups and geographic areas may be specifically excluded from cash assistance		
	Score	3	1	3	3
Criterion # 4: Programme quality (quality standards, including Sphere standards) **(Weight: 3)** *Which response option offers the best chance of achieving: the minimum quality and quantity of commodities and services that target groups should get access to / consume according to humanitarian standards?*	Advantages / pros	Food nutritional value aligned with international standards (CSB, Plumpy nut etc)		Voucher restricts purchase of prescribed food (Famix etc)	Flexible but also meets nutrition needs through IK
	Disadvantages / cons	Delay in procurement Diversion to chat chewers who enjoy PlumpyNut	Difficult to ensure that beneficiaries buy the needed micro-nutrient foods	Famix may not always be available	
	Score	3	1	2	3
PUBLIC SERVICES AND MARKETS					
Criterion # 5: Capacity of existing public service systems (e.g. education, health, public water system, other essential services) **(Weight:)** *Do the local public services, facilities, and infrastructure have the capacity to support and respond positively, timely and at scale to the proposed response options?* *If not, how easily and efficiently can they be enabled?*	Advantages / pros				
	Disadvantages / cons				
	score	N/A			
Criterion # 6: Consequences for the public service systems **(Weight:)** *Will the public service system and its facilities and infrastructure be damaged or supported by the proposed response option?*	Advantages / pros				
	Disadvantages / cons				
	score	N/A			
Criterion # 7: Capacity of market actors and private sector services **(Weight: 2)**	Advantages / pros	In Tuliguled markets are distant and access is an issue so in-kind makes more sense	Positively impact local traders In rural markets there are almost always liquidity issues		

Do the relevant markets and private sector services have the capacity to respond positively, timely and at scale to the proposed response option? *If not, how easily and efficiently can they be enabled?*			which a cash injection would help		
	Disadvantages / cons	Can take time to import PlumpyNut (all internationally sourced)	Micro-nutrient rich food may not be available on the local market		
	score				
Criterion # 8: Consequences for relevant market actors and private sector services **(Weight: 2)** *Will the market actors (or other parts of the system) be damaged or supported by the proposed response option? Examples of unintended negative effects on markets: reduced competition, reduced demand, higher prices.*	Advantages / pros				
	Disadvantages / cons	Micro-nutrient high supplements are imported from international markets – so in-kind assistance does not support local markets, but does not do any harm either The sale of goods may distort the market; the sale of therapeutic food may mislead customers and create wrong consumption habits as it should not be consumed as regular food			
	score	3	1	2	3
IMPLEMENTING AGENCIES' CAPACITY TO OPERATE AT SCALE AND IN A TIMELY MANNER					
Criterion # 9: Sector members' familiarity with the modality **(Weight: 3)** *In the targeted geographic areas, what portion of the sector members are familiar with the response option (# of experienced organisations out of total # of members)?*	Advantages / pros	There is existing nutrition Expertise and experience implementing in kind	No experience supporting through cash	Experience	Experience
	Disadvantages / cons	Logistic heavy	It Might not be utilized for intended purpose and difficult to monitor	Might undermine the local supplies	
	score	3	2	3	3
Criterion # 10: Capacity to start and go to scale (caseload size) in a short timeframe **(Weight: 3)** *In the targeted locations, which of the response options has the shortest start-up time for the sector partners, and the capacity to go to scale in the shortest timeframe?*	Advantages / pros	There is existing nutrition Expertise and experience implementing in kind	No expertise in the cash specific nutritional expert	There is capacity to scale up	
	Disadvantages / cons	Limited imported micro nutritive food	Lack of funding source	Lack of funding source and needs huge man power	Lack of funding source
	score	2	2	2	3
RISKS					

Criterion # 11: Protection **(Weight: 3)** *Which response option offers fewer and more manageable intra-household and community protection risks for beneficiaries, with specific attention to those with special needs and vulnerabilities?*	Advantages / pros	Targeting more vulnerable groups	Easily reached to the Vulnerable group beneficiaries	They can shop what they need at a time (depends on the voucher)	Gives more options to the beneficiaries
	Disadvantages / cons	Distance to the distribution point and carrying of heavy amount of food. It may be shared with in the household	Can create HOUSEHOLD conflicts The items may be locally not available		Distance to the distribution point and carrying of heavy amount of food. It may be shared with in the household
	Score	3	2	3	3
Criterion # 12: Operational, financial, and institutional risks **(Weight: 3)** *Which response option offers fewer and more manageable operational and institutional risks?*	Advantages / pros	More control	Easier to manage	Controlled	Easily reached to the beneficiaries
	Disadvantages / cons	Logistic delay	Easily to divert	It needs high manpower and more logistic	It needs high manpower and more logistic
	Score	3	2	2	3
Criterion # 13: Contextual risks **(Weight: 3)** *Which response option is more vulnerable to external factors and changing conditions?*	Advantages / pros				
	Disadvantages / cons	Limited Access and transport	FSP and government policy	Availability of nutrition supplements, supplies	Limited Access and transport Availability of nutrition supplements, supplies
	Score	2	2	2	2
COSTS					
Criterion # 14: Costs and efforts for the organisation **(Weight: 2)** *Which of the response options has lower costs for the organisation?*	Observations and envisaged costs (list and estimated total)		Less costs		Lower costs that in-kind; more expensive than cash alone
	score	2	3	2	2
Criterion # 15: Costs and efforts for the beneficiaries **(Weight: 3)** *Which of the response options is most convenient for the beneficiaries (in terms of costs incurred to benefit)?*	Observations and envisaged costs (list and estimated total)				
	Score	2	3	2	2
Overall score (WEIGHTED: maximum = 36)		**32**	**21**	**29**	**33**

(UNWEIGHTED: maximum = 45)					

WASH cluster tables

Table 8: Estimation of people in severe need for water

		IDPs			RESIDENT			
	Location	female-headed HH	male-headed HH		female-headed HH	male-headed HH		
% of HH severly water affected	Babile	50%	40%		55%	37%		
	Hareshen	3%	12%		8%	3%		
	Kebribeyah	17%	9%		35%	9%		
	Tuliguled	68%	46%	**TOTAL**	74%	59%	**TOTAL**	**GRAND TOT**
Number of HHs severely affected?	Babile	1,234	2,900	**4,134**	2,318	4,581	**6,899**	**11,033**
	Hareshen	1	8	**8**	351	387	**738**	**746**
	Kebribeyah	57	89	**146**	3,177	2,399	**5,576**	**5,722**
	Tuliguled	281	748	**1,028**	11,420	26,741	**38,161**	**39,189**
	Total	**1,573**	**3,744**	**5,316**	**17,266**	**34,108**	**51,374**	**56,690**
Number of individuals severely affected?	Babile	8,451	19,856	**28,307**	14,837	29,316	**44,153**	**72,460**
	Hareshen	5	57	**62**	2,247	2,475	**4,722**	**4,784**
	Kebribeyah	410	638	**1,048**	20,332	15,356	**35,688**	**36,736**
	Tuliguled	2,116	5,635	**7,751**	73,086	171,143	**244,229**	**251,980**
	Total	**10,982**	**26,187**	**37,169**	**110,503**	**218,289**	**328,792**	**365,961**

Table 9: Estimation of people in severe need for sanitation

		IDPs			RESIDENT			
	Location	female-headed HH	male-headed HH		female-headed HH	male-headed HH		
% of HH severly sanitation affected	Babile	30%	39%		2%	16%		
	Hareshen	12%	18%		6%	2%		
	Kebribeyah	27%	12%		51%	18%		
	Tuliguled	37%	39%	TOTAL	67%	49%	TOTAL	GRAND TOT
Number of HHs severely affected?	Babile	741	2,827	**3,568**	84	1,981	**2,065**	**5,633**
	Hareshen	3	11	**14**	263	258	**521**	**535**
	Kebribeyah	91	118	**209**	4,629	4,799	**9,428**	**9,637**
	Tuliguled	153	634	**786**	10,339	22,209	**32,548**	**33,335**
	Total	**986**	**3,591**	**4,577**	**15,316**	**29,246**	**44,562**	**49,139**
Number of individuals severely affected?	Babile	5,071	19,360	**24,431**	540	12,677	**13,217**	**37,647**
	Hareshen	19	86	**105**	1,685	1,650	**3,335**	**3,441**
	Kebribeyah	652	851	**1,503**	29,627	30,711	**60,338**	**61,841**
	Tuliguled	1,151	4,778	**5,929**	66,173	142,136	**208,309**	**214,237**
	Total	**6,893**	**25,074**	**31,967**	**98,025**	**187,174**	**285,199**	**317,166**

Table 10: Estimation of people in severe need for hygiene commodities

		IDPs			RESIDENT			
	Location	female-headed HH	male-headed HH		female-headed HH	male-headed HH		
% of HH severly hygiene commodity deprived	Babile	17%	34%		5%	13%		
	Hareshen	7%	6%		1%	1%		
	Kebribeyah	26%	10%		35%	9%		
	Tuliguled	26%	34%	TOTAL	63%	32%	TOTAL	GRAND TOT
Number of HHs severely affected?	Babile	420	2,465	**2,884**	211	1,609	**1,820**	**4,705**
	Hareshen	2	4	**5**	44	129	**173**	**178**
	Kebribeyah	87	98	**186**	3,177	2,399	**5,576**	**5,762**
	Tuliguled	107	553	**660**	9,722	14,504	**24,226**	**24,886**
	Total	**616**	**3,120**	**3,735**	**13,154**	**18,641**	**31,795**	**35,530**
Number of individuals severely affected?	Babile	2,873	16,878	**19,751**	1,349	10,300	**11,649**	**31,400**
	Hareshen	11	29	**40**	281	825	**1,106**	**1,146**
	Kebribeyah	628	709	**1,337**	20,332	15,356	**35,688**	**37,025**
	Tuliguled	809	4,165	**4,974**	62,222	92,824	**155,045**	**160,019**
	Total	**4,321**	**21,781**	**26,102**	**84,184**	**119,304**	**203,488**	**229,590**

Table 11: How target groups meet their hygiene needs and why they cannot currently do so (from BNA)

CAUSES AND SITUATION Of UNMET HYGIENE NEEDS						
Immediate causes (including quality)		1, 2, 3 (order of frequency) (Source BNA)	4. Lack of income 5. Lack of support 6. Lack of supplies in the local market			
How and where needs are met			**Babile**	**Hareshen**	**Kebribeyah**	**Tuliguled**
Hygiene commodities	**How affected groups typically meet the need** Ranking of source (1 most common) (Source BNA)	1	Purchase / trade (48%)	Purchase / trade (98%)	Purchase / trade (85%)	Purchase / trade (79%)
		2	NGOs / local support (35%)	NGOs / local support (<1%)	NGOs / local support (12%)	NGOs / local support (14%)
		3	Nature (12%)	Government (<1%)	Nature (2%)	Nature (5%)
	How far do they need to travel to procure the relevant commodity / use the relevant service?		< 1 hr (87%)	< 1 hr (98%)	< 1 hr (96%)	> 2 hrs (71%)
Hygiene	**How affected groups typically meet the need**	1	NGOs / local support (47%)	Purchase / trade (75%)	Purchase / trade (64%)	Nature (58%)

	Ranking of source (1 most common) (Source BNA)	2	Government (20%)	NGOs / local support (17%)	Government (28%)	NGOs / local support (22%)
		3	Purchase / trade (17%)	Nature (8%)	NGOs / local support (8%)	Government (14%)
	How far do they need to travel to procure the relevant commodity / use the relevant service?		< 1 hr (86%)	< 1 hr (99%)	< 1 hr (98%)	< 1 hr (56%)

Table 12: How target groups meet their water needs and why they cannot currently do so (from BNA)

CAUSES AND SITUATION OF UNMET WATER NEEDS					
Immediate causes (including quality)	1, 2, 3 (order of frequency) (Source BNA)	1. Lack of income 2. Lack of support 3. Lack of supplies in the local market			
How and where needs are potable water needs met in:		**Babile**	**Hareshen**	**Kebribeyah**	**Tuliguled**
How affected groups typically meet the need Ranking of source (1 most common) (Source BNA)	1	Government (68%)	Purchase / trade (84%)	Government (47%)	Nature (53%)
	2	NGOs / local support (29%)	NGOs / local support (5%)	Purchase / trade (43%)	NGOs / local support (28%)
	3	Purchase / trade (2%)	Government (4%)	NGOs / local support (9%)	Government (16%)
How far do they need to travel to procure the relevant commodity / use the relevant service?		< 1 hr (97%)	< 1 hr (94%)	< 1 hr (92%)	>2 hr (68%)

Table 13: Minimum expenditure basket for WASH needs

Item	Specification	Unit	Frequency (times per year)	Timing of expenditure	Quantity month	Unit price (ETB)	Total (ETB)
Jerrycan (large)	20 Litres	I piece	1	Start of programme	1	170	170
Jerrycan (small)	10 Litres	I piece	1	Start of programme	1	110	110
Safety pins	12 piece pack	1 pack	1	Start of programme	1	30	30
WASH standard Bucket	10/15 litres with lid and tap	1 piece	1	Start of programme	1	125	125

Washing basin	65cm diameter	1 piece	1	Start of programme	1	150	150
Nail cutter		1	1	Start of programme	1	15	15
Fabric Sanitary pads	Pack of 3 pieces	2 packs per HH	2	Twice per year	2	86	344
Female underwear	2 pcs per pack	2 packs per HH	2	Twice per year	2	50	200
Women's fabric	2 pcs per pack	N/A	2	Twice per year	1	100	200
General cotton fabric roll	2mts x 1 mts	1 piece	4	Quarterly	1	200	800
Glycerine/Cream	100ml	1 piece x month	4	Quarterly	1	60	240
Buffer hygiene commodity	cash		4	Quarterly	1	50	200
Water vouchers-dry season	Cash vouchers	5 litres person x day	4	Quarterly	1	1,575	6300
Bath soap	125 grms	3 pieces x month x 7 HH members	12	Quarterly	3	15	540
Shampoo	250 mls	1 piece/month	12	Quarterly	1	40	480
Laundry soap	250 grms	2 packs x month	12	Quarterly	2	11	264
Total							**10168**

Table 14: Overall comparative analysis of water response options (objective 1)

OBJECTIVE 1 **Potable water objective: severely affected household in Babile, Tuliguled (50,222) and Kebribeyah (5,722) have access to a minimum of 5LP/D of safe water.**						
CRITERIA	**Considerations**	**Response options**				
		Cash transfer	In-kind (Babile & Tuliguled) I.e. Water trucking	Services (Babile & Tuliguled) I.e. Fixing non-functioning boreholes,	Voucher i.e. Vouchers for vulnerable income-	Combination

				pipeline extension, digging new boreholes.	poor households in Kebribeyah	
ACCEPTANCE BY LOCAL AND NATIONAL AUTHORITIES						
Criterion # 1: Acceptance by authorities **(Weight:)** **If no, then option is vetoed and removed** *Is the response option acceptable for the local and national authorities in all the targeted locations? What concerns do / may they have?*	Yes / No / Not yet verified	Broad acceptance of cash from national and Somali regional government PSNP is based on 'cash first' principle (for residents) GoE has used CT for refugees in Dollo in the past.	Yes, preferred	Yes, preferred	TBC by regional Governments	TBC by regional Governments
	Possible concerns (actual or anticipated)	CT might make beneficiaries more unwilling to move (and the government is aiming to resettle IDPs in some places)	**Potential operational implementation challenges:** -The Government may not agree with vulnerability targeting. They may insist on blanket coverage, which would reduce the # of communities that we could afford to target. -Complexities in Somali region – Government has purchased 120 trucks – method of running them (directly, through partners etc.) is still not agreed.	Intervention subject to temporality due to GoE IDP Resettlement Policies	TBC by regional Governments	TBC by regional Governments
	score					
APPROPRIATENESS (TAKEN FROM QUESTION 1)						
Criterion # 2: Suitability to objectives and target groups, according to beneficiaries **(Weight:)** *Is the response option appropriate to achieve the objectives? Is it the case for all intended groups? In all targeted locations?*	Advantages / pros	Simplification of the NGO operational response. Easier to reach targeted goals Flexible and contextualized response to changing response environment.	Improves availability, allows for quality control, and reduces protection issues with walking long distances.	Sustainability – value for money Reduces vulnerabilities seasonally because it increases availability.	Water market exists in Kebribeyah. Water availability not an issue. Vouchers would help vulnerable purchase from traders (easier to monitor vouchers than cash)	TBC by regional Governments

Are the target groups in the position to use and benefit from the response option, considering distance from providers, possible discrimination, cost incurred, security and protection risks?		Boost local economies.				
	Disadvantages / cons	No water market in Babile & Tuliguled (No trading) Cash transfers would not meet the availability issue. CT might be used for other purposes than just water consumption. Potential artificial inflation of the market	**IDPs response focus:** Expensive. Immediate support only and not long-term benefit. Required a multi-stakeholder quality control engagement (i.e. Local, traders, Local authorities, NGOs etc.) Time sensitive – this will be irrelevant when rainy seasons starts, so this option depends on programme launch date	Expensive, time consuming (not fast enough results for emergency response), and may not solve distance issues.	No water market in Babile & Tuliguled (No trading) Cash transfers would not meet the availability issue.	TBC by regional Governments
	Score	2	2	2	2	Score #2: Final response profile TBC by regional Governments at Woreda level
Criterion # 3: Suitability to meet the objectives for target groups with special needs **(Weight:)** *Is the response option appropriate to achieve the objectives for people with special needs / vulnerabilities in all targeted locations?* *Are the identified groups with special needs in the position to use and benefit from the response option, considering distance from providers, possible discrimination, cost incurred, security and protection risks?*	Advantages / pros	Yes, flexibility for hosting communities and IDPs. Ensures dignity of targeted beneficiaries	Yes. Bring water to people – avoids having to travel long distances. Yes. Reduces distance so reduces protection risks. Free.	Yes, more sustainable water availability Reduces vulnerabilities seasonally because it increases availability of water sustainably	Same as CT + better for Protection targeting	Yes, as per the need at Woreda level
	Disadvantages / cons	Potential artificial inflation of the market Not suitable for IDPs durable solutions at this stage of the crisis Potential appearance of Aid dependence. As pre-condition, is required to establish an effective	Not sustainable. Must ensure that water is distributed equitably Potential discrimination would need to be addressed in distribution targeting and process. As pre-condition, is required to establish an effective feedback and complaint mechanisms	May or may not be close to their home. Might not solve access issues May not resolve discrimination once handed over to the local community As pre-condition, is required to establish an effective feedback and complaint mechanisms	Same as CT + selection of traders may not solve access issues due to distance. As pre-condition, is required to establish an effective feedback and complaint mechanisms	Need of simplified and friendly CT and vouchers methods for ensuring understanding and endorsement by targeted population (literacy) Increases monitoring needs in complex environment

		feedback and complaint mechanisms				As pre-condition, is required to establish an effective feedback and complaint mechanisms
	Score	3	3	3	2	2
Criterion # 4: Programme quality (quality standards, including Sphere standards) **(Weight:)** *Which response option offers the best chance of achieving: the minimum quality and quantity of commodities and services that target groups should get access to / consume according to humanitarian standards?* *COMMENT: whereas the target is 5L/P/D minimum standards are already 7.5 L/P/D Moreover there are social, cultural and climate factors (muslim communities and desertic areas) that may raise the minimum daily requirements*	Advantages / pros	N/A (minimum 5LP/D)	N/A (minimum 5LP/D)	N/A (minimum 5LP/D)	N/A (minimum 5LP/D)	N/A (minimum 5LP/D)
	Disadvantages / cons	N/A (minimum 5LP/D)	N/A (minimum 5LP/D)	N/A (minimum 5LP/D)	N/A (minimum 5LP/D)	N/A (minimum 5LP/D)
	Score	1	1	1	1	1
PUBLIC SERVICES AND MARKETS						
Criterion # 5: Capacity of existing public service systems (e.g. education, health, public water system, other essential services) **(Weight:)** *Do the local public services, facilities, and infrastructure have the capacity to support and respond positively, timely and at scale to the proposed response options?*	Advantages / pros	N/A	Suitable. Complements Government efforts for emergency response. Does not create competition as there is no water market. Quality control on water is of public health benefit. Benefit to protection and education systems because less time spent by women and children walking to sources.	In the long run, money saved on emergency water trucking, reduced seasonal protection risks due to access/availability to water, improved access to education because children are not spending +4hrs per day to access water.	N/A	N/A

If not, how easily and efficiently can they be enabled?				Somali region already has drilling rigs (Government owned)		
	Disadvantages / cons	N/A	Local assessments needed to verify if the capacity of available water sources (recharge rate) could handle higher water trucking rates. Alternative sources may need to be identified. Government free water trucking would need support (either fuel, transport costs, truck maintenance, disinfection) It is a lot of money propping up a temporary emergency intervention with no sustainability	Need to check land rights and water sharing agreements of new boreholes and pipe extensions Access to Government drilling rigs becomes politicized.	N/A	N/A
	score		3	2		
Criterion # 6: Consequences for the public service systems **(Weight:)** *Will the public service system and its facilities and infrastructure be damaged or supported by the proposed response option?*	Advantages / pros		As above	As above		
	Disadvantages / cons					
	score					
Criterion # 7: Capacity of market actors and private sector services **(Weight:)** *Do the relevant markets and private sector services have the capacity to respond positively, timely and at scale to the proposed response option?* *If not, how easily and efficiently can they be enabled?*	Advantages / pros	N/A	No market for water sales. Not applicable Transport resources exist for this seasonal business/system. The option just injects more money rather than creating business or requiring additional support	Drilling rigs available in Somali. Skills and equipment also available	N/A	N/A
	Disadvantages / cons	N/A		Could be time consuming to obtain skilled labour/equipment.	N/A	N/A

				Likely also expensive given remoteness. May require skills/equipment from Addis that is not available locally. Some equipment may need to be sourced internationally if needed quickly.		
	score		3	3		
Criterion # 8: Consequences for relevant market actors and private sector services **(Weight:)** *Will the market actors (or other parts of the system) be damaged or supported by the proposed response option? Examples of unintended negative effects on markets: reduced competition, reduced demand, higher prices.*	Advantages / pros		No consequence. This is supporting existing free public water through the government. There is no water market in the woreda. Cash injection into local area for labour & transport.	Cash injection into local area (as a priority), and Addis for skills/equipment unavailable locally.		
	Disadvantages / cons		Only injecting money into a seasonal system that exists. Not creating businesses. No significant economic advantage			
	score					
IMPLEMENTING AGENCIES' CAPACITY TO OPERATE AT SCALE AND IN A TIMELY MANNER						
Criterion # 9: Sector members' familiarity with the modality **(Weight:)** *In the targeted geographic areas, what portion of the sector members are familiar with the response option (# of experienced organisations out of total # of members)?*	Advantages / pros		Assuming consortium members are very familiar	Assuming consortium members are very familiar		
	Disadvantages / cons					
	score					
Criterion # 10: Capacity to start and go to scale (caseload size) in a short timeframe **(Weight:)** *In the targeted locations, which of the response options has the*	Advantages / pros		Yes, several partners available in the zone	Yes, several partners available in the zone		
	Disadvantages / cons		Geographic coverage: Depends on where the water source is and ground water availability.	A mapping of sources to be rehabilitated etc would need to be done.		

shortest start-up time for the sector partners, and the capacity to go to scale in the shortest timeframe?				Mapping of available water reservoirs for new boreholes also needs to be done.		
	score					
RISKS						
Criterion # 11: Protection **(Weight:)** *Which response option offers fewer and more manageable intra-household and community protection risks for beneficiaries, with specific attention to those with special needs and vulnerabilities?*	Advantages / pros		Yes. Reduces distance so reduces protection risks. Free.			
	Disadvantages / cons					
	Score		3			
Criterion # 12: Operational, financial, and institutional risks **(Weight:)** *Which response option offers fewer and more manageable operational and institutional risks?*	Advantages / pros					
	Disadvantages / cons					
	Score					
Criterion # 13: Contextual risks **(Weight:)** *Which response option is more vulnerable to external factors and changing conditions?*	Advantages / pros					
	Disadvantages / cons					
	Score					
COSTS						
Criterion # 14: Costs and efforts for the organisation **(Weight:)** *Which of the response options has lower costs for the organisation?*	Observations and envisaged costs (list and estimated total)					
	score					
Criterion # 15: Costs and efforts for the beneficiaries **(Weight:)**	Observations and envisaged costs (list and estimated total)					

Which of the response options is most convenient for the beneficiaries (in terms of costs incurred to benefit)?						
Overall score (WEIGHTED: maximum = ?) (UNWEIGHTED: maximum = 45)						

Table 15: How target groups meet their water needs and why they cannot currently do so (from BNA)

OBJECTIVE 2 **Ensuring access to sanitation facilities, services , hygiene awareness to most severely affected population and specific vulnerable groups in IDP camps and hosting communities for 1 year period**				
CRITERIA	**Considerations**	**Response options** **CT** Hygiene kits provision	**Services** • Toilet/latrines provision • Handwashing facilities • Hygiene promotion	**Combined** (services and CT for waste management staff services only)
ACCEPTANCE BY LOCAL AND NATIONAL AUTHORITIES				
Criterion # 1: Acceptance by authorities **(Weight:)** **If no, then option is vetoed and removed** *Is the response option acceptable for the local and national authorities in all the targeted locations? What concerns do / may they have?*	Yes / No / Not yet verified	Broad acceptance of cash from national and Somali regional government PSNP is based on 'cash first' principle (for residents) Gov has used CT for refugees in Dollo	yes	yes
	Possible concerns (actual or anticipated)	CT might make beneficiaries more unwilling to move (and the government is aiming to resettle IDPS in some places)	none	GoE considers IDP camps as temporal solution, potentially not suitable to existing facilities and structures. none
	score			
APPROPRIATENESS (TAKEN FROM QUESTION 1)				
Criterion # 2: Suitability to objectives and target groups, according to beneficiaries **(Weight:)**	Advantages / pros	Community can access to kits through cash transfers Well-targeted groups	They cover the most urgent (hygiene) humanitarian needs	Foster the waste management sustainability at community level.

Is the response option appropriate to achieve the objectives? Is it the case for all intended groups? In all targeted locations? *Are the target groups in the position to use and benefit from the response option, considering distance from providers, possible discrimination, cost incurred, security and protection risks?*				
	Disadvantages / cons	If kits are not locally available, community won't get true access to them. Vulnerable to market fluctuation and security situation.	None identified Time for construction is required. Is not an immediate solution.	Not a traditional community practice, dependant of external aid.
	Score			
Criterion # 3: Suitability to meet the objectives for target groups with special needs **(Weight:)** *Is the response option appropriate to achieve the objectives for people with special needs / vulnerabilities in all targeted locations?* *Are the identified groups with special needs in the position to use and benefit from the response option, considering distance from providers, possible discrimination, cost incurred, security and protection risks?*	Advantages / pros	Will reach particularly identified vulnerable groups (women and girls) Usability: Yes	They cover the most urgent (hygiene) humanitarian needs Usability: Yes, but it needs special commitments	Ensures a safe hygienic environment. Fosters community engagement. Usability: Yes, but needs integration
	Disadvantages / cons	We cannot ensure that cash is effectively used by vulnerable groups for kits purposes	Lack of commitment may challenge for addressing on discrimination, cost incurred, security and protection risks points of view	Dependant of external aid Lack of commitment may challenge for addressing on discrimination, cost incurred, security and protection risks points of view
	Score			
Criterion # 4: Programme quality (quality standards, including Sphere standards) **(Weight:)** *Which response option offers the best chance of achieving: the minimum quality and quantity of commodities and services that target groups should get access to / consume according to humanitarian standards?*	Advantages / pros			
	Disadvantages / cons			
	Score			
PUBLIC SERVICES AND MARKETS				
Criterion # 5: Capacity of existing public service systems (e.g. education, health, public water system, other essential services) **(Weight:)** *Do the local public services, facilities, and infrastructure have the capacity to support and respond positively, timely and at scale to the proposed response options?*	Advantages / pros	Reduces patients' caseload to health facilities. No support required by the public service providers	Complements with awareness education and health systems Support may be required depending on the location health or educations	Reduces patients' caseload to health facilities. Support requirement differ depending on the location health or educations
	Disadvantages / cons	Dependant of external aid in the long run Little capacity challenges	They are not permanent solutions Medium capacity and support requirement challenges	Is not permanent solution. Medium challenges

If not, how easily and efficiently can they be enabled?	score			
Criterion # 6: Consequences for the public service systems **(Weight:)** *Will the public service system and its facilities and infrastructure be damaged or supported by the proposed response option?*	Advantages / pros	Reduces patients' caseload to health facilities.	Complements with awareness education and health systems	Reduces patients' caseload to health facilities.
	Disadvantages / cons	None	None	None
	score			
Criterion # 7: Capacity of market actors and private sector services **(Weight:)** *Do the relevant markets and private sector services have the capacity to respond positively, timely and at scale to the proposed response option?* *If not, how easily and efficiently can they be enabled?*	Advantages / pros	Yes	yes	Ideal for sustainability
	Disadvantages / cons	Little disadvantages If level of need is very high then smaller market traders may not be able to respond to the increased demand so may need support	No Face serious challenges	Medium disadvantages
	score			
Criterion # 8: Consequences for relevant market actors and private sector services **(Weight:)** *Will the market actors (or other parts of the system) be damaged or supported by the proposed response option? Examples of unintended negative effects on markets: reduced competition, reduced demand, higher prices.*	Advantages / pros	Positively impact local traders In rural markets there are almost always liquidity issues which a cash injection would help	Beneficiaries selling on the goods may distort the market (more of a problem if food that is unsuitable / not preferred is distributed)	
	Disadvantages / cons			Disadvantages smaller traders
	score	3	1	2
IMPLEMENTING AGENCIES' CAPACITY TO OPERATE AT SCALE AND IN A TIMELY MANNER				
Criterion # 9: Sector members' familiarity with the modality **(Weight:)** *In the targeted geographic areas, what portion of the sector members are familiar with the response option (# of experienced organisations out of total # of members)?*	Advantages / pros	It is not clear	Too familiar	Somehow familiar
	Disadvantages / cons	May be sector members new for the modalities	No disadvantage	It somehow there will be disadvantage
	score			
Criterion # 10: Capacity to start and go to scale (caseload size) in a short timeframe **(Weight:)** *In the targeted locations, which of the response options has the shortest start-up time for the sector*	Advantages / pros	No This one will have larger geographic coverage This will be the fastest to set up	Yes It somehow it will have medium coverage Difficult for service	May be Medium coverage
	Disadvantages / cons	Yes there will have disadvantage	Yes, because it will be time taken	Medium disadvantages

partners, and the capacity to go to scale in the shortest timeframe?		May not be feasible in some areas Start-up may create dependency	Large geographic coverage possible	Large geographic coverage possible
	score			
RISKS				
Criterion # 11: Protection **(Weight:)** *Which response option offers fewer and more manageable intra-household and community protection risks for beneficiaries, with specific attention to those with special needs and vulnerabilities?*	Advantages / pros	yes	yes	Yes, but best one
	Disadvantages / cons	yes	May be	yes
	Score			
Criterion # 12: Operational, financial, and institutional risks **(Weight:)** *Which response option offers fewer and more manageable operational and institutional risks?*	Advantages / pros	More manageable	Less manageable	Medium
	Disadvantages / cons	yes	Medium disadvantages	Yes it will have
	Score			
Criterion # 13: Contextual risks **(Weight:)** *Which response option is more vulnerable to external factors and changing conditions?*	Advantages / pros	Medium risks	Lower risks	Low risks
	Disadvantages / cons	yes	Low risks	yes
	Score			
COSTS				
Criterion # 14: Costs and efforts for the organisation **(Weight:)** *Which of the response options has lower costs for the organisation?*	Observations and envisaged costs (list and estimated total)	High cost	*has lower costs*	Medium cost
	score			
Criterion # 15: Costs and efforts for the beneficiaries **(Weight:)** *Which of the response options is most convenient for the beneficiaries (in terms of costs incurred to benefit)?*	Observations and envisaged costs (list and estimated total)	yes	Little disadvantages	yes medium
Overall score **(WEIGHTED: maximum = ?)** **(UNWEIGHTED: maximum = 45)**				

Health cluster tables

Table 16: Population in severe need for health commodities

		IDPs			RESIDENT			
	Location	female-headed household	male-headed household		female-headed household	male-headed household		
% of household severly health commodity deprived	Babile	38%	42%		26%	18%		
	Hareshen	4%	8%		7%	0%		
	Kebribeyah	22%	10%		35%	8%		
	Tuliguled	29%	35%	**TOTAL**	59%	43%	**TOTAL**	**GRAND TOT**
Number of households severely health commodity deprived	Babile	938	3,045	**3,983**	1,096	2,228	**3,324**	**7,307**
	Hareshen	1	5	**6**	307	-	**307**	**313**
	Kebribeyah	74	98	**172**	3,177	2,133	**5,310**	**5,482**
	Tuliguled	120	569	**688**	9,105	19,489	**28,594**	**29,283**
	Total	**1,132**	**3,717**	**4,849**	**13,685**	**23,850**	**37,535**	**42,385**
Number of individuals severely affected	Babile	6,423	20,849	**27,272**	7,014	14,262	**21,276**	**48,548**
	Hareshen	6	38	**45**	1,966	-	**1,966**	**2,011**
	Kebribeyah	531	709	**1,240**	20,332	13,649	**33,982**	**35,222**
	Tuliguled	902	4,288	**5,190**	58,271	124,732	**183,003**	**188,193**
		7,863	**25,884**	**33,747**	**87,584**	**152,643**	**240,226**	**273,973**

Table 17: Population in severe need for health services

	IDPs		RESIDENT	
Location	female-headed household	male-headed household	female-headed household	male-headed household

% of household severly health service deprived	Babile	41%	47%		16%	26%		
	Hareshen	23%	26%		5%	2%		
	Kebribeyah	23%	13%		33%	8%		
	Tuliguled	26%	37%	**TOTAL**	61%	49%	**TOTAL**	**GRAND TOT**
Number of households severely affected?	Babile	1,012	3,407	**4,419**	674	3,219	**3,893**	**8,313**
	Hareshen	5	16	**21**	219	258	**477**	**499**
	Kebribeyah	77	128	**205**	2,995	2,133	**5,128**	**5,333**
	Tuliguled	107	601	**709**	9,414	22,209	**31,622**	**32,331**
	Total	**1,201**	**4,153**	**5,355**	**13,303**	**27,818**	**41,121**	**46,475**
Number of individuals severely affected?	Babile	6,930	23,331	**30,261**	4,316	20,600	**24,916**	**55,177**
	Hareshen	37	124	**161**	1,404	1,650	**3,054**	**3,216**
	Kebribeyah	555	922	**1,477**	19,171	13,649	**32,820**	**34,297**
	Tuliguled	809	4,533	**5,341**	60,247	142,136	**202,383**	**207,724**
	Total	**8,331**	**28,909**	**37,241**	**85,138**	**178,035**	**263,173**	**300,414**

Table 18: Causes and situation of unmet health needs

CAUSES AND SITUATION for unmet health commodity needs when IDP and vulnerable host populations need prescription medication they are able to obtain a prescription and the necessary drugs from a qualified provider without financial hardship.		
Immediate causes (including quality)	1, 2, 3 (order of frequency) (Source BNA)	7. insufficient purchasing power 8. insufficient assistance 9. insufficient access within the local market
How affected groups typically meet the need	1, 2, 3 (order of frequency) (Source BNA)	4. Local traders 5. Government assistance 6. NGO / local support However, in Babile the order is Government assistance; NGO / local support/ then trade.

How far do they need to travel to procure the relevant commodity / use the relevant service?	Average time for most popular source (Source BNA)	For the vast majority of people, the distance from their source of health commodities is less than one hour In Tuliguled it's mostly more than two hours)

Table 19: Costing health expenditure

	Item	Unit	Frequency (one-off, monthly etc)	Timing of expenditure	Quantity	Unit price	Total cost
One off expenditures **For patient and caregiver only**	Baby kit	Baby	One off, predictable	At birth			
	Medical and hospitalisation fees for catastrophic event	catastrophic event	One off, unpredictable	At catastrophic event			
	Transportation for catastrophic event (including ambulance)	catastrophic event	One off, (un)predictable	At catastrophic event			
	Accommodation for accompanying family members	Days	One off, unpredictable	At catastrophic event			
	Medicines/treatment for catastrophic event, illness	catastrophic event	One off, unpredictable	At catastrophic event, illness			
	Fees for professionally assisted delivery	Pregnancy	One off, predictable	At baby delivery			
	Immunisation fees	Lumpsum/baby	One off, predictable	At appropriate age			

TOTAL ONE-OFF (YEARLY) EXPENDITURES							
Recurrent **For patient**	Medicines for chronic health issues	Lumpsum	Recurrent, monthly	When stocks to be replenished			
	Therapeutic food	Person (PLW, child)	Recurrent, monthly	In presence of SAM and MAM			
	Healthcare fees for regular check-ups (antenatal, child)	PLW, child	Recurrent, monthly	Pregnancy and young childhood			
	Transportation for regular check-ups	Check-up	Recurrent, monthly	See above			
TOTAL RECURRENT EXPENDITURES							

Table 20: Overall comparative analysis of health response options (objective 1)

HEALTH OBJECTIVE 1 Increase provision of free or subsidised primary healthcare services to the most vulnerable populations in Babile (mostly IDPs), Tuliguled (mostly resident) and Kabribayah (mostly female-headed households) over the next 12 months				
CRITERIA	**Considerations**	**Response options**		
		Direct service provision (Mobile health units where services are far from population (Tuliguled); setting up and operating the clinics in areas with highest prevalence of severe needs)	Hire extra staff to increase service delivery capacity in existing primary healthcare centres, with an adequate skill mix	Subcontracting "capable" secondary service providers for complicated referred cases
ACCEPTANCE BY LOCAL AND NATIONAL AUTHORITIES				
Criterion # 1: Acceptance by authorities **(Weight:)** **If no, then option is vetoed and removed** *Is the response option acceptable for the local and national authorities in all the targeted locations? What concerns do / may they have?*	Yes / No / Not yet verified	This would be accepted. In IDP camps the health facilities have mostly a triage function. They actually want to have more teams	The government is up for it They have to get authorisation to work with PHC from health bureau and ministry. It has to be justified	
	Possible concerns (actual or anticipated)		Important to sit down and agree with the government. It requires	

			good relationship; it is coordination among partners	
	score			
APPROPRIATENESS (TAKEN FROM QUESTION 1)				
Criterion # 2: Suitability to objectives and target groups, according to beneficiaries **(Weight:)** *Is the response option appropriate to achieve the objectives? Is it the case for all intended groups? In all targeted locations?* *Are the target groups in the position to use and benefit from the response option, considering distance from providers, possible discrimination, cost incurred, security and protection risks?*	Advantages / pros	Bringing the service as close as possible to the people in need The service if free		
	Disadvantages / cons	Possibly not sustainable in the long term		
	Score			
Criterion # 3: Suitability to meet the objectives for target groups with special needs **(Weight:)** *Is the response option appropriate to achieve the objectives for people with special needs / vulnerabilities in all targeted locations?* *Are the identified groups with special needs in the position to use and benefit from the response option, considering distance from providers, possible discrimination, cost incurred, security and protection risks?*	Advantages / pros			
	Disadvantages / cons			
	Score			
Criterion # 4: Programme quality (quality standards, including Sphere standards) **(Weight:)** *Which response option offers the best chance of achieving: the minimum quality and quantity of commodities and services that target groups should get access to /*	Advantages / pros		Quality improvement of the services offered by the clinic Ensures an improved and more adequate skill mix	
	Disadvantages / cons	If they do not follow SOPs the service may be of low quality; for	It has to go hand in hand with infrastructures and facilities and commodities	

consume according to humanitarian standards?		instance they should have stocks of health commodities Unaccompanied children who may need specific psychosocial support Possible cases of GBV: they have to be able to refer them to specific providers		
	Score			
PUBLIC SERVICES AND MARKETS				
Criterion # 5: Capacity of existing public service systems (e.g. education, health, public water system, other essential services) **(Weight:)** *Do the local public services, facilities, and infrastructure have the capacity to support and respond positively, timely and at scale to the proposed response options?* *If not, how easily and efficiently can they be enabled?*	Advantages / pros	They would need to monitor the services and plan the locations where the health clinics or mobile units are set up	This is intended to support the public system, which is an inherent advantage of the option	
	Disadvantages / cons	Monitoring and follow up of all the different agencies providing this service is a challenge	Resistance from the existing staff against the newcomers Salaries are not the same hence there could be conflicts	
	score			
Criterion # 6: Consequences for the public service systems **(Weight:)** *Will the public service system and its facilities and infrastructure be damaged or supported by the proposed response option?*	Advantages / pros	These extra services reduce the burden and workload on the local services (especially those in permanent areas)	Strengthen the existing system Capacity to reach more people It ensures greater sustainability because leaves behind trained staff in the existing clinic	
	Disadvantages / cons	Disrupt the local healthcare service system	If there is no money to keep the staff after the project is finished, the extra personnel will be let go	
	score			
Criterion # 7: Capacity of market actors and private sector services **(Weight:)** *Do the relevant markets and private sector services have the capacity to*	Advantages / pros			
	Disadvantages / cons			
	score			

respond positively, timely and at scale to the proposed response option? *If not, how easily and efficiently can they be enabled?*				
Criterion # 8: Consequences for relevant market actors and private sector services **(Weight:)** *Will the market actors (or other parts of the system) be damaged or supported by the proposed response option? Examples of unintended negative effects on markets: reduced competition, reduced demand, higher prices.*	Advantages / pros		Those who do not have the money would not be clients anyway	
	Disadvantages / cons		May disrupt private healthcare providers;	
	score			
IMPLEMENTING AGENCIES' CAPACITY TO OPERATE AT SCALE AND IN A TIMELY MANNER				
Criterion # 9: Sector members' familiarity with the modality **(Weight:)** *In the targeted geographic areas, what portion of the sector members are familiar with the response option (# of experienced organisations out of total # of members)?*	Advantages / pros			
	Disadvantages / cons			
	score			
Criterion # 10: Capacity to start and go to scale (caseload size) in a short timeframe **(Weight:)** *In the targeted locations, which of the response options has the shortest start-up time for the sector partners, and the capacity to go to scale in the shortest timeframe?*	Advantages / pros	No infrastructure costs, can send the teams or use existing teams and structures Relying on existing infrastructures and teams, it does not need to be set up Fast start up for the mobile clinics; physical/stable facilities instead take time to be set up	Capacity to reach more people in the same timeframe Faster to do this As long as the government is not handling the budget it is faster.	
	Disadvantages / cons			
	score			
RISKS				
Criterion # 11: Protection **(Weight:)**	Advantages / pros	Reduces protection risks for those who have to travel far		

Which response option offers fewer and more manageable intra-household and community protection risks for beneficiaries, with specific attention to those with special needs and vulnerabilities?	Disadvantages / cons	Risks for the teams, who may be from different clan and be exposed to risks of violence	Protection risks for the households living far from the centre	
	Score			
Criterion # 12: Operational, financial, and institutional risks **(Weight:)** *Which response option offers fewer and more manageable operational and institutional risks?*	Advantages / pros			
	Disadvantages / cons	Security and access for mobile health clinics is an issue in certain areas, when they cross boundaries Bribery when trying to access Reputational risk for the organisation that is setting up the clinic or mobile unit	Reputational risk for the organisation that is hiring the staff Line management lines are blurred; less supervisory authority on the staff Strengthen coordination and response mechanisms between stakeholders	
	Score			
Criterion # 13: Contextual risks **(Weight:)** *Which response option is more vulnerable to external factors and changing conditions?*	Advantages / pros			
	Disadvantages / cons	Security risks may disrupt the services		
	Score			
COSTS				
Criterion # 14: Costs and efforts for the organisation **(Weight:)** *Which of the response options has lower costs for the organisation?*	Observations and envisaged costs (list and estimated total)	No infrastructure costs, can send the teams or use existing teams and structures Mobile clinics instead have a cost: vehicle; salary of staff (4-5 each unit); health commodities	Expanding the facility to accommodate for extra staff; stocks; efforts to coordinate with partners and government	
	score			
Criterion # 15: Costs and efforts for the beneficiaries **(Weight:)**	Observations and envisaged costs (list and estimated total)	Free for beneficiaries; when the mobile health clinics cannot access		

Which of the response options is most convenient for the beneficiaries (in terms of costs incurred to benefit)?		the community then beneficiaries have to walk		
Overall score (WEIGHTED: maximum = ?) (UNWEIGHTED: maximum = 45)				

Table 21: Overall comparative analysis of health response options (objective 2)

HEALTH OBJECTIVE **Ensure increased access to RH to women in reproductive age and PLW in Babile (mostly IDPs), Tuliguled (mostly resident, far away from services) and Kabribayah (mostly female-headed households) over the next 12 months**				
		Response options		
CRITERIA	**Considerations**	Conditional cash transfer to referred women in multiple tranches of a value corresponding to the costs associated to ANC, skilled delivery, PNC. Recommended mild conditionality, that they get at least one awareness raising session during ANC out of the preferred three	Voucher (AKA referral slip) to referred women for family planning, antenatal care/check-ups to pregnant women, assisted delivery (including abortion), complicated case/advanced services and post-natal care to lactating women	Direct service provision to referred women: family planning, antenatal care/check-ups to pregnant women, skilled delivery (including abortion), complicated case/advanced services, and post-natal care to lactating women NA NA
ACCEPTANCE BY LOCAL AND NATIONAL AUTHORITIES				
Criterion # 1: Acceptance by authorities **(Weight:)** **If no, then option is vetoed and removed** *Is the response option acceptable for the local and national authorities in all the targeted locations? What concerns do / may they have?*	Yes / No / Not yet verified	Not yet verified	Not yet verified	Yes, currently accepted and in use
	Possible concerns (actual or anticipated)	This has never been done so agreements must be made first with the regional health bureau	This has never been done so agreements must be made first with the regional health bureau	
	score			
APPROPRIATENESS (TAKEN FROM QUESTION 1)				
Criterion # 2: Suitability to objectives and target groups, according to beneficiaries **(Weight:)**	Advantages / pros	Easier and faster access to health services Flexibility, wherever they are (camps or informal settings); can		Immediate solution to the problem, for free for beneficiaries, without administrative set up of the cash component

Is the response option appropriate to achieve the objectives? Is it the case for all intended groups? In all targeted locations? *Are the target groups in the position to use and benefit from the response option, considering distance from providers, possible discrimination, cost incurred, security and protection risks?*		be used also for transportation which is a cost This is mostly suitable for Kebribeyah Empowerment, especially for household headed by women The conditionality adds an awareness raising component Along the preferences of the households		
	Disadvantages / cons	If services are far away, this is not suitable to meet needs May be used for other purposes		
	Score			
Criterion # 3: Suitability to meet the objectives for target groups with special needs **(Weight:)** *Is the response option appropriate to achieve the objectives for people with special needs / vulnerabilities in all targeted locations?* *Are the identified groups with special needs in the position to use and benefit from the response option, considering distance from providers, possible discrimination, cost incurred, security and protection risks?*	Advantages / pros			
	Disadvantages / cons			
	Score			
Criterion # 4: Programme quality (quality standards, including Sphere standards) **(Weight:)** *Which response option offers the best chance of achieving: the minimum quality and quantity of commodities and services that target groups should get access to / consume according to humanitarian standards?*	Advantages / pros	Chances to have access to skilled birth attendants, rather than cheap or free unskilled birth attendants	Compared to cash, control over quality of service providers that would be selected at the start of the project	Allows to monitor and evaluate the quality of the services and have control over tehm and make changes when needed
	Disadvantages / cons	No control over the quality of the service. No quality assurance		
	Score			

PUBLIC SERVICES AND MARKETS				
Criterion # 5: Capacity of existing public service systems (e.g. education, health, public water system, other essential services) **(Weight:)** *Do the local public services, facilities, and infrastructure have the capacity to support and respond positively, timely and at scale to the proposed response options?* *If not, how easily and efficiently can they be enabled?*	Advantages / pros			Provides lessons learned for replicable model that can be transferred to existing service
	Disadvantages / cons	May not be sustainable What happens when the project is over? → at a certain point there need to be a graduation through scale up of public services		
	score			
Criterion # 6: Consequences for the public service systems **(Weight:)** *Will the public service system and its facilities and infrastructure be damaged or supported by the proposed response option?*	Advantages / pros			Support to the existing system
	Disadvantages / cons			
	score			
Criterion # 7: Capacity of market actors and private sector services **(Weight:)** *Do the relevant markets and private sector services have the capacity to respond positively, timely and at scale to the proposed response option?* *If not, how easily and efficiently can they be enabled?*	Advantages / pros			
	Disadvantages / cons	Situation not known		
	score			
Criterion # 8: Consequences for relevant market actors and private sector services **(Weight:)** *Will the market actors (or other parts of the system) be damaged or supported by the proposed response option? Examples of unintended negative effects on markets: reduced competition, reduced demand, higher prices.*	Advantages / pros			
	Disadvantages / cons			
	score			

IMPLEMENTING AGENCIES' CAPACITY TO OPERATE AT SCALE AND IN A TIMELY MANNER				
Criterion # 9: Sector members' familiarity with the modality **(Weight:)** *In the targeted geographic areas, what portion of the sector members are familiar with the response option (# of experienced organisations out of total # of members)?*	Advantages / pros	Health sector not familiar with CTP, but there is cash expertise in other sectors		Agencies are familiar with doing this
	Disadvantages / cons			
	score			
Criterion # 10: Capacity to start and go to scale (caseload size) in a short timeframe **(Weight:)** *In the targeted locations, which of the response options has the shortest start-up time for the sector partners, and the capacity to go to scale in the shortest timeframe?*	Advantages / pros	Yes, more than direct service provision, if private healthcare service providers are available and of quality Slow start-up because agreements have to be made with regional health bureau Once agreements are signed, may be faster to set up than vouchers and in-kind		
	Disadvantages / cons			
	score			
RISKS				
Criterion # 11: Protection **(Weight:)** *Which response option offers fewer and more manageable intra-household and community protection risks for beneficiaries, with specific attention to those with special needs and vulnerabilities?*	Advantages / pros	Reduced exposure to harmful coping strategies especially for female-headed household Use awareness raising sessions as an opportunity to talk about sensitive and important matters such as FGM (and therefore reduce them)		
	Disadvantages / cons	Potential intra-household conflicts in a male-headed household		
	Score			
	Advantages / pros			

Criterion # 12: Operational, financial, and institutional risks **(Weight:)** *Which response option offers fewer and more manageable operational and institutional risks?*	Disadvantages / cons	Potential drop-out of beneficiaries who are unable to comply with conditionalities		
	Score			
Criterion # 13: Contextual risks **(Weight:)** *Which response option is more vulnerable to external factors and changing conditions?*	Advantages / pros			
	Disadvantages / cons			
	Score			
COSTS				
Criterion # 14: Costs and efforts for the organisation **(Weight:)** *Which of the response options has lower costs for the organisation?*	Observations and envisaged costs (list and estimated total)	Additional administrative costs especially to monitor conditionalities		
	score			
Criterion # 15: Costs and efforts for the beneficiaries **(Weight:)** *Which of the response options is most convenient for the beneficiaries (in terms of costs incurred to benefit)?*	Observations and envisaged costs (list and estimated total)	Effort to attend the sessions		
Overall score **(WEIGHTED: maximum = ?)** **(UNWEIGHTED: maximum = 45)**				

Table 22: Overall comparative analysis of health response options (objective 3)

OBJECTIVE 3 When IDP and vulnerable host populations need prescription medication they are able to obtain a prescription and the necessary drugs from a qualified provider without financial hardship.		
CRITERIA	**Considerations**	**Response options**

		Provide existing public primary care facilities with key medicines in sufficient quantities to meet demand from vulnerable residents and IDPs and provide training to key staff	Directly pay the community-based insurance healthcare premiums of vulnerable resident and IDPs	Provide vulnerable resident and IDPs who are referred by primary health clinics or registered medical professionals with a cash transfer to cover the costs of key medicines as well as associated incurred costs of transport and food	Reimburse hospitals (on provision of receipts) for the costs of providing vulnerable resident and IDPs who are referred with prescribed medicines
ACCEPTANCE BY LOCAL AND NATIONAL AUTHORITIES					
Criterion # 1: Acceptance by authorities **(Weight:)** **If no, then option is vetoed and removed** *Is the response option acceptable for the local and national authorities in all the targeted locations? What concerns do / may they have?*	Yes / No / Not yet verified	Yes	Yes, community-based insurance schemes are accepted	Cash is accepted for other commodities and services but has not been used to systematically meet health care / commodity needs	Yes, currently used.
	Possible concerns (actual or anticipated)			Cash for health needs has not yet been tested and the MofH may object	
	score				
APPROPRIATENESS (TAKEN FROM QUESTION 1)					
Criterion # 2: Suitability to objectives and target groups, according to beneficiaries **(Weight:)** *Is the response option appropriate to achieve the objectives? Is it the case for all intended groups? In all targeted locations?* *Are the target groups in the position to use and benefit from the response option, considering distance from providers, possible discrimination, cost incurred, security and protection risks?*	Advantages / pros	People have access to free, quality, medicines and will reduce their health expenditures	People have access to free, quality, medicines and will reduce their health expenditures	All costs of medicine and access to medicine can be covered.	People have access to free, quality, medicines and will reduce their health expenditures
	Disadvantages / cons	Costs of accessing medicines still exist and this will potentially cause financial hardship	Costs of accessing medicines still exist and this will potentially cause financial hardship May still have to pay upfront costs as insurance will only pay out retrospectively.	No guarantee of quality. Does not address issues of stock-outs in the private pharmacies / clinics.	Costs of accessing medicines still exist and this will potentially cause financial hardship.

			Does not address issues of stock-outs in the private pharmacies / clinics.		
	Score				
Criterion # 3: Suitability to meet the objectives for target groups with special needs **(Weight:)** *Is the response option appropriate to achieve the objectives for people with special needs / vulnerabilities in all targeted locations?* *Are the identified groups with special needs in the position to use and benefit from the response option, considering distance from providers, possible discrimination, cost incurred, security and protection risks?*	Advantages / pros				
	Disadvantages / cons		IDPs are not currently included in community-based insurance schemes		
	Score				
Criterion # 4: Programme quality (quality standards, including Sphere standards) **(Weight:)** *Which response option offers the best chance of achieving: the minimum quality and quantity of commodities and services that target groups should get access to / consume according to humanitarian standards?*	Advantages / pros	Medicine quality standards assured	Medicine quality standards assured		Medicine quality standards assured
	Disadvantages / cons			Medicine quality standards not assured	
	Score				
PUBLIC SERVICES AND MARKETS					
Criterion # 5: Capacity of existing public service systems (e.g. education, health, public water system, other essential services) **(Weight:)** *Do the local public services, facilities, and infrastructure have the capacity to support and respond positively, timely and at scale to the proposed response options?* *If not, how easily and efficiently can they be enabled?*	Advantages / pros				
	Disadvantages / cons				
	score				
Criterion # 6: Consequences for the public service systems **(Weight:)**	Advantages / pros	Improve access to medicine in the short-term and in the longer term (through			

Will the public service system and its facilities and infrastructure be damaged or supported by the proposed response option?		provision of medicines and training respectively)			
	Disadvantages / cons		Focus is on provision of private health medicines so may undermine public health care provision	Focus is on provision of private health medicines so may undermine public health care provision	Focus is on provision of private health medicines so may undermine public health care provision
	score				
Criterion # 7: Capacity of market actors and private sector services **(Weight:)** *Do the relevant markets and private sector services have the capacity to respond positively, timely and at scale to the proposed response option?* *If not, how easily and efficiently can they be enabled?*	Advantages / pros				
	Disadvantages / cons		In areas where coverage of community-based insurance if low (possibly Somali Region) widening coverage may be a slow process and market actors may be unwilling to do this unless appropriately incentivised.	Substantive lack of medication is some areas that may not be improved by increased demand	
	score				
Criterion # 8: Consequences for relevant market actors and private sector services **(Weight:)** *Will the market actors (or other parts of the system) be damaged or supported by the proposed response option? Examples of unintended negative effects on markets: reduced competition, reduced demand, higher prices.*	Advantages / pros				
	Disadvantages / cons		May lead to increased demand / inflation of medicine costs (which would then have to be addressed through government rules and enforcement of standard pricing)	Can't address stock-out issues in private sector (beyond increasing demand which may increase supply) May lead to increased demand / inflation of medicine costs (which would then have to be addressed through government rules and enforcement of standard pricing)	
	score				
IMPLEMENTING AGENCIES' CAPACITY TO OPERATE AT SCALE AND IN A TIMELY MANNER					
Criterion # 9: Sector members' familiarity with the modality **(Weight:)**	Advantages / pros	Sector very familiar with this approach across all geographic areas	Health sector familiar with community-based insurance schemes		Reimbursement of service costs done in other sectors in

In the targeted geographic areas, what portion of the sector members are familiar with the response option (# of experienced organisations out of total # of members)?					Ethiopia and in other countries for health
	Disadvantages / cons			No experience within the Ethiopian health sector of CTs	Not done in health in Ethiopia
	score				
Criterion # 10: Capacity to start and go to scale (caseload size) in a short timeframe **(Weight:)** *In the targeted locations, which of the response options has the shortest start-up time for the sector partners, and the capacity to go to scale in the shortest timeframe?*	Advantages / pros	Can go to scale quickly (if medicine stocked locally as restocking of facilities is usually done each week and changes in demand can be readily adapted to)	Can be done quickly if community-based insurance covers this area	Cash in hand can be set-up / distributed quickly If e-transfer / mobile money systems already available for other sectors can piggy back on this	Can usually be done quickly, especially if agreements already exist with hospitals. However, hospitals are susceptible to stock-outs due to access / transportation issues.
	Disadvantages / cons		However, in areas where community-based insurance coverage is low (including possibly Somali Region) this could be a slow process	Capacity to start this approach quickly limited by inexperience within sector	
	score				
RISKS					
Criterion # 11: Protection **(Weight:)** *Which response option offers fewer and more manageable intra-household and community protection risks for beneficiaries, with specific attention to those with special needs and vulnerabilities?*	Advantages / pros				
	Disadvantages / cons				
	Score				
Criterion # 12: Operational, financial, and institutional risks **(Weight:)** *Which response option offers fewer and more manageable operational and institutional risks?*	Advantages / pros				
	Disadvantages / cons				
	Score				
Criterion # 13: Contextual risks **(Weight:)**	Advantages / pros				

Which response option is more vulnerable to external factors and changing conditions?	Disadvantages / cons				
	Score				
COSTS					
Criterion # 14: Costs and efforts for the organisation **(Weight:)** *Which of the response options has lower costs for the organisation?*	Observations and envisaged costs (list and estimated total)			Would require developing cash capacity within the health sector staff	
	score				
Criterion # 15: Costs and efforts for the beneficiaries **(Weight:)** *Which of the response options is most convenient for the beneficiaries (in terms of costs incurred to benefit)?*	Observations and envisaged costs (list and estimated total)	Costs of transport and food whilst accessing medicines still incurred	Costs of transport and food whilst accessing medicines still incurred (unless insurance also covers these) Costs of medicines likely incurred upfront	No additional costs (except to travel to distribution site)	Costs of transport and food whilst accessing medicines still incurred
Overall score **(WEIGHTED: maximum = ?)** **(UNWEIGHTED: maximum = 45)**					

ES/NFI cluster tables

Table 23: Estimation of people in severe need of shelter structures

		IDPs			RESIDENT			
	Location	female-headed household	male-headed household		female-headed household	male-headed household		
% of household severly shelter / structure deprived	Babile	27%	44%		23%	13%		
	Hareshen	35%	24%		9%	5%		
	Kebribeyah	24%	11%		37%	8%		
	Tuliguled	34%	53%	**TOTAL**	65%	60%	**TOTAL**	**GRAND TOT**
Number of households	Babile	666	3,190	**3,856**	969	1,609	**2,579**	**6,435**

severely affected?	Hareshen	8	15	**23**	395	645	**1,040**	**1,062**
	Kebribeyah	80	108	**189**	3,358	2,133	**5,491**	**5,680**
	Tuliguled	140	861	**1,002**	10,031	27,194	**37,225**	**38,227**
	Total	**895**	**4,175**	**5,069**	**14,754**	**31,581**	**46,335**	**51,404**
Number of individuals severely affected?	Babile	4,564	21,842	**26,406**	6,205	10,300	**16,505**	**42,910**
	Hareshen	57	114	**171**	2,528	4,125	**6,653**	**6,824**
	Kebribeyah	579	780	**1,359**	21,494	13,649	**35,144**	**36,503**
	Tuliguled	1,058	6,493	**7,550**	64,197	174,044	**238,241**	**245,792**
	Total	**6,258**	**29,229**	**35,486**	**94,424**	**202,118**	**296,542**	**332,029**

Table 24: Estimation of people in severe need of shelter commodities

		IDPs			RESIDENT			
	Location	female-headed household	male-headed household		Female-Headed household	male-headed household		
% of household severly shelter commodity deprived	Babile	27%	39%		0%	8%		
	Hareshen	31%	26%		3%	3%		
	Kebribeyah	33%	15%		51%	17%		
	Tuliguled	42%	54%	**TOTAL**	74%	54%	**TOTAL**	**GRAND TOT**
Number of households severely affected?	Babile	666	2,827	**3,494**	-	990	**990**	**4,484**
	Hareshen	7	16	**23**	132	387	**518**	**542**

	Kebribeyah	111	148	**258**	4,629	4,532	**9,161**	**9,420**
	Tuliguled	173	878	**1,051**	11,420	24,475	**35,895**	**36,945**
	Total	**957**	**3,869**	**4,826**	**16,181**	**30,384**	**46,565**	**51,391**
Number of individuals severely affected?	Babile	4,564	19,360	**23,924**	-	6,338	**6,338**	**30,262**
	Hareshen	50	124	**174**	843	2,475	**3,318**	**3,492**
	Kebribeyah	797	1,063	**1,860**	29,627	29,005	**58,632**	**60,492**
	Tuliguled	1,307	6,615	**7,922**	73,086	156,640	**229,726**	**237,648**
	Total	**6,717**	**27,162**	**33,880**	**103,556**	**194,458**	**298,014**	**331,894**

Table 25: Estimation of people in severe need of household items

		IDPs			RESIDENT			
	Location	female-headed HOUSEHOLD	male-headed HOUSEHOLD		female-headed HOUSEHOLD	male-headed HOUSEHOLD		
% of household severly household item deprived	Babile	35%	33%		7%	18%		
	Hareshen	15%	15%		6%	4%		
	Kebribeyah	22%	14%		33%	10%		
	Tuliguled	32%	34%	**TOTAL**	59%	40%	**TOTAL**	**GRAND TOT**
Number of households severely affected?	Babile	864	2,392	**3,256**	295	2,228	**2,523**	**5,780**
	Hareshen	3	10	**13**	263	516	**779**	**792**
	Kebribeyah	74	138	**212**	2,995	2,666	**5,661**	**5,873**

	Tuliguled	132	553	**685**	9,105	18,130	**27,234**	**27,919**
	Total	**1,073**	**3,092**	**4,165**	**12,659**	**23,539**	**36,198**	**40,363**
Number of individuals severely affected?	Babile	5,916	16,382	**22,297**	1,888	14,262	**16,150**	**38,447**
	Hareshen	24	72	**96**	1,685	3,300	**4,985**	**5,081**
	Kebribeyah	531	993	**1,524**	19,171	17,062	**36,232**	**37,756**
	Tuliguled	996	4,165	**5,161**	58,271	116,029	**174,301**	**179,461**
	Total	**7,467**	**21,611**	**29,077**	**81,016**	**150,653**	**231,668**	**260,746**

Table 26: How shelter needs are usually met

CAUSES AND SITUATION for unmet shelter structure needs		
Immediate causes (including quality)	1, 2, 3 (order of frequency) (Source BNA)	10. insufficient purchasing power 11. insufficient assistance 12. insufficient infrastructure within the local market
How affected groups typically meet the need	1, 2, 3 (order of frequency) (Source BNA)	7. Local traders 8. Nature (for Babile and Tuliguled only) / own supply (for Hareshen and Kebribeyah) 9. NGO / local support (for Hareshen and Kebribeyah over 90% is covered by the first two options)
How far do they need to travel to procure the relevant commodity / use the relevant service?	Average time for most popular source (Source BNA)	For the vast majority of people, the distance from their source of shelter structure commodities is less than one hour In Tuliguled it's mostly more than two hours

Table 27: Calculating the expenditure gap

Category	**Desired expenditure for recurrent costs per HH (according the HHs)**	**Actual expenditure for recurrent costs per HH (from BNA)**	**Expenditure gap per HH** ***MPG amount***

	IDP HHs	Resident HHs	IDP HHs	Resident HHs	IDP HHs	Resident HHs
Shelter structure & housing	186 ETB	170 ETB	95 ETB	133 ETB	91 ETB	37 ETB
HH items	320 ETB	260 ETB	247 ETB	248 ETB	73 ETB	12 ETB

Table 28: Calculating a shelter MEB

Item	Household item or shelter	Frequency	Quantity	Unit price per child (ETB)	Total ETB
Jerry Can 20 Lt -non-collapsible, plastic, white	household item	once a year	1	132.00	132
Cooking pot -Aluminium, 7 Lt, with lid and handles	household item	once a year	2	235.00	470
Drinking cup with Handle –Stainless Steel 300 ml	household item	once a year	5	20.00	100
Plate –Individual plate, round, Stainless steel 30cm	household item	once a year	5	20.00	100
Bowl	household item	once a year	2	150.00	300
Aluminium or Stainless Kettle, 2L capacity	household item	once a year	1	130.00	130
Sleeping mat -2 m x 2.5 m, plastic woven	household item	once a year	2	135.00	270
Mosquito Net –Square, WHO Standard, Impregnated	household item	once a year	2	264.00	528
Soap –Multipurpose (washing & laundry), 250g	household item	once a year	4	110.00	440
Cooking Ladle –Stainless Steel , 125 ml	household item	once a year	1	32.00	32
Blanket –Wool, 1.60 m x 2.20 m, 2 kg (+/-5%)	household item	once a year	2	574.00	1148

Solar lamp	household item	once a year	1	500.00	500
energy saving stove	household item	once a year	1	500.00	500
charcoal	household item	recurrent	2	200.00	400
Canvas NFI Bag with strong straps, Size L=65cm, H=70cm W=40cm	Shelter	once a year	1	170.00	170
Plastic Sheeting-4*5	Shelter	once a year	2	766.22	1532.44
Rope -20 m, plastic, strong 6mm	Shelter	once a year	2	69.00	138
transportation					
Total					3016.22

Table 29: Overall comparative analysis of NFI response options (objective 1)

OBJECTIVE **Ensure access to life saving ES/NFI for 75% of the vulnerable IDPs in Babile and Tuligulip within six months from the time of displacement**					
CRITERIA	**Considerations**	**Response options**			
		[One off Unconditional Cash Based Response]	[Direct Service]	[one off In-Kind distribution]	[Combined cash and in-kind]
ACCEPTANCE BY LOCAL AND NATIONAL AUTHORITIES					
	Yes / No / Not yet verified	Yes	Yes	Yes	Yes
Criterion # 1: Acceptance by authorities **(Weight:)** **If no, then option is vetoed and removed** *Is the response option acceptable for the local and national authorities in all the targeted locations? What concerns do / may they have?*	Possible concerns (actual or anticipated)	-Lack of service providers -Distance to Market – Tuligulib Security -Beneficiary preference -flexibility	Inadequate skilled labour for latrine, communal shelter and shelter construction	Road access Time taken to procure	See under cash and in-kind
	score	3	1	2	2.5
APPROPRIATENESS (TAKEN FROM QUESTION 1)					

Criterion # 2: Suitability to objectives and target groups, according to beneficiaries **(Weight:)** *Is the response option appropriate to achieve the objectives? Is it the case for all intended groups? In all targeted locations?* *Are the target groups in the position to use and benefit from the response option, considering distance from providers, possible discrimination, cost incurred, security and protection risks?*	Advantages / pros	-quicker -functioning markets -favourable policy environment -preference and acceptability by IDPs -economic benefit to local markets	- Income to local skilled individuals/HHs - quality infrastructure - protects environment and the IDPs from disease -	- Access where there is no functioning markets - Communities are not affected by inflation	-complementary
	Disadvantages / cons	- High inflation - -un-intended use - High service charge cost by SP	-Lack of quality materials -deserted if IDPs are resettled elsewhere	-takes long to programme and deliver -quaity of items purchased -Sold by IDPs affecting local market prices -May not be IDP preference	-burden on Humanitarian organisation to plan and organise -likely to take time
	Score	3	1.5	1	2
Criterion # 3: Suitability to meet the objectives for target groups with special needs **(Weight:)** *Is the response option appropriate to achieve the objectives for people with special needs / vulnerabilities in all targeted locations?* *Are the identified groups with special needs in the position to use and benefit from the response option, considering distance from providers, possible discrimination, cost incurred, security and protection risks?*	Advantages / pros	-prioritize how they meet their needs Empower them -	-can be tailored to meet special needs -no additional direct costs to those with disabilities	-Access where there is no functioning markets -Communities are not affected by inflation	complementary
	Disadvantages / cons	- challenges of moving to the markets and require support	-does not benefit many of the IDPs directly	- may not address their special needs	
	Score	3	2	1	2
Criterion # 4: Programme quality (quality standards, including Sphere standards) **(Weight:)** *Which response option offers the best chance of achieving: the minimum quality and quantity of commodities and services that target groups*	Advantages / pros	-Meets specific needs of different HH members -timeliness of response -reach more IDPs compared to in-kind	- Reduction of communicable diseases -social needs – related to the communal shelter - protection from elements -quality construction using standards	-meet people's needs where there is no functioning markets -control quality standards -	-Control standards and quality of items -Cash complementary

should get access to / consume according to humanitarian standards?	Disadvantages / cons	-may purchase items of lesser standards/quality -	No major disadvantage	Sell of materials Exchange for low quality items	Response Quality may be compromised- human resource stretched
	Score	3	2	1.5	2
PUBLIC SERVICES AND MARKETS					
Criterion # 5: Capacity of existing public service systems (e.g. education, health, public water system, other essential services) **(Weight:)** *Do the local public services, facilities, and infrastructure have the capacity to support and respond positively, timely and at scale to the proposed response options?* *If not, how easily and efficiently can they be enabled?*	Advantages / pros				
	Disadvantages / cons				
	score				
Criterion # 6: Consequences for the public service systems **(Weight:)** *Will the public service system and its facilities and infrastructure be damaged or supported by the proposed response option?*	Advantages / pros				
	Disadvantages / cons				
	score				
Criterion # 7: Capacity of market actors and private sector services **(Weight:)** *Do the relevant markets and private sector services have the capacity to respond positively, timely and at scale to the proposed response option?* *If not, how easily and efficiently can they be enabled?*	Advantages / pros	-market activated due to increased demand -frequency restocking -economic benefit for market actors eg. traders -increased demand leading to increased trade -access to credit/loans -increased investment -improved relationship and trust between IDPs and vendors	-high income for the skilled labourer -engagement of the skilled IDPs in income generation -skills transfer	-engagement of transporters - -benefits -purchase in larger market	-Market actors benefit including vendors, transporters -items not available are provided in good quality
	Disadvantages / cons	-monopolizing trade -increased completion	- lack of intended capacity/skill Availability of skilled persons	-purchase in larger market to the disadvantage of the local economy	-not high benefits compared to full cash

		- legally registered/licenced trade -high cost of service provision	-The cash benefits few people -seasonal access Distortion of labour market -insecurity -road closure	-distortion of market prices due to sell of in-kind support (deflation) -Demotivation for market actors	
	score	3	2	1	2
Criterion # 8: Consequences for relevant market actors and private sector services **(Weight:)** *Will the market actors (or other parts of the system) be damaged or supported by the proposed response option? Examples of unintended negative effects on markets: reduced competition, reduced demand, higher prices.*	Advantages / pros	-multiplier effects of cash on markets and the actors therein - market interconnectedness and flow of commodities -market actor competition -basic needs met with dignity -less likely to be shared	-multiplier effects of purchases on markets and the actors therein e.g. Purchase of construction materials -improved skills -working relations and capacity (btwn market actors and Humanitarian)	-transporters benefit -daily labourers benefit -Fuel supplier benefit -warehousing -can meet specific standards -basic needs met	-No pressure on local suppliers -positive market connectedness
	Disadvantages / cons	-inflation will affect all -too much cash can cause supply shortages of targeted commodities	- humanitarian actors may not achieve their objectives -beneficiaries will not get a timely assistance -Standards may not be met	-discourage market actors - markets less connected/competitive -long period of planning ad organisation/distribution -inadequate warehousing -impact of security causing delays -importation permits/delays -enhances culture of sharing	-no full benefit to markets/actors
	score	3	2	1	2
IMPLEMENTING AGENCIES' CAPACITY TO OPERATE AT SCALE AND IN A TIMELY MANNER					
Criterion # 9: Sector members' familiarity with the modality **(Weight:)** *In the targeted geographic areas, what portion of the sector members are familiar with the*	Advantages / pros	-Many individuals trained -capacity internationally that can be tapped on -cluster capacity can be tapped on	-humanitarian actors familiar and having the capacity availability of the service providers	-has been used for long and lots of experience -procurement/finance departments supporting	-provides opportunity for a well-balanced response -provides opportunity for learning and gives orgs' flexibility

response option (# of experienced organisations out of total # of members)?		-coordination forums availing experience sharing -donors familiar and willingness to invest in cash response		-advanced re-stocking by supplier in anticipation of humanitarian response	
	Disadvantages / cons	-cash at scale -operations staff in some agencies not well trained or familiar -availability of technology by service providers -inadequate skilled manpower to support CTP	-service provider challenges -in some cases, service providers not available in remote areas -capacity of the service providers a challenges in some locations	-delays by suppliers as there are not many options e.g. In country -quality specification by suppliers	-less experience by humanitarian actors -requires manpower to organise and deliver
	score	2.5	2	2	2
Criterion # 10: Capacity to start and go to scale (caseload size) in a short timeframe **(Weight:)** *In the targeted locations, which of the response options has the shortest start-up time for the sector partners, and the capacity to go to scale in the shortest timeframe?*	Advantages / pros	-capacity available and accessible -cluster capacity and support system -ongoing training of different cluster members -policy environment and government awareness of cash -contracts with service providers in place	- Availability of labour force - Availability of materials at local market - The market is with low price Willingness of government actors	- There is good experience and most partners have the experience - Functionality of the central market Availability of market actors who are willing to engage	- Gives partners to use both options with flexibility and considering the market - Supports timely delivery Easy address the beneficiary needs
	Disadvantages / cons	-inadequate technological solutions for CTP	- Requires trained man power to mobilize skilled labour - In some areas there will be lack of trained man power	- Market price fluctuation, due to devaluation of ETB - Delay of material delivery - Will affect the income of local market actors, due to the in-kind support - Limits beneficiaries interest/options - Affects local market price; will create deflation on the market price	- Requires both pipeline and cash manpower Stretches programme staff

				- Requires high manpower - Requires high operational cost High cost of physical structure like warehouse	
	score	3			
RISKS					
Criterion # 11: Protection **(Weight:)** *Which response option offers fewer and more manageable intra-household and community protection risks for beneficiaries, with specific attention to those with special needs and vulnerabilities?*	Advantages / pros	-meets specific needs -flexibility -support systems with other HH members	- Will provide the required skill to the beneficiary without any ups and down - Better quality service and user friendly structures will be constructed Contributes to the dignity and builds their confidence	- Protect beneficiaries to travel in insecure areas to purchase the items - Quality material in organized way will be provided	- Helps to identify the right item that meets their need - Provides the IDPs better option to fill their need - Provides the chance to interact with the host community
	Disadvantages / cons	-people with disability may need assistance to travel to markets to use cash	- Will create dependence on skilled manpower Will limit their interaction with the hosting community	- Will limit their need and preferences Limits the interaction between the IDPs and hosting community	- Doesn't give full right to the beneficiaries
	Score	3			
Criterion # 12: Operational, financial, and institutional risks **(Weight:)** *Which response option offers fewer and more manageable operational and institutional risks?*	Advantages / pros	-training opportunities -institutional capacity -lower manpower - no need for warehousing -minimal logistical support -	- Fewer people to deal with - Easy management	- Long-term contract with specific vendors - The risk related to cash movement is less Availability of market actors in the larger markets	- Helps to consider materials with short delivery time line Gives flexibility to consider both options
	Disadvantages / cons	-mismanagement - misappropriation -Lack of preparedness plans in some cases	- Will require time to sign contract with service providers, skilled - Needs time to open account - Needs skilled manpower/engineers to	- Requires high man power - Longer period of procurement and delivery - Risks related to transportation where there is insecurity - Cn be exposed to corruption	- Requires high number of staffing - Required skilled manpower on both cash and in-kind

			specify the needed services - Needs high operational manpower Lack of skilled service providers	- It will affect the relation between humanitarian actors and local vendors - Risk of theft	
	Score				
Criterion # 13: Contextual risks **(Weight:)** *Which response option is more vulnerable to external factors and changing conditions?*	Advantages / pros	-if done well, there are minimal risks -having preparedness plans and scenarios for risk mitigation	- Less negative external factors	- Availability of experienced suppliers - Availability of market	Risk can be minimized considering either of response options
	Disadvantages / cons	- depended on new methods of transfer that sometimes require prior training -inflation -ETB devaluation -conflict/insecurity	- Risk of corruption - Fluctuation of prices - Risk of insecurity Access to land	- Risk of corruption - Fluctuation of prices Risk of insecurity - Risk of contraband Pipeline breakage	- Risk of corruption - Fluctuation of prices Risk of insecurity
	Score	2			
COSTS					
Criterion # 14: Costs and efforts for the organisation **(Weight:)** *Which of the response options has lower costs for the organisation?*	Observations and envisaged costs (list and estimated total)	-transfer cost -Beneficiary withdrawal costs if any -training costs - SP transactional cost - disbursement, M&E - Market assessment cost			
	score	2.5			
Criterion # 15: Costs and efforts for the beneficiaries **(Weight:)**	Observations and envisaged costs (list and estimated total)	-agencies bear the costs of transfer so beneficiaries do not have to pay anything -transport cost in the MEB			

Which of the response options is most convenient for the beneficiaries (in terms of costs incurred to benefit)?					
Overall score (WEIGHTED: maximum = ?) (UNWEIGHTED: maximum = 45)					

Table 30: Overall comparative analysis of durable shelter response options (objective 2)

	OBJECTIVE Support voluntary return and reintegration for 30% displaced HH trough durable shelter solution in Babile and Tulguled						
CRITERIA	**Considerations**		**Response options**				
		Restricted commodity voucher for tools + transitional shelter kit	Restricted CASH voucher for tools + transitional shelter kit	Unrestricted CASH voucher for tools + transitional shelter kit	In Kind distribution for tools + transitional shelter kit	Service provision for transitional shelter - materials + labour provision	Conditional (training) CASH for transitional kit
ACCEPTANCE BY LOCAL AND NATIONAL AUTHORITIES							
Criterion # 1: Acceptance by authorities **(Weight:)** **If no, then option is vetoed and removed** *Is the response option acceptable for the local and national authorities in all the targeted locations? What concerns do / may they have?*	Yes / No / Not yet verified	Yes	Yes	Yes	Yes		Yes
	Possible concerns (actual or anticipated)						Cash not used for intended purpose – concerns of misuse
	score	3	3	3	3	3	2
APPROPRIATENESS (TAKEN FROM QUESTION 1)							
Criterion # 2: Suitability to objectives and target groups, according to beneficiaries **(Weight:)** *Is the response option appropriate to achieve the objectives? Is it the case for all*	Advantages / pros	Items of quality restricted	Items of quality restricted	Increased flexibility in quantity of items for specific needs	Quality items that may not be available in country	Fast and equal support to all	Flexibility / better prices in local market Supporting diverse markets

intended groups? In all targeted locations? *Are the target groups in the position to use and benefit from the response option, considering distance from providers, possible discrimination, cost incurred, security and protection risks?*							Flexible community associations for managing transitional constructions
	Disadvantages / cons	Restrictions in terms of meeting specific shelter needs for diverse families Availability of quality items / limited supply in the local market	Restrictions in terms of meeting specific shelter needs for diverse families Availability of quality items / limited supply in the local market	Lack of knowhow on material requirement Availability of quality items / limited supply in the local market	Not supporting local market Logistical delays – warehousing / duties	Community ownership Standardisation	Lack of know how/importance given on material requirement + quality Availability of quality items / limited supply in the local market
	Score						
Criterion # 3: Suitability to meet the objectives for target groups with special needs **(Weight:)** *Is the response option appropriate to achieve the objectives for people with special needs / vulnerabilities in all targeted locations?* *Are the identified groups with special needs in the position to use and benefit from the response option, considering distance from providers, possible discrimination, cost incurred, security and protection risks?*	Advantages / pros			Flexibility to purchase items for special needs	Can be included in the kit when early assessment conducted	All receive support	Social support system
	Disadvantages / cons	Can't access market or build themselves + needs special support	Can't access market or build themselves + needs special support	Can't access market or build themselves + needs special support	Usual standard kits don't always take into account special needs	Standard design may not meet specific needs	Can't access market or build themselves
	Score						
Criterion # 4: Programme quality (quality standards, including Sphere standards) **(Weight:)**	Advantages / pros	Quantity and quality restrictions can ensure quality	Quantity and quality restrictions can ensure quality		Quality assurance prior to dispatch	Technical supervision from experienced team	

Which response option offers the best chance of achieving: the minimum quality and quantity of commodities and services that target groups should get access to / consume according to humanitarian standards?	Disadvantages / cons			May not adhere to standards quality and sizing		Potential to select poor contractor – quality and delays	May not adhere to standards quality and sizing
	Score						
PUBLIC SERVICES AND MARKETS							
Criterion # 5: Capacity of existing public service systems (e.g. education, health, public water system, other essential services) **(Weight:)** *Do the local public services, facilities, and infrastructure have the capacity to support and respond positively, timely and at scale to the proposed response options?* *If not, how easily and efficiently can they be enabled?*	Advantages / pros						
	Disadvantages / cons						
	score						
Criterion # 6: Consequences for the public service systems **(Weight:)** *Will the public service system and its facilities and infrastructure be damaged or supported by the proposed response option?*	Advantages / pros						
	Disadvantages / cons						
	score						
Criterion # 7: Capacity of market actors and private sector services **(Weight:)** *Do the relevant markets and private sector services have the capacity to respond positively, timely and at scale to the proposed response option?*	Advantages / pros						
	Disadvantages / cons	Potentially limited market suppliers providing quality items Costly service providers	Potentially limited market suppliers providing quality items Costly service providers	Potentially limited market suppliers providing quality items Costly service providers			
	score						

If not, how easily and efficiently can they be enabled?							
Criterion # 8: Consequences for relevant market actors and private sector services **(Weight:)** *Will the market actors (or other parts of the system) be damaged or supported by the proposed response option? Examples of unintended negative effects on markets: reduced competition, reduced demand, higher prices.*	Advantages / pros						
	Disadvantages / cons						
	score						
IMPLEMENTING AGENCIES' CAPACITY TO OPERATE AT SCALE AND IN A TIMELY MANNER							
Criterion # 9: Sector members' familiarity with the modality **(Weight:)** *In the targeted geographic areas, what portion of the sector members are familiar with the response option (# of experienced organisations out of total # of members)?*	Advantages / pros	50%	50%	50%	50%	50%	50%
	Disadvantages / cons						
	score						
Criterion # 10: Capacity to start and go to scale (caseload size) in a short timeframe **(Weight:)** *In the targeted locations, which of the response options has the shortest start-up time for the sector partners, and the capacity to go to scale in the shortest timeframe?*	Advantages / pros						
	Disadvantages / cons						
	score						
RISKS							
Criterion # 11: Protection **(Weight:)** *Which response option offers fewer and more manageable*	Advantages / pros						
	Disadvantages / cons						
	Score						

intra-household and community protection risks for beneficiaries, with specific attention to those with special needs and vulnerabilities?							
Criterion # 12: Operational, financial, and institutional risks **(Weight:)** *Which response option offers fewer and more manageable operational and institutional risks?*	Advantages / pros						
	Disadvantages / cons						
	Score						
Criterion # 13: Contextual risks **(Weight:)** *Which response option is more vulnerable to external factors and changing conditions?*	Advantages / pros						
	Disadvantages / cons						
	Score						
COSTS							
Criterion # 14: Costs and efforts for the organisation **(Weight:)** *Which of the response options has lower costs for the organisation?*	Observations and envisaged costs (list and estimated total)						
	score						
Criterion # 15: Costs and efforts for the beneficiaries **(Weight:)** *Which of the response options is most convenient for the beneficiaries (in terms of costs incurred to benefit)?*	Observations and envisaged costs (list and estimated total)	Transport costs	Transport costs	Transport costs			Transport costs
Overall score (WEIGHTED: maximum = ?) (UNWEIGHTED: maximum = 45)							

Annex 3: Task Team TORs

Task Team for Basic Needs Focused Response Analysis

Background

The Task Team for Response Analysis (known as the Task Team) aims to oversee and draw together all the various elements of the ECHO's Enhanced Response Capacity (ERC) funded pilot for the uptake of quality, collaborative Multipurpose Grants (MPGs) in Ethiopia. This work is led by a Consortium consisting of CaLP, the Danish Refugee Council (DRC), Mercy Corps, OCHA and Save the Children.

In October 2017, the Consortium began the pilot in Ethiopia with the aim of providing technical and strategic support to country-based humanitarian organisations, enabling them to engage in collaborative assessments and decision making. Whilst the Consortium has not been conceived to provide direct assistance to crisis-affected populations, it is intended to have an indirect, positive impact on their lives, by means of influencing humanitarian actors to design better quality and more collaborative and contextually appropriate MPG programmes. As such, it supports and is line with the commitments made by donors and humanitarian partners as part of the Grand Bargain.

The pilot project will provide information and analysis for selected woredas Fafan Zone in the Somali Region on:

- Basic needs of crisis-affected people, through the Basic Needs Assessment (BNA)
- Minimum expenditure basket (MEB)
- Market functionality and related feasibility of CTP, through the Multi-Sector Market Assessment (MSMA)
- Payment mechanisms and financial service providers
- Partners' and government's capacity to implement Cash Transfer Programming (CTP)
- Effectiveness of MPG, based on existing experiences

The Task Team will play a key role in bringing together and analysing the information generated by these Consortium assessments. This analysis process will be guided by Consortium technical experts and will make use of the Consortium's Response Options Analysis and Planning (ROAP) Facilitation Guide.

Ultimately, it is hoped that the Consortium's approach will lead to response analysis that is better structured, and more robust, transparent and people-centred. It will consider cash (in its various forms) and in combination and combined with other modalities (in-kind, cash, services, technical assistance, a combination of these) from the start.

Assessment and decision-making tools, their findings (including the recommendations resulting from the response analysis workshop), and learning on the efficiency and effectiveness of collaborative MPGs will be shared with the country-level members of the Consortium, relevant IASC Clusters/Sectors, Cash Working Groups in country, and Cash Consortia (if any), as well as other key stakeholders in the pilot context. The pilot will help the humanitarian community in Ethiopia make more effective and wider use of MPGs, if and when appropriate and feasible.

Objectives and Expected Deliverables

The Task Team will identify possible response options based on needs and feasibility utilising the information collected through the Consortium's assessments.

The key deliverables will be:

- a note validating the findings of the BNA
- a note validating the findings of the Consortium's other assessments (MSMA, payment mechanisms assessment, Partners' and government's capacity to implement CTP)

– a note on concrete recommendations to the Inter-Cluster Working Group and other relevant fora for priority interventions to be implemented in the short and medium term to address basic needs of specific groups of affected people in Fafan Zone.[18]

Timeline

The Task Team was established in late October 2017. Initial activities relating to the review of assessment outcomes will be followed by a response analysis work that will take place throughout March 2018 (exact dates tbc). If there are humanitarian needs / response planning activities occurring at approximately the right time (i.e. March / April) the Consortium will aim to feed into these so as to improve the uptake of its' outputs. After the deliverables are produced the Task Team will be disbanded.

Composition

The Task Team is a sub-group of the Inter-Cluster Working Group, with the technical support of ERC Consortium Members. The Task Team will include:

– representatives from all the sectors of the humanitarian response (sector experts and IMOs)

– cash experts from the Cash Working Group (CWG)

– protection experts

The sector experts will validate the priority needs and consider interventions, cash experts will provide expert advice on if and how cash can be used to address priority needs, and protection experts will ensure the interventions mainstream protection concerns.

Membership is voluntary but is strongly encouraged as participation will provide active partners and sectors with in-depth information and guidance on how to prioritise multi-modality interventions, in line with the commitments of the Grand Bargain. This will be an advantage to both individual actors and the sectors they represent.

The Task Team will choose one of its members to lead the group and this person(s) will also act as co-spokesperson on behalf of the group.

Roles and responsibilities

The Task Team will:

– Conduct a peer review of the Consortium's tools (e.g. to determine if the basic needs questionnaires are contextually appropriate)

– Possible participation in the Consortium's assessments (e.g. as sector experts in the Multi-Sector Market Assessment)

– Undertake a desk review and validation of the findings of the ERC Consortium's assessments

– Present the validated BNA findings at appropriate fora external to the Consortium

– Participate in Response Analysis training

– During the final ROAP Workshop (to be organised and facilitated by the Consortium in March 2018): identify possible sector specific and inter-sector response options based on needs and make a final recommendation based on operational feasibility and appropriateness

– Document the results of the above steps

[18] The key strategic, programmatic and technical decisions that would result from this process will include: Priority population groups in each area (HNO); Priority needs of each population group (HNO); Operational Environment/Feasibility; Critical markets to be supported or to operate through Critical **systems of service provision** to be supported or to operate through; Response options / assistance modalities (cash transfers, in-kind, services/technical assistance, combinations); If In-kind: what items; If services provision: what services or technical assistance; If Cash transfers: sector-specific (one or more sectors) or multipurpose; If Cash transfers: what modality; If Cash transfers: what amount; If Cash transfers: what transfer mechanism; Which aid delivery organizations, where, when; Beneficiary targeting approach and mechanism.

This work is expected to involve a commitment of approximately 12 - 15 days between November 2017 and March 2018 with the majority of the work to be done in Feb - March 2018.

Roles within the Task Team

The Task Team Coordinators will form and initiate the Task Team, raising awareness on the Consortium's work and collecting expressions of interest. They will represent the group to the relevant external fora (when the group report on their response analysis recommendations) and will also likely chair meetings and ensure decisions are made in a timely and effective manner, and are effectively documented. The Task Team Coordinators will advocate for the Task Team's recommendations to be reflected in the broader humanitarian response planning to the extent that is appropriate and possible.

The Consortium members will provide technical support and facilitation of a structured approach to identify response options. Each partner will provide the technical guidance for the data produced by their tool and Save the Children, in its capacity of Consortium lead, will provide additional coordination support in the preparatory phase (by preparing, as necessary, the workshop concept note, the agenda and presentation power points). OCHA will ensure either adequate agenda time has been provided at a regular ICWG, or dedicate a specific meeting to this (depending on how much time is required). Any feedback or follow up from sectors would also be collated by OCHA and supported as required.

Consortium members were

The Consortium was generously

Funded by
European Union
Humanitarian Aid

The following actors participated in the ROAP process in Ethiopia

NGOs: ADRA, CARE Ethiopia, Child Fund DRC, GOAL, International Rescue Committee, NorCap (deployed to IOM), Norwegian Church Aid, Save the Children, and World Vision. From the UN: IOM, OCHA UNFPA, UNICEF, WFP, and WHO.