MQSUN+ REPORT

Strengthening the Humanitarian-Development Nexus for Nutrition in Ethiopia

An analysis of nutrition programming and the enabling environment

June 2020

About MQSUN+

MQSUN+ aims to provide the UK Department for International Development (DFID) with technical services to improve the quality of nutrition-specific and nutrition-sensitive programmes. The project is resourced by a consortium of five leading non-state organisations working on nutrition. PATH leads the consortium.

The group is committed to:

- Expanding the evidence base on the causes of undernutrition.
- Enhancing skills and capacity to support scaling up of nutrition-specific and nutrition-sensitive programmes.
- Providing the best guidance available to support programme design, implementation, monitoring and evaluation.
- Increasing innovation in nutrition programmes.
- Knowledge-sharing to ensure lessons are learnt across DFID and beyond.

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About this publication

Emergency Nutrition Network produced this report through the MQSUN+ programme as a case study examining how to strengthen the humanitarian-development nexus to support the reduction of wasting and other forms of malnutrition.

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Abbreviations

CBN	Community-Based Nutrition
CINUS	Comprehensive Integrated Nutrition Services
CM	Crisis Modifier
CMAM	Community-based Management of Acute Malnutrition
CO	Collective Outcome
DFID	Department for International Development
DRM	Disaster Risk Management
ECHO	European Civil Protection and Humanitarian Aid Operations
EHCT	Ethiopian Humanitarian Country Team
ENCU	Emergency Nutrition Coordination Unit
EHF	Ethiopian Humanitarian Fund
ENN	Emergency Nutrition Network
EU	European Union
FAO	Food and Agriculture Organization
FDRE	Federal Democratic Republic of Ethiopia
FMoH	Federal Ministry of Health
GEQIP	General Education Quality Improvement Programme
GMP	Growth Monitoring and Promotion
GoE	Government of Ethiopia
GTP	Growth and Transformation Plan
HDN	Humanitarian Development Nexus
HNO	Humanitarian Needs Overview
HDRP	Humanitarian and Disaster Resilience Plan
HRP	Humanitarian Response Plan
HSS	Health System Strengthening
IDP	Internally Displaced Person
IMAM	Integrated Management of Acute Malnutrition
INGO	International Non-Governmental Organisation
INSPIRE	Improving Nutritional Status of Pregnant and Lactating Women and Children in Rural Ethiopia
IYCF	Infant and Young Child Feeding

MAM	Moderate Acute Malnutrition
MQSUN+	Maximising the Quality of Scaling Up Nutrition Plus
MYRS	Multi-Year Resilience Strategy
NDRMC	National Disaster Risk Management Commission
NFI	Non-Food Items
NGO	Non-governmental organisation
NNP	National Nutrition Programme
NWOW	New Ways of Working
OCHA	Office for Coordination of Humanitarian Affairs
ODA	Official Development Assistance
OFDA	Office of US Foreign Disaster Assistance
ORDA	Organisation for Rehabilitation and Development in Amhara
PLW	Pregnant and Lactating Women
PSNP	Productive Safety Net Programme
RCO	Resident Coordinator Office
RESET	Resilience Building and Creation of Economic Opportunities in Ethiopia
SAM	Severe Acute Malnutrition
SBC	Social and Behaviour Change
SUN	Scaling up Nutrition
UN	United Nations
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
USAID	US Agency for International Development
WASH	Water, Sanitation and Hygiene
WFP	World Food Programme
WB	World Bank

Executive Summary

This is one of four[i] country case studies on 'Strengthening the Humanitarian-Development Nexus for Nutrition'. It reviews the type of nutrition programming being implemented in Ethiopia and examines the enabling environment (plans, policies, frameworks, coordination and financing) for appropriate, comprehensive and coherent nutrition programming in a context where acute and chronic nutrition coexist and both treatment and prevention are needed.

Over the past decade, Ethiopia has achieved spectacular economic growth and substantial reductions in malnutrition. However, both appear to be stalling, perhaps in part due to a growing humanitarian situation (close to 1 million refugees and up to 3 million internally displaced persons). Development, resilience building and humanitarian plans and strategies are well aligned to nutrition targets and reflect an expanding agenda. However, they also demonstrate a tension between the need for short-term humanitarian life-saving actions and longer-term system building and prevention programming. Increased clarity is needed around responsibility, accountability and funding commitments. At the same time, the institutional architecture has been evolving to support a stronger humanitarian-development nexus (HDN)—for instance, by creating advisory positions within the country United Nations (UN) team and outcomes in the 2019 Multi-Year Resilience Strategy (RCO 2019).

As in other contexts affected by protracted crisis, financing arrangements are a crucial element of strengthening the HDN in Ethiopia. A growing humanitarian budget—as well as the high transaction costs of channelling these funds through UN agencies and international and local nongovernmental organisations—raises questions about the cost-effectiveness and opportunity cost of not investing in government systems through longer-term direct budget support or sector-aligned and administered pooled-funding arrangements. The Government of Ethiopia (GoE) vision is for direct budget support to become the norm for country programmable aid; some donors, like the World Bank and the UK Department for International Development (DFID), are increasingly 'on board' with this agenda. There appears to be a significant proportion of 'development' or resilience-building funding for nutrition which takes place outside of priority emergency-prone hotspots. Humanitarian Response Plans have attempted to address this by expanding their remit to include resilience and nutrition security building but failed to generate the resources needed. Furthermore, humanitarian financing and targeting do not lend themselves easily to linking humanitarian and development programming.

Ethiopia now faces the challenge of how to move towards greater longer-term financing for drought-prone and conflict-affected *woredas*, or districts, and how to ensure that this financing strengthens government-owned programmes and systems, like the Productive Safety Net Programme (PSNP) and community-based management of acute malnutrition (CMAM). One way that this might be expedited is by modelling the cost efficiency of direct budget support and/or pooled sector support versus short-term financing programming through international development partners. This should include an analysis of financing for nutrition programming (specific and sensitive).

Humanitarian nutrition programming in Ethiopia is largely treatment focussed, with infant and young child feeding (IYCF) support linked as the main form of prevention. Whilst there is consensus on the

[i] The other three are Somalia, Kenya and Yemen.

need for resilience building—including programmes which prevent malnutrition—there is a lack of clarity about how to prevent malnutrition and how to measure success. Despite a great deal of nutrition security[ii] / longer-term nutrition prevention programmes, there is no coordination or systematic mapping (geographic distribution, scale and resources) of such programming. Furthermore, there is no curation of evidence for effectiveness of nutrition security programming that is multisectoral, systems-strengthening or nutrition-sensitive. There is a need to develop a methodology for assessing effectiveness of prevention programmes in vulnerable and risk-prone areas and to widely share lessons around prevention and nutrition security building.

Furthermore, if chronically vulnerable *woredas* are to graduate out of humanitarian need, the scale and duration of prevention programming needed cannot be realised through the 'humanitarian back door'. The humanitarian funding context (terms, duration, scope, etc.) is largely unworkable and ultimately ineffective for resilience building. As a first step, stakeholders need to recalibrate the targeting approach and vision for official development assistance in Ethiopia. It should be less about strengthening the HDN and more about the balance between humanitarian and development resourcing and programming, with the latter being better coordinated, targeted and evaluated with respect to effectively preventing malnutrition when seasonal, cyclical and unusual hazards occur.

[ii] Nutrition security exists when all people have adequate nutritional status which is sustained over time, even in the face of man-made and natural hazards such as conflict, political instability, displacement, disease outbreaks, floods, droughts, etc.

Introduction

This report was written based on a desk review and a two-week visit by two Emergency Nutrition Network (ENN) technical directors to Addis Ababa, followed by three days of fieldwork in Ebinat Woreda (i.e. 'District') in the Amhara Region of Ethiopia. They conducted over 30 interviews with government, UN agencies, donors and both international nongovernmental organisations (INGOs) and local nongovernmental organisations (NGOs). Several of these interviews were in the form of focus group discussions to examine *woreda*-level disaster risk-management planning and implementation. The field visit enabled the team to investigate resilience-building programmes in action, including the PSNP and Save the Children's multisectoral Growth Through Nutrition programme. This review was further supported by a review of policies, plans and frameworks, as well as programme reports and evaluations, which were provided during interviews and meetings.

This case study examines the ways in which humanitarian and development actors work together to improve nutrition. It reviews how nutrition security-building programmes align with policies, plans and frameworks; how financing mechanisms are supporting efforts to build nutrition security; and, where possible, identifies how much progress has been made in achieving a stronger HDN. It is part of a larger project to investigate the frameworks developed for nutrition programming in protracted crisis, led by the ENN and funded through Maximising the Quality of Scaling Up Nutrition Plus (MQSUN+). The aim is to analyse humanitarian and development practices for nutrition security in protracted crises and identify needed shifts in programming, policies, architecture and financing to improve nutritional impact across different contexts. This analysis of practices follows a theory of change prepared under this same assignment (for details, see **Annex 1**).

Situational Analysis

Economic situation

Ethiopia is one of the most rapidly developing countries in Africa, expected to achieve middle-income status by 2025. Real gross domestic product growth in the 12 years prior to 2016 averaged 11 percent per annum. The proportion of the population living in areas below the national poverty line fell from 39 percent in 2003/4 to 26 percent in 2016; recently, the poorest quintile experienced limited improvements in income (UN Ethiopia 2019).

Nutrition profile

Poor nutrition contributes to this poverty, with the cost of undernutrition in Ethiopia estimated at 16 percent of gross domestic product in 2013 (FDRE 2016). Ethiopia's nutrition profile has seen massive shifts: Between 2005 and 2019, there was a decrease in stunting from 51 percent to

37 percent, with 12 percent severely stunted; in wasting, from 12 percent to 7 percent[iii]; and in underweight, from 33 to 21 percent. Exclusive breastfeeding increased from 49 to 59 percent.

Geographic disparities include higher stunting rates in rural versus urban areas (41 versus 26 percent respectively) and very large regional differences (i.e. 49 percent stunting in Tigray Region versus 14 percent in Addis Ababa). Women of reproductive age are extremely vulnerable, with 22 percent being wasted—potentially related to early marriage and adolescent pregnancy (USAID 2019). Furthermore, only an estimated 14 percent of children over 6 months of age consume four food groups or more (UNICEF 2018).

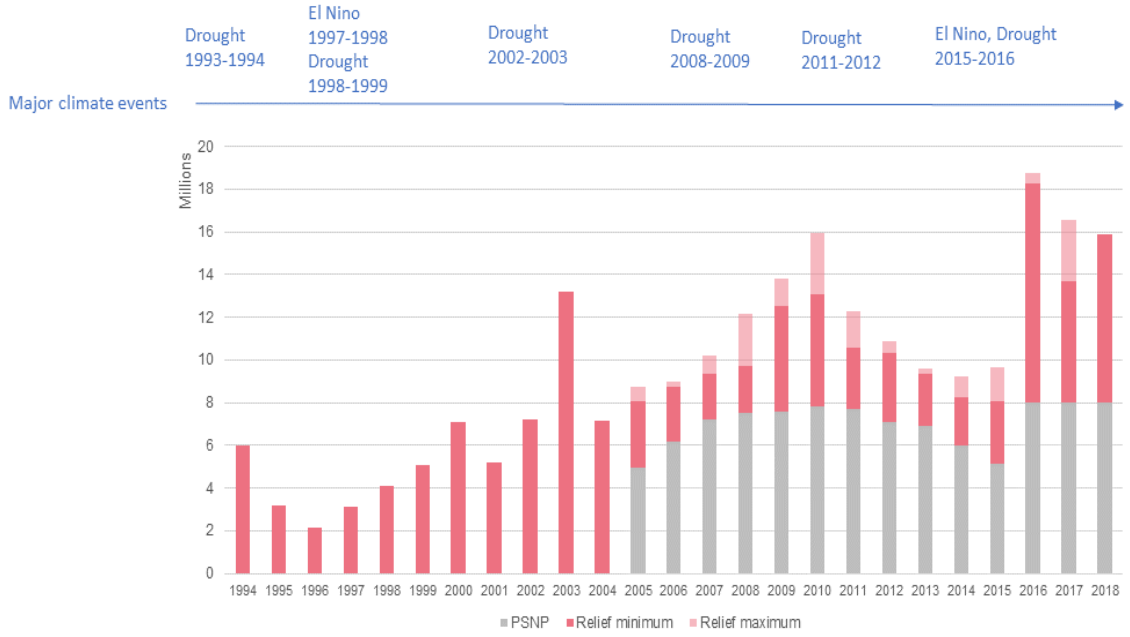
Ethiopia's reduction of stunting and child mortality (UNDAF 2015) is considered attributable to the agricultural growth programme, the PSNP, community-based nutrition (CBN) programme, national school feeding programme, Community-Led Total Sanitation programmes and efforts to reduce anaemia in pregnant and lactating women. It is estimated that 70 percent of GoE spend is on pro-poor sectors (Transform Nutrition 2017). These factors are similar to those identified in the Conceptual Framework for Determinants of Undernutrition in Protracted Crisis (**Annex 1**).

Humanitarian context and exacerbators

As is characteristic of many protracted crises contexts (**Annex 1**), Ethiopia is vulnerable to a variety of shocks, including drought, flooding and internal conflict (largely between pastoral communities), leading to large-scale internal displacement, with internally displaced persons (IDPs) estimated at 3 million people as of February 2019 (National Disaster Risk Management Commission, Humanitarian Country Team, and Partners 2019). In 2019, out of a total population of 108 million people, 26 million (24 percent) remained below the poverty line and were chronically food insecure, 8.2 million (8 percent) required long-term food assistance and 8.3 million (8 percent)—including IDPs—were targeted in the Humanitarian Response Plan (HRP). The HRP appeals have escalated from US$651 million in 2010 to US$1.6 billion in 2015/16 (**Annex 4**). Ethiopia is very vulnerable to environmental risk, with a 20 percent reduction in short rains over the past 50 years (HDRP 2018, HRP 2019).

[iii] There are widespread reservations about the wasting data due to the very small sample sizes and, hence, lack of power to discern whether this difference is statistically significant (consultations, Annex 5).

Figure 1. Caseloads referred to in Humanitarian Response Plan based on food assistance.



Source: (UNDP, UNICEF, and WFP 2019) *Abbreviation*: PSNP, Productive Safety Net Programme.

Refugees

Ethiopia hosts over 900,000 refugees from four neighbouring countries. Its 26 refugee camps are mostly in the least developed regions. In 2018, acute malnutrition levels were above emergency thresholds in 72 percent of camps (compared with 38 percent in 2017). Only 22 percent and 44 percent of camps have below-emergency thresholds of anaemia and stunting prevalence, respectively (UNHCR 2018).

Refugee programmes in Ethiopia have a very separate policy and financing environment to host population programmes (displaced and nondisplaced). The recently adopted Comprehensive Refugee Response Framework has dramatically shifted the focus from emergency response to longer-term and sustainable programming, with an emphasis on integrating refugees into host communities. Until recently, the United Nations High Commissioner for Refugees (UNHCR) rarely accepted development funding directly to support refugees, rather collaborated with development partners like World Bank (WB) and the Food and Agriculture Organization of the UN (FAO); however, now they await a 'push' from development donors to use these resources directly for longer-term health and nutrition programming.

Humanitarian-Development Framework in Ethiopia

Nutrition-related policies and architecture

Ethiopia has numerous policies and frameworks which address or include nutrition, for example, the Growth Transformation Plan II (national development plan), United Nations Development Assistance Framework (UNDAF), HRPs and the National Nutrition Programme (**Annex 2**). Nutrition targets are largely aligned amongst them. These documents clearly state the need to strengthen linkages between humanitarian and development programmes and to move away from a cyclical humanitarian response—which appears to lead to a growing humanitarian caseload in HRPs over time (**Figure 1**)—whilst at the same time building the resilience of shock-vulnerable communities to shrink their humanitarian caseload. National documents clearly articulate that nutrition targets can only be achieved by building the resilience of populations vulnerable to malnutrition.

There are several common features to the narrative and the conceptualisation of a strengthened HDN in Ethiopia within the policies and plans. These fit within a theory of change developed for nutrition security in protracted crises (**Annex 1**) and include:

- Linking humanitarian and development programming.
- Strengthening government systems and services to deliver better nutrition-specific and nutrition-sensitive programming and capacity to scale up in the event of a shock.
- Delivering multisectoral programming with nutrition objectives.
- Developing collective outcomes (COs), as per the *UN New Way of Working (NWOW)* for humanitarian and development programming, with clear lines of responsibility (OCHA 2017).
- Providing longer-term programming in chronically vulnerable areas.

The introduction of a Humanitarian and Disaster Resilience Plan (HDRP) in 2018 reflects the need to move away from cyclical humanitarian responses towards a more resilience-focussed agenda encompassing preparedness and system building and strengthening (Government of Ethiopia 2018).

The policies, plans and frameworks which have nutrition objectives and that focus on the importance of a stronger HDN will not, however, on their own lead to significant improvements in nutrition without enabling finance and appropriately targeted and designed programming.

Institutional arrangements and coordination

GoE coordination of nutrition

Figure 2 outlines the key institutional arrangements for the GoE's approach to nutrition. Humanitarian coordination in Ethiopia benefits from strong government commitment and leadership, both at national and subnational levels. Whilst government and humanitarian partners maintain various internal coordination forums, many are joint. The highest-level joint forum, cochaired by the National Disaster Risk Management Commission (NDRMC) and the humanitarian coordinator, is the

Strategic Multi-Agency Coordination, which provides overall guidance on the humanitarian response. The NDRMC was brought out of the Food Security Directorate of the Ministry of Agriculture in 2015 to give humanitarian needs and response greater visibility and authority. However, the NDRMC has not yet managed to achieve full integration or coordination with either the international humanitarian system or the PSNP.

The Emergency Nutrition Coordination Unit (ENCU) is situated within the NDRMC and collaborates with UN agencies to produce a biannual hotspot assessment of areas needing emergency support. The assessment takes place after the two main rains (Meher and Belg) and is based on six sector-specific sets of indicators and severity thresholds (Priority 1 through Priority 3): (I) health and nutrition, (II) agriculture, (III) market prices, (IV) water, (V) education and (VI) other markers, such as unusual migration and major disruption to livelihoods (ENCU 2018).

The Disaster Risk Management Technical Working Group, chaired by the NDRMC, brings together the UN cluster system and government line ministries. This platform provides both strategic and overall operational guidance for joint assessments, planning and response. The Ethiopian Humanitarian Country Team (EHCT), at a strategic level, mobilises coordinated support to government leadership. Both the Public Health Emergency Management and hotspot guidelines describe procedures for responding to acute malnutrition in emergencies (ENCU 2018).

Coordination of multisectoral nutrition programming within the GoE is challenging as responsibility resides with the Federal Ministry of Health (FMoH), which has limited influence over other sectors. The FMoH argues that, to ensure multisectoral and nutrition-sensitive programming, each sector requires a nutrition department at the regional level. Although there are around 15 nutrition staff at the federal level within the FMoH, nutrition's status as a unit—rather than as a higher-level department or directorate—diminishes its influence and impact on other sectors. It is hoped that the Nutrition Unit will be upgraded to a Nutrition Directorate in due course. The FMoH has a Technical Nutrition Task Force which brings together humanitarian and development actors.

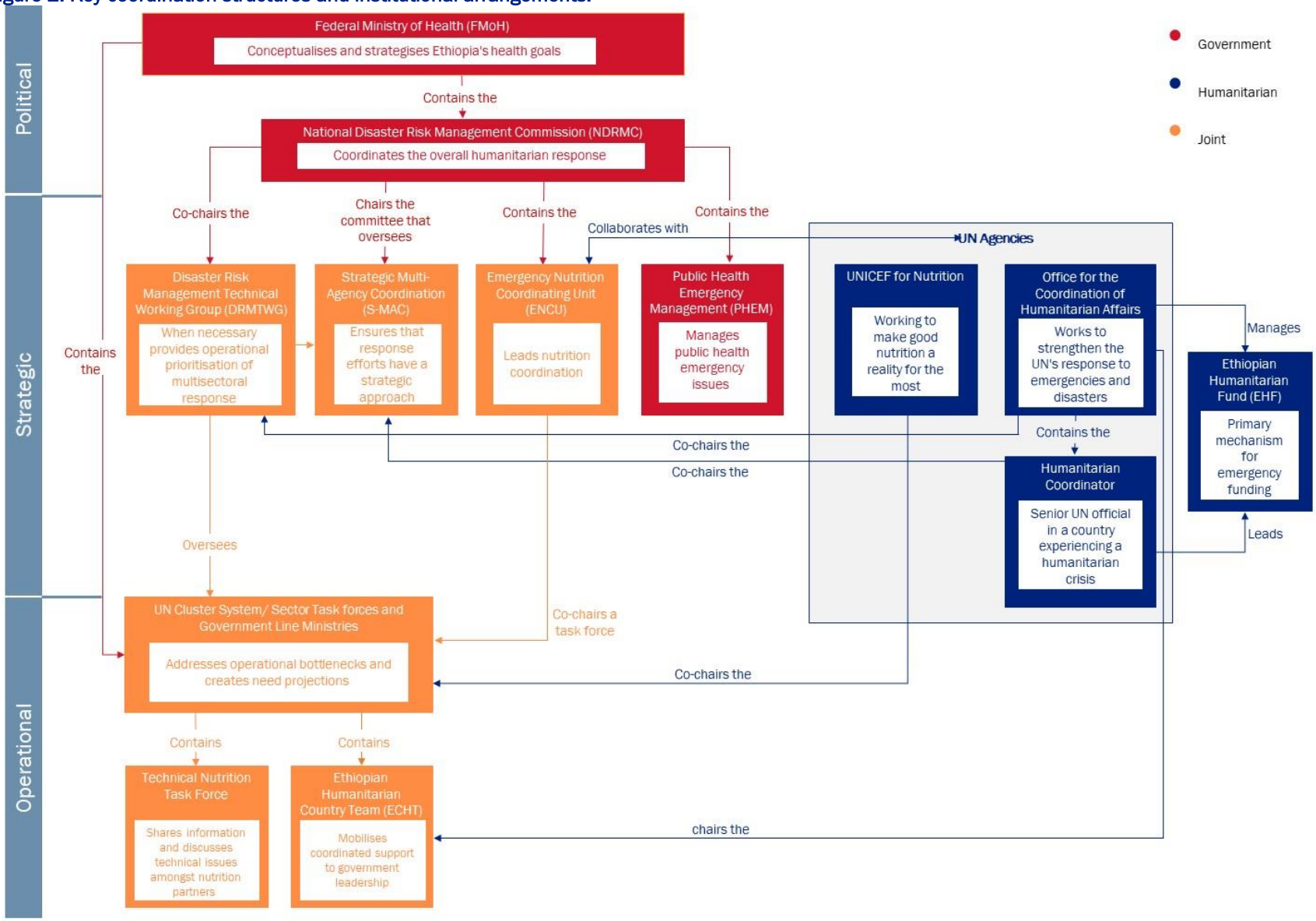
UN humanitarian and nutrition coordination

The cluster system operates in Ethiopia with the UN's Office for Coordination of Humanitarian Affairs (OCHA) chairing the EHCT. Clusters / sector task forces are chaired by relevant line ministries and cochaired by UN agencies (United Nations Children's Fund [UNICEF] for nutrition). There are currently eight clusters / sector task forces active in the country (i.e. Agriculture, Education, Non-food Items [NFI], Food, Health, Nutrition, Protection and Water, Sanitation and Hygiene [WASH]), each with sectoral priorities and responsibilities for operational coordination. CARE represents INGOs in the EHCT and participates in many key clusters, such as WASH, Nutrition, Health, Shelter and Protection (i.e. child protection, gender-based violence protection). The Ethiopian Humanitarian Fund (EHF) is the primary mechanism for emergency funding and constitutes a country-based multi-donor pooled fund managed by OCHA under the leadership of the humanitarian coordinator (UNDAF 2015).

NGOs coordination

From mid-2017 to the end of 2018, Ethiopia has seen a 24 percent increase in nongovernmental, international and national partners managing or implementing coordinated humanitarian responses. (UNDAF 2015). This can be attributed to the number of incidents of intercommunal conflict resulting in increases in the IDP and IDP returnee caseload. The Scaling Up Nutrition networks have helped drive the development of the national food security and nutrition policy (FDRE 2018a).

Figure 2. Key coordination structures and institutional arrangements.



Evolving HDN architecture and processes

The HDN architecture in Ethiopia has evolved quite rapidly over the past two years. There appears to be a high level of shared understanding of the NWoW due to advocacy by UN Resident and Humanitarian coordinators in 2017 and 2018, although some assert that there is a lack of a consolidated UN-wide position on the NWoW. This is partly attributed to Ethiopia's rapidly evolving humanitarian context with its multitude of actors with varying interests.

Ethiopia offers several examples of the UN's support of the HDN agenda. In 2017, a humanitarian-development adviser was deployed to the UN Resident Coordinator Office (RCO) with co-financing by the United Nations Development Programme (UNDP) Crisis Response Unit and local donors. There were also joint visits of the UNDP administrator and OCHA Emergency Relief coordinator and of senior representatives from UN agencies. A high-level dialogue chaired by the secretary general in Addis in 2018 reinforced UN efforts on the ground. A Joint Steering Committee was established under the executive committees of the Development Assistance Group and the EHCT, with participation from the UN Country Team, humanitarian and development donors, the WB and INGOs/NGOs. Unfortunately, this was discontinued later in 2018.

An ad hoc think tank called the 'Nexus Group'—comprising DFID, the European Union (EU) / European Civil Protection and Humanitarian Aid Operations (ECHO), Irish Aid, OCHA, Save the Children, Joint United Nations Programme on HIV/AIDS, UNDP, UNHCR, UNICEF, WB and World Food Program (WFP)—was formed and generated evidence to feed into the collective analysis and planning by government and by humanitarian and development partners. This group prepared several discussion papers to generate common thinking, including identifying concrete areas for acceleration of development resources to address acute needs, but was eventually abandoned due to a lack of commitment from members (UN 2018).

Analysis by several joint missions of the UN, donors and GoE led to the first HDRP in 2018, but Pillar 1 (prevention and mitigation through humanitarian and development funding) and Pillar 3 (national system strengthening and funding), were poorly funded. Joined-up analysis also took place for the social safety net and the One WASH national programme, Comprehensive Integrated Nutrition Services (CINUS) and other nutrition-related flagship programmes. OCHA and partners developed the Humanitarian Needs Overview using Household Economy Analysis tools to help identify short-term versus longer-term assistance needs (RCO 2019).

Good examples of HDN thinking—where both humanitarian and development objectives are met as both development and resilience-building activities are implemented in emergency-prone areas—include FAO/UNDP development interventions in hotspot areas of Somali Region, UNICEF WASH interventions, WFP/FAO collaborations on pastoralists and farmer resilience and adaptive capacity.

OCHA has mapped development programmes in areas of recurrent humanitarian shocks and developed an analysis of relief beneficiaries over the last three to six years showing high numbers since 2016 and that many are not in recently drought-affected areas. The RCO conducted a humanitarian-development mapping exercise for the Somali Region. This has generated interest by the regional government to craft an integrated humanitarian and development strategy with a focus in key areas of convergence to reduce vulnerabilities and need over time (HRD 2019).

The development of the Multi-Year Resilience Strategy by UN partners in conjunction with the GoE reflects a clear effort to come at the problem from the opposite direction (i.e. scale up development and longer-term programming in highly vulnerable areas—often categorised as Priority 1 hotspots), with a view to shrinking humanitarianism. Whilst the drafted Resilience Strategy has COs, a Regional Coordinator Office consultant developed the strategy, so it is unclear how much GoE ownership there is of this strategy. Furthermore, it is unclear who is going to input into the COs, which many argue are too broad for the HRP to report against. There is a prevailing sense of lack of accountability or leadership from the UN and GoE for the NWoW and a sense that, until this is established, there is little prospect of meaningful progress. Without this clarity, it is difficult to understand where resources and leadership will come from for implementation and what can realistically be achieved.

A joint steering group review of progress with regard to COs in Ethiopia has recently concluded that there has been a loss of momentum and lack of a common analytical process to define COs for humanitarian and development activities and that there is a need for a platform to integrate existing but siloed information into joint priorities (UN 2018). In 2019, the UN and partners in Ethiopia were to embark on the development of a new UNDAF, now renamed the UN Sustainable Development Cooperation Framework, and a new Multi-Year Humanitarian Strategy. The GoE, UN, NGOs and donors agreed to develop COs that will link these two and other relevant strategies with the GoE's new Growth and Transformation Plan.

Significant differences exist between donors in the extent to which humanitarian and development processes are aligned within organisations. Some donors, like the US Agency for International Development (USAID) / Office of US Foreign Disaster Assistance (OFDA) and the directorate general for International Development and Cooperation / ECHO have clearly demarcated structures and processes, whilst others, like DFID and Irish Aid, think and organise programming more holistically and through a more HDN-oriented lens.

Financing for strengthening the HDN

Ethiopia as an aid recipient and GoE financing vision

Ethiopia is one of the largest recipients of international assistance from major humanitarian donors. Humanitarian assistance is largely channelled through pooled funds like the EHF or directly to implementing partners by donors such as the OFDA, ECHO and DFID. In 2014, Ethiopia received US$320 million for humanitarian assistance, whilst in 2019 the HRP was costed at US$1.6 billion (**Annex 4**). Between 2006 and 2018, the EHF allocated more than US$538 million in emergency assistance. In 2018 alone, the EHF allocated US$86.4 million, supporting 142 projects (of which 109 were implemented by NGOs and 33 by UN agencies) in the nutrition, WASH, health, protection, NFI, agriculture and education sectors. The leading humanitarian donors are the United States (39 percent), the UK (13 percent), and the EU also contributing. The GoE provides an estimated 8 percent of spend, and the remaining funding comes from smaller donors (RCO 2019).

The limited GoE contribution to humanitarian assistance partly reflects a low tax revenue and a lack of planning for financing emergency responses, despite humanitarian responses being invariably underfunded, with the GOE's contribution reaching only 56 percent of need in 2014 and 59 percent in 2018 (**Annex 1**).

Ethiopia received a total of US$3.9 billion in development assistance in 2013, which was an increase of 66 percent since 2004. Overall official development assistance (ODA) in Ethiopia had reached US$4.07 billion by 2016 and was largely allocated through pooled-funding arrangements to national programmes such as the PSNP, One WASH, the General Education Quality Improvement Programme (GEQIP) and the Agricultural Growth Programme. ODA has focussed on four sectors: health (23 percent), humanitarian (16 percent), agriculture and food security (16 percent) and social protection (9 percent). In 2016, humanitarian aid comprised approximately 18 percent of total ODA (US$757 million).

The GoE clearly stated its aim (HDRP 2018) to bring humanitarian and development funding together in a more joined-up strategy. To achieve this, the GoE encourages pooled funding to complement its own resources and approved a record budget of US$10.8 billion from 2015/16, with 70 percent from domestic resources (90 percent from taxes). This compares with 57 percent of spending from domestic resources in 2007/8. An example of the GoE funding more of its service provision is the PSNP, in which GoE funding has been gradually increasing for each phase, currently reaching 12 percent of costs (excluding support in kind). The overarching GoE vision for ODA is to shift funding that has historically been routed through humanitarian and development partners to instead be managed through direct budget and sector support—only routing it through partners in the case of unanticipated shock to which the GoE would like assistance responding. Some donors are aligning with this approach (FDRE 2018a, UNDAF 2015).

National Nutrition Programme costing was undertaken using the OneHealth Tool for nutrition-specific activities and activity-based costing for nutrition-sensitive activities (FDRE 2016). The total estimated cost for the plan is US$1.1 billion over five years, with 88 percent of the budget for nutrition-specific and 12 percent for nutrition-sensitive activities. Of this, the GoE expects to provide 25 percent and, despite donor support, anticipates a 38 percent budget gap (i.e. US$430 million) (FDRE 2016).

Development partner financing vision for Ethiopia

There is an emerging consensus amongst many (but not all) donors that Ethiopia needs a government-led and increasingly government-financed response system. There is frustration amongst government and development partners that, despite the largely predictable annual humanitarian needs, beneficiaries rely on underfunded appeals. Furthermore, as the response system is largely administered through UN and INGOs, the transaction costs are considered high, and the 6- to 12-month planning and reprogramming, costly and inefficient. There are also tensions between externally driven and administered humanitarian systems and government-administered services, such as competition for logistics and staff time (UN 2018, RCO 2019).

The lack of funding (see section below) obtained for resilience-building and systems-strengthening components of the 2018 HDRP (Pillars 1 and 3) reflect both the challenges of implementing an HDN approach, where the humanitarian imperative will inevitably be prioritised over more development-type activities and the siloed programme funding and implementation architecture in Ethiopia.

It is increasingly recognised that the way out of this cycle of humanitarianism is greater development spend in areas prone to hazards to build resilient communities and mitigate shocks. Donors, such as the DFID and WB, are clear that the GoE can deliver excellent development programmes at a lower cost than international partners. There is a need for surge models for CMAM and the PSNP and equivalent programmes, with the GoE budgeting for normal shocks and with humanitarian actors only intervening when an emergency threshold has been reached. These more ‘forward-thinking’

partners can provide direct budget support through government channels—for instance, DFID supports pooled funds for five Sustainable Development Goals via the FMoH for ten development partners, and the WFP's newly endorsed five-year strategy (2020-2025) anticipates that a significant portion of its humanitarian programme funding will be channelled via the GoE. Simultaneously, development partners recognise that it will not be easy for the GoE to allocate more funding to humanitarian spend whilst there is a need for better coordination of resources via the Ministry of Finance, NDRMC and line ministries. One challenge may be that the GoE perceives that humanitarian actors have responsibility for the highest priority hotspot *woredas* (Priority 1).

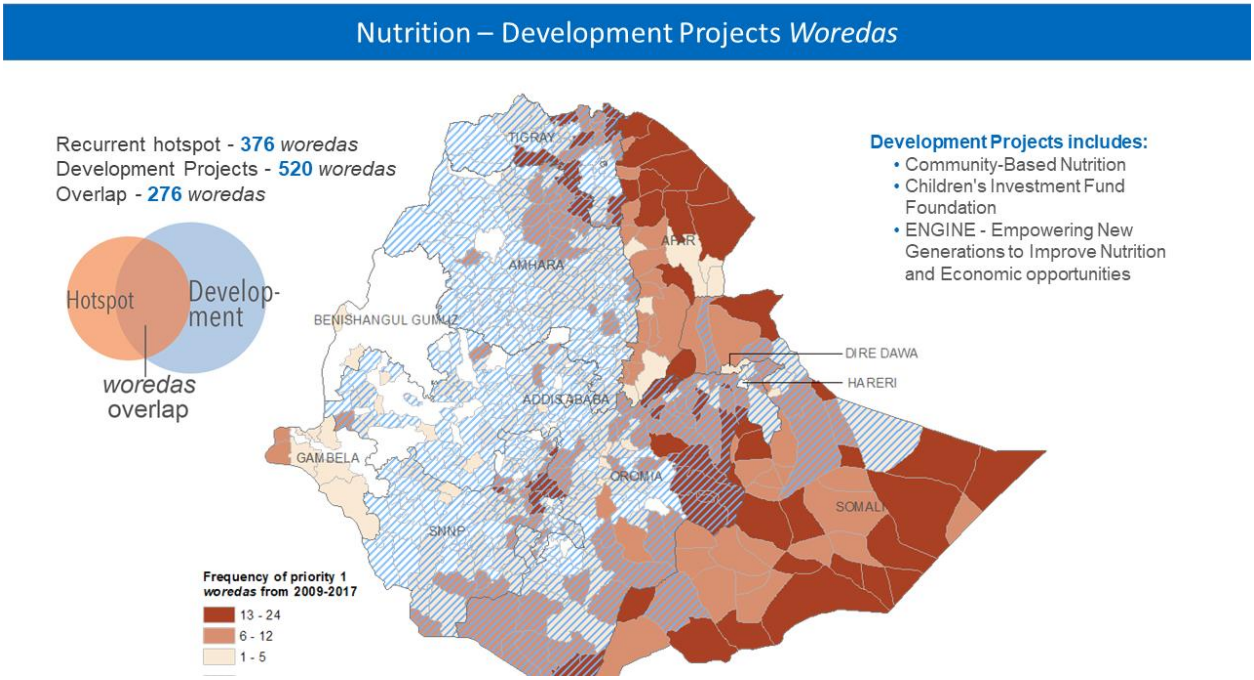
Humanitarian versus development nutrition spend

Though HRP caseloads and associated budgets have been increasing gradually, actual funding of HRPs has ranged from 56 to 94 percent, and most humanitarian programming in nutrition has been on CMAM and IYCF. In the 2018 HDRP, the nutrition requirement was US$218 million with US$201 million for treatment/commodities (HRD 2019).

There does not appear to be data in the public domain on the amount of spending on nutrition allocated to humanitarian versus longer-term development nutrition, broadly classified as nutrition and health systems strengthening (HSS) and multisectoral nutrition-sensitive programming. However, through consultations with stakeholders, it appears that many INGOs/NGOs report a greater spend on humanitarian nutrition programmes within their organisations, including amongst larger agencies like Save the Children. Some INGOs report a relatively faster increase in humanitarian rather than development resources and spend, which is partly due to the limited government contingency resources at zonal and regional levels to respond when shocks occur.

OCHA has produced a map of *woredas* showing the locations of what they classify as humanitarian and development programmes, which shows not only significant overlap in investment but also enormous nutrition-development investment outside of hotspot *woredas* (**Figure 3**).

Figure 3. Nutrition-development projects across *woredas* in Ethiopia.



Experience of implementing partners with humanitarian financing

Humanitarian funds received through the EHF are generally for 6-month durations, whilst humanitarian bilateral funding from donors, such as the OFDA, ECHO and DFID, may be for longer (up to 12 months) but closely follow the HRP in terms of objectives and scope of activities. Fifty DFID humanitarian grants administered in 2018 went mainly to INGOs and UN agencies for 6- to 9-month durations and were almost entirely geared to supporting CMAM and IYCF.

Many INGOs/NGOs and UN agencies are frustrated by short-term funding emergency mechanisms, which mainly allow for CMAM and IYCF programmes, and instead would like to utilise funding to add to, or create, more sustainable activities that contribute to preventing malnutrition. This can be done by:

- Strengthening capacity and effectiveness of government health systems.
- Integrating short-term emergency activities with development programmes.
- Implementing multisectoral programming.
- Stretching the remit and scope of funding by utilising it for a broader range of activities which contribute to prevention as well as treatment—for instance, the linkage of CMAM to PSNP, Vitamin A campaigns, deworming and growth monitoring and promotion (GMP).

However, these activities and associated objectives are not easily achieved with short-term funding.

Challenges of short-term emergency funding

HSS through capacity building of staff may involve recruitment, development of memoranda of understanding and training. This is difficult to accomplish in a 6- to 12-month funding window and

often then ends with laying off of staff due to funding gaps. In some cases, health posts may cease to operate when there is a funding gap of one or two months. Such gaps are, in fact, a regular occurrence with hotspot *woredas*. Some agencies anecdotally report an increase in relapses from treatment programmes during the 'stop' phase of programming. Furthermore, more than six months is required to set up activities like IYCF or hand over activities to government staff following a short-term humanitarian CMAM capacity-building or HSS programme.

Donors and implementing partners may also have different targeting criteria for longer-term prevention programming so that it is not easy to join up emergency and development programmes. If implementing partners have their own humanitarian funding sources (e.g. crisis modifiers [CMs]) attached to development programmes or, like UNICEF or World Vision, have access to their own humanitarian and development pots, it is easier to join up programming more effectively than can be done with smaller implementing partners who are dependent on humanitarian pooled funding. A frustration of some implementing partners is that they cannot obtain humanitarian funding to work in the *woredas* where they are implementing development programmes and question why donors cannot be more flexible.

Effective multisectoral response with short-term humanitarian funding is difficult due to the different sectoral priorities within the cluster system. Funding envelopes are often limited to a single sector—for instance, a WASH component of an emergency nutrition project usually entails hygiene promotion and provision of NFI for CMAM clients rather than investing in water schemes or infrastructure development. There is a recognised need for funding of joint cluster activities. One approach recently tried, for enabling multisectoral humanitarian programming, is the Swan[iv] programme, which combines WASH and Health Clusters that are funded by the EHF and implemented by a consortium of partners in the same location.

The HRPs' nutrition activities appear to be expanding in scope. There is now explicit mention of other (in addition to CMAM and IYCF) nutrition-specific and nutrition-sensitive health activities, including GMP, vitamin A provision and deworming, as well as outreach services (HDRP 2018, HRP 2019). This contrasts with earlier HRPs, which focused mainly on CMAM and IYCF. Other challenges working within the humanitarian sector include that implementing partners find EHF funding to be not flexible enough (e.g. it is not permissible to leave vehicles for health posts' use at the end of short-term humanitarian programmes so that referrals are almost impossible after the implementing partner has left the area).

Contingency and Crisis Modifiers

One means of financing that ensures a stronger link between humanitarian and development programming is the use of what some donors refer to as CMs attached to longer-term development-type programmes. The aim of CMs is to ensure that if a shock occurs there are enough funds to address acute humanitarian needs and ensure progress of longer-term/development programmes. USAID, the EU-funded RESET (Resilience Building and Creation of Economic Opportunities in Ethiopia) programme and NGOs such as Save the Children have been using this approach (RESET II 2019).[v] CM support is invariably channelled via partners rather than government; however, if CM

[iv] Swan Management Plc is a private consulting company in Ethiopia focussing on environmental work.
[v] In 2015/16 USAID had an experience where two different development activities were affected by the El Nino drought in Ethiopia and where the OFDA topped up partner development funding with humanitarian funding as a CM to help the implementing partner respond.

funds are inadequate to meet humanitarian needs, implementing partners may request additional funding from the EHF. The percentage of overall programme costs allocated to CMs varies enormously, from 2 to 20 percent amongst stakeholders interviewed.

The PSNP has its own form of CM (referred to as contingency funding) which allows scale up to emergency-affected communities and inclusion of non-PSNP households where a malnourished child is identified and referred to the programme. The federal government holds a 20 percent contingency budget, whilst *woreda* administrations hold a 5 percent PSNP contingency budget (EDRI 2018).

Nutrition Programme Approaches

This report distinguishes two main types of nutrition programmes implemented in Ethiopia: treatment and prevention. Treatment refers mainly to the care of wasted or acutely malnourished children (moderately or severely), whilst prevention refers to any activity which contributes to preventing all forms of malnutrition from occurring in the face of shock (seasonal, predictable or hazard related). Although simplistic, this dichotomisation fits reasonably well with the way in which humanitarian nutrition programming can be distinguished from nonhumanitarian nutrition programming in Ethiopia. This case study assumes and proposes that programmes which succeed in preventing malnutrition strengthen nutrition security, which in turn, contributes to overall resilience. The design and objectives of many of these programmes fit within a comprehensive risk-management approach to nutrition (**Annex 1**).

Malnutrition prevention

Programmes which focus mainly on addressing the underlying and basic causes of malnutrition—either by converging multisectoral activities on a population group or by increasing the nutrition sensitivity of select sector activities—contribute to the prevention of malnutrition. **Table 1** provides a brief overview of several past and presents multisectoral nutrition programming in Ethiopia, and **Annex 3** provides more details on a few key programmes. The Seqota Declaration[vi] implementation plan includes the rolling out of evidence-based and innovative interventions to test and generate learning to end stunting in Ethiopia for all children under 2 years of age through effective coordination and collaboration between sectors, communities and partners (FDRE 2018a).

Table 1. Examples of multisectoral nutrition programmes in Ethiopia.

Programme	Focus and objectives	Primary partners
Comprehensive Integrated Nutrition Services (CINUS)	Preventive multisectoral programme covering the whole life cycle, including WASH, health, education and agriculture activities, which aims to improve complementary feeding and increase WASH and health systems' capacity to deliver nutrition-specific interventions.	GoE and UNICEF

[vi] The Seqota Declaration is the Ethiopian government commitment in 2015 of a 15-year road map to end stunting in children under 2 years of age by 2030. It builds on and supports the National Nutrition Plan. It focusses on delivering high-impact nutrition-specific, nutrition-smart and infrastructure interventions across multiple sectors.

Programme	Focus and objectives	Primary partners
Growth Through Nutrition (USAID 2019)	Multisectoral initiative focussed on food-insecure areas with nutrition and WASH targets for PLWs and children under 2 years of age.	Save the Children & consortium (USAID funded)
Improving Nutritional Status of Pregnant and Lactating Women and Children in Rural Ethiopia-INSPIRE (Save the Children 2019)	Multiyear programme to improve health and nutrition of PLW and children under 5 years of age, with the objective to increase access to, and utilisation of, high-quality nutrition services, nutritious foods and water and sanitation services. Expected to end in 2020.	Save the Children
Integrated Food and Nutrition Security (IFaNS)	Programme that works at the household level and focusses on nutrition-sensitive agriculture, climate change, economic development and nutrition.	World Vision
Strengthen PSNP4 Institutions and Resilience	Programme that has the goal to build resilience to shocks and improve food security and nutrition for vulnerable households and that includes integrated components: livelihoods, health and nutrition, women's empowerment, resilience and institutional capacity enhancement.	World Vision, CARE, ORDA and MoAg
Growing Nutrition for Mothers and Children in Ethiopia - GROW	Programme with the aim to improve growth patterns of children in chronically food-vulnerable areas and provide multisectoral support in the form of seed provision, goats, IYCF and livelihoods, along with a governance-strengthening component.	CARE
Resilience Building and Creation of Economic Opportunities in Ethiopia - RESET (RESET II 2019)	Programme that undertakes both emergency response and resilience building targeted to the poorest households and that provides health and nutrition, WASH, livelihoods and food-security activities with the key objective of reducing the risk from drought.	EU funded

Abbreviations: CINUS, Comprehensive Integrated Nutrition Services; INSPIRE, Improving Nutritional Status of Pregnant and Lactating Women and Children in Rural Ethiopia; IYCF, infant and young child feeding; ORDA, Organisation for Rehabilitation and Development in Amhara; PLW, pregnant and lactating women; PSNP4, Productive Safety Net Programme, phase 4; RESET, Resilience Building and Creation of Economic Opportunities in Ethiopia; USAID, US Agency for International Development; WASH, water, sanitation and hygiene.

Not only in Ethiopia but also in all countries facing protracted crises, there is a consensus on the need for resilience building—including programmes to prevent malnutrition. However, there is a lack of clarity about *how* to prevent malnutrition, what this programming looks like and how to measure success.

Evidence of the impact of prevention programming

Few preventive or nutrition security programmes identified through this study have generated robust data on nutrition impact. There are undoubtedly many reasons for this, such as the ethical and programmatic difficulty in allocating populations to control groups, cost of rigorous studies and limited external validity given complexity and variation of livelihood systems in Ethiopia.

Although many programmes have conducted mid- and end-term reviews and evaluations, most impact findings relate to non-anthropometric outcomes. There have been no studies which looked specifically at the success of any of the interventions in terms of preventing malnutrition, except for one looking at the impact of targeted supplementary feeding programme services for moderate acute malnutrition (MAM) on preventing severe acute malnutrition (SAM). The methodology for a study on prevention of malnutrition may be challenging as it would require data for a set of baseline years and seasonal trends where shocks have occurred to discern the reduced impact of shock post-intervention. Shocks would also need to be standardised in some way (Berhani et al 2018, EDRI 2018, CARE 2019, Feed the Future, 2019, RESET II 2019).

In Ethiopia, even though a great deal of this type of programming is ongoing, there is no systematic mapping (geographic distribution, scale and resources) of nutrition security / longer-term nutrition programmes which purportedly build nutrition security and prevent malnutrition. Therefore, it is challenging to know whether enough effort is being expended in the prevention of malnutrition in relation to the emerging vision for resilience building in Ethiopia. The OCHA mapping (**Figure 3**) does give an indication of where greater prevention programming focus is needed, although this mapping is a one-off initiative and provides no data on the scale of resources.

Furthermore, there is no coordination or curation of evidence for the effectiveness of nutrition security programming. An assessment of effectiveness would support decision-making around building nutrition security in fragile areas. It is also recommended to investigate how resources being invested in HSS for nutrition-specific activities (either through humanitarian or longer-term resourcing) are or could be evaluated against sustainability criteria.

Nutrition-sensitive programmes

There are numerous examples of sector programmes being made more nutrition-sensitive over time. An outstanding example of this is the PSNP—a large national social protection programme administered by the Ministry of Agriculture and dedicated to improving food security amongst the most vulnerable people in the country. It is designed to help beneficiaries get through the lean season without depleting household assets. The programme is currently in its fourth phase and reaches nearly 8 million of the most vulnerable individuals in six regions and two urban centres. Beneficiaries participate in public works activities in exchange for food or cash transfers for part of the year. Changes which went into effect in June 2015 at the start of the fourth PSNP phase have attempted to explicitly tie agriculture and health efforts together with a unified vision for improving nutrition outcomes nationwide through nutrition-sensitive programming (**Annex 3** has further details).

In addition to the PSNP, the Agricultural Growth Program, a five-year programme funded by the Bill & Melinda Gates Foundation, working closely with the Ministry of Agriculture, aims to strengthen capacity and systems to integrate nutrition into large-scale agricultural programmes (Berhani et al. 2018). It focusses on increasing crop production in high-production areas and undertook a pilot study to assess potential nutrition-sensitive pathways. Another example is the Feed the Future-supported public and private partnership, the African Alliance for Improved Food Processing, through which the GoE, UNICEF and Global Alliance for Improved Nutrition are working towards wheat fortification and universal salt iodisation.

Other means of increasing nutrition sensitivity of sector work is through linking and targeting these programmes more directly to households with identified cases of malnutrition. Action Contre la Faim

(Action Against Hunger) and Plan International, for example, target livelihood and WASH programmes to households with malnourished individuals.

Within the humanitarian sphere in Ethiopia, there is very little evidence of multisectoral nutrition programming, and the clusters have not made much progress in working together since the 2016 Rome Declaration in which integrated sector programming was recommended.

Treatment of wasting

There has been massive scale up of treatment of wasting in Ethiopia over the past ten years, with an estimated 98 percent of health facilities and health posts providing treatment of SAM through CMAM services. However, estimated treatment coverage of SAM cases is only around 25 to 30 percent due in large part to poor access to health facilities (HDRP 2018, HRP 2019). Treatment of MAM cases is only available in Priority 1 hotspot *woredas*,[vii] although recent guidance produced by the GoE and partners advocates for the inclusion of MAM treatment in CMAM programming. Humanitarian nutrition programming is largely geared towards supporting treatment interventions targeted at Priority 1 and, to a lesser extent, Priority 2 *woredas*. The intervention approach of most humanitarian partners, and one which is advocated by the government, is to analyse where services most need support—for example, training of staff, strengthening of supply chains, infrastructure development—and provide the necessary support to fill these gaps. Most of this humanitarian work takes place within short project timelines of 6 to 12 months. The aspiration of many of these programmes is to enable health facilities to 'graduate' to a level where they no longer need external support. The main other nutrition activity conducted during humanitarian programming and linked to CMAM programming is IYCF, which is considered a malnutrition prevention programme (FDRE 2016).

HSS programmes

There have been and continue to be longer-term systems-strengthening programmes in Ethiopia with different degrees of focus on nutrition. Some are multisectoral (**Table 1**), and others focus solely on HSS. These programmes aim to improve the quality of nutrition service delivery, including treatment of wasting, provision of vitamin A and iron-folate supplementation, deworming and GMP. Activities include training facilities and outreach staff, strengthening supply pipelines, strengthening data systems and developing reporting and infrastructure. These programmes fall somewhere between treatment and prevention, as strengthening capacity to sustainably deliver high-quality wasting treatment programmes will improve early detection and treatment and should support scale up in the event of a seasonal or unusual shock. Additionally, vitamin A, iron-folate and deworming will not only treat those who are micronutrient deficient or infected by worms but also prevent deficiency or infection in those who are vulnerable. GMP is more preventive in scope, as it identifies growth faltering and, in most cases, leads to some form of intervention (DFID 2019).

Both Action Contre la Faim and GOAL focus on HSS programming where they are active, whilst the DFID-funded Building Resilience in Ethiopia programme and the USAID-funded Transform Primary

[vii] Priority hotspot *woreda* identification is based on a biannual assessment carried out by ENCU and UN agencies to define areas needing emergency relief support. The assessment, which takes place after the two main rains, is based on six sector-specific sets of indicators and severity thresholds.

Health Care are delivered at a larger scale and for a greater duration. UNICEF has been working continuously in Ethiopia to strengthen the delivery of nutrition services through the GoE health system; and most recently, they have been implementing the CBN programme, which has been rolled out in 365 *woredas* and are now implementing CINUS in 100 *woredas*, with implementation by partners in a further 300 *woredas*.[viii]

With recent policy changes around MAM programming in Ethiopia and concurrent guidance development on its more widespread integration into CMAM programming, it is interesting to reflect whether this is more treatment or prevention motivated and from where funding emanates. Although the mortality risk associated with MAM is significant—up to 3 or 4 times more than normal with uncomplicated and complicated MAM, respectively (ENN 2019)—there are widely differing views as to the priority which government and development actors should afford to MAM treatment, especially where resources are scarce. Treatment involves specialised foods, as well as medical care in cases of complications. Where resources are scarce (as has been the case in many non-Priority 1 areas of Ethiopia), the approach to dealing with MAM has been to enrol children in GMP, IYCF and other related social behaviour change (SBC) actions and, in some areas, to link households with MAM children to other forms of support (e.g. PSNP, income generation, etc.). It appears, however, that one of the factors that has led to a renewed focus on treatment of MAM is the continued large caseload of SAM children and evidence from a recent study in Ethiopia which has purportedly demonstrated a significant role for MAM treatment in preventing the development of SAM (consultations, **Annex 5**).

Surge capacity for emergency

Capacity to scale up treatment programmes for wasting in the event of hazard or emergency has, in recent years, largely been built around the ENCU-led humanitarian system in Ethiopia. In Kenya, Concern Worldwide piloted and provided proof of concept of a CMAM surge model with a central aim to improve the resilience of health system supplies and infrastructure to cope with periods of high demand. The approach maps and quantifies the localised SAM caseload over two to three years and then defines thresholds for each health facility based on available resources. The idea is that government budgets for normal patterns and shocks in any given year and that humanitarian actors bring in (surge) support when thresholds are surpassed. Concern Worldwide has piloted this approach in many *woredas* in Amhara (January to June 2019) and is considering another pilot in Somalia Region (Concern Worldwide 2018).

Targeting of humanitarian programming

A *woreda*-level review of the sustained high number of relief food beneficiaries between 2016 and 2018 revealed that many of those who were targeted reside in areas impacted by previous droughts, rather than in areas recently affected by shock (UN 2018). The inclusion of these *woredas* in the HRP is likely to be indicative of assessments identifying chronic food insecurity and a lack of recovery from previous climate shocks (UN 2018). Nationally, the minimum number of people consistently targeted within given *woredas* over the three-year period has been 3.7 million (post-Meher[ix]). This compares with 7.88 million in the 2018 HDRP targeted for relief. It is estimated that 47 percent of those assessed as having acute humanitarian needs or targeted for relief assistance are chronically

[viii] Broadly speaking, CINUS has a more multisectoral approach than the CBN programme, which is more focussed on nutrition-specific activities.
[ix] Meher is a grain production season running from May to September.

food insecure and that many of the affected *woredas* are in areas that experienced the brunt of the El Nino drought and that their recovery has been difficult (UN 2018, RCO 2019). Given climate change and cyclical drought in Ethiopia, it is likely that this humanitarian caseload, yet to recover, will continue to grow. A more recent NDRMC estimate is that the humanitarian caseload may be as high as 14 million people (UN 2018).

The humanitarian caseload is growing, and humanitarian relief is targeting an increasing number of chronically vulnerable households rather than those with acute needs. Many stakeholders recognise the need to recalibrate criteria that target humanitarian relief. This will need further assessment of recovery needs (e.g. addressing asset depletion and indebtedness) in *woredas* with high repeated number of target beneficiaries. Expanding the PSNP to target the chronically poor in endemically vulnerable *woredas* or a cost-neutral retargeting of PSNP to *woredas* with repeated relief beneficiaries may be warranted.

Conclusions

Ethiopia has made enormous progress in tackling undernutrition over the past 15 years. This improvement is commonly attributed to economic growth, agricultural growth programmes, an increasingly nutrition-sensitive PSNP, national improvements in the availability of WASH, wheat and salt fortification and rollout of the CMAM programmes. However, Ethiopia still has a long way to go in reducing malnutrition and may not achieve significant progress without increasing GoE spending on nutrition-related programming and a fundamental realignment of how ODA is delivered.

Higher-level policies and plans all speak to closer alignment of humanitarian and development programming and resilience building in cyclically drought-prone *woredas* (Priority 1 and Priority 2 hotspot *woredas*). This requires strengthening nutrition security through both treatment and prevention programmes. However, policies and plans do not automatically translate into effective implementation and practice. None of these nutrition-relevant policies and plans confers sufficient responsibility and accountability, and there may be a tension between an HDN approach and a nonhumanitarian approach focussed on areas and populations that are regularly identified as humanitarian zones/caseloads.

Two areas identified in this study need attention: (1) the funding environment and (2) the approach to, and coordination of, nutrition programming. There is a need for longer-term funding through treasury and sector-specific pooled funding for vulnerable areas and populations rather than short-term and less cost-effective funding models with high transaction costs. Longer-term financing and implementation of nutrition security programming need to be clearly tracked and mapped to better understand coverage, scope and scale and how treatment and prevention programmes overlap and complement each other.

The humanitarian funding context (terms, duration, scope, etc.) is not conducive to resilience-building and prevention programmes in chronically vulnerable *woredas*, and there is a need for evaluations of the effectiveness of prevention and nutrition security-building programmes. This should be based on a technically sound methodology that can answer the question: Does this programme help prevent malnutrition when a shock occurs? Results must be widely shared.

Implementing partners face enormous challenges in trying to link humanitarian and development programming, in part due to differences in targeting criteria amongst donors supporting

humanitarian versus development programming. Implementing partners and donors are using CMs and contingency funding to circumvent this, but there has been little review of how successful the approach is in both supporting scale up in emergencies and preventing disruption to longer-term programmes. Many donors find it difficult to blend humanitarian and development financing in a way that allows flexibility within the span of a project cycle. It would be useful to explore and understand the practical barriers to providing this type of flexibility in fragile contexts.

These findings indicate a need for facilitated dialogue around how to break structural silos in donor financing and move towards greater longer-term financing for drought-prone and conflict-affected *woredas*. In addition, there needs to be systematic finance tracking of longer-term development funding allocated by sector (including nutrition-specific and nutrition-sensitive spend) and scale of resources. This should be led by the government with external partner support, as needed. Finally, there is a need to model the cost efficiency of direct budget support and/or pooled sector support versus financing programming through international development partners. This should be carried out specifically for nutrition programming (specific and sensitive) and should contribute to an analysis and position on whether it is more cost-effective to expand the remit of humanitarian financing to enable more nutrition security-type programming (prevention) or whether cost efficiency will be improved by financing longer-term nutrition security-building initiatives through the government with support from international agencies in Priority 1 *woredas*.

The humanitarian system in Ethiopia, and its attempts to address resilience building, is arguably a symptom of a flawed overall ODA system, which will always be expensive and compromised in achieving resilience and nutrition security. As a first step, stakeholders in Ethiopia need to recalibrate the targeting approach and vision for the ODA. It should be less about strengthening the HDN and more about right-sizing the balance between humanitarian and development resourcing and programming—with the latter being better coordinated, retargeted and evaluated with respect to effectively preventing malnutrition when seasonal, cyclical and unusual hazards occur.

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Annex 1: Key Methodology Framing for the Study

Box: Key characteristics of protracted crises (Maxwell, Russo, and Alinovi 2012).

Time duration and magnitude: Many have lasted ≥ 30 years and have extreme food insecurity.

Complexity of drivers: Few protracted crises are traceable to a single acute shock. Conflict is often one cause, but climatic, environmental or economic factors may also be causes. Unsustainable livelihoods are both a consequence and cause of protracted crises.

Weak intervention mechanisms: In protracted crisis contexts, development donors are often not willing to make significant investments, and private-sector engagement is often lacking or dominated by informal or illegal economic activities that extract wealth but do little to invest in sustainable improvements, making market-led or technology-driven development extremely difficult to sustain in protracted crises.

Outcomes vs. architecture: Protracted crises remain on the humanitarian agenda (a) because of poor food security or nutritional outcomes and (b) because humanitarian agencies are often the only available vehicle for intervention under the prevailing international assistance architecture.

Political will: Protracted crises often occur in contexts in which states are incapable of providing or unwilling to provide basic services or infrastructure or are predatory towards the population.

Protracted crises—and populations caught in them—fall between standard intervention categories and so are often forgotten.

Figure 4. Conceptual framework of determinants of undernutrition in protracted crises.

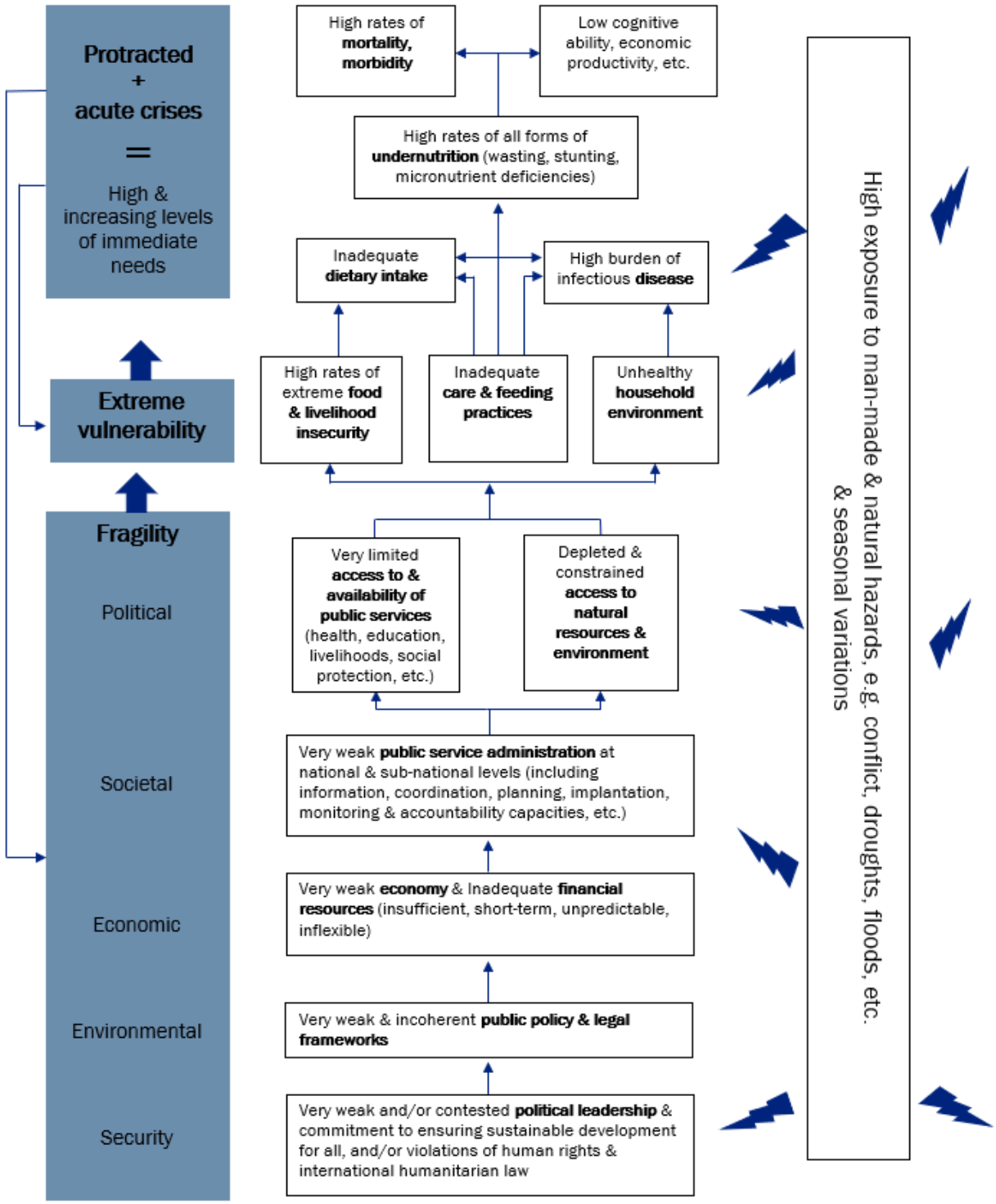
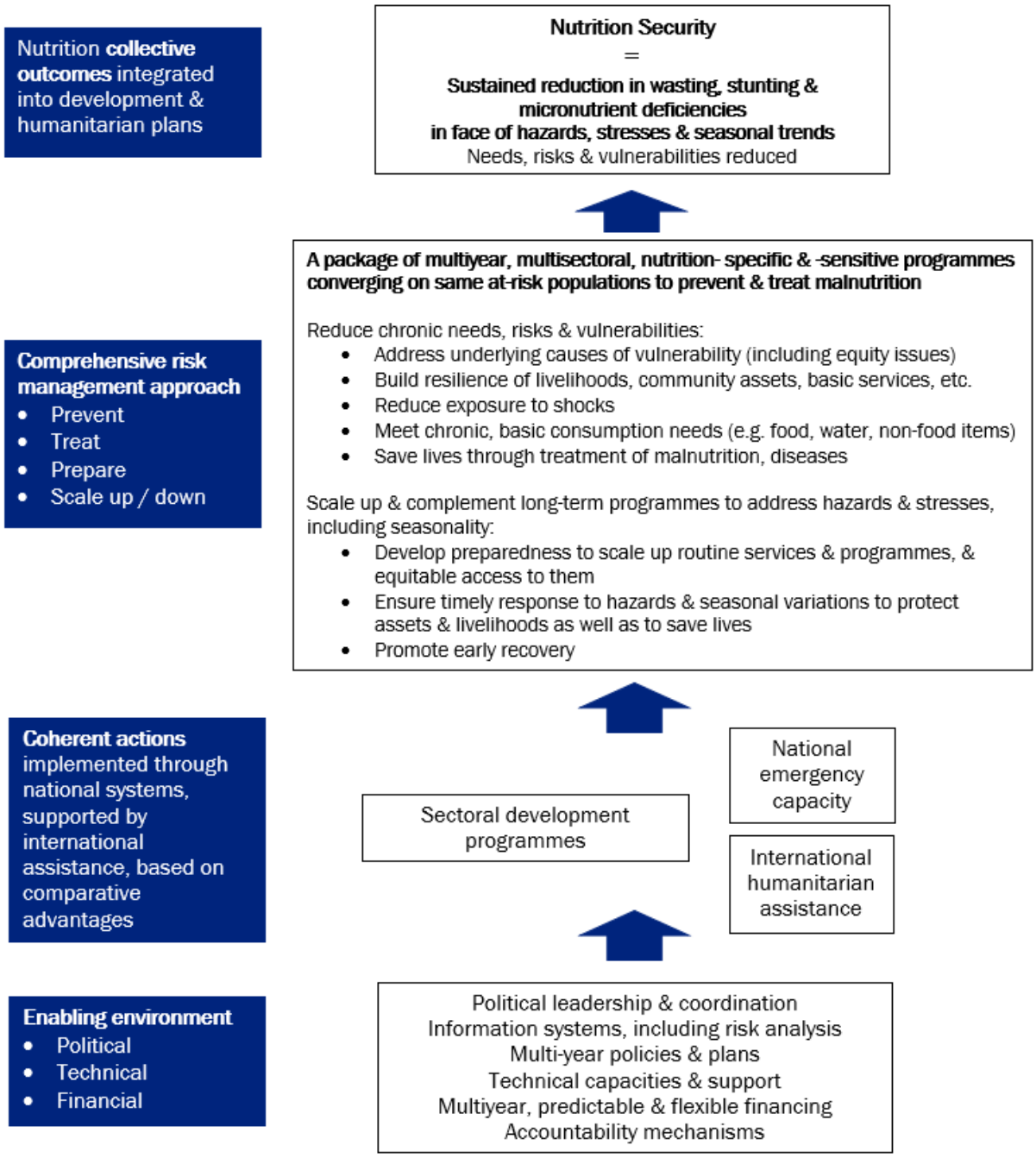


Table 2. The characteristics of programmes and approaches in contexts of protracted fragility.

	Characteristic of contexts	Needed approaches
Protracted crisis	Higher, on-going prevalence of all forms of undernutrition and disease.	Large scale, longer-term, scalable services to treat all forms of undernutrition.
	Higher levels of protracted, extreme household poverty and food insecurity, i.e. large numbers of people unable to meet their food, income and other basic needs.	Large scale, multiyear social protection programmes, including resource transfers to assist people in accessing food of adequate quality and quantity.
Recurrent acute crises	More frequent and larger-scale acute crises, with increased prevalence of acute malnutrition, micronutrient deficiencies, disease and food insecurity.	Emphasis on emergency preparedness and early response to protect livelihoods, meet basic food and other needs and treat crisis-affected people.
	Higher vulnerability of individuals, households, communities, public services and governance systems to impacts of hazards.	Actions to build resilience and mitigate impacts of hazards on individuals, communities, services, infrastructure and systems, e.g. livelihood diversification.
	Higher incidence of natural / human-made hazards.	Actions to prevent and reduce exposure to hazards.
Fragility	More complex range of basic and underlying causes.	Multisectoral nutrition-sensitive programmes (e.g. universal health coverage, agriculture and livelihoods, water, sanitation and hygiene) converging on same at-risk populations to address underlying causes and prevent undernutrition.
	Much weaker governance, finance and operational capacities, leading to higher dependence on international assistance.	Actions for enhanced nutrition coordination, planning, implementation and monitoring (national/subnational).
	Lack of political will, violations of human rights and international humanitarian law.	Initiatives to promote adherence to international human rights obligations.

Actions to promote nutrition security must be informed by, and be coherent with, broader principles and processes to reduce needs, risk and vulnerability. Reviewing the growing body of guidance on good practice in achieving this outcome in fragile contexts informed the development of a theory of change (TOC) for promoting nutrition security in contexts of protracted fragility.

Figure 5. Theory of change for nutrition security in protracted crises: reducing needs, risks & vulnerabilities.



This TOC takes internationally recognised good practice in *aligning humanitarian and development actions to reduce needs, risks and vulnerabilities* and applies it to efforts to promote nutrition security in contexts of protracted fragility and conflict. It provides a basis for developing strategies and plans for nutrition security in such contexts, as well as for describing and analysing current practices (e.g. in-country case studies).

Annex 2: Plans, Policies and Frameworks

Table 3. Description of plans, policies and frameworks.

Government's second Growth and Transformation Plan 2016 – 2020 (GTP II)
Nutrition is a key priority in the GTP II. Nutrition targets include the following: reduction of stunting from 40% in 2014/15 to 26% in 2019/20, reduction in wasting from 9.0% to 4.9% and percentage of households using iodised salt increasing from 15% to 80%. The GTP II highlights prevention and preparedness in the food-security sector to mitigate the impact of drought through increasing reserves of food and non-food items, increasing the PSNP caseload and graduates from it and providing credit to household asset building, as well as supporting households affected by the resettlement programme. It identifies the main risk as a lack of availability of development finance and drought, asserting that reducing vulnerability to drought via natural resource management and watersheds, coupled with irrigation development, is key.
United Nations Development Assistance Framework (UNDAF)

The UNDAF 2016–2020 is aligned with GTP II and has a strong focus on building a resilient social protection system. The UNDAF priority is to build community resilience sustainably through linking development and humanitarian programming. It cites a need to strengthen linkages between Disaster Risk Management (DRM) programmes and PSNP (e.g. strengthen *woreda* disaster risk profiles and contingency plans and incorporate them into the PSNP). Lessons from the previous UNDAF include the need for strong and clear monitoring and evaluation frameworks with baselines and targets for indicators. The framework also highlights that the United Nations (UN) also needs to define sustainable strategies, as well as transfer service delivery to the Government of Ethiopia (GoE).
 	
With respect to nutrition, the focus is on:
• Stimulating nutrition-sensitive agriculture under Pillar 1 (Inclusive Growth and Structural Transformation).
• Reducing acute malnutrition through local disaster risk reduction and the PSNP under Pillar 2 (Resilience and the Green Economy).
• Enhancing appropriate feeding and care practices for improved nutrition status of children under 5 years of age, adolescents and pregnant and lactating women by implementing the National Nutrition Programme (NNP) under Pillar 3 (Investing in Human Capital and Basic Services) through:
  ○ Coordination at national, regional and zonal levels.
  ○ Capacity building in health, agriculture and education sectors.
  ○ Improvement in household care practices.
  ○ Treatment of acute malnutrition.
  ○ Strengthened monitoring.
  ○ Emergency preparedness capacity building.
 	
There is a strong emphasis in the UNDAF, under Pillar 2, on ensuring disaster-prone areas are more resilient and *able to better prepare, respond to and recover from emergencies and disasters* (Outcome 3). 'The UN system in Ethiopia will work with the relevant agencies to increase the number and scope of development programmes in areas of cyclical humanitarian need and to strengthen the technical capacity (skills and knowledge) of institutions responsible for DRM governance at national and regional levels' (UN Ethiopia 2019). Outcome 3 is the number of disaster-prone areas that are more resilient, have diversified sources of income and are better able to prepare for, respond to and recover from emergencies. Pillar 2 is costed at US$1.9 billion.
 	
Targets include reduction of acute malnutrition to <10%, number of *kebeles* (or neighbourhoods) in disaster-prone areas able to create community assets, number of *woredas* with disaster risk profiles and multisectoral disaster risk reduction plans and number of internally displaced persons and host communities assisted with livelihood restoration activities.

The National Policy and Strategy on DRM (2013)
National disaster management is overseen by the DRM Commission. Its vision is to see the capacity for withstanding the impact of hazards and related disasters built at the national, local, community, household and individual levels and ensure that damages caused by disasters are significantly reduced by 2023.

Specific objectives include reducing and eventually preventing disaster risk and vulnerability that pose challenges to development through enhancing the culture of integrating disaster risk reduction into development plans and programmes, as well as by focussing on and implementing activities to be carried out before, during and after the disaster period to address underlying factors of recurrent disasters.

In times of disaster, the objective is to save lives, protect livelihoods and ensure all disaster-affected populations are provided with recovery and rehabilitation assistance. The strategy also aims to reduce dependency on, and expectations for, relief aid by bringing attitudinal change and building resilience of vulnerable people and to ensure that DRM is mainstreamed into development plans and programmes across all sector institutions and implemented at all levels.

The DRM Strategic Programme and Investment Framework provides a strategic framework for the prioritisation and planning of investments that will drive Ethiopia's DRM system. It is designed to operationalise the DRM policy by identifying priority investment areas with estimates of the financing needs to be provided by the government and its development partners.

Humanitarian Response Plan (HRP) 2018 & 2019

The 2018 Humanitarian and Disaster Resilience Plan (HDRP) was the first of its type and was partly a response to the continual and expanding HRPs, which were costed at US$452 million in 2014 and US$1.6 billion in 2019. It was a multiyear framework with the aim to save lives, protect and restore livelihoods and prepare for and respond to humanitarian shock. It had three pillars. Pillar 1 was prevention and mitigation through humanitarian and development funding; Pillar 2 was preparedness and response, largely relief through partners in hotspot *woredas*; and Pillar 3 was national systems strengthening and recovery. The HDRP was intended to mainly focus on Pillars 1 and 3 to reduce the need for future humanitarian assistance. The stated GoE ambition in the plan was to shift funding through humanitarian and development partners to direct budget support with funding through partners only for unanticipated shock. The main nutrition programmes under the HDRP were the Comprehensive Integrated Nutrition Services (CINUS) and the community-based nutrition (CBN) programme led by the Federal Ministry of Health (see section 3). The HDRP strove to link humanitarian and development programming under Pillars 1 and 3. It aimed to include treatment and prevention of malnutrition in CINUS and CBN, targeting 316 chronically vulnerable *woredas* that have links to the PSNP. The health systems strengthening component (Pillar 3) included early warning systems and guidelines for linkages between IMAM and PSNP. In the event, Pillars 1 and 3 received less than 10% of the required funding, whilst Pillar 2 was 60% funded.

In 2019, the plan reverted to an HRP seeking US$1.34 billion for 8.3 million people. The plan highlighted where linkages with development programmes already existed and encouraged partners to support the GoE to take forward DRM and to focus on shock resilience. The plan stated that the GoE aims to bring humanitarian and development funding together and to have a joined-up multiyear strategy. It asserted that to support the process, partners needed to enhance programming and funding support to decrease reliance on short-term humanitarian response. Objectives included saving lives and livelihoods and basic service delivery supported to strengthen resilience to recurrent shocks. The approach should be complementary to the GoE, be multisectoral and aim to strengthen links with development programmes.

The plan argued for coordinating health and nutrition screening in advance of vaccination and nutrition interventions and leveraging health and nutrition campaigns for coordinated health and nutrition programmes. Multisectoral nutrition programmes were encouraged in areas prone to high levels of acute malnutrition and numbers of internally displaced persons. The plan also highlighted close collaboration between the Nutrition and Health Clusters to better integrate emergency health services and wasting treatment. It also urged expansion of CINUS where high rates of acute malnutrition existed and better utilisation of US Agency for International Development transform sites (see section 3) to strengthen health and nutrition systems. In addition, the plan encouraged expanded monitoring and screening prevention and micronutrient support in high food-insecure *woredas*, as well as improved links to social protection for families with acute malnutrition and promotion of livelihoods with a focus on women. The plan also emphasises the need to collaborate with the WASH and health sectors. Finally, the plan stated that linking HRP and development means building resilient health systems to respond to crisis whilst maintaining routine health and nutrition services and strengthening resilience by incorporating nutrition-prevention actions, like micronutrient supplementation.

There is a section of the HRP on the HDN which highlights the process during 2019 for developing the Multi-Year Resilience Strategy (MYRS). The budget for resilience building (Objective 3) accounts for 16.3% of the total 2019 HRP budget.

MYRS (in press)

A vision statement in the MYRS states that, at the system level, the aim is to deliver adequate development assistance through government systems to enable the phased withdrawal of humanitarian interventions in normal years and that, at the community level, the aim is to significantly improve the resilience of chronically food-insecure households, including in years of moderate drought shocks. The overall mission statement is 'to right-size development and humanitarian assistance to meet the chronic and acute needs of dryland communities'. The MYRS is intended to be implemented between 2020 and 2025 in 12 dryland zones in north-east Ethiopia (9 highland moisture-deficit zones and 3 pastoral lowland zones). The intention is to achieve collective outcomes (COs). These include the following:

- CO1 – End poverty and hunger, achieve food security and improve nutrition and sustainable agriculture. Design and implement scalable social protection to provide adequate and predictable cash/food for the chronically food insecure, including in modest drought. End child malnutrition via achieving national targets for stunting and wasting.
- CO2 – Ensure improved access to basic services and promote wellbeing for all ages. This means universal health coverage.
- CO5 – Strengthen governance systems to manage disaster, climate and environmental risk.

MYRS is led by the NDRMC, Ministry of Peace and Office of the Prime Minister. The resourcing is to be realised through realigning GoE funds, mainstreaming DRM contingency funds, harmonising cash and food assistance and mobilising new funds. The strategy recognises that, when drought occurs, the GoE will need partner assistance. It also states that the GoE will develop guidelines for humanitarian interventions that include phased withdrawal of partners in the recovery phase and that drought disaster response is the responsibility of many ministries, with shock managed at each administrative level and escalated upwards when that level is overwhelmed. It further states that the MYRS is an opportunity to bridge the HDN and inform GTP III, PSNP 2020-25, UNDAF 2020-24 and a potential multiyear HRP.

Ethiopia Refugee Response Plan (Jan 2019 – Dec 2020)

Ethiopia became one of the first countries to apply the Comprehensive Refugee Response Framework in February 2017. It will receive funds in the order of US$350 million to support the GoE's shift from a focus on an encampment policy towards activities that promote refugees' welfare and inclusion in the country's socioeconomic structures (i.e. expand out of camp policy, provide work permits, enrol refugees at all three levels of education, ensure access to irrigatable land, facilitate integration with host communities where protracted refugee programmes exist and provide access to basic social services).

There are six strategic objectives, including the development of strong linkages with local and national development-related interventions. Cash-based transfers are to be rolled out in many camps.

CMAM is implemented in all camps, with blanket supplementary feeding where the prevalence of global acute malnutrition is above 15%. There is also mainstreaming of infant and young child feeding in emergencies in all sectors. The refugee programme aims to provide 2,100 kcals per capita in the camps, but the current mean average is only 1,750 kcals. The aim in 2019/20 is to strengthen multisectoral linkages between nutrition-sensitive WASH, food-security protection, shelter and livelihoods. Interventions in camps include micronutrient provision, CBN, early warning and surveillance, cash replacement of food, fresh foods and backyard gardening to increase dietary diversity, linking of livelihood programmes to allow economic integration and reduction in food-assistance dependency.

The GoE has established a Comprehensive Refugee Response Framework governance structure—which includes a Steering Committee, chaired by the Office of the Prime Minister and comprising line ministries, federal agencies, development actors, the UN, nongovernmental organisations and donors based in Ethiopia—to drive the practical implementation of the pledges.

NNP II 2016-2020 and the Seqota Declaration

The goal of the NNP is to provide a framework for the coordinated implementation of nutrition interventions to end hunger by 2030. The programme was developed in step with the government's efforts to realise the Seqota Declaration (see below) through the integrated and coordinated implementation of high-impact nutrition interventions to reduce malnutrition amongst children, women of

reproductive age, adolescents and the general population. The main interventions under NNP II include optimal breastfeeding, optimal complementary feeding, mitigation and prevention of micronutrient deficiencies, WASH, deworming, food fortification and management of acute malnutrition.

NNPII is predicated on many of the challenges faced and identified in NNP I (i.e. coordination mechanisms that are not accountable, absence of implementation guidelines or staff at the sector level and lack of reporting mechanisms and measurable indicators).

There are five strategic objectives for NNP II, as follows:

I. Improve the nutrition status of women between 15 and 49 years and adolescent girls between 10 and 19 years of age (e.g. anaemia and low birth weight targets).
II. Improve child nutrition status up to 10 years of age, including reducing stunting from 40% to 28%, underweight from 25% to 13%, wasting from 9.9% to 4.9% and anaemia from 39% to 24%; increase the percentage of the population with a minimum dietary diversity score from 5% to 40%.
III. Improve the delivery of nutrition services for communicable and noncommunicable diseases.
IV. Strengthen implementation of nutrition-sensitive interventions in the Ministry of Agriculture and Natural Resources and Ministry of Livestock and Fisheries.
V. Improve multisectoral coordination and capacity to implement NNP II.

The Seqota Declaration is the GoE commitment, unveiled in 2015, to end stunting in children under 2 years of age by 2030, building on and supporting the NNP.

The 15-year Seqota Declaration road map focusses on delivering high-impact nutrition-specific, nutrition-smart and infrastructure interventions across multiple sectors—namely, health, agriculture and natural resources, livestock and fishery, water, irrigation and electricity, education, labour and social affairs, women and children affairs and the environment, forest and climate change.

The current innovation phase is testing various actions, one of which is a community lab and model of a nutritional household/family concept. This has been developed to serve as a sustainable community-development approach to end stunting by focussing on the delivery of an integrated package of priority, evidence-based high-impact interventions that address the immediate, underlying and basic determinants of stunting.

National Food and Nutrition Policy 2018

The 2018 Food and Nutrition Policy states that attaining food and nutrition security is a constitutional and human right of Ethiopians, and hence the GoE has the responsibility to ensure that its citizens are food and nutrition secure. Objectives include ensuring the availability and accessibility of adequate food to all Ethiopians at all times by the following actions:

- Improve accessibility and quality of nutrition and nutrition-smart health services at all stages of the lifespan in an equitable manner.
- Improve consumption and utilisation of a diversified and nutritious diet that ensures citizens' optimal health throughout their life cycle.
- Improve the safety and quality of food throughout the value chain.
- Reduce food and nutrient losses along the value chain.
- Improve food and nutrition emergency risk management, preparedness and resilience systems.
- Improve food and nutrition knowledge of all Ethiopians.

The policy states that a Food and Nutrition Council shall be established at the national level to facilitate and coordinate the implementation of the Food and Nutrition Policy. The leadership and members of the Food and Nutrition Council are to be assigned by the prime minister. Regional Food and Nutrition Councils should be chaired by a body to be assigned by regional presidents and be accountable to the governing body, to be assigned by the prime minister. Similar structures should be established at zonal and *woreda* levels, to be led by the respective zonal and *woreda* administrators to efficiently coordinate and implement the food and nutrition activities. At the *kebele* level, the food and nutrition committees will be established and led by the *kebele* administrators.

Abbreviations: CMAM, community-based management of acute malnutrition; HDN, humanitarian-development nexus; IMAM, Integrated Management of Acute Malnutrition; NDRMC, National Disaster Risk Management Commission; PSNP, Productive Safety Net Programme; WASH, water, sanitation and hygiene.

Annex 3: Multisectoral Nutrition-Sensitive Programmes

Table 4. Description of key multisectoral nutrition programmes in Ethiopia.

CINUS (Government of Ethiopia [GoE and United Nations Children's Fund [UNICEF])
In 400 *woredas* (100 *woredas* implemented by UNICEF), CINUS targets children between 24 and 59 months of age and adolescents. It is fundamentally a preventive multisectoral programme covering the whole life cycle and includes WASH, health, education and agriculture activities. The GoE contributes resources in kind. The programme aims to improve complementary feeding and increase WASH and health system capacity to deliver nutrition-specific interventions. Key outcome indicators include dietary diversity. Pillar 1 is health systems strengthening for nutrition (e.g. growth monitoring and promotion, vitamin A supplementation, etc.). Pillar 2 aims to improve complementary feeding via SBC and food grain cooperatives and has a value chain transformation component. Pillar 3 focusses on access to WASH at health facilities. Pillar 4 focusses on social protection for the neediest (e.g. non-PSNP beneficiaries), and Pillar 5 focusses on activities to strengthen adolescent nutrition through provision of iron-folate and SBC for adolescents at school. This programme is operating in *woredas* with some of the highest levels of wasting and endeavours to link up with Transform Primary Health Care, where possible.
Growth Through Nutrition (USAID funded, Save the Children & consortium of INGOs/NGOs)
The programme focusses on food-insecure areas and seeks to attain a set of nutrition and WASH targets for pregnant and lactating women and children under 2 years of age. Activities are geared towards increasing smallholder farmer access to safe and diverse quality food, promoting nutrient-dense crops and small livestock and improving post-harvest practices. SBC activities are provided via health and agricultural outreach systems, concurrent with nutrition quality improvements through health facilities, including improving nutrition supplies and strengthening links with the PSNP. Growth Through Nutrition also aims to strengthen multisectoral coordination capacity at the subnational level. WASH activities include the supply and restoration of new and non-functional water points, respectively, as well as the strengthening of the management of these infrastructures and improvement in sanitation facilities.
PSNP (GoE)
This large national social-protection programme—started in 2005 and administered by the Ministry of Agriculture—is dedicated to improving food security amongst the most vulnerable people in the country. It is designed to help beneficiaries get through the lean season without depleting household assets. Beneficiaries participate in public works activities in exchange for food or cash transfers for part of the year. If physically unable to work, beneficiaries may receive direct support. To achieve a more holistic approach to reducing poverty and increasing resilience, targeted livelihood packages were added on through the Household Asset Building Program. Nutrition-sensitive provisions were added to the third phase of the programme. For example, descriptions of possible linkages between the PSNP and the National Health Extension Program were provided, and the list of eligible public works was expanded to include class attendance for nutrition education. However, capacity constraints and a lack of guidance and monitoring are claimed to have prevented most of the provisions from being fully realised. The changes to the PSNP, which went into effect in June 2015 at the start of the fourth phase, have attempted to explicitly tie agriculture and health efforts together with a unified vision for improving nutrition outcomes nationwide through nutrition-sensitive programming. It currently reaches nearly 8 million of the most vulnerable individuals (in six regions and two urban centres). It is mainly orientated towards drought-affected regions and *woredas* and does not generally have a role with conflict-affected displaced populations. During phase 3, the GoE only funded the PSNP through contributions in kind, but in phase 4 the GoE has provided 11% of PSNP financing. One measure proposed to affect greater nutrition impact of the PSNP (phase 4) is stronger linkages between health services and the PSNP (i.e. referral of households with identified malnourished children for inclusion in the PSNP). In addition, behaviour change communication materials focussing on nutrition have been developed, and clients are given the option to replace a portion of their public works obligations with

attendance at behaviour change communication sessions. Pregnant women are also meant to be transferred to direct support, which they are to receive for up to one year after they give birth. Targeting criteria are also intended to be increasingly sensitised to 'nutritionally vulnerable' households, such as those with pregnant or lactating women. Public works are meant to be made more sensitive to gender and feature reduced physical requirements for women. Furthermore, households with temporary nutrition emergencies are to be considered for temporary inclusion. PSNP (phase 4) has also been renewing its focus on livelihood development and support, but with a nutrition-sensitive spin.

However, a large funding gap over the last two years has led to a reduction in the value and diversity of the food basket, and thus reduced the potential nutrition impact since the cash value was eroded due to serious inflationary pressures. It is understood that donors are unlikely to spend more on phase 5 of the PSNP and are keen to link the PSNP with other programmes rather than trying to expand its remit. However, there are concerns over the lack of capacity and capability at the regional and *woreda* levels, where staff turnover is very high and there is a reliance on a few people in critical roles who hold responsibility for multiple packages of interventions.

There are numerous other examples of nutrition-sensitive programming in Ethiopia. Bill & Melinda Gates Foundation is funding and working closely with the Ministry of Agriculture, a partnership in which Save the Children is also involved, on a five-year effort to strengthen capacity and systems to integrate nutrition into large-scale agricultural programmes.

Abbreviations: CINUS, Comprehensive Integrated Nutrition Services; INGO, international nongovernmental organisation; NGO, nongovernmental organisation; PSNP, Productive Safety Net Programme; SBC, social and behaviour change; USAID, US Agency for International Development; WASH, water, sanitation and hygiene.

Annex 4: Humanitarian Response Plan Budgets and Funding

Table 5. Humanitarian Response Plan requirements and % funded by year.

Year	Total Requirement	Food			Non-Food			Total	
		Requirement	Contribution	% fund	Requirement	Contribution	% fund	Contributions	% fund
2010	651,836,899	542,310,063	488,843,196	90%	109,526,836	73,337,303	67%	562,180,499	86%
2011	785,329,775	574,343,794	533,170,874	93%	210,985,981	161,965,080	77%	695,135,954	89%
2012	689,623,559	524,246,955	439,367,192	84%	165,376,604	165,922,641	100%	605,289,833	88%
2013	499,885,728	373,478,784	332,359,526	89%	126,406,944	138,378,721	109%	470,738,247	94%
2014	451,945,863	342,489,090	173,434,850	51%	109,456,773	79,688,004	73%	253,122,854	56%
2015	596,400,000	470,213,297	335,712,187	71%	126,186,703	109,207,237	87%	444,919,424	75%
2016	1,619,840,085	1,109,265,921	679,880,423	61%	510,574,164	436,022,948	85%	1,115,903,371	69%
2017	1,417,400,000	892,800,000	772,067,861	86%	524,600,000	436,737,876	83%	1,208,805,737	85%
2018	1,493,908,689	750,752,360	723,722,204	96%	743,156,330	434,765,405	59%	1,158,487,609	78%
2019	1,313,589,885	600,300,000	556,957,847	93%	713,289,885	268,546,142	38%	825,503,989	63%

Annex 5: Interviewed Organisations

Table 6. Addis Ababa interviewed organisations for this case study.

Organisation
Action contre la Faim (Action Against Hunger)
CARE
Concern Worldwide
DFID (Health)
European Commission
European Union
Federal Ministry of Health
GOAL
Humanitarian Food Assistances Linkages
Mothers and Children Multisectoral Development Organization
Mercy Corps
NDRMC
Nutrition Cluster
OCHA
PLAN International
Productive Safety Net Programme
Save the Children
Scaling Up Nutrition Focal Point
United Nations Children's Fund
US Agency for International Development
World Health Organization
World Bank
World Food Programme
World Vision

Abbreviations: DFID, UK Department for International Development; NDRMC, National Disaster Risk Management Commission; OCHA, Office for Coordination of Humanitarian Affairs.

Table 7. Interviewed offices/organisations* in Ebinat Woreda, Amhara, for this case study.

Organisation
Nutrition adviser to *woreda* government
Livelihood and Nutrition Technical Project head
Food Security specialist
Economic Development specialist
Operations and Monitoring specialist
World Vision representative*
Emergency Nutrition specialist
Health and Nutrition adviser
Head of Livelihood and Nutrition

* All are government officials except for the World Vision representative.