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Working towards inclusion – Refugees within the national systems of Ethiopia

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Table of acronyms

ARRA	Administration for Refugee and Returnee Affairs, Ethiopia
ART	Antiretroviral Therapy
CRRF	Comprehensive Refugee Response Framework
DICAC	Ethiopian Orthodox Church Development and Inter-Church Aid Commission
DFID	UK's Department for International Development
ECCE	Early Childhood Care and Education
ECHO	European Civil Protection and Humanitarian Aid Operations
EMIS	Education Management Information System
EPI	Expanding Programme on Immunization
ETB	Ethiopian Birr (currency)
FHAPCO	Federal HIV/AIDS Prevention and Control Office
FMOE	Federal Ministry of Education
FMOH	Federal Ministry of Health
FVERA	Federal Vital Events Registration Agency
HIV	Human Immunodeficiency Virus
IDA	International Development Assocation
IOM	International Organization for Migration
IRC	International Rescue Committee
IRS	Indoor Residual Spraying (malaria control)
MSF	Médecins Sans Frontières
OCP	Out-of-Camp Policy
OWNP	ONE WASH National Programme
TTC	Teacher Training College
TB	Tuberculosis
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WFP	World Food Programme
WHO	World Health Organization

Introduction

Ethiopia has a long history of welcoming refugees onto its territory. Today, it provides protection to 894,000 refugees and asylum seekers from 24 countries, making it the second largest hosting country in Africa and the sixth hosting country worldwide.[1] Refugee demographics vary, with an estimated 420,000 South Sudanese living along the Southwestern border, 253,000 Somali refugees residing along the Eastern border, and 169,000 Eritrean refugees living mainly along the Northern border, and other groups living both in urban and rural areas of the country.[2]

As a party to the 1951 Convention relating to the Status of Refugees, its 1967 Protocol and the 1969 Refugee Convention of the Organization of African Unity, the Federal Democratic Republic of Ethiopia maintains an open door policy for refugees into the country and allows humanitarian access and protection to those seeking asylum on its territory.[3] Ethiopia recognizes *prima facie* refugees from South Sudan, Eritrea, Yemen, and Somalia (those originating from South and Central Somalia).[4] For others, the Government's Eligibility Committee, on which UNHCR sits as an observer, undertakes individual refugee status determination.

Refugees have found safe haven across the whole country, including in the capital Addis Ababa, as well as the seven Regional States of Afar, Benishangul-Gumuz, Gambella, Oromia, Somali, Southern Nations, Nationalities and Peoples' Region and Tigray.[5] Many of these border regions face the challenges of poor infrastructure, high levels of poverty, adverse weather conditions, low capacity and poor development indicators. Notwithstanding these challenges, these regions continue to receive refugees, year after year.

By opening up its borders, Ethiopia has provided protection to people fleeing their homes as a result of insecurity, political instability, military conscription, conflict, and other problems in their countries of origin. Refugees account for 0.85 per cent of the estimated 99 million population of Ethiopia.[6] While the percentage of the overall population is very small, the geographical distribution by region can be significant. In Gambella region, for instance, the refugee population was recorded at 399,174 at the end of October 2017 while the host population stood at 307,097[7], which meant that refugees made up 57% of the overall population.

The Government maintains a policy requiring refugees to reside in refugee camps, however some exemptions have been made for those with serious protection concerns, for health and humanitarian reasons, as well as for Eritrean refugees covered by the Out-of-Camp policy.[8] Authorities in Ethiopia are also reflecting on an

[1] UNHCR, Global Trends: Forced Displacement in 2016, 2017.
[2] UNHCR, Ethiopia Fact Sheet, November 2017.
[3] Ethiopia ratified both the 1951 Convention and the 1967 Protocol on 10 November 1969, and the OAU Convention on 15 October 1973.
[4] The Ethiopian Government grants automatic refugee status to Yemenis who arrived after 1 January 2015.
[5] UNHCR has 26 offices in the country, including the UNHCR Representation in Ethiopia (in Addis Ababa), as well as Sub and Field Offices in five Regional States: Afar (Aysaita, Barahle), Benishangul-Gumuz (Assosa, Tsore, Bambasi, Sherkole, Tongo), Gambella (Gambella, Dimma, Itang, Pugnido), Somali (Jijiga, Melkadida, Aw-barre, Sheder, Kebribeyah, Dollo Ado, Bokolmanyo, Kobe, Hilaweyn, Buramino) and Tigray (Shire, Mekele, Embamadre, Shimelba).
[6] World Bank Group, Ethiopia: Country at a Glance, 2017.
[7] Central Statistics Agency of Ethiopia, 2017.
[8] The Government issued the Out-of-Camp (OCP) policy in 2010, providing Eritrean refugees in particular an opportunity to live in Addis Ababa and other non-camp locations of their choice.

expansion of the Out-of-Camp policy, giving priority consideration to respond to the new refugee influx, and in particular to those arriving from South Sudan. To date, more than 100,000 South Sudanese have arrived since January 2017.[9] Recognizing that many seek to remain close to border, and some do travel home for brief 'go-and-see' visits, authorities in Ethiopia are considering to relax the encampment restrictions for this group.

The institutional responsibility for the implementation of all policies relating to refugees and returnees lies with the Administration for Refugee and Returnee Affairs (ARRA) under the National Intelligence Security Service.[10] ARRA is the main Government entity working on refugee affairs with the UN High Commissioner for Refugees (UNHCR) and administers the refugee camps with financial and technical assistance from UNHCR and other aid agencies in accordance with the 2004 Refugee Proclamation. It is responsible for overseeing the security of the camps, providing protection and coordinating services provided to refugees. ARRA oversees camp management, general food distribution, implements primary healthcare and education services, and acts as the main liaison with line Ministries that administer national programmes.

Over the last few years, the collaboration with Ministries at the Federal and State levels has grown. ARRA, UNHCR, sister UN agencies and NGO partners are increasingly relying on the technical support of line Ministries to deliver basic services to refugees in key sectors, such as education, health, child protection, and water and sanitation.[11] The value added of this approach is clear: by facilitating the inclusion of refugees in the national systems, the Government ensures a more holistic, cost-efficient and coordinated response that can benefit both host and refugee populations alike.

Such an approach is all the more significant given that Ethiopia is the second-most populous country in sub-Saharan Africa, and has an estimated 30 percent of the population still living under the poverty line.[12] With only 19 percent of its population living in urban areas, agriculture production remains the source of livelihood for a great majority of the population.[13] The Government's pro-poor programmes implemented in rural areas have sought to further reduce poverty, yet much remains to be done. The poverty levels require the Government, UN agencies and donors to invest in basic services to ensure that Ethiopia continues to make progress in education, health and living standards for both the host population and refugees. It is also a strategic move for a country that is likely to continue receiving refugees, as most of Ethiopia's neighbors are experiencing continuing political instability or conflict.

Any Eritrean refugee in Ethiopia can benefit from the OCP if they have the necessary means to financially support themselves, have relatives or friends who commit to supporting them and have no criminal record.

[9] UNHCR, Ethiopia Fact Sheet, September 2017.

[10] In the aftermath of the 1973 famine in Ethiopia, the Government established the Relief and Rehabilitation Commission. It was then renamed as the Commission for Disaster Prevention and Preparedness, and worked on forced displacement issues until the early 1980s when ARRA was created.

[11] Ethiopia's tiered government system consists of a federal government overseeing regional states, zones, districts (*woredas*) and neighborhoods (*kebele*). At present, Ethiopia is administratively structured into nine geographical regions– Tigray, Afar, Amhara, Oromiya, Somali, Beneshangul-Gumuz, Southern Nations nationalities and Peoples, Gambella and Harari – and two administrative cities, Addis Ababa and Dire Dawa Administration Councils.

[12] World Bank Group, Ethiopia Poverty Assessment 2014, 2015.

[13] Federal Ministry of Education, Education Sector Development Programme V (ESDP V), August 2015.

The pledges made by the Prime Minister of Ethiopia on 20 September 2016 at the Leaders' Summit on the global refugee crisis in New York highlight the engagement of the Government in setting clear targets involving both development and humanitarian actors, as well as donors. These pledges, outlined a day after the adoption of the New York Declaration on Refugees and Migrants and its annex on the Comprehensive Refugee Response Framework (CRRF), are ambitious as they embody a vision whereby refugees would be gradually allowed to live out of camps, work, cultivate land, access improved education and health services as well as national birth and vital events registration, and even be provided with formal legal integration for those who have spent more than 20 years in Ethiopia. The Government's decision in February 2017 to be a roll-out country for the CRRF may further improve access to rights and basic service delivery to refugees.

This study seeks to document the existing cooperation between ARRA, UNHCR and the concerned Federal and State Ministries on refugee inclusion. It is based on a desk review of key documents and semi-structured interviews carried out in April 2017 in Ethiopia to collect baseline information.[14] The findings of this research are laid out in four separate sections, focusing on health, water, education, and child protection. These areas were selected for documentation purposes as ARRA, UNHCR and line Ministries have forged close collaboration in each of them. The study concludes by suggesting additional areas that could potentially lend themselves to even greater collaboration.

To ensure the sustainability of these efforts in the medium-term, they will need to be anchored in Ethiopia's development plans and national budget. The country has the largest and fastest growing economy in East Africa. It has recorded double digit growth and between 2000 and 2011 reduced the percentage of the population below the national poverty line from 55.3 percent to 33.5 percent.[15] Ethiopia's national development policy, outlined in the Growth and Transformation Plan II (2015-2020), has been designed to accelerate the reduction of poverty, in order to move the country towards a middle-income economy by 2025. Such economic progress and ambition provide a favourable environment for the refugee reform agenda outlined by the Government in its pledges and roll-out of the CRRF.

The World Bank Group's new Country Partnership Framework for Ethiopia (2018-2022) should facilitate access to several financial instruments that will likely help propel this economic growth. Equally important is the decision of the WB's Governing Body to approve the International Development Association's 18 round (IDA-18) of development financing to address the consequences of forced displacement in the country. For Ethiopia, the notional allocation range from the IDA-18 regional sub-window for refugees and host communities is in the order of 170 million to 215 million USD. This funding is meant to support the Government's policy shift from a focus on encampment to a sustainable management of refugee situations within a medium-term

[14] Interviews were carried out with staff from ARRA, the Federal Ministries of Health and Education, the Federal Vital Events Registration Agency, UNICEF and UNHCR based in Addis Ababa. Interviews were also conducted in Gambella with the Regional Bureaus of Water, Health, Education, Women and Children, Labour and Social Affairs, UNHCR, and the International Rescue Committee. In addition, teleconferences were held with UNHCR staff in Melkadida and Shire. Particular thanks go to Mamadou Dian Balde, Betsy Lippman, Jose Egas, Ewen Macleod, David Karp, Girma Yadeta, Sandra Harlass, Dejene Kebede, David Githiri Njoroge, Rana Milhem, Dominique Reinecke, Karene Melloul, Yonatan Araya and Berhanu Geneti for their initiatives and contributions.

[15] Michael Geiger and Priyanka Kanth, "What Studies in Spatial Development Show in Ethiopia – Part I", World Bank blog, 20 September 2017.

perspective. The World Bank has also approved a 100 million USD Development Response to Displacement Impact Project aimed at improving access to basic social services across several countries in the Horn of Africa, including Ethiopia. The availability of this funding will be significant in gradually mainstreaming service provision to refugees into national delivery systems.

The issue of refugee inclusion in the national systems is at the heart of a longer-term approach that needs to be pursued simultaneously with emergency response, in order to build the self-reliance of refugees and the host population as well as the resilience of entire communities to withstand shocks and protect development gains. Its success will be contingent upon effective joint planning, adequate donor support and an ability of all stakeholders to work side by side, in a complementary fashion, in order to deliver on the Government's pledges aimed at ensuring a comprehensive refugee response.

1. Refugee inclusion in the national health system

Ethiopia has made the strengthening of its health care system a priority over the past two decades. Its investments have resulted in increasing access to health services and significantly improving health outcomes of the population. Under-five mortality has dropped by 67 percent, contributing to an increase in average life expectancy at birth from 45 in 1990 to 64 in 2014.[16]

This progress notwithstanding, the country still has high rates of morbidity and mortality from preventable causes, such as lower respiratory infections and diarrheal disease. The Government has outlined in the Health Sector Transformation Plan its goals to improve equity, coverage and utilization of essential health services, improve quality of health care as well as enhance the implementation capacity of the health sector at all levels of the system. The Government has also endorsed UNHCR's Ethiopian Refugee Programme Public Health Sector Strategic Plan 2014-2018 that outlines the principles and strategic areas for response throughout the displacement cycle.

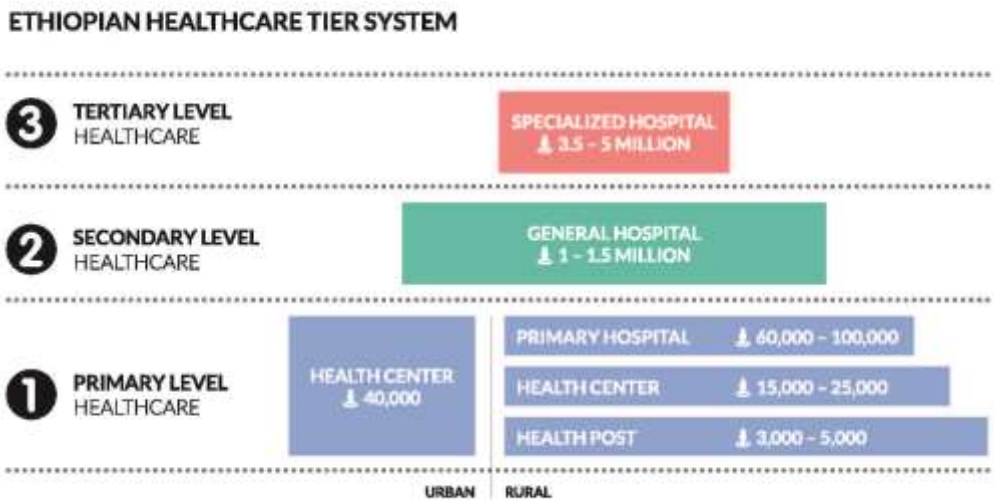
Nationwide, the health sector accounts for 5 to 6 percent of government spending, but there are large variations between regions. [17] The spread between regions is substantial in terms of both proportion of spending on health and per capita health expenditure. While health spending has increased in recent years to about 21 USD per capita, it has been driven primarily by non-government sources. Government expenditure contributes less than 20 percent of total health spending, while external assistance from development partners accounts for about 50 percent and out-of-pocket spending for about one-third.[18]

It is within this broader context that the provision of health care to refugees and host communities must be seen. The investments made by the Government of Ethiopia in the health system are meant to cover everyone, including nationals, refugees and other foreigners living in the country. The support provided by humanitarian organizations and ARRA within the refugee response therefore contribute to improving the country's health outcomes.

UNHCR, ARRA and NGO partners are facilitating access to health care services to prevent excess morbidity and mortality. They ensure that all refugees are able to fulfill their rights to lifesaving and essential health care including HIV and reproductive health services, as well as services for food security and nutrition, water sanitation and hygiene services. [19] Primary health care centers provide services free of charge for refugees and host communities in all the 26 refugee camps. The health facility utilization rate reached 1.2 consultation per refugee per year in 2017 (standard: 1 to 4 consultations). The mortality rate in children under five was 0.2 per 1,000 per month and remains within the expected range in all camps.[20]

[16] The Federal Democratic Republic of Ethiopia, Health Sector Transformation Plan 2015/16-2019/20, October 2015.
[17] World Bank Group, Ethiopia Public Expenditure Review, April 2016.
[18] Ibid.
[19] The main NGOs working in the health sector include: Action Contre la Faim (ACF), CONCERN, GOAL, HUMEDICA, International Medical Corps, International Rescue Committee (IRC), MSF-Holland, MSF-Espagna, and Rural Aid and Development Organization (RADO).
[20] UNHCR, Health Information System, November 2017.

1.1 One system, two administrative bodies



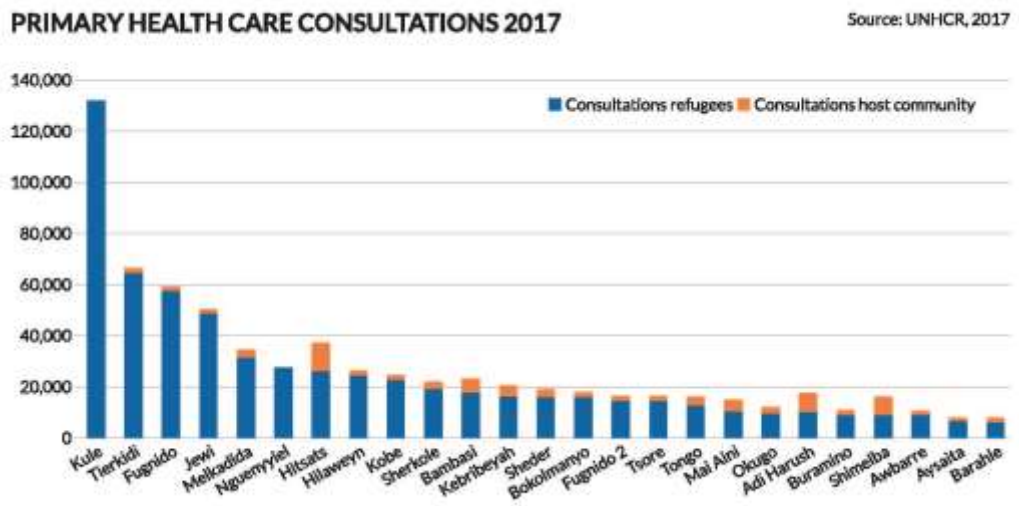
Health care services in Ethiopia are provided through a system of health posts, health centers, hospitals and referral hospitals. In accordance with Ethiopia's federal system, the Regional Health Bureau at the State level is the main administrative body responsible for the overall management of the health system. Within each Regional State, there is a network of management structures that involve Zonal Health Departments and Woreda (district level) health offices. This decentralized model implies that each Regional Health Bureau is both administratively and financially responsible for health care delivery, and receives a substantial subsidy from the Federal Government every year.

Typically, the Regional Health Bureau will develop an annual work plan and provide the documentation to the Federal Ministry of Health to ensure conformity with national guidelines. UNHCR and ARRA participate in some regions in the development of disease-specific micro-planning exercises at regional level that include the refugee population. However, the Regional Health Bureau does not manage the administration of primary health facilities in the refugee camps, which falls under ARRA's remit of responsibilities.

ARRA is the second administrative body. It acts both as a coordinator and the main implementing partner for primary health care services in refugee camps, which are fully funded by UNHCR. In most refugee camps, there is one primary health care center that is managed by ARRA. A few primary healthcare facilities (health centers and health posts) are managed by NGO partners, such as Médecins Sans Frontières (MSF) (Gambella, Melkadida) and Humedica (Melkadida). Depending on the number of refugees residing in the camp, additional health centers or health posts are established to support the health center and ensure access of the refugees to healthcare services. ARRA and UNHCR have also established with district health centers and hospitals an exchange system for drugs with excess and short expiry dates.[21]

[21] ARRA will send the list of drugs to the government-run health facility neighbouring the refugee camps, and upon receiving a positive response, will dispatch the supplies. Drugs are usually sent from the refugee health facility to the hospital six months before the set expiry (three months

Refugees have access to the national health care system at the same costs as Ethiopians. Costs for health care are subsidized by the Ethiopian government and payments are out-of-pocket, as health insurances schemes are in the planning but not yet available. Primary health care facilities in refugee camps are also accessible for host community members at no costs. In 2016, altogether 868,746 consultation were provided, of which 12.6% (109,895 consultations) were for host community members.



Source: UNHCR, 2017.

For access to secondary health care, refugees are referred to health facilities outside the camp, which are run by the Regional Health Bureau. Sometimes hospitals or health centers in the districts and the regions are supported by NGOs like MSF.[22] ARRA will cover the costs of treatment for referral care provided to the refugees in these facilities. Recognizing the fact that refugees access the national health system for more advanced treatment at secondary and tertiary healthcare facilities, UNHCR has over the last ten years donated medical equipment to regional hospitals. These donations have helped to enhance service availability and improve the quality of care provided to both nationals and refugees alike.[23] If treatment is not available at regional level (e.g. for advanced diagnostics, cancer therapy), refugees are further referred to tertiary hospitals located in larger cities.

ARRA's remit of responsibilities extends to urban areas. In addition to those referred on medical grounds, access to health care and referrals are provided to refugees who are in urban locations for reasons like scholarships, resettlement interviews, and protection reasons.[24] UNHCR and ARRA work closely with the Ministry of Health and

expiry dates are also accepted given the large volume of patients that a hospital receives). ARRA also runs a camp to camp drug exchange mechanism.

[22] For example, UNHCR, ARRA, the Regional Health Bureau and the Gambella Hospital carried out a needs assessment in 2014 and found that more than 50% per cent of the patients in the hospital were refugees. Gambella hospital then has the power to refer patients to Addis Ababa or Metou hospitals and other facilities.

[23] UNHCR has provided the following equipment: X-ray and ultra-sound machines to Jijiga hospital, X-ray and ultra-sound machines, beds and anesthetic machine to Assosa hospital, and ultra-sound machine and beds to both Shire and Gambella hospitals.

[24] The Ethiopian Orthodox Church Development and Inter-Church Aid Commission (DICAC) is the main health partner for the urban assistance programme. The International Organization for

other authorities to make public health services available at similar costs to that of nationals. Such an approach of integration aims to strengthen the national public health system.

1.2 Disease surveillance, emergency preparedness and response

Crises caused by armed conflict resulting in forced population displacement usually result in high rates of excess morbidity and mortality from communicable diseases and/or malnutrition. Refugees and internally displaced persons have experienced high mortality rates during the period immediately following their migration. For example, the 2011 refugee crisis in Dollo Ado on the border with Somalia saw mortality rates soar during the peak of the influx to 14 times above the standard.[25] The most common causes of death are diarrheal diseases, measles, acute respiratory infections and malaria. High prevalence of acute malnutrition also contributes to high case fatality rate.

Emergency preparedness and response to epidemics stands out as one area of close collaboration between the Regional Health Bureau, ARRA, UNHCR and the Federal Ministry of Health. The Regional Health Bureau is in the lead for contingency planning both for refugee camps and host communities. It chairs the Emergency Preparedness Task Force and regularly holds meetings with ARRA and UNHCR on health related issues. Refugees are not a stand-alone group in the population for outbreak preparedness and response; rather, all national public health initiatives include refugees as one target group among others. Moreover, the Regional Health Bureau works closely with the World Health Organization (WHO), ARRA and UNHCR on epidemic surveillance at the border, and coordinates regularly with the Ministry of Health.[26]

During an emergency resulting from the new influx of refugees in some regions, the Regional Health Bureau is often amongst the first to arrive to the scene, even before the humanitarian organizations and ARRA have established a presence on the ground. For example, during the influx of South Sudanese refugees in 2014, the Regional Health Bureau established a system for nutritional screening, undertook immunization of target groups and provided clinical services with support from the UN Children's Fund (UNICEF) until the refugees were transferred to camps and activities were taken over by UNHCR, ARRA and partners.[27] The services also included systematic distribution of vitamin A and deworming tablets for the new arrivals.

In addition, in 2014 the Regional Health Bureau, with the support of UNICEF, organized oral polio and measles vaccination for all new arrivals below the age of 15 in Gambella region, mainly in the entry points of Akobo, Burubiey, Matar, Pagak and Raad along the border with South Sudan. More recently in September 2016, the Regional Health Bureau worked efficiently with ARRA and UNHCR to vaccinate over 55,000 children under the age of 15 against polio and measles at the entry points, covering all those eligible.[28]

Migration (IOM) handles UNHCR medical assessment for consideration of resettlement and is also responsible for the transportation of cases of resettlement.

[25] UNHCR, Ethiopia Refugee Programme, Strategic Plan, Public Health Sector, 2014-2018.

[26] The Regional Health Bureau has a programme of disease surveillance covering guinea worm and 20 other disease surveillance. The Ministry of Health has also increasingly begun including refugees and host communities in its assessments.

[27] The collaboration between UNHCR and UNICEF in the response to the emergency influx from South Sudan was praised in an evaluation available at http://www.unhcr.org/56b1d8df9.pdf

[28] UNHCR, Health report, April 2017.

When disease outbreaks occur in refugee camps, the first responder to learn about an outbreak in a refugee camp is typically ARRA or an NGO partner, which in turn informs UNHCR, the Woreda Health Office and the Regional Health Bureau. In the case of outbreak, extra vaccines are needed, and both the Regional Health Bureau and the Ministry of Health will lead efforts to mobilize additional resources.[29]

1.3 Prevention and control of major disease burdens

For many years now, refugees have been included in the national health system dealing with disease prevention and control as they are not considered a separate stand-alone group. The most recent example is the decision of the Ministry of Health to include refugees in Gambella and Assosa in the national programme for the elimination of neglected tropical diseases since 2017. Thus, the national disease control programmes represent another major area of collaboration between ARRA, UNHCR and both federal and regional health authorities.

In terms of planning, UNHCR, ARRA and NGO partners are typically involved in the forecasting exercises of the Regional Health Bureau (e.g. determining vaccine or HIV/TB drug quantities), which in turn are relayed to the Ministry of Health responsible for securing the required resources. The Regional Health Bureau orders different medicines to treat Human Immunodeficiency Virus (HIV), leprosy, malaria and tuberculosis (TB) directly from the Pharmaceutical Fending Supply Agency of the Ministry of Health. UNHCR continues to fill gaps in supply, especially for the diagnosis and treatment of malaria.

HIV treatment – HIV diagnosis and treatment efforts are invariably disrupted in conflict situations due to the unavailability of services, delayed treatment-seeking and discontinuation of treatment. Once refugees have found safety across the border, efforts are made to prevent and control HIV/AIDS. The Regional Health Bureau provides to the refugee health facilities testing kits and antiretroviral drugs obtained from the Ministry of Health. Only when there are shortages nationwide will UNHCR consider stepping in to purchase of the required HIV testing kits in order to fill the gaps.

When a patient is diagnosed as HIV positive, the refugee is referred either to a refugee health center within the camp or a Antiretroviral Therapy for HIV (ART) facility run by the Regional Health Bureau. ART treatment centers are established with approval of the Ministry of Health in refugee camps if there is no HIV center nearby and when the number of HIV positive cases requiring treatment has reached a certain threshold. These treatment sites serve both refugees and host communities. At the end of 2016, 8 ART centers in refugee camps served 1,467 persons living with HIV, including 485 host community members.[30]

Moreover, since December 2016, refugees are included in national HIV prevention catch-up campaign organized across the 9 regional states and two city administrations by the Federal HIV/AIDS Prevention and Control Office together with the Federal Ministry of Health. By the end of May 2017, the collaboration between ARRA, UNHCR and the line Ministries resulted in 126,823 tests conducted in refugee camps across

[29] For example, in Gambella region, the Regional Health Bureau coordinated the response to the measles outbreak in 2014, Hepatitis E outbreak in 2014-2015, the meningitis outbreak in 2016 and the flooding in Leitchuor during late 2014 and beginning of 2015. The Regional Health Bureau also handled a measles outbreak in Shire effectively in 2014, by providing technical support to staff on the ground, guidelines for response, mass vaccination and programme drugs.
[30] UNHCR, Health Information System, December 2016.

the country and 374 HIV positive cases (0.3%) were newly identified and linked to ART services.[31]

Tuberculosis - Much like HIV treatment, tuberculosis control programmes are disrupted in conflict situations. Ethiopia's Government is committed to reducing the TB mortality burden as it remains a major public health problem in the country.[32] Emphasis is placed on ensuring early detection of cases, response and close follow up. TB treatment in the initial phases of an emergency is provided at closer public health facilities until the service is established in the refugee camps. All TB cases are linked to HIV prevention and treatment and are screened for HIV.

All the supplies to diagnose TB in the laboratory and treat cases are obtained from the Ministry of Health, through the Regional Health Bureau and are provided to ARRA to run the health facilities, which provide the service free of charge.[33] ARRA is also a member of the Steering Committee for TB at the Ministry of Health. In order to improve the health system's ability to undertake proper case detection, treatment and follow up, ARRA has discussed with the Ministry on the possibility of organizing joint supervision of health facilities in the camps. This joint supervision is expected to the TB programme among the refugee population by strengthening case detection, diagnostic capacities of the laboratories, the treatment and follow up services.

Vaccination of children - Similarly, refugee children often miss their vaccination in their country of origin due to conflict and disruption of services. The Regional Health Bureau, together with ARRA and UNHCR, are striving to bring refugee children under coverage of the national Expanded Programme on Immunization (EPI) as such an approach is considered to be the most cost-efficient preventive intervention to reduce childhood morbidity and mortality.[34] The Ministry of Health has long provided vaccine and related supplies to the refugee camps since the introduction of EPI. The Regional Health Bureau undertakes the vaccination of children between 6 months and 15 years at the border point of entry while ARRA is ensuring vaccination of infants under the national EPI after they are settled in camps. A formal agreement was signed between ARRA, UNHCR and the Ministry of Health in 2012 to ensure the sustainable supply of vaccines and related supplies.

Malaria - In addition, the Government has as a priority to reduce the overall burden of morbidity and case fatality rate due to malaria, which remains high in the country. ARRA, UNHCR and its partners coordinate with the national malaria prevention and control programme. Prevention and control strategies for malaria include early detection and treatment, distribution of Long Lasting Insecticide Nets, Indoor Residual Spraying (IRS) and environment management. Indoor Residual Spraying against malaria in refugee and host community households is held once a year before the peak transmission season in June and July in collaboration with the Regional Health Bureau for which funding is provided by UNHCR. UNHCR also funds the distribution of bed nets and the purchase of testing kits and malaria drugs that are used in the ARRA-run health centers. In the event that international drug procurement is delayed or shortage is created, ARRA will approach the Regional Health Bureau to access local supplies to fill gaps.

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[31] UNHCR, HIV catch-up campaign data in refugee camps, 2017.

[32] Ethiopia is on the WHO "high-burden country" for tuberculosis. A total of 30 countries are on this list and account for over 85% of the global burden.

[33] In 2016 alone, there were 522 newly enrolled TB cases and 310 cases receiving treatment in the refugee population.

[34] The immunizations cover polio, measles, TB, pneumonia, meningitis, Rota virus, pertussis, tetanus, diphtheria, and hepatitis.

1.4 Staffing of health facilities

Health facilities in refugee camps have faced challenges in the recruitment, training and retention of health professionals, which in turn has impacted the availability of services and quality of care.

In the past, ARRA undertook direct recruitment of health practitioners for the refugee health facilities. Yet it proved difficult to retain staff, particularly medical doctors for more than six months as most of the camps are located in isolated, underdeveloped parts of the country. Some health professionals have also been demotivated by requirements to participate in monthly food distribution exercises (which can take anywhere between three to seven days per month), during which time the health facilities run at minimal capacity as the service is limited to providing emergency medical care. Moreover, the work done by health practitioners in refugee health facilities has not counted towards the years of public service experience that young graduates from a public university are expected to complete before receiving their final certificate.

Recognizing these difficulties, ARRA formalized recruitment efforts with the Ministry of Health in 2016. The Ministry now deploys staff to ARRA-run health facilities on the basis of the requests that it receives from ARRA.[35] Staff is then officially employed and paid by ARRA. Refugee incentive workers with medical training are also being recruited in all regions.[36] Staff recruited include nurses, midwifes and para-medics, and they help to address the existing language barrier between ARRA staff and refugees. To further enhance their capacity, they will need to access the clinical and public health trainings offered by Regional Health Bureaus, which are currently only available for formal ARRA staff and other health professionals. [37]

The inclusion of refugee medical staff who are currently working as incentive staff in the national training programmes has the potential to improve the quality of health care provided in the camps and mitigate staff turnover challenges. In seeking to reduce staff turnover, the payment of incentives could be another area worth revisiting, as refugee health workers currently receive incentives of 700 Birr (30 USD) per month, which is a cause for dissatisfaction and leaving employment. The new Government pledges made in September 2016 may offer an opportunity to legalize their employment at standard wages.

1.5 The persistent challenge of malnutrition

Malnutrition is a major problem in Ethiopia. In 2016, nutrition surveys conducted by UNHCR, ARRA and partners revealed that 10 out of 24 camps had global acute malnutrition prevalence above the emergency threshold of 15%.[38] Malnutrition is often linked to the limited availability of other sources of food, water, sanitation and hygiene

[35] The Ministry of Health appoints the medical doctors, health officers, nurses and midwifes and ARRA will assign them to a specific health facility.
[36] Incentive staff are refugee staff living in the camps. They receive incentives rather than a salary and are not considered full staff. Depending on their position and qualification the maximum incentive is 700 ETB/ 30USD/month.
[37] For instance, midwives are usually sent for basic emergency maternal obstetric and neonatal care training at the Government-run Gandhi hospital in Addis that is a center for gynecological health and obstetric health.
[38] UNHCR, SENS (nutrition) surveys, 2015/ 2016.

(WASH) services, poor infant and young child feeding practices, poor hygiene practices and food ration cut due to lack of resources. [39]

Refugees remain mostly dependent on the monthly food assistance consisting mainly of a food ration and cash. As food rations have gone down in recent years, refugees have reported 5-10 days of monthly food gap, and even longer for single households.[40] Food is distributed in sites, which are often overcrowded and involve long waiting hours. Most refugee school aged children receive an extra meal a day through the school-feeding programme (with the exception of some schools in Gambella and Assosa camps, which lack cooking facilities and cooks).

In order to address the persistent issue of malnutrition, UNHCR, ARRA, UNICEF, and the World Food Programme (WFP) have worked more closely together since 2014 in developing nutrition action plans for refugees in regions with high Global Acute Malnutrition Prevalence. ARRA and UNHCR focus on support to refugee populations, while UNICEF and WFP run programmes with the Regional Health Bureau to support host communities that are affected by malnutrition. The procurement of the supplies for severely and moderately malnourished children are done by UNHCR and WFP respectively, and in some cases they are obtained from UNICEF. As a result, no significant shortage has been encountered.

Yet in spite of significant efforts, data suggests that the malnutrition is cyclical in nature, with refugee children going through the nutrition programmes and then falling sick again. To better understand the underlying causes of the malnutrition, UNHCR has commissioned an anthropological study to have a nutrition causal analysis, and a basis to better advocate for policies that encourage self-reliance of refugees, including the ability to farm the land and grow their own food.

In addition, UNHCR, ARRA and the government health authorities are exploring ways to bolster staff capacity to tackle nutrition issues. Regional Health Bureaus provide training of trainers on community management of acute malnutrition and young child feeding curriculum. The staffing situation could be further improved if refugees working as health practitioners attend the courses on nutrition offered by the national training system.

1.6 Looking towards the future

The Government of Ethiopia pledged in September 2016 at the Leaders' Summit on Refugees to strengthen, expand and enhance basic and essential social services such as health for refugees. [41] Such a strong public commitment will further reinforce efforts to build synergies between the national health system and health services provided to the refugee population in the country. Existing coordination groups, such as the Health and Nutrition Working Group (chaired by ARRA and UNHCR) and sub-sector specific groups (dealing with particular diseases) will need to discuss ways of supporting a development-oriented agenda.

[39] In 2015, WFP's rations were cut from 16 kg to 13.5 kg; in May 2017, it has been further reduced to 10 kg.
[40] ARRA, UNHCR, WFP, Ethiopia Joint Assessment Mission (JAM) 2016 Report, publication forthcoming.
[41] Pledge 8 states: "The Government pledges to strengthen, expand and enhance basic and essential social services such as health, immunization, reproductive health, HIV and other medical services provided for refugees within the bound of national law."

Another way of fostering closer collaboration is through joint data collection. Data on the refugee population is currently managed in an internal UNHCR health information system (using international standards) and balanced scorecard assessments are provided to the health facilities. UNHCR also carries out surveys regularly to ascertain the health status of the population (e.g. a nutrition survey is done annually). In the future, there may be scope for refugees to be included in ongoing data collections at the national level. For example, the Government carries out a Demographic Health and Nutrition Survey every five years, and may be open to collecting data both on nationals and refugees. This approach would enable better comparison between refugee and host community health concerns and progress towards joint indicators.

With time, it will be important to consider ways of further aligning or integrating refugee health facilities within the national health system. This could start, for example, with better integration of refugee concerns in annual work plans of the Regional Health Bureaus and joint monitoring visits. Another opportunity would be to review existing refugee health facilities in light of the growing public health infrastructure of the Ministry of Health and to explore further areas of mutual benefit. Dialogue between UNHCR, ARRA and the Ministry of Health should preferably result in a rebalancing of financing towards the latter.

2. Refugee inclusion in the national water system

Water and sanitation are at the very core of sustainable development in Ethiopia. Over the last three decades, significant investments have been made to improve access to drinking water supplies, especially in rural areas, resulting in over 52 million people being able to access an improved drinking water source as compared to only 6 million in 1990.[42] An estimated 57% of the population now have access to safe drinking water (compared to 14% in 1990) and 28% have access to basic sanitation (up from a 3% baseline in 1990).[43] These investments have effectively improved health outcomes of the population.

However, challenges remain. Poor quality water, lack of sanitation and hygiene practices are underlying causes of malnutrition, disease, impaired growth and mortality. Children under five are particularly at risk of debilitating bouts of diarrhea and other diseases that kill or stunt their development, including helminthic infections, guinea worm, trachoma, acute watery diarrhea, as well as fluoride and arsenic poisoning. Global research has found that every dollar invested in improving water and sanitation is estimated to result in an average return of 9 USD value in terms of avoidable deaths, more productivity due to less down-time due to illness as well as saved health costs.[44]

The Government has put in place various policies, strategies, sectoral development plans and institutional arrangements to ensure access to clean water supply and sanitation. The responsibility for the development and provision of these services is shared among the Federal Ministries (water, health, education and finance) and their respective regional bureaus, zonal and woreda/town offices. The sector is predominantly financed by the national Treasury, which on average account for 76 percent of the total budget allocated for water supply and sanitation.[45] Providing access to improved services is among the most important government priorities classified as "pro-poor" but it remains largely underfunded, and will require resource mobilization from external partners.

Water and sanitation service provision in refugee camps should be considered within this broader context. In response, ARRA and UNHCR, together with partners, effectively operate a parallel system to the national one to ensure that refugees have access to a package of potable water and sanitation that meet minimum service provision standards close to their dwellings, and remain involved in designing priority hygiene responses.[46]

Daily water supplies to the refugee camps are provided by the NGO partners either through water schemes or by water trucking to the camps.[47] The unit cost of water is

[42] UNICEF, Evaluation of the UNICEF Ethiopia Water, Sanitation & Hygiene (WASH) Country Programme Document, January 2012-June 2016.
[43] The Federal Democratic Republic of Ethiopia Ministry of Health, Health Sector Transformation Plan 2015/16-2019/20, October 2015.
[44] UNHCR, Ethiopia Refugee Program Strategic Plan 2014-2018 - Public Health Sector.
[45] World Bank Group, Ethiopia Public Expenditure Review, April 2016.
[46] The main implementing partners in the WASH sector in Ethiopia are: Action for Needy Ethiopians, Adventist Development and Relief Agency Japan, African Humanitarian Action, Danish Refugee Council, International Rescue Committee, Lutheran World Federation, GOAL Ireland, Norwegian Church Aid, Norwegian Refugee Council, Oxfam, UNICEF and World Vision.
[47] ARRA only manages water provision in 2 refugee camps (Okugo and Kebribeyah) and has otherwise assumed a coordinating function in the WASH sector for the other refugee camps in

relatively high in most of the refugee locations, mainly as a result of low yielding water sources, high depth of ground water, long distances from source to camps, and the technology employed for abstraction, treatment and conveyance.[48]

Achievement of minimum UNHCR standards in water, sanitation and hygiene varies from one camp to another primarily as a result of the status of camp (emergency, transition or protracted) and the type of investment.[49] By the end of 2016, 17 out of the 25 camps had achieved the minimum standards for water provision of water (according to the standard of 20 liters per refugee per day).[50] These standards have been reached with the support humanitarian financing and alternative funding will be needed to ensure sustainable access to water, unless the refugees are able to have livelihoods options and pay for the water themselves.

Of the 12.6 million liters of water treated and supplied daily, 1.95 million liters (15%) goes to the hosting population.[51] The amount of water supplied to the host population will vary from camp to camp, and according to the season of the year. For older camps, the percentage to the hosting population is higher than for the newer camps.[52] Every year, from April to June, there are also major water shortages in the Eritrean refugee camps of Adi Harush, Mai Aini and Hitsats due to low ground water potential, deterioration in water quality over time, rising hosting population and inadequate funding to support operation and maintenance.

The high unit cost of providing water, the limited financial resources for water provision during protracted humanitarian crises, compounded by climate change causing cycle of drought as well as flooding, have led the Government, humanitarian and development actors, along with donors, to consider new models for water provision to refugees and host communities. Ethiopia's willingness to include refugees in the national water system makes it stand apart from other more traditional humanitarian responses found in other countries. In many respects, its experience is likely to shape future water programming in other refugee camp settings.

2.1 A paradigm shift: An integrated water system for refugees and host communities

Some of the oldest refugee camps in Ethiopia can be found in Jijiga, where UNHCR has been providing water supplies to refugees since 1988. In 2013, UNHCR calculated that it was providing in Kebribeyah camp 70% of the water to host communities and

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the country. The Regional Water Bureau is typically not involved in the provision of water and sanitation services in refugee camps.

[48] Of the 26 camps, only 4 camps have water sources located within the perimeter of the refugee camps: Pugnido, Pugnido II, Barhale and Bambasi camps. The remaining 21 camps rely on water sources outside the camps with distances as far as 25 km to central storage reservoirs. All depends on the hydrogeology of the camp.

[49] UNHCR utilizes a progressive standards approach with regards to water supply and sanitation, based on domestic consumption. During the acute emergency phase (0-6 months after event), the target is to provide a minimum of 15 liters per capita per day. During the transition phase (6 months – 2 years), the target is 20 liters per capita per day. In protracted situations, the goal is for +20 liters per capita per day.

[50] ARRA, UNHCR, WFP, Ethiopia Joint Assessment Mission (JAM) 2016 Report.

[51] UNHCR, Ethiopia WASH Factsheet, April 2017.

[52] During dry seasons, Awbare and Sheder in Somali region receive many pastoralists from neighboring Woredas, who migrate to the area in search of water and fodder for their livestock. As a result, host community can receive more than 70% of the daily output of water between the months of March and May.

only 30% to refugees. The water destined to host communities was pumped into a water tank managed by the Woreda Water Bureau, which in turn sold the water to the host communities. Over the years, Aw-barre Woreda accumulated significant funds from the Aw-barre and Sheder hosting population from the sale of water (mainly for livestock) but continued to rely on UNHCR and ARRA to support the operation, maintenance and rehabilitation efforts of the water system in the area. [53] Such a scenario exists across 17 refugee camps, whereby water management committees in the host community, aided by the Regional Water Bureaus, collect tariffs from users in accordance with federal legislation but do not yet use these revenues to cover the costs of the water schemes.

Recognizing that this model of water management and maintenance is unsustainable over the long term, UNICEF and UNHCR began discussing in 2014 alternatives that could be put in place to benefit both refugee and host communities alike. Upon close reading of the national laws, legal ground was found in the Ethiopian Water Resources Management Proclamation No. 197 of 2000 to advocate for the establishment of a professional water utility management system in a refugee camp setting, as the law requires that a water utility should be established for water systems serving more than 15,000 people.[54] ARRA saw in this new water service provision model an opportunity to build a more sustainable system, and supported it.

All stakeholders agreed to pilot the new water supply scheme in Gambella region at the start of the new influx of South Sudanese refugees in 2014, as they knew that the lack of groundwater meant water provision from Itang town would be necessary for both the host community and refugees. [55] UNHCR and UNICEF carried out an economic analysis in 2014 based on the costs of two years of water trucking (over 13 km) in Kule and Tierkidi refugee camps in Gambella, and found that the associated costs were equivalent to the capital expenditure required to build the entire water network in the camp, after which only the running costs and pumping would need to be covered.

The analysis brought to light the huge savings in investment that could be made by expanding the national water system into refugee hosting areas. On average, it costs 4.49 USD (0.089 ETB per liter) to supply 1000 liters of water by trucking. The unit cost of implementing the permanent water system and operations costs will amount to 0.32-0.50 USD for same amount of water (1000 liters). For every 1 USD spent on permanent water system 5 USD is saved from current temporary water trucking in place. To break it down further, it costs 2.02 USD per month to supply 15 liters per day to a refugee by water trucking at the moment.

With the empirical evidence clearly supporting the new vision, ARRA, UNHCR, UNICEF and the Regional Water Bureau went ahead with the building of one system that spans the newly established two refugee camps (Kule and Tierkidi) and two towns

[53] The Water Management Committees in Aw-Barre and Sheder charge 20 ETB per household per month. In Aw-barre and Sheder around 1350 and 1000 households respectively are benefiting from the UNHCR supported water supply systems. Hence, the monthly income of the WMCs is around 27,000 ETB and 20,000 ETB in Aw-barre and Sheder respectively.

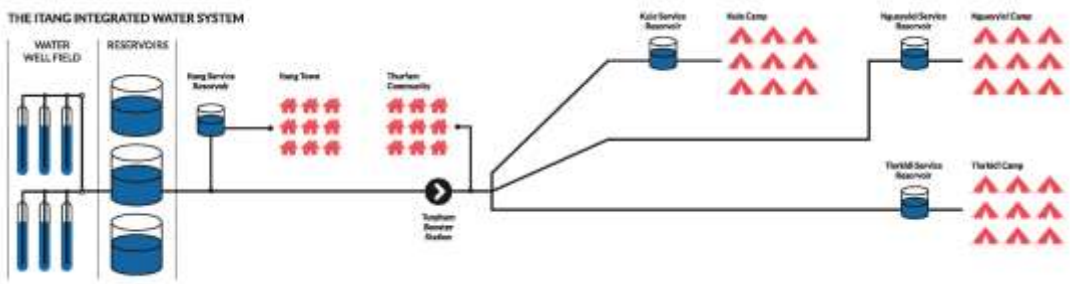
[54] The Proclamation is accompanied by the Council of Ministers Ethiopian Water Resources Management Regulations (No. 115/2005).

[55] UNICEF supported UNHCR through the deployment of two WASH experts to support the development of the Itang water system. These deployments played a key role in sharing expertise, harmonizing inter-agency approaches and facilitating the linkages with line Ministries and ARRA. For more information, please consult: UNHCR-UNICEF, Joint Review of the UNICEF Deployments to UNHCR, Ethiopia, Gambella, May 2016.

(Itang and Thurfam). The distribution of the water would be done with a pipe network covering 100 km. The large infrastructure development, known as the Itang integrated water project, allowed for economy of scale, resulting in reduced running costs and simpler monitoring of the water quality for the entire system.

The new Itang integrated water system has been functioning in two refugee camps since early 2016, and is currently being extended to one additional refugee camp and two neighboring towns. In the first phase of the project, water was taken from six boreholes[56] along the Baro River and pumped to a series of storage tanks and a pumping station located Itang.[57] Priority was given to the construction of the water system in Kule and Tierkidi camps, as the host community had hand pumps and understood that the system would be extended to them.

At the end of 2016, the construction of the new Ngueyyiel refugee camp had begun to accommodate an additional 60,000 refugees who had arrived in September 2016 from South Sudan. This emergency led to a second phase of the project, which saw the expansion of the water system to a third refugee camp, through the installation of a parallel pipeline to the existing boosting station. The extension of the water system to adequately cover Itang and Thurfam towns is also being done.[58]



Overall, the host community has been supportive of the project from its inception, as the piped public water supply system that served Itang town had been non-functional for many years due to failure of the electro-mechanical components. Thurfam, a business transit center that has grown exponentially in size with the arrival of the refugees, had no water supply system of its own. The center relied on vendor-supplied from 7 km distance, which drew water from Itang hand pumps and transported the water using donkey and horse carts and light vehicle mounted tankers.[59]

Such innovation in durable infrastructure was made possible thanks to several development partners who contributed to the Itang integrated water system. The main donors were the KfW German development bank, which contributed 61% of the investment, the Humanitarian Response Fund, the Italian Cooperation Agency, the UN's Central Emergency Response Fund, the United Kingdom's Department for International Development (DFID), the European Civil Protection and Humanitarian Aid Operations (ECHO), UNICEF and other minor contributors. The Regional Water

[56] With financial support from UNHCR, IRC drilled six shallow boreholes along the Baro River in 2014, and in 2015 World Vision drilled an additional 3 shallow boreholes.
[57] UNICEF built the collection chamber and boosting station and main pressure line connecting the chamber and the water stations. IRC built the service reservoir and in camp pipe network for the Tierkidi refugee camp, while World Vision built the same installations in Kule refugee camp.
[58] A large reservoir is under construction by UNICEF and will be connected with the water kiosks of the city.
[59] Zenas Engineering Plc., "Willingness and Ability to Pay Analysis of Itang and Thurfam Residents: Volume I", April 2016.

Bureau in Gambella and UNICEF are the two entities responsible for the project design and implementation, while ARRA and UNHCR are responsible for coordinating the in-camp works. UNHCR also played an advocacy role to enable WASH development funds to be directed to refugee and host community water projects, and has been involved in the development of the UNICEF proposals and reviews.

2.2 A more sustainable approach to water management

Governance mechanism - The Itang integrated water system is a first in the country, connecting refugee camps with the local communities. A total of 250,000 people will benefit from the new water system (75% or more are refugee beneficiaries) once the construction of the entire water system is complete. Its system of governance has also been newly engineered. Rural communities typically manage the water resources, by establishing committees at the Woreda level that are comprised of volunteer members. However, instead of relying on community members, the primary stakeholders in this project decided to professionalize the management of the water system, with the hope that its structure will remain once humanitarian actors leave the area.

The Regional Water Bureau has the responsibility of establishing the Integrated Itang Town Utility. Given the large presence of refugees, it revised Proclamation No. 49/1999 in Gambella in February 2017, expanding the size of the utility board to include an ARRA representative as well as three members from the refugee central committee.[60] Once established, the water utility will need to be technically supported in accordance with UNICEF's "Build-Capacity-Build-Transfer" methodology.[61] The International Rescue Committee has been selected for the capacity building of the water utility until it becomes self-sufficient.[62] Once the handover is complete, the Itang utility board will provide the policy directions to the utility and the technical support to ensure the sustainability of the system.

Financial mechanism - Sustainability of the entire water system will depend on the financial management of the water. Ethiopian water resources management policy favors the adoption of site-specific water service charges, which looks at ensuring equitable and inclusive delivery of water supply services for the least privileged population group. The primary stakeholders of the project thus commissioned a business case study to determine the appropriate levels of tariffs to charge, based on the ability and willingness of Itang and Thurfam urban population to pay for the water supply services.[63] The business is based on zero subsidy.

The research found that the creation of the water system had effectively reduced the price of water for the host community to an average of 9 Ethiopian Birr (ETB) per cubic

[60] The board will appoint the General Manager and Deputy Manager of the utility, who will report to the Regional Water Bureau.
[61] As the theory goes, a firm that wins the construction mandate to build the water system and operate it for one year will also have the responsibility to train the water utility to operate the system, maintaining specific service level benchmarks before the system can be fully transferred to the utility (at which point the contract is paid).
[62] The third phase of the project is responsible disengagement by IRC to the utility in 2018. IRC has planned a 6 months to handover, followed by a reduced presence in the region. This approach was agreed upon by the key stakeholders of the Itang project during a workshop in February 2017. See for further reading: Zerihun Associates, "Inception Workshop on the Implementation Modalities: Convergence towards a Unifying Implementation Model".
[63] A total of 231 households were selected for the survey, using systematic random sampling methods. Field observations were used to enrich the quantitative data collection process.

meter in Itang and Thurfam towns.[64] The host communities will continue to pay reduced tariffs for the water, while UNHCR and ARRA cover the water provision costs for refugees. In the future, and with the introduction of cash-based interventions and livelihood opportunities in the refugee camps, the utility will start to sell water by the cubic meter to refugees. The overall costs of water provision will also likely go down as UNHCR will no longer have to cover the NGO overhead costs to manage the water provision in camps.

This progress notwithstanding, the challenge remains of ensuring that all the revenue from the water sales covers the costs of the capital, operation and maintenance, as well as those of service deployment. Most water supplies around the world are subsidized or reply on complex cross-subsidies. Additional rigorous and fully inclusive cost analyses of the capital, as well as the running costs of the Itang project, will need to be conducted overtime to match the realistic estimated income from institutions and water kiosks.

2.3 Ripple effects in other regions of the country

Conflict mitigation - Ensuring safe and accessibly water supplies to both refugees and host communities help to mitigate conflict. The building of the Itang integrated water system has already allowed for a positive narrative to be told about the arrival of refugees, who are more often blamed by host communities for depleting natural resources rather than facilitating access to them. The Itang host community now benefits from a sustainable, resilient water supply system, which is a marked improvement from the past, where members of the host communities used to queue to collect water. Without the presence of refugees, a rural community in Ethiopia like this one may have waited many more years to see the installation of such a low cost and safe water supply system.

Innovation spurred elsewhere - The experience in Gambella has prompted similar discussions in other parts of the country, including in Assosa, Jijiga, Melkadida and Shire. Yet each project is specific to its regional context. In Shire, for instance, the conversation has revolved around the feasibility of building a water pipe network connected to a dam built in 2014 for local irrigation purposes. An environmental and socio-economic impact assessment done in 2015 established that water can be used both for agriculture and human consumption. DFID and the European Union subsequently provided in 2016 sufficient funds to build a distribution network sourcing water from the dam and pumping it into the Adi Harush and Mai-Aini refugee camps and surrounding host community areas.[65] By having a holistic approach (involving water safety plans) and investing resources in more resilient designs for refugees, these investments can be leveraged to satisfy the needs for the host population. ARRA is supportive of finding a long-term solution to water as a conflict mitigating strategy, together with the Regional Water Bureau, UNICEF, UNHCR and donors.

In Melkadida in the Somali region, UNHCR and ARRA have been able to build a water system when the camps were established. The area is arid and sparsely populated, so the water provision largely focused on meeting the refugee needs, and as the

[64] For more information, please read the report by Zerihun Associates, entitled "Revised Business Plan and Tariff Setting for Itang Town Water Utility". The plan puts into perspective how the water system can sustainably run, recover costs and operational maintenance without needing external support.

[65] DFID is funding a 5 year self-reliance project and the EU is funding a 3 year Regional Development and Protection Programme. Both started in October 2016 and are in the inception phase.

numbers in the host community increased, the water pipe network was gradually extended from the camp to the host population areas. As a result, the focus in Melkadida is less on building an integrated water system, and more on ensuring its sustainability.[66] A community-based water management model was established in 2015, leading to a gradual handover of the operation and water supply system. In order to further reduce costs, UNHCR and ARRA have also sought to move away from fuel-based powered system of assistance to a solar power system.[67]

The innovations happening in the water sector are being replicated for sanitation and hygiene too. While there is a relatively high latrine coverage rate of about 63% for refugees, emphasis is being placed on anticipating long-term problems (including epidemic outbreaks) that will occur from the waste produced by refugee camps.[68] The focus now is on trying to build longer-term, "waste to value" sanitation options in the refugee camps, including the urine diversion dry toilets, tiger worms that convert human waste into useful fertiliser, biogas latrines and briquetting from solid waste.[69] The other priority area is to support municipalities to manage sludge both in adjacent Woreda towns by providing them with vacuum trucks and construction of sludge drying beds. In Gambella, for instance, such investments are significant given that the municipality did not have adequate capacity.[70]

2.4 Coordination in the water, sanitation and hygiene sector

Coordination in the WASH sector is quite advanced in Ethiopia. The country launched in 2014 the ONE WASH National Programme (OWNP), which currently covering 6 key components: rural water supply, rural sanitation and hygiene, urban water supply, institutional WASH and water quality. It brings together the Federal Ministries of Water, Education, Health and Finance, as well as all donors and implementing partners around one plan, one budget, and one report. OWNP has a budget of 2.5 billion USD over 5-7 years, as it has secured blended financing assistance (loans, grants) from UNICEF, DFID, the World Bank Group, the African Development Bank and the Government of Finland through the Consolidated WASH Account.

In the future, it may be worthwhile integrating the refugee WASH coordination mechanism (which UNHCR and ARRA co-chair) into the ONE WASH programme (under the emergency sector co-chaired by UNICEF and the Ministry of Water). This merger may only take place once the Refugee Proclamation is revised on the basis of the Government's pledges of September 2016, which aim to facilitate the inclusion of refugees into national systems.

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[66] Discussions have been primarily with the Woreda Water Bureau, as the refugee camps are physically far from the Regional Water Bureau.

[67] There are currently 5 water schemes in refugee camps in Ethiopia using solar energy for pumping. IKEA, KFW and the EU have committed funding to implement additional solar projects until 2018.

[68] A total of 39,000 family latrines were functional and in use as of the end of December 2016. Comparing this figure to the total number of households in all camps for the same period (about 155,000 if we consider only camp based refugees) and assuming that 2.5 households/families share one latrine, the required number of latrines comes to approximately 62,000. This extrapolation yields a latrine coverage rate of about 63%.

[69] These "waste to value" interventions are being funded by the Gates Foundation, the US Bureau of Population, Refugees and Migration and UNHCR's Innovation Fund.

[70] UNHCR provided a vacuum truck (previously the municipality had to rent one truck that was stationed 350 km away) and capacity training.

3. Refugee inclusion in the national education system

Remarkable progress has been made in Ethiopia to extend education to its population. Over the past ten years, the education system has expanded from 10 million learners to more than 25 million learners, and this access has improved across all levels of education (from pre-school to higher education).[71] Ensuring access to education is nonetheless challenging given that a large majority of the Ethiopian population lives in rural areas and in fairly dispersed communities. Demographic pressures are also increasing the demand for quality education; children under 15 years of age account for over 33 million of the total population.[72]

The Government has heavily invested in education, as evidenced by the steady share of the education budget in the total government budget at 20 percent for the last ten years (representing about four percent of the GDP).[73] In doing so, it has underscored its commitment to improve access to quality education in order to make sure that all children, youth and adults acquire the competencies and skills required to fully participate in the development of Ethiopia. Progress on the education front is indeed necessary in order to achieve the long-term vision of transforming Ethiopia into a middle-income country, which increasingly relies on industry and manufacturing jobs that require higher-skilled manpower. As such, the successive Education Sector Development Plans are closely linked with the national macroeconomic plans, including the Growth and Transformation Plan II.[74]

The authorities recognize that providing education for refugees is also immensely complex, due in part to the continuing influx of refugees, the trauma which children may have experienced as a result of displacement, differences in curriculum and language instruction, and educational delays. UNHCR's operation in Ethiopia has been providing education for refugee children since the late 1980s but the rollout of UNHCR Global Education Strategy in 2012 and the National Refugee Education Strategy 2015-2018 has resulted in a more structured approach towards supporting refugee inclusion in national education systems.

An estimated 179,022 refugees are enrolled in general education in the 2016/2017 school year, including 75,359 female students. The overall enrollment of refugee children in school is at a rate of 52%; the enrollment rate stands at 45% of girls and 58% of boys. In total, there are 80 Early Childhood Care and Education (ECCE) establishments, 56 primary and 18 secondary schools in and around 26 refugee camps catering to the learning needs of students.[75]

3.1 One system, two administrative bodies

In accordance with Ethiopia's federal system, the Regional Education Bureau at the State level is responsible for the overall administration and management of the educational system, with the exception of tertiary education that is managed in a centralized fashion by the Ministry of Education. Within each Regional State, there is a network of management structures that involve Zonal Educational Departments and Woreda education offices at the district level. This decentralized model implies that each Regional Education Bureau is both administratively and financially responsible

[71] World Bank Group, Ethiopia Public Expenditure Review, April 2016.

[72] Education for All 2015 National Review Report: Ethiopia

[73] World Bank Group, Ethiopia Public Expenditure Review, April 2016.

[74] Ibid.

[75] UNHCR Ethiopia Factsheet, March 2017.

for education delivery, and receives a substantial subsidy from the Federal Government in support of general education, technical vocational training and teacher training colleges that operate in the State.

However, the Ministry of Education and Regional Education Bureaus do not manage the administration of refugee schools, which falls under ARRA's remit of responsibilities. ARRA acts both as a coordinator and the main implementing partner for primary school education, and relies on NGO partners for early childhood education and secondary education.[76] Yet it ensures that the entire refugee education programme follows the Ethiopian Ministry of Education's system. As such, both the Federal Ministry of Education and ARRA are supporting the same educational system for refugee children and nationals – a precursor to inclusion in national systems.[77]

To enhance collaboration between ARRA, the Federal Ministry of Education and the Regional Education Bureau, policies have been put in place to clarify institutional arrangements. In 2010, ARRA officially requested the support of the Ministry to facilitate refugee inclusion in the school systems and higher education. In 2013, the State Minister for General Education issued Office Circular No 13/1-11795/8297/35 to all directorates of the Ministry of Education and Regional Bureaus identifying 5 broad areas for collaboration on refugee education.

These areas include: 1) the use of the national curriculum and supply of textbooks in refugee schools; 2) ensuring teacher training both in service and pre-service training; 3) allowing for supervision and inspection of refugee schools; 4) including refugees in the education sector development plan; and 5) ensuring that the learning assessments done by the National Education and Learning Agency under the Ministry of Education are carried out in refugee schools. ARRA and the Ministry of Education intend to scale up its engagement by signing a MoU. This framework agreement will help to specify and formalize the roles and responsibilities of ARRA and the Ministry of Education, and make the relationship more predictable than with the circulars. In addition, the Ministry of Education has plans to establish a Follow-Up Unit of Refugee Education to facilitate coordination matters.

3.2 Access to national schools

The issue of refugee children accessing national schools has been a source of debate in the country. Previous interpretations of the Refugee Proclamation 409/2004 led some to the erroneous interpretation that refugees do not have the right to access national schools, as the language of the text had wording to the effect that refugees shall be entitled to "the same restriction as are conferred or imposed generally by the relevant laws on persons who are not citizens of Ethiopia" (Article 21, sub-article 3).

[76] The main NGOs working in the education sector include: Association of Ethiopians Educated in Germany, DAFI Scholarship Programme, Development Inter-Church Aid Commission, International Rescue Committee, Save the Children, Plan International, and World Vision.

[77] In Ethiopia, ECCE (preschool) is for children 4-6 years old; primary education is divided into basic education in grades 1-4 for children 7-10 years old; and general primary education in grades 5-8 for children 11-14 years old. Completion of primary school is followed by two years of general secondary education in grades 9-10 for youth ages 15-16 years old and then preparatory secondary education in grades 11-12. Grades 9 and 10 of general secondary education are organized so that students can transit to either further academic training in grades 11 and 12, and potentially university training or professional training.

However this clause does not in and of itself represent a limiting barrier to refugee children accessing the national education system legally.[78]

In fact, the law and directives issued by the Ministry of Education to its Regional Education Bureaus allow for the inclusion of refugee children in national schools, and in practice, refugees do access national schools in both camp settings (host community schools) and urban areas. Host community children also can access refugee schools. In Shire, at Mai-Ani refugee camp for example, refugee schools sometimes have a larger proportion of host community children than refugee children. In Melkadida, about 10% of the host community students as access primary education in refugee schools, and approximately 30% of host community youth access secondary education at DICAC secondary school in Bokolmanyo.

3.3 Government pledge to increase enrollment rates of refugee children

While refugee children have a right to access national schools, 48% remain out of the formal school system.[79] Limited capacity of local schools and the location of refugee camps in very remote parts of the country explain this low enrollment rate. In addition, other factors include shortage of classrooms and other school infrastructure, inadequate supply of qualified teachers alongside cultural practices of refugee communities. The Government's Pledge 4 on education during the Leaders' Summit in September 2016 aims to significantly increase the enrollment rate of refugee children in schools.[80] It has created a platform for lobbying and advocacy on inclusion of refugees into the national education system at all levels of education including Woreda, Regional Bureau and Federal government.

Capacity issues are central to the ability of the Government to implement the pledges as planned. The country's 5th Education Sector Development Plan aims to increase the gross enrollment rate of secondary education to 74% over the next three years by training teachers and adding classrooms to primary schools for secondary school teaching and by building new secondary schools.[81] However the new pledges made by the Government related to increasing the enrollment of refugee children come in addition to the targets set in the national plan, and as such require extra effort and resources by the public administration.

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[78] This overall impression was strengthened by another widely accepted erroneous interpretation of the reservations made by Ethiopia when it acceded the 1951 Refugee Convention. In the reservations, the Government indicated that the provision of the Convention relating, amongst others to education, were considered by Ethiopia as "recommendations", not as "obligations".

[79] UNHCR Annual Country Report 2016.

[80] Pledge 4 states: "Ethiopia will provide primary, secondary and tertiary education to all qualified refugees without discrimination and within available resources. It will also expand schools and other necessary inputs within available resources, based on the available international cooperation and in accordance with the education policy of the country. Ethiopia pledges to:

- Increasing enrollment of pre-school age refugee children from the current 46,276 (44%) to 63,040 (60%)
- Increasing enrollment of primary school age children from the current 96,700 (54%) to 137,000 (75%)
- Increasing enrollment of secondary school age children in secondary school from the current 3,785 (9%) to 10,300 (25%)
- Increasing opportunities for higher education enrollment from the current 1,600 to 2,500 students.

[81] Schools construction is typically taken care of by members of the communities, and once completed the Government will provide teachers and materials to the new establishment.

In order to increase the enrollment rate of refugee children, donors will need to provide financial support to enable ARRA, the Regional Education Bureaus, UNICEF, UNHCR and other partners to establish more learning centers for pre-school children, as well as construct more primary and secondary schools as space is very limited. Refugee schools already run double shifts for children throughout the country and even with this schedule, not all children can go to school.[82] Education authorities will also need to consider how to expand technical vocational trainings to refugees so that they can acquire basic skills as an alternative education pathway if they cannot access nor transit to secondary education.

3.4 Enhancing the coordination model through a clear division of labour

The confluence of major events and planning process, such as the Government pledges during the Leaders' Summit on Refugees, the Education Cannot Wait Global Initiative, as well as the World Bank financial support at the country-level has focused attention on the targets set by the Government pledges and bolstered coordination attempts.

At the Addis Ababa level, the Ministry of Education has shown strong leadership in co-chairing the Education Technical Working Group together with UNICEF.[83] The Ministry of Education has also joined the Refugee Education Working Group co-chaired by ARRA and UNHCR. Such participation highlights the commitment of the Ministry to dealing with refugee education in the country in close coordination with ARRA and UNHCR.

While education coordination mechanisms are in place in the regions, they are not yet strongly institutionalized. Replicating the coordination structure of the federal level at the regional level may be unnecessary, but a formal structure with a secretariat could support planning, service delivery and monitoring work. Organizing review meetings about the current situation of regional educations system would help all the stakeholders to make informed, concerted agreements on actions to increase enrollment and completion rates, and to improve the quality of education in the region. Joint planning could help reduce the disparities between humanitarian-type programmes (managed by ARRA, UNHCR and NGO partners) and development programmes (managed by Regional Education Bureaus with support from UNICEF). It could also reduce the tensions that obvious disparities create between the host community and refugees.

The new 15 million USD programme "Education Cannot Wait" provides impetus for further enhancing the coordination model. Indeed, it may be the first time whereby ARRA, the Ministry of Education, UNHCR and UNICEF develop a project proposal in one voice. The other 10 million USD 5-year programme funded by DFID is called "Building Self-Reliance Project (BSRP) for refugees and host communities".[84] Without

[82] Double shifts are used in refugee schools throughout Ethiopia, with the exception of the Dollo Ado operation. In Dollo Ado, only one out of five camps use the double shift system due to a shortage of classrooms.
[83] The Education Technical Working Group is the highest coordinating body for education, mainly in the development field. ETGW coordinates and manages the implementation of the Global Pool funding for the General Education Quality Improvement Programme (GEQIP).
[84] This project supports primary and ECCE in school expansions, teacher development, education quality improvement and capacity building in five regions for host community and refugee schools.

a doubt, these resources are essential means to implement the Government pledges on refugee inclusion in the national systems.

3.5 Improving data collection and analysis in refugee schools

Until very recently, Government officials, professionals in the education sector and UNICEF struggled to understand progress being made in the refugee education front due to a lack of systematic data collection and reporting tools. [85] To improve data collection and analysis, and facilitate the inclusion of refugee children in the national system, UNHCR invested an estimated 30,000 USD in 2015-2016 to support ARRA to use a new data collection system in all refugee education schools based on the Ministry of Education's Education Management Information System (EMIS).[86]

ARRA and implementing partners are now in charge of data collection and the Ministry of Education will continue to provide training and tools. Once data has been collected, it will be published in the Education Statistics Annual Abstract. Capturing the data will allow the Ministry of Education and ARRA for the first time ever to inform higher officials, UN agencies and donor representatives on the number of refugees who are educated in the country, and support planning and resource allocation in the education sector. The EMIS data will further allow the Government to track progress made towards implementing the pledge on education. The Ministry of Education has expressed strong interest in this type of data, as it would be the first of its kind in the Horn and East Africa.[87]

3.6 Investing in the quality of education

Investments in school infrastructure and the data management system could be accompanied by coordinated efforts to enhance the quality of education programming and delivery for refugee and host community children. Quality delivery of education for refugees need to be tied to government systems and procedures on quality assurance. This should entail the use of Government curriculum and textbooks, systematic training and development for teachers, systematic quality assurance using government monitoring and supervision standards, as well as access to learning assessments, national examinations and certification. The Ministry of Education and Regional Education Bureaus will have a key role to play in technical support to the refugee education programme to make sure it is in line with the national education system.

There are already a number of technical areas where ARRA, the Ministry of Education and the Regional Education Bureaus work closely together to support refugee inclusion in the national education system. Promoting the use of the national curriculum and educational tools is one such area. Previously, refugee schools had a

[85] For example, it was not possible to compare enrollment rates year after year or examine the ratio of refugee teachers and national teachers.

[86] Given its limited human resource capacity, the Ministry of Education recommended that UNHCR hire a dedicated consultant to customize the UNESCO-approved EMIS software and the capacity building of staff in the refugee schools. This capacity building work was done by preparing the required questionnaires and training data collectors/enumerators at the school level in 5 centers across the country.

[87] In the future, it will be necessary to consider the data deficit in urban settings, as currently there are no reliable statistics on the number of urban refugee children out of school. The population in Addis Ababa has grown quickly over the last decade, both in terms of numbers and in actual aerial expansion, making it difficult to follow individual refugee cases. UNHCR and ARRA only currently know about the vulnerable refugee children who are assisted through its urban programme.

certain degree of flexibility in the type of curriculum, in order to maintain links to the country of origin's national curriculum.[88] Efforts are now being made at the refugee camp level to align the refugee education programme to the national system. Since 2016, all refugee schools in the country have followed the national curriculum and use textbooks and other resources developed by the Ministry of Education.[89]

The provision of student certifications is another area requiring close collaboration between ARRA, the Ministry of Education and the Regional Education Bureaus, as each has clearly defined responsibilities. The Regional Education Bureau is responsible for administering the national learning achievement assessments at grade 4 as well as the secondary school placement exams to determine in which grade refugee children should be.[90] The Ministry of Education and the Regional Bureaus deliver the national examination that qualifies students for different purposes.[91] In order for refugee students to sit the national exam at grade 10, the Regional Education Bureau certifies the refugee school.

Refugee schools typically rely on both national teachers and refugee incentive teachers to administer the national curriculum.[92] Yet only an estimated 35% of teachers are officially qualified across all the refugee camps.[93] The system is now changing, as ARRA is planning to hire graduates from the university system and the Teacher Training Colleges run by the Regional Education Bureaus.[94] The impetus for changing the system stems from the minimum standard of qualification required to teach at first and second cycle primary schools. Efforts are also being made to improve the qualification of refugee teachers through in-service teacher training that are linked to the Teacher Training Colleges.[95]

[88] The country of origin curriculum was used in the 1st cycle of primary school (grades 1-4). The national curriculum has always been used in the second cycle of primary school (grades 5-8). For example, in the Melkadida region, which is located on the border with Somalia, the national curriculum had been contextualized for the Somali refugees.

[89] As textbook publishers are centrally located in Addis Ababa, ARRA will channel the textbook requests through the Regional Education Bureau.

[90] Different institutions at different levels give placement exams. Primary schools have the prerogative to administer the placement examination at that level; secondary school placement exams are administrated by the Bureau of Education; and placement exams for tertiary education is by Federal Ministry of Education. ARRA plays a major role in facilitating the processes of placement examination.

[91] At grade 8, the exam is required to proceed on to secondary school. At grade 10, the exam results determine who can access higher education and who can enroll in the Technical Vocational Education and Training programme. Refugee students can enroll in tertiary education if they pass a special higher education exam for refugees that ARRA organizes with the Regional Education Bureau.

[92] Refugee incentive teachers are not paid salary and in most cases do not have contractual status as teachers. They are also referred to as volunteers. These are refugees living in the camps. Depending on the position and qualification the maximum incentive is 800 ETB/month.

[93] UNHCR, National Refugee Education Strategy 2015-2018 (Ethiopia)

[94] In the past, ARRA would recruit primary school teachers simply by issuing a vacancy and hiring a teacher with 2 years of professional experience and a Bachelors' degree.

[95] UNHCR, ARRA and NGO partners have sought to provide *ad hoc* training on teaching methodologies, classroom management, and how to prepare exams. In Pugnido refugee camp in Gambella, for example, refugee teachers can go as regular students and get admitted in the teacher training college or alternatively attend the summer programme.[95] In Assosa, Dollo Ado, Gambella and Jijiga, this connection to national training institutions has existed for the last several years.

3.7 Planning joint school supervisions in the future

School supervision is one area where ARRA and the Regional Education Bureau have limited cooperation as it depends on the regional situation, and availability of budget. Usually ARRA and the Regional Education Bureau will only participate in joint supervision of a refugee school if one of the NGO implementing partners requests it.

Yet such joint supervisions help to identify key issues that are affecting the performance of students. For example, refugee schools face high turnover as teachers take on new, better-paid jobs.[96] The widespread practice of relying on teachers for food distribution in the refugee camp has also been known to provoke discontentment among the staff in refugee schools and affects student attendance when some teachers miss out days of teachings in a month. Other challenges that contribute to teachers' attrition include the low incentives due to the fact that refugee teachers are paid less than national teachers (with no possibility for pay increase, even with added degree), the lack of opportunities for professional development training and certification and the teaching environment (e.g. basic instructional tools, heavy workloads and managing overcrowded classrooms).

To tackle these concerns, the DFID-funded multi-year, multi-partner project will support the inclusion of all refugee schools in the regional school supervision programme as of early 2018. In the future, it may be necessary for educational authorities to formalize the supervision of refugee schools, to make sure they are operating in accordance with national standards, and delivering the highest quality education possible to students.

[96] The turnover is due to the different salary scales used by ARRA and NGO implementing partners to recruit teachers in the refugee schools. Comparatively speaking, host community teacher salaries are also higher after the new adjustment of all salaries that was introduced for Ethiopian teachers starting from January 2017.

4. Refugee inclusion in the national child protection system

Conflict and violence in their country of origin or during displacement have a profound effect on children. Their protection needs differ from adults as they are generally at greater risk of violence, abuse and exploitation, including trafficking or forced recruitment into armed forces or armed groups. Girls in particular face increased gender-related protection risks in the context of conflict and displacement.[97]

Providing refugee child protection services in Ethiopia is no small undertaking, given the large number of children in both refugee camps and urban areas. An estimated 58% of the 894,000 total refugees are children.[98] There are a number of protection issues to address, notably regarding the 70,000 refugee children born over the last ten years without birth certificates and the 42,900 unaccompanied or separated refugee children.[99]

UNHCR, ARRA, sister UN agencies and NGO partners strive to deliver protection to these children by responding to their specific needs and the risks they face. This includes protecting them against all forms of discrimination, preventing and responding to abuse, neglect, violence and exploitation, as well as ensuring immediate access to appropriate services and access to durable solutions in the child's best interests.[100]

Greater emphasis is being placed on the need to strengthen national child protection systems and services and advocate for access of refugee, displaced and stateless children to them. This systems approach to child protection, as endorsed by UNHCR's Executive Committee (ExCom Conclusion No. 107, 2007), is the foundation of UNHCR's Framework for the Protection of Children and reflects international best practice. It also features in the UNHCR National Child Protection Strategy 2017-2019, which provides a basis for field operations.

Applied to refugee child protection responses in Ethiopia, this system's strengthening approach could translate into: (i) ensuring refugee children are registered at birth through the host Government civil registration system, and (ii) enhancing access to services within the national education, social services, judicial and correctional systems of the host country to be on par with national children.

4.1 Ethiopia's commitment to vital events registration

The issue of refugee birth certification needs to be viewed within the broader civil registration system in Ethiopia. Only 7% of Ethiopian children currently have birth certificates.[101] Recognizing the scale of the challenge, the Government established in 2012 the Federal Vital Events Registration Agency (FVERA) (Proclamation No. 278/2012) under the Ministry of Justice to record births, marriages, divorces, adoptions and deaths. It created a legal framework for the registration of vital events (Proclamation No. 760/2012), making it compulsory for Ethiopians to record major events with the government. A National Strategy and Action Plan for 2013-2020 were subsequently developed.

Once established, FVERA supported the creation of nine regional agencies and two city administrations to manage the system. FVERA, the Ministry of Health, Regional

[97] UNHCR, Ethiopia National Child Protection Strategy 2017-2019.
[98] UNHCR, Ethiopia Factsheet, November 2017.
[99] UNHCR, Ethiopia Child Protection Factsheet, May 2017..
[100] UNHCR, Framework for the Protection of the Rights of Children, 2012.
[101] UNICEF, Ethiopia: Key demographic indicators, 2017.

Vital Events Registration Agency and the Regional Health Bureaus inaugurated the decentralized national registration system in August 2016. The country relies now on harmonized approach, using the same registration tools (registers, certificates and directives) at federal and regional levels.

The Government of Ethiopia subsequently pledged in September 2016 at the Leaders' Summit to issue birth certificates to children of refugees born in Ethiopia (Pledge 9).[102] The Government pledge led the Board of Management of FVERA, chaired by the country's Attorney General, to accept the recommendation of including refugees and other non-Ethiopians into the national system. [103]

This decision presented a major opportunity to include refugees in the national vital events system. FVERA and ARRA conducted a joint assessment late 2016 in Shire and Jijiga refugee camps to determine how to include refugee children in the national registration system. It was found that refugee children born in health facilities receive birth notifications in the health facilities or upon the presentation of witnesses who attended to the birth at the home, but are not registered in a national civil registration or issued with official birth certificates.

4.2 Revising the Proclamation to include refugees

On 25 November 2016, the Council of Ministers discussed a proposal to amend the directive to Proclamation 760/2012 allowing for the vital events registration of refugees and foreigners. The Council of Ministers recommended that the Proclamation itself be revised. The Ministry of Justice, FVERA and ARRA with the technical support from UNHCR and UNICEF, worked together to revise the Proclamation and submitted it to FVERA's Board of management, which approved it and submitted to the Council of Ministers for approval. The Council of Ministers endorsed it on 16 June 2017. The revised Proclamation was subsequently passed through Parliament on 7 July 2017.

The revision of the Proclamation enables ARRA to join FVERA's federal structure as a legally recognized registering body that can record all the vital events for refugees.[104] ARRA will also join the Board of Management of FVERA. By embedding ARRA in FVERA's federal structure, the Government effectively has avoided the creation of a parallel structure.

4.3 Investing in the system and awareness raising

Since September 2017, documents have been issued to refugees in each of the 26 camps and other urban areas where refugees reside. The issue of building capacity is cornerstone to vital events registration for refugees, be it in terms of staffing, reporting, storage of the documents. FVERA will provide capacity training to ARRA staff along with the necessary tools and materials in order to manage and store vital events

[102] Pledge 9 states: "Ethiopia pledges to provide facilities for refugees to open bank accounts, obtain driving licenses and all the other benefits to which any foreigner with a legal permanent residence permit is entitled to. Ethiopia also pledges to issue birth certificates to children of refugees born in Ethiopia."

[103] FVERA's Board of Management consists of 9 members at the Federal Level, which supervise the activities of the agency and approve the budget and reports. FVERA's Council consists of representatives at the regional level, and it is tasked to oversee the coordination and knowledge sharing between the federal and regional levels. The Council is responsible for ensuring that the Proclamation is implemented throughout the country.

[104] There are three registering bodies: Federal Ministry of Defense (that records death events), embassies and consulates, and the Ethiopian shipping lines (that records only births and deaths).

documents of refugees (and copies shall be shared with FVERA). Securing financial resources is of paramount importance to make the system operational. UNICEF and UNHCR are in discussions with donors to secure the required funding to support vital events registration for nationals and refugees.[105] Investments are needed for both FVERA and ARRA at the federal level, but also at the regional level.[106]

Awareness-raising is another considerable challenge. The majority of the population, including both nationals and refugees, has not yet fully realized the importance of registering vital events with the Government.[107] As a result, it will be necessary to provide trainings to health extension workers, the registrars and Kebele leaders in the host communities, as well as refugees themselves. In doing so, ARRA, UNHCR and NGO partners will have to raise awareness among the refugee population about the need to have birth notifications formally recognized through the delivery of a birth certificate.[108]

The registration of vital events of refugees will avoid serious protection risks. The 70,000 refugee children who currently only have birth notifications are at risk of being at greater risk of exploitation, including sexual abuse and child labour, due to the limited access to national systems and services (including when seeking legal redress). They are also at risk of becoming stateless, should they not receive adequate legal documentation.[109] The risk is further compounded by the fact that there are frequent cross-border movements by refugees, and as a result there may be a contestation of nationality by the relevant authorities down the road. Hence the need to continue advocacy efforts with donors and other stakeholders to make the Government Pledge 9 a reality.

4.4 Enhancing access to services within the national child protection system

Providing access to services to refugee children in need of protection is immensely challenging in Ethiopia. A more sustainable approach would benefit from the involvement of line Ministries that have social workers within their structure and real expertise on the subject. Knowing what type of child protection services are available at the national level, and how these could benefit refugee children would be an

[105] UNICEF and WHO are the global leads on birth registration, and work with different regional mechanisms and Governments to support the establishment of national systems that meet the criteria of a civil registration system.

[106] UNICEF currently supports FVERA both technically and financially. UNHCR made a contribution to FVERA in 2016 of 14,400 USD of equipment (printers, computers etc.) at the federal level to enhance the capacity of the agency, and will support capacity building of ARRA and FVERA staff on vital event registration, data collection and management, use of registration books and certificates.

[107] The Government will also rely on birth certificates to issue passports and other forms of identification, enroll children in school and allow access to health services, insurances etc. Other vital event registration is equally important. For instance, if a wife does not have a marriage certificate, she will not be entitled to receive her share of the family property during a divorce.

[108] FVERA and the Ministry of Health have signed an agreement in 2016 detailing the process whereby every health facility provides a birth notification, which will need to be then registered at the Kebele level by the parents, before FVERA issues a birth certificate. The same applies for death notifications from the health facility. Children also have a right to be registered even if they are born outside a health facility. Health workers at the community level can confirm the birth as the mother will have attended pre-natal courses at the health post.

[109] Refugee children born in Ethiopia cannot gain Ethiopian nationality according to the national law, which requires at least one parent to be a national (Article 3 of Nationality Proclamation No.378/2003). Naturalization process is possible, but only if certain conditions are met (e.g. inter-marriage).

important first step to ensuring better access to services. Closer collaboration between ARRA, UNHCR, UNICEF and the line Ministries, notably the Ministry of Labour and Social Affairs, the Ministry of Education, the Ministry of Justice, the Ministry of Women and Children Affairs could help to identify entry points within the existing legal and policy frameworks on child protection.

Making this connection is all the more important given the magnitude of the challenge. Family separation is a major child protection issue in refugee camps. UNHCR estimates that there are currently 44,453 unaccompanied or separated refugee children in Ethiopia.[110] The situation is particularly acute in Shire, where there are an estimated 4,000 mostly unaccompanied refugee children. The inherent difficulties in finding families for these children has led ARRA and UNHCR to arrange for community care, which enables a group of 6 to 9 children to live on their own with guardians nearby. This arrangement represents an informal foster care system, yet it would be important to create stronger linkages with the national foster care system. This inclusion could be facilitated if national foster care policies and guidance also reflect the situation of refugee children.

Child marriage is yet another major protection concern. Under Ethiopian law, child marriage is prohibited under the age 18. Recognizing the difficulty in accessing the formal justice mechanisms in the country, due to geographic isolation and a tendency to rely on transitional justice mechanisms, UNHCR and ARRA worked with the Judiciary of the Somali Regional State to establish the extension of mobile hearings of the district court to Dollo Ado refugee camps in June 2014 involving the Ministry of Justice, Judiciary and Police Commission.[111] The mobile court has resolved 23 child marriages cases since June 2014 and also acted as a deterrent for the practice in the refugee community of Dollo Ado.

The positive experience of the mobile court sessions of the district court in Dollo Ado has prompted UNHCR's operation in Gambella region to develop a similar access to justice initiative in response to local conflict in and around refugee communities in 2015 and 2016.[112] While refugees will continue to use traditional justice mechanisms for civil cases (dowry, adultery, divorce), the formal justice will deal with criminal cases, through the use of mobile courts. Such experiences highlight the need for humanitarian and development actors to support longer-term initiatives that facilitate access to national judicial services rather than creating parallel, informal response mechanisms within the camp.

At the regional level, UNICEF and UNHCR jointly commissioned in 2016 research to review the legislation, policies and practices vis-à-vis inclusion of refugee children in national child protection systems in Eastern Africa and the Great Lakes (including Ethiopia).[113] This research is significant as it has identified a number of potential entry

[110] UNHCR, Ethiopia Child Protection Factsheet, March2017.
[111] A MoU was signed in June 2014 between ARRA, UNHCR and the Judiciary of the Somali Regional State of Ethiopia on the mobile court services in Melkadida/Dollo Ado refugee camps. An addendum to this MoU was endorsed by the three parties in May 2016.
[112] This multi-year project aims to improve community security, refugee protection and access to justice in 7 refugee camps and host communities by reinforcing the capacities of local institutions, and bringing together both refugee and host communities to address concerns of injustice, insecurity and inter-community violence.
[113] Mariana Muzzi, Bridging the Humanitarian-Development Divide for Refugee Children in Eastern Africa and the Great Lakes: UNHCR & UNICEF Formative review of legislation, policies and practice vis-à-vis inclusion of refugee children in National Child Protection Systems in Ethiopia, Kenya, Rwanda, South Sudan, Sudan, Tanzania and Uganda, 2017.

points for the inclusion of refugee children in national legal and policy frameworks, child protection services and systems. These entry points (as well as potential other entry points) can guide country level efforts to work towards greater engagement by national authorities in protection of refugee children.

Conclusion

The inclusion of refugees within the national systems in Ethiopia has faced two critical challenges. Firstly, refugees have remained largely in camps in the peripheral and poorest regions of the country where public investment in development has been limited. Secondly, service delivery has remained largely externally financed through the provision of humanitarian aid. As this report has demonstrated, some important progress has been recorded in addressing these issues. Through the adoption of long term, sustainable approaches such as the Itang water infrastructure project, external financing and agencies have combined with their Government counterparts to build local capacity and provide improved services to both refugees and local communities.

This study shows the value added of establishing partnerships across the different sectors, be it in health, water, education or child protection, to avoid as much as possible the creation of parallel systems. At the invitation of ARRA, line Ministries and their corresponding Regional Bureaus are increasingly contributing their expertise to the refugee response. The new Government pledges of September 2016 and roll-out of the CRRF will serve to further advance work on refugee inclusion in the national systems.

Yet the issue of funding remains central to these efforts. Local authorities have the responsibility to deliver quality services to the host population, so any efforts to promote refugee inclusion cannot come without additional resources. Over the next few years, new development concessional financing to address forced displacement will be made available by the World Bank and other actors in order to address more effectively the poverty and development challenges of both refugees and host populations. This funding provides a window of opportunity to further support the mainstreaming of basic services to refugees into national delivery systems, and expand economic opportunities for host communities and refugees.

This study, and the proposed recommendations listed below, have been drafted with the hope that they will stimulate more creative, principled, pragmatic and inclusive responses to refugee displacement.

Recommendations

Health

Investing in strengthening the national health system is a prerequisite to supporting the self-reliance and resilience of refugees and the host population. Following the emergency phase where external financing is critical, there are many opportunities to improve health outcomes over the longer term through strengthening local health systems capacity and service delivery. The following recommendations are made with the view of further improving access to health services for refugees and host community alike:

1. Include refugees in national plans and policies on health, such as the next iteration of the Health Sector Transformation Plan, as well as the Demographic Health and Nutrition Survey in order to enable better comparison between refugee and host community health concerns and progress towards joint indicators.

2. Building on the MOU between the Federal Ministry of Health, ARRA, UNHCR and UNICEF on vaccine planning and supply for refugees, develop an expanded

framework agreement to ensure the sustainability of prevention efforts in national disease programmes, the consistent inclusion of refugees in micro-plans formulated by the Regional Bureaus of Health, constant supply of medicines to refugees and joint monitoring for improved quality control in laboratories.

3. Improve staffing capacity in refugee health facilities by allowing refugee health practitioners to enroll in advanced courses offered by the national training system on relevant clinical and public health topics, recognizing their certificates and providing them with work permits in health facilities in the camps.

4. Pursue initiatives to further align or integrate refugee health facilities within the national health system, with the view of ensuring equitable treatment between refugee and host populations and supporting more sustainable long-term investments.

5. Sustain advocacy efforts to ensure refugees are included in the national proposals and grant cycles submitted to different donors, including the upcoming grant for 2019-2020 of the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Water

The Itang water infrastructure project is the first attempt in country to invest in durable infrastructure that serves both refugees and host populations in a defined geographic area, providing a high level of service albeit at a significant cost for the initial capital investment. The following recommendations could further improve access to water services for refugees and host community alike:

1. Refine the development approach of the Itang integrated water system to ensure that the Government operates the system with minimal external assistance. The overall sustainability of the system will depend on the ability and willingness of the end user to pay water. Refugees will need access to livelihoods if they are to pay for water themselves.

2. Replicate this development-oriented approach from Gambella in other regions (e.g. in Shire and Jijiga), in close partnership with development actors and regional water authorities. In doing so, it will be important to document and widely disseminate lessons learned from the Itang water project in Gambella.

3. Explore cost recovery models, such as solar powered water systems to reduce the unit cost of water, and transferring the operation and maintenance to the population.

4. Support the adoption of professionalized community-based management models to enhance the cost effectiveness of water supply systems. These models should enhance the involvement of refugees in WASH service delivery, ensuring that they are responsible for the general management of water collection points and for basic repairs within the camps.

5. Continue to invest in longer-term “waste to value” sanitation options in the refugee camps as well as support municipalities to manage sludge both in adjacent Woreda towns by providing them with vacuum trucks and construction of sludge drying beds.

6. House under the ONE WASH National programme all water, sanitation and hygiene interventions for refugees and host populations. Such enhanced coordination would increase the ability to attract funds for integrated water management schemes from development donors, in close partnership with UNICEF.

Education

The inclusion of refugees into national education systems is the only way to ensure sustainable, quality and long term education for refugees. Providing education is necessary to ensure social cohesion between local communities and refugees and facilitate a return to normalcy for children and youth. It also increases their self-reliance over time. Within the refugee camps and neighboring host communities, current interventions are not meeting the full extent of educational needs and access to education remains low across the high number of school-aged children. The following recommendations could further improve education for refugee and host community children:

1. Include refugee education in the national planning processes by ensuring that refugee education is incorporated into education sector plans and budgets of the Woreda Education Offices, Regional Education Bureaus and the Federal Ministry of Education. Previously refugee education used to be seen only as a short-term, emergency response, however the thinking has evolved now and long term development in education is part of refugee response planning and programming.

2. Formalize areas of joint collaboration between ARRA and the Federal Ministry of Education, clearly outlining key areas of responsibility in refugee education and ways by which to improve planning and oversight. An agreement at the Federal level will then enable ARRA and the Regional Education Bureaus to work in a more coordinated, systematic manner.

3. Right from the inception of a new refugee camp, plan for the building of new refugee schools, with the ultimate goal of connecting these establishments to the national education system. An opportunity to do such long-term planning is possible with the establishment of a new camp in Assosa for refugees from South Sudan.

4. Standardize teacher management and development policies across refugee and host community schools with the support of the Regional Education Bureau, in order to enhance access to continuing education, as well as improve teacher training and working conditions for both nationals and refugee incentive teachers. Alternative staffing solutions for food distribution in the refugee camps should be found, to ensure that teachers are able to do their primary job in the school without any interruption.

5. Secure additional resources to support the building of additional schools for host and refugee children, the recruitment of additional qualified staff as well as the management of these establishments. Additional funding also should support the full rollout of the Education Management and Information System in refugee schools.

Child Protection

The building of a civil vital events registration system in the country offers real momentum to include refugees in the national system. These efforts can be expanded to other areas of child protection as well, including education and judicial services. The following recommendations could further improve child protection services:

1. Explore together with ARRA, UNICEF and the line Federal Ministries potential entry points for the gradual inclusion of refugees in national systems, including for both refugee children in camp and urban settings, to improve strategic long-term planning and interventions.

2. Build government capacity in the long-term to deal with child protection in emergency situations. Invest in particular in the capacities of the Federal Ministry of Social and Labour Affairs to respond to child protection needs in future refugee influxes where they have specific technical expertise, in close collaboration with ARRA.

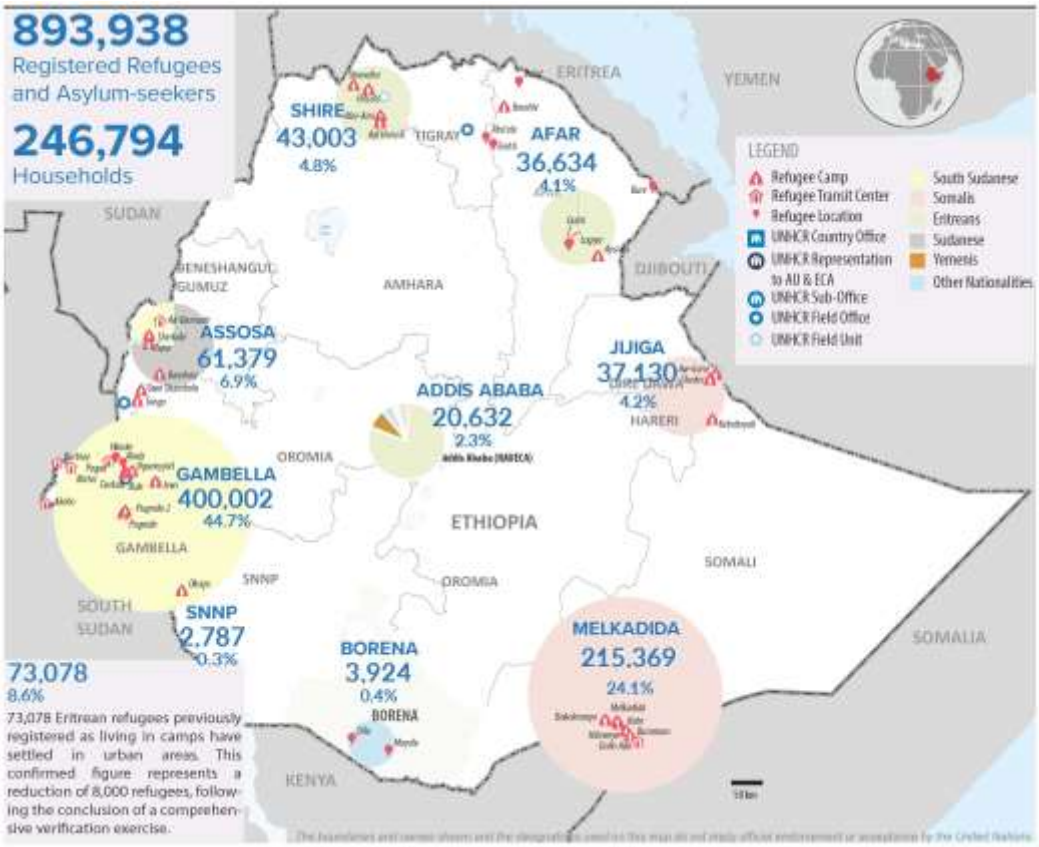
3. Strengthen the collaboration between development and humanitarian actors in order to place the issue of refugee child protection on the agenda of the line Ministries and enable the sharing of good practices (e.g. on case management and referral systems).

4. Advocate for additional resources to support the delivery of vital events certificates to refugees. Support is needed to enable FVERA to deliver trainings to ARRA staff, as well as for the printing of registers, certificates and directives that ARRA will need to use to the register vital events of refugees.

5. Organize joint planning between FVERA and ARRA to plan, supervise, monitor and evaluate vital events registration in refugee camps. UNHCR could facilitate experience sharing with another country that has a more advanced system of vital event registration of refugees.

Annex I – Map of UNHCR operation in Ethiopia

*Infographic on refugees and asylum seekers, as of November 2017.



Annex II – Map of Gambella region