USAID
FROM THE AMERICAN PEOPLE

July 15, 2020

Ms. Susan Farrell
Chief Administrative Officer
Pathfinder International
9 Galen Street, Suite 217
Watertown, MA 02472-4523

E-mail: sfarrell@pathfinder.org

Subject: Award No. **720FDA20GR00161**

Dear Ms. Farrell:

Pursuant to the authority contained in the Foreign Assistance Act of 1961, as amended, the U.S. Agency for International Development (hereinafter referred to as "USAID" or "Grantor") hereby provides to **Pathfinder International** (hereinafter referred to as "**Pathfinder,**" "Grantee," or "Recipient" or "non-Federal entity) the sum set forth in Section 1.3 of this Agreement to provide support for a program entitled "**Responding to COVID-19 in Hotspot Areas of Ethiopia,**" as described in Attachment 2 of this Agreement entitled "Program Description."

This Agreement is effective and obligation is made as of the date of this letter and shall apply to expenditures and obligations made by the Recipient in furtherance of program objectives for the period described in Section 1.2 of this Agreement. USAID shall not be liable for reimbursing the Recipient for any costs in excess of the obligated amount.

This Agreement is awarded to the Recipient on condition that the funds will be administered in accordance with the terms and conditions as set forth in the attachments listed under my signature below, which together constitute the entire award document, and to which your organization has agreed.

Please sign the second page of this cover letter to acknowledge your receipt of this award, and forward a scanned copy of only the signed page to jrgrants@ofda.gov.

Sincerely,

RENEE REED NEWTON (affiliate)

Digitally signed by RENEE REED NEWTON (affiliate)
Date: 2020.07.15 21:24:25 -04'00'

Renee Newton
Agreement Officer
Office of Acquisition and Assistance
M/OAA/DCHA

Attachments:

1. Schedule
2. Program Description
3. Standard Provisions
4. Branding Strategy and Marking Plan

ACKNOWLEDGED: Pathfinder International

By: DocuSigned by: Susan Farrell 75125CB8AA7B4EA...

Name: Susan Farrell

Title: CAO

Date: 7/23/2020

ACCOUNTING AND APPROPRIATION DATA

A. GENERAL

A.1.	Total Estimated USAID Amount	:	$500,000.00
A.2.	Total Obligated USAID Amount	:	$500,000.00
A.3.	Cost-Sharing Amount (Non-Federal)	:	N/A
A.4.	Agreement Officer's Representative (AOR)	:	See Section 1.12
A.5.	Tax I.D. Number	:	53-0235320
A.6.	DUNS Number	:	062157045
A.7.	LOC Number	:	HHS-51A5P
A.8.	USAID CFDA Number	:	98.001

B. SPECIFIC

B.1.(a)	Award Number	:	720FDA20GR00161
B.1.(b)	REQ Number	:	REQ-OFDA-20-000642
B.1.(c)	Organization ID	:	12504
B.1.(d)	Control Number	:	D20202605
B.1.(e)	Fund	:	FD-X20-CV2
B.1.(f)	Program Element	:	N/A
B.1.(g)	Operating Unit	:	DCHA/OFDA
B.1.(h)	Program Area	:	HA.1
B.1.(i)	Distribution Code	:	663-W
B.1.(j)	BGA	:	663
B.1.(k)	SOC	:	4100201
B.1.(l)	Amount	:	$500,000.00

Request to USAID/OFDA for a:

New Award *or* Modification to an Existing Award (#_____)

☒Country/Region of Country: Ethiopia

Submission/Revision Date: **June 30, 2020**

Program Title: Responding to COVID-19 in Hotspot Areas of Ethiopia (RIHA)

Applicant Organization Name: Pathfinder International

Headquarters Contact Information	Field Contact Information
Contact Person: Stephanie Hawkins	Contact Person: Mengistu Asnake
Mailing Address: 9 Galen Street, Suite 217	Mailing Address: Haji Kelifa Sabit Building
Watertown, MA 02472	Nifasilk/Lafto Sub-city Woreda 3, Addis Ababa
Telephone: +1 617 924 7200	Telephone: +251 0 113 203 501
Fax: +1 617 924 3833	Fax: +251 11 320 3572
E-mail: SHawkins@pathfinder.org	E-mail: MAsnake@pathfinder.org

☒For new awards:

Proposed Period of Performance Start Date: August 1, 2020

Proposed Period of Performance Duration: January 31, 2021

☐ For modifications to existing awards

Check boxes below if your application requests USAID/OFDA funding for procurement of the following categories of restricted goods:

Restricted Goods
☐ Seeds*
☐ Livestock*
☐ Fertilizer
☐ Pesticides and Pesticide-containing Materials, including LLINs, ITPSs**
☐ Pharmaceuticals: Human**
☐ Pharmaceuticals: Veterinary**
☐ Purchase of vehicles not manufactured in the U.S. or leases greater than 180 days
☐ Used Equipment
☐ USG-owned Excess Property

Dollar Amount Requested from USAID/OFDA: ___$500,000 _____
Dollar Amount from Other Sources: $_____
Dollar Value of In-kind Contributions: $_____
Total Dollar Amount of Program: _____$500,000_____

Program Goal: Resilient primary health care system with absorptive, adaptive and transformative capacity
Total Number of People Affected in the Target Area: 1,500,000
Total Number of People Targeted (Individuals): 1,500,000

Total Number of Internally Displaced Persons (IDP) Targeted (Individuals) as subset of above: 29,540

Executive Summary:

Pathfinder International, in partnership with the Amhara, Oromia, Southern Nations Nationalities and Peoples (SNNP), and Tigray Regional Health Bureaus (RHBs), is pleased to submit this application for Office of Federal Disaster Assistance (OFDA) funding to support the COVID-19 response in Ethiopia. The RHBs have conducted needs assessment and requested training, supportive supervision, and logistics support to address emerging challenges in the midst of COVID-19 that includes combination of increased workload and a reduced number of health workers, shortages of personal protective equipment (PPE), and the lack of clear messages about when and where to seek care. To fill gaps in these areas, our team of country experts will contribute to the RHBs efforts of ensuring a resilient health system that can persistently provide essential health services and can respond to COVID-19 pandemic. To this effect, our concerted effort will strive to improve facility readiness to provide essential health services; strengthen risk communication and community engagement (RCCE); improve effective surveillance; and improve COVID-19 case management through adaptive needs-based Technical Assistance (TA). Our support will target COVID-19 hotspot areas, sites with internally displaced persons (IDP), and COVID-19 quarantine and treatment centers prioritized in conjunction with the RHBs. Our plan is to reach the entire catchment population in the identified sites utilizing different interventions. A total of **1.5 million** beneficiaries will be targeted with this assistance and **29,540** IDPs will benefit from the interventions. To ensure rapid start-up, synergistic implementation, effective coordination, sustainable outcomes, and value for money, we will implement the proposed activities through the management structure of United States Agency for International Development (USAID) Transform: Primary Health Care (PHC) Activity. Across all interventions and interactions with Government of Ethiopia (GOE), we will promote gender and protection analysis and mainstreaming by addressing multi-leveled power hierarchies and ensuring that policies, practices, and behaviors at all levels of service delivery management and provision are examined and transformed toward equitable access. In support of USAID's Journey to Self-Reliance efforts, USAID Transform: Primary Health Care Activity has a strong sustainability plan and has a Memorandum of Understanding (MOU) with the GOE. This project will build on this and continue our strong partnership with the government and at all levels of the health system to build local capacity and ownership in order to transition responsibility for the OFDA activities to relevant government and community structures.

Sector Table:

Sector Name:	Health
Objective:	**Resilient primary health care system with absorptive, adaptive and transformative capacity**
Dollar Amount Requested:	$500,000
Number of People Targeted:	1,500,000
Number of IDPs Targeted:	29,540
Geographic Area(s):	Amhara (Metema, Habru Woreda, D/Brihan Town Woreda, Kombolcha Woreda); Tigray (Kafta Humera Woreda, Tselemti Woreda); Oromia (Mede Welabu Woreda, Toke Kutaye Woreda); and SNNP (Mareko Woreda, Geresse Woreda)

Keyword(s):	WASH in health facilities
Sub-sector Name:	Public Health Emergencies of International Concern and Pandemics
Indicator 1:	Number of outpatient health facilities supported
Indicator 2:	Number of inpatient health facilities supported
Indicator 3:	*(Number of hospitalizations)* *
Indicator 4:	*(Number of individuals screened or triaged for COVID-19 at supported health facilities)* *
Indicator 5:	Number of people reached through risk communication activities, disaggregated by channel
Indicator 6:	Number of health care staff trained, disaggregated by sex by health care staff type
Indicator 7: (Custom)	Number of supportive supervision and TA visits by project staff in collaboration with public staff to ensure HFs adapt and continue essential services
Indicator 8: (Custom)	Number of health facilities supported with waste disposal materials and/or water containers
Indicator 9: (Custom)	Number of RCCE materials Adapted, produced and disseminated, disaggregated by type
*Note: The Activity will not monitor these indicators because the scope of the Activity and the current national and regional COVID-19 monitoring system does not align with the Activity's monitoring mechanism. Please refer to the Annex Monitoring & Evaluation Plan for detailed information.	

A. Justification

Problem Statement

The Government of Ethiopia (GOE) is committed to ***one COVID-19 response*** that is initially integrated across the health sector, and ultimately feeds into one national multi-sectoral response, including all relevant actors. The response is guided by one plan, with an integrated view of all activities across the response in the health sector and beyond. The Ministry of Health has activated its Public Health Emergency Operation Center (PHEOC) to lead the response and ensure effective coordination across sectors.[1] The OFDA funding requested by Pathfinder will support the GOE to accelerate its response to achieve its goal of maximally suppress communitywide transmission of COVID-19.

Country Situation

Since the first COVID-19 case was reported in Ethiopia on March 13, 2020, the number of total infections has risen to 4,532 as of June 21, with 3,243 active cases and 74 deaths (2.28% of active cases).[2] While COVID-19 transmission was initially linked to imported cases, there is now evidence of community transmission in Addis Ababa and identified clusters of cases and emerging sporadic cases of COVID-19 in other regions. Older adults and people of any age who have serious

[1] Ethiopia Ministry of Health and Ethiopian Public Health Institute. Preparedness and Response Plan for COVID-19: Scenario 3. https://www.rvo.nl/sites/default/files/2020/05/Nationaal-Actieplan-Ethiopie-COVID-19-ENG.pdf
[2] Ethiopian COVID-19 Case Update. Last retrieved at https://ethiocovid19.info/ on June 18, 2020.

underlying medical conditions are at higher risk for severe illness from COVID-19.[3] The Government of Ethiopia (GOE) estimates 102,000 COVID-19 cases within the initial three months of the epidemic.[4] Given limited capacity for testing and the need for better supported surveillance and contact tracing, the number of actual cases is likely under reported. Evidence from past pandemics and outbreaks suggests there are different impacts on women and men due to risk of exposure and biological susceptibility to infection based on social and economic inequities. Therefore, countries are encouraged to collect, report, and analyze data on confirmed COVID-19 cases and deaths that are disaggregated by sex and age, at a minimum, in accordance with WHO's global surveillance and national surveillance guidance.[5]

Ethiopia has been ranked by the African Center for Strategic Studies among the top ten countries vulnerable to COVID-19 in Africa. It is anticipated that subsequent stages of the epidemic are likely to be fueled by other vulnerabilities such as size and density of urban population, ongoing parallel epidemics, high levels of poverty, capacity for testing and contact tracing, strength of the health systems, size of displaced populations, and openness of communication channels. The COVID-19 epidemic is also happening in Ethiopia as the country approaches its slow season of agricultural productivity (June to September) in the lowlands of central and eastern Oromia, the lowlands of Waghimra Zone of Amhara, and Tekeze River catchments of Tigray. In addition, the GOE has now postponed the national election day, originally scheduled prior to the pandemic declaration, to now be held later to no longer be a public health emergency. Given these factors, political stability and security could also be undermined.[6]

Compounding Factors

Ethiopia, like many countries, is finding it challenging to strike an appropriate balance between responding to the COVID-19 and maintaining essential health service delivery and mitigating the risk of potential health system collapse. According to a report from Ethiopian Public Health Institute (EPHI), yellow fever, cholera, Acute Flaccid Paralysis (AFP), measles, and anthrax are currently active epidemics in Ethiopia. The COVID-19 epidemic is therefore expected to add to the burden of epidemic prone infectious diseases that already prevail in the country. Pre-existing poor hygiene practices, poor coverage in water and sanitation services, and overcrowded living conditions also exacerbate the spread of these multiple epidemics. As health system capacities are stretched, the GOE and health facilities are making choices about prioritizing the provision of some health services and scaling back others.

Experience and evidence from previous outbreaks (e.g., Ebola epidemics in the Democratic Republic of the Congo, Guinea, and Sierra Leone, and the Zika epidemic) and other humanitarian emergencies indicate that sexual and reproductive health services – including pregnancy care, contraceptives, sexual assault services, child health services and post abortion care – are likely to

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[3] CDC. Coronavirus Disease 2019. Last retrieved on June 17, 2020 at: https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/groups-at-higher-risk.html
[4] Ethiopia Ministry of Health and Ethiopian Public Health Institute. Op.Cit.
[5] WHO. COVID-19 and Gender. Advocacy Brief. May 14, 2020. P. 1
[6] Mapping COVID-19 Risk Factors – Africa Center for Strategic Studies. https://africacenter.org/spotlight/mapping-risk-factors-spread-covid-19-africa/

be scaled back.[7] [8] [9] This can result in an increased risk of maternal mortality, unintended pregnancies, and other adverse sexual and reproductive health outcomes among women and girls. A recent modeling study that estimated the indirect effects of COVID-19 on reducing essential health services coverage and the resulting maternal and child mortality, provided evidence that these essential health services, including voluntary family planning, preventive health care, and immunizations need to be maintained to prevent indirect mortalities.[10]

Critical resources, such as trained health workers and medical supplies, are being diverted from essential health services to respond to COVID-19, thereby leaving these services heavily under-resourced and vulnerable.

The resulting combination of increased workload and a reduced number of health workers in Ethiopia is expected to severely strain the capacity to maintain essential services, as well as the COVID-19 response. In addition, the scarcity of drugs, infection prevention and control materials, personal protective equipment, non-food items, and food at COVID-19 treatment and isolation centers is critical and requires immediate action. The need to redirect supplies to treat patients with COVID-19, compounded by ongoing supply chain disruptions in Ethiopia, is also likely to lead to further stock-outs of commodities and equipment needed for essential services. Clear messages about when and where to seek care, vulnerable populations most at risk (e.g., elderly, people with pre-existing conditions), and reassurance about the safety of care are also needed and should be mainstreamed as part of the outbreak response communication strategy.

In addition to the reduction in services delivery, Ethiopia's epidemic infectious diseases have led to complications and morbidity associated with delayed care-seeking exacerbating infectious diseases such as tuberculosis, HIV/ AIDS, and others. The COVID-19 associated confinement, fear, job loss, and uncertainty about the future has also been linked with an increase in gender-based violence and with an overall increase in mental health conditions, including depression, anxiety, and substance use disorders.

When health systems are overwhelmed and people fail to access needed care, both direct mortality from an outbreak and indirect mortality from preventable and treatable conditions increase dramatically. [11] [12] [13] Maintaining population trust in the capacity of the Ethiopian health system to

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[7] Smith J. Overcoming the "tyranny of the urgent": integrating gender into disease outbreak preparedness and response. Gend Dev. 2019;27(2):355–69 (https://doi.org/10.1080/13552074.2019.1615288, accessed 28 April 2020).

[8] McKay G, Black B, Mbambu Kahamba S, Wheeler E, Mearns S, Janvrin A. Not all that bleeds Is Ebola: how has the DRC Ebola outbreak impacted sexual and reproductive health in North-Kivu. New York (NY): The International Rescue Committee; 2019 (https://www.rescue.org/report/not-all-bleeds-ebolahow-drc-outbreak-impacts-reproductive-health, accessed 28 April 2020).

[9] Camara BS, Delamou A, Diro E, Béavogui AH, El Ayadi AM, Sidibé S et al. Effect of the 2014/2015 Ebola outbreak on reproductive health services in a rural district of Guinea: an ecological study. Trans R Soc Trop Med Hyg. 2017;111(1):22–9 (https://academic.oup.com/trstmh/article/111/1/22/307 4506, accessed 28 April 2020)

[10] Roberton T, Carter ED, Chou VB, Stegmuller A, Jackson BD, Tam Y, Sawadogo-Lewis T, Walker N. Early estimates of the indirect effects of the COVID-19 pandemic on maternal and child mortality in low-income and middle-income countries: a modelling study. The Lancet Global Health. Published: May 12, 2020. DOI: https://doi.org/10.1016/S2214-109X(20)30229-1

[11]Parpia AS, Ndeffo-Mbah ML, Wenzel NS, Galvani AP. Effects of response to 2014–2015 Ebola outbreak on deaths from malaria, HIV/AIDS, and tuberculosis, West Africa. Volume 22, Number 3—March 2016 - Emerg Infect Dis, 2016;22(3):433-441. doi:10.3201/ eid2203.150977 2. 3.

[12] Brolin Ribacke KJ, Saulnier DD, Eriksson A, von Schreeb J. Effects of the West Africa Ebola virus disease on health-care utilization - a systematic review. Front Public Health. 2016;4:222. doi: 10.3389/fpubh.2016.00222.

[13] Elston JWT, Cartwright Ç, Ndumbi P, Wright J. The health impact of the 2014-15 Ebola outbreak. Public Health. 2017;143:60–70. doi: 10.1016/j.puhe.2016.10.020.

safely meet essential needs and to control infection risk in health facilities is key to ensuring appropriate care-seeking behavior and adherence to public health advice.

Justification for Intervention and Needs Assessment Summary

Based on this, there is an increased need for support to Ethiopia's COVID-19 response as well as maintaining existing essential health services. Maintaining essential services while responding to the COVID-19 pandemic requires additional resources as health facilities adapt key Infection Prevention and Control (IPC) practices to safely deliver services and restore provider and client confidence in the health system.

As indicated in Table 1, Amhara, Oromia, SNNP, and Tigray Regions are currently experiencing rising cases of COVID-19. This is occurring while the regions are also confronting the other active epidemics previously mentioned. The woredas in these regions do not currently have emergency partner support to address COVID-19 and the health systems are becoming overburdened with additional needs due to the pandemic. The situation in IDP sites is even worse and IDPs are expected to be disproportionately affected by the direct and indirect consequences of the pandemic. The Regional Health Bureaus (RHBs) in these four regions have identified gaps in the response and prepared comprehensive COVID-19 response plans with detailed activities including appropriate budgets to address the identified gaps.

Table 1: Reported COVID-19 cases and deaths by regions and city administrations as of June 21, 2020

Region	Total Cases	Total Deaths	Case Fatality Rate
Addis Ababa	3,237	57	1.8%
Somali	3,36	2	0.6%
Amhara	274	2	0.7%
Oromia	236	4	1.7%
Tigray	180	0	0%
Afar	65	0	0%
SNNPR	48	0	0%
Dire Dawa	42	1	2.4%
Harari	32	1	3.1%
Gambela	6	0	0%
Benshangul Gumuz	6	0	0%

Source: Covid19.et. Last retrieved on June 18 at https://www.covid19.et/covid-19/

As a trusted partner to both the GOE and USAID, the Pathfinder-led USAID Transform: Primary Health Care Activity is well positioned to support the RHBs to address the gaps and meet these challenges. Pathfinder has a long history of successfully managing large, complex, multi-partner USAID projects in Ethiopia and worldwide, including the USAID Transform: Primary Health Care Activity. The project has brought a new approach to health systems strengthening driven by GOE priorities, while promoting adaptive leadership, critical thinking, iterative learning and adapting, and gender transformation at all levels of the health system. The project also addresses bottlenecks to close the equity gaps for underserved populations including rural women, youth, and people with disabilities such as obstetric fistula – thereby improving health outcomes.

The USAID Transform: Primary Health Care Activity also has direct experience supporting the GOE's COVID-19 response. With funding from the USAID Transform: Primary Health Care

Activity Crisis Modifier Activation, the project is currently implementing the following ongoing COVID-19 activities in the four regions:

1. Strengthening subnational coordination
2. Risk communication and community engagement activities
3. Supporting health sector and facilities to adapt and function during the pandemic
4. Supporting provision of COVID-19 treatment services in selected facilities
5. Supporting surveillance and contact tracing activities

As of June 2020, some key results include:

- 43 audio-mounted vehicles have done RCCE activities in 151 woredas in the four regions where the project operates. These activities have reached approximately 14,756,621 (48% female) people with interventions in more than 300 identified key places.
- 279 health facilities (247 health centers and 32 primary hospitals) were supported with COVID-19 adapted essential service delivery. Issues demanding higher-level attention were brought to Zonal Health Departments (ZHDs) and RHBs including in the nine regional and 25 zonal coordination sessions/meetings that the project staffs have participated in.
- COVID-19 case management training in SNNP Region and integrated surveillance activities were technically and financially supported in Oromia, Amhara, and SNNP Regions. Materials (blankets, linens, etc.) were provided and shipped to the treatment, isolation, and quarantine sites of Central Gondar Zone, and drugs and materials were transported to the North Wollo and South Gondar zones.
- Most of the Activity's regional staff are involved in different task forces and other technical working groups in the implementating regions, including those for revitalizing essential services.

The RHBs in the four regions have requested further support from the USAID Transform: Primary Health Care Activity to address remaining gaps in their COVID-19 response plans. The Activity's results-oriented, decentralized, and integrated approaches to project management and implementation will facilitate the rapid roll-out of the proposed OFDA funded activities. The Activity already has extensive infrastructure and staff in the four regions that can provide a foundation for adaptive technical assistance (TA) to the RHBs, ZHDs, and Woreda Health Offices (WorHOs) in the four regions.

The Activity's staffing structure is designed to effectively manage project resources for the successful implementation of deliverables and provides clear lines of authority. The Activity is led Dr. Mengistu Asnake, the Chief of Party (COP), an accomplished and respected public health leader in Ethiopia with over three decades of experience in program management, systems strengthening, RMNCAH, primary health care, child survival, community health services, training, implementation research, and clinical services delivery. The Deputy Chief of Party/ Health Systems Strengthening (HSS) Director, Monitoring, Evaluation and Learning (MEL) Director, two Technical Directors, and Finance & Operations (F&O) Director form the senior management team of the Activity.

At the regional level, the USAID Transform: Primary Health Care Activity has staff with expertise in the different technical areas who give direct technical support to the RHBs, Zonal Health Office, and WorHOs. At the zonal level, the Activity has cluster offices which are co-located within the

ZHDs and provide day to day technical support in the areas of RMNCAH-N, including health system strengthening. The cluster level team also provides close technical support to the WorHOs overall implementation, covering three woredas per technical personnel. The Activity has 30 Cluster Offices and 169 technical and 147 support staff who are responsible for coordinating and implementing multi-thematic activities including joint supportive supervision, on the job training, capacity enhancement on clinical services, IPC, and emergency preparedness and response. They are equipped to support the OFDA activities, providing the necessary technical support to the selected woredas and IDP centers.

B. Program Description

Goal

The proposed OFDA activities will be integrated with and complement the USAID Transform: Primary Health Care Activity's ongoing health systems strengthening activities in the four regions. Since the Activity aims to strengthen primary health care, the theory of change (TOC) developed for this application focuses on creating a ***resilient primary health care system*** to achieve the following two strategic objectives:

1. To support continuity of essential health services during COVID-19
2. To respond to the COVID-19 pandemic itself

Our theory of change posits that **IF** the OFDA funded activities support essential services delivery in the COVID-19 context and respond to COVID-19 through four technical approaches 1) improving health facility readiness to provide essential services; 2) strengthening RCCE; 3) improving surveillance and contact tracing; and 4) improving COVID-19 case management in four regions of Ethiopia, **THEN**, the results will lead to strengthened capacity at primary level care to absorb, adapt, and contribute to transforming towards a resilient primary health care system.

Our two objectives contribute to filling important gaps in the COVID-19 response in Ethiopia. As gaps at the national, regional, and zonal levels are being addressed by other partners, the RHBs have requested that the proposed OFDA activities address the shortage of trained health workers and the reduced demand for and access to services at the health facility and community levels. The proposed technical approaches and associated activities to achieve our two objectives link directly to OFDA's sectors and sub-sector. All four approaches fall under the Public Health Emergencies of International Concern and Pandemics sub-sector. The approaches and activities are fully described in the Sector section below.

A more resilient health care system will contribute to the GOE's COVID-19 preparedness and response goal to maximally suppress community-wide transmission of COVID-19 in order to reduce related mortalities. [14] Aligned with USAID/OFDA's conceptual framework to guide its Disaster Risk Reduction (DRR) programming, we will integrate COVID-19 preparedness and DRR within the broader GOE health sector response by building local capacity and ownership at all levels; supporting community engagement when implementing DRR; and expanding partnerships and multi-sectoral programming.

Beneficiary Numbers

[14] Suppression is a modified form of containment as we assume unknown level of community spread which can lead to either direction i.e. to containment or mitigation.

We have chosen the indicators in line with the OFDA recommended COVID-19 indicators as well as custom indicators for monitoring essential health services during the time of COVID-19. For detailed information on indicator selection, please refer to Annex 12: Monitoring and Evaluation (M&E) Plan Narrative. For selected indicators, the data collected will be disaggregated by gender and geographic area, to reduce inequalities in response. Indicator definition, source and frequency of data collection, and targets are established for each indicator (see Annex 13: Monitoring Table). Relevant indicators are listed under the sub-sector below.

A total of ***1.5 million beneficiaries*** will be targeted with this assistance and ***29,540 IDPs*** will benefit from the interventions.

Critical Assumptions

The GOE is planning for a worst case COVID-19 scenario. Based on the GOE's scenario, our theory of change is reliant on the following set of assumptions and external factors that may not be under the direct and immediate control of the Activity:

- The health system can be overwhelmed with the increase in cases and limited surge capacity for intensive care of patients with Acute Respiratory Distress Syndrome.
- Ethiopia has limited testing capacity and needs additional support for surveillance including and contact tracing. of COVID-19 patients.
- Direct mortalities from COVID-19 and indirect mortalities due to reduced availability of essential health services will continue to rise.
- GOE's COVID-19 guidelines and protocols will be followed by project staff and health workers in the regions and woredas prioritized for the OFDA-funded activities.
- Government political commitment will continue to deliver and sustain the OFDA activities.
- OFDA funding will be prioritized to underserved populations and areas of the country.
- Willingness of individuals to receive COVID-19 information and change behaviors.
- Non-health sectors will proactively respond to growing needs to improve negative social norms associated with intimate partner and non-partner sexual violence and gender-based violence.
- Contact tracing and surveillance activities remain priority agendas for the supported regions.
- The COVID-19 mitigation support from partners, regional health bureaus, and other sectors will continue.
- RHB mitigation actions will continue to include response to essential health service's needs,
- Support to community-level interventions will also continue in line with social/physical distancing and no contact guidelines by the Ministry of Health

In summary, for the successful implementation of the Activity, we are making critical assumptions that contact tracing and surveillance activities remain priority agendas for the supported regions; additional COVID-19 mitigation support including Personal Protection Equipment's (PPE) provided from other partners, regional health bureaus and other non-health sectors will continue; and regional health bureau mitigation actions will continue to include response to essential health service needs. Moreover, we assume that support to community level interventions will also continue in line with the national and global recommendations and guidelines for physical distancing and other precautionary measures.

Program Strategy

The OFDA activities will build on and complement the positive gains in the regions and facilities currently supported by the USAID Transform: Primary Health Care Activity. Recognizing the potential disruption in essential health services delivery, which can lead to reduction in service coverage, we will support ***adaptive*** capacity of the primary health care (PHC) to respond to emerging service delivery needs and approaches. In close collaboration with the government and other partners supporting PHC, we will address those needs prioritized by the RHBs. Moreover, through the USAID Transform: Primary Health Care Activity, we will contribute to the ongoing efforts of building the PHCU's ***transformative*** capacity by documenting lessons for innovative solutions to existing PHC problems that can be sustained over the long term.

To ensure strategic coordination among partners and across funding streams, the RHBs have identified priority hotspots for the pandemic response including the already established IDPs, and new IDPs, for the internally displaced from big cities. The USAID Transform: Primary Health Care Activity also used updates and recommendations from health and nutrition partner coordination forums to further select priority zones and woreda for the OFDA funding. In addition to the importance of the selected activities, the Activity's experience and its expertise were considered in prioritizing the activities. The OFDA activities will target COVID-19 hotspot areas; IDP sites; and quarantine and treatment centers – prioritized in conjunction with the RHBs with the triple burden of COVID-19 infection, malnutrition, and other health emergencies in Amhara, Oromia, SNNP, and Tigray Regions. Please see geographic coverage section below for additional details.

As previously mentioned, our country team of experts will deploy ***adaptive TA*** that is driven by GOE demand and in response to RHBs, ZHDs, and WorHO needs as they evolve. This approach promotes coordination and collaboration across all levels of the health system, and sustainability through building adaptive management capacity. This includes use of data for decision-making (UDDM), ongoing learning, and generation of knowledge to enhance results.

In addition to adaptive TA, achieving added gains in the COVID-19 response requires targeting barriers that prevent equitable access to quality services. Our support will enable the RHBs, ZHDs, and WorHOs to identify and ***address bottlenecks and take transformative action to close gaps in the COVID-19 response*** – strengthening systems and skills to address challenges for greatest impact. Across all activities and interactions with GOE, the USID Transform: Primary Health Care Activity promotes ***gender and protection analysis and mainstreaming*** by addressing multi-leveled power hierarchies. The Activity also ensures that policies, practices, and behaviors at all levels of service delivery management and provision, are examined to ensure equitable access. This includes prioritizing the safety and dignity of people, arranging for meaningful access to impartial assistance and services in proportion to need for women/girls, older people, and people with disabilities.

Sectors

a) **Sector Name and objective:** Health
   Objective/Goal: Resilient primary health care system with absorptive, adaptive and transformative capacity

b) **Dollar Amount:** $500,000

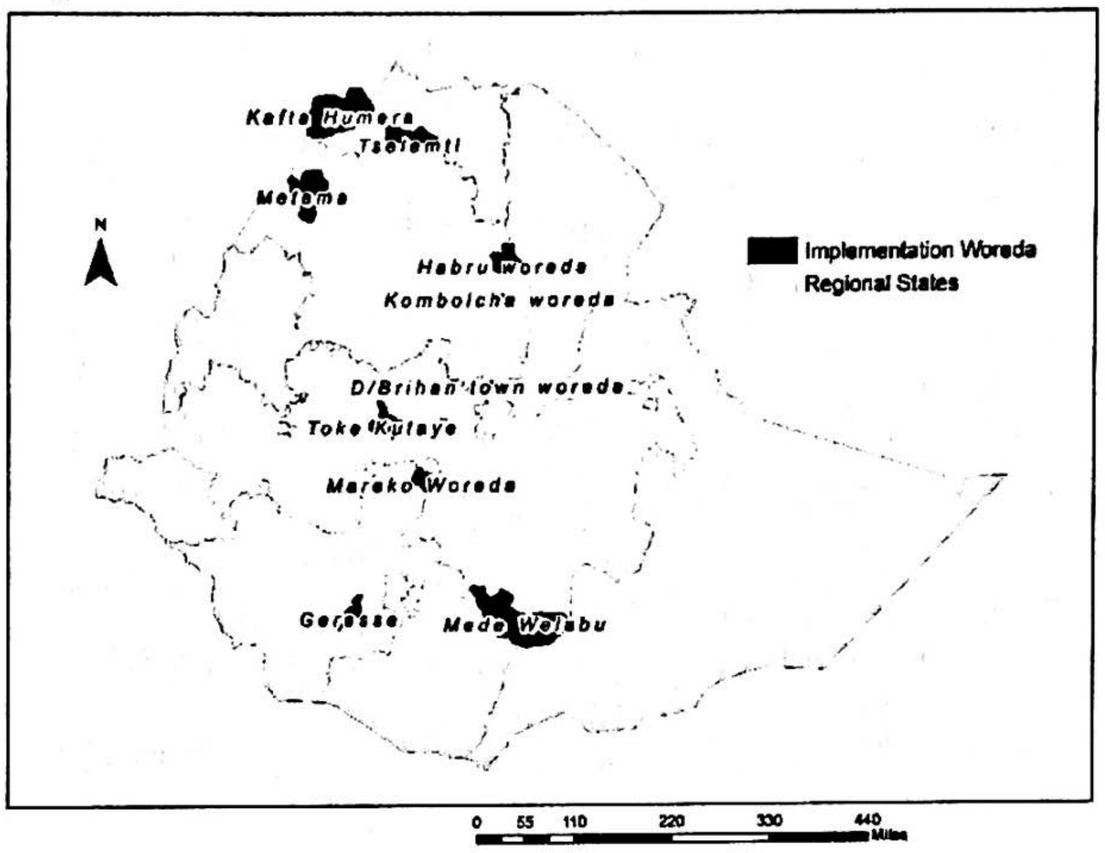
c) Beneficiary Numbers

- Number of People Targeted: 1,500,000
- Of the above total, number of IDPs Targeted: 29,540

d) Geographic Areas

The USAID Transform: Primary Health Care Activity currently supports more than half of the Woredas (400) in the four regions. Based on periodic multisectoral assessments done by disaster risk management (DRM), a significantly higher proportion of Activity woredas are regularly identified as priority districts for different risks. Given this, the Activity addresses ongoing emergencies in its day to day implementation. Due to its ground-level presence, the Activity has supported most of the health emergency responses in the regions with technical and logistics support (See Figure 1).

Figure 1: Hotspot Woredas with Treatment/Isolation/ /Quarantine Centers and Health Facilities



Except for Addis Ababa, COVID-19 data is not currently available at the woreda level. In collaboration with RGBs, we identified geographic hotspots with the highest level of potential COVID-19 risks, and that are linked to IDPs. Table 2 summarizes the regions and woredas that have active COVID-19 cases and deaths reported, as well as malnutrition hotspot areas, quarantine and treatment centers, and IDP sites. These woredas are also affected by other ongoing endemic diseases and emergencies

Table 2: Hotspot woredas selected in each region with treatment and isolation centers and health facilities under each woreda

Region	Hotspot Woreda(s)	Treatment centers	IDPs	Health facilities in the Woreda	Remark
4 regions	**10 Woredas**	**5 Treatment centers**	**29,540**	**53 HCs and 7 Hospitals**	
Amhara	Metema	Gondar University Treatment Center	N/A	Metema Yohannes HC; Shinfa HC; Kokit HC; Mesha HC; Meka HC	
	Habru Woreda	Kobo Primary Hospital Treatment Center	160	Mersa HC; Girana HC; Sirinka HC; Haro HC; Bohoro HC; Harerty HC; Wurgessa HC	Positive cases identified through screening at the afar boarder
	D/Brihan town Woreda	Tebase Health Center Treatment Center	500	D/Brehan -0 4 HC; Ayertena HC; Tebase HC	This Woreda is currently number one hot spot adjacent to AA
	Kombolcha Woreda	Kombolcha 05 HC & Kombolcha Agricultura College - Isolation Centers	264	Kombolcha 01 HC; Kombolcha 02 HC; Kombolcha 03 HC; Kombolcha 04 HC; Kombolcha 05 HC	On June 15th, one positive case for COVID was found from 150 tests

Region	Hotspot Woreda(s)	Treatment centers	IDPs	Health facilities in the Woreda	Remark
4 regions	**10 Woredas**	**5 Treatment centers**	**29,540**	**53 HCs and 7 Hospitals**	
		Boru Meda Hospital Treatment Center			
Tigray	Kafta Humera	Humera Town High School Treatment Center	696	Adi Goshu HC, Adi Hrdi HC, Mi-Kadra HC, Turkana HC, Rawian HC, Adebay HC, Baeker HC, Mi-Weini HC, Bereket HC	Satellite health posts under each HC will also be included in the support. On average, one health center has five health posts
	Tselemti	Mai-Tesbri Hospital – Isolation Center	623	Mi-Tsebri PHL, Chechere HC, Dimma HC, Fyel Wuha HC, Emba madre HC, Sekota HC, Tseda Kerni HC	
Oromia	Mede Welabu	Mede Welabu Hospital and Welabu High School - Isolation centers	10,541	Bidire HC; Gobelle HC; Meda HC; Oborso HC; Wadhuma HC; Ware HC; Mede Welabu HO	
	Toke Kutaye	Guder Hospital Treatment Center	NA	Gorosole HC; Guder HC; Maruf HC; Toke HC; Guder Hospital	
SNNP	Mareko Woreda	Koshe Primary School Treatment Center	16,000	Koshe HC; Mekakelegna Jare Dembaka HC; Udasa Washeweira HC	
	Geresse	Geresse School Isolation Center	756	Geresse HC; Dimale HC; Dembile HC; Shalekay HC; Bulla HC	

e) Sector-Level Coordination

The USAID Transform: Primary Health Care Activity is well represented on national and regional COVID-19 response EOCs and other relevant Technical Working Groups (TWGs) (e.g. COVID-19 emergency response committees, RCCE TWG, etc.). Various Activity staff represent the Activity in these fora. The TWGs meet weekly and/or daily if needed. The COP also participates in monthly USAID partner coordination meetings. Through these mechanisms, the COP and other Activity staff will help ensure a well-aligned and coordinated COVID-19 response across sectors as well as optimize leveraging opportunities from other ongoing projects.

f) Keywords

- WASH in Health Facilities

g) Technical Design

Technical Approaches

To date a total 228 health centers and 31 primary hospitals in Oromia, Amhara, Tigray & SNNP Regions have been supported by the USAID Transform: Primary Health Care Activity to provide COVID-19 related health services. Based on preliminary findings from this ongoing work, our project team will implement our four technical approaches to address gaps in the RHB response plans. All four approaches fall under the Public Health Emergencies of International Concern and Pandemics sub-sector.

Due to a lack of financial resources approximately 48% of the staff at the currently supported COVID-19 sites are not using the right PPE as per national and WHO guidelines. In addition,

approximately 44% do not have guiding documents or protocols on optimizing essential health services.[15] Current gaps in regional plans include: adapting, printing, and distributing the national guidelines and protocols on IPC and essential health services continuity; orienting staff on the new national guidelines on essential health services during the COVID-19 pandemic; ensuring the provision of essential services for IDPs in a safe, periodic integrated service delivery outlet; and ensuring availability of basic IPC materials in the health facilities, in isolation and quarantine sites. To address some of these gaps our first approach will **improve health facilities' readiness to provide essential services** with optimum infection prevention and control (IPC) measures through training and procurement of basic waste disposal materials.

Supporting Health Extension Workers (HEWs) and community level structures on case identification and contact tracing; printing and distributing IPC materials, guides, algorithms, guidelines, job-aids; dissemination of key messages through mass media, vans, and audio-mounted vehicles; TA and monitoring of risk communication and community engagement (RCCE) activities, panel discussions, etc. are further gaps in regional plans. **Strengthening RCCE** is the second technical approach our team will deploy to address these gaps. This requires context-specific interventions at lower levels of the health system and the community and in the IDP setups. It also entails maintaining health-seeking behaviors for health workers providing essential services.

Using the COVID-19 monitoring checklist, the USAID Transform: Primary Health Care Activity has conducted 252 supervisory visits to health centers and primary hospitals in the four regions to date. Data from these visits indicate that approximately 30% of COVID-19 supported sites are not monitoring key performance indicators on a weekly basis as per MOH guidelines.[16] In addition, 31% of health workers don't know what to do when they find expected cases and 33% of supported sites don't have the standard reporting tool for suspected cases.[17] Our third strategy is to **improve effective surveillance** through capacity building of teams on IPC and specific contact tracing skills. The diverse groups include laboratory technicians, sample collectors, isolation center staff, contact tracers, as well as call center staff.

Approximately 35% of supported sites do not have efficient systems in place to triage suspected cases effectively.[18] In addition, 30% of supported sites have not made spacing arrangements based on physical distancing guidelines and 37% of sites have not assigned crowd managers to help facilitate effective patient flow.[19] Ambulance management and maintenance, case management training, fulfilling IPC in the treatment centers, printing different forms (admissions & discharge registration, patient follow up charts, lab request & prescriptions), cleaning materials and supplies (washing machine, heavy-duty gloves, soap, disinfectants, alcohol-based wipes and scrubs, closed waste bins, jars, brooms), and equipping in-patient wards (mattresses, bedsheets, blankets, pillows, guans, patient pajamas, boots) have all been identified as gaps by the RHBs. **Improving COVID-19 case management** is the fourth and final technical approach we will deploy. Based on the projections done at all levels, the demand for COVID-19 treatment is expected to be very high.

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[15] Findings based on the USAID Transform: Primary Health Care Activity's ongoing clinical monitoring and supervisory visits.
[16] Findings based on USAID Transform: Primary Health Care Activity's ongoing clinical monitoring and supervisory visits.
[17] Findings based on USAID Transform: Primary Health Care Activity's ongoing clinical monitoring and supervisory visits.
[18] Findings based on USAID Transform: Primary Health Care Activity's ongoing clinical monitoring and supervisory visits.
[19] Findings based on USAID Transform: Primary Health Care Activity's ongoing clinical monitoring and supervisory visits.

The regional EOCs have developed a plan to ensure treatment facilities have surge capacity, however, this is one element of the plans with the greatest resource gaps.

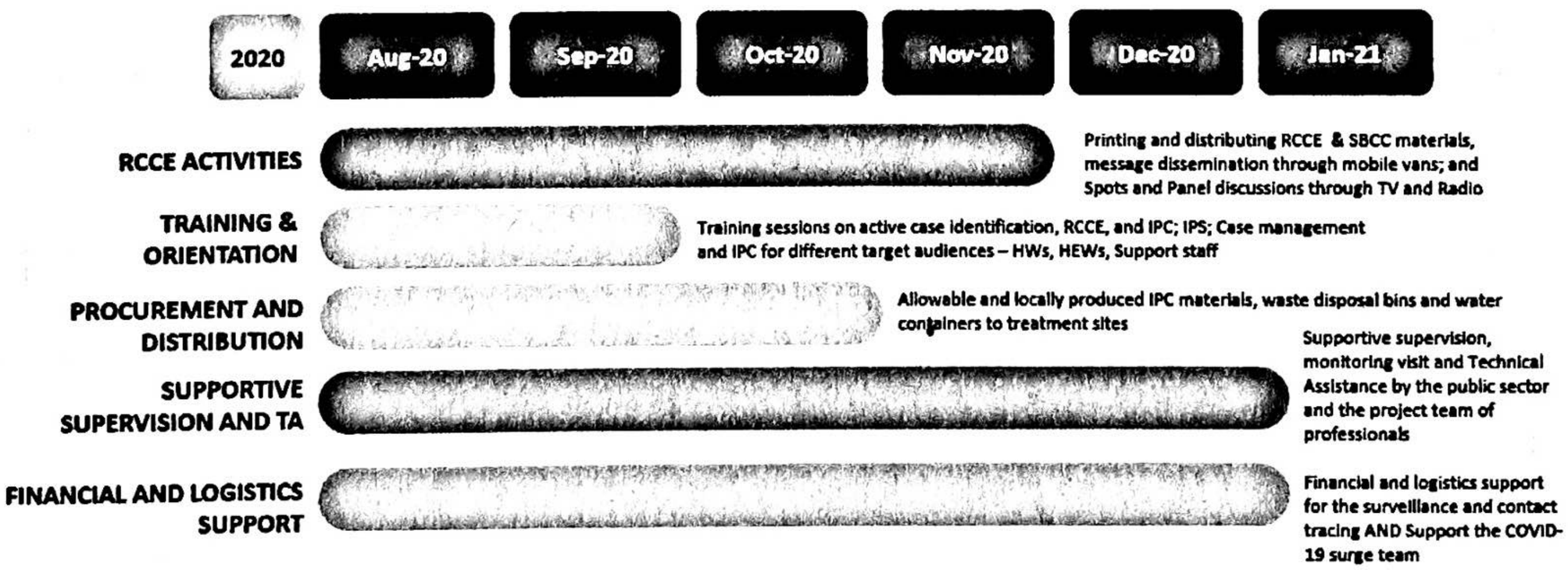
Pathfinder-led assm.

Implementation Plan

To ensure synergy with the ongoing COVID-19 activities being rolled out by the USAID Transform: Primary Health Care Activity, and other partners, the OFDA activities will be implemented through USAID Transform: Primary Health Care Activity's current management structure and by existing project staff. We will leverage and build on the lessons learned from these ongoing COVID-19 activities. This will lead to broader coverage of hotspots and IDP sites and value added through economies of scale (e.g. lower transportation costs, use of government venues for meetings and trainings).

Figure 2 summarizes our implementation timeline. The project works within, not parallel to, existing GOE systems and health structures to ensure that they are strengthened rather than duplicated. The OFDA activities will be integrated with the USAID Transform: Primary Health Care Activity's annual work planning process. Separate OFDA activity plans will be developed per region. As part of project start-up we will collaborate with the RGBS to rapidly map and analyze existing partner support in the target areas This process will strengthen RHB staff capacity for critical thinking and data use and analysis, resulting in a map showing regional strengths and bottlenecks to COVID-19, including those that hinder gender and protection mainstreaming. This will ensure close collaboration with RHBs, Regional Emergency Response Centers (RERCs), USAID, other projects, and other stakeholders through a clear and concise OFDA activity plan that is based on the RHB led assessment of COVID-19 needs in each region.

Figure 2: Illustrative Implementation timeline



Since the situation is unprecedented and the capacity at the regional level is in its initial stages, the frequency, dose, and intensity of support activities will be context-specific in each of the regions and facilities. The emerging critical needs, direction and guidance from the government, and new global and national developments will be critically monitored and complied to satisfy the needs of the health facilities and respond to donor requirements and expectations.

The different assumptions made, and scenarios planned for USAID Transform: Primary Health Care Activity's ongoing COVID-19 interventions will be applied to the OFDA activities. Adaptive, innovative, and flexible technical and management support will be prioritized to ensure that the health facilities and health professionals at the forefront of the COVID-19 response in

hotspot Woredas receive timely inputs and guidance. While utilizing existing COVID-19 response and coordination platforms, we will still utilize the project's adaptation and response framework throughout the implementation stages.

Gender Analysis

The general characteristics of the relationships among men, women, girls, and boys along with roles and responsibilities of each of these gender groups in the targeted area. **In the proposed project intervention area, several gender disparities exist between women, men, boys, and girls about roles and responsibilities and associated time use both within and outside of the home. In the proposed intervention region, a woman spends, on average, between 6 and 13 hours a day on household duties such as food preparation.[20] Between household duties and childcare, the significant amount of responsibilities attributed to women make it increasingly difficult for them to access health centers and their associated services, attend informative meetings, or take up formal work.[21] Women and girls are also at a greater disadvantage in ownership and use of resources, including less access to smart phones, radio, television, and other technologies.[22]**

Household duties are also prioritized for young girls and results in significant detrimental impact on their educational attainment. A study showed that the rate of female enrollment in secondary education is low because girls are expected to prioritize household duties, resulting in poor academic performance and/or withdrawal from schools.[23] Overall, the percentage of female enrollment is considerably lower than that of males, significantly impacting their opportunities in the formal workforce.[24]

Significant imbalances exist in overall power dynamics between women and men in Ethiopia, contributing to gender-based violence (GBV). The types of GBV prevalent in the project intervention areas include sexual coercion and abuse, rape, intimate partner violence, and harmful practices such as child, early, and forced marriage (CEFM), and female genital cutting. Recent studies show that 68 percent of women and 45 percent of men agree wife beating is acceptable[25] and 35 percent of married women have reported that they have experienced some sort of violence (physical, emotional, or sexual) from an intimate partner.[26]

In the past few decades, Ethiopia has made significant policy strides for gender equality. Several Ethiopian laws, policies, regulations, and institutional practices have contributed to addressing gender inequalities within the healthcare system by creating new policies where none previously existed or revising policies that were historically inequitable or harmful. Key among them are the National Policy on Ethiopian Women, the National Action Plan for Gender Equality, National Strategy and Action Plan on Harmful Traditional Practices

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[20] PRIN International Consultancy & Research Services PLC. 2013. *Gender Analysis and Gender Audit Report.* Save the Children International, USAID/ENGINE Project: Addis Ababa, Ethiopia.
[21] EnCompass LLC for the Transform: Primary Health Care project funded by the United States Agency for International Development. 2018. *Transform: Primary Health Care Project Gender Analysis.*
[22] ibid
[23] Abelson, A. and J. Banerjee. 2017. Empowering Female Health Science Students in Ethiopia: A Case Study. Jhpiego: Baltimore, MD, USA.
[24] USAID. 2016. USAID Gender Analysis [Ethiopia]. PowerPoint presentation.
[25] ibid
[26] Central Statistical Agency (CSA) [Ethiopia] and ICF. 2016. Ethiopia Demographic and Health Survey 2016: Key Indicators Report. CSA and ICF: Addis Ababa, Ethiopia, and Rockville, MD, USA.

against Women and Children in Ethiopia, and laws criminalizing rape, CEFM, and spousal violence. However, despite this progress gaps remain. Women and girls remain disadvantaged compared to men and boys in areas such as literacy, health, livelihoods, and basic human rights.

How the proposed disaster assistance or DRR activities may affect or be affected by the different roles and statuses of men, women, girls, and boys within the community, political sphere, workplace, and household. **In the proposed intervention areas socially constructed values, attitudes, and beliefs regarding gender can adversely affect health outcomes of women, men, boys, and girls, including participation in the health activities outlined in this proposal and access to essential health services and accurate COVID-19 information. Early reports indicate that although globally women and men have similar prevalence for COVID-19, men are at a higher risk for adverse outcomes and women and girls are at greater risk for secondary impacts.[27,28] Moreover, recent reports are showing increase in sexual and GBV and forced early marriage because schools are closed amidst COVID-19.**

Motivated to comply with social norms of masculinity, many men and boys in Ethiopia are more likely to engage in risk-taking behaviors, such as excessive consumption of tobacco, alcohol, and drug use. These risk-taking behaviors place them at risk of direct morbidity and mortality as well as patterns of negative secondary health impacts[29], including increased risk of adverse COVID-19 case outcomes. Gender and social barriers regarding agency to seek and participate in essential health services and RCCE activities disproportionately impact women, girls, and unmarried youth. The USAID Transform Primary Health Care Gender Analysis found that financially dependent women are not the primary decision makers about healthcare for themselves or their family. Also, a recent study showed that although husbands agreed that their wives should attend community health events and access services that HEWs offer within their communities, they also simultaneously agreed that a woman's domestic duties remain her priority.[30] Additionally, the USAID Transform Primary Health Care gender analysis showed unmarried adolescents and youth perceived that family planning and reproductive health services did not address their needs and they received a lower quality of care due to stigma of being unmarried.

Women healthcare workers, including HEWs, also face increased risks of GBV, including workplace violence exposures such as travel risks due to disruptions in normal travel protections (e.g. options of travel times, decreases in numbers of other travelers due to COVID-19) and violence from patients and their families exacerbated by acute stress. Additionally, PPE sizing most often defaults to the size of the average man, often resulting in female health workers not receiving equipment that best protects them.

Mobility restrictions and lack of transportation is another factor that prevents many women and men from accessing healthcare facilities, which are often located far from residences, as

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[27] Global Health 50/50 COVID-19 Data Compiler- https://globalhealth5050.org/covid19/
[28] COVID-19: The Gendered Impacts of the Outbreak
[29] Policy and Planning Directorate (PPD). April 2014. *Quarterly Health Bulletin Policy and Practice Information for Action.* Federal Democratic Republic of Ethiopia, Ministry of Health: Addis Ababa.
[30] PRIN International Consultancy & Research Services PLC. 2013. *Gender Analysis and Gender Audit Report.* Save the Children International, USAID/ENGINE Project: Addis Ababa, Ethiopia.

well as participate in RCCE.[31] This lack of transportation also affects the ability of HEWs (who are primarily female) to reach the communities they serve, often leaving community members with inadequate access to health services and information—a contributing factor to the high morbidity rate among child-bearing women[32]—as well as a barrier to conducting critical COVID-19 prevention and response activities, such as contact tracing, active case identification, and dissemination social behavior change messages to communities.

Additionally, under the best circumstances Ethiopian women are 'information poor'. COVID-19 has exacerbated access to information as many channels of information sharing, such as schools and marketplaces are out of reach due to COVID-19 related mobility fears and restrictions. Also, the average literacy rate for women in Ethiopia is 42%.[33] As a result, RCCE and SBC dissemination efforts will need to pay attention to gendered levels of literacy to ensure all beneficiaries are reached with accurate messaging.

How the anticipated results of the activities may affect men, women, girls, and boys differently and how they could help to reduce existing inequalities and avoid creating new inequalities. **The project will leverage the legacy of work of USAID Transform Primary Health Care support to gender mainstreaming in the Ethiopian health sector to ensure that a gender lens is applied to all aspects of interventions, including support to the RHBs, ZHDs, and WorHOs. Efforts around training and support to COVID-19 surveillance and case management approaches will be carefully reviewed to ensure they consider the differential gendered risks of COVID-19 to men and women. Other key gender integration activities include:**

- **Ensure GBV is integrated into all essential health service areas and services are updated and active.**
- **Support RHB to systematically integrate gender issues into health systems, service delivery, and demand creation at all levels of primary health care**
- **Support RHB efforts to strengthening multi sectoral collaboration, community participation and male engagement in the prevention of GBV, including child early and forced marriage in the COVID-19 context**
- **Support RHBs to ensure safe working conditions for all health workers, but especially for lower level frontline workers, such as HEWs, including equitable distribution of necessary and properly fitting personal protective equipment (PPE).**
- **Adapt existing SBCC messaging and materials to raise awareness of increases in GBV exacerbated by COVID-19, such as intimate partner violence and CEFM, along with accessibility of relevant services and support.**
- **Support health sector to incorporate a gender lens into their COVID-19 prevention and response, as well as ongoing essential health services, such as family planning and maternal health.**
- **Advocate for identification of safe housing options near health facilities to reduce travel risks for female health workers.**
- **Support health sector planning to identify additional equipment needs during the COVID-19 crisis to support female health workers, such as mobile phones and/or data**

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[31] Jackson, R. and D. Kilsby. 2015. "*We are dying while giving life:" Gender and the Role of Health Extension Workers in Rural Ethiopia*. Improving the use of maternal, neonatal and child health services in rural and pastoralist Ethiopia, Australian Aid.
[32] Ibid
[33] USAID, STAT Compiler – The DHS Program (Accessed June 29, 2020). https://www.statcompiler.com/en/

cards, transportation stipends, menstrual hygiene supplies, as well as PPE in sizes that accommodate female workers.

- **Consult with female health workers from all cadres regarding their needs, priorities, and ideas and clearly communicate with them on decisions and updates.**
- **COVID-19 RCCE will be disseminated through multiple channels in order to ensure we reach women and girls and developed to be understood by lower literacy individuals.**

*How the activities can be undertaken in order to create an environment conducive to improving gender equality and equitable access to basic rights, services, and resources***The project will leverage and/or adapt USAID Transform Primary Health Care project activities, tools, learnings, and project gender strategy to ensure gender integration and that, at minimum, a gender responsive approach is utilized along with gender transformative SBCC messaging on key topics, such as women's agency in accessing health services. The focus will be to promote women's agency to seek and access essential family planning, reproductive health, and COVID-19 health information and services. Women play a key role in managing their families' health. Numerous studies support the idea that when women have access to information and resources, they make decisions that support better outcomes for the whole family – in terms of health, resource management and livelihoods.[34]**

Protection Mainstreaming Activities

Describe how you will ensure that health facilities, including both the infrastructure and location, are safely accessible for vulnerable groups, including women, adolescents, children, older people, and persons with disabilities. **As part of our Risk Communication and Community Engagement response, we will address those vulnerable groups with the appropriate time, frequency and channel so that they can access services in the health facilities. With the panel discussions through the mainstream medias, translations with sign languages will be used to address part of the groups with hearing impairments and try to reach young people through peer educators and volunteers with the social media – with the existing Telegram Groups of peer educators, young people, healthcare providers and Transform's staff members. Moreover, by supporting continuity of essential services we will reach women, children, youth, older people and persons with disabilities through both the essential services and integrated preventive measures for COVID-19**

Describe how health care workers are or will be trained in knowledge and skills relevant to working with populations with unique needs, e.g. women, adolescents, children, persons with disabilities, and older people. **Most of the healthcare providers in the proposed health facilities to be supported with this funding are trained on service friendliness including youth friendly services; compassionate, respectful, and caring service provision (this is one of the Health Sector Transformation Plan (HSTP) core agendas; and women friendly service provision – respectful maternity care which helps healthcare providers understand unique needs of these groups and respond their needs a respectful and compassionate manner. The USAID**

[34] FINLAY, J.E. and LEE, M.A. (2018), Identifying Causal Effects of Reproductive Health Improvements on Women's Economic Empowerment Through the Population Poverty Research Initiative. The Milbank Quarterly, 96: 300-322. doi:10.1111/1468-0009.12326

Transform: Primary Health Care Activity is supporting this endeavor for the last three and half years.

Describe how you will ensure that staff representative of relevant gender and ethnic differences are available to provide services. Describe how health care will be made accessible to persons with disabilities and/or limited mobility, including outreach activities that target these groups. **In the four regions we propose to use this funding, health workers provide health services in the local languages of the regions and even the specific location where the health facility operates so that providers understand and respond to the clients' needs. In terms of gender representation, most of the health workers in health centers and hospitals and all the community level health workers - Health Extension Workers – are females and there is a very good gender representation and balance among healthcare providers. Moreover, while arranging training for health professionals at health centers and hospitals level, we always request the public sector to consider under balance during selection of trainees.**

Describe how you have consulted with people of diverse age, gender, ethnic, religious, and socio-economic groups, including displaced and host communities, and/or ensured their representation on any program committees so that their concerns are heard and addressed to avoid community tensions. **Since we work within the government structure and strengthen their capacity to address varying needs of the different population segments, we assess these issues through our community level activities. These include the Community Mobilization and Health Post Open Hour events where we hear feedback from the community members, and our frequent follow-up and monitoring visits to the community structures and households every quarter. We have also an intervention to pause and reflect on the satisfaction of community members from different groups on the service provision and provide feedback in a townhall meeting.**

Describe the measures for beneficiary selection or distributions you will put in place to prevent sexual exploitation and abuse of people seeking access to health facilities and services. **All woredas are recipients of the USAID Transform: Primary Health Care Activity subgrant support and have received proper orientation, agreed with the terms and conditions, and signed the subgrant agreement which includes measures linked with trafficking in persons and prohibition on the promotion and advocacy of the legalization of practice of prostitution or sex trafficking provision and certification. Based on recent increase in reports of gender-based and domestic violence during the COVID-19 pandemic, we have already made gender issues in the era of COVID-19 one of our top priorities to address. This will be accomplished through various interventions including the media, panel discussions, and working with local administrations and lower level leaders to prevent sexual exploitation and abuse. In addition, we will advocate for stronger legal measures to be taken by law enforcement agencies when incidences of GBV have been uncovered.**

Describe the mechanism being used to establish a safe and effective feedback/complaint system for beneficiaries and non-beneficiaries. **As a CSO, we are not allowed to directly meet with the community and collect feedback on the services provided by the government. But, as mentioned above, we have systematically created a client-provider interface through town hall meetings. In addition, the cluster level team has a separate and structured questionnaire for household and community level follow-up visits which we use to identify areas to intervene and collect feedback from the community and households. Building on these existing feedback mechanisms, we will ensure that safe and effective feedback mechanism is established.**

Describe how you will monitor protection issues and how you will use that information to reduce existing and newly identified risks. **Through our cluster offices based at the zonal levels, we will regularly assess risks integrating with routine and COVID-19 specific activities, monitor any of the required expectations including the protection issues, and discuss with the health system leaders and other stakeholders at all levels to reduce existing and newly identified risks. As soon as risks are identified at any level, Pathfinder will take immediate corrective measures and bring the issue to the table in any of the technical working groups and emergency response teams we are involved for timely action.**

Describe how you will tailor the program to men's and women's roles in decision-making and access to resources. Describe how key program stakeholders will be made aware of the advantages of health programming. **Since the proposed activities with this funding are directed to enhance capacity at health facilities and increase health literacy at the community levels, we will ensure gender equity in any of the proposed activities and program stakeholders will be made aware of this support through the different partnership coordination platforms, technical working groups, and regular emergency response updates including the weekly COVID-19 response bulletin and reports.**

Public Health Emergency of International Concern (PHEIC)

Technical Description

Infection Prevention and Control

To support essential services delivery in the COVID-19 context we will improve health facility readiness to provide essential services with infection prevention and control (IPC) measures. We will train health care providers and facility support staff on IPC and provide health facilities with IPC supplies including waste disposal materials and water containers. We will ensure national COVID-19 guidelines are followed during training activities (e.g. physical distancing, face coverings, limiting trainees per session to ten or less) and comply with the State of Emergency (SOE) restrictions on movement and mass gatherings during training activities. This includes limiting the number of trainees per session to ten or less, offering concurrent training sessions for ten or less trainees based on need, etc. We use the national IPC training curriculum, based on national IPC guidelines and protocols. Approvals for the training and selection of trainees will be done in consultation with the Ministry of Health at all levels, State of Emergency Command Posts and facility health management teams. We assume COVID-19 protocols will be maintained during training sessions and the relevant bodies that provide approvals for training will do so in in a timely manner. **As part of the technical assistance (TA) visits and monitoring follow-ups to the treatment and isolation centers, the cluster office level team will ensure that PPE and other important/required materials and commodities are made available to clinical staff by the government, and that providers are consistently using them. This is also in line with the USAID Transform: Primary Health Care Project's requirement to ensure both staff safety and that all healthcare providers comply with environmental compliance requirements.**

Logistics support for IPC supplies will in done in accordance with the national procurement guidelines and Pathfinder's organizational procurement procedures. Items we procure will be checked against required standards and quality measures. We assume stakeholders in the national supply chain management system will view the procurement as urgent and that the items are available in Ethiopia.

In addition, we will conduct joint supportive supervision visits with MOH managers to build their capacity on integrated supportive supervision including the application of actions to address any quality issues in essential service delivery identified during visits. Clinical staff from the USAID Transform: Primary Health Care Activity will also conduct supervisory visits to ensure managers and health workers continue to provide essential services based on IPC guidelines. This will entail close coordination with relevant government stakeholders to schedule supervisory visits, transport to the sites, use of standardized monitoring/supervisory checklist for essential services, and ongoing feedback and support to sites. To minimize the spread of COVID-19 we assume supervisory teams will be limited to two people per team, supervisors and supervisees will wear medical masks and gloves during supervisory visits, and supervisory visits will be shorter in duration to minimize exposure. **It is the FMOH's role to provide PPE during supervisory visits and the Activity will be only procuring commodities listed in the budget narrative. No BHA funds will be used to procure pharmaceuticals and/or medical commodities.**

Clinical Case Management

In the four regions we will also train health workers on case management and IPC per the national COVID-19 guidelines in 10 hotspot woredas. We will also cover the per diem for health workers providing surge capacity to COVID-19 in 20 treatment centers and isolation centers with high need. **The government has assigned trained healthcare providers to the treatment centers and is providing the necessary commodities and materials to support them. Because of budget deficit, the government is challenged to continue paying per diem. As a result, Pathfinder will be building on the government's role by ensuring that trained healthcare providers are able to remain at the treatment and isolation centers. In addition, Pathfinder will be providing case management training in order to have additional trained healthcare providers.** We will also supply health centers and satellite health posts with IPC materials and supplies. The training activity will follow the same COVID-19 protocols and training steps as outlined above for the IPC and training. We will support effective planning by the public sector for surge capacity, including timely submission of requests to regional or cluster officers. We will follow the GOE's professional compensation pay scales based on the level of effort and profession of the health worker. We will follow similar procurement steps, described above, for procuring IPC materials for COVID-19 treatment centers and isolation centers under this activity. **Pathfinder will direct all support to targeted health facilities and communities. The Quarantine and Isolation centers were noted in the table only to indicate their existence.**

We assume government policies and procedures will be adhered too. We also assume needs will differ from site to site and stakeholders will continuously assess and reprioritize needs. **Pathfinder will distribute items to the end users; provide a separate follow-up of the availability and proper use of PPE by health care providers; and conduct joint supportive supervision with the government supervisory team, who are responsible for providing the PPE to the health facilities. Pathfinder will not be procuring or distributing any PPE – this is being done by the GOE.** As part of the technical assistance (TA) visits and monitoring follow-ups to the treatment and isolation centers, the cluster office level team will ensure that PPE and other important/required materials and commodities are made available to clinical staff by the government, and that providers are consistently using them. This is also in line with the TRANSFORM Project's requirement to ensure both staff safety and that all healthcare providers comply with environmental compliance requirements.

Risk Communication and Community Engagement

To support the regions' response to COVID-19 at all levels of the PHCU, we will strengthen RCCE by adapting/developing and disseminating RCEE materials including 10 different types of COVID-19 and/or essential health services guidelines, protocols, and SBC materials. In addition, we will support RCCE through mass media and social media channels including TV transmission, radio spots, live panel discussions, mobile vans, and SMS messaging. An average of twenty-minute TV and radio messages will be transmitted for 7 days a month over a 3-month period.

The SBC Advisor from the USAID Transform: Primary Health Care Activity will lead a working group, including the National Emergency Focal Person and Regional Community Engagement Officers, in a process to collect up to date guidelines, manuals, protocols, SOPs, and SBC materials and adapt and produce relevant RCEE materials in local languages. Dissemination of RCCE materials will be integrated into the project's ongoing SBC activities at the Woreda and community levels. Additional we will train HEWs on COVID-19 prevention protocols and SBC messages for the community. We will also update other community volunteers on relevant protocols and SBC messages as needed based on previous orientations they received from other partners.

Through our Adolescent and Youth Health and Development team we have created telegram groups involving peer educators and healthcare providers from the youth friendly services and the project staff at the central, regional and clusters level. The primary purpose of this group is to facilitate accurate and timely COVID-19 information sharing with community members across the four regions.

To conduct RCCE activities using audio-mounted mobile vans in targeted public places, we will assign and orient project drivers and COVID-19 response drivers in each region based on a mass media guide. These drivers already have experience delivering SBC messages. Flash disks loaded with pre-recorded messages about COVID-19 and essential health services will be provided to each driver. The drivers will target pocket areas, busy roads, marketplaces for airing the pre-recorded messages based on scheduled days. The drivers will also be provided with a reporting template for estimating the number of people reached by their activities. They will submit their reports to the community engagement officers on a weekly basis who in turn will submit consolidated reports to the project's central project office. A local health worker will also be available as needed to accompany the driver and address any community questions that arise from community members who approach the mobile van. We assume this activity will reach individuals with limited or no access to social or print media.

The project will use existing TV and radio spots developed by the project. We will target hotspot areas for broadcasting the spots. We will also use a panel of live experts to engage the audience in discussions on important issues such as health worker safety, continuity of essential services, GBV, and IDPs. Listeners and viewers can call-in to pose questions to panel members. We will do this through close coordination with ongoing government and non-government SBC structures and platforms to prioritize critical information gaps. We assume existing RCCE materials can be easily adapted and that we can leverage existing structures/platforms for RCCE dissemination.

Disease Surveillance

In prioritized hotspot Woredas and towns in Amhara and Tigray regions we will train health workers and HEWs in contact tracing, active case identification, RCCE, and IPC. We will also

provide financial and logistic support for the surveillance and contact tracing related activities of the trained surveillance team members. Like the trainings described above, we will ensure national COVID-19 and SOE protocols for training activities are followed during training sessions. To conduct the sessions, we will use the national contact tracing curriculum, based on national contact tracing guidelines and protocols.

Approvals for the training and selection of trainees will be done in consultation with the relevant government bodies. Following the training we will provide logistics support and cover per diems, for the surveillance teams to conduct their activities. This will be facilitated through requests submitted to the regional or cluster officer. We will follow the GOE's professional compensation pay scales based on the level of effort and profession of the health worker. We assume COVID-19 protocols will be maintained during training sessions and the relevant bodies overseeing trainings will provide approvals in a timely manner. We also assume that contact tracing and surveillance activities will remain a top priority for the regions in the coming months.

Illustrative Indicators

OFDA indicators
Indicator #1: Number of outpatient health facilities supported
- Measurable Target: 93

Indicator #2: Number of inpatient health facilities supported
- Measurable Target: 7

Indicator #3: Number of people reached through risk communication activities
- Measurable Target: 1,500,000

Indicator #4: Number of health care staff trained
- Measurable Target: 680

Custom indicators
Indicator #1: Number of supportive supervision and TA visits by project staff in collaboration with public staff to ensure HFs adapt and continue essential services
- Measurable Target: 60

Indicator #2: Number of health facilities supported with waste disposal materials and/or water containers
- Measurable Target: 100

Indicator #3: Number of RCCE materials Adapted, produced and disseminated
- Measurable Target: 4

C. Transition or Exit Strategy

Government ownership and sustainability are core guiding principles of the USAID Transform: Primary Health Care Activity. Across all result areas, including the OFDA activities, capacity enhancement activities will result in the RHBs and ZHDs increased ability to provide TA to the WorHOs. This in turn will lead to decreased reliance on project support. The project will build sustainability milestones into the OFDA regional activity plans to monitor the capacity building interventions and ensure that capacity at WorHO and health facility levels is increasing as a result of the project's TA. Key approaches to ensuring sustainability will include:

- Setting clear targets and milestones to ensure effective and sustainable knowledge and skills transfer for WorHO and health facility staff.

- Strengthening capacity at PHCU level for generation and allocation of local resources for under-funded COVID-19 response activities.

Led by the RHBs and EOCs in conjunction with the USAID Transform: Primary Health Care Activity Management Team we help facilitate a hand over process during start-up of the OFDA funded activities. All OFDA funded activities will have either a transition strategy or sunset plan associated with them. Wherever possible, we will ensure transition strategies are linked to governmental operational planning and budgeting cycles as well as donor funding processes. With key milestones and a clear timeline, the handover plan will ensure that essential technical elements are transitioned into existing government and community structures and operational plans or other implementing partners program platforms before the OFDA funding comes to an end. We will also ensure that the knowledge generated from the project and lessons learned are documented and shared with relevant stakeholders.

D. Supporting Documentation (included as Annexes)

Annex 1: Proposal Budget

Annex 2: Budget Narrative

Annex 3: Signed SF-424

Annex 4: SF-424A

Annex 5: SF-424B

Annex 6: Signed Certifications and Assurances

Annex 7: Branding Strategy and Marking Plan

Annex 8: Safety and Security Plan

Annex 9: Code of Conduct and Protection from Sexual Exploitation and Abuse

Annex 10: Code of Conduct and PSEA Implementation Details

Annex 11: Accountability to Affected Populations Framework

Annex 12: Monitoring and Evaluation Plan

Annex 13: Monitoring Table

Annex 14: Structure and Past Performance References Documentation

Annex 15: Logistics Requirements