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ANNEX 1

of the Commission Implementing Decision on the financing of the individual measures in favour of the Federal Democratic Republic of Ethiopia for 2022 (part 1)

Action Document for Contributing Actions to Restore Essential Health Services (CARE4Health)

ANNUAL MEASURE
This document constitutes the annual work programme in the sense of Article 110(2) of the Financial Regulation, and measure in the sense of Article 23 of NDICI-Global Europe Regulation.

1 SYNOPSIS

1.1 Action Summary Table

1. Title **CRIS/OPSYS business reference** **Basic Act**	Contributing Actions to Restore Essential Health Services (CARE4Health) CRIS number: NDICI AFRICA/2021/043-896 OPSYS ref.: ACT-60684 Financed under the Neighbourhood, Development and International Cooperation Instrument (NDICI-Global Europe)
2. Team Europe Initiative	No
3. Zone benefiting from the action	The action shall be carried out in Ethiopia
4. Programming document	Not applicable. Individual Measures outside the scope of programming documents (NDICI-Global Europe Regulation, Article 23.3)
5. Link with relevant MIP(s) objectives / expected results	Not applicable. Individual Measures outside the scope of programming documents (NDICI-Global Europe Regulation, Article 23.3)
PRIORITY AREAS AND SECTOR INFORMATION	
6. Priority Area(s), sectors	Not applicable. Individual Measures outside the scope of programming documents (NDICI-Global Europe Regulation, Article 23.3).
7. Sustainable Development Goals (SDGs)	Main SDG: 3 – Good Health and Well-being Target 3.1: reduce maternal mortality ratio Target 3.2: end preventable deaths of newborn and children under five years of age Target 3.4: ensure a reduction of mortality from non-communicable diseases and promote mental health Target 3.7: ensure universal access to sexual reproductive health care services, including for family planning services Target 8: achieve universal health coverage, including financial risk protection and access to quality essential health care services

	Other significant SDG: 5 – Gender Equality; SDG: 10 Inequalities			
8 a) DAC code(s)	Basic healthcare – 12220 Basic health infrastructure – 12230 Health education – 12261 Health personnel development – 12281 Promotion of mental health and well-being – 12340 Reproductive health care – 13020 Family planning – 13030			
8 b) Main Delivery Channel	NGOs and civil society – 20000 –Third Country Government (Delegated co-operation) – 13000 United Nations Agencies - 41000			
9. Targets	☐ Migration ☐ Climate ☒ Social inclusion and Human Development ☒ Gender ☐ Biodiversity ☐ Education ☐ Human Rights, Democracy and Governance			
10. Markers **(from DAC form)**	**General policy objective** @	**Not targeted**	**Significant objective**	**Principal objective**
	Participation development/good governance	☒	☐	☐
	Aid to environment @	☒	☐	☐
	Gender equality and women's and girl's empowerment	☐	☒	☐
	Trade development	☒	☐	☐
	Reproductive, maternal, new-born and child health	☐	☐	☒
	Disaster Risk Reduction @	☒	☐	☐
	Inclusion of persons with Disabilities @	☐	☒	☐
	Nutrition @	☒	☐	☐
	RIO Convention markers	**Not targeted**	**Significant objective**	**Principal objective**
	Biological diversity @	☒	☐	☐
	Combat desertification @	☒	☐	☐
	Climate change mitigation @	☒	☐	☐
	Climate change adaptation @	☒	☐	☐
11. Internal markers and Tags:	**Policy objectives**	**Not targeted**	**Significant objective**	**Principal objective**
	Digitalisation @	☒	☐	☐

	digital connectivity digital governance digital entrepreneurship digital skills/literacy digital services	YES ☐ ☐ ☐ ☐ ☐	NO ☐ ☐ ☐ ☐ ☐	
	Connectivity @	☒	☐	☐
	digital connectivity energy transport health education and research	YES ☐ ☐ ☐ ☐	NO ☐ ☐ ☐ ☐	
	Migration @ (methodology for tagging under development)	☒	☐	☐
	Reduction of Inequalities @ (methodology for marker and tagging under development)	☐	☒	☐
	Covid-19	☒	☐	☐
BUDGET INFORMATION				
12. Amounts concerned	Budget line(s) (article, item): BGUE-B2022-14 02 01 21-C1-INTPA Total estimated cost: EUR 41 000 000. Total amount of EU budget contribution: EUR 39 500 000. This action is co-financed in parallel co-financing by: - Member state organisation(s) for an amount of EUR 1 500 000.			
MANAGEMENT AND IMPLEMENTATION				
13. Type of financing	**Indirect management** with the entities to be selected in accordance with the criteria set out in sections 4.4.1 and 4.4.2.			

1.2 Summary of the Action

Since November 2020, Ethiopia has been engulfed in a civil war. While the conflict is mainly affecting Ethiopia's northern regions, spill over effects and smaller pockets of interrelated conflicts increased significantly the geographical area with population affected by the conflict. This has had significant effects on the provision of health services to Ethiopians, as health facilities were destroyed, damaged and/or looted.

The present Action aims at contributing to improved health of Ethiopian citizens through access and provision of conflict sensitive equitable and quality health services. Restoring health gains in conflict affected areas, focusing on women and girls, reducing inequalities in health service delivery and utilization, and strengthening the quality of health services at all levels are the three specific objectives of this Action.

The Action has a total budget of EUR 41 000 000, out of which an EU contribution of EUR 39 500 000, and will have a duration of 36 months. It will be implemented exclusively through indirect management, by United Nations (UN) agencies and EU Member States organisations. The main beneficiaries of this Action will be the population

living in conflict affected areas, with a special focus on women and girls, mainly in the northern regions (Tigray, Amhara and Afar) as well as other conflict affected areas. Other population living in the most vulnerable situations such as persons with disabilities, the elderly and Internally Displaced People (IDPs) and refugees will also benefit from this action.

This Action will be complementary to other ongoing EU funded projects in the health sector, in particular the project 'Social Determinants for Health for Gender Equality' (EUR 24 000 000). It is also complementary to projects funded by EU Member States active in the sector. The Action will also benefit from synergies with the Action on Education under the same Individual Measure, in particular with what relates to sexual and reproductive health and family planning.

2 RATIONALE

2.1 Context

Ethiopia is the second most populous country in Africa with around 115 million people (of which 45 million children are 0-14 years old) and the population growth remains high at around 2.5% per year, despite having been decreasing for the past three decades[1]. The UN estimates that its population will reach 200 million by 2050, becoming one of the world's ten largest countries[2]. According to the World Bank[3], Ethiopia's economy experienced strong, broad-based growth averaging 9.4% a year from 2010/11 to 2019/20, although slowed down to 6.1% in 2019/20 due to the COVID-19 pandemic. Ethiopia has also managed to increase life expectancy from 47.1 in 1990 to 66.6 in 2020[4]. Public investments in basic services provision such as education and health have also contributed to poverty reduction, as did rural safety nets (e.g. the Productive Safety Net Program - PSNP), which contributed to sustain growth and to preferentially increase the welfare of the poor. Education and health access and utilization have increased over the last decade as the number of primary health posts, health centres, and schools increased[5]. Nonetheless, Ethiopia is also one of the poorest ranking 174 out of 189 countries at the Human Development Index (2018); in fact, while inequality has remained low, the very poorest became poorer, posing a challenge to the goal of shared prosperity in Ethiopia. Despite rapid growth, Ethiopia continued to be one of the most equal countries in the world, with a Gini coefficient that remained at 30 percent from 2005 to 2011[6].

Since November 2020, Ethiopia has been engulfed in a civil war. While the conflict is mainly affecting Ethiopia's northern regions (Tigray, Amhara and Afar), spill over effects and smaller pockets of interrelated conflicts (i.e. in Oromia) increase significantly the geographical area with population affected by the conflict. The conflict has caused significant damage to health facilities, translating into thousands of health facilities becoming non-functional. This increased pressure into an already strained health system, which was under difficulties since the start of the pandemic: as of December 2021, there are a total of 377 056 confirmed COVID-19 cases, and over 6,800 deaths have been reported since the beginning of the pandemic[7].

The conflict has also affected the performance of the health system in most regions. While the regions affected by the conflict, in particular Tigray, Amhara and Oromia, have highly performing health systems (ranking amongst the highest in the country), wide inequalities exist within these regions, having woredas that perform significantly worse than the national average. The trend analysis from the Demographic Health Survey (DHS) results indicate that there are drought prone woredas (poverty areas) within a particular region that perform far below the regional/national average of health status. These low performing woredas have been also affected by the conflict, in particular in Amhara.

Another consequence of the conflict has been delayed improvements in the quality of health care. This has a particular negative effect on women's and girls' access to health services, which is already hampered in the non-conflict areas. Despite Ethiopia's striding change in maternal death over the last decades (decreased from 1 030 in

[1] World Bank, World Development Indicators, Ethiopia. Consulted on 21 December 2021.
[2] UN Department of Economics and Social Affairs, World Population Prospects 2019.
[3] World Bank report (2021) - Eighth Ethiopia Economic Update : Ensuring Resilient Recovery from COVID-19
[4] UNDP, Human Development Reports, Ethiopia. Consulted on 21 December 2021.
[5] World Bank (2016) Ethiopia: Priorities for Ending Extreme Poverty and Promoting Shared Prosperity
[6] *idem*
[7] WHO COVID-19 Dashboard. Consulted on 21 December 2021.

2000 to 401 per 100 000 in 2017, maternal and neonatal mortalities (28 per 1 000 live births[8]) remain high mainly due to poor quality of maternal, neonatal and child health services. In 2019, only 43% of pregnant women had four or more visits to health facilities during her pregnancy, mothers delivering with the assistance of skilled birth attendants remains low at around 50%. This progress has stalled because of the conflict. In a similar manner, increasing the capacity of other medical specialties has lagged behind, including for specialised medicine greatly needed in conflict settings, such as traumatology, surgery and emergency services, including rehabilitation.

Although Ethiopia has made significant progress in the access to basic health facilities, young people still face a number of health challenges that have increased with the current conflict and the COVID 19 pandemic, including inadequate access to sexual and reproductive health information/services, malnutrition, prevalence of HIV/AIDS and substance abuse (particularly khat, tobacco, alcohol and drug use). Young women, including women and girls with disabilities, represent a high-risk group in Ethiopia, being especially vulnerable to gender-based violence, female genital mutilation and early marriage.

In this context, addressing the human capital and development of the population through health (as well as education) is vital, not only to address the needs arising from the conflict, but also for the economic development of the country, its political and social stability, and to improve the livelihoods of the population to drive poverty and inequality reduction.

Under these circumstances, it is vital that the EU ensures continued support to people in Ethiopia, in particular those most affected by the conflict. The current cooperation between the EU and the government of Ethiopia has been limited due to the ongoing conflict. Such a situation has also led to a delayed approval of the 2021-2027 Multiannual Indicative Programme (MIP) for Ethiopia.

The increasing needs of the communities living in the most vulnerable situations in Ethiopia, in particular girls and women, persons with disabilities and Internally Displaced People (IDPs) and refugees must be addressed promptly and translate into the need for Individual Measures. The use of these measures is appropriate as the EU currently lacks the relevant programming document due to the ongoing conflict in Ethiopia.

Within such a challenging context, the government has developed the second Health Sector Transformation Plan (HSTP-II, 2020/21-2024/25) with the aim to improve the health status of the population through accelerating progress towards Universal Health Coverage (UHC), protecting people from emergencies, creating woreda transformation and making the health system responsive to people's needs and expectations. The HSTP-II also aspires to achieve Universal Health Coverage through expanding access to services and improving the provision of quality and equitable health services at all levels. Reproductive, maternal, newborn, child, adolescent and youth health (RMNCAYH) and nutrition interventions continue to be the major focus areas. As for woreda transformation, it is expected to be realised through its Primary Health Care (PHC) approach. It mainly focuses on strengthening and transforming district health systems through improving key health system investments and implementing high-impact health interventions at household and primary health care levels. It also addresses implementation of woreda management standards, reforms and implementation of health-financing strategies (including expanding of Community Based Health Insurance coverage) to reduce financial risks to the community.

This Action is aligned with the reforms envisaged by the HSTP-II, in particular with its objectives of a) accelerating progress towards universal health coverage, and b) improving health system responsiveness. The Ministry of Health has also started assessing the needs assessment arising from the conflict, focusing on assessing damage and destruction of health facilities.

The present Action is also fully consistent and aligned with European Commission policies, objectives and priorities. The action is aligned to the European Consensus for Development[9], the Gender Action Plan III[10], the EU Disability Rights Strategy 2021-2030, the EU vision of the future Africa-EU partnership as per its Communication "Towards a Comprehensive Strategy with Africa" [11] and especially with the Partnership for

[8] World Bank, Data bank. Consulted on 21 December 2021.

[9] Joint declaration by the Council and the representatives of the governments of the Member States meeting within the Council, the European Parliament and the Commission on the development policy of the European Union entitled "The European Consensus" [Official Journal C 210 of 30.6.2017].

[10] EU Gender Action Plan (Gap) III – An Ambitious Agenda for Gender Equality and Women's Empowerment in EU External Action - European Parliament resolution of 10 March 2022 on the EU Gender Action Plan III (2021/2003(INI))

[11] JOIN(2020) 4 final

Sustainable Growth and Jobs, which aims at increasing access to quality education, skills, research, innovation, health and social rights. Finally, it also contributes to the 2030 Agenda for Sustainable Development through the SDG 3 (global health and wellbeing), which is also closely linked to SDG 5 (gender equality).

The Action will link up with the EU's past and ongoing humanitarian aid funded actions in the health sector, aimed at providing life-saving emergency healthcare access to vulnerable people in locations hit by conflict, natural hazards and underprivileged conditions. Such linkage and coordination will be done with a view to strengthening resilience, promoting access to quality and sustainable services, addressing the root causes of humanitarian crises and developing shock-responsive safety nets for crisis-affected populations, avoiding duplication in interventions.

This Action will be complementary to other ongoing EU funded projects in the health sector, in particular the project "Social Determinants for Health for Gender Equality" which started implementation in late 2021. With an overall budget of EUR 24 000 000, this programme provides support to the four developing regional states (Afar, Benishangul Gumuz, Gambella and Somali) by contributing to addressing sectors indirectly related to the health status of the population. It is also complementary to projects funded by EU Member States active in the sector, mainly France, Germany, Ireland, Italy (also funding social determinants), the Netherlands and Spain. The Action will also benefit from synergies with the Action on Education under the same Individual Measure, in particular with what relates to sexual reproductive health and family planning.

2.2 Problem Analysis

Damaged health systems in conflict affected areas

The health system in Ethiopia is currently facing unprecedented challenges due to the on-going armed conflict coupled with the impact of COVID-19. The consequences of this crisis are expected to potentially impact in losing the health gains achieved so far, including through the past performance results of the Health Budget Support programme.

The conflict has disrupted the health system particularly in northern parts of Ethiopia (Tigray, Amhara, and Afar). It is already overstretched and further weakened to respond to the health needs of the population affected by the conflict. In most parts of these regions, health infrastructures/water, sanitation and hygiene (WASH) facilities, medical equipment and Health Management Information System (HMIS) units/tools are severely damaged and/or demolished. As of January 2022, the Ministry of Health (MoH) reported that a total of 42 hospitals (40 in Amhara and 2 in Afar), 479 health centres (453 in Amhara and 26 in Afar), 1,895 health posts (1,850 in Amhara and 45 in Afar) were damaged and currently not functional. The extent of damage in Tigray cannot be quantified, due to the lack of unrestricted access over the past year.

Currently, health service referral systems are not functional and/or adequate to provide timely and appropriate linkages to other levels of services. This is mainly because the Health Management Information System (HMIS) tools and equipment are severely damaged for which health facilities' institutional data need to be retrieved and/or re-established, but also due to restrictions of movements and lack of functionality of health facilities. Technical and material support needs to be mobilised through different means, including exchanges between health facilities and universities and specialized hospitals (see below). Overall, the financial need for rehabilitation and restoration of damaged health facilities is expected to be significant.

Gender-based violence is experienced by nearly half of Ethiopian women in their lifetimes, a situation exacerbated by the conflict. Despite such a significant problem across the nation, little has been done on its prevention and managing of the victims. According to UNFPA study report[12], only five hospitals in the country have dedicated a separate clinic that provides sexual and gender-based violence victims with clinical services. In other health facilities, survivors of sexual violence are managed like any other patients, denied of time for counselling and psychological rehabilitation. With the current conflict, the extent of the problem is larger: cases have been reported from different parts of the country of primary school girls, elderly women and pregnant women being raped. The

[12] UNFPA Report 2020: Universal Health Coverage Policies and Progress towards the Attainment of Universal Sexual and Reproductive Health and Rights Services in Ethiopia

need for rehabilitation of victims with mental health and psychosocial support particularly in conflict affected areas is critical.

Inequalities in health service delivery

In Ethiopia, health status variations across regions are dominant, caused by multiple factors such as gender norms and harmful traditional practices, low economic and educational status, low access to basic utilities, etc. The government strategy (HSTP-II) recognises the need for transformation in addressing inequalities with increased attention for hard to reach populations – urban poor, pastoralist and identified poverty areas (often drought affected zones/woredas). Low human development in Ethiopia (as indicated by low outcomes in education and health) has been identified as a binding constraint[13] to strengthening the livelihoods of the bottom 40 % of the wealth distribution. Recognising this challenge, Ethiopia has improved human capital outcomes as a result of high levels of public investment in education and health. Together, in the past, these sectors have accounted for a third of government expenditure[14], as public spending on primary education and preventative health care is quite progressive and pro-poor. However, despite promising practices being observed to reach out to underserved populations, analysis of progress across regional states and/or zones indicates the need for further investment in addressing inequalities. In addition, these inequalities have been further deepened due to the ongoing conflict.

National reports[15] also hide stark inequalities across zones/woredas, calling for innovative and context specific interventions within poverty areas. The analysis from regional reports indicate that there are poverty areas that perform far below the regional and/or national average in terms of maternal and child health indicators. For instance, Amhara is amongst the developed regions. They are amongst the best regions when considering maternal health care indicators, and the second region with most use of contraceptives, only behind Addis Ababa[16]. Maternal education is negatively associated with immunization rates and is a main driver of inequality in maternal and child health outcomes. However, there are significant inequalities when comparing performance amongst woredas in Amhara: those further away from the regional capital, Bahir Dar, fare worse in almost all performance indicators, some behind the average of better performing regions[17]. This inequality is being further deepened due to the conflict, as these woredas (in the border with Tigray) have suffered from intense fighting.

Limited improvement in quality of care at all levels

Improving quality of health services across the continuum of care is one of the pillars of the HSTP-II. However, despite encouraging results in reducing under-five mortality rate (from 222 in 1990 to 49 deaths per 1 000 live births in 2020), still an estimated 173 000 under-five children die from preventable childhood diseases every year mainly due to poor quality of care particularly during the neonatal period[18]. Unfortunately, efforts made so far in reducing neonatal mortality rates have not been satisfactory, with conflicting data regarding its progress, but in any case proving it remains very high[19]. High numbers of stillbirths occur, representing a "silent epidemic". Close to half of stillbirths occur during the process of labour and delivery, and over 80% of all newborn deaths are caused by preventable and treatable conditions. Maternal mortality is also unacceptably high in Ethiopia, though it has been reduced from 1,030 in 2000 to 401 deaths per 100,000 live births in 2017[20].

These issues are manly attributed to sub-optimal quality of care, low nutritional status of mothers, uneven distribution of health resources, low maternal and child health care seeking behaviour of communities, and shortage of essential health commodities and equipment at service delivery. As an example, among the direct

[13] World Bank (2016).
[14] World Bank. 2015. 'Ethiopia Poverty Assessment 2014.'
[15] 2019 Ethiopian Mini Demographic and Health Survey (DHS) report
[16] *idem*.
[17] Improved performance of district health systems through implementing health center clinical and administrative standards in the Amhara region of Ethiopia, BMC Health Services research, 2019.
[18] United Nations Children's Fund (UNICEF), Data bank. Consulted on 21 December 2021.
[19] While DHS 2016 and 2019 reports point to an increase, UNICEF data points to a continuous decrease in the neonatal mortality rate.
[20] World Bank, Data bank. Consulted on 21 December 2021.

causes of maternal deaths, bleeding during and after childbirth are the causes of most of the deaths. This is due to poor quality of antenatal care, during delivery and postnatal health care services: only 50% of women delivered with the assistance skilled birth attendance[21]. To add to this, there are reports of pregnant women delivering in the bushes, IDP camps/sites, and at home due to lack of access to health facilities and health care providers[22].

The performance of maternal and neonatal health care is expected to further decline as health facilities/services are severely affected by the conflict, and resource allocation for priority interventions has also been compromised as a result of the conflict.

The conflict has also delayed efforts in other fields of medicine. The demand for a higher level quality of health care has become necessary due to epidemiological transition, rapid urbanisation, and broad social and economic changes occurring in the country. While Ethiopia has increased the number of health professionals trained in the previous years, there has been considerable variability and the need for speciality training in some prioritised areas including emergency services, intensive care, anaesthesiology and surgery, rehabilitation professionals amongst others. This is particularly relevant in the context of the current conflict.

Identification of main stakeholders and corresponding institutional and/or organisational issues (mandates, potential roles, and capacities) to be covered by the action:

The main beneficiaries of this Action will be the rights holders, population living in conflict affected areas, with a special focus on women and girls. Other population living in the most vulnerable situations such as persons with disabilities, the elderly and IDPs and refugees will also benefit from this action.

Other key stakeholders include:

- **EU Member States (MS):** almost all EU MS are present in Ethiopia and some are actively engaged in the health sector. Most of them (Spain, Ireland, Italy and the Netherlands) provided support to health through contribution to the Sustainable Development Goals Performance Fund (SDG PF), which is a non-earmarked pooled fund managed by the Ministry of Health using its financial management systems and procedures. The EU also supported the sector mainly through budget support operations. Currently, due to the country's situation, most have stopped channelling resources through government systems.
- **UN agencies:** the UN system is also an important partner supporting the health sector in Ethiopia. UNICEF, UNFPA, the World Health Organisation (WHO) and the World Bank are the most active UN actors in health, with relatively defined mandates.
- **International NGOs:** Save the Children, the African Medical and Research Foundation (AMREF), Médecins Sans Frontières, Médecins du Monde, International Rescue Committee, Collegio Universitario Aspiranti e Medici Missionari (CUAMM) and the Catholic Organization for Relief and Development Aid (Cordaid) are amongst the most active international NGOs in the health sector.
- **Government (duty bearers):** Ministry of Health, Regional Bureau of Health and Woreda Health Offices are important stakeholders. Coordination with them from implementing partners will be encouraged.

3 DESCRIPTION OF THE ACTION

3.1 Objectives and Expected Outputs

The Overall Objective (Impact) of this action is to improve health of Ethiopian citizens focusing on conflict affected population.

The Specific Objectives (Outcomes) of this action are to

1. Restore health gains in conflict affected areas, focusing on women and girls
2. Reduce inequalities in health service delivery and utilization

[21] 2019 Ethiopian Mini Demographic and Health Survey (DHS) report
[22] United Nations Population Fund (UNFPA) – Humanitarian response plan for Ethiopia

3. Strengthen quality of healthcare at all levels of service delivery tiers

The Outputs to be delivered by this action contributing to the corresponding Specific Objectives (Outcomes) are

1.1 contributing to Outcome 1 (or Specific Objective 1) – health facilities in conflict affected areas rehabilitated

1.2 contributing to Outcome 1 (or Specific Objective 1) – support to gender based violence survivors and others with trauma provided

2.1 contributing to Outcome 2 (or Specific Objective 2) – improved access to quality health services in pastoral and low performing zones and/or poverty areas

3.1 contributing to Outcome 3 (or Specific Objective 3) –quality of maternal and neonatal care improved, including continued health system strengthening trainings

3.2 contributing to Outcome 3 (or Specific Objective 3) - specialised medical trainings provided

3.2 Indicative Activities

Activities related to Output 1.1 may include, amongst others:

- rehabilitation and refurbishment of conflict affected/damaged health infrastructures (potentially including sustainable energy, WASH and information and communication systems) with due consideration of accessibility and for disability friendly services;
- equipment of health centres and hospitals with emergency reproductive health kits and others to restore sexual reproductive health, gender based violence and other relevant clinical services in conflict affected areas; and/or
- support to restore and/or strengthen health management information system and referral linkage disrupted by the conflict.

Activities related to Output 1.2 may include, amongst others:

- provision of psychosocial support and gender based violence (GBV) case management services to survivors of sexual abuse and other vulnerable communities affected by the conflict.

Activities related to Output 2.1 may include, amongst others:

- conduct assessment to critically analyse determinants of equity in health service delivery;
- design and implement supply- and demand- side prioritised interventions to address inequalities in selected low performing zones/woredas and/or poverty areas;
- implement alternative health service delivery modalities for hard-to-reach and special need communities; including mobile and/or eHealth services, outreach programs, etc and/or
- support for implementation of Community-Based Health Insurance schemes in low performing woredas and/or poverty areas.

Activities related to Output 3.1 may include, amongst others:

- equip hospitals and health centres with maternal and neonatal care equipment for improved quality of services;
- training, coaching and mentorship of health workers on new-born care and other related services;
- strengthen maternal and child health information system ; and/or
- support for accessible health infrastructure and basic amenities (including water supply, communication technologies, and others) to improve quality of health services.

Activities related to Output 3.2 may include, amongst others:

- conduct assessments for specialised training needs, in particular to address needs arising from the conflict;
- facilitate training of health professionals on prioritised speciality areas, in particular those related to conflict, such as traumatology, emergency services and surgery.

3.3 Mainstreaming

Environmental Protection & Climate Change

In line with the EU sustainable energy and climate change mitigation objectives, the interventions may seek to apply renewable solar-powered based energy solution such as stand-alone systems in the rehabilitation of health facilities. Climate change adaptation and environmental sustainability will also be improved through applying principles in construction leading to an improvement over the pre-existing quality and sustainability of facilities, including through climate proofing, and "one health" approach, recognizing that the health of people is connected to the health of the close environment.

Outcomes of the EIA (Environmental Impact Assessment) screening

The EIA (Environment Impact Assessment) screening classified the action as Category B (not requiring an EIA, but for which environment aspects will be addressed during design).

Outcome of the CRA (Climate Risk Assessment) screening

The Climate Risk Assessment (CRA) screening concluded that this action at risk (climate risk will be addressed as part of an EIA).

Gender equality and empowerment of women and girls

As per OECD Gender DAC codes identified in section 1.1, this action is labelled as G1. This implies that a gender perspective is integrated throughout the Action: one of the specific objectives in point 3.1 "Restore health gains in conflict affected areas, focusing on women and girls" being directly focused on improving access to health care to women and girls recognising their disadvantage situation, outputs for other specific objectives include i.e. health facilities specifically for women and girls. A systematic assessment of the particular needs and strengths of women and girls of the planned activities will be conducted and sex- and disability (where possible) disaggregated data will be collected and presented at all levels.

Human Rights

Access to health services is a basic human right recognised in the international legal framework. While the final beneficiaries of this Action do have special needs arising from the conflict, their right to enjoy such services will also be underscored, moving from a needs approach to a rights approach. Such a human rights based approach will ensure as well the sustainability of the gains achieved, including through awareness raising activities aiming at ensuring the population is aware of their rights so to be able to fully exercise them. The action will respect the 5 working principles: respect to all human rights, meaningful participation, non-discrimination, transparency and accountability in all the phases and activities.

Disability

As per OECD Disability DAC codes identified in section 1.1, this action is labelled as D1. This implies that a disability perspective is integrated throughout the Action and a systematic assessment of the particular needs people with disabilities will be taken into consideration in the planned activities. In particular, disability is addressed in the activities related to rehabilitation of health facilities, raising awareness around stigma and prejudice among health workers, and improving health management systems.

Democracy

A human rights based approach, was followed in the design of the identification of the present action, and the five principles will further be applied in the formulation and implementation of the project: participation, accountability, non-discrimination, transparency and respect to all human rights empowerment and legality.

Conflict sensitivity, peace and resilience

The choice of locations for implementation, to be made at a later stage, will take a conflict sensitive approach, ensuring that no particular region or ethnicity is receiving more support than other, while maintaining due consideration for the needs of the population. Psychological support and possibly stress management training for practitioners will be provided in a conflict sensitive manner. Possibilities of working on the nexus and building resilience will be further explored during detail programming/contracting with implementing partners.

Disaster Risk Reduction

N/A

Other considerations if relevant

Nutrition:

Addressing malnutrition (prevention and treatment) of vulnerable categories of the population (notably under 2 and under 5 years old children, adolescent girls) in an effective and efficient manner will contribute to strengthening the health outcomes. A focus on nutrition specific interventions during the first 1 000 days is foreseen, as well as other essential nutrition actions such as breastfeeding promotion, complementary feeding, prevention and control of anaemia, prevention and control of micronutrients and vitamin deficiencies.

3.4 Risks and Lessons Learnt

Category	Risks	Likelihood (High/ Medium/ Low)	Impact (High/ Medium/ Low)	Mitigating measures
External environment	**Vulnerability to shocks and crises:** Ethiopia remains vulnerable to significant shocks, natural and man-made, affecting the target population. The impact of climate change, ongoing active conflict and COVID-19 risks exacerbating these vulnerabilities, which could have detrimental effects in the implementation of projects.	**H**	**H**	Flexibility in terms of implementation (choice, sequencing and modalities of activities) will be built into the programme in order to adjust to the evolution of the situation in a conflict-sensitive manner.
	Difficult access to regions in conflict: some conflict areas may remain closed to access by implementing partners, and areas that have recently stabilised may become unstable again, which risks delaying the implementation of some activities and/or losing gains made during the implementation.	**H**	**H**	The programme will develop clear criteria for access to zones, woredas and kebeles which will include a consideration of safety issues and safeguards to these risks. Alternative locations should be pre-identified to quickly adapt implementation if needed.
Planning, processes	**Lack of data at woreda level:** as there is no	**L**	**M**	The implementing partner will need to analyse data from multiple sources, in

	consistent, exhaustive data of performance of health facilities at woreda level, selection of low performing woredas risk being done based on wrong assumptions, which would lead to a misuse of EU funding to areas that should not have been prioritised.			order to determine which woredas, amongst those affected by conflict, should be prioritised. Exchanges with other partners in the health sector will also take place to minimise the risk of choosing the wrong locations for implementation. The implementing partner will as well have to ensure that all relevant data is sex-disaggregated.

Lessons Learnt:

Previous EU funded interventions in the health sector highlighted the importance of school clubs and youth clubs as an entry point for sexual reproductive health and family planning. The project "ASURE – HEALTH: Access, Service and Utilisation of Reproductive Health" was implemented between 2015 and 2019 by AMREF Health Africa, an international NGO. Amongst other activities, the project supported strengthening of adolescent and youth friendly services (AYFS) within the health centres it worked on. This led to improved quality and increased utilisation of Sexual and Reproductive Health (SRH) services by the youth. Three key lessons were learned from this project:

- Strengthening AYFS units leads to improved SRH services and education.
- Further creativity in equipping AYFS units with relevant youth games for both boys and girls, and solar panel for charging and electricity supported games, would enhance service utilisation and youth participation in awareness raising activities.
- There is a need to further strengthen close collaboration and linkages between AYFS (health centers) and school clubs for increased utilization of SRH and family planning services.

This last recommendation was also suggested as a lesson learned of the project "Promoting Sexual and Reproductive Health Services and Family Planning services for marginalized women and girls in Afar and Amhara Regional States of Ethiopia", implemented between 2015 and 2019 by Save the Children. This project also proved that strengthening AYFS is key in improving access and quality of SRH services for youth and adolescents. For future intervention, the lesson learned is again to establish close collaboration and linkage with education sector interventions (support for school clubs) for increased utilization of SRH and family planning services.

This past experience suggests that teenagers are more receptive to trainings, discussions and similar activities when conducted not only in AYFS units, but also in the framework of school clubs. This action will therefore seek synergies with the Action on education prepared under the same Individual Measure, which foresees support to girls in primary and secondary education and the creation of "safe spaces" in schools.

3.5 The Intervention Logic

The underlying intervention logic for this action is that by carrying out activities to rehabilitate health facilities and support the victims of the conflict living in the most vulnerable situations, including through psychosocial support, gains lost or at risk due to the conflict will be restored. By implementing context specific activities in low performing woredas or poverty areas, in particular in those most affected by the conflict, inequalities in health service delivery in these areas will be reduced. As for activities such as equipping hospitals and health centres with Neonatal Intensive Care Units (NICUs) and newborn corner equipment/facilities, training of healthcare workers on maternal and neonatal care, as well as other specialised medical training provided (in particular those related to needs arising from the conflict), these will contribute to strengthening the quality of health care at all levels. If conflict recedes or is contained, these outcomes will be realised in the targeted locations.

These outcomes will contribute to achieving improved health and well-being status of Ethiopian citizens, as has been seen in past contributions to the health sector. The impact achieved in this sector with support from the international community can not only be restored, but also enhanced by reaching more Ethiopian citizens and diversifying the areas of medicine covered by the support provided.

3.6 Logical Framework Matrix

This indicative logframe constitutes the basis for the monitoring, reporting and evaluation of the intervention.

On the basis of this logframe matrix, a more detailed logframe (or several) may be developed at contracting stage. In case baselines and targets are not available for the action, they should be informed for each indicator at signature of the contract(s) linked to this AD, or in the first progress report at the latest. New columns may be added to set intermediary targets (milestones) for the Output and Outcome indicators whenever it is relevant.

- At inception, the first progress report should include the complete logframe (e.g. including baselines/targets).
- Progress reports should provide an updated logframe with current values for each indicator.
- The final report should enclose the logframe with baseline and final values for each indicator.

The indicative logical framework matrix may evolve during the lifetime of the action depending on the different implementation modalities of this action.

The activities, the expected Outputs and related indicators, targets and baselines included in the logframe matrix may be updated during the implementation of the action, no amendment being required to the Financing Decision.

Results	Results chain: Main expected results	Indicators:	Baselines (values and years)	Targets (values and years)	Sources of data	Assumptions
Impact	Improved health of Ethiopian citizens focusing on conflict affected population	1. Maternal mortality ratio per 100 000 live births 2. Under-five mortality rate per 1 000 live births 3. Neonatal mortality rate per 1 000 live births	1. 401 2. 59 3. 33	1. 279 (2024/25) 2. 43 (2024/25) 3. 21 (2024/25)	1-3. Ethiopian Demographic and Health Survey (EDHS)	*Not applicable*
Outcome 1	1. Restored health gains in conflict affected areas, focusing on women and girls	1.1 Proportion of deliveries attended by skilled health personnel 1.2 Coverage of services in conflicted affected areas for mental health disorders	1.1 (tbd) 1.2 (tbd)	1.1 (tbd) 1.2 (tbd)	1.1-2 Programme reports	Conflict is contained or decreases, ensuring accessibility to areas having been affected by conflict. Warring parties ensure access to conflict affected areas.
Outcome 2	2. Reduced inequalities in health service delivery and utilization	2.1 Proportion of woredas with Penta 3 coverage of 80 % or more 2.2 Proportion of pregnant women in attended four or more antenatal care (ANC) visits (disaggregated by disability)	2.1 (tbd) 2.2 (tbd)	2.1 (tbd) 2.2 (tbd)	2.1-2 Programme reports	
Outcome 3	3. Strengthened quality of healthcare at all levels of service delivery tiers	3.1 Percentage of newborns with neonatal sepsis/VSD who received treatment 3.2 Percentage of new-borns in targeted woredas receiving postnatal care within two days of birth	3.1 30 % 3.2 50 %	3.1 45 % 2024/25) 3.2 76 % (2024/25)	3.1 Health Management Information System (HMIS) 3.2 EDHS	
Output 1 **related to Outcome 1**	1.1 Health facilities in conflict affected areas rehabilitated	1.1.1 Number of damaged health centres and hospitals in conflict affected areas rehabilitated and accessible by the Action	1.1.1 (tbd)	1.1.1 (tbd)	1.1.1 Programme reports	Implementing partner identified has necessary capacity to implement activities.
Output 2 **related to Outcome 1**	1.2 Support to gender based violence and others with trauma provided	1.1.2 Number of GBV survivors provided with response services funded by the Action (disaggregated by sex and disability)	1.2.1 (tbd)	1.2.1 (tbd)	1.2.1 Programme reports	
Output 1 **related to Outcome 2**	2.1 Improved access to quality health services in pastoral and low performing zones and/or poverty areas	2.1.1 Number of 1-year olds in pastoral and/or low performing zones fully immunised with support from the Action** 2.1.2 Number of health facilities in targeted pastoral and/or low performing zones providing	2.1.1 (tbd) 2.1.2 (tbd)	2.1.1 (tbd) 2.1.2 (tbd)	2.1.1-2 Programme reports	

		minimum package of adolescent and youth friendly services with support from the Action				
Output 1 related to Outcome 3	3.1 Quality of maternal and neonatal care improved, including continued health system strengthening trainings	3.1.1 Number of hospitals equipped with NICU (Neonatal Intensive Care Unit) equipment 3.1.2 Number of health workers trained on neonatal intensive care units (NICU) and newborn care services with support from the Action (disaggregated by sex)	3.1.1 (tbd) 3.1.2 (tbd)	3.1.1 (tbd) 3.1.2 (tbd)	3.1.1-2 Programme reports	
Output 2 related to Outcome 3	3.2 Specialised medical trainings provided	3.2.1 Number professionals trained in selected priority speciality areas with support from the Action (disaggregated by sex)	3.2.1(tbd)	3.2.1 (tbd)	3.2.1 Programme reports	

**: EU Results Framework indicator

4 IMPLEMENTATION ARRANGEMENTS

4.1 Financing Agreement

In order to implement this action, it is not envisaged to conclude a financing agreement with the Federal Democratic Republic of Ethiopia.

4.2 Indicative Implementation Period

The indicative operational implementation period of this action, during which the activities described in section 3 will be carried out and the corresponding contracts and agreements implemented, is 36 months from the date of adoption by the Commission of this Financing Decision.

Extensions of the implementation period may be agreed by the Commission's responsible authorising officer by amending this Financing Decision and the relevant contracts and agreements.

4.3 Implementation Modalities of the Budget Support Component

N/A

4.4 Implementation Modalities

The Commission will ensure that the EU appropriate rules and procedures for providing financing to third parties are respected, including review procedures, where appropriate, and compliance of the action with EU restrictive measures[23].

4.4.1 Indirect Management with an international organisation

A part of this action may be implemented in indirect management with an entity, which will be selected by the Commission's services using the following criteria:

- Proven experience in supporting the health sector in Ethiopia;
- Experience in rehabilitation and refurbishment of health infrastructure; procurement of medical equipment
- Working experience in health system strengthening in post conflict situations

The implementation by this entity entails the activities contributing to achieve Specific Objectives 1 and 2 and part of Specific Objective 3, in particular Output 3.1.

In case the envisaged entity would need to be replaced, the Commission's services may select a replacement entity using the same criteria. If the entity is replaced, the decision to replace it needs to be justified.

If negotiations with the above-mentioned entity fail, that part of this action may be implemented in direct management in accordance with the implementation modalities identified in section 4.4.3.

4.4.2 Indirect Management with Member State Organisations

A part of this action may be implemented in indirect management with one or several entities, which will be selected by the Commission's services using the following criteria:

- Proven experience in facilitating and supporting speciality medicine training; and

[23] www.sanctionsmap.eu. Please note that the sanctions map is an IT tool for identifying the sanctions regimes. The source of the sanctions stems from legal acts published in the Official Journal (OJ). In case of discrepancy between the published legal acts and the updates on the website it is the OJ version that prevails.

- Proven experience in capacity building of teaching hospitals for speciality medicine training.

This implementation entails the activities contributing to achieve part of Specific Objective 3, in particular Output 3.2. Specifically, Member State Organisations are expected to provide training and capacity building opportunities for medical students as they enter their residency years (and thus specialise). They will also be expected to provide technical assistance, where relevant, to universities and university hospitals where specialised resident doctors are being taught about a particular medical speciality. The support will be needed in particular in specialties related to addressing the needs arising from conflict (such as traumatology, emergency services and surgery), but may also cover other underrepresented specialties such as ophthalmology, oncology and paediatrics, to name a few.

In case the envisaged entity would need to be replaced, the Commission's services may select a replacement entity using the same criteria. If the entity is replaced, the decision to replace it needs to be justified.

4.4.3 Changes from indirect to direct management mode (and vice versa) due to exceptional circumstances (one alternative second option)

In case the preferred implementation modality under 4.4.1 cannot be implemented due to circumstances outside the Commission's control, this part of the action related to Specific Objectives 1 and 2 and part of Specific Objective 3, in particular Output 3, will be implemented in direct management through a grant as described below:

Grants: (direct management)

(a) Purpose of the grant(s)

Specific Objectives 1 and 2 and part of Specific Objective 3, in particular Output 3**.**

(b) Type of applicants targeted

International NGOs.

4.5 Scope of geographical eligibility for procurement and grants

The geographical eligibility in terms of place of establishment for participating in procurement and grant award procedures and in terms of origin of supplies purchased as established in the basic act and set out in the relevant contractual documents shall apply.

The Commission's authorising officer responsible may extend the geographical eligibility on the basis of urgency or of unavailability of services in the markets of the countries or territories concerned, or in other duly substantiated cases where application of the eligibility rules would make the realisation of this action impossible or exceedingly difficult (Article 28(10) NDICI-Global Europe Regulation).

4.6 Indicative Budget

Indicative Budget components	EU contribution (amount in EUR)	Third-party contribution (amount in EUR)
Implementation modalities – cf. section 4.4		
Indirect management with an international organisation (Specific Objectives 1 and 2, and output 3.1 of Specific Objective 3)	35 000 000	
Indirect management with Member State Organisation(s) (output 3.2 of Specific Objective 3)	4 500 000	1 500 000
Evaluation – cf. section 5.2 **Audit** – cf. section 5.3	Will be covered by another decision	N.A.
Totals	39 500 000	1 500 000

4.7 Organisational Set-up and Responsibilities

The Action is expected to involve different stakeholders and its implementation requires strong coordination mechanism. The implementing partners will be responsible for the financial and technical reporting and overall management and coordination of the activities as defined in section 4.3. Some of the interventions, particularly contributing to Specific Objective 3, require close working relationships and cross sharing of plans, progress and lessons learnt among the different implementing partners.

A Steering Committee will be established for oversight and overall coordination and monitoring of the Action's implementation process. The Steering Committee will meet at least once a year to discuss strategic issues and provide direction in addressing programme implementation challenges. The composition and mandate of the Steering Committee will be decided by the EU Delegation and implementing partners upon signature of contracts.

As part of its prerogative of budget implementation and to safeguard the financial interests of the Union, the Commission may participate in the above governance structures set up for governing the implementation of the action.

5 PERFORMANCE MEASUREMENT

5.1 Monitoring and Reporting

The day-to-day technical and financial monitoring of the implementation of this action will be a continuous process, and part of the implementing partner's responsibilities. To this aim, the implementing partner shall establish a permanent internal, technical and financial monitoring system for the action and elaborate regular progress reports (not less than annual) and final reports. Every report shall provide an accurate account of implementation of the action, difficulties encountered, changes introduced, as well as the degree of achievement of its results (Outputs and direct Outcomes) as measured by corresponding indicators, using as reference the logframe matrix.

The Commission may undertake additional project monitoring visits both through its own staff and through independent consultants recruited directly by the Commission for independent monitoring reviews (or recruited by the responsible agent contracted by the Commission for implementing such reviews).

Indicators shall be disaggregated at least by sex and disability when relevant. All monitoring and reporting shall assess how the action is taking into account the human rights-based approach and gender equality, including the inclusion of persons with disabilities.

The performance of the programme will also be closely monitored by the Steering Committee through reviewing biannual progress reports. Implementing partners will present a summary of project implementation progress and the Steering Committee will discuss at strategic level and provide direction in

addressing key challenges. In addition, when negotiating contracts, the Commission and implementing partners will align with the logframe matrix in this Action Document, and implementing partners will provide baseline and suggest targets.

Monitoring and reporting of the Action's implementation process may involve use of both internal and external sources of data. Primarily, programme reports/data will be used to monitor and assess progress of implementation at output level. Achievements of indicators defined at outcome and impact level require contribution from other interventions and will need use of external sources of data including the Ethiopian Demographic and Health Survey (EDHS), Health Management Information System (HMIS), other assessments/surveys and facility reports. When missing, baselines and suggested targets will be proposed through conducting surveys, which will be a responsibility of the implementing partners, and will be conducted at the inception phase.

Moreover, as the action is aligned to the priorities of the Health Sector Transformation Plan (HSTP, 2020/21-2024/25), its implementation progress may be reviewed through the HSTP performance review mechanisms including the Annual Review Meeting (ARM) and Government of Ethiopia – Development Partners Joint Review Mechanism (JRM).

5.2 Evaluation

Having regard to the nature of the action, a final evaluation will be carried out for this action or its components via independent consultants contracted by the Commission.

It will be carried out for accountability and learning purposes at various levels (including for policy revision), taking into account the fact that this Action is taking place in response to the conflict in Ethiopia and may inform future conflict sensitive approaches.

All evaluation shall assess to what extent the action is taking into account the human rights-based approach as well as it contributes to gender equality and women's empowerment. Expertise on human rights and gender equality will be ensured in the evaluation teams.

The Commission shall inform the implementing partner at least 15 days in advance of the dates envisaged for the evaluation missions. The implementing partner shall collaborate efficiently and effectively with the evaluation experts, and inter alia provide them with all necessary information and documentation, as well as access to the project premises and activities.

The evaluation reports may be shared with the partners and other key stakeholders following the best practice of evaluation dissemination. The implementing partner and the Commission shall analyse the conclusions and recommendations of the evaluations and, where appropriate, apply the necessary adjustments.

The financing of the evaluation will be covered by another measure constituting a Financing Decision.

5.3 Audit and Verifications

Without prejudice to the obligations applicable to contracts concluded for the implementation of this action, the Commission may, on the basis of a risk assessment, contract independent audit or verification assignments for one or several contracts or agreements.

6 STRATEGIC COMMUNICATION AND PUBLIC DIPLOMACY

The 2021-2027 programming cycle will adopt a new approach to pooling, programming and deploying strategic communication and public diplomacy resources.

It will remain a contractual obligation for all entities implementing EU-funded external actions to inform the relevant audiences of the Union's support for their work by displaying the EU emblem and a short funding statement as appropriate on all communication materials related to the actions concerned. This obligation will

continue to apply equally, regardless of whether the actions concerned are implemented by the Commission, partner countries, service providers, grant beneficiaries or entrusted or delegated entities such as UN agencies, international financial institutions and agencies of EU member states.

However, action documents for specific sector programmes are in principle no longer required to include a provision for communication and visibility actions promoting the programmes concerned. These resources instead should be consolidated in Cooperation Facilities established by support measure action documents, allowing Delegations to plan and execute multiannual strategic communication and public diplomacy actions with sufficient critical mass to be effective on a national scale.

Appendix 1 REPORTING IN OPSYS

An Intervention (also generally called project/programme) is the operational entity associated to a coherent set of activities and results structured in a logical framework aiming at delivering development change or progress. Interventions are the most effective (hence optimal) entities for the operational follow-up by the Commission of its external development operations. As such, Interventions constitute the base unit for managing operational implementations, assessing performance, monitoring, evaluation, internal and external communication, reporting and aggregation.

Primary Interventions are those contracts or groups of contracts bearing reportable results and respecting the following business rule: 'a given contract can only contribute to one primary intervention and not more than one'. An individual contract that does not produce direct reportable results and cannot be logically grouped with other result reportable contracts is considered a 'support entities'. The addition of all primary interventions and support entities is equivalent to the full development portfolio of the Institution.

The present Action identifies as;

Action level		
☒	Single action	Present action: all contracts in the present action