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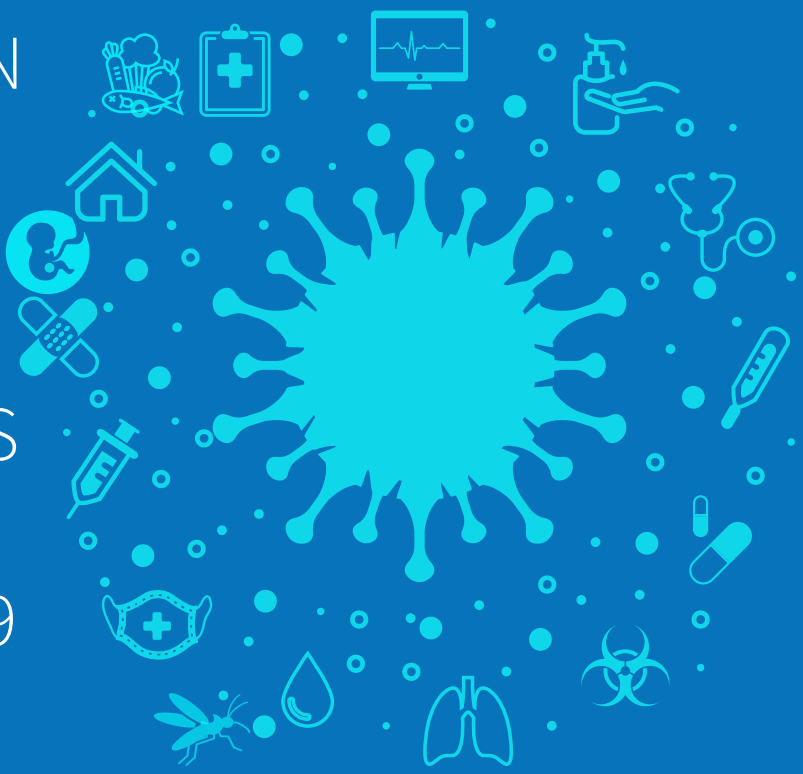
MINISTRY OF HEALTH - ETHIOPIA

IMPLEMENTATION GUIDE FOR NON-COVID-19 ESSENTIAL HEALTH SERVICES IN ETHIOPIA DURING COVID-19 PANDEMIC



JUNE 2020

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FORWARD

Our health system is being challenged by increasing demand for care of people with COVID-19, compounded by fear, stigma, misinformation and limitations on movement that disrupt the delivery of health care for all conditions. 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. Maintaining population trust in the capacity of the health system to safely meet essential needs and to control infection risk in health facilities is key to ensure appropriate care-seeking behavior and adherence to public health advice.

Countries, including Ethiopia, in their coordinated effort to respond to COVID-19, have significantly shifted their priorities towards COVID-19 pandemic response. However, the same health systems must continue to provide essential health services to avert preventable morbidity and mortality from commonly known conditions like maternal and child health issues, communicable and non-communicable diseases.

When the delivery of essential health services comes under threat, effective governance and coordination mechanisms, and protocols for service prioritization and adaptation, can mitigate the risk of outright system failure. To this end, the Ministry of Health has given due emphasis for ensuring facilities continue providing essential health services while responding to the pandemic. Accordingly, Ministry of Health published and distributed a directive to all regions and city administration on prioritization and continuity of essential health services, and this is an improved version of the first directive which has incorporated more areas of essential services deliveries.

A standardized approach will assist effective and efficient provision of essential health services during this pandemic. Therefore, this Implementation Guideline is expected to guide decision makers and health professionals at all level.

The FMOH would like to acknowledge every member that was involved in the write up, for their commitment and unreserved effort in finalizing the task in a very short period of time and advising the Ministry on various issues related to essential health care services at this critical time.

H. E. Dr Dereje Duguma

State Minister
Ministry of Health

ACRONYMS

AIDS	Acquired Immuno Deficiency Syndrome
ANC	Antenatal Care
ARV	Antiretroviral
C/T	Case Team
CAC	Comprehensive Abortion Care
CD	Communicable Disease
CED	Chief Executive Director
CEO	Chief Executive Officer
COPD	Chronic Obstructive Pulmonary Disease
COVID-19	Coronavirus Disease 2019
DHIS 2	District Health Information System
DM	Diabetes mellites
DPCD	Disease prevention control Directorate
EAC	Enhanced Adherence Counselling
EHS	Essential Health Services
EmONC	Emergency Obstetric and Newborn Care
EPHI	Ethiopian Public Health Institute
EPSA	Ethiopian Pharmaceutical and Supply Agency
FP	Family Planning
GBV	Gender Based Violence
GMP	Growth Monitoring
HC	Health Center
HEW	Health Extension Workers
HF	Health Facility
HIV	Human Immuno Virus
HMIS	Health Management Information System
HP	Health Post
HTN	Hypertension
HVL	High Viral Load
ICU	Intensive Care Unit
IFA	Iron-folic Acid
IMNCI	Integrated Management of Childhood Illness
IPC	Infection Prevention and Control
IYCF	Infant and Young Child Feeding
L/INGO	Local/International Non-Governmental Organizations
LMG	Leadership Management and Governance
LQAS	Lot Quality Assurance Sampling
MCH	Maternal and Child Health
MNCH	Maternal Newborn & Child Health
MOH	Ministry of Health
MSG	Medical Service General
NCD	Non-communicable Disease

OPD	Outpatient Department
PHCU	Primary Health Care Unit
PHEM	Public Health Emergency Management
PMED	Pharmaceutical and Medical Equipment Directorate
PMT	Performance Monitoring Team
PMTCT	Prevention of Mother-to-Child Transmission
PNC	Postnatal Care
PPE	Personal Protective Equipment
PPMED	Plan Monitoring and Evaluation Directorate
RHB	Regional Health Bureau
RMNCH	Reproductive Maternal Neonate and Child Health
RR/MDR-TB	Rifampicin Resistant/Multi Drug Resistant TB
SARI	Severe Acute Respiratory Infection
SOP	Standard Operating Procedure
SRH	Sexual Reproductive Health
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
TB	Tuberculosis
TBD	To Be Determined
TBL	Tuberculosis and Leprosy
UN	United Nation
VPD	Vaccine Preventable Disease
WaSH	Water Sanitation and Hygiene
WHO	World Health Organization
WoHO	Woreda Health Office
ZHD	Zonal Health Department

LIST OF CONTRIBUTORS

Sr.No.	Name	Institute
1	Abdissa Kabeto (MD, MPH)	AAU/CHS
2	Abera Dibabe (BSc, MSC)	MOH
3	Abreham Kassahun (BSc,MSc)	MOH
4	Abreham Tariku (MD)	MOH
5	Addisu Worku (BSc)	MOH
6	Aklilu Azazh (Prof. ECCM)	AAU/CHS
7	Andargachew Kumsa (MD, MPH)	MOH
8	Aregash Molla (BSc, MSc)	MOH
9	Aschalew Worku (MD, PCCM)	AAU/CHS
10	Ashrafedin Youya (BSc, MPH)	MOH
11	Berhane Redae (MD, Surgeon)	MOH, Jhpiego Ethiopia
12	Bethelehem Tebebe (MD)	SPHMMC
13	Birara Melese (BSc, MPH-N)	MOH
14	Birkity Lulu (MD)	MOH
15	Biruk Abate (BA, MSc)	MOH
16	Daniel Getachew (BSc, MPH)	WHO
17	Emiamrew Sisay (BSc, MSc)	MOH
18	Fekadu Yadeta (BSc, MPH)	MOH
19	Fitsume Kibret (MD, MPH)	Save-the-Children
20	Girma Gemechu (BSc, MSc)	MOH
21	Girma Shifa (PhD)	MOH
22	Haile Ayana (MPH)	AAU/CHS
23	Hillina Tadesse (MD)	MOH
24	Hiwot Darsene (BSc, MSc)	MOH
25	Hiwot Solomon (BSc, MPH)	MOH
26	Mebrahtom Haile (BSc, MPH)	MOH
27	Mebratu Massebo (MHA)	AAU/CHS
28	Menbeu Sultan (MD, Internist)	SPHMMC
29	Meseret Zelalem (MD, Pediatrician)	MOH
30	Miraf Walelegn (MPH)	MOH
31	Mirtie Getachew (BSc, MPH)	MOH
32	Mulat Niguse (BSc, MSc)	MOH
33	Muluwork Tefera (MD, Pediatric ECCM)	AAU/CHS
34	Mussie G/michaiel (MD, MPH)	MOH
35	Nejat Ibrahim (BSc)	MOH
36	Natnael Asres (MD)	MOH
37	Natnael Brhanu (MD, MPH)	Save the Children
38	Netsnet Birhanu (BSc, MPH)	MOH
39	Peteros Mitiku (MD, MPH)	MOH
40	Rahel Argaw (MD, Pediatric PCCM)	AAU/CHS

41	Semalegn Samuel (BSc, MPH)	MOH
42	Sisay Sinamo (MD, MPH, PhD)	MOH
43	Sisay Teklu (MD, Gyn-Obstetrician)	AAU/CHS
44	Sisay Yifru (MD, Pediatrician)	MOH
45	Shegaw Mulu (BSc, MPH, MSc)	MOH
46	Solomon Kassahun (BSc, MPH)	MOH
47	Taye Letta (BSc, MPH)	MOH
48	Temesgen Lemma (BSc, MPH)	MOH
49	Temesgen Tesfu (MA)	CHAI
50	Tigist Worku (BSc, MSc)	MOH
51	Wassie Tsehay (MD, MPH)	MOH
52	Woldesenbet Waganew (MD, ECCM)	SPHMMC
53	Wubshet Denboba (BSc, MPH)	MOH-DUP
54	Yakob Seman (MPH)	MOH
55	Yalewlayker Yilma (MPH)	CHAI
56	Yemane Berhane (MD, MPH, PhD, Professor of Epidemiology and Public Health)	Addis Continental Institute of Public Health
57	Zebideru Zewudie (BSc, MSc)	MOH
58	Zenebe Akale (BSc, MSc)	MOH
59	Zerihun Bogale (MD, MPH)	MOH

AIM OF THE DOCUMENT

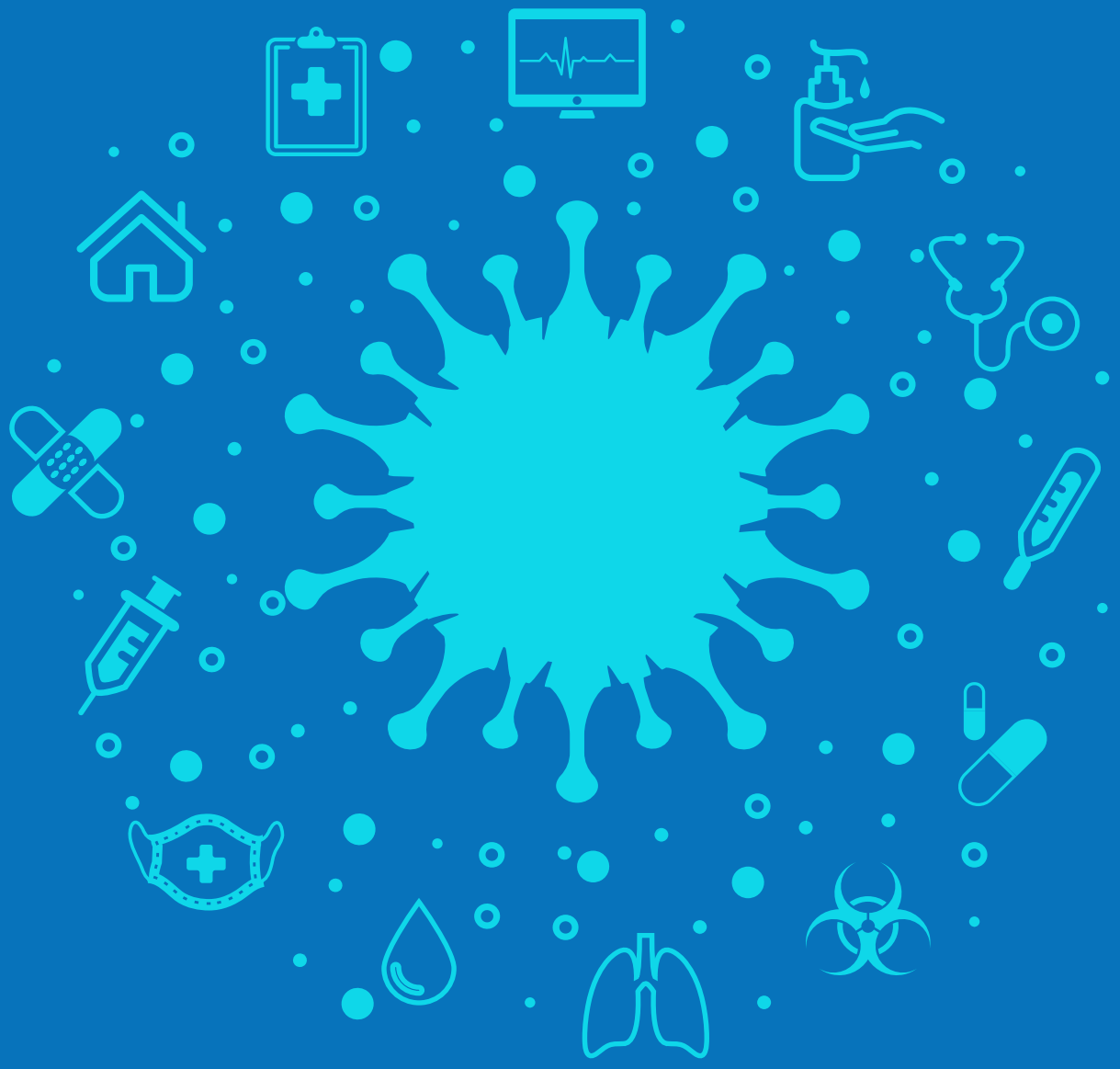
Recommence and maintain the Non- COVID-19 essential services, which were halted as COVID-19 epidemic response and panic in health facilities by articulating temporary governance and leadership structure, different new approaches for the service provision during the epidemic, engaging in strategic planning and coordinated actions to maintain essential health service delivery for the community during the COVID-19 epidemic period.

SCOPE OF THE DOCUMENT

This document will be implemented in all public facilities, which are not officially dedicated for COVID-19 treatment center in all tier level including comprehensive specialized hospitals, general hospitals, and PHCUs. In addition, it will be implemented by all MOH, Regional health bureaus, Zonal health offices and Woreda health office and in all teaching and federal hospitals.

SECTIONS

SECTION 1: INTRODUCTION
SECTION 2: LEADERSHIPE AND GOVERNANCE
SECTION 3: PRIORITY ESSENTIAL SERVICES
SECTION 4: HEALTH SYSTEM AND FACILITY PREPAREDNESS TO MAINTAIN ESSENTIAL SERVICES
SECTION 5: NEW APPROACHES TO DELIVER ESSENTIAL SERVICE
SECTION 6: RESOURCE MOBLIZATION
SECTION 7: COMMUNICATION
SECTION 8: SURVEILLANCE
SECTION 9: ENFORCEMNT
SECTION 10: MONITORING AND EVALUATION OF ESSENTIAL HEALTH SERVICES DURING COVID 19 PANDEMIC



SECTION 1: INTRODUCTION

Experience from recent epidemics in the world shows that when all the attention is diverted to the epidemics, the existing health services are significantly compromised. The Ebola outbreak in West Africa is a very good example where death registered due to neglected essential services during the outbreak was much higher than death caused by Ebola. There are a number of factors that leads to essential services to be compromised. These factors are either related to leadership and governance, service provider or society demand for the services. The leadership and governance factor include lack of clear direction and guidance on the essential health services during outbreak. Provider related factors include absenteeism of health care providers from their duty due to fear of the outbreak, lack of space to deliver the routine services or shortage of supplies. In addition, society demand related factors may include clients lack of confidence due to safety related fears and issues or lack of information about the presence of essential services in that facility during the outbreak.

Due to frustrating number of case and death reports coming from different countries where the outbreak was first reported, there was confusion, anxiety and uncertainty among health care providers and the general population when the first case was reported in Ethiopia. That led to disorganized and arbitrary reaction by public health care facilities. Most facilities preferred to get prepared for the forthcoming outbreak and decided to take a unilateral decision and started to practically shut down all essential services. Similar measures were taken by regional states in Ethiopia when regional states decided to shut down all public transports from and to Addis Ababa when the first few confirmed case were reported. This is not unexpected as we have never been to an epidemic of this scale involving almost the whole world in the past decades.

Currently in Ethiopia, we are witnessing the effect of this uncoordinated response during the past two months to the current pandemic. Reports show that vaccine preventable diseases are appearing as an outbreak in different part of the country since some of essential programs and services like TB, HIV, malaria and maternal-child health are not being delivered as they should be delivered, the country will suffer much more than the damage COVID-19 may cause in the future.

Ethiopia now has to make wise decisions to balance the direct response COVID-19 demands, while simultaneously engaging in strategic planning and coordinated action to maintain essential health service delivery, mitigating the risk of system collapse. Many routine and elective services may be postponed or suspended without causing significant effect on the health of the public and the health system.

This requires an urgent decision by policy makers. Given the current emergency situation in the nation, COVID-19 and non COVID-19 essential health services have to be given equal emphasis. Implementation, monitoring and evaluation of these activities have to be made under one command chain.

SECTION 2: LEADERSHIPE AND GOVERNANCE

Experiences from past similar epidemics in resource limited setting shows that epidemics of this scale need to be managed by National Federal Task Force. In this case a Federal Task Force for COVID-19 will be an appropriate central body. The task force will be composed of the members from Federal Ministry of Health, EPHI, Regional Health bureau and Ministry of Higher Education representing university hospitals and medical schools. Essential health services coordinator led by State Minster of Health, under this Task force will be responsible for monitoring and evaluating the proper administration of essential services. This structure will be in place at all level of health care and administrative level of the country. The Federal task force will overlook and monitor essential health services that are in place by introducing weekly reporting and monitoring mechanisms for all levels of health care facilities throughout the country both at federal and regional.

*This requires an urgent decision by policy makers and all levels of health system leaders.

The clinical advisory team recommends interventions including:

1. Assigning non COVID-19 essential health service coordinator in the COVID-19 task force at all levels
2. Immediate revision of the 4th quarter plan, check spill over activities from the previous quarters, lead time plan for six months and recovery time seven months plan (one month overlap with lead time plan) separately for Addis Ababa, major cities and other towns
3. Define hot spot clearly and revise roadmap
4. Mentorship by respective program directors at all level
5. Create Centralized and frequent reporting mechanism
6. Providers should continue the essential health care service as it was before COVID-19 however redesigning the service per the status of the pandemic is required, i.e,
    a. Continue all services in the early phase of the epidemic as it was previously during non COVID-19 time
    b. Deliver slim service and design a new way to provide services that are interrupted
    c. Continue the must to do services at any time of the pandemic
7. Create community awareness both on COVID-19 and non COVID-19 essential health services

COVID-19 task force responsible for COVID-19 will be led by the Ministry of Health and all COVID-19 cases will be managed in dedicated COVID-19 treatment centers. The existing health care system and facilities will continue activities like ANC and delivery, immunization, family planning, TB, Malaria, HIV, mental health and emergency services with full capacity. Non-emergency surgical services can be reduced to 70% to mobilize resources to the epidemic and chronic disease services can be carried out with prolonging appointments for reasonable time depending on the patient condition.

Human resources and to some extent supplies can be reallocated to dedicated COVID-19 centers for period of the epidemic.

Figure 1a: National Governance Structure for COVID-19 and Essential Services

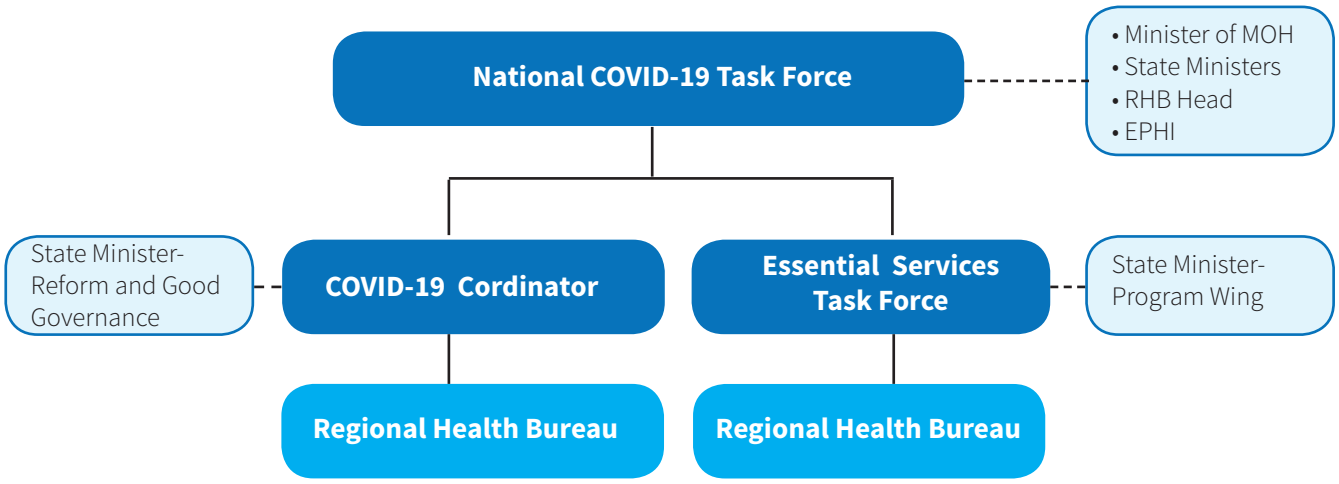


Figure 1b: Regional Governance Structure for COVID-19 and Essential Services

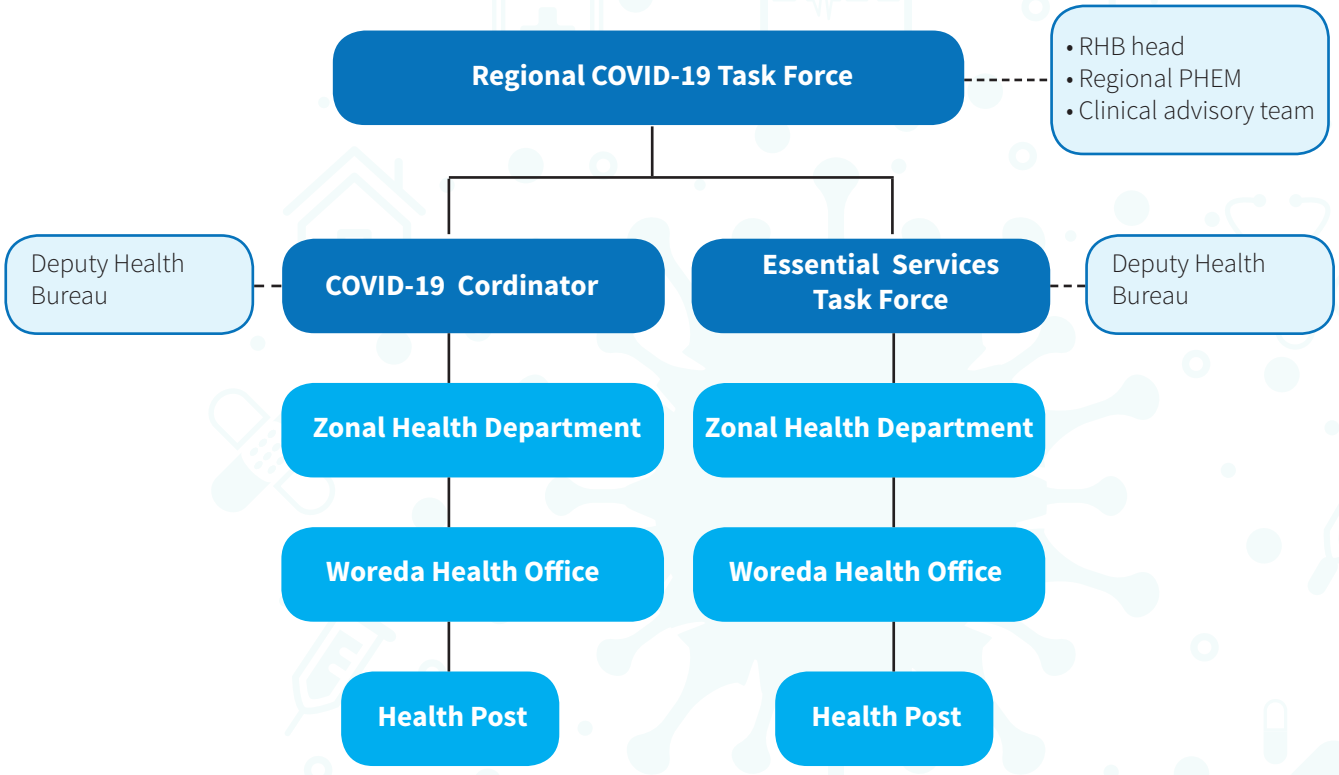


Figure 1c: Zonal Governance Structure for COVID-19 and Essential Services

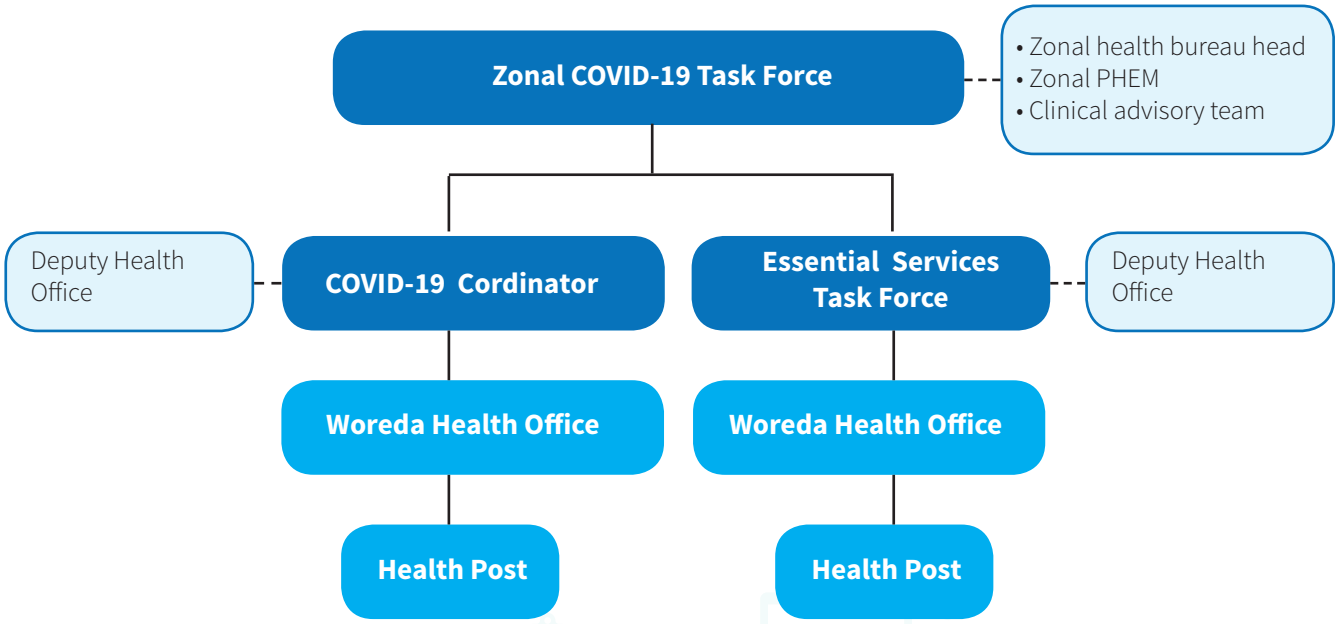


Figure 1d, Woreda Governance Structure for COVID-19 and Essential Services

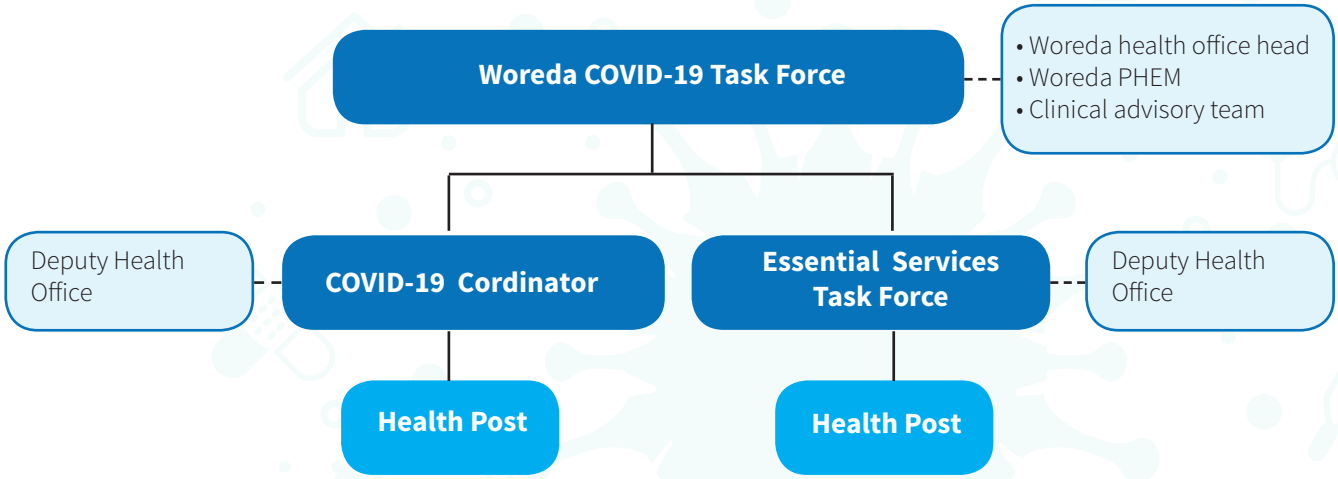
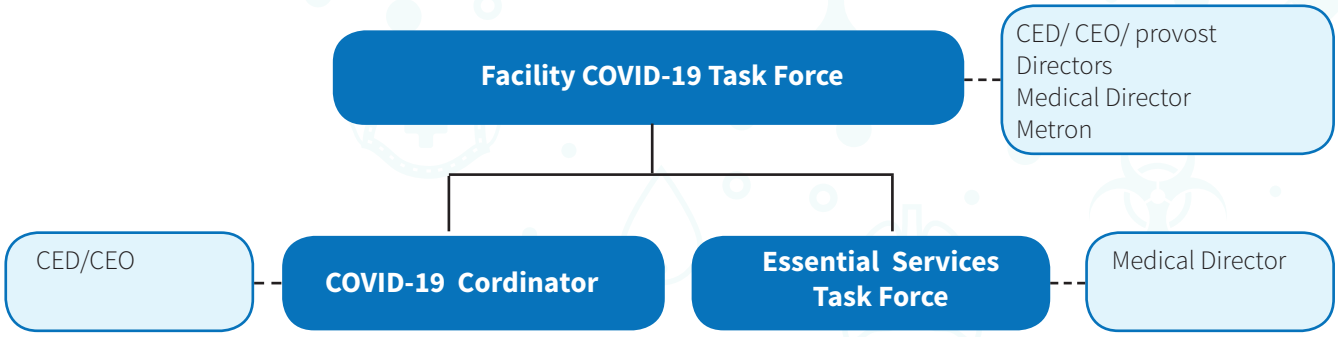


Figure 1e, Facility for COVID-19 & Essential Services



2.1. MEMBERS, ROLES AND RESPONSIBILITIES OF RESPECTIVE TASK FORCE

Specific Objectives:

- Tailor the roles and responsibilities of different actors in the health sectors to support the delivery of essential health care,
- Ensuring the needed inputs and strategies are in place to mitigate potential consequences of the COVID-19 Pandemic to the health sectors providing core essential service in the country

Members at Different Level

1. **National Essential Service Task Force**
    - MCH Vice Chair
    - MSG
    - Disease Prevention and Control Directorate: (Communicable and Non-Communicable Disease)
    - Public Relation
    - PMED
    - PPMED
    - Blood Bank
    - Hygiene and Environmental Health
    - EPSA
    - EPHI/ PHEM
2. **Regional Essential Service Task Force**
    - Deputy Health Bureau
    - Regional MCH Service Process Owner
    - Regional Medical Service Process Owner
    - Disease Prevention and Control Process Owner (Communicable and Non-communicable disease)
    - Public Relation
    - Regional Pharmaceutical and Medical Equipment Process Owner:
    - Regional Planning and Program Process Owner
    - Blood Bank
    - PSA Regional Branch
    - Regional PHEM
    - Regional clinical advisory team
3. **Zonal Essential Service Task Force**
    - Deputy Health Office
    - Zonal MCH Department
    - Zonal Medical Service Department
    - Disease Prevention and Control Department (Communicable and Non-communicable Disease)
    - Zonal PPME Department
    - Zonal PHEM
    - Zonal Clinical Advisory Team
4. **Woreda Essential Service Task Force**
    - Woreda MCH Service Delegate
    - Woreda Medical Service Representative
    - Disease Prevention and Control Delegate (Communicable and Non-communicable Disease)
    - Woreda planning officer
    - Woreda PHEM
    - Woreda Clinical Advisory Team
5. **Health Facility (Hospitals and HCs) Essential Service Task Force**
    - Medical Directors
    - Service Directors
    - Metron
    - IPC Focal Person
    - Department Heads
6. **Health post Essential Service Task force**
    - Health Extension Worker delegated for essential service

- Community Representative
- Other Stakeholders

N.B: The members will not be limited to what has been mentioned above but it can be customized accordingly at different levels.

MEMBERS' ROLES AND RESPONSIBILITIES AT DIFFERENT LEVELS

1. National level

National MOH Essential Service Task Force

- Will be accountable and report to the Minster of Health
- Will follow Non-COVID-19 essential health services

The State Minister

- Chair the weekly meeting, provide guidance, follow the progress

A. **MCH Vice Chair:**

- Triage and protective measures at service point
- Follow regions closely that these service provisions are maintained at health facilities
- Collect weekly report, analyze and share report to the committee led by state minister
- Provide weekly feedback to regions
- Will follow non-COVID-19 essential health services and collect reports from regions and federal hospitals weekly
- Report to the task force weekly

B. **Medical Services General**

- Follow regional and tertiary hospitals for the provision of General essential services
- Follow quality and standard of general essential services
- Collect report and send feedback to respective facilities

C. **Disease Prevention and Control Directorate:**

- Organize and lead, maintaining quality core communicable and non- communicable diseases service delivery, i.e., TBL, HIV, Malaria, Asthma, COPD, HTN, DM, Cancer patients on treatment amidst the COVID19 outbreak,
- Direction on multi-month provision (ARVs, NCDs, and appointments, 6 month and 3 months)
- Triage and protective measures at service point
- Follow regions closely that these service provisions are maintained at health facilities
- Collect weekly report, analyze and share report to the committee led by state minister
- Provide weekly feedback to regions

D. **Public Relation Directorate:**

- In collaboration with relevant programs, develop and disseminate contextualized messages to prevent the acquisition/mitigation of consequences of COVID19 infection by clients and Health workers

- Provide update at official media regularly and when needed
- Equip hot line access for information and remote consultation

E. **PMED:**

- In collaboration with EPSA and RHBs, monitor the logistic management of essential service commodities
- Facilitate the procurement of commodities to the extent of placing emergency orders for stock out commodities
- Facilitate the refill and requisition of commodities of essential commodities
- Update the stock status, procurement process of necessary commodities to the committee led by state minister weekly
- Provide weekly feedback

F. **PPMED:**

- Issue guidance on weekly tracking of essential service availability at health facilities using DHIS II
- Monitor the provision of services using selected indicators,
- Collect weekly report, analyze and report performance status of maintained essential services to the committee led by the state minister
- Provide weekly feedback

G. **Blood Bank Service Directorate:**

- Anticipate and mitigate the influence of COVID-19 outbreak on Blood donation
- Review and update the WHO recommendation of blood donation deferral criteria
- Closely follow the demand and availability of blood donation, minimize wastage and promote safe donation by minimizing the risk for donors
- Evaluate the blood donation status as per the plan set for the 39 donation sites and expedite mitigation plan when challenges encountered
- Expedite the safe blood donation by implementing protective measures for donors and health care workers
- Regularly update the regional blood banks for availability of adequate stock of blood
- Provide weekly feedback

H. **Hygiene & Environmental Health Directorate:**

- Ensure the safety of water sources in the community by ensuring availability and utilization of purification chemicals at different level
- Perform quality control on municipality and other local water supplies
- In collaboration with other sectors and partners, support health care facilities get adequate water supply
- Support health care facilities to improve medical waste management
- Supervise the hygiene and sanitation status of public facilities, food & catering services, congregation settings like prisons, and others

I. **EPHI/ PHEM:**

PHEM Regional office:

EPSA:

- Follow the stock status of basic essential and program drugs& supplies
- Monitor the utilization of program drugs following the implementation of

multi-month dispensing, analyze the stock request, consumption and distribution status

- Fast track essential commodities on procurement process, and place new orders for commodities urgently required
- Strengthen collaboration and information exchange with hubs, RHBs and facilities on sustained availability of program commodities, and provide prompt responses for requests,
- Report the stock status and logistics management of essential commodities to the committee led state minister weekly

J. **EPSA Hubs:**

- Improving communication with EPSA and facilities, Ensure Health care facilities are provided with the necessary program drugs and commodities
- Follow health care facilities to place timely orders and avoid unnecessary stock out/ overstock of commodities considering the multi-month dispensing for clients in context of covid-19 outbreak
- Place request to central EPSA timely to make commodities available for facility distribution
- Send report and Update EPSA on the essential drugs and commodities logistic management on weekly bases

K. **National Clinical advisory team**

- Develop and review essential guidelines, protocols, SOPs.,
- Analyze and Generate data for policy makers as a general guide
- Provide recommendation on identified gaps

2. Regional level

RHBs:

- Ensure core essential services are maintained with proper protection during COVID-19 outbreak,
- In collaboration with the COVID-19 task force, implement prevention and awareness creation for at risk groups attending the core essential services-
- In collaboration with PSA hubs, follow the sustained availability of essential program drugs and commodities at health care facilities,
- Report weekly on the performance of maintained essential services and related challenges encountered to MOH using the selected indicators,

A. Regional Health Bureau Deputy

- Chair the weekly meeting, provide guidance, follow the progress, approve reports which will be forwarded to MOH

B. Medical Services Process Owner

- Follow hospitals for the provision of General essential services
- Follow quality and standard of general essential services
- Collect report and send feedback to respective facilities

C. Disease Prevention and Control Process Owner

- Will be secretary
- Organize and lead, maintaining quality core communicable and non- communicable diseases service delivery, i.e., TBL, HIV, Malaria, Asthma, COPD, HTN, DM, Cancer

patients on treatment amidst the COVID19 outbreak

- Direction on multi-month provision (ARVs, NCDs, and appointments, 6 month and 3 months)
- Triage and protective measures at service point

- Follow, Mentor and Supervise zones and special woredas closely that these service provisions are maintained at health facilities and directory under zonal office department
- Collect weekly report, analyze and share report to the committee led by Task force
- Provide weekly feedback to zones

D. MCH Process Owner

Vice Chair:

- Triage and protective measures at service point
- Follow zones closely that these service provisions are maintained at health facilities
- Collect weekly report, analyze and share report to the committee led by task force
- Provide weekly feedback to zones

E. Public Relation

- In collaboration with relevant programs, develop and disseminate contextualized messages to prevent the acquisition/mitigation of consequences of COVID19 infection by clients and Health workers
- Provide update at official media regularly and when needed
- Equip hot line access for information and remote consultation

F. Regional Pharmaceutical and Medical Equipment Process Owner:

- In collaboration with PSA, monitor the logistic management of essential service commodities
- Facilitate the procurement of commodities to the extent of placing emergency orders for stock out commodities
- Facilitate the refill and requisition of commodities of essential commodities
- Update the stock status, procurement process of necessary commodities to the committee led by health bureau head weekly
- Provide weekly feedback

G. Regional Planning and Program Process Owner

- Issue guidance on weekly tracking of essential service availability at health facilities using DHIS II
- Monitor the provision of services using selected indicators
- Collect weekly report, analyze and report performance status of maintained essential services to the committee led by health bureau head
- Provide weekly feedback

H. Blood Bank Service

- Anticipate and mitigate the influence of COVID-19 outbreak on blood donation
- Closely follow the demand and availability of blood donation, minimize wastage and promote safe donation by minimizing the risk for donors
- Evaluate the blood donation status as per the plan set for the 39 donation

sites and expedite mitigation plan when challenges encountered

- Expedite the safe blood donation by implementing protective measures for donors and health care workers
- Regularly update the zonal blood banks for availability of adequate stock of blood
- Provide weekly feedback
- Review and approve report

I. Regional PSA Hubs:

- Improving communication with EPSA and facilities, Ensure Health care facilities are provided with the necessary program drugs and commodities
- Follow health care facilities to place timely orders and avoid unnecessary stock out/ overstock of commodities considering the multi-month dispensing for clients in context of covid-19 outbreak
- Place request to central EPSA timely to make commodities available for facility distribution
- Send report and Update EPSA on the essential drugs and commodities logistic management on weekly bases

J. Regional Clinical Advisory Team:

- Adopt, translate to local language and apply the essential guidelines, protocols, SOPs prepared by national clinical advisory team
- Analyze and Generate data for higher officials
- Provide recommendation on identified gaps

3. Zonal Level

A. Zonal Health Bureau Deputy:

- Chair the weekly meeting, provide guidance, follow the progress, approve reports which will be forwarded to RHB and provide direction on identified gaps

B. Medical Services Department

- Follow hospitals for the provision of General essential services
- Follow quality and standard of general essential services
- Collect report and send feedback to respective facilities

C. Disease Prevention and Department:

- Will be secretary
- Organize and lead, maintaining quality core communicable and non- communicable diseases service delivery, i.e., TBL, HIV, Malaria, Asthma, COPD, HTN, DM, Cancer patients on treatment amidst the COVID19 outbreak
  - Direction on multi-month provision (ARVs, NCDs, and appointments, 6 month and 3 months)
  - Triage and protective measures at service point
- Follow, Mentor and Supervise woredas closely that these service provisions are maintained at health facilities and directory under zonal office department
- Collect weekly report, analyze and share report to the committee led by Task force
- Provide weekly feedback to woredas

D. **MCH Department**

- Will be Vice chair and in addition
- Triage and protective measures at service point
- Follow woredas closely that these service provisions are maintained at health facilities and provide mentorship
- Collect weekly report, analyze and share report to the committee led by task force
- Provide weekly feedback to woredas

E. **Zonal PPME Department**

- Issue guidance on weekly tracking of essential service availability at health facilities using DHIS II
- Monitor the provision of services using selected indicators
- Collect weekly report, analyze and report performance status of maintained essential services to the committee led by health bureau head
- Provide weekly feedback

F. **Zonal Clinical Advisory Team**

- Adopt, translate to local language and apply the essential guidelines, protocols, SOPs prepared by national and regional clinical advisory team
- Analyze and Generate data for higher officials
- Provide recommendation on identified gaps

4. Woreda Level

A. **Woreda Health Bureau Deputy**

- Chair the weekly meeting, provide guidance, follow the progress, approve reports which will be forwarded to zonal health bureau and provide direction on identified gaps

B. **Medical Services Delegate**

- Follow health facilities for the provision of General essential services
- Follow quality and standard of general essential services
- Collect report and send feedback to respective facilities

C. **Disease Prevention and Control Representative**

- Will be secretary
- Organize and lead, maintaining quality core communicable and non- communicable diseases service delivery, i.e., TBL, HIV, Malaria, Asthma, COPD, HTN, DM, Cancer patients on treatment amidst the COVID19 outbreak,
  - Direction on multi-month provision (ARVs, NCDs, and appointments, 6 month and 3 months)
  - Triage and protective measures at service point
- Follow, Mentor and Supervise health facilities closely that these service provisions are maintained at health facilities and directory under zonal office department
- Collect weekly report, analyze and share report to the committee led by Task force
- Provide weekly feedback to health facilities under

D. **MCH Delegate**

- Will be Vice Chair
- Triage and protective measures at service point
- Follow health facilities closely that these service provisions are maintained at health facilities and provide mentorship
- Collect weekly report, analyze and share report to the committee led by task force
- Provide weekly feedback to health facilities

E. **Woreda Health Office Plan Officer**

- Issue guidance on weekly tracking of essential service availability at health facilities using DHIS II,
- Monitor the provision of services using selected indicators,
- Collect weekly report, analyze and report performance status of maintained essential services to the committee led by health bureau head.
- Provide weekly feedback

F. **Woreda Clinical Advisory Team**

- Adopt, translate to local language and apply the essential guidelines, protocols, SOPs prepared by national, regional and zonal clinical advisory team
- Analyze and Generate data for higher officials
- Provide recommendation on identified gaps

5. **Health facilities (Hospitals and HC) in all levels**

- All health facilities shall implement protective measures to prevent COVID-19 outbreak,
- Unless the health facility is closed for COVID-19 management, the facility shall prioritize essential service and maintain them at high protection mode,
- Notify the list of essential services available in the facility and the conditions to access them,
- The identified essential services continued in contest of COVID-19 outbreak
- Clarify risk communication map and share
- Plan to maintain essential service in all phases of COVID 19 and apply new initiatives
- Health facilities shall report performance of these essential service and any challenges encountered to the respective reporting line on weekly bases,
- The focal persons of the respective programs in the facility shall report the performance and major challenges to the facility CEO/head weekly,
- The CEO/ head of the facility shall report on the essential services to its respective reporting line (RHB/ZHD/ WHO) on twice weekly bases and implement directions passed from above in the reporting line.

6. Health post level

Health extension worker delegated for COVID-19

- Surveillance and gives awareness for the community members
- And other COVID-19 related activities
- Chair for health post task force

Health extension worker delegated for essential service

- Secretary for the task force
- Maintain the essential services

N.B. Reports should be summarized by specific team assigned to analyze data under Policy Planning Directorate

Table 1: Monitoring and Evaluation for Non-COVID 19 Health Services Governance

Indicators									
	Baseline	Wk 1	Wk 2	Wk 3	Wk 4	Wk 5	Wk 6	Wk 7	Data source
#of support mechanisms(guideline, financial, supply) implemented									Administrative
# of mentorship given									Administrative
# of constructive feedbacks									Administrative
# of reporting facilities									Administrative
# of administrative/corrective actions taken									Administrative

SECTION 3: PRIORITY ESSENTIAL SERVICES

As the case load of patients increase, health care workers may assume positions beyond their scope of practice. So due diligence and preparedness of facilities is needed by initially planning the mobilization of staffs and supplies from other units. It is also advisable to conduct drills on essential services.

Health bureaus and facilities should have their own essential service provision and outbreak response plan in aligned manner.

3.1. High Priority Health Facility Services

3.1.1. Emergency and other general services

I. Emergency and critical care

Pre-hospital Service: It is recommendable to prepare non-COVID-19 ambulance services for patients as the community may fear to board ambulances. We also recommend recruiting the red cross volunteers to act as paramedics following basic resuscitation training. In addition, public and private vehicles can be mobilized to give service for vulnerable groups (e.g. pregnant, children, elderly, disabled) volunteer with possible partial cost coverage to provide transportation to and from the health facilities.

- Facilities should maintain all types of emergency services 24/7
- Facilities should update non-COVID emergency referral plan and communicate to all catchments and stakeholders
- The facility should ensure availability of oxygen and means of respiratory support 24/7
- Ensure continuous and safe patient transportation

Effective patient flow: Pre-triage and Triaging

All clients that came to the facility should get pre-triaged and then sorted to fever clinic and regular service (essential service). Triaging is thus important in all facilities. The following should be ensured:

Entry point screening during pre-triaging would help minimize contact between probable COVID-19 and non COVID-19 cases. If possible, temporary structures outside the building could be set up to facilitate pre-triaging.

- All healthcare facilities should establish pre-triaging mechanisms for beneficiaries/patients visiting the facility
- All frontline health workers should be trained in protocols for COVID screening, isolation and pre-triage which are to be followed for anyone arriving with acute onset of cough, fever, and breathlessness within the last 14 days
- All service providers at peripheral facilities and frontline workers need to be vigilant and to report rise in cases of not only severe acute respiratory infections (SARIs), including pneumonia and influenza-like illnesses but also all fever cases, including dengue, TB, malaria, etc
- All frontline health care workers in these facilities should be trained in IPC and provided appropriate PPE for their protection as per the guidance. The PPE could be prioritized in areas/ clusters where suspected COVID patients are likely to report

II. Outpatient Services

- The facility should identify essential and non-essential services to manage which service types to cancel or postpone; communicate to relevant units
- The facility should consider tele consultation for stable patients where possible to limit OPD

visits; designated staff should be assigned and call center/ communication mechanism

- Facilities should implement pre-triage screening for patient
- Taking into consideration the back log of patients needing surgical intervention, we suggest to continue the service with 50% capacity for the following reasons:
- The number of surgical beds may reduce after instituting appropriate distance in between beds
- As surgeries consume PEP, oxygen, and emergency and sedative drugs needed in ICU for COVID-19 resources may not suffice to conduct the full service
- Since evidences show that intubations of COVID-19 affected patients have added risk to health professionals, we strongly recommend that all patients needing surgery be tested for SARS Corona 2 virus. Facilities are also advised to revise their list and prioritize patients based on their case proportions, risk of malignant transformation among other. This has to be transparently communicated to the community as well as regional health bureaus.

III. In-patient Services

- Facilities can consider transferring of stable in-patients to lower level facilities where capacity exists and is possible
- Vigilant to cross contamination and 1-meter distancing between beds
- Maintain sufficient beds for non-COVID-19

IV. Communication, Liaison, and Referral

- The facility should identify essential emergency and non-emergency health services that need to be maintained during the pandemic; communicate these and admission criteria to catchment network of facilities, and stakeholders including patient
- The facility should map referral networks and update them on revised plans
- The facility should post continued service at facility gates and other required areas
- The facility should work on awareness creation activities using different channels

V. Specialty/Sub-Specialty Services

- Specialty services should continue for all patients by providing required PPE materials

VI. Logistics and Supplies

- The facility should conduct inventory and re-forecasting of all essential supplies, commodities and pharmaceuticals

VII. Bio-medical maintenance

- The facility ensures a mechanism for the prompt maintenance and repair of the equipment required for the essential services

VIII. Diagnostics Services

- The facility should make inventory, forecasting and planning of supplies for diagnostic services of non-COVID essential services proactively
- The facility should assign adequate laboratory and other diagnostic personnel for non-COVID services

IX. Infection Prevention and Control

- The facility should assign 24/7 personnel needed for IP and waste management
- The facility should avail adequate amount of PPE including medical masks, N95 masks, and goggles, adequate amount of water, soap, and alcohol-based sanitizer and assess as per the guideline
- The facility should ensure more than 2-meter distance and 1-meter distance at every corner and at wards respectively

- Cleanness
- The facility should have a policy to limit visitors and attendants to reduce overcrowding and ensure visitors and attendants apply droplet and contact precautions

3.1.2 Reproductive, maternal, newborn, child and nutrition Routine Health Services

Maintaining the health of mothers, adolescents, children, infants, and Newborns is an essential part of the health sector, regardless of the current circumstances. Stakeholders are encouraged to engage adolescents and youths for the COVID -19 pandemic responses as they will promote solidarity and help bridge the gap between age groups Essential Maternal, Newborn and Child Health Services as well as diseases prevention services will be continued to be provided during the COVID-19 pandemic with adjustments indicated below. In providing services, patients should be advised as follows:

- Limit attendants to one person to accompany the patients during facility visit
- Keep physical distancing (put a mark with one meter apart) while waiting for the queue to get the service at the health facility
- To avoid case overload in one time (morning or afternoon), clearly appoint the number of clients coming for the service in the morning and afternoon time.

The essential RMNCH-N services that should continue at each health facilities during COVID-19 pandemic response include:

- Antenatal care
- Delivery and essential newborn care
- Postnatal care
- Emergency obstetric and newborn care (EmONC) services
- Comprehensive abortion care
- Family planning services
- PMTCT services
- Immunization services
- Child and newborn case management services
- Adolescent health services
- Nutrition services

I. Antenatal Care

- In the current context of our country, the service will continue on a regular basis as usual
- When the number of cases of COVID 19 is alarmingly increasing around the catchment area, by discussion with health care providers, extend date of appointments for pregnant mothers who do not have danger signs and pregnancy related problems. Use telephone to monitor mothers' conditions and also use the health extension workers to conduct antenatal care in worst case scenarios.
- Mothers with health problems will continue with their regular follow-up at all service delivery level.
- All pregnant mothers should have a Covid-19 screening during their follow-up

II. Delivery and newborn care

- To prevent maternal and newborn death, delivery and essential newborn care service will continue throughout the pandemic
- All laboring mothers should have a Covid-19 screening and managed accordingly as per COVID 19 protocol
- As much as possible all pregnant mothers shall give birth at a health center & if her condition demanding further cares, make a referral to a higher level with communication of hospitals.
- Continue essential newborn care at all delivery sites with necessary precautions
- Newborn intensive care will continue to be provided at hospital levels without interruption

- Community based newborn care at health post level and newborn management with IMNCI algorithm will continue without interruption

II. Postnatal care (PNC)

- Minimize the postnatal stay time in health facilites from the current 24 hours to at least 4-6 hours if both are stable
- Subsequent PNC visits should be at home visit by HEW unless the Mother and newborn have problem

III. Comprehensive abortion care

- Ensure service availability as per the technical and procedural guideline
- Consider self-care at least for urban and task sharing for L4HEWs and providing mentoring if possible

IV. Emergency obstetric and newborn care (EmONC) services

- At all health facilities, EmONC service will continue to provide lifesaving emergency services
- Any emergency conditions during ANC, delivery and postnatal period endangering the life of woman or her newborn will be provided emergency management as per the national protocol

V. Family planning service

- Educating the community on FP services through media and using all opportunities should continue strongly
- Family planning counseling & services provision will continue on a regular basis at PHCU (Primary hospitals, HCs health post)
- For short term contraceptives like pills, condom, etc. provide supplies for longer period (3-6 months)
- Provide FP counseling for long-term family planning services by ensuring full free informed choice, Provide emergency contraceptive pill for those in need with proper counseling
- Ensuring facility readiness with adequate FP commodities, supplies, PPE and IPC materials should continue
- As the Covid-19 pandemic continues to expand, health facilities (referral Hospitals) with high patient-load need to transfer routine FP services to health posts

VI. PMTCT services

- The essential services like ARV for HIV positive pregnant and lactating women, AZT+NVP prophylaxis and Cotrimoxazole and EID should be available and maintained as parts of essential services for all PMTCT clients and their infants.
- Test for HIV and syphilis for all pregnant women coming to health facility for ANC
- Access to ARV for all HIV positive pregnant and lactating women
- Strictly Monitoring the continuation of the NVP + AZT Prophylaxis and cotrimoxazole syrup for HEIs timely
- EID testing for HIV-exposed infants
- Viral load testing for HIV positive pregnant and lactating women

VII. Adolescent and Youth Health

- Maintain SRH information including HIV/STI prevention measures at all level
- Abortion and post abortion care including post abortion complications management at PHCU and hospitals should continue
- Clinical care for rape survivors including post exposure prophylaxis and HIV testing for adolescents should continue at all level
- Access to contraceptives for adolescents will continue with provision of supplies for longer period (3 to 6 months) for short term contraceptives

- Mental health and psychological support will continue for adolescents at all level including state of the art innovations such as online counseling

VIII. **Any emergency pregnant mother, child and newborn care services**

- Emergency services will continue to be available on a regular basis for pregnant, laboring and postnatal, child and newborn
- Comprehensive abortion care service
- SRH emergency like GBV

IX. **Immunization services**

- Vaccination service will continue to be regularly maintained at vaccination service delivery points
- Possibility of conducting measles/polio integrated campaign will be figured out and implemented during COVID19
- Monitoring VPDs surveillance on weekly basis in communication with EPHI
- Figuring out possibility of conducting Catch up campaigns to address missed vaccination service

X. **Child health services**

- All emergency child health services will continue at hospital level
- Pediatric intensive care unit services should continue at hospital level
- Integrated community case management at health post level and IMNCI at health center level will continue without interruption with more emphasis given to pneumonia case reassurance and differentiation with COVID 19

XI. **Nutrition**

- Nutrition services will continue to be regularly available at the health post and at the health center. (GMP, nutritional screening for under five children, pregnant and lactating women, vit A supplementation, IFA supplementation, acute malnutrition management, IYCF counseling)
- At a hospital level complicated Sever acute malnutrition management and IYCF counseling will continue
- Continue collaboration with other sectors for productive safety net program, one wash and agriculture sectors. Generally, strengthen the multi sectoral nutrition, coordination and linkage at all level
- Maintain nutrition communication and advocacy at all level

3.1.3 Essential Health Services for the Prevention and Control of Communicable and Non-communicable Diseases

Major infectious diseases like malaria, TB, other respiratory tract infections as well as asthma have got similar clinical symptoms with COVID-19. This requires proper patient evaluations for the detection of the right diagnosis.

It is known that patients with underlying HIV, underlying lung damages due to TB and COPD/Asthma, and Diabetes are more vulnerable to COVID-19 disease severity as well as mortality due to their weakened immune system. Health Facilities with high patient loads should therefore ensure that adequate patient waiting areas with proper set up for physical spacing to minimize the transmission risk to their patients.

I. **ART clinic service**

HIV patients are going to be more susceptible to opportunistic infections and would be at considerable risk if they are exposed to Covid-19. Considering this, maintain HIV/AIDS care & antiretroviral therapy to be regularly available and ensure facilities providing prevention of mother-to-child transmission of HIV need to be strengthened.

Steps to be taken by to health facilities offering ART & PMTCT services:

- Provide 6 Months' Multi-month Dispensing (6MMD) for patients eligible for Appointment spacing model
- Provide 3 Months Multi-month Dispensing (3MMD) for: PMTCT, Pediatrics, newly identified clients, Clients on second line ART and Those unstable clients with HVL and on EAC that doesn't seek admission
- Encourage HIV exposed infants (born of HIV-infected mothers) to take their medication (combined ARV prophylaxis & cotrimoxazole) every three months with their mothers
- Considering family-based refill (if there are more than one family member on ART, one of them can collect for all the other family members on treatment) but the index case should contact ART provider through phone call)
- Ensure all Clients are given the Health Facility (HF) phone number (ART Clinic phone number should be clearly displayed) so that clients can easily contact the HF e.g. to plan for collection/delivery of medication

II. TB and leprosy

- Encourage identification of more TB treatment supporters at community levels to enhance TB treatment adherence
- Provide Support to TB and Leprosy patients to continue their treatment and prevent treatment interruption related health issues (high mortality, occurrence and further spread of drug resistance) through strengthening community based TBL Prevention and care activities
- Drug susceptible TB patients having their TB treatment follow ups at hospital DS-TB Clinics should be linked to nearby health centers immediately for treatment continuation in order to reduce TB patients' higher vulnerability to COVID-19 infection and severe conditions
- All RR/MDR-TB Treatment Initiation Centers and Leprosy Referral Care centers should continue to provide their RR/MDR-TB and Leprosy referral care services without any interruptions
- DR-TB care and treatment at all TICs will continue their routine services as usual. Monthly medicine pickup and treatment monitoring will applicable to DR-TB patients until further notice. If public transport option interrupted, TICs in collaboration with local government and partners including red-cross should arrange transport for DR-TB patients to bring and send back to ensure adherence and laboratory monitoring. DR-TB patients who are receiving injection should continue their daily injection as per PMDT guideline.
- Ensure that all health facilities have TB &leprosy medicines and lab supplies sufficient for about 2-4 months
- Arrangement should be in place to ensure RR/MDR-TB Patients transport from TFCs to TICs for regular monthly clinical and laboratory follow ups
- Ensure that all health institutions continue to provide TB diagnostic services without interruption
- Ensure continued provision of therapeutic feeding services for TB/DR-TB patients requiring the intervention per the national policy

To minimize TBL frequent Health Facility Visits

- If TB patients have to stay at home for a certain period of time due to COVID-19 epidemic, NTP recommends that TB clinic officers should provide one-month adequate dose of anti TB medicines for patients either intensive or continuous phase for TB patients. So monthly medicine pick-up of medicine and treatment monitoring will continue until further notice.

- Provide at least a one-month supply of TB medicines for patients to continue taking their medications at home with treatment supporters
- Facilitate a situation in which a family member / guardian is to be able to collect their TBL medications from the health facility
- Follow-up treatment continuation through Health Extension Worker &TB Treatment Supporter (TTS) as well as telephone call monitoring.
- Provide professional follow up and advices over the phone

III. Malaria

One of the symptoms of malaria is fever, which is similar to the symptoms of COVID-19, which can lead patients to mistaken suspicion. If malaria patients are not treated timely, it can lead to serious illness and death.

- Diagnosis of all people with fever for malaria and provide treatment service as per the national guideline
- Make sure that severe malaria cases are still getting service at Health center and Hospital
- Make sure essential anti-malaria commodities are available at health facility level
- Monitor the situation of malaria on weekly basis and submit weekly situational report to the next level
- Follow up according to the malaria outbreak tracking form on weekly basis

IV. Non-communicable diseases

A. High blood pressure, heart disease, diabetes, Chronic respiratory Diseases (Asthma &COPD)

Since the COVID-19 disease makes patients with Hypertension, Cardiovascular disorders, Diabetes, COPD and Asthma highly vulnerable, the provision of the required health care must be provided to these patients without interruptions along with adequate supply of medicines and medical counseling services.

- For patients with complications due to these NCDs, it is essential to maintain access to specialized care at health facilities

To minimize patient follow-up

- Providing one to three months of medication for patients with NCD related complex medical conditions according to the patient's condition.
- Provide professional follow-up and advice over the phone.
- Advice on a healthy diet and lifestyle

B. Cancer

Cancer treatment is one of the essential health services that should not be interrupted, and therefore, the existing few cancer treatment facilities must continue to provide services without interruption.

- Attention should be given to the continued provision of cancer care services for children and adults without interruption to prevent progression of disease.
- This also applies to facilities that provide cervical cancer screening and treatment services

3.1.4 Ensuring the blood supply safety during COVID 19

To reduce the impact of the COVID 19 on the blood supply and safety the following will be the major strategies to be implemented:

- Ensure the Health and safety of blood donor and blood bank staff
- Mitigate the risk to the blood supply and availability
- Monitor blood demand and supply and reduce wastage
- Mitigate the risk to the availability of critical supplies
- Mitigate the potential risk of transmission through blood transfusion

The following major activities will be carried out to achieve these objectives:

- Monitor the blood demand and implement systems to proactively reduce shortages
- Implement arrangements to reduce the impact of reduced availability of blood donors and blood bank staff
- Reduce the risk of blood donors and blood bank staff exposure to covid19 in collaboration with MOH and Implement infection prevention action and ensure the availability of necessary PPE
- Revised blood donor deferral criteria based on WHO recommendations
- Implement communication strategies for blood donors, regional blood banks and improve appropriate use of blood in health facilities
- Ensure the availability of critical supplies for the blood transfusion service with MOH
- Educate the community on the mechanisms to prevent and control the spread of COVID-19

3.2 Hygiene and Environmental Health

Hygiene and environmental health include water quality control, hygiene promotion, basic sanitation and waste management at community and institutions level.

3.2.1 Drinking Water quality control

Major Activities

- Conduct drinking water sanitary survey and water testing in priority and hotspot areas and categorize based on WHO quality index
- Recommend based on the result
- Avail water treatment chemicals for drinking water from source to consumption at hotspot areas based on the Ethiopian compulsory water quality treatment requirements for water systems. These prevents waterborne pathogens contaminating drinking water including chemical disinfection, solar disinfection and filtration
- Promote safe drinking water handling and storage

3.2.2 Strengthen Health care facilities and other institutions WASH

Major activities

- Ensure availability of sufficient quality and quantity of water at health facilities through maintenance and rehabilitation. Woreda health offices will facilitate these activities by working with the respective local government and the woreda/town water office
- Provide and ensure of optimal and adequate sanitation facilities at health facility through provision/maintenance including construction of waste disposal pits (liquid and solid waste seepage pit) and construction/maintenance of toilets in coordination with other sector offices in woredas and with municipalities and water utilities in towns
- Support government and other public institutions to avail basic WaSH service like water, latrine, and hygiene services
- Ensure proper infection prevention practices at all health institutions
- Monitor and make functional HCFs waste management system

3.2.3 Strengthen Community basic sanitation

Major activities

- Ensure the availability of basic sanitation facility at community level
- Ensure proper waste management at community level
- Strengthen awareness creation activities on hand hygiene, waste management, food hygiene with the due consideration of bringing

all stakeholders onboard and maximize the existing efforts of the health system to the level required to avoid the risk of having double public health burdens

3.2.4 Basic hygiene promotion services

Major activities

- Proper hand washing practices both at household and institutions
- Facilitate the availability of hand washing facility and detergents
- Create awareness on proper utilization of PPE like mask, glove, gown, goggle
- Safe disposal of wastes
- Promote safe social distancing

3.3 Special support regions non- COVID -19 health activities

I. Strengthen Leadership Management and Governance/LMG

Major activities

- Strengthen technical supports and follow ups through assigned TAs at special support regions at regional, zonal/woredas and facility level while in equity zones woredas at woredas health office and facilities level.
- Strengthen capacity for health managers at woredas and facilities through conducting coaching for post leadership training on DMR/ desirable measurable results and guide and support technically.
- Strengthen health management committee by monitoring and supporting technically to weekly conduct regular meeting to track challenges for essential health services and help to guide and set appropriate directions

II. Strengthen Health Information Systems

Major activities

- Strengthen established performance monitoring teams to evaluate reports completeness and timeliness monthly at regional, zonal/ woredas and health facilities level.
- Supporting technically for health facilities to conduct LQAS for data quality validation of monthly report.

III. Strengthen Health Service Delivery

Major activities

- Strengthen maternal and child health programs technically through monitoring and evaluations of performances
- Strengthens and follow nutrition services provisions at facilities level
- Strengthen disease prevention and control programs (TB, HIV, Malaria)

IV. Strengthen Health Care Finances

Major activities

- Support technically for health facilities implements health care finance to utilize budgets for drugs and supplies
- Strengthen governing boards to conduct regular meetings and set directions on the essential health service
- Conducting integrated supportive supervisions for the health facilities on HCF and health service deliveries performances

SECTION 4: HEALTH SYSTEM AND FACILITY PREPAREDNESS TO MAINTAIN ESSENTIAL SERVICES

Facility disaster planning and preparedness

Planning for any type of disaster consists of common elements. A facility disaster planning group is responsible for generating the facility emergency operations plan. Include a diverse membership of facility employees and decision makers. Planning should include and align with COVID 19 response and maintaining essential services.

4.1 Components of facility disaster plan

Components of the disaster plan include

1. Hazard vulnerability analysis
2. Joint facility member
3. Facility–community coordination,
4. Integration with national response assets and other stakeholders
5. Training and disaster drills

4.1.1 Hazard vulnerability analysis

What is/are most likely other system may be affected during outbreak?

Used to prioritize planning efforts because different challenges are characterized by different morbidity and mortality patterns and different effect at different facility

Develop specific plans (for radiation, explosions, mass casualties, decontamination and outbreaks) based on an assessment of the potential disasters in the area as well as study of the events that would cause the most disruption to the health facility and system.

4.1.2 Joint facility member (JFM)

Joint Facility member is collection of facilities' collaborates to respond for disaster based on memorandum of understanding. It could be government to government, region to region or facility to facility. Number of member facilities is based on their interest. It should not only be limited to outbreak but for other essential health service and need.

Requirements;

A written plan for the timely care of outbreak as well as maintaining essential services, regarding, human resource, drugs equipment etc. should be readily available.

4.1.3 Facility to community coordination

Since the community is the primary stakeholder, the plan should include all phases of outbreak preparation mitigation risk reduction response and recovery

4.1.4 Integration with national response assets

During a response, these community agencies (Police service red cross society traffic police command post national emergency management agency, MOH) play pivotal roles

4.1.5 Training and disaster drills

Regular training and disaster and essential services drills familiarize staff with their disaster roles and responsibilities and identify weaknesses in the plan that requires revisions.

Drills can range from full-scale, community-wide simulations, with use of makeup or theater techniques to represent injuries, to tabletop triage scenarios, mini-drills that test only certain components of the disaster plan (such as call-up of personnel), and tests of communications. The scenarios should reflect incidents that are most likely to occur in the community as determined by the hazard vulnerability analysis. It has to include how to maintain essential service.

4.2 Facility Planning Group

4.2.1 Public safety and security, crowd control, and facility access control

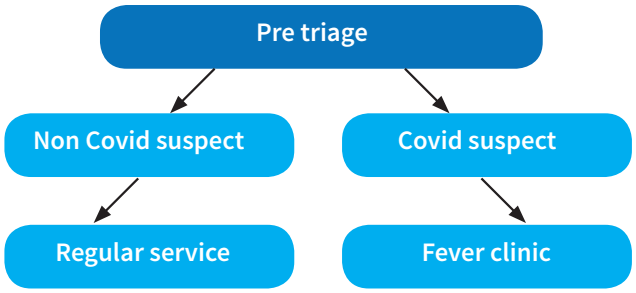


Figure 2: Patient flow

- All clients into facility should get pre-triaged and sorted to fever clinic and regular service / essential service

Triaging is thus important in all facilities. The following should be ensured:

- Entry point screening during pre-triaging would help minimize contact between probable COVID-19 and non COVID-19 cases. If possible, temporary structures outside the building could be set up to facilitate pre-triaging.
- All healthcare facilities should establish pre-triaging mechanisms for beneficiaries/patients visiting the facility.
- All frontline health workers should be trained in protocols for COVID-19 screening, isolation and pre-triage which are to be followed for anyone arriving with acute onset of cough, fever, and breathlessness within the last 14 days.
- All service providers at peripheral facilities and frontline workers need to be vigilant and to report rise in cases of not only severe acute respiratory infections (SARIs), including pneumonia and influenza-like illnesses but also all fever cases, including dengue, TB, malaria, etc.
- All frontline health care workers in these facilities should be trained in IPC and provided appropriate PPE for their protection as per the guidance. The PPE could be prioritized in areas/ clusters where suspected COVID-19 patients are likely to report.

Facilities/engineering: Evaluate structural damage and advice on stability of facilities

Logistics/equipment supply: Evaluate structural damage and advice on stability of facilities

Pharmacy: Provide pharmaceuticals

Transportation: Assist with patient and staff transport

Clinical fields: Wide array of clinical fields should be represented, including representatives from the ED, primary specialties (internal medicine, family medicine, pediatrics), and surgical specialties

Media/public relations: Act as single point of contact for media; liaise between media and clinical areas, emergency operations center, and other facility resources

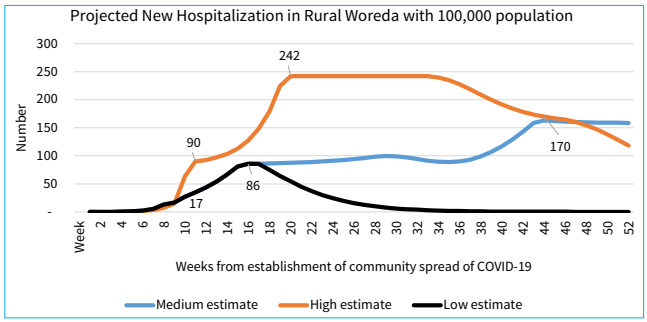
Communications officer: Coordinate communication to employees during a disaster through e-mail, Web site, paging groups, phone, or social media

Nonclinical patient care: Housekeeping and food services

Safety officer: Determine and ensure safe practices for employees as well as patients

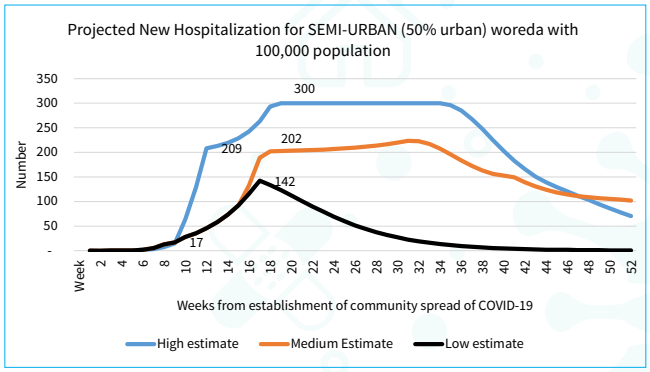
Infection control officer: Prepare for and respond to infectious disease emergencies.

Figure 3: Projections for new hospitalization per week in rural areas



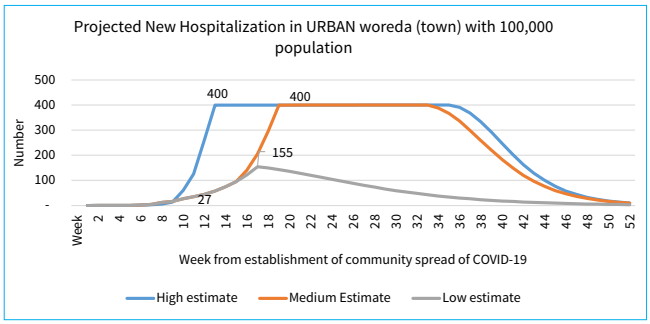
- Weekly new admission could rise to 17/100,000 pop in about 10 weeks
- At peak 86-242 new weekly admission/100,000 pop at 16 weeks and 20 weeks
- High demand for new admission can continue for a long time in medium and high projections.

Figure 4: Projections for new hospitalization per week in semi-urban areas



- Weekly new admission could rise to 17/100,000 pop in about 10 weeks
- At peak 86 - 242 new weekly admission/100,000 pop at 16 weeks and 20 weeks
- High demand for new admission can continue for a long time in medium and high projections.

Figure 5: Projections for new hospitalization per week in urban areas



- Weekly new admission could rise to 17/100,000 pop in about 10 weeks
- At peak new weekly admission/100,000 pop can be 142 at week 16 (low), 202 at week 18 (medium) and 300 at week 20 (high); high demand can start at week 12 in high scenario
- High demand for new admission can continue for about 20-25 weeks in medium and high projections.

Summary

Demand for new hospitalization grows quite rapidly once community spread is established.

The proportion of beds to be reserved for COVID-19 should be calculated as follows:

Number of beds needed for the 1st 10 weeks/ Total number of beds X [2 or 3] for length of hospital stay

- Preparation must be completed to rapidly expand beds for COVID-19
- Consider staffing, PPE, medications, supplies, oxygen
- Non-COVID-19 services can continue until community spread of COVID-19 is established.

Prepare for the worst scenario, but absolutely for at least the medium projections.

Table 2: Estimation of health facilities preparedness at the time of COVID-19

Establishment of community transmission of COVID-19	Urban duration in weeks	Semi-urban duration in weeks	Rural duration in weeks	Urban/semi-urban Non-COVID-19 to COVID-19 proportion	Rural Non-COVID-19 to COVID-19 proportion *
Before community establishment	TBD***	TBD	TBD	70/30-%	80/20%
After community	14 weeks	16 weeks	18 weeks	50/50%	50/50%
Peak	14-38 weeks	16-42 weeks	18-44 weeks	30/70%	40/60%
overlap periods (weeks)	4 weeks	4 weeks	4weeks	30/70%	40/60%
Recovery phase	42- weeks ** to Seven months	46-weeks to Seven months	48-weeks to Seven months	70/30%	70/30%

Table description:

1) Before community transmission / Phase 1- duration of this phase is unknown it is primarily preparation phase. During this period facility and health system can delegate up to 30% of their activity and resource to COVID response and the rest will be => 70% will be invested for essential services.

   To maximize the basic essential service to full capacity facility and health system administration should plan and apply new initiative to maintain essential service full capacity.

2) After community transmission/ Phase 2- the phase from community transmission to peak will stay for 14 weeks in Urban, 16 weeks in semi urban and 18 weeks in rural areas according to medium estimation model. During this period facilities, health system and all level will delegate activity and resource to 50% COVID VS essential service to maximize essential service into its full capacity leaders in different level should apply new approaches i.e, Tele health.

3) During COVID 19 Peak phase - this is most over whelming phase of all phases. The effect of COVID is very significant in this stage. It is going to stay on peak for 24 weeks in urban, 26 weeks in Semi urban and 26 weeks in rural areas. At this stage the proportion to non COVID to COVID service will be 30/70% in urban to semi urban area. While in rural areas, it will be 40/60%. During this period the essential service will be significantly affected. To maintain the essential service into full capacity leaders in health facility and system should compensate the rest 70% by developing new initiatives.

   N.B – peak to recovery transition will take 4 weeks overlap on every level so at this time leaders should use this period as a good opportunity to plan for recovery phase.

4) Recovery phase the proportion to non COVID to COVID response will be 70/30% has need seven months stocks to prevent any second wave of infections *Health facilities out of major town and cities, **Overlap periods (weeks), *** announcement will be given by MOH. This is a period where there will shift in Governmental focus to other sectors. And this is the period where the anticipated financial decline in the health sector will occur. The health sector should plan for their financial crisis.

   N.B- this projection model has limitation on exact prediction and only would be used for planning.

4.2.2 Facility Planning Group joint activities

The group should meet on a regular basis in a frequent manner:

- To assess hazards
- Develop and update short- and long-term disaster plans
- plan exercises and training
- Redesign the disaster plan based on evaluations of exercises and real events

SECTION 5: NEW APPROACHES TO DELIVER ESSENTIAL SERVICE

In order to optimize essential services delivery during COVID-19 outbreak and hence respond to the unnecessary compromise of these services during the outbreak, there is a need to rearrange and make changes to methods of service delivery of these essential health services, repurpose some of the physical spaces to meet the demand and use appropriate technologies as required. The following strategies will help to strengthen essential services:

1. Making both emergency and non-emergency essential health service available after working hours
2. Include and upgrade facilities like health centers with less client burden before the outbreak; to refer clients for some essential services from highly burdened health facilities
3. Introduce tele-health
4. For those on routine care follow up for chronic health condition extend the appointment time
5. Provide some of the essential services using outreach by deploying health care providers house to house
6. Mobilize human resources and supplies to places where these services are more compromised over the past weeks and months due to COVID-19 to avert the potential epidemic outbreak in these areas
7. Trace those who lost to follow up from the registry and include them in the tele-health services
8. Promote the availability of the essential services in all facilities by the federal and regional task force to the public by all means available
9. Introduce monitoring and evaluation tool
10. Appropriate PPE for professionals with potential exposure to COVID-19
11. Optimize blood and blood product supply for regular services including delivery and operating room
12. Make COVID-19 testing and isolation facility for all suspected cases while delivering essential services with the aim of early identification of COVID-19 and relieving health care providers from anxiety

SECTION 6: RESOURCE MOBLIZATION

6.1 Resource mobilization

Resource mobilization is critical for the following reasons: *Programmatic, Institutional and Financial sustainability.* The availability of funds for health is a fundamental question for all countries, including Ethiopia; in this particular time of pandemic, Ministry of Health cannot implement measures to increase funding by its own, but it is the responsibility to try to influence the rest of the government. This calls for more and better dialogue between the health policy makers and those that control public spending - the ministries of finance and the wider political actors and institutions (such as the parliament and the heads of state).

For Ethiopia, the challenge is to increase the funding available for health so able to provide and make accessible the needed set of health services of sufficient quality - namely treatment, prevention, promotion and rehabilitation.

Ethiopia is still under the levels of health expenditure that been defined as critical minimums for providing at least a minimal set of health services. Thus, the MoH should mobilize resources and repurposing any available resource to run the essential health services in this particular time of COVID 19 epidemic; to restart essential health care service PPE should be available to all health care providers as follows;

Pharmaceutical supplies

EPSA should reorganize to respond the emergency and should stock pile all essential medicines through:

- Do all country wide rapid inventory
- Waive International procurement
- Collect all the essential medicines from private pharmaceutical companies
- Order pharmaceutical companies to produce more and focus on essential medicines
- Collect and predict from pharmacies (private/ public) all the essential drugs and medicines across the country

Societies/ Faith based organizations/ professional associations/ self-help community associations etc…

- Engage all to contribute and discharge their duties with accountabilities

Local and international NGOs

Map and find out all INGOs/LNGOs capacity and in what level they can respond and repurpose and give responsibilities to fight the pandemic with accountability; waive any policies that may hinder to respond.

International Donors

Even with substantial increases in domestic health expenditure, increased external financial flows is necessary for many reasons to Ethiopia for a considerable period. Development partners can raise more funds to channel in innovative ways, but they should also focus on providing more predictable, harmonized and long-term aid flows to run the public health service like Immunization, MCH and other essential health services.

Diasporas

Despite technical support on remote basis let them to engage on to collect medicine and medical equipment, mobilize fund raising campaign.

Transport associations

Engage all type of transport associations for emergency response with only cost recovery

- Taxis/ three-wheeler/mini-bus and mid-bus should be assigned to transport any pregnant mothers to and fro for a nearby health facilities and also
- Government vehicles should transport all health workers
- Bus, Trucks and lories to transport logistics across the country

Mobilization of health supplies through PPE

All private health facilities to support the COVID-19 response need to repurpose and engage at all level of health care.

Build Financial capacity through: -

- Repurpose 15% sure tax for COVID-19 response. (may need legislation)
- Call individual philanthropies to contribute
- Create hotline or chip 5' cent per call from mobile subscribers. (may need legislation)

6.2 Rapid re-distribution of health workforce capacity, including re-assignment and task shifting

Nationwide outbreak is a situation where essential services including life-saving health services are disrupted and all healthcare resources including essential supplies and health manpower are re-prioritized and re-directed towards reducing deaths from a crisis of the magnitude. While there is a need to fight with this virus on all fronts, we also need to ensure that essential health services having direct impact on health and saving lives are also maintained even during a crisis of this scale and a well-organized health system has the capacity to maintain equitable access to essential service delivery throughout an emergency, limiting direct mortality and avoiding elevated indirect mortality.

Due to the current situation of COVID-19 where caseloads are increasing and the pressure is mounting on the health systems, the capacity to maintain routine service delivery in addition to managing increased demand for COVID-19 patient care need to be maintained at any cost to protect the health gains achieved over the year. Therefore, MOH should maintain these services through strategic shifts ensuring efficiency in this resource limited situation for the population.

The combination of increased workload and reduced number of health workers is expected to pose a severe strain on the capacity to maintain essential services.

Taking in to account the current situation of COVID-19 in our country, there is no any supporting evidence which will force us to disrupt the health services in the our hospitals specially in the tertiary centers across the country. Rather, these hospitals should allocate human resource and mix to the dedicated COVID-19 treatments centers based on the proposed health facility readiness scenario and resume delivering essential services to the public considering there geography and area of specialty. These predictable challenges should be offset through a combination of strategies.

- Critical support measures include, ensuring appropriate working hours and enforced rest periods, providing guidance, training and supplies to limit health worker exposures
- Health workers in high-risk categories for complications of COVID-19 may need to be reassigned to tasks that reduce risk of exposure
- Mechanisms to identify additional health workforce capacity includes:
    - Request part-time staff to expand hours and full-time staff to work remunerated overtime
    - Re-assign staff from non-affected areas (ensuring alignment of clinical indemnity arrangements where necessary)

  - Utilize registration and certification records to identify additional qualified workers, including licensed retirees and trainees for appropriate supervised roles
  - Mobilize non-governmental, military, Red Cross/Crescent, and private sector health workforce capacity, including through temporary deployment to the public sector where relevant
- Where appropriate, consider establishing pathways for accelerated training and early certification of medical, nursing, and other key trainee groups, ensuring supportive supervision
- Identify high-impact clinical interventions for which rapid training would facilitate safe task sharing, and consider expansion of scopes of practice where possible
- Utilize web-based platforms to provide key trainings (e.g., on management of time-sensitive conditions and common undifferentiated presentations in frontline care), clinical decision support and direct clinical services where appropriate
- Formalize organized lay provider systems (such as Community First Aid Responders, Red Cross/Crescent volunteers)
- Train and repurpose government and other workers from non-health sectors to support functions in health facilities (administration, maintenance, catering, etc.)
- Give tasks for teachers and university students for advocacy and filling gaps for documentations and other necessary tasks as needed
- Increase home-based service support by appropriately trained, remunerated and supplied community health workers
- Increase capacity of informal care givers for home care support such as family, friends, and neighbors

Key Points

- Map health worker requirements (including critical tasks and time expenditures) in the four COVID-19 transmission scenarios
- Maximize occupational health and staff safety measures in all categories listed above
- Create a roadmap for phased implementation of the strategies above for timely scale-up
- Allocate finances for timely payment of salaries, overtime, sick leave, and incentives or hazard pay, including for temporary workers
- Initiate rapid training mechanisms and job aids for key capacities, including diagnosis, triage, clinical management, and essential infection prevention and control

SECTION 7: COMMUNICATION

To enables stakeholders and partners to provide input and agree upon the best way forward so that actions are unified and agreed-upon communication activities also partners have a map where they can refer to through the various program.

Communications Approaches:

This communication strategy and implementation plan outlines the overall approaches to engaging and streamlining the communication of health staffs and the community at large to equip them and deal with the external stakeholders in an effective way while also interacting with their counterpart within the MOH.

MOH will lead the role and undertake the mandate given by the Council of Ministers Regulations No. 4/1992, to prime and organize all the communication materials, media briefing, and content of messages to federal and regional health bureaus with common channels (**Interpersonal**, **Community-based**, **Mass media and Digital and social media**) and reach the population. This will remove confusion and unnecessary information and helps to monitor resource allocation and fill gaps. It is effective to use a variety of channels, keeping in mind that there is no one perfect channel and each communication channels will best reach the population. All health facilities governed by Federal, Regional, Woredas, and Kebele (Referral Hospitals, R. Hospitals, Health Centers, and health posts) should provide service per recommendation of this guideline.

This communication strategy and implementation plan outlines the overall approaches to engaging and streamlining the communication of health staffs and the community at large to equip them and deal with the external stakeholders in an effective way while also interacting with their counterpart within the MOH.

MOH should, prepare, and emphasize on essential health service key messages through mainstream media, social media broadcasting, and entertaining format.

Key Messages:

MCH (Pediatrics service, Routine Vaccination) Nutrition and Maternal Health including ANC, PNC, delivery and CAC) TB/HIV and all other services are running in full capacity as well chronic illness and emergency services.

1. USE the COVID task force through the prime miser office press secretaries.
2. Use flagship TV program and prime times to advocate the existence and continuations of essential health services.
3. Use social networks to disseminate information by Identifying key persons, societies, professional associations, public figures who can advocate for in their networks.
4. Engage regional and Woreda health bureau to mobilize health workers and Health extension workers to aware and sensitize the need and existence of EHS.

Table 3: Outlets and deliverables

Tools	Activities
Mainstream media campaign	Develop TV serials Channels Produce and air TV spots supporting drama
Community Channels (Support channels)	Train folk drama troupes Conduct community folk dramas
Community mobilizations (support channels)	Develop community discussion guides Hold community viewing groups Advocate for support from elderly peoples
Publication (support channels)	Produce print materials for community discussion Develop Bus hoardings
Social media	Create pages and regular update

SECTION 8: SURVEILLANCE

Surveillance of traditional outbreaks during COVID-19 response

- Public health surveillance is key element to detect outbreaks in general population or specific groups like children. This ensures early response and brings into control of public health emergency, and by so doing it minimizes the health and socioeconomic consequences
- A pandemic like COVID-19 masks routine surveillance and may contribute to a larger scale morbidity and mortality. Furthermore, some infectious disease outbreaks like measles and yellow fever have overlapping symptoms, and clear case definitions should be designed to detect them
- To lessen this effect and make the system resilient careful planning, coordination of stakeholders, effect surveillances of routine problems without any interruption and careful monitoring is needed
- Hence, it is expected that EPHI will continue the surveillance of outbreaks with public emergency scale as usual. The fear is COVID-19 preparedness and response is huge task and may overwhelm it. Hence, EPHI should conduct immediate internal assessment and see if it is organizationally capable of conducting this task without interruption
- Should EPHI is overwhelmed by the pandemic MOH and other relevant partners should assist it or establish a temporary team that can conduct surveillance on other important issues

SECTION 9: ENFORCEMNT

Enforcement of the responsibilities in this document during the period of COVID-19 outbreak

Many epidemics in the past have left nations with broken health system. It took them long time and outside support to bring the health system back to where it was. Similar fragility is being observed in our health system. If it is not corrected early and appropriate measures are taken, we will definitely face similar system break down. Therefore, it is mandatory to enforce recommendations in this document to save unnecessary loss of life of citizens and future system breakdown. All stakeholders at all level of the COVID-19 Task force hierarchy in the administrative ladder starting from the health extension worker at health post to the Prime Minster Office are expected to enforce this document.

1. All health professionals at public, non-governmental and private institutions should be available at their regular workplace during working hours and according to their schedule during off working hours. The Human Resource department of each health facility will make regular report to responsible office if there are absenteeism without good reason. The authority may revoke license of health professionals who is absent from duty station during the period of the epidemic for no good reason.
2. The responsible authority in a health institution should publicly announce that the institution is open 24/7 as usual and no change on the usual services. Any announcement by any form or means of communication stating that the institution is not delivering the usual service is punishable.
3. Failure to report activities of an institution regularly as recommended in this document during the period of the outbreak amounts to participation in breaking the health system and is punishable.
4. Failure to make the necessary supplies available at all levels of the health care system, unless in case of force majeure is punishable. This includes failure to request timely, holding back pharmaceuticals and health care supplies, misusing supplies, etc.
5. False rumors about the safety and availability of essential health services in health institutions during period of COVID- 19 pandemic is punishable. When it is intentional, the punishment may be more than administrative.

SECTION 10: MONITORING AND EVALUATION OF ESSENTIAL HEALTH SERVICES DURING COVID 19 PANDEMIC

During a public health emergency like COVID-19, monitoring essential health services in a weekly basis is very imperative. This could be achieved through identifying good tracer indicators that serves as a litmus for the comprehensive routine health services in all the facilities. To this regard, the MOH has identified key and few indicators that will be monitored weekly with a strong intension not to affect the routine Health Management Information System. Therefore, the data elements, recording and reporting activities on our routine DHIS2 system will remain as it is. This will create a good opportunity to strengthen the routine HMIS anticipating greater quality of data and report completeness on DHIS through weekly monitoring of these tracer indicators. Moreover, facilities might also use this opportunity to activate and strengthen their PMT.

Data source and reporting system

Data Source: This refers to the actual sources of the specific data element. This include tallies, registers, PHEM and admin reports.

Reporting System: It is known that DHIS2 is the ultimate reporting system that our health system is using, and it is monthly. However, for this specific purpose, these selected indicators are expected to be reported and monitored weekly. Therefore, this reporting system is basically considered as a command post reporting system.

About the tracer indicators

The selected tracer indicators to monitor the essential health service in a weekly basis are generally categorized in to four based on the reporting mechanism.

PHEM: These are data elements to be drawn from the weekly PHEM report.

Command Post: These data elements are those which were being reported though DHIS2 in a monthly basis. However, for this specific purpose these indicators will be reported weekly through command post reporting mechanism.

Admin Indicators: Admin indicators are those data elements that are expected to be reported by Woreda Health Offices and above. These includes reports about the functionality of HPs and HCs.

Blood Bank Indicators: these are reports from National Blood Bank and will be reviewed nationally.

Reporting Period

The reporting period for the selected weekly essential health service monitoring indicators will be in line with the PHEM reporting period. Therefore, PHEM reporting calendar will be used.

i.e. One-week report includes Monday – Sunday of that specific week.

Reporting date

Right after the completion of the reporting period, the selected data elements will be collected using the weekly reporting format (Annexed) on Monday of the immediate week. The report should be completed and sent to the next level on the same day of report compilation. (i.e. Monday)

Regional aggregate report must reach to the MOH by Tuesday morning.

E.g. If the reporting period is May 4 – 10, 2020. The weekly report will be compiled and reported on Monday, May 11th, 2020. Then the report will reach to MOH on Tuesday morning, May 12th, 2020.

Reporting Format

A standard excel template designed based on the selected indicators will be shared to all facilities, Woreda Health Offices, Zonal Health Departments and Regional Health Bureaus.

Data flow

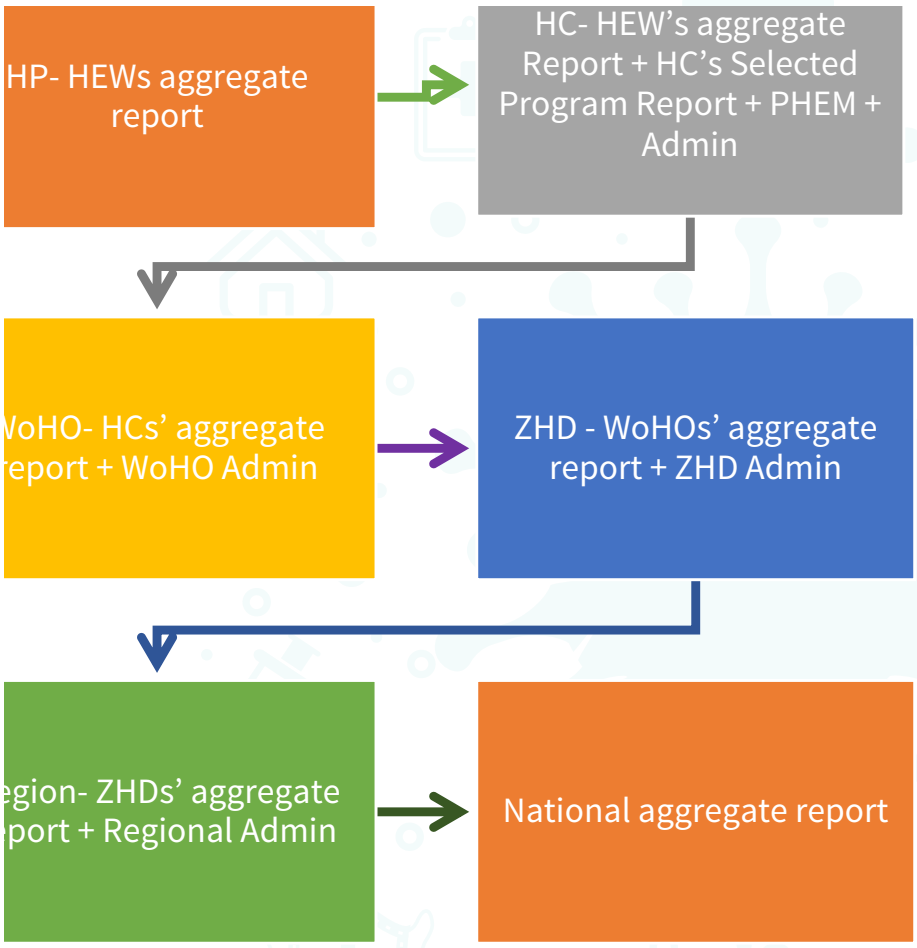
The selected indicators for this purpose will be collected and reported to the next administration level. Since most of the data elements are from health facilities, each administrative unit are expected to compile the data and include additional administrative reports and send to the next level. These indicators have to be sent to the next administration unit after a critical review and endorsement by reporting unit.

Report Dissemination & Information Use

Weekly the report will be compiled and analyzed at each level. The national level report will be analyzed and disseminated to the wider by PPMED. The regions are responsible to analyze their own data respective to their zones, woredas and facilities.

The analyzed report should be used by the respective programs, department and stakeholders and are expected to conduct root cause analysis and prepare improvement plan on the findings.

Figure 6: Report flow of essential health service monitoring tracer indicators



ANNEXES

Annex 1: Monitoring and evaluation tools

Essential Health Service Monitoring Tracer Indicators

Weekly Regional Health Bureau Reporting Format For Essential Health Service Monitoring

Name of RHB_____

Reporting Week _____

Report Date_____

Reported By _____

Sr.No.	Data Element	Number	Data Source	Reporting System
1	**Maternal Newborn and Child Health**			
1.1	# of maternal deaths		PHEM	PHEM
1.2	# of perinatal deaths		PHEM	PHEM
1.3	# of children vaccinated for measles (MCV1)		EPI Tally	Command Post
1.4	# of AFP/ polio cases		PHEM	PHEM
1.5	# of confirmed measles cases		PHEM	PHEM
1.6	# of <5 children screened for malnutrition		PHEM	PHEM
1.7	# of <5 children with acute malnutrition			
1.7.1	# of <5 children with Moderate Acute Malnutrition		PHEM	PHEM
1.7.2	# of <5 children with Sever Acute Malnutrition		PHEM	PHEM
1.8	# of births attended by skilled health personnel		Delivery Register	Command Post
2	**Hygiene and Environmental Health**			
2.1	# of water sources monitored & surveyed for quality & safety		Admin report	Command Post
3	**HE and PHCU**			
3.1	# of HCs providing essential health services		Admin report	Command Post
3.2	# of HPs providing community health services		Admin report	Command Post
4	**DPC**			
4.1	**Malaria**			
4.1.1	# of HFs that reports stock out of ACT within the reporting week		Admin report	Command Post
4.1.2	# of malaria cases diagnosed over the week		OPD register	Command Post
4.1.3	Total # of admitted malaria cases – inpatient		PHEM	PHEM
4.1.4	Submitted weekly malaria situational report (SitREPs) to FMoH.		PHEM	PHEM
4.2	**NCD**			
4.2.1	# of new hypertension patients put on treatment		NCD Register	Command Post

4.2.2	# of new DM patients put on treatment		NCD Register	Command Post
4.2.3	# of patients with CVD risk> or =30% receiving drug treatment during the reporting week		NCD Register	Command Post
4.3	**TB**			
4.3.1	# of all forms of TB cases notified in a specified time period		TB register	Command Post
4.3.2	# of DR TB detected		DR register	Command Post
4.4	**HIV**			
4.4.1	# of individuals counselled and tested for HIV		PITC and VCT tallies	Command Post
4.4.2	# of HIV tested positive individuals linked to ART		ART register	Command Post
5	**Medical Services**			
5.1	# of total outpatient visit		OPD register	Command Post
5.2	# of total emergency room attendances		Emergency register	Command Post
5.3	# of total inpatient admission		Inpatient register	Command Post
5.4	# of total inpatient death		Inpatient register	Command Post
5.5	# of total death in the emergency unit		Emergency register	Command Post
5.6	# of new mental illness cases visited HFs within the reporting week		OPD register	Command post
6	**Blood bank**			
6.1	# of blood banks that have collected blood		BBIS	BBIS
6.2	Amount of blood collected (in blood unit)		BBIS	BBIS
6.3	Amount of blood distributed to health facilities (in blood unit)		BBIS	BBIS

Weekly Zonal Health Department Reporting Format For Essential Health Service Monitoring

Name of Zonal Health Department_____

Reporting Week _____

Report Date_____

Reported By _____

Sr.No.	Data Element	Number	Data Source	Reporting System
1	**Maternal Newborn and Child Health**			
1.1	# of maternal deaths		PHEM	PHEM
1.2	# of perinatal deaths		PHEM	PHEM
1.3	# of children vaccinated for measles (MCV1)		EPI Tally	Command Post
1.4	# of AFP/ polio cases		PHEM	PHEM
1.5	# of confirmed measles cases		PHEM	PHEM
1.6	# of <5 children screened for malnutrition		PHEM	PHEM
1.7	# of <5 children with acute malnutrition			
1.7.1	# of <5 children with Moderate Acute Malnutrition		PHEM	PHEM
1.7.2	# of <5 children with Sever Acute Malnutrition		PHEM	PHEM
1.8	# of births attended by skilled health personnel		Delivery Register	Command Post
2	**Hygiene and Environmental Health**			
2.1	# of water sources monitored & surveyed for quality & safety		Admin report	Command Post
3	**HE and PHCU**			
3.1	# of HCs providing essential health services		Admin report	Command Post
3.2	# of HPs providing community health services		Admin report	Command Post
4	**DPC**			
4.1	**Malaria**			
4.1.1	# of HFs that reports stock out of ACT within the reporting week		Admin report	Command Post
4.1.2	# of malaria cases diagnosed over the week		OPD register	Command Post
4.1.3	Total # of admitted malaria cases – inpatient		PHEM	PHEM
4.1.4	Submitted weekly malaria situational report (SitREPs) to FMoH.		PHEM	PHEM
4.2	**NCD**			
4.2.1	# of new hypertension patients put on treatment		NCD Register	Command Post
4.2.2	# of new DM patients put on treatment		NCD Register	Command Post
4.2.3	# of patients with CVD risk> or =30% receiving drug treatment during the reporting week		NCD Register	Command Post
4.3	**TB**			
4.3.1	# of all forms of TB cases notified in a specified time period		TB register	Command Post

4.3.2	# of DR TB detected		DR register	Command Post
4.4	**HIV**			
4.4.1	# of individuals counselled and tested for HIV		PITC and VCT tallies	Command Post
4.4.2	# of HIV tested positive individuals linked to ART		ART register	Command Post
5	**Medical Services**			
5.1	# of total outpatient visit		OPD register	Command Post
5.2	# of total emergency room attendances		Emergency register	Command Post
5.3	# of total inpatient admission		Inpatient register	Command Post
5.4	# of total inpatient death		Inpatient register	Command Post
5.5	# of total death in the emergency unit		Emergency register	Command Post
5.6	# of new mental illness cases visited HFs within the reporting week		OPD register	Command Post

Weekly Woreda Health Office Reporting Format For Essential Health Service Monitoring

Name of Health Woreda HO_____

Reporting Week _____

Report Date_____

Reported By _____

Sr.No.	Data Element	Number	Data Source	Reporting System
1	**Maternal Newborn and Child Health**			
1.1	# of maternal deaths		PHEM	PHEM
1.2	# of perinatal deaths		PHEM	PHEM
1.3	# of children vaccinated for measles (MCV1)		EPI Tally	Command Post
1.4	# of AFP/ polio cases		PHEM	PHEM
1.5	# of confirmed measles cases		PHEM	PHEM
1.6	# of <5 children screened for malnutrition		PHEM	PHEM
1.7	# of <5 children with acute malnutrition			
1.7.1	# of <5 children with Moderate Acute Malnutrition		PHEM	PHEM
1.7.2	# of <5 children with Sever Acute Malnutrition		PHEM	PHEM
1.8	# of births attended by skilled health personnel		Delivery Register	Command Post
2	**Hygiene and Environmental Health**			
2.1	# of water sources monitored & surveyed for quality & safety		Admin report	Command Post
3	**HE and PHCU**			
3.1	# of HCs providing essential health services		Admin report	Command Post
3.2	# of HPs providing community health services		Admin report	Command Post
4	**DPC**			
4.1	**Malaria**			
4.1.1	# of HFs that reports stock out of ACT within the reporting week		Admin report	Command Post
4.1.2	# of malaria cases diagnosed over the week		OPD register	Command Post
4.1.3	Total # of admitted malaria cases – inpatient		PHEM	PHEM
4.1.4	Submitted weekly malaria situational report (SitREPs) to FMoH.		PHEM	PHEM
4.2	**NCD**			
4.2.1	# of new hypertension patients put on treatment		NCD Register	Command Post
4.2.2	# of new DM patients put on treatment		NCD Register	Command Post
4.2.3	# of patients with CVD risk> or =30% receiving drug treatment during the reporting week		NCD Register	Command Post
4.3	**TB**			
4.3.1	# of all forms of TB cases notified in a specified time period		TB register	Command Post

4.3.2	# of DR TB detected		DR register	Command Post
4.4	**HIV**			
4.4.1	# of individuals counselled and tested for HIV		PITC and VCT tallies	Command Post
4.4.2	# of HIV tested positive individuals linked to ART		ART register	Command Post
5	**Medical Services**			
5.1	# of total outpatient visit		OPD register	Command Post
5.2	# of total emergency room attendances		Emergency register	Command Post
5.3	# of total inpatient admission		Inpatient register	Command Post
5.4	# of total inpatient death		Inpatient register	Command Post
5.5	# of total death in the emergency unit		Emergency register	Command Post
5.6	# of new mental illness cases visited HFs within the reporting week		OPD register	Command Post

Weekly PHCU Reporting Format For Essential Health Service Monitoring

Name of Health Facility_____

Reporting Week _____

Report Date_____

Reported By _____

Sr.No.	Data Element	Number	Data Source	Reporting System
1	**Maternal Newborn and Child Health**			
1.1	# of maternal deaths		PHEM	PHEM
1.2	# of perinatal deaths		PHEM	PHEM
1.3	# of children vaccinated for measles (MCV1)		EPI Tally	Command Post
1.4	# of AFP/ polio cases		PHEM	PHEM
1.5	# of confirmed measles cases		PHEM	PHEM
1.6	# of <5 children screened for malnutrition		PHEM	PHEM
1.7	# of <5 children with acute malnutrition			
1.7.1	# of <5 children with Moderate Acute Malnutrition		PHEM	PHEM
1.7.2	# of <5 children with Sever Acute Malnutrition		PHEM	PHEM
1.8	# of births attended by skilled health personnel		Delivery Register	Command Post
2	**Hygiene and Environmental Health**			
2.1	# of water sources monitored & surveyed for quality & safety		Admin report	Command Post
3	**HE and PHCU**			
3.1	# of HPs providing community health services		Admin report	Command Post
4	**DPC**			
4.1	**Malaria**			
4.1.1	# of HFs that reports stock out of ACT within the reporting week		Admin report	Command Post
4.1.2	# of malaria cases diagnosed over the week		OPD register	Command Post
4.1.3	Total # of admitted malaria cases – inpatient		PHEM	PHEM
4.1.4	Submitted weekly malaria situational report (SitREPs) to FMoH.		PHEM	PHEM
4.2	**NCD**			
4.2.1	# of new hypertension patients put on treatment		NCD Register	Command Post
4.2.2	# of new DM patients put on treatment		NCD Register	Command Post
4.2.3	# of patients with CVD risk> or =30% receiving drug treatment during the reporting week		NCD Register	Command Post
4.3	**TB**			
4.3.1	# of all forms of TB cases notified in a specified time period		TB register	Command Post
4.3.2	# of DR TB detected		DR register	Command Post

4.4	**HIV**			
4.4.1	# of individuals counselled and tested for HIV		PITC and VCT tallies	Command Post
4.4.2	# of HIV tested positive individuals linked to ART		ART register	Command Post
5	**Medical Services**			
5.1	# of total outpatient visit		OPD register	Command Post
5.2	# of total emergency room attendances		Emergency register	Command Post
5.3	# of total inpatient admission		Inpatient register	Command Post
5.4	# of total inpatient death		Inpatient register	Command Post
5.5	# of total death in the emergency unit		Emergency register	Command Post
5.6	# of new mental illness cases visited HFs within the reporting week		OPD register	Command Post

Annex 2: National personal protective equipment guidelines

COVID-19 personal protective equipment (PPE)

Since COVID 19 was declared a global pandemic by WHO in March/2020, much emphasis was given on PPE and IPC. Lack of uniform protocol and shortage of the required PPE in many centers led to anxiety among health workers. Ethiopian National Comprehensive COVID 19 management guideline has tried to address PPE in the first edition. But the practice we have observed at the COVID treatment center in Addis Ababa and our assessment on some health care providers about PPE for COVID 19 revealed that there is inconsistency and ambiguity regarding types, use, and indications of PPE. Besides, hospital staffs are getting more anxious when they see sample collecting team with full PPE while limited PPE in the hospital setting where more exposed staffs are working. Therefore, the National COVID 19 Clinical advisory committee decided on the need to release a separate protocol on the use of PPE as an update of the existing national guideline. We believe this update will help to have uniform understanding of rational use of PPE among health care providers throughout the country and avoids anxiety and ambiguity among all levels of providers.

This update requires that all health workers, social workers and others who may have direct contact with suspected or confirmed COVID 19 case should get training on donning and doffing PPE.

NB: COVID19 is no longer categorized as a high consequence infectious disease and therefore enhanced PPE is not recommended. PPE should be worn as described in this guidance.

Health care providers in this setting are expected to:

1. Change their regular cloths and wear scrubs and shoes suitable for health care facility, example doctors' shoes (OR dedicated personal cloth and shoes dedicated only for COVID treatment center) in their office before they go to donning.
2. Then they go to donning and they put on PPE at donning on top of their scrub and shoe (or dedicated cloth and shoe) and directly go to area of assignment in the center.
3. After completing their session, they leave the center with the scrub and shoes (or dedicated cloth and shoe) after removing the apron, gowns, shoe cover, face mask, face shield or eye cover and hand washed at doffing.

Single session means the period of time health care provider stays in the facility after donning until doffing. Most PPE are used for single session while disposable glove and disposable apron should be changed after each patient in a single session depending on the extent of contamination. Hand hygiene should be routine if there is a need to change any of the PPE during a session.

A. **Aerosol generating procedures (AGP)**

1. A long-sleeved disposable fluid repellent gown (covering the arms and body) or disposable fluid repellent coveralls,
2. N95 face mask,
3. A full-face shield
4. Gloves
5. Shoe cover

PPE is subject to single use with disposal after each patient contact or procedure as appropriate.

AGPs for COVID 19 are described in the National guideline,

B. **Higher risk acute inpatient care areas for confirmed or suspected COVID 19**

1. Long-sleeved disposable fluid repellent gowns or disposable fluid repellent coveralls,
2. N95 face mask,
3. Full face shield or eye googles, and

4. Gloves must be worn in higher risk areas containing possible or confirmed cases, or as indicated by local risk assessment.
5. If non-fluid-resistant gowns are used, a disposable plastic apron should be worn underneath.
6. Shoe cover

NB: A higher risk acute inpatient care area is defined as a clinical environment where AGPs are regularly performed. Ex. ICU, emergency room resuscitation areas, wards with NIV, operating theater, etc.

Ambulance staff conveying a patient into a high-risk area are not required to change or upgrade their PPE for the purposes of patient handover.

C. **Inpatient areas with suspected or confirmed COVID 19**

1. A fluid resistant surgical facemask or N95 if available
2. Disposable gloves,
3. Aprons and
4. Eye protection
5. Shoe cover

Use of aprons, surgical masks, eye protection and gloves are recommended for health and social care workers working in Emergency department and acute admission areas, those transferring patients and involved in other duties requiring close contact.

For operating theatres and operative procedures, labor ward and ambulance and ambulance staffs: Where AGPs are performed use PPE guidance set out for AGPs and when there is no AGP, use recommendation for non AGP setting.

For primary care, ambulatory care and other non-emergency outpatient clinical settings: plastic aprons, surgical mask, eye protection and gloves should be used for any direct care of possible and confirmed cases.

For health and social care workers working in reception and communal areas but not involved in direct patient care, social distancing of 2 meters, if not possible surgical face mask.

For health care workers in individual's home or quarantine sites for individuals coming from abroad: plastic aprons, surgical face mask, eye protection and gloves are recommended.

Pharmacy: if social distancing of 2 meters is maintained there is no indication for PPE in a pharmacy setting, if not surgical face mask.

For collection of nasopharyngeal swabs for COVID 19: plastic aprons, surgical face mask, eye protection and gloves should be used.

Patient use of PPE: in clinical areas, communal waiting areas and during transportation, it is recommended that possible or confirmed COVID-19 cases wear a surgical face mask if tolerated, for example, not using oxygen.

Disposable fluid repellent coveralls or long-sleeved gowns must be worn when a disposable plastic apron provides inadequate cover of staff uniform or clothes for the procedure or task being performed, and when there is a risk of splashing of body fluids such as during AGPs in higher risk areas or in operative procedures. If non-fluid-resistant gowns are used, a disposable plastic apron should be worn. If extensive splashing is anticipated, then use of additional fluid repellent items may be appropriate.

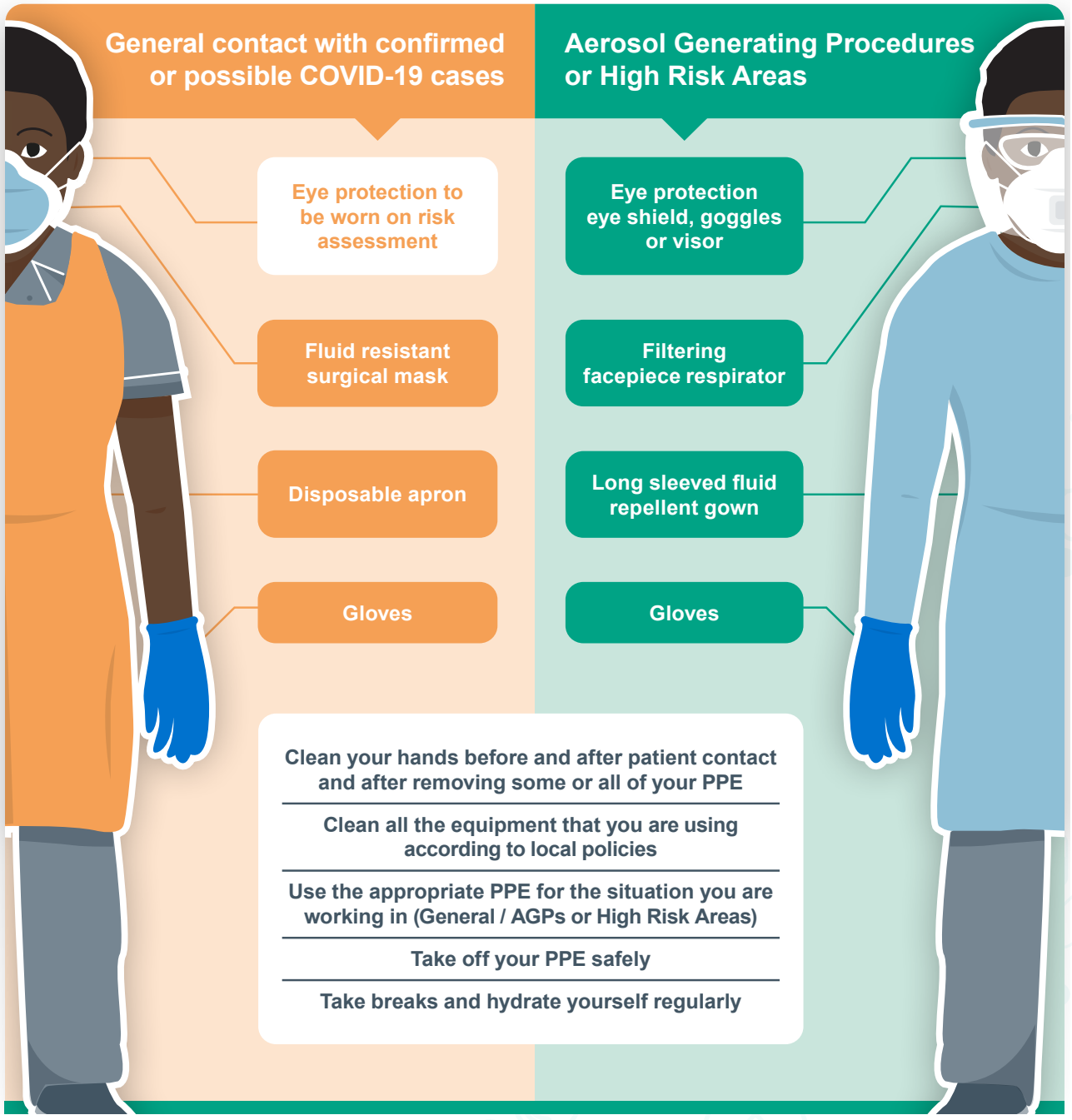
The following procedures are currently considered to be potentially infectious AGPs for COVID-19:

1. Intubation, ex-tubation and related procedures, for example, manual ventilation and open suctioning of the respiratory tract (including the upper respiratory tract).
2. Tracheotomy or tracheostomy procedures (insertion or open suctioning or removal) bronchoscopy and upper ENT airway procedures that involve suctioning.
3. Upper gastro-intestinal endoscopy where

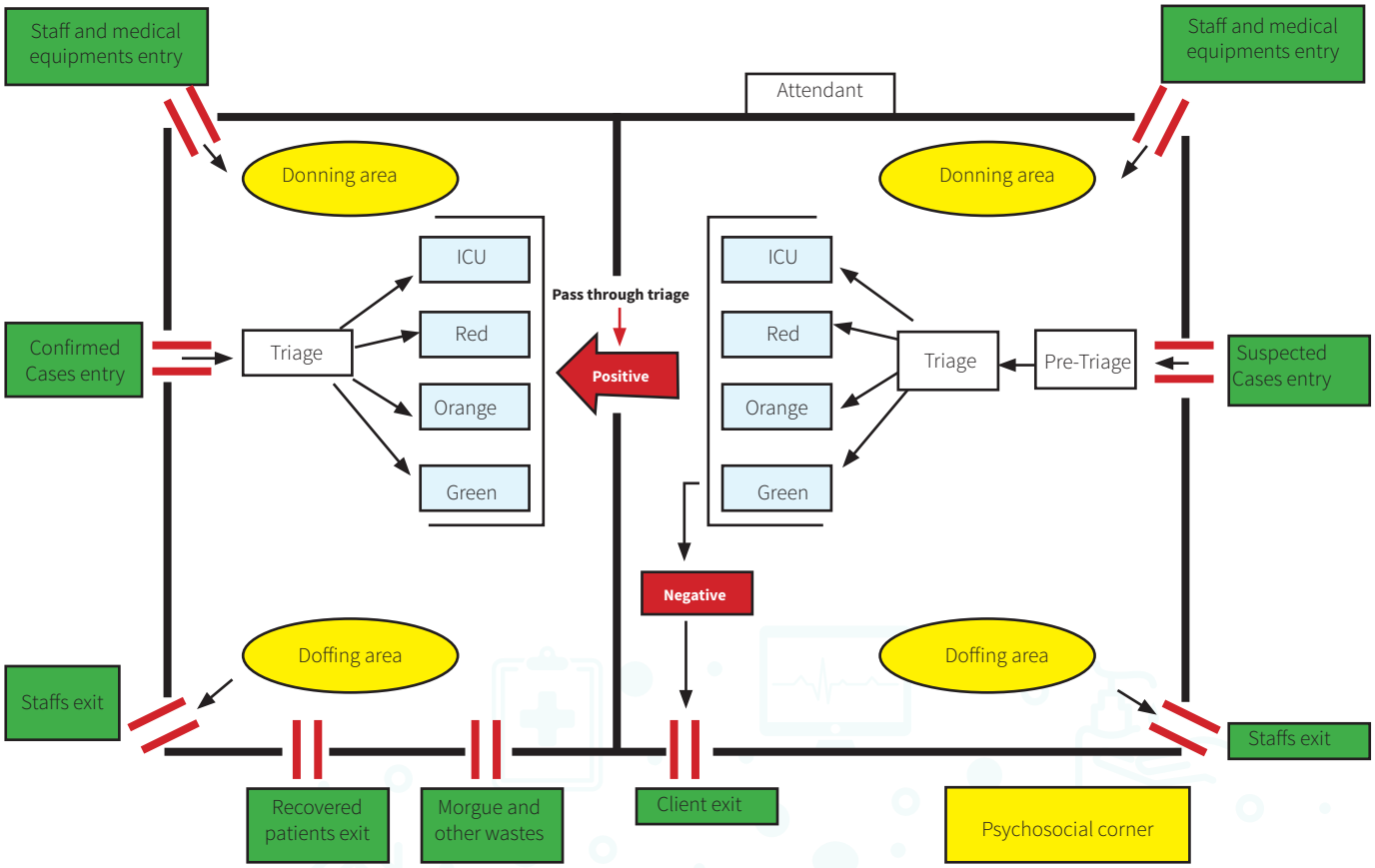
there is open suctioning of the upper respiratory tract surgery and postmortem procedures involving high-speed devices.

4. Some dental procedures (for example, high-speed drilling)
5. Non-invasive ventilation (NIV); Bi-level Positive Airway Pressure Ventilation (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP)
6. High Frequency Oscillatory Ventilation (HFOV) induction of sputum high flow nasal oxygen (HFNO)
7. Use of nebulizer

Annex 3: Rapid visual guide for PPE in Ethiopia



Annex 4: Floor map for COVID-19 service providing facility



IMPLEMENTATION GUIDE FOR NON-COVID-19 ESSENTIAL HEALTH SERVICES IN ETHIOPIA DURING COVID-19 PANDEMIC