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Request for Information

RFI Number:	72066322RFI00007
Issuance Date:	May 9, 2022
Response Due Date and Time:	June 7, 2022, 17:00 ADDIS ABABA TIME
Response to:	caddis@usaid.gov
Subject:	Community Nutrition Activity

This Request for Information (RFI) relates to an activity with the preliminary title of "Community Nutrition Activity".

USAID|Ethiopia is contemplating to provide $50-$70 million over 5 years for this activity. This includes the module for restoration of nutrition services with an estimated cost of $15 million that will depend on availability of additional funding.

This RFI solely seeks additional information and inputs from experts, organizations, and/or consortia in the field of nutrition. USAID/Ethiopia strongly encourages organizations to respond to the RFI questions after reviewing the draft concept note. The responses will help USAID to gain a deeper understanding of the nutrition context, current interventions, and approaches for a nutrition program design with a focus on the community level. The information received in response to this RFI will only be used to inform planning decisions and will not be publicly released. At this time, USAID/Ethiopia is not seeking applications or proposals, nor will accept unsolicited proposals or applications.

This is not a Request for Proposals (RFP) or a Request for Applications (RFA) and is not to be construed as a commitment by the U.S. Government to issue any Solicitation or Notice of Funding Opportunity, or ultimately award a contract or assistance agreement on the basis of this RFI. Responses to this RFI shall not be portrayed as proposal/s or application/s and will not be accepted by the U.S. Government (USG) to form a binding agreement. Responders are solely responsible for all expenses associated with responding to this RFI. It should be noted that responding to or providing comment on this RFI will not give any advantage to any organization in any subsequent procurement.

Interested parties should provide a short submission, not to exceed 15 pages, addressing the RFI questions in addition to any comments related to Attachment A.

Responses (comments, suggestions, and enhancements) must be submitted by email to caddis@usaid.gov with a copy to Tesfaye Wolde, twolde@usaid.gov no later than 17:00 Addis Ababa time by the Response Due Date indicated above. The subject line of the email must read "**RFI: Community Nutrition Activity**". USAID is under no obligation to acknowledge receipt of the information, answer questions or provide feedback to respondents with respect to any information submitted.

All information provided will become the property of USAID and will not be returned. USAID reserves the right to use information provided by respondents for its purposes. Responses may be used by USAID without restriction or limitation. Proprietary information must not be submitted.

This RFI does not restrict the Government's approach to a future solicitation. USAID has not determined the type of instrument that will be used (e.g., acquisition or assistance). For this reason, this RFI will be posted on the Federal Grants website at grants.gov, and the Federal Government Business Opportunities website at SAM.gov. Please continue to monitor these two websites for any updates to this RFI.

Interested parties who are not able to retrieve the RFI from the Internet can request a copy by contacting the Office of Acquisition and Assistance via email at twolde@usaid.gov.

We look forward to receiving your feedback and thank you for your interest in USAID|Ethiopia development programs.

Sincerely,

/S/

Alula Abera
Contracting/Agreement Officer

Attachment A: Concept paper for Community Nutrition activity

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Community Nutrition

Attachment A: Concept Paper

Table of Contents

Acronyms

ANC	Antenatal Care
AOR	Agreement Officer's Representative
BMI	Body Mass Index
CBO	Community Based Organization
CDCS	Country Development Cooperation Strategy
DHA	Digital Health Activity
DO	Development Objective
ECBH	Empowered Communities for Better Health
ECH	Empowered Communities for Health Activity
EDHS	Ethiopia Demographic and Health Survey
EMDHS	Ethiopia Mini Demographic and Health Survey (2019)
FBO	Faith Based Organization
FNC	Food and Nutrition Council
FNP	Food and Nutrition Policy
FNS	National Food and Nutrition Strategy
FP	Family Planning
FTF	Feed the Future
GDP	Gross Domestic Product
GMP	Growth Monitoring and Promotion
GOE	Government of Ethiopia
HC	Health Center
HDI	Human Development Index
HEP	Health Extension Program
HEW	Health Extension Worker
HMIS	Health Management Information System
HP	Health Post
HSS	Health System Strengthening
HSTP	Health Sector Transformation Plan
IR	Intermediate Result
LOE	Level of Effort
MAD	Minimum Acceptable Diet
MEL	Monitoring, Evaluation and Learning
MOH	Ministry of Health
MUAC	Mid Upper Arm Circumference
NGO	Non-government Organization
NNP	National Nutrition Program
PHC	Primary Health Care
PHCU	Primary Health Care Unit
PLW	Pregnant and Lactating Women
PNC	Postnatal Care
PPHC	Pastoral Primary Health Care Activity
QOC	Quality of Care
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
RMNCH	Reproductive, Maternal, Newborn and Child Health

SBC	Social and Behavior Change
SBCH	Social and Behavior Change for Health Activity
SCHIP	Supply Chain for Health Improvement Program
STTA	Short-Term Technical Assistance
TBC	To be Confirmed
USAID	United States Agency for International Development
WASH	Water, Sanitation and Hygiene
WDA	Women Development Army
WHA	World Health Assembly

Country Context and Problem Statement

Country context: With over 112 million people, Ethiopia is Africa's second most populous country. Despite a GDP growth of 8.4% percent in 2019 and 6.1% in 2020[1] during the COVID-19 pandemic, Ethiopia still ranks as one of the poorest countries, with a per capita annual income of $890[2]. In 2020, inflation reached 20.6% due to the pandemic and other economic factors. Ethiopia aims to reach lower-middle-income status by 2025[3]; however, the escalation of conflict in multiple regions during 2021 is having significant negative impacts on the economy.

Ethiopia has a total of eleven regional states and two chartered cities, Addis Ababa and Dire Dawa. The regions were formed based on ethnicity and language and vary widely in area and population. Based on the 2019 Human Development Index (HDI)[4], the regions and cities in Ethiopia have substantial differences, and Addis Ababa had the highest score of 0.722 while Afar had the lowest at 0.428[5].

Nutrition context: Ethiopia has had remarkable success in reducing the child stunting rate from 58 to 37 percent between 2000 and 2019; however, gains have been insufficient until now to meet the global World Health Assembly (WHA) target by 2025[6]. Many targets in Ethiopia's second National Nutrition Program (NNP-II) were not attained as planned by 2020. The 2019 Ethiopia Mini Demographic and Health Survey (EMDHS) shows a 37% stunting rate against a 26% target; 59% exclusive breastfeeding rate against an 80% target; and only 11% children of 6-23 months receive the Minimum Acceptable Diet (MAD) against a 35% target. The underweight rate among the Ethiopian children is 21% while wasting is 7%, with 1% suffering from severe wasting across the country[7].

Substantial variation in nutritional status exists among Ethiopia's different regions. As per the 2019 EMDHS, the stunting rates in the Afar, Amhara, Benishangul Gumuz and Tigray regions remain very high in exceeding 40%, while albeit still problematic, rates are lower in other regions such as 17.6% in Gambella and 13.9% in Addis Ababa. On the other hand, the Somali region has the highest wasting rate (21.4%) followed by Afar (13.5%) and Gambella (13.1%). Afar, Benishangul-Gumuz, Somali, and Tigray regions have child underweight rate above 30%[8].

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[1] The World Bank data: https://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG?locations=ET
[2] The World Bank data for 2020: https://data.worldbank.org/indicator/NY.GNP.PCAP.CD?locations=ET
[3] Ethiopia Economic Update II - Laying the Foundation for Achieving Middle Income Status (June 2013): https://documents1.worldbank.org/curated/en/885721468031488091/pdf/785010Revised00Box0379884B00PUBLIC0.pdf
[4] Human Development Index (HDI) is a summary measure of average achievement in key dimensions of human development: a long and healthy life, being knowledgeable and having a decent standard of living
[5] Global Data Lab – Human Development Indices: https://globaldatalab.org/shdi/shdi/ETH/?levels=1%2B4&interpolation=1&extrapolation=0&nearest_real=0&years=2019
[6] Global Nutrition Targets 2025 - Policy Brief Series: https://apps.who.int/iris/rest/bitstreams/665585/retrieve
[7] Ethiopian Public Health Institute (EPHI) [Ethiopia] and ICF. 2021. Ethiopia Mini Demographic and Health Survey 2019: Final Report. Rockville, Maryland, USA: EPHI and ICF.
[8] Ethiopian Public Health Institute (EPHI) [Ethiopia] and ICF. 2021. Ethiopia Mini Demographic and Health Survey 2019: Final Report. Rockville, Maryland, USA: EPHI and ICF.

Regarding women's nutrition, the 2016 Ethiopian Demographic and Health Survey (EDHS) shows that 22% women of reproductive age are thin (BMI below 18.5), against the 16% NNP-II target by 2020. Around 29% of the adolescent girls aged 15-19 were thin and 20% were anemic[9].

Nutrition service coverage in Ethiopia's health system has increased in recent years under the NNP-II; however, it has not been sufficient to meet the targets and varies regionally. For example, Growth Monitoring and Promotion (GMP) coverage is 55% against an 80% target, and iron supplementation during pregnancy is 11% against 40% respectively. Furthermore, no significant programming currently exists to address adolescent nutrition, which remains a critical gap across the country.

For the Agriculture sector, progress tracking under NNP-II started in 2019, and most indicators for nutrition-sensitive interventions showed a positive trend. Targets for fruit nursery sites, household poultry production, and nutrition corners at farmer training centers were achieved and exceeded by a large margin for the most part. Water, Sanitation and Hygiene (WASH) and nutrition are inextricably interlinked; therefore, WASH practices have significant impact on the nutrition situation. In Ethiopia, approximately 69% households have access to safe drinking water and only 20% of households were using an improved toilet[10].

Multisectoral nutrition coordination and governance in Ethiopia is still a challenge. A recent stakeholder consultation process showed that cross-sectoral coordination and collaboration engaging different actors are weak. Subnational capacity for multisectoral coordination, program management, and data use for decision-making are inadequate. Enhanced ownership and leadership at the regional to woreda levels are needed to improve community-based nutrition services.

In 2018, Ethiopia approved its Food and Nutrition Policy (FNP) and recently endorsed its National Food and Nutrition Strategy (FNS) to operationalize the FNP, which will establish the proposed Food and Nutrition Council (FNC) to facilitate both national and subnational multisectoral coordination and collaboration. The FNC will be based in the Prime Minister's Office at the federal level, in the President's Office in each region, and in similar platforms at the zonal and woreda levels.

Nutrition interventions from different sectors, including health, were seriously challenged last year due to the COVID-19 pandemic and security issues stemming from the Northern Ethiopia conflicts in the Afar, Amhara and Tigray regions. By all accounts, Ethiopia's nutritional situation has deteriorated.

Health System: The Ministry of Health (MOH) provides nutrition services as a part of a comprehensive package of health services, delivered through a three-tier system: primary, secondary, and tertiary care. Primary care includes primary hospitals, health centers (HCs), and health posts (HP). The primary health care unit (PHCU) consists of one HC, with five satellite HPs in the rural area with a catchment population of 15,000–25,000 people and provides all

[9] Central Statistical Agency (CSA) [Ethiopia] and ICF. 2016. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: CSA and ICF.
[10] Ethiopian Public Health Institute (EPHI) [Ethiopia] and ICF. 2021. Ethiopia Mini Demographic and Health Survey 2019: Final Report. Rockville, Maryland, USA: EPHI and ICF.

essential health services. The HPs are designed to serve a catchment population of 3,000–5,000, with two health extension workers (HEW), who deliver a package of 18 services including the nutrition services. Approximately 90 percent of Ethiopia's population obtain health services at the PHC level, which serves rural populations and the urban poor. Primary hospitals serve a catchment population of between 60,000 and 100,000 and are managed by district level health authorities. Secondary care is delivered by general hospitals with a catchment population of 1.5 million and overseen by regional health bureaus. Tertiary care is provided by specialized hospitals with a catchment population of approximately 5 million people and with regional and federal oversight[11].

The health sector's priorities and goals were outlined in the first Health Sector Transformation Plan (HSTP) 2015-20 and the current HSTP-II 2020-25. While the key RMNCH indicators showed an overall positive trend during this time, progress in newborn health and nutrition stagnated. Between 2005 and 2016, the maternal mortality rate declined by 39 percent to 412 per 100,000 live births. Under-five mortality rate dropped from 123 to 59 per 1,000 and use of modern family planning (FP) methods increased from 14 to 41 percent. However, newborn mortality increased from 29 percent in 2016 to 33 percent in 2019 indicating the need for priority focus on newborn health[12,13].

More than 90% of the primary hospitals and HCs offer nutrition services, such as malnutrition screening, vit-A supplementation, growth monitoring etc. In contrast, less than 80% of HPs offer such services. Additionally, for all types of health facilities, iron supplementation is less available compared to other services. The availability is similar for treatment of pneumonia, diarrhea and malaria that have a huge impact on the nutritional status[14].

The MOH initiated Quality of Care (QOC) improvement initiatives at the health facilities, but the implementation of service quality standards is not yet complete. QOC improvements will require meeting critical facility readiness indicators including competent, motivated health providers, community-facility referral systems across multiple service levels, etc.

Gender inequality: Major challenges to addressing nutrition in Ethiopia are women's access and control over household resources, time, knowledge, food insecurity, and traditional beliefs about practice. Since women in Ethiopia are the primary preparers of household food, it is important to address their challenges. Global evidence clearly demonstrates that empowering women is central to tackling malnutrition, without which the effectiveness of nutrition programming will be compromised.

Problem statement: Despite significant progress in the past two decades, women and children still suffer from high rates of malnutrition, especially in the rural areas. Learning from the previous programming, national surveys and research findings, and stakeholder consultations

[11] Improving Health System Efficiency, Ethiopia Human Resources for Health Reforms, World Health Organization 2015. https://apps.who.int/iris/bitstream/handle/10665/187240/WHO_HIS_HGF_CaseStudy_15.6_eng.pdf
[12] Central Statistical Agency (CSA) [Ethiopia] and ICF. 2016. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: CSA and ICF.
[13] Ethiopian Public Health Institute (EPHI) [Ethiopia] and ICF. 2021. Ethiopia Mini Demographic and Health Survey 2019: Final Report. Rockville, Maryland, USA: EPHI and ICF.
[14] Services Availability and Readiness Assessment (SARA) - 2018 Final Report. Ethiopian Public Health Institute, Federal Ministry of Health, Ethiopia.

show poor nutritional practices at the household level and low utilization of health and nutrition services. This is largely due to poor knowledge and inadequate access to relevant, culturally appropriate and trusted information, and weak local systems to innovate solutions for social and behavior change, compounded by gender inequality. In addition, nutrition services at the local level are not well integrated into the public health system and are often inconsistent and low quality, which occurs because health care facilities and frontline workers lack the resources, supplies, information, and know-how required to provide quality, timely, and tailored services. Communities depend primarily on the public health system for the services due to lack of services from private or NGO sectors. Finally, capacity for sustained, effective multi-sectoral coordination amongst public and private actors is low at the local, regional, and federal levels. As a result of these challenges, adoption of good nutritional practices and use of key health and nutrition services among women and children remain low.

Activity Objective

The overall objective of this activity is to improve appropriate nutrition behavior and utilization of nutrition services to improve the nutritional status among women and children in Ethiopia. This can be achieved through the intermediate results; 1) Improved nutritional practices and demand for services at the community level; 2) Improved quality of nutrition services at the community level; and 3) Improved capacity for coordination among the nutrition stakeholders across sectors.

Activity Logic Model

Links to the CDCS: This Activity responds to USAID/Ethiopia's 2019-2024 CDCS Development Objective (DO) 4: "Sustained improvement in essential service delivery outcomes, focused on women and girls." Specifically, the activity responds directly to Intermediate Results (IR) 4.4: Utilization of quality health and nutrition services increased; and supports IR 4.5: Health and nutrition systems strengthened for greater self-reliance, as the activity will strengthen the health system at the community level to improve the access and quality of nutrition services. The activity also responds to CDCS Strategic Principle 1: Improved citizen empowerment and household and community resilience and well-being, and Strategic Principle 2: More effective and accountable systems and institutions at all levels. Engagement of the citizens is essential for sustainable, systemic improvement.

The Activity is a part of a suite of activities called the Empowered Communities for Better Health-**ECBH Project** and contributes to its results: 1) Increased sustained adoption of appropriate health and nutrition behaviors, 2) Increased accountability and responsiveness to community health needs by primary level health facilities, woreda, zonal and regional health offices, and 3) Improved quality of health services at primary level health facilities. The Activity will also contribute to Health System Strengthening-**HSS Project** results: 1) Increased health system responsiveness, and 2) Improved quality of essential services. More specifically, IR 1.1 Improved leadership, management, governance, and regulation; IR 1.2 Strengthened health information systems and evidence; IR 1.3 Enhanced timely availability of quality commodities, supplies and equipment; IR 1.5 Optimized health workforce management and retention; IR 2.1 Strengthened adherence to service delivery standards and improved clinical oversight; and IR 2.3 Improved pre- and in-service training with a focus on the nutrition service delivery.

Theory of change:
If the appropriate nutritional practices in households can be improved at the community level,

If demand for nutrition services can be improved,

If quality of the nutrition services can be improved and made accessible at the community level,

If capacity of the nutrition stakeholders across sectors can be improved and efforts can be coordinated,

THEN the appropriate nutrition behavior and utilization of nutrition services will improve among the people, contributing to an overall improvement of nutritional status among women and children.

Results framework:

Goal: Nutritional status of women and children improved		
Objective: Improved appropriate nutritional behavior and utilization of nutrition services		
IR 1 – Improved nutritional practices and demand for services at the community level	**IR 2 – Improved quality of nutrition services at the community level**	**IR 3 – Improved capacity for coordination among the nutrition stakeholders across sectors**
Sub-IR 1.1 – Nutrition and health knowledge and skills improved. Sub-IR 1.2 – Nutrition and health service seeking behavior improved. Sub-IR 1.3 – Increased utilization of community platforms for improved nutrition.	Sub-IR 2.1 – Improved readiness[15] of primary health care facilities to provide quality nutrition-specific services including restoration of services in the conflict-affected areas. Sub-IR 2.2 – Frontline workers' capacity developed. Sub-IR 2.3 – Nutrition information system and supply chain management strengthened and coordinated. Sub-IR 2.4 – Increased NGO and private sector provision of nutrition services.	Sub-IR 3.1 – Improved mechanisms for productive and sustained multisectoral coordination at the community level. Sub-IR 3.2 – Key nutrition stakeholders' (e.g., civil society, NGOs, academia, and private sector) capacity is strengthened. Sub-IR 3.3 – Multisectoral nutrition coordination and governance capacity strengthened at national and regional levels.

[15] Readiness for nutrition specific services at the facility level include trained staff, guidelines, equipment, diagnostic capacity, and medicines and commodities.

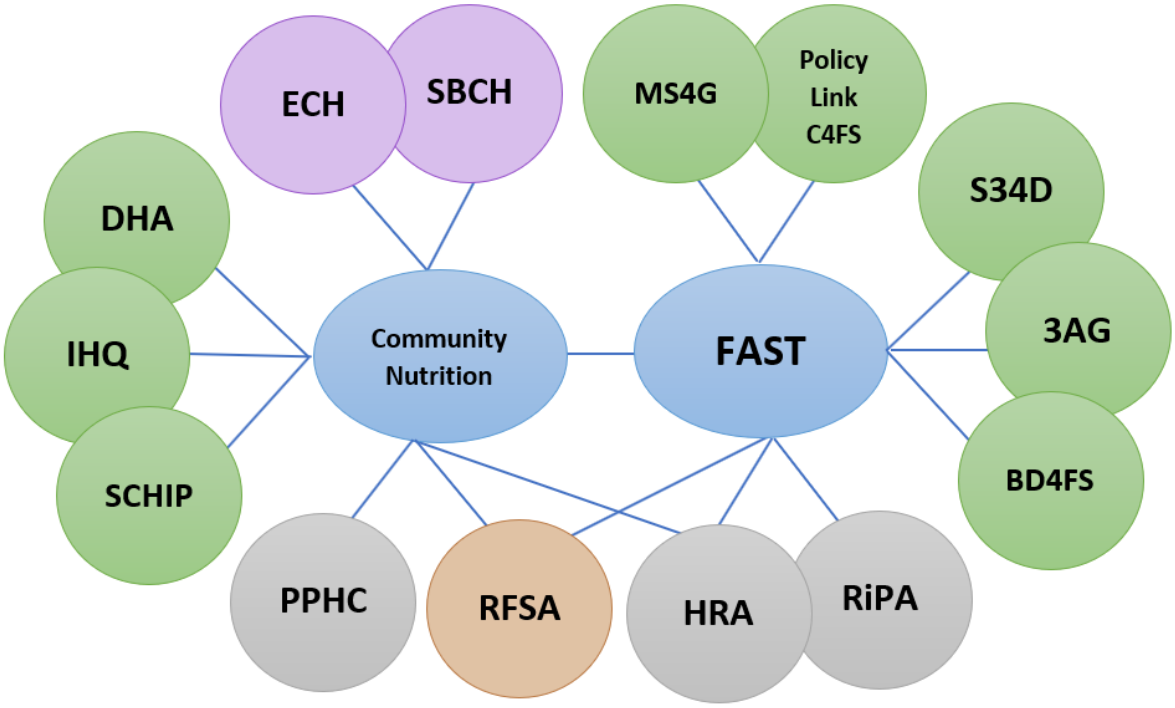
Linkages with other USAID activities:
The activity will coordinate and collaborate with several USAID activities managed by different Mission offices. Community Nutrition will work with the relevant activities, as mentioned below, to develop letter of collaboration (LOCs) that will describe the specific details on coordination and collaboration. These activities include:

- **Food and Agriculture Systems Transformation (FAST)** will work across the full Feed the Future Zone of Influence and associated secondary cities, linking with USAID's social protection, economic, and WASH activities to increase access to healthy diets and improve income-generating opportunities among chronically vulnerable households and youth; reduce constraints to growth, employment, and trade; and promote sustainable and effective natural resource management. FAST will partner with this activity to amplify nutrition promotion and coordination towards increasing consumption of healthy diets and other nutrition outcomes. Close collaboration and layering (geographic overlap) of Community Nutrition and FAST is essential to amplify nutrition education, to increase adoption of key nutrition practices, consumption of healthy diet and utilization of nutrition services. While FAST will work closely with all other nutrition sensitive activities in the Mission, this activity will work with the nutrition specific ones, and a linkage between these two will facilitate multisectoral coordination.
- **USAID Healthy Behavior** activity will support increased sustained adoption of appropriate health and nutrition behaviors by increasing adoption of optimal household health practices, demand for health and nutrition services, and an enabling environment for gender equitable and healthy behavior. Community Nutrition will closely engage with this activity to receive technical advice and linkage with SBC initiatives in the country to enhance community-based behavior change approaches in the implementation areas (IR-1.1), it will also provide nutrition technical advice for SBCH interventions.
- **USAID Quality Healthcare** activity will build capacity of urban and peri-urban PHCUs, and referral health facilities in planning and delivering of client-centered quality RMNCAH services. Community Nutrition will work with this activity to receive technical directions and coordinate with quality improvement initiatives to strengthen nutrition services at the PHCU level (IR-1.2).
- **Empowered Communities for Health (ECH)** will empower communities to improve their own health through enhanced community ownership for health, strengthening accountability systems and platforms, and organizational capacity development of CSOs. For the community engagement component (IR-1.3), Community Nutrition will collaborate with the ECH activity and improve utilization of community-based platforms for nutrition. It will provide technical support to ECH to integrate nutrition.
- **USAID Lowlands Health** activity will improve RMNCAH-Nutrition outcomes in the pastoralist areas through strengthening primary health care systems, improving access to quality services at the primary level and improving adoption of healthy behaviors. Community Nutrition will provide technical support and maintain coordination with this activity to improve nutrition integration.
- **Digital Health Activity (DHA)** supports information technology systems and data repositories at all levels, builds the culture of data use and capacity of the MOH in health information systems. Community Nutrition will receive technical support from DHA for nutrition information system strengthening in the implementation areas.

- **Supply Chain for Health Improvement Program (SCHIP)** will improve availability of medicines, medical supplies, and medical equipment at the right time and in the right quantity at all health care system levels, and access to improved quality pharmaceutical services. Community Nutrition will closely work with this activity to mainstream the nutrition commodities supply chain in the health system.

Some other relevant activities with which technical coordination would be useful include Highland Resilience Activity (HRA), Resilience and Food Security Activities (RFSA), Urban Water, Sanitation and Hygiene (Urban WASH), Climate-Resilient Water, Sanitation and Hygiene (CR-WASH), and Market-Based Sanitation and Hygiene (MBSH) Activity.

The existing Ethiopia Mission Nutrition Working group, consisting of members from the different offices in the Mission, and Washington DC will be the platform to strengthen coordination and prevent duplication of efforts. Community Nutrition is expected to lead the implementing partners' nutrition working group that will further enhance activity level coordination. The Activity will be an active member of the Nutrition Development Partners Forum (NDPF) and the SUN Movement in Ethiopia to coordinate with other nutrition stakeholders including the relevant government ministries.

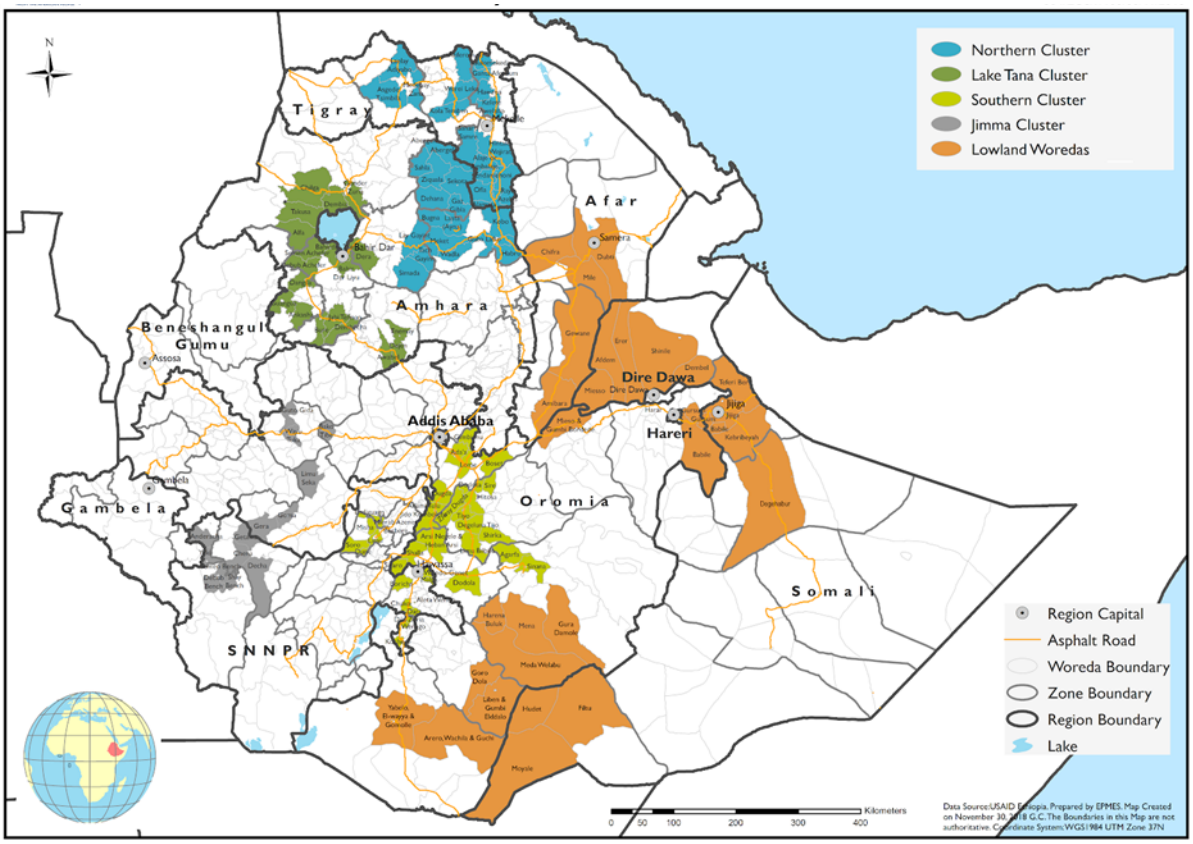


The above figure shows linkage between the USAID/Ethiopia activities contributing to improving nutrition through layering of implementation, technical coordination and collaboration.

Activity Description and Expected Results

USAID/Ethiopia's layering approach to comprehensively address multisectoral nutrition programming forms the foundation for this activity. The overall goal is to improve the nutritional status of women and children. Three core focus areas have emerged within this aim. First, the activity will improve household level knowledge and skills to facilitate adoption of better nutrition practices and health seeking behavior. Second, the activity will strengthen community

engagement and service utilization in formalizing linkages between communities and nutrition services at primary health care facilities. Lastly, the activity will diversify its stakeholder engagement (but still inclusive of the Government of Ethiopia (GOE)) to ensure strengthened capacity and coordination of nutrition-specific interventions and investments.



USAID/Ethiopia Feed the Future Zone of Influence Map

This activity's intermediate results and sub-results are outlined below:

IR 1 – Improved nutritional practices and demand for services at the community level.
Knowledge of health risks and benefits within household caregivers determine dominant nutrition practices at home, especially for vulnerable young children and pregnant-lactating women (PLW). Attitudes and relevant skills regarding nutrition, including dietary practices, health care seeking, and WASH behaviors, are also critical in bolstering individual, household, and community confidence to act and reduce barriers that result in adverse nutritional outcomes. Environmental and social factors underscore the importance of the enabling environment and civic engagement in improving basic health knowledge and sustaining adoption of healthy behaviors and practices. For this result area, the activity will work closely with the SBCH, ECH and FAST activities.

Sub-IR 1.1 – Nutrition and health knowledge and skills improved.
Comprehensive knowledge and an enabling environment are the key factors behind optimal nutritional practices. In most settings, people recognize key health facts but have low comprehensive knowledge, or full understanding of a health issue. A context-specific social and

behavior change (SBC) initiative delivered through appropriate channels to reach intended audiences, can effectively increase community knowledge on appropriate nutritional practices. Such tailored, evidence-based approaches will be crucial to successfully shape initiatives in outreach to ensure that knowledge is disseminated, retained and translated into action.

The activity will address underlying barriers related to healthy behaviors and increase comprehensive understanding of nutrition issues, including gender norms, gender power dynamics, women's empowerment and men engagement related to nutrition improvement through intentional collaboration with SBCH and FAST activities. It will support MOH's efforts within communities, engage the private sector in nutrition education and promotion activities, and also contribute to sustained SBC interventions through community adoption and ownership.

Expected results

- *Improved knowledge on appropriate nutrition practices at the household level.*
- *Increased adoption of optimal nutrition behaviors at household level.*
- *Improved gender norms at the household level for nutritional practices.*
- *Increased engagement of the private sector in nutrition promotion.*

Sub-IR 1.2 – Nutrition and health service seeking behavior improved.

Utilization of health and nutrition services remain low in Ethiopia, especially in rural areas, socio-economically-deprived communities such as pastoralist communities, and amongst those without formal education[16]. Approaches to improve knowledge should be complemented with information on accessing available health and nutrition services. Individuals often experience difficulty understanding how to access and navigate various services; therefore, health system literacy is crucial. The activity will improve individual capacity to appropriately access and use information shared by health providers for informed decision-making and increased service utilization at health posts (HP), HCs and primary hospitals. Under IR-2, this activity will address capacity building of health providers to relay appropriate and accurate information to clients and communities.

Expected results

- *Improved informed decision-making on nutrition service seeking at household level.*
- *Improved nutrition and health services seeking from primary level facilities.*

Sub-IR 1.3 – Increased community mobilization and utilization of community platforms for nutrition.

Community engagement is a relationship-building process engaging stakeholders to collaboratively address health issues and promote well-being to achieve positive health impact and outcomes[17]. In addition to improving nutrition knowledge, it is essential to engage individuals, households, and communities to make informed decisions on managing their own health. This mobilization will increase community understanding of nutrition issues and motivate the leadership in influencing families to adopt appropriate nutritional practices. Cultural beliefs, traditional practices and community rituals significantly impact nutrition practices and often

[16] Health Sector Transformation Plan (HSTP)-II, 2020-2025.
[17] Community Engagement. a health promotion guide for universal health coverage in the hands of the people. Geneva: World Health Organization; 2020.

hinder uptake of appropriate practices. This activity will increase community engagement in addressing these issues and to create an enabling environment for improving nutrition.

The Women Development Army (WDA) serves as a primary community engagement platform in Ethiopia, but a recent assessment highlighted the limited network capacity and underutilization of other community members such as men, and religious and community leaders[18]. The activity will strengthen the existing and potential community groups, institutions and CBOs to provide support to families on nutrition issues. The community platforms should also support community-based nutrition education and services through linkages with primary health care services.

Expected results

- *Improved capacity of community leaders and networks to reinforce nutrition support at community level.*
- *Improved utilization of community platforms for dissemination of nutrition knowledge.*
- *Linkages established with primary health care services to strengthen outreach and referral for nutrition services.*

IR 2 – Improved nutrition services at the community level

Essential nutrition services should be available to families at the community level in facilitating access to appropriate services, especially for RMNCAH and nutrition. To complement, utilization of services such as ANC-PNC, GMP, micronutrient supplementation, screening for acute malnutrition, and nutrition counseling is important. One major challenge is health facility readiness in providing such nutrition services in addition to other curative services.

The 2016-20 Ethiopia National Health Care Quality Strategy prioritized maternal, newborn and child health, and nutrition services and also defined quality as "comprehensive care that is measurably safe, effective, patient-centered, and uniformly delivered in a timely way that is affordable to the Ethiopian population and appropriately utilizes resources and services efficiently"[19]. As a result, MOH launched several quality improvement initiatives to improve services, including nutrition services at the PHC level[20] for which USAID extended support. For this result area, the activity will closely coordinate with DHA, QOC and SCHIP activities.

Other actors including NGOs and private sector entities will have to become increasingly engaged in the provision of basic health and nutrition services, in order to facilitate greater service accessibility and also reduce stress on the public health sector.

Sub-IR 2.1 – Improved readiness of primary health care facilities to provide quality nutrition services including restoration of services in conflict-affected areas.

Health facility readiness for basic health and nutrition services refers to a facility's capacity and functioning, including basic infrastructure, electricity and power systems, clean water sources,

[18] National Assessment of the Ethiopian Health Extension Program: Evidence Brief for Action. Addis Ababa, Ethiopia: MERQ Consultancy PLC. August 2020.

[19] Federal Democratic Republic of Ethiopia Ministry of Health. Ethiopian National Health Care Quality Strategy, 2016-2020.

[20] Federal Democratic Republic of Ethiopia, Ministry of Health - Ethiopia Health Care Quality Bulletin. Continuous Health Care Quality Improvement through Knowledge Management. Vol-1, May 2019

sanitation structures, competent, quality trained staff at care and management levels, essential medical and office equipment and supplies, standard care guidelines and tools, bidirectional referral networks, and record keeping systems. The activity will work to improve the readiness for nutrition services, strengthen the QOC initiatives, and improve the referral system to ensure continuum of care.

The conflict in Northern Ethiopia resulted in the destruction of health facilities, and now, millions of people no longer have access to services. Recovery efforts will prioritize and coordinate facility renovation and restoration of basic health and nutrition services in conflict-affected areas. Frontline health workers such as the HEWs will inevitably play a vital role in restoring services at community and household levels. This activity will support the HPs, HCs and primary hospitals in the conflict-affected, target areas to rebuild their capacity and restore nutrition services, subject to availability of funding and the extent of needs across facilities.

Expected results

- *Improved and maintained readiness of community-based health facilities (HPs, HCs and primary hospitals) in providing nutrition services.*
- *Nutrition services restored in health facilities in conflict-affected areas.*
- *Improved capacity of health care providers in providing nutrition services.*
- *Referral system established/strengthened from community to facility and within facility level for nutrition services.*
- *Improved capacity of health care providers in providing gender responsive nutrition services.*

Sub-IR 2.2 – Frontline workers' capacity developed.

Frontline workers play the most important role in outreach and in establishing linkage between communities and the health system. Community members receive information on appropriate nutritional practices, basic nutrition, and available services at the health facilities. Frontline workers also conduct community-based screening and referrals for appropriate treatment.

The MOH developed a 15-year roadmap for optimizing the 2020-2035 Ethiopian Health Extension Program (HEP). The roadmap guides the HEP's evolution with a primary purpose of meeting the current and future health needs of individuals, households, and communities through health service delivery predominantly at the kebele level[21]. Assessment findings showed that the high workload of the Health Extension Workers (HEWs) affects the timeliness of their service provision. Also, as HEWs are female, their outreach to men was deemed inadequate[22].

This Community Nutrition activity will work closely with the HEWs to improve their capacity on community-based SBC approaches, outreach services, and referrals. This activity will also establish linkages with community-based platforms described under IR-1.2 to facilitate greater access to HEWs. The activity will also explore utilizing private and/or NGO health extension

[21] Realizing UHC Through Primary Health Care - A Roadmap for Optimizing the Ethiopian Health Extension Program 2020 - 2035

[22] National Assessment of the Ethiopian Health Extension Program: Evidence Brief for Action. Addis Ababa, Ethiopia: MERQ Consultancy PLC. August 2020.

worker networks to increase community access to nutrition support services (see IR-2.4 for additional information).

Expected results

- *Improved capacity of Health Extension Workers and other available frontline worker networks in providing community-based nutrition SBC, outreach services and referrals.*
- *Linkages established between community-based platforms and frontline workers to make nutrition support easily accessible.*

Sub-IR 2.3 – Nutrition information system and supply chain management strengthened and coordinated.

Ethiopia's Health Management Information System (HMIS) captures routine RMNCAH services data, including critical nutrition indicators. The HMIS needs more nutrition indicators to facilitate better monitoring of nutrition-specific services by service providers and managers. In addition, given that data quality and use are paramount for decision-making on service improvements, this activity will strengthen health care provider and facility capacity in data reporting, management and use.

This activity will also strengthen health facility capacity in supply chain management to support health and nutrition services with the necessary equipment and health commodities (including medicines and nutritional products).

The activity will closely collaborate with other USAID/Ethiopia activities, e.g. DHA, SCHIP, etc. to establish linkages with broader national level digital health information and supply chain management efforts, including digital solutions for improved efficiency.

Expected results

- *Improved capacity at health facility level in utilizing nutrition information systems to monitor and improve nutrition service delivery.*
- *Improved nutrition supply chain management for HPs, HCs and primary hospitals.*

Sub-IR 2.4 – Increased NGO and private sector provision of nutrition services.

To improve access to community services, multiple service outlets are important. Primary health and nutrition services are mainly provided through the public health sector, thereby creating widespread dependency on a single service provider. Should public health facilities experience any challenges with infrastructure, human resources, supply chain, etc., communities face possible service disruption which can exacerbate their health needs. To make multiple service delivery points available to the people, NGOs, including CBOs/FBOs and the private sector should be encouraged and supported to be engaged in primary health and nutrition service provision. Availability of multiple service delivery platforms will encourage healthy competition in improving service delivery quality as well as cross learning. In the long term, this will help to sustain the gains of improving community-based nutrition services.

Expected results

- *Improved access to community-based nutrition services beyond the government health system.*

IR 3 – Improved capacity and coordination among the nutrition stakeholders across sectors
Addressing malnutrition requires interventions from different sectors, which firmly categorizes nutrition as a multisectoral issue. Having adequate knowledge and appropriate nutritional practices depend on household food security, health status and care-seeking behavior, WASH, education, gender norms, etc. To achieve optimum impact on nutritional status, these relevant sectors should coordinate in their design and implementation of nutrition-specific interventions. Also for greater breadth and sustainability of achievements, non-governmental actors including academia, civil society, NGOs, and the private sector can be significant in nutrition advocacy, technical evidence generation, capacity development, and program management.

Sub-IR 3.1 – Improved mechanisms for productive and sustained multisectoral coordination at community level.
To fully support multisectoral approaches to improving nutrition outcomes, context-specific interventions should be coordinated for optimal cross-sectoral collaboration in activity planning, implementation and monitoring. This activity will collaborate with multiple sectors such as Agriculture, Education, Health, Livestock, and Women and Children Affairs to establish and strengthen coordination mechanisms. Although coordination at the national level has been observed with relative success, subnational coordination is typically weaker or even absent. Therefore, this activity will strengthen community-level coordination in activity planning, implementation and monitoring for communities to directly benefit from such partnerships. This activity will also establish linkages with community platforms discussed under IR-1 to underscore the importance of multisectoral approaches and coordination at community level.

Expected results
- *Coordinated implementation of nutrition interventions from different sectors at community level.*
- *Linkages among different sectors and community platforms established to support coordination.*

Sub-IR 3.2 – Key nutrition stakeholders' (e.g., civil society, NGOs, academia, and private sector) capacity is strengthened.
To accelerate and sustain progress in nutrition achievements, the activity will closely collaborate with civil society (including NGO, CBO and FBO), other USAID implementing partners, academia, and the private sector to increase their engagement. These sectors can be significant in nutrition advocacy and communication, research and evidence generation, technical capacity building, and nutrition program management. Such engagement would significantly improve Ethiopia's capacity in nutrition programming and simultaneously reduce burden on the public health sector.

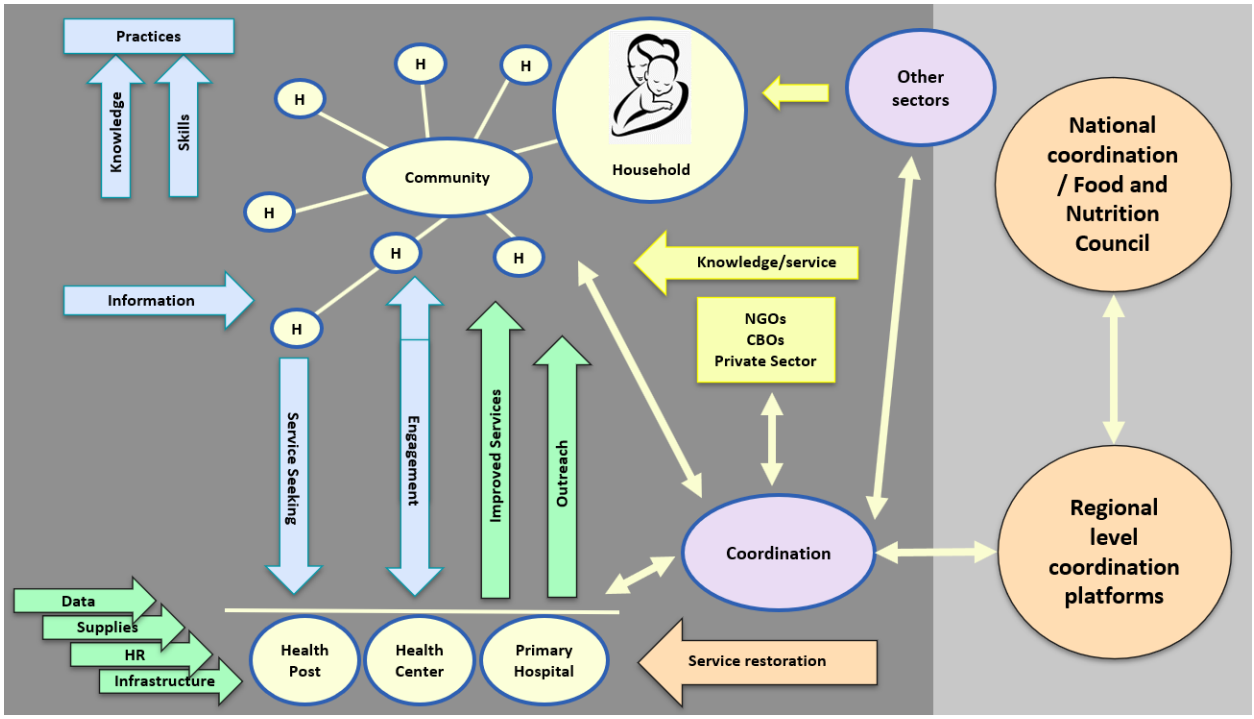
Expected results
- *Improved capacity of civil society, NGOs, academia, and private sector in nutrition advocacy and communication, research, technical support, and program management.*
- *Strengthened linkages with government systems for coordination and collaboration.*

Sub-IR 3.3 – Multisectoral nutrition coordination and governance capacity strengthened at national and regional levels.

Supporting multisectoral, community-level approaches and multi-stakeholder engagement, national and regional level platforms are a core focus for strengthening coordination. The Food and Nutrition Strategy (FNS) supports development of a Food and Nutrition Council (FNC) under the Prime Minister's Office to govern multisectoral coordination platforms at national and regional levels. The FNS plans for replication of similar council platforms at regional level under the Presidents' Offices. This activity will support the formation, management and technical capacity of these regional council platforms, subject to availability of funding and Ethiopia's post-conflict status towards stability.

Expected results

- *The Food and Nutrition Council is fully established and functional.*
- *Regional and community level multisectoral coordination platforms established, fully functional, and linked to the FNC.*
- *Linkage among the woredas, the FNC and regional platforms established to support coordination of community-level implementation.*



Schematic presentation of the Community Nutrition approaches

Local Ownership and Sustainability

The Activity is aligned with the GOE's multisectoral Food and Nutrition Policy and its National Food and Nutrition Strategy. On the ground, the Activity will remain aligned with the MOH's HSTP II (2021-2025) and the Health Extension Program (HEP) interventions.

The Activity aims to support improving nutritional practices at the communities and increasing utilization of nutrition services. To ensure sustainability and ownership of approaches and tools,

in addition to strengthening MOH services at the community level, the activity will build capacity of communities, NGOs, and the private sector.

Summary of Conclusions of Analyses

The Concept Note cites sources relevant to specific sections throughout. This concept note presents a high-level summary and along with select cross-cutting issues here, not an exhaustive recounting of all analyses referenced above. As discussed above, while Ethiopia has seen improvements in key malnutrition indicators, the reduction in malnutrition rates needs to be accelerated, especially in high malnutrition burden areas. Communities need support to improve appropriate nutritional practices and utilize essential nutrition services delivered through the health system. To facilitate that, access to high quality services needs to improve and communities need to be educated and empowered to demand those services. Nutrition improvement efforts from different sectors on the ground requires a coordinated approach to enhance impact and accelerate achievements.

Gender Analysis: The mission conducted a macro level gender analysis as part of the CDCS development in December 2016, complemented by a project-specific gender analysis completed in August 2019. The study underlined the impact of sociocultural norms that limit utilization and negatively influence health-seeking behavior. Based on its recommendations, this activity considers gender, age, and cultural contexts and utilizes existing community structures. In addition, the activity focuses on gender sensitive SBC for nutrition education and gender sensitive approaches for community mobilization. Existing gender dynamics at the community level need to be taken into account while implementing interventions on appropriate nutritional practices, demand creation for services and making services accessible.

MEL and CLA Considerations

The activity will have a comprehensive Monitoring, Evaluation and Learning (MEL) plan that includes a comprehensive set of standard and custom indicators, and overall targets to measure the activity's performance. The recipient will develop a monitoring plan with valid indicators (defined in performance indicator reference sheets) to track progress towards results.

The activity will integrate collaboration, learning and adapting best practices into all aspects of its operations and programming. This involves strategic collaboration, systematic and continuous learning, and adaptive management. In addition, there will be required course correction in the approaches depending on the learning from the initial years of implementation, and any change in the local context. In addition, USAID will conduct an external evaluation of the activity. Due to the current socio-political situation and the recurrent natural and manmade disasters in the country, Community Nutrition will use crisis modifiers for up to $1 million to mitigate the impact of shocks.

Community Nutrition will have a module for restoration of nutrition services in the conflict affected areas. The activity will generate and share new knowledge to improve implementation. Learning agenda and questions will be identified and answered during implementation. The partner should plan how to answer the learning questions as part of implementation of interventions.

RFI Questions

1. Are the results described in the logic model and theory of change clear and appropriate for the objective as articulated? Is anything missing or not essential?
2. What new approaches and interventions could improve nutrition service delivery through the health system and sustainably integrate with the RMNCAH services?
3. What new approaches could strengthen subnational multisectoral coordination to support nutrition service delivery?
4. What approaches could mobilize private and NGO sectors to sustainably provide nutrition services?
5. What are the most significant challenges and/or opportunities in achieving the activity results given the compounded impacts of COVID-19, climate change, and internal conflict?
6. What approaches would be most effective to restore nutrition services in conflict-affected areas?
7. In general, what other critical intervention or approach is missing in the draft concept note?

Please note any other comments you have, referencing the relevant section in the draft Concept Note.

- END OF ATTACHMENT A -