Joint appraisal report

Country	ETHIOPIA
Reporting period	*July 8 2014 – July 7, 2015*
cMYP period	*2011-2015*
Fiscal period	*July 7 – July 8*
Graduation date	*Only relevant for graduating countries*

1. EXECUTIVE SUMMARY

(MAXIMUM 2 PAGES)

1.1. GAVI grant portfolio overview

The Expanded Program on Immunization (EPI) in Ethiopia was started in the 1980's with six antigens. Currently Ethiopia's immunization system encompasses eleven antigens including Tetanus Toxoid (TT) vaccination.

Most of the Traditional vaccine procurement cost and overall program expenditures are covered by Government of Ethiopia. According to a recent analysis, the MoH and UNICEF have spent 1,833,621 and 1,083,600 USD respectivelyfor traditional Vaccine procurement. However, the overall government expenditure on vaccines (this includes traditional vaccines, 20% government contribution for New and under used Vaccines) used in routine immunization is, 8,679,282 USD. In general, government expenditure for the EPI program has been increasing over the years, with the current contribution representing 33.2% of the overall national EPI budget.

GAVI's immunization portfolio in Ethiopia represents one of the largest among all of the Horn of Africa countries. GAVI support to Ethiopia includes: Health System Strengthening (HSS); New Vaccine Introduction (NVI); Operational costs (OPC) support for SIAs; and a Vaccine Introduction Grant (VIG).

The joint reporting format (JRF) 2014also revealed that the total expenditure on routine immunization including vaccines procurement cost is 108,194,949 USD. In the year 2014, GAVI contributed the following to Ethiopia: 61,172,074 USD for New and Underused Vaccines; 798,428 USD for Injection Supplies; and 15,879,262 USD for Men A Operational Cost Support.

All financial support from GAVI, including Health System Strengthening (HSS),is well reflected in the health sector budgetand in the EPI-specificcomprehensive multi-year plan (cMYP).

1.2. Summary of grant performance, challenges and key recommendations

Grant performance (programmatic and financial management of NVS and HSS grants)

Achievements

- The rotavirus vaccine was launched and introduced nationwide in Nov 2013, except in Somali region. The introduction in Somali Region was delayedto August 2014 due to the Horn of Africa Polio Outbreak Response activities. About 2,042,111(73%) of under-one children received two doses of Rota Vaccine in 2014 out of the targeted 2,804,717 children. The post introduction evaluation was conducted in April2015.

- Men A PhaseII campaignwas implemented in 45 zones reflecting Addis Ababa, Oromia and SNNPR regions from 17-26 October 2014.The administrativereport demonstratedthat 97.6% (26,268,708) of the target population 26,910,708) was reached. The post-SIA coverage survey indicates coverage of 93.5%. Regional coverage was93.9%, 93.4%, and 92.2% in Oromia, SNNPR and Addis Ababa respectively.
- Requested Operational cost was timeouslydisbursedby GAVI.
- Funds for vaccine procurement were timeously transferred to UNICEF SD.

Challenges

- Delayed Rota Virus Vaccine introduction in some areas had an impact on the coverage. The delay of introductionon Somali Region was due to thePolio Outbreak in 2013 and ensuing response.
- Men A Vaccine requires a large volume of space. Therefore, this fact created uncertainty in the timing of vaccine delivery.
- Delayed update of reporting and recording tools resulted in gaps in data quality.
- Work overload at the Ethiopian Public Health Institute resulted in delayed implementation of the Men Apost SIA-coverage survey.
- Post Introduction evaluation or Rota Virus Vaccine was delayed due to the late introduction of the Rotavirus vaccine in Somali region.
- Delay in sending Statement of Expenditure report by regions

Key recommended actions to achieve sustained coverage and equity (list the most important 3-5 actions)

1. **The Intensification Plan** articulates strategies to intensify defaulters tracing,,strengthen supportive supervision at all levels, improve reporting data quality including the inconsistency in the denominator, and increase use of data to inform programmatic action.
2. **The Vaccine Transition Plan** highlights the issue of equity and quality in immunization services asone of the main bottlenecks that need to be addressed to improve the national immunization program. One of the key focus areas to address this barrier is the phased vaccine transition plan. In this plan, PFSA will eventually develop the capacity to deliver vaccine up to the health facility level. **Strengthening vaccine cold chain and supply chain system**the implementation of effective Vaccine management practices including appropriate and evidence-based forecasting, min/max levels, inventory management, stock and vaccine wastage monitoring is a priority. In addition, implementation of the cold chain rehabilitation and expansion plan that includes having anational database for CCE inventory, strengthening cold chain maintenance systems, and use of modern technologies such as the Direct Derive Solar Refrigerator for kerosene refrigerator replacement and expansion in the inaccessible areas will be operationalized.
3. **Supporting a priority Zones and Regions** financially and economically to build their human resourceand infrastructural capacity is underway. Program evaluation and redesign support strategies based on the findings of program evaluation.
4. **Pastoralist tailored Immunization delivery systems** will be developedbased on existing evidence and new/workable strategies will be implemented in the coming few years.
5. **Legacy Planning will** prioritize the use of Polio assets to strengthen Routine immunization.

1.3. Requests to GAVI's High Level Review Panel

Grant Renewals

New and underused vaccine support

- Renewal of vaccine DTP-HepB-Hib, 1 dose per vial, in the existing presentation up 2020
- Renewal of vaccine Rotavirus 2-dose schedule in the existing presentation up to 2020
- Operational cost Support for Phase III Men A Campaign.

Health systems strengthening support

- The approved budget for EFY 2007 of 22 million USD has not been released to date
- Ethiopia has applied for a new HSS support grant for 2016 - 2020

1.4. Brief description of joint appraisal process

The joint appraisal was developed by a team of experts from WHO and UNICEF country offices and from the Ministry of Health.It has also been endorsed by the ICC.

2. COUNTRY CONTEXT

(MAXIMUM 1-2 PAGES)

2.1. Comment on the key contextual factors that directly affect the performance of GAVI grants.

Ethiopia is a federal government administratively divided intonine regional states and two city administrations which are further subdivided in to 103 zones and more than 840 woredas. With a total population of 90 million, the national routine immunization program targets to fully vaccinate a birth cohort of more than 3 million to protect against ten vaccine-preventable diseases.

In 2014, the country started implementing a 28-million USD two-year (2014/2015) comprehensive routine immunization improvement plan (RIIP) with the main aim of supporting 51 high priority zones representing the large numbers of unimmunized children and having low overall immunization coverage. The RIIPaims at increasing immunization coverage by strengthening individualimmunization system components as part of strengthening the overall health system.

In addition to the ICC and its working groups, the MOHestablished the Ministerial Delivery Unit to strengthen leadership of immunization program and to make immunization a standing agenda at key platforms including the Joint steering committees where decision makers regularly meet to discuss strategic issues. In the reporting period, the Government expenditure for the overall immunization program and vaccine purchase was estimated as8,679,282USD. The country fully paid its co-financing share for the purchase of new and under-utilized vaccines worth 5,955,395 USD.

The MOHengaged civil society organizations and provided them with financial and technical support to strengthen the routine immunization program in hard to reach areas where routine immunization coverage has been low. Particular focus is given to pastoralist areas where support has been enhanced with regards to human resources including using the polio surge staff to augment routine immunization, funding for capacity building and provision of cold chain equipment. However, the largeresource demand has not had sufficient funding to support the vast implementation needs of the RIIP, particularly in the pastoralist areas.

The MOH,in collaboration with partners, is also implementing the 2013-2018 cold chain rehabilitation and the national effective vaccine management improvement plan.

As the time for the end of the HSDP IV and MDG is approaching, the country has prepared the Health Sector Transformation Plan (HSTP) 2016-2020 that emphasizesquality and equity. Special emphasis in the HSTP is given to protecting the lives of mothers and children through effective interventions such as immunization.The immunization comprehensive multi-year plan (CMYP) is also drafted and is aligned with the HSTP and the Global Vaccine Action Plan.The total estimated 5-year budget of the cMYP is 1,426,912,879 USD of which, 1billionUSD is immunization specific and the remaining cost

reflecthealth system strengthening activities and SIAs. The 2008 EFY annual plan is drafted based on the five year CMYP. The plan aims to: increase immunization coverage benefiting underserved communities and supporting priority zones; maintain polio free status; implement a wide age range national measles campaign; introduce new vaccines including IPV, bOPVand HPV; and expand the national cold chain capacity along with transitioning the responsibility of vaccine supply chain and delivery to PFSA.

In addition to the routine activities, in 2014 the country successfully conducted a phase-II MenAfrivac campaign, several rounds of polio SIAs including two NIDs, a targeted vaccination response to measles outbreaks in selected areas and a post-Rota introduction evaluation after nationwide introduction of Rotavirus vaccine. Additional polio SIAs are planned for 2015 in addition to continuing the effort of mobilizing resources for a wide age range measles SIAs in response to address the continued outbreak.

In 2014, the national DPT-Hib-HepB3 coverage increased to 87% compared to 82% in 2013 and a total of 207,214 additional children were vaccinated for Penta 3 (in 2014, 2,466,426 vaccinated for penta 3 compared to 2,259,212, in 2013).The number of zones achieving at least 80% penta3 coverage increased from 29% in 2013 to 48% in 2014.

The following table illustrates the 12 months EPI performance as per the GOE Health Management Information System data from July 7, 2014 to July 8, 2015.

Indicator	National Performance	Coverage
Penta 3	2681638	94%
Measles	2563901	90%
DOR	Penta1 to Penta3	6%
	Penta1 to Measles	10%

3. GRANT PERFORMANCE, CHALLENGES AND RENEWAL REQUESTS

(MAXIMUM 3-5 PAGES)

3.1. New and underused vaccine support

3.1.1. Grant performance and challenges

[Comment on all bolded areas listed in the table in this section of the guidance document]

A grant for Rota vaccine introduction was utilized for a nationwide introduction. As per JRF Rota coverage is 73 % in 2014. A Phase II Men A SIA was conducted in 2014.

3.1.2. NVS renewal request / Future plans and priorities

The ComprehensiveMulti Year Plan aims to improve the Coverage, Equityand Quality of the Immunization Program by reaching 95 % coverage of the eligible 2,908,682 surviving Infants. Every year, the expected coverage performance is expected to increase by 1percentage a minimum from the baseline.

In the coming two years period, Ethiopia has no plan to change presentation of any of routine vaccines enrolled in routine immunization program, with the exception of the switch from tOPV to bOPV.

Before the year 2018, no new vaccines are planned to be introduced tothe routine schedule. However, this plan is subject to change. We will notify GAVI there are changes to the current new vaccine introduction plan in the country.

The following are priorities for the national immunizationProgramme:

1. **Measles elimination -** Measles elimination activities will be implemented as per themeasles elimination strategic document 2012 – 2020. For the next two years, priority will be given to conducting a wide age range (under 15 years) campaign to hasten measleselimination.
2. **Cold chain rehabilitation** – Fully implementing therehabilitation plan. To replace all kerosene based and aged cold chain equipment by new equipmentwith a renewable energy source.
3. **Phase III Men A campaign -** preparatory activitiesto implement phase Men A campaign in 27 zones will be conducted to support the November 2015 campaign.
4. **Advocacy and social mobilization –**A robust and comprehensive social Mobilization strategy will be implemented to strengthen routine as well as supplemental immunization activitiesand pastoralist focused communication strategy will be developed and operationalized.
5. **NVI -** AHPV demonstration project will be launched intwo districts (one in Oromia and the one in Tigray) in 2015.
6. **NNTE Validation –**The MOH goal is to sustain NNT Elimination status in 2016.
7. **IPV introduction:** IPV will be introduced in the routine immunization schedule in October 2015.
8. **Monitoring and evaluation** – It has been morethan three years since the last coverage survey. As a DHS will be conducted in 2016, the ICC will assist in conducting a high quality EPI coverage survey by the year 2018.
9. **Intensification plan –** Defaulters tracingand identification of unimmunized children will be strengthened through the new intensification plan.

3.2. Health systems strengthening (HSS) support

3.2.1. Grant performance and challenges

The GAVI HSS support is part of the MDG Performance Fund, which is a pooled funding mechanism managed by the Government using the GOE's financial management, audit and procurement systems. This funding mechanism is managed according to the agreed Joint Financing Arrangement to which GAVI is a signatory. The account is housedin the National Bank of Ethiopia. GAVI HSS funds have beenused as per originally approved proposals and if/when reprogramming needs arise, the matter is taken to the Joint Core Coordinating Committee for approval. In the reporting period, there was no reprogramming of GAVI HSS funds.

There are 12 major Development Partners who contribute to the pooled fund. The pooled fund has one plan, one budget and one reporting mechanism. This agreement prevents contributors from conducting separate assessments or bilateral discussionson achievements and challenges regardingthe MDG PF. , Thequarterly MDG PF report that is shared on a quarterly basis will comprehensively address all issues related to grant performance and challenges.

3.2.2. Strategic focus of HSS grant

Objective 1: The strategic focus for the GAVI HSS/MDG PF is to support the overall system strengthening efforts with a special focus on Maternal and Child health. The Immunization program is part and parcel of child health services.

The overall objectives of the GAVI HSS support were:

1. To Improve EPIoutcomes through community and facility based integrated child health services
1.1: Provide Integrated Refresher Training (IRT) for Health Extension Workers
1.2: Equip newly constructed health centers
1.3: Implement an Electronic Medical Recording system in selected district/primary hospitals
1.4: Implement mHealth at community level
1.5: Procure of essential drugs and supplies for health post

Objective 2: To improveaccess to primary health care services in selected low performing and hard to reach areas to improve immunization outcomes
2.1: To implement astrategy to respond to the needs of number of low performing and hard to reach areas through CSO participation
2.2: To strengthen theHealth Forum to facilitate overall involvement and collaboration of CSOs working in immunization and child health

Objective 3: Strengthen the capacity and management of Cold Chain system at all levels
3.1: Strengthenthe capacity of the cold chain system
3.2: Establish and Strengthen regional medical equipment maintenance workshops with special focus on the cold chain system
3.3: Supply PV solar for health centers
3.4: Train appropriate persons on the management of cold chain maintenance

3.2.3. Request for a new traunch, no-cost extension, re-allocation or reprogramming of HSS funding / Future HSS application plans

- The approved budget for EFY 2007 of 22 million USD has not yet been released
- Ethiopia has applied for a new HSS support grant for 2016

3.3. Graduation plan implementation*(if relevant)*

[Comment on all bolded areas listed in the table in this section of the guidance document]

3.4. Financial management of all cash grants

Meningitis A - operational costs cash grant with a total of 15,879,282 disbursed to Ethiopia.

A. 1,180,179.30 USD requested for other trainings and meetings. The total amount disbursed to the Regions was 1,298,800 USD for the same purpose.

B. Funds wererequested to cover the cost of human resource and incentives forVaccinators, volunteers, and supervisorand program management and coordination totaling2,805,797.68 USD. The total amount disbursed to the regions was 3,287,502.00 USD.

C. A total of 1,851,420.42 USD was requested for transportation, implementation and supervision. Of this amount, a total of 334,662 USD was disbursedto cover the petrol costs of government vehicles. The operational budget for the distribution of vaccines

totaling1,562,734 USD will be disbursed to PFSA upon request by PFSA. The financial transfer is usually effective at the end of the Ethiopian fiscal year, 2007 EFY (July, 2015).

D. 2,305,000 USD was requested to support and strengthen cold chain system equipment. Of the overall total, 1,420,000 USD is committed for the procurement of cold boxes and cold rooms. However, financial transfer will be effective after a comprehensive technical evaluation is completed and the cost estimate is received.

E. In order to strengthen RI, 2,278, 095.59 USD is requested. As part of the routine immunization strengthening activities, the FMOH developed the Routine immunization intensification plan requiring a total of 11,967,507.05 USD to support the major objectives of identifying unimmunized and tracing defaulters for increased uptake of immunization.

F. Accordingly, 6,697,386 USD was transferred and utilized for the implementation of Phase II Men A campaign. In addition, 2,278,095.59 USD, 1,562,734.25 USD and 1,420,000 USD is already committed for RI strengthening activities, cost of supplies distribution and procurement of cold chain equipment respectively totaling 5,260,830 USD.

In the 2013 JA,the Government was required to propose a plan for the utilization of all remaining funds supporting the RIIP implementation. Thus, the Intensification plan has been developed. The main overall objective of the intensification plan is to reduce the number of unimmunized children by 80% in each zone with specific objectives articulated to identify unimmunized or defaulted children using the HEP and ensure Catch up immunizations, with the exception of BCG.

The GAVI HSS grant is managed as per the government Public Financial Management rules and regulations. Procurement and auditsare also conductedas per Joint Financing Agreement (JFA).

3.5. Recommended actions

Actions	**Responsibility** (government, WHO, UNICEF, civil society organizations, other partners, Gavi Secretariat)	Timeline	Potential financial resources needed and source(s) of funding
Extension of NVS (Penta and Rota)	Gavi	2016-2020	GAVI
Continuation of HSS grant	Gavi	2016-2020	GAVI
RI strengthening activities,	WHO, UNICEF, CSO	2016 - 2017	GAVI, WHO, UNICEF
Measles wide age range SIA	GAVI	October ,2016	GAVI
Intensification Plan	GAVI	2016	GAVI

4. TECHNICAL ASSISTANCE

(MAXIMUM 1 PAGE)

4.1 Current areas of activities and agency responsibilities

WHO, UNICEF, CHAI, JSI, USAID, PATH, Core Group, Rotary, and CDC are available to support theoverallEPI programs. These partners facilitate the country's commitment on new initiatives and programs. On the basis of the current circumstances, a particular focus for TA and coordination are

already part of the partners' support to the RIIP. Fifty-one technical assistants are in place to support the equity focused zonal approach where high numbers of unimmunized children were identified following the 2012 EPI coverage survey. The TAs are distributed between UNICEF (20), WHO (15), CDC (10) and USAID/ L10K (6) .

WHO and UNICEF seconded EPI Technical Assistants to support capacity enhancement and to provide support within the MoH to strengthen leadership and oversight of the EPI Programme.TA is required to increases support for equity improvement, data quality cold chain and supply chain with a focus on stock management.

4.2 Future needs

- **Continued support for quality improvement** that is already part of the partners' support to the RIIP to improve the routine immunization program
- **Logistics and cold chain management support** - TA at FMOH and PFSA is needed to support immunization supply chain activities with regards to: forecasting vaccines and devices; streamlining procurement process, receiving, distribution and monitoring vaccine utilization (stock management). The technical assistants will assist in: development and implementation of CCE and EVM;capacity building/mentoring;strengthening the vaccines/cold chain management activities; conducting temperature monitoring and vaccine wastage studies;conducting CC storage capacity assessment; developing expansion and replacement plans; andinstalling cold chain maintenance and repair systems at center and sub center level.
- **EPI Technical Assistance** is needed to: support EPI capacity in Data management and coverage improvement processes; conduct a coverage verification survey; conduct a data quality self-assessment and develop an immunization data quality improvement plan review; support the cMYP revision; provide capacity building support of the existing EPI structures at regional, zonal, and district levels;assist the GOE to develop an investment and sustainability plan for EPI; support the development of aNVI application; and help the country develop an investment and sustainability plan for EPI.
- **BCC Technical Assistance** demand generation and communication- Increase of demand for immunization services

5. ENDORSEMENT BY ICC, HSCC OR EQUIVALENT& ADDITIONAL COMMENTS

(MAX. 1 PAGE)

The ICC Minute is attached here with.

6. ANNEXES

[Please include the following Annexes when submitting the report, and any others as necessary]

- **Annex A. Key data** (this will be provided by the Gavi Secretariat)

- **Annex B. Status of implementation of the key actions from the last joint appraisal and any additional High Level Review Panel (HLRP) recommendations**

Key actions from the last appraisal or additional HLRP recommendations	Current status of implementation
MOH was Requested to submit plan for unutilized funds from GAVI	**Intensification plan is submitted**

- **Annex C. Description of joint appraisal process** (e.g. team composition, how information was gathered, how discussions were held)

The joint appraisal was developed by a team of experts from WHO and UNICEF country offices and from the Ministry of Health. It has also been endorsed by the ICC.

- **Annex D. HSS grant overview**

General information on the HSS grant							
1.1 HSS grant approval date			March 2012				
1.2 Date of reprogramming approved by IRC, if any			No reprogramming				
1.3 Total grant amount (US$)			75,199,484				
1.4 Grant duration			2012/13 - 2014/15				
1.5 Implementation year			2012/13 - 2014/15				
(US$ in million)	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
1.6 Grant approved as per Decision Letter	6,255,481	40,440,366	19,662,818	8,840,818			
1.7 Disbursement of tranches	6,255,481	34,000,000	22,000,000 (Approved but not yet disbursed)				
1.8 Annual expenditure	Part of pooled fund						
1.9 Delays in implementation (yes/no), with reasons			Very critical delay in disbursement of the third traunchwhich was supposed to be done in October 2014				

1.10 Previous HSS grants (duration and amount approved)	2006/7 to 2009/10 total amount **76,493,933**
1.11 List HSS grant objectives 1. Strengthen Health Workforce 2. Supply distribution and maintenance system 3. Improve Organization and management	
1.12 Amount and scope of reprogramming (if relevant)	

- **Annex E. Best practices (OPTIONAL)**