Joint appraisal report

When submitting this report, the country confirms that the grant performance framework has been reviewed as part of this joint appraisal. Performance against agreed metrics has been analyzed, and explained where relevant.

Country	Ethiopia
Reporting period	*July 8, 2015 – July 7, 2016*
Fiscal period	*July 8, 2015 – July 7, 2016*
If the country reporting period deviates from the fiscal period, please provide a short explanation	*The fiscal year is 2008 EFY which covers the period from July 8, 2015 – July 7, 2016 Though the reporting period is the same as per the report guidance performance framework is a baseline for Program performance evaluation*
Comprehensive Multi Year Plan (cMYP) duration	*2016-2020*
National Health Strategic Plan (NHSP) duration	*2015/16 - 2019/20*

1. SUMMARY OF RENEWAL REQUESTS

Programme	Recommendation	Period	Target	Indicative amount paid by Country	Indicative amount paid by Gavi
NVS – *PCV in existing presentation*	*Extension*	*2017*	3,037,507	*US$ 1,786,500*	*US$ 28,651,000*
NVS – *Pentavalent in existing presentation*	*Renewal*	*2017*	3,037,507	*US$ 1,920,500*	*US$ 16,292,500*
NVS –Rota *in existing presentation*	*Extension*	*2017*	3,037,507	*US$ 1,259,500*	*US$ 12,896,500*

Indicate interest to introduce new vaccines or HSS with Gavi support*	Programme	Expected application year	Expected introduction year
	MR	*2017*	*2018*
	Men A	*2017*	*2018*
	HPV	*2017*	*2017*

	Yellow Fever	*2017*	*2018*

**Not applicable for countries in final year of Gavi support*

2. COUNTRY CONTEXT *(maximum 1 page)*

Leadership and Governance

Ethiopia is a federal parliamentary republic, with the Prime Minister serving as head of government. Executive power is exercised by the government. Administratively divided into nine regional states and two city administrations which are further subdivided in to 103 zones and 957 woredas with estimated total population of 92.5 million, the national routine immunization program targets to fully vaccinate an estimated 2.85 million surviving infants to protect against 10 vaccine-preventable diseases.

In Ethiopia, immunization is one of the high impact interventions and continues to be a priority program. The ICC, which is chaired by the state minister or his delegate and with representation of all EPI partners in the country, provides oversight of the immunization program in terms of coordination and implementation of key activities. Ministers, heads of agencies and heads of regional health bureaus (9 regions and 2 city administrations) are briefed and discussions are made on key milestones, progresses and important challenges during joint steering committee meetings. The steering committee which convenes every two months' time is a key driving event to move the EPI program in that pertinent achievements as well as challenges are addressed to the regional states by their representatives to be shared with program focal persons. The country established NITAG in May 2016 which is officially recognized to be the technical deliberative body for the country EPI program.

Both the health sector development plan IV and the cMYP came to an end in 2015. The country prepared a five year Health Sector Transformation Plan (HSTP) 2015/16-2019/20 likewise new cMYP 2016-2020 was also prepared where the goals and priorities are aligned with that of the HSTP.

Coverage & equity

Inequities in immunization coverage exist in Ethiopia (DHS 2011). Children from rural areas, lowest wealth quintile and from non-educated mothers tend to receive lower DTP3 vaccines: 14%, 26%, 31% compared to those living in urban locations, highest wealth and with at least secondary education: 54%, 61%, 80% respectively. Gender gap on DTP3 coverage is not wide (5%) between boys and girls: 34% and 39% respectively.

Service Provision Assessment 2014 also showed some evidence that there are bottlenecks and variations on availability of the immunization services across regions. Service provision offered in health facilities ranged from 47% -83% while availability of all basic vaccines in the health facilities during the time of survey ranged from 39%-84%. MoH also prepared equity plan of action to be implemented from 2016 to 2020 G.C.

The MoH through the Health system strengthening directorate is providing technical support for regions that need special support in terms of equity by deploying 35 health experts who are mainly engaged in the health system strengthening building blocks.

Ethiopia will adopt the FMOH HSS equity determinants analysis framework, implement REC to address inequities to be able to provide services fairly in all locations and reach marginalized groups of children.

Considering 2008 EFY (July 2015-June 2016), as the first year for HSTP, the Ministry guidance for all regions was to strive towards sustaining coverage and improving quality and equity. Technical and financial support was provided to regions to strengthen routine immunization and increase coverage. Immunization targets were further agreed with GAVI through the performance framework in February 2016 where the set targets were aligned with cMYP. Support to 51 priority areas continued in 2008 EFY as part of the routine immunization improvement plan. Technical assistants deployed in 15 out of 19 zones of the total pastoralist regions (excluding towns) as a way of improving immunization and equity.

Through the GAVI support, the MoH provided civil society organizations with financial and technical support to strengthen the routine immunization program in hard to reach areas where immunization coverage has been low. Particular focus was given to pastoralist areas where support has been enhanced with regards to human resources such as using the polio surge staff to augment routine immunization, funding for capacity building and provision of cold chain equipment.

In 2008 EFY the national DPT-Hib-HepB3 coverage reached 97.6% and a total of 176, 300 additional children were vaccinated for Penta3 compared to 2007 EFY. Nationally, 75% of woredas achieved >=80% Penta 3 coverage (Lowest in Ethiopian Somalia region and highest in Addis Ababa 23% & 90% respectively)

Immunization Supply Chain System:

Immunization supply chain has great leadership and strong commitment led by the government to realize the cold chain rehabilitation and expansion plan. Following Ministry's decision to transfer the role and responsibilities on vaccine supply chain management in to Pharmaceutical Fund & Supply Agency (PFSA), a number of activities have been implemented to effect the transition plan. Dessie and Gondar PFSA hubs have implemented the vaccine transition plan in addition to Bahir Dar, Mekelle and Jimma PFSA hubs which successfully implemented the transition. Baseline assessment has been conducted in 6 PFSA hubs which have catchment areas to deliver vaccine in Oromia, Harari, Dire Dewa, SNNPR and Somali Regions. Moreover, vaccine costing analysis for all delivery routes and temperature mapping for refrigerated vehicles was conducted.

Capacity building activities provided in vaccine management and cold chain maintenance.

Ethiopia conducted the EVM assessments in 2013 and developed an EVM improvement plan in 2014. Activities were regularly followed and implemented in collaboration with the development partners. The recent assessments shows that Ethiopia has addressed 41 recommendations, partially Achieved 28 recommendation and only 4 are under

process. As part of the continuous improvement and planning, vaccine forecasting and supply planning is timely prepared and shared to all concerned. Remote Temperature Monitoring Devices (RTMD) procured and installed in all cold rooms and stand by generator installed along with the newly installed 17 cold rooms at PFSA Hubs. In order to improve vaccine management and contingency planning, more than 5,000 and 3,000 job aids (flip chart) distributed. Fridge tag analysis regularly done and feedbacks provided.

Reliable, well-maintained and cost-effective cold chain equipment is vital to ensure quality in the immunization service delivery. Moreover, due to the fact that more than 60% of the refrigerators are Kerosene refrigerators where there is a risk of kerosene supply interruption, frequent breakage of refrigerators and also expose the vaccine to freezing. Hence, FMoH procured 2,000 SDD refrigerators and additional SDD are under the procurement process. In addition, special attention is given to the pastoralist Region where immunization service is low. Moreover, Ethiopia applied to the GAVI CCEOP window to benefit from the opportunity. In PFSA hubs, 17 cold rooms are installed and relocation of cold room from Amhara and Tigray RHB was effected to PFSA to build the cold chain capacity.

Government procured spare parts which was the second major reason for non-functionality of refrigerator. It was also procured with the support of UNICEF and CHAI. During the period, curative and preventive maintenance was conducted in parallel with the SDD installation. In addition, FMoH is strengthening the maintenance structure by recruiting more biomedical technicians from federal down to the health system. This is supported by the pre-service training currently provided to biomedical technicians in Tegbare'ed vocational school and Jimma Univeristy.

Immunization financing

In the reporting period, the Ministry procured all traditional vaccines as well as paid the 2015 co-financing commitment for new and under-utilized vaccines. Percentage of total Government expenditure for routine immunization showed improvement from 33.2%, in 2014 to 39.25%, in 2015.

3. GRANT PERFORMANCE AND CHALLENGES *(maximum 3-4 pages)*

3.1. New and underused vaccine (NVS) support

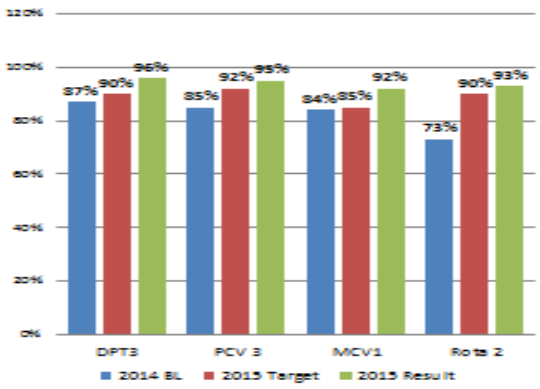
3.1.1. Grant performance, lessons and challenges

A) Routine immunization

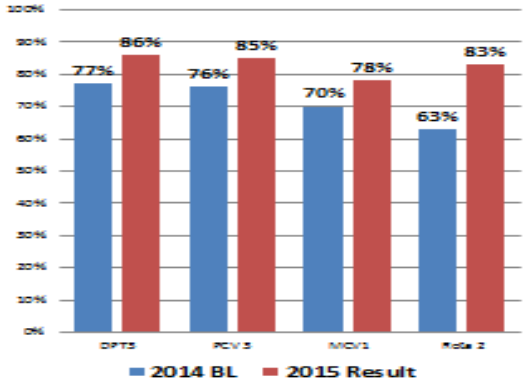
Routine immunization strengthening efforts continued in 2015 (2008 EFY) aiming to achieve 92% DPT3/PCV3/Rota2 coverage and reduce dropout rates to below 7%. Attention was also given to reduce disparity between regions and districts by providing technical and financial support to low performing areas.

Administrative reports and WHO-UNICEF estimates showed increased immunization performance and targets set in the performance framework are met for all antigens with national average penta 3 coverage of 96%. (Graphs 1&2) Additional 300,000 new children received DPT-Hib-HepB3 in 2015 compared to 2014. There is minimal coverage discrepancy observed among vaccines administered at the same visit or schedule.

Graph 1: Comparison of key immunization performance using administrative data 2014-2015, Ethiopia (JRF 2015)

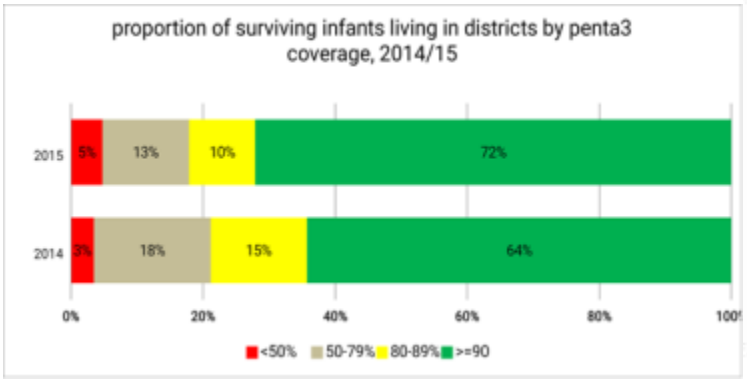


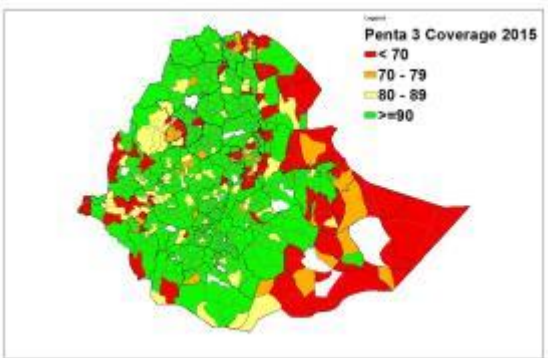
Graph 2: Comparison of immunization performance using WHO-UNICEF estimate, 2014-2015, Ethiopia



In 2015, the number of children unvaccinated for penta-1 decreased dramatically; in the same manner, number of unvaccinated for penta-3 and measles reduced by 67% and 50% respectively compared to 2014. In 2015, 72% of surviving infants were living in an area with >=90% penta 3 coverage compared to 64% in 2014. However, 5% of the children were living in an area with <50% penta 3 coverage which shows a slight increment from the previous year (3%). (Graph 3) A more comprehensive analysis of equity by socio-economic characteristics will be done once the DHS 2016 is finalized.

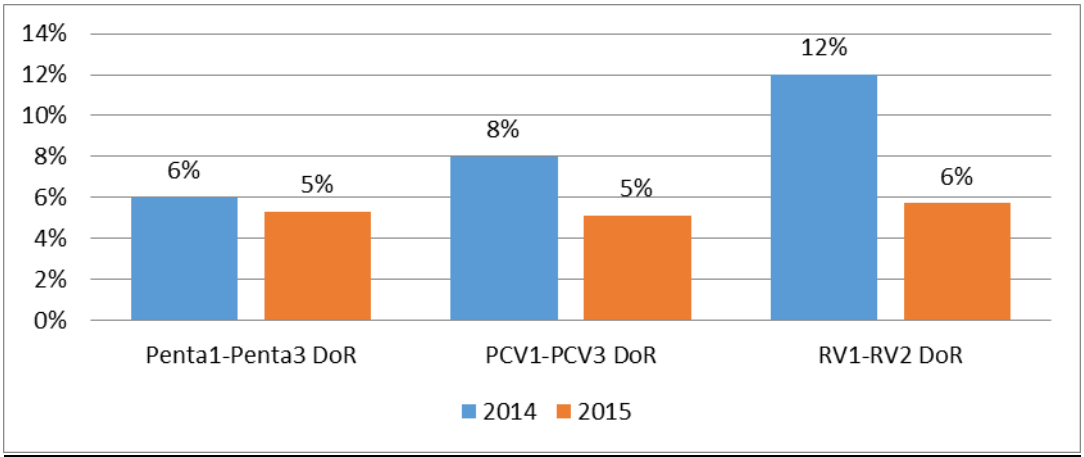
Figure: showing distribution of surviving infants by district immunization performance, 2014-2015, Ethiopia (JRF





Despite encouraging performance improvement, denominator problems might have affected actual coverage as shown by penta 1 >100%. There is also performance disparity between agrarian regions and pastoralist regions as shown in the figure1 below. The disparity, among other factors, has to do with maturity of the Health Extension Program (HEP) which continues to play important role in delivering equitable health services, including immunization services, to communities. The HEP is working better in Agrarian regions and there is improvement in pastoralist areas as grade 10 graduated HEWs are being recruited and deployed. However, utilization of health services is not optimal in hard to reach and pastoralist areas due to life style and infrastructure challenges. The health development army initiative is providing grass root level support to the HEP including through community discussion, updating vital events registration and tracing defaulters. The social mobilization network is used more often in pastoralist regions.

Graph 4: Dropout rates between first and last dose of selected antigens, 2014-2015, Ethiopia(JRF 2015)



B) HPV Demo Program

The country also planned to implement year 1 HPV demo program in 2015 targeting grade 4 girls and 10 years old out of school girls. HPV dose 1 was colorfully launched in the two districts, Aheferom and Gomma, in December 2015. Dose 2 was implemented in June 2016 followed by PIE in the same month. While waiting for the coverage survey report as per requirement of the Gavi grant performance frame work; administrative report from the demo regions show way above the required 50% coverage in the first year (HPV1=93.3%; HPV2=86.3%). Timing of HPV1 was close to mid-year which affected timing of dose 2 which was a lesson learnt to plan better for year 2 Demo program. School vaccination was the main strategy used to vaccinate target girls because of high school enrollment while those out of school were vaccinated in health facilities. The demo program also suffered from denominator related issues where out of school girls were much more less than planned.

C) New vaccine introduction

The country planned to introduce IPV in to the routine immunization program in July/August 2015 but this was delayed until December 2015 mainly due to delay in confirming availability of adequate supply for national introduction. There was also delayed delivery of IPV in health facility once the vaccine was in country because of

the short rain drought related emergency situation and other competing priorities. The country successfully implemented the switch from tOPV to bOPV as per global timeline.

D) GAVI supported campaign

The third phase of MenAfrivac campaign was implemented in October/November targeting individuals 1-29 years living in 257 woredas under 27 zones of Afar, Amhara, Harari, Oromiya, Somali, and Tigray regions as well as Dire Dawa city administration.

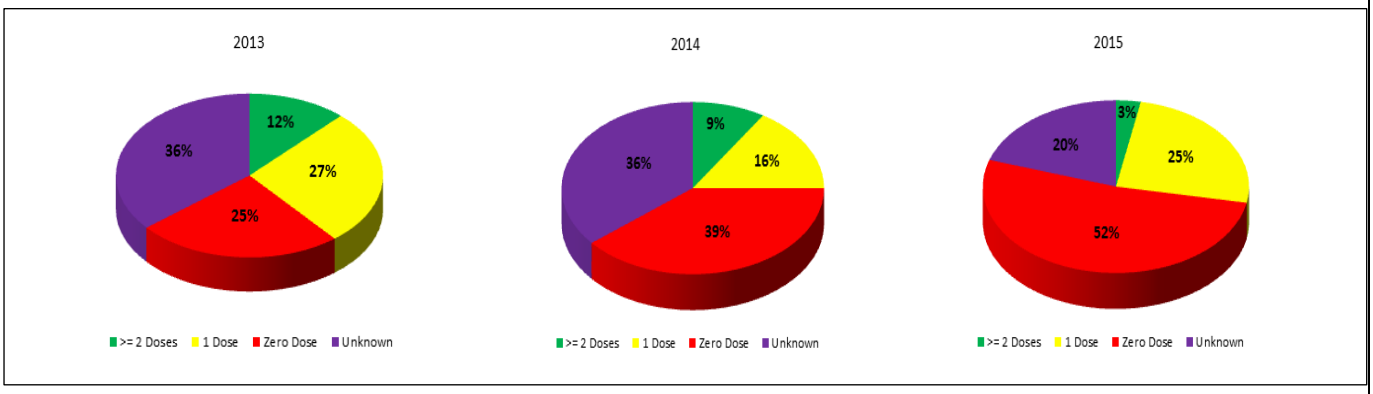
High administrative coverage was achieved in this round. It was planned to vaccinate 15,910,620 individuals and 16,174,546 were vaccinated achieving administrative coverage of 101.7%. Post campaign coverage survey report showed overall coverage of 94%.

E) Status of strengthening surveillance systems (for AEFI and disease surveillance)

The Ethiopian surveillance system is organized to cover the whole population including hard to reach areas of the country. The overall coordination is under the public health emergency management (PHEM), and this trickles down to health facility level.

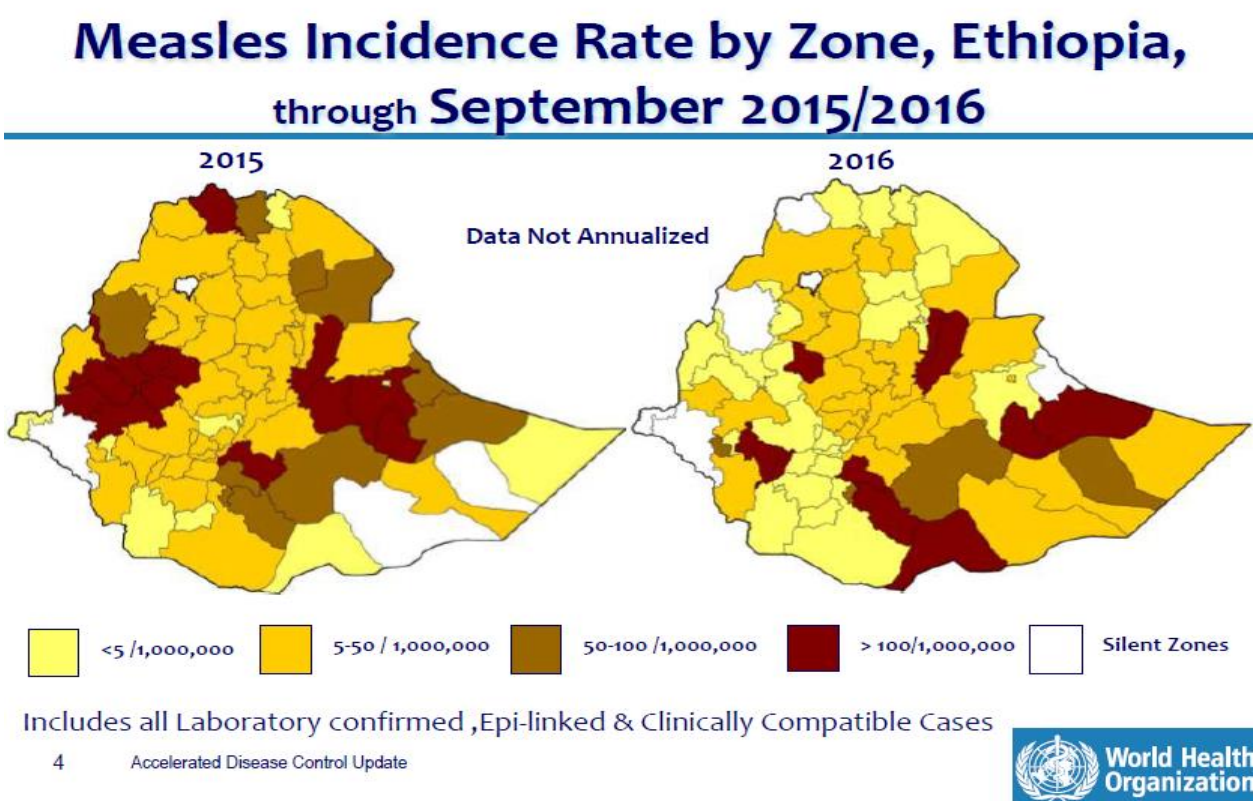
To strengthen surveillance, capacity building activities are carried at sub national level for focal persons as well as health workers including community based surveillance in Somali region. On top of capacity building activities review meetings are conducted at national and sub-national level.

Measles, rubella and NNT surveillance is embedded in to polio surveillance to detect, investigate and confirm suspected cases. The country has also established new vaccine sentinel surveillance for purulent bacterial meningitis, Rota intussusception and congenital rubella syndrome. Surveillance data is triangulated with administrative data to better guide immunization activities in the country. Based on measles surveillance data over 50 % of the confirmed cases among under five year children had vaccination status of zero dose showing that these children were missed either in the routine immunization, SIAs or both. Figure showing vaccination status of confirmed measles cases among under-five children, Ethiopia, 2013-2015



Measles incidence showed remarkable reduction in 2016 compared to 2015 following implementation of wide age range SIAs (6 month up to <15 years) in 505 woredas in April 2016. However surveillance data shows children under five years of age to be proportionally highly affected with 56% of confirmed

cases in 2016 being in this age group. The declining measles surveillance over the years is also a challenge which among other factors is affected by resource constraint.



There is a progressive improvement in the AEFI surveillance under the FMHACA guidance and collaboration of MOH and WHO. Activities conducted to strengthen AEFI include:

1. The national guideline for AEFI finalized, printed and distributed throughout the country
2. Two rounds of ToT trainings were conducted and a total of 98 trainers were trained which was followed by a cascaded training given for a total of 1298 health workers.
3. The national causality assessment committee is revitalized by replacing some of the task force members. orientation of the task force members is planned from 18-21 October 2016
4. There is an ongoing effort to establish a national database for all reported AEFI cases.

Challenges

1. Competing/overlapping activities resulted in change in implementation timelines
2. Sustaining the IPV introduction in the context of shortage of IPV at global level
3. There are still large number of unvaccinated children and denominator issue might be a challenge as well
4. Low coverage in pastoralist areas/hard to reach; no innovative and proven approach to address the concern in acceptable and sustainable way.
5. Budget shortage to adequately address activities in the RIIP

3.1.2. NVS future plans and priorities

The Proposed targets (first and last dose as applicable) for next implementation year for the new vaccines are determined using demographic data and conduct forecasting to determine the quantity of different antigens required for routine and campaign activities. The target population is calculated based on figures of 2007 population and housing census using official population projections. Woreda based population figures shared from Plan and Policy Directorate in FMoH is used to estimate total population, birth and surviving infants and under five and fifteen children. In addition, data shared from Administrative for Refuges and Returnee Affaire (ARRA)/UNHCR is used to estimate under one, five and fifteen children in refugee camps. Since there is no documented study on wastage factors in local context, the WHO wastage rate indicators are considered with some revision done based on the field experience and consensus reached during planning exercises.

The major priorities for the immunization program will be:

- Derive annual EPI plans based on the cMYP 2016-2020 and monitor their implementation.
- Enhance immunization service quality and equity at all levels
- Emphasis on disease specific outcome/impact monitoring
- Strengthen immunization data quality and management at all levels
- Continue intensified polio eradication efforts, certification; strengthen IPV implementation; ensure virus containment and Polio transition planning.
- Ensure measles mortality and morbidity reduction through wider age group measles SIA for the remaining Woredas.
- Eliminate measles and advocate for the elimination of rubella and congenital rubella syndrome.

3.2. Health systems strengthening (HSS) support

3.2.1. Strategic focus of HSS grant

GAVI HSS support is part of the Ministry of Health pooled funding mechanism managed by the Government to support the immunization program of the country giving due emphasis to reduce disparity between regions and districts by providing technical and financial support to low performing areas. As demonstrated earlier 2015/2016 routine immunization performance showed improvement compared to previous year as well as the planned target. The number of unvaccinated/under vaccinated children was also reduced significantly this year compared to 2014/2015.

On other hand, the Health Extension Program (HEP) continues to play important role in delivering equitable health services including immunization services to communities. With the experience of the HEP is working better in agrarian regions so far, currently there is improvement in pastoralist areas as grade 10 graduated HEWs are being recruited and deployed to improve access and equity for immunization services. The health development army initiative is providing grass root level support to the HEP including through community discussion, updating births and deaths and tracing defaulters. The social mobilization network is used in pastoralist regions and these will significantly contribute the sustainability of the gains so far.

3.2.2. Grant performance and challenges

Challenges:

- Long outstanding balance at regions due to pooling financial system
- Staff turnover

➢ **Proposal for unspent funds**

Grant Name	**Unspent fund**	**Planned activities**
ETH-VIG-IPV	$ 78,283	Post introduction evaluation
ETH-MENAOPC III	$ 113,202	RI Strengthening activities (PIRI)
ETH-MEASLESOPC	$ 20,465	PIRI
ETH-VIG-ROTA	$ 419,872	Reprogramming and no cost extension planned to implement routine immunization support at low performing region.
Grand total	**$631,822.00**	

➢ **Complementarity between VIGs, operational costs and HSS funds** (i.e. alignment between activities funded through VIGs or operational support for campaigns and HSS grant activities)

FMoH has annual plan preparation process. As part of it, there is a plan alignment with in the directorate, agencies and developmental partners. The plan has its own budget line and an alignment is made with regard to the activity and budget plan. Following this process, VIG support, SDG-PF and other cash support will be aligned and approved by the top management in the Ministry.

➢ **Overall Financial capacity to manage NVS grants**

The FMoH administer all the grants in accordance with the financial guidelines of the government. Finance and procurement directorate (FPD) organized into six case teams [Grant Management, Grant Finance, Procurement, property Management, Treasury and IFMIS] in order to strengthen the internal control system and segregation of duties. All grant funds are managed separately through computerized Peachtree Accounting software and IFMIS.

Currently, the ministry has cascaded grant management system to all regions and zones; and hired Grant Management and Grant Finance Officer. These helped the ministry to manage all donor funds as per their rules and regulation.

Furthermore, FPD conduct continuous supportive supervision to the RHB; then RHB to Zones and Zones to Woredas, that improved the grant and financial management system. Also the FMoH - FPD organizes quarter based review meeting to RHB, Agencies and Hospital that is a platform for capacity building, knowledge and best practice

sharing among the participants. Therefore, the ministry has the capacity to manage NVS Grant with an acceptable level.

3.2.3. Describe any changes to HSS funding and plans for future HSS applications

Refer MDG/SDG quarterly activity report

3.2.4. Transition planning (if relevant)

No plan is prepared on transitioning out of GAVI support. The country is eligible for GAVI support based on current GDP

3.2.5. Financial management of all cash grants (e.g. HSS, VIG, campaign operational cost grant, transition grant)

- Cash Utilization Performance

During the reporting period the FMoH received a total amount of USD 8,553,671 for VIG and Operational cost to implement HPV DEMO, IPV VIG and MenA phase III campaign. The below table shows the cash utilization performance from July 8, 2015 – July 7, 2016

Grant Name	Amount approved in USD	Amount disbursed (USD) 2015/2016	Local currency ETB	In Local Currency - Birr		USD equ. (1USD= 21.8308 Birr) date 07/July/2016		Unutilized %	Remarks
				Cash balance - In Birr	Advances - In Birr	Cash balance	Advances		
ETH-DEMO-HPV	$ 195,000	$ 169,982	3,518,270	2,322,720	457,597	$ 106,396	$ 20,961	66%	Two years program
ETH-VIG-IPV	$ 2,536,500	$ 2,536,482	52,469,413	1,708,972	9,806,467	$ 78,283	$ 449,203	3%	
ETH-MENAOPC III	$ 9,768,488	$ 5,847,421	121,846,973	2,471,281	19,965,763	$ 113,202	$ 914,569	2%	
Grand total	**$ 12,499,988**	**$ 8,553,885**	**177,834,656**	**6,502,973**	**30,229,827**	**$ 297,881**	**$ 1,384,733**		

As can be seen in the table above the utilization for HPV program is less due to the fact that the program implementation period is for two years and the report only shows the eight months program achievement.

On the other hand, the ministry utilized cash from the balance brought forward funds. For detail refer the below table

Grant Name	BBF as of July 8, 2015		Utilization		Balance as of July 7, 2016		Unutilized %
	In local Currency	USD	In local Currency	USD	In local Currency	USD	
ETH-MEASLESOPC	39,645,979	$ 1,878,040	39,199,216	$ 1,822,880	446,764	$ 20,465	1%
ETH-MENAOPC II	186,115,122	$ 8,816,318	145,414,416	$ 6,762,203	40,700,707	$ 1,864,371	22%
ETH-VIG-ROTA	9,183,192	$ 435,010	17,060	$ 793	9,166,132	$ 419,872	100%
Grand total	**234,944,294**	**$ 11,129,368**	**184,630,692**	**$ 8,585,877**	**50,313,602**	**$ 2,304,707**	

As depicted in the above table MENAOPC II grant unutilized performance of 22% was the committed amount for the procurement of cold chain equipment to strength the immunization service in the hard to reach areas. The ministry ordered the items from UNICEF and the procurement process is ongoing.

The unutilized fund of ROTA is planned to request GAVI for reprogramming and period extension. The plan is to support routine immunization strengthening activities in low performing regions.

- Financial Management Capacity Constraint

FMoH managed all the grant funds according to approved budgets in a transparent and accountable manner with financial records and accounts meeting the requirements of GAAP and IFRS. Furthermore the finance and procurement system have strong budgeting, financial management, accounting, internal controls, reporting and auditing function.

Though the following are financial capacity constraints in the system:-

- Pool financing system at Zonal and Woreda level might lag liquidation,
- Running two Financial parallel systems (IFMIS and Peachtree) in MoH,
- Delay of IFMIS roll out to Regions and Federal Agencies and
- Long transaction hierarchy from FMoH up to down to the Woreda level.

During the reporting period there is no Modifications made to the financial management arrangements.

- Major issue from Programme Audit or Monitoring review

During the reporting period GAVI has made Programme Audit and Monitoring review. However, the final audit report is not yet officially shared.

- Degree of compliance with Financial Management Requirements

The ministry adheres the financial management requirements that are stated on the Gavi Aide Memoire/Financial Management Requirements.

4. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

Prioritized strategic actions from previous joint appraisal HLRP process	Current status

1. Intensification plan	• The intensification plan was prioritized in order to intensify defaulters tracing, strengthen supportive supervision at all levels, improve data quality including the inconsistency in the denominator and increase use of data to inform programmatic action giving due attentions to low performing and pastoralist regions. • So, the following major activities were executed and achieved during last reporting year: - Gavi funds were disbursed to the regions in order to help them in defaulter tracing and installation of SDD, as well as strong program monitoring. - The targeted support continued to 51 low performing zones with high number of unvaccinated children to strengthen capacity building and program monitoring, improve data quality and local data use, and facilitate timely supply provision through deployed zonal immunization assistants. - As a result, the country achieved significant coverage improvements. Penta3 coverage has increased by 18% in the ZIA deployed zones between 2013/14 to 2015/16.
2. NVI - HPV	• The launch of the HPV demonstration project was a priority for the report period. It was successfully demonstrated in two districts (Ahferom and Gomma) in two different regions with administrative coverage result of HPV1=93.3%; HPV2=89.5% and DoR 4%. • Coverage survey and costing analysis are under way for better informed decision for national rollout.
3. NNTE Validation	• All regions have been validated as planned during this reporting period. • TT campaign was implemented in the region during the reporting period.
4. IPV introduction	• IPV was fully introduced at national scale • Switch from tOPV to bOPV was also successfully conducted in April 2016 and validated in line with the global standard during report period.
5. Measles Elimination Efforts	• Measles elimination strategy developed earlier was under implementation during this reporting period. • Measles SIAs was conducted in October and November 2015 • Again, wide age range Measles SIA was conducted integrated with polio NID in April 2016 in 505 drought-affected and measles hotspots districts.

	• The post campaign coverage survey showed 94% coverage. • During this reporting period, measles outbreaks were adequately responded in collaboration with Public health emergency management unit of Ethiopian Public Health Institute and regional health bureaus. o As a result, measles incidence reduction was consistently documented with reduction from 81 cases in 2014/2015 to 37 in 2015/2016 per 1,000,000.

6. Vaccine supply transition and Cold chain rehabilitation	• The interruption of supply and lack of proper cold chain management are the main bottlenecks to achieve equity and quality in immunization services. This was among the priorities identified and the key focus areas were to address this barrier through Cold chain rehabilitation and vaccine supply transition
	• During this reporting period:
	  o From previously procured total of 27 cold rooms, 21 were successfully installed which will significantly improve the cold chain capacity of the country. The remaining six cold rooms are currently under installation.
	  o 2000 Solar Direct Drive were installed across the country's health facilities giving special emphasis to pastoralist and inaccessible geographic areas which will improve the cold chain capacity and optimality at the service delivery points.
	  o Cold chain spare parts were procured which are worth of 25 million Birr. Distribution is planned for the regions and PFSA hubs
	  o Vaccine supply transition which was planned in phased approach has been successfully undertaken at four sites (Mekelle, Bahr Dar, Dessie and Gondar) and the assessment of another eight sites (Adama, Dire Dawa, Hawasa, Negelle, Jimma, Nekemte, Dire Dawa and Semera PFSA hubs) have been conducted and the remaining will take place in coming period.

7. Polio transition/legacy	• Polio transition planning committee was established and the participants meet on a regular basis. A plan of action was developed and all polio best practices were reviewed and identified.
8. Phase III Men A campaign	• Phase III Men A campaign was conducted in 27 zones in October/November targeting 1 to 29 years and reached 16,174,546 with more than 100% coverage.

9. Advocacy and social mobilization	• Advocacy, communication and demand generation activities have been conducted in order to strengthen routine immunization and other immunization related activities. • Communication strategy was developed during this reporting period and immunization messages were harmonized with other health programs. • The 5th round of African vaccination week was conducted with the objective of tracing and vaccinating unvaccinated/ under vaccinated children. • Radio and TV messages as well as Job aids were produced and transmitted for both routine immunization activities and for different campaigns mobilizations.

5. PRIORITISED COUNTRY NEEDS[1]

Draft priorities for targeted country assistance for Ethiopia are attached separately for reference.

	Prioritized needs and strategic actions	**Associated timeline for completing the actions**	**Does this require technical assistance?*** *(yes/no)* If yes, indicate type of assistance needed
1			
2			

**Technical assistance not applicable for countries in final year of Gavi support*

6. ENDORSEMENT BY ICC, HSCC OR EQUIVALENT AND ADDITIONAL COMMENTS

Brief description of how the joint appraisal was endorsed by the relevant national coordination mechanism	
Issues raised during debrief of joint appraisal findings to national coordination mechanism	
Any additional comments from:	

[1] Subsequent planning and discussions on Targeted Country Assistance will take place - detailed guidance on the process will be shared in May 2016.

• **Ministry of Health** • **Gavi Alliance partners** • **Gavi Senior Country Manager**	

7. ANNEXES

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

Joint Appraisal Team was formed by participants from WHO, UNICEF, CCRDA, L10K, UIFHS, CHAI, PATH and from different directorates of the Ministry of Health including EPI from MCHD, GMU from Finance & Procurement Directorate, Plan Policy Directorate and Pharmaceutical Logistics management Directorate. Role and responsibilities were divided among all team members and successive meetings were continuing and exchange of communications was in place to monitor progresses including revision after feedback at different levels. Therefore, this Joint Appraisal Report is the work of all relevant stakeholders.

Annex B: Changes to transition plan *(if relevant)*

Changes proposed	Rationale for changes	Related cost (US$)	Source of funding for amended activities	Implementation agency	Expected result

Annex C: Grant Performance

HPV - Income and Expenditure Statement

	July 8, 2015- July 7, 2016				Comments on variance
	Budget	Actual	Variance $	Variance %	
Income					
Receipts from GAVI	195,000	169,982	-25,018	-13%	The second trench payment not yet transferred
Total Income	**195,000**	**169,982**	**-25,018**	**-13%**	
Expenditure					
TAG meetings	4,278	-	4,278	100%	The meeting is started but expenditure is after July 2016
Personnel, including salary supplements and/or per diems	45,241	21,342	23,899	53%	Advance to regions not yet liquidated
Transport	28,187	-	28,187	100%	Advance to regions not yet liquidated
Training	10,428	2,910	7,518	72%	Advance to regions not yet liquidated

Community sensitization and mobilization(including IEC Materials)	29,556	6,001	23,555	80%	Advance to regions not yet liquidated
Waste disposal	2,674	-	2,674	100%	
Monitoring and supportive supervision	13,636	2,718	10,918	80%	
Evaluation of vaccine delivery	32,000	-	32,000	100%	The coverage survey is started by Jimma & Mekelle university in October 2016
Drafting national cervical cancer prevention and control strategy	4,000	-	4,000	100%	
Total Expenditure	**170,000**	**32,971**	**137,029**	**81%**	The expenditure report is only for six month progress there are unliquidated advance on regions
Surplus/(Deficit) for the Period	25,000	137,011	-162,047	-648%	

IPV - Income and Expenditure Statement

	July 8,2015-July 7,2016				Comments on variance
	Budget	**Actual**	**Variance $**	**Variance %**	
Income					
Receipts from GAVI IPV	2,536,500	2,536,482	-18	0%	
Total Income	2,536,500	2,536,482	-18	0%	
Expenditure					
Training	1,480,436	1,428,384	52,052	4%	
Logistic	47,582	5,250	42,332	89%	
Program mx and coordination	209,927	134,715	75,212	36%	Advance to regions not yet liquidated
Monitoring & Evaluation	514,430	470,256	44,174	9%	
communication	313,121	64,803	248,318	79%	
Total Expenditure	**2,565,496**	**2,103,409**	**462,087**	**18%**	
Surplus/(Deficit) for the Period	-28,996	433,073	(462,105.4)	1594%	The activity budget as per the VIG have a gap of 28,996

* All amounts are in USD