Application Form B from the CJSC to GAVI Alliance Secretariat for:

GAVI Alliance CSO Support in 10 Pilot GAVI Eligible Countries (Ethiopia)

Please fill in text directly in the boxes below, which can be expanded to accommodate your text by computer

Abbreviations and Acronyms

Please ensure that all abbreviations and acronyms presented in the application and supporting documents are included at the beginning of the application form.

APDA	Afar Pastoralist Development Association
CBRHA	Community Based Reproductive Health Agent
CJSC	Central Joint Steering Committee
cMYP	Comprehensive Multi-Year Plan
CRDA	Christian Relief and Development Association
CSO	Civil Society Organisation
DPPA	Disaster Prevention and Preparedness Agency
EHNRI	Ethiopian Health and Nutrition Research Institute
EMA	Ethiopian Medical Association
EOC/DICAC	Ethiopian Orthodox Church/Development and Inter-Church Aid Commission
EOS	Enhanced Outreach Strategy
EPI	Extended Programme for Immunisation
EPHA	Ethiopian Public Health Association
EU	European Union
FMoH	Federal Ministry of Health
GAVI	Global Alliance for Vaccination and Immunisation
GoE	Government of Ethiopia
HEW	Health Extension Worker
HMIS	Health Management Information System
HPN	Health, Population and Nutrition
HSDPIII	Third Health Sector Development Programme
HEP	Health Extension Programme
HSS	Health Service Strengthening
HW	Health Worker
ICC	Inter-agency Coordinating Committee (also Immunisation Coordinating Committee)
IEC	Information, Education and Communication
IIP	Immunisation in Practice
JCCC	Joint Core Coordinating Committee
MAPPP	Medical Association of Physicians in Private Practice
MDG	Millennium Development Goal
M&E	Monitoring and Evaluation
MLM	Mid-Level Management
MoJ	Ministry of Justice
MUAC	Middle Upper Arm Circumference
ODA	Oromia Development Association
OPV	Oral Polio Vaccine
PPD	Planning and Programming Department

RED	Reach Every District
RHB	Regional Health Bureau
RNE	Royal Netherlands Embassy
TBA	Traditional Birth Attendants
TT	Tetanus Toxoid
UN	United Nations
UNICEF	United Nations Childrens' Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organisation

Executive Summary (two pages)

Please provide an executive summary of the proposal. Please include details of any Technical Working Groups that have been created to support the process, review proposals etc.

Ethiopia is the second most populous country in sub-Saharan Africa, however recent evaluations have concluded that Ethiopia needs substantial support to strengthen its health system in order to achieve its medium and long-term targets for health which are aligned to the MDGs.

Ethiopia's third Health Sector Development Plan (HSDPIII) constitutes the health chapter of the national poverty reduction strategy. The design of HSDPIII was shaped by the recommendations of several reviews. HSDPIII's ambitious objectives include a substantial increase in immunisation coverage and a massive decrease in under-five mortality.

The health service currently reaches about 72% of the population but there are critical shortages of skilled human resources. The community based health service, designed to address the needs of increasing access, is still young. The FMoH aims to reach 85% of the population by 2009 through the HEP.

The HEP is the centrepiece of HSDPIII. The HEP is an innovative strategy designed to deliver preventative services and a limited number of high impact curative interventions at community level. Implementation of the HEP is led by Health Extension Workers (HEWs). Two HEWs are deployed in each Kebele (smallest administrative unit) and local authorities are responsible for ensuring that HEWs have a health-post from which to work. Health-post kits (which include vaccine storage facilities and vaccines) are now being distributed to enhance the capability of health-posts to deliver essential services to the population. The HEP is well-placed to achieve sustained increases in immunisation coverage by registering births, sensitising parents, offering regular immunisation sessions that are convenient to households and following up defaulters in their homes.

The Ethiopian immunisation policy was updated in 2006 with the launch of a new cMYP for immunisation. Children of under-one year of age and women of reproductive age (15-49) are the targets for EPI vaccines (BCG, Measles, DPT-HepB-Hib or Pentavalent, OPV and TT vaccines). The immunisation schedule for the six EPI vaccines for children, and tetanus immunisation for women, strictly follows WHO recommendations for developing countries.

Currently, immunisation services are provided in 70% of health facilities, and also through the EOS (designed for communities living further than 5km from a health-post).

Civil Society plays a vital role in filling the gaps left by the FMoH. Professional Associations, Faith-based Organisations, Development Associations and NGOs all play a part in providing communities, especially communities in hard-to-reach areas and within semi-pastoralist and pastoralist societies, with access to healthcare.

The FMoH believes that GAVI CSO Support is a unique opportunity for Ethiopia, which will bring Civil Society and Government closer together in the Health Sector. In this way, maximum outreach can be achieved while the efficiency of health programming is improved and the level of overlap reduced.

The JCCC is the technical arm of the CJSC, which is the coordinating body of the health sector in Ethiopia, and is composed of a range of organisations; Government, the UN, Development Partners and Donors. It is the body which was mandated with selecting CSOs for GAVI CSO Support. The JCCC was not established for the single purpose of selecting CSOs for GAVI Support; however it ensured that a democratic and fair process was used in the selection process. Once applications had been collected, a pointing system was established and used to select CSOs. CSOs were selected based on the type of organisation they were (i.e. development association, NGO, professional association, faith-based organisation) and then also on their compatibility with GAVI and Government criteria.

The JCCC, with the approval of the CJSC, has selected five organisations which it believes will best complement present HSS and cMYP strategies. The organisations were selected because of the quality of their applications and also because of their diverse nature. Two NGOs were selected, one faith-based organisation, one development association and one professional association.

The FMoH proposes to allocate the Christian Relief and Development Association (CRDA) with USD 1,715,071.72, the Oromia Development Association (ODA) with USD 552,107.11 the Afar Pastoralist Development Association (APDA) with USD 232,467.63, the Ethiopian Orthodox Church (EOC) with USD 260,346 and the Ethiopian Medical Association (EMA) with 211,659.90. Once management and auditing costs of the selected CSOs as well as the JCCC are taken into account (USD 258,630.04 and USD 89,540 respectively) the total amount of support comes to: USD 3,319,822.39.

The amounts allocated will be used for programmes ranging from training of HEWs to actual vaccination of pastoralist women and children. The FMoH has attempted to keep geographical and programmatic overlap to a minimum within the areas of operations by establishing, in partnership with CSOs, a common implementation plan over the given period of time in the different regions of the country.

GAVI Funding for strengthening the role of Civil Society in overall HSS will be used to complement efforts already being made and programmes already being implemented by the FMoH within the HSS and cMYP framework.

General Background

Ethiopia, with a population of over 77.4 million people, covers an area of over 1.1 million square km. The country is divided into 9 National Regional States (NRSs) and two administrative states. The Regional States are administratively divided into 78 Zones and 710 Woredas (Districts). Women and children under five-years of age constitute about three-quarters of the population. Life expectancy for both sexes currently stands at 54 years. 85% of the population lives in rural areas and about 38.7% live in absolute poverty. The population is also growing rapidly and by 2015 Ethiopia is expected to have a population of about 94 million people.

The Government prioritizes budgetary allocations to 'pro-poor' sectors, namely education, agriculture and rural development, including food security, roads, water, sanitation and health. Between 2001-2002 and 2004-2005 over 50% of Government expenditure was allocated to pro-poor expenditure. Pro-poor expenditure is expected to increase to 75% of all Government expenditure during the country's second Poverty Reduction Strategy Paper (PRSP) – the Plan for Accelerated and Sustained Development to End Poverty (PASDEP) – period. Despite impressive growth and poverty-oriented expenditure patterns, nearly 80% of all Ethiopians lived on less than US$ 2 a day in 1998-1999.

At the macro-economic level, Ethiopia's per capita income growth has, over the past half-decade, exceeded the average of sub-Saharan Africa (average growth rate 6.7% for the period 2000/1-2006/7 compared to an average of 5.8% in sub-Saharan Africa). While the agricultural sector continues to be the major driver of the economy, recent expansion has been broad; with significant contributions from the manufacturing, construction and service sectors. The deployment of agricultural extension workers to every rural village has opened the door for new perspectives for sustained knowledge and skills transfer to smallholder farmers.

With regard to Health, CSOs play a crucial role in the delivery of health services in Ethiopia; however ownership of Health Facilities remains the sole right of the Government.

The country currently receives about US$ 1.1 billion per annum in aid, including emergency aid and technical assistance. In per capita terms, this is equivalent to US$ 14.8 for 2005/06 and is still substantially lower than in other low-income countries. The country faces challenges such as lack of information and unpredictability of aid flows. The World Bank designed the Protecting Basic Social Services modality to support PASDEP after the last national election in 2005. This remained the preferential funding channel for bi-lateral partners throughout 2007.

Ethiopia has made important gains in the recent past in ensuring the survival and wellbeing of children. Infant mortality rate is estimated to be 77/1000 live births and mortality in children under five-years of age has been decreasing steadily from 166/1000 live births in 2000 to 123/1000 in 2005, this is a rate which sets Ethiopia on target to achieve the MDG on Child Survival by 2015. The maternal mortality ratio stood at 673/100,000 live births in 2005. Access and utilization of health services is on the increase. As of December 2007, 17,683 HEWs (of the 30,000 planned) were deployed in rural areas to provide basic health care.

The gains in Child Survival can be attributed to decreased prevalence of Acute Respiratory Infection (ARI) and diarrhoea, improved nutrition, increased vaccination coverage, bednet ownership and an increase in households with access to water and sanitation.

The Health System Context

HSDPIII is the health chapter of the PASDEP and aims to achieve universal coverage of PHC services through the Health Extension Programme (HEP). The HEP is designed to deliver health promotion, immunisation and other disease prevention measures along with a limited number of high-impact curative interventions in order to address the main causes of maternal, neonatal and childhood morbidity and mortality.

Implementation of Ethiopia's decentralisation policy has recently given Districts more decision-making power and more management responsibility in terms of delivery of basic services, including healthcare. The remit of the Woreda Health Office (WorHO) now has responsibility for 30-40 Health Posts and 6-8 Health Centres.

System issues are being addressed: the first national Human Resources for Health Strategy is under discussion; a study of motivation and incentives has been completed and a health workers' census is underway; the Pharmaceutical and Logistics Master Plan (PLMP) is in its first year of implementation; the semi-autonomous Pharmaceutical Procurement and Supply Agency has been established; the new Health Monitoring Information System (HMIS) covers 25% of Districts and will be rolled out nationwide in December 2008. The HMIS will collect data at all levels, including Health Post level. Indicators are driven by their relevance to decision-making at each level. The sector and its development partners have been proactive in pushing the alignment/harmonization agenda; adherence to the 2005 Code of Conduct has been reviewed; a Health Harmonization Manual has been developed; the Joint Consultative Committees (FMoH, multilateral and bilateral technical working group – of which UNICEF is a member) oversight role has been expanded; and the Health Pooled Fund II, a trust managed by UNICEF, has been set up.

In addition, a National Health Commodities Supply System (HCSS) was adopted in October 2006. Its aim is to ensure that vaccines, essential drugs and other health commodities of approved quality are readily available to public sector health facilities for use in prevention, diagnosis and treatment of priority health problems, in adequate quantities at the lowest possible cost. Under HSCC, the FMoH retains the policy and standard-setting role, while procurement and distribution are delegated to an autonomous unit.

Routine Immunisation Coverage by District in 2006

Region	No. of Districts	No. of Live Births	Administrative Coverage %							
			BCG %	OPV3 %	HepB1 %	HepB3 %	DPT1 %	DPT3 %	MCV1 %	TT2+ %
Addis Ababa	10	75,763	67	64.4	-	-	67.2	63.1	58.9	45.6
Afar	5	52,729	42.2	44.5	-	-	54.4	44.5	41.3	31
Amhara	11	771,725	68.9	71.2	-	-	78.8	72.4	65.1	79.6
Benishangul Gumuz	5	25,538	69.7	68.3	-	-	88.2	73.4	63	23
Dire Dawa	1	14,574	61.5	63.3	-	-	69.6	63	50.1	36.1
Gambella	4	10,934	57.9	35.1	-	-	62	33.8	36	22.1
Harari	1	7,048	87	65.4	-	-	87.7	69.6	64.4	48.2
Oromia	23	1,121,780	78.4	74.3	-	-	89.2	76.4	65	67.1
SNNPR	22	634,823	85.3	82.5	-	-	93.3	86.8	81.7	67.1
Somali	9	215,023	20.2	18.1	-	-	22.3	18	15.7	3
Tigray	6	183,760	79	83.4	-	-	84.7	80.2	74.8	37.3
Total	**97**	**3,113,697**	**72.4**	**70.8**	**-**	**-**	**81.2**	**72.6**	**64.8**	**62.2**

Source: WHO/UNICEF JRF Data for 2006

Section 1: Application Development Process (one – two pages)

The aim of this section is to describe the process for developing the application for GAVI Alliance CSO support. Please begin with a description of the Health Sector Coordinating Committee (HSCC) or equivalent, including:

- Name of HSCC (or equivalent)
- Date HSCC has been operational since
- Frequency of meetings
- Overall role and function of the HSCC
- Name of any CSOs represented on the HSCC

The equivalent of the HSCC in Ethiopia is the Central Joint Steering Committee (CJSC). The CJSC has been operational since 1998. The CJSC meets on a quarterly basis.

The CJSC is Ethiopia's highest governing Health body that gives direction to the Health Sector Development Program (HSDP). The purpose of the CJSC is to coordinate, at the highest level, policy related issues such as the HEP and HSS. The CJSC also gives general guidance for the preparation of health sector strategic plans, annual review meetings, joint review missions and evaluations of the Health Sector's plans.

It is composed of: the Federal Minister of Health, the State Minister of Health, the State Minister of Finance and Economic Development, the State Minister of Education, the State Minister of Water Resources, resident representatives of; the WHO, UNICEF and the World Bank; the EU, the Chairperson of the Health, Population and Nutrition (HPN) Donors Group, Heads of the Oromia and Addis-Ababa Health Bureaus, the Executive Director of the Christian Relief and Development Association (CRDA) – representing NGOs, the President of the Medical Association of Physicians in Private Practice (MAPPP) – representing the private sector, and finally two elected representatives from various associations of health professionals.

Next, please describe the process your country followed to develop the application, including details of the Technical Working Group (if such a group has been established / used) covering:

- Who coordinated and provided oversight to the application development process?
- Who led the drafting of the overall application and was any technical assistance provided?
- What was the process for individual CSOs to submit their applications for support?
- What mechanism was adopted for choosing which CSOs to put forward for support?

The PPD of the FMoH and the JCCC were the two principle bodies which provided oversight to the application development process. UNICEF and the WHO provided technical assistance when required.

The JCCC represents the technical arm of the CJSC and the HPN Donor

Consultancy Forum – a forum created to bring together the FMOH and the largest HSDP Donors to promote dialogue on HSDP progress – and is composed of representatives from: the MoH, the WHO, Italian Cooperation, RNE, USAID, Irish Aid, the World Bank, UNICEF and UNFPA.

An additional set of Guidelines to those of the GAVI Alliance were formulated and drafted by the PPD and approved by the JCCC. These Guidelines were disseminated among interested CSOs working in Health. The Guidelines contained an application form for CSOs to fill and return to the PPD by the 31st of December 2007. CSOs had to deliver their application both in person to the PPD and electronically to two focal people from the PPD and JCCC.

Awareness raising workshops were organised twice by the coordinating body. Relevant CSOs which were not aware of, or did not have the opportunity to attend, either of the workshops were notified by e-mail of GAVI's new programme. Adverts in national newspapers, on the radio and on television were also developed and broadcast throughout the country. Links to both GAVI and Government guidelines were posted on the FMoH's website.

The PPD was mandated with coordinating and providing assistance in the drafting of Government Guidelines and providing office space and resources to the development of the proposals.

The JCCC was the body which authorised and decided the content of the Guidelines and which also selected the CSOs to be added in this proposal.

UNICEF and the WHO provided technical assistance to the application process and the preparation of this proposal.

Once applications were received, the JCCC selected, in accordance with GAVI and Government criteria, the most suited CSOs to receive funding and to be considered by GAVI within this proposal.

Following the collection of all proposals, the JCCC convened on the 1st of February 2008 for a special session dedicated to selecting which CSOs best fulfilled both GAVI and Government criteria.

To complete this task, a "Pointing System" was established in matrix form, awarding a number of points to each proposal, based on both Government and GAVI criteria.

The matrix's weighting system was designed to ensure that the core reasoning behind GAVI's CSO Support (enhancing Government/CSO and CSO/CSO collaboration, filling the gaps left by the National Health System and the HSS Project) was taken into account and placed at the centre of the selection process.

In addition, summaries of all proposals were provided to JCCC members to facilitate in the selection process. These summaries contained information on planned projects and funding being requested by each organisation.

Finally, once all CSOs' proposals had been discussed and pointed, three scenarios were run to eliminate candidate organisations in the fairest way possible. Organisations which remained once this process had been exhausted are the ones which the JCCC has recommended for funding.

It was also decided in the JCCC meeting that at least one of each category (i.e. faith-based group, development association, professional association and NGO) should be selected for funding. It was on this premise that the three scenarios were run.

Please then outline the specific roles and responsibilities that key partners played in this process in the table below:

Roles and responsibilities of key partners (HSCC / TWG members and others)

Title / Post	Organisation	HSCC / TWG member?	Roles in the development of the application for GAVI Alliance CSO support
Dr. Nejmudin Kedir (Head of PPD, Chairman of the JCCC)	**PPD of the FMoH (Government)**	**Yes**	**Overall coordination of the whole process from the development and dissemination of Government Guidelines to selection of CSOs.**
Dr. Mekdim Enkossa (Project Monitoring and Coordination Team Consultant)	**PPD of the FMoH (Government)**	**Yes**	**Coordination of technical aspects of the application process from development and dissemination of Government Guidelines to the drafting of application forms to GAVI.**
Dr. Cornelia Astyor (WHO)	**WHO**	**No**	**Involved in the development of the pointing system matrix used to select successful CSO candidates.**
Dr. Luwei Pearson (Head of Health Section)	**UNICEF**	**Yes**	**Involved in the development of the pointing system matrix used to select successful CSO candidates.**
Kahsu Bekuretsion (UNICEF Consultant)	**UNICEF**	**No**	**Involved in the drafting of Government Guidelines including all financial and technical details, coordinating workshops, raising awareness amongst CSOs of GAVI CSO Support.**
Thomas Orrell (UNICEF Consultant)	**UNICEF**	**No**	**Involved in coordinating workshops, raising awareness amongst CSOs of GAVI CSO Support, drafting Application forms.**
Dr. Nighist Tesfaye	**Family Health Department of the FMoH**	**Yes**	**Will be involved with the Monitoring and Evaluation of the project.**

Finally, please use this opportunity to include any additional comments or recommendations that the HSCC (or TWG) would like to make on the application to the GAVI Alliance Secretariat and the Independent Review Committee at the end of this section.

No comment.

Section 2: Overview of GAVI Alliance CSO Support (one – two pages)

The purpose of this section is to describe the current and the intended future role of CSOs in the delivery or strengthening of health services, in particular immunisation, child health care and health system strengthening.

Please begin by outlining the current role of CSOs in the delivery or strengthening of immunisation, child health care services and the health system. Then please state the overall objectives of this application for GAVI Alliance CSO Support. Please ensure the chosen objectives are SMART (specific, measurable, achievable, realistic and time-bound).

Please then list the CSOs that have been chosen as potential recipients of the GAVI Alliance CSO support. In the table below, please summarise the major activities that will be undertaken by each CSO during the course of the GAVI Alliance CSO support, and the expected outcomes per year.

CSOs play a vital role in the development of Ethiopia's health system, EPI provision and within the HSDP as a whole. CSOs' primary role is to fill the gaps left by the Government Health system, more specifically in HSS and in the cMYP. As mentioned in the "Executive Summary", immunisation services are only provided in about 70% of health facilities throughout the country, CSOs therefore play a vital role in helping narrow the significant and recognised gaps in health service provision.

Although GAVI HSS support has been vital to the further development and strengthening of Ethiopia's health sector, the focus of the fund has so far been mainly on the FMoH's role, this has meant that the inclusion of CSOs in that process is something that until now has not been not adequately accounted for.

So far, CSOs have played roles in: training HWs, HEWs and District and Regional Health Officers; helping raise awareness in communities through producing and disseminating IEC materials; conducting research and gathering baseline information; conducting M&E activities; and in extreme cases (like that of APDA in Afar) providing direct immunisation services to hard-to-reach populations, especially semi-pastoralist and pastoralist populations where the State apparatus has difficulty reaching all communities.

The overall objectives of this application to the GAVI Alliance for CSO Support are to increase immunisation coverage within seven regions in Ethiopia (Somali Region, Gambella, Afar, Benishangul Gumuz, Oromia, Amhara and the SNNPR). Somali, Afar and Gambella stand out as the regions with the lowest levels of EPI coverage in the country.

The CSOs which have been chosen as potential recipients of GAVI CSO Support are: the Christian Relief and Development Association (CRDA), the Afar Pastoralist Development Association (APDA), the Oromia Development Association (ODA), the Ethiopian Orthodox Church Development and Inter-Agency Aid Commission (EOC/DICAC) and the Ethiopian Medical Association (EMA).

Each organisation has its own specific objectives; however the way organisations have been selected ensures that overlap in activities is kept to a minimum.

CRDA **has as its stated goal within its application; to contribute toward the achievement of MDG 4, which calls for the reduction of child mortality by 2/3 by 2015, and to the cMYP through increasing the number of immunised children in remote, hard-to-reach and pastoralist communities in the country.**

Specific objectives include increasing DPT3-HepB3-Hib3 vaccination coverage by at least 35% in the lowest coverage areas throughout; Somali, Gambella, Benishangul Gumuz and Afar; by 2010. Additionally, CRDA will aim to reduce DPT1-HepB1-Hib1 and DPT3-HepB3-Hib3 dropout rates by 50% from the baseline by 2010. Measles coverage is to be increased by at least 25% in Assosa, Gambella, Mejenger, Agnuak, Nuer, South Omo, Shinile, Liben, Afder, Afar Zone 3 and Borena Zones by 2010. Finally, TT2+ coverage in pregnant women is to be increased by 10% from the 2007 baseline by 2010 and to be increased by 25% in non-pregnant women in the same time period.

APDA **has stated as its overall objective that it will improve the current health situation of 40% of the population of Dagaba, Daaba, Kori Zones in Afar; specifically, 'Ada'ar, Goolina, Magaale and Eribte Districts (a total population of 56,517 mothers and children) enabling them to sustain their health actively through awareness raising and routine preventative measures.**

Within these communities, APDA will; improve OPV, Measles, DPT, BCG and TT1/2 coverage of 66,182 mothers and under-fives from minimal levels to 90% coverage by 2010. Current levels of immunisation in APDA's operational areas stand at:

EPI districts	Polio %	Measles %	DPT hib2 hepB %	BCG %	TT1/ TT2 %
'Adda'ar	42	37	12	12	86
Goolina	37	45	15	15	84
Erebti	26	17	10	10	82
Magaale	24	25	15	15	80

APDA will also improve the nutritional status of the same population through monitoring, screening and providing the appropriate response within the same timeframe through biannual MUAC screening and training 40 HWs capable of performing enhanced outreach screening (EOS) and growth monitoring promotion. 66,182 vulnerable people (children, childbearing women) will be screened and monitored ('Adda'ar and Goolina in the 1st year and all districts in the second year).

In addition APDA will improve child disease resistance in the same areas through de-worming and Vitamin-A supplementation against abdominal parasites. 24,852 under-5 children (80% of under-5's in project Districts) will benefit.

Malaria infections in project Districts will be reduced by 50% once 40 HWs are trained on the use of Rapid Diagnostic Tests (RDTs) and co-artem as treatment in

addition to quinine and the use of Insecticide Treated Nets (ITNs). In total, 56,517 people will be targeted.

The risk of unsafe birth in 4,970 expected childbirths will be reduced through the annual training of 40 TBAs and safe motherhood awareness-raising.

***The EOC/DICAC* have adopted a particularly innovative, yet potentially very effective, approach. The stated aim of the EOC/DICAC is to increase clergy participation in child survival and immunisation activities. The target area is Amhara. Specific aims include, increasing access for women and children to at least 90% in targeted districts to "full antigens" with a maximum drop-out rate of 5% and enabling 1,768 trained clergy to refer eligible mothers and children for immunisation and health services. A total of 1.5 million people, 361,530 mothers and children will benefit from this project by 2010.**

***EMA's* aim is to reduce morbidity and mortality in under-fives due to vaccine preventable diseases. This is to be done by providing good quality immunisation services through skilled health workers. The targeted areas are: 112 Districts from Somali, Afar and Benishangul Gumuz and 150 Districts of Oromia, Amhara and the SNNPR. The primary targets of interventions are EPI coordinators at District level, vaccinators at health-post and health-centre level.**

In order to achieve its above stated aims, EMA will ensure that 80% (262) of District EPI coordinators receive training on MLM and IIP to enhance their operational capacity and effectiveness. One coordinator from each operational District in Benishangul Gumuz, Somali and Afar will be trained in addition to coordinators from 150 Districts with the lowest coverage in Oromia and Amhara.

EMA will also increase Pentavalent coverage to above 80% in 90% of its operational Districts in the three emerging Regions in selected Zones in Oromia and Amhara by the end of 2010. The defaulter rate in the same areas will be reduced by 80% in the same time period. These objectives will be achieved through the training on immunisation of HWs working in Health Centres and Health Posts in the selected areas. A total of 224 HWs from the three emerging Regions and 150 from Oromia and Amhara will be trained by 2010.

Supportive supervision will be provided to at least 50% of Districts three months after training to enhance the effectiveness of the project.

***ODA's* aim is to improve the health status of mothers and children in targeted areas of Oromia (Jimma, East Wollega, Horo Guduru Wollega, West Wollega, Illuababor, East Harerge, S/W Shoa, Qellem Wollega) through community-awareness activities focused on vaccination and immunisation, expanding immunisation services to 95 Districts in Oromia, and enhancing the capacity of District Health Officers by training Health Workers at different levels in the 95 project Districts. Other aims include, increasing and internalising community awareness of vaccination, strengthening collaboration with local Health Offices and improving HWs immunisation skills. In total, 3,000 CBRHAs and 3,040 HWs will be trained and deployed by 2010 in order to accomplish these aims.**

Major activities and outcomes for each CSO over the duration of the GAVI support

<table>
<tr><th rowspan="2">Name of each CSO, type of organisation and their activities to be supported</th><th colspan="2">Expected outcomes</th></tr>
<tr><th>2008/09</th><th>2009/10</th></tr>
<tr><td colspan="3">CRDA</td></tr>
<tr><td>Strengthen and support existing static and outreach immunisation service delivery, establish mobile immunisation service delivery and support Enhanced Routine Immunisation Services in selected difficult to reach areas though:
– Strengthening the defaulter tracing mechanism;
– Provision of motorbikes, fuel, refrigerators and their maintenance;
– Ensuring availability of recording and reporting formats.</td><td>20% of infants and 10% of women of child bearing age in targeted areas will benefit, and the dropout rate will decrease to 20%.

The number of measles vaccinated children will increase by 15%.</td><td>The number of infants and women of child bearing age receiving support will increase by 15% from 2008 levels and the defaulter rate will drop to 10%.

The number of children vaccinated against measles will increase by 10% from 2008 levels.</td></tr>
<tr><td>To improve management capacity to deliver services, CRDA will:
– Conduct training on HMIS and DQS and IIP;
– Conduct Cold-chain users training for HWs;
– Train EPI staff on motorbike maintenance and use;
– Assist district-level RED micro-planning;
– Conduct a baseline survey at the Zonal level;
– Plan and organise quarterly district review meetings;
– Plan and organise bi-annual zonal review meetings
– Conduct a national level joint review meeting with zones from project areas at the end of the year.</td><td>60% of health facilities will have at least two HWs trained in EPI.

100% of districts will have prepared RED micro-plans.

At least 60% of district health offices in the project area will have proper documentation mechanisms to report and record.

80% of districts will conduct joint supportive supervision activities at least twice a year at each health facility.</td><td>90% of health facilities will have at least two HWs trained in EPI.

100% of districts will have prepared RED micro-plans.

At least 90% of district health offices in the project area will have proper documentation mechanisms to report and record.

95% of districts will conduct joint supportive supervision activities at least twice a year at each health facility.</td></tr>
<tr><td>To increase participation of all stakeholders to create demand for immunisation services, CRDA will:
– Support social mobilisation activities involving school communities;</td><td>Knowledge of mothers benefiting from immunisation services will increase by 20% from the baseline.

Most of the district council and all stakeholders will show increased commitment to support</td><td>Knowledge of mothers benefiting from immunisation services will increase by 40% from the baseline.

All of the district council and all stakeholders will show increased commitment to support</td></tr>
</table>

– Establish community mobilisation mechanisms using community volunteers; – Prepare promotions material with key EPI messages; – Prepare and provide immunisation diplomas for infants who completed all rounds of immunisation; – Design a strategy for EPI communication, advocacy and social mobilisation; – Organise regional advocacy workshops on immunisation in Gambella and Afar; – Establish and strengthen ICC in Gambella and Benishangul Gumuz	immunisation and focus on implementation.	immunisation and focus on implementation.
EOC/DICAC		
In order to achieve a target of 90% of children and mothers in project districts getting full antigens with a maximum dropout rate of 5%, the EOC/DICAC will: – Conduct Zonal sensitisation workshops; – Conduct ToTs; – Conduct district level training for clergy; – Conduct public rallies in each project district; – Produce and disseminate IEC/BCC materials.	2 Zonal workshops to be conducted (1 in Woldiya and 1 in Addis-Ababa). 1 ToT session in Addis-Ababa to be held. 50 district level training sessions for clergy to be conducted. 550 posters and 10,000 leaflets to be produced and disseminated.	5,000 leaflets to be produced and disseminated.
In order to enable trained clergy to refer eligible mothers and children for immunisation and other child health services, the EOC/DICAC will: – Print and distribute referral cards; – Conduct district level review meetings; – Distribute registration books and reporting formats for parishes.	181,000 referral cards will be printed and distributed. 22 District review meetings will be conducted. 872 registration books and reporting formats will be distributed to parishes.	181,000 referral cards will be printed and distributed. 11 District review meetings will be conducted.
APDA		

To improve EPI coverage, APDA will launch 4 EPI campaigns in targeted districts.	2,323 children and 20,023 females will be vaccinated.	2,154 children and 18,574 females will be vaccinated.
To improve the nutritional status of women and children in target areas, nutritional surveillance and support will be provided as necessary.	36,506 vulnerable people will be nutritionally secure.	29,646 vulnerable people will be nutritionally secure.
To improve child resistance to disease, Vitamin-A supplementation and de-worming will be carried out on a bi-annual basis.	13,708 children will receive Vitamin-A supplementation and de-worming.	11,156 children will receive Vitamin-A supplementation and de-worming.
To decrease Malaria levels by 50% within target communities, APDA will train HWs, awareness will be raised, ITNs distributed and acute cases will be treated.	Exposure to malaria will be reduced for 31,174 people.	Exposure to malaria will be reduced for 25,343 people.
Health education will be provided to help reduce diarrhoea.	Reduced instances of diarrhoea in 36,506 people.	Reduced instances of diarrhoea in 29,646 people.
TBA training and post/ante-natal monitoring will be used to reduce unsafe birthing practices.	2,741 mothers will have less risk in pregnancy and delivery.	2,229 mothers will have less risk in pregnancy and delivery.
Primary health activities will be institutionalised.	40 HWs will be given refresher training. 20 HWs will be given initial training.	40 HWs will be given refresher training. 20 HWs will be given initial training.
EMA		
Train Woreda (district) EPI coordinators on MLM.	262 EPI coordinators will be trained by the end of 2009.	
Train Health Workers from Health facilities on immunisation practices.	374 Health workers will be trained by October 2010.	
Conduct supportive supervision to at least 50% of districts and health facilities, 3 months after training.	Supportive supervision every three months	Supportive supervision every three months
Conduct a sample survey	Conduct a sample survey by October 2010.	
ODA		
Knowledge and skills of HWs on immunisation are improved.	3,040 HWs in targeted areas will be trained in immunisation delivery by October 2010.	
CBRHAs trained.	3,000 CBRHAs in targeted areas will be trained by October 2010.	
Increase community awareness on immunisation in target areas.	Increase awareness in targeted communities about immunisation from the 50% baseline in November 2007 to 95% by October2010.	

REGIONAL JUSTIFICATION

CRDA	
Region/Zone/District	**Justification of Activities**
GAMBELLA	General Inter-zonal Issues: • High number of pastoralist/semi-pastoralist populations, poor infrastructure and hard-to-reach areas. • The majority of sub-Districts have no access to immunisation services. • There is a shortage of health workers, transportation and supply chains including limited technical capacity for maintaining and repairing cold-chain equipment. • Poor recording, documenting and reporting at health facilities and WorHO's. • Cross-border movement of communities' high risk of importing wild polio virus.
Agnuak Zone	• DPT3 coverage is 15.1% and 3.7% were fully immunised in 06/07. • Dropout rate is 61.5%.
Nuer Zone	• DPT3 coverage is 3% and 1% were fully immunised in 06/07. • Dropout rate is 75.4%.
Mejenger Zone	• DPT3 coverage 12.3% and 12.3% were fully immunised in 06/07. • Dropout rate is 56.5%.
SNNPR/South Omo Zone	• High number of pastoralist/semi-pastoralist populations, poor infrastructure and hard-to-reach areas. • EPI coverage very low, DPT3 coverage at 51.7% and fully immunised at 34.5% in 06/07. • Dropout rate is very high at 35.88%. • Based on the EPI Cluster Sampling Coverage Survey in 2006, Ethiopia indicated that there was a documentation problem in the visited health facilities. • Majority of sub-Districts have no access to immunisation services. • Inadequate number of health facilities in the Zone. • Cross-border movement of communities' high risk of importing wild polio virus.
SOMALI REGION	General Inter-Zonal Issues: • High number of pastoralist/semi-pastoralist populations, poor infrastructure and hard-to-reach areas. • The majority of sub-Districts have no access to immunisation services. • There is a shortage of health workers, transportation and supply chains including limited technical capacity for maintaining and repairing cold-chain equipment. • Poor recording, documenting and reporting at health facilities and WorHO's. • Cross-border movement of communities' high. • Prevalence of cultural taboos against immunisation.
Afder Zone	• DPT3 coverage is 11.4% and only 7.3% were fully immunised in

	06/07. • Dropout rate is 39.8%.
Liben Zone	• DPT3 coverage 13.3% with only 7% fully immunised in 06/07. • Dropout rate is 42.8%.
Shinile Zone	• DPT3 coverage 7.2% with only 4.1% fully immunised. • Dropout rate is 25.1%.
BENISHANGUL-GUMUZ REGION/Assosa Zone	• Many Districts are hard-to-reach due to harsh climate conditions, difficult geographical access. • DPT3 coverage is high however only 38.8% were fully immunised in 06/07. • Dropout rate is 13.9%. • Based on the EPI Cluster Sampling Coverage Survey in 2006, Ethiopia indicated that the awareness levels of communities were very low. • Majority of sub-Districts have no access to immunisation services. • There are inadequate health facilities in the Zone and a shortage of health workers assigned in the Zone. • Cross-border movement of communities' high risk of importing wild polio virus.
APDA	
AFAR REGION/Goolina, Magaale, Erebiti and 'Adda'ar Districts	• Afar pastoralists have some of the lowest EPI coverage levels in Ethiopia. • Recurrent, and presently intensifying, drought conditions mean that the need for children and childbearing mothers to be immunised is even more important. • Goolina, Magaale and Erebiti Woredas have not had any form of coverage until now due to their remoteness, and 'Adda'ar's coverage is extremely patchy as is evident by the fact that measles and whooping-cough repeatedly break out in the district.
EOC/DICAC	
AMHARA REGION	General Inter-zonal Issues: • Immunisation levels in most of the districts in the selected Zones are low (the average is under 50%). • Infrastructure in Districts which have been selected is less developed than that in other Zones and districts in Amhara.
EMA	
SOMALI, AFAR and BENISHANGUL GUMUZ	• 93 Districts from these three emerging regions were selected because they are some of the least-developed of Ethiopia's regions and have some of the lowest immunisation coverage. • They suffer from critical shortages of skilled manpower in general and in immunisation in particular. • They have very poorly organised health infrastructure.
OROMIA, AMHARA, SNNPR	• 126 districts from 8 Zones were selected from these regions because there are over 20,000 unvaccinated children in each of the 8 Zones. • These areas suffer from poor health infrastructure and a shortage of skilled manpower.
ODA	
OROMIA	• Oromia is the largest and most populous region of Ethiopia consisting of 18 administrative zones, 8 urban zones and 257 districts). The majority of the population is young; this creates potential problems in terms of family planning and reproductive

	health. ODA has been implementing a reproductive health and family planning programme in 6 Zones. Implementation is based on recruiting and training CBRHA's. DPT3 dropout rates in Oromia average 32%. The new ODA initiative aims to link existing programming with HEWs to trace down defaulters and by actively participating in immunisation and malaria campaigns.

Finally, please indicate how you intend to sustain the programme, both technically and financially when GAVI resources terminate (if relevant), stating the source and amount of potential funding.

Many of the proposed programmes are self-sustaining. For example, the EOC/DICAC proposal, based on the concept of training clergy to promote immunisation to their congregations, is a self-sustaining strategy once it is off the ground.

In terms of training activities, once HWs and EPI coordinators are trained they have the capacity to deliver immunisation and healthcare services and thus increase the Health Sectors capacity to deliver services to hard-to-reach, semi-pastoralist and pastoralist populations.

In addition, as GAVI CSO Support is designed to complement the HSS and cMYP, it is integrated into a wider strategy which has multiple sources of funding from various donors.

Finally, since most programmes are government led and/or designed to complement government activities within the cMYP and HSS, government and donor resources are a key factor in the continuation of successful programmes, resultant of this pilot project.

CSO	***Other Sources of Funding***
APDA	• **APDA/UNICEF (Awareness Raising): $58,022.** • **APDA (Equipment): $13,716.** • **APDA (Salary and Training Support): $7,033.**
CRDA	• **USAID: $1,163,375.**
EOC/DICAC	• **EOC: $33,256**
ODA	• **The David and Lucile Packard Foundation: $2,170,368** • **Pathfinder International: $1,142,387** • **CORHA-SIDA Fund: $181,054** • **German Foundation for World Population: $30,110** • **Engender Health: $25,096**
EMA	• **N/A**

Section 3: Programme Implementation Plan (one – two pages)

Please prepare and submit an overall Programme Implementation Plan for the entire duration of the CSO support, based on the individual Programme Implementation Plans received in the applications from CSOs. Please decide upon the most appropriate framework for your plan, and ensure that it includes the following:

- Introduction: rationale and summary of expected results, objectives and milestones
- Specific activities for implementing the project and implementation schedule
- Organisation and management of the project
- Overall strategy to achieve results
- Specify how the project will support the cMYP and / or the GAVI HSS proposal
- Specify how this project will be coordinated with others, and the roles of key stakeholders

In accordance with GAVI and Government selection criteria, funding should be aimed at increasing immunisation coverage in the most marginalised communities and/or high-catchment areas, should integrate and encourage Government/Civil Society and Civil Society/Civil Society collaboration, should complement efforts being made in the HSS and cMYP and should be results based.

The five organisations which have been selected represent four different kinds of CSOs. EMA is a professional association, APDA and CRDA are NGOs, ODA is a development association and the EOC/DICAC is a faith-based organisation. In addition to this, CRDA, as an umbrella organisation itself of 283 local and international NGOs, submitted a proposal on behalf of itself (as an umbrella organisation) and of the seven NGOs which make up the CORE Group.

The variety of programmes set out in this application form cover seven of Ethiopia's regions (Afar, Amhara, Benishagul Gumuz, Gambella, Oromia, SNNPR, and Somali Region).

In early 2007, The Federal Democratic Republic of Ethiopia requested US$ 76.5 million from GAVI for HSS, to be utilised by mid-2010. Out of this money, it was proposed that 19% by used for Human Resource strengthening, 61% for improving supply, distribution and maintenance systems, and 21% to enhancing the organisation and management of health services delivery. Significant progress in rolling out the HEP has been partially made as a result of GAVI HSS funding. GAVI CSO funds fill the gap left by HSS by bringing together the different actors working in the Health Sector in Ethiopia.

The FMoH of Ethiopia has so far received USD 68.1 million from GAVI for HSS. Progress in implementing HSS so far is as follows:

1. **Workforce Mobilization, Distribution and Motivation**

The Health Education and Extension Centre (HEEC) has distributed Integrated Refresher Training funds to regions based on the national equity formula. HEW apprenticeships are also being supported.

IMNCI training, being managed by the Family Health Department (FHD) of the FMoH, has been outsourced to the Ethiopian Paediatric Society (EPS). Over 650 health professionals are being trained on IMNCI case management, facilitation and supervision. A proposal for a second round of training has been prepared, an MOU has been signed and funds have been transferred to the EPS.

The HEEC has distributed funds to the regions for capacity building activities in districts, namely for District Health Management Teams.

2. **Supply, Distribution and Maintenance Systems for PHC Drugs, Equipment and Infrastructure**

Funding for the upgrading of 212 Health Stations to Health Centres has been outsourced to GTZ based on performance as evaluated by regional authorities and the engineering team of the PPD.

187,500 USD has been transferred to each of the four emerging regions (Afar, Benishangul Gumuz, Gambella and Somali) for the construction of 25 Health posts in each region. Thus far, Afar, Gambella and Somali have reported that funds transferred will not be enough to construct all 25 health posts in each region. An agreement has been reached with these regions to construct as many Health Posts as possible with the funding available.

Benishangul Gumuz disbursed its allocation to all 20 Woredas for the construction of health posts, using the money for the purchase of cement, iron sheets, nails and for payment of the contractor. Other expenses will be covered by the local community.

UNICEF is in the process of distributing 3670 Health-post kits to Health Posts throughout the country. A cost estimate for a further 3674 kits has been sent to the FMoH.

3. **Organisation and Management of Health Services at District and Sub-District Level**

The HMIS team based in the PPD of the FMoH have begun rolling out the new HMIS M&E system throughout the country.

Over 100 4x4 vehicles have been procured for use by District Health Offices. A further 25 vehicles are in the process of being bought and the Road Transport Authority is in the process of procuring four buses.

Almost 400 PC's, printers and USP's are being procured for use by HMIS focal people in Woreda Health Offices. Out of these, 180 computers and UPS's are being funded by the GAVI HSS project.

Implementation of the Health Commodities Supply System is under way. The PFSA has reported that procurement of 4,300,000 USD worth of pharmaceuticals is under way. 1,500,000 USD is being used for the construction of central warehouses and the remaining balance will be used for direct procurement of packages.

Programme objectives of the five-year (06-10) cMYP include: achieving 80% DPT-HepB+Hib3, OPV and measles coverage in 90% of districts by 2010; to train at least one health worker on interpersonal communication and vaccine management in 80% of hospitals and health centres by 2010 and to provide pentavalent immunisation throughout the country.

It is within this context that the GAVI CSO project in Ethiopia has been designed. Compatibility of CSOs' programming with the cMYP and HSS was a prerequisite criterion for selection of organizations.

The programmes designed by CSOs provide extra technical and human assistance to the ongoing projects within the HSS and cMYP. Activities designed to enhance the capacity of health workers and health centres to provide EPI services within the context of the HEP in areas where there are capacity gaps left by RHB's and Woreda Health Offices provide invaluable assistance to the FMoH's attempt to meet HSDPIII targets. Especially in the four emerging regions (Afar, Benishangul Gumuz, Gambella and Somali) the proposed CSO activities would be crucial to enhancing the Health Sectors ability to provide EPI services and reaching some of the hardest-to-reach populations.

All of the organisations selected are involved in some form of training activity. The EOC/DICAC aims to train clergy to raise awareness of the importance of immunisation and to encourage their followers to take their children to be immunised. The EOC/DICAC aims to hold two Zonal workshops and hold 50 district level training sessions to train their clergy. Their activities will be carried out in Amhara, where there is a majority Christian following.

ODA aims to carry out training for 3,000 CBRHA's in Oromia region as well as training for 3,040 HWs in the same areas.

EMA aims to train 262 EPI coordinators on MLM by 2009 and also to train 374 HWs by the same date. EMAs operations are to be carried out in Somali, Afar and Benishangul Gumuz and in 10 zones of Oromia, Amhara and the SNNPR.

APDA focuses specifically on Afar and as well as conducting training sessions for HWs, APDA is the only organisation selected which is involved in the actual immunisation of women and children. APDA aims to benefit over 60,000 people in its areas of operations with GAVI CSO funding by October 2010.

CRDA, as an umbrella organisation of over 200 NGOs and CSOs, has submitted a proposal in conjunction with the CORE Group of seven NGOs. CRDAs areas of operations are: Somali, Benshangul Gumuz, SNNPR and Gambella. CRDA's operations range from training EPI workers and HWs to providing technical and material assistance to HWs and community EPI coordinators.

By having a number of different organisations with different structures and different activities, working in different areas (where there is geographic overlap, organisations have been urged to cooperate between themselves to integrate programming wherever possible) the FMoH hopes to create a lasting 'alliance' of

different kinds of CSOs, which will work together with the common goals of achieving the MDGs and also the targets of the cMYP.

The primary actor in health service provision remains the FMoH, however the selected CSOs in the selected regions will play crucial complementary roles to standard Health Service provision. Although there is no direct ownership of health facilities by CSOs in Ethiopia, CSOs do have clearly outlined geographical areas of responsibility.

The overall organisational management of the project rests with the PPD of the FMoH and also with the JCCC. The PPD is the coordinating body of the FMoH and as such will oversee the implementation of GAVI CSO Support funding.

The individual organisations which have been selected will also play a role in managing their own projects and ensuring that they meet their targets and deadlines. Monitoring is the responsibility of individual CSOs, however the new HMIS system could be used where possible to streamline monitoring costs and harmonise indicators and targets throughout the course of the programmes based on those set out in the HSDP and cMYP. HMIS can also be used to ensure that duplication of activities does not occur in areas where there is geographical overlap between Government and CSO programming.

The CSO mapping exercise which will be conducted using GAVI Type-A Support for CSO Mapping and Representation will also facilitate monitoring activities and will provide the PPD with an indicator as to how future partnerships with CSOs could practically be carried out.

A meeting was held between the PPD and representatives of the above organisations on the 15th of February 2008 to discuss and come to a consensus on how programmes can best complement each other. More meetings of that nature, aimed at discussing implementation and results, will happen between implementing partners and the PPD to discuss how best to achieve results.

The innovation of some of the proposed programming, that of the EOC/DICAC for example, means that new techniques could emerge that prove to be highly successful. As GAVI CSO Support funding is a pilot project, the FMoH is attempting to support existing structures within the cMYP and HSS with new and innovative methods which may prove highly effective. In this way strengthening the overall healthcare system in the country and providing more people with access to immunisation and other healthcare services.

The JCCC as the technical arm of the CJSC is the main coordinating body. Since the JCCC is composed of the PPD of the FMoH, UN bodies such as the WHO and UNICEF and major international donors, coordination with major stakeholders is already integrated into the programming and monitoring of projects.

IMPLEMENTATION TIMEFRAME/SCHEDULE

2008/2009 Implementation Timetable

Organisation/Activity	**2008**			**2009**											
	Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
CRDA															
Strengthen and support existing static and outreach immunisation service delivery, establish mobile immunisation service delivery and support Enhanced Routine Immunisation Services in selected difficult to reach areas. • Strengthen the defaulter tracing mechanism – decrease dropout rate to 10%; • Increase DPT3-HepB3-Hib3, TT2+ and measles coverage by 35%, 10% and 25% respectively.															
Conduct Baseline Assessment															
Assisting in the conduct of Woreda-based RED micro-planning – ensure that 100% of operational Districts have RED microplans.															
Improving management capacity to deliver services. • Ensuring availability of recording and reporting formats – ensure 60% of District Health Offices have proper documentation mechanisms in place.															
Support social mobilisation activities.															
EOC/DICAC															
Conducting Zonal sensitisation workshops.															
Conducting ToTs – training a total of 1768 clergy.															
Conducting public rallies in each project district															
Produce and disseminate IEC/BCC materials.															
Print and distribute referral cards – a total of 872 cards.															
Conduct district level review meetings															
APDA															
Improving OPV, Measles, DPT, BCG and TT1/2 coverage to 90% in targeted areas. APDA will															

launch 4 EPI campaigns in targeted districts.															
Nutritional Surveillance – 40 HWs trained in EOS.															
Vitamin-A Supplementation and de-worming. 80% of under-5's in project areas will receive biannual Vitamin-A supplementation and de-worming.															
Promoting use of ITNs to achieve a 50% reduction in malaria in project areas.															
Health education to reduce diarrhoea. 80% of under-5's in project areas receive biannual de-worming and Vitamin-A supplementation.															
Training and refresher training of HEWs.															
TBA training – 40 TBAs trained.															
EMA															
Train Woreda EPI coordinators on MLM and IIP – 80% (262) District EPI coordinators are trained.															
Train HWs from Health facilities on immunisation practices 374 HWs trained in EPI skills over the project period. This will help ensure Pentavalent coverage exceeds 90% in 80% of project districts.															
Conduct supportive supervision to at least 50% of districts and health facilities.															
Conduct a sample survey.															
Provision of training materials and guidelines.															
ODA															
Improving the knowledge and skills of over 3,000 HWs on immunisation.															
CBRHA training – 3000 trained by end of project.															
Activities aimed at increasing community awareness – 95% of Health facilities will receive supportive supervision by the end of the project.															
CBRHAs Refreshed															
Door-to-door calls, registration and referral of children to health facilities															

2010 Implementation Timetable

Organisation/Activity	**2010**									
	Jan	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**
CRDA										
Strengthen and support existing static and outreach immunisation service delivery, establish										

mobile immunisation service delivery and support Enhanced Routine Immunisation Services in selected difficult to reach areas. • Strengthen the defaulter tracing mechanism – decrease dropout rate to 10%; • Increase DPT3-HepB3-Hib3, TT2+ and measles coverage by 35%, 10% and 25% respectively.										
Improving management capacity to deliver services. Ensuring availability of recording and reporting formats – ensure 90% of District Health Offices have proper documentation mechanisms in place.										
Support social mobilisation activities										
Assisting in the conduct of Woreda-based RED micro-planning – ensure that 100% of operational Districts have RED micro-plans.										
Conduct final evaluation										
EOC/DICAC										
Conducting public rallies in each project district										
Produce and disseminate IEC/BCC materials – a total of 15,500 materials over the project period.										
Conduct district level review meetings										
Conduct final meeting and handing over of activities.										
APDA										
Nutritional Surveillance – 40 HWs trained in EOS.										
Vitamin-A Supplementation and de-worming. 80% of under-5's in project areas will receive biannual Vitamin-A supplementation and de-worming.										
Promoting use of ITNs to achieve a 50% reduction in malaria in project areas.										
Health education to reduce diarrhoea. 80% of under-5's in project areas receive biannual de-worming and Vitamin-A supplementation.										
Training and refresher training of HEWs.										
TBA training – 40 TBAs trained.										
EMA										
Conduct supportive supervision to at least 50% of districts and health facilities.										
Conduct a sample survey.										
Final Review Meeting										
ODA										
Door-to-door calls, registration and referral of children to health facilities										
Conduct evaluation meeting										

Section 4: Monitoring and Evaluation (one page)

The purpose of this section is to present the indicators that will be used to monitor performance during the course of the GAVI Alliance CSO support. The indicators in this application should be based on the indicators given in the CSO applications, which should reflect the indicators used in the cMYP and / or GAVI HSS proposal. Please insert the relevant information in the table below.

Indicators that will be used to monitor performance by CSOs

Indicator	Estimate of baseline[1]	Data Source (if any)	Date of Baseline	Target	Date for Target
ADPA: EPI (OPV, Measles, DPT, BCG, TT1/2) % coverage	10%	n/a	n/a	90%	End of project
No. of safe deliveries performed	n/a	n/a	n/a	Over 4,900 through the training of 40 TBAs	Each project year
% of under-5s to receive biannual vitamin-A supplementation and de-worming.	n/a	n/a	n/a	80% of under-5's in project areas.	End of project
% malaria reduction in project areas	n/a	n/a	n/a	50% reduction in project areas.	End of project
No. of Health Workers capable of performing EOS.	n/a	n/a	n/a	40 HWs trained in EOS, including the use of MUACs.	End of project
No. of TBAs trained	n/a	n/a	n/a	40 TBAs trained	End of project
ODA: Rate of decrease in child mortality	50%	Statistics from Zonal Health Office	Nov, 2007	90%	Oct, 2010
% of health facilities providing quality immunisation services in 95 Districts of Oromia.	64%	Statistics from Zonal Health Office	Nov, 2007	70%	Oct, 2010
No. of EPI coordinators trained	n/a	n/a	n/a	262 coordinators	End 2009.
No. of trained HWs	n/a	n/a	n/a	3,040 HWs trained.	End 2009.
No. of CBRHAs trained	n/a	n/a	n/a	3,000 CBRHAs trained.	End 2009.
% of Health facilities receiving supervision	50%	Statistics from Zonal Health Office	Nov, 2007	95%	Oct, 2010
EMA: % of District EPI coordinators in project	n/a	n/a	n/a	80% (262) of District EPI	Oct 2010

Districts provided with MLM and IIP training				coordinators	
No. of HWs with adequate EPI skills	n/a	n/a	n/a	374 trained HWs	Oct 2010
% of operational Districts with Pentavalent-3 coverage above 80%	n/a	n/a	n/a	90% of operational Districts	Oct 2010
CRDA: DPT3-HepB3-Hib3 coverage	32.3% - across all areas	FMoH-EPI	June 2007	+ 35% in low coverage areas	Oct 2010
Measles immunisation coverage	32% - across all areas	FMoH-EPI	June 2007	+ 25% in low coverage areas	Oct 2010
DPT-HepB-Hib1 to DPT-HepB-Hib3 dropout rate	37.5% - across all areas	FMoH-EPI	June 2007	Decrease the dropout rate to 10%	Oct 2010
TT2+ pregnant women coverage	16.7% - across all areas	FMoH-EPI	June 2007	TT2+ +10%	Oct 2010
TT2+ non-pregnant women coverage	6.3% - across all areas	FMoH-EPI	June 2007	TT2+ +25%	Oct 2010
% of Health facilities with at least 2 HWs trained in EPI	n/a	n/a	n/a	60% 90%	Oct 2009 Oct 2010
% of Districts with RED micro-plans	n/a	n/a	n/a	100%	Oct 2010
% of District Health Offices with proper documentation mechanisms to report and record	n/a	n/a	n/a	60% 90%	Oct 2009 Oct 2010
EOC/DICAC: No. of clergy trainings	-	-	-	2 sessions, a total of 1768 clergy	First quarter of 2009
No. of IEC materials produced/disseminated	-	-	-	15,500	Throughout project (until Oct 2010)
No. of referral cards printed and distributed	-	-	-	872	Throughout 2009

[1] *If baseline data is not available indicate whether baseline data collection is planned and when.*

Where there are gaps, provisions for the collection of baseline data exist. CSOs themselves, notably CRDA, have made provisions for the collection of baseline data within their programming.

UNICEF will provide technical assistance in the collection of baseline data where gaps persist.

In addition, The new Health Management Information System (MHIS) will be rolled-out country-wide as of December 2008 and will used as a tool to record results-based performance at each level of the health system.

Finally, please give details of the mechanisms that will be adopted to monitor these indicators, including the role of beneficiaries in the monitoring of the progress of the activities, if appropriate.

Mechanisms to be used to monitor these indicators exist on different levels within the system.

During the implementation of HSDPII, the Health Management Information System (HMIS) was refined and established at all levels from Federal to Health Facility level. In addition, the FMoH has revised and reduced the number of reporting formats from 25 to 12. The HMIS is the central M&E tool of the FMoH, therefore the indicators selected within this system will also be used to monitor GAVI CSO Support. By using HMIS as an M&E tool, the PPD intends to directly link monitoring of GAVI CSO Support funding to monitoring of the HSDP and cMYP.

Since most of the proposed monitoring programmes are part of the HSS and HEP, the indicators presented by the selected CSOs correspond with the major indicators already being used.

In addition, as part of the *GAVI Alliance Support to Strengthen Coordination and Representation of Civil Society Organisations* the PPD, through the JCCC, intends to develop a viable monitoring mechanism specifically designed for the monitoring of CSOs' indicators as laid out in the table above, this will be done as part of the mapping exercise within the proposal. This tool will be developed in the run up to the start of implementation and will be directly linked to the HMIS.

Furthermore, CSOs which have been selected, with the exception of the EOC/DICAC, all have previous experience in providing complementary services to the HSS, CMYP and FMoH in general and as such already have developed monitoring tools.

Finally, as laid out in the Government Guidelines to CSOs, each implementing CSO will have to report to the PPD on a quarterly basis, reports should include financial and activity reports, challenges and suggestions for the future. In this way, flexibility of projects is also being ensured.

Section 5: Implementation Arrangements (one – two pages)

Please describe in this section how the GAVI Alliance CSO support will be managed. Please provide the following information:

- Name of lead organisation responsible for managing implementation of the programmes
- Name of lead organisation responsible for coordination, monitoring and quality control
- Role of HSCC (or equivalent) in implementation
- Mechanism for coordinating GAVI Alliance CSO support

The organisation responsible for managing implementation of GAVI CSO Support funding will be the PPD of the FMoH. The JCCC will continue to give technical assistance in the management of the implementation. Additionally, the CSOs themselves will be responsible for managing their programming and producing quarterly and annual reports.

The PPD of the FMoH, with the assistance of the JCCC, will be the body responsible for monitoring and quality control. Monitoring mechanisms will be further developed before programming starts. So far, implementing CSOs have had a meeting with the PPD and have agreed on quarterly reporting and meetings to assess the progress of programming. In addition, the PPD and some members of the JCCC will arrange regular field visits to substantiate the validity of the reports

In addition, the ICC and the Family Health Department of the FMoH will also be involved in the management of the programmes since they are involved in the oversight of the national EPI programme.

The PPD of FMoH plays a central role in ensuring the implementation of proposed programming. Its mandate covers technically overseeing and monitoring the implementation of health programmes in Ethiopia. The JCCC and CJSC's role in implementation will be the general monitoring of events. As the highest health authority in Ethiopia, the CJSC will be responsible for the general oversight of activities and ensuring that proposed programmes become a reality on the ground.

The CJSC will expect regular reports from the JCCC on progress, not just of GAVI CSO Support but also of progress in terms of HSS implementation and more broadly the implementation of the HEP within the context of the HSDP.

It should be noted that the PPD serves as the Secretariat of the CJSC and of the HSDP as a whole.

The CJSC meets every quarter and also convenes meetings with Regional Joint Steering Committees (RJSCs) every other quarter. By doing so, the CJSC will have access to information regarding GAVI CSO Support implementation and other issues directly from the Regional Health Bureaus, thus adding to its capability to coordinate, plan and monitor HSDP implementation in the country.

The mechanism which will coordinate GAVI Alliance CSO Support in the JCCC, as it is the technical arm of the CJSC and reports directly to them on health planning progress in the country.

Since the JCCC is also responsible for assisting the Secretariat in organising the review, monitoring and evaluation activities of HSDP, GAVI CSO Support implementation activities will be integrated into these activities.

Please then outline the specific roles and responsibilities of key partners in implementation in the table below:

Roles and responsibilities of key partners (HSCC / TWG members and others)

Title / Post	Organisation	HSCC/TWG member?	Roles in the implementation of the application for GAVI Alliance CSO support
Dr. Nejmudin Kedir	PPD	Yes (JCCC)	As chair of the JCCC and Head of the PPD of the FMoH, Dr. Nejmudin is the overall coordinator for the GAVI CSO Support Pilot Project in Ethiopia.
Semira Alhadi	CRDA	CRDA is a CJSC Member	Ms. Alhadi is responsible for implementing CRDA's action plan and programming.
Valerie Browning	APDA	No	Ms. Browning is responsible for implementing APDA's action plan and programming.
Dr. Negussu Legesse	EOC/DICAC	No	Dr. Negussu is responsible for implementing the EOC/DICAC's action plan and programming.
Dr. Birhanu Gebreamlak	EMA	No	Dr. Birhanu is responsible for implementing EMA's action plan and programming.
Awed Jibril	ODA	No	Mr. Jibril is responsible for implementing ODA's action plan and programming.

Please also describe the financial management arrangements for the GAVI Alliance CSO support:

- Mechanism for channelling GAVI Alliance CSO funds into the country
- Mechanism (and responsibility) for budget use and approval
- Expected duration of the budget approval and transfer process
- Mechanism for disbursement of GAVI Alliance CSO funds
- Auditing procedures (and details of auditors, if known)
- Justification of management fees (if applicable)

Finally, please describe the arrangements for reporting on the progress in implementing and using GAVI Alliance CSO funds, including the responsible entity for preparing the APR.

Funds allocated to Ethiopia will be channelled to the MDG Performance Package Fund account, which is managed by the FMoH. The FMoH will then distribute the agreed funds to the account of the implementing CSO based on the agreed schedule and performance. Funding will be released bi-annually based on activity

schedules, after the initial release; the following will be based on achievement and the CSOs' stated plan for the next period.

The expected duration of the budget approval and transfer process largely depends on the timing of CSO Support Funding arriving in Ethiopia. Since the MDG Performance Package Fund is already operational a minimum of delays is expected.

It should be noted that separate ledgers exist for the account, and that funds which are transferred into the account are subject to external monitoring. Finally, it should also be noted that while this proposal is with GAVI, the PPD has committed to resolving any outstanding issues in this regard.

The FMoH will need to receive audit reports from CSOs within six months of the termination of planned projects. These audit reports should be generated through the existing country system. The FMoH reserves the right to request an external audit. GAVI partners, government, in particular the PPD and JCCC, can raise any concern they may have about the use of funds to the GAVI Alliance Secretariat at any time and up to five years after the termination of projects.

Finally, arrangements have been made with CSOs to report on a quarterly basis to the PPD. The PPD will compile these reports, financial expenditures and include field-visit reports to prepare the Annual Progress Report which will be reviewed by the JCCC, endorsed by the CJSC, and then submitted to the GAVI Alliance.

Section 6: Costs and Funding for GAVI Alliance CSO Support (one page)

The aim of this section is to confirm the total amount of GAVI Alliance CSO funds available, and to calculate the costs of all proposed activities per year, and ensure that the costs do not exceed the funds available.

The amount of GAVI Alliance CSO funds available are indicated in Table 2 of Chapter 4 of the GAVI Alliance CSO Guidelines. Please indicate this total at the beginning of this section.

Then, please prepare a budget, based on the costs of all activities (by CSO) for the period of the GAVI Alliance support. Please add or delete rows in the table below to give the right number of activities for each CSO. Please ensure that the total costs of managing the support (from the perspective of the HSCC or TWG as well as the CSOs) is included, as well as the costs of audit.

The amount allocated to Ethiopia for GAVI CSO Support is: USD 3,319,962.

The FMoH proposes to allocate the Christian Relief and Development Association (CRDA) with USD 1,715,071.72, the Oromia Development Association (ODA) with USD 552,107.11 the Afar Pastoralist Development Association (APDA) with USD 232,467.63, the Ethiopian Orthodox Church (EOC) with USD 260,346 and the Ethiopian Medical Association (EMA) with 211,659.90. Once management and auditing costs of the selected CSOs as well as the JCCC are taken into account (USD 258,630.04 and USD 89,540 respectively) the total amount of support comes to: USD 3,319,822.39.

Please convert all costs from the CSO applications into US$ (at the current exchange rate).

Cost of implementing GAVI Alliance CSO support

Support for Activities (for each CSO	**Cost per Year in US$**		**Total Costs**
	2008/09	**2010**	
CRDA			
Activities to Improve Documentation	58,052.36	71,724.10	129,776.46
Activities to Support existing and re-establishing of static and outreach immunisation services	231,364	108,780.40	340,144.40
Activities to Support the establishment of Enhanced Immunisation Services	105,014.00	106,489	211,503
Training	89,076.29	47,644.80	136,721.09
Activities for Awareness Creation, Social Mobilisation and Advocacy	101,804.92	73,139.50	174,944.42
Monitoring & Evaluation	150,109.56	159,109.52	309,219.08
Personnel	104,073.91	108,816.01	212,889.92
Equipment and Furniture	122,279.43	77,593.92	199,873.35
***TOTAL CRDA* (excluding Audit and Management costs)**	**961,774.47**	**753,297.25**	**1,715,071.72**
APDA			

EPI & Activity Campaigns	60,000	52,417.58	112,418
Project Staff Support	45,230.77	45,230.77	90,461.54
Awareness Raising	29,010.99	22,417.58	51,428.57
Training HWs and TBAs	21,978.02	21,978.02	43,956.04
Monitoring and Evaluation	3,067	3,067	6,134
***TOTAL APDA* (excluding Management and Auditing costs)**	**159,286.78 (-35,965.05 from APDA)**	**145,110.95 (-35,965.05 from APDA)**	**304,397.73* (232,467.63 from GAVI)**
EOC/DICAC			
Staff Salaries	16,121.05	12,667.99	28,789.04
Zonal Sensitisation	1,813.19	-	1,813.19
Conducting ToT's for Focal People	3,032.97	-	3,032.97
Clergy Training at Woreda level	121,239.39	-	121,239.39
Public Rallies	2,659.34	2,659.34	5,318.68
Production and Dissemination of IEC/BCC Materials	1,032.97	549.45	1,582.42
Annual Immunisation Day Celebrations in all Parishes	29,032.97	29,032.97	58,065.94
Print & Distribute Referral Cards	10,945.05	-	10,945.05
Review Meeting	2,912.10	1,456	4,368.10
Print & Distribute Registration Books and Formats	21,081.32	-	21,081.32
Monitoring & Evaluation	2,054.90	2,054.90	4,109.80
***TOTAL EOC/DICAC* (excluding Management and Auditing Costs)**	**211,925.30**	**48,420.70**	**260,346.00**
EMA			
Training of Woreda EPI Coordinators on MLM	52,085.08	10,255.82	62,340.90
HP and HC HWs Training	75,234	-	75,234
Providing Training Materials and Guidelines	10,744.62	-	10,744.62
Monitoring Performance of Trained HWs	10,935	7,290	18,225
Evaluation of Project Effects	-	45,115.38	45,115.38
***TOTAL EMA* (excluding auditing and management costs)**	**148,998.70**	**62,661.20**	**211,659.90**
ODA			
Community Sensitisation	26,098.90	-	26,098.90
ToT	23,906.59	-	23,906.59
HEW Training	79,758.24	-	79,758.24
CBRHA Training	85,824.18	-	85,824.18
IEC Material Production	10,989.01	-	10,989.01
Supervision Costs	25,494.51	25,494.51	50,989.02
Annual Evaluation Meeting	20,439.56	20,439.56	40,879.12
CBRHA Quarterly Review Meetings	37,362.64	39,497.20	76,859.84
Salary of Project Focal Person	4,450.55	5,934.07	10,384.62
CBRHA Refresher Training	-	68,021.98	68,021.98
WPC & WHO Supervision Costs	6,263.74	3,692.31	9,956.05
Monitoring and Evaluation	20,000	20,000	40,000
Top up for four Project Staff	2,769.23	3,692.31	6,461.54

Final Evaluation	-	21,978.02	21,978.02
***TOTAL ODA* (excluding auditing and management costs)**	**343,357.15**	**208,749.96**	**552,107.11**
Management costs (of all CSOs)	**142,736.56**	**90,777.67**	**233,514.23**
Management costs (of JCCC)	**44,770**	**44,770**	**89,540**
Financial auditing costs (of all CSOs)	**6,593.41**	**18,522.4**	**25,115.81**
Total Costs	**1,983,477.31**	**1,336,345.08**	**3,319,822.39**[1]

* **(APDA is requesting 232,467 from GAVI, the remaining 71,930 is their contribution)**

Section 7: Endorsement of the Application

Representatives of the Health Sector Coordinating Committee (HSCC), or equivalent, should endorse the application, and the Chair of the HSCC should sign the application on their behalf. All HSCC members (or equivalent) should sign the minutes of the meeting where the GAVI CSO application was endorsed. The minutes should be submitted with the application.

Please note that the signature of HSCC members represents their agreement with the information and plans provided in this application, as well as their support for the implementation of the plans. It does not imply any financial or legal commitment on the part of the partner agency or individual.

“The Central Joint Steering Committee (CJSC) representing Government and partners commits itself to providing support to the Civil Society Organisations in this application to implement the strategy. The CJSC further certifies that the CSOs are bona fide organisations with the expertise and management capacity to complete the work described successfully.

The HSCC requests that GAVI Alliance funding partners provide financial assistance to

support CSOs that can contribute to the implementation of the GAVI HSS proposal and / or the cMYP as outlined in this application.

- **Chair of HSCC (or equivalent):** Name, Post, Organisation, Date, Signature

Dr. Tedros Adhanom Gebreyesus

The Minister of Health of the Federal Democratic Republic of Ethiopia, Chairperson of the CJSC, signed 10th September 2008.

[1] Please keep in mind APDA’s further contribution of USD 71,930.

Members of the HSCC (or equivalent) endorsed this application at a meeting on ……………………. The signed minutes are attached."
This section should also include the name and contact details of the person for the GAVI Alliance Secretariat to contact in case of any queries. Please provide the following information:

- **Contact person:** Name, Post, Organisation, Tel No., Fax No., Address, Email

Dr. Nejmudin Kedir
Head of PPD of FMoH, Chair person of JCCC and Secretary of CJSC
Tel: +251 911 388945(Mob)
Email: moh@ethionet.et or nejmudink@yahoo.com

ANNEX Documents Submitted in Support of the GAVI CSO Support Application

Please submit the following documents with this application (in electronic coy if possible). Please number and list the documents in the table below:

Document (with equivalent name used in-country)	Available (Yes/No)	Duration	Attachment Number
Last CSO annual and audited report			
Registration document			
CSO constitution			
Strategic plan (if available)			
Reports of recent similar projects completed (if any)			
Reports of any external evaluations of the CSO (if any)			
Banking Form			