Health Systems Strengthening Support based on a jointly assessed National Health Strategy

Funding Request Template - Pilot Version 2.0, 3 June 2011

Applicant Details

Country	Federal Democratic Republic of Ethiopia	
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Funding requested from GAVI only?	√
Funding requested from Global Fund only?	
Funding requested from the Global Fund and GAVI (in this request form)?	

Background

Duration of the National Health Strategy	
From (Month and year)	**To (Month and year)**
07 July 2010	06 July 2015
Planned Start and End dates for HSS support	
For GAVI, the maximum duration of the funding request is determined by the duration of the current national health strategy. For the Global Fund, the maximum duration of the funding request is determined by the duration of the current national health strategy. If this is less than five (5) years, applicants may include a request for one (1) additional year of funding. In any case, the maximum of five years from the planned grant start date (including the remaining implementation of the strategy and the indicative year) may not be exceeded.	
From (Month and year)	**To (Month and year)**
Global Fund: N/A	**Global Fund: N/A**
GAVI: Feb 2012	**GAVI**: July 2015
Describe how the start and end dates above were selected. Also describe how they contribute to alignment with national financial Fiscal and/or program review cycle/s.	

Response:

The start date is selected based on the options provided in the *'GAVI and Global Fund Guidance Note for Developing Joint Health System Strengthening Funding request based on the National Health Strategy'*. As Ethiopia has opted for 'option 2' from the three options given in the Annex E of *the Guideline for developing common HSS funding request*, the start dates will be on Feb 2012.

The Ethiopian fiscal year starts on 7th of July and ends on 6th of July of the next year. Quarterly reporting and reviews align with the above start and end dates of the fiscal year while Midyear and annual reviews are done in January and September/October respectively. Although the start dates of this application does not align with the health sector calendar year, subsequent reporting and review will be aligned with reporting and review cycle of the Health Sector Development Program. In addition, once the request for funding has been approved and allocation of finance for the programmatic interventions is known, then yearly funding through this grant will be reflected in the resource mapping exercise and will be part of the consolidated annual budget for the health sector.

The funding request is based on the Five-year National Strategy, HSDP IV (2010/11-2014/15), and the Joint Assessment of National Health Strategies (JANS) conducted on 2009/10.

Currency: 'Tick' (✓) which currency is used throughout this application.	√ **USD**	**EURO**
	Note that GAVI will disburse in USD only	

Period	Summary of HSS Funding Request					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
	Feb 2012-July 2012 to	July2012–July 2013	July2013–July 2014	July2014– July 2015	N/A	
Funds requested from the Global Fund	N/A	N/A	N/A	N/A	N/A	N/A
Funds requested from GAVI	6,255,481	40,440,366	19,662,818	8,840,818	N/A	75,199,484
Total Funding Request						75,199,484

Eligibility

N/A

Global Fund eligibility – CCM eligibility and other requirements for requests to the Global Fund

Please fill out the separate eligibility document, which is available here. Kindly note that applicants submitting a request to the Global Fund will also have to submit “Attachment C”, the signed membership list as sign of request endorsement by all CCM members.

For more information on Global Fund eligibility, please refer to the Global Fund's Guidance Note: CCM Requirements.

If the JANS report identified weaknesses in multi-stakeholder involvement (MSI) in the development of the national health strategy, please describe below how you intend to improve MSI in future development processes.

Response:

N/A

GAVI eligibility - Government endorsement and other requirements for requests to GAVI

Please note that this application will not be reviewed or approved by GAVI without the signatures of both the Minister of Health & Finance and their delegated authority.

Minister of Health	Minister of Finance
Name:	Name:
 GAVI.pdf	
Signature:	Signature:
Date:	Date:

Applicants to GAVI are also requested to fill out this eligibility section. For more information on GAVI eligibility, please refer to the following document.

Note: In filling out the sections below please cross-reference as much as possible to the existing documentation of the National Health Strategy.

In the case of requests to both Global Fund and GAVI, please clearly delineate, programmatically and in the budget and work plan, what is being requested from the Global Fund, and what is being requested from GAVI.

List of acronyms

AIDS	Acquired Immuno Deficiency Syndrome
ARM	Annual Review Meeting
CCRDA	Consortium of Christian Relief and Development Association
cMYP	Comprehensive Multy-Year Plan
CSO	Civil Society Organizations
CSS	Community Systems Strengthening
EMR	Electronic Medical Records
EPI	Expanded Program of Immunization
ERIA	Enhanced Routine Immunization Activities
FMA	Financial Management Assessment
FMoH	Federal Ministry of Health
GAVI	Global Alliance for Vaccine and Immunization
GF	Global Fund
GTZ	German Technical Corporation
GoE	Government of Ethiopia
GTP	Growth and Transformation Plan
HC	Health Centre
HEP	Health Extension Program
HEWs	Health Extension Workers
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSDP	Health Sector Development Plan
HP	Health post
HSS	Health system Strengthening

ICT	Information Communication Technology
ICCM	Integrated Community Childhood illnesses Management
IMNCI	Integrated Management of Neonatal and Child Hood Illness
IRT	Integrated Refresher Training
JANS	Joint Assessment for National Strategies
JCCC	Joint Core Coordinating Committee
JCF	Joint Consultative Forum
JFA	Joint Financing Arrangement
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MDG PF	Millennium Development Goal Pool Fund
PCV10	Pneumococcal Conjugate Vaccine 10
POA	Plan Of Action
PEPFAR	President's Emergency Plan for AIDS Relief
PFSA	Pharmaceutical Fund & Supply Agency
PV	Photo Volatic
SDA	Service Delivery Areas
TOT	Training Of trainers
TVET	Technical Vocational Training and Education Center
UNICEF	United Nations Children's Fund
US	United States
WHO	World Health Organization

SECTION 1: EXECUTIVE SUMMARY

Applicants are strongly encouraged to complete the Executive Summary only after completing sections 2 to 7.

In this section, applicants are required to provide a CONCISE SUMMARY of this application being presented to the Global Fund and/or GAVI. Details should be described in section 2.

The summary should provide an overview on the following points:

- For which elements of the National Health Strategy health systems strengthening (HSS) and community systems strengthening (CSS) support is requested, and why and how these elements were selected for the funding request.
- What is requested, and how the support requested is additional to, and complementary to existing support, as well as Global Fund and/or GAVI support.
- How this support will help achieve expected outcomes and impact as described in the National Health Strategy, and how it is expected to contribute to:
  - Improved outcomes in at least two of the three diseases (HIV/AIDS, Tuberculosis, Malaria) – for Global Fund support
  - Strong links to immunisation outcomes – for GAVI support

Response:

Health sector development is one of the main social development pillars of Ethiopia's overall strategic framework for the five years period, the Growth and Transformation Plan (GTP), 2010/11 till 2014/15.The GTP prioritizes improving access and quality of health care to achieve the health related MDGs. In line with the GTP, the fourth phase of Health Sector Development Plan prioritizes achieving the health related MDGs by 2015. To this end, improving child health and reducing child mortality through implementation of selected high impact intervention remains to be one of the major priorities of HSDP IV.

An effectively performing health system is key to achieve broadly defined national health sector goals. Health Systems Strengthening (HSS) is an integral component of the national strategy, and it addresses more specific objectives, fulfilment of which contributes to achieving the national health goals. Thus, HSS is a means to an end, not the end objective in itself. Based on Ethiopia's circumstances, and depending on the countries' national health strategy goals, addressing health systems bottlenecks through HSS interventions are prioritized. GAVI focuses its HSS support to improving Immunization outcomes and the activities in this proposal are linked directly or indirectly to this.

This funding request for GAVI HSS support phase two, aims at contributing to Ethiopia's overall goal of reducing child mortality from the current levels of 101 to 68 per 1000 live births by the end of 2015 to meet MDG4 and hence improving Immunization outcomes through strengthening integrated child health service delivery and health system

strengthening.

During the proposal development, much emphasis was given to facilitate the integration between EPI and other child health services and to ensure the iterative nature of the activities funded between the earlier and current phases of GAVI and Global Fund.

In the first phase of GAVI HSS support, more emphasis were given to fill the basic gaps related to health infrastructure development and supplies provision, which was the priority gap identified at the time in line with HSDP-III. The first phase has resulted in; upgrading of 212 health stations in to health centres and equipping 300 health centres and 7340 health posts. At the same time, strengthen the capacity of health workforce, through training for Health Extension Workers, health centres' staff and Woreda management teams, in implementation and follow up of successful immunization and child health promotion activities at different health care delivery units was also the focus area addressed. Accordingly, in the first phase of the GAVI support a total of 7,440 health extension workers were trained on Integrated Refresher Training and 5,400 health centre staff were trained on IMNCI case management.

The first phase of GAVI HSS was channelled through the MDG PF and was managed by Ministry of Health together with Joint Core Coordinating Committee (JCCC). This mechanism was the first of its kind and was with much less transaction cost. The management of HSS grant coasted only 0.6% of the whole grant. This was mainly because the grant used the existing system for financial management, procurement and overall program management. In general the support targeted and addressed the major bottlenecks in the health system that impede progress in improving the provision of and demand for immunization and other child health services.

The current phase has aimed at the expansion of the gains in the earlier phase with additional innovative and evidence based interventions that are identified as potential gap-filling in the areas of cold chain management, strengthening and building the capacity of health workforce, involving civil society organizations and initiating mHealth and electronic Medical Recording systems with an intent to reach unreached communities throughout the country.

In this phase there will not be major construction of health facilities, as this is covered by other development partners. Instead GAVI support will be focus on covering partially the cost of improving the quality of service and expansion of basic service in the country including hard –to- reach and low performing areas. To this effect, there is a plan to train 45,000 health workers out of which GAVI will cover the training of 16,780 HEWs; 397 health extension program focal persons and 5418 health extension supervisors, to fill the knowledge and skill gap in implementation, supervision and evaluation of integrated immunization and child health activities. Moreover, equipping 250 health centres as per the standard and supplying of essential drugs including drugs and supplies for integrated community case management of child hood illnesses for 6,928 health posts, procurement and distribution of 1790 Motor bikes to the health extension program supervisors in order to assure timely supportive supervision of the health extension workers are planned.

On the other hand, Global Fund (GF) is supporting the prevention and control of Malaria, Tuberculosis and HIV/AIDS and the health system strengthening component of Global Fund is to support the supplies of different tools to strengthen HMIS, which is different but

complementary to the mHealth support planned to be implemented through GAVI HSS support. In addition, GAVI and GF, will provide support to strengthen the cold chain system through provision of solar plants to 300 health centres and 2960 health posts, respectively, which further strengthen the interlink between the two different but interlinked levels of health care service delivery for better cold chain management.

The Health sector strategy has prioritized the need to support the pastoralist, low performing and hard to reach areas. Four Regions needing special support, i.e., Afar, Somali, Beneshangul-Gumuz and Gambella, present unique challenges for health service delivery and health system development. These regions are characterised by poor infrastructure, harsh environmental conditions, and pastoral or semi-pastoral populations. HSDP I, II and III have emphasised the need for regionally tailored approaches and support to bring them to equal footing with the rest of the country.

HSDP-IV will continue and further strengthen the special support provided to these regions through various suit strategies as stipulated below;

1 Participate in multi-sectoral planning under the coordination of the Ministry of Federal Affairs; which is arranged for the Emerging Regions. This is an inter-ministerial board with members from six ministries which was established under the Ministry of Federal Affairs
2 Develop & implement a contextualised health service standard including pastoralist Health Extension Programme (HEP), Health Centres (HCs) relevant to population ratio, staffing pattern & hardship allowances;
3 Provide special support for health planning, budgeting, implementation, monitoring & evaluation of health programmes;
4 Provide needs-based capacity building to ensure sustainability

These strategies are also grounded in the experience that effective partnerships with CSOs enable an exponential expansion of impact. The type B GAVI CSO support proved this partnership to have better ground to justify this impact. The CSOs participation in immunization and child health services in this phase serves to leverage the skills, resources, and also to complement efforts of government, community members, and the private sector, given that they have better experience and organized structure in low performing, hard to reach and pastoralist areas.

In summary, there are three objectives under this funding request for GAVI HSS Support which include:

1) Improve Immunization outcomes through community and facility based integrated child health services,

2) Improve access to primary health care services in selected low performing and hard to reach areas so as to improve immunization outcomes and

3) Strengthen the capacity and management of Cold chain system at all levels.

Under objective one, GAVI will be supporting the countrywide improvement of the quality of integrated child health services with special focus to immunization and related interventions.

Under objective two, GAVI will provide the same support, but with more focus on the hard to reach and low performing areas through various strategies including involving CSOs. Under objective three, a country wide expansion and improved management of the cold chain system has been prioritized considering the expansion of health services to newly constructed health facilities and also the introduction of new and high cost vaccines in the planed period.

The outcome of the GAVI HSS support will be monitored through the following three main outcome indicators: Penta 3 coverage and dropout rate between Penta 1 and Penta 3 for objective one and two and Penta vaccine wastage rate for the third objective. Penta vaccine wastage rate is defined as the proportion of Penta vaccine doses consumed that were not consumed to deliver a vaccination to a person. It represents the proportion of total doses lost among those used.

The three objectives identified are:

Objective one: Improve Immunization outcomes through community and facility based integrated child health services

1.1: Integrated Refresher Training (IRT) for Health Extension Workers

Lady health extension workers, trained for 12 months, are the mainstay to the implementation of essential health services, including immunization activities in the country. The health extension workers render integrated primary health care services at the doorsteps of the communities and play a key role in bridging the gap between the health facilities and communities.

HEWs played a significant role to the improvement in household latrine ownership and use as well as overall personal hygiene and environmental sanitation. However, there are still gaps in their skills on promotion of maternal, newborn and child health services. The HEWs are the back bone of the service given to the community at the lowest level (HP) and they handle all immunization related activities such as; demand creation and avoiding missed opportunities among infants and mothers visiting health posts seeking for treatment, giving the vaccine, and recording and reporting etc. In order to deliver a successful immunization program there is a need to put in place adequately skilled health workers, a quality logistic system and adequate supplies and commodities. Improving the HEW skills will have direct effect on the outcomes and impact of the EPI program.

To this effect, in the coming four years of HSDP IV, the country is planning to conduct Training of Trainers (ToT) for 2970 health workers out of which GAVI will cover the cost for 346. Out of the planned 45,000 health workers to be trained on Integrated Refresher Training (IRT) GAVI will cover the cost for 397 HEP focal persons, 5,418 supervisors and Health centre staffs, and 16,780 Health Extension Workers. In addition 15,000 copies of family health booklet printing, 40,000 copies of the facilitators guideline, 240,000 copies of the participants manual, 20,000,000 copies of the family health card, 3,000 copies of the IRT implementation plan, 54,485 copies of the HEW hand book and 15,000 copies of the first aid materials will be printed.

1.2: Equip newly constructed health centers

Health infrastructure is basic to provide any type of health service which includes Child Health services and immunization. Primary health care initiatives, that put health centers as a focal point to provide technical support for five health posts, will help to strengthen the capacity of health extension workers to effectively deliver the sixteen packages including routine immunization. Despite the sustained increment in the number of newly constructed health facilities some of the facilities still lack adequate infrastructure setups to provide comprehensive health services as per the standard. Among the infrastructure needs of health facilities, the availability of necessary medical equipment, electricity and water are critical for the delivery of health services, the quality and safety of patient care, as well as provider safety.

A total of 717 health centers will be equipped during HSDP IV period, out of which 217 were constructed by the regional governments and 500 are planned to be constructed by federal government and other partners to meet the growing need as a result of population growth. These Health Centers need to be functional and give the required health services including child health and immunization services. GAVI support will cover the cost to equip 250 of the newly constructed health centers and the cost for the remaining health centers will be covered by Government and other partners. In addition, government will cover the human resource and other running costs.

1.3: Implement Electronic Medical Recording system in selected district/primary hospitals

The documentation and reporting mechanism in the Ethiopian health care system is weak and is characterized by incomplete documentation and delays of reporting at all levels. The data is computed manually in almost all cases which undermine its quality and requiring long time for data to be available. As a result the duration for a report to be available at the federal level is 28 days. This necessitates the use of ICT and digitalizing the reporting and documentation system to be able to produce a complete, reliable and timely data and a smoother flow of information. So far EMR was implemented in thirteen hospitals by the support from CDC and PEPFAR and is planned to be scaled up to 103 hospitals during HSDP IV period out of which GAVI will cover the cost for eight primary hospitals and the remaining will be covered by others partners. This support will involve procurement of hard-wares and installation of soft-wares for the Electronic Medical Records system.

1.4: Implement mHealth at community level

The introduction of mobile health (mHealth), the provision of health-related services via mobile communications, is planned to ensure timely technical and logistic support for HEWs during different occasions, including cold chain dysfunctions thereby prevent vaccine wastages and missed opportunities in the provision of different services at the health posts. This activity is based on a study conducted by Vital WAVE consulting in may 2011 which showed that mHealth in Ethiopia could be an effective tool for advancing the government's key health initiatives, particularly community based interventions that have women as their centre.

In-order to implement mHealth at community level, this funding request will cover the procurement of smart phone for 15,000 health posts, development of phone-based and

server based application software's program/platform and training for 15,000 health extension workers (1HEW/health post) on the system.

1.5: Procurement of essential drugs and supplies for health post

Health posts are the lowest units of the health care service delivery system. They provide preventive, promotive and basic curative services by two HEWs assigned permanently. To provide these services the health posts need continuous supply of basic drugs and supplies. Since the integration of services at the health posts has enabled the demand for one service to enhance the utilization of the other , availing safe and adequate vaccines in health facilities has to be complemented by ensuring continues supply of other health facility essential drugs and supplies for child health and related primary health care services. There is currently a huge need for essential drugs and supplies as the number of health posts is growing and has reached so far 15,095 all over the country. GAVI support will cover the cost of drugs and supplies for 6,928 health posts. The cost for the remaining health posts will be covered by government and other partners.

Objective two: Improving access to primary health care services in selected low performing and hard to reach areas so as to improve immunization outcomes.

SDA 2.1: Implement strategy to respond to the needs of number of low performing and hard to reach areas through CSO participation

According to EPI cMYP table 4, the immunization coverage varies significantly by region. Over 90% of children in SNNPR (Southern Nations Nationalities People Region) are immunized with DPT3 by the age of one and the most populous regions Oromiya and Amhara have achieved 84% and 80% respectively. However the immunization coverage decreased dramatically to less than 50% in Somali, Afar and Gambela Regions. In response to this the Ethiopian health sector strategy emphasizes different mechanisms to address the health needs of the communities in the hard to reach and low performing areas through implementation of a context based health service standard and different supports. Recently, 2009, Enhanced Routine Immunization Activities (ERIA), has been implemented in all pastoralist regions to reduce the number of unvaccinated children in the zones with large number of unimmunized children.

In addition, there are also a number of CSOs working in the country to complement the Government effort to reach low performing and hard to reach areas. Ethiopia is one of the pilot countries for GAVI CSO support and with this regard the Ministry of Health has worked with five selected CSOs and the program is still ongoing.

Type B support is relevant, given the important complementary role of CSOs in the country's immunisation program. The Type B funded programme activities are as closely aligned with country needs. For example, one of the criteria for government selection of CSOs to be funded under Type B support was their alignment with the country HSDP. In addition, the government has embarked on an extensive health extension programme, and hence there is an important role for CSOs in training health workers – which is one of the key focus activities of the Type B support in Ethiopia. Other activities include advocacy and community mobilisation events. Some of the funding will also be used to maintain motor bikes and purchase kerosene for refrigerators in support of the EPI outreach activities – identified as

key gaps at the local level.

2.2: Strengthening Health Forum to facilitate overall involvement and collaboration of CSOs working in the immunization and child health

Many CSOs are involved in the health system in different part of the country. Although there is some effort being done by CCRDA to bring CSOs together, still there are some CSOs which are not included in the consortium. CCRDA has about 360 member CSOs under the umbrella. There was an assessment done by independent consultants on how to revitalize the one plan, one budget and one report. It has outlined the barriers on various stakeholders not to harmonize and align with government's system. One of the most important barriers to CSOs/ NGOs is that there is no strong coordination amongst them. The assessment in its roadmap has recommended that the CSOs need to strengthen their coordination mechanism. The progress of implementation of the roadmap will be monitored by JCCC and reported in the next Annual Review Meeting (ARM). This shows that there is a strong need to strengthen the existing CSOs collaboration among themselves and the government to effectively address health and health related issues. It coordinates the efforts of CSOs towards achieving health related MDGs. This forum will be working on information sharing, avoiding duplication of efforts, synergizing and forwarding the voice of the community to higher level and facilitating communication with government.

Objective 3: Strengthen the capacity and management of Cold Chain system at all levels

3.1: Strengthening the capacity of cold chain system

Vaccines play a crucial role in the reduction of morbidity and mortality in children. Immunization programs, when implemented effectively, contribute towards achieving the MDG4 of reducing childhood mortality by two third, by 2015. Among the strategies to achieve the MDG4 is improving the national immunization coverage to 90%.
A functional cold chain system is a key and mandatory for effective immunization program. As part of improving immunization services priority has been given to strengthen the capacity and management of cold chain system which is vital for maintaining the safety and potency of vaccines across the various chains**.**

Moreover, the country has introduced new Pneumococcal Conjugate Vaccine 10 (PCV10) and under preparation to introducee rotavirus vaccine. The introduction of these expensive and logistic intensive new vaccines and the expansion of service to the newly constructed health facilities will further compromise the already overstretched cold-chain system, therefore any effort to ensure adequate and sustainable cold chain systems that ensures reliable storage conditions and transportation is a worthwhile exercise.

There is one refrigerated truck currently operating in the cold chain system. As a result of the business process reengineering and as part of recommendations from the recent vaccines management and cold chain assessment, PFSA, the procurement agency, is expanding the regional hubs by renting and constructing four central and 17 regional hubs. Under this grant procurement and supply of refrigerators and their spare-parts and procurement of five refrigerated trucks are planned. One of the five trucks will serve to strengthen the service given by the existing truck at the national level and the rest will serve to distribute vaccines

and drugs from four hubs to the 17 regional hubs.

3.2: Establishment and Strengthening of regional medical equipment maintenance workshops with special focus on the cold chain system

The medical equipments which are already functional faces various minor and major problems which need maintenance at local level. Improving the maintenance of equipment at regional and lower levels help reach the HSDP IV target of improving the quality of health services provided to the community at all levels. Currently there is no such facility at regional level and this is aggravated by the absence of skilled man power to cover the maintenance needs.

To address this gap the government is training biomedical technicians at TVET colleges and these will be deployed soon to work in the new maintenance workshops. The running cost for these new medical maintenance workshops including salary for the technicians will be covered by the government. This support contributes a great deal to the health system through increasing the performance of medical equipment, by decreasing equipment down time and by strong maintenance support so that the potency of vaccine and other drugs will be maintained.

3.3: Supply PV solar for health centres

Power supply is mandatory to facilitate service delivery at facility level especially immunization services as vaccines have to be kept under specific temperatures. But in Ethiopian context the majority of the health facilities have no direct source of power and therefore service delivery is impaired and critical areas such as refrigerators for vaccine storage cannot function resulting in a serious compromise in quality of service provided.

PV solar power has a relative advantage as compared to kerosene with respect to less recurrent cost to run the system. Therefore investing in solar power system can provide a more sustainable power supply to ensure safe and reliable cold chain system. Though the long-term solution for this is to install the hydro-electric power; MoH plans to supply PV solar system as short term solution which can be used even in power interruption in the future.

Currently there is a survey being undertaken by federal ministry of health to identify the exact number and locations of health facilities with no power and water supply. Based on the result of the survey further plan of action will be developed to equip the health facilities with solar power.

GTZ has installed PV solar for 100 health centers. Currently, based on the information from regional health bureaus, it is estimated that 928 health centers are without power supply. The GAVI HSS support is expected to finance procurement and installation of 300 PV solar panels for 300 selected health centers. The remaining 628 health centers will be covered from other sources but currently will remain as a gap.

3.4: Training on management and preventive cold chain maintenance

The challenge for sustaining immunization activities lies in maintaining equipment at various levels. As the same time it is the responsibility of the district EPI focal person, health worker and supervisor that equipments and machineries in the district run to their optimum. This requires their preventive maintenance knowledge and skill to properly execute their duties.

The training will build the capacity of the health workers mainly EPI focal persons at Woreda level. EPI focal persons and relevant health workers will be identified (four per Woreda) and a total of 3484 health workers will be trained on the management and preventive cold chain maintenance. In-addition, 1738 HEW supervisors (two per Woreda) will be trained on supportive supervision focused on cold chain management. The training cost for the rest 1756 health extension supervisors will be covered by the government.

The trained health professionals are expected to visit the health facilities in their district to identify and provide timely support for the activities of health workers and health extension workers in the areas of cold chain management and other related activities. To this effect, availing motor bikes to facilitate transportation is mandatory for the effective execution of their aforementioned responsibilities. GAVI HSS support will provide motor bikes for 1790 health extension program supervisors and the cost for the remaining motor bikes will be covered by other partners and government will cover the running cost for the day to day activities of the trained people including fuel and maintenance for motor bikes.

Financial Gap analysis, Work Plan and Budget

The costing framework for the implementation of HSDP IV is developed in two scenarios and provides a detailed costing analysis and results for both of scenarios. Each scenario calls for a certain level of reinforcement of the cornerstones of the health system or the coverage determinants. Total budget for the five years is estimated at US$ 8.83 billion under the base-case scenario and US$ 10.828 billion for the best-case scenario.

The base-case scenario assumes that there would be no compromising of the plan to achieve the health MDGs by the year 2014/15. This scenario considers universal access to health centers, staffing, equipping and availing drugs and supplies to health centers as per the standard. There would be strengthening for the supply chain management systems to make health facilities fully functional and provide quality health service. The investment is estimated to reduce under-five mortality by 33.8% and maternal mortality by 54.8%. The best-case scenario calls for a higher supplemental investment of US$ 13.96 per capita per year, but it would result in much higher reductions in mortality – bringing down under-five mortality by 46% and maternal mortality by 56.6%. This request for HSS funding will cover 10% of the HSDP IV budget gap for system strengthening and capacity building and almost 50% of HSDP IV resource gap for Child Health service by mobilizing a total of 75 million USD for four years of HSDP IV (2010/11-2014/15).

The activities started through various donor supports are planned to be sustained through different resource mobilizations mechanisms and health care financing schemes including community and social health insurance, retention of revenues at facility level and increasing government spending for public health in the coming five years.

Financial Management and Implementation Arrangements:

GAVI HSS support will be channelled to the MDG PF, which is the GoE's preferred modality for scaling up Development Partners assistance in support of HSDP. The MDG Fund is pooled funding mechanism managed by the FMOH using the Government of Ethiopia procedures.

In March 2011, GAVI, World Bank, AusAid and Netherlands Embassy did a Financial Management Assessment (FMA) on the MDG PF which identified strengths and weaknesses of the mechanism. Ministry of Health together with the Development Partners have developed Plan of action to improve the weaknesses identified in this assessment. The Joint Financing Arrangement has been revised based on findings of the FMA and will be signed by MDG PF funders in January 2012. Majority of the POA are being implemented and this is being monitored by JCCC and JCF.

GAVI's fund will use the existing government system and procedures for financial management and procurement. It will also use the quarterly report of the MDG PF and the annual progress with the progress in the indicators specified in this proposal will be reported in the annual performance report of the sector. (see the attached quarterly reporting format for MDG PF)

The framework for the dialogue, governance and decision-making of the MDG Fund is provided by the health sector coordination framework which consists of a two tier collaborative governance system made up of the Joint Consultative Forum (JCF) and the Joint Core Coordinating Committee (JCCC). GAVI doesn't have country office and therefore is not member of these structures. However GAVI can express interests through UNICEF and WHO as has been done in the previous support.

Monitoring and Evaluation:

The monitoring and evaluation mechanism for this grant will draw lessons learnt from implementation of various health sector support grants. It will be made to align with the jointly agreed up on 'One M & E Framework' in the health sector. Therefore, the data collection, reporting time and channels will follow existing national arrangements and will be carried out by the existing structure and system, which is the HMIS.

The Resource Mobilization and Project Coordination Directorate under the Policy Planning and Finance General Directorate of the FMOH will be responsible for providing GAVI with reporting relevant to the HSS grant. Quarterly activity and financial reports of the grant will be complied as part of the MDG PF report and presented to the JCCC for follow-up and annual HSS Grant performance report will be part of the annual sector performance report.

SECTION 2: PROGRAMMATIC INFORMATION

Please describe:

1) The nature of the support requested and linkages to the National Health Strategy, with reference to the National Health Strategy and any other relevant annual or sub-sector plans (for example, human resources or HMIS plan). Explain how the support will address identified health system gaps, and why priority was given to these particular gaps, relative to other unfunded gaps. Summarize what support is requested from the Global Fund and what support is requested from GAVI.

2) How the support requested is additional to, and complementary to existing support, including Global Fund and/or GAVI support. Please reference the financial gap analysis in section 3 below.

3) How funds requested are expected to contribute to:

    - Expected outcomes and impact as described in the National Health Strategy
    - Improved outcomes in at least two of the three diseases (HIV/AIDS, Malaria, Tuberculosis) – for Global Fund support
    - Strong links to immunisation outcomes – for GAVI support

4) Please fill in the logframe (Attachment 1). The goals, objectives, SDAs and activities requested need to be provided here, and how they will be implemented. Please delineate what HSS support is requested from the Global Fund and what support is requested from GAVI.

Please see the guidance note entitled: ''Practical Information for Developing Joint Health System Strengthening Funding Requests Based on National Health Strategies'' that details what types of HSS support can be requested. Note that Community Systems Strengthening (CSS) activities can be included under HSS. To identify constraints to community systems, applicants can refer to the Global Fund Community Systems Strengthening Framework. The CSS framework is intended for use by all those who play a role in dealing with major health challenges and have a direct interest in community involvement and action to improve health outcomes, including governments, community actors, donors, partner organisations and other key stakeholders.

Response:

Ethiopia's overall strategic development framework, the Growth and Transformation Plan (GTP 2010/11-2014/15), is geared towards achieving the MDGs. The GTP can be considered as an important enabling strategic framework for the realization of the MDGs and their targets. Much broader in scope, the GTP is inclusive of all the MDG relevant sectors (road, water, education, health) and most of the targets for these sector programs are in line with MDG targets.

The medium of translating the health component of the GTP is the Health Sector Development Program (HSDP 2010/11-2014/15), the main program of the health sector that is being implemented within the framework of the Sector-Wide Approach to Development (SWAP). It is a 20 years program launched in 1998 and includes incremental investment programs and mid-term plans to reform the health service system through sector-wide approaches. It serves as guiding framework for detailed planning, implementation and monitoring and evaluation of intervention in the health sector throughout the country. The primary goal of this program is to provide comprehensive and integrated primary health care system for rural communities where 85% of the total population lives. In 2009/2010, the Ministry of Health developed the fourth HSDP which was consulted and jointly assessed using the JANS tools.

HSDP IV has put clear strategies how to achieve the MDGs in the coming five years before 2015. The costing of HSDP IV has shown a big funding gap in its base scenario, which is achieving MDGs. This funding gap needs to be filled both by the government and development partners. The Government has committed itself to cover as much prevailing gaps as possible so as to reach the MDGs. As per the IHP+ compact Development Partners have also committed themselves to provide predictable additional financing and work towards aid effectiveness.

Various studies show that it is possible for Ethiopia to achieve the MDGs 4 and 5 but sustained, increased financing to maternal, newborn, child health and nutrition is required. The sound policies and strategies that are in place require support in the form of harmonized, widespread, equitable implementation from all stakeholders. In addition, investment in the building blocks of health system strengthening needs to be an essential focus as a reduction in maternal mortality cannot be achieved without it.

The request for HSS funding from GAVI plays a vital role in securing the implementation of the HSDP IV 2010/11-2014/15 by providing additional financial resources to the health sector on top of existing funds from other Development Partners and Government.

Goal:

This funding request for HSS aims at contributing to Ethiopia's overall goal of reducing under five mortality (U5MR) from the current levels of 101 to 68 per 1000 live births by the end of 2015 to meet MDG4 through strengthening of child health service delivery and health systems.

The goal is in line with Ethiopia's Health Sector Development Program (HSDP IV 2010/11 – 2014/15) vision of reaching MDG 4 by the year 2015. According to HSDP IV, Ethiopia's MDG target for child mortality reduction is set at 68 per 1000 live births. Based on their resource needs and potential impacts key child interventions identified in HSDP IV are prioritized and selected for funding under this HSS grant. In order to reach to this goal, this grant will support the HSDP IV target of reaching pentavalent immunization coverage (Penta 3) to 96% by 2015 and the cMYP target of reducing Penta vaccine dropout rate from 8% to 3% nationally and to less than 10% in all districts by the end of 2015 and achieve Penta vaccine wastage rate of 5% in each year up to 2015.

There are three objectives under this funding request for HSS which include 1*)* Improve Immunization outcomes through community and facility based integrated child health services*, 2)* Improving access to primary health care services in selected low performing and hard to reach areas so as to improve immunization outcomes and *3)* Strengthen the capacity and management of Cold chain system at all levels

The service delivery areas included under each objective are identified in a manner that they contribute to strengthening of immunization services through improvement service delivery or building of district health system/primary level health care. The activities mainly focus on reducing child health mortality through strengthening of community or facility based immunization and health service. As part of strengthening district health system focus has been given to improving logistics, human resources, health information system and infrastructure in primary health care facilities.

Objective 1: Improve Immunization outcomes through community and facility based integrated child health services

To address the gaps in child health services, the strategic document HSDP IV plans to provide round the clock delivery services in health centers nation-wide, develop and implement a functional referral strategy, continue demand creation for health services through HEP, avail community case management of pneumonia while strengthening the management of malaria, diarrhea and malnutrition by HEW.

Main service delivery areas selected for support through GAVI HSS in order to improve child health services include:

- Integrated Refresher Training for Health Extension Workers
- Equip newly constructed health centers
- Procurement of essential drugs and supplies for HPs
- Implement EMR system in selected district/primary hospitals
- Implement mHealth at community level

SDA 1.1: Integrated Refresher Training for (IRT) Health Extension Workers

According to household survey conducted by the NGO '*Last 10 kilometers'* in four agrarian regions of Ethiopia, HEWs played a significant role to the improvement in household latrine ownership and use as well as overall personal hygiene and environmental sanitation. However, assessment recommended better emphasis to the promotion of maternal, newborn and child health services underlining the need for building up the skills of HEWs in these areas.

One of the key focus areas under HSDP IV is improving quality of the Health Extension Program by building the skills and basic competencies of HEWs in continuing education and by increasing the availability of basic supplies and equipment at health posts.

FMOH has developed Integrated Refresher Training (IRT) modules for health extension workers to address the identified and observed knowledge, skill and competency gaps that the HEWs and their supervisors have. The aim of the IRT is to provide a framework for harmonization of community-based interventions and standardized methods to train HEWs,

HEW supervisors and community health promoters in an integrated and cost-effective manner optimizing the support of partners and avoiding duplication and overburdening of HEWs/CHPs by vertical programmes.

In the coming four years of HSDP IV the country is planning to conduct Training of Trainers for 2970 health workers and Integrated Refresher Training (IRT) for a total of 45,000 health professionals including Woreda health extension program focal persons, supervisors, Health centre staff, and Health Extension Workers. This creates an opportunity to equip and continuously update health extension workers and their supervisors with the necessary skills for provision of quality promotive, preventive and basic curative interventions close to the community. This grant will support the printing of required training materials and part of the cost of training. The remaining will be covered by the government and other partners The indicator for this SDA is the proportion of HEWs received integrated refresher training.

Activities:

- Training of Trainers for 346 health workers.
- Provide Integrated Refresher Training (IRT) for 397 Woreda health extension program focal persons, 5,418 supervisors and Health centre staff, and 16,780 health extension workers.
- Printing family health booklet in 15,000 copies, facilitators guideline in 40,000 copies, participants manual in 240,000 copies, family health card in 20,000,000 copies, IRT implementation plan in 3,000 copies,, HEW hand book in 54,485 copies, first aid materials in 15,000 copies for each Health post

SDA 1.2: Equipping newly constructed health centers

During HSDP III period 2,299 health centers have been equipped and made functional while resources for the remaining health centers have been secured and are on the process of distribution and installation. HSDP IV has clearly identified the needs and directions in equipping and staffing of all health facilities as per the standard to ensure universal coverage of health services. This involves fully equipping all health centers newly constructed during HSDP IV period and the 217 health centres constructed by regional governments.

Primary health care initiatives, that put health centres as a focal point to provide technical support for five health posts, will help to strengthen the capacity of health extension workers to effectively deliver the sixteen packages including routine immunization.

The HSDP IV plan is to construct 500 Health centers to meet the growing need as a result of population growth. The construction is being done by the government with additional support from other donors. This grant will cover the cost to equip 250 newly constructed health centres and the cost for the rest 467 health centres will be covered by government and other partners. The running cost, including salaries, for these newly constructed health centres will be covered by the government. The indicator for this SDA is the proportion of equipped newly constructed health centres.

Activity:

- Equip the newly constructed 250 health centers during HSDP IV period

SDA 1.3: Implement Electronic Medical Recording system in selected district/primary hospitals.

An Electronic Medical Record (EMR) is a computerized medical record created in an organization that delivers care. Electronic medical records tend to be part of a local stand-alone health information system that allows storage, retrieval and modification of medical records. So far 13 hospitals have fully implemented EMR with the support from CDC and PEPFAR and HSDP IV has clearly considered that the use of ICT as an opportunity to enhance the accessibility and quality of care. Commitment has been made from government and other partners to support the implementation of EMR system in the remaining 103 hospitals out of which GAVI support will cover the cost for the eight selected primary/district hospitals. The running cost will be covered by the government. The indicator for this SDA is the number of hospitals who have implemented EMR system.

Activity:

- Procurement of hard ware equipment,
- Installation of the system and train the staff.

SDA 1.4: Implement mHealth at community level

To strengthen the reporting mechanism at community level mobile SMS text messaging will be used by health extension worker to report the immunization coverage to the health facilities, where by reducing unnecessary travel from the duty station. Additionally, it gives opportunities for HEWs to request the required technical and logistical support from the health centres and district/primary hospitals in their catchment area. Therefore, the supervisors will have a chance to monitor the status of cold chain and immunization coverage in each kebele and provide feedback to the HEWs. HEWs can also effectively use the technology for child and maternal health activities. A study, conducted by Vital WAVE consulting in may 2011 shows that mHealth in Ethiopia could be an effective tool for advancing the government's key health initiatives, particularly community based interventions that have women as their centre. The study also describes that around 90% of health extension workers have mobile ownership which supports to the previous studies conducted by SC4CCM/JSI in 2010, Addis Ababa University and UNICEF in the same year. The indicator for this SDA is proportion of health posts using mobile health technology for child health and immunization activities.

Activity:

- Procurement of smart phones for 15,000 health posts
- Development of phone-based application software's
- Development of server based application program/ platform for mHealth application.
- Training for 15,000 health extension workers(one/health post)

SDA 1.5: Procurement of essential drugs and supplies for health posts

Health posts are the lowest units of the health care service delivery system. They are staffed

by 2 Health Extension Workers (HEWs). The majority of their time (about 80%) the HEWs are expected to work at household level. In the remaining 20% they give basic curative and preventive works at the HP level which also includes Integrated Community Childhood illnesses Management (ICCM) service to contribute to increased coverage of immunization through demand creation and avoiding missed opportunities among infants and mothers visiting health posts seeking treatment.

To provide all these services the health posts need continuous supply of basic drugs and supplies. The need to fill the drug gap of health posts is at greater concern by considering its impact on utilization of other preventive services, mainly immunization. There is currently a huge need for essential drugs and supplies as the number of health posts is growing and has reached so far 15,095. Thus, GAVI will support the cost of essential drugs and supplies for 6,928 health posts including those in hard to reach and low coverage areas whereas the cost for the rest of the health posts will be covered by government and other partners.

The indicators for this SDA are

- proportion of health posts supplied with essential drugs and supplies and
- Integrated Childhood Illness case management (ICCM) implementation coverage at health post.

Activities:

- Supply 6,928 health posts with regular supply of health posts essential drugs and supplies including drugs and supplies for Integrated Community Case Management of childhood illnesses.

Objective 2: Improving access to primary health care services in selected low performing and hard to reach areas so as to improve immunization outcomes

SDA 2.1: Implement strategy to respond to the needs of number of low performing and hard to reach areas through CSO participation.

According to EPI cMYP table 4, the immunization coverage varies significantly by region. Over 90% of children in SNNPR (Southern Nations Nationalities People Region) are immunized with DPT3 by the age of one and the most populous regions Oromiya and Amhara have achieved 84% and 80% respectively. However the immunization coverage decreased dramatically to less than 50% in Somali Afar and Gambela Regions. In response to this the Ethiopian health sector strategy emphasizes different strategies to address the health needs of the communities in the hard to reach and low performing areas through developing and implementing a context based health service standard including pastoralist Health Extension Program, HC relevant to population ratio, provide special support for health planning, budgeting, implementation, monitoring & evaluation of health programmes and provide needs-based capacity building to ensure sustainability. Recently, 2009, Enhanced Routine Immunization Activities (ERIA), has been implemented in all pastoralist regions to reduce the number of unvaccinated children in the zones with large number of unimmunized children.

To complement the effort of government there are also a number of CSOs in Ethiopia,

focusing on poverty reduction and development, as well as specific aspects of health. Most CSOs support the immunization sector as part of their broader work on maternal and child health, rather than specifically focusing on immunization. Their role is complementary to that of the government, and includes training health workers, community mobilization, technical assistance, etc. CSOs are not directly involved in the delivery of immunization, except in a few hard-to-reach areas – most notably the 'emerging regions' of Afar, Benishangul-Gumuz, Gambella and Somali, where government services have limited reach, and populations are mainly nomads/ pastoralists.. As noted above, CSOs' role is complementing the public delivery systems by providing health worker training and technical assistance, mobilising communities, and service delivery to selected hard-to-reach areas. CSOs contribution is vital to achieve HSDP IV targets.

Activities:

The CSOs are targeted for this specific area considering their experience and better organized structure at low performing and pastoralist areas.

- Call for CSO proposals to address the specific needs in a number of low performing and hard to reach areas based on the strategy and a specific Terms of Reference prepared by MoH, which will focus on the following two areas
    - Strengthen and support the existing static and outreach immunization service, re-establishment of out reaches, establishment of mobile immunization teams, Support Enhanced Routine Immunization
    - Conduct operational research, documentation, dissemination of good practice and lessons learnt in pastoralist areas (attach the detailed activities prepared by CSOs)
- Review and award CSO proposals by JCCC
- Monitor and evaluate implementation of approved projects by Ministry of Health and Regional Bureaus

The indicators for this SDA are;

- the proportion of children who received Penta 3 vaccine and
- the dropout rate between Penta 1 and Penta 3, in hard to reach and low coverage districts.

SDA 2.2: Strengthening Health Forum to facilitate overall involvement and collaboration of CSOs working in the immunization and child health

This GAVI HSS support has a plan to strengthen a health forum among CSOs working in the areas of child health to facilitate effective collaboration. CCRDA has about 360 member CSOs under the umbrella. There was an assessment done by independent consultants on how to revitalize the one plan, one budget and one report. It has outlined the barriers on various stakeholders not to harmonize and align with government's system. Many CSOs are involved in the health system in different part of the country. Although there is some effort being done by CCRDA to bring CSOs together, still there are some CSOs which are not included in the consortium. One of the most important barriers to CSOs/ NGOs is that there is no strong coordination amongst them. The assessment in its roadmap has recommended

that the CSOs need to strengthen their coordination mechanism. The progress of implementation of the roadmap will be monitored by JCCC and reported in the next Annual Review Meeting (ARM). This shows that there is a strong need to strengthen the existing CSOs collaboration among themselves and the government to effectively address health and health related issues. It coordinates the efforts of CSOs towards achieving health related MDGs. This forum will be working on information sharing, avoiding duplication of efforts, synergizing and forwarding the voice of the community to higher level and facilitating communication with government. The indicator for this SDA is the number of health forum conducted to facilitate effective collaboration between CSOs and public health sector

Activities:

- Strengthen the health forum to facilitate and effective collaboration between CSOs and public health sector through:
  - Coordinate the efforts of CSOs towards achievement of health related MDGs
  - Collect good practices in the partners project areas and share with government and partners
  - Organize various discussion forums

Objective 3: Strengthen the capacity and management of Cold chain system at all levels

Vaccines play a crucial role in the reduction of morbidity and mortality in children. Immunization programs, when implemented effectively, contribute towards achieving the MDG4 of reducing childhood mortality by two third, by 2015. Among the strategies to achieve the MDG4 is improving the national immunization coverage to 90%. In order to deliver a successful immunization program there is a need to put in place adequately skilled health workers, a quality logistic system and adequate supplies and commodities. As part of strengthening immunization services priority has been given to strengthening the capacity and management cold chain system as it determines the quality of vaccines which is central to the effectiveness of the national immunization program. A well functioning cold chain system is vital in order to provide safe and potent vaccines to children.

Additionally, the country introduced a new vaccine, Pneumococcal Conjugate Vaccine 10 (PCV10) and preparation is underway for introduction of rotavirus vaccine. All these vaccines require adequate and appropriate cold chain capacity because new vaccines are expensive and have bulkier packed volume and therefore an increased pressure and demand for storage and transportation in the cold chain. Introduction of these logistic intensive new vaccines and the expansion of service to the newly constructed health facilities will further compromise the already overstretched cold chain system. Therefore, any effort to ensure adequate and sustainable cold storage conditions and transportation is a worthwhile exercise.

During a rapid cold chain assessment conducted in May 2011, 25% of the refrigerators observed by the assessment team were found non-functional due to unavailability of spare parts. The assessment also revealed that 35% of the refrigerators observed were older than 10 years of service passing the maximum recommended time for refrigerators before they become obsolete which is 10 years of service. As a result 10% of the refrigerators need to

be replaced every year. In addition, there is a challenge in transporting vaccines from airport to cold rooms as there is currently only one refrigerated truck available for the transportation of vaccines. On the other hand, availing safe and adequate vaccines in health facilities has to be complemented by ensuring continues supply of other health facility drugs and supplies for child health and related primary health care services. This is a huge challenge because the number of health facilities has significantly increased in the past five years and there is a need for continued supply of health commodities and supplies to meet the growing needs.

Therefore two important areas selected for financing through the GAVI HSS to improve the logistic needs are:

- Strengthening the capacity of cold chain system
- Establish and strengthen regional medical equipment maintenance workshops with special focus on the cold chain system

SDA 3.1: Strengthening the capacity of the cold chain system

The FMOH is working to improve the country's cold chain system so as to maintain the quality of vaccines. Strengthening the storage and distribution system of vaccines is essential to ensure adequate stock and continuous supply of vaccines to the facilities and to ultimately increase the immunization coverage. Vaccines are sensitive and need to be kept and transported at conducive temperature from the time of manufacturing till administration. The cold chain consists of a series of storage and transport links, which are designed to keep vaccines within an acceptable temperature range until it reaches the end user. Vaccine wastage can occur at any stage in this process, in the cold store at central level, at various intermediate levels, at the point of use at an immunization session and during transportation. Cold rooms, refrigerators, cold boxes, spare parts and refrigerated trucks are therefore very essential for consistent availability of potent and safe vaccines.

As a result of the business process reengineering and as part of recommendations from the recent vaccines management and cold chain assessment, PFSA, the procurement agency is expanding the regional hubs by renting and constructing four central and 17 regional hubs. These indicated that there is a need to procure additional five refrigerated trucks which will serve to strengthen the service given by the one existing refrigerated truck.
The indicator for this SDA is proportion of the 10,000 health facilities with functional refrigerators

Activities:

- Procure and supply of 4,000 refrigerators. The country has around 10,000 refrigerators functioning and around 10% of the refrigerators must be replaced per year and the calculation is to Procure 1000 Refrigerators per year for four consecutive years.

- Procure and supply spare-parts for 10,000 refrigerators in health facilities. EPI spare parts include consumables; each refrigerator needs a certain recommended amount of spare part per year. According to the available guidelines about cold chain the spare parts for the existing and functioning 10,000 Refrigerators is based on packs

and to sustain the functioning of refrigerators spare parts will be procured.

- Procurement of five refrigerated trucks to improve transportation services for vaccines including transportation of vaccines from airports. One vehicle will be used centrally to support the existing vehicle by transporting vaccines from airport to central hubs(Addis Ababa & Adama).The remaining four vehicles will be used to transport vaccines from four central stores to 17 hubs throughout the country.

SDA 3.2: Establishment and strengthening regional medical equipment maintenance workshops with special focus on the cold chain system

The medical equipment which is already functional faces various minor and major problems which need maintenance at local level. Improving the maintenance of equipment at regional and lower levels will help reach the HSDP IV target of improving the quality of medical services given to the community at all levels. Currently there is no such facility at regional level and this is aggravated by the absence of skilled man power to cover the maintenance needs. To address this skill gap the government is training biomedical technicians at Technical Vocational Training and Education Center (TVET) colleges and they will be deployed soon to work in these maintenance workshops.

This support is believed to contribute a great deal to the health system through increasing the performance of medical equipment and by decreasing equipment down time by strong maintenance support so that the potency of vaccine and other drugs will be maintained. The deployment of staff/biomedical technicians and the running cost for these new medical maintenance workshops will be covered by the government. In addition to these for other non medical equipments private maintenance workshops will be used and the cost will be covered by the government. There are many other options, including private maintenance workshops for most of the other non medical equipments. The indicator for this SDA is the number of functional medical equipment maintenance workshops

Activities:

- Construction of medical equipment maintenance workshop in 10 regions
- Procure and install necessary equipment for the 10 medical equipment maintenance workshops.

SDA 3.3: Supply PV solar for health centers

As various studies including Joint Review Missions have shown that the majority of the health centers have no direct source of power, service delivery is impaired and critical areas such as refrigerators for vaccine storage cannot function resulting in a serious compromise in quality of service provided.

Currently based on the information from the regional health bureaus, it is estimated that there are 928 health centres with no power supply. A plan of action is developed to equip these health facilities with alternative power supply which is PV solar. The FMOH is conducting a survey to identify the exact number of health facilities in the country with limited or no access to water and power supply. Based on the findings of this survey, the plan of action will be adjusted. GAVI HSS will support the procurement and installation of PV solar

panel for selected 300 health centers. The indicator for this SDA is proportion of the 300 health centers with PV solar panel installed

Activities:

- Procurement of PV solar panels for 300 health centers
- Installation of PV solar panels for 300 health centers

SDA 3.4: Training on management and preventive cold chain maintenance

A well functioning cold chain system is vital in order to provide safe and potent vaccines to children. The challenge for sustaining immunization activities lies in maintaining equipment at various levels. As cold chain handlers, who will be responsible for day to day component of preventive maintenance at PHC/district level, and also for the technician, who will be responsible for undertaking minor/major repairs, it is very essential to know the details related to breakdown of equipment, categorization of repairs as major and minor, concept of spare units to be redeployed to replace defective units.

As the same time it is the responsibility of the district EPI focal person, health worker and supervisor that equipments and machineries in the district run to their optimum. This requires their preventive maintenance knowledge and skill to properly execute their duties. In addition, procurement and distribution of 1790 motor bikes to the health extension program supervisors is part of the plan in order to assure timely supportive supervision of the health extension workers. The cost for the rest motor bikes will be covered by other partners and government will cover the running cost for the day to day activities of the trained peoples including salary.The indicator for this SDA is proportion of health workers trained on management and preventive cold chain maintenance.

Activities:

- The training will build the capacity of the health workers mainly EPI focal persons at Woreda level. EPI focal people and relevant health workers will be identified (4/woreda) and a total of 3484 people will be trained on the management and preventive cold chain maintenance. In-addition, 1738 HEW supervisors will be trained on Supported Supervision focused on cold chain management. This training will cover 2 supervisors per woreda.
- Procure and distribute 1790 motor bikes for health extension supervisors. This activity will enable the trained health professionals in reaching every facility in the district to provide timely support for the activities of health workers and health extension workers in the areas of cold chain management and other related activities. The need for additional motor bikes will be covered by other partners.

SECTION 3: FINANCIAL GAP ANALYSIS, WORKPLAN and BUDGET

3.1 Financial Gap Analysis

Please provide an updated financial gap analysis at the level of the health sector, with an estimation of current and expected domestic and external funding.

For requests to GAVI, applicants can use their own format, or alternatively, use Attachment 2. The financial gap analysis should be based on the Medium Term Expenditure Framework and refer to the health financing section in the National Health Strategic Plan.

For requests to the Global Fund, applicants must fill in Attachment 2. Describe how contributions from various sources of funds were estimated, and assumptions made, including reference to:

a. any changes in contributions anticipated over the period of support and the reason for any identified reductions over time; and
b. any current delays in accessing the funding that should be explained, including the reason for the delay, and plans to resolve the issue(s).

At an aggregate level, show how the current and forthcoming government budget and other funding sources, contribute to financing the national health strategy in the near term.

Guidelines and instructions on how to fill the financial gap analysis and the counterpart financing tables can be found in additional sheets in the budget template file.

3.2. Financial Gap Analysis at the level of the Health Systems Component[1]

In order to better understand the financial context of the request, applicants can optionally complete detailed financial gap analyses for requested HSS components (e.g. health information systems or human resources). This should be possible if a country has a specific strategy for a health systems component that includes financial estimates for strategy implementation. Instructions on how to fill the tables are included in the budget template.

3.3 Budget

Applicants are required to submit a budget that reflects the areas of the National Health Strategy for which funding is requested. As such, this budget should represent a part of the National Health Strategy budget. Applicants are given the choice to either submit their National Health Strategy budget by indicating the specific parts for which funding is requested, or submit the budget by filling in the template provided by GAVI and the Global Fund (Attachment 3).

Applicants who choose to submit their national budget and workplan need to ensure that it contains the relevant information as described in the guidance on the use of the GAVI and Global Fund budget template, which is available at:

- Detailed budget and work plan Guidance [link to Tool here]

Explain how the amounts requested were calculated. Explain links, as appropriate, to previous financial gap analyses and annual plans.

[1] For a definition of the health system components please refer to the document ''Guidance for Monitoring and Evaluation of National Health Strategies including HSS efforts'' (*to be found on xx*) as well as the annex ''HSS &CSS SDA annex.''

Note that GAVI and the Global Fund seek to ensure that any proposed financing of salaries, per diems, other compensation, volunteer stipends and top-ups is consistent with current HR compensation in the health sector, specifically national salary or interagency frameworks.[2] Please explain how compensation issues in the health sector have been analyzed and what steps have been taken to ensure Global Fund and GAVI supported salaries are consistent with national salary or interagency frameworks, and include relevant documentation.

3.4 Workplan

Please attach the current annual or biannual work plan of the areas of the National Health Strategy for which funding is requested. Countries can either submit their existing national work plans or use the Global Fund/GAVI budget template by providing further information on the timing of planned activities. If the annual budget breakdown is contained in a separate document from the operational plan, please submit the relevant documentation together with the operational plan. For requests to GAVI, in addition, please attach the latest approved cMYP, preferably costed, that covers the duration of the requested HSS support.

[2] If they are not consistent, this could lead to diversion of staff from existing programs to new programs financed by GAVI and/or the Global Fund, which is something the Global Fund and GAVI want to avoid. If some or all of your salary costs are not consistent with existing compensation policies, provide a solid justification for this. Relevant documentation must be attached, even if the documentation is only in draft form. If no such documentation is available, provide a clear description of current practices as well as efforts to elaborate and document in-country compensation policies.

Response:

The costing and budgeting of the GAVI funding request for the child health interventions is linked with the HSDP costing. Costing of HSDP IV was conducted by using the Marginal Budgeting for Bottlenecks (MBB) method, which is a result based planning and budgeting tool that utilizes knowledge about the impact of existing interventions on health in Ethiopia.

The costing framework for the implementation of HSDP IV is developed in two scenarios and provides a detailed costing analysis and results for both of them. Each scenario calls for a certain level of reinforcement of the cornerstones of the health system or the coverage determinants. Total budget for the five years is estimated at US$ 8.83 billion under the base-case scenario and US$ 10.828 billion for the best-case scenario.

Table. Total budget, projected commitment & funding gap for child Health programme areas in Million USD

Program in HSDP-IV (2010/11-2014/15)	Total budget estimate		Projected resources committed	Funding gap 2010/11-2014/15	
	Base-case Scenario	Best-case Scenario		Base-case Scenario	Best-case Scenario
Child Health	225.70	307.42	76.01	149.69	231.41
Total Health Budget	8,826.50	10,828.05		4,337.00	6,338.55

The Child Health Program has a resource commitment of USD 76.01 million from different partners, for activities which are not included in GAVI funding request for HSS both from the GOE and others for the coming 5 years. As we can see from the HSDP-IV Funding Gap analysis to achieve the MDG of child Health under base case scenario it requires USD 225.70 million and the resource gap based on the resource mapping conducted in 2010 is USD 149.69 million. This request for HSS funding tries to cover 10% of the HSDP IV budget gap for system strengthening and capacity building and almost 50% of HSDP IV resource gap for Child Health service by mobilizing a total of 75 million USD for four years of HSDP IV (2010/11-2014/15). The remaining funding gap after the approval of the GAVI funding request will be 74.49 USD Million.

Financial sustainability:

During the first three years of PASDEP, Ethiopia averaged a double digit economic growth of 11.8% per annum with steady and strong positive performance in real GDP. The government of Ethiopia has also committed itself to increase public health spending by 9% over the coming five years. Revenue retention at the hospital and health centres level is also showing proven efficacy. Among the hospitals and health centres where health care financing reform is introduced, 95% of them have retained and used the revenue collected at the facility level.

In the past two years the government has started to allocate budget specifically for immunization which were totally dependent on donor support in the previous years. Moreover, according to the cMYP, the contribution of the government for immunization specific financing is 12% and it has been increasing compared to the past years. These measures will go a long way to sustain the activities supported by GAVI and other development partners.

To meet the health financing needs of the country the FMOH has already introduced community based and social health insurance schemes. Parallel to the work on social health insurance, various activities have been undertaken to develop and pilot community-based health insurance (CBHI). The CBHI, which aims to cover more than 83.6% of the population, is being piloted in thirteen Woredas in four pilot regions (Tigray, Amhara, Oromia and SNNPR). To ensure the acceptability and sustainability of the CBHI, feasibility studies have been made in the four pilot regions and the reports of the studies have served as inputs to the design of the scheme. Preparations for the Woreda level piloting, including detailed implementation plans, have been finalised and the schemes are expected to provide services to their members by early 2011.The community based health insurance scheme and social health insurance are being rolled out throughout the country and are expected to enrol 50% of the population by 2015. Furthermore, innovative health care financing methods are being planned to be introduced to mobilize more financial resource for HSDP IV.

Below, budget summary is presented of the 3 objectives and 11 SDAs.

Obj. 1	Improve Immunization outcomes through community and facility based integrated child health services	Unit	Total quantity	Unit cost ($USD)	Total cost in $USD
SDA 1.1	**Integrated Refresher Training for Health Extension Workers**				
1.1.1	Training of Trainers for HEW IRT trainer health workers	No of trainees	347	277	95,842
1.1.2	Provide Integrated Refresher Training (IRT) for a total of 22,595 trainees (397 Woreda HEP focal persons, 5,418 supervisors and Health centre staff, and 16,780 HEWs)	No of trainees	22,603	277	6,258,815
1.1.3	Printing facilitators guideline	No of copies	40,000	1.96	78,400
1.14	Printing of Participants manual	No of copies	240,000	1.65	396,000
1.1.5	Printing of Family health	No of copies	20,000,000	0.23	4,600,000
1.1.6	printing of IRT implementation	No of copies	3,000	0.59	1,770
1.1.7	Printing of HEW hand book	No of copies	54,485	1.65	89,900
1.1.8	Printing of First Aid Materials	No of copies	15,000	15.96	239,400
SDA 1.2	**Equip newly constructed Health Centres**				
1	Equip newly constructed Health Centres as per the minimum standards of the Health system of Ethiopia to provide regular service so that to contribute to decrease the child health mortality	No of Health centers	250	34,000	8,500,000
SDA 1.3	**Implement electronic Medical Recording system in selected Hospitals**				

	Procurement and installation of the equipment and material for EMR (Electronic Medical Recording) system in selected primary/district hospitals in the country.	No of Hospitals	8	149,835	1,198,680
SDA 1.4	**Implement mHealth at community level**				
1	Procurement of smart phones for 15,000 health posts	Number of phones	15,000	117.96	1,769,400
2	Development of phone-based application software's	No of application soft ware	1	40,000	40,000
3	Development of server based application program/ platform for mHealth application	No of server based application soft ware	1	22,000	22,000
4	Training for 15,000 health extension workers	No of trainees	15,000	170	2,550,000
5	Development of web sites for information sharing and special support for HEWs	No of web sites	1	20,000	20,000
6	Maintenance and management cost of smart phones and the application/program soft ware	Average cost	1	14,671.33	14,671.33
SDA 1.5	**Procurement of essential drugs and supplies including for Integrated Community Childhood illnesses Management**				
1.5.1	Procurement of essential drugs and supplies for health posts	No of health posts	6,928	1,800	12,470,400
Obj. 2	**Improving access to primary health care services in selected low performing and hard to reach areas so as to improve immunization outcomes**	**Unit**	**Total quantity**	**Unit cost ($USD)**	**Total cost in $USD**
SDA 2.1	Implement strategy to respond to the needs of number of low performing and hard to reach areas through CSO participation.				
2.1.1	Review, approve and award a grant for CSOs who presented a proposal based on the TOR.	Total grant			7,520,000
SDA 2.1	Strengthening Health Forum to facilitate overall involvement and collaboration of CSOs working in the immunization and child health				
2.2.1	Strengthen the health forum to facilitate and effective collaboration between CSOs and public health sector	No of discussion forum	8	60,000	480,000
Obj. 3	**strengthen the capacity and management of cold chain systems at all levels**	**Unit**	**Total quantity**	**Unit cost ($USD)**	**Total cost in $USD**

SDA 3.1	**Strengthening the capacity of the cold chain system**				
3.1.1	Procure and supply refrigerators (1000)per year for 4 consecutive years)	Number	4,000	1,500	6,000,000
3.1.2	Procure and supply cold chain equipment and spare parts for refrigerators in health facilities	Packs	4	600,000	2,400,000
	Procurement of cold chain equipment-Cold rooms	Number	7	35,000	245,000
	Procurement of cold boxes for newly constructed health facilities	Number	1,600	800	1,280,000
3.1.3	Procurement of refrigerated trucks for transportation of vaccines from centre to regions	Number	5	240,000	1,200,000
SDA 3.2	**Establishing and strengthening regional medical equipment maintenance workshops with special focus on the cold chain system**				
3.2.1	Construction of ten medical maintenance workshop	Number of workshops	10	465,000	4,650,000
3.2.2	Equipping of the ten medical equipment maintenance workshop constructed	Number of workshops	10	231,500	2,315,000
SDA 3.3	**Supply PV solar for health centers**				
3.3.1	Procure and install PV solar panels for health centres	Number of HCs	300	20,600	6,180,000
SDA 3.4	**capacity building of health extension supervisors and Woreda EPI focal persons on management and preventive maintenance of cold chain**				
3.4.1	Training of health extension supervisors and Woreda health office EPI focal persons on management and preventive maintenance of cold chain	Number of trainees	5,222	87.72	458,070
3.4.2	Procurement of Motor-bikes to HEW supervisors	Number	1790	1,815	3,248,850
	Management of GAVI HSS grant				
	Management of GAVI HSS grant.		4	219,321.36	877,285.44
	Grand Total				**75,199,484**

SECTION 4: FINANCIAL MANAGEMENT ARRANGEMENTS

Outline the financing channel to be used and specific financial management arrangements. Use of existing country-level financial management arrangements is encouraged. Reference should be made to any relevant Financial Management Assessment (FMAs) and to relevant sections of the JANS report. Requested support should be ”on-budget’’.

Detail any relevant actions which will be taken to ensure that sufficient capacity exists for financial management, including financial risk management, of the requested funds.

Response:

In Ethiopia, financial management standards are set by the Federal Government despite a significant degree of autonomy held by Regional Government in most of the aspects of fiscal decentralization. The overall responsibility for the management of public funds including federal subsidies is the mandate of Ministry of Finance and Economic Development, (MoFED). Expenditure reporting from the Regional Governments is also made as per the formats and at times specified by MoFED.

The HSDP Harmonization Manual identifies three major ways through which funds flow to finance HSDP III. These are namely Channel 1a and 1b, Channel 2a and 2b, and Channel 3. Channel 1a and 1b entail financial resources pooled and managed by MoFED and earmarked by agencies respectively with direct disbursement; Channel 2a and 2b refers to donor held financing provided directly to sector units or decentralized regional offices; earmarked and un earmarked respectively; finally channel 3 refers to those directly donor programmed funds disbursed by Development Partners to finance specific contributions to HSDP usually through NGOs. The MDG Pooled Fund is Government’s preferred channel (2a) with seven Development Partners currently contributing towards it. However, a considerable amount of resources from donors such as the Global Fund are channeled through Channel 2. Channel 3 is the least preferred channel by Government as it is neither on budget nor on account.

GAVI HSS support will be channelled to the MDG PF, which is the GoE’s preferred modality for scaling up Development Partners assistance in support of HSDP. The MDG Fund is pooled funding mechanism managed by the FMOH using the Government of Ethiopia procedures.

According to the JFA all procurement using the MDG fund will follow the determining procedures of Public Procurement Agency, the Federal Public Procurement directives and the standard bidding documents issued by this organization (PPA). The FMoH is the budget holder for the MDG Fund and will delegate the procurement of goods to PFSA. The FMoH (Policy Planning and Finance General Directorate, the Human Resources Development Directorate and Health Facility Expansion and Rehabilitation Directorate) will be responsible for procurement of services, consultancies and works. PFSA may engage, based on their particular expertise or comparative advantage, a UN agency as a supplier or procurement agent. The UN Agency contracted by PFSA would undertake the procurement activities in accordance with the UN agency’s own procurement procedures. PFSA will select the agent

in accordance with its procurement manual.

There are 3 sections in the finance department, namely: disbursement and collection, financial records and procurement and property administration. The total number of staff in these teams is 46 and the department is being assisted by four local consultants financed by Health Pooled Fund. Periodic reports will be produced and annual financial and physical reports will be prepared by the Resource Mobilization and Project Coordination Directorate of FMOH including consolidated reports from other implementers of GAVI HSS funding. The accounting and reporting of transactions for this grant will therefore be in line with government's procedures.

The Federal Office of the Auditor General (FOAG) is the supreme auditing institution in Ethiopia, with responsibility for auditing all federal funds, including subventions to the regional states. It is directly accountable to the Council of the Peoples Representatives. On the other hand, the internal audit directorate at FMOH has recently embraced internationally accepted standards to re-orient the role of internal auditing around "*assurance and consultancy"*. In light of this, the directorate has placed a blue-print BPR in which the scope of internal audit is broadened to encompass both financial and performance audit roles. Despite a number of challenges to institutionalize, the directorate is working towards scaling up the internal auditing function to all levels. In addition, FMOH and Development Partners have also agreed to strengthen the Internal Audit Directorate through recruiting of more competent expertise to conduct both financial and performance audits.

In March 2011, a Financial Management Assessment (FMA) was put as a precondition by GAVI before joining the pooled fund arrangement. The FMA came up with strengths and weaknesses of the funding arrangement and the Ministry together with DPs has developed a plan of action on how to improve the identified weaknesses and how to sustain the achievements. The major focus on this plan of action is improving the procurement process in PFSA. Strengthening financial system through hiring more capable staff for accounting and programming is also planned as part of improving the management of MDG PF.

An Integrated Financial Management Information System (IFMIS) is currently under design through support from Development partners in order to significantly improve to the financial management, quality and speed of reporting for all stakeholders from all levels of the health system. The new system is expected facilitate the linkage of financial expenditure (performance) with physical implementation performance, thereby enhancing the efficiency and effectiveness of health programme management at all levels. The system, which will ultimately be automated as a web-based programme, will provide access to information on physical performance and financial expenditure status of health programmes up to the level of districts.

SECTION 5: IMPLEMENTATION ARRANGEMENTS

Briefly explain the implementation arrangements for the National Health Strategy, and how these arrangements will be used to implement this funding request and/or how implementer(s) will coordinate with existing arrangements.

If the application includes a request to the Global Fund, please describe the implementing institution(s) with responsibility for ensuring that the activities are successfully implemented and performance is monitored. Include for each implementer details of past experience, technical, managerial, procurement and/or financial arrangements and capacities, and any relevant actions that will be taken to ensure necessary capacity.

If there are multiple lead implementers (Principal Recipients in the Global Fund context[3] and Ministry of Health in the GAVI context), describe how co-ordination will occur between these lead implementers to ensure timely and transparent performance updates and disbursement requests, on separate and joint reporting.

For requests to the Global Fund, please provide the same information for sub-implementers with responsibility for implementing activities. In addition, describe how they were selected, and which activities they will conduct.

Response:

The Federal Ministry of Health has successfully been implementing a wide range of activities under the HSDP framework through support from a number of Development Partners. The implementation arrangement of this GAVI HSS grant will follow the same implementation arrangement which has been operational for projects and activities supported by a number of Development Partners including the Global Fund.

As most of the expenditure of this grant are related to health system building and procurement of equipments and commodities whose majority expenditure will be incurred at the federal level to attain economy of scale and facilitate effective and efficient international procurements. The procured items will be transferred to respective regions or woredas in kind. The majority of the procurement, distribution of the procured equipment, commodities and supplies will be lead, coordinated and monitored by Resource Mobilization and Project Coordination Directorate under the Policy, Planning and Finance General Directorate of FMOH as per the plan.

Infrastructure support related to renovation, upgrading, construction and equipping of health facilities will be lead, coordinated and monitored by Health Infrastructure Directorate of the Federal Ministry of Health Under the responsibility of Resource Mobilization and Project Coordination Directorate. Training of health workers related to child health services will also be implemented through the team responsible for child health programs under the Health Promotion and Disease prevention Directorates of FMOH. Interventions that involve distribution of infrastructure facilities and equipment as well as health workers training that will be undertaken at lower levels including Regional Health Bureaus and Woredas will be implemented in coordination with the respective Regional Health Bureau teams and the Woreda Health Office teams. The Resource Mobilization and Project Coordination

[3] For more details on the dual track financing policy of the Global Fund, refer to the section on CCM eligibility.

Directorate will be responsible to coordinate all the various stakeholders and implementers of the grant, for the implementation of activities as outline in the approved grant.

Once CSOs/NGOs have been identified as sub-recipients of this grant after passing through proposal review process, then an agreement (MoU) will be signed between the CSOs/NGOs and FMOH. The bilateral agreement will define clear roles and responsibilities of both parties in the grant implementation. A clear result framework will be developed and regular monitoring of the implementation of the project will be undertaken by Policy Planning Finance General Directorate of FMOH. FMOH will receive, interpret and analyze reports from implementing CSOs/NGOs and take actions as needed. FMOH will also compile reports from the CSOs/NGOs and submit to GAVI as per agreed time frame. The CSOs/NGOs will also be linked with the Regional health Bureaus of the regions in which their project are planned to be implemented. The role of the Regional Health Bureau in monitoring, follow up and support of project will be clearly stated in the MOUs to be signed.

SECTION 6: GOVERNANCE AND OVERSIGHT ARRANGEMENTS

Describe the body (CCM for Global Fund requests and/or the relevant Health Sector Co-ordinating Committee for GAVI requests) that will have the responsibility for oversight (including financial oversight) of Global Fund and/or GAVI supported activities.

If the funding request is to both Global Fund and GAVI, please outline how the Committee(s) will coordinate to perform this oversight function, including monitoring implementation and budgets. Also, describe how the Committee(s) will coordinate with other relevant stakeholders.

Response:

The framework for the dialogue, governance and decision-making of the MDG Fund is provided by the health sector coordination framework which consists of a two tier collaborative governance system made up of the Joint Consultative Forum (JCF) and the Joint Core Coordinating Committee (JCCC). The institutional arrangements for the MDG Fund will be fully integrated within overarching sector planning and coordination structures.

JCF: The Joint Consultative Forum (JCF) is the highest governing body and will serve as a joint forum for dialogue on sector policy and reform issues between GOE, DPs and other stakeholders; it will oversee the implementation of the IHP, allocation and utilization of MDG PF, PBS, GAVI and all other donor supported projects.

This highest body will ensure effective linkage between development partners, regional bureaus and other sectors and will be chaired by the Minister of Health and co-chaired by HPN co-chairs.

JCCC: The Joint Core Coordinating Committee (JCCC) will continue to be the technical arm of the JCF and also the Policy Plan and Finance General Directorate. The major functions of the JCCC will be to give operational oversight and monitor the implementation of all pooled funds including the Health Pooled Fund, GAVI, MDG PF, organize and coordinate the

monitoring, review and evaluation missions and meetings of HSDP and facilitate the implementation of the findings and recommendations of these meetings and missions. It will also undertake other technical assignments as instructed by JCF. In addition JCCC will analyze and agree to FMOH recommendations on allocation or reprogramming of funding. It also reviews quarterly financial and activity plans and reports of MDG PF and GAVI HSS.

It will be chaired by the Director General for Policy, Plan and Finance General Directorate and the members will be FMOH – PPF GD and other Directors as needed, and 6 individuals from HPN to include managing agent of TA pool fund plus one co-chair from HPN. Members are nominated by HPN and agreed by FMOH.

SECTION 7: MONITORING AND EVALUATION

Explain how impact and performance of the funded activities will be measured – what indicators will be collected and what data sources will be used. Please use the relevant sections of the national M&E plan, the national health strategy and/or the national health management information system (HMIS). If these are not available, please submit this information using the attached template (Attachment 4).

Describe how existing monitoring activities -- e.g. joint annual reviews, surveillance by the HMIS -- will be used to monitor the program.

List relevant actions that will be taken to ensure that the capacity exists to collect and analyse the necessary information. Any requested support should be included as part of a technical assistance plan, which should be attached to the funding request.

Please refer to the document ''Guidance for Monitoring and Evaluation of National Health Strategies including HSS efforts'' (*to be found on xx*) as well as the annex ''HSS &CSS SDA annex.''[4]

Response:

The monitoring and evaluation system of the health sector utilizes a set of combination of mechanisms which include routine administrative reporting, performance monitoring & reviews, supportive supervision, inspection and evaluation of programs.

Routine administrative report (HMIS) is done based on sector-wide indicators that have been jointly agreed and endorsed by the Government and Development Partners. There is an agreement that all stakeholders operating in the health sector should support and use the HMIS for programme monitoring. Health facilities and administrative units at all levels are making all the necessary efforts to put in place the necessary institutional mechanisms (HMIS technician, infrastructure etc) as per the standard indicated in the new design of HMIS. Data from client records will be collected from health facilities, aggregated and analysed for the facility's own evidence based corrective actions. Facilities will supply data to the relevant administrative levels through the routine reporting mechanism as per the HMIS reporting calendar, these data will be aggregated and analyzed by the next upper level of the system which could be the RHBs or FMOH that will use the relevant evidences for

[4] http://www.theglobalfund.org/en/documents/

appropriate informed decision making. Validation of the data received through the HMIS is done through performance monitoring, Reviews, Supportive Supervision (ISS), surveys and regular inspections.

The monitoring and evaluation mechanism for the GAVI HSS support is aligned with the jointly agreed up on 'One M & E Framework' in the health sector. Hence, monitoring will be done based on an agreed up on single result-based framework through the coordination of Policy, Planning and Finance General Directorate of the FMOH.

Most of the proposed program's indicators in this grant are taken from the National Health Sector Development Plan (2010/11-2014/15). The targets for many of the indicators are also aligned with the targets for the national Health Sector Development Program. The targets for objective one and two under this support are increasing Pentavalent immunization coverage (Penta 3) to 96% and reducing Penta vaccine dropout rate from 8% to 3% nationally and less than 10% in all districts by the end of 2015 and the target for objective three is to achieve Penta vaccine wastage rate of 5% in each year up to 2015. Therefore, the data collection, reporting time and channels will follow existing national arrangements and will be carried out by the existing structure and system, which is the HMIS.

There are three main outcome indicators for the three objectives in this GAVI HSS funding request:

1. Penta 3 coverage rate
2. Penta dropout rate between Penta 1 and Penta 3
3. Penta Vaccine wastage rate

The Resource Mobilization and Project Coordination Directorate of the FMOH will be responsible for providing GAVI with reporting relevant to the HSS grant. Quarterly activity and financial reports of the grant will be complied and presented to the JCCC for follow-up and annual HSS Grant performance report will be produced and communicated to GAVI annually. The HSS related interventions, activities and major achievements will be included in the annual performance report of the sector.

The regular reviews and evaluation undertaken by the FMOH or jointly with DPs such as the JRM and ARMs will be conducted in a manner that involves overall impact of programs implemented in the health sector including impact of GAVI HSS.

APPLICATION ANNEXES

LIST OF ATTACHMENTS (TEMPLATES)

The following should be submitted with the completed funding request template:

Document
Attachment 1: Logframe
Attachment 2: Financial Gap Analysis (Excel worksheet)
Attachment 3: Detailed Budget of Funding Request (Excel worksheet)
Attachment 4: Summary of Indicators
Attachment 5: Justification table
Attachment 6: Response to IRC comment on APR

LIST OF SUPPORTING DOCUMENTS

A number of supporting documents need to be annexed to this application (see the table below). Additional documents which applicants believe are essential for the review of the request should be included in this table (add rows as needed and clearly name and number annexes).

Description	Required	File Name	No
Report of the Joint Assessment of the national health strategy (including an assessment how feedback received during the JANS has been reflected in the final national health strategy) Report of the Joint Assessment of the national disease strategy if the country has also recently conducted a joint assessment of one of the national disease strategies	All applicants	**Ethiopia JANS Lessons_August 2010**	**1**
Final National Health Strategy		**Health Sector Development Program IV**	**2**
National M&E plan (if not already part of the national health strategy document)		**Part of the HSDP IV**	
Current annual operational plan and budget relevant to areas for which support is request		**N/A**	
Additional supporting documents: See below			
Integrated Refresher Training Plan for HEWs		**IRT_Documents**	**4**
Equipment list for Medical equipment maintenance workshops		**Equipments for workshop**	**6**
Technical Assistance plan and budget if being requested (if not included in the annual operational plan)		**N/A**	
For requests from GAVI: cMYP		**CMYP_Ethiopia**	**7**