

Global Vaccine Action Plan

Secretariat Annual Report 2016

Priority Country report on progress towards GVAP-RVAP goals

ETHIOPIA

A. Progress towards achievement of GVAP goals

1. Summary

This summary table describes the current situation in Ethiopia regarding achieving the GVAP goals. Data used to assess progress towards achievement of GVAP goals are included in the annex (Country immunization profile).

Area	Indicator	Ethiopia
9. NITAG	NITAG established?	Yes: in 2016 (no meeting has yet taken place)

2. Country ownership of the immunization program

2.1 Overview of country ownership in its primary health care system, including immunization

The Ethiopian government has made a significant commitment to increase access to primary health care services for its nearly 100 million people in the past 12 years or so, with the construction of more than 16,000 new health posts in order to bring health services to where people live. The health care delivery system now consists of a three-tiered Primary Health Care Unit in each of the country's 914 districts – each comprising a primary care hospital, health centers (serving 15,000 – 25,000 people) and five satellite health posts for each health center (serving 3,000 – 5,000 people) – all connected by a referral system. Approximately 90% of the population now lives within 10 kilometers of a health facility, even if rudimentary.¹ Concurrently, the Government has rapidly scaled up its workforce of health extension workers (HEWs) – created in 2004 as part of its Health Extension Program – to staff the new health posts, and created a Health Development Army of community-based volunteers to further increase population access to health care services (both are further described in Section 2.4 below).

¹ Ethiopia: summary on key barriers in EPI, June 2013.

Country ownership of the immunization program, including response to infectious disease outbreaks, such as measles, was described by one informant, as “strong, almost to a fault”. Plans for vaccination campaigns in response to outbreaks are not always shared with partners; the lack of a detailed proposal to GAVI for a measles campaign resulted in GAVI delaying its release of funds for this purpose. At the local level, with the devolution of power to the 11 regions and city administrations, ownership of the EPI is demonstrated by the fact that some regions and districts (*woredas*) are starting to allocate funds from their budgets for immunization operational costs.²

2.2 Immunization policy decision-making capacity

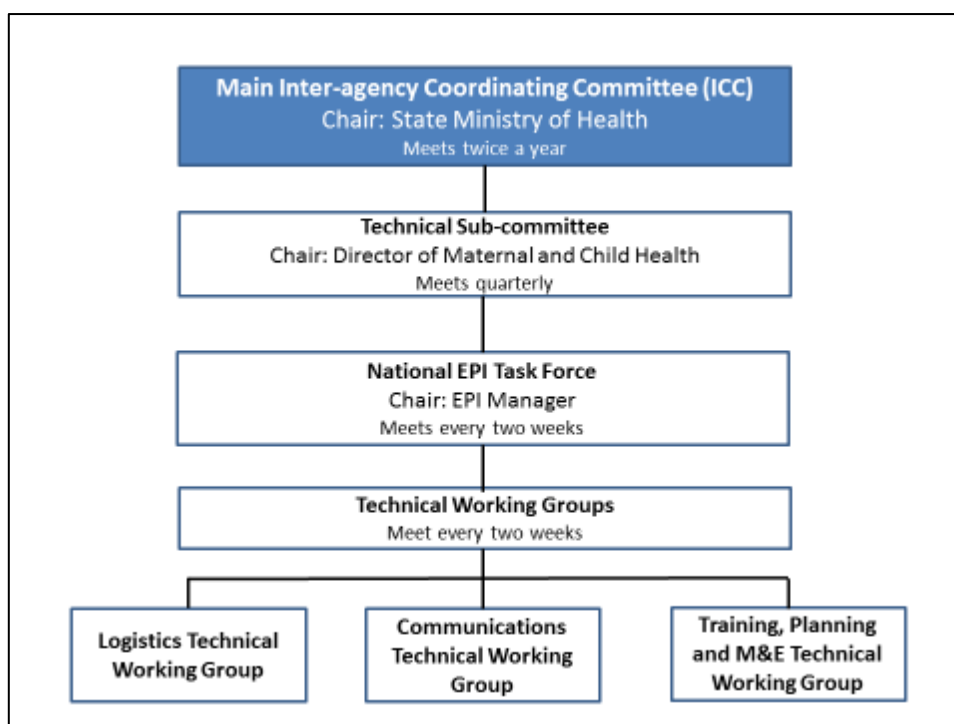
The ICC has been the principal group advising the Government on immunization and in assisting with resource mobilization and advocacy, as well as with the preparation of new vaccine introductions. The main ICC meets twice a year, is chaired by State Minister of Health and includes members from UN agencies, NGOs, Directorates of the Federal Ministry of Health and civil society organizations. The ICC also has a technical sub-committee that meets quarterly (see Figure 1). Under the technical sub-committee is a National EPI Task Force, which meets every two weeks, and along with technical working groups, is responsible for preparing and overseeing new vaccine introductions, vaccination campaigns, and improvements with the routine immunization program. In the absence of a NITAG, the ICC has made recommendations on the introduction of new vaccines.

A NITAG has only recently been established, with WHO and SIVAC assistance. Its first meeting had not yet taken place as of mid-July 2016. It took some time for government officials to understand the role and importance of having an advisory group independent of both the Government and development partners. The newly-formed NITAG consists of professionals with strong and diverse skills.

The FMOH has also established a Ministerial Delivery Unit to strengthen leadership in the immunization program and to make immunization a regular agenda item in key policymaker meetings.

Figure 1: The ICC structure in Ethiopia

² Ethiopia National Expanded Programme on Immunization. Comprehensive multi-year plan 2016-2020. Federal Ministry of Health, April 2015.



2.4 Human resource situation and its impact on EPI performance

Immunization services in Ethiopia are largely provided by Health Officers (nurses) working from health centers and by the large cadre of health extension workers (HEWs) operating from the 16,000 or so health posts built in the 2000s. The workforce of community-based HEWs, created to address Ethiopia's critical shortage of skilled health workers, numbered more than 35,000 by 2013. These female health workers are recruited from the communities in which they served, with the active participation of community leaders and members. They must have at least 10 years of schooling and are trained for one year at technical vocational education centers, including practical training at health centers. Two HEWs work at each health posts – splitting their time between the health post and nearby communities – and are responsible for providing a range of health services, from immunization and other MCH services, to the prevention and treatment of infectious diseases (e.g., TB, HIV/AIDS, malaria), first aid, sanitation and health education. They also work with community volunteers, village councils and local health offices and health centers.

According to several studies, these health workers have become the focal point in many communities for health and specifically for immunization.³ Through their work organizing immunization sessions, raising awareness about immunization, establishing partnerships with community leaders and volunteers, and default tracking, they are considered a key factor in the country's increase in immunization coverage since 2004, when DPT3 rates were 40% nationally. According to informants, the problems of high attrition rates and low morale among rural health workers that plague many countries are less prominent thus far among the HEWs. This is due to the fact that they come from the communities in which they serve

³ JSI. Africa Routine Immunization System Essentials (ARISE) project. A study of the drivers of routine immunization system performance in Ethiopia. August 2012; Workie NW and Ramana GNV. UNICO Studies Series 10: The Health Extension Program in Ethiopia. The World Bank, Washington, DC, January 2013.

and their government salaries (paid out of the MDG Development Fund) have increased over time and are considered quite competitive.

Assessments have found deficiencies in the skills and knowledge of this new workforce⁴ and consequently, they are currently receiving additional training and will continue to do through in-service training. There are also gaps in the supervision, monitoring and accountability of HEWs by district and health center officials. In addition, the HEWs sometimes have other responsibilities beyond health and in some cases are reportedly spending increasing amounts of time attending political meetings, taking time away from their service delivery duties.

Another key strategy of the Health Extension Program to improve access to health services was the development, beginning in 2010/11, of the Health Development Army (HDA), consisting of one community-based volunteer for every five households in a village, who together form health development teams. The purpose of the HDA is to improve the use of high-impact maternal, newborn and child health services by identifying cultural, behavioral and other bottlenecks preventing families from using these services, and to devise and execute strategies to overcome these bottlenecks. HDA members receive 7-10 days of training from HEWs and district health officials. To increase immunization coverage, these volunteers promote immunization among their assigned households, help organize outreach activities in their community, and assist with default tracking. According to the Government, there were three million HDA volunteers as of 2016.

EPI-specific staff in the Government consist of 7-8 people on the national EPI team, as well as immunization focal points in each of the country's 11 regions or city administrations, who deal exclusively with immunization. However, there are no longer EPI focal points devoted exclusively to immunization in most of the country's 103 zones and more than 900 districts, and those responsible for EPI at these levels have many other responsibilities. To fill in this critical gap, the partner-supported Routine Immunization Improvement Plan (RIIP) includes funding and support for EPI technical assistants in the 51 zones where the Plan is operating (see more information on the RIIP in Section B below).

B. Partner support to address remaining challenges to meet the GVAP goals and targets

The Ethiopian government has benefited from every type of GAVI support that the organization offers, including support for new vaccine introductions, immunization system strengthening (ISS), health system strengthening (HSS) and civil society organizations (CSO).

Technical and financial support from GAVI and many other partners has been critical in developing the country's disease surveillance system for polio, measles and other vaccine-preventable diseases, and in the implementation of numerous polio and measles SIAs, the national meningitis vaccination campaigns and TT campaigns in high-risk areas. Partners, including through the HSS grant, also provide critical aid to the routine immunization program, by supporting refresher training of HEWs; equipping newly constructed health centers; procuring essential drugs and supplies for health posts; and assisting with

⁴ UNICO Studies Series 10: The Health Extension Program in Ethiopia. The World Bank, Washington, DC, January 2013.

microplanning and data quality improvements. GAVI's CSO grant has supported local organizations to improve immunization services in hard-to-reach and low-coverage areas, especially pastoralist areas.

Two partner-supported activities to highlight that are aimed at resolving key bottlenecks and challenges to the country further strengthening and expanding its immunization program are the following:

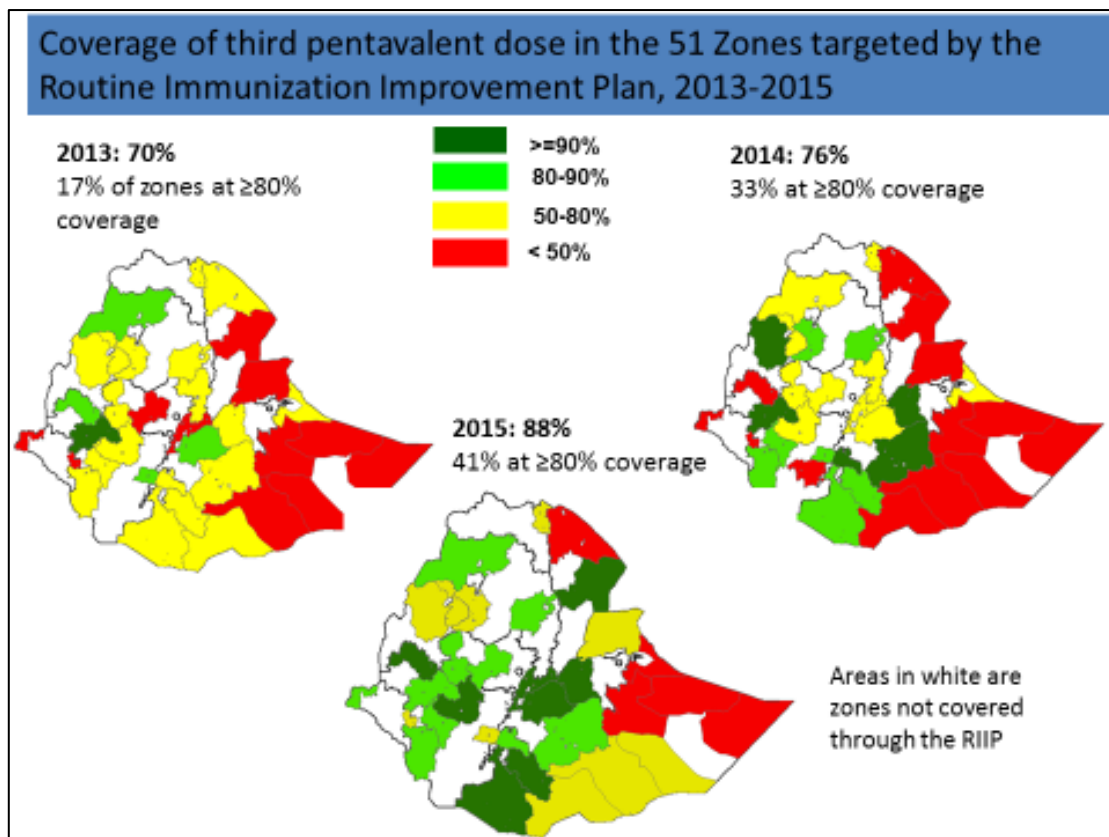
The Cold Chain Rehabilitation and Expansion Plan (2014-18)

This plan, supported by the GAVI HSS grant and many partners, will enable the country to introduce HPV, MR and other new vaccines without compromising the cold chain system. It should also help increase the availability of daily EPI services at health facilities, including health posts, by equipping them with cold chain equipment and by improving the local distribution of vaccines. The plan involves the transition of the vaccine supply chain system from the FMOH to the PFSA and includes constructing cold rooms at the airport in Addis Ababa; procuring 20 refrigerator trucks and thousands of vaccine carriers and cold boxes; establishing a network for 17 regional storage and distribution hubs; establishing a continuous temperature monitoring system at all vaccine storage sites; and providing refrigerators and other cold chain equipment to all health facilities, including health posts, with a focus on solar-powered equipment. Four regional hubs have already been established, manned by several newly-created and trained Technical Assistants responsible for cold chain maintenance and vaccine management. While the regional hubs are currently delivering vaccines and supplies to the zonal and district-level stores, during the last phase of the transition plan, these hubs will make monthly deliveries directly to health facilities, eliminating the need for the zonal and regional stores or for health facilities to pick up vaccines. The delivery of vaccines to health facilities, coupled with the acquisition of refrigerators in all facilities, will enable health centers and posts to comply with the government policy of providing immunization services on a daily basis, and should therefore have an important impact on immunization coverage.

The Routine Immunization Improvement Plan (RIIP)

This plan, started in 2014 to increase immunization coverage in the country's 51 poorest-performing zones, is heavily supported by multiple partners, including UNICEF, WHO, CDC and USAID's Last 10 Kilometers (L10K) project. A key component of the plan involves the recruitment, training and placement of 51 EPI Technical Assistants (one per zone) whose salaries and other costs are supported by the various partners. These EPI Technical Assistants help zones and districts with immunization-related trainings, microplanning, social mobilization, and monitoring and reporting. Coverage data collected by the project shows a marked improvement in the overall coverage of three pentavalent doses in the 51 zones and in the percent of zones achieving coverage of $\geq 80\%$ (from 17% in 2013 to 41% in 2015) (Figure 2). However, partner funding for the RIIP is only assured for 2.5 years, after which time the Government will need to assume the costs of the Technical Assistants and associated operational costs or mobilize new resources.

Figure 2: Coverage data for three doses of pentavalent vaccine in the 51 target zones of the partner-supported Routine Immunization Improvement Plan (project data)



Many partners are providing assistance to the immunization program in Ethiopia, often in specific parts of the country. It has been suggested that a mapping of partner activities be undertaken to allow better coordination and planning by the Government, avoid duplication and identify current gaps in support.

ANNEXES

- Planning and management:
 - Stockouts : No stockouts reported in 2015 (as reported in JRF 2015)
 - cMYP: 2011-2015
 - Annual Action Plan: Yes
- Country decision making: NITAG established in 2015.