GAVI ALLIANCE

EVALUATION OF GAVI SUPPORT TO CIVIL SOCIETY ORGANISATIONS

17 January 2012

COUNTRY EVALUATION REPORT - ETHIOPIA

Prepared by:

Cambridge Economic Policy Associates LLP

CEPA

CONTENTS

ACRONYMS AND ABBREVIATIONS

Acronym	Full description
APDA	Afar Pastoralist Development Association
APR	Annual Progress Report
CBO	Community Based Organisation
CCRDA	Consortium of Christian Relief Development Associations
CEPA	Cambridge Economic Policy Associates
CJSC	Central Joint Steering Committee
CORHA	Consortium of Reproductive Health Associations
CSO	Civil Society Organisation
DFID	Department for International Development
EC	European Commission
EECMY	Ethiopian Evangelical Church Mekane Yessus
EMA	Ethiopian Medical Association
EOC	Ethiopian Orthodox Church
EPI	Expanded Programme on Immunisation
FBO	Faith Based Organisation
FMA	Financial Management Assessment
GAVI	GAVI Alliance
GDP	Gross Domestic Product
GHP	Global Health Partnership
HEW	Health Extension Worker
HDI	Human Development Index
HSCC	Health Sector Coordination Committee
HSDP	Health Sector Development Programme
HSEP	Health Sector Extension Programme
HSFP	Health Systems Funding Platform
HSS	Health Systems Strengthening
HW	Health Worker
ICC	Inter-agency Coordination Committee
IIP	Immunisation in Practice
INS	Injection Safety Support
ISS	Immunisation Services Support
JCCC	Joint Core Coordinating Committee
JCF	Joint Consultative Forum

Acronym	Full description
JICA	Japan International Cooperation Agency
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MLM	Mid-level Manager
MoH	Ministry of Health
MoU	Memorandum of Understanding
NGO	Non Governmental Organisation
NVS	New and Underused Vaccines Support
ODA	Oromia Development Association
RHB	Regional Health Bureau
SC/US	Save the Children US
SIDA	Swedish International Development Cooperation Agency
TAP	Transparency & Accountability Policy
UN	United Nations
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

Ethiopia is a low income country with an under-resourced health system. Civil Society Organisations (CSOs) are recognised as important stakeholders in the health system, although they do not partake in the actual service delivery of immunisations per se (which is almost exclusively through the public health system, except in a few hard-to-reach areas[1]). CSOs typically provide complementary services to support the government's Expanded Programme on Immunisation (EPI), including training health workers, community mobilisation, technical assistance, etc.

GAVI approved both CSO Type A and B support for Ethiopia, in April and November 2008, respectively. Type A funding of $100,000 has been disbursed, primarily to support a mapping exercise of CSOs working in immunisation/ health. Of the $3,320,000 Type B support approved, $1,983,500 has been disbursed to date. This supports a range of activities undertaken through five main CSOs[2], such as training Health Extension Workers (HEWs) and EPI managers, community mobilisation and advocacy events, and the procurement of equipment and supplies to support routine immunisation activities.

While Type A and B support are generally regarded as relevant and important for Ethiopia to meet the targets of the current Health Sector Development Programme (HSDP), some stakeholders commented that EPI in Ethiopia faces a number of pressing issues (in particular, related to the introduction of pneumococcal and rotavirus vaccines) that should be prioritised by GAVI over providing additional funding to CSOs.

CSO support in Ethiopia has faced a few challenges – primary amongst these being the initial delay in the approval of funding by GAVI which resulted in higher costs for CSOs due to inflation and the withholding of the second tranche of funds due to the GAVI Transparency & Accountability Policy (TAP) / Financial Management Assessment (FMA) requirements. This has caused considerable disruption to the CSO activities, and in fact diminished some of the value add of the support, in terms of hampering relations between the CSOs and government due to delays in implementation. In addition, the overall size of funding has been viewed as too small in relation to the cost of activities (Type A) and need (Type B), and there has also been a lack of clarity on the programme objectives in the country.

At the same time, some aspects of the support have worked well in Ethiopia – namely, proposal development and channelling of funding through the government. It is instructive to note that stakeholders in Ethiopia did not view the channelling of funds through government as problematic and the majority of consultees suggested that this is the preferred method. There was limited enthusiasm for routing funds through in-country bilateral donors and even lesser enthusiasm for routing funds through an international CSO with a local network. However, routing funds through an existing national umbrella CSO organisation was viewed relatively positively – and has in fact worked well in Ethiopia's case, where the umbrella organisation is one of the recipients for the support who provide funding for seven further sub-recipient CSOs.

[1] We also note that some private and mission facilities deliver immunisations in some urban areas.

[2] One of the CSOs sub-contracted a further seven CSOs to implement the agreed activities.

In terms of results, Type A support has not reported any discernible results so far.[3] However, considerable progress has been made on the achievement of Type B outputs – although these are at risk given the delay in disbursement of the second tranche of funds, as noted above. Some of the outputs to date include: training the majority of the proposed HEWs and EPI mid-level managers; provision of health facilities with the proposed equipment and supplies[4]; and carrying out of a number of the proposed community mobilisation workshops and events.

[3] The mapping exercise has not been completed and no additional CSOs appear to have been nominated to the coordination committees as a result of Type A funding.

[4] Such as motorbikes and kerosene.

1. INTRODUCTION

This report provides an evaluation of GAVI CSO support in Ethiopia and forms a part of CEPA's overall GAVI CSO evaluation report. The report has been prepared by CEPA, with input from our country-level partners – Dr. Yayehyirad Kitaw and Prof. Shibru Tedla.[5]

1.1. Objectives of the country study

Ethiopia is one of five country studies undertaken under this evaluation.[6] The specific objectives of the country study are as follows:

- to understand the relevance of GAVI CSO support in the country, including the alignment of country funded programmes with broader immunisation/ health sector plans and priorities, as well as the suitability of various aspects of the programme design;
- to document the country's experience in implementing the programme, including identifying factors that have promoted or impeded effectiveness;
- to collate information on the results achieved through the funding to date; and
- solicit feedback on the suggestions for improving the effectiveness of the programme going forward.

The country study forms an important source of evidence for our evaluation of the policy rationale and programme design, implementation, and results of GAVI CSO support.

1.2. Methodology

The country study draws on information from: (i) country-level documentation; and (ii) interviews with local stakeholders during a visit to Ethiopia during 3-7 October 2011.

1.3. Structure of the report

The report is structured as follows: Section 2 provides the country context and overview of GAVI support in Ethiopia. Sections 3, 4, and 5 respectively present an evaluation of the policy rationale and programme design, implementation, and results of GAVI CSO support in Ethiopia. Section 6 provides some recommendations on improving GAVI CSO support, based on country-specific experience and feedback.

This 14 page country report is supported by annexes on: bibliography (Annex 1); list of consultations (Annex 2); background statistics on the country health sector (Annex 3); summary results through Type B funding (Annex 4); and factors impacting effectiveness (Annex 5).

[5] Dr. Yayehyirad Kitaw and Prof. Shibru Tedla were employed through ECO-Consult Ltd for the purposes of this consultancy.

[6] The other country studies are on DR Congo, Indonesia, Afghanistan and Pakistan. The CEPA team is visiting the former two countries, and local partners have been appointed for the latter two countries.

2. COUNTRY CONTEXT AND GAVI SUPPORT

2.1. Brief background on Ethiopia

Ethiopia is one of Africa's poorest countries yet is relatively stable, despite facing political upheaval with elections, issues related to opposition movements in country[7], and conflicts with neighbouring countries (the Ethio-Eritrean War, Somalia).

In 1995, Ethiopia introduced a federal structure comprised of nine semi-autonomous administrative regions[8] and two urban city administrations.[9] The majority of its population is rural (82%[10]) and two main religions dominate – Ethiopian Orthodox Christian (43.5%) and Muslim (33.9%)[11]. Table 2.1 provides some key statistics on Ethiopia.

Table 2.1: Ethiopia – key statistics[12]

Indicator	Value (year)
Population size	82,949,541 (2010)
GDP per capita (current US$)	$358 (2010)
Human Development Index (HDI)	Ranked 157 (2010)

2.2. Health and immunisation sector

The fourth successive HSDP (HSDP IV) targets life expectancy, infant and maternal mortality, immunisation coverage, contraceptive usage, population growth rate, and primary health care service coverage. The government has also recently embarked on an extensive effort to improve health extension across the country (Health Sector Extension Programme (HSEP).

Government health expenditure as a proportion of its total budget has remained fairly constant since 1995, at around 10%. However, government health expenditure as a percentage of total health expenditure has declined dramatically, while external resources for health as a percentage of total health expenditure have grown dramatically from approximately 10% in 1995 to 40% 2009.[13] [14] [15]

As indicated in Figure 2.1, there have been some improvements in the DTP3 coverage rate – however, there is considerable variation across Ethiopia, with immunisation coverage in the

[7] Oromo Liberation Front, Ogaden National Liberation Front.

[8] These include 'emerging regions' – Afar, Benishangul-Gumuz, Gambella and Somali. These are frontier areas, mostly arid lands with pastoralists and/or shifting agriculture and very low development status, even by Ethiopian standards.

[9] The country is further divided into 756 *woredas* (equivalent to districts) and 20,000 *kebeles* (lowest administrative level).

[10] Data from: http://data.worldbank.org/country/ethiopia

[11] Data from: http://www.state.gov/r/pa/ei/bgn/2859.htm

[12] Data from: http://data.worldbank.org/country/ethiopia and http://hdrstats.undp.org/en/countries/ETH

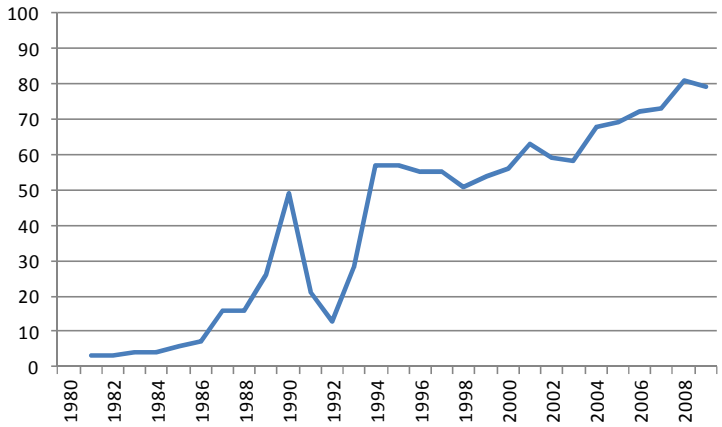
[13] This period of growth mainly occurred during 2002-2004.

[14] Ethiopia has received external resources for health from no less than 10 multilateral sources, more than 22 bilateral sources, and more than 50 international NGOs. The largest donors to the Ethiopian health sector are GAVI, Global Fund and PEPFAR (USAID). Other active donors include: DFID, EC, Irish Aid, Italian cooperation, JICA, Netherlands, SIDA, UNFPA, UNICEF, World Bank and WHO (Source: Alemu (2009), Case Study on Aid Effectiveness in Ethiopia, Wolfensohn Centre for Development at Brookings, Working Paper 9).

[15] http://databank.worldbank.org

emerging regions of Afar, Somali, Benishangul-Gumuz and Gambella, as well as other regions such as Amhara and SNNPR, being relatively low (see Annex 3). Under 5 mortality rate has steadily decreased from 220 per 1,000 in 1980 to 106 in 2010.[16]

Figure 2.1: Percentage of children aged 12-23 months immunised with DTP3 in Ethiopia (1980-2008)[17]



There are a number of coordinating mechanisms in the health sector. The Central Joint Steering Committee (CJSC) is the main coordinating body which gives guidance to the HSDP. The Joint Core Coordinating Committee (JCCC) acts as the technical arm of the CJSC and comprises of the government, the UN, development partners and donors. In addition, there are two ICCs - one central and the other technical - which oversee immunisation activities. CSOs are represented on the ICC and are invited to join the JCCC when appropriate.

2.3. CSO context and role in immunisation

There are a large number of CSOs in Ethiopia, focusing on poverty reduction and development, as well as specific aspects of health.[18] Most CSOs support the immunisation sector as part of their broader work on maternal and child health, rather than specifically focusing on immunisation.[19] Their role is complementary to that of the government, and includes training health workers, community mobilisation, technical assistance, etc. CSOs are not directly involved in the delivery of immunisation, 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.[20]

[16] http://databank.worldbank.org

[17] Data from http://databank.worldbank.org/

[18] In Ethiopia, it is generally agreed that CSOs comprise the following types of organisations: (i) Community Based Organisations (CBOs) i.e. organisations created by representatives of the community; (ii) Faith Based Organisations (FBOs) – who are particularly relevant in Ethiopia, given its large Christian Orthodox and Islamic population; and (iii) Non Governmental Organisations (NGOs) – including both international and national organisations.

[19] There are currently estimated to be between 1000 and 3000 CSOs in Ethiopia, of which around 300 are thought to be involved in health, and less than 300 specifically involved in immunization activities.

[20] Of 6.2m visits to health facilities in 2000, 46% were to government facilities, 15% to private facilities, 16% to pharmacies, 12% to individual health personnel, and 3% to NGO facilities (Source: MOH Health Care Finance Strategy (2003)). Although dated, the situation has not changed and provides an indication of the limited role of NGOs in direct health service delivery. We note that some private and mission facilities deliver immunisations in some urban areas.

Important context on the relationship between CSOs and government is the CSO Law (2009), which sets out a number of regulations on the operations of CSOs in the country.[21] Many view the law as useful and timely, given the rise of a number of CSOs and the need for better regulation, but the law also created a degree of conflict between CSOs and the government. One of the primary reasons for this is the tenet that requires CSOs that are involved in advocacy to raise at least 90% of their resources domestically. Feedback suggests that the intended objective of the law was to limit internationally funded political advocacy, but it created problems for CSOs that derive most of their funding from international sources.[22] There was mixed opinion on whether this tenet has impacted CSOs advocating for health, however, our general sense is that this has had a limited effect on health-focused CSOs.[23]

2.4. Overview of CSO and other GAVI support in Ethiopia

GAVI has approved both CSO Type A and B support for Ethiopia, in April and November 2008, respectively. Table 2.2 below provides information on the timing and amount of approval and disbursement of funds for both types of support.

Table 2.2: Summary of Type A and B support

Type of support	Type A	Type B
Date of proposal submission	5th March 2008	5th March 2008
Date of approval	15th April 2008	25th November 2008
Date of disbursement	30th July 2008	29th January 2009[24]
Total funds approved	$100,000	$3,320,000
Amount disbursed (as on July 2011)	$100,000	$1,983,500[25]
Channelling of funds	Govt.-MoH	MDG Pool Fund[26]

Source: Finance Data, July 2011, GAVI

Ethiopia has also received support from GAVI for NVS ($142,098,400 from 2007 for pentavalent vaccine and $37,449,439 from 2011 for pneumococcal vaccine), HSS ($76,493,935 in 2007 and 2009), ISS ($17,813,320 from 2002 to 2008) and INS ($2,696,697 from 2002 to 2004).

[21] Proclamation No. 621/2009 enacted by the Federal Democratic Republic of Ethiopia on the 13th February 2009.

[22] Activities include: advancing human and democratic rights; promoting gender and religious equality as well as human rights for children and the disabled; promoting conflict resolution or reconciliation; and promoting efficiency of the justice and law enforcement services.

[23] Another government mandate is that CSOs need to spend 70% of their resources on direct beneficiary-related activities and 30% on management costs. We understand that this mandate seeks to prevent misuse of money and to encourage spending on actual activities.

[24] The 2009 and 2010 APRs note that funds for Type B CSO support were not received until March 2009.

[25] APR submitted for January 2010 for a second tranche release is pending subject to audit report submission

[26] Held by the MoH in the National Bank of Ethiopia.

3. EVALUATION OF POLICY RATIONALE AND PROGRAMME DESIGN

3.1. Relevance of GAVI CSO support in Ethiopia

Relevance of supporting CSOs in Ethiopia

Overall feedback suggests that GAVI CSO support is regarded as important, and useful in meeting the health and immunisation sector goals in the country. As noted above, although CSOs' role is not in service delivery (except in a few hard-to-reach areas), they complement the public delivery systems by providing health worker training and technical assistance, mobilising communities, etc. Country stakeholders note that the HSDP IV is an ambitious plan, and the contributory role of CSOs is vital to achieve its targets.

However, some stakeholders (including government and locally-based donors) commented that the EPI in Ethiopia faces a number of pressing issues that need to be prioritised by GAVI, rather than GAVI providing additional funding for CSOs. For example, given Ethiopia is planning to introduce pneumococcal and rotavirus vaccines, the main funding priority should be on improving country readiness and strengthening its immunisation systems.

Relevance of Type A and B support

Both the Type A mapping exercise and the Type B supported activities are viewed as important in Ethiopia. However, Type A nomination of CSOs to the country planning bodies is not viewed as particularly relevant:

- The government wish to undertake the Type A supported mapping exercise of CSOs to more effectively coordinate and work closely with them to achieve their HSDP targets (although note that the mapping exercise is still not complete). The demand for this support is evident in that there have been previous attempts to map CSOs, however, these are not considered comprehensive enough.[27]
- Feedback suggests that there was not much enthusiasm for the Type A CSO nomination support, given that CCRDA already represented CSOs on the ICC. In addition, the utility of representation was questioned as the ICCs are not viewed as very effective bodies (although the technical ICC is thought to operate more efficiently and meet more regularly than the main ICC).
- Type B support is viewed as relevant, given the important complementary role of CSOs in the country's immunisation sector.

Alignment of Type B activities funded with health/ immunisation plans

The Type B funded programme activities are viewed 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 a far-reaching health extension programme, 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

[27] Documented in country APRs as well as indicated during meetings in country.

Ethiopia. Other activities include advocacy and community mobilisation events as well as the provision of per diems to HEWs that travel to remote areas. Some of the funding was also used to purchase and maintain motorcycles and kerosene for refrigerators in support of EPI outreach activities – identified as key gaps at the local level.

3.2. Programme design

A key issue for the evaluation is the assessment of the suitability of GAVI's approach of channelling funds for the CSO programme through country governments. Stakeholder feedback in Ethiopia suggests that this has worked well, as there is a good relationship between government and the Type B implementing CSOs. In addition, this approach has ensured greater accountability of CSOs and their coordination with the government.

While the government has been working with CSOs in health for many years, it has not previously funded CSOs from its own budget. Some are of the view that GAVI CSO support, where funds are routed via government, is a step in the right direction in encouraging closer cooperation between the government and CSOs. In Ethiopia's recent GAVI HSS proposal, a proportion of funds have been allocated to CSOs.[28] However, we understand that this was conveyed as a requirement by GAVI rather than being included at the behest of the government. There is no clear indication therefore that Type B funding through governments will encourage funding of CSOs by governments in the future.

Some of the Type B CSO-recipients expressed a preference for direct funding from GAVI, however, in their view, this was less of an issue than the disbursement delays (see below).

That said, stakeholders noted that this approach was a first in Ethiopia, and the government had to develop appropriate systems for selecting, funding and monitoring CSOs. It was noted that many other development agencies (including USAID, SIDA, Irish Aid – see box below) support CSOs directly, although the government is informed of the funding. This 'direct' approach was perceived to be quicker and more responsive to change.

Case study: Irish Aid[29]

In Ethiopia, Irish Aid has supported CSOs in a number of health related projects, in areas such as HIV/AIDS and food security. They have provided funding to CSOs via two channels: (i) direct funding to CSOs; and (ii) funding through Management Agents (MAs). The government is aware of the activities that CSOs receive funding for and the CSOs are expected to align their work closely with that of the government.

On the second approach, Irish Aid has contracted MAs (being international organisations at present only), who are selected through a competitive tender process to sub-contract other CSOs to implement the activities. The MAs are responsible for the funding, contracting and monitoring requirements of the implementing CSOs; and Irish Aid representatives conduct some field visits for review.

Our consultation with Irish Aid representatives suggests that both models work well – direct funding helps develop close relationships and monitoring; while funding through MAs enables a more 'hands-off' approach.

Other aspects of programme design that have worked well include the GAVI proposal and APR formats, which are seen as acceptable and not dissimilar to other donor requirements.

[28] We understand this was increased to around 7% of the total proposal value subsequent to discussions with GAVI.

[29] Please note that this case study is based on our in-country interviews only.

On the other hand, a number of design issues were highlighted in our consultations, including:

- *Lack of clarity on programme objectives.* The objectives of Type A and B support are viewed as too broad. It was suggested that GAVI needs to be more prescriptive, in terms of the activities and types of CSOs to be supported to reach the defined objectives. The programme is perceived to be more focussed on countries where CSOs are involved in service delivery, rather than where they play a complementary role, as in Ethiopia. Accordingly, it is not clear if an increase in immunisation coverage should be the overall objective of the support – in Ethiopia, given the CSO role, they could only ever meet this objective indirectly.

- *Limited coordination with decentralised structures.* Ethiopia has a federal system with nine semi-autonomous administrative regions where the Regional Health Bureaus (RHBs) play a large role in planning health sector activities at the local level. However, GAVI's interaction is with the federal government, which may not allow the regions to plan effectively and make the best use of GAVI support.

- *Lack of clarity of M&E roles.* There is a lack of clarity on stakeholder roles, particularly in the monitoring and supervision of CSO activities. GAVI Partners would like a clear memorandum of understanding describing their role in M&E, if this is expected of them by GAVI (given they are required to sign off the APRs). It was suggested that the country coordination bodies should assume oversight, as a more 'neutral' body as compared to the government.

- *Small size of funding.* The size of funding for Type A and B support is viewed as too low. In the case of Type A funding, this was cited as a key reason for not being able to conduct the mapping exercise to date.[30] For Type B funding, many CSOs noted that the GAVI funding was very small in relation to other donor funding, with little or no provision for administrative and management costs.[31] Hence a primary objective for their participation in the GAVI programme was to build global partnerships, and not necessarily for the funds per se (given their small size).

A more general issue highlighted vis-à-vis GAVI's reporting requirements, is the requirement for one report to be submitted across all programmes. It was noted that this causes issues for countries, as ISS funding to Ethiopia was delayed due to slower reporting back on progress against the CSO support.

[30] Ethiopia has not been able to find a suitable consultant for the available funds, especially given its geography. See Section 4.2.1 for more details on the mapping exercise.

[31] One CSO noted one of their donors required timesheets for administrative time spent on its programme and would not pay for any time spent on GAVI programmes.

4. EVALUATION OF PROGRAMME IMPLEMENTATION

4.1. Role of GAVI institutions

4.1.1. GAVI Secretariat

The Secretariat's role in support of the programme is viewed differently across stakeholders:

- Government reported that the Secretariat provides timely and appropriate guidance in relation to the CSO programme. It was noted that the GAVI workshop at programme inception raised awareness and encouraged the government to adopt a fairer and more transparent selection process of CSOs for Type B support.
- While the selected Type B CSOs have not interacted with the GAVI Secretariat directly, they do not view this as problematic as the Government provides them with the required information. However, some CSOs indicated that they would prefer some interaction with the Secretariat so that they can better understand the context of, and more details on, the support, as well as to communicate with GAVI on any issue.

A key issue raised, however, was the delay in GAVI's approval and disbursement of the second tranche of funding for Type B (due to the ongoing/ recently completed TAP / FMA checks).[32] This has caused considerable disruption to the implementation of Type B support resulting in increased frustration among the CSOs.

- Initially, there was a delay of almost a year in the approval of the country proposal which implied that CSOs could not start their activities as planned. This resulted in higher costs due to inflation.
- Secondly, there was a delay in the disbursement of the second tranche of funding from GAVI which has meant that CSO activities have either stopped or are being funded temporarily from other sources (with the expectation that the GAVI disbursement will come through). This has resulted in additional (inflation-related) costs as well as staff leaving due to job insecurity arising from the uncertain timing of funding.
- In addition, an unintended consequence of the programme was that the delays in funding resulted in weakened relationships between the CSOs and regional and district (woreda) governments, as they have been unable to deliver services/ equipment as agreed.[33] This has been highlighted by a number of CSOs as an important issue.
- Funding delays have also resulted in a change in the indicators for CSO activities, and in some cases, a change in the activities. Where CSOs have proposed changes to their implementation plan, these have been forwarded to the government and JCCC for re-approval. The substantial time taken to re-approve proposals has caused further delays.

[32] At the time of the country visit, we understand that the second tranche of funding has not been disbursed.

[33] In particular, CSOs were not able to hand over motorcycles to health facilities as planned as the programme did not finish as expected.

4.1.2. GAVI Partners

The government views GAVI Partners - WHO and UNICEF - as important contributors to the CSO programme through their role in the country-level planning mechanisms (ICC and JCCC etc.). We understand that UNICEF has been involved in the selection of CSOs under Type B support, through its participation in the JCCC.

However, GAVI Partners have not been much involved in the implementation of the CSO programme. GAVI Partners state that this is partly because the government and the CSOs are not obliged to ask for their assistance, and also because there is a lack of clarity in their role. It was suggested that there needs to be a more 'concrete agreement' in place, defining the respective roles of the stakeholders. Given limited involvement in implementation, GAVI Partners view their requirement as a signatory to the APRs as superfluous.

4.1.3. Functioning of the GAVI model

GAVI's delivery model, with the Secretariat based in Geneva and an absence of country presence, was viewed differently among stakeholders. While the government view GAVI's 'hands-off' approach as favourable as it encourages country ownership, they require GAVI's guidance to ensure that the roles of all parties are well understood. GAVI Partners and other donors stated that GAVI would benefit from some form of country presence to ensure that activities were monitored and supervised effectively.

4.2. Country implementation

4.2.1. Type A support

Ethiopia has not completed the mapping exercise to date. Despite three separate advertisements for consultants to conduct the exercise, the MoH has not been able to select a consultant with suitable experience and within the allocated budget. In addition, some suggested that the CSO Law had created an environment wherein the government was 'hesitant' to undertake this exercise, as it did not want to appear to be 'controlling' the CSOs by instituting a mapping exercise. It was also suggested that CSOs were not keen to be mapped, as it may result in government imposing the requirement of raising 90% of their resources from domestic sources (see Section 2 above).

In relation to the CSO nomination, the APRs note that one additional CSO representative (CORHA) was nominated to the ICC and two CSOs (CCRDA and CORHA) to the JCF as part of Type A funding. However, stakeholders were mostly unaware of this and did not attribute the nomination to CSO support. Furthermore, as mentioned above, the utility of representation was questioned as the ICC is not viewed as a very effective body.

4.2.2. Type B support

We provide feedback below from country consultees on some key aspects of the implementation of Type B support in Ethiopia.

Selection of CSOs

CSOs were asked to submit proposals for GAVI support which were assessed by the JCCC. A number of selection criteria were employed, including whether the CSOs work in hard-to-reach areas, have experience and a track record in immunisation, have developed a strong proposal and understand the programme objectives, amongst others. In addition, there was a requirement to fund a mix of types of CSOs (i.e. faith-based organisation, development associations, professional associations and NGOs).

Five CSOs were selected from a total of 16 that submitted proposals – CCRDA, the Ethiopian Medical Association (EMA), the Ethiopian Orthodox Church (EOC), Oromia Development Association (ODA), and the Afar Pastoralist Development Association (APDA). While all five CSOs are indigenous organisations, a majority of funds (approximately 52%) has gone to CCRDA who has seven sub-recipients, four of which are international CSOs.[34]

Based on our consultations, our view is that the selection of CSOs has worked well. CCRDA has had a long-term working relationship with the government and is a key association of CSOs in the country. We also note that ODA is a parastatal organisation (and hence not a CSO in a strict sense).

Country implementation approach and issues

A key aspect of Ethiopia's approach to implementing Type B support that is useful to highlight is the role of CCRDA. As an umbrella organisation, CCRDA has wide experience of being contracted by donors and sub-contracting implementing CSOs.[35] CCRDA instituted a CSO selection process while developing its proposal for the government, and verified progress/ results of its sub-recipients before providing M&E information to the government. In general, this arrangement with CCRDA appears to be working well, and offers a possible lesson in terms structuring CSO support in-country.

Implementation issues faced relate to coordination difficulties between the government and CSOs. In general, the government notes that it faces difficulties in working with CSOs as they needed to organise themselves better.[36] A criticism noted by the CSOs was that the government does not have a focal point for immunisation and the CSO programme in particular, and also the departments have a high turnover of staff – this has made accessing information particularly difficult.

In addition, CSOs have faced hurdles in implementing their activities due to a lack of supporting infrastructure and weak health systems, as well as poor attendance at EPI training sessions.[37]

---

[34] The seven CSOs that were sub-contracted through CCRDA are Save the Children US (SC/US), CORE Group, AMREF, International Rescue Committee Ethiopia (IRC), World Vision, Pastoralist Concern and the Ethiopian Evangelical Church Mekane Yessus (ECMY/D Assoc).

[35] In particular, CCRDA has experience of working with USAID, SIDA and Global Fund.

[36] We understand that CCRDA is establishing a Task Force to strengthen coordination between government and CSOs.

[37] Poor attendance at training sessions has led to a slightly lower number of trained personnel than expected. In the case of the Ethiopian Medical Association (EMA), we note that they had invited 200 EPI coordinators to be trained on Mid-level Management (MLM) and only 153 attended. In addition, they had invited 300 facility health workers to be trained in Immunisation in Practice and only 209 attended. In addition, a number of the personnel were trained

5. EVALUATION OF PROGRAMME RESULTS

5.1. Type A support

Given that the mapping exercise has not yet been completed and the nomination process of CSOs to the country coordinating mechanisms has not been clear, as such, Type A support has not had any discernible results in Ethiopia to date.

5.2. Type B support

Results framework – outputs, outcomes and impacts

Both the desk-based review of country APRs as well as consultations in-country suggest considerable progress with regards to the achievement of outputs. However, delays from GAVI in disbursing the second tranche of funds has detracted from these results considerably – as noted above.

Annex 4 provides the summarised progress on outputs based on the APRs. While we cannot verify the actual achievement of these detailed outputs, our judgement from country consultations with the CSO-recipients, government and locally-based donors is that considerable progress has been made by most of the CSOs.

Table 5.1 presents some key outputs of the CSO funding in Ethiopia. CSOs have indicated that they have received requests from other 'woredas' to conduct the GAVI supported activities more widely, which suggests that GAVI support was generally well received at the local level.

Table 5.1: Summary of outputs

Key outputs through CSO Type B funding in Ethiopia

• Trainings have been delivered to:
  o 1,100 HEWs in immunisation related activities - who subsequently trained a further 2,600 HEWs.
  o 153 MLMs and 511 HEWs were trained on EPI Mid-Level Management (MLM).
  o 2,200 Volunteer Community Health Workers to educate and mobilise the community.
  o 23 Ethiopian Orthodox Church clergies on EPI and community mobilisation - who subsequently trained a further 1,776 clergy on EPI and community mobilisation.
• Other activities that were delivered included: supervision of newly trained HEWs; the procurement of equipment and supplies to support routine immunisation activities; community mobilisation workshops and rallies; community health education; nutritional screening; and antenatal care services.

This conclusion however has the following caveats:[38]

- We cannot contextualise this progress in terms of, for example, what proportion of the required health workers in an area have been trained and the extent to which the gaps in training have been met.

in fields different from their work – possibly because personnel were sent for training because they were available rather than their potential applicability.

[38] Additional caveats are noted in Annex 4.

- We cannot comment on how these outputs compare with plans, given limited information on plan indicators, and also changes to the indicators due to delays in country approval and disbursement.
- These results reflect reporting by the Type B implementing CSOs (and verification by CCRDA for its seven CSO sub-recipients). However, GAVI Partners questioned the reporting mechanisms in place to supervise and verify their results. Government also acknowledged that while review meetings were conducted to discuss CSO results, there were very few supervisory visits which meant that verification of results is difficult.

It is difficult to translate these outputs into outcomes and impacts – as also noted from the scanty information in the APRs (see Annex 4). It is difficult to say if Type B support has had any impact in terms of coverage in the project areas, given the type of activities, small size of funding and very localised activities. In addition, attributing any results to CSO activities would be challenging, particularly as any statistics would not distinguish between government and CSO contributions.

The box below provides a case study of the EMA - one of the implementing Type B CSOs. The case study provides a summary of EMA's experience with GAVI CSO support and the main problems encountered while implementing the programme.

Case study: Ethiopian Medical Association (EMA)

EMA were funded to provide training to 200 EPI coordinators on Mid-level Management (MLM) and 300 facility HWs on Immunisation in Practice (IIP). In addition, EMA were funded to conduct one round of supportive supervision to the trainees, three months after the training took place, and conduct a sample survey at the end of programme implementation. The trainings were proposed to take place over six regions[39] and 200 woredas.

- MLM training focuses on planning, management, monitoring, supportive supervision, cold chain & logistics management, disease surveillance, and communication in support of the programme.
- IIP training focuses on updating HWs with the most recent knowledge, skills, new technologies, and information on the immunisation programme.
- EPI supervision aimed to ensure HWs were providing quality services and further improve HW skills as well as assess the programme.

EMA developed training modules, selected training facilitators and conducted six sessions of training and supervision resulting in 153 trained EPI coordinators on MLM and 209 trained HWs in IIP. EMA currently plan to implement the rest of the training and supervision sessions when the residual funds are received.

The assessment of activities performed, as part of EPI supervision, found that the trainings delivered make HWs more confident in the delivery of services and enhanced the quality of services being delivered. Training also helped to promote supportive supervision in the health facilities for further capacity building. In addition, there was evidence to suggest that training had strengthened the management of cold chain system and encouraged HWs to pay more attention to registering, compiling, reporting and documenting the activities performed.

The main problems encountered by EMA were:

- The delay in funding ,which interrupted the programme implementation and also led to a shortage of funds. During the delay, programme costs increased from inflation.

[39] The regions where trainings were conducted are Afar, Benishangul Gumuz, Somali, Oromia, Amhara and SNNPR.

- A number of invitees did not attend the trainings which led to the number of trained staff being less than expected.
- 20% of trained personnel were not actually working in relevant positions within three months of being trained. This was thought to be due to the inappropriate selection of staff for training, high staff turnover and inappropriate positioning of trained staff in health facilities.

In order to improve the programme going forward, EMA would recommend more careful selection of trainees, additional refresher trainings, further review meetings with health facilities and most importantly a sustainable allocation of funds for essential equipment (supply of kerosene, transportation, supply of recording and reporting materials, and cold chain equipment and maintenance) to supplement the training and ensure that trained HWs are fully utilised.

Sustainability

The MoH indicated that they would rely on donor support to fund CSOs after this window of support. CSOs also indicated that they would not expect government to fund them independently. Therefore, there are issues of sustainability after GAVI support ends.

A summary of the factors that have impacted the effectiveness of the programme is presented in Annex 5.

6. RECOMMENDATIONS

This section presents the suggestions provided by the stakeholders in Ethiopia to improve GAVI's support to CSOs.

6.1. Recommendations to improve effectiveness of the programme

Key suggestions to address some of identified issues in the CSO programme design and implementation include:

- *Improving the clarity of programme objectives.* GAVI should clarify the objectives of CSO support and better define the activities and types of CSOs it wishes to fund. The objectives of the programme should reflect the role that CSOs play in country. For example, where CSOs are not directly involved in service delivery, targeting increasing immunisation coverage may not be directly achievable/ attributable.
- *Improve disbursement procedures.* All stakeholders have requested that GAVI minimise delays and keep its disbursement procedures in line with pre-agreed schedules. Also, given that the CSO support was a 'pilot', it should not have been delayed on account of the TAP/ FMA requirements.
- *Improve clarity of roles and responsibilities of various stakeholders.* The need to improve clarity in the roles and responsibilities of the various stakeholders involved in the CSO programme was emphasised. This includes:
    - clearly defining the role of the Secretariat and GAVI Partners – including the expectations from Partners and whether these are realistic to achieve; and
    - defining how governments and CSOs are expected to interact – e.g. CSOs in-country were unclear if Type A support should be provided to them rather than to the government for the mapping exercise.
- *Strengthen the ICC.* Many stakeholders commented that the ICC could be strengthened through multi-stakeholder representation to act as a neutral reviewer of CSO proposals and also undertake routine M&E activities.
- *Increase GAVI's country interaction.* While the government noted that they preferred GAVI's 'hands off' approach which allowed them more freedom, other stakeholders commented that if GAVI were to have more of a country presence, it would increase their ability to efficiently support and supervise the programme.

6.2. Channelling of funds

As noted, in general, the channelling of GAVI CSO funding through the government appears to have worked well in Ethiopia. That said, we requested stakeholder feedback on other feasible options. Key points to note are as follows:

- There was limited enthusiasm for routing funds through in-country bilateral donors. Bilateral donors consulted noted that this option could be considered, but that GAVI support would need to be aligned with their country programmes. Other stakeholders responded that not many bilaterals are directly supporting immunisation in Ethiopia at

present. The main criticism for this approach was that it would result in a third party being involved and consequently additional costs.

- Routing funds through an international CSO with a local network was viewed highly unfavourably. Consultees noted that this would cause tensions with the existing network of CSOs, particularly the umbrella organisations.
- Routing funds through a national umbrella organisation was viewed relatively positively. For example, CCRDA (one of the main umbrella organisations in Ethiopia) have experience of contracting CSOs in this manner and have done so as part of Type B support. CCRDA are widely reported to know the local CSOs well and also provide advisory and M&E support to the CSOs.

6.3. Integration with the HSFP

Most consultees were not aware of the ongoing discussions on the HSFP (as can be expected), but the government was not opposed to this approach.

Donors in country had specific reservations about the HSFP concept and the potential integration of the CSO programme with the Platform. They commented that it would be difficult to expect government to include CSOs in their HSS proposals, unless specifically required to do so. At the same time, it would be important for the HSFP to remain flexible given considerable differences between countries – and hence GAVI would need to consider if earmarking funds for CSOs is its specific objective or not.

ANNEX 1: LIST OF REFERENCES

- Abramson, W. (2009): "GAVI CSO Type B Funding Case Study Ethiopia", John Snow International
- Akalewold, B., Rahmato, D., and Endeshaw, Y. (2008): "CSOs/NGOs in Ethiopia: Partners in Development and Good Governance", GAVI Alliance
- Alemu, G (2009): "A Case Study on Aid Effectiveness in Ethiopia", Wolfensohn Centre for Development at Brookings, Working Paper 9
- Annual Progress Reports: 2008, 2009, 2010
- Putnam, E (2009): "GAVI Alliance support for Civil Society Organisations – An analysis of Type A funding"
- Ethiopia CJSC (2008): "Application Form B for GAVI Alliance CSO Support"
- GAVI (2008): "CSO Report Ethiopia"
- GAVI (2010): "GAVI Support to civil society organisations in Ethiopia"
- GAVI (2011): "CSO Window Disbursements at 15 July 2011", as sent by GAVI
- GAVI (2011): "GAVI Finance Data from July 2011"
- Gondwe, F., Steinglass, R., Ostmark, S. and Sandkjaer, B (2007): "Facilitating implementation of GAVI's new CSO support: Visit to Ethiopia 24 – 28 September 2007", John Snow, Inc.
- Government of Ethiopia CSO law (2009): "Proclamation No. 621/2009": Federal Democratic Republic of Ethiopia on the 13th February 2009.
- International Human Development Indicators (2011): http://hdrstats.undp.org/en/countries/ETH
- US Department of State (2011): http://www.state.gov/r/pa/ei/bgn/2859.htm
- WHO (2011): "Global Health Observatory database"
- World Bank (2011): "World Bank Database"

ANNEX 2: LIST OF CONSULTATIONS

Individual	Organisation	Position
Government and Ministry of Health		
Dr Kebede Worku	Ministry of Health	Minister of State
Dr Abduljelil Reshad	Ministry of Health	Director of Resource Mobilisation Directorate
Ato Abera Seifu	OROMIA Regional Health Bureau	Coordinator Health Services Promotion Team
Bilaterals, mulitilaterals and GAVI Partners		
Alison Forder	DFID	Health Advisor
Colleen Wainwright	Irish Aid	Head of Development
Bezuwork Ketete	Irish Aid	
Takele Geressu	Irish Aid	
Ben Siddle	Irish Aid	
Dr Luwei Pearson	UNICEF	Section Chief for Health
Dr Pascal Makanda	WHO	EPI Team Leader
Dr Assefu	WHO	EPI Team
Type B implementing CSOs		
Medhanit Getachew	AMREF	Management and Training Coordinator
Tilahun Bezabih	AMREF	Management and Planning Coordinator
Dr Filimona Bisrat	CORE Group	Director
Bezunesh Dinku	CCRDA/CORE Group	Monitoring and Evaluation Officer
Yetnyat Kebede	CORE Group	Communication Officer
Dr Abiy Hiruy	Ethiopian Medical Association	Executive Director
Solomon Zeleke	Ethiopian Evangelical Church Mekane Yessus	Health Project Officer
Dr Agedew Redie	Ethiopian Orthodox Church	Commissioner
Ato Teferra Haile	Ethiopian Orthodox Church	Project Coordinator
Ato Kebede Beyene	Ethiopian Orthodox Church	Head of Finance
Jemal Abdela	Ethiopian Orthodox Church	
Sileshi Zenebe	Ethiopian Orthodox Church	
Tadesse Gossaye	International Rescue Committee	Health Coordinator
Ato Mulugata Debebe	Oromia Development Organisation	Director
Abebech Sereke	Save the Children US	Grant/ Contract management specialist
Mirafe Solomon	Save the Children US	Project Officer

Individual	Organisation	Position
Gemech Demissie	World Vision Ethiopia (WVE)	Programme Coordinator
Others		
Tesfaye Bulto	IFP	Deputy Technical Director

ANNEX 3: KEY STATISTICS ON THE HEALTH SECTOR

Figure A3.1: Immunisation Coverage (%) by region (2009)[40]

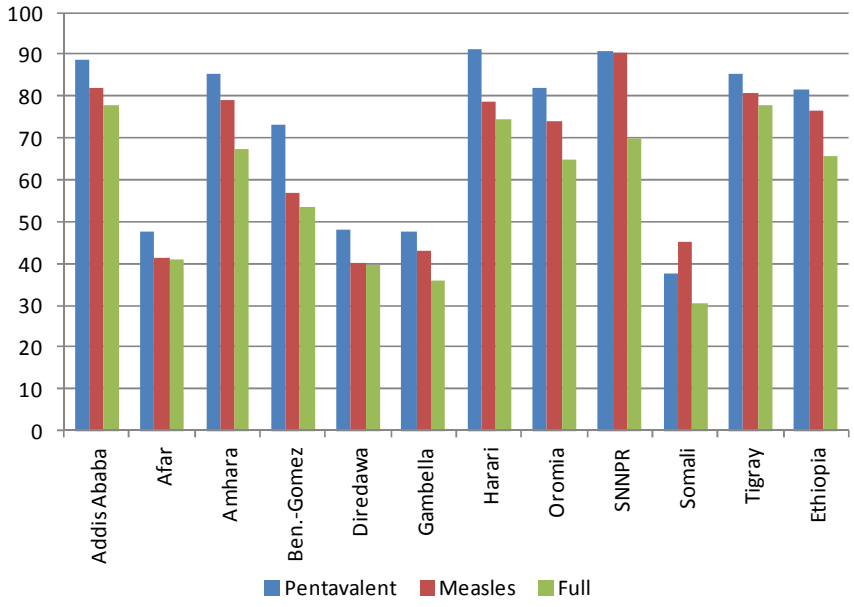
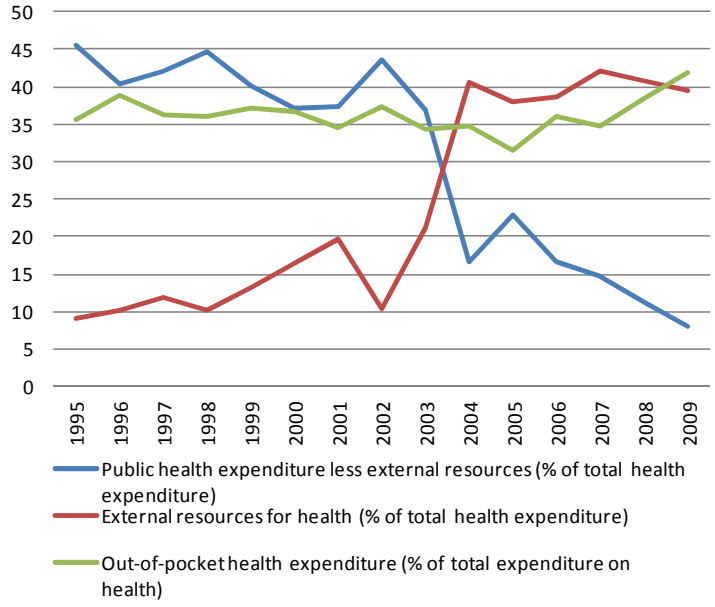
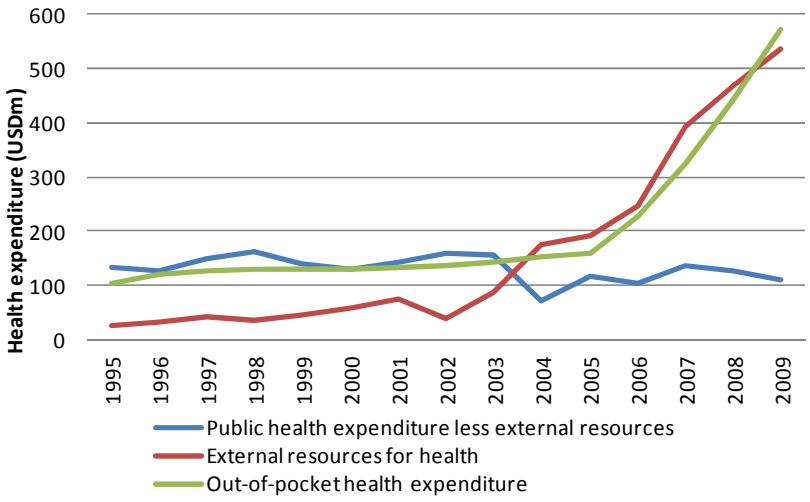


Figure A3.2: Sources of health expenditure as a % of total health expenditure[41]



[40] Source: MoH 2010b
[41] Data from http://databank.worldbank.org/

Figure A3.3: Sources of health expenditure, totals[42]



[42] Data adapted from Figure A3.2: please note, we cannot guarantee the validity of this data as the measure of GDP used to calculate total health expenditure is not stated on the World Bank database. The measure of GDP used is in current US$.

ANNEX 4: DESK REVIEW OF RESULTS OF TYPE B FUNDING

This annex provides a summary of the progress reported in the APRs against the activities and expected results detailed in the Ethiopia country proposal for Type B support. It is entirely desk-based, although the results were largely reinforced by our in country consultations.

It should be noted that this draft analysis is based entirely on reported progress on indicators by countries, and CEPA has not sought to verify/ validate any of these (and indeed this is not possible given the mandate and timelines of our evaluation). We have however used our judgement, based on the information provided, to present a summary status on the progress achieved.

Structure of analysis

We have structured our analysis as follows:

- We present two tables – the first focusing on activities and outputs, and the second on outcomes and impacts. We have tried to construct these in a consistent manner following CEPA's results hierarchy, given the varying presentations across countries.
- These tables do not intend to map the progress against *all* activities undertaken, but rather, provide an overview of the *main* country level activities and progress achieved.
- We have tried to map both activities that can be assessed quantitatively (e.g. number of trained health workers) as well as activities that can be assessed based on whether they have been completed or not (e.g. conducting a baseline survey).
- We have attempted to summarise the extent of progress achieved by the following categories: "Considerable progress", "Some progress" and "Unknown"[43] – however this represents CEPA's subjective opinion based on the information in the proposal and APR documents available, and may not be completely accurate given the poor quality of information contained in these documents (see limitations below).

[43] Our categories for summary progress are self-explanatory, however please note that where it is not clear either (i) what progress has been achieved; and / or (ii) the context for the progress (i.e. where targets or milestones are not noted), we have marked the progress as "unknown", despite APRs reporting on the progression of activities.

Limitations

There are a number of limitations to our analysis, as detailed below:

- The latest APRs we have been able to analyse was the 2010 APR. It is likely that further progress will be reported in future APRs (especially 2011, given ongoing funding support in the countries).
- Activities, outputs, outcomes and impacts (baselines and targets) are generally not clearly laid out in the country proposal and APRs. For example, sometimes these are noted on a general basis rather than defined by specific targets and timelines. Also, the context for some of these results is not clear – i.e. what part of the problem are these activities and their results aiming to solve?
- It is often unclear how the results hierarchy, or logical framework, has been constructed. For example, activities proposed do not always match outputs or outcomes proposed/ reported.
- As timelines and other factors have changed during the implementation of activities, target timelines, and sometimes the targets themselves, have changed.
- It is difficult to track progress along the results hierarchy as the information in the APRs does not always relate directly to the proposals (including inconsistencies between subsequent APRs).
- While we recognise that outcome and impact indicators may not be possible to measure as part of this evaluation, often they are not reported in the APRs. Where this is the case, we have inserted the summary status 'unknown' into the tables.
- The categorisation of summary progress is based on our subjective opinion – and is not directly comparable across countries, as the level and quality of information varies considerably across countries.

Country level summary

The tables below provide a work-in-progress summary for Ethiopia:

Table A4.1: Progress on outputs

CSO	Proposed activities	Progress against outputs	Summary status
CRDA	• Training of at least 2 HWs in EPI for each health facility • Procurement of equipment to support outreach immunisation • Support advocacy and demand creation campaigns	• 511 trained HWs • Equipment procured and maintenance expenditure provided • Numerous advocacy activities taken place	**Considerable progress**
APDA	• Vaccinate 2,154 children and 18,574 women • Monitoring and screening of nutritional status • Provide Vitamin A supplements and de-worming to 13,708 children • Provide health education to reduce diarrhoea and raise awareness of malaria, including providing ITNs and treating acute cases • Provide training and monitoring to reduce unsafe birthing practices • Provide 20 initial trainings and 40 refresher trainings to HWs on primary health activities	• Immunisation services delivered to 50,000 women and children • 45,000 women and children received nutritional screening • Vitamin A supplements and de-worming provided to 13,708 children • Health education given to 47,567 women and children • Antenatal care services delivered to 1,517 mothers and delivery services given to 1,270 women • EPI training delivered to 80 HWs	**Considerable progress**
EOC/ DICAC	• Conduct 2 Zonal advocacy workshops, public rallies in each project district and produce and disseminate advocacy materials • Train 20 clergies to train other clergies • Conduct 50 district level clergy training sessions • Produce distribute operational materials for clergy to deliver services • Conduct district review meetings in 11 woredas	• 11 public rallies held and advocacy materials produced • 23 clergies trained to train other clergies • 1776 clergies trained • Operational materials provided to clergies • Review meetings conducted in 2 woredas	**Some progress**
EMA	• Train 262 woreda EPI coordinators on mid-level management (MLM) • Train 374 HWs on immunisation • Conduct 1 round of supportive supervision to at least 50% of districts and health facilities, 3 months after training	• 153 EPI coordinators trained on MLM • 209 HWs trained on immunisation • Supportive supervision delivered to 68 woredas and 71 health facilities	**Considerable progress**

CSO	Proposed activities	Progress against outputs	Summary status
ODA	• 3,040 HWs trained in immunisation delivery • 3,000 Community Based Reproductive Health Agent (CBRHAs) trained • Trained HWs and CBRHAs to deliver community sensitisation workshops	• 2,600 HWs trained • 2,220 CVHWs trained • Health education given to 4,448,093 women and children	Some progress

Table A4.2: Progress on outcomes and impacts

CSO	Proposed outcomes and impacts	Reported progress	Summary status
CRDA	• Increase pentavalent coverage by 35% in remote, hard to reach and pastoral communities, and measles by 25%; decrease pentavalent drop-out rates to 10%; increase TT2+ coverage rates for pregnant women by 10% and 25% for non-pregnant women	• Pentavalent coverage increased from 48% to 70% in Gambella, 5% to 72% in Sherkole woreda and 68% to 85% in Benishangul • Measles coverage reached 71% in Gambella and 73% in Benishangul	Considerable progress
APDA	• EPI coverage to reach 90% in project areas	• Immunisation coverage is reported at 'around 90% in the project woredas'	Considerable progress
EOC/ DICAC	• Increasing access for women and children to 'full antigens' to at least 90% in project areas with a maximum drop out rate of 5%	• Progress on access and drop out rates not reported	Unknown
EMA	• 80% of HWs to have adequate EPI skills • 90% of districts to have pentavalent vaccine coverage above 80%	• Progress on % of HWs with adequate skills not reported • Immunisation coverage increased to 50% in Somali and 60% in Afar	Unknown
ODA	• Increased community awareness of immunisation from 50% to 95% • Rate of decrease in maternal mortality from 53% to 90% • Rate of decrease in child mortality from 50% to 90%	• Progress on community awareness not reported • Progress on maternal mortality rates not reported • Progress on child mortality rates not reported	Unknown

ANNEX 5: FACTORS IMPACTING EFFECTIVENESS

There are a number of factors (both positive and negative) which have affected the effectiveness of the CSO programme in Ethiopia. These factors are summarised in the table below. Positive factors are indicated by '+' while negative factors are indicated by '-' and factors which have been viewed differently by different stakeholders are indicated by '±'.

Table A5.1: Summary of factors affecting effectiveness

Type	Factors
GAVI-specific factors	– Limited funding and disbursement (of Type B) delays + GAVI Secretariat technical support to government has been timely and efficient ± GAVI institutional model was viewed differently among stakeholders with government appreciating the 'hands-off' approach while others preferring greater GAVI participation at the country level
Country-specific factors	– High turnover of government (MoH staff) made accessing information difficult for CSOs – CSO Law may have delayed the mapping exercise and impacted on some CSO advocacy activities + Government/ CSO relationship has been strong for a number of years
Programme-specific: Type A	– Inability to identify suitable consultants to conduct mapping exercise – Funding envelope too low – Value of the CSO nomination process was unclear to many stakeholders
Programme-specific: Type B	+ GAVI workshop at programme inception helped to raise awareness and encourage a fairer selection process of CSOs + Channelling money via the government + Inclusion of faith-based CSOs has helped to mobilise communities – Unclear role of GAVI Partners – Unclear objectives of GAVI CSO support