GAVI Alliance

Annual Progress Report 2014

Submitted by

The Government of

Somalia

Reporting on year: **2014**
Requesting for support year: **2016**
Date of submission: **16/06/2015**

Deadline for submission: 27/05/2015

Please submit the APR 2014 using the online platform https://AppsPortal.gavialliance.org/PDExtranet

Enquiries to: apr@gavi.org or representatives of a GAVI Alliance partner. The documents can be shared with GAVI Alliance partners, collaborators and general public. The APR and attachments must be submitted in English, French, Spanish, or Russian.

Note: *You are encouraged to use previous APRs and approved Proposals for GAVI support as reference documents. The electronic copy of the previous APRs and approved proposals for GAVI support are available at* http://www.gavialliance.org/country/

The GAVI Secretariat is unable to return submitted documents and attachments to countries. Unless otherwise specified, documents will be shared with the GAVI Alliance partners and the general public.

GAVI ALLIANCE
GRANT TERMS AND CONDITIONS

FUNDING USED SOLELY FOR APPROVED PROGRAMMES

The applicant country ("Country") confirms that all funding provided by the GAVI Alliance will be used and applied for the sole purpose of fulfilling the programme(s) described in the Country's application. Any significant change from the approved programme(s) must be reviewed and approved in advance by the GAVI Alliance. All funding decisions for the application are made at the discretion of the GAVI Alliance Board and are subject to the Independent Review Committee (IRC) and its processes and the availability of funds.

AMENDMENT TO THE APPLICATION

The Country will notify the GAVI Alliance in its Annual Progress Report (APR) if it wishes to propose any change to the programme(s) description in its application. The GAVI Alliance will document any change approved by the GAVI Alliance, and the Country's application will be amended.

RETURN OF FUNDS

The Country agrees to reimburse to the GAVI Alliance all funding amounts that are not used for the programme(s) described in its application. The country's reimbursement must be in US dollars and be provided, unless otherwise decided by the GAVI Alliance, within sixty (60) days after the Country receives the GAVI Alliance's request for a reimbursement and be paid to the account or accounts as directed by the GAVI Alliance.

SUSPENSION/ TERMINATION

The GAVI Alliance may suspend all or part of its funding to the Country if it has reason to suspect that funds have been used for purpose other than for the programmes described in the Country's application, or any GAVI Alliance-approved amendment to the application. The GAVI Alliance retains the right to terminate its support to the Country for the programmes described in its application if a misuse of GAVI Alliance funds is confirmed.

ANTICORRUPTION

The Country confirms that funds provided by the GAVI Alliance shall not be offered by the Country to any third person, nor will the Country seek in connection with its application any gift, payment or benefit directly or indirectly that could be construed as an illegal or corrupt practice.

AUDITS AND RECORDS

The Country will conduct annual financial audits, and share these with the GAVI Alliance, as requested. The GAVI Alliance reserves the right, on its own or through an agent, to perform audits or other financial management assessment to ensure the accountability of funds disbursed to the Country.

The Country will maintain accurate accounting records documenting how GAVI Alliance funds are used. The Country will maintain its accounting records in accordance with its government-approved accounting standards for at least three years after the date of last disbursement of GAVI Alliance funds. If there is any claims of misuse of funds, Country will maintain such records until the audit findings are final. The Country agrees not to assert any documentary privilege against the GAVI Alliance in connection with any audit.

CONFIRMATION OF LEGAL VALIDITY

The Country and the signatories for the Country confirm that its application, and APR, are accurate and correct and form legally binding obligations on the Country, under the Country's law, to perform the programmes described in its application, as amended, if applicable, in the APR.

CONFIRMATION OF COMPLIANCE WITH THE GAVI ALLIANCE TRANSPARANCY AND ACCOUNTABILITY POLICY

The Country confirms that it is familiar with the GAVI Alliance Transparency and Accountability Policy (TAP) and complies with the requirements therein.

USE OF COMMERCIAL BANK ACCOUNTS

The Country is responsible for undertaking the necessary due diligence on all commercial banks used to manage GAVI cash-based support. The Country confirms that it will take all responsibility for replenishing GAVI cash support lost due to bank insolvency, fraud or any other unforeseen event.

ARBITRATION

Any dispute between the Country and the GAVI Alliance arising out of or relating to its application that is not settled amicably within a reasonable period of time, will be submitted to arbitration at the request of either the GAVI Alliance or the Country. The arbitration will be conducted in accordance with the then-current UNCITRAL Arbitration Rules. The parties agree to be bound by the arbitration award, as the final adjudication of any such dispute. The place of arbitration will be Geneva, Switzerland. The languages of the arbitration will be English or French.

For any dispute for which the amount at issue is US$ 100,000 or less, there will be one arbitrator appointed by the GAVI Alliance. For any dispute for which the amount at issue is greater than US $100,000 there will be three arbitrators appointed as follows: The GAVI Alliance and the Country will each appoint one arbitrator, and the two arbitrators so appointed will jointly appoint a third arbitrator who shall be the chairperson.

The GAVI Alliance will not be liable to the country for any claim or loss relating to the programmes described in the application, including without limitation, any financial loss, reliance claims, any harm to property, or personal injury or death. Country is solely responsible for all aspects of managing and implementing the programmes described in its application.

By filling this APR the country will inform GAVI about:

Accomplishments using GAVI resources in the past year

Important problems that were encountered and how the country has tried to overcome them

Meeting accountability needs concerning the use of GAVI disbursed funding and in-country arrangements with development partners

Requesting more funds that had been approved in previous application for ISS/NVS/HSS, but have not yet been released

How GAVI can make the APR more user-friendly while meeting GAVI's principles to be accountable and transparent.

1. Application Specification

Reporting on year: **2014**

Requesting for support year: **2016**

1.1. NVS & INS support

Type of Support	Current Vaccine	Preferred presentation	Active until
Routine New Vaccines Support	DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	2015

DTP-HepB-Hib (Pentavalent) vaccine: Based on current country preferences the vaccine is available through UNICEF in fully liquid 1 and 10 dose vial presentations and in a 2 dose-2 vials liquid/lyophilised formulation, to be used in a three-dose schedule. Other presentations are also WHO pre-qualified, and a full list can be viewed on the WHO website, but availability would need to be confirmed specifically.

1.2. Programme extension

Type of Support	Vaccine	Start year	End year
Routine New Vaccines Support	DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	2016	2017

1.3. ISS, HSS, CSO support

Type of Support	Reporting fund utilisation in 2014	Request for Approval of	Eligible For 2014 ISS reward
HSS	Yes	next tranche of HSS Grant No	No

VIG: Vaccine Introduction Grant; COS: Campaign Operational Support

1.4. Previous Monitoring IRC Report

APR Monitoring IRC Report for year 2013 is available here.

2. Signatures

2.1. Government Signatures Page for all GAVI Support (ISS, INS, NVS, HSS, CSO)

By signing this page, the Government of Somalia hereby attests the validity of the information provided in the report, including all attachments, annexes, financial statements and/or audit reports. The Government further confirms that vaccines, supplies, and funding were used in accordance with the GAVI Alliance Standard Grant Terms and Conditions as stated in this Annual Progress Report (APR).

For the Government of Somalia

Please note that this APR will not be reviewed or approved by the High Level Review Panel (HLRP) without the signatures of both the Minister of Health & Minister Finance or their delegated authority.

Minister of Health (or delegated authority)		Minister of Finance (or delegated authority)	
Name	Dr, Mohamed Abdi FARAH, Director General, Ministry of Health & Human Servcies	**Name**	NA
Date		**Date**	
Signature		**Signature**	

This report has been compiled by (these persons may be contacted in case the GAVI Secretatiat has queries on this document):

Full name	Position	Telephone	Email
Dr. Katja Schemionekl	HSS Country Programme Advisor, WHO Somalia	+254-733770212	schemionekka@who.int
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Dr. William Baguma Mbabazi	Immunization Specialist, UNICEF Somalia	+254-726352703	wmbabazi@unicef.org

2.2. ICC signatures page

If the country is reporting on Immunisation Services (ISS), Injection Safety (INS) and/or New and Under-Used Vaccines (NVS) supports

In some countries, HSCC and ICC committees are merged. Please fill-in each section where information is appropriate and upload in the attached documents section the signatures twice, one for HSCC signatures and one for ICC signatures

The GAVI Alliance Transparency and Accountability Policy (TAP) is an integral part of GAVI Alliance monitoring of country performance. By signing this form the ICC members confirm that the funds received from the GAVI Alliance have been used for purposes stated within the approved application and managed in a transparent manner, in accordance with government rules and regulations for financial management.

2.2.1. ICC report endorsement

We, the undersigned members of the immunisation Inter-Agency Coordinating Committee (ICC), endorse this report. Signature of endorsement of this document does not imply any financial (or legal) commitment on the part of the partner agency or individual.

Name/Title	Agency/Organization	Signature	Date

NA	NA		

ICC may wish to send informal comments to: apr@gavi.org

All comments will be treated confidentially

Comments from Partners:

Please note that Somalia does not have an ICC.

Comments from the Regional Working Group:

2.3. HSCC signatures page

We, the undersigned members of the National Health Sector Coordinating Committee (HSCC), Somalia , endorse this report on the Health Systems Strengthening Programme. Signature of endorsement of this document does not imply any financial (or legal) commitment on the part of the partner agency or individual.

The GAVI Alliance Transparency and Accountability Policy is an integral part of GAVI Alliance monitoring of country performance. By signing this form the HSCC members confirm that the funds received from the GAVI Alliance have been used for purposes stated within the approved application and managed in a transparent manner, in accordance with government rules and regulations for financial management. Furthermore, the HSCC confirms that the content of this report has been based upon accurate and verifiable financial reporting.

Name/Title	Agency/Organization	Signature	Date
Dr. Abdihamid Ibrahim, Director for Policy and Planning	Federal Government of Somalia, Ministry of Health and Human Services		

HSCC may wish to send informal comments to: apr@gavi.org

All comments will be treated confidentially

Comments from Partners:

No comments.

Comments from the Regional Working Group:

2.4. Signatures Page for GAVI Alliance CSO Support (Type A & B)

Somalia is not reporting on CSO (Type A & B) fund utilisation in 2015

3. Table of Contents

This APR reports on Somalia's activities between January – December 2014 and specifies the requests for the period of January – December 2016

Sections

4. Baseline & annual targets

Countries are encouraged to aim for realistic and appropriate wastage rates informed by an analysis of their own wastage data. In the absence of country-specific data, countries may use indicative maximum wastage values as shown on the **Wastage Rate Table** available in the guidelines. Please note the benchmark wastage rate for 10ds pentavalent which is available.

Please also note that if the country applies the WHO multi-dose vial policy for IPV, the maximum indicative wastage rates are 5%, 15% and 20% for the 1-dose, 5-dose and 10-dose presentations respectively.

Number	Achievements as per JRF		Targets (preferred presentation)					
	2014		2015		2016		2017	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2014	Current estimation	Previous estimates in 2014	Current estimation
Total births	391,569	391,569	403,316	403,316		497,171		512,087
Total infants' deaths	42,681	42,681	43,961	43,961		49,787		51,280
Total surviving infants	348888	348,888	359,355	359,355		447,384		460,807
Total pregnant women	391,569	391,569	403,316	403,316		509,919		525,217
Number of infants vaccinated (to be vaccinated) with BCG	234,941	139,409	282,321	282,321		348,020		358,461
BCG coverage*[1]*	60 %	36 %	70 %	70 %	0 %	70 %	0 %	70 %
Number of infants vaccinated (to be vaccinated) with OPV3	209,332	170,715	244,222	244,222		304,222		313,348
OPV3 coverage*[2]*	60 %	49 %	68 %	68 %	0 %	68 %	0 %	68 %
Number of infants vaccinated (to be vaccinated) with DTP1*[3]*	261,666	195,261	279,110	279,110		345,707		356,078
Number of infants vaccinated (to be vaccinated) with DTP3*[3][4]*	209,332	170,871	244,222	244,222		304,222		313,348
DTP3 coverage*[2]*	60 %	49 %	68 %	68 %	0 %	68 %	0 %	68 %
Wastage*[5]* rate in base-year and planned thereafter (%) for DTP	20	20	20	20		25		25
Wastage*[5]* factor in base-year and planned thereafter for DTP	1.25	1.25	1.25	1.25	1.00	1.33	1.00	1.33
Number of infants vaccinated (to be vaccinated) with 1st dose of DTP-HepB-Hib	327,955	195,261	279,110	279,110		345,707		356,078
Number of infants vaccinated (to be vaccinated) with 3rd dose of DTP-HepB-Hib	262,363	170,871	244,222	244,222		304,222		313,348
DTP-HepB-Hib coverage*[2]*	75 %	49 %	68 %	68 %	0 %	68 %	0 %	68 %
Wastage*[5]* rate in base-year and planned thereafter (%) *[6]*	25	20	25	25		25		25
Wastage*[5]* factor in base-year and planned thereafter (%)	1.33	1.25	1.33	1.33	1	1.33	1	1.33
Maximum wastage rate value for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	0 %	0 %	0 %	25 %	0 %	25 %	0 %	25 %
Number of infants vaccinated (to be vaccinated) with 1st dose of Measles	313,999	240,337	341,387	341,387		425,015		437,766

Number	Achievements as per JRF		Targets (preferred presentation)					
	2014		2015		2016		2017	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2014	Current estimation	Previous estimates in 2014	Current estimation
Measles coverage*[2]*	90 %	69 %	95 %	95 %	0 %	95 %	0 %	95 %
Pregnant women vaccinated with TT+	254,520	326,753	282,321	282,321		356,944		367,652
TT+ coverage*[7]*	65 %	83 %	70 %	70 %	0 %	70 %	0 %	70 %
Vit A supplement to mothers within 6 weeks from delivery	0	0	0	0		0		0
Vit A supplement to infants after 6 months	313,999	0	341,387	341,387	N/A	425,015	N/A	437,765
Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100	20 %	12 %	12 %	12 %	0 %	12 %	0 %	12 %

[1] Number of infants vaccinated out of total births

[2] Number of infants vaccinated out of total surviving infants

[3] Indicate total number of children vaccinated with either DTP alone or combined

[4] Please make sure that the DTP3 cells are correctly populated

[5] The formula to calculate a vaccine wastage rate (in percentage): [(A – B) / A] x 100. Whereby: A = the number of doses distributed for use according to the supply records with correction for stock balance at the end of the supply period; B = the number of vaccinations with the same vaccine in the same period.

[6] GAVI would also appreciate feedback from countries on feasibility and interest of selecting and being shipped multiple Pentavalent vaccine presentations (1 dose and 10 dose vials) so as to optimise wastage, coverage and cost.

[7] Number of pregnant women vaccinated with TT+ out of total pregnant women

5. General Programme Management Component

5.1. Updated baseline and annual targets

Note: Fill in the table in section 4 Baseline and Annual Targets before you continue

The numbers for 2014 must be consistent with those that the country reported in the **WHO/UNICEF Joint Reporting Form (JRF) for 2014.** The numbers for 2015 - 2015 in Table 4 Baseline and Annual Targets should be consistent with those that the country provided to GAVI in previous APR or in new application for GAVI support or in cMYP.

In fields below, please provide justification and reasons for those numbers that in this APR are different from the referenced ones:

- Justification for any changes in **births**

  The country had an official estimate of the total population revised. The new population estimates, now published and used by all UN agencies and partners for health development in Somalia can be downloaded from http://reliefweb.int/report/somalia/population-estimation-survey-2014-18-pre-war-regions-somalia

- Justification for any changes in **surviving infants**

  Following the changes in total population estimates derived from the UNFPA consultants report

- Justification for any changes in targets by vaccine. **Please note that targets in excess of 10% of previous years' achievements will need to be justified.** For IPV, supporting documentation must also be provided as an attachment(s) to the APR to justify ANY changes in target population.

  No changes in target coverage for the reporting and prospective years

- Justification for any changes in **wastage by vaccine**

  No changes in Wastage rates used in estimation of vaccines.

5.2. Monitoring the Implementation of GAVI Gender Policy

5.2.1. At any point in the past five years, were sex-disaggregated data on DTP3 coverage available in your country from administrative data sources and/or surveys? **no, not available**

If yes, please report the latest data available and the year that it is from.

Data Source	Reference Year for Estimate	DTP3 Coverage Estimate	
		Boys	Girls

5.2.2. How have any discrepancies in reaching boys versus girls been addressed programmatically?

5.2.3. If no sex-disaggregated data are available at the moment, do you plan in the future to collect sex-disaggregated coverage estimates? **Yes**

5.2.4. How have any gender-related barriers to accessing and delivering immunisation services (eg, mothers not being empowered to access services, the sex of service providers, etc) been addressed programmatically ? (For more information on gender-related barriers, please see GAVI's factsheet on gender and immunisation, which can be found on http://www.gavialliance.org/about/mission/gender/)

In all training sessions, vaccinators are instructed to advise parents to present all their children, irrespective of sex, for immunization. Vaccinators are advised to report any such discrimination, if and when they occur. Health workers have been trained to provide services, irrespective of the gender of infants. Supervisors are advised to report and take immediate action, in an event of overt/covert gender discrimination.

Secondly, the Joint Health and Nutrition program for Somalia has sex-disaggregated routine immunization data in project districts. The data obtained from these project districts will be used to inform decisions and actions for quantification of the gender disparities. If gender disparities are found, the indicator will be included in all future immunization surveys to determine the root-causes. The evidence collected and the guidance notes from GAVI's factsheet on gender and immunization shall be used to guide development of program interventions.

Although the country does not have sex-disaggregated data on service providers, field supervision and monitoring reports indicate that the vast majority of vaccinators are females.

5.3. Overall Expenditures and Financing for Immunisation

The purpose of **Table 5.3a** is to guide GAVI understanding of the broad trends in immunisation programme expenditures and financial flows. Please fill the table using US$.

Exchange rate used	1 US$ = 1	Enter the rate only; Please do not enter local currency name

Table 5.3a: Overall Expenditure and Financing for Immunisation from all sources (Government and donors) in US$

Expenditure by category	Expenditure Year 2014	Source of funding						
		Country	GAVI	UNICEF	WHO	JHNP	0	0
Traditional Vaccines*	730,760	0	0	730,760	0	0	0	0
New and underused Vaccines**	3,818,235	0	3,560,700	0	0	257,535	0	0
Injection supplies (both AD syringes and syringes other than ADs)	248,980	0	0	248,980	0	0	0	0
Cold Chain equipment	1,636,628	0	0	1,636,628	0	0	0	0
Personnel	2,598,600	0	0	2,524,980	73,620	0	0	0
Other routine recurrent costs	0	0	0	0	0	0	0	0
Other Capital Costs	135,000	0	0	0	0	135,000	0	0
Campaigns costs	23,691,107	0	0	11,407,581	12,283,526	0	0	0

CHD and measles outbreak		0	0	847,286	3,250,000	0	0	0
Total Expenditures for Immunisation	32,859,310							
Total Government Health		0	3,560,700	17,396,215	15,607,146	392,535	0	0

Traditional vaccines: BCG, DTP, OPV, Measles 1st dose (or the combined MR, MMR), TT. Some countries will also include HepB and Hib vaccines in this row, if these vaccines were introduced without GAVI support

5.4. Interagency Coordinating Committee (ICC)

How many times did the ICC meet in 2014? **0**

Please attach the minutes **(Document nº 4)** from the ICC meeting in 2015 endorsing this report.

List the key concerns or recommendations, if any, made by the ICC on sections 5.1 Updated baseline and annual targets to 5.3 Overall Expenditures and Financing for Immunisation

Are any Civil Society Organisations members of the ICC? **No**

If Yes, which ones?

List CSO member organisations:

5.5. Priority actions in 2015 to 2016

What are the country's main objectives and priority actions for its EPI programme for 2015 to 2016

Routine immunization delivery and systems strengthening have been identified as main priorities Global Vaccine Action Plan (GVAP), the overall strategy in global immunization. Not everything can be done at the same time. Prioritization is needed with time-bound dates. Because coverage in Somalia is very low we need to focus on immunization infrastructure and systems development and on operationalizing the programme. However, other coverage and disease elimination targets need to be considered. The points herewith below are part of the key priorities for 2015:

1. Sustaining the polio free status. The country will prioritize implementation of the TAG recommendations for sustaining the gains made in the wild polio virus outbreak response. Key among the recommendations are:

a. Conducting at least three rounds of nationwide OPV SIAs

b. Implement two rounds of OPV sub-national immunization days

c. Investments and activities for maintaining certification standards surveillance system for Acute Flaccid Paralysis (AFP)

2. Strengthening immunization system using polio assets and other prevalent opportunities (GAVI HSS and JHNP/EPHS) and manage the program through:

a. Implementation of Immunization Policy and practice standards

b. Build a functional EPI management structure, improving planning and management skills

c. Ensuring effective coordination and accountability framework

d. Expanding and maintaining a functional cold chain and vaccine supply system

e. Efficient use of available resources and mobilization of additional resources

3. Using IPV introduction to strengthen routine immunization and Polio eradication in Somalia. The country, with support from UNICEF and WHO successfully applied for a GAVI grant for the introduction of inactivated Polio Vaccine (IPV) into its routine immunization program

4. Maximize reach and mobilize people to use available vaccination services by implementing strategic communication for development initiatives at national and Zonal levels .

5. Build synergies of Routine Immunization, Polio and new vaccine introduction activities

6. Meet global and regional elimination targets for measles and neonatal tetanus.

5.6. Progress of transition plan for injection safety

For all countries, please report on progress of transition plan for injection safety

Please report what types of syringes are used and the funding sources of Injection Safety material in 2014

Vaccine	Types of syringe used in 2014 routine EPI	Funding sources of 2014
BCG	AD syringes for BCG	Funded by UNICEF
Measles	AD syringes	Funded by UNICEF
TT	AD syringes	Funded by UNICEF
DTP-containing vaccine	AD syringes	Funded by UNICEF
IPV		

Does the country have an injection safety policy/plan? **No**

If Yes: Have you encountered any obstacles during the implementation of this injection safety policy/plan?

If No: When will the country develop the injection safety policy/plan? (Please report in box below)

Immunization safety standards is one of the key priorities for translation of the the newly developed national EPI policy into practice. Therefore, implementation of EPI policy will among others include development and implementation of injection safety plan of action and guidance notes for vaccination program staff.

Please explain in 2014 how sharps waste is being disposed of, problems encountered, etc.

All sharp wastes are collected in safety boxes, and later on incinerated and buried.

6. Immunisation Services Support (ISS)

6.1. Report on the use of ISS funds in 2014

Somalia is not reporting on Immunisation Services Support (ISS) fund utilisation in 2014

6.2. Detailed expenditure of ISS funds during the 2014 calendar year

Somalia is not reporting on Immunisation Services Support (ISS) fund utilisation in 2014

6.3. Request for ISS reward

Request for ISS reward achievement in Somalia is not applicable for 2014

7. New and Under-used Vaccines Support (NVS)

7.1. Receipt of new & under-used vaccines for 2014 vaccine programme

7.1.1. Did you receive the approved amount of vaccine doses for 2014 Immunisation Programme that GAVI communicated to you in its Decision Letter (DL)? Fill-in table below

Table 7.1: Vaccines received for 2014 vaccinations against approvals for 2014

Please also include any deliveries from the previous year received against this Decision Letter

	[A]	[B]	[C]	
Vaccine type	**Total doses for 2014 in Decision Letter**	**Total doses received by 31 December 2014**	**Total doses postponed from previous years and received in 2014**	**Did the country experience any stockouts at any level in 2014?**
DTP-HepB-Hib	1,344,300	1,344,300	0	No

If values in [A] and [B] are different, specify:

- What are the main problems encountered? (Lower vaccine utilisation than anticipated due to delayed new vaccine introduction or lower coverage? Delay in shipments? Stock-outs? Excessive stocks? Problems with cold chain? Doses discarded because VVM changed colour or because of the expiry date? ...)

  The program noted that there is low coverage for the vaccines utilized in the completed and reporting period. Due to a weak and/or dysfunctional health management information systems, the program was unable to document completeness of the reported immunizations. Specifically challenging are the following:

  1) Immunization services delivery in Somalia is done largely by NGOs (Local and international). With weak/no structure for health services management, there is no coherent structure that organizes and manages the reported immunizations in the country. The reporting of immunization outputs is done by the NGOs to their donors and the data on immunization outputs reported is only that accessed and shared with UNICEF and WHO.

  2) There is no formal vaccine utilization monitoring reporting system to record, report and monitor vaccine wastage in Somalia. In turn, there is no record of vaccines lost due to expiry, change of VVM, loss of labels or partial use.

  3) Limited access to health facilities to mentor and monitor vaccine utilization practices. Although large parts of the country is been liberated and therefore major towns can be accessed by air, its not possible to have access to the maternal and child health clinics in the rural areas where the most of the vaccines utilization and/or wastage takes place.

- What actions have you taken to improve the vaccine management, e.g. such as adjusting the plan for vaccine shipments? (in the country and with UNICEF Supply Division)

  GAVI would also appreciate feedback from countries on feasibility and interest of selecting and being shipped multiple Pentavalent vaccine presentations (1 dose and 10 dose vials) so as to optimise wastage, coverage and cost.

The country is rolling out the implementation of the EVM improvement plan as the single most important approach to ameliorating the vaccine supply and utilization challenges. However, given the geo-political context of Somalia, its the opinion of the program that GAVI and UNICEF supply division does not consider shipment of multiple pentavalent vaccine presentations. The immunization system is weak, health workers used in management of the vaccine chain are not easily trained or reachable for briefing on different presentation and the limited access the program has would better be used for strengthening services delivery.

If **Yes** for any vaccine in **Table 7.1**, please describe the duration, reason and impact of stock-out, including if the stock-out was at the central, regional, district or at lower facility level.

7.2. Introduction of a New Vaccine in 2014

7.2.1. If you have been approved by GAVI to introduce a new vaccine in 2014, please refer to the vaccine introduction plan in the proposal approved and report on achievements:

DTP-HepB-Hib, 10 dose(s) per vial, LIQUID		
Nationwide introduction	No	
Phased introduction	No	
The time and scale of introduction was as planned in the proposal? If No, Why ?	No	DTP-HepB-Hib was introduced in 2013 and nothing to report for 2014

When is the Post Introduction Evaluation (PIE) planned? **September 2015**

7.2.2. If your country conducted a PIE in the past two years, please attach relevant reports and provide a summary on the status of implementation of the recommendations following the PIE. (Document N° 9))

Somalia introduced Pentavalent vaccine in 2013 but did not conduct a post introduction evaluation. A post introduction evaluation was planned in the 2nd quarter of 2015 (May/June) but did not take place due to under-funding of the one-EPI plan of action.

7.2.3. Adverse Event Following Immunization (AEFI)

Is there a national dedicated vaccine pharmacovigilance capacity? **No**

Is there a national AEFI expert review committee? **No**

Does the country have an institutional development plan for vaccine safety? **No**

Is the country sharing its vaccine safety data with other countries? **No**

Does your country have a risk communication strategy with preparedness plans to address vaccine crises? **No**

7.2.4. Surveillance

Does your country conduct sentinel surveillance for:

a. rotavirus diarrhea? **No**

b. pediatric bacterial meningitis or pneumococcal or meningococcal disease? **No**

Does your country conduct special studies around:

a. rotavirus diarrhea? **No**

b. pediatric bacterial meningitis or pneumococcal or meningococcal disease? **No**

If so, does the National Immunization Technical Advisory Group (NITAG) or the Inter-Agency Coordinating Committee (ICC) regularly review the sentinel surveillance and special studies data to provide recommendations on the data generated and how to further improve data quality? **No**

Do you plan to use these sentinel surveillance and/or special studies data to monitor and evaluate the impact of vaccine introduction and use? **No**

Please describe the results of surveillance/special studies and inputs of the NITAG/ICC:

7.3. New Vaccine Introduction Grant lump sums 2014

7.3.1. Financial Management Reporting

	Amount US$	Amount local currency

Funds received during 2014 (A)	0	0
Remaining funds (carry over) from 2013 (B)	0	0
Total funds available in 2014 (C=A+B)	0	0
Total Expenditures in 2014 (D)	0	0
Balance carried over to 2015 (E=C-D)	0	0

Detailed expenditure of New Vaccines Introduction Grant funds during the 2014 calendar year

Please attach a detailed financial statement for the use of New Vaccines Introduction Grant funds in the 2014 calendar year (Document No 10,11) . Terms of reference for this financial statement are available in **Annexe 1** Financial statements should be signed by the Finance Manager of the EPI Program and and the EPI Manager, or by the Permanent Secretary of Ministry of Health

7.3.2. Programmatic Reporting

Please report on major activities that have been undertaken in relation to the introduction of a new vaccine, using the GAVI New Vaccine Introduction Grant

None in 2014

Please describe any problem encountered and solutions in the implementation of the planned activities

Not Applicable

Please describe the activities that will be undertaken with any remaining balance of funds for 2015 onwards

Not applicable

7.4. Report on country co-financing in 2014

Table 7.4 : Five questions on country co-financing

	Q.1: What were the actual co-financed amounts and doses in 2014?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
Awarded Vaccine #1: DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	257,535	131,300
	Q.2: Which were the amounts of funding for country co-financing in reporting year 2014 from the following sources?	
Government	0	
Donor	257535	
Other	0	
	Q.3: Did you procure related injections supplies for the co-financing vaccines? What were the amounts in US$ and supplies?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
Awarded Vaccine #1: DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	0	0
	Q.4: When do you intend to transfer funds for co-financing in 2016 and what is the expected source of this funding	
Schedule of Co-Financing Payments	Proposed Payment Date for 2016	Source of funding
Awarded Vaccine #1: DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	April	Joint Health and Nutrition Program for Somalia
	Q.5: Please state any Technical Assistance needs for developing financial sustainability strategies, mobilising funding for immunization, including for co-financing	

	Development of an immunization financial sustainability plan

*__Note:__ co-financing is not mandatory for IPV

Is support from GAVI, in form of new and under-used vaccines and injection supplies, reported in the national health sector budget? **Yes**

7.5. Vaccine Management (EVSM/VMA/EVM)

Please note that Effective Vaccine Store Management (EVSM) and Vaccine Management Assessment(VMA) tools have been replaced by an integrated Effective Vaccine Management (EVM) tool. The information on EVM tool can be found at http://www.who.int/immunization/programmes_systems/supply_chain/evm/en/index3.html

It is mandatory for the countries to conduct an EVM prior to an application for introduction of a new vaccine. This assessment concludes with an Improvement Plan including activities and timelines whose progress report is reported with annual report. The EVM assessment is valid for a period of three years.

When was the latest Effective Vaccine Management (EVM) or an alternative assessment (EVSM/VMA) carried out? **June 2013**

Please attach:

(a) EVM assessment **(Document No 12)**

(b) Improvement plan after EVM **(Document No 13)**

(c) Progress report on the activities implemented during the year and status of implementation of recommendations from the Improvement Plan **(Document No 14)**

Progress report on EVM/VMA/EVSM Improvement Plan' is a mandatory requirement

Are there any changes in the Improvement plan, with reasons? **No**

If yes, provide details

When is the next Effective Vaccine Management (EVM) assessment planned? **June 2016**

7.6. Monitoring GAVI Support for Preventive Campaigns in 2014

Somalia does not report on NVS Preventive campaign

7.7. Change of vaccine presentation

Somalia does not require to change any of the vaccine presentation(s) for future years.

7.8. Renewal of multi-year vaccines support for those countries whose current support is ending in 2015

If 2015 is the last year of approved multiyear support for a certain vaccine and the country wishes to extend GAVI support, the country should request for an extension of the co-financing agreement with GAVI for vaccine support starting from 2016 and for the duration of a new Comprehensive Multi-Year Plan (cMYP).

The country hereby requests an extension of GAVI support for the years 2016 to 2017 for the following vaccines:

* **DTP-HepB-Hib, 10 dose(s) per vial, LIQUID**

At the same time it commits itself to co-finance the procurement of the following vaccines in accordance with the minimum Gavi co-financing levels as summarised in section 7.11 Calculation of requirements.

* **DTP-HepB-Hib, 10 dose(s) per vial, LIQUID**

The multi-year support extension is in line with the new cMYP for the years 2016 to 2017, which is attached to this APR (Document N°**16**). The new costing tool is also attached (Document N°**17**) for the following vaccines:

* **DTP-HepB-Hib, 10 dose(s) per vial, LIQUID**

The country ICC has endorsed this request for extended support of the following vaccines at the ICC meeting whose minutes are attached to this APR. (Document N°**18**)

* **DTP-HepB-Hib, 10 dose(s) per vial, LIQUID**

7.9. Request for continued support for vaccines for 2016 vaccination programme

In order to request NVS support for 2016 vaccination do the following

Confirm here below that your request for 2016 vaccines support is as per 7.11 Calculation of requirements
Yes

If you don't confirm, please explain

7.10. Weighted average prices of supply and related freight cost

Table 7.10.1: Commodities Cost

Estimated prices of supply are not disclosed

Table 7.10.2: Freight Cost

Vaccine Antigen	Vaccine Type	2013	2014	2015	2016	2017
DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	DTP-HepB-Hib, 10 dose(s) per vial, LIQUID		3.40 %	4.30 %	3.60 %	4.40 %

7.11. Calculation of requirements

Table 7.11.1: Specifications for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID

ID		Source		2014	2015	2016	2017	TOTAL
	Number of surviving infants	Parameter	#	348,888	359,355	447,384	460,807	1,616,434
	Number of children to be vaccinated with the first dose	Parameter	#	327,955	279,110	345,707	356,078	1,308,850
	Number of children to be vaccinated with the third dose	Parameter	#	262,363	244,222	304,222	313,348	1,124,155
	Immunisation coverage with the third dose	Parameter	%	75.20 %	67.96 %	68.00 %	68.00 %	
	Number of doses per child	Parameter	#	3	3	3	3	
	Estimated vaccine wastage factor	Parameter	#	1.33	1.33	1.33	1.33	
	Stock in Central Store Dec 31, 2014		#	52,720				
	Stock across second level Dec 31, 2014 (if available)*		#	0				
	Stock across third level Dec 31, 2014 (if available)*	Parameter	#	0				
	Number of doses per vial	Parameter	#		10	10	10	
	AD syringes required	Parameter	#		Yes	Yes	Yes	
	Reconstitution syringes required	Parameter	#		No	No	No	
	Safety boxes required	Parameter	#		Yes	Yes	Yes	
cc	**Country co-financing per dose**	Parameter	$		0.20	0.20	0.20	
ca	**AD syringe price per unit**	Parameter	$		0.0448	0.0448	0.0448	
cr	**Reconstitution syringe price per unit**	Parameter	$		0	0	0	
cs	**Safety box price per unit**	Parameter	$		0.0054	0.0054	0.0054	
fv	**Freight cost as % of vaccines value**	Parameter	%		4.30 %	3.60 %	4.40 %	

* Please describe the method used for stock count in the text box below. We assume the closing stock (Dec 31, 2014) is the same as the opening stock (Jan 1, {1}). If there is a difference, please provide details in the text box below.

For pentavalent vaccines, GAVI applies a benchmark of 4.5 months of buffer + operational stocks. Countries should state their buffer + operational stock requirements when different from the benchmark up to a maximum of 6 months. For support on how to calculate the buffer and operational stock levels, please contact WHO or UNICEF. By default, a buffer + operational stock of 4.5 months is pre-selected.

Not defined

Co-financing tables for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID

Co-financing group	Low

	2014	2015	2016	2017
Minimum co-financing	0.20	0.20	0.20	0.20
Recommended co-financing as per			0.20	0.20
Your co-financing	0.20	0.20	0.20	0.20

Table 7.11.2: Estimated GAVI support and country co-financing (**GAVI support**)

		2014	2015	2016	2017
Number of vaccine doses	#	1,213,000	1,062,000	1,433,500	1,605,100
Number of AD syringes	#	1,121,600	1,011,200	1,411,000	1,661,800
Number of re-constitution syringes	#	0	0	0	0
Number of safety boxes	#	12,450	11,125	17,675	20,300
Total value to be co-financed by GAVI	$	2,550,500	2,190,500	2,725,500	2,547,000

Table 7.11.3: Estimated GAVI support and country co-financing (**Country support**)

		2014	2015	2016	2017
Number of vaccine doses	#	131,300	117,500	172,600	238,500
Number of AD syringes	#	0	0	0	0
Number of re-constitution syringes	#	0	0	0	0
Number of safety boxes	#	0	0	0	0
Total value to be co-financed by the Country ***[1]***	$	269,000	236,000	328,500	378,500

Table 7.11.4: Calculation of requirements for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID (part 1)

		Formula	2014	2015		
				Total	Government	GAVI
A	**Country co-finance**	*V*				
B	**Number of children to be vaccinated with the first dose**	*Table 4*	327,955	279,110		
B 1	**Number of children to be vaccinated with the third dose**	*Table 4*	262,363	279,110		
C	**Number of doses per child**	*Vaccine parameter (schedule)*	3	3		
D	**Number of doses needed**	*B + B1 + Target for the 2nd dose ((B -0.41 x (B - B1))*	891,381	788,138		
E	**Estimated vaccine wastage factor**	*Table 4*	1.33	1.33		
F	**Number of doses needed including wastage**	*D x E*		1,048,224		
G	**Vaccines buffer stock**	***Buffer on doses needed*** *+* ***buffer on doses wasted*** ***Buffer on doses needed*** *= (D - D of previous year original approved) x 0.375* ***Buffer on doses wasted*** *=* • *if(wastage factor of previous year current estimation < wastage factor of previous year original approved): ((F - D) - ((F - D) of previous year original approved - (F - D) of previous year current estimation)) x 0.375* • *else: (F - D - ((F - D) of previous year original approved)) x 0.375 >= 0*				
H	**Stock to be deducted**	*H1 - (F (2015) current estimation x 0.375)*				
H 1	**Calculated opening stock**	*H2 (2015) + H3 (2015) - F (2015)*				
H 2	**Reported stock on January 1st**	*Table 7.11.1*	0	52,720		
H 3	**Shipment plan**	*Approved volume*		1,179,500		
I	**Total vaccine doses needed**	*Round up((F + G - H) / vaccine package size) x vaccine package size*		1,179,500		
J	**Number of doses per vial**	*Vaccine Parameter*				
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) x 1.10*				
L	**Reconstitution syringes (+ 10% wastage) needed**	*(I / J) x 1.10*				
M	**Total of safety boxes (+ 10% of extra need) needed**	*(I / 100) x 1.10*				
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*				
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*				
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*				
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*				
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*				
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*				
T	**Total fund needed**	*(N+O+P+Q+R+S)*				
U	**Total country co-financing**	*I x country co-financing per dose (cc)*				
V	**Country co-financing % of GAVI supported proportion**	*U / (N + R)*				

Given that the shipment plan of 2014 is not yet available, the volume approved for 2014 is used as our best proxy of 2014 shipment. The information would be updated when the shipment plan will become available.

Table 7.11.4: Calculation of requirements for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID (part 2)

		Formula	2016		
			Total	Government	GAVI
A	Country co-finance	*V*	10.74 %		
B	Number of children to be vaccinated with the first dose	*Table 4*	345,707	37,140	308,567
B 1	Number of children to be vaccinated with the third dose	*Table 4*	304,222	32,683	271,539
C	Number of doses per child	*Vaccine parameter (schedule)*	3		
D	Number of doses needed	*B + B1 + Target for the 2nd dose ((B -0.41 x (B - B1))*	978,628	105,134	873,494
E	Estimated vaccine wastage factor	*Table 4*	1.33		
F	Number of doses needed including wastage	*D X E*	1,301,575	139,828	1,161,747
G	Vaccines buffer stock	***Buffer on doses needed*** + ***buffer on doses wasted*** ***Buffer on doses needed*** = *(D - D of previous year original approved) x 0.375* ***Buffer on doses wasted*** = • *if(wastage factor of previous year current estimation < wastage factor of previous year original approved): ((F - D) - ((F - D) of previous year original approved - (F - D) of previous year current estimation)) x 0.375* • *else: (F - D - ((F - D) of previous year original approved)) x 0.375 >= 0*	95,007	10,207	84,800
H	Stock to be deducted	*H1 - (F (2015) current estimation x 0.375)*	- 209,086	- 22,461	- 186,625
H 1	Calculated opening stock	*H2 (2015) + H3 (2015) - F (2015)*	183,997	19,767	164,230
H 2	Reported stock on January 1st	*Table 7.11.1*			
H 3	Shipment plan	*Approved volume*			
I	Total vaccine doses needed	*Round up((F + G - H) / vaccine package size) x vaccine package size*	1,606,000	172,532	1,433,468
J	Number of doses per vial	*Vaccine Parameter*	10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) x 1.10*	1,410,994	0	1,410,994
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(I / 100) x 1.10*	17,666	0	17,666
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	2,885,982	310,039	2,575,943
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	63,213	0	63,213
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	97	0	97
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	103,896	11,162	92,734
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0
T	Total fund needed	*(N+O+P+Q+R+S)*	3,053,188	328,002	2,725,186
U	Total country co-financing	*I x country co-financing per dose (cc)*	321,200		
V	Country co-financing % of GAVI supported proportion	*U / (N + R)*	10.74 %		

Given that the shipment plan of 2014 is not yet available, the volume approved for 2014 is used as our best proxy of 2014 shipment. The information would be updated when the shipment plan will become available.

Table 7.11.4: Calculation of requirements for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID (part 3)

		Formula	2017		
			Total	Government	GAVI
A	Country co-finance	*V*	12.94 %		
B	Number of children to be vaccinated with the first dose	*Table 4*	356,078	46,060	310,018
B 1	Number of children to be vaccinated with the third dose	*Table 4*	313,348	40,533	272,815
C	Number of doses per child	*Vaccine parameter (schedule)*	3		
D	Number of doses needed	*B + B1 + Target for the 2nd dose ((B -0.41 x (B - B1))*	1,007,985	130,386	877,599
E	Estimated vaccine wastage factor	*Table 4*	1.33		
F	Number of doses needed including wastage	*D X E*	1,340,620	173,413	1,167,207
G	Vaccines buffer stock	***Buffer on doses needed*** + ***buffer on doses wasted*** ***Buffer on doses needed*** = *(D - D of previous year original approved) x 0.375* ***Buffer on doses wasted*** = • *if(wastage factor of previous year current estimation < wastage factor of previous year original approved): ((F - D) - ((F - D) of previous year original approved - (F - D) of previous year current estimation)) x 0.375* • *else: (F - D - ((F - D) of previous year original approved)) x 0.375 >= 0*	502,733	65,030	437,703
H	Stock to be deducted	*H1 - (F (2015) current estimation x 0.375)*			
H 1	Calculated opening stock	*H2 (2015) + H3 (2015) - F (2015)*			
H 2	Reported stock on January 1st	*Table 7.11.1*			
H 3	Shipment plan	*Approved volume*			
I	Total vaccine doses needed	*Round up((F + G - H) / vaccine package size) x vaccine package size*	1,843,500	238,462	1,605,038
J	Number of doses per vial	*Vaccine Parameter*	10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) x 1.10*	1,661,790	0	1,661,790
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(I / 100) x 1.10*	20,279	0	20,279
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	2,730,224	353,161	2,377,063
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	74,449	0	74,449
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	111	0	111
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	120,130	15,540	104,590
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0
T	Total fund needed	*(N+O+P+Q+R+S)*	2,924,914	378,345	2,546,569
U	Total country co-financing	*I x country co-financing per dose (cc)*	368,700		
V	Country co-financing % of GAVI supported proportion	*U / (N + R)*	12.94 %		

Given that the shipment plan of 2014 is not yet available, the volume approved for 2014 is used as our best proxy of 2014 shipment. The information would be updated when the shipment plan will become available.

8. Health Systems Strengthening Support (HSS)

Instructions for reporting on HSS funds received

1. Please complete this section only if your country **was approved for and received HSS funds before or during January to December 2014**. All countries are expected to report on:

   a. Progress achieved in 2014

   b. HSS implementation during January – April 2015 (interim reporting)

   c. Plans for 2016

   d. Proposed changes to approved activities and budget (see No. 4 below)

For countries that received HSS funds within the last 3 months of 2014, or experienced other delays that limited implementation in 2014, this section can be used as an inception report to comment on start up activities.

2. In order to better align HSS support reporting to country processes, for countries of which the 2014 fiscal year starts in January 2014 and ends in December 2014, HSS reports should be received by the GAVI Alliance before **15th May 2015**. For other countries, HSS reports should be received by the GAVI Alliance approximately six months after the end of country fiscal year, e.g., if the country fiscal year ends in March 2015, the HSS reports are expected by GAVI Alliance by September 2015.

3. Please use your approved proposal as reference to fill in this Annual Progress Report. Please fill in this reporting template thoroughly and accurately and use additional space as necessary.

4. If you are proposing changes to approved objectives, activities and budget (reprogramming) please request the reprogramming guidelines by contacting your Country Responsible Officer at GAVI or by emailing gavihss@gavi.org.

5. If you are requesting a new tranche of funding, please make this clear in Section 8.1.2.

6. Please ensure that, **prior to its submission to the GAVI Alliance Secretariat, this report has been endorsed by the relevant country coordination mechanisms** (HSCC or equivalent) as provided for on the signature page in terms of its accuracy and validity of facts, figures and sources used.

7. Please attach all required supporting documents. These include:

   a. Minutes of all the HSCC meetings held in 2014

   b. Minutes of the HSCC meeting in 2015 that endorses the submission of this report

   c. Latest Health Sector Review Report

   d. Financial statement for the use of HSS funds in the 2014 calendar year

   e. External audit report for HSS funds during the most recent fiscal year (if available)

8. The GAVI Alliance Independent Review Committee (IRC) reviews all Annual Progress Reports. In addition to the information listed above, the IRC requires the following information to be included in this section in order to approve further tranches of HSS funding:

   a. Reporting on agreed indicators, as outlined in the approved M&E framework, proposal and approval letter;

   b. Demonstration of (with tangible evidence) strong links between activities, output, outcome and impact indicators;

   c. Outline of technical support that may be required to either support the implementation or monitoring of the GAVI HSS investment in the coming year

8. Inaccurate, incomplete or unsubstantiated reporting may lead the IRC to either send the APR back to your country for clarifications (which may cause delays in the release of further HSS funds), to recommend against the release of further HSS funds or only approve part of the next tranche of HSS funds.

8.1. Report on the use of HSS funds in 2014 and request of a new tranche

Please provide data sources for all data used in this report.

8.1.1. Report on the use of HSS funds in **2014**

Please complete Table 8.1.3.a and 8.1.3.b (as per APR) for each year of your country's approved multi-year HSS programme and both in US$ and local currency

Please note: If you are requesting a new tranche of funding, please make sure you fill in the last row of Table 8.1.3.a and 8.1.3.b.

8.1.2. Please indicate if you are requesting a new tranche of funding **No**

If yes, please indicate the amount of funding requested: US$

These funds should be sufficient to carry out HSS grant implementation through December 2016.

Table 8.1.3a (US)$

	2009	2010	2011	2012	2013	2014
Original annual budgets (*as per the originally approved HSS proposal*)	0	0	2786791	2476727	2222902	2017222
Revised annual budgets (*if revised by previous Annual Progress Reviews*)			48150	1019474	2839438	3899631
Total funds received from GAVI during the calendar year (*A*)			2786791	2470387	0	2549515
Remaining funds (carry over) from previous year (*B*)				3257258	2382731	2364627
Total Funds available during the calendar year (*C=A+B*)			2786791	5727645	2382731	4914142
Total expenditure during the calendar year (*D*)			7758	1412524	1461831	2227187
Balance carried forward to next calendar year (*E=C-D*)			2779033	4315121	920900	1729873
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	0	2786791	2786791	2470387	0	2549515

	2015	2016	2017	2018
Original annual budgets (*as per the originally approved HSS proposal*)	2040538	0		
Revised annual budgets (*if revised by previous Annual Progress Reviews*)	3738808	0		
Total funds received from GAVI during the calendar year (*A*)	3738808			
Remaining funds (carry over) from previous year (*B*)	3664505			
Total Funds available during the calendar year (*C=A+B*)	7403313			
Total expenditure during the calendar year (*D*)	2090314			
Balance carried forward to next calendar year (*E=C-D*)	5312999			
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	0	0	0	0

Table 8.1.3b (Local currency)

	2009	2010	2011	2012	2013	2014
Original annual budgets (*as per the originally approved HSS proposal*)	0	0	0	0	0	0
Revised annual budgets (*if revised by previous Annual Progress Reviews*)	0	0	0	0	0	0
Total funds received from GAVI during the calendar year (*A*)	0	0	0	0	0	0
Remaining funds (carry over) from previous year (*B*)	0	0	0	0	0	0
Total Funds available during the calendar year (*C=A+B*)	0	0	0	0	0	0
Total expenditure during the calendar year (*D*)	0	0	0	0	0	0
Balance carried forward to next calendar year (*E=C-D*)	0	0	0	0	0	0
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	0	0	0	0	0	0

	2015	2016	2017	2018
Original annual budgets (*as per the originally approved HSS proposal*)	0	0	0	0
Revised annual budgets (*if revised by previous Annual Progress Reviews*)	0	0	0	0
Total funds received from GAVI during the calendar year (*A*)	0	0	0	0
Remaining funds (carry over) from previous year (*B*)	0	0	0	0
Total Funds available during the calendar year (*C=A+B*)	0	0	0	0
Total expenditure during the calendar year (*D*)	0	0	0	0
Balance carried forward to next calendar year (*E=C-D*)	0	0	0	0
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	0	0	0	0

Report of Exchange Rate Fluctuation

Please indicate in the table Table 8.3.c below the exchange rate used for each calendar year at opening and closing.

Table 8.1.3.c

Exchange Rate	2009	2010	2011	2012	2013	2014
Opening on 1 January						
Closing on 31 December						

Detailed expenditure of HSS funds during the 2014 calendar year

Please attach a detailed financial statement for the use of HSS funds during the 2014 calendar year *(Terms of reference for this financial statement are attached in the online APR Annexes)*. Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health. **(Document Number: 19)**

If any expenditures for the January April 2015 period are reported in Tables 8.1.3a and 8.1.3b, a separate, detailed financial statement for the use of these HSS funds must also be attached **(Document Number: 20)**

Has an external audit been conducted? No

External audit reports for HSS programmes are due to the GAVI Secretariat six months following the close of your governments fiscal year. If an external audit report is available during your governments most recent fiscal year, this must also be attached (Document Number: 21)

8.2. Progress on HSS activities in the 2014 fiscal year

Please report on major activities conducted to strengthen immunisation using HSS funds in Table 8.2. It is very important to be precise about the extent of progress and use the M&E framework in your original application and approval letter.

Please provide the following information for each planned activity:

- The percentage of activity completed where applicable
- An explanation about progress achieved and constraints, if any
- The source of information/data if relevant.

Table 8.2: HSS activities in the 2014 reporting year

Major Activities (insert as many rows as necessary)	**Planned Activity for 2014**	**Percentage of Activity completed (annual)** (where applicable)	**Source of information/data** (if relevant)
1.1.Develop list of priority health facilities and conduct survey to identify gaps in 40 MCH centres	Completed in 2014/15	100	UNICEF/WHO report
1.2.: Rehabilitation of selected MCH centers	Completed in 2014/15	100	UNICEF reports Partners reports MoH certification documents
1.3. Procurement and supply of essential medicines and equipment for MCH services (based on gaps)	ongoing	100	UNICEF reports Waybills Health facilities reports
1.4. Provide comprehensive support for BEMONC in selected MCH centres (3)	ongoing	75	UNICEF reports Partners reports MoH Meeting minutes
1.5. Development / adapt curriculum for training of MCH and EPI staff in supervision, outreach and HMIS	Q4	60	Supervision tools for MCH facilities and HPs;
1.6. Conduct training of MCH and EPI staff (in 40 MCH centres) communities	started in Q4; repetetive activity	60	Training Reports;
1.7. Develop curriculum for training of all MCH staff in EPI injection safety and vaccine management	Implemented in Q4: EPI manual adapted	100	EPI training manual;
1.8. Training of MCH centre staff (EPI, injection safety and vaccine management)	Completed Q1 in 2014	100	Training Reports;
1.9. Renovation of cold chain equipment in all MCH centres		100	UNICEF reports Partners reports Cold chain technician field visit reports
1.10. Develop a system of regular EPI outreach from MCH centres to the catchment areas of health posts and FHWs	started in Q4	30	Under process; training and micro-planning in preparation; be completed in Q2/2015
1.11. Develop a system for regular supervision for MCH centres from regional and zonal MOH	started in Q3	30	Supervision tools, supervisory visits reports
1.12. Provide transport support to MOH for supervision of regional offices, facilities and communities	Ongoing	100	Technical / financial report Direct Financial Contribution (DFC, MoH) or Direct Implementation report (WHO

1.13. Provide transport support to regional managers for supervision of MCH centres	Ongoing	100	see above
1.14. Provide incentives for EPI outreach and RH staff at MCH centres	ongoing	100	Technical and financial reports
1.15. Provide incentives for MoH HSS focal points	Ongoing	100	see above
2.7. Develop and implement a system of supportive supervision for LHWs and outreach activities	Q3/4	70	Monthly supervisors' report produced by LHWs supervisors; Outreach activities (carried out by health facility staff have not started yet
2.8. Develop and implement a community based HMIS	Q3/4	100	Monthly LHWs reports
2.9. Printing and distribution of HMIS tools	Q3/4	100	HIS forms
2.10. Procure and distribute/resupply FCHW kits	Q3/4	80	Avalibility of kits
2.11. Procure and distribute/re-supply medicines for Health posts (50%)	Q3/4	100	UNICEF reports Way bills Partners reports MoH supervision reports
2.13. Provide incentives to CHWs	as of Q1	100	DFC reports
2.14. Provide incentives to LHWs	as of Q1`	100	DFC (technical and financial reports)
3.1. Formative research to identify key maternal and child caring behaviors and barriers		100	Formative Research Report
3.2. Develop five year strategic		100	Zone C4D strategy
3.3. Develop print, audio-visual and IPC package for health workers	on-going	80	IPC video for Health Workers Community grain sack for LCHWs
3.4. Develop and broadcast radio programme on key child caring and health practices;		100	Activity reports from zones
3.5. Identify three strong communication NGOs to build capacity of existing NGOs and to scale up public awareness at community level	on-going	30	Implementing partners' reports
3.6. Strengthen and establishing structured/systematized partnership with religious leaders, religious organizations, clan leaders, community elders and networks		100	Implementing partners' reports
3.7. Work with school structures to increase dialogue on key child survival and development messages		100	Implementing partners' reports

3.8. Develop community friendly materials (discussion guides etc) with key iCCM messages for LCHWs, CHWs, TBAs for home based family promotion	Ongoing	80	Sample of materials available
3.9. Partner with m-health videos to remind on key child survival messages	Partially implemented	45	Reprogrammed to be implemented in 2015. Funding was inadequate.
4.2. Establish and support operational research committee	completed in Q1/2015	75	Terms of Reference, list of members
4.1. Conduct baseline and end-line surveys	Conducted	50	
4.2. Establish and support operational research committee	completed in Q1/2015	75	Terms of Reference, list of members
4.3. Commission operational research studies	Not started	0	Priority for 2015/2016 (request for no cost extension)
4.4. Conduct focus groups for operational research	Completed	100	This was incorporated in the KAP study.
4.5. Support data analysis and use	Partial implementation	10	HIS training of facility staff but scale mot yet reflecting national character
4.6. Training of MoH managers in operational research	Not started	0	
4.8. Technical Assistance for Operational Research	Not started	0	
Management costs (e.g. travel)	on-going		Financial / technical reports
M&E support costs - UNICEF	on-going		
Technical Support - WHO	on-going		Technical reports
Technical Support - UNICEF	on-going		

8.2.1 For each objective and activity (i.e. Objective 1, Activity 1.1, Activity 1.2, etc.), explain the progress achieved and relevant constraints (e.g. evaluations, HSCC meetings).

Major Activities (insert as many rows as necessary)	**Explain progress achieved and relevant constraints**

Activity 1.1. (WHO)	All facilities have been re-assessed in 2014 on their service delivery: (detailed reports in annex). Number of facilities supported by the grant: SL: 13 MCHs; 28 HPs; PL: 12 MCHs; 24 HPs; SC: 15 MCH; 0 HPs; Key findings (general): • Non-existence of a referral system; low immunization coverage; very low ANC 3rd + visits coverage (estimated 10%); • Low utilization of services; • High dropout rate (>10%) and wastage rate; vaccinators not familiar with details to fill monitoring charts; • Frequent stock out of supplies; • No outreach activities; • Only 50% of facilities provide MCH AND EPI services; • Lack of registration of health workers except in Somaliland; • Absence of treatment protocols; • Most of selected 40 MCH facilities do not have other support than from GAVI which is insufficient to provide essential services; South Central: Galgadud Region: out of the 3 supported MCH centres: Godinlabe MCH operational, providing EPI services; Abdudwak MCH operational but no EPI services due to lack of cold chain; Herale MCH no EPI services; Mudug region; all 3 MCH facilities functional but no immunization services; Benadir Region: 9 MCHs: 1 (Hodan MCH) not operational; has been included into EPHS but is not functioning; district commissioner closed due to lack of supplies; Somaliland: no functioning cold chain in Faraweine MCH; Puntland: 4/12 MCH clinics do not have sufficient space, resulting in non-delivery of essential services such as deliveries; some rooms are not in use due to absence of organizational management among staff and lack of basic equipment; in some cases lack of water; only 10/12 provide EPI services;
Activity 1.2. (UNICEF):	Joint assessments of 40 health facilities (South Central: 15, Somaliland 13, Puntland 12) were conducted in all three Zones, in 2013. Funds have been provided to the three zonal Ministries of Health (MOHs) to undertake the rehabilitation of GAVI-HSS-selected facilities and work is now in progress. GAVI-supported facilities rehabilitation was completed and work was duly certified in the 3 Zones, in 2014.
Activity 1.3. (UNICEF):	UNICEF employed an international medical logistician to support the MoH in the 3 Zones of Somalia to streamline and improve supply chain. Essential medicines and equipment have been procured and are continuing to be supplied to these facilities on a quarterly basis. Ongoing activity throughout the project lifecycle. JHNP resources being leveraged for this activity; no cold chain: SL 3; Mudug 3;.
Activity 1.4. (UNICEF):	The 3 BeMOC Health Facilities have been identified in 2013; however the initial selected facilities were not functioning at all and thus did not have minimum requirement to run as BeMONC, the MoHs in NWZ and NEZ changed the facilities and identified others to be BeMONC (official communication available). In NEZ, medical equipment have already been provided to MoH for BeMONC. JHNP resources are being leveraged for this activity.
Activity 4.1. (UNICEF):	Baseline report shared with relevant stakeholders. (Survey done based on secondary data analysis e.g. HMIS data, desk review of available relevant surveys and related key reports i.e. MICS-2011, MIS, EPHS baseline, formative research report, SC KAP study in Puntland). End line to be conducted through HFA

Activity 4.2. (WHO):	• In SL, a Health Systems Research Unit has been established; members of the Research Committees in Somaliland have been nominated and includes six members from GAVI/HSS partners, chaired by Ministry of Health; the committee has supported the formative research conducted by UNICEF. • In PL, a Health Research Unit has been established; the committee members have been nominated by the MoH; WHO has deployed national experts as part of the Health Systems Analysis Team (HSAT) to Somaliland and Puntland MoH to support the analysis and research function (JHNP funded) in support to decision making processes of the health sector coordination committee; ToRs for research committees have been developed; HSAT will also support the SHAs to identify a prioritized research agenda;
Activity 4.3. (WHO):	Has been reprogrammed for 2015 and will be supported and being implemented in complementarity of the technical assistance provided by the Health Systems Analysis Team (HSAT)
Activity 4.4. (UNICEF):	Conduct focus groups for operational research (refer to activity 3.1.)
Activity 3.9. (UNICEF):	The activity was reprogrammed because of inadequate funds. In 2015 plans have been developed to implement mother reminder messages aimed at increasing knowledge on ANC, skilled birth deliveries and completion of routine immunization.
Activity 3.8. (UNICEF):	In CSZ a health programme has been implemented in 18 schools/madarassas in the GAVI-supported regions. A total of 176 (139 male and 37 female) teachers have been trained on integrated health messages to reach 1135 (480 girls and 655 boys) in the madrassa schools and 3,455 (1,465 girls and 1,990 boys) in public schools. In NWZ a comprehensive mapping of all schools was conducted in preparation for implementation of the programme which will commence in 2015.
Activity 3.7. (UNICEF):	Partnerships have been established with religious leaders to advocate and mobilize communities to take up immunization and MCH services. A total of 165 religious organizations, clan leaders, community elders have been trained and sensitized on integrated messages and will work closely with FCHW to support community mobilization activities.
Activity 3.6. (UNICEF):	Identified three NGOs one per zone: NWZ: SONALDO, NEZ: ANPCCAN and CSZ: WARDI. Implementation on going and reports will be available by June 2015.
Activity 1.5.(WHO):	Supervision visits have been carried out jointly by the programme management team (WHO, UNICEF, MoH zonal, regional and district teams); HIS training has been conducted; plans for establishing outreach activities are being implemented in 2015; training in supervision of outreach activities as well as for conducting supportive supervision will take started in 2015;
Activity 1.6.(WHO):	Existing curricula have been adapted for training purpose of facility staff; since EPHS implementation has been launched, it was decided to develop standard training material for all health workers who implement EPHS and strategize training activities (link to Health Workforce Planning and HR development); However, the strategy for GAVI HSS supported facilities shifted: until today, no standard curriculum for in-service training has been developed; as the Somali Health Authorities are planning to introduce IMCI and had endorsed in September 2013 the IMPAC guidelines, WHO and MoH decided to kick start both approaches at GAVI HSS facilities; • SL: a training workshop was held for 39 MCH staff from 13 GAVI-HSS MCH clinics on MCH services including nutritional screening and antenatal care; • PL: 36 MCH staff and 24 CHWs (health post based) from Bari, Nugal, Sool, Haylan Region on key areas of GAVI HSS;

Activity 1.8. (WHO):	In Somaliland, basic EPI training for 35 vaccinators / nurses from MCH facilities in Maroodijeex Region including 3 District Medical Officers (DMOs) from Balligubadle, Hargeisa and Gabiley districts; (objectives: strengthening capacities of the vaccinators on basic immunization services, cold chain management, administration, injection safety, health education, possible side effects and recording and monthly activity reports). 100 Immunization Monitoring Charts and 90 Health facility registers printed and distributed to all 13 GAVI supported health facilities. In Puntland, 36 MCH staff were trained on basic EPI for 2 weeks; referring to last health facility assessment: 75% of vaccinators have good knowledge and skills); In South Central, a 2 weeks EPI training was conducted for 32 MCH/EPI staff;
Activity 1.9. (UNICEF):	UNICEF employed an international Cold chain expert to support the MoHs in the 3 zones to strengthen immunization activities and expand EPI coverage; to that effect, UNICEF conducted assessment of cold chain capacity in health facilities; additionally modern solar-powered cold chain equipment have been procured and installed in selected facilities; in 2015, all GAVI-supported facilities cold chains will be re-assessed and equipment renewed
Activity 1.10. (WHO):	Preparation for outreach / micro plans: consultative meetings for three zonal EPI units held in December 2014, followed by a 'Middle and Low Level Managers training' held in Hargeisa in January 2015. EPI outreach plans for GAVI HSS supported clinics have been developed for Somaliland and Puntland; implementation starts in May – June 2015
Activity 1.11. (WHO):	In all zones, harmonized supervision tools for MCH clinics and HPs have been endorsed and a supervision task force at each zone was established; a supervision manual has been drafted; a national consultant will be contracted to training and form a team of key MoH staff in supportive supervision; health systems analysis team (HSAT) will provide support in the processing and utilizing information collected;
Activity 1.12. (WHO):	Costs of transportation and DSA covered for regional and central Ministry of health supported under this activity to perform supportive supervision of programme implementation at Regional / district and health facility level;
Activity 1.13. (WHO):	Costs for transportation and DSA covered to carry out supportive supervision and to collect the monthly community based HIS reports from the LHWs; complements activity 1.12; .
Activity 1.14. (WHO):	Amount of incentives had been agreed with SHAs at start of project implementation; they are provisioned on top of staff salaries and are in line with adopted middle scenario adopted by the SHA to pay for and incentivize health workers; these incentives should motivate and improve health workers performance since the salary from the Ministry of Health is either irregular or very little. • SL: 40 staff working at 13 MCH facilities, including 2 staff taking care of Marodijex training center; 27 HP staff; ; • PL: 60 staff from 12 MCH facilities; 36 HP staff; • SC: 75 staff from 15 MCH centers;
Activity 1.15. (WHO):	FPs from zonal MoH coordinate programme implementation, provide oversight, and ensure that all stakeholders are informed about activities of the grant. They participate in national / regional / international meetings on GHI and HSS relevant aspects as part of improving their knowledge and to serve at the zonal MoH as a resource person HSS/GHI related matters. Regional / district focal points are included as to contribute to their professional development and to the success of the programme at regional, district and as such facility level; they ensure that work of LHWs supervisors is being linked to respective facilities • SL: 1 central, 1 regional and 3 DMO; • PL: 1 central; 8 regional (RHO and PHC officers) medical officers; • SC: 1 central, 2 regional (RHO) medical officers; • In Somaliland, provision of office equipment and furniture;

Activity 2.2.(WHO):	Completed (200 LHWs recruited); new recruitments if at all planned for 2015;
Activity 2.3. (WHO):	Completed; revision of curriculum planned for Q2 2015 supported by other programme (JHNP);
Activity 2.5.(WHO):	Completed; planned for Q4 2015 for new comers and as refreshment
Activity 2.6.(WHO):	idem
Activity 2.7. (WHO):	The LHWs' supervisors have undergone supervision training of one months; they plan and provide supported supervision to the health workers through on the job training and they identify the gaps existed in terms of capacity and community organization and relationship between the community and the LHWs. Supervisors collect the monthly community based HIS reports, compiles and shared with the partners for review and discussions. The data includes birth and deaths of children and mothers, referral cases and basic information related to water sources etc. In PL, five LHW supervisors provide supportive supervision for 10-15 LHWs on monthly basis; In SL, four LHW supervisors work with 65 LHWs; In SC, 3 LHW supervisors work with 45 LHWs in Benadir region; 2 supervisors for 35 LHWs in Galgaduud / Muduug Region;
Activity 2.8.(WHO):	Community based HIS forms have been developed, printed and disseminated to LHWs; data collection is ongoing; a review is planned for Q2/2015, in collaboration with GFATM support to HIS;
Activity 2.9.(WHO):	Completed.
Activity 2.10.(UNICEF/WHO):	Funds for this activity were all transferred to WHO; WHO procures kits for all LHWs sufficient to cover 6 months; consumption is being analyzed through the community based HIS and content and quantity are under revision;
Activity 2.11.(UNICEF):	Selected facilities quarterly receive health posts supplies – PHU kits – this is an ongoing facilities.
Activity 2.12. (WHO):	SL: 2 refresher training for LHWs, 1 week each; complements activity 2.2. and 2.3; foreseen for 2015
Activity 2.13. (WHO):	Complements (in terms of funding) provision of incentives for MCH staff; CHWs are HP based; , provides incentives for staff based at HP level. SL: 27 HP, staffed with one CHW since March 2013; the community health workers received short courses of weeks or one month duration, they require to get longer duration of nine months which is in line with the curriculum developed by THET. PL: MoH has not selected HPs to be supported; SC: HP and CHWs not selected so far
Activity 2.14. (WHO):	• SL: start in April 2013 for 65 LHWs and 4 supervisors; • PL: start in May 2013 for 70 LHWs and 5 supervisors; • SC: start in October 2013; 45 LHWs, 3 supervisors Benadir; 30 LHWs, 2 supervisors start April,2014 Monthly incentive of 80 US$; as of April 1, amount was increased to 100 USD;
Activity 3.1.(UNICEF):	Formative Research conducted and final report submitted
Activity 3.2. (UNICEF):	Zonal strategies have been developed with the involvement of stakeholders.
Activity 3.3. (UNICEF):	Training video on IPC was developed and 100 copies duplicated and disseminated to the zoned. A total of 300 grain sacks (C4D tools with relevant pictorial health messages utilised by FCHWs to conduct community dialogues) were developed and produced with dissemination and training of FCHW on the use of the grains sacks to commence in 2015.

Activity 3.4.(UNICEF):	All three zones have engaged local radio stations to air programmes messages on MCH with six radio spots on ANC, immunisation, breastfeeding, nutrition and WASH developed and aired on five radio stations. A total of 167 radio programmes and 357 radio spots have been aired on the following radio stations (NEZ; Nation and Delgir, NWZ: Hargeisa 1, and CSZ: Mogadishu and Kumlye). Radio stations were selected based on the formative research findings that radio was the most trusted and listened to medium for delivery of health messages.
Management costs	Includes costs for transporation and travel, communication, stationery, etc. Also covers costs for regular zonal GAVI/HSS coordination and review meetings;
Technical Support	1 international (HSS country programme advisor) and 2 national staff plus 2 programme support;

8.2.2 Explain why any activities have not been implemented, or have been modified, with references.

Most of activities are on-going as routine activities such as support to the work of the Lady Health Workers (LHWs), their supervision, the support to 40 Maternal Child Health (MCH) clinics staff as well as 52 attached Health Posts. Central, regional and district MoH focal points are being supported in the areas of programme management, coordination, financial management, supervision as well as data collection, processing and analysis. <?xml:namespace prefix = o />

Substantial delay has been hampering the delivery of services due to late payments of incentives and transportation costs for supplies to LHWs. WHO administrative requirements stipulate closure of previous financial transactions prior to starting new ones. Late reporting from the side of the Ministries as well as slow processing from WHO side contributed to these delays. However, all payments for 2014 have been settled.

Support to 3 BeMONC: The 3 BeMOC Health Facilities have been identified in 2013; however the initial selected facilities were not functioning at all and thus did not have minimum requirement to run as BeMONC, the MoHs in NWZ and NEZ changed the facilities and identified others to be BeMONC (official communication available). This has delayed the implementation of this activity; however in NEZ, medical equipment have already been provided to MoH for BeMONC. JHNP resources are being leveraged for this activity.

The pick-up of implementing planned activities has been slow in general; therefore, the component of operational research has been re-planned as to be implemented in 2015. This work will complement activities that are being carried out by the Health Systems Analysis Team (HSAT) such as establishing a national research agenda, capacity building in performing research functions as well as involvement of Ministry staff in research activities, especially the first national Health Facility Assessment (HFA) utilizing the SARA methodology. Unused funds from the operational research budget will be utilized to complement this survey that is cofunded by the Joint Health and Nutrition Programme (JHNP) and the Global Fund (Malaria grant).

Due to the slow implementation in the earlier phase of the grant as well as delays in transferring funds from the secretariat to UNICEF and WHO, sufficient funds will be available until end of the grant on October 1, 2016 for the continuation of routine activities as well as support to accelerating the implementation of Somalia's ONE EPI PLAN.

8.2.3 If GAVI HSS grant has been utilised to provide national health human resources incentives, how has the GAVI HSS grant been contributing to the implementation of national Human Resource policy or guidelines?

As part of the GAVI HSS grant, incentives are paid to MoH staff at the three zones who are involved in the implementation of the grant. These include management staff from the central Ministry and respective staff from Regional and District Health Management Teams. In addition, health workers at HP and MCH clinics receive a modest level of incentives. These cadres are employees of the Government. Following a “review of compensation, salaries, incentives and benefits for health personnel” carried out in late 2012, the Ministry of Health has adopted a middle scenario for salay and incentives payments that is below the foreseen costing of the Health Sector Strategic Plan. The health authorities however plan to review this salary scale.

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The applied incentives complement government salaries; at this point SHAs are not in the position to provide the middle scenario salary level to its entire staff.

The newly introduce cadres of Lady Health Workers receive a monthly remuneration of 100 US $, their supervisors 300 US $. Somali Health Authorities are conscientious about the question of the sustainability of the programme and are committed to take these new staff on board in the future. The remuneration of these health workers who carry the load of the programme, given the scope of work and the expectations from the communities as well as the very long distances between the communities to cover, needs a revision of current levels of incentives.

Their presence has been reiterated and officially endorsed in the recently developed 'Community Health Care Strategy'.

8.3. General overview of targets achieved

Please complete **Table 8.3** for each indicator and objective outlined in the original approved proposal and decision letter. Please use the baseline values and targets for 2013 from your original HSS proposal.

Table 8.3: Progress on targets achieved

Name of Objective or Indicator (Insert as many rows as necessary)	Baseline		Agreed target till end of support in original HSS application	2014 Target						Data Source	Explanation if any targets were not achieved
	Baseline value	Baseline source/date			2010	2011	2012	2013	2014		
# of MCH centers providing routine immunization services including outreach;	0	monitoring and supervision visits;	100	40					28	Field visit report; Baseline survey	Only 28 of the 40 MCH supported by GAVI provide RI; this is due to resources leveraged by UNICEF from other sources e.g. JHNP. UNICEF support to the cold chain strengthening has been critical to achieve this result. No implementation of outreach services so far; i

# of MCH clinics offering immunisation services that have tracer items for delivery of immunisation including:	tbd	Baseline survey	100	40					NA		in 13 MCH Somailand: cold boxes 85%; functioning fridge and thermometer: 92%; sharp container: 100%; # of immunization sessions planned and completed: 92%; in Puntland, 10/12 have these tracer items available; no information from South Central;
Availability of vaccinators in the selected MCH clinics with good knowledge and skills;	tbd	Baseline survey (pre- and post-test);	100	40					NA		77% in SL; 100% in SC; 75% in PL;
Vaccine wastage rates at selected facilities ;	tbd	EPI HMIS records;	tbd						tbd	NA	Vaccine wastage rate cannot be assessed due to lack of proper vaccine stock management; SL: BCG 63%; Penta 30%; measles: 40%; TT 41 %; Polio 57%
% of target population (pregnant women, children < 1) in LHW catchment area fully immunized;	tbd	Household Survey; family register (community based HIS);	95	45					NA		12- 23 months old children fully immunized: 27% (no trend of improvement over the year); TT2+: 16% (data from Puntland); 32% in Somaliland; No improvement is due to lack of outreach activities; very small number of vaccination sites; low demand; data from LHW registry
# of persons referred to the next MCH, disaggregated by gender and age	0	Community based HMIS reports (referral slips)	tbd								SL: 632 cases of whom 259 are children < 5 referred to the nearest MCH in 2014: PL and SC NA;

% of mothers and fathers having knowledge about immunization and danger signs of pregnancy and childhood illnesses;	29% of mothers know pregnancy danger signs 60% know the importance of vaccination 37% know the childhood danger signs (Average for NEZ and NWZ)	Formative research									
Annual production of operational research reports on programme relevant topics;	0	HSAT activity reports;	4/y	4/y					0		No activity as yet
DPT3 data verification	NA	Monitoring and supervision visits;	tbd	tbd					NA		NA
Timeliness and completeness of facility reporting	NA	Monitoring and supervision visits; compiled HIS reports zonal level;	100	60 - 100					80		100% timeliness for the 13 MCH facility reports in Somaliland but Data quality Audit (DQA) system is required to improve completeness. 60% reports on timelines for the15 MCH in South Central; Puntland: 86%

8.4. Programme implementation in 2014

8.4.1. Please provide a narrative on major accomplishments in 2014, especially impacts on health service programmes, and how the HSS funds benefited the immunisation programme

Procurement and quarterly supply of essential medicines and equipment for MCH and HP services (based on gaps): UNICEF has provided quarterly supplies of essential medicines to the MCH clinics. The supplies are MCH kits and HP kits; the contents of the supplies was previously discussed and agreed by the Zonal MoH.<?xml:namespace prefix = o />

Procure and distribute/re-supply medicines for Health posts (50%): UNICEF has provided quarterly supplies of essential medicines to the PHUs. The supplies are PHU kits; the contents of the supplies was previously discussed and agreed by the Zonal MoH

Rehabilitation of cold chain equipment: UNICEF conducted the renovation of cold chain equipment in all 40 health facilities. The MoHs deployed staff according to EPHS requirements; a number of MCH clinics had been up-graded from a previous health post level;

Training of Health Workers on IPC skills: The training through the use of the training video on IPC will contribute the improved the health worker - client relationships. In Puntland 51 participants were trained on IPC and developed social mobilization strategies to strengthen routine immunization. Of the 51 participants (15 vaccinators, 11 midwives, 7 Traditional Birth Attendants (TBAs), 7 Nutrition Officers and 11 heads of MCHs. Participants came from Sool, Ayn, Mudug and Nugal regions and represented 46 health facilities in the 13 GAVI districts.

In partnership with SONALDO NGO, Interpersonal Communication (IPC) training was conducted for 25 Health workers in M/Jeex region and for 22 lady health workers (LHWs) in the GAVI-HSS area of Gebilay, Arabsiyo, Wajaale and kalabaidh in Somaliland.

The 300 grain sacks with dialogues guides are user friendly materials to be used by the Female Community Health Workers. The materials include messages on immunization, antenatal care, nutrition and WASH. The materials are more pictorial which making them more appropriate for conducting community dialogue sessions. It is hoped that the FCHWs will conduct approximately 100 dialogue sessions reaching about 2,000 community members.

Consolidation of the work of LHWs: this new cadre is widely respected by their communities and their services are highly demanded. The Somali Health Authorities are expanding their number with support of the JHNP. Their function has been integrated into the newly developed Community Based Heath Care Strategy and it is planned to increase their responsibilities such as providing immunization services once PHC services would be more responsive and of better quality.

In Somaliland: 65 LHWs, supported by 4 supervisors have:

- Established 63 village health committees;
- Registered 8,090 families and 48,540 persons;
- Out of 1941 pregnant women, 19% completed TT2 vaccination;
- Managed 3,971 cases of diarrhea;
- Referred 632 cases to the next facility (373 < 5, 259 > 5 years), including pregnant women;

In Puntland, 59 LHWs and 5 supervisors:

- have supported the constitute of 50 health committees;

. 7,798 families were registered.

- The proportion of newborns whose mothers initiated breast feeding within one hour of birth was at 93% in total for 2014;
- < 5: 2,435 cases of diarrhea, 1981 of ARI, 3512 of fever treated;
- < 5: 208 referred cases; > 5 244 referred;

In South Central, 45 LHWs working in Benadir Region, supported by 3 supervisors and 35 LHWs working in Galgadud and Mudug, supported by 2 supervisors, have:

- registered 14,800 families;
- treated < 5: 1844 cases of diarrhea; 3,522 ARI, 4,037 fever cases treated;
- referred a total of 9,385 (6,213 / 3,172) cases to next MCH clinics.

Support to Health Facilities

Somaliland - 13 MCH clinics and 28 Health Posts supported:

Total number of children vaccinated: Penta 1 5,930 (55%); Penta 3: 4,670 (43%); Measles: 7,244 (25%);

Total number of women vaccinated TT2+: 9,784; pregnant: 5,620 (32%);

Puntland – 12 MCH clinics and 24 HPs supported:

In South Central – 15 MCH clinics supported:

In **Benadir** Region, the 9 functional and supported MCH clinics in 2014 have vaccinated: <- 1- year children for :

• BCG: 8,652;

• Penta-1: 13,299;

• Penta-3: 10,782;

• Measles: 9,918;

And 17,082 pregnant women with TT2+ (population figures not available); .

A total of 152,552 consultations were carried and 2,360 deliveries conducted (details see annex reports).

Intensified training of vaccinators was conducted in all three zones, based on assessment findings of service provision in all facilities. The grant supports the preparation of the production of micro-plans and will support outreach activities at the 40 supported facilities.

Technical Assistance through senior international HSS advisor and 2 national staff, supported by 2 programme assistants; areas of support include: supervision of health systems analysis team; support to M&E framework formulation and data analysis; establishment of supportive supervision system; supply chain management; revision of therapeutic guidelines; coordination; health financing; contracting; support to implement activities planned under One-EPI-Policy;

8.4.2. Please describe problems encountered and solutions found or proposed to improve future performance of HSS funds.

The **3 BeMOC** Health Facilities have been identified in 2013; however the initial selected facilities were not functioning at all and thus did not have minimum requirements to run as BeMONC. Tthe MoHs in NWZ (Somaliland) and NEZ (Puntland) changed the facilities and identified others to be BeMONC (official communication available). This has delayed the implementation of this activity; however in NEZ, medical equipment has already been provided to MoH for BeMONC. JHNP resources are being leveraged to enable implementation of this activity.<?xml:namespace prefix = o />

Lady Health Workers: the selection of implementation sites (communities) poses a serious problem to the effectiveness of the programme: most of communities are more than 5 km at distance from the next facility; mothers do not accept advice to seek services due to distance;

Whilst the LHWs are provided the expected services, immunization rates have not improved. The current level of availability of services, their distance to communities and the lack of outreach activities make the referral of children and mothers as well as sick people impossible; a referral system that would include transport and management of different levels is not in place.

Facilities: The facilities included under this grant are mostly located in remote areas and do not receive any additional support that from the Ministry. Many of the MCH facilities have been up-graded from HP without having the required staff in place. Only in Somaliland, with support of the National health Professions Council (NHCP), health workers have been registered according to standards. It was found that most of the staff has the relevant qualification but some staff members (4) working in those health facilities are not qualified due to the fact that institutions they graduated are not certified by the Ministry.

Up to now, a strategy to up-grade their knowledge and skills and a strategic direction and plan for in-service training has not yet been developed; similarly, a decision on how to handle non-qualified staff has not yet been taken.

Treatment protocols for EPHS implementation are not developed. Although the SHAs had endorsed guidelines for IMCI and IMPACT, little action is being taken to implement those.

Supplies: there is a frequent stock-out of supplies. Facilities do not provide consumption reports which are required to trigger the next delivery of supplies. Many equipment are not used due to lack of knowledge, others are missing.

A national M&E framework had been developed for all three zones but there is no implementation. The community based HIS in place is large and not integrated in the national HMIS. However, data are not analyzed and actions are not taken.

Lack of coordination of implementing partners at field level affects effective implementation. SHAs need to exert more political and technical stewardship of the programme.

The valuable findings and data generated by the LHWs, consolidated by their supervisor and processed to the district, regional and central Ministry teams are not reviewed or discussed; therefore, they are not triggering any action. The exception is the continued low coverage rates at community level.

The health information delivery team, supported by WHO's international Health Systems Analysis Team (HSAT) advisor, will include data analysis from the community level, seek integration of community bases HIS into the HIS and ensure, through support of the Health Information Liaison Officer (HILO) that data analysis remains at zonal and cross-zonal coordination as standing agenda item.

An exception is the remaining low coverage at community level; the programme has developed the development of EPI micro-plans and will start implementing outreach activities at supported facilities. Current lack of funding will be an impediment to fully roll out outreach services.

As for data availability, despite the release of the Population Estimate Survey for Somalia (PESS), catchment population figures for facilities are not available or in use. The PESS has been conducted across Somalia, supported by UNFPA. It is said that it does not include population figures per district. As such it is difficult to calcite accurate facility coverage. It is anticipated that the district micro-plans will fill this gap.

8.4.3. Please describe the exact arrangements at different levels for monitoring and evaluating GAVI funded HSS activities.

Regular supervision visits are being conducted by zonal teams (WHO, UNICEF and MoH) to facilities and LHW and supervisors. In coordination meetings findings and challenges are being discussed. <?xml:namespace prefix = o />

Up-dates on GAHI HSS implementation are provided to each health sector coordination committee meeting.

Financial transfers to the zonal Ministry require the production of technical and financial reports.

In the near future an external evaluation is being planned.

8.4.4. Please outline to what extent the M&E is integrated with country systems (such as, for example, annual sector reviews). Please describe ways in which reporting on GAVI HSS funds can be more organization with existing reporting systems in your country. This could include using the relevant indicators agreed in the sector-wide approach in place of GAVI indicators.

Currently, there is little integration of activities that monitor and evaluate GAVI HSS supported activities in the national system as the developed M&E framework is not being implemented although plans do exist that also foresee the integration of GAVI activities. <?xml:namespace prefix = o />

An evaluation is recommended to provide recommendations for the next grant as well as introducing a data quality assurance system to verify the HMIS data from the health facilities.

However, jointly funded by the Joint Health and Nutrition Progamme (JHNP) and Global Funds grants, the first National Health Facility Assessment is in its initial stage.

8.4.5. Please specify the participation of key stakeholders in the implementation of the HSS proposal (including the EPI Programme and Civil Society Organisations). This should include organisation type, name and implementation function.

From three Somali health Authorities: Directorate for Policy & Planning; EPI department; regional and district health teams; WHO: provision of programme management team and HSS international and national TA; UNICEF: TA for BCC; rehabilitation of facilities, provision of cold chain, vaccines, supplies and equipment. CSOs for implementing BCC activities.

8.4.6. Please describe the participation of Civil Society Organisations in the implementation of the HSS proposal. Please provide names of organisations, type of activities and funding provided to these organisations from the HSS funding.

Behavior Change interventions have been implemented primarily through national NGOs. (**Name, Zone, Activity)**<?xml:namespace prefix = o />

WARDI

SCZ

Media engagement, social and micro mapping, production of IEC materials, training of FCHWs and Health workers on IPC, religious leaders

SSFA

SCZ

Health education in schools

SONALDO

NWZ

Media engagement, social and micro mapping, production of IEC materials, training of FCHWs and Health workers on IPC, health education in schools, religious leaders and supervision

ANPCANN

NEZ

Media engagement, social and micro mapping, production of IEC materials, training of FCHWs and Health workers on IPC, health education in schools, religious leaders and supervision

Somali National Religious Leaders Council [IHSAN Religious Leaders' Network]

SCZ

Sensitization and mobilization of religious leaders

8.4.7. Please describe the management of HSS funds and include the following:

- Whether the management of HSS funds has been effective
- Constraints to internal fund disbursement, if any
- Actions taken to address any issues and to improve management
- Any changes to management processes in the coming year

In 2014, funds released from GAVI secretariat only reached UNICEF/WHO accounts in June whilst 2013 funds had been exhausted during Q1. These delays pose a problem for internal management matters and create additional burden on financial management. <?xml:namespace prefix = o />

The management of HSS funds is being performed by the UNICEF and WHO respective management team.

Considering internal requirements, processes are slow and further delayed occured until funds reach the field level where the programme is being implemented.

Changes to management processes in the remaining life span of the grant are not foreseen.

8.5. Planned HSS activities for 2015

Please use **Table 8.5** to provide information on progress on activities in 2015. If you are proposing changes to your activities and budget in 2015 please explain these changes in the table below and provide explanations for these changes.

Table 8.5: Planned activities for 2015

Major Activities (insert as many rows as necessary)	**Planned Activity for 2015**	**Original budget for 2015** (as approved in the HSS proposal or as adjusted during past annual progress reviews)	**2015 actual expenditure** (as at April 2015)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2015** (if relevant)
1.3.	Procurement and supply of essential medicines and equipment for MCH services	98000	201867	UNICEF will continue the procurement and supply of essential medicines and equipment for 40 MCH services	no changes	
1.4.	Provide comprehensive support for BEMONC in selected MCH centres (3)	102000	106268	UNICEF will continue to support the MoH to provide comprehensive support for BEMONC in selected 3 MCH centres.	no changes	
1.6.	Training of MCH/EPI staff	65000	28043	will be increased by 15% and carried over to enxt year	increase by 15%; revised is plus 15% - spent	46707
1.8.	Training of MCH staff in EPI related matters	65000	10698	Middle Level Management Training conducted in PL and SL as planned in the EPI work plan	increase by 15%; revised is plus 15% - spent	64052
1.10.	Develop/implement EPI outreach	130000	106274	GAVI HSS grants supports development of EPI district micro plans	increase by 15%; revised is plus 15% - spent	43226
1.12.	Transport supervision of RHTs	26400	26400	Transportation is very costly and Government funds are rarely available;	increase by 15%; revised is plus 15% - spent	3960
1.13.	Transport supervision of MCH clinics	81000	13070	Same as above	unchanged	
1.14.	Incentives MCH staff	288000	331200	GAVI supported facilities are to the largest part exclusively operated by the MoH; salaries of staff are meager or only nominal; occurred costs for 12 months are larger than planned for	increase by 15%; revised is plus 15% - spent; needs to be recovered from CHWs incentives	0
1.15.	Provide incentives for MoH HSS Focal Points	120000	138000	Grant supports as well regional and district health team to be closely involved with activity implementation and strengthen their capacities	Increase by 15%; revised is plus 15% - spent; needs to be recovered from CHWs incentives	0

2.2.	Recruitment of LHWs (to account for those pulled out)	15000	0	through JHNP, LHW are being expanded in numbers; new recruitments are mainly being covered under this expansion;	Decrease by 15%	12750
2.3.	Curriculum for LHWs (revision)	10000	0	Funded by JHNP	Will be taken to 2016	
2.7.	Develop and implement supervision system / outreach	250000	72132	In complementarity with EPHS supervision and implementation of outreach activities in grant supported facilities;	Increase by 15%	287500
2.10.	Procurement of supplies for LHWs	80000	0		no changes	
2.11.	Procure and distribute/re-supply medicines for Health posts (50%)	50000	50000	UNICEF will continue to Procure and distribute/re-supply medicines for Health posts (50%)	no changes	
2.13.	Incentives CHWs	93312	82859	Includes excess spending for incentives health workers / focal points	no changes	
2.14.	Incentives for LHWs	223949	285600	Agreement with SHAs to increase monthly incentive from 80 to 100$	Increase by 15%; excess to be covered by underspent budget lines of incentives	257541
3.10.	Evaluation of C4D interventions	60000				
4.1.	Conduct baseline and end-line surveys	60000	30000	End line survey to be integrated with HFA	no changes	
4.2.	Support to operational research committees	18000	18000	no spending in 2014	unspent balance to be carried forward to 2016	36000
4.3.	Commission OR studies	37500	0	no spending in 2014	unspent balance to be carried forward to 2016	75000
4.4.	Conduct focus groups for operational research	36000	36000	No spending in 2014	unspent balance to be carried forward to 2016	72000
4.5.	Support to data analysis and use	41416	0	No spending in 2014	unspent balance to be carried forward to 2016	76416
4.6.	Training of MoH managers in OR	65000	0	No spending in 2014	unspent balance to be carried forward 2016	135000
4.8.	TA for OR	47741	0	No spending in 2014		95481
3.4 to 3.8	Implementation of BCC interventions	140000	144871	no changes		
	M&E support costs - UNICEF	153140	85999			
	Technical Support - WHO	553544	140697			
	Technical Support - UNICEF	422212	166076			

	Management Operational/management Costs	102000	16260	no changes		
2.12.	Refresher training for FCHWs and Supervisors	100000				
		3534214	2090314			1205633

8.6. Planned HSS activities for 2016

Please use **Table 8.6** to outline planned activities for 2016. If you are proposing changes to your activities and budget please explain these changes in the table below and provide explanations for each change so that the IRC can recommend for approval the revised budget and activities.

Please note that if the change in budget is greater than 15% of the approved allocation for the specific activity in that financial year, these proposed changes must be submitted for IRC approval with the evidence for requested changes

Table 8.6: Planned HSS Activities for 2016

Major Activities (insert as many rows as necessary)	**Planned Activity for 2016**	**Original budget for 2016** (as approved in the HSS proposal or as adjusted during past annual progress reviews)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2016** (if relevant)
1.4.	Provide comprehensive support for BEMONC in selected MCH centers (3)	0	Continued activiy		200,000
1.6.	Training of MCH/EPI staff	0	Continued activiy		41,438
1.8.	Training of MCH staff in EPI related matters	0	Continued activiy		48,750
1.10.	Develop/implement EPI outreach	0	Continued activiy		82,875
1.12.	Transport supervision of RHTs	0	Continued activiy		16,830
1.13.	Transport supervision of MCH clinics	0	Continued activiy		51,683
1.14.	Incentives MCH staff	0	Continued activiy		183,600
1.15.	Incentives for MoH focal points	0	Continued activiy		76,500
2.2.	Recruitment of LHWs (to account for those pulled out)	0	Continued activiy		9,563
2.3.	Curriculum for LHWs (revision)	0	Continued activiy		6,375
2.7.	Develop and implement supervision system	0	Continued activiy		159,375
2.10.	Procurement of supplies for LHWs	0	Continued activiy		51,000
2.12.	Refresher training for FCHWs and Supervisors	0	Continued activiy		63,750

2.13.	Incentives CHWs	0	Continued activiy		59,486
2.14.	Incentives for LHWs	0	Continued activiy		142,767
3.4.	Develop and broadcast radio program on key child caring and health practices	0	Continued activiy		60,000
3.5.	Identify three strong communicatio n NGOs to build capacity of existing NGOs and to scale up public awareness at community level	0	Continued activiy		20,000
3.6.	Strengthen and establishing structured/syst ematized partnership with religious leaders, religious organizations, clan leaders, community elders and networks	0	Continued activiy		20,000
3.7.	Work with school structures to increase dialogue on key child survival and development messages	0	Continued activiy		20,000
3.8.	Develop community friendly materials (discussion guides etc) with key iccm messages for FCHWs, CHWs, TBAs for home based family promotion	0	Continued activiy		20,000
4.1.	Conduct baseline and end-line surveys	0	planned end of programme		30,000
4.2.	Support to operational research committees	0	not started		11,475
4.3.	Commission OR studies	0	not started		23,906
4.4.	Conduct focus groups for operational research	0	not started		22,960
4.5.	Support to data analysis and use	0	not started		26,403

4.6.	Training of MoH managers in OR	0	not started		41,438
4.8.	TA for OR	0	not started		30,435
	Management Operational/management Costs	0			65,025
	M&E support costs - UNICEF	0			96,000
	Technical Support - WHO	0			352,884
	Technical Support - UNICEF	0			422,212
		0			

8.7. Revised indicators in case of reprogramming

Countries planning to submit reprogramming requests may do so any time of the year. Please request the reprogramming guidelines by contacting your Country Responsible Officer at GAVI or by emailing gavihss@gavi.org

8.8. Other sources of funding for HSS

If other donors are contributing to the achievement of the country's objectives as outlined in the GAVI HSS proposal, please outline the amount and links to inputs being reported on:

Table 8.8: Sources of HSS funds in your country

Donor	Amount in US$	Duration of support	Type of activities funded
GFATM	112000000	3 years	Malaria, TB, HIV/AIDS, HSS: supply chain management
Health Consortium Somalia	43342536	ends 3/2016	NGO Consortium, DFID funded, focuses on servcices delivery at PHC level but also supports HR planning and development
Joint Health and Nutrition Progamme: DFID, SIDA, USAID, Swiss Development Cooperation,	99700000	5 years	Support to health system development; includes EPHS roll out; 85% of total budget;

8.8.1. Is GAVI's HSS support reported on the national health sector budget? **No**

8.9. Reporting on the HSS grant

8.9.1. Please list the **main** sources of information used in this HSS report and outline the following:

- How information was validated at country level prior to its submission to the GAVI Alliance.
- Any important issues raised in terms of accuracy or validity of information (especially financial information and the values of indicators) and how these were dealt with or resolved.

Table 8.9.1: Data sources

Data sources used in this report	How information was validated	Problems experienced, if any
Supervision field visits Facility based HIS reports Community based HIS Baseline Survey	WHO HSS techncial officer ; MoH HIS team; LHWs supervisors; Review by HSC	Data quality audits or self assessments not conducted in the reporting period;

8.9.2. Please describe any difficulties experienced in putting this report together that you would like the GAVI Alliance and IRC to be aware of. This information will be used to improve the reporting process.

No space to ask for no-cost extension;

Geographical distance between programme management team and implementing partners impede close consultation and discussion;
<?xml:namespace prefix = o />

The fragmented government of Somalia and in turn the lack of national level structures for health sector coordination, makes organization of meetings to endorse this report difficult. However, the zonal coordination mechanisms that are functional and used for all other programs and projects in Somalia were not considered for the reporting of this HSS grant.

The Health Advisory Board of Somalia composed of the three Zonal Ministers of health should be consulted on possible execution of the task and responsibility of approving the GAVI annual progress report

8.9.3. How many times did the Health Sector Coordinating Committee (HSCC) meet in 2014?2

Please attach:

1. The minutes from the HSCC meetings in 2015 endorsing this report **(Document Number: 6)**
2. The latest Health Sector Review report **(Document Number: 22)**

9. Strengthened Involvement of Civil Society Organisations (CSOs) : Type A and Type B

9.1. TYPE A: Support to strengthen coordination and representation of CSOs

Somalia **has NOT received GAVI TYPE A CSO support**

Somalia is not reporting on GAVI TYPE A CSO support for 2014

9.2. TYPE B: Support for CSOs to help implement the GAVI HSS proposal or cMYP

Somalia **has NOT received GAVI TYPE B CSO support**

Somalia is not reporting on GAVI TYPE B CSO support for 2014

10. Comments from ICC/HSCC Chairs

Please provide any comments that you may wish to bring to the attention of the monitoring IRC in the course of this review and any information you may wish to share in relation to challenges you have experienced during the year under review. These could be in addition to the approved minutes, which should be included in the attachments

No comments are provided on the GAVI annual progress report for 2014

11. Annexes

11.1. Annex 1 – Terms of reference ISS

TERMS OF REFERENCE:

FINANCIAL STATEMENTS **FOR IMMUNISATION SERVICES SUPPORT (ISS)** AND **NEW VACCINE INTRODUCTION GRANTS**

I. All countries that have received ISS /new vaccine introduction grants during the 2014 calendar year, or had balances of funding remaining from previously disbursed ISS/new vaccine introduction grants in 2014, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

II. Financial statements should be compiled based upon countries' own national standards for accounting, thus GAVI will not provide a single template to countries with pre-determined cost categories.

III. **At a minimum**, GAVI requires a simple statement of income and expenditure for activity during the 2014 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on the next page.

a. Funds carried forward from the 2013 calendar year (opening balance as of 1 January 2014)

b. Income received from GAVI during 2014

c. Other income received during 2014 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2014

f. A detailed analysis of expenditures during 2014, based on ***your government's own system of economic classification.*** This analysis should summarise total annual expenditure for the year by your government's own system of economic classification, and relevant cost categories, for example: wages & salaries. If possible, please report on the budget for each category at the beginning of the calendar year, actual expenditure during the calendar year, and the balance remaining for each cost category as of 31 December 2014 (referred to as the "variance").

IV. Financial statements should be compiled in local currency, with an indication of the USD exchange rate applied. Countries should provide additional explanation of how and why a particular rate of exchange has been applied, and any supplementary notes that may help the GAVI Alliance in its review of the financial statements.

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2014 financial year. Audits for ISS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

11.2. Annex 2 – Example income & expenditure ISS

MINIMUM REQUIREMENTS FOR **ISS** AND VACCINE INTRODUCTION GRANT FINANCIAL STATEMENTS *1*

An example statement of income & expenditure

Summary of income and expenditure – GAVI ISS		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2013 (balance as of *31Decembre 2013*)	25,392,830	53,000
Summary of income received during 2014		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	38,987,576	81,375
Total expenditure during 2014	30,592,132	63,852
Balance as of 31 December 2014 (balance carried forward to 2015)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2014, the exchange rate at closing 31.12.2014, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

Detailed analysis of expenditure by economic classification ** – GAVI ISS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2014	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

** Expenditure categories are indicative and only included for demonstration purpose. Each implementing government should provide statements in accordance with its own system for economic classification.

11.3. Annex 3 – Terms of reference HSS

TERMS OF REFERENCE:

FINANCIAL STATEMENTS FOR **HEALTH SYSTEMS STRENGTHENING (HSS)**

I. All countries that have received HSS grants during the 2014 calendar year, or had balances of funding remaining from previously disbursed HSS grants in 2014, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

II. Financial statements should be compiled based upon countries' own national standards for accounting, thus GAVI will not provide a single template to countries with pre-determined cost categories.

III. At a minimum, GAVI requires a simple statement of income and expenditure for activity during the 2014 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on the next page.

a. Funds carried forward from the 2013 calendar year (opening balance as of 1 January 2014)

b. Income received from GAVI during 2014

c. Other income received during 2014 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2014

f. A detailed analysis of expenditures during 2014, based on your government's own system of economic classification. This analysis should summarise total annual expenditure for each HSS objective and activity, per your government's originally approved HSS proposal, with further breakdown by cost category (for example: wages & salaries). Cost categories used should be based upon your government's own system for economic classification. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditure during the calendar year, and the balance remaining for each objective, activity and cost category as of 31 December 2014 (referred to as the "variance").

IV. Financial statements should be compiled in local currency, with an indication of the USD exchange rate applied. Countries should provide additional explanation of how and why a particular rate of exchange has been applied, and any supplementary notes that may help the GAVI Alliance in its review of the financial statements.

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2014 financial year. Audits for HSS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

11.4. Annex 4 – Example income & expenditure HSS

MINIMUM REQUIREMENTS FOR **HSS** FINANCIAL STATEMENTS:

An example statement of income & expenditure

Summary of income and expenditure – GAVI HSS		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2013 (balance as of *31Decembre 2013*)	25,392,830	53,000
Summary of income received during 2014		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	38,987,576	81,375
Total expenditure during 2014	30,592,132	63,852
Balance as of 31 December 2014 (balance carried forward to 2015)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2014, the exchange rate at closing 31.12.2014, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

Detailed analysis of expenditure by economic classification ** - GAVI HSS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2014	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

** Expenditure categories are indicative and only included for demonstration purpose. Each implementing government should provide statements in accordance with its own system for economic classification.

11.5. Annex 5 – Terms of reference CSO

TERMS OF REFERENCE:

FINANCIAL STATEMENTS FOR **CIVIL SOCIETY ORGANISATION (CSO)** TYPE B

I. All countries that have received CSO 'Type B' grants during the 2014 calendar year, or had balances of funding remaining from previously disbursed CSO 'Type B' grants in 2014, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

II. Financial statements should be compiled based upon countries' own national standards for accounting, thus GAVI will not provide a single template to countries with pre-determined cost categories.

III. At a minimum, GAVI requires a simple statement of income and expenditure for activity during the 2014 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on page 3 of this annex.

a. Funds carried forward from the 2013 calendar year (opening balance as of 1 January 2014)

b. Income received from GAVI during 2014

c. Other income received during 2014 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2014

f. A detailed analysis of expenditures during 2014, based on your government's own system of economic classification. This analysis should summarise total annual expenditure by each civil society partner, per your government's originally approved CSO 'Type B' proposal, with further breakdown by cost category (for example: wages & salaries). Cost categories used should be based upon your government's own system for economic classification. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditure during the calendar year, and the balance remaining for each objective, activity and cost category as of 31 December 2014 (referred to as the "variance").

IV. Financial statements should be compiled in local currency, with an indication of the USD exchange rate applied. Countries should provide additional explanation of how and why a particular rate of exchange has been applied, and any supplementary notes that may help the GAVI Alliance in its review of the financial statements.

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2014 financial year. Audits for CSO 'Type B' are due to the GAVI Secretariat 6 months following the close of each country's financial year.

11.6. Annex 6 – Example income & expenditure CSO

MINIMUM REQUIREMENTS FOR **CSO 'Type B'** FINANCIAL STATEMENTS

An example statement of income & expenditure

Summary of income and expenditure – GAVI CSO		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2013 (balance as of *31Decembre 2013*)	25,392,830	53,000
Summary of income received during 2014		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	38,987,576	81,375
Total expenditure during 2014	30,592,132	63,852
Balance as of 31 December 2014 (balance carried forward to 2015)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2014, the exchange rate at closing 31.12.2014, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

Detailed analysis of expenditure by economic classification ** - GAVI CSO						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2014	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

** Expenditure categories are indicative and only included for demonstration purpose. Each implementing government should provide statements in accordance with its own system for economic classification.

12. Attachments

Document Number	Document	Section	Mandatory	File
1	Signature of Minister of Health (or delegated authority)	2.1	✓	APR signature page.pdf **File desc:** **Date/time :** 14/05/2015 07:38:56 **Size:** 1 MB
2	Signature of Minister of Finance (or delegated authority)	2.1	✓	Signature of Minister of Finance.docx **File desc:** **Date/time :** 15/05/2015 09:50:45 **Size:** 12 KB
3	Signatures of members of ICC	2.2	✓	Minutes of ICC meeting in 2015 endorsing the APR 2014.docx **File desc:** **Date/time :** 15/05/2015 09:48:35 **Size:** 14 KB
4	Minutes of ICC meeting in 2015 endorsing the APR 2014	5.4	✓	Minutes of ICC meeting in 2015 endorsing the APR 2014.docx **File desc:** **Date/time :** 15/05/2015 09:50:57 **Size:** 14 KB
5	Signatures of members of HSCC	2.3	✓	APR signature page.pdf **File desc:** **Date/time :** 15/05/2015 09:45:54 **Size:** 1 MB
6	Minutes of HSCC meeting in 2015 endorsing the APR 2014	8.9.3	✓	Minutes of HSCC meeting in 2015 endorsing the APR 2014.docx **File desc:** **Date/time :** 19/05/2015 05:49:14 **Size:** 12 KB
7	Financial statement for ISS grant (Fiscal year 2014) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	6.2.1	✗	No file loaded
8	External audit report for ISS grant (Fiscal Year 2014)	6.2.3	✗	No file loaded
9	Post Introduction Evaluation Report	7.2.1	✗	No file loaded
10	Financial statement for NVS introduction grant (Fiscal year 2014) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	7.3.1	✓	Financial statement for NVS introduction grant.docx **File desc:** **Date/time :** 20/05/2015 07:57:51 **Size:** 12 KB

11	External audit report for NVS introduction grant (Fiscal year 2014) if total expenditures in 2014 is greater than US$ 250,000	7.3.1	✓	External Audit Report for NVS introduction grant.docx **File desc:** **Date/time :** 20/05/2015 01:02:36 **Size:** 12 KB
12	Latest EVSM/VMA/EVM report	7.5	✓	EVM_Somalia report_v7.pdf **File desc:** **Date/time :** 19/05/2015 10:43:32 **Size:** 964 KB
13	Latest EVSM/VMA/EVM improvement plan	7.5	✓	EVM_improvement_plan_Somalia - origenal(1).xls **File desc:** **Date/time :** 20/05/2015 02:00:25 **Size:** 201 KB
14	EVSM/VMA/EVM improvement plan implementation status	7.5	✓	EVM_improvement_plan_Somalia_update.xls **File desc:** **Date/time :** 20/05/2015 02:00:49 **Size:** 208 KB
16	Valid cMYP if requesting extension of support	7.8	✓	cMYP I.docx **File desc:** **Date/time :** 16/06/2015 03:15:13 **Size:** 12 KB
17	Valid cMYP costing tool if requesting extension of support	7.8	✓	cMYP I.docx **File desc:** **Date/time :** 16/06/2015 03:15:40 **Size:** 12 KB
18	Minutes of ICC meeting endorsing extension of vaccine support if applicable	7.8	✓	ICC Somalia.docx **File desc:** **Date/time :** 16/06/2015 03:17:11 **Size:** 12 KB
19	Financial statement for HSS grant (Fiscal year 2014) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	8.1.3	✓	Financial Statement WHO Dec 2014.pdf **File desc:** **Date/time :** 15/05/2015 09:56:28 **Size:** 100 KB
20	Financial statement for HSS grant for January-April 2015 signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	8.1.3	✓	Financial statement for the period January to April 2015.docx **File desc:** **Date/time :** 15/05/2015 10:05:29 **Size:** 12 KB
21	External audit report for HSS grant (Fiscal Year 2014)	8.1.3	✓	External Audit report.docx **File desc:** **Date/time :** 15/05/2015 10:06:08 **Size:** 12 KB
22	HSS Health Sector review report	8.9.3	✓	HSS Health Sector Review Report 2014.docx **File desc:** **Date/time :** 19/05/2015 05:52:46 **Size:** 12 KB

23	Report for Mapping Exercise CSO Type A	9.1.1	✗	No file loaded
24	Financial statement for CSO Type B grant (Fiscal year 2014)	9.2.4	✗	No file loaded
25	External audit report for CSO Type B (Fiscal Year 2014)	9.2.4	✗	No file loaded
26	Bank statements for each cash programme or consolidated bank statements for all existing cash programmes if funds are comingled in the same bank account, showing the opening and closing balance for year 2014 on (i) 1st January 2014 and (ii) 31st December 2014	0	✓	Bank statement for each cash programme 2014.docx **File desc:** **Date/time :** 15/05/2015 10:08:28 **Size:** 13 KB
27	Minutes ICC meeting endorsing change of vaccine prensentation	7.7	✗	No file loaded
28	Justification for changes in target population	5.1	✗	No file loaded
	Other		✗	20150616 Unavailability of Certified Financial Statement.pdf **File desc:** **Date/time :** 16/06/2015 03:06:01 **Size:** 293 KB Final Draft 1_EPI_Plan_Mar 4.docx **File desc:** **Date/time :** 19/05/2015 08:55:25 **Size:** 298 KB GAVI Grant Financial Statement SC110552_uncertified_donor_FS_as_at_31_Dec_2014.pdf **File desc:** **Date/time :** 20/05/2015 01:12:09 **Size:** 68 KB GAVI-HSS SUPPORTED MCHS ASSESSMENT REPORT.doc **File desc:** **Date/time :** 19/05/2015 05:51:43 **Size:** 156 KB HFA Somaliland July 2014.docx **File desc:** **Date/time :** 19/05/2015 05:49:53 **Size:** 478 KB

	Other		×	Income and Expenditure on HSS grant for 2014.pdf **File desc:** **Date/time :** 20/05/2015 01:13:54 **Size:** 21 KB Join GAVI HSS Facilities Reassessment Report Oct 21.docx **File desc:** **Date/time :** 19/05/2015 05:48:09 **Size:** 94 KB Mail to HSC.pdf **File desc:** **Date/time :** 19/05/2015 05:47:48 **Size:** 877 KB