

1. Brief Description of Process

This Internal Appraisal was conducted for GAVI by independent technical expert **Gordon Larsen**, in close cooperation with GAVI CRO for the country **Anne Cronin**, and is based on reports and documentation supplied to GAVI by the national authorities and institutions in the country for the year 2013. The draft appraisal was shared with the in-country partners, WHO and UNICEF, who manage GAVI support, and their comments are incorporated.

2. Achievements and Constraints

The country did not meet any of its coverage targets in 2013 and this is clearly stated in the APR. Targets for all the traditional EPI vaccines were missed, and in some cases, targets were missed by very wide margins (26% vs 80%). The main reasons given were insecurity and accessibility problems in most regions of south Somalia. In the Central Southern zone (CSZ), about half the districts were not accessible during the year, and immunization sessions could only be held at fixed health facilities. Activities outside the MCH facilities, such as outreach or mobile immunization activities, CHDs or other immunization campaigns were not allowed by the authorities. It was noted that DTP 3 coverage in CS zone, where about 70% of the population resides, was around half the level of coverage reported in the relatively stable areas of North Somalia. As a result of the insecurity, targets for OPV, DPT and Penta were revised downwards for 2014 and 2015 by 25% pt. and 22% pt. respectively (and by 34% pt. in the case of Penta in 2014). Inexplicably, the targets for BCG, measles and TT all remained unchanged. WHO is provided technical assistance in the development of a coverage improvement plan for Somalia.

Targets for DPT1-DPT3 drop-out were also not met in 2013 (16% is reported, compared to a target of 13%), and possibly as a response to these results, it is noted that targets for 2014 and 2015 are revised upwards to 20% and 12% respectively, from the previously approved targets of 10% and 7%.

According to APR section 5.1 there are no changes in vaccine wastage rates, but baseline Table 4 shows Penta wastage is reduced from 25% to 20% for 2013 and 2014, and remains at 20% in 2015.

Sex-disaggregated data on immunization is not available from administrative sources at present, but according to MICS surveys in 2011, Somaliland and Puntland had slightly higher immunization coverage rates in boys compared to that in girls. Differences were not statistically significant however, and no sex discrimination has been observed in immunization services. In all training sessions, vaccinators are instructed to advise parents to present all children, irrespective of sex, and vaccinators are instructed to report any signs of discrimination. Health workers are trained to provide services irrespective of gender and supervisors need to report and take immediate action in the event of overt or covert gender discrimination. The country plans to collect sex-disaggregated data on routine immunization in the future and the surveillance system already collects sex-disaggregated data on EPI related diseases.

No other equity issues are mentioned on the APR template. The difference in DTP3 coverage between 5th and 1st wealth quintile is 23.4%.

Most of the challenges faced by immunization services in the country are the result of serious and long-running insecurity and inaccessibility issues that affect many areas, and the general deficiency of public health infrastructure and capacity due to the long-term lack of a functioning national government. These are not issues where GAVI HSS funds can or should be applied, and it is believed that the alliance is already contributing to the extent possible.

3. Governance

An ICC was established within the country, and this group met 4 times in 2012 and 4 times during 2013 which was considered satisfactory. Minutes for the ICC meeting at which this APR was

endorsed for submission to GAVI were to be sent ASAP by the country (this would also require a list of members attending and a signature sheet). However, WHO and UNICEF country partners advise there is no longer a separate ICC operating in the country, and the HSCC took over the functions of the former ICC.

Unfortunately, WHO and UNICEF country partners reported the HSCC also came to a halt in September 2013. The 'ad hoc' group that subsequently replaced the HSCC reportedly met on 28 May 2014 and eventually gave endorsement of the APR for submission to GAVI, and the required list of participants and signature sheet of the members and chair were apparently provided to WHO and UNICEF. The APR was subsequently endorsed by an e-poll.

According to information that the country routinely provides on the JRF, a NITAG has been established since 2010, but there is no mention of the membership of this body and no indication of the frequency of its meetings. However, WHO and UNICEF country partners advise there is presently no NITAG operating in Somalia and JRF data is apparently reported in error.

It is assumed that when these bodies were operating, there would have been a degree of shared membership between ICC and HSCC.

Copies of minutes provided show conclusions and actions to be taken. Two major concerns have been expressed by the ICC over a long period: the weak population figures and lack of catchment area definitions, and the sustainability of the programme and especially the issue of co-financing. The new government has yet to establish itself financially however, and until this happens, the co-financing issue would have continued being discussed by the Health Sector Committee (HSC). With the non-functionality of the latter however, it is unclear how discussions on this issue will now proceed.

CSOs were participating actively in both the ICC and the HSCC. The APRs list 14 CSOs who were members of the ICC in 2012 and 12 CSOs as members in 2013. Provinces and states, together with the CSOs were apparently represented on the HSCC but without a membership list, this cannot be confirmed. The CSOs were represented on the HSCC through the NGOs; although the HSCC was aware that CSOs should be dealt with differently from the NGOs in terms of membership. This issue will require further discussion. No official nominations were received from the Civil Society which was previously represented by Non-State Actors (NSA) through a project funded by the EU. The support from EU stopped at the beginning of 2012 however, and it became difficult for the civil society to travel to meetings and have feedback consultative meetings within the zones. The current status of beneficiary feedback to the 'ad hoc' group is thus unclear and there is no reference to this issue in the APR.

4. Programme Management

A national immunization structure does not exist and there are 3 zonal authorities at present, each with its own health structure. In the Northern zone, organization of immunization services at regional and district level is extremely weak or non-existent. In Central Southern zone, management of EPI has been supported by WHO, UNICEF and NGO partners. There is no existing district health system and EPI units have no infrastructure. There are no functional links between management at MOH level, the regions and the MCHs on the ground. The absence of any link between the management structure and service delivery points has a highly negative effect on planning, implementation and monitoring of immunization services.

National immunization plans cannot be produced in the absence of a national structure and regional plans, where they exist, are not believed to be costed, budgeted or reviewed by the ICC or HSCC. Such management functions are not possible in the country at present. No regional plans are mentioned or referred to in this APR for 2013, nor are they provided as supporting documents. There has been some discussion of using the Pakistan model of developing sub-national cMYPs, although in Pakistan, the sub-national entities are recognized as part of the official health infrastructure by the national government.

It is planned to utilize GAVI HSS funds in 2014 for production of microplans, under the Coverage Improvement Plan.

All baseline data, performance indicators and future targets are adequately included in APR Table 4, although it is noted that for 2013, numbers of reported births and surviving infants are revised upwards against the baseline, and numbers of pregnant women are increased by more than 25% compared to the baseline. For 2014 and 2015, however, all numbers remain as previously approved in the GAVI letter, and inexplicably, numbers of pregnant women are shown to fall back to the levels previously approved.

As noted in section 2, targets for all antigens were revised downwards for 2014 and 2015, with Penta 3 set at 60% compared to 94% in the decision letter.

Bearing in mind the insecurity, inaccessibility and difficulties caused by a lack of functional infrastructure in many parts of the country, activities are generally implemented approximately to schedule and budget, although it was not possible to meet any of the targets set in 2013. As noted in section 2, targets for OPV, DPT and Penta are all revised downwards for 2014 and 2015, but targets for BCG, measles and TT remain unchanged, and especially in the case of measles, this is considered to be overly ambitious and unrealistic. It is recommended that the latter be revised downwards to bring it more into line with the revised targets already provided for other vaccines, and the WHO and UNICEF country partners advise that this will be done, especially in view of the lack of funds for immunization services.

5. Programme Delivery

An EVM assessment was conducted in the first quarter of 2013; and an improvement plan based on the EVM recommendations was developed and dated 25 December 2013. This plan shows no budget for any of the improvement tasks listed however, no planned start and finish date for any of the activities, and no completion indicators. No status report on this improvement plan was provided (although one is listed as a document attached to the APR) and it was unclear whether any of the items had been implemented to schedule and budget during the year. WHO and UNICEF country partners subsequently advised that a number of the EVM improvement activities were actually implemented, and noted that:

‘It is planned to utilize GAVI HSS funds for activities under the Coverage Improvement Plan; and as a first step, the production of zonal micro plans is foreseen. However, no GAVI HSS funds were used so far for the following EVM improvement activities that have been implemented:

- 1) Procure and distribute 25 continuous temperature data ledgers and 700 freeze tags to all cold chain equipment at all levels.
- 2) Provide spare parts for cold chain equipment maintenance according to the need.
- 3) Develop a multi-year plan for renewal / replacements of all old aged equipment (according to the WHO/ UNICEF standards) at all levels (done for SC zone; and pending for Somaliland and Puntland).
- 4) Ensure the availability of at least 3 years signed documentation for electronic temperature alarm monitoring devices.
- 5) 110 voltage stabilizers procured for all refrigerated equipment inside stores where there is no stability of electricity or where there is no generator.
- 6) Separate office for the store keeper provided outside the cold chain equipment’s room for better working environment. (Done for Puntland).

Again, no budget for any of these improvement tasks are given however, no planned start and finish date for any of the activities are mentioned, no status or completion indicators are shown and none of the tasks indicate which of the EVM criterion they are supposed to be addressing. It thus cannot be determined whether any of EVM improvement activities are being implemented to schedule and budget during the year.

The APR indicates there were no vaccine stock-outs of Penta vaccine at any level during 2013, but no information is provided on any other vaccines. During a recent mission to Somalia it was reported that there are stock outs of some antigens, but details of the vaccines affected and the

duration of stock interruptions are not reported. It is noted that various vaccine stock management improvements were recommended by the 2013 EVM assessment and WHO and UNICEF country partners report that some vaccine management improvements were made in Somaliland and Puntland, with efforts to continue in SCZ.

The recent introduction of Penta vaccine went to plan and schedule according to the APR and no problems were encountered with this activity. The Penta vaccine was introduced nationwide and has now completely replaced the former DTP vaccine. There are no stocks of the latter remaining in the vaccine management system.

6. Data Quality

Data is collected by more than 40 partners, with coverage calculated by UNICEF and WHO and endorsed by local health authorities. Immunization coverage is not monitored on a regular basis however, and quality of data has not been validated, so there are large discrepancies between reported coverage and MICS survey coverage, with both under- and over-reporting observed. Coverage data and vaccine management indicators are not monitored at intermediate levels, and data has never been used at all at the peripheral level. All the EPI activities reported are based on rounded estimates provided by the central level in cooperation with WHO and UNICEF staff.

High rates of population movement due to conflict and insecurity, a nomadic lifestyle and drought has made it difficult to have proper denominators at regional and district levels. (some 30% of the population is estimated to be nomadic) MCH catchment areas have no defined target populations, so denominators cannot be determined exactly, and the last population census was conducted in 1974. The very weak and unreliable population and catchment area data has been a long-term concern of partners and the ICC.

The APR section 5.1 states there are no changes in the numbers of births and surviving infants, but this is not correct. In baseline Table 4 it is noted that numbers of births, deaths, surviving infants and pregnant women are all changed for 2013, the latter being increased by more than 25% compared to the baseline figure approved by GAVI's decision letter. There is no explanation or justification for these changes, and again, this is a routine requirement for APR data under GAVI rules.

In response, WHO and UNICEF country partners state 'there is an increase of 3% of population per year, and we use an estimate of 4% for live births and 5% for the number of pregnant women. That explains the changes in population.' However, this information in no way explains the discrepancies noted in APR section 5.1 and in no way addresses the need for explanation or justification for these changes noted.

A comprehensive EPI review was conducted in 2012 in Somaliland. (NW Zone) but one of the major concerns in HMIS administrative data was the uncertain denominators used, since catchment populations for health facilities are not clearly defined. Activities carried out to improve data management include:

- Transfer ownership of HMIS from UNICEF to MOH in stable zones of Somaliland and Puntland, through phase-out and tailored capacity building strategies.
- Assist establishment of MOH National HMIS and regional HMIS units in Somaliland and Puntland.
- Standardization of HMIS tools to be used across all 3 zones through coordination with the 3 MOHs.
- Print, supply and distribute standardized HMIS tools to 3 MOHs and the NGO partners.
- Support capacity building at all levels, eg, training, workshops, field technical support and supervision.
- Future plans for making further improvements to data quality include extending these data improvement activities to the Central Southern zone to ensure that strengthening is carried out uniformly nation-wide.

7. Global Polio Eradication Initiative, if relevant

Polio campaigns were reported to be held however not reported in APR and no expenditure for polio campaigns is mentioned. Information provided by the WHO and UNICEF country partners shows a completely different picture, with US\$ 17 million used for polio campaigns during the year, and 10 OPV rounds being conducted. The use of GPEI assets in Somalia is being initiated in 2014.

8. Health System Strengthening

WHO and UNICEF country partners provide the following details: 'The current HSS grant of \$11,545,000 was recommended for approval by the IRC in October 2009, for the period 2010 to 2014. To date, \$5,257,178 of this budget has been disbursed, with the last disbursement in December 2012. The next tranche of \$2,549,515 was approved in May 2014, has been disbursed. There are some variations between the original approved budget and actual planned expenditure for 2014. The 2013 APR requests for the approval of \$3,738,808 for implementation during the financial year 2015.

The objectives of the HSS grant are:

1. To improve availability and utilization of immunisation and other essential maternal & child health services - by strengthening and supporting selected MCH/Health centres based on the Essential Package of Health Services (EPHS).
2. To improve the access of rural communities to immunisation and other basic but essential preventive promotive and curative health services through support to: Health posts and CHWs; and introducing on a pilot basis a new cadre of Female Community-based Health Workers (FCHWs) providing mainly preventive services to a defined catchment population
3. To improve awareness and demand for immunization and other essential quality maternal and child health services through a comprehensive and sustained campaign of behavioural change communication.
4. To provide evidence (on utilization impact and cost of services) in order to generate appropriate and affordable health care delivery models for maximisation of efficiency health essential services through managing a programme of operational research

Due to funding delays, the country saw the need to reschedule activities and its M&E targets to subsequent years. The country requested for reprogramming in November 2013 (for \$8,610,880), due to continued implementation delays (arising from security constraints). All activities under Objective 3 were changed to focus more on improving the availability and quality of vaccination activities, data processing and analysis and demand generation. The revised end date of the HSS grant is 2015.

For objective 4, low progress has been made in 2012 and 2013 and activities have been reprogrammed as the required institutional framework at the MoH level and human resources were set in place only in late 2013 and early 2014. There were delays in recruitment of a consultant for formative research.

HSS funds are channelled through UNICEF and WHO, and the Ministry of Health in the 3 zones are the implementing partners. The HSS funds are not reflected in the national health sector plan or national health budget, but a JAR is on-going as part of the HSS programme annual work plan. There is no external audit report available. Due to the security situation in the country, there have been challenges in implementation and hence long delays.'

There was no government budget contribution or allocation for EPI in 2012 and also none in 2013. There is no immediate prospect of the country moving to financial and programmatic sustainability in the near future.

This Internal Appraisal was satisfied with the quality of the country's reporting of HSS results. Comprehensive information on each activity is provided and explanations are given where targets were not met or not met according to schedule. Quality of data at present, including baselines and performance indicators, and plans for its improvement in the future are already described in

section 6.

WHO and UNICEF country partners provide the following information on CSOs. The CSOs involved in HSS implementation are Kow Media Corp, IHSA religious network Puntland, Puntland Students Consultancy association, Radio Daljir, Telsom Media and Radio Hargeisa. Their tasks and activities include: school education events, community mobilisation activities and radio programmes on child survival, interactive SMS services for maternal and child health. The partners were selected based on the existing partners selected for implementing UNICEF activities which is through competitive bidding process or through Programme Cooperation Agreements (PCAs). The selected partners had to have presence in the GAVI regions while for the radio stations the criteria was overall reach to the GAVI regions.

The major constraint with the implementation of the C4D activities was the small amounts of funding allocated to each activity and zone. For example \$ 20,000 was allocated for all the three zones for partnerships with religious leaders which meant that each zone was allocated about \$6000. This makes it difficult to conduct activities that will have a long term impact, and are difficult to implement and monitor due to having different partners for each intervention. There was also a delay in the disbursement of funds because most partners thought they would not be able to achieve the desired results with the limited funds provided. This was one of the reasons UNICEF opted to work with partners that already have existing agreements in the respective regions. This challenge has been addressed by increasing funds through the re-programming, though not to sufficient levels. In 2014 it is also planned to have one partner coordinate and implement all C4D activities in each zone so it can ease implementation, monitoring and reporting.

No information is provided on whether management of HSS funds was considered to have been effective. However, the proposed future HSS activities are described in detail and are considered to be logical and appropriate continuations of the activities already being implemented. They are believed to align within broader HSS activities and other donors' initiatives according to the description given in the APR.

9. Use of non-HSS Cash Grants from GAVI

The country has not received ISS funding since 2003/4. The country has not received CSO support (either Type A or B) and is not reporting on fund utilisation for 2013.

Funds received in 2013 as a Vaccine Introduction Grant amounted to US\$304,500 and the whole amount was used during the year, with no balance carried forward to 2014. Funds were reportedly used for:

- Training of health workers,
- Cold chain maintenance and improvement,
- Advocacy and communications,

These activities appear to be appropriate and reasonable expenditures for the VIG.

10. Financial Management

Financial management is undertaken by WHO and UNICEF in accordance with their rules and regulations. No FMA has been conducted prior to or during the 2012 calendar year.

WHO has not submitted financial statements for VIG. The VIG income reported in the 2013 APR of US\$ 304,500 does not agree with GAVI records that show US\$190,000 disbursed in 2013. It appears that the full budget (not actual total ledger transactions) is reported as spent in the APR. The amounts reported in APR for HSS do not reconcile to financial statements submitted by UNICEF for HSS. Once the financial statements from WHO are received, PFO will be able to review the reported figures in a more holistic way. This issue can be followed with the partners without stopping disbursements.

11. NVS Targets

As already mentioned in section 2, targets for OPV, DPT and Penta are all revised downwards for 2014 and 2015, but targets for BCG, measles and TT remain unchanged. The target for measles especially is considered to be overly ambitious and unrealistic and it is recommended that this be revised downwards to bring it more into line with the revised targets already suggested for other vaccines. The WHO and UNICEF country partners have advised that this recommendation will be adopted, especially in view of the lack of funds for immunization services.

12. EPI Financing and Sustainability

There are multiple funding sources for routine immunization activities but there was no government budget contribution or allocation for EPI in 2012 and also none in 2013. The programme is entirely donor-dependent at present, un-predictable and un-sustained, with a dwindling budget for routine activities at fixed-centres. Funds for outreach activities have been allocated from re-programming of GAVI/HSS funds in 2013, but this is also un-sustained for the future. WHO has been the largest donor over the past two-year period, contributing 63% of the budget in 2012 and 40% in 2013. UNICEF was the other main partner until the start of GAVI support in 2013, and contributed 37% in 2012, decreasing to 22% in 2013. GAVI's contribution was 35% of the total budget in 2013, but although the total budget has increased in 2013, the dollar value of both WHO and UNICEF support has decreased from 2012 to 2013. UNICEF has confirmed that it will continue to provide the traditional EPI vaccines in 2014.

According to the APR, support from GAVI, in the form of NVS and injection supplies is reported in the national health sector budget.

It is by no means certain that the programme can continue to develop in the near term, and as already mentioned, it is entirely donor-dependent at present, and thus totally reliant on the extent and direction of such support for further progress. There are no prospects for the country graduating from GAVI support at any time in the foreseeable future. The establishment of nation-wide security and improved stability will be needed before the process of building a national infrastructure and establishing adequate national institutions can begin.

13. Renewal Recommendations

Topic	Recommendation
NVS HSS	Renewal subject to discussion on revision of targets and doses without a change in vaccine presentation is recommended. Continuation of support disbursement value US\$3,738,808 for 2015.

14. Other Recommended Actions

Topic	Action Point	Responsible	Timeline
EPI targets	Targets for OPV, DPT and Penta are all revised downwards for 2014 and 2015, but targets for BCG, measles and TT remain unchanged. Postponement of the penta shipment.	UNICEF GAVI Sec.	Asap
EVM	Country is required to provide further information on the progress in implementation of EVM recommendations and forward an updated Progress Report on the current status of EVM 'Improvement Plan'.		Asap
HSS	HSS disbursement of value US\$3,738,808 for 2015 is recommended (note there is a discrepancy of US\$10,000 between the amount requested in APR 9.1.2 and that shown in Table 9.1.3a. The amount recommended is taken as the higher figure)		

