Joint Appraisal Report
SOMALIA 2016

Joint Appraisal Report

When submitting this report, the country confirms that the grant performance framework has been reviewed as part of this joint appraisal. Performance against agreed metrics has been analysed, and explained where relevant.

Country	Somalia
Reporting period	January 2015 to December 2015
Fiscal period	January 2015 to December 2015
If the country reporting period deviates from the fiscal period, please provide a short explanation	January 2015 to December 2015
Comprehensive Multi Year Plan (cMYP) duration	2016- 2020
National Health Strategic Plan (NHSP) duration	2011 – 2016. New NHSP is being drafted and planned to be ready by end of 2017.

1. SUMMARY OF RENEWAL REQUESTS

[These tables will be pre-populated by the Gavi Secretariat. If there are any changes to be made, this should be discussed as a group during the joint appraisal and flagged in the report – see the guidance document for more details]

Programme	Recommendation	Period	Target	Indicative amount paid by Country	Indicative amount paid by Gavi
NVS – *Penta*	*Extension*	*2017-2020*	*300,199*	*US$*	*US$*
NVS – *IPV*	*Extension*	*2017-2018*	*300,199*	*US$*	*US$*
HSS 2	*Renewal*	*2017-2020*	*N/A*	*N/A*	*US$*

Indicate interest to introduce new vaccines or HSS with Gavi support*	Programme	Expected application year	Expected introduction year
	HSS 2	*2016*	*2020*

**Not applicable for countries in final year of Gavi support*

2. COUNTRY CONTEXT *(maximum 1 page)*

This section does not need to be completed for joint appraisal update in interim years

[If relevant, comment only on any changes since the previous joint appraisal to key contextual factors that directly affect the performance of Gavi grants – see guidance document for more details]

A new environment is emerging in the Somali health sector, consequential to the peace dividend along with the investment made by international partners.

Somalia has one of the lowest DTP3 coverage rates in the world (42% WUENIC 2014), following decades of civil war. In 2015, maternal mortality ratio was estimated at 732 per 100,000 live births, whereas under-5-mortality rate was 137 per 1000 live birth[1]. In terms of JRF data, pentavalent I coverage was estimated at 50%, Penta III at 46 % and Measles at 43% (JRF 2015).

[1] Inter agency estimates http://www.childmortality.org/index.php?r=site/graph#ID=SOM_Somalia

The Federal Government of Somalia (FGS) is developing a three years National Development Plan (2017 – 2020) (NDP) that will follow Somalia's New Deal Compact. The NDP reflects priorities of the health sector and include key objectives defined in Somalia's National Health Policy 2014.

Administratively, Somalia is divided into three zonal authorities: Somaliland (North-West Zone), Puntland (North-East Zone) and South-Central Zone. In addition, in 2015, new Federal States have emerged from South Central namely Jubbaland, South West and Galmudug administrations. Parliamentary and presidential elections are expected to take place in 2016 in Federal Somalia and 2017 in Somaliland. Their results might have implications for the way in which the next phase of the HSS grant will be planned and managed in South Central Somalia.

As such, it was felt that current mechanisms for health sector coordination[2] need to be revisited and adjusted to account for these new situations, ensuring that sector coordination is implemented in a decentralized way and reflects community needs.

The country is now in the processes of developing the next phase of health sector strategic plans (2017 to 2021) (HSSP) that will be aligned with zonal, national and international reference frameworks as well as health sector policies, the NDP and the Sustainable Development Goals (SDG). The priorities of the next HSSP, along with the already finalized Country Multi Year Plan (cMYP) for 2016-2020 constitute the basis of the next GAVI HSS grant application.

Somalia's population is rapidly increasing. The population is estimated to be 13 million in 2016 with 42.5% living in urban areas and 22.8% living in rural areas3. Urban settlements are growing at an unprecedented rate with enormous urban-rural migration, fueling much of the concentration of the population in and around urban centers.

Key high-risk groups include 2.4 million children under the age of 5 and more than 3 million women of child bearing age. Nomads constitutes one-fourth of the total Somali population whereas there arean estimated 1.1 million (8.6% of the total population) internally displaced people living mainly in the outskirts of urban towns (PESS data 2014). This has considerable ramifications in an environment where public sector capacities to deliver health and related services are limited; development and humanitarian assistance are declining and there are persistent areas of conflict, natural disasters and health emergencies such as drought and epidemic outbreaks.

Capacities of public institutions have improved, but the prevailing health system weaknesses pose major challenges for ensuring equitable access to quality and safe basic health services. These include weak coordination mechanism and limited availability of health intelligence for informed decision making process; chronic shortage of qualified health workers; inadequate and unsustainable levels of financing and deficient procurement and supply systems.

The first post-civil war countrywide health sector policy was developed in 2014. The Somali Health Policy provides a national frame of references, outlining health sector priorities. Sub-sector policies including EPI have also been developed, reviewed by the Health Sector Coordination Committee (HSC) and endorsed by the Health Advisory Board (HAB). The next phase of a comprehensive multi-year plan (CMYP) 2016 - 2020 for immunization was developed. The Somali cMYP 2016 – 2020 is aligned with the existing health sector strategic plans from Somaliland, Puntland and South-Central and has separate chapters for each of the three zones besides the consolidated section pertaining to Somalia.

Health service delivery is structured around the framework of an Essential Package of Health Services (EPHS), developed in 2009. It comprises four levels of service provision, six core programs including immunization, four additional programs and six management components. However, implementation of EPHS is not being implemented uniformly across the country and covers only nine regions, supported through two main implementing programmes (JHNP and Health Consortium for Somalia). In the remaining nine regions, health service delivery is inconsistent and dependent on the presence of humanitarian organizations. Vaccines, supported by GAVI though are available in all public health facilities across the country.

At the moment of producing this report, the funding situation of the Somali health sector beyond 2016 is uncertain and a drop in overall funding is anticipated. The largest health sector development programs, the Joint Health and Nutrition Programme (JHNP) which provides the largest contribution to the delivery

[2] The Health Sector Coordination Committee (HSCC) assembles constituencies from the donor community, UN agencies and NGOs; it is chaired by the three zonal health authorities and meets on quarterly basis in Nairobi. Similar structures are established at zonal level, feeding back to the HSCC. The HSCC spells out recommendations to the Health Advisory Board (HAB). Let by the three health Ministers.

3 Population projection based on Population Estimate Survey Somalia (PESS) 2014, UNFPA Somalia and Ministry of Planning & International Cooperation

of health services through contracted NGOs is coming to an end in December 2016. However, the continuation of funding the implementation of the EPHS in the same location is likely to continue under different implementation arrangements. The Global Fund renewed their commitment to support the Somali health sector through grant for HIV/AIDS, Malaria and TB with a modest contribution to HSS (in the area of HIS, supply chain and Essential Medicines) and so did GAVI. Somalia intends to submit a new HSS application in September this year.

3. GRANT PERFORMANCE AND CHALLENGES *(maximum 3-4 pages)*

Describe only what has changed since the previous year's joint appraisal. For those countries conducting the joint appraisal 'update', only include information relevant to upcoming needs and strategic actions described in section 5

3.1. New and underused vaccine (NVS) support

3.1.1. Grant performance, lessons and challenges

[Comment on the relevant bolded areas listed in the table in this section of the guidance document, e.g.: programmatic performance of each vaccine programme against approved targets and planned activities, including progress and bottlenecks in implementation; actual versus planned financial expenditure, associated challenges, proposals for using unspent funds, and complementarity between all cash grants]

EPI services are being provided in all accessible[4] districts of the country. In 2015, the routine immunization package included BCG, tOPV, DPT-HepB-Hib, measles (MCV), TT and Inactivated Polio Vaccine (IPV). The country has developed and is using the cYMP from 2016-2020 with revised performance framework and targets. UNICEF and the Government (MoH) continue to improve the cold chain infrastructure and management. A comprehensive cold chain inventory was conducted as per requirement of the cYMP and results were used to develop the expansion and replacement plan 2016-2020. These will serve as the basis for a CCEOP application early 2017.

In relation to objective 2 of the GPEI end-game strategy, Somalia introduced the IPV vaccine, with a delay mostly linked to training of health workers, in November 2015 (against original date of June 2015) in some of districts of Puntland and South central zone Due to further logistics and monitoring tool challenges other districts introduced early 2016. IPV was introduced into the routine immunization service targeting children aged 0-11 months. IPV introduction before the switch from tOPV to bOPV (in April 2016) was to ensure that the population vaccinated is protected against type 2 polio virus after OPV2 cessation, mitigating the risks associated with OPV2 cessation, such as the emergence of vaccine-derived polioviruses (VDPV).

The preferred formulation by the Somali health authorities was 10 doses, however only 5 doses formulation was available at the time of purchase. IPV 0.5m IM is administered along with Penta 3 or at time of 1st contact if after 14 weeks, to eligible children. The pre-implementation activities were successfully implemented late 2015 and early 2016 and included the sensitization of all stakeholders, training of EPI managers and health workers, assessment and improvement of cold chain, revising and printing of registration, distribution to zones and data management tools, advocacy and social mobilization. IPV is now fully administered in all accessible areas of Somalia.

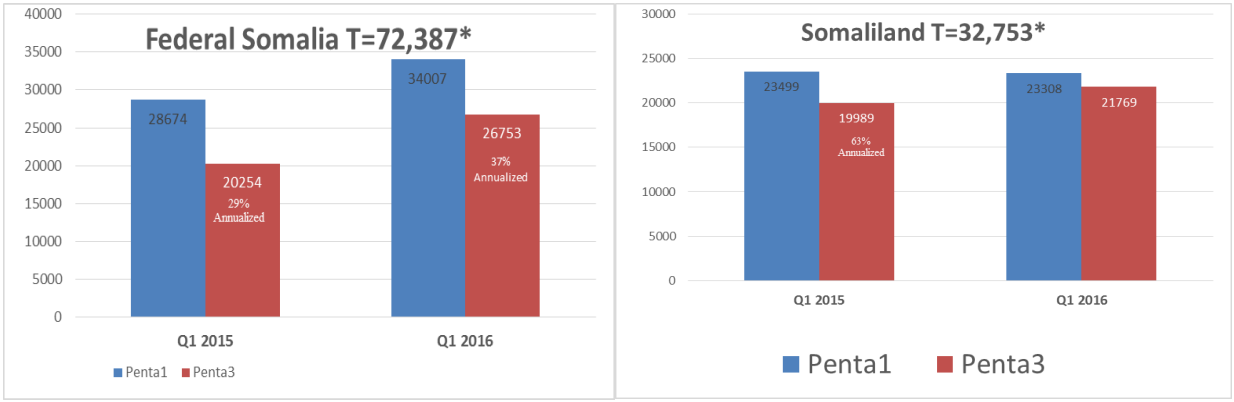
Pentavalent vaccine (DPT-HepB-Hib) is in its third year of introduction and is administered throughout the country. A post-introduction evaluation (PIE) was, although planned, not conducted after introduction.

Coverage levels for all the vaccines remain very low (<60%) for all vaccines as shown by the specific antigens:

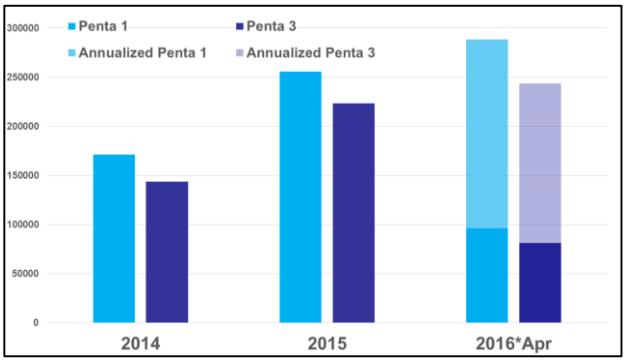
[4] Out of estimated 90 district, completely inaccessible for immunization are (18 districts): Badade, Hagar, Jamamme East & West, Jilib, Buaale, Sakow, Salagle, Sablale, Qoryole, Awdheegle, Adan Yabel, Runnigod, Galad, Eldhere, Galhareri, Elgras. Partially accessible (19 districts) are: Kismayo, Afmadow, Bardera, Dinsor, Burakhaba, Quansha Dher, Burdubo, Gabarhare, Bardale, Baidoa,Wajid, Rabdhure, Hudur, Tieglo, Beladwein, Bulo burti, Jalalaqsi, Adale, Elbur.

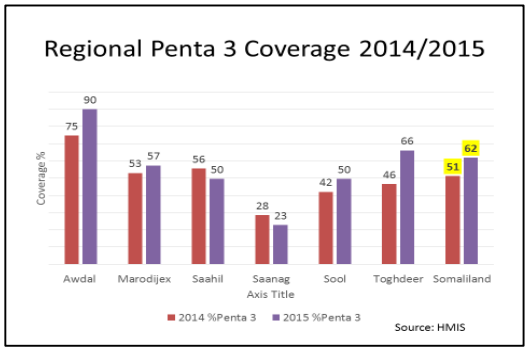
- PENTA-3 coverage is 46% in 2015 (JRF) as compared to 29% in 2014 (JRF) – (WUENIC coverage rate for same year was 42%). The PENTA-1 coverage also increased from 36% in 2014 (JRF) to 53% in 2015 (JRF);
- While 2015 targets were missed for all vaccines, the largest margin was for Penta-3 for which the target was missed by 26% points. The drop-out rate for Penta-1 to Penta-3 in 2015 is 12.7% (as recorded in 2015). It should be noted that the drop-out rate target for 2015 was met;
- Measles (MCV1) coverage stood at 43 %;TT2+ coverage for pregnant women 60%;
- Data on IPV is not yet presented since the data were not captured by the HMIS reporting tool though the new EPI Registers capture the data;
- Vaccine wastage rate has been revised to 25% from 20% in 2015 and is applied for Penta. 26% of population in Somalia as per PESS are nomadic population. Reaching out to these populations has been challenging and contributed to high wastage rates due to few eligible children.

Penta vaccine uptake improved in all the zones 2015 e.g 44% in 2015 as compared to 23 % in 2014 in CSZ. Similarly in Puntland, Penta 3 increased in coverage to 38% as compared to 27% in 2014 and in Somaliland Penta 3 coverage improved to 62% as compared to 51% in 2014. Very few districts reported above 80% of Penta 3 coverage.

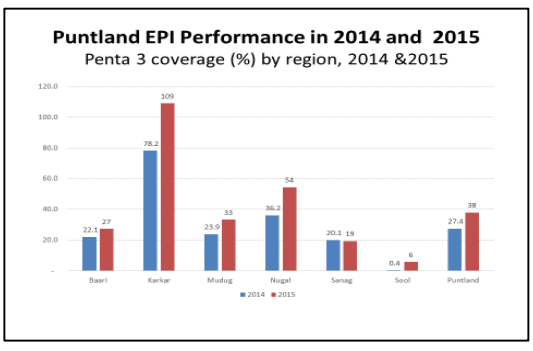


Immunization coverage in Somalia 2014-2016



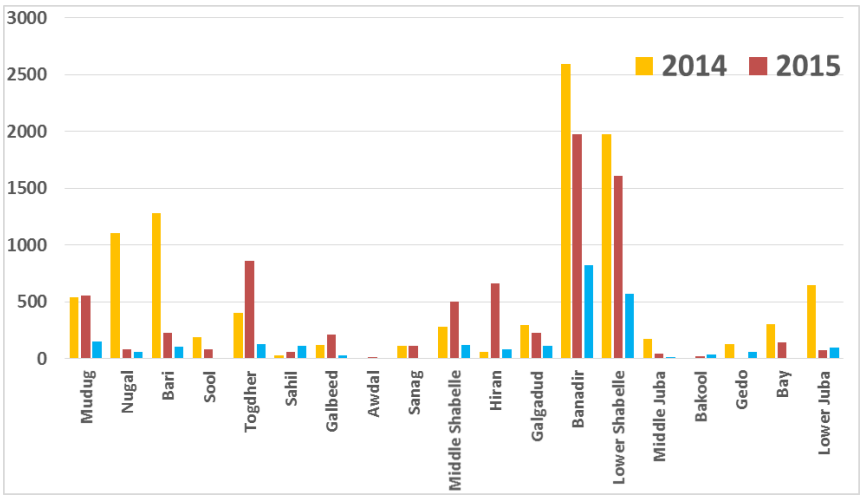


Somaliland



Puntland

Suspected Measles (Fever & Rash) cases in Somalia, 2014-2016



Coverage GAVI supported MCHs in Marodijex Region, Somaliland (HIS data)

	Penta1	Penta3	Measles	Penta 1-3 DO
2014	67%	50%	47%	25%
2015	82%	67%	80%	18%

Coverage in Marodijex Region, Somaliland (all MCHs):

	Penta1	Penta3	Measles	Penta 1-3 DO
2014	61%	52%	42%	14%
2015	64%	57%	54%	14%

Somalia has progressed in developing cold chain infrastructure and vaccine management practices. After conducting the EVMA in 2013, a number of recommendations were prioritized under the EVM improvement plan and to date over 80% of the recommendations have been implemented according to UNICEF. Among the main key achievements are:

- Vaccine Management Standard Operating Procedures have been developed, approved and printed for all supply chain levels. These SOPs help guide health workers and vaccinators who have attended previous trainings in EPI;
- Data management: new vaccine stock registers have been developed and old EPI tools revised to match the global guidelines;
- Somalia has procured over 500 electronic data loggers for HFs, 5 central monitoring systems for all zonal cold room, and introduced new temperature charts as per WHO/UNICEF guidelines
- In late 2015 early 2016, Somalia conducted a compressive cold chain equipment inventory which results have led to formulation/ development of the cold chain expansion and replacement plan 2016-2020.
- Cold chain equipment; Somalia procured over 200 Solar Direct Drive fridges (SDDs) for opening up of new HFs, replacement of obsolete equipment as well as installation in the newly accessible/ liberated areas especially for SCZ.
- Somalia is preparing for a CCEOP application in first quarter of 2017.

Lessons:

- IPV introduction offered a new opportunity to build staff capacity through training, provision of IEC materials
- The introduction was an opportunity for cold chain management strengthening and capacity building of MoH and implementing partner staff.
- HMIS reporting tool should have been revised prior to introduction of IPV.

Challenges:

EPI service provision faces a lot of challenges with respect to programme management, service provision, data, demand creation and vaccine/cold chain management.

A. ***Programme management***:

- Despite support under the grant strengthening EPI management at zonal level, weak coordination of multiple stakeholders who are contributing to EPI is weak due to limited functional MoH management teams at all levels;
- Vertical plans of work for sometimes the same EPI improvement activities from different programmes (*Polio, EPHS, GAVI);*
- Lack of monitoring of plan of actions and absence of field monitoring and supportive supervision systems.

B. Vaccine/logistics and Cold chain Management

- Vaccine consumption report not available;
- Stock management books not yet available;
- Cold chain maintenance plan and report not yet available;
- Despite investments, there is still lack of and inadequate cold-chain equipment in newly upgraded health facilities and hospitals.

C. ***Service Delivery***:

- Unavailability of micro-plans for the implementation of fixed, outreach and mobile services for most of the districts; only few districts have completed the micro-plans and are starting implementation; Outreach is only conducted in Gavi supported MCH facilities and some of EPHS focus districts.
- Security challenges in term of inaccessibility to many locations of Somalia, leading to limited or no access to EPI services.
- Non-availability of immunization services in functional health facilities (short working hours per day, stock outs of traditional vaccines, lack of vaccinators, care and treatment priorities in MCH clinics with limited human resources, practically limited monitoring and supervision);
- Lack of routine immunization services in both public and private hospitals;
- Irregular availability of of printed data tools(EPI registers, health cards etc.) at the HFs level leading to delayed implementation despite early arrival of vaccines.
- No review meetings to discuss data to direct service package;
- Lack of or inadequate immunization job aides does not support service providers adequate knowledge and skills for service provision.

D. Data Management (Data Quality Issues):

- IPV data was not captured in the HMIS reporting system hence no data of IPV available at district, zonal and national level though data are available in the EPI register. The HMIS tool was updated in Feb/March 2016.
- Poor or no use of tally sheets at service delivery points;
- HMIS data inaccuracy and incompleteness at various levels;
- Data reporting flow is not systematic: many health facilities are sending reports direct to central, others to regional HMIS unit; – no data are collected or compiled at district level;
- EPHS facilities are supervised by Regional teams with support from INGOs, but findings not shared with zonal level;
- Lack of feedback mechanism and quality assurance systems at all levels;

E. **Demand Creation**:

- No C4D related survey conducted to date to assess the effectiveness and results of demand creation/communication activities (KAP, Media survey etc) carried out recently (lack of baseline);
- Weak C4D structure at all levels;
- Non consistent Radio and TV health promotion activities;
- Most staff lack IPC skills;
- Limited use of traditional and government mechanisms to create demand among communities;

3.1.2. NVS future plans and priorities

[Comment on the relevant bolded areas listed in the table in this section of the guidance document, e.g.: for existing vaccines - reasonableness of targets for next implementation year, plans for any changes in presentation or type, risks to future implementation and mitigating actions; for new applications – any expected future applications (include in table 1 above), emerging new priorities for the national immunisation programme]

The country would like to focus on enhancing the EPI programme capacity at all levels of the health system and scale-up coverage with equity for existing vaccines before considering introduction of any new vaccines. Key health system bottlenecks include cold chain limitations and data system and reporting weaknesses.

3.2. Health systems strengthening (HSS) support

3.2.1. Strategic focus of HSS grant

[Comment on the extent to which the HSS grant contributes to improve coverage and equity in access to immunisation, and how it helps to address the technical, health systems and financial bottlenecks that might jeopardize the sustainability of these gains. See guidance document for more details]

The first tranche of Gavi HSS funding was disbursed in October 2011. A reprogramming was approved in September 2013. A no-cost extension of 1 year to October 2016 was provided in 2015 and last disbursement under the grant was made in 2015.

An independent evaluation of the HSS grant was conducted in 2015. The results of the evaluation inform the proposal development for the next HSS, with an application expected to be submitted in September 2016.

Key findings of the HSS evaluation included the following points in terms of strategic focus:

1. The scope of Gavi HSS proposal in terms of geographic coverage was narrow, implemented in few districts and in less than 20 % of the MCHs while the level of funding was too limited to yield the envisaged impact.

2. The link between the HSS and immunisation outcomes was weak. For example, the Female Health Workers (FHWs) are trained to promote utilization of primary health care (PHC) in general but their work is not directly linked to EPI provision except through community sensitization.

3 Paucity of data hampered a comprehensive assessment of the contribution of Gavi HSS in terms of the key outcome indicators. Many of the endline or midline indicators in the HSS M&E framework could not be derived due to a lack of data.

4. The Health Authorities do not express overall control over implementation of the Gavi HSS grant. Further, marginalisation of some EPI staff within the country has caused tension which might undermine programme implementation in future. In addition, limited capacity strengthening within the government has occurred under Gavi HSS.

The grant activities in 2015 were implemented in line with the work plan. These include:

- support to FHWs through payment of a monthly remuneration, provisioning with supplies and registration form, supervision and continuous training;
- support to MCH facility staff through salary top ups, supportive supervision and training;
- support to selected Ministry focal points at central, regional district level through salary top ups, training and support in programme management, coordination and implementation;
- strengthen MoH capacities for EPI planning, management and data analysis through embedded national TA; This includes support for supervision, training of health workers and MLM training.
- Support micro-planning in priority districts under the One EPI plan.
- ongoing first national health facility assessment using SARA methodology;

- support to MoH teams in data quality improvement and data analysis of FHW and MCH data.
- BCC activitie

3.2.2. Grant performance and challenges:

[Comment on the relevant bolded areas listed in the table in this section of the guidance document, e.g.: achievements of targets and intermediate results; actual versus planned activity implementation and financial expenditure; use of PBF reward and budgets/plans; degree of participation of key stakeholders in implementation of HSS proposal; implementation bottlenecks and key challenges regarding financial management of HSS grant; compliance with data quality and survey requirements]

Grant performance

The performance reporting of the HSS1 grant has been challenging due to the complexities in aggregating results at the national level. The performance indicators were revisited during the introduction of the performance framework and adjustments were made to allow for subnational reporting of the results. Subsequently, the reporting of the indicators using the performance framework has improved from 2014 to 2015. However, very few indicators had a baseline and some indicators couldn't be measured and hence not reported. The lessons learnt from the HSS1 monitoring and evaluation framework and the challenges have been taken into account to develop a more robust framework for the HSS2 application that will be submitted for review in September 2016.

Key achievements of the HSS1 grant include:

- Out of 40 MCH centres supported by GAVI HSS1 grant, 37 are functional, providing comprehensive immunization services to the catchment population serviced by them.

- In Somaliland coverage seems to have improved from 2014 to 2015 in GAVI supported MCHs (WHO evaluation based on HIS data). Coverage also seems higher in GAVI MCHs compared with the overall region. (Marodijex Region). Outreach activities conducted from GAVI facilities have contributed substantially to the improvements. The higher Penta dropout rate in GAVI facilities compared with Marodijex Region overall may be the consequence of higher numbers of children reached for Penta 1 through one round of outreach. The difference may be reduced through follow-up outreach sessions (WHO consultancy on data quality assurance and operational research).

- In Puntland, facility-level target populations have not yet been finalized so facility catchment coverage could not be calculated. However, there was a modest increase noted from 2014 to 2015 in the number of doses administered for Penta1, Penta3 and measles in GAVI supported MCH facilities. Penta drop out decreased from 8% to 5% between 2014 and 2015 in Puntland overall, while in GAVI MCHs drop out remained at 13% for both years (WHO consultancy on data quality assurance and operational research).

Leadership and Governance

- Strengthened Ministry of Health capacities in EPI management, planning, coordination and data analysis through embedded national technical assistance and support from implementing partner agencies;

- Increased planning and operational capacities of district EPI health management teams through the 'mid-level and low level management training (MLM)' and development of district micro plans. The current status of district micro plan development, supported by the current grant and plans until its end is:

Somaliland: 2 out of 7 EPI priority districts are supported by GAVI HSS (total number of districts: 19) through support to FHW and MCH facilities; 11 districts in Somaliland have micro plans, including the priority ones.

Puntland: 3 out of 8 EPI priority districts are supported by GAVI HSS as above. The production of micro plans for all districts is planned for until the end of the grant (8 plus 11 non-priority districts).

South Central: 10 out of 22 priority districts are supported by current GAVI HSS grant. It is planned to produce micro plan for all 22 until end of the grant.

Data Quality

- Established functional health information delivery teams at central Ministry level with support from the Health Systems Analysis Team (HSAT) to improve data analysis and assist in operational research, including data collection and analysis from FHWs (monthly based data from FHWs for 2014 and 2015 is ongoing);

- Improved data quality through revamping the recording and reporting system, review of data for action at various levels and capacity building of the staff for this purpose.

- Data quality and denominator issues affect coverage calculations. High movement of population due to conflict/insecurity, lifestyle and drought has made it difficult to have proper denominators at region/district levels. MCH catchment areas have no defined target population.

- DQS are planned to be launched in all zones. A data strengthening action plan with prioritized actions is being developed and shall feed into the HSS2 proposal.

Behavior Change Communication

In relation to Communication for Development and BCC, the HSS1 grant has contributed to the following:

- Generated key data on the attitudes and social determinants of health behaviors in Somalia through formative assessment to understand the social dynamics and how normative behaviors are shaped and practiced that have direct and indirect influence on health of Somali, especially mothers and children. Based on the above, a five years strategic communication plan was developed and endorsed by the Government.

- 893 religious leaders in NEZ, 740 in SCZ and 30 in NWZ were oriented on the importance of immunization. In SL specifically, the Sheikhs delivered 180 weekly sessions at health facilities during the period of March – June 2015 reaching 5,860 mothers. More than 100 schools were reached with information about Polio in NWZ, NEZ and CSZ.

- In Somaliland 60 schools were targeted for comprehensive immunization awareness through peer education approach. 120 teachers were trained, 280 community education committee members sensitized and 500 students were trained as peer educators who educate their peers. Moreover, the students carried out the key messages to more than 28,000 households. Printed Immunization IEC materials (posters) were disseminated in all targeted schools and health facilities. Increased awareness about immunization for mothers, caregivers and public through the training of 95 health workers on Interposal communication skills (IPC) was achieved

- More than 700 radio and TV spots were broadcast in the three zones of Somalia. The capacity of three local NGO in Somaliland was supported to carry out effective community engagement activities that have contributed to demand creation for better utilization of health services.

- The impact of the BCC activities is not yet measured and challenging as a baseline is often missing. UNICEF is currently reviewing the approach and way forward. This should be taken into account in the new HSS proposal.

Grant management

The absence of operational supervision teams to conduct field visits have affected the effectiveness of training activities and transfer of knowledge and skills to the facility level.

Governance and Coordination

In Somaliland, MLM training and district micro planning was completed, including in those districts that are supported by other partners.In Puntland and South Central, both activities will be implemented within the life span of the grant.

Overall, knowledge and skills in EPI especially among facility health workers and district health management teams, are still not adequate for ensuring the provision of safe immunization services, data processing and analysis, planning and monitoring. In some locations, district health management

teams (DHMT) have not been established. The preparation of clear ToRs and the inclusion of DHMTs in the MoH organograms is still pending.

Coordination at district and regional level, particularly in regard to immunization, is still weak and, overall, there is little supervision from zonal to regional and facility level. Whilst addressing GAVI and EPI issues at the Nairobi based HSC as a standing agenda item with substantial progress made in terms of the level of technical discussions, bringing together technical and policy, planning, coordination and communication staff and teams at zonal level still remains weak. In this context the FMoH requested Gavi support for the establishment of both Federal and zonal ICCs to improve coordination and oversight over not only Gavi grants, but the overall immunisation program. Gavi is in the process of launching a RFI under the expanded partners pool to contract consultants who can support ToRs and establishment of ICCs.

Demand Creation

The demand for immunization services is still low in many parts of the country due to inadequate skills of health workers on behavior change interventions and low community knowledge about the benefits of immunization.

Data Quality Improvement

A Data Quality Self-Assessment (DQS) is planned for July-September 2016 in all three zones. As preparation for the DQS, reviews of the EPI data collection system were conducted in Somaliland and Puntland and are planned for South Central in August.

Reviews of 2014-2015 EPI data for all three zones have been conducted. These activities identified various data quality challenges, including inconsistent use of registers and tally sheets, non-standardized data bases, incomplete reporting, duplication and unlikely values.

In the context of a wider HMIS review that started in 2014, EPI data tools were revised, printed and distributed (registration books, tally books and EPI cards). However, the HMIS tools do not capture all needed EPI data (e.g. IPV), the use of tools is not standardized and staff not sufficiently trained on the use of tally books. Vaccine stock registers / BIN cards were produced, but are not yet used in all MCHs.

Somaliland and Puntland use a standardized HMIS excel data base to capture and consolidate EPI data at regional and central levels, which works reasonably well. South Central uses a different system with significantly more data quality problems. The use of different systems and unclear denominators impedes the calculation of coverage.

While data flow is well standardized in Somaliland and Puntland, this is unclear in South Central with some facilities supported by NGOs sending data directly to the central level.

Capacities for data analysis in MCH clinics, as at district and regional level, are limited, with inconsistent use of monitoring charts and lack of understanding of links between micro plans and monitoring charts.

Facility data are aggregated for districts at regional level. While MLM training addresses some data aspects, the role of districts in data management is not yet established and district level staff lack data management capacity.

Reporting back feedback and regular data review meetings are nonexistent.

A review was conducted on FHW data in Somaliland; multiple data quality issues were identified. Reviews of FHW data for South Central and Puntland are planned for June/July 2016. However, an external evaluation is foreseen, targeting the work of the FHW and utilize the remaining time for moving forward on immunization data quality improvement.

Corrective actions – short and long term:

Governance and Leadership

- Develop the capacity of district health management teams including in planning, communication and monitoring through implementing MLM training and development of district micro plans and the supervision of their implementation in the missing districts; - include in HSS2 proposal
- Ensure improved coordination at regional level by holding regular meeting with all partners involved in GAVI HSS, EPI, planning, HIS, etc activities; - establish zonal ICC with Gavi support

- Finalize plans for integrated supervision and implement on monthly and quarterly basis - ongoing
- Revise ToRs and organograms for regional and district health and immunization teams; - MoH to validate.

Data quality

- Interim measure – collect IPV data from health facilities using DPO and DSMC
- Define standard processes and develop job aids for use of registers and tally books for both fixed and outreach services - .support through HSS2 proposal
- Train MCH staff on standard use of data collection tools and monitoring charts as part of micro plan training.) - ongoing
- Develop data quality plan with costed priority actions – align with other donors and finance key priorities through HSS2 proposal – ongoing
- Conduct C&E assessment – planned by UNICEF under PEF TCA.

Vaccine and logistics management:

- Train staff zonal, regional and facility on basic vaccines and logistics management by September 2016
- Provide basic stock management tools Vaccine ledgers, bin cards by September 2016
- Shift from push to pull system- start from zone to regional level and from regional to major locations by September 2016
- Provide cold chain facilities (preferably solar powered).
- Finalisation of of 2016 cold chain expansion plan.
- Apply to CCEOP in Q1 2017

Service delivery:

- Train health facility and supervisory staff at various levels on micro-planning and outreach;
- Use FHW, DSMC to carry out defaulter tracing;
- Start supervision field activities

Demand Creation

- Undertake an assessment on effectiveness on current demand generation activities – planned by UNICEF in 2017
- Conduct IPC training workshops for health workers - September 2016
- Provide necessary material in conducting audio, visual, TV and drama messages- September 2016
- Government officials to advocate for the uptake of immunization and conduct sensitization meetings for different community groups (Sheikhs, women, elders)

Grant Management

- Accelerate any pending procurement and payment of incentives;
- Closely assist and mentor embedded national TA and focal points at Ministry levels;
- Ensure coordination and continued dialogue at zonal and regional level between Policy & Planning, EPI, HMIS/M&E/HSAT and health promotion;
- Submit costed plan to Gavi to cover gap in funding between HSS1 and HSS2 grant start to secure minimum of continuation of support to zonal EPI programs and key activities. Take into account any undisbursed HSS1 grant funds.

Progress on PEF TCA UNICEF

Four main areas were supported through UNICEF with relevant outcomes as below:

<u>Supply Chain</u>

- Last EVMA was conducted in 2013 and a new EVMA is planned for Q4 2016.
- Over 80% of the previous improvement plan has been implemented
- Both class room and on job trainings have been conducted with over 20 staff trained in cold chain vaccine management
- Electronic EPI stock management has been rolled out in 2 zones (NWZ&SCZ), however still pending in one zone (NEZ).

- Plans are under way to monitor vaccine utilization and the national and zonal stores by end Q4
- Cold chain inventory completed and updated in all zones which has led to the development of the expansion and replacement plan.
- Plans are under way to hire a consultant to develop a maintenance plan.
- Cold chain technicians have been trained on maintenance and servicing of cold chain equipment and expected to cascade the training to health workers.

Demand Promotion

- IPC trainings for Health workers (HWs) already started and will continue to reach the total target of HWs to be trained on IPC (awaiting Numbers from field).
- Job aids materials for health workers are developed and being printed.
- Strategic discussion and partnership with Ministry of Endowment and Religion on how to use religious networks to support immunizations and wider health intervention was initiated. Religious training manual is being developed in Somaliland which will be followed by TOT for prominent Sheikhs/Scholars by end of September 2016.
- Roll out will follow next year for other Imams at districts and villages level.

Coverage & Equity

- A TOR has been prepared for the consultant required for Equity analysis, inputs from Regional office were solicited and received. These have been incorporated in the TOR.
- Recruitment process for the consultant will be initiated soon.
- 7 districts have completed the micro planning in NWZ.
- Micro planning workshops planned in Q3 for all zones

Data

Data Reporting

- Each public health facility reports on standard reporting tools to the regional level on a monthly basis. National MoH HMIS Managers regularly receive data reports in standard format from the regions. These are compiled and shared with stakeholders after 20th of the following month. This has been more regular and complete since the beginning of this year although overall HMIS coverage is still only at 50% of the country.

National HMIS Indicators List

- The National HMIS Indicators List was endorsed by the Health Sector Committee in February 2016.

Data recording and reporting tools revision. Following endorsement of the National HMIS Indicators List, the data tools (including registers and monthly reporting tool) are undergoing revision. Workshops with MoH in Somaliland and FGS have been conducted and plans made for Puntland. After this inputs from other stakeholders will be solicited for the tools revision.

HMIS database. DHIS2

- Currently all the Somali Health Authorities are using formatted Excel sheets to report from regions and national level. The MoH had requested for a more appropriate database for HMIS. It was agreed to use DHIS2. A consultancy firm has been identified and the contract will be finalised soon. The Global Fund is the main funder of the DHIS2 roll out.

Data Quality Audit

- The Somali MoH Supervision form include a table for a simple DQA comparing the monthly data reported to actual patient data in registers at health facilities. However this is not being regularly conducted nor reported. Plans are being made to improve the DQA system and operationalising it for regular conduct, reporting and use for better quality HMIS data.

Progress on PEF TCA WHO

Support targets the areas:

Coverage and equity:

- District micro plans developed for 37 districts: from the total 37 focus districts in Somalia, 5 districts in Somaliland (14% of the total target) developed micro plan; Puntland – Under preparation of budget. Submission by mid-June . Training will be held in July – Aug; SCZ – Budget is at MoH for 17 districts and additional budget for the 5 districts will be submitted by mid-June and training will be held in Sep;
- MLM training conducted: in SL and PL, pending in SC to be conducted in Sep;
- Vaccine management training: Conducted as part of MLM training in Somaliland and Puntland and will also be included during the MLM training in South and Central zone. Refresher tailored MLM/EPI/ Vaccine Management ToT training for all zones planned for Oct 1– 13/2016 by EMRO;
- Data quality training conducted: consultant for DQA contracted;
- PEI/EPI integration plan implemented: One national EPI plan developed and being implemented; (The Polio structure is being used in implementing the one EPI plan and supporting strengthening or RI);
- District EPI team established in 37 districts: establishment of EPI management still to be addressed in zones; will also be included under HSS2;
- cMYP 2016 - 2020 developed: completed;
- Mini EPI review conducted: MoH, WHO and UNICEF joint EPI/PEI annual program review and planning done in early 2016 in Hargesia and annual work plan developed based on the 2015 program review findings;
-

Data

- Training on data improvement conducted: Review of data quality on-going; Data quality improvement plan will be developed based on the data quality review findings; DQS planned for the three zones after Ramadan; data quality is one topic in the upcoming tailored EPI/MLM training planned in Oct 2016;
- Training on case-based surveillance conducted: Training on case-based surveillance included in the annual EPI/PEI work plan to be implemented before Dec 2016;
- Measles surveillance put under AFP surveillance, and implemented by District Polio Officers (DPOs): The plan to use DPOs for measles case based surveillances is indicated in the work plan and going to started before 2016. DPOs are already reporting aggregate suspected Mealses cases data;
- Options are being explored to include EPI performance indicators to the Malaria Indicator Survey which is planned for 2017;

HSS

Based on the cMYP and led by an external consultant, jointly with the Ministry and stakeholder teams from Somaliland, Puntland and South Central, a health and immunization system bottle neck analysis was conducted which formed the basis of the next HSS grant application. A joint workshop was then held in Nairobi, bringing all teams together to consolidate and prioritize planned interventions. Yet, substantive work had to go into the production of various budget components after substantive reduction of initially proposed activities, narrative and technical annexes. The proposal was submitted on 2nd. May. However, due to uncertainty about the follow-up of the Joint Health Nutrition Fund, currently coming to an end in 2016 and its alignment, it was decided to take more time to see how this would take shape.
In addition, based on the WHO peer review and Gavi feedback it was felt that more time was required to further strategize and prioritize planned activities, ensuring also complementarity with other funding. Therefore, the application for HSS2 was deferred to September.

3.2.3. Describe any changes to HSS funding and plans for future HSS applications

[Present the rationale for a new tranche of HSS funds (and the associated amount as per table in section 1) or no-cost extension, or any planned changes in terms of re-allocation or reprogramming]

The last tranche of this grant had been disbursed in May 2015. The grant ends in October 2016. A new HSS2 proposal is planned to be submitted in September 2016, after the country decided to delay its May submission.

However, an approval for a costed extension is be requested to bridge the estimated one year gap between HSS1 and HSS2 grant start to sustain some of the critical vaccine management and EPI management activities as well as national staff and embedded TA support for the three zones.

Plans for future HSS application:

- Expand coverage of services and access through establishment of news immunization centres (hospitals, private sector, MCH);
- Increase geographical coverage through outreach and mobile services;
- Improve service standards and planning;
- Increase capacity and management of cold chain and logistic system;
- Improve awareness and demand for immunization services;
- Strengthen governance, planning and coordination capacities through establishment of district/regional (EPI) health management systems and specific support to M&E and supportive supervision;
- Improve data availability, quality and use (programme reviews; operational research on demand generation interventions; post introduction evaluation on vaccines; EVM assessment; DQAS);
- Regularly review the programme performance and take remedial actions as appropriate.
- Strengthen Vaccine Preventable Diseases (VPD) surveillances review and establish harmonized / Integrated Disease Surveillances (IDSR)

CCEOP application

UNICEF CO is working in finalization of the Cold Chain Equipment Expansion and Replacement Plan (CCEERP) in alignment with the CCEOP guidance document. The output of the plan will be embedded in the Gavi HSS proposal to be submitted in Sept 2016. Taking into consideration the status of the CCEERP and the required documents and attachments, the CCEOP application will be submitted in early 2017. UNICEF will technically lead the CCEOP application process.

3.3. Transition planning *(NA)*

[Comment on all bolded areas listed in the table in this section of the guidance document, e.g. progress of implementation of planned activities; implementation bottlenecks; changes required to the transition plan for coming years, including rationale and costing/proposed financing]

n.a.

3.4. Financial management of all cash grants *(e.g. HSS, VIG, campaign operational cost grant, transition grant)*

[Comment on the bolded areas listed in the table in this section of the guidance document, e.g.: cash utilization performance and financial capacity constraints; modifications to financial management arrangements; major issues arising from cash programme audits or monitoring review; degree of compliance with Financial Management Requirements]

UNICEF and WHO manage GAVI HSS funds. Financial statements have been submitted. Final clarifications are ongoing. Towards the end of the grant, estimated savings can support the costed extension.

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

4. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

[Status of top 5 prioritised strategic actions from previous joint appraisal and any additional IRC or HLRP recommendations (if relevant)]

Prioritised strategic actions from previous joint appraisal / HLRP process	Current status
Close collaboration with EPI programme: remaining grant will support activities as outlined in the 'ONE EPI PLAN';	A number of activities outlined in the One-EPI-Plan were supported by the ongoing HSS grant: Support to MLM training and micro plan development: in Puntland MLM training completed for 20 districts; these staff will be involved in the development, monitoring and implementation of district micro-plans, planned under this grant for July 2016; all GAVI supported facilities implemented outreach activities in last two quarter 2015; a total of 240 EPI sessions were conducted; SCZ: cascaded MLM training for regional and district levels not done in 2015, planned in 2016; district micro plans have not been developed in 2016..being planned in 2016; In Somaliland, 11 districts (77/105 facilities): comprehensive EPI micro plan has been developed both EPHS and non EPHS districts, this Micro plan will to guide the proper implementation of the acceleration of routine EPI to boost district immunization coverage. In 2015, in only 13 Gavi facilities EPI outreaches were carried out, leading to an improvement of coverage to the MCHs supported by GAVI. In 2016 355 EPI outreach sessions and mobile EPI services covering 32 MCHs has been implemented with GAVI funds to the three non EPHS districts among the above 11 districts. Two of the remaining 8 districts micro plan will be developed in the next quarter. The EPI support includes both technical and incentives to the MOH staff in the GAVI target health facilities. Meeting conducted in NBO to agree on district population (PESS data); Support to HSCC meetings and ensure that RI as standing agenda (see HSCC meeting minutes); Ground prepared for DQAS; preliminary data analysis performed in SL and PL, SCZ to follow after Ramadan;
WHO/UNICEF to support routine immunization as standing agenda point at HSC and zonal coordination; improve zonal GAVI task force / coordination mechanisms	At zonal level, regular coordination meetings are being held among partners implementing GAVI HSS activities, led by the MoH and involving EPI teams to also address immunization issues; similar is taking place at the Nairobi based Health Sector Coordination Committee (HSCC) (for details see annex minutes HSCC);

	SCZ: EPI/Polio Technical meeting is conducted in Mogadishu on monthly basis by MOH-WHO-UNICEF on monthly basis EPI Working group meeting in Mogadishu among all partners; MOH, WHO, UNICEF and Implementing Partners on quarterly basis. there are no EPI-related meetings happen at regional and district levels. SL: monthly GAVI/HSS coordination meetings are held chaired by MOH, in this coordination forum EPI is a standing agenda. In the last meetings the improvements of the ongoing EPI outreach has been discussed in detail and action points has been drawn.
Support / review development of job descriptions (where not available) and ToRs for MoH GAVI focal points;	PL: RHMT and DHMO of four regions supported and central MoH focal point; SL: 1 RHMT, 2 DHMT; SC: 2 RHMT; ToRs were developed to address and provide support for all ongoing EPI activities such MLM training, supervision and active involvement in EPI meetings at regional and zonal level.
Implement the supportive supervision system	Standardized tools have been developed; progress on implementing 'integrated supportive supervision' (ISS) varies: in Puntland, SPOs have been developed; teams go for supervision on quarterly basis; a progress tracker is being utilized; In Somaliland: tools developed and taskforce was established; standard checklist for ISS is being applied; however, in 2016, supervision activities focused more on EPI. In south Central Zone: Integrated Supportive Supervision Tools were developed and tested by all health teams in MOH, WHO and UNICEF in 2015.
Ensure provision of immunization services / availability of cold chain / supplies at all 40 MCHs	Except in three MCH facilities in Galgudug / Mudug (South Central), all facilities supported by the programme are providing EPI services and have a functional cold chain.
Support development of micro plans and implement outreach services at GAVI sites	In Somaliland: micro plan developed for 77 MCHs; for 32 MCH outreach activities funded, including all GAVI supported facilities; an additional 42 MCH facilities implemented outreach services; PL: see point 1. SCZ: District EPI Micro plans not developed in 2015; being planned in 2016
Complete in-service training activities in IMCI and IMPACT	SL: 32 staff from MCH facilities trained in IMCI; it had been decided that training in IMPACT will divert resources from support to the One-EPI Plan; in addition, resources to support the

	implementation of services that are not EPI are limited; PL: 24 staff from MCH facilities were trained in IMCI; In Somaliland 32 staff from MCH facilities trained on Integrated Management of Childhood Illnesses; it had been decided that training in IMPACT will divert resources from support to the One-EPI Plan; in addition, resources to support the implementation of services that are not EPI are limited; Follow up supervision has been conducted to the target MCH staff to oversee if the staff has applied the skills provided, added values and challenges faced as a result of the new application.
Review composition LHW kit to reflect high demand for certain services	Content revised; however, provision of supplies substantially delayed due to identify adequate supplier in Nairobi;
Continuous training of LHWs	SL: one week continuous training per quarter in key areas of FHW compendium; Only one time continuous training for LHW is done in 2015, CSZ has planned at least 2 times continuous refresher training for LHW.
Develop standardized BCC approach for MCH clinics and LHWs	The Somali C4D Strategy has been developed and endorsed for implementation by all zones. LHWs have been trained using standardized approach BCC/IEC Materials were developed and printed and training were provided to LHW, but the IEC Materials were not distributed to LHWs SL: Supported implementation of social mapping exercise around 13 Health facilities to identify key influential people, develop sketch maps and community registers. 13 MCH conducted social mapping activities. IPC skills training to 13 religious leaders at GAVI 13 MCHs
Support reporting and supportive supervision capacities	The EPI outreach and mobile sessions has a component of Supportive supervision, while supervision checklists specific to Routine EPI services has been developed during GAVI technical coordination meeting and adopted. SL: 7 supervisors are among the Ministry of Health monitoring the quality of EPI outreach in Maroodijeex region.
Development of 3rd generation cMYP	cMYP for 2017 to 2021 developed and approved

Embedded EPI technical advisors in all three zonal MOH	For EPI in Somaliland and Puntland; for operational research / data quality improvement all three zones;
Embedded cold chain and logistics advisors in all three zonal MOH	All three zones have cold chain technicians who are dealing on vaccine and cold chain management. This advisors/ cold chain technicians are involved in day -to day management including ensuring the use of Stock Management Tool which recently the training was conducted. Vaccine management capacity development activities have involved the MOH vaccine managers in Somaliland and Puntland and the NGOs managing vaccines in CSZ.

5. **PRIORITISED COUNTRY NEEDS**[5]

[Summarise the highest priority country needs and strategic actions that could significantly improve coverage, equity and financial sustainability; the timeline for completing the actions and the type of technical assistance needed if applicable – see guidance document for more details]

Prioritized needs and strategic actions	**Associated timeline for completing the actions**	**Does this require technical assistance?*** *(yes/no)* If yes, indicate type of assistance needed
Evidence and data		
Conduct rapid equity analysis through review of EPI service availability and coverage across all regions of all zones using SARA findings, available cold chain data and available coverage data.	2016	Yes. UNICEF and WHO
PIE for IPV *delayed – combined with mini EPI review – to be included in PEF TCA 2017	Q4 2016 – Q1 2017	Yes. UNICEF with support of WHO
EVM assessment conducted and EVM IP developed	Q4 2016 / Q1 2017	Yes. UNICEF
Train selected and relevant MoH staff in data quality assurance	August 2016	Yes. WHO
Follow-up on data quality strengthening activities	2017	Yes, WHO PEF TCA 2017.
Conduct Data quality Self-Assessment (DQS)	July 2016 and July 2017	Yes WHO- continued in 2017 with PEF TCA
Define the MCH/EPI reporting flow and level of analysis – using SOP	July 2016	WHO
Finalize review of EPI data collection tools and develop SOPs for data collection, reporting and data flow.	Dec 2016	Yes. UNICEF, WHO, national workshop
Leadership, coordination and planning		

[5] Subsequent planning and discussions on Targeted Country Assistance will take place - detailed guidance on the process will be shared in May 2016.

Development of annual plan of action in line with One-EPI and cMYP for each of the three zone	July for remaining period of 2016	WHO –PEF TCA 2016
Finalize training on MLM and district micro plan development and outreach approaches	September 2016 – 2017	WHO – PEF TCA 2016 and 2017
Services		
Sustain the performance of the 40 MCHs supported by HSS1 through provisioning of supplies, training and supportive supervision.	October 2016 onwards	WHO/UNICEF – proposed to be covered by costed-HSS1 extension.

**Technical assistance not applicable for countries in final year of Gavi support*

6. ENDORSEMENT BY ICC, HSCC OR EQUIVALENT AND ADDITIONAL COMMENTS

This section does not need to be completed for joint appraisal update in interim years, instead the EPI manager is expected to endorse the joint appraisal report.

Brief description of how the joint appraisal was endorsed by the relevant national coordination mechanism	
Issues raised during debrief of joint appraisal findings to national coordination mechanism	
Any additional comments from: • **Ministry of Health** • **Gavi Alliance partners** • **Gavi Senior Country Manager**	

7. ANNEXES

This section does not need to be completed for joint appraisal update in interim years. Please include the following Annexes when submitting the report, and any others as necessary

Annex A. Description of joint appraisal process (e.g. team composition, how information was gathered, how discussions were held)

In preparation of the joint appraisal process, relevant documents were shared with Ministry of Health Team. Teams from Somaliland, Puntland and South Central had already been working in Nairobi during the earlier week to address comments received on the submission of the HSS II grant. At current state, assembling health authorities inside Somalia is for political reasons not possible.

Colleagues from the GAVI secretariat, WHO's and UNICEF's regional offices, WHO HQ and both country offices then joint in Nairobi for a preparatory meeting on 31 May and June 1, followed by a 2-days JA mission meeting. These days were marked by a high level of technical discussions with active involvement of various Ministry sections such as EPI, policy & planning, HIS, critically reviewing not only progress made within the current HSS grant but many areas of Somalia's immunization system.

Ministry teams prepared, still in Nairobi, their input to the JA mission report that then was consolidated by WHO and UNICEF with input from regional offices and Gavi Secretariat.

Annex B: Changes to transition plan *(if relevant)*

Changes proposed	Rationale for changes	Related cost (US$)	Source of funding for amended activities	Implementation agency	Expected result