Somalia Joint Appraisal Report 2017

Country	Somalia
Full Joint Appraisal or Joint Appraisal update	Full Joint Appraisal
Date and location of Joint Appraisal meeting	Kampala, August 21-25th
Participants / affiliation	List of participants available in section 8.
Reporting period	2016-2017
Fiscal period[1]	2016
Comprehensive Multi Year Plan (cMYP) duration	2016-2020

1. SUMMARY OF RENEWAL AND EXTENSION REQUESTS

1.1. New and Underused Vaccines Support (NVS) renewal request(s)

Type of support (routine or campaign)	Vaccine	End year of support	Year of requested support	Target (population to be vaccinated)	Indicative amount to be paid by country	Indicative amount to be paid by Gavi
NVS	IPV	2017	2017	367,934	US$ 0	US$1,383,500
NVS	Pentavalent	2019	2018	367,934	US$277,000	US$$763,000

1.2. New and Underused Vaccines Support (NVS) extension request(s)

Type of Support	Vaccine	Starting year	Ending year
NVS	IPV	2016	2019
NVS	Pentavalent	2016	2019

1.3. Health System Strengthening (HSS) renewal request

Note to the HLRP: At the time of HLRP, Somalia's HSS application was still under the review and approval process at the Secretariat.

1.4. Cold Chain Equipment Optimisation Platform (CCEOP) renewal request

Note to the HLRP: At the time of HLRP, Somalia's CCE OP application was still under the review and approval process at the Secretariat.

1.5. Indicative interest to introduce new vaccines or request Health System Strengthening support from Gavi in the future[2]

[1] If the country reporting period deviates from the fiscal period, please provide a short explanation.

[2] Providing this information does not constitute any obligation for either the country or Gavi, it merely serves for information purposes.

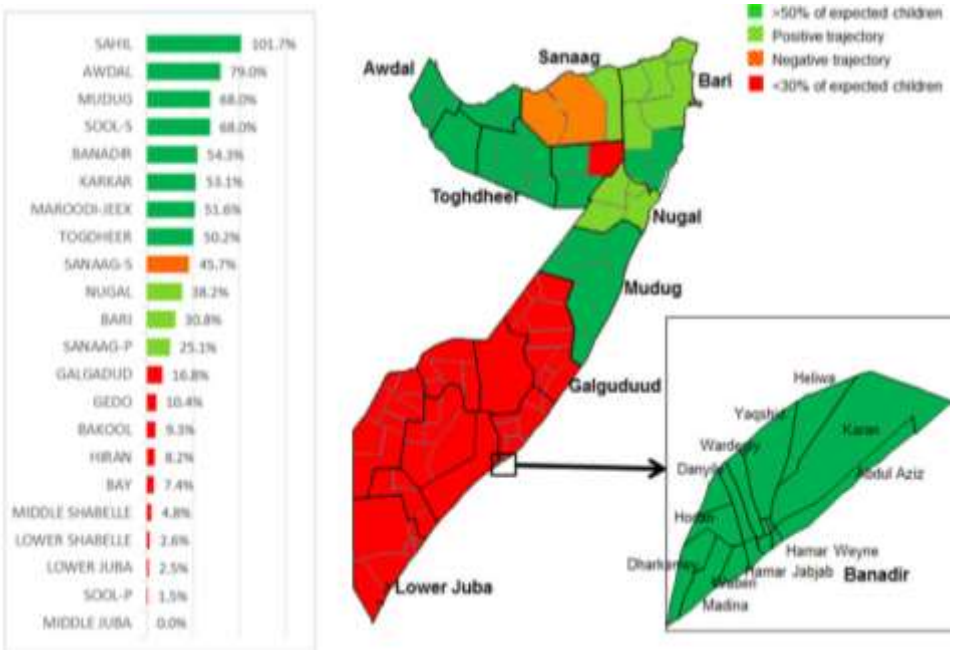
Indicative interest to introduce new vaccines or request HSS support from Gavi	Programme	Expected application year	Expected introduction year
	Measles 2nd dose	2018	2018/2019

Background

2. CHANGES IN COUNTRY CONTEXT SINCE LAST JOINT APPRAISAL

Somalia has one of the lowest DTP3/Pentavalant coverage rates in the world (42% WUENIC 2016), following decades of civil war, natural disasters and disease outbreaks during 2016 and 17. In 2016, maternal mortality ratio was estimated at 732 per 100,000 live births, whereas under-5-mortality rate was 137 per 1000 live births.

Figure 1: DTP3/Pentavalent coverage (Source: JHNP, 2014)



The population is estimated to be more than 13 million in 2017 with 42.5% living in urban areas and 22.8% living in rural areas. Urban settlements are growing at an unprecedented rate with significant urban-rural migration, fuelling a concentration of the population in and around urban centres. 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 constitute one-fourth of the total Somali population whereas an estimated 1.1 million (8.6% of the total population) internally displaced people living mainly in the outskirts of urban towns have been reported from June 2016 to June 2017. Out of these, around 79% have been displaced due to drought and around 18% displaced due to conflict and insecurity. This significant growth in the number of IDPs in 2017 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 areas of conflict, natural disasters and health emergencies such as drought and epidemics persist.

Table 1: Trends of internally displaced population in Somalia (June 2016 – June 2017), UNHCR

Categories	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Total
Conflict/Insecurity	7137	11868	1625	4396	83280	4408	3194	604	3274	891	11814	32400	18170	183061
Drought	1835	2136	1970	1254	2262	71031	18210	61922	106100	293361	142018	45931	52197	800227
Other	303	115	534	232	31	8760	1267	118	209	2153	2711	5587	2152	24172
Floods	552	0	10	0	0	0	0	5	0	0	0	4236	0	4803
Total	**9827**	**14119**	**4139**	**5882**	**85573**	**84199**	**22671**	**62649**	**109583**	**296405**	**156543**	**88154**	**72519**	**1,012,263**

In recent years, the 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 mechanisms and limited availability of health intelligence for informed decision making; a chronic shortage of qualified health workers; inadequate and unsustainable levels of financing and deficient procurement and supply systems.

Political Context:

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 took place in 2016 in Federal Somalia and elections are expected in November 2017 in Somaliland. The results might have implications for the way in which the next phase of the HSS grant will be planned and managed in Somaliland.

The new states emerging in the country provides an opportunity for strengthening routine immunization programs while creating further challenges to manage the program with limited resources available to support multiple layers of program administration.

Humanitarian Context:

Since 2015, Somalia has been facing a drought situation in most of the regions resulting in displacement of population, economic crisis and disease outbreaks. The country experienced AWD/Cholera and measles outbreaks for an extended period in 2016-2017.

Health Sector Development and Coordination

The model for health sector coordination is currently being revisited and adjusted to account for the evolving political situation to assure that sector coordination is implemented in a decentralized way and reflects community needs. The Federal Government of Somalia (FGS) has developed a three year National Development Plan (NDP) that is part of the Somalia Partnership Agreement. The NDP reflects priorities of the health sector and includes key objectives defined in Somalia's National Health Policy 2014. The Somalia Partnership Agreement is replacing the New Deal and will similarly include a pillar for 'Human and Social Development', led by the Federal Ministry of Health with health constituting a sub-working group.

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 in addition to a consolidated section pertaining to Somalia.

Health service delivery is structured around the framework of an Essential Package of Health Services (EPHS). It comprises four levels of service provision, six core programs including immunization, four additional programs and six management components. The EPHS had largely been implemented by NGOs, however, not uniformly across the country and came to a halt with the end of a multi-donor pooled funded Joint Health Nutrition Programme (JHNP).

The low vaccine coverage and humanitarian situation, including poor water access has led to the outbreak of multiple diseases including Cholera and Measles.

Cholera

In response to the Cholera outbreak, in 2017, Somalia executed two OCV campaigns, the last in May 2017. The campaign was successful with between 74% and 91% coverage and showed the success of collaboration and coordination across different areas of the country and partners. Challenges in the logistics (cost and execution) were noted as potential lessons learned for future planning. Approximately 400,000 doses of OCV are still present in the country and plans are being made on how best to utilize these including covering areas that were not entirely reached in previous campaigns.

Table 2: Highlights of Cholera Campaigns, Somalia, 2017

Action	Round 1	Round 2
>1 Y target	411,883	414,931
Coverage	91%	74%
Regions	Banadir, Beletweyne , Baidoa and Kismayo	Baidoa and Jowhar

Measles

Detailed epidemiological analysis by Zone and outbreak response activities is provided in the sections below. An appeal for funding for a nation-wide Measles campaign by WHO was released in August 2017 and a campaign is expected in late 2017/early 2018. To further improve Measles vaccination coverage the country is planning to apply for Measles second dose in January 2018, following the development of a five year measles control strategy.

Flexibilities requested:

Under the new Fragility Policy, approved by the Gavi board in 2017, Somalia qualifies for a series of flexibilities. No new flexibilities are requested at this time, however, the country team requests the continuation of flexibilities provided under Somalia's Country Tailored Approach (CTA);

- Submission of 5 year HSS proposal in 2016, while new health sector plan for 2017-21 is being finalised.
- The cost for the Data Quality Improvement Plan (DQIP) will be met from the PBF allocation as approved by the Independent Review Committee (IRC).
- There is currently a waiver in place for the Partnership Framework Agreement due to the shifting political environment.

3. PERFORMANCE OF THE IMMUNISATION SYSTEM IN THE REPORTING PERIOD

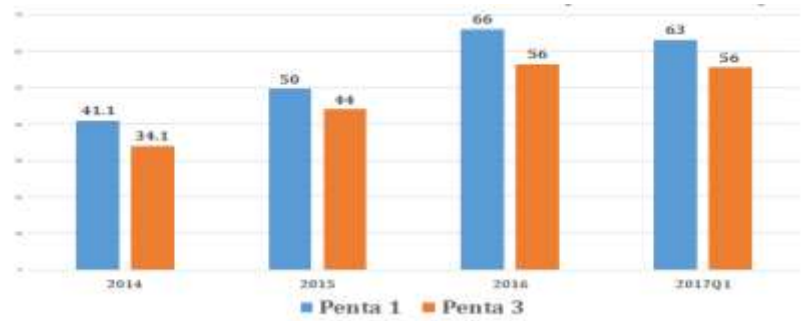
3.1. Coverage and equity of immunisation

EPI services are being provided in all accessible districts of the country. In 2016, the routine immunization package included BCG, bOPV, Penta, measles (MCV), TT and Inactivated Polio Vaccine (IPV). Somalia has developed and is using the cYMP from 2016-2020 with revised performance framework and targets. No coverage targets for 2016 were met. Coverage levels for all the vaccines remain very low (<60%) as shown by the specific antigens:

- Penta-3 coverage is 51% in 2016 (JRF) as compared to 29% in 2014 (JRF) and 46% in 2015 (JRF)
- The Penta-1 coverage also increased from 36% in 2014 (JRF) 53% in 2015 (JRF) to 60% in 2016 JRF)
- The drop-out rate for Penta-1 to Penta-3 in 2016 is 15% (as recorded in 2016)
- Measles (MCV1) coverage stood at 46 %;TT2+ coverage for pregnant women 62%
- 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.

The consistently low coverage over the past decade poses severe challenges and results in repeated disease outbreaks. Enhancing coverage and equity must attain a major priority in the health sector in Somalia.

Figure 2: Trend of Penta 1 and Penta 3, Somalia (2014-2017)



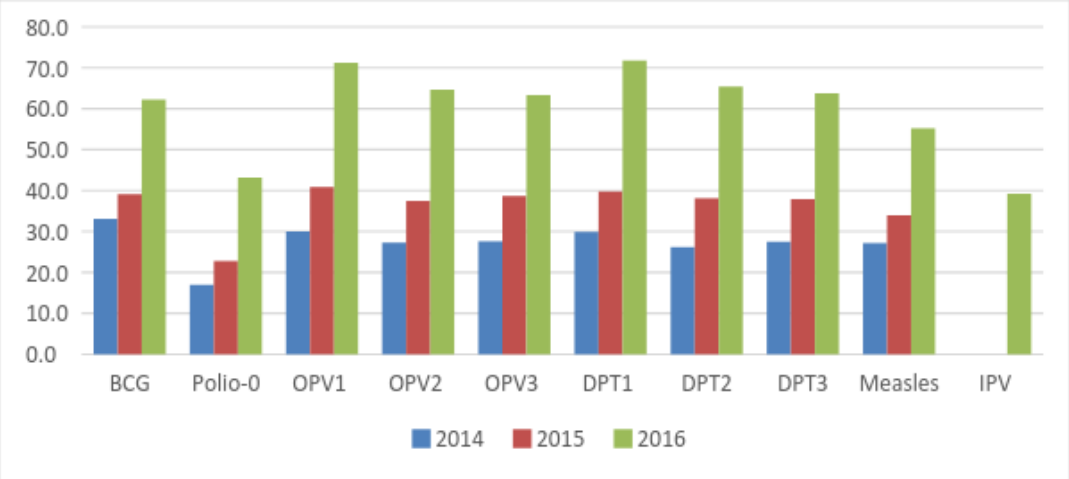
The low coverage has resulted in a disease outbreaks, particularly measles. An analysis of each zone is provided below with regards to the equitable coverage of immunisation.

Puntland:

Immunization coverage in Puntland has been generally low but has seen an increase in recent years. The percentage of infants who received the third dose of the Penta-valent vaccine increased from 27.4 per cent in 2014 to 37.9 per cent in 2015 and to 63.7 per cent in 2016 according to administrative data. The data also showed significant increase in measles vaccination coverage during the same period – from 27.1 per cent in 2014, 33.9 per cent in 2015 and 55.2 per cent in 2016. The increase is due to the number of health facilities providing routine immunization services, improved capacity of health staff to plan and deliver services; improved management of vaccines and immunization supplies reducing stock-outs and improved completeness of reporting.

The Figure 3 below shows the infant immunization coverage by antigen from 2014 to 2016.

Figure 3: Graph showing infant Immunization coverage (%) by antigen in Puntland from 2014 – 2016

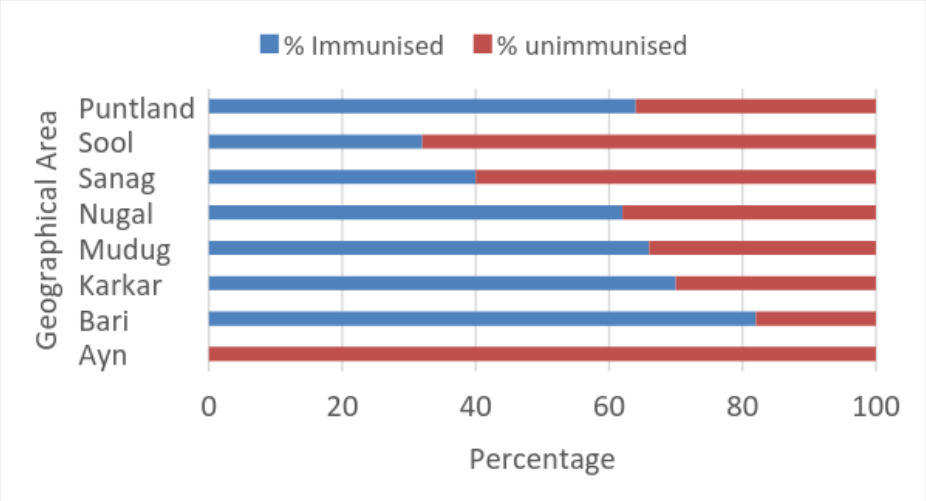


Despite the improvement in coverage the target of 70% for Penta 3 coverage for 2016 was not achieved. This is due mainly to the fact that services are still provided mainly at fixed sites with very few outreach sites and mobile teams. There is no sustained strategy to reach the high proportion, about 25%, of nomads and pastoralists, although there are plans for priority districts as part of HSS-2 support to begin in late 2017.

Infants who received the third dose of the Pentavalent vaccine has shown a steady increasing trend during last three years. The trend is seen in all except the Karkar region which reported a decrease in coverage in 2016.

The total number of children who have not been immunized in the zone at the end of 2016 stood at 32,922. Figure 4 shows the percentage of unimmunized children by region.

Figure 4: Percentage of unimmunized children by region in Puntland



The top 10 districts with respect to unimmunized children account for almost 80 per cent of unimmunized children. Districts such as Hudun, Dhahar, Buhoodle and Taleh contribute a significantly higher proportion of unimmunized children.

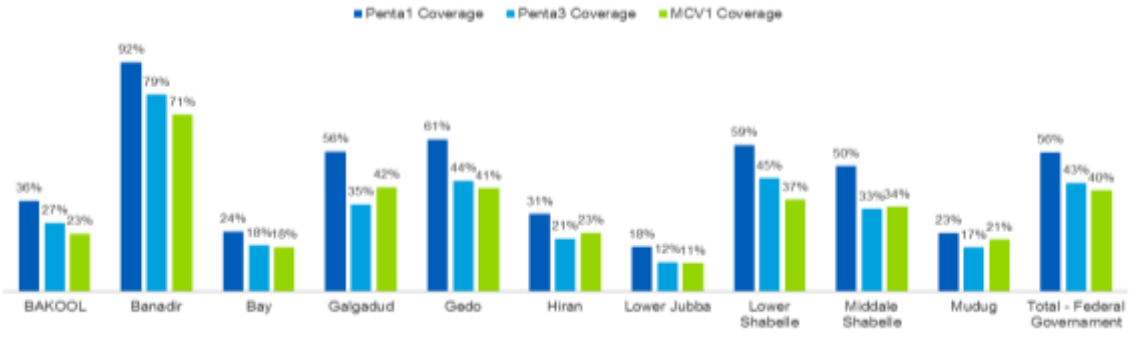
Analysis of performance at the district level shows that less than 50% of the districts had Penta 3 coverage more than 50%. 12 (40 %) out of the 30 districts in the zone achieved Penta 3 coverage of 80 % or more.

There was a measles outbreak between April and July 2016. An outbreak response campaign which reached 140,553 children (9 – 59 months) with a coverage of 74.3%.

South and Central Zone:

The immunisation programme exhibited poor performance in 2016 with high drop-out rates of up to 20% between Penta 1 and MCV1. Of the 10 regions, only Banadir shows coverage rates which exceed 70% due to the gains acquired through JHNP support. Coverage rates for the first half of 2017 suggest similar program performance.

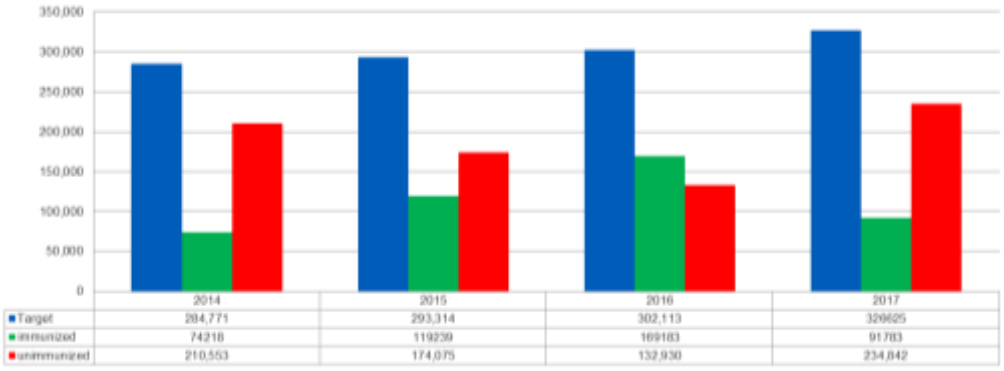
Figure 5: Immunisation Core Indicator: Coverages per region (Jan-Dec 2016)



With respect to IPV coverage, it is lower than what has been observed for MCV1. This is partly due to poor reporting of IPV coverage and the current HMIS not allowing for the appropriate recording of doses administered.

While the number of unimmunised children has slightly decreased from 2014 to 2015, in 2017, there has been an increase in the number of children not receiving basic vaccines. This is due to low number of outreach sessions and unavailability of micro plans in 2016. Moreover, as highlighted by the Data Quality Assessment conducted at the end of 2016, target population estimates are of varying quality and may not take into account internally displaced persons. Consequently, this has resulted in suboptimal planning of fixed, outreach and mobile sessions.

Figure 6: Unimmunized Children per Year (2014-2017)



	2014	2015	2016	2017
Target	284,771	293,314	302,113	329625
immunized	74218	119239	169183	91783
unimmunized	210,553	174,075	132,930	234,842

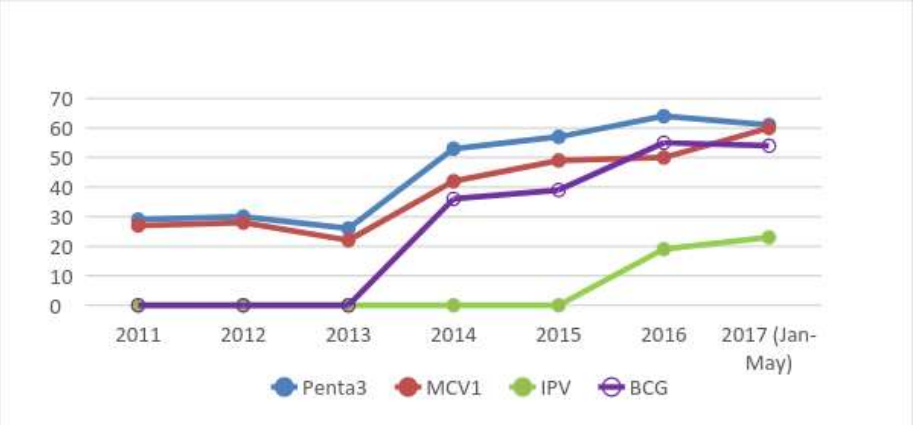
In 2016, substantial efforts were made to improve measles case-based surveillance. In addition to training focal points from 22 sentinel sites, polio staff have been mobilised to support community and health facility data collection and reporting. As a result, an increasing number of fever and rash cases have been reported in 2017 as compared to 2016. This increasing trend is in line with consistently low measles coverage reported through the administrative system.

Over 8,000 rash and fever cases were reported from January to June 2017, of which roughly 60% were between 1 to 4 years of age. Half of cases were identified in Banadir region, owing to a relatively stronger surveillance system.

Somaliland

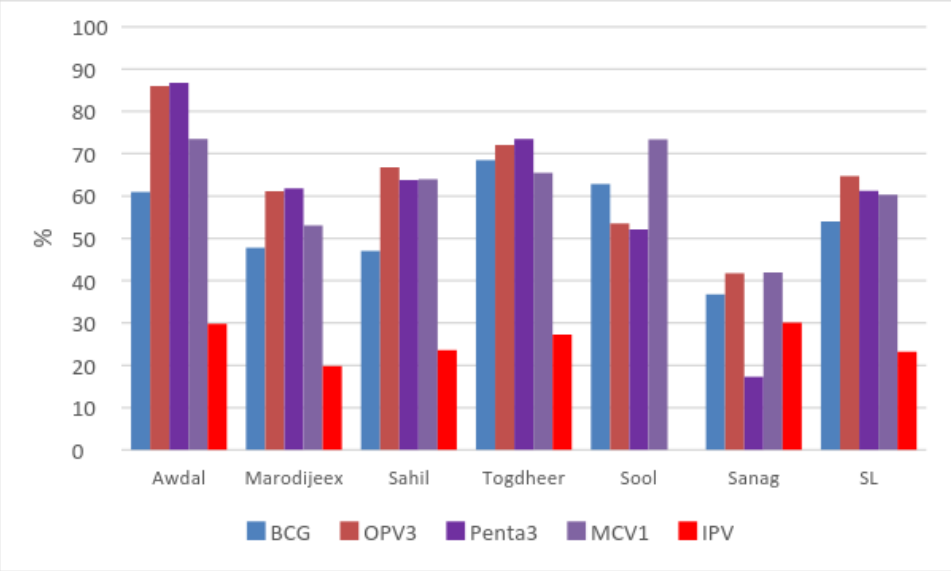
Somaliland program has seen an increase from 2013-2015 but stagnating coverage rates between 2015 and 2017 for most antigens. No outreach service in Somaliland was available in 2017 as EPHS package came to an end in 2016. Limited mobile sessions were held as a package of drought emergency response.

Figure 7: Trend of immunisation coverage, Somaliland 2011-2017



Further challenges include; no functional EPI district Management Teams, irregular EPI working group meetings and the few meetings do not involve the NGOs or all partners and delay in receiving monthly EPI data and poor data quality.

Figure 7: RI Performance by Regions of Somaliland, Jan-May 2017



3.2. Key drivers of low coverage/ equity

The Somalia EPI programme faces challenges in all areas of EPI programming including; programme management, service provision, data, demand creation, vaccine/cold chain management

Despite HSS-1 support to EPI management at the Zonal level, the MoH management teams have significant weaknesses with an evident lack of coordination across EPI, Polio and EPHS. Monitoring of programs also remain very weak.

Leadership, management and coordination:

Across the country, leadership and management challenges focused on the inadequate funding for RI activities from both government and partners resources. Zonal participants, expressed the need to map

existing resources to identify the funding gap in order to advocate for additional support from partners and government, avoid duplication of function/activities and maximize the use of relatively small resources available.

Specific details on management and issues per zone are outlined below:

Puntland:

- The EPI program in Puntland is under the Directorate of Primary Health Care at the Ministry of Health and is responsible for coordination of all EPI activities.
- At the Central level Coordination of EPI activities is carried through structures such as the EPI Working group and the EPI Taskforce (consisting of MOH, UNICEF and WHO) at the zonal level. Both entities meet quarterly with government and partners. Coordination at the regional and district level is weak and variable. There are no meetings at the district level.
- Challenges include weak district EPI teams, poor coordination of activities and weak supportive supervision monitoring. The government's fiscal space is very limited so over 90% of the EPI budget is funded by the UN Agencies and to a lesser extent by NGOs. The inadequate funding is the underlying cause of many other challenges.

South and Central Zone

- Limited to no supervision of health facilities was carried in 2016. While HSS-1 funds (through the costed extension) were budgeted for supporting this activity, only 53% of the 40 targets health facilities in Somalia were supervised at least once since January 2016.
- At the district level, there is no management team resulting in no outreach vaccination sessions conducted since January 2017
- Despite the fact that mid-level management training was provided to zonal and regional health and EPI managers, the immunization practices and management training has not been cascaded to lower levels - district and health facility levels
- Limited and ineffective coordination of immunisation activities between all levels

Somaliland:

- No dedicated officer at MOH for Routine EPI data Management
- Irregular EPI working group meeting and the few meetings do not involve the NGOs or all partners
- No functional EPI district Management Teams
- Weak National and Regional EPI Management Teams
- Delay in receiving monthly EPI data
- Delays in receiving available funds
- Absence of vaccine utilization report
- Private hospital data not captured more than one year of providing immunization services

Service Delivery:

The absence of outreach services contributes to the low coverage. Not all health facilities offer immunisation and limited micro-plans were available. There is no functional defaulter tracking system.

Specific issues of service delivery, by Zone is presented below;

Puntland

- Immunisation services were provided by 84 health centres or referral health centres (out of 98) and 7 hospitals. These fixed sites provide services for a limited amount of time.
- The 7 hospitals provide BCG and Oral Polio Vaccine to newborns but not the full package of antigens.
- The main vaccine delivery strategy is through fixed points based in the health centres and hospitals. About 15 health centres conduct outreach service delivery. There are 8 permanent mobile teams which provide services to some far and hard to reach communities.
- Twelve health centres out of the ninety-one health facilities (including hospitals and health centres), which provided routine immunization services in 2016 were supported with funds under the GAVI-HSS1 grant.
- Funding for outreach activities was not available.

South Central

- 252 out of 321 health centres and 21 out of 37 hospitals do provide routine immunization services
- Only 15 health centres providing routine immunization were supported through GAVI/HSS I grant
- No outreach sessions for RI conducted in the South and Central regions of Somalia
- 23 priority districts have completed the micro-plans for routine immunization in 2017
- Immunisation services are delivered through fixed, outreach and mobile sites. No outreach and mobile sessions were conducted and reported in 2016.
- In terms of fixed immunisation sessions, 79% of health centres and 57% of hospitals provide immunisation services. A total of 363 trained EPI staff – e.g. qualified nurses and vaccinators – are distributed across the 283 health facilities and hospitals providing immunisation services.

Somaliland

- No outreach service held in the GAVI supported districts in 2016
- No outreach services in 2017 as EPHS package came to an end in 2016 (only mobile sessions have been utilized to some extent)
- EPI training (MLM) conducted in Hargeisa for EPI and WHO team involved in the EPI management, both training facilitated by EMRO.
- 13/19 district micro plans developed through UNICEF support for 11 districts.
- All focused districts (100%) have their EPI micro plan completed.
- Facility-based micro-plans implemented for 10/19 districts.

Supply chain:

Vaccines continue to be supplied to the Zones from Nairobi on a quarterly basis. The supply from Nairobi does not usually include the buffer stock and the consequence of this is that when there is shortage at the zonal level, supplies are airlifted at a very high cost or the stock-out is left unmet until the time of the next quarterly supply. The regional stores are supplied by the Zonal level on a quarterly basis and the regional store supplies health facilities or vaccination centres on a monthly basis.

2016 saw improvements in capacity (through training) and the distribution of key tools and IT equipment. Vaccine management tools (ledgers and bin cards) have been printed and distributed. The zonal and regional vaccine store managers have been trained on the computerized stock management tools as part of the immunization supply chain management training. Computers have been supplied to

enable the use of the Stock Management Tool (SMT). Lower level training on immunization supply chain management is yet to take place. All cold chain and EPI managers participated in an Effective Vaccine Management Training in Entebbe January 2017.

Continued challenges across the country are identified as:

- Unavailability of Vaccine consumption reports
- Zones and regions do not have cold chain maintenance plans
- System for reporting faulty cold chain equipment is not well developed leading to prolonged equipment down time;
- Despite investments, there is still lack of and inadequate cold-chain equipment in newly upgraded health facilities and hospitals.

An EVM assessment was completed in 2017 and shows improvements in all areas. Further, Somalia's CCE OP application was approved with clarifications which were still pending at the time of the Joint Appraisal.

Puntland:

- The cold chain system consists of a hub in the zonal capital, Garowe. There are 5 regional stores and 100 health facility (hospitals and health centres) stores. The zonal level has a walk-in-cold room freezers and ice-lined refrigerators.
- Each of the 5 regional stores use freezers and ice-lined refrigerators. The health facilities use either electric or solar refrigerators. In 2016, a total of 69 new equipment was installed as part of replacement (e.g. replacement of kerosene refrigerators) or expansion to facilities which did not previously have any equipment. These were made up of 60 solar refrigerators and 9 electric refrigerators or freezers.
- Ninety-eight health centres and 7 hospitals have adequate functional cold chain equipment. The Effective Vaccine Management Assessment conducted in late 2016 showed that there is adequate vaccine storage capacity at all levels – zonal, regional and health facility. The updated inventory also shows adequate quantity of cold boxes, vaccine carriers and ice-packs.
- The zonal vaccine store uses computerized continuous temperature monitoring for the WICR. Over 50 per cent of the health centres and hospitals providing immunization services continue to us the stem and dial type of thermometer despite the recommendation to replace this with data loggers or other devices capable of storing the temperature for up to 30 days.

South and Central:

- The cold chain capacity of the zone has expanded in 2016-2017, including the completion of the Dhusamareb cold room. With the capacity expansion, South Central has been able to distribute vaccine for two round hence reducing on the deliver and warehousing costs.
- Training of trainers on immunization supply chain management has been completed and cascade training has started.

Somaliland:

- There is functional cold chain available in all Somaliland including (1) Central Cold Chain with 1 walk-in cold room, (2) 6 regional cold chain stores and (3) consistent monitoring of cold chain functionality, through the weekly and bi-weekly AFP surveillance activity by the Polio structure
- Unicef has discussed handing over cold chain management to the government in Somaliland

Demand generation:

There has been no Communications for Development (C4D) related survey conducted to date to assess the effectiveness and results of demand creation/communication activities (KAP, Media survey etc.) carried out recently and there is a weak C4D structure at all levels. The Social Mobilisation Network of Zonal, Regional and District Social Mobilisation Coordinators; and community social mobilization volunteers is still focused on polio SIA and not on routine immunisation.

Puntland:

- The Social Mobilization Network (SMNet) made up of Regional Social Mobilization Coordinators (7) District Social Mobilization Coordinators (36); and community social mobilization volunteers (1312) engage households and community groups to inform and educate them about polio SIAs.
- All the regional and district social mobilisation coordinators were trained on the use of the global communication tool and on polio eradication. A total of 36 staff including regional social mobilisation coordinators and other health workers in malaria, TB, HIV and nutrition programmes were given a training of trainers on interpersonal communication skills. The roll-out training has not yet been carried out.
- A C4D working group was formed in the zone to bring together government ministries and NGOs implementing communication activities however due to funding challenges it is not functioning well as the group does not meet regularly.

South and Central Zone

- Social mobilization are being conducted only during the NIDs and HTR campaigns
- 1448 mobilizers, 73 Regional/District Social Mobilization Coordinators visit households, conduct advocacy meetings for elders/religious leaders, and hold community sensitization sessions
- Social mobilization were also taken place for OCV and measles campaigns
- SM Net has strong potential to improve community demand for and raise awareness on the importance of routine immunization, once given an opportunity

Somaliland

- 241 HWs and CHWs trained on IPC integrated package on immunization, family health and CCM
- 1,200,000 SMS, 36 Radio/24 TV programs on RI & SIAs
- 321 members from religious leaders, local authorities and community elders conducted community sensitization meetings & community dialogues on immunization

Gender-related barriers to immunisation:

There were no reported gender-related barriers during Joint Appraisal discussions and report drafting. However, an equity analysis currently underway by Unicef shows evidence of a 20% difference in immunisation of children to uneducated mothers. The results of this survey will be further shared and used to define needed interventions.

Future plans for 2017

An EPI questionnaire was included in the upcoming Malaria Indicator Survey which will provide detailed information on the coverage of immunisation. The roll-out of HSS-2 in late 2017 will address some issues of the district EPI management and coordination efforts. Technical assistance is proposed for the further development of micro-plans, integration of HMIS and EPI data collection, the implementation of a Data

Quality Improvement Plan. However, current funding does not support outreach in all areas of the country which is a clear bottleneck to improved immunisation.

3.3. Data

Compliance with Gavi's Data Quality Requirements:

Requirement	Status Update	Comments
Strategic Data Improvement Plan		▪ Partially developed; structured by area of focus ▪ Main activities specified ▪ Responsibilities and timelines not clear
Update on implementation of improvement plan		▪ No update provided on activities for which implementation was scheduled for 2016-2017 (supported by PEF TCA funds)
In-depth assessment		▪ DQS conducted in 2015
Annual desk review		▪ Conducted in 2016 ▪ Unclear what are plans for 2017
Survey		▪ Last national coverage survey in 2005; subnational surveys in 2011 ▪ Coverage survey planned for Nov-Dec 2017

Data Management (Data Quality Issues):

Overall data collection remains a challenge including;

- 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;
- Lack of feedback mechanism and quality assurance systems at all levels;

Further, available data is not analysed or used for decision making at the point where it is generated.

Puntland: Revised data collection and reporting tools including EPI registers, tally books, immunization cards have been distributed to all health facilities. The revised tools enable all facilities to capture newly introduced vaccines and to report on vaccine stocks. The proportion of reports submitted (completeness of reporting at district level) is 8%. There is very little analysis and use of data at the regional and facility level. There is no monitoring of performance using data. Reports are generally submitted late from the health facilities to the zonal level. At the zonal level the data is analysed and feedback is sent to the regional health authorities and NGO partners. The EPI Working Group, made up of officers from the MOH, UNICEF, WHO and NGOs working in EPI, meets quarterly to discuss the EPI performance based on the data. It is not clear if this feedback from the zonal level reaches the health facility level.

A limited data quality audit has been conducted by National HMIS Team but no concrete feedback was sent to the health facilities. A data quality self-assessment (DQSA) was conducted in late 2016. This assessment showed various data quality issues including data inconsistency. The Regional office quality of immunization data monitoring scored on 55% while the health centres scored 48%.

South and Central

The overall health data quality is poor where the newly rolled out web-based district health information system - version 2 (DHIS2) only captured 58% of data for the past 6 months (Jan-Jun 2017) and <10% submitted the reported data on time.

A data quality self-assessment (DQS) was conducted in mid-2016 at mainly 2 levels; health facility level and health management and information at regional level. At the health facility level; the accuracy ratio (of penta 3 for the last 3 months) showed 97% which shows more data were reported to higher level compared to what was captured in the register (not considered the tally sheet since no facility was summarizing data from the tally sheet) and all the dimensions of data monitoring system showed only 56% performance at the health facility level. However, the accuracy ratio at the regional level showed 124% which means around 24% of data have not been reported to higher (national level) but similar performance of data monitoring system which showed only 57% of performance.

Despite the assessment conducted, no feedback was sent to the assessed health facility but the recommended action points were monitored and acted on the national level.

Somaliland
No specific issues reported.

VPD surveillance:

Puntland: The vaccine preventable disease surveillance system in place focuses on Acute Flaccid Paralysis and to a lesser extent on measles. Surveillance workers visit 202 health facilities (health centres, hospitals, private clinics and pharmacies) in four regions weekly and gather data about AFP and measles. Forty-two AFP cases and 578 suspected measles cases (based on fever and rash) were reported.

The weakness of the vaccine preventable diseases surveillance system includes its narrowness in focus (e.g. does not include MNT); failure to cover all regions and districts in the zone and lack of sex disaggregated data. There is no laboratory support for case confirmation and the system does not report deaths. There is no case based investigation and no data on immunization status of suspected cases.

South and Central Zone:
A Data Quality Assessment was conducted at the end of 2016, which showed the following issues at the health facility level:

- Recording of immunisation data: (1) Inaccurate filling of child vaccination cards; and (2) incorrect use of tally sheets
- Recording of stock management data: (1) lack of standardized vaccine stock management tools & processes at MCH level; (2) poor recording of wastage; and (3) poor temperature monitoring and recording
- Reporting and archiving: (1) no use of tally sheets for accounting for reporting completeness; (2) incomplete monthly summary reports; and (3) lack of AEFI reporting procedures
- Demographic information and planning: lack of defined and robust target populations and maps
- Analysis, presentation and use of information: (1) lack of use of monitoring charts; and (2) lack of standardized default tracking mechanism.

Somaliland:
- Measles surveillance integrated in to the AFP Surveillance structure
- Measles case based surveillance training held.
- Specimen collection and reported started.
- Data Quality Assessment has been conducted.
- EPI Working Group has been conducted at central level to enhance the coordination among the partners.
- EPI/Polio review meeting has been conducted.
- EPI service provider training for 12 private hospitals and provided to cold chain equipment
- Supportive supervision supported for 4 target districts.

3.4. Role and engagement of different stakeholders in the immunisation system

The Somalia EPI program is struggling to establish an ICC. The country recognises the need for a more coherent ICC but is limited by the political division in the country. Recent support from Gavi in identifying the way forward in this area is secured, however, the country needs to define their next steps/ICC model in the coming months.

Civil society have limited role in routine immunization program in Somalia. UNICEF have partnerships with some organizations and they are providing EPI services in different areas in the country. Private sector has limited involvement, although some of the hospitals are providing EPI services in the country.

4. PERFORMANCE OF GAVI GRANTS IN THE REPORTING PERIOD

4.1. Programmatic performance

Gavi is providing support for routine immunisation programme of Somalia, through health system strengthening and vaccine support. In 2016, the performance of immunisation programme did not meet target as shown in Figure 7 in spite of targets being revised downwards. Targets shown below are informed by the 2011-2016 cMYP but adjusted based on the vaccine renewal request. In terms of equity metrics, these will be evaluated once the results from the Malaria Immunisation Coverage Survey are available (i.e. early 2018). Rationale for low performance has been detailed out in Section 3.3 of this

Figure 7: Target achievement for NVS grants for 2014-2016 based on administrative estimates

report. Targets for 2017 onwards have been aligned to the 2017-2020 cMYP, which was developed on the basis of the lessons learned from the implementation of the previous cMYP.

In October 2016, Somalia has benefited from a one-year costed extension to the 1st generation HSS grant. During the last JA, performance indicators and targets were set for monitoring the implementation of prioritised activities. A total of 14 indicators were shortlisted, of which target was met for four indicators. For example, targeted health facilities supported have functional cold chain equipment and none of these facilities reported stock outs of vaccines or commodities. Table 3 details the level of target achievement by HSS Grant Category.

Table 3: Target achievement by HSS grant category for 2016

HSS Grant Category	# indicators met target	# indicators did not meet target	# invalid indicators
Service Delivery		1	
Health and Community Workforce	1	2	
Procurement & Supply Chain Management	2	2	
Health Information Systems	1	4	
Policy and Governance		1	
Community & Other Local Actors	Not applicable		
Program Management	Not applicable		
Health Financing	Not applicable		
All HSS Grant Indicators	**4**	**10**	

Of the remaining 10 indicators, 6 are of real concern. These indicators are as follows:

- Number of measles sample collection kits purchased
- Number of suspected measles cases lab tested
- Percentage of targeted health facilities with at least 1 supportive supervisory visit
- Number of EPI districts implementing supportive supervision tools
- Number of zonal ICC meetings conducted
- EPI/HMIS reporting completeness

For the two measles-related indicators, procurement and distribution of sample collection kit is expected to be completed by the end of August 2017. In addition, measles and rubella diagnostic kits will be provided by the WHO Regional Office by the end of 2017. Technical assistance is being provided to ensure that a greater number of suspected measles cases are lab tested. Indeed, three national professional officers and 3 lab focal persons, one in each zone are in place.

Only 53% of health facilities are supervised with at least one supervisory visit quarterly. On a positive note, 193 staff received refresher trainings on microplanning which is essential to identify pockets of under immunised children.

Only 81% of health facilities have sent completed EPI/HMIS report and 79% of health facilities sent timely reports. A total of 32 districts did not report any coverage data in the 2016 WHO-UNICEF Joint Reporting Form. The Data Improvement Plan, which addresses main bottlenecks to data availability, analysis and quality, has yet to be finalised. It is expected that HSS 2 and 2017 PEF TCA funds will be used as main funding sources.

Discussion were held on the need to develop a 5 years measles elimination plan. The WHO Regional Office has agreed to take the lead in this process and will aim to finalise before the end of the year.

In April 2016, the switch from the use of t-OPV to b-OPV for both routine and supplementary immunization was effected as part of the Polio Endgame Strategy. This came 6 months after the introduction of Injectable Polio Vaccine. Following the switch all unused t-OPV in the Puntland zone was withdrawn and destroyed.

Progress on HSS-1 Costed- Extension:

A costed-extension was approved in 2016 as bridge funding between HSS-1 and HSS-2 commencement. The following tables outline the status and expenditure of activities to be performed by Unicef and WHO. Full expenditure is expected of the grant with the exception of $11,000 for ICC meetings under WHO which may be reprogrammed in the coming weeks.

Unicef Activities (All amounts in USD)

Activities	CSZ	SL	PL	National	Total
Incentives	48000	34448	38393		120,841
Cold chain meetings	20000				20,000
MYR EPI review	10000	5000	5000		20,000
Cold chain running costs	210259	70400	76268		356,927
Transport from Nairobi to Zonal EPI stores including insurances				50000	50,000
Warehouse cost in Nairobi				80000	80,000
Bank charges	3%	1.5%	1.5%		-
Total					$647,768

WHO Activities (All amounts in USD)

Activity	Progress	Total funds	Funds used
Provide technical support to MoH institutional capacity building through 03 national professional officers	03 National Professional officers are in place	154,080	154,080

Conduct refresher training of vaccinators in facilities with micro-plans	Trainings conducted in ____ MCHs using funds on loan basis from other sources of WHO	74,180	21393/SL
Purchasing of sample collection kits	Procurement process completed	21,400	21,400
Maintenance of Garowe Lab facility	Maintenance under process	21,400	
Incentive for 3 lab focal persons (Mogadishu, Hargesia and Garowe)	03 lab focal persons are in place, will be paid after receiving funds	18,000	
Joint supervision of health facilities by regional HMIS, EPI and cold chain staff	Joint supervision done to some MCHs	250,320	5500
Organize biannual review meetings for district EPI management team (MT) to monitor micro/workplan implementation;	It can be done in Sep/October	42,200	
Organizing regular coordination meetings (ICC) per 'zone on quarterly basis	ICC currently does not exist	11,000	To be established
			$202,373

4.2. Financial management performance (for all cash grants, such as HSS, vaccine introduction grants, campaign operational cost grants, transition grants, etc.)

Figure 8 outlines the financial expenditure and compliance on Gavi support to Somalia. The needed actions are being followed up with respective agencies to assure compliance of the portfolio.

Figure 8: Finance expenditure and compliance on Gavi-grants

Grant	Start Year	End Year	Fund recipient	Amounts Disbursed (USD)	Latest Known Cash balance (USD)	Source of info	Needed Action
HSS-1	2010	2017	**Unicef**	$5,572,862	$-1,698	Financial Statement	**Grant Closure**
HSS-1	2010	2017	**WHO**	$7,338,575	$2,643,103* 2015 information	Financial Statement* 2016 statement still pending	**Financial Statement Overdue**
VIG - Penta	2015	2015	**WHO**	$114,500	0	Financial Statement	**Final Statement**
VIG-IPV	2013	2013	**Unicef**	$184,042	-424	Certified SoA	**Grant closure**
VIG-IPV	2013	2013	**WHO**	$199,458	Unknown	No information	**Financial Statement Overdue**
Costed Extension	2017	2017	**Unicef**	$1,365,939	$718,171	$647,768	**Estimated numbers presented in JA**
Costed Extension	2017	2017	**WHO**	$634,061	$431,688	$202,373	**Estimated numbers presented in JA**
HSS -2	*2017*	*2021*	***TBD***				**MOU under review**

4.3. Sustainability and (if applicable) transition planning

Polio transition:

In 2017, Somalia has been declared polio-free for three years and this was formally recognized by the World Health Organization in August. Following this designation, polio transition planning will continue. Key points of transition include;

- A drop in funding from 2017 to 2018 from $18 million to $11 million
- Completion of asset mapping which includes 700 staff currently on polio funding

The impact of this transition while not entirely clear has led to discussions on the need to ensure that Somalia receives consideration in minimising the effects of the drop in polio support and funding. It would be meaningful if WHO and UNICEF were to consider the country needs while national systems are able to move towards some form of normalcy within the country limitations.

4.4. Technical Assistance (TA)

PEF TCA Reporting:

The following figures outline the progress on PEF TCA expenditure and milestone for 2016 and 2017 from Unicef and WHO.

Figure 9: 2016 Expenditure and Milestone accomplishment

	2016 Staffing			2016 TCA Expenditure		
Partner	Staff Budgeted	Staff recruited	Vacant Positions	Budgeted (Incl. PSC)	Disbursed	% Utilized (of Disbursed)
UNICEF	2.0	2.0	--	$444,684	$411,744	100
WHO	2.2	0.2	2: P4, NOB	$600,912	$505,400	80

Figure 10: 2017 Expenditure and Milestone accomplishment

	2017 Mid-year progress update (30 June)		2017 TCA Expenditure		
Partner	Milestones (#)	Milestones completed or on track (%)	Budgeted (Incl. PSC)	Disbursed	% Utilized (of Disbursed)
UNICEF	6	83	$444,641	$355,404	14
WHO	6	67	$686,854	N/A*	N/A*

UNICEF completed the following activities from the outlined 2017 PEF TCA workplan

- EVMA Completed
- EVM IP Completed
- CCE OP application finalized and submitted
- Train the trainer trainings held
- Training completed for EVM and SMT
- Cold Chain inventory updated
- Q4 planning for the implementation of cold chain maintenance
- New manual for vaccine control
- Social mobilisation micro planning training 150 people trained
- Continued roll out to 5000 persons

The following activities are pending completion:

- Distribute VM guidelines and tools
- Fridge Tag 2 to be in use by end of year/Q1 2018

Caption: Train the trainer activities in demand generation, Unicef 2017

WHO completed the following activities from the outlined 2017 PEF TCA workplan

- Trainings on MLM and vaccine management conducted, participants from all zones attended the training.
- HSS proposal developed, incorporating lessons learned from past GAVI grants, Proposal approved. AFP and measles surveillance are integrated, building on the AFP surveillance.
- Data Quality improvement plans will be developed in October 2017. Somaliland, Puntland and 16 districts of south central zone have trained vaccinators of the MCH facilities on the use of monitoring charts. Joint supervision checklist developed, joint supervision plans developed.

The following activities are pending completion:

- Coverage verification survey is planned with Malaria survey in October/November
- Trainings on cold chain will be conducted in last quarter of 2017
- Workshops for data tools will be done in last quarter of 2017, after consensus data tools will be printed and distributed.
- Situation analysis for dashboard will be done in November /December 2017. Measles control plan is under the discussion. POL AFP surveillance is providing regular reports on measles, Trainings on measles case based surveillance is completed in SCZ and SL, will be done in September in PL

5. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

Prioritized needs and strategic actions	Timeline	**Status of achievement**	Comments from mission members on progress
Conduct rapid equity analysis through review of EPI service availability and coverage across all regions of all zones using	2016	SARA has been conducted (but there is need to check the findings on EPI service	Lots of information related to EPI service availability, cold chain and other

SARA findings, available cold chain data and available coverage data.		availability , cold chain, and coverage data in those assessed heath facilities)	related equipment were included into SARA Assessment findings
EVM assessment conducted and EVM IP developed	Q4 2016 / Q1 2017	Conducted and IP developed	done
Train selected and relevant MoH staff in data quality assurance	August 2016	Conducted	done
Conduct Data quality Self-Assessment (DQS)	July 2016, July 2017	Conducted in all zones	done
Define the MCH/EPI reporting flow and level of analysis – using SOP	July 2016	It is done,	HMIS SOP developed and EPI is part of the HMIS data flow and analysis
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	Drafted	The Annual plan 2017 need to be finalized / updated by EPI team (MOH/WHO/UNICEF)
Finalize training on MLM and district micro plan development and outreach approaches	September 2016 – 2017	Conducted	done
Sustain the performance of the 40 MCHs supported by HSS1 through provisioning of supplies, training and supportive supervision.	October 2016 onwards	Technical and vaccine supported / no Financial support; incentives etc.	Technical and vaccine supply support is sustained
Corrective Actions			
Action	Status	Comments from mission members	
Develop the capacity of district health management teams	17 District Health Teams trained on MLM training & development and implementation of district micro plans	In Federal Government, 24 District Health Management team were trained on Microplanning	

		development and implementation, but the MLM training not planned/conducted for District Management teams - MLM training for District Teams is being prioritized during HSS2/PEF TCA 2018	
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	Quarterly meetings of EPI Partners (MOH, UNICEF, WHO and NGOs) held regularly; Zonal ICC not established	Irregular monthly EPI technical meeting (MOH, WHO, UNICEF) and adhoc EPI working group (MOH, WHO, UNICEF, NGO) conducted in Mogadishu….There are no coordination activities at state and regional levels	We need to strengthen the national/zonal coordination activities and establish state and regional level coordination activities.
Finalize plans for integrated supervision and implement on monthly and quarterly basis	Plans are developed and 53% of MCH are visited	FGS- Supervision to all HSS1 Health facilities conducted in 2016 and supervision plan for 2017 (Q1 & Q2) developed but not yet conducted for funding gap.	We are trying to utilize the cost extension grant to conduct supervision activities for the remaining period until October 2017
Revise ToRs and organograms for regional and district health and immunization teams.	ToRs and organograms revised	FGS - revision of the TORs and Organogram is still ongoing.	FGS - This is planned to be finalized in 2017 - in line with HSSP general health sector review for health authorities at all levels.
Train staff zonal, regional and facility on basic vaccines and logistics management	ToT completed in PL, cascade training yet to be conducted	FGS - Cascade training of basic vaccine (refresher training) at district and health facility staff yet to be conducted	FGS - Utilize cost extension grant to ensure health facility staff under district with microplans to be trained during the remaining period

Provide basic stock management tools - vaccine ledgers, bin cards	Stock management tools supplied to zones, regions and health facilities	FGS - this is done.	
Shift from push to pull system - start from zone to regional level and from regional to major locations	System changed from Push to pull with lower level submitting requisitions to higher level	FGS - This is done	
Provide cold chain facilities (preferably solar powered).	Adequate cold chain equipment available, plan has been prepared for facilities which are to be upgraded	FGS - included into the cold chain inventory and Improvement plan	
Finalise cold chain expansion plan	Cold Chain improvement and expansion plan	FGS - This is done	
Apply to CCEOP in Q1 2017	Application submitted	FGS - This is done	
Interim measure – collect IPV data from health facilities using DPO and DSMC	Data on IPV included in data collection and reporting forms and submitted monthly	FGS - IPV is included into the national HMIS tools and online reporting system (DHIS2) from January 2017,	
Define standard processes and develop job aids for use of registers and tally books for both fixed and outreach services	Development of Job aids under way, to be finalized and produced with funds under HSS2 support	FGS - Not yet finalized	
Train MCH staff on standard use of data collection tools and monitoring charts as part of micro plan training.)	Done as part of micro-planning training	FGS- This is done	
Develop data quality plan with costed priority actions – align with other donors and finance key priorities through HSS2 proposal	It will be done in October/November	FGS - not yet done	

Train health facility and supervisory staff at various levels on micro-planning and outreach	Done as part of micro-planning training	FGS - This is done	
Undertake an assessment on effectiveness on current demand generation activities – planned by UNICEF in 2017	Not done for RI specifically however recently done an evaluation for Polio network been done by Kimetrica	FGS - not done for RI	
Conduct IPC training workshops for health workers	ToT on IPC conducted, cascade training yet to be conducted	FGS - cascaded training to be conducted	
Provide necessary material in conducting audio, visual, TV and drama messages	Visual materials (posters, flip charts, comic books) provided. Audio and video materials yet to be developed	FGS - this is yet to be developed	
Government officials to advocate for the uptake of immunization and conduct sensitization meetings for different community groups (Sheikhs, women, elders)	On-going sensitization of community members by Sheikhs/ Imams	FGS - this is ongoing and to be strengthened / monitored	
Undertake an assessment on effectiveness on current demand generation activities – planned by UNICEF in 2017	Not done for RI specifically however recently done an evaluation for Polio network been done by Kimetrica	FGS - this is a repetition / not yet done for RI	
Conduct IPC training workshops for health workers	ToT on IPC conducted, cascade training yet to be conducted	FGS - This is a repetition / cascade training to be conducted	
Accelerate any pending procurement and payment of incentives;	Funding constraints , payment of incentives from HSS cost extension to key EPI team members	FGS - this is ongoing	

3 National staff to support MoH in each zone	They are in Place	FGS - in place in WHO	

6. ACTION PLAN: SUMMARY OF FINDINGS, ACTIONS AND TECHNICAL ASSISTANCE NEEDS IDENTIFIED AND AGREED DURING THE JOINT APPRAISAL

The following recommendations and technical assistance needs were identified during the Joint Appraisal mission.

Recommendation	TA Needs
1. Strengthen coordination and planning of EPI program by improving capacity of district and regional management teams and the development of Annual EPI Operational Plans (including M and E)	• Develop Zonal Annual EPI Operational Plan in line with the cMYP (with C4D, M&E plan and data management and use) • cMYP alignment with the National Plan and regular reviews to review progress against targets • Conduct Annual and Mid-year Reviews and Planning meeting at State/Regional Levels (Quarterly Regional and District) • Development of Manuals and SOPs (in local languages) • On-job training for State, Regional and District teams on supportive supervision, immunisation practices, vaccine mgmt; including new State management • MLM training at District Level • Conduct two days consultative meeting to develop projection based on PESS at district and section level • Perform Mapping of all EPI actors • Address outcomes of ongoing equity assessment
2. Advocate for improved financial contribution to immunisation (Government and Partner)	• Development of resource mobilisation strategy (to be shared with partners and potential donors) • Analysis of current funding (and asset) availability and gaps in EPI program resources • Stakeholder mapping • High level advocacy for local commitment (e.g. use of Goodwill Ambassador) • MOH Capacity development on dialogue with donors • Development of forum for dialogue on Public-Private partnerships in Health • Strategy to improve routine EPI through engagement of PPP and CSOs

3. Develop five years Measles Control and elimination strategy and undertake measles catch-up campaign	• Conduct Measles catch-up campaign • Development of five-year plan • Development of Gavi Measles Proposal • Stronger measles case-based surveillance, develop measles response (including measles lab capacity) • Measles case management training
4. Gavi to further support the development of ICC(s) and other forums to improve the oversight and monitoring of EPI program	• Support to ICC (s) and the development of ICC Secretariat(s) following decision on ICC and coordination model to be proposed
5. Improve resilience of EPI program to emergencies and further integrate immunisation into responses as appropriate	• Training on Early Warning System • OCV and WASH strategy

6. Improve the quality and use of data through capacity strengthening	Data improvement and use
	• IT support for Shape Files
	• Exporting of historical data from excel to DHIS2
	• Local language guidance availability
	• Data analysis
	DHIS 2
	• Cascade training on the following areas:
	  • Data quality review (testing the new WHO data quality tool for DHIS 2)
	  • Data analysis (including EPI Dashboard)
	  • Data interpretation (PSI technique)
	  • Data use (PSI technique)
	  • Data presentation and dissemination
	  • National EPI indicators
	Training for;
	• Regional HMIS officers (monthly- 1 extra day per month to be held after the monthly HMIS review meetings already supported by GF)- DHIS2 (combined training for HMIS and Programme Managers)

	• RHOs/PHCs/PMs (3 days, Quarterly)- DHIS 2
	• Health Facility-In-Charges (3 days, every 6 months)- HMIS
	• DHIS 2 Academy trainings
	• DHIS 2 Developer/programmer with at least 10 years uninterrupted and current experience in DHIS 2 front-end and back-end interfaces (not Nairobi-based):
	  • Training on all IT related areas including system Apps development and system trouble shooting
	  • System trouble shooting
	• High level trainings on front-end interface

7. Establish effective VPD surveillance system	- TA Needs identified in the DQIP to be supported
	Technical assistance for Supply chain; • Translation of standard operating procedures, manuals etc. • Curriculum developed for cold chain technicians • District and Health Facility level trainings on preventative and basic maintenance • Implementation of CCE OP – if approved (operational deployment plans, deviation plans, decommission SOPs etc.) • Logistics vaccine management data – to be included in DQIP

The following chart outlines specific recommendations and technical assistance needs specific to Zones.

Zone	Recommendation	TA Need
South Central	Not applicable	• Transition period (plan) of handing over the cold chains from the local partners to the government
Puntland	Improve immunisation coverage in high mobility of nomadic population and hard to reach areas. • Integrated mobile clinics (health and nutrition) • Awareness raising through religious leaders and health workers for acceptance of immunization	• Develop strategy for hard to reach areas (e.g. Alula district) • Integration of mobile clinics data onto DHIS2 (shape files for maps)
Somaliland	Not Applicable	Not Applicable

7. JOINT APPRAISAL PROCESS, ENDORSEMENT BY THE NATIONAL COORDINATION FORUM (ICC, HSCC OR EQUIVALENT) AND ADDITIONAL COMMENTS

The Joint Appraisal was held in Kampala, Uganda in order to facilitate visa and travel for Somali attendees. The first three days were dedicated to the Joint Appraisal and the following two days to work planning for the first year of HSS-2 implementation, which aims to start in October 2017.

Zones performed group work on identifying key challenges and technical assistance required to overcome them. This has been reflected in the section above outlining recommendations and associated technical assistance. The TA needs were then used to populate the One TA plan which will be submitted in November 2017 after a review by all partners.

A draft of the Joint Appraisal was developed before the mission and further updated during the mission and distributed to Zonal focal points. They prepared feedback and edits up until submission.

The country expressed their concern regarding partner performance with specific reference to WHO and Unicef and are interested in engaging other expanded partners on key activities. Expanded partners will be engaged in the DQIP work and the technical assistance activities proposed for the financing and advocacy components.

The presence of the Zonal planning representatives greatly facilitate the discussion and deliberations.

There was regional representation by Unicef and WHO but limited country office presence.

List of participants:

NAME	AGENCY	POSITION	DUTY STATION
Dr. Abdulrasaq Yusuf Ahmed	MOH	Director General	Federal - Mogadishu
Mr. Adam Osman Sheikh	MOH	Direct of planning and policy	Federal - Mogadishu
Abdirahman Abdullahi Ibrahim	MOH	Director of Public Health	Federal - Mogadishu
Osman Abdi Omar	MOH	EPI Manager	Federal - Mogadishu
Tahlil Ibrahim Abdi	MOH	Director General Hirshablle	Federal - Mogadishu
Isaak Mohamud Mursal	MOH	Director General southwest state	Federal - Mogadishu
Nur Ali MOHAMUD	WHO	National Professional Officers (GAVI/HSS)	Mogadishu
Mohamed Abdillahi Omer	WHO	EPI Officer	Mogadishu
Ibrahim Mohamed Nur	MOH	National HMIS Manager	Federal - Mogadishu

Suleiman Jama Derie	MOH	Director General	Somaliland - Hargeisa
Faisa Ahmed Ibrahim	MOH	Direct of planning and policy	Somaliland - Hargeisa
Abiib Aden Nur	MOH	Director of Public Health	Somaliland - Hargeisa
Abdillahi Barre Farah	WHO	National Professional Officers (GAVI/HSS)	Somaliland - Hargeisa
Dr. Mohamed Abdirahman	MOH	National EPI manager	Somaliland - Hargeisa
Mohamed Bashir Mohamed	MOH	Director General	Puntland - Garowe
Mohamed Abdulkadir Hersi	MOH	Direct of planning and policy	Puntland - Garowe
Said Mohamed Warabe	MOH	Director of Public Health	Puntland - Garowe
Mohamed Abdi Jama	WHO	National Professional Officers (GAVI/HSS)	Puntland - Garowe
Abdirizak abshir Hirsi	MOH	National EPI manager	Puntland - Garowe
Dr Muhammad Farid	WHO	EPI Medical Officer	Hargeisa
Dr Eltayeb Elfakki	WHO	EPI/POL Coordinator	Nairobi
Dr Umra Alumar	Unicef	Immunization Specialist UNICEF	Nairobi
Dr. Rehan Hafiz	Gavi	Senior Country Manager	Geneva
Dr. Katja Schemionek	Gavi	Senior Specialist HSS	Geneva
Rachel Belt	GAVI	Programme Officer, Country Support	Geneva
Riswana Soundardjee	GAVI	Senior Programme Manager Monitoring and Evaluation	Geneva
Dr Nasrin Muse	EMRO		EMRO
Dr Momin Abdi Ahmed	EMRO		EMRO

8. ANNEX

Compliance with Gavi reporting requirements

Please confirm the status of reporting to Gavi, indicating whether the following reports have been uploaded onto the Country Portal.

It is important to note that delayed reporting may impact the decision by Gavi to renew its support.

	Yes	No	Not applicable
Grant Performance Framework (GPF) reporting against all due indicators	X		
Financial Reports	X		
Periodic financial reports			
Annual financial statement			
Annual financial audit report			
End of year stock level report	X		
Campaign reports			X
Immunisation financing and expenditure information		X	
Data quality and survey reporting		X	
Annual desk review			
Data quality improvement plan (DQIP)			
If yes to DQIP, reporting on progress against it			
In-depth data assessment (conducted in the last five years)			
Nationally representative coverage survey (conducted in the last five years)			
Annual progress update on the Effective Vaccine Management (EVM) improvement plan	X		

Post Introduction Evaluation (PIE)	X		
Measles-rubella 5 year plan			X
Operational plan for the immunisation program			X
HSS end of grant evaluation report		X	
HPV specific reports			X
Transition Plan			X

In case any of the required reporting documents is not available at the time of the Joint Appraisal, provide information when the missing document/information will be provided.

Immunisation financing information is expected to be provided in early 2018 through a donor-coordinated review of health expenditure. The DQIP development is planned for Q4 2017.