Somalia Joint Appraisal Report 2018

Country	Somalia
Full JA or JA update	☑ **full JA**☐ JA update
Date and location of Joint Appraisal meeting	6-9th August 2018 , Nairobi, Kenya
Participants / affiliation	Refer to Annex A
Reporting period	Jan-Dec 2017
Fiscal period	2017 (2018 performance reviewed to-date)
Comprehensive Multi Year Plan duration	2016 - 2020
Gavi transition / co-financing group	Initial self-financing

1. RENEWAL AND EXTENSION REQUESTS

Renewal requests were submitted on the country portal

Vaccine (NVS) renewal request (by 15 May)	Yes X	No ☐	N/A ☐
HSS renewal request	Yes X	No ☐	N/A ☐
CCEOP renewal request	Yes ☐	No X	N/A ☐

Observations on vaccine request

Population	**14,133,919**	
Birth cohort	**565,357**	
Vaccine	**Penta**	**IPV**
Population in the target age cohort	**518,927**	**518,927**
Target population to be vaccinated (first)	**367,934**	**367,934**
Target population to be vaccinated (last)		
Implied coverage rate	**70%**	**70%**
Last available WUENIC coverage rate	**42%**	**Not included in JRF**
Last available admin coverage rate	**63%**	**40.5%**
Wastage rate	**20%**	**10%**
Buffer	**25%**	**25%**
Stock reported	**489,670**	**136,685**

Indicative interest to introduce new vaccines or request Health System Strengthening support from Gavi in the future

Indicative interest to	**Programme**	**Expected**	**Expected**

introduce new vaccines or request HSS support from Gavi		**application year**	**introduction year**
	Measles 2nd dose	2019	2019/2020
	HSS additional support	2019	2019-2022
	Measles SIA	2018	2019

2. RECENT CHANGES IN COUNTRY CONTEXT AND POTENTIAL RISKS FOR NEXT YEAR

I. Background

The total population of Somalia is estimated to be more than 14 million in 2017.[1] The infant mortality rate is extremely high at 85/1000 (2015) with a child mortality rate of 137/1000.[2] The estimated number of live births a year is 565,357 with 537,089 surviving infants. Urban settlements are growing at an unprecedented rate with significant urban-rural migration which has resulted in a concentration of the population in and around urban centres.

Due to the prolonged conflict and political instability, Somalia's health system, including immunization services, remains very weak, fragmented, fragile and severely under-funded. The control of Vaccine-Preventable Diseases (VPDs) remains a challenge in Somalia due to low immunization coverage. Furthermore; service delivery options are limited to routine immunizations in some health centres (as fixed posts) and periodic mass vaccination activities conducted in accessible districts. The coverage has been stagnating for the past decade with significant inequities across the different zones/states and within states and thousands of Somali children remain unvaccinated, with an estimated 372,000 children missed with dtp3, annually. With support from partners the country is slowly rebuilding various systems of service delivery.

II. Humanitarian Context

The impact of nearly 25 years of armed conflict in Somalia, compounded by drought and other natural hazards, challenges the resilience and the coping mechanisms of Somalia's most vulnerable inhabitants. Key high-risk groups include 2.4 million children under the age of 5 and more than 3 million women of childbearing age. Nomads constitute one-fourth of the total population. An estimated 1.1 million (7.8% of the total population) internally displaced people live mainly in the outskirts of urban towns. Of these; around 79% have been displaced due to drought and around 18% displaced due to conflict and insecurity.

Somalia has been trapped in a devastating cycle of hunger and disease with more than two years of insufficient rainfall and poor harvests which led in 2017 to drought, food insecurity and severe famine. This resulted in large movements of people and livestock congregating around watering holes. Large numbers of internally displaced people from remote rural areas have moved to urban settings; where they are affected by lack of food, lack of clean water, medical supplies and poor hygiene and sanitation. These populations were at high risk of severe malnutrition and outbreak of acute water diarrhoea/Cholera, which had affected 17,807 people and has led to 298 deaths, nationally, a 1.7% case fatality rate. Sequentially, there was a large measles outbreak with < 23,000 cases and a ~4% fatality rate. This was one of the worst humanitarian crises in the world which took the attention of the global community and partners to support Somalia during these emergencies in 2016-2017.

The semi-autonomous state of Puntland, like the rest of Somalia, has been in state of emergency for several years now. The civil war followed by several years of weak central and

[1] https://knoema.com/atlas/Somalia/topics/Health/Health-Status/Under-5-mortality-rate

[2] https://knoema.com/atlas/Somalia/topics/Health/Health-Status/Under-5-mortality-rate

state governments have led to the collapse of health and other social infrastructure and created insecurity in several locations. Poor coordination results in inefficiency in service provision. In spite of these challenges the coverage in Puntland has been increasing steadily over the last few years, however, quality of services remains an issue as do services to nomadic populations.

Recently, the security situation has deteriorated in areas of Puntland and Somaliland. For instance, the Qandala district in the Bari region has become inaccessible and services cannot be delivered there due to the presence of insurgents. There has been a flare up in the simmering land dispute between Somaliland and Puntland in the Sool region and this has also negatively affected service provision and caused the displacement of people in Tukaraq area. Galkaio remains a hot spot with the possibility of inter-clan conflict between Galkaio North and Galkaio South erupting at any time. In these conflict-prone areas, UN agencies have developed Programme Cooperation agreements with NGOs, which includes the setting up of mobile teams to provide services to displaced populations. The transit point vaccination strategy is used to reach populations living in inaccessible areas, where they receive the service while moving from inaccessible to accessible areas.

III. Political Context

In 2015, new Federal States emerged from South Central namely Jubaland, South West and Galmudug administrations. Parliamentary and presidential elections took place in 2016 in Federal Somalia. Somaliland considers themselves as a separate entity and elections were completed in November 2017. These two elections resulted in two new government bodies (Federal states government and Somaliland government).

South Central regions are highly populated regions in Somalia and contain 11 regions and 69 districts which could be translated into 65% of the Somalia Population. Due to Federalism it is comprised of five administrations which are outlined in **Table 1.**

Table 1: South Central region administrations

Banadir administration	1 region (Mogadishu, Capital town of Somalia)
South west state	3 regions (Lower Shabele, Bay and Bakol)
Jubbaland state	3 regions (Lower Juba, Middle Jubba and Gedo)
Hirshabelle state	2 regions (Lower Shabelle and Hiran)
Galmudug state	2 region (Galgadud and part of Mudug)
Puntland semi-autonomous state	4 regions (Bari, Mudug, Nugal and Karkar)

In Somaliland, a presidential election was held in November 2017. There is a new elected president for a five year term and he will be the fifth president democratically elected in Somaliland. This was followed by the formulation of new governmental officials (new Minister, Vice Minister, and Director General of Health and entire team of departmental directorate).

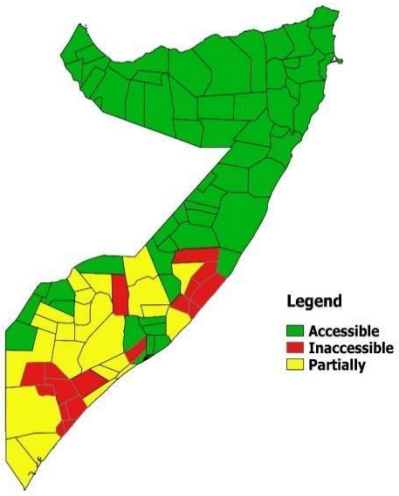
IV. Key contextual issues affecting programme performance

Armed conflict especially in the South-Central: UN Agencies including UNICEF rely on NGOs and to some extent, Government Authorities to respond to humanitarian needs of affected areas. Refer to *Figure 1* for more information on accessibility.

Disease outbreaks-Polio, Measles and AWD/Cholera: There is strong surveillance system to pick early signals and respond to the outbreaks using the outbreak preparedness plans. There has been prompt donor positive response to the outbreaks.

Natural disasters-drought, floods: The United Nation Systems use the systems like Health cluster respond rapidly to these disasters. These are often urgent issues, causing development efforts to be delayed.

Figure 1: Map of accessibility status, 2018[3]



V. Health Sector Development and Coordination

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 which includes; 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.

Recently, the coordination of EPI activities has improved across the three zones. Immunisation activities are coordinated through quarterly meetings of the EPI Working Groups (consisting of MOH, UNICEF, WHO and Partners) that are led by health authorities to review performance and plan for the next quarter. The EPI Taskforce (consisting of MOH, UNICEF and WHO) at the zonal level meets weekly and discusses operational aspects of EPI. The taskforce meets more frequently in case of emergency or when preparing for an SIA. Following lengthy discussions, the ICC was launched in mid-2018 by the Minister in the Central-Southern Regions, with participation of the high authorities of the Ministry of Health and other key Ministries of the Government. Somaliland also called their first ICC meeting in 2018. These meetings are planned to be held on a quarterly basis and are supported by technical assistance. Coordination and regular meetings at the regional and district levels are almost non-existent. This is due to inadequate funds, human resource capacity and inadequate infrastructure but are expected to be revived following the recent establishment of district and regional teams, supported from HSS-2.

VI. Status of polio transition and polio programmes

One National Immunisation Day (NID; bOPV) was conducted. Data is currently being cleaned and results will be shared once data are analysed. In addition to this bOPV campaign, South Central Regions conducted three limited campaigns using mOPV2 and IPV in direct response to cVDPV2 isolates identified from environmental sample. The last mOPV2 campaign was synchronised with Kenya and Ethiopia. No coverage survey was conducted for any of these campaigns. Independent monitoring assessments and Lot Quality Assurance Survey (LQAS)

[3]Polio campaign and surveillance data

were used to evaluate coverage and quality of the campaigns.

The Global Polio Eradication Initiative (GPEI) is in transition. Somalia is among the 16 priority countries where majority of polio programme functions are located. All these countries are currently engaged in transition planning and implementation, ensuring that the most valuable assets of the programme are sustained and passed on to other health programmes, and that these assets are used in the most effective way to benefit communities. The negative impact will be on human resource as the programme has been the cornerstone of the routine immunization activities and most of the accelerated child survival activities in Somalia. The transition is leading to dwindling financial support to critical polio staff and other primary health care programmes benefiting from polio support. Cold Chain and office infrastructure have also benefited from the Polio Programme and this could also suffer deterioration with no support from other sources. The C4D structure of the MoH will be affected most significantly in the draw-down of polio funding, including a C4D position which currently support RI activities. The GAVI selected districts will support less than 25% of the workforce of 157 social mobilisers. Somalia has developed Polio Transition Plan with the main aim of integrating polio assets to routine health delivery so as to maintain the human resource and physical assets for optimal primary health care delivery.

Three health priorities were identified for asset transition and these were: (1) surveillance, (2) basic health service delivery including child health and the (3) Expanded Programme on Immunization and the Emergency Health Programme, including nutrition.

The Polio Transition Communication Plan has also been developed. This is being used to communicate the transition plan to the country authorities, the programme staff and service delivery partners. It is also an important tool to advocate for funds to support the implementation of the transition plan.

Forward looking analysis for 2018-2019 on country context:

Country context: The drought situation continues to be closely monitored, with significant population living in food insecure areas. The country is planning a Cholera campaign (6 districts) and national Measles SIA campaign in 2019. Somalia is due to hold elections in 2020.

Gavi support: In mid-2018, Gavi's support for HSS-2 and CCE OP (Year 1 and 2) was operationalised following a costed extension on HHS-1 for 2017. This support totals more than $27 million over 5 years and aims to improve access toand demand for immunisation, focused on 25 priority districts. The implementation of this grant is meant to improve immunisation service delivery and cold chain capacity in 2019. The progress on this support is monitored quarterly. Further, an additional $12.5 million of health systems strengthening support will be programmed in 2019 on priority areas of integration, data quality, vaccine management and urban internally displaced persons.

3. PERFORMANCE OF THE IMMUNISATION PROGRAMME

3.1. Coverage and equity of immunisation

I. Summary of overall coverage and equity situation:

Somalia is considered one of the 10 countries in the world that has low and stagnant DTP3/Pentavalent coverage rates (42% WUENIC 2017) and a low and stagnant measles coverage (46% WUENIC 2017) as shown in *Figures 2-4.* In, 2017 more districts fell in the <50% coverage category for Penta 3 as compared to 2013 and this is consistently increasing.

With the new SAGE recommendation for the introductions of the measles 2nd dose regardless the coverage of the DTP and MCV1 coverage, Somalia plans to apply for 2nd dose of measles with Gavi support in 2019.

Figure 2: Coverage - Pentavalent (3rd dose) and MCV (1st dose) 2000-2017

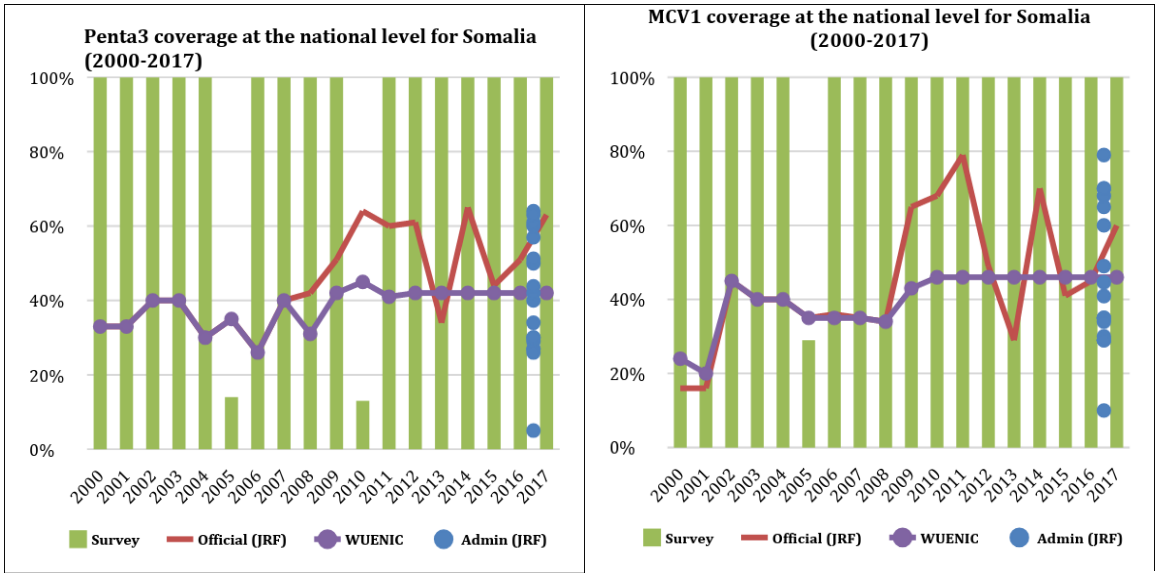


Figure 3: Districts Penta3 Coverage data reporting 2005-2017

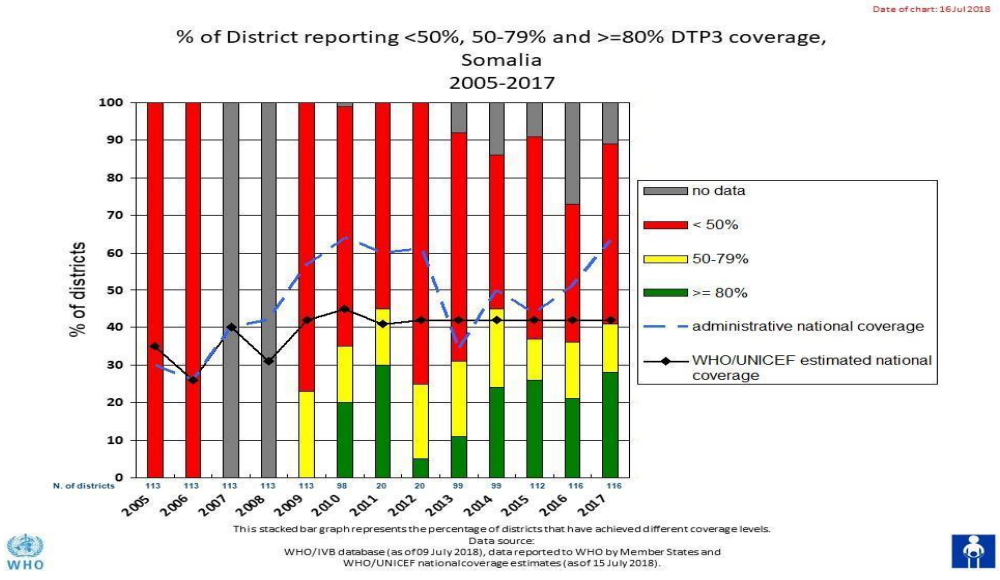


Figure 4: Somalia % of District coverage of measles vaccine 2010-2016

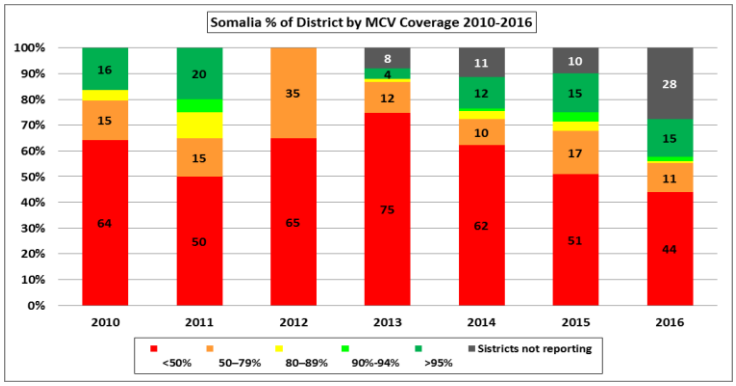


Figure 5: Regional disparity in pentavalent coverage (DHIS, 2016)

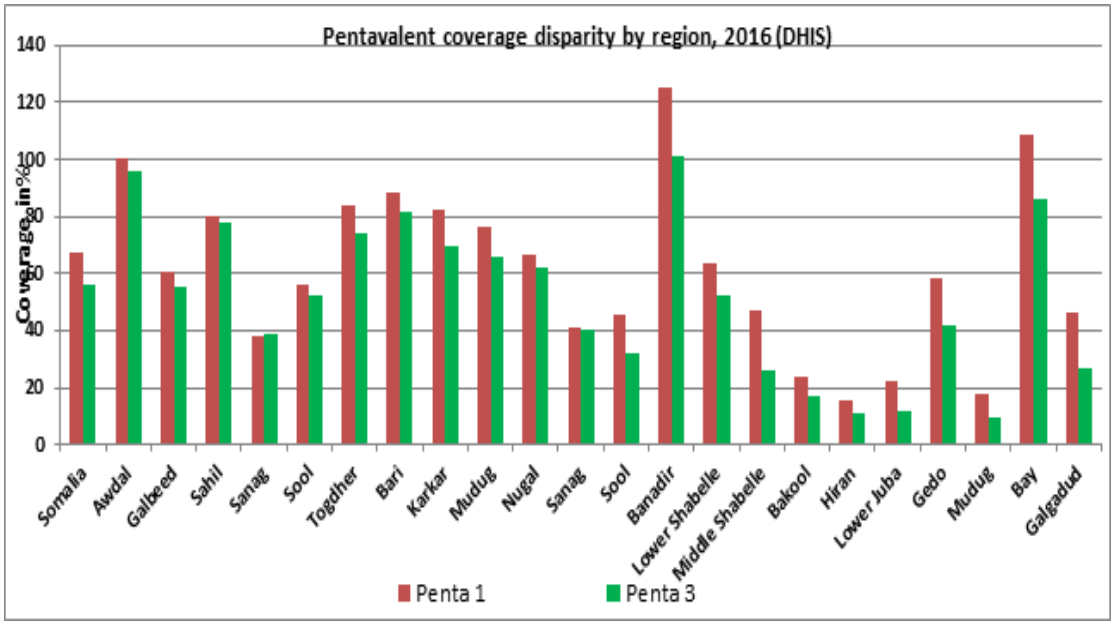
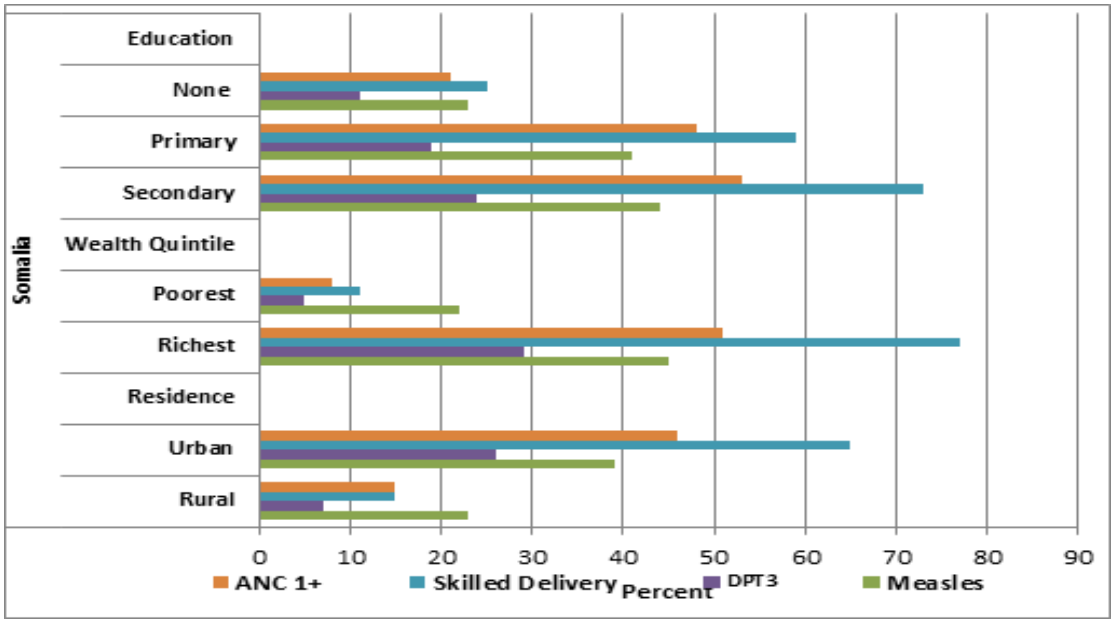


Figure 6: Measures of inequity for selected indicators by socio-economic status in Somalia (Source: MICS, 2006)



In terms of equity, the DPT-3 coverage was higher in urban areas (26%) than in rural areas

(7%). More children from mother's (24%) with higher education (secondary or more) received pentavalent 3 than those with none (11%). 27% of children from the richest families were vaccinated as compared to those from the poorest families (5%).

Concerning measles, the coverage was higher in urban (39%) than in rural areas (23%). More children from mother's (44%) with higher education (secondary or more) received measles vaccination than those with none (23%). More children from the richest (45%) families were vaccinated received measles vaccination compared to those from poorest families (22%).

Nationally, only 49% of health facilities provide immunisation services. More urban health facilities (64%) provide immunisation services than in the rural health facilities (25%). On average, only 10% of the health facilities offer outreach immunisation services. There were more health facilities offering immunisation services in the CSR (66%), than in Somaliland (49%). Sanaag and Sool regions of Somaliland were found to have less than 30% of the health facilities providing immunisation services, while Bay and Lower Jubba region in the Central-South Regions had more than 80% providing the service.

An equity assessment conducted in 2017 in the CSR showed that 47% of the areas were accessible, 39% partially accessible and 14% inaccessible.[4] Geographical coverage showed that 13 districts with a coverage <80%, 14 districts with a coverage between 50%-80% and 48 districts with a coverage below 50%, respectively. Low coverage was mostly among the nomads, population living in inaccessible areas, and internally displaced populations.

II. South Central

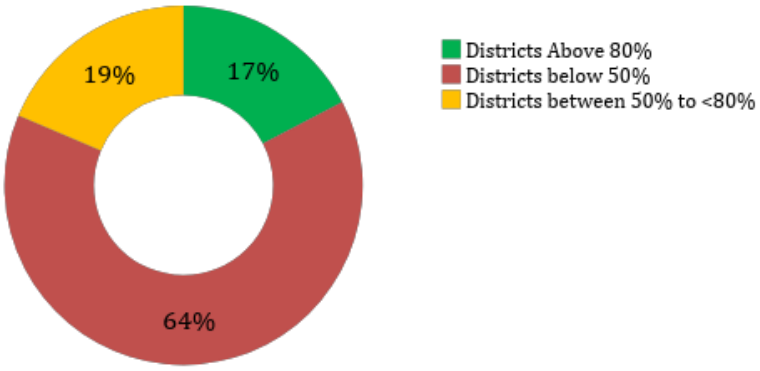
The routine immunisation coverage is lowest in the Central-South Regions of Somalia, where the administrative Pentavalent 3 coverage is 47% and the Measles vaccine coverage at 46%. The immunisation coverage in Somaliland and Puntland is almost identical. Overall, the pentavalent administrative coverage in Somalia is less than 70% and measles coverage less than 50%, respectively.

Hiranm, Mudug, Bakool, Hiran, Lower Jubba and Mudug have a pentavalent 3 coverage less than 20%. Only the regions of Awdal and Banadir have a penta 1 and penta 3 coverage of more than 80%.

The equity analysis (the accessibility of EPI services to all areas and geographical coverage) showed that the accessibility is 47%; partially accessible is 39% and inaccessible 14%. Geographical coverage equity showed: districts of coverage of <80% =13, 50%-80%=14 and below 50%=48. Most of the low coverage areas are nomads, inaccessible areas, and internally displaced populations.

Figure 7: Geographical Equity of Penta3 Coverages in all regions of Federal Government of Somalia (Jan-Dec 2017)

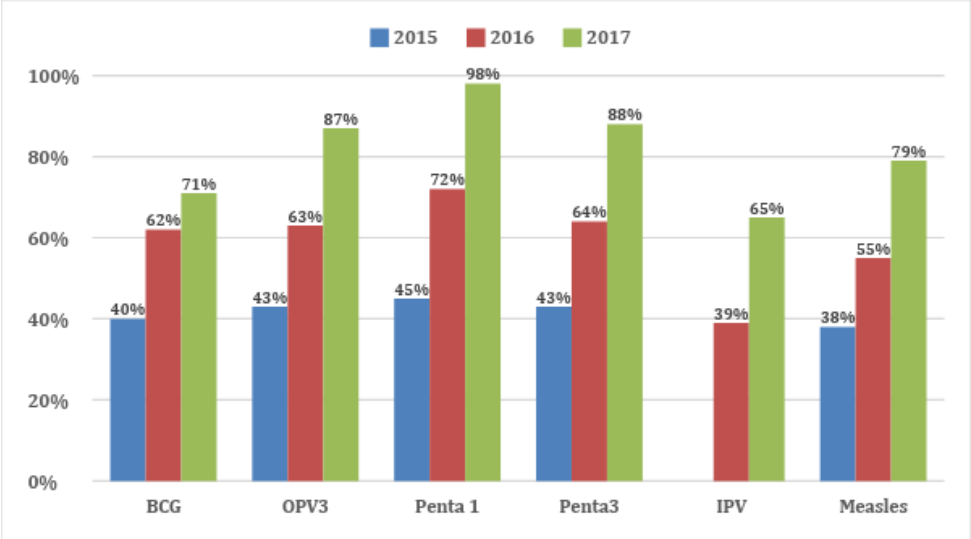
[4] Source needed



III. Puntland

Immunization coverage in Puntland has increased over the last few years, according to administrative data. The percentage of infants who received the third dose of the Penta-valent vaccine increased from 43% in 2015 to 64% in 2016 to 88% in 2017. The data also showed significant increase in measles vaccination coverage during the same period – from 38% in 2015, and 55.2% in 2016 and 79% in 2017. 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. *Figure 9* below shows the infant immunization coverage by antigen from 2015 to 2017.

Figure 8: Graph showing infant Immunization coverage (%) by selected antigens in Puntland from 2015 –2017.



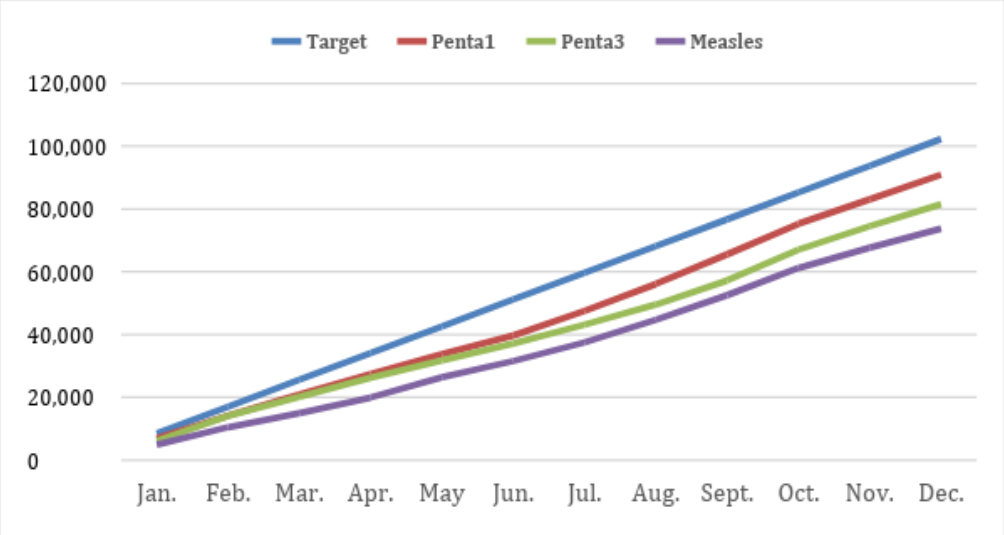
This improvement is mainly due to the fact that services there is increase in the number of facilities providing immunisation services though the majority offer services only at fixed sites (health centres and hospitals). The hospitals now provide the full complement of vaccines in the immunisation schedule and not only OPV0 and BCG. Some facilities have been providing services at outreach points although the number of such sessions remain low.

There is no sustained strategy to reach the nomads and pastoralists who make up about 25 per cent of the population except during SIAs (Polio, Measles and Vitamin A supplements). Other reasons which contributed to the failure to achieve all immunisation targets include weak District Health Management Teams, absence of functional district EPI teams and

inadequate (in quantity and quality) supportive supervision. There is an issue of denominator (target setting) in Puntland.

Figure 9 below shows the cumulative number of infants vaccinated with Penta 1, Penta 3 and Measles compared with the cumulative monthly target. The chart shows that over 9,000 children were missed (the difference between the total number of surviving infants and the number who received Penta 1.) The chart also shows that out of the 75,274 children who received Penta 1, over 8,000 did not receive Penta 3 giving a drop-out rate of 11%. There is no effective defaulter prevention or tracking system.

Figure 9: Chart showing cumulative number of children vaccinated (Penta1, Penta3 and Measles) from Jan-Dec 2017



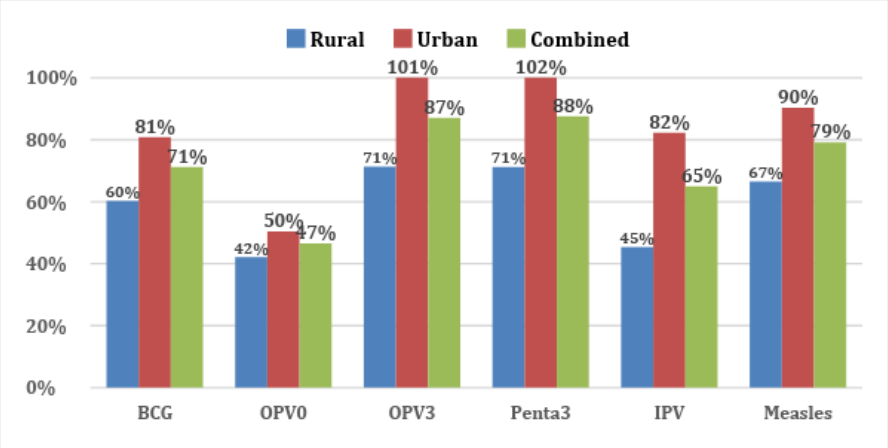
The improvement in performance was not across the whole of Puntland. The below table shows that only 3 out of 29 districts have BCG coverage above 80% while 15 and 12 out of 29 districts have above Penta 1 and Penta 3 coverage respectively.

Table 2: Distribution of districts by immunisation coverage categories.

S. No	Antigen	# districts < 50%	# Districts 50 – 79%	# districts 80 and above
1	BCG	15	11	3
2	OPV zero	22	5	2
3	Penta 1	7	7	15
4	Penta 3	10	7	12
5	IPV	18	3	8
6	Measles	10	12	7
7	TT2	7	4	18

Facilities in the urban areas and districts with a high proportion of the population living in urban areas perform better than those whose population is predominantly rural. The coverage for all the vaccines is higher in the urban areas compared with the rural areas.

Figure 10: Chart showing immunisation coverage for selected antigen based on Rural – Urban divide



Analysis of unimmunized children (infants who have not received Penta 3):
The coverage of Penta 3 is 66%. This means that 34% of surviving infants or 4 out every 10 infants has not received Penta 3. The total number of children who have not been immunized in the zone at the end of 2017 stood at 20,812. One out every five infants has not received Penta 3. The regional breakdown of unimmunised children in 2017 is shown in *Table 3*below. The Sanaag and Sool regions account for over 50% of under-immunised children but the population of the two regions is about 15% of the total Puntland's population. These regions are predominantly rural; access to services is poor due to poor road network and the prevailing conflict situation. It is estimated that approximately 13,000 children are missed with Penta 3 in rural areas.

Table 3: Number of unimmunized children (Penta 3) in 2017 by region

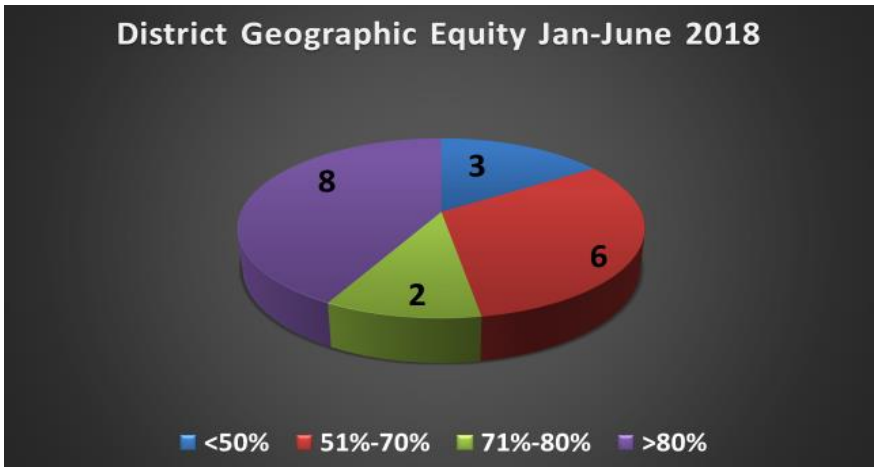
Region	Target	Number immunised	Number unimmunised	Unimmunised as % of zonal total
Ayn[5]	2,976	1,446	1,530	7%
Bari	26,636	23,383	3,253	15%
Karkar	12,384	12,666	(282)	
Mudug	27,267	25,599	1,668	8%
Nugal	17,859	14,079	3,780	18%
Sanag	6,974	1,786	5,188	25%
Sool	8,218	2,543	5,675	27%
Puntland	102,314	81,502	20,812	

IV. Somaliland:

Somaliland has six regions and 19 districts. Each district has several health facilities that provide immunization services. The district coverage varies from one another due to the number of facilities in service and accessibility, the coverage is as shown in *Figure 12.*

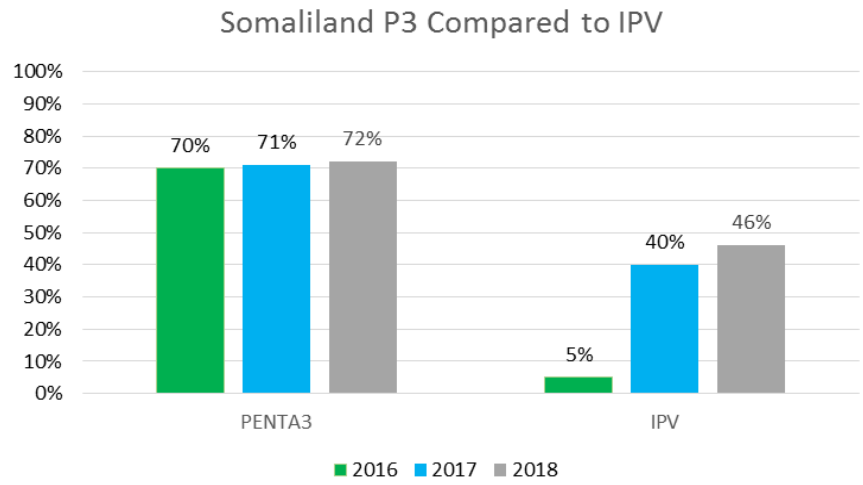
Figure 11: District Geographic Equity January – June 2018 (Administrative data)

[5] The number of immunized children is indicated as 0 as no reports were received from the facilities in the region



IPV has increased dramatically from year to year, following introduction. The coverage was 5% at the year of the introduction in 2016, 40% in 2017 and 46% in 2018. This reveals that parents and entire community have started to accept of the new vaccine introduction and communication strategies for education of the community is working inproving.

Figure 12: Coverage of Penta 3 vs IPV, Somaliland 2016-2018 (Administrative data)



As shown in *Figure 12*, Penta3 has shown little improvement from 2016 - 2018. There was a Measles outbreak in 2017 and early 2018 and many children travelled to the health centres to get protected from this illnesses. For this reason, the coverage of measles improved as shown by *Figure 13.*

Figure 13: Measles vaccine coverage, Somaliland, 2017-2018

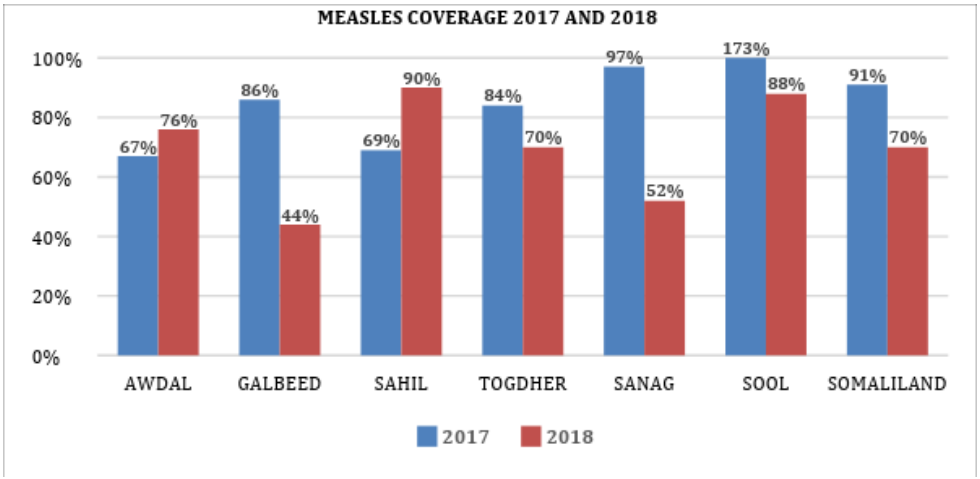


Table 4: Number of unreached children (Penta 1) in 2017 by six regions of Somaliland

Region	Target	Number children reached P1	Number of children unreached	% unreached per region
Awdal	27309	26621	688	3%
Maroodijeex	42671	31115	11,556	27%
Sahil	8964	7681	1,283	14%
Togdeer	28003	18372	9,631	34%
Sanaag	22071	12686	9,385	43%
Sool	13281	11393	1,888	14%
Somaliland	142299	107868	34,431	24%

Despite overall improvements in performance, there are remain large numbers of missed children as summarised in *Table 4.*

3.2. Key drivers of sustainable coverage and equity

I. Background:

Primary Healthcare:

The primary healthcare package in Somalia is defined and referred to as the Essential Primary Healthcare Services (EPHS). Routine immunization services are currently delivered as part of integrated mother and child health care interventions at health centre/MCH level, although the quality of health care and the working hours in the MCHs are not uniform. MCHs are staffed with at least 1 qualified nurse and auxiliaries trained for EPI to perform specific jobs like registration, vaccination, or cold chain monitoring/maintenance.

Provision of health care in the country is poor in general and organized at MCH/OPD or hospital levels which mainly run by INGOs or LNGOs since the Ministry of Health has limited human and financial capacity. The MCHs provide maternal and child health services including immunization and most hospitals provide exclusively curative services. Immunization is not usually given in hospitals, although this is a priority area of expansion in Year 1 HSS-2 (2018-2019).

All MCHs do not have defined catchment area or annual, monthly and daily estimates of targets for immunization, in 2017; 25 district micro plans was developed in the Gavi HSS priority districts but not yet implemented because of funding.[6] The remaining districts will have microplans as part of PEF TCA 2018. There were no planned outreach activities in the districts and most MCHs do not use immunization monitoring charts.

II. Specific bottlenecks to achieving coverage and equity:

Country-wide issues include the following challenges to coverage and equity, in line with the findings of the 2017 equity assessment;

Health Work Force: The assessment found an inadequate, uneven distribution and mix of skilled health workforce that is characterised by high a turnover.

Demand Generation: There was little emphasis on carrying outreach activities to vaccinate children living in hard-to-reach areas. Inadequate community involvement and empowerment led to low demand for services, and thus low utilisation of immunisation services. Cultural preferences, attitudes and norms also hindered the demand for immunisation services. The transition of polio resources will create a gap in support to existing social mobilisation activities. Support is outlined in PEF TCA 2019 for the design of new support to improve demand (tentative).

Service delivery: The assessment found out that the population settlements are dispersed and thus increasing the operational costs, as well as the time required to reach every child. Puntland has put in place a mobile strategy that targets nomads who constitute approximately 25% of the population. The list of nomads is compiled by the clan elders and thereafter shared to the health authorities for ease of tracking. 1,300 volunteers have been trained and are usually deployed during supplementary immunisation activities to visit households and remind caregivers about upcoming campaigns.Over 180 EPI sites are supported by INGOs and LNGOS which provide routine immunization in the South Central zone. Only Middle Jubba region has no immunization facilities due to in accessibility issues.

The facilities providing immunization services are maternal and child health centres, EPI centres and very few hospitals which MCH or EPI centre located inside hospital. Private hospitals

[6] HSS-2 support began in early 2018.

involvement in the routine immunization is very limited although pilots on private sector engagement were presented during the Joint Appraisal. A health facility assessment began in May & June 2018 and is ongoing in Federal member states with FGS. A SARA survey was completed in 2016 and a recent analysis of Private Healthcare Providers published in 2018. The Private Sector report showed a demand for immunisation services from the private sector and this will be further reviewed with support from PEF TCA 2019 (tentative).

Table 5: Functional EPI facilities in each region of the Federal States and number of the partners:

SN	Regions	Districts	# of EPI Facilities	EPI Partners
1	Banadir	17	53	16
2	L/Shabelle	8	28	8
3	M/Shabelle	6	12	6
4	Hiran	5	16	7
5	Galgadud	6	14	7
6	Bakool	6	10	7
7	Bay	4	22	12
8	Gedo	7	21	5
9	L/Jubba	4	14	12
10	M/Jubba	3	0	0
11	S/Mudug	3	6	3
Total		69	196	83

Due to the tension of the border dispute between Somaliland and the Puntland state, conflict areas are served by UN agencies working with government which have developed Programme Cooperation Agreements with NGOs. This includes the setting up of mobile teams to provide services to displaced populations. In areas which become inaccessible, transit point vaccination strategies will be used to vaccinate some people who may be moving between the accessible and the inaccessible area. UNICEF will work with the respective MoH in 2018-2019 to establish these transit points to vaccinate children and women moving from to inaccessible areas.

Cold chain: The following are the key findings of the EVM assessment, and the support of the CCEOP in remedying them.

Key EVMA Finding	Support from CCEOP
A formal review process should be established to review temperature records on a monthly basis to identify problems for remedial actions. Keep records of these reviews and other transactions for at least three years.	The CCEOP will procure fridge tags to monitor temperature in the cold chain at the various levels. Remote monitoring technology has also been put in place in the vaccine stores.
Provision of cold chain equipment in regions and facilities with inadequate storage capacities. For example, the following facilities were highlighted in the report: -Sahil and Awdal have inadequate storage capacities for vaccines -Provide refrigerator to Fanoole health facility. -Provide refrigerator with adequate storage	The CCEOP supports the procurement of cold chain equipment for new immunisation centres, replacement of obsolete or malfunctioning equipment in health facilities, district and regional cold chain stores.

capacity to Beletweine and Hinna health facilities.	
Use fridge tags for continuous temperature monitoring	The CCEOP will procure fridge tags to monitor temperature in the cold chain at the various levels.

The total cost of the costed EVM-IP is 7,723,460 USD, and the CCEOP covers approximately 30%. Other recommendations from the EVMA have been addressed in the HSS 2 such as training on vaccine management, training on repair & maintenance and use of stock monitoring tools. PEF TCA 2019 will include support to the implementation of the improvement plen.

Leadership, management and coordination: There were capacity gaps in health governance and leadership that were noted in the equity assessment. Micro-plans were of poor quality at both the district and health facility levels (although now supported through PEF TCA 2018). Since the time of the assessment, significant improvements have been made in management and coordination. In 2017 around 4 EPI working group meetings have been conducted in Mogadishu where all key implementing partners were invited and contributed for information sharing and progress updates. Meeting minutes have been generated and circulated for action.

Similarly, EPI technical team of MOH, WHO and UNICEF had ad hoc meetings on at least once or twice per month to update on operational planning and monitoring. Following political engagement and technical assistance in 2017-2018, ICC members were nominated in this year 2018 and first meeting was conducted in July, 2018.

During the Joint Appraisal, opportunities to improve coverage and equity included the potential to integrate with other key programmes, such as nutrition, to review the status of immunisation in major cities, with a focus on displaced populations and to review engagement with the private sector.

III. Puntland:

Service delivery and demand generation: In 2017, immunisation services were still delivered largely at fixed sites of static facilities. This greatly limits access to services by the population in the rural areas. Efforts have been made to map out location of nomads and pastoralist but there was no systemic way of reaching them with routine immunisation services. Over 1300 volunteers have been trained and are usually deployed during supplementary immunisation activities to visit households and remind caregivers about upcoming campaigns. Due to financial constraints, these volunteers cannot be deployed to support routine immunisation. Generation of demand for routine immunisation services is weak as it is limited to information provided by health workers. Even though some of these health workers have been trained on interpersonal communication, observations during the limited supervisory visits indicate that they do not communicate effectively with caregivers. Parents are not informed about the vaccines administered to their children, about possible adverse events following administration of these vaccines (AEFI) and what actions to take in case of AEFI. The system for defaulter tracking is limited to telephone calls and no home visits are conducted.

Health Workforce: Each facility providing immunisation service has at least one skilled service provider. The distribution is skewed in favour of urban health facilities availability. The staff turnover is very high and there is always a need to train newly recruited staff. A series of capacity building sessions including basic and mid-level management trainings targeting health facility, district and regional staff have been conducted. In addition to this, other basic training on vaccine management has been conducted and vaccine management tools has been distributed to health facilities and regional cold chain, 17 district EPI micro-plans have been established to form the basis for establishing outreach services, planning for every outreach session including

costing and its monitoring and supervision, demarcation of catchment areas for health care facilities.

Supply chain: The cold chain capacity has been increased with the provision of additional vaccine refrigerators to health facilities which were upgraded to start to provide immunisation services. The complete shift from the use of electricity powered to solar powered equipment in the smaller health facilities has meant a minimal maintenance cost. Since most of the equipment are relatively new there has not much need for repairs. Additional equipment will be required for the health posts which will be upgraded to health centres and to replace aging ones. Some data loggers provided for monitoring vaccine storage temperatures in some facilities are not working and they have reverted to the use of stem and dial thermometers or using the thermometer inbuilt in the refrigerators. There is a need to replace these non-functional data loggers.

Thirteen vaccine store management staff from the regional and zonal level were trained on the Stock Management Tool (SMT). Evidence from the data submitted by the regional staff and obtained from follow-up visits to the regions indicate that these staff still have gaps in the knowledge of the tool and a refresher training is necessary. Ledgers are available and in use in all vaccine stores, however entries are incomplete. There are challenges with reporting on vaccines used with some facilities reporting in vials while others report in doses. At the zonal level wastage rates derived for the data is not very useful. While the standard is to report in doses it seems most staff are more comfortable with reporting in vials. There is a need to develop a consensus on this issue with other zones.

Gender-related barriers faced by caregivers: Majority of caregivers who send children for immunisation services are females. Some of these women are engaged in petty trading activities to support their families. Travelling long distances to access services interrupts their economic activities. The working hours is very short, starting from 8.00 am and closing at 12:00pm. Attempts have been made to compensate for this by working for six days a week.

IV. Somaliland

Leadership and Management of the Ministry of Health are partially receiving support from Gavi HSS, including four national officers. Regional Management and District Health management are among the leaders and managers whose are essential for better management EPI and HSS programs. The coordination meeting between the EPI partners has improved and regular meetings on EPI performance and challenges is discussed and action points regularly monitored, in these monthly coordination forums EPI data from the regions and districts are presented by the newly recruited officers in a summarised manners and minutes produced.

3.3. Data

I. Status of health information system:

The District Health Information System (DHIS 2) was introduced in Somalia in 2016 by the Ministry of Health (MoH) as the official routine Health Management Information System (HMIS). This choice was informed by the tool's ability to generate automated analyses and data visualisation facilitating data use at all levels. The DHIS 2 immunisation, data quality and vaccine safety modules have not yet been introduced; the University of Oslo has been contracted to support Somalia in this process. A scoping mission is planned for Q1 2019.

Currently, monthly paper reports are sent by all public health facilities to their respective Regional Health Management Team; information is entered on a facility-by-facility basis by the Regional Health Management Information System (RHMIS) Officer. As of 2019, partly facilitated by Gavi's Data Improvement Plan support, data will be entered and reviewed at the district level.

The monthly summary form (i.e. F01) includes stock records for each antigen, namely the starting balance at the beginning of the month, number of doses received throughout the month, the total number of doses used as well as the closing balance at the end of the month.

Queries relating to data accuracy are shared with facilities at this stage; this has resulted in improved reporting completeness (approximately 605), and in some cases, timeliness (although still low). However, feedback specific to the planning of immunisation activities is not yet provided. Coverage data analysis occurs mainly at the Federal level. Monitoring charts at the facility level are seldom found.

Denominator related information:
Whereas the estimates derived from the 2014 UNFPA-supported Population Estimation Survey (PESS) are used by UNICEF, MoH uses different estimates. This is because the PESS estimates are not available at the district level and below (i.e. villages, health facilities and communities)

It has been recognised that poor accuracy of immunisation target population is a real challenge. In response, the Somalia Country Team is proposing the following two actions:
(1) Use of PEF TCA funds (already earmarked in 2018 plan) to review existing data sources (e.g. PESS estimates, polio data, etc.) with the aim to come up with a population of consensus. This review will be based on the WHO's methodology for improving the accuracy of denominators.
(2) Accelerate the development of micro-plans at the health facility level (using PEF TCA and HSS funds).

II. Key challenges relating to data availability, quality and use

A Data Quality Self-Assessment (DQS) was conducted in 2016 in six regions in each of the three zones. The focus of the DQS was health facility and regional levels. Findings were collected and summarised by zone as illustrated by the table below.

	Federal Government of Somalia	**Puntland**	**Somaliland**
Health facility	Good overall accuracy ratios for card/register and register/monthly summary. However, poor recording of child card number and age. Shortages of child cards Limited to no use of tally sheets (whether for fixed or outreach sessions) Poor vaccine data management Limited to no use of monitoring charts; no defaulter tracking mechanism	Good overall accuracy ratios for card/register and register/monthly summary. However, poor recording of child card number and age. Shortages of child cards Limited to no use of tally sheets (fixed sessions) Inconsistent use of registers and tally sheets for outreach Lack of standardized vaccine stock management tools and processes Limited to no use of monitoring charts; no defaulter tracking mechanism	Good overall accuracy ratios for card/register and register/monthly summary. However, poor recording of child card number and age. Shortages of child cards Limited to no use of tally sheets (fixed sessions) Inconsistent use of registers and tally sheets for outreach Lack of standardized vaccine stock management tools and processes Limited to no use of monitoring charts; no defaulter tracking mechanism

Region	Penta 3 accuracy ratio for MCH monthly summary /regional electronic database is questionable Lack of maps Limited monitoring of wastage and stock outs	Penta 3 accuracy ratio for MCH monthly summary /regional electronic database is questionable Lack of maps Some regions are not monitoring wastage and stock outs at facility level	Lack of supervision from regional to health facility level Limited analysis of immunisation data; no consistent use of standardised presentation Some regions are not monitoring wastage and stock outs at facility level

The 2017 and 2018, PEF TCA funds were used to address the aforementioned challenges. As a result, the following activities were completed:

- **Improved regular feedback and supervision** from regional to health facility leading to increased completeness of health facility reportingthat reflected in improving of reporting rates and timeliness.
- **Training of national and regional HMIS Officers** on data issues; most public health facility workers have been trained on HMIS data collection and reporting tools. Three regions each in Somaliland and FGS have still not been trained.
- **The introduction of the DHIS 2** has facilitated the use of data, for example during presentations at meetings or in joint assessments and planning sessions. Equity issues are better understood and discussed owing to improved data visualisations which are facilitated by DHIS2. There is still need for regular systematic use of data for monitoring, planning and decision making with a view towards developing equity-focused strategies.

III. Compliance with Gavi's Data Quality and Survey Requirements

The following table shows Somalia's compliance with data quality requirements.

Table 6: Compliance with Data Quality Requirements, Somalia, 2017

Survey	In-Depth Assessment	Annual Review	Desk DIP	Progress Report DIP	Compliance
Non-compliant	*Completed in 2016*	*Analysis shown at JA; no report submitted to Gavi*	*Draft developed; being finalised*	*Not applicable*	Not compliant

Immunization indicators were integrated into a recently conducted malaria survey (funded by PEF TCA). However, WHO standards for immunization coverage surveys were not respected and therefore, results from this exercise should be treated with caution.

A Data Improvement Plan has been developed to address the findings of the 2016 DQS with support from expanded partners (i.e. ALMACO). Field visits in the three zones were conducted to inform proposed activities that stem across data availability, quality and use. Implementation is expected to start in 2019.

Despite the challenges of population dynamics, limited data quality in terms of its completeness of 60%, we had to use the existing data to present the findings of the analysis.

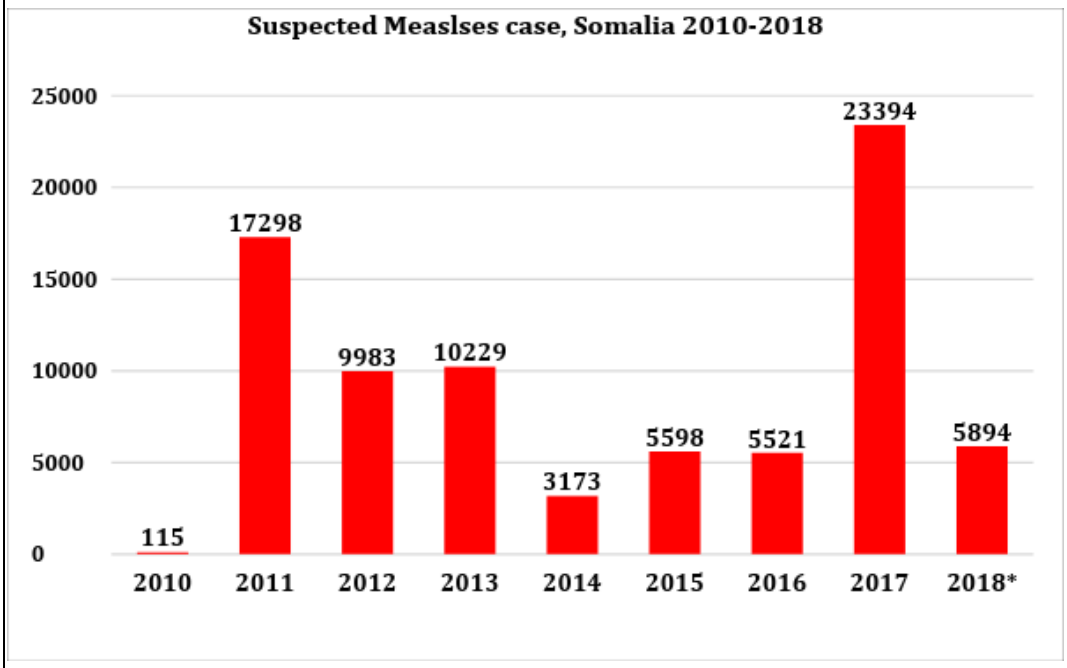
IV. Surveillance

VPD surveillance (mainly AFP and measles) is run by AFP surveillance system which is quite functional all over the country and includes focal points who report from 870 reporting sites,

including 62 sites that are in inaccessible areas and 145 who live in inaccessible areas in the country.[7] The AFP surveillance system is collecting information on rash and fever cases. Line listing of patients with rash and fever are collected and reported during weekly visits from limited reporting sites. It is fully active only in ad hock bases (during outbreaks); cases of fever and rash are shared by districts, region, Zone and by week of reporting. AFP surveillance system reported 10279 cases of fever and rash in 2014, 7498 in 2015, 5657 in 2016 and 23352 in 2017.

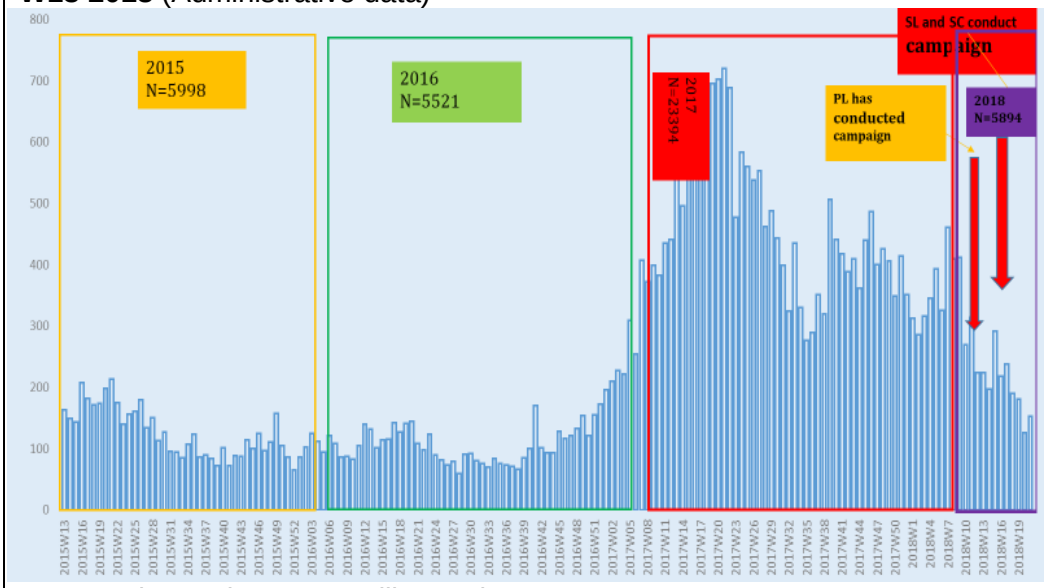
Measles case based surveillance is sub optimally working in Somalia, the Ministry of Health have limited capacity to run the program efficiently, both in human resource capacity and financially. In recent years between 5000- 10,000 suspected cases of measles are reported yearly. There are periodic large outbreaks superimposed on this endemic transmission. Prior to the outbreak in 2017, the largest recent outbreak was in 2011; however there have been numerous smaller outbreaks since that time.

Figure 14: Reported measles cases Somalia 2010 – May 2018 (data from JRF and 2018 surveillance reports):



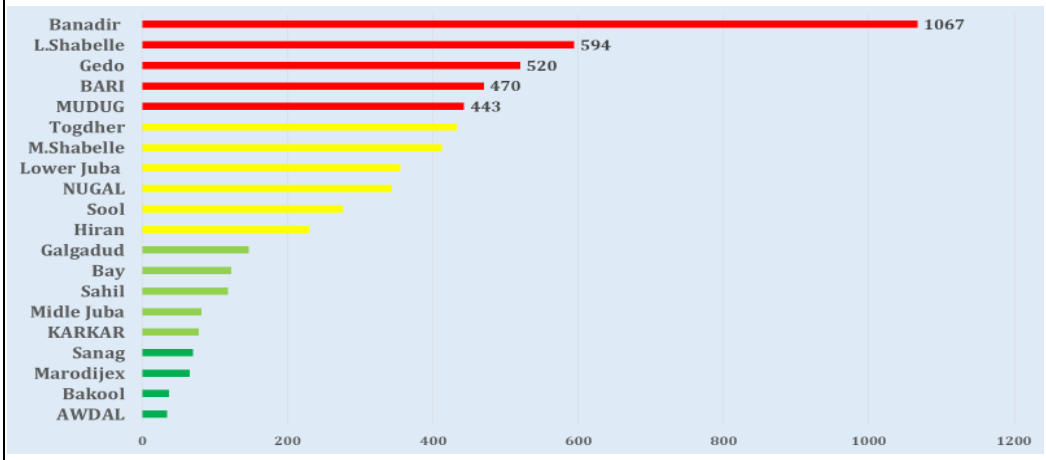
[7]Polio campaign and AFP surveillance data

Figure 15: Number of reported fever and rash cases by week in Somalia/Somaliland 2015-W13 2018 (Administrative data)



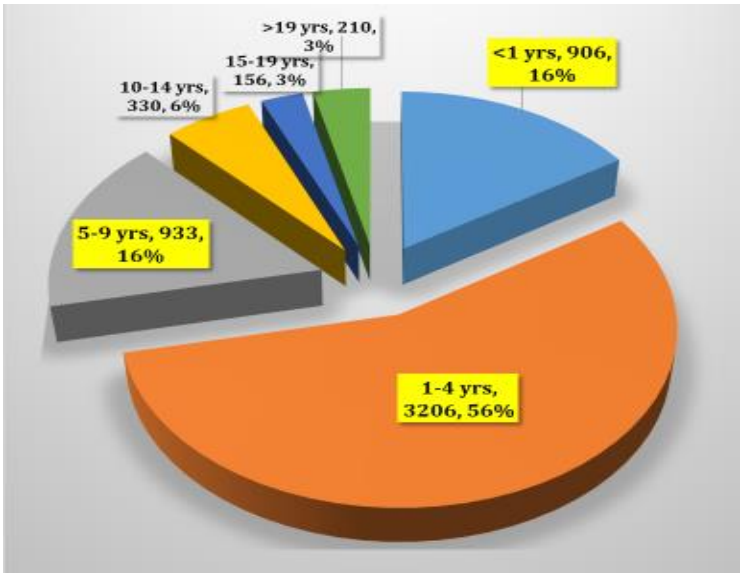
*Measles and AFP surveillance data

Figure 16: Cumulative number of Fever & Rash cases reported in Somalia 2018 by region (Measles and AFP surveillance data)



In Somalia and Somaliland, measles is mainly a disease of younger children less than 5 years of age however there are anecdotal reports of older children and adult cases of fever and rash from rural areas. According to 2018 fever and rash surveillance data, 56% of cases were under 5 years of age, 16% were between 5 years and 10 years, and 6 % were between 10 and 15 years of age.

Figure 17: Age distribution of Fever & Rash cases in Somalia Jan-May 2018 (Measles and AFP surveillance data)



During April and May 2017, a series of sub-regional measles SIAs were conducted as a response to 2016-2017 outbreaks of suspected measles cases and as part of an emergency response to protect drought affected IDPs. These very focused measles immunization activities were integrated with Vitamin A administration and conducted in selected districts of Somaliland, Puntland and Central zone.

Measles mass campaign conducted from January 2-6, 2018 targeting a total of 1,014,791 children aged from 6 months to 10 Years living in 30 districts of Puntland concluded vaccinating 933,406 children. Measles mass campaign conducted from March 11th-18th in south, Central and Somaliland. The campaign conducted targeting 2.6 Million (6 Months to 10 years) Zone aged children living in accessible and partially accessible districts of South-central zone and 1.1 Million aged children (9M to 10years) on all districts of Somaliland. In general around 4.8 million children were targeted in the mass campaign and around 4.4 million were reached (93%). Only Somaliland was achieved the threshold of 95%.

No coverage survey was conducted, independent monitoring assessments are used as proxy indicators to access the coverage and the quality of the campaigns and the result was satisfactory 93%. The campaign was supported by WHO, Unicef and other donors.

Figure 18: Results of Mass campaign on measles immunization Jan/Mar 2018

Zone and region	Target Measles(6 months -10 yrs)	Total Vaccinated(6m-10years)	Coverage
central	**1818072**	**1670798**	**92%**
BANADIR	827104.32	758048	92%
GALGADUD	222143.4	187974	85%
HIRAN	174116.16	166963	96%
LOWER SHABELLE	357724.44	326778	91%
MIDDLE SHABELLE	236983.68	231035	97%
Puntland	**1014791**	**933406**	**92%**
Ayn	24057.04	20056	83%
BARI	272341.56	274066	101%
Karkar	92165.58	79857	87%
Mudug	395771.52	352942	89%
Nugal	159981.14	145011	91%
SANAG	45230.64	41232	91%
SOOL	25243.02	20242	80%
Somaliland	**1,116,234**	**1,064,143**	**95%**
AWDAL	212173	197572	93%
GALBEED	340445	334114	98%
SAHIL	69646	67174	96%
SANAG	171476	132713	77%
SOOL	104931	114319	109%
TOGDHER	217563	218251	100%
South	**875855**	**828193**	**95%**
BAKOL	104155	98591	95%
BAY	402449	386566	96%
GEDO	205804	189777	92%
LOWER JUBA	163447	153259	94%
Grand Total	**4824952**	**4496540**	**93%**

V. Puntland

The DHIS platform is now the main source of immunisation data. The platform became fully operational in middle of the year 2017. The total population and the various population segments are determined by projections based on the 2014 UNFPA PESS complemented with data from Polio NID campaigns. The PESS was based on the old Regions and districts in Somalia in 1991. New regions and districts have been created in Puntland thus making it difficult to estimate population of the regions and districts as they exist now. Polio NID data has been used to estimate the catchment population of each health centre and this has been aggregated to form the district population. The quality of the estimate is this limited by the quality of the NID data. The operational growth rate used for the general population is 3%, live birth is estimated as 4% while the proportion of surviving infants is 3.64%.

The Data Quality Self-Assessment (DQSA) in 2016 showed that staff at the service delivery sites were compiling their monthly data from immunisation registers and had no immunisation monitoring charts and did know their catchment area population. There were widespread data inconsistencies across levels (national, regional and facility). There were no vaccine stock management tools.

In response to the DQSA findings, in 2017 micro-planning training was conducted for staff in 17 districts covering 77 health centres and additional support is available in PEF TCA 2018 for microplanning in all districts. Immunisation tally books and report summary forms were distributed to all facilities providing immunisation services. EPI data generated at the various service delivery points is aggregated into the immunisation tally book at the end of each immunisation session. Data from the tally book is collated and submitted monthly to the regional level where the Regional HMIS officers input it into the DHIS-2 database. Challenges with the data collation at the health facility level includes errors when transcribing from the tally book into the summary report form. The main challenges with this arrangement are the non-use of data at

the point of generation. The regional levels do not analyse the data and provide feedback to the facilities. Anomalies in data go un detected until the zonal level conducts analysis. At the regional level the data is not analysed is not feedback to the facilities The platform became fully operational in middle of the year there were some challenges with the timeliness and completeness of reporting. At the end of the year 2017 the coverage target of 80% for Penta 3 was exceeded.

VI. Somaliland

The target population is often determined by the Population Estimate Survey for Somalia (PESS) which has been produced by the UNFPA in 2014, these estimates have not been cascades down to the district levels, but administrative have made some district population estimates whereby at least three district populations are very similar in figures which result denominator problems.

The MICs and EPI coverage which has been conducted in December 2017, which was to determine immunization coverage among children aged between 12-23months at national and zonal levels interviewed only 757 children of this age group which is very small number which cannot built the coverage survey results. The above survey revealed >74% of MCV1 coverage and >80% of Penta3 coverage at National level. Data Quality Improvement plan consensus workshops at HFs, regional and national levels have been held in March-April 2018 and necessary information and suggestions has been collected from different levels of service delivery and management.

The HMIS system has moved from excel sheet for data analysis to DHIS2 which has not been cascaded to the regional and district levels. The use of the system is still confined to HMIS department for data entry and analysis, however, the MOH departments have no access to utilise the data for decision making and planning purpose.Across all areas, funding has been allocated in 2018 PEF TCA for the improvement of the denominator.

3.4. Immunisation financing

Immunization financing is depending to the external donors and UN agencies mainly Unicef and WHO and GAVI. Health Authorities have requested technical assistance to develop a Resource Mobilisation plan for immunisation with a focus on fundraising from the Private Sector. This is outlined as a Joint Appraisal recommendation in 2017 and is carried over as a JA recommendation in 2018.

4. PERFORMANCE OF GAVI SUPPORT

4.1. Performance of vaccine support

I. Vaccine support

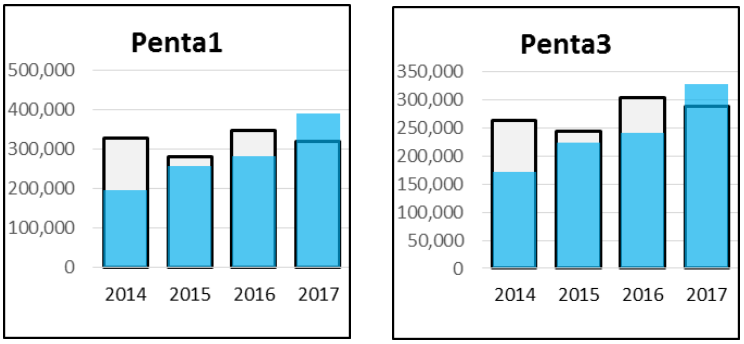
In terms of vaccine support, the total number of children who received the 1st and 3rd recommended doses of pentavalent vaccine exceeded the target. This data should be viewed in relation to the poor accuracy of denominators as PESS estimates are not available for levels lower than district. Section 3.3 (data) includes a discussion on the accuracy of population estimates as well as follow-up action items.

In spite of the measurement challenges, a number of positive developments can be noted. For example, in Puntland, the overall number of facilities offering immunisation services increased from 98 to 106; moreover, an additional 7 mobile teams were introduced. In Somaliland, trainings on basic immunisation practices for public and private immunisation providers were completed (owing to Gavi HSS support). In South Central Regions, vaccine supply has

improved; vaccines are supplied to the cold chain store in Mogadishu on a quarterly basis for onward distribution to the regions and districts. There are still significant remaining challenges including the lack of quality micro-plans, insufficient outreach and supportive supervisory sessions to insufficient HMIS tools and child passports/immunisation cards at the lower level. These are further discussed in sections 4.2 and 6 of this report.

IPV data was not included in Somalia's Joint Reporting Form (JRF). This is because the number of IPV doses administered was recorded and entered into an Excel database independent from the DHIS 2 (tool used for Somalia's HMIS). This issue has been fixed and 2018 data is now entered into DHIS 2.

Figure 19: Coverage of Penta 1 and Penta 3, Somalia 2014-2017



The core indicators of immunization present the coverages of BCG (45%), Pentavalent_1 (62%), pentavalent_3(49%), IPV (30%) and measles-contained vaccine (63%) with variations of the 11 regions located in the southern and central parts of Somalia, except Middle Jubba Region, Galgadud region has shown the lowest performing whose pentavalent_3 shows 20% and Banadir shows the highest performing region with pentavalent_3 of 97%. The overall dropout rate of pentavalent (1-3) is as high as 18% for the 11 regions.

Except BCG, the other antigen vaccine coverages exceeds the zonal target coverages (central and southern parts of Somalia) but on the contrary, all the antigen vaccines coverages are below the national targets of BCG as 61%, Penta3 as 59% and MCV as 56%.

It is worth to mention that 13% of the population in the central and southern part of Somalia is inaccessible, 39% of them are partially accessible and only 47% of the population are fully accessible. Penta3 coverage shows 86%, 32% and 3% for the fully accessible, partially accessible and inaccessible population respectively (Source: Polio program).

There are significant inequity of coverage among the districts in the southern and central parts of Somalia where only 17% of the districts show penta3 coverage of above 80% which is far below the national target of 60% of the districts

Figure 20: EPI administrative Coverage per Zone 2016-June 2018 (Administrative data)

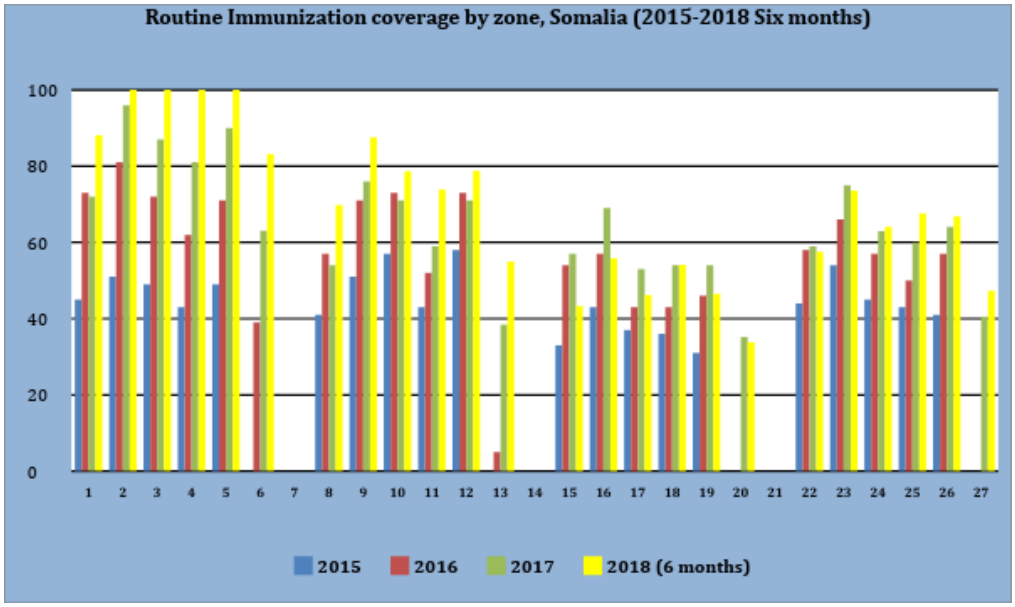
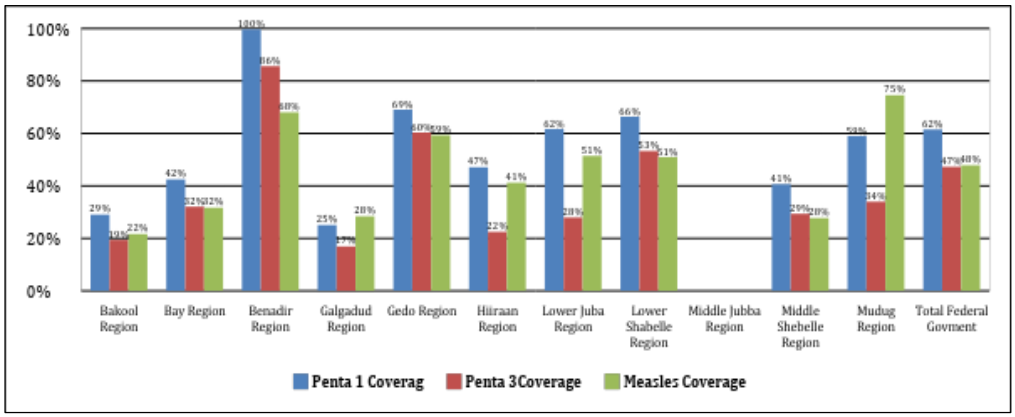


Figure 21: EPI Coverage per region Jan-Dec 2017 (Administrative data)



II. Overall implementation progress

In 2017, a few activities / initiatives affecting Gavi's vaccine support were completed in each zone, which are listed below. Of note, the list below does not include Gavi HSS supported activities and is therefore not exhaustive; progress of the HSS grant is discussed in section 4.2.

- South Central Regions: The Effective Vaccine Management (EVM) assessment was conducted and resulting improvement plan developed at the level of each region. These plans were shared in July 2018.
- Somaliland: The EPI Technical Working Group was established; it includes representation from MoH and technical partners. This group meets on a monthly basis; The EPI policy was reviewed; a draft was produced in Jul 2018; and the Effective Vaccine Management (EVM) assessment was conducted and resulting improvement plan developed at the level of each region. These plans were shared in Jul 2018;
- Puntland: Training on the DHIS 2 for regional staff which has contributed to improved reporting rates; and revised HMIS tools were distributed to health facilities. An EVMA was conducted in Puntland . As per the costed EVM-IP, 1,930,865 USD is required to address the gaps noted in Puntland.

III. Key actions related to Gavi vaccine support in the coming year

Somalia is applying for Gavi support to the introduction of Measles 2nd dose and a follow-up

Measles Campaign. Support has been allocated in PEF TCA 2017 and subsequently in PEF TCA 2018. A OCV campaign covering 6 urban districts has been requested and is currently under review.

4.2. Performance of Gavi HSS support

I. Background

In January, 2018, a mission was held to launch both CCE OP and HSS-2 support to Somalia. At this workshop, MoH and partners developed a Year 1 workplan, including regular milestones and key areas of focus. A quarterly check-in was held via teleconference in April and the Joint Appraisal mission in August 2018 served as the mid-year check-in on the progress of HSS-2 in addition to a review of the progress on the costed-extension. Although challenges were present with regards to fund flow, key activities for the launch of the support were realised, including;

- Establishment of district and regional teams in Gavi-supported areas, completed
- Selection of supported facilities
- Completion of EVM IP
- Commencement of hiring for hospital and facility staff
- Microplanning across all districts is organized and expected to comments in September 2018
- ICC's have been established in Federal States and Somaliland. The first meetings were held in Q3 2018, including to

Activities which remain to be completed and are on track include the CCE OP deployment, microplanning and training activities. The operationalisation and hiring of all facility staff is facing delays and is the focus of close programme monitoring over the next two quarters.

The 2017 costed extension activities were executed by Unicef and underspent significantly by WHO and approximately $400,000 will be returned. Activities related to laboratory strengthening for Measles, the hiring of a position and other trainings remain incomplete.

Somalia has two opportunities for additional HSS investments which are currently under development.

II. Progress of HSS-1 Costed Extension

The Costed Extension aimed to cover key activities (partner staff at sub-national level) and basic activity funding between the end of HSS-1 and the commencement of HSS-2. Unfortunately, the WHO office signature delayed resulted in low utilisation of activity funding and due to the non-recruitment of some staff, low utilisation of staff funding. Unicef used the funding to continue funding support staff and the development of CCE OP. The fund utilisation is discussed further in the relevant section.

III. Additional HSS eligibility under the Gavi Fragility, Refugees and Emergencies policy and next steps: $12.5 million

In 2018, under Gavi's new Fragility, Refugees and Emergencies policy, Somalia is eligible for an additional $12.5 million Health Systems Strengthening investment to complement ongoing support from 2018-2022. In order to prepare an adapted application to the IRC, a consultant will be hired to support the development of costed plans in priority areas identified in an initial consultation with Ministry teams and key stakeholders. This work will be in close collaboration with the different Ministry of Health technical teams (EPI, Policy & Planning, Public health) and with technical UNICEF and WHO teams of the Expanded Programme on Immunization

(EPI). The selected firm or person will prepare a second consultative meeting and finalise the development of an application for additional GAVI Health Systems Strengthening (HSS) support for 2019-2022.

Key principles of the additional HSS support will be reviewed based on the expected impact, including the number of children reached, equity across the regions, cost and feasibility. The support should align with ongoing and potential investments by large health donors (i.e. DFID, Global Fund) and be informed by the Measles 5-Year Plan and Cholera WASH Strategy currently supported through Gavi technical assistance.

In preliminary consultations, the following areas have been identified as areas of focus;

- Immunisation added to existing activities (i.e. nutrition, integrated mobile health)
- Tailored approach to large population centres (IDP camps, cities)
- Priority activities from the costed EVM Improvement Plan 2017
- Investments in Child Health Card (to be determined by Zone)
- Inclusion of priority activities from an ongoing urban diagnostic in Mogadishu, Garowe and Hargeysa
- Improved programming for mobile populations
- Investments in demand generation

IV. Additional HSS ceiling: $4 million

Somalia has access to an additional $4 million, approved during the 2017 HLRP. This amount was reserved for investments in Data Quality and will include support to newly emerged State EPI management. The Joint Appraisal included a day consultation to finalised the budget and priority activities for the Data Quality Improvement Plan. Health authorities and partners will finalise this budget in this coming weeks and then a consultation will be held to finalised implementing arrangements which are to be shared between WHO, Unicef and an expanded partner, via a Request for Proposal.

Objective 1	
Objective of the HSS grant (as per the HSS proposals or PSR)	**Expand and strengthen availability of routine immunisation services**
Priority geographies / population groups or constraints to C&E addressed by the objective	GAVI HSS2 grant will benefit a total population of 5.7 million in 25 priority districts, 45% of the total population in Somalia. The State-specific coverage is projected at Puntland 1.5 million (74% of total population), Somaliland 1.9 million (60% of total population) and Southern States 2.1 million (30% of total population). The beneficiary population includes: 0.22 million new-borns (0.20 million surviving infants) and 0.29 million women of child bearing age. The precise estimates are not available, however, nomadic population in present in 24 out of 25 priority districts. In 18 priority districts, IDPs are living in IDP camps near cities or big towns (Puntland-6, Somaliland-2 and Southern States-10). The districts being supported with a full package of immunisation services are: Bosaso, Qardho, Galdogob, Galkayo-PL, Jariban, Burtinle, Dangorayo, Garowe in Puntland; Gabiley, Hargeisa, Bali Gubadle, Laascaanod, Hudun, Badhan, Burco in

	Somaliland; and Balcad, Jowhar, Afgooye, Baraawe, Kurtunwaarey, Marka, Qoryooley, WanlaWeyn, Baidoa, BuurHakaba in the Southern States. The following districts in Puntland will be supported with the development of micro-plans only; Eyl, Badhan, Dhahar, Lasqoray, Bo'ame, Hudun, Taleh and Tukaraq.
% activities conducted / budget utilisation	52% (32/62) of new immunisation centres at the DH, RH and MCH are functional. 100% (4/4) of mobile units are functional in Puntland. One workshop of EPI microplanning has been conducted for Burao District in Somaliland which has been attended by 18 MCH team leaders, District and Regional Health Management Teams and EPI partners both UN and NGOs. As a result of the above meeting four outreach sessions has been identified to the HSS2 selected health facilities in Burao District.
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	32 out 62 new immunisation centres planned under HSS-2 are functional in Somaliland and Puntland. The Nurses have been recruited and furniture procured. In some centres, the EPI teams have liaised with the cold chain technicians to repair fridges, before the arrival of new ones under the CCEOP. Vaccination services are carried out in the maternity and out-patient department, so as not to miss opportunities for vaccination. 45 MCHC in Puntland are providing immunisation services at both fixed and outreach sites, of whom 38 MCHC are found in 11 of the largest towns in 5 regions of Puntland. Mapping with a view to commencing outreach services is on-going in other large towns. 4 mobile units to track nomads are operational in Puntland. The EPI team liaised with the nomadic elders so as to obtain the list of nomadic communities and those in the hard-to-reach areas. Tracking of nomads will be carried in Jerriban, Eyl, B/beyla and Badhan Districts. The FMoH has finalised a definitive list of health facilities to be supported via GAVI HSS 2 funding. Recruitment of Nurses will be done in collaboration with the FMoH, State MoH and implementing partners supporting the identified health facilities. Immunisation services at the health facilities will commence and outreach activities will commence after the finalisation of the micro-planning process slated for the month of August 2018. **Somaliland:** Two days orientation workshop has been held and attended by regional and central management of MOHD, the first purpose of the meeting was to familiarise the new MOH management team on the HSS2 program since they have not been involved in the HSS2 program formulation, the second purpose was to establish the district management teams and identify the Health facilities supported by HSS2 program. As a result of the above meeting DHMT has been established, HF identified and one of the target districts has been replaced due to support provided by another partner NGO.

	HSS2 program was to support the development of District EPI micro plan for the target districts but so far to district Micro plans has been developed, the remaining five district micro plan development will be developed between August and October 2018. Formal letters has been sent to the membership intuitions in order to officially nominate the members of Interagency Coordination Committees (ICC). Supportive supervision training has been conducted to the mid-level managers of Ministry of Health development Somaliland attended by regional Health team, NGO's and district health management team members, the objective was to stream line the supervision tools and improve the capacity of managers on the supervision methodologies. WHO supervision guidelines have been used for this two days training. Four technical officers are on board and embedded to the Ministry of Health to provide the necessary technical assistance and policy advice. The coordination with in the EPI partners has improved since the new MOH team embedded and regular monthly coordination meetings are held and EPI data are among the discussed agenda. Joint Supportive supervision has been carried out to improve routine immunization.
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **needs for technical assistance**[11]	Finalise the recruitment of Nurses in the South-Central Regions, and commence service provision at the fixed as well as outreach sites. **Puntland**: There are only 4 mobile services in the plan and they were allocated in Jerriban, Eyl, Beyla and Badhan districts. List of Nomadic community and hard-to reach areas is in place and will be used to identify movement of these communities. This activity is planned from August. **Somaliland:** Development of remaining EPI Micro plans for the 6 districts of Somaliland will be finalised in August- September 2018
Objective 2:	
Objective of the HSS grant (as per the HSS proposals or PSR)	**Enhance the physical capacity and effective management of cold chain and logistic system**
Priority geographies / population groups or constraints to C&E addressed by the objective	Same as objective 1.
% activities conducted / budget utilisation	83% (5/6) of the activities have been conducted. The remaining activity is on-going.

Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	Following the Decision Letter on CCEOP, the procurement process of cold chain equipment and monitoring devices for new centres, stores and to replace obsolete/malfunctioning ones, is on-going. More details are given in the sub-chapter on CCEOP above. Salaries of cold chain staff from the Zonal to the District level are paid regularly, either through the MoH in Somaliland and Puntland, and through a combination of both FMoH and cold chain implementing partners, in the SCR. ToT trainings for cold chain and vaccine management were conducted in each zone. Cascade trainings to the districts and health facility levels, are on-going. Routine maintenance and repair of cold chain equipment is carried out regularly. The vaccine supply chain is on-going. Vaccines are supplied to the zones on a quarterly basis, for onward distribution to the regions and districts. Management of the cold chain infrastructure in the SCR is done via cold chain implementing partners, who are directly contracted by UNICEF.
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **needs for technical assistance**[11]	- Proceed with the procurement process of the CCEOP. - Continuation of cold chain maintenance and repair routinely and when necessary. - Review recent EVM IP in order to support identified areas for improvement requiring both TA and additional HSS support.
Objective 3:	
Objective of the HSS grant (as per the HSS proposals or PSR)	**Increase demand for immunisation services**
Priority geographies / population groups or constraints to C&E addressed by the objective	Same as objective 1.
% activities conducted / budget utilisation	50% (2/4) 3 advocacy meetings with prominent community leaders were organized in Galkaio, Garowe and Bossaso during African Vaccination Week in April, in Puntland. 2-days training session for RSMCs and DSMCs from 8 priority districts was conducted in early May. H2H social mobilization is organised in outreach form by 38 MCHs where EPI outreach vaccination is happening. This is organised prior to the vaccination. In addition that, health education sessions including EPI is organised in 38 MCHs in 8 priority districts.

Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	Puntland and Somaliland have conducted advocacy sessions with key stakeholders. The SCR will conduct its stakeholders meeting on 12th Aug 2018. Puntland has conducted training for RSMC and DSMC in 8 priority districts. Cascade trainings are planned at a future date. Following the nomination of the district EPI teams in the SCR, this activity will be carried out at a future date. 38 MCH in the 8 priority districts of Puntland are conducting sensitisation campaigns prior to vaccination sessions in the outreach sites. In addition to this, health education sessions including EPI are organised in 38 MCHs in 8 priority districts, prior to the commencement of service delivery. The messages for the radio and TV spots have been validated by the FMoH. The production of the messages is currently going-on. Thereafter, the MoH will collaborate with the Ministry of Information, so as to air the message on National Radio that has a wide reach. The FMoH will also explore possibilities of doing a public private partnership (PPP) with private radio stations with a wide reach. In Puntland, radio messaging will be done from mid-August. IEC materials have been developed, validated by the FMoH and are artwork is currently being done, before printing commences.
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **needs for technical assistance**[1]	Holding the stakeholders' workshop in August 2018 in the SCR Train health workers on creating demand for immunisation services. Finalise the production of radio and TV spots and commence airing Print and distribute IEC materials The Resource Mobilisation and Private Sector and HSIS teams at Gavi has been engaged to review possible demand interventions through mobile technology.
Objective 4:	
Objective of the HSS grant (as per the HSS proposals or PSR)	**Support immunisation programme leadership and management**
Priority geographies / population groups or constraints to C&E addressed by the objective	Same as objective 1.
% activities conducted / budget utilisation	– 100% (2/2) Following the formal appoint by the respective MoH, Regional Health Management Teams and District EPI Teams are functional in the 25 priority districts. – ICCs have been called in Somaliland and Federal States.

Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	– Regional Health Teams and District EPI Teams have been formally appointed in the 25 Districts and 9 Regions. UNICEF and WHO supported the MoH in the developed of their Terms of Reference. The SCR plans to orient the new members on their ToR. – These teams play an important role in coordination of health and EPI activities within the MoH and with partners, development and implementation of micro-plans, and quality assurance by conducting regular supervisions to the fixed and outreach sites. – The incentives are paid regularly.
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **needs for technical assistance**[2]	– Intensify the activities of the RHMT and District EPI Teams in the SCR; micro-planning, coordination and supervision. – Challenge: In Puntland, the approved budget caters for the salary/incentives of 1 RHMT, instead of 3/ 4 regions that the 8 priority districts are found. To overcome the challenge, the Zonal EPI Manager was delegated to supervise the 4 regions. – Expanded partner and WHO support is ongoing in the operationalisation of ICCs. This support will be reviewed in Q1 2018 to determine a 2nd phase of TA is required.

4.3. Performance of Gavi CCEOP support (if country is receiving Gavi CCEOP support)

I. Background

GAVI, via a revised Decision Letter dated 18th May 2018, approved Somalia's application for funding under the CCEOP for Year 1 and exceptionally expedited Year 2 under the fragility policy in order to reduce costs in distributing equipment throughout the country. The letter detailed the approved number of cold chain equipment that were to be procured through the support of GAVI in 2018 and 2019. In total, 419 different cold chain equipment, 519 temperature monitoring devices, 5 remote temperature monitoring devices and 81 voltage regulators were approved. In addition, the UNICEF Supply Division was appointed to procure the equipment and associated 'service bundle'.

The Operational Development Plan (ODP) has also been prepared and this is presented on zonal basis. UNICEF Supply Division in close collaboration with the UNICEF Somalia Country Office drafted Terms of Reference for the in-country transportation, installation, training and commissioning of cold chain equipment in Somalia under the GAVI-supported Cold Chain Equipment Optimisation Platform (CCEOP). This is with the objective of identifying contractors who are able to provide the 'service bundle' in Somalia for the planned implementation schedule of a maximum period of 12 months. The cold chain equipment and associated monitoring devices will be procured under existing UNICEF framework of Long-Term Agreement(s) for immunisation refrigerators and freezers.

Based on the evaluation of this tender, UNICEF will propose one or several scenarios as Costed Operational Plan (COP) to GAVI and the Federal Ministry of Health Somalia for final approval. It is noteworthy to mention that the budget as confirmed by GAVI is the ceiling for the overall procurement value of equipment and associated services. Depending on the outcome of this tender, the final quantities per category might have to be adjusted to match the approved

budget.TheToRs have not been finalised by UNICEF Supply Division as of August 2018.

II. Effective Vaccine Management Assessment

An Effective Vaccine Management Assessment (EVMA) was conducted between 14th Dec 2016 and 24th March 2017 in the Federal Government of Somalia, Puntland and Somaliland. Key strengths and weaknesses in 9 different areas of effective vaccine management at the four levels of the supply chain, were assessed. The levels of supply chain are the primary (national), sub-national (state), lowest distribution (regional) and service point levels (MCH). The 9 nine areas (criteria) of vaccine management that were assessed are; pre-shipment and arrival procedures (E1), temperature monitoring (E2), storage capacity for cold and dry stores capacity (E3), buildings, cold chain equipment and transport (E4), maintenance (E5), stock management (E6), effective distribution (E7), good vaccine management practices (E8), and information systems and supportive management functions (E9). 29 facilities were assessed; 1 primary vaccine store, 2 State Stores, 12 Regional Stores and 14 MCHCs.

Summary of EVMA findings:

National Vaccine Store
The National Vaccine Store had a mean EVM score of 80%, which corresponds to the minimum score of 80% that is encouraged by the EVM initiative. Key strengths that were noted are; manual and remote monitoring of temperature, temperature mapping for the cold and freezer rooms, and adequate storage capacity for vaccines and diluents. Building and equipment maintenance was also managed properly and consistently. Some of the weaknesses were; delays in clearing vaccines at the airport where they are kept at the cold room for more than three days before they are sent to the National Vaccine Store, the stock monitoring tool in the warehouse does not record the type of diluent and other vaccine parametres for stock management, and expired vaccines are not removed from the monitoring system.

State Level Stores
8 criteria were assessed at this level, excluding pre-shipment and arrival procedure that is only applicable to the National Vaccine Store. Two criteria attained the minimum score; E3 (90%) and E4 (83%). In Garowe, five criteria scored above 80%; E2 (87%), E3 (90%), E4 (82%), E6 (85%) and E9 (82%). Criteria E3 (90%) and E4 (85%) attained the minimum score in Hargeisa. Strengths in both Garowe and Hargeisa include; new $30m^3$ cold rooms that have adequate storage capacity, installed multi-log remote temperature monitoring devices, and well trained personnel to monitor the temperature. Some of the weaknesses were; non-utilisation of SMT for stock management despite being installed in the computers; non-availability of SOPs, protective clothing, fire extinguishers, job aids for VVM, and non-utilisation of fridge tags during the distribution of freeze-sensitive vaccines. In addition, vaccine requisition forms and report forms are also not standardised.

Regional Level Stores
At this level, only one criteria E3 (84%) achieved an average minimum score in all the twelve regional stores that were assessed. However, Sahil (72%), Awdal (70%) and Galmudug (79%) scored less than the minimum for criteria E3.

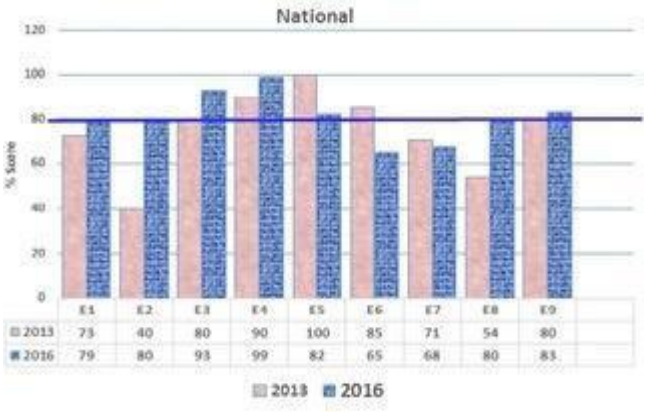
MCHC
Overall, only criteria E3 met the minimum score (81%), and this was attributed to the distribution of new Solar Direct Drive (SDD) fridges. However, Hinna MCHC (58%), Beletweine MCHC (67%) and Fanoole MCHC (50%) attained less than the minimum score.

Comparison of the 2017 EVMA with 2013 EVMA

Improvement was noted for the National Vaccine Store in six different criteria as compared to

the 2013 EVMA. The improvements are mainly in vaccine arrival, temperature monitoring, storage capacity, building, equipment & transport, vaccine management and MIS support functions. Decline was observed in maintenance, stock management and distribution. Following the findings of the 2017 EVMA, an EVM-IP was developed, taking into account the findings of the EVMA.

Figure 22: Comparison between 2013 EVMA and 2017 EVMA



III. Costed Effective Vaccine Management Implementation Plan (EVM-IP)

A costed EVM-IP per administrative area was developed to address the gaps noted in the EVM assessment of 2017. The plan is divided into 6 strategic areas, namely, data management, temperature monitoring, distribution, cold chain equipment & management, system design and human resource development for immunisation logistics. The total cost of the implementation plan is 7,723,460 USD, divided into 4 years (2018 – 2021). Funding from GAVI HSS-2 and the CCEOP will cover 67% of the total cost of the EVMIP, leaving a gap of 2,566,800 USD to be considered during the development of the additional HSS investment.

4.4. Financial management performance

Table 7: Financial absorption, HSS-1 and HSS-2 Implementation, 2017-2018

Support	Total Amount	Total utilised	Comments
WHO Costed Extension (combined HSS-1 and costed extension)	$7,972,639	94%	Grant closed and funds to be returned ($415,310).
UNICEF Costed Extension	$1,366,578	100%	
WHO HSS-2 Year 1	$1,420,043	32% of total budget is utilized by 24th Sept 2018.	
UNICEF HSS-2 Year 1	A total of 3,112,744 USD was disbursed for Yr 1, of which 2,008,823 USD was for disbursement to	1,329,253 USD (42.7%) have been utilised. Out of the funds meant for disbursement to the zones, 823,059 USD (41%) have	

	the respective MoH and for running cold chain in the CSZ.	been disbursed as of 12 Sep 2018.	

Fund flow challenges

1. There has been delay of fund disbursement to the WHO country office (Gavi disbursed in March 2018, award developed at Country Level in June 2018) which hindered the timely implementation of planned activities in first quarters, however the activities will be accelerated in the remaining period of the year. The delay in the formal appoint of District and Regional Management Teams delayed the disbursement of funds in one zone.
2. The delay in the liquidation of funds in some zones also delayed the disbursement.
3. Successive polio campaigns conducted in 2018 also shifted focus in terms of planning, and more efforts were deployed to this response, to the detriment of initially planned routine immunisation campaigns causing a delay in disbursement and utilisation.

Table 8: Compliance with financial and audit reporting

Support	Financial Statement provided	Audit Provided	Comments
WHO Costed Extension	Yes	Not applicable	Provided via consolidated statement
UNICEF Costed Extension	Yes	Not applicable	
WHO HSS-2 Year 1	Not applicable	Not applicable	Not due until June 2019 for 2018
UNICEF HSS-2 Year 2	Yes	Not applicable	Year 1 Statement provided Dec 2019

Table 9: Progress on Programme Capacity Assessment Recommendations

	Requirement	Timelines	Responsible	Status
1	**Funding for HSS2 Year 5** The health authorities will work to ensure sustainability measures are put in place for absorption of various cadres of staff supported under the HSS2 grant. Particularly, funding will be secured to cater for counterpart funding in year five of the HSS2 grant.	By start of year 5 of the HSS2 grant	Federal MoH and Health Authorities	TA request by MoH for resource mobilisation support.
2	**Financing of vaccine logistics from regional to health facilities** Sufficient evidence should be provided that the movement of vaccines from regional to health	Effective immediately	Health Authorities	This GMR is already addressed with funding included in the UNICEF

	facilities is adequately financed, particularly for Puntland and South Central.			HSS2 budget as per communication with UNICEF, October 2017
3	**Exemption from taxes and other charges** Federal MoH will use reasonable efforts to ensure that the relevant exemptions from taxes, customs, duties, toll or other charges on importation of vaccines, related devices and assets are obtained from the respective ministries, departments and agencies in Somalia.	Ongoing	Federal MoH	No issues on tax payment to-date.
4	**Assets management** Alliance partners will maintain comprehensive Fixed Asset Registers (FAR) for all assets, including but not limited to cold chain equipment, vehicles and IT equipment procured or to be procured through Gavi grants to Somalia. This Fixed Assets Registers will be maintained and updated regularly. All assets procured with Gavi funds will be tagged with unique identifiers and asset verification will be carried out at least annually, reconciling the physical assets count and condition to the FAR at all levels.	Fixed assets registers updated continuously and verification of assets conducted annually	Health authorities	Communication by Unicef confirmed this is performed, annually.
5	**Vaccine Management Committees** Vaccine Management Committees to assure vaccines and cold chain management will be established and operationalised at state level.	Within the first 6 months from effective date of this document	Health authorities	The establishment of these management committees was budgeted in PEF TCA 2018 which was not disbursed until May 2018. Slight delays.
6	**Data improvement plan** Health authorities, with the support of Alliance Partners, will develop a comprehensive data improvement plan and submit it to Gavi for review and approval.	Within the first 6 months from effective date of this document.	Health Authorities and WHO	The DQIP is under finalisation.

4.5. Transition planning (if applicable, e.g. country is in accelerated transition phase)

Not applicable.

4.6. Technical Assistance (TA)

The Technical Assistance in Somalia for 2018-2019 is focused on supporting the operationalisation of significant new support to Somalia including the launch of a new 5-year HSS grant and CCE OP. Significant staffing support is available in PEF TCA and HSS and is summarised in *Table 10* and *11.*

2018 Programmatic Areas

$1.8 million of PEF TCA 2018 to Alliance Partners:

UNICEF: Supply Chain; Demand Promotion; Program Implementation; Sustainability
WHO: Leadership, Management, & Coordination; Vaccine-Specific Support (Measles, Cholera); Data

Expanded partners:

One23: Leadership, Management, & Coordination: Support to ICC functioning
ALMACO: Data: Development of a Data Quality Improvement Plan

In 2018-2019, there will be additional expanded partner contracts for an (1) urban diagnostic across three major cities, (2) in support of the Data Quality Improvement Plan implementation, (3) for resource mobilisation activities by the MoH and (4) in the engagement of the private sector healthcare providers in immunisation.

The support to alliance partners includes critical staff, outlined in *Table 10 and 11.* The challenge in hiring WHO staff at country level remains a challenge. The WHO office, particularly has faced challenges adding staff to the organigram and in the hiring process.

Table 10: Gavi supported positions, Unicef Somalia

Source	Staff position	Status
PEF TCA 2017/2018	Coldchain Specialist	Position in place
PEF TCA 2017/2018	Immunization officer	Position in place (Mogadishu)
PEF TCA 2017/2018	HSS /EPI officer P2* 2018	Recruited and in place from April 2018
HSS-2	Health (EPI) Specialist (P4)	To be recruited
HSS-2	Immunization Officers NOB (3)	3 positions in place
HSS-2	Program/supply Assistant	Position in place

Table 11: Gavi supported positions, WHO Somalia

Source	Staff position	Status
PEF 2017/2018	Medical officer (EPI) P4	Recruitment process to begin (10/18). Position approved by RD.
PEF 2017/2018	Immunization officer NOB	Just began process of recruitment (with HR, not advertised yet)
HSS-2	HSS Coordinator change to	In place

	Medical Officer (HSS/EPI) (P4)	
HSS-2	GAVI Zonal Focal Points (3 positions)	3 positions are in place
HSS-2	Program Assistant (G Level)	Recruitment process started

5. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

Recommendation 2017	Status
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)	Started coordination; ICC established at Federal level; some district training has taken place; Annual EPI operational plan developed. Puntland: district EPI review meeting, two rounds supervisory visits, capacity building from district staff Somaliland: New plan to address areas where Gavi support not earmarked; training in supervision for district and regional health management teams through two-day workshop.
Advocate for improved financial contribution to immunisation (Government and Partner)	No specific indications on activities in this area
Develop five years Measles Control and elimination strategy and undertake measles catch-up campaign	Five-year plan developed and being reflected in on-going work on new applications for measles SIA
Gavi to further support the development of ICC(s) and other forums to improve the oversight and monitoring of EPI program	ICC functional at Federal level (July 2018) Through this JA follow up on support to Somaliland and Puntland discussed and will be reflected through Gavi supported activities commencing September
Improve resilience of EPI program to emergencies and further integrate immunisation into responses as appropriate	EPI programme has been able to meet some emergent requirements using stocks of available vaccines such as measles. Support also provided during cholera and AWD related activities.
Improve the quality and use of data through capacity strengthening	DQIP completed and next steps and support being defined during this JA
Establish effective VPD surveillance system	Measles; fever and rash is being addressed through the AFP set up; additional opportunities exist and can be addressed, OCV in reporting as well (weekly)

Recommendation 2 will be carried forward to the 2018 workplan do to the non-identification of technical assistance to the Ministry to support resource mobilisation efforts.

6. ACTION PLAN: SUMMARY OF FINDINGS, ACTIONS AND RESOURCE/SUPPORT NEEDS IDENTIFIED AND AGREED DURING THE JOINT APPRAISAL

The key priority activities and areas for focus in 2019 include the full implementation of activities in HSS-2; including the operationalisation of all supported facilities and ongoing supervision from established district and regional health teams. The commencement of DQIP and EVM IP plans, supported by Gavi will be underway, following the finalisation of programming of additional support in 2018. No changes to HSS workplans were requested. However, funding to WHO for Year 1 and 2, dedicated to a Coverage Evaluation Survey will instead be used to implement the Data Quality Improvement Plan activities.

Priority areas of focus through PEF TCA include the support to microplanning, the planning of campaigns through the development of a Measles five-year plan and Cholera WASH strategy through PEF TCA and the submission of two Measles applications.

Other planned activities include;

- The results of the urban diagnostic, planned for 2018 will be disseminated in 2019, with support planned for major cities.
- CC EOP deployment for Year 1 and 2 should be complete by end of Q1 2019.
- Additional HSS support application is expected to go to a light IRC in Q2 2019 following further consultation and prioritisation as outlined in this report. This will include the contracting of an HSS consultant for 2018 - mid-2019.

The following JA recommendations and TA needs were drafted during the mission and will be used as the basis for TA planning for a February submission of the PEF TCA plan.

Joint Appraisal Recommendations and associated technical assistance needs:

1. **Significant progress in the commencement of HSS-2 has been realised, however, due to delays in fund disbursement there is a need to accelerate HSS-2 implementation for 2018 funds to be utilised and activities to be implemented.**

   No TA needs proposed

2. **The private sector represents an opportunity to expand service delivery; it is recommended that (1) the MoH develops a framework for PPP in immunisation and (2) explore contracting models.**

   TA needs: Support to development of framework for private sector engagement.

3. **Not enough is known regarding the barriers to seeking immunisation services. Generation and synthesis of social data to inform the development of priority demand generation interventions to be included in additional HSS support.**

   TA needs: Synthesis and design data collection and explore options for demand generation (e.g. mobile platforms / SMS reminders) to increase coverage for new HSS support.

4. **There are opportunities to further integrate immunisation in other ongoing health activities, particularly nutrition. The following options should be explored for feasibility;**

- Utilize existing nutrition services, both at fixed and outreach sites, to provide immunization services;
- Define package for outreach services (e.g. ANC, PNC, Nutrition, Malaria, WASH, ensure presence of vaccinator, cold chain);
- Explore options of emergency / resilience programmes to include immunization services

TA needs: HSS consultant will include a review of feasibility and key potential challenges for integration.

5. **Increasing the availability of outreach activities for RI and ensure it is recognized as a key priority.**

6. **The EVM improvement plan should be reviewed and priorities resourced in order to address remaining gaps in the immunisation supply chain system.**

   Action: Unicef and partners to review EVM IP budget to assure it include relevant maintenance priorities from CCE OP

7. **Advocate for improved financial contribution to immunisation (Government and Partner)**

   TA needs: Development of resource mobilisation package for RI with MoH.

8. **The Data Quality Improvement Plan aims to resolve a number of critical issues for immunisation data system and for the wider health system. The DQIP should be finalised and a resources identified by the end of 2018.**

   TA needs: To be discussed during the finalisation of the DQIP in Q3 and Q4

9. **Review existing TORs, membership and existing work plans for ICCs. ICCs should be operational in order to approve upcoming TA plan (December) and additional HSS application (January). Note: Operationalisation of ICC in Somaliland and Puntland focused on membership and functionality. ICC in FRS focus on membership, roles and linking with technical groups at state level.**

   TA needs: Support to the operationalisation of the ICCs.

10. **Revise the EPI policy / strategy in order to provide a relevant and updated guidance for further workplanning. Include dissemination and training plan for immunisation service delivery on the new policy to relevant private sector entities and CSOs.**

    TA needs: Revision of policy, consultation and dissemination.

11. **The uptake of IPV is low. Develop plan to improve uptake of IPV including demand activities, supportive supervision and health worker training improvements. Immediately incorporate IPV training in upcoming scheduled training opportunities.**

    TA needs: Develop key actions to improve IPV uptake in line with HSS-2 activities.

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

The Joint Appraisal took place in Nairobi from August 6th - 9th and was inclusive of all subnational entity representation, UN partner agencies (country office and regional offices), donors, including DFID and other implementing partners, including PSI and IOM. The ICC was announced preceding the mission but a meeting not called at the time of the JA.

Recommendations were developed by consensus and TA needs identified for further development into a TA plan in November 2018.

8. ANNEX: Compliance with Gavi reporting requirements

	Yes	No	Not applicable
Grant Performance Framework (GPF) * reporting against all due indicators	Yes		
Financial Reports *			
Periodic financial reports	Yes		
Annual financial statement	Yes		
Annual financial audit report			Not applicable
End of year stock level report (which is normally provided by 15 May as part of the vaccine renewal request) *****	Yes		
Campaign reports *			
Supplementary Immunisation Activity technical report			Not applicable
Campaign coverage survey report			Not applicable
Immunisation financing and expenditure information			Not available (TA proposed)
Data quality and survey reporting			
Annual data quality desk review			See comments in section
Data improvement plan (DIP)	Yes		
Progress report on data improvement plan implementation			Not applicable
In-depth data assessment (conducted in the last five years)			See comments in section
Nationally representative coverage survey (conducted in the last five years)		No	
Annual progress update on the Effective Vaccine Management (EVM) improvement plan	Yes*		
CCEOP: updated CCE inventory	Yes		
Post Introduction Evaluation (PIE)		No	
Measles & rubella situation analysis and 5 year plan	Yes		

Operational plan for the immunisation programme	Yes		
HSS end of grant evaluation report	Yes		
HPV specific reports			Not applicable
Reporting by partners on TCA and PEF functions	Yes		

*The EVM IP was published in 2018. A DQIP is under finalisation and should be complete at the time of the HLRP. Reports have been provided for HSS-1 final report. The development of the 5-year measles plan was done in 2018, including a consultation meeting. This shows significant progress in planning and development of additional support. Somalia has 4 GPFs (accounting for the subnational entities) and they are complete for 2017.