

APPLICATION FORM FOR
GAVI NVS SUPPORT

Submitted by
The Government of Somalia
for
Measles follow-up campaign



Reach Every Child
www.gavi.org

1 Gavi Grant terms and conditions

1.2 Gavi terms and conditions

1.2.1 Gavi terms and conditions

The terms and conditions of the Partnership Framework Agreement (PFA) between Gavi and the Country, including those provisions regarding anti-corruption and anti-terrorism and money laundering, remain in full effect and shall apply to any and all Gavi support made pursuant to this application. The terms and conditions below do not create additional obligations or supersede those of the PFA. In the event the Country has not yet executed a PFA, the terms and conditions of this application shall apply to any and all Gavi support made pursuant to this application.

GAVI GRANT APPLICATION TERMS AND CONDITIONS

FUNDING USED SOLELY FOR APPROVED PROGRAMMES

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

AMENDMENT TO THE APPLICATION

The Country will notify Gavi in its Joint Appraisal, or in any other agreed annual reporting mechanism, if it wishes to propose any change to the programme(s) description in its application. Gavi will document any change approved by Gavi according with its guidelines, and the Country's application will be amended.

RETURN OF FUNDS

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

SUSPENSION/ TERMINATION

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

NO LIABILITY

The Country shall be solely responsible for any liability that may arise in connection with: (i) the implementation of any programme(s) in the Country; and (ii) the use or distribution of vaccines

and related supplies after title to such supplies has passed to the Country.

Neither party shall be responsible for any defect in vaccines and related supplies, which remain the responsibility of the relevant manufacturer. Gavi shall not be responsible for providing any additional funding to replace any vaccines and related supplies that are, or became, defective or disqualified for whatever reason.

INSURANCE

Unless otherwise agreed with Gavi, the Country shall maintain, where available at a reasonable cost, all risk property insurance on the Programme assets (including vaccines and vaccine related supplies) and comprehensive general liability insurance with financially sound and reputable insurance companies. The insurance coverage will be consistent with that held by similar entities engaged in comparable activities.

ANTI-CORRUPTION

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

ANTI-TERRORISM AND MONEY LAUNDERING

The Country confirms that funds provided by Gavi shall not be used to support or promote violence, war or the suppression of the general populace of any country, aid terrorists or their activities, conduct money laundering or fund organisations or individuals associated with terrorism or that are involved in money-laundering activities; or to pay or import goods, if such payment or import, to the Country's knowledge or belief, is prohibited by the United Nations Security Council.

AUDITS AND RECORDS

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

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

CONFIRMATION OF LEGAL VALIDITY

The Country and the signatories for the Country confirm that its application, or any other agreed annual reporting mechanism, is accurate and correct and forms legally binding obligations on the Country, under the Country's law, to perform the programme(s) described in its application, as amended, if applicable.

COMPLIANCE WITH GAVI POLICIES

The Country confirms that it is familiar with all Gavi policies, guidelines and processes relevant

to the programme(s), including without limitation the Transparency and Accountability Policy (TAP) and complies with the requirements therein. All programme related policies, guidelines and processes are available on Gavi's official website and/or sent to the Country.

USE OF COMMERCIAL BANK ACCOUNTS

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

ARBITRATION

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

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

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

1.3 Gavi Guidelines and other helpful downloads

1.3.1 Guidelines and documents for download

Please refer to the relevant guidelines concerning your request for support.

Please ensure to consult and download all documents. It is important to note that some documents must be completed offline, and will need to be uploaded in the final steps of your application.

This application form is designed to collect information needed by Gavi to process requests for support, plan procurement of vaccines, plan technical assistance, track data for future reporting, and more.

A key component of the application is a solid operational plan (New Vaccine Introduction Plan for routine support, or Plan of Action for campaign support), explaining how the country will

introduce the vaccine or conduct the envisaged campaign, with a corresponding budget. The New Vaccine Introduction Plan or Plan of Action must be submitted together with this application form and will be considered as the foundation of the support request.

For more information on the documents to submit with your application and what they should contain, please refer to the appropriate guidelines: <http://www.gavi.org/support/process/apply/>

2 Review and update country information

2.1 Country profile

2.1.1 Country profile

Eligibility for Gavi support

Eligible

Co-financing group

Initial self-financing

Date of Partnership Framework Agreement with Gavi

No Response

Country tier in Gavi's Partnership Engagement Framework

2

Date of Programme Capacity Assessment

June 2017

2.1.2 Country health and immunisation data

Please provide the following information on the country's health and immunisation budget and expenditure.

What was the total Government expenditure (US\$) in 2016?

US\$ 248.000,000

What was the total health expenditure (US\$) in 2016?

US\$ 1.248,099

What was the total Immunisation expenditure (US\$) in 2016?

The total expenditure for immunization in 2016 was mainly related to staff salary which is US\$ 63,600

Please indicate your immunisation budget (US\$) for 2016.

US\$ 63,600

Please indicate your immunisation budget (US\$) for 2017 (and 2018 if available).

In 2017 the total expenditure for Immunization from FMOH was 63,600 and 2018 was the same amount.

[2.1.3 National health planning and budgeting cycle, and national planning cycle for immunisation:](#)

The government planning cycle starts on the

No Response

The current National Health Sector Plan (NHSP) is

From

2017

To

2021

Your current Comprehensive Multi-Year Plan (cMYP) period is

2016-2020

Is the cMYP we have in our record still current?

Yes

No

If you selected “No”, please specify the new cMYP period, and upload the new cMYP in country documents section.

Note 1

From

To

If any of the above information is not correct, please provide additional/corrected information or other comments here:

No Response

2.1.4 National customs regulations

Please describe local customs regulations, requirements for pre-delivery inspection, and special documentation requirements that are instrumental for the delivery of the vaccine.

The following is the list of documents required to import medical, vaccine, equipment and nutritional supplies to Somalia;

- Request letter
- Address and contact of the organisation
- Certificate of origin
- Purchase Order
- Quality control
- Invoice
- Packing list
- Original Bill of Lading
- Air bill/shipment manifesto
- Total weight in KGs
- Delivery Order
- Distribution plan

2.1.5 National Regulatory Agency

Please provide information on the National Regulatory Agency in the country, including status (e.g. whether it is WHO-certified). Please mention a point of contact with phone number and e-mail address. UNICEF will support the process and may need to communicate licensing requirements to the vaccine manufacturers where relevant.

- There is no National Regulatory Agency per se, but the Ministry of Health provides regulations and guidance for the importation of medical, equipment and nutritional supplies, such as breast-milk substitutes.
- Osman Abdi Omar, National EPI Manager, Federal Ministry of Somalia

2.2 National Immunisation Programmes

2.2.2 Financial Overview of Active Vaccine Programmes

IPV Routine

Note 2

	2018	2019	2020	2021	2022
Country Co-financing (US\$)					
Gavi support (US\$)	763,000	899,386	944,355	977,580	1,011,316

Measles-rubella follow-up campaign

	2018	2019
Country Co-financing (US\$)		
Gavi support (US\$)		

Pentavalent Routine

	2018	2019	2020	2021	2022
Country Co-financing (US\$)	289,638	357,776	375,693	364,625	376,919
Gavi support (US\$)	848,500	925,500	971,500	924,058	955,215

Summary of active Vaccine Programmes

	2018	2019	2020	2021	2022
Total country co-financing (US\$)	289,638	357,776	375,693	364,625	376,919
Total Gavi support (US\$)	1,611,500	1,824,886	1,915,855	1,901,638	1,966,531
Total value (US\$) (Gavi)	1,901,138	2,182,662	2,291,548	2,266,263	2,343,450

+ Country co-financing)

2.3 Coverage and Equity

2.3.1 Coverage and equity situation analysis

Note: If a recent analysis of the coverage and equity analysis is already available, for example as part of a Joint Appraisal report, you may simply reference the report and section where this information can be found.

Describe national and sub-national evidence on the coverage and equity of immunisation in the country and constraints to improvement. In particular, identify the areas and groups of low coverage or high inequity linked to geographic, socioeconomic, cultural or female literacy considerations, as well as systematically marginalized communities. Specify both the areas and/or populations with low coverage (%) and those with the largest absolute numbers of un-/under-vaccinated children. Among data sources, consider administrative data, coverage surveys, DHS/MCS, equity analyses, Knowledge-Attitude-Practice surveys, and patterns of diseases like measles.

Describe the challenges underlying the performance of the immunisation system, such as:

- o Health work force: availability and distribution;
- o Supply chain readiness;
- o Gender-related barriers: any specific issues related to access by women to the health system;
- o Data quality and availability;
- o Demand generation / demand for immunisation services, immunisation schedules, etc;
- o Leadership, management and coordination: such as key bottlenecks associated with the management of the immunisation programme, the performance of the national/ regional EPI teams, management and supervision of immunisation services, or broader sectoral governance issues;
- o Financing issues related to the immunisation programme that impact the ability to increase coverage, including bottlenecks related to planning, budgeting, disbursement and execution of resources;
- o Other critical aspects: any other aspect identified, for example based on the cMYP, EPI review, PIE, EVM or other country plans, or key findings from available independent evaluations reports.

Describe lessons learned and best practices on the effectiveness of implemented activities to improve coverage and equity; recommendations on changes or new interventions that might be required to accelerate progress (include data to support any findings or recommendations).

Federal Republic of Somalia is located in horn of Africa; it is bordered by Ethiopia to the West, Republic of Djibouti to the northwest, the Gulf of Aden to the north, the Guardafui and Indian Ocean to the east and Kenya. Somalia has a longest coastline across the Gulf of Aden and Indian Ocean. It is 44th largest country in the world, having total of 627,337 square kilometers area. Somalia has total estimated population of 13.164 million in 2017 (*2014– PESS), 46.94% are below 15 years.

The Federal 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 but because of federalism system it became 5 administrations which are;

- | | |
|-----------------------------------|---|
| 1. Banadir administration | 1 region (Mogadishu, Capital town of Somalia) |
| 2. South west state | 3 regions (Lower shabele, bay and bakol) |
| 3. Jubbaland state | 3 regions (Lower juba, Middle Jubba and Gedo) |
| 4. Hirshabelle state | 2 regions (lower shabelle and Hiran) |
| 5. Galmudug state | 2 regions (Galgadud and part of Mudug) |
| 6. Puntland semi-autonomous state | 4 regions (Bari, Mudug, Nugal and Karkar) |

The semi-autonomous state of Puntland, Somalia, 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 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 has been increasing steadily over the last few years, however, quality of services remains an issue. Recently the security situation has been deteriorated in Qandala district in the Bari region due to the presence if ISIS and this severely affected the services delivery.

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

The longstanding conflict between Puntland and Somaliland over land in the Sool region recently flared up leading to the displacement of people in Tukaraq area. This has negatively affected service delivery. Galkaio remains a hot spot with the possibility of inter clan conflict between Galkaio North and Galkaio South erupting at any time.

Health work force: availability and distribution:

Table 1: Facility-based Immunization Staff per region from reporting Health facility/EPI centers

Service delivery:

Health service delivery is organized on four levels of service provision and ten health programs.

The levels of service delivery include:

- o Primary health units (health posts and PHC centers)
- o Health centers (MCH centers)
- o Referral health centers (District hospitals)
- o Regional hospitals

The MCHs provide maternal and child health services including immunization and most hospitals provide exclusively curative services, Immunization is not usually given in hospitals where some of deliveries are happened unless the MCH is located inside the hospital.

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 is not standard but MCH/OPDs are staffed with at least 1 qualified nurse and auxiliaries trained for EPI to perform specific jobs like registration, vaccination, or cold chain. Private hospitals involvement in the routine immunization is very limited.

Immunization services are delivered through fixed sites at health facilities, complemented by outreach and mobile activities, depending on fund availability

The challenges underlying the performance of the immunisation system

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 ministry of health has no human and financial capacity to manage fully.

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. There were no planned outreach activities in the districts and most MCHs do not use immunization monitoring charts.

EPI facilities and Partners

Although routine immunization coverage is extremely low again over 180 EPI facilities supported by INGOs and LNGOS are providing routine immunization in South central zone, only Middle Jubba region has no immunization facilities due to in accessibility issues.

Key contextual issues affecting programme performance

1. Armed conflict especially in the South-Central: UN Agencies including UNICEF/WHO rely on NGOs and to some extent, Government Authorities to respond to humanitarian needs of the affected areas.
2. 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.
3. Access to services is poor due to poor road network
4. The population settlements are dispersed and thus increasing the operational costs, as well as the time required to reach every child
5. Inadequate, uneven distribution and mix of skilled health workforce that is characterized by high a turnover.
6. Inadequate community involvement and empowerment led to low demand for services, and thus low utilization of immunization services.
7. Cultural preferences, attitudes and norms also hindered the demand for immunization services.
8. There has been prompt donor positive response to the Natural disasters-drought, floods: The United Nation Systems use the systems like Health cluster respond rapidly to these disasters.

Coverage and equity of immunisation

Somalia is considered one of the 10 countries in the world that have had low and stagnant DTP3/Pentavalent coverage rates (42% WUENIC 2017) and a low and stagnant one dose of measles coverage (46% WUENIC 2017) as shown in below graph.

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

Equity:

Most of the districts are in the <50% coverage category as compared to 2013 and consistently increasing. There is remarkable regional disparity in coverage, only the regions of Awdal and Banadir have a penta 1 and penta 3 coverage < 80% compared to less than 20% in Hiran and Mudug ,Bakool, Hiran, Lower Jubba and Mudug. Penta-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%).

Figure (2): Regional disparity in pentavalent coverage (DHIS, 2016)

An equity assessment conducted in 2017 in the CSR showed that 47% of the areas were accessible, 39% partially accessible and 14% inaccessible. 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.(report attached). There is no sustained strategy to reach the nomads and pastoralists who make up about 25 per cent of the population except during SIAs with specific antigens mainly like Polio, Measles and Vitamin A supplementation. Other reasons which contributed to the failure to achieve all immunization targets include weak District Health Management Teams, absence functional district EPI teams inadequate (in quantity and quality) of supportive supervision. There is an issue of denominator (target setting) in Puntland. This is the reason beyond the objective of sustaining the outreach service for this group 6 months after the campaign implementation and will be highly cost effective for strengthen routine immunization.

Analysis of unimmunized children (infants who have not received Penta 3)

The coverage of Penta 3 is 66 per cent, which means that 34 per cent 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 Sanaag and Sool regions account for over 50 per cent of un immunized children but the population of the two regions is about 15 per cent 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 130,000 children are missed with Penta 3 in urban areas.

Table 2: Number of unimmunized children (Penta 3) in 2017 by region:

Region	Target	Number immunised	Number unimmunised	Unimmunised as % of zonal total
Ayn	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	100%

Somaliland:

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

Table (3): 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%

Supply chain readiness

As per the last EVM conducted March 2017, the country has good storage capacity at all levels; its overall score was 83%, 93% for the national, 90% states, 84% the regional and 81% for the health facilities; which reflects the country readiness for good storage capacity for the vaccine of the campaign as well as for routine immunization.

o 187 health facilities have functioning cold chain system.

- One sub national cold room in Mogadishu
- Two walk in cold room in Baidoa and Mogadishu
- Seven regional cold chain
- 54 district cold chain
- 133 health facility level cold chain

o 18 facility level cold chain have no/difficulty access with road in 09 districts

o 31 facility level cold chain are >50 away from district center

o Five district cold chain requires access through flights

o 158 health facilities are accessible throughout the year.

o At least one staff of 185 health facilities received training on cold chain management

Figure (3): Distribution of cold chain

Data quality and availability

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 visualization facilitating data use at all levels. The DHIS 2 immunization, 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 Q4 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 (RHMS) 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 immunization activities is not yet provided. Coverage data analysis occurs mainly at the Federal level. Monitoring charts at the facility level are seldom found.

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; 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. Gavi will support partially this plan using the performance-based reward linked to Somalia's HSS grant. Implementation is expected to start in 2019

(Attached the reports of the DQS and improvement plan).

Demand generation / demand for immunisation services, immunisation schedules,

At state level, there is dedicated focal person for communication and social mobilization. A communication plan and IEC material exists at central level and some health facilities. Anti-vaccine groups do not exist in majority of areas

The formative research on key behavior and communication barrier towards MCH in Somalia;

was conducted from September 2013 through July 2014. The research covered immunization as one of the MCH components.

The main findings were:

1. Women in all zones appear to be better informed than men on maternal and child health issues.
2. Men have strong opinions on issues relating to vaccination, birth spacing and HIV.
3. Overall, the research indicates a low of awareness on matters of maternal and child health, specifically the need for complete vaccination
4. There are misconceptions and misinformation among mothers and men on vaccination for children and TT injections for mothers during pregnancy.
5. Men have limited information on, and interest in, issues relating to antenatal care, breast-feeding and child illness. However, they have strong influence on issues relating to vaccination for children as well as TT injection for women and birth spacing methods. Breastfeeding is one the only methods of birth spacing which is widely known and encouraged by men.
6. Community leaders and religious leaders have limited influence on mothers, as mothers do not have direct contact with them. But community leaders and religious leaders influence men to a great extent.
7. Men are the main decision-makers in the family. Therefore, community leaders and religious leaders have indirect influence on health decisions relating to women and children
8. Regarding media preference:
 - a. Women receive health information from health care providers. The health care providers are their preferred source of information. Men and community leaders prefer that an educated person (doctor, officials from the health ministry and International agencies) deliver information and education on health issues.
 - b. Both men and women prefer one-to-one interaction and community interaction that allows for clarification.
 - c. Announcements (microphone based publicity) are reportedly the most effective way of gathering a community in one location in the village and delivering information on health issues - especially messages for vaccination.
 - d. Radio is another preferred way of receiving messages. Television has a limited reach, especially in rural and nomadic areas, and is not a preferred source of information.
 - e. Printed and written materials are not a preferred source of information. The diagram below illustrates the educational level among KIs – this might explain the lack of effectiveness of printed and written informational materials.

Based on these findings; Somali C4D strategy on Maternal and child health was developed (attached the survey report and the strategy), Messages for the radio and TV spots have been developed and validated. The messages are currently under production. FMOH will collaborate with the Ministry of Information on the dissemination of these messages (National TV & Radio) which has a wide reach

Demand need to be generated actively as the country showed high dropout rates

Figure (4): Dropout Rates per region and Federal level 2016/2017/2018

Leadership, management and coordination

As per the last EPI review, there is high political commitment from the MoH to the EPI program with strong support from Partners and NGOs and immunization recognized as government responsibility. The structure of the ministry of health is well defined and EPI unit is established. A national agreed upon immunization policy and schedule are in place, but the policy is generic and some important issues not addressed like introduction of new vaccines, as well there is cMYP in place despite it is not supported by operational planning. There is high level oversight bodies and structure for partner coordination, health sector coordination committee (HSCC) & EPI working groups. Non-governmental sector formally involved in EPI service delivery.

Recently coordination mechanism was established in place in the states. Immunization activities are coordinated through quarter meetings of the EPI Working Groups (consisting of MOH, UNICEF, WHO and Partners) that are led by WHO in each zone to review performance and plan for the next quarter, also EPI Taskforce (consisting of MOH, UNICEF and WHO) at the zonal level that meets weekly and discusses operational aspects of EPI, and they meets more frequently in case of emergency or when preparing for SIA.. The ICC was recently launched in the Central-Southern Regions, with participation of the high authorities of the Ministry of Health, and other key Ministries of the Government. These meetings planned to be held on a quarterly basis. Coordination and regular meetings at the regional and district levels almost not exist. However at the regional level ad hoc meetings are usually driven by NGOs requests. This is due to inadequate funds, weak human resource capacity and inadequate infrastructure (as still no functioning district EPI team).

Table (4): National Immunization schedule

Vaccine	Schedule
	birth 6 Week 10 Week 14 Week 9 Month
BCG	✓
OPV	✓ ✓ ✓ ✓
DTP-HepB+Hib	✓ ✓ ✓
IPV	✓
Measles	✓
TT	Pregnant women at health facilities and WCBA during

Financing issues related to the immunisation programme
 Immunization financing is depending on the external donors and UN agencies mainly UNICEF and WHO and GAVI. UNICEF is responsible to all cold chain management and Social mobilization activities while WHO provides technical support including capacity building, development of guidelines and initiative of polio eradication campaigns.

2.4 Country documents

2.4.1 Upload country documents

Please provide **country documents** that are relevant for the national immunisation programme and for multiple vaccines, to be taken into account in the review of your application. If you have already provided one or more of these country documents, you do not need to upload it/them again unless the document version changed. If documents cannot be provided, please use the comment functionality to explain why, or by when they will be available.

Note that only general country documents are uploaded here; at the end of section 3 (sub-section “Upload new application documents”) you will be required to provide those documents that are specific to the support requested (for example the new vaccine introduction plan and/or campaign plan of action, new budget, application endorsements etc.)

Country and planning documents

- ✓

Country strategic multi-year plan

Comprehensive Multi-Year Plan for Immunisation (cMYP) or equivalent country strategic plan

[National CMYP Somalia Final 10-09-18 10.48.57.pdf](#)
- ✓

Country strategic multi-year plan / cMYP costing tool

[Copy of SLD_ 11-09-18 11.24.32.xlsx](#)

[PUN_ 11-09-18 11.22.54.xlsx](#)

[SCL_ 11-09-18 11.22.29.xlsx](#)

[Copy of CMYPCOMBO_ 11-09-18 11.20.40.xlsx](#)
- ✓

Effective Vaccine Management (EVM) assessment

[SomaliaEVMAFinal Report20170406 10-09-18 10.49.46.pdf](#)
- ✓

Effective Vaccine Management (EVM): most recent improvement plan progress report

[Somalia EVMA Comprehensive Improvement PlanFinal 20170406 11-09-18 11.25.18.pdf](#)
- ✓

Data quality and survey documents: Final report from most recent survey containing immunisation coverage indicators

[MICS4 Puntland Final report Draft4 for review October2013 11-09-18 11.27.35.docx](#)
- ✓

Data quality and survey documents: Immunisation data quality improvement plan

[Data Improvement PlanSomalia_ 11-09-18 11.28.20.docx](#)

- ✓ **Data quality and survey documents: Report from most recent desk review of immunisation data quality** [Somalia DQS final report 2016_ 11-09-18_ 11.29.43.pdf](#)
- ✓ **Data quality and survey documents: Report from most recent in-depth data quality evaluation including immunisation** [Comprehensive EPI reviewSomalia2017_ 11-09-18_ 11.30.40.pdf](#)
- ✓ **Human Resources pay scale**
 If support to the payment of salaries, salary top ups, incentives and other allowances is requested [003 Somalia Health Staff Remuneration Study REVISED_ 11-10-18_ 20.03.06.pdf](#)

Coordination and advisory groups documents

- ✓ **National Coordination Forum Terms of Reference** [ICCs Terms of Reference Somalia_ 12-09-18_ 10.47.12.pdf](#)
 ICC, HSCC or equivalent
- ✓ **National Coordination Forum meeting minutes of the past 12 months** [ICC Meeting Minutes Somalia 09 September 2018_ 11-09-18_ 11.37.49.pdf](#)

Other documents

- ✓ **Other documents (optional)**
 Please also provide other country documents to support the review of the applications, for example Health Facility [Measles Outbreak Response Plan Somalia Sep2018_ 12-09-18_ 15.23.30.pdf](#)
[Somalia MNCH KAPcompressed_ 11-09-18_ 11.39.44.pdf](#)

Assessment Reports, Knowledge-Attitude-Practice surveys or other demand-related surveys, if available.

3 Measles follow-up campaign

3.1 Vaccine and programmatic data

3.1.1 Choice of presentation and dates

For each type of support please specify start and end date, and preferred presentations.

Note 3

Measles follow-up campaign

Preferred presentation	M, 10 doses/vial, lyo
Is the presentation licensed or registered?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
2nd preferred presentation	
Is the presentation licensed or registered?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Required date for vaccine and supplies to arrive	1 July 2019
Planned launch date	1 September 2019
Support requested until	2019

3.1.2 Vaccine presentation registration or licensing

If any of the selected presentations are not yet licensed or registered, please describe the duration of the registration or licensing procedure, whether the country's regulations allow the expedited procedure for national registration of WHO-pre-qualified vaccines, and confirm whether the licensing procedure will be completed ahead of the introduction or campaign.

Since the vaccine is WHO-pre-qualified vaccines and procured by UNICEF , this a guarantee to be used in the country as the national regularity system is not established

3.1.3 Vaccine procurement

Gavi expects that most countries will procure vaccine and injection supplies through UNICEF or PAHO's Revolving Fund. Does the country request an alternative mechanism for procurement and delivery of vaccine supply (financed by the country or Gavi)?

Yes

No

If you have answered yes, please attach the following in the document upload section:* A description of the mechanism, and the vaccines or commodities to be procured by the country through this mechanism.* A confirmation that vaccines will be procured from the WHO list of pre-qualified vaccines, indicating the specific vaccine from the list of pre-qualification. OR, for the procurement of locally-produced vaccines directly from a manufacturer which may not have been prequalified by WHO, a confirmation should be provided that the vaccines purchased comply with WHO's definition of quality vaccines, for which there are no unresolved quality problems reported to WHO, and for which compliance is assured by a fully functional National Regulatory Authority (NRA), as assessed by WHO in the countries where they are manufactured and where they are purchased.

3.2 Target Information

3.2.1 Targets for campaign vaccination

Please describe the target age cohort for the measles follow-up campaign:

Note 4

From	6	weeks <input type="checkbox"/>	months <input checked="" type="checkbox"/>	years <input type="checkbox"/>
To	10	weeks <input type="checkbox"/>	months <input type="checkbox"/>	years <input checked="" type="checkbox"/>

	2019
Population in target age cohort (#)	5,980,401
Target population to be vaccinated (first dose) (#)	5,681,381
Estimated wastage rates for preferred presentation (%)	10

3.2.2 Targets for measles routine first dose (M1)

To be eligible for measles and rubella vaccine support, **countries must be fully financing with domestic resources the measles mono-valent vaccine component of MCV1** which is

already in their national immunisation schedule, or have firm written commitments to do so. Please provide information on the targets and total number of doses procured for measles first dose.

	2019
Population in the target age cohort (#)	517,377
Target population to be vaccinated (first dose) (#)	410,183
Number of doses procured	615,275

3.3 Co-financing information

3.3.1 Vaccine and commodities prices

Price per dose (US\$) - Measles follow-up campaign

	2019
10 doses/vial,lyo	0.32

Commodities Price (US\$) - Measles follow-up campaign (applies only to preferred presentation)

	2019
AD syringes	0.04
Reconstitution syringes	0.04
Safety boxes	0.47
Freight cost as a % of device value	0.02

3.3.2 Country choice of co-financing amount per vaccine dose

The table below shows the estimated financial commitment for the procurement of vaccines and supplies for the country, and the portion of Gavi support

Note 5

	2019
Country co-financing share per dose (%)	
Minimum Country co-financing per dose (US\$)	

Country co-financing per dose (enter an amount equal or above minimum)(US\$)	0.01
--	------

3.3.3 Estimated values to be financed by the country and Gavi for the procurement of supply

Measles follow-up campaign

	2019
Vaccine doses financed by Gavi (#)	6,125,300
Vaccine doses co-financed by Country (#)	181,100
AD syringes financed by Gavi (#)	6,249,600
AD syringes co-financed by Country (#)	
Reconstitution syringes financed by Gavi (#)	693,700
Reconstitution syringes co-financed by Country (#)	
Safety boxes financed by Gavi (#)	76,400
Safety boxes co-financed by Country (#)	
Freight charges financed by Gavi (\$)	213,648
Freight charges co-financed by Country (\$)	6,317

2019

Total value to be co-financed (US\$) Country	63,500
Total value to be financed (US\$) Gavi	2,452,500
Total value to be financed (US\$)	2,516,000

3.3.4 Estimated projection of the required domestic financing for the measles monovalent component of MCV1

Countries are required to domestically finance the first dose in their measles containing vaccine routine (MCV1) in order to be able to receive Gavi support for any measles/ measles-rubella programmes. Below is the estimated projection of the required domestic financing for MCV1, based on the information provided in the previous sections.

Note 6

	2019
Minimum number of doses financed from domestic resources	615,275
Country domestic funding (minimum)	188,275

3.3.5 Co-financing payment

Please indicate the process for ensuring that the co-financing payments are made in a timely manner.

Somalia under fragility marker should be considered for waiver from co-financing contributions

If your country is in the accelerated transition phase for Gavi support, please answer the following question:

Please provide evidence that the co-financing obligations for the new introduction have been budgeted for, and elaborate on how the country plans to pay for the fully self-financing amounts. Please discuss the extent to which medium-term immunisation/health plans and medium-term expenditure frameworks incorporate the additional costs associated with this introduction. Discuss any co-financing defaults that may have happened in the last five years.

No co-financing defaults in the last five year from FMOH

Following the regulations of the internal budgeting and financing cycles the Government will annually release its portion of the co-financing funds in the month of:

July

The payment for the first year of co-financed support will be made in the month of:

Month

July

Year

2020

3.4 Financial support from Gavi

3.4.1 Campaign operational costs support grant(s)

Measles follow-up campaign

Population in the target age cohort (#)

Note 7

5,980,401

Gavi contribution per person in the target age cohort (US\$)

0.65

Total in (US\$)

3,887,260.65

Funding needed in country by

30 June 2019

3.4.2 Operational budget

Please complete the Gavi budgeting and planning template to document how the Campaign Operational Costs support grant will be used to facilitate the timely and effective implementation of critical activities in advance of and during the campaign. Please ensure to upload the completed budgeting and planning template as part of this application.

If Gavi's support is not enough to cover the full needs please indicate how much and who will be

complementing the funds needed in the Operational Budget template. In the following fields please provide an overview of your request.

Total amount - Gov. Funding / Country Co-financing (US\$)

0

Total amount - Other donors (US\$)

0

Total amount - Gavi support (US\$)

8,627,489

Amount per target person - Gov. Funding / Country Co-financing (US\$)

0

Amount per target person - Other donors (US\$)

0

Amount per target person - Gavi support (US\$)

1.52

3.4.3 Financial management procedures

Please describe the financial management procedures that will be applied for the management of the NVS direct financial support, including any procurement to be incurred.

UNICEF uses its own procurement procedures to procure vaccines from WHO-approved suppliers. This is based on a procurement request that is initiated by the particular Country Office.

UNICEF uses the Harmonized Approach to Cash Transfer (HACT) approach to disburse funds to implementing partners. This is the common approach agreed on by the UNDG ExCom agencies in Somalia (UNICEF, UNFPA, UNDP and WFP). Funds are disbursed for activities on a quarterly basis based on the agreed work plan signed between UNICEF and the relevant Ministries of Health. NGO implementing partners receive disbursements in a similar manner upon submission of a simplified FACE form (Financial Authorization and Cost Estimate Form).

Disbursed funds are expected to be liquidated within three months with maximum allowable time of six months failing which, no further disbursements can be made to that implementing partner.

WHO uses GSM (Global service Mechanism system) for fund management and monitoring through GSC (Global Service center). Grants allocated to WHO by Donors are received by HQ and released to country through Regional office which activates the award for implementation and joint review on budgeted work plan which is approved by technical and financial unit in alignment to Donor agreement. The activities are outlined in the approved work plan prior to receiving the funds and is developed in accordance with WHO guidance on proposals. Each activity has a predefined expenditure types. For activities that are implemented directly by the government like Field work, supervisory visits, training and surveys funds are transferred to MOH official account as Direct financial cost (DFC). Similar activities (training, field work and surveys) that are implemented directly by WHO technical staff in collaboration with MOH are spent as Direct implementation (DI). WHO supports other activities like procurement of goods (medical supplies and equipment) and services (fellowships, APWs, general expenses, etc.), travel cost, ...etc. The expenses of each activity is uploaded and settled in the GSM separately. Technical unit in country and Regional office reviewed and cleared the activity technically. Each activity required Justification forms, Budget breakdown and concept notes to be uploaded in the system which leads to signed system generated contract between WHO and implementing party. Technical and financial reports are cleared by Senior management for final uploading in the system. Liquidation process requires uploading of FACE report and technical report in GSM system within 3 months with maximum time of six months after end of agreed activity date. There are spots checks by finance team to ensure accountability and quality assurance.

3.4.4 Financial management procedures

Please describe the financial management procedures that will be applied for the management of the NVS direct financial support, including any procurement to be incurred.

Repeated Above

3.4.5 Fiduciary management

Please indicate whether funds for operational costs should be transferred to the government or WHO and/or UNICEF and when funding is expected to be needed in country. Attach banking form if funding should be transferred to the government. Please note that UNICEF and WHO will require administrative fees as follows.

- o **UNICEF Tripartite Agreement: 5%**
- o **UNICEF Bilateral Agreement: 8%**
- o **WHO Bilateral Agreement: 7%.**

Due to the absence of authorized and recognized banking system in Somalia. Donor channel their fund through WHO and UNICEF who will implement according to their mandate, this also ensure accountability, monitoring of fund utilisation and timely reporting

3.4.6 Use of financial support to fund additional Technical Assistance needs

Gavi funds through its Partner Engagement Framework / TCA, tailored and differentiated technical assistance in response to specific country needs. Please review the currently approved technical assistance plan (also referred to as the “One TA plan”) with a view to assess that required support for the implementation of the new vaccine support is contained in the approved technical assistance plan. If gaps in technical assistance are identified for the new vaccine support, the additionally required technical assistance may be funded through the vaccine introduction grant or campaign operational costs support. In this case, the relevant costs must be reflected in the budgeting and planning template. In addition, please indicate the programmatic areas for additional technical assistance needs and the respective agencies providing the technical assistance (if already identified) below.

Note 8

To ensure high quality campaign UNICEF and WHO proposes the following Technical Assistance needs;

- 1 international consultant for 6 months to develop high quality district and sub district micro plans for the measles campaign special focus on;(health centre level micro-planning, identification of high risk areas, mapping, logistics planning, injection safety, waste management and monitoring response to adverse events following immunization (AEFI), strengthen routine immunization ,monitoring high quality implementation of the campaign , campaign data management, social mobilization) and writing the final campaign report
- 3 nationals for (one Somaliland, one Puntland and federal states) to support preparation and of the campaign, data management, cold chain management and insure implementation of high quality campaign.

3.5 Strategic considerations

3.5.1 Rationale for this request

Describe the rationale for requesting these new programme(s), including the burden of disease. If already included in detail in the Campaign Plan of Action, please cite the sections only.

Measles is highly endemic in Somalia and Somaliland. 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 (Figure6).

Figure (5): Reported measles cases Somalia 2000 – 2018 (data from JRF and 2018 surveillance reports)

In 2017 Somalia reported 23,394 fever and rash cases, compared to 5521 cases in 2016, and 5598 cases in 2015 (Figure 6) . The weekly number of reported cases has shown an increasing number from the yearly number for 2015 as the Fever and rash surveillance system was very weak.

With the low and stagnant MCV1 coverage over the past years as (46%), and accumulation of

susceptible measles will continue to spread and the outbreak will not be halt. In Somalia and Somaliland, measles is mainly a disease of younger children under 5 years of age, however, a significant proportion of cases occur among children between the age of 5 and 10 years of age.

This why Somalia need to reach all these children by good quality measles campaign and must be repeated every two to three years till the routine coverage reach 95% and the MCV2 introduced to save the children life. Additionally; this campaign will also distribute vitA preventive doses. Distribution of vitamin A therapeutic dose during the campaign will reduce measles complications and reduce death especially in areas where there is no proper case management.

Figure (6): Number of reported fever and rash cases by week in Somalia/Somaliland 2015-W13 2018

3.5.2 Alignment with country strategic multi-year plan / comprehensive multi-year plan (cMYP)

Please describe how the plans and key assumptions in this request align with the most recent country strategic multi-year plan (cMYP) and other national health and immunisation plans.

This campaign is align with the cMYP for 2016-2020, it is already planned and budgeted for under five years, but because of the epidemiology of the disease and the age distribution it is highly recommended to cover children aged 6 moth to under 10 years

3.5.3 Coordination Forum (ICC, HSCC or equivalent) and technical advisory committee (NITAG)

Provide a description of the roles of the national Coordination Forum (ICC, HSCC or equivalent body) and national immunization technical advisory group (NITAG) in developing this request.

If any of Gavi's requirements to ensure basic functionality of the relevant national Coordination Forum (ICC, HSCC or equivalent) were not met, please describe the reasons and the approach to address this. Requirements can be found in the general application guidelines.

In the absence of a NITAG, countries should clarify the role and functioning of the advisory group and describe plans to establish a NITAG.

Somalia don't have NITAG as the required qualifications and capacities among nationals are very limited, instead WHO and UNICEF and other technical partners are the advisory bodies for the country. The ICC in the Federal Government of Somalia was launched on 26th July 2018. During the last Joint Appraisal, it was recommended that Puntland and Somaliland would also launch their respective ICC, and decide on the membership, depending on the uniqueness of each administrative unit. The ICC in Mogadishu will meet in each quarter to deliberate on the implementation of the GAVI HSS 2 in the 3 target regions. WHO and UNICEF offer technical support to the respective MoH in the planning and implementation of the ICC. A workshop to validate a Measles Strategic Plan for Somalia was held in May 2018. This

workshop brought together decision-makers of the respective MoH, and it recommended the introduction of 2nd dose of MCV.

3.5.4 Financial sustainability

Please discuss the financing-related implications of the new vaccine programs requested, particularly how the government intends to fund the additional co-financing obligations. Please mention if any defaults occurred in the last three years and, if so, describe any mitigation measures that have been implemented to avoid future defaults. Additionally has the country taken into account future transition from Gavi support?

Financial sustainability of the immunization programme is the primary responsibility of the Ministries of Health and the National Health Policy 2014 recognizes that 'this developmental health process envisages the scaling up of government leadership, management and service delivery capacity, while sustaining health partners' support, thus averting the transitional funding gap, often encountered during the post-conflict period, when the health system is transiting to recovery, institutional building and development'.

Given the weak economic situation, depth of poverty levels and limited ability to collect taxes, the Government will not be able to finance a reasonable level of health services within the next 10 years. In the long-term, the prospects would ease in view of the growing economy and presuming security and stability., the reality is that Somalia's immunization programme continues to be heavily reliant on external funding through direct financing of EPI, and indirect financing of immunization as part of the EPHS. This situation is well captured in the CMYP. Therefore, financial sustainability remains a critical question in Somalia, now and in the near-future.

3.5.5 Programmatic challenges

Summarise programmatic challenges that need to be addressed to successfully implement the requested vaccine support, and describe plans for addressing those. These may include plans to address the barriers identified in the coverage and equity situation analysis section, and include vaccine supply chain, demand generation/ community mobilisation, data quality/ availability/ use and leadership, management and coordination, etc.

All the programmatic challenges will be will addressed during the planning and implementation process, the microplanning will start early and detailed plans will be developed with clear division of tasks and timelines, this will be monitored by the readiness tool , example there will be especial plans for the IDPs and for the nomads. Technical support will be availed by WHO through recruitment of two consultants to support the country in the whole process starting from the microplanning step, then external auditors will work during the campaign implementation to ensure quality implementation and reaching the target coverage

3.5.6 Improving coverage and equity of routine immunisation

Explain how the proposed NVS support will be used to improve the coverage and equity of routine immunisation, by detailing the proposed activities and budget will contribute to overcoming key barriers.

Somalia will use the measles follow up campaign as an opportunity to strengthen the routine immunization services and other child health programmes, this will be considered during all the process of the campaign. Specific activities to strengthen RI will be carried out before, during and after the completion of the SIA. All activities will be identified and agreed upon to be included in the campaign plan, based on Somalia's RI assessment. (attached detailed plan on how to use the campaign to strengthen the routine coverage and equity)

3.5.7 Synergies

Describe potential synergies across planned introductions or campaigns. If relevant, comment on capacity and appropriate systems to introduce multiple vaccines in a year. Also describe how the country will mitigate any programmatic and financial risks associated with multiple introductions.

Note 9

The country will implement the follow up campaign in 2019 and will prepare for introduction of MCV second dose in 2019-2020, this will be requested in a separately and with good preparation to avoid any risk of having both in the same year, the follow up campaign will be used as an opportunity to prepare for introduction of the MCV second dose in term of revision of the targets, the cold chain capacity, community awareness and implementation strategies

3.5.8 Indicative major measles and rubella activities planned for the next 5 years

Summarise in one paragraph the indicative major measles and rubella activities planned for the next five years that are reflected in the annual EPI plan (e.g. measles second dose introduction, measles or measles-rubella follow up campaign, etc.).

1. Achieving high population-based immunity and disease incidence for measles and rubella
 - o By 2023 achieve MCV1 coverage > 85% at the national level.
 - o Implement high quality measles SIAs (>95% coverage) in 2019
 - o Introduce 2nd dose measles in 2019-2020.
 - o Achieve MCV2 coverage > 65% by 2023
 - o Introduction of MR vaccine by 2023.
 - o Reduction in measles incidence to < 5 per million by 2023
2. Outbreak preparedness and response
 - o Develop and implement outbreak readiness and response plan by the end of 2019
 - o More than 90% of outbreaks are detected and responded to within 8 weeks from the date of onset of index case by 2022
 - o By 2020, build capacity on measles case management in all regional hospital
 - o By 2019, ensure measles outbreak detection and response is included into the country emergency and preparedness response plan
 - o By 2022, identify measles genotypes in 80% of measles chains of transmission

3. Surveillance

- o Expand measles rubella case -based surveillance to all regions by the end of 2019
- o Expand measles/rubella case-based surveillance nationwide by the end of 2022.
- o Conduct nested surveillance for measles mortality by 2022.
- o Establish CRS surveillance by 2022

4. Advocacy and communication

- o Reduce Penta1/MCV1 drop-out rates in each zone by 50% by 2020 compared to 2017
- o Update and implement integrated communication strategy for measles/ rubella and EPI by the end of 2023
- o Prepare plan and support implementation of “immunization week” with focus on measles vaccination in high risk communities each year from 2019 through 2023
(Attached is the Five Year Plan for Measles and Rubella in Somalia, 2019-23)

3.6 Report on Grant Performance Framework

3.6.1 Grant Performance Framework – Application Instructions

The Grant Performance Framework (GPF) contains all indicators that will be used to monitor programmatic performance for your requested type of support. Targets that were entered for number to be vaccinated in section 3 on the Target Information tab, have been carried over into their respective indicators in the GPF. Based on these numbers, coverage and dropout rate targets were calculated (where applicable). These appear as “calculated targets”. If you wish to revise these target values, please revise in the application form – they are not editable in the performance framework. In addition, as a part of your application, there are several items to be filled directly into the GPF. These are broken into required and optional items, below:

Required

1. In addition to the calculated targets, country targets are required to be submitted for outcome indicators. These targets should align to those in your cMYP or NHSP. If these targets are not in your cMYP or NHSP, or are the same as the calculated targets, please enter “NA” for each target value.
2. Additional indicators that appear in the Performance Framework that are not included in the application form. Please enter targets for these indicators.
3. For many indicators, reporting dates have been pre-populated. For those that have not yet been pre-populated, please add reporting dates.

Optional

1. Adding data sources to existing indicators: If there are data sources for indicators that you would like to include, you may add an additional source by clicking on the pencil icon next to the indicator name.
2. Adding new indicators: Gavi requires all countries to report on core indicators, which are already included in the GPF. If you wish to add supplemental indicators to monitor performance, you may do so by clicking the “Add indicator” button at the respective performance level (Outcome, Intermediate Result, or Process).

Please note that the GPF is filtered by default to only show indicators that are relevant to the specific types of support contained in the application. You may view the entire GPF by using the “Grant Status” filter. Please ensure your pop-up blocker is disabled when launching the GPF.

If you have any questions, please send an email to countryportal@gavi.org.


3.7 Upload new application documents



3.7.1 Upload new application documents

Below is the list of **application specific documents** that must be provided with your application.

In the case a document cannot be provided, please use the comment box to explain why, or by when it will be available.


Application documents


-  **New vaccine introduction plan (NVIP) and/or campaign plan of action (PoA), including checklist & activity list and timeline** [Somalia measles plan of Action_12-09-18_12.22.35.pdf](#)

If support for a campaign and routine introduction is requested at the same time, the new vaccine introduction plan and campaign plan of action can be combined into one document to minimise duplication.
-  **Gavi budgeting and planning template** [Budgeting and Planning Template Somalia final_12-09-18_17.13.34.xlsm](#)
-  **Most recent assessment of burden of relevant disease** [Somalia measles plan of Action_12-09-18_17.35.27.pdf](#)

If not already included in detail in the Introduction Plan or Plan of Action.
- Campaign target population (if applicable)** **No file uploaded**


Endorsement by coordination and advisory groups


-  **National coordination forum meeting minutes, with endorsement of application, and including signatures** [ICC Meeting Minutes Somalia 09 September 2018_12-09-18_13.07.06.pdf](#)

The minutes of the national coordination forum meeting should mention the domestic funding of MCV1
-  **NITAG meeting minutes** [ICC Meeting Minutes Somalia 09 September 2018_12-09-18_17.14.17.pdf](#)

with specific recommendations on the NVS introduction or campaign

Vaccine specific

-  **cMYP addendum** [Measles Strategy 5 yr plan for Somalia Final Sep 2018_12-09-18_15.00.47.pdf](#)

Situation analysis and 5 year plan captured in the cMYP or as an addendum to the cMYP
-  **Annual EPI plan** [Fin2018 EPIPolio work plan_12-09-18_14.39.19.xlsx](#)

Annual EPI plan detailing planning of all measles and rubella-related activities for the current year, including realistic timelines, designated responsible individual(s) and a budget
- MCV1 self-financing commitment letter** **No file uploaded**

If the country is not yet financing the measles monovalent component of MCV1, a letter signed by the Minister of Health and Minister of Finance committing for the country to self-finance MCV1 from 2018 onwards.

- ✓ **Measles (and rubella) strategic plan for elimination** [Measles Strategy 5 yr plan for Somalia Final Sep 2018_12-09-18_13.10.57.pdf](#)

If available

- ✓ **Other documents (optional)** [ImmuEquityAssessmentFinalRep_12-09-18_13.11.39.pdf](#)

4 Review and submit application

4.1 Submission Details

Country vaccine funding summary

Please review the estimated projections for new vaccine programmes included in this application.

Active Vaccine Programmes

Note 10

IPV Routine

	2018	2019	2020	2021	2022
Country Co-financing (US\$)					
Gavi support (US\$)	763,000	899,386	944,355	977,580	1,011,316

Measles-rubella follow-up campaign

	2018	2019
Country Co-financing (US\$)		
Gavi support (US\$)		

Pentavalent Routine

	2018	2019	2020	2021	2022
--	------	------	------	------	------

Country Co-financing (US\$)	289,638	357,776	375,693	364,625	376,919
Gavi support (US\$)	848,500	925,500	971,500	924,058	955,215

Total Active Vaccine Programmes

	2018	2019	2020	2021	2022
Total country co-financing (US\$)	289,638	357,776	375,693	364,625	376,919
Total Gavi support (US\$)	1,611,500	1,824,886	1,915,855	1,901,638	1,966,531
Total value (US\$) (Gavi + Country co-financing)	1,901,138	2,182,662	2,291,548	2,266,263	2,343,450

New Vaccine Programme Support Requested

Measles follow-up campaign

	2019	2020
Country Co-financing (US\$)	63,500	500
Gavi support (US\$)	2,452,500	500

	2019	2020
Total country co-financing (US\$)	63,500	500
Total Gavi support (US\$)	2,452,500	500
Total value (US\$) (Gavi + Country co-financing)	2,516,000	1,000

Total Portfolio Overview – Existing Programs + New Vaccine Support Requested (US\$)

	2018	2019	2020	2021	2022
Total country co-financing (US\$)	289,638	421,276	376,193	364,625	376,919

Total Gavi support (US\$)	1,611,500	4,277,386	1,916,355	1,901,638	1,966,531
Total value (US\$) (Gavi + Country co-financing)	1,901,138	4,698,662	2,292,548	2,266,263	2,343,450

Contacts

Person(s) who should be contacted in case Gavi needs to ask for more information in regard to the application.

Name	Position	Phone Number	Email	Organisation
Dr Osman Abdi	National EPI Manager,	+252615353783	osman.a2004@yahoo.com	
UMAR, Al-umra	Health System Strengthening –EPI Medical officer	+254205121597	aumar@who.int	
Chantal Umutoni	Chief, Health	+254 728 601 202	cumutoni@unicef.org	

Comments

Please let us know if you have any comments about this application

we are waiting for the signature of the minister of health tomorrow, also the budget still under revision will be sent soon to be substituted by the one uploaded here, the application document failed to be downloaded it give me an error , it was sent to proposals@gavi.org, Rachel and Rehan by email

Government signature form

The Government of Somalia would like to expand the existing partnership with Gavi for the improvement of the immunisation programme of the country, and specifically hereby requests Gavi support for:

Measles follow-up campaign

The Government of Somalia commits itself to developing national immunisation services on a sustainable basis in accordance with the national health and immunisation strategic plans. The Government requests that Gavi and its partners contribute financial and technical assistance to support immunisation of children as outlined in this application.

The co-financing commitments in this application include the amount of support in either supplies or cash that is requested from Gavi, and the financial commitment of the Government for the procurement of this new vaccine.

Please note that Gavi will not review this application without the signatures of both the Minister of Health and Minister of Finance (and Minister of Education, if applicable) or their delegated authority.

We, the undersigned, affirm that the objectives and activities in this request are fully aligned with the national health and immunisation strategic plans (or equivalent), and that funds for implementing all activities, including domestic funds and any needed vaccine co-financing will be included in the annual budget of the Ministry of Health.

We, the undersigned, further affirm that the requested funding for salaries, salary top-ups/allowances, per diems and incentives does not duplicate funding from other sources (e.g. from other donors).

We, the undersigned, further affirm that the terms and conditions of the Partnership Framework Agreement between Gavi and the Country remain in full effect and shall apply to any and all Gavi support made pursuant to this application.¹

Minister of Health (or delegated authority)

Name

Date

Signature

Minister of Finance (or delegated authority)

Name

Date

Signature

For countries requesting HPV support, with a school linked strategy, the signature of the Minister of Education (or delegated authority) is also required.

Minister of Education (or delegated authority)

Name

Date

Signature

¹ In the event the Country has not yet executed a Partnership Framework Agreement, the terms and conditions of this application shall apply to any and all Gavi support made pursuant to this application.

Appendix

NOTE 1

The new cMYP must be uploaded in the country document section.

NOTE 2

The purpose of these estimates is to provide visibility into the current and future vaccine funding requirements. The values reflected here are a combination of actuals and estimates.

Specifically, current year values reflect values approved by the secretariat, while future values are based on data provided by the country – when data isn't available we rely on extrapolations to estimate funding needs. Please note that any future values might be subject to change, and for the official obligations a country should refer to its active Decision Letter.

NOTE 3

* For more information on the vaccine presentations available, please refer to the detailed product profiles available here: <http://www.gavi.org/about/market-shaping/detailed-product-profiles/>

* Please note Gavi may not be in a position to accommodate all countries first product preferences. In such cases, Gavi will contact the country and partners to explore options.

* Due to a variety of factors, the launch date may vary compared to the date stipulated in the application. Gavi will work closely with countries and their partners to address these issues.

* For routine vaccine introduction, support is usually requested until the end of the country's valid cMYP, as per the guidelines and may be extended in the future. If you wish to request Gavi support for a shorter time period than the end of your cMYP you may do so.

* For campaigns the "support requested until" field will normally be one calendar year from the launch date, but can be extended for a phased campaign.

NOTE 4

* The population in the target age cohort represents 100% of people in the specified age range in your country.

* The target population to be vaccinated is the number of people in the cohort that are expected to be vaccinated.

* For indicative wastage rates, please refer to the detailed product profiles available here: <http://www.gavi.org/about/market-shaping/detailed-product-profiles/>

* The wastage rate applies to first and last dose.

NOTE 5

Co-financing requirements are specified in the guidelines.

NOTE 6

*The price used to calculate costs is based on UNICEF-single dose per vaccine procurement cost for measles monovalent vaccine.** This value will differ from the total cost if the vaccine selection is MR, as a country is only required to finance the cost of the measles monovalent vaccine.

NOTE 7

Note: The population in the target age cohort used here is the number you entered for year one in the target information section.

NOTE 8

A list of potential technical assistance activities in each programmatic area is available here: <http://www.gavi.org/support/pef/targeted-country-assistance/>

NOTE 9

E.g. if two introductions are planned in the same year, there should be synergies at least in training and social mobilisation events.

NOTE 10

The purpose of these estimates is to provide visibility into the current and future vaccine funding requirements. The values reflected here are a combination of actuals and estimates.

Specifically, current year values reflect values approved by the secretariat, while future values are based on data provided by the country – when data isn't available we rely on extrapolations to estimate funding needs. Please note that any future values might be subject to change, and for the official obligations a country should refer to its active Decision Letter.